Quality of life in men with prostate cancer

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Much of the controversy surrounding prostate cancer screening revolves around the negative effects of treatment on quality of life. This issue continues to come into play even though prostate cancer is consistently in the top three leading causes of cancer mortality in men in most high-income countries. The fact that, in many studies, the side-effects of treatment do not necessarily translate into diminished quality of life is also intriguing. Is it possible that patients in clinical trials might not report problems as much as those in real-world settings?

These issues are addressed in the paper in *The Lancet Oncology* by Amy Downing and colleagues,[1] who studied patient-reported outcomes from more than 30 000 patients in the UK with prostate cancer. Although much has been written about quality of life in patients with prostate cancer, no studies have been as extensive as this study by Downing and colleagues or included as many patients—over 10 000—with advanced prostate cancer. Balancing the side-effects of treatment and the risks related to the cancer itself has become a priority in the field of prostate cancer. This balance is critically important but has unfortunately produced situations in which delays in treatment might have resulted in suboptimal outcomes.

One would assume that avoiding treatment, and its inherent side-effects, in localised prostate cancer would lead to better preservation of quality of life, but this was not the case in the Scandinavian prostate trial.[2,3] The study in fact showed that watchful waiting not only resulted in diminished survival, but also in diminished quality of life in those who did not undergo surgery. Although the study was done in the pre-screening era, it does oblige us to realise that newly diagnosed patients need to be individualised. Obviously, any treatment, whether it be radiotherapy or surgery, risks leading to functional adverse events. Reassuringly, Downing and colleagues report that overall patient-reported outcomes in patients treated for localised prostate cancer are similar to those of the general population. However, there is a need to address the sexual complications caused by treatment at every stage of the disease (81% of patients in the study reported poor sexual function). With regards to more advanced prostate cancer, knowing how aggressively to treat these patients with androgen deprivation therapy, given all the known side-effects of this treatment, remains a dilemma. Repeated efforts have been made to reduce the intensity of androgen deprivation therapy at the time of diagnosis and to delay the introduction of therapy for as long as possible in those with recurrent disease. Again, these efforts have sometimes led to negative outcomes without necessarily improving quality of life.[4–6]

Ideally, we will eventually develop predictive markers that will allow us to discriminate between the more aggressive cancers that are most in need of early aggressive therapy and allow us to predict which patients are at highest risk of adverse events with androgen deprivation therapy. Until then, we must re-establish some reasonable equilibrium and return the focus to the fact that, first and foremost, we are treating a life-threatening disease for most of those diagnosed. I, for one, admit that issues of quality of life, and the worry of doing more harm than good, have sometimes made me delay interventions in cancers I underestimated. I have humbly regretted some of the decisions I made with the best possible intentions. The work presented by Downing and colleagues does help to put these issues into better perspective and is a step in the right direction in helping those of us who treat prostate cancer to obtain a better understanding of how patients are coping with their disease and treatments. The treatment of prostate cancer has come under severe scrutiny since the era in which every patient in some parts of the world was aggressively screened and treated. In retrospect, we were probably doing more harm than good in many cases. The worry now is that the pendulum might have swung in the opposite direction and we fear that we might slowly creep back to the era in which most patients were treated at a late or incurable stage. Clearly, continued intensive efforts in research are needed to achieve the aim of optimising and personalising care of patients with prostate cancer. For the time being, we can be reassured, however, that in terms of patient-perceived quality of life, we might be doing a better job than we previously thought.

Fred Saad
University of Montreal Hospital Center, Montreal, H2x 0A9, QC, Canada
fred.saad@umontreal.ca

I declare no competing interests.

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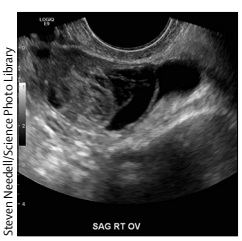
Conservative management of adnexal masses



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Adnexal masses are common and often identified incidentally.[1] This diagnosis often leads to additional investigations and interventions that could cause morbidity with unknown or questionable clinical benefit.[1,2] Generally, ovarian tumours do not undergo preoperative biopsy to avoid disrupting the ovarian capsule, which can cause dissemination of malignant cells.[3] Hence, without a definitive tissue diagnosis, clinicians are often reliant on other tools to determine the clinical implications of a neoplasm. Therefore, reliable clinical tools are essential to aid in decision making when a woman presents with a new adnexal lesion. Many practitioners often depend on additional investigations such as serum tumour markers, MRI, and the risk of malignancy index (RMI) algorithm;[4,5] however, these tests are non-specific and carry low predictive values.

In *The Lancet Oncology,* Wouter Froyman and colleagues report on the 2-year interim results of the International Ovarian Tumor Analysis phase 5 (IOTA5) study.[6] This is a prospective, multicentre, cohort study of patients with adnexal masses (ovarian, tubal, and paratubal) classified as benign by use of ultrasonography. The primary outcomes of the interim study were to determine the 2-year cumulative incidence of spontaneous resolution of these masses and adverse events including borderline or invasive malignancy, cyst rupture, and torsion.[6] This study focuses on a crucial topic that affects many women and poses a common challenge in clinical practice. Reducing unnecessary testing (ie, imaging, biopsies, blood tests, and surgical interventions) has the potential to optimise use of resources. Furthermore, defining clear criteria of the malignant potential of a tumour and the associated risks of complications would be helpful to triage patients to conservative versus surgical management. the authors report a low risk of malignancy and acute complications and strongly support conservative management of adnexal masses classified as benign by use of ultrasound.[6] The overall 2-year cumulative incidence of spontaneous resolution of these masses was 20·2% (95% CI 18·4–22·1).[6] The 2-year cumulative incidence of finding invasive malignancy at surgery was 0·4% (95% CI 0·1–0·6), 0·3% (<0·1–0·5) for a borderline tumour, 0·4% (0·1–0·7) for torsion, and 0·2% (<0·1–0·4) for cyst rupture.

Although these data are encouraging, some limitations are noted. The study is a 2-year interim analysis of a large multicentre trial that originally identified 8519 women with adnexal masses, of whom 4567 (54%) were selected for conservative management and 3906 (46%) for surgical management; only those selected for conservative management are discussed in the Article. Of those selected for conservative management, 120 (3%) patients were excluded because their diagnosis did not match the inclusion criteria (ie, they were diagnosed with an invasive or borderline malignant lesion, or the ultrasound examiner was uncertain of their diagnosis) and a further 1303 (29%) patients were excluded because their data was of insufficient quality or their study site had not collected enough data. Hence, the primary analysis comprised a subgroup of 3144 patients. Of these patients, an additional 557 (18%) were excluded because of either incomplete data (n=221) or unplanned surgery (n=336). Of the remaining 2587 patients, 668 (26%) had masses that had been diagnosed before inclusion in the study and potentially are a confounding subgroup