Are we overtreating low risk prostate cancer?

¿Estamos sobretratando el cáncer de próstata de bajo riesgo?

In Spain, 18,872 new cases of prostate cancer (PCA) are detected every year, according to information from the first National Registry for Prostate Cancer (LXXVI Congress of Urology, Málaga, June 2011). Overdiagnosis and overtreatment are, very likely, the most significant adverse effects of PCA screening. Despite therapeutic advances, the consequences of the disease and the treatment given itself affect the patient’s quality of life for years.

The recent annual congress of the American Urological Association, held in Washington, had an area that we could qualify as historic. On May 17, 2011, Dr. Timothy Wilt, professor of Medicine at the University of Minnesota, presented the results of the PIVOT study (Prostate Cancer Intervention Versus Observation Trial). Started in 1994, this study included 731 patients who agreed to be randomly subjected to radical prostatectomy (RP) or maintain watchful waiting (WW). In order to be eligible, patients had to be <75, have clinically localized PCAs, and PSA <50 ng/ml. The average age was 67. The mean and median PSA were 10.2 and 7.8 ng/ml, respectively. According to the classification of tumor risk, approximately 40% had low-risk tumors, 33% intermediate-risk tumors, and 22% high-risk tumors.

At 12, 354 of the 731 men (48.4%) had died, with an absolute reduction in general mortality and disease-specific mortality of approximately 3% in the RP group compared to the WW group. In men with low-risk disease, there was an absolute difference in mortality of PCAs between treatment groups of 1.4% for observation. But, in men with high-risk disease, the absolute difference was 8.4% for surgery (webcast on AUA website). The PIVOT shows that this ‘cancer’ does not imply an inexorable progression to metastasis and death.

The increasing number of men diagnosed with PCAs in Spain involves serious consequences. It places the psychological burden of the cancer diagnosis on thousands of patients and generates an unnecessary fear in them. In addition, it distracts attention, time, and material resources that are needed to identify the tumors that require aggressive treatment. In a recent Spanish work, the low-risk group was 43.3% of the patients undergoing RP, 25.5% of whom received external radiotherapy, and 96.7% of the patients who received brachytherapy.

We must understand that this PIVOT study report is not ‘bad news’ but ‘good news’ because it points the way to be followed in the search for the truth and the benefit to our patients. Meanwhile, I propose some thoughts on what our attitude to follow should be:

1. To accept that population screening and diagnostic examinations detect a considerable number of indolent tumors.
2. To redefine what low-risk PCAs really is. To consider the elimination of the use of the word ‘cancer’ and its replacement by a term like ‘IDLE tumor’ (indolent lesions of epithelial origin).
3. To restrict the indication for prostate biopsies.
4. Genetics can help us differentiate between aggressive tumor phenotypes and indolent ones.
5. To propose, as suggested by the National Comprehensive Cancer Network guidelines (NCCN), active or watchful surveillance as the first therapeutic option in low-risk patients.
6. Last, but not least, to convey reassurance to our patients with a tumor that, obviously, will not kill them.

References


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doi:10.1016/j.acuroe.2011.06.016