WITH THE AGING OF renal transplant recipients, oncology may become one of the new aspects of transplantation due to few data controversies exist concerning the management of prostate cancer in the male renal transplant recipients.\(^1\)\(^{-4}\) The objectives of our study were to evaluate the incidence, diagnosis, and therapeutic modalities of prostate cancer in this population. For this survey, a questionnaire was mailed to 22 French renal transplant centers, members of the Renal Transplantation Committee of the French Urological Association. The questionnaire concerned modalities of evaluation of the prostate after transplantation and incidence of prostate cancer after renal transplantation.

Thirteen of 22 centers responded to the questionnaire. Prostatic evaluation was rarely or never done after transplantation in 60% of the centers. In 1998, among 1680 male renal transplant recipients being followed in these 22 centers, 14 prostatic biopsies had been performed and 11 (annual incidence: 0.6%) prostatic cancers diagnosed. In contrast at the 13 centers, which were following 2338 male renal transplant recipients, 28 (prevalence: 1%) prostatic cancers had diagnosed after transplantation. One center that performed routine PSA testing had seven cases.\(^4\) The mean ages at transplantation versus diagnosis were 58 ± 11006 6 years and 64 ± 11006 5 years. The mean time between transplantation and diagnosis was 58 ± 41 months. The diagnosis was obtained by systematic digital rectal examination (DRE) in two cases and by systematic serum PSA determinations in 18 cases. DRE was normal in 15 cases. Mean serum PSA at diagnosis was 40 ± 78 ng/mL. The clinical stages were: T1, 50%; T2, 25%; T3, 20%; N1, 4%; and M1, 8%. The mean Gleason score was 6 ± 1 and 36% of recipients had a Gleason score >6. The treatment was a radical prostatectomy in 11 (perineal: n = 4; retropubic: n = 7; no or unilateral pelvic lymphadenectomy (n = 10), curative radiotherapy (mean: 60 Gy) in six, hormonal deprivation in seven and watchful-waiting in four. Immunosuppression was unchanged in 11 cases. The mean follow-up was 18 ± 12 months. Two of 24 recipients died of cancer at 5 (T3bM1 Gleason score 7-hormonal deprivation) and 12 months (T4aN1 Gleason score 9-hormonal deprivation). Twenty-two of 28 recipients were alive. Sixteen of 28 were alive without evidence of disease (16/23 T1–2; 5/10, score >6) at 19 ± 11 months follow-up. Fifteen of 17 recipients who had a curative treatment and 15 of 17 recipients who had a T1–T2 cancer were alive with no disease at 19 and 15 months mean follow-up. Five of 10 recipients with >6 Gleason score cancer were alive with no disease at 21 months mean follow-up.

In conclusion, the incidence of prostate cancer among renal transplant recipient is underestimated. At diagnosis, the rate of poorly differentiated tumors seems higher in this group than in the general prostate cancer population. The treatment is similar to that in the general population. Immunosuppression may be reduced for patients bearing poorly differentiated tumors. A prospective screening study is needed to evaluate the incidence, the aggressiveness, and the optimal treatment modalities for prostate cancer in the renal transplant population.

REFERENCES


From the Renal Transplantation Committee of the French Urological Association, Paris, France.

Address reprint requests to Eric Lechevallier, Urologie—Hôpital Salvator, 249, Bd Sainte Marguerite, 13274 Marseille, France. e-mail: elechevallier@mail.ap-hm.fr