Modified Guidelines for Prostate Cancer Radiation

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Andrew Schorr:
Radiation, is that typically a—years ago, they developed the seeds they could put in, and there are other ways of delivering radiation too, right?

Dr. Hussain:
The seeds are one tool. Generally, the more—tool is what we call the external beam radiation, and these are given generally daily, five days a week for a period of time. Recently, actually, ASCO and I believe ASTRO modified the guidelines and this hopefully will be reflected in patient material to look into in terms of shortening the duration of the radiation so that patients don't have to go for two months' worth of treatment or something of that sort. That would be the case.
In terms of the seeds, there are two types of seeds, there are the permanent seed implants, which are general put for the lower grade, like the Gleason 6 cancer, but there are the high seed implants that generally are placed, then they're removed, and these are intended to maximize the radiation together with the external beam radiation.

Andrew Schorr:
Okay, and Gary, am I right, you did have radiation to the prostate, is that correct?

Gary Andrus:
I did.

Andrew Schorr:
Okay, how long did you have that for?

Gary Andrus:
43 treatments.

Andrew Schorr:
Okay, so we're talking about maybe more compressed now, Dr. Hussain?

Dr. Hussain:
Yes.

Andrew Schorr:
Okay, new guidelines. All right, Brenda. Hold on.

Dr. Hussain:
I'm sorry, there are tradeoffs, and I think that's where it critical for the patient to talk with their radiation doctor about the side effects.

Andrew Schorr:
Dr. Hussain, and I know at least there's one radiopharmaceutical. What does that mean and how does that come into prostate cancer treatment?

Dr. Hussain:
Radiation, as you know, is a technology that is intended to kill the cancer cells in a directed manner. In patients who have metastatic disease, you obviously cannot put the body through a radiation machine and try to hit it in multiple areas. There are times where we can do that, and certainly, we have done that with Gary when you have limited number of spots, certainly, that the trend nowadays is—what we do is to target as much as possible those areas to try to maximize the cell kill, the kill of the cancer, on top of getting the hormone treatment to starve it.

One of the features of prostate cancer and what I call the hallmark of metastatic prostate cancer is actually spread to bone, and it's still puzzling, why does it go to bone, say, compared to any other cancer as the number one site in the vast majority of times? Trying to target the bone while you're sparing other body parts from treatment is certainly a legitimate treatment approach with the intent of maximizing the potential benefit and minimizing the potential side effects. Radium–223 is such a radiopharmaceutical, I would point out, it's not the first radiopharmaceutical that was utilized in prostate cancer.

Years ago, there were other radiopharmaceuticals that were approved by the FDA then, I would say, and this is more like the '90s. Those were not life-prolonging. They were more of a palliative-type treatment. Radium, on the other hand, was a treatment that demonstrated the potential for prolonging life. Same thing, I think, for patients. If, in fact, they are interested in it, they should discuss with their doctors whether it's appropriate for them, and the reason that is the case, it's not going to work for cancers that are outside the bone. If a person has bone and lymph nodes or spots in the lung, or spots in the liver, or somewhere else, then certainly, the Radium would not be the appropriate treatment for them.