### PROSTATE CANCER LIST SERV

**SCENARIO 3:**
**HIGH RISK PROSTATE CANCER PATIENT**

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<th>LEARNING OBJECTIVES</th>
<th>CASE PRESENTATION</th>
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<td>1. Discuss the role of MCCs</td>
<td>● A 61 year old male presents with a PSA 18ng/ml.</td>
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<td>2. Examine the appropriateness of different surgical techniques</td>
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<td>3. Assess the significance of diffusely positive surgical margins on local recurrence</td>
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<td>4. Identify the role of adjuvant therapy</td>
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### QUESTIONS FOR DISCUSSION

- What are the treatment options for this patient? Which treatment would you recommend?
- Should the pathology be reviewed to confirm the Gleason score and rule out evidence of extraprostatic extension from the biopsy?

### INVESTIGATIONS

- DRE reveals a T2 nodule on the left side
- Biopsy shows a Gleason 9 (4+5) score in 3 of 12 cores, all in the left base (20% of each core is positive)
- Bone scan shows no evidence of metastasis

### FOLLOW-UP

### TREATMENT DECISION

- The surgeon reviews all treatment options with the patient and after consultation the patient elects for a radical prostatectomy
- The patient has a non-nerve sparing radical prostatectomy with PLND

### PATHOLOGY

- The pathological stage is pT3b with focal extraprostatic extension and focal invasion of the seminal vesicle
- The nodes are all negative
- The left lateral margin is positive in multiple foci
- At eight week post-op the PSA is detectable at 0.27ng/ml

### QUESTIONS FOR DISCUSSION

- Should this patient be presented at a MCC (multidisciplinary cancer conference)/tumor board again?
- What is the next step in the management of this patient? Should this patient be referred for post-operative radiation?
- How would you follow this patient?

### GUIDELINE INFORMATION

- “Guideline for optimization of surgical and pathological quality performance for radical prostatectomy in prostate cancer management: Surgical and pathological guidelines”
  [http://www.cancercare.on.ca/pdf/pebc17-3f.pdf](http://www.cancercare.on.ca/pdf/pebc17-3f.pdf)
- For key evidence, see pages:
  - Section 1: pages 2-4
  - Section 2: pages 6-7, 11-13, 33-35, Appendix 4 (65-66)
SCENARIO 3: HIGH RISK PROSTATE CANCER PATIENT

FOLLOW-UP

KEY LEARNING POINTS

Multidisciplinary Cancer Conferences:
- Both intermediate and high-risk patients will benefit most from a multimodality approach and should therefore receive discussion at a MCC or referral to radiation oncology.
- MCCs can help inform adjuvant/salvage therapy following failure of primary treatment.

Treatment Options:
- The main treatment options for high-risk patients are surgery +/- or radiation + 2-3 years of hormone therapy.
- These patients may also be candidates from clinical trials.

Pathology Interobserver Variability:
- In specimens with positive margins or extra-prostatic extension, it may be useful to have the findings reviewed by a second pathologist.
- In high-risk patients, a review of the pathology findings (to confirm Gleason score, etc.) is not routinely necessary, but would be warranted if there was variance between the clinical and pathological findings or at the patient’s request.

Significance or Positive Surgical Margins:
- Positive RP margins includes focal positivity at the apex to multiple foci at other locations, as well as concurrent presence or absence of capsular or seminal vesicle invasion.
- Management of a positive margin is dependant on location.
  - In patients with organ-confined disease and a positive margin at the apex, carefully monitoring PSA is considered appropriate management.
  - In patients with extraprostatic extension and margin positivity in the same region, a referral for adjuvant therapy should be made.

Role of Adjuvant Therapy:
- There is variation among clinicians regarding referring patients for adjuvant therapy.
- Post-operative PSA is the major determinant for referral for adjuvant treatment.
- Definitions of PSA failure/biochemical recurrence range from 0.1-0.4ng/ml.
- Currently, there is no data comparing the advantages of adjuvant radiotherapy versus early salvage radiotherapy.