RADICALS-RT

Radiotherapy and Androgen Deprivation In Combination After Local
A randomised controlled trial in prostate cancer.

February 2011

Welcome to the February 2011 edition of the **RADICALS** newsletter. You will have noticed that we now have a newsletter for RADICALS-RT and one for RADICALS-HD. We can now fit even more news about each randomisation into the newsletters. If you have anything you would like to see in either newsletter, let us know at **radicals@ctu.mrc.ac.uk**.

Do Margins Matter?

It seems obvious that men with positive margins at radical prostatectomy should benefit more from post-operative radiotherapy than men with negative margins. However, two new lines of evidence suggest that margin status may be a red herring:

At the ASTRO annual meeting, Scott Morgan from Ottawa presented a meta-analysis of the three randomised trials of post-operative RT (SWOG 8794, EORTC 22911 and ARO 96-02). For patients with positive margins, post-op RT reduced the risk of biochemical progression with a HR of 0.45 (CI: 0.36-0.57). For men with negative margins, post-op RT reduced the risk of progression with a HR of 0.61 (CI: 0.44-0.85). These results are not statistically significantly different from each other.

In the current Journal of Urology, Scott Eggener et al. present data on 15-year prostate cancer specific mortality (PCSM) in over 20,000 men who underwent radical prostatectomy in one of 4 US centres between 1987 and 2005. As one would expect, Gleason score and T stage were important predictor of PCSM. For example, 15-year PCSM for men with Gleason 8-10 cancers was 26-37%, compared with 4-11% for men with Gleason 7 disease. Interestingly, margin status was not significantly associated with PCSM.

What are the take-home messages?

- First, positive margins do not mean that adjuvant RT is essential. Many men with positive margins will never develop PSA failure after surgery.
- Second, negative margins do not mean that adjuvant RT is futile. Post-operative radiotherapy appears to be effective regardless of margin status.

These apparently surprising results make sense if you consider that a pathologist will only ever examine a tiny proportion of the entire surgical margin. Many patients with negative margins on the sections examined will in fact have positive margins elsewhere in the specimen.

RADICALS-RT is relevant to patients whatever the status of their surgical margins.
Most patients entered into RADICALS-RT so far have positive margins. I would encourage you to consider RADICALS-RT for all high risk cases, regardless of margin status.

EAU Section of Oncological Urology (ESOU) Webcasts

The 8th meeting of the ESOU was held in London on 21st—23rd January 2011. Many of the presentations are available to be viewed by webcast on the ESOU website (http://esou2011.uroweb.org/scientific-programme/) including a debate about the use of adjuvant radiotherapy after radical prostatectomy which is very relevant to RADICALS-RT.

RADICALS-RT accrual going well!

We are very pleased to report that the accrual rates to RADICALS-RT have been improving over the past several months. We have had record numbers of patients joining the randomisation each month and we're confident that it will keep going up and up! There is now an average of **14** patients per month joining RADICALS-RT. The top ten centres recruiting to RADICALS-RT are listed below:

Centre	Pts	Centre	Pts
Southmead Hospital	13	Maidstone Hospital	7
Mount Vernon Hospital	12	Hope Hospital	6
Mid-Yorkshire Hospitals	12	Guy's Hospital	6
Royal Gwent Hospital	8	Birmingham Heartlands Hospital	6
Bradford Royal Infirmary	7	Croydon University Hospital	5

The great improvement in accrual rates is down to the hard work of many people and we would like to thank everyone and ask them to keep up the hard work so that this randomisation, which is considered difficult to recruit to, will be a success.

Amit Bahl's Recruitment Method for RADICALS-RT

My top tip is to provide the information for RADICALS-RT at the time of the consultation prior to surgery. I explain to patients that radical prostatectomy for prostate cancer is a treatment that can result in 3 outcomes after the final histology is available: **1st**: No further treatment needed **2nd**: Role of further treatment like radiotherapy uncertain and is being addressed in RADICALS-RT **3rd**: Radiotherapy would be strongly recommended. This way when the patients are approached for RADICALS-RT after the results of RP, it is put to them that the good news is that the results of surgery are favourable and there is no definite need for radiotherapy and they should consider randomisation in the trial. I have noted that this takes away the perceived disappointment felt by some patients and this results in effective team working with the urologists and oncologists and in my opinion is a factual representation of where we are with the role of radiotherapy in post-RP setting. For some patients who like to discuss the possibility of the three options post-RP, I put a rough estimate of 25-30%, 40-50% and 25-30% respectively and highlight that the commonest group is the 2nd option and reiterate the uncertainty which RADICALS is trying to address.

International Collaboration with RTOG

RTOG® Radiation Therapy Oncology Group

We are pleased to report that the international collaborations in RADICALS are being extended even further. The Radiation Therapy Oncology Group (RTOG) in the United States has formally agreed to join RADICALS-RT and has started the process of activation. We would like to welcome all our new colleagues to RADICALS and wish them every success in recruiting to this important trial.

Quality of Life Questionnaires

Please remember to ask all RADICALS-RT patients to complete the Quality of Life Questionnaire at baseline, 1 year, 5 years and 10 years. Quality of life is a very important outcome measure for the trial so complete data collection is crucial. RADICALS-HD only patients, do not need to complete any questionnaires.

RANDOMISATION LINE

020 7670 4777

(Mon –Fri 9am-5pm)

For SAE reporting please refer to the flow diagram in section 11 of the protocol

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