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EDITORIAL COMMENTS

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Multiple studies previously showed low rates of treatment intensification (TI) with either a novel hormonal therapy or chemotherapy added to androgen deprivation therapy for men with metastatic castration-sensitive prostate cancer.[1–3] Regarding systemic therapy, one question naturally arises, “Who is doing better: urologists or oncologists?” The manuscript by Swami and colleagues clearly shows the answer is neither.[4] While treatment rates were better when patients were seen by oncologists, TI rates were extremely low overall, regardless of specialty. While these data are from 2019, recent data suggest undertreatment remains low.[2]

These data are a wake-up call to the urological community. Overall, urologists used TI in only 15% of cases despite clear evidence of improved survival. While not every patient is a good candidate for TI (poor performance status, competing mortality risks, financial toxicity, etc), it should be the norm, not the exception. We can and need to do better.

To improve these numbers, we need to understand reasons for TI underutilization, which the authors acknowledge may be due to factors including perceived patient tolerability, quality of life, patient’s disease complexity, information gaps, and cost. We realize there are real barriers to prescribing TI including prior authorizations, specialty pharmacies, managing side effects, etc. Thus, it is unrealistic to expect every urologist to be an expert in advanced prostate cancer care. However, we owe a duty to our patients to provide the best care possible. This only happens if we better manage these patients or refer to another physician who can. That can be another urologist within your practice, an outside urologist, a medical oncologist, or via a team of specialists through a multidisciplinary tumor board. It is unacceptable to give androgen deprivation therapy alone, noting the exceptions above, when guidelines and robust clinical trial data unequivocally show TI improves survival.

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