Managing advanced prostate cancer: No longer the primary domain of general urology

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The CUA exists to promote the highest standard of urologic care for Canadians and to advance the art and science of urology.

Early in many of our careers, the management of advanced prostate cancer (PCa) was done primarily by the general urologist. For decades, urologists treated metastatic (m) PCa with surgical/chemical castration. We did a great job managing the disease and played the central physician role, even into the palliative stage. Fortunately, the life expectancy for men with mPCa has increased significantly due to the advent of many new treatment options; however, the field has become very complex.

There are now several options available for untreated mPCa. Beyond androgen deprivation therapy (ADT), new life-prolonging approaches include several androgen receptor axis targeted therapies (ARATs), docetaxel chemotherapy, and ARAT/docetaxel combination. In addition, many patients still benefit from local radiotherapy despite having metastases. We can add to the mix the growing need to verify the mutational status of the germline and/or tumor tissue for homologous recombination deficiency and the eventual addition of poly (ADP-ribose) polymerase inhibitors. Moreover, the entire field of prostate-specific membrane antigen (PSMA) imaging, PSMA-targeted therapies, and stereotactic radiation to select metastases is rapidly evolving, adding to the complexities of management.

When ARATs became indicated in the castration-resistant stage, we argued general urologists were well-positioned to employ these agents since they are essentially an extension of ADT. Many CME hours were offered to fulfill the educational needs for urologists to get on board. Well, it turns out many patients are not receiving ADT intensification in the castration-sensitive or -resistant stages despite these drugs being available for years. There are several possible reasons for this, including the need for closer monitoring of internal medicine-type parameters, greater side effects, and the "hassle factor" in getting provincial permission. Perhaps another reason is that these patients have not been consulted by a urologic or medical oncologist and their team. Surprisingly, and unfortunately, there are still many men who die from PCa who never even received chemotherapy despite being eligible. Referring patients to medical oncology when they are fast-progressing, symptomatic, and frail is too late.

The management of advanced PCa requires a team, with strong nursing and pharmacy support, frequent assessments, and lab monitoring. The traditional, "If PSA is OK, all is good," approach is no longer appropriate; more is required to monitor the patient and the disease. Furthermore, with the benefit of docetaxel chemotherapy in the castration-sensitive metastatic state, evaluation of whether a patient is "fit for chemotherapy" cannot be done by general urology. The same argument applies as to who is best suited to weigh the clinical merits of chemotherapy vs. ARAT or combination with the patient. Finally, decisions made at early stages of mPCa, as well as timing of referral, can profoundly affect potential remaining therapeutic options down the road.

We should accept that general urologists are not the best-equipped to be at the center of advanced PCa management but rather be members of a team, where the medical or urologic oncologist has the principal role. We need greater integration of general urology with medical/urologic oncologists involving the establishment of local teams and access to regional tumor boards. We should take advantage of the benefits learned from the pandemic regarding tele/virtual medicine. With the help of our colleagues in GUMOC (GU Medical Oncologists of Canada) and our Community Urology Committee, the CUA is poised to facilitate this integration as much as possible.