



available at www.sciencedirect.com
journal homepage: www.europeanurology.com



European Association of Urology

Letter to the Editor

Re: Gaëtan Devos, Gert De Meerleer, Steven Joniau. Have We Entered the Era of Imaging Before Salvage Treatment for Recurrent Prostate Cancer? Eur Urol 2019;76:265–7

We read the Platinum Opinion by Devos et al. [1] with great interest and would like to take the opportunity to respond to some of the issues raised.

First, Devos et al. indicate that our study [2] might have had different results if carried out using a prostate-specific membrane antigen (PSMA) ligand and not choline. Although the sensitivity of PSMA is superior, the pattern of relapse as detected via PSMA will be the same as with choline. Devos et al. provide proof of their own by publishing their own lesion-based analysis of PSMA positron emission tomography/computed tomography data. When comparing their anatomic distribution with ours using choline, this becomes obvious: prostate bed, 21% versus 22%; lymph nodes, 71% versus 70%; bone, 18% versus 26%; and visceral, 0% versus 3% [1,3]. As we indicated in our previous research, others have come to the same conclusions [3].

Second, they mention that it would have been more interesting to record all anatomic recurrences without restriction to fewer than five nodal recurrences, and claim that the reason why we did so is unclear, and that we failed to provide these insights. We want to point out that we depicted the full landscape of relapses in a previously published paper [3]. The goal of the current study was different, as mentioned in our paper [2]. We focused on patients with a limited number of nodal recurrences as these patients might benefit from local salvage treatments. The paper offers one of the first three-dimensional models of the possible location of nodal recurrences in relation to the known anatomic landmarks used for surgery and radiotherapy (RT), raising awareness of potential pitfalls of these templates [2].

Third, Devos et al. advocate using imaging before salvage treatment and avoiding “blind” salvage RT (SRT) of the prostate bed. We believe that this advice lacks evidence and would like to emphasize that the ideal window for

delivering SRT is limited, and it is uncertain what the true value of a scan result means in clinical practice. For example, “blind” SRT resulted in biochemical control reaching 85% in the GETUG-16 trial [4] with 10-yr metastasis-free survival of 75%, as reported at the 2019 American Society of Clinical Oncology meeting. However, 42% of these patients are supposed to have PSMA-positive lesions outside the prostate bed [5], but only 25% develop metastases at 10 yr [4]. Does this imply that not all PSMA-positive lesions are true positives or that some lesions lack the potential to drive the disease? There are only two ways to solve this question: (1) an SRT trial with PSMA for all patients for which physicians remain blinded, or (2) a randomised trial comparing SRT with PSMA-guided SRT with metastasis-free survival as the primary endpoint. In the meantime, “blind” SRT should remain the standard of care outside clinical trials as we are not ready to enter the era of imaging for all before SRT.

Conflicts of interest: Aurélie De Bruycker has nothing to disclose. Valérie Fonteyne has acted in a consulting or advisory role and received institutional research funding from Ipsen and has received travel and accommodation expenses from Ipsen and Ferring Pharmaceuticals. Piet Ost has acted in a consulting or advisory role for Ferring Pharmaceuticals, Bayer AG, and Janssen, has received institutional research funding from Merck and Varian, and has received travel and accommodation expenses from Ipsen and Ferring Pharmaceuticals.

References

- [1] Devos G, De Meerleer G, Joniau S. Have we entered the era of imaging before salvage treatment for recurrent prostate cancer? *Eur Urol* 2019;76:265–7.
- [2] De Bruycker A, De Bleser E, Decaestecker K, et al. Nodal oligorecurrent prostate cancer: anatomic pattern of possible treatment failure in relation to elective surgical and radiotherapy treatment templates. *Eur Urol* 2019;75:826–33.
- [3] De Bruycker A, Lambert B, Claeys T, et al. Prevalence and prognosis of low-volume, oligorecurrent, hormone-sensitive prostate cancer amenable to lesion ablative therapy. *BJU Int* 2017;120:815–821.
- [4] Carrie C, Hasbini A, de Laroche G, et al. Salvage radiotherapy with or without short-term hormone therapy for rising prostate-specific antigen concentration after radical prostatectomy (GETUG-AFU 16):

DOI of original article: <https://doi.org/10.1016/j.eururo.2019.06.034>.

<https://doi.org/10.1016/j.eururo.2019.06.033>

0302-2838/© 2019 European Association of Urology. Published by Elsevier B.V. All rights reserved.



a randomised, multicentre, open-label phase 3 trial. *Lancet Oncol* 2016;17:747–56.

- [5] Rauscher I, Duwel C, Haller B, et al. Efficacy, predictive factors, and prediction nomograms for ⁶⁸Ga-labeled prostate-specific membrane antigen-ligand positron-emission tomography/computed tomography in early biochemical recurrent prostate cancer after radical prostatectomy. *Eur Urol* 2018;73:656–61.

Department of radiotherapy, Ghent University Hospital, Ghent, Belgium

*Corresponding author. Department of Radiotherapy, Ghent University Hospital, C. Heymanslaan 10, B-9000 Ghent, Belgium. Tel. +32 3322411. E-mail address: piet.ost@ugent.be (P. Ost).

June 27, 2019

Aurélie De Bruycker
Valérie Fonteyne
Piet Ost*