

Prostatic Cancer: The Case for Conservatism

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Carcinoma of the prostate is the most common malignancy in men. It is the second leading cause of cancer deaths in men, with a five-year survival rate of 72 percent. One asks, "Is the cure necessary in those in whom it may be possible? Is cure possible in those whom it may be necessary?"

Carcinoma of the prostate is the most common malignancy in men. It is the second leading cause of cancer deaths in men, with an overall five-year survival rate of 72 percent. New diagnostic and therapeutic weapons are being used, but there is an evolving controversy about their effectiveness. Willett Whitmore asked, "Is cure necessary in those in whom it may be possible? Is cure possible in those in whom it may be necessary?"

Carcinoma of the prostate is variable. Its aggressiveness correlates with the Gleason scale. Many older men have cancer of the prostate but die of other diseases. On the other hand, there is a small percentage of men whose cancers are discovered, treated early, and cured. Jewett did the definitive study of radical prostatectomy in men who had a small localized nodule. These men had a 15-year survival rate, as good as the normal population, but only a few months better than men with localized nodules who were not treated. There are costs: impotence, even with nerve-sparing surgery; incontinence; and small operative morbidity and mortality.

Radiation therapy has been used successfully; it seems to be almost as effective as surgery, but with complications. Palliative radiation for the pain of bony metastases, on the other hand, is very effective.

Huggins became famous when he removed the testes of men with more advanced cancer; these men had impressive symptomatic improvement. It is hard to demonstrate increased longevity. The cancer goes into remission, yet it does return. There seems to be evidence of improved survival that is measured in months.

Diethylstilbestrol accomplished the same thing as orchiectomy, but at a cost of increased vascular disease. It has been suggested that 1 or 2 mg/day may control the cancer (as compared to 5 mg/day) without the vascular complications. The LHRH agonists, leuprolide (Lupron®), goserelin (Zoladex®), and others, are as effective as diethylstilbestrol without the vascular effects; they also cost about \$300 a month. The anti-androgens, flutamide (Eulexin®) and others, have the advantage of blocking adrenal as well as testicular androgen; there are questions about the significance of the advantage. It has been hard

to show any advantage of early over late hormonal therapy, and physicians have advocated not using it until necessary. There is evidence of survival for a few months with early treatment.

Transrectal ultrasound, especially with needle biopsy, can detect a few more cancers than the standard rectal examination. Prostate specific antigen (PSA) is considered normal if it is under 4, and diagnostic of metastases is normal if it is over 40. There is a big questionable area in between these figures, but neither test is routinely advised for screening because of false positives and negatives, the cost (estimated in the \$20 billions), the morbidity of treatment in men who might not need prostate surgery, and the lack of improvement in survival.

Many well-known urologists go to extremes. Every man with a suspicious nodule undergoes an ultrasound and a biopsy. If localized disease is found, he receives a radical prostatectomy, or radiation. If it is not localized, he receives LHRH and antiandrogens or an orchiectomy and antiandrogens.

If I were 50 and had a localized nodule, I would think a bit about a radical. But I am 65, and if I have an asymptomatic cancer in my prostate, I do not want to know about it. ■

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