Month 85 — Learning about Salvage Radiation Therapy

December 11, 2017 By Daniel Zeller

Now that I'm officially halfway to the widely accepted 0.2 ng/ml definition of biochemical recurrence, it's time to dig deeper into the most likely next step for me: Salvage Radiation Therapy (SRT).

I've already done considerable research on reputable websites and through reading studies or books, but the one area that I would like more information about is from those who have actually gone through SRT after a prostatectomy. Having those firsthand insights can be invaluable.

If you have had a radical prostatectomy and subsequent salvage radiation therapy because your PSA was on the rise just as mine is, please take a few minutes to answer my questions about your experience in my Salvage Radiation Therapy Questionnaire.

It's only 9 questions long and should take just a few minutes to complete. I'll be truly grateful for your input.

If I'm being perfectly honest, I have real reservations and concerns about starting SRT. Like most everything else in dealing with prostate cancer, it seems to be yet another crap shoot with questionable outcomes at potentially significant cost to quality of life.

Based on my research, SRT doesn't seem to have all that high of a success rate, with 30%–50% of patients being progression-free at 5 or 6 years after receiving SRT. That means that 50%–70% of the patients have the cancer remain and, as an added bonus, those patients now have increased incontinence and erectile dysfunction issues, as well as potential bowel control issues.

Before we start zapping my body with radiation, I want to know with a high degree of certainty that we're zapping the actual location of the cancer. That poses two problems.

First, studies show that the earlier you start SRT, the higher the success rate. In fact, I would not be surprised to find a few survey respondents who have started SRT at a PSA level lower than my 0.10 ng/ml. The assumption is that any remaining cancer will be in the prostate bed or pelvic region, and that's where they focus the radiation. But how do you know that it hasn't spread beyond the pelvis at those PSA levels? You don't. (That 30%-50% success rate tells me it isn't the best assumption to be making.)

That brings us to the second problem. Current imaging techniques won't locate the cancer until the PSA is at much higher levels. Even a choline-PET scan won't consistently detect tumors until PSA reaches 2.0 ng/ml (it may be able to detect down to 1.0 ng/ml, but the number of false readings goes up considerably).

Do I risk all those nasty lifelong side effects on the assumption that the cancer is still in the prostate bed, or do I wait until imaging technology can accurately detect the cancer's location?

I'll have a thorough discussion with my doctor next week when we review my latest PSA results, so it will be interesting to get that input. I'll keep you posted.

Thanks again if you've taken time to complete my questionnaire.

This blog post originally appeared on Dan's Journey through Prostate Cancer. It is reprinted with permission.
