PRIMARY CARE 10 TOP TIPS

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Prostate cancer

1 Prostate cancer is not a trivial disease. It is a leading cause of male mortality and the commonest cancer in men. About a third of men with prostate cancer die as a result of their illness.

2 Men at increased risk include:

- Afro-Carribbeans (2–3 times increased risk compared with white Europeans).
- Those with a family history of the disease in a first degree relative, especially an aggressive form or with younger onset of the disease (2–3 times increased risk).

3 Early prostate cancer is usually asymptomatic. Lower urinary tract symptoms (LUTS) such as change in frequency, nocturia, hesitancy are not significantly associated with prostate cancer, which usually starts in the periphery of the gland. However, exceptionally large tumours, detectable on rectal examination, may cause symptoms after some time. Haematospermia and erectile dysfunction are unusual manifestations of prostate cancer.

4 Aggressive prostate cancer presents at a younger age, probably because of faster growth. Slow growing prostate cancer in men of 70 or 80 years of age is unlikely to cause death.

5 Digital rectal examination (DRE) with patient standing, leaning forward makes accurate assessment much easier than other common positions.

6 Prostate biopsy can miss 25% of cancers. Repeat biopsy in three months if original indicators are still present. Stop warfarin and clopidogrel but continue aspirin prior to prostate biopsy.

7 A key decision after diagnosis is whether the aim is disease control or cure. These are distinct and separate pathways. (see the below flow chart for men with localised prostate cancer)

8 If prostate cancer escapes hormonal control, shown by rising prostate specific antigen (PSA), don't just give palliative care but refer back to secondary care as much can be done to regain control of the disease (eg Dexamethasone or Zolendronate). Maintain hormonal blockade as some tumour cells will retain responsiveness.

9 Patients on hormonal blockade, eg luteinising-hormone releasing hormone (LHRH), analogues Goserelin (Zoladex) or Leuprorelin (Prostap), are at risk of osteopenia (present in 40% of cases) and metabolic syndrome, with 20% increased cardiovascular risk. Exercise offsets both these increased risks. Intermittent hormonal treatment protocols may soon be recommended to minimise adverse effects of treatment.

10 A patient with widespread bony metastases is at risk of hypercalcaemia. Spinal metastases risk spinal cord compression – a reason for emergency admission.

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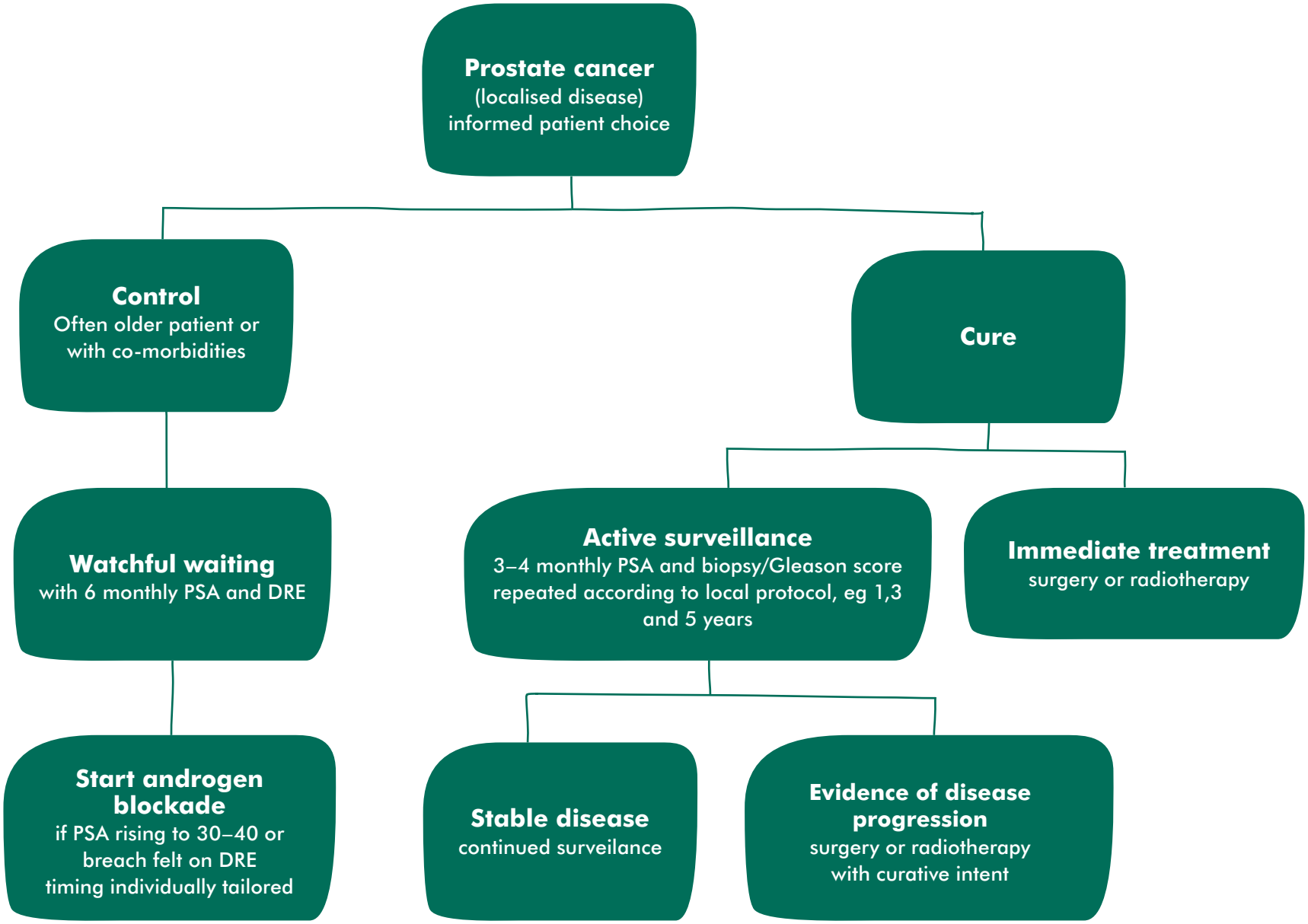

NB Active Surveillance (AS) is different from Watchful Waiting (WW).
The aim of WW is to control the disease. The aim of AS is to pick out those patients with early cancer who may benefit from a curative approach.

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