LETTERS TO THE EDITOR

Very high-risk prostate cancer: multimodality treatment will be the new frontier

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During the last years, management of prostate cancer (PCa) has changed on the basis of the development of minimally invasive procedures (laparoscopic and robotic surgery, three-dimensional conformal and intensity-modulated external-beam radiotherapy, brachytherapy, cryoablation, HIFU) and medical therapies (new hormonal drugs, chemotherapy, bone-targeted therapies). In a recent article, Kliment et al. [1] have reported their experience on radical prostatectomy in very high-risk PCa (HGPCa) patients with a median follow up period of 62 months. After 10 years the biochemical and clinical progression-free survival was 35% and 69.2% respectively, with 26% of patients not requiring any adjuvant therapy. Until 2014, the EAU guidelines had not considered surgery as a standard option in HGPCa. Since 2015, these recommendations have slightly changed and now surgery can only be considered as an option in a multimodal setting for selected patients (LE3; GRC). This is an effect of the younger age at diagnosis related to a wider use of PSA dosage and increased standardization of minimally invasive treatments, with good oncological and functional results, which have promoted new therapeutic strategies. In this regard, retrospective papers focusing on radical prostatectomy, alone or in a multimodal setting, are increasingly published for HGPCa [2]. Furthermore, this trend is encouraged by different aspects: emerging data from pre-clinical studies suggesting that local tumor control might enhance the effectiveness of subsequent systemic therapies also in metastatic settings, similarly to other malignancies (colon, kidney, ovarian and breast cancer), new hormonal therapies which have prolonged the overall survival and the improvements in local therapies which have reduced morbidity [3, 4]. Several trials are still ongoing to evaluate surgery in HGPCa alone or in a multimodality setting (available at: www.clinicaltrials.gov, trials numbers: NCT00430183, NCT01385059, NCT02949284, NCT02971358, NCT02946008, NCT01753297, NCT00528866, NCT01927627, NCT03124433, NCT02789878, NCT02903368, NCT01197625, NCT02268175, NCT02543255). Even if retrospective evidence supports a multimodal approach, such as the study by Kliment [1], the results from these above-mentioned clinical trials are needed before considering inclusion of these approaches within the guidelines. As underlined by Malewski, there is increasing interest in the urologic community in the management of HGPCa and metastatic PCa. However, treatment decisions should be planned based on real disease staging and histological grading, not on suspected stages [5]. Progress in the understanding of tumor biology and genetics, development of new neoadjuvant drugs, and the availability of more precise diagnostic tools to guide targeted therapies will likely contribute in increasing overall survival, thus changing the natural history of PCa.

References

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