



## Letter to the Editor

### Re: Abdenour Nabid, Nathalie Carrier, André-Guy Martin, et al. Duration of Androgen Deprivation Therapy in High-risk Prostate Cancer: A Randomized Phase III Trial. *Eur Urol* 2018;74:432–31

We read with interest the article by Nabid et al. [1] describing the results of a randomized trial (NCT00223171) comparing 18 mo versus 36 mo of androgen deprivation therapy (ADT) combined with radiation therapy (RT) for high-risk prostate cancer.

Contemporary international guidelines discriminate between localized prostate cancer (cT1–2cN0cM0) with high-risk disease features (eg, Gleason score >7, prostate-specific antigen >20 ng/ml) and locally advanced prostate cancer (eg, cT3–4cN0cM0) [2]. These two prostate cancer patient populations should not be mixed into one “high-risk group”, but should better be reported separately and treated differently. In the present article, however, patients with locally advanced prostate cancer were rare (only up to 20%), with the remaining majority of patients having localized prostate cancer with high-risk disease features [1].

A secondary analysis of the RTOG 85-31 trial on RT alone versus RT combined with ADT for locally advanced prostate cancer suggested an advantage from longer ADT, comparing ≤1 yr versus 1–5 yr versus >5 yr [3]. In a landmark European trial showing an overall survival benefit for 36 mo of ADT plus RT versus RT alone, approximately 91% of patients had locally advanced prostate cancer [4]. In the subsequent EORTC 22961 trial showing the inferiority of 6 mo of ADT plus RT versus 36 mo plus RT, again the majority of patients (approx. 78%) had locally advanced prostate cancer [5]. Thus, long-term ADT plus RT was established as the standard of care for patients with locally advanced prostate cancer, and to challenge this paradigm, a trial needs to include enough patients with locally advanced prostate cancer to be valid.

The authors of the present article correctly state that the proportion of patients with T3–4 locally advanced prostate cancer in their cohort was smaller than in the aforementioned trials. Moreover, a potential difference in the effect of

ADT duration could have been attenuated by the relatively poor adherence to the 36-mo protocol, which was only 53%. For comparison, of the 487 patients assigned to long-term ADT in the EORTC 22961 study, 349 (71.7%) completed the 3-yr course [5]. Interestingly, the 5-yr overall survival was 85% versus 81% in the EORTC trial, and 91% versus 86% in the current study with long-term and short-term ADT, respectively. As the patients in EORTC 22961 were slightly younger in terms of median age, this difference might in part be due to the distribution of clinical risk factors such as the proportion of pT3–4 patients, but could also be treatment-related.

However, the conclusion by Nabid et al. that ADT combined with RT may potentially be reduced to 18 mo for selected men should be specified explicitly. In our opinion, it is valid, if at all, only for patients with localized prostate cancer and high-risk features, as these patients accounted for the majority of the trial cohort [1]. Without this specification, the conclusion is misleading, should not be generalized to all patients with high-risk disease features, and is particularly not true for patients with locally advanced prostate cancer.

**Conflicts of interest:** The authors have nothing to disclose.

## References

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