Prostate Cancer Management Varies by Specialty

BY JANE SALODOF MACNEIL
Senior Editor

CHICAGO — Whether a man consults with a urologist, a radiation oncologist, or a primary care physician after being diagnosed with clinically localized prostate cancer can lead to different treatment choices.

A study of 85,088 men, aged 65 years and older and diagnosed from 1994 to 2002, found that half saw only a urologist. These patients were more likely to have a radical prostatectomy, primary androgen deprivation therapy, or expectant management. Only 5% went on to radiation therapy.

Fewer than half (44%) of men diagnosed during this time period consulted a radiation oncologist after diagnosis by a urologist. Most men who saw both specialists had radiation therapy. Only 8% underwent radical prostatectomy. Even fewer chose the conservative options of hormone treatment or watchful waiting.

For the most part, men did not visit their primary care physicians after diagnosis. The 17% who did tended to be older and usually opted for a conservative strategy.

Just 6% of all men in the study also consulted a medical oncologist.

"[Whom you see] does sort of influence what you get," Dr. Thomas L. Jang said after reporting the results of the study at the annual meeting of the American Society of Clinical Oncology.

Dr. Jang, a urologist at Memorial Sloan-Kettering Cancer Center, New York, emphasized that no treatment has been proved better than others for early prostate cancer. The results show that treatment choices are strongly associated with which specialists a patient consults, he said, but other factors—such as patient preferences and distance to radiation or surgical facilities—might also play a role.

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DR. JANG

Urologists generally make the diagnosis of prostate cancer and coordinate care. Dr. Jang said he did not recommend that urologists send all prostate cancer patients to consult with both radiation oncologists and medical oncologists. The health care costs would be too great, and it would lessen the efficiency of physician practices.

Rather, he advocated that urologists and radiation oncologists collaborate on standard informational materials that urologists could give to patients. "It is essential that all men with prostate cancer have balanced information prior to making a treatment decision," he said, noting that urologists, radiation oncologists, and medical oncologists collaborated on the study he presented.

Dr. Jang and his coinvestigators matched information from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) database with Medicare claims and the American Medical Association's Physician Masterfile. They found that for the 8-year period studied, 42% of localized prostate cancer patients aged 65 and older underwent radiation therapy, 21% had a radical prostatectomy, 17% had primary androgen deprivation therapy, and 20% had expectant management.

In general, patients younger than 75 were more likely to have surgery and/or radiation, whereas most of those aged 80 and older opted for more conservative strategies. During the in-between age of 75-79 years, half had radiation therapy, 24% expectant management, 20% primary androgen deprivation therapy, and just 6% radical prostatectomy.

Radical prostatectomies were performed in 34% of all 42,309 men who saw only a urologist, but the proportion fell from 70% of those aged 65-69, to 45% of those 70-74, to 10% of those 75-79, and to just 1% of those 80 and older.

In contrast, 83% of 37,540 patients who also consulted a radiation oncologist had radiation therapy. The lowest rate, 78%, was in the group aged 65-69. The rate climbed to 85% of those aged 70-74, and 87% of those aged 75-79, before leveling at 79% of those 80 and older.

Just 14,599 men also visited a primary care physician. Expectant management was the leading treatment in these patients, followed by androgen deprivation. Even among those who also consulted a urologist and a radiation oncologist, 51% chose watchful waiting, whereas just over a third (34%) opted for radiation therapy. Regardless of which specialists they consulted, fewer than 10% of men who saw a primary care provider decided on surgery.

Dr. Archie Bleyer, moderator of a press briefing on patterns of care, called the study a tour de force. "The results are of concern and affect more men than not," said Dr. Bleyer of St. Charles Medical Center, Bend, Ore. ■

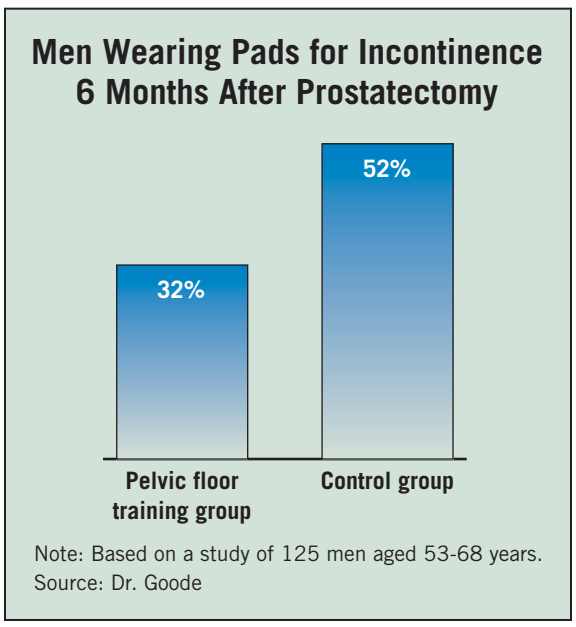
Single Biofeedback Session Eases Postprostatectomy Incontinence

BY TIMOTHY F. KIRN
Sacramento Bureau

SEATTLE — Behavioral training can help men with urinary incontinence after radical prostatectomy, Dr. Patricia S. Goode said at the annual meeting of the American Geriatrics Society.

"There are urology practices themselves that have developed wonderful expertise at behavioral training," said Dr. Goode, medical director of the continence program at the University of Alabama, Birmingham. "Referral doesn't necessarily have to be to a continence center."

In a recent published study, she and her group randomly assigned 125 men aged 53-68 years before prostatectomy to a single training session with biofeedback to allow them to learn to contract their pelvic floor muscles at will, or to a usual care control group.



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After surgery, it took the men who received training a median of 3.5 months to stop leaking, versus 6 months in the control group. At 6 months, only 32% of the trained men were wearing pads, versus 52% of the control group. And, they calculated that the number of individuals who needed to be treated to stop one man from having to wear a pad was five.

In a study of 20 men aged 55-87 years who had been incontinent after prostatectomy for a mean of 2.5 years, Dr. Goode found that four sessions of training reduced incontinence accidents by 78%, and 3 of the subjects had no accidents after training.

Dr. Goode said that they use biofeedback to teach the men to contract their pelvic floor muscles, but one can also do it during a digital rectal exam, since one can feel when there is proper contraction.

Then the patients are sent home and told to do exercises at home, three times daily, contracting and then relaxing 15 times in a row. At first, she has them contract for 3 seconds and then relax for the same amount of time in each repetition, adding a few seconds a week until they get to hold the contractions for 10-15 seconds.

She tells patients to incorporate the exercises into their daily activities and routine, such as using certain television commercials as a cue. Patients also are told to contract the muscles before they sneeze or cough or are about to lift something or exert themselves. Patients who have urge incontinence also are taught to stop when they feel the urge, instead of rushing to the bathroom. They then are instructed to squeeze their pelvic floor until the urge eases. Then, they can walk calmly to the bathroom, stopping again if necessary.

Dr. Goode also recommends that men avoid caffeine. ■

Men Don't Tell, if You Don't Ask About BPH Symptoms

ANAHEIM, CALIF. — Only about a third of men with moderate to severe lower urinary tract symptoms and evidence of an enlarged prostate intended to discuss these issues during a routine visit to their primary care physicians, according to a national, multisite study presented at the annual meeting of the American Urological Association.

Dr. Michael J. Naslund and his associates from the University of Maryland, Baltimore, distributed a questionnaire to 448 men older than age 50 years when they arrived for routine appointments at one of six primary care practices across the United States. The men were roughly evenly distributed by age categories, with 153 in their 50s, 151 in their 60s, and 144 in their 70s.

The men were asked the reason for their visit, their current lower urinary tract symptoms (LUTS), prior history of use of drugs and herbal remedies to treat LUTS, and whether they were planning to discuss their symptoms with the physician. A total of 42% of the men described moderate to severe LUTS on the International Prostate Symptom Score (IPSS) scale.

Upon enrollment, 48% of the men had an enlarged prostate on digital rectal examination (DRE) and 43% had a prostate-specific antigen (PSA) level of 1.5 ng/mL or greater. Two-thirds of the men had either an enlarged prostate on DRE or an elevated PSA level.

An estimated 29% of the men in the study would be considered at risk for progression of symptoms of benign prostatic hypertrophy, based on a high score on the IPSS scale and either a positive DRE or elevated PSA level.

Just 33% of men in this at-risk group—who were fairly evenly distributed by age—said they intended to discuss LUTS or prostate issues with their primary care physicians.

This finding raises the possibility that physicians may need to increase their efforts to detect men with LUTS, said Dr. Naslund, professor of surgery and interim head of urology at the university, and a consultant and on the speaker's bureau for GlaxoSmithKline Inc. and Sanofi Aventis.

—Betsy Bates