

1Cardiff University School of Medicine, Velindre Hospital, London, United Kingdom
2NCIC Clinical Trials Group, Queen’s University, Kingston, Canada
3Medical Research Council Clinical Trials Unit at University College London, London, United Kingdom
4Cancer Centre of Southeastern Ontario, Kingston, Canada
5The Clatterbridge Cancer Centre National Health Service Foundation Trust, Wirral, United Kingdom
6University of Toronto, Princess Margaret Cancer Centre, Toronto, Canada
7Christie Hospital, University of Manchester, Manchester, United Kingdom
8Fraser Valley Cancer Centre, Surrey, Canada
9Sheffield Teaching Hospitals, National Health Service Foundation Trust, Sheffield, United Kingdom
10University of Texas Health Science Center, San Antonio, TX, USA
11University of Toronto, Carlo Fidani Peel Regional Cancer Center, Toronto, Canada
12Castle Hill Hospital, Hull, United Kingdom
13Memorial University of Newfoundland, St Johns, Newfoundland and Labrador, Canada
14Velindre Hospital, Cardiff, United Kingdom
15Vancouver Cancer Centre, Vancouver, British Columbia
16South West Wales Cancer Centre, Swansea, United Kingdom
17McGill University, Montreal, Quebec, Canada
18The James Cook University Hospital, Middlesbrough, United Kingdom


EDITORIAL COMMENT

No certain treatment recommendations were given for locally advanced or high-risk prostate cancer in the European Association of Urology (EAU) guidelines (1). In the guidelines, studies supporting surgery or radiotherapy (RT) were listed, and the readers were left alone to make their own decisions.

In the present study, Mason et al. reported the impact of adding RT to androgen deprivation therapy (ADT). One thousand two hundred and five patients with T3-4, N0/Nx, M0 prostate cancer or T1-2 disease with either PSA more than 40 μg/L or PSA 20 to 40 μg/L plus Gleason score of 8 to 10 were randomized to ADT alone (n=602) or to ADT+RT (n=603). A lower dose radiation 64 to 69 Gy was used for RT. Overall survival (OS) risk reduction was 30% for ADT+RT group (P<0.001) at a median follow-up of 8 years. Cancer-specific survival (CSS) was significantly improved by the addition of RT to ADT (HR: 0.46, 95% CI: 0.34 to 0.61; p<0.001).

Patients on ADT+RT reported a higher frequency of adverse events related to bowel toxicity. However, reported frequency of ADT-related toxicities (impotence, hot flushes, urinary frequency, ischemia, and hypertension) were similar for both arms. The present study provided results of high-risk patients in a longer median follow-up time than SPCG-7 study (2). Because the study took place between 1995 and 2005, less than 70 Gy was used for RT. Even at lower radiation doses, the authors confirmed that adding RT to ADT improved both OS and cancer-specific survival (CSS) with minimal general toxicity. In the modern era, improved RT techniques may help achieve better outcomes with much higher radiation doses without increased morbidity in this group of patients.

REFERENCES