Poggio Rusco
(MN)
17 marzo 2018

Con il Patrocinio
Ordine dei Medici di Mantova
Sistema Socio Sanitario
Regione Lombardia
ATS Val Padana

AGGIORNAMENTI IN UROLOGIA:
SPECIALISTI E MMG A CONFRONTO

Il tumore prostatico: la chirurgia

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- SORVEGLIANZA ATTIVA
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- RADIOTERAPIA
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ProtecT Trial

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 OCTOBER 13, 2016 VOL. 375 NO. 15

10-Year Outcomes after Monitoring, Surgery, or Radiotherapy for Localized Prostate Cancer

F.C. Hamdy, J.L. Donovan, J.A. Lane, M. Mason, C. Metcalfe, P. Holding, M. Davis, T.J. Peters, E.L. Turner, R.M. Martin, J. Oxley, M. Robinson, J. Staffurth, E. Walsh, P. Bollina, J. Catto, A. Doble, A. Doherty, D. Gillatt, R. Kockelbergh, H. Kynaston, A. Paul, P. Powell, S. Prescott, D.J. Rosario, E. Rowe, and D.E. Neal, for the ProtecT Study Group*

CONCLUSIONS

At a median of 10 years, prostate-cancer–specific mortality was low irrespective of the treatment assigned, with no significant difference among treatments. Surgery and radiotherapy were associated with lower incidences of disease progression and metastases than was active monitoring. (Funded by the National Institute for Health Research; ProtecT Current Controlled Trials number, ISRCTN20141297; ClinicalTrials.gov number, NCT02044172.)

ProtecT Trial

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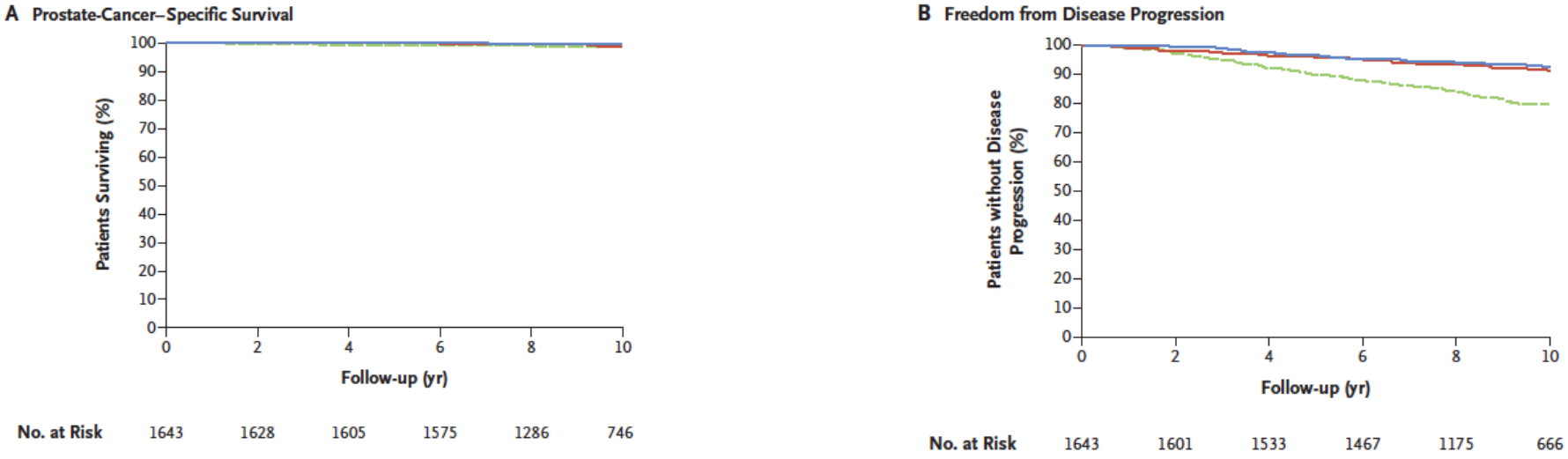
Surgery Radiotherapy Active monitoring



JAMA | Original Investigation

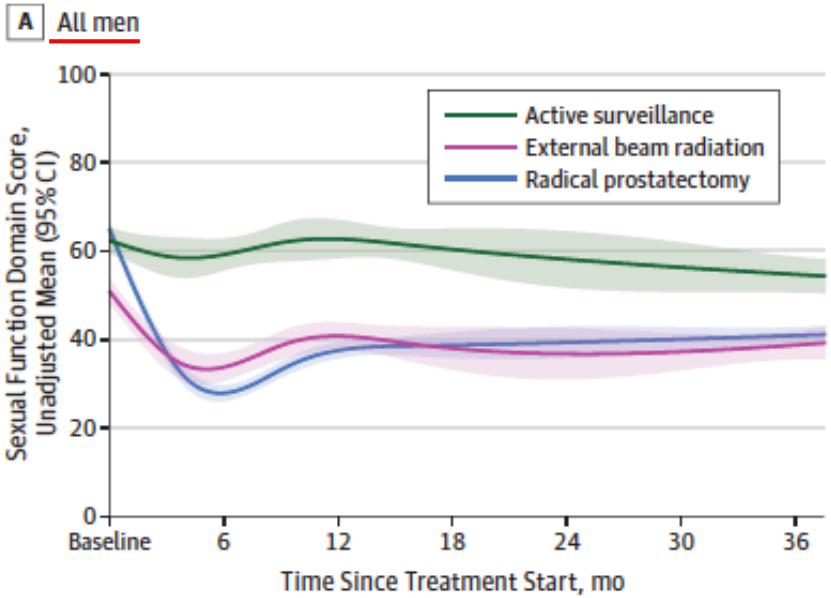
Association Between Radiation Therapy, Surgery, or Observation for Localized Prostate Cancer and Patient-Reported Outcomes After 3 Years

Daniel A. Barocas, MD, MPH; JoAnn Alvarez, MA; Matthew J. Resnick, MD, MPH; Tatsuki Koyama, PhD; Karen E. Hoffman, MD, MHSc, MPH; Mark D. Tyson, MD; Ralph Conwill, BS; Dan McCollum, BS; Matthew R. Cooperberg, MD, MPH; Michael Goodman, MD, MPH; Sheldon Greenfield, MD; Ann S. Hamilton, PhD, MA; Mia Hashibe, PhD, MPH; Sherrie H. Kaplan, PhD, MS, MPH; Lisa E. Paddock, PhD, MPH; Antoinette M. Stroup, PhD; Xiao-Cheng Wu, MD, MPH; David F. Penson, MD, MPH

CONCLUSIONS AND RELEVANCE In this cohort of men with localized prostate cancer, radical prostatectomy was associated with a greater decrease in sexual function and urinary incontinence than either EBRT or active surveillance after 3 years and was associated with fewer urinary irritative symptoms than active surveillance; however, no meaningful differences existed in either bowel or hormonal function beyond 12 months or in in other domains of health-related quality-of-life measures. These findings may facilitate counseling regarding the comparative harms of contemporary treatments for prostate cancer.

JAMA. 2017;317(11):1126-1140.

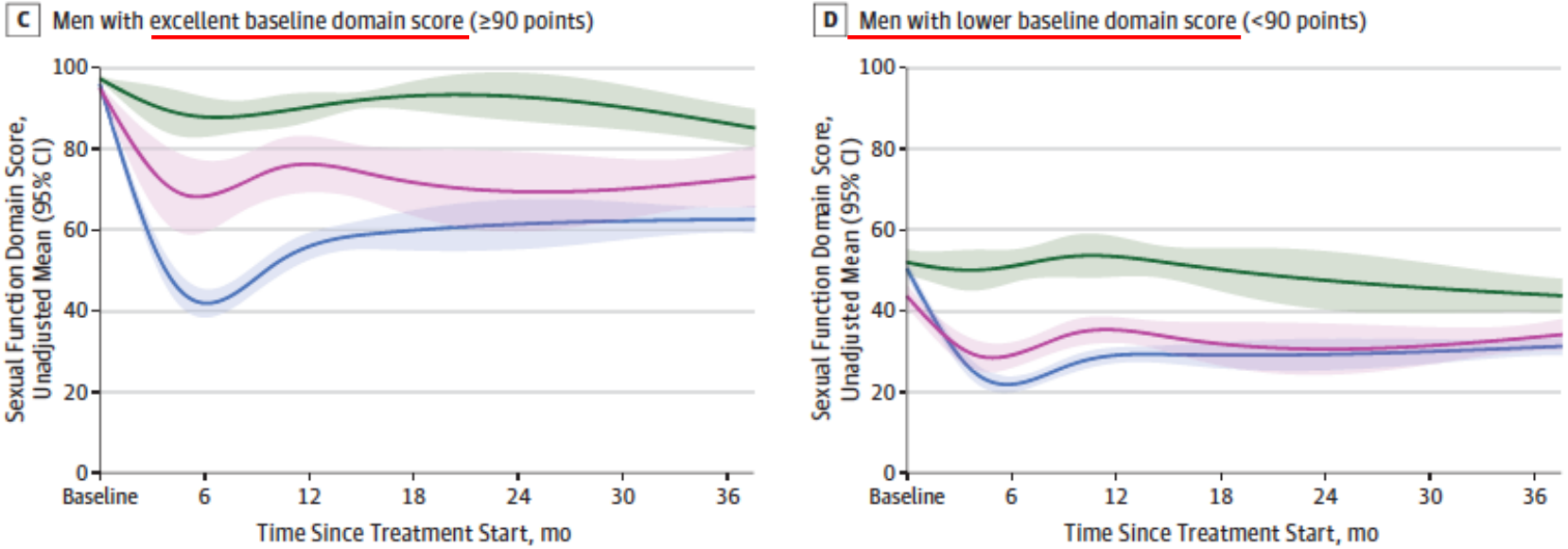
Association Between Initial Treatment of Prostate Cancer and Sexual Function Outcomes



No. of patients					
Active surveillance	402	390	360		329
External beam radiation	558	541	535		454
Radical prostatectomy	1447	1407	1401		1276

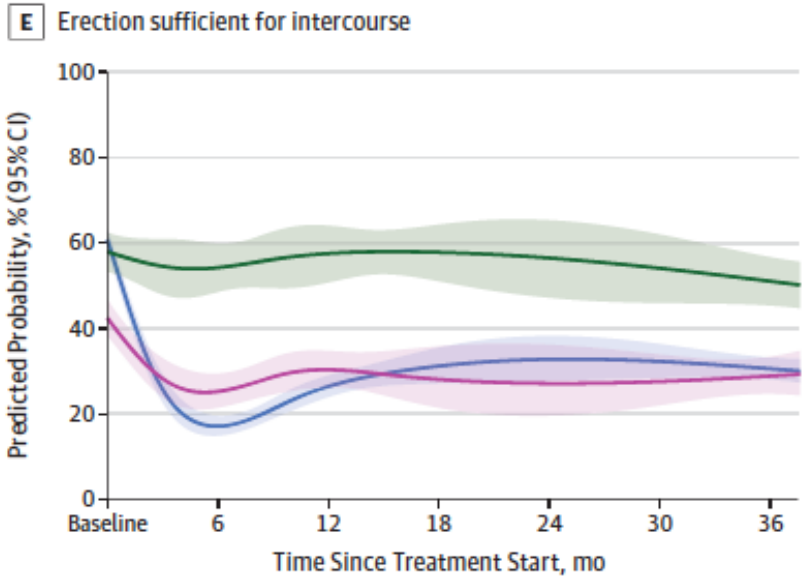
JAMA. 2017;317(11):1126-1140.

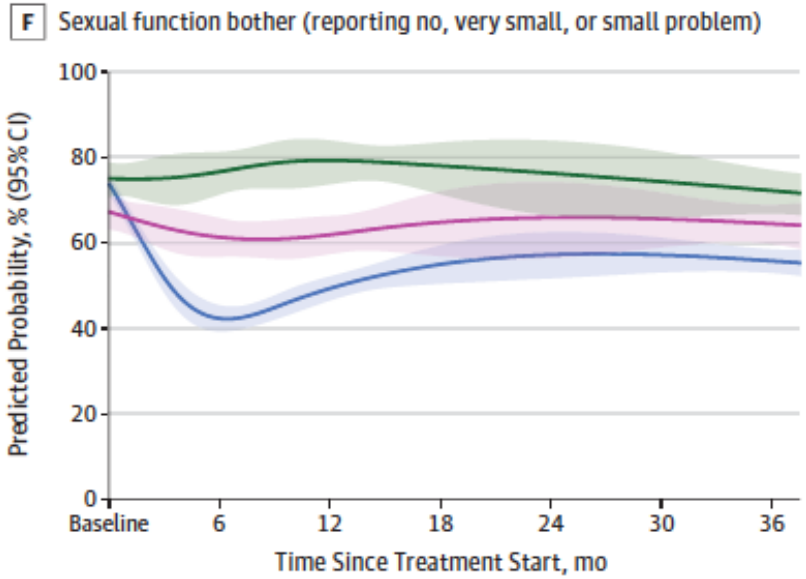
Association Between Initial Treatment of Prostate Cancer and Sexual Function Outcomes



JAMA. 2017;317(11):1126-1140.

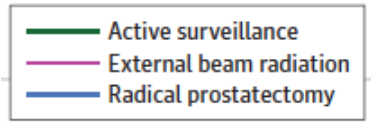
Association Between Initial Treatment of Prostate Cancer and Sexual Function Outcomes





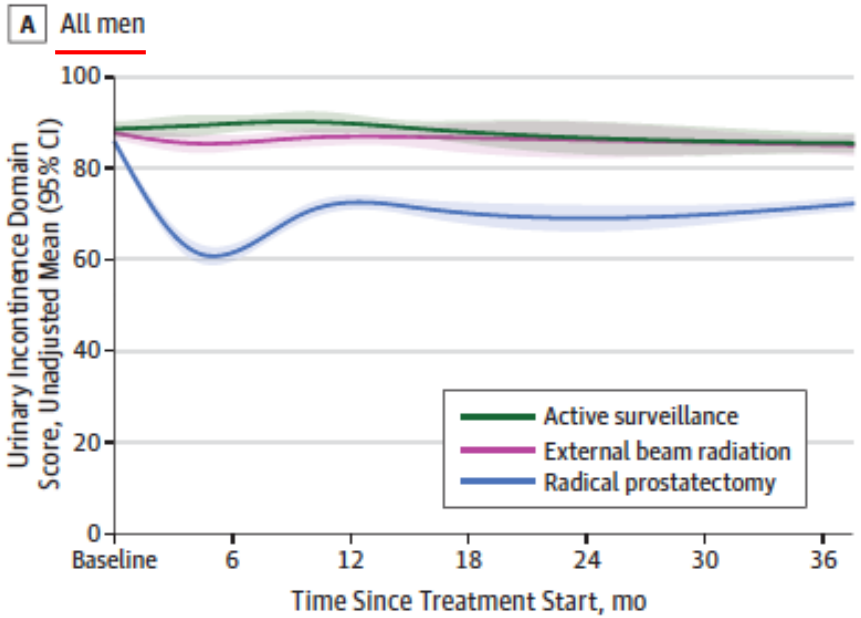
No. of patients

Active surveillance	404	393	369	331	401	397	365	331
External beam radiation	567	556	540	460	565	556	537	458
Radical prostatectomy	1462	1413	1395	1284	1451	1417	1409	1286



JAMA. 2017;317(11):1126-1140.

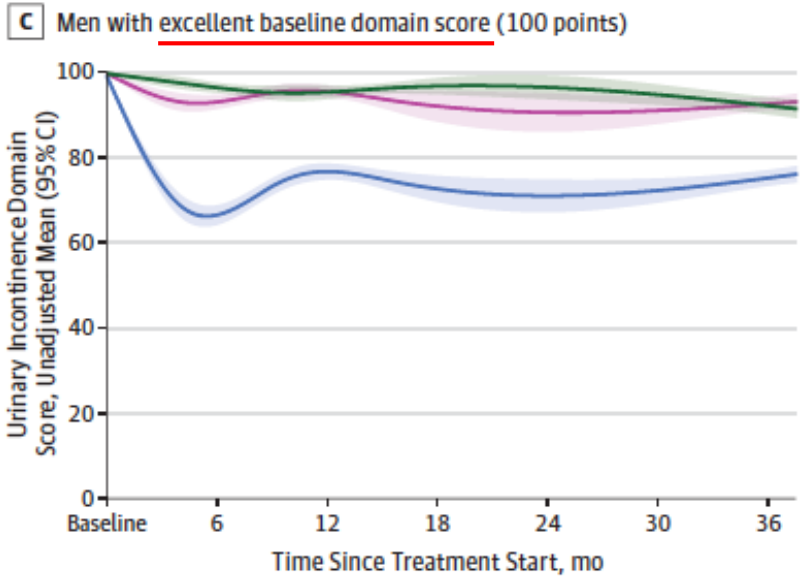
Association Between Initial Treatment of Prostate Cancer and Urinary Incontinence Outcomes

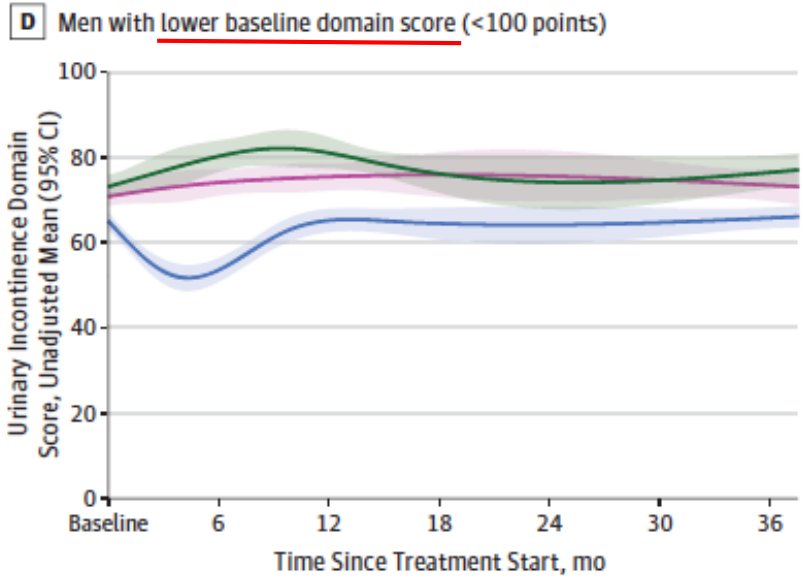


No. of patients					
Active surveillance	409	408	374		339
External beam radiation	575	576	532		467
Radical prostatectomy	1467	1434	1368		1277

JAMA. 2017;317(11):1126-1140.

Association Between Initial Treatment of Prostate Cancer and Urinary Incontinence Outcomes





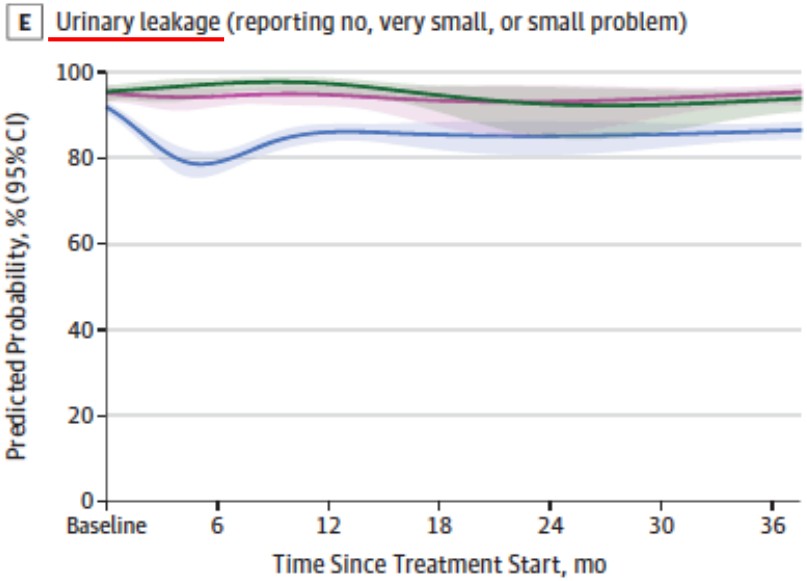
No. of patients

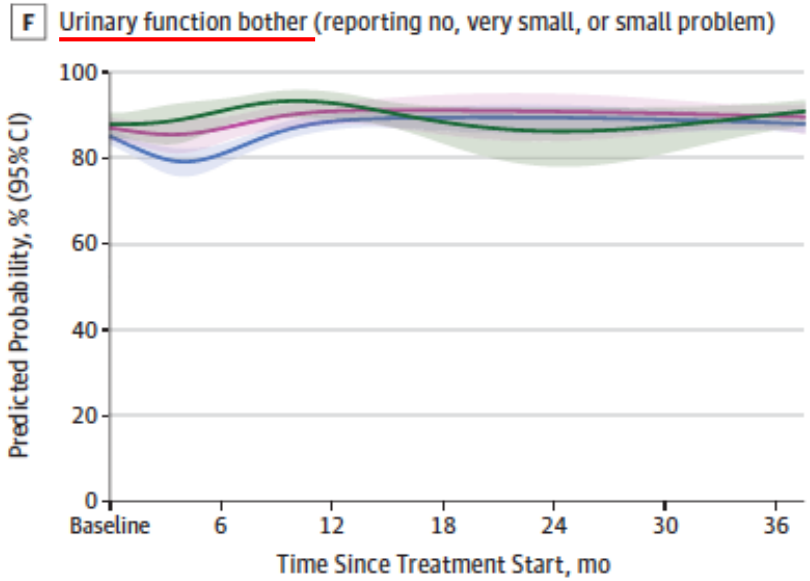
Active surveillance	240	228	208	192	169	161	149	131
External beam radiation	337	325	300	282	238	228	212	172
Radical prostatectomy	901	849	830	790	566	532	495	445

Active surveillance
External beam radiation
Radical prostatectomy

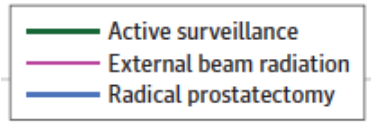
JAMA. 2017;317(11):1126-1140.

Association Between Initial Treatment of Prostate Cancer and Urinary Incontinence Outcomes



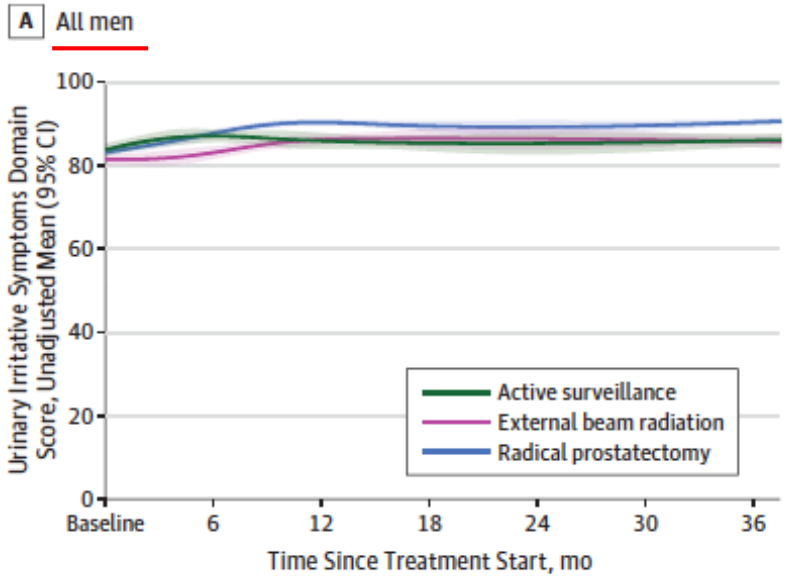


No. of patients									
Active surveillance	415	410	385	347	405	409	376	345
External beam radiation	582	579	551	474	580	576	543	477
Radical prostatectomy	1492	1442	1411	1293	1468	1432	1394	1302



JAMA. 2017;317(11):1126-1140.

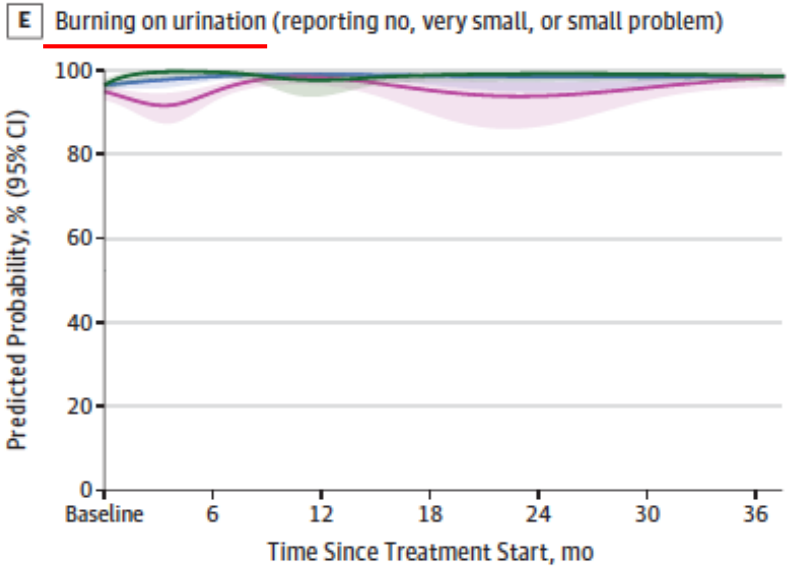
Association Between Initial Treatment of Prostate Cancer and Urinary Irritative Outcomes

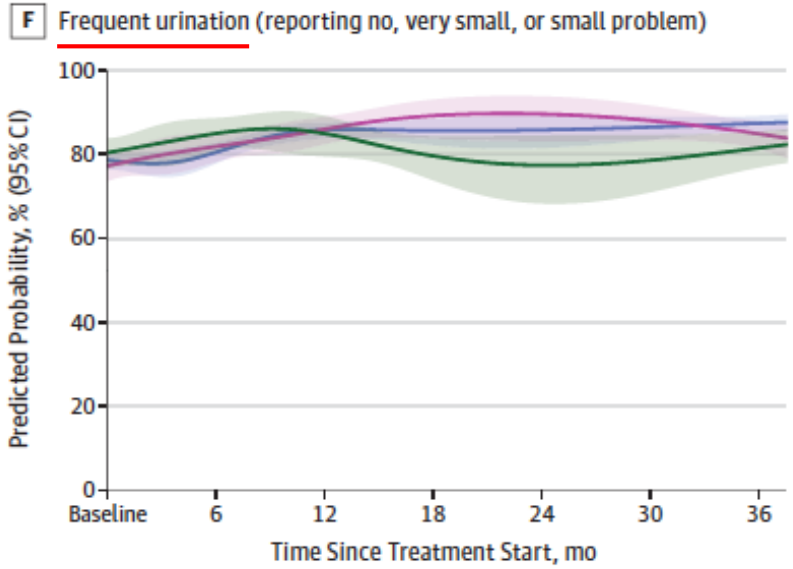


No. of patients				
Active surveillance	409	403	379	340
External beam radiation	574	571	547	466
Radical prostatectomy	1463	1419	1397	1282

JAMA. 2017;317(11):1126-1140.

Association Between Initial Treatment of Prostate Cancer and Urinary Irritative Outcomes





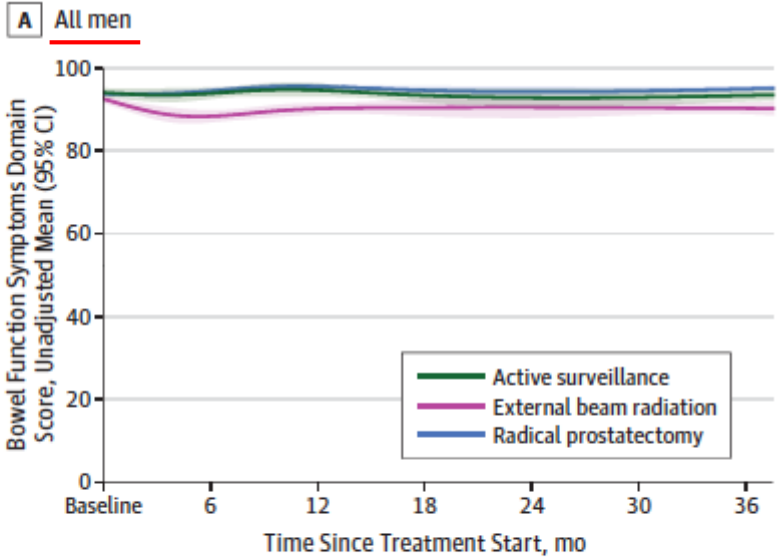
No. of patients

Active surveillance	413	409	385	347	414	409	382	347
External beam radiation	582	576	554	477	585	577	555	479
Radical prostatectomy	1488	1439	1410	1298	1491	1440	1413	1299

Active surveillance
External beam radiation
Radical prostatectomy

JAMA. 2017;317(11):1126-1140.

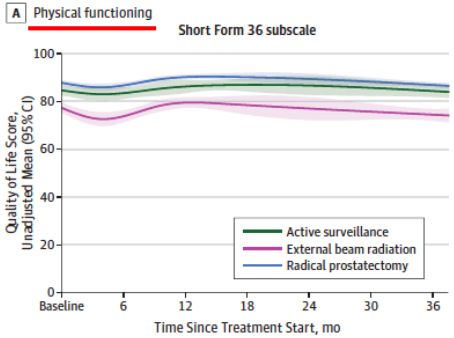
Association Between Initial Treatment of Prostate Cancer and Bowel Function Outcomes



No. of patients					
Active surveillance	415	411	385		349
External beam radiation	585	576	557		476
Radical prostatectomy	1492	1439	1415		1297

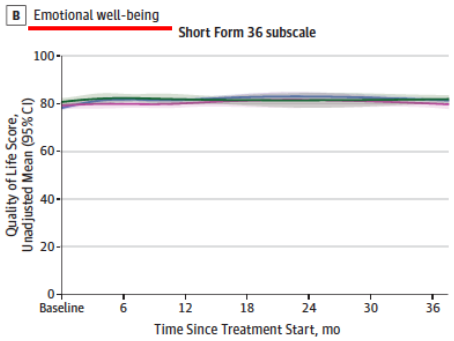
JAMA. 2017;317(11):1126-1140.

Association Between Initial Treatment of Prostate Cancer and Overall Quality-of-Life Outcomes



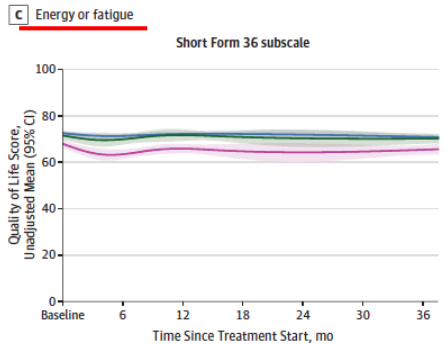
No. of patients

Active surveillance	405	409	387	347
External beam radiation	577	578	558	480
Radical prostatectomy	1477	1442	1419	1298



No. of patients

Active surveillance	413	410	386	346
External beam radiation	586	577	556	476
Radical prostatectomy	1492	1442	1412	1297



No. of patients

Active surveillance	414	410	386	346
External beam radiation	586	577	556	476
Radical prostatectomy	1493	1441	1412	1298

JAMA. 2017;317(11):1126-1140.

Active surveillance
External beam radiation
Radical prostatectomy

JAMA | Original Investigation

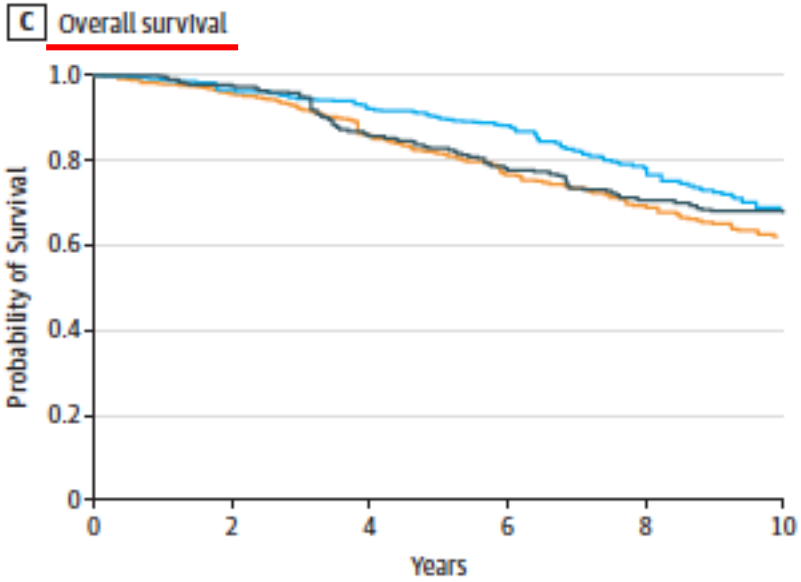
Radical Prostatectomy, External Beam Radiotherapy, or External Beam Radiotherapy With Brachytherapy Boost and Disease Progression and Mortality in Patients With Gleason Score 9-10 Prostate Cancer

Amar U. Kishan, MD; Ryan R. Cook, MSPH; Jay P. Ciezki, MD; Ashley E. Ross, MD, PhD; Mark M. Pomerantz, MD; Paul L. Nguyen, MD; Talha Shaikh, MD; Phuoc T. Tran, MD, PhD; Kiri A. Sandler, MD; Richard G. Stock, MD; Gregory S. Merrick, MD; D. Jeffrey Demanes, MD; Daniel E. Spratt, MD; Eyad I. Abu-Isa, MD; Trude B. Wedde, MD; Wolfgang Lilleby, MD, PhD; Daniel J. Krauss, MD; Grace K. Shaw, BA; Ridwan Alam, MPH; Chandana A. Reddy, MS; Andrew J. Stephenson, MD; Eric A. Klein, MD; Daniel Y. Song, MD; Jeffrey J. Tosoian, MD; John V. Hegde, MD; Sun Mi Yoo, MD, MPH; Ryan Fiano, MPH; Anthony V. D'Amico, MD, PhD; Nicholas G. Nickols, MD, PhD; William J. Aronson, MD; Ahmad Sadeghi, MD; Stephen Greco, MD; Curtiland Deville, MD; Todd McNutt, PhD; Theodore L. DeWeese, MD; Robert E. Reiter, MD; Johnathan W. Said, MD; Michael L. Steinberg, MD; Eric M. Horwitz, MD; Patrick A. Kupelian, MD; Christopher R. King, MD, PhD

CONCLUSIONS AND RELEVANCE Among patients with Gleason score 9-10 prostate cancer, treatment with EBRT+BT with androgen deprivation therapy was associated with significantly better prostate cancer–specific mortality and longer time to distant metastasis compared with EBRT with androgen deprivation therapy or with RP.

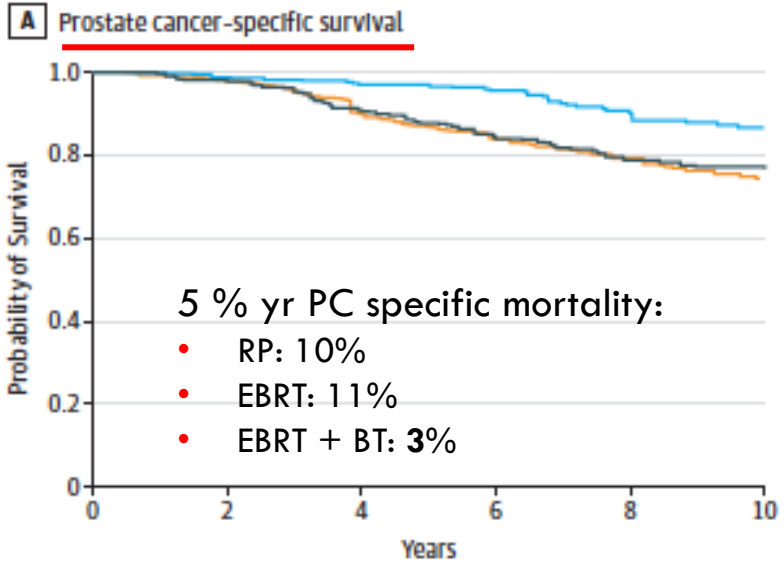
- retrospettivo

JAMA. 2018;319(9):896-905



No. at risk						
Prostatectomy	634	534	347	212	131	81
EBRT	734	643	470	295	175	103
EBRT + brachytherapy	436	406	326	231	164	90

JAMA. 2018;319(9):896-905.

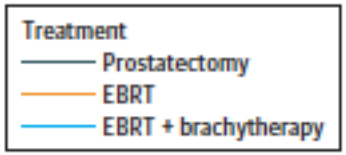


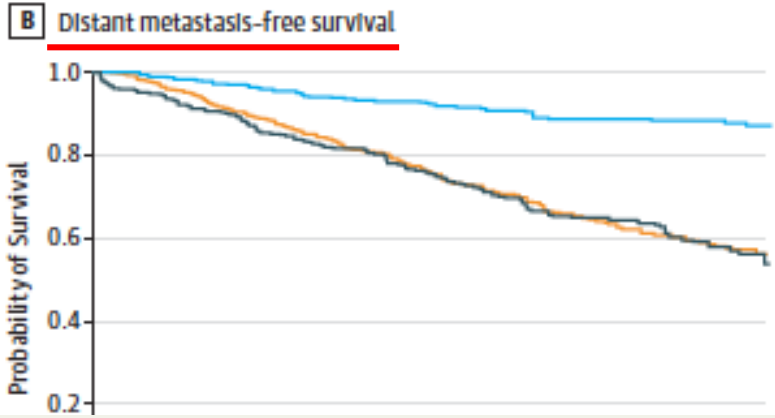
5 % yr PC specific mortality:

- RP: 10%
- EBRT: 11%
- EBRT + BT: **3**%

No. at risk

Prostatectomy	634	530	346	211	131	81
EBRT	725	635	457	288	172	102
EBRT + brachytherapy	431	397	317	222	159	87



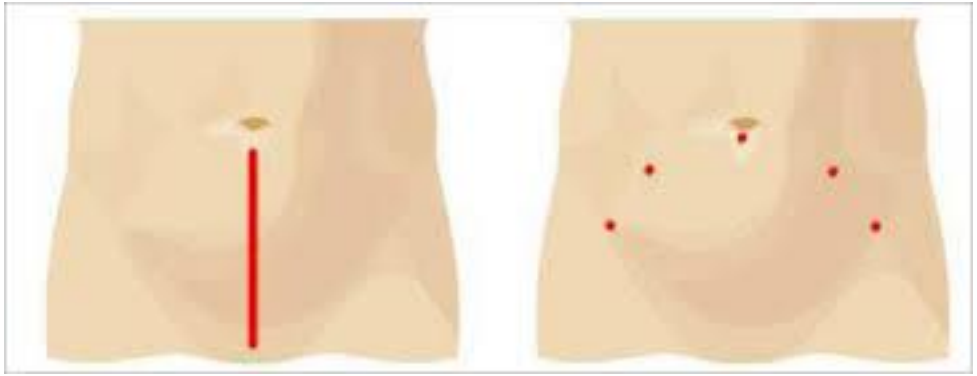


Treatment Cohort	Evaluable Patients at Time 0	Interval, y	No. of Events	No. of Patients Censored[a]	No. at Risk (End of Interval)	Cumulative Incidence at End of Interval, % (95% CI)
Distant Metastasis						
Radical prostatectomy	634	0-5	102	285	247	21 (17-25)
		>5-10	44	142	61	43 (36-49)
EBRT	734	0-5	153	262	319	26 (22-29)
		>5-10	54	188	77	45 (40-51)
EBRT+BT	436	0-5	30	147	259	8 (5-11)
		>5-10	10	163	86	13 (9-17)

JAMA. 2018;319(9):89

TECNICA OPEN

TECNICA LAPAROSCOPICA

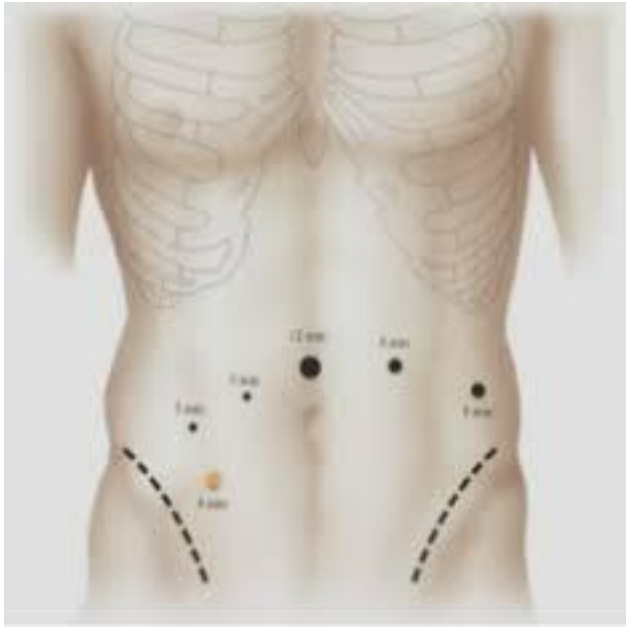


TECNICHE OPEN

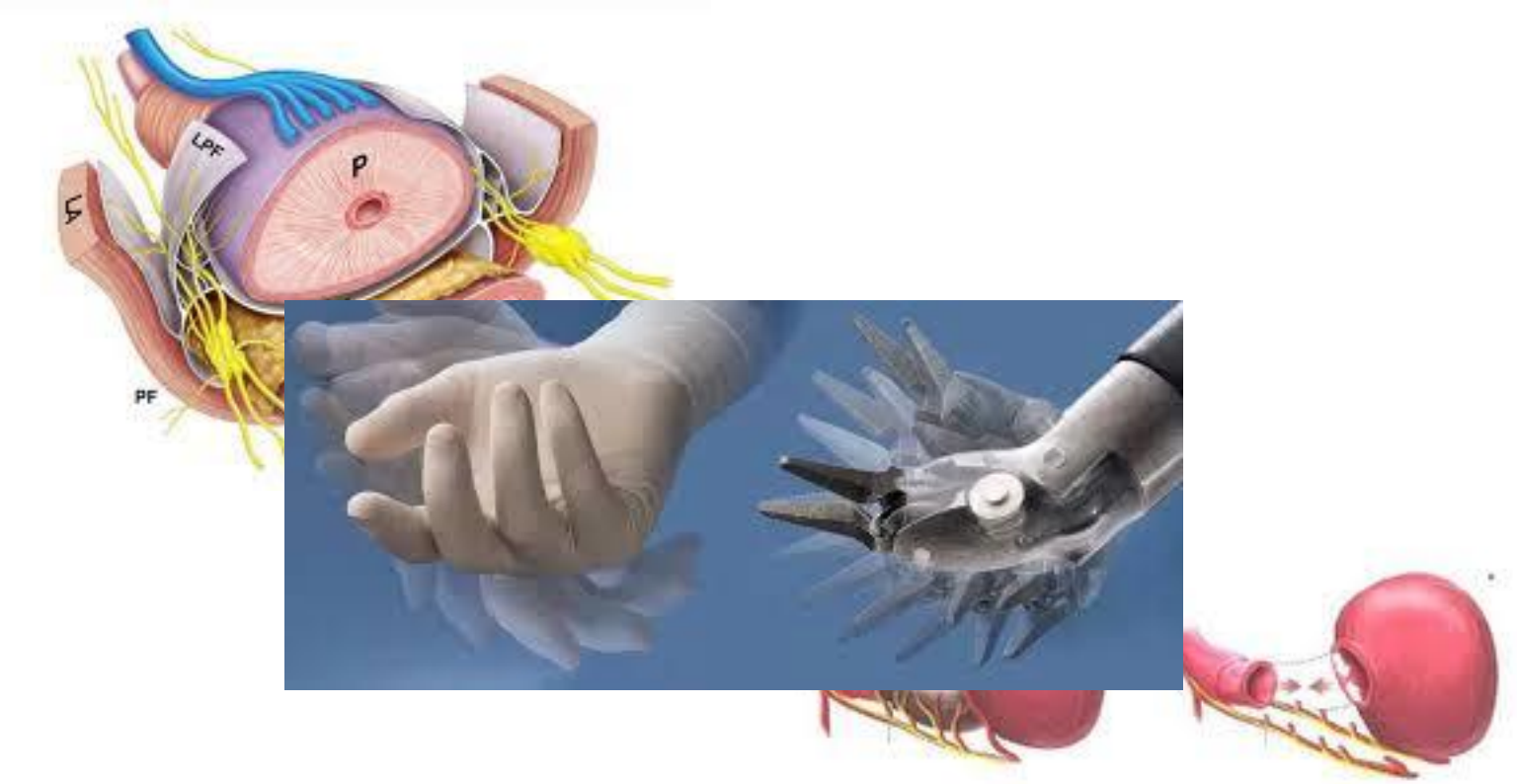
RETROPUBICA PERINEALE

TECNICHE LAPAROSCOPICHE

STANDARD



ROBOTICA


LPF
P
PF

PROSTATECTOMIA RADICALE

Allo stato attuale non vi sono dati che indicano che una metodica sia superiore ad un'altra se si considera l'outcome oncologico

Procedura robotica

Robot-assisted laparoscopic prostatectomy versus open radical retropubic prostatectomy: early outcomes from a randomised controlled phase 3 study

John W Yaxley, Geoffrey D Coughlin, Suzanne K Chambers, Stefano Occhipinti, Hema Samaratunga, Leah Zajdlewicz, Nigel Dunglison, Rob Carter, Scott Williams, Diane J Payton, Joanna Perry-Keene, Martin F Lavin, Robert A Gardiner

Interpretation These two techniques yield similar functional outcomes at 12 weeks. Longer term follow-up is needed. In the interim, we encourage patients to choose an experienced surgeon they trust and with whom they have rapport, rather than a specific surgical approach.

Lancet 2016; 388: 1057–66

Comparison of outcomes between pure laparoscopic vs robot-assisted laparoscopic radical prostatectomy: a study of comparative effectiveness based upon validated quality of life outcomes

BJUI
BJU INTERNATIONAL

Daniel L. Willis, Mark L. Gonzalgo*, Michelle Brotzman*, Zhaoyong Feng*, Bruce Trock* and Li-Ming Su

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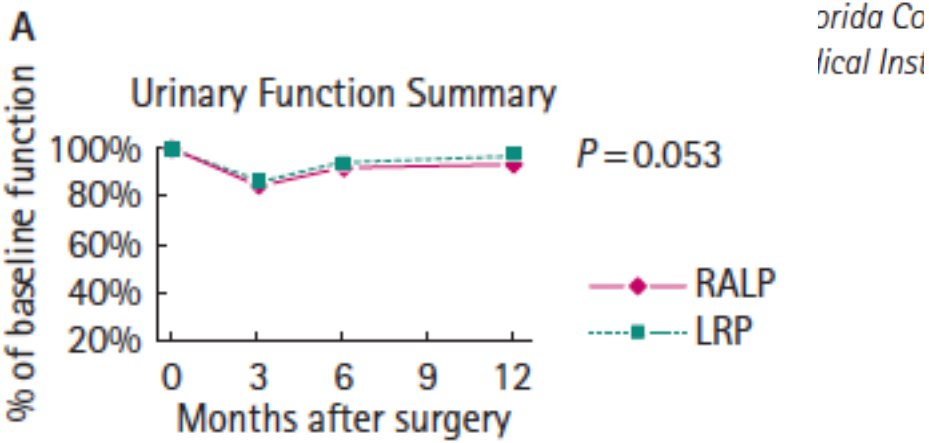

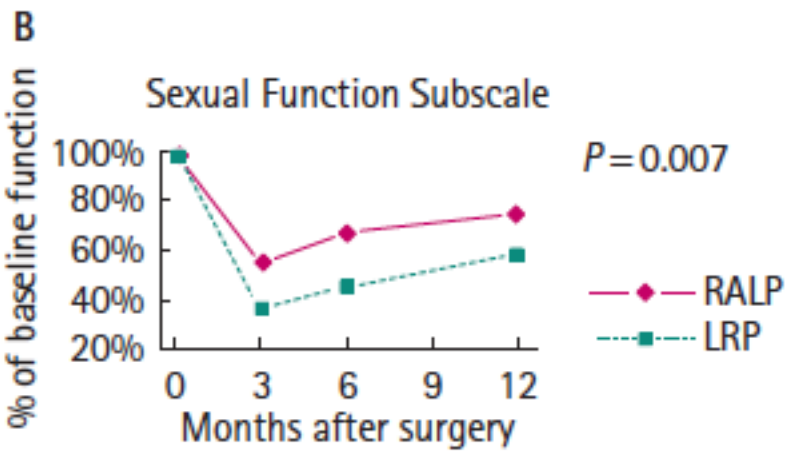

Operative Outcomes of Open Radical Prostatectomy, Laparoscopic Radical Prostatectomy, and Robotic-Assisted Laparoscopic Radical Prostatectomy from Selected Single Institution Series

Reference	Institution	Technique	Patients (N)	OR Time (min)	EBL (mL)	LOS (d)	Length of Catheterization (d)	Complication Rate (%)
Schroeck et al.[20]	University of Florida College of Medicine (Gainesville, FL)	ORP	500	143	820	2.11	8	0.2
Palisaar et al.[29]	Ruhr-Universität Bochum (Bochum, Germany)	ORP	62	161	790	11	10	N/A
Gregori et al.[11]	Ospedale Luigi Sacco (Milan, Italy)	LRP	80	218	376	4.5	10	22.5
Hakimi et al.[23]	Montefiore Medical Center (Bronx, NY)	LRP	75	232	311	3.4	N/A	14.7
Guillonneau et al.[30]	L'Institut Mutualiste Montsouris (Paris, France)	LRP	350	170	290	5	4.2	N/A
Badani et al.[15]	Vattikuti Urology Institute (Detroit, MI)	RALRP	2766	154	142	1.14	10	12.2
Hakimi et al.[23]	Montefiore Medical Center	RALRP	75	199	230	1.95	N/A	10.7

EBL, estimated blood loss; LOS, length of stay; LRP, laparoscopic radical prostatectomy; OR, operating room; ORP, open radical prostatectomy; RALRP, robotic-assisted laparoscopic radical prostatectomy.

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World J Mens Health 2017 April 35(1): 1-13
https://doi.org/10.5534/wjmh.2017.35.1.1

Review Article

Orgasmic Dysfunction after Radical Prostatectomy

Paolo Capogrosso[1,2], Eugenio Ventimiglia[1,2], Walter Cazzaniga[1,2], Francesco Montorsi[1,2], Andrea Salonia[1,2]

[1]Università Vita-Salute San Raffaele, [2]Division of Experimental Oncology, Unit of Urology, Urological Research Institute, IRCCS Ospedale San Raffaele, Milan, Italy

- climaturia: 20-93%
- dolore orgasmo-associato: fino al 19%
- anorgasmia: 33-77%

Comparative Effectiveness of Cancer Control and Survival after Robot-Assisted versus Open Radical Prostatectomy

Jim C. Hu,*,†,‡ Padraic O'Malley,†,§ Bilal Chughtai, Abby Isaacs, Jialin Mao, Jason D. Wright, Dawn Hershman and Art Sedrakyan||

From the Department of Urology, Weill Cornell Medical College-New York Presbyterian Hospital (JCH, PO, BC), Department of Healthcare Policy and Research, Weill Cornell Medical College (AI, JM, AS), Department of Obstetrics and Gynecology (JDW), Herbert Irving Comprehensive Cancer Center (JDW, DH) and Department of Medicine (DH), Columbia University College of Physicians and Surgeons, Department of Epidemiology, Columbia University Mailman School of Public Health (DH), New York, New York, and Department of Urology, Dalhousie University, Halifax, Canada (PO)

Results: A total of 6,430 robot-assisted radical prostatectomies and 9,161 open radical prostatectomies performed during 2003 to 2012 were identified. The use of robot-assisted radical prostatectomy increased from 13.6% in 2003 to 2004 to 72.6% in 2011 to 2012. After a median followup of 6.5 years (IQR 5.2–7.9) robot-assisted radical prostatectomy was associated with an equivalent risk of all cause mortality (HR 0.85, 0.72–1.01) and similar cancer specific mortality (HR 0.85, 0.50–1.43) vs open radical prostatectomy. Robot-assisted radical prostatectomy was also associated with less use of additional treatment (HR 0.78, 0.70–0.86).

Comparative Effectiveness of Cancer Control and Survival after Robot-Assisted versus Open Radical Prostatectomy

Jim C. Hu,*,†,‡ Padraic O'Malley,†,§ Bilal Chughtai, Abby Isaacs, Jialin Mao, Jason D. Wright, Dawn Hershman and Art Sedrakyan||

From the Department of Urology, Weill Cornell Medical College-New York Presbyterian Hospital (JCH, PO, BC), Department of Healthcare Policy and Research, Weill Cornell Medical College (AI, JM, AS), Department of Obstetrics and Gynecology (JDW), Herbert Irving Comprehensive Cancer Center (JDW, DH) and Department of Medicine (DH), Columbia University College of Physicians and Surgeons, Department of Epidemiology, Columbia University Mailman School of Public Health (DH), New York, New York, and Department of Urology, Dalhousie University, Halifax, Canada (PO)

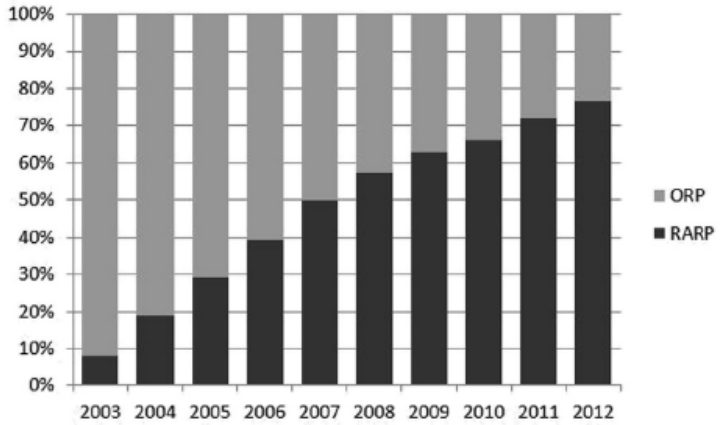

Figure 2. Increasing use of RARP vs ORP over time ($p < 0.001$)

Comparative Effectiveness of Cancer Control and Survival after Robot-Assisted versus Open Radical Prostatectomy

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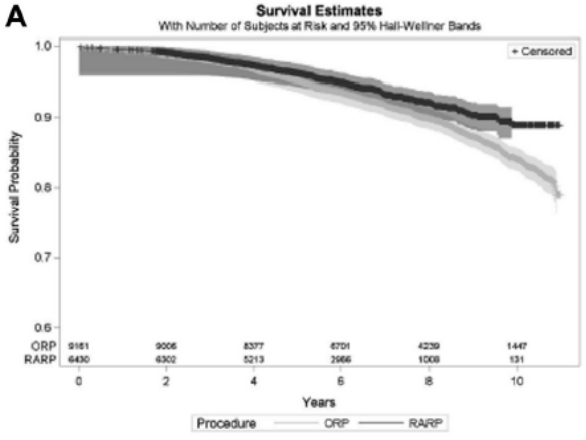
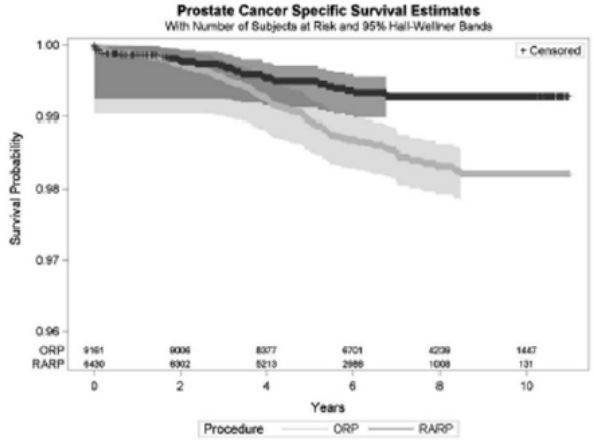
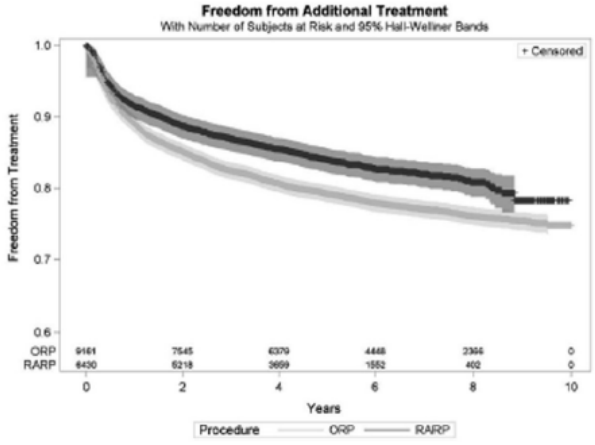
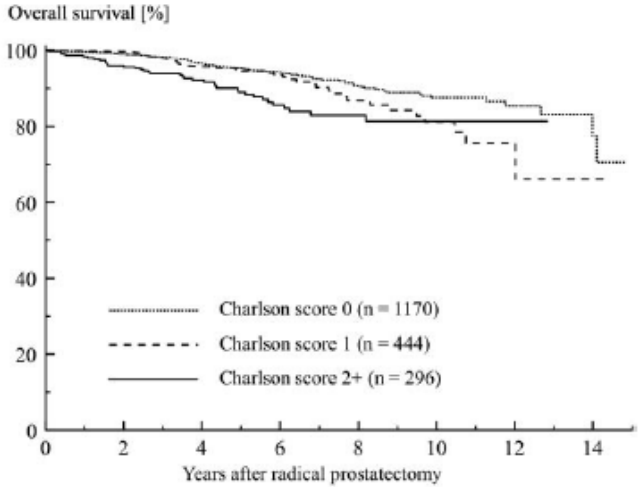


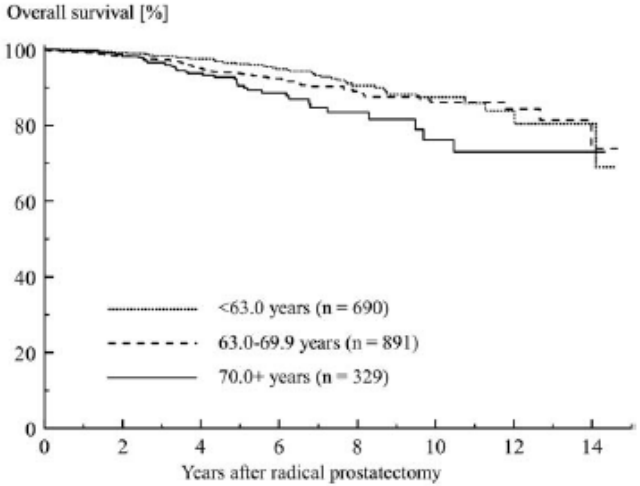




Detailed Analysis of Charlson Comorbidity Score as Predictor of Mortality After Radical Prostatectomy

Michael Froehner, Rainer Koch, Rainer J. Litz, Sven Oehlschlaeger, Lars Twelker, Oliver W. Hakenberg, and Manfred P. Wirth





Comorbidity score

Età

UROLOGY 72: 1252–1257, 2008. © 2008

CHIRURGIA & DISFUNZIONE ERETTIVA

- SEX OVER 70: > 50% **M** & > 30% **F** [1]
- DE in PC surgery: dal 20 al 90% [2-8]
- ↓ lunghezza / volumetria peniena post-RP: 70% [9]

1. *Lindau ST et al.: N Engl J Med 2007; 357: 762*
2. *Fowler FJ Jr. et al.: Urology 1993; 42: 622*
3. *Kundu SD et al.: J Urol 2004; 172: 2227*
4. *Litwin MS et al.: Urology 1999; 54: 503*
5. *Rabbani F et al.: J Urol 2000; 164: 1929*
6. *Rozet F et al.: J Urol 2005; 174: 908*
7. *Stanford JL et al. : JAMA 2000; 283: 354*
8. *Walsh PC et al.: Urology 2000; 55: 58*
9. *Mulhall J: Eur Urol 2007; 52: 626*

5-yr-BRFS

updated GRADE GROUPS

%		GS equivalent	Characteristic Features
96	Grade Group 1	3+3=6	Only individual discrete well-formed glands
88	Grade Group 2	3+4=7	Predominantly well-formed glands with a lesser component of poorly-formed/fused/cribriform glands
63	Grade Group 3	4+3=7	Predominantly poorly-formed/fused/cribriform glands with a lesser component of well-formed glands †
48	Grade Group 4	8	Only poorly-formed/fused/cribriform glands or Predominantly well-formed glands and a lesser component lacking glands †† or Predominantly lacking glands and a lesser component of well-formed glands ††
26	Grade Group 5	9-10	Lack of gland formation (or necrosis) with or without poorly formed/fused/cribriform glands †

Epstein J, 2013

CONCLUSIONI

- La PR rimane procedura di riferimento nel CaP per:
  - solidità dei risultati
  - sicurezza
  - accettabilità delle complicanze
  - diffusione delle informazioni
- Le Tecniche Mininvasive sono in ⬆
- Altre metodiche guadagnano spazio
- ⬆ diffusione delle informazioni → ⬆ CONDIVISIONE della scelta