Better guidelines, coordination needed for prostate cancer specialists

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With a deluge of promising new drug treatments for advanced prostate cancer on the market, a new model of care is needed that emphasizes collaboration between urologists and medical oncologists, according to UC Davis prostate cancer experts.

In an article published online today in the journal *Urologic Oncology*, urologist Ralph de Vere White and medical oncologist Primo Lara, Jr. of the UC Davis Comprehensive Cancer Center describe a framework for urology and medical oncology interactions to enhance patient care, improve outcomes and yield clinical research advances.

The physicians aim to address the general lack of collaboration between the two specialties when patients with prostate cancer develop resistance to drugs that block the hormone testosterone, which fuels prostate cancer growth. Until now, only a handful of medications, including chemotherapies, have been available for this group of patients. All of the new drugs on the market for prostate cancer are designed to treat these so-called "castrate-resistant" patients.

"Patients with castrate-resistant prostate cancer (CRPC) will benefit if all caregivers buy into an integrated and comprehensive approach," said de Vere White, who also directs the UC Davis Comprehensive Cancer Center. "When both specialties jointly manage the CRPC patient from the start, the artificial boundaries between specialties dissolve and transitions of care become seamless."

The UC Davis experts explain that castration-resistant prostate cancer patients are now often managed by either a medical oncologist (who specializes in chemotherapy treatment) or a urologist (who specializes in surgery to remove a cancerous prostate). Historically, urologists have referred patients to medical oncologists after their cancers become castrate resistant, and chemotherapy or other types of treatment are warranted.

The new drugs, sipuleucel-T, radium 223, enzalutamide, abiraterone, and cabazitaxel, vary in their mechanism of action, but all target castrate-resistant disease, and some can be prescribed by either medical specialist.

"There is an extra level of complication that this scenario engenders," Lara said. "It has become blurry – who manages what, and when."

Clinical dilemmas have arisen in which clinicians are not clear on whether patients should be treated similarly or which drugs should be used and in what order to be most effective.

"With so many new drugs, how do you use them, and in what sequence?" Lara asks. "Is one better than the other? While we don't have those answers, we can work on a framework to deliver patient-centered treatment."

Lara and de Vere White call for a urology-medical oncology partnership to establish consensus guidelines to identify the most appropriate sequence of available therapeutic options and clearly define treatment goals and responsibilities of each provider throughout the trajectory of a prostate cancer patient's care.

"Thus the patient receives state-of-the-art care regardless of the specialty of the treating physician," they write.

De Vere White notes that a coordinated approach is also more cost-effective because of efficiencies in the delivery of care.

Because a lack of collaboration among the specialties is most prominent in the community, non-academic setting, the authors suggest expanded use of telemedicine. They cite the genitourinary tumor board at UC Davis Comprehensive Cancer Center, which links community oncologists with urologists and other specialists at UC Davis via videoconferencing. These conferences allow all providers to discuss and optimize options for individual patients in the community.

Lara and de Vere White also suggest clinical studies to test various models of integrated patient management, in the same way that solid organ transplant patients are managed by both surgical and medical specialists. Clinical trials also could be developed to test new therapeutic approaches or to optimize sequencing of available therapies.

The authors note that there are potential barriers to successful implementation of the plan, notably the financial incentives for physicians to hold on to patients as long as possible, as well as logistical and regulatory obstacles to multidisciplinary coordination outside of highly organized health delivery units. But they also emphasize that the vast majority of physicians will follow "best practice" guidelines when they are provided in an unbiased fashion.

De Vere White said he believes if the model is successful for castrate-resistant prostate cancer, it could be adopted by different specialties treating patients with other types of advanced cancer.

"As the nation tries to reign in health-care costs, and health systems focus on delivery of patient-centered care. We have no choice but to create guidelines to ensure that new treatments are used effectively for the benefit of each patient," de Vere White said.

Provided by UC Davis