



Ethical commitment of Spanish oncologists to patients with prostate cancer: reflections on the statements of the new ASTRO/AUA guideline (2019 guideline amendment)

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A systematic review of the literature was performed in 2013 using PubMed, Embase, and the Cochrane database to identify peer-reviewed publications related to the use of radiation therapy after prostatectomy published from January 1, 1990 to December 15, 2012 [1]. The review yielded 294 articles which had been used to create evidence-based guideline statements. A particular treatment was assigned a rating of A (high-quality evidence), B (moderate-quality evidence), or C (low-quality evidence) according to the strength of the scientific evidence available, and evidence-based statements of standard and recommendation were developed. The guideline also provides additional guidance as clinical principles (expert opinion) when there was insufficient evidence to rate the treatment. These guideline statements were provided for patient counseling about the use of radiation therapy (RT) in the adjuvant (ART) and salvage (SRT) context, defining biochemical recurrence (BR) and conducting restaging evaluation.

The first amendment to the guideline was made in April 2018 and published in April 2019 [2]. This amendment incorporated evidence from three randomized controlled trials, and a new evidence-based statement was also developed including the uses of hormone therapy (HT) in SRT.

Ten guideline statements (GS) were made in this guideline update: two were standard evidence A, GS 3 and GS 9; three were recommendation and evidence C, GS 5, GS 6, and GS 7, and the last five were clinical principles (CLP) or expert opinion.

The summary of GS 3, with A as the maximum level of evidence, is that physicians should offer ART in the event of adverse pathologic findings [seminal vesicle invasion (SVI), positive surgical margins (M+) or extraprostatic extension

(EE)] because of demonstrated reductions in BR, local recurrence (LR) and clinical progression. The second grade A level of evidence is GS 9 in which clinicians should offer HT to patients treated with SRT with postoperative PSA levels ≥ 0.2 ng/ml.

At the level of recommendation of evidence C, we find GS 5, in which BR is defined as a PSA value after surgery ≥ 0.2 g/ml; GS 6 which can be considered as an option for restaging evaluation in patients with PSA recurrence; and GS 7 recommends that it is mandatory to offer SRT to patients with PSA or LR after prostatectomy in the absence of metastatic disease.

The expert opinion or CLP is an elaborated consensus between radiation oncologists and urologists and is the most numerous group of statements. In the first GS, specialists emphasize that each patient considered for radical prostatectomy should be informed of the potential adverse pathologic findings associated with a higher risk of cancer recurrence and the possible benefits of additional therapy. In the second GS, physicians agree with the results of three randomized trials which show that patients with SVI, M+, and EE should be informed that ART, compared with prostatectomy alone, reduces the risk of BR, LR and clinical progression. Patients should also be informed that, according to the results of one of these three phase III trials, ART may improve M1 and overall survival (OS) [3]. The other two trials [4, 5] did not demonstrate this benefit, however, they were not statistically designed to identify a significant reduction in M1 or OS with ART. The CLP of GS 4 is that patients should be informed that the development of a PSA recurrence after surgery is associated with a higher risk of development of metastatic prostate cancer or death by the disease. GS 8 emphasizes that patients should be informed that the effectiveness of RT for PSA recurrence is greatest when given at lower PSA levels.

GS 10, the last CLP of the expert panel states that patients should be informed of the possible short- and long-term

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