INTRODUCTION

Historically, the medical oncologist has been involved in the care of prostate cancer patients at the end of their lives; however, with newer chemotherapy interventions, clinical trials, more options, and increased involvement of patients in their medical care, the role of the medical oncologist should be revisited. A survey of the practice of British urologists clearly demonstrates the problem. “In clinical practice, 82% of urologists have close links with oncology, available through joint clinics or on-site referral. However, <5% refer patients to an oncologist before the development of hormone refractory disease. At relapse, only 53% of urologists referred their patients to oncologists or palliative-care clinicians. A wide variety of hormonal treatments were offered at relapse; only 24% of urologists treated their patients by antiandrogen withdrawal or introduction, which is currently, the most effective second-line treatment for recurrent prostate cancer” (1). With involvement from the day of diagnosis, the medical oncologist can assist in the coordination of treatments and the appropriate application of interventions. The assumption of the authors of this chapter is that it is never too early to refer a patient to a medical oncologist.

LOCALIZED LOW-RISK DISEASE: MIDDLE GROUND

It is generally recognized in the urologic oncology community that a controversy exists in the management of localized prostate cancer. In the investigation by Moore et al. (2) of this issue, they found that 95% of surveyed urologic oncology specialists were aware of this controversy; however, data representing a bias to use their own treatment modality were discovered. Moore et al. (3) also report that patients are rarely informed of alternative treatment option and even if they are, they lack the background information to make an informed choice between options.
In a published telephone survey of 1000 patients with prostate cancer and 200 urologists who provided care for men with prostate cancer, there was a significant disparity between what the urologist felt he or she had communicated and what the patient recalled being told (4). Nearly 100% of the urologists reported that they always discussed important considerations such as options for no therapy, patient preference, and changes in sexual function; however, only 20% of the patients recalled a similar discussion. Furthermore, 20% of patients felt they had not discussed treatment options with their physician, whereas only 1% of the urologists said that treatment options were not discussed.

Most physician treatment decisions are based on personal experience, education, literature review, and discussion among peers. However, judgments regarding toxicities and potential benefits of alternate treatments are made despite their direct experience being limited to one modality (2).

Many studies have been performed on the evaluation of patient preferences in the decision making process; however, few have evaluated the actual process of decision making. O’Rourke (5) completed such a project in which she found that the lack of a multidisciplinary approach with prostate cancer patients compromised their access to information about options. Most patients were presented with three possibilities: prostatectomy, radiation, and their perception of “doing nothing.” O’Rourke found that those surveyed did not experience a review of each option with an unbiased current perspective of the potential risks and benefits and an accurate prognosis. Only one went on to receive a second opinion from a different urologist. None went on to speak to a radiation oncologist or medical oncologist. She found that most decisions were based on a lifetime’s accumulation of attitudes, experiences, and their social context, with the urologist’s recommendation one of the strongest influences on decision making.

A patient referral to a medical oncologist would complete the team, facilitate the educational process, and provide balance to the options offered. Moore et al.’s (3) survey results also included the medical oncologist. The preference of the surveyed medical oncologists for management of their own localized prostate cancer was divided between surgery and radiation therapy. In contrast, there was a very strong preference by surgeons and radiation oncologists to desire treatment with their own modality (3). We conclude that the medical oncologist is a valuable “middle-ground” consultant in the evaluation of current appropriate treatment options offered to patients.

**LOCALIZED HIGH-RISK DISEASE:**
**THE MULTIMODALITY APPROACH IS CRITICAL**

Over the last 10–15 yr, the clinical presentation of prostate cancer has changed significantly in the United States, with most men now presenting with clinically localized disease (T1, T2) (6). Despite this change, it has been found that 40–50% of men undergoing curative-intent prostatectomy will actually have disease beyond the prostate gland and be at high risk for treatment failure (7). It has also been found that among men with a normal digital rectal examination and a prostate-specific antigen (PSA) elevation (T1c), 30–50% will be found to have extraprostatic extension (7). Although prostatectomy is considered curative in most men with disease confined to the prostate, there is clearly a need for additional approaches in men identified as high risk for recurrence.

Methods to identify patients at increased risk for spread of the cancer outside the prostate have been developed by several investigators, allowing estimates for risk of