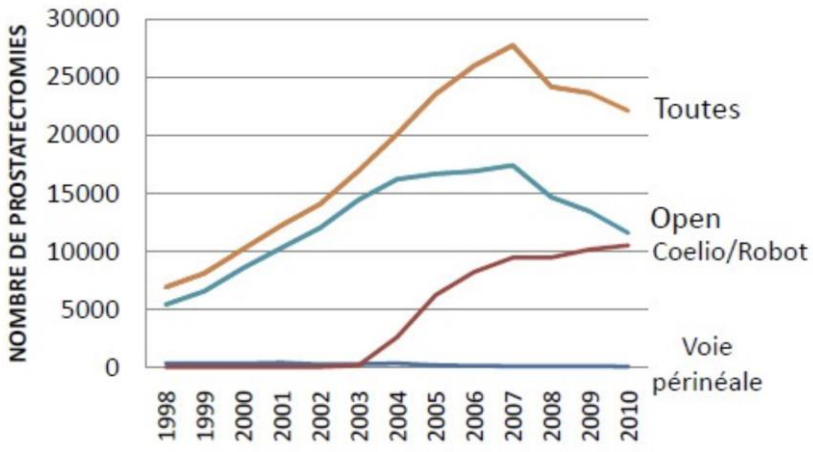
SESSION CHIRURGIE ONCOLOGIE DE LA PROSTATE :

Actualités en chirurgie

Victor Lescure 19/02/20
CHU limoges - CH Gueret

1

La prostatectomie en France



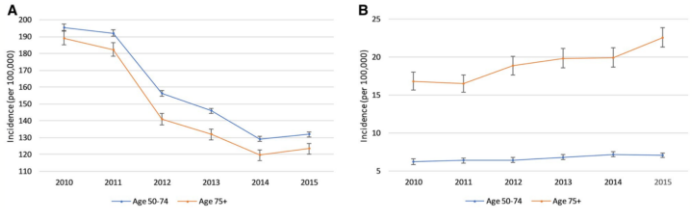
2

Prostate Cancer Incidence Across Stage, NCCN Risk Groups, and Age Before and After USPSTF Grade D Recommendations Against Prostate-Specific Antigen Screening in 2012

Butler SS[1], Muralidhar V[1], Zhao SG[2], Sanford NN[3], Franco I[1], Fullerton ZH[1], Chavez J[1], D'Amico AV[1], Feng FY[4], Rebbeck TR[1,5], Nguyen PL[1], Mahal BA[1].

Cancer. 2020 Feb 15;126(4):717-724. doi: 10.1002/cncr.32604. Epub 2019 Dec 3.

- Diminution de l'indidence des PCa localisés: 195,4 à 131,9/100000 et 189,0 à 123,4 (p<0,01) pour des patient de 50-75 ans et >75 ans
- Augmentation de l'incidence des mPCa : 16,8 à 22,8 (p<0,001)
- Diminution de l'incidence des bas risques et risques intermédiaires: 60.6 à 31.4 /100000 et 104,2 à 84,3 (p<0,01)



3

Contemporary national trends in prostate cancer risk profile at diagnosis

MARS 2019

Sean A. Fletcher[1,2] · Nicolas von Landenberg[2,3] · Alexander P. Cole[1,2] · Philipp Gild[2,4] · Toni K. Choueiri[5] · Stuart R. Lipsitz[2] · Quoc-Dien Trinh[1,2] · Adam S. Kibel[1]

Results In our cohort of 755,567 men diagnosed between 2004 and 2014, there was a decrease in the proportion of men diagnosed with low-risk PCa (38.32 to 27.23%, $p < 0.001$) and a consequent increase in the proportion of localized intermediate-risk (40.49 to 46.72%, $p < 0.001$) and high-risk diagnoses (21.19 to 26.05%, $p < 0.001$). This was primarily driven by an increased proportion of Gleason 7 and Gleason 8–10 cancer, respectively. The number of men presenting with metastatic disease consistently increased from 3251 (2.88%) in 2004 to 6886 (7.19%) in 2014 ($p < 0.001$).

Conclusions The proportion of localized intermediate/high risk and metastatic PCa has substantially increased over the past decade, while the proportion of low-risk disease has decreased. This shift has been primarily driven by increased diagnosis of high-grade disease. National guidelines advising against PSA screening may have contributed to these findings.

4

Prostate-Specific Antigen–Based Screening for Prostate Cancer: A Systematic Evidence Review for the U.S. Preventive Services Task Force

MARS 2019

Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services

Conclusions: PSA screening for prostate cancer may reduce risk of prostate cancer mortality but is associated with harms including false-positive results, biopsy complications, and overdiagnosis in 20 percent to 50 percent of screen-detected prostate cancers. Early, active treatment for screen-detected prostate cancer may reduce the risk of metastatic disease, although the long-term impact of early, active treatment on prostate cancer mortality remains unclear. Active treatments for prostate cancer are frequently associated with sexual and urinary difficulties.

5

EUO Priority Article – Prostate Cancer
Editorial by XXX on pp. x–y of this issue

Increase in the Annual Rate of Newly Diagnosed Metastatic Prostate Cancer: A Contemporary Analysis of the Surveillance, Epidemiology and End Results Database

Marco Bandini [a,b,c,], Elio Mazzone [a,b,c], Felix Preisser [a,b,d], Sebastiano Nazzani [a,b,e], Emanuele Zaffuto [a,b,c], Michele Marchioni [a,b,f], Zhe Tian [a,b], Raisa S. Pompe [d], Derya Tilki [d], Markus Graefen [d], Shahrokh F. Shariat [g], Francesco Montorsi [c], Fred Saad [a,b], Alberto Briganti [c], Pierre Karakiewicz [a,b]*

Results and limitations: Between 2004 and 2014, the age-adjusted incidence of newly diagnosed mPCa increased from 1.9 to 2.4 cases per 100 000 population (odds ratio [OR] 1.30, 95% confidence interval [CI] 1.18–1.44; $p < 0.0001$). Rates of cT1 (from 23% to 37%; OR 1.85; $p < 0.0001$), GS 8–10 (from 67% to 85%; OR 2.62; $p < 0.0001$), and M1a disease (from 4.5% to 6.0%; OR 2.16; $p = 0.006$) increased. Conversely, patient age at initial mPCa diagnosis decreased from 71 to 68 yr (coefficient −0.14; $p < 0.001$). The PSA level at diagnosis remained stable over time. A limitation is the lack of detail on the distribution of m[illegible]se.
Conclusions: The rate of newly diagnosed mPCa increase[illegible]y 25% over the p[illegible] decade and the age at initial presentation decreased. These [illegible]be indicative of diagnostic delays related to less frequent PSA screening.

6

EUO Priority Article – Prostate Cancer
Editorial by XXX on pp. x–y of this issue

Increase in the Annual Rate of Newly Diagnosed Metastatic Prostate Cancer: A Contemporary Analysis of the Surveillance, Epidemiology and End Results Database

Marco Bandini[a,b,c,], Elio Mazzone[a,b,c], Felix Preisser[a,b,d], Sebastiano Nazzani[a,b,e], Emanuele Zaffuto[a,b,c], Michele Marchioni[a,b,f], Zhe Tian[a,b], Raisa S. Pompe[d], Derya Tilki[d], Markus Graefen[d], Shahrokh F. Shariat[g], Francesco Montorsi[c], Fred Saad[a,b], Alberto Briganti[c], Pierre Karakiewicz[a,b]*

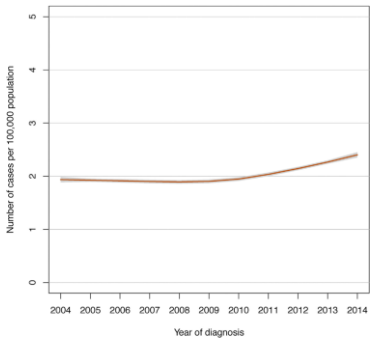


Fig. 1 – Age-adjusted temporal trends during 2004–2014 for newly diagnosed metastatic prostate cancer per 100 000 population.

7

AFU	LEO	G
La détection précoce ne s'adresse qu'aux patients ayant un bon état fonctionnel et une probabilité de **survie prolongée (10-15 ans**)	3	B
Il est donc non recommandé de réaliser un dosage du PSA **sans avoir préalablement informé le patient**	3	B
La détection précoce du CaP repose sur l'identi cation des **facteurs de risque**, le **toucher rectal**, et le **dosage du PSA**.	-	-
La **période de diagnostic précoce** s'étend de **50 ans - 75 ans**	3	B
Un **rythme de 2 ans** est probablement indiqué lorsque la valeur du PSA est **supérieure à 1 ng/ml à 40 ans ou supérieur à 2 ng/ml à 60 ans**	3	B

8

European Association of Urology		
Do not subject men to prostate-specific antigen (PSA) testing **without counselling them on the potential risks and benefits**	3	Strong
Offer an **individualised risk-adapted strategy** for early detection and a **life-expectancy of at least ten to fifteen years**	3	Strong
early PSA testing in well-informed men at **elevated risk of having PCa**: **> 50 years** **> 45 years and a family history** **African-Americans > 45 years**	2b	strong
risk-adapted strategy with **follow-up intervals of two years** for those initially at risk: **PSA level of > 1 ng/mL at 40 years** **PSA level of > 2 ng/mL at 60 years** **Postpone follow-up to eight years** in those not at risk	3	weak
Stop early diagnosis of PCa based on life expectancy and PS; men who have a life-expectancy of < 15 years are unlikely to benefit.	3	strong

9

Early Detection of Prostate Cancer: AUA Guideline

H. Ballentine Carter, Peter C. Albertsen, Michael J. Barry, Ruth Etzioni, Stephen J. Freedland, Kirsten Lynn Greene, Lars Holmberg, Philip Kantoff, Badrinath R. Konety, Mohammad Hassan Murad, David F. Penson and Anthony L. Zietman

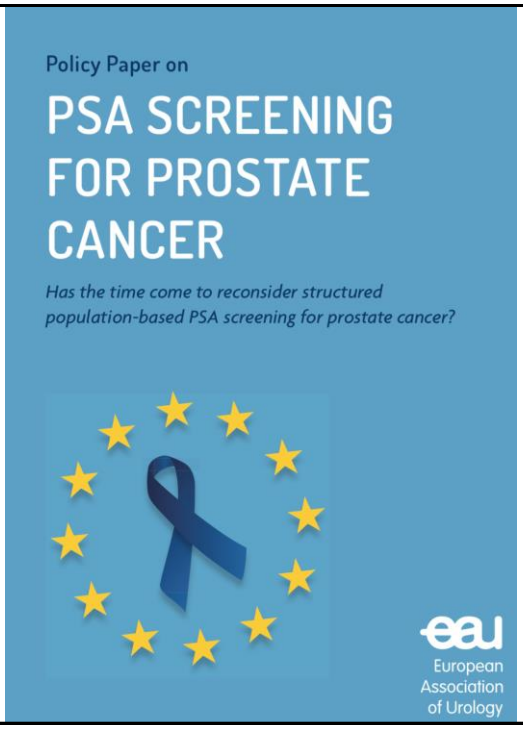
From the American Urological Association Education and Research, Inc., Linthicum, Maryland

2013

American Urological Association

Against PSA screening in men under age **40 years**		C
Not recommend routine screening in men between ages **40 to 54 years at average risk**		C
Panel strongly recommends **shared decision-making for men age 55 to 69** years that are considering PSA screening and proceeding based on a man's values and preferences		B
routine screening interval of two years or more may be preferred over annual screening in those men who have participated in shared decision-making and decided on screening		C
The Panel does **not recommend** routine PSA screening in men age 70 years or more, or any man with less than a **10 to 15 year life expectancy**		C

10



11

3. Is PSA-based screening reducing mortality? New evidence proves it is.

12

- **Recent evidence demonstrates the efficacy of prostate cancer screening**

The European Randomised Study of Screening for Prostate Cancer (ERSPC) demonstrates that PSA screening **reduces disease-specific mortality by 21%, which is equivalent to one death prevented per 781 men invited for screening or one per 27 prostate cancer detected**. The evidence shows that after 20 yrs of follow-up the number of patients needed to screen and diagnose prostate cancer decreased to 101 and 13, respectively, to prevent one prostate cancer death [8, 10]. As such, PSA screening results in mortality reduction are obviously better than in breast or colon cancer screening.

13

TAKE HOME MESSAGE

- Le PSA semble avoir un **intérêt** dans le dépistage

MAIS

- **Hétérogénéité** des pratiques
- **Continuer à suivre les guidelines sur une UTILISATION**

PERSONNALISÉE = INFORMATIONS++

14

Combien de biospies ciblées faut-il faire par lésion ?

Journal of Clinical Medicine

MDPI

Article

Assessment of the Minimal Targeted Biopsy Core Number per MRI Lesion for Improving Prostate Cancer Grading Prediction

Guillaume Ploussard [1,2,*], Jean-Baptiste Beauval [1], Raphaële Renard-Penna [3], Marine Lesourd [2,4], Cécile Manceau [4], Christophe Almeras [1], Jean-Romain Gautier [1], Guillaume Loison [1], Daniel Portalez [5], Ambroise Salin [1], Michel Soulié [4], Christophe Tollon [1], Bernard Malavaud [2,4] and Mathieu Roumiguié [2,4]

Janvier 2020

- Au moins 4 biopsies ciblées pour PIRADS 3
- 3 biopsies ciblées PIRADS 4–5 cases to improve GG prediction and limit upgrading risk

15

Résultats de la SA à long terme

Long-Term outcomes of active surveillance for prostate cancer – the memorial sloan kettering cancer center experience

Sigrid Carlsson, Nicole Benfante, Ricardo Alvim, Daniel D. Sjoberg, Andrew Vickers, Victor E. Reuter, Samson W. Fine, Hebert Alberto Vargas, Michal Wiseman, Maha Mamoor, Behfar Ehdaie, Vincent Laudone, Peter Scardino, James Eastham, Karim Touijer

2664 patient de Groupe 1
Biopsies tous les 2-3 ans ou si élévation PSA
the treatment-free probability at 5, 10, and 15 years was 76% (95% CI 74%–78%), 64% (95% CI 61%–68%), and 58% (95% CI 51%–64%)
. The median follow-up for those without metastasis was 4.3 years (95% CI 2.3–6.9). Five men developed distant metastasis. Upon case note review, only two of these men were deemed to have disease that could have been cured on immediate treatment. The risk of distant metastasis was 0.6% (95% CI 0.2%–2.0%) at 10 years.

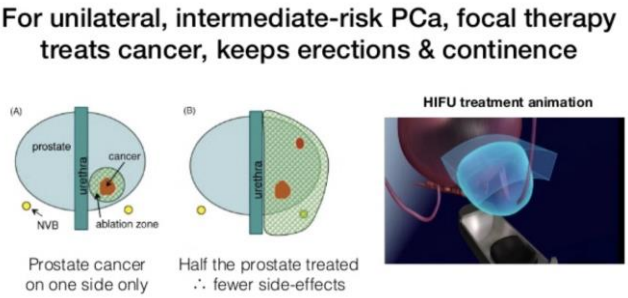
16

J Urol. 2020 Feb;203(2):320-330. doi: 10.1097/JU.0000000000000506. Epub 2019 Aug 22.

Focal Therapy for Localized Prostate Cancer with Either High Intensity Focused Ultrasound or Cryoablation: A Single Institution Experience.

Tourinho-Barbosa RR[1,2], Sanchez-Salas R[1], Claros OR[1], Collura-Merlier S[1], Bakavicius A[1], Carneiro A[1], Stabile A[1], Moschini M[1], Cathala N[1], Tobias-Machado M[1,2], Cathelineau X[1].

- Mono-centrique
- Risque faible ou intermédiaire
- 309 patients
- Suivi médian 45 mois
- 0 décès
- Taux de survie sans métastase et 98% à 5 ans
- Taux de survie sans échec du ttt 54% à 5 ans



ISUP>2 et un PSA nadir associés à un risque d'échec du ttt focal

17

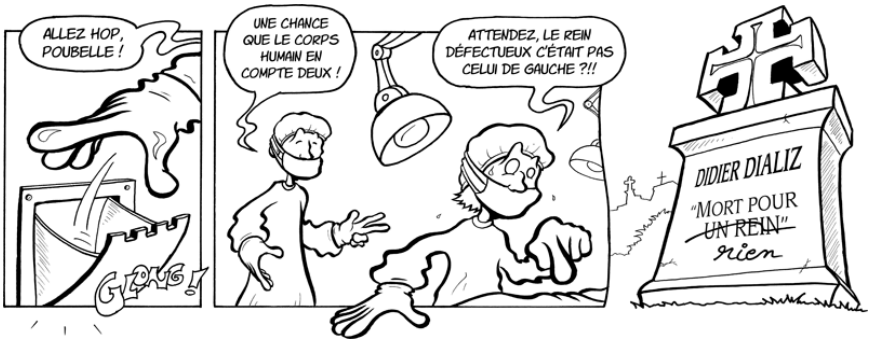
BMJ Open. 2020 Feb 10;10(2):e036609. doi: 10.1136/bmjopen-2019-036609.

Robotic versus open urological oncological surgery: study protocol of a systematic review and meta-analysis.

Cacciamani GE[1], Gill K[2], Gill IS[2].

18

Et la technique …



19

Retzius-sparing robot-assisted radical prostatectomy vs the standard approach: a systematic review and analysis of comparative outcomes.

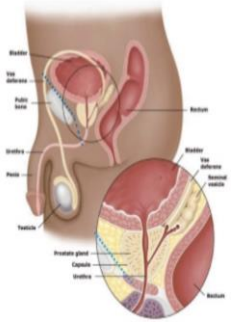
Checcucci E[1], Veccia A[2,3,4], Fiori C[1], Amparore D[1], Manfredi M[1], Di Dio M[1], Morra I[1], Galfano A[5], Autorino R[4], Bocciardi AM[5], Dasgupta P[6], Porpiglia F[1].

Robotic prostatectomy traditionally releases bladder from abdominal wall

Weakens continence support

Hernias more common

Easy to remove fat from front of prostate



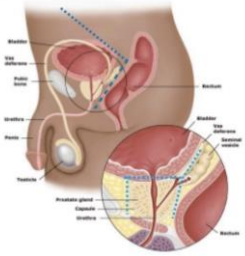
New 'Retzius-sparing' approach to prostatectomy gives fastest continence recovery

Posterior approach preserves bladder & urethral attachments important for continence

Fewer hernias compared with anterior approach

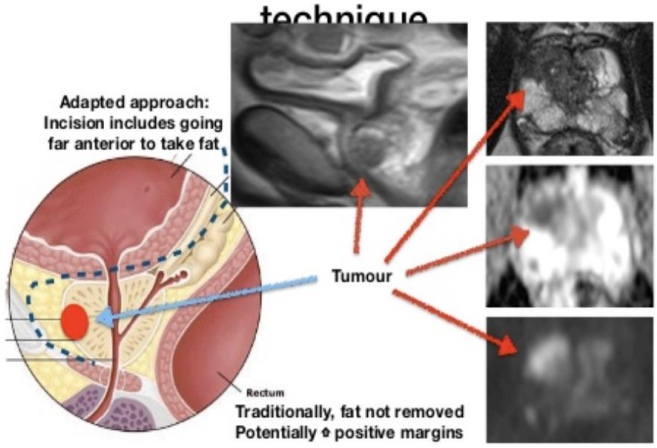
Impossible by open surgery

Demonstrated at RCT
Dalela 2017 Eur Urol



20

Anterior tumours indicate either traditional anterior approach or modification of Retzius-sparing technique



21

22

Place des HT de Seconde génération en Néoadjuvant ?

- Étude de **phase III randomisée vs. Placebo**
- CaP Haut risque non métastatique **isup 4**
- Neo adj apalutamide + HT 6 mois
- Chirurgie
- 6 mois adj apalutamide

PROTEUS

- **Critère de jugement principal:**
  - **Amélioration de survie sans métastase**
  - **Taux de réponses complète**

23

Place de la Prostatectomie dans la pec du M+

Prostate Int. 2019 Dec;7(4):125-130. doi: 10.1016/j.pnil.2019.10.001. Epub 2019 Dec 3.

Role of surgery in oligometastatic prostate cancer.

Jenjitranant P[1,2], Touijer KA[2].

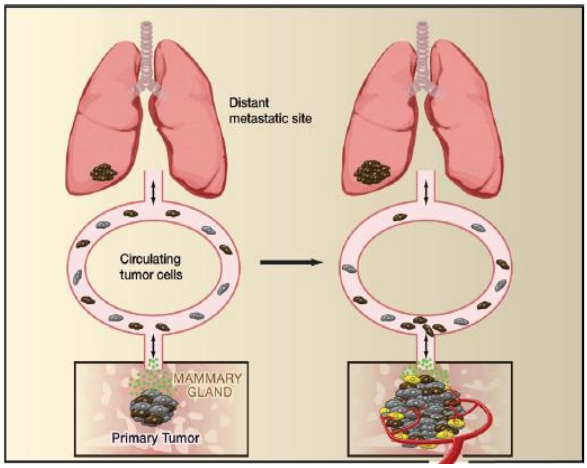
BMC Cancer. 2020; 20: 97. PMCID: PMC7001324
Published online 2020 Feb 4. doi: 10.1186/s12885-020-6565-5 PMID: 32019501

Development and validation of a preoperative nomogram for predicting survival of patients with locally advanced prostate cancer after radical prostatectomy

Xianghong Zhou,[#1,2] Qingyang Ning,[#1,3] Kun Jin,[2] Tao Zhang,[3] and Xuelei Ma[#1]

24

Tumor Self-Seeding: Bidirectional Flow of Tumor Cells



Circulating tumor cells are responsible for seeding metastatic growth at distant sites. Kim et al. (2009) now discover that circulating tumor cells can reinfiltrate tumors at their primary organs and promote tumor progression.

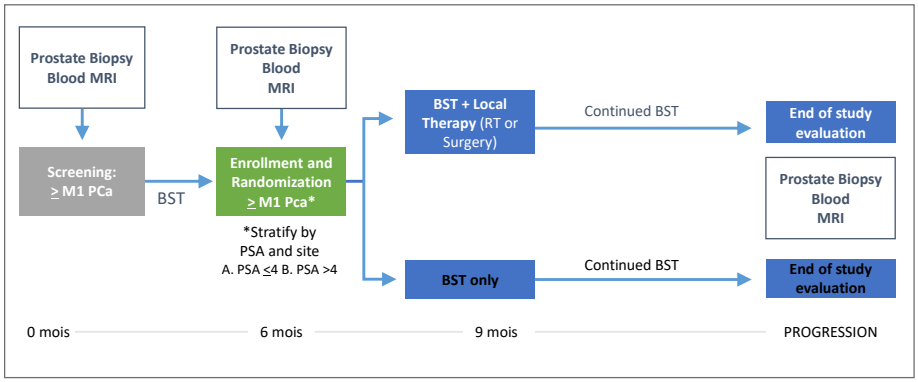
25

6.4.9 Guidelines for the first-line treatment of metastatic disease

Recommendations	Strength rating
Offer surgery and/or local radiotherapy to any patient with M1 disease and evidence of impending complications such as spinal cord compression or pathological fracture.	Strong
Offer castration combined with prostate radiotherapy to patients whose first presentation is M1 disease and who have low volume of disease by CHAARTED criteria.	Weak
Offer castration alone, with or without an anti-androgen, to patients unfit for, or unwilling to consider, castration combined with docetaxel or abiraterone acetate plus prednisone or prostate radiotherapy.	Strong

26

Multicenter, Randomized, Phase II Trial of Best Systemic Therapy (BST) or BST Plus Definitive Treatment of the Primary Tumor in Metastatic Prostate Cancer



Clinical Trial: NCT01751438

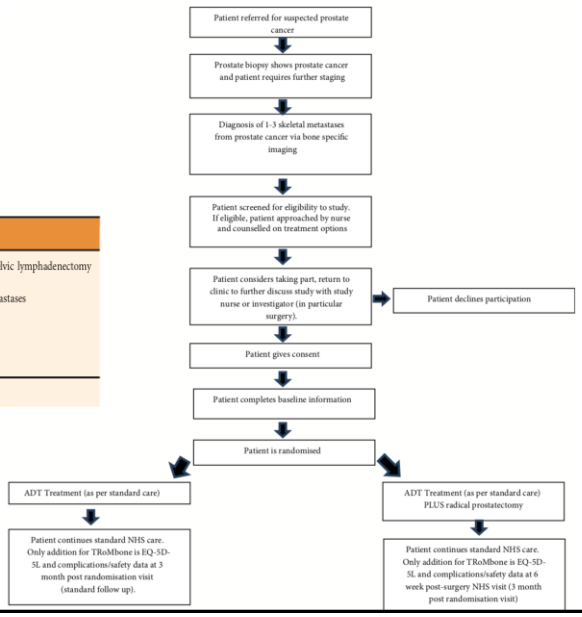
27

TROMBONE TRIAL

Testing radical prostatectomy in men with prostate cancer and oligometastases to the bone: a randomized controlled feasibility trial

Inclusion criteria	Exclusion criteria
Willing and able to give informed consent Male, aged 18–74 years Synchronous oligometastatic prostate cancer (1–3 lesions on standard imaging) Locally resectable disease ECOG PS 0–1 Suitable for radical prostatectomy and extended pelvic lymphadenectomy within 12 months of starting standard care	Contraindications to radical prostatectomy and extended pelvic lymphadenectomy Visceral metastases Prior radiotherapy to the abdomen/pelvis or to skeletal metastases Any systemic therapy for prostate cancer for ≥12 months Participation in another prostate cancer clinical trial

ECOG PS, Eastern Cooperative Oncology Group performance status.

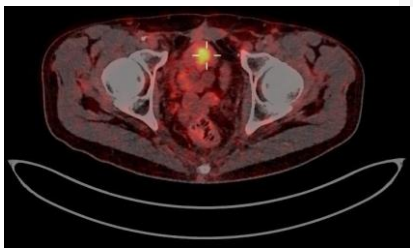


28

- HT : reste encore le traitement de référence du M+
- Importance du contrôle de local chez le patient localement avancé et métastatique
- Chirurgie de l'oligoM : faisable
  - Probable bénéfice oncologique
  - Amélioration des symptômes locaux
- Intérêt de la sélection des patients

Table 6.4.1 Definition of high- and low volume and risk in CHAARTED [789-791] and LATITIDE [795]

	High	Low
CHAARTED (volume)	≥ 4 Bone metastasis including ≥ 1 outside vertebral column or spine **OR** Visceral metastasis	Not high
LATITUDE (risk)	≥ 2 high risk features of • ≥ 3 Bone metastasis • Visceral metastasis • ≥ ISUP grade 4	Not high



29

- MERCI

30