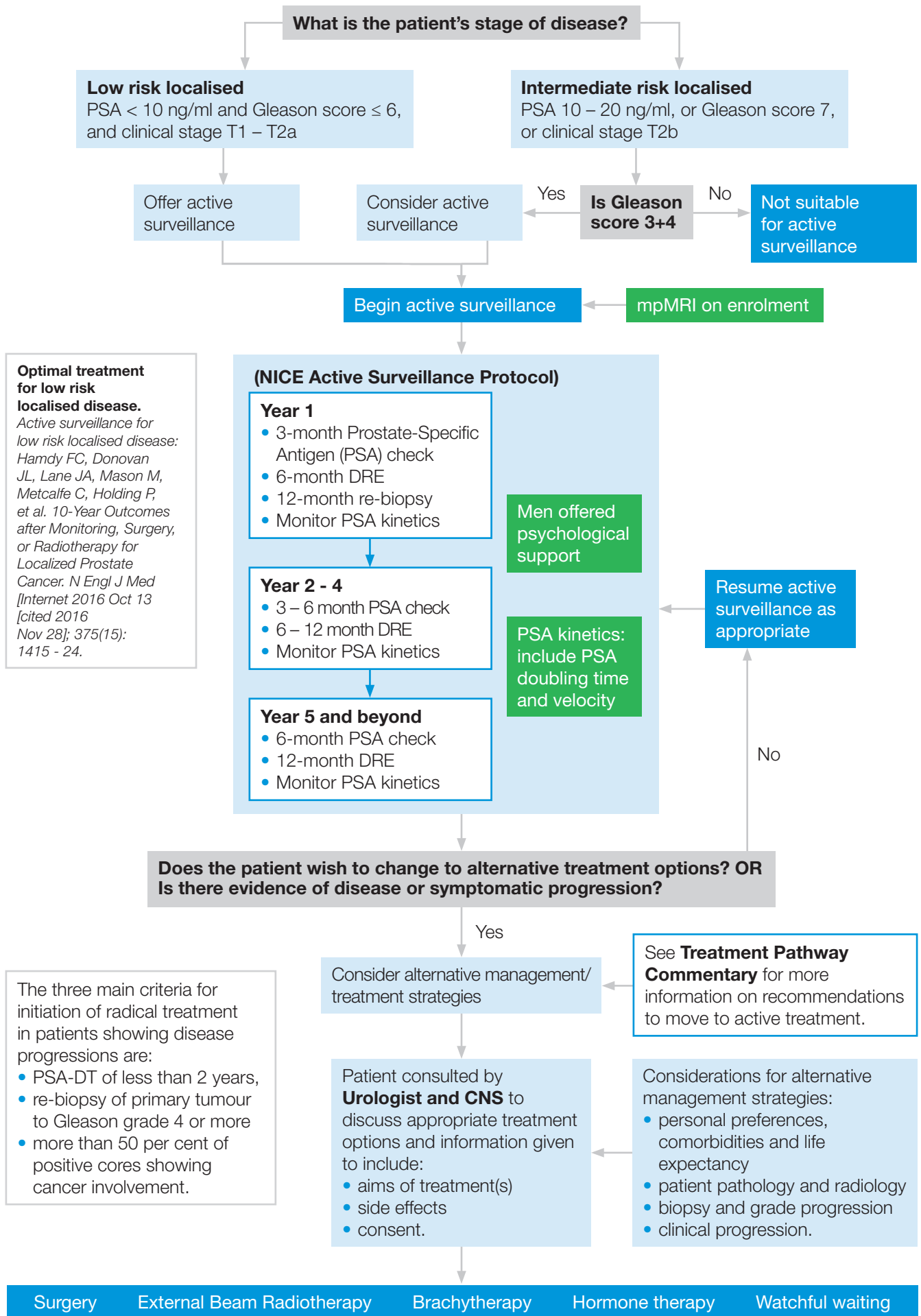


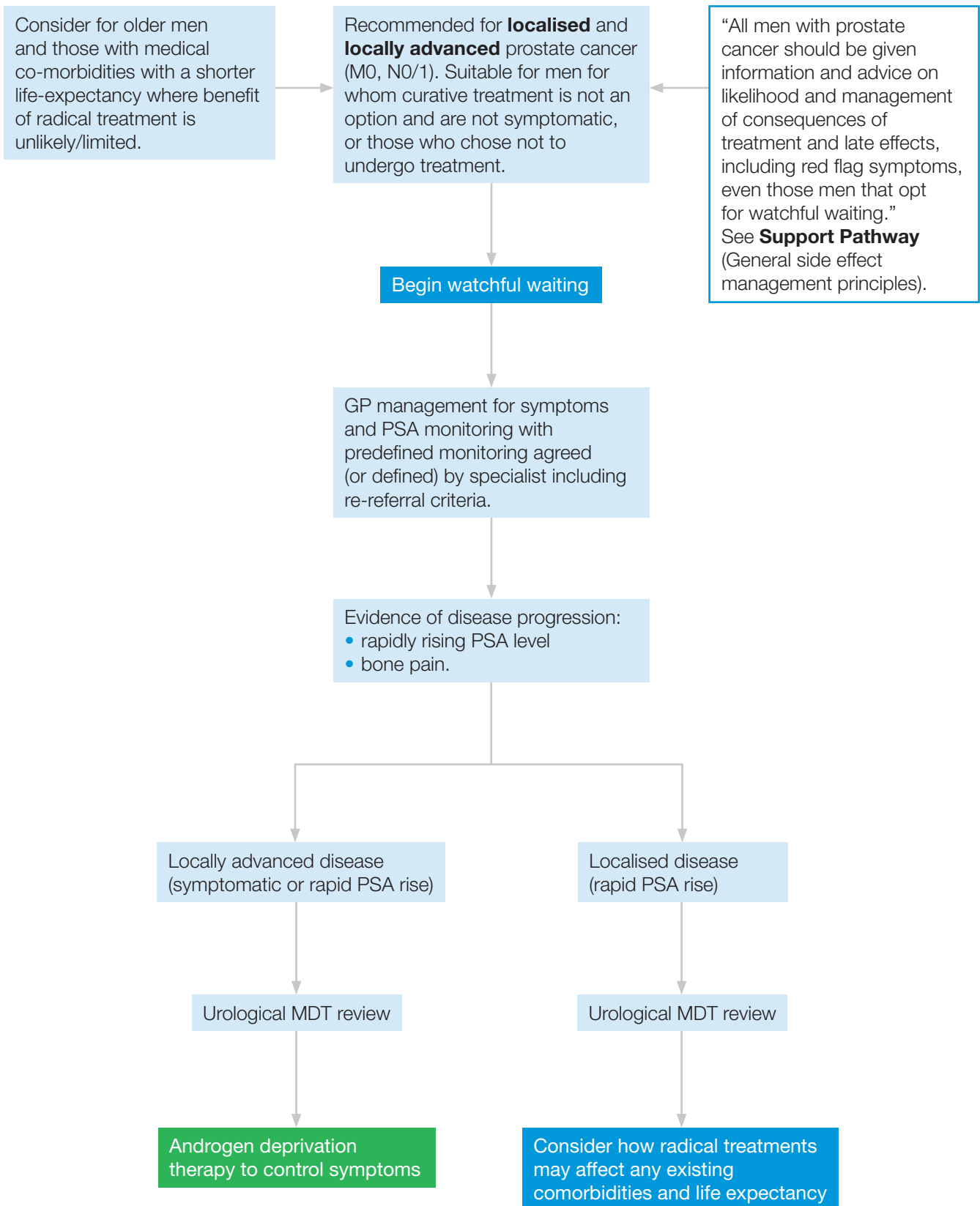
Prostate Cancer UK's Best Practice Pathway

TREATMENT

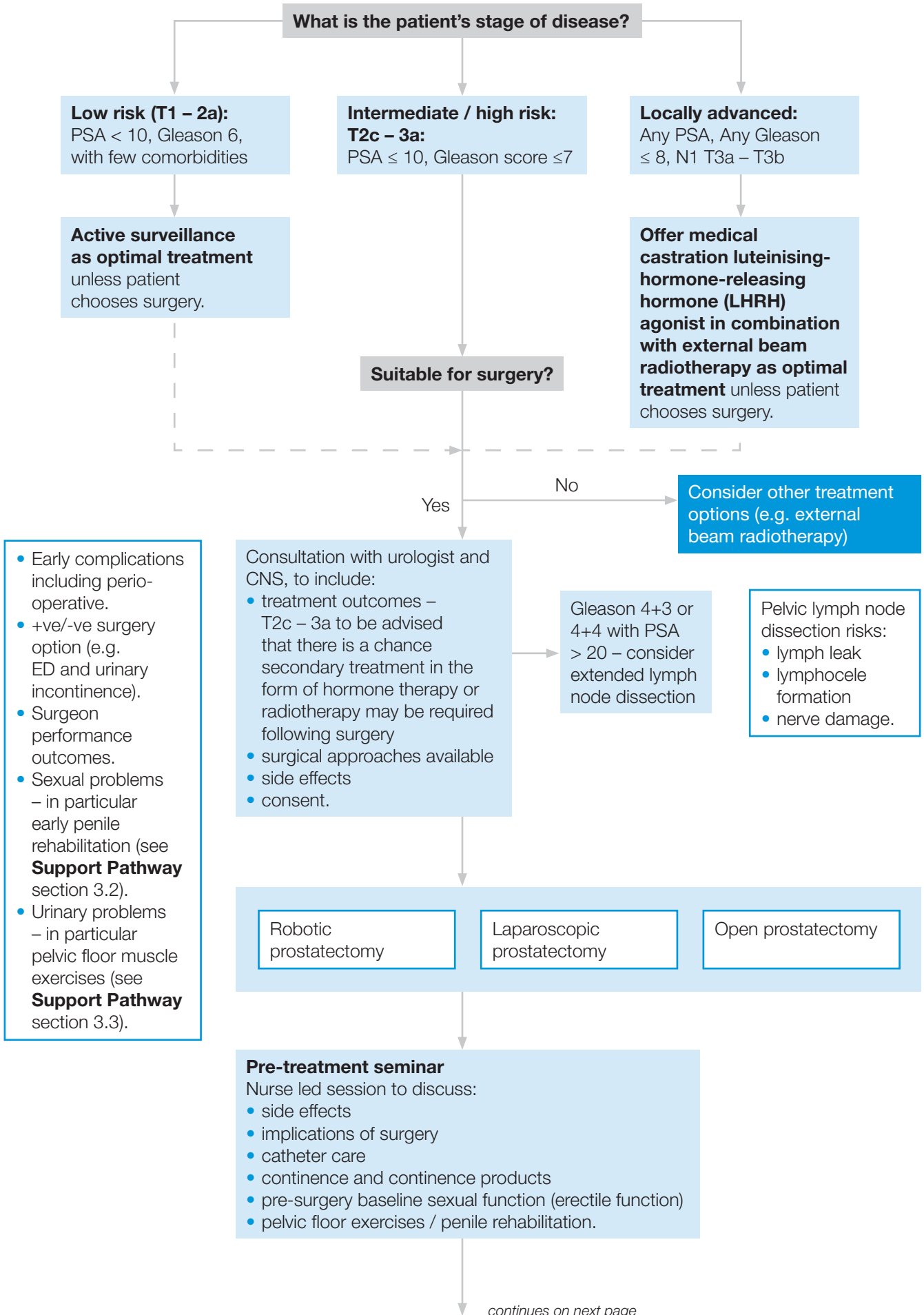
Active surveillance



Watchful waiting



Surgery – radical prostatectomy



- Early complications including peri-operative.
- +ve/-ve surgery option (e.g. ED and urinary incontinence).
- Surgeon performance outcomes.
- Sexual problems – in particular early penile rehabilitation (see **Support Pathway** section 3.2).
- Urinary problems – in particular pelvic floor muscle exercises (see **Support Pathway** section 3.3).

Consultation with urologist and CNS, to include:

- treatment outcomes – T2c – 3a to be advised that there is a chance secondary treatment in the form of hormone therapy or radiotherapy may be required following surgery
- surgical approaches available
- side effects
- consent.

Gleason 4+3 or 4+4 with PSA > 20 – consider extended lymph node dissection

Pelvic lymph node dissection risks:

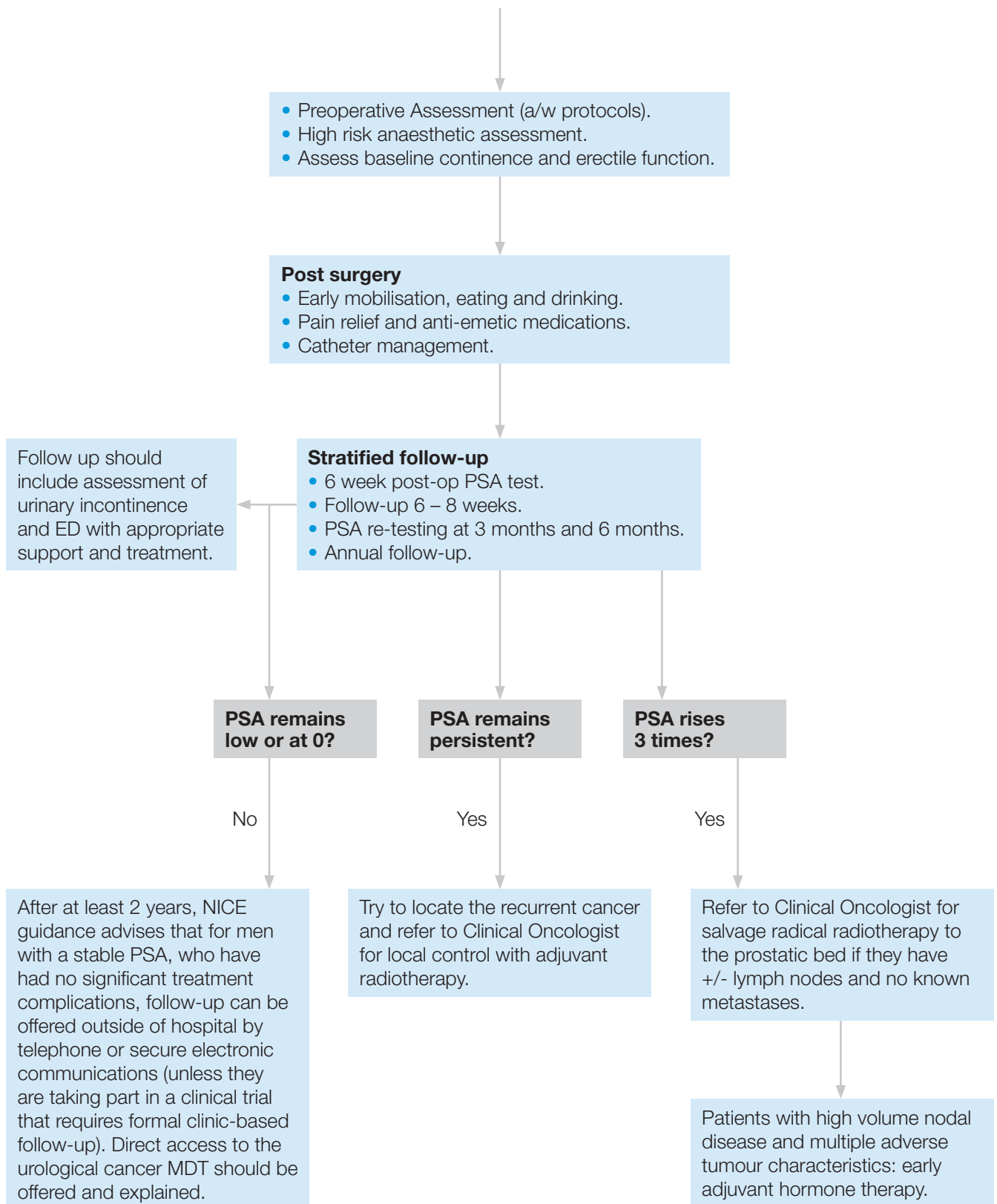
- lymph leak
- lymphocele formation
- nerve damage.

Robotic prostatectomy Laparoscopic prostatectomy Open prostatectomy

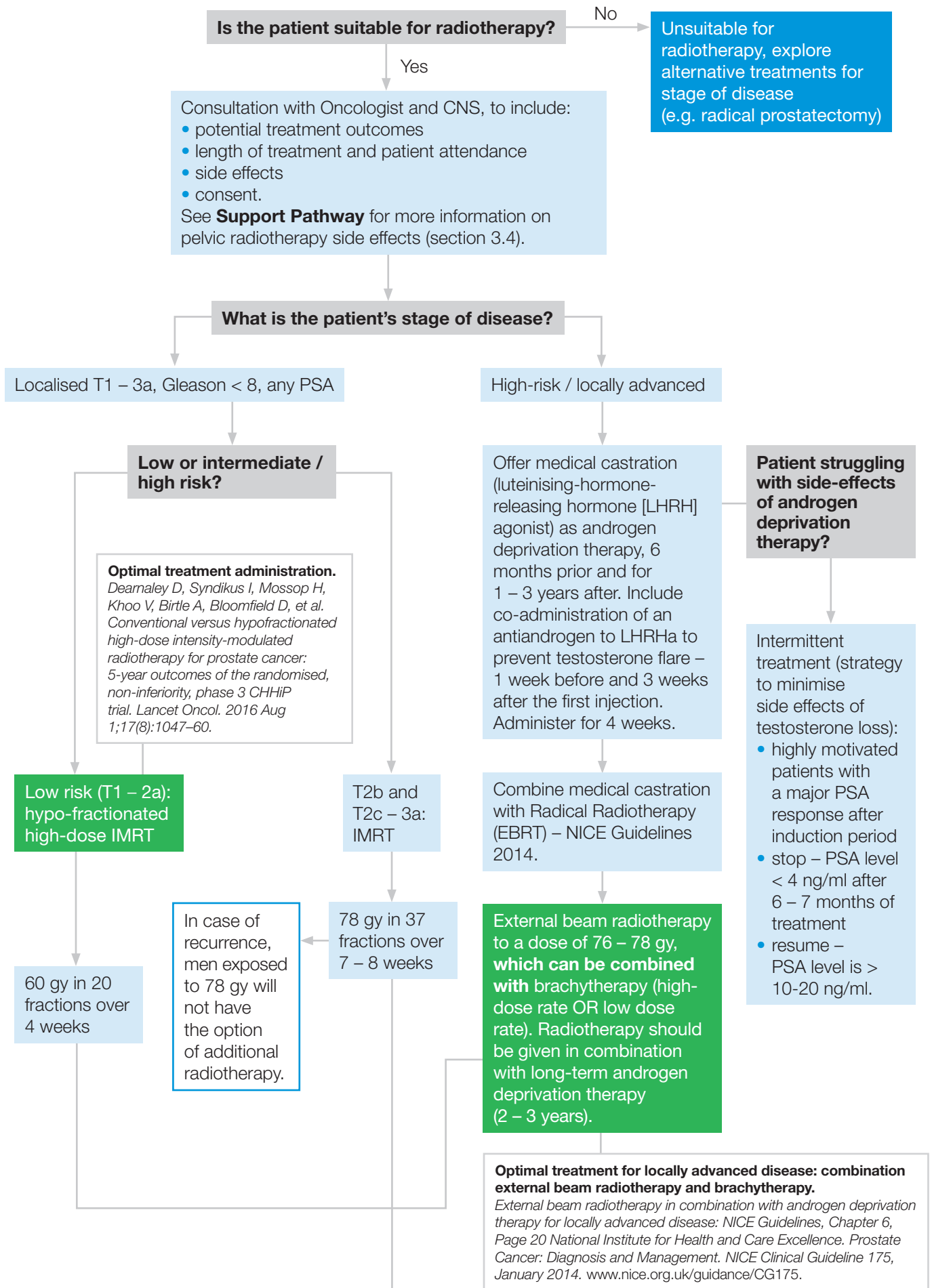
Pre-treatment seminar
Nurse led session to discuss:

- side effects
- implications of surgery
- catheter care
- continence and continence products
- pre-surgery baseline sexual function (erectile function)
- pelvic floor exercises / penile rehabilitation.

Surgery – radical prostatectomy continued...

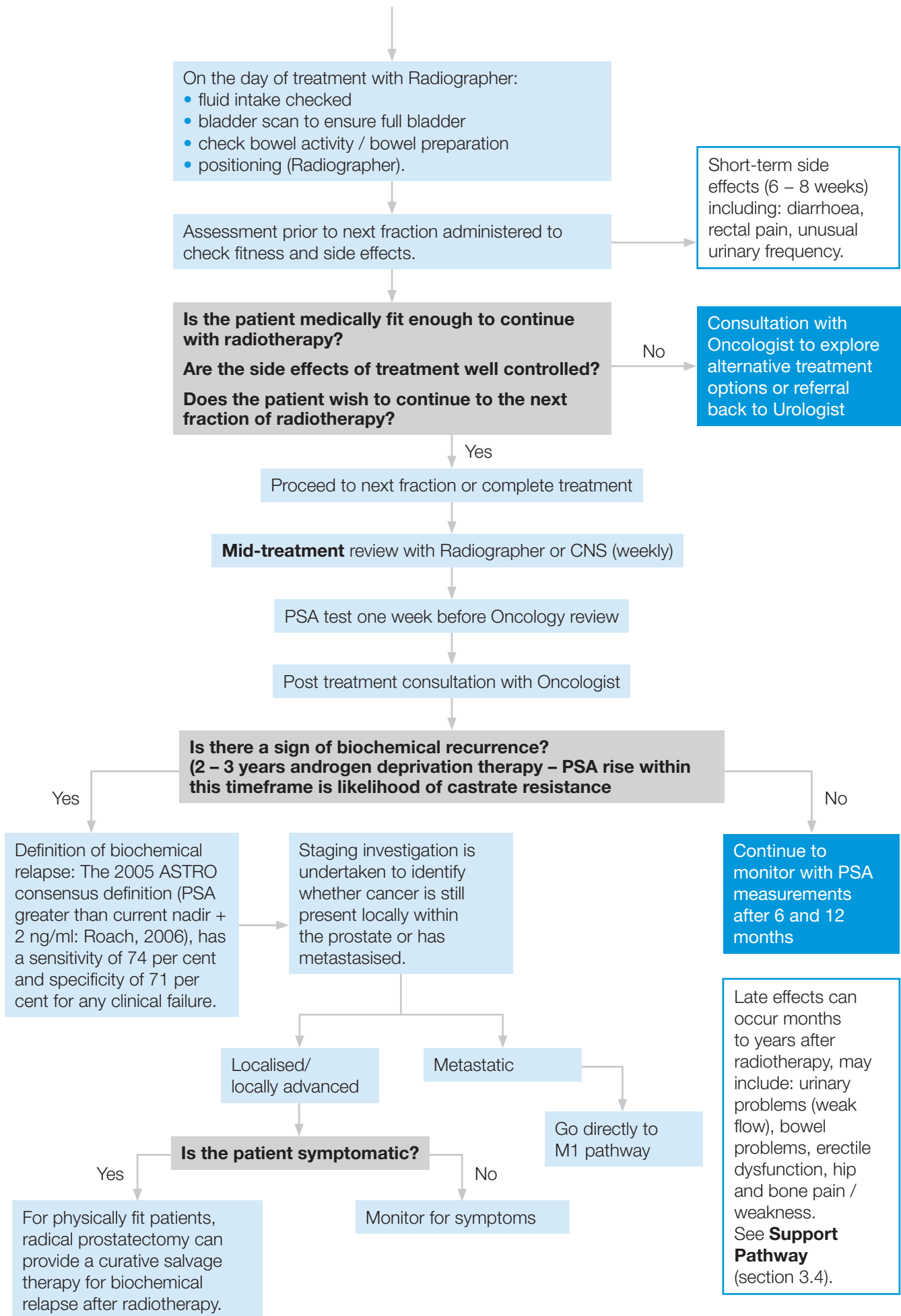


External beam radiotherapy (EBRT)



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External beam radiotherapy (EBRT) continued...



Brachytherapy

See **Support Pathway** (for more information on pelvic radiotherapy side effects (section 3.4).

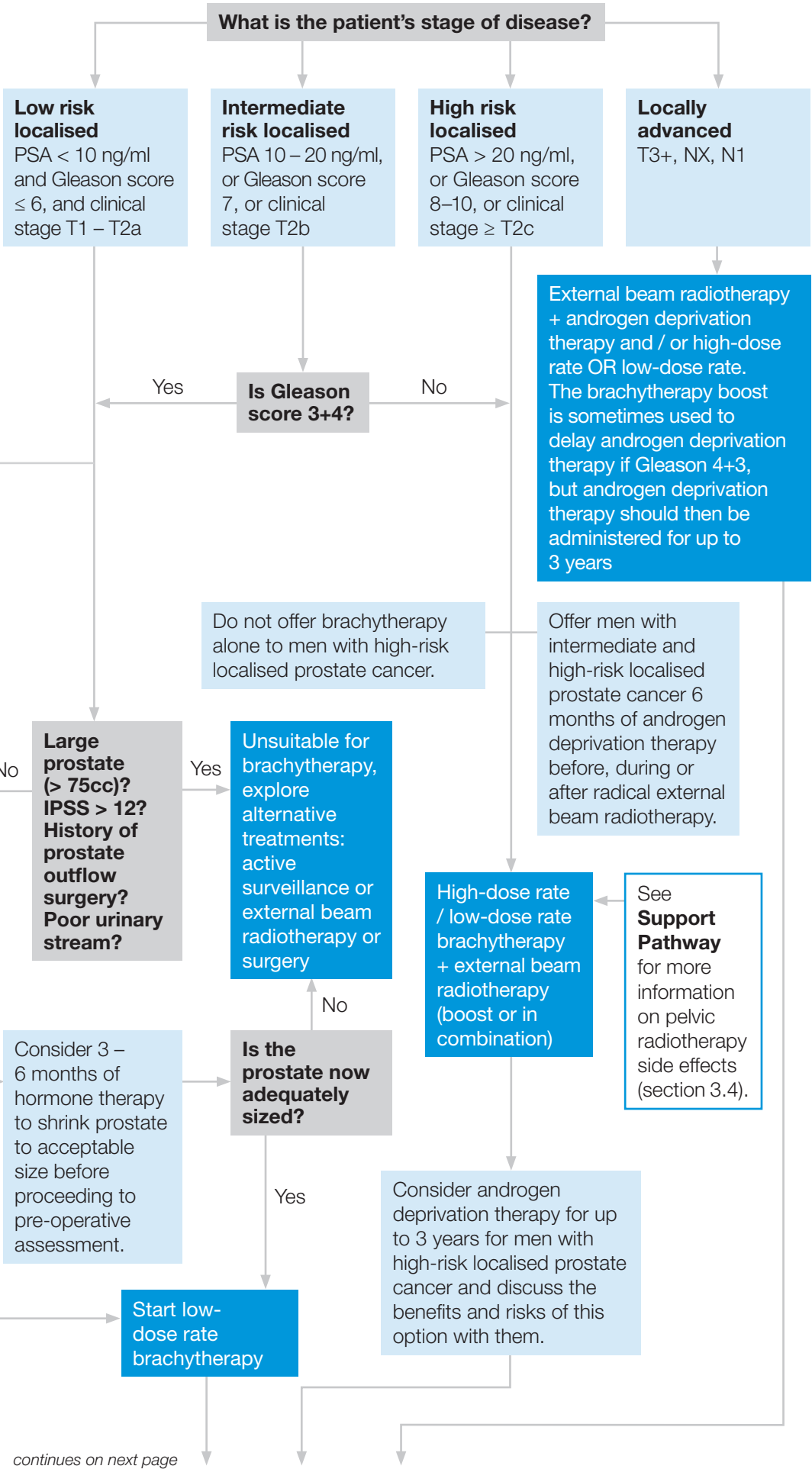
Treatment considerations:

- recovery time is often quicker than other treatment options (day case setting)
- general/spinal anaesthetic
- reduced long-term risk of urinary incontinence
- reduced hospital attendances related to treatment.

Planning session in theatre; volume study – with estimate based on MRI.

Is the prostate less than 60cc?

Yes
Same day



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Brachytherapy continued...

Stratified follow-up

- Initial follow-up 4 – 6 weeks.
- PSA testing and subsequent follow-up (for men not on androgen deprivation therapy):
 - Year 1: every 3 months
 - Years 2 – 5: every 6 months
 - Years 6+: every 12 months
 - Men on androgen deprivation therapy will have their PSA levels suppressed for up to 3 years
- Ensure effective short-term side-effect support.
- Ensure support for late-effects.

**Is there a sign of biochemical recurrence?
(2 – 3 years androgen deprivation therapy – PSA rise within this timeframe is likelihood of castrate resistance)**

Yes

No

Definition of biochemical relapse: The 2005 ASTRO consensus definition (PSA greater than current nadir + 2 ng/ml: Roach, 2006), has a sensitivity of 74 per cent and specificity of 71 per cent for any clinical failure.

Staging investigation is undertaken to identify whether cancer is still present locally within the prostate or has metastasised.

Continue to monitor with PSA measurements after 6 and 12 months

Localised/
locally advanced

Metastatic

Is the patient symptomatic?

Go directly to M1 pathway

Yes

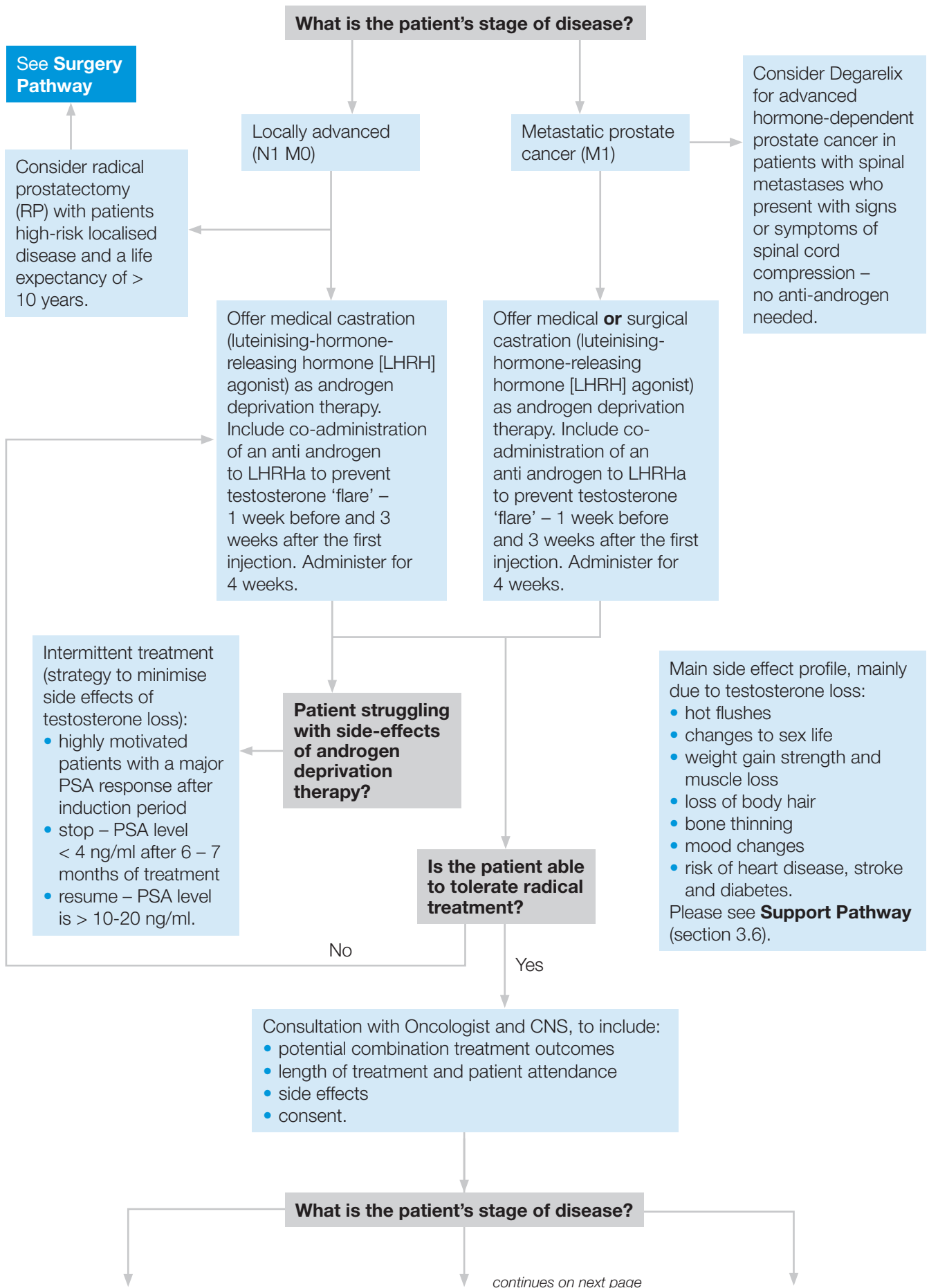
No

For physically fit patients, radical prostatectomy can provide a curative salvage therapy for biochemical relapse after radiotherapy.

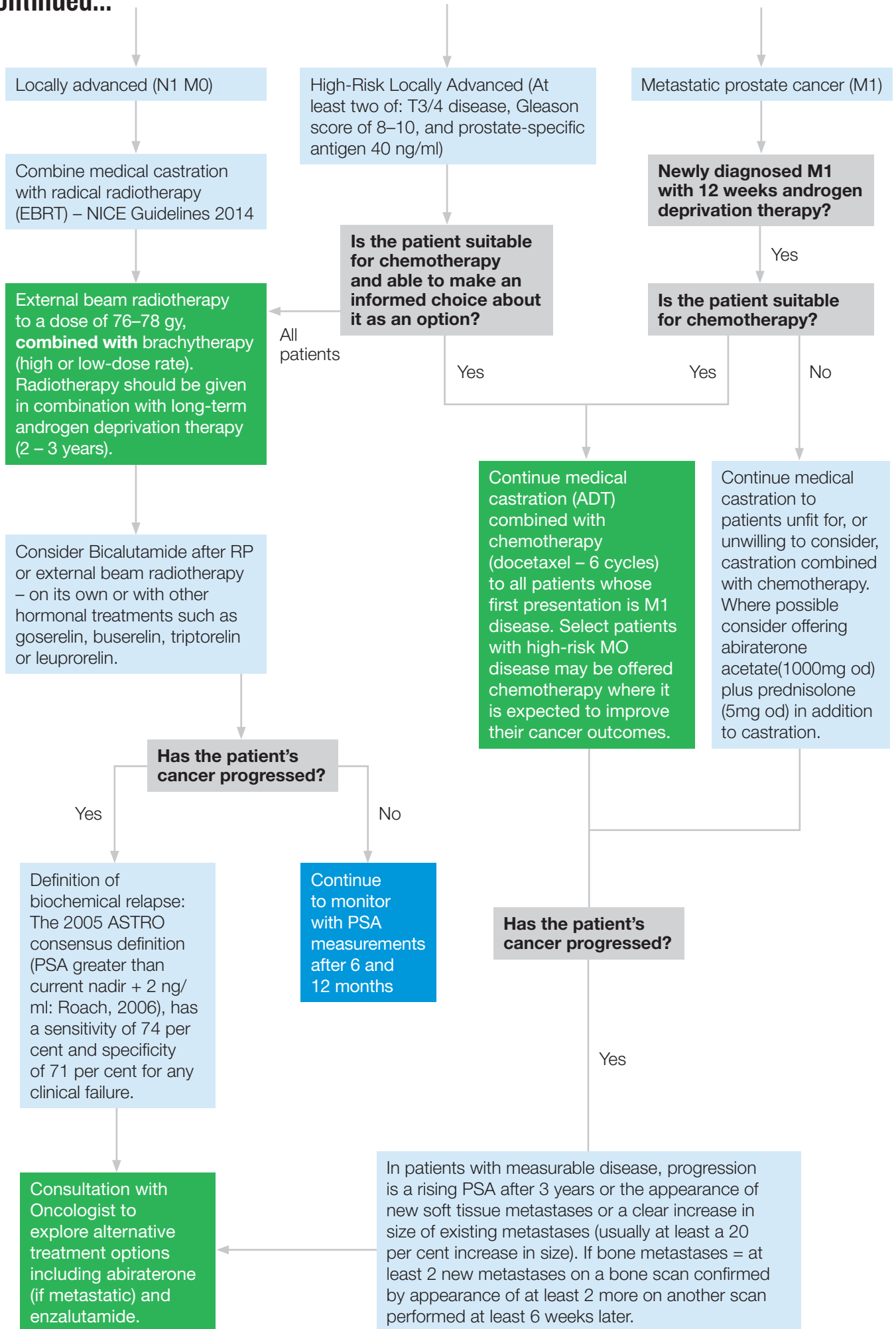
Monitor for symptoms

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

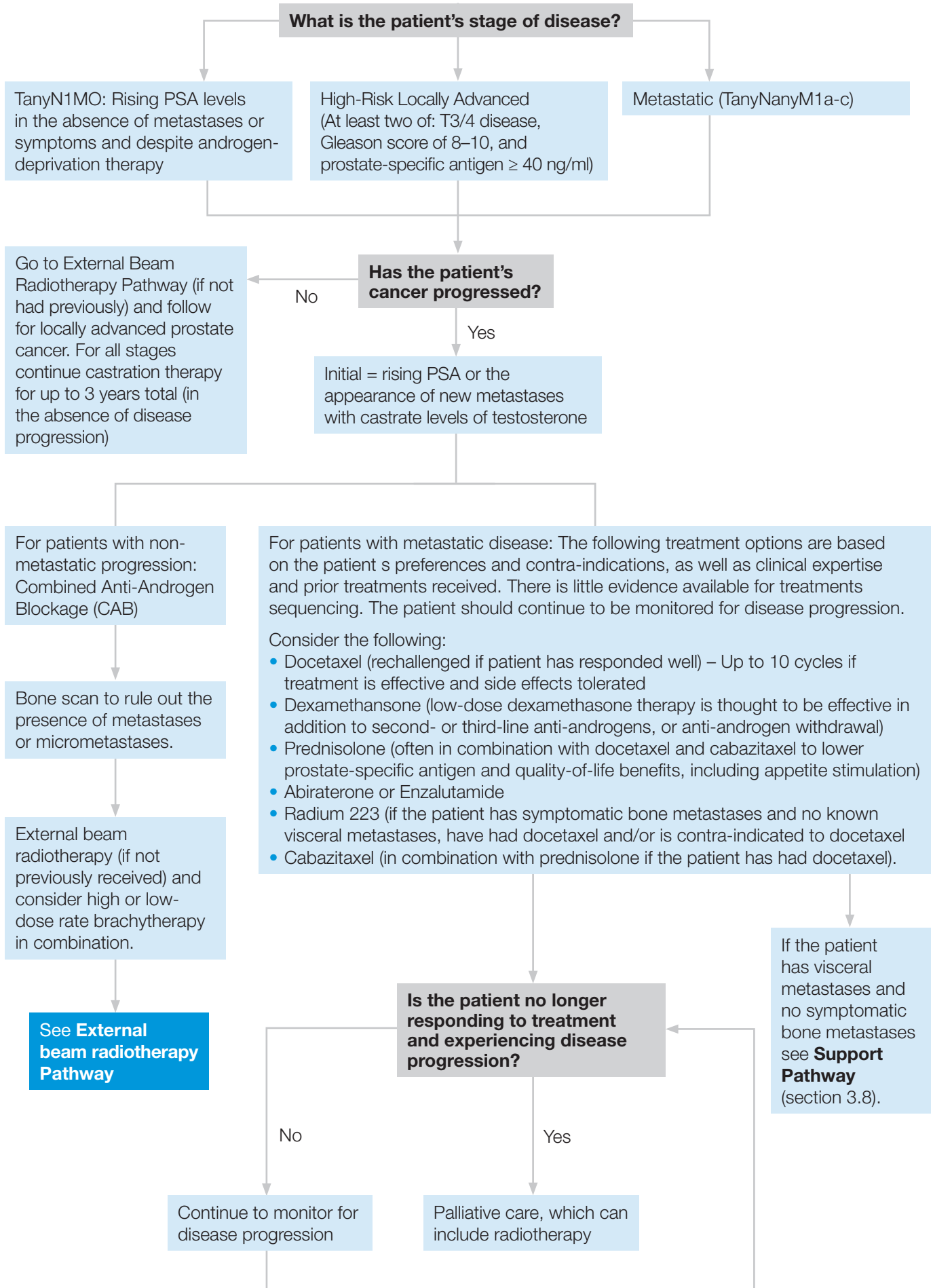
Hormone therapy (first line): locally advanced and metastatic prostate cancer



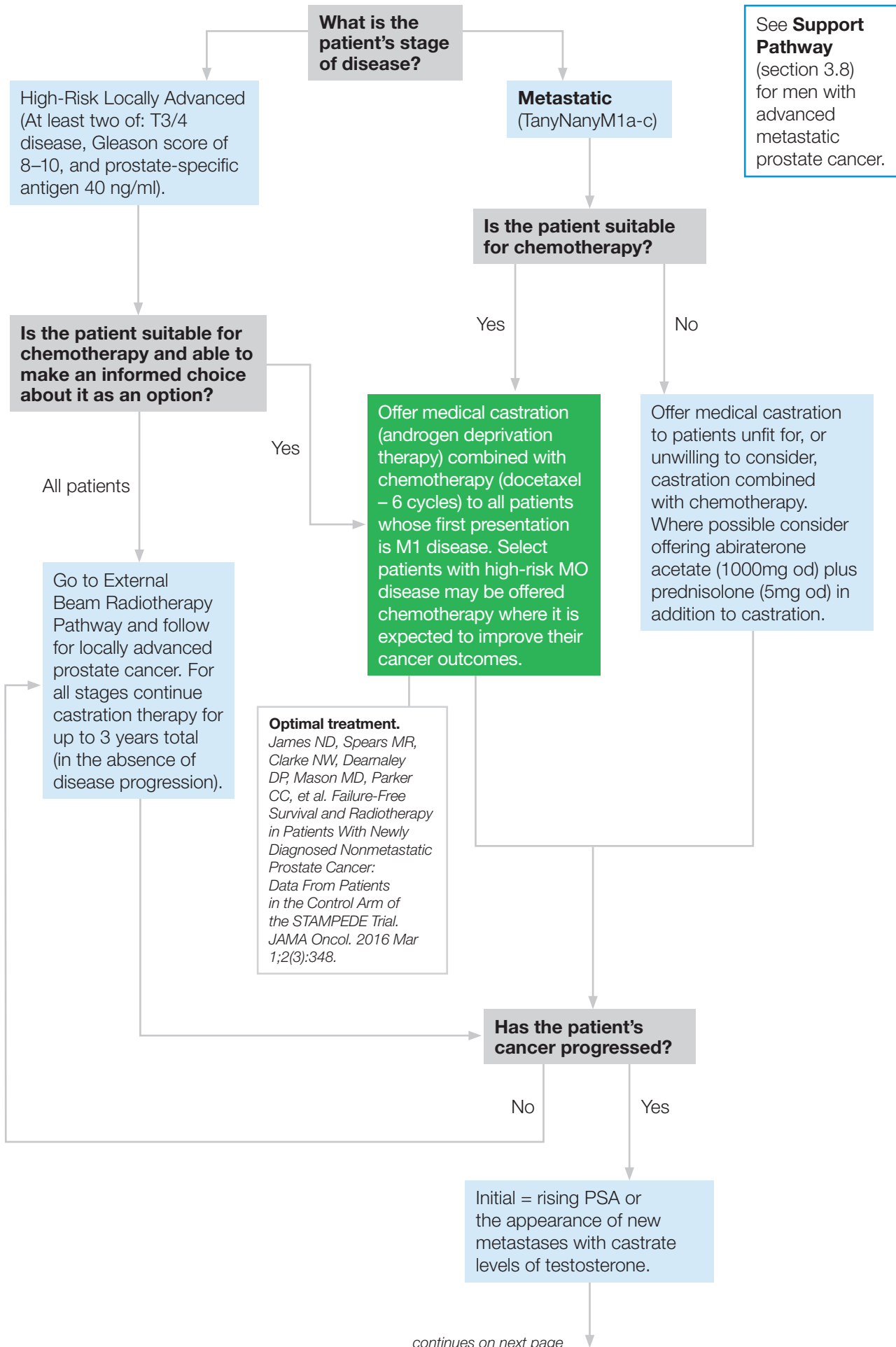
Hormone therapy (first line): locally advanced and metastatic prostate cancer continued...



Hormone therapy (second line)



Chemotherapy



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Chemotherapy continued...

If the patient has visceral metastases and no symptomatic bone metastases see **Support Pathway** (section 3.8).

For patients with metastatic disease: The following treatment options are based on the patient's preferences and contra-indications, as well as clinical expertise and prior treatments received. There is little evidence available for treatments sequencing. The patient should continue to be monitored for disease progression.

Consider the following:

- Docetaxel (rechallenged if patient has responded well) – Up to 10 cycles if treatment is effective and side effects tolerated
- Dexamethasone (low-dose dexamethasone therapy is thought to be effective in addition to second- or third-line anti-androgens, or anti-androgen withdrawal)
- Prednisolone (often in combination with docetaxel and cabazitaxel to lower prostate-specific antigen and quality-of-life benefits, including appetite stimulation)
- Abiraterone or Enzalutamide
- Radium 223 (if the patient has symptomatic bone metastases and no known visceral metastases, have had docetaxel and/or is contra-indicated to docetaxel)
- Cabazitaxel (in combination with prednisolone if the patient has had docetaxel).

