



MODERATO IPOFRAZIONAMENTO NEL TRATTAMENTO RADIOTERAPICO POST- PROSTATECTOMIA: RISULTATI PRELIMINARI MONO-ISTITUZIONALI DI FATTIBILITÀ E TOSSICITÀ ACUTA

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Background



POST PROSTATECTOMY SETTING: ADJUVANT RT OR SALVAGE??

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ASCO SPECIAL ARTICLE

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Adjuvant and Salvage Radiotherapy After Prostatectomy: American Society of Clinical Oncology Clinical Practice Guideline Endorsement

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ABSTRACT

Purpose

To endorse the American Urological Association (AUA)/American Society for Radiation Oncology (ASTRO) guideline on adjuvant and salvage radiotherapy after prostatectomy. The American Society of Clinical Oncology (ASCO) has a policy and set of procedures for endorsing clinical practice guidelines developed by other professional organizations.

Methods

The guideline on adjuvant and salvage radiotherapy after prostatectomy was reviewed for developmental rigor by methodologists. An ASCO endorsement panel then reviewed the content and recommendations.

Results

The panel determined that the guideline recommendations on adjuvant and salvage radiotherapy after prostatectomy, published in August 2013, are clear, thorough, and based on the most relevant scientific evidence. ASCO endorsed the guideline on adjuvant and salvage radiotherapy after prostatectomy, adding one qualifying statement that not all candidates for adjuvant or salvage radiotherapy have the same risk of recurrence or disease progression, and thus, risk-benefit ratios are not the same for all men. Those at the highest risk for recurrence after radical prostatectomy include men with seminal vesicle invasion, Gleason score 8 to 10, extensive positive margins, and detectable postoperative prostate-specific antigen (PSA).

Recommendations

Physicians should discuss adjuvant radiotherapy with patients with adverse pathologic findings at prostatectomy (ie, seminal vesicle invasion, positive surgical margins, extraprostatic extension) and salvage radiotherapy with patients with PSA or local recurrence after prostatectomy. The discussion of radiotherapy should include possible short- and long-term adverse effects and potential benefits. The decision to administer radiotherapy should be made by the patient and multidisciplinary treatment team, keeping in mind that not all men are at equal risk of recurrence or clinically meaningful disease progression. Thus, the risk-benefit ratio will differ for each patient.

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Comments:

Endorsement of AUA/ASTRO GUIDELINES

-adding one qualifying statement:
not all candidates for adjuvant or salvage RT have the same risk of recurrence or disease progression, and thus, risk-benefit ratios are not the same for all men.

-highest risk for recurrence after radical prostatectomy include men with seminal vesicle invasion, Gleason score 8 to 10, extensive positive margins, and detectable postoperative PSA.

-The decision to administer radiotherapy should be made by the patient and multidisciplinary treatment team, keeping in mind that not all men are at equal risk of recurrence or clinically meaningful disease progression.

**PERSONALIZED
APPROACH BASED ON
RISK FACTORS**



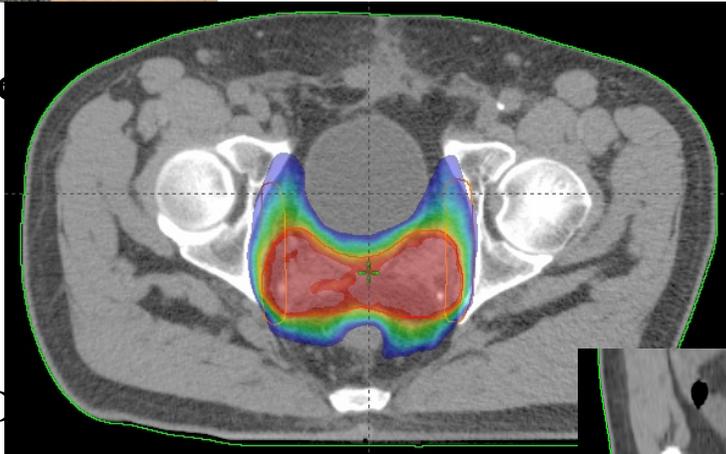
Background



- ✓ low α/β for prostate cancer
- ✓ ample evidence exists in support of dose escalation to ≥ 78 Gy and hypofractionation for **radical RT**
- ✓ the strongest direct evidence in support of **more aggressive local treatment** is the findings from both randomized adjuvant trials that **local failure** rates were **significantly greater than the metastatic failure rates** (local failure was four times greater than the metastatic failure in the EORTC trial and 30% greater in the SWOG trial)
- ✓ An analysis of the patterns of failure from SWOG trial demonstrated that treatment failure is predominantly local, and, therefore, an **improvement in local therapy will result in improved outcomes**

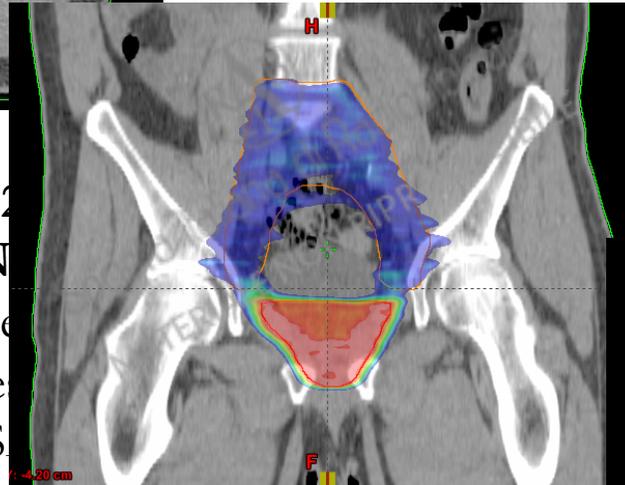
Study Design

To evaluate the efficacy of moderate hypo-fractionated regimen with volumetric modulated arcs (IGRT-VMAT)



Design and methods

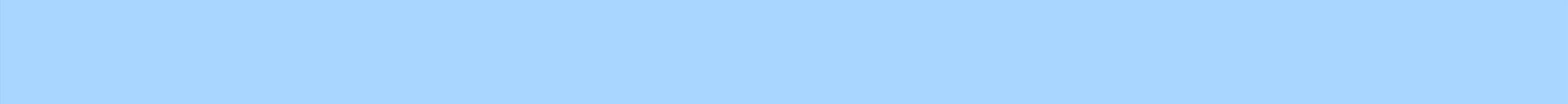
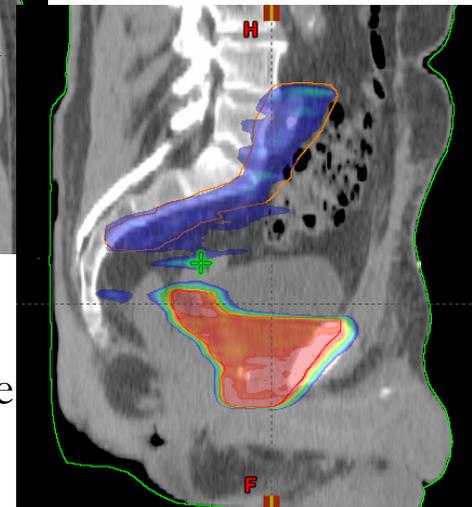
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(T- 61 Salvage RT)

Eligible patients: ECOG 0-2
 pT2-4 pN1
 at least one positive
 seminal vesicle
 and/or PSA

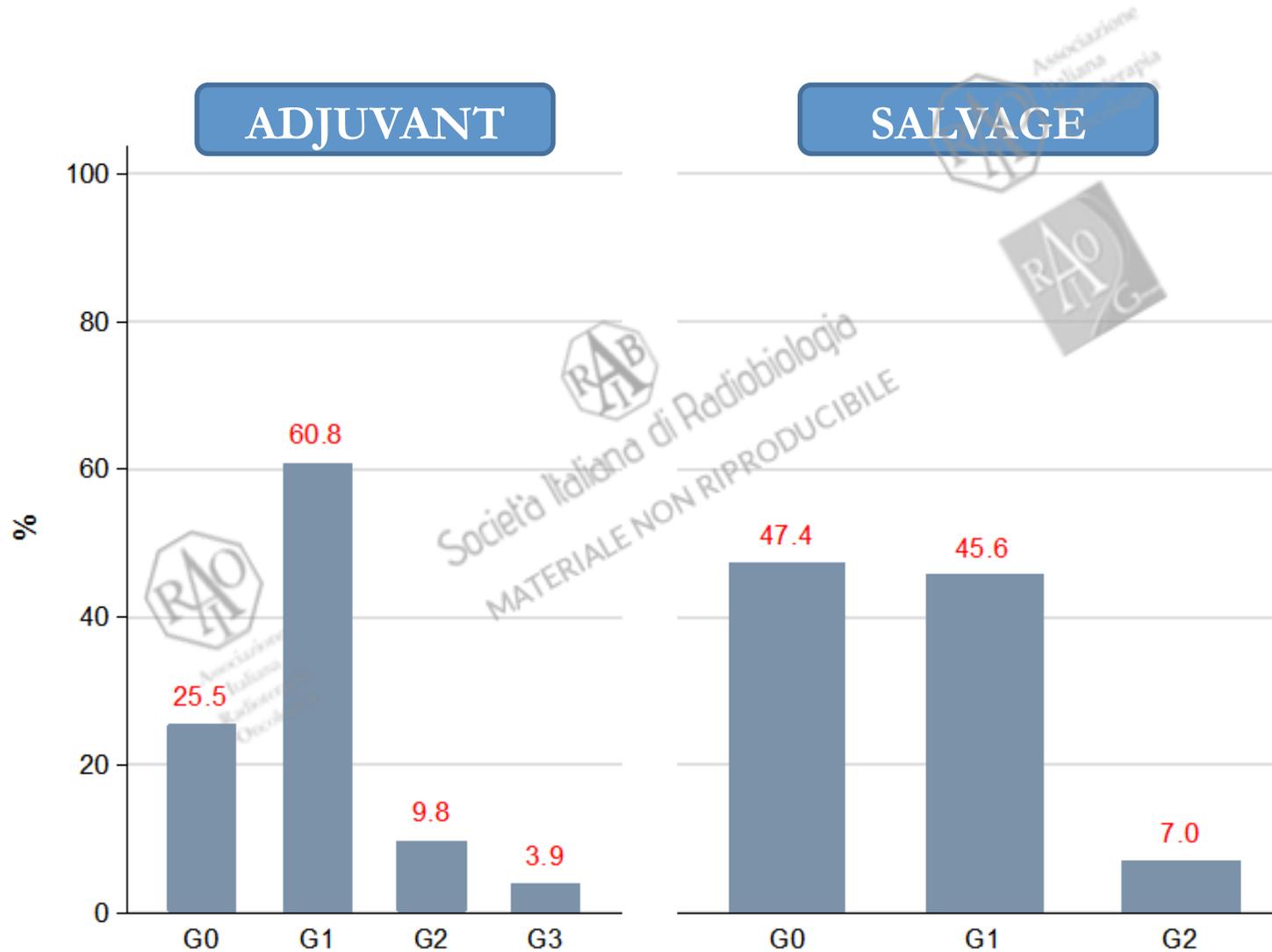
RT doses: 65.5-71.4 Gy to prostatic bed
 52.5 Gy (range 50.4-54) to the pelvic lymph node
 in 28-30 fractions





Results: Acute Genitourinary Toxicity (CTCAE v4.0)

Median Follow-up: 15 months (range 6-53)



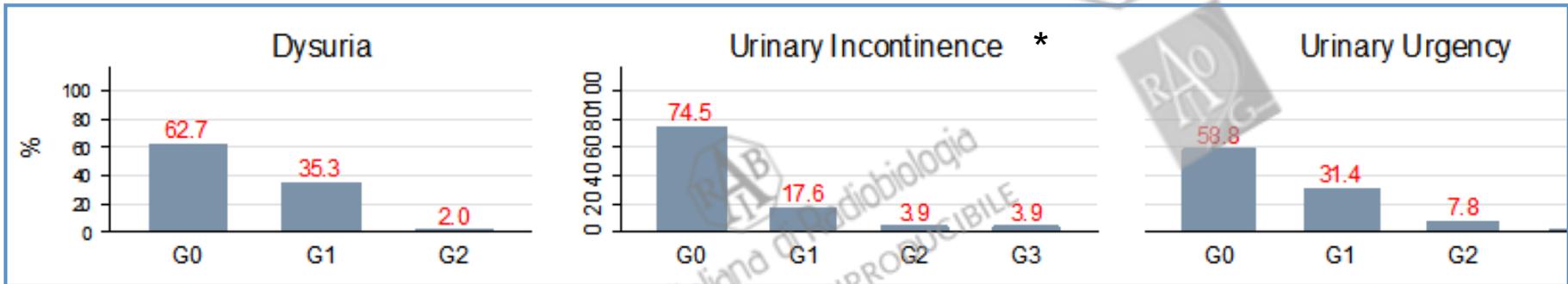


Results: Acute Genitourinary Toxicity (CTCAE v4.0)

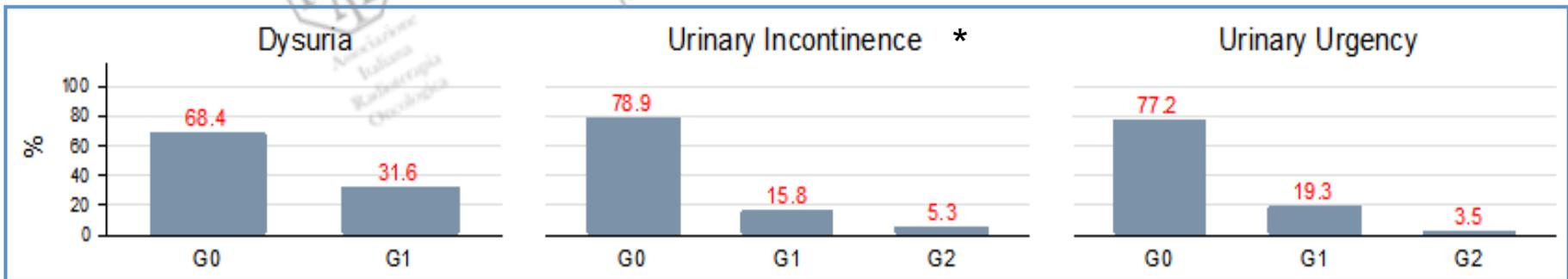


Median Follow-up: 15 months (range 6-53)

ADJUVANT



SALVAGE

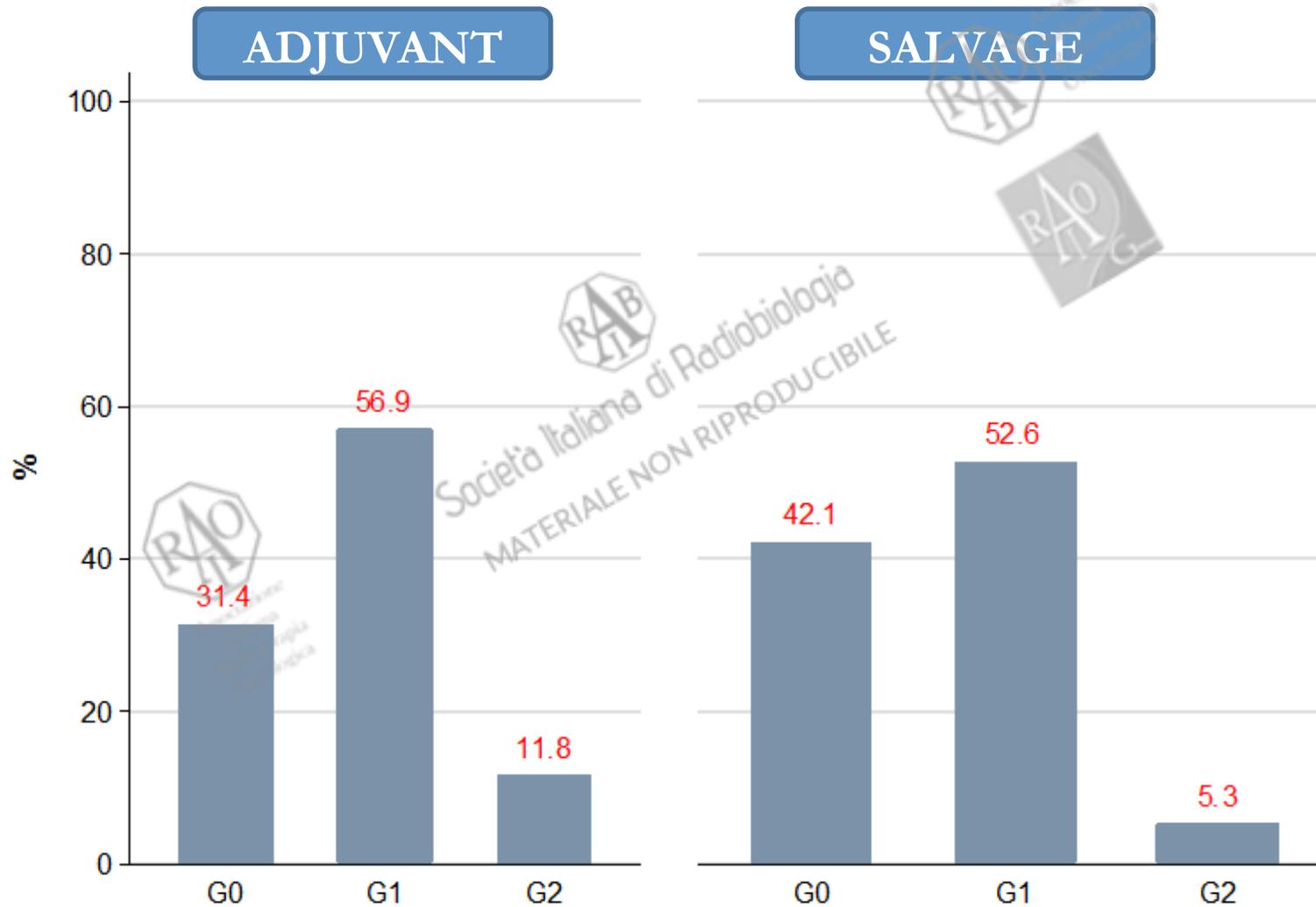


* 52% patients with UI before RT



Results: Acute Gastrointestinal Toxicity (CTCAE v4.0)

Median Follow-up: 15 months (range 6-53)



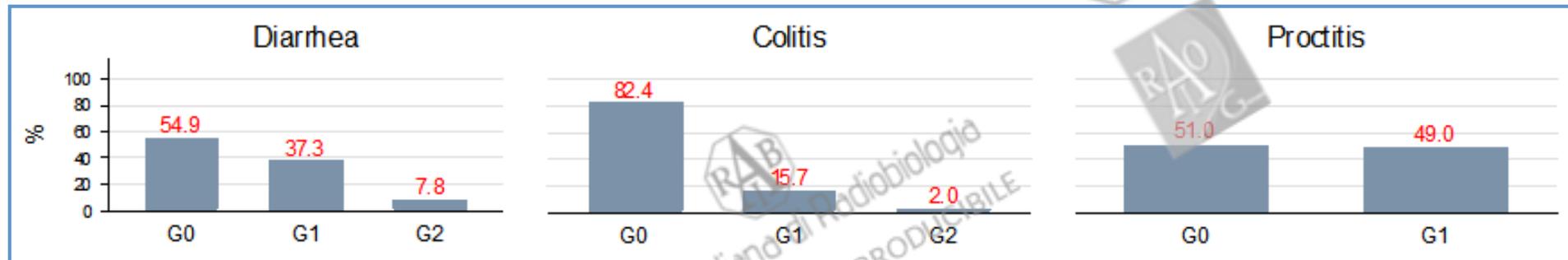


Results: Acute Gastrointestinal Toxicity (CTCAE v4.0)

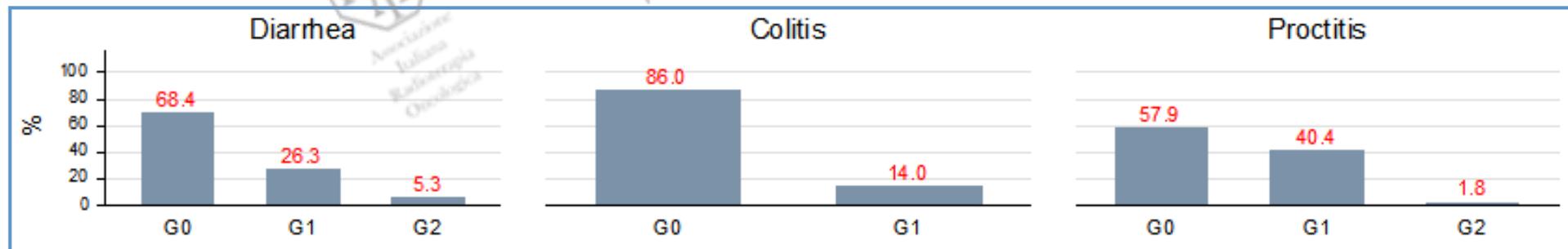


Median Follow-up: 15 months (range 6-53)

ADJUVANT



SALVAGE





Results



Median Follow-up: 15 months (range 6-53)

- Analyzing data according to RT intent, a higher rate of GU toxicity ≥ 2 was found in the adjuvant setting (13.7%) respect to salvage group (7%).
- no difference was found between the type of surgery (Robotic, Laparoscopic or Open) and incidence of urinary incontinence.
- at time of analysis no late GU or GI toxicity ≥ 3 were registered.



Conclusions



- ✓ moderate hypo-fractionated postoperative RT with VMAT was feasible and safe with acceptable acute GU and GI toxicities
- ✓ Longer follow-up is needed to assess late toxicity and clinical outcome



Società Italiana di Radiobiologia
MATERIALE NON RIPRODUCIBILE



THANKS FOR ATTENTION!