PROFESSIONAL
SUPPORT

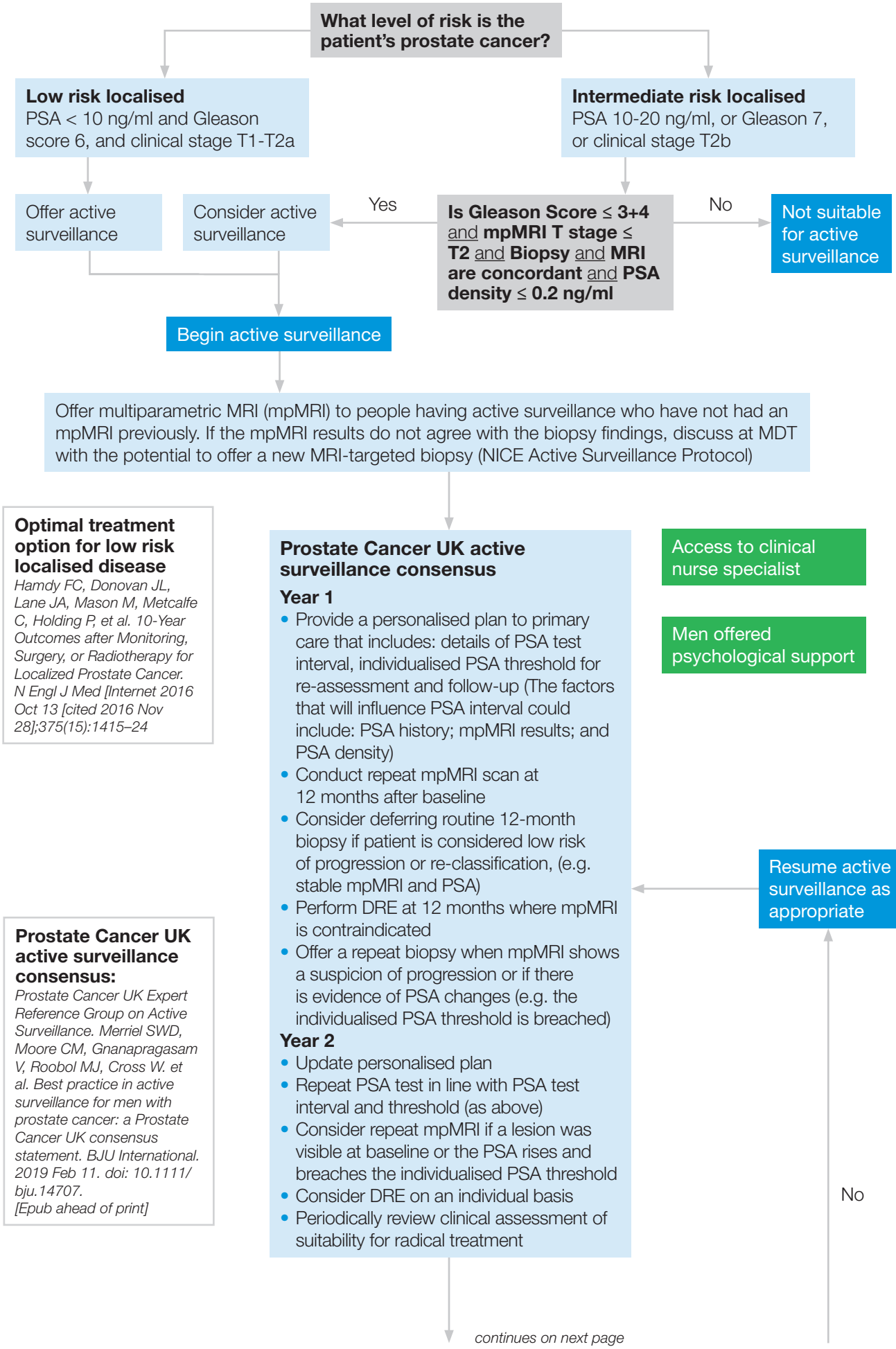
Reviewed June 2019
To be reviewed in 2020

Prostate Cancer UK's Best Practice Pathway

TREATMENT

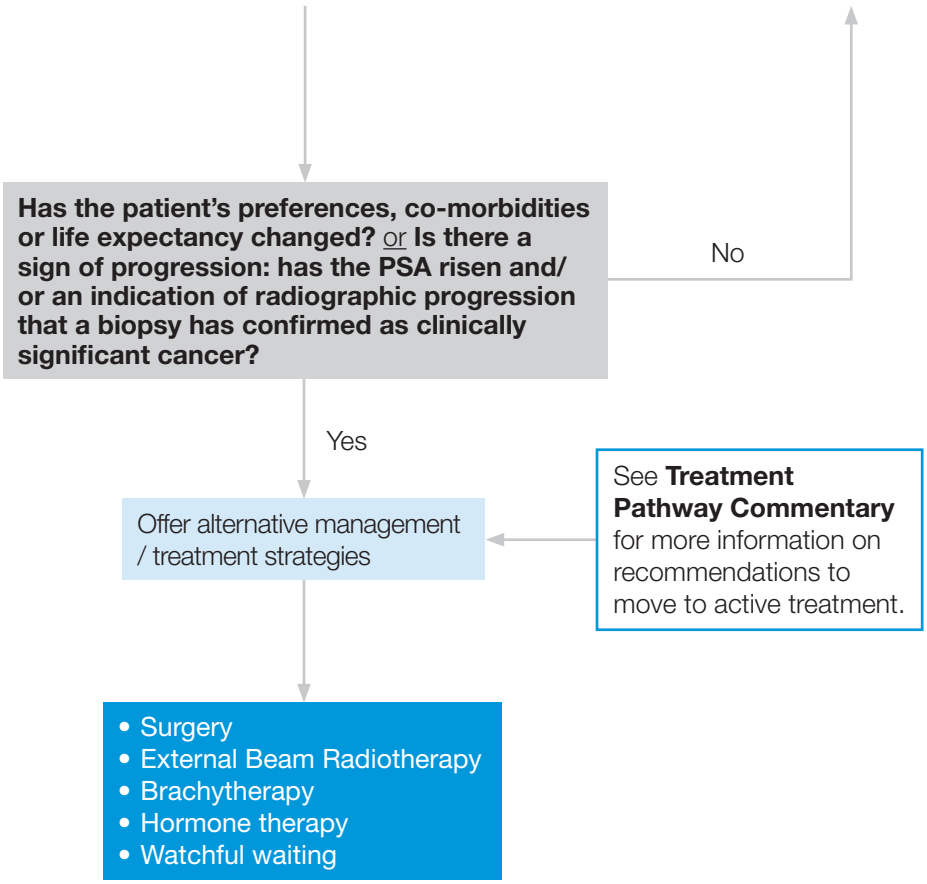
PROSTATE
CANCER UK

Active surveillance

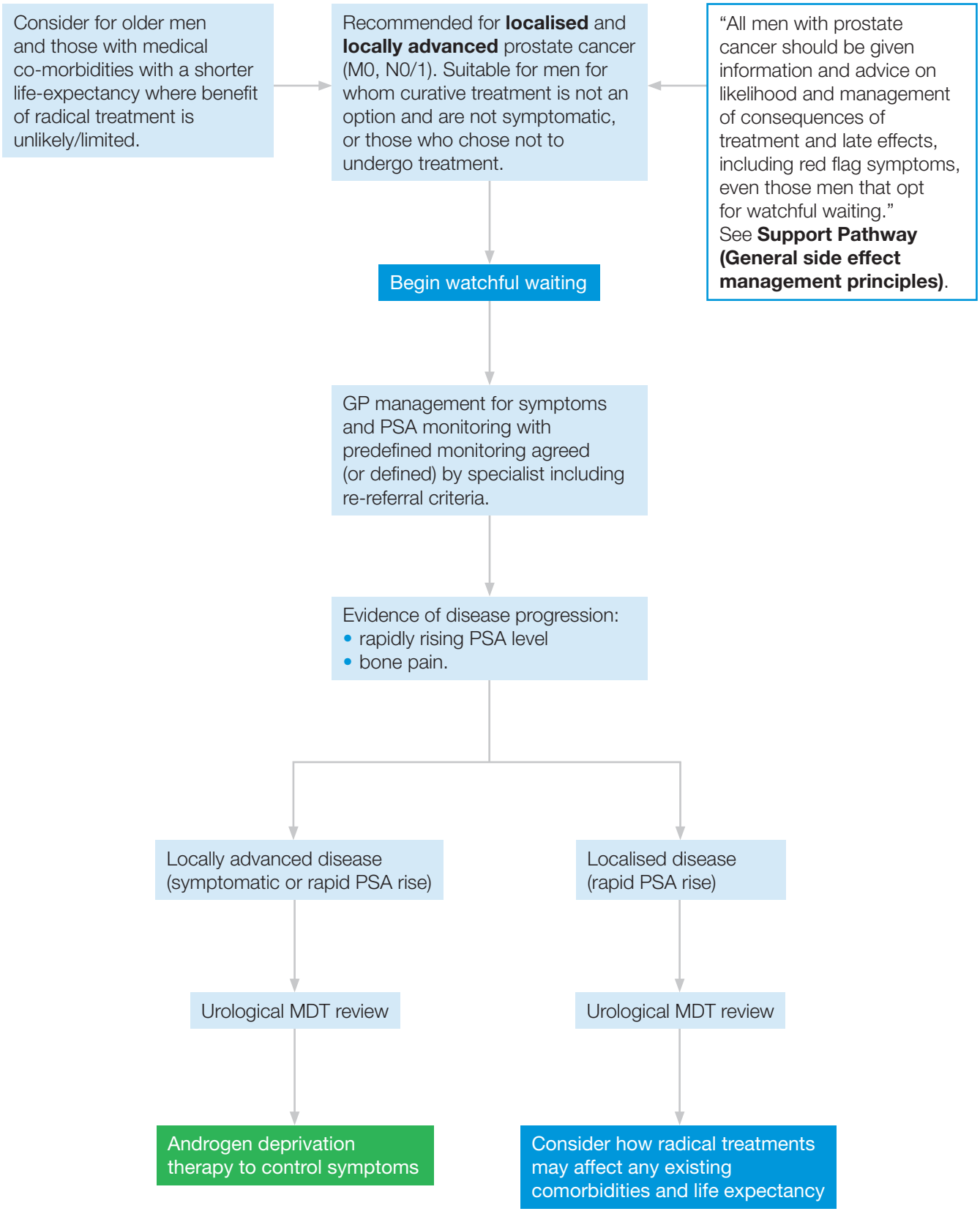


continues on next page

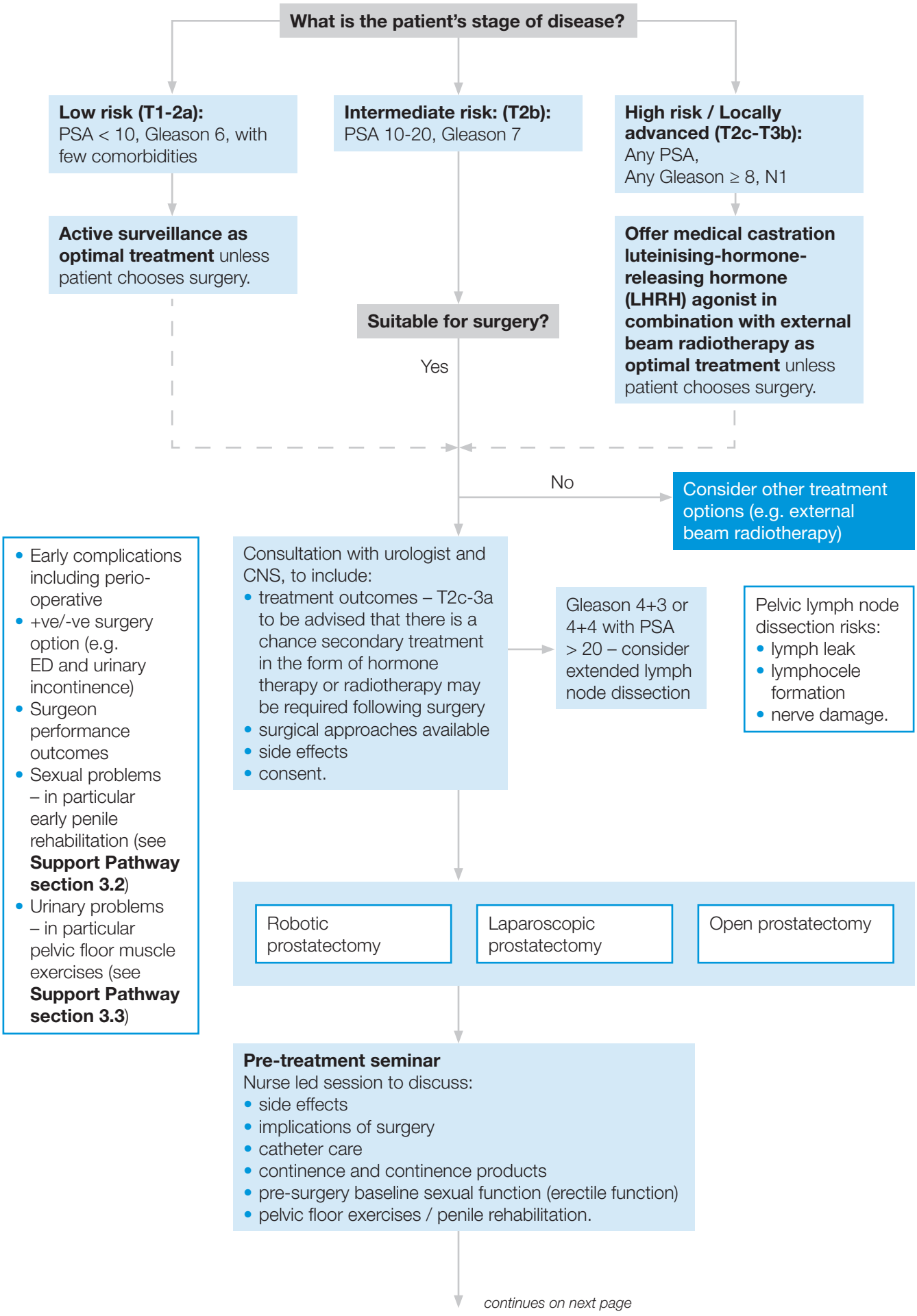
Active surveillance continued...



Watchful waiting

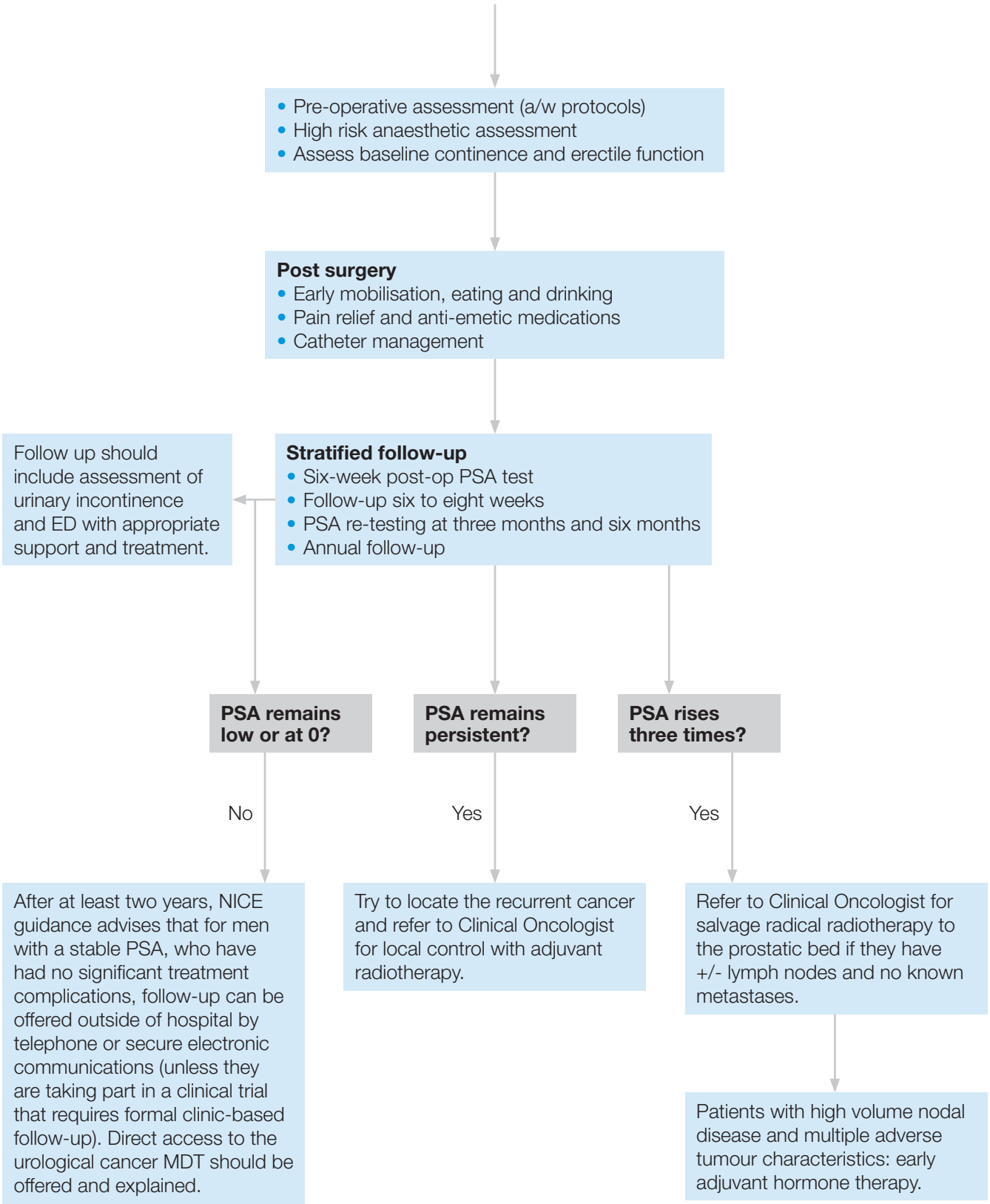


Surgery – radical prostatectomy



continues on next page

Surgery – radical prostatectomy continued...



External beam radiotherapy (EBRT)

Is the patient suitable for radiotherapy?

No → Unsuitable for radiotherapy, explore alternative treatments for stage of disease (e.g. radical prostatectomy)

Yes → **What is the patient's stage of disease?**

Late effects can occur months to years after radiotherapy, may include: urinary problems (weak flow), bowel problems, erectile dysfunction, hip and bone pain/weakness. See **Support Pathway (section 3.4)**.

Short-term side effects (six to eight weeks) including: diarrhoea, rectal pain, unusual urinary frequency.

What is the patient's stage of disease?

- Low risk (T1a): go to Active Surveillance pathway
- Localised low and Intermediate risk T1b-3a, Gleason < 8, any PSA
- Locally Advanced (N0, any T3/T4, N1MO)
- Metastatic prostate cancer (M1)

Localised low and Intermediate risk T1b-3a, Gleason < 8, any PSA:

- Intermediate risk T2a: hypo-fractionated high-dose IMRT
- T2b and T2c-3a: IMRT

Intermediate risk T2a: hypo-fractionated high-dose IMRT → 60 gy in 20 fractions over four weeks → Consider short-term ADT for < six months

T2b and T2c-3a: IMRT → 78gy in 37 fractions over seven to eight weeks → Consider short-term ADT for > six months

78gy in 37 fractions over seven to eight weeks → In case of recurrence, men exposed to 78gy will not have the option of additional radiotherapy.

Optimal treatment administration. *Optimal treatment administration. Dearnaley D, Syndikus I, Mossop H, Khoo V, Birtle A, Bloomfield D, et al. Conventional versus hypofractionated high-dose intensity-modulated radiotherapy for prostate cancer: 5-year outcomes of the randomised, non-inferiority, phase 3 CHHiP trial. Lancet Oncol. 2016 Aug 1;17(8):1047–60.*

Locally Advanced (N0, any T3/T4, N1MO) → Offer medical castration (luteinising-hormone-releasing hormone [LHRH] agonist) as androgen deprivation therapy, six months prior and for one-three years after. Include co-administration of an antiandrogen to LHRHa to prevent testosterone flare – one week before and three weeks after the first injection. Administer for four weeks.

Metastatic prostate cancer (M1) → **Does the patient have ≥ four metastases, including one outside the pelvis and spine or visceral metastases?**

- Yes → Go to **Chemo-therapy Pathway**
- No → Offer medical castration (luteinising-hormone-releasing hormone [LHRH] agonist) as androgen deprivation therapy (ADT) for 18 months to three years. Include co-administration of an antiandrogen to LHRHa to prevent testosterone flare – one week before and three weeks after the first injection. Administer for four weeks.

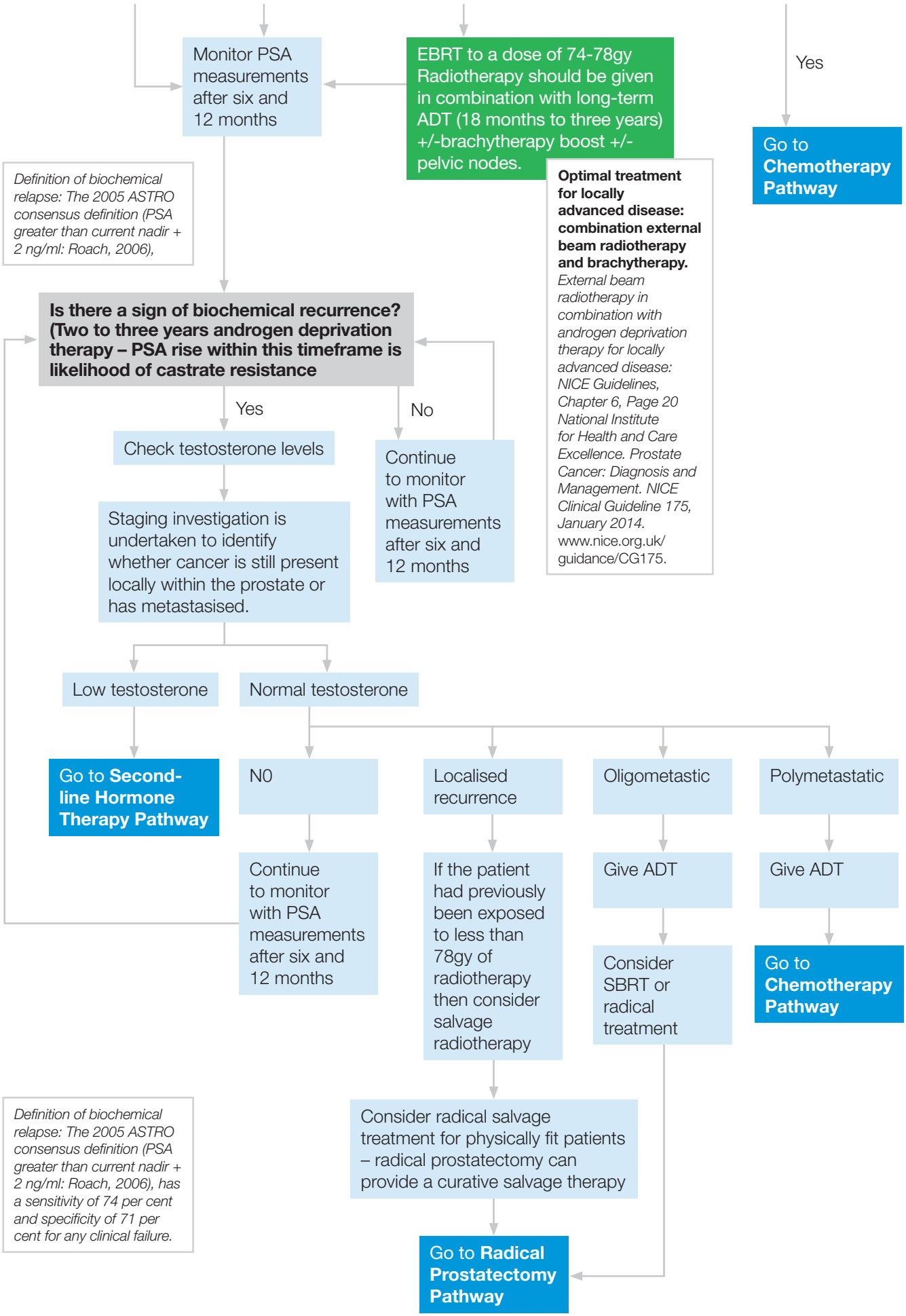
Offer medical castration (luteinising-hormone-releasing hormone [LHRH] agonist) as androgen deprivation therapy (ADT) for 18 months to three years. Include co-administration of an antiandrogen to LHRHa to prevent testosterone flare – one week before and three weeks after the first injection. Administer for four weeks. → Consider radiotherapy to the prostate only, 36gy over six fractions for six weeks, using the CHHiP schedule → Go to **Chemo-therapy Pathway**

Is the patient T3/T4, Gleason ≤ 7 and PSA < 40?

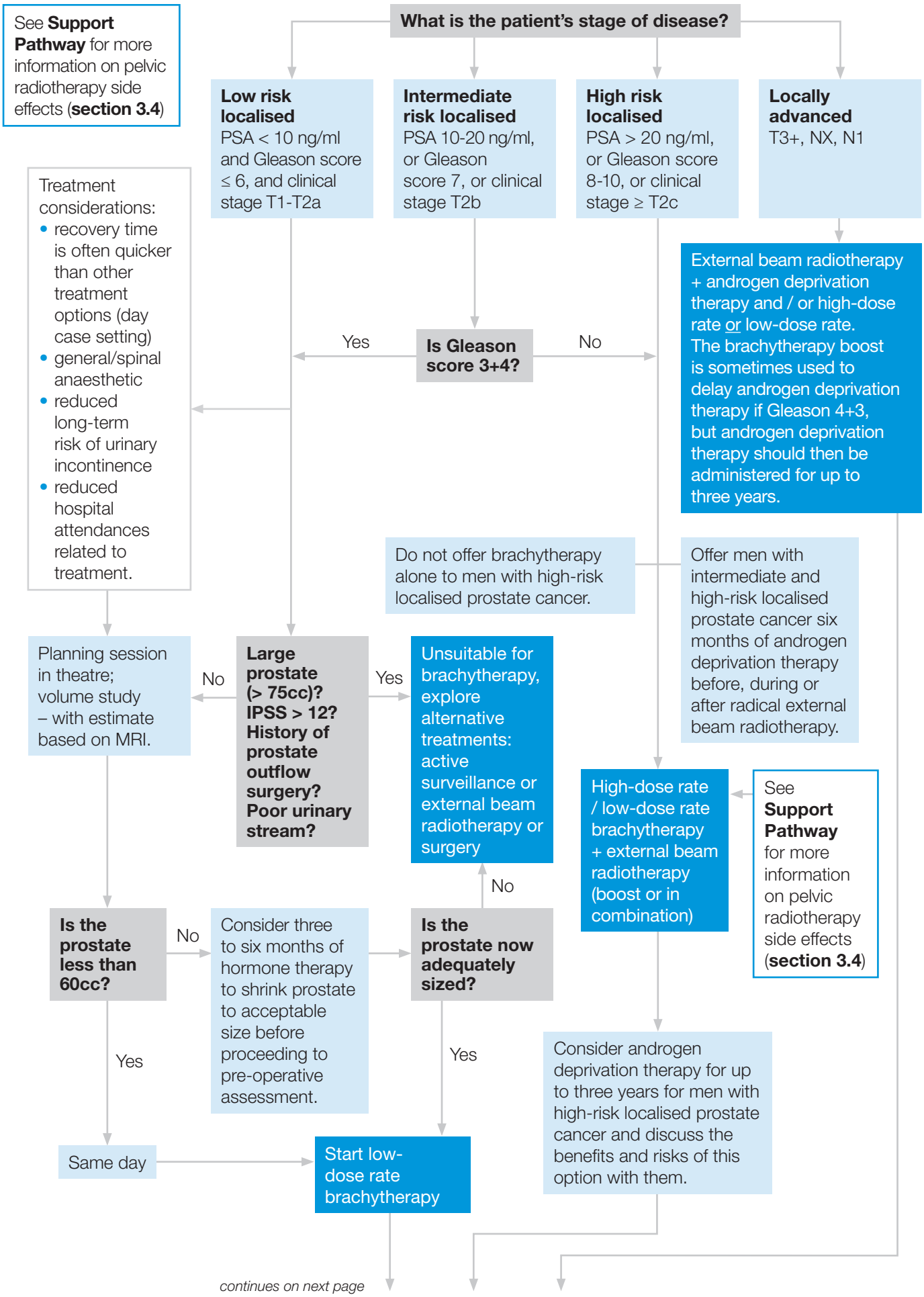
- No → **Is the patient at least two of: T3/T4 disease, Gleason 8-10, and PSA ≥ 40 ng/ml or TanyN1MO?**
  - No → Combine ADT with Radical Radiotherapy (EBRT) – NICE Guidelines 2014
  - Yes → **Is the patient able to tolerate chemotherapy?**
    - No → Combine ADT with Radical Radiotherapy (EBRT) – NICE Guidelines 2014
    - Yes
- Yes → Combine ADT with Radical Radiotherapy (EBRT) – NICE Guidelines 2014

continues on next page

External beam radiotherapy (EBRT) continued...

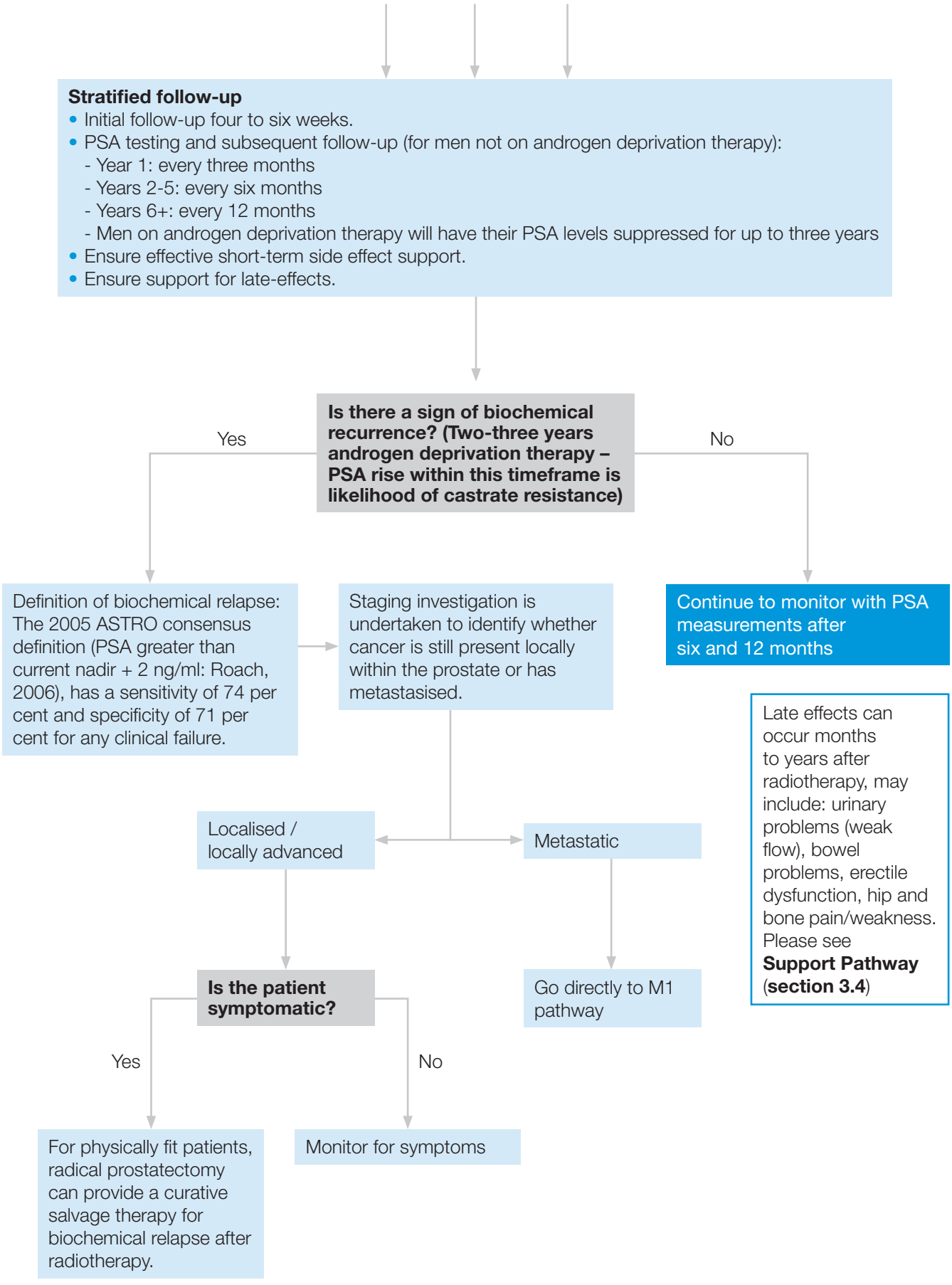


Brachytherapy

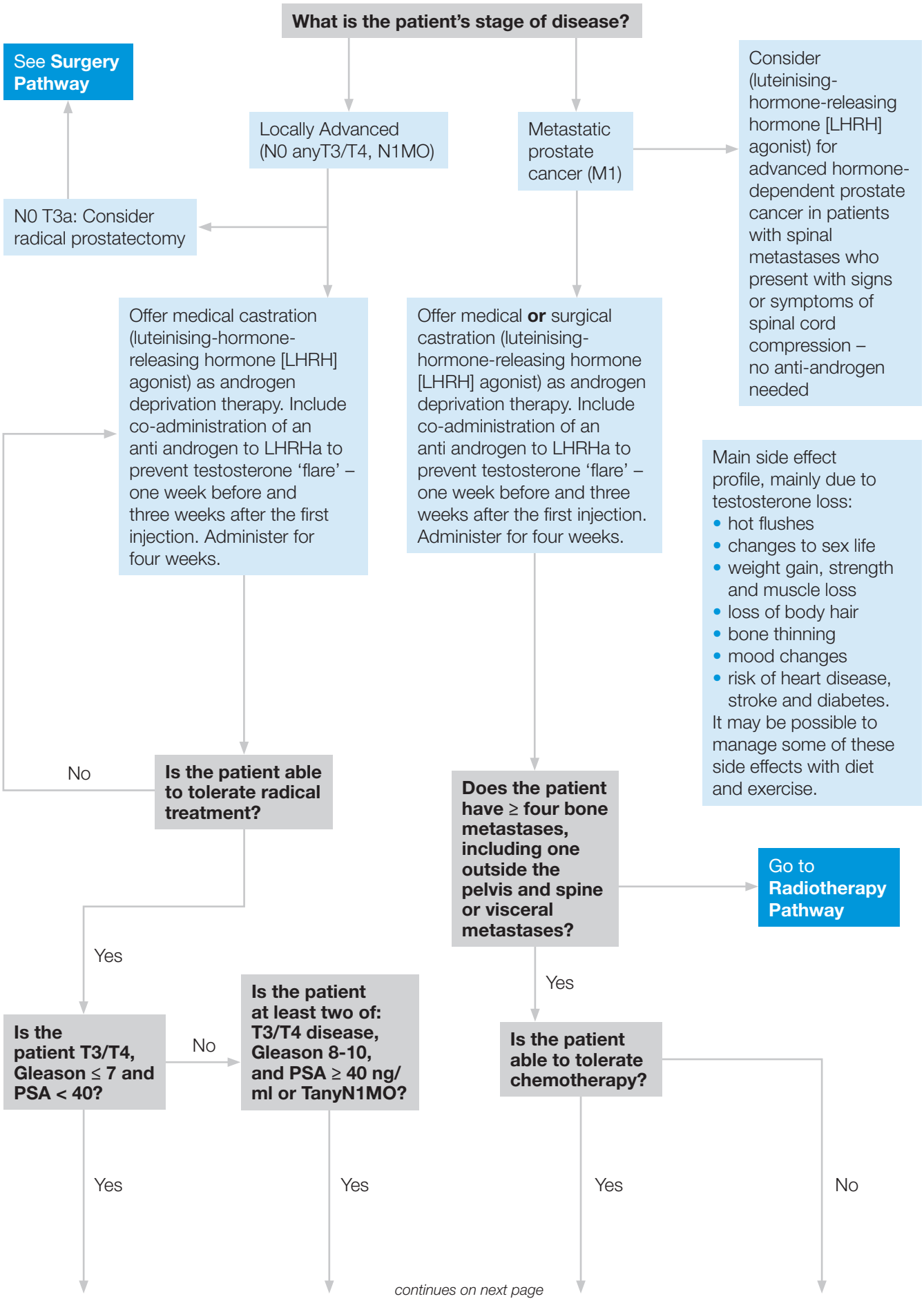


continues on next page

Brachytherapy continued...

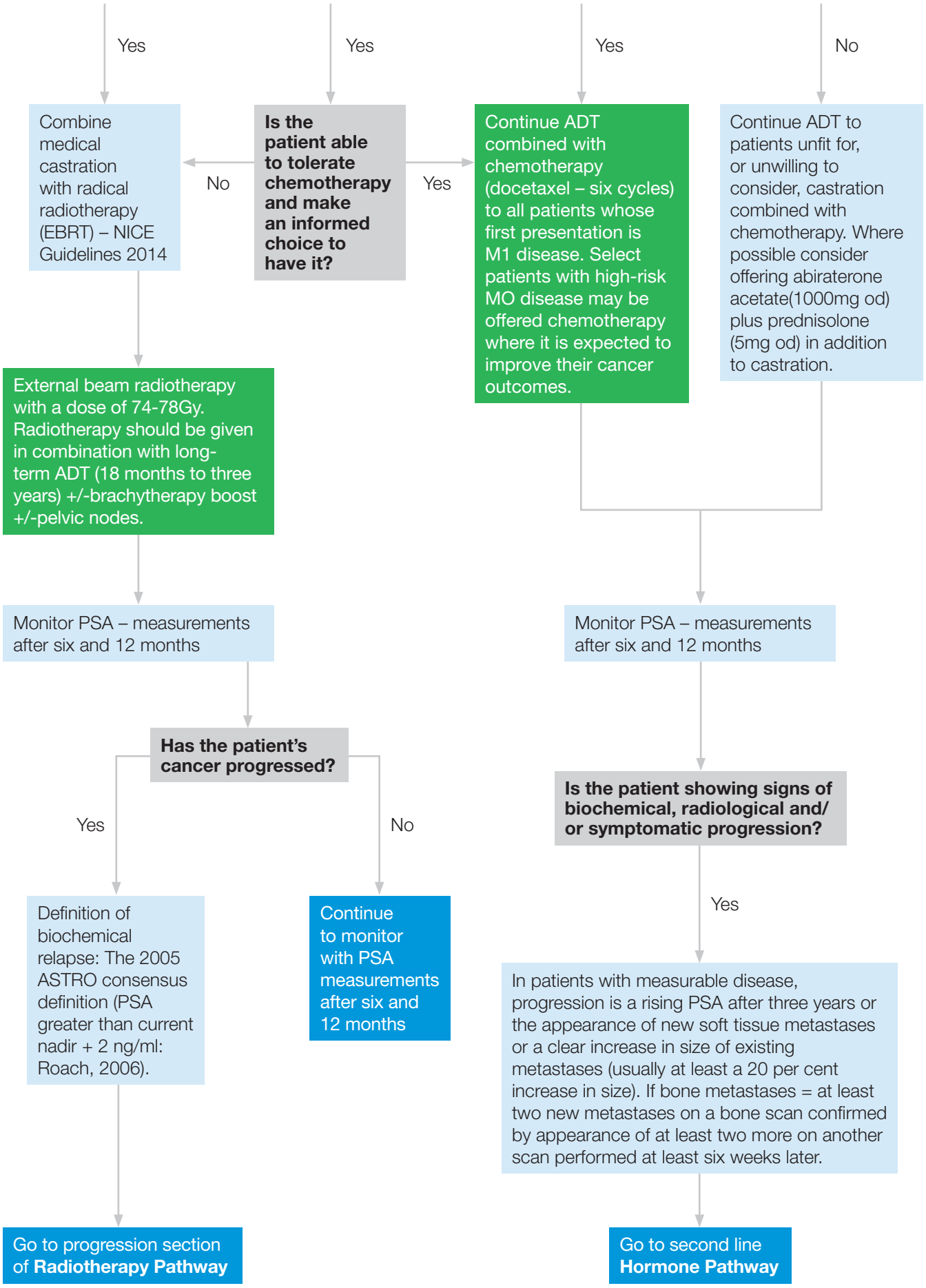


Hormone therapy (first line): Locally advanced and metastatic prostate cancer

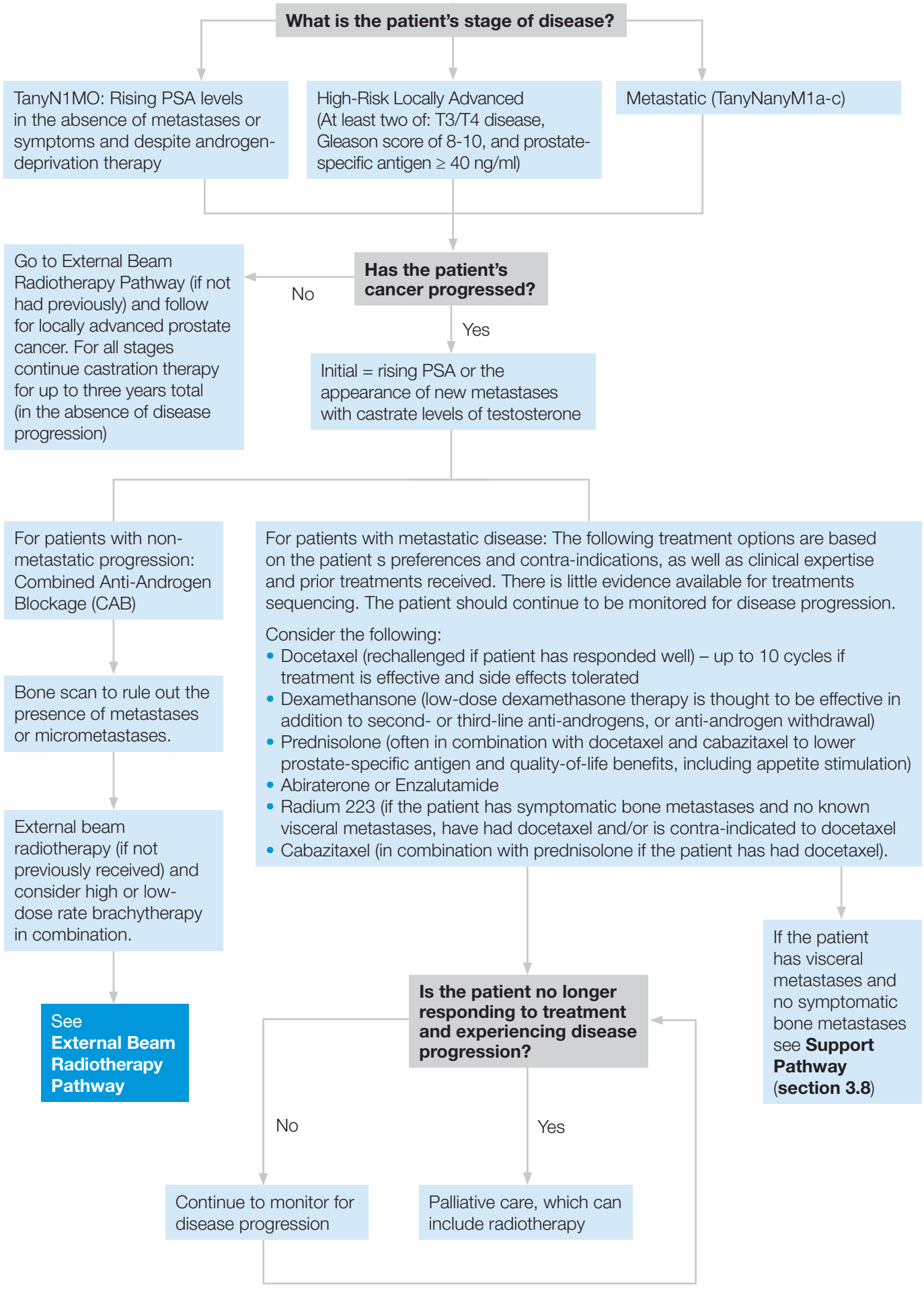


continues on next page

Hormone therapy (first line): Locally advanced and metastatic prostate cancer continued...



Hormone therapy (second line)



Chemotherapy

What is the patient's stage of disease?

High-Risk Locally Advanced (At least two of: T3/T4 disease, Gleason score of 8-10, and prostate-specific antigen 40 ng/ml).

Metastatic prostate cancer (M1)

See **Support Pathway** (**section 3.8**) for men with advanced metastatic prostate cancer.

Is the patient suitable for chemotherapy and able to make an informed choice about it as an option?

Yes

No

Offer medical **or** surgical castration (luteinising-hormone-releasing hormone [LHRH] agonist) as androgen deprivation therapy (ADT). Include co-administration of an antiandrogen to LHRHa to prevent testosterone 'flare' – one week before and three weeks after the first injection. Administer for four weeks.

Main side effect profile, mainly due to testosterone loss:

- hot flushes
- changes to sex life
- weight gain, strength and muscle loss
- loss of body hair
- bone thinning
- mood changes
- risk of heart disease, stroke and diabetes

Go to **External Beam Radiotherapy Pathway** and follow for locally advanced prostate cancer. For all stages continue castration therapy for up to three years total (in the absence of disease progression).

Does the patient have ≥ four bone metastases, including one outside the pelvis and spine or visceral metastases?

No

Go to **Radiotherapy Pathway**

Yes

Come from the **Radiotherapy Pathway**

Is the patient able to tolerate chemotherapy?

No

Yes

Continue ADT to patients unfit for, or unwilling to consider, castration combined with chemotherapy. Where possible consider offering abiraterone acetate (1000mg od) plus prednisolone (5mg od) in addition to castration.

Continue ADT combined with chemotherapy (docetaxel – six cycles) to all patients whose first presentation is M1 disease. Select patients with high-risk MO disease may be offered chemotherapy where it is expected to improve their cancer outcomes.

Optimal treatment.
James ND, Spears MR, Clarke NW, Dearnaley DP, Mason MD, Parker CC, et al. Failure-Free Survival and Radiotherapy in Patients With Newly Diagnosed Nonmetastatic Prostate Cancer: Data From Patients in the Control Arm of the STAMPEDE Trial. JAMA Oncol. 2016 Mar 1;2(3):348.

Monitor PSA – measurements after six and 12 months

continues on next page

Chemotherapy continued...