Seed implant brachytherapy for prostate cancer

Kudos to Juanita Crook and colleagues for attempting to wrestle some scientific sense into recommendations for seed implant brachytherapy for prostate cancer.[1]

Unfortunately, there are no data from randomized trials on which to base a comparison of brachytherapy with prostatectomy and external beam radiotherapy for early-stage prostate cancer. The literature in the era of prostate-specific antigen (PSA) screening is too immature to allow one to accurately comment on disease-specific survival, with most studies having a follow-up period of 3–4 years after surgery, radiotherapy or brachytherapy.

Although results are promising for brachytherapy as monotherapy for patients at low risk (T1 or T2a tumour, Gleason score of 6 or lower and serum PSA level of 10 μg/L or less), we should remain skeptical about the durability of these results, just as we should be skeptical about the results of surgical and external radiotherapy series in the era of PSA screening.

It is even more difficult to make a recommendation concerning brachytherapy for patients at intermediate risk (T2b tumour, Gleason score of 7 or lower and serum PSA level of 10–20 μg/L). Very few such patients are included in the studies quoted by Crook and colleagues, and continuing evolution of the seed implantation technique is likely to affect outcomes for patients at intermediate risk even more dramatically than for those at low risk. In addition, because the intermediate-risk group encompasses a broad range of patients, any recommendation for the entire group is likely to be an oversimplification. A recent study showed that some patients with one intermediate risk factor do as well with brachytherapy alone as patients in the low-risk group described by Crook and colleagues.[2]

In my opinion, the authors' statement that "brachytherapy should be offered only to selected patients with favourable disease (T1c or T2a tumour, Gleason score of 6 or lower and serum PSA of 10 μg/L or less)" is too strongly worded for the evidence upon which it is based. It would be more appropriate if the word "only" were left out.

Ross Halperin
Assistant Professor
Department of Radiation Oncology
Cross Cancer Institute
Edmonton, Alta.

References

1. Crook J, Lukka H, Klotz L, Bestic N, Johnston M, and the Genitourinary Cancer Disease Site Group of the Cancer Care Ontario Practice Guidelines Initiative. *CMAJ* 2001;164(7):975-81.
2. Blasko JC, Grimm PD, Sylsvester JE, Cavanagh W. The role of external beam radiotherapy with I-125/Pd-103 brachytherapy for prostate carcinoma. *Radiother Oncol* 2000;57(3):273-8.s

Juanita Crook and colleagues have provided a timely review of the use of brachytherapy in men with prostate cancer.[1] We agree that permanent interstitial implants as monotherapy should be reserved for those with early-stage, localized prostate cancer. However, commentator Curtis Nickel was skeptical about the use of brachytherapy in such patients.[2] We challenge the assertion that these patients represent a "small minority" of men found to have prostate cancer. In fact, with the advent of prostate-specific antigen screening, men are being diagnosed at a younger age with disease at an earlier stage than previously.[3,4] On the basis of the available 10-year data, brachytherapy is an effective intervention for early-stage prostate cancer and is no longer considered experimental therapy.

It is unclear why Nickel characterizes the rates of side effects as "disturbing." The most common one, irritative urinary symptoms, is generally self-limited. Impotence rates compare

Submitting letters

Letters may be submitted via our Web site or by mail, courier, email (pubs@cma.ca) or fax. They should be no more than 250 words long and must be signed by all authors. A signed copy of letters submitted by email must be sent subsequently to *CMAJ* by fax or regular mail. Letters written in response to an article published in *CMAJ* must be submitted within 2 months of the article's publication date. Letters are subject to editing and abridgement.

eLetters

We encourage readers to submit letters to the editor via the eLetters service on our Web site (www.cma.ca/cmaj). Our aim is to post by the next business day correspondence that contributes significantly to the topic under discussion. eLetters will be appended to the article in question in *eCMAJ* and will also be considered for print publication in *CMAJ*. Beginning with the Aug. 22, 2000, issue, eLetters can be submitted by clicking on the mailbox icon at the end of the HTML text of any *eCMAJ* article.