Jai Pausch Advises Caregivers to Balance Urgency for Care with Thoughtful Treatment Decisions in NCCN.com column

Despite feeling a sense of urgency when a loved one is diagnosed with cancer, it is important to invest adequate time to research and consider treatment options, according to Jai Pausch in her new “Ask Jai” column on NCCN.com. Ms. Pausch, widow and caregiver of the late Randy Pausch, acclaimed Carnegie Mellon University professor and author of the internationally best-selling book The Last Lecture, responds to a reader’s question about feeling as though “time is slipping away” in this month’s column.

Ms. Pausch reminds the reader that battling cancer “is a marathon, not a sprint” — a mantra that should be kept in mind when prioritizing time and energy. In addition, she emphasizes the need to address caregiver anxieties through support groups and the importance of nutrition and exercise to strengthen both the caregiver and patient as they prepare for treatment. Visit NCCN.com to read the column in its entirety.

“Ask Jai” is a monthly column on NCCN.com, the patient Web site of NCCN. NCCN.com features the NCCN Guidelines for Patients as well as enhanced content for patients and caregivers.

Active Surveillance Monitoring More Stringent in Updated NCCN Guidelines for Prostate Cancer

Active surveillance or immediate treatment? The question that many men with prostate cancer and their clinicians struggle with continues to be a focus in the updated NCCN Guidelines for Prostate Cancer. James L. Mohler, MD, of Roswell Park Cancer Institute and chair of the NCCN Guidelines Panel for Prostate Cancer, discussed more rigorous monitoring of men undergoing active surveillance and new treatment options for advanced prostate cancer in the recently updated NCCN Guidelines during a presentation at the NCCN 16th Annual Conference.

Active surveillance, also referred to as watchful waiting, is a viable option for many men with low-risk prostate cancer although the concept continues to cause distress and confusion for many men, especially when they read about the controversies associated with the use of prostate-specific antigen (PSA) for the early detection of prostate cancer, noted Dr. Mohler.

“The NCCN Guidelines Panel remains concerned about over-diagnosis and overtreatment of prostate cancer as growing evidence suggests that over-treatment of prostate cancer commits too many men to side effects that outweigh a very small risk of prostate cancer death,” stated Dr. Mohler.

Dr. Mohler discussed various organizations’ prostate cancer screening recommendations, including those by the American Cancer Society and American Urological Association as well as the NCCN Guidelines for Prostate Cancer Early Detection.

“The current NCCN Guidelines recommend that at age 40, high-risk men begin annual PSA and prostate exams. All other men at age 40 should be offered a baseline PSA and prostate exam and, if their PSA is 1.0 ng/mL or greater, they should receive annual follow-ups. If their PSA is less than 1.0, the NCCN Guidelines recommend that these men be early detected again at age 45,” said Dr. Mohler.

Dr. Mohler noted that the screening debate exploded in early 2009 as a result of the ERSPC (European) and the PLCO (American) studies published in The New England Journal of Medicine that led to media reports stating that PSA screening has little impact on the risk of death from the disease.

However, the 40% reduction in prostate cancer mortality in the United States since 1992 may be due to use of PSA. Results published recently from a Swedish population-
based trial that was part of the larger ERSPC study, the Göteborg study, suggested that PSA screening for prostate cancer reduced prostate cancer-specific mortality by approximately 50%, a rate similar to the overall reduction that has occurred in the United States.

In 2010, the NCCN Guidelines established a new “very low risk” category that incorporated the strictest Epstein criteria from all definitions for clinically insignificant prostate cancer and recommended active surveillance as the sole initial treatment for men who meet these criteria and have a life expectancy of more than 20 years. Men with low risk prostate cancer and a life expectancy of less than 10 years should also be recommended for active surveillance.

In the updated 2011 NCCN Guidelines, active surveillance monitoring was made more rigorous for men in the very low risk category. For those with a life expectancy of less than 20 years, PSA must be measured at least every 6 months, a prostate exam must be performed at least every 12 months, and repeat prostate biopsies should be considered as often as every 12 months.

Dr. Mohler noted that there are several conundrums related to active surveillance that complicate the issue further, including over-treatment rates, clinical risks associated with prostate biopsies, and differing criteria for active surveillance and disease progression in large clinical series, all of which need to be taken into consideration when making treatment decisions.

“Ultimately, this decision must be based on careful individualized weighting of a number of factors and is an option that needs to be thoroughly discussed with the patient and all of his physicians. Clearly, more clinical research is necessary to better inform decision-making,” said Dr. Mohler.

Another significant update to the NCCN Guidelines includes the addition of sipuleucel-T as an immunotherapy option for asymptomatic or minimally symptomatic castration-recurrent metastatic prostate cancer. A recent clinical trial showed that sipuleucel-T extends the median survival of men with advanced prostate cancer who were treated with the drug.

“The NCCN Guidelines have been modified to include sipuleucel-T as a category 1 recommendation that is appropriate as salvage treatment for patients with castration-recurrent prostate cancer who have minimally symptomatic disease, an ECOG performance score of 0 or 1, and a life expectancy of at least 6 months,” noted Dr. Mohler.

The updated NCCN Guidelines also include cabazitaxel as a new second-line option for men with castration-recurrent metastatic prostate cancer who fail docetaxel. The recommendation was added following a clinical trial showing a 30% risk reduction of death for those treated with cabazitaxel compared to mitoxantrone.

“The addition of both of these therapies into the NCCN Guidelines represents a significant advancement in the care of men with advanced prostate cancer,” said Dr. Mohler.

Lastly, denosumab has been added to the NCCN Guidelines as an alternative to zoledronic acid for the prevention of skeletal-related events.

“In men with castration-recurrent prostate cancer who have bone metastases, denosumab was shown superior to zoledronic acid in preventing disease-related skeletal complications, which include fracture, spinal cord compression, or the need for surgery or radiation therapy to bone,” said Dr. Mohler.

However, he noted that the choice of which agent to use should depend upon several variables, including underlying comorbidities and whether the patient has been treated with zoledronic acid.