As recently as October 18, the Seattle Post-Intelligencer ran a medical article on age as a deciding factor for radical prostatectomy. While patients as old as 79 seem to tolerate the procedure, a more important determinant is coronary disease. “Having heart disease or other serious ailments in addition to the cancer proved a bigger predictor of surgical complications than increasing age, Canadian researchers report in Wednesday’s edition of the Journal of the National Cancer Institute.”

Whether a prostate cancer patient is considered high risk according to the D’Amico classification or for other clinical reasons—or as in this month’s case study, for both—cryotherapy offers an effective, minimally invasive and well-tolerated treatment option.

Dr. Stephen Scionti presents the case of a patient whose repeat biopsies over almost four years detected High Grade PIN but no cancer. The patient also had a chronic coronary condition necessitating maintenance on Coumadin and a history of dyslipidemia. By the time prostate cancer was diagnosed, the patient was 73 years old. His clinical parameters, i.e. PSA and Gleason grade as well as MRI, placed him in a high risk category.

Of the annual localized prostate cancer patients in each urologist’s practice, a percentage will clearly be non-surgical candidates. While radiotherapy may be an option for many, cryotherapy occupies a unique practice niche, especially when patients psychologically shrink from the idea of radiation. “The primary therapy results are comparable to the rates of efficacy of both beam radiation and brachytherapy. Moreover, cryoablation also appears to be comparable in the treatment of higher risk disease. Modern cryoablation, as a definitive therapy for both primary and radio-resistant prostate cancer, is associated with minimal side effects and no known latent complications. In fact, quality of life seems to continually improve following the procedure.”

Keep these points in mind as you join Dr. Scionti in this month’s case study, and read the patient’s account of his experience.

Case Study 1002:

CASE HISTORY: EDWIN KAYLOR  DOB: 10/20/31

Medical History

• Chronic atrial fibrillation; Dyslipidemia; BPH, on Flomax

• Medications: Flomax; Coumadin; Simvastatin; Celebrex; Lanoxin

Urologic History

March 2001 - Elevated PSA of 7.3, asymptomatic.

Sept. 2001 - TRUS guided biopsy showed 28cc prostate. 12 biopsies obtained.

Results: High grade PIN at Left mid-gland, 2 sites.

July 2003 - PSA rises to 13. Repeat biopsy. TRUS volume 46cc. 12 biopsies obtained. Results: High grade PIN at Left apex, 2 sites, Left mid 1 site.

PSA stable for 1 year at 13.7, but due to high grade PIN, repeat biopsy recommended.

Jan 2005 - Repeat TRUS and biopsy. Prostate volume 40g.

Results: Prostate cancer present, Gleason score 3+4 at Left mid, lateral biopsy, and Gleason score 3+3 cancer present at left base. High grade PIN Left lateral apex, Right mid, medial and Right lateral base.

Staging: MRI reveals large focus of cancer seen at Left lateral and Left posterolateral hemiprostatic peripheral zone with capsular bulging, strongly suggestive of capsular penetration. A second much smaller focus of cancer is seen at Right lateral and posteraolateral hemiprostate at apex.

Bone Scan: Negative

Summary: PSA >10, Gleason 7: Risk Category = HIGH (D'Amico classification), Stage T1c clinically, but capsular involvement on MRI suggests Stage T3a. Location multifocal.

Erectile Function: able to have erection with medication

Treatment


Rationale: High risk disease, poor candidate for radical prostatectomy. Erectile dysfunction likely result of any intervention chosen.

Follow-up

SP tube removed at POD #7; Frequency and Nocturia for 1 month after removal.

3 Months post op: Nocturia 1-2. No urgency or urge incontinence, voiding is normal

Erectile Function: no spontaneous erections. Started on “penile recovery” with VED Pump at 3 months. Post-tx PSA (7 mos.) 0.20.

Ultrasound Images

(See PATIENT EXPERIENCE page 4)
Physician Profile and Case Discussion:

Stephen Scionti, MD

Describe the details of Mr. Kaylor's cryo.

We administered general anesthesia. I prefer this, since even under spinal, patients move. What if a patient coughs and his prostate moves? It throws off my calculations. Treating the apex is the key to good PSA control. I did not do a pullback of the cryoprobes to get good target temperatures at the apex, though I would have done that if his gland length required it. I did a total gland ablation since he had multi-focal disease, and used a double freeze-thaw. His actual procedure time took under 1½ hours. I average 70-80 minutes per case, not including turnaround time in the OR.

How did you evaluate his candidacy for various treatment modalities?

In his case, a history of atrial fibrillation did not contraindicate anesthesia, but a major surgical procedure with the possibility of blood loss would be more risky. His underlying cardiac disease makes surgery more of a stress than if he underwent a 1½ hour cryo without the risk of blood loss and hypotension, so the decision of definitive treatment came down to radiation or cryo.

He had a series of biopsies from March 2001 to January 2005. Did you administer the entire series?

I did not do his initial set of biopsies. When he became my patient in summer 2003, his PSA was still elevated and he already demonstrated high grade PIN. Diagnostically, I tend to be more aggressive in such a case. He needed another biopsy and I also established a program for sequential biopsies. To reduce biopsy anxiety and discomfort, I use a local anesthetic (Lidocaine). And of course his Coumadin had to be stopped 5 days prior to each biopsy, as for any invasive procedure.

What was your line of thinking once you obtained a positive biopsy?

On the one hand, his disease needs treatment because it has a very definite chance of progression. On the other hand, this is a disease that’s not likely to kill the patient. At age 74 he needs attention due to his risk factors but I don’t want to overtreat this disease. As I tell patients, “We don’t want to shoot a mouse with an elephant gun. If I control your cancer so it doesn’t progress but leave you with a pad or painful urination for the rest of your life, I haven’t done you any favors. I want a treatment modality that will give you the least risk of long term lifestyle complications.”

With cryo the chance of side effects is much lower, particularly when you look at combination radiotherapy. If a patient ends up with prolonged painful urination, radiation cystitis or radiation proctitis, I now have a man with a permanent condition for which there are no cures. I haven’t done him any favors.

How did you address Mr. Kaylor’s overall concerns?

As soon as his MRI results were in, we scheduled his cryo less than 2 weeks later. People are uncomfortable knowing they’ve got cancer, so once they’ve made a treatment decision they want to get it over and get back to life. I say, “We’re going to take a 4-6 week period out of your life, beat your cancer, get you recovered and then you’re going to go on with your life.” When I explain cryo to them, they have realistic expectations. They expect that for a month after treatment they’ll have abnormal urinary symptoms, but then they’re going to get better. That’s the usual experience.

His urologic history included some nocturia due to BPH and also erectile dysfunction prior to his cryo. How is he less than a year out from treatment?

He describes his urination as getting up once a night, but he might say that’s even better than before his cryo when he was getting up twice a night with BPH. Other than that, he says his urination is normal. Regarding ED, he’s been on medication since 2001, and given his cardiac condition and age, ED would be expected. No matter what treatment modality he chose, he would have had post-treatment ED. With the VED he’s able to have functional erections, though currently he has no spontaneous function. But remember that the Donnelly study demonstrated regained function in nearly 50% of total gland cryoablation over time (18-36 months). So time will tell.

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Dr. Scionti has been my doctor for years. I had an enlarged prostate, and I was getting regular PSA blood tests. They tended to be high, so I also had annual biopsies. They were negative for cancer but showed some precursors.

When the January 2005 biopsy came back positive, Dr. Scionti arranged a meeting with me and my wife. It lasted about two hours. He went through the various options, the benefits of each, the advantages and disadvantages. He felt that the cancer was contained in the prostate. In my case, he thought surgical removal would be difficult, so he recommended cryotherapy. He then ordered an MRI and bone scan, and found no evidence of cancer outside the prostate. Since that seemed to be the case, I was a very good candidate for cryo.

In early February, ten days after the biopsy, I had my cryo. The treatment apparently went wonderfully. Dr. Scionti was very satisfied with the freeze. It was supposed to be an outpatient treatment, but due to my late in the day surgery and time in recovery, I ended up spending the night in the hospital. I had some swelling, but no bruising or tenderness; I did have a catheter (suprapubic) for about 2-3 weeks. About a week before the catheter was removed, I began urinating normally, which went smoothly. Initially, I had minor incontinence but it resolved itself in about two weeks. Before the catheter was removed my activity was rather limited. I went out to eat, but I was slower to get into sporting activity or exercise.

I feel very good about having chosen cryo. Given that I had prostate problems for so long, I think it was really the smart option. It seems to me to be a very logical solution. I’m very pleased that Dr. Scionti offers different treatment options and makes intelligent recommendations according to the circumstances—there is not one treatment that’s right for everybody.