Survivorship – Prostate Cancer

Disclaimers: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care.

ELIGIBILITY
Prostate cancer ≥ 2 years from completion of treatment\(^1\) and NED

CONCURRENT COMPONENTS OF VISIT

Category 1\(^2\) and 2\(^3\)

Years 2-5:
- History and physical exam annually
- PSA and consider testosterone level\(^4\) every 6 months
- DRE\(^5\)

Years 6 and up:
- History and physical exam annually
- PSA and consider testosterone level\(^4\) annually
- DRE\(^5\)

Years 2-5:
- History and physical exam annually
- PSA and consider testosterone level\(^4\) every 4 months
- DRE annually

Years 6 and up:
- History and physical exam annually
- PSA and consider testosterone level\(^4\) annually
- DRE annually

SURVEILLANCE

Category 3\(^6\)

MONITORING FOR LATE EFFECTS

RISK REDUCTION/EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

See Page 2

DRE = digital rectal exam
NED = no evidence of disease
PSA = prostate specific antigen

\(^1\) PSA < 0.1 ng/mL for status post prostatectomy and < 1 ng/mL for status post radiation therapy

\(^2\) Category 1: status-post radical prostatectomy or radiation therapy; pathologic stage pT2, N0, M0, negative margins, or clinical stage cT2, N0, M0; Gleason score ≤ 7 and PSA < 0.1 ng/mL or < 1 ng/mL if treated with radiation therapy

\(^3\) Category 2: status-post prostatectomy or status-post prostatectomy plus radiation therapy; pathologic stage pT2, N0, M0, positive margins; Gleason score ≤ 7 and PSA < 0.1 ng/mL

\(^4\) As clinically indicated for patients with reported symptoms, failed to recover, borderline values or per provider’s discretion. Can discontinue after 2 consecutive normal levels.

\(^5\) As clinically indicated if PSA is undetectable

\(^6\) Category 3: status-post prostatectomy or status-post prostatectomy plus radiation therapy or status-post radiation therapy; pathologic staging pT3, N0, M0; clinical stage, cT3, N0, M0; Gleason score 8-10 and PSA < 0.1 ng/mL or < 1 ng/mL if treated with radiation therapy only

\(^7\) GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

Department of Clinical Effectiveness V8
Approved by The Executive Committee of the Medical Staff on 05/21/2024
Survivorship – Prostate Cancer

Disclaimer: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care.

ELIGIBILITY

CONCURRENT COMPONENTS OF VISIT

- Patient education, counseling, and screening:
  - Lifestyle risk assessment
  - Cancer screening
  - Vaccinations as appropriate
  - Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management and Hepatitis C Virus (HCV) Screening algorithms)
  - Cardiovascular risk reduction
  - Genetic counseling if family history of prostate or pancreas cancer or family history consistent with Lynch syndrome

- Urinary incontinence
- Erectile dysfunction
- Bowel dysfunction
- Bone health screening as clinically indicated

MONITORING FOR LATE EFFECTS

RISK REDUCTION/EARLY DETECTION

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Body image
- Financial stressors
- Social support

PSYCHOSOCIAL FUNCTIONING

DISPOSITION

Prostate cancer ≥ 2 years from completion of treatment and NED

Refer or consult as indicated

1 PSA < 0.1 ng/mL for status post prostatectomy and < 1 ng/mL for status post radiation therapy
2 See Physical Activity, Nutrition, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
3 Includes colorectal, liver, lung, pancreatic, and skin cancer screening
4 Based on Centers for Disease Control and Prevention (CDC) guidelines
5 Consider use of Vanderbilt’s ABCDE’s approach to cardiovascular health
SUGGESTED READINGS


MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy. Advance Care Planning (ACP) Conversation Workflow (ATT1925)


Continued on next page
SUGGESTED READINGS - continued


DEVELOPMENT CREDITS

This survivorship algorithm is based on minority expert opinion of the Genitourinary Survivorship workgroup at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

**Core Development Team Leads**

Curtis Pettaway, MD (Urology)

**Workgroup Members**

John W. Davis, MD (Urology)
Olga N. Fleckenstein, BS*
Katherine Gilmore, BA, MPH (Cancer Survivorship)
Rincy Joby, MSN FNP-C, AGACNP BC (Genitourinary Medical Oncology)
Deborah A. Kuban, MD (Radiation Oncology)
Christopher J. Logothetis, MD (Genitourinary Medical Oncology)
Johnny L. Rollins, MSN, APRN, ANP-C (Survivorship)
Hannah Warr, MSN, RN, CPHON*

*Clinical Effectiveness Development Team