

Postoperative radiotherapy after prostatectomy: whom to treat. Finally light at the end of the tunnel?

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The authors have to be commended for this publication; they did what every academic physician should do: maintain a prospectively maintained database and analyze results for quality control thereby enabling them to contribute to the knowledge and care of our patients.

This article addresses our daily challenges in the care of patients post prostatectomy.

The authors of the present article found that the initial PSA response, a rising PSA after postoperative radiotherapy measured at a mean of 4.7 ± 1.5 months after radiotherapy, was predictive of overall survival.¹ To my surprise, the 5-year estimates of overall survival were a dismal 80% in those with a rising PSA following radiotherapy. There are other interesting findings in this paper, for example, that men with an undetectable PSA following salvage radiotherapy were more likely to have had positive surgical margins. This finding and the high mortality rate highlight one of the challenges in the care of patients with aggressive cancer at prostatectomy or biochemical persistence/recurrence: when and how these patients should be treated. Treating each and every patient with high risk cancer results in overtreatment a good number of patients. Discussions must be had and decisions taken whenever possible within a multidisciplinary setting, as suggested in the AUA/ASTRO guidelines.²

This paper clearly shows that some patients are already metastatic at the time of radiotherapy. We recently got a bit closer to identify patients who might

not need postoperative radiotherapy. Den et al³ used a genomic classifier to identify patients who metastasized after postoperative radiotherapy. Patients with high GC scores had a cumulative incidence of metastasis at 5 years of 29%.

In other patients, adjuvant radiotherapy alone is not enough and concomitant androgen deprivation is necessary. The recently published French GETUG-AFU 16 trial randomized patients with a rising PSA of 0.2 to < 2.0 µg/L following radical prostatectomy to radiotherapy alone or a combination with an LHRH agonist as concomitant and adjuvant (3 months) therapy. The combined treatment arm showed a significant benefit in terms of biochemical progression or clinical progression at 5 years.⁴

All in all, this paper shows the need to identify as early as possible which patients need which adjuvant or salvage treatment. With recent advances in biomarker development⁵ we got closer in being able to be more selective in our choosing the right treatment for our patients. □

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