III SIMPÓSIO INTERNACIONAL
GU - REVIEW 2019 - LACOG

I CONSENSO BRASILEIRO DE CÂNCER DE PÊNIS

I SIMPÓSIO MULTIPROFISSIONAL ABRENFOH-LACOG GU

29 e 30 de Novembro | Hotel Intercontinental

CaP alto risco : Papel da Cirurgia

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Uro Oncologista Rede D'or – São Paulo

Conflito de interesses

	Palestrante	Elaborar Material técnico-científico	Apoio científico p/ participar em eventos	Pesquisa Clínica Financiada	Advisory Board
JANSSEN	x	x		x	x
FERRING		x			X
ASTELLAS	x	x	x		x
PFIZER	x				
HANDLE COOK			x		
ACHE	X	X			

European Association of Urology

= AUA e NCCN

Definition			
Low-risk	**Intermediate-risk**	**High-risk**	
PSA < 10 ng/mL	PSA 10-20 ng/mL	PSA > 20 ng/mL	any PSA
and GS < 7 (ISUP grade 1)	or GS 7 (ISUP grade 2/3)	or GS > 7 (ISUP grade 4/5)	any GS (any ISUP grade)
and cT1-2a	or cT2b	or cT2c	cT3-4 or cN+
Localised			**Locally advanced**

GS=Gleason score; ISUP=International Society for Urological Pathology; PSA=prostate-specific antigen.

T3a: extensão extra capsular com invasão de tecido peri capsular

T3b: vesículas seminais

T4: colo vesical, reto, esfinter externo, m. levantador do ânus , parede pélvica

Qual o papel para Cirurgia no cenário Multi modal atual ???

1. *Melhor estadiamento (Linfadenectomia e A.P)*
2. *Diminuir fonte de clones tumorais (citoredução)*
3. *Possibilidade de cura*
4. *Parte importante do tratamento multi modal*
5. *Evitar complicações prostáticas locais*
6. *Menor morbidade cirúrgica com novas técnicas*

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Melhor estadiamento

Linfadenectomia e Anatomo patológico

Papel da Linfadenectomia

AUA

40. Pelvic lymphadenectomy can be considered for any localized prostate cancer patients undergoing radical prostatectomy and is recommended for those with unfavorable intermediate-risk or high-risk disease. Patients should be counseled regarding the common complications of lymphadenectomy, including lymphocele development and its treatment. (Expert Opinion)

NCCN

Pelvic Lymph Node Dissection:

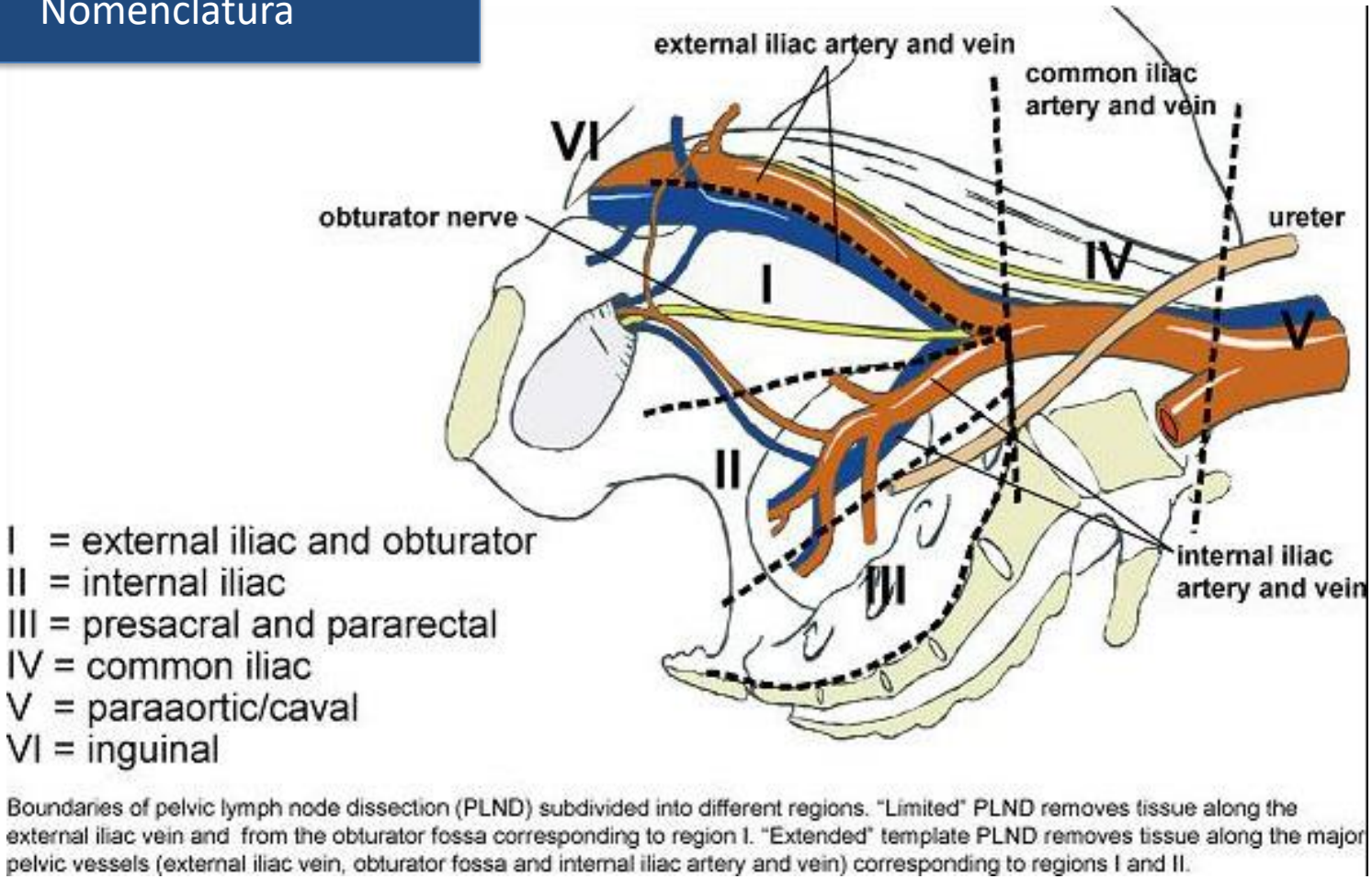
- **An extended PLND will discover metastases approximately twice as often as a limited PLND. Extended PLND provides more complete staging and may cure some men with microscopic metastases; therefore, an extended PLND is preferred when PLND is performed.**
- **An extended PLND includes removal of all node-bearing tissue from an area bound by the external iliac vein anteriorly, the pelvic sidewall laterally, the bladder wall medially, the floor of the pelvis posteriorly, Cooper's ligament distally, and the internal iliac artery proximally.**
- **A PLND can be excluded in patients with <2% predicated probability of nodal metastases by nomograms, although some patients with lymph node metastases will be missed.**
- **PLND can be performed using an open, laparoscopic, or robotic technique.**

EAU

Extended pelvic lymph node dissection (ePLND)	
Perform an ePLND in high-risk disease.	Strong
Do not perform a frozen section of nodes during RP to decide whether to proceed with, or abandon, the procedure.	Strong

Linfadenectomia no CaP
Como Fazer?

Nomenclatura



Boundaries of pelvic lymph node dissection (PLND) subdivided into different regions. "Limited" PLND removes tissue along the external iliac vein and from the obturator fossa corresponding to region I. "Extended" template PLND removes tissue along the major pelvic vessels (external iliac vein, obturator fossa and internal iliac artery and vein) corresponding to regions I and II.

1- Dundee et al. BJU int 2014.

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NOMOGRAMAS

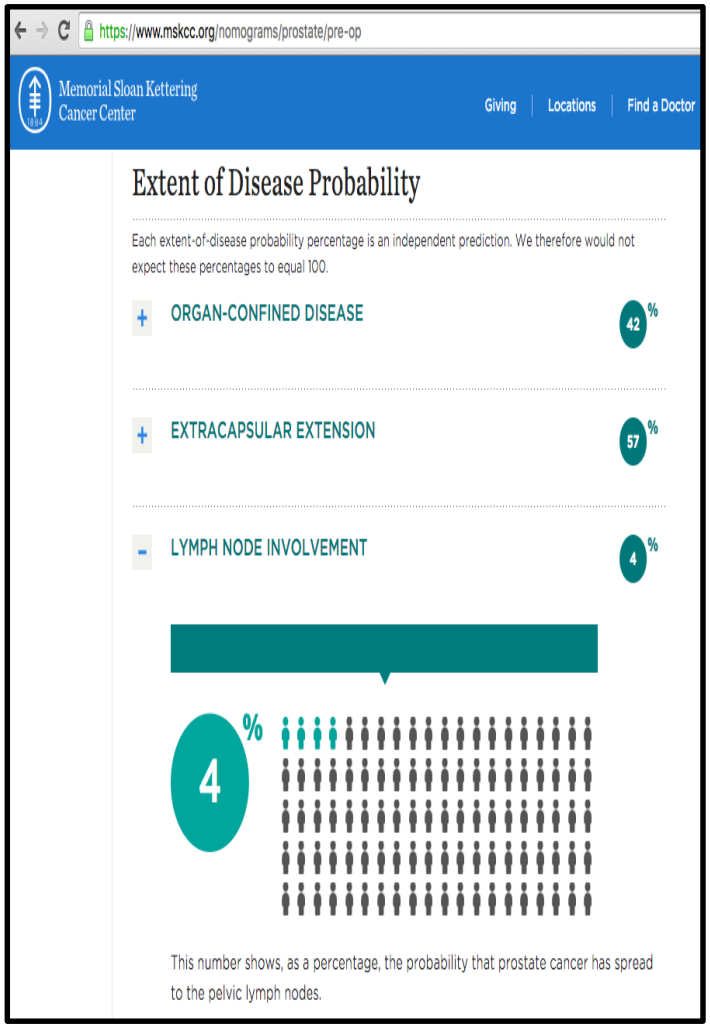
Probabilidad de invasión de ganglios linfáticos en pacientes sometidos a Linfadenectomía Pélvica Extendida (LPE) basada en el Nomograma de Briganti (NB)

PSA	0	*(decimales con punto)*
Estadío clínico	Seleccionar	
Grado primario de Gleason	Seleccionar	
Grado secundario de Gleason	Seleccionar	
% de cilindros positivos	0	
Puntos totales	0	
Probabilidad de invasión	0	%

Nota: punto de corte en el 5%

Fuente: Probability prediction of lymph nodes invasion (LNI) in patiens undergoing extended pelvic lymphadenectomy
www.europeanurology.com/article/S0302-2838%2811%2901230-9/

http://www.pixelhive.net/nomograma_briganti/



https://www.mskcc.org/nomograms/prostate/pre-op

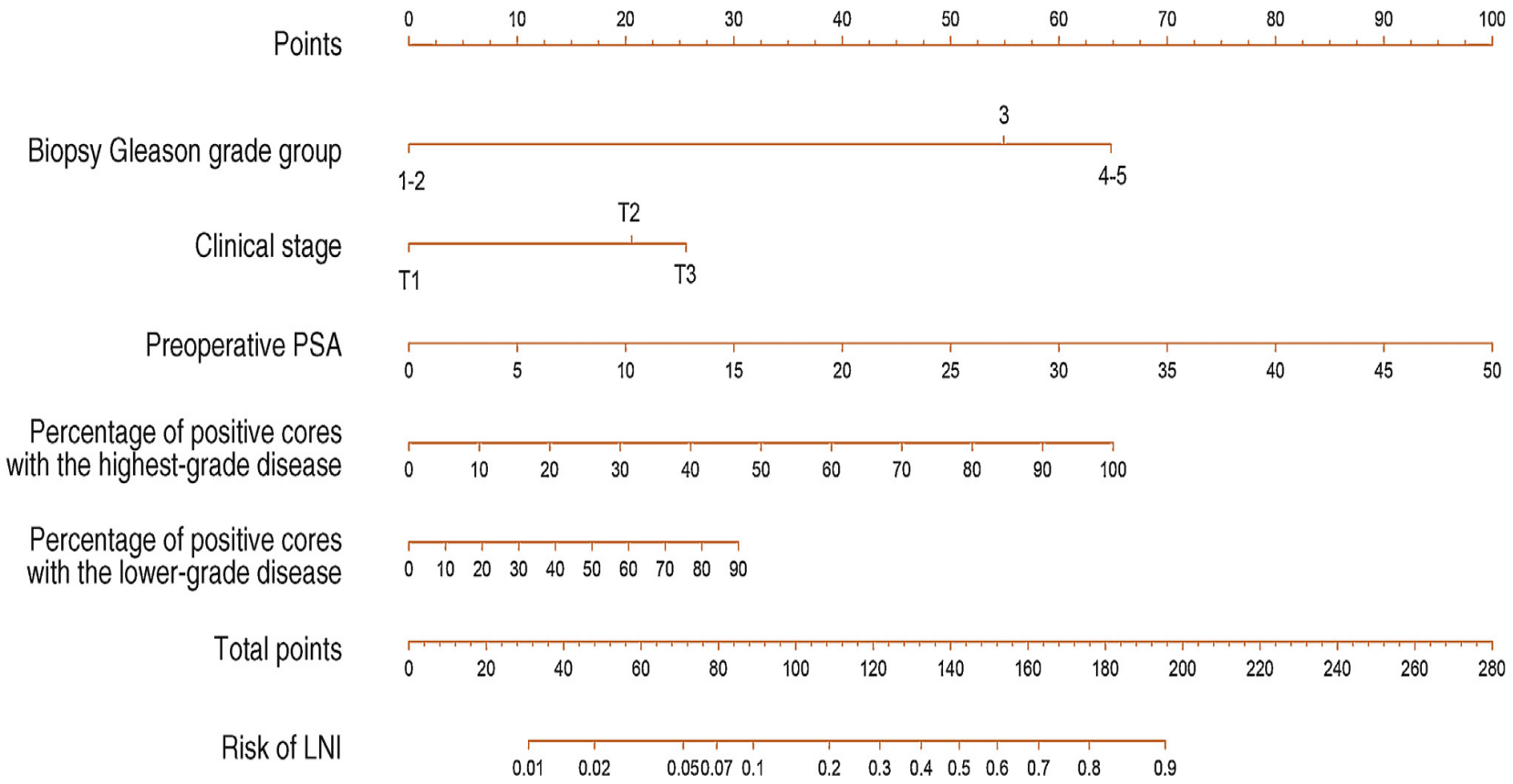
available at www.sciencedirect.com
journal homepage: www.europeanurology.com

European Association of Urology

Prostate Cancer

Development and Internal Validation of a Novel Model to Identify the Candidates for Extended Pelvic Lymph Node Dissection in Prostate Cancer

Giorgio Gandaglia [a,b], Nicola Fossati [a,b], Emanuele Zaffuto [a,b,c], Marco Bandini [a,b], Paolo Dell'Oglio [a,b], Carlo Andrea Bravi [a,b], Giuseppe Fallara [a,b], Francesco Pellegrino [a,b], Luigi Nocera [a,b], Pierre I. Karakiewicz [c], Zhe Tian [c], Massimo Freschi [d], Rodolfo Montironi [e], Francesco Montorsi [a,b], Alberto Briganti [a,b,*]


Points
0 10 20 30 40 50 60 70 80 90 100
Biopsy Gleason grade group
3
1-2
4-5
Clinical stage
T2
T1
T3
Preoperative PSA
0 5 10 15 20 25 30 35 40 45 50
Percentage of positive cores with the highest-grade disease
0 10 20 30 40 50 60 70 80 90 100
Percentage of positive cores with the lower-grade disease
0 10 20 30 40 50 60 70 80 90
Total points
0 20 40 60 80 100 120 140 160 180 200 220 240 260 280
Risk of LNI
0.01 0.02 0.05 0.07 0.1 0.2 0.3 0.4 0.5 0.6 0.7 0.8 0.9

Novo Nomograma:

Table 4 – Clinical implications according to treatment option (novel nomogram vs Briganti nomogram vs MSKCC nomogram)

Treatment option	Patients in whom PLND is not recommended according to the cutoff (below cutoff)	Patients below cutoff without histologic LNI	Patients below cutoff with histologic LNI	Patients in whom PLND is recommended according to the cutoff (above cutoff)	Patients above cutoff without histologic LNI	Patients above cutoff with histologic LNI
Novel nomogram, 7% cutoff	471 (69)	464 (99)	7 (1.5)	210 (31)	138 (66)	72 (34)
Briganti nomogram, 7% cutoff	464 (68)	454 (98)	10 (2.2)	217 (32)	148 (68)	69 (32)
MSKCC nomogram, 7% cutoff	451 (66)	443 (98)	8 (1.8)	230 (34)	159 (69)	71 (31)

LNI = lymph node invasion; MSKCC = Memorial Sloan Kettering Cancer Center; PLND = pelvic lymph node dissection.

Ponto de corte de 7%:

- ✓ Evita e-LND desnecessária em 69% dos pacientes
- ✓ Perde linfonodos positivos em APENAS 1,5% dos pacientes

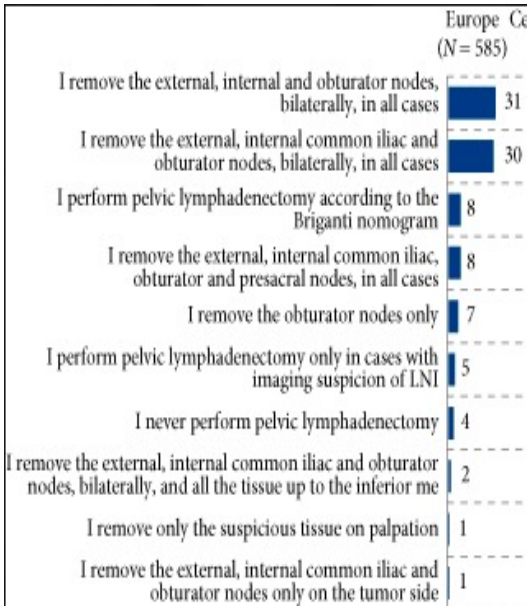
Mas...

 | doi:10.1111/bju.12796
Published by John Wiley & Sons Ltd. www.bjui.org

BJU Int 2015; **115:** 571–579
wileyonlinelibrary.com
BJUI
BJU International

Preferences in the management of high-risk prostate cancer among urologists in Europe: results of a web-based survey

Cristian I. Surcel*, Prasanna Sooriakumaran†‡, Alberto Briganti§, Pieter J.L. De Visschere§§, Jurgen J. Fütterer†††, Pirus Ghadjar‡‡, Hendrik Isbarn¶¶, Piet Ost**, Guillaume Ploussard‡‡‡, Roderick C.N. van den Bergh††, Inge M. van Oort***, Ofer Yossepowitch§§§¶¶¶, J.P. Michiel Sedelaar*** and Gianluca Giannarini¶; Members of the Prostate Cancer Working Group of the Young Academic Urologists Working Party and Members of the Young Urologists Office of the European Association of Urology

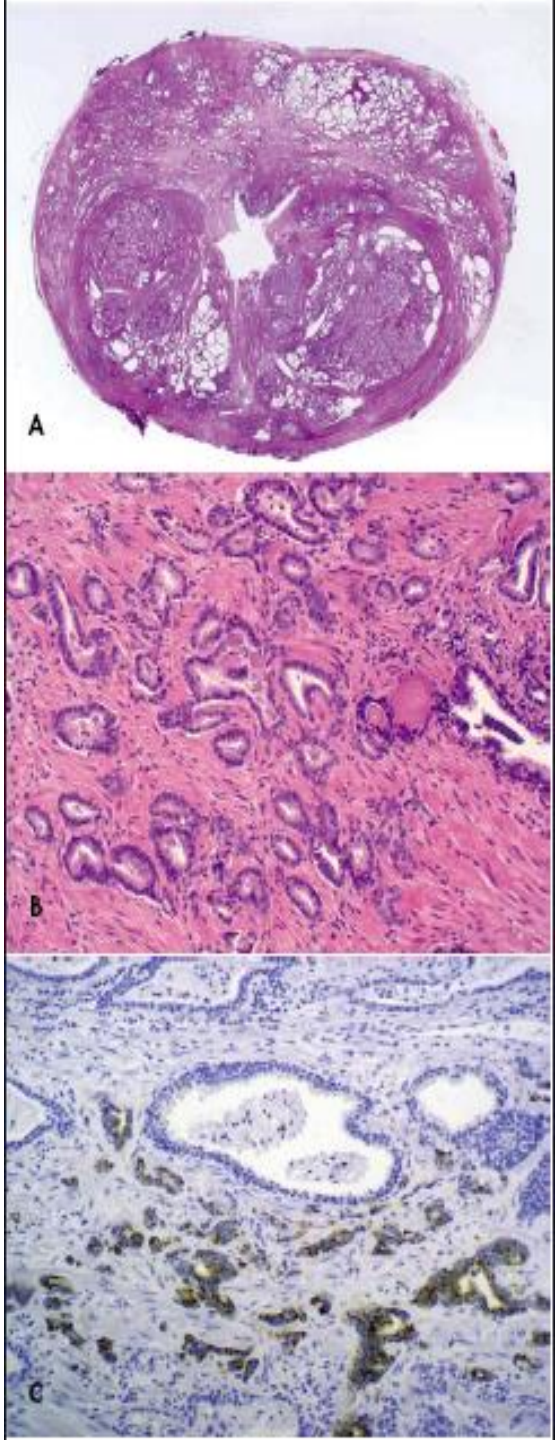


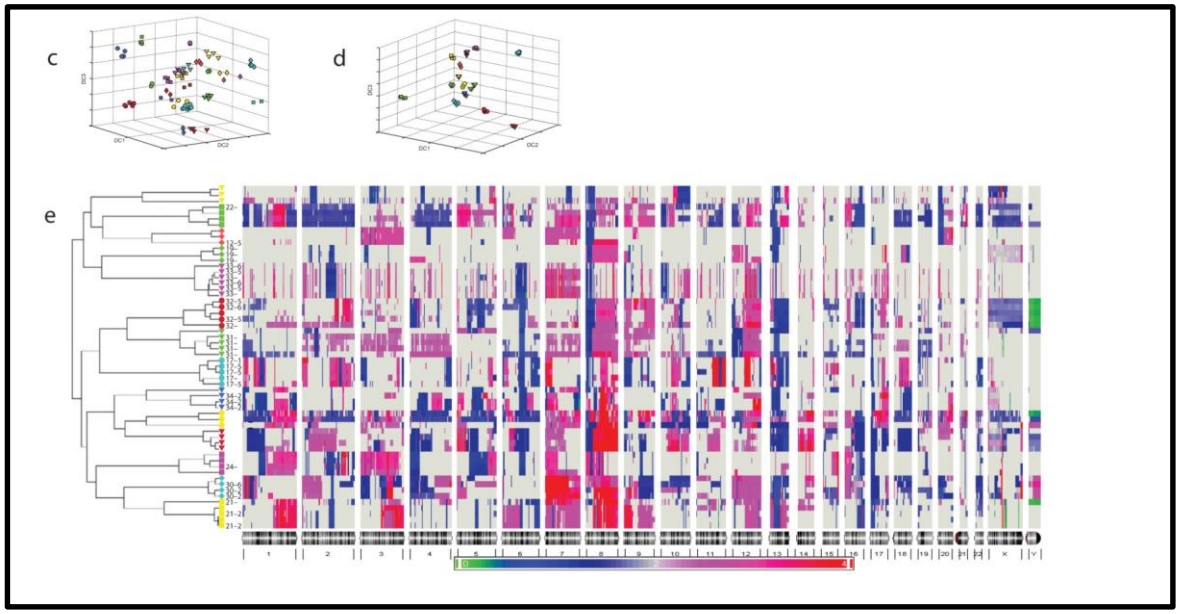
- Prostatectomia radical: 60%
  - Apenas metade realiza linfadenectomia estendida

Anatomia Patológica de toda a próstata

Entender melhor a doença a ser tratada.

- ✓ Estadiamento mais acurado
- ✓ Avaliação de fatores prognósticos
- ✓ Num mesmo grupo de risco clínico existem diferentes graus de agressividade tumoral.
- ✓ Mais informação para escolha de terapias subsequentes.





Heterogeneidade tumoral

- ✓ **CaP é multifocal.**
- ✓ **Os diferentes focos não guardam semelhanças somáticas entre si.**

Liu W. Nat Med 2009

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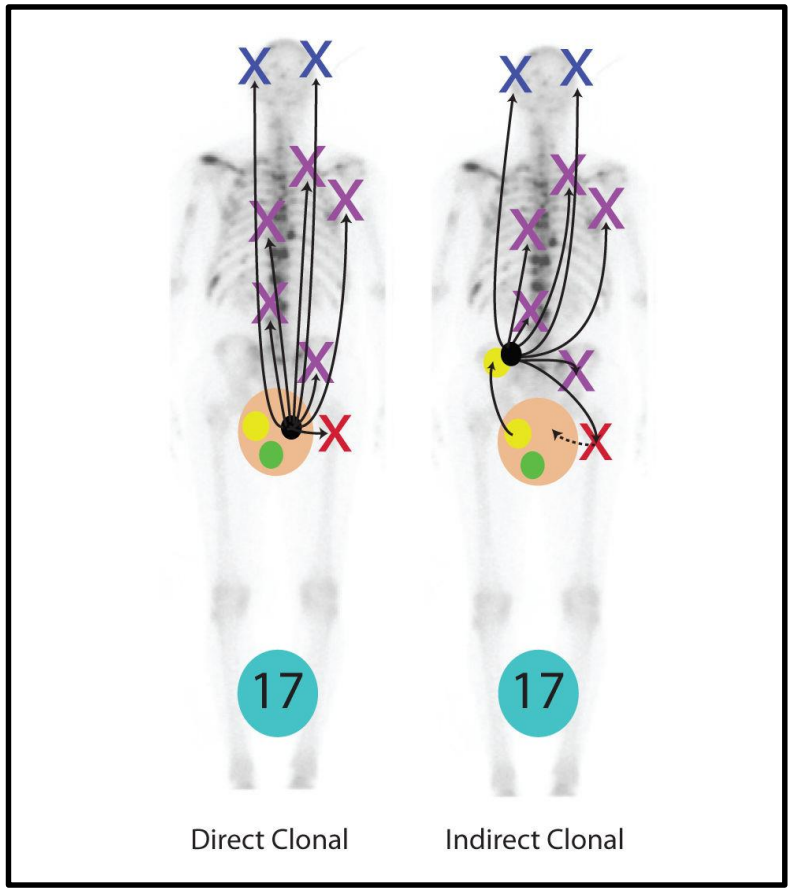
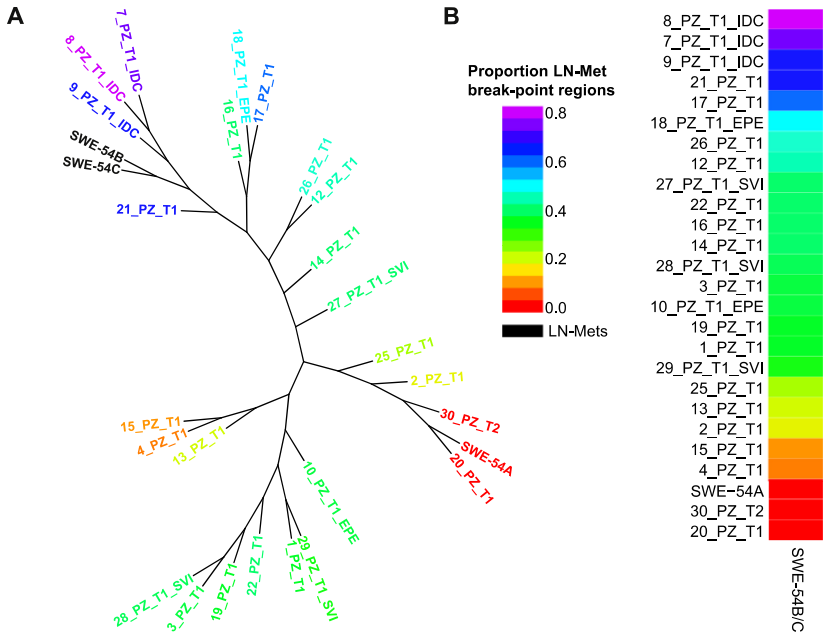
Diminuir fontes de clones tumorais





2. *A origem das metástases é monoclonal !!*

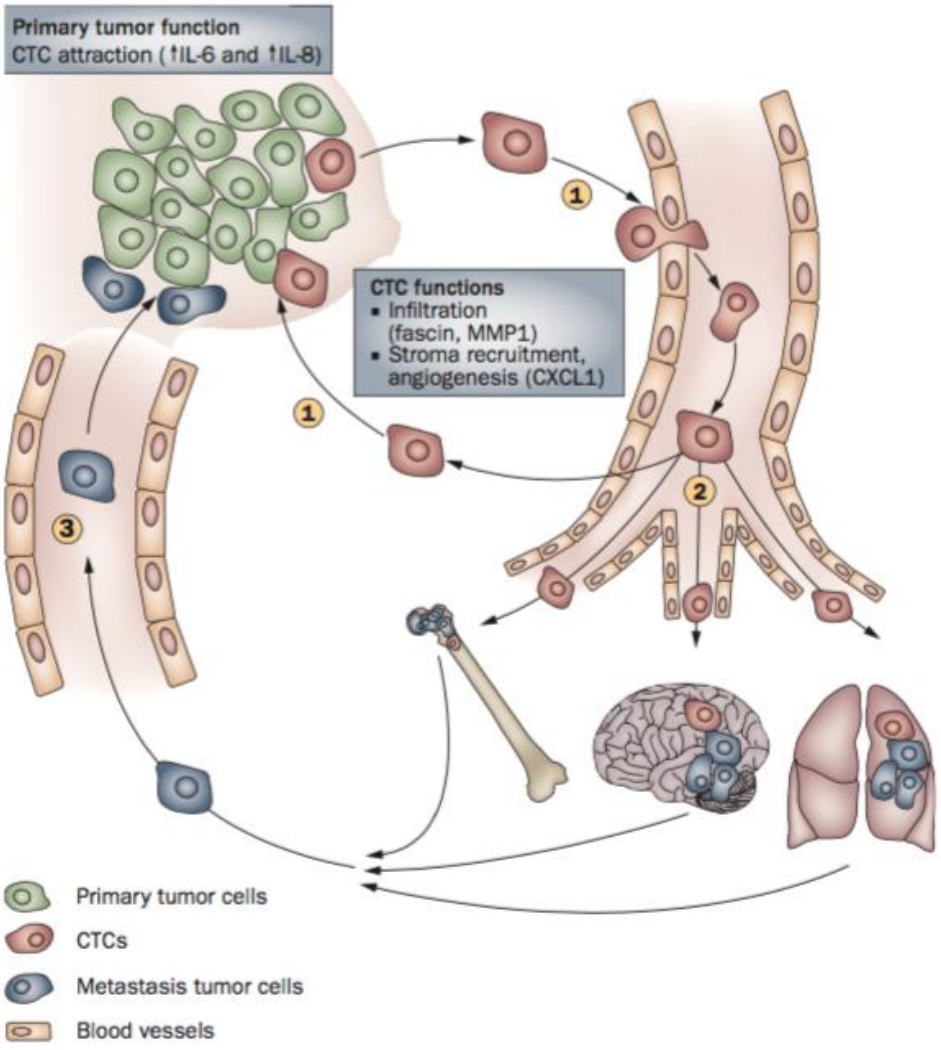
- ✓ *E não necessariamente é a lesão index.*

- ✓ *Relação com carcinoma ductal invasor e invasão peri neural*

Lindenberg J, et al . Euro Urol 2015

Clinical implications of cancer self-seeding

Elizabeth Comen, Larry Norton and Joan Massagué



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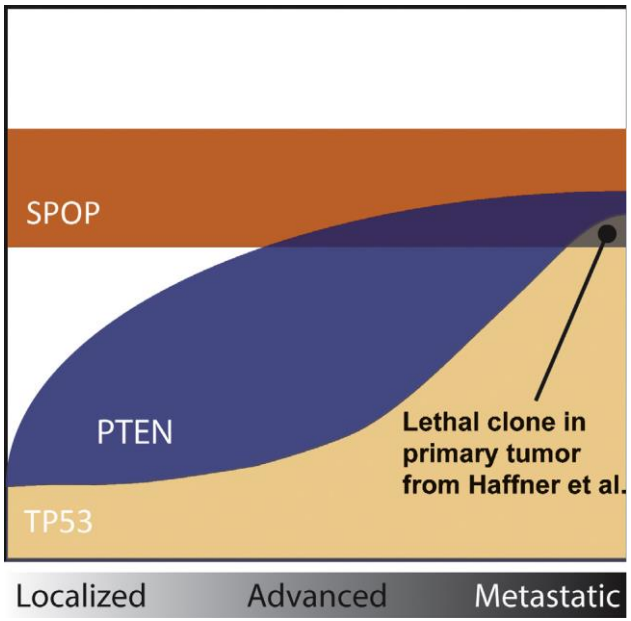
Comen E, et al. Nat Rev Clin Oncol. 2011

Platinum Opinion

The Lethal Clone in Prostate Cancer: Redefining the Index

Christopher E. Barbieri [a,b,c], Francesca Demichelis [c,d], Mark A. Rubin [a,b,c,*]

[a] Department of Urology, Weill Medical College of Cornell University, New York, NY, USA; [b] Department of Pathology and Laboratory Medicine, Weill Medical College of Cornell University, New York, NY, USA; [c] Institute for Precision Medicine of Weill Medical College and New York-Presbyterian Hospital, New York, NY, USA; [d] Centre for Integrative Biology, University of Trento, Trento, Italy



sequencing of multiple metastatic sites defined the genomic characteristics of the lethal disease, followed by targeted analysis of multiple foci from the primary prostatectomy specimen to reconstruct the evolutionary path of the metastatic cancer. Not surprisingly, they found heterogeneity within the primary PCa, with evidence for several different tumor clones, with a single area having the same genomic profile as the distant metastases. The clone giving rise to the metastases harbored mutations in speckle-type POZ protein (SPOP), phosphatase and tensin homolog (PTEN), and tumor protein 53 (TP53) and appeared histologically as "a single small (2.2 mm × 1.3 mm) lesion... composed solely of Gleason pattern 3 tumor glands" [2] within a large volume of high-grade disease.

Possibilidade de cura

Most Gleason 8 Biopsies are Downgraded at Prostatectomyd Does 4 D 4 [7?

Ted Gansler,* Stacey Fedewa, Robert Qi, Chun Chieh Lin, Ahmedin Jemal† and Judd W. Moul†

From Intramural Research, American Cancer Society (TG, SF, CCL, AJ), Atlanta, Georgia, and Division of Urology, Department of Surgery and Duke Cancer Institute, Duke University Medical Center (RQ, JWM), Durham, North Carolina

https://doi.org/10.1016/j.juro.2017.10.014
Vol. 199, 706-712, March 2018
Printed in U.S.A.

Registros do NCDB (National Cancer Data Base) entre 2010 e 2013.

- ✓ 5474 pctes com critério de alto risco baseado somente no Gleason 8. (PSA < 20 e < cT2c)
- ✓ 3263 (60%) receberam *downgrade* patológico para um risco intermediário.

CONCLUSÕES

Muitos casos de alto risco clínico podem ser curados apenas com cirurgia, sem tratamentos complementares.

Estes casos, se fossem tratados com radioterapia, receberiam bloqueio hormonal num período possivelmente maior que o necessário.

Linfadenectomia no CaP

Ganho de sobrevida??

EUROPEAN UROLOGY 55 (2009) 261–270

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

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Platinum Priority – Prostate Cancer

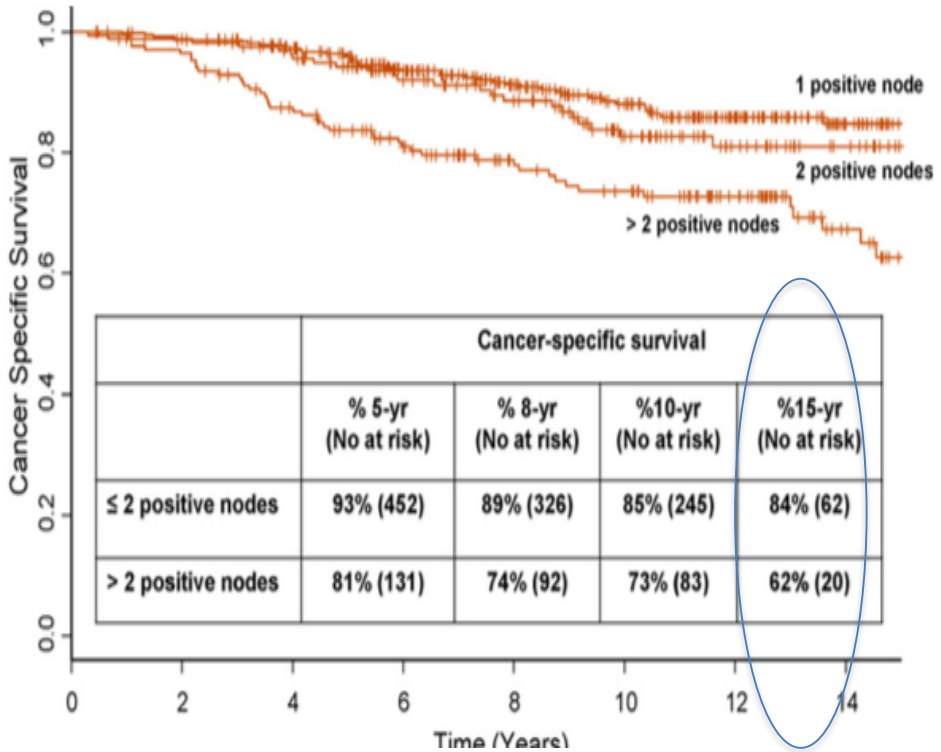
Editorial by George N. Thalmann on pp. 271–272 of this issue

Two Positive Nodes Represent a Significant Cut-off Value for Cancer Specific Survival in Patients with Node Positive Prostate Cancer. A New Proposal Based on a Two-Institution Experience on 703 Consecutive N+ Patients Treated with Radical Prostatectomy, Extended Pelvic Lymph Node Dissection and Adjuvant Therapy

Alberto Briganti [a,], Jeffrey R. Karnes [c], Luigi Filippo Da Pozzo [a], Cesare Cozzarini [d], Andrea Gallina [a], Nazareno Suardi [a], Marco Bianchi [a], Massimo Freschi [b], Claudio Doglioni [b], Ferruccio Fazio [d], Patrizio Rigatti [a], Francesco Montorsi [a], Michael L. Blute [c]*

[a] Department of Urology, Vita-Salute University, Milan, Italy
[b] Department of Pathology, Vita-Salute University, Milan, Italy
[c] Department of Urology, Mayo Medical School and Mayo Clinic, Rochester, Minnesota, USA
[d] Department of Radiotherapy, Vita-Salute University, Milan, Italy

- ✓703 pacientes LND +
  - ✓ 532 (75%)→ </= 2 LND +
  - ✓ 171 (24,3%) → > 2 LND



	Cancer-specific survival			
	% 5-yr (No at risk)	% 8-yr (No at risk)	%10-yr (No at risk)	%15-yr (No at risk)
≤ 2 positive nodes	93% (452)	89% (326)	85% (245)	84% (62)
> 2 positive nodes	81% (131)	74% (92)	73% (83)	62% (20)

EUROPEAN UROLOGY 54 (2008) 344–352

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

European Association of Urology

Prostate Cancer

Good Outcome for Patients with Few Lymph Node Metastases After Radical Retropubic Prostatectomy

Martin C. Schumacher [a], *Fiona C. Burkhard* [a], *George N. Thalmann* [a], *Achim Fleischmann* [b], *Urs E. Studer* [a,*]

[a] *Department of Urology, University of Bern, Switzerland*
[b] *Institute of Pathology, University of Bern, Switzerland*

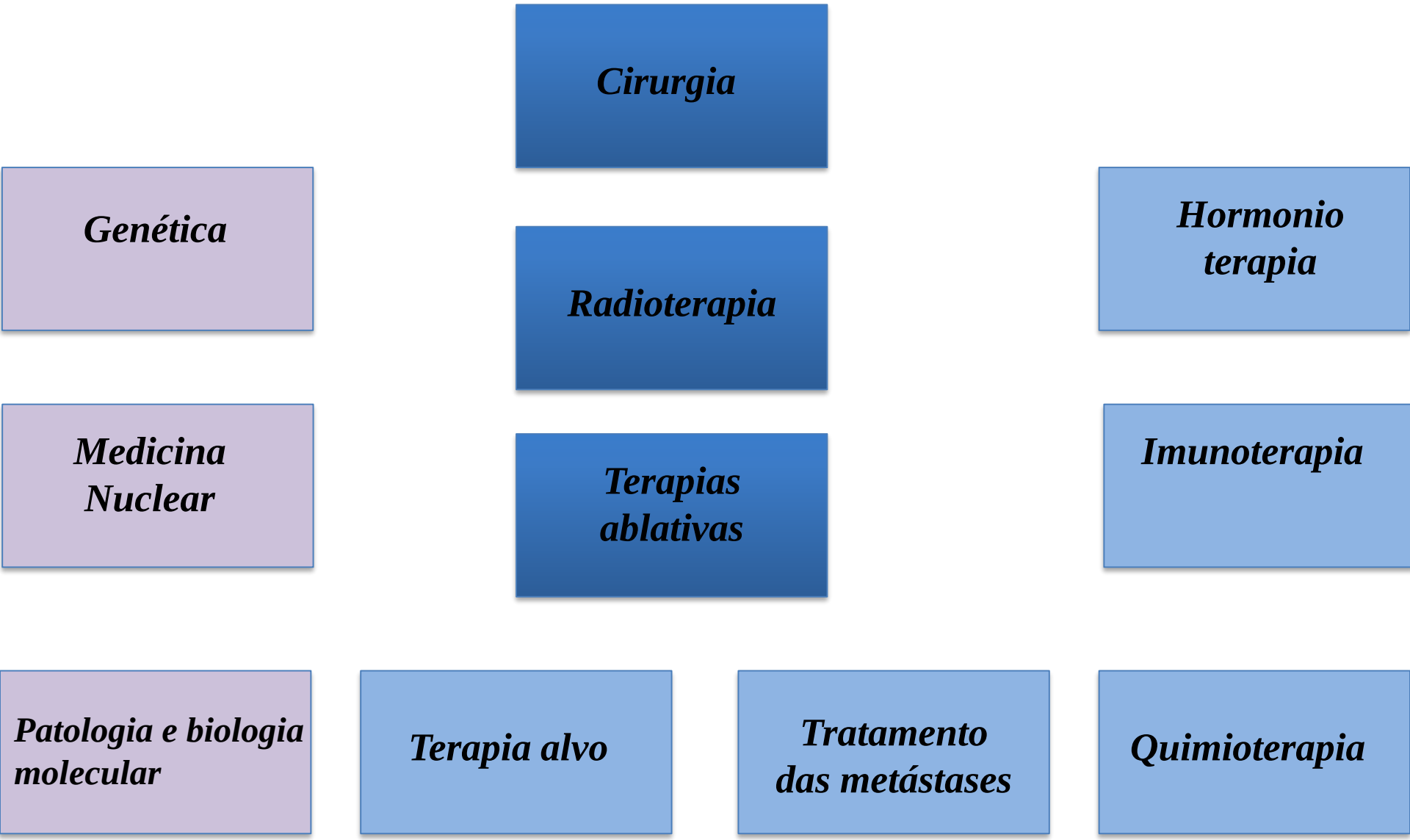
- ✓ 122 pacientes cN0 pN+

Survival in node-positive patients				
Feature	All 122 node positive patients	Patients with 1 pN+ ($n = 47$)	Patients with 2 pN+ ($n = 27$)	Patients with ≥3 pN+ ($n = 48$)
Median biochemical recurrence-free survival (95% CI)				
5 yr	13.9% (0.07–0.21)	24.7% (0.39–0.11)	11.8% (0.27–0.03)	4.9% (0.09–0.02)
10 yr	2.9% (0.01–0.07)	–	–	–
15 yr	–	–	–	–
Median cancer-specific survival (95% CI)				
5 yr	84.5% (0.77–0.92)	94.9% (0.88–1.00)	93.2% (0.85–1.00)	67.7% (0.54–0.82)
10 yr	60.1% (0.43–0.71)	72.1% (0.50–0.94)	79.1% (0.52–0.97)	33.4% (0.16–0.51)
15 yr	45.4% (0.27–0.64)	–	–	–
Median overall survival (95% CI)				
5 yr	83.3% (0.77–0.91)	92.8% (0.85–1.00)	88.5% (0.78–1.00)	67.7% (0.54–0.82)
10 yr	52.4% (0.39–0.66)	70.5% (0.49–0.92)	71.9% (0.44–0.99)	27.2% (0.10–0.44)
15 yr	41.9% (0.24–0.56)	–	–	–

CI = confidence interval.

Parte importante de um tratamento multi modal

Conceito de tratamento multi modal e multidisciplinar

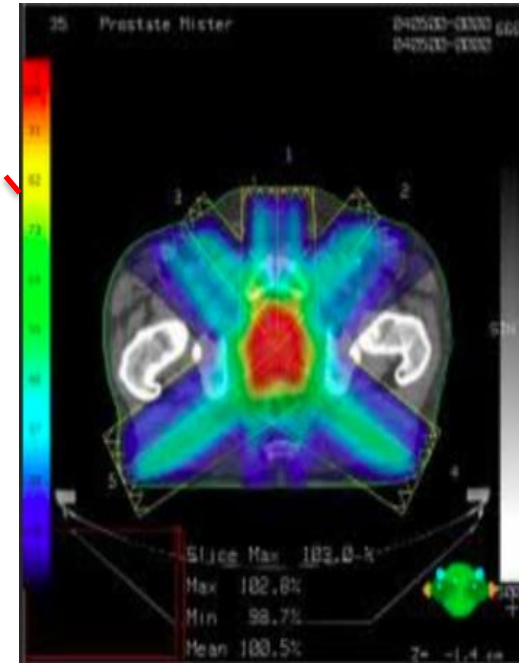


Tratamento primário

Cirurgia

X

Radioterapia



Doença localizada de Alto Risco

6.2.3.4. Guidelines for radical treatment of high-risk localised disease

Recommendation	Strength rating
Radical Prostatectomy (RP)	
Offer RP to patients with high-risk localised PCa and a life expectancy of > ten years only as part of multi-modal therapy.	Strong
Radiotherapeutic treatments	
In patients with high-risk localised disease, use external-beam radiation therapy (EBRT) with 76-78 Gy in combination with long-term androgen deprivation therapy (ADT) (two to three years).	Strong
In patients with high-risk localised disease, use EBRT with brachytherapy boost (either high-dose rate or low-dose rate), in combination with long-term ADT (two to three years).	Weak

eau European Association of Urology

American Urological Association

23. Clinicians should recommend radical prostatectomy or radiotherapy plus ADT as standard treatment options for patients with high-risk localized prostate cancer. (Strong Recommendation; Evidence Level: Grade A)

34. Clinicians should inform localized prostate cancer patients that younger or healthier men (e.g., <65 years of age or >10 year life expectancy) are more likely to experience cancer control benefits from prostatectomy than older men. (Strong Recommendation; Evidence Level: Grade B)

Melhor seleção para
RADIOTERAPIA ADJUVANTE

Extensão extra capsular / VS + / Margens positivas

3 trials randomizados mostrando benefício:

- ✓ **European Organization for Research and Treatment of Cancer(EORTC) – trial 22911**
- ✓ **Southwest Oncology Group (SWOG) – trial 8794**
- ✓ **German Intergroup trial ARO 96-02 / AOU AP 09-95**

Ganho de SL recidiva bioquimica – todos

SL livre de recorrência local – EORTC

SL metástases e SG – sem benefício estatisticamente significativo

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Evitar complicações locais pelo crescimento tumoral

Complicações locais pelo crescimento tumoral

- ✓ **Hematúria**
- ✓ **Retenção urinária aguda**
- ✓ **Obstrução ureteral e hidronefrose**
- ✓ **Prostatite e infecção urinária**
- ✓ **Dor pélvica**
- ✓ **Fístula reto-uretral**

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Primary treatment of the prostate improves local palliation in men who ultimately develop castrate-resistant prostate cancer

Andy C.M. Won, Howard Gurney*, Gavin Marx†, Paul De Souza‡ and Manish I. Patel

Análise retrospectiva
5 hospitais em Sidney

263 pacientes com mCPCR

Grupos:

1. Prostatectomia Radical
2. Radioterapia
3. Bloqueio hormonal

Avaliação de complicações locais.

Won et al. BJU 2013

Primary treatment of the prostate improves local palliation in men who ultimately develop castrate-resistant prostate cancer

Andy C.M. Won, Howard Gurney*, Gavin Marx†, Paul De Souza‡ and Manish I. Patel

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Characteristic	Local prostatic treatment			Total
	Group 1 (RRP)	Group 2 (EBRT)	Group 3 (Nil)	
Total, *n*	45	45	173	263
Median age at diagnosis (years)	63.2	67.9	70.2	
Median age at CRPC (years)	70.5	75.9	74.6	
Clinical stage at diagnosis, *n*				
Localized	45	38	44	127
Locally advanced	0	4	16	20
Metastatic	0	3	113	116
Gleason score, *n*				
≤6	3	3	4	10
7	15	13	28	53
≥8	12	13	88	116
Missing	15	16	53	84
Time to CRPC (years) , *n*				
<1	0	6	25	31
1–3	7	3	67	77
3–5	7	5	38	50
5–10	14	16	34	64
>10	17	15	9	41
Maximal metastatic involvement at CRPC, *n*				
Lymph node	10	10	36	56
Bone	45	45	171	261
Visceral	5	7	26	38

CRPC, castrate-resistant prostate cancer; EBRT, external beam radiation therapy; RRP, retropubic radical prostatectomy.

Primary treatment of the prostate improves local palliation in men who ultimately develop castrate-resistant prostate cancer

Andy C.M. Won, Howard Gurney*, Gavin Marx†, Paul De Souza‡ and Manish I. Patel

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Table 2 Type of local treatment and complications secondary to local disease.

Local prostatic treatment	Complaints	Complication, *n* (%)				Haematuria, *n* (%)		
		Ureteric obstruction	Bladder outlet obstruction	Pelvic pain	Prostatitis	Clot retention	Heavy	Occasional
Group 1: RRP ($n = 45$)†	20.0%	6 (13.3)	2 (4.4)	1 (2.2)	0 (0)	0 (0)	1 (2.2)	0 (0)
Group 2: EBRT ($n = 45$)*	46.7%	8 (17.8)	16 (35.6)	3 (6.7)	2 (4.4)	1 (2.2)	.0%	2 (4.4)
Group 3: Nil ($n = 173$)†	54.3%	26 (15.0)	74 (42.8)	8 (4.6)	1 (0.6)	1 (0.6)	8 (4.6)	8 (4.7)
Total	46.8%	40 (15.2)	92 (35.0)	12 (4.6)	3 (1.2)	2 (0.8)	9 (3.4)	10 (3.8)

**EBRT compared to no local treatment (46.7% vs 54.3%; P = 0.4). †RRP compared to EBRT (20.0% vs 46.7%; P = 0.007). EBRT, external beam radiation therapy; RRP, retropubic radical prostatectomy.*

Menos sintomas obstrutivos e hematúria franca no grupo da Prostatectomia

Primary treatment of the prostate improves local palliation in men who ultimately develop castrate-resistant prostate cancer

Andy C.M. Won, Howard Gurney*, Gavin Marx†, Paul De Souza‡ and Manish I. Patel

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Table 3 Presence of local treatment and complications secondary to local disease.

Local prostatic treatment	Complication, *n* (%)	TURP
	Acute urinary retention	
Group 1 (RRP)	2 (4.4)	0 (0)
Group 2 (EBRT)	7 (15.6)	7 (15.6)
Group 3 (Nil)	21 (12.1)	39 (22.5)
Total	30 (11.4)	46 (17.5)

EBRT, External beam radiation therapy; RRP, retropubic radical prostatectomy.

Menos R.U.A. e RTU

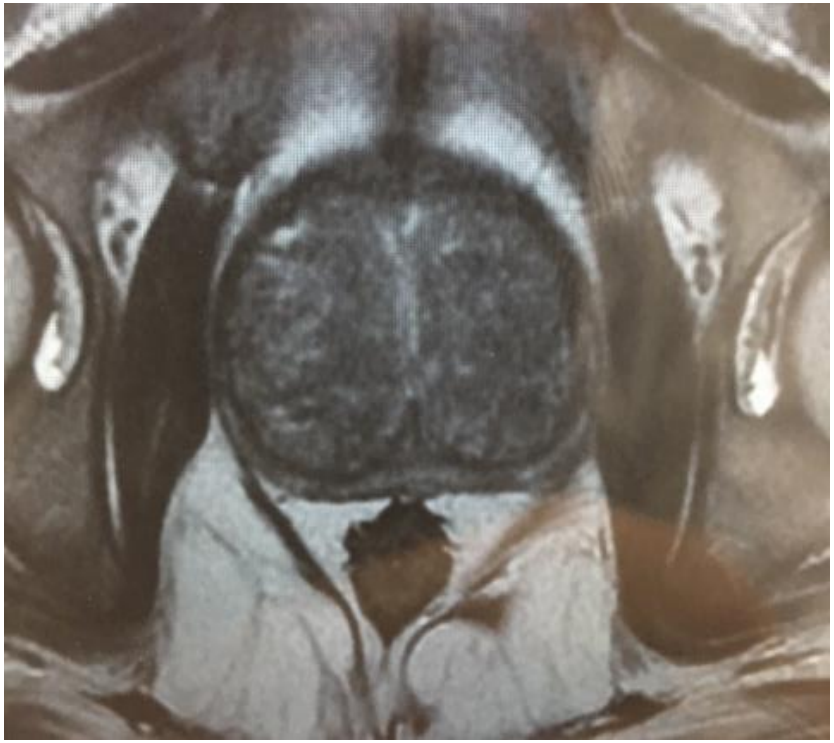
Table 4 Type of local treatment and complications as a result of ureteric obstruction.

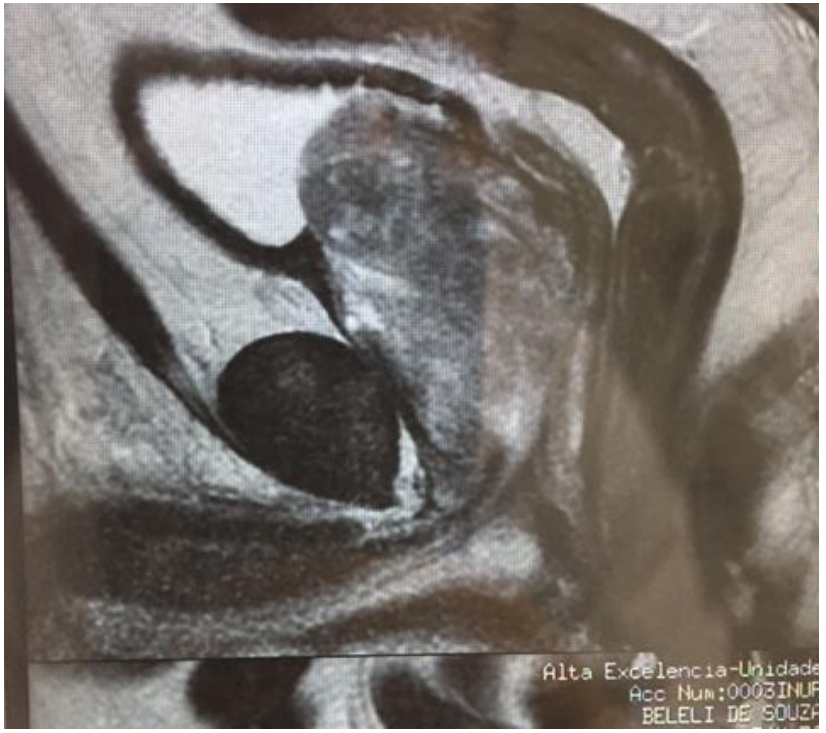
Local prostatic treatment	Complication, *n* (%)	Stent insertion
	Hydronephrosis (total)	
Group 1 (RRP)	6 (13.3)	2 (4.4)
Group 2 (EBRT)	8 (17.8)	7 (15.6)
Group 3 (Nil)	24 (13.9)	12 (6.9)
Total	38 (14.4)	21 (8.0)

EBRT, External beam radiation therapy; RRP, retropubic radical prostatectomy.

Menos Hidronefrose e Stent

CaP + HPB





- ✓ **Casos ruins para Radioterapia**
- ✓ **Cirurgia mais trabalhosa, mas trata as duas patologias.**

Menor morbidade cirúrgica com novas técnicas

The Changing Face of Urologic Oncologic Surgery over 17 Years (63 141 patients): The Impact of Robotics

Inderbir S. Gill, MD and Giovanni Cacciamani, MD
University of Southern California
Los Angeles, California

Registration

PROSPERO
International prospective register of systematic reviews

NHS
National Institute for Health Research

The changing face of urologic oncologic surgery: the impact of robotics
Inderbir Gill, Giovanni Cacciamani

PROSPERO

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Our Research Strategy

TRANSPARENT REPORTING OF SYSTEMATIC REVIEWS AND META-ANALYSES

METHODS GUIDE FOR EFFECTIVENESS AND COMPARATIVE EFFECTIVENESS REVIEWS

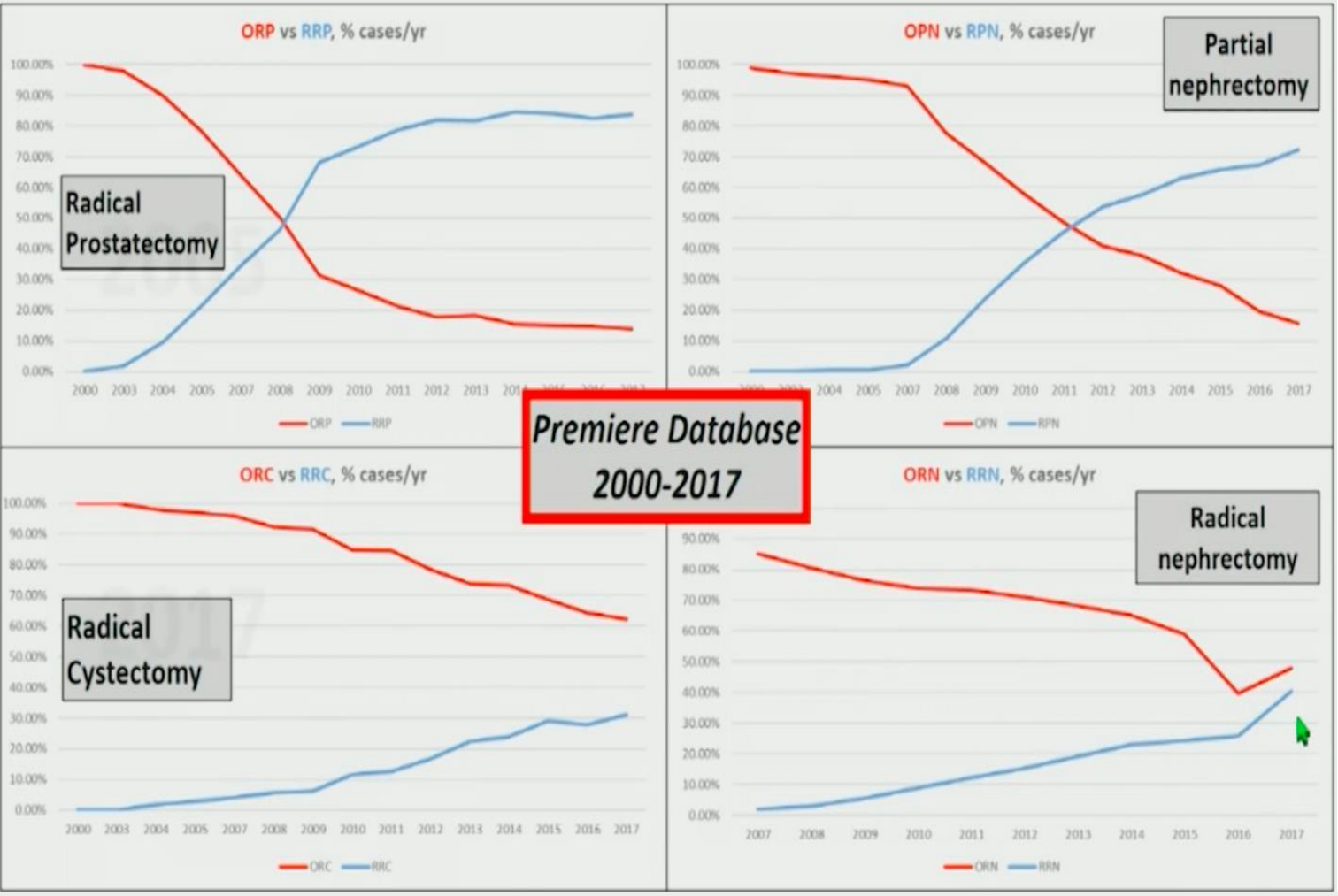
OXFORD
LEVEL OF EVIDENCE CRITERIA

5 Key Questions (KQs)
(Open vs Robotic)

- **KQ1:** Penetrance in the field
- **KQ2:** Peri-operative outcomes
- **KQ3:** Oncologic outcomes & Survival
- **KQ4:** Functional outcomes
- **KQ5:** Financial costs

+ 2.450 Forest plots

Penetrance in the Field – Open vs Robotic

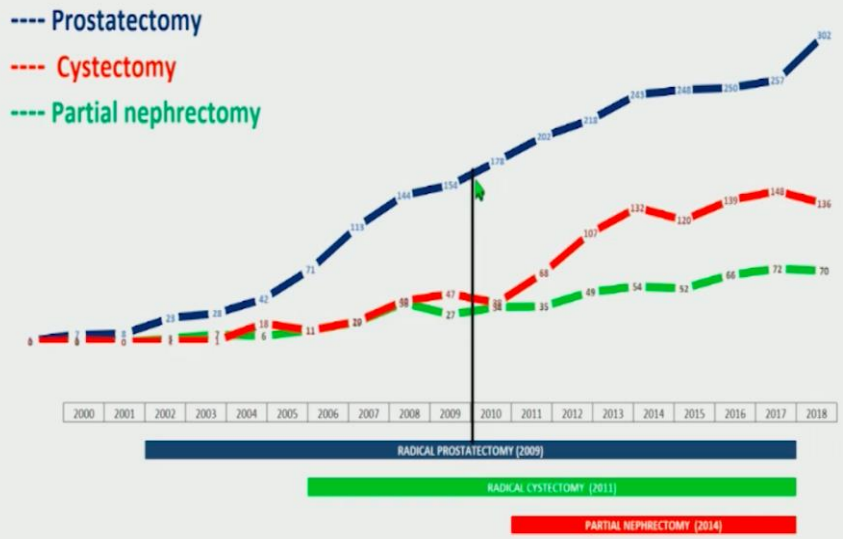


PROSTATECTOMY

Open vs Robotic

49 846 (25 204 vs 24 642)

Temporal meta-analysis

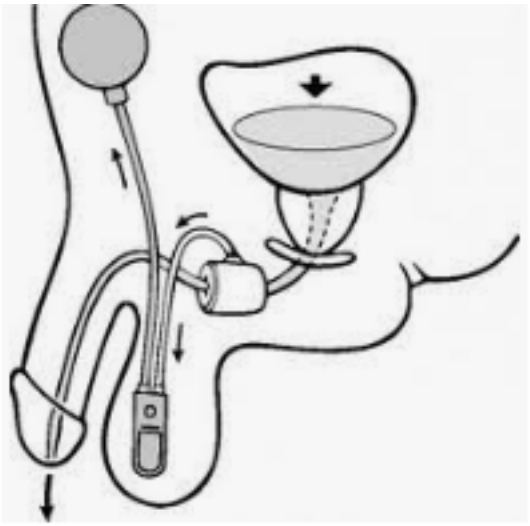


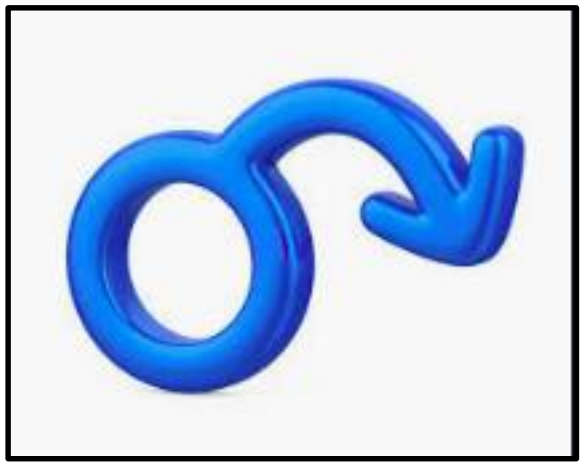
Temporal meta-analysis

Open vs Robotic Radical Prostatectomy: cut off 2009

Outcome	2000-2009		2010-2017	
	WMD/OR/RR [95%CI]	p value	WMD/OR/RR [95%CI]	p-value
Operative Times	-45.24 [-59.75, -30.72]	< 0.00001	-41.68 [-61.02, -22.35]	< 0.0001
Estimated Blood Loss (EBL)	599.12 [506.95, 691.30]	< 0.00001	340.08 [214.40, 465.76]	< 0.00001
Overall Transfusion Rate	5.76 [3.17, 10.46]	< 0.00001	4.01 [2.06, 7.82]	< 0.0001
Length of Hospital Stays (LOS)	1.85 [1.17, 2.54]	< 0.00001	2.00 [1.07, 2.93]	< 0.00001
Overall Complication	1.31 [0.91, 1.90]	0.15	1.69 [1.17, 2.43]	0.005*
Minor Post-Op Complication	1.55 [0.68, 3.52]	0.3	1.61 [1.05, 2.48]	0.03*
Major Post-Op Complication	1.12 [0.59, 2.12]	0.73	2.68 [1.75, 4.11]	< 0.00001*
Positive Margins	1.20 [0.98, 1.47]	0.08	1.12 [1.00, 1.26]	0.04*
Continence	1.42 [0.94, 2.13]	0.09	1.49 [1.07, 2.10]	0.02*
Potency	1.28 [0.99, 1.66]	0.06	1.15 [1.02, 1.30]	0.03*
Readmission and unscheduled visit	0.86 [0.64, 1.15]	0.31	1.78 [1.08, 2.94]	0.02*
Recurrence	1.13 [0.77, 1.64]	0.54	1.39 [1.11, 1.72]	0.004*
Overall Morality rate	1.31 [0.46, 3.71]	0.34	1.74 [0.76, 3.97]	0.19
Cancer Specific Mortality rate	2.57 [0.11, 62.15]	0.56	-	-

Efeitos colaterais reversíveis





Cirurgia x Radioterapia

Existe vantagens do ponto de vista oncológico???

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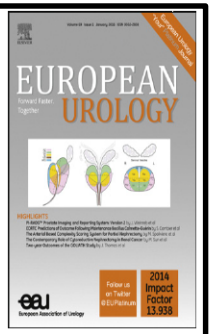


Platinum Priority – Brief Correspondence

Editorial by XXX on pp. x–y of this issue

Comparative Effectiveness of Radical Prostatectomy Versus External Beam Radiation Therapy Plus Brachytherapy in Patients with High-risk Localized Prostate Cancer

Base de dados americana – 13 mil pacientes

✓ ***Idade < 65 anos***

✓ ***Charlson Comorbidity Index = 0***

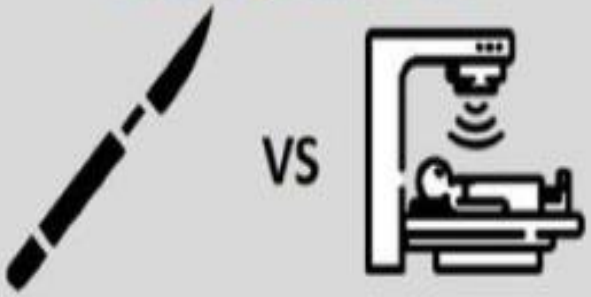
Berg et al. Euro Urol 2018

Comparative Effectiveness of RP Versus EBRT + Brachytherapy in Patients with High-risk Localized Prostate Cancer.

Berg et al. Eur Urol 2018

Design

Objective: Compare OS of EBRT + BT vs RP in young (≤65 yr) and healthy men (CCI = 0) with high-risk PCa



13,985 men in NCDB

88% RP

12% EBRT + BT

Outcomes

Median F/U: 92 mo

Use of ADT

RP: 15%

EBRT + BT: 69%

Salvage Rx

RP: 15% adjuvant RT

EBRT + BT: 0% salvage RP

IPTW adjusted Cox regression for OS:

EBRT + BT vs RP: HR 1.22 (95%CI 1.05-1.43)

Conclusions

Young and healthy men: *significant OS benefit* for RP vs EBRT + BT

Highlights need for continued shared-decision making

@EUplatinum

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Platinum Priority – Review – Prostate Cancer
Editorial by Martin Spahn, Alan Del Pra, Daniel Aebersold and Bertrand Tombal on pp. 31–32 of this issue

Surgery Versus Radiotherapy for Clinically-localized Prostate Cancer: A Systematic Review and Meta-analysis

Christopher JD. Wallis[a,b,c], Refik Saskin[c], Richard Choo[e], Sender Herschorn[a,b], Ronald T. Kodama[a,b], Raj Satkunasivam[a,b], Prakesh S. Shah[c,f,g], Cyril Danjoux[h], Robert K. Nam[a,b,c,*]

- ✓ *19 estudos*
- ✓ *118 mil pacientes*
- ✓ *Risco de viés – baixo para moderado*

Table 3 – Newcastle-Ottawa Scale for risk of bias assessment of studies included in the meta-analysis

Study	Selection				Comparability	Outcome			Overall
	Representativeness of exposed cohort	Selection of nonexposed	Ascertainment of exposure	Outcome not present at start		Assessment of outcome	Adequate follow-up length	Adequacy of follow-up	
Abdollah (2012)	☆	☆	☆	☆	☆☆	☆			7
Albertsen (2007)	☆	☆	☆	☆	☆☆	☆	☆		8
Arvold (2011)	☆		☆	☆	☆☆				5
Boorjian (2011)	☆		☆	☆	☆☆	☆	☆		7
Cooperberg (2010)	☆	☆	☆	☆	☆☆	☆			7
DeGroot (2013)	☆	☆	☆	☆	☆☆	☆	☆		8
Hoffman (2013)	☆	☆	☆	☆	☆☆	☆	☆	☆	9
Jeldres (2008)	☆	☆	☆	☆	☆☆	☆	☆		8
Kibel (2012)	☆	☆	☆	☆	☆☆	☆	☆		8
Ladjevardi (2010)	☆	☆	☆	☆	☆☆	☆		☆	8
Lee (2014)	☆	☆	☆	☆	☆☆	☆	☆		8
Merglen (2007)	☆	☆	☆	☆	☆☆	☆	☆	☆	9
Merino (2013)	☆	☆	☆	☆	☆☆		☆		7
Rice (2013)	☆	☆	☆	☆	☆☆	☆	☆		8
Sooriakumaran (2014)	☆	☆	☆	☆	☆☆	☆	☆	☆	9
Sun (2013)	☆	☆	☆	☆	☆☆	☆		☆	7
Tewari (2007)	☆	☆	☆	☆	☆☆	☆			7
Westover (2012)	☆		☆	☆	☆☆	☆			6
Zelefsky (2010)	☆		☆	☆	☆☆	☆		☆	7

Sobrevida Global

Sobrevida Câncer Específica

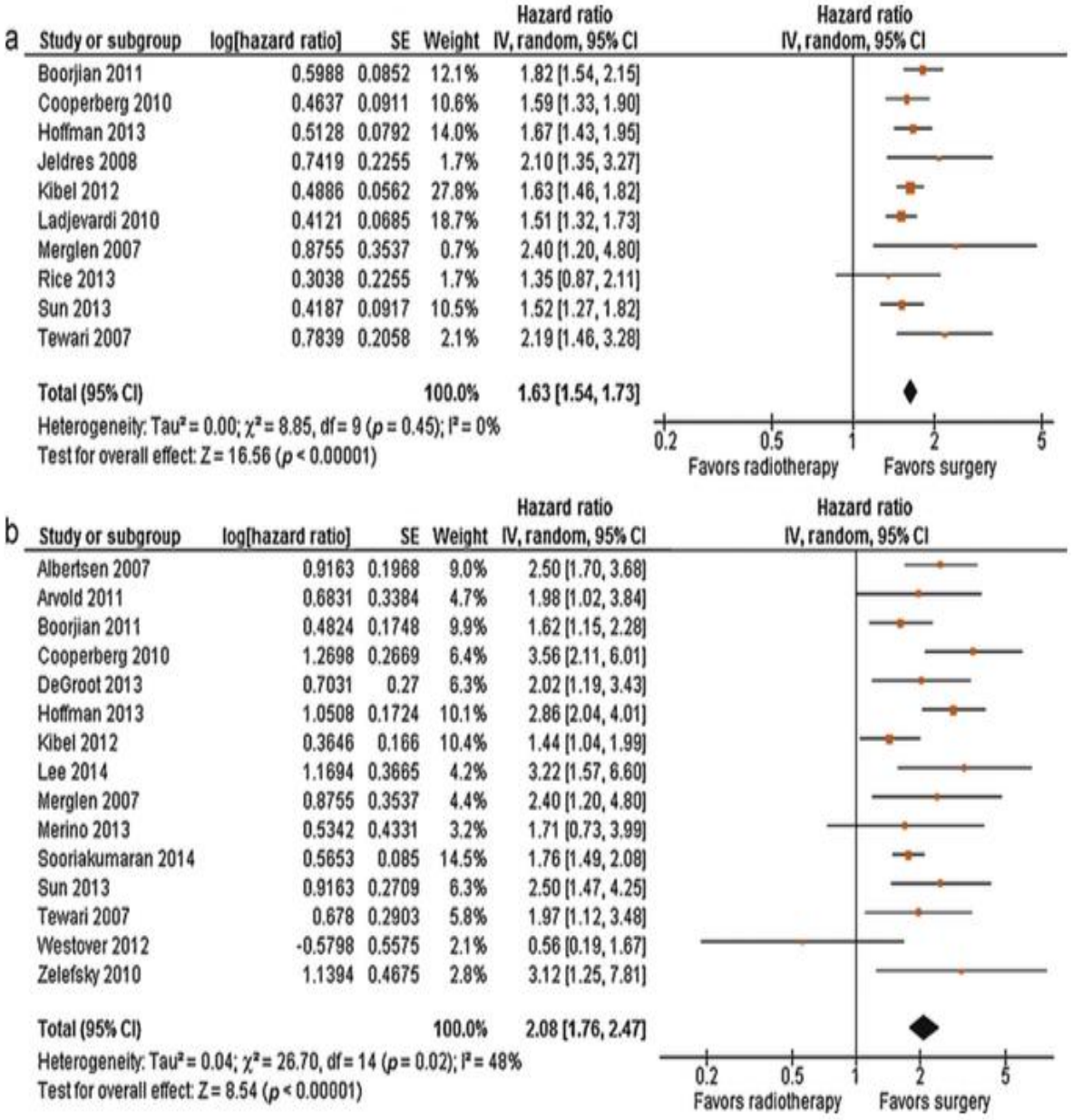

Fig. 2 – Forrest plot assessing the risk of (a) overall mortality and (b) prostate cancer-specific mortality following radiotherapy and surgery for prostate cancer.

CI = confidence interval; IV = inverse variance; SE = standard error.

Table 4 – Subgroup analysis assessing risk of overall mortality and prostate cancer-specific mortality following treatment with surgery or radiotherapy

	Overall mortality		Prostate cancer-specific mortality	
	Adjusted HR (95% CI, *p* value)	I^2	Adjusted HR (95% CI, *p* value)	I^2
Risk category				
Low risk	1.47 (1.19–1.83, $p = 0.0004$)	59%	1.70 (1.36–2.13, $p < 0.00001$)	0%
Intermediate risk	1.50 (1.24–1.82, $p < 0.0001$)	NA	1.80 (1.45–2.25, $p < 0.0001$)	0%
High risk	1.88 (1.64–2.16, $p < 0.00001$)	0%	1.83 (1.51–2.22, $p = 0.0001$)	42%
Radiotherapy modality				
EBRT (CRT and IMRT)	1.69 (1.55–1.85, $p < 0.00001$)	8%	2.26 (1.94–2.63, $p < 0.00001$)	0%
IMRT	No studies available		2.26 (1.21–4.21, $p = 0.01$)	0%
Brachytherapy	1.70 (1.40–2.10, $p < 0.001$)	NA	1.58 (1.01–2.49, $p = 0.05$)	0%
Duration of follow-up				
<5 yr	1.54 (1.38–1.71, $p < 0.00001$)	0%	1.51 (0.25–9.19, $p = 0.66$)	89%
5–8 yr	1.73 (1.49–2.02, $p < 0.00001$)	18%	1.80 (1.57–2.05, $p < 0.00001$)	0%
>8 yr	1.74 (1.55–1.95, $p < 0.00001$)	0%	2.26 (1.60–3.20, $p < 0.00001$)	65%
Era of accrual				
Early	1.75 (1.57–1.97, $p < 0.00001$)	5%	2.04 (1.54–2.72, $p < 0.00001$)	44%
Later	1.59 (1.48–1.70, $p < 0.00001$)	0%	2.12 (1.69–2.66, $p < 0.00001$)	58%
Geographic region				
United States	1.63 (1.54–1.73, $p < 0.00001$)	0%	2.11 (1.65–2.69, $p < 0.00001$)	59%
Rest of the world	1.65 (1.55–1.76, $p < 0.0001$)	42%	1.85 (1.59–2.15, $p < 0.00001$)	0%

CI = confidence interval; CRT = conformal radiation therapy; EBRT = external beam radiotherapy; HR = hazard ratio; IMRT = intensity modulated radiotherapy; NA = not applicable.

Maior mortalidade global e câncer específica nos pacientes de alto risco tratados com Radioterapia.

Cirurgia x Radioterapia Existe vantagens do ponto de vista oncológico???

- ✓ Não existe nível 1 de evidência (prospectivos e randomizados)
- ✓ Séries de casos retrospectivos
- ✓ Aparente benefício de SG e SCE para cirurgia em pacientes < 65 anos.
- ✓ Viés de seleção (pctes mais graves vão para Radioterapia)
- ✓ Grandes base de dados populacionais (ex: SEER) não tem condutas homogêneas

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Vale a pena tratar

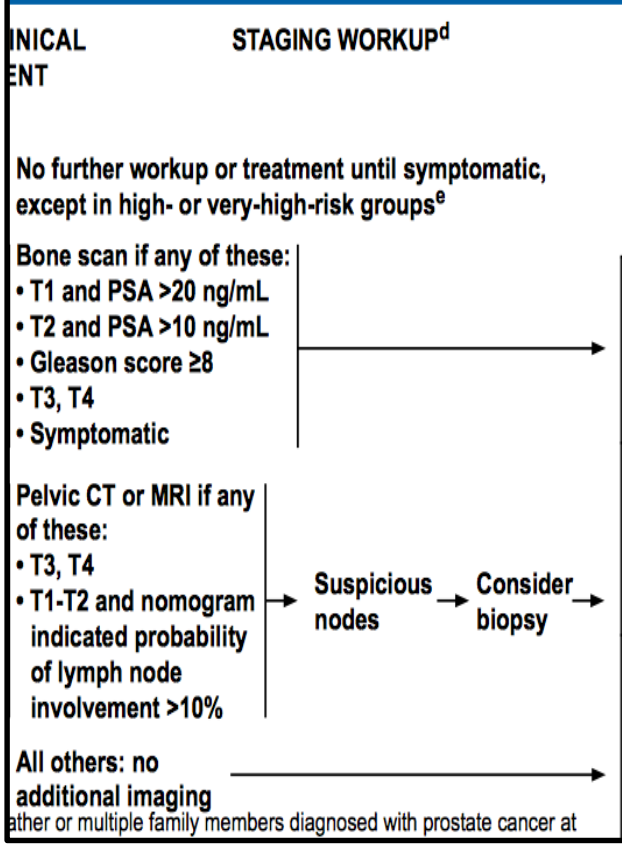
cT3 ??

ESTADIAMENTO LOCAL

Clássico – toque retal

RNM – Forte recomendação nos guidelines

High-risk localised PCa/locally advanced PCa	LE	Strength rating
Use prostate mpMRI for local staging.	2b	Strong
Perform metastatic screening including at least cross-sectional abdominopelvic imaging and a bone-scan.	2a	Strong



High-Risk Disease

22. Clinicians should stage high-risk localized prostate cancer patients with cross sectional imaging (CT or MRI) and bone scan. (Clinical Principle)

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6.2.4.4. Guidelines for radical treatment of locally-advanced disease

Recommendations	Strength rating
Radical Prostatectomy (RP)	
Offer RP to highly selected patients with (cT3b-T4 N0 or any T N1) only as part of multi-modal therapy.	Strong
Extended pelvic lymph node dissection (eLND)	
Perform an eLND in high-risk PCa.	Strong
Do not perform a frozen section of nodes during RP to decide whether to proceed with, or abandon, the procedure.	Strong
Radiotherapeutic treatments	
In patients with locally advanced cN0 disease, offer radiotherapy in combination with long-term androgen deprivation therapy (ADT).	Strong
Offer long-term ADT for two to three years.	Weak
Other therapeutic options outside surgery and radiotherapy	
Do not offer whole gland treatment or focal treatment to high-risk patients.	Strong
Only offer ADT monotherapy to those patients unwilling or unable to receive any form of local treatment and who are either symptomatic or asymptomatic, but with a prostate-specific antigen (PSA)-doubling time < 12 months or a PSA > 50 ng/mL or a poorly-differentiated tumour.	Strong

Paciente ideal : cT3a / PSA < 20 ng/ml / Gleason ≤ 8

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Review – Prostate Cancer

An Analysis of Radical Prostatectomy in Advanced Stage and High-Grade Prostate Cancer

Hendrik Van Poppel *, Steven Joniau

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

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Localised and Locally Advanced Prostate Cancer: Who to Treat and How?

David Gillatt [a,*], Laurence Klotz [b], Colleen Lawton [c], Kurt Miller [d], Heather Payne [e]

- ✓ ***Benefício de um tratamento mais localmente agressivo e imediato.***
- ✓ ***Menor risco de progressão de doença e maior sobrevida câncer específica.***
- ✓ ***Considerar principalmente em pacientes < 65 anos e expectativa de vida > 10 anos.***
- ✓ ***Pouco aumento da morbidade cirúrgica***

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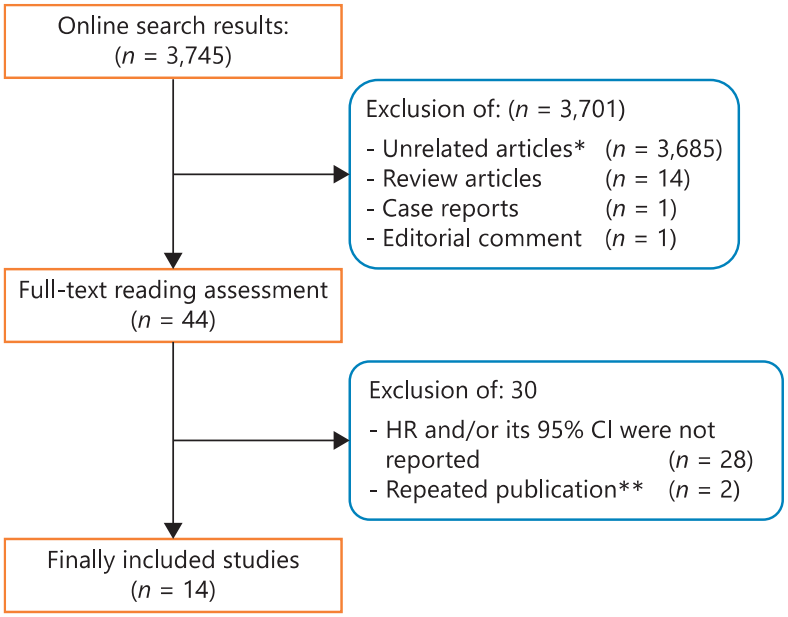
Published online: July 4, 2017

Review

The Role of Radical Prostatectomy and Radiotherapy in Treatment of Locally Advanced Prostate Cancer: A Systematic Review and Meta-Analysis

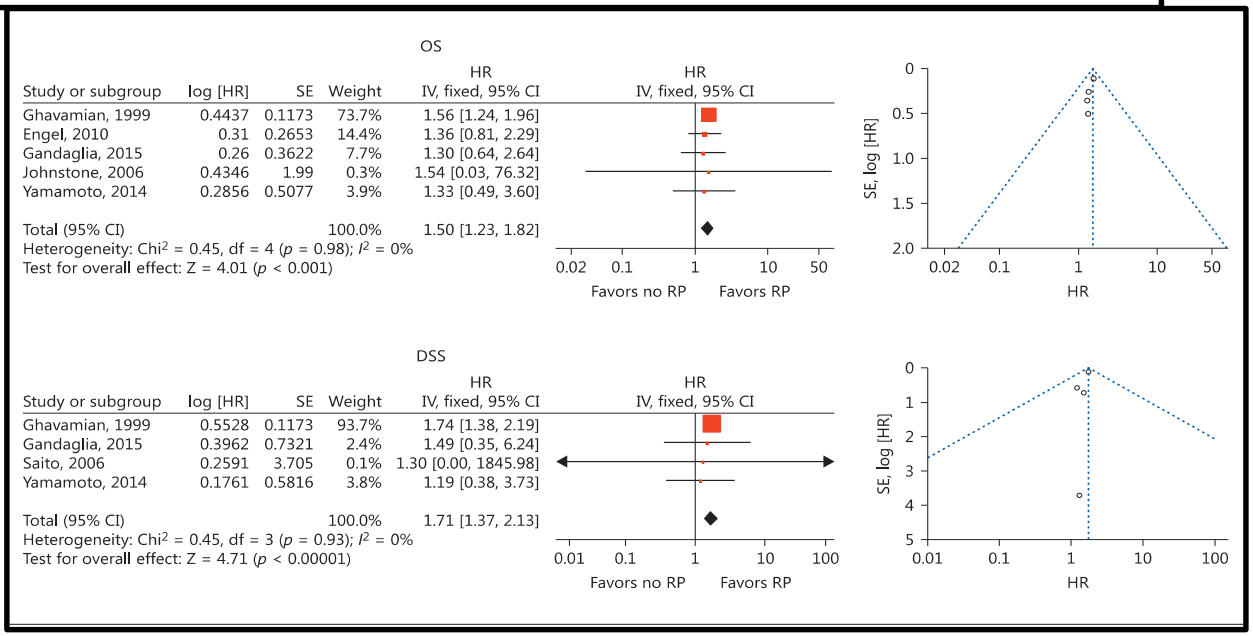


Fahmy O. et al Urol Int 2017

Table 1. Summary of the included studies

First author, year	Design	Number of patients	Inclusion criteria	Follow up, months, mean (median)	Treatment, *n* (%)					Adjuvant therapy (post RP), *n* (%)			Age, years, mean (median)				
					RP	RT	HT	RT + HT	NT	RT	HT	both	total	RP	RT	HT	NT
Gandaglia, 2014	Retrospective	948	≥cT3	N/A	474 (50)				474 (50)				69.6 (69)	69.8 (69)			69.4 (69)
Saito, 2006	Retrospective	209	≥cT3	N/A	30 (14)		101 (48)	78 (37)		30 (100)				64	69.3	78.1	
Johnstone, 2006	Retrospective	1,093	cT4	N/A	72 (7)	82 (8)	400 (37)	258 (24)	281 (26)	4 (6)	13 (18)	5 (7)					
Messing, 2006	RCT	98	pTxN+	(55)	98 (100)					47 (48)			(65.5)				
Gandaglia, 2015	Retrospective	7,616	≥pT3	71.9 (66)	7,616 (100)					404 (5)	1,955 (26)	484 (6)	69				
Moschini, 2016	Retrospective	1,586	≥pT3	80 (72)	1,586 (100)					865 (55)	547 (34)		65.8 (66.1)				
Schumacher, 2008	Retrospective	122	pTxN+	(67)	122 (100)						18 (15)	61 (50)	(64)				
Engel, 2010	Retrospective	1,413	pTxN+	77 (67)	957 (68)	88 (6)	349 (25)	19 (1)		184 (19)	690 (72)		65.3 (65.4)	64.5 (65)			
Ghavamian, 1999	Retrospective	158	pTxN+	N/A	79 (50)		79 (50)				79 (100)			65		66	
Mitchell, 2012	Retrospective	843	cT3	(172)	843 (100)					109 (13)	344 (40)		(65)				
Iversen, 2010	Retrospective	2,681	≥cT3 or pTxN+	N/A	1,719 (64)	305 (11)			657 (25)								
Fosså, 2016	RCT	682	cT3	(163)			341 (50)	341 (50)					N/A				
Souhami, 2009	RCT	189	T3orTxN+	(115)				189 (100)					(70)				
Yamamoto, 2014	Retrospective	231	cT3	(93)	112 (48)	119 (52)								(67)	(72)		

✓ Benefício de SG e SLD



What is the Role of Surgery for Locally Advanced Disease?

Michel Soulié*

Table 1 – Pathologic results of radical prostatectomy specimen in cT3 prostate cancer

	n	pT2	pN$^+$	SV+	PSM	Adj Tt
Lerner et al [22]	812	17%	33%	18%	—	50%
Gerber et al [19]	298	9%	31%	11%	—	40%
Van den Ouden et al [14]	83	18%	12%	40%	66%	0%
Van Poppel et al [10]	158	13%	11%	16%	60%	30%
Ward et al [4]	842	27%	27%	—	56%	76%
Carver et al [6]	176	30%	19%	34%	30%	36%

Oncologic results in cT3a: 47 patients from Van Poppel [10]

- N$^+$: 10%.
- SV involved: 6%.
- PSM rate: 53%.

SV+ = seminal vesicles involved; PSM = positive surgical margins; Adj Tt = adjuvant treatment.

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- PSM rate: 53%.

SV+ = seminal vesicles involved; PSM = positive surgical margins; Adj Tt = adjuvant treatment.

cT3	5 anos	10 anos
SG	64-86%	36-70%
SCE	83-92%	72-82%

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Vale a pena tratar

cT4 ??

BJUI
BJU International

Radical prostatectomy in T4 prostate cancer after inductive androgen deprivation: results of a single-institution series with long-term follow-up

Turkan Hajili, Carsten H. Ohlmann, Johannes Linxweiler, Christina Niklas, Martin Janssen, Stefan Siemer, Michael Stoeckle and Matthias Saar

Department of Urology and Pediatric Urology, Saarland University, Homburg/Saar, Germany

Figure 1 Flowchart of study cohort.

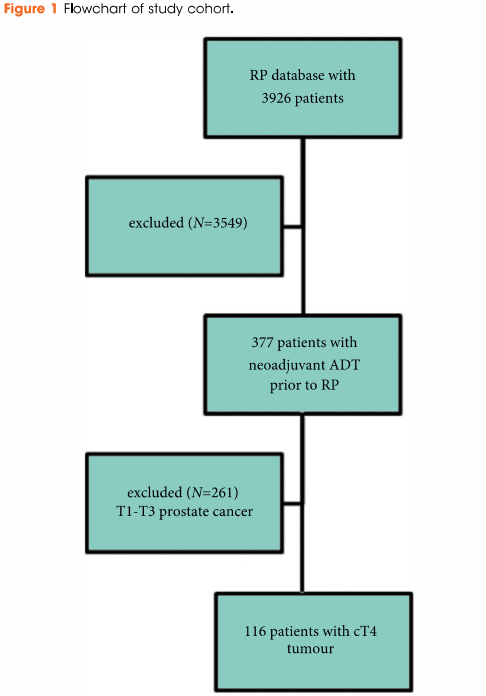

Table 1 Patients' demographics.

Variables	Value
Number of patients	116
Age, years, median (range)	66 (50–76)
Initial PSA level, ng/mL, median (range)	37.6 (2.44–284)
Gleason score (biopsy), *n*	
≤7	42
>7	60
Unknown	14
Inductive ADT duration, months, median (range)	6 (3–14)
Preoperative PSA level, ng/mL, median (range)	0.73 (0.01–34)

Massa tumoral fixa, considerada inoperável

Hajili T. et al. BJUI 2018

Table 2 Perioperative and pathological data.

Variables	Value
Operative duration, min, median (range)	151 (73–309)
N (%)	
Intraoperative complications	
Rectum lesion	3 (2.5)
Blood transfusion	2 (1.7)
Postoperative complications	
Grade 0	89 (76.7)
Grade I	3 (2.6)
Grade II	12 (10.3)
Grade III	12 (10.3)
Grade IV/V	0
Total complications	27 (23.2)
TNM classification	
pT0–T2	23 (19.8)
pT3	88 (75.8)
pT4	5 (4.3)
Positive surgical margins	46 (39.6)
LNI	39 (33.6)
Positive surgical margins and LNI	26 (22.4)
Positive surgical margins or LNI	58 (50)

LNI, lymph node invasion.

Figure 4 OS.

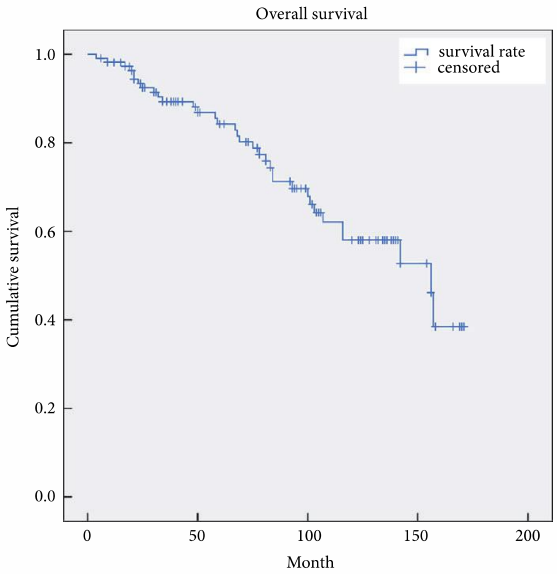

Figure 5 PCSS.

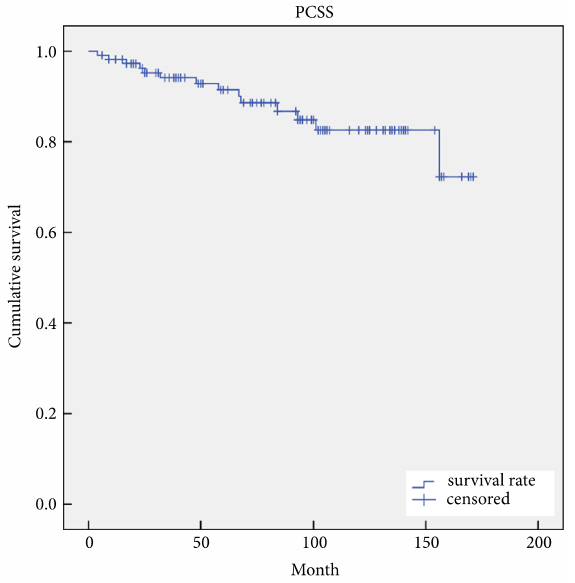

Figure 2 MRI before (**A**) and after 14 weeks of inductive ADT (**B**). This patient with 'PSA-negative disease' started inductive ADT with a PSA level of 5 ng/mL and an extensive Gleason 8 prostate cancer. A fixed mass was described by DRE and confirmed as cT4 by MRI, indicating an infiltration of the bladder neck and especially the rectal wall (a, two grey arrows). Imaging before RP after 14 weeks of ADT showed a volume reduction by >60% (130.3 to 49.3 mL) and as a result downstaging with only slight contact to the rectal wall (b, one grey arrow) but no signs of infiltration confirmed by final pathology (pT3b pN1 pR1).

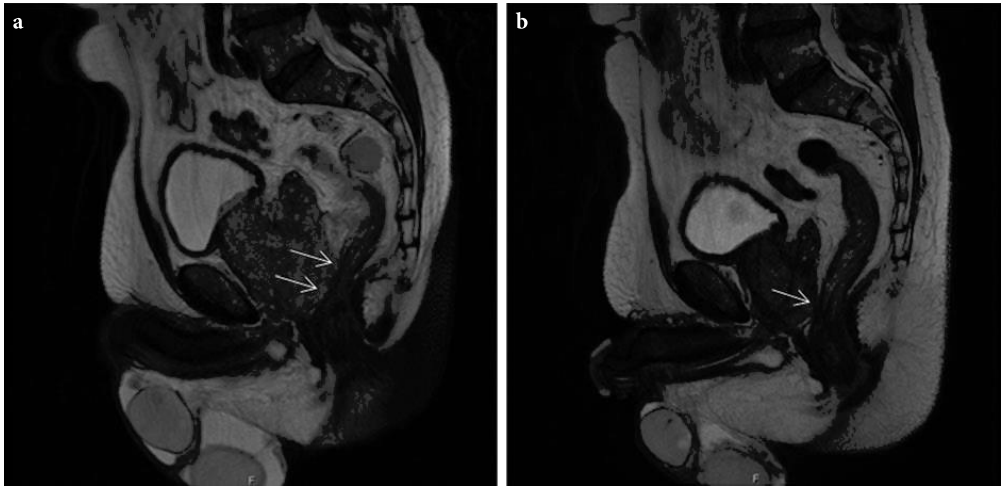

Table 3 Preoperative PSA levels and pathological data of the 19 patients without adjuvant therapy and biochemical remission after RP.

Patient number	Initial PSA level, ng/mL	PSA nadir, ng/mL	Preoperative PSA level, ng/mL	TNM		
				pT	pR	pN
1.	284	0.08	0.08	3b	0	0
2.	37.6	0.54	0.6	3b	1	1
3.	60.6	0.53	0.53	2c	0	0
4.	227.6	0.97	0.97	4	1	0
5.	63.1	0.52	0.52	3b	0	1
6.	8.5	0.1	0.4	3a	0	0
7.	32.9	0.04	0.04	3b	0	0
8.	39.6	0.5	0.5	3b	0	0
9.	43.6	0.65	1.49	T0	0	0
10.	5.45	0.25	0.25	2c	0	0
11.	3.32	1.92	1.92	2a	0	0
12.	18	0.53	0.53	3a	0	0
13.	49	0.01	0.01	4	0	0
14.	7	0.8	1.09	3b	0	0
15.	10.08	5.4	9.88	3a	0	0
16.	23.6	0.07	0.12	2c	1	0
17.	53.7	0.04	0.04	2c	1	0
18.	6.5	1.28	1.28	3b	0	0
19.	33	0.62	0.62	2b	0	0

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Neoadjuvancia

Hormonal

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Review Article

NEOADJUVANT HORMONAL ABLATIVE THERAPY BEFORE RADICAL PROSTATECTOMY: A REVIEW. IS IT INDICATED?

MICHAEL J. SCOLIERI, ANDREW ALTMAN AND MARTIN I. RESNICK*

From the Department of Urology, Case Western Reserve University, School of Medicine, Cleveland, Ohio

TABLE 1. *Randomized prospective studies*

References	LH-RH	Antiandrogen	No. Mos.
Witjes et al[11]	Goserelin	Flutamide	3
Labrie et al[12]	Leuprolide	Flutamide	3
Soloway et al[13]	Leuprolide	Flutamide	3
Hugosson et al[14]	Triptorelin	Cyproterone	3
Dalkin et al[15]	Goserelin		3
Goldenberg et al[16]		Cyproterone	3
Van Poppel et al*,[17]			1.5

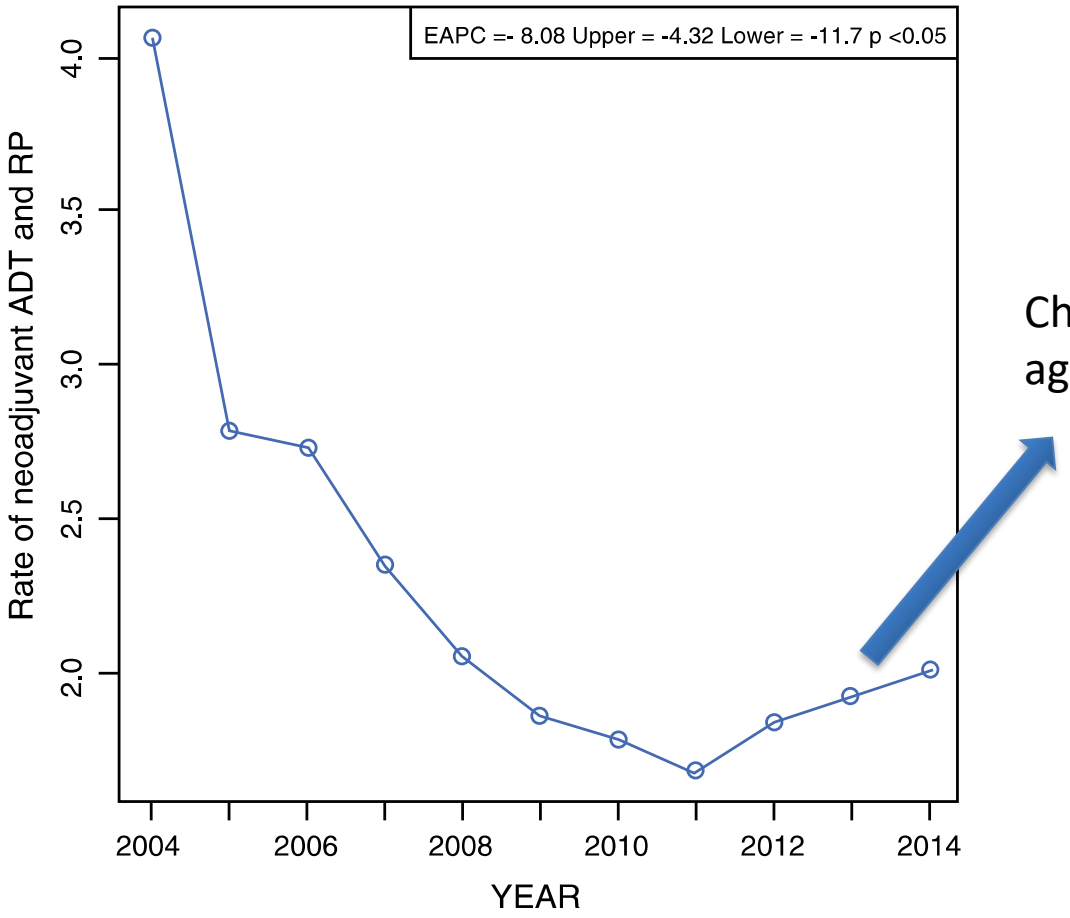
* Estramustine was given.

TABLE 2. *Positive margin rates*

References	Stage (No. margins)	% Pos. Margin		Significant (p value)
		Neoadjuvant Hormonal Therapy	Radical Prostatectomy	
Witjes et al[11]	T2 (92 vs. 107)	14	36	Yes (<0.01)
	T3 (72 vs. 83)	43	59	No (0.14)
Overall (164 vs. 190)		27	46	Yes (<0.01)
Labrie et al[12]	B0	0	33	No
	B1	2.3	25.5	Yes
	B2	10.8	58.8	Yes
	C1	0	0	No
	C2	14.3	80	Yes
Overall		7.8	33.8	Yes
Soloway et al[13]	T2b (138 vs. 144)	18	48	Yes
Hugosson et al[14]	T1b–c (10 vs. 15)	30	33	
	T2a–b (9 vs. 9)	22	11	
	T2c–T3a (37 vs. 31)	22	61	Yes (0.0008)
Overall (56 vs. 55)		23	41	Yes (0.013)
Dalkin et al[15]	T1c (17 vs. 16)			
	T2a (8 vs. 12)			
	T2b (3 vs. 0)			
Overall (28 vs. 28)*		17.9*	14.3*	No
Goldenberg et al[16]	T1b (5 vs. 4)			
	T1c (5 vs. 3)			
	T2a (30 vs. 33)			
	T2b (19 vs. 17)			
	T2c (42s vs. 42)			
Overall (101 vs. 91)		27.7	64.8	Yes
Van Poppel et al[17]	T2b (36 vs. 37)	16.7	32.4	Yes
	T3 (29 vs. 25)	41.3	44.0	No
Overall (65 vs. 62)		27.7	37.1	

* Includes positive surgical margins and seminal vesicle invasion.

Histórico do uso de Neoadjuvância nos EUA



Chegada de novos agentes hormonais

FIG. 2 Proportion of patients receiving neoadjuvant ADT over time, calculated using the EAPC. *ADT* androgen deprivation therapy, *EAPC* estimated annual percentage change, *RP* radical prostatectomy

Neoadjuvância "Vintage"		*Neoadjuvância Atual*
Casos cT1 - T 2	→	*Casos cT3 – T4*
Duração 03 meses	→	*Curva de PSA Aprox 06 meses*
ADT Apenas	→	*Novos agentes (abi/enza/apa) Quimioterapia*

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Recruitment :

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- ☐ Terminated
- ☐ Completed
- ☐ Withdrawn

Row	Saved	Status	Study Title	Conditions	Interventions	Locations
1	☐	Recruiting	**Neoadjuvant** Apalutamide (ARN509) and Radical Prostatectomy in Treatment of Intermediate to High Risk **Prostate Cancer**	• **Cancer of the Prostate**	• Drug: Apalutamide	• Department of Urology Singapore, Singapore
2	☐	Recruiting	**Neoadjuvant** Stereotactic Body Radiotherapy Prior to Radical Prostatectomy for High Risk **Prostate Cancer**	• **Prostate Cancer**	• Radiation: Stereotactic Body Radiation Therapy • Procedure: Radical Prostatectomy	• The University of Michigan Comprehensive Cancer Center Ann Arbor, Michigan, United States
3	☐	Recruiting	**Neoadjuvant** Enoblituzumab (MGA271) in Men With Localized Intermediate and High-Risk **Prostate Cancer**	• **Prostate Cancer**	• Drug: Enoblituzumab	• Johns Hopkins Sidney Kimmel Comprehensive Cancer Center Baltimore, Maryland, United States
4	☐	Recruiting	A Phase II **Neoadjuvant** Study of Apalutamide, Abiraterone Acetate, Prednisone, Degarelix and Indomethacin in Men With Localized **Prostate**	• Stage III **Prostate**	• Drug: Abiraterone Acetate • Drug: Apalutamide	• Fred Hutch/University of Washington Cancer Consortium

Ann Surg Oncol
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ORIGINAL ARTICLE – UROLOGIC ONCOLOGY

Neoadjuvant Androgen Deprivation Therapy Prior to Radical Prostatectomy: Recent Trends in Utilization and Association with Postoperative Surgical Margin Status

Tyler R. McClintock, MD, MS[1], Nicolas von Landenberg, MD[1,2], Alexander P. Cole, MD[1], Stuart R. Lipsitz, ScD[3], Philipp Gild, MD[1,4], Maxine Sun, MPH, PhD[5], Sean A. Fletcher[3], Florian Roghmann, MD[1], Mani Menon, MD[6], Paul L. Nguyen, MD[5], Joachim Noldus, MD[1], Toni K. Choueiri, MD[5], Adam S. Kibel, MD[1,5], and Quoc-Dien Trinh, MD[5]

- ✓ ***NCDB Database from 20014 to 2014***
- ✓ ***Pacientes cT1-4N0M0***
- ✓ ***386.027 pacientes***
- ✓ ***ADT neoadjuvante + PR X PR sozinha***

McClintock TR et al. Ann Surg Oncol 2018

ADT relacionado à diminuição de margens cirúrgicas positivas.

TABLE 2 Propensity-adjusted effect of neoadjuvant ADT and RP versus RP alone on prediction of positive surgical margins in the whole cohort and stratified to National Comprehensive Cancer Network subgroups

	Odds ratio	95% CI	*p* value
Whole cohort	0.85	0.79–0.90	< 0.001
Low risk	0.65	0.51–0.84	< 0.001
Intermediate risk	0.76	0.69–0.85	< 0.001
High risk	1.08	1.00–1.16	0.077
Very high risk	1.14	0.91–1.44	0.258

OR odds ratio, *CI* confidence interval, *ADT* androgen deprivation therapy, *RP* radical prostatectomy

Variables	Unweighted			Weighted (%)		
	RP only [no neo-ADT] (%)	Neo ADT and RP (%)	Stand. difference (%)	RP only	Neo ADT and RP	Stand difference (%)
cT stage						
1	260,131 (68.85)	4481 (54.75)	− 29.30	68.55	68.72	0.40
2	108,013 (28.59)	3004 (36.71)	17.40	28.76	28.16	− 1.30
3	9463 (2.50)	659 (8.05)	25.00	2.62	3.03	2.50
4	236 (0.06)	40 (0.49)	8.10	0.1	0.1	0.50
PSA (ng/mL)						

6. How to improve the oncologic outcomes of RP in stage cT3 tumours?

6.1. *Neoadjuvant hormonal therapy*

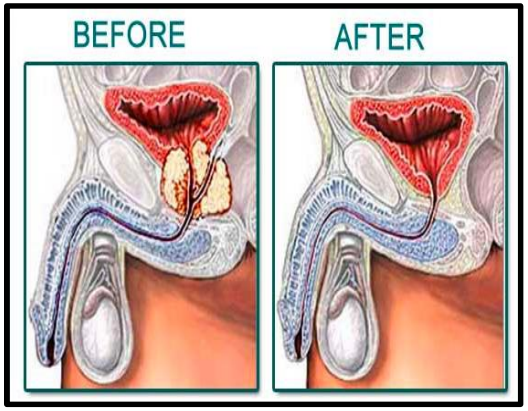
Neoadjuvant hormonal therapy before RP, even in case of cT3 tumours, is not recommended in current practice because no study showed a benefit on survival. Previous studies have shown a 30% clinical down-staging and a 25% pathologic down-staging in men treated with neoadjuvant hormone therapy (mean time 3 mo). But this treatment has not shown any statistical difference in disease-free or overall survival between men with or without neoadjuvant therapy [39–42].

Neoadjuvant combination of chemotherapy and hormone therapy before RP has been reported in locally advanced prostate cancer and high-risk tumours [43]. These new modalities can be effective and used in the future to improve local oncologic issues of local treatments.

Klotz L et al J Urol 2013

Take Home Messages

Existe papel para a Cirurgia ????



- ✓ ***Possibilidade de cura ou controle prolongado em casos de doença localizada de alto risco***
- ✓ ***A cirurgia é a melhor maneira de começar um tratamento multi modal !***
- ✓ ***É a maneira mais eficaz de eliminar clones letais***
- ✓ ***Nos casos cT3, tratamento cirúrgico mais agresssivo num cenário multi modal.***
- ✓ ***Nos casos cT4, a cirurgia pode ser considerada para casos selecionados.***
- ✓ ***A neoadjuvância pode ajudar no downstaging de tumores localmente avançados.***
- ✓ ***Efeitos colaterais minimizados com melhora da técnica. E corrigíveis.***