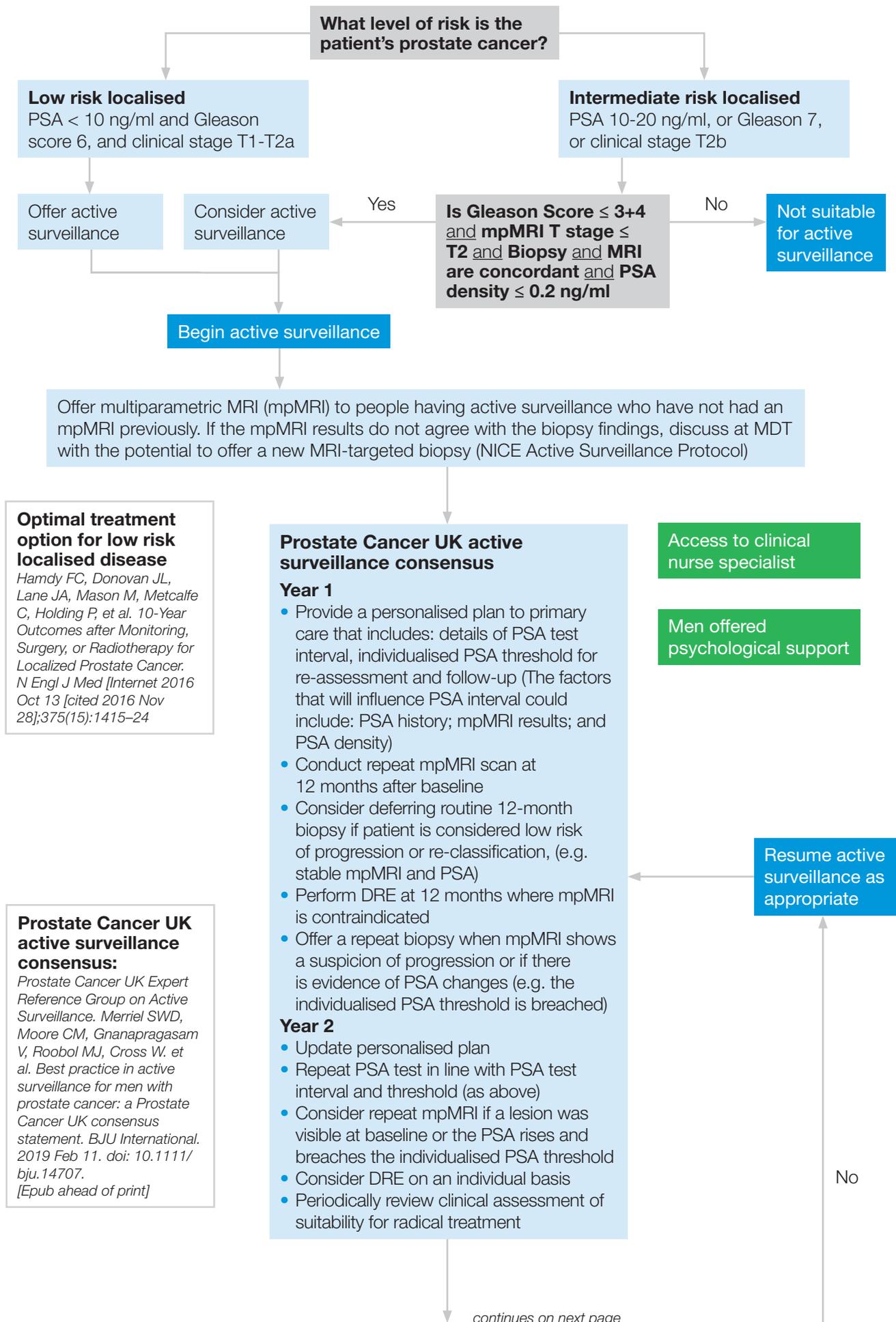


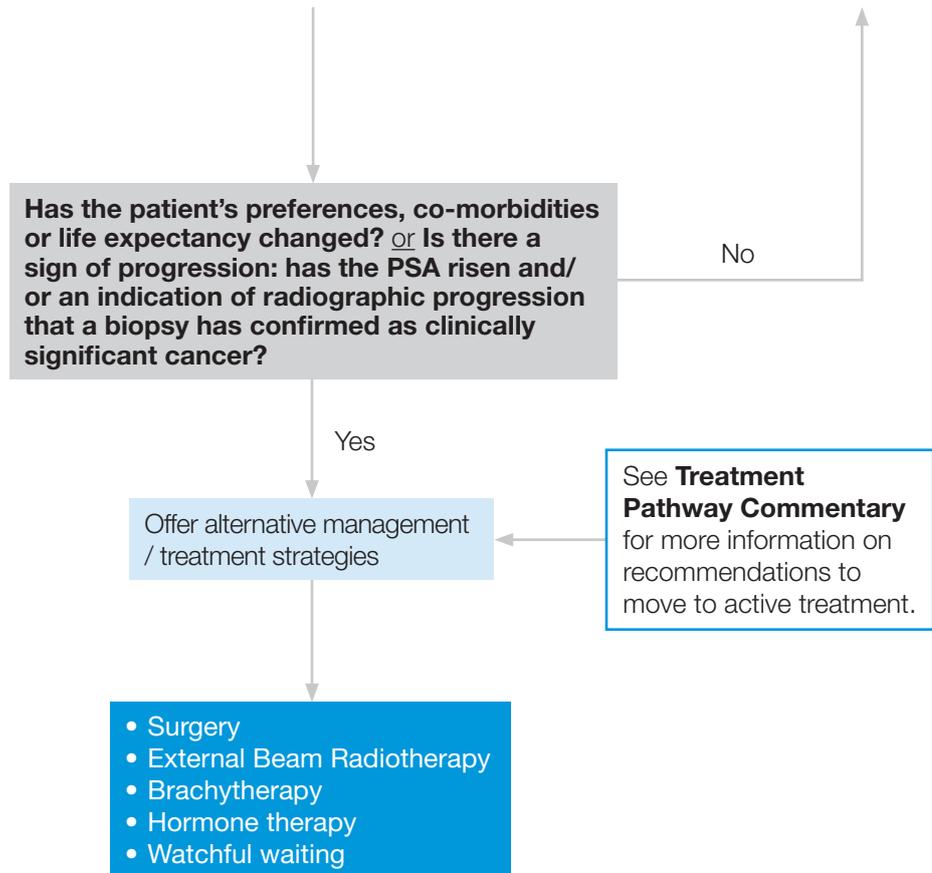
Prostate Cancer UK's Best Practice Pathway

TREATMENT

Active surveillance



Active surveillance continued...



Watchful waiting

Consider for older men and those with medical co-morbidities with a shorter life-expectancy where benefit of radical treatment is unlikely/limited.

Recommended for **localised** and **locally advanced** prostate cancer (M0, N0/1). Suitable for men for whom curative treatment is not an option and are not symptomatic, or those who chose not to undergo treatment.

“All men with prostate cancer should be given information and advice on likelihood and management of consequences of treatment and late effects, including red flag symptoms, even those men that opt for watchful waiting.”
See **Support Pathway (General side effect management principles)**.

Begin watchful waiting

GP management for symptoms and PSA monitoring with predefined monitoring agreed (or defined) by specialist including re-referral criteria.

Evidence of disease progression:

- rapidly rising PSA level
- bone pain.

Locally advanced disease (symptomatic or rapid PSA rise)

Localised disease (rapid PSA rise)

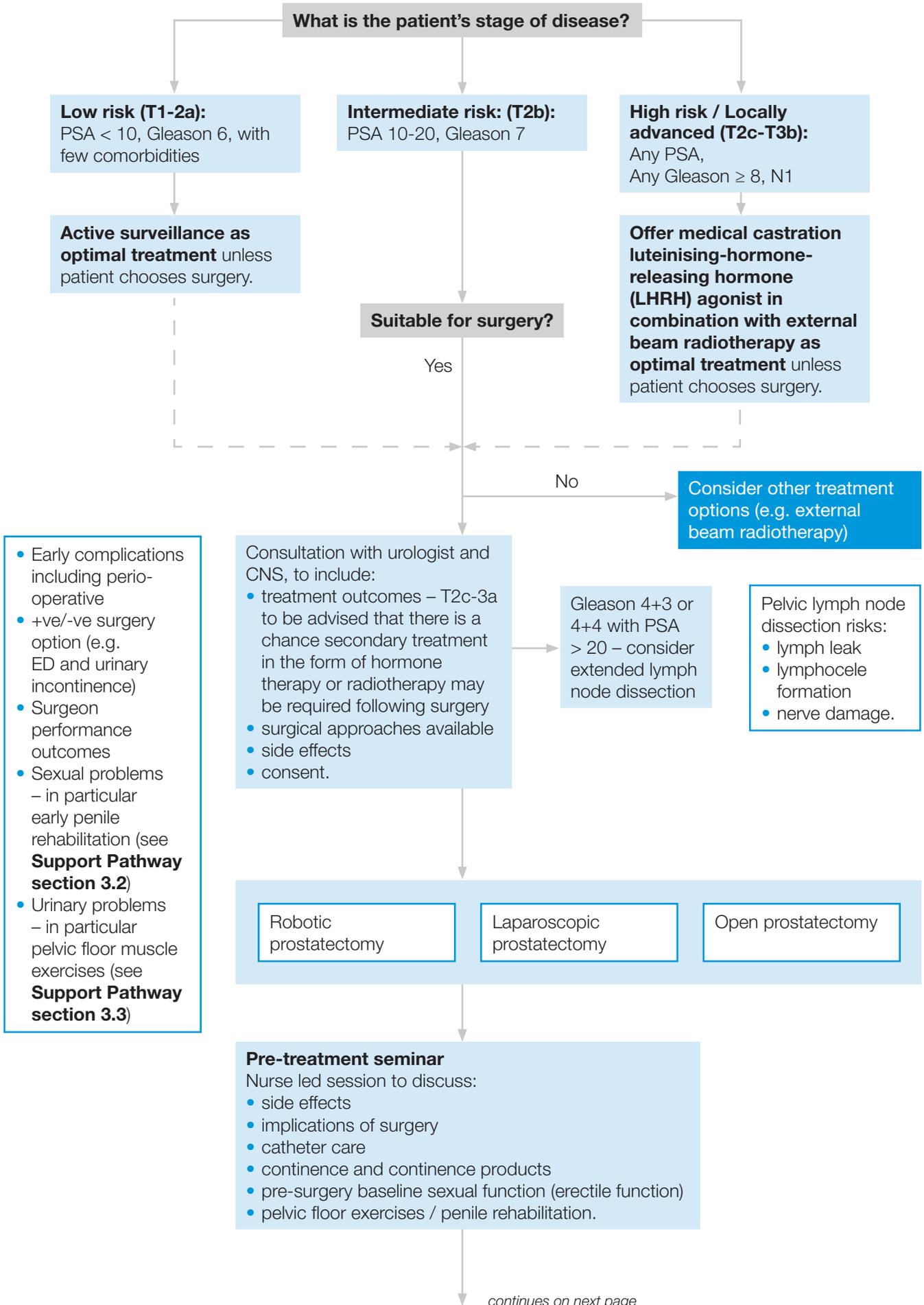
Urological MDT review

Urological MDT review

Androgen deprivation therapy to control symptoms

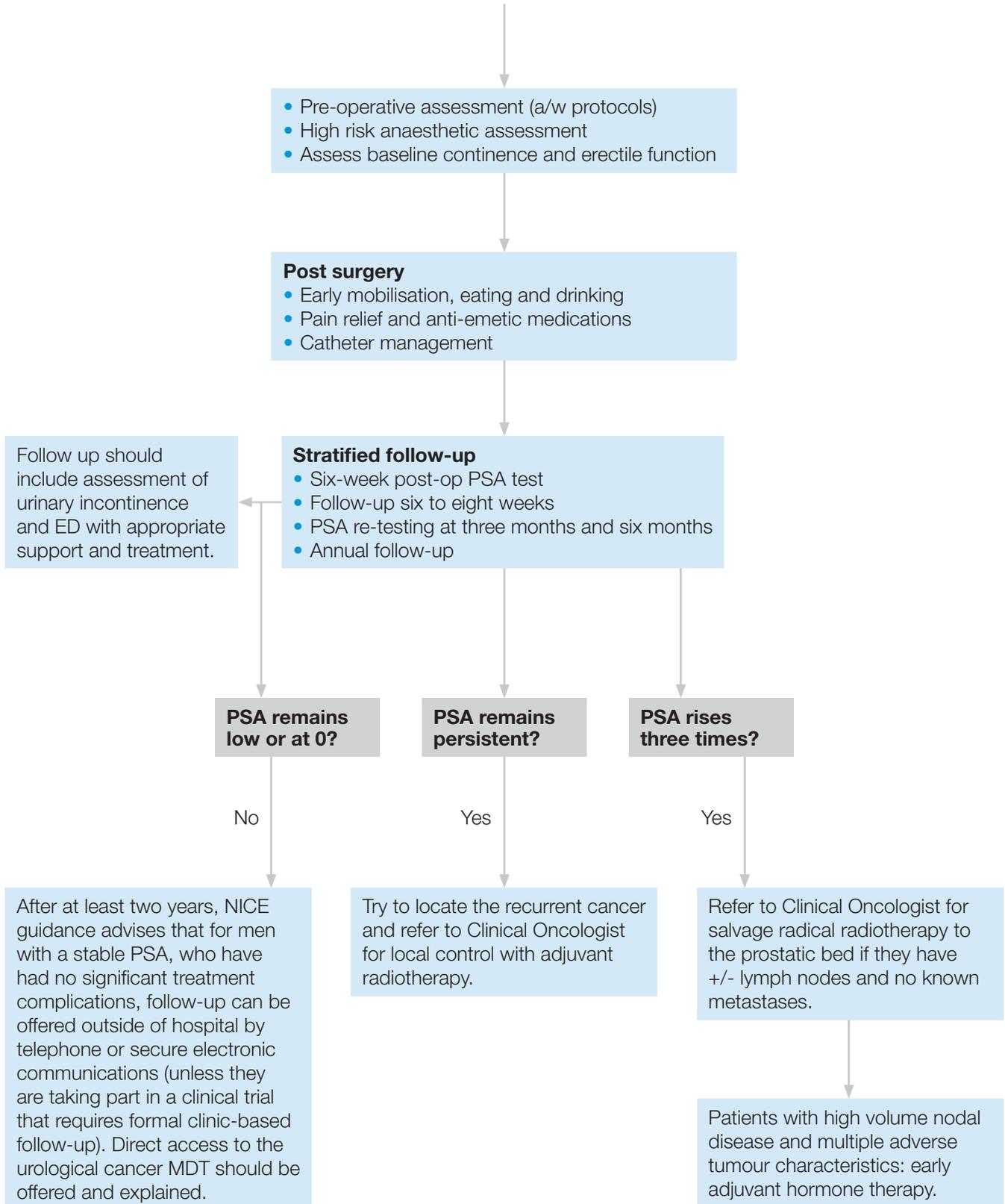
Consider how radical treatments may affect any existing comorbidities and life expectancy

Surgery – radical prostatectomy

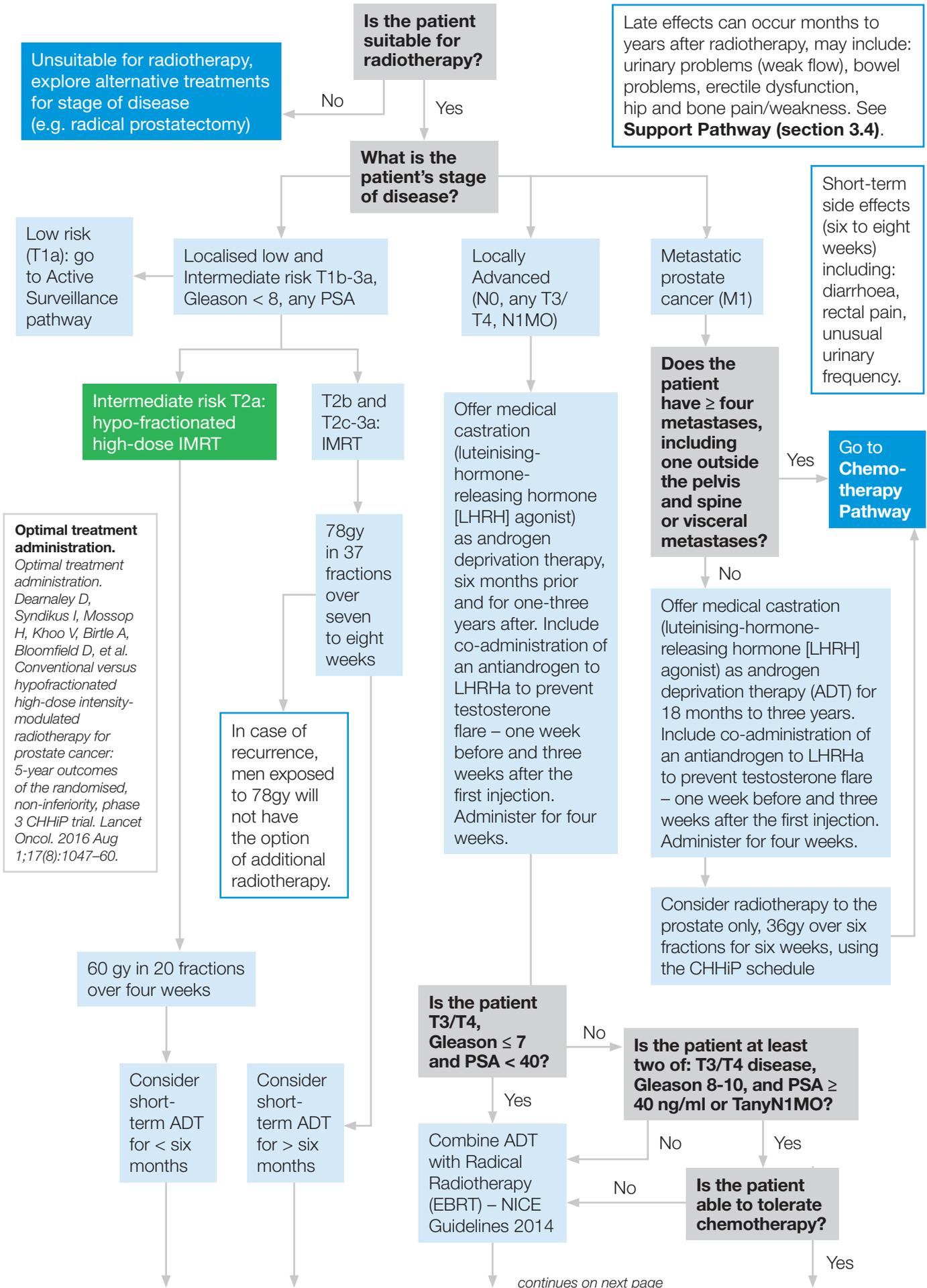


- Early complications including peri-operative
- +ve/-ve surgery option (e.g. ED and urinary incontinence)
- Surgeon performance outcomes
- Sexual problems – in particular early penile rehabilitation (see **Support Pathway section 3.2**)
- Urinary problems – in particular pelvic floor muscle exercises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

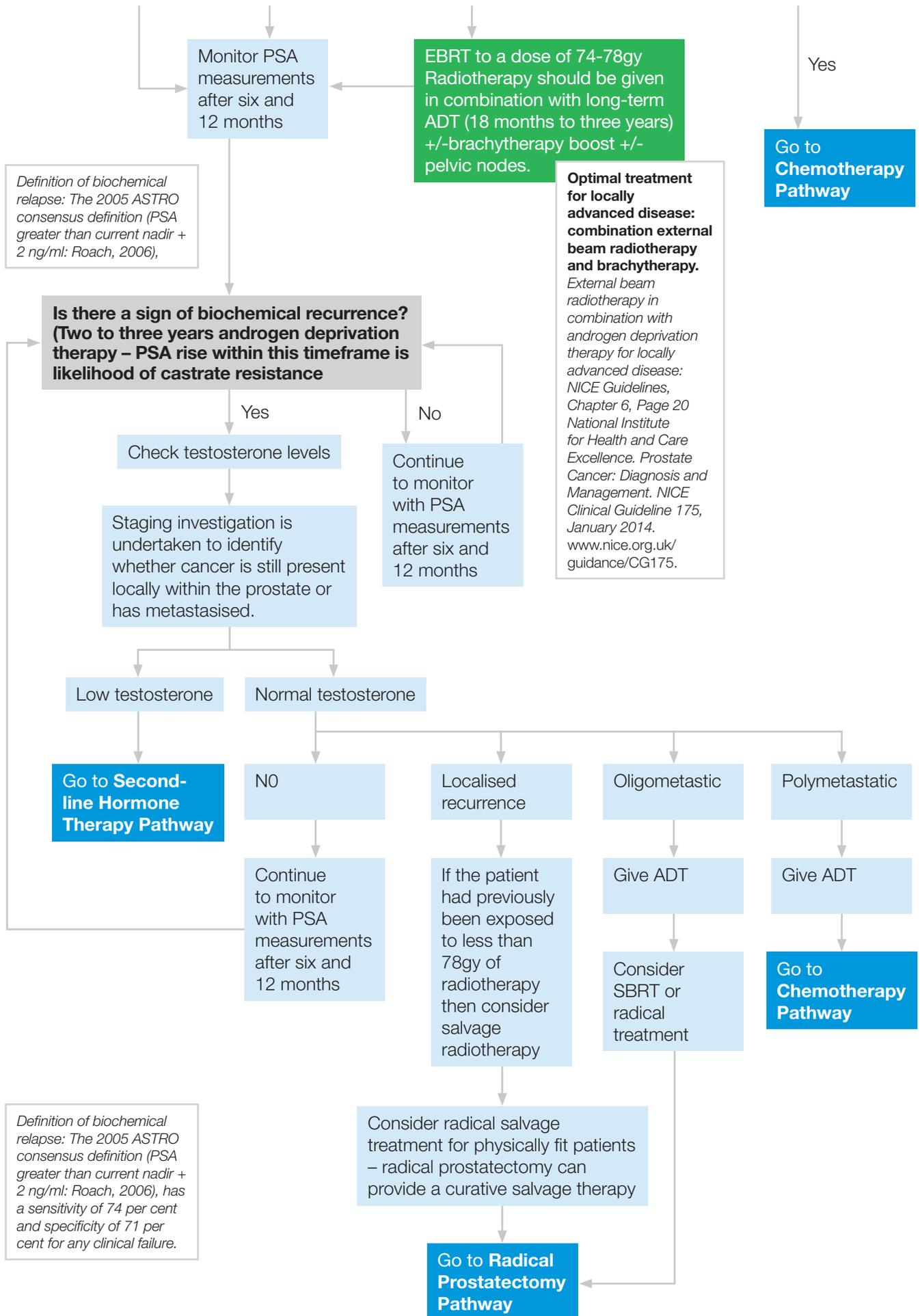
Surgery – radical prostatectomy continued...



External beam radiotherapy (EBRT)



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

No
Consider three to six months of hormone therapy to shrink prostate to acceptable size before proceeding to pre-operative assessment.

Is the prostate now adequately sized?

Yes
Start low-dose rate brachytherapy

Low risk localised
PSA < 10 ng/ml and Gleason score ≤ 6, and clinical stage T1-T2a

Intermediate risk localised
PSA 10-20 ng/ml, or Gleason score 7, or clinical stage T2b

High risk localised
PSA > 20 ng/ml, or Gleason score 8-10, or clinical stage ≥ T2c

Locally advanced
T3+, NX, N1

What is the patient's stage of disease?

Is Gleason score 3+4?

Yes

No

External beam radiotherapy + androgen deprivation therapy and / or high-dose rate or low-dose rate. The brachytherapy boost is sometimes used to delay androgen deprivation therapy if Gleason 4+3, but androgen deprivation therapy should then be administered for up to three years.

Do not offer brachytherapy alone to men with high-risk localised prostate cancer.

Offer men with intermediate and high-risk localised prostate cancer six months of androgen deprivation therapy before, during or after radical external beam radiotherapy.

Large prostate (> 75cc)? IPSS > 12? History of prostate outflow surgery? Poor urinary stream?

No

Yes

Unsuitable for brachytherapy, explore alternative treatments: active surveillance or external beam radiotherapy or surgery

No

High-dose rate / low-dose rate brachytherapy + external beam radiotherapy (boost or in combination)

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

Consider androgen deprivation therapy for up to three years for men with high-risk localised prostate cancer and discuss the benefits and risks of this option with them.

continues on next page

Brachytherapy continued...

Stratified follow-up

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

Is there a sign of biochemical recurrence? (Two-three 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 six and 12 months

Localised / locally advanced

Metastatic

Is the patient symptomatic?

Go directly to M1 pathway

Yes

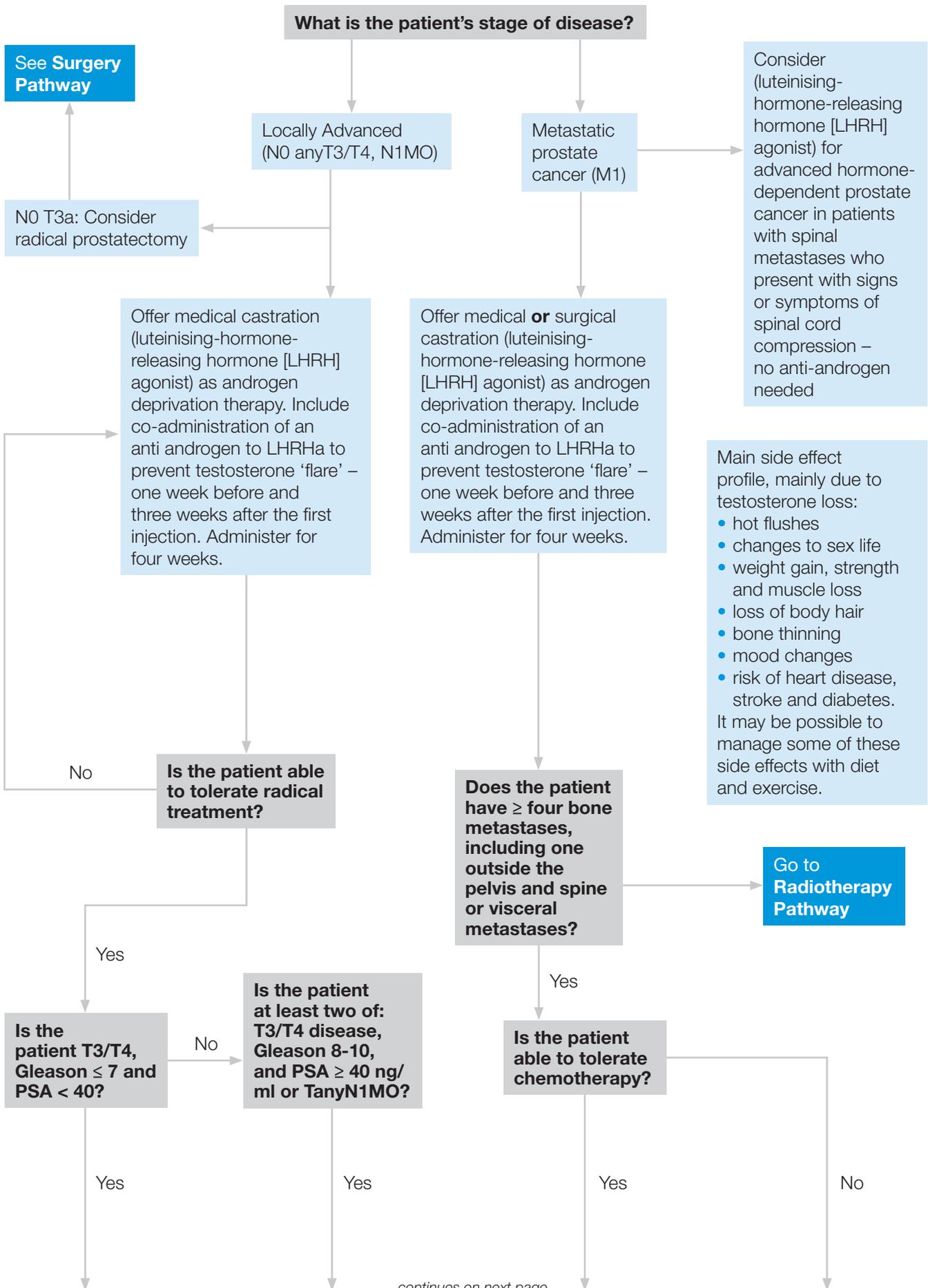
No

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

Monitor for symptoms

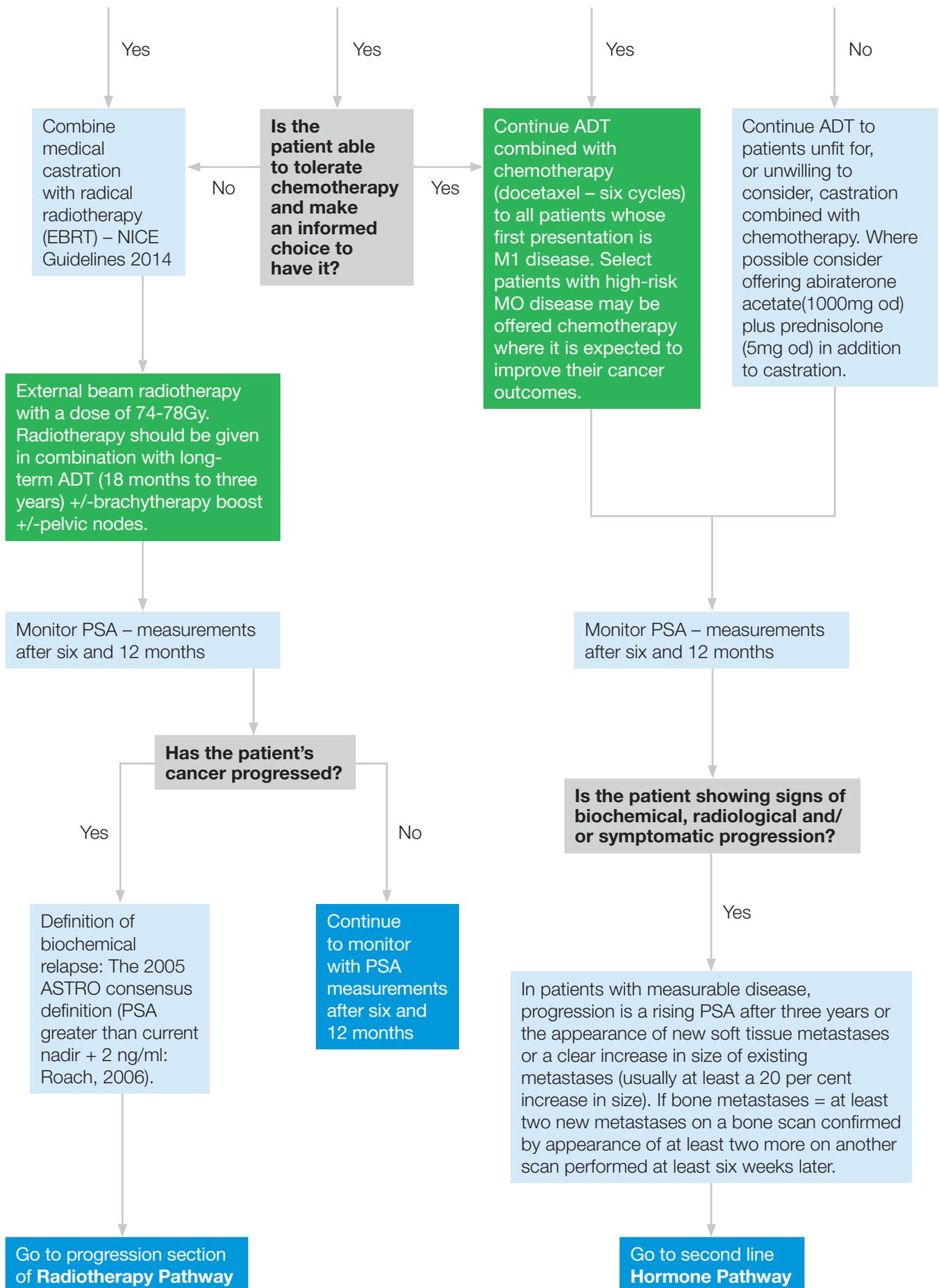
Late effects can occur months to years after radiotherapy, may include: urinary problems (weak flow), bowel problems, erectile dysfunction, hip and bone pain/weakness. Please see **Support Pathway (section 3.4)**

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

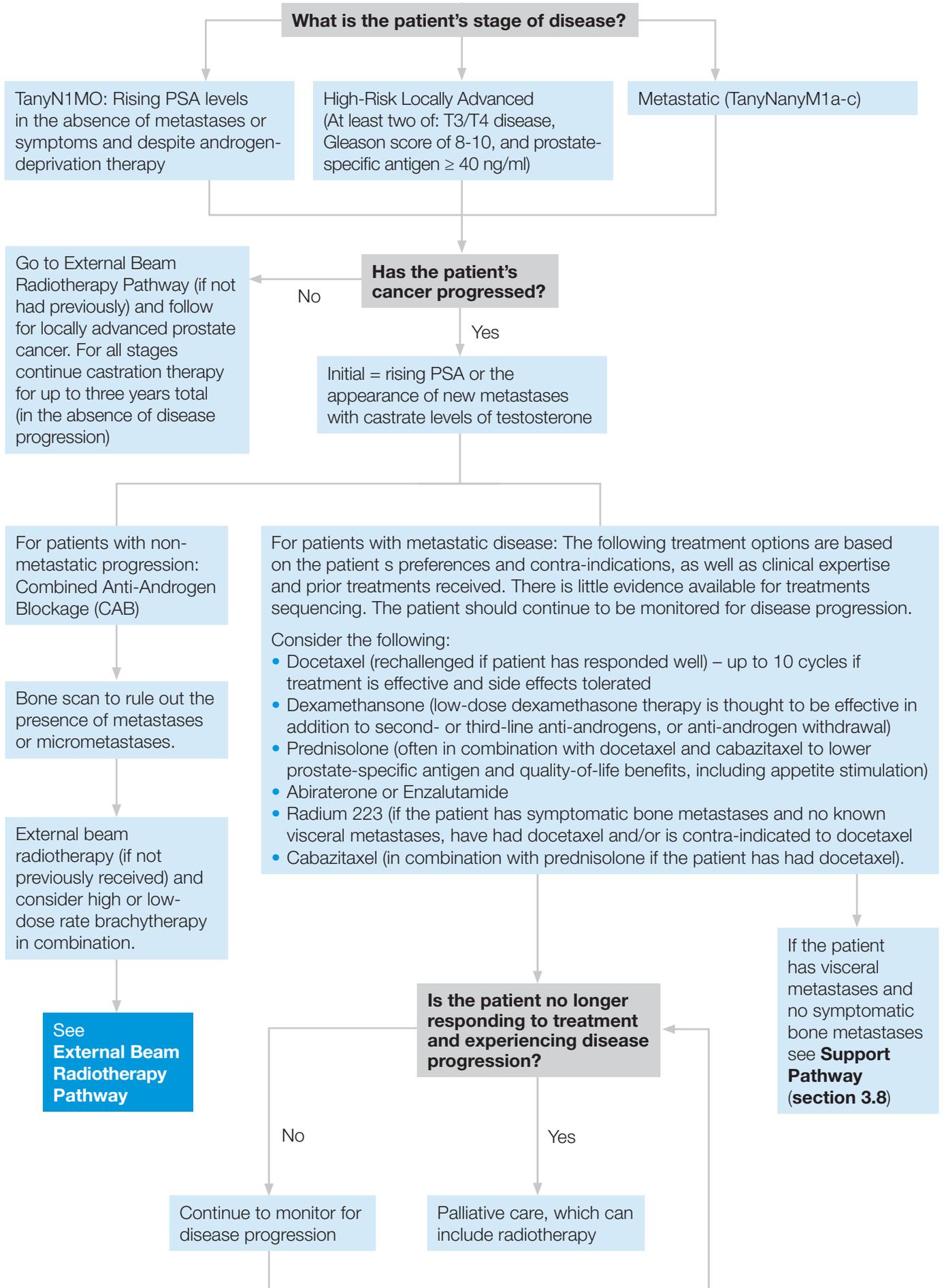


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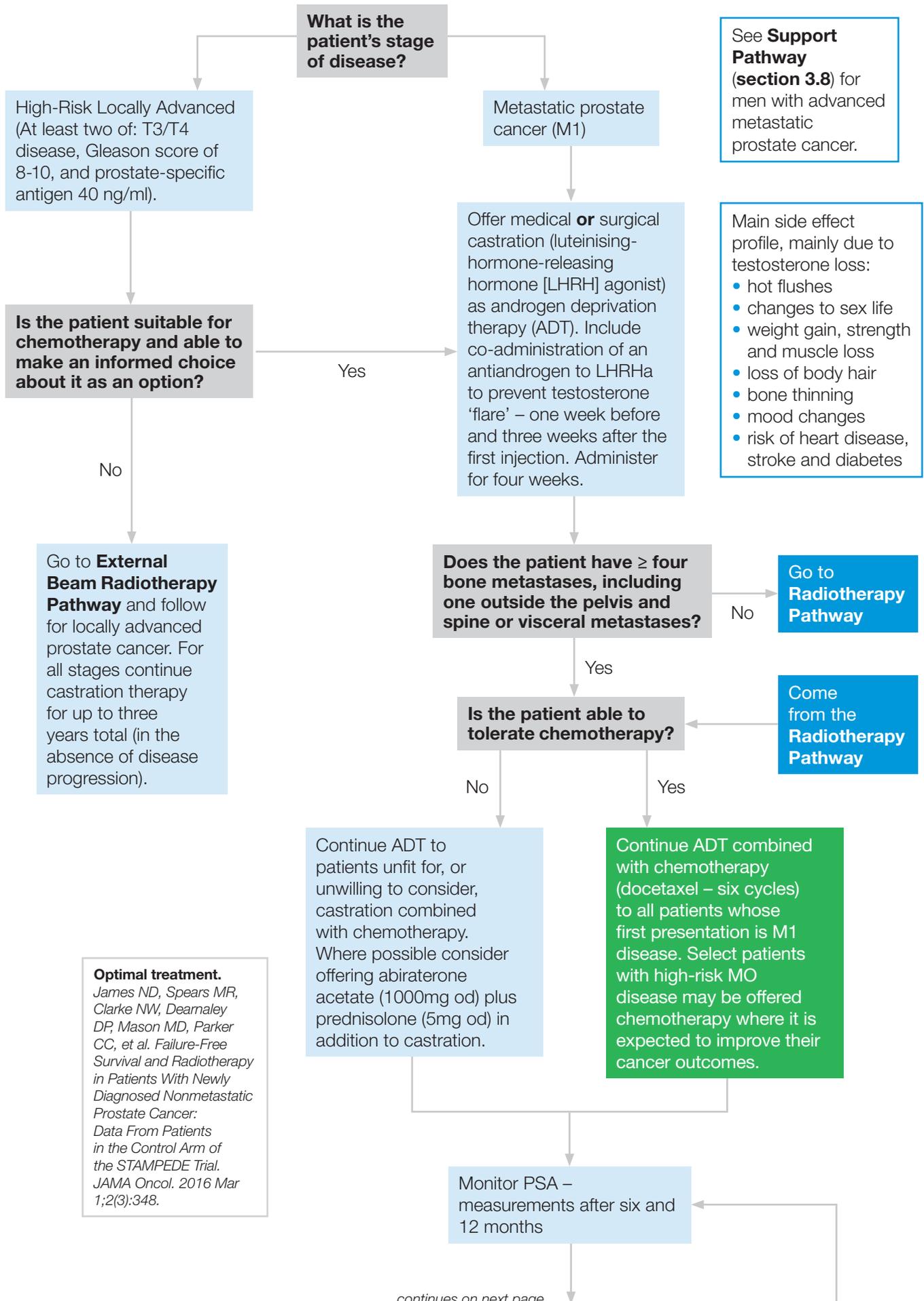
Hormone therapy (first line): Locally advanced and metastatic prostate cancer continued...



Hormone therapy (second line)



Chemotherapy



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

- 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

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.

Chemotherapy continued...

