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IX Congresso Internacional de Uro-Oncologia
IV SIMPÓSIO MULTIPROFISSIONAL DE URO-ONCOLOGIA
1 a 3 de Março de 2018
SHERATON SÃO PAULO WTC HOTEL

Tratamento do CaP risco intermediário e alto

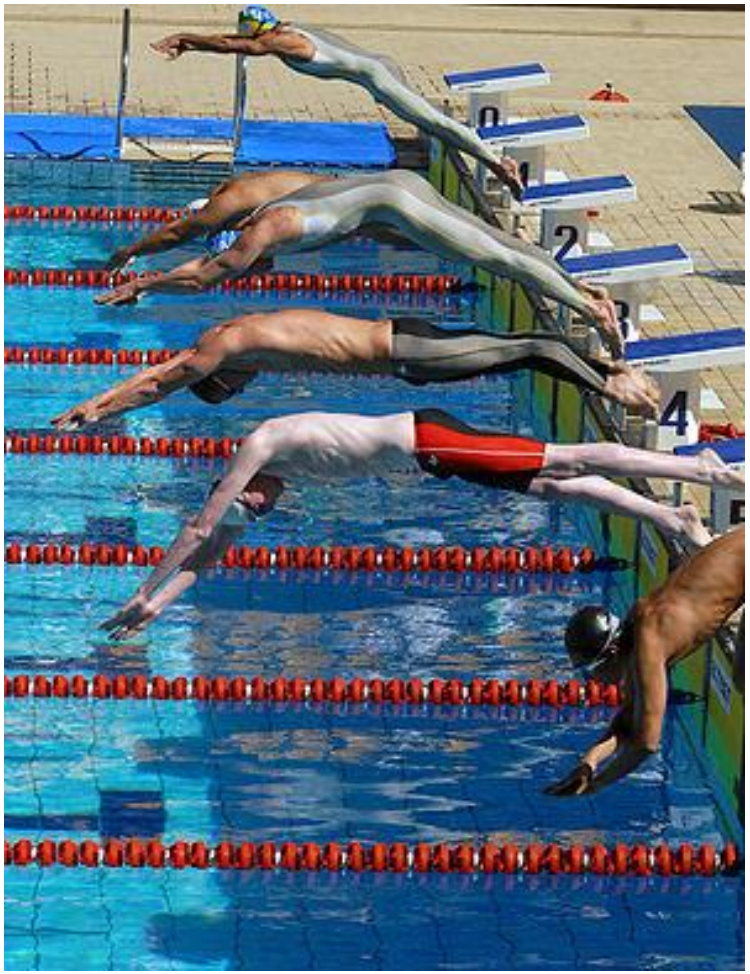
Como eu faço ?

- **Como avaliar …**
- **Quem tratar …**
- **Como tratar…**

Ariê Carneiro, MD
Urologista – Centro de Oncologia do Hospital Israelita Albert Einstein

Papel do urologista / oncologista: PROTAGONISTA!

- Diagnóstico correto
- Estadiamento preciso
- Tratamento adequado
  - Sistêmico
  - Local



Tratamento do Câncer de Próstata

Cabe ao urologista / oncologista…

Como avaliar a qualidade de vida?

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THE JOURNAL of UROLOGY®
Official Journal of the American Urological Association

Clinical Use of EPIC for Clinical Practice (EPIC-CP) to Assess Patient-Reported Prostate Cancer Quality-of-Life Following Robot-Assisted Radical Prostatectomy

Andrew A. Wagner, MD *, Philip J. Cheng, MD *, Arie Carneiro, MD, Ostap Dovirak, MD, Arjun Khosla, MD, Kimberly N. Taylor, BS, Catrina M. Crociani, MPH, Kyle C. McAnally, BS, Andrew Percy, MA, Lauren E. Dewey, BS, Martin G. Sanda, MD, Peter Chang, MD, MPH Press enter key to Email the author

*Shared lead authorship

Published Online: July 27, 2016

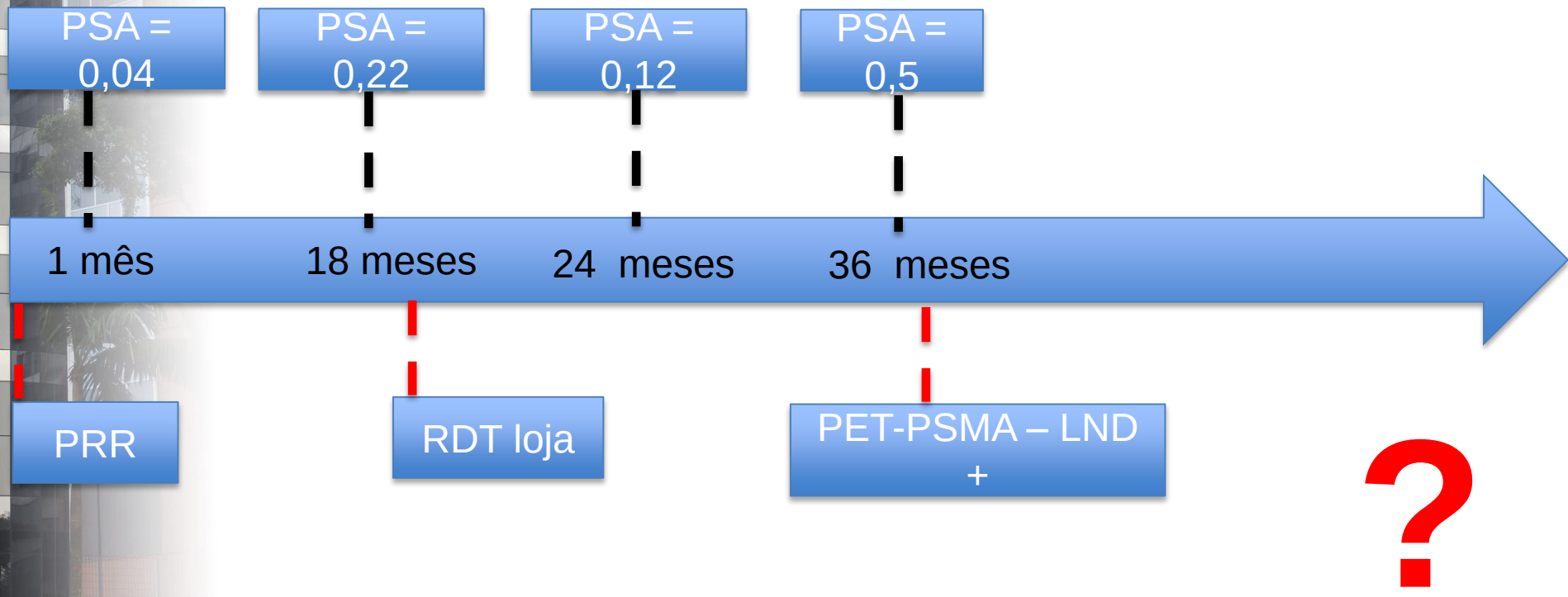
Qualidade de Vida

≠

Significativa

Cenário 1

CaP Gleason 7 (4+3), PSAi= 8,5; Estadiamento Negativo



Cenário 1

CaP Gleason 7 (4+3), PSAi= 8,5; Estadiamento Negativo

PSA = 0,04

PSA = 0,22

PSA = 0,12

1 mês

18 meses

24 meses

36 meses

PRR

RDT loja

PET-PSMA – LND +

?

Cenário 2

CaP Gleason 8 (4+3), PSAi= 20;
Estadiamento= Negativo

PSA = 2

PSA = 3

1 mês

3 meses

PRR

PET-PSMA – 3 metastases ósseas

?

Cenário 2

CaP Gleason 8 (4+3), PSAi= 20;
Estadiamento= Negativo

PSA = 3

1 mês

3 meses

PRR

PET-PSMA – 3 metastases ósseas

?

CIRURGIA OU RADIOTERAPIA OU VIGILÂNCIA

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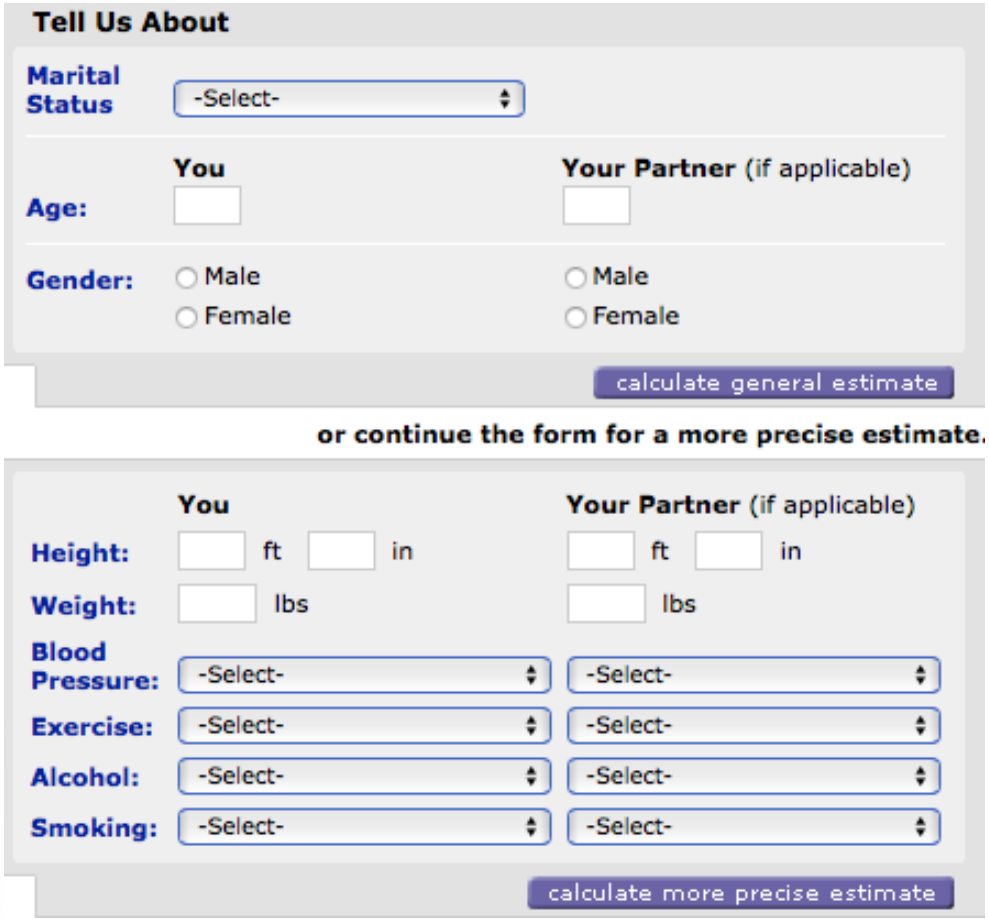
Conceitos

- Expectativa de vida ?
- Comorbidades ?
- Estadiamento apropriado ?
- Ganho de Sobrevida Global ?
- Ganho de Sobrevida Câncer Específica ?
- Impacto na qualidade de vida e morbidade ?
- Tratamento Adequado Disponível ?

Avaliação Clínica

Expectativa de vida :

- G8, Minnesota Metropolitan Life Insurance



Alto Risco > 5 anos

RI > 10 anos

https://rslic.metlife.com/lic/corpLongevity.do

EUROPEAN UROLOGY 63 (2013) 693–701

available at www.sciencedirect.com
journal homepage: www.europeanurology.com

European Association of Urology

Prostate Cancer

Impact of Age and Comorbidities on Long-term Survival of Patients with High-risk Prostate Cancer Treated with Radical Prostatectomy: A Multi-institutional Competing-risks Analysis

Alberto Briganti[a,*], *Martin Spahn*[b], *Steven Joniau*[c], *Paolo Gontero*[d], *Marco Bianchi*[a], *Burkhard Kneitz*[b], *Felix K.H. Chun*[e], *Maxine Sun*[f], *Markus Graefen*[g], *Firas Abdollah*[a], *Giansilvio Marchioro*[h], *Detlef Frohenberg*[i], *Simone Giona*[d], *Bruno Frea*[j], *Pierre I. Karakiewicz*[f], *Francesco Montorsi*[a], *Hein Van Poppel*[c], *R. Jeffrey Karnes*[k],

on behalf of the European Multicenter Prostate Cancer Clinical and Translational Research Group (EMPaCT)

mpeting-risks models depicting cancer-specific mortality (CSM) and other-cause mortality (OCM) survival curves up to 10 yr (n = 3828
to age group and comorbidity status assessed by the Charlson Comorbidity Index (CCI) score. White = alive; blue = OCM; orange = C

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Avaliação Clínica

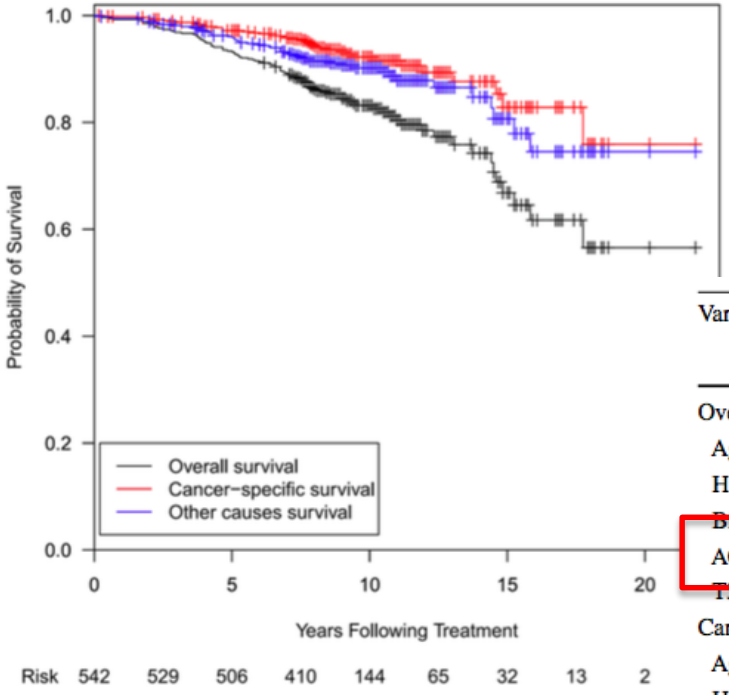


Fig. 1 Kaplan–Meier curves for the probability of overall, ca
specific, and other-cause survival after radical prostatectomy

Variable	Univariate			Multivariate		
	HR	95 % CI	*P* value	HR	95 % CI	*P* value
Overall[a]						
Age	1.05	1.02–1.09	0.002	–	–	–
High PSA (≥20 ng/mL)	1.44	0.93–2.23	0.103	1.19	0.75–1.90	0.465
Biopsy Gleason sum	1.14	0.98–1.33	0.084	1.05	0.90–1.23	0.539
ACCI	1.42	1.21–1.68	<0.001	1.41	1.19–1.66	<0.001
T3/4	1.65	1.09–2.48	0.017	1.52	0.98–2.36	0.060
Cancer specific[b]						
Age	1.04	0.99–1.11	0.121	–	–	–
High PSA (≥ 20 ng/mL)	2.25	1.18–4.34	0.014	1.33	0.642.77	0.450
Biopsy Gleason sum	1.65	1.23–2.22	<0.001	1.44	1.05–.97	0.025
ACCI	1.13	0.86–1.49	0.364	1.07	0.81–1.41	0.620
T3/4	3.69	1.78–7.65	<0.001	2.60	1.26–5.39	0.010
Other cause[b]						
Age	1.05	1.00–1.09	0.037	–	–	–
High PSA (≥ 20 ng/mL)	0.996	0.54–1.85	0.990	1.138	0.578–2.24	0.710
Biopsy Gleason sum	0.876	0.72–1.07	0.194	0.845	0.698–1.02	0.081
ACCI	1.54	0.65–1.30	<0.001	1.568	1.315–1.87	<0.001
T3/4	0.95	0.56–1.60	0.848	1.048	0.581–1.89	0.880

ACCI Age-adjusted Charlson comorbidity index, *PSA* prostate-specific antigen

[a] Cox proportional hazards regression model

[b] Competing risk regression model by Fine and Gray

Charlson Score

RISK STRATIFICATION AND STAGING WORKUP

Risk group	Clinical/pathologic features	Imaging[i,j]	Molecular testing of tumor	Germline testing	Initial therapy[p]
Very low[g]	• T1c AND • Gleason score ≤6/grade group 1 AND • PSA <10 ng/mL AND • Fewer than 3 prostate biopsy fragments/cores positive, ≤50% cancer in each fragment/core[h] AND • PSA density <0.15 ng/mL/g	Not indicated	Not indicated	Consider if strong family history[c]	See PROS-4
Low[g]	• T1-T2a AND • Gleason score ≤6/grade group 1 AND • PSA <10 ng/mL	Not indicated	Consider if life expectancy ≥10y[l]	Consider if strong family history[c]	See PROS-5
Favorable intermediate[g]	• T2b-T2c OR • Gleason score 3+4=7/grade group 2 OR • PSA 10–20 ng/mL AND • Percentage of positive biopsy cores <50%	• Bone imaging[k]: not recommended for staging • Pelvic ± abdominal imaging: recommended if nomogram predicts >10% probability of pelvic lymph node involvement	Consider if life expectancy ≥10y[l]	Consider if strong family history[c]	See PROS-6
Unfavorable intermediate[g]	• T2b-T2c OR • Gleason score 3+4=7/grade group 2 or Gleason score 4+3=7/grade group 3 OR • PSA 10–20 ng/mL	• Bone imaging[k]: recommended if T2 and PSA >10 ng/mL • Pelvic ± abdominal imaging: recommended if nomogram predicts >10% probability of pelvic lymph node involvement	Not routinely recommended	Consider if strong family history[c]	See PROS-7
High	• T3a OR • Gleason score 8/grade group 4 or Gleason score 4+5=9/grade group 5 OR • PSA >20 ng/mL	• Bone imaging[k]: recommended • Pelvic ± abdominal imaging: recommended if nomogram predicts >10% probability of pelvic lymph node involvement	Not routinely recommended	Consider[o]	See PROS-8[p]
Very high	• T3b-T4 OR • Primary Gleason pattern 5 OR • >4 cores with Gleason score 8–10/ grade group 4 or 5	• Bone imaging[k]: recommended • Pelvic ± abdominal imaging: recommended if nomogram predicts >10% probability of pelvic lymph node involvement	Not routinely recommended	Consider[o]	See PROS-8[p]
Regional	Any T, N1, M0	Already performed	Consider tumor testing for homologous recombination gene mutations and for microsatellite instability (MSI) or mismatch repair	Consider[o]	See PROS-9

Risco intermediário

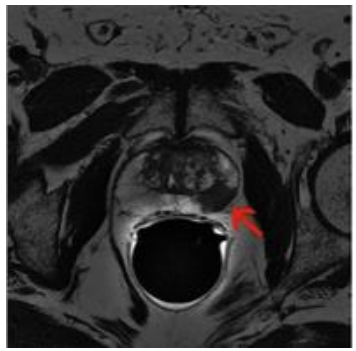
Se Expectativa de vida > 10 anos
→ Tem benefício o tratamento

Favorable intermediate[g]	• T2b-T2c OR • Gleason score 3+4=7/grade group 2 OR • PSA 10–20 ng/mL AND • Percentage of positive biopsy cores <50%	• Bone imaging[k]: not recommended for staging • Pelvic ± abdominal imaging: recommended if nomogram predicts >10% probability of pelvic lymph node involvement
Unfavorable intermediate[g]	• T2b-T2c OR • Gleason score 3+4=7/grade group 2 or Gleason score 4+3=7/grade group 3 OR • PSA 10–20 ng/mL	• Bone imaging[k]: recommended if T2 and PSA >10 ng/mL • Pelvic ± abdominal imaging: recommended if nomogram predicts >10% probability of pelvic lymph node involvement

Desafio = Estadiamento!

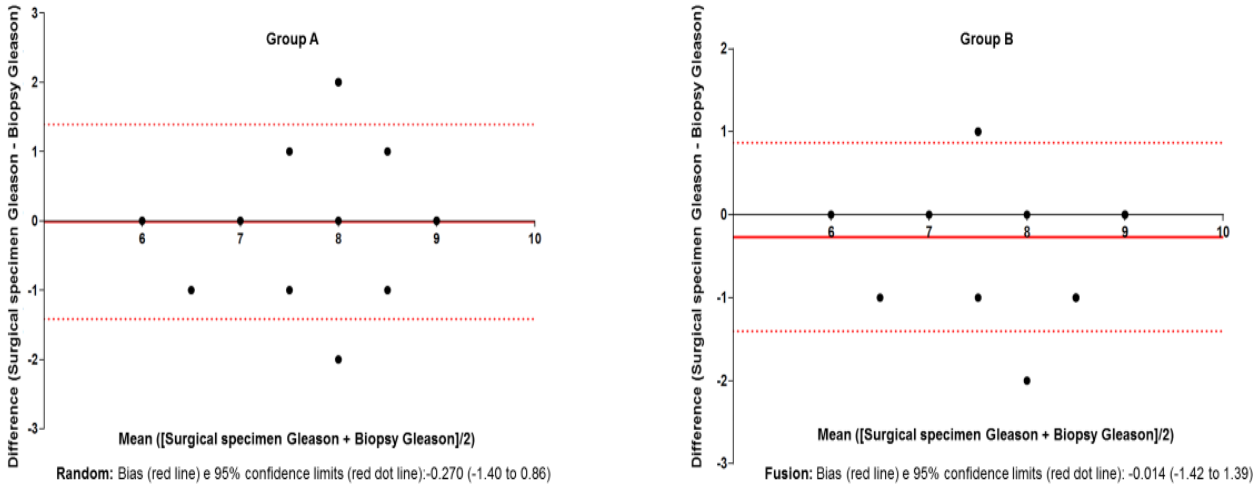
Câncer de Próstata Localmente Avançado

ESTADIAMENTO



Gleason Upgrading → 44% [1] (T3-4 N1 = 9,7%)

Figure 1: Bland - Altman Plot Group A vs Group B



Gleason Upgrading → 31,5% vs 16% (Randômica versus Fusão)[2]

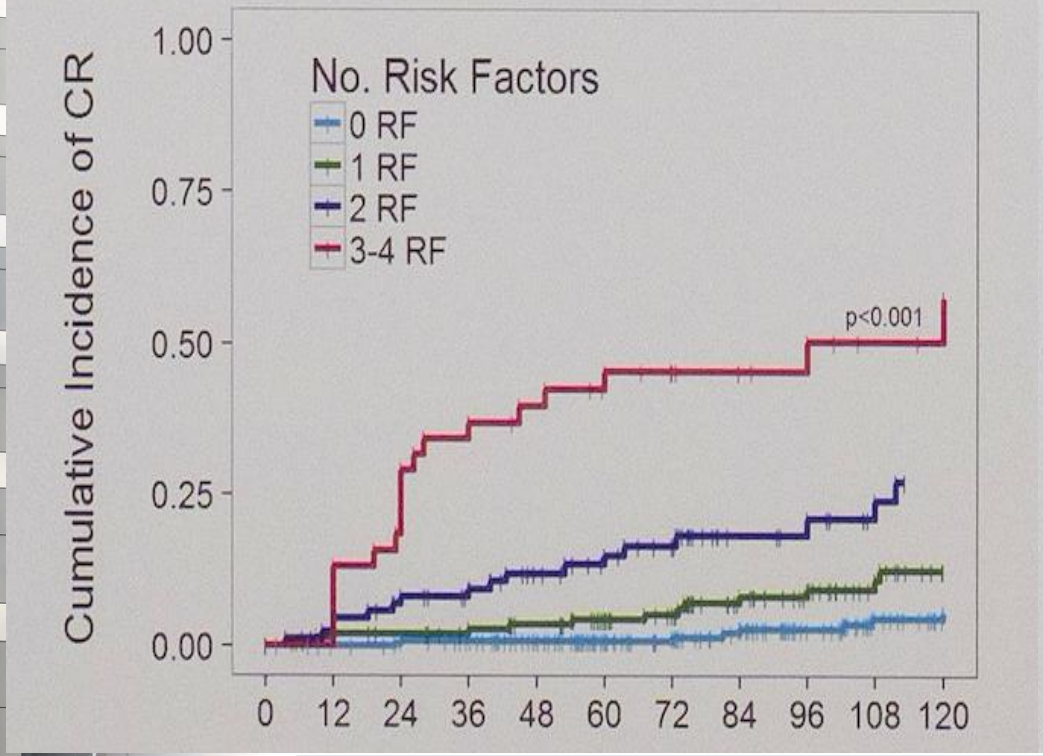
1- Dinh KT et al (SEER database)– Urology 2015

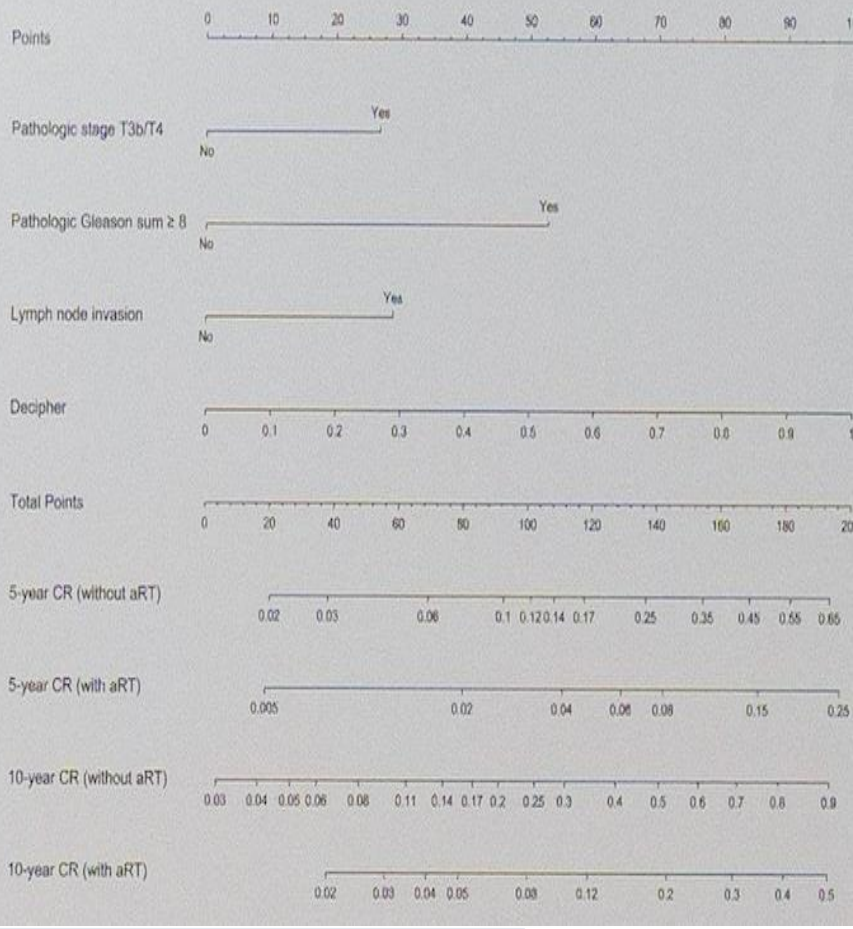
2- Carneiro A, Baroni R, Castilho TML, Claros OR, Kayano PP, Lemos

Genomic Classifier augments the role of pathological features in identifying optimal candidates for adjuvant radiation therapy in patients with prostate cancer: Development and internal validation of a multivariable prognostic model

Deepansh Dalela[1], Maria Santiago-Jiménez[2], Kasra Yousefi[3], R. Jeffrey Karnes[4], Ashley E. Ross[5], Robert B. Den[6], Stephen Freedland[7], Edward M. Schaeffer[7], Adam P. Dicker[8], Mani Menon[1], Alberto Briganti[9], Elai Davicioni[2], Firas Abdollah[1]

Figure 3. Cumulative incidence plot depicting clinical recurrence curves in 512 prostate cancer patients with adverse pathological features at RP





>= 2 fatores de risco → melhores candidatos a RDT adjuvante

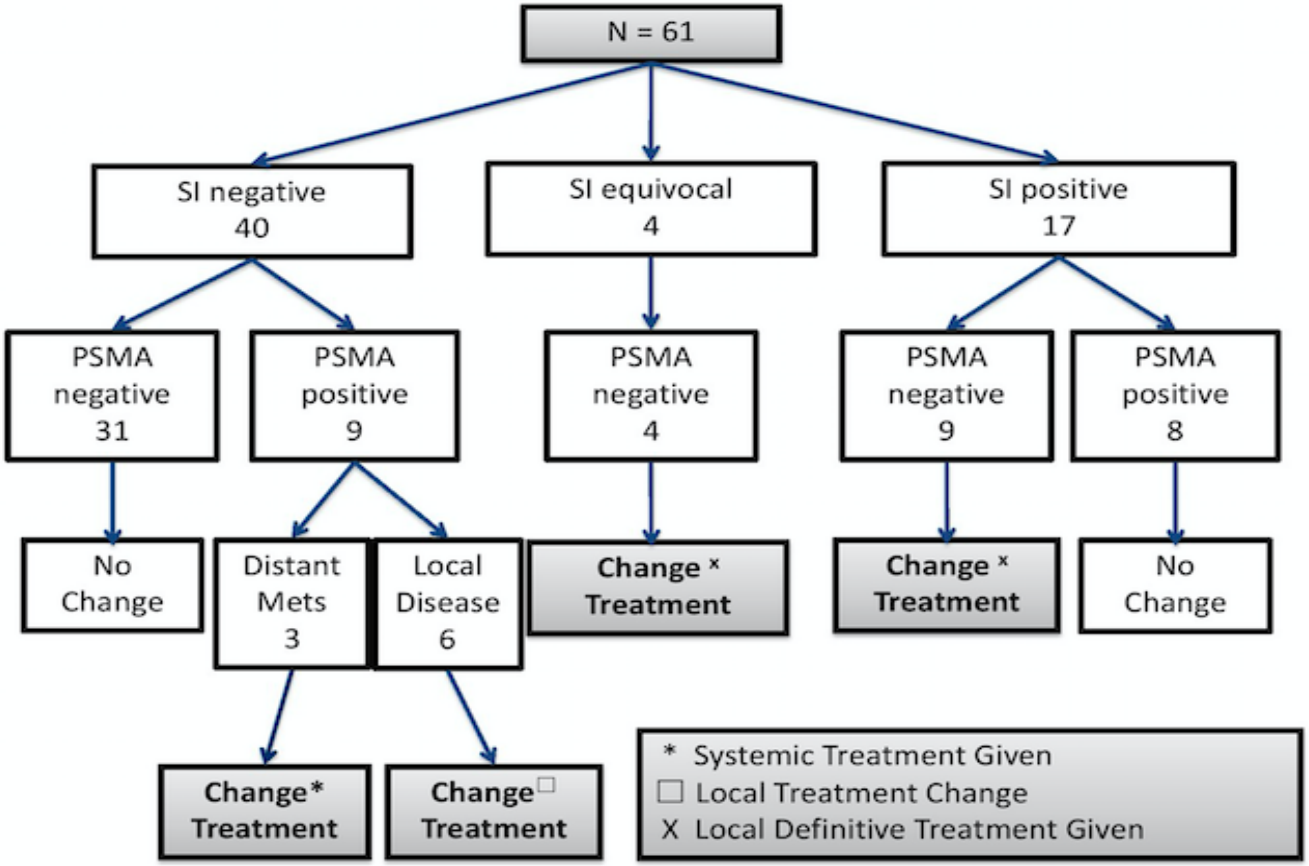
- pT3b/4, GS 8-10, LND+ ou Decipher > 0,6

0-1 fatores de risco → apenas seguir

Abstract Number: 13

The CHAPPP study: CHanging care with PSMA-PET for Prostate cancer — A retrospective study of the role of PSMA imaging in altering treatment pathways.

Andrew Schmidt[1], Jeffrey C. Goh[1], Manoj Bhatt[2], Paul Thomas[2], Aneta Suder[1];
[1] Department of Medical Oncology, [2] Department of Nuclear Medicine, Royal Brisbane and Women's Hospital, Brisbane, Australia



Mudança de conduta → 36% dos casos

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RDT vs Cirurgia ?

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RDT vs Cirurgia ?

VS

- Resultado Oncológico
- Morbidade
- Resultado funcional

LITERATURA COM DADOS DE BAIXA QUALIDADE!

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CG vs RDT

- Cirurgia :
  - Preservação da banda neurovascular ?
  - Linfadenectomia ?
  - Robótica ?
  - Cirurgião com treinamento adequado ?
- Radioterapia
  - Apenas Próstata ?
  - Pelve ?
  - Com hormônio ? (quanto tempo ?)
  - Tecnologia ?

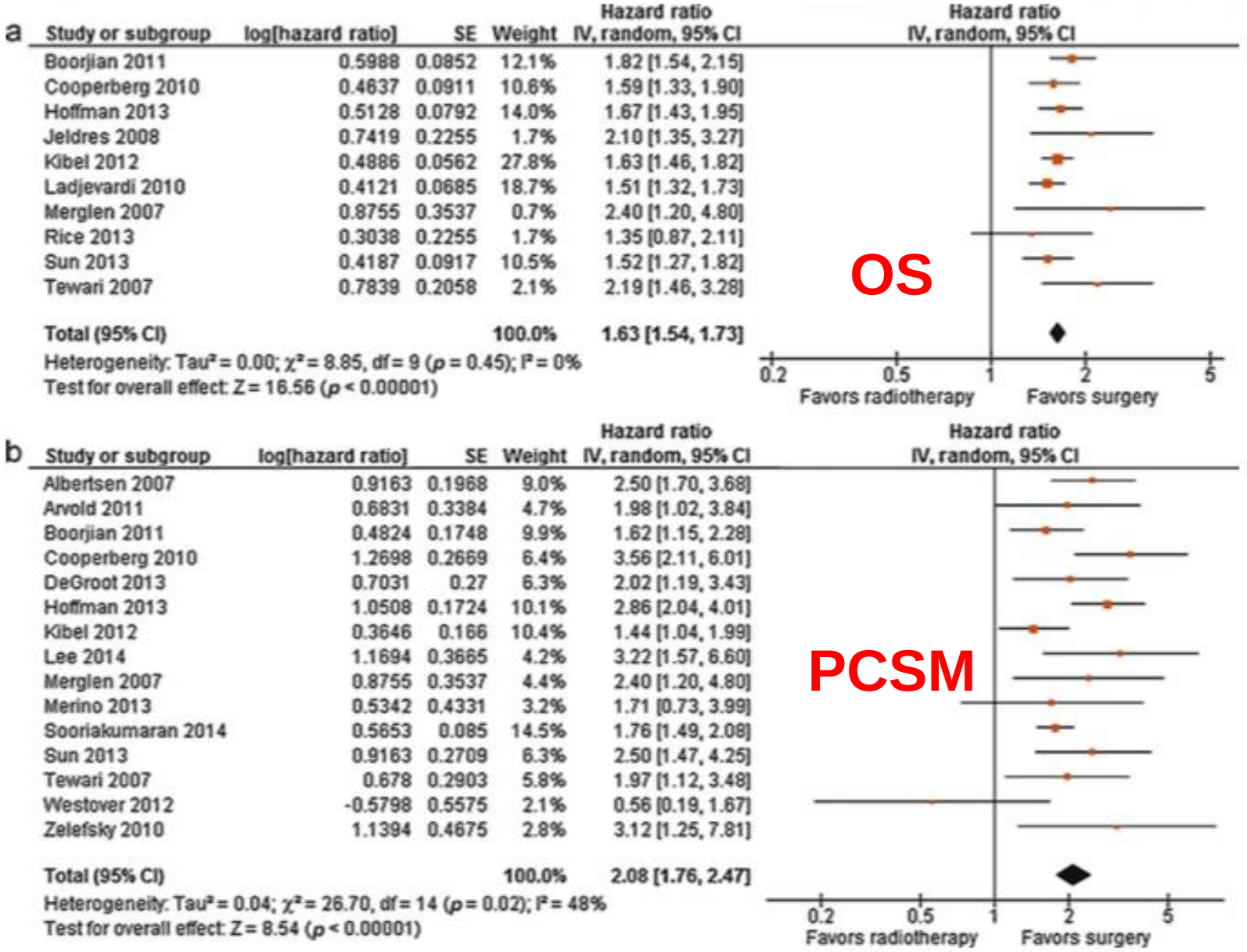

Fig. 2 – Forrest plot assessing the risk of (a) overall mortality and (b) prostate cancer-specific mortality following radiotherapy and surgery for prostate cancer.

Wallis CJD et al. Eur Urol 2016

Morbidade da prostatectomia

Morbidade

Robot-assisted laparoscopic prostatectomy versus open radical retropubic prostatectomy: early outcomes from a randomised controlled phase 3 study

John W Yaxley, Geoffrey D Coughlin, Suzanne K Chambers, Stefano Occhipinti, Hema Samaratunga, Leah Zajdlewicz, Nigel Dunglison, Rob Carter, Scott Williams, Diane J Payton, Joanna Perry-Keene, Martin F Lavin, Robert A Gardiner

Lancet 2016

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Robot-assis
radical retr
a randomis

John W Yaxley, Geoffrey D C
Scott Williams, Diane J Pay

	Total (n=308)	Radical retropubic prostatectomy (n=151)	Robot-assisted laparoscopic prostatectomy (n=157)	p value
Perioperative outcomes				
Operative duration				
Surgery, min	217·97 (47·63)	234·34 (37·07)	202·03 (51·36)	<0·0001
Recovery, min*	107·54 (111·64)	107·12 (146·63)	107·94 (61·18)	0·95
Operating room, min	263·00 (49·79)	280·37 (36·36)	246·08 (55·12)	<0·0001
Intraoperative adverse event	15 (5%)	12 (8%)	3 (2%)	0·02
Estimated total blood loss, mL	886·54 (645·62)	1338·14 (591·47)	443·74 (294·29)	<0·0001
Blood transfusions				
Non-autologous intraoperative	0	0	0	..
Non-autologous postoperative	7 (2%)	6 (4%)	1 (1%)	0·12
Admitted to intensive care unit				0·18
Planned	6 (2%)	3 (1%)	3 (2%)	..
Unplanned	5 (2%)	5 (3%)	0	..
Readmission	20 (7%)	12 (8%)	8 (5%)	0·32
Indwelling catheter, days	8·31 (3·47)	8·42 (3·28)	8·21 (3·64)	0·59
Length of hospital stay, days	2·39 (2·30)	3·27 (1·49)	1·55 (2·61)	<0·0001
Postoperative complications†	20, 24 (6%)	14, 17 (9%)	6, 7(4%)	0·05
Grade I	10, 10 (3%)	6, 6 (4%)	4, 4 (3%)	..
Grade II	5, 6 (2%)	3, 4 (2%)	2, 2 (1%)	..
Grade IIIa	3, 3 (1%)	2, 2 (1%)	1, 1 (1%)	..
Grade IIIb	3, 3 (1%)	3, 3 (2%)	0, 0	..
Grade IVa	2, 2 (<1%)	2, 2 (<1%)	0, 0	..

4 x
3 x
4 x
2 x
2 x
3 x

Linfadenectomia no CaP

seLDN → 75%

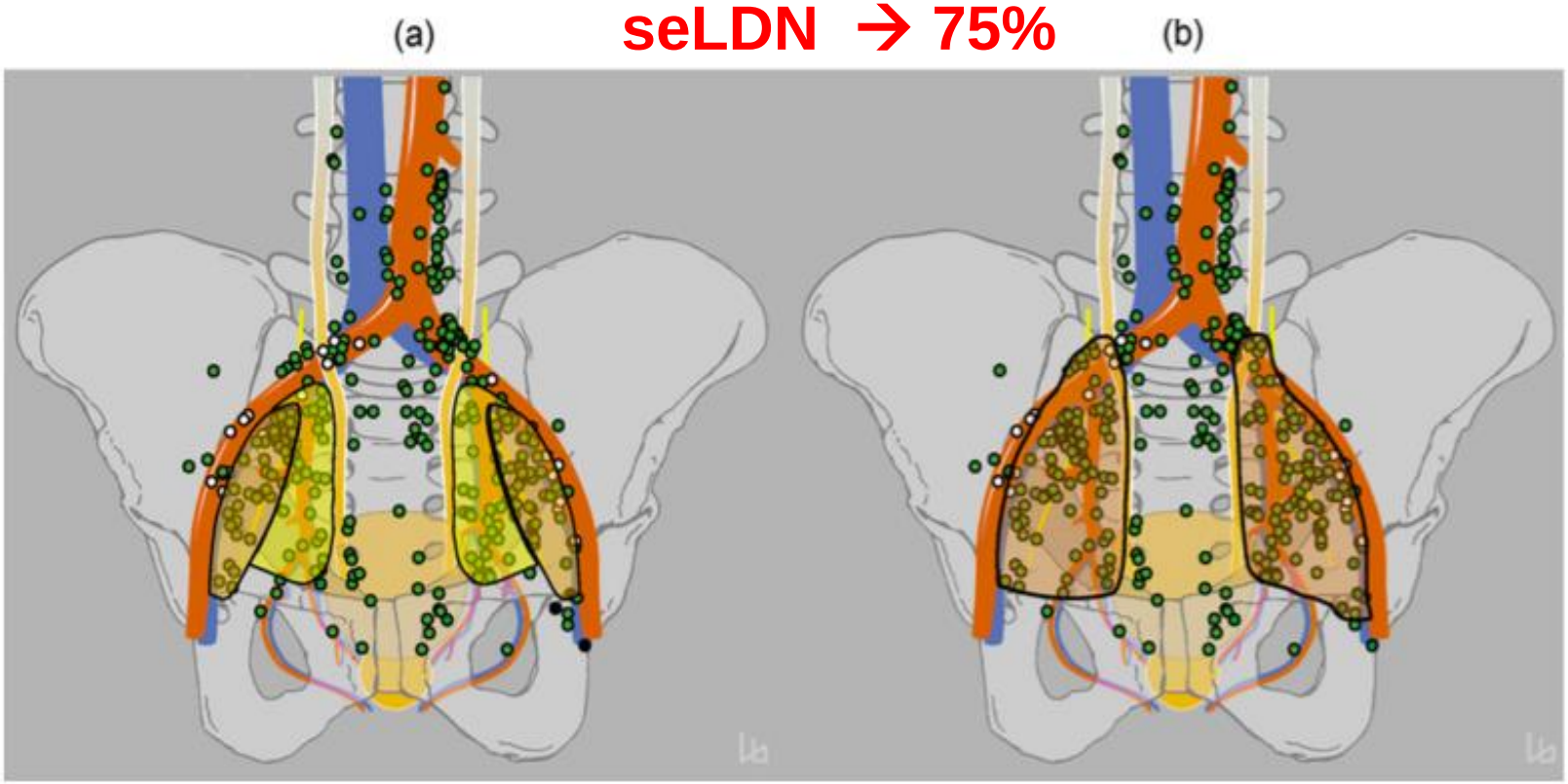

Fig. 4 – Anatomical extent of classical extended pelvic lymphadenectomy (PLND) (a) and of a proposed (new) extended PLND (b) for prostate cancer. (a) Area of classical extended template PLND for prostate cancer encompassing the nodes along the major pelvic vessels including the internal iliac, external iliac and obturator regions to the iliac bifurcation (yellow and orange areas). (b) Area of the proposed (new) extended template PLND extending along the common iliac vessels to the ureteric crossing (pale red area).

Linfadenectomia no CaP

MORBIDADE

EUROPEAN UROLOGY 50 (2006) 1006–1013

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peanurology.com

European Association of Urology

Prostate Cancer

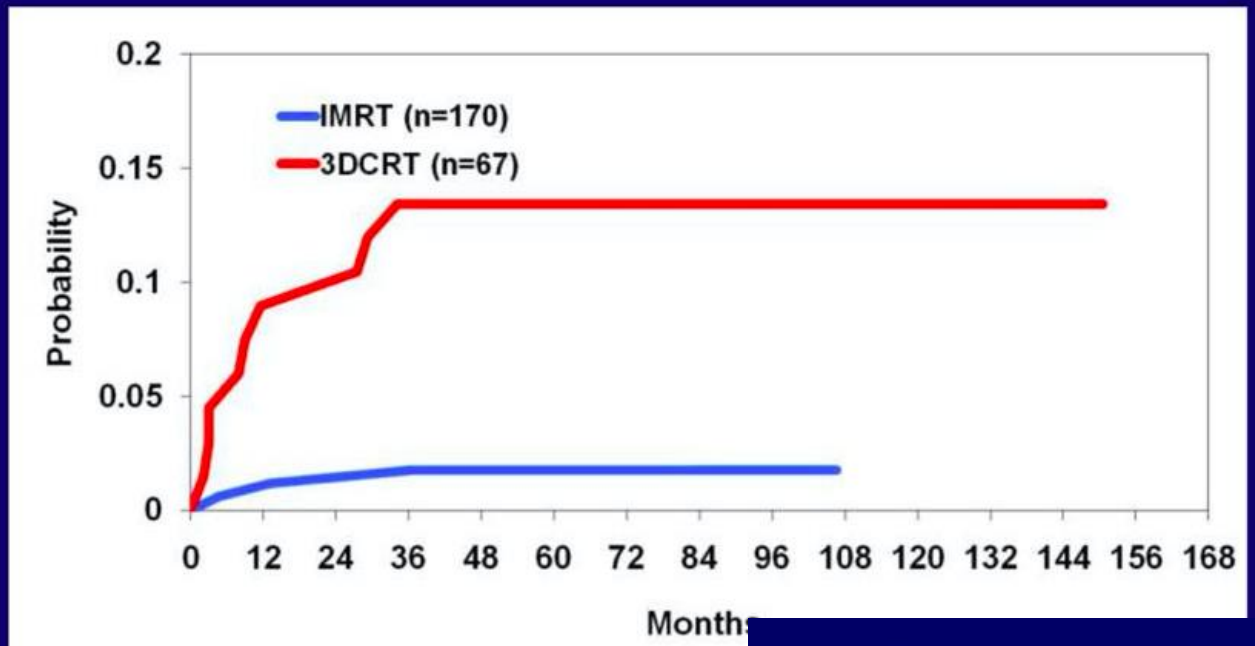
Complications and Other Surgical Outcomes Associated with Extended Pelvic Lymphadenectomy in Men with Localized Prostate Cancer

Variables	All patients (no. [%])	Patients subjected to ePLND (no. [%])	Patients subjected to lPLND (no. [%])	*p* value
Overall complications	168 (17.4)	152 (19.8)	16 (8.2)	<0.001
Lymphocele	88 (9.1)	79 (10.3)	9 (4.6)	0.01
Deep venous thrombosis	7 (0.7)	6 (0.8)	1 (0.5)	0.6
Pelvic haematoma	6 (0.6)	5 (0.7)	1 (0.5)	0.6
Fever	17 (1.7)	16 (2.1)	1 (0.5)	0.2
Acute urinary retention	4 (0.4)	4 (0.5)	0	0.05
Urinary anastomotic leakage	26 (2.7)	24 (3.1)	2 (1)	0.07
Surgical reintervention for pelvic haematoma	4 (0.4)	3 (0.4)	1 (0.5)	0.8
Ultrasound-guided percutaneous drainage	5 (0.5)	4 (0.5)	1 (0.5)	1.0
Pulmunary embolism	1 (0.1)	1 (0.1)	0	0.6
Ureteral injury	0	0	0	NA
Others	15 (1.5)	13 (1.7)	2 (1)	0.7

ePLND: extended pelvic lymph node dissection; lPLND: limited pelvic lymph node dissection; NA: not available.

Improved Targeting of Radiotherapy with IMRT

(Zelefsky et al J Urol 2006)



Slides: Dr. Ícaro

- Gastrointestinal
  - Grade 2 proctitis 3-4%
  - Grade 3 ulceration 1%
- Genitourinary
  - Grade 2 urethritis/urgency: 15-20%
  - Grade 3: 2-3%
- Sexual Dysfunction
  - Permanent loss of erections: 30-40%
  - Ejaculatory Dysfunction- nearly all patients

Morbidade da Hormonioterapia

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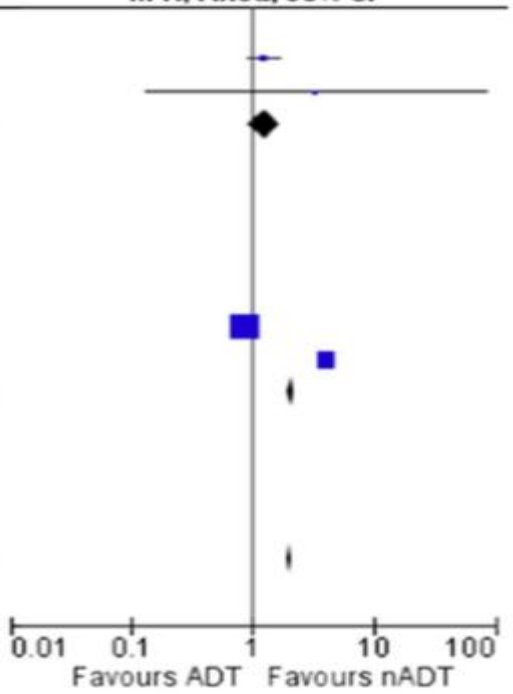
World J Urol (2015) 33:1281–1289
DOI 10.1007/s00345-014-1439-6

ORIGINAL ARTICLE

Cardiovascular events associated with androgen deprivation therapy in patients with prostate cancer: a systematic review and meta-analysis

Arie Carneiro · Andre Deeke Sasse · Andrew Aurel Wagner · Guilherme Peixoto · André Kataguiri · Ary Serpa Neto · Bianca Alves Vieira Bianco · Peter Chang · Antônio Carlos Lima Pompeo · Marcos Tobias-Machado

Study or Subgroup	ADT Events	ADT Total	nADT Events	nADT Total	Weight	Odds Ratio M-H, Fixed, 95% CI
2.2.1 RCT ADT vs nADT						
Iversen P 2010	103	4052	85	4061	4.8%	1.22 [0.91, 1.63]
Messing 1999	1	47	0	51	0.0%	3.32 [0.13, 83.58]
Subtotal (95% CI)		**4099**		**4112**	**4.8%**	**1.23 [0.92, 1.64]**
Total events	104		85			
Heterogeneity: Chi² = 0.37, df = 1 (P = 0.54); I² = 0%						
Test for overall effect: Z = 1.41 (P = 0.16)						
2.2.2 Cohort ADT vs nADT						
Alibhai 2009	949	19079	1085	19079	60.1%	0.87 [0.79, 0.95]
Van Hemelrijck 2010	2080	30642	807	45958	35.1%	4.07 [3.75, 4.43]
Subtotal (95% CI)		**49721**		**65037**	**95.2%**	**2.05 [1.93, 2.17]**
Total events	3029		1892			
Heterogeneity: Chi² = 619.45, df = 1 (P < 0.00001); I² = 100%						
Test for overall effect: Z = 24.31 (P < 0.00001)						
Total (95% CI)		**53820**		**69149**	**100.0%**	**2.01 [1.90, 2.13]**
Total events	3133		1977			
Heterogeneity: Chi² = 630.30, df = 3 (P < 0.00001); I² = 100%						
Test for overall effect: Z = 24.13 (P < 0.00001)						
Test for subgroup differences: Chi² = 11.46, df = 1 (P = 0.0007), I² = 91.3%						



ADT: Androgen Deprivation Therapy, nADT: Non Androgen Deprivation Therapy, RCT: Randomized Clinical Trials

Fig. 3 Acute myocardial infarct associated with ADT

The NEW ENGLAND JOURNAL of MEDICINE

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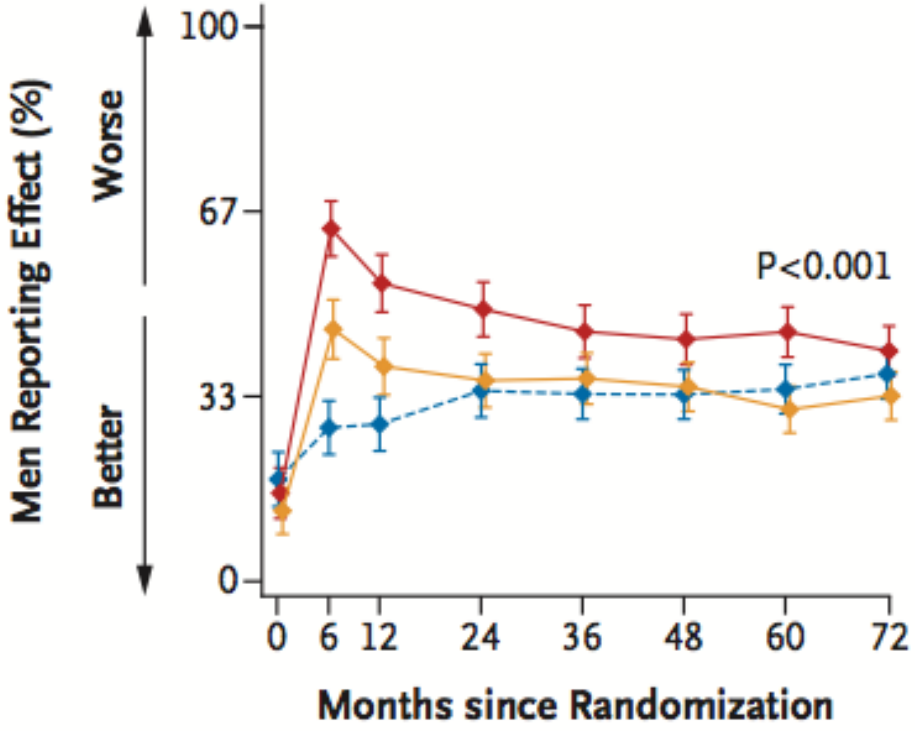
ORIGINAL ARTICLE

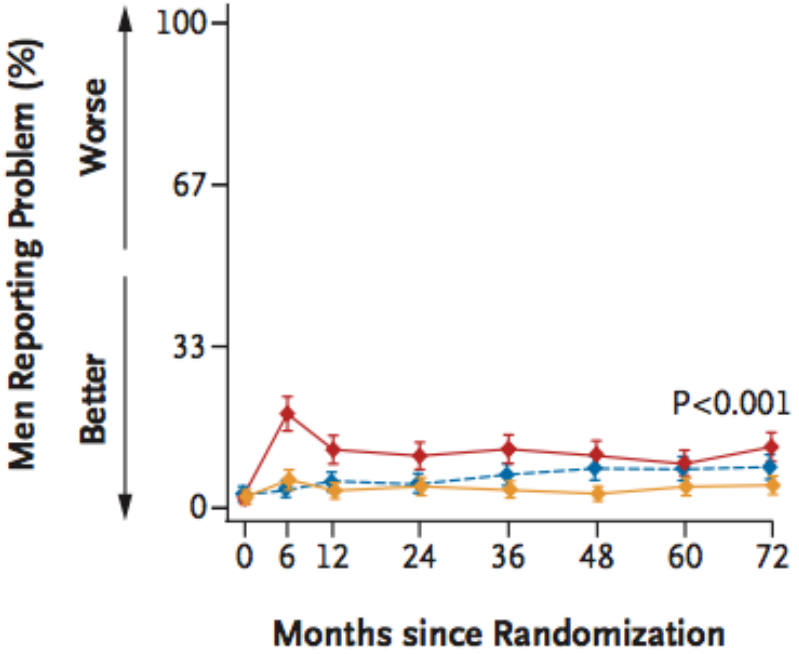
Patient-Reported Outcomes after Monitoring, Surgery, or Radiotherapy for Prostate Cancer

J.L. Donovan, F.C. Hamdy, J.A. Lane, M. Mason, C. Metcalfe, E. Walsh, J.M. Blazeby, T.J. Peters, P. Holding, S. Bonnington, T. Lennon, L. Bradshaw, D. Cooper, P. Herbert, J. Howson, A. Jones, N. Lyons, E. Salter, P. Thompson, S. Tidball, J. Blaikie, C. Gray, P. Bollina, J. Catto, A. Doble, A. Doherty, D. Gillatt, R. Kockelbergh, H. Kynaston, A. Paul, P. Powell, S. Prescott, D.J. Rosario, E. Rowe, M. Davis, E.L. Turner, R.M. Martin, and D.E. Neal, for the ProtecT Study Group*

EPIC Sexual Quality of Life

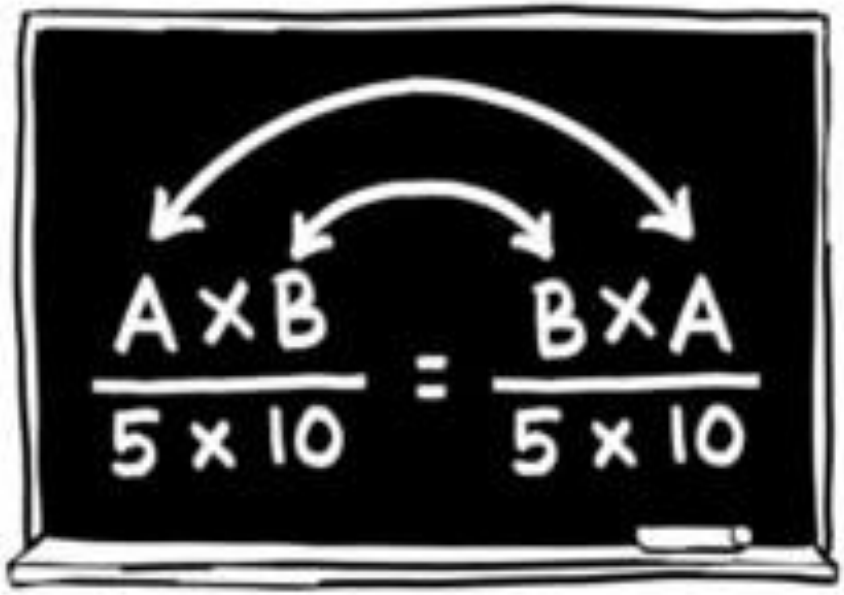


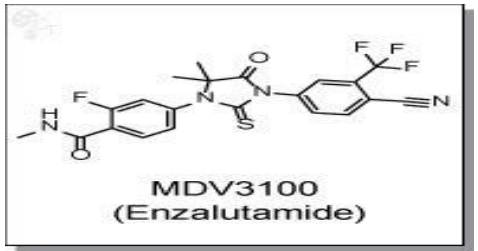
ICIQ Incontinence Problem



Câncer de Próstata Localmente Avançado

MULTIMODAL





Câncer de Próstata Localmente Avançado

PR → RDT → Tratamento Sistêmico

NCCN Guidelines Version 1.2018
Prostate Cancer

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Discussion

FAVORABLE INTERMEDIATE RISK GROUP

EXPECTED PATIENT SURVIVAL[b]

INITIAL THERAPY

ADJUVANT THERAPY

≥10 y

- **Active surveillance[r]**
  - PSA no more often than every 6 mo unless clinically indicated
  - DRE no more often than every 12 mo unless clinically indicated
  - Repeat prostate biopsy no more often than every 12 mo unless clinically indicated
  - Consider mpMRI if anterior and/or aggressive cancer is suspected when PSA increases and systematic prostate biopsies are negative

  → **Progressive disease[v]** See Initial Clinical Assessment (PROS-1)

- **EBRT[e] or brachytherapy alone[e]** →

- **RP[s] ± PLND if predicted probability of lymph node metastasis ≥2%**
  - Adverse feature(s) and no lymph node metastases:[u] EBRT[e] or Observation[t] →
  - No adverse features or lymph node metastases →
  - Lymph node metastasis: ADT[f] (category 1) ± EBRT[e] (category 2B) or Observation[t] →

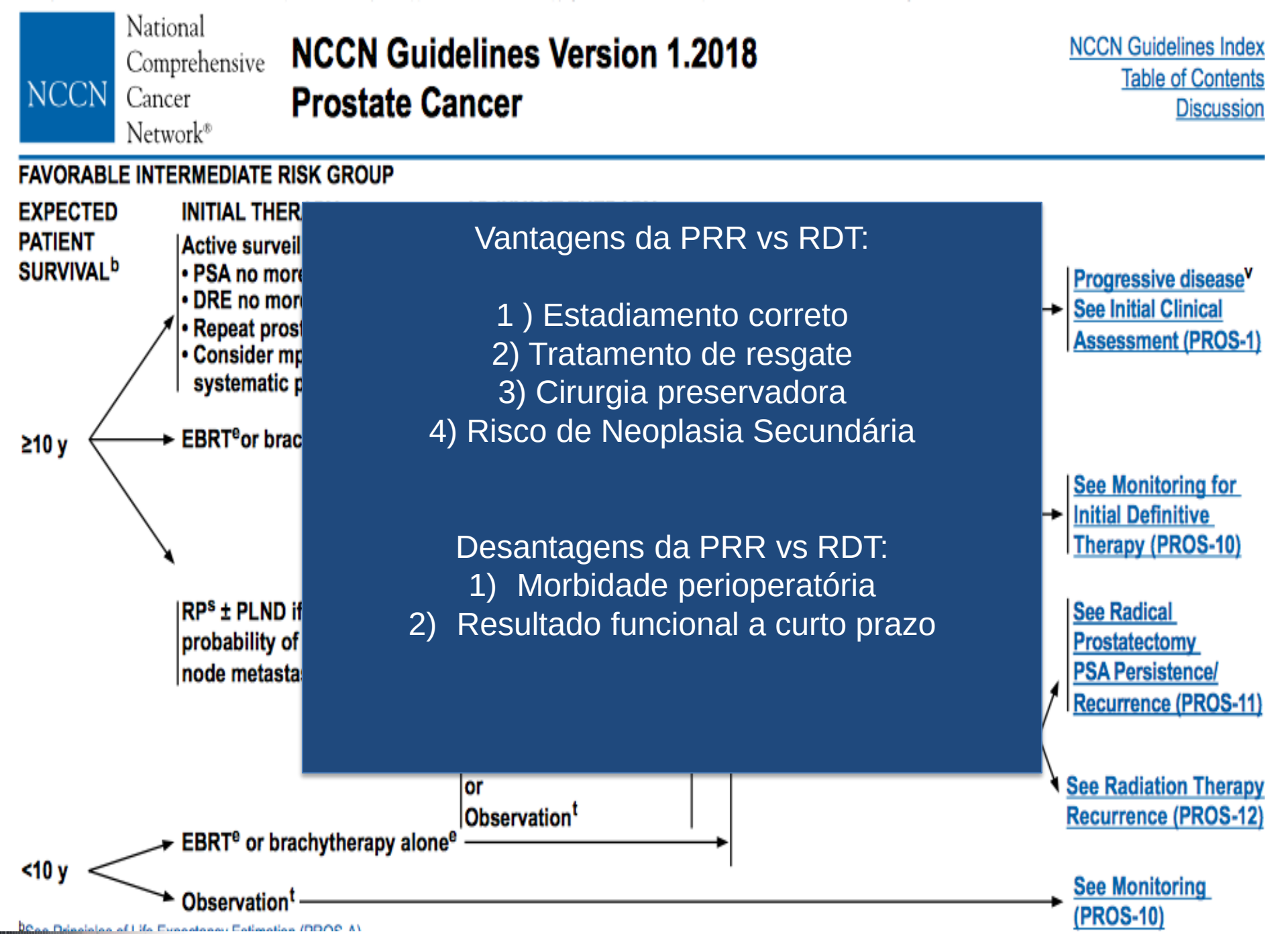
→ **Undetectable PSA after RP or PSA nadir[w] after RT** → See Monitoring for Initial Definitive Therapy (PROS-10)

→ **PSA persistence/recurrence[x,y]**
- → See Radical Prostatectomy PSA Persistence/ Recurrence (PROS-11)
- → See Radiation Therapy Recurrence (PROS-12)

<10 y

- **EBRT[e] or brachytherapy alone[e]** →
- **Observation[t]** → See Monitoring (PROS-10)

[b] See Principles of Life Expectancy Estimation (PROS-A)


National Comprehensive Cancer Network
NCCN Guidelines Version 1.2018
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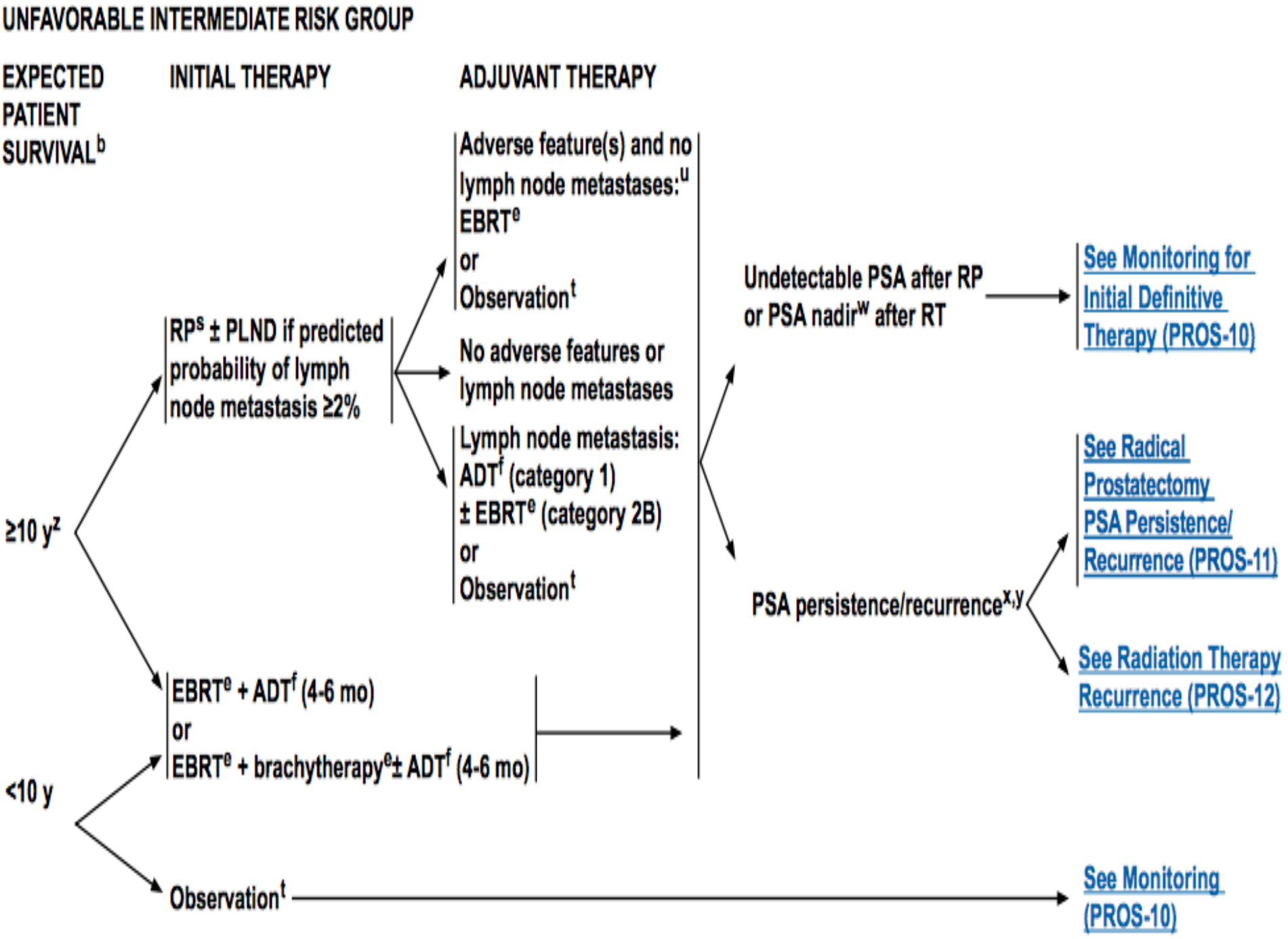
Discussion
FAVORABLE INTERMEDIATE RISK GROUP
EXPECTED PATIENT SURVIVAL[b]
INITIAL THER
Active surveil
• PSA no mor
• DRE no mor
• Repeat pros
• Consider mp
systematic p
≥10 y
EBRT[e] or brac
RP[s] ± PLND if
probability of
node metasta
Vantagens da PRR vs RDT:
1) Estadiamento correto
2) Tratamento de resgate
3) Cirurgia preservadora
4) Risco de Neoplasia Secundária
Desantagens da PRR vs RDT:
1) Morbidade perioperatória
2) Resultado funcional a curto prazo
Progressive disease[v]
See Initial Clinical Assessment (PROS-1)
See Monitoring for Initial Definitive Therapy (PROS-10)
See Radical Prostatectomy PSA Persistence/ Recurrence (PROS-11)
See Radiation Therapy Recurrence (PROS-12)
or
Observation[t]
EBRT[e] or brachytherapy alone[e]
<10 y
Observation[t]
See Monitoring (PROS-10)


UNFAVORABLE INTERMEDIATE RISK GROUP
EXPECTED PATIENT SURVIVAL[b]
INITIAL THERAPY
ADJUVANT THERAPY
≥10 y[z]
<10 y
RP[s] ± PLND if predicted probability of lymph node metastasis ≥2%
EBRT[e] + ADT[f] (4-6 mo) or EBRT[e] + brachytherapy[e] ± ADT[f] (4-6 mo)
Observation[t]
Adverse feature(s) and no lymph node metastases:[u] EBRT[e] or Observation[t]
No adverse features or lymph node metastases
Lymph node metastasis: ADT[f] (category 1) ± EBRT[e] (category 2B) or Observation[t]
Undetectable PSA after RP or PSA nadir[w] after RT
PSA persistence/recurrence[x,y]
See Monitoring for Initial Definitive Therapy (PROS-10)
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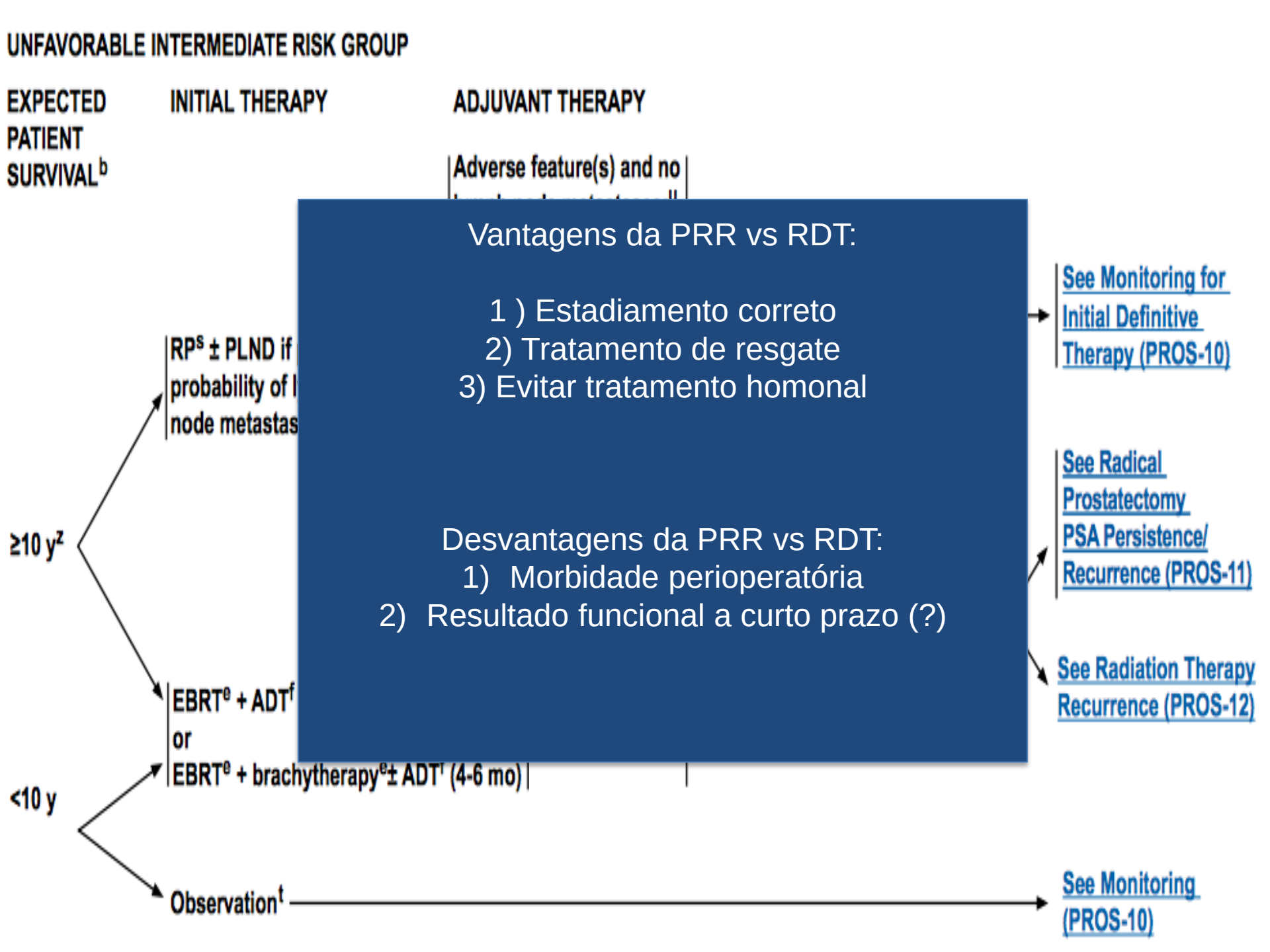
See Radiation Therapy Recurrence (PROS-12)
See Monitoring (PROS-10)


UNFAVORABLE INTERMEDIATE RISK GROUP
EXPECTED PATIENT SURVIVAL[b]
INITIAL THERAPY
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node metastas
≥10 y[z]
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or
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Observation[t]
See Monitoring for Initial Definitive Therapy (PROS-10)
See Radical Prostatectomy PSA Persistence/ Recurrence (PROS-11)
See Radiation Therapy Recurrence (PROS-12)
See Monitoring (PROS-10)
Vantagens da PRR vs RDT:
1) Estadiamento correto
2) Tratamento de resgate
3) Evitar tratamento homonal
Desvantagens da PRR vs RDT:
1) Morbidade perioperatória
2) Resultado funcional a curto prazo (?)

Câncer de Próstata Localmente Avançado

Oncológico

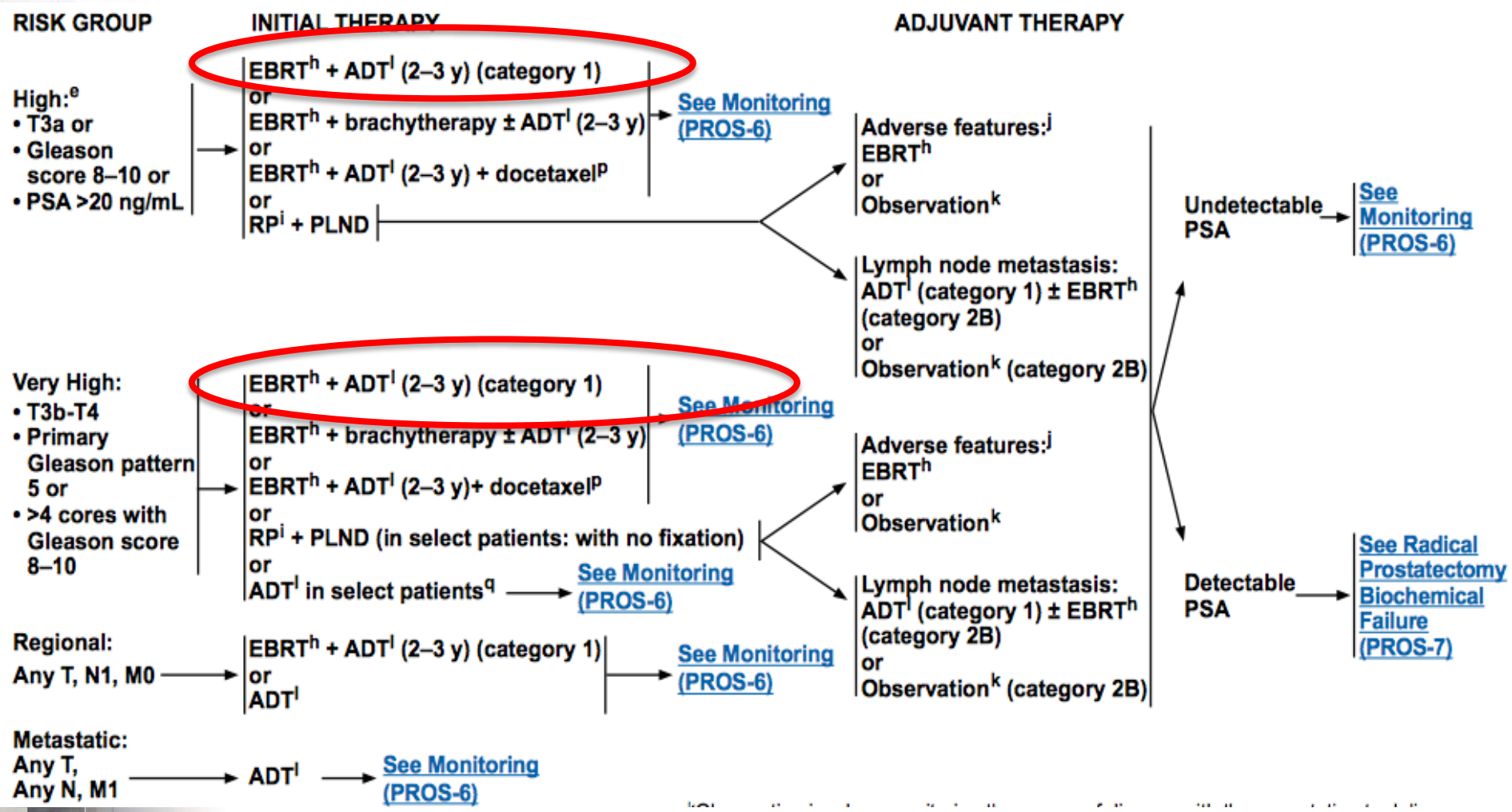
⇧ Risco de Falha e Necessidade de mais de 1 tratamento

- Tto Curativo → CSS 28,8% - 35% (10 – 15 anos)

- GS 8-10 → 26-31% Doença Localizada!
  - CSS = 96%, 88% e 66% (5, 10 e 15 anos)

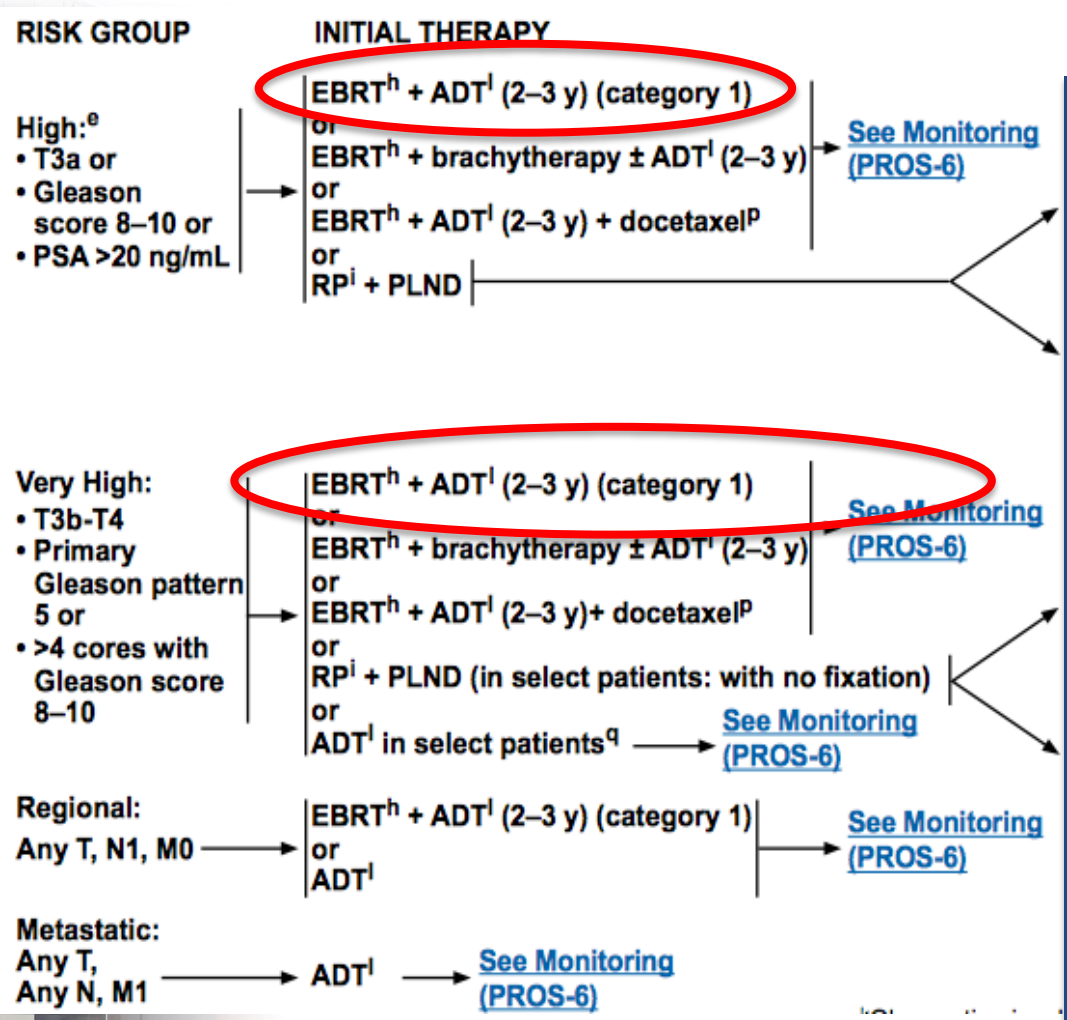
1- Rider JR et al. Eur Urol 2013
2- Yossepowitch O et al. Eur Urol 2008

Câncer de Próstata Localmente Avançado



NCCN Guidelines Version 3.2016 – Prostate cancer

Câncer de Próstata Localmente Avançado



PR ?

Incont. ~ 100%

DE ~ 60 - 100%

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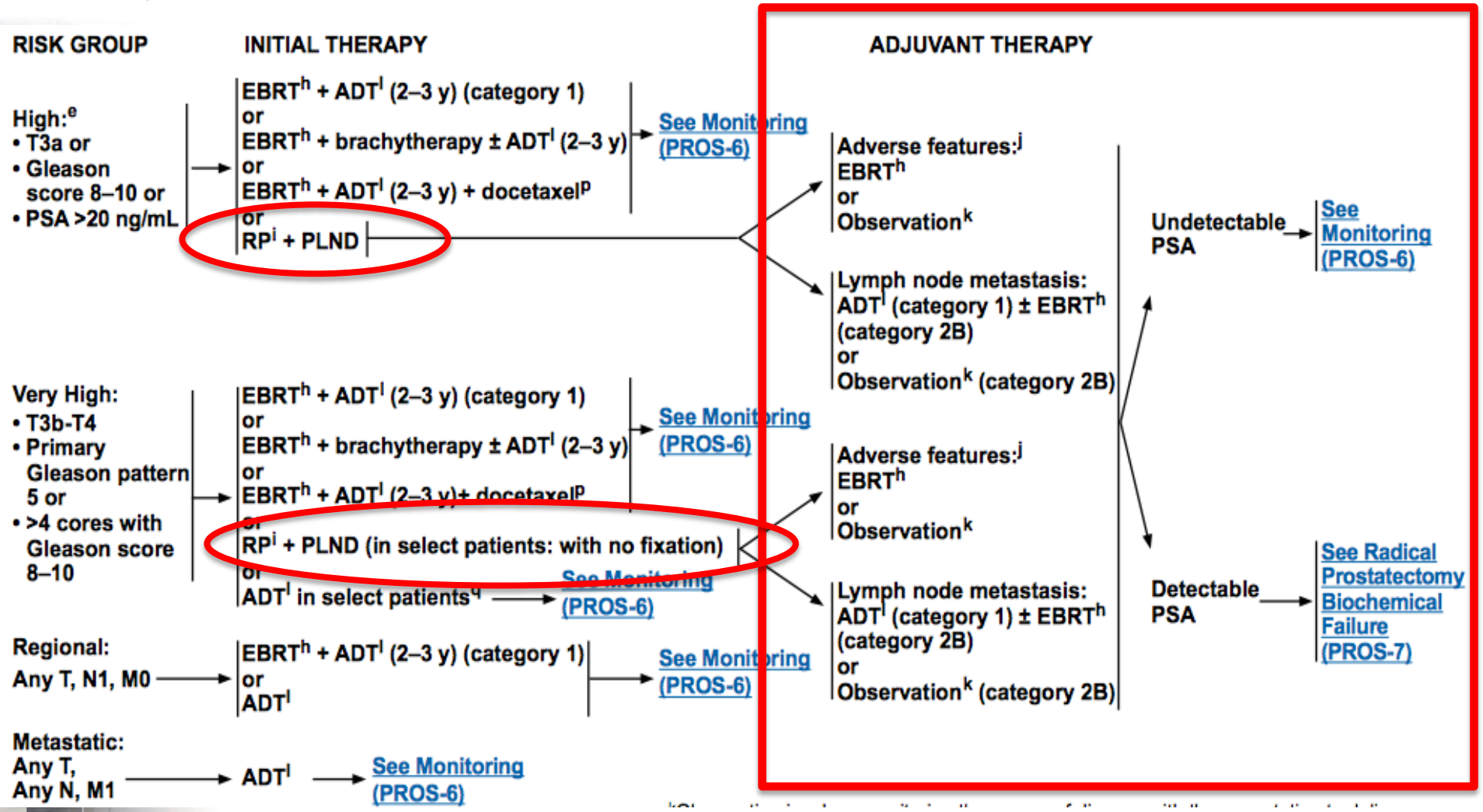
Câncer de Próstata Localmente Avançado



NCCN Guidelines Version 3.2016 – Prostate cancer

Vigilância Ativa

TORONTO

Toronto – Klotz et al. 2010 – JCO

	< 70 a	> 70a
Gleason	6	≤7(3+4)*
# frag +	NC	NC
% frag comp	NC	NC
PSA	≤ 10	≤ 15
PSAd	< 0,15	< 0,15
Estadio	T1c - T2a	T1c - T2a

*após 2000 apenas pctes com comorbidades e EV<10 anos

HOPKINS

Hopkins– Tosoian et al. 2011– JCO

Gleason	6
# frag +	<3
% frag comp	< 50%
PSA	<10*
PSAd	NC
Estadio	T1c - T2a

RES. ONCOL.

	Seg	OS	CSS	Progressão	META	Morte por CaP
Klotz - J Urol 2002	4	100%	100%	17,10%	0	0
Klotz - JCO 2010	5	SD	99.7%	24,60%	5 (1%)&	5 (1%)&
Klotz - JCO 2010	10	68%	97.2%			
Klotz - JCO 2015	10	80%	98%	21.7%	**28 (2,8%)¶**	15 (1,5%)
Klotz - JCO 2015	15	62%	94%			
Toison - JCO 2011	5	100%	100%	35%	0	0
Toison - JCO 2015	10	93%	99,90 %	49,00%	**5 (<1%) #**	2*
Toison - JCO			99,90			

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Tratamento Focal

World J Urol (2016) 34:1373–1382
DOI 10.1007/s00345-016-1782-x

CrossMark

ORIGINAL ARTICLE

Standardization of definitions in focal therapy of prostate cancer: report from a Delphi consensus project

A. W. Postema[1] · T. M. De Reijke[1] · O. Ukimura[3,4] · W. Van den Bos[1] · A. R. Azzouzi[5] · E. Barret[6] · D. Baumunk[7] · A. Blana[8] · A. Bossi[9] · M. Brausi[10] · J. A. Coleman[11] · S. Crouzet[12] · J. Dominguez-Escrig[13] · S. Eggener[14] · R. Ganzer[15] · S. Ghai[16] · I. S. Gill[3] · R. T. Gupta[17] · T. O. Henkel[19] · M. Hohenfellner[20] · J. S. Jones[21] · F. Kahmann[22] · C. Kastner[22] · K. U. Köhrmann[23] · G. Kovacs[24] · R. Miano[25] · R. J. van Moorselaar[26] · N. Mottet[27] · L. Osorio[28] · B. R. Pieters[2] · T. J. Polascik[18] · A. R. Rastinehad[29] · G. Salomon[30] · R. Sanchez-Salas[6] · M. Schostak[7] · L. Sentker[31] · K. J. Tay[18] · I. M. Varkarakis[32] · A. Villers[33] · J. Walz[34] · J. J. De la Rosette[1]

Conclusion

Focal therapy is a rapidly evolving field of prostate cancer treatments that intends to prevent or delay whole-gland treatment associated morbidity without compromising oncologic safety for a large group of patients. For the development and implementation of these treatments, it is important to have standardized reporting criteria. The current consensus project provides recommendations for standardized definitions endorsed by a wide group of experts in the field.

Tratamento Focal

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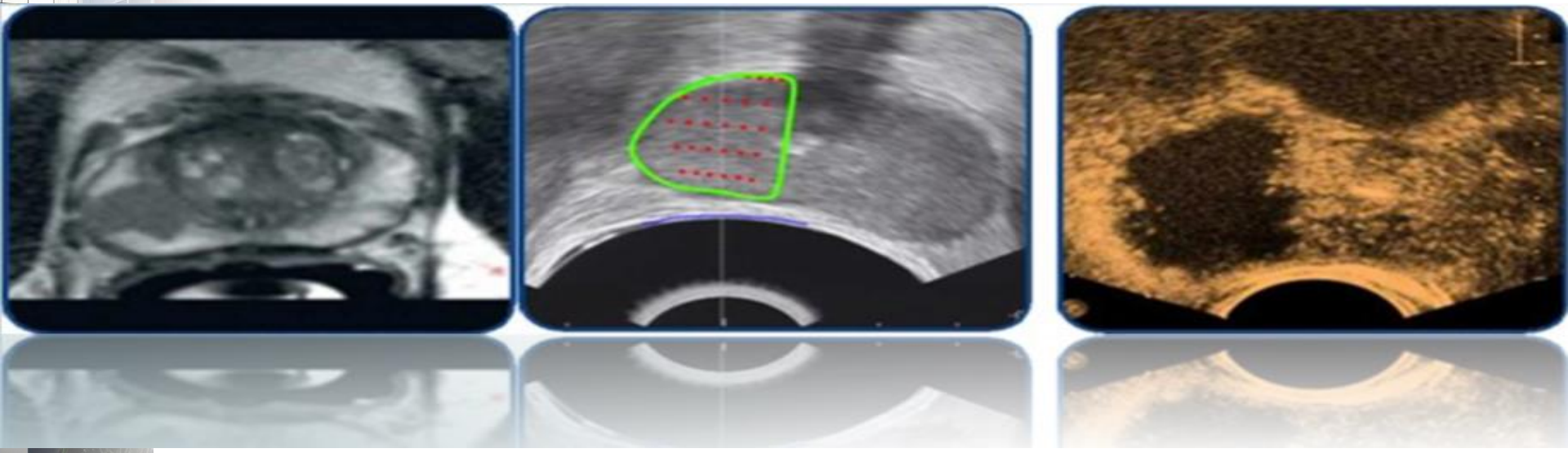

Focal therapy is a rapidly evolving field of prostate cancer treatments that intends to prevent or delay whole-gland treatment associated morbidity without compromising oncologic safety for a large group of patients. For the development and implementation of these treatments, it is important to have standardized reporting criteria. The current consensus project provides recommendations for standardized definitions endorsed by a wide group of experts in the field.

Indicações

- Baixo risco ou intermediário → Doença Localizada

- 7 (3+4) → lesão única, expectativa de vida > 10 anos, pequeno volume (< 3ml ou < 5ml em casos selecionados)

Única lesão Gleason 7 (3+4), localização favorável, pequeno volume → "sweet spot"para tto focal

RTUp deve ser coniderada para ptt > 40-50 gramas

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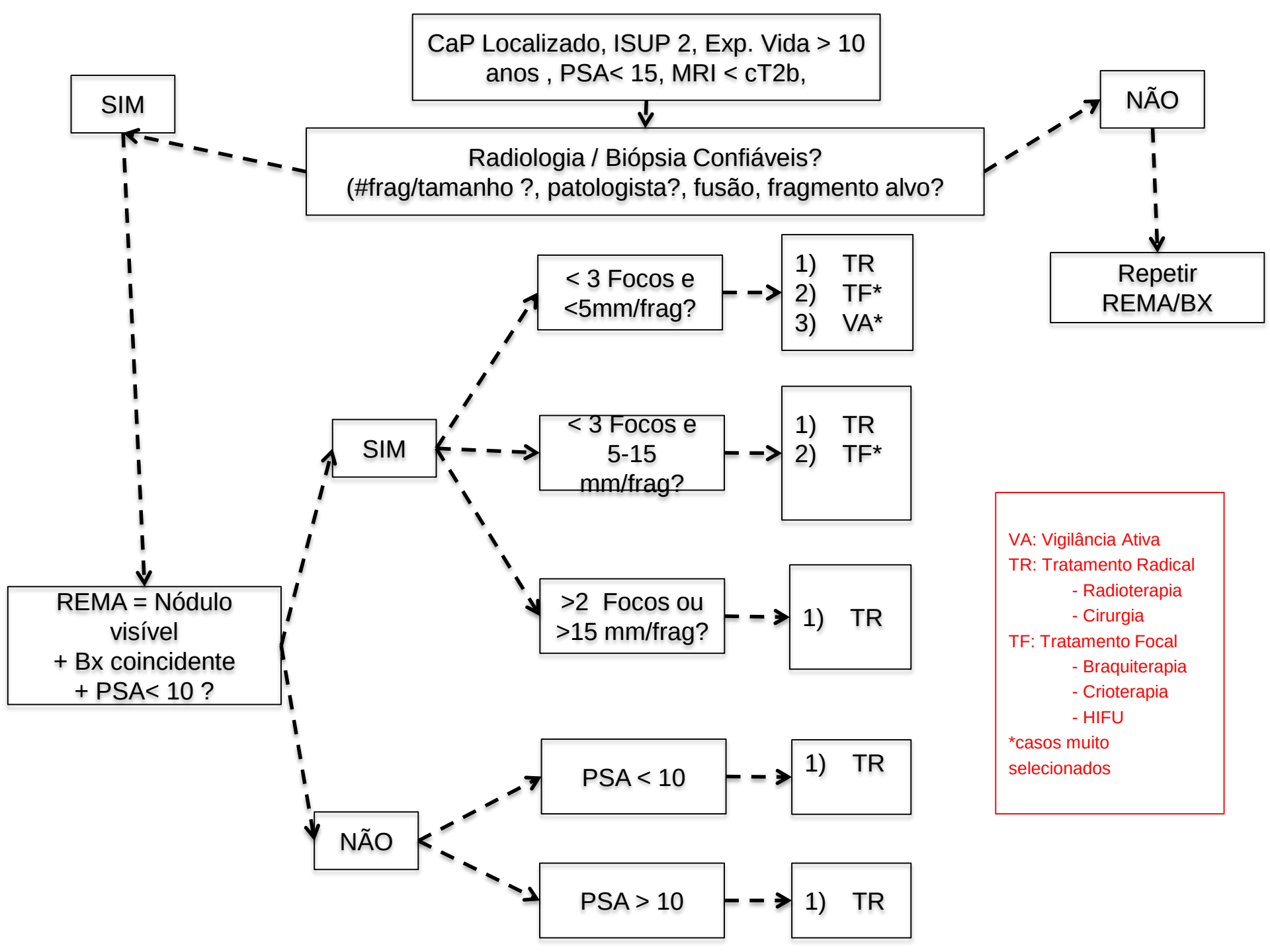
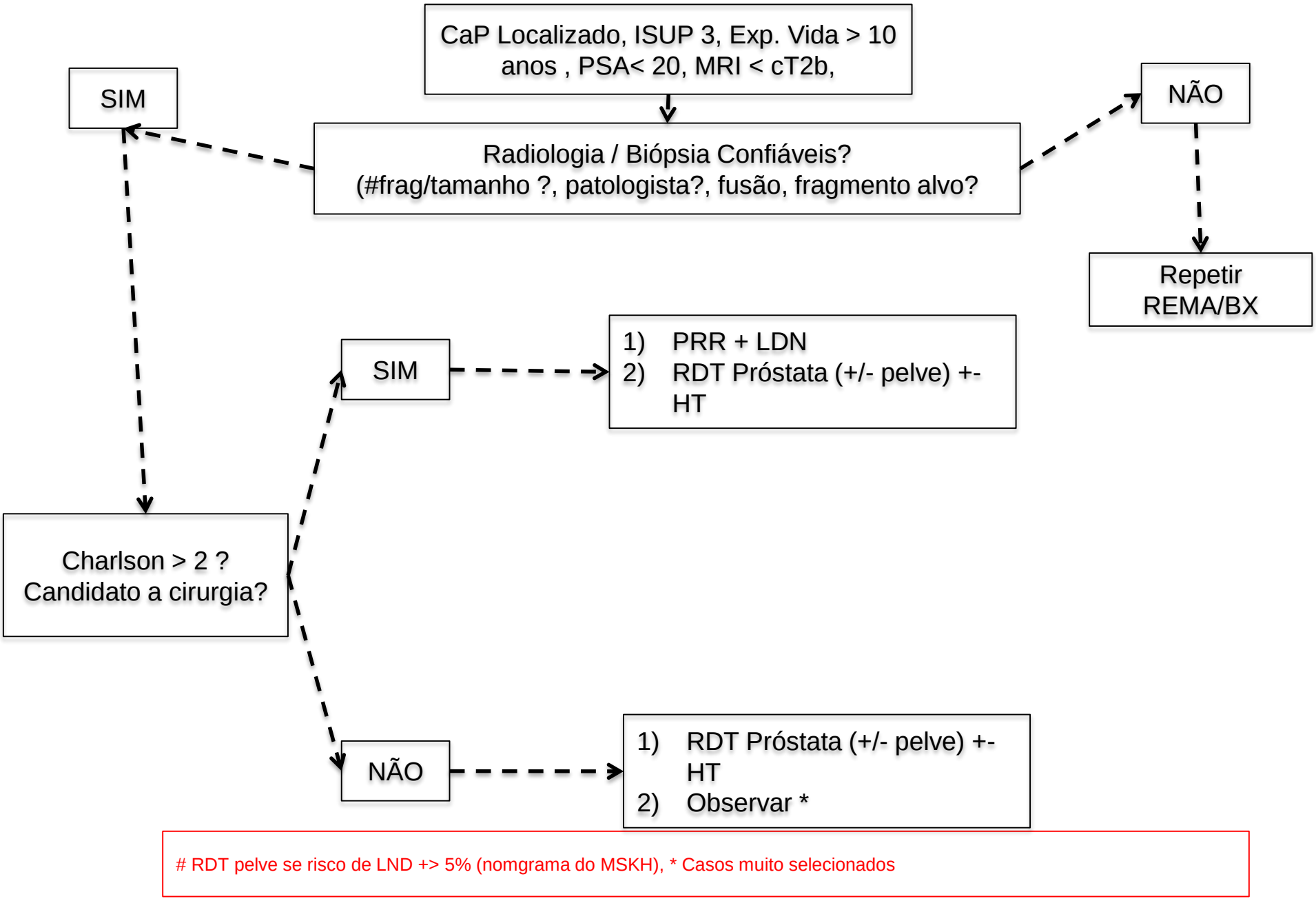
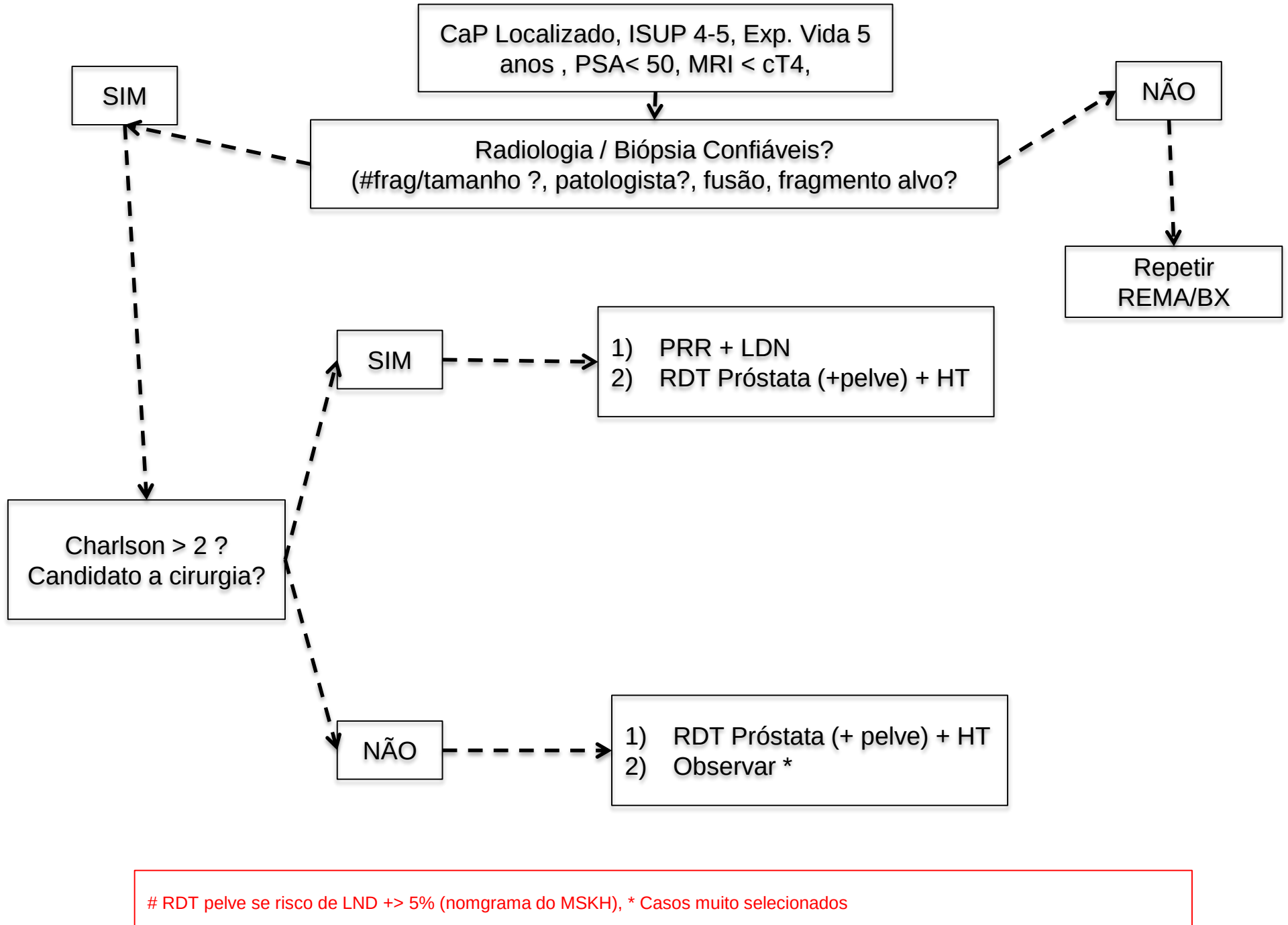
Tratamento de Câncer de Próstata a la carte


CaP Localizado, ISUP 2, Exp. Vida > 10 anos , PSA< 15, MRI < cT2b,
Radiologia / Biópsia Confiáveis? (#frag/tamanho ?, patologista?, fusão, fragmento alvo?
SIM
NÃO
Repetir REMA/BX
REMA = Nódulo visível + Bx coincidente + PSA< 10 ?
SIM
< 3 Focos e <5mm/frag?
1) TR 2) TF* 3) VA*
< 3 Focos e 5-15 mm/frag?
1) TR 2) TF*
>2 Focos ou >15 mm/frag?
1) TR
NÃO
PSA < 10
1) TR
PSA > 10
1) TR
VA: Vigilância Ativa
TR: Tratamento Radical
- Radioterapia
- Cirurgia
TF: Tratamento Focal
- Braquiterapia
- Crioterapia
- HIFU
*casos muito selecionados


CaP Localizado, ISUP 3, Exp. Vida > 10 anos , PSA< 20, MRI < cT2b,
SIM
Radiologia / Biópsia Confiáveis?
(#frag/tamanho ?, patologista?, fusão, fragmento alvo?
NÃO
Repetir REMA/BX
SIM
1) PRR + LDN
2) RDT Próstata (+/- pelve) +- HT
Charlson > 2 ?
Candidato a cirurgia?
NÃO
1) RDT Próstata (+/- pelve) +- HT
2) Observar *
RDT pelve se risco de LND +> 5% (nomgrama do MSKH), * Casos muito selecionados



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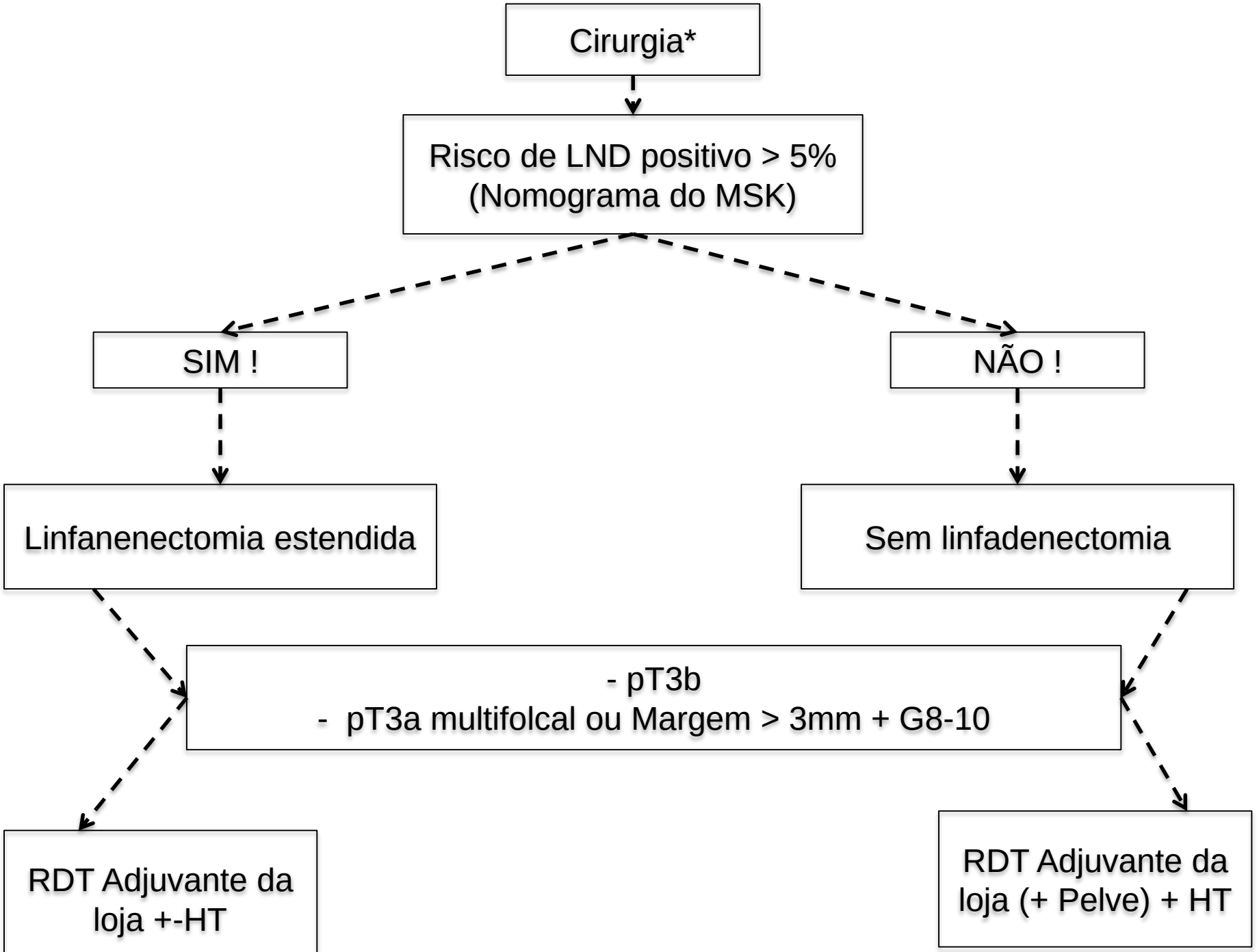
Cirurgia*
Risco de LND positivo > 5%
(Nomograma do MSK)
SIM !
NÃO !
Linfanenectomia estendida
Sem linfadenectomia
- pT3b
- pT3a multifolcal ou Margem > 3mm + G8-10
RDT Adjuvante da loja +-HT
RDT Adjuvante da loja (+ Pelve) + HT

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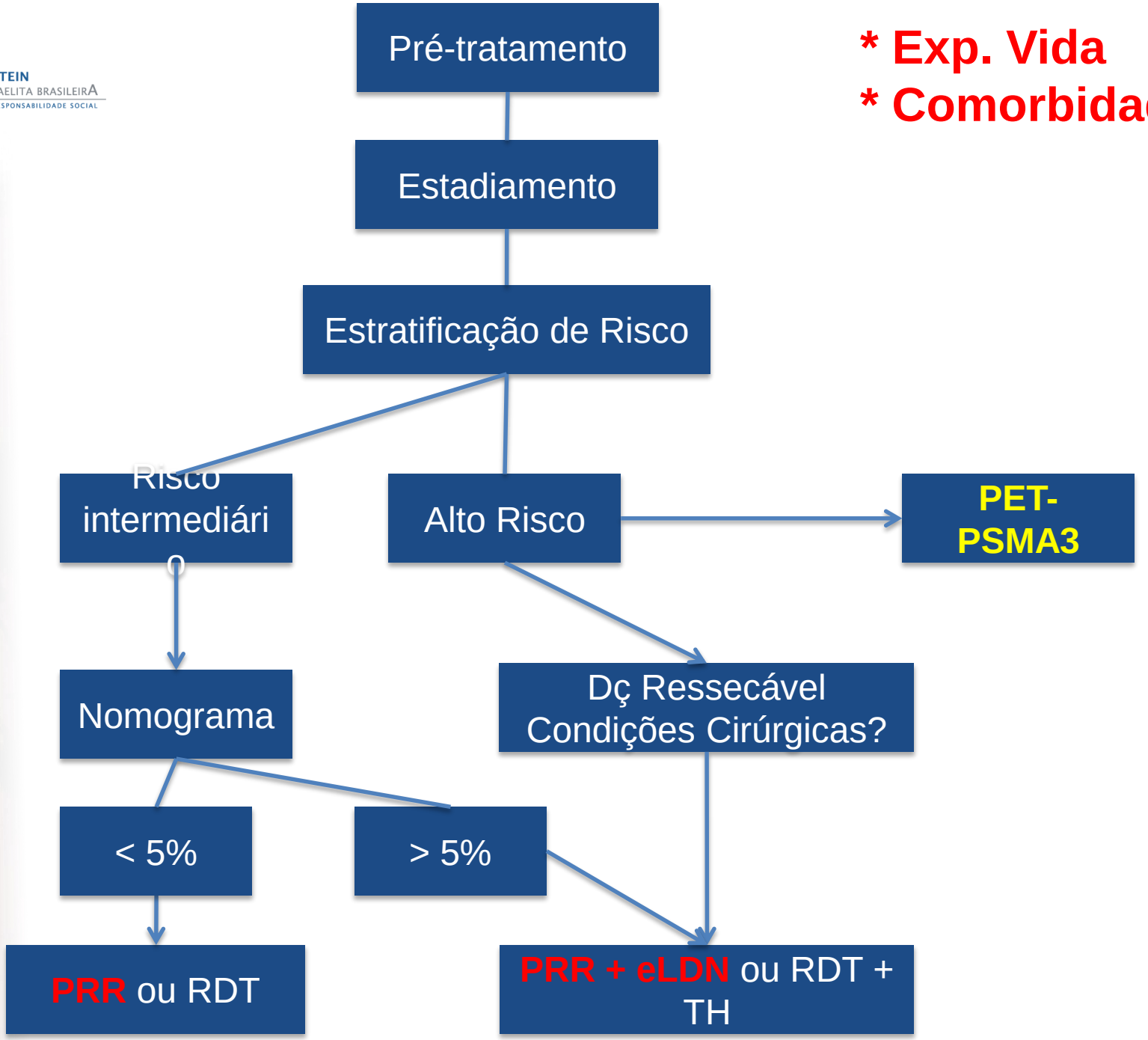
*** Exp. Vida**
*** Comorbidades**



SUMÁRIO

- Estadiamento PRECISO
  - PET-PSMA
  - Marcadores
- RDT → ASSOCIADA A HT = DE e eventos CDV!
- “Qualidade” da PR
- “Qualidade” da RDT
- **SEQUÊNCIA IDEAL = PR → RDT**

ABORDAGEM INDIVIDUALIZADA E MULTIDISCIPLINAR É O SEGREDO DO SUCESSO!

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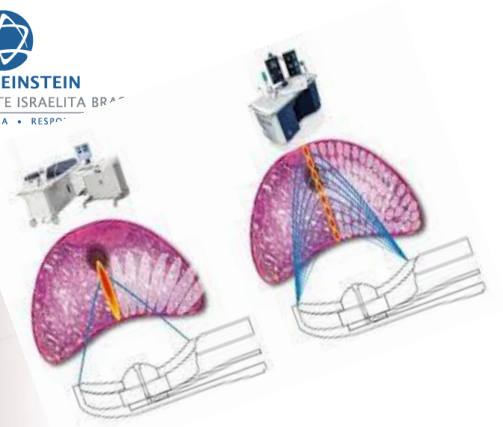
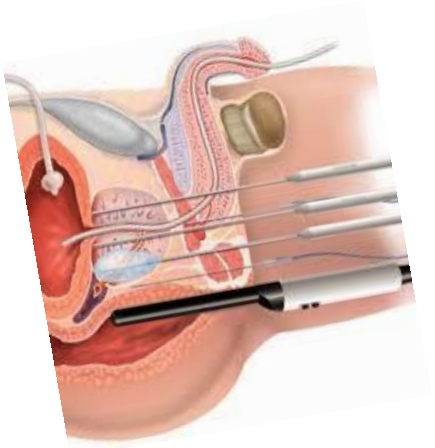
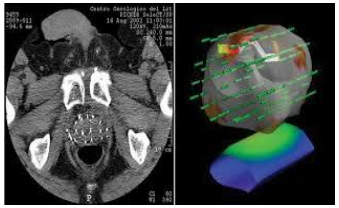
HOSPITAL • ENSINO E PESQUISA • RESPO







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