



European Association of Urology



Letter to the Editor

Re: Daher C. Chade, Shahrokh F. Shariat, Angel M. Cronin, et al. Salvage Radical Prostatectomy for Radiation-recurrent Prostate Cancer: A Multi-institutional Collaboration. Eur Urol 2011;60:205–10

Chade and coworkers presented the largest multicenter series on patients treated with salvage radical prostatectomy (SRP) with encouraging results. Biochemical recurrence-free survival was 48% and 37% at 5- and 10-yr follow-up, respectively, and corresponding metastasis-free and cancer-specific survival rates were 77% and 83%, respectively. Patients with lower pre-SRP prostate specific antigen levels (<4 ng/ml) and lower postradiation prostate biopsy Gleason score (<7) have the highest probability of cure from SRP [1]. By proving that SRP is technically available, at least in tertiary medical centers, the authors provided confidence to both urologists and patients faced with recurrence after radiotherapy (RT). Due to the aim of this study, SRP complications, which are certainly of serious concern when any procedure is applied, were not mentioned by the authors; however, it is one thing to accept SRP after RT and quite another to take it for granted that we could put radical prostatectomy (RP) in a position secondary to RT.

Except for those with low-risk prostate cancer who were referred to brachytherapy, patients usually take RT because of comorbidities contraindicating surgery, short life-expectancy, or more advanced disease. In other words, if RP could be carried out in patients after failure of RT, why should it not be considered as a primary therapy? Furthermore, given the facts that medical and surgical complications of prostatectomy are significantly increased in the setting of prior RT, only one of four potent patients with SRP who underwent bilateral nerve sparing recovered erection adequate for intercourse, and the 3-year actuarial recovery of continence was 30% [2]; if one could have a second chance, we believe few would choose secondary RP.

We believe one may easily neglect the truth that, compared with choosing a secondary treatment regimen after failure of a primary one, deciding on a better primary therapy is more difficult but more important. We usually do not have too much choice when faced with the failure of a primary therapy, so we had best not indulge our will when choosing a primary therapy. However, maybe it is not just a matter of different medical decisions that we make but a strategy that we take or even some health policy that we

should follow. For advanced prostate cancer patients, definitive therapy alone is not enough to provide cure, so adjuvant or salvage therapies are warranted.

It seems reasonable that RP has a salvage role secondary to RT, and data also support adjuvant or salvage application of RT after RP. In contrast, high-grade gastrointestinal and genitourinary toxicities and complications of adjuvant or salvage RT were limited in prospective randomized studies [3–5]. In this light, we have another new decision to make: In a multimodal treatment strategy, which pattern is better for our patients, RP secondary to RT or RT secondary to RP? Only a prospective study comparing these two patterns could answer the question, and both oncologic outcomes and complications should be taken into consideration and balanced.

Conflicts of interest: The authors have nothing to disclose.

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XiaoJian Qin^{a,b}
DingWei Ye^{a,b,*}

^aDepartment of Urology, Fudan University Shanghai Cancer Center, Shanghai, China

^bDepartment of Oncology, Fudan University Shanghai Medical College, Shanghai, China

*Corresponding author. 270 Dong'an Road, Shanghai, 200032, China.
Tel. +862164175590; Fax: +862164175590
E-mail address: dwyeli@yahoo.com.cn (D.-W. Ye)

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