

## Editorial Comment

### Editorial Comment to Impact of prior local therapy on overall survival in men with metastatic castration-resistant prostate cancer: Results from Shared Equal Access Regional Cancer Hospital

The retrospective study by Patel *et al.* suggests that men with metastatic castration-resistant prostate cancer (CRPC) who have undergone prior prostatectomy have improved survival (cancer-specific survival and overall survival) compared with men with no prior local therapy.<sup>1</sup> Where other authors investigate the role of cytoreductive prostatectomy in already advanced disease with known metastases,<sup>2,3</sup> Patel *et al.* are to be commended for investigating whether or not patients with metastatic CRPC who underwent local therapy show better outcomes.

However, readers should be aware of the selection used in this study. Selection of patients was based on non-metastatic CRPC, excluding patients with positive imaging for distant metastases before the CRPC diagnosis and non-metastatic CRPC patients who did not develop metastases during follow up. The authors comment that this was done to control for metastatic tumor burden, but this selection is susceptible to introducing important bias.

In fact, this study states that men who progress from M0 CRPC to M1 CRPC have improved survival when they have undergone prior local therapy (radical prostatectomy) compared with those who were treated with androgen deprivation therapy (ADT) for localized disease. Patients receiving prostatectomy might have more favorable patient and tumor characteristics than those receiving no local treatment (or radiotherapy or multimodal therapy), and do have more favorable patient and tumor characteristics than those receiving ADT for localized disease.<sup>2</sup>

In contrast, patients with improper imaging are also included. With the improvement of imaging (e.g. prostate-specific membrane antigen positron-emission tomography), many of the so-called “non-metastatic” CRPC patients will harbor M1 disease.<sup>4</sup> Additionally, the group of patients with progression under ADT to CRPC after radical prostatectomy without local recurrence could be different from those where the prostate is still *in situ*. Patients with a prostate in place could have disease progression inside the prostate without metastatic lesions, as well as patients with local recurrence after radical prostatectomy or radiotherapy. The authors justly mentioned the possibility for an earlier detection bias in patients with prior local therapy. In the real clinical setting, this could be advantageous. Data provided to fully evaluate

the different additional treatments, radiotherapy modalities and settings are, however, insufficient.

With the development of novel potent (systemic) treatments in the past decade, one could question if prior local treatment is even necessary, or, if we should select a maximized multimodal treatment to gain control of these aggressive tumors. Current study favors the latter; however, we should never forget the potential bias in carrying out retrospective studies. In the future, we should evaluate if cytoreduction of the tumor bulk could be an option to prevent resistance of some aggressive tumor cells to radiotherapy and systemic agents, and also prevent local progression and complications when progressing to a more advanced disease stage.<sup>2</sup>

Filip Poelaert M.D.,<sup>1</sup> Peter Schatteman M.D.<sup>2</sup> and Nicolaas Lumen M.D., Ph.D.<sup>1</sup>

<sup>1</sup>Department of Urology, Ghent University Hospital, Ghent, and <sup>2</sup>Department of Urology, OLV Clinic Aalst, Aalst, Belgium

filip.poelaert@uzgent.be

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## Conflict of interest

None declared.

## References

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