NICE BULLETIN

NHS
National Institute for
Health and Clinical Excellence

Diagnosis & treatment of prostate cancer

Nursing IN PRACTICE

Introduction

In February 2008, the National Institute for Health and Clinical Excellence (NICE) published a new clinical guideline on best practice for the diagnosis and treatment of prostate cancer

The guideline, produced for NICE by the National Collaborating Centre for Cancer, aims to help clinicians to provide coherent and consistent care for men with suspected or diagnosed prostate cancer across England and Wales.

Around 35,000 men are diagnosed with and 10,000 men die from prostate cancer in England and Wales every year, making it one of the most common cancers in men. However, it can also be a slow growing cancer and may not necessarily affect a man's general health for many years.

Over the past 10 to 15 years there have been a number of significant advances in prostate cancer management but also differing views on the most effective treatments, especially about the clinical management of men with early, non-metastatic disease. These uncertainties can potentially cause anxieties for men with prostate cancer and their families.

One of the major challenges is to identify and treat aggressive cancers that may be life threatening while avoiding over treatment of slow growing cancers that may not need treating for many years. Prostate cancer is more common in older men. This is why it is so important that men with prostate cancer are able to understand the treatment options available them and, with the support of their healthcare professional, are able to make a choice to suit their individual needs, both clinically and related to their quality of life.

This guidance aims to ensure that wherever people are diagnosed and treated, they will have access to the same high quality standard of care from trained professionals; providing consistent, high quality information to help them make the right decisions for them.

WHAT NICE RECOMMENDS

Communication and support

- Men with prostate cancer should be offered individualised information tailored to their own needs. This information should be given by a healthcare professional (for example, a consultant or specialist nurse) and may be supported by written and visual media (for example, slide sets or DVDs).
- Healthcare professionals should adequately inform men with prostate cancer and their partners or carers about the effects of prostate cancer and the treatment options on their sexual function, physical appearance, continence and other aspects of masculinity. Healthcare professionals

should support men and their partners or carers in making treatment decisions, taking into account the effects on quality of life as well as survival.

Biopsy

The aim of prostate biopsy is to detect prostate cancers with the potential for causing harm rather than detecting each and every cancer. Men with clinically insignificant prostate cancers that are unlikely to cause symptoms or affect life expectancy may not benefit from knowing that they have the disease. Indeed, the detection of clinically insignificant prostate cancer should be regarded as an under-recognised adverse effect of biopsy.

- To help men decide whether to have a prostate biopsy, healthcare professionals should discuss with them their prostate specific antigen (PSA) level, digital rectal examination (DRE) findings (including an estimate of prostate size) and comorbidities, together with their risk factors (including increasing age and black African or black Caribbean ethnicity) and any history of a previous negative prostate biopsy. The serum PSA level alone should not automatically lead to a prostate biopsy.

Watchful waiting and active surveillance

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

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

Radical treatment
- Healthcare professionals should offer radical prostatectomy or radical radiotherapy (conformal) to men with intermediate-risk localised prostate cancer. The same treatment should be offered to men with high-risk localised prostate cancer when there is a realistic prospect of long-term disease control.
- Men undergoing radical external beam radiotherapy for localised prostate cancer should receive a minimum dose of 74 Gy to the prostate at no more than 2 Gy per fraction.

Managing adverse effects of treatment
- 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 a specialist surgical oncologist and a specialist clinical oncologist.
- Healthcare professionals should ensure that men and their partners have early and ongoing access to specialist erectile dysfunction services.
- Healthcare professionals should ensure that men with troublesome urinary symptoms after treatment have access to specialist continence services for assessment, diagnosis and conservative treatment. This may include coping strategies, along with pelvic floor muscle re-education, bladder retraining and pharmacotherapy.
- Healthcare professionals should refer men with intractable stress incontinence to a specialist surgeon for consideration of an artificial urinary sphincter.

Managing relapse after radical treatment
- Biochemical relapse (a rising PSA) alone should not necessarily prompt an immediate change in treatment.
- 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
  - an isotope bone scan should be performed if symptoms or PSA trends are suggestive of metastases.
- 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 < 3 months.

Locally advanced prostate cancer

There is no universally accepted definition of locally advanced prostate cancer. It covers a spectrum of disease from a tumour that has spread through the capsule of the prostate (T3a) to large T4 cancers that may be invading the bladder or rectum or have spread to pelvic lymph nodes.

Hormone-refractory prostate cancer

Sometimes hormonal treatments for prostate cancer can cease to be effective and the disease is then said to be hormone-refractory.

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

Palliative care

- 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 prostate cancer. They should have the opportunity to discuss any significant changes in their disease status or symptoms as these occur.
- Palliative interventions at any stage should be integrated into coordinated care, and any transitions between care settings should be facilitated as smoothly as possible.
- 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.
- 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.

FURTHER INFORMATION

Since the publication of this guideline, NICE has also recommended the use of abiraterone as a treatment option for castration-resistant metastatic prostate cancer that has progressed on or after one docetaxel-containing therapy. The final guidance is available at www.guidance.nice.org.uk/TA259.

To read the full recommendations in NICE's clinical guideline on the diagnosis and treatment of prostate cancer and to access tools to help nurses implement the recommendations and supporting advice that nurses can give to parents or carers, please visit: www.nice.org.uk/CG058. NICE has also developed a fast, easy summary view of NICE guidance on prostate cancer in the form of a pathway which is available on the website: http://pathways.nice.org.uk/pathways/prostate-cancer.