

COMPARISON OF TREATMENT FOR HIGH RISK PROSTATE CANCER

By: Gil Lederman, M.D.

Deciding on the best treatment for prostate cancer is a daily phenomenon. It's the rule rather than the exception. There are a variety of treatment options available for men with prostate cancer. Often much confusion exists about these different possibilities. I just returned from lectures in Japan and meetings with previously treated patients and families. To hear of their earlier plights and attempts to gain information is educational and motivating. The results often are dramatically varied.

Personally I believe that men and their families should make decisions based upon data. Personalities of different physicians and institutions obviously are interesting but don't change the outcome. It's the facts, mister. One might choose a physician that is very likable yet unfortunately has an approach that is unlikely to have a good treatment outcome. What are the results for high-risk prostate cancer?

At the American Society for Therapeutic Radiology and Oncology National Meeting in Boston this week, I had a chance to present our group's high-risk data to an auditorium of thousands. The seminar included major figures in the field of radiation oncology, urology and medical oncology concerned with the treatment of prostate cancer.

Discussed at this seminar was a patient with a Gleason 8 prostate cancer. Gleason was a pathologist who tried to define the aggressiveness of a cancer based upon its appearance under the microscope. Each of two dominant areas would be graded from one to five with one being the best and five being the worst. These two numbers were then added to come up with a Gleason score. After extensive deliberation among the panelists I presented our results.

I compared our treatment results to other major institutions and figures in the urologic world using methods of treatment including radical prostatectomy, seeds alone, standard radiation and conformal radiation. We publish and distribute this data in a booklet for those inquiring about treatment options. Currently our database is comprised of nearly 2000 men treated with prostate seeds plus radiation now starting its 14th year. I personally have placed about 200,000 seeds into the prostate. The beauty of our program, in addition to the results, is that essentially every man receives the same dose of radiation on the same schedule. It makes interpretation of results easy. Translating this data to any prospective patient is a crucial point of our informed consent process.

The results using seed plus radiation have had a superior outcome compared to radical prostatectomy, conformal radiation, seeds alone or proton beam. This means more men are cancer-free. Our results are even better than other institutions using the same seed plus radiation approach. We believe the difference is experience and treatment techniques - including intra-operative fluoroscopy, ultrasound, dosimetry and use of full seed dose and radiation. Many centers have cut the seed dose - meaning a lesser dose of radiation. This means a smaller chance of being cancer-free. Yet is the man aware of this? With our group, computers are even brought into the operating room to monitor seed placement and dose.

Nevertheless, at the end of my remarks there was a major figure from San Francisco who got up to say that his results were better. Based upon that unsubstantiated comment, I looked to compare our data head-to-head.

Our data was recently published in a journal entitled "International Journal of Radiation, Oncology, Biology, Physics," which is the major radiation journal. Their data as well was published in the same journal earlier this year with the lead author Fiveash, et al.

Comparing the Gleason 8, 9 and 10 patients I found several remarkable features. The first included our follow-up of patients on average is forty-five months compared to their follow-up of thirty-six months. Thus there is a longer follow-up - which gives strength to our case. Every researcher would confirm the importance of longer follow-up.

Furthermore 22% of our patients are evaluated at five years compared to only 7% of their patients. The greater proportion of patients followed longer gives greater importance to our data. More follow-up and longer follow-up enhance our program's importance.

What is most critical is the likelihood of being free of cancer at five years. In their hands, this rate is 62.5%. For this same group of patients treated with seeds and body radiosurgery, the results are 76%.

In the overall survival or likelihood of being alive five years after treatment, 67% of their patients have met that criteria compared to 77% of our patients. Thus, our patients are living longer than their patients and more are cancer-free. Perhaps our ability to treat patients produces many benefits from our technology.

The other authors quoted various series using radical prostatectomy for Gleason 8, 9 and 10 patients. With radical prostatectomy, they quoted surgical five-year disease free rates of 28% to 46%.

On average our patients have twice the likelihood of being alive and free of cancer five years later using seeds and radiation compared to those undergoing radical prostatectomy. Our comparison data to Walsh's series of radical prostatectomy patients shows similarly favorable results when treated with seeds plus radiation or radiosurgery by us.

This data is important for men with prostate cancer. Obviously men with adverse prognostic indicators such as elevated prostatic specific antigen (PSA) or high Gleason scores are likely to derive the greatest benefit from this knowledge but in fact other risk groups also can learn the language and techniques of evaluation of prostate cancer treatment.

I believe that all men with prostate cancer and their families can learn from this knowledge. Treatment decisions should be based upon the likelihood of being free of cancer as well as quality of life issues such as maintaining urinary continence and sexual function as well as avoiding radical prostatectomy.

Frequently, when seeing men in consultation, I state that most men choose treatment based upon the ability to avoid radical prostatectomy and its associated convalescence, having a greater likelihood of being free of cancer while maintaining sexual and urinary function in the vast majority. The final choice is the patient's, not the doctor's. We are here to serve.

There is a revolution going on in the treatment of men with prostate cancer. Surgery is one option. Its features must be weighed against other competing new technologies such as seeds plus body radiosurgery. As our data enters into its eleventh year, with so many men being followed - more comparison data is available to all for analysis.

Addendum:

In our 14th year, data is stronger than ever. Treatment is better and more precise. Toxicity is less. All this is true thanks to technical advances in equipment and the experience of our physicians. We continue to treat our patients – continue to present our current data.