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Is clinical stage T2C prostate cancer intermediate- or high-risk disease?

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Abstract

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Background: Clinical stage T2c (cT2c) is an indeterminate factor in the algorithm for prostate cancer (CaP) risk stratification. According to the D'Amico risk stratification and the American Urological Association (AUA) guidelines, cT2c is high−risk, whereas the National Comprehensive Cancer Network (NCCN) and EUA classify cT2c as intermediate−risk. Since determining whether cT2c is intermediate- or high-risk has implications for treatment, it is important to define what exact risk cT2c portends. Thus, we sought to assess whether cT2c tumors, without associated other high−risk factors (cT2c not otherwise specified (cT2c−nos)), behave as intermediate− or high−risk by analyzing biochemical recurrence (BCR) after radical prostatectomy (RP). Methods: We retrospectively analyzed 2,759 men who underwent RP from 1988 to 2011 from the Shared Equal Access Regional Cancer Hospital (SEARCH) database. Comparisons in time to BCR between cT2c−nos patients and intermediate−risk (prostate-specific antigen [PSA] 10 to 20 ng/ml or Gleason sum (GS) =7 or cT2b), and high−risk (PSA greater than 20 ng/ml, GS 8 to 10, cT3) patients was performed using log−rank test and Cox proportional hazards analyses. Given changes in CaP, we adjusted for year of surgery (continuous) and to adjust for case mix among centers contributing to SEARCH we included a categorical term for center. Results: A total of 99 men (4%) were classified as cT2c−nos. During a median follow-up of 66 months (IQR: 34−101 months), cT2c−nos patients had similar BCR risk as intermediate-risk (p=0.27), but significantly lower BCR risk versus high-risk patients (p<0.001, Figure). After

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adjusting for year and center and compared to low-risk disease, the HRs for cT2c−nos patients was similar to those with intermediate-risk (HR 1.90 vs. 2.28). When specifically compared to intermediate-and high-risk patients, and after adjusting for year and center, cT2c−nos patients had outcomes comparable to intermediate−risk (p=0.44), but significantly better than high-risk patients (HR 0.55; 95%CI 0.38,0.78; p=0.001). Conclusions: BCR risk for patients with clinical stage T2c was comparable to men who had intermediate-risk disease and significantly better than men with high-risk CaP. These findings suggest men with cT2c disease should be offered treatment options for intermediate-risk CaP.

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