

Management of men post Radical Prostatectomy (RP) that develop a detectable Prostate-Specific Antigen (PSA) while enrolled in a Prostate Cancer Survivorship Program.

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Introduction: It is estimated that there are nearly 2.8 million men living with a history of prostate cancer in the US and more than one-half (57%) of these men aged younger than 65 are treated with radical prostatectomy (RP). At MSKCC, men who undergo a RP are eligible to enter a nurse practitioner led survivorship program. Men are followed according to NCCN guidelines. While many patients may be cured, some will develop a detectable prostate-specific antigen (PSA) and there are no standard guidelines for the management of these patients. We report on a cohort of patients with a detectable PSA enrolled in a prostate cancer survivorship program. The algorithm involved in the management of these patients will be presented and patients referred for additional therapies will be reported.

Design/Setting /Participants: A total of 2,551 men were enrolled in the prostate cancer survivorship program from January 2007 to July 2012, each undergoing a RP at MSKCC. Standard clinicopathologic variables were recorded and entered into a secure database called Caisis. The patient's PSA was evaluated at each visit. The assay used at MSKCC is an automated enzyme immunoassay analyzer, AIA, from Tosoh. Undetectable PSA is defined as a value reported at <0.05ng/ml. Patients with a confirmed PSA value of ≥ 0.05 ng/ml were considered to have a detectable PSA. Management of these patients involves multiple variables: PSA at time of diagnosis, Gleason grade, stage, PSA kinetics, time to a detectable PSA, and patient's age.

Results: 155 (6.1%) patients had a confirmed detectable PSA. 64 for T2 disease (3.4% of all T2), 89 for T3 (13.6% of all T3) and 2 for T4 (20% of all T4). Median age at time of RP was 59 and median PSA was 6.07. Gleason scores of ≤ 6 accounted for 8.3%, 46 % for Gleason 3+4, 35.2% for Gleason 4+3, and 10.5 % for Gleason ≥ 8 of patients with a detectable PSA. The median time to detectable PSA was 4.08 years.

63 (41%) patients were referred to radiation oncology for consideration of salvage therapy (median age 63.2 and median time to detectable PSA 3.2 years). 17 (11%) referred to medical oncology (median age 64.9 and median time to detectable PSA of 4.4 years) and 37 (24%) referred to both radiation oncology and medical oncology for consideration of additional therapy. The total number of patients referred was 117 (75%) while 38 (25%) of patients remain in the survivorship program for continued surveillance.

Conclusion: We report on the largest cohort of men enrolled in a prostate cancer survivorship program and their rate and time to a detectable PSA. The management of these patients is complex; the algorithm we use will be presented. Many variables such as PSA at time of diagnosis, Gleason grade, stage, PSA kinetics, time to a detectable PSA, and patient's age are all variables that need to be analyzed to determine if a patient should go on to additional therapy or continued surveillance. Further research is recommended to determine the optimal management of patients with a detectable PSA.