UCCH Universitäres Cancer Center Hamburg
UCCSH Universitäres Cancer Center Schleswig-Holstein

UCCH / UCCSH Pathway

Guideline
Prostate Cancer

Version March/2024

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Version 08, March/2024

according to TNM classification 8th edition

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Implemented	Apr/2008
Update	May/2012, May/2014, May/2016, May/2018, May/2020, Jun/2021, March 2024
Next planned review	Jun/2026

Legend of Colours

= Therapeutic procedure

= Clinical or diagnostical condition

= Diagnostic procedure

= Clinical trial

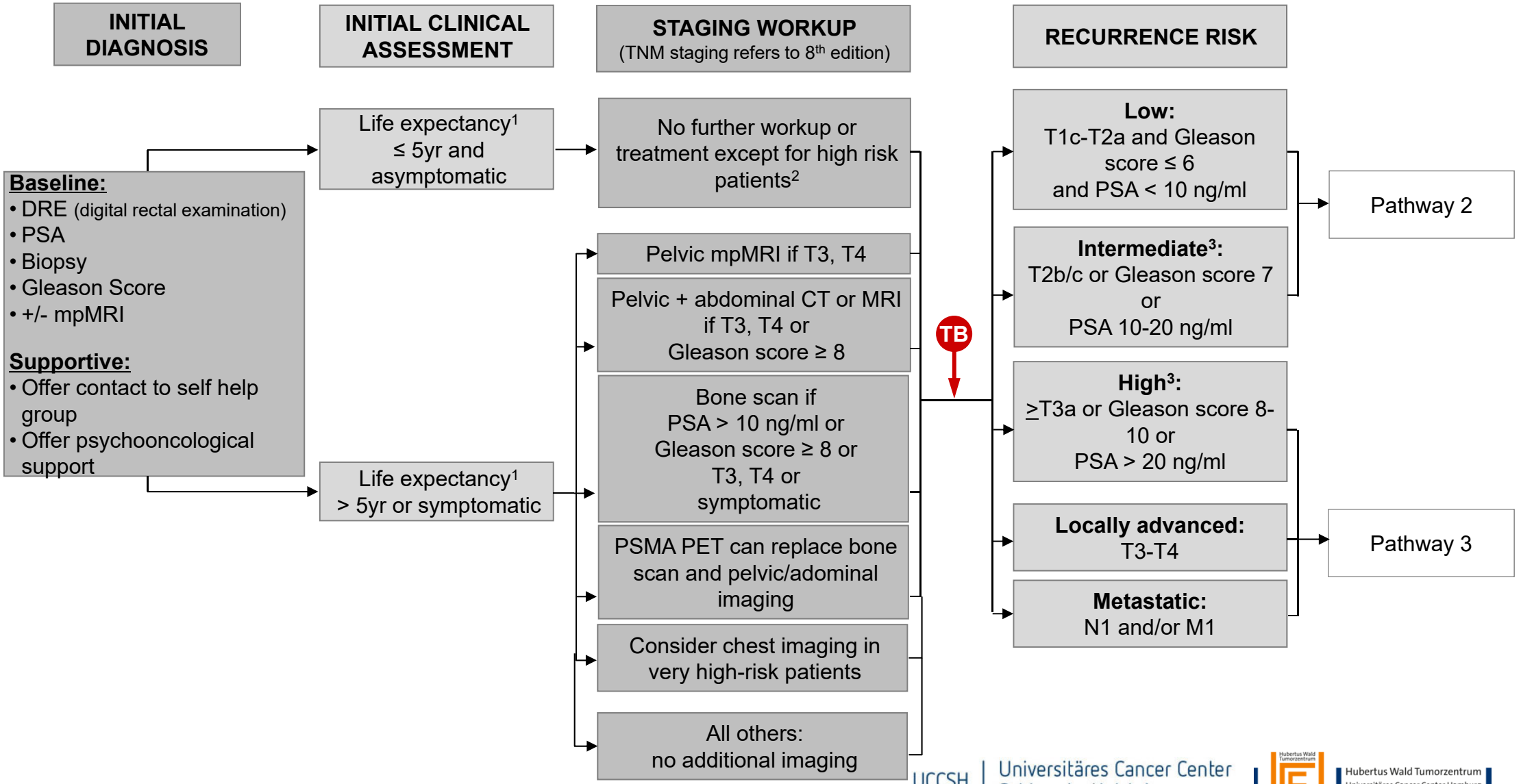
= Supportive measure

= Referral

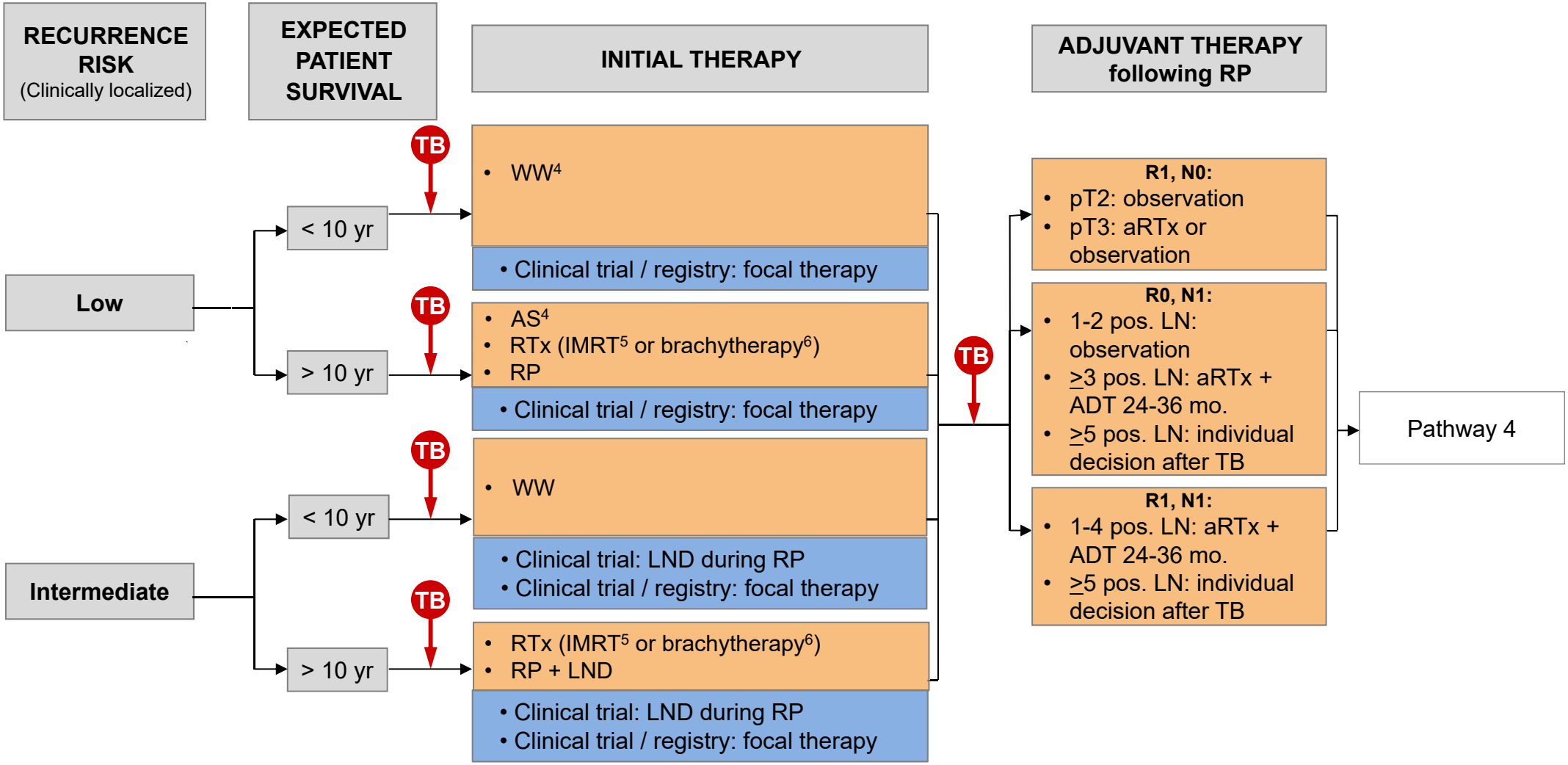
TB = Tumorboard (including post tumorboard interaction with patient that follows the principles of shared decision-making)

Abbreviations:
AS: Active surveillance
ADT: Androgen Deprivation therapy
RP: radical prostatectomy
RTx: radiotherapy
sRT: salvage RTx
aRT: adjuvant RTx
LND: Lymph-node dissection
PSMA: prostate-specific membrane antigen
PET: positron-emission tomography
mpMRI: multiparametric magnet resonance imaging
WW: Watchful waiting

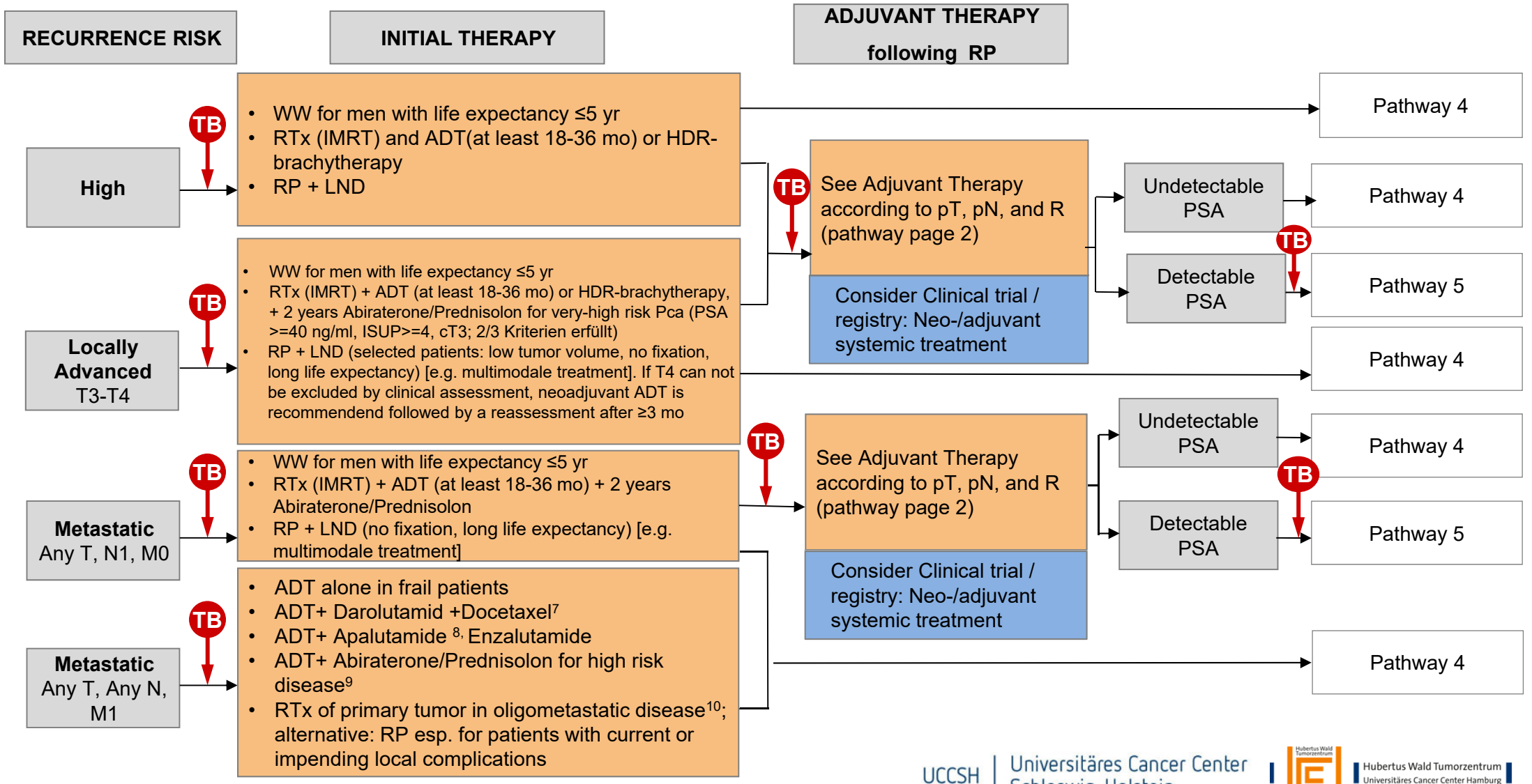
Pathway 1: Clinical Assessment



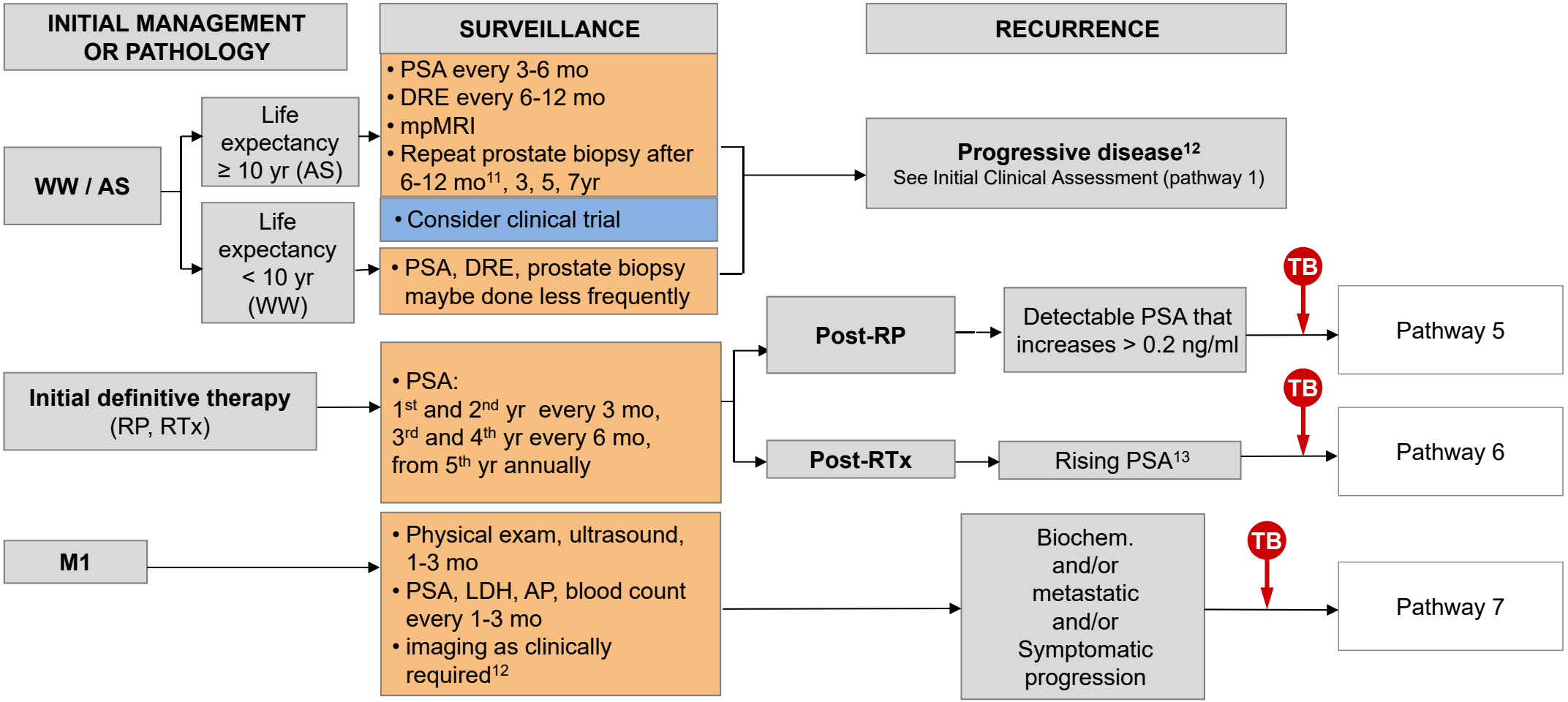
Pathway 2: Initial Therapy



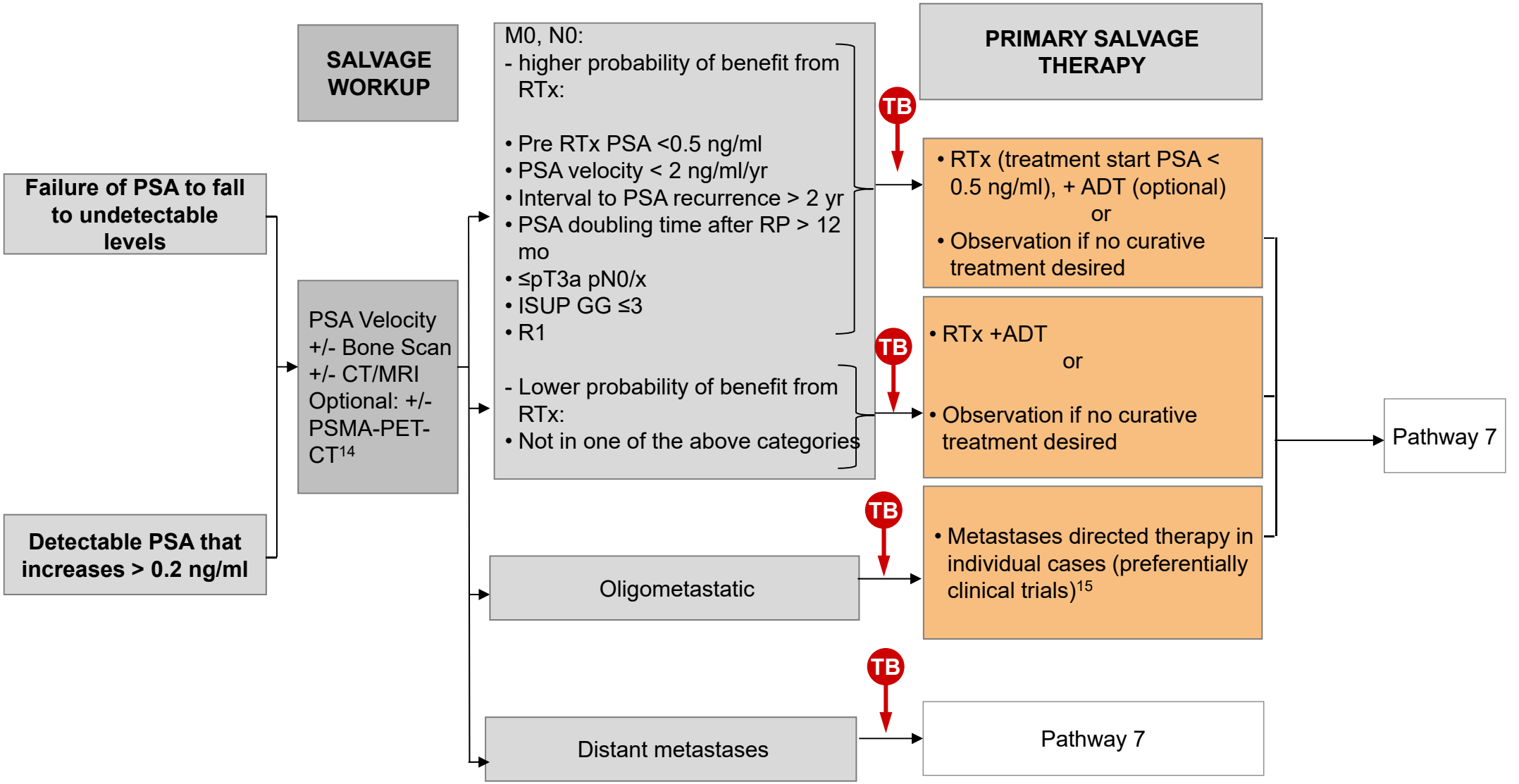
Pathway 3: Initial Therapy



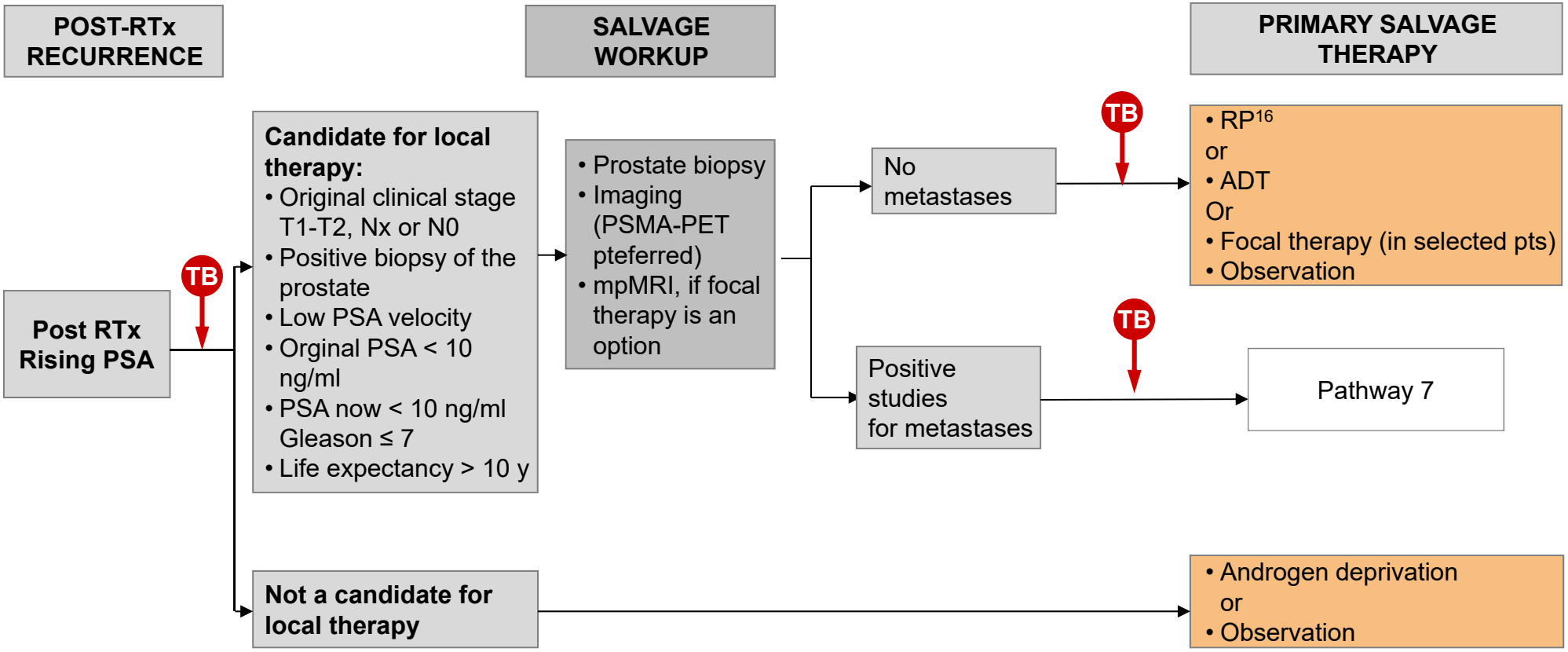
Pathway 4: Surveillance



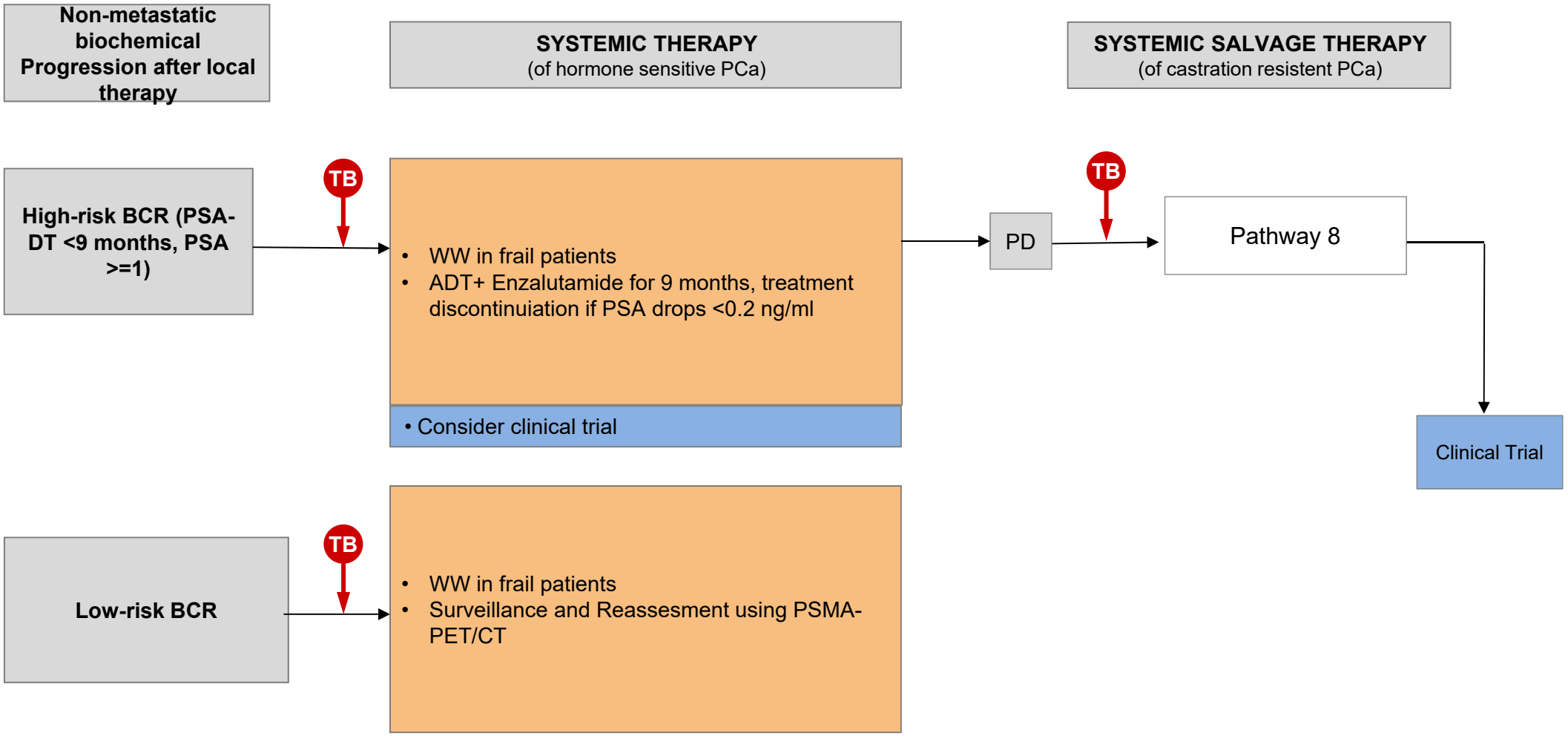
Pathway 5: Primary Salvage Therapy after RP



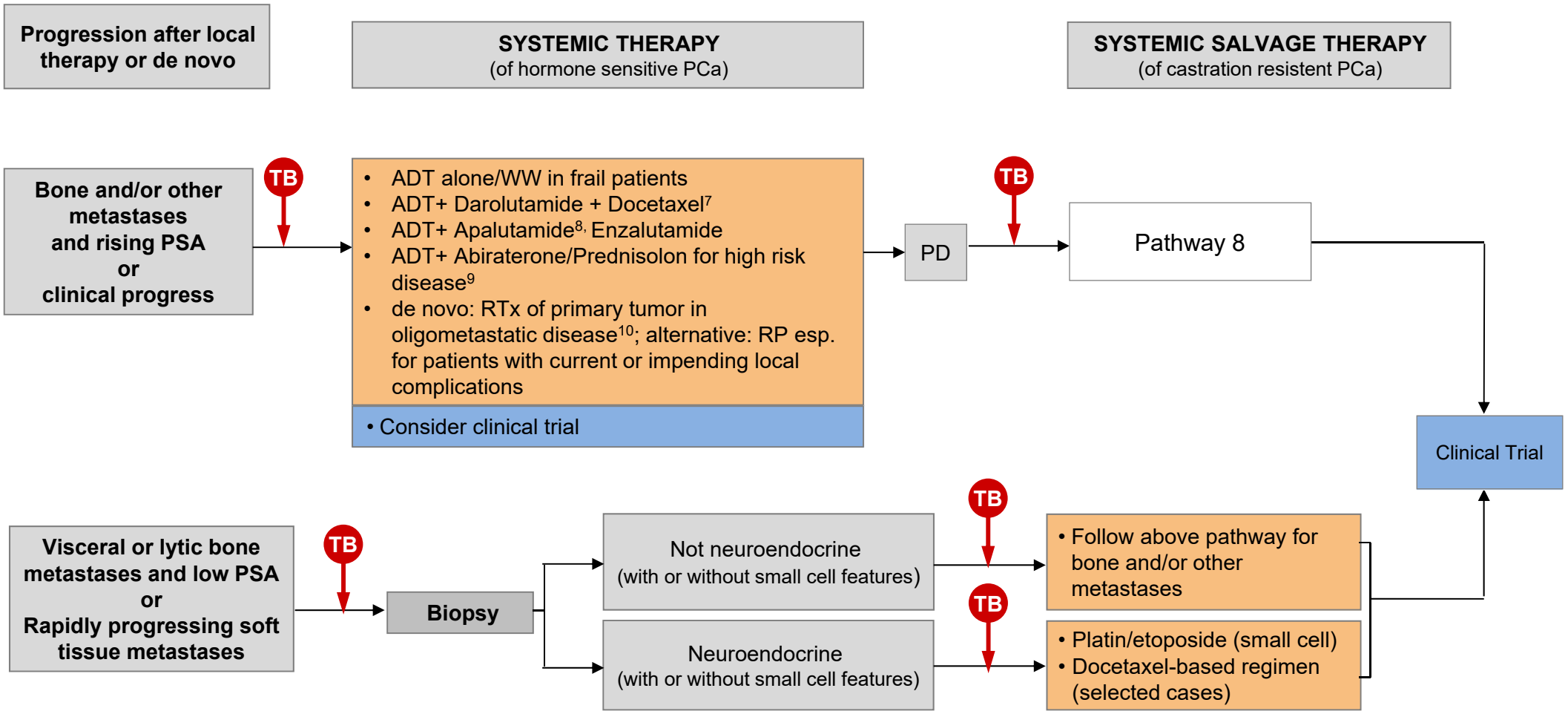
Pathway 6: Primary Salvage Therapy after RTx



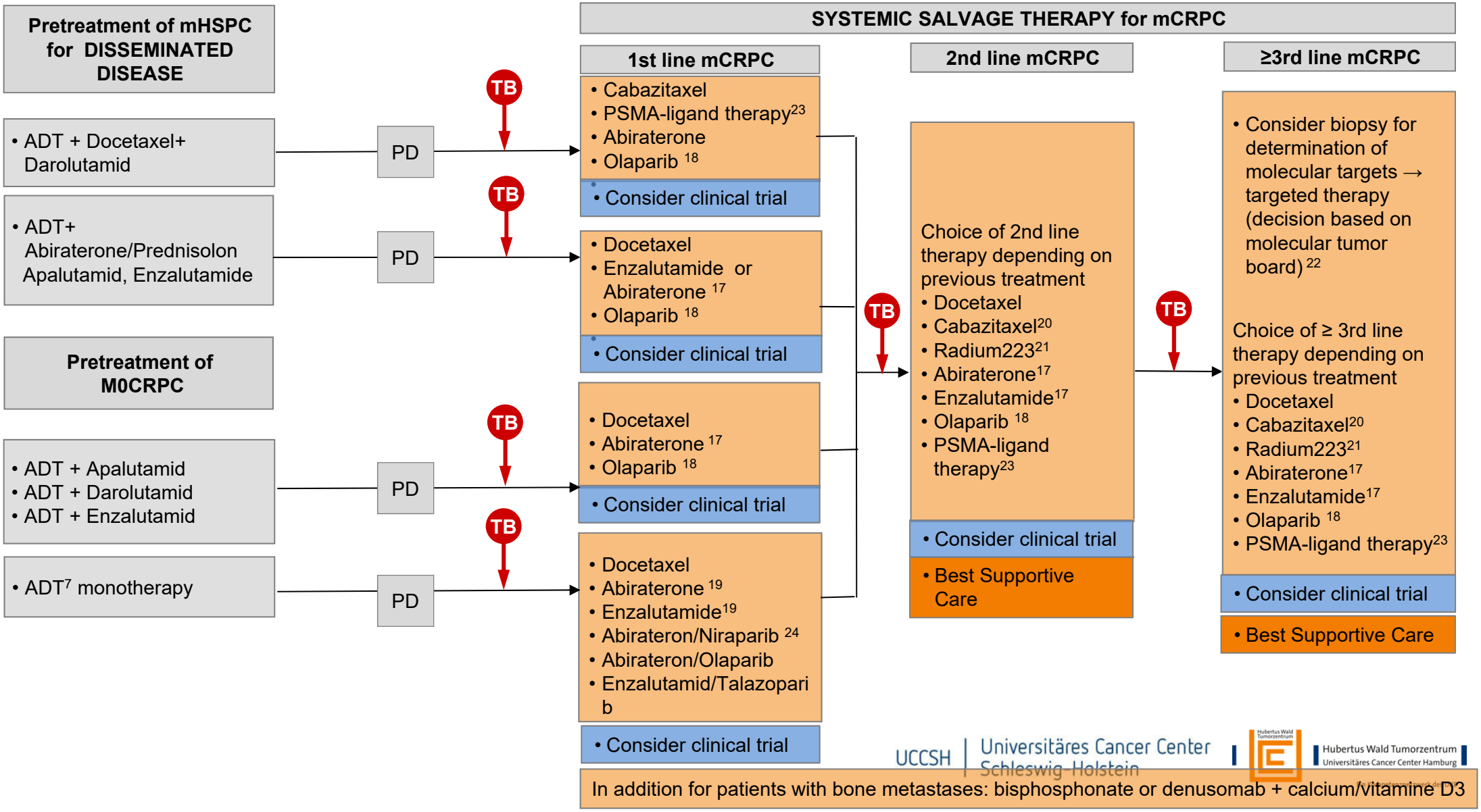
Pathway 7: Systemic Salvage Therapy I



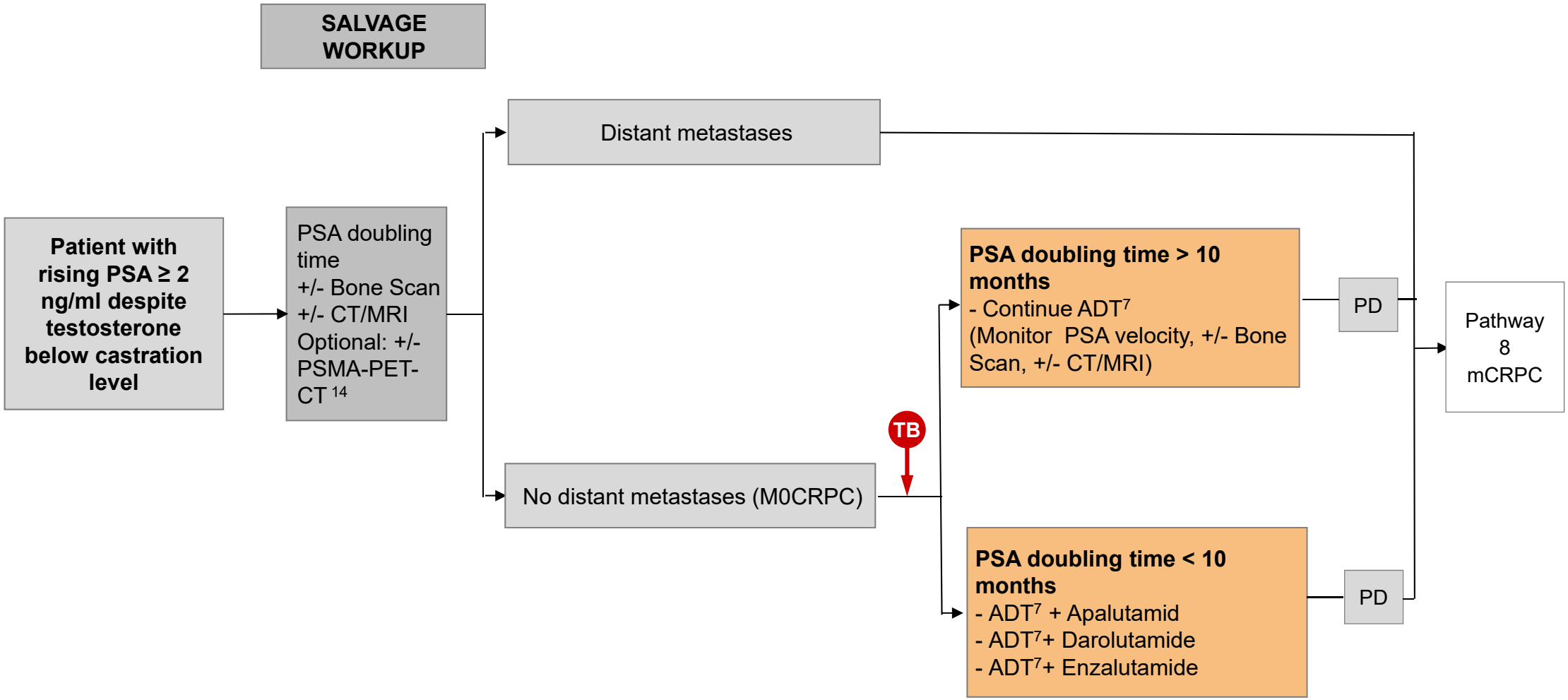
Pathway 7: Systemic Salvage Therapy II



Pathway 8: Systemic Salvage Therapy II: mCRPC



Pathway 9: Systemic Salvage Therapy III: Treatment of castration resistant prostate cancer without distant metastases (M0CRPC)



Pathway 9: Systemic Salvage Therapy: Features of neuroendocrine or aggressive variant

Features of neuroendocrine or aggressive variant[25] :

- Predominantly lytic bone lesions
- Predominantly visceral metastases
- Low PSA-value compared to tumor burden
- Neuroendocrine marker in serum or previous histologies
- Progressive disease under 1st line treatment for mHNPC < 12 months

TB

Biopsy

- Histopathological analyses
- Consider determination of molecular targets → targeted therapy (decision based on molecular tumor board)[22]

	TB	
Typical adenocarcinome, no signs of transdiffentation	TB	• Follow pathway page 8
Aggressive features (no small cell neurendocrine carcinoma)	TB	• Platin/Taxane based treatment • Consider clinical trial
Small cell neurendocrine carcinoma	TB	• Platin/Etoposide based treatment • Consider clinical trial

Footnotes:

[1] Estimation of life expectancy is possible for groups but challenging for individuals. Life expectancy can be estimated using the Deutsches Bundesamt für Statistik tables (http://www.destatis.de) in combination with the individual patient comorbidities.
[2] In selected patients where complications such as hydronephrosis or metastasis can be expected within 5yr, ADT or RTx or palliative TUR-P may be considered. High risk factors includeT3-T4 or Gleason 8-10 or PSA >20 ng/ml.
[3] Patients with multiple adverse factors may be shifted into the next higher group.
[4] AS involves actively monitoring the course of disease with the expectation to intervene if the cancer progresses or if symptoms become imminent (see pathway 4)
[5] Dose of 74-80 Gy in fractions to the prostate (± seminal vesicles) for patients with low-risk cancers; In intermediate risk cancer patients neoadjuvant ± ADT for a total of 6 – 12 mo could be added.
[6] Permanent brachytherapy (SEEDS) as monotherapy is indicated for patients with low-risk or low intermediate risk cancers. For intermediate- and high-risk cancers HDR-Brachytherapy in combination with EBRT is recommended. Patients with a large prostate (> 60 ml), symptoms of bladder outlet obstruction (IPSS score > 12) and residual bladder volume are not appropriate candidates because of increased risk of urinary morbidity. Neoadjuvant ADT may be used to shrink the prostate to an acceptable size
[7] In selected patients. Addition of docetaxel or bisphosphonates to standard of care in men with localised or metastatic, hormone-sensitive prostate cancer: A systematic review and meta-analyses of aggregate data. Vale CL et al Lancet Oncol, 2016
[8] TITAN Trial, low- and high volume de novo M1. Chi K et al. N Engl J Med 2019
[9] High risk M1 disease (Latitude criteria): Gleason score ≥ 8, ≥ 3 bone lesions, visceral metastases (2 of 3 criteria)
[10] max. 3-5 bone lesions, no visceral disease, no bulky lymph node disease according to STAMPEDE trial. Parker C, Lancet 2018
[11] If primary diagnoses was done by MRT-guided biopsy repeated biopsy is recommended after 12 mo. If primary diagnosis was done without initial MRT of the prostate repeat biopsy + MRT is recommended after 6 mo.
[12] Imaging includes bone scan plus CT/MRI abdomen and chest, alternatively PSMA-PET, treatment response should be assessed using imaging after 3- 6 mo, biochemical or clinical signs of progression should trigger further imaging
[13] RTOG-ASTRO (Radiation Therapy Oncology Group – American Society for Therapeutic Radiology and Oncology) Phoenix Consensus – (1) PSA rise by 2 ng/ml or more above the nadir PSA is the standard definition for biochemical failure; (2) the date of failure is determined "at call" (not backdated).
[14] Possibly request of reimbursement required.
[15] Preferentially to pelvic lymph node metastatic disease with limited number of LN on PSMA-PET and low PSA/PSA DT.
[16] Salvage radical prostatectomy is an option for highly selected patients with local recurrence after EBRT, HDR- or LDR-brachytherapy, HIFU or cryotherapy in the absence or metastases
[17] Propably low response rates due to cross resistance between androgen receptor targeting agents after previous AR targeted therapy
[18] for patients with BRCA1/2 mutations in mCRPC after previous treatment with androgen receptor targeting therapy (ARTA)
[19] Mildly or asymptomatic patients
[20] approved only after previous docetaxel therapy,
[21] Symptomatic bone limited disease only, or unfit for chemotherapy, concomittent bone supportive agents recommended
[22] approval by health insurance company required, no standard of care yet
[23] PSMA-PET CT required, pretreatment with ARTA and Docetaxel
[24] for patients with BRCA1/2 mutation
[25] According to „Apparicio criteria“ Clinical Cancer research 2015