Prostate cancer : and follow up

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Prostate cancer

- Lifetime probability of developing prostate cancer in UK, is 14 %. America Cancer Society 2011

- In 2010, 40,975 New cases of prostate ca
- 10,721 Deaths from prostate ca,

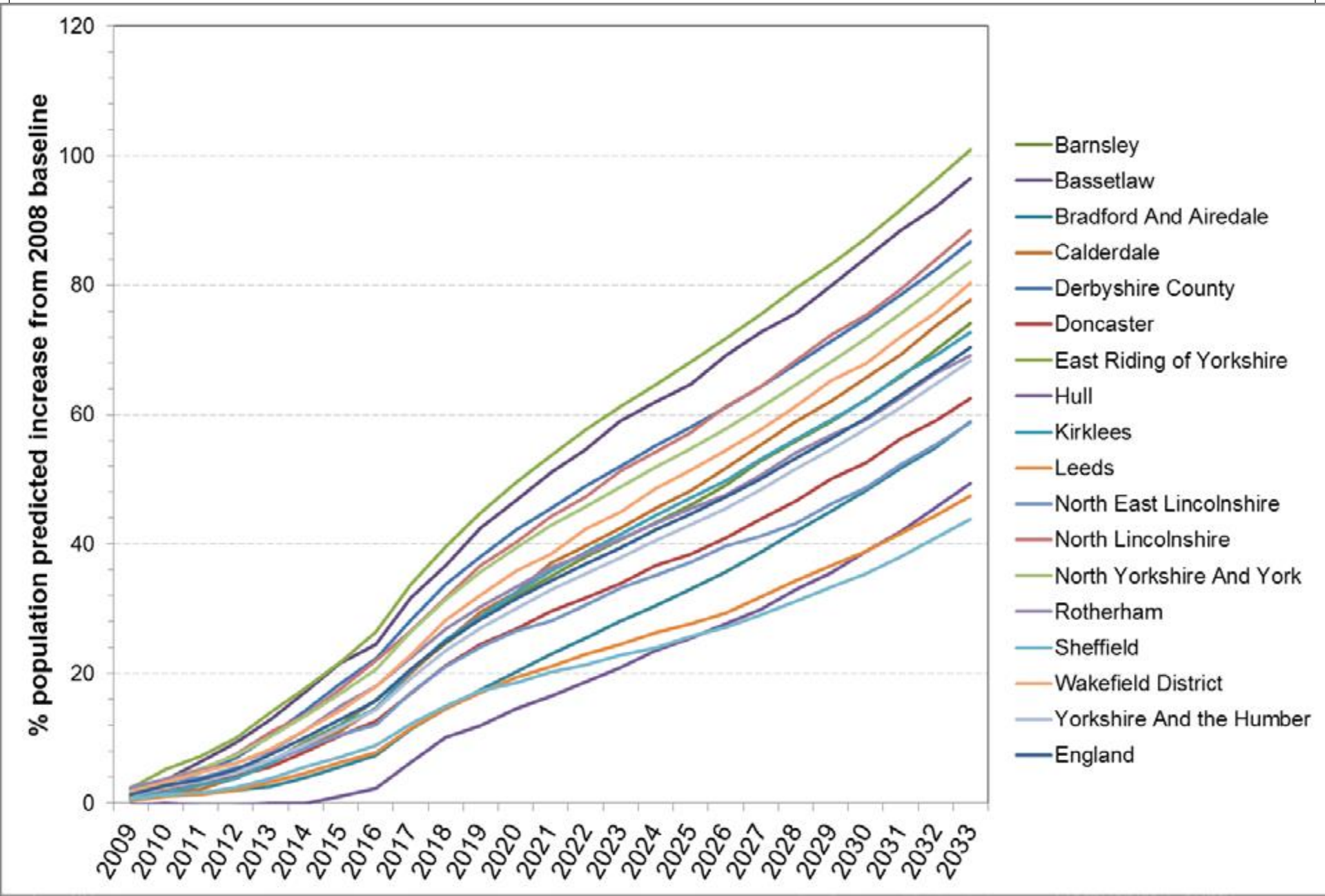
Cancer Research UK, 2011

Prostate cancer

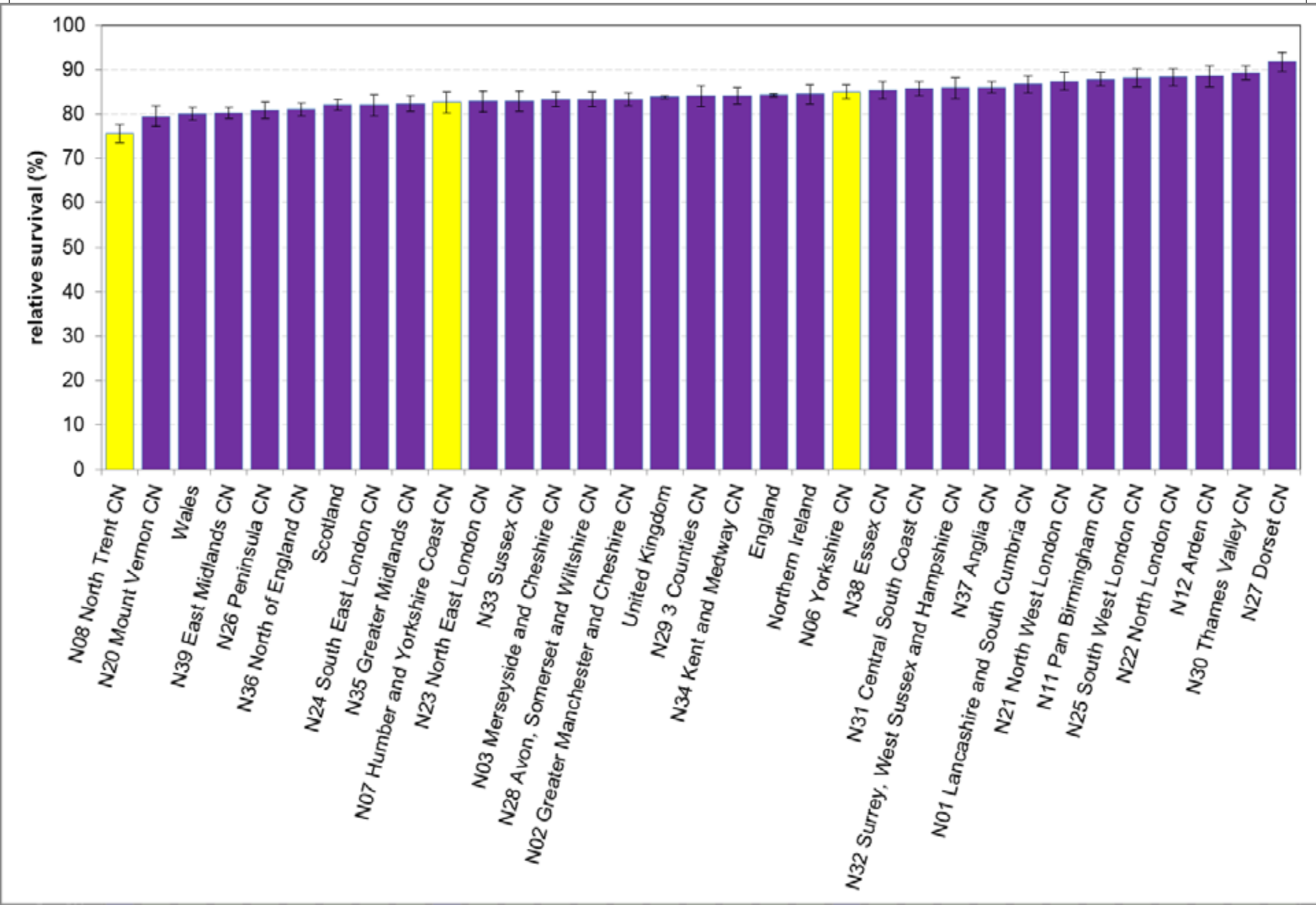
- Incidence of prostate cancer is rising globally, and mortality rates have remained consistent over past decade.

- Resulting in a sharp rise in the number of patients living with prostate cancer, coupled with an ageing population, mean more men surviving. EurUrol. 2012:6:1079-92

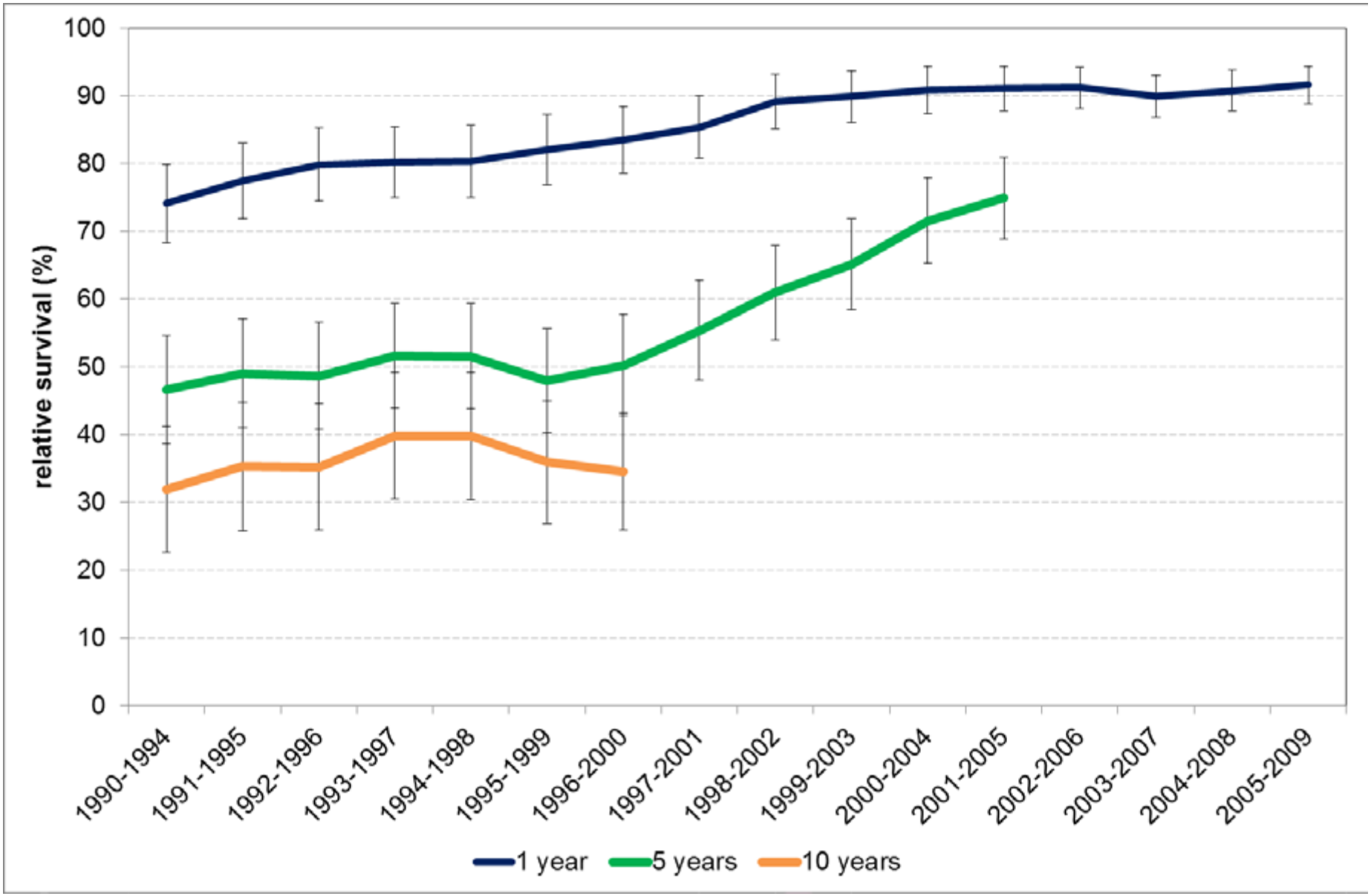
Projected % change in population from 2008 baseline: 70+ age group by PCT



5 yr survival



Barnsley HA


relative survival (%)
100
90
80
70
60
50
40
30
20
10
0
1990-1994
1991-1995
1992-1996
1993-1997
1994-1998
1995-1999
1996-2000
1997-2001
1998-2002
1999-2003
2000-2004
2001-2005
2002-2006
2003-2007
2004-2008
2005-2009
1 year
5 years
10 years

Prostate cancer

- “Patients are now living with advanced prostate cancer for longer, with improved quality of life and better palliation of symptoms. With the advent of so many new treatment options, we are recognising advanced prostate cancer as a chronic disease rather than a fatal one.”

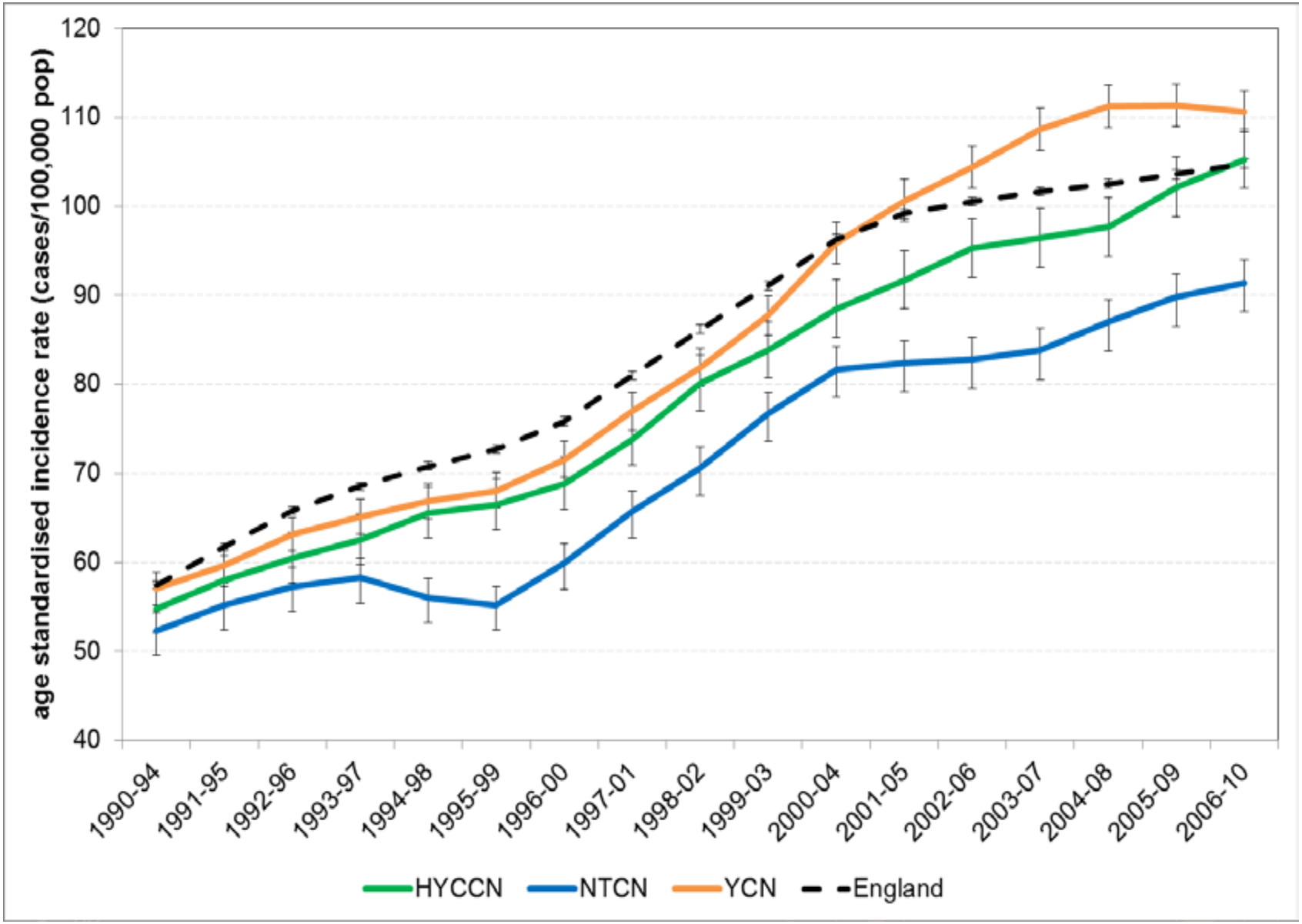
Trends in Urology and Men’s Health. Feb 2014

Cancer survival rates in UK lag behind those in Europe for all cancers.
Survival rates for prostate ca 78-83% UK
Lancet 2012/3 83% Europe

5 yr relative survival		
	1998-2001	2002-2005
England	65.2	74.4
North Trent	54.7	64.9
Barnsley	48.6	65.2
Doncaster	53.9	59.4
Rotherham	46.7	44.7
Sheffield	62.6	73.0
Bassetlaw	55.8	58.0
N.Derbyshire	50.2	67.1

Prostate cancer Incidence 2007-9

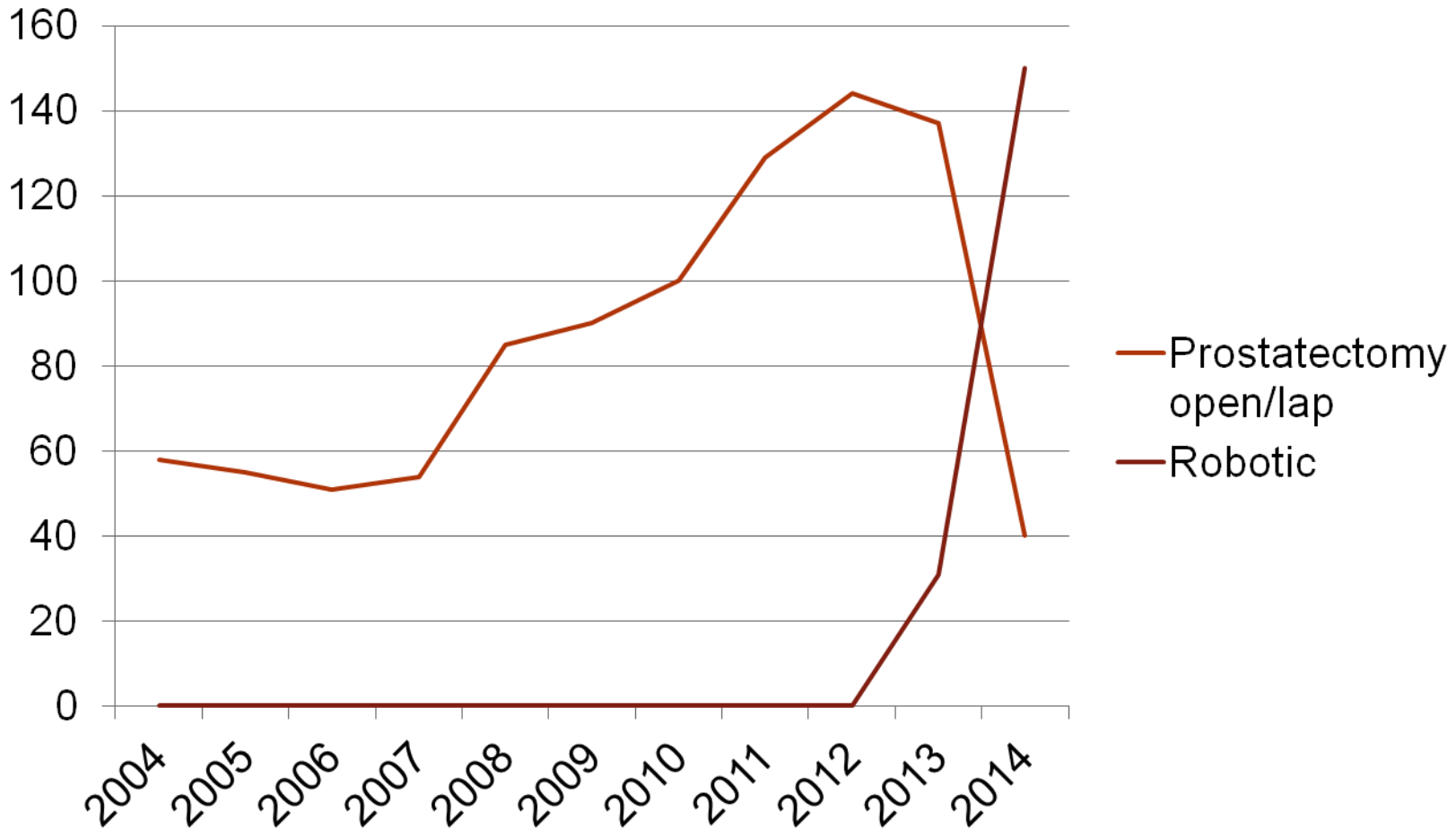
	Incidence per 100,000 men
England	104.1
North Trent	93.8
Barnsley	88.7
Doncaster	101.4
Rotherham	84.8
Sheffield	80.5
Bassetlaw	108.3
N.Derbyshire	107.2
Mid Trent	109.4
Leicester	100.9


age standardised incidence rate (cases/100,000 pop)
120
110
100
90
80
70
60
50
40
1990-94
1991-95
1992-96
1993-97
1994-98
1995-99
1996-00
1997-01
1998-02
1999-03
2000-04
2001-05
2002-06
2003-07
2004-08
2005-09
2006-10
HYCCN
NTCN
YCN
England

Trends in prostate cancer surgery at STH

Year	Prostatectomy . Lap or open	Robotic
2004	58	
2005	55	
2006	51	
2007	54	
2008	85	
2009	90	
2010	100	
2011	129	
2012	144	
2013	137 (73 lap and 64 open)	31
2014	40 ~	150 ~

Trends in prostatic cancer at STH



Nice guidelines for prostate cancer (2008, and 2014)

- "After, at least 2 years, men with a stable PSA and who have had no significant treatment complications should be offered follow up outside the hospital (for example in primary care) by telephone or secure electronic communications, unless they are taking part in a clinical trial that requires more formal clinic based follow up. Direct access to the urological cancer MDT should be offered and explained."

Follow up

Discuss the purpose, duration, frequency and location of follow-up with each man with localised prostate cancere, and if he wishes, his partner or carers. **[2008]**

Clearly advise men with prostate cancer about potential longer-term adverse effects of treatment and when and how to report them. [2008]

Men with prostate cancer who have chosen a watchful waiting regimen with no curative intent should normally be followed up in primary care in accordance with protocols agreed by the local urological cancer MDT and the relevant primary care organisation(s). Their PSA should be measured at least once a year. [2008]

Check PSA levels for all men with prostate cancer who are having radical treatment at the earliest 6 weeks following treatment, at least every 6 months for the first 2 years and then at least once a year thereafter. [2008]

Do not routinely offer DRE to men with localised prostate cancer while the PSA remains at baseline levels. [2008]

After at least 2 years, offer follow-up outside hospital (for example, in primary care) by telephone or secure electronic communications to men with a stable PSA who have had no significant treatment complications, unless they are taking part in a clinical trial that requires formal clinic-based follow-up. Direct access to the urological cancer MDT should be offered and explained. [2008]

North Trent Cancer

- NSSG
- Chesterfield pilot – MJ & N James, L Merriman

- NSSG Guidelines

- Local PCT discussion
- Local CCG implemention

Treated – localised disease.

Men treated with curative intent – "classical survivor"

- Radical surgery. Stable disease at 2 years post treatment, with controlled continence and potency. PSA < 0.1
- Radical radiotherapy. Stable disease at 2 years post treatment, with controlled therapy side effects can be discharged to community care follow up. 6/12 years of ADT treatment typical.
- Brachytherapy. Likely discharge at 3 yrs. Details awaited from Leeds

Locally advanced disease

- Radical surgery. Stable disease at 2 years maybe discharged to community care at discretion of urological surgeon. Higher risk of recurrence.
- Radical radiotherapy. Stable disease at 3 years post treatment (ADT) maybe discharged to community care at the discretion of the oncologist
- Watchful wait. Where a joint decision to start ADT at a later time with symptoms or rising PSA; appropriate for community care for 6/12 PSA and referral back at PSA 40, or symptoms.
- Androgen deprivation therapy. Stable disease with PSA responsive to ADT.

Discharge to Community care

- Clinical summary from the discharging consultant with local contact details.
- Expectation that community care will perform 6/12 review with symptom assessment and PSA estimation. (DRE not required)

- Rising PSA
- Deteriorating symptoms

- Urgent New Patient Referral to local MDT

Active surveillance for localised disease.

- Hospital based follow up until active treatment decided upon.

- 6/12 PSA, DRE
- Repeat TRUS biopsy at 12/12
- MRI scan

- Possible future community shared care follow up as guidelines

Metastatic (advanced) disease

- Watchful wait. Anticipate ADT treatment when PSA >40 or symptoms. Community care follow up appropriate before and after ADT as stable.

- ADT. (bilat orchidectomy/LHRH/anti-androgens). Men who have stable disease, documented fall of PSA to nadir, and minimal side effects are safe to be followed up in community care. 2-3 yr before castrate resistance develops typical.

- Trials. All men kept in secondary care.
- Metastatic disease who do not respond to ADT

Discharge to community care

- Clinical summary from discharging consultant with local contact details
- Expectation that community care will perform 6/12 review with symptom review and PSA assessment. (DRE not required)

- Rising PSA
- Deteriorating symptom

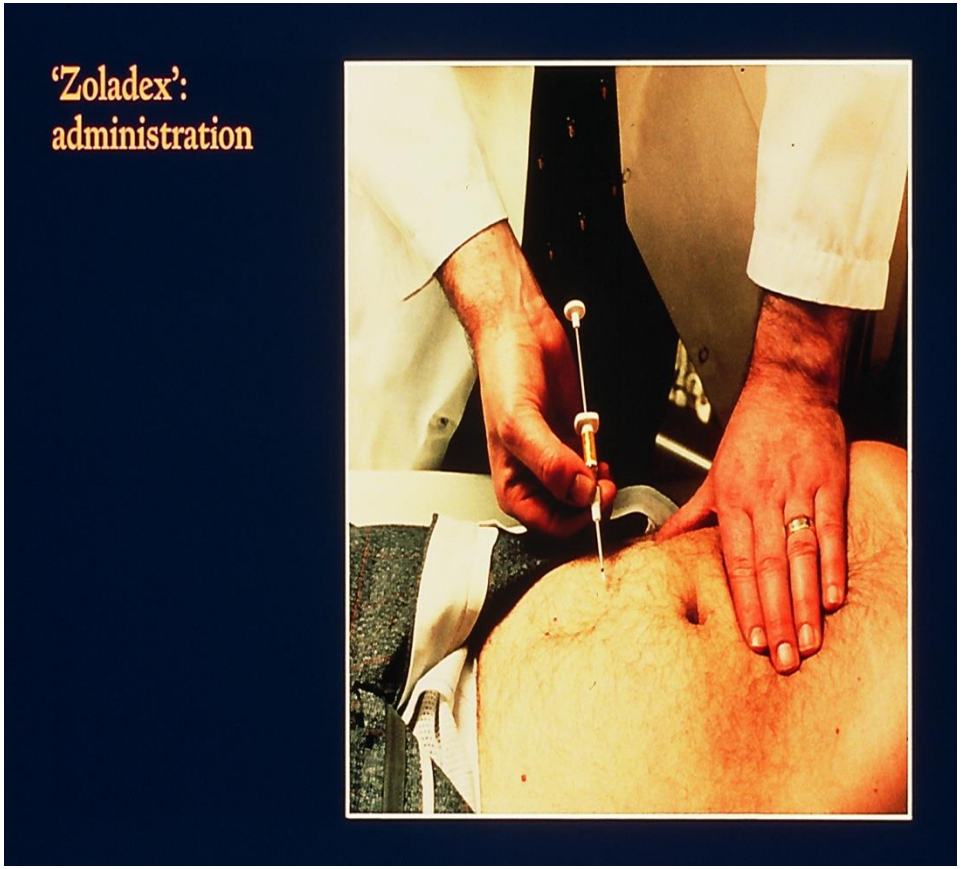
- Urgent New Patient Referral to local MDT

CCG - GP challenge

- 6/12 reviews on a growing number of men
- PSA
- ADT administration

- Do GP practices have adequate recall systems ?
- Patient choice : prefer community ?
- Chesterfield audit – 93% preferred specialist team follow up
- Do GP's want the responsibility of follow up ?
- Additional support – LES payment ?

LHRH analogue subcut injection, 3 monthly injection - ADT



Nurse led service ?

Managing complications of treatment

Urinary symptoms - Offer men experiencing troublesome urinary symptoms before treatment a urological assessment Ensure men with troublesome urinary symptoms after treatment have access to specialist continence services Refer men with intractable stress incontinence to a specialist surgeon for consideration of an artificial urinary sphincter

Sexual dysfunction - Ensure men have early and ongoing access to specialist erectile dysfunction services Offer phosphodiesterase type 5 (PDE5) inhibitors to men who experience loss of erectile function If PDE5 inhibitors fail to restore erectile function or are contraindicated, offer a choice of intraurethral inserts, penile injections, penile prosthesis, vacuum devises

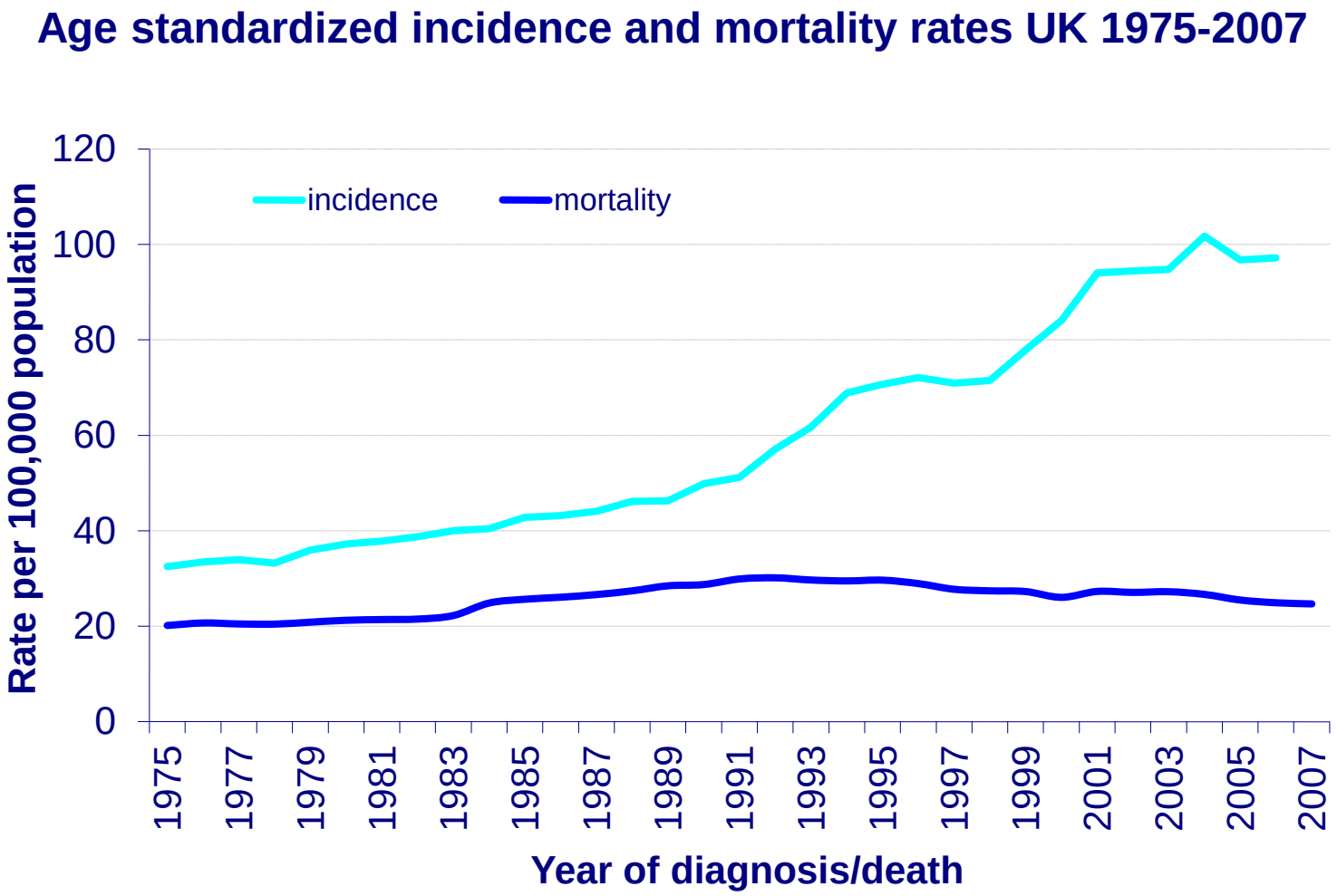
Bowel symptoms - Ensure men with signs or symptoms of radiation induced enteropathy (RIE) are offered care from a team of professionals with expertise in RIE Tell men there is a small increase in the risk of colorectal cancer after radical external beam radiotherapy for prostate cancer Carry out full investigations, including flexible sigmoidoscopy, in men who have symptoms of RIE to exclude inflammatory bowel disease for malignancy of the large bowel and to ascertain the nature of the radiation injury

Endocrine
Hot flushes Offer medroxyprogesterone (20mg a day), initially for 10 weeks. Evaluate the effect at the end of the treatment Consider cyproterone acetate or megestrol acetate (20mg twice a day for four weeks) if medroxyprogesterone is not effective or not tolerated Tell men there is no good quality evidence for the use of complimentary therapies
Gynaecomastia Offer men starting long term bicalutamide monotherapy (>6 months) prophylactic radiotherapy to both breast buds within the first month of treatment. Choose a single fraction of 8 Gy using orthovoltage or electron beam radiotherapy. Consider tamoxifen if radiotherapy is unsuccessful in preventing gynaecomastia
Fatigue Tell men who are starting androgen deprivation therapy that fatigue is a recognised side effect of this treatment Offer men who are having androgen deprivation therapy supervised resistance and aerobic exercise at least twice a week for 12 weeks to reduce fatigue

Osteoporosis
Preventing osteoporosis - For men having androgen deprivation therapy Consider assessing fracture risk in line with Osteoporosis Fragility Fracture Risk (NICE clinical guideline 146) Do not routinely offer bisphophonates to prevent osteoporosis
Managing osteoporosisFor men having androgen deprivation therapy Offer bisphosphonates Consider denosumab if bisphosphonates are contraindicated or not tolerated

Managing complications of treatment
* The nature and treatment of radiation –induced enteropathy should be included in the training programmes for oncologists and gastroenterologists

Incidence has increased over time but mortality has not…



http://info.cancerresearchuk.org/cancerstats/types/prostate/incidence/

Questions ?