Tailoring Prostate Cancer Care in Men With Limited Longevity

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> Managing prostate cancer in older men or those with significant comorbidities presents a clinical dilemma: how to balance the potential benefits of aggressive treatment against the risks of overtreatment and diminished quality of life. The immediate takeaway is that treatment decisions must be highly individualised, prioritising patient longevity and symptom burden over disease eradication in many cases.

KEY TAKEAWAYS

- The Pivot: Individualised care based on life expectancy and comorbidity is paramount for prostate cancer.
- The Data: Active surveillance or watchful waiting may be appropriate for men with a life expectancy of less than 10 years.
- The Action: Clinicians should integrate geriatric assessments and shared decision-making into prostate cancer management for this population.

Prostate cancer is a common malignancy in older men. While many prostate cancers are indolent, the disease can be aggressive. Treatment options range from active surveillance to radical prostatectomy, radiation therapy, and systemic therapies. The selection of an appropriate treatment strategy is complex, particularly for men with limited longevity, where the potential for treatment-related morbidity may outweigh the benefits of cancer control. The goal of care in this population often shifts from curative intent to symptom management and preservation of quality of life.

Individualised Treatment Approaches

For men with prostate cancer and a life expectancy estimated at less than 10 years, the risks associated with definitive treatments such as radical prostatectomy or external beam radiation therapy may exceed the potential survival benefit. These treatments carry risks of urinary incontinence, erectile dysfunction, and bowel toxicity, which can significantly impair quality of life. In such cases, active surveillance or watchful waiting may be more appropriate. Active surveillance involves regular monitoring of prostate-specific antigen (PSA) levels, digital rectal examinations (DRE), and repeat biopsies, with intervention initiated only upon evidence of disease progression. Watchful waiting, conversely, involves monitoring for symptoms and initiating palliative treatment if symptoms develop, without the intent to cure the cancer. The choice between these strategies depends on the patient's specific clinical characteristics, including Gleason score, PSA level, and clinical stage, as well as their personal preferences and overall health status.

For men with intermediate or high-risk localised prostate cancer who have a limited life expectancy but are symptomatic or at high risk of symptomatic progression, less intensive treatments may be considered. These can include short-course radiation therapy, brachytherapy, or androgen deprivation therapy (ADT). ADT, while effective in controlling prostate

cancer growth, is associated with side effects such as hot flashes, fatigue, decreased libido, and bone demineralisation, which can further impact quality of life in an already vulnerable population. The duration and intensity of ADT should be carefully considered, with intermittent ADT being an option to mitigate some of these side effects.

Shared decision-making is a critical component of tailoring prostate cancer care in men with limited longevity. This process involves a thorough discussion between the clinician and the patient, incorporating the patient's values, preferences, and understanding of the potential benefits and harms of each treatment option. A comprehensive geriatric assessment can provide valuable information regarding a patient's functional status, comorbidities, cognitive function, and social support, which are all important factors in determining the most appropriate management strategy. This assessment helps to identify patients who may be particularly susceptible to treatment-related toxicities or who may not live long enough to experience the benefits of long-term cancer control.

The management of metastatic prostate cancer in men with limited longevity also requires a nuanced approach. While systemic therapies such as novel hormonal agents (e.g., abiraterone, enzalutamide) and chemotherapy (e.g., docetaxel, cabazitaxel) can prolong survival, they also carry significant side effect profiles. The decision to initiate or continue these therapies should be based on the patient's performance status, symptom burden, and overall goals of care. Palliative care integration early in the disease course can help manage symptoms, improve quality of life, and align treatment with patient preferences.

The estimation of life expectancy is a complex clinical judgment, often relying on validated prognostic tools and the clinician's experience. Factors such as age, presence of significant comorbidities (e.g., cardiovascular disease, chronic obstructive pulmonary disease, diabetes, renal insufficiency), functional status (e.g., Eastern Cooperative Oncology Group performance status), and nutritional status contribute to this assessment. For instance, a man with multiple severe comorbidities and a poor performance status is less likely to benefit from aggressive, long-term treatments compared to a man of similar age with fewer health issues. The potential for treatment-related complications, such as surgical risks in radical prostatectomy or cumulative toxicity from prolonged radiation or systemic therapies, must be carefully weighed against the anticipated survival benefit, which may not be realised within a limited lifespan.

Furthermore, the psychological and social impact of prostate cancer and its treatments on older men with limited longevity warrants consideration. The burden of frequent medical appointments, diagnostic procedures, and managing treatment side effects can significantly diminish an individual's quality of life and independence. Therefore, treatment plans should aim to minimise these burdens while effectively addressing cancer-related symptoms. The involvement of caregivers and family members in the shared decision-making process is often crucial, as they can provide insights into the patient's daily functioning and preferences, and offer support in managing the disease and its treatment.

> **CLINICAL IMPLICATIONS**
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> The persistent inclination to treat prostate cancer aggressively, even in men unlikely to benefit from long-term disease control, remains a significant concern in clinical practice. Guidelines from bodies like the National Comprehensive Cancer Network (NCCN) and the European Association of Urology (EAU) increasingly emphasise individualised risk assessment, yet the practical application often lags. The drive for 'cure' can overshadow the immediate impact on a patient's remaining years, leading to unnecessary morbidity from interventions like radical prostatectomy or prolonged androgen deprivation therapy in men with multiple

comorbidities and a life expectancy of less than a decade.

For clinicians, this means a more rigorous commitment to shared decision-making, moving beyond simply presenting options to truly understanding patient priorities. Integrating geriatric assessments into routine oncology practice for older men with prostate cancer is not merely good practice, it is essential. This allows for a more realistic appraisal of a patient's physiological age versus chronological age, identifying those who will genuinely benefit from definitive treatment versus those for whom active surveillance or watchful waiting offers a superior quality of life outcome. The industry, particularly pharmaceutical companies developing novel systemic therapies, must also acknowledge that not every patient benefits from extended survival at the cost of significant toxicity; the focus should broaden to include quality of life metrics in their trial designs for this specific population.

Patients, often influenced by societal narratives of 'fighting cancer,' may also need careful counselling to understand that less aggressive treatment can sometimes be the most compassionate and effective path. The perception that 'doing nothing' is a failure must be challenged. Ultimately, the goal is to ensure that the treatment burden does not outweigh the disease burden, particularly when the patient's remaining time is finite. This requires a shift in mindset across the entire healthcare ecosystem, from guideline developers to prescribing clinicians and patient advocacy groups, to prioritise patient-centred outcomes over oncological metrics alone in this vulnerable population.

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