Editorial

Subsequent treatment(s) for prostate cancer recurrence following radical prostatectomy deteriorate functional outcome and quality of life

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Comment on: Adam M, Tennstedt P, Lanwehr D, *et al.* Functional Outcomes and Quality of Life After Radical Prostatectomy Only Versus a Combination of Prostatectomy with Radiation and Hormonal Therapy. Eur Urol 2017;71:330-6.

Submitted Dec 26, 2016. Accepted for publication Jan 11, 2017.
doi: 10.21037/tcr.2017.02.15
View this article at: http://dx.doi.org/10.21037/tcr.2017.02.15

Radical prostatectomy is indicated in patients with intermediate- and high-risk prostate cancer. Especially, in these patients there is the risk on positive surgical margins and positive lymph nodes. In case positive surgical margins are found in the pathological specimen it is questioned still if immediate adjuvant radiotherapy should be offered to the patient (1-3). There are three trials underway evaluating the optimal timing of radiotherapy following radical prostatectomy in case of pT3 disease or positive surgical margins (RADICALS, RAVES and GETUG-17) (4). It is obvious that patients receiving subsequent treatments will experience more side effects. The rate of side effects was evaluated in his adjuvant radiotherapy trials, but in these trials no validated questionnaires were used. Adam *et al.* did use validated questionnaires in their study (5).

A very large patient group was evaluated and as to be expected subsequent treatments following radical prostatectomy do have a negative impact on urinary function, potency and Quality of Life. However, there are a couple of issues that have to be taken into account, although these are minor issues. Unfortunately, the gastro-intestinal side effects were not evaluated. It is not clear from the data what was the indication for one of the adjuvant treatments, why was ADT plus radiotherapy offered and what were the baseline (pre-radical prostatectomy) scores. It is not clear for me how ADT could increase the number of patients with incontinence. Or were these patients with more advanced disease? Another puzzling issue is that patients on ADT were not all impotent? What regimen of ADT was provided? The Quality of Life scores were also still quite good for patients that had triple therapy. This evaluation is spanning a long time period and several surgical techniques and radiotherapy regimens have been used. Was there a difference? Did robot assisted and/or nerve sparing influence outcome?

What is evident from these data is the increase of side effects if more than one treatment is necessary to control the prostate cancer and it is obvious that this should be discussed with the patient, but if the patient hears that the cancer is present again he is usually willing to accept these complications.

At this moment in time we have the tools to identify in a better way the extent of the disease, since imaging modalities have been improved, although these have to be validated still (e.g., mpMRI, PSMA PET scan). These imaging modalities can help (hopefully) to identify patients that have a locally advanced disease before the treatment. Patients can then be counselled in advance about the best treatment for their disease and the consequences. Especially if there is disease outside the prostate the treatment regimen could be adapted and in case of evident locally advanced disease radiotherapy plus concomitant ADT could be discussed. Of course these treatments also have their specific side effects and these must be discussed with the patient. The pivotal question if surgery in high-risk local disease is better compared to radiotherapy plus ADT is still open, but if a randomized trial is performed comparing these two approaches (which I doubt) than quality of life

aspects is a very important outcome parameter to be taken into account.

Acknowledgments

Funding: None.

Footnote

Provenance and Peer Review: This article was commissioned and reviewed by the Section Editor Hong-Chao He MD, PhD (Department of Urology, Shanghai Ruijin Hospital, Shanghai Jiaotong University School of Medicine, Shanghai, China).

Conflicts of Interest: The author has completed the ICMJE uniform disclosure form (available at http://dx.doi.org/10.21037/tcr.2017.02.15). The author has no conflicts of interest to declare.

Ethical Statement: The author is accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Cite this article as: de Reijke TM. Subsequent treatment(s) for prostate cancer recurrence following radical prostatectomy deteriorate functional outcome and quality of life. Transl Cancer Res 2017;6(Suppl 1):S149-S150. doi: 10.21037/tcr.2017.02.15

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