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Prostate cancer is focus of two studies, commentary

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Management for low-risk prostate cancer varies widely among physicians

Management of low-risk prostate cancer (which is unlikely to cause symptoms or affect survival if left untreated) varies widely among urologists and radiation oncologists, with patients whose diagnosis is made by a urologist that treats non-low-risk prostate cancer more likely to receive treatment vs. observation.

Most men in the United States with low-risk prostate cancer usually receive treatment with prostatectomy or radiotherapy and thus are exposed to treatment-related complications including urinary dysfunction, rectal bleeding and impotence. Observation is an alternative approach. Previous research indicates that older men with low-risk prostate cancer who choose observation have similar survival and fewer complications. However, it is not known whether decisions about disease management are influenced by physician factors, including characteristics of the diagnosing urologist.

Authors analyzed data from a group of men (ages 66 years and older) with low-risk prostate cancer (diagnosed from 2006 through 2009) to examine the impact of physicians on disease management.

A total of 2,145 urologists diagnosed low-risk prostate cancer in 12,068 men during the study period, of whom 80.1 percent received treatment and 19.9 percent were observed. Observation varied widely across

urologists from 4.5 percent to 64.2 percent of patients. Urologists who treat non-low-risk prostate cancer and graduated less recently from medical school were less likely to manage low-risk disease with observation. Patients were more likely to undergo medical interventions, including prostatectomy or external-beam radiotherapy, if their urologist performed that procedure. Rates of observation varied across consulting radiation oncologists from 2.2 percent to 46.8 percent.

"We postulate that the diagnosing urologist plays an important role in treatment selection because he or she is the first to convey the diagnosis to the patient and discuss disease severity and management options." Karen E. Hoffman, M.D., M.H.Sc., of the University of Texas MD Anderson Cancer Center, Houston, and colleagues wrote in their *JAMA Internal Medicine* article.

Primary ADT Not Associated with Improved Survival for Men with Localized Prostate Cancer

The hormone treatment primary androgen-deprivation therapy (ADT) was not associated with improved survival (overall or disease-specific) in men with localized prostate cancer.

There has been no data to support the use of ADT for early-stage prostate cancer, yet it has been widely used as a primary therapy for localized disease, especially among older men. Because the cancers of most patients treated with ADT will become resistant to treatment within a few years and because there are adverse effects associated with ADT, the timing of ADT is crucial.

The authors used data from the Surveillance, Epidemiology and End Results (SEER) Program to assess whether ADT had an impact on long-term survival in various geographic areas around the U.S. The study

included 66,717 Medicare patients ages 66 years or older diagnosed from 1992 through 2009 who received no definitive local therapy (surgery or radiation) within 180 days of diagnosis.

After a median follow-up of 110 months, primary ADT was not associated with improved 15-year overall or prostate cancer-specific survival after a diagnosis of low-risk prostate cancer. The 15-year overall survival was 20 percent in areas with high primary ADT use vs. 20.8 percent in areas of low primary ADT use among patients with moderately differentiated cancer. The 15-year prostate cancer survival was 90.6 percent in both high- and low-use areas. Among patients with poorly differentiated cancers, the 15-year cancer-specific survival was 78.6 percent in high-use areas vs. 78.5 percent in low-use areas; and the 15-year overall survival was 8.6 percent in high-use areas vs. 9.2 percent in low-use areas.

"Health care providers and their older patients should carefully weigh our findings against the considerable adverse effects and costs associated with primary ADT before initiating this therapy in men with clinically localized prostate cancer." Grace L. Lu-Yao, M.P.H., Ph.D., of the Rutgers Cancer Institute of New Jersey and Robert Wood Johnson Medical School, New Brunswick, N.J., and colleagues wrote in their JAMA Internal Medicine paper.

Commentary: Measuring the Effectiveness of ADT for Prostate Cancer in Medicare Patients

In a related commentary, Quoc-Dien Trinh, M.D. F.R.C.S.C, and Deborah Schrag, M.D., M.P.H., of the Dana-Farber Cancer Institute, Boston, write: "In summary, on the basis of both randomized trials and observational data from SEER-Medicare and from integrated health care networks, there is no compelling evidence to prescribe ADT alone for

men with localized prostate cancer. Given persistent high use rates, primary ADT for localized prostate cancer is a prime candidate for inclusion in the American Board of Internal Medicine Foundation and the American Urological Association "Choosing Wisely" campaign to encourage clinicians to avoid use of therapeutic interventions with marginal benefits."

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