II SIMPÓSIO INTERNACIONAL

GU - REVIEW 2018 - LACOG

23 E 24 | NOVEMBRO 2018 | HOTEL INTERCONTINENTAL | SÃO PAULO

Câncer de **Próstata** de **Risco Intermediário**: Eu indico PROSTATECTOMIA

Marcelo Langer Wroclawski

Declaração de conflito de interesse

- De acordo com a Resolução 1595/2000 do Conselho Federal de Medicina e RDC 96/08 da ANVISA, declaro que:
  - SOU CIRURGIÃO!

Risco Intermediário

	Classificação de D'Amico											
	Classificação de Epstein											
	PSA		ISUP		Estadiamento		Densidade de PSA		Fragmentos +		Envolvimento de cada fragmento
Muito Baixo-Risco	< 10	E	1	E	T1 – T2a	E	< 15%	E	< 34%	E	< 50%
Baixo Risco	< 10	E	1	E	T1 – T2a		-		-		-
Risco Intermediário	10 – 20	OU	2 – 3	OU	T2b – T2c		-		-		-
Alto Risco	> 20	OU	4 – 5	OU	≥ T3		-		-		-

	ISUP	PSA	Estadiamento
Risco Intermediário Favorável	1	10 -20	T1 – T2a
	2	< 10	
Risco Intermediário Desfavorável	2	10 – 20	T2b – T2c
	3	-	-

Diretrizes

Clinically Localized Prostate Cancer: AUA/ASTRO/SUO Guideline

Published 2017

Martin G. Sanda, MD; Ronald C. Chen, MD; Tony Crispino; Stephen Freedland, MD; Kirsten Greene, MD; Laurence H. Klotz, MD; Danil V. Makarov, MD; Joel B. Nelson, MD; James Reston, PhD; George Rodrigues, MD; Howard M. Sandler, MD; Mary Ellen Taplin, MD; Jeffrey A. Cadeddu, MD

Intermediate-Risk Disease

15. Clinicians should consider staging unfavorable intermediate-risk localized prostate cancer patients with cross sectional imaging (CT or MRI) and bone scan. (Expert Opinion)
16. Clinicians should recommend radical prostatectomy or radiotherapy plus androgen deprivation therapy (ADT) as standard treatment options for patients with intermediate-risk localized prostate cancer. (Strong Recommendation; Evidence Level: Grade A)
17. Clinicians should inform patients that favorable intermediate-risk prostate cancer can be treated with radiation alone, but that the evidence basis is less robust than for combining radiotherapy with ADT. (Moderate Recommendation; Evidence Level: Grade B)
18. In select patients with intermediate-risk localized prostate cancer, clinicians may consider other treatment options such as cryosurgery. (Conditional Recommendation; Evidence Level: Grade C)
19. Active surveillance may be offered to select patients with favorable intermediate-risk localized prostate cancer; however, patients should be informed that this comes with a higher risk of developing metastases compared to definitive treatment. (Conditional Recommendation; Evidence Level: Grade C)
20. Clinicians should recommend observation or watchful waiting for men with a life expectancy ≤5 years with intermediate-risk localized prostate cancer. (Strong Recommendation; Evidence Level: Grade A)
21. Clinicians should inform intermediate-risk prostate cancer patients who are considering focal therapy or HIFU that these interventions are not standard care options because comparative outcome evidence is lacking. (Expert Opinion)

European Association of Urology

presented at the EAU Annual Congress Copenhagen 2018

N. Mottet (Chair), R.C.N. van den Bergh, E. Briers (Patient Representative), L. Bourke, P. Cornford (Vice-chair), M. De Santis, S. Gillessen, A. Govorov, J. Grummet, A.M. Henry, T.B. Lam, M.D. Mason, H.G. van der Poel, T.H. van der Kwast, O. Rouvière, T. Wiegel
Guidelines Associates: T. Van den Broeck, M. Cumberbatch, N. Fossati, T. Gross, M. Lardas, M. Liew, L. Moris, I.G. Schoots, P.M. Willemse

6.2.2.5. Guidelines for the treatment of intermediate-risk disease

Recommendations	Strength rating
Active surveillance (AS)	
Offer AS to highly selected patients (< 10% pattern 4) accepting the potential increased risk of further metastases.	Weak
Radical prostatectomy (RP)	
Offer RP to patients with intermediate-risk disease and a life expectancy > ten years.	Strong
Offer nerve-sparing surgery to patients with a low risk of extracapsular disease (refer to nomograms).	Strong
Pelvic lymph node dissection (ePLND)	
Perform an ePLND in intermediate-risk disease if the estimated risk for positive lymph nodes exceeds 5%.	Strong
Radiotherapeutic treatment	
Offer low-dose rate brachytherapy to selected patients (see Section 6.2.3.2.3); patients without a previous transurethral resection of the prostate and with a good International Prostatic Symptom Score and a prostate volume < 50 mL.	Strong
For external-beam radiation therapy (EBRT), use a total dose of 76-78 Gy, in combination with short-term neoadjuvant plus concomitant androgen deprivation therapy (ADT) (four to six months).	Strong
In patients not willing to undergo ADT, use an escalated dose of EBRT (76-80 Gy) or a combination with brachytherapy.	Weak
Other therapeutic options	
Only offer whole gland treatment (such as cryotherapy, high-intensity focused ultrasound, etc.) or focal treatment within a clinical trial setting.	Strong

Diretrizes

National Comprehensive Cancer Network®

NCCN Guidelines Version 4.2018 Prostate Cancer

FAVORABLE INTERMEDIATE RISK GROUP

EXPECTED PATIENT SURVIVAL[b]	INITIAL THERAPY
≥10 y	Active surveillance[r]
	EBRT[e] or brachytherapy alone[e]
	RP[s] ± PLND if predicted probability of lymph node metastasis ≥2%

UNFAVORABLE INTERMEDIATE RISK GROUP

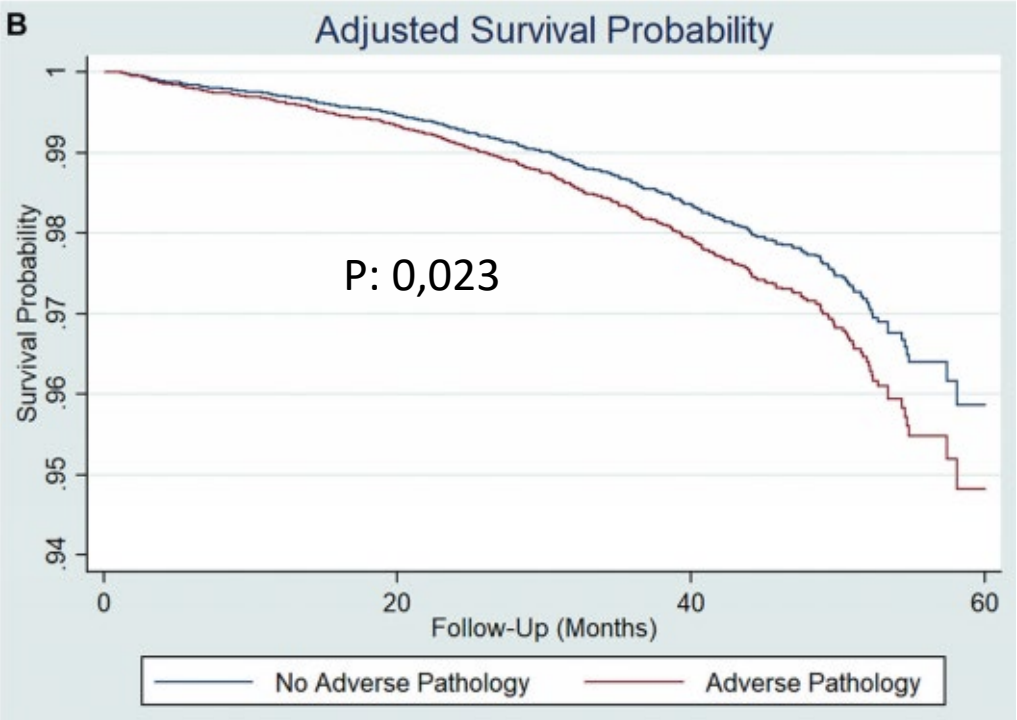
EXPECTED PATIENT SURVIVAL[b]	INITIAL THERAPY
≥10 y[z]	RP[s] ± PLND if predicted probability of lymph node metastasis ≥2%
	EBRT[e] + ADT[f] (4-6 mo) or EBRT[e] + brachytherapy[e] ± ADT[f] (4-6 mo)

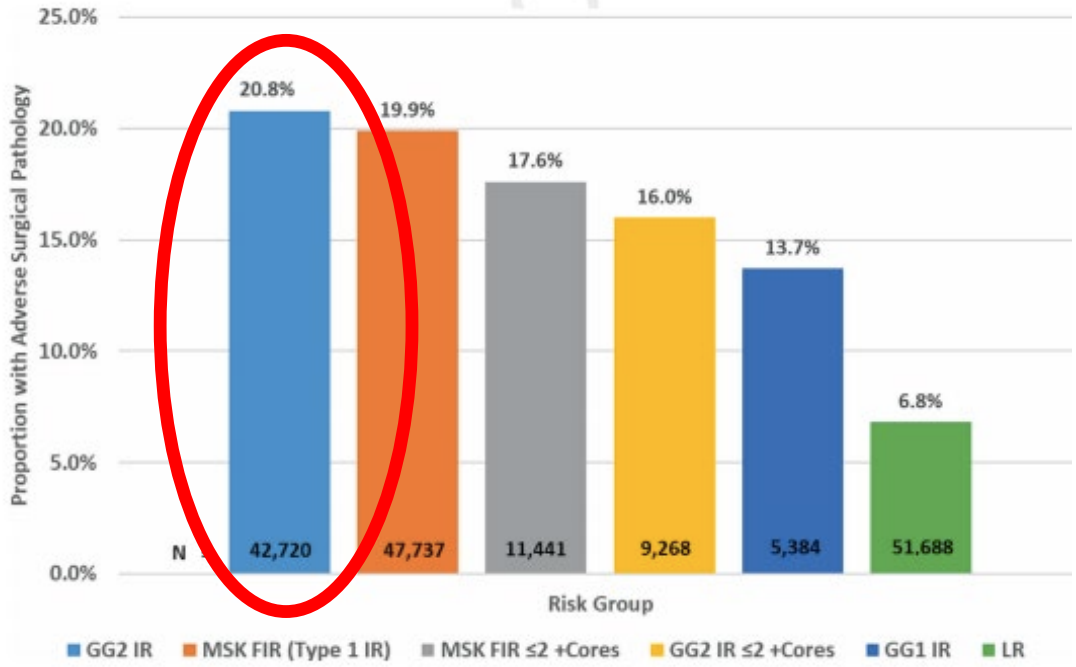
THE JOURNAL of UROLOGY
November 2018 Volume 200, Issue 5, Pages 1068–1074

Subtyping the Risk of Intermediate Risk Prostate Cancer for Active Surveillance Based on Adverse Pathology at Radical Prostatectomy

Hiten D. Patel,* Mohit Gupta, Jeffrey J. Tosoian, H. Ballentine Carter, Alan W. Partin and Jonathan I. Epstein

- National Cancer DataBase
- 42.720 Prostate Radical por RI Favorável (GG2)
- Incidência de Patologia Adversa
  - GG3, pT3b





EUROPEAN UROLOGY XXX (2018) XXX–XXX

A Novel Nomogram to Identify Candidates for Extended Pelvic Lymph Node Dissection Among Patients with Clinically Localized Prostate Cancer Diagnosed with Magnetic Resonance Imaging-targeted and Systematic Biopsies

Giorgio Gandaglia [a], Guillaume Ploussard [b], Massimo Valerio [c], Agostino Mattei [d], Cristian Fiori [e], Nicola Fossati [a], Armando Stabile [a], Jean-Baptiste Beauval [f], Bernard Malavaud [f], Mathieu Roumiguié [f], Daniele Robesti [a], Paolo Dell'Oglio [a], Marco Moschini [d], Stefania Zamboni [d], Arnas Rakauskas [c], Francesco De Cobelli [g,h], Francesco Porpiglia [e], Francesco Montorsi [a,h], Alberto Briganti [a,h,]*

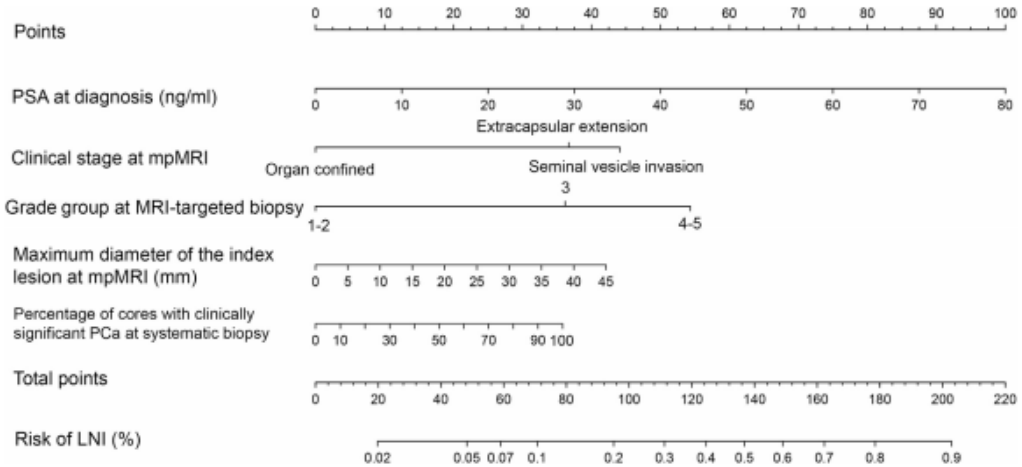


Table 3 – Systematic analyses of the novel nomogram-derived cutoffs used to discriminate between patients with or without hLNI

Nomogram cutoff	Number of patients, *n* (%)					
	Below the cutoff (PLND not recommended)			Above the cutoff (PLND recommended		
	Total	Without hLNI	With hLNI	Total	Without hLNI	With hLNI
2%	13 (3.2)	12 (92)	1 (7.7)	415 (97)	362 (87)	53 (13)
3%	164 (38)	162 (98)	2 (1.2)	264 (62)	212 (80)	52 (20)
4%	200 (47)	197 (98)	3 (1.5)	228 (53)	177 (78)	51 (22)
5%	217 (51)	213 (98)	4 (1.8)	211 (49)	161 (76)	50 (24)
6%	231 (54)	227 (98)	4 (1.7)	197 (46)	147 (75)	50 (25)
7%	244 (57)	240 (98)	4 (1.6)	184 (43)	134 (73)	50 (27)
8%	256 (60)	251 (98)	5 (2.0)	172 (40)	123 (71)	49 (29)
9%	266 (62)	260 (98)	6 (2.3)	162 (38)	114 (70)	48 (30)
10%	283 (66)	276 (97)	7 (2.5)	145 (34)	98 (68)	47 (32)

LNI = lymph node invasion; hLNI = histologically confirmed LNI; PLND = pelvic lymph node dissection.

Classicamente

Diagnóstico de CaP

↓ 66%

Tratamento Curativo

↓ 40%

Recidiva Bioquímica

→ Suspeita de Recidiva local → RTx ou Cirurgia de salvamento

→ Doença Sistêmica → HTx

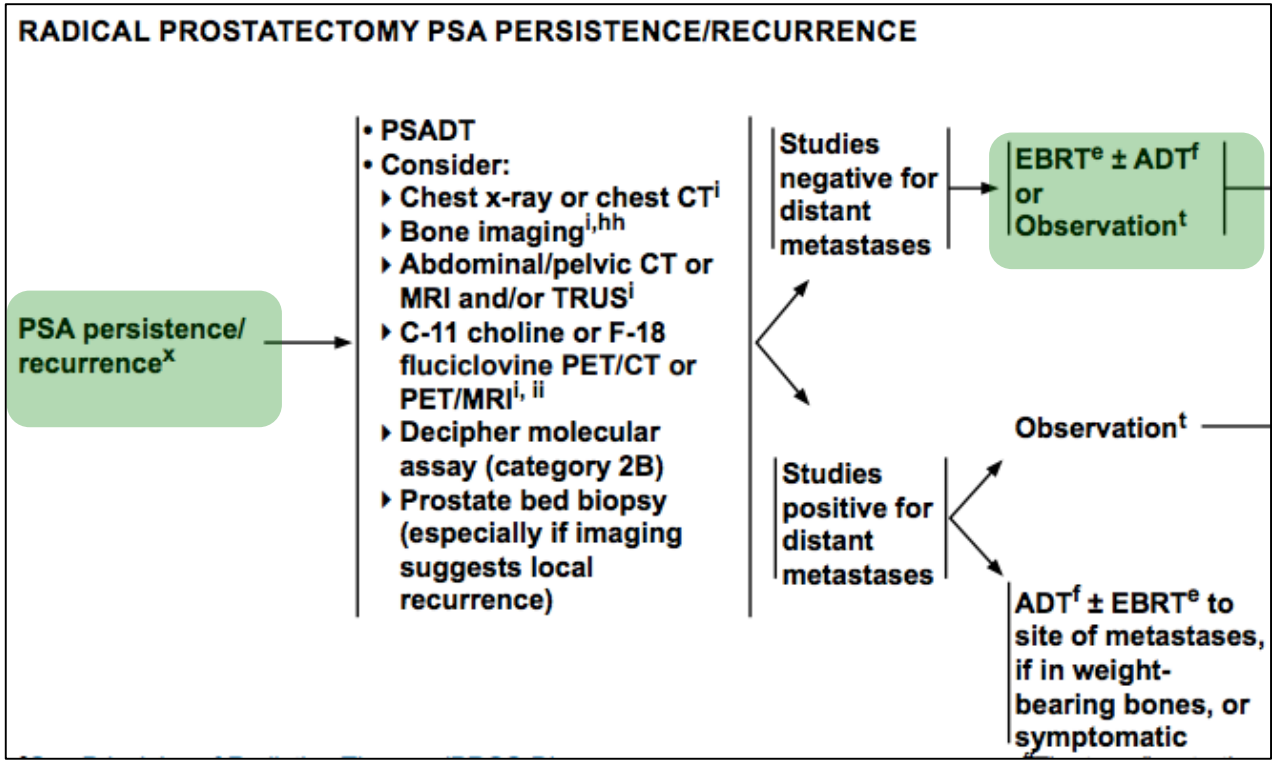
- > 50.000 casos/ano (EUA)

Suardi N, et al. Cancer;112:1254–63, 2008

RECIDIVA LOCAL → RESGATE

National Comprehensive Cancer Network®

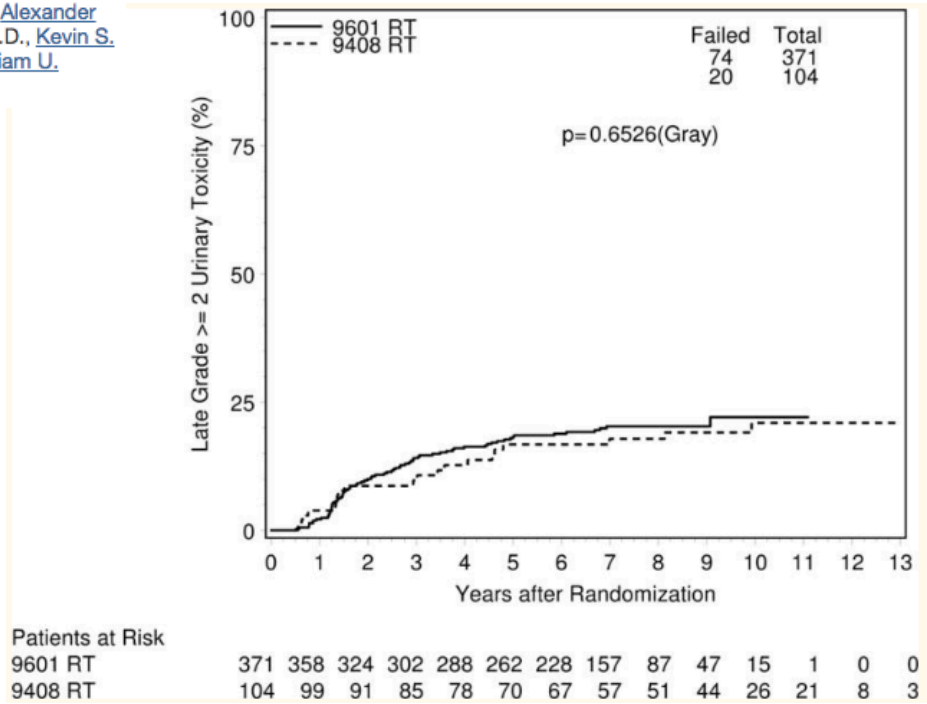
NCCN Guidelines Version 4.2018
Prostate Cancer



UROLOGIC ONCOLOGY
Seminars and Original Investigations
October 2016 Volume 34, Issue 10, Pages 430.e1–430.e7

Acute and late urinary toxicity following radiation in men with an intact prostate gland or after a radical prostatectomy: A secondary analysis of RTOG 94-08 and 96-01

Raymond H. Mak, M.D., Daniel Hunt, Ph.D., Jason A. Efstathiou, M.D., D.Phil., Niall M. Heney, M.D., Christopher U. Jones, M.D., Himu R. Lukka, M.D., Jean-Paul Bahary, M.D., Malti Patel, M.D., Alexander Balogh, M.D., Abdenour Nabid, M.D., Mark H. Leibenhaut, M.D., Daniel A. Hamstra, M.D., Ph.D., Kevin S. Roof, M.D., Robert Jeffrey Lee, M.D., Elizabeth M. Gore, M.D., Howard M. Sandler, M.D., William U. Shipley, M.D.



- RTOG 94-08
  - 104 RT prostática primária (68,4 Gy)
- RTOG 96-01
  - 371 RT fossa prostática (64,8 Gy)
- Toxicidade urinária aguda e tardia

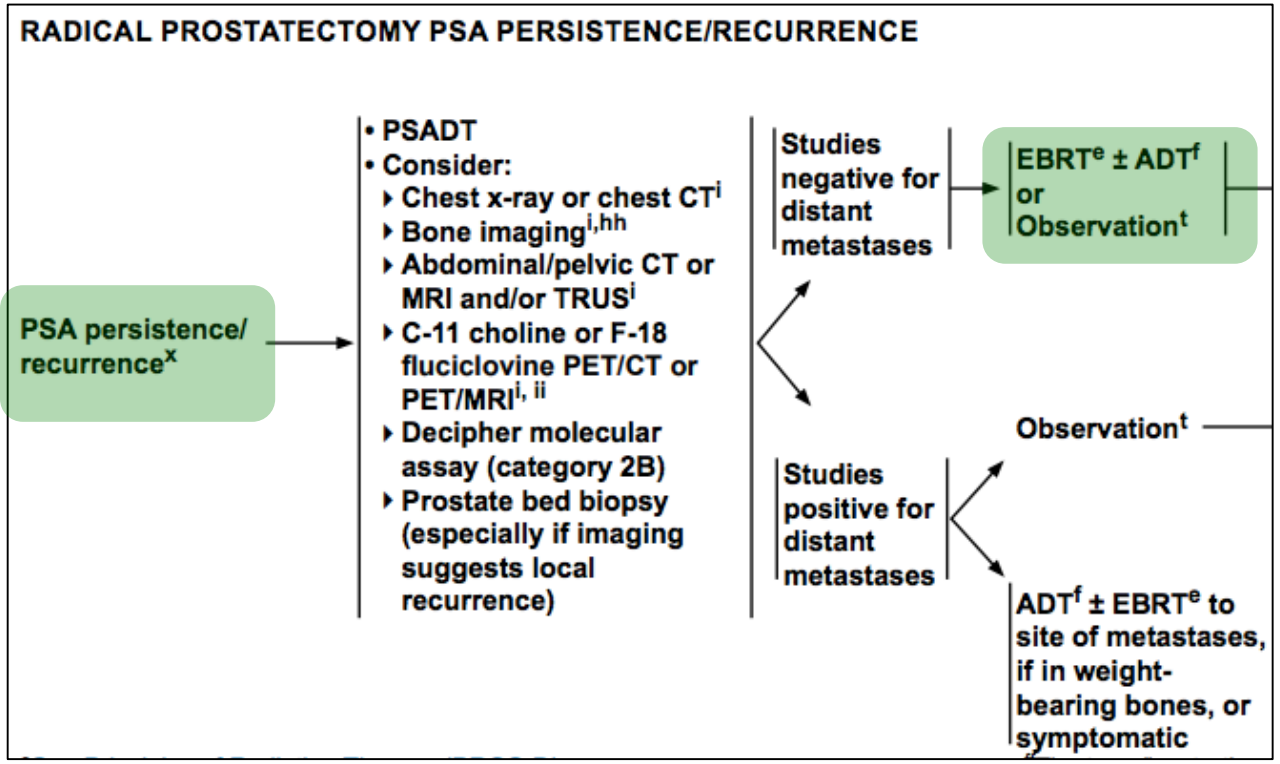
Toxicidade Aguda

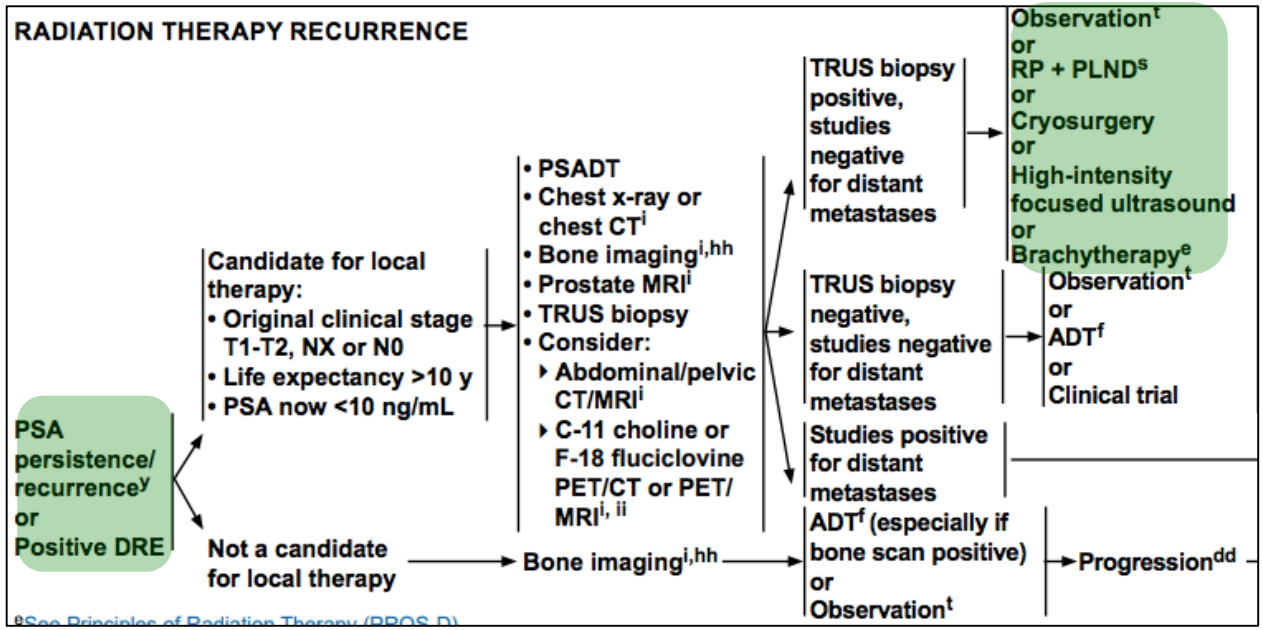
	Grau 1	Grau 2	Grau 3	Grau 4
RTOG 9408	39 (37,5%)	28 (26,9%)	4 (3,8%)	0
RTOG 9601	125 (33,7%)	42 (11,3%)	10 (2,7%)	0
p		0,02		

RECIDIVA LOCAL → RESGATE

National Comprehensive Cancer Network®

NCCN Guidelines Version 4.2018
Prostate Cancer





EUROPEAN UROLOGY 61 (2012) 961–971

Cancer Control and Functional Outcomes of Salvage Radical Prostatectomy for Radiation-recurrent Prostate Cancer: A Systematic Review of the Literature

Daher C. Chade [a,b,], James Eastham [a], Markus Graefen [c], Jim C. Hu [d], R. Jeffrey Karnes [e], Laurence Klotz [f], Francesco Montorsi [g], Hendrik van Poppel [h], Peter T. Scardino [a], Shahrokh F. Shariat [i]*

Table 2 – Surgical complications after salvage surgery

First author	Yr	No.	Technique	Operating time, min, median	Rectal injury, %	Anastomotic stricture, %	Clavien 3–5, %	Blood loss, ml, mean, range	Blood transfusion, %
			Open						
Neerhut	1988	16	SRP	–	19	25	6	–	–
Rainwater	1988	30	27 SRP; 3 SCP	–	0	17	–	–	–
Link	1991	14	SRP	185	0	7	7	1000# (300–8000)	–
Moul	1991	22	4 SPP; 18 SCP/RCP	480 (SPP 260)	–	–	–	800# (200–1800)	–
Stein	1992	13	11 SRP; 2 SCP	211	8	15	0	1100 (500–2350)	–
Pontes	1993	43	35 SRP; 8 SCP	180–360	9	11	–	–	–
Lerner	1995	132	79 SRP; 53 Ex/PLND	–	6	12	–	–	–
Rogers	1995	40	40 SRP	270	15	27.5	22.5	910 (350–2200)	–
Gheiler	1998	40	30 SRP; 10 SCP	220	–	–	–	1100#	–
Amling	1999	108	108 SRP	–	6	21	–	–	43
Pisters	2000	13	13 SRPcath	–	0	–	30	1850 (800–2800)	–
Stephenson	2004	100	100 SRP*	264 vs 222	15 vs 2	30	33 vs 13	–	–
Ward	2005	199	138 SRP; 61 SCP	–	5 vs 10	22	–	–	–
Darras	2006	11	SRP	119	–	18	–	494 (300–800)	–
Sanderson	2006	51	SRP	–	2	41	6	–	–
Leonardo	2009	32	SRP	122	0	12	0	550 (350–1200)	–
Gotto	2010	98	SRP	–	9	41	25	–	–
Heidenreich	2010	55	SRP	120	2	11	3.6	360 (150–1450)	4
			Laparoscopic						
Vallencien	2003	7	Transperitoneal	190	0	0	0	387 (50–1100)	0
Stolzenburg	2007	9	Extraperitoneal	148	0	0	11	238 (100–400)	0
Nunez-Mora	2009	9	Transperitoneal	170	0	0	11	260 (100–500)	0
			Robotic						
Kaouk	2008	4	Robotic SRP	125	0	–	0	117 (50–250)	–
Boris	2009	11	Robotic SRP	183	9	9	9	113 (50–300)	–
Eandi	2010	18	Robotic SRP	160	0	17	17	150 (50–350)	0
Strope	2010	6	Robotic SRP	356	0	33	33	280 (50–800)	–
Chauhan	2011	15	Robotic SRP	140	0	–	6	75# (50–100)	0

SRP = salvage radical prostatectomy; SCP = salvage cystoprostatectomy; RCP = radical cystoprostatectomy; SPP = salvage perineal prostatectomy; Ex = exenteration; PLND = pelvic lymph node dissection; SRPcath = SRP with urinary catheterizable reconstruction.
* SRP performed before vs after 1993.
\# Median.

Table 3 – Functional outcomes after salvage surgery

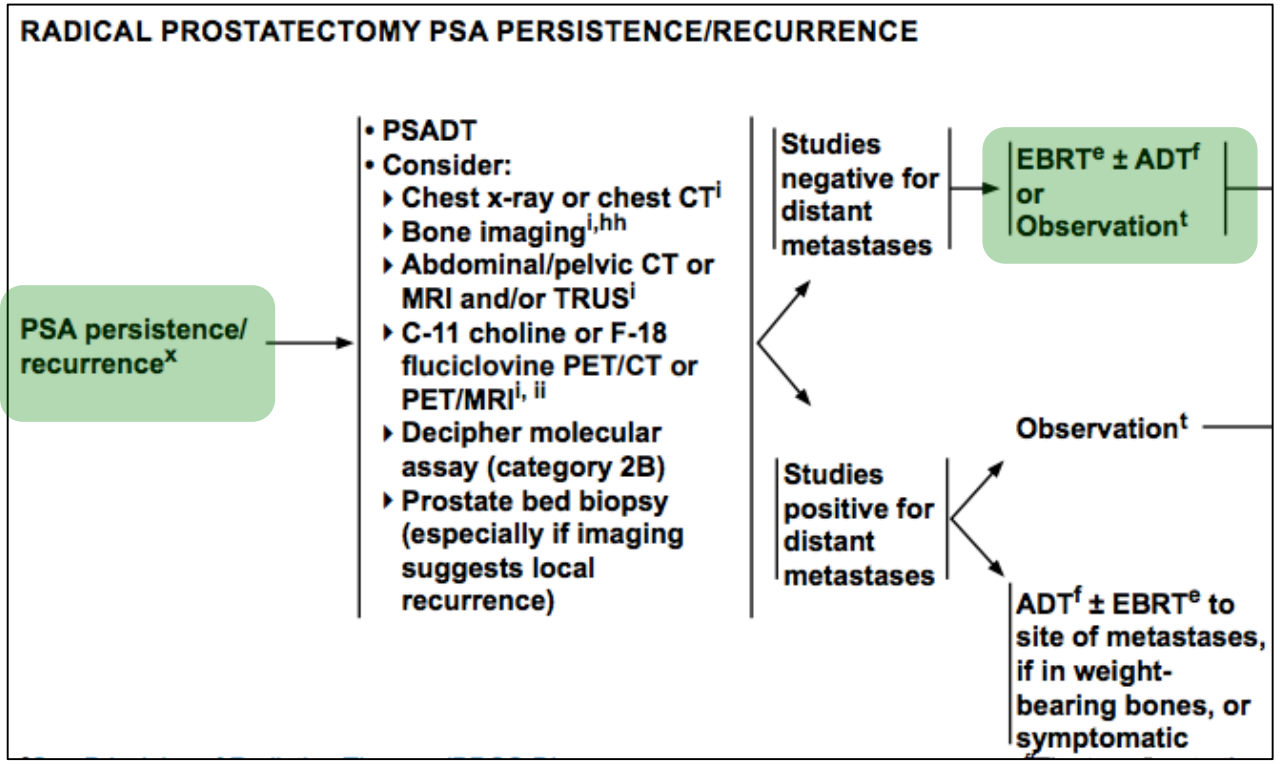
First author	Yr	No.	Technique	Follow-up, mo, median	Pre-SRP EF, %	Post-SRP EF, %	Urinary continence, %
			Open				
Neerhut	1988	16	SRP	–	–	–	75
Rainwater	1988	30	27 SRP; 3 SCP	81	–	–	90
Link	1991	14	SRP	18	43	0	45
Moul	1991	22	4 SPP; 18 SCP/RCP	49	–	–	100 (Pr)
Ahlering	1992	35	11 SRP; 24 SCP		–	–	36 (SRP)
Stein	1992	13	11 SRP; 2 SCP	–	–	–	46
Pontes	1993	43	35 SRP; 8 SCP	120	–	–	54
Lerner	1995	132	79 SRP; 53 Ex/PLND	60	–	–	61
Rogers	1995	40	40 SRP	39	–	–	42
Gheiler	1998	40	30 SRP; 10 SCP	36	–	–	50
Amling	1999	108	108 SRP	–	–	–	49
Pisters	2000	13	13 SRPcath	–	–	–	83
Stephenson	2004	100	100 SRP	–	–	28	68
Masterson	2005	59	SRP	–	47	21*	–
Ward	2005	199	138 SRP; 61 SCP	84	–	–	56
Darras	2006	11	SRP	83	–	0	45
Sanderson	2006	51	SRP	90	–	13–66#	70#
Leonardo	2009	32	SRP	35	9	9*	21
Gotto	2010	98	SRP	34	33	8	30
Heidenreich	2010	55	SRP	23	27	7	81
			Laparoscopic SRP				
Vallencien	2003	7	Transperitoneal	11	28	0	71
Stolzenburg	2007	9	Extraperitoneal	17	33	0	78
Nunez-Mora	2009	9	Transperitoneal	27	20	0	67
			Robotic				
Kaouk	2008	4	Robotic SRP	–	–	–	75
Boris	2009	11	Robotic SRP	20	90	20	80
Eandi	2010	18	Robotic SRP	18	44	0	33
Strope	2010	6	Robotic SRP	–	50	0	0
Chauhan	2011	15	Robotic SRP	5	67	0	71

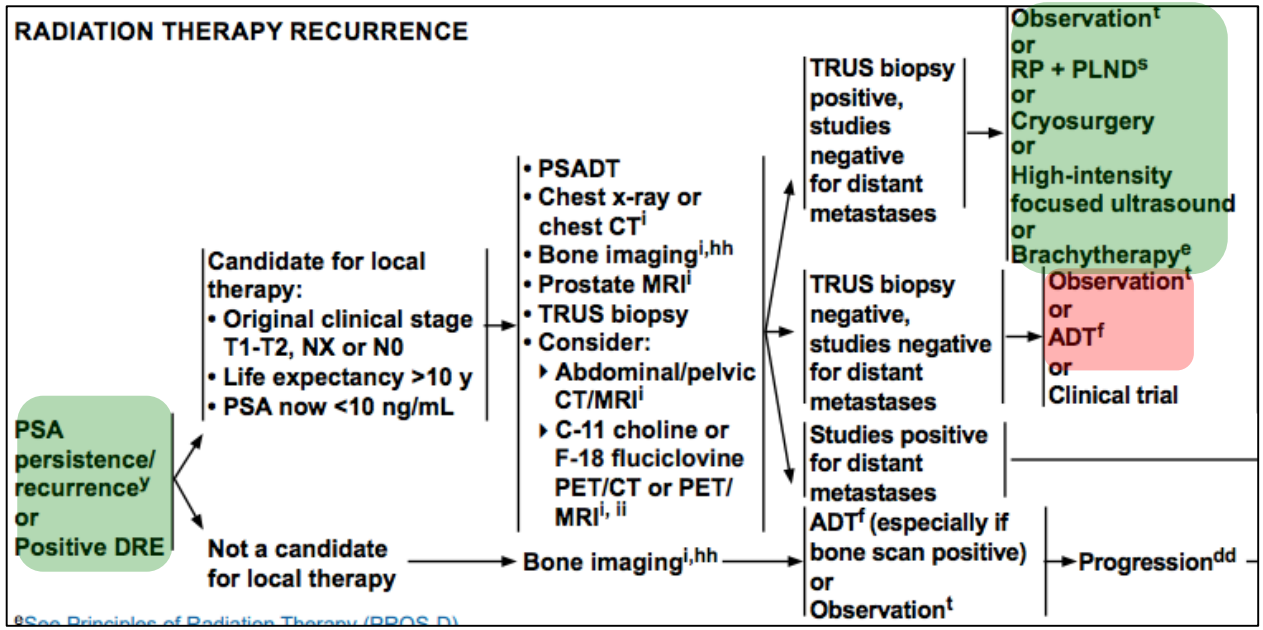
SRP = salvage radical prostatectomy; EF = erectile function; SCP = salvage cystoprostatectomy; RCP = radical cystoprostatectomy; Ex = exenteration; PLND = pelvic lymph node dissection; SRPcath = SRP with urinary catheterizable reconstruction.
* With sildenafil.
\# University of California, Los Angeles, Prostate Cancer Index.

RECIDIVA LOCAL → RESGATE

National Comprehensive Cancer Network®

NCCN Guidelines Version 4.2018
Prostate Cancer



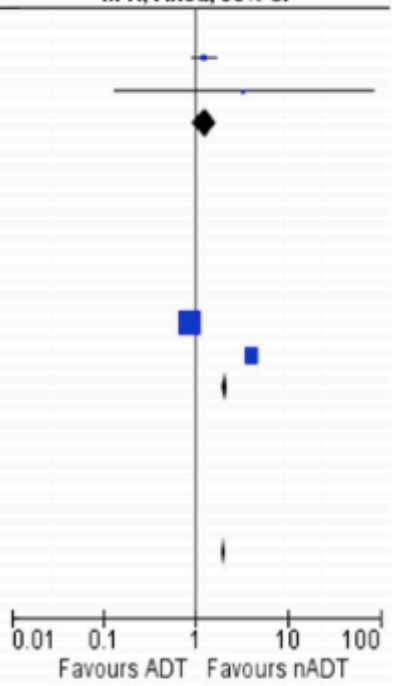


Cardiovascular events associated with androgen deprivation therapy in patients with prostate cancer: a systematic review and meta-analysis

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

World Journal of Urology
September 2015, Volume 33, Issue 9, pp 1281–1289

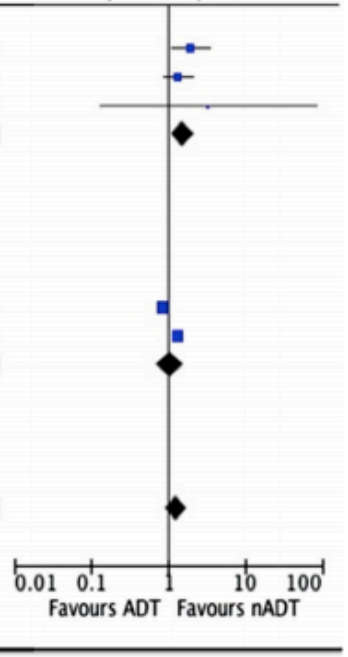
Study or Subgroup	ADT Events	ADT Total	nADT Events	nADT Total	Weight	Odds Ratio M-H, Fixed, 95% CI
2.2.1 RCT ADT vs nADT						
Iversen P 2010	103	4052	85	4061	4.8%	1.22 [0.91, 1.63]
Messing 1999	1	47	0	51	0.0%	3.32 [0.13, 83.58]
Subtotal (95% CI)		**4099**		**4112**	**4.8%**	**1.23 [0.92, 1.64]**
Total 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

Study or Subgroup	ADT Events	ADT Total	nADT Events	nADT Total	Weight	Odds Ratio M-H, Random, 95% CI
4.2.1 RCT ADT vs nADT						
Iversen P 2004	34	607	18	611	15.8%	1.95 [1.09, 3.50]
Iversen P 2006	48	605	37	609	20.0%	1.33 [0.85, 2.08]
Messing 1999	1	47	0	51	1.0%	3.32 [0.13, 83.58]
Subtotal (95% CI)		**1259**		**1271**	**36.8%**	**1.55 [1.09, 2.20]**
Total events	83		55			
Heterogeneity: Tau² = 0.00; Chi² = 1.27, df = 2 (P = 0.53); I² = 0%						
Test for overall effect: Z = 2.44 (P = 0.01)						
4.2.2 Cohort ADT vs nADT						
Alibhai 2009	4502	19079	5051	19079	31.5%	0.86 [0.82, 0.90]
Van Hemelrijck 2010	8807	30642	10821	45958	31.6%	1.31 [1.27, 1.35]
Subtotal (95% CI)		**49721**		**65037**	**63.2%**	**1.06 [0.70, 1.61]**
Total events	13309		15872			
Heterogeneity: Tau² = 0.09; Chi² = 213.22, df = 1 (P < 0.00001); I² = 100%						
Test for overall effect: Z = 0.28 (P = 0.78)						
Total (95% CI)		**50980**		**66308**	**100.0%**	**1.24 [0.89, 1.72]**
Total events	13392		15927			
Heterogeneity: Tau² = 0.09; Chi² = 217.43, df = 4 (P < 0.00001); I² = 98%						
Test for overall effect: Z = 1.27 (P = 0.20)						
Test for subgroup differences: Chi² = 1.86, df = 1 (P = 0.17), I² = 46.3%						



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

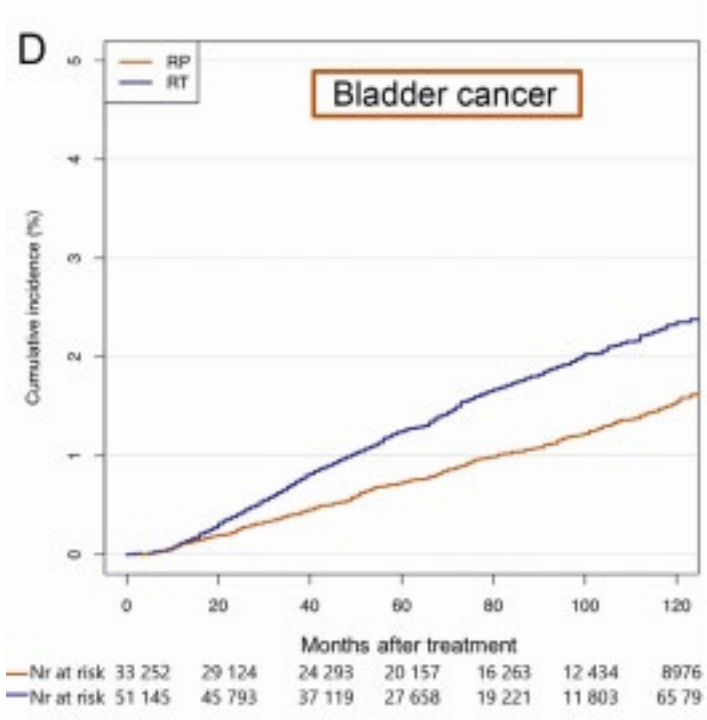
Fig. 5 Nonfatal cardiovascular events risk associated with ADT

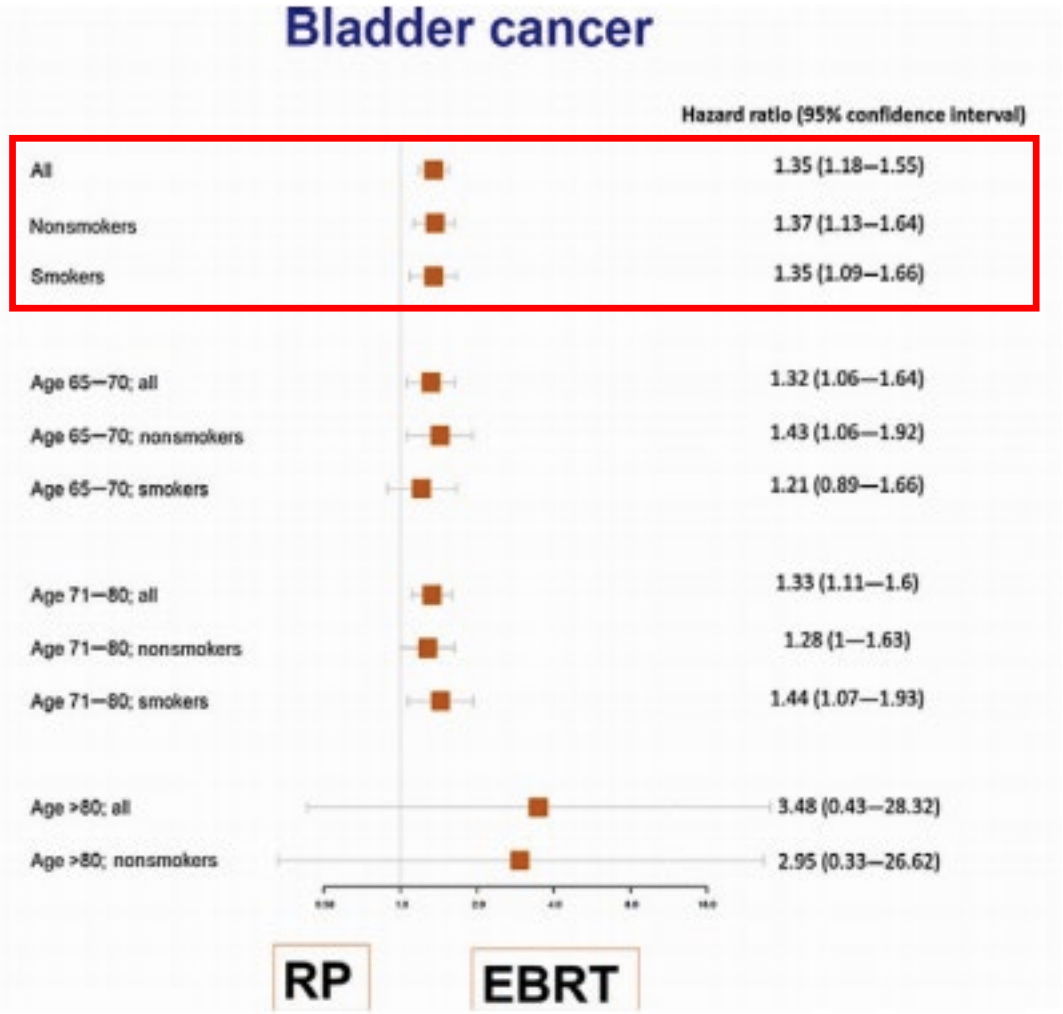
EUROPEAN UROLOGY XXX (2018) XXX–XXX

External Beam Radiotherapy Increases the Risk of Bladder Cancer When Compared with Radical Prostatectomy in Patients Affected by Prostate Cancer: A Population-based Analysis

Marco Moschini [a,b,c,†,], Emanuele Zaffuto [b,d,†], Pierre I. Karakiewicz [d], David D. Andrea [a], Beat Foerster [a], Mohammad Abufaraj [a,e], Francesco Soria [a], Agostino Mattei [c], Francesco Montorsi [b], Alberto Briganti [b], Shahrokh F. Shariat [a,f,g,h]*

- SEER DataBase
- 84.397 CaP localizado > 65 anos, de 1988 a 2009
  - 33.252 (39%) PR x 51.145 (61%) RT
- Seguimento mediano: 69 meses



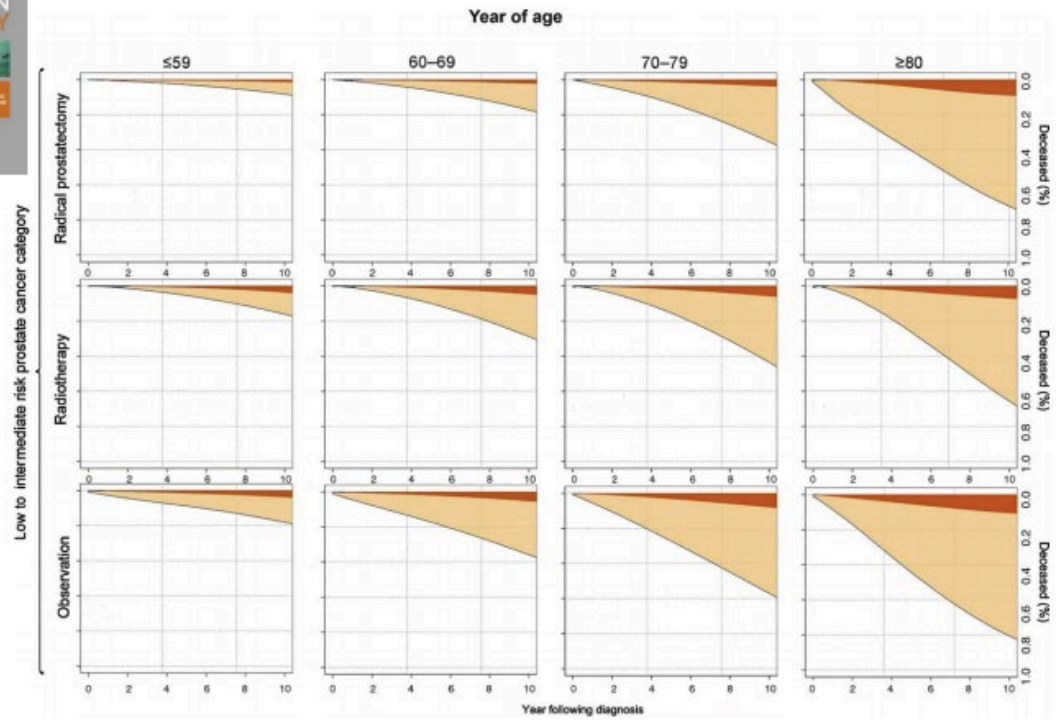


EUROPEAN UROLOGY 59 (2011) 88–95

A Competing-Risks Analysis of Survival After Alternative Treatment Modalities for Prostate Cancer Patients: 1988–2006

Firas Abdollah [a,b,], Maxine Sun [a], Rodolphe Thuret [a,b,c], Claudio Jeldres [a,b,c,d,e], Zhe Tian [a], Alberto Briganti [b], Shahrokh F. Shariat [d], Paul Perrotte [a,b,c,d,e], Patrizio Rigatti [b], Francesco Montorsi [b], Pierre I. Karakiewicz [a,b,c,d,e]*

- Mortalidade Câncer-Específica e Mortalidade por outras causas, em 10 anos
- SEER Data-Base
- 404.604 CaP localizado, de 1988 a 2006
  - 271.898 CaP risco baixo e intermediário
- PR x RT x OBS
  - PR: 107.610
  - RT: 101.688
  - Obs: 62.600



Mortalidade Câncer-Específica

Mortalidade por outras causas

Vivos

Table 2 – Estimates of 10-yr cancer-specific and other-cause mortality rates of 404 604 patients with nonmetastatic adenocarcinoma of the prostate managed with radical prostatectomy, radiation therapy, or observation within 17 Surveillance, Epidemiology and End Results registries, stratified according to age category and tumor risk group

Management (n)	Age at surgery, yr							
	≤59		60–69		70–79		80	
	CSM (95% CI)	OCM (95% CI)	CSM (95% CI)	OCM (95% CI)	CSM (95% CI)	OCM (95% CI)	CSM (95% CI)	OCM (95% CI)
Low- to intermediate-risk tumor category								
RP (107 610)	1.3 (1.3–1.3)*†	6.9 (6.7–6.8)*†	2.0 (2.0–2.0)*†	14.8 (14.8–14.8)*†	3.7 (3.7–3.7)*†	31.6 (31.6–31.6)*†	8.9 (8.8–9.2)	62.8 (62.5–63.1)**
RT (101 688)	3.2 (3.1–3.2)	12.0 (12.0–12.0)*	4.5 (4.5–4.5)*	23.9 (23.9–23.9)*	5.6 (5.6–5.6)*	37.5 (37.5–37.5)*	6.9 (6.8–6.9)*	59.7 (59.6–59.8)*
Observation (62 600)	3.6 (3.6–3.6)	14.7 (14.6–14.8)	4.8 (4.8–4.8)	30.5 (30.5–30.5)	7.6 (7.6–7.6)	49.2 (49.2–49.2)	10.5 (10.5–10.5)	70.9 (70.8–71.0)

CLINICAL Genitourinary Cancer
Prostate, Kidney, & Bladder
February 2018 Volume 16, Issue 1, Pages e39–e46

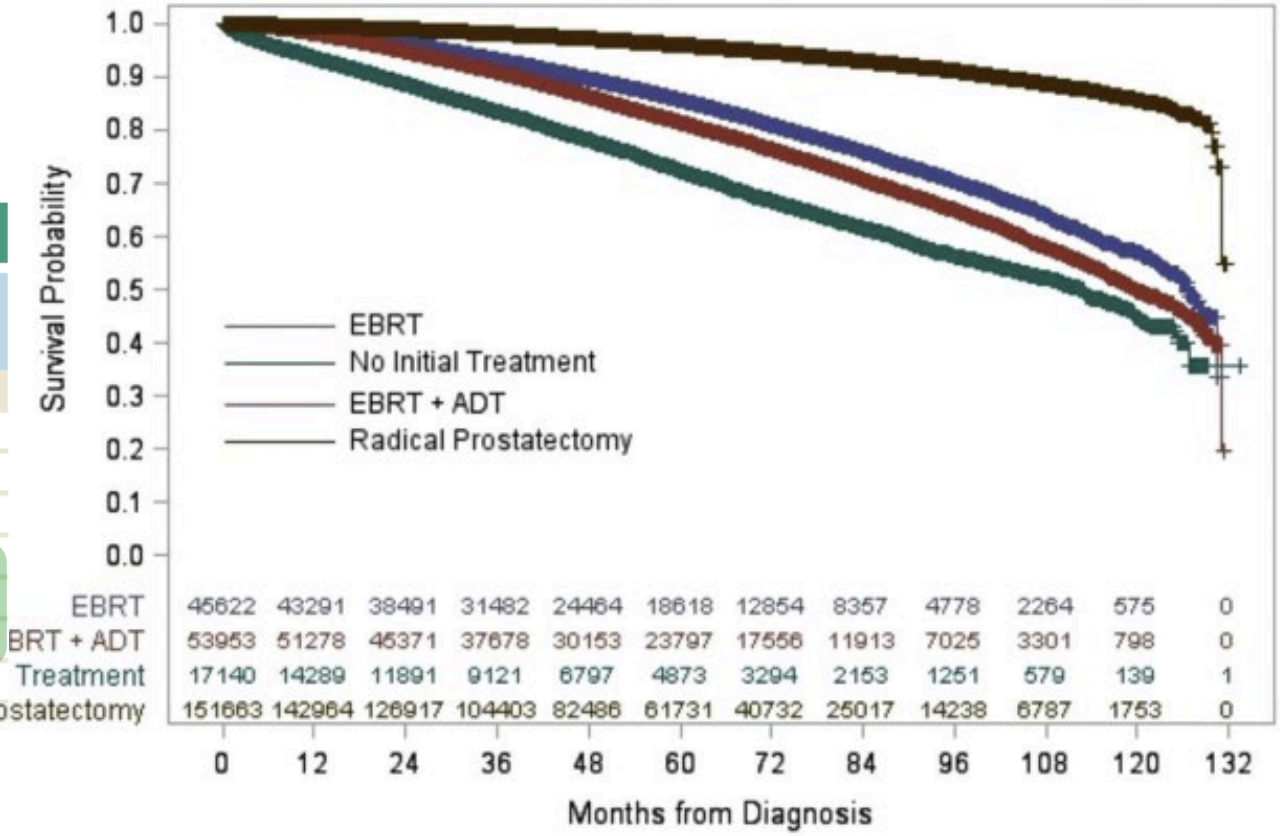
Survival Outcomes of Radical Prostatectomy Versus Radiotherapy in Intermediate-Risk Prostate Cancer: A NCDB Study

Sydney Marsh, Ryan W. Walters, Peter T. Silberstein

- Sobrevida Global
- National Cancer Data-Base
- 268.378 CaP RI, de 2004 a 2012
- PR x RT x RT+HT x OBS

Table 3 Results of Multivariable Cox Regression

Characteristic	HR	95% CI for HR		*P*
		Lower	Upper	
Patient Clinical Characteristics				
Treatment				
EBRT vs. no treatment	0.59	0.55	0.62	<.001
EBRT + ADT vs. no treatment	0.58	0.55	0.61	<.001
RP vs. no treatment	0.24	0.23	0.25	<.001
RP vs. EBRT	0.41	0.39	0.43	<.001
RP vs. EBRT + ADT	0.41	0.39	0.43	<.001
EBRT vs. EBRT + ADT	1.01	0.97	1.05	.624

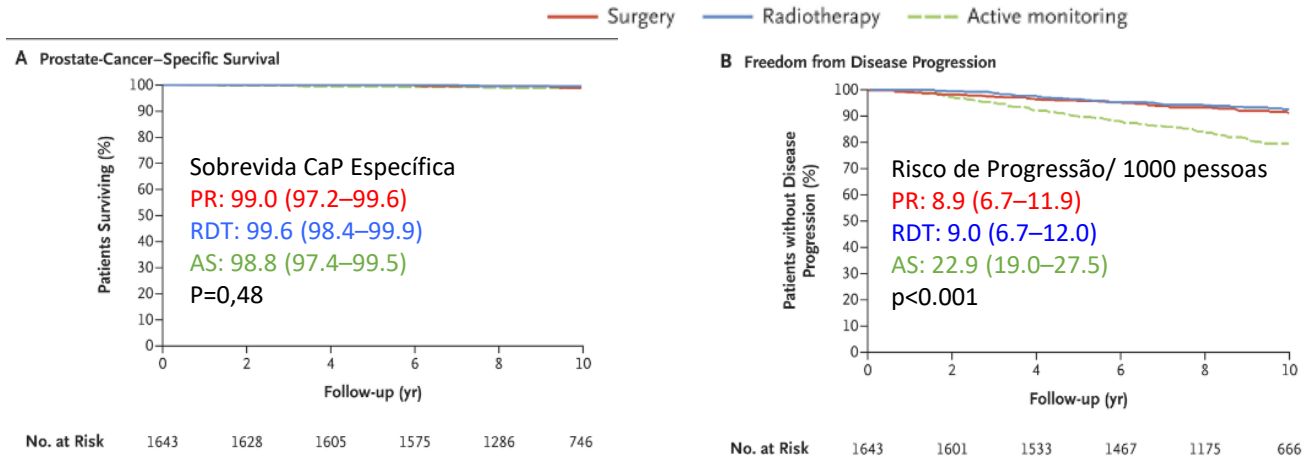


The NEW ENGLAND JOURNAL of MEDICINE
ESTABLISHED IN 1812 OCTOBER 13, 2016 VOL. 375 NO. 15

10-Year Outcomes after Monitoring, Surgery, or Radiotherapy for Localized Prostate Cancer

F.C. Hamdy, J.L. Donovan, J.A. Lane, M. Mason, C. Metcalfe, P. Holding, M. Davis, T.J. Peters, E.L. Turner, R.M. Martin, J. Oxley, M. Robinson, J. Staffurth, E. Walsh, 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, and D.E. Neal, for the ProtecT Study Group*

- PROTECT → Prospectivo, randomizado
- Mortalidade Câncer-Específica, em 10 anos
  - Progressão, Metástase e Mortalidade global
- 1.643 CaP localizado, entre 50 e 69 anos, de 1999 a 2009
  - 77% G6
  - 76% T1c
  - 10% PSA>10, 20% G7, 24% T2 → Quantos Risco Intermediário?
- Mortalidade Câncer-Específica, em 10 anos
  - Progressão, Metástase e Mortalidade global



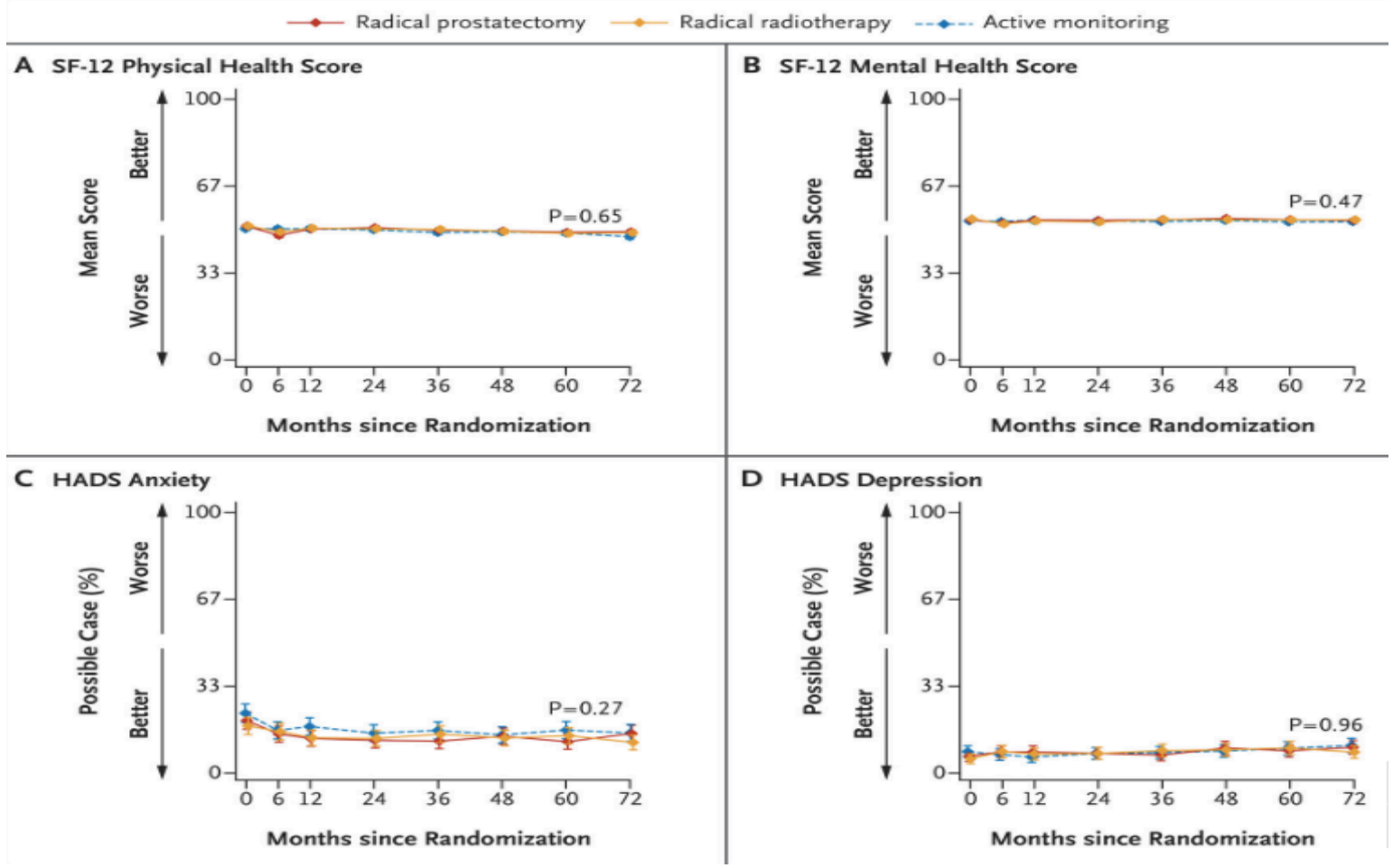
Tratamento	N randomizado	N Tratado (%)	Recidiva Bioquímica (%)	Tratamento de resgate	Metástases	NNT para evitar 1 meta	Mortes por Qualquer Causa	Mortes Por CaP
AS	545	482 (88%)	-	291	33	-	59	8
PR	553	391 (71%)	9 (2%)	5 RT, 1 HT	13	27	55	5
RT	545	405 (74%)	55 (14%)	3 PR, 14 Ht, 1 HIFU	16	33	55	4

The NEW ENGLAND JOURNAL of MEDICINE
ESTABLISHED IN 1812 OCTOBER 13, 2016 VOL. 375 NO. 15

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*

- PROTECT, com seguimento de 5 anos
- QoL



The NEW ENGLAND JOURNAL of MEDICINE

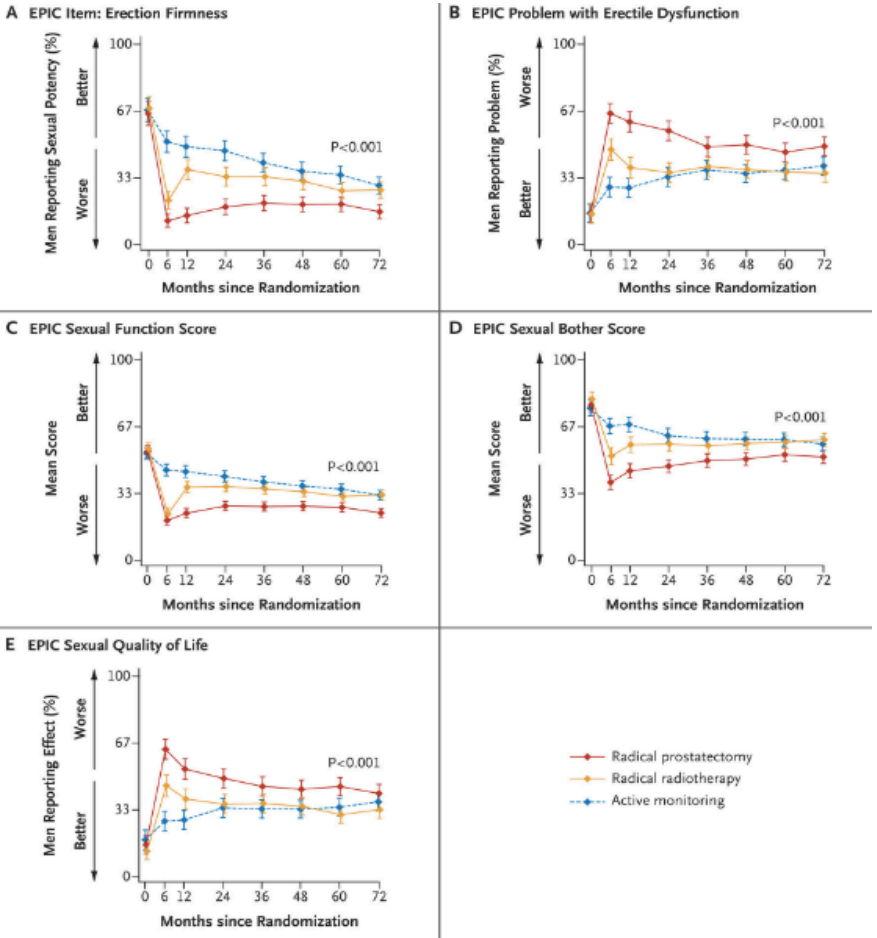
ESTABLISHED IN 1812 OCTOBER 13, 2016 VOL. 375 NO. 15

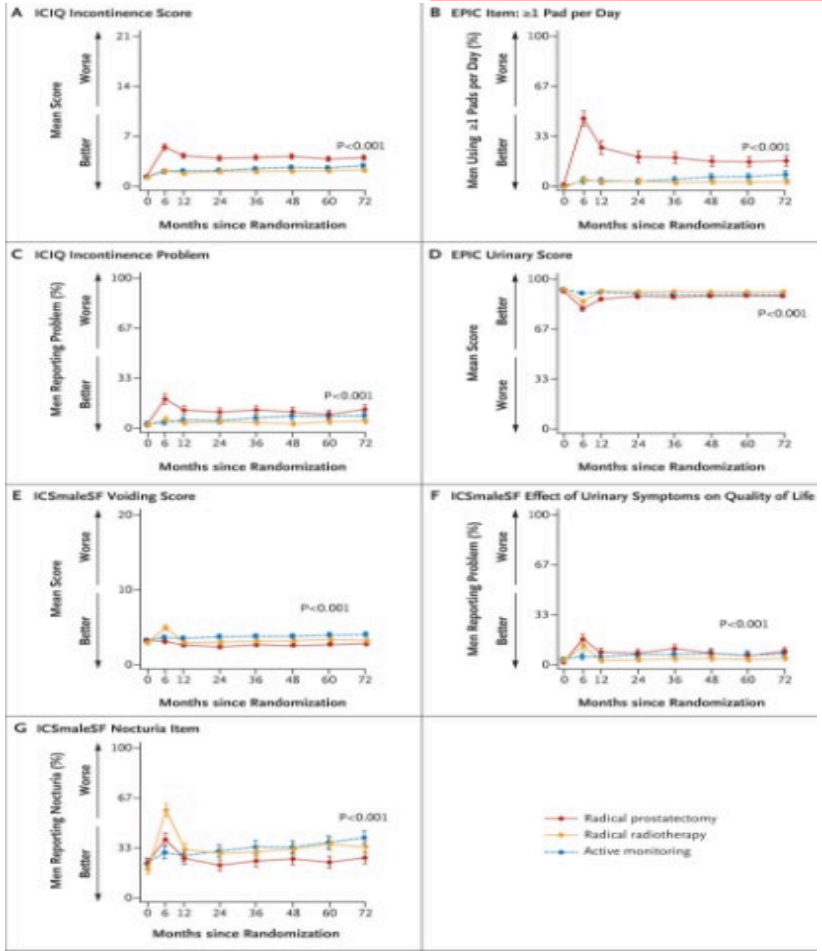
Patient-Reported Outcomes after Monitoring, Surgery, or Radiotherapy for Prostate Cancer

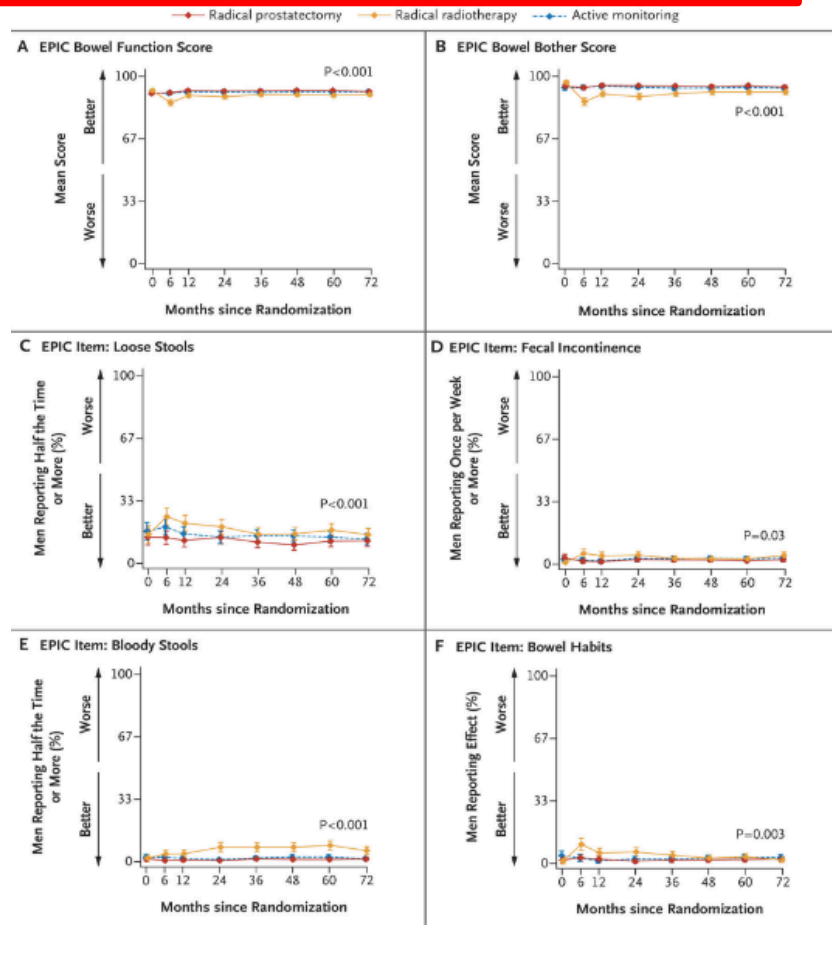
J.L. Donovan, F.C. Hamdy, J.A. Lane, M. Mason, C. Metcalfe, E. Walsh, J.M. Blazeby, T.J. Peters, P. Holding, S. Bonnington, T. Lennon, L. Bradshaw, D. Cooper, P. Herbert, J. Howson, A. Jones, N. Lyons, E. Salter, P. Thompson, S. Tidball, J. Blaikie, C. Gray, P. Bollina, J. Catto, A. Doble, A. Doherty, 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*

- PROTECT, com seguimento de 5 anos (CURTO PRAZO)
- Fç Sexual, Urinária e Intestinal

- Prostatectomia Radical
  - 324 abertas, 25 robóticas e 23 laparoscópicas
  - 205 preservação FVN bilateral







The NEW ENGLAND JOURNAL of MEDICINE

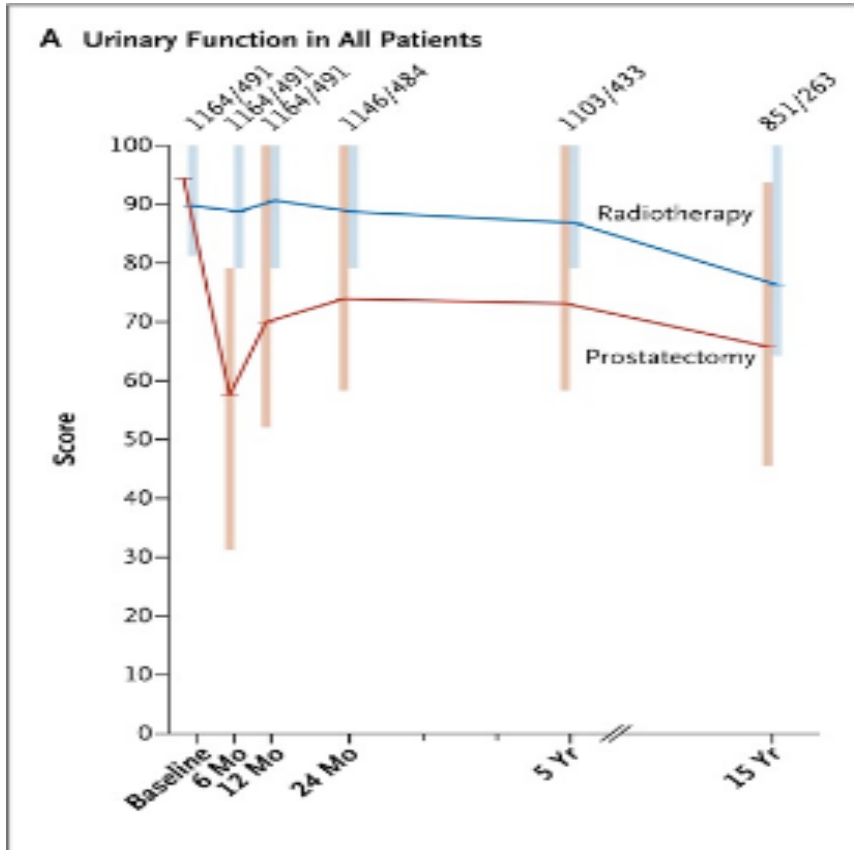
ORIGINAL ARTICLE

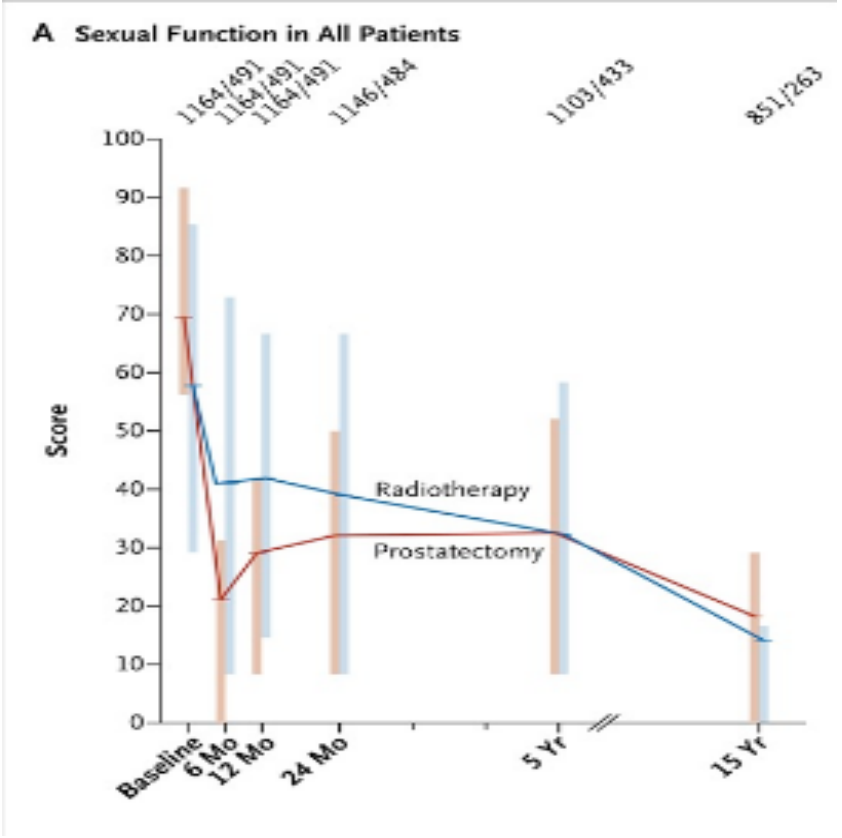
Long-Term Functional Outcomes after Treatment for Localized Prostate Cancer

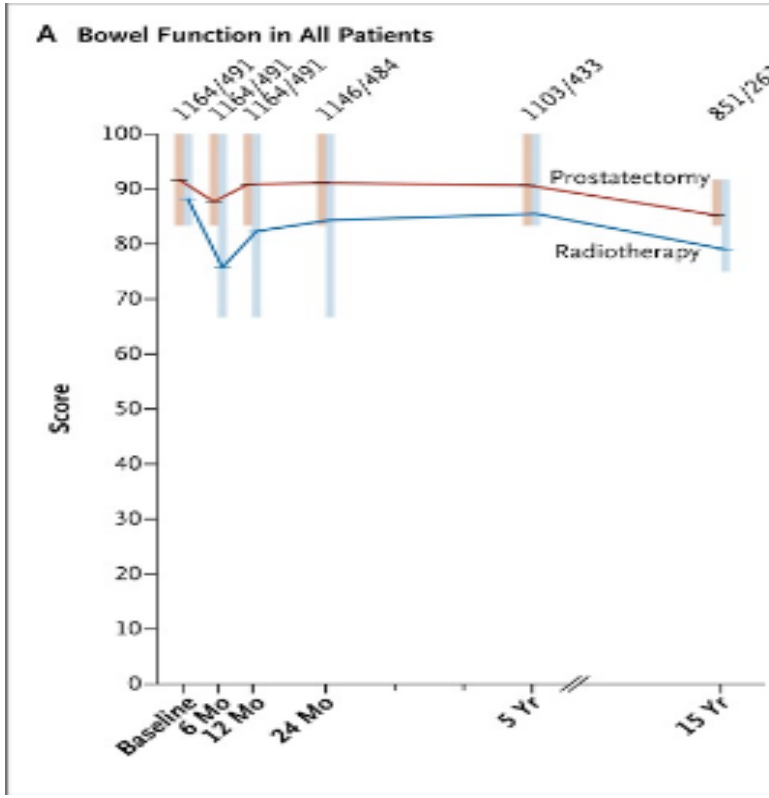
2013; 368:436-445

Matthew J. Resnick, M.D., Tatsuki Koyama, Ph.D., Kang-Hsien Fan, M.S., Peter C. Albertsen, M.D., Michael Goodman, M.D., M.P.H., Ann S. Hamilton, Ph.D., Richard M. Hoffman, M.D., M.P.H., Arnold L. Potosky, Ph.D., Janet L. Stanford, Ph.D., Antoinette M. Stroup, Ph.D., R. Lawrence Van Horn, Ph.D., and David F. Penson, M.D., M.P.H.

- 1655 CaP localizado, diagnosticado em 94 e 95
  - 1164 PR x 491 RT







Prostatectomia em CaP de Risco Intermediário

VANTAGENS

- Estadiamento real
- Tratamento adjuvante ideal e só quando necessário
- Tratamento de resgate adequado
- Menor Risco de Neoplasia 2^{aria}
- Melhor sobrevida (?)

DESVANTAGENS

- Pior resultado funcional em curto prazo