Surveillance for Stage I Seminoma: Part I

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By Bruce Roth, MD [1]

Dr. Bruce Roth discusses the large Danish study reported at ASCO (abstract 4502) that showed surveillance alone is sufficient after orchiectomy for stage I seminoma.

Dr. Bruce Roth, Professor of Oncology in the Division of Medicine at Siteman Cancer Center, Washington University at St. Louis, spoke with CancerNetwork at the 2013 ASCO meeting about topics in seminoma. Here he discusses the impact on clinical practice of the large Danish study by Mortenson et al (ASCO abstract 4502), which showed surveillance alone is sufficient after orchiectomy for men with stage I seminoma and identified several adverse prognostic factors.

Cancer Network: So, back to this large Danish study reported at ASCO this year, by Dr. Mette Sakso Mortensen and colleagues, it’s abstract 4502. They found 99.6% of patients with stage I seminoma followed by surveillance alone after surgery were alive after 10 years. How much of an impact do you think this finding will have on patient management and reducing the use of RT following orchiectomy in these patients?

Dr. Roth: There’s certainly a cadre of us who have already committed to surveillance as a primary strategy, and have for several years. There are a number of us from around the world who’ve decided that [surveillance is] the most appropriate approach—the best way to minimize unnecessary therapy for the largest number of individuals with no compromise in the cure rate. What this [the Mortenson study] represents is the largest single study [in this setting], and represents a nation-wide result based on various different follow-up strategies, and various pathologists, and all of that that has an impact on outcome. And still, only 6 patients out of 1,822 died of seminoma. So, I think it’s really very difficult to advocate for active therapy in a clinical stage I seminoma patient with [the current study] results like this.

Cancer Network: Dr. Mortenson and colleagues also found some factors that smaller studies of higher-risk [seminoma] patients had shown were predictive of a higher risk of relapse, and these were tumor size larger than 1.5 inches, spread to blood or lymphatic vessels, and elevated blood levels of HCG [> 200 IU/L]. What impact will these findings have on patient management?

Dr. Roth: The issue regarding HCG is interesting, because a number of us believe, particularly on this side of the Atlantic, that HCGs of 200 [IU/L] may, in fact, indicate the presence of non-seminomatous components, and it may well be that, in the Danish study, the reason that the relapse rate was 19.5%, as opposed to the standard 15% that we’re used to seeing, is that there were non-seminoma patients included, and those patients have about a 30% relapse rate from clinical stage I disease—so that may account for the higher relapse rate.

The presence or absence of lymphovascular invasion I think is a very helpful marker [to be used by] trained pathologists who see large numbers of slides of testicular cancer patients. So, there’s no doubt, in a center of excellence, high-volume testis cancer center, that that’s a reliable, predictive marker in terms of relapse. The question is, with only 7,200 cases a year in the United States, what will happen for the patient who goes to a physician who sees [only] 1 case a year—meaning the [institution’s] pathologists see 1 case a year, meaning their radiologists see 1 case per year in terms of follow-up. So, I think the translatableity of that particular marker remains to be seen, in the community at large.

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