CORRESPONDENCE

Radiotherapy and Hormone Treatment in Prostate Cancer

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Avoid Downplaying Side Effects

We read the article with interest (1). In particular when an oncology endpoint comes to the foreground, side effects are placed in the background, even though these may drastically affect quality of life.

We would like to make a few comments on the mentioned side effects.

The sentence “All acute side effects usually cease quickly after the therapy has been concluded” is confusing and downplays the situation. Acute symptoms can become chronic, while some patients with no acute side effects develop late side effects, sometimes more than ten years after irradiation. These side effects are usually not treated by radiation oncologists. Long-term side effects that affect the anorectal area (such as fecal incontinence/tenesmus) have a major impact on quality of life (2).

Many side effects can be treated with simple, non-evidence-based resources. However, there are also patients with refractory side effects. The hyperbaric oxygen therapy mentioned in the article is not available everywhere, and the cost must be approved by the insurance company.

The potential risk of radiochemotherapy-induced cancer in normal tissues, such as the rectum, must also be considered. An epidemiological study of more than 80 000 participants found an increased risk of rectal cancer in patients whose prostate had been irradiated, as compared to patients who underwent surgery (3).

It should be reiterated that seed implantation also is radiation therapy, with side effects similar to percutaneous irradiation.

In our opinion, (preventive) colonoscopy should be performed before radiochemotherapy. Proctitis developed after radiation in these patients can be deemed as most likely radiation-induced. This proctitis should not be confirmed by biopsy, as poorly healing ulcers or fistulas—including rectourethral fistulas—can occur at the biopsy site (4). The colonoscopy should be repeated based on the diagnosis.

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In Reply:

We appreciate the constructive feedback. In particular, we are pleased to see the comments from Dr. Jongen about the issue of performing a biopsy after endoscopic diagnosis of radiation proctitis. This highlights the importance of interdisciplinary cooperation in side effect management. However, we would like to point out that a routine colonoscopy is not indicated before radiotherapy.

We agree with Dr. Jongen that the issues of side effects of external beam radiation therapy or seed brachytherapy were presented too briefly in the article (1), mainly due to space limitations. Indeed, a small proportion of patients (0.1%–6%) have serious late side effects after radiotherapy. The sentence quoted by Dr. Jongen from the original article is indeed confusing—even though “usually” was intended to clarify “all,” it could be misleading.

Hyperbaric oxygen therapy is evidence-based. In our experience, an individual application to the respective health insurance company indicating the randomized study usually leads to a positive decision for the patient.

Overall, there is no doubt that ionizing radiation can induce secondary cancer. However, the studies and publications of second primary tumors following radiotherapy of prostate cancer patients show a high degree of heterogeneity, reflecting the extremely heterogeneous group of patients with a high risk of bias included in these studies. For example, the increased rate of rectal cancer after radiation therapy compared to radical prostatectomy reflects the naturally increased rate in a population treated with radiotherapy that is older by an average of five years (2).

An analysis published in 2011 found a significant increase only in patients who had been treated with

outdated radiation techniques. For brachytherapy, no significant differences were observed between 3-D conformal radiation therapy and intensity-modulated radiation therapy (3). However, as the patients were around 70 years old, this was a rare side effect.

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