POINT: It's never too soon

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A multidisciplinary approach to prostate cancer has become the rule and not the exception. Involving the entire team, which includes a medical oncologist, from the time of initial diagnosis is optimal. This facilitates maximal patient education regarding treatment options and enhances informed decision making. A coordinated approach also promotes enrollment on clinical trials, which are often, multimodality, especially in high-risk early stage prostate cancer. Integrated therapeutic strategies throughout the patient's disease course can improve both patient care and satisfaction.

Key Words: multidisciplinary, prostate cancer, medical oncologist

Tradition is nice; mom's pumpkin pie on Thanksgiving or a favorite annual summer outing, but sometimes its best to break with tradition. Urologists have always been the gatekeepers for the care of men with prostate cancer. A "paternal" role that assumes they always know what is best for their patient. Well intended as he, it usually is a he, may be, in today s world in which 5,000 articles a year are being published on prostate cancer, he should not only consider sharing the responsibility of his patient's care, he should embrace it. This is the era of the multidisciplinary approach to men with prostate cancer. Urologists need to join the 21st century and their team of empowered specialists. What's stopping you?

Your team can only enhance the care of your patient. A medical oncologist, a radiation oncologist and the urologist are the nucleus, with numerous supporting roles from nutritionalists, social workers, psychologists and spiritual counselors, to name a few of the other key players. A man diagnosed with prostate cancer should be given the opportunity to have appropriate input from these specialists from the time of initial diagnosis. WHY? Because it affords them the opportunity to make truly informed decisions about their choice of treatment and may allow them to participate in novel cutting edge therapies that will potentially improve the survival and quality of life of these men.

Surveys have shown that given the choice of

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therapy for their own localized prostate cancer, over 90% of urologists would choose surgery, over 90% of radiation therapists would choose radiation and the medical oncologists split in their modality preference. What does this tell us? Specialists don't want inferior treatment for themselves, but rather they believe their modality is superior and they can back that opinion with facts. Looking at published statistics, one can defend either treatment choice. It's how and which facts you choose to consider. Assuming a patient is an appropriate candidate for either surgery or radiation, the physicians who have the hands-on experience with the risks and benefits of that modality are the most qualified to present the information and the patient should be encouraged to seek these consultations. So where does the medical oncologist come in? We have been often dubbed as "middle ground" and this is probably a reasonable title. But often our role is more than that. Multimodality therapy for the high-risk patient is progressively emerging as the preferred approach to men with high-risk localized disease and medical oncologists are an integral part of this approach.

A man with good prognosis prostate cancer may benefit from hearing why a man might choose or not choose surgery or radiation from a specialist who is knowledgeable in the field, but does not benefit from their choice of treatment. A man with high risk cancer with a pathologic Gleason score of 8-10, PSA level greater than 20 or extensive disease on multifocal biopsy is at higher risk of having non-organ confined disease and of ultimately developing and dying of systemic disease. This patient population is the focus of numerous phase II and phase III clinical trials combining either radiation or surgery with androgen deprivation and chemotherapy. Neoadjuvant, adjuvant and concomitant interjection of chemotherapy are all being explored. The premise being that it is androgen independent cells that lead to refractory systemic disease and that targeting these cells when they are present in small number may allow an increased number of men to be cured of their cancer. Enhanced survival with the early use of chemotherapy has already been established in other cancers such as breast and colon cancer. So why should this not be true in prostate cancer as well. The only way to prove this is to complete critical clinical trials addressing this issue. This requires early referral to the medical oncologist and early collaborative efforts.

Once the team is established, the barrier to referring the patients is lowered. Your knowledge of what clinical trial opportunities exist is also enhanced. So when the pathology report on your radical prostatectomy specimen indicates unexpected positive surgical margins, seminal vesicles or lymph nodes, you have already counseled your patient about the current Intergroup trial of adjuvant hormonal therapy with or without chemotherapy and with optional radiation or some other available adjuvant trial and you and your team have a supplemental plan already in place. And your patient has been given the best possible care he can get.

Your team is also established when the PSA rises after prostatectomy or radiation or watchful waiting and appropriate discussions by each specialists fall into place. Local salvage options, hormonal therapy and novel investigational approaches with vaccines, endothelin-A receptor antagonists or COX-2 inhibitors or even chemotherapy all can be explored. Again there is a team approach and the medical oncologist is one of the key players.

Chemotherapy has been traditionally labeled as ineffective and too toxic. Chemotherapy has made rapid strides in the last decade in prostate cancer treatment. The new era of cytotoxic therapy began with the mitoxantrone/corticosteroids combination, which not only palliated pain, but also was associated with improved global quality of life, refuting the traditional viewpoint that chemotherapy is too toxic for men with advanced disease. The taxanes, paclitaxel and docetaxel, emerged next and are not only active drugs, but when the two recently completed phase III trials comparing mitoxantrone versus docetaxel are analyzed in the near future, the standard statement that chemotherapy does not improve survival in hormone-refractory prostate cancer may be negated. Intravenous bisphosphonate therapy has also emerged as a means of reducing skeletal morbidity in men with osseous metastases. These agents are also being assessed in earlier stage disease to prevent the development of bone metastases again facilitated by early referral to your medical oncology colleague.

My bottom line is, it is never too early to refer a man with prostate cancer to medical oncologist. We are an integral part of the team. Integrated therapeutic strategies are the way to optimal patient care and satisfaction. With established collaborative teams, patients benefit from a balanced and thorough presentation of treatment options at every step of the disease course. The input from each specialist shifting as the patient's needs change. Urologists need to abandon their role as gatekeeper in favor of that of team leader. There is truly nothing to lose and everything to gain from this approach. Join the bandwagon and be part of the solution. □