

Mixed Outcomes in Laparoscopy for Prostates

By NICHOLAS BAKALAR

Laparoscopic operations for prostate cancer, a minimally invasive surgery that is in rising demand, result in fewer immediate complications and quicker recovery than the more common open procedure, a new study reports. But the surgery increases the chance for longer term problems that require further therapy, the research says.

The widely advertised procedure is becoming more popular, said Dr. Jim C. Hu, the lead author of the study and an in-

structor in surgery at Harvard.

"This paper," Dr. Hu said, "demonstrates that there are hidden risks for patients who opt for laparoscopic or robotic surgery."

In laparoscopy, a surgeon inserts instruments through small cuts in the skin instead of making large incisions to expose the organs. The laparoscope is a slender tube that allows the surgeon to see inside the body. Most minimally invasive prostate operations are robot assisted.

The study, published on May 10 in *The Journal of Clinical Oncology*, examined a sample of 2,702 Medicare patients undergoing radical prostatectomy, the complete removal of the prostate, from 2003 to 2005. Minimally invasive procedures increased to 31 percent of all radical prostatectomies in 2005 from 12.2 percent in 2003.

Laparoscopic surgeries — the study does not specify how many were robot assisted — resulted in a 27 percent lower risk of complications during and immediately after the operation. Those patients had less bleeding, fewer

breathing problems, fewer cardiac problems and fewer immediate complications over all. The patients needed an average of 1.42 days in the hospital, compared with more than four days for those who had open surgery.

But the men who had the laparoscopies had a 40 percent greater risk of scarring that interferes with organ function, a complication that requires additional surgery. And within six months of their operations, more than one-quarter needed additional hormonal or drug therapy compared

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with one in 10 of those who had conventional surgery.

Dr. Mark L. Gonzalgo, an assistant professor of urology at Johns Hopkins who was not involved in the study, said the laparoscopic procedure had disadvantages. "You can't feel the cancer in robotic operations," he said. "And the ability to feel the cancer with your hands may provide some additional advantage."

Even in robotic procedures, he added, "the operation is performed by the surgeon, not the robot. You have to have a surgeon who understands the anatomy."

At Johns Hopkins, Dr. Gonzalgo said, the open procedure con-

tinues to be used in most radical prostatectomies.

Other experts found the study noteworthy. "It's a very important paper, the first that has come out in the field that has used a national database to examine outcomes," said Dr. Peter T. Scardino, chairman of the surgery department at the Memorial Sloan-Kettering Cancer Center.

The study has some problems, he said, noting that data on the seriousness of the cancer in each case was not available, leaving no way to know whether less serious tumors were consistently selected for laparoscopic surgery. Still, he said, the results "fit with everything we know."

THE NEW YORK TIMES, TUESDAY, MAY 27, 2008

This article is still valid as of January, 2015

A-336

Robotic Surgery has Worse Side Effects than Standard Radical Prostatectomy

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A351

ABSTRACT

Context Minimally invasive radical prostatectomy (MIRP) has diffused rapidly despite limited data on outcomes and greater costs compared with open retropubic radical prostatectomy (RRP).

Objective To determine the comparative effectiveness of MIRP vs RRP.

Design, Setting, and Patients Population-based observational cohort study using US Surveillance, Epidemiology, and End Results Medicare linked data from 2003 through 2007. We identified men with prostate cancer who underwent MIRP (n = 1938) vs RRP (n = 6899).

Main Outcome Measures We compared postoperative 30-day complications, anastomotic stricture 31 to 365 days postoperatively, long-term incontinence and erectile dysfunction more than 18 months postoperatively, and postoperative use of additional cancer therapies, a surrogate for cancer control.

Conclusion: Men undergoing Robotic Surgery vs Standard Radical Prostatectomy, experienced shorter length of stay, fewer respiratory and miscellaneous surgical complications and strictures, and similar postoperative use of additional cancer therapies but experienced more genitourinary complications, incontinence, and erectile dysfunction.

HEALTH

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Aches & Claims / By Robert J. Davis

Proton-Beam Therapy for Cancer

Some regard it as a well-kept secret in the war on cancer: **proton-beam therapy**, a type of radiation that can precisely target tumors while sparing surrounding tissue and causing far fewer side effects than traditional radiation. The treatment is showing promise against a variety of cancers, including those of the prostate, brain, eye and lung. It's now available at only a few centers in the U.S., but with more on the way, you may start seeing ads touting its benefits.

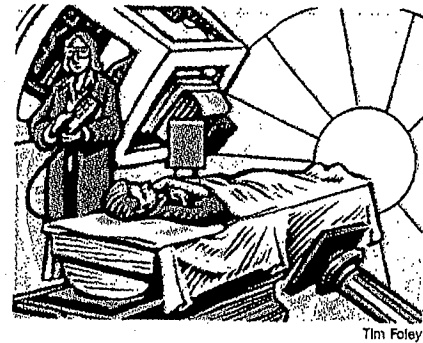
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Because traditional radiation therapy zaps everything in its path, doctors have to limit the dose in order to reduce serious side effects. Proton beams work differently, delivering a low dose of energy as they enter the body and then gradually increasing to a maximum when reaching the cancerous target. The dose drops to zero as proton beams exit

the body. Because damage to healthy tissue is minimized, doctors can treat cancers with higher and therefore more-effective doses of radiation.

Using a CT and other scans, doctors first take a three-dimensional picture of the tumor. The proton beam is then shaped to exactly match the shape of the tumor. Because of this precision, the treatment can be used for deeply embedded cancers in sensitive areas such as the eye or brain. Proton therapy can also offer advantages for pediatric cancers because it causes fewer long-term adverse effects on growth and development than conventional radiation.

Though the technology is approved to treat a variety of cancers, it has been studied most thoroughly for prostate cancer. A recently published study of more than 1,200 men with localized prostate cancer found that 75% of those who had received proton therapy were disease-free after five years—a success rate comparable with that of



Tim Foley

surgery and conventional radiation. Men with the lowest score on their prostate-specific-antigen (PSA) test before surgery had a 90% chance of being disease-free. The risk of side effects such as impotence, incontinence and gastrointestinal problems is lower than that from other treatments.

Depending on the type of cancer, anywhere from a couple of treatments to several dozen can be required. Patients with prostate cancer typically need about 40 treatments administered over a two-month period. The treatment itself is painless, taking anywhere from 15 to 90 minutes, and it doesn't require hospitalization. The cost, which can range from \$10,000 to \$80,000, can be at

least twice that of traditional radiation but less than that of surgery. It's usually covered by insurance.

Because of the enormous cost of building proton-therapy facilities, there are currently only few, at Loma Linda Medical Center in Southern California; Massachusetts General Hospital in Boston; and the Midwest Proton Radiotherapy Institute in Bloomington, Ind. Treatment is available for eye cancers only at the University of California, Davis.

Facilities are under construction at MD-Anderson Cancer Center in Houston and the Shands Medical Center in Jacksonville, Fla. Both are expected to open next year.

Because of its limited availability, the treatment is usually reserved for cancers that are contained, though it can be used for metastasized cancer. It's best to get a referral from your physician, but you can also call a proton-therapy facility and arrange for a consultation. If you are approved for treatment, expect a wait of anywhere from a week to two months.

—With reporting by John M. Gunn

E-mail Aches@wsj.com.

Comparison of Proton Beam vs X-Ray External Beam Radiation Therapy

-----Original Message-----

From: stan klein [mailto:klein@rcn.com]

Sent: Sun 1/21/2007 12:01 PM

To: Zietman, Anthony Laurence, Md

Cc: stan klein

Subject: Proton Beam Radiation

A-319

Hello Dr Zietman,

A few men from the east have traveled west to be treated with Proton Beam Radiation, because the side effects are supposed to be fewer. MGH has this treatment option.

Q1 Is this true? ANS: Absolutely no evidence!

Q2- How does the recurrence rate compare to EBR? ANS: Identical if the same radiation dose is used

Q3 If recurrence does occur, how long after treatment does it usually take? (I realize it depends on the PSA and Gleason grade at the start)

ANS: Exactly the same as regular EBR.....years to many years

Q4- If it is as good as claimed by Loma Linda, why does the MGH not do more of these?

ANS: It is superb for pediatrics, eye, brain, and spine tumors. These cancers are our top priority because they are inevitable killers and because there is clear evidence of benefit. At MGH only 20-30% of our proton volume consists of prostate cancer cases because every case for which there is uncertain benefit takes away from one in which the benefit clearly exists. We still treat around 60-80 prostate patients a year with protons which is a reasonable number!

Q5 Is there an authentic analysis / comparison of Proton Beam VS X-Ray EBR?

ANS: No. We are starting a randomized trial next year comparing the two.

Best wishes AZ

The MEDICAL PROFESSION does not know, or does not care, how to treat, but treat they will

A-279

On May 15, 2005 The Boston Globe had a story quoting Dr. Peter Greenwald, Director of Cancer Prevention for the National Cancer Institute. He said there is little agreement how to treat Prostate Cancer. Never-the-less, doctors treat their patients using their specialty

This insipient practice is very prevalent, & is why I strongly advocate that every man with PC consult with a Medical Oncologist who specializes in PC.. These clinicians & researchers will probably recommend delayed treatment (Active Surveillance) if the man qualifies. Treatment will then be recommended only if the cancer progresses. (A279)

Article A337 below is an example.

A-337

Prostate cancer treatment differs between county and private hospitals

New findings show differences in how prostate cancer is treated, depending on whether the facility is a county hospital or a private hospital. Treatments for localized prostate cancer include surgery or hormone therapy and radiation.

A study conducted by Moores Cancer Center at the University of California, San Diego shows that men whose prostate cancer is treated at a county hospital are more likely to undergo surgery. Men at private hospitals are more frequently receive radiation and hormone therapy for prostate cancer.

"The study examined the factors that drive treatment choices for patients with prostate cancer" said J. Kellogg Parsons, MD, MHS, principal investigator and urologic oncologist at Moores UCSD Cancer Center. "We found that decisions are significantly influenced by the type of health care facility where they receive care."

Data for the study was extracted from the records of 559 men with prostate cancer who were part of the Improving Access, Counseling and Treatment for Californians with Prostate Cancer (IMPACT) program between 2001 and 2006. Even though prostate cancer tumors were similar in both groups, the study found that prostate cancer patients treated in private hospitals were more likely to be white and less likely to receive surgery. Men in private hospitals were 2 ½ times more likely to receive radiation and 4 ½ times more likely to receive hormone therapy for prostate cancer, compared to men in county hospitals.

The reason for the difference in prostate cancer treatment between county and private hospitals is not clear. Private hospitals represented urologists, radiation oncologists, and medical oncologists, while county hospital patients with prostate cancer were more likely to be under the care of a urologist.

"The fact that prostate cancer patients are treated differently based on the type of hospital has implications for health policy, quality of care and equality of care - particularly because public hospitals are funded by city and state governments to provide health care for underserved, poor populations," said Parsons. The study is published January 25 in the journal Cancer. 2010.

Cancer screening can do more harm than good

BY MELISSA WEBER | JULY 20, 2009

Score one against conventional wisdom: Those cancer screening tests for early detection that are constantly urged? Turns out they don't save lives in most cases.

Patients may consider them fighting words, but unfortunately, the research backs it up when it comes to most cancers beyond cervical and colorectal. In fact, research shows screening for other cancer types can wind up doing more harm than good.

In our summer issue of CURE, Dr. Len Lichtenfeld of the American Cancer Society explained the latest controversy over PSA (short for prostate-specific antigen) screening for prostate cancer. We're taking this subject a step further in our upcoming fall issue, laying out the benefits versus harms, and why in some cases screening doesn't make a difference. As for one of those reasons, contributing writer Laura Beil summed it up this way in the upcoming article:

"Screening can fail partly because of the nature of cancer, and the shortcomings of current technology. Because aggressive tumors--the ones you most want to find--tend to grow rapidly, screening is less likely to pick them up. And slow-moving tumors are generally less deadly and may never even clinically manifest during a person's lifetime."

It's a complicated (and delicate) subject. So to dig a little deeper, we asked **Dr. Barnett S. Kramer, the associate director for disease prevention at the National Institutes of Health**, to author the fall issue's Speaking Out column. He writes: **"It has been estimated that as many as 50 percent of prostate cancers detected by PSA screening are so slow-growing that they never would have caused any medical problems, had they not been detected by screening."**

In CURE TODAY.com

Stan's Comment

I strongly believe screening is important to find the 20% of men who Have an aggressive or advanced PC. The problem is to NEVER HAVE ANY TREATMENT UNTIL ALL 3 PC SPECIALISTS ARE CONSULTED ESPECIALLY THE MEDICAL ONCOLOGIST

Los Angeles Times July 27, 2010 |

Many men with low-risk prostate cancer over treated, study finds

About three-quarters of men with low-risk prostate tumors that can safely be ignored for months or years receive aggressive treatment, despite the risk of complications, researchers reported Monday. The findings, published in the Archives of Internal Medicine, shed further light on the ongoing dispute about the levels of prostate-specific antigen (PSA) that should be used to trigger further diagnosis and treatment. Currently, a cutoff of PSA levels of 4.0 nanograms per milliliter is used to decide whether a man needs a biopsy or other follow-up, but some experts are recommending the cutoff be reduced to 2.5. If that were to occur, the authors report, the number of U.S. men considered to have abnormal PSA levels would double to about 6 million, and many more would undergo unnecessary procedures.

Cancer epidemiologist Grace Lu-Yao of the Cancer Institute of New Jersey at the University of Medicine and Dentistry of New Jersey and her colleagues used the federal government's Surveillance, Epidemiology and End Results (SEER) database to study the records of 123,934 men over the age of 25 who had newly diagnosed prostate cancer from 2004 to 2006. About 14% of the men had PSA values lower than 4, generally younger men. In that group, 54% had low-risk disease that could be safely monitored for progression with little risk. Nonetheless, 75% of them received aggressive treatment, including a radical prostatectomy and radiation therapy. Among men in that group over the age of 65, in which "watchful waiting" is generally advised for low-risk disease, 66% had aggressive therapy. In both cases, the percentages were similar to those in the group with PSA levels between 4 and 20. Complications of such aggressive treatment include impotence and incontinence, among other problems.

"It is clear from our current study that men are choosing aggressive forms of treatment when they may not need to," Lu-Yao said in a statement. "This is especially concerning for older men, as previous studies done by our team show excellent disease-specific survival for men with low-risk cancer following conservative management."

NOTE 1

More than 192,000 new cases of prostate cancer were diagnosed in this country in 2009, according to the American Cancer Society, and more than 27,000 died from it. More than 90% of all prostate cancers are diagnosed before the disease has spread to other parts of the body, and the five-year survival rate for them is almost 100%. The five-year survival rate for all stages of the disease, both localized and metastatic, increased from 69% in 1975 to almost 99% in 2003, the authors said.

NOTE 2

The bottom line, Lu-Yao said, is that clinicians need a better way to distinguish between those tumors that are likely to progress and those that won't.

— Thomas H. Maugh II

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Note 1- Means delayed treatment, i.e., Active Surveillance

Note 2-By treating more men who do not need treatment, the Survival Rate increases

Two-Thirds Of Prostate Cancer Patients Do Not Need Treatment, Study Reveals

ScienceDaily (Sep. 24, 2009) — Research at the University of Liverpool involving more than 500 prostate cancer patients has revealed two thirds of cases did not require urgent treatment, due to the absence of a protein that indicates progressive disease.

In the largest study of its kind, the international team of pathologists studied an initial 4,000 prostate cancer patients over a period of 15 years to further understanding into the natural progression of the disease and how it should be managed. The research, published in the *British Journal of Cancer*, could be used to develop a blood test to distinguish between aggressive and non-aggressive forms of prostate cancer.

Globally, prostate cancer is the fifth most common malignancy and accounts for 13% of male deaths in the UK. Studies have shown that men with non-aggressive prostate cancer can live with the disease untreated for many years, but aggressive cancer requires immediate treatment.

Pathologists found that the presence of a protein, called Hsp-27, in cancer cells was an indicator that the disease will progress and require treatment. The study showed, however, that in more than 60% of cases the protein was not expressed and the cancer could be managed by careful monitoring, rather than with active intervention methods, such as drug treatment or surgery.

Journal reference:

1. C S Foster, A R Dodson, L Ambroisine, G Fisher, H Møller, J Clark, G Attard, J De-Bono, P Scardino, V E Reuter, C S Cooper, D M Berney and J Cuzick. **Hsp-27 expression at diagnosis predicts poor clinical outcome in prostate cancer independent of ETS-gene rearrangement.** *British Journal of Cancer*, 2009; DOI: 10.1038/sj.bjc.6605227

Adapted from materials provided by University of Liverpool, via EurekAlert!, a service of AAAS.

Poor Sources Guide Prostate Cancer Treatment Decisions

03.27.06, 12:00 AM ET

A-295

MONDAY, March 27 (HealthDay News) — Too many men with prostate cancer are basing important treatment decisions on biased information rather than scientific evidence, a new study finds.

The review of studies, published in the May 1 issue of *Cancer*, examined patients' prostate cancer treatment decisions and concluded that a lack of medical evidence and consistent, comprehensive messages about treatment options is forcing men to turn to a wide number of popular and biased sources instead. This often results in prostate cancer patients receiving treatments that don't reflect their actual preferences, said researchers at Fred Hutchinson Cancer Center in Seattle.

Cancer eradication or control was the primary treatment objective for prostate cancer patients, the review found, while minimizing side effects played a minor role in patients' treatment decisions. However, in selecting a treatment, patients didn't consistently rely on the scientific evidence of a therapy's effectiveness in either controlling the cancer or prolonging life, the review found.

For example, one study found that as few as one in four patients based their decision on evidence that a treatment actually worked to eradicate disease.

Doctors often presented prostate cancer treatments in ways that were both confusing and dismissive of patient concerns about risks, the study found. This either biased patients' decisions about treatments or made them turn to other sources of information, the review said.

Stan's Comment: It is incumbent for the doctors to clearly explain the patient's condition, and it is mandatory to visit all three PC specialists, one at a time, to obtain a clear assessment of the treatment options and side effects.