Quality of Life Issues

Advanced prostate cancer

Update on PSA and screening

PSA Screening

- Two randomised prospective trials
- Inconclusive results but favouring screening
- Contamination issues
- ?Inadequate length of follow up
- Screen 1500, treat 50, save 1 CaP death

- PSA <0.67ng/L age 44-50 virtually no risk Advanced CaP at age 75

To Refer and when?

- If I have a biopsy I can be reassured by a negative result and determine my options including active surveillance if positive, ……or
- I do not want to undergo a potentially hazardous procedure until medical knowledge can better determine who will benefit from treatment.

Two quite different observations

Watchful waiting

- Decision not to treat with curative intent
- Follow PSA and other parameters
- End point is hormone treatment (ADT)

Active surveillance

- Biopsy positive low risk disease
- Close PSA follow up
- Re-biopsy at 1 year
- Treat if PSA ↑ or biopsy shows increasing disease

The PSA age

- Significant down staging at diagnosis
- Increased incidence
- Falling death rate
- Treatment effect or lead time bias?

- Race, family history, age, life expectancy, co-morbidities.
- Risk% = age -10

PSA characteristics

- Absolute level 4.0 ng/ml ?2.5ng/ml
- Doubling time >0.75ng/ml over 1 year
- Velocity (3 tests over 1 year)
  - 0.25 age 40 59
  - 0.5 60-69
  - 0.75 70+
- Free to total ratio (<10% suspicious >30% benign)
- Density PSA/vol<0.15 (not useful screening tool)

- Urinary PCA3
- Genomes

Quality of Life Issues

Prostate cancer

And Why GPs will become specialists in treating APC

Prostate cancer

- Most men with prostate cancer will die of cardiac or other causes
- Reducing cardiac risk factors can reduce incidence of CaP by 25 – 50% and improve survival
- Cardiac risk factors (Cholesterol, TGs, hs-CRP)
- Smoking
- Body mass index
- Exercise, aerobic and weights
- Statins, 5α reductase inhibitors reduce risk (PSA 50%)
- Dietary Selenium, mutlivitamins, lycopenes

These are all things GPS do on a daily basis

New role for GPS

LHRH analogues no longer require special authority, can be prescribed and administered by GP

Advanced prostate cancer

- Treatment has failed as determined by rising PSA (following radical prostatectomy, external beam radiotherapy, brachytherapy, cryotherapy…)
- Patient presents with high PSA (>50)and clinical stage T3 disease (No biopsy needed!!!)
- Patient presents with obvious multiple metastases

Treatment options

- Androgen blockade flutamide, bicalutamide
- Cyproterone acetate
- LHRH analogues (Eligard, Zoladex, Lucrin)

- Combination
- Intermittent

- Chemotherapy (docetaxel)
- Immumotherapy (sipuleucil-T Provenge)

Effects of hormone treatment

1. Anaemia
2. Breast pain, enlargement (radiation)
3. Decrease HDL
4. Cognitive impairment
5. Depression and mood change
6. Erectile dysfunction and loss of libido
7. Reduction of genital size
8. Fatigue

Effects continued

9. Hot flashes/flushes
10. Muscle loss, weakness
11. Osteoporosis
12. Change of hair distribution
13. Joint pain
14. Increased cardiovascular and thrombo-embolic event risk
15. Local and systemic allergic type reaction

Is the treatment worse than the disease? Often

- Early or late intervention remains controversial
- Current consensus is delay treatment where patients are asymptomatic with good QOL

When to treat

- High PSA (50 – 100) or rapidly rising PSA
- Anaemia, weight loss, altered liver function
- Local symptoms (T4)
- Bone pain or multiple metastases on bone scan
- Patient choice

How to treat

- Consider antiandrogens if still sexually active
- LHRH analogue with antiandrogen to cover flare
- Cyproterone acetate (also for hot flushes)
- Orchidectomy

- Consider intermittent ADT

ADT escape

- If on LHRH check testosterone
- Second line hormone therapy
- Radiotherapy for pain control

- Chemotherapy
- Immunotherapy

Promoting Wellnesss

for Prostate Cancer Patients

Mark A. Moyad, MD,MPH

Second Edition

In summary

- Cardiovascular health, obesity, exercise and diet all have significant effect on prostate cancer prevention and outcomes
- Family history, race, age, and co-morbidities are important factors in discussing screening
- Use of PSA and guidelines are evolving. Targeted informed screening not population screening
- Quality of Life must be weighed against unproven advantage of early ADT in advanced CaP

“Treat the whole man, not the PSA”