RE: Racial Differences in Mortality Among Medicare Recipients After Treatment for Localized Prostate Cancer

The recent article by Godley et al. (1) raises important concerns for those who manage localized prostate cancer. The authors found that African Americans who underwent surgery, radiation, or non-aggressive therapy for localized prostate cancer had a median overall survival that was 1.8, 0.7, and 1.0 years less than that of Caucasians treated with the same respective modality. Moreover, a significant disadvantage in overall survival was seen in African American surgical patients after adjusting for age, comorbidity score, stage, cancer grade, SEER site, and race-specific census tract level measures of education and income. Although the multivariable analysis was limited by the exclusion of serum prostate-specific antigen (PSA) level, one must still question why African American men have a 23% greater adjusted risk of death after surgical treatment, a therapy that is generally unavailable to the elderly population and those with significant comorbidities.

Also disturbing were the observations that a higher proportion of African Americans (38%) than Caucasians (27%) underwent non-aggressive treatments and that a smaller proportion of African Americans (24%) than Caucasians (33%) were treated with very aggressive therapy (i.e., surgery). These results are surprising because, when compared with Caucasians, a larger proportion of African Americans were less than 70 years of age (37% versus 34%) and were treated in the more recent era of widespread PSA use (59% versus 51%). These findings may relate to population differences in overall health, but it is important to consider possible reasons why African American men may be offered or select less aggressive therapies.

The main treatment decision variables for localized prostate cancer patients who opt for external radiotherapy, brachytherapy, or watchful waiting are the desire for less invasive therapy and few resultant side effects (2). In men who opt for surgery the overwhelming concern is cancer cure, although in many cases the treatment is pursued because of previous experiences of family and friends (2). Although treatment choice may be influenced by age, race, cancer risk group, and comorbidity (3), physician recommendation remains the most influential factor in treatment decision making (2). The treatment patterns described by Godley et al. (1) may, therefore, be greatly influenced by the lack of consensus of the best treatment strategy for African Americans or Caucasians with localized disease and also the common misconceptions about the quality of life after treatment delivery (1). The authors posed several interesting theories about racial disparities in treatment planning and survival but did not mention an ongoing trial that may ultimately clarify some of their findings.

This trial, the SPIRIT trial, is a randomized study of radical prostatectomy versus brachytherapy for patients with T1c or T2aN0M0 prostate cancer. The study, developed by the American College of Surgeons Oncology Group (ACOSOG) and supported by the Na-
tional Cancer Institute, is open at 37 centers around the United States and Canada. Its endpoints include overall, metastasis-free, and symptom-free survival as well as treatment-related side effects. A companion study will directly compare health-related quality of life of patients undergoing the two treatments. The trial has a projected accrual of 436 African American participants (22%) out of the total anticipated accrual of 1980 men.

Both studies are of particular interest for the African American community, because a prospective study of this size may elucidate treatment-related survival discrepancy, if one exists. A clarification of survival benefit from the two modalities will also permit better treatment recommendations by physicians. Likewise, careful documentation of side effects and quality of life, particularly in the subset of African American men, may provide the tools for patients to make better treatment choices. As of December 1, 2003, the study had accrued 48 patients, including three African Americans. To attain the projected goal of African American participants in this study, enthusiastic support will be required from all physicians who have access to African American populations. The Special Populations Committee of ACOSOG strongly urges clinicians to discuss this trial with their patients.

CHERYL T. LEE

REFERENCES


NOTES

1Editor’s note: SEER is a set of geographically defined, population-based, central cancer registries in the United States, operated by local nonprofit organizations under contract to the National Cancer Institute (NCI). Registry data are submitted electronically without personal identifiers to the NCI on a biannual basis, and the NCI makes the data available to the public for scientific research.

Affiliation of author: Michigan Urology Center, University of Michigan, Ann Arbor, MI.

Correspondence to: Cheryl T. Lee, MD, Comprehensive Cancer Center, University of Michigan, 7303 CCGC, 1500 E. Medical Center Dr., Ann Arbor, MI 48109-0946 (e-mail: ctlee@umich.edu).

DOI: 10.1093/jnci/djh139