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Prostate Oncology Specialists

The 2013 ASCO Genitourinary Conference in Review

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Every year, like a religious calendar, I attend at least four prostate cancer meetings to stay abreast of new developments. The first meeting of the year is hosted by the American Society of Clinical Oncology, Genitourinary Division. It is a multi-disciplinary affair, joining doctors from all three specialties: Roughly, 1,000 medical oncologists, 400 urologists and 300 radiation therapists were present.

Multiparametric MRI and Active Surveillance

The most compelling presentations were those discussing how to improve active surveillance. Dr. Peter Choyke of the NCI presented multiparametric-magnetic resonance imaging (MP-MRI) data that has given him confidence to use MP-MRI instead of using repeat random biopsies for monitoring men on active surveillance. Biopsy is only used when a change in MP-MRI (or PSA) occurs. Dr. Chris Parker from the Royal Marston Hospital in England has gone one step further using MP-MRI *before* the initial random biopsy to diagnose prostate cancer. He reported that MP-MRI improves the odds of finding cancer. In certain cases he *forgoes biopsy altogether* when the MP-MRI shows only low grade disease. Both doctors reported that fusing the MP-MRI with an ultrasound-guided targeted biopsy improves biopsy accuracy. As its use increases and doctors become more familiar with this new technology, MP-MRI has tremendous potential to reduce the number of men requiring random biopsy either for screening purposes or for monitoring men on active surveillance.

Additional topics presented relating to active surveillance were: 1) The need to encourage greater implementation in the community, 2) the likelihood that prostate imaging will be substituted for needle biopsy in the future, 3) reducing the number of random biopsies and increasing the number of targeted biopsies, 4) further refining the accuracy of Gleason scoring and finally, 5) pointing out the relative weakness of PSA alone to detect cancer progression, especially when compared to imaging.

Testing for Two Molecular Targeted Therapies Fails

The results of two phase III multimillion dollar clinical trials evaluating survival in men with advanced disease were also reported. Sadly, when tested against placebo, neither of these two new targeted molecular therapies (afilbercept and dasatinib) showed improvement in overall survival.

Selected Abstracts from the Meeting

Perhaps a dozen of the 245 written abstracts and posters scientific presentations that were presented at the meeting caught my attention. I'll briefly highlight what they were about and why I think they are pertinent.

How Long should Hormone Blockade Continue in Men with *High-Risk* Prostate Cancer?

These days, men with *High-Risk* prostate cancer are generally treated with radiation combined with testosterone-inactivating pharmaceuticals (TIP)—also known as androgen deprivation. Many published studies have established that the anticancer effects of TIP are further enhanced with more prolonged administration. However, the unanswered question had been, “What is the precise point of diminishing returns? What is the optimal duration for TIP to be continued.?” Previously published studies indicate that 24 to 36 months were necessary to extract the maximum benefit from TIP. However, Dr. Nabid from Canada did a study that was reported in Abstract #3 indicating that men treated with 18 months of TIP did just as well as those treated with 36 months. Along similar lines, in Abstract #83, Dr. Nanda from MD Anderson reported that 12 months of TIP was significantly better than 4 months in men with *High-Risk* disease. In my practice at Prostate Oncology Specialists our target treatment period for men with *High-Risk* is usually in the range of 12-18 months. We have long suspected that more protracted treatment simply adds unnecessary side effects without prolonging survival.



Does Proscar Convert Prostate Cancer from Low Grade into High Grade?

In the Prostate Cancer Prevention Trial that compared Proscar (finasteride) with placebo for preventing prostate cancer, slightly more men in the Proscar group were *diagnosed* with high grade prostate cancer. As a result, the FDA put out a warning about Proscar, suggesting that Proscar might *cause* high grade cancer. Most, but not all, experts derided the FDA’s warning as scientifically unfounded because there was another perfectly plausible explanation for why more high grade disease was found in Proscar-treated men—Proscar diminished the size of men’s prostate glands making high grade disease easier to detect with a random

biopsy. In any case, at this year’s meeting Abstract #10 summarized an eighteen-year follow-up of the men from the original Proscar trial. It turns out that Proscar reduces prostate cancer mortality in men with low-grade disease. In men with high grade disease there was no effect on mortality one way or the other.

How Out of Control is the Overtreatment of Low Grade Prostate Cancer?

No one disputes that too many men are getting unnecessary radical treatment for prostate cancer. Several abstracts at the meeting quantified the degree of overtreatment. Dr. Hoffman from MD

Anderson concluded in his study published in Abstract #15 that, “The vast majority of older men, even those over 80, receive active treatment for favorable prostate cancer.” In another study published by Dr. Gilbert from the University of Florida in Abstract #140, “Only 26% of men over age 75 are managed expectantly.” He also reported lower observation rates in geographic areas where greater numbers of radiation oncologists were located. In Abstract #161 Dr. Aizer from Harvard studied the management of 11,000 elderly men with Low-Risk prostate cancer who had a life expectancy of less than 10 years. He reported that two-thirds of men were given unnecessary treatment.

When the Task Force said, “No More PSA Testing,” Did Primary Doctors Listen?

Over the last few months I have heard various urologists and radiation therapists commenting that they are seeing lower numbers of patients with prostate cancer compared to previous years. They suspect that the widely-publicized 2011 US Task Force “D rating” of the PSA test is discouraging primary care physicians from recommending PSA screening to their patients, resulting in fewer patients being referred to urologists and less prostate cancer being diagnosed. Dr. Kathleen McGinley from the University of Medicine in New Jersey studied this issue in a 32-physician urology practice. She reported in Abstract #25 that the number of new patients referred was *reduced by 12% compared to the previous year.*

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