Re: Results of a randomized trial of treatment modalities in patients with low or early-intermediate risk prostate cancer (PREFERE trial)

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Abstract

The authors of this “Letter to the Editors” express their major concern about selective and biased reporting in this paper.

Abbreviations

PSI	Permanent seed implantation
RP	Radical prostatectomy
EBRT	External beam radiation therapy
AS	Active surveillance
CTCAE	Common terminology criteria for adverse events

Sir,

It is with concern that we read this publication.

In the abstract, the authors conclude on “an increased toxicity related to (PSI)”, neglecting the results as “treatment-related acute grade 3 toxicity was reported in 3 RP patients and 2 PSI patients”. Selectively emphasizing side effects of one treatment whilst neglecting even higher toxicity in another does not mirror scientific neutrality.

Wiegel, T., Albers, P., Bartkowiak, D. et al. Results of a randomized trial of treatment modalities in patients with low or early-intermediate risk prostate cancer (PREFERE trial). *J Cancer Res Clin Oncol* (2020). <https://doi.org/10.1007/s00432-020-03327-2>.

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The results show that most patients accepted AS as a treatment strategy (84%). However, of all radical therapy options, PSI was the most accepted one (PSI 65%; RP 49%; EBRT 44%).

Furthermore, the lowest switch-over from one randomized radical therapy to another therapy was in PSI (change of randomized therapy from PSI 11%, EBRT 19%, and RP 19%). These data emphasize the relatively high acceptance of patients to PSI, but unfortunately remains uncommented by the authors.

CTCAE acute toxicity (< 12 months) grade 3 occurred in five patients, three in RP, and two in PSI, respectively. Figure 3a shows a higher percentage of overall toxicity (grades 1–3), a higher percentage of grade 3 toxicity, and a higher percentage of grade 2 toxicity in EBRT as compared to PSI.

CTCAE late toxicity (at 12 months) grade 3 occurred in 28 patients, 15 in RP, 9 in PSI, and 4 in EBRT, respectively. Figure 3b of the original article shows a higher percentage of overall toxicity (grades 1–3), a higher percentage of grade 3 toxicity, a higher percentage of grade 2 toxicity, and a higher percentage of grade 1 toxicity in EBRT as compared to PSI. Neglecting their own data, the authors state that “Interestingly, the preliminary data suggest an increased risk of toxicity after PSI compared with EBRT.” This statement

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is heavily biased toward EBRT and not supported by the facts.

The authors state that the study review revealed more quality-assurance issues in PSI than in RP and EBRT. This statement is not proven by any data given in the results. Furthermore, the authors neglect that in PSI, other than in EBRT and RP, a post-therapy quality control within 8 weeks is possible by so-called post-planning calculation. Notwithstanding the fact that post-planning documentation was missing/incomplete in 19%, an existing post-procedural quality-assurance in PSI cannot be compared to no post-procedural quality assurance at all, as in RP and EBRT.

Finally, with no data whatsoever reported on oncological outcomes, the authors state without proof that “oncological outcomes after PSI are unlikely to become superior to EBRT at the current state.” Again, we feel this statement is not supported by any facts and heavily biased toward EBRT.

Sincerely,

Andreas Boehle.

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Thomas Oliver Henkel.

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Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. For this type of study, formal consent was not required.

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