What urologists say they do for men with prostate cancer

Aggressive treatment for the younger man and by a specialist

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I used to tell patients having difficulty deciding what treatment to choose for their early prostate cancer that they could get any medical opinion they wanted. Some colleagues have long preferred no treatment (watchful waiting), whereas others have thought radical prostatectomy the most reliable treatment. Several referred all such men for external beam radiotherapy. I used to make the point that if three good doctors could offer such different treatments to the same individual then there couldn't be that much difference between the treatments in terms of their efficacy. Pauker and Kassirer have recently argued that when key elements of outcome are similar between two or more treatments patients should focus on other, more personal considerations when making their decisions.[1]

It looks as though I will have to modify my advice. The survey of urologists reported on p 299 shows that patients can no longer get any opinion they want.[2] If they are young (aged 70 or less) they will be offered radical (potentially curative) treatments. The younger patient will be offered surgery, the older one radiotherapy. Once in his mid-70s a man has only a one in five chance of being offered a radical treatment. Anybody over 75 is unlikely to be offered a radical treatment and when, rarely, it is offered, it will always be radiotherapy.

Does allocating treatments on the basis of age make sense? Although it is not founded on high quality evidence, most urologists and oncologists tend to offer radical therapies to men with life expectancies of 10 years or more in the belief that benefit (a reduction in the likelihood of prostate cancer progression or death) will be realised only on such a time scale. The long natural course of early prostate cancer means that fewer than one in 10 men with early prostate cancer will die of it within 10 years if it is left untreated.[3] In other words a radical prostatectomy undertaken on a 70 year old man with diabetes and severe ischaemic heart disease will not only be more hazardous than in a fit man of the same age but will be unlikely to confer additional years if the patient dies of ischaemic heart disease within a few years. This patient will have been exposed to harm (operative risk, pain, incapacity) and side effects such as urinary incontinence and erectile dysfunction but denied the benefits.

By restricting radical therapies to those men with long life expectancies urologists are trying to maximise the potential benefits of the operation and minimise the harms. The balance is a delicate one.[4] Age alone is not a good predictor of mortality; comorbidity is better.[5] Though the troublesome side effects of radical surgery are less likely in younger men, if they do occur their effects will have to be endured for longer.

If radical prostatectomy and radical radiotherapy are deemed to be roughly equivalent in prolonging life and preventing future morbidity (in the available and inadequate literature),[6] why are urologists encouraging younger men to opt for surgery rather than radiotherapy? Would radiation or medical oncologists have responded differently? Or do the urologists believe (for there is no reliable evidence) that surgery is better at prolonging life and preventing future morbidity? The survey does not help us answer these questions, but similar questionnaires aimed at oncologists would be of interest.

Another aspect of this survey needs highlighting. Although most of the responding urologists saw a substantial number of men with prostate cancer and though most favoured radical surgery for younger men, few were personally engaged in performing radical surgery. Only 12 of the 244 consultants performed 20 or more radical prostatectomies a year. The study does not tell us why this is so, but this finding suggests that the procedure is being concentrated in relatively few hands. For a complex procedure where the balance of benefits and harms is delicately poised this must be a good thing. Units with an appreciable workload should be better able to maximise the benefits (high rates of cancer clearance because of good technique) and minimise the harms (by sound patient selection and lower rates of urinary incontinence and erectile dysfunction). Moreover, their clinicians will be better able to audit their outcomes and compare their results with those of others. These figures could then be made available to patients who are trying to decide which treatment, if any, to have.

In the absence of sound evidence this survey tells us that urologists are not prepared to leave younger men untreated. By doing this, not only are they are treating men who have the greatest potential to derive benefit, but it looks as if they are—probably deliberately—clustering these cases in the hands of a few subspecialists. Given that there are no randomised trials in the United Kingdom currently recruiting patients with early prostate cancer this situation (combined with careful audit) is probably the best we can hope for. Now all we need to know is how closely actual practice reflects the views of these urologists.

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