Letters to the Editor

Re: Local treatment for metastatic prostate cancer: A systematic review

We read with interest the published article by Tilki et al., which was a systematic review of local treatments for metastatic prostate cancer (mPCa). Recently, there has been growing interest in the possible prognostic impact of adding definitive local treatment to systemic therapy. Although the effectiveness of androgen deprivation therapy (ADT) plus radiotherapy (RT) and its association with improved survival are promising for lymph node-positive prostate cancer, limited retrospective data exist regarding the additive role of RT to the prostate to treat mPCa. Therefore, this review is timely and improves our comprehensive understanding of local treatment for patients with de novo mPCa.

In 2017, we published a retrospective study on definitive local RT to the prostate in Japanese patients with de novo mPCa using a single institution database. That study showed an overall survival benefit (hazard ratio 0.327 vs control) when RT was added to prostate treatment, which is in accordance with previous reports. Similarly, in propensity score-matched analysis, there was a statistically significant difference in overall survival between patients treated with ADT and ADT plus RT.

We agree with the suggestions provided by the authors of this review article that the results of retrospective studies, which are associated with unmeasured biases, should be interpreted with caution. The results of several ongoing prospective studies should confirm the possible clinical benefit of adding local definitive treatment to ADT. The patients in whom local treatment with ADT is beneficial, when to provide local treatment for these patients and which local treatment modality is optimal remain to be elucidated. Post-hoc subgroup analyses of prospective randomized controlled studies might answer these questions in the near future.

Patients with de novo mPCa often have local complications, such as bladder outlet obstruction and intractable bleeding caused by a local recurrent tumor in the final progressive castration-resistant prostate cancer stage. The addition of local treatment to ADT during the period of castration-sensitive prostate cancer might provide another clinical benefit: reduction of these late local complications. Regardless of the survival benefit, investigating whether a local treatment can result in the reduction of local complications, in contrast, evaluating the early and late adverse events associated with the local treatment, requires further study.

Dear Editor,

Inoue et al. reported an increased risk of secondary hematological neoplasms in patients with metastatic germ cell tumor receiving multiple regimens of chemotherapy. Our group has already reported on the incidence of secondary hematological neoplasms in Japanese patients with germ cell tumor receiving chemotherapy. In our series of 139 patients, three patients (2.2%) developed acute myeloid leukemia or myelodysplastic syndrome, of whom all had received a single first-line regimen of conventional chemotherapy. Here, we would like to emphasize that we should consider that the risk of secondary hematological neoplasms is not negligible, not only in germ cell tumor patients receiving multiple regimens, but also in those receiving a single regimen of chemotherapy. Hereafter, an increase in the number of survivors of germ cell tumor is expected, and early detection of secondary hematological neoplasms should be a critical issue in the follow up. The number of such patients is extremely limited in a single institution. Therefore, nationwide data collection is urgent to establish the management strategy. We would like to suggest that the Japanese Urological Association should take the initiative on this issue.

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Conflict of interest

None declared.

References

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Corrigendum

The publisher would like to draw the reader’s attention to an error in the following article:

Under the Results heading of the Abstract section, the first sentence is written incorrectly. The correct sentence should read:
There was no significant difference in preoperative characteristics between the two groups except for tumor size ($P = 0.001$).

The authors apologize for this error and any inconvenience it has caused.

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References