Prostate Cancer-The More We Know, the More We Get Confused?

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The recent release of the clinical results of the Prostate Cancer Intervention vs. Observation Trial (PIVOT) on early prostate cancer [1] and enzalutamide on Castration Refractory Prostate Cancer (CRPC) [2], together with the quality of life analysis of prostate cancer screening by the European Randomized Study of screening for Prostate Cancer (ERSPC) group [3], had added fuel to the hot debate about the optimal management of prostate cancer. In the past few years, there was rapid development in management of various stages of prostate cancer, from chemoprevention, screening, to management of advanced stage disease. However, despite all these new information, it is still uncertain about what is the “best approach” to manage prostate cancer in our daily practice: whether it is a true “fierce tiger” that needs aggressive effort to detect and treat it early to avoid advanced stage diseases or it is just a “little kitten” with which we can live for years peacefully without any need of early intervention.

There was a long publication list of the clinical results of various agents for the management of advanced prostate cancer [2,4-7]. Some of these agents have already approved by FDA for clinical use. Judging from the great interest of doctors and patients on the drugs and the tremendous input from the industry in the development of these products, there was a real and unmet demand in management of advanced prostate cancer. From these studies, the outlook of patients with castration refractory disease after using these drugs was still limited [2,4-6]. Therefore, interest has also been raised in chemoprevention by using 5-alpha reductase inhibitors to prevent development of prostate cancer [8]. Though the best regime for chemoprevention (such as time to start, dosage, and optimal duration, etc.) is still uncertain, it has already aroused great interest of physicians and the public.

Although we know that prostate cancer can progress and is potentially fatal, the role of screening and early treatment is still controversial. The results of the two big trials on prostate cancer not only help us to clear this uncertainty, they just add more confusion to the community [9,10]. The updated thirteen year follow-up data of the Prostate, Lung, Colorectal and Ovarian (PLCO) suggested that there was no evidence of survival benefit for organized annual screening for prostate cancer and also the concept of active surveillance maybe beneficial to some patients when they were diagnosed to have low risk early stage prostate cancer [3]. Therefore, risk stratification is important, i.e. identifying those prostate cancer patients who would be more benefited by active treatment and who would be put on observation (or active surveillance). Currently, there are already many systems of risk stratification systems to guide our decision making process [13]. However, we may still need some refinement on the criteria, in particular the possibility of incorporating some molecular markers in the systems to help the improvement in their accuracy. The option of active surveillance should be included in one of the treatment options for early stage prostate cancer, in particular for low risk patients. However, the concept of active surveillance is still not very popular in some clinical practice [14]. While we are still waiting for the final result of ProtecT study, [15] a better education of physician and patients to understand more about the clinical behavior of prostate cancer and also the concept of active surveillance maybe beneficial to some patients when they were diagnosed to have low risk early stage prostate cancer.

References
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