CORRESPONDENCE

RE: Androgen Deprivation With or Without Radiation Therapy for Clinically Node-Positive Prostate Cancer

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We read with interest the article by Lin et al., who studied the impact of radiation therapy in addition to androgen deprivation therapy (ADT) in patients with clinically node-positive (cN+) prostate cancer (PCa) (1). The authors found a benefit of the combination treatment as compared with ADT alone. Even in the absence of solid prospective data testing the role of pelvic local treatment, men with cN+ have been always considered as affected by systemic disease. Therefore, ADT has been used as the standard of care over time (2). However, even though retrospective, the study by Lin et al. seems to challenge this approach, reinforcing previous evidence on the role of accurate pelvic treatment in men with node-positive PCa (3). This indirectly also supports the hypothesis that nodal spread does not equal to systemic dissemination in all patients (4).

However, we believe that this study, as many in this setting, can be considered only as hypothesis generating. Indeed, despite the use of an accurate methodological approach, several key data and prognostic factors have not been considered. First, the authors did not report on the imaging used to detect nodal dissemination. Moreover, regardless of the (supposedly conventional) imaging used, the extent and the presence of nodal invasion may have been highly inaccurate given the poor performance characteristics of any standard imaging modality in assessing pelvic lymph node status in PCa (5). Second, no information is provided with regards to the criteria used for node positivity definition; also, no data is available about the number of suspicious nodes at imaging. Although subanalyses have been made in the subcohort of men with available numbers of positive lymph nodes, no matching has been made between the two groups with regards to the extent of nodal dissemination. Therefore, the groups of patients could be unbalanced in this regard. This is key because the number of affected lymph nodes is the major predictor of mortality among patients with N1 disease (3,6). Third, no information is given regarding RT dose and fields. Finally, despite the lack of virtually any data, surgery may still play a role in selected cN+ patients (2). Advantages of surgery over RT in this setting may reside on the following points: 1) accurate assessment of the real extent of nodal invasion, as specificity of conventional imaging for lymph node invasion is not optimal; 2) more accurate pelvic nodal treatment when a metastolic and extended pelvic lymph node dissection is provided; 3) use of a multimodal approach with accurate tumor debulking. However, this approach should be tailored to each patient’s characteristics and balanced again with possible treatment-related toxicity.

In conclusion, we believe that the time has come to assess the role of pelvic local treatment among cN+ patients in the setting of a well-designed, prospective, randomized controlled trial (RCT). We cannot indeed ignore the increasing retrospective evidence confuting the dogma that N1 PCa represents an invariable systemic disease. However, only an RCT may overcome many of the possible biases inherent to any retrospective study.

References