

# After a radical prostatectomy

This information sheet is to inform you that some of the recommendations we give to our patients on discharge have been altered or standardized. We hope these recommendations find your approval.

## 1. Patients undergoing therapy with anticoagulants

In most of the patients with uncomplicated postoperative course anticoagulant therapy can be continued on day three after surgery. In some patients it might be necessary to pause anticoagulants for a longer time. We will therefore, in cooperation with the coagulation outpatients' center at the UKE, issue an individual recommendation for your patients.

## 2. Postoperative thrombosis prophylaxis

The current interdisciplinary German S3 guidelines „Prophylaxis of venous thromboembolism“ recommend a postoperative thrombosis prophylaxis after radical prostatectomy using low molecular weight heparin if there are no contraindications, e.g. Clexane® 40 mg, 1 x daily s.c., Mono-Embolex® 0.3 ml, 1 x daily s.c.) for altogether 4 weeks. Our patients are given heparin for the first two days following discharge in pre-filled syringes, which we show them how to use.

## 3. Recommendations on adjuvant radiation therapy

The data situation on the indication of adjuvant radiotherapy has meanwhile altered, in particular with regard to an accompanying hormone therapy. The following table presents our current recommendations on adjuvant radiotherapy after radical prostatectomy, based on the postoperative histology. We have compiled these recommendations in collaboration with our colleagues from the radiotherapy department at the UKE.

We still continue to discuss each individual patient who has an R1 or positive lymph node status with our pathologists and radiotherapists during our weekly tumor conferences. If there is any individual divergence from our recommendations, it is documented in our letter of discharge.

| Tumorstatus             | Therapie  |
|-------------------------|---|
| pT2 pN0 R0              | Follow-up by periodical PSA testing                           |
| pT2 pN0 R1              | Follow-up by periodical PSA testing                           |
| pT2 pN1 (≤2 LK) R0      | Follow-up by periodical PSA testing                           |
| pT2 pN1 (>2 LK) R0      | Adj. radiotherapy of prostate bed + pelvic LN area + ADT **   |
| pT2 pN1 R1              | Adj. radiotherapy of prostate bed + pelvic LN area + ADT **   |
| pT3a pN0 R0             | Follow-up by periodical PSA testing                           |
| pT3a pN0 R1 Gleason ≤ 7 | Follow-up by periodical PSA testing                           |
| pT3a pN0 R1 Gleason ≥ 8 | Adj. radiotherapy of prostate bed *                           |
| pT3a pN1 (≤2 LK) R0     | Follow-up by periodical PSA testing                           |
| pT3a pN1 (>2 LK) R0     | Adj. radiotherapy of prostate bed * + pelvic LN area + ADT ** |
| pT3a pN1 R1             | Adj. radiotherapy of prostate bed * + pelvic LN area + ADT ** |
| pT3b pN0 R0             | Follow-up by periodical PSA testing                           |
| pT3b pN0 R1             | Adj. radiotherapy of prostate bed *                           |
| pT3b pN1 (≤2 LK) R0     | Follow-up by periodical PSA testing                           |

\* for pT3a, radiotherapy of the prostate bed; for pT3b and pT4, radiotherapy of the prostate and seminal vesicle bed with adequate inclusion of the extraprostatic tumor boundaries. LN = lymph nodes/ ADT = androgen deprivation therapy (Note: since various drugs proved to have positive effects in the combination of radiation therapy and ADT in the literature, we do not issue any specific recommendation for ADT).

\*\* German S3 guidelines (Version 5.0) recommend ADT for 24 to 36 months.

**References** ① Thompson IM, Tangen CM, Paradelo J, Lucia MS, Miller G, Troyer D, et al. Adjuvant radiotherapy for pathological T3N0M0 prostate cancer significantly reduces risk of metastases and improves survival: long-term follow-up of a randomized clinical trial. *J Urol*. 2009 Mar;181(3):956–62. ② Bolla M, van Poppel H, Tombal B, Vekemans K, Da Pozzo L, de Reijke TM, et al. Postoperative radiotherapy after radical prostatectomy for high-risk prostate cancer: long-term results of a randomised controlled trial (EORTC trial 22911). *Lancet*. 2012 Dec 8;380(9858):2018–27. ③ Wiegel T, Bartkowiak D, Bottke D, Bronner C, Steiner U, Siegmann A, et al. Adjuvant radiotherapy versus wait-and-see after radical prostatectomy: 10-year follow-up of the ARO 96-02/AUO AP 09/95 trial. *Eur Urol*. 2014 Aug;66(2):243–50. ④ Tilki D, Preisser F, Tennstedt P, Tober P, Mandel P, Schlomm T, et al. Adjuvant radiation therapy is associated with better oncological outcome compared with salvage radiation therapy in patients with pN1 prostate cancer treated with radical prostatectomy. *BJU Int*. 2017;119(5):717–23. ⑤ Shipley WU, Seiferheld W, Lukka HR, Major PP, Heney NM, Grignon DJ, et al. Radiation with or without Antiandrogen Therapy in Recurrent Prostate Cancer. *N Engl J Med*. 2017 Feb 2;376(5):417–28. ⑥ Parker CC, Clarke NW, Cook AD, Kynaston HG, Petersen PM, Catton C, et al. Timing of radiotherapy after radical prostatectomy (RADICALS-RT): a randomised, controlled phase 3 trial. *Lancet*. 2020 Sep 28; ⑦ Sargos P, Chabaud S, Latorzeff I, Magné N, Benyoucef A, Supiot S, et al. Adjuvant radiotherapy versus early salvage radiotherapy plus short-term androgen deprivation therapy in men with localised prostate cancer after radical prostatectomy (GETUG-AFU 17): a randomised, phase 3 trial. *Lancet Oncol*. 2020;21(10):1341–52. ⑧ Kneebone A, Fraser-Browne C, Duchesne GM, Fisher R, Frydenberg M, Herschtal A, et al. Adjuvant radiotherapy versus early salvage radiotherapy following radical prostatectomy (TROG 08.03/ANZUP RAVES): a randomised, controlled, phase 3, non-inferiority trial. *Lancet Oncol*. 2020;21(10):1331–40. ⑨ Vale CL, Fisher D, Kneebone A, Parker C, Pearse M, Richaud P, et al. Adjuvant or early salvage radiotherapy for the treatment of localised and locally advanced prostate cancer: a prospectively planned systematic review and meta-analysis of aggregate data. *Lancet*. 2020 Sep 28; ⑩ Tilki D, D’Amico AV. Timing of radiotherapy after radical prostatectomy. *Lancet*. 2020 Sep 28.

## 1. Cystogram

We do not perform routine cystograms on our patients before removal of the catheter. If there is no longer any visible macrohaematuria, the catheter is usually removed from the 10th postoperative day onwards. Should, however, a cystogram be necessary, we would discuss this with your patient and mention it in the letter of discharge.

## 2. Erectile function therapy

In order to improve postoperative erectile function, we recommend that patients take, as required, a PDE-5-inhibitor in the period following the operation, if there are no cardiac contraindications. The patient offered to take Tadalafil 5 mg daily starting with day 4 after surgery. This treatment should be continued on a daily basis for at least three months, based on data of the REACTT study. Of course this recommendation could be modified on an individual basis. Then, if erectile function is still inadequate, a temporary course of Prostaglandin injections into the penis (corpus cavernosum), urethral suppositories (e.g. MUSE®) or vacuum devices should be considered.

**Ref.:** Montorsi F, Stolzenburg JW et al., „Effect of Tadalafil treatment on erectile function recovery following bilateral nerve-sparing radical prostatectomy: a randomized placebo-controlled study (REACTT)“, *European Urology* 2014; 65 (3):587-96).

## 3. Physical activity

We are often asked questions about physical activity such as swimming, sauna etc. and we recommend resuming such activities 4 weeks postoperatively. We also recommend that any pelvic floor exercises/physiotherapy should commence from the 2nd postoperative week onwards, at the earliest, and in individual cases maybe even later.

## 4. PSA recurrence

The Martini Clinic in Hamburg has in the past strictly adhered to a cut-off-value of 0.1 ng/ml. when defining PSA recurrence. In the current S3 guidelines a PSA value of 0.2 ng/ml. is defined as the threshold value for a recurrence. We have decided to adopt this recommendation as it is in consensus with international guidelines. The general ruling is that if in an individual case there is a rapid increase in PSA values, even from a value of 0.1 ng/ml. upwards, but below 0.2 ng/ml., radiation therapy can be initiated.

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