

Professor Christian G. Stief: the role of surgery for prostate cancer with bone metastases

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Professor Christian G. Stief (Figure 1) is the Director of the Urological Clinic and Department, Grosshadern Campus, Munich University Hospital. His main fields include smooth muscle pharmacology, bladder carcinoma and reconstructive surgery. His current interests focus on laser in prostate and bladder carcinoma, laser for urinary stones, molecular markers in bladder carcinoma and lymph nodes in prostate carcinoma. We are honored to have a chance to do this interview with Professor Stief in the International Hi-Tech Urological Surgery Forum organized by Professor Chunxiao Liu in Zhujiang Hospital, Guangzhou, China. During the interview, Professor Stief presented his opinions regarding the role of surgery for prostate cancer with bone metastases.

TAU: *Could you please give us a brief introduction on the role of surgery for non-positive and bone metastatic prostate cancer?*

Prof. Stief: The concept is that we have seen that all of our treatment strategies which we applied for the last 35 years to prostate cancer patients with bone metastases have not increased a single day of survival to these patients. Thus we have set down with different specialties such as radiology, orthopedic oncological surgery, nuclear medicine, and with epidemiologists and oncologists to develop different strategies to really prolong the survival of patients with metastatic prostate cancer while maintaining the quality of life or even improve the quality of life. The most important thing is what the patient wants with the life span they have. At least in my philosophy, it is absolutely inadequate to prolong the life span of patients if these days are lack of quality of life. So we must always consider what we can do, what side effects will the treatments induce and what the balance is between prolonging life span and lack of quality of life.

TAU: *How have the treatments for metastatic prostate cancer evolved overtime?*

Prof. Stief: Up to now, if the patient presents prostate cancer



Figure 1 Professor Christian G. Stief

with bone metastases, they will be given hormonal treatment, which is basically the chemical castration or surgical castration. If the patient progresses dramatically, he will be given cytotoxic chemotherapy. Cytotoxic chemotherapy in prostate cancer exists in the overwhelming majority, based on taxane-based therapy that is given in all patient settings. It's very tolerated, like for 6 or 12 times. But if it is given on a really long term basis, side effects of cytotoxic chemotherapy become very heavy, for example, the patients will lose their nails or hair. Their life span may be prolonged for a mean of three weeks, as it is the mean gain of chemotherapy in this setting, but they lose a lot of quality of life. So we have to make a balance and find out some good approach for

patients. For most of my patients, I actively advise them not to undergo cytotoxic chemotherapy if they are in advanced prostate cancer. Only when they have a very strong bone pain, will I advise them to receive cytotoxic chemotherapy. Because in that case, there are benefits for them and the ratio of effects and side effects is pretty good. We have set down and calculated all the cases and we have found that we did not do a good job in the treatment of these patients. Since we have witnessed that we can do a very good job in patients with prostate cancer and lymph node metastases by removing the prostate, we think that we could add significant life time gains to patients who present bone metastases. We can remove the 'primary tumor', that is, to remove the prostate and then go for the treatment for every senior bone metastases. At least, the advantage is the mobility for the patient is very low because in an organized setting, the so-called radical prostatectomy is a reasonable, well-controlled surgical intervention. The blood-loss is minimal and the chance of incontinence is very low, so you can remove the primary tumor in a very reasonable side effect profile. The therapies for solitary or multiple metastases with a very low mobility are mostly done in an out-patient basis, and the patients usually tell us that "I don't feel anything".

TAU: *Is there any controversial aspect in the surgery for prostate cancer?*

Prof. Stief: Sure, at the moment, experimental medicine is controversial. We have to tell everything to a patient about the setting and the knowledge about experimental medicine. Experimental medicine means that we have very good basic data which support that very specific concept but we do not have a final answer. This is done in a clinical study setting, which means we have a study protocol that has been agreed upon multiple different specialists who have considered the quality of life for patients, the environment and social economic aspects. The patient has to sign the written form of consent to show that the patient knows about the experimental medicine, but he really wants to undergo this kind of option. We try to play it very openly, so that the controversy could be very limited.

TAU: *What do you think about the future treatment for prostate cancer?*

Prof. Stief: In prostate cancer, we have several things to

do. The first is that we have to stop thinking either if the patient gets nothing of what he calls active surveillance, or he gets surgery of prostate, in a sense that prostate is out. We are even able to do very early detection of prostate cancer, to detect the very small focal in his prostate. What we are developing at the moment in different centers worldwide is that we develop strategies to do 'focal therapy', which means the prostate remains in place, and we just eradicate that very first small focus called 'index tumor'. It is called 'index' because it is the very first focus. This is similar to breast cancer treatment. If breast cancer is detected early enough, we can just remove this small nodule and leave the remaining breast entirely intact.

TAU: *How to decide resection for metastatic prostate cancer?*

Prof. Stief: When we talk about metastatic cancer, it always depends on the general state of the patient, whether the patient is young or healthy. If the patient with aggressive tumor has no other diseases like heart attack or severe stroke and he is in really good health, he would receive strongly recommendation of undergoing surgery and taking out the primary tumor that continuously sends out the metastases load. If the patient is very sick and the general health state is deteriorating so heavily that you are kind of seeing his final days, you will definitely not perform aggressive treatment for him. Because the influence on his quality of life is so negatively that the patient would not benefit from your therapy.

TAU: *Thank you very much.*

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