DR. CHARLES METZGER'S SATURDAY EVENING NEWSLETTER
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AUA 2025: State-of-the-Art Lecture: Focal Therapy in Prostate Cancer: Prime Time or Not Time?
Professor Samir Taneja, M.D. New York University Langone Health Center
Presentation to the 2025 American Urological Association (AUA) annual meeting held in Las Vegas, NV, Saturday, April 26 - Tuesday, April 29, 2025
https://www.urotoday.com/conference-highlights/aua-2025/aua-2025-prostate-cancer/159970-aua-2025-state-of-the-art-lecture-focal-therapy-in-prostate-cancer-prime-time-or-not-time.html?utm_source=newsletter_14198&utm_medium=email&utm_campaign=uroalerts-prostate-cancer-weekly

Good Saturday evening.

Professor Samir Taneja, M.D of New York University's Langone Health Center's Urology, Oncology and Radiology Departments. (https://nyulangone.org/doctors/1386638187/samir-taneja) presented on several issues concerning focal therapies in the United States at the American Urology Association Conference. At issue was who was right for focal treatments, how does the medical community define a successful outcome and balancing treatments and their effect on ending or at least limiting cancer's growth against side effects and overtreatment. Patent issues such as not-so-active surveillance allowing controllable disease to flourish and patient anxiety about either or both prostate cancer and treatment downsides open the curtain to more tolerable yet effective therapies.

Go ahead and download my newsletter and click the link to the **UroToday** article. It's semi-patient friendly but it is dense. I'll summarize it here.

WHO'S A CANDIDATE FOR A FOCAL TYPE THERAPY?
Those seeking an alternative to active surveillance to remove low risk cancers. Men with favorable disease will not die from it and are prone to more treatment risk than benefit. Intermediate and high-risk patients who will benefit from local intervention. Ideally, Intermediate patents would fare the best since they qualify for salvage therapies (radiation, surgery) if focal fails. And, they have a lower risk of mortality and longer lead time for advanced disease. Patients whose MRI's line up with actual biopsies (the absence of MRI silent cancers) are better candidates for focal treatment. Anterior tumors are easier and safer to treat. Tumors in the posterior area should be smaller and away from the distal apex to minimize negative effects.

WHO SHOULD AVOID FOCAL THERAPIES?
Men with locally advanced disease in the seminal vesicle and or gross extracapsular extension even if the cancer has not left the gland. Patents with cancer in many different places in the gland that is also clinically significant since the size of the area to be treated must be balanced against the side of the prostate overall.

Young men expecting long term cure may be disappointed by results as current data does not address long term outcomes.

High risk disease is a gamble since there may be disease beyond the gland and a greater chance of recurrence in the prostate. These patients are better suited for surgery, radiation or perhaps a "kitchen sink" approach.

WHAT IS A SUCCESSFUL OUTCOME?
While focal treatments collectively have a good safety record and better overall than radiation or surgery, how do we compare it's success against traditional treatments? Should the benchmark be…

Metastasis Free Survival	No disease beyond the gland.
Cancer-Specific Survival	The patient dies of something, even another cancer but not prostate cancer. There are implications for the risk of treatment here, too.
Disease (Recurrence) Free Survival	No detectable prostate cancer anywhere. As close to "cure" as you get with cancer.
Progression Free Survival	There may be significant cancer someplace but it's not growing.
Significant Cancer Free Survival	Only low risk cancer in the gland detected.
Re-Treatment Free Survival	Patient does not need more treatment. So, if there is disease it's not significant.

How would you assess a focal therapy study? Dr. Taneja explained a focal trial using an energy source we've not discussed at Prostate Forum; bipolar radio frequency ablation.

Without saying how many subjects completed the study, the statistics are encouraging no matter what the criteria.

First treatment only:
- Disease free survival 38%
- Clinically Significant Cancer Free Survival 57%
- When including men who needed more than one treatment the numbers look better
- Disease free survival 57%

Clinically significant cancer free survival 71%
Freedom from secondary treatment (radiation, ADT's) 52%
Freedom from radical therapy 81%
Metastasis free survival, cancer specific survival and overall survival were all100%

The Professor cites other studies in the above **UroToday** article. All statistics are encouraging no matter how you define success. Remember, focal therapy to date has been used on low risk and some intermediate risk cancers so that alone would tilt the numbers.

THE NEED FOR MORE ACCURATE DETECTION AND DEFINING FOCAL THERAPY'S GOALS

One of the most interesting questions is why only treat lesions shown on ultrasound when treating the whole gland would potentially eliminate silent cancer cells. Examination of prostates removed from patients and compared to the MRI's showed that only 86% of solitary lesions and 77% of index lesions were detected. Looking at non-index tumors, 14% were equal to or greater than 7mm with 18 each missed by MRI and 5% of those were Gleason 4+3 or higher. Missed tumors were smaller than those seen with MRI and their relationship to the index lesions was unclear. But many of the patients with more widespread or higher risk disease would not qualify for focal therapy anyway. Patients who suffered biochemical recurrence and Mets had more MRI detectable tumors. Not really a vote of no confidence for MRI and almost an argument for radiation with ADT or surgery. Since medicine cannot detect all cancer in the gland, the state of the art still favors "shotgun" approaches.

Dr. Taneja advice to surgeons…

> MRI is still a reliable guide especially with low and intermediate risk cancer. And improvements are in the works with artificial intelligence assisted reading and more sensitive portable ultrasound.
>
> Focal treatment's goal is not cure but management. Retreatment is acceptable and doable so keep that on the table for your patients.
>
> There are no long-term comparable outcomes nor consensus of what successful treatment is.
>
> Select your patients carefully and continue to follow up with them.
>
> Most metastatic progression comes from a clonal source in the prostate. Eliminate that and the surgeon has largely solved the problem.

I think the doctor is on track. There are many diseases where the patient dies with the illness instead of from it and that's acceptable for now.

SO, IS FOCAL ABLATION READY FOR PRIME TIME? YES, IF…

The patient has a skilled, experienced, meticulous surgeon and meticulous treatment planning. Ira likes to say, “you need an artist”.

The patient is a good match for focal treatment

There’s rigorous follow up and early salvage of recurrence.

PARTING THOUGHTS

No wonder UCLA and others are dragging their feet while making their own treatment plan given the newness and complexity of focal therapy. It makes sense to me to treat with focal therapy anyone on AS with any small amount of 4+3, or 3+4 and then put them back on AS.

I have sent a request for a presentation to Prostate Forum to Dr. Taneja.

Prostate Forum looks forward to seeing you at our 2nd and 4th Tuesday evening Support and Information Groups.
Please bookmark these zoom links so you can join us easily:

2nd Tuesday at 5:00 p.m. Pacific Time: https://us02web.zoom.us/j/86164783897

4th Tuesday at 5:00 p.m. Pacific Time: https://us02web.zoom.us/j/85450819246

See you at our meetings and presentations.

Warmly,

CKM