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Editorial on an international survey of androgen deprivation therapy (ADT) for non-metastatic prostate cancer in 19 countries

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The widespread use of prostatic specific antigen (PSA) testing has greatly impacted on the epidemiology of prostate cancer. Patients are often discovered at an early stage and testing is also performed in patients who are too elderly or frail for local treatments such as prostatectomy or radiation therapy. Only recently has there been an increased uptake in the use of active surveillance for selected patients with localised prostate cancer.[1]

Androgen deprivation therapy (ADT) has traditionally been reserved for patients with metastatic disease or in combination with radiation therapy for locally advanced disease.

The subject of when and how and to whom ADT should be given in patients with non-metastatic prostate cancer is highly controversial and filled with mystery, beliefs and differing practice patterns. This paper is a very interesting online survey of real world treatment decisions among 441 urologists, oncologists and radiation oncologists treating prostate cancer in 19 countries; 47% work in a non-academic setting and 46% in an academic setting.[2] The physicians estimated that they had 99 177 patients with prostate cancer in their care.

The reasons for prescribing ADT in patients with non-metastatic prostate cancer were: PSA ≥10 ng/mL in 81% of physicians, doubling time of ≤6 months in 78% or Gleason score >7 in 91%. ADT differed by region with the highest rates reported in Eastern Europe, (Hungary, Poland) for 6 months or longer as continuous or intermittent (>75% of patients). How this relates to the quantity of surgery and RT is unclear. However, practitioners in the USA used ADT in this way in less than 70% of their patients, possibly due to consequences of reimbursement.

The paper also provides real world determining factors in prescribing intermittent androgen deprivation (IAD) therapy as opposed to continuous ADT. IAD was selected based on PSA level in 65%, Gleason score in 52%, treatment guidelines in 48% and patient request in 48% of cases. Of note, treatment guidelines vary among regions and different societies, based on the interpretation of different studies.

This early use of hormonal therapies for patients with non-metastatic disease has led to an extremely heterogeneous new population of patients with non-metastatic M0 castration-resistant prostate cancer (CRPC).[3] Large scale clinical trials with novel hormonal agents such as enzalutamide, ARN-509 and ODM-201 are now investigating this new entity.

European treatment guidelines recommend the use of hormonal therapy for the treatment of advanced prostate cancer, including (CRPC), but there are also differences in prostate cancer treatment. In another European survey, 348 physicians (191 urologists and 157 oncologists) reported on patients with prostate cancer. Of 3477 patients, 1405 (40%) were categorised as having CRPC, and 1119 of these had metastatic CRPC.

Overall, addition of an antiandrogen to an luteinizing hormone releasing hormone (LHRH) agonist was the most commonly prescribed therapy when patients failed initial LHRH agonist therapy, with considerable variations between countries. At the time of the survey, prior to approvals of abiraterone and enzalutamide prechemotherapy in asymptomatic metastatic patients, 72% of the physicians chose chemotherapy as the next treatment option after diagnosis of CRPC, but 31% of this group would initially prescribe this without an LHRH agonist, which is not what is recommended by most guidelines.[4]

There are obvious limitations to surveys, such as lack of confirmation of physician

reported data, different definitions of intermittent and continuous therapy, and the possibility that those completing surveys have a different work load from those who do not answer surveys. Results from these types of survey are, nonetheless, important in beginning to understand treatment practices and in highlighting inconsistencies in the use of hormonal therapy worldwide.

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REFERENCES

1. Klotz L, Thompson I. Early prostate cancer—treat or watch? *N Engl J Med* 2011;365:569.
2. Liede A, Hallett DC, Hope K, *et al*. International survey of androgen deprivation therapy (ADT) for nonmetastatic prostate cancer in 19 countries. *ESMO Open* In press. doi:10.1136/esmoopen-2016-000040
3. Tombal B. Non-metastatic CRPC and asymptomatic metastatic CRPC: which treatment for which patient? *Ann Oncol* 2012;23(Suppl 10):x251–8.
4. Sternberg CN, Baskin-Bey ES, Watson M, *et al*. Treatment patterns and characteristics of European patients with castration-resistant prostate cancer. *BMC Urol* 2013;13:58.