Carcinoma della prostata: quali novita’ per il 2015?

Negrar, 1 aprile 2015

IL TRATTAMENTO CHIRURGICO DELLA NEOPLASIA PROSTATICA LOCALMENTE AVANZATA

mauro pastorello

Unità Operativa di Urologia – Direttore dr S. Cavalleri
The surgical treatment of prostate cancer (PCa) consists of radical prostatectomy (RP). This involves removal of the entire prostate gland between the urethra and bladder, and resection of both seminal vesicles, along with sufficient surrounding tissue to obtain a negative margin. Often, this procedure is accompanied by bilateral pelvic lymph node dissection.

Locally advanced prostate cancer:  
- **cT3a**: No  
  - High Risk
- **cT3b**: No  
  - Very High Risk
- **cT4**: No  
  - Very High Risk
correva l'anno ....... 1981

a Genova

PROTOCOLLO OBIETTIVO NAZIONALE PER IL CARCINOMA PROSTATICO
(P.O.N.C.A.P.)

COORDINATORI: Prof. L. Giuliani (Genova)
               Prof. L. Santi (Genova)

SEGRETERIA: Dott. F. Boccardo (Genova)
Progetto Obiettivo Nazionale per il Carcinoma Prostatico
«P.O.N.C.A.P.»

IL CARCINOMA DELLA PROSTATA

NOVEMBRE 1985

Prof. Luciano Giuliani
Clinica Urologica
Università degli Studi
V.le Benedetto XV, 10
16132 GENOVA

Dott. Francesco Boccardo
Istituto Nazionale per la Ricerca sul cancro
V.le Benedetto XV, 10
16132 GENOVA

Prof. Mario Cappellini
Divisione di Radioterapia
Arcispedale S. Maria Nuova
V.le Pieraccini, 18
50134 FIRENZE

Prof. M. Alberto Dina
Istituto di Anatomia Patologica
Università Cattolica
Via Pineta Sacchetti, 644
00168 ROMA

Prof. Giuseppe Martorana
Clinica Urologica
Università degli Studi
V.le Benedetto XV, 10
16132 GENOVA

Prof. Michele Pavone Macaluso
Istituto di Clinica Urologica
Università degli Studi
90127 PALERMO

Prof. Salvatore Rocca Rossetti
Cattedra di Urologia dell'Università
C.so Polonia, 14
10126 TORINO
correva l’anno ....... 1981

Al San Martino, a Santa Margherita ...

incontri di studio *multidisciplinare* tra oncologi, urologi, radioterapisti, farmacologi, ... per una elaborazione *condivisa* di protocolli diagnostici terapeutici e di follow-up sul carcinoma prostatico
correva l'anno ....... 1981
sono trascorsi 34 aa

A quel tempo ........ epidemiologia

La maggior parte dei casi, viene diagnosticata in stadio localmente avanzato e/o con metastasi a distanza: T3 - T4', N1-4', M0-1 (Stadi C e D).
La tabella illustra la frequenza degli stadi avanzati al momento della diagnosi.

**TABELLA N.1: Correlazione fra stadio e frequenza alla diagnosi**

<table>
<thead>
<tr>
<th>Estensione della neoplasia</th>
<th>Frequenza alla diagnosi</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Tumore non palpabile</td>
<td>5 - 10%</td>
</tr>
<tr>
<td>- Tumore intracapsulare</td>
<td>5 - 10%</td>
</tr>
<tr>
<td>- Tumore extracapsulare, assenza di metastasi clin. apprezzabili</td>
<td>40 - 45%</td>
</tr>
<tr>
<td>- Metastasi linfatiche o ematogene</td>
<td>30 - 35%</td>
</tr>
</tbody>
</table>
correva l'anno .... 1981

A quel tempo .... indicazioni terapeutiche

6.2 Prostatovesiculectomia radicale

6.2.1 Indicazioni

In questo protocollo di base si è convenuto che la prostatovesiculectomia sia oggi formalmente indicata solo per gli stadi a sviluppo realmente ed esclusivamente intraprostatico, comunque senza interessamento delle vescicole seminali. Una estensione dell'indicazione a tali casi è da considerarsi opzionale.
correva l’anno ....... 1981

A quel tempo ...

......

In pratica, ad eccezione delle forme iniziali del tutto intraprostatiche e che sono estremamente rare all’osservazione clinica (meno del 20% dei casi), la terapia chirurgica si è rivelata troppo spesso insufficiente ai fini di una terapia veramente radicale.
correva l’anno ...... 1981

A quel tempo ... tecniche chirurgiche

* eseresi dall'alto in basso con sezione e allacciatura preventiva e progressiva dei peduncoli vascolari nel corso dell'isolamento prostatico, in quanto è da ritenere che ciò diminuisca il rischio della diffusione ematogeno e linfatica intraoperatoria;

* isolamento del blocco prostatico-vescicolo-deferenziale su di un piano rigorosamente extra-aponeurotico, rispetto alla fascia di Denonvilliers e alle aponevrosi prostatiche laterali che devono essere comprese nella eseresi;

* sezione delle lamine di Delbet (porzione prostatico-ret tale dei ligamenti longitudinali laterali) del tutto rasente alla parete del retto;
Dopo trentaquattro anni ... ...

- modificazione dei riscontri epidemiologici
- rilevante affinamento della diagnostica clinica e patologica
Dopo trentaquattro anni ... ... 

- modificazione dei riscontri epidemiologici
- rilevante affinamento della diagnostica clinica e patologica
- evoluzione delle conoscenze in tema di anatomia chirurgica
- perfezionamento delle tecniche operative
- introduzione di supporti innovativi (dalla Laparoscopia al Robot)

nuove prospettive terapeutiche
nuove prospettive terapeutiche

Hruby S, Janetschek G  J Urol 2015
Ed oggi, nel 2015

precocità diagnostica con
downstaging e downgrading ..
(e conseguente alto rischio di overtreatment)

ma ancora circa il 18% di paz diagnosticati in avanzato stadio clinico

Locally Advanced Prostate Cancer

Locally advanced prostate cancer is defined as a tumor that has extended clinically beyond the prostatic capsule, with invasion of the pericapsular tissue, apex, bladder neck or seminal vesicle, but without lymph node involvement or distant metastasis.

It is estimated that 12% to 15% of prostate cancers are stage T3.

Overstaging or understaging of early prostatic cancer are common. The correct staging of clinical T3 disease is even difficult, and both overstaging pT2 and understaging pT4 or pN+ are common.
Locally Advanced Prostate Cancer

The overstaging of T3 prostate cancer occurs in about 13% to 27% of cases, meaning that these patients, who have organ-confined disease, can be cured with complete removal of the gland.

### Table 4: The percentage of overstaging and understaging in clinical locally advanced T3 prostate cancer.

<table>
<thead>
<tr>
<th>Authors</th>
<th>pT2</th>
<th>pT4/N+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Poppel et al. [28]</td>
<td>13%</td>
<td>8%/11%</td>
</tr>
<tr>
<td>Van den Ouden et al. [29]</td>
<td>15%</td>
<td>3.4%/15.6%</td>
</tr>
<tr>
<td>Lerner et al. [16]</td>
<td>17%</td>
<td>—/33%</td>
</tr>
<tr>
<td>Morgan et al. [32]</td>
<td>22%</td>
<td>42% (stage D1)</td>
</tr>
<tr>
<td>Ward et al. [33]</td>
<td>27%</td>
<td>—/27%</td>
</tr>
</tbody>
</table>

### Table 3: Comparison between positive surgical margins and pathologic staging after radical retropubic prostatectomy.

<table>
<thead>
<tr>
<th></th>
<th>Positive surgical margins</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>13.7%</td>
</tr>
<tr>
<td>pT2</td>
<td>4.8%</td>
</tr>
<tr>
<td>pT3a</td>
<td>17.4%</td>
</tr>
<tr>
<td>pT3b</td>
<td>18.2%</td>
</tr>
<tr>
<td>pT4</td>
<td>50%</td>
</tr>
</tbody>
</table>
Non vi è dubbio che la prostatectomia radicale (RP) sia il trattamento di elezione per il Ca Prost (PCa) localizzato.

Currently, RP is the only treatment for localized PCa to show a benefit for OS and cancer-specific survival (CSS), compared with conservative management, as shown in one prospective randomized trial (5). After a follow-up of 15 years, the SPCG-4 trial showed that RP was associated with a reduction of all-cause mortality: relative risk (RR) = 0.75 (0.61-0.92).

Surgical expertise has decreased the complication rates of RP and improved cancer cure (6-10). If performed by an experienced surgeon, the patient’s subsequent QoL should be satisfactory. Lower rates of positive surgical margins for high-volume surgeons suggest that experience and careful attention to surgical details, adjusted for the characteristics of the cancer being treated, can decrease positive surgical margin rates and improve cancer control with RP (11, 12).


## PCa localizzato:

<table>
<thead>
<tr>
<th>Reference</th>
<th>Prospective/retrospective</th>
<th>n</th>
<th>Year of RP</th>
<th>Median follow-up (months)</th>
<th>10-year PSA-free survival (%)</th>
<th>10-year CCS (%)</th>
<th>15-year CCS (%)</th>
<th>25-year CCS (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wilt et al. (2012) (6)</td>
<td>Prospective</td>
<td>364 randomized to RP</td>
<td>1994-2002</td>
<td>120</td>
<td>95.6 (12-year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Porter et al. (2006) (31)</td>
<td>Retrospective</td>
<td>752</td>
<td>1954-94</td>
<td>137</td>
<td>71</td>
<td>96</td>
<td>91</td>
<td>82</td>
</tr>
<tr>
<td>Han et al. (2001) (33)</td>
<td>Retrospective</td>
<td>2404</td>
<td>1982-99</td>
<td>75</td>
<td>74</td>
<td>96</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Stephenson et al. (36)</td>
<td>Retrospective</td>
<td>6398</td>
<td>1987-2005</td>
<td>48</td>
<td></td>
<td></td>
<td></td>
<td>88</td>
</tr>
</tbody>
</table>

CSS = cancer-specific survival; n = number of patients; PSA = prostate-specific antigen; RP = radical prostatectomy.
Stage T3a cancer is defined as cancer that has perforated the prostate capsule. In the past, locally advanced PCa was seen in about 40% of all clinically diagnosed tumours. This figure is lower today; nevertheless its management remains controversial.

The surgical treatment of clinical stage T3 PCa has traditionally been discouraged (39), mainly because patients have an increased risk of positive surgical margins and lymph node metastases and/or distant relapse (40,41).


There is no consensus regarding the optimal treatment of men with high-risk PCa. Decisions on whether to elect surgery as local therapy should be based on the best available clinical evidence. Provided that the tumour is not fixed to the pelvic wall, or that there is no invasion of the urethral sphincter, **RP is a reasonable first step in selected patients with a low tumour volume.**

**Extended LND should be performed in all high-risk PCa cases, because the estimated risk for positive lymph nodes is 15-40% (25). Limited LND should no longer be performed, because it misses at least half the nodes involved.**

9.4.1 Locally advanced prostate cancer: cT3a

Several randomized studies of radiotherapy combined with ADT versus radiotherapy alone have shown a clear advantage for combination treatment but no trial has ever proven combined treatment to be superior to RP (42).

In recent years, there has been renewed interest in surgery for locally advanced PCa and several retrospective case series have been published. Although still controversial, it is increasingly evident that surgery has a place in treating locally advanced disease (43-45).

Overstaging of cT3 PCa is relatively frequent and occurs in 13-27% of cases. Patients with pT2 disease and those with specimen-confined pT3 disease have similarly good biochemical and clinical PFS (44,45). In 33.5-66% of patients, positive section margins are present, and 7.9-49% have positive lymph nodes (46). Thus, 56-78% of patients primarily treated by surgery eventually require adjuvant or salvage radiotherapy or HT (44,45).

Records of 139 consecutive patients who underwent a radical prostatectomy (RP) for cT3 PCa with a mean follow-up of 8 years.

Our experience with 139 patients confirms the surgical feasibility of RP for cT3 PCa, showing complication rates comparable with RP in organ-confined PCa and showing a very low incidence of positive surgical margins and associated failure of surgery. Improvement can be expected by further defining the patient population most suitable for surgery and by further optimising adjuvant treatments such as RT and HT. Continenence rates were also comparable with those achieved after RP for localized PCa.
9.4.1  **Locally advanced prostate cancer: cT3a**

The problem remains the selection of patients before surgery. Nomograms, including PSA level, stage and Gleason score, can be useful in predicting the pathological stage of disease (21,46). In addition, nodal imaging with CT or MRI, and seminal vesicle imaging with MRI, or directed specific biopsies of the nodes or seminal vesicles can help to identify those patients unlikely to benefit from a surgical approach (47).

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Increased overall surgical experience must contribute to decreased operative morbidity and to improved functional results after RP for clinical T3 cancer (44,48). It has been shown that continence can be preserved in most cases, and in selected cases, potency can also be preserved (49).


9.4.1 Locally advanced prostate cancer: cT3a

Recent studies demonstrate 5-, 10- and 15-year biochemical progression-free survival (BPFS) to range between 45-62%, 43-51% and 38-49%, respectively. RP may provide excellent tumour control in selected patients with cT3 disease, with 5-, 10- and 15-year CSS ranging between 90-99%, 85-92% and 82-84%, respectively.

Even though more than half of the patients received adjuvant HT and/or RT in most of the presented studies, the high CSS suggests that local cancer control remains especially important in men with locally advanced disease. Five- and 10-year OS ranged from 90-96% and 76-77%, respectively (Table 9.2). These survival rates surpass radiotherapy alone and similar to radiotherapy combined with adjuvant HT (42).

Table 9.2: Overall survival (OS) and cancer-specific survival (CSS) rates for high-risk localized and locally advanced PCa treated with RP as first treatment in a multimodal approach.

<table>
<thead>
<tr>
<th>Reference</th>
<th>n</th>
<th>Time span</th>
<th>OS 5-yr</th>
<th>OS 10-yr</th>
<th>OS 15-yr</th>
<th>CSS 5-yr</th>
<th>CSS 10-yr</th>
<th>CSS 15-yr</th>
<th>PSA-free survival 5-yr</th>
<th>PSA-free survival 10-yr</th>
<th>PSA-free survival 15-yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward et al. (2005) (44)</td>
<td>841</td>
<td>1987-1997</td>
<td>90</td>
<td>76</td>
<td>53</td>
<td>95</td>
<td>90</td>
<td>79</td>
<td>58</td>
<td>43</td>
<td>38</td>
</tr>
<tr>
<td>Carver et al. (2006) (61)</td>
<td>176</td>
<td>1983-2003</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>94</td>
<td>85</td>
<td>76</td>
<td>48</td>
<td>44</td>
<td>-</td>
</tr>
<tr>
<td>Hsu et al. (2007) (45)</td>
<td>200</td>
<td>1987-2004</td>
<td>96</td>
<td>77</td>
<td>-</td>
<td>99</td>
<td>92</td>
<td>-</td>
<td>60</td>
<td>51</td>
<td>-</td>
</tr>
<tr>
<td>Freedland et al. (2007)</td>
<td>62</td>
<td>1987-2004</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>98</td>
<td>91</td>
<td>84</td>
<td>62</td>
<td>49</td>
<td>49</td>
</tr>
<tr>
<td>Yossepowitch et al. (2008) (57)</td>
<td>243</td>
<td>1985-2005</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>96</td>
<td>89</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Xylinas et al. (2009) (63)</td>
<td>100</td>
<td>1995-2005</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>90</td>
<td>-</td>
<td>-</td>
<td>45</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Stephenson et al. (2009) (36)</td>
<td>254</td>
<td>1987-2005</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>85</td>
<td>62</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Walz et al. (2010) (58)</td>
<td>293</td>
<td>1987-2005</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>52</td>
<td>44</td>
<td>-</td>
</tr>
</tbody>
</table>

CSS = cancer-specific survival; n = number of patients; PSA = prostate-specific antigen; RP = radical prostatectomy.
LA TERAPIA CHIRURGICA
nel PCa localmente avanzato/“High Risk”

• il solo trattamento unimodale con realistiche possibilità di cura definitiva (ca 50%)
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nel PCa localmente avanzato/”High Risk”

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• permette perfezionamento diagnostico, utile per eventuali successive terapie multimodali, ove necessarie
LA TERAPIA CHIRURGICA nel PCa localmente avanzato/“High Risk”

- il solo trattamento unimodale con realistiche possibilità di cura definitiva (ca 50%)
- permette perfezionamento diagnostico, utile per eventuali successive terapie multimodali, ove necessarie
- consente notevole beneficio, anche psicologico, nei pazienti che risultino “downstaged” (25 – 44%)
LA TERAPIA CHIRURGICA nel PCa localmente avanzato/“High Risk”

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- offre risultati funzionali sostanzialmente equivalenti alla P.R. dei pazienti con PCa organo-confinato (T1-T2)
LA TERAPIA CHIRURGICA nel PCa localmente avanzato/"High Risk"

- il solo trattamento unimodale con realistiche possibilità di cura definitiva (ca 50%)

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- consente notevole beneficio, anche psicologico, nei pazienti che risultino "downstaged" (25 – 44%)

- offre risultati funzionali sostanzialmente equivalenti alla P.R. dei pazienti con PCa organo-confinato (T1-T2)

- consente procedura "nerve-sparing" efficace sino al 64% dei casi (Briganti)
LA TERAPIA CHIRURGICA nel PCa localmente avanzato/“High Risk”

• risulta gravata, nel tempo, da minori complicanze rispetto alle terapie alternative multimodali oggi disponibili

rispetto alla RxT: dose escalated IMRT + (long term) ADT in 100 of pts (Briganti, Eur Urol 2012)
rispetto alla ADT: CVD, diabetes, QoL,

True morbidity of multimodality treatment: Conclusions
• The risk of short- and long-term side effects is not negligible among PCa patients receiving a multimodal approach.
• Nonetheless, the harms of a multimodal approach should not preclude its adoption when clinically indicated.
• Baseline patient characteristics, as well as the type of treatment planned, might help clinicians in the identification of individuals at higher risk of morbidity.
• Accurate patient selection is mandatory in order to reduce the risk of short- and long-term adverse events associated with the administration of these treatment modalities.

The risk of short and long term side-effects is not negligible among PCa pts receiving an multimodal approach (RT + ADT).
Touijer:

“We have to put our heads together, get out of our comfort zones and rethink the paradigm.”
Counseling multidisciplinare pre-trattamento

- sempre necessario
- indispensabile nel pt PCa LocAdv/HR (plurime variabili cliniche da ponderare)
- condizionato dai limiti attuali della diagnostica, in particolare dell’imaging, sia nei confronti del T che dell’N
An US study has shown that 72 patients who underwent RP for cT4 disease had better survival than those who received HT or radiotherapy alone, and showed comparable survival to men who received radiotherapy plus HT (66).

Another study has compared the outcomes of RP in very-high-risk PCa (T3-T4, N0-N1, N1, M1a) with those in localized PCa. The two groups did not differ significantly in surgical morbidity except for blood transfusion, operative time, and lymphoceles, which showed a higher rate in patients with advanced disease.

The OS and CSS at 7 years were 76.69% and 90.2% in the advanced disease group and 88.4% and 99.3% in the organ-confined disease group, respectively (65).

Another recent study assessed the outcomes of RP in 51 patients presenting with cT3b or cT4 PCa.

Intriguingly, overstaging in this group was still substantial, with approximately one-third of patients having either organ-confined disease (7.8%) or capsular perforation only (29.4%).

Overstaged patients were often cured by surgery alone: 35.3% of the whole group did not receive any form of (neo)adjuvant treatment and 21.6% remained free of additional therapies at a median follow-up of 108 months (64).

9.5.2 Advanced prostate cancer: any T, N1

The combination of RP and early adjuvant HT in pN+ PCa has been shown to achieve a 10-year CSS rate of 80% (67,68).

A retrospective observational study has shown a dramatic improvement in CSS and OS in favour of completed RP versus abandoned RP in patients who were found to be N+ at the time of surgery.


These results suggest that **RP may have a survival benefit** and the abandonment of RP in N+ cases may not be justified (69). These findings have been corroborated in a contemporary retrospective analysis (70).

Radical prostatectomy resulted in superior survival of patients with N+ PCa after controlling for lymph node tumour burden. **The findings from these studies support the role of RP as an important component of multimodal strategies of N+ PCa.**


Table 9.3: Overall survival (OS), cancer-specific survival (CSS) rates for very-high-risk PCa treated with RP as first treatment in a multimodal approach

<table>
<thead>
<tr>
<th>Reference</th>
<th>n</th>
<th>Time span</th>
<th>OS 5-yr</th>
<th>10-yr</th>
<th>15-yr</th>
<th>CSS 5-yr</th>
<th>10-yr</th>
<th>15-yr</th>
<th>PSA-free survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnstone et al. (2006) (66)</td>
<td>72</td>
<td>1995-2001</td>
<td>73</td>
<td>-</td>
<td>-</td>
<td>88</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Joniau et al. (2012) (64)</td>
<td>51</td>
<td>1989-2004</td>
<td>88</td>
<td>71</td>
<td>-</td>
<td>92</td>
<td>92</td>
<td>-</td>
<td>53</td>
</tr>
<tr>
<td>Messing et al. (2006) (68)</td>
<td>98</td>
<td>1988-1993</td>
<td>55*</td>
<td>36*</td>
<td>(11.5 yr)</td>
<td>85*</td>
<td>51 (11.5 yr)</td>
<td>53*</td>
<td>14 (11.5 yr)</td>
</tr>
<tr>
<td>Schumacher et al. (2008) (72)</td>
<td>122</td>
<td>1989-2007</td>
<td>83</td>
<td>52</td>
<td>42</td>
<td>85</td>
<td>60</td>
<td>45</td>
<td>14</td>
</tr>
<tr>
<td>Da Pozzo et al. (2009) (74)</td>
<td>250</td>
<td>1988-2002</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>89</td>
<td>80</td>
<td>-</td>
<td>72</td>
</tr>
<tr>
<td>Engel et al. (2010) (69)</td>
<td>688</td>
<td>1988-2007</td>
<td>84</td>
<td>64</td>
<td>-</td>
<td>95</td>
<td>86</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Steuber et al. (2011) (70)</td>
<td>108</td>
<td>1992-2004</td>
<td>79</td>
<td>69</td>
<td>-</td>
<td>84</td>
<td>81</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Briganti et al. (2011) (73)</td>
<td>364</td>
<td>1988-2003</td>
<td>85</td>
<td>60</td>
<td>-</td>
<td>90</td>
<td>75</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

CSS = cancer-specific survival; n = number of patients; PSA = prostate-specific antigen; RP = radical prostatectomy.
OBIETTIVI per 2015

- molecular imaging (optical biology) to improve staging
- biomarkers of disease aggressiveness / predictive models
- improve risk stratification and integration of genomic characterisation
OBIETTIVI per 2015

- molecular imaging (optical biology) to improve staging
- biomarkers of disease aggressiveness / predictive models
- improve risk stratification and integration of genomic characterisation

- INCREASE UTILISATION OF SURGERY

- multimodality approach with systemic therapy, surgery and radiation therapy
"Urologists will play a central role in the managing PCa and they are going to start exploring -in a thoughtful and scientific way- the role of surgery in oligometastatic PCa.

“In other malignancies, we have seen great value in treating primary cancer through surgical excision," added Touijer.
OBIETTIVI MSKCC per 2015

K.Touijer

- AFFRONTARE IL PCa OLIGOMETASTATICO CON:
  
  CHIRURGIA
  
  RADIOTERAPIA
  
  TERAPIA SISTEMICA  docetaxol, cabazitaxel, radium 223, abiraterone acetate, enzalutamide

- RISERVARE LA ADT ALLA COMPARSA DI METASTASI CLINIC. SINTOMATICHE
It has forced us who do robotic surgery to specifically define our techniques and outcomes in a way that can be verified, reproduced, and examined critically as huge audiences watch by closed-circuit transmission [3]. Perhaps the future may include video revalidation of surgical skills [4]. As such, robotic technology has improved our field and has made us better surgeons and better doctors.
costituiscono ad oggi i migliori strumenti per un controllo locale - locoregionale di una malattia anche estesa
9.7 Recommendations for radical prostatectomy and eLND in low-, intermediate- and high-risk prostate cancer

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>LE</th>
<th>GR</th>
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<tbody>
<tr>
<td>RP is a reasonable treatment option in selected patients with cT3a PCA, GS 8-10 or PSA &gt; 20.</td>
<td>2b</td>
<td>B</td>
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<tr>
<td>Furthermore, RP is optional in highly selected patients with cT3b-4 N0 or any cT N1 PCA in the context of a multimodality approach.</td>
<td>3</td>
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<tr>
<td>Management decisions should be made after all treatments have been discussed by a multidisciplinary team (including urologists, radiation oncologists, medical oncologists and radiologists), and after the balance of benefits and side effects of each therapy modality has been considered by the patients with regard to their own individual circumstances.</td>
<td>1b</td>
<td>A</td>
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<td>If RP is performed, pelvic eLND must be performed, because the estimated risk for positive lymph nodes is 15-40%.</td>
<td>2a</td>
<td>A</td>
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<tr>
<td>The patient must be informed about the likelihood of a multimodal approach.</td>
<td>1a</td>
<td>A</td>
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<tr>
<td>When nodal involvement is detected after surgery:</td>
<td></td>
<td></td>
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<tr>
<td>• Adjuvant ADT is recommended when &gt; 2 nodes are involved;</td>
<td>1b</td>
<td>A</td>
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<td>• Expectant management is optional when the patient has undergone eLND and ≤ 2 nodes show microscopic involvement.</td>
<td>2b</td>
<td>B</td>
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<td>eLND is not necessary in low-risk PCA, because the risk for positive lymph nodes does not exceed 5%.</td>
<td>2b</td>
<td>A</td>
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<tr>
<td>eLND should be performed in intermediate-risk PCA if the estimated risk for positive lymph nodes exceeds 5%, as well as in high-risk cases. In these circumstances, the estimated risk for positive lymph nodes is 15-40%.</td>
<td>2b</td>
<td>A</td>
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<tr>
<td>Limited LND should no longer be performed, because it misses at least half the nodes involved.</td>
<td>2a</td>
<td>A</td>
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</tbody>
</table>

ADT = androgen deprivation therapy; eLND = extended lymph node dissection; GS = Gleason score; LND = lymph node dissection; PCA = prostate cancer; RP = radical prostatectomy;
Touijer:

"We have to put our heads together, get out of our comfort zones and rethink the paradigm."

"Enhancement of local / locoregional control is the keystone of success."
In particular, three key questions need to be answered for the patient:

1. Will I survive?
2. Will I be treated well?
3. What will I be like afterwards?

... it is imperative that the whole health economy (purchasers, providers, and the health charities) continue to actively embrace, promote, and support consumers in working to enhance the quality of care and survival of those affected by PCa.