



Treatment of Localized and Locally Advanced, High- Risk Prostate Cancer: A Case Report

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75 yrs., old male, handicapped with his right limb amputated, referred from urology department with pathology report show adenocarcinoma, GS 4+3 =7 and PSA 85. His first presentation was recurrent urine retention, physical examination was normal and digital rectal examination revealed moderately enlarged and fixed prostate, Catheterized. His lap data is within a normal range including the alkaline phosphatase. Abdominal U/S show moderately enlarged prostate is otherwise normal. Biopsy report demonstrated adenocarcinoma Gleason score 4+3=7 Patient had a history of Rt limb amputation above the knee joint 7 yrs. ago due to lump of the knee joint no report enviabale about the pathology but the patient received chemotherapy cycles in Khartoum oncology center (co-patient memory)

Abstract

These groups include T3—T4 rarely T2C. RP or surgery is usually difficult for these groups of patients and RTX has a poor outcome with 50% of patients developing Mets by ten yrs. One challenge in making a comparison surgery VS RTX in locally advanced disease is the use of rick grouping which depends on GS & PAS more than staging. androgen deprivation act as cytoreductive therapy which improves the local control decreases Mets & improves tumor control when combine with RTX and adjuvant.

What is recognized in the treatment of high-risk patients??

The ADT alone for patients not candidates for local therapy? Comparing of androgen deprive therapy with local treatment improves OS & DFS with grade 3 toxicity limited in RTX to < 02%. RTX alone is inferior to RTX with ADT. (EORTC.....RTOG 8610..... RTOG 85-31). Using the prolonged course of ADT has a survival advantage VS short course (RTOG 9202..EORTC.. SPCG-7). prostatectomy is the local treatment that decreases mortality (Mayo/FCCC), RP + lymph nodes dissection is a stander of care, extended LNs dissection has more therapeutic benefits and more lymphocele 0,3% Dose escalation increase FFMD (MDACC—Harvard...Dutch...MRC).

What is controversial in the treatment of high-risk patients??

RP VS RTX most of the studies in favor of RP (MSKCC-capSURE- CCF/WASHU) endpoint MR, these factors must be mentioned:- the limitation of the data imbalance between two groups, salvage therapy influence, comparison out date sub-optimal doses/ADT today standardized, quality of life, toxicity and company of EBRT with brachytherapy in favor of RTX.

Whole pelvic irradiation VS only prostate WPRT increases PFF+ acute &Late bowel toxicity (RTOG 9413) but newer technology (IMRT/IGRT) not conceder in this study.

Adjuvant RTX VS Salvage RTX post-prostatectomy in high-risk disease (T3,+ve margin, LVI, ECE) EORTC PPFs, SOWG 8794 reduce PF & Mets but update review show early salvage not inferior while avoiding overtreatment (RADICALS-RT, RAVES and GETUG-AFU 17) the urinary toxicity high in adjuvant RTX arm. ARTISTIC meta-analysis aggregated the data from these three studies, It failed to bring evidence that adjuvant RT outperformed early salvage RT in event-free survival

Diagram of treatment for prostate cancer options associated with disease factors first diagram Localized prostate:- surgery is the preferable option. The second diagram locally advanced disease, the RTX IS a good choice

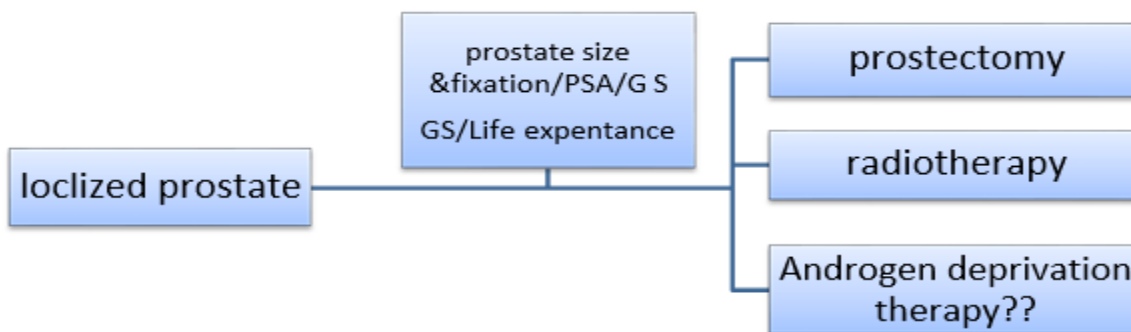


Figure 1

Citation: Dr. Omer Hashim "Treatment of Localized and Locally Advanced, High- Risk Prostate Cancer: A Case Report."

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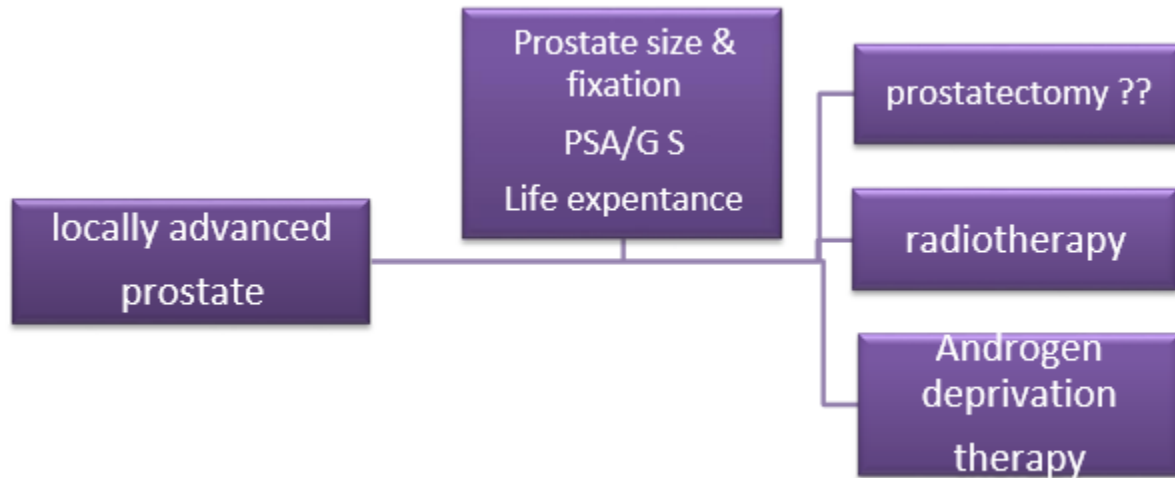


Figure 2

Table 1: outline the role of life expectancy associated with disease factor indetermination treatment options of prostate cancer.

> 10----15 yrs.	G S 8--10	PSA > 20 ng/ml	Localized	Surgery (RP/LAP-) + LNs dissection
10----15 yrs.			T3/T4 and/or clinical N+	RTX + LHRH+BT
< 10---15 yrs.	G S 8--10	Or PSA > 20		RTX

RTX :- EBRT (IMRT preferred). BT:- Brachytherapy

3rd diagram explain the use of androgen deprivation therapy according to local treatment of prostate cancer

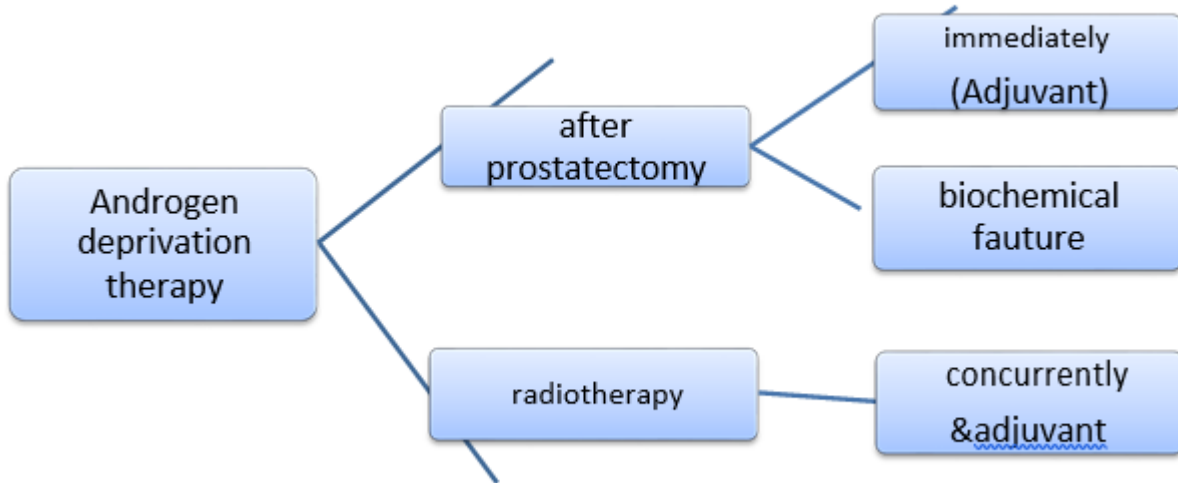


Figure 3

4th diagram the postoperative treatment options adjuvant.-RTX VS Salvage RTX and observation, comparing between salvage RTX and Observation show an advantage in OS & CSS in the arm of salvage RTX (Johns Hopkins JAMA 2008 – Duke cancer 2011)

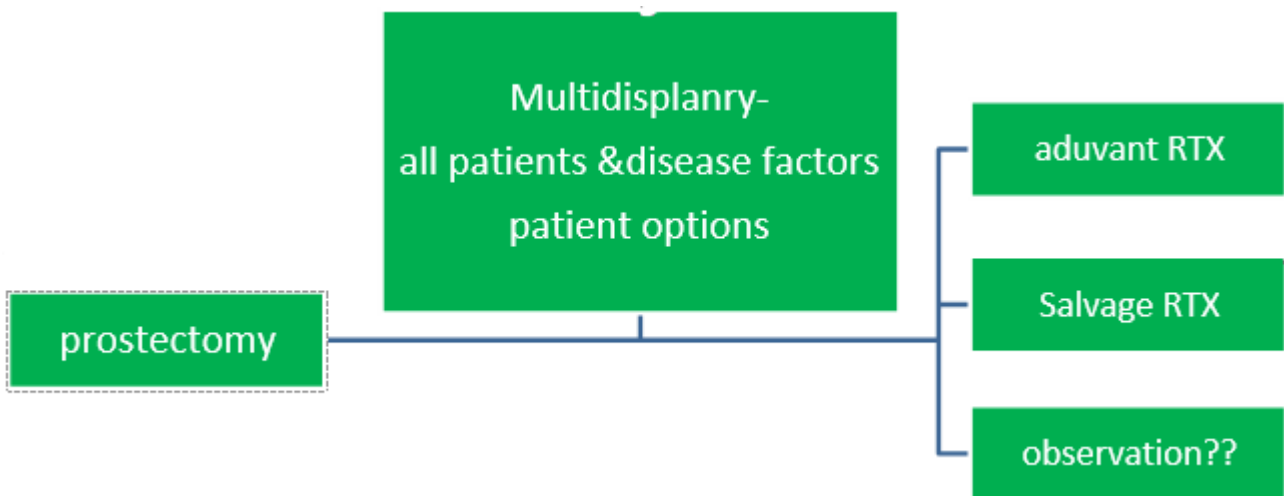


Figure 4

Patient Outcome

This is a newly diagnosed case our plan of treatment is to refer the patient Khartoum to radiotherapy for conventional whole pelvic AP & 2 LAT- fields to 45 GY then Mini pelvic to 65 GY.

Then we will refer him back to the urology department. Our patient is a special case. He is a disabled elder man who lives in rural areas far away from the city and with low income and they have a transportation problem. It is difficult to attend the patient monthly to take a dose of Zoladex inj. That is why we preferred Orchiectomy.

About his past condition most probably had no relation with present illness if the patient really received chemotherapy most probably diagnosis osteosarcoma or even Ewing sarcoma, other possibilities *benign* bone tumors. Mets from occult prostate to knee joint then activating after 7 yrs the probability very low.