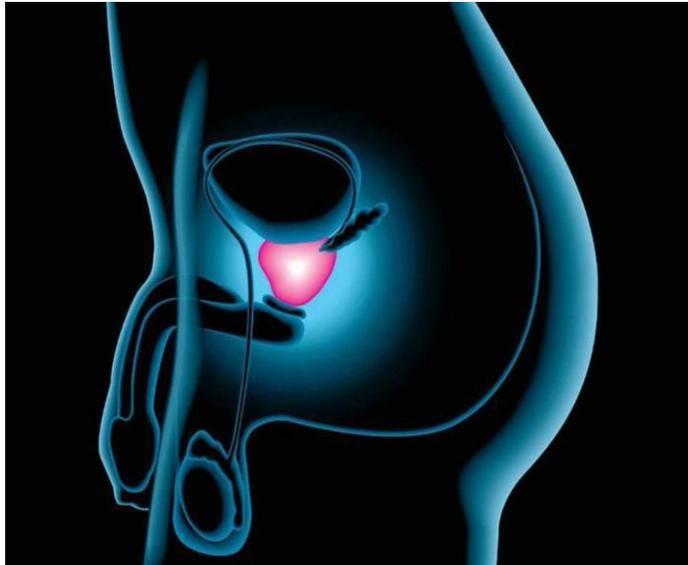




**IV JORNADAS INTERHOSPITALARIAS  
DE ACTUALIZACIÓN EN UROLOGÍA**



# **Cáncer de Próstata**

## ***Cuestión de imagen***

**Moderador: JL Parra Escobar. Mérida**

**Ponentes: Rocío Mora Monago. Don Benito**

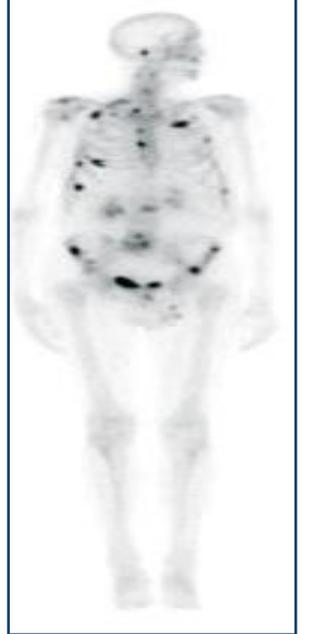
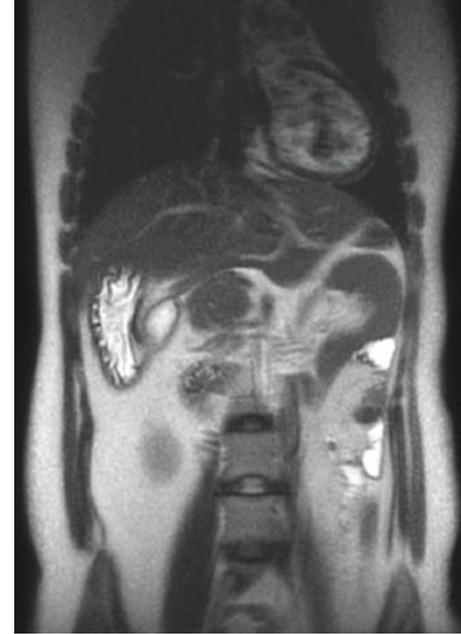
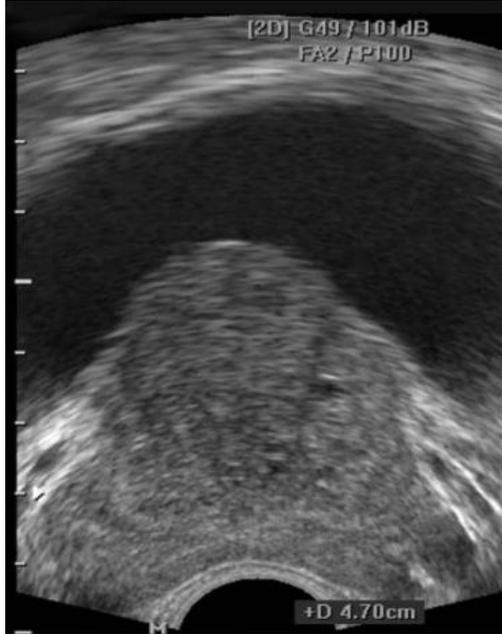
**Antonio Rodríguez Fernández. Granada**

Mérida, 24-25 de Noviembre de 2017



# CP. Cuestión de imagen

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- ✓ RMN multiparamétrica
- ✓ PET-TAC



# Cap. Cuestión de imagen

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1. Imagen del Tumor Primario
2. Imagen de la Extensión Tumoral
3. Imagen de la Enfermedad Recurrente
  - Recidiva bioquímica tras tratamiento de IC
  - CPRC



# Cap. Cuestión de imagen

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## 1. Imagen del Tumor Primario

- El diagnóstico de cáncer de próstata se realiza generalmente sobre la base del tacto rectal y niveles de PSA
- El diagnóstico definitivo depende de la verificación histopatológica en el espécimen de biopsia o de RTU/adenomectomía en pacientes intervenidos por HBP
- **RMNmp:**
  - Mayor impacto diagnóstico antes de realizar 2ª biopsia **(NE=1a. GR=A)**
  - Dos estudios en marcha en pre-biopsia: MRI-FIRST y PRECISION
  - Vigilancia activa: antes de biopsia de confirmación **(NE=2b. GR=B)**



# Cap. Cuestión de imagen

## 2. Imagen de la extensión tumoral

European Association of Urology

<b>Any risk group staging</b>	<b>LE</b>	<b>GR</b>
Do not use computed tomography and transrectal ultrasound for local staging.	2a	A

<b>Low-risk localised PCa</b>	<b>LE</b>	<b>GR</b>
Do not use additional imaging for staging purposes.	2a	A

<b>Intermediate-risk PCa</b>	<b>LE</b>	<b>GR</b>
In predominantly Gleason pattern 4 (ISUP grade 3), include at least cross-sectional abdominopelvic imaging and a bone-scan for metastatic screening.	2a	A*
In predominantly Gleason pattern 4 (ISUP grade 3), use prostate multiparametric magnetic resonance imaging (mpMRI) for local staging.	2b	A

*\*Upgraded following panel consensus.*

<b>High-risk localised PCa/High-risk locally advanced PCa</b>	<b>LE</b>	<b>GR</b>
Use prostate mpMRI for local staging.	2b	A
Perform metastatic screening including at least cross-sectional abdominopelvic imaging and a bone-scan.	2a	A



# Cap. Cuestión de imagen

## 3. Imagen de la enfermedad recurrente

- Recidiva bioquímica tras tratamiento de IC

European Association of Urology	<b>Prostate-specific antigen (PSA) recurrence after radical prostatectomy</b>		
	PSA < 1 ng/mL: no imaging is recommended.	3	A
	PSA $\geq$ 1 ng/mL: positron emission tomography (PET)/computed tomography (CT) imaging is recommended using choline or prostate-specific membrane antigen (PMSA).	2b	A
	Perform bone scan and/or abdominopelvic CT only in patients with PSA > 10 ng/mL, or with adverse PSA kinetics (PSA-doubling time (DT) < 6 months, PSA velocity > 0.5 ng/mL/month).	3	A
	<b>PSA recurrence after radiotherapy</b>		
	Perform prostate multiparametric magnetic resonance imaging (mpMRI) only in patients who are considered candidates for local salvage therapy, use mpMRI to localise abnormal areas and guide biopsies.	3	B
	Choline PET/CT imaging is recommended to rule out lymph nodes or distant metastases in patients fit enough for curative salvage treatment.	2b	B
Perform bone scan and/or abdominopelvic CT only in patients with PSA > 10 ng/mL, or with adverse PSA kinetics (PSA-DT < 6 months, PSA velocity > 0.5 ng/mL/month).	3	A	



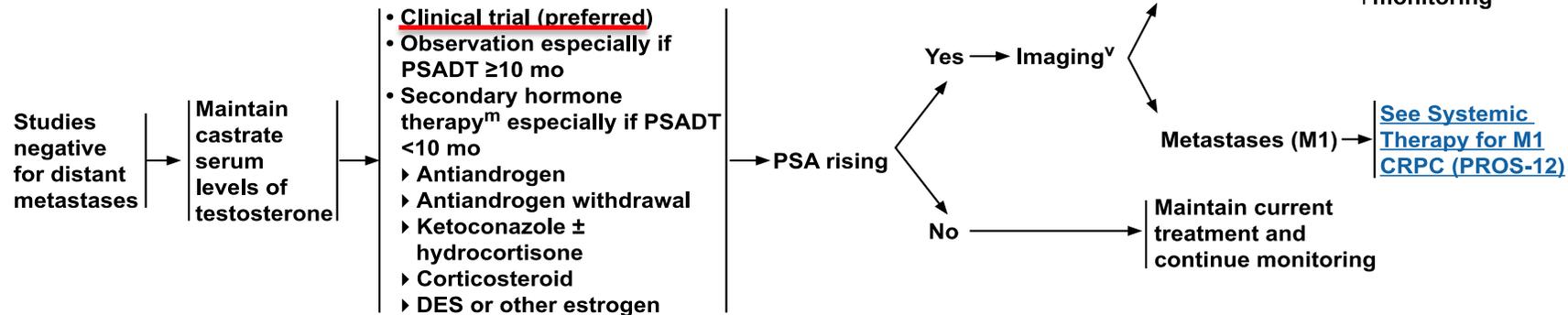
# Cap. Cuestión de imagen

## 3. Imagen de la enfermedad recurrente: CPRC



**NCCN Guidelines Version 1.2017**  
**Prostate Cancer**  
**NCCN Evidence Blocks™**

**SYSTEMIC THERAPY FOR M0 CASTRATION-RECURRENT PROSTATE CANCER**



Recommendation	LE	GR
Ensure that testosterone levels are confirmed to be < 50 ng/mL, before diagnosing CRPC.	4	A
Do not treat patients for <u>non-metastatic</u> CRPC outside of a clinical trial.	3	A
Counsel, manage and treat patients with mCRPC in a multidisciplinary team.	3	A
In men treated with maximal androgen blockade, stop anti-androgen therapy once PSA progression is documented. <i>Comment: Four to six weeks after discontinuation of flutamide or bicalutamide, an eventual anti-androgen withdrawal effect will be apparent.</i>	2a	A

Guidelines on  
**Prostate Cancer**  
**EAU - ESTRO - SIOG**

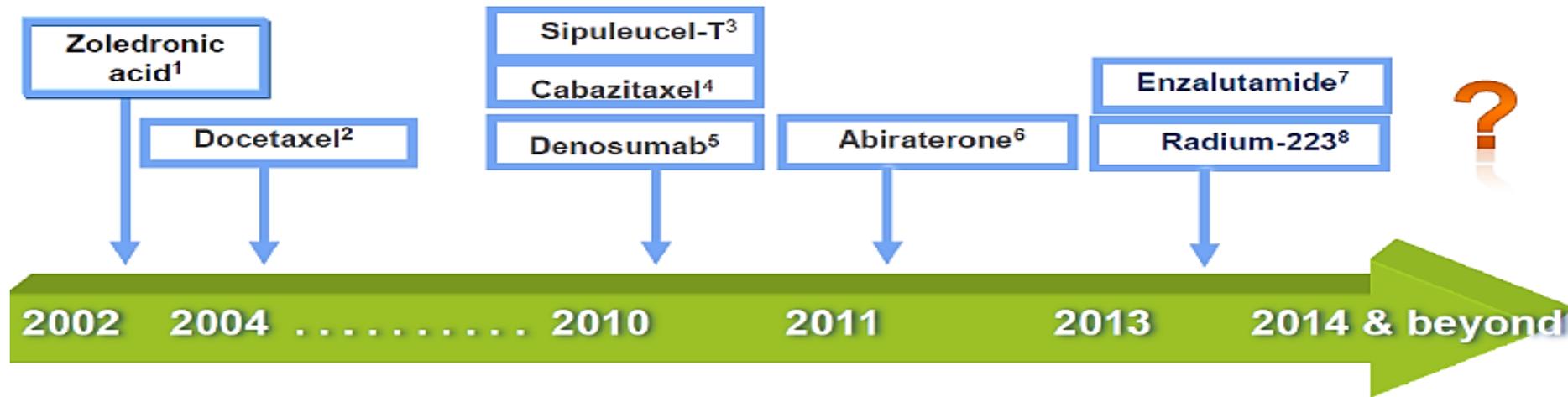
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# Cap. Cuestión de imagen

## 3. Imagen de la enfermedad recurrente: CPRC

- Actualmente evidencias de nivel 1 prueban la eficacia de nuevos tratamientos en pacientes con CPRC-M1 asintomáticos o levemente sintomáticos



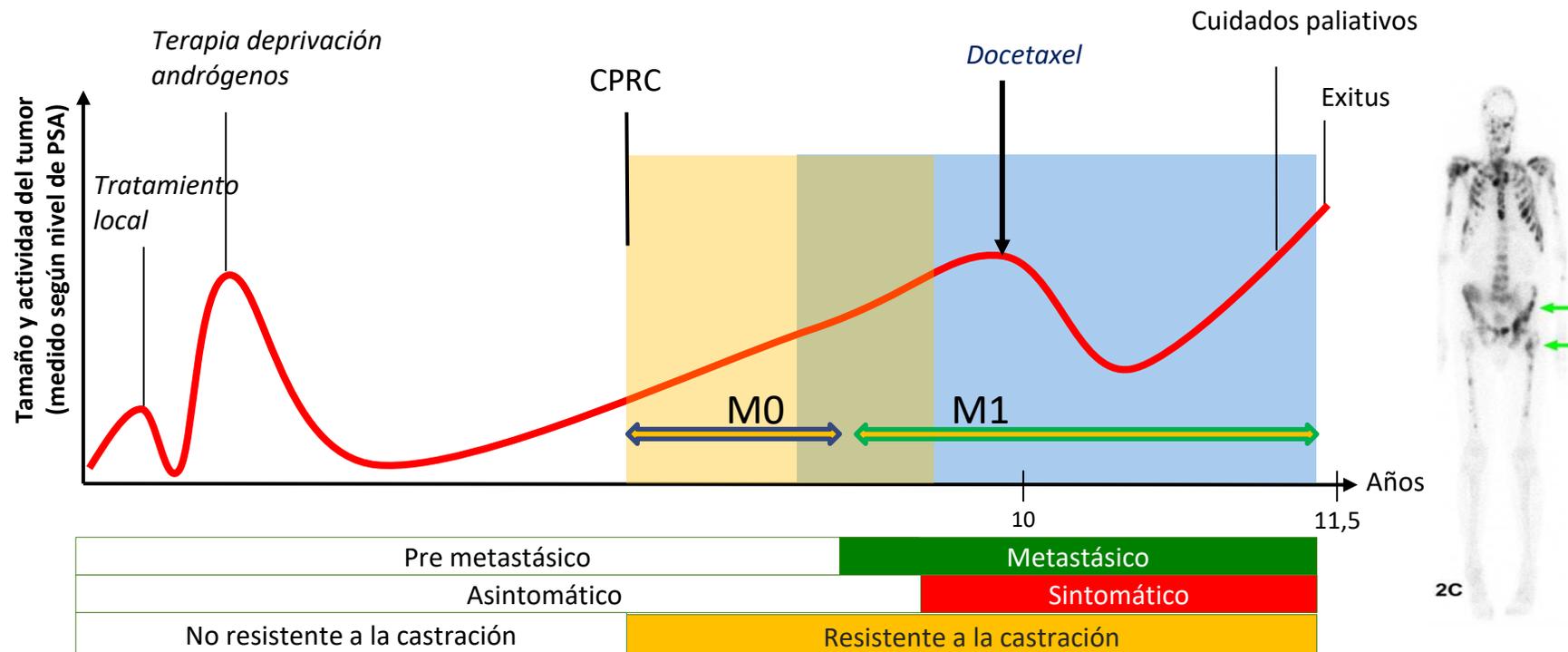
- Los nuevos fármacos demuestran mayor eficacia en pacientes asintomáticos o mínimamente sintomáticos.



# Cap. Cuestión de imagen

## 3. Imagen de la enfermedad recurrente: CPRC

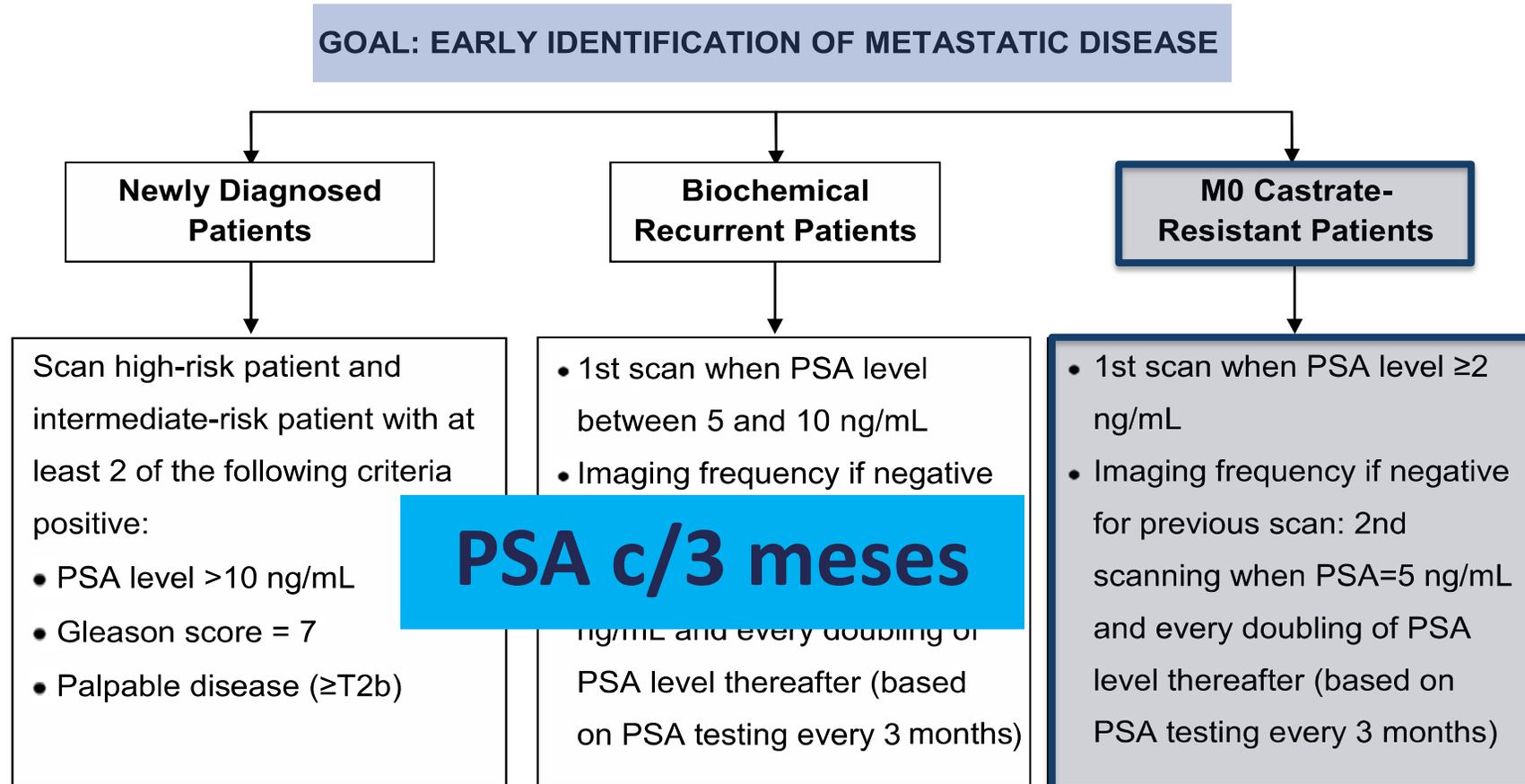
- CPRC: ¿Estamos seguros de que nuestros M0 son realmente M0?





# Cap. Cuestión de imagen

## 3. Imagen de la enfermedad recurrente: CPRC



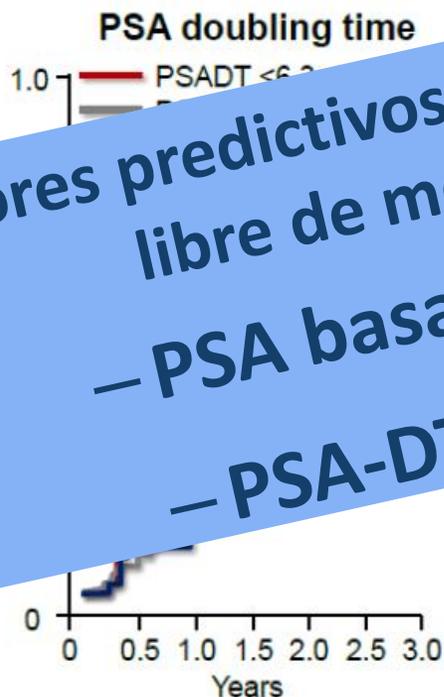
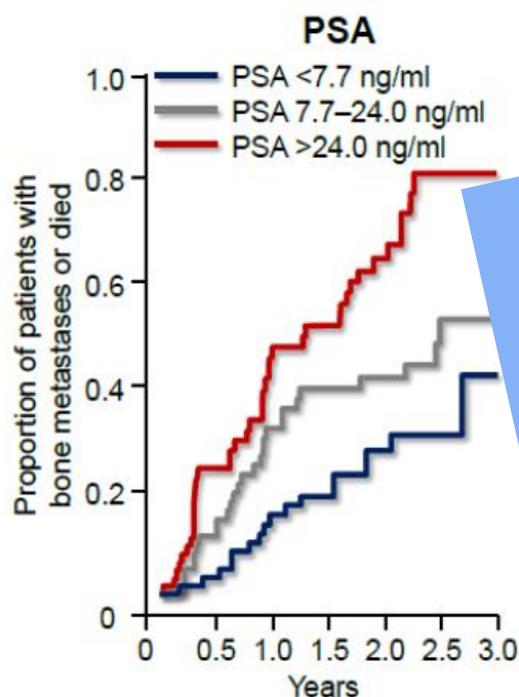


# Cap. Cuestión de imagen

## 3. Imagen de la enfermedad recurrente: CPRC

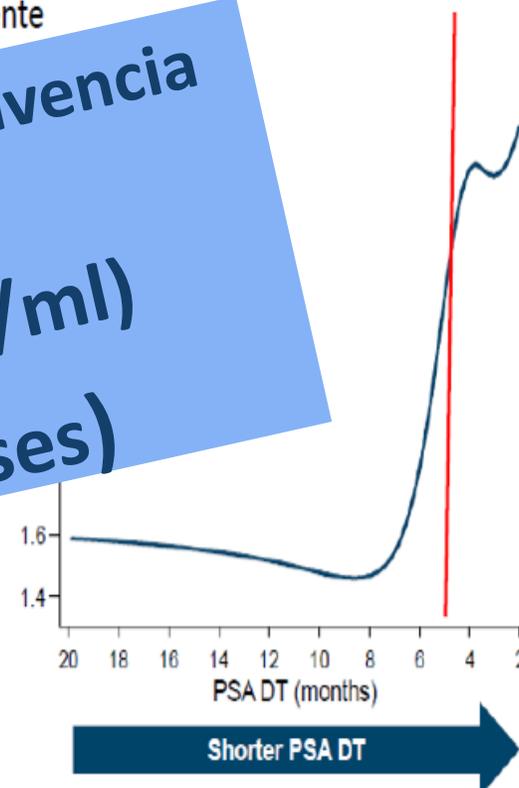
PSA basal y PSADT son factores de riesgo para el desarrollo de metástasis óseas en el CPRC

A partir de un PSA-DT < 6 meses el riesgo de presentar metástasis aumenta exponencialmente



**Factores predictivos de supervivencia libre de metástasis:**

- PSA basal ( $\geq 10$  ng/ml)
- PSA-DT ( $\leq 6$  meses)

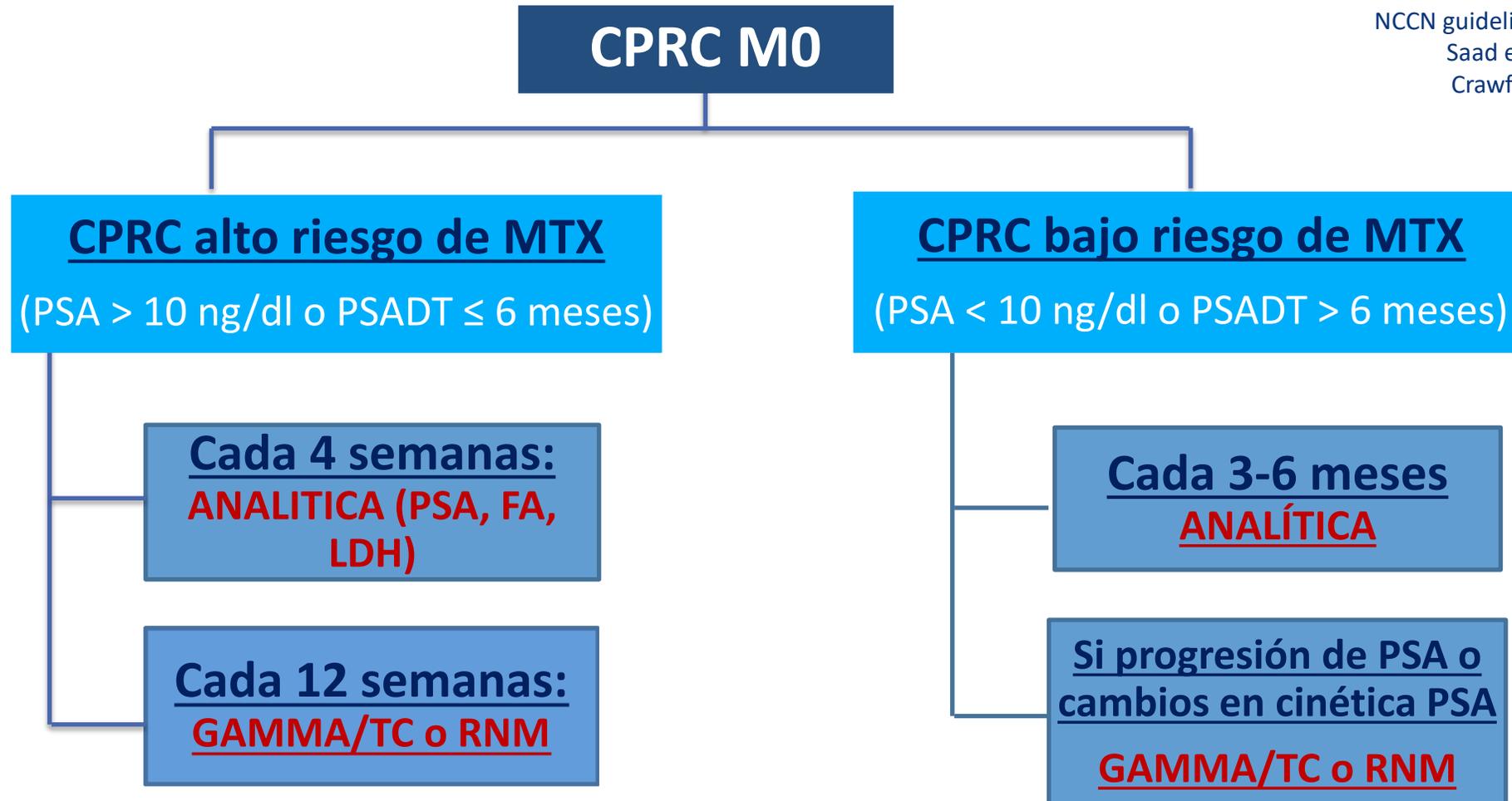




# Cap. Cuestión de imagen

## 3. Imagen de la enfermedad recurrente: CPRC

NCCN guidelines prostate cancer 2017  
Saad et al. CUA guidelines 2016  
Crawford (St Gallen consensus)  
RADAR group





# Cap. Cuestión de imagen

## 3. Imagen de la enfermedad recurrente: CPRC

### ENTHUSE study

**Detection of Previously Unidentified Metastatic Disease as a Leading Cause of Screening Failure in a Phase III Trial of Zibotentan Versus Placebo in Patients with Nonmetastatic, Castration Resistant Prostate Cancer**

Evan Y. Yu<sup>1</sup>, Kurt Miller<sup>2</sup>, Joel Nelson, Martin Gleave, Karim Fizazi<sup>3</sup>, Judd W. Moul<sup>4</sup>, Faith E. Nathan<sup>5</sup>, and Celestia S. Higano<sup>1,6</sup>

Fallos de screening 32 %

### IMAAGEN study

**Unsuspected Metastases Found During Screening for a Trial of Patients With Non-Metastatic Castration Resistant Prostate Cancer**

E. David Crawford,<sup>1</sup> Philip W. Kantoff,<sup>2</sup> Neal Shore,<sup>3</sup> Willie Underwood,<sup>4</sup> Jannell R. DePalantino,<sup>5</sup> Vijay Reddy,<sup>6</sup> Suneel Mundie,<sup>7</sup> Zane Yang,<sup>8</sup> Tracy McCowan,<sup>9</sup> Jim Wang,<sup>10</sup> Charles J. Ryan<sup>11</sup>  
<sup>1</sup>University of Colorado Cancer Center, Aurora, CO, USA; <sup>2</sup>Deane-Fisher Cancer Institute, Harvard Medical School, Boston, MA, USA; <sup>3</sup>Carolina Oncologic Research Center, Myrtle Beach, SC, USA; <sup>4</sup>Roswell Park Cancer Institute, Buffalo, NY, USA; <sup>5</sup>Janssen Scientific Affairs, LLC, Horsham, PA, USA; <sup>6</sup>Janssen Research & Development, LLC, Raritan, NJ, USA; <sup>7</sup>Helms-Diller Family Comprehensive Cancer Center, University of California - San Francisco, San Francisco, CA, USA

Fallos de screening 37 %

### SPARTAN study

**A Randomized Double-Blind, Comparative Study of ARN-509 Plus Androgen Deprivation Therapy (ADT) Vs ADT Alone in Non-metastatic Castration-Resistant Prostate Cancer – the SPARTAN Trial**

Matthew R. Smith,<sup>1</sup> Glenn Liu,<sup>2</sup> S. Martin Shreeve,<sup>3</sup> Shannon Matheny,<sup>4</sup> Antonieta Sosa,<sup>5</sup> Thian Kheoh,<sup>6</sup> Margaret K. Yu,<sup>7</sup> Eric J. Small<sup>8</sup>

<sup>1</sup>Harvard Medical School and Massachusetts General Hospital Cancer Center, Boston, MA; <sup>2</sup>University of Wisconsin Carbone Cancer Center, Madison, WI; <sup>3</sup>Janssen Research & Development, Los Angeles, CA; <sup>4</sup>University of California San Francisco, San Francisco, CA

Fallos de screening 46%

Empleando TC y GGO  
1/3 de los pacientes  
etiquetados como CPRC M0  
son realmente M1



# Cap. Cuestión de imagen

## 3. Imagen de la enfermedad recurrente: CPRC

EURURO-7424; No. of Pages 34

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EUROPEAN UROLOGY XXX (2017) XXX-XXX

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European Association of Urology



- RMNmp de cuerpo entero
- PET-TAC

Platinum Priority – Prostate Cancer  
Editorial by XXX on pp. x–y of this issue

**Management of Patients with Advanced Prostate Cancer:  
The Report of the Advanced Prostate Cancer Consensus  
Conference APCCC 2017**

Gillessen S, et al. Management of Patients with Advanced Prostate Cancer: The Report of the Advanced Prostate Cancer Consensus Conference APCCC 2017. *Eur Urol* (2017), <http://dx.doi.org/10.1016/j.eururo.2017.06.002>

- There are sufficient data indicating that next-generation imaging technologies have better accuracy for detecting metastases than CT and bone scintigraphy. However, their current use is dependent on costs, local availability, and expertise of interpretation and the better accuracy has not been shown to correlate with improvement of clinical outcomes.



IV JORNADAS INTERHOSPITALARIAS DE  
ACTUALIZACIÓN EN UROLOGÍA DE  
EXTREMADURA

Mérida, 24 y 25 de Noviembre de 2017

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# Cáncer de Próstata

## *Cuestión de imagen*

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