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Prostate Cancer Management: How much of it is meant for developing third world nations?

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Abstract:

Introduction:

Prostate cancer is the second most common cancer in men in the West. It has an indolent course compared to other cancers. As a urologist, the whole of prostate cancer, is in real sense, a grey zone area. We have AUA (American Urological Association) and EAU (European Urological Associations) updates with guidelines coming up every year with new recommendations and suggestions. In all this chaos, where do the third world countries stand? How much of the guidelines are really followed and is it really possible to abide by the recommendations? In this review, I shall try and visit some of these areas.

Screening of Prostate Cancer:

The ERSPC (European randomised study of screening for prostate cancer) trial, did point out the importance of prostate cancer screening. It supported the role of PCa screening as it reduced the incidence of high-grade prostate cancer as well as prostate cancer specific mortality. The UPSTF (United states preventive services task force) refuted it and labelled it as grade D recommendation. Though, in 2017 they have changed the recommendation to grade C for age 55-69 years; for age > 70 years, grade D recommendations still persists.

Now let us talk about some local data from the sub-continent. In India, still 60-70% of the prostate cancer presents with metastasis. Lack of proper health care structure, lack of education, awareness, low socioeconomic status and handful to trained urologist are few of the factors that underlies our inability to identify patients who would benefit from curative interventions. Here, in our outpatient departments, an average doctor attends in average 110 patients of all urological spectrum per day. When it comes to opportunistic screening, we fail m iserably reason being that hardly few will ever come back even to collect their investigation reports. Patients come for spot treatment, that's all, be it for LUTS or backache.

Investigational Paradox

Again, something which is so fascinating to read, yet so difficult to digest. We are talking about MRI-US targeted fusion biopsy where we don't have a TRUS (Transrectal ultrasound) machine in most of the district hospitals in this part of the world. So, centres don't even possess an ultrasound machine. All the advances, like multiparametric MRI (mpMRI), sonoelastography, histoscanning and gene testing, are miles from the reach of an average patient.

Thankfully, Serum PSA (Prostate Specific antigen) and a meticulously done DRE(Digital rectal examination), is the most important investigation that we rely upon and our patients really benefit a lot from it. Digital hand guided biopsy is still the most common method of taking prostatic biopsy in developing countries. So, it is quite clear that people who have a multiple hard nodule or a grossly hard prostate stands the most chance from benefiting from it.

Treatment:

surveillance is only limited to books in this part of the world and rightfully so. Losing a patient to follow up is a norm. So, even if diagnosed with very low risk disease and life expectancy of > 10 years, we offer definite treatment. Watching waiting is also limited to books. Here people come for palliative treatment mostly. We have a dedicated team of urooncology in my institution. In the last 3 years, we have just performed couple of open radical prostatectomies. It might be unbelievable to my colleagues in the west, but all the remaining patients were metastatic PCa (Prostate Cancer).

We only perform open radical prostatectomy. Our patients can't afford LHRH agonist or antagonist. Almost 100% of our patients undergo surgical castration. The radiotherapy units are limited to the tertiary care centres but taking no credit away from them, I need to point this out as well that there are the pillars of PCa treatment and not surgeons. I owe it to those beautiful minds who had this wisdom to make the radiotherapy units quite capable enough to handle or I should say "Cover up" for our inabilities. Still most of the centres in India, use only bicalutamide as antiandrogens and Docetaxel for metastatic PCa. Remaining drugs like enzalutamide, abiraterone acetate, darulatamide, cabazitaxel, PARP inhibitors and AKT pathway inhibitors and immune check point inhibitors looks good only on power point presentation.