Your Views on
NICE Guideline (CG58):
Prostate Cancer: diagnosis and treatment

The publication of the National Institute for Health & Clinical Excellence (NICE) Guideline: *Prostate Cancer: diagnosis and treatment* (CG58), published in February this year, has been the subject of key debates at national oncology and urology meetings. Indeed the Guideline has been a key topic at both the BUG and BAUS Annual Meetings.

BUG has invited its members to record their level of opinion on key statements from the NICE Guideline and would like to invite BAUS Section of Oncology members to provide their views too. This will enable us, as recognised stakeholders within the NICE process and as groups committed to sharing of best practice, to feedback our collective view to decision-makers of the future.

Individual responses will remain anonymous, but we would appreciate completion of your details for general information in order that we can provide you with a collective overview of the findings. We would be very grateful if you could complete this questionnaire and return it to the BUG Secretariat: Right Angle Communications:
Fax: 020 8846 3189 or email to: hibist.mesfin@rightangleuk.com

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Key Statements Drawn from: *Prostate Cancer: diagnosis and treatment* (CG58)

Please rate your level of agreement/disagreement by ticking the relevant box below the statement.

Localised Prostate Cancer

Urological cancer multidisciplinary teams (MDTs) should assign a risk category to all newly diagnosed men with localised prostate cancer.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Men with localised prostate cancer who have chosen a watchful waiting regimen and who have evidence of significant disease progression (that is, rapidly rising prostate specific antigen (PSA) level or bone pain) should be reviewed by a member of the urological cancer MDT.

☐ ☐ ☐ ☐ ☐

Strongly agree | Agree | No opinion | Disagree | Strongly disagree

Men with low-risk localised prostate cancer who are considered suitable for radical treatment should first be offered active surveillance.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Healthcare professionals should offer radical prostatectomy or radical radiotherapy (conformal) to men with intermediate-risk localised prostate cancer.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Healthcare professionals should offer radical prostatectomy or radical radiotherapy (conformal) to men with high-risk localised prostate cancer where there is a realistic prospect of long-term disease control.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Brachytherapy is not recommended for men with high-risk localised prostate cancer.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Men undergoing radical external beam radiotherapy for localised prostate cancer1 should receive a minimum dose of 74 Gy to the prostate at no more than 2 Gy per fraction.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Adjuvant hormonal therapy is recommended for a minimum of 2 years in men receiving radical radiotherapy for localised prostate cancer who have a Gleason score of ≥ 8.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

High intensity focused ultrasound (HIFU) and cryotherapy are not recommended for men with localised prostate cancer other than in the context of controlled clinical trials comparing their use with established interventions.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Given the range of treatment modalities and their serious side effects, men with prostate cancer who are candidates for radical treatment should have the opportunity to discuss their treatment options with both a specialist surgical oncologist and a specialist clinical oncologist.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Men presenting with symptoms consistent with radiation-induced enteropathy should be fully investigated (including using flexible sigmoidoscopy) to exclude inflammatory bowel disease or malignancy of the large bowel and to ascertain the nature of the radiation injury. Particular caution should be taken with anterior wall rectal biopsy following brachytherapy because of the risk of fistulation.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Men treated with radical radiotherapy for prostate cancer should be offered flexible sigmoidoscopy every 5 years.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Steroid enemas should not be used for treating men with radiation proctopathy.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

The nature and treatment of radiation-induced injury to the gastrointestinal (GI) tract should be included in the training programmes for oncologists and gastroenterologists.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Prior to treatment, men and their partners should be warned that treatment for prostate cancer will result in an alteration of sexual experience, and may result in loss of sexual function.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Healthcare professionals should ensure that men and their partners have early and ongoing access to specialist erectile dysfunction services.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Men experiencing troublesome urinary symptoms before treatment should be offered a urological assessment.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Men undergoing treatment for prostate cancer should be warned of the likely effects of the treatment on their urinary function.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Healthcare professionals should discuss the purpose, duration, frequency and location of follow-up with each man with localised prostate cancer, and if he wishes, his partner or carers.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Men with prostate cancer should be clearly advised about potential longer term adverse effects and when and how to report them.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Men with prostate cancer who have chosen a watchful waiting regimen with no curative intent should normally be followed up in primary care in accordance with protocols agreed by the local urological cancer MDT and the relevant primary care organisation(s). Their PSA should be measured at least once a year.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

PSA levels for all men with prostate cancer who are having radical treatment should be checked at the earliest 6 weeks following treatment, at least every 6 months for the first 2 years and then at least once a year thereafter.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Routine digital rectal examination (DRE) is not recommended in men with prostate cancer while the PSA remains at baseline levels.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

After at least 2 years, men with a stable PSA and who have had no significant treatment complications, should be offered follow-up outside hospital (for example, in primary care) by telephone or secure electronic communications, unless they are taking part in a clinical trial that requires more formal clinic-based follow-up. Direct access to the urological cancer MDT should be offered and explained.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Further research is required into the identification of prognostic indicators in order to differentiate effectively between men who may die with prostate cancer and those who might die from prostate cancer.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Research is required into the effectiveness and cost-effectiveness of treatments aimed at the elimination of disease in men with localised prostate cancer, with locally advanced disease and with locally recurrent disease. This research should include a rigorous examination of the value of procedures such as brachytherapy (localised disease only), cryosurgery and high intensity focused ultrasound, as well as combinations of surgery and radiotherapy with hormonal therapy and chemotherapy. The end points should include survival, local recurrence, toxicity and quality of life outcomes.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Research into the causes, and clinical trials of prevention and management of radiation-induced enteropathy should be undertaken.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Further research should be conducted into the timing and effectiveness of treatments for erectile dysfunction after all treatments for prostate cancer.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Further research is required into the causes, prevention and treatment strategies for urinary incontinence in men with prostate cancer.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Managing Relapse after Radical Treatment

Analyse serial prostate specific antigen (PSA) levels after radical treatment using the same assay technique.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Biopsy of the prostatic bed should not be performed in men with prostate cancer who have had a radical prostatectomy.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Biopsy of the prostate after radiotherapy should only be performed in men with prostate cancer who are being considered for local salvage therapy in the context of a clinical trial.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

For men with evidence of biochemical relapse following radical treatment and who are considering radical salvage therapy:

- Routine MRI scanning should not be performed prior to salvage radiotherapy in men with prostate cancer
- Perform an isotope bone scan if symptoms or PSA trends are suggestive of metastases.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Biochemical relapse (a rising PSA) alone should not necessarily prompt an immediate change in treatment.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Biochemical relapse should trigger an estimate of PSA doubling time, based on a minimum of 3 measurements over at least a 6 month period.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Men with biochemical relapse after radical prostatectomy, with no known metastases, should be offered early radical radiotherapy to the prostatic bed.

☐ ☐ ☐ ☐ ☐

Hormonal therapy is not routinely recommended for men with prostate cancer who have a biochemical relapse unless they have:

- symptomatic local disease progression, or
- any proven metastases, or
- a PSA doubling time of < 3months.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Clinical trials should be set up to examine the effect of local salvage therapies on survival and quality of life in men with biochemical relapse after radiotherapy.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Locally Advanced Prostate Cancer

Neoadjuvant and concurrent luteinising hormone-releasing hormone agonist (LHRHa) therapy is recommended for 3 to 6 months in men receiving radical radiotherapy for locally advanced prostate cancer.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Adjuvant hormonal therapy in addition to radical prostatectomy is not recommended, even in men with margin-positive disease, other than in the context of a clinical trial.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Adjuvant hormonal therapy is recommended for a minimum of 2 years in men receiving radical radiotherapy for locally advanced prostate cancer who have a Gleason score of ≥ 8.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Bisphosphonates should not be used for the prevention of bone metastases in men with prostate cancer.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Clinical oncologists should consider pelvic radiotherapy in men with locally advanced prostate cancer who have a > 15% risk of pelvic lymph node involvement[2] who are to receive neoadjuvant hormonal therapy and radical radiotherapy.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Immediate post-operative radiotherapy after radical prostatectomy is not routinely recommended, even in men with margin-positive disease, other than in the context of a clinical trial.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

High intensity focussed ultrasound (HIFU) and cryotherapy are not recommended for men with locally advanced prostate cancer other than in the context of controlled clinical trials comparing their use with established interventions.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

More research should be conducted into the prevention and management of osteoporosis in men receiving long-term withdrawal deprivation therapy.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

The role of radical surgery and extended lymphadenectomy as primary therapy for locally advanced prostate cancer should be studied in clinical trials.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Metastatic Prostate Cancer

Healthcare professionals should offer bilateral orchidectomy to all men with metastatic prostate cancer as an alternative to continuous LHRHa therapy.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Combined androgen blockade is not recommended as a first-line treatment for men with metastatic prostate cancer.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

For men with metastatic prostate cancer who are willing to accept the adverse impact on overall survival and gynaecomastia in the hope of retaining sexual function, antiandrogen monotherapy with bicalutamide (150 mg)[1] is appropriate.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Intermittent androgen withdrawal may be offered to men with metastatic prostate cancer providing they are informed that there is no long-term evidence of its effectiveness.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Synthetic progestogens (administered orally or parenterally) are recommended as firstline therapy for the management of troublesome hot flushes. If oral therapy is used, it should be given for 2 weeks, and re-started, if effective, on recurrence of symptoms.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Men starting long-term bicalutamide monotherapy (> 6 months) should receive prophylactic radiotherapy to both breast buds within the first month of treatment. A single fraction of 8 Gy using orthovoltage or electron beam radiotherapy is recommended.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

If radiotherapy is unsuccessful in preventing gynaecomastia, weekly tamoxifen should be considered.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Inform men starting androgen withdrawal therapy that regular resistance exercise reduces fatigue and improves quality of life.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

When men with prostate cancer develop biochemical evidence of hormone-refractory disease, their treatment options should be discussed by the urological cancer multidisciplinary team (MDT) with a view to seeking an oncological and/or specialist palliative care opinion as appropriate.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Docetaxel is recommended, within its licensed indications, as a treatment option for men with hormone-refractory metastatic prostate cancer only if their Karnofsky performance-status score is 60% or more.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

It is recommended that treatment with docetaxel should be stopped:

- at the completion of planned treatment of up to 10 cycles, or
- if severe adverse events occur, or
- in the presence of progression of disease as evidenced by clinical or laboratory criteria, or by imaging studies.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Repeat cycles of treatment with docetaxel are not recommended if the disease recurs after completion of the planned course of chemotherapy.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

A corticosteroid such as dexamethasone (0.5 mg daily) daily is recommended as third line hormonal therapy after androgen withdrawal and anti-androgen therapy for men with hormone-refractory prostate.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Men with hormone-refractory prostate cancer shown to have extensive metastases in the spine (for example, on a bone scan) should have spinal MRI if they develop any spinal related symptoms.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

The use of bisphosphonates to prevent or reduce the complications of bone metastases in men with hormone-refractory prostate cancer is not recommended.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Bisphosphonates should not be used routinely to prevent osteoporosis in men with prostate cancer receiving androgen withdrawal therapy.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Strontium-89 should be considered for men with hormone-refractory prostate cancer and painful bone metastases, especially those men who are unlikely to receive myelosuppressive chemotherapy.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Decompression of the upper urinary tract by percutaneous nephrostomy or by insertion of a double J stent should be offered to men with obstructive uropathy secondary to hormone-refractory prostate cancer.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

The option of no intervention should also be discussed with men with obstructive uropathy secondary to hormone-refractory prostate cancer and remains a choice for some

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Men with metastatic prostate cancer should be offered tailored information and access to specialist urology and palliative care teams to address the specific needs of men with metastatic cancer. They should have the opportunity to discuss any significant changes in their disease status or symptoms as these occur.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

The regular assessment of needs should be applied systematically to men with metastatic prostate cancer.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Palliative interventions at any stage should be integrated into coordinated care, and any transitions between care settings should be facilitated as smoothly as possible.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Healthcare professionals should discuss personal preferences for palliative care as early as possible with men with metastatic prostate cancer, their partners and carers. Treatment/care plans should be tailored accordingly and the preferred place of care should be identified.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Healthcare professionals should ensure that palliative care is available when needed and is not limited to the end of life. It should not be restricted to being associated with hospice care.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Further clinical trials should be conducted to determine if there is a role for bisphosphonates in men with prostate cancer.

☐ Strongly agree ☐ Agree ☐ No opinion ☐ Disagree ☐ Strongly disagree

Please return your completed questionnaire to the BUG Secretariat: Right Angle Communications – Fax: 020 8846 3189 or Email: hibist.mesfin@rightangleuk.com

Thank you very much for your time.