Leitlinienprogramm Onkologie

Leitlinienreport

der S3 Leitlinie „Interdisziplinäre Leitlinie der Qualität S3 zur Früherkennung, Diagnose und Therapie der verschiedenen Stadien des Prostatakarzinoms“

AWMF-Register-Nummer (034-022OL)

Version 2.2, Konsultationsfassung der 2. Aktualisierung 2014

Leitlinienreport

Bitte senden Sie Kommentare, Hinweise und Verbesserungsvorschläge zu dieser Leitlinie unter Verwendung des Kommentierungsbogens bis zum 29.05.2014 an info@azq.de oder per Post an:

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DKG Krebsgesellschaft · Deutsche Krebshilfe Helfen. Forschen. Informieren. · AWMF

Inhaltsverzeichnis

1. Informationen zu dieser Leitlinie

1.1. Autoren des Leitlinienreports

Ersterstellung: Christoph Röllig, Christina Niederstadt, Monika Lelgemann, Achim Wöckel, Monika Nothacker, Marga Cox, Susanne Weinbrenner, Günter Ollenschläger

1. Aktualisierung: Monika Nothacker, Thomas Langer, Susanne Weinbrenner, Günter Ollenschläger

2. Aktualisierung: Susanne Schorr, Carmen Khan

Ärztliches Zentrum für Qualität in der Medizin (ÄZQ), Gemeinsame Einrichtung von Bundesärztekammer und Kassenärztlicher Bundesvereinigung

1.2. Herausgeber

Leitlinienprogramm Onkologie der Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften e.V. (AWMF), Deutschen Krebsgesellschaft e.V. (DKG) und Deutschen Krebshilfe e.V. (DKH).

1.3. Federführende Fachgesellschaft

Deutsche Gesellschaft für Urologie e. V. (DGU)

1.4. Finanzierung der Leitlinie

Diese Leitlinie wurde von der Deutschen Krebshilfe im Rahmen des Leitlinienprogramms Onkologie gefördert.

1.5. Kontakt

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1.6. Zitierweise des Leitlinienreports

Leitlinienprogramm Onkologie (Deutsche Krebsgesellschaft, Deutsche Krebshilfe, AWMF): Konsultationsfassung : Interdisziplinäre Leitlinie der Qualität S3 zur Früherkennung, Diagnose und Therapie der verschiedenen Stadien des Prostatakarzinoms, Leitlinienreport 2.2, [2014] AWMF Registernummer: 034/022OL,

http://leitlinienprogramm-onkologie.de/Leitlinien.7.0.html (Zugriff am: TT.MM.JJJJ)

1.7. Weitere Dokumente zur Leitlinie

Die Lang- und Kurzversion der S3-Leitlinie zur “Früherkennung, Diagnose und Therapie der verschiedenen Stadien des Prostatakarzinoms“, ist über die folgenden Seiten zugänglich

- http://www.leitlinienprogramm-onkologie.de/OL/leitlinien.html
- http://www.awmf.org/leitlinien/aktuelle-leitlinien.html
- http://www.krebsgesellschaft.de/wub_llevidenzbasiert,120884.html
- http://www.krebshilfe.de/
- http://www.arztbibliothek.de

sowie auf den Seiten der beteiligten Fachgesellschaften.

Neben Lang- und Kurzversion gibt es folgende ergänzende Dokumente zur Leitlinie:

- Leitlinienreport zur Leitlinie (vorliegendes Dokument)
- Dokument mit Evidenztabellen zur Leitlinie
- Patientenleitlinie "Früherkennung von Prostatakrebs"
- Patientenleitlinie: “Prostatakrebs 1 - Lokal begrenztes Prostatakarzinom“
- Patientenleitlinie "Prostatakrebs 2 - Lokal fortgeschrittenes und metastasiertes Prostatakarzinom"
- Übersetzung (geplant)

1.8. Verwendete Abkürzungen

Abkürzung	Erläuterung
AS	Active Surveillance (Aktive Überwachung)
AUA	American Urological Association
AWMF	Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften
ÄZQ	Ärztliches Zentrum für Qualität in der Medizin
BT	Brachytherapie
BPS	Bundesverband Prostatakrebs Selbsthilfe
CT	Computertomographie
DGU	Deutsche Gesellschaft für Urologie
DNA	Deoxyribonucleic acid, Desoxyribonukleinsäure
DRU	Digital-Rektale Untersuchung
EAU	European Association of Urology
EBRT	External Beam Radiotherapy = Perkutane Strahlentherapie
ECOG	Eastern Cooperative Oncology Group
fPSA	freies Prostata-spezifisches-Antigen
GS	Gleason-Score
GIN	Guideline International Network
Gy	Kurzbezeichnung für die Maßeinheit der Energiedosis
HDR	High-Dose-Rate
HIFU	Hochintensive Fokussierte Ultraschall
HT	Hormontherapie
HTA	Health Technology Assessment
Kryo	Kryotherapie
LDR	Low-Dose-Rate
LoE	Level of Evidence
MRT	Magnetresonanztomographie
NICE	National Institute of Clinical Excellence
OL	Onkologisches Leitlinienprogramm
PCa	Prostatakarzinom
PCA3	Prostate Cancer Gene 3
PET/CT	Positronen-Emissions-Tomographie/Computertomographie

Abkürzung	Erläuterung
PSA	Prostata-spezifisches-Antigen
PSADT	PSA-Doubling-Time
QOL	Quality Of Life
RCT	Randomized Controlled Trial
RPE	Radikale Prostatektomie
RT	Strahlentherapie, Radiotherapie
SIGN	Scottish Intercollegiate Guidelines Network
TED	Tele-Dialog
TRUS	Transrektale Ultraschalluntersuchung
TURP	Transurethrale Resektion der Prostata
WW	Watchful Waiting
Z. n.	Zustand nach

2. Geltungsbereich und Zweck

2.1. Adressaten

Die interdisziplinäre Leitlinie der Qualität S3 zur Früherkennung, Diagnose und Therapie der verschiedenen Stadien des Prostatakarzinoms richtet sich an alle Betroffenen und alle Berufsgruppen, die mit der Prävention und Früherkennung von Prostatakarzinom befasst sind sowie alle Berufsgruppen, die Patienten mit Verdacht auf bzw. mit nachgewiesenem Prostatakarzinom jeglichen Stadiums behandeln, sowie deren Angehörige betreuen. Weitere Adressaten dieser Leitlinie sind übergeordnete Organisationen (z. B. Krankenkassen und Einrichtungen der ärztlichen Selbstverwaltung) und die interessierte Fachöffentlichkeit.

2.2. Zielsetzung

Die interdisziplinäre Leitlinie der Qualität S3 zur Früherkennung, Diagnose und Therapie der verschiedenen Stadien des Prostatakarzinoms ist ein evidenz- und konsensbasiertes Instrument, um Früherkennung, Diagnostik und Therapie des Prostatakarzinoms zu verbessern.

Männer und Ärzte sollen durch die Leitlinie bei der Entscheidung über Früherkennungsmaßnahmen unterstützt werden. Die Leitlinie soll dazu beitragen, eine angemessene Gesundheitsversorgung bei der Früherkennung sicherzustellen.

Es ist weiterhin die Aufgabe der Leitlinie, dem Patienten (mit Verdacht auf Prostatakarzinom oder nachgewiesenem Prostatakarzinom) angemessene, wissenschaftlich begründete und aktuelle Verfahren in der Diagnostik, Therapie und Rehabilitation anzubieten. Dies gilt sowohl für die lokal begrenzte oder lokal fortgeschrittene Erkrankung als auch bei Vorliegen eines Rezidivs oder von Fernmetastasen.

Die Leitlinie soll neben dem Beitrag für eine angemessene Gesundheitsversorgung auch die Basis für eine individuell zugeschnittene, qualitativ hochwertige Therapie bieten. Mittel- und langfristig sollen so die Morbidität und Mortalität von Patienten mit Prostatakarzinom gesenkt und die Lebensqualität erhöht werden.

3. Zusammensetzung der Leitliniengruppe

3.1. Autoren-Steuergruppe der Leitlinie

Manfred Wirth (Vorsitzender), Lothar Weißbach (stellvertretender Vorsitzender), Rolf Ackermann (bis 2009), Winfried Alberti (bis 2009), Clemens Albrecht (bis 2009), Bernt Göckel-Beining, Michael Fröhner, Wolfgang Hinkelbein (bis 2013), Kurt Miller, Herbert Rübben, Michael Stöckle (seit Aktualisierung 2011), Frederik Wenz (seit Aktualisierung 2011), Thomas Wiegel, Johannes Wolff, Bernhard Wörmann

3.2. Beteiligte Autoren und Mitglieder der Leitliniengruppe

Die bei der Erstellung der Leitlinie 2009 beteiligten Personen die bei der 1. Aktualisierung 2011 sowie die bei der 2. Aktualisierung 2013/2014 beteiligten Personen können Tabelle 1 entnommen werden.

Tabelle 1: Mitglieder der Leitliniengruppe 2006-2014

Name	Organisation	Zeitraum
Ackermann, Prof. Dr. med. Rolf	DGU	2006-2009
Alberti, Prof. Dr. med. Winfried	DEGRO	2006-2009
Albrecht, Dr. med. Clemens	DEGRO/ BDVST	2006-2014
Beyersdorff, PD Dr. med. Dirk	DRG	2006-2009
Blana, PD Dr. med Andreas	DGU	2011-2014
Böhmer, PD Dr. med. Dirk	DEGRO	2006-2014
Börgermann, Dr. med. Christof	DGU	2006-2014
Borchers, Dr. med. Holger	DGU	2006-2009
Burchardt, Prof. Dr. med. Martin	DGU	2006-2014
Deger, Prof. Dr. med. Serdar	DGU	2006-2009
Doehn, Prof. Dr. med. Christian	DGU	2006-2014
Donner-Banzhoff, Prof. Dr. Norbert	DEGAM	2013-2014
Ebermayer, Dr. med. Johann	DGU	2006-2009
Ebert, Prof. Dr. med. Thomas	DGU	2006-2009
Egidi, Dr. med. Günther	DEGAM	2013-2014
Enders, Dipl. Ing. Paul	BPS	2006-2014
Fichtner, Prof. Dr. med. Jan	DGU	2006-2009
Fiebrandt, Hanns-Jörg	BPS	2006-2014
Fornara, Univ.-Prof. Dr. med. Paolo	DGU	2006-2014
Fröhner, PD Dr. med. Michael	DGU	2006-2014
Galalae, PD Dr. med. Razvan-Mircea	DEGRO	2006-2009
Ganswindt, Dr. med. Ute	DEGRO	2013-2014
Göckel-Beining, Dr. med. Bernt	BDU	2006-2014
Goldner, Dr. med. Gregor	DGU	2006-2009
Graefen, Prof. Dr. med. Markus	DGU	2006-2014
Grimm, Prof. Dr. med. habil. Marc-Oliver	DGU	2006-2014
Grün, Dr. med. Arne	DEGRO	2006-2009

Name	Organisation	Zeitraum
Hampel, PD Dr. med. Christian	DGU	2006–2009
Hakenberg, Prof. Dr. med. Oliver	DGU	2006–2014
Hammerer, Prof. Dr. med. Peter	DGU	2006–2009
Hartmann, Prof. Dr. med. Arndt	DGP/BDP	2013–2014
Hautmann, Prof. Dr. med. Richard	DGU	2006–2009
Heidenreich, Prof. Dr. med. Axel	DGU	2006–2014
Henkel, Dr. med. Thomas-Oliver	DGU	2006–2014
Hinkelbein, Prof. Dr. med. Wolfgang	DEGRO	2006–2014
Höcht, Prof. Dr. med. Stefan	DEGRO	2006–2014
Hölscher, Dr. med. Tobias	DEGRO	2006–2014
Hoffmann, Prof. Dr. med. Wolfgang	BVDST	2013–2014
Jakse, Prof. Dr. med. Gerhard	DGU	2006–2009
Jocham, Prof. Dr. med. Dieter	DGU	2006–2009
Jünemann, Prof. Dr. med. Klaus-Peter	DGU	2006–2009
Kahl, Dr. med. Philip	DGP	2006–2009
Kaufmann, Dr. med. Sascha	DGU	2006–2009
Klein, Tobias	KOK	2013–2014
Kotzerke, Prof. Dr. med. habil. Jörg	DGN	2013–2014
Krause, Prof. Dr. med. Bernd	DGN	2011–2014
Kristiansen, Prof. Dr. med. Glen	DGP/BDP	2013–2014
Küfer, PD Dr. med. Rainer	DGU	2006–2009
Lein, Prof. Dr. med. Michael	DGU	2011–2014
Loch, Prof. Dr. med. Tillmann	DGU	2013–2014
Loertzer, Prof. Dr. med. Hagen	DGU	2006–2014
Luboldt, PD Dr. med. Hans-Joachim	DGU	2006–2014
Lümmen, Prof. Dr. med. Gerd	DGU	2006–2014
Machtens, Dr. med. Stefan	DGU	2006–2014
Martin, Dr. med. Thomas	DEGRO	2006–2014
Miller, Prof. Dr. med. Kurt	DGU	2006–2014
Moser, Dr. med. Lutz	DEGRO	2006–2014
Mueller-Lisse, Prof. Dr. med. Ullrich G.	DRG	2006–2014
Otto, Prof. Dr. med. Ullrich	DGU	2006–2014
Palmedo, Prof. Dr. med. Holger	DGN	2006–2014
Pummer, Univ.-Prof. Dr. med. Karl	DGU	2006–2014
Rohde, Dr. med. Volker	DGU	2006–2014
Roth, Prof. Dr. med. Wilfried	DGP/BDP	2013–2014
Rübben, Prof. Dr. med. Dr. h.c. Herbert	DGU	2006–2014
Schmitz-Dräger, Prof. Dr. med. Bernd Jürgen	DGU	2006–2014
Schostak, Prof. Dr. med. Martin	DGU	2006–2014
Schrader, Prof. Dr. med. Mark	DGU	2006–2014
Schulz, Prof. Dr. rer. nat. Wolfgang Arthur	DGU	2006–2009
Sedlmayer, Prim. Univ.-Prof. Dr. Felix	DEGRO	2006–2014
Semjonow, Prof. Dr. med. Axel	DGU	2006–2014
Steuber, PD Dr. Thomas	DGU	2006–2009, 2013–2014

Name	Organisation	Zeitraum
Stöckle, Prof. Dr. med. Michael	DGU	2011–2014
Tedsen, Dr. med. Sönke	DGU	2006–2009
Thomas, Dr. med. Christian	DGU	2006–2009
Thüroff, Prof. Dr. med. Joachim W.	DGU	2006–2009
Vögeli, Prof. Dr. med. Thomas-Alexander	DGU	2011–2014
Volkmer, Dr. med. Jens-Peter	DGU	2006–2009
Wagner, Dr. med. Sigrid	DGU	2009–2014
Walden, Dr. med. Oliver	DGU	2006–2009
Wedding, PD Dr. med. Ulrich	DGG	2013–2014
Weißbach, Prof. Dr. med. Lothar	DGU	2006–2014
Wenz, Prof. Dr. med. Frederik	DEGRO	2006–2014
Wernert, Prof. Dr. med. Nicolas*	DGP	2006–2014
Wetterauer, Prof. Dr. med. Ulrich	DGU	2006–2009
Wiedemann, PD Dr. med. Andreas	DGG	2013–2014
Wiegel, Prof. Dr. med. Thomas	DEGRO	2006–2014
Wirth, Prof. Dr. med. Dr. h.c. Manfred P.	DGU	2006–2014
Wörmann, Prof. Dr. Bernhardt	DGHO	2006–2014
Wolff, Prof. Dr. med. Johannes M.	DGU	2006–2014
Zacharias, Dipl. Ing. Jens-Peter	BPS	2006–2014
Zastrow, Dr. med. Stefan	DGU	2013–2014
Zips, Prof. Dr. med. Daniel	DEGRO	2013–2014

Abkürzungen: BDP = Bundesverband Deutscher Pathologen e.V., BDU = Berufsverband der Deutschen Urologen, BPS = Bundesverband Prostatakrebs Selbsthilfe , BVDST = Berufsverband Deutscher Strahlentherapeuten, DEGAM = Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin, DEGRO = Deutsche Gesellschaft für Radioonkologie, DGG = Deutsche Gesellschaft für Geriatrie, DGHO = Deutsche Gesellschaft für Hämatologie und Onkologie, DGN = Deutsche Gesellschaft für Nuklearmedizin, DGP = Deutsche Gesellschaft für Pathologie, DGU = Deutsche Gesellschaft für Urologie, DRG = Deutsche Röntgengesellschaft, KOK = Konferenz Onkologischer Kranken- und Kinderkrankenpflege.
* Bei der 2. Aktualisierung 2014 als Beratendes Mitglied der Leitliniengruppe

Für die 2. Aktualisierung 2014 waren folgende Experten als Vertreter für die Konsensuskonferenz benannt: Grün, Dr. med. Arne (DEGRO), Hinkelbein, Prof. Dr. med. Wolfgang (DEGRO), Carl, Ernst-Günther (BPS), Dietz, Josef (BPS).

3.3. Fachgesellschaften

Deutsche Gesellschaft für Urologie (DGU), Berufsverband der Deutschen Urologen (BDU), Berufsverband Deutscher Strahlentherapeuten (BVDST), Deutsche Gesellschaft für Radioonkologie (DEGRO), Deutsche Gesellschaft für Hämatologie und Onkologie (DGHO), Deutsche Gesellschaft für Pathologie (DGP), Bundesverband Deutscher Pathologen e.V. (BDP), Deutsche Gesellschaft für Nuklearmedizin (DGN), Deutsche Röntgengesellschaft (DRG), Bundesverband Prostatakrebs Selbsthilfe (BPS), Deutsche Krebsgesellschaft (DKG), Deutsche Gesellschaft für Geriatrie (DGG), Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin (DEGAM), Konferenz Onkologischer Kranken- und Kinderkrankenpflege (KOK)

3.4. Andere Institutionen

Redaktion, Koordination, Moderation und Gestaltung

Ärztliches Zentrum für Qualität in der Medizin ÄZQ, Gemeinsame Einrichtung von Bundesärztekammer und Kassenärztlicher Bundesvereinigung.

- Ersterstellung (Christoph Röllig, Christina Niederstadt, Monika Lelgemann, Achim Wöckel, Monika Nothacker, Marga Cox, Susanne Weinbrenner, Günter Ollenschläger)
- 1. Aktualisierung (Monika Nothacker, Thomas Langer, Susanne Weinbrenner, Günter Ollenschläger)
- 2. Aktualisierung (Susanne Schorr, Carmen Khan)

Methodische Begleitung

1. Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften, AWMF (Ina Kopp, Monika Nothacker (nur 2.Aktualisierung))
2. Leitlinienprogramm Onkologie, OL (Markus Follmann, Thomas Langer (nur 2. Aktualisierung))

Beteiligte externe Experten:

Ersterstellung (2006–2009, Version 1.0):

- Behre, Prof. Dr. med. Hermann M.; Kapitel 2.2.2. Testosteronsubstitution
- Koller, Prof. Dr. med. Michael; Kapitel 8.1.2. Psychosoziale Unterstützung

1. Aktualisierung (2011, Version 2.0):

- Dubben, PD Dr. rer. nat Hans-Herrmann.; Kapitel 3.1. PSA und DRU in Früherkennung/Screening

2. Aktualisierung (2014, Version 3.0):

- Böcking, Prof. Dr. med. Alfred; Kapitel 4.3 Pathomorphologische Untersuchungen
- Seitz, Prof. Dr. med. Gerhard; Kapitel 4.3 Pathomorphologische Untersuchungen

3.5. Patientenbeteiligung

An der Erstellung der Leitlinien waren Vertreter der Patientenorganisation ‚Bundesverband Prostatakrebs Selbsthilfe e.V. (BPS)' direkt beteiligt. Vertreter des BPS (siehe Tabelle 1) waren an den Arbeitsgruppen beteiligt und bei den Konsensuskonferenzen stimmberechtigt.

4. Fragestellungen und Gliederung

Die Grundstruktur der Leitlinie basiert auf der Einteilung in Hauptkomplexe, die mit den folgenden Kapiteln der vorliegenden Leitlinie korrespondieren:

Kapitel 2: Epidemiologie, Risikofaktoren, Prävention und Ernährung

Kapitel 3: Früherkennung, Screening und Biopsie

Kapitel 4: Diagnostik und Stadieneinteilung

Kapitel 5: Therapie des nichtmetastasierten Prostatakarzinoms

Kapitel 6: Diagnostik und Therapie des rezidivierten oder metastasierten Prostatakarzinoms

Kapitel 7: Rehabilitation und Nachsorge

Kapitel 8: Psychosoziale Aspekte und Lebensqualität

Zur Bearbeitung der verschiedenen Aspekte dieser Hauptkomplexe formulierte das Leitliniengremium zu Beginn des Erstellungsprozesses der Leitlinie Schlüsselfragen. Die aufgestellten Schlüsselfragen wurden in einem formalisierten Konsensusverfahren durch die gesamte Leitliniengruppe gebilligt. An den konsentierten Schlüsselfragen orientierte sich die Literaturrecherche und spätere Formulierung von Empfehlungen und Statements. Die Schlüsselfragen sind in Kapitel 14.1aufgelistet. Bei der 1. Aktualisierung 2011 erfolgte eine Priorisierung der zu bearbeitenden Themen bzw. Kapitel durch die Steuergruppe. Hierbei wurden neue Schlüsselfragen ergänzt (siehe Kapitel 5.1.2). Bei der 2. Aktualisierung 2014 erfolgte eine Priorisierung der zu bearbeitenden Themen bzw. Kapitel durch die Steuergruppe. Hierbei wurden neue Schlüsselfragen ergänzt (siehe Kapitel 5.1.3).

5. Methodik

5.1. Evidenzbasierung

5.1.1. Erstellung der Leitlinie 2006-2009

Die Evidenzbasis für die S3-Leitlinie wurde durch die folgenden systematischen Recherchen vom ÄZQ festgelegt:

5.1.1.1. Berücksichtigung evidenzbasierter Leitlinien

Die Suche nach Leitlinien erfolgte im August 2006 über die Datenbank des Guidelines International Network (G-I-N), den Guideline Finder des britischen National Health Service sowie die Pubmed-Suchoberfläche der National Library of Medicine. Leitlinien in anderen Sprachen als deutsch oder englisch wurden nur im Falle Frankreichs und der Niederlande zugelassen, da hier eine orientierende Lektüre möglich war und teilweise auch englische Übersetzungen oder Zusammenfassungen vorhanden sind. Der Recherchezeitraum wurde primär für Publikationen ab 2002 festgelegt. Eine Aktualisierung der Recherche erfolgte im Juni 2008. Die EAU-Leitlinie 2009 wurde zusätzlich berücksichtigt.

Zusätzlich wurden gezielt die Webseiten folgender Organisationen gesichtet:

- Frankreich (ANAES);
- Niederlande (NEDERLANDS HUISARTSEN GENOOTSCHAP);
- England (NICE);
- Irland (Royal College of Surgeons in Ireland (RCSI);
- Europa (EAU – European Association of Urology);
- USA (NCCN – National Comprehensive Cancer Network);
- Kanada (Cancer Care Ontario);
- Australien (National Health and Medical Research Council);
- Neuseeland (New Zealand Guidelines Group).

Leitlinien wurden berücksichtigt, wenn sie die folgenden Kriterien einer evidenzbasierten Leitlinie erfüllten:

- Systematische Recherche nach Primär- bzw. Sekundärliteratur
- Bei der Mehrheit der Empfehlungen sind die zugrunde liegende Primär- / Sekundärliteratur hinterlegt.
- Bei der Mehrheit der Empfehlungen ist eine Evidenz- und / oder Empfehlungseinstufung (Level of Evidence [LoE] und / oder Grade of Recommendation [GoR]) angegeben.

Eine Ausnahme hinsichtlich der methodischen Mindestanforderungen wurde wegen ih-

rer internationalen Bedeutung für die EAU-Leitlinie gemacht.

Folgende Leitlinien wurden in der Folge als Quellleitlinien herangezogen:

- "Guideline for the Management of Clinically Localized Prostate Cancer: 2007 Update" (2007) der AUA (American Urological Association) [1];
- Clinical practice guidelines: evidence based information and recommendations for the management of localized prostate cancer (2002) der Australian National Networking Party on Management of localised prostate cancer [2];
- "Guidelines on Prostate Cancer" (2007+2009) der EAU (European Urological Association) [3; 4];
- "Prostate Cancer. Nationwide-Guideline" (2007) der DUA (Dutch Urological Association) [5];
- "Prostate Cancer. Diagnosis and Treatment" (2008) des NICE (National Institut of Clinical Excellence) [6].

Die Schlüsselempfehlungen der genannten Leitlinien wurden extrahiert und sind Bestandteil der Evidenztabellen zu dieser Leitlinie.

5.1.1.2. Systematische Recherche nach aggregierter Evidenz (Übersichtsarbeiten, Metaanalysen und Health Technology Asssessment (HTA)- Berichte)

Die systematische Recherche erfolgte in:

- den Datenbanken der Cochrane Library;
- Pubmed (unter Verwendung eines Suchfilters für systematisch recherchierte aggregierte Evidenz).
- Vorliegende systematische Übersichtarbeiten/Metaanalysen/HTA-Berichte wurden in den Evidenztabellen gesondert ausgewiesen und den extrahierten Einzelpublikationen vorangestellt.

5.1.1.3. Systematische Recherche nach Einzelpublikationen (bevorzugt RCT's)

Aufbauend auf den Ergebnissen der identifizierten aggregierten Evidenzquellen wurden systematische, themenbezogene Recherchen nach Einzelstudien in folgenden Datenbanken durchgeführt:

- Pubmed (inklusive Daten der ehem. Cancerlit-Datenbank und "In-process-Citations"); Sprache Deutsch oder Englisch, Erscheinungsjahr ab 2002 bzw. bei Themen ohne gute aufbereitete Evidenz auch ab 2000. Wichtige, in aufbereiteter Evidenz zitierte Studien wurden zusätzlich dann im Original eingesehen, wenn sie nach 1990 publiziert worden waren und dies für die Bewertung der aufbereiteten Quelle (Leitlinie, Review, HTA) hilfreich oder notwendig war.
- Cochrane Clinical Trials Database (thematische Suche nach "Prostatakarzinom"; keine Einschränkungen während der Recherche) und manuelle Sichtung und Zuordnung zu einzelnen Themenblöcken.

Das Ergebnis der Literatursuche wurde zentral beim ÄZQ erfasst und in eine Online-Datenbank eingespeist. Die Ergebnislisten wurden an die Fachexperten verschickt und

per Internet zugänglich gemacht. Von den Methodikerinnen und Methodikern des ÄZQ wurde ggf. unter Einbeziehung der Fachexperten methodisch hochwertige Literatur identifiziert, die vom ÄZQ nach EbM-Kriterien bewertet und den Experten als Grundlage für die Formulierung von Empfehlungen zur Verfügung gestellt wurde. Die spezifischen Suchstrategien erfolgten themenbezogen und wurden zusammen mit dem Recherchezeitraum den Evidenztabellen zu den einzelnen Themen vorangestellt. Die Trefferzahl vor Titel/Abstract Sichtung ist angegeben oder kann auf Anfrage beim ÄZQ eingesehen werden.

Themenübergreifend wurden die folgenden Suchfilter eingesetzt:

a) Methodische Filter

Strategie zur Identifikation systematischer Reviews und Metanalysen:

((Prostat*[ti] AND ((Prostate Cancer[mh] OR prostatic neoplasms[majr]) AND (cancer*[tiab] OR neoplas*[tiab] OR growth[tiab] OR malign*[tiab] OR tumor[tiab] OR tumour[tiab] OR carcino*[tiab] OR adenocarcino*[tiab]))) NOT benign*[ti] NOT prostatitis[ti])

AND ("review"[pt] OR "review"[ti] OR "review academic" OR "systematic review" OR "Meta-Analysis"[mh] OR "Meta-Analysis"[pt] OR "meta analysis" OR metaanaly*))

OR systematic[sb]

Strategie zur Identifikation randomisiert kontrollierter Studien:

(Prostat*[ti] AND ((Prostate Cancer[mh] OR prostatic neoplasms[majr]) AND (cancer*[tiab] OR neoplas*[tiab] OR growth[tiab] OR malign*[tiab] OR tumor[tiab] OR tumour[tiab] OR carcino*[tiab] OR adenocarcino*[tiab]))) NOT benign*[ti] NOT prostatitis[ti])

AND ((clinical[tiab] AND trial[tiab]) OR ("clinical trials"[mh] OR random*[tiab] OR "random allocation"[mh] OR quantitativ*[tiab] OR quality[tiab] OR qualitativ*[tiab] OR systematic*[tiab] OR stringent[tiab] OR strict[tiab] OR rigorous[tiab] OR controlled[tiab] OR placebo[ti] OR (double[ti] AND blind*[ti])))

b) Übergreifende Suchstrategie zur Identifizierung des Prostatakarzinoms

Die Suchstrategie zu den Themenbereichen und Schlüsselthemen wurde modular aufgestellt. Die Strategien enthielten einen Themenblock „Prostatakarzinom“ (PCa), weitere Strategiemodule wurden je nach Fragestellung kombiniert. Die Ergebnisqualität wurde nach jedem Suchprozess durch Vergleich mit Literaturlisten aus Schlüsselpublikationen sowie durch Bildung von Differenzmengen mit und ohne Anwendung der Filter für die Studienqualität geprüft. Bei nicht ausreichend sensitiver Suche wurden die benutzten Filter für die Studienqualität entfernt und die Suchen erneut durchgeführt.

Strategie-Block „Modul zur Identifikation von Publikationen zum Thema Prostatakarzinom“:

(Prostat*[ti] AND ((Prostate Cancer[mh] OR prostatic neoplasms[majr]) AND (cancer*[tiab] OR neoplas*[tiab] OR growth[tiab] OR malign*[tiab] OR tumor[tiab] OR tumour[tiab] OR carcino*[tiab] OR adenocarcino*[tiab]))) NOT benign*[ti]

NOT prostatitis[ti]

Das Modul wurde bezüglich des gesuchten Stadiums des Prostatakarzinoms angepasst oder, falls nicht erforderlich, in der vorliegenden, übergreifenden Form verwendet.

5.1.1.4. Auswahl und Bewertung der Evidenz

Die vollständigen Ergebnisse der systematischen Recherchen wurden den Experten als Listen mit bibliographischen Angaben und Abstrakts online über eine Internetplattform zur Verfügung gestellt.

Zielgruppe

Für die Themen Risikofaktoren, Prävention und Ernährung sowie Früherkennung war die Zielgruppe auf Männer beschränkt. Abhängig von den weiteren Schlüsselfragen war die Zielgruppe Männer, die an einem lokal begrenzten, lokal fortgeschrittenen, rezidivierten oder metastasierten Prostatakarzinom leiden.

Eingeschlossene Studientypen

Zur Beantwortung der Fragestellung Nutzen und Schaden der einzelnen Verfahren sind grundsätzlich randomisierte kontrollierte Studien mit den Endpunkten Morbidität, Mortalität und Lebensqualität geeignet. Nur in solchen Studien kann gezeigt werden, ob ein relevanter klinischer Nutzen erreicht werden kann oder wie die Effektivität eines Verfahrens im Vergleich zu anderen zu beurteilen ist. Deshalb erfolgte im ersten Schritt grundsätzlich eine Suche nach randomisiert kontrollierten Studien oder Quellen aggregierter Evidenz (HTA-Berichte, systematische Reviews und Metaanalysen) in denen entsprechende randomisierte prospektive Studien selektiert und gewichtet vorliegen. Wenn orientierende Vorrecherchen ergaben, dass bei den einzelnen diagnostischen oder therapeutischen Verfahren keine oder nur wenige randomisiert kontrollierte Studien zu der fokussierten Fragestellung vorlagen, wurde im nächsten Schritt nach prospektiven Kohortenstudien gesucht. Auch retrospektive Kohortenstudien wurden in die Auswertung bei schwacher oder Fehlen von prospektiver Evidenz miteinbezogen. Im Weiteren wurden auch Fallserien eingeschlossen, vorzugsweise bei Anwendung einer klinisch und methodische sinnvollen Stratifizierung und multivariaten Analyse.

Die in den Recherchen identifizierte Literatur wurde durch die Methodikerinnen und Methodiker des ÄZQ einem Titel- und Abstraktscreening unterzogen. Die ausgewählten Abstrakts wurden im Volltext bestellt und nach erneuter Sichtung und Kommentierung durch Mitarbeiter des ÄZQ ggf. unter inhaltlicher Beteiligung der Fachexperten eingeschlossen, wenn die Volltexte als relevant und methodisch geeignet bewertet wurden. .Die eingeschlossenen Studien wurden in Evidenztabellen extrahiert. Die formal methodische Bewertung der Evidenz erfolgte nach den Kriterien des Scottish Intercollegiate Guidelines Network (SIGN) (siehe Tabelle 2).

Tabelle 2: Schema der Evidenzgraduierung des Scottish Intercollegiate Guidelines Network (SIGN)

Grad	Beschreibung Evidenzgraduierung 2006-2011	Beschreibung Evidenzgraduierung 2013-2014
1++	Qualitativ hochwertige Metaanalysen, systematische Übersichten von RCTs, oder RCTs mit sehr geringem Risiko systematischer Fehler (Bias)	
1+	Gut durchgeführte Metaanalysen, Systematische Übersichten von RCTs, oder RCTs mit geringem Risiko systematischer Fehler (Bias)	Gut durchgeführte Metaanalysen, Systematische Übersichten, oder RCTs mit geringem Risiko systematischer Fehler (Bias)
1-	Metaanalysen, Systematische Übersichten von RCTs, oder RCTs mit hohem Risiko systematischer Fehler (Bias)	Metaanalysen, Systematische Übersichten, oder RCTs mit hohem Risiko systematischer Fehler (Bias)
2++	Qualitativ hochwertige systematische Übersichten von Fall-Kontroll- oder Kohortenstudien oder Qualitativ hochwertige Fall-Kontroll- oder Kohortenstudien mit sehr niedrigem Risiko systematischer Verzerrungen (Confounding, Bias, „Chance“) und hoher Wahrscheinlichkeit, dass die Beziehung ursächlich ist	
2+	Gut durchgeführte Fall-Kontroll-Studien oder Kohortenstudien mit niedrigem Risiko systematischer Verzerrungen (Confounding, Bias, „Chance“) und moderater Wahrscheinlichkeit, dass die Beziehung ursächlich ist	
2-	Fall-Kontroll-Studien oder Kohortenstudien mit einem hohen Risiko systematischer Verzerrungen (Confounding, Bias, „Chance“) und signifikantem Risiko, dass die Beziehung nicht ursächlich ist	
3	Nicht-analytische Studien, z. B. Fallberichte, Fallserien	
4	Expertenmeinung	

Anmerkung: Ein Evidenzlevel 2+ -3 wurde auch vergeben bei Fallserien, bei denen multivariate Analysen vorlagen.

Die eingeschlossenen Studien wurden als Evidenzgrundlage für die Empfehlungen mit den Experten der Arbeitsgruppen besprochen. In einer folgenden Gegenprüfung wurden die Aussagen der Arbeitsgruppen mit den Inhalten der Studien und der gesamten Evidenzlage von den Methodikerinnen und Methodikern (ÄZQ) abgeglichen und Optimierungsvorschläge für die Konsensuskonferenz erarbeitet. Die Evidenztabellen mit den extrahierten Angaben der berücksichtigten Studien sind in einem gesonderten Dokument veröffentlicht worden (z. B. unter www.leitlinienprogramm-onkologie.de oder www.awmf-online.de.

5.1.1.5. Erstellung von Kapiteln für die keine systematische Literaturrecherche nach Primärliteratur erfolgte

Aus Gründen einer effizienten Ressourcenallokation wurden folgende Kapitel auf Basis von Leitlinien, Konsensuspapieren und ergänzenden Literaturangaben der jeweiligen

Autoren erstellt:

4.2 Pathomorphologische Diagnostik;

5.1 Therapieplanung und Aufklärung;

6.1 Definition und Diagnostik des Tumorrezidivs;

6.7 Supportiv- und Palliativtherapie;

7.2.1 Nachsorge nach lokaler, kurativ intendierter Therapie;

7.2.3 Follow-up unter Hormontherapie.

5.1.2. Erstellung der ersten modularen Aktualisierung 2011

5.1.2.1. Themen der Aktualisierung

Die erste Aktualisierung der Leitlinie erfolgte modular, d.h. es wurden nicht alle Kapitel der Leitlinie im ersten Schritt überarbeitet. Das Gesamtkonzept für die Aktualisierung der Prostatakarzinomleitlinie ist das einer „living guideline“ mit einer geplanten modularen Überarbeitung in etwa jährlichen Abständen. Der für die erste Überarbeitung identifizierte Aktualisierungsbedarf bestand zum einen aus Themen, die bei der Erststellung der Leitlinie nicht bearbeitet werden konnten und dort bereits benannt wurden, sowie aus Themen, die während der öffentlichen Konsultationsphase eingebracht wurden. Zum anderen wurden Themen berücksichtigt, die sich aus einer Befragung der Autorengruppen und der Patientenvertreter ergaben. Die Steuergruppe nahm eine Priorisierung von 18 Einzelrecherchen aus einer Liste von insgesamt 24 Themen vor. Es erfolgten 11 Aktualisierungsrecherchen und 5 Recherchen zu neuen Themen, die im Folgenden genannt sind. 2 Themen (neue Marker und DNA-Zytometrie) konnten aus Kapazitätsgründen nicht bearbeitet werden.

Aktualisierungsrecherchen:

- Nutzen und Schaden der Früherkennung/des Screening
- MRT und TRUS zu Primärdiagnostik und Staging
- Stellenwert des Active Surveillance
- Radikale Prostatektomie bei Operation bei Patienten mit hohem Risikoprofil bzw. lokal fortgeschrittenem Prostatakarzinom
- LDR-Brachytherapie bei Patienten mit mittleren/hohem Risikoprofil
- Perkutane Strahlentherapie bei Patienten mit hohem Risikoprofil bzw. lokal fortgeschrittenem Prostatakarzinom
- Perkutanen Strahlentherapie mit Dosiseskalation beim lokal begrenzten Prostatakarzinom
- HIFU zur Primär- und Rezidivtherapie
- Prävention und Behandlung von Knochenmetastasen
- Therapie des androgenunabhängigen oder kastrationsresistenten Prostatakar-

zinoms

Recherchen zu Themen, die erstmalig in der Leitlinie bearbeitet wurden:

- Elastographie und Histoscanning zu Primärdiagnostik und Staging
- PET/CT zu Primärdiagnostik und Staging
- Kombination der LDR-Brachytherapie mit perkutaner Strahlentherapie bzw. mit adjuvanter hormonablativer Therapie
- Nutzen der Protonentherapie

5.1.2.2. Berücksichtigung evidenzbasierter Leitlinien

Auf eine erneute systematische Leitlinienrecherche wurde nach Rücksprache mit den Mitgliedern der Steuergruppe verzichtet, da keine wesentlichen neuen evidenzbasierten Leitlinien zu erwarten waren. Es wurde beschlossen, die aktuellen Versionen der bisherigen Quell-Leitlinien zu nutzen. Ergänzend zu den Literaturrecherchen wurden dementsprechend die Empfehlungen der Leitlinien der European Association of Urology (EAU) von 2011 [7; 8], des National Institute of Clinical Excellence (NICE) von 2008 [6] und der 2009 revidierten Leitlinie der American Urological Association (AUA) [1] extrahiert und berücksichtigt. Eine erneute methodische Bewertung der Leitlinien wurde nicht vorgenommen. Die EAU-Leitlinie wurde nicht aufgrund ihrer Methodik, sondern aufgrund ihrer internationalen Bedeutung berücksichtigt.

5.1.2.3. Systematische Recherche nach aggregierter Evidenz und Einzelstudien

Zu allen Fragestellungen erfolgte eine spezifische systematische Literaturrecherche in den Datenbanken Medline (Pubmed) und den Datenbanken der Cochrane Library. Für erstmals bearbeitete Fragestellungen erfolgte die Recherche ab dem Jahr 2000. Für alle aktualisierten Fragestellungen wurde ab dem Datum der letzten Recherche der 1.Auflage gesucht. Es wurden außerdem Studien berücksichtigt, die in Referenzlisten bekannter Studien oder durch Hinweise aus der Leitliniengruppe identifiziert wurden.

5.1.2.4. Auswahl und Bewertung der Evidenz

Die Auswahl der Studien zu den einzelnen Fragestellungen erfolgte durch Methodikerinnen und Methodiker (Monika Nothacker, Thomas Langer) des ÄZQ nach vorab definierten Ein- und Ausschlusskriterien. Die eingeschlossenen Studien wurden in Evidenztabellen extrahiert und nach dem Evidenzklassen-System des Scottish Intercollegiate Guidelines Network (SIGN) (siehe Tabelle 2) bewertet.

Eine formale methodische Bewertung der berücksichtigten Leitlinien wurde nicht durchgeführt, da eine Adaptation bereits bestehender Leitlinienempfehlungen nicht vorgesehen war.

Die spezifischen Fragestellungen, Ein- und Ausschlusskriterien sowie die Recherchestrategien und Trefferangaben und die ein- und ausgeschlossenen Publikationen können dem Kapitel 0 entnommen werden. Die Evidenztabellen mit den extrahierten Angaben der berücksichtigten Studien sind in einem gesonderten Dokument veröffentlicht worden (z. B. unter www.leitlinienprogramm-onkologie.de oder www.awmf-online.de)

5.1.3. Erstellung der zweiten modularen Aktualisierung 2014

5.1.3.1. Themen der Aktualisierung

Die zweite Aktualisierung der Leitlinie erfolgte modular. Angesichts des Aufwands einer Aktualisierung erschien eine 2-jährliche Aktualisierung an Stelle der ursprünglich jährlich geplanten Aktualisierung als eine praktikable Vorgehensweise. Überarbeitet wurden die Themen, die bei von der Steuergruppe priorisiert wurden. Die Steuergruppe nahm eine Priorisierung von 10 Einzelrecherchen vor. Es erfolgten 8 Aktualisierungsrecherchen und 2 Recherchen zu neuen Themen, die im Folgenden genannt sind. Ein Thema (intermittierende Hormontherapie) konnte aus Kapazitätsgründen nicht bearbeitet werden.

Aktualisierungsrecherchen:

- Früherkennung hinsichtlich risikoadaptierter Zeitabstände, Altersbeginn der Früherkennung
- Stellenwert des PET/CT bzw. PET/MRT beim PSA-Rezidiv nach radikaler Prostatektomie bzw. Strahlentherapie
- Stellenwert der DNA-Zytometrie
- Stellenwert immunhistochemischer Zusatzuntersuchungen
- Behandlung des Low-Risk-Karzinom
- Systemtherapie des kastrationsresistenten Prostatakarzinoms
- Behandlung ossärer Metastasen

Recherchen zu Themen, die erstmalig in der Leitlinie bearbeitet wurden:

- Stellenwert von Komorbiditätsklassifikationen als Unterstützung bei der Therapieentscheidung beim frühen Prostatakarzinom
- Geriatrisches Assessment vor Chemotherapie

5.1.3.2. Berücksichtigung evidenzbasierter Leitlinien

Auf eine erneute systematische Leitlinienrecherche wurde verzichtet, da keine wesentlichen neuen evidenzbasierten Leitlinien zu erwarten waren. Es wurde stattdessen systematisch nach (fokusierten oder modularen) Updates der bisher verwendeten Quell-Leitlinien gesucht (Stand 19.06.2013):

- Guideline for the Management of Clinically Localized Prostate Cancer: 2009 Hrsg: American Urological Association (AUA) –Reviewed and validity confirmed 2011[1]

  Die Leitlinie ist unverändert gültig, es wurden zwei ausgegliederte Module, die Inhalte der Schlüsselfragen behandeln, identifiziert:

  - Carter HB, Albertsen PC, Barry MJ, Etzioni R, Freedland SJ, Greene KL, Holmberg L, Kantoff P, Konety BR, Murad MH, Penson DF, Zietman AL. Early Detection of Prostate Cancer: AUA Guideline. Journal of Urology 2013; [1]

- Cookson MS, Roth BJ, Dahm P, Engstrom C, Freedland SJ, Hussain M, Lin DW, Lowrance WT, Murad MH, Oh WK, Penson DF, Kibel AS. Castration-Resistant Prostate Cancer: AUA Guideline. Journal of Urology 2013; [9]

- Clinical practice guidelines: evidence based information and recommendations for the management of localized prostate cancer (2002) Hrsg: Australian National Networking Party on Management of localized prostate cancer [2]

  Die Leitlinie wurde im Jahr 2013 außer Kraft gesetzt, es wurden keine (fokusierte oder modulare) Updates identifiziert.

- Guidelines on Prostate Cancer (2013) Hrsg: European Urological Association (EAU) [10]

  Die Leitlinie wurde mehrfach (jährlich) fokusiert aktualisiert unter anderem auch zu Schlüsselfragen der 2. Aktualisierung.

- Prostate Cancer. Nationwide-Guideline (2007) Hrsg: Dutch Urological Association (DUA) [5]

  Die Leitlinie ist unverändert gültig und wird momentan überarbeitet.

- Prostate Cancer. Diagnosis and Treatment (2008) Hrsg: National Institute for Health and Care Excellence (NICE).[6]

  Die Leitlinie ist weiterhin gültig und wird momentan überarbeitet. Sie wurde im Januar 2014 publiziert.

Die Schlüsselempfehlungen von aktualisierten Quellleitlinien wurden extrahiert und sind Bestandteil der Evidenztabellen zu dieser Leitlinie.

Zusätzlich wurden per Handsuche nach Referenzleitlinien zu spezifischen Schlüsselfragen gesucht.

5.1.3.3. Systematische Recherche nach aggregierter Evidenz und Einzelstudien

Zu allen Fragestellungen erfolgte eine spezifische systematische Literaturrecherche in den Datenbanken Medline (Pubmed) und den Datenbanken der Cochrane Library. Für erstmals bearbeitete Fragestellungen erfolgte die Recherche ab dem Jahr 2003. Für alle aktualisierten Fragestellungen wurde ab dem Datum der letzten Recherche gesucht. Es wurden außerdem Studien berücksichtigt, die in Referenzlisten bekannter Studien oder durch Hinweise aus der Leitliniengruppe identifiziert wurden.

5.1.3.4. Auswahl und Bewertung der Evidenz

Die Auswahl der Studien zu den einzelnen Fragestellungen erfolgte durch Methodikerinnen (Susanne Schorr, Carmen Khan, Corinna Schäfer) des ÄZQ nach vorab definierten Ein- und Ausschlusskriterien. Die eingeschlossenen Studien wurden in Evidenztabellen extrahiert und nach dem Evidenzklassen-System des Scottish Intercollegiate Guidelines Network (SIGN) bewertet. Dabei kam die im April 2013 von SIGN modifizierte Version zur Anwendung (siehe Tabelle 2)

Eine formale komplette methodische Bewertung der Quellleitlinien wurde nicht durchgeführt, da eine Adaptation bereits bestehender Leitlinienempfehlungen nicht vorgesehen war. Die Quellleitlinien wurden genauso wie weitere über die Literaturrecherche

identifizierte Leitlinien jedoch bezüglich methodischer Exaktheit und Umgang mit Interessenkonflikten kritisch bewertet. Die EAU-Leitlinie wurde nicht aufgrund ihrer Methodik, sondern aufgrund ihrer internationalen Bedeutung berücksichtigt. Weitere per Handsuche identifizierte mögliche Referenzleitlinien wurden mit DELBI bewertet.

Die spezifischen Fragestellungen, Ein- und Ausschlusskriterien sowie die Recherchestrategien und Trefferangaben und die ein- und ausgeschlossenen Publikationen können dem Kapitel 14.4 entnommen werden. Die Evidenztabellen mit den extrahierten Angaben der berücksichtigten Studien und Leitlinien sind in einem gesonderten Dokument veröffentlicht worden (z. B. unter www.leitlinienprogramm-onkologie.de oder www.awmf-online.de)

5.2. Formulierung der Empfehlung und formale Konsensusfindung

In der Leitlinie sind die wesentlichsten Aussagen in gesonderten Kästen unter Angaben der zugrundeliegenden Evidenz, der jeweiligen Evidenzklasse, des Empfehlungsgrades und der Konsensstärke sowie des Erstellungs- bzw. Aktualisierungsdatums dargestellt. Die Kernaussagen sind entweder als handlungsleitende Empfehlungen oder Statements formuliert. Als Statements werden Darlegungen oder Erläuterungen von spezifischen Sachverhalten oder Fragestellungen ohne unmittelbare Handlungsaufforderung bezeichnet.

Die Verabschiedung von Empfehlungen und Statements sowie die Festlegung der Empfehlungsgrade erfolgten bei der Erstellung der Leitlinie und bei den Aktualisierungen vorwiegend im Rahmen von Konsensuskonferenzen unter Verwendung formaler Konsensusverfahren. Empfehlungen die nicht in den Konsensuskonferenzen abschließend abgestimmt werden konnten, wurden schriftlich durch die Leitlinienautoren konsentiert. Bei den Konsensuskonferenzen erfolgte jeweils eine Einführung zum Stand der Leitlinienbearbeitung durch einen Methodiker des ÄZQ und die Teilnehmer wurden in die Technik der strukturierten Konsensusfindung eingewiesen. Die Konsensuskonferenzen waren gegliedert in themenbezogene Gruppenarbeit und eine nachfolgende Plenumssitzung.

Tabelle 3: Konsensuskonferenzen und behandelte Themen

Konsensuskonferenzen	Datum	Themen
1. Konferenz (Erstellung)	31.10. 2005	▪ Initiierungstreffen der gesamten Leitliniengruppe und der AWMF, Besprechung der methodischen Vorgehensweise.
2. Konferenz (Erstellung)	20.09. 2007	▪ Stellenwert des Watchful Waiting/Active Surveillance beim lokal begrenzten PCa ▪ Stellenwert der primären Hormontherapie beim lokal begrenzten PCa ▪ Stellenwert anderer Verfahren (Kryotherapie, HIFU-Therapie, Hyperthermie) zur Primärtherapie des lokal begrenzten PCa
3. Konferenz (Erstellung)	2./3.04. 2008	▪ Stellenwert der radikalen Prostatektomie bei lokal begrenztem PCa ▪ Stellenwert der Lymphadenektomie bei lokal begrenztem PCa ▪ Stellenwert der adjuvanten/neoadjuvanten Therapie bei lokal begrenztem PCa ▪ Stellenwert der perkutanen Strahlentherapie bei lokal begrenztem PCa ▪ Stellenwert der LDR-Brachytherapie bei lokal begrenztem PCa ▪ Therapie der Harnstauung bei kastrationsresistentem PCa ▪ Testosteronsubstitution im Zusammenhang mit dem PCa
4. Konferenz (Erstellung)	28.08. 2008	▪ Früherkennung und Biopsie ▪ Diagnostik und Stadieneinteilung ▪ Therapieplanung des nichtmetastasierten PCa ▪ Watchful Waiting und primäre Hormontherapie ▪ Radikale Prostatektomie beim lokal fortgeschrittenen PCa ▪ Stellenwert der HDR-Brachytherapie beim lokal begrenzten und lokal fortgeschrittenen PCa

Konsensuskonferenzen	Datum	Themen
5. Konferenz (Erstellung)	23.01. 2009	▪ Perkutane Strahlentherapie beim lokal fortgeschrittenen PCa ▪ Lymphadenektomie beim lokal fortgeschrittenen PCa ▪ (neo-) adjuvante Hormontherapie beim lokal fortgeschrittenen PCa ▪ Andere lokale Verfahren (Kryo, HIFU, Hyperth.) beim lokal fortgeschrittenen PCa ▪ Hormontherapie beim metastasierten PCa ▪ Therapie des kastrationsresistentend PCa ▪ Rehabilitation nach kurativer Therapie ▪ Lebensqualität und psychosoziale Aspekte
6. Konferenz (Erstellung)	4./5.06. 2009	▪ Pathomorphologische Diagnostik ▪ adjuvante Strahlentherapie des nichtmetastasierten PCa ▪ Behandlung des lymphknotenpositiven PCa ▪ Supportiv- und Palliativtherapie ▪ Nachsorge/Verlaufskontrolle: Wann und wie? ▪ Definition und Diagnostik des Tumorrezidivs/Bildgebung im Verlauf des metastasierten PCa ▪ Behandlung des PSA-Rezidivs nach RPE und des PSA-Progresses nach Strahlentherapie ▪ Therapie von Knochenmetastasen
7. Konferenz (1. Konferenz der 1. Aktualisierung)	30./31. 05. 2011	▪ Früherkennung ▪ Diagnostik ▪ Active Surveillance ▪ Radikale Prostatektomie (bei Patienten mit hohem Risiko oder lokal fortgeschrittenem Prostatakarzinom) ▪ Perkutane Strahlentherapie (bei Patienten mit hohem Risiko oder lokal fortgeschrittenem Prostatakarzinom) ▪ HIFU

Konsensuskonferenzen	Datum	Themen
8. Konferenz (2. Konferenz der 1. Aktualisierung)	28.06. 2011	▪ Diagnostik und Staging ▪ Active Surveillance ▪ Perkutane Strahlentherapie und hormonablative Therapie ▪ LDR-Brachytherapie ▪ Behandlung des kastrationsresistenten Prostatakarzinoms ▪ Knochenmetastasen ▪ Früherkennung
9. Konferenz (1. Konferenz der 2. Aktualisierung)	08.09. 2013	▪ Früherkennung ▪ PET/CT, MRT beim PSA-Rezidiv ▪ DNA-Zytometrie ▪ Immunhistochemische Zusatzuntersuchungen ▪ Komorbiditätsklassifikationen beim frühen Prostatakarzinom ▪ Behandlung des Low-Risk-Karzinoms ▪ Geriatrisches Assessment vor Chemotherapie ▪ Systemtherapie des kastrationsresistenten Prostatakarzinoms ▪ Behandlung ossäre Metastasen

5.2.1. Themenbezogene Gruppenarbeit

Arbeitsgruppen mit je etwa 15- bis 20 Mitgliedern arbeiteten zunächst parallel themenbezogen. In den Gruppen wurden die von den Kapitel-Autoren in Kleingruppen erarbeiteten Empfehlungen und Statements nach den Regeln des nominalen Gruppenprozesses (siehe unten) diskutiert, gegebenenfalls modifiziert und (vor-) abgestimmt. Die (vor-)abgestimmten Empfehlungen dienten als Vorlage für die Plenumsabstimmung.

Die Sitzungen der Arbeitsgruppen bei der Erstellung wurden von Frau Prof. Dr. I. Kopp (AWMF), Frau Dr. M. Nothacker (ÄZQ), Herrn Prof. Dr. Dr. G. Ollenschläger (ÄZQ) und Frau Dr. S. Weinbrenner (ÄZQ) moderiert. Bei der 1. Aktualisierung moderierten Dr. M. Nothacker und Dr. S. Weinbrenner (beide ÄZQ) und Dr. M. Follmann (DKG) die Sitzungen der Arbeitsgruppen. Bei der 2. Aktualisierung moderierte M. Nothacker (AWMF) die Arbeitsgruppe 1 (DNA-Zytometrie, immunhistochemische Zusatzuntersuchungen, Behandlung des Low-Risk-Karzinoms, geriatrisches Assesment vor Chemotherapie), I.Kopp die Arbeitsgruppe 2 (Früherkennung, Komorbiditätsklassifikationen beim frühen Prostatakarzinom) und C. Khan (ÄZQ) die Arbeitsgruppe 3 (PET/CT, MRT beim PSA-Rezidiv, Systemtherapie des kastrationsresistenten Prostatakarzinoms, Behandlung ossärer Metastasen).

In den Arbeitsgruppen wurden der folgende Ablauf des nominalen Gruppenprozesses befolgt (gemäß Leitlinienmanual von AWMF und ÄZQ [11][12]):

- stille Generierung von Änderungsvorschlägen;
- Registrierung der Ideen im Einzel- Umlaufverfahren;
- Reihendiskussion;
- Vorabstimmung;
- Debattieren und Diskutieren;
- endgültige (Vor-)Abstimmung.

Wurde im Rahmen der Abstimmung in den Arbeitgruppen kein Konsens erreicht, konnte in der Plenumsrunde auch ein fortbestehender Dissens dargestellt werden.

Definition des Konsens: Gemäß dem Regelwerk der AWMF wird die Konsensusstärke wie folgt definiert:

Starker Konsens	> 95 % der Teilnehmer
Konsens	> 75-95 % der Teilnehmer
Mehrheitliche Zustimmung	> 50-75 % der Teilnehmer
Kein Konsens	< 50 % der Teilnehmer

5.2.2. Plenumssitzung mit endgültiger Verabschiedung der Empfehlungen

Im zweiten Teil wurden die zuvor in den Arbeitsgruppen abgestimmten Empfehlungsvorschläge dem gesamten Expertengremium vorgestellt. Die definitive Abstimmung erfolgte im Plenum in Form einer strukturierten Konsensuskonferenz in Anlehnung an die vom amerikanischen National Institut of Health entwickelte Methode [13]:

- Vorstellung der Empfehlungsvorschläge vor dem Plenum;
- Gelegenheit zu Rückfragen, zur Klärung der Evidenzgrundlage durch das Plenum;
- Vorabstimmung über die Empfehlungen und ihre Graduierung;
- bei fehlendem Konsens Diskussion;
- endgültige Abstimmung.

Für das Abstimmungsverfahren wurde ein TED-System eingesetzt, um die Voten der einzelnen Teilnehmer zu schützen (Anonymisierung).

5.2.2.1. Abstimmung im Delphi-Verfahren im Nachgang der 2. Konsensuskonferenz der 2. Aktualisierung 2014 (methodisch betreut durch die AWMF)

Es wurde vom Vorsitzenden der Steuergruppe (Prof. Wirth) festgelegt, dass die nicht in der Konsensuskonferenz konsentierten Empfehlungen der Kapitel 5.1 Therapieplanung und Aufklärung und 5.2 Active Surveillance in einem dreistufigen Verfahren nochmals bearbeitet werden sollen. Für die Entscheidung waren drei Ursachen maßgeblich:
1.) In der bei Konsensuskonferenz hatten zum Zeitpunkt der Abstimmung bereits viele Experten die Konferenz verlassen müssen. Mangels Repräsentativität konnten daher die Empfehlungen nicht konsentiert werden.

2.) Die Diskussionen innerhalb der Kleingruppenarbeit der AG 1 am Vormittag der Konsensuskonferenz wurden aufgrund von Zeitdruck als nicht ausreichend von der Moderatorin der AWMF erachtet.
3.) Auch im Vorfeld der Konsensuskonferenz war trotz intensiver Bemühungen kein ausreichender Austausch in der ursprünglich festgelegten Kleingruppe organisierbar.

Das dreistufige Verfahren sah vor, dass diese Empfehlungen zunächst in einer Kleingruppe, dann in der AG 1 der Konsensuskonferenz und anschließend im Delphi-Konsensusverfahren von der Gesamtgruppe abgestimmt werden sollten. Als Stufe 1 wurden die Empfehlungen unter der methodischen Leitung von Frau Nothacker in einer Kleingruppe erneut bearbeitet und in einer Telefonkonferenz am 20.09.2013 diskutiert. Teilnehmer der Kleingruppe waren die Experten Börgermann, Göckel-Beining, Hakenberg, Kristiansen, Schostak, Stöckle, Wirth, Wörmann. Als Stufe 2 wurden die Empfehlungen an die AG 1 der Konsensuskonferenz zur Vorabstimmung im Delphi-Verfahren gesendet. Stufe 3 stellte die Abstimmung der Empfehlungen in der Gesamtgruppe zur finalen Konsentierung dar. An der Abstimmung haben sich 53 Experten (84 %) beteiligt. Alle Empfehlungen wurden mit über 75 % Zustimmung in der ersten Runde final konsentiert.

5.2.3. Empfehlungen und deren Graduierung

Empfehlungen sind thematisch bezogene handlungsleitende Kernsätze der Leitlinie. Die OL-Methodik sieht eine Vergabe von Empfehlungsgraden durch die Leitlinien-Autoren im Rahmen eines formalen Konsensusverfahrens vor. Dementsprechend wurde ein durch die AWMF moderierter, mehrteiliger Nominaler Gruppenprozess durchgeführt. Die Empfehlungsgrade drücken den Grad der Sicherheit aus, dass der erwartbare Nutzen der Intervention den möglichen Schaden aufwiegt (Netto-Nutzen) und die erwartbaren positiven Effekte ein für die Patienten relevantes Ausmaß erreichen. Im Fall von Negativempfehlungen (soll nicht) wird entsprechend die Sicherheit über einen fehlenden Nutzen bzw. möglichen Schaden ausgedrückt.
Bei der Graduierung der Empfehlungen werden neben den Ergebnissen der zugrunde liegenden Studien, die klinische Relevanz der in den Studien untersuchten Effektivitätsmaße, die beobachteten Effektstärken, die Konsistenz der Studienergebnisse; die Anwendbarkeit der Studienergebnisse auf die Patientenzielgruppe, die Umsetzbarkeit im ärztlichen Alltag oder ethische Verpflichtungen sowie Patientenpräferenzen berücksichtigt.

Empfehlungsgrad	Beschreibung	Ausdrucksweise
A	Starke Empfehlung	soll
B	Empfehlung	sollte
0	Empfehlung offen	kann

5.2.4. Statements

Als Statements werden Darlegungen oder Erläuterungen von spezifischen Sachverhalten oder Fragestellungen ohne unmittelbare Handlungsaufforderung bezeichnet. Sie werden entsprechend der Vorgehensweise bei den Empfehlungen im Rahmen eines formalen Konsensusverfahrens verabschiedet und können entweder auf Studienergebnissen oder auf Expertenmeinungen beruhen.

5.2.5. Expertenkonsens (EK)

Als Expertenkonsens (EK) werden Empfehlungen bezeichnet, zu denen keine Recherche nach Literatur durchgeführt wurde. In der Regel adressieren diese Empfehlungen Vorgehensweisen der guten klinischen Praxis, zu denen keine wissenschaftlichen Studien notwendig sind bzw. erwartet werden können. Der Begriff ‚Expertenkonses' ersetzt den in den bisherigen Versionen der Leitlinie genutzten Begriff ‚Good Clinical Practice' (GCP).

6. Qualitätsindikatoren

6.1. 1. Aktualisierung 2011

Die Ableitung der Qualitätsindikatoren aus starken Empfehlungen (Empfehlungsgrad A) und ggf. handlungsrelevanten Statements mit hochwertiger Evidenz (LoE1) erfolgte bis März 2012. Im Dezember 2011 wurde eine Liste mit 93 potentiell messbaren Indikatorenvorschlägen erstellt. Von den insgesamt 128 starken Empfehlungen und Statements mit LoE 1 waren zuvor 35 durch die beteiligten Methodiker primär als nicht messbar eingeschätzt worden oder es waren Empfehlungen zu pathomorphologischen Untersuchungen. Letztere wurden zurückgestellt.

Die 93 potentiell messbaren Indikatorenvorschläge wurden zu einer Vorabstimmung in die Arbeitsgruppen gegeben. Die Arbeitsgruppenmitglieder gaben ihre Einschätzung zu den von ihnen bearbeiteten Themen hinsichtlich der Bedeutung der Empfehlungen/Statements für das Versorgungssystem ab (Kriterium: „Bedeutung für die Versorgungsqualität“ der NVL-Methodik für die Erstellung von Leitlinien, siehe Langfassung). 54 potentiellen Qualitätsindikatore wurde von den Arbeitsgruppenmitgliedern eine hohe Bedeutung beigemessen. Diese sind in der Langfassung tabellarisch zusammengefasst. Eine weitere Bewertung dieser Vorschläge steht aus und wird bei der nächsten Aktualisierung angestrebt. Als Ziel sollen etwa 10 Indikatoren entwickelt werden.

6.2. 2. Aktualisierung 2014

7. Externe Begutachtung und Verabschiedung

7.1. Erstellung der Leitlinie 2006-2009

Die S3-Leitlinie zum Prostatakarzinom konnte vom 7.7.09 bis 2.8.09 öffentlich kommentiert werden. Es gingen in dieser Zeit insgesamt Kommentare von 23 Personen oder Organisationen ein. Von diesen Kommentaren bezogen sich 19 auf Inhalte der Leitlinie und vier auf formale Aspekte. Auf Wunsch können die Kommentare im ÄZQ eingesehen werden.

Redaktionelle Änderungen wurden in Absprache mit den verantwortlichen Kapitelautoren und der Steuergruppe vorgenommen. Für fünf Empfehlungen erfolgte eine schriftliche Neuabstimmung.

Die Kommentare (ggf. mehrere Aspekte pro Kommentator) und die daraus resultierten Änderungen der Leitlinie sind in Kapitel 14.1 aufgeführt.

7.2. 1. Aktualisierung 2011

Die aktualisierte Fassung der Leitlinie konnte vom 12.09. bis 12.10.2011 öffentlich kommentiert werden. Es gingen in dieser Zeit insgesamt Kommentare von 29 Personen oder Organisationen ein. Von diesen Kommentaren bezogen sich 22 auf Inhalte der Leitlinie und 7 auf formale Aspekte. Von den inhaltlichen Kommentaren bezogen sich 9

Kommentare ausschließlich auf Änderungen an Hintergrundtexten. Auf Wunsch können die vollständigen Kommentare im ÄZQ eingesehen werden.

In Absprache mit den verantwortlichen Kapitelautoren und der Steuergruppe wurden redaktionelle Änderungen vorgenommen oder Empfehlungen zur Neuabstimmung vorgeschlagen.

Die Kommentare (ggf. mehrere Aspekte pro Kommentator) und die daraus resultierten Änderungen der Leitlinie sind im Anhang aufgeführt.

7.3. 2. Aktualisierung 2014

8. Redaktionelle Unabhängigkeit

Die Leitlinienerstellung erfolgte in redaktioneller Unabhängigkeit von den finanzierenden Trägern.

An alle Teilnehmer an der Leitlinienerstellung 2009 wurden Formulare zur Erklärung von Interessenkonflikten verschickt. Die Bewertung inwiefern durch die jeweiligen Interessenkonflikte die erforderliche Neutralität für die Tätigkeit als Experte in Frage gestellt ist, sollte im Rahmen einer Selbsterklärung der Experten erfolgen. Ein Ausschluss von Experten wurde bei Erstellung der 1. Auflage der Leitlinie nicht vorgenommen.

Für die Aktualisierung der Leitlinie 2011 haben ebenfalls alle Beteiligten das aktuelle Formblatt der AWMF zur Erklärung von Interessenkonflikte ausgefüllt. Die darin offengelegten Beziehungen und Sachverhalte sind in Kapitel 13.9.1 dargestellt. Das Thema Interessenkonflikte wurde während des Aktualisierungsprozesses mehrfach in der Leitliniengruppe besprochen. Ein Ausschluss von Experten wurde nicht vorgenommen. Die Gefahr von unangemessener Beeinflussung durch Interessenkonflikte wurde dadurch reduziert, dass die Recherche, Auswahl und Bewertung der Literatur durch Methodikerinnen und Methodiker (des ÄZQ) ohne bedeutende Beziehungen zur Industrie oder Interessengruppen erfolgte. Die formale Konsensbildung und die interdisziplinäre Erstellung, sowie die Möglichkeit der öffentlichen Begutachtung bildeten weitere Elemente, die das Risiko von Verzerrungen (auch aufgrund von Interessenkonflikten einzelner Personen) reduzieren können.

Für die Aktualisierung der Leitlinie 2014 haben erneut alle Beteiligten das aktuelle Formblatt der AWMF zur Erklärung von Interessenkonflikte ausgefüllt. Die darin offengelegten Beziehungen und Sachverhalte sind in Kapitel 13.9.2 dargestellt. Das Thema Interessenkonflikte wurde während des Aktualisierungsprozesses mehrfach in der Leitliniengruppe besprochen. Experten wurde angehalten, sich bei den Abstimmungen zu enthalten, bei denen sie einen Interessenkonflikt haben. Enthaltungen wurden im Protokoll der Konsensuskonferenz dokumentiert. Die Gefahr von unangemessener Beeinflussung durch Interessenkonflikte wurde dadurch reduziert, dass die Recherche, Auswahl und Bewertung der Literatur durch Methodikerinnen und Methodiker (des ÄZQ) ohne bedeutende Beziehungen zur Industrie oder Interessengruppen erfolgte. Die formale Konsensbildung und die interdisziplinäre Erstellung, sowie die Möglichkeit der öffentlichen Begutachtung bildeten weitere Elemente, die das Risiko von Verzerrungen (auch aufgrund von Interessenkonflikten einzelner Personen) reduzieren können.

9. Verbreitung und Implementierung

10. Gültigkeitsdauer der Leitlinie

Die Leitlinie ist bis zur nächsten Aktualisierung gültig, höchstens jedoch bis September 2016 Vorgesehen sind weitere regelmäßige modulare Aktualisierungen in einem etwa 2-3 jährlichen Abstand.

Kommentare und Änderungsvorschläge zur Leitlinie bitte an folgende Adresse:

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E-Mail: Manfred.Wirth@uniklinikum-dresden.de

11. Tabellenverzeichnis

12. Anhänge

12.1. Schlüsselfragen und Autoren 2009/2011/2014

Schlüsselfragen	Autoren	Jahr / Aktualisierung
Lokal begrenztes Prostatakarzinom		
Behandlung des Low-Risk-Karzinom		2. Aktualisierung 2014
Stellenwert von Komorbiditäts-klassifikationen als Unterstützung bei der Therapieentscheidung beim frühen Prostatakarzinom	Fröhner, Wirth, Wedding	2. Aktualisierung 2014
Stellenwert des Watchful Waiting und der Active Surveillance.	Weißbach, Graefen, Burchardt, Grimm, Fiebrandt, Fornara, Heidenreich, Rübben, Wagner, Wernert, Wiegel	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert der radikalen Prostatektomie: Für welche Patienten ist die radikale Prostatektomie am geeignetsten?	Wirth, Grimm, Enders, Fröhner, Thomas, Thüroff , Steuber, Heidenreich, Vögeli	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert der perkutanen Strahlentherapie: Für welche Patienten die Radiotherapie?	Böhmer, Hölscher, Machtens, Wenz, Wiegel, Höcht, Sedlmayer, Martin, Moser, Hinkelbein, Zacharias.	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert der Brachytherapie/Seedbehandlung: Für welche Patienten die LDR-Brachytherapie?	Borchers, Machtens, Jakse, Alberti, Henkel, Schmitz-Dräger, Zacharias	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert der Brachytherapie/Seedbehandlung: Für welche Patienten die HDR-Brachytherapie?	Böhmer, Alberti, Deger, Galalae, Goldner, Martin, Wiegel	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert der hormonablativen Therapie: Für welche Patienten die primäre hormonablative Therapie?	Ebert, Lümmen	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert der Lymphadenektomie: Wann ist die Lym-	Thüroff, Thomas, Burchard, Heidenreich, Küfer, Wiegel	Ersterstellung 2009 und/oder

Schlüsselfragen	Autoren	Jahr / Aktualisierung
phadenektomie sinnvoll?		1. Aktualisierung 2011
Stellenwert der adjuvanten und neoadjuvanten Therapie.	Miller, Borchers, Fichtner, Rübben, Schostak, Wiegel	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert anderer interventioneller Verfahren.	Jocham, Jakse, Tedsen, Doehn, Schmitz-Dräger, Blana, Schostak, Enders	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Lokal fortgeschrittenes Prostatakarzinom		
Ist Watchful Waiting in Kategorie T3 oder T4 vertretbar?	Weißbach, Heidenreich	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Welchen Patienten in der klinischen Kategorie T3 soll eine operative Therapie angeboten werden? Gibt es Indikationen, bei denen die T4-Kategorie operiert werden kann?	Wirth, Grimm, Fröhner, Thomas, Thüroff, Steuber, Heidenreich, Vögeli, Enders	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Sollen Patienten in der Kategorie cT3 eine andere RT erhalten als Patienten in der Kategorie cT1/2? Kann die RT oder BT in der Kategorie cT4 kurativ sein? Soll der klinisch-präoperativ definierte cN-Status die Therapie-Entscheidung beeinflussen?	Böhmer, Hölscher, Machtens, Wenz, Wiegel, Höcht, Sedlmayer, Martin, Moser, Hinkelbein, Zacharias.	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Kann die HDR in der Kategorie cT4 kurativ sein?	Böhmer, Alberti, Deger, Galalae, Goldner, Martin, Wiegel	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Gibt es eine Indikationsstellung für die primäre hormonablative Therapie beim nichtmetastasierten PCa?	Ebert, Lümmen	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Sollen Patienten in der klinischen Kategorie T3 und T4, die eine lokale kurativ intendierte Therapie (RPE, RT, BT) erhalten, lymphadenektomiert werden?	Thüroff, Thomas, Burchard, Heidenreich, Küfer, Wiegel	Ersterstellung 2009 und/oder 1. Aktualisierung 2011

Schlüsselfragen	Autoren	Jahr / Aktualisierung
Sollen alle Patienten in der klinischen Kategorie T3 und T4, die eine lokale kurativ intendierte Therapie (RPE, RT, BT) erhalten, adjuvant oder/und neoadjuvant therapiert werden?	Miller, Borchers, Fichtner, Rübben, Schostak, Wiegel	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Mit welcher Zielsetzung können HIFU, Kryo- bzw. Hyperthermie für die Kategorie T3/4 eingesetzt werden?	Jakse, Jocham, Doehn, Tedsen, Schmitz-Dräger, Blana, Schostak, Fiebrandt	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Lymphknotenpositives PCa: Welche Therapie?	Wolff, Hinkelbein, Höcht, Thomas, Thüroff,	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Rezidiviertes oder metastasiertes Prostatakarzinom		
Geriatrisches Assessment bei Patienten vor Chemotherapie	Wedding, Weißbach	2. Aktualisierung 2014
Systemtherapie (inkl. Kombinationstherapie) des kastrationsresistenten Prostatakarzinom	Wörmann, Zastrow, Palmedo, Miller, Wirth	2. Aktualisierung 2014
Behandlung ossärer Metastasen	Wörmann, Zastrow, Palmedo, Miller, Heidenreich, Wirth	2. Aktualisierung 2014
Behandlung des metastasierten PCa: Therapie der symptomatischen/asymptomatischen Knochenmetastasen.	Rohde, Albrecht, Palmedo, Wörmann, Lümmen, Luboldt, Lein, Wolff	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Behandlung des metastasierten PCa: Supportivtherapie: Maßnahmen bei belastenden Symptomen (Tumor-/Therapiebedingt).	Wörmann, Albrecht, Enders, Schmitz-Dräger	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Behandlung des metastasierten PCa: Therapie der Harnstauung bei kastrationsresistentem PCa.	Weißbach, Heidenreich	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Behandlung des metastasierten PCa: Bildgebung im Verlauf des metastasierten PCa (ging ein in Diagnostik des Re-	Luboldt, Beyersdorff, Palmedo	Ersterstellung 2009 und/oder 1. Aktualisierung 2011

Schlüsselfragen	Autoren	Jahr / Aktualisierung
zidivs/Staging).		
Besonderheiten von Rezidivtumoren: Therapie des PSA-Rezidivs nach RPE (lokal/systemisch).	Wiegel, Alberti, Börgermann, Hakenberg, Heidenreich, Sedlmayer	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Besonderheiten von Rezidivtumoren: Therapie des PSA-Rezidivs nach Bestrahlung.	Hakenberg, Heidenreich, Alberti, Börgermann, Sedlmayer	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Therapie des kastrationsresistenten PCa: Welche Medikamente bei kastrationsresistentem PCa?	Wirth, Fröhner, Grimm, Miller, Pummer, Schulz, Wörmann, Wolff, Hakenberg, Heidenreich, Rohde	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Wann ist die maximale Androgendeprivation der einfachen Androgendeprivation (Orchiektomie, LHRH-Analoga) überlegen?	Rhode, Grimm, Lümmen, Wolff	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert der intermittierenden Androgenblockade: Intermittierende Androgenblockade: Standardbehandlung?	Grimm, Wolff, Hammerer, Lümmen, Rohde	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Diagnostik/ Stadieneinteilung		
Stellenwert des PET/CT bzw. PET/MRT beim PSA-Rezidiv nach radikaler Prostatektomie bzw. Strahlentherapie	Kotzerke, Miller, Wiegel	2. Aktualisierung 2014
Stellenwert der DNA-Zytometrie	Kristiansen, Weißbach, Dietz, Böcking, Wernert	2. Aktualisierung 2014
Stellenwert immunhistochemischer Zusatzuntersuchungen	Kristiansen, Wernert, Weißbach	2. Aktualisierung 2014
Diagnostik, Stadieneinteilung, Befundbewertung: Stadieneinteilung, Ausbreitungsdiagnostik.	Miller, Beyersdorff, Enders, Fornara, Göckel-Beining, Graefen, Krause, Müller-Lisse, Palmedo, Schrader	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Diagnostik, Stadieneinteilung, Befundbewertung: Pathomorphologische Untersuchungen.	Wernert, Jakse, Kahl, Ludoldt, Wetterauer	Ersterstellung 2009 und/oder 1. Aktualisierung 2011

Schlüsselfragen	Autoren	Jahr / Aktualisierung
Risikofaktoren/Prävention/Früherkennung		
Risikoadaptierte Zeitabstände, Altersbeginn der Früherkennung	Rübben, Börgermann, Egidi	2. Aktualisierung 2014
Risikofaktoren/Prävention inklusive Ernährung: Prävention für PCa.	Schmitz-Dräger, Fiebrandt, Lümmen	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Prävention inklusive Ernährung: Stellenwert der Ernährung bei manifestem PCa.	Schmitz-Dräger, Fiebrandt, Lümmen	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert der Früherkennung/Screening: Ist PCa-Screening sinnvoll?	Rübben, Börgermann, Dubben, Fiebrandt, Fornara, Loertzer, Luboldt, Schulz, Semjonow, Stöckle, Vögeli, Weißbach,	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert der Früherkennung/Screening: Wann ist ein PCa insignifikant?	Fornara, Rübben, Wagner, Wernert, Wiegel	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Testosteronsubstitution im Zusammenhang mit dem PCa.	Ackermann, Behre, Nieschlag, Volkmer, Wetterauer	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert der Biopsie: Biopsie – wann und wie?	Rübben, Börgermann, Fornara, Hammerer, Loertzer, Luboldt, Schulz, Semjonow	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Reha/Nachsorge		
Stellenwert der Rehabilitation nach kurativer Therapie.	Jünemann, Ebermayer, Kaufmann, Otto, Weißbach	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert von Verlaufskontrollen/Nachsorge-Parametern: Verlaufskontrolle: Wann und wie?	Graefen, Alberti	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Tumorrezidiv: Definition und Diagnostik.	Sedlmayer, Alberti, Börgermann, Hakenberg, Palmedo	Ersterstellung 2009 und/oder 1. Aktualisierung 2011
Stellenwert der Lebensqualität: Psychosoziale Aspekte und Lebensqualität beim PCa.	Jocham, Tedsen, Doehn, Koller, Rohde, Vertreter der Selbsthilfegruppen	Ersterstellung 2009 und/oder 1. Aktualisierung 2011

12.2. Methodik und Ergebnisse der Recherchen zur Erstellung der Leitlinie 2009

12.2.1. Recherche zum Thema Epidemiologie, Risikofaktoren, Prävention und Ernährung

12.2.1.1. Epidemiologie

Zum Thema Epidemiologie wurden keine systematischen Recherchen durchgeführt.

12.2.1.2. Risikofaktoren

Zum Thema Risikofaktoren wurden die folgenden Recherchen durchgeführt:

Recherchezeitraum: ab 1.1.2000

Suchstrategie 1 (Leitlinien und aggregierte Evidenz):

Suchworte „prostate“ und „cancer“; Datenbanken: Cochrane Collaboration, National Guidelines Clearinghouse (NGC, USA), Guidelines International Network (GIN), AWMF; Suchzeitpunkt: 03.11.2007

Suchstrategie 2 (Metaanalysen und Leitlinien in PubMed):

Suchworte “prostate” und “cancer”, Limits: ab 2000, English, German, Meta-Analysis, Practice Guideline, Clinical Conference, Consensus Development Conference, Guideline; Datenbanken: PubMed; Suchzeitpunkt: 03.11.2007

Suchstrategie 3 (systematische Reviews in PubMed):

Suchworte: ((systematic and review) OR metaanalysis OR meta-analysis) AND ((prevention) OR ("prevention and control"[Subheading]) OR ("Primary Prevention"[Mesh]) AND ((prostate and cancer) OR ("Prostatic Neoplasms"[Mesh])); Datenbanken: PubMed; Suchzeitpunkt: 07.11.2007; Trefferzahl: n=2389, davon durchgesehene Review: Treffer: n= 793 +Pubmed-Filter für Metaanalysen angewendet: Treffer: 20; Ausschlusskriterien: Unsystematische Reviews, Experimentelle Publikationen ohne klinischen Bezug, Veröffentlichung vor 2000, Literatur zu Vitamin E oder Selen

Eingeschlossene Volltexte: n=20

Suchstrategie 4 (Alter als Risikofaktor):

Suchworte: ((meta-analysis) OR (systematic and review) AND (prognos* OR survival OR failure OR outcome)) AND ("Prostatic Neoplasms"[Mesh]) AND (("Age Factors"[Mesh]) OR ("Life Expectancy"[Mesh])), Trefferzahl: 8, Eingeschlossene Volltexte: n=0

12.2.1.3. Testosteronsubstitution

Recherchezeitraum: 1.1.1996 - 26.4.2007

Suchstrategie: ("testosterone"[MeSH Terms] OR testosterone [Text Word]) AND (("replantation"[TIAB] NOT Medline[SB]) OR "replantation"[MeSH Terms] OR replacement[Text Word]) AND (("prostatic neoplasms"[TIAB] NOT Medline[SB]) OR "prostatic neoplasms"[MeSH Terms] OR prostate cancer[Text Word])

Trefferzahl: 121

Eingeschlossene Volltexte: 3 aggregierte Evidenzquellen, 12 Primärstudien, 19 Publikationen als Kontextliteratur

12.2.1.4. Prävention

Recherchezeitraum: 1.1.2000 bis 07.11.2007 bzw. für Suchstrategie 6 bis 04.12.2007

Such-Strategien zu Ernährung und Prävention – aggregierte Evidenz:

Suchstrategie 1 (Leitlinien und aggregierte Evidenz): Suchworte „prostate“ und „cancer“; Datenbanken: Cochrane Collaboration, National Guidelines Clearinghouse (NGC, USA), Guidelines International Network (GIN), AWMF

Suchstrategie 2 (Meta-analysen und Leitlinien in PubMed): Suchworte “prostate” und “cancer”, Limits: ab 2000, English, German, Meta-Analysis, Practice Guideline, Clinical Conference, Consensus Development Conference, Guideline

Suchstrategie 3 (systematische Reviews in PubMed): Suchworte: ((systematic and review) OR metaanalysis OR meta-analysis) AND ((prevention) OR ("prevention and control"[Subheading]) OR ("Primary Prevention"[Mesh]) OR (finasteride) OR ("Finasteride"[Mesh])) AND ((prostate and cancer) OR ("Prostatic Neoplasms"[Mesh]))

Trefferzahl: n=66, Recherchezeitraum 1.1.2000 bis 4.12.2007

Suchstrategie 4 (ergänzende Primärpublikationen in PubMed): Suchworte: (prevention and prostate and cancer AND (("2000/01/01"[PDat] : "2007/12/03"[PDat])) AND (("Finasteride"[Mesh]) OR (finasteride OR dutasteride OR alpha-reductase OR (alpha and reductase)) OR ("Testosterone 5-alpha-Reductase"[Mesh]))

Trefferzahl: 197,

Suchstrategie 5: Suchworte: (("Selenium"[Mesh]) OR (Selenium)) AND (prevention OR chemoprevention) AND (prostate and cancer) AND (("2000/01/01"[PDat] : "2007/12/04"[PDat]) AND (Humans[Mesh]) AND (English[lang] OR German[lang])).

Trefferzahl:179

Suchstrategie 6: (prostate and cancer) AND ((vitamin and e) OR (vitamin e) OR (tocopherol) OR ("Vitamin E"[Mesh])) AND (prevention OR chemoprevention) Limits: Publication Date from 2000/01/01 to 2007/12/04

Trefferzahl: 173

Ergebnis: 23 aggregierte Evidenzquellen, 24 Primärstudien, 7 Publikationen als Kontextliteratur

Eingeschlossene Volltexte: 3 aggregierte Evidenzquellen, 24 Primärstudien

12.2.2. Recherche zum Thema Früherkennung und Biopsie

Recherchezeitraum: 1.1.2000- 22.10.2007

Suchstrategie aggregierte Evidenz: prostate and cancer and screening and ((systematic and review) or metaanalysis or meta-analysis)

Treffer: 203

Recherchezeitraum: 1.1.2000- 2.5.2008

Suchstrategie Primärpublikationen: ("Mass Screening"[MeSH Major Topic] AND (("2000/01/01"[PDat] : "2008/05/02"[PDat])) AND ("Prostatic Neoplasms"[MeSH Major Topic] AND (("2000/01/01"[PDat] : "2008/05/02"[PDat])) AND (prostate specific antigen AND (("2000/01/01"[PDat] : "2008/05/02"[PDat])) AND (("2002/01/01"[PDat] : "2008/05/02"[PDat]))

Trefferzahl: 398

Eingeschlossene Volltexte: 3 aggregierte Evidenzquellen, 30 Primärstudien

In 2009 ergänzt: Andriole et al, Schröder et al.

12.2.3. Recherche zum Thema Diagnostik und Stadieneinteilung

12.2.3.1. Klinischen und apparativen Diagnostik

(Verfahren alphabetisch geordnet):

<u>Computertomographie</u>

Recherchezeitraum 1.1.2000-22.11.2007

Suchstrategie 3 (systematische Reviews):
Suchworte: (CT OR (compute* AND and tomogra*)) AND ("Prostatic Neoplasms"[Mesh]) AND ((systematic and review) OR meta-analysis OR metaanalysis)
Datenbanken: PubMed

Trefferzahl: 15

Suchstrategie 4 (ergänzende Primärpublikationen in PubMed) ab 2000:
Suchworte: (((diagnosis OR diagnoses OR diagnostic OR diagnostical) OR (accurate OR accuracy OR accurately)) OR ("Sensitivity and Specificity"[Mesh])) AND ("Prostatic Neoplasms"[MeSH Major Topic]) AND ("Tomography, X-Ray Computed"[MeSH Major Topic]) AND (English[lang] OR German[lang])) Limits: Publication Date from 1990/01/01 to 2000/01/01, Humans, English, German
(((diagnosis OR diagnoses OR diagnostic OR diagnostical) OR (accurate OR accuracy OR accurately)) OR ("Sensitivity and Specificity"[Mesh])) AND ("Prostatic Neoplasms"[MeSH Major Topic]) AND ("Tomography, X-Ray Computed"[MeSH Major Topic]) AND (("2000/01/01"[PDat] : "2007/11/19"[PDat]) AND (English[lang] OR German[lang]))
Datenbanken: PubMed

Trefferzahl: 138

Recherchezeitraum 1.1.1990-22.11.2007:

Suchstrategie 5 (ergänzende Primärpublikationen in PubMed) von 1990- 2000:
((((diagnosis OR diagnoses OR diagnostic OR diagnostical) OR (accurate OR accuracy OR accurately)) OR ("Sensitivity and Specificity"[Mesh])) AND ("Prostatic Neoplasms"[MeSH Major Topic]) AND ("Tomography, X-Ray Computed"[MeSH Major Topic]) AND (English[lang] OR German[lang])) Limits: Publication Date from 1990/01/01 to 2000/01/01, Humans, English, German

Trefferzahl: 67

DRU:

Recherchezeitraum 1.1.2000-23.11.2007

Suchstrategie 6 (aggregierte Evidenz): (DRE OR digital rectal examination) AND ("Prostatic Neoplasms"[Mesh]) AND ((systematic and review) OR meta-analysis OR metaanalysis)

Trefferzahl: 27

Suchstrategie 7 (ergänzende Primärpublikationen in PubMed):
Suchworte: (DRE OR clinical examination) AND prostate AND (prostatectomy or RPE) AND (stage or staging)
Datenbanken: PubMed

Trefferzahl: 238

MRT:

Recherchezeitraum: 1.1.2000 – 19.11.2007
Suchstrategie 8 (systematische Reviews in PubMed):
Suchworte: ("Magnetic Resonance Imaging"[Mesh]) AND (("Prostatic Neoplasms"[Mesh] AND (Humans[Mesh])) AND ((systematic and review) OR meta-analysis OR metaanalysis AND (Humans[Mesh])) AND (Humans[Mesh]))
Datenbanken: PubMed

Trefferzahl: 6

Suchstrategie 9 (ergänzende Primärpublikationen):
Suchworte: ((((diagnosis OR diagnoses OR diagnostic OR diagnostical) OR (accurate OR accuracy OR accurately)) OR ("Sensitivity and Specificity"[Mesh])) AND ("Prostatic Neoplasms"[MeSH Major Topic]) AND ("Magnetic Resonance Imaging"[MeSH Major Topic]) AND (("2000/01/01"[PDat] : "2007/11/19"[PDat]) AND (Humans[Mesh]) AND (English[lang] OR German[lang]))
Datenbanken: PubMed

Trefferzahl: 317

Szintigraphie:

Recherchezeitraum: 1.1.2000 – 6.11.2007 bzw. 19.11.2007

Suchstrategie 10 (systematische Reviews):
Suchworte: ("Radionuclide Imaging"[Mesh] AND (("2000/01/01"[PDat] : "2007/11/06"[PDat]) AND (Humans[Mesh]))) and ("Prostatic Neoplasms"[Mesh] AND (("2000/01/01"[PDat] : "2007/11/06"[PDat]) AND (Humans[Mesh]))) AND ((systematic

and review) OR meta-analysis OR metaanalysis AND (("2000/01/01"[PDat] : "2007/11/06"[PDat]) AND (Humans[Mesh]))) AND (("2000/01/01"[PDat] : "2007/11/06"[PDat]) AND (Humans[Mesh]))
Datenbanken: PubMed

Trefferzahl: 2

Suchstrategie 11 (ergänzende Primärpublikationen):
Suchworte: (prostate and cancer) AND (((diagnosis OR diagnoses OR diagnostic OR diagnostical) OR (accurate OR accuracy OR accurately)) OR ("Sensitivity and Specificity"[Mesh])) AND ((bone and scan) OR scintigraphy OR (radionuclide and imaging)) AND (("2002/07/01"[PDat] : "2007/11/19"[PDat]) AND (Humans[Mesh]) AND (English[lang] OR German[lang]))
Datenbanken: PubMed

Trefferzahl: 476

TRUS

Recherchezeitraum: 1.1.2000-6.11.2007 bzw. 20.11.2007

Suchstrategie 12 (systematische Reviews):
Suchworte: (("Ultrasonography"[Mesh] AND (("2000/01/01"[PDat] : "2007/11/06"[PDat]) AND (Humans[Mesh]))) AND ("Prostatic Neoplasms"[Mesh] AND (("2000/01/01"[PDat] : "2007/11/06"[PDat]) AND (Humans[Mesh]))) AND (("2000/01/01"[PDat] : "2007/11/06"[PDat]) AND (Humans[Mesh]))) AND ((systematic and review) OR metaanalysis OR meta-analysis AND (("2000/01/01"[PDat] : "2007/11/06"[PDat]) AND (Humans[Mesh]))) AND (("2000/01/01"[PDat] : "2007/11/06"[PDat]) AND (Humans[Mesh]))
Datenbanken: PubMed

Trefferzahl: 16

Suchstrategie 13 (ergänzende Primärpublikationen:
Suchworte: ("Ultrasonography"[MeSH Major Topic]) AND ("Prostatic Neoplasms"[MeSH Major Topic]) AND (diagnosis OR diagnoses OR diagnostic OR diagnostical OR accurate OR accuracy OR accurately OR sensitivity OR specificity) AND (("2000/01/01"[PDat] : "2007/11/20"[PDat]) AND (Humans[Mesh]) AND (English[lang] OR German[lang]))

Trefferzahl: 167

Suchstrategie 14 (ergänzende Primärpublikationen 1990-2000):
Suchworte: ("Ultrasonography"[MeSH Major Topic]) AND ("Prostatic Neoplasms"[MeSH Major Topic]) AND (diagnosis OR diagnoses OR diagnostic OR diagnostical OR accurate OR accuracy OR accurately OR sensitivity OR specificity) AND (("2000/01/01"[PDat] : "2007/11/20"[PDat]) AND (Humans[Mesh]) AND (English[lang] OR German[lang])) ("Ultrasonography"[MeSH Major Topic]) AND ("Prostatic Neoplasms"[MeSH Major Topic]) AND (diagnosis OR diagnoses OR diagnostic OR diagnostical OR accurate OR accuracy OR accurately OR sensitivity OR specificity) AND (Humans[Mesh]) AND (English[lang] OR German[lang]) Limits: Publication Date from 1990/01/01 to 1999/12/31
Datenbanken: PubMed

Trefferzahl: 81

Volltexte gesamt: 9 aggregierte Evidenzquellen, 51 Primärstudien

Eingeschlossene Volltextet: 1 aggregierte Evidenzquelle, 7 Primärstudien

12.2.3.2. Pathomorphologische Diagnostik

Dieses Kapitel orientiert sich an den Empfehlungen des College of American Pathologists [14], der WHO/UICC [15], des Royal College of Pathologists (RCPath, UK) [16] sowie des Berufsverbandes Deutscher Pathologen und der Deutschen Gesellschaft für Pathologie [17]. Dabei geht es in den Anforderungen an einigen Stellen über die genannten Konsensuspapiere hinaus. Dem Kapitel liegt weiterhin vom Autor eingebrachte Literatur zugrunde. Da hier keine systematische Recherche von Publikationen erfolgte, wurden keine Evidenztabellen erstellt.

12.2.4. Recherche zum Thema Therapie des nichtmetastasierten Prostatakarzinoms

12.2.4.1. Therapieplanung und Aufklärung

Das Kapitel beruht auf den Quell-Leitlinien [3; 5; 6] und einer tabellarischen Zusammenstellung der Therapieeffekte aus den zu den Therapieverfahren vorhandenen Studien oder agggregierten Evidenzquellen, die aus den spezifischen Recherchen zu den jeweiligen Therapieverfahren identifiziert wurden.

12.2.4.2. Active Surveillance

Recherchezeitraum: 1.1.2000 - 01.08.2006

Aktualisierungsrecherche: 19.03.2009 (Trefferzahlen nicht dargestellt, aus Aktualisierungsrecherche erfolgte kein Einschluss neuer Volltexte)

Such-Strategie zum Stellenwert des Watchful-Waiting beim Prostatakarzinom:

("Modul zur Identifikation von Publikationen zum Thema Prostatakarzinom")
AND
("watchful-waiting"[tiab] OR "wait-and-see"[tiab] OR "expectant management"[tiab] OR "conservative management"[tiab] OR "deferred treatment"[tiab])

Trefferzahl: 162

Such-Strategie zum Stellenwert der active-surveillance-Strategie:

("Modul zur Identifikation von Publikationen zum Thema Prostatakarzinom")
AND
(Nach Ergebnisprüfung entfernt: Filter für Studienqualität)
AND ("active-surveillance"[tiab] OR "expectant management"[tiab])

Trefferzahl: 102

Eingeschlossene Volltexte: 7 aggregierte Evidenzquellen, 14 Primärstudien (im Hintergrundtext: 7 Publikationen als Kontextliteratur, 4 Publikationen zur Lebensqualität

Such-Strategie zum insignifikanten Prostatakarzinom (ab 1.1.2000- 23.5.2008): ((prostate OR prostatic) AND (*carcinoma OR tumor OR tumour OR cancer OR neoplas* OR malign*)) AND ("indolent" OR "clinically indolent" OR "clinically significant" OR "clinically insignificant")

Trefferzahl: 705

12.2.4.3. Insignifikantes Prostatakarzinom

Suchzeitraum: 1.1.1960 – 23.5.2008

Suchworte: ((prostate OR prostatic) AND (*carcinoma OR tumor OR tumour OR cancer OR neoplas* OR malign*)) AND ("indolent" OR "clinically indolent" OR "clinically significant" OR "clinically insignificant")

Trefferzahl: 705

Eingeschlossene Volltexte: 30 Einzelstudien, 1 syst. Review

12.2.5. Recherche zum Thema Lokale Therapie des lokal begrenzten Prostatakarzinoms

12.2.5.1. Recherche Radikale Prostatektomie

Recherchezeitraum: 1.1.2000 - 15.5.2007

Such-Strategie zum Stellenwert der radikalen Prostatektomie beim lokal betrenzten Prostatakarzinom:

"localized prostate cancer" OR "localised prostate cancer" OR "local prostate cancer" OR "localized prostatic carcinoma" OR "organ confined" OR "locally confined" OR "clinical localized disease" OR "localized tumor" OR "localized tumour" OR "localised tumour" OR "localised cancer*" OR "localized cancer*"
AND
(prostatectomy[ti] OR (postprostatectomy OR post-prostatectomy OR preprostatectomy OR pre-prostatectomy))

Trefferzahl: 714

Eingeschlossene Volltexte: 3 aggregierte Evidenzquellen, 3 Primärstudien

Weitere Primärliteratur zu Volumen vs. Morbidität bzw. Mortalität (Systematische Übersicht bei Nuttall et al., 2004) wurde durch die Autoren ergänzt.

12.2.5.2. Perkutane Strahlentherapie

Recherchezeitraum: 1.1.2000 - 23.1.2008

Such-Strategie zum Stellenwert der Strahlentherapie:

("Modul zur Identifikation von Publikationen zum Thema Prostatakarzinom")
AND
(radiotherapy[ti] OR radiotherapeutic[ti] OR radiation[ti] OR "Interstitial Radiation" OR brachytherapy[ti] OR "Dose Fractionation"[ti] OR fractionation[ti] OR fractionated[ti] OR Irradiation[ti])

Trefferzahl: 656

Eingeschlossene Volltexte: 4 aggregierte Evidenzquellen, 36 Primärstudien

12.2.5.3. LDR-Brachytherapie

Recherchezeitraum : 1.1.2000 - 21.5.2007

Such-Strategie zum Stellenwert der LDR-Brachytherapie/Seedbehandlung:

In Suchstrategie zu Strahlentherapie enthalten

Eingeschlossene Volltexte: 17 Primärstudien, 10 Publikationen zur Lebensqualität, 1 Publikation als Kontextliteratur

12.2.5.4. HDR-Brachytherapie

Recherchezeitraum: 1.1.2000- 21.5.2007

Asugewertet wurde Suchstrategie zur Strahlentherapie und zusätzlich:

Such-Strategie zum Stellenwert der HDR-Brachytherapie:

("high-dose-rate"[All Fields] OR "HDR"[All Fields] OR "hdr"[All Fields]) AND "Brachytherapy"[Mesh] AND "Prostatic Neoplasms"[Mesh] AND ((English[lang] OR German[lang]) AND (Meta-Analysis[ptyp] OR Practice Guideline[ptyp] OR Randomized Controlled Trial[ptyp] OR Review[ptyp]))

Trefferzahl: 22

Eingeschlossene Volltexte: 18 Primärstudien, 21 Publikationen als Kontextliteratur

12.2.5.5. Lymphadenektomie

Recherchezeitraum: 1.1.2000 - 10.09.2007

Such-Strategie zum Stellenwert der Lymphadenektomie:

Suchworte: lymphadenectomy[ti] OR lymphadenectomies[ti] OR "lymph node dissection"[ti] OR "lymph node dissections"[ti] OR "lymph node excision"[ti] OR "lymph node excisions"[ti]) AND prostat*[ti]

Trefferzahl: 83

Eingeschlossene Volltexte: 17 Primärstudien, 3 Publikationen als Kontextliteratur

12.2.5.6. Andere interventionelle Verfahren

1. Cryotherapie:

Suchzeitraum und Suchbegriffe:

(cryotherapy OR cryosurgery OR cryoablat*) AND ((prostate OR prostatic) AND (*carcinoma OR tumor OR tumour OR cancer OR neoplas* OR malign*)) AND (("2006/12/01"[EDat] : "2008/09/11"[EDat]))

Hier wurde aufgrund des erst seit wenigen Jahren eingesetzten Verfahrens ab 2006 gesucht.

Trefferzahl: 102

Eingeschlossene Volltexte: 3 aggregierte Evidenzquellen

2. High-intensity focused ultrasound (HIFU):
Recherchen für 1. Auflage 2009:

((high-intensity[tiab] AND ultrasound[tiab]) OR "focused ultrasound"[tiab])
AND ("Modul zur Identifikation von Publikationen zum Thema Prostatakarzinom")

Eingeschlossene Volltexte: 4 aggregierte Evidenzquellen, 15 Primärstudien

3. Hyperthermia
(hyperthermia[tiab] OR hypertherm*[tiab] OR thermotherap*[tiab] OR thermotherap*[tiab])
AND
("Modul zur Identifikation von Publikationen zum Thema Prostatakarzinom")

+ 4. Magnetfeld-Therapien:
((magnet*[ti] OR magnetic[tiab])
AND
("Modul zur Identifikation von Publikationen zum Thema Prostatakarzinom")

Eingeschlossene Volltexte: 5 Primärstudien

12.2.6. Recherche zum Thema Lokale Therapie des lokal fortgeschrittenen Prostatakarzinoms

12.2.6.1. Radikale Prostatektomie

Recherchedatum: 01.04.2008

Suchstrategie: (prostate OR prostatic) AND (*carcinoma OR tumor OR tumour OR cancer OR neoplas* OR malign*) AND Prostatectomy AND (advanced OR T3 OR T4) AND (survival OR prognosis OR relapse) Limits: **Entrez Date from 2000/01/01 to 2008/05/16, Humans, English, German**

Eingeschlossene Volltexte: 20 Primärstudien

12.2.6.2. Perkutane Strahlentherapie

Recherchedatum: 31.08.2008

Suchstrategie: ((prostate OR prostatic) AND (*carcinoma OR tumor OR tumour OR cancer OR neoplas* OR malign*)) (advanced OR T3 OR T4) AND radiotherapy AND (survival OR prognosis OR relapse) Limits: **Publication Date from 2000/01/01 to 2008/08/31**

Trefferzahl: 578

Eingeschlossene Volltexte: 3 aggregierte Evidenzquellen, 41 Primärstudien

12.2.6.3. HDR-Brachytherapie

Recherchedatum: 23.07.2008

Suchstrategie: **(**(prostate OR prostatic) AND (*carcinoma OR tumor OR tumour OR cancer OR neoplas* OR malign*)) AND ((("Brachytherapy"[Mesh]) OR (brachytherapy)) AND

("high-dose-rate" OR "high dose rate" OR "HDR" OR "hdr"))

Trefferzahl: 280

Eingeschlossene Volltexte: 9 Primärstudien

12.2.6.4. Lymphadenektomie beim lokal fortgeschrittenen PCa

Recherchedatum: 03.09.2008

Suchstrategie: ("Lymph Node Excision"[Mesh]) AND ((prostate OR prostatic) AND (*carcinoma OR tumor OR tumour OR cancer OR neoplas* OR malign*)) AND (("2000/01/01"[EDat] : "2008/09/03"[EDat]) AND (English[lang] OR German[lang]))

Trefferzahl: 337

Eingeschlossene Volltexte: 18 Primärstudien

12.2.6.5. Andere interventionelle Verfahren

Recherchedatum: 14.10.2008

Suchstrategie: (("Ultrasound, High-Intensity Focused, Transrectal"[Mesh]) OR (HIFU[tiab] OR "high-intensity focused ultrasound" OR "high intensity focused ultrasound")) AND ((prostate OR prostatic) AND (*carcinoma OR tumor OR tumour OR cancer OR neoplas* OR malign*)) Limits: **Publication Date from 2005/03/01 to 2008/10/14**

12.2.6.5.1. Stellenwert der HIFU beim lokal fortgeschrittenen PCa

Siehe Angaben zur Recherche HIFU beim lokal begrenzten PCa

12.2.6.5.2. Stellenwert der Kryotherapie beim lokal fortgeschrittenen PCa

Recherchedatum: 09.09.2008

Suchstrategie: (cryotherapy OR cryosurgery OR cryoablat*) AND ((prostate OR prostatic) AND (*carcinoma OR tumor OR tumour OR cancer OR neoplas* OR malign*)) AND (("2006/12/01"[EDat] : "2008/09/11"[EDat])) AND [Modul Prostata local fortgeschritten]

Eingeschlossene Volltexte: 3 aggregierte Evidenzquellen, 6 Primärstudien

12.2.6.6. Adjuvante perkutane Strahlentherapie

Recherchedatum: 13.01.2009

Suchstrategie: ((prostate[tiab] OR prostatic[tiab]) AND (*carcinoma[tiab] OR tumor[tiab] OR tumour[tiab] OR cancer[tiab] OR neoplas*[tiab] OR malign*[tiab])) AND ((randomized controlled trial[pt] OR controlled clinical trial[pt] OR randomized[tiab] OR placebo[tiab] OR clinical trials as topic[mesh:noexp] OR randomly[tiab] OR trial[ti]) AND humans[mh]) AND ((("Radiotherapy"[Mesh]) OR (radiation OR radiotherapy)) AND (adjuvant))

Trefferzahl: 203

Eingeschlossene Volltexte: 3 aggregierte Evidenzquellen, 9 Primärstudien

12.2.6.7. Therapie des lymphknotenpositiven Prostatakarzinoms

Recherchedatum: 06.02.2009

Suchstrategie: Search ((prostate[tiab] OR prostatic[tiab]) AND (*carcinoma[tiab] OR tumor[tiab] OR tumour[tiab] OR cancer[tiab] OR neoplas*[tiab] OR malign*[tiab])) AND ((randomized controlled trial[pt] OR controlled clinical trial[pt] OR randomized[tiab] OR placebo[tiab] OR clinical trials as topic[mesh:noexp] OR randomly[tiab] OR trial[ti]) AND humans[mh]) AND ("nodal disease"[tiab] OR "nodal involvement"[tiab] OR "node positive"[tiab] OR "node-positive"[tiab] OR "N+"[tiab] OR "N1"[tiab] OR "N2"[tiab] OR "N3"[tiab] OR "lymph node spread"[tiab] OR "lymph node metastasis"[tiab] OR "node involvement"[tiab]) AND (treatment[tiab] OR therapy[tiab] OR intervention[tiab] AND (("2000/01/01"[PDat] : "2009/02/06"[PDat])))

Trefferzahl: 259

Eingeschlossene Volltexte: 1 aggregierte Evidenzquelle, 11 Primärstudien

12.2.6.8. Neoadjuvante und adjuvante Hormontherapie des lokal begrenzten und des lokal fortgeschrittenen Prostatakarzinoms

Recherchedatum: 03.09.2008

Such-Strategie zum Stellenwert der adjuvanten Therapie:

adjuvant[ti] OR adjuvant*[ti])
AND ((prostat*[ti] OR
("Modul zur Identifikation von Publikationen zum Thema Prostatakarzinom"))

Such-Strategie zum Stellenwert der neo-adjuvanten Therapie:

neo-adjuvant[ti] OR neoadjuvant*[ti]) AND
((prostat*[ti] OR ("Modul zur Identifikation von Publikationen zum Thema Prostatakarzinom"))

Ergebnis: 1 aggregierte Evidenzquelle, 3 Primärstudien, 19 Publikationen als Kontextliteratur

Such-Strategie zum Stellenwert der Hormontherapie:

("Modul zur Identifikation von Publikationen zum Thema Prostatakarzinom")
AND
((Therapeutics[mh] OR therapy[majr] OR "therapeutic use"[sh])
AND (therap*[tiab] OR treat*[tiab] OR manage*[tiab] OR strategy[tiab] OR procedure[tiab] OR administ*[tiab] OR respon*[tiab] OR medication[tiab] OR care[tiab] OR caring[tiab]))
AND
(Block zur Identifikation von Therapie-Studien guter Qualität) OR (Randomized Controlled Trial[pt] OR Randomized Controlled Trials[mh] OR Controlled Clinical Trial[pt] OR Clinical Trial, Phase I[pt] OR Clinical Trial, Phase II[pt] OR Clinical Trial, Phase III[pt] OR Clinical Trial, Phase IV[pt] OR Multicenter Studies[mh] OR Comparative Study[mh] OR Clinical Trial[pt] OR Clinical Trials[mh] OR Statistics[mh] OR Statistics, Nonparametric[mh] OR statistics and numerical data[sh] OR Follow-up Studies[mh] OR random allocation[mh])))
AND
(("Androgen Antagonists" OR "Anti Androgen" OR "Antiandrogenic Agent" OR "Anti-

androgenic Drug" OR (Bicalutamide OR Cyoctol OR Cyproterone OR "Cyproterone Acetate" OR Epitestosterone OR Flutamide OR Hydroxyflutamide "Inocoterone Acetate" OR "Lavanducyanin" OR Methylestrenolone OR Nilutamide OR "Osaterone Acetate" OR Oxendolon OR Propylmesterolone OR Spironolactone OR Topterone "Trichloro Alpha Chloromethyl Alpha Hydroxypropionanilide" OR "Alpha,Alpha,Alpha Trifluoro 2 Methyl 4 Nitro Meta Lactotoluidide" OR "WS 9659 B" OR Zanoterone)) OR (Hormon*[ti] AND prostat*[ti]))

Eingeschlossene Volltexte: 4 aggregierte Evidenzquellen, 30 Primärstudien

A) Quellen aggregierter Evidenz und B) Primärliteratur

Siehe zu diesem Kapitel auch die Angaben in den Kapitel zur Strahlentherapie und radikalen Prostatektomie

12.2.6.9. Primäre Hormontherapie und Watchful Waiting

Recherchedatum: 19.7.2007, 23.7.2008

Suchsstrategie: (prostate OR prostatic) AND (*carcinoma OR tumor OR tumour OR cancer OR neoplas* OR malign*) AND advanced AND ((watchful AND waiting) OR (wait AND see) OR (expectant AND management) OR (conservative AND management) OR (deferred AND treatment))

Trefferzahl: 94

Eingeschlossene Volltexte: 6 aggregierte Evidenzquellen, 16 Primärstudien

12.2.7. Recherche zum Thema Diagnostik und Therapie des rezidivierten oder metastasierten Prostatakarzinoms

Dieses Kapitel wurde auf der Basis der Quell-Leitlinien [3; 5; 6] sowie aufgrund von Literatur erstellt, die durch die Autorengruppe eingebracht wurde.

12.2.7.1. Therapie des PSA-Rezidivs / der PSA-Progression sowie der PSA-Persistenz

Recherchedatum: 07.02.2009

Suchstrategie: (("Salvage Therapy"[Mesh]) OR ("Recurrence"[Mesh]) OR (recurrence OR relapse) OR salvage) AND ((prostate[tiab] OR prostatic[tiab]) AND (*carcinoma[tiab] OR tumor[tiab] OR tumour[tiab] OR cancer[tiab] OR neoplas*[tiab] OR malign*[tiab])) AND ((randomized controlled trial[pt] OR controlled clinical trial[pt] OR randomized[tiab] OR placebo[tiab] OR clinical trials as topic[mesh:noexp] OR randomly[tiab] OR trial[ti]) AND humans[mh]) Limits: Publication Date from 2000/01/01 to 2009/02/07

Trefferzahl: 360

Eingeschlossene Volltexte: 3 aggregierte Evidenzquellen, 12 Primärstudien

Literatur zur PSA-Persistenz wurde von den Autoren eingebracht

12.2.7.2. Hormontherapie des metastasierten Prostatakarzinoms

Recherchedatum: 21.10.2008

Suchstrategie: ((prostate[tiab] OR prostatic[tiab]) AND (*carcinoma[tiab] OR tumor[tiab] OR tumour[tiab] OR cancer[tiab] OR neoplas*[tiab] OR malign*[tiab])) AND ("Androgen Antagonists"[tiab] OR "Anti Androgen"[tiab] OR "Antiandrogenic Agent"[tiab] OR "Anti-androgenic Drug"[tiab] OR hormone[tiab] OR hormonal[tiab] OR endocrin*[tiab]) AND ((randomized controlled trial[pt] OR controlled clinical trial[pt] OR randomized[tiab] OR placebo[tiab] OR clinical trials as topic[mesh:noexp] OR randomly[tiab] OR trial[ti]) AND humans[mh]) Limits: **Publication Date from 2000/01/01 to 2008/10/21, English, German**

Trefferzahl: 769

Eingeschlossene Volltexte: 4 aggregierte Evidenzquellen, 6 Primärstudien

12.2.7.3. Therapie des androgenunabhängigen oder kastrationsresistenten PCa

Recherchedatum: 22.10.2008

Suchstrategie: ((prostate[tiab] OR prostatic[tiab]) AND (*carcinoma[tiab] OR tumor[tiab] OR tumour[tiab] OR cancer[tiab] OR neoplas*[tiab] OR malign*[tiab])) AND ("hormone-refractory" OR "hormone refractory" OR chemotherapy[tiab] OR docetaxel[tiab] OR prednisolone[tiab] OR mitoxanthrone[tiab] OR dexamethasone OR ketoconazole OR hydrocortisone OR thalidomide OR doxorubicin OR paclitaxel OR carboplatin OR estramustine OR vinblastine) AND ((randomized controlled trial[pt] OR controlled clinical trial[pt] OR randomized[tiab] OR placebo[tiab] OR clinical trials as topic[mesh:noexp] OR randomly[tiab] OR trial[ti]) AND humans[mh]) Limits: **Entrez Date from 2000/01/01 to 2008/10/22, English, German**

Trefferzahl:

Eingeschlossene Volltexte: 1 aggregierte Evidenzquelle, 7 Primärstudien

12.2.7.4. Therapie von Knochenmetastasen

Recherchedatum: 14.2.2009

Suchstrategie: ((prostate[tiab] OR prostatic[tiab]) AND (*carcinoma[tiab] OR tumor[tiab] OR tumour[tiab] OR cancer[tiab] OR neoplas*[tiab] OR malign*[tiab])) AND (bone AND (metastasis OR metastases)) AND ("Radioisotopes"[Mesh]) OR radionuclide*[tiab] OR"Radiotherapy"[Mesh] OR radiation OR radiotherapy OR ("Diphosphonates"[Mesh])) AND ((randomized controlled trial[pt] OR controlled clinical trial[pt] OR randomized[tiab] OR placebo[tiab] OR drug therapy[sh] OR randomly[tiab] OR trial[tiab] OR groups[tiab]) AND humans[mh]) Limits: **Publication Date from 2000/01/01 to 2009/02/14**

Trefferzahl: 385

Eingeschlossene Volltexte Strahlentherapie: 1 aggregierte Evidenzquelle, 5 Primärstudien

Eingeschlossene Volltexte Radionuklide: 2 aggregierte Evidenzquellen, 2 Primärstudien

Eingeschlossene Volltexte Bisphosphonate: 1aggregierte Evidenzquelle, 5 Primärstu-

dien

(2 Primärstudien, Saad 2002 und Saad 2004, nach Konsultation ergänzt)

12.2.7.5. Therapie der tumorbedingten Harnstauung

Recherchedatum: 22.7.2007

Such-Strategie zur Therapie der Harnstauungsniere bei kastrationsresistentem Prostatakarzinom:

((("hydronephrosis"[MeSH Terms] OR Hydronephrosis[Text Word]) OR "Ureteral obstruction"[All Fields]) AND ("Pelvic Neoplasms"[Mesh] OR "Prostatic Neoplasms"[Mesh]) AND (("2002/07/02"[PDAT] : "2007/07/02"[PDAT]) AND "humans"[MeSH Terms] AND (English[lang] OR German[lang]))
((("pelvic neoplasms"[TIAB] NOT Medline[SB]) OR "pelvic neoplasms"[MeSH Terms] OR pelvic cancer[Text Word]) OR ((("prostatic neoplasms"[TIAB] NOT Medline[SB]) OR "prostatic neoplasms"[MeSH Terms] OR prostate cancer[Text Word]) AND ("locally advanced"[All Fields] OR "Metastatic"[All Fields]))) AND (("stents"[TIAB] NOT Medline[SB]) OR "stents"[MeSH Terms] OR Stent[Text Word])

Eingeschlossene Volltexte: 14 Primärstudien

12.2.7.6. Supportiv- und Palliativtherapie

Für den Abschnitt Supportivtherapie wurden zusätzllich zu den Quell-Leitlinien weitere Leitlinien und Primärliteratur von den Autoren eingebracht.

Für den Abschnitt Palliativtherapie erfolgte im Februar 2009 eine systematische Suche nach themenbezogenen Leitlinien. Nach Sichtung und Bewertung der Ergebnisse wurden neben den Quell-Leitlinien [3; 5; 6] die evidenzbasierten Leitlinien ‚Hausärztliche Leitlinie Palliativversorgung' der Leitliniengruppe Hessen 2009 [18], die Therapieempfehlungen der deutschen Arzneimittelkommission zu Tumorschmerz [19], die ‚Clinical practice guideline' des ‚American College of Physicians' 2008 zu Palliativversorgung [20], die NCCN-Leitlinie 2008 zu Palliativmedizin [21] und die S3-Leitlinie zur Diagnostik, Therapie und Nachsorge des Mammakarzinoms 2008 [22] herangezogen.

12.2.8. Recherche zum Thema Rehabilitation und Nachsorge

12.2.8.1. Rehabilitation nach kurativer Therapie

Recherchedatum: 08.10.2008

Suchstrategie: (((prostate OR prostatic) AND (*carcinoma OR tumor OR tumour OR cancer OR neoplas* OR malign*)) AND (rehabilitation OR "recovery of function"[mh] OR "exercise"[mh] OR "education"[mh] OR "counseling"[mh])) OR (((prostate OR prostatic) AND (*carcinoma OR tumor OR tumour OR cancer OR neoplas* OR malign*)) AND (rehabilitation OR "recovery of function"[tiab] OR "exercise"[tiab] OR "education"[tiab] OR "counseling"[tiab]))) AND ((randomized controlled trial[pt] OR controlled clinical trial[pt] OR randomized[tiab] OR placebo[tiab] OR drug therapy[sh] OR randomly[tiab] OR trial[tiab] OR groups[tiab]) AND humans[mh])

Trefferzahl: 565

Eingeschlossene Volltexte: 1 aggregierte Evidenzquelle, 7 Primärstudien

12.2.8.2. Nachsorge und Verlaufskontrollen

Diese beiden Abschnitte wurden unter Bezugnahme der Quell-Leitlinien [3; 5; 6] und aufgrund von Literatur, die durch die Autoren beigetragen wurde, erstellt.

12.2.8.3. Testosteronsubstitution

Siehe Recherche zur Testosteronsubstitution in Abschnitt 14.2.1.3.

12.2.9. Recherche zum Thema Psychosoziale Aspekte und Lebensqualität

Recherchedatum: 15.11.2007

Die Studien zu psychosozialen Aspekten und Lebensqualität sind in ihrem Design nicht in das verwendetet SIGN-Schema einzuordnen, deshalb wurden sie nicht in Evidenztabellen extrahiert.

12.3. Methodik und Ergebnisse der Recherchen zur 1. Aktualisierung 2011

12.3.1. Recherche zum Thema Stellenwert der Früherkennung / Screening

12.3.1.1. Fragestellung

Population	Intervention	Kontrolle	Outcomes	Time aspects
Menschen ohne bekanntes Prostatakarzinom	Screeningprogramm zur Früherkennung eines Prostatakarzinoms	Normalversorgung	Gesamtmortalität Prostatakrebsspezifische Mortalität Morbidität (PSA-Kinetik, Histologie) Lebensqualität Nebenwirkungen/ Schäden	Keine Einschränkungen

12.3.1.2. Recherchestrategien

Ausschlusskriterien für erste Relevanzsichtung:

A1: andere Erkrankung

A2: anderes Thema (z. B. Therapie, animal testing, in vitro)

A3: anderer Publikationstyp (nicht RCT oder SR oder Metaanalyse oder HTA aus Europa)

PubMed (10. Februar 2011)

Nr.	Suchfrage	Anzahl
#8	#3 AND #6 Limits: English, German, Publication date from 2007/08	571
#7	#3 AND #6	1763
#6	#4 OR #5	2166383
#5	(randomized controlled trial [pt] OR controlled clinical trial [pt] randomized [tiab] OR placebo [tiab] OR drug therapy [sh] OR randomly [tiab] OR trial [tiab] OR groups [tiab]) AND humans [mh]	2062287
#4	systematic[sb]	149480
#3	#1 AND #2	6774
#2	"screening"[All Fields] OR "mass screening"[MeSH Terms] OR "early detection of cancer"[MeSH Terms] OR "early detection of cancer"[All Fields]	303453
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	91664

Anzahl der Treffer: 571

Davon relevant: 298

Cochrane (03. Januar 2011)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and screening in Title, Abstract or Keywords, from 2007 to 2011	139

- Cochrane Database of Systematic Reviews (4)
- Database of Abstracts of Reviews of Effects (2)
- Cochrane Central Register of Controlled Trials (122)
- Cochrane Methodology Register (3)
- Health Technology Assessment Database (1)
- NHS Economic Evaluation Database (7)

Anzahl der Treffer: 139

Davon neu: 45

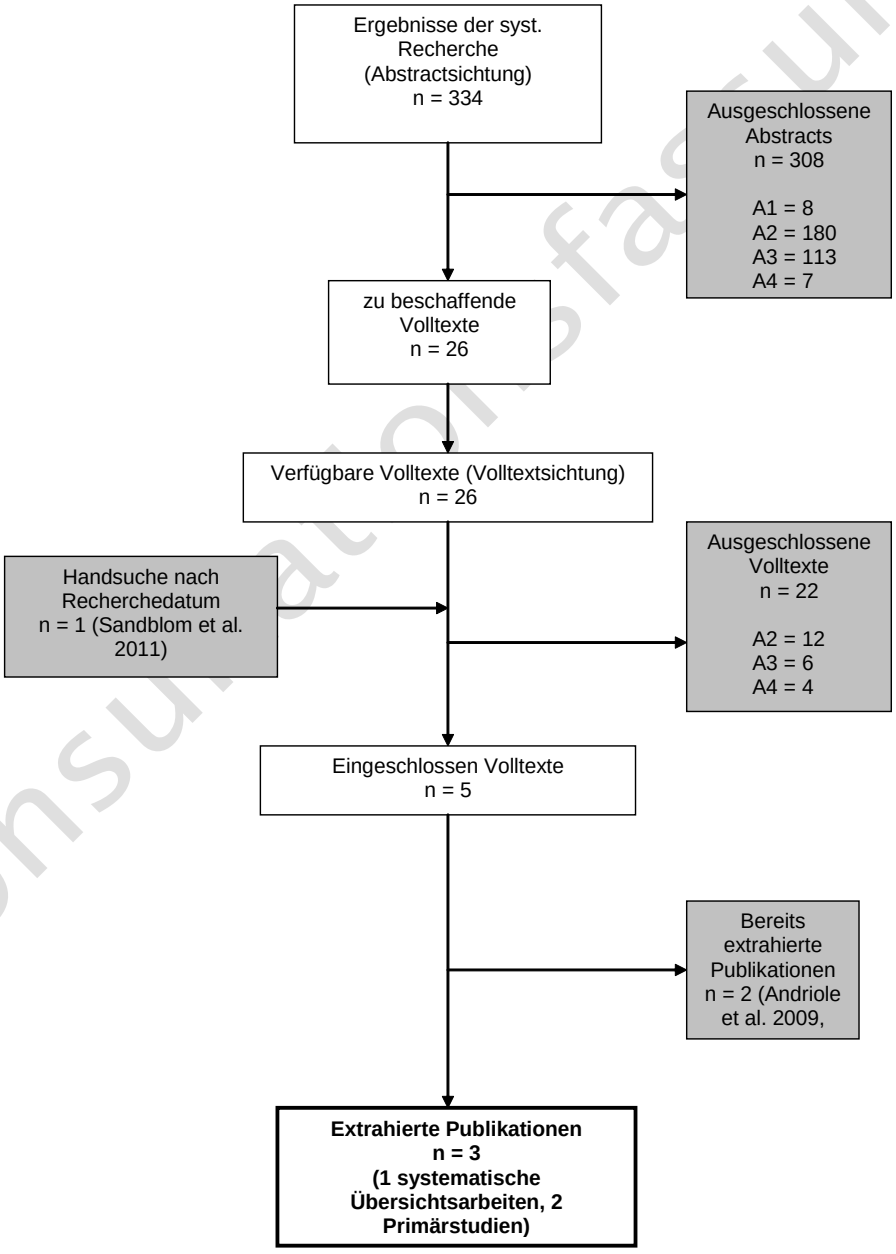
Davon relevant: 36

12.3.1.3. Ein- und Ausschlusskriterien

Einschlussgründe	
E1 Zielgruppe	Patienten ohne bekanntes Prostatakarzinom
E2 Publikationstyp	Randomisierte kontrollierte Studien (RCTs) oder systematische Übersicht mit/ohne Metaanalyse oder HTA aus RCTs
E3:	Publikationen seit August 2008 (letzte Recherche S3 Leitlinien-Gruppe)

Einschlussgründe	
Suchzeitraum	
E4: Sprachen	deutsch, englisch
E5 Intervention	Screening (Untersuchung einer gesunden Population) auf Prostatakarzinom
Ausschlussgründe	
A1	andere Erkrankung
A2	Nicht Fragestellung (siehe oben)
A3	Anderer Publikationstyp (Editorial, Fallbericht, Brief etc.)
A4	Doppelpublikation oder aktuellere Publikation vorhanden

12.3.1.4. Ergebnisse der Recherche



12.3.1.4.1. Eingeschlossene Publikationen

1. Djulbegovic M, Beyth RJ, Neuberger MM, Stoffs TL, Vieweg J, Djulbegovic B, Dahm P. Screening for prostate cancer: systematic review and meta-analysis of randomised controlled trials. BMJ 2010;341:c4543.
2. Hugosson J, Carlsson S, Aus G, Bergdahl S, Khatami A, Lodding P, Pihl CG, Stranne J, Holmberg E, Lilja H. Mortality results from the Goteborg randomised population-based prostate-cancer screening trial. Lancet Oncol 2010;11(8):725-32.
3. Andriole GL, Crawford ED, Grubb RL, III, Buys SS, Chia D, Church TR, Fouad MN, Gelmann EP, Kvale PA, Reding DJ, Weissfeld JL, Yokochi LA, O'Brien B, Clapp JD, Rathmell JM, Riley TL, Hayes RB, Kramer BS, Izmirlian G, Miller AB, Pinsky PF, Prorok PC, Gohagan JK, Berg CD. Mortality results from a randomized prostate-cancer screening trial. N Engl J Med 2009;360(13):1310-9.
4. Schroder FH, Hugosson J, Roobol MJ, Tammela TL, Ciatto S, Nelen V, Kwiatkowski M, Lujan M, Lilja H, Zappa M, Denis LJ, Recker F, Berenguer A, Maattanen L, Bangma CH, Aus G, Villers A, Rebillard X, van der KT, Blijenberg BG, Moss SM, de Koning HJ, Auvinen A. Screening and prostate-cancer mortality in a randomized European study. N Engl J Med 2009;360(13):1320-8.

12.3.1.4.2. Ausgeschlossene Publikationen (Volltextscreening)

Ausschlussgrund A2: Anderes Thema (nicht Fragestellung)

1. Kilpelainen TP, Tammela TL, Maattanen L, Kujala P, Stenman UH, la-Opas M, Murtola TJ, Auvinen A. False-positive screening results in the Finnish prostate cancer screening trial. Br J Cancer 2010;102(3):469-74.
2. Kilpelainen TP, Auvinen A, Maattanen L, Kujala P, Ruutu M, Stenman UH, Tammela TL. Results of the three rounds of the Finnish Prostate Cancer Screening Trial--the incidence of advanced cancer is decreased by screening. Int J Cancer 2010;127(7):1699-705.
3. van Leeuwen PJ, Connolly D, Gavin A, Roobol MJ, Black A, Bangma CH, Schroder FH. Prostate cancer mortality in screen and clinically detected prostate cancer: estimating the screening benefit. Eur J Cancer 2010;46(2):377-83.
4. Wolters T, Roobol MJ, Steyerberg EW, van den Bergh RC, Bangma CH, Hugosson J, Ciatto S, Kwiatkowski M, Villers A, Lujan M, Nelen V, Tammela TL, Schroder FH. The effect of study arm on prostate cancer treatment in the large screening trial ERSPC. Int J Cancer 2010;126(10):2387-93.
5. Bergdahl AG, Aus G, Lilja H, Hugosson J. Risk of dying from prostate cancer in men randomized to screening: differences between attendees and nonattendees. Cancer 2009;115(24):5672-9.
6. Croswell JM, Kramer BS, Kreimer AR, Prorok PC, Xu JL, Baker SG, Fagerstrom R, Riley TL, Clapp JD, Berg CD, Gohagan JK, Andriole GL, Chia D, Church TR, Crawford ED, Fouad MN, Gelmann EP, Lamerato L, Reding DJ, Schoen RE. Cumulative incidence of false-positive results in repeated, multimodal cancer screening. Ann Fam Med 2009;7(3):212-22.
7. Roobol MJ, Kerkhof M, Schroder FH, Cuzick J, Sasieni P, Hakama M, Stenman UH, Ciatto S, Nelen V, Kwiatkowski M, Lujan M, Lilja H, Zappa M, Denis L, Recker F, Berenguer A, Ruutu M, Kujala P, Bangma CH, Aus G, Tammela TL, Villers A, Rebillard X, Moss SM, de Koning HJ, Hugosson J, Auvinen A. Prostate cancer mortality reduction by prostate-specific antigen-based screening adjusted for nonattendance and contamination in the European Randomised Study of Screening for Prostate Cancer (ERSPC). Eur Urol 2009;56(4):584-91.
8. Grubb RL, Pinsky PF, Greenlee RT, Izmirlian G, Miller AB, Hickey TP, Riley TL, Mabie JE, Levin DL, Chia D, Kramer BS, Reding DJ, Church TR, Yokochi LA, Kvale PA, Weissfeld JL, Urban DA, Buys SS, Gelmann EP, Ragard LR, Crawford ED, Prorok PC, Gohagan JK, Berg CD, Andriole GL. Prostate cancer screening in the Prostate, Lung, Colorectal and Ovarian cancer screening trial: update on findings from the initial four rounds of screening in a randomized trial. BJU international 2008;102:1524-30.
9. Stephens RL, Xu Y, Volk RJ, Scholl LE, Kamin SL, Holden EW, Stroud LA. Influence of a patient decision aid on decisional conflict related to PSA testing: a structural equation model. Health Psychol 2008;27(6):711-21.
10. Carlsson S, Aus G, Wessman C, Hugosson J. Anxiety associated with prostate can-

cer screening with special reference to men with a positive screening test (elevated PSA) - Results from a prospective, population-based, randomised study. European journal of cancer 2007;43:2109-16.
11. Postma R, Schröder FH, van-Leenders GJ, Hoedemaeker RF, Vis AN, Roobol MJ, van-der-Kwast TH. Cancer detection and cancer characteristics in the European Randomized Study of Screening for Prostate Cancer (ERSPC)--Section Rotterdam. A comparison of two rounds of screening. European urology 2007;52:89-97.
12. Volk RJ, Hawley ST, Kneuper S, Holden EW, Stroud LA, Cooper CP, Berkowitz JM, Scholl LE, Saraykar SS, Pavlik VN. Trials of decision aids for prostate cancer screening: a systematic review. Am J Prev Med 2007;33(5):428-34.#

Ausschlussgrund A3: Anderer Publikationstyp (Editorial, Fallbericht, Brief etc.)

1. Brooks DD, Wolf A, Smith RA, Dash C, Guessous I. Prostate cancer screening 2010: updated recommendations from the American Cancer Society. J Natl Med Assoc 2010;102(5):423-9.
2. Wolf AM, Wender RC, Etzioni RB, Thompson IM, D'Amico AV, Volk RJ, Brooks DD, Dash C, Guessous I, Andrews K, DeSantis C, Smith RA. American Cancer Society guideline for the early detection of prostate cancer: update 2010. CA Cancer J Clin 2010;60(2):70-98.
3. Boyle P, Brawley OW. Prostate cancer: current evidence weighs against population screening. CA Cancer J Clin 2009;59(4):220-4.
4. Greene KL, Albertsen PC, Babaian RJ, Carter HB, Gann PH, Han M, Kuban DA, Sartor AO, Stanford JL, Zietman A, Carroll P. Prostate specific antigen best practice statement: 2009 update. J Urol 2009;182(5):2232-41.
5. Kjellman A, Akre O, Norming U, Tornblom M, Gustafsson O. 15-year followup of a population based prostate cancer screening study. J Urol 2009;181(4):1615-21.
6. Schroder FH. Screening for prostate cancer (PC)--an update on recent findings of the European Randomized Study of Screening for Prostate Cancer (ERSPC). Urol Oncol 2008;26(5):533-41.

Ausschlussgrund A4: Doppelpublikation, veraltete Publikation

1. Bryant RJ, Hamdy FC. Screening for prostate cancer: an update. Eur Urol 2008;53(1):37-44.
2. Aus G, Bergdahl S, Lodding P, Lilja H, Hugosson J. Prostate cancer screening decreases the absolute risk of being diagnosed with advanced prostate cancer--results from a prospective, population-based randomized controlled trial. European urology 2007;51:659-64.
3. Ilic D, O'Connor D, Green S, Wilt T. Screening for prostate cancer: a Cochrane systematic review (Brief record). Cancer Causes and Control 2007;18:279-85.
4. Lin K, Lipsitz R, Miller T, Janakiraman S. Benefits and Harms of Prostate-Specific Cancer Screening: An Evidence Update for the U.S. Preventive Services Task Force. Evidence Synthesis No. 63. AHRQ Publication No. 08-05121-EF-1. Rockville, Maryland: Agency for Healthcare Research and Quality. August 2008.

12.3.2. Recherche zu den Fragestellungen im Kapitel Diagnostik und Stadieneinteilung

12.3.2.1. Fragestellungen

Population	Intervention	Control	Referenzstandard	Outcomes	Time aspects
Patienten mit V.a. Prostatakarzinom	TRUS – (Graustufen-sonographie)	Systematische Biopsie	Histologie vorzugsweise aus OP-Präparat	Testgüteparameter	Ab 10/2007 bis 1/2011
Patienten mit V.a.	Sonographie	TRUS - gesteuerte	Histologie vorzugs-	Testgüteparameter	Ab 10/2007 bis 1/2011

Population	Inter-vention	Control	Referenz-standard	Outcomes	Time aspects
Prostata-karzinom	kontrast-verstärkte	Biopsie	weise aus OP-Präparat	Klinische Konsequen-zen	
Patienten mit V.a. Prostata-karzinom	Elasto-graphie	TRUS	Histologie vorzugs-weise aus OP-Präparat	Testgüte-parameter klinische Konsequen-zen	Ab 01/2000, da neues Thema
Patienten mit V.a. Prosta-takarzinom	Histo-scanning	gesteuerte Biopsie			
Patienten mit V.a. Prostata-karzinom	MRT – ein-schließ-lich MRS, DCE-MRT und diff. gew. MRT	TRUS ges-teuerte sys-tematische Biopsie	Histologie vorzugs-weise aus OP-Präparat	Testgüte parameter für Diagnose und lokales Staging Klinische Konsequen-zen	Ab 10/2007 bis 12/2010
Patienten mit persis-tierend er-höhtem PSA-Wert nach mind. 1 negativer Biopsie	MRT ein-schließ-lich MRS, DCE MRT und diff. gew. MRT + MRT gesteuer-te oder TRUS ge-steuerte systema-tische Biopsie	TRUS ges-teuerte sys-tematische Biopsie	Histologie vorzugs-weise aus OP-Präparat	Testgüte-parameter für Diagnose Klinische Konsequen-zen	Ab 10/2007 bis 12/2010
Patienten mit durch Biopsie nach-gewiese-nem Pros-tata-karziom	Cholin PET/CT zum Staging	MRT, Kno-chen-szinitgraphie, ggf. Keine Kon-trollgruppe	Histologie vorzugs-weise aus OP-Präparat	Testgüte-parameter für Staging Klinische Konsequen-zen	Ab 2000 bis 12/2010

12.3.2.2. Recherchen

12.3.2.2.1. Histoscanning

Prostate AND Cancer AND (Histoscanning OR "computer-aided ultrasonography" OR computer aided ultrasonography) AND diagnosis

12.3.2.2.2. Elastographie

PubMed (19. Dezember 2010)

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 Limits: English, German	66
#3	#1 AND #2	67
#2	Elastography (Details: "elasticity imaging techniques"[MeSH Terms] OR ("elasticity"[All Fields] AND "imaging"[All Fields] AND "techniques"[All Fields]) OR "elasticity imaging techniques"[All Fields] OR "elastography"[All Fields])	2065
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	90615

Anzahl der Treffer: 66

Cochrane (19. Dezember 2010)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and elastography OR elasticity imaging in Title, Abstract or Keywords	1

- Cochrane Database of Systematic Reviews (0)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (1)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (0)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 1

Davon neu: 0

12.3.2.2.3. Sonographie

Ausschlusskriterien für erste Relevanzsichtung:

A1: andere Erkrankung

A2: anderes Thema (nicht Diagnose)

A3: Methodik (Letter, Editorial u.ä.)

PubMed (19. Dezember 2010)

Nr.	Suchfrage	Anzahl
#4	Search #1 AND #2 Limits: English, German, Publication date from 2007/10	479
#3	#1 AND #2	3483
#2	Ultrasonography (Details: "ultrasonography"[Subheading] OR "ultrasonography"[All Fields] OR "ultrasonography"[MeSH Terms])	294615
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	90615

Anzahl der Treffer: 479

Davon relevant: 212

Cochrane (19. Dezember 2010)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and ultrasonography in Title, Abstract or Keywords, from 2007 to 2010	24

- Cochrane Database of Systematic Reviews (1)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (21)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (2)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 24

Davon neu: 8

Davon relevant: 5

12.3.2.2.4. MRT

Ausschlusskriterien für erste Relevanzsichtung

A1: andere Erkrankung

A2: anderes Thema (nicht Primärdiagnostik)

A3: Methodik (Letter, Editorial u.ä., Fallberichte, Feasibility Studie)
A4: nicht systematischer Review

A5: retrospektiv

A6 >20

PubMed (10. Dezember 2010)

Nr.	Suchfrage	Anzahl
#4	Search #1 AND #2 Limits: English, German, Publication date from 2007/10	668
#3	#1 AND #2	2342
#2	Magnetic Resonance Imaging (Details: "magnetic resonance imaging"[MeSH Terms] OR ("magnetic"[All Fields] AND "resonance"[All Fields] AND "imaging"[All Fields]) OR "magnetic resonance imaging"[All Fields])	267768
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	90394

Anzahl der Treffer: 668

Davon relevant: 298

Cochrane (10. Dezember 2010)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and magnetic resonance imaging in Title, Abstract or Keywords, from 2007 to 2010	19

- Cochrane Database of Systematic Reviews (0)
- Database of Abstracts of Reviews of Effects (3)
- Cochrane Central Register of Controlled Trials (13)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (1)
- NHS Economic Evaluation Database (2)

Anzahl der Treffer: 19

Davon neu: 7

Davon relevant: 2

12.3.2.2.5. PET/CT

Ausschlusskriterien für erste Relevanzsichtung

A1: andere Erkrankung

A2: anderes Thema (nicht Staging)

A3: Methodik (Letter, Editorial u.ä.)

A4: retrospektiv

A5 < 25

A6 kein PET/CT

PubMed (19. Dezember 2010)

Nr.	Suchfrage	Anzahl
#4	#1 AND #4 Limits: English, German	322
#5	#1 AND #4	345
#4	#2 AND #3	21237
#3	Positron emission tomography (Details: "positron-emission tomography"[MeSH Terms] OR ("positron-emission"[All Fields] AND "tomography"[All Fields]) OR "positron-emission tomography"[All Fields] OR ("positron"[All Fields] AND "emission"[All Fields] AND "tomography"[All Fields]) OR "positron emission tomography"[All Fields])	35755
#2	Computed tomography (Details: "tomography, x-ray computed"[MeSH Terms] OR ("tomography"[All Fields] AND "x-ray"[All Fields] AND "computed"[All Fields]) OR "x-ray computed tomography"[All Fields] OR ("computed"[All Fields] AND "tomography"[All Fields]) OR "computed tomography"[All Fields])	313143
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	90615

Anzahl der Treffer: 322

Davon relevant: 212

Cochrane (19. Dezember 2010)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and computed tomography in Title, Abstract or Keywords and positron emission tomography in Title, Abstract or Keywords	5

- Cochrane Database of Systematic Reviews (0)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (5)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (0)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 5

Davon neu: 1

Davon relevant: 0

12.3.2.3. Ausschlusskriterien

12.3.2.3.1. Histoscanning

A1: andere Erkrankung

A2: andere Fragestellung

A3: anderer Publikationstyp (keine Studie/Review, Fallberichte)/inadäquate Methodik

A4: unsystematischer Review

12.3.2.3.2. Elastographie

A1: andere Erkrankung

A2: anderer Publikationstyp (keine Studie/Review, Fallberichte (bis n=9))

A3: erkennbar unsystematischer Review

A4: anderes Thema/hauptsächlich Biopsietechniken

A5: Doppelpublikation oder nicht erhältlich

12.3.2.3.3. Sonographie

A1: andere Erkrankung

A2: anderes Thema (nicht Diagnose)

A3: Methodik (Letter, Editorial u.ä.)

A4: retrospektive Studien

A5: unsystematischer Review

A6: bereits in extrahiertem Review enthalten

A7: Doppelpublikation oder nicht erhältlich

12.3.2.3.4. MRT

A1: andere Erkrankung

A2: anderes Thema (nicht Primärdiagnostik)

A3: Methodik (Letter, Editorial u.ä., Fallberichte, Feasibility Studie)

A4: nicht systematischer Review

A5: n ≤ 50

A6: bereits in extrahiertem Review enthalten

A7: Doppelpublikation oder nicht erhältlich

12.3.2.3.5. PET/CT

A1: andere Erkrankung

A2: anderes Thema (nicht Staging)

A3: Methodik (Letter, Editorial u.ä.)

A4: retrospektiv

A5: nicht systematischer Review

A6: < 25

A7: kein PET/CT

A8: Doppelpublikation oder nicht erhältlich

12.3.2.4. Rechercheergebnisse

12.3.2.4.1. Histoscanning

Insgesamt 15 Treffer, davon 6 Volltexte bestellt und 2 Publikationen eingeschlossen

Eingeschlossene Volltexte:

5. Braeckman J, Autier P, Garbar C, Marichal MP, Soviany C, Nir R, Nir D, Michielsen D, Bleiberg H, Egevad L, Emberton M. Computer-aided ultrasonography (HistoScanning): a novel technology for locating and characterizing prostate cancer. BJU Int 2008;101(3):293-8.
6. Braeckman J, Autier P, Soviany C, Nir R, Nir D, Michielsen D, Treurnicht K, Jarmulowicz M, Bleiberg H, Govindaraju S, Emberton M. The accuracy of transrectal ultrasonography supplemented with computer-aided ultrasonography for detecting

small prostate cancers. BJU Int 2008;102(11):1560-5.

Ausgeschlossene Volltexte

A2 (andere Fragestellung)

1. Aigner F, Frauscher F. RE: Computer-aided ultrasonography (HistoScanning): a novel technology for locating and characterizing prostate cancer. BJU Int 2009;103(1):115-6.

A3 (anderer Publikationstyp (keine Studie/Review, Fallberichte)/inadäquate Methodik)

1. Dinter DJ, Weidner AM, Wenz F, Pelzer AE, Michel MS, Schoenberg SO. Bildgebung der Prostata. Der Urologe Ausg A 2010;49(8):963-75.

A4 (unsystematischer Review)

1. Moradi M, Mousavi P, Abolmaesumi P. Computer-aided diagnosis of prostate cancer with emphasis on ultrasound-based approaches: a review. Ultrasound Med Biol 2007;33(7):1010-28.
2. Ukimura O. Evolution of precise and multimodal MRI and TRUS in detection and management of early prostate cancer. Expert Rev Med Devices 2010;7(4):541-54.

12.3.2.4.2. Elastographie

Insgesamt 66 Treffer, davon 35 Volltexte bestellt und 14 Publikationen eingeschlossen

Eingeschlossene Volltexte:

1. Tsutsumi M, Miyagawa T, Matsumura T, Kawazoe N, Ishikawa S, Shimokama T, Shiina T, Miyanaga N, Akaza H. The impact of real-time tissue elasticity imaging (elastography) on the detection of prostate cancer: clinicopathological analysis. Int J Clin Oncol 2007;12(4):250-5.
2. Sumura M, Shigeno K, Hyuga T, Yoneda T, Shiina H, Igawa M. Initial evaluation of prostate cancer with real-time elastography based on step-section pathologic analysis after radical prostatectomy: a preliminary study. Int J Urol 2007;14(9):811-6.
3. Sommerfeld HJ, Garcia-Schurmann JM, Schewe J, Kuhne K, Cubick F, Berges RR, Lorenz A, Pesavento A, Scheipers U, Ermert H, Pannek J, Philippou S, Senge T. [Prostate cancer diagnosis using ultrasound elastography. Introduction of a novel technique and first clinical results]. Urologe A 2003;42(7):941-5.
4. Scattoni V, Zlotta A, Montironi R, Schulman C, Rigatti P, Montorsi F. Extended and saturation prostatic biopsy in the diagnosis and characterisation of prostate cancer: a critical analysis of the literature. Eur Urol 2007;52(5):1309-22.
5. Salomon G, Kollerman J, Thederan I, Chun FK, Budaus L, Schlomm T, Isbarn H, Heinzer H, Huland H, Graefen M. Evaluation of prostate cancer detection with ultrasound real-time elastography: a comparison with step section pathological analysis after radical prostatectomy. Eur Urol 2008;54(6):1354-62.
6. Nelson ED, Slotoroff CB, Gomella LG, Halpern EJ. Targeted biopsy of the prostate: the impact of color Doppler imaging and elastography on prostate cancer detection and Gleason score. Urology 2007;70(6):1136-40.
7. Miyanaga N, Akaza H, Yamakawa M, Oikawa T, Sekido N, Hinotsu S, Kawai K, Shimazui T, Shiina T. Tissue elasticity imaging for diagnosis of prostate cancer: a preliminary report. Int J Urol 2006;13(12):1514-8.
8. Miyagawa T, Tsutsumi M, Matsumura T, Kawazoe N, Ishikawa S, Shimokama T, Miyanaga N, Akaza H. Real-time elastography for the diagnosis of prostate cancer: evaluation of elastographic moving images. Jpn J Clin Oncol 2009;39(6):394-8.
9. Konig K, Scheipers U, Pesavento A, Lorenz A, Ermert H, Senge T. Initial experiences with real-time elastography guided biopsies of the prostate. J Urol 2005;174(1):115-7.
10. Kamoi K, Okihara K, Ochiai A, Ukimura O, Mizutani Y, Kawauchi A, Miki T. The utility of transrectal real-time elastography in the diagnosis of prostate cancer. Ultrasound Med Biol 2008;34(7):1025-32.

11. Gravas S, Mamoulakis C, Rioja J, Tzortzis V, de RT, Wijkstra H, de la RJ. Advances in ultrasound technology in oncologic urology. Urol Clin North Am 2009;36(2):133-45, vii.
12. Eggert T, Khaled W, Wenske S, Ermert H, Noldus J. [Impact of elastography in clinical diagnosis of prostate cancer. A comparison of cancer detection between B-mode sonography and elastography-guided 10-core biopsies]. Urologe A 2008;47(9):1212-7.
13. Cochlin DL, Ganatra RH, Griffiths DF. Elastography in the detection of prostatic cancer. Clin Radiol 2002;57(11):1014-20.

Ausgeschlossene Volltexte

A3 (erkennbar unsystematischer Review)

1. Ukimura O. Evolution of precise and multimodal MRI and TRUS in detection and management of early prostate cancer. Expert Rev Med Devices 2010;7(4):541-54.
2. Trabulsi EJ, Sackett D, Gomella LG, Halpern EJ. Enhanced transrectal ultrasound modalities in the diagnosis of prostate cancer. Urology 2010;76(5):1025-33.
3. Seitz M, Strittmatter F, Roosen A, Tilki D, Gratzke C. Current status of ultrasound imaging in prostate cancer. Panminerva Med 2010;52(3):189-94.
4. Purohit RS, Shinohara K, Meng MV, Carroll PR. Imaging clinically localized prostate cancer. Urol Clin North Am 2003;30(2):279-93.
5. Pallwein L, Mitterberger M, Pelzer A, Bartsch G, Strasser H, Pinggera GM, Aigner F, Gradl J, Zur ND, Frauscher F. Ultrasound of prostate cancer: recent advances. Eur Radiol 2008;18(4):707-15
6. Pallwein L, Mitterberger M, Gradl J, Aigner F, Horninger W, Strasser H, Bartsch G, Zur ND, Frauscher F. Value of contrast-enhanced ultrasound and elastography in imaging of prostate cancer. Curr Opin Urol 2007;17(1):39-47.
7. Oehr P, Bouchelouche K. Imaging of prostate cancer. Curr Opin Oncol 2007;19(3):259-64.
8. Moradi M, Mousavi P, Abolmaesumi P. Computer-aided diagnosis of prostate cancer with emphasis on ultrasound-based approaches: a review. Ultrasound Med Biol 2007;33(7):1010-28.
9. Lorenzen J, Sinkus R, Adam G. [Elastography: Quantitative imaging modality of the elastic tissue properties]. Rofo 2003;175(5):623-30.
10. Loch T. Urologic imaging for localized prostate cancer in 2007. World J Urol 2007;25(2):121-9.
11. Linden RA, Halpern EJ. Advances in transrectal ultrasound imaging of the prostate. Semin Ultrasound CT MR 2007;28(4):249-57.
12. Janssen J. [(E)US elastography: current status and perspectives]. Z Gastroenterol 2008;46(6):572-9.
13. Ginat DT, Destounis SV, Barr RG, Castaneda B, Strang JG, Rubens DJ. US elastography of breast and prostate lesions. Radiographics 2009;29(7):2007-16.
14. el-Gabry EA, Halpern EJ, Strup SE, Gomella LG. Imaging prostate cancer: current and future applications. Oncology (Williston Park) 2001;15(3):325-36.
15. Dinter DJ, Weidner AM, Wenz F, Pelzer AE, Michel MS, Schoenberg SO. [Imaging diagnostics of the prostate]. Urologe A 2010;49(8):963-75.
16. Candefjord S, Ramser K, Lindahl OA. Technologies for localization and diagnosis of prostate cancer. J Med Eng Technol 2009;33(8):585-603.
17. Beissert M, Lorenz R, Gerharz EW. [Rational imaging in locally advanced prostate cancer]. Urologe A 2008;47(11):1405-16.
18. Aigner F, Mitterberger M, Rehder P, Pallwein L, Junker D, Horninger W, Frauscher F. Status of transrectal ultrasound imaging of the prostate. J Endourol 2010;24(5):685-91.
19. Salomon G, Graefen M, Heinzer H, Huland H, Pallwein L, Aigner F, Frauscher F. [The value of real-time elastography in the diagnosis of prostate cancer]. Urologe A 2009;48(6):628-36.

A5 (Doppelpublikation oder nicht erhältlich)

1. Mitterberger M, Horninger W, Aigner F, Pinggera GM, Steppan I, Rehder P, Frauscher F. Ultrasound of the prostate. Cancer Imaging 2010;10:40-8.

2. Tsutsumi M, Miyagawa T, Matsumura T, Endo T, Kandori S, Shimokama T, Ishikawa S. Real-time balloon inflation elastography for prostate cancer detection and initial evaluation of clinicopathologic analysis. AJR Am J Roentgenol 2010;194(6):W471-W476.

12.3.2.4.3. Sonographie

Insgesamt 217 Treffer, davon 32 Volltexte bestellt und 15 Publikationen eingeschlossen

Eingeschlossene Volltexte

1. Mitterberger M, Aigner F, Pinggera GM, Steiner E, Rehder P, Ulmer H, Halpern EJ, Horninger W, Frauscher F. Contrast-enhanced colour Doppler-targeted prostate biopsy: correlation of a subjective blood-flow rating scale with the histopathological outcome of the biopsy. BJU Int 2010;106(9):1315-8.
2. Mitterberger M, Horninger W, Aigner F, Pinggera GM, Rehder P, Steiner E, Wiunig C, Reissigl A, Frauscher F. Contrast-enhanced colour Doppler-targeted vs a 10-core systematic repeat biopsy strategy in patients with previous high-grade prostatic intraepithelial neoplasia. BJU Int 2010;105(12):1660-2.
3. Aigner F, Pallwein L, Mitterberger M, Pinggera GM, Mikuz G, Horninger W, Frauscher F. Contrast-enhanced ultrasonography using cadence-contrast pulse sequencing technology for targeted biopsy of the prostate. BJU Int 2009;103(4):458-63.
4. Ching CB, Moussa AS, Li J, Lane BR, Zippe C, Jones JS. Does transrectal ultrasound probe configuration really matter? End fire versus side fire probe prostate cancer detection rates. J Urol 2009;181(5):2077-82.
5. Eisenberg ML, Cowan JE, Davies BJ, Carroll PR, Shinohara K. The importance of tumor palpability and transrectal ultrasonographic appearance in the contemporary clinical staging of prostate cancer. Urol Oncol 2009.
6. Lee HY, Lee HJ, Byun SS, Lee SE, Hong SK, Kim SH. Classification of focal prostatic lesions on transrectal ultrasound (TRUS) and the accuracy of TRUS to diagnose prostate cancer. Korean J Radiol 2009;10(3):244-51.
7. Sen J, Choudhary L, Marwah S, Godara R, Marwah N, Sen R. Role of colour Doppler imaging in detecting prostate cancer. Asian J Surg 2008;31(1):16-9.
8. Tang J, Yang JC, Luo Y, Li J, Li Y, Shi H. Enhancement characteristics of benign and malignant focal peripheral nodules in the peripheral zone of the prostate gland studied using contrast-enhanced transrectal ultrasound. Clin Radiol 2008;63(10):1086-91.
9. Wink M, Frauscher F, Cosgrove D, Chapelon JY, Palwein L, Mitterberger M, Harvey C, Rouviere O, de la RJ, Wijkstra H. Contrast-enhanced ultrasound and prostate cancer; a multicentre European research coordination project. Eur Urol 2008;54(5):982-92.
10. Yang JC, Tang J, Li J, Luo Y, Li Y, Shi H. Contrast-enhanced gray-scale transrectal ultrasound-guided prostate biopsy in men with elevated serum prostate-specific antigen levels. Acad Radiol 2008;15(10):1291-7.
11. Colleselli D, Bektic J, Schaefer G, Frauscher F, Mitterberger M, Brunner A, Schwentner C, Bartsch G, Horninger W, Pelzer AE. The influence of prostate volume on prostate cancer detection using a combined approach of contrast-enhanced ultrasonography-targeted and systematic grey-scale biopsy. BJU Int 2007;100(6):1264-7.
12. Linden RA, Trabulsi EJ, Forsberg F, Gittens PR, Gomella LG, Halpern EJ. Contrast enhanced ultrasound flash replenishment method for directed prostate biopsies. J Urol 2007;178(6):2354-8.
13. Mitterberger M, Horninger W, Pelzer A, Strasser H, Bartsch G, Moser P, Halpern EJ, Gradl J, Aigner F, Pallwein L, Frauscher F. A prospective randomized trial comparing contrast-enhanced targeted versus systematic ultrasound guided biopsies: impact on prostate cancer detection. Prostate 2007;67(14):1537-42.
14. Tang J, Yang JC, Li Y, Li J, Shi H. Peripheral zone hypoechoic lesions of the prostate: evaluation with contrast-enhanced gray scale transrectal ultrasonography. J Ultrasound Med 2007;26(12):1671-9.
15. Taymoorian K, Thomas A, Slowinski T, Khiabanchian M, Stephan C, Lein M, Deger S, Lenk S, Loening SA, Fischer T. Transrectal broadband-Doppler sonography with intravenous contrast medium administration for prostate imaging and biopsy in

men with an elevated PSA value and previous negative biopsies. Anticancer Res 2007;27(6C):4315-20.

Ausgeschlossene Volltexte

A2 (anderes Thema (nicht Diagnose))

1. Zhu Y, Chen Y, Jiang J, Wang R, Zhou Y, Zhang H. Contrast-enhanced harmonic ultrasonography for the assessment of prostate cancer aggressiveness: a preliminary study. Korean J Radiol 2010;11(1):75-83.
2. Matsumoto K, Nakagawa K, Hashiguchi A, Kono H, Kikuchi E, Nagata H, Miyajima A, Oya M. Contrast-enhanced ultrasonography of the prostate with Sonazoid. Jpn J Clin Oncol 2010;40(11):1099-104.

A4 (retrospektive Studien)

1. Tamsel S, Killi R, Hekimgil M, Altay B, Soydan S, Demirpolat G. Transrectal ultrasound in detecting prostate cancer compared with serum total prostate-specific antigen levels. J Med Imaging Radiat Oncol 2008;52(1):24-8.

A5 (unsystematischer Review)

1. Aigner F, Mitterberger M, Rehder P, Pallwein L, Junker D, Horninger W, Frauscher F. Status of transrectal ultrasound imaging of the prostate. J Endourol 2010;24(5):685-91.
2. De VP, Oosterlinck W, De MG, Villeirs G. Clinical and imaging tools in the early diagnosis of prostate cancer, a review. JBR -BTR 2010;93(2):62-70.
3. Mitterberger M, Horninger W, Aigner F, Pinggera GM, Steppan I, Rehder P, Frauscher F. Ultrasound of the prostate. Cancer Imaging 2010;10:40-8.
4. Trabulsi EJ, Sackett D, Gomella LG, Halpern EJ. Enhanced transrectal ultrasound modalities in the diagnosis of prostate cancer. Urology 2010;76(5):1025-33.
5. Ukimura O. Evolution of precise and multimodal MRI and TRUS in detection and management of early prostate cancer. Expert Rev Med Devices 2010;7(4):541-54.
6. Candefjord S, Ramser K, Lindahl OA. Technologies for localization and diagnosis of prostate cancer. J Med Eng Technol 2009;33(8):585-603.
7. Gravas S, Mamoulakis C, Rioja J, Tzortzis V, de RT, Wijkstra H, de la RJ. Advances in ultrasound technology in oncologic urology. Urol Clin North Am 2009;36(2):133-45, vii.
8. Hou AH, Swanson D, Barqawi AB. Modalities for imaging of prostate cancer. Adv Urol 2009;818065.
9. Puech P, Huglo D, Petyt G, Lemaitre L, Villers A. Imaging of organ-confined prostate cancer: functional ultrasound, MRI and PET/computed tomography. Curr Opin Urol 2009;19(2):168-76.
10. Pallwein L, Mitterberger M, Pelzer A, Bartsch G, Strasser H, Pinggera GM, Aigner F, Gradl J, Zur ND, Frauscher F. Ultrasound of prostate cancer: recent advances. Eur Radiol 2008;18(4):707-15.
11. Garra BS. Imaging and estimation of tissue elasticity by ultrasound. Ultrasound Q 2007;23(4):255-68.
12. Mitterberger M, Pelzer A, Colleselli D, Bartsch G, Strasser H, Pallwein L, Aigner F, Gradl J, Frauscher F. Contrast-enhanced ultrasound for diagnosis of prostate cancer and kidney lesions. Eur J Radiol 2007;64(2):231-8.

12.3.2.4.4. A7 (Doppelpublikation oder nicht erhältlich)

1. Futterer JJ, Spermon JR. Recent advances in imaging of male reproductive tract malignancies. Cancer Treat Res 2008;143:331-64.
2. Sano F, Terao H, Kawahara T, Miyoshi Y, Sasaki T, Noguchi K, Kubota Y, Uemura H. Contrast-enhanced ultrasonography of the prostate: various imaging findings that indicate prostate cancer. BJU Int 2010.

12.3.2.4.5. MRT

Insgesamt 300 Treffer, davon 62 Volltexte bestellt und 31 Publikationen eingeschlos-

sen

Eingeschlossene Volltexte

1. Colleselli D, Schilling D, Lichy MP, Hennenlotter J, Vogel UH, Krueger SA, Kuehs U, Schlemmer HP, Stenzl A, Schwentner C. Topographical sensitivity and specificity of endorectal coil magnetic resonance imaging for prostate cancer detection. Urol Int 2010;84(4):388-94.
2. Iwazawa J, Mitani T, Sassa S, Ohue S. Prostate cancer detection with MRI: is dynamic contrast-enhanced imaging necessary in addition to diffusion-weighted imaging? Diagn Interv Radiol 2010.
3. Jeong IG, Kim JK, Cho KS, You D, Song C, Hong JH, Ahn H, Kim CS. Diffusion-weighted magnetic resonance imaging in patients with unilateral prostate cancer on extended prostate biopsy: predictive accuracy of laterality and implications for hemi-ablative therapy. J Urol 2010;184(5):1963-9.
4. Labanaris AP, Engelhard K, Zugor V, Nutzel R, Kuhn R. Prostate cancer detection using an extended prostate biopsy schema in combination with additional targeted cores from suspicious images in conventional and functional endorectal magnetic resonance imaging of the prostate. Prostate Cancer Prostatic Dis 2010;13(1):65-70.
5. Nogueira L, Wang L, Fine SW, Pinochet R, Kurta JM, Katz D, Savage CJ, Cronin AM, Hricak H, Scardino PT, Akin O, Coleman JA. Focal treatment or observation of prostate cancer: pretreatment accuracy of transrectal ultrasound biopsy and T2-weighted MRI. Urology 2010;75(2):472-7.
6. Panebianco V, Sciarra A, Ciccariello M, Lisi D, Bernardo S, Cattarino S, Gentile V, Passariello R. Role of magnetic resonance spectroscopic imaging ([(1)H]MRSI) and dynamic contrast-enhanced MRI (DCE-MRI) in identifying prostate cancer foci in patients with negative biopsy and high levels of prostate-specific antigen (PSA). Radiol Med 2010.
7. Park SY, Kim JJ, Kim TH, Lim SH, Han DH, Park BK, Kim CK, Kwon GY, Choi HY, Lee HM. The role of endorectal magnetic resonance imaging in predicting extraprostatic extension and seminal vesicle invasion in clinically localized prostate cancer. Korean J Urol 2010;51(5):308-12.
8. Sciarra A, Panebianco V, Ciccariello M, Salciccia S, Cattarino S, Lisi D, Gentilucci A, Alfarone A, Bernardo S, Passariello R, Gentile V. Value of magnetic resonance spectroscopy imaging and dynamic contrast-enhanced imaging for detecting prostate cancer foci in men with prior negative biopsy. Clin Cancer Res 2010;16(6):1875-83.
9. Turkbey B, Pinto PA, Mani H, Bernardo M, Pang Y, McKinney YL, Khurana K, Ravizzini GC, Albert PS, Merino MJ, Choyke PL. Prostate cancer: value of multiparametric MR imaging at 3 T for detection--histopathologic correlation. Radiology 2010;255(1):89-99.
10. Villeirs GM, Oosterlinck W, Vanherreweghe E, De Meerleer GO. A qualitative approach to combined magnetic resonance imaging and spectroscopy in the diagnosis of prostate cancer. Eur J Radiol 2010;73(2):352-6.
11. Wang L, Akin O, Mazaheri Y, Ishill NM, Kuroiwa K, Zhang J, Hricak H. Are histopathological features of prostate cancer lesions associated with identification of extracapsular extension on magnetic resonance imaging? BJU Int 2010;106(9):1303-8.
12. Watanabe H, Kanematsu M, Kondo H, Kako N, Yamamoto N, Yamada T, Goshima S, Hoshi H, Bae KT. Preoperative detection of prostate cancer: a comparison with 11C-choline PET, 18F-fluorodeoxyglucose PET and MR imaging. J Magn Reson Imaging 2010;31(5):1151-6.
13. Brown JA, Rodin DM, Harisinghani M, Dahl DM. Impact of preoperative endorectal MRI stage classification on neurovascular bundle sparing aggressiveness and the radical prostatectomy positive margin rate. Urol Oncol 2009;27(2):174-9.
14. Cheikh AB, Girouin N, Colombel M, Marechal JM, Gelet A, Bissery A, Rabilloud M, Lyonnet D, Rouviere O. Evaluation of T2-weighted and dynamic contrast-enhanced MRI in localizing prostate cancer before repeat biopsy. Eur Radiol 2009;19(3):770-8.
15. Kumar V, Jagannathan NR, Kumar R, Nayyar R, Thulkar S, Gupta SD, Hemal AK, Gupta NP. Potential of (1)H MR spectroscopic imaging to segregate patients who are likely to show malignancy of the peripheral zone of the prostate on biopsy. J

Magn Reson Imaging 2009;30(4):842-8.
16. Lawrentschuk N, Fleshner N. The role of magnetic resonance imaging in targeting prostate cancer in patients with previous negative biopsies and elevated prostate-specific antigen levels. BJU Int 2009;103(6):730-3.
17. Puech P, Potiron E, Lemaitre L, Leroy X, Haber GP, Crouzet S, Kamoi K, Villers A. Dynamic contrast-enhanced-magnetic resonance imaging evaluation of intraprostatic prostate cancer: correlation with radical prostatectomy specimens. Urology 2009;74(5):1094-9.
18. Ren J, Huan Y, Li F, Wang H, Ge Y, Chang Y, Yin H, Sun L. Combined T2-weighted and diffusion-weighted MRI for diagnosis of urinary bladder invasion in patients with prostate carcinoma. J Magn Reson Imaging 2009;30(2):351-6.
19. Schmuecking M, Boltze C, Geyer H, Salz H, Schilling B, Wendt TG, Kloetzer KH, Marx C. Dynamic MRI and CAD vs. choline MRS: where is the detection level for a lesion characterisation in prostate cancer? Int J Radiat Biol 2009;85(9):814-24.
20. Seitz M, Shukla-Dave A, Bjartell A, Touijer K, Sciarra A, Bastian PJ, Stief C, Hricak H, Graser A. Functional magnetic resonance imaging in prostate cancer. Eur Urol 2009;55(4):801-14.
21. Shimizu T, Nishie A, Ro T, Tajima T, Yamaguchi A, Kono S, Honda H. Prostate cancer detection: the value of performing an MRI before a biopsy. Acta Radiol 2009;50(9):1080-8.
22. Umbehr M, Bachmann LM, Held U, Kessler TM, Sulser T, Weishaupt D, Kurhanewicz J, Steurer J. Combined magnetic resonance imaging and magnetic resonance spectroscopy imaging in the diagnosis of prostate cancer: a systematic review and meta-analysis. Eur Urol 2009;55(3):575-90.
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24. Zhang J, Hricak H, Shukla-Dave A, Akin O, Ishill NM, Carlino LJ, Reuter VE, Eastham JA. Clinical stage T1c prostate cancer: evaluation with endorectal MR imaging and MR spectroscopic imaging. Radiology 2009;253(2):425-34.
25. Jung DC, Lee HJ, Kim SH, Choe GY, Lee SE. Preoperative MR imaging in the evaluation of seminal vesicle invasion in prostate cancer: pattern analysis of seminal vesicle lesions. J Magn Reson Imaging 2008;28(1):144-50.
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28. Nishimoto K, Nakashima J, Hashiguchi A, Kikuchi E, Miyajima A, Nakagawa K, Ohigashi T, Oya M, Murai M. Prediction of extraprostatic extension by prostate specific antigen velocity, endorectal MRI, and biopsy Gleason score in clinically localized prostate cancer. Int J Urol 2008;15(6):520-3.
29. Torricelli P, Barberini A, Cinquantini F, Sighinolfi M, Cesinaro AM. 3-T MRI with phased-array coil in local staging of prostatic cancer. Acad Radiol 2008;15(9):1118-25.
30. Wang P, Guo YM, Liu M, Qiang YQ, Guo XJ, Zhang YL, Duan XY, Zhang QJ, Liang W. A meta-analysis of the accuracy of prostate cancer studies which use magnetic resonance spectroscopy as a diagnostic tool. Korean J Radiol 2008;9(5):432-8.
31. Manikandan R, Qazi HA, Philip J, Mistry R, Lamb GH, Woolfenden KA, Cornford PA, Parsons KF. Routine use of magnetic resonance imaging in the management of T(1c) carcinoma of the prostate: is it necessary? J Endourol 2007;21(10):1171-4.

Ausgeschlossene Volltexte

A2 (anderes Thema (nicht Primärdiagnostik)

1. Katahira K, Takahara T, Kwee TC, Oda S, Suzuki Y, Morishita S, Kitani K, Hamada Y, Kitaoka M, Yamashita Y. Ultra-high-b-value diffusion-weighted MR imaging for the detection of prostate cancer: evaluation in 201 cases with histopathological corre-

lation. Eur Radiol 2011;21(1):188-96.
2. Isbarn H, Kellermann S, Salomon G, Steuber T, Huland H, Graefen M. [Type and extent of preoperative imaging before radical prostatectomy]. Urologe A 2010;49(3):396-400.
3. Kitajima K, Kaji Y, Fukabori Y, Yoshida K, Suganuma N, Sugimura K. Prostate cancer detection with 3 T MRI: comparison of diffusion-weighted imaging and dynamic contrast-enhanced MRI in combination with T2-weighted imaging. J Magn Reson Imaging 2010;31(3):625-31.
4. Park KK, Lee SH, Lim BJ, Kim JH, Chung BH. The effects of the period between biopsy and diffusion-weighted magnetic resonance imaging on cancer staging in localized prostate cancer. BJU Int 2010;106(8):1148-51.
5. Weinreb JC, Blume JD, Coakley FV, Wheeler TM, Cormack JB, Sotto CK, Cho H, Kawashima A, Tempany-Afdhal CM, Macura KJ, Rosen M, Gerst SR, Kurhanewicz J. Prostate cancer: sextant localization at MR imaging and MR spectroscopic imaging before prostatectomy--results of ACRIN prospective multi-institutional clinicopathologic study. Radiology 2009;251(1):122-33.
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A3 (Methodik (Letter, Editorial u.ä., Fallberichte, Feasibility Studie))

1. Sciarra A, Panebianco V, Ciccariello M, Salciccia S, Lisi D, Osimani M, Alfarone A, Gentilucci A, Parente U, Passariello R, Gentile V. Magnetic resonance spectroscopic imaging (1H-MRSI) and dynamic contrast-enhanced magnetic resonance (DCE-MRI): pattern changes from inflammation to prostate cancer. Cancer Invest 2010;28(4):424-32.
2. Joseph T, McKenna DA, Westphalen AC, Coakley FV, Zhao S, Lu Y, Hsu IC, Roach M, III, Kurhanewicz J. Pretreatment endorectal magnetic resonance imaging and magnetic resonance spectroscopic imaging features of prostate cancer as predictors of response to external beam radiotherapy. Int J Radiat Oncol Biol Phys 2009;73(3):665-71.
3. Nayyar R, Kumar R, Kumar V, Jagannathan NR, Gupta NP, Hemal AK. Magnetic resonance spectroscopic imaging: current status in the management of prostate cancer. BJU Int 2009;103(12):1614-20.
4. 239. Masterson TA, Touijer K. The role of endorectal coil MRI in preoperative staging and decision-making for the treatment of clinically localized prostate cancer. MAGMA 2008;21(6):371-7.

A4 (nicht systematischer Review)

1. Puech P, Huglo D, Petyt G, Lemaitre L, Villers A. Imaging of organ-confined prostate cancer: functional ultrasound, MRI and PET/computed tomography. Curr Opin Urol 2009;19(2):168-76.
2. Westphalen AC, McKenna DA, Kurhanewicz J, Coakley FV. Role of magnetic resonance imaging and magnetic resonance spectroscopic imaging before and after radiotherapy for prostate cancer. J Endourol 2008;22(4):789-94.

A5 (n ≤ 50)

1. Akin O, Riedl CC, Ishill NM, Moskowitz CS, Zhang J, Hricak H. Interactive dedicated training curriculum improves accuracy in the interpretation of MR imaging of prostate cancer. Eur Radiol 2010;20(4):995-1002.
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9. Kim CK, Choi D, Park BK, Kwon GY, Lim HK. Diffusion-weighted MR imaging for the evaluation of seminal vesicle invasion in prostate cancer: initial results. J Magn Reson Imaging 2008;28(4):963-9.
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A6 (bereits in extrahiertem Review enthalten)

1. Chen M, Dang HD, Wang JY, Zhou C, Li SY, Wang WC, Zhao WF, Yang ZH, Zhong CY, Li GZ. Prostate cancer detection: comparison of T2-weighted imaging, diffusion-weighted imaging, proton magnetic resonance spectroscopic imaging, and the three techniques combined. Acta Radiol 2008;49(5):602-10.
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A7 (Doppelpublikation oder nicht erhältlich)

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12.3.2.4.6. PET/CT

Insgesamt 212 Treffer, davon 57 Volltexte bestellt und 21 Publikationen eingeschlossen

Eingeschlossene Volltexte

1. Picchio M, Briganti A, Fanti S, Heidenreich A, Krause BJ, Messa C, Montorsi F, Reske SN, Thalmann GN. The Role of Choline Positron Emission Tomography/Computed Tomography in the Management of Patients with Prostate-Specific Antigen Progression After Radical Treatment of Prostate Cancer. Eur Urol 2010.
2. Beheshti M, Vali R, Waldenberger P, Fitz F, Nader M, Hammer J, Loidl W, Pirich C, Fogelman I, Langsteger W. The use of F-18 choline PET in the assessment of bone metastases in prostate cancer: correlation with morphological changes on CT. Mol Imaging Biol 2010;12(1):98-107.
3. Beheshti M, Imamovic L, Broinger G, Vali R, Waldenberger P, Stoiber F, Nader M, Gruy B, Janetschek G, Langsteger W. 18F choline PET/CT in the preoperative staging of prostate cancer in patients with intermediate or high risk of extracapsular disease: a prospective study of 130 patients. Radiology 2010;254(3):925-33.
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A2 (anderes Thema: nicht Staging)

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2. Igerc I, Kohlfurst S, Gallowitsch HJ, Matschnig S, Kresnik E, Gomez-Segovia I, Lind P. The value of 18F-choline PET/CT in patients with elevated PSA-level and negative prostate needle biopsy for localisation of prostate cancer. Eur J Nucl Med Mol Imaging 2008;35(5):976-83.

A3 (Methodik (Letter, Editorial u.ä.)

1. Heidenreich A, Albers P, Classen J, Graefen M, Gschwend J, Kotzerke J, Krege S, Lehmann J, Rohde D, Schmidberger H, Uder M, Zeeb H. Imaging studies in metastatic urogenital cancer patients undergoing systemic therapy: recommendations of a multidisciplinary consensus meeting of the Association of Urological Oncology of the German Cancer Society. Urol Int 2010;85(1):1-10.
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A4 (retrospektiv)

1. Fuccio C, Castellucci P, Schiavina R, Santi I, Allegri V, Pettinato V, Boschi S, Martorana G, Al-Nahhas A, Rubello D, Fanti S. Role of 11C-choline PET/CT in the restaging of prostate cancer patients showing a single lesion on bone scintigraphy. Ann Nucl Med 2010;24(6):485-92.
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4. Rinnab L, Simon J, Hautmann RE, Cronauer MV, Hohl K, Buck AK, Reske SN, Mottaghy FM. [(11)C]choline PET/CT in prostate cancer patients with biochemical recurrence after radical prostatectomy. World J Urol 2009;27(5):619-25.
5. Steiner C, Vees H, Zaidi H, Wissmeyer M, Berrebi O, Kossovsky MP, Khan HG,

Miralbell R, Ratib O, Buchegger F. Three-phase 18F-fluorocholine PET/CT in the evaluation of prostate cancer recurrence. Nuklearmedizin 2009;48(1):1-9.
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A5 (nicht systematischer Review)

1. Mease RC. Radionuclide based imaging of prostate cancer. Curr Top Med Chem 2010;10(16):1600-16.
2. Bouchelouche K, Oehr P. Positron emission tomography and positron emission tomography/computerized tomography of urological malignancies: an update review. J Urol 2008;179(1):34-45.
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4. Scher B, Seitz M, Albinger W, Reiser M, Schlenker B, Stief C, Mueller-Lisse U, Dresel S. Value of PET and PET/CT in the diagnostics of prostate and penile cancer. Recent Results Cancer Res 2008;170:159-79.
5. Shvarts O, Han KR, Seltzer M, Pantuck AJ, Belldegrun AS. Positron emission tomography in urologic oncology. Cancer Control 2002;9(4):335-42.

A6 (nicht systematischer Review)

1. Beauregard JM, Williams SG, Degrado TR, Roselt P, Hicks RJ. Pilot comparison of F-fluorocholine and F-fluorodeoxyglucose PET/CT with conventional imaging in prostate cancer. J Med Imaging Radiat Oncol 2010;54(4):325-32.
2. Luboldt W, Kufer R, Blumstein N, Toussaint TL, Kluge A, Seemann MD, Luboldt HJ. Prostate carcinoma: diffusion-weighted imaging as potential alternative to conventional MR and 11C-choline PET/CT for detection of bone metastases. Radiology 2008;249(3):1017-25.
3. Rinnab L, Mottaghy FM, Simon J, Volkmer BG, de PR, Hautmann RE, Wittbrodt M, Egghart G, Moeller P, Blumstein N, Reske S, Kuefer R. [11C]Choline PET/CT for targeted salvage lymph node dissection in patients with biochemical recurrence after primary curative therapy for prostate cancer. Preliminary results of a prospective study. Urol Int 2008;81(2):191-7.
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A7 (kein PET/CT)

1. Han EJ, H O J, Choi WH, Yoo IR, Chung SK. Significance of incidental focal uptake in prostate on 18-fluoro-2-deoxyglucose positron emission tomography CT images. Br J Radiol 2010;83(995):915-20.
2. Richter JA, Rodriguez M, Rioja J, Penuelas I, Marti-Climent J, Garrastachu P, Quincoces G, Zudaire J, Garcia-Velloso MJ. Dual tracer 11C-choline and FDG-PET in the diagnosis of biochemical prostate cancer relapse after radical treatment. Mol Imaging Biol 2010;12(2):210-7.

3. Vees H, Buchegger F, Albrecht S, Khan H, Husarik D, Zaidi H, Soloviev D, Hany TF, Miralbell R. 18F-choline and/or 11C-acetate positron emission tomography: detection of residual or progressive subclinical disease at very low prostate-specific antigen values (<1 ng/mL) after radical prostatectomy. BJU Int 2007;99(6):1415-20.
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5. De J, I, Pruim J, Elsinga PH, Vaalburg W, Mensink HJ. 11C-choline positron emission tomography for the evaluation after treatment of localized prostate cancer. Eur Urol 2003;44(1):32-8.
6. Fricke E, Machtens S, Hofmann M, van den HJ, Bergh S, Brunkhorst T, Meyer GJ, Karstens JH, Knapp WH, Boerner AR. Positron emission tomography with 11C-acetate and 18F-FDG in prostate cancer patients. Eur J Nucl Med Mol Imaging 2003;30(4):607-11.
7. Nakamoto Y, Osman M, Wahl RL. Prevalence and patterns of bone metastases detected with positron emission tomography using F-18 FDG. Clin Nucl Med 2003;28(4):302-7.
8. Picchio M, Messa C, Landoni C, Gianolli L, Sironi S, Brioschi M, Matarrese M, Matei DV, De CF, Del MA, Rocco F, Rigatti P, Fazio F. Value of [11C]choline-positron emission tomography for re-staging prostate cancer: a comparison with [18F]fluorodeoxyglucose-positron emission tomography. J Urol 2003;169(4):1337-40.
9. De J, I, Pruim J, Elsinga PH, Vaalburg W, Mensink HJ. Visualization of prostate cancer with 11C-choline positron emission tomography. Eur Urol 2002;42(1):18-23.
10. Kotzerke J, Volkmer BG, Neumaier B, Gschwend JE, Hautmann RE, Reske SN. Carbon-11 acetate positron emission tomography can detect local recurrence of prostate cancer. Eur J Nucl Med Mol Imaging 2002;29(10):1380-4.
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12. Kotzerke J, Prang J, Neumaier B, Volkmer B, Guhlmann A, Kleinschmidt K, Hautmann R, Reske SN. Experience with carbon-11 choline positron emission tomography in prostate carcinoma. Eur J Nucl Med 2000;27(9):1415-9.

A8 (Doppelpublikation oder nicht erhältlich)

1. Beer AJ, Eiber M, Souvatzoglou M, Holzapfel K, Ganter C, Weirich G, Maurer T, Kubler H, Wester HJ, Gaa J, Krause BJ. Restricted Water Diffusibility as Measured by Diffusion-weighted MR Imaging and Choline Uptake in (11)C-Choline PET/CT are Correlated in Pelvic Lymph Nodes in Patients with Prostate Cancer. Mol Imaging Biol 2010.
2. De J, I, De Haan TD, Wiegman EM, Van Den Bergh AC, Pruim J, Breeuwsma AJ. PET/CT and radiotherapy in prostate cancer. Q J Nucl Med Mol Imaging 2010;54(5):543-52.

12.3.3. Recherche zu Active Surveillance bei lokal begrenztem Prostatakarzinom

12.3.3.1. Fragestellungen

Population	Intervention	Control	Outcomes	Time aspects
Pat mit PCa	Active Surveillance (Deskription der Einschlusskriterien)	RPE, EBRT (es wurden keine kontrollierten Studien erwartet)	Zeit bis zur Metatasierung, Überleben Ggf. stratifiziert nach low risk und intermediate risk	Nachbeobachtung mind. 2J
Pat. mit PCa und AS	a)Monitoring-kriterien b)Trigger für definitive Therapie unter besonderer Berücksichtigung von PSA-DT und PSA-V	-	Anteil Pat. mit definitiver Therapie Anteil Progression nach Therapie PCa-spezifische Mortalität	-

12.3.3.2. Recherchen

PubMed (17. Januar 2011)

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 Limits: English, German, Publication date from 2006/06	813
#3	#1 AND #2	2010
#2	active surveillance OR "expectant management" OR "deferred treatment" OR "delayed intervention" OR "defensive strategies" OR "PSA kinetics" OR "PSA velocity" OR "PSA doubling time" OR "PSA density" (Details: ("watchful waiting"[MeSH Terms] OR ("watchful"[All Fields] AND "waiting"[All Fields]) OR "watchful waiting"[All Fields] OR ("active"[All Fields] AND "surveillance"[All Fields]) OR "active surveillance"[All Fields]) OR "expectant management"[All Fields] OR "deferred treatment"[All Fields] OR "delayed intervention"[All Fields] OR "defensive strategies"[All Fields] OR "PSA kinetics"[All Fields] OR "PSA velocity"[All Fields] OR "PSA doubling time"[All Fields] OR "PSA density"[All Fields]	10134
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All	91220

	Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	

Anzahl der Treffer: 813

Davon relevant: 751

Cochrane (17. Januar 2011)

Nr.	Suchfrage	Anzahl
#1	(active surveillance OR watchful waiting OR expectant management OR deferred treatment OR delayed intervention OR defensive strategies OR PSA kinetics OR PSA velocity OR PSA doubling time OR PSA density):ti,ab,kw and (prostate cancer):ti,ab,kw, from 2006 to 2011	69

- Cochrane Database of Systematic Reviews (4)
- Database of Abstracts of Reviews of Effects (1)
- Cochrane Central Register of Controlled Trials (62)
- Cochrane Methodology Register (1)
- Health Technology Assessment Database (1)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 69

Davon neu: 32

Davon relevant: 31

Ausschlusskriterien für erste Relevanzsichtung:

- andere Erkrankung
- Methodik (Letter, Editorial u.ä.)

12.3.3.3. Ein- und Ausschlusskriterien

Einschlussgründe	
E1 Zielgruppe	Patienten mit Low Risk oder ggf. Intermediate Risk
E2 Publikationstyp	Systematische Übersichtsarbeit, RCT, prospektive kontrollierte Studie, prospektive Fallserie, retrospektive Auswertung von Registern alle n>100
E3: Suchzeitraum	Juni 2006 bis 17.1.2011
E4: Sprachen	Englisch, Deutsch,
E5 Intervention	Active Surveillance
Ausschlussgründe	
A1	Methodik (Brief, experimentelle Studie, Editorial, unsystematischer Review,

	retrospektive Studie außer Rgisterstudie)
A2	Nicht das Thema (Publikation behandelt nicht Patienten mit AS)
A3	Nicht die Patientengruppe mit lokal begrenztem PCa
A4	Nachbeobachtungszeit unter 2J
A5	Doppelpublikation (Dublette) oder gleicher Inhalt, bereits für Erstauflage extrahiert
A6	Veraltete, d.h. aktuellere Studiendaten sind bereits publiziert
A7	Setting nicht übertragbar (z.B. ökonomische Analyse nicht aus der BRD)
A8	N<100
A9	AS aber nicht vereinbarte Aspekte
A10	Nicht bestellbar

12.3.3.4. Ergebnisse der Recherche

12.3.3.4.1. Eingeschlossene systematische Reviews

1. Bastian PJ, Carter BH, Bjartell A, Seitz M, Stanislaus P, Montorsi F, Stief CG, Schroder F. Insignificant prostate cancer and active surveillance: from definition to clinical implications. Eur Urol 2009;55(6):1321-30.
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12.3.3.4.2. Eingeschlossene Einzelstudien

Fallserien/Kohorten unter Active Surveillance

1. Finelli A, Trottier G, Lawrentschuk N, Sowerby R, Zlotta AR, Radomski L, Timilshina N, Evans A, van der Kwast TH, Toi A, Jewett MA, Trachtenberg J, Fleshner NE. Impact of 5alpha-Reductase Inhibitors on Men Followed by Active Surveillance for Prostate Cancer. Eur Urol 2010.
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5. van den Bergh RC, Essink-Bot ML, Roobol MJ, Wolters T, Schroder FH, Bangma CH, Steyerberg EW. Anxiety and distress during active surveillance for early prostate cancer. Cancer 2009;115(17):3868-78.
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12.3.3.4.3. Ausgeschlossene Publikationen (Volltextscreening)

A1: Methodik (Brief, experimentelle Studie, Editorial, unsystematischer Review, retrospektive Studie außer Registerstudie)

1. Bangma CH, Roobol MJ, Steyerberg EW. Predictive models in diagnosing indolent cancer. Cancer 2009;115(13 Suppl):3100-6.
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A2: Nicht das Thema (Publikation behandelt nicht spezifisch Patienten unter AS)

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2. Thaxton CS, Loeb S, Roehl KA, Kan D, Catalona WJ. Treatment outcomes of radical prostatectomy in potential candidates for 3 published active surveillance protocols. Urology 2010;75(2):414-8.
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2009;181(4):1628-33.
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nificant prostate cancer who underwent radical prostatectomy. Int Braz J Urol 2010;36(3):292-9.
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A4: Nachbeobachtungszeit < 2 Jahre

1. van den Bergh RC, Vasarainen H, van der Poel HG, Vis-Maters JJ, Rietbergen JB, Pickles T, Cornel EB, Valdagni R, Jaspars JJ, van der HJ, Staerman F, Oomens EH, Rannikko A, Roemeling S, Steyerberg EW, Roobol MJ, Schroder FH, Bangma CH. Short-term outcomes of the prospective multicentre 'Prostate Cancer Research International: Active Surveillance' study. BJU Int 2010;105(7):956-62.

A5: Doppelpublikation (Dublette) oder gleicher Inhalt/bereits extrahiert

1. Khatami A, Aus G, Damber JE, Lilja H, Lodding P, Hugosson J. PSA doubling time predicts the outcome after active surveillance in screening-detected prostate cancer: results from the European randomized study of screening for prostate cancer, Sweden section. Int J Cancer 2007;120(1):170-4.
2. Klotz L. Active surveillance versus radical treatment for favorable-risk localized prostate cancer. Curr Treat Options Oncol 2006;7(5):355-62.
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4. Harnden P, Shelley MD, Naylor B, Coles B, Mason MD. Does the extent of carcinoma in prostatic biopsies predict prostate-specific antigen recurrence? A systematic review. Eur Urol 2008;54(4):728-39.

A7: Setting nicht übertragbar (z.B. ökonomische Analyse nicht aus der BRD)

1. Manoharan M, Eldefrawy A, Katkoori D, Antebi E, Soloway MS. Comparison of urologist reimbursement for managing patients with low-risk prostate cancer by active

surveillance versus total prostatectomy. Prostate Cancer Prostatic Dis 2010;13(4):307-10.
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A8: Fallzahl <100

1. Cooperberg MR, Konety BR. Management of localized prostate cancer in men over 65 years. Curr Opin Urol 2009;19(3):309-14.
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A9: AS aber nicht vereinbarte Aspekte (siehe Fragestellungen)

Die folgenden Arbeiten wurden zunächst als potentiell relevant für das Thema Active Surveillance gewertet, wurden aber für die Überarbeitung im Weiteren aus Kapazitätsgründen nach Abwägen des Erkenntnisgewinns v.a. in Bezug auf die zu erwartende Sicherheit der Ergebnisse nicht berücksichtigt, da sie in den vereinbarten Fragestellungen nicht enthalten waren. Dies betrifft zum Einen Arbeiten, die sich mit der Definition/Erkennung des sogenannten insignifikanten Prostatakarzinoms beschäftigen, einschließlich retrospektiv erhobener histopathologischer Analysen und Zum Anderen Arbeiten zu Prognosefaktoren bei AS einschließlich neuer molekularer Marker.

1. Raventos CX, Orsola A, de T, I, Cecchini L, Trilla E, Planas J, Morote J. Preoperative prediction of pathologically insignificant prostate cancer in radical prostatectomy specimens: the role of prostate volume and the number of positive cores. Urol Int 2010;84(2):153-8.
2. Jang TL, Bekelman JE, Liu Y, Bach PB, Basch EM, Elkin EB, Zelefsky MJ, Scardino PT, Begg CB, Schrag D. Physician visits prior to treatment for clinically localized prostate cancer. Arch Intern Med 2010;170(5):440-50.
3. Duffield AS, Lee TK, Miyamoto H, Carter HB, Epstein JI. Radical prostatectomy findings in patients in whom active surveillance of prostate cancer fails. Journal of Urology 2009;182(5):2274-8.
4. Ploussard G, Xylinas E, Salomon L, Allory Y, Vordos D, Hoznek A, Abbou CC, de la TA. The role of biopsy core number in selecting prostate cancer patients for active surveillance. Eur Urol 2009;56(6):891-8.
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11. Nakanishi H, Wang X, Ochiai A, Trpkov K, Yilmaz A, Donnelly JB, Davis JW, Troncoso P, Babaian RJ. A nomogram for predicting low-volume/low-grade prostate cancer: a tool in selecting patients for active surveillance. Cancer 2007;110(11):2441-7.
12. Roemeling S, Roobol MJ, Kattan MW, van der Kwast TH, Steyerberg EW, Schroder FH. Nomogram use for the prediction of indolent prostate cancer: impact on screen-detected populations. Cancer 2007;110(10):2218-21.
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26. Loeb S, Sutherland DE, D'Amico AV, Roehl KA, Catalona WJ. PSA velocity is associated with gleason score in radical prostatectomy specimen: marker for prostate cancer aggressiveness. Urology 2008;72(5):1116-20.
27. Loeb S, Kettermann A, Ferrucci L, Landis P, Metter EJ, Carter HB. PSA doubling time

versus PSA velocity to predict high-risk prostate cancer: data from the Baltimore Longitudinal Study of Aging. Eur Urol 2008;54(5):1073-80.
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29. Nakanishi H, Groskopf J, Fritsche HA, Bhadkamkar V, Blase A, Kumar SV, Davis JW, Troncoso P, Rittenhouse H, Babaian RJ. PCA3 molecular urine assay correlates with prostate cancer tumor volume: implication in selecting candidates for active surveillance. Journal of Urology 2008;179(5):1804-9.
30. Adolfsson J, Tribukait B, Levitt S. The 20-Yr outcome in patients with well- or moderately differentiated clinically localized prostate cancer diagnosed in the pre-PSA era: the prognostic value of tumour ploidy and comorbidity. Eur Urol 2007;52(4):1028-35.
31. Ploussard G, Durand X, Xylinas E, Moutereau S, Radulescu C, Forgue A, Nicolaiew N, Terry S, Allory Y, Loric S, Salomon L, Vacherot F, de la TA. Prostate Cancer Antigen 3 Score Accurately Predicts Tumour Volume and Might Help in Selecting Prostate Cancer Patients for Active Surveillance. Eur Urol 2010.
32. Tosoian JJ, Loeb S, Kettermann A, Landis P, Elliot DJ, Epstein JI, Partin AW, Carter HB, Sokoll LJ. Accuracy of PCA3 measurement in predicting short-term biopsy progression in an active surveillance program. Journal of Urology 2010;183(2):534-8.
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A10: Nicht bestellbar/ePub

1. Hegarty JM, Wallace M, Comber H. Uncertainty and quality of life among men undergoing active surveillance for prostate cancer in the United States and Ireland. Am J Mens Health 2008;2(2):133-42.
2. Anandadas CN, Clarke NW, Davidson SE, O'Reilly PH, Logue JP, Gilmore L, Swindell R, Brough RJ, Wemyss-Holden GD, Lau MW, Javle PM, Ramani VA, Wylie JP, Collins GN, Brown S, Cowan RA. Early prostate cancer - which treatment do men prefer and why? BJU Int 2010.
3. Dall'Era MA, Cowan JE, Simko J, Shinohara K, Davies B, Konety BR, Meng MV, Perez N, Greene K, Carroll PR. Surgical management after active surveillance for low-risk prostate cancer: pathological outcomes compared with men undergoing immediate treatment. BJU Int 2010.
4. Hong SK, Na W, Park JM, Byun SS, Oh JJ, Nam JS, Jeong CW, Choe G, Lee HJ, Hwang SI, Lee SE. Prediction of pathological outcomes for a single microfocal (</=3 mm) Gleason 6 prostate cancer detected via contemporary multicore (>/=12) biopsy in men with prostate-specific antigen </=10 ng/mL. BJU Int 2010.
5. Mohan R, Beydoun HA, Beydoun MA, Barnes-Eley M, Davis J, Lance R, Schellhammer P. Self-rated health as a tool for estimating health-adjusted life expectancy among patients newly diagnosed with localized prostate cancer: a preliminary study. Qual Life Res 2010.
6. It's sometimes safe to delay prostate surgery. "Watchful waiting" plus active surveillance still leaves a window of opportunity if surgery is necessary. Health News 2006;12(6):13-4.
7. Bailey DE, Jr., Wallace M. Critical review: is watchful waiting a viable management option for older men with prostate cancer? Am J Mens Health 2007;1(1):18-28.

12.3.4. Recherche zum Thema Radikale Prostatektomie bei Patienten mit hohem Risikoprofil

12.3.4.1. Fragestellung – Lokal begrenztes PCa (high risk)

Population	Intervention	Kontrolle	Outcomes	Time aspects
Patienten mit lokal begrenztem Prostatakarzinom des hohen Risikos	Radikale Prostatektomie (offen,r laparoskopisch, roboter-assisitiert.)	Perkutane Strahlentherapie, interstitielle Brachytherapie, Watchful Waiting	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben, PCa spezifisches Überleben) Morbidität Lebensqualität Nebenwirkungen/Schäden	-

12.3.4.2. Fragestellung – Lokal fortgeschrittenes PCa

Population	Intervention	Kontrolle	Outcomes	Time aspects
Patienten mit lokal fortgeschrittenem Prostatakarzinom (>T3)	Radikale Prostatektomie (offen,r laparoskopisch, roboter-assisitiert.)	externe Strahlentherapie, interstitielle Brachytherapie, Watchful Waiting	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben) Morbidität (PSA-Kinetik, Histologie) Lebensqualität Nebenwirkungen/Schäden	Keine Einschränkungen

12.3.4.3. Recherchen

Anmerkung: die eingeschlossenen Studien zum lokal begrenzten Prostatakarzinoms des hohen Risikos wurden im Rahmen der Aktualisierungsrecherche zur perkutanen Strahlentherapie beim lokal begrenzten Prostatakarzinom des hohen Risikos identifiziert (siehe Recherchestrategie dort).

Ausschlusskriterien für erste Relevanzsichtung:

andere Erkrankung

Methodik (Letter, Editorial u.ä.)

PubMed (10. Februar 2011)

Nr.	Suchfrage	Anzahl
#5	#1 AND #2 AND #3 Limits: English, German, Publication date from 2008/03	153
#4	#1 AND #2 AND #3	879

#3	"locally advanced" OR T3 OR T4 (Details: "locally advanced"[All Fields] OR T3[All Fields] OR T4[All Fields])	58373
#2	prostatectomy (Details: "prostatectomy"[MeSH Terms] OR "prostatectomy"[All Fields])	24635
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	91664

Anzahl der Treffer: 153

Cochrane (10. Februar 2011)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and prostatectomy in Title, Abstract or Keywords and locally advanced OR T3 OR T4 in Title, Abstract or Keywords, from 2008 to 2011	8

- Cochrane Database of Systematic Reviews (4)
- Database of Abstracts of Reviews of Effects (1)
- Cochrane Central Register of Controlled Trials (3)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (0)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 8

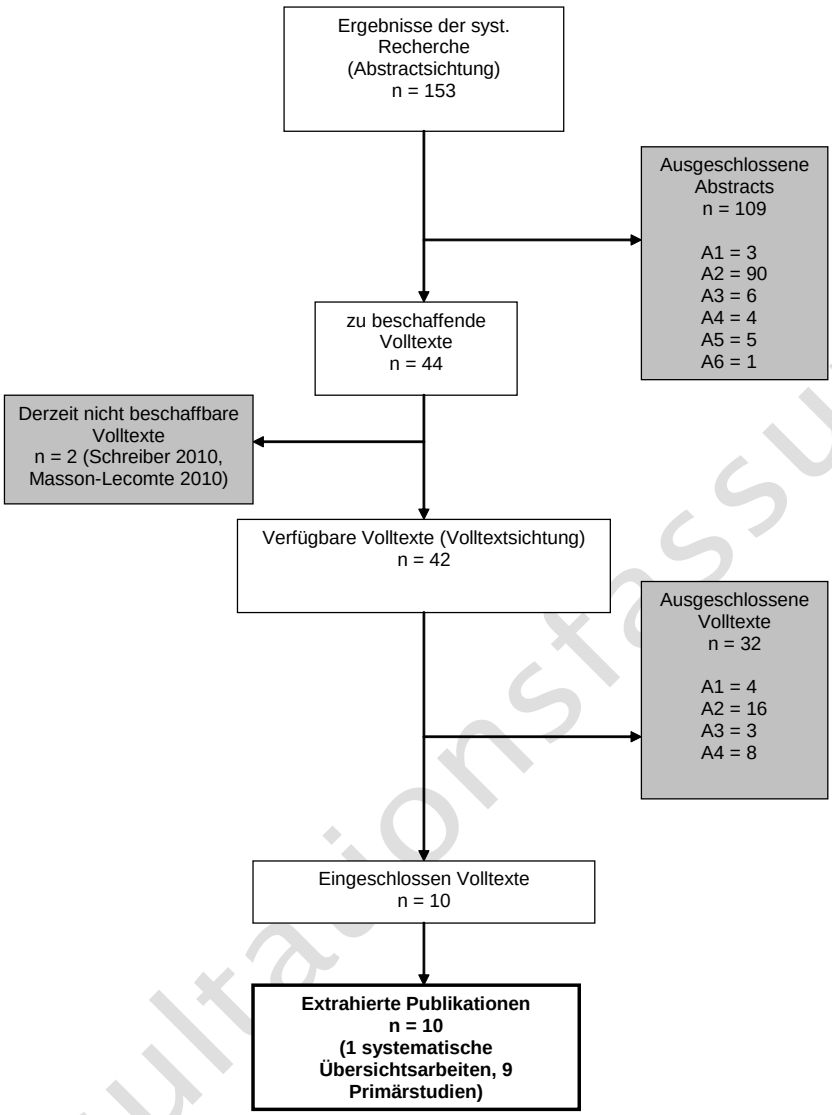
Davon neu: 4

Davon relevant: 0

12.3.4.4. Ein- und Ausschlusskriterien

Einschlussgründe	
E1 Zielgruppe	Patienten mit lokal fortgeschrittenem primären Prostatakarzinom (cT3-cT4)
E2 Publikationstyp	Klinische Studien inklusive Fallserien oder systematischer Review/HTA-Bericht (mit oder ohne Metaanalyse)
E3: Suchzeitraum	Publikationen seit August 2008 (letzte Recherche S3 Leitlinien-Gruppe)
E4: Sprachen	deutsch, englisch
E5 Intervention	Radikale Prostatektomie
Ausschlussgründe	
A1	andere Population
A2	Nicht Fragestellung (siehe oben)
A3	Anderer Publikationstyp (Editorial, Fallserie n<50, Fallbericht, Brief etc.)
A4	Unsystematischer Review
A5	Doppelpublikation oder aktuellere Publikation vorhanden

12.3.4.5. Ergebnisse der Recherche



12.3.4.5.1. Eingeschlossene Publikationen

Zur RPE beim lokal begrenzten Prostatakarzinom mit hohem Risiko im Vergleich zu anderen Therapieoptionen

1. Bill-Axelson A, Holmberg L, Ruutu M, Garmo H, Stark JR, Busch C, Nordling S, Haggman M, Andersson SO, Bratell S, Spangberg A, Palmgren J, Steineck G, Adami HO, Johansson JE. Radical prostatectomy versus watchful waiting in early prostate cancer. The New England journal of medicine 2011;364(18):1708-17.
2. Cooperberg MR, Vickers AJ, Broering JM, Carroll PR. Comparative risk-adjusted mortality outcomes after primary surgery, radiotherapy, or androgen-deprivation therapy for localized prostate cancer. Cancer 2010;116(22):5226-34.
3. Abdollah F, Sun M, Thuret R, Jeldres C, Tian Z, Briganti A, Shariat SF, Perrotte P, Rigatti P, Montorsi F, Karakiewicz PI. A competing-risks analysis of survival after alternative treatment modalities for prostate cancer patients: 1988-2006. Eur Urol 2011;59(1):88-95.
4. Arcangeli G, Strigari L, Arcangeli S, Petrongari MG, Saracino B, Gomellini S, Papalia R, Simone G, De CP, Gallucci M. Retrospective comparison of external beam radiotherapy and radical prostatectomy in high-risk, clinically localized prostate cancer.

Int J Radiat Oncol Biol Phys 2009;75(4):975-82.
5. Takizawa I, Hara N, Nishiyama T, Kaneko M, Hoshii T, Tsuchida E, Takahashi K. Oncological results, functional outcomes and health-related quality-of-life in men who received a radical prostatectomy or external beam radiation therapy for localized prostate cancer: a study on long-term patient outcome with risk stratification. Asian J Androl 2009;11(3):283-90.
6. Zhou EH, Ellis RJ, Cherullo E, Colussi V, Xu F, Chen WD, Gupta S, Whalen CC, Bodner D, Resnick MI, Rimm AA, Koroukian SM. Radiation therapy and survival in prostate cancer patients: a population-based study. Int J Radiat Oncol Biol Phys 2009;73(1):15-23.
7. Zelefsky MJ, Eastham JA, Cronin AM, Fuks Z, Zhang Z, Yamada Y, Vickers A, Scardino PT. Metastasis after radical prostatectomy or external beam radiotherapy for patients with clinically localized prostate cancer: a comparison of clinical cohorts adjusted for case mix. Journal of clinical oncology : official journal of the American Society of Clinical Oncology 2010;28(9):1508-13.

Zur RPE beim lokal fortgeschrittenen Prostatakarzinom

1. Namiki S, Tochigi T, Ishidoya S, Ito A, Numata I, Arai Y. Long-term quality of life following primary treatment in men with clinical stage T3 prostate cancer. Qual Life Res 2011;20(1):111-8.
2. Hsu CY, Wildhagen MF, Van PH, Bangma CH. Prognostic factors for and outcome of locally advanced prostate cancer after radical prostatectomy. BJU Int 2010;105(11):1536-40.
3. Mearini L, Zucchi A, Costantini E, Bini V, Nunzi E, Porena M. Outcomes of radical prostatectomy in clinically locally advanced N0M0 prostate cancer. Urol Int 2010;85(2):166-72.
4. Ham WS, Park SY, Rha KH, Kim WT, Choi YD. Robotic radical prostatectomy for patients with locally advanced prostate cancer is feasible: results of a single-institution study. J Laparoendosc Adv Surg Tech A 2009;19(3):329-32.
5. Xylinas E, Drouin SJ, Comperat E, Vaessen C, Renard-Penna R, Misrai V, Bitker MO, Chartier-Kastler E, Richard F, Cussenot O, Roupret M. Oncological control after radical prostatectomy in men with clinical T3 prostate cancer: a single-centre experience. BJU Int 2009;103(9):1173-8.
6. Patel VR, Palmer KJ, Coughlin G, Samavedi S. Robot-assisted laparoscopic radical prostatectomy: perioperative outcomes of 1500 cases. J Endourol 2008;22(10):2299-305.
7. White WM, Sadetsky N, Waters WB, Carroll PR, Litwin MS. Quality of life in men with locally advanced adenocarcinoma of the prostate: an exploratory analysis using data from the CaPSURE database. J Urol 2008;180(6):2409-13.
8. Yossepowitch O, Eggener SE, Serio AM, Carver BS, Bianco FJ, Jr., Scardino PT, Eastham JA. Secondary therapy, metastatic progression, and cancer-specific mortality in men with clinically high-risk prostate cancer treated with radical prostatectomy. Eur Urol 2008;53(5):950-9.
9. Verhagen PC, Schroder FH, Collette L, Bangma CH. Does local treatment of the prostate in advanced and/or lymph node metastatic disease improve efficacy of androgen-deprivation therapy? A systematic review. Eur Urol 2010;58(2):261-9.
10. Walz J, Joniau S, Chun FK, Isbarn H, Jeldres C, Yossepowitch O, Chao-Yu H, Klein EA, Scardino PT, Reuther A, Poppel HV, Graefen M, Huland H, Karakiewicz PI. Pathological results and rates of treatment failure in high-risk prostate cancer patients after radical prostatectomy. BJU Int 2010.

12.3.4.5.2. Ausgeschlossene Publikationen (Volltextscreening)

Ausschlussgrund A1: Andere Population

1. Murphy DG, Kerger M, Crowe H, Peters JS, Costello AJ. Operative details and oncological and functional outcome of robotic-assisted laparoscopic radical prostatectomy: 400 cases with a minimum of 12 months follow-up. Eur Urol 2009;55(6):1358-66.
2. Shikanov S, Song J, Royce C, Al-Ahmadie H, Zorn K, Steinberg G, Zagaja G, Shalhav A, Eggener S. Length of positive surgical margin after radical prostatectomy as a

predictor of biochemical recurrence. J Urol 2009;182(1):139-44.
3. Ploussard G, Salomon L, Allory Y, Terry S, Vordos D, Hoznek A, Abbou CC, Vacherot F, de la TA. Pathological findings and prostate-specific antigen outcomes after laparoscopic radical prostatectomy for high-risk prostate cancer. BJU Int 2010;106(1):86-90.
4. Rodriguez-Covarrubias F, Castillejos-Molina RA, Sotomayor M, Gabilondo F, Feria-Bernal G. The role of radical prostatectomy in the management of patients with high-grade prostate cancer and/or locally advanced disease. Rev Invest Clin 2009;61(6):456-60.

Ausschlussgrund A2: Anderes Thema (nicht Fragestellung)

1. Budaus L, Spethmann J, Isbarn H, Schmitges J, Beesch L, Haese A, Salomon G, Schlomm T, Fisch M, Heinzer H, Huland H, Graefen M, Steuber T. Inverse stage migration in patients undergoing radical prostatectomy: results of 8916 European patients treated within the last decade. BJU Int 2011.
2. Lee HW, Seo SI, Jeon SS, Lee HM, Choi HY. Can we predict real T3 stage prostate cancer in patients with clinical T3 (cT3) disease before radical prostatectomy? Yonsei Med J 2010;51(5):700-7.
3. Pierorazio PM, Epstein JI, Humphreys E, Han M, Walsh PC, Partin AW. The significance of a positive bladder neck margin after radical prostatectomy: the American Joint Committee on Cancer Pathological Stage T4 designation is not warranted. J Urol 2010;183(1):151-7.
4. Ploussard G, Rotondo S, Salomon L. The prognostic significance of bladder neck invasion in prostate cancer: is microscopic involvement truly a T4 disease? BJU Int 2010;105(6):776-81.
5. Villari D, Nesi G, Della MA, Palli D, Ceroti M, Castigli M, Filocamo MT, Li M, V, Nicita G. Radical retropubic prostatectomy for prostate cancer with microscopic bladder neck involvement: survival and prognostic implications. BJU Int 2010;105(7):946-50.
6. Yamamoto S, Kawakami S, Yonese J, Fujii Y, Tsukamoto T, Okubo Y, Kijima T, Ishikawa Y, Fukui I. Feasibility of antegrade radical prostatectomy for clinically locally advanced prostate cancer: a comparative study with clinically localized disease. Int J Urol 2010;17(8):720-5.
7. Inagaki T, Kohjimoto Y, Nishizawa S, Kuramoto T, Nanpo Y, Fujii R, Matsumura N, Shintani Y, Uekado Y, Hara I. PSA at postoperative three months can predict biochemical recurrence in patients with pathological T3 prostate cancer following radical prostatectomy. Int J Urol 2009;16(12):941-6.
8. Ploussard G, Rotondo S, Salomon L. Bladder neck involvement as pT4 disease in prostate cancer: implications for prognosis and patient surveillance. Future Oncol 2009;5(6):803-10.
9. Schelin S, Madsen M, Palmqvist E, Makela E, Klintenberg C, Aus G. Long-term follow-up after triple treatment of prostate cancer stage pT3. Scand J Urol Nephrol 2009;43(3):186-91.
10. Shelley MD, Kumar S, Coles B, Wilt T, Staffurth J, Mason MD. Adjuvant hormone therapy for localised and locally advanced prostate carcinoma: a systematic review and meta-analysis of randomised trials. Cancer Treat Rev 2009;35(7):540-6.
11. Walz J, Chun FK, Klein EA, Reuther A, Graefen M, Huland H, Karakiewicz PI. Risk-adjusted hazard rates of biochemical recurrence for prostate cancer patients after radical prostatectomy. Eur Urol 2009;55(2):412-9.
12. Richstone L, Bianco FJ, Shah HH, Kattan MW, Eastham JA, Scardino PT, Scherr DS. Radical prostatectomy in men aged >or=70 years: effect of age on upgrading, upstaging, and the accuracy of a preoperative nomogram. BJU Int 2008;101(5):541-6.
13. Trabulsi EJ, Linden RA, Gomella LG, McGinnis DE, Strup SE, Lallas CD. The addition of robotic surgery to an established laparoscopic radical prostatectomy program: effect on positive surgical margins. Can J Urol 2008;15(2):3994-9.
14. Vickers AJ, Bianco FJ, Gonen M, Cronin AM, Eastham JA, Schrag D, Klein EA, Reuther AM, Kattan MW, Pontes JE, Scardino PT. Effects of pathologic stage on the learning curve for radical prostatectomy: evidence that recurrence in organ-confined cancer is largely related to inadequate surgical technique. Eur Urol 2008;53(5):960-6.
15. Yee DS, Narula N, Amin MB, Skarecky DW, Ahlering TE. Robot-assisted radical prostatectomy: current evaluation of surgical margins in clinically low-, intermediate-, and high-risk prostate cancer. J Endourol 2009;23(9):1461-5.

16. Vickers AJ, Savage CJ, Bianco FJ, Klein EA, Kattan MW, Secin FP, Guilloneau BD, Scardino PT. Surgery confounds biology: The predictive value of stage-, grade- and prostate-specific antigen for recurrence after radical prostatectomy as a function of surgeon experience. Int J Cancer 2011;128(7):1697-702.

Ausschlussgrund A3: Anderer Publikationstyp (Editorial, Fallserie n<50, Fallbericht, Brief etc.)

1. Egevad L, Srigley JR, Delahunt B. International Society of Urological Pathology (ISUP) consensus conference on handling and staging of radical prostatectomy specimens: rationale and organization. Mod Pathol 2011;24(1):1-5.
2. Magi-Galluzzi C, Evans AJ, Delahunt B, Epstein JI, Griffiths DF, van der Kwast TH, Montironi R, Wheeler TM, Srigley JR, Egevad LL, Humphrey PA. International Society of Urological Pathology (ISUP) Consensus Conference on Handling and Staging of Radical Prostatectomy Specimens. Working group 3: extraprostatic extension, lymphovascular invasion and locally advanced disease. Mod Pathol 2011;24(1):26-38.
3. Boorjian SA, Blute ML. Surgical management of high risk prostate cancer: the Mayo Clinic experience. Urol Oncol 2008;26(5):530-2.92.
4. Casey JT, Meeks JJ, Greco KA, Wu SD, Nadler RB. Outcomes of locally advanced (T3 or greater) prostate cancer in men undergoing robot-assisted laparoscopic prostatectomy. J Endourol 2009;23(9):1519-22.

Ausschlussgrund A4: Unsystematischer Review

1. Boorjian SA, Karnes RJ, Viterbo R, Rangel LJ, Bergstralh EJ, Horwitz EM, Blute ML, Buyyounouski MK. Long-term survival after radical prostatectomy versus external-beam radiotherapy for patients with high-risk prostate cancer. Cancer 2011.
2. Heidenreich A, Schrader AJ. [Node-positive prostate cancer. Value of radical prostatectomy]. Urologe A 2010;49(10):1266-73.
3. Rosenthal SA, Sandler HM. Treatment strategies for high-risk locally advanced prostate cancer. Nat Rev Urol 2010;7(1):31-8.
4. Xylinas E, Dache A, Roupret M. Is radical prostatectomy a viable therapeutic option in clinically locally advanced (cT3) prostate cancer? BJU Int 2010;106(11):1596-600.
5. You D, Jeong IG, Kim CS. Role of radical prostatectomy for high-risk prostate cancer. Korean J Urol 2010;51(9):589-95.
6. Payne H. Management of locally advanced prostate cancer. Asian J Androl 2009;11(1):81-7.
7. Stratton KL, Chang SS. Locally advanced prostate cancer: the role of surgical management. BJU Int 2009;104(4):449-54.
8. Zantl N, Gschwend JE. [Value of cystoprostatectomy in locally advanced prostate carcinoma]. Urologe A 2008;47(11):1447-52.

12.3.5. Recherche zum Thema LDR-Brachytherapie

12.3.5.1. Fragestellungen

Population	Intervention	Kontrolle	Outcomes	Time aspects
Patienten mit mittlerem und hohen Risiko (PSA-Wert > 10 und/oder Gleason-Score > 7 und/oder cT-Kategorie > T2b)	LDR-Brachytherapie	Radikale Prostatektomie, perkutane Strahlentherapie Watchful Waiting, Hormontherapie	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben) Morbidität (PSA-Kinetik, Histologie) Lebensqualität Nebenwirkungen/Schäden	Keine Einschränkungen
Patienten mit lokal begrenztem Prostatakarzinom (<T3).	LDR-Brachytherapie + perkutane Strahlentherapie	Radikale Prostatektomie, perkutane Strahlentherapie Watchful Waiting/Active Surveillance, LDR-Brachytherapie allein	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben) Morbidität (PSA-Kinetik, Histologie) Lebensqualität Nebenwirkungen/Schäden	Keine Einschränkungen
Patienten mit lokal begrenztem Prostatakarzinom (<T3).	LDR-Brachytherapie + adjuvante Hormontherapie	LDR-Brachytherapie allein	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben) Morbidität (PSA-Kinetik, Histologie) Lebensqualität Nebenwirkungen/Schäden	Keine Einschränkungen

12.3.5.2. Recherchen

Ausschlusskriterien für erste Relevanzsichtung:

A1: andere Erkrankung

A2: Methodik (Letter, Editorial u.ä.)

PubMed (10. März 2011)

Nr.	Suchfrage	Anzahl
#5	#1 AND #2 AND #3 Limits: English, German, Publication date from 2000	255
#4	#1 AND #2 AND #3	293
#3	low dose rate OR LDR (Details: (low[All Fields] AND dose[All Fields] AND rate[All Fields]) OR LDR[All Fields])	29964
#2	brachytherapy (Details: "brachytherapy"[MeSH Terms] OR "brachytherapy"[All Fields])	15455
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All	92213

	Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	

Anzahl der Treffer: 255

Davon relevant: 231

Cochrane (10. März 2011)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and brachytherapy in Title, Abstract or Keywords and low dose rate OR LDR Title, Abstract or Keywords, from 2008 to 2011	13

- Cochrane Database of Systematic Reviews (1)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (10)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (1)
- NHS Economic Evaluation Database (1)

Anzahl der Treffer: 13

Davon neu: 7

Davon relevant: 6

12.3.5.3. Ein- und Ausschlusskriterien

Für Frage 1

Einschlussgründe	
E1 Zielgruppe	Patienten mit mittlerem und hohen Risiko (PSA-Wert > 10 und/oder Gleason-Score > 7 und/oder cT-Kategorie > T2b)
E2 Publikationstyp	RCT oder systematischer Review, ggf. mit Metaanalyse aus RCTs und Kohortenstudien, Fallserien mit Fallzahl > 50
E3: Suchzeitraum	Publikationen seit August 2008 (letzte Recherche S3 Leitlinien-Gruppe)
E4: Sprachen	deutsch, englisch
E5 Intervention	LDR-Brachytherapie

Für Frage 2

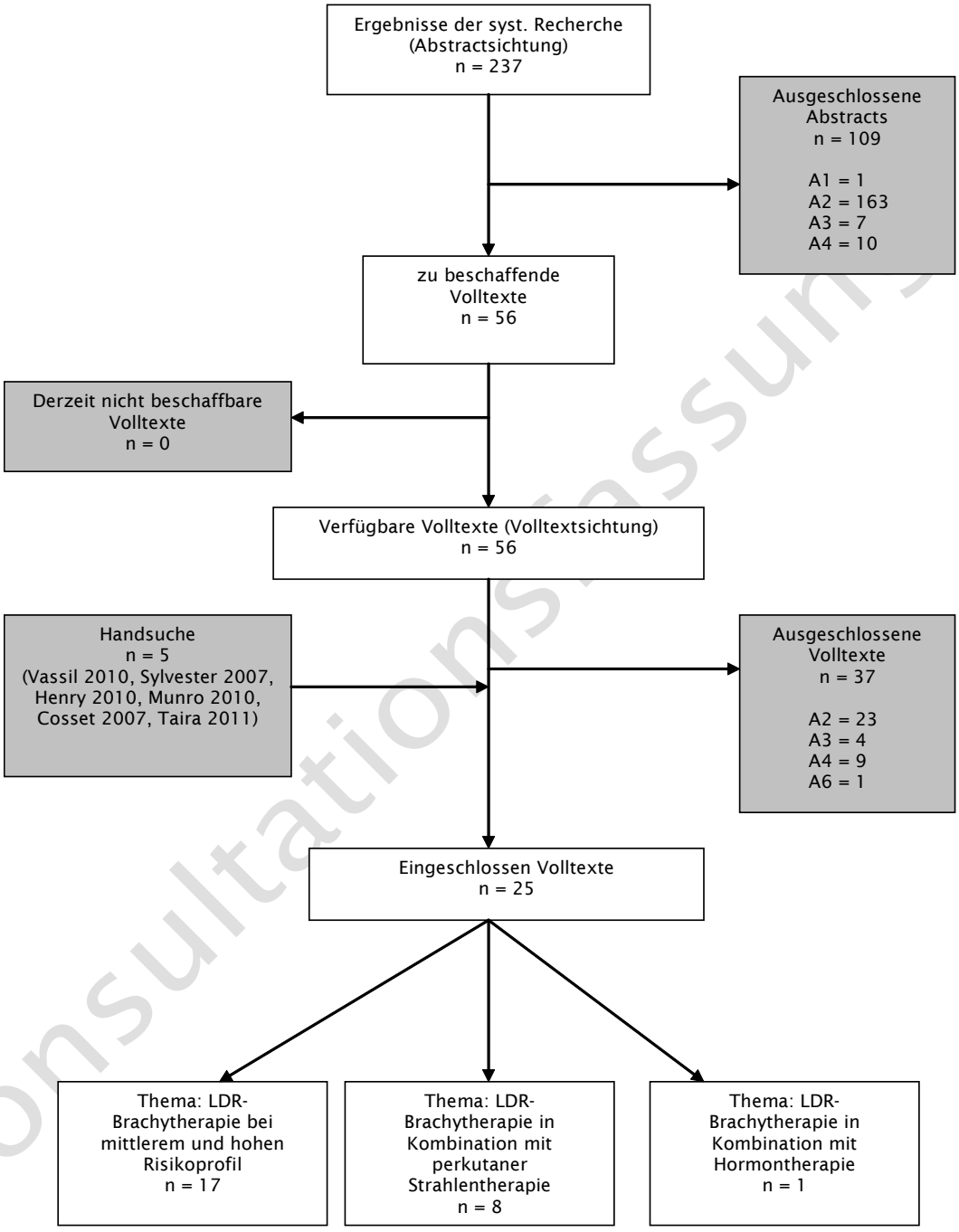
Einschlussgründe	
E1 Zielgruppe	Patienten mit lokal begrenztem Prostatakarzinom (<T3).
E2 Publikationstyp	RCT oder systematischer Review, ggf. mit Metaanalyse aus RCTs und Kohortenstudien, Fallserien mit Fallzahl > 50
E3: Suchzeitraum	Publikationen seit 2000 (Primärecherche, da neues Thema)
E4: Sprachen	deutsch, englisch
E5 Intervention	LDR-Brachytherapie + perkutane Strahlentherapie

Für Frage 3

Einschlussgründe	
E1 Zielgruppe	Patienten mit lokal begrenztem Prostatakarzinom (<T3).
E2 Publikations-typ	RCT oder systematischer Review, ggf. mit Metaanalyse aus RCTs und Kohor-tenstudien, Fallserien mit Fallzahl > 50
E3: Suchzeit-raum	Publikationen seit August 2008 (letzte Recherche S3 Leitlinien-Gruppe)
E4: Sprachen	deutsch, englisch
E5 Intervention	LDR-Brachytherapie + adjuvante Hormontherapie

Ausschlussgründe für Fragen 1-3	
A1	andere Population
A2	Nicht Fragestellung (siehe oben)
A3	Anderer Publikationstyp (Kohortenstudie, Fallserie, Editorial, Fallbericht, Brief etc.)
A4	Unsystematischer Review
A5	Doppelpublikation oder aktuellere Publikation vorhanden
A6	Außerhalb des Suchzeitraums

Ergebnisse der Recherche



12.3.5.3.1. Eingeschlossene Publikationen

Thema LDR-Brachytherapie bei mittlerem und hohen Risiko

17. Stone NN, Stone MM, Rosenstein BS, Unger P, Stock RG. Influence of pretreatment and treatment factors on intermediate to long-term outcome after prostate brachytherapy. J Urol 2011;185(2):495-500.
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Thema LDR-Brachytherapie in Kombination mit perkutaner Strahlentherapie

1. Valakh V, Kirichenko A, Miller R, Sunder T, Miller L, Fuhrer R. Combination of IG-IMRT and permanent source prostate brachytherapy in patients with organ-confined prostate cancer: GU and GI toxicity and effect on erectile function. Brachytherapy 2010.
2. Koontz BF, Chino J, Lee WR, Hahn CA, Buckley N, Huang S, Kim J, Reagan R, Joyner R, Anscher MS. Morbidity and prostate-specific antigen control of external beam radiation therapy plus low-dose-rate brachytherapy boost for low, intermediate, and high-risk prostate cancer. Brachytherapy 2009;8(2):191-6.
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8. Wong WW, Vora SA, Schild SE, Ezzell GA, Andrews PE, Ferrigni RG, Swanson SK. Radiation dose escalation for localized prostate cancer: intensity-modulated radiotherapy versus permanent transperineal brachytherapy. Cancer 2009;115(23):5596-606.

Thema: LDR-Brachytherapie in Kombination mit Hormontherapie

1. Stock RG, Yalamanchi S, Hall SJ, Stone NN. Impact of hormonal therapy on intermediate risk prostate cancer treated with combination brachytherapy and external beam irradiation. J Urol 2010;183(2):546-50.

12.3.5.3.2. Ausgeschlossene Publikationen (Volltextscreening)

Ausschlussgrund A2: Anderes Thema (nicht Fragestellung)

1. Puthawala AA, Syed AM, Austin PA, Cherlow JM, Perley JM, Shanberg AM, Sawyer DE, Ingram JE, Baghdassarian R, Wachs BH, Perley JE, Londrc A, Espinoza-Ferrel T. Long-term results of treatment for prostate carcinoma by staging pelvic lymph node dissection and definitive irradiation using low-dose rate temporary iridium-192 interstitial implant and external beam radiotherapy. Cancer 2001;92(8):2084-94.
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5. Jabbari S, Weinberg VK, Shinohara K, Speight JL, Gottschalk AR, Hsu IC, Pickett B, McLaughlin PW, Sandler HM, Roach M, III. Equivalent biochemical control and improved prostate-specific antigen nadir after permanent prostate seed implant

brachytherapy versus high-dose three-dimensional conformal radiotherapy and high-dose conformal proton beam radiotherapy boost. Int J Radiat Oncol Biol Phys 2010;76(1):36-42.
6. Kalakota K, Rakhno E, Pelizzari CA, Jani AB, Liauw SL. Late rectal toxicity after prostate brachytherapy: influence of supplemental external beam radiation on dose-volume histogram analysis. Brachytherapy 2010;9:131-6.
7. Krauss D, Kestin L, Ye H, Brabbins D, Ghilezan M, Gustafson G, Vicini F, Martinez A. Lack of Benefit for the Addition of Androgen Deprivation Therapy to Dose-Escalated Radiotherapy in the Treatment of Intermediate- and High-Risk Prostate Cancer. Int J Radiat Oncol Biol Phys 2010.
8. McGrath SD, Antonucci JV, Fitch DL, Ghilezan M, Gustafson GS, Vicini FA, Martinez AA, Kestin LL. PSA bounce after prostate brachytherapy with or without neoadjuvant androgen deprivation. Brachytherapy 2010;9(2):137-44.
9. Tanaka N, Fujimoto K, Asakawa I, Hirayama A, Yoneda T, Yoshida K, Hirao Y, Hasegawa M, Konishi N. Variations in health-related quality of life in Japanese men who underwent iodine-125 permanent brachytherapy for localized prostate cancer. Brachytherapy 2010;9(4):300-6.
10. Zelefsky MJ, Yamada Y, Pei X, Hunt M, Cohen G, Zhang Z, Zaider M. Comparison of Tumor Control and Toxicity Outcomes of High-dose Intensity-modulated Radiotherapy and Brachytherapy for Patients With Favorable Risk Prostate Cancer. Urology 2010.
11. Keyes M, Miller S, Moravan V, Pickles T, McKenzie M, Pai H, Liu M, Kwan W, Agranovich A, Spadinger I, Lapointe V, Halperin R, Morris WJ. Predictive factors for acute and late urinary toxicity after permanent prostate brachytherapy: long-term outcome in 712 consecutive patients. Int J Radiat Oncol Biol Phys 2009;73(4):1023-32.
12. Morris WJ, Keyes M, Palma D, Spadinger I, McKenzie MR, Agranovich A, Pickles T, Liu M, Kwan W, Wu J, Berthelet E, Pai H. Population-based study of biochemical and survival outcomes after permanent 125I brachytherapy for low- and intermediate-risk prostate cancer. Urology 2009;73(4):860-5.
13. Morris WJ, Keyes M, Palma D, McKenzie M, Spadinger I, Agranovich A, Pickles T, Liu M, Kwan W, Wu J, Lapointe V, Berthelet E, Pai H, Harrison R, Kwa W, Bucci J, Racz V, Woods R. Evaluation of dosimetric parameters and disease response after 125 iodine transperineal brachytherapy for low- and intermediate-risk prostate cancer. Int J Radiat Oncol Biol Phys 2009;73(5):1432-8.
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18. Soumarova R, Homola L, Perkova H, Stursa M. Three-dimensional conformal external beam radiotherapy versus the combination of external radiotherapy with high-dose rate brachytherapy in localized carcinoma of the prostate: comparison of acute toxicity. Tumori 2007;93(1):37-44.
19. Merrick GS, Butler WM, Wallner KE, Galbreath RW, Allen Z, Lief JH, Adamovich E. Influence of body mass index on biochemical outcome after permanent prostate brachytherapy. Urology 2005;65(1):95-100.
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22. Theodorescu D, Gillenwater JY, Koutrouvelis PG. Prostatourethral-rectal fistula after prostate brachytherapy. Cancer 2000;89(10):2085-91.

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Ausschlussgrund A3: Anderer Publikationstyp (Editorial, Fallbericht, Brief etc.)

1. Law AB, McLaren DB. Non-surgical treatment for early prostate cancer. J R Coll Physicians Edinb 2010;40(4):340-2.
2. Peinemann F, Grouven U, Bartel C, Borchers H, Pinkawa M, Heidenreich A, Hemkens LG, Schnell IP, Jahn R, Sauerland S. Low-dose rate brachytherapy for men with localized prostate cancer. Peinemann Frank , Grouven Ulrich , Bartel Carmen , Borchers Holger , Pinkawa Michael , Heidenreich Axel , Hemkens Lars G , Schnell Inderst Petra , Jahn Rebecca , Sauerland Stefan Low dose rate brachytherapy for men with localized prostate cancer Cochran 2010.
3. Borchers H, Pinkawa M, Donner A, Wolter TP, Pallua N, Eble MJ, Jakse G. Rectourethral fistula following LDR brachytherapy. Urol Int 2009;82(3):365-6.
4. Wyler SF, Engeler DS, Seelentag W, Ries G, Schmid HP. Health-related quality of life after radical prostatectomy and low-dose-rate brachytherapy for localized prostate cancer. Urol Int 2009;82(1):17-23.

Ausschlussgrund A4: Unsystematischer Review

1. Mabjeesh NJ, Matzkin H. The role of brachytherapy in the 21st century for prostate cancer. Minerva Urol Nefrol 2010;62(2):203-11.
2. Soto DE, McLaughlin PW. Combined permanent implant and external-beam radiation therapy for prostate cancer. Semin Radiat Oncol 2008;18(1):23-34.
3. Stubinger SH, Wilhelm R, Kaufmann S, Doring M, Hautmann S, Junemann KP, Galalae R. [Brachytherapy of the prostate cancer]. Urologe A 2008;47(3):284-90.
4. Voulgaris S, Nobes JP, Laing RW, Langley SE. State-of-the-art: prostate LDR brachytherapy. Prostate Cancer Prostatic Dis 2008;11(3):237-40.
5. Bratt O. The urologist's guide to low dose-rate interstitial brachytherapy with permanent seed implants for localized prostate cancer. BJU Int 2007;99(3):497-501.
6. Horwitz EM, Uzzo RG, Miller N, Theodorescu D. Brachytherapy for prostate cancer: follow-up and management of treatment failures. Urol Clin North Am 2003;30(4):737-ix.
7. Blasko JC, Mate T, Sylvester JE, Grimm PD, Cavanagh W. Brachytherapy for carcinoma of the prostate: techniques, patient selection, and clinical outcomes. Semin Radiat Oncol 2002;12(1):81-94.
8. Siegsmund M, Musial A, Weiss J, Alken P. [Ldr brachytherapy, a minimally invasive alternative in the treatment of organ-confined prostate cancer]. Onkologie 2001;24 Suppl 5:46-50.
9. Boehmer D, Buchali A, Deger S, Loening SA, Budach V. [Value of radiotherapy in urology]. Urologe A 2000;39(2):120-5.

Ausschlussgrund A6:Außerhalb des Suchzeitraums

1. Merrick GS, Butler WM, Wallner KE, Galbreath RW, Lief JH, Allen Z, Adamovich E. Impact of supplemental external beam radiotherapy and/or androgen deprivation therapy on biochemical outcome after permanent prostate brachytherapy. Int J Radiat Oncol Biol Phys 2005;61(1):32-43.

12.3.6. Recherchen zum Thema perkutane Strahlentherapie

12.3.6.1. Fragestellungen zum lokal begrenzten Prostatakarzinom

Population	Intervention	Kontrolle	Outcomes	Time aspects
Patienten mit lokal begrenztem Prostatakarzinom (<T3) und hohem Risikoprofil (PSA > 20 ng/ml, Gleason Score ≥ 8,	Externe Strahlentherapie +/- Hormontherapie	Radikale Prostatektomie, interstitielle Brachytherapie, Watchful Waiting, Hormontherapie	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben) Morbidität (PSA-Kinetik, Histologie) Lebensqualität Nebenwirkungen/Schäden	Keine Einschränkungen
Patienten mit lokal begrenztem Prostatakarzinom (<T3).	Externe Strahlentherapie mit Dosiseskalation	Externe Strahlentherapie ohne Dosiseskalation	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben) Morbidität (PSA-Kinetik, Histologie) Lebensqualität Nebenwirkungen/Schäden	Keine Einschränkungen

12.3.6.1.1. Recherchen

Ausschlusskriterien für Relevanzsichtung festlegen:

A1: andere Erkrankung

A2: Methodik (Letter, Editorial u.ä.)

PubMed (12. April 2011)

Nr.	Suchfrage	Anzahl
#5	#1 AND #2 AND #3 Limits: English, German, Publication date from 2008/06	326
#4	#1 AND #2 AND #3	1040
#3	"high risk" (Details: " high risk "[All Fields])	130956
#2	radiotherapy OR radiation OR radiotherapeutic OR EBRT (Details: ("radiotherapy"[Subheading] OR "radiotherapy"[All Fields] OR "radiotherapy"[MeSH Terms]) OR ("radiation"[MeSH Terms] OR "radiation"[All Fields]) OR ("radiotherapy"[MeSH Terms] OR "radiotherapy"[All Fields] OR "radiotherapeutic"[All Fields]) OR EBRT[All Fields])	681657
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	92895

Anzahl der Treffer: 326

Davon relevant: 320

Davon noch nicht in 1. Recherche: **263**

Cochrane (12. April 2011)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and radiotherapy or radiation or radiotherapeutic or EBRT in Title, Abstract or Keywords and high risk in Title, Abstract or Keywords, from 2008 to 2011	31

- Cochrane Database of Systematic Reviews (1)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (30)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (0)
- NHS Economic Evaluation Database (0)

12.3.6.1.2. Ein- und Ausschlusskriterien

Für Frage 1

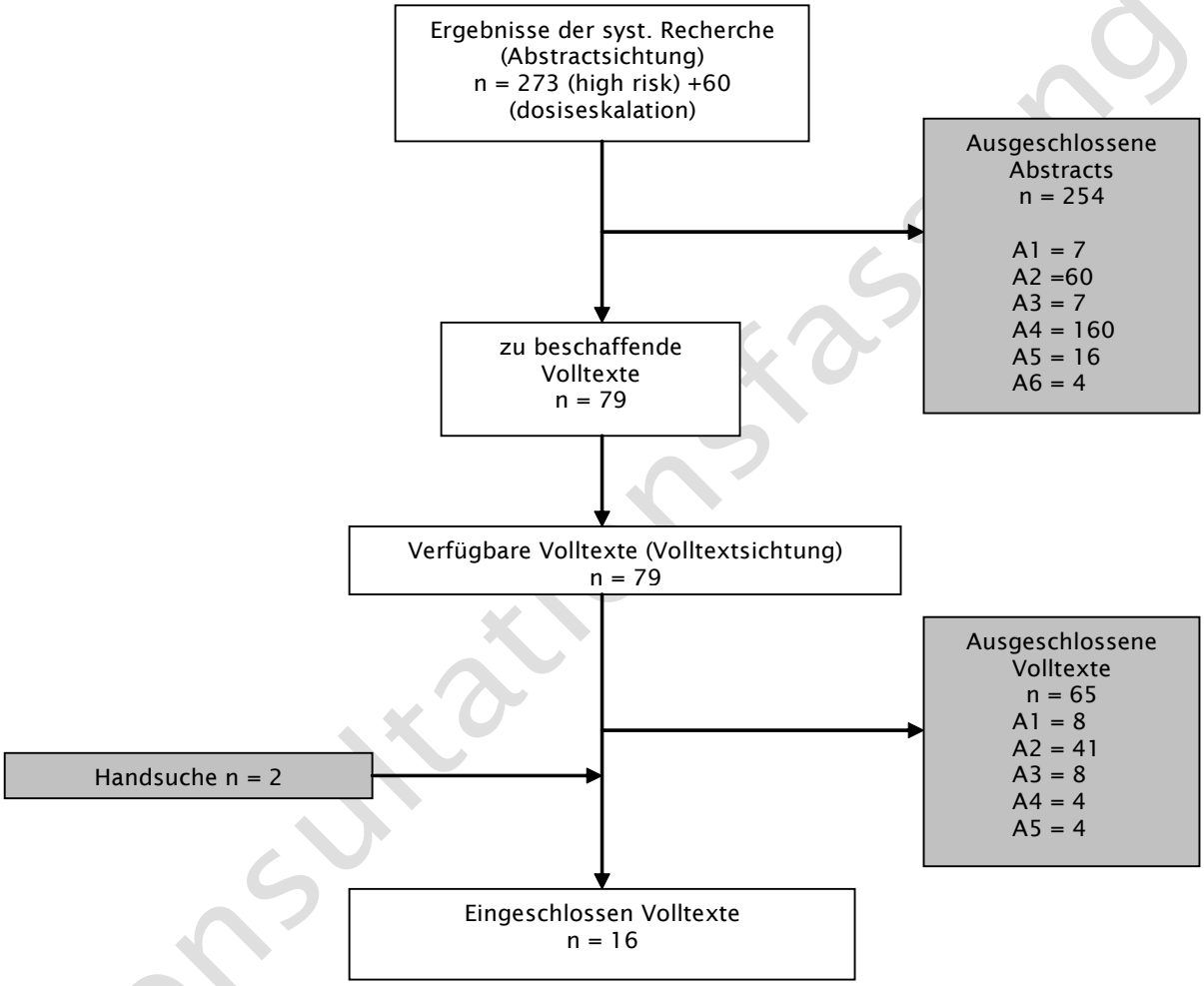
Einschlussgründe	
E1 Zielgruppe	Patienten mit lokal begrenztem Prostatakarzinom (<T3) und hohem Risikoprofil (PSA > 20 ng/ml, Gleason Score > 8,
E2 Publikationstyp	RCT oder systematischer Review, ggf. mit Metaanalyse aus RCTs und Kohortenstudien
E3: Suchzeitraum	Publikationen seit August 2008 (letzte Recherche S3 Leitlinien-Gruppe)
E4: Sprachen	deutsch, englisch
E5 Intervention	Externe Strahlentherapie
Ausschlussgründe	
A1	andere Population
A2	Nicht Fragestellung (siehe oben)
A3	Anderer Publikationstyp (Editorial, Fallbericht, Brief etc.)
A4	Unsystematischer Review
A5	Doppelpublikation oder aktuellere Publikation vorhanden

Für Frage 2

Einschlussgründe	
E1 Zielgruppe	Patienten mit lokal begrenztem und lokal fortgeschrittenem primären Prostatakarzinom (cT1-cT4)
E2 Publikationstyp	RCT oder systematischer Review, ggf. mit Metaanalyse aus RCTs
E3: Suchzeitraum	Publikationen seit August 2008 (letzte Recherche S3 Leitlinien-Gruppe)
E4: Sprachen	deutsch, englisch
E5 Intervention	Externe Strahlentherapie + Dosiseskalation
Ausschlussgründe	
A1	andere Population

Einschlussgründe	
A2	Nicht Fragestellung (siehe oben)
A3	Anderer Publikationstyp (Kohortenstudie, Fallserie, Editorial, Fallbericht, Brief etc.)
A4	Unsystematischer Review
A5	Doppelpublikation oder aktuellere Publikation vorhanden

12.3.6.1.3. Ergebnisse der Recherche



12.3.6.1.4. Eingeschlossene Publikationen

1. Abdollah F, Sun M, Thuret R, Jeldres C, Tian Z, Briganti A, Shariat SF, Perrotte P, Rigatti P, Montorsi F, Karakiewicz PI. A competing-risks analysis of survival after alternative treatment modalities for prostate cancer patients: 1988-2006. Eur Urol 2011;59(1):88-95.
2. Arcangeli G, Fowler J, Gomellini S, Arcangeli S, Saracino B, Petrongari MG, Benassi M, Strigari L. Acute and late toxicity in a randomized trial of conventional versus hypofractionated three-dimensional conformal radiotherapy for prostate cancer. Int J Radiat Oncol Biol Phys 2011;79(4):1013-21.
3. Kuban DA, Levy LB, Cheung MR, Lee AK, Choi S, Frank S, Pollack A. Long-term failure patterns and survival in a randomized dose-escalation trial for prostate cancer. Who dies of disease? Int J Radiat Oncol Biol Phys 2011;79(5):1310-7.
4. Al-Mamgani A, Heemsbergen WD, Levendag PC, Lebesque JV. Subgroup analysis of patients with localized prostate cancer treated within the Dutch-randomized dose

escalation trial. Radiother Oncol 2010;96(1):13-8.
5. Arcangeli G, Saracino B, Gomellini S, Petrongari MG, Arcangeli S, Sentinelli S, Marzi S, Landoni V, Fowler J, Strigari L. A prospective phase III randomized trial of hypofractionation versus conventional fractionation in patients with high-risk prostate cancer. Int J Radiat Oncol Biol Phys 2010;78(1):11-8.
6. Cooperberg MR, Vickers AJ, Broering JM, Carroll PR. Comparative risk-adjusted mortality outcomes after primary surgery, radiotherapy, or androgen-deprivation therapy for localized prostate cancer. Cancer 2010;116(22):5226-34.
7. Arcangeli G, Strigari L, Arcangeli S, Petrongari MG, Saracino B, Gomellini S, Papalia R, Simone G, De CP, Gallucci M. Retrospective comparison of external beam radiotherapy and radical prostatectomy in high-risk, clinically localized prostate cancer. Int J Radiat Oncol Biol Phys 2009;75(4):975-82.
8. Takizawa I, Hara N, Nishiyama T, Kaneko M, Hoshii T, Tsuchida E, Takahashi K. Oncological results, functional outcomes and health-related quality-of-life in men who received a radical prostatectomy or external beam radiation therapy for localized prostate cancer: a study on long-term patient outcome with risk stratification. Asian J Androl 2009;11(3):283-90.
9. Viani GA, Stefano EJ, Afonso SL. Higher-than-conventional radiation doses in localized prostate cancer treatment: a meta-analysis of randomized, controlled trials. Int J Radiat Oncol Biol Phys 2009;74(5):1405-18.
10. Zietman AL, Bae K, Slater JD, Shipley WU, Efstathiou JA, Coen JJ, Bush DA, Lunt M, Spiegel DY, Skowronski R, Jabola BR, Rossi CJ. Randomized trial comparing conventional-dose with high-dose conformal radiation therapy in early-stage adenocarcinoma of the prostate: long-term results from proton radiation oncology group/american college of radiology 95-09. Journal of clinical oncology : official journal of the American Society of Clinical Oncology 2010;28:1106-11.
11. Al-Mamgani A, van Putten WL, van der Wielen GJ, Levendag PC, Incrocci L. Dose Escalation and Quality of Life in Patients With Localized Prostate Cancer Treated With Radiotherapy: Long-Term Results of the Dutch Randomized Dose-Escalation Trial (CKTO 96-10 Trial). Int J Radiat Oncol Biol Phys 2011;79(4):1004-12.
12. Al-Mamgani A, van Putten WL, Heemsbergen WD, van Leenders GJ, Slot A, Dielwart MF, Incrocci L, Lebesque JV. Update of Dutch multicenter dose-escalation trial of radiotherapy for localized prostate cancer. Int J Radiat Oncol Biol Phys 2008;72(4):980-8.
13. Al-Mamgani A, Heemsbergen WD, Peeters ST, Lebesque JV. Role of intensity-modulated radiotherapy in reducing toxicity in dose escalation for localized prostate cancer. Int J Radiat Oncol Biol Phys 2009;73(3):685-91.
14. Goldner G, Dimopoulos J, Kirisits C, Potter R. Moderate dose escalation in three-dimensional conformal localized prostate cancer radiotherapy: single-institutional experience in 398 patients comparing 66 Gy versus 70 Gy versus 74 Gy. Strahlenther Onkol 2009;185(7):438-45.
15. Goldner G, Bombosch V, Geinitz H, Becker G, Wachter S, Glocker S, Zimmermann F, Wachter-Gerstner N, Schrott A, Bamberg M, Molls M, Feldmann H, Potter R. Moderate risk-adapted dose escalation with three-dimensional conformal radiotherapy of localized prostate cancer from 70 to 74 Gy. First report on 5-year morbidity and biochemical control from a prospective Austrian-German multicenter phase II trial. Strahlenther Onkol 2009;185(2):94-100.
16. Zhou EH, Ellis RJ, Cherullo E, Colussi V, Xu F, Chen WD, Gupta S, Whalen CC, Bodner D, Resnick MI, Rimm AA, Koroukian SM. Radiation therapy and survival in prostate cancer patients: a population-based study. Int J Radiat Oncol Biol Phys 2009; 73:15-23

12.3.6.1.5. Ausgeschlossene Publikationen (Volltextscreening)

Ausschlussgrund A1: Andere Population

1. Grubb RL, Kibel AS. High-risk localized prostate cancer: role of radical prostatectomy. Curr Opin Urol 2010;20(3):204-10.
2. Engels B, Soete G, Tournel K, Bral S, De CP, Verellen D, Storme G. Helical tomotherapy with simultaneous integrated boost for high-risk and lymph node-positive prostate cancer: early report on acute and late toxicity. Technol Cancer Res Treat 2009;8(5):353-9.

3. Milecki P, Baczyk M, Skowronek J, Antczak A, Kwias Z, Martenka P. Benefit of whole pelvic radiotherapy combined with neoadjuvant androgen deprivation for the high-risk prostate cancer. J Biomed Biotechnol 2009;2009:625394.
4. Wong WW, Vora SA, Schild SE, Ezzell GA, Andrews PE, Ferrigni RG, Swanson SK. Radiation dose escalation for localized prostate cancer: intensity-modulated radiotherapy versus permanent transperineal brachytherapy. Cancer 2009;115(23):5596-606.
5. Payne H. Radiation in high-risk prostate cancer: how much is enough? BJU Int 2008;102(6):663-5.
6. Zelefsky MJ, Yamada Y, Fuks Z, Zhang Z, Hunt M, Cahlon O, Park J, Shippy A. Long-term results of conformal radiotherapy for prostate cancer: impact of dose escalation on biochemical tumor control and distant metastases-free survival outcomes. Int J Radiat Oncol Biol Phys 2008;71(4):1028-33.
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Ausschlussgrund A2: Anderes Thema (nicht Fragestellung)

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Ausschlussgrund A3: Anderer Publikationstyp (Editorial, Fallbericht, Brief etc.)

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2. Guerrero UT, Khoo V, Staffurth J, Norman A, Buffa F, Jackson A, Adams E, Hansen V, Clark C, Miles E, McNair H, Nutting C, Parker C, Eeles R, Huddart R, Horwich A, Dearnaley DP. Intensity-modulated radiotherapy allows escalation of the radiation dose to the pelvic lymph nodes in patients with locally advanced prostate cancer: preliminary results of a phase I dose escalation study. Clin Oncol (R Coll Radiol) 2010;22(3):236-44.
3. Zilli T, Jorcano S, Rouzaud M, Dipasquale G, Nouet P, Toscas JI, Casanova N, Wang H, Escude L, Molla M, Linero D, Weber DC, Miralbell R. Twice-Weekly Hypofractionated Intensity-Modulated Radiotherapy for Localized Prostate Cancer with Low-Risk

Nodal Involvement: Toxicity and Outcome from a Dose Escalation Pilot Study. Int J Radiat Oncol Biol Phys 2010.
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7. Jereczek-Fossa BA, Vavassori A, Fodor C, Santoro L, Zerini D, Cattani F, Garibaldi C, Cambria R, Fodor A, Boboc GI, Vitolo V, Ivaldi GB, Musi G, de CO, Orecchia R. Dose escalation for prostate cancer using the three-dimensional conformal dynamic arc technique: analysis of 542 consecutive patients. Int J Radiat Oncol Biol Phys 2008;71(3):784-94.
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Ausschlussgrund A4: Unsystematischer Review

1. Al-Mamgani A, Lebesque JV, Heemsbergen WD, Tans L, Kirkels WJ, Levendag PC, Incrocci L. Controversies in the treatment of high-risk prostate cancer--what is the optimal combination of hormonal therapy and radiotherapy: a review of literature. Prostate 2010;70(7):701-9.
2. Picard JC, Golshayan AR, Marshall DT, Opfermann KJ, Keane TE. The multidisciplinary management of high-risk prostate cancer. Urol Oncol 2009.
3. Staffurth J. A review of the clinical evidence for intensity-modulated radiotherapy. Clin Oncol (R Coll Radiol) 2010;22(8):643-57.
4. Herfarth K, Sterzing F. [Radiotherapy for locally advanced prostate cancer]. Urologe A 2008;47(11):1424-30.

12.3.7. Recherchen zum Thema perkutane Strahlentherapie

12.3.7.1. Fragestellungen zum lokal fortgeschrittenen Prostatakarzinom

Population	Intervention	Kontrolle	Outcomes	Time aspects
Patienten mit lokal fortgeschrittenem Prostatakarzinom (≥T3)	Externe Strahlentherapie	Radikale Prostatektomie, interstitielle Brachytherapie, Watchful Waiting, Hormontherapie	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben) Morbidität (PSA-Kinetik, Histologie) Lebensqualität Nebenwirkungen/Schäden	Keine Einschränkungen
Patienten mit lokal fortgeschrittenem Prostatakarzinom (≥T3)	Externe Strahlentherapie + neoadjuvante oder adjuvante Hormontherapie	Externe Strahlentherapie ohne neoadjuvante oder adjuvante Hormontherapie oder alleinige	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben) Morbidität (PSA-Kinetik, Histologie) Lebensqualität Nebenwirkun-	Keine Einschränkungen

Population	Intervention	Kontrolle	Outcomes	Time aspects
		Hormontherapie	gen/Schäden	
Patienten mit lokal begrenztem oder lokal fortgeschrittenem Prostatakarzinom (cT1-T4)	Externe Hochdosisstrahlentherapie in Verbindung mit 3DCRT oder IMRT oder Normaler Bestrahlungsplanung	Externe Strahlentherapie mit konventionellen Dosierungen	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben) Morbidität (PSA-Kinetik, Histologie) Lebensqualität Nebenwirkungen/Schäden	Keine Einschränkungen

12.3.7.2. Recherche

Recherchestrategien für Fragen 1 und 2
Ausschlusskriterien für erste Relevanzsichtung:

A1: andere Erkrankung

A2: Methodik (Letter, Editorial u.ä.)

PubMed (10. März 2011)

Nr.	Suchfrage	Anzahl
#5	#1 AND #2 AND #3 Limits: English, German, Publication date from 2008/06	199
#4	#1 AND #2 AND #3	1288
#3	"locally advanced" OR T3 OR T4 (Details: "locally advanced"[All Fields] OR T3[All Fields] OR T4[All Fields])	58640
#2	radiotherapy OR radiation OR radiotherapeutic OR EBRT (Details: ("radiotherapy"[Subheading] OR "radiotherapy"[All Fields] OR "radiotherapy"[MeSH Terms]) OR ("radiation"[MeSH Terms] OR "radiation"[All Fields]) OR ("radiotherapy"[MeSH Terms] OR "radiotherapy"[All Fields] OR "radiotherapeutic"[All Fields]) OR EBRT[All Fields])	678589
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	92213

Anzahl der Treffer: 199

Davon relevant: 183

Cochrane (10. März 2011)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and radiotherapy or radiation or radiotherapeutic or EBRT in Title, Abstract or Keywords and locally advanced OR T3 OR T4 in Title, Abstract or Keywords, from 2008 to 2011	23

- Cochrane Database of Systematic Reviews (5)
- Database of Abstracts of Reviews of Effects (1)
- Cochrane Central Register of Controlled Trials (17)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (0)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 23

Davon neu: 10

Davon relevant: 7

Recherchestrategien für Frage 3
PubMed (10. März 2011)

Nr.	Suchfrage	Anzahl
#6	#1 AND #2 AND #3 AND #4 Limits: English, German, Publication date from 2008	60
#5	#1 AND #2 AND #3 AND #4	242
#4	"locally advanced" OR T3 OR T4 OR localized OR T1 OR T2 (Details: "locally advanced"[All Fields] OR T3[All Fields] OR T4[All Fields] OR localized[All Fields] OR T1[All Fields] OR T2[All Fields])	296050
#3	dose escalation (Details: dose[All Fields] AND escalation[All Fields])	6549
#2	radiotherapy OR radiation OR radiotherapeutic OR EBRT (Details: ("radiotherapy"[Subheading] OR "radiotherapy"[All Fields] OR "radiotherapy"[MeSH Terms]) OR ("radiation"[MeSH Terms] OR "radiation"[All Fields]) OR ("radiotherapy"[MeSH Terms] OR "radiotherapy"[All Fields] OR "radiotherapeutic"[All Fields]) OR EBRT[All Fields])	678589
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	92213

Anzahl der Treffer: 60

Cochrane (10. März 2011)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and radiotherapy or radiation or radiotherapeutic or EBRT in Title, Abstract or Keywords and locally advanced or T3 or T4 or localized or T1 or T2 in Title, Abstract or Keywords and dose escala-	7

	tion in Title, Abstract or Keywords, from 2008 to 2011	

- Cochrane Database of Systematic Reviews (0)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (7)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (0)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 7

Davon neu: 0

12.3.7.3. Ein- und Ausschlusskriterien

Für Frage 1

Einschlussgründe	
E1 Zielgruppe	Patienten mit lokal fortgeschrittenem primären Prostatakarzinom (cT3-cT4)
E2 Publikations-typ	RCT oder systematischer Review, ggf. mit Metaanalyse aus RCTs oder Kohortenstudie
E3: Suchzeit-raum	Publikationen seit August 2008 (letzte Recherche S3 Leitlinien-Gruppe)
E4: Sprachen	deutsch, englisch
E5 Intervention	Externe Strahlentherapie
Ausschlussgründe	
A1	andere Population
A2	Nicht Fragestellung (siehe oben)
A3	Anderer Publikationstyp (Editorial, Fallbericht, Brief etc.)
A4	Unsystematischer Review
A5	Doppelpublikation oder aktuellere Publikation vorhanden

Für Frage 2

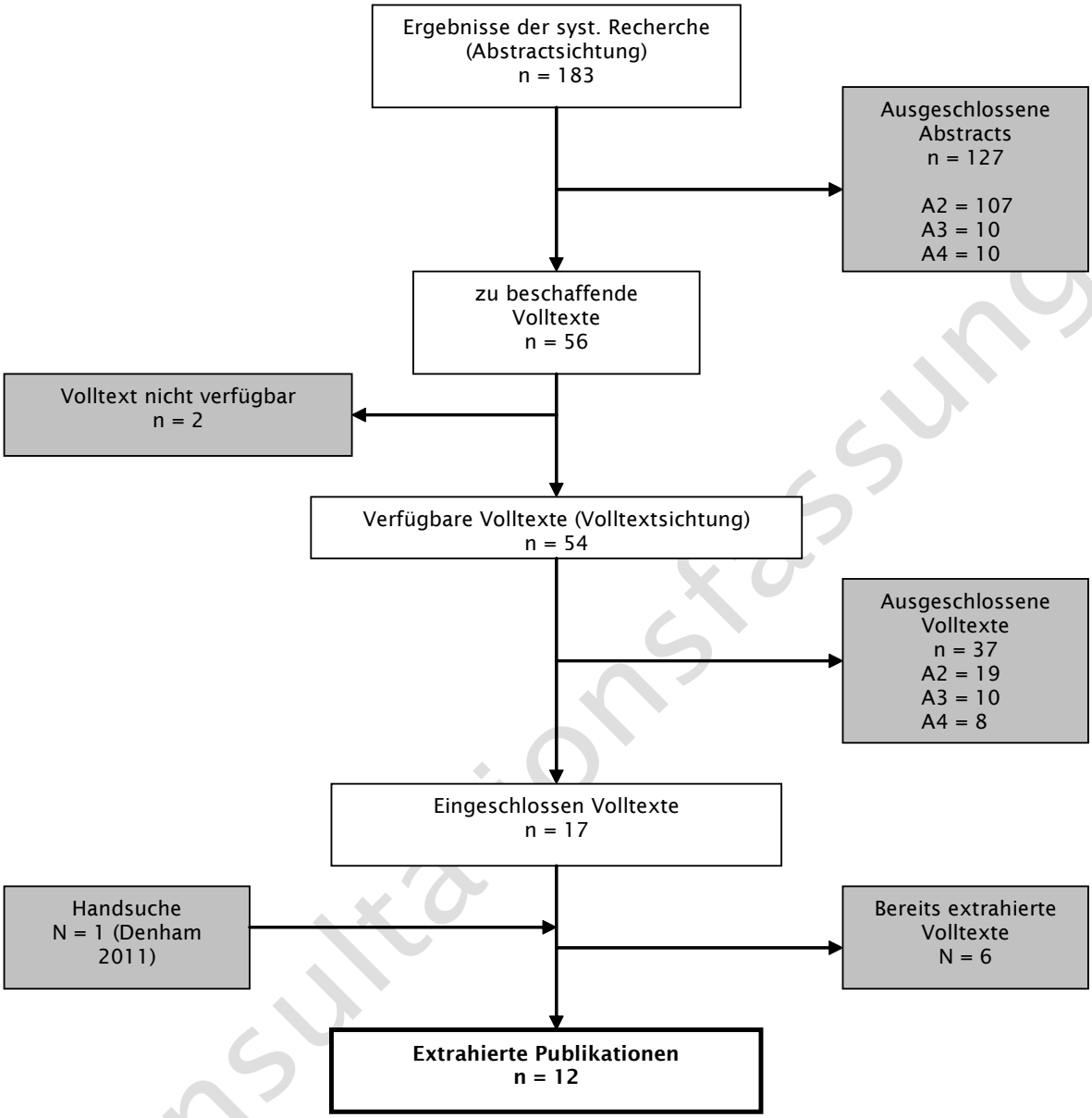
Einschlussgründe	
E1 Zielgruppe	Patienten mit lokal fortgeschrittenem primären Prostatakarzinom (cT3-cT4)
E2 Publikations-typ	RCT oder systematischer Review, ggf. mit Metaanalyse aus RCTs
E3: Suchzeit-raum	Publikationen seit August 2008 (letzte Recherche S3 Leitlinien-Gruppe)
E4: Sprachen	deutsch, englisch
E5 Intervention	Externe Strahlentherapie + Hormontherapie
Ausschlussgründe	
A1	andere Population
A2	Nicht Fragestellung (siehe oben)
A3	Anderer Publikationstyp (Kohortenstudie, Fallserie, Editorial, Fallbericht, Brief etc.)

Einschlussgründe	
A4	Unsystematischer Review
A5	Doppelpublikation oder aktuellere Publikation vorhanden

Für Frage 3

Einschlussgründe	
E1 Zielgruppe	Patienten mit lokal begrenztem und lokal fortgeschrittenem primären Prostatakarzinom (cT1-cT4)
E2 Publikationstyp	RCT oder systematischer Review, ggf. mit Metaanalyse aus RCTs
E3: Suchzeitraum	Publikationen seit August 2008 (letzte Recherche S3 Leitlinien-Gruppe)
E4: Sprachen	deutsch, englisch
E5 Intervention	Hochdosisstrahlentherapie +/- Hormontherapie
Ausschlussgründe	
A1	andere Population
A2	Nicht Fragestellung (siehe oben)
A3	Anderer Publikationstyp (Editorial, Fallbericht, Brief etc.)
A4	Unsystematischer Review
A5	Doppelpublikation oder aktuellere Publikation vorhanden

12.3.7.4. Ergebnisse der Recherche



12.3.7.4.1. Eingeschlossene Publikationen

1. Armstrong JG, Gillham CM, Dunne MT, Fitzpatrick DA, Finn MA, Cannon ME, Taylor JC, O'Shea CM, Buckney SJ, Thirion PG. A Randomized Trial (Irish Clinical Oncology Research Group 97-01) Comparing Short Versus Protracted Neoadjuvant Hormonal Therapy Before Radiotherapy for Localized Prostate Cancer. Int J Radiat Oncol Biol Phys 2010.
2. Bolla M, Van TG, Warde P, Dubois JB, Mirimanoff RO, Storme G, Bernier J, Kuten A, Sternberg C, Billiet I, Torecilla JL, Pfeffer R, Cutajar CL, Van der KT, Collette L. External irradiation with or without long-term androgen suppression for prostate cancer with high metastatic risk: 10-year results of an EORTC randomised study. Lancet Oncol 2010;11(11):1066-73.
3. Kuban DA, Levy LB, Cheung MR, Lee AK, Choi S, Frank S, Pollack A. Long-term Failure Patterns and Survival in a Randomized Dose-Escalation Trial for Prostate Cancer. Who Dies of Disease? Int J Radiat Oncol Biol Phys 2010.
4. Bolla M, de Reijke TM, Van TG, Van Den Bergh AC, Oddens J, Poortmans PM, Gez E,

Kil P, Akdas A, Soete G, Kariakine O, van der Steen-Banasik EM, Musat E, Pierart M, Mauer ME, Collette L. Duration of androgen suppression in the treatment of prostate cancer. N Engl J Med 2009;360(24):2516-27.
5. Efstathiou JA, Bae K, Shipley WU, Hanks GE, Pilepich MV, Sandler HM, Smith MR. Cardiovascular mortality after androgen deprivation therapy for locally advanced prostate cancer: RTOG 85-31. J Clin Oncol 2009;27(1):92-9.
6. Shelley MD, Kumar S, Coles B, Wilt T, Staffurth J, Mason MD. Adjuvant hormone therapy for localised and locally advanced prostate carcinoma: a systematic review and meta-analysis of randomised trials. Cancer Treat Rev 2009;35(7):540-6.
7. Shelley MD, Kumar S, Wilt T, Staffurth J, Coles B, Mason MD. A systematic review and meta-analysis of randomised trials of neo-adjuvant hormone therapy for localised and locally advanced prostate carcinoma. Cancer Treat Rev 2009;35(1):9-17.
8. Widmark A, Klepp O, Solberg A, Damber JE, Angelsen A, Fransson P, Lund JA, Tasdemir I, Hoyer M, Wiklund F, Fossa SD. Endocrine treatment, with or without radiotherapy, in locally advanced prostate cancer (SPCG-7/SFUO-3): an open randomised phase III trial. Lancet 2009;373(9660):301-8.
9. Efstathiou JA, Bae K, Shipley WU, Hanks GE, Pilepich MV, Sandler HM, Smith MR. Cardiovascular mortality and duration of androgen deprivation for locally advanced prostate cancer: analysis of RTOG 92-02. Eur Urol 2008;54(4):816-23.
10. Horwitz EM, Bae K, Hanks GE, Porter A, Grignon DJ, Brereton HD, Venkatesan V, Lawton CA, Rosenthal SA, Sandler HM, Shipley WU. Ten-year follow-up of radiation therapy oncology group protocol 92-02: a phase III trial of the duration of elective androgen deprivation in locally advanced prostate cancer. Journal of clinical oncology : official journal of the American Society of Clinical Oncology 2008;26:2497-504.
11. Kuban DA, Tucker SL, Dong L, Starkschall G, Huang EH, Cheung MR, Lee AK, Pollack A. Long-term results of the M. D. Anderson randomized dose-escalation trial for prostate cancer. International journal of radiation oncology, biology, physics 2008;70:67-74.
12. Lawton CA, Bae K, Pilepich M, Hanks G, Shipley W. Long-term treatment sequelae after external beam irradiation with or without hormonal manipulation for adenocarcinoma of the prostate: analysis of radiation therapy oncology group studies 85-31, 86-10, and 92-02. International journal of radiation oncology, biology, physics 2008;70:437-41.
13. Roach M, Bae K, Speight J, Wolkov HB, Rubin P, Lee RJ, Lawton C, Valicenti R, Grignon D, Pilepich MV. Short-term neoadjuvant androgen deprivation therapy and external-beam radiotherapy for locally advanced prostate cancer: long-term results of RTOG 8610. Journal of clinical oncology : official journal of the American Society of Clinical Oncology 2008;26:585-91.
14. Bria E, Cuppone F, Giannarelli D, Milella M, Ruggeri EM, Sperduti I, Pinnaro P, Terzoli E, Cognetti F, Carlini P. Does hormone treatment added to radiotherapy improve outcome in locally advanced prostate cancer?: meta-analysis of randomized trials. Cancer 2009;115(15):3446-56.
15. Cuppone F, Bria E, Giannarelli D, Vaccaro V, Milella M, Nistico C, Ruggeri EM, Sperduti I, Bracarda S, Pinnaro P, Lanzetta G, Muti P, Cognetti F, Carlini P. Impact of hormonal treatment duration in combination with radiotherapy for locally advanced prostate cancer: meta-analysis of randomized trials. BMC Cancer 2010;10:675.
16. Hummel S, Simpson EL, Hemingway P, Stevenson MD, Rees A. Intensity-modulated radiotherapy for the treatment of prostate cancer: a systematic review and economic evaluation. Health Technol Assess 2010;14(47):1-iv.
17. Namiki S, Tochigi T, Ishidoya S, Ito A, Numata I, Arai Y. Long-term quality of life following primary treatment in men with clinical stage T3 prostate cancer. Qual Life Res 2011;20(1):111-8.

12.3.7.4.2. Ausgeschlossene Publikationen (Volltextscreening)

Ausschlussgrund A2: Anderes Thema (nicht Fragestellung)

18. Heidenreich A, Richter S, Thuer D, Pfister D. Prognostic parameters, complications, and oncologic and functional outcome of salvage radical prostatectomy for locally recurrent prostate cancer after 21st-century radiotherapy. Eur Urol

2010;57(3):437-43.
19. Nguyen PL, Chen MH, Beard CJ, Suh WW, Renshaw AA, Loffredo M, McMahon E, Kantoff PW, D'Amico AV. Radiation with or without 6 months of androgen suppression therapy in intermediate- and high-risk clinically localized prostate cancer: a postrandomization analysis by risk group. Int J Radiat Oncol Biol Phys 2010;77(4):1046-52.
20. Odrazka K, Dolezel M, Vanasek J, Vaculikova M, Zouhar M, Sefrova J, Paluska P, Vosmik M, Kohlova T, Kolarova I, Macingova Z, Navratil P, Brodak M, Prosvic P. Time course of late rectal toxicity after radiation therapy for prostate cancer. Prostate Cancer Prostatic Dis 2010;13(2):138-43.
21. Ojha RP, Fischbach LA, Zhou Y, Felini MJ, Singh KP, Thertulien R. Acute myeloid leukemia incidence following radiation therapy for localized or locally advanced prostate adenocarcinoma. Cancer Epidemiol 2010;34(3):274-8.
22. Schmitz MD, Padula GD, Chun PY, Davis AT. Normalization of prostate specific antigen in patients treated with intensity modulated radiotherapy for clinically localized prostate cancer. Radiat Oncol 2010;5:80.
23. Choo R, Danjoux C, Gardner S, Morton G, Szumacher E, Loblaw DA, Cheung P, Pearse M. Prospective study evaluating postoperative radiotherapy plus 2-year androgen suppression for post-radical prostatectomy patients with pathologic T3 disease and/or positive surgical margins. Int J Radiat Oncol Biol Phys 2009;75(2):407-12.
24. Da Pozzo LF, Cozzarini C, Briganti A, Suardi N, Salonia A, Bertini R, Gallina A, Bianchi M, Fantini GV, Bolognesi A, Fazio F, Montorsi F, Rigatti P. Long-term follow-up of patients with prostate cancer and nodal metastases treated by pelvic lymphadenectomy and radical prostatectomy: the positive impact of adjuvant radiotherapy. Eur Urol 2009;55(5):1003-11.
25. Fransson P, Lund JA, Damber JE, Klepp O, Wiklund F, Fossa S, Widmark A. Quality of life in patients with locally advanced prostate cancer given endocrine treatment with or without radiotherapy: 4-year follow-up of SPCG-7/SFUO-3, an open-label, randomised, phase III trial. Lancet Oncol 2009;10(4):370-80.
26. Koontz BF, Das S, Temple K, Bynum S, Catalano S, Koontz JI, Montana GS, Oleson JR. Dosimetric and radiobiologic comparison of 3D conformal versus intensity modulated planning techniques for prostate bed radiotherapy. Med Dosim 2009;34(3):256-60.
27. Lips IM, van Gils CH, van der Heide UA, Kruger AE, Van VM. Health-related quality of life 3 years after high-dose intensity-modulated radiotherapy with gold fiducial marker-based position verification. BJU Int 2009;103(6):762-7.
28. Sasaki T, Nakamura K, Ogawa K, Onishi H, Okamoto A, Koizumi M, Shioyama Y, Mitsumori M, Teshima T. Radiotherapy for patients with localized hormone-refractory prostate cancer: results of the Patterns of Care Study in Japan. BJU Int 2009;104(10):1462-6.
29. Schelin S, Madsen M, Palmqvist E, Makela E, Klintenberg C, Aus G. Long-term follow-up after triple treatment of prostate cancer stage pT3. Scand J Urol Nephrol 2009;43(3):186-91.
30. Chin JL, Ng CK, Touma NJ, Pus NJ, Hardie R, Abdelhady M, Rodrigues G, Radwan J, Venkatesan V, Moussa M, Downey DB, Bauman G. Randomized trial comparing cryoablation and external beam radiotherapy for T2C-T3B prostate cancer. Prostate cancer and prostatic diseases 2008;11:40-5.
31. Choo R, Pearse M, Danjoux C, Gardner S, Morton G, Szumacher E, Loblaw DA, Cheung P. Analysis of gastrointestinal and genitourinary morbidity of postoperative radiotherapy for pathologic T3 disease or positive surgical margins after radical prostatectomy using national cancer institute expanded common toxicity criteria. Int J Radiat Oncol Biol Phys 2008;72(4):989-95.
32. Fang FM, Wang YM, Wang CJ, Huang HY, Chiang PH. Comparison of the outcome and morbidity for localized or locally advanced prostate cancer treated by high-dose-rate brachytherapy plus external beam radiotherapy (EBRT) versus EBRT alone. Jpn J Clin Oncol 2008;38(7):474-9.
33. Ganswindt U, Stenzl A, Bamberg M, Belka C. Adjuvant radiotherapy for patients with locally advanced prostate cancer--a new standard? Eur Urol 2008;54(3):528-42.
34. Heidenreich A, Semrau R, Thuer D, Pfister D. [Radical salvage prostatectomy : Treatment of local recurrence of prostate cancer after radiotherapy]. Urologe A

2008;47(11):1441-6.
35. Morgan SC, Waldron TS, Eapen L, Mayhew LA, Winquist E, Lukka H. Adjuvant radiotherapy following radical prostatectomy for pathologic T3 or margin-positive prostate cancer: a systematic review and meta-analysis. Radiother Oncol 2008;88(1):1-9.
36. Shelley M, Wilt T, Coles B, Mason M. Cryotherapy for localised prostate cancer. Shelley Mike , Wilt Timothy , Coles Bernadette , Mason Malcolm Cryotherapy for localised prostate cancer Cochrane Database of Systematic Reviews: Reviews 2007 Issue 3 John Wiley & Sons , Ltd Chichester, UK DOI : 10 1002 /14651858 CD005010 pub2 2007.

Ausschlussgrund A3: Anderer Publikationstyp (Editorial, Fallbericht, Brief etc.)

1. Engineer R, Bhutani R, Mahantshetty U, Murthy V, Shrivastava SK. From two-dimensional to three-dimensional conformal radiotherapy in prostate cancer: an Indian experience. Indian J Cancer 2010;47(3):332-8.
2. Krauss D, Kestin L, Ye H, Brabbins D, Ghilezan M, Gustafson G, Vicini F, Martinez A. Lack of Benefit for the Addition of Androgen Deprivation Therapy to Dose-Escalated Radiotherapy in the Treatment of Intermediate- and High-Risk Prostate Cancer. Int J Radiat Oncol Biol Phys 2010.
3. Liauw SL, Stadler WM, Correa D, Weichselbaum RR, Jani AB. Dose-escalated radiotherapy for high-risk prostate cancer: outcomes in modern era with short-term androgen deprivation therapy. Int J Radiat Oncol Biol Phys 2010;77(1):125-30.
4. Sakamoto M, Mizowaki T, Mitsumori M, Takayama K, Sasai K, Norihisa Y, Kamoto T, Nakamura E, Ogawa O, Hiraoka M. Long-term outcomes of three-dimensional conformal radiation therapy combined with neoadjuvant hormonal therapy in Japanese patients with locally advanced prostate cancer. Int J Clin Oncol 2010;15(6):571-7.
5. Lim TS, Cheung PC, Loblaw DA, Morton G, Sixel KE, Pang G, Basran P, Zhang L, Tirona R, Szumacher E, Danjoux C, Choo R, Thomas G. Hypofractionated accelerated radiotherapy using concomitant intensity-modulated radiotherapy boost technique for localized high-risk prostate cancer: acute toxicity results. Int J Radiat Oncol Biol Phys 2008;72(1):85-92.
6. Yamazaki H, Nishiyama K, Tanaka E, Maeda O, Meguro N, Kinouchi T, Usami M, Kakimoto K, Ono Y, Nishimura T. Reduction of irradiation volume and toxicities with 3-D radiotherapy planning over conventional radiotherapy for prostate cancer treated with long-term hormonal therapy. Anticancer Res 2008;28(6B):3913-20.
7. Gryn S, Winquist E. Effects of the duration of androgen deprivation therapy for localized or locally advanced prostate cancer in patients treated with radiotherapy. Gryn Steven , Winquist Eric Effects of the duration of androgen deprivation therapy for localized or locally advanced prostate cancer in patients treated with radiotherapy Cochrane Database of Systematic Reviews: Protocols 2007 Issue 4 John Wiley & Sons 2007.
8. Souhami L, Bae K, Pilepich M, Sandler H. Impact of the duration of adjuvant hormonal therapy in patients with locally advanced prostate cancer treated with radiotherapy: a secondary analysis of RTOG 85-31. J Clin Oncol 2009;27(13):2137-43.

Ausschlussgrund A4: Unsystematischer Review

1. Sanfilippo N, Hardee ME, Wallach J. Review of chemoradiotherapy for high-risk prostate cancer. Rev Recent Clin Trials 2011;6(1):64-8.
2. Sumey C, Flaig TW. Adjuvant medical therapy for prostate cancer. Expert Opin Pharmacother 2011;12(1):73-84.
3. Staffurth J. A review of the clinical evidence for intensity-modulated radiotherapy. Clin Oncol (R Coll Radiol) 2010;22(8):643-57.
4. Verhagen PC, Schroder FH, Collette L, Bangma CH. Does local treatment of the prostate in advanced and/or lymph node metastatic disease improve efficacy of androgen-deprivation therapy? A systematic review. Eur Urol 2010;58(2):261-9.
5. Herfarth K, Sterzing F. [Radiotherapy for locally advanced prostate cancer]. Urologe A 2008;47(11):1424-30.
6. Kollmeier MA, Zelefsky MJ. What is the role of androgen deprivation therapy in the treatment of locally advanced prostate cancer? Nat Clin Pract Urol 2008;5(11):584-5.

7. Miller K, Lein M, Schostak M, Schrader M. [Adjuvant and neoadjuvant drug therapy for prostate cancer]. Urologe A 2008;47(11):1460-4.
8. Palisaar RJ, Noldus J. [The role of surgery in locally advanced prostate cancer]. Urologe A 2008;47(11):1417-23.

12.3.8. Recherchen zum Thema Protonentherapie

12.3.8.1. Fragestellungen

Population	Intervention	Kontrolle	Outcomes	Time aspects
Patienten mit lokal begrenztem oder lokal fortgeschrittenem Prostatakarzinom (cT1-cT4)	Externe Strahlentherapie mit Protonen oder Kombination von Photonen und Protonen	Externe Strahlentherapie mit Photonen	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben) Morbidität (PSA-Kinetik, Histologie) Lebensqualität Nebenwirkungen/Schäden	Keine Einschränkungen

12.3.8.2. Recherchen

12.3.8.2.1. Recherchestrategien für Fragen 1 und 2

Ausschlusskriterien der ersten Relevanzsichtung:

A1: andere Erkrankung

A2: Methodik (Letter, Editorial u.ä.)

PubMed (10. März 2011)

Nr.	Suchfrage	Anzahl
#5	#1 AND #2 AND #3 Limits: English, German, Publication date from 2008/06	199
#4	#1 AND #2 AND #3	1288
#3	"locally advanced" OR T3 OR T4 (Details: "locally advanced"[All Fields] OR T3[All Fields] OR T4[All Fields])	58640
#2	radiotherapy OR radiation OR radiotherapeutic OR EBRT (Details: ("radiotherapy"[Subheading] OR "radiotherapy"[All Fields] OR "radiotherapy"[MeSH Terms]) OR ("radiation"[MeSH Terms] OR "radiation"[All Fields]) OR ("radiotherapy"[MeSH Terms] OR "radiotherapy"[All Fields] OR "radiotherapeutic"[All Fields]) OR EBRT[All Fields])	678589
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	92213

Anzahl der Treffer: 199

Davon relevant: 183

Cochrane (10. März 2011)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer" in Title, Abstract or Keywords and radiotherapy or radiation or radiotherapeutic or EBRT in Title, Abstract or Keywords and locally advanced OR T3 OR T4 in Title, Abstract or Keywords, from 2008 to 2011	23

- Cochrane Database of Systematic Reviews (5)
- Database of Abstracts of Reviews of Effects (1)
- Cochrane Central Register of Controlled Trials (17)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (0)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 23

Davon neu: 10

Davon relevant: 7

12.3.8.2.2. Recherchestrategien für Frage 3

PubMed (10. März 2011)

Nr.	Suchfrage	Anzahl
#6	#1 AND #2 AND #3 AND #4 Limits: English, German, Publication date from 2008	60
#5	#1 AND #2 AND #3 AND #4	242
#4	"locally advanced" OR T3 OR T4 OR localized OR T1 OR T2 (Details: "locally advanced"[All Fields] OR T3[All Fields] OR T4[All Fields] OR localized[All Fields] OR T1[All Fields] OR T2[All Fields])	296050
#3	dose escalation (Details: dose[All Fields] AND escalation[All Fields])	6549
#2	radiotherapy OR radiation OR radiotherapeutic OR EBRT (Details: ("radiotherapy"[Subheading] OR "radiotherapy"[All Fields] OR "radiotherapy"[MeSH Terms]) OR ("radiation"[MeSH Terms] OR "radiation"[All Fields]) OR ("radiotherapy"[MeSH Terms] OR "radiotherapy"[All Fields] OR "radiotherapeutic"[All Fields]) OR EBRT[All Fields])	678589
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	92213

Anzahl der Treffer: 60

Cochrane (10. März 2011)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and radiotherapy or radiation or radiotherapeutic or EBRT in Title, Abstract or Keywords and locally advanced or T3 or T4 or localized or T1 or T2 in Title, Abstract or Keywords and dose escalation in Title, Abstract or Keywords, from 2008 to 2011	7

- Cochrane Database of Systematic Reviews (0)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (7)
- Cochrane Methodology Register (0)

- Health Technology Assessment Database (0)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 7

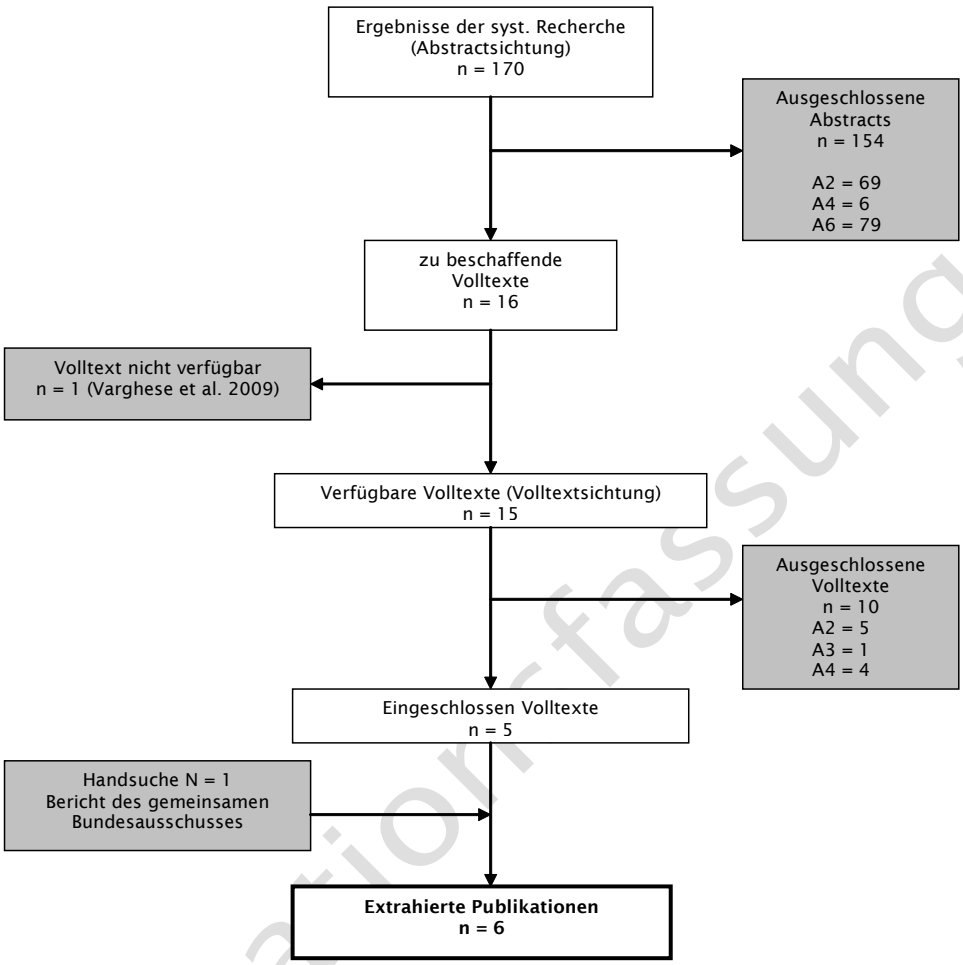
Davon neu: 0

12.3.8.3. Ein- und Ausschlusskriterien

Für Frage 1

Einschlussgründe	
E1 Zielgruppe	Patienten mit lokal begrenztem und lokal fortgeschrittenem primären Prostatakarzinom (cT1-cT4)
E2 Publikationstyp	Klinische Studien inklusive Fallserien (n ≥ 50) oder systematischer Review/HTA-Bericht (mit oder ohne Metaanalyse)
E3: Suchzeitraum	Publikationen seit 2008 (letzte Recherche des Gemeinsamen Bundesausschuss bei der Bewertung der Protonentherapie)
E4: Sprachen	deutsch, englisch
E5 Intervention	Externe Strahlentherapie mit Protonen oder einer Kombination aus Protonen und Photonen
Ausschlussgründe	
A1	andere Population
A2	Nicht Fragestellung (siehe oben)
A3	Anderer Publikationstyp (Editorial, Fallbericht, Brief etc.)
A4	Unsystematischer Review
A5	Doppelpublikation oder aktuellere Publikation vorhanden
A6	Publikationszeitpunkt innerhalb des Recherchezeitraums der Recherche des G-BA (06.05.2008)

12.3.8.4. Ergebnisse der Recherche



12.3.8.4.1. Eingeschlossene Publikationen

1. Mendenhall NP, Li Z, Hoppe BS, Marcus RB, Jr., Mendenhall WM, Nichols RC, Morris CG, Williams CR, Costa J, Henderson R. Early Outcomes from Three Prospective Trials of Image-guided Proton Therapy for Prostate Cancer. Int J Radiat Oncol Biol Phys 2010.
2. Nihei K, Ogino T, Onozawa M, Murayama S, Fuji H, Murakami M, Hishikawa Y. Multi-Institutional Phase II Study of Proton Beam Therapy for Organ-Confined Prostate Cancer Focusing on the Incidence of Late Rectal Toxicities. Int J Radiat Oncol Biol Phys 2010.
3. Brada M, Pijls-Johannesma M, De RD. Current clinical evidence for proton therapy. Cancer J 2009;15(4):319-24.
4. Terasawa T, Dvorak T, Ip S, Raman G, Lau J, Trikalinos TA. Systematic review: charged-particle radiation therapy for cancer. Ann Intern Med 2009;151(8):556-65.
5. Ollendorf DA, Hayes J, McMahon P, Kuba M, Tramontano A, Pearson SD. Brachytherapy/proton beam therapy for clinically localized, low-risk prostate cancer (Structured abstract). Boston : Institute for Clinical and Economic Review 2008;114.

12.3.8.4.2. Ausgeschlossene Publikationen (Volltextscreening)

Ausschlussgrund A2: Anderes Thema (nicht Fragestellung)

1. Fontenot JD, Bloch C, Followill D, Titt U, Newhauser WD. Estimate of the uncertainties in the relative risk of secondary malignant neoplasms following proton therapy

and intensity-modulated photon therapy. Phys Med Biol 2010;55(23):6987-98.
2. Jabbari S, Weinberg VK, Shinohara K, Speight JL, Gottschalk AR, Hsu IC, Pickett B, McLaughlin PW, Sandler HM, Roach M, III. Equivalent biochemical control and improved prostate-specific antigen nadir after permanent prostate seed implant brachytherapy versus high-dose three-dimensional conformal radiotherapy and high-dose conformal proton beam radiotherapy boost. Int J Radiat Oncol Biol Phys 2010;76(1):36-42.
3. Talcott JA, Rossi C, Shipley WU, Clark JA, Slater JD, Niemierko A, Zietman AL. Patient-reported long-term outcomes after conventional and high-dose combined proton and photon radiation for early prostate cancer. JAMA 2010;303(11):1046-53.
4. Yoon M, Ahn SH, Kim J, Shin DH, Park SY, Lee SB, Shin KH, Cho KH. Radiation-induced cancers from modern radiotherapy techniques: intensity-modulated radiotherapy versus proton therapy. Int J Radiat Oncol Biol Phys 2010;77(5):1477-85.
5. Zietman AL, Bae K, Slater JD, Shipley WU, Efstathiou JA, Coen JJ, Bush DA, Lunt M, Spiegel DY, Skowronski R, Jabola BR, Rossi CJ. Randomized trial comparing conventional-dose with high-dose conformal radiation therapy in early-stage adenocarcinoma of the prostate: long-term results from proton radiation oncology group/american college of radiology 95-09. J Clin Oncol 2010;28(7):1106-11.

Ausschlussgrund A3: Anderer Publikationstyp (Editorial, Fallbericht, Brief etc.)

1. Fontenot JD, Lee AK, Newhauser WD. Risk of secondary malignant neoplasms from proton therapy and intensity-modulated x-ray therapy for early-stage prostate cancer. Int J Radiat Oncol Biol Phys 2009;74(2):616-22

Ausschlussgrund A4: Unsystematischer Review

1. Kagan AR, Schulz RJ. Proton-beam therapy for prostate cancer. Cancer J 2010;16(5):405-9.
2. Printz C. "Boost" of proton therapy helps reduce prostate cancer recurrence. Cancer 2010;116(7):1619.
3. Proton beam therapy for prostate cancer. Johns Hopkins Med Lett Health After 50 2009;21(2):3, 7.
4. Efstathiou JA, Trofimov AV, Zietman AL. Life, liberty, and the pursuit of protons: an evidence-based review of the role of particle therapy in the treatment of prostate cancer. Cancer J 2009;15(4):312-8.

12.3.9. Recherchen zum Thema HIFU

12.3.9.1. Fragestellungen

Population	Intervention	Control	Outcomes	Time aspects
Patienten mit lokal begrenztem, primären, Prostatakarzinom (T1-T2, N0-Nx, M0)	Hochintensiver Fokussierter Ultraschall (HIFU)	Active Surveillance, radikale Prostatektomie, Strahlentherapie, interstitielle Brachytherapie	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben) Morbidität (PSA-Kinetik, Histologie) Lebensqualität	Keine Einschränkungen
Patienten mit lokal fortgeschrittenem, primären, Prostatakarzinom (T3-T4, N0-Nx, M0)	Hochintensiver Fokussierter Ultraschall (HIFU)	Active Surveillance, radikale Prostatektomie, Strahlentherapie, interstitielle Brachytherapie,	Mortalität (inkl. 5-Jahres Überleben, krankheitsfreies Überleben) Morbidität (PSA-Kinetik, Histologie) Lebensqualität	Keine Einschränkungen

12.3.9.2. Recherchen

Ausschlusskriterien für erste Relevanzsichtung:

A1: andere Erkrankung

A2: Methodik (Letter, Editorial u.ä.)

PubMed (03. Januar 2011)

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 Limits: English, German, Publication date from 2008/08	107
#3	#1 AND #2	315
#2	HIFU (Details: "high-intensity focused ultrasound ablation"[MeSH Terms] OR ("high-intensity"[All Fields] AND "focused"[All Fields] AND "ultrasound"[All Fields] AND "ablation"[All Fields]) OR "high-intensity focused ultrasound ablation"[All Fields] OR "hifu"[All Fields])	1002
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	90835

Anzahl der Treffer: 107

Davon relevant: 94

Cochrane (03. Januar 2011)

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and hifu OR high-intensity focused ultrasound in Title, Abstract or Keywords, from 2008 to 2011	6

- Cochrane Database of Systematic Reviews (1)
- Database of Abstracts of Reviews of Effects (0)

- Cochrane Central Register of Controlled Trials (3)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (2)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 6

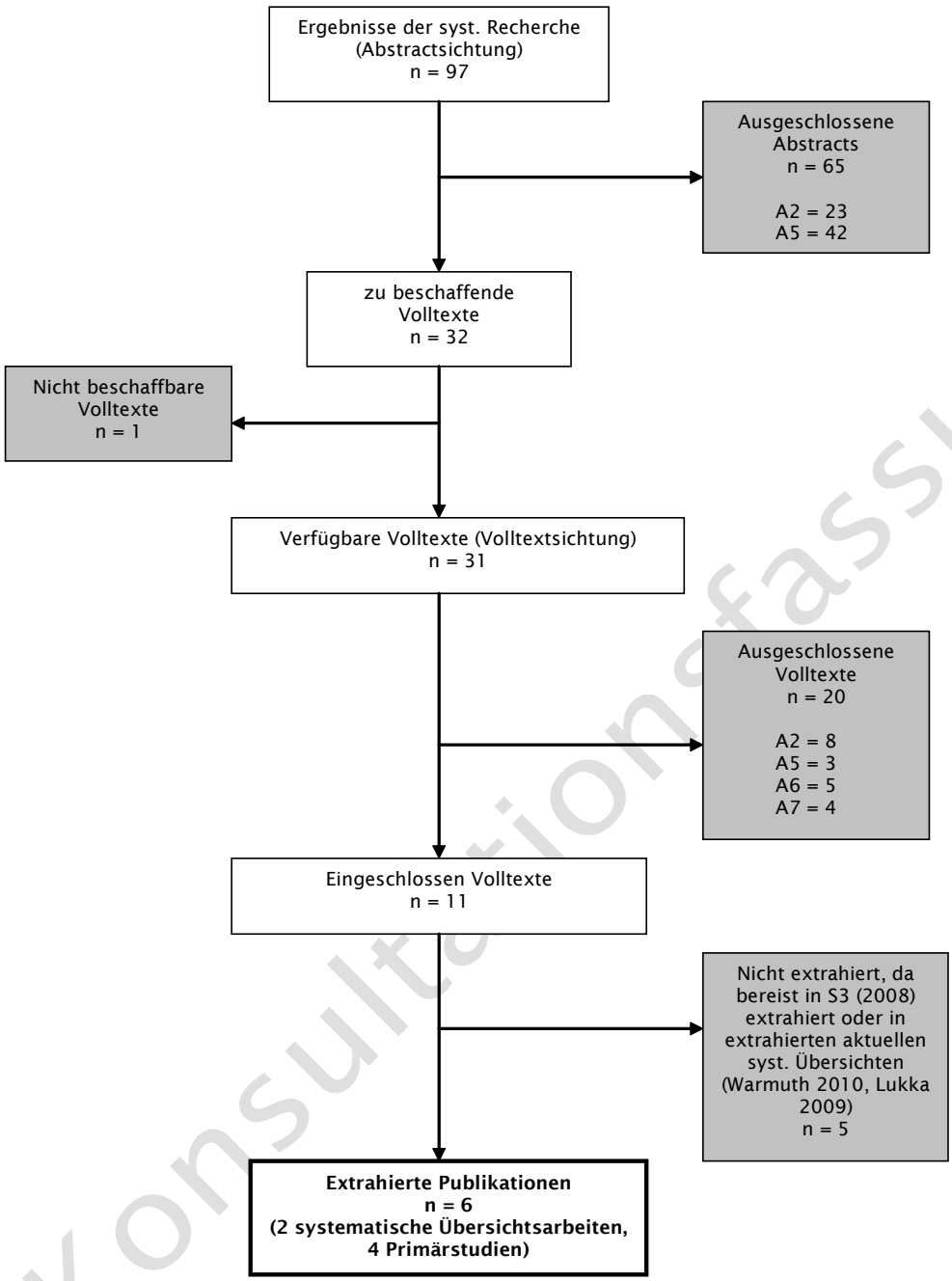
Davon neu: 4

Davon relevant: 3

12.3.9.3. Ein- und Ausschlusskriterien

Einschlussgründe	
E1 Zielgruppe	Patienten mit lokal begrenztem oder lokal fortgeschrittenem primären Prostatakarzinom oder Patienten mit Lokalrezidiv nach Prostatektomie oder Strahlentherapie
E2 Publikationstyp	Klinische Studien inklusive Fallserien oder systematischer Review/HTA-Bericht (mit oder ohne Metaanalyse)
E3: Suchzeitraum	Publikationen seit August 2008 (letzte Recherche S3 Leitlinien-Gruppe)
E4: Sprachen	deutsch, englisch
E5 Intervention	HIFU, auch nicht-kontrollierte Studien werden berücksichtigt
Ausschlussgründe	
A1	Nicht Zielgruppe
A2	Keine klinische Studie oder sytematischer Review (mit oder ohne Metaanalyse)
A3	Publikation vor August 2008 erschienen
A4	Sprache nicht englisch oder deutsch
A5	Nicht Fragestellung: HIFU zur Therapie des Prostatakarzinoms

12.3.9.4. Ergebnisse der Recherche



12.3.9.4.1. Eingeschlossene Publikationen

Eingeschlossene Publikationen	Einschluss in Warmuth 2010	Einschluss in Lukka 2009
Ahmed HU, Zacharakis E, Dudderidge T, Armitage JN, Scott R, Calleary J, Illing R, Kirkham A, Freeman A, Ogden C, Allen C, Emberton M. High-intensity-focused ultrasound in the treatment of primary prostate cancer: the first UK series. Br J Cancer 2009;101(1):19-26.	X	
Blana A, Rogenhofer S, Ganzer R, Lunz JC, Schostak M, Wieland WF, Walter B. Eight years' experience with high-intensity focused ultrasonography for treatment of localized prostate cancer. Urology 2008;72(6):1329-33.	Diese Arbeit wurde im Rahmen der Konsultationsphase der Version 2008 identifiziert und ist in der jetzigen Version der S3-Leitlinie bereits extrahiert.	
Crouzet S, Rebillard X, Chevallier D, Rischmann P, Pasticier G, Garcia G, Rouviere O, Chapelon JY, Gelet A. Multicentric oncologic outcomes of high-intensity focused ultrasound for localized prostate cancer in 803 patients. Eur Urol 2010;58(4):559-66.	Wurde extrahiert	
Li LY, Lin Z, Yang M, Gao X, Xia TL, Ding T. Comparison of penile size and erectile function after high-intensity focused ultrasound and targeted cryoablation for localized prostate cancer: a prospective pilot study. J Sex Med 2010;7(9):3135-42.	Ergebnisse für HIFU wurden extrahiert	
Lukka H, Waldron T, Chin J, Mayhew L, Warde P, Winquist E, Rodrigues G, Shayegan B. High-intensity Focused Ultrasound for Prostate Cancer: a Systematic Review. Clin Oncol (R Coll Radiol) 2010.	Wurde extrahiert	
Mearini L, D'Urso L, Collura D, Zucchi A, Costantini E, Formiconi A, Bini V, Muto G, Porena M. Visually directed transrectal high intensity focused ultrasound for the treatment of prostate cancer: a preliminary report on the Italian experience. J Urol 2009;181(1):105-11.		X
Netsch C, Pfeiffer D, Gross AJ. Development of bladder outlet obstruction after a single treatment of prostate cancer with high-intensity focused ultrasound: experience with 226 patients. J Endourol 2010;24(9):1399-403.	Wurde extrahiert	
Shoji S, Nakano M, Nagata Y, Usui Y, Terachi T, Uchida T. Quality of life following high-intensity focused ultrasound for the treatment of localized prostate cancer: a prospective study. Int J Urol 2010;17(8):715-9.	Wurde extrahiert	
Uchida T, Shoji S, Nakano M, Hongo S, Nitta M, Murota A, Nagata Y. Transrectal high-intensity focused ultrasound for the treatment of localized prostate cancer: eight-year experience. Int J Urol 2009;16(11):881-6.	X	
Warmuth M, Johansson T, Mad P. Systematic Review of the Efficacy and Safety of High-Intensity Focussed Ultrasound for the Primary and Salvage Treatment of Prostate Cancer. Eur Urol 2010.	Wurde extrahiert	

Obyn C, Mambourg F. Assessment of high intensity focused ultrasound for the treatment of prostate cancer. Acta Chir Belg 2009;109(5):581-6.	X	X

12.3.9.4.2. Ausgeschlossene Publikationen (Volltextscreening)

Ausschlussgrund A2 (Keine klinische Studie oder sytematischer Review (mit oder ohne Metaanalyse))

1. Ahmed HU, Emberton M. Active surveillance and radical therapy in prostate cancer: can focal therapy offer the middle way? World J Urol 2008;26(5):457-67.
2. Abdel-Wahab M, Pollack A. Prostate cancer: Defining biochemical failure in patients treated with HIFU. Nat Rev Urol 2010;7(4):186-7.
3. Chaussy C, Thuroff S. High-intensity focused ultrasound in the management of prostate cancer. Expert Rev Med Devices 2010;7(2):209-17.
4. Kimura M, Mouraviev V, Tsivian M, Mayes JM, Satoh T, Polascik TJ. Current salvage methods for recurrent prostate cancer after failure of primary radiotherapy. BJU Int 2010;105(2):191-201.
5. Lukka H, Waldron T, Chin J, Mayhew L, Warde P, Winquist E, Rodrigues G, Shayegan B. High-intensity focused ultrasound for prostate cancer: a practice guideline. Can Urol Assoc J 2010;4(4):232-6.
6. Mazzucchelli R, Scarpelli M, Cheng L, Lopez-Beltran A, Galosi AB, Kirkali Z, Montironi R. Pathology of prostate cancer and focal therapy ('male lumpectomy'). Anticancer Res 2009;29(12):5155-61.
7. Ward JF. Prostate cancer: HIFU is effective, but associated morbidity still remains unclear. Nat Rev Urol 2010;7(11):597-8.
8. Ward JF. Contemporary outcomes of focal therapy in prostate cancer: what do we know so far.. World J Urol 2010;28(5):593-7.

Ausschlussgrund A5 (Nicht Fragestellung: HIFU zur Therapie des Prostatakarzinoms)

1. Biermann K, Montironi R, Lopez-Beltran A, Zhang S, Cheng L. Histopathological findings after treatment of prostate cancer using high-intensity focused ultrasound (HIFU). Prostate 2010;70(11):1196-200.
2. Blana A, Brown SC, Chaussy C, Conti GN, Eastham JA, Ganzer R, Murat FJ, Pasticier G, Rebillard X, Rewcastle JC, Robertson CN, Thuroff S, Ward JF. High-intensity focused ultrasound for prostate cancer: comparative definitions of biochemical failure. BJU Int 2009;104(8):1058-62.
3. Li LY, Yang M, Gao X, Zhang HB, Li JF, Xu WF, Lin Z, Zhou XL. Prospective comparison of five mediators of the systemic response after high-intensity focused ultrasound and targeted cryoablation for localized prostate cancer. BJU Int 2009;104(8):1063-7.

Ausschlussgrund A6 (n < 50)

1. Berge V, Baco E, Karlsen SJ. A prospective study of salvage high-intensity focused ultrasound for locally radiorecurrent prostate cancer: early results. Scand J Urol Nephrol 2010;44(4):223-7.
2. Challacombe BJ, Murphy DG, Zakri R, Cahill DJ. High-intensity focused ultrasound for localized prostate cancer: initial experience with a 2-year follow-up. BJU Int 2009;104(2):200-4.
3. Maestroni U, Ziveri M, Azzolini N, Dinale F, Ziglioli F, Campaniello G, Frattini A, Ferretti S. High Intensity Focused Ultrasound (HIFU): a useful alternative choice in prostate cancer treatment. Preliminary results. Acta Biomed 2008;79(3):211-6.
4. Murota-Kawano A, Nakano M, Hongo S, Shoji S, Nagata Y, Uchida T. Salvage high-intensity focused ultrasound for biopsy-confirmed local recurrence of prostate cancer after radical prostatectomy. BJU Int 2010;105(12):1642-5.
5. Zacharakis E, Ahmed HU, Ishaq A, Scott R, Illing R, Freeman A, Allen C, Emberton M. The feasibility and safety of high-intensity focused ultrasound as salvage therapy for recurrent prostate cancer following external beam radiotherapy. BJU Int

2008;102(7):786-92.

Ausschlussgrund A7 (restropspektive Auswertung)

1. Misrai V, Roupret M, Chartier-Kastler E, Comperat E, Renard-Penna R, Haertig A, Bitker MO, Richard F, Conort P. Oncologic control provided by HIFU therapy as single treatment in men with clinically localized prostate cancer. World J Urol 2008;26(5):481-5.
2. Murat FJ, Poissonnier L, Rabilloud M, Belot A, Bouvier R, Rouviere O, Chapelon JY, Gelet A. Mid-term results demonstrate salvage high-intensity focused ultrasound (HIFU) as an effective and acceptably morbid salvage treatment option for locally radiorecurrent prostate cancer. Eur Urol 2009;55(3):640-7.
3. Ripert T, Azemar MD, Menard J, Barbe C, Messaoudi R, Bayoud Y, Pierrevelcin J, Duval F, Staerman F. Six years' experience with high-intensity focused ultrasonography for prostate cancer: oncological outcomes using the new 'Stuttgart' definition for biochemical failure. BJU Int 2010.
4. Ripert T, Azemar MD, Menard J, Bayoud Y, Messaoudi R, Duval F, Staerman F. Transrectal high-intensity focused ultrasound (HIFU) treatment of localized prostate cancer: review of technical incidents and morbidity after 5 years of use. Prostate Cancer Prostatic Dis 2010;13(2):132-7.

12.3.10. Recherchen zum Thema Therapie von Knochenmetastasen

12.3.10.1. Fragestellungen

Population	Intervention	Control	Outcomes	Time aspects
Pat. mit kurativ behandeltem PCa	Präventive Gabe von Bisphosphonaten	-	Auftreten von Knochenmetastasen	-
Pat mit PCa und Knochenmetastasen	Perkutane Radiotherapie, Radioisotope, operative Interventionen, Spezifische Medikamente zur Behandlung von Knochenmetastasen	Placebo/Goldstandard	Auftreten von Skeletal related events Schmerzreduktion Nebenwirkungen Gesamtüberleben	-

12.3.10.2. Recherchen

1. Recherche zu Prävention von Knochenmetastasen
(ab 1/2000 – 10.3.2011)

Pubmed

Nr.	Suchfrage	Anzahl
#5	#1 AND #2 AND #3 Limits: English, German	153
#4	#1 AND #2 AND #3	165
#3	prevention (Details: "prevention and control"[Subheading] OR ("prevention"[All Fields] AND "control"[All Fields]) OR "prevention and control"[All Fields] OR "prevention"[All Fields])	1038408

#2	bone metastasis (Details: ("bone and bones"[MeSH Terms] OR ("bone"[All Fields] AND "bones"[All Fields]) OR "bone and bones"[All Fields] OR "bone"[All Fields]) AND ("neoplasm metastasis"[MeSH Terms] OR ("neoplasm"[All Fields] AND "metastasis"[All Fields]) OR "neoplasm metastasis"[All Fields] OR "metastasis"[All Fields]))	21188
#1	Prostate cancer (Details: "prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields])	92213

Anzahl der Treffer: 153

Davon relevant: 150

Cochrane

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and bone metastasis in Title, Abstract or Keywords and prevention in Title, Abstract or Keywords	33

- Cochrane Database of Systematic Reviews (2)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (29)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (1)
- NHS Economic Evaluation Database (1)

Anzahl der Treffer: 33

Davon neu: 26

Davon relevant: 26

2. Recherche zu Behandlung von Knochenmetastasen (2/2009-8.6.2011)

Pubmed

Nr.	Suchfrage	Anzahl
#9	#4 AND #7 Limits: English, German; Publication Date from 2009	36
#8	#4 AND #7	275
#7	#5 OR #6	2297626
#6	(randomized controlled trial [pt] OR controlled clinical trial [pt] OR randomized [tiab] OR placebo [tiab] OR drug therapy [sh] OR randomly [tiab] OR trial [tiab] OR groups [tiab]) AND humans [mh]	2194815
#5	systematic[sb]	156356
#4	#1 AND #2 AND #3	687
#3	("Radioisotopes"[Mesh]) OR radionuclide*[tiab] OR"Radiotherapy"[Mesh] OR radiation OR radiotherapy OR ("Diphosphonates"[Mesh])	900425
#2	bone metastasis	21468
#1	Prostate cancer	94089

Anzahl der Treffer: 36

Davon relevant: 34

Cochrane

Nr.	Suchfrage	Anzahl
#1	"prostate cancer in Title, Abstract or Keywords and bone metastasis in Title, Abstract or Keywords in Title, Abstract or Keywords from 2009 to 2011	9

- Cochrane Database of Systematic Reviews (4)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (15)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (1)
- NHS Economic Evaluation Database (0)

Davon relevant: 2

12.3.10.3. Ein – und Ausschlusskriterien

Einschlussgründe	
E1 Zielgruppe	Patienten mit kurativ behandeltem PCa Patienten mit KNochenmetastasen
E2 Publikations-typ	Therapie: Randomisierte kontrollierte Studien Phase III Unerwünschte Wirkungen: Fallserien mit v.a. PCa, mind, n=11
E3: Suchzeitraum	Prävention: ab 2000 Behandlung : ab 2009
E4: Sprachen	Deutsch, Englisch
E5 Intervention	Prävention: Medikation Behandlung: Medikation (Bisphosphonate, Denosumab) , perkutane Strahlentherapie, Therapie mit Radioisotopen, operative Therapie

Ausschlusskriterien für erste Relevanzsichtung der Volltexte

A1: Methodik (Letter, Editorial, experimentelle Phase I - Studie, Phase II-Studie, Nebenwirkungen Fallberichte <10)

A2: andere Erkrankung bzw. nicht v.a. PCa

A3: kein Fokus auf Prävention oder Behandlung von Knochenmetastasen bei Prostatakarzinompatienten

A4: unsystematische Übersichtsarbeit

12.3.10.4. Ergebnisse der Recherche

12.3.10.4.1. Recherche zu Prävention

Abstracts:
Pubmed: 153, Cochrane: n= 26, Referenzlisten:1

Volltexte: 12

Nach Volltextsichtung eingeschlossene Texte

1. (nur im Hintergrund zitiert, nicht extrahiert) Mason MD, Sydes MR, Glaholm J, Langley RE, Huddart RA, Sokal M, Stott M, Robinson AC, James ND, Parmar MK, Dearnaley DP. Oral sodium clodronate for nonmetastatic prostate cancer--results of a randomized double-blind placebo-controlled trial: Medical Research Council PR04 (ISRCTN61384873). J Natl Cancer Inst 2007;99(10):765-76.
2. Morgan G, Lipton A. Antitumor effects and anticancer applications of bisphosphonates. Semin Oncol 2010;37 Suppl 2:S30-S40.
3. Smith MR, Kabbinavar F, Saad F, Hussain A, Gittelman MC, Bilhartz DL, Wynne C, Murray R, Zinner NR, Schulman C, Linnartz R, Zheng M, Goessl C, Hei YJ, Small EJ, Cook R, Higano CS. Natural history of rising serum prostate-specific antigen in men with castrate nonmetastatic prostate cancer. Journal of clinical oncology : official journal of the American Society of Clinical Oncology 2005;23(13):2918-25. (siehe Evidenztabellen, aus Referenzliste)
4. (nur im Hintergrund zitiert, nicht extrahiert) Witjes W, Tammela T, Wirth M. Effectiveness of zoledronic acid for the prevention of bone metastases in high risk prostate cancer patients: A randomised, open label, multicenter study of the European Association of Urology (EAU) in cooperation with the Scandinavian Prostate Cancer Group (SPCG) and the Arbeitsgemeinschaft Urologische Onkologie (AUO). An initial report of the "ZEUS" study. Journal of Clinical Oncology: ASCO annual meeting proceedings 2006;24(18S):14644.

Ausgeschlossene Volltexte

A3 nicht Fokus Prävention von Knochenmetastasen bei PCa:

1. Ryan CW, Huo D, Bylow K, Demers LM, Stadler WM, Henderson TO, Vogelzang NJ. Suppression of bone density loss and bone turnover in patients with hormone-sensitive prostate cancer and receiving zoledronic acid. BJU Int 2007;100(1):70-5. (Prävention Osteoporose)
2. Smith MR, McGovern FJ, Zietman AL, Fallon MA, Hayden DL, Schoenfeld DA, Kantoff PW, Finkelstein JS. Pamidronate to prevent bone loss during androgen-deprivation therapy for prostate cancer. The New England journal of medicine 2001;345(13):948-55. (Prävention Osteoporose)
3. Smith MR, Eastham J, Gleason DM, Shasha D, Tchekmedyian S, Zinner N. Randomized controlled trial of zoledronic acid to prevent bone loss in men receiving androgen deprivation therapy for nonmetastatic prostate cancer. Journal of Urology 2003;169(6):2008-12. (Prävention Osteoporose)
4. Taxel P, Fall PM, Albertsen PC, Dowsett RD, Trahiotis M, Zimmerman J, Ohannessian C, Raisz LG. The effect of micronized estradiol on bone turnover and calciotropic hormones in older men receiving hormonal suppression therapy for prostate cancer. J Clin Endocrinol Metab 2002;87(11):4907-13. (Prävention Osteoporose)

A4 nicht systematischer Review:

1. Body JJ. Bisphosphonates for malignancy-related bone disease: current status, future developments. Support Care Cancer 2006;14(5):408-18.
2. Chen TC, Holick MF. Vitamin D and prostate cancer prevention and treatment. Trends Endocrinol Metab 2003;14(9):423-30.
3. Coleman R, Gnant M. New results from the use of bisphosphonates in cancer patients. Curr Opin Support Palliat Care 2009;3(3):213-8.
4. Gnant M. Bisphosphonates in the prevention of disease recurrence: current results and ongoing trials. Curr Cancer Drug Targets 2009;9(7):824-33.
5. Lattouf JB, Saad F. Preservation of bone health in prostate cancer. Curr Opin Support Palliat Care 2007;1(3):192-7.
6. Saad F, McKiernan J, Eastham J. Rationale for zoledronic acid therapy in men with hormone-sensitive prostate cancer with or without bone metastasis. Urol Oncol 2006;24(1):4-12.
7. Santini D, Galluzzo S, Vincenzi B, Schiavon G, Fratto E, Pantano F, Tonini G. New developments of aminobisphosphonates: the double face of Janus. Ann Oncol

2007;18 Suppl 6:vi164-vi167.

12.3.10.4.2. Recherche zu Behandlung

Abstracts nach Ausschluss von Dubletten:

Pubmed: 37 Cochrane Reviews: 4, Referenzlisten, Handsuche 2 (Walter, Rades); Volltexte: 15

12.3.10.4.3. Einschluss nach Volltextscreening

1. Aragon-Ching JB, Ning YM, Chen CC, Latham L, Guadagnini JP, Gulley JL, Arlen PM, Wright JJ, Parnes H, Figg WD, Dahut WL. Higher incidence of Osteonecrosis of the Jaw (ONJ) in patients with metastatic castration resistant prostate cancer treated with anti-angiogenic agents. Cancer Invest 2009;27(2):221-6.
2. Fizazi K, Carducci M, Smith M, Damiao R, Brown J, Karsh L, Milecki P, Shore N, Rader M, Wang H, Jiang Q, Tadros S, Dansey R, Goessl C. Denosumab versus zoledronic acid for treatment of bone metastases in men with castration-resistant prostate cancer: a randomised, double-blind study. Lancet 2011;377(9768):813-22.
3. George R, Jeba J, Ramkumar G, Chacko AG, Leng M, Tharyan P. Interventions for the treatment of metastatic extradural spinal cord compression in adults. Cochrane Database Syst Rev 2010;(1):CD006716.
4. Walter C, Al-Nawas B, Grotz KA, Thomas C, Thuroff JW, Zinser V, Gamm H, Beck J, Wagner W. Prevalence and risk factors of bisphosphonate-associated osteonecrosis of the jaw in prostate cancer patients with advanced disease treated with zoledronate. Eur Urol 2008;54(5):1066-72.
5. Sze WM, Shelley M, Held I, Mason M. Palliation of metastatic bone pain: single fraction versus multifraction radiotherapy - a systematic review of the randomised trials. Cochrane Database Syst Rev 2011;(5):CD004721. (aus Referenzliste)

Zusätzlich aus Handsuche:

1. Chow E. , Metaanalyse zur Einzeit vs. Mehrzeitbestrahlung von Knochenmetastasen, JCO 2007 (Zitat wird ergänzt)
2. Dearnaley D.P. et al, 2009 Adjuvant therapy with oral sodium clodronate in locally advanced and metastatic prostate cancer…(Zitat wird ergänzt)

12.3.10.4.4. Ausgeschlossene Volltexte

A1 (Methodik):

1. Chaturvedi P, Pai PS, Chaukar DA, Gupta S, D'cruz AK. Bisphosphonate induced osteonecrosis of the jaw masquerading as tumor: a word of caution for oral surgeons and oncologists. Eur J Surg Oncol 2010;36(6):541-5. Fallberichte Kiefernekose n=6
2. Frei M, Bornstein MM, Schaller B, Reichart PA, Weimann R, Iizuka T. Bisphosphonate-related osteonecrosis of the jaw combined with jaw metastasis of prostate adenocarcinoma: report of a case. J Oral Maxillofac Surg 2010;68(4):863-7. Fallbericht Kiefernekose
3. Hatoum HT, Lin SJ, Guo A, Lipton A, Smith MR. Zoledronic acid therapy impacts risk and frequency of skeletal complications and follow-up duration in prostate cancer patients with bone metastasis. Curr Med Res Opin 2011;27(1):55-62. retrospektive Registerauswertung zu Zoledronsäure
4. Krishnan A, Arslanoglu A, Yildirm N, Silbergleit R, Aygun N. Imaging findings of bisphosphonate-related osteonecrosis of the jaw with emphasis on early magnetic resonance imaging findings. J Comput Assist Tomogr 2009;33(2):298-304. Fallberichte Kiefernekrose n=6
5. Rades D, Huttenlocher S, Dunst J, Bajrovic A, Karstens JH, Rudat V, Schild SE. Matched pair analysis comparing surgery followed by radiotherapy and radiotherapy alone for metastatic spinal cord compression. J Clin Oncol 2010;28(22):3597-604. retrospektive Matched Pair Studie zu Rückenmarkkompressionstherapie (radiotherapie vs. Radiotherapie+operat. Dekompression, n.s.) (aus Handsuche)
6. Saad F, Eastham J. Zoledronic Acid improves clinical outcomes when administered before onset of bone pain in patients with prostate cancer. Urology

2010;76(5):1175-81. retrospektive exploratische Analyse eines RCT zu Zoledronsäure
7. Velde NV, Wu EQ, Guo A, Lu M, Yu AP, Sharma H, Liu J, Fan CP, Shi L. The benefits of timely intervention with zoledronic acid in patients with metastatic prostate cancer to bones: a retrospective study of the US Veterans Affairs population. Prostate Cancer Prostatic Dis 2011;14(1):79-84. retrospektive Auswertung zu Zoledronsäure

A2 nicht vorwiegend PCa:

1. Junquera L, Gallego L, Cuesta P, Pelaz A, de Vicente JC. Clinical experiences with bisphosphonate-associated osteonecrosis of the jaws: analysis of 21 cases. Am J Otolaryngol 2009;30(6):390-5. Fallserie Kiefernekosen (nur 10% Pat mit PCa (2/21)

A3 nicht Fokus Behandlung von Knochenmetastasen bei PCa:

1. Gnant M. Bisphosphonates in the prevention of disease recurrence: current results and ongoing trials. Curr Cancer Drug Targets 2009;9(7):824-33. Prävention von Knochenmetastasen

A4 nicht systematischer Review:

1. Buijs JT, Kuijpers CC, van der PG. Targeted therapy options for treatment of bone metastases; beyond bisphosphonates. Curr Pharm Des 2010;16(27):3015-27.
2. Tu SM, Lin SH, Podoloff DA, Logothetis CJ. Multimodality therapy: bone-targeted radioisotope therapy of prostate cancer. Clin Adv Hematol Oncol 2010;8(5):341-51.

12.3.11. Recherche zum Thema Behandlung des kastrationsresistenten Prostatakarzinoms

12.3.11.1. Fragestellungen

	Population	Intervention	Control	Outcomes	Time aspects
1	Patienten mit kastrationsresistentem Prostatakarzinom (ohne Einschränkung)	Systemtherapie (nicht spezifisch für Knochenmetastasen)	Placebo/Goldstandard	Überleben, Nebenwirkungen Lebensqualität	-

12.3.11.2. Recherchen

PubMed (06. Juni 2011)

Nr.	Suchfrage	Anzahl
#8	#3 AND #6, Limits English, German, Publication Date from 2008/08	679
#7	#3 AND #6	3767
#6	#4 OR #5	2296269
#5	(randomized controlled trial [pt] OR controlled clinical trial [pt] OR randomized [tiab] OR placebo [tiab] OR drug therapy [sh] OR randomly [tiab] OR trial [tiab] OR groups [tiab]) AND humans [mh]	2193575
#4	systematic[sb]	156150
#3	#1 AND #2	6498
#2	"hormone-refractory" OR "hormone refractory" OR chemotherapy[tiab] OR docetaxel[tiab] OR prednisolone[tiab] OR mitoxanthrone[tiab] OR dexamethasone OR ketoconazole OR hydrocortisone OR thalidomide OR doxo-	382071

	rubicin OR paclitaxel OR carboplatin OR estramustine OR vinblastine OR Abirateron	
#1	prostate AND cancer	81449

Anzahl der Treffer: 679

Davon relevant: 620

Cochrane (06. Juni 2011)

Nr.	Suchfrage	Anzahl
#4	#1 And #2, from 2008 to 2011	85
#3	#1 AND #2	629
#2	"hormone?refractory" OR chemotherapy OR docetaxel OR prednisolone OR mitoxanthrone OR dexamethasone OR ketoconazole OR hydrocortisone OR thalidomide OR doxorubicin OR paclitaxel OR carboplatin OR estramustine OR vinblastine OR Abirateron:ti,ab,kw	38897
#1	(prostate):ti,ab,kw and (cancer):ti,ab,kw	3060

- Cochrane Database of Systematic Reviews (3)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (80)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (1)
- NHS Economic Evaluation Database (1)

Anzahl der Treffer: 85

Davon neu: 45

Davon relevant: 42

12.3.11.3. Ein – und Ausschlusskriterien

Ausschlussgründe

A1: andere Erkrankung

A2: nicht Fragestellung (siehe oben)

A3: Methodik (keine Phase III RCTs oder systematische Übersichten)

A4: unsystematische Übersichtsarbeit

A5: Doppelpublikation oder Volltext nicht erhältlich

12.3.11.4. Ergebnisse der Recherche

12.3.11.4.1. Nach Volltextsichtung eingeschlossene Texte

1. de Bono JS, Logothetis CJ, Molina A, Fizazi K, North S, Chu L et al. Abiraterone and increased survival in metastatic prostate cancer. N Engl J Med 2011 May 26;364(21):1995-2005.
1. Shamash J, Powles T, Sarker SJ, Protheroe A, Mithal N, Mills R et al. A multi-centre

randomised phase III trial of Dexamethasone vs Dexamethasone and diethylstilbestrol in castration-resistant prostate cancer: immediate vs deferred Diethylstilbestrol. Br J Cancer 2011 February 15;104(4):620-8.
2. Chao HH, Mayer T, Concato J, Rose MG, Uchio E, Kelly WK. Prostate cancer, comorbidity, and participation in randomized controlled trials of therapy. J Investig Med 2010 March;58(3):566-8.
3. Colloca G, Venturino A, Checcaglini F. Patient-reported outcomes after cytotoxic chemotherapy in metastatic castration-resistant prostate cancer: a systematic review. Cancer Treat Rev 2010 October;36(6):501-6.
4. de Bono JS, Oudard S, Ozguroglu M, Hansen S, Machiels JP, Kocak I et al. Prednisone plus cabazitaxel or mitoxantrone for metastatic castration-resistant prostate cancer progressing after docetaxel treatment: a randomised open-label trial. Lancet 2010 October 2;376(9747):1147-54.
5. Kantoff PW, Higano CS, Shore ND, Berger ER, Small EJ, Penson DF et al. Sipuleucel-T immunotherapy for castration-resistant prostate cancer. N Engl J Med 2010 July 29;363(5):411-22.
6. Higano CS, Schellhammer PF, Small EJ, Burch PA, Nemunaitis J, Yuh L et al. Integrated data from 2 randomized, double-blind, placebo-controlled, phase 3 trials of active cellular immunotherapy with sipuleucel-T in advanced prostate cancer. Cancer 2009 August 15;115(16):3670-9.
7. Steinberg M. Degarelix: a gonadotropin-releasing hormone antagonist for the management of prostate cancer. Clin Ther 2009;31 Pt 2:2312-31.
8. Beer TM, Ryan CW, Venner PM, Petrylak DP, Chatta GS, Ruether JD et al. Intermittent chemotherapy in patients with metastatic androgen-independent prostate cancer: results from ASCENT, a double-blinded, randomized comparison of high-dose calcitriol plus docetaxel with placebo plus docetaxel. Cancer 2008;112:326-30.
9. Berthold DR, Pond GR, Soban F, de WR, Eisenberger M, Tannock IF. Docetaxel plus prednisone or mitoxantrone plus prednisone for advanced prostate cancer: updated survival in the TAX 327 study. Journal of clinical oncology : official journal of the American Society of Clinical Oncology 2008;26:242-5.
10. Machiels JP, Mazzeo F, Clausse M, Filleul B, Marcelis L, Honhon B et al. Prospective randomized study comparing docetaxel, estramustine, and prednisone with docetaxel and prednisone in metastatic hormone-refractory prostate cancer. J Clin Oncol 2008 November 10;26(32):5261-8.
11. Nelson JB, Love W, Chin JL, Saad F, Schulman CC, Sleep DJ et al. Phase 3, randomized, controlled trial of atrasentan in patients with nonmetastatic, hormone-refractory prostate cancer. Cancer 2008 November 1;113(9):2478-87.

12.3.11.4.2. Ausgeschlossene Volltexte

A2 (nicht Fragestellung)

1. Armstrong AJ, Halabi S, de WR, Tannock IF, Eisenberger M. The relationship of body mass index and serum testosterone with disease outcomes in men with castration-resistant metastatic prostate cancer. Prostate Cancer Prostatic Dis 2009;12(1):88-93.
2. Haidar A, Jonler M, Folkmar TB, Lund L. Bisphosphonate (zoledronic acid)-induced osteonecrosis of the jaw. Scand J Urol Nephrol 2009;43(6):442-4.
3. Inoue T, Segawa T, Kamba T, Yoshimura K, Nakamura E, Nishiyama H et al. Prevalence of skeletal complications and their impact on survival of hormone refractory prostate cancer patients in Japan. Urology 2009 May;73(5):1104-9.
4. Millikan RE, Wen S, Pagliaro LC, Brown MA, Moomey B, Do KA et al. Phase III trial of androgen ablation with or without three cycles of systemic chemotherapy for advanced prostate cancer. J Clin Oncol 2008 December 20;26(36):5936-42.
5. Walter C, Al-Nawas B, Grotz KA, Thomas C, Thuroff JW, Zinser V et al. Prevalence and risk factors of bisphosphonate-associated osteonecrosis of the jaw in prostate cancer patients with advanced disease treated with zoledronate. Eur Urol 2008 November;54(5):1066-72.

A3 (Methodik)

1. Picus J, Halabi S, Kelly WK, Vogelzang NJ, Whang YE, Kaplan EB et al. A phase 2

study of estramustine, docetaxel, and bevacizumab in men with castrate-resistant prostate cancer: results from Cancer and Leukemia Group B Study 90006. Cancer 2011 February 1;117(3):526-33.
2. Smith TJ, Dow LA, Virago EA, Khatcheressian J, Matsuyama R, Lyckholm LJ. A pilot trial of decision aids to give truthful prognostic and treatment information to chemotherapy patients with advanced cancer. J Support Oncol 2011 March;9(2):79-86.
3. Antonarakis ES, Carducci MA, Eisenberger MA. Novel targeted therapeutics for metastatic castration-resistant prostate cancer. Cancer Lett 2010 May 1;291(1):1-13.
4. Azuma H, Inamoto T, Takahara K, Ibuki N, Koyama K, Utimoto S et al. Combination therapy with VP16 and ethinylestradiol for hormone-refractory prostate cancer: good response with tolerability. Anticancer Res 2010 September;30(9):3737-45.
5. Caffo O, Sava T, Comploj E, Giampaolo MA, Segati R, Valduga F et al. Estramustine plus docetaxel as second-line therapy in patients with hormone-refractory prostate cancer resistant to docetaxel alone. Urol Oncol 2010 March;28(2):152-6.
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A4 (unsystematische Übersichtsarbeit)

1. Galsky MD, Vogelzang NJ. Docetaxel-based combination therapy for castration-resistant prostate cancer. Ann Oncol 2010 November;21(11):2135-44.
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4. Walter B, Rogenhofer S, Vogelhuber M, Berand A, Wieland WF, Andreesen R et al. Modular therapy approach in metastatic castration-refractory prostate cancer. World J Urol 2010 December;28(6):745-50.

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6. Meulenbeld HJ, Hamberg P, de WR. Chemotherapy in patients with castration-resistant prostate cancer. Eur J Cancer 2009 September;45 Suppl 1:161-71.

A5 (Doppelpublikation oder Volltext nicht erhältlich)

1. Sissung TM, Danesi R, Kirkland CT, Baum CE, Ockers SB, Stein EV et al. Estrogen receptor alpha and aromatase polymorphisms affect risk, prognosis, and therapeutic outcome in men with castration-resistant prostate cancer treated with docetaxel-based therapy. J Clin Endocrinol Metab 2011 February;96(2):E368-E372.
2. Sonpavde G, Attard G, Bellmunt J, Mason MD, Malavaud B, Tombal B et al. The Role of Abiraterone Acetate in the Management of Prostate Cancer: A Critical Analysis of the Literature. Eur Urol 2011 April 2

12.4. Methodik und Ergebnisse der Recherchen zur 2. Aktualisierung 2014

12.4.1. Recherche zum Thema Früherkennung/Screening (Kapitel 3.1 der Leitlinie)

12.4.1.1. Fragestellung

Fragestellung/Themenbereich	Population	Inter-vention	Kontrolle	Outcome	Evidenzgrundlage
Früherkennung „intelligent“: risikoadaptierte Zeitabstände, Altersbeginn der Früherkennung (PSA, Nomogramm, digital-rektale Tastuntersuchung) Börgermann, Rübben, Egidi	Männer (1) Alter >= 40 bis Lebenserwartung <10 Jahre und PSA <1 ng/ml baseline, low risk? (2) Alter >= 40 bis Lebenserwartung <10 Jahre und PSA >1 <3 ng/ml baseline, mittleres Risiko? (3) Alter >= 40 bis Lebenserwartung <10 Jahre	Jährliche PSA- Kontrolle	Andere Zeitabstände: (A) Keine PSA - Kontrolle (B) zweijährliche PSA Kontrolle (C) dreijährliche PSA Kontrolle (D) vierjährliche PSA Kontrolle	PCa-spezifische Mortalität, Gesamtüberleben, Histo	Aggregierte Evidenz (Systematischer Review, Leitlinienadapta-tion) + RCT, prospektive Kohortenstudien

Fragestellung/Themenbereich	Population	Inter-vention	Kontrolle	Outcome	Evidenzgrundlage
	und PSA >3 ng/ml baseline high risk?				

12.4.1.2. Recherchestrategien

Ausschlusskriterien für Relevanzsichtung:
A1: andere Erkrankung (nicht PCa)
A2: Methodik (Letter, Editorial, News, Comment)
A3: Dubletten durch Suche in verschiedenen Datenbanken
A4: Publikationen vor 2011 und nicht deutsch oder englisch (Cochrane Library)

PubMed (10. April 2013)
Suchstrategie:

Nr.	Suchfrage	Anzahl
#5	#1 AND #2 AND #3 Limits: English, German, Publication date from 2011/01/01	674
#4	#1 AND #2 AND #3	4198
#3	("prostate-specific antigen"[MeSH Terms] OR ("prostate-specific"[All Fields] AND "antigen"[All Fields]) OR "prostate-specific antigen"[All Fields] OR ("prostate"[All Fields] AND "specific"[All Fields] AND "antigen"[All Fields]) OR "prostate specific antigen"[All Fields]) OR PSA[All Fields]	32371
#2	"screening"[All Fields] OR "mass screening"[MeSH Terms] OR "early detection of cancer"[MeSH Terms] OR "early detection of cancer"[All Fields]	360428
#1	"prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields]	107976

Anzahl der Treffer: 674;

Davon relevant: 594

Cochrane (10. April 2013)
Suchstrategie:

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 from 2011 to 2013, in Cochrane Reviews (Reviews only), Other Reviews, Trials, Methods Studies, Technology Assessment and Economic Evaluations	51
#3	#1 AND #2	536

Nr.	Suchfrage	Anzahl
#2	screening OR early detection:ti,ab,kw	17312
#1	(prostatic OR prostate) AND (neoplasm OR neoplasms OR cancer):ti,ab,kw	4111

- Cochrane Database of Systematic Reviews (4)
- Database of Abstracts of Reviews of Effects (4)
- Cochrane Central Register of Controlled Trials (41)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (1)
- NHS Economic Evaluation Database (1)

Anzahl der Treffer: 51

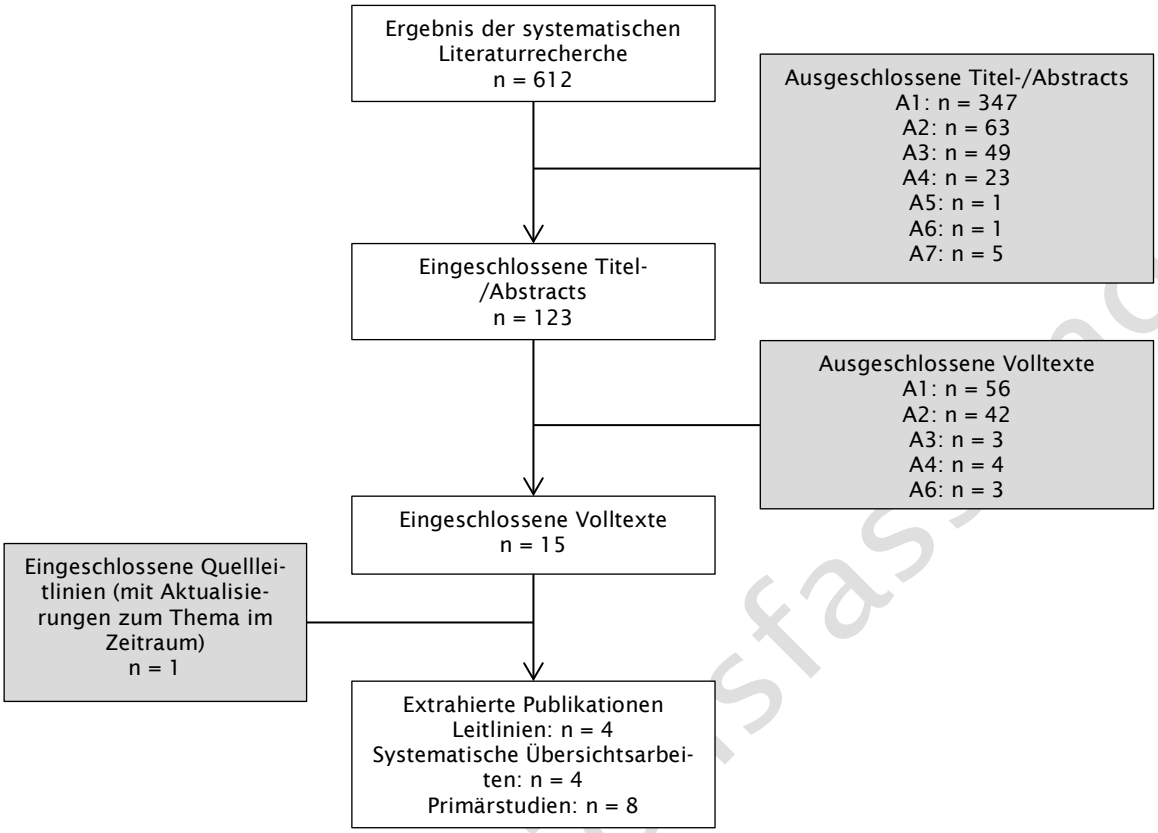
Davon neu: 25

Davon relevant: 18

12.4.1.3. Ein- und Ausschlusskriterien

Ausschlussgründe (Mehrfachnennungen möglich)	
A1	andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle – Auszug s.u.)
A2	anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)
A3	unsystematischer Review oder Review **ohne** Einschluss von RCT und/ oder prospektiven Kohortenstudien)
A4	retrospektive Kohortenstudie
A5	n < 25
A6	Doppelpublikation oder nicht erhältlich
A7	Sonstiges (z.B. Sprache, Publikation außerhalb des Suchzeitraums etc.)
Einschlussgründe	
E1	Systematischer Review (aus RCTs und / oder prospektiven Kohortenstudien) (wahrscheinlich) passend zur Fragestellung analog PICO-Tabelle
E2	RCT, prospektive Kohortenstudien (wahrscheinlich) passend zur Fragestellung analog PICO-Tabelle

12.4.1.4. Ergebnisse der Recherche



12.4.1.4.1. Extrahierte Publikationen

Eingeschlossene Volltexte (nach Volltextsichtung)

1. Ilic D, Neuberger MM, Djulbegovic M, Dahm P. Screening for prostate cancer. Cochrane Database Syst Rev 2013;1:CD004720 PM:23440794, DOI: 10.1002/14651858.CD004720.pub3.
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3. Basch E, Oliver TK, Vickers A, Thompson I, Kantoff P, Parnes H, Loblaw DA, Roth B, Williams J, Nam RK. Screening for prostate cancer with prostate-specific antigen testing: American Society of Clinical Oncology Provisional Clinical Opinion. J Clin Oncol 2012;30(24):3020-5 PM:22802323, DOI: JCO.2012.43.3441 [pii];10.1200/JCO.2012.43.3441 .
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6. Zhu X, Albertsen PC, Andriole GL, Roobol MJ, Schroder FH, Vickers AJ. Risk-based prostate cancer screening. Eur Urol 2012;61(4):652-61 PM:22134009, DOI: S0302-2838(11)01269-3 [pii];10.1016/j.eururo.2011.11.029.
7. Lin K, Croswell JM, Koenig H, Lam C, Maltz A. Prostate-Specific Antigen-Based Screening for Prostate Cancer: An Evidence Update for the U.S. Preventive Services Task Force. Internet 2011; PM:22171385, DOI: NBK82303 [bookaccession].

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11. Schroder FH, Hugosson J, Roobol MJ, Tammela TL, Ciatto S, Nelen V, Kwiatkowski M, Lujan M, Lilja H, Zappa M, Denis LJ, Recker F, Paez A, Maattanen L, Bangma CH, Aus G, Carlsson S, Villers A, Rebillard X, van der Kwast T, Kujala PM, Blijenberg BG, Stenman UH, Huber A, Taari K, Hakama M, Moss SM, de Koning HJ, Auvinen A. Prostate-cancer mortality at 11 years of follow-up. N Engl J Med 2012;366(11):981-90 PM:22417251, DOI: 10.1056/NEJMoa1113135.
12. van Leeuwen PJ, Roobol MJ, Kranse R, Zappa M, Carlsson S, Bul M, Zhu X, Bangma CH, Schroder FH, Hugosson J. Towards an optimal interval for prostate cancer screening. Eur Urol 2012;61(1):171-6 PM:21840117, DOI: S0302-2838(11)00862-1 [pii];10.1016/j.eururo.2011.08.002.
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14. Lilja H, Cronin AM, Dahlin A, Manjer J, Nilsson PM, Eastham JA, Bjartell AS, Scardino PT, Ulmert D, Vickers AJ. Prediction of significant prostate cancer diagnosed 20 to 30 years later with a single measure of prostate-specific antigen at or before age 50. Cancer 2011;117(6):1210-9 PM:20960520, DOI: 10.1002/cncr.25568.
15. Sandblom G, Varenhorst E, Rosell J, Lofman O, Carlsson P. Randomised prostate cancer screening trial: 20 year follow-up. BMJ 2011;342:d1539 PM:21454449.

Extrahierte Quellleitlinie

Carter HB, Albertsen PC, Barry MJ, Etzioni R, Freedland SJ, Greene KL, Holmberg L, Kantoff P, Konety BR, Murad MH, Penson DF, Zietman AL. Early Detection of Prostate Cancer: AUA Guideline. Journal of Urology 2013

12.4.1.4.2. Ausgeschlossene Volltexte (nach Volltextsichtung)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

1. Barocas DA, Grubb R, III, Black A, Penson DF, Fowke JH, Andriole G, Crawford ED. Association between race and follow-up diagnostic care after a positive prostate cancer screening test in the Prostate, Lung, Colorectal, and Ovarian cancer screening Atrial. Cancer 2013; PM:23559420, DOI: 10.1002/cncr.28042.
2. Hessels D, Schalken JA. Urinary biomarkers for prostate cancer: a review. Asian J Androl 2013; PM:23524531, DOI: aja20136 [pii];10.1038/aja.2013.6.
3. Ito K, Miyakubo M, Sekine Y, Koike H, Matsui H, Shibata Y, Suzuki K. Diagnostic significance of [-2]pro-PSA and prostate dimension-adjusted PSA-related indices in men with total PSA in the 2.0-10.0 ng/mL range. World J Urol 2013;31(2):305-11 PM:22903772, DOI: 10.1007/s00345-012-0927-9.
4. Kim JH, Shim JS, Bae JH, Park HS, Moon dG, Kwon SS, Park JY. Association between percent-free prostate-specific antigen and glomerular filtration rate in transrectal ultrasound-guided biopsy-proven patients with prostate-specific antigen levels ranging from 4 to 10 ng/ml. World J Urol 2013;31(2):313-8 PM:23283411, DOI: 10.1007/s00345-012-1012-0.

5. Neves AF, Dias-Oliveira JD, Araujo TG, Marangoni K, Goulart LR. Prostate cancer antigen 3 (PCA3) RNA detection in blood and tissue samples for prostate cancer diagnosis. Clin Chem Lab Med 2013;51(4):881-7 PM:23241599, DOI: 10.1515/cclm-2012-0392 [doi];/j/cclm.ahead-of-print/cclm-2012-0392/cclm-2012-0392.xml [pii].
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8. Adedapo KS, Arinola OG, Shittu OB, Kareem OI, Okolo CA, Nwobi LN. Diagnostic value of lipids, total antioxidants, and trace metals in benign prostate hyperplasia and prostate cancer. Niger J Clin Pract 2012;15(3):293-7 PM:22960963, DOI: NigerJClinPract_2012_15_3_293_100623 [pii];10.4103/1119-3077.100623.
9. Ankerst DP, Boeck A, Freedland SJ, Thompson IM, Cronin AM, Roobol MJ, Hugosson J, Stephen JJ, Kattan MW, Klein EA, Hamdy F, Neal D, Donovan J, Parekh DJ, Klocker H, Horninger W, Benchikh A, Salama G, Villers A, Moreira DM, Schroder FH, Lilja H, Vickers AJ. Evaluating the PCPT risk calculator in ten international biopsy cohorts: results from the Prostate Biopsy Collaborative Group. World J Urol 2012;30(2):181-7 PM:22210512, DOI: 10.1007/s00345-011-0818-5.
10. Avery KN, Metcalfe C, Vedhara K, Lane JA, Davis M, Neal DE, Hamdy FC, Donovan JL, Blazeby JM. Predictors of attendance for prostate-specific antigen screening tests and prostate biopsy. Eur Urol 2012;62(4):649-55 PM:22244151, DOI: S0302-2838(12)00002-4 [pii];10.1016/j.eururo.2011.12.059.
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12. Boniol M, Boyle P, Autier P, Ruffion A, Perrin P. Critical role of prostate biopsy mortality in the number of years of life gained and lost within a prostate cancer screening programme. BJU Int 2012;110(11):1648-52 PM:22984785, DOI: 10.1111/j.1464-410X.2012.11513.x.
13. Botelho F, Pina F, Figueiredo L, Cruz F, Lunet N. Does baseline total testosterone improve the yielding of prostate cancer screening? Eur J Cancer 2012;48(11):1657-63 PM:22342552, DOI: S0959-8049(12)00066-4 [pii];10.1016/j.ejca.2012.01.025.
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17. Chiriva-Internati M, Yu Y, Mirandola L, D'Cunha N, Hardwicke F, Cannon MJ, Cobos E, Kast WM. Identification of AKAP-4 as a new cancer/testis antigen for detection and immunotherapy of prostate cancer. Prostate 2012;72(1):12-23 PM:21520158, DOI: 10.1002/pros.21400.
18. Consedine NS. Are we worrying about the right men and are the right men feeling worried? Conscious but not unconscious prostate anxiety predicts screening among men from three ethnic groups. Am J Mens Health 2012;6(1):37-50 PM:21862565, DOI: 1557988311415513 [pii];10.1177/1557988311415513.
19. Demichelis F, Setlur SR, Banerjee S, Chakravarty D, Chen JY, Chen CX, Huang J, Beltran H, Oldridge DA, Kitabayashi N, Stenzel B, Schaefer G, Horninger W, Bektic J, Chinnaiyan AM, Goldenberg S, Siddiqui J, Regan MM, Kearney M, Soong TD, Rickman DS, Elemento O, Wei JT, Scherr DS, Sanda MA, Bartsch G, Lee C, Klocker

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A2: anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)

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A4: retrospektive Kohortenstudie

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A6: Doppelpublikation oder nicht erhältlich

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12.4.1.4.3. Ausgeschlossene Titel-/Abstracts (nach Titel-/Abstractscreening durchgeführt von Rübben/Börgermann)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

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A4: retrospektive Kohortenstudie

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A5: Eingeschlossene Patienten n < 25

1. Kim Y, Ignatchenko V, Yao CQ, Kalatskaya I, Nyalwidhe JO, Lance RS, Gramolini AO, Troyer DA, Stein LD, Boutros PC, Medin JA, Semmes OJ, Drake RR, Kislinger T. Identification of differentially expressed proteins in direct expressed prostatic secretions of men with organ-confined versus extracapsular prostate cancer. Mol Cell Proteomics 2012;11(12):1870-84 PM:22986220, DOI: M112.017889 [pii];10.1074/mcp.M112.017889.

A6: Doppelpublikation oder nicht erhältlich

1. 66. Roobol MJ, Carlsson SV. Risk stratification in prostate cancer screening. Nat Rev Urol 2013;10(1):38-48 PM:23247693, DOI: nrurol.2012.225 [pii];10.1038/nrurol.2012.225.

A7: Sonstiges (z.B. Sprache, Publikation außerhalb des Suchzeitraums etc.)

1. 26. Greene KL, Albertsen PC, Babaian RJ, Carter HB, Gann PH, Han M, Kuban DA, Sartor AO, Stanford JL, Zietman A, Carroll P. Prostate specific antigen best practice statement: 2009 update. J Urol 2013;189(1 Suppl):S2-S11 PM:23234625, DOI: S0022-5347(12)05479-1 [pii];10.1016/j.juro.2012.11.014.
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3. 420. Ennis R, Jotkowitz A. Good ethics begins with sound medicine: prostate cancer screening and chemoprevention. Am J Bioeth 2011;11(12):26-7 PM:22146026,

DOI: 10.1080/15265161.2011.568583.
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12.4.2. Recherche zum Thema PET-CT/MRT beim PSA-Rezidiv (Empfehlung 3.19 der Leitlinie)

12.4.2.1. Fragestellung

Fragestellung/Themenbereich	Population	Intervention	Kontrolle	Outcome	Evidenzgrundlage
Diagnostik und Therapie des Rezidivs nach Operationen / nach Strahlentherapie: Ist ein PET-CT/MRT beim PSA-Rezidiv nach radikaler Prostatektomie/Strahlentherapie in Korrelation zum PSA-Wert indiziert? Wiegel, Miller, Kotzerke	Patienten mit PCa nach radikaler Prostatektomie und / oder Strahlentherapie mit PSA Rezidiv	PET CT PET MRT	Kein PET (Referenz: Histologie)	Sensitivität, Spezifität, PPW (Testgüte), Likelihood-Ratio, Mortalität, therapeutische Konsequenzen	Aggregierte Evidenz (Systematischer Review) + RCT + prospektive Kohortenstudien

12.4.2.2. Recherchestrategien

Ausschlusskriterien für Relevanzsichtung:
A1: Dubletten aufgrund Suche in mehreren Datenbanken
A2: Methodik (Letter, Editorial u.ä.)

PubMed (08. Mai 2013)
Suchstrategie:

Nr.	Suchfrage	Anzahl
#9	Search #1 AND #7 Limits: English, German, Publication date from 2008/01/01	369
#8	#1 AND #7	594
#7	#5 OR #6	31572

Nr.	Suchfrage	Anzahl
#6	#3 AND #4	27226
#5	#2 AND #4	10736
#4	"positron-emission tomography"[MeSH Terms] OR ("positron-emission"[All Fields] AND "tomography"[All Fields]) OR "positron-emission tomography"[All Fields] OR ("positron"[All Fields] AND "emission"[All Fields] AND "tomography"[All Fields]) OR "positron emission tomography"[All Fields]	47672
#3	"tomography, x-ray computed"[MeSH Terms] OR ("tomography"[All Fields] AND "x-ray"[All Fields] AND "computed"[All Fields]) OR "x-ray computed tomography"[All Fields] OR ("computed"[All Fields] AND "tomography"[All Fields]) OR "computed tomography"[All Fields]	369781
#2	"magnetic resonance imaging"[MeSH Terms] OR ("magnetic"[All Fields] AND "resonance"[All Fields] AND "imaging"[All Fields]) OR "magnetic resonance imaging"[All Fields]	328644
#1	"prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields]	108586

Anzahl der Treffer: 369

Davon relevant: 351

Cochrane (08. Mai 2013)
Suchstrategie:

Nr.	Suchfrage	Anzahl
#9	#1 AND #7 from 2008 to 2013, in Cochrane Reviews (Reviews only), Other Reviews, Trials, Methods Studies, Technology Assessment and Economic Evaluations	4
#8	#1 AND #7	8
#7	#5 OR #6	811
#6	#3 AND #4	700
#5	#2 AND #4	208
#4	positron emission tomography:ti,ab,kw	1532
#3	computed tomography:ti,ab,kw	6078
#2	magnetic resonance imaging:ti,ab,kw	5832
#1	(prostatic OR prostate) AND (neoplasm OR neoplasms OR cancer):ti,ab,kw	4162

- Cochrane Database of Systematic Reviews (0)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (3)
- Cochrane Methodology Register (0)

- Health Technology Assessment Database (1)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 4

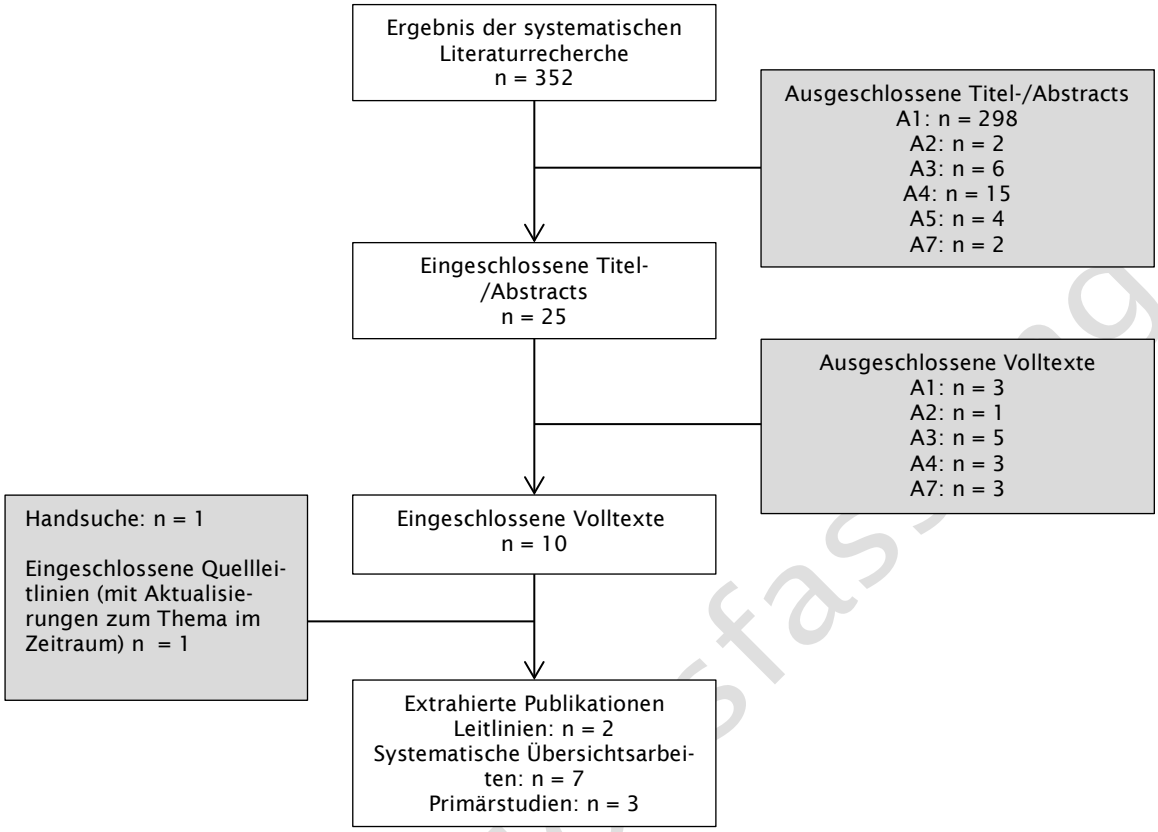
Davon neu: 2

Davon relevant: 1

12.4.2.3. Ein- und Ausschlusskriterien

Ausschlussgründe (Mehrfachnennungen möglich)	
A1	andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle – Auszug s.u.)
A2	anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)
A3	unsystematischer Review oder Review **ohne** Einschluss von RCT und/ oder prospektiven Kohortenstudien)
A4	retrospektive Kohortenstudie
A5	n < 25
A6	Doppelpublikation oder nicht erhältlich
A7	Sonstiges (z.B. Sprache, Publikation außerhalb des Suchzeitraums etc.)
Einschlussgründe	
E1	Systematischer Review (aus RCTs und / oder prospektiven Kohortenstudien) (wahrscheinlich) passend zur Fragestellung analog PICO-Tabelle
E2	RCT, prospektive Kohortenstudien (wahrscheinlich) passend zur Fragestellung analog PICO-Tabelle

12.4.2.4. Ergebnisse der Recherche



12.4.2.4.1. Extrahierte Publikationen

Eingeschlossene Volltexte (nach Volltextsichtung)

1. 22. Umbehr MH, Muntener M, Hany T, Sulser T, Bachmann LM. The Role of 11C-Choline and 18F-Fluorocholine Positron Emission Tomography (PET) and PET/CT in Prostate Cancer: A Systematic Review and Meta-analysis. Eur Urol 2013; PM:23628493, DOI: S0302-2838(13)00382-5 [pii];10.1016/j.eururo.2013.04.019.
2. 29. Bauman G, Belhocine T, Kovacs M, Ward A, Beheshti M, Rachinsky I. 18F-fluorocholine for prostate cancer imaging: a systematic review of the literature. Prostate Cancer Prostatic Dis 2012;15(1):45-55 PM:21844889, DOI: pcan201135 [pii];10.1038/pcan.2011.35.
3. 88. Panebianco V, Sciarra A, Lisi D, Galati F, Buonocore V, Catalano C, Gentile V, Laghi A, Passariello R. Prostate cancer: 1HMRS-DCEMR at 3T versus [(18)F]choline PET/CT in the detection of local prostate cancer recurrence in men with biochemical progression after radical retropubic prostatectomy (RRP). Eur J Radiol 2012;81(4):700-8 PM:21330082, DOI: S0720-048X(11)00145-8 [pii];10.1016/j.ejrad.2011.01.095.
4. 115. Zengerling F, Schrader AJ, Schrader M, Jentzmik F. [Diagnostic relevance of choline-PET / CT in patients with prostate cancer]. Aktuelle Urol 2012;43(1):49-54 PM:21769763, DOI: 10.1055/s-0031-1271553.
5. 120. Beer AJ, Eiber M, Souvatzoglou M, Schwaiger M, Krause BJ. Radionuclide and hybrid imaging of recurrent prostate cancer. Lancet Oncol 2011;12(2):181-91 PM:20599424, DOI: S1470-2045(10)70103-0 [pii];10.1016/S1470-2045(10)70103-0.
6. 158. Martino P, Scattoni V, Galosi AB, Consonni P, Trombetta C, Palazzo S, Maccagnano C, Liguori G, Valentino M, Battaglia M, Barozzi L. Role of imaging and biopsy to assess local recurrence after definitive treatment for prostate carcinoma (surgery, radiotherapy, cryotherapy, HIFU). World J Urol 2011;29(5):595-605

PM:21553276, DOI: 10.1007/s00345-011-0687-y.
7. 163. Mottet N, Bellmunt J, Bolla M, Joniau S, Mason M, Matveev V, Schmid HP, Van der Kwast T, Wiegel T, Zattoni F, Heidenreich A. EAU guidelines on prostate cancer. Part II: Treatment of advanced, relapsing, and castration-resistant prostate cancer. Eur Urol 2011;59(4):572-83 PM:21315502, DOI: S0302-2838(11)00046-7 [pii];10.1016/j.eururo.2011.01.025.
8. 168. Picchio M, Briganti A, Fanti S, Heidenreich A, Krause BJ, Messa C, Montorsi F, Reske SN, Thalmann GN. The role of choline positron emission tomography/computed tomography in the management of patients with prostate-specific antigen progression after radical treatment of prostate cancer. Eur Urol 2011;59(1):51-60 PM:20869161, DOI: S0302-2838(10)00859-6 [pii];10.1016/j.eururo.2010.09.004.
9. 198. Beresford MJ, Gillatt D, Benson RJ, Ajithkumar T. A systematic review of the role of imaging before salvage radiotherapy for post-prostatectomy biochemical recurrence. Clin Oncol (R Coll Radiol) 2010;22(1):46-55 PM:19948393, DOI: S0936-6555(09)00368-9 [pii];10.1016/j.clon.2009.10.015.
10. 243. Richter JA, Rodriguez M, Rioja J, Penuelas I, Marti-Climent J, Garrastachu P, Quincoces G, Zudaire J, Garcia-Velloso MJ. Dual tracer 11C-choline and FDG-PET in the diagnosis of biochemical prostate cancer relapse after radical treatment. Mol Imaging Biol 2010;12(2):210-7 PM:19543774, DOI: 10.1007/s11307-009-0243-y.

Extrahierte Quelleitlinie

1. Heidenreich A, Bolla M, Joniau S, Mason MD, Matveev V, Mottet N, Schmid HP, van der Kwast TH, Wiegel T, Zattoni F. EAU guidelines on prostate cancer. 2013

Eingeschlossene Volltexte (Handsuche)

1. Beheshti M, Haim S, Zakavi R, Steinmair M, Waldenberger P, Kunit T, Nader M, Langsteger W, Loidl W. Impact of 18F-Choline PET/CT in Prostate Cancer Patients with Biochemical Recurrence: Influence of Androgen Deprivation Therapy and Correlation with PSA Kinetics. J Nucl Med 2013;54(6):833-40

12.4.2.4.2. Ausgeschlossene Volltexte (nach Volltextsichtung)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

1. 44. Fortuin AS, Deserno WM, Meijer HJ, Jager GJ, Takahashi S, Debats OA, Reske SN, Schick C, Krause BJ, van O, I, Witjes AJ, Hoogeveen YL, van Lin EN, Barentsz JO. Value of PET/CT and MR lymphography in treatment of prostate cancer patients with lymph node metastases. Int J Radiat Oncol Biol Phys 2012;84(3):712-8 PM:22417806, DOI: S0360-3016(11)03819-3 [pii];10.1016/j.ijrobp.2011.12.093.
2. 97. Reske SN, Moritz S, Kull T. [11C]Choline-PET/CT for outcome prediction of salvage radiotherapy of local relapsing prostate carcinoma. Q J Nucl Med Mol Imaging 2012;56(5):430-9 PM:23069922, DOI: R39122498 [pii].
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A2: anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)

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A7: Sonstiges (z.B. Sprache, Publikation außerhalb des Suchzeitraums etc.)

1. 28. Atienza MG. Role of PET/CT with choline analogue radiotracers in the diagnosis and staging of prostate cancer (Structured abstract). Health Technology Assessment Database 2012;2 http://onlinelibrary.wiley.com/o/cochrane/clhta/articles/HTA-32013000091/frame.html.
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12.4.2.4.3. Ausgeschlossene Titel-/Abstracts (nach Titel-/Abstractscreening)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

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7. 9. Garg K, Chang S, Scherzinger A. Obesity and diabetes: newer concepts in imaging. Diabetes Technol Ther 2013;15(5):351-61 PM:23634670, DOI: 10.1089/dia.2013.0039.
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A2: anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)

1. 3. Barrett JA, Coleman RE, Goldsmith SJ, Vallabhajosula S, Petry NA, Cho S, Armor T, Stubbs JB, Maresca KP, Stabin MG, Joyal JL, Eckelman WC, Babich JW. First-in-man evaluation of 2 high-affinity PSMA-avid small molecules for imaging prostate cancer. J Nucl Med 2013;54(3):380-7 PM:23303962, DOI: jnumed.112.111203 [pii];10.2967/jnumed.112.111203.
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A3: unsystematischer Review oder Review ohne Einschluss von RCT und/ oder prospektiven Kohortenstudien)

1. 13. Kitajima K, Murphy RC, Nathan MA. Choline PET/CT for imaging prostate cancer: an update. Ann Nucl Med 2013; PM:23632880, DOI: 10.1007/s12149-013-0731-7.
2. 41. Farsad M, Schwarzenbock S, Krause BJ. PET/CT and choline: diagnosis and staging. Q J Nucl Med Mol Imaging 2012;56(4):343-53 PM:23013664, DOI: R39122492 [pii].
3. 234. Mease RC. Radionuclide based imaging of prostate cancer. Curr Top Med Chem 2010;10(16):1600-16 PM:20583988, DOI: BSP/ CTMC /E-Pub/-0102-10-16 [pii].
4. 250. Weidner A, Michaely HJ, Pelzer A, Michel MS, Wenz F, Schoenberg SO, Dinter DJ. [Imaging of prostate cancer by diagnostic radiology and nuclear medicine]. Aktuelle Urol 2010;41(1):35-42 PM:20101785, DOI: 10.1055/s-0029-1224730.

5. 256. Bouchelouche K, Capala J, Oehr P. Positron emission tomography/computed tomography and radioimmunotherapy of prostate cancer. Curr Opin Oncol 2009;21(5):469-74 PM:19535981, DOI: 10.1097/CCO.0b013e32832d56e4.
6. 283. Picchio M, Crivellaro C, Giovacchini G, Gianolli L, Messa C. PET-CT for treatment planning in prostate cancer. Q J Nucl Med Mol Imaging 2009;53(2):245-68 PM:19293771.

A4: retrospektive Kohortenstudie

1. 10. Giovacchini G, Picchio M, Garcia-Parra R, Mapelli P, Briganti A, Montorsi F, Gianolli L, Messa C. [11C]choline positron emission tomography/computerized tomography for early detection of prostate cancer recurrence in patients with low increasing prostate specific antigen. J Urol 2013;189(1):105-10 PM:23164385, DOI: S0022-5347(12)04813-6 [pii];10.1016/j.juro.2012.09.001.
2. 46. Fuccio C, Castellucci P, Schiavina R, Guidalotti PL, Gavaruzzi G, Montini GC, Nanni C, Marzola MC, Rubello D, Fanti S. Role of 11C-choline PET/CT in the restaging of prostate cancer patients with biochemical relapse and negative results at bone scintigraphy. Eur J Radiol 2012;81(8):e893-e896 PM:22621862, DOI: S0720-048X(12)00202-1 [pii];10.1016/j.ejrad.2012.04.027.
3. 49. Giovacchini G, Picchio M, Parra RG, Briganti A, Gianolli L, Montorsi F, Messa C. Prostate-specific antigen velocity versus prostate-specific antigen doubling time for prediction of 11C choline PET/CT in prostate cancer patients with biochemical failure after radical prostatectomy. Clin Nucl Med 2012;37(4):325-31 PM:22391699, DOI: 10.1097/RLU.0b013e31823363b0 [doi];00003072-201204000-00001 [pii].
4. 90. Picchio M, Spinapolice EG, Fallanca F, Crivellaro C, Giovacchini G, Gianolli L, Messa C. [11C]Choline PET/CT detection of bone metastases in patients with PSA progression after primary treatment for prostate cancer: comparison with bone scintigraphy. Eur J Nucl Med Mol Imaging 2012;39(1):13-26 PM:21932120, DOI: 10.1007/s00259-011-1920-z.
5. 101. Soyka JD, Muster MA, Schmid DT, Seifert B, Schick U, Miralbell R, Jorcano S, Zaugg K, Seifert HH, Veit-Haibach P, Strobel K, Schaefer NG, Husarik DB, Hany TF. Clinical impact of 18F-choline PET/CT in patients with recurrent prostate cancer. Eur J Nucl Med Mol Imaging 2012;39(6):936-43 PM:22415598, DOI: 10.1007/s00259-012-2083-2.
6. 122. Bertagna F, Abuhilal M, Bosio G, Simeone C, Rossini P, Pizzocaro C, Orlando E, Finamanti M, Biasiotto G, Rodella C, Cosciani CS, Giubbini R. Role of (1)(1)C-choline positron emission tomography/computed tomography in evaluating patients affected by prostate cancer with suspected relapse due to prostate-specific antigen elevation. Jpn J Radiol 2011;29(6):394-404 PM:21786095, DOI: 10.1007/s11604-011-0570-1.
7. 179. Souvatzoglou M, Krause BJ, Purschel A, Thamm R, Schuster T, Buck AK, Zimmermann F, Molls M, Schwaiger M, Geinitz H. Influence of (11)C-choline PET/CT on the treatment planning for salvage radiation therapy in patients with biochemical recurrence of prostate cancer. Radiother Oncol 2011;99(2):193-200 PM:21620494, DOI: S0167-8140(11)00197-6 [pii];10.1016/j.radonc.2011.05.005.
8. 212. Fuccio C, Castellucci P, Schiavina R, Santi I, Allegri V, Pettinato V, Boschi S, Martorana G, Al-Nahhas A, Rubello D, Fanti S. Role of 11C-choline PET/CT in the restaging of prostate cancer patients showing a single lesion on bone scintigraphy. Ann Nucl Med 2010;24(6):485-92 PM:20544323, DOI: 10.1007/s12149-010-0390-x.
9. 213. Giovacchini G, Picchio M, Coradeschi E, Bettinardi V, Gianolli L, Scattoni V, Cozzarini C, Di MN, Rigatti P, Fazio F, Messa C. Predictive factors of [(11)C]choline PET/CT in patients with biochemical failure after radical prostatectomy. Eur J Nucl Med Mol Imaging 2010;37(2):301-9 PM:19756592, DOI: 10.1007/s00259-009-1253-3.
10. 214. Giovacchini G, Picchio M, Briganti A, Cozzarini C, Scattoni V, Salonia A, Landoni C, Gianolli L, Di MN, Rigatti P, Montorsi F, Messa C. [11C]choline positron emission tomography/computerized tomography to restage prostate cancer cases with biochemical failure after radical prostatectomy and no disease evidence on conventional imaging. J Urol 2010;184(3):938-43 PM:20643445, DOI: S0022-5347(10)03519-6 [pii];10.1016/j.juro.2010.04.084.
11. 215. Giovacchini G, Picchio M, Scattoni V, Garcia PR, Briganti A, Gianolli L, Mon-

torsi F, Messa C. PSA doubling time for prediction of [(11)C]choline PET/CT findings in prostate cancer patients with biochemical failure after radical prostatectomy. Eur J Nucl Med Mol Imaging 2010;37(6):1106-16 PM:20306038, DOI: 10.1007/s00259-010-1403-7.

12. 257. Castellucci P, Fuccio C, Nanni C, Santi I, Rizzello A, Lodi F, Franceschelli A, Martorana G, Manferrari F, Fanti S. Influence of trigger PSA and PSA kinetics on 11C-Choline PET/CT detection rate in patients with biochemical relapse after radical prostatectomy. J Nucl Med 2009;50(9):1394-400 PM:19690023, DOI: jnumed.108.061507 [pii];10.2967/jnumed.108.061507.
13. 289. Rinnab L, Simon J, Hautmann RE, Cronauer MV, Hohl K, Buck AK, Reske SN, Mottaghy FM. [(11)C]choline PET/CT in prostate cancer patients with biochemical recurrence after radical prostatectomy. World J Urol 2009;27(5):619-25 PM:19234708, DOI: 10.1007/s00345-009-0371-7.
14. 296. Steiner C, Vees H, Zaidi H, Wissmeyer M, Berrebi O, Kossovsky MP, Khan HG, Miralbell R, Ratib O, Buchegger F. Three-phase 18F-fluorocholine PET/CT in the evaluation of prostate cancer recurrence. Nuklearmedizin 2009;48(1):1-9 PM:19212605, DOI: 09010001 [pii].
15. 345. Schilling D, Schlemmer HP, Wagner PH, Bottcher P, Merseburger AS, Aschoff P, Bares R, Pfannenberg C, Ganswindt U, Corvin S, Stenzl A. Histological verification of 11C-choline-positron emission/computed tomography-positive lymph nodes in patients with biochemical failure after treatment for localized prostate cancer. BJU Int 2008;102(4):446-51 PM:18410442, DOI: BJU7592 [pii];10.1111/j.1464-410X.2008.07592.x.

A5: Eingeschlossene Patienten n < 25

1. 176. Savir-Baruch B, Schuster DM, Jarkas N, Master VA, Nieh PT, Halkar RK, Nye JA, Lewis MM, Crowe RJ, Voll RJ, Camp VM, Bellamy LM, Roberts DL, Goodman MM. Pilot evaluation of anti-1-amino-2-[18F] fluorocyclopentane-1-carboxylic acid (anti-2-[18F] FACPC) PET-CT in recurrent prostate carcinoma. Mol Imaging Biol 2011;13(6):1272-7 PM:20976627, DOI: 10.1007/s11307-010-0445-3.
2. 195. Beauregard JM, Williams SG, Degrado TR, Roselt P, Hicks RJ. Pilot comparison of F-fluorocholine and F-fluorodeoxyglucose PET/CT with conventional imaging in prostate cancer. J Med Imaging Radiat Oncol 2010;54(4):325-32 PM:20718912, DOI: ARA2178 [pii];10.1111/j.1754-9485.2010.02178.x.
3. 251. Winter A, Uphoff J, Henke RP, Wawroschek F. First results of [11C]choline PET/CT-guided secondary lymph node surgery in patients with PSA failure and single lymph node recurrence after radical retropubic prostatectomy. Urol Int 2010;84(4):418-23 PM:20299773, DOI: 000296298 [pii];10.1159/000296298.
4. 301. Winter A, Uphoff J, Henke RP, Wawroschek F. [First results of PET / CT-guided secondary lymph node surgery on patients with a PSA relapse after radical prostatectomy]. Aktuelle Urol 2009;40(5):294-9 PM:19533582, DOI: 10.1055/s-0028-1098914.

A7: Sonstiges (z.B. Sprache, Publikation außerhalb des Suchzeitraums etc.)

1. 129. Castellucci P, Fuccio C, Rubello D, Schiavina R, Santi I, Nanni C, Allegri V, Montini GC, Ambrosini V, Boschi S, Martorana G, Marzola MC, Fanti S. Is there a role for (1)(1)C-choline PET/CT in the early detection of metastatic disease in surgically treated prostate cancer patients with a mild PSA increase <1.5 ng/ml? Eur J Nucl Med Mol Imaging 2011;38(1):55-63 PM:20848281, DOI: 10.1007/s00259-010-1604-0.
2. 348. Tuncel M, Souvatzoglou M, Herrmann K, Stollfuss J, Schuster T, Weirich G, Wester HJ, Schwaiger M, Krause BJ. [(11)C]Choline positron emission tomography/computed tomography for staging and restaging of patients with advanced prostate cancer. Nucl Med Biol 2008;35(6):689-95 PM:18678354, DOI: S0969-8051(08)00114-5 [pii];10.1016/j.nucmedbio.2008.05.006.

12.4.3. Recherche zum Thema DNA-Zytometrie (Empfehlung 4.20 der Leitlinie)

12.4.3.1. Fragestellung

Fragestellung/Themenbereich	Population	Intervention	Kontrolle	Outcome	Evidenzgrundlage
Stellenwert der DNA-Zytometrie (de novo-Recherche): Bringt die DNA-Zytometrie zusätzliche Informationen gegenüber den etab-lierten Prognosefaktoren/ prädiktive Fak-toren (Gleason-Score), die für die Therapieentscheidung (active surveillance) relevant sind? Dietz, Böcking, Wernert, Kristiansen, Weißbach	Pat mit PCa unter Active surveillance	Histo Gleason-Score 6 3+4 und 4+3. DNA Zytometrie, PSA und Follow up	Histo Gleason 6 3+4 und 4+3, PSA und Follow up	Prostataspezifische Mortalität (primär), PSA-Progress (sekundär)	Leitlinienadaptation: Übernahme eines Satzes, ggf. modifiziert, aus der Pa thologen-LL „Anleitung zur pathologisch-anatomischen Diagnostik von Prostatatumoren des Bundesverbandes Deutscher Pathologen e. V. und der Deutschen Gesellschaft für Pathologie e. V.“

12.4.3.2. Recherchestrategie

In der LL-Gruppe wurde zu Beginn festgelegt, dass für diese Fragestellung keine systematische Recherche durchgeführt werden soll. Es wurde festgelegt, dass die nachfolgende Leitlinie als Referenz berückichtigt wird. Diese Leitlinie wurde mit Hilfe von DELBI bewertet (dabei ist 0 der niedrigste und 1 der höchste zu erreichende Wert).

Bundesverband Deutscher Pathologen (BDP), Deutsche Gesellschaft für Pathologie (DGP). Anleitung zur pathologisch-anatomischen Diagnostik von Prostatatumoren. Version 2.0 des Bundesverbandes Deutscher Pathologen und der Deutschen Gesellschaft für Pathologie. 2011

Domäne 1: Geltungsbereich und Zweck	Domäne 2: Beteiligung von Interessengruppen	Domäne 3: Methodische Exaktheit der Leitlinienentwicklung	Domäne 4: Klarheit und Gestaltung	Domäne 5: Generelle Anwendbarkeit	Domäne 6: Redaktionelle Unabhängigkeit	Domäne 7: Anwendbarkeit im deutschen Gesundheitssystem
0,33	0,08	0,10	0,25	0,00	0,00	0,11

12.4.4. Recherche zum Thema immunhistochemische Untersuchungen (Kapitel 4.3 der Leitlinie)

12.4.4.1. Fragestellung

Fragestellung/Themenbereich	Population	Intervention	Kontrolle	Outcome	Evidenzgrundlage
Pathomorphologische Untersuchungen: Welche immunhistochemischen Zusatzuntersuchungen sind notwendig? Wernert, Kristiansen, Weißbach	Patienten mit histologischem Verdacht auf PCa (Primärdiagnose), der konventionell-morphologisch nicht zweifelsfrei gesichert werden kann	Immunhistochemische Zusatzuntersuchung: Basalzellmarker (z.B. p63, 34betaE12, CK5/6). Optional: AMACR. Ggf. weitere Marker zur Differentialdiagnose	Ohne jeweilige Zusatzuntersuchung Referenz: Histologie	Sensitivität, Spezifität (Testgüteparameter)	Aggregierte Evidenz (Systematischer Review, Leitlinienadaptation)

12.4.4.2. Recherchestrategien

Ausschlusskriterien für Relevanzsichtung:
A1: Methodik (Letter, Editorial u.ä.)
A2: andere Erkrankung

PubMed (08. Mai 2013)

Nr.	Suchfrage	Anzahl
#8	#5 AND #6 Limits: English, German, Publication date from 2008/01/01	19
#7	#5 AND #6	33
#6	systematic[sb]	202356
#5	#1 AND #4	6340
#4	#2 AND #3	451536
#3	"diagnosis"[Subheading] OR "diagnosis"[All Fields] OR "diagnosis"[MeSH Terms]	8070583
#2	“immunohistochemistry"[MeSH Terms] OR "immunohistochemistry"[All Fields]	539454
#1	"prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields]	108586

Anzahl der Treffer: 19

Cochrane (08. Mai 2013)
Suchstrategie:

Nr.	Suchfrage	Anzahl
#6	#1 AND #4 from 2008 to 2013, in Cochrane Reviews (Reviews only), Other Reviews, Trials, Methods Studies, Technology Assessment and Economic Evaluations	0
#5	#1 AND #4	4
#4	#2 AND #3	104
#3	diagnosis:ti,ab,kw	24252
#2	immunohistochemistry:ti,ab,kw	1543
#1	(prostatic OR prostate) AND (neoplasm OR neoplasms OR cancer):ti,ab,kw	4162

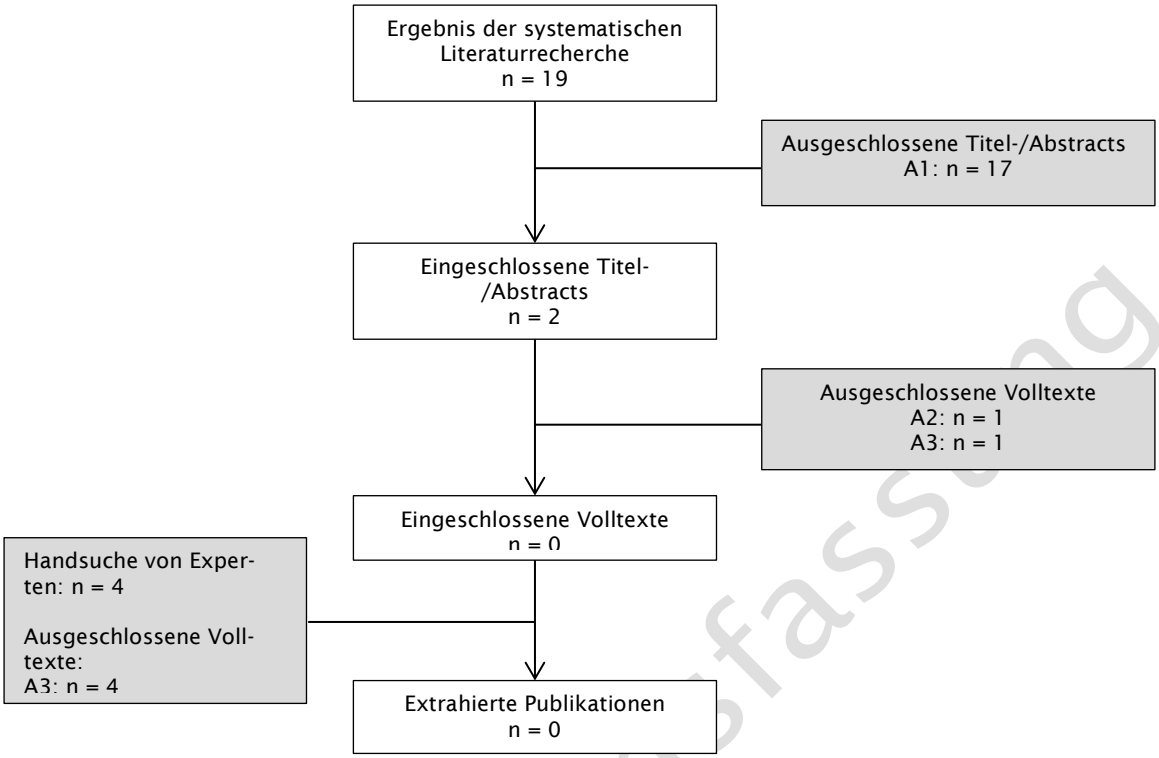
- Cochrane Database of Systematic Reviews (0)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (0)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (0)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 0

12.4.4.3. Ein- und Ausschlusskriterien

Ausschlusskriterien für erste Relevanzsichtung:	
A1:	andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle – Auszug s.u.)
A2:	anderer Publikationstyp (z.B. RCT, Kohortenstudien, Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, Leitlinien)
A3:	unsystematischer Review oder Review **ohne** Einschluss von RCT und/ oder prospektiven Kohortenstudien)
A4:	retrospektive Kohortenstudie
A5:	n < 25
A6:	Doppelpublikation oder nicht erhältlich
A7:	Sonstiges (z.B. Sprache, Publikation außerhalb des Suchzeitraums etc.)
Einschlusskriterien für erste Relevanzsichtung:	
E1:	Systematischer Review (aus RCTs und / oder prospektiven Kohortenstudien) (wahrscheinlich) oder Leitlinien passend zur Fragestellung analog PICO-Tabelle

12.4.4.4. Ergebnisse der Recherche



12.4.4.4.1. Ausgeschlossene Volltexte (Handsuche von Experten)

A3: unsystematischer Review oder Review ohne Einschluss von RCT und/ oder prospektiven Kohortenstudien)

1. Kristiansen G. Diagnostic and prognostic molecular biomarkers for prostate cancer. Histopathology 2012;60(1):125-41 http://www.ncbi.nlm.nih.gov/pubmed/22212082, DOI: 10.1111/j.1365-2559.2011.04083.x.
2. Brimo F, Epstein JI. Selected common diagnostic problems in urologic pathology: perspectives from a large consult service in genitourinary pathology. Arch Pathol Lab Med 2012;136(4):360-71 http://www.ncbi.nlm.nih.gov/pubmed/22458899, DOI: 10.5858/arpa.2011-0187-RA.
3. Brimo F, Epstein JI. Immunohistochemical pitfalls in prostate pathology. Hum Pathol 2012;43(3):313-24 http://www.ncbi.nlm.nih.gov/pubmed/22325142, DOI: 10.1016/j.humpath.2011.11.005.
4. Paner GP, Aron M, Hansel DE, Amin MB. Non-epithelial neoplasms of the prostate. Histopathology 2012;60(1):166-86 http://www.ncbi.nlm.nih.gov/pubmed/22212085, DOI: 10.1111/j.1365-2559.2011.04020.x.

12.4.4.4.2. Ausgeschlossene Volltexte (nach Volltextscreening)

A2: anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, Leitlinienadaptation)

1. 9. Minner S, Enodien M, Sirma H, Luebke AM, Krohn A, Mayer PS, Simon R, Tennstedt P, Muller J, Scholz L, Brase JC, Liu AY, Schluter H, Pantel K, Schumacher U, Bokemeyer C, Steuber T, Graefen M, Sauter G, Schlomm T. ERG status is unrelated to PSA recurrence in radically operated prostate cancer in the absence of antihormonal therapy. Clin Cancer Res 2011;17(18):5878-88 PM:21791629, DOI:

1078-0432.CCR-11-1251 [pii];10.1158/1078-0432.CCR-11-1251.

A3: unsystematischer Review oder Review ohne Einschluss von RCT und/ oder prospektiven Kohortenstudien)

1. 16. Paner GP, Luthringer DJ, Amin MB. Best practice in diagnostic immunohistochemistry: prostate carcinoma and its mimics in needle core biopsies. Arch Pathol Lab Med 2008;132(9):1388-96 PM:18788849, DOI: 2008-0261-CPR [pii];10.1043/1543-2165(2008)132[1388:BPIDIP]2.0.CO;2.

12.4.4.4.3. Ausgeschlossene Titel-/Abstracts (nach Titel-/Abstractscreening durchgeführt von Kristiansen)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

1. 1. Yi Y, Breau RH, Witiuk K, Neuberger MM, Dahm P. Diagnostic tests in urology: percentage of free prostate-specific antigen (PSA). BJU Int
2. 2. Abern MR, Tsivian M, Polascik TJ. Focal therapy of prostate cancer: evidence-based analysis for modern selection criteria. Curr Urol Rep 2012;13(2):160-9 PM:22298223, DOI: 10.1007/s11934-012-0241-5.
3. 3. Ashida S, Orloff MS, Bebek G, Zhang L, Zheng P, Peehl DM, Eng C. Integrated analysis reveals critical genomic regions in prostate tumor microenvironment associated with clinicopathologic phenotypes. Clin Cancer Res 2012;18(6):1578-87 PM:22275508, DOI: 1078-0432.CCR-11-2535 [pii];10.1158/1078-0432.CCR-11-2535.
4. 4. Katafigiotis I, Tyritzis SI, Stravodimos KG, Alamanis C, Pavlakis K, Vlahou A, Makridakis M, Katafigioti A, Garbis SD, Constantinides CA. Zinc alpha2- glycoprotein as a potential novel urine biomarker for the early diagnosis of prostate cancer. BJU Int 2012;110(11 Pt B):E688-E693 PM:23020913, DOI: 10.1111/j.1464-410X.2012.11501.x .
5. 5. Wang EC, Kwah YC, Tan WP, Lee JS, Tan SH. Extramammary Paget disease: Immunohistochemistry is critical to distinguish potential mimickers. Dermatol Online J 2012;18(9):4 PM:23031371.
6. 6. Zumsteg ZS, Zelefsky MJ. Short-term androgen deprivation therapy for patients with intermediate-risk prostate cancer undergoing dose-escalated radiotherapy: the standard of care? Lancet Oncol 2012;13(6):e259-e269 PM:22652234, DOI: S1470-2045(12)70084-0 [pii];10.1016/S1470-2045(12)70084-0.
7. 7. Ficarra E, Di CS, Acquaviva A, Macii E. Automated segmentation of cells with IHC membrane staining. IEEE Trans Biomed Eng 2011;58(5):1421-9 PM:21245003, DOI: 10.1109/TBME.2011.2106499.
8. 8. Grifantini R, Pagani M, Pierleoni A, Grandi A, Parri M, Campagnoli S, Pileri P, Cattaneo D, Canidio E, Pontillo A, De CE, Bresciani A, Marinoni F, Pedrazzoli E, Nogarotto R, Abrignani S, Viale G, Sarmientos P, Grandi G. A novel polyclonal antibody library for expression profiling of poorly characterized, membrane and secreted human proteins. J Proteomics 2011;75(2):532-47 PM:21920474, DOI: S1874-3919(11)00433-7 [pii];10.1016/j.jprot.2011.08.018.
9. 10. Stovsky M, Ponsky L, Vourganti S, Stuhldreher P, Siroky MB, Kipnis V, Fedotoff O, Mikheeva L, Zaslavsky B, Chait A, Jones JS. Prostate-specific antigen/solvent interaction analysis: a preliminary evaluation of a new assay concept for detecting prostate cancer using urinary samples. Urology 2011;78(3):601-5 PM:21783231, DOI: S0090-4295(11)00567-X [pii];10.1016/j.urology.2011.03.071.
10. 11. Murphy T, Darby S, Mathers ME, Gnanapragasam VJ. Evidence for distinct alterations in the FGF axis in prostate cancer progression to an aggressive clinical phenotype. J Pathol 2010;220(4):452-60 PM:19960500, DOI: 10.1002/path.2657.
11. 12. Briganti A, Blute ML, Eastham JH, Graefen M, Heidenreich A, Karnes JR, Montorsi F, Studer UE. Pelvic lymph node dissection in prostate cancer. Eur Urol 2009;55(6):1251-65 PM:19297079, DOI: S0302-2838(09)00244-9 [pii];10.1016/j.eururo.2009.03.012.
12. 13. Lee JH, Kim SH, Lee ES, Kim YS. CD24 overexpression in cancer development and progression: a meta-analysis. Oncol Rep 2009;22(5):1149-56 PM:19787233.
13. 14. Babaian RJ, Donnelly B, Bahn D, Baust JG, Dineen M, Ellis D, Katz A, Pisters L,

Rukstalis D, Shinohara K, Thrasher JB. Best practice statement on cryosurgery for the treatment of localized prostate cancer. J Urol 2008;180(5):1993-2004 PM:18817934, DOI: S0022-5347(08)02017-X [pii];10.1016/j.juro.2008.07.108.
14. 15. Billis A, Guimaraes MS, Freitas LL, Meirelles L, Magna LA, Ferreira U. The impact of the 2005 international society of urological pathology consensus conference on standard Gleason grading of prostatic carcinoma in needle biopsies. J Urol 2008;180(2):548-52 PM:18550106, DOI: S0022-5347(08)00947-6 [pii];10.1016/j.juro.2008.04.018.
15. 17. Roupret M, Yates DR, Comperat E, Cussenot O. Upper urinary tract urothelial cell carcinomas and other urological malignancies involved in the hereditary non-polyposis colorectal cancer (lynch syndrome) tumor spectrum. Eur Urol 2008;54(6):1226-36 PM:18715695, DOI: S0302-2838(08)00948-2[pii];10.1016/j.eururo.2008.08.008.
16. 18. Tomlins SA, Rhodes DR, Yu J, Varambally S, Mehra R, Perner S, Demichelis F, Helgeson BE, Laxman B, Morris DS, Cao Q, Cao X, Andren O, Fall K, Johnson L, Wei JT, Shah RB, Al-Ahmadie H, Eastham JA, Eggener SE, Fine SW, Hotakainen K, Stenman UH, Tsodikov A, Gerald WL, Lilja H, Reuter VE, Kantoff PW, Scardino PT, Rubin MA, Bjartell AS, Chinnaiyan AM. The role of SPINK1 in ETS rearrangement-negative prostate cancers. Cancer Cell 2008;13(6):519-28 PM:18538735, DOI: S1535-6108(08)00152-9 [pii];10.1016/j.ccr.2008.04.016.
17. 19. Varambally S, Laxman B, Mehra R, Cao Q, Dhanasekaran SM, Tomlins SA, Granger J, Vellaichamy A, Sreekumar A, Yu J, Gu W, Shen R, Ghosh D, Wright LM, Kladney RD, Kuefer R, Rubin MA, Fimmel CJ, Chinnaiyan AM. Golgi protein GOLM1 is a tissue and urine biomarker of prostate cancer. Neoplasia 2008;10(11):1285-94 PM:18953438.

12.4.5. Recherche zum Thema Prognosescore für das frühe Prostatakarzinom (de novo Recherche)

12.4.5.1. Fragestellung

Fragestellung/Themenbereich	Population	Intervention	Comparison	Outcome	Evidenzgrundlage / Zusatzinformation
Bestimmung und Umgang mit der Komorbidität der Betroffenen: Welche Klassifikation/ Score (Prognosescore) kann die Therapieentscheidung beim frühen Prostatakarzinom am wirksamsten unterstützen? Wirth, Fröhner, Wedding	Pat mit frühem PCa, die kurativ behandelbar wären (=Patienten vor Behandlung	Score, Klassifikation [ASA, Charlson Score, Body Mass, Kombination von Scores]	Keine	Validierung der Scores, Prognostische Güte: 10-Jahres-Überlebensraten, konkurrierende Sterblichkeit = (Gesamtmortali-tät minus prostataspezifische Mortalität), Alters- und/oder Komorbiditätsgrenzen für eine kurative Therapie	Kohortenstudien, RCT

12.4.5.2. Recherchestrategien

12.4.5.2.1. Recherche

Ausschlusskriterien für Relevanzsichtung:
A1: andere Erkrankung (nicht PCa)

A2: Methodik (Letter, Editorial, News, Comment)

A3: Dubletten durch Suche in verschiedenen Datenbanken

A4: Publikationen vor 2003 und nicht deutsch oder englisch (Cochrane Library)

PubMed (18. April 2013)

Nr.	Suchfrage	Anzahl
#6	#3 AND #4 Limits: English, German, Publication date from 2003/01/01	1428
#5	#3 AND #4	2240
#4	"prognosis"[All Fields] OR "therapy decision"[All Fields] OR "treatment decision"[All Fields] OR "therapy plan*"[All Fields] OR "treatment plan*"[All Fields]	466981
#3	#1 AND #2	10494
#2	"classification"[All Fields] OR score[All Fields] OR scores[All Fields]	973865
#1	"prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields]	108143

Anzahl der Treffer: 1428

Davon relevant: 1389

Cochrane (18. April 2013)
Suchstrategie:

Nr.	Suchfrage	Anzahl
#6	#3 AND #4 from 2003 to 2013, in Cochrane Reviews (Reviews only), Other Reviews, Trials, Methods Studies, Technology Assessment and Economic Evaluations	85
#5	#3 AND #4	125
#4	prognosis OR ((treatment OR therapy) AND (decision OR plan)):ti,ab,kw	22786
#3	#1 AND #2	636
#2	classification OR score:ti,ab,kw	71200
#1	(prostatic OR prostate) AND (neoplasm OR neoplasms OR cancer):ti,ab,kw	4111

- Cochrane Database of Systematic Reviews (2)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (82)
- Cochrane Methodology Register (1)
- Health Technology Assessment Database (0)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 85

Davon neu: 47

Davon relevant: 45

12.4.5.2.2. Recherche: Nomogramm

Ausschlusskriterien für Relevanzsichtung:
A1: andere Erkrankung (nicht PCa)

A2: Methodik (Letter, Editorial, News, Comment)

A3: Dubletten durch Suche in verschiedenen Datenbanken

A4: Publikationen vor 2008 und nicht deutsch oder englisch (Cochrane Library)

A5: Dubletten aus Recherche vom 18. April zu klassifikation-score

PubMed (14. Mai 2013)

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 Limits: English, German, Publication date from 2008/01/01	113
#3	#1 AND #2	690
#2	"nomograms"[MeSH Terms] OR "nomograms"[All Fields] OR "nomogram"[All Fields]	4652
#1	"prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields]	108657

Anzahl der Treffer: 113

Davon relevant: 77

Cochrane (14. Mai 2013)
Suchstrategie:

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 from 2008 to 2013, in Cochrane Reviews (Reviews only), Other Reviews, Trials, Methods Studies, Technology Assessment and Economic Evaluations	8

Nr.	Suchfrage	Anzahl
#3	#1 AND #2	17
#2	nomogram OR nomograms:ti,ab,kw	192
#1	(prostatic OR prostate) AND (neoplasm OR neoplasms OR cancer):ti,ab,kw	4162

- Cochrane Database of Systematic Reviews (0)
- Database of Abstracts of Reviews of Effects (1)
- Cochrane Central Register of Controlled Trials (7)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (0)
- NHS Economic Evaluation Database (0)

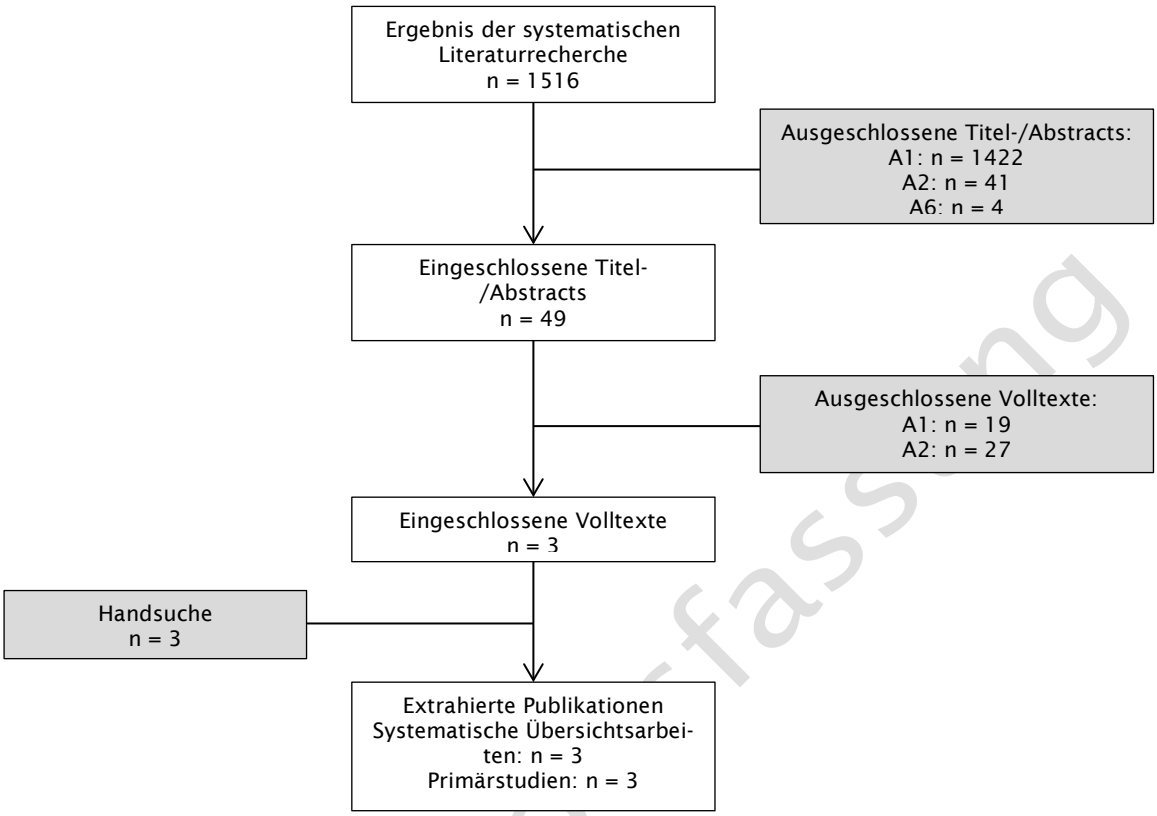
Anzahl der Treffer: 8

Davon relevant: 5

12.4.5.3. Ein- und Ausschlusskriterien

Ausschlusskriterien	
A1:	andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle – Auszug s.u.)
A2:	anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: RCT + Kohortenstudien)
A3:	unsystematischer Review oder Review **ohne** Einschluss von RCT und/ oder Kohortenstudien
A4:	Keine vergleichende Studie
A5:	n < 25
A6:	Doppelpublikation oder nicht erhältlich
A7:	Sonstiges (z.B. Sprache, Publikation außerhalb des Suchzeitraums etc.)
Einschlusskriterien	
E1:	Systematischer Review (aus RCTs und / oder Kohortenstudien) (wahrscheinlich) passend zur Fragestellung analog PICO-Tabelle
E2:	RCT, Kohortenstudien (wahrscheinlich) passend zur Fragestellung analog PICO-Tabelle

12.4.5.4. Ergebnisse der Recherche



12.4.5.4.1. Extrahierte Publikationen

Eingeschlossene Volltexte (nach Volltextsichtung)

1. Walz J, Gallina A, Saad F, Montorsi F, Perrotte P, Shariat SF, Jeldres C, Graefen M, Benard F, McCormack M, Valiquette L, Karakiewicz PI. A nomogram predicting 10-year life expectancy in candidates for radical prostatectomy or radiotherapy for prostate cancer. J Clin Oncol 2007;25(24):3576-81 http://www.ncbi.nlm.nih.gov/pubmed/17704404, DOI: 10.1200/JCO.2006.10.3820.
2. Rodrigues G, Warde P, Pickles T, Crook J, Brundage M, Souhami L, Lukka H. Pre-treatment risk stratification of prostate cancer patients: A critical review. Can Urol Assoc J 2012;6(2):121-7 http://www.ncbi.nlm.nih.gov/pubmed/22511420, DOI: 10.5489/cuaj.11085.
3. Sutcliffe P, Hummel S, Simpson E, Young T, Rees A, Wilkinson A, Hamdy F, Clarke N, Staffurth J. Use of classical and novel biomarkers as prognostic risk factors for localised prostate cancer: a systematic review. Health Technol Assess 2009;13(5):iii, xi-iiixiii PM:19128541, DOI: 10.3310/hta13050.

Eingeschlossene Volltexte (nach Handsuche)

1. Daskivich TJ, Fan KH, Koyama T, Albertsen PC, Goodman M, Hamilton AS, Hoffman RM, Stanford JL, Stroup AM, Litwin MS, Penson DF. Effect of age, tumor risk, and comorbidity on competing risks for survival in a U.S. population-based cohort of men with prostate cancer. Ann Intern Med 2013;158(10):709-17 http://www.ncbi.nlm.nih.gov/pubmed/23689764, DOI: 10.7326/0003-4819-158-10-201305210-00005.

12.4.5.4.2. Ausgeschlossene Volltexte (nach Volltextsichtung)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

1. Froehner M, Koch R, Litz R, Oehlschlaeger S, Noack B, Manseck A, Albrecht DM, Wirth MP. Preoperative cardiopulmonary risk assessment as predictor of early noncancer and overall mortality after radical prostatectomy. Urology 2003;61(3):596-600 http://www.ncbi.nlm.nih.gov/pubmed/12639654.
2. Ritvo P, Irvine J, Naglie G, Tomlinson G, Bezjak A, Matthew A, Trachtenberg J, Krahn M. Reliability and validity of the PORPUS, a combined psychometric and utility-based quality-of-life instrument for prostate cancer. J Clin Epidemiol 2005;58(5):466-74 http://www.ncbi.nlm.nih.gov/pubmed/15845333, DOI: 10.1016/j.jclinepi.2004.08.019.
3. Froehner M, Koch R, Litz RJ, Haase M, Klenk U, Oehlschlaeger S, Baretton GB, Wirth MP. Comparison of tumor- and comorbidity-related predictors of mortality after radical prostatectomy. Scand J Urol Nephrol 2005;39(6):449-54 http://www.ncbi.nlm.nih.gov/pubmed/16303719, DOI: 10.1080/00365590510031174.
4. Froehner M, Koch R, Litz RJ, Hakenberg OW, Oehlschlaeger S, Wirth MP. Comorbidity is poor predictor of survival in patients undergoing radical prostatectomy after 70 years of age. Urology 2006;68(3):583-6 http://www.ncbi.nlm.nih.gov/pubmed/16979740, DOI: 10.1016/j.urology.2006.03.050.
5. Walz J, Gallina A, Perrotte P, Jeldres C, Trinh QD, Hutterer GC, Traumann M, Ramirez A, Shariat SF, McCormack M, Perreault JP, Benard F, Valiquette L, Saad F, Karakiewicz PI. Clinicians are poor raters of life-expectancy before radical prostatectomy or definitive radiotherapy for localized prostate cancer. BJU Int 2007;100(6):1254-8 http://www.ncbi.nlm.nih.gov/pubmed/17979925, DOI: 10.1111/j.1464-410X.2
6. Gallina A, Chun FK, Briganti A, Shariat SF, Montorsi F, Salonia A, Erbersdobler A, Rigatti P, Valiquette L, Huland H, Graefen M, Karakiewicz PI. Development and split-sample validation of a nomogram predicting the probability of seminal vesicle invasion at radical prostatectomy. Eur Urol 2007;52(1):98-105 http://www.ncbi.nlm.nih.gov/pubmed/17267098, DOI: 10.1016/j.eururo.2007.01.060.
7. Froehner M, Koch R, Litz RJ, Oehlschlaeger S, Twelker L, Hakenberg OW, Wirth MP. Detailed analysis of Charlson comorbidity score as predictor of mortality after radical prostatectomy. Urology 2008;72(6):1252-7 http://www.ncbi.nlm.nih.gov/pubmed/18723211, DOI: 10.1016/j.urology.2008.05.037.
8. Thanigasalam R, Rasiah KK, Stricker PD, Haynes AM, Sutherland SI, Sutherland RL, Henshall SM, Horvath LG. Stage migration in localized prostate cancer has no effect on the post-radical prostatectomy Kattan nomogram. BJU Int 2010;105(5):642-7 http://www.ncbi.nlm.nih.gov/pubmed/19751263, DOI: 10.1111/j.1464-410X.2009.08842.x.
9. Ohori M, Kattan MW, Yu C, Matsumoto K, Satoh T, Ishii J, Miyakawa A, Irie A, Iwamura M, Tachibana M. Nomogram to predict seminal vesicle invasion using the status of cancer at the base of the prostate on systematic biopsy. Int J Urol 2010;17(6):534-40 http://www.ncbi.nlm.nih.gov/pubmed/20370843, DOI: 10.1111/j.1442-2042.2010.02513.x.
10. Lai JS, Bode R, Wee HL, Eton D, Cella D. A brief assessment of physical functioning for prostate cancer patients. Patient Relat Outcome Meas 2010;1:51-6 http://www.ncbi.nlm.nih.gov/pubmed/22915952 .
11. Tamblyn DJ, Chopra S, Yu C, Kattan MW, Pinnock C, Kopsaftis T. Comparative analysis of three risk assessment tools in Australian patients with prostate cancer. BJU Int 2011;108 Suppl 2:51-6 http://www.ncbi.nlm.nih.gov/pubmed/22085129, DOI: 10.1111/j.1464-410X.2011.10687.x.
12. Ploussard G, Masson-Lecomte A, Beauval JB, Ouzzane A, Bonniol R, Buge F, Fadli S, Roupret M, Rebillard X, Gaschignard N, Pfister C, Villers A, Soulie M, Salomon L. Radical prostatectomy for high-risk prostate cancer defined by preoperative criteria: oncologic follow-up in national multicenter study in 813 patients and assess-

ment of easy-to-use prognostic substratification. Urology 2011;78(3):607-13 http://www.ncbi.nlm.nih.gov/pubmed/21783233, DOI: 10.1016/j.urology.2011.05.021.
13. Oon SF, Watson RW, O'Leary JJ, Fitzpatrick JM. Epstein criteria for insignificant prostate cancer. BJU Int 2011;108(4):518-25 http://www.ncbi.nlm.nih.gov/pubmed/21320276, DOI: 10.1111/j.1464-410X.2011.09979.x.
14. Major JM, Klonoff-Cohen HS, Pierce JP, Slymen DJ, Saltzstein SL, Macera CA, Mercola D, Kattan MW. Prostate cancer postoperative nomogram scores and obesity. PLoS One 2011;6(2):e17382 http://www.ncbi.nlm.nih.gov/pubmed/21390220, DOI: 10.1371/journal.pone.0017382.
15. Cooperberg MR, Hilton JF, Carroll PR. The CAPRA-S score: A straightforward tool for improved prediction of outcomes after radical prostatectomy. Cancer 2011;117(22):5039-46 http://www.ncbi.nlm.nih.gov/pubmed/21647869, DOI: 10.1002/cncr.26169.
16. Shukla-Dave A, Hricak H, Akin O, Yu C, Zakian KL, Udo K, Scardino PT, Eastham J, Kattan MW. Preoperative nomograms incorporating magnetic resonance imaging and spectroscopy for prediction of insignificant prostate cancer. BJU Int 2012;109(9):1315-22 http://www.ncbi.nlm.nih.gov/pubmed/21933336, DOI: 10.1111/j.1464-410X.2011.10612.x.
17. Abdollah F, Sun M, Schmitges J, Thuret R, Bianchi M, Shariat SF, Briganti A, Jeldres C, Perrotte P, Montorsi F, Karakiewicz PI. Survival benefit of radical prostatectomy in patients with localized prostate cancer: estimations of the number needed to treat according to tumor and patient characteristics. Journal of Urology 2012;188(1):73-83 http://www.ncbi.nlm.nih.gov/pubmed/22578732, DOI: 10.1016/j.juro.2012.03.005.
18. van Vugt HA, Roobol MJ, van der Poel HG, van Muilekom EH, Busstra M, Kil P, Oomens EH, Leliveld A, Bangma CH, Korfage I, Steyerberg EW. Selecting men diagnosed with prostate cancer for active surveillance using a risk calculator: a prospective impact study. BJU Int 2012;110(2):180-7 PM:22112199, DOI: 10.1111/j.1464-410X.2011.10679.x.
19. Guzzo TJ, Dluzniewski P, Orosco R, Platz EA, Partin AW, Han M. Prediction of mortality after radical prostatectomy by Charlson comorbidity index. Urology 2010;76(3):553-7 PM:20627284, DOI: S0090-4295(10)00420-6 [pii];10.1016/j.urology.2010.02.069.

A2: anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)

1. Kattan MW. Nomograms are superior to staging and risk grouping systems for identifying high-risk patients: preoperative application in prostate cancer. Curr Opin Urol 2003;13(2):111-6 http://www.ncbi.nlm.nih.gov/pubmed/12584470, DOI: 10.1097/01.mou.0000058631.64616.54.
2. Ramsden AR, Chodak G. An analysis of risk factors for biochemical progression in patients with seminal vesicle invasion: validation of Kattan's nomogram in a pathological subgroup. BJU Int 2004;93(7):961-4 http://www.ncbi.nlm.nih.gov/pubmed/15142143, DOI: 10.1111/j.1464-410X.2003.04760.x.
3. Poulakis V, Witzsch U, de VR, Emmerlich V, Meves M, Altmannsberger HM, Becht E. Preoperative neural network using combined magnetic resonance imaging variables, prostate specific antigen, and Gleason score to predict prostate cancer recurrence after radical prostatectomy. Eur Urol 2004;46(5):571-8 http://www.ncbi.nlm.nih.gov/pubmed/15474265, DOI: 10.1016/j.eururo.2004.07.010.
4. Froehner M, Koch R, Litz R, Oehlschlaeger S, Wirth MP. Which conditions contributing to the Charlson score predict survival after radical prostatectomy? Journal of Urology 2004;171(2 Pt 1):697-9 http://www.ncbi.nlm.nih.gov/pubmed/14713789, DOI: 10.1097/01.ju.0000108138.36333.09.
5. Kefi A, Irer B, Ozdemir I, Tuna B, Goktay Y, Yorukoglu K, Esen A. Predictive value of the international prostate symptom score for positive prostate needle biopsy in

the low-intermediate prostate-specific antigen range. Urol Int 2005;75(3):222-6 http://www.ncbi.nlm.nih.gov/pubmed/16215309, DOI: 10.1159/000087798.
6. Froehner M, Koch R, Litz RJ, Oehlschlaeger S, Hakenberg OW, Wirth MP. Feasibility and limitations of comorbidity measurement in patients undergoing radical prostatectomy. Eur Urol 2005;47(2):190-5 http://www.ncbi.nlm.nih.gov/pubmed/15661413, DOI: 10.1016/j.eururo.2004.07.031.
7. Roach M, III, Weinberg V, Nash M, Sandler HM, McLaughlin PW, Kattan MW. Defining high risk prostate cancer with risk groups and nomograms: implications for designing clinical trials. Journal of Urology 2006;176(6 Pt 2):S16-S20 http://www.ncbi.nlm.nih.gov/pubmed/17084158, DOI: 10.1016/j.juro.2006.06.081.
8. Kastner C, Armitage J, Kimble A, Rawal J, Carter PG, Venn S. The Charlson comorbidity score: a superior comorbidity assessment tool for the prostate cancer multidisciplinary meeting. Prostate Cancer Prostatic Dis 2006;9(3):270-4 http://www.ncbi.nlm.nih.gov/pubmed/16770340, DOI: 10.1038/sj.pcan.4500889.
9. Epstein JI. What's new in prostate cancer disease assessment in 2006? Curr Opin Urol 2006;16(3):146-51 http://www.ncbi.nlm.nih.gov/pubmed/16679850, DOI: 10.1097/01.mou.0000193389.31727.9b.
10. Cooperberg MR, Freedland SJ, Pasta DJ, Elkin EP, Presti JC, Jr., Amling CL, Terris MK, Aronson WJ, Kane CJ, Carroll PR. Multiinstitutional validation of the UCSF cancer of the prostate risk assessment for prediction of recurrence after radical prostatectomy. Cancer 2006;107(10):2384-91 http://www.ncbi.nlm.nih.gov/pubmed/17039503, DOI: 10.1002/cncr.22262.
11. Chun FK, Steuber T, Erbersdobler A, Currlin E, Walz J, Schlomm T, Haese A, Heinzer H, McCormack M, Huland H, Graefen M, Karakiewicz PI. Development and internal validation of a nomogram predicting the probability of prostate cancer Gleason sum upgrading between biopsy and radical prostatectomy pathology. Eur Urol 2006;49(5):820-6 http://www.ncbi.nlm.nih.gov/pubmed/16439050, DOI: 10.1016/j.eururo.2005.11.007.
12. May M, Knoll N, Siegsmund M, Fahlenkamp D, Vogler H, Hoschke B, Gralla O. Validity of the CAPRA score to predict biochemical recurrence-free survival after radical prostatectomy. Results from a european multicenter survey of 1,296 patients. Journal of Urology 2007;178(5):1957-62 http://www.ncbi.nlm.nih.gov/pubmed/17868719, DOI: 10.1016/j.juro.2007.07.043.
13. Chun FK, Karakiewicz PI, Briganti A, Walz J, Kattan MW, Huland H, Graefen M. A critical appraisal of logistic regression-based nomograms, artificial neural networks, classification and regression-tree models, look-up tables and risk-group stratification models for prostate cancer. BJU Int 2007;99(4):794-800 http://www.ncbi.nlm.nih.gov/pubmed/17378842, DOI: 10.1111/j.1464-410X.2006.06694.x.
14. Roupret M, Hupertan V, Comperat E, Drouin SJ, Phe V, Xylinas E, Demanse D, Sibony M, Richard F, Cussenot O. Cross-cultural validation of a prognostic tool: example of the Kattan preoperative nomogram as a predictor of prostate cancer recurrence after radical prostatectomy. BJU Int 2009;104(6):813-7 http://www.ncbi.nlm.nih.gov/pubmed/19254280, DOI: 10.1111/j.1464-410X.2009.08473.x.
15. Hsu CY, Joniau S, Oyen R, Roskams T, Van PH. Correlations between age, Charlson score and outcome in clinical unilateral T3a prostate cancer. Asian J Androl 2009;11(1):131-7 http://www.ncbi.nlm.nih.gov/pubmed/19050679, DOI: 10.1038/aja.2008.35.
16. Roeloffzen EM, Van VM, Battermann JJ, van Roermund JG, Saibishkumar EP, Monninkhof EM. Pretreatment nomogram to predict the risk of acute urinary retention after I-125 prostate brachytherapy. Int J Radiat Oncol Biol Phys 2011;81(3):737-44 http://www.ncbi.nlm.nih.gov/pubmed/20888131, DOI: 10.1016/j.ijrobp.2010.06.009.
17. Ploussard G, Epstein JI, Montironi R, Carroll PR, Wirth M, Grimm MO, Bjartell AS, Montorsi F, Freedland SJ, Erbersdobler A, van der Kwast TH. The contemporary concept of significant versus insignificant prostate cancer. Eur Urol 2011;60(2):291-303 http://www.ncbi.nlm.nih.gov/pubmed/21601982, DOI:

10.1016/j.eururo.2011.05.006.
18. Ngo TC, Turnbull BB, Lavori PW, Presti JC, Jr. The prostate cancer risk calculator from the Prostate Cancer Prevention Trial underestimates the risk of high grade cancer in contemporary referral patients. Journal of Urology 2011;185(2):483-7 http://www.ncbi.nlm.nih.gov/pubmed/21167519, DOI: 10.1016/j.juro.2010.09.101.
19. Korets R, Motamedinia P, Yeshchina O, Desai M, McKiernan JM. Accuracy of the Kattan nomogram across prostate cancer risk-groups. BJU Int 2011;108(1):56-60 http://www.ncbi.nlm.nih.gov/pubmed/21062396, DOI: 10.1111/j.1464-410X.2010.09838.x.
20. Ishizaki F, Hoque MA, Nishiyama T, Kawasaki T, Kasahara T, Hara N, Takizawa I, Saito T, Kitamura Y, Akazawa K, Takahashi K. External validation of the UCSF-CAPRA (University of California, San Francisco, Cancer of the Prostate Risk Assessment) in Japanese patients receiving radical prostatectomy. Jpn J Clin Oncol 2011;41(11):1259-64 http://www.ncbi.nlm.nih.gov/pubmed/21940731, DOI: 10.1093/jjco/hyr136.
21. Heidenreich A, Pfister D, Thuer D, Brehmer B. Percentage of positive biopsies predicts lymph node involvement in men with low-risk prostate cancer undergoing radical prostatectomy and extended pelvic lymphadenectomy. BJU Int 2011;107(2):220-5 http://www.ncbi.nlm.nih.gov/pubmed/20590538, DOI: 10.1111/j.1464-410X.2010.09485.x.
22. Sengupta S, Weerakoon M, Sethi K, Ischia J, Webb DR. Algorithm for selecting men for pelvic lymph node dissection (PLND) during radical prostatectomy based on clinical risk factors in an Australian population. BJU Int 2012;109 Suppl 3:48-51 http://www.ncbi.nlm.nih.gov/pubmed/22458494, DOI: 10.1111/j.1464-410X.2012.11047.x.
23. Loeb S, Carvalhal GF, Kan D, Desai A, Catalona WJ. External validation of the cancer of the prostate risk assessment (CAPRA) score in a single-surgeon radical prostatectomy series. Urol Oncol 2012;30(5):584-9 http://www.ncbi.nlm.nih.gov/pubmed/20822930, DOI: 10.1016/j.urolonc.2010.06.007.
24. Graversen JA, Suh LK, Mues AC, Korets R, Donovan MJ, Khan FM, Liu Q, Landman J, Gupta M, McKiernan JM, Badani KK. Independent diagnostic and post-treatment prognostic models for prostate cancer demonstrate significant correlation with disease progression end points. J Endourol 2012;26(5):451-6 http://www.ncbi.nlm.nih.gov/pubmed/21942796, DOI: 10.1089/end.2011.0192.
25. Froehner M, Koch R, Litz RJ, Hakenberg OW, Wirth MP. Which patients are at the highest risk of dying from competing causes </= 10 years after radical prostatectomy? BJU Int 2012;110(2):206-10 http://www.ncbi.nlm.nih.gov/pubmed/22044591, DOI: 10.1111/j.1464-410X.2011.10693.x.
26. Budaus L, Isbarn H, Tennstedt P, Salomon G, Schlomm T, Steuber T, Haese A, Chun F, Fisch M, Michl U, Heinzer H, Huland H, Graefen M. Risk assessment of metastatic recurrence in patients with prostate cancer by using the Cancer of the Prostate Risk Assessment score: results from 2937 European patients. BJU Int 2012;110(11):1714-20 http://www.ncbi.nlm.nih.gov/pubmed/22520619, DOI: 10.1111/j.1464-410X.2012.11147.x.
27. Briganti A, Capitanio U, Abdollah F, Gallina A, Suardi N, Bianchi M, Tutolo M, Salonia A, Freschi M, Rigatti P, Montorsi F. Assessing the risk of lymph node invasion in patients with intermediate risk prostate cancer treated with extended pelvic lymph node dissection. A novel prediction tool. Prostate 2012;72(5):499-506 http://www.ncbi.nlm.nih.gov/pubmed/22468270.

12.4.5.4.3. Ausgeschlossene Titel-/Abstracts (nach Titel-/Abstractscreening)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

1. Castle KO, Hoffman KE, Levy LB, Lee AK, Choi S, Nguyen QN, Frank SJ, Pugh TJ, McGuire SE, Kuban DA. Is androgen deprivation therapy necessary in all intermediate-risk prostate cancer patients treated in the dose escalation era? Int J Radiat Oncol Biol Phys 2013;85(3):693-9 PM:22836052, DOI: S0360-3016(12)00856-5

[pii];10.1016/j.ijrobp.2012.06.030.
2. Chang CF, Pao JB, Yu CC, Huang CY, Huang SP, Yang YP, Huang CN, Chang TY, You BJ, Lee HZ, Hour TC, Bao BY. Common Variants in IGF1 Pathway Genes and Clinical Outcomes After Radical Prostatectomy. Ann Surg Oncol 2013; PM:23397154, DOI: 10.1245/s10434-013-2884-y.
3. Cirak Y, Sarsik B, Cakar B, Sen S, Simsir A, Uslu R. Predictive and prognostic values of Tau and BubR1 protein in prostate cancer and their relationship to the Gleason score. Med Oncol 2013;30(2):526 PM:23475578, DOI: 10.1007/s12032-013-0526-7.
4. Dietrich D, Hasinger O, Banez LL, Sun L, van Leenders GJ, Wheeler TM, Bangma CH, Wernert N, Perner S, Freedland SJ, Corman JM, Ittmann MM, Lark AL, Madden JF, Hartmann A, Schatz P, Kristiansen G. Development and clinical validation of a real-time PCR assay for PITX2 DNA methylation to predict prostate-specific antigen recurrence in prostate cancer patients following radical prostatectomy. J Mol Diagn 2013;15(2):270-9 PM:23266319, DOI: S1525-1578(12)00306-6 [pii];10.1016/j.jmoldx.2012.11.002.
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A2: anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)

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A6: Doppelpublikation oder nicht erhältlich

1. Cooperberg MR, Hilton JF, Carroll PR. The CAPRA-S score: A straightforward tool for improved prediction of outcomes after radical prostatectomy. Cancer 2011;117(22):5039-46 PM:21647869, DOI: 10.1002/cncr.26169.
2. Kattan MW, Yu C, Salomon L, Vora K, Touijer K, Guillonneau B. Development and validation of preoperative nomogram for disease recurrence within 5 years after laparoscopic radical prostatectomy for prostate cancer. Urology 2011;77(2):396-401 PM:20970840, DOI: S0090-4295(10)00665-5 [pii];10.1016/j.urology.2010.05.013.
3. Donovan MJ, Costa J, Cordon-Cardo C. Personalized approach to prostate cancer prognosis. Minerva Urol Nefrol 2010;62(3):231-9 PM:20940693, DOI: R19101881 [pii].
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12.4.6. Recherche zum Thema Active Surveillance, Behandlung des Low-Risk PCa (Kapitel 5.1 und 5.2 der Leitlinie)

12.4.6.1. Fragestellung

Fragestellung/Themenbereich	Population	Intervention	Comparison	Outcome	Evidenzgrundlage/Zusatzinformation
Low-risk-Karzinom (lokal begrenzt): kurativ Fröhner, Börgermann	Patienten mit Low risk Karzinom (lokal begrenzt) PSA-Wert max. 10 ng/ml, Gleason Score max. 6 und 3+4 und cT1c und cT2a, Tumor in weniger als <= 2 Stanzen, <= 50% Tumor pro Stanze	Radikale Prostatektomie, kurative Radiatio, kurative Brachytherapie	Active Surveillance, Watchful Waiting	Morbidität, PCA-Mortalität, PSA-Progress, kurative Intervention	Aggregierte Evidenz (Systematischer Review, Leitlinienadaptation) + RCT, prospektive Kohortenstudien

12.4.6.2. Recherchestrategien

Anmerkung: Nach bereits erfolgter Recherche wurde der Suchzeitraum weiter eingegrenzt: Zeitraum nach der Recherche (17.01.2011) für die Aktualisierung 2011 bis 03.04.2013.

Ausschlusskriterien für Relevanzsichtung:

A1: andere Erkrankung (nicht PCa)

A2: Methodik (Letter, Editorial, News, Comment)

A3: Dubletten durch Suche in verschiedenen Datenbanken

A4: Publikationen vor 2011 und nicht deutsch oder englisch (Cochrane Library)

PubMed (03. April 2013)

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 Limits: English, German, Publication date from 2008/01/01	1194
#3	#1 AND #2	2659
#2	("watchful waiting"[MeSH Terms] OR ("watchful"[All Fields] AND "waiting"[All Fields]) OR "watchful waiting"[All Fields] OR ("active"[All Fields] AND "surveillance"[All Fields]) OR "active surveillance"[All Fields]) OR "expectant management"[All Fields] OR "deferred treatment"[All Fields] OR "delayed intervention"[All Fields] OR "defensive strategies"[All Fields] OR "PSA kinetics"[All Fields] OR "PSA velocity"[All Fields] OR "PSA doubling time"[All Fields] OR "PSA density"[All Fields]	13146
#1	"prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields]	107786

Anzahl der Treffer: 1194

Davon relevant: 1078

Davon nach 2011: 584

Cochrane (03. April 2013)
Suchstrategie:

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 from 2008 to 2013, in Cochrane Reviews (Reviews only), Other Reviews, Trials, Methods Studies, Technology Assessment and Economic Evaluations	53
#3	#1 AND #2	137
#2	(watchful AND waiting) OR (active AND surveillance) OR "expectant management" OR "deferred treatment" OR "delayed intervention" OR "defensive strategies" OR "PSA kinetics" OR "PSA velocity" OR "PSA doubling time" OR "PSA density":ti,ab,kw	875
#1	(prostatic OR prostate) AND (neoplasm OR neoplasms OR cancer):ti,ab,kw	4111

- Cochrane Database of Systematic Reviews (4)
- Database of Abstracts of Reviews of Effects (1)
- Cochrane Central Register of Controlled Trials (45)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (2)
- NHS Economic Evaluation Database (1)

Anzahl der Treffer: 53

Davon neu: 7

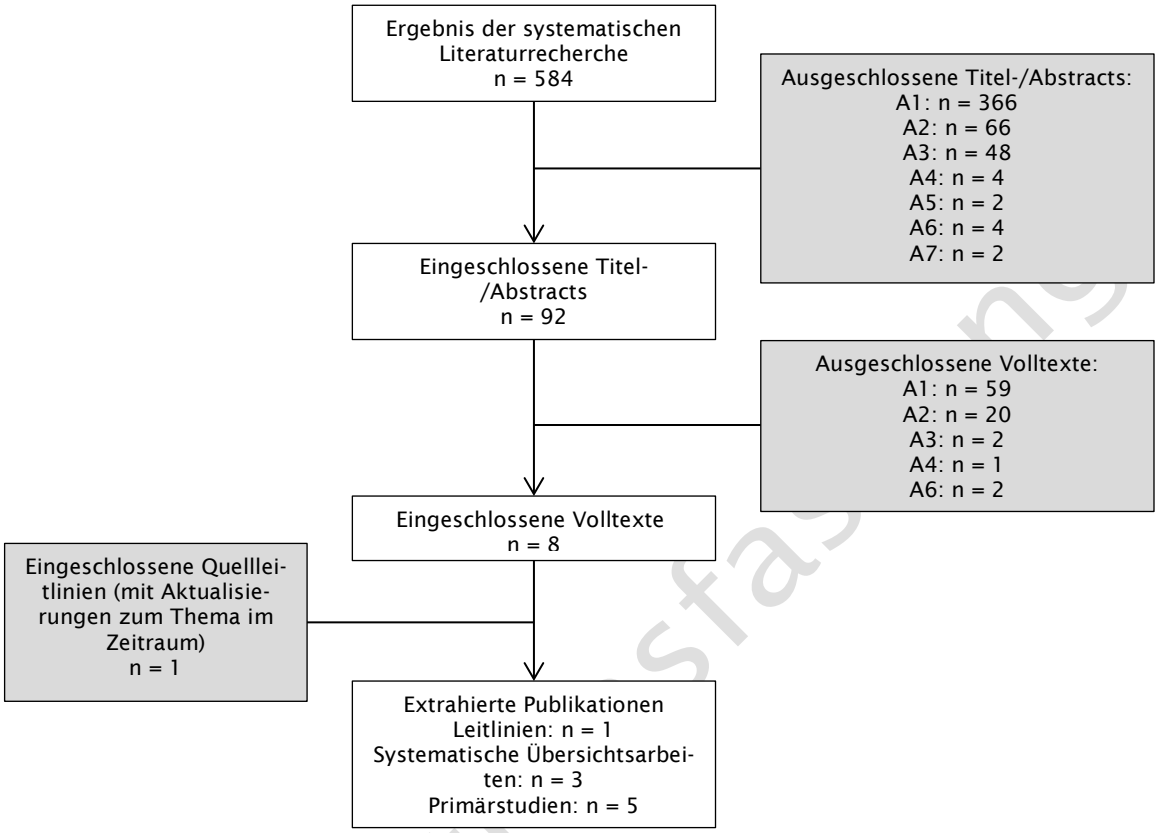
Davon relevant: 4

Davon nach 2011: 0

12.4.6.3. Ein- und Ausschlusskriterien

Ausschlusskriterien	
A1:	andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle – Auszug s.u.)
A2:	anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT)
A3:	unsystematischer Review oder Review ohne Einschluss von RCT und/ oder prospektiven Kohortenstudien
A4:	retrospektive Kohortenstudie
A5:	n < 25
A6:	Doppelpublikation oder nicht erhältlich
A7:	Sonstiges (z.B. Sprache, Publikation außerhalb des Suchzeitraums etc.)
Einschlusskriterien	
E1:	Systematischer Review (aus RCTs und/oder prospektiven Kohortenstudien) (wahrscheinlich) passend zu Fragestellungen 7.1 und/oder 7.3 analog PICO-Tabelle
E2:	RCT (wahrscheinlich) passend zu Fragestellungen 7.1 und/oder 7.3 analog PICO-Tabelle

12.4.6.4. Ergebnisse der Recherche



12.4.6.4.1. Extrahierte Publikationen

Eingeschlossene Volltexte

1. 152. Dall'era MA, Albertsen PC, Bangma C, Carroll PR, Carter HB, Cooperberg MR, Freedland SJ, Klotz LH, Parker C, Soloway MS. Active surveillance for prostate cancer: a systematic review of the literature. Eur Urol 2012;62(6):976-83 PM:22698574, DOI: S0302-2838(12)00691-4 [pii];10.1016/j.eururo.2012.05.072.
2. 372. Wilt TJ. The Prostate Cancer Intervention Versus Observation Trial: VA/NCI/AHRQ Cooperative Studies Program #407 (PIVOT): design and baseline results of a randomized controlled trial comparing radical prostatectomy with watchful waiting for men with clinically localized prostate cancer. J Natl Cancer Inst Monogr 2012;2012(45):184-90 PM:23271771, DOI: lgs041 [pii];10.1093/jncimonographs/lgs041.
3. 373. Wilt TJ, Brawer MK, Jones KM, Barry MJ, Aronson WJ, Fox S, Gingrich JR, Wei JT, Gilhooly P, Grob BM, Nsouli I, Iyer P, Cartagena R, Snider G, Roehrborn C, Sharifi R, Blank W, Pandya P, Andriole GL, Culkin D, Wheeler T. Radical prostatectomy versus observation for localized prostate cancer. N Engl J Med 2012;367(3):203-13 PM:22808955, DOI: 10.1056/NEJMoa1113162.
4. 359. van den Bergh RC, Korfage IJ, Roobol MJ, Bangma CH, de Koning HJ, Steyerberg EW, Essink-Bot ML. Sexual function with localized prostate cancer: active surveillance vs radical therapy. BJU Int 2012;110(7):1032-9 PM:22260273, DOI: 10.1111/j.1464-410X.2011.10846.x.
5. 406. Bill-Axelson A, Holmberg L, Ruutu M, Garmo H, Stark JR, Busch C, Nordling S, Haggman M, Andersson SO, Bratell S, Spangberg A, Palmgren J, Steineck G, Adami HO, Johansson JE. Radical prostatectomy versus watchful waiting in early prostate cancer. N Engl J Med 2011;364(18):1708-17 PM:21542742, DOI: 10.1056/NEJMoa1011967.
6. 448. Ganz PA, Barry JM, Burke W, Col NF, Corso PS, Dodson E, Hammond ME,

Kogan BA, Lynch CF, Newcomer L, Seifter EJ, Tooze JA, Viswanath KV, Wessells H. NIH State-of-the-Science Conference Statement: Role of active surveillance in the management of men with localized prostate cancer. NIH Consens State Sci Statements 2011;28(1):1-27 PM:23392076, DOI: 2011-00035-STMT [pii].
7. 467. Ip S, Dahabreh IJ, Chung M, Yu WW, Balk EM, Iovin RC, Mathew P, Luongo T, Dvorak T, Lau J. An evidence review of active surveillance in men with localized prostate cancer. Evid Rep Technol Assess (Full Rep) 2011;(204):1-341 PM:23126653.
8. 470. Johansson E, Steineck G, Holmberg L, Johansson JE, Nyberg T, Ruutu M, Bill-Axelson A. Long-term quality-of-life outcomes after radical prostatectomy or watchful waiting: the Scandinavian Prostate Cancer Group-4 randomised trial. Lancet Oncol 2011;12(9):891-9 PM:21821474, DOI: S1470-2045(11)70162-0 [pii];10.1016/S1470-2045(11)70162-0.

Extrahierte Quelleitlinie

1. Heidenreich A, Bolla M, Joniau S, Mason MD, Matveev V, Mottet N, Schmid HP, van der Kwast TH, Wiegel T, Zattoni F. EAU guidelines on prostate cancer. 2013

12.4.6.4.2. Ausgeschlossene Volltexte (nach Volltextsichtung)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

1. 9. Bangma CH, Bul M, Van Der Kwast TH, Pickles T, Korfage IJ, Hoeks CM, Steyerberg EW, Jenster G, Kattan MW, Bellardita L, Carroll PR, Denis LJ, Parker C, Roobol MJ, Emberton M, Klotz LH, Rannikko A, Kakehi Y, Lane JA, Schroder FH, Semjonow A, Trock BJ, Valdagni R. Active surveillance for low-risk prostate cancer. Crit Rev Oncol Hematol 2013;85(3):295-302 PM:22878262, DOI: S1040-8428(12)00154-0 [pii];10.1016/j.critrevonc.2012.07.005.
2. 10. Bellardita L, Rancati T, Alvisi MF, Villani D, Magnani T, Marenghi C, Nicolai N, Procopio G, Villa S, Salvioni R, Valdagni R. Predictors of Health-related Quality of Life and Adjustment to Prostate Cancer During Active Surveillance. Eur Urol 2013; PM:23357351, DOI: S0302-2838(13)00012-2 [pii];10.1016/j.eururo.2013.01.009.
3. 11. Berg KD, Toft BG, Roder MA, Brasso K, Vainer B, Iversen P. Is it possible to predict low-volume and insignificant prostate cancer by core needle biopsies? APMIS 2013;121(4):257-65 PM:23030402, DOI: 10.1111/j.1600-0463.2012.02965.x.
4. 16. Bul M, Zhu X, Valdagni R, Pickles T, Kakehi Y, Rannikko A, Bjartell A, van der Schoot DK, Cornel EB, Conti GN, Boeve ER, Staerman F, Vis-Maters JJ, Vergunst H, Jaspars JJ, Strolin P, van ME, Schroder FH, Bangma CH, Roobol MJ. Active Surveillance for Low-Risk Prostate Cancer Worldwide: The PRIAS Study. Eur Urol 2013;63(4):597-603 PM:23159452, DOI: S0302-2838(12)01336-X [pii];10.1016/j.eururo.2012.11.005.
5. 33. Godtman RA, Holmberg E, Khatami A, Stranne J, Hugosson J. Outcome following active surveillance of men with screen-detected prostate cancer. Results from the Goteborg randomised population-based prostate cancer screening trial. Eur Urol 2013;63(1):101-7 PM:22980443, DOI: S0302-2838(12)01019-6 [pii];10.1016/j.eururo.2012.08.066.
6. 50. Lin DW, Newcomb LF, Brown EC, Brooks JD, Carroll PR, Feng Z, Gleave M, Lance RD, Sanda MG, Thompson IM, Jr., Wei JT, Nelson PS. Urinary TMPRSS2:ERG and PCA3 in an active surveillance cohort: results from a baseline analysis in the Canary Prostate Active Surveillance Study. Clin Cancer Res 2013; PM:23515404, DOI: 1078-0432.CCR-12-3283 [pii];10.1158/1078-0432.CCR-12-3283.
7. 73. Selvadurai ED, Singhera M, Thomas K, Mohammed K, Woode-Amissah R, Horwich A, Huddart RA, Dearnaley DP, Parker CC. Medium-term Outcomes of Active Surveillance for Localised Prostate Cancer. Eur Urol 2013; PM:23473579, DOI: S0302-2838(13)00132-2 [pii];10.1016/j.eururo.2013.02.020.
8. 80. Thomsen FB, Roder MA, Hvarness H, Iversen P, Brasso K. Active surveillance can reduce overtreatment in patients with low-risk prostate cancer. Dan Med J 2013;60(2):A4575 PM:23461989, DOI: A4575 [pii].
9. 87. Vasarainen H, Lahdensuo K, Savolainen R, Ruutu M, Taari K, Rannikko A. Dif-

fusion-weighted magnetic resonance imaging in prostate cancer patients on active surveillance one year after diagnosis and before repeat biopsy. Scand J Urol 2013; PM:23327661, DOI: 10.3109/21681805.2013.765910.
10. 130. Bul M, Zhu X, Rannikko A, Staerman F, Valdagni R, Pickles T, Bangma CH, Roobol MJ. Radical prostatectomy for low-risk prostate cancer following initial active surveillance: results from a prospective observational study. Eur Urol 2012;62(2):195-200 PM:22342775, DOI: S0302-2838(12)00186-8 [pii];10.1016/j.eururo.2012.02.002.
11. 131. Bul M, van den Bergh RC, Zhu X, Rannikko A, Vasarainen H, Bangma CH, Schroder FH, Roobol MJ. Outcomes of initially expectantly managed patients with low or intermediate risk screen-detected localized prostate cancer. BJU Int 2012;110(11):1672-7 PM:22928973, DOI: 10.1111/j.1464-410X.2012.11434.x.
12. 132. Bul M, van den Bergh RC, Rannikko A, Valdagni R, Pickles T, Bangma CH, Roobol MJ. Predictors of unfavourable repeat biopsy results in men participating in a prospective active surveillance program. Eur Urol 2012;61(2):370-7 PM:21704447, DOI: S0302-2838(11)00651-8 [pii];10.1016/j.eururo.2011.06.027.
13. 158. Donovan JL. Presenting treatment options to men with clinically localized prostate cancer: the acceptability of active surveillance/monitoring. J Natl Cancer Inst Monogr 2012;2012(45):191-6 PM:23271772, DOI: lgs030 [pii];10.1093/jncimonographs/lgs030.
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18. 299. Radomski L, Gani J, Trottier G, Finelli A. Active surveillance failure for prostate cancer: does the delay in treatment increase the risk of urinary incontinence? Can J Urol 2012;19(3):6287-92 PM:22704315.
19. 330. Shapiro RH, Johnstone PA. Risk of Gleason grade inaccuracies in prostate cancer patients eligible for active surveillance. Urology 2012;80(3):661-6 PM:22925240, DOI: S0090-4295(12)00674-7 [pii];10.1016/j.urology.2012.06.022.
20. 341. Sooriakumaran P, Srivastava A, Christos P, Grover S, Shevchuk M, Tewari A. Predictive models for worsening prognosis in potential candidates for active surveillance of presumed low-risk prostate cancer. Int Urol Nephrol 2012;44(2):459-70 PM:21706297, DOI: 10.1007/s11255-011-0020-0.
21. 375. Wong LM, Johnston R, Sharma N, Shah NC, Warren AY, Neal DE. General application of the National Institute for Health and Clinical Excellence (NICE) guidance for active surveillance for men with prostate cancer is not appropriate in unscreened populations. BJU Int 2012;110(1):24-7 PM:22077729, DOI: 10.1111/j.1464-410X.2011.10730.x.
22. 483. Klotz L. Active surveillance for prostate cancer: a review. Arch Esp Urol 2011;64(8):806-14 PM:22052761.
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early-stage prostate cancer as a foundation for parenchyma-sparing prostate cancer therapies: active surveillance and focal targeted therapy. BJU Int 2011;108(7):1074-85 PM:21489116, DOI: 10.1111/j.1464-410X.2010.10039.x.
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29. 323. Seiler D, Randazzo M, Leupold U, Zeh N, Isbarn H, Chun FK, Ahyai SA, Baumgartner M, Huber A, Recker F, Kwiatkowski M. Protocol-based active surveillance for low-risk prostate cancer: anxiety levels in both men and their partners. Urology 2012;80(3):564-9 PM:22770614, DOI: S0090-4295(12)00503-1 [pii];10.1016/j.urology.2012.04.053.
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A4: retrospektive Kohortenstudie

1. 3. Abern MR, Bassett MR, Tsivian M, Banez LL, Polascik TJ, Ferrandino MN, Robertson CN, Freedland SJ, Moul JW. Race is associated with discontinuation of active surveillance of low-risk prostate cancer: results from the Duke Prostate Center. Prostate Cancer Prostatic Dis 2013;16(1):85-90 PM:23069729, DOI: pcan201238 [pii];10.1038/pcan.2012.38.

A6: Doppelpublikation oder nicht erhältlich

1. 151. Dahabreh IJ, Chung M, Balk EM, Yu WW, Mathew P, Lau J, Ip S. Active surveillance in men with localized prostate cancer: a systematic review. Ann Intern Med 2012;156(8):582-90 PM:22351515, DOI: 0003-4819-156-8-201204170-00397 [pii];10.1059/0003-4819-156-8-201204170-00397.
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12.4.6.4.3. Ausgeschlossene Titel/Abstracts (nach Titel-/Abstractscreening durchgeführt von Weißbach)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

1. 1. Locally advanced prostate cancer: effective treatments, but many adverse effects. Prescrire Int 2013;22(134):18-3 PM:23367679.
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5. 17. Ceci F, Castellucci P, Mamede M, Schiavina R, Rubello D, Fuccio C, Ambrosini V, Boschi S, Martorana G, Fanti S. (11)C-Choline PET/CT in patients with hormone-resistant prostate cancer showing biochemical relapse after radical prostatectomy. Eur J Nucl Med Mol Imaging 2013;40(2):149-55 PM:23151910, DOI: 10.1007/s00259-012-2272-z.
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A2: anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)

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A3: unsystematischer Review oder Review ohne Einschluss von RCT und/ oder prospektiven Kohortenstudien)

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A4: retrospektive Kohortenstudie

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A5: Eingeschlossene Patienten n < 25

1. 379. Xu J, Neale AV, Dailey RK, Eggly S, Schwartz KL. Patient perspective on watchful waiting/active surveillance for localized prostate cancer. J Am Board Fam Med 2012;25(6):763-70 PM:23136314, DOI: 25/6/763 [pii];10.3122/jabfm.2012.06.120128.
2. 489. Kravchick S, Peled R, Cytron S. Watchful waiting and active surveillance approach in patients with low risk localized prostatic cancer: an experience of outpatients clinic with 12-year follow-up. Pathol Oncol Res 2011;17(4):893-7 PM:21655925, DOI: 10.1007/s12253-011-9400-0.

A6: Doppelpublikation oder nicht erhältlich

1. 172. Garcia-Cruz E, Huguet J, Piqueras M, Marquez MP, Peri L, Izquierdo L, Franco A, Alvarez-Vijande R, Ribal MJ, Alcaraz A. Low testosterone bioavailability is related to prostate cancer diagnose in patients submitted to prostate biopsy. World J Urol 2012;30(3):361-5 PM:21833558, DOI: 10.1007/s00345-011-0741-9.
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3. 543. Sartor O. Randomized studies of PSA screening: an opinion. Asian J Androl 2011;13(3):364-5 PM:21358665, DOI: aja201112 [pii];10.1038/aja.2011.12.
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A7: Sonstiges (z.B. Sprache, Publikation außerhalb des Suchzeitraums etc.)

1. 476. Kazer MW, Bailey DE, Jr., Colberg J, Kelly WK, Carroll P. The needs for men undergoing active surveillance (AS) for prostate cancer: results of a focus group study. J Clin Nurs 2011;20(3-4):581-6 PM:21219530, DOI: 10.1111/j.1365-2702.2010.03489.x.
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12.4.7. Recherche zum Thema Systemtherapie beim metastasierten kastrationsresistenten Prostatakarzinom (Kapitel 6.4 und 6.5 der Leitlinie)

12.4.7.1. Fragestellung

Fragestellung/ Themenbereich	Population	Intervention	Kontrolle	Outcome	Evidenz-grundlage
Systemtherapie beim metastasierten Prostatakarzinom: Welche Substanzen sind beim kastrationsresistenten Prostatakarzinom wirksam?	Patienten mit metastasiertem PCA und Progress der Erkrankung unter Hormontherapie (kastrationsresistentes PCa)	Docetaxel, Cabazitaxel, Abirateron, Enzalutamid	symptomorientiert, Gabe von Glukokortikoiden	PSA-Ansprechrate, Toxizität, PSA-Progression, Mortalität, PCa-Mortalität, Gesamtmortalität, Morbidität, Lebensqualität	Aggregierte Evidenz (Systematischer Review) + RCT
Systemtherapie beim metastasierten Prostatakarzinom: Sind Kombinationstherapien beim kastrationsresistenten Prostatakarzinom wirksam? Wörmann, Zastrow, Heidenreich, Wirth, Miller	Kastrationsresistentes PCa	Standard-Kombination: -LH-RH Antagonist oder Agonist + Abirateron; Bei Knochenmetastasen zusätzlich Bisphosphonat oder Denosumab. Abirateron kombiniert mit Cabazitaxel oder Docetaxel	Keine Kombinationstherapien, sondern Monotherapie mit LH-RH Agonist ODER LH-RH Antagonist	PSA-Ansprechrate, Toxizität, PSA-Progression, Mortalität, Morbidität, Lebensqualität	Aggregierte Evidenz (Systematischer Review, Leitlinienadaptation) + RCT

12.4.7.2. Recherchestrategien

Ausschlusskriterien für Relevanzsichtung festlegen:

A1: andere Erkrankung (nicht PCa)

A2: Methodik (Letter, Editorial, News, Comment)

A3: Dubletten durch Suche in verschiedenen Datenbanken

A4: Publikationen vor 2008 und nicht deutsch oder englisch (Cochrane Library)

PubMed (10. April 2013)

Nr.	Suchfrage	Anzahl
#10	#5 AND #8 Limits: English, German, Publication date from 2008/01/01	451
#9	#5 AND #8	746
#8	#6 OR #7	2566395
#7	(randomized controlled trial [pt] OR controlled clinical trial [pt] OR randomized [tiab] OR placebo [tiab] OR drug therapy [sh] OR randomly [tiab] OR trial [tiab] OR groups [tiab]) AND humans [mh]	2434194
#6	systematic[sb]	199523
#5	#3 AND #4	965
#4	#1 AND #2	4165
#3	("docetaxel"[Supplementary Concept] OR "docetaxel"[All Fields]) OR ("cabazitaxel"[Supplementary Concept] OR "cabazitaxel"[All Fields]) OR ("abiraterone"[Supplementary Concept] OR "abiraterone"[All Fields]) OR ("MDV 3100"[Supplementary Concept] OR "MDV 3100"[All Fields] OR "enzalutamide"[All Fields])	9090
#2	(("orchiectomy"[MeSH Terms] OR "orchiectomy"[All Fields] OR "castration"[All Fields] OR "castration"[MeSH Terms]) AND resistant[All Fields]) OR (("hormones"[MeSH Terms] OR "hormones"[All Fields] OR "hormone"[All Fields] OR "hormones"[Pharmacological Action]) AND refractory[All Fields])	10870
#1	"prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields]	107976

Anzahl der Treffer: 451

Davon relevant: 432

Cochrane (10. April 2013)
Suchstrategie:

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 from 2008 to 2013, in Cochrane Reviews (Reviews only), Other Reviews, Trials, Methods Studies, Technology Assessment and Economic Evaluations	64
#3	#1 AND #2	81
#2	((orchiectomy OR castration) AND resistant) OR (hormone? AND refractory):ti,ab,kw	122
#1	(prostatic OR prostate) AND (neoplasm OR neoplasms OR cancer):ti,ab,kw	4111

- Cochrane Database of Systematic Reviews (2)
- Database of Abstracts of Reviews of Effects (1)
- Cochrane Central Register of Controlled Trials (54)

- Cochrane Methodology Register (0)
- Health Technology Assessment Database (6)
- NHS Economic Evaluation Database (1)

Anzahl der Treffer: 64

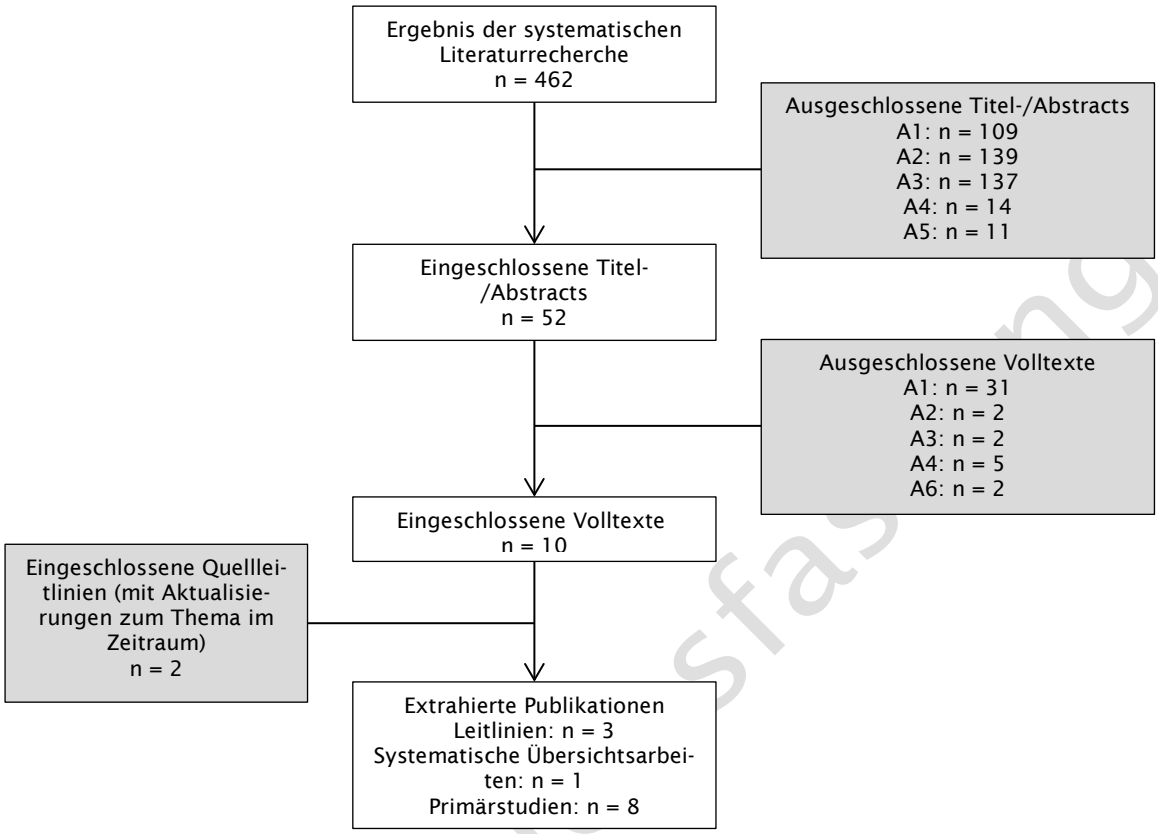
Davon neu: 32

Davon relevant: 30

12.4.7.3. Ein- und Ausschlusskriterien

Ausschlusskriterien	
A1:	andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle – Auszug s.u.)
A2:	anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT)
A3:	unsystematischer Review oder Review ohne Einschluss von RCT und/ oder prospektiven Kohortenstudien
A4:	retrospektive Kohortenstudie
A5:	n < 25
A6:	Doppelpublikation oder nicht erhältlich
A7:	Sonstiges (z.B. Sprache, Publikation außerhalb des Suchzeitraums etc.)
Einschlusskriterien	
E1:	Systematischer Review (aus RCTs und/oder prospektiven Kohortenstudien) (wahrscheinlich) passend zu Fragestellungen 7.1 und/oder 7.3 analog PICO-Tabelle
E2:	RCT (wahrscheinlich) passend zu Fragestellungen 7.1 und/oder 7.3 analog PICO-Tabelle

12.4.7.4. Ergebnisse der Recherche



12.4.7.4.1. Extrahierte Publikationen

Eingeschlossene Volltexte (nach Volltextsichtung)

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A2: anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)

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A3: unsystematischer Review oder Review ohne Einschluss von RCT und/ oder prospektiven Kohortenstudien)

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12.4.7.4.3. Ausgeschlossene Titel-/Abstracts (nach Titel-/Abstractscreening durchgeführt von Wörmann/Miller/Zastrow)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

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A2: anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)

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A3: unsystematischer Review oder Review ohne Einschluss von RCT und/ oder prospektiven Kohortenstudien)

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8. 406. Blagden SP, Molife LR, Seebaran A, Payne M, Reid AH, Protheroe AS, Vasist LS, Williams DD, Bowen C, Kathman SJ, Hodge JP, Dar MM, de Bono JS, Middleton MR. A phase I trial of ispinesib, a kinesin spindle protein inhibitor, with docetaxel in patients with advanced solid tumours. Br J Cancer 2008;98(5):894-9 PM:18319713, DOI: 6604264 [pii];10.1038/sj.bjc.6604264.
9. 416. Di LG, Figg WD, Fossa SD, Mirone V, Autorino R, Longo N, Imbimbo C, Perdona S, Giordano A, Giuliano M, Labianca R, De PS. Combination of bevacizumab and docetaxel in docetaxel-pretreated hormone-refractory prostate cancer: a phase 2 study. Eur Urol 2008;54(5):1089-94 PM:18276061, DOI: S0302-2838(08)00136-X [pii];10.1016/j.eururo.2008.01.082.
10. 454. Suttmann H, Grgic A, Lehmann J, Zwergel U, Kamradt J, Gouverneur E, Pinkert J, Stockle M, Kirsch CM, Nestle U. Combining 153Sm-lexidronam and docetaxel for the treatment of patients with hormone-refractory prostate cancer: first experience. Cancer Biother Radiopharm 2008;23(5):609-18 PM:18999933, DOI: 10.1089/cbr.2008.0487.
11. 455. Takenaka A, Yamada Y, Kurahashi T, Soga H, Miyake H, Fujisawa M. Combination chemotherapy with weekly docetaxel and estramustine for hormone refractory prostate cancer in Japanese patients. Int J Urol 2008;15(1):106-9 PM:18184188, DOI: IJU1929 [pii];10.1111/j.1442-2042.2007.01929.x.

12.4.8. Recherche zum Thema Knochenmetastasen (Kapitel 6.5 der Leitlinie)

12.4.8.1. Fragestellung

Fragestellung/Themenbereich	Population	Intervention	Comparison	Outcome	Evidenzgrundlage/ Zusatzinformation
Systemtherapie beim metastasierten Prostatakarzinom Welche Substanzen sind beim ossär metastasierten Prostatakarzinom wirksam? Wörmann, Zastrow, Heidenreich, Wirth, Miller, Palmedo	Patienten mit ossär metastasiertem PCa	Denosumab, Bis-phosphonat (Zoledronsäure) Radium (Alpharidin)	Symptomorientiert, Gabe von Glukokortikoiden	PSA-Ansprechrate, Toxizität, PSA-Progression, Mortalität, PCa-Mortalität, Gesamtmortalität Morbidität, Lebensqualität	Aggregierte Evidenz (Systematischer Review) + RCT AKdÄ-Seiten

12.4.8.2. Recherchestrategien

12.4.8.2.1. 1. Recherche

Ausschlusskriterien für Relevanzsichtung festlegen:
A1: Dubletten durch Suche in verschiedenen Datenbanken

A2: Publikationen vor 2008 und nicht deutsch oder englisch (Cochrane Library)

PubMed (10. April 2013)

Nr.	Suchfrage	Anzahl
#10	#5 AND #8 Limits: English, German, Publication date from 2008/01/01	111
#9	#5 AND #8	344
#8	#6 OR #7	2566395
#7	(randomized controlled trial [pt] OR controlled clinical trial [pt] OR randomized [tiab] OR placebo [tiab] OR drug therapy [sh] OR randomly [tiab] OR trial [tiab] OR groups [tiab]) AND humans [mh]	2434194
#6	systematic[sb]	199523
#5	#3 AND #4	829
#4	#1 AND #2	3264
#3	("denosumab"[Supplementary Concept] OR "denosumab"[All Fields]) OR ("diphosphonates"[MeSH Terms] OR "diphosphonates"[All Fields] OR "bisphos-	969244

Nr.	Suchfrage	Anzahl
	phonate"[All Fields]) OR ("zoledronic acid"[Supplementary Concept] OR "zoledronic acid"[All Fields]) OR (("radium"[MeSH Terms] OR "radium"[All Fields]) AND 233[All Fields]) OR ("Radioisotopes"[Mesh] OR radionuclide*[tiab] OR"Radiotherapy"[Mesh] OR radiation OR radiotherapy)	
#2	("bone and bones"[MeSH Terms] OR ("bone"[All Fields] AND "bones"[All Fields]) OR "bone and bones"[All Fields] OR "bone"[All Fields]) AND ("neoplasm metastasis"[MeSH Terms] OR ("neoplasm"[All Fields] AND "metastasis"[All Fields]) OR "neoplasm metastasis"[All Fields] OR "metastasis"[All Fields])	23756
#1	"prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields]	107976

Anzahl der Treffer: 111

Davon relevant: 111

Cochrane (10. April 2013)
Suchstrategie:

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 from 2008 to 2013, in Cochrane Reviews (Reviews only), Other Reviews, Trials, Methods Studies, Technology Assessment and Economic Evaluations	51
#3	#1 AND #2	260
#2	bone metastasis:ti,ab,kw	1128
#1	(prostatic OR prostate) AND (neoplasm OR neoplasms OR cancer):ti,ab,kw	4111

- Cochrane Database of Systematic Reviews (4)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (44)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (1)
- NHS Economic Evaluation Database (2)

Anzahl der Treffer: 51

Davon neu: 45

Davon relevant: 40

12.4.8.2.2. Zusätzliche Recherche in den Rote-Hand-Briefen der AkdÄ (2008-2013)

unter http://www.akdae.de/Arzneimittelsicherheit/RHB/Archiv/index.html

Anzahl der Treffer: 3

12.4.8.2.3. Ergänzende Recherche

Ausschlusskriterien für Relevanzsichtung:
A1: Dubletten durch Suche in verschiedenen Datenbanken

A2: Publikationen vor 2008 und nicht deutsch oder englisch (Cochrane Library)

PubMed (12. Juni 2013)

Nr.	Suchfrage	Anzahl
#10	#5 AND #8 Limits: Publication date from 2008/01/01 to 2013/04/10	283
#9	#5 AND #8	824
#8	#6 OR #7	2592357
#7	(randomized controlled trial [pt] OR controlled clinical trial [pt] OR randomized [tiab] OR placebo [tiab] OR drug therapy [sh] OR randomly [tiab] OR trial [tiab] OR groups [tiab]) AND humans [mh]	2456960
#6	systematic[sb]	204074
#5	#3 AND #4	1842
#4	#1 AND #2	5315
#3	("denosumab"[Supplementary Concept] OR "denosumab"[All Fields]) OR ("diphosphonates"[MeSH Terms] OR "diphosphonates"[All Fields] OR "bisphosphonate"[All Fields]) OR ("zoledronic acid"[Supplementary Concept] OR "zoledronic acid"[All Fields]) OR (("radium"[MeSH Terms] OR "radium"[All Fields]) AND 233[All Fields]) OR ("Radioisotopes"[Mesh] OR radionuclide*[tiab] OR"Radiotherapy"[Mesh] OR radiation OR radiotherapy)	976143
#2	("bone and bones"[MeSH Terms] OR ("bone"[All Fields] AND "bones"[All Fields]) OR "bone and bones"[All Fields] OR "bone"[All Fields]) AND (("neoplasm metastasis"[MeSH Terms] OR ("neoplasm"[All Fields] AND "metastasis"[All Fields]) OR "neoplasm metastasis"[All Fields] OR "metastasis"[All Fields]) OR ("neoplasm metastasis"[MeSH Terms] OR ("neoplasm"[All Fields] AND "metastasis"[All Fields]) OR "neoplasm metastasis"[All Fields] OR "metastases"[All Fields]))	35096
#1	"prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields]	110051

Anzahl der Treffer: 283

Davon noch nicht in der Suche vom 10. April 2013 enthalten: 122

Cochrane (12. Juni 2013)
Suchstrategie:

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 from 2008 to 2013, in Cochrane Reviews (Reviews only), Other Reviews, Trials, Methods Studies, Technology Assessment and Economic Evaluations	53
#3	#1 AND #2	262
#2	bone AND (metastasis OR metastases):ti,ab,kw	1137
#1	(prostatic OR prostate) AND (neoplasm OR neoplasms OR cancer):ti,ab,kw	4182

- Cochrane Database of Systematic Reviews (4)

- Database of Abstracts of Reviews of Effects (1)
- Cochrane Central Register of Controlled Trials (45)
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (1)
- NHS Economic Evaluation Database (2)

Anzahl der Treffer: 53

Davon noch nicht in Suche vom 10. April 2013 enthalten: 2

Davon noch nicht in PubMed gefunden: 1

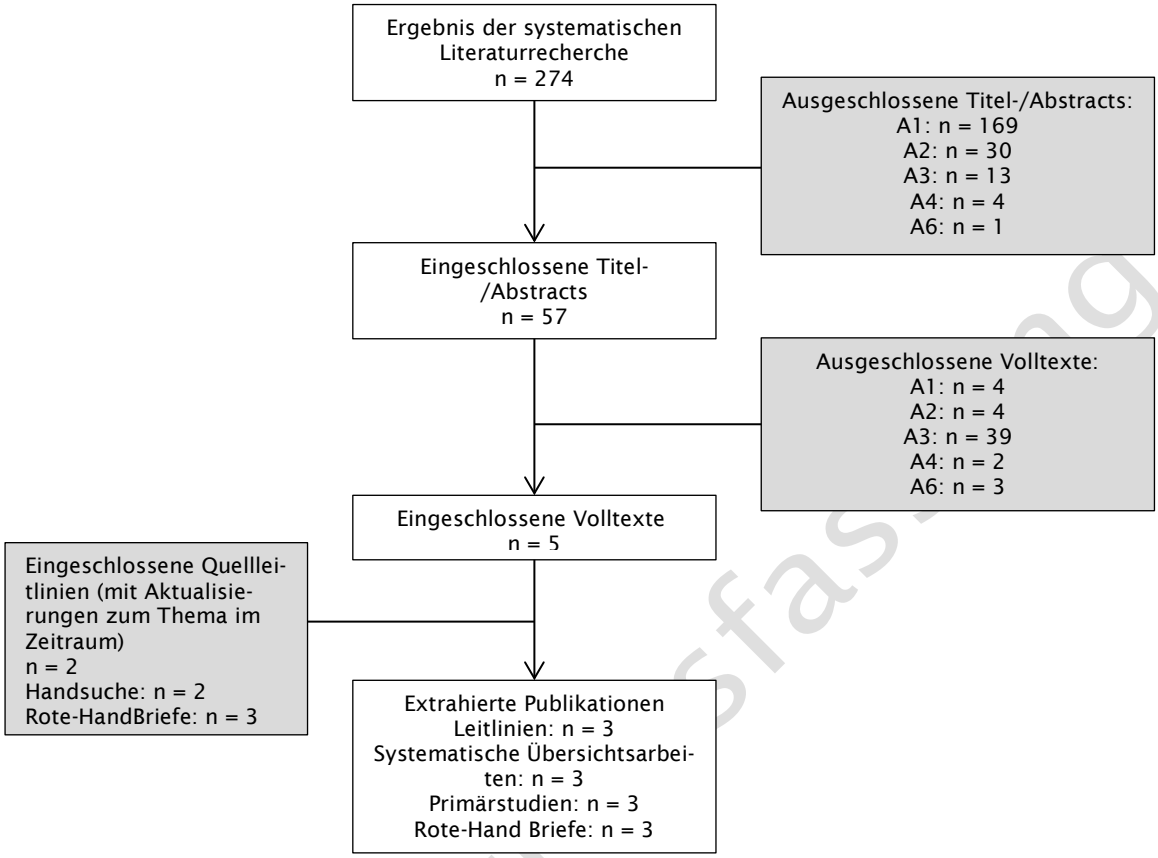
12.4.8.2.4. Handsuche nach Publikationen zu Radium-223

Zusätzlich erfolgte eine Handsuche in PubMedund im Internet zu Publikationen, Abstracts und Kongressberichten zu Radium-223.

12.4.8.3. Ein- und Ausschlusskriterien

Ausschlusskriterien:	
A1:	andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle – Auszug s.u.)
A2:	anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT)
A3:	unsystematischer Review oder Review **ohne** Einschluss von RCT und/ oder prospektiven Kohortenstudien)
A4:	retrospektive Kohortenstudie
A5:	n < 25
A6:	Doppelpublikation oder nicht erhältlich
A7:	Sonstiges (z.B. Sprache, Publikation außerhalb des Suchzeitraums etc.)
Einschlusskriterien:	
E1:	Systematischer Review (aus RCTs und / oder prospektiven Kohortenstudien) (wahrscheinlich) passend zur Fragestellung analog PICO-Tabelle
E2:	RCT (wahrscheinlich) passend zur Fragestellung analog PICO-Tabelle

12.4.8.4. Ergebnisse der Recherche



12.4.8.4.1. Extrahierte Publikationen

Eingeschlossene Volltexte (nach Volltextsichtung)

1. 3. Agarwal N, Sonpavde G, Sternberg CN. Novel molecular targets for the therapy of castration-resistant prostate cancer. Eur Urol 2012;61(5):950-60 PM:22209376, DOI: S0302-2838(11)01412-6 [pii];10.1016/j.eururo.2011.12.028.
2. 12. Climent MA, Piulats JM, Sanchez-Hernandez A, Arranz JA, Cassinello J, Garcia-Donas J, Gonzalez del AA, Leon-Mateos L, Mellado B, Mendez-Vidal MJ, Perez-Valderrama B. Recommendations from the Spanish Oncology Genitourinary Group for the treatment of patients with metastatic castration-resistant prostate cancer. Crit Rev Oncol Hematol 2012;83(3):341-52 PM:22285697, DOI: S1040-8428(12)00003-0 [pii];10.1016/j.critrevonc.2012.01.002.
3. 98. Saad F, Eastham J. Zoledronic Acid improves clinical outcomes when administered before onset of bone pain in patients with prostate cancer. Urology 2010;5 http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/725/CN-00770725/frame.html.
4. 1. Ford JA, Jones R, Elders A, Mulatero C, Royle P, Sharma P, Stewart F, Todd R, Mowatt G. Denosumab for treatment of bone metastases secondary to solid tumours: systematic review and network meta-analysis. Eur J Cancer 2013;49(2):416-30 PM:22906748, DOI: S0959-8049(12)00577-1 [pii];10.1016/j.ejca.2012.07.016.
5. 110. Dhillon S, Lyseng-Williamson KA. Zoledronic acid : a review of its use in the management of bone metastases of malignancy. Drugs 2008;68(4):507-34 PM:18318568, DOI: 68410 [pii].

Extrahierte Quelleitlinien

1. Cookson MS, Roth BJ, Dahm P, Engstrom C, Freedland SJ, Hussain M, Lin DW, Lowrance WT, Murad MH, Oh WK, Penson DF, Kibel AS. Castration-Resistant Prostate Cancer: AUA Guideline. Journal of Urology 2013
2. Heidenreich A, Bolla M, Joniau S, Mason MD, Matveev V, Mottet N, Schmid HP, van der Kwast TH, Wiegel T, Zattoni F. EAU guidelines on prostate cancer. 2013

Eingeschlossene Volltexte (Handsuche)

1. Parker C, Nilsson S, Heinrich D, Helle SI, O'Sullivan JM, Fossa SD, Chodacki A, Wiechno P, Logue J, Seke M, Widmark A, Johannessen DC, Hoskin P, Bottomley D, James ND, Solberg A, Syndikus I, Kliment J, Wedel S, Boehmer S, Dall'oglio M, Franzen L, Coleman R, Vogelzang NJ, O'Bryan-Tear CG, Staudacher K, Garcia-Vargas J, Shan M, Bruland OS, Sartor O. Alpha emitter radium-223 and survival in metastatic prostate cancer. The New England journal of medicine 2013;369(3):213-23
2. Nilsson S, Franzen L, Parker C, Tyrrell C, Blom R, Tennvall J, Lennernas B, Petersson U, Johannessen DC, Sokal M, Pigott K, O'Bryan-Tear CG, Thuresson M, Bolstad B, Bruland OS. Two-year survival follow-up of the randomized, double-blind, placebo-controlled phase II study of radium-223 chloride in patients with castration-resistant prostate cancer and bone metastases. Clin Genitourin Cancer 2013;11(1):20-6

Extrahierte Rote-Hand-Briefe

1. AMGEN. XGEVA (Denosumab). Rote Hand Brief. 2012
2. AMGEN. Prolia (Denosumab). Rote Hand Brief. 2013
3. Novartis. Ergänzende Sicherheitsinformationen zu Berichten über Nierenfunktionsstörung und Nierenversagen unter Aclasta (Zoledronsäure, 5 mg Infusionslösung). Rote Hand Brief. 2010

12.4.8.4.2. Ausgeschlossene Volltexte (nach Volltextsichtung)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

1. 8. Berruti A, Cook R, Saad F, Buttigliero C, Lipton A, Tampellini M, Lee KA, Coleman RE, Smith MR. Prognostic role of serum parathyroid hormone levels in advanced prostate cancer patients undergoing zoledronic acid administration. Oncologist 2012;17(5):645-52 PM:22523198, DOI: theoncologist.2011-0448 [pii];10.1634/theoncologist.2011-0448.
2. 27. Nilsson S, Strang P, Aksnes AK, Franzen L, Olivier P, Pecking A, Staffurth J, Vasanthan S, Andersson C, Bruland OS. A randomized, dose-response, multicenter phase II study of radium-223 chloride for the palliation of painful bone metastases in patients with castration-resistant prostate cancer. Eur J Cancer 2012;48(5):678-86 PM:22341993, DOI: S0959-8049(11)01072-0 [pii];10.1016/j.ejca.2011.12.023.
3. 35. Semenas J, Allegrucci C, Boorjian SA, Mongan NP, Persson JL. Overcoming drug resistance and treating advanced prostate cancer. Curr Drug Targets 2012;13(10):1308-23 PM:22746994, DOI: CDT-EPUB-20120629-1 [pii].
4. 108. Fizazi K, Lipton A, Mariette X, Body JJ, Rahim Y, Gralow JR, Gao G, Wu L, Sohn W, Jun S. Randomized phase II trial of denosumab in patients with bone metastases from prostate cancer, breast cancer, or other neoplasms after intravenous bisphosphonates. Journal of clinical oncology : official journal of the American Society of Clinical Oncology 2009;10 http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/470/CN-00684470/frame.html.

A2: anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)

1. 52. Coleman R. Prostate cancer: targeted therapy for prostate cancer metastases

to bone. Nat Rev Urol 2011;8(6):296-8 PM:21587226, DOI: nrurol.2011.63 [pii];10.1038/nrurol.2011.63.
2. 71. Weintraub B. Trials define anti-tumor effects of anti-resorptive agents: denosumab ahead of zoledronate 2 to 1. BioDrugs 2011;25(2):135-8 PM:21443276, DOI: 6 [pii];10.2165/11590730-000000000-00000.
3. 81. Chedgy EC, Niematallah I, Hawary A. Osteosclerotic prostatic metastasis. ScientificWorldJournal 2010;10:1330-1 PM:20623091, DOI: 10.1100/tsw.2010.105.
4. 127. Benowitz S. As metastasis yields its biological secrets, researchers hope to apply findings. J Natl Cancer Inst 2008;100(15):1054-7 PM:18664646, DOI: djn283 [pii];10.1093/jnci/djn283.

A3: unsystematischer Review oder Review ohne Einschluss von RCT und/ oder prospektiven Kohortenstudien)

1. 35. So A, Chin J, Fleshner N, Saad F. Management of skeletal-related events in patients with advanced prostate cancer and bone metastases: Incorporating new agents into clinical practice. Can Urol Assoc J 2012;6(6):465-70 PM:23282666, DOI: cuaj.12149 [pii];10.5489/cuaj.12149.
2. 36. Spencer S, Marini BL, Figg WD. Novel approaches in the pharmacotherapy of skeletal-related events in metastatic castrate-resistant prostate cancer. Anticancer Res 2012;32(7):2391-8 PM:22753695, DOI: 32/7/2391 [pii].
3. 48. Bishr M, Lattouf JB, Gannon PO, Saad F. Updates on therapeutic targets and agents in castration-resistant prostate cancer. Minerva Urol Nefrol 2011;63(2):131-43 PM:21623331, DOI: R19111920 [pii].
4. 56. Lee RJ, Saylor PJ, Smith MR. Treatment and prevention of bone complications from prostate cancer. Bone 2011;48(1):88-95 PM:20621630, DOI: S8756-3282(10)01289-5 [pii];10.1016/j.bone.2010.05.038.
5. 72. Lee RJ, Saylor PJ, Smith MR. Contemporary therapeutic approaches targeting bone complications in prostate cancer. Clin Genitourin Cancer 2010;8(1):29-36 PM:21208853, DOI: S1558-7673(11)70005-2 [pii];10.3816/CGC.2010.n.005.
6. 81. Saad F, Eastham J. Maintaining bone health in prostate cancer throughout the disease continuum. Semin Oncol 2010;37 Suppl 1:S30-S37 PM:20682370, DOI: S0093-7754(10)00086-2 [pii];10.1053/j.seminoncol.2010.06.007.
7. 90. Doggrell SA. Clinical efficacy and safety of zoledronic acid in prostate and breast cancer. Expert Rev Anticancer Ther 2009;9(9):1211-8 PM:19761424, DOI: 10.1586/era.09.95.
8. 100. Morgan C, Wagstaff J. Is there a role for ibandronate in the treatment of prostate cancer patients with bony metastases? Acta Oncol 2009;48(6):882-9 PM:19925378, DOI: 10.1080/02841860902874748.
9. 103. Santini D, Fratto ME, Galluzzo S, Vincenzi B, Tonini G. Are bisphosphonates the suitable anticancer drugs for the elderly? Crit Rev Oncol Hematol 2009;69(1):83-94 PM:18692400, DOI: S1040-8428(08)00148-0 [pii];10.1016/j.critrevonc.2008.07.008.
10. 107. Aapro M, Abrahamsson PA, Body JJ, Coleman RE, Colomer R, Costa L, Crino L, Dirix L, Gnant M, Gralow J, Hadji P, Hortobagyi GN, Jonat W, Lipton A, Monnier A, Paterson AH, Rizzoli R, Saad F, Thurlimann B. Guidance on the use of bisphosphonates in solid tumours: recommendations of an international expert panel. Ann Oncol 2008;19(3):420-32 PM:17906299, DOI: mdm442 [pii];10.1093/annonc/mdm442.
11. 122. Saad F. New research findings on zoledronic acid: survival, pain, and antitumour effects. Cancer Treat Rev 2008;34(2):183-92 PM:18061356, DOI: S0305-7372(07)00156-9 [pii];10.1016/j.ctrv.2007.10.002.
12. 6. Brown JE, Coleman RE. Denosumab in patients with cancer-a surgical strike against the osteoclast. Nat Rev Clin Oncol 2012;9(2):110-8 PM:22231759, DOI: nrclinonc.2011.197 [pii];10.1038/nrclinonc.2011.197.
13. 8. Cassinello EJ, Gonzalez Del Alba BA, Rivera HF, Holgado ME. SEOM guidelines for the treatment of bone metastases from solid tumours. Clin Transl Oncol 2012;14(7):505-11 PM:22721794, DOI: 1383 [pii];10.1007/s12094-012-0832-0.
14. 13. Coleman RE. Adjuvant bone-targeted therapy to prevent metastasis: lessons from the AZURE study. Curr Opin Support Palliat Care 2012;6(3):322-9 PM:22801464, DOI: 10.1097/SPC.0b013e32835689cd.
15. 18. Helo S, Manger JP, Krupski TL. Role of denosumab in prostate cancer. Prostate Cancer Prostatic Dis 2012;15(3):231-6 PM:22370723, DOI: pcan20122

[pii];10.1038/pcan.2012.2.
16. 19. Iranikhah M, Wilborn TW, Wensel TM, Ferrell JB. Denosumab for the prevention of skeletal-related events in patients with bone metastasis from solid tumor. Pharmacotherapy 2012;32(3):274-84 PM:22392458, DOI: 10.1002/j.1875-9114.2011.01092.x.
17. 26. Mackiewicz-Wysocka M, Pankowska M, Wysocki PJ. Progress in the treatment of bone metastases in cancer patients. Expert Opin Investig Drugs 2012;21(6):785-95 PM:22500564, DOI: 10.1517/13543784.2012.679928.
18. 29. Moltzahn F, Thalmann GN. [Bone metastasis in prostate cancer]. Urologe A 2012;51(1):20-6 PM:22258372, DOI: 10.1007/s00120-011-2741-1.
19. 30. Paller CJ, Carducci MA, Philips GK. Management of bone metastases in refractory prostate cancer--role of denosumab. Clin Interv Aging 2012;7:363-72 PM:23049248, DOI: 10.2147/CIA.S27930 [doi];cia-7-363 [pii].
20. 33. Richardson ED, Price DK, Figg WD. Significant addition to treatment options for bone metastasis in prostate cancer. Cancer Biol Ther 2012;13(2):69-70 PM:22336908, DOI: 18441 [pii];10.4161/cbt.13.2.18441.
21. 41. Yuasa T, Yamamoto S, Urakami S, Fukui I, Yonese J. Denosumab: a new option in the treatment of bone metastases from urological cancers. Onco Targets Ther 2012;5:221-9 PM:23055747, DOI: 10.2147/OTT.S30578 [doi];ott-5-221 [pii].
22. 47. Castellano D, Sepulveda JM, Garcia-Escobar I, Rodriguez-Antolin A, Sundlov A, Cortes-Funes H. The role of RANK-ligand inhibition in cancer: the story of denosumab. Oncologist 2011;16(2):136-45 PM:21285392, DOI: theoncologist.2010-0154 [pii];10.1634/theoncologist.2010-0154.
23. 50. Coleman R, Cook R, Hirsh V, Major P, Lipton A. Zoledronic acid use in cancer patients: more than just supportive care? Cancer 2011;117(1):11-23 PM:21235033.
24. 51. Coleman R. The use of bisphosphonates in cancer treatment. Ann N Y Acad Sci 2011;1218:3-14 PM:20946581, DOI: 10.1111/j.1749-6632.2010.05766.x.
25. 52. Coleman RE, McCloskey EV. Bisphosphonates in oncology. Bone 2011;49(1):71-6 PM:21320652, DOI: S8756-3282(11)00055-X [pii];10.1016/j.bone.2011.02.003.
26. 68. Sonpavde G, Sternberg CN. Contemporary management of metastatic castration-resistant prostate cancer. Curr Opin Urol 2011;21(3):241-7 PM:21455038, DOI: 10.1097/MOU.0b013e3283449e19 [doi];00042307-201105000-00013 [pii].
27. 69. Todenhofer T, Schwentner C, Schilling D, Gakis G, Stenzl A. [Treatment of metastatic bone disease and treatment-induced osteoporosis in prostate cancer. Evolution of osteoprotective strategies]. Urologe A 2011;50(9):1055-63 PM:21744161, DOI: 10.1007/s00120-011-2623-6.
28. 79. Buijs JT, Kuijpers CC, van der Pluijm G. Targeted therapy options for treatment of bone metastases; beyond bisphosphonates. Curr Pharm Des 2010;16(27):3015-27 PM:20722621, DOI: BSP/CPD/E-Pub/000205 [pii].
29. 92. Lipton A. Implications of bone metastases and the benefits of bone-targeted therapy. Semin Oncol 2010;37 Suppl 2:S15-S29 PM:21111244, DOI: S0093-7754(10)00172-7 [pii];10.1053/j.seminoncol.2010.10.002.
30. 93. Morgan G, Lipton A. Antitumor effects and anticancer applications of bisphosphonates. Semin Oncol 2010;37 Suppl 2:S30-S40 PM:21111246, DOI: S0093-7754(10)00175-2 [pii];10.1053/j.seminoncol.2010.10.005.
31. 100. Tu SM, Lin SH, Podoloff DA, Logothetis CJ. Multimodality therapy: bone-targeted radioisotope therapy of prostate cancer. Clin Adv Hematol Oncol 2010;8(5):341-51 PM:20551894.
32. 102. Woodward EJ, Coleman RE. Prevention and treatment of bone metastases. Curr Pharm Des 2010;16(27):2998-3006 PM:20722624, DOI: BSP/CPD/E-Pub/000202 [pii].
33. 105. Coleman R, Gnant M. New results from the use of bisphosphonates in cancer patients. Curr Opin Support Palliat Care 2009;3(3):213-8 PM:19561507, DOI: 10.1097/SPC.0b013e32832f4149.
34. 110. Gnant M. Bisphosphonates in the prevention of disease recurrence: current results and ongoing trials. Curr Cancer Drug Targets 2009;9(7):824-33 PM:20025570.
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12.4.8.4.3. Ausgeschlossene Titel-/Abstracts (nach Titel-/Abstractscreening)

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A4: retrospektive Kohortenstudie

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A6: Doppelpublikation oder nicht erhältlich

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12.4.9. Recherche zum Thema Geriatrisches Assessment (de novo Recherche)

12.4.9.1. Fragestellung

Fragestellung/Themenbereich	Population	Intervention	Comparison	Outcome	Evidenzgrundlage/Zusatzinformation
Geriatrisches Assessment Weißbach, Wedding	Patienten vor Chemotherapie	Bewertung der Behandlungsfähigkeit mit ChT durch Comprehensive Geriatric Assessment (CGA)	Kein Assessment	Abbruchrate, UAW, Dosismodifikation	Leitlinienadaptation, RCT, prospektive Kohortenstudien

12.4.9.2. Recherchestrategien

PubMed (15. April 2013)

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 Limits: English, German, Publication date from 2003/01/01	137
#3	#1 AND #2	202
#2	("geriatric assessment"[MeSH Terms] OR ("geriatric"[All Fields] AND "assessment"[All Fields]) OR "geriatric assessment"[All Fields]) OR CGA[All Fields]	24723
#1	"prostatic neoplasms"[MeSH Terms] OR ("prostatic"[All Fields] AND "neoplasms"[All Fields]) OR "prostatic neoplasms"[All Fields] OR ("prostate"[All Fields] AND "cancer"[All Fields]) OR "prostate cancer"[All Fields]	108062

Anzahl der Treffer: 137

Cochrane (15. April 2013)
Suchstrategie:

Nr.	Suchfrage	Anzahl
#4	#1 AND #2 from 2003 to 2013, in Cochrane Reviews (Reviews only), Other Reviews, Trials, Methods Studies, Technology Assessment and Economic Evaluations	2
#3	#1 AND #2	2
#2	geriatric assessment:ti,ab,kw	1428
#1	(prostatic OR prostate) AND (neoplasm OR neoplasms OR cancer):ti,ab,kw	4111

- Cochrane Database of Systematic Reviews (0)
- Database of Abstracts of Reviews of Effects (0)
- Cochrane Central Register of Controlled Trials (2)

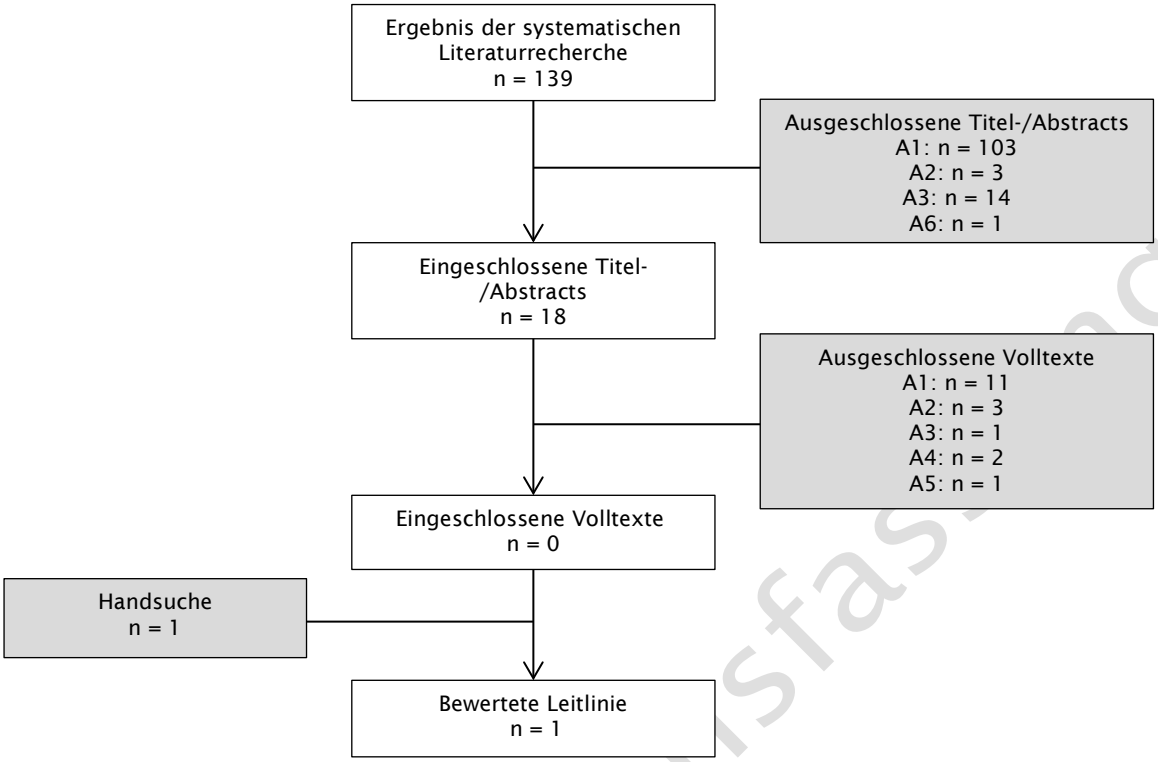
- Cochrane Methodology Register (0)
- Health Technology Assessment Database (0)
- NHS Economic Evaluation Database (0)

Anzahl der Treffer: 2

12.4.9.3. Ein- und Ausschlusskriterien

Ausschlussgründe (Mehrfachnennungen möglich)	
A1	andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle – Auszug s.u.)
A2	anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)
A3	unsystematischer Review oder Review **ohne** Einschluss von RCT und/ oder prospektiven Kohortenstudien)
A4	retrospektive Kohortenstudie
A5	n < 25
A6	Doppelpublikation oder nicht erhältlich
A7	Sonstiges (z.B. Sprache, Publikation außerhalb des Suchzeitraums etc.)
Einschlussgründe	
E1	Systematischer Review (aus RCTs und / oder prospektiven Kohortenstudien) (wahrscheinlich) passend zur Fragestellung analog PICO-Tabelle
E2	RCT, prospektive Kohortenstudien (wahrscheinlich) passend zur Fragestellung analog PICO-Tabelle

12.4.9.4. Ergebnisse der Recherche



12.4.9.4.1. Bewertete Leitlinie

Die gefundene Leitlinie wurde mit DELBI bewertet (dabei ist 0 der niedrigste und 1 der höchste zu erreichende Wert).

Droz JP, Balducci L, Bolla M, Emberton M, Fitzpatrick JM, Joniau S, Kattan MW, Monfardini S, Moul JW, Naeim A, Van PH, Saad F, Sternberg CN. Management of prostate cancer in older men: recommendations of a working group of the International Society of Geriatric Oncology. BJU Int 2010;106(4):462-9

Domäne 1: Geltungsbereich und Zweck	Domäne 2: Beteiligung von Interessengruppen	Domäne 3: Methodische Exaktheit der Leitlinienentwicklung	Domäne 4: Klarheit und Gestaltung	Domäne 5: Generelle Anwendbarkeit	Domäne 6: Redaktionelle Unabhängigkeit	Domäne 7: Anwendbarkeit im deutschen Gesundheitssystem
0,44	0,08	0,24	0,17	0,00	0,17	0,00

12.4.9.4.2. Ausgeschlossene Volltexte (nach Volltextsichtung)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

1. 16. Flechon A, Pouessel D, Ferlay C, Perol D, Beuzeboc P, Gravis G, Joly F, Oudard

S, Deplanque G, Zanetta S, Fargeot P, Priou F, Droz JP, Culine S. Phase II study of carboplatin and etoposide in patients with anaplastic progressive metastatic castration-resistant prostate cancer (mCRPC) with or without neuroendocrine differentiation: results of the French Genito-Urinary Tumor Group (GETUG) P01 trial. Ann Oncol 2011;22(11):2476-81 PM:21436186, DOI: mdr004 [pii];10.1093/annonc/mdr004.

2. 29. Sciarra A, Cattarino S, Gentilucci A, Alfarone A, Innocenzi M, Gentile V, Salciccia S. Predictors for response to intermittent androgen deprivation (IAD) in prostate cancer cases with biochemical progression after surgery. Urol Oncol 2011; PM:21665494, DOI: S1078-1439(11)00144-X [pii];10.1016/j.urolonc.2011.05.005.
3. 51. Loriot Y, Massard C, Gross-Goupil M, Di PM, Escudier B, Bossi A, Fizazi K. Combining carboplatin and etoposide in docetaxel-pretreated patients with castration-resistant prostate cancer: a prospective study evaluating also neuroendocrine features. Ann Oncol 2009;20(4):703-8 PM:19179557, DOI: mdn694 [pii];10.1093/annonc/mdn694.
4. 63. Greenspan SL, Nelson JB, Trump DL, Wagner JM, Miller ME, Perera S, Resnick NM. Skeletal health after continuation, withdrawal, or delay of alendronate in men with prostate cancer undergoing androgen-deprivation therapy. J Clin Oncol 2008;26(27):4426-34 PM:18802155, DOI: 26/27/4426 [pii];10.1200/JCO.2007.15.1233.
5. 90. Dyche DJ, Ness J, West M, Allareddy V, Konety BR. Prevalence of prostate specific antigen testing for prostate cancer in elderly men. J Urol 2006;175(6):2078-82 PM:16697807, DOI: S0022-5347(06)00266-7 [pii];10.1016/S0022-5347(06)00266-7.
6. 106. Kurtz ME, Kurtz JC, Given CW, Given BA. Utilization of services among elderly cancer patients--relationship to age, symptoms, physical functioning, comorbidity, and survival status. Ethn Dis 2005;15(2 Suppl 2):S17-S22 PM:15822832.
7. 124. Stommel M, Kurtz ME, Kurtz JC, Given CW, Given BA. A longitudinal analysis of the course of depressive symptomatology in geriatric patients with cancer of the breast, colon, lung, or prostate. Health Psychol 2004;23(6):564-73 PM:15546224, DOI: 2004-20316-002 [pii];10.1037/0278-6133.23.6.564.
8. 125. Terret C, Albrand G, Droz JP. Geriatric assessment in elderly patients with prostate cancer. Clin Prostate Cancer 2004;2(4):236-40 PM:15072607.
9. 126. Toliusiene J, Lesauskaite V. The nutritional status of older men with advanced prostate cancer and factors affecting it. Support Care Cancer 2004;12(10):716-9 PM:15322967, DOI: 10.1007/s00520-004-0635-0.
10. 127. Weber BA, Roberts BL, Resnick M, Deimling G, Zauszniewski JA, Musil C, Yarandi HN. The effect of dyadic intervention on self-efficacy, social support, and depression for men with prostate cancer. Psychooncology 2004;13(1):47-60 PM:14745745, DOI: 10.1002/pon.718.
11. 131. Di SF, Sciarra A. Combination therapy of ethinylestradiol and somatostatin analogue reintroduces objective clinical responses and decreases chromogranin a in patients with androgen ablation refractory prostate cancer. J Urol 2003;170(5):1812-6 PM:14532782, DOI: 10.1097/01.ju.0000092480.71873.26 [doi];S0022-5347(05)62939-4 [pii].

A2: anderer Publikationstyp (z.B. Fallberichte, Fall-Kontroll-Studien, Editorial u.ä.) als a priori für die Fragestellung definiert (hier: Systematischer Review, RCT, prospektive Kohortenstudien)

1. 14. Deckx L, van AD, Nelissen K, Daniels L, Stinissen P, Bulens P, Linsen L, Rummens JL, Robaeys G, de Jonge ET, Houben B, Pat K, Walgraeve D, Spaas L, Verheezen J, Verniest T, Goegebuer A, Wildiers H, van den Berkmortel F, Tjan-Heijnen VC, Buntinx F, van den Akker M. Study protocol of KLIMOP: a cohort study on the wellbeing of older cancer patients in Belgium and the Netherlands. BMC Public Health 2011;11:825 PM:22026575, DOI: 1471-2458-11-825 [pii];10.1186/1471-2458-11-825.
2. 71. Assessing care of vulnerable elders-3 quality indicators. J Am Geriatr Soc 2007;55 Suppl 2:S464-S487 PM:17910572, DOI: JGS1329 [pii];10.1111/j.1532-5415.2007.01329.x.
3. 80. Mohile SG, Bylow K, Dale W, Dignam J, Martin K, Petrylak DP, Stadler WM, Ro-

din M. A pilot study of the vulnerable elders survey-13 compared with the comprehensive geriatric assessment for identifying disability in older patients with prostate cancer who receive androgen ablation. Cancer 2007;109(4):802-10 PM:17219443, DOI: 10.1002/cncr.22495.

A3: unsystematischer Review oder Review ohne Einschluss von RCT und/ oder prospektiven Kohortenstudien)

1. 61. Droz JP, Chaladaj A. Management of metastatic prostate cancer: the crucial role of geriatric assessment. BJU Int 2008;101 Suppl 2:23-9 PM:18307689, DOI: BJU7486 [pii];10.1111/j.1464-410X.2007.07486.x.

A4: retrospektive Kohortenstudie

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2. 49. Italiano A, Ortholan C, Oudard S, Pouessel D, Gravis G, Beuzeboc P, Bompas E, Flechon A, Joly F, Ferrero JM, Fizazi K. Docetaxel-based chemotherapy in elderly patients (age 75 and older) with castration-resistant prostate cancer. Eur Urol 2009;55(6):1368-75 PM:18706755, DOI: S0302-2838(08)00934-2 [pii];10.1016/j.eururo.2008.07.078.

A5: Eingeschlossene Patienten n < 25

1. 92. Hurria A, Fleming MT, Baker SD, Kelly WK, Cutchall K, Panageas K, Caravelli J, Yeung H, Kris MG, Gomez J, Miller VA, D'Andrea G, Scher HI, Norton L, Hudis C. Pharmacokinetics and toxicity of weekly docetaxel in older patients. Clin Cancer Res 2006;12(20 Pt 1):6100-5 PM:17062686, DOI: 12/20/6100 [pii];10.1158/1078-0432.CCR-06-0200.

12.4.9.4.3. Ausgeschlossene Volltexte (nach Titel-/Abstractscreening durchgeführt von Wedding)

A1: Andere Erkrankung, andere Fragestellung, anderes Thema (analog Festlegung in PICO-Tabelle siehe oben)

1. 1. Kani K, Malihi PD, Jiang Y, Wang H, Wang Y, Ruderman DL, Agus DB, Mallick P, Gross ME. Anterior gradient 2 (AGR2): blood-based biomarker elevated in metastatic prostate cancer associated with the neuroendocrine phenotype. Prostate 2013;73(3):306-15 PM:22911164, DOI: 10.1002/pros.22569.
2. 2. Nordin A, Wang W, Welen K, Damber JE. Midkine is associated with neuroendocrine differentiation in castration-resistant prostate cancer. Prostate 2013;73(6):657-67 PM:23129424, DOI: 10.1002/pros.22607.
3. 3. Vanella L, Barbagallo I, Acquaviva R, Di GC, Cardile V, Abraham NG, Sorrenti V. Ellagic Acid: cytodifferentiating and antiproliferative effects in human prostatic cancer cell lines. Curr Pharm Des 2013;19(15):2728-36 PM:23092326, DOI: CPD-EPUB-20121018-12 [pii].
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5. 6. De NC, Albisinni S, Presicce F, Lombardo R, Cancrini F, Tubaro A. Serum levels of chromogranin A are not predictive of high-grade, poorly differentiated prostate cancer: Results from an Italian biopsy cohort. Urol Oncol 2012; PM:23153859, DOI: S1078-1439(12)00254-2 [pii];10.1016/j.urolonc.2012.07.012.
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7. 13. Matei DV, Renne G, Pimentel M, Sandri MT, Zorzino L, Botteri E, De CC, Musi G, Brescia A, Mazzoleni F, Tringali V, Detti S, de CO. Neuroendocrine differentiation in castration-resistant prostate cancer: a systematic diagnostic attempt. Clin Genitourin Cancer 2012;10(3):164-73 PM:22401754, DOI: S1558-7673(12)00039-0 [pii];10.1016/j.clgc.2011.12.004.
8. 15. Deng X, Elzey BD, Poulson JM, Morrison WB, Ko SC, Hahn NM, Ratliff TL, Hu CD. Ionizing radiation induces neuroendocrine differentiation of prostate cancer cells in vitro, in vivo and in prostate cancer patients. Am J Cancer Res 2011;1(7):834-44 PM:22016831.
9. 17. Glossmann H. Vitamin D, UV, and skin cancer in the elderly: to expose or not to expose? Gerontology 2011;57(4):350-3 PM:21196703, DOI: 000322521 [pii];10.1159/000322521.
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11. 19. Heinrich E, Probst K, Michel MS, Trojan L. Gastrin-releasing peptide: predictor of castration-resistant prostate cancer? Prostate 2011;71(6):642-8 PM:20945407, DOI: 10.1002/pros.21280.
12. 20. Janelsins MC, Kohli S, Mohile SG, Usuki K, Ahles TA, Morrow GR. An update on cancer- and chemotherapy-related cognitive dysfunction: current status. Semin Oncol 2011;38(3):431-8 PM:21600374, DOI: S0093-7754(11)00084-4 [pii];10.1053/j.seminoncol.2011.03.014.
13. 22. Joung JY, Lee YS, Park S, Yoon H, Lee SJ, Park WS, Seo HK, Chung J, Kim SY, Hong SH, Kim JS, Lee KH. Haplotype analysis of prostate stem cell antigen and association with prostate cancer risk. J Urol 2011;185(6):2112-8 PM:21497359, DOI: S0022-5347(11)00235-7 [pii];10.1016/j.juro.2011.01.083.
14. 23. Khan MO, Ather MH. Chromogranin A--serum marker for prostate cancer. J Pak Med Assoc 2011;61(1):108-11 PM:22368921.
15. 24. Krauss DJ, Hayek S, Amin M, Ye H, Kestin LL, Zadora S, Vicini FA, Cotant M, Brabbins DS, Ghilezan MI, Gustafson GS, Martinez AA. Prognostic significance of neuroendocrine differentiation in patients with Gleason score 8-10 prostate cancer treated with primary radiotherapy. Int J Radiat Oncol Biol Phys 2011;81(3):e119-e125 PM:21596486, DOI: S0360-3016(11)00069-1 [pii];10.1016/j.ijrobp.2010.12.064.
16. 25. Man YG, Fu SW, Liu AJ, Stojadinovic A, Izadjoo MJ, Chen L, Gardner WA. Aberrant expression of chromogranin A, miR-146a, and miR-146b-5p in prostate structures with focally disrupted basal cell layers: an early sign of invasion and hormone-refractory cancer? Cancer Genomics Proteomics 2011;8(5):235-44 PM:21980038, DOI: 8/5/235 [pii].
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18. 30. Sidana A, Wang M, Chowdhury WH, Toubaji A, Shabbeer S, Netto G, Carducci M, Lupold SE, Rodriguez R. Does valproic acid induce neuroendocrine differentiation in prostate cancer? J Biomed Biotechnol 2011;2011:607480 PM:20981253, DOI: 10.1155/2011/607480.
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Pol 2010;61(4):384-7 PM:20806183.
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12.5. Ergebnisse der Konsultationsphase zur 1. Auflage der Leitlinie 2009

12.5.1. Kapitel Epidemiologie, Risikofaktoren, Ernährung und Prävention

Inhalt des Kommentars	Änderung der Leitlinie,ggf. Begründung
Hintergrundtext **Empfehlung 2.1**: keine Angaben zur Prävalenz genannt.	Angaben zur Prävalenz des Prostatakarzinoms unter Verwendung der vom Kommentator zitierten Quelle aufgenommen.
Empfehlung 2.2 und Hintergrundtext: erhöhtes Risiko für PCa bei familiärer Belastung durch Mammakarzinom soll thematisiert werden.	Keine Änderung, da bisher kein eindeutiger Nachweis der klinischen Relevanz bei familiärer Belastung durch Mammakarzinom erbracht wurde.
Empfehlung 2.2 und Hintergrundtext: Diabetes mellitus als Risikofaktor für das Entstehen eines Prostatakarzinoms in der schwarzen Bevölkerung soll thematisiert werden.	Keine Änderung, da die Kausalität von Diabetes mellitus als Risikofaktor schwer nachzuweisen ist und sich die Leitlinie trotz bekannter Migrationsphänomene v. a. auf die kaukasische Bevölkerung bezieht.
Hintergrundtext **Empfehlung 2.7**: „five a day“, d. h. die Empfehlung, fünfmal Obst und Gemüse pro Tag zu sich zu nehmen, ist nicht wissenschaftlich nachgewiesen.	Der Ausdruck „five a day“ wurde im Leitlinientext gestrichen.
Hintergrundtext **Empfehlung 2.7**: die gezielte Supplementierung (Selen, Vit. E) ist erfolgreich, das negative Ergebnis der SELECT-Studie zum Nutzen von Selen-Substitution zur Prävention soll hinterfragt werden.	Keine Änderung, die aktuellen Studienergebnisse werden weiterhin berücksichtigt, es liegen keine spezifischen anderslautenden Ergebnisse für Deutschland vor.

12.5.2. Kapitel Früherkennung und Biopsie

Inhalt des Kommentars	Änderung der Leitlinie ggf. Begründung
Hintergrundtext **Empfehlung 3.3**: Aufklärungsinhalte zur Früherkennung sollen spezifiziert werden, es sollen korrekte Angaben für die Studie von Schröder et al. 2009 angeführt werden – insbesondere, dass es sich um 48 Übertherapien pro gerettetem Leben handelt. Es sollen auch unabhängige Aufklärungs-Stellen empfohlen werden.	Der Hintergrundtext in der Leitlinie in Bezug auf die Zahlen der Studie von Schröder et al, 2009 wurde geändert und als unabhängige mögliche zusätzliche Aufklärungsstelle wird das Deutsches Krebsforschungszentrum (DKFZ) genannt.
Empfehlung 3.5 und Hintergrundtext: Antrag auf Nennung des 3-dimensionalen Farbduplex-Transrektalsonographie- Systems (3D-FCDES-TRUS) als für die Früherkennung geeignetes bildgebendes Verfahren.	Keine Änderung. Die vom Kommentator genannte Studie weist einen interessanten Ansatz auf, beinhaltet aber keinen randomisierten Vergleich mit der Standardmethode. Die Testgüteparameter sind deshalb - bei fraglicher Reproduzierbarkeit – nicht realistisch einzuordnen. Die Technik ist kaum verfügbar.
Empfehlung 3.11: Antrag auf Aufnahme des Prostatavolumens als Indikation zur Biopsie , nicht nur starres Festhalten an Grenzwert von 4 ng/ml. **Kapitel 3.2**: Antrag auf Empfehlung auch der Feinnadelbiopsie als diagnosesicherndes minimal-invasives Verfahren.	Keine Änderung, da die Indikationsstellung zur Biopsie anhand des Prostatavolumens als nicht ausreichend wissenschaftlich gesichert eingeschätzt wurde. Keine Änderung, da die Feinnadelbiopsie nicht als ausreichende wissenschaftlich gesichert eingeschätzt wurde.
Empfehlung 3.15 und Hintergrundtext: es erfolgt keine explizite Thematisierung des Zugangswegs zur Biopsie, insbesondere der perinealen Biopsie, bei der kein Antibiotikumschutz erforderlich ist.	Keine Änderung der Leitlinie, die perineale Biopsie wurde als Rarität eingestuft und der Zugangsweg wurde deshalb nicht thematisiert.
Empfehlung 3.17: Antrag auf Änderung der Empfehlung, da laut neuerer Literatur eine Rebiopsie bei hochgradige prostatischer intraepitheliale Neoplasie (HIGH-Grade PIN) nicht grundsätzlich erforderlich sei, die Literatur in der Leitlinie wird als nicht aktuell eingeschätzt.	Die Empfehlung zur hochgradigen prostatischen intraepithelialen Neoplasie (High-Grade-PIN) wurde neu abgestimmt, eine Rebiopsie wird nun nur bei ausgedehnter High-Grade-PIN empfohlen (Nachweis in mind. vier Gewebeproben). Es erfolgte eine Aufnahme der vom Kommentator genannten Literaturzitate.

12.5.3. Kapitel Diagnostik und Stadieneinteilung

Inhalt des Kommentars	Änderung der Leitlinie ggf. Begründung
Kapitel 4.1: Primärdiagnose: Antrag auf Aufnahme einer kann-Empfehlung zur MRT nach erfolgloser Biopsie mit Verweis auf die besseren Testgüteparameter im Vergleich zum TRUS.	Es erfolgte eine Aufnahme der folgenden Empfehlung nach Neuabstimmung: Die endorektale MRT kann als ergänzende bildgebende Diagnostik nach negativer Biopsie eingesetzt werden.
Kapitel 4.2: Staging: Antrag auf Berücksichtigung der MRT-Untersuchung zum Staging entsprechend der niederländischen Leitlinie von 2007.	Keine Neuabstimmung. Die Empfehlungen zum Staging wurden belassen, die MRT erschien adäquat gewürdigt – gestrichen wurde lediglich der Zusatz „ein CT“ in Empfehlung

Inhalt des Kommentars	Änderung der Leitlinie ggf. Begründung
	4.5 und im Hintergrundtext wird darauf verwiesen, dass bei Verfügbarkeit die MRT die vorzuziehende Untersuchung ist.
Kapitel 4.3.1:Antrag auf Aufnahme der DNA-Zytometrie als prognostischer Faktor. Es wurde kritisiert, dass offensichtlich keine systematische Recherche zu dem Thema prognostische Faktoren für das Prostatakarzinom erfolgt ist.	Keine Änderung von Empfehlungen. Die Empfehlung 4.10 des Kapitels 4.3.1 zu prognostischen Faktoren beruht auf einem Consensusstatement des College of American Pathologists von 2000, aufgenommen wurden Prognosefaktoren der Kategorie 1. Für das Kapitel pathomorphologische Diagnostik erfolgten bislang keine systematischen Recherchen nach Primärstudien, sondern es handelt sich um ein auf Leitlinien gestütztes Kapitel.
Empfehlung 4.15: Antrag auf Aufnahme des modifizierten Gleason-Grading mit Literatur (Helpap 2008) in den Hintergrundtext. Begründung: bei Einsatz dieses Gradings wird eine bessere Korrelation zwischen Biopsie- und Operationspräparat erreicht. Allerdings verändert (erhöht) sich der Gleason-Score der Biopsie.	Das modifizierte Gleason-Grading wurde in den Hintergrundtext aufgenommen.
Kapitel 4.3: Antrag auf Überprüfung des Gebrauchs der Bezeichnungen „T-Stadium“ und „R-Status“.	Die Hintergrundtexte wurden modifiziet: T-Stadium wurde an den entsprechenden Stellen korrigiert in T-Kategorie, R-Status wurde erläutert als Residualtumor nicht als Status bezüglich des Randsaums des Operationspräparats.
Empfehlung 4.12 Antrag auf Überprüfung der Notwendigkeit dreier Kriterien zur Karzinomdiagnose.	Es wurde redaktionell bezüglich der Erfordernis der drei Kriterien eingefügt „in der Regel“.
Empfehlung 4.17: Antrag auf Streichen des Empfehlungsteils: Prostatastanzbiopsien sollten in Histologiekapseln auf Schaumstoffplättchen gelegt und in 4 % gepuffertem Formalin fixiert werden, da zum Beispiel der Transport auf Filterpapier im Ergebnis gleichwertig ist.	Die Empfehlung wurde neu abgestimmt. Die genannte Passage wurde gestrichen. Im Hintergrundtext heißt es nun: Prostatastanzbiopsien können zur gestreckten Fixierung (in 4 % Formalin) zum Beispiel auf Schaumstoffplättchen (oder Filterpapier) gelegt werden.
Empfehlung 4.20: die Notwendigkeit der ventralen und dorsalen Farbmarkierung wird in ihrer Relevanz in Frage gestellt.	Keine Änderung. Die Angabe trägt zur standardisierten Aufarbeitung des Operationspräparats bei.
Empfehlung 4.20: die Bezeichnung „Kapseldurchbruch“ bei Kategorie pT3a ist nicht korrekt – Vorschlag der Bezeichnung: extraprostatische Tumorausdehnung.	Der Begriff extraprostatische Tumorausdehnung wurde ergänzt.
Empfehlung 4.20: die Angabe des minimalen Randsaums ist überflüssig und führt ggf. zur Übertherapie.	Keine Änderung. Die Angabe trägt zur standardisierten Aufarbeitung bei und wurde nicht als eine Übertherapie fördernd eingeschätzt. Eine Strahlentherapie wird nur bei nicht tumorfreiem Randsaum empfohlen.
Empfehlung 4.21/4.22: die Leitlinie emp-	Redaktionell wurde bei Empfehlung 4.22 er-

Inhalt des Kommentars	Änderung der Leitlinie ggf. Begründung
fiehlt generell die Einbettung einer sehr großen Menge von TUR-Material ohne Abgleich mit der klinischen Situation.	gänzt: „wenn der Nachweis eines Karzinoms therapeutische Kosequenzen hat“.
Empfehlung4.23: Antrag auf Streichen der Empfehlung zur Angabe der Zahl makroskopisch erkennbarer Lymphknoten, da diese in Praxi schlecht abgrenzbar sind.	Keine Änderung, die Angabe der makroskopisch erkennbaren Lymphknoten wurde als machbar eingeschätzt und ist auch bei anderen Tumoren Usus.

12.5.4. Therapie des nichtmetastasierten Prostatakarzinoms

Inhalt des Kommentars	Änderung der Leitlinie ggf. Begründung
Hintergrundtext **zu Empfehlung 5.5**: das Risiko für eine Entwicklung von Zweitmalignomen für die LDR-Brachytherapie ist nicht korrekt dargestellt.	Der Hintergrundtext wurde spezifiziert und Ergebnisse einer vom Kommentator genannten Studie aufgenommen.
Empfehlung 5.1 und 5.3: Antrag auf Änderung der Empfehlung zur Aufklärung über Active Surveillance (AS). Hier sollte eine vorsichtigere Formulierung gewählt werden, da es sich um eine „experimentelle Therapie“ handelt und die Kriterien für AS nicht klar sind.	Keine Änderung der Empfehlung. Es erfolgte eine Ergänzung des Hintergrundtextes um erforderliche Informationsinhalte zu AS. Eine Tabelle mit Ergebnissen neuerer Studien zu Active Surveillance wurde ergänzt.
Hintergrundtext zum den **Empfehlungen 5.11 und 5.12**: Antrag auf folgende Änderungen: bei dem RCT (Bill-Axelson et al, 2005+2008) handelt es sich in der Kontrollgruppe um eine palliative, nicht eine abwartende Therapiestrategie. Es erfolgte für die Studiengruppe keine Stratifizierung nach Risikogruppen. Weiterhin erfolgte ein Antrag auf Ergänzung von Aufklärungsinhalten in Bezug auf die Patienten die nach den Ergebnissen der Publikation des RCT von Bill-Axelson et al. 2008 (im Vergleich zu 2005) von der RPE profitieren.	In den Hintergrundtexten wurde abwartende Strategie durch palliative Strategie ersetzt. Es wird nun dargelegt, dass keine Stratifizierung der Ergebnisse nach Risikogruppen möglich ist. Weiterhin wurden die Angaben zum altersstratifizierten relativen und absoluten Vorteil der Operation in Bezug auf die prostataspezifische Mortalität ergänzt.
Antrag auf Aufnahme einer Fallserie zur RPE, da diese aktuelle deutsche Ergebnisse der operativen Therapie aufweist.	Studie wurde nicht aufgenommen, da nicht gut nach Tumorstadien auswertbar.
Kapitel 5.3.3.1: 3 Antrag, die LDR-Brachytherapie entsprechend der EAU-Leitlinie auch für Tumoren des mittleren Risikoprofils zu empfehlen. Antrag, die LDR-Brachytherapie als Monotherapie oder mit perkutaner Strahlentherapie kombinierte Therapie auch für Tumoren des mittleren und des hohen Risikoprofils zu empfehlen. Antrag, Literatur zu LDR bzw. LDR+perkutane Strahlentherapie für Tumoren des mittleren oder hohen Risikoprofils zu ergänzen.	Keine Änderung von Empfehlungen. Es erfolgte eine Änderung Hintergrundtextes: bisher wurde eine systematische Literaturrecherche für LDR-Monotherapie durchgeführt. Für die Überarbeitung der Leitlinie ist eine systematische Recherche und eine Neubewertung der LDR-Monotherapie und der LDR-Therapie kombiniert mit perkutaner Strahlentherapie geplant.

Inhalt des Kommentars	Änderung der Leitlinie ggf. Begründung
Empfehlung 5.36: Antrag auf Neubewertung der HIFU-Therapie unter Berücksichtigung von Literatur aus 2008.	Es erfolgte eine redaktionelle Änderung der Empfehlung zur HIFU-Therapie. Sie lautet nun: Es liegen keine Studiendaten vor, die derzeit eine Bewertung der HIFU-Therapie in der Behandlung des lokal begrenzten Prostatakarzinoms ermöglichen. Daher ist ein routinemäßiger Einsatz der HIFU für diese Indikation nicht gerechtfertigt. Der Hintergrundtext wurde unter Berücksichtigung der vom Kommentator genannten Literatur aus 2008 aktualisiert.

12.5.5. Diagnostik und Therapie des rezidivierten und metastasierten Prostatakarzinoms

Inhalt des Kommentars	Änderung der Leitlinie ggf. Begründung
Empfehlung 6.4: Antrag auf Änderung der Empfehlung zur Biopsie bei V. a. Rezidiv nach RPE. Begründung: Die Biopsie hat zwar schlechte Testgüteparameter, der Karzinomnachweis erlaubt aber eine gesicherte und ggf. anders dosierte Strahlentherapie.	Die Empfehlung wurde neu abgestimmt und lautet nun: Eine bioptische Sicherung eines biochemischen Rezidivs nach RPE ist nicht erforderlich.
Empfehlung 6.2 und 6.3: Antrag auf Präzisierung des Zeitabstands der zweiten Messung bei V. a. ein Rezidiv nach RPE/nach Strahlentherapie.	Die Angabe zum Mindestabstand zur zweiten Messung wurde im Hintergrundtext ergänzt: „mindestens zwei Wochen“ nach RPE, „nach ca. drei Monaten“ nach Strahlentherapie.
Empfehlungen 6.39 und 6.40: Antrag zu Erhöhung des Empfehlungsgrads für die beiden Empfehlungen zum Einsatz von Bisphosphonaten bei Knochenmetastasen und Antrag auf eine neue Empfehlung in Bezug auf symptomatische Knochenmetastasen. Änderung des Hintergrundtextes zur Schmerzreduktion durch Bisphophonate und zum Therapieansprechen osteoblastischer Knochenmetastasen. Aufnahme der Einzelstudie zur Wirksamkeit der Zoledronsäure (2002/2004).	Die Empfehlungsgrade wurden jeweils belassen. Die Empfehlung 6.40 zum Einsatz von Zoledronsäure bei Knochenmetastasen wurde neu abgestimmt – der Zusatz symptomfrei ist nun gestrichen. Redaktionell wurde in den Empfehlungen ergänzt: „im hormonrefraktären Stadium“. Die Hintergrundtexte zu den Empfehlungen wurden geändert und die Literatur ergänzt.

12.6. Ergebnisse der Konsultationsphase zur 1. Aktualisierung 2011

12.6.1. Allgemeine Kommentare

Inhalt des Kommentars	Änderung der Leitlinie,ggf. Begründung
Es wird darauf hingewiesen, dass die neuen Substanzen Denosumab, Cabizitaxel und Abirateron nicht berücksichtigt wurden.	Keine Änderungen, da die Substanzen berücksichtigt wurden (z. B. Empfehlungen 6.41, 6.35, 6.34)

Inhalt des Kommentars	Änderung der Leitlinie,ggf. Begründung
Es wird darauf aufmerksam gemacht, dass im Kapitel Nachsorge nicht spezifisch darauf eingegangen, welche Diagnostik bei Verdacht auf Rezidiv durchgeführt werden muss. Es wird eine klare Empfehlung gewünscht, damit bestimmte Verfahren dem gesetzlich versicherten Patienten nicht vorenthalten werden.	Keine Änderung, da die Überarbeitung zum jetzigen Zeitpunkt zu aufwendig ist. Thema wird aber für die nächste Aktualisierung priorisiert.

12.6.2. Kommentare zum Thema Früherkennung und Biopsie

Inhalt des Kommentars	Änderung der Leitlinie, ggf. Begründung
Unter Verweis auf aktuelle Daten (Lilja et al. 2011) wird vorgeschlagen, bzgl. der Kontrollintervalle für die Früherkennung mit PSA-Test, eine gesonderte Empfehlung für Männer zwischen 40 und 50 Jahren abzugeben. Es wird argumentiert, dass die Daten abhängig vom PSA-Wert wesentlich längere Intervalle rechtfertigen und durch risikoabhängige Intervalle die bestehende Überversorgung für diese Altersgruppe reduziert werden kann.	Es wurde eine Ergänzung der Empfehlung 3.7 vorgenommen. Für die Altersgruppe 40-50 wurde eine Empfehlung zur risikoabhängigen Wahl der Kontrollintervalle ergänzt und durch eine schriftliche Abstimmung konsentiert.
Es wird vorgeschlagen aufgrund der Zunahme von Fluorchinolon-resistenter Enterobakterien in der Darmflora und der daraus resultierenden Zunahme von febrilen Harnwegsinfektionen und Urosepsis, Patienten vor einer Prostatastanzbiopsie auf Fluorchinolon-resistente Erreger zu screenen und bei positivem Befund eine Antibiotikaprophylaxe mit Cephalosporin durchzuführen.	Keine Änderung, da die Überarbeitung zum jetzigen Zeitpunkt zu aufwendig ist. Thema wird aber für die nächste Aktualisierung priorisiert.
Es wird angemerkt im Hintergrundtext zur Empfehlung 3.15 die Optionen nach wiederholter negativer Biopsie zu nennen.	Der Hintergrundtext wurde entsprechend geändert.

12.6.3. Kommentare zum Thema Diagnostik und Stadieneinteilung

Inhalt des Kommentars	Änderung der Leitlinie,ggf. Begründung
Es wird gefordert, für die transrektale Ultraschalluntersuchung der Prostata (TRUS) Qualitätskriterien bzgl. technischer Anforderungen zu benennen.	Die Empfehlung 4.2 wurde geändert und im schriftlichen Umlaufverfahren konsentiert (Änderungen unterstrichen): Die transrektale Ultraschalluntersuchung kann als ergänzende bildgebende Diagnostik eingesetzt werden, <u>wenn sie den geltenden Qualitätsanforderungen genügt</u>. Im Rahmen der Biopsie können gezielte Biopsien auffälliger Areale im Ultraschall nach definierten Malignitätskriterien zusätzlich zur systematischen Biopsieentnahme durchgeführt werden. Im Hintergrundtext wurden Qualitätskriterien

Inhalt des Kommentars	Änderung der Leitlinie,ggf. Begründung
	ergänzt.
Es wird darauf hingewiesen, dass im Hintergrundtext zur Empfehlung 4.3 die Formulierung „eher nicht empfohlen“ unverständlich ist. Weiterhin wird vorgeschlagen den Satz zu streichen, dass der kontrastverstärkte Ultraschall nur angewendet werden soll, wenn prospektive belegt wurde, dass damit statistisch und klinisch signifikant verbesserte Testgüteparameter erreicht wurden.	Der Hintergrundtext wurde geringfügig für eine bessere Verständlichkeit geändert (statt eher nicht empfohlen nun „nicht routinemäßig empfohlen“).
In mehreren Kommentaren wurden Änderungen im Abschnitt 4.3 Pathomorphologische Untersuchungen gefordert. Zu 4.24 wurde gefordert, die Anzahl der Stanzen mit HGPIN anzugeben. Zu 4.28 wurde vorgeschlagen, den Prozentsatz des Karzinoms pro Stanze sowie den Gleason Score pro Stanze anzugeben. Zu Empfehlung 4.31 wurde angemerkt, hier eine ‚standardisierte Aufarbeitung’ statt einer kompletten Einbettung zu empfehlen und die angegebene Literatur für das empfohlene Lamellieren in 3-5 mm dicke Scheiben nicht geeignet ist. Hinsichtlich der Empfehlung 4.33 wird gefordert, den Empfehlungsgrad auf 0ption (0, kann) zu reduzieren oder gänzlich zu streichen, da die Literatur die Empfehlung nicht stützt. Für Empfehlung 4.34 wurde angemerkt, dass es eine Kategorie pT1a oder pT1b nach der UICC Klassifikation nicht definiert ist (es existiert lediglich die cT1-Kategorie).	Da eine umfangreiche Überarbeitung des Kapitels im aktuellen Aktualisierungsverfahren nicht mehr möglich ist, werden keine Änderungen vorgenommen und das Kapitel für die nächste Aktualisierung priorisiert.

12.6.4. Kommentare zum Thema Therapie des nichtmetastasierten Prostatakarzinoms

Inhalt des Kommentars	Änderung der Leitlinie,ggf. Begründung
Es wird darauf hingewiesen, dass bei der Active Surveillance (AS) Strategie (Empfehlung 5.8) die PSA-Verdopplungszeit (PSADT) zwar als Abbruchkriterium aufgeführt wird, aber nicht als Voraussetzung für AS.	Die Empfehlung wird nicht geändert, da die PSA-Verdopplungszeit zu diesem Zeitpunkt oft nicht vorliegt. Der Hintergrundtext wurde entsprechend ergänzt.
Es wird angemerkt, dass in der Empfehlung 5.8 im Unterschied zur EAU-Leitlinie die Stadien T1a und T1b nicht als Indikationen für AS aufgeführt werden.	Die Empfehlung wurde nicht geändert, da es dafür keine ausreichenden Daten gibt. Der Hintergrundtext wurde um entsprechende Erläuterungen ergänzt.
Es wird vorgeschlagen, DNA-zytometrische Untersuchungen im Einzelfall als Zusatzuntersuchung bei bestimmten Fragestellungen zu empfehlen.	Es werden keine Änderungen an der Leitlinie vorgenommen. Das Thema soll bei der nächsten Aktualisierung bearbeitet werden.

Inhalt des Kommentars	Änderung der Leitlinie,ggf. Begründung
Unter Hinweis auf methodische Diskussionen und die Entscheidung eines Landessozialgerichtes, die Mindestmenge für Knieendoprothesen für unwirksam zu erklären, wird gefordert, die Empfehlung 5.18 zu streichen.	Es werden keine Änderungen an der Leitlinie vorgenommen. An der Datenlage hat sich seit Verabschiedung der Empfehlung nichts Wesentliches geändert. Die methodischen Limitationen der verfügbaren Daten sind bekannt und wurden bei der Verabschiedung der Empfehlung berücksichtigt. Der Hintergrundtext wurde um aktuellere Studien ergänzt.
In mehreren Kommentaren wurde gefordert, die Formulierung in Empfehlung 5.39 „Die HIFU-Therapie ist ein experimentelles Verfahren…“ zu streichen bzw. zu ändern.	Es werden keine Änderungen an der Leitlinie vorgenommen. Die Formulierung der Empfehlung wurde im formalen Konsensusverfahren abgestimmt. Im Rahmen der Konsultation wurden keine aktuelleren Studien mit relevanten Ergebnissen eingebracht, die eine Änderung der Empfehlung rechtfertigen würden. Es wird außerdem darauf hingewiesen, dass auch in der EAU-Leitlinie HIFU im Kapitel „EXPERIMENTAL LOCAL TREATMENT OF PROSTATE CANCER“ behandelt wird. HIFU soll bei Vorliegen neuer relevanter Daten prioritär bei Aktualisierungen berücksichtigt werden.
Es wird darauf hingewiesen, dass zum Thema ‚Bestrahlung der pelvinen Lymphabflusswege’ mehrere Hintergrundtexte mit teilweise unterschiedlichen Studien existieren.	Es wurde ein einheitlicher Hintergrundtext erstellt, auf den in den jeweiligen Abschnitten verwiesen wird.

12.6.5. Kommentare zum Thema Diagnostik und Therapie des rezidivierten oder metastasierten Prostatakarzinoms

Inhalt des Kommentars	Änderung der Leitlinie, ggf. Begründung
Bei der Empfehlung 6.5 wird nachgefragt, ob tatsächlich wie im Hintergrundtext formuliert, die transperineal durchgeführte Stanzbiopsie ausgeschlossen werden soll.	Die transperineale Stanzbiopsie soll nicht grundsätzlich ausgeschlossen werden und wurde deshalb im Hintergrundtext ergänzt.
Bei Empfehlung 6.20 wird angezweifelt, angesichts von zwei gleichwertigen Alternativen eine starke Empfehlung abzugeben	Die Leitlinienautoren erachteten eine Änderung der Empfehlung nicht als notwendig. Medikamentöse und operative Androgendeprivation sollen gleichermaßen empfohlen werden
Es wurde vorgeschlagen, in Empfehlung 6.31 den folgenden Satz zu ergänzen: „Zytostatika sollten nur durch Ärzte verabreicht werden, die auf die Gabe von zytotoxischen Substanzen spezialisiert sind. Eine adäquate Patientenselektion und ein sorgfältiges Monitoring potentieller Nebenwirkungen sind unerlässlich.“	Die Empfehlung wurde nicht geändert. Es wurde nicht als Aufgabe der Leitlinie gesehen, die Fachinformationen zu Arzneimitteln zu zitieren.

Inhalt des Kommentars	Änderung der Leitlinie, ggf. Begründung
Für den Hintergrundtext der Empfehlung 6.34 wurde vorgeschlagen, Informationen aus der Fachinformation zum Monitoring und Hinweise auf das bisher untersuchte, eingeschränkte Patientenkollektiv aufzunehmen. Es wurde außerdem darauf hingewiesen, dass die Zulassung für Abirateron mittlerweile erfolgt ist.	Im Hintergrundtext wurden die Angaben zum Zulassungsstatus von Abirateron aktualisiert.
Es wurde vorgeschlagen, in der Empfehlung 6.35 zu Cabazitaxel, die adressierte Population von ECOG Status 0-1 auf 0-2 zu ändern. Außerdem wurde gefordert, den letzten Satz zu den Nebenwirkungen entweder im Hintergrundtext aufzuführen oder die Nebenwirkungsprofile von Docetaxel und Mitoxantron in ähnlicher Weise zu adressieren.	Die Empfehlung wurde nicht geändert, da die Leitliniegruppe sich bewusst dazu entschieden hat, Cabazitaxel nur bei ECOG 0-1 zu empfehlen, da ECOG 2 nur 8 % der Studienteilnehmer in der relevanten Studie von de Bono et al. 2010 hatten. Die Leitliniengruppe hatte sich außerdem bewusst dafür entschieden, bei Cabazitaxel auf die erhöhte Rate der Nebenwirkungen hinzuweisen.
Es wurde vorgeschlagen, den Satz zum fehlenden Vergleich mit Docetaxel-Zweitlinientherapie im Hintergrundtext zur Empfehlung 6.35 zu streichen oder auch bei den anderen Therapieoptionen (Mitoxantron, Abirateron, Docetaxel in wöchentlicher und dreiwöchentlicher Dosis) aufzuführen. Dies wurde (mit Verweis auf de Bono et al. 2010) damit begründet, dass eine Studie mit Abirateron oder Cabazitaxel bei docetaxelrefraktären Patienten nicht durchführbar ist.	Der Hintergrundtext wurde nicht geändert, da eine Docetaxel-Zweitlinientherapie nach einer Ersttherapie nach einem Intervall von 6 Mo. grundsätzlich wieder möglich ist.
Unter Verweis auf die Fachinformation wurde vorgeschlagen, zur Empfehlung 5.35 den Hinweis auf ein Neutropenie-Management zu ergänzen.	Die Empfehlung wurde nicht geändert. Es wurde nicht als Aufgabe einer Leitlinie gesehen, die Fachinformationen zu Arzneimitteln zu zitieren.
Zur Empfehlung 6.36 wurde angemerkt, dass der Evidenzlevel von 1+ nicht für Estramustin gilt, da zu dieser Substanz keine RCTs mit relevanten Endpunkten vorliegen.	Der Evidenzlevel wurde nicht geändert. Estramustin wird von den Autoren zwar als „Auslaufmodell“ angesehen, es liegen aber RCTs vor, die einen LoE von 1+ rechtfertigen
Zum Statement 6.42 (in der Konsultationsfassung) wurde gefordert, zu Denosumab eine ähnlich starke Handlungsempfehlung anzugeben wie zu Zoledronsäure.	Es wurde eine gemeinsame Empfehlung zu den Substanzen entwickelt und im schriftlichen Umlaufverfahren konsentiert (siehe 6.41).
Es wurde darauf hingewiesen, in der Tabelle zu ‚Typischen und häufigen Nebenwirkungen einer hormonablativen Therapie und Möglichkeiten der Prophylaxe und Behandlung ’Denosumab als Therapie bei ‚Reduktion der Knochendichte’ aufzuführen.	Die Tabelle wurde entsprechend ergänzt

12.7. Ergebnisse der Konsultationsphase zur 2. Aktualisierung 2014

12.8. Formblatt der AWMF zur Erklärung von Interessenkonflikten

12.8.1. Erklärung über Interessenkonflikte

(S3-Leitlinie zur Früherkennung, Diagnose und Therapie der verschiedenen Stadien des Prostatakarzinoms, 043 - 022OL)

zu Händen

Prof. Dr. med. Dr. h.c. M. Wirth

Vorbemerkung

Die Entwicklung von Leitlinien für die medizinische Versorgung verlangt über die fachliche Expertise hinaus eine Vermeidung kommerzieller Abhängigkeiten oder anderer Interessenkonflikte, die die Leitlinieninhalte beeinflussen. Es gibt eine Vielzahl von materiellen (z.B. finanzielle oder kommerzielle) und immateriellen (z.B. politische, akademische oder persönliche) Beziehungen, deren Ausprägungsgrade und Bedeutungen variieren können. Interessenkonflikte sind somit zumeist unvermeidbar, aber nicht zwangsläufig problematisch in Hinblick auf eine Beeinflussung der Leitlinieninhalte.

Eine Erklärung zu den Beziehungen und den daraus entstehenden Interessenkonflikten durch die Autoren der Leitlinien und die Teilnehmer am Konsensusverfahren ist für die Qualitätsbeurteilung von Leitlinien, aber auch für ihre allgemeine Legitimation und Glaubwürdigkeit in der Wahrnehmung durch Öffentlichkeit und Politik entscheidend.

Die Erklärungen werden zu Beginn des Leitlinienprojekts gegenüber dem Leitlinienkoordinator abgegeben. Bei länger andauernden Projekten kann eine zusätzliche Abgabe im Verlauf erforderlich sein. Ob davon die erforderliche Neutralität für die Mitarbeit bei der Leitlinienentwicklung in Frage gestellt ist oder in welchen Bereichen das professionelle Urteilsvermögen eines Experten durch die Interessen Dritter unangemessen beeinflusst sein könnte, ist in der Leitliniengruppe zu diskutieren und zu bewerten.

Die Inhalte der Erklärungen und die Ergebnisse der Diskussion zum Umgang mit Interessenkonflikten sollten im Leitlinienreport offen dargelegt werden. In der Langfassung der Leitlinien ist auf das Verfahren der Sammlung und Bewertung der Erklärungen hinzuweisen.

Wir möchten Sie bitten, untenstehende Erklärung auszufüllen und zu unterzeichnen.

Erklärung

Die Erklärung betrifft finanzielle und kommerzielle (materielle) sowie psychologische und soziale (immaterielle) Aspekte sowie Interessen der Mitglieder selbst und/oder ihrer persönlichen/professionellen Partner innerhalb **der letzten 3 Jahre**. Bitte machen Sie **konkrete Angaben zu folgenden Punkten**:

1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit in einem wissenschaftlichen Beirat eines Unternehmens der Gesundheitswirtschaft (z.B. Arzneimittelindustrie, Medizinproduktindustrie), eines kommerziell orientierten Auftragsinstituts oder einer Versicherung

☐ Nein

☐ Ja

Falls ja, bitte konkrete Angabe:

2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autoren- oder Co-Autorenschaften im Auftrag eines Unternehmens der Gesundheitswirtschaft, eines kommerziell orientierten Auftragsinstituts oder einer Versicherung

☐ Nein

☐ Ja

Falls ja, bitte konkrete Angabe:

3. Finanzielle Zuwendungen (Drittmittel) für Forschungsvorhaben oder direkte Finanzierung von Mitarbeitern der Einrichtung von Seiten eines Unternehmens der Gesundheitswirtschaft, eines kommerziell orientierten Auftragsinstituts oder einer Versicherung

☐ Nein

☐ Ja

Falls ja, bitte konkrete Angabe:

4. Eigentümerinteresse an Arzneimitteln/Medizinprodukten (z. B. Patent, Urheberrecht, Verkaufslizenz)

☐ Nein

☐ Ja

Falls ja, bitte konkrete Angabe:

5. Besitz von Geschäftsanteilen, Aktien, Fonds mit Beteiligung von Unternehmen der Gesundheitswirtschaft

☐ Nein

☐ Ja

Falls ja, bitte konkrete Angabe:

6. Persönliche Beziehungen zu einem Vertretungsberechtigten eines Unternehmens Gesundheitswirtschaft

☐ Nein

☐ Ja

Falls ja, bitte konkrete Angabe:

7. Mitglied von in Zusammenhang mit der Leitlinienentwicklung relevanten Fachgesellschaften/Berufsverbänden, Mandatsträger im Rahmen der Leitlinienentwicklung

☐ Nein

☐ Ja

Falls ja, bitte konkrete Angabe:

8. Politische, akademische (z.B. Zugehörigkeit zu bestimmten „Schulen"), wissenschaftliche oder persönliche Interessen, die mögliche Konflikte begründen könnten

☐ Nein

☐ Ja

Falls ja, bitte konkrete Angabe:

9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre

Bewertung

Ergeben sich aus allen oben angeführten Punkten nach Ihrer Meinung für Sie oder die ganze Leitliniengruppe bedeutsame Interessenkonflikte?

☐ Nein

☐ Ja

Falls ja, bitte Angabe eines Vorschlags zur Diskussion in der Leitliniengruppe

(z.B. Stimmenthaltung zu speziellen Fragestellungen):

Ort, Datum

Name (bitte Druckschrift) Unterschrift

Adresse (Einrichtung, Strasse, Ort, Emailadresse)

12.9. Ergebnisse der Interessenkonflikterklärungen

12.9.1. Interessenkonflikterklärungen 2011

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwend-ungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre
Clemens Albrecht	nein	nein	nein	nein	n.a.	nein	S3-LL ProstataCa, BVDST	nein	Gemeinschaftspraxis für Strahlentherapie, Nürnberg,
Dirk Böhmer	nein	Vortragstätigkeit für Takeda Pharma, Vortrags- und Schulungstätigkeit für Varian Medical Systems*	nein	nein	nein	nein	Vorstand AG Radioonkologie der DKG, Advisory Board der DEGRO	nein	Charité Universitätsmedizin, Berlin,
A. Blana	Mitglied Advisoryboard Amgen, Ferring, EDAP/TMS	Honorare für Vorträge Ferring, Astellas, EDAP/TMS	nein	nein	nein	nein	EAU, DGU	nein	Seit 7/2009 Klinikum Fürth, zuvor Caritaskranken-haus St. Josef in Regensburg,
Christof Börgermann	nein	nein	nein	nein	nein	nein	DGU, BDU	nein	Klinik f. Urologie und Kinderurologie, urologische Onkologie, Düren,

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Martin Burchardt	nein	nein	Dr. Robert-Pfleger-Stiftung – Androgenrezeptorforschung bei Prostatakarzinom → Drittmittel für Abteilung/ Forschungsprojekt	nein	habe die typischen „XXX- Aktienfonds“ in überschaubarem Maße. Ob darin irgendwelche Pharmafirmen enthalten sind, entzieht sich meiner Kenntnis	nein	DGU	nein	Universitätsmedizin Greifswald, Klinik und Poliklinik für Urologie, Greifswald,
Hans-Hermann Dubben	nein	Vortrags- und Schulungstätigkeiten: Deutsche Gesellschaft f. wissenschaftliche und angewandte Kosmetik e.V., 2011, Thieme Verlag KG, Stuttgart, 2008, Sana Kliniken AG, Ismaning, 2009, Roche Farmaceutska, Ljubljana, Slowenien, 2010	nein	nein	nein	nein	nein	nein	UK Hamburg-Epppendorf, Zentrum für psychosoziale Medizin, Institut für Allgemeinmedizin, Hamburg,

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Christian Doehn	nein	Bayer HealthCare, Amgen, Pfizer, Wyeth, GSK, Novartis, Roche	Olympus	nein	AstraZeneca	nein	DGU	nein	Selbständig, bis 05/2011 UK Lübeck
Paul Enders	nein	nein	nein	nein	nein	nein	BPS	nein	Keine,
Hanns-Jörg Fiebrandt	nein	nein	nein	nein	nein	nein	BPS	nein	Keine
Paolo Fornara	nein	nein	GILUPI (Studie zur Detektion mittels Nanodetektorsonden von zirkulierenden Tumorzellen)	nein	nein	nein	DGU	nein	Martin-Luther-Universität Halle-Wittenberg, C4-Professur,
Michael Fröhner	nein	Pfizer, Apogepha, Takeda	nein	nein	nein	nein	DGU	nein	UK Dresden, Klinik und Poliklinik für Urologie,
Marc-Oliver Grimm	Beratertätigkeit für: Bayer Healthcare, Pfizer, Roche,	Vortragstätigkeit für: Bayer Healthcare AG, Pfizer AG, Novar-	Novartis – Drittmittel für Forschungsvorhaben	nein	Aktienbesitz folgender Unternehmen: Bayer AG,	nein	DGU, AUA, EAU, BDU, DKG	nein	UK Jena (derzeitiger Arbeitgeber), UK Dresden (2006-2010),

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	Janssen Cilag	tis, Glaxo Smith Kline, Takeda Pharma, Apogepha			Glaxo Smith Kline				
Markus Graefen	nein	Honorar für Vortragstätigkeit: Ipsen, Amgen	nein	nein	nein	nein	DGU	nein	Universitätsklinik Hamburg-Eppendorf „Martini-Klinik“,
Bernt Göckel-Beining	nein	nein	nein	nein	nein	nein	Vorsitzender im Ausschuss für Evidence Based Medicine des Berufsverbandes der Deutschen Urologen (BDU)	nein	Selbständig (Facharzt f. Urologie),
Marc-Oliver Grimm	Bayer HealthCare, Pfizer, Roche, Janssen-Cilag	Bayer HealthCare, Pfizer, Novartis, Glaxo Smith Kline, Takeda, Apogepha, Roche, Janssen-Cilag	Novartis für Forschungsvorhaben	nein	Bayer HealthCare, Glaxo Smith Kline,	nein	DGU, AUA, EAU, BDU, DKG	nein	UK Jena, bis 2010 UK Dresden
Oliver Hakenberg	nein	nein	nein	nein	nein	nein	DGU, BDU	nein	UK Rostock / Universität,

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwend-ungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre
Axel Heidenreich	Astellas, Aventis, Ipsen, Novartis, Amgen	Amgen, Astellas, Sanofi-Aventis, Glaxo, Ipsen, Merck, Novartis, Roche, Pfizer, Takeda	Ipsen	nein	nein	nein	EAU, DGU, AUA, ASCO	nein	UK Aachen, UK Köln,
Thomas Oliver Henkel	nein	Kurse Brachytherapie	nein	nein	nein	nein	DGU, BDU, BUG	nein	Niedergelassener Urologe seit 1998
Wolfgang Hinkelbein	nein	nein	nein	nein	Beteiligung über Aktienfonds nicht auszuschließen	nein	DEGRO, DKG, BVDST	nein	Charité Berlin,
Stefan Höcht	Beratervertrag Sanofi Aventis 2008 (HNO-Bereich), Autorenvertrag Sanofi Aventis 2008 (HNO-Bereich)	Vortragshonorare Roche Pharma 2009/2010/2011 (Bronchial-Ca), Vortragshonorare „Roadshow S3-Leitlinie Prostata-Ca“ BDU/BVDST	nein	nein	nein	nein	DEGRO, BVDST	nein	Bis 2008 Charité Berlin, jetzt selbständig,
Tobias Hölscher	Klinische Reviews für Strahlentherapiepläne (HNO-Bereich), 3600 €/Jahr EQUAL-ESTRO	nein	nein	nein	nein	nein	DEGRO, ESTRO, BVDST	nein	Aktuell: UK Dresden und MVZ am UK Dresden, Zuvor: Med. Fakultät, TU-Dresden,

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwend-ungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre
Bernd Joachim Krause	nein	GE Healthcare 700 €, Hirnliga Symposium, 700€, 3. Round-Table-Diskussion „Forschungsprojekt Demenzdiagnostik Lilly Pharma 2000 €, Lilly-Fortbildung, Takeda-Pharma 1000 €, PCA-Symposium, Solutionakademie 1000 €, Intensivkurs Uro-Onkologie, Ferring Arzneimittel GmbH 1000 €, Urologisches Live-Symposium	nein	nein	nein	nein	DGN	nein	UK Rostock, Klinik und Poliklinik für Nuklearmedizin,
Michael Lein	Advisory Board Novartis Pharma GmbH 2008-2011, Amgen 2010 Advisory Board	Vorträge 2009 Novartis, Vorträge 2008 Ferring + Novartis	Zeus Studie (Knochenmarkerbestimmung)	nein	nein	nein	nein	nein	Klinikum Offenbach GmbH, Charité Campus Mitte, Urologie,

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwend-ungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre
Hagen Loertzer	nein	nein	nein	nein	nein	nein	nein	nein	Universitätsmedizin Göttingen, Klinik für Urologie,
Hans-Joachim Luboldt	nein	nein	nein	nein	nein	nein	nein	nein	Selbständig: Klinikpraxis für Urologie, Dinslaken,
Gerd Lümmen	Farco-Pharma	Medac, Lilly, Sanofi-Aventis	nein	nein	nein	nein	DGU, BDU	nein	St. Josef Hospital, Troisdorf
Stefan Machtens	nein	Vortragshonorare Bayer, Novartis, GE Healthcare, Sanofi Aventis, Pfizer, BARD Honorar Deutsche Krankenhausgesellschaft für Gutachtertätigkeit im G-BA („Interstitielle Brachytherapie“ Vortragshonorar durch den Bundesverband Medizintechnik (BV Med)	50% Sekretariatsstelle durch die Fa. BARD als Dokumentationsassistentin für die europäische Pro-Brachy Datenbasis.	nein	nein	nein	DGU	nein	Marienkrankenhaus Bergisch Gladbach gGmbH,

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwend-ungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre
Thomas Martin	nein	Honorare für Vorträge (Roche, Merck)	nein	nein	nein	nein	DEGRO	nein	Klinikum Bremen-Mitte und Ambulanz Bremen GmbH,
Kurt Miller	Amgen, AstraZeneca, Astellas, BMS, Janssen-Cilag, Novartis	Amgen, AstraZeneca, Astellas, BMS, Janssen-Cilag, Novartis	nein	nein	nein	nein	DGU	nein	UK Charité Berlin,
Lutz Moser	nein	nein	nein	nein	nein	nein	DEGRO	nein	UK Charité Berlin
Ullrich G. Mueller-Lisse	nein	Teilnahme an der Fortbildungsveranstaltung “Uro Update 2010” der Fa. Med Update GmbH, Hagenauer Str. 53, 65203 Wiesbaden einschl. Vortrag und Autorenschaft (Handbuch Urologie 2010, Springer Medizin Verlag)	nein	nein	nein	nein	Deutsche Röntgengesellschaft: Vorsitzender der AG Urora-diologie	nein	UK München, Institut für klinische Radiologie,

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwend-ungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre
Ullrich Otto	nein	nein	nein	nein	nein	nein	nein	nein	Kliniken Hartenstein GmbH, Bad Wildungen,
Holger Palmedo	nein	Honorar für Vortragstätigkeit der Firmen JBA, Covidien	nein	nein	nein	nein	DGN, BDN	nein	Seit 2008 freiberuflich tätig, Niederlassung,
Karl Pummer	Astellas Pharma	Astellas, Takeda, Ferring, Janssen-Cilag	nein	nein	nein	nein	DGU	nein	Medizinische Universität Graz, Klinik f. Urologie,
Volker Rohde	nein	Sanofi Aventis: „Palliativmedizin“ 2010	nein	nein	nein	nein	DGU	nein	Eigene Praxis für Urologie,
Herbert Rübben	Astellas, Fresenius, Innovacell, DKV, AOK	nein	Studien, interne Forschungsgelder der Universität	nein	nein	nein	DGU, BDU, NRWGU, EAU, AUA	nein	UK Essen
Bernd Jürgen Schmitz-Dräger	AstraZeneca, Astellas, Cmi, EDAP (Frankreich), Ferring, GPC Biotech, Janssen,, Novar-	Gen-Probe Inc. San Diego, Novartis, Takeda	nein	nein	nein	nein	DGU, DKG, AUA, SIU, URS, ESUR, EAU, IBCN, Classification on Urological	nein	Selbständig (privatärztliche urologische Gemeinschaftspraxis, Fürth),

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	tis, SEP						Diseases (ICUD) Bladder Cancer 1999, 2005, 2010		
Martin Schostak	Advisory Board Lilly Pharma und AstraZeneca, Klinischer Berater für EDAP TMG GmbH und CureVac GmbH	LKP bei multiplen Studien: bioMérieux ProtecSys, Lilly, EDAP	nein	nein	nein	nein	nein	nein	Charité (Universitätsmedizin, Urologische Klinik) seit 15 Jahren,
Mark Schrader	nein	nein	nein	nein	nein	nein	nein	nein	UK Ulm, Klinik f. Urologie,
Felix Sedlmayer	nein	Honorare für firmen-initiierte Fortbildungsveranstaltungen	nein	nein	nein	nein	derzeit ÖGRO-Präsident	nein	Salzburger Landeskliniken GmbH (SALK),
Axel Semjonow	nein	Abbott, Ärztekammer Westfalen-Lippe, Beckman-Coulter, DAK, GenProbe, GlaxoSmithKline (EuMedCom) Labor Nordwest, Nordhorn, Novartis, Sanofi, Sie-	Beckman-Coulter, Brahms, Epigenomics, Protagen, Siemens	Patent “Charakterisierung von Tumoren”	nein	Partnerin ist als Medical Director bei Phillips Health Care beschäftigt	DGU, European Group on Tumor Markers (EGTM), National Academy of Clinical Biochemists (NACB)	nein	UK Münster, Prostatazentrum,

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		mens, TAD, Takeda, Vivantes							
Michael Stöckle	nein	honorierter Vortrag im Rahmen des DGU-Kongresses 2011 (Fa. Janssen, Honorar 1000 €)	klinische Studien für fast alle Unternehmen, die Präparate für rologische Erkrankungen entwickeln, auch beim Prostatakarzinom. Zwei study nurses sind darüber finanziert.	nein	Aktienbesitz Fa. Intuitive Surgical	nein	DGU: Vorstand	nein	UK des Saarlandes, Klinik für Urologie und Kinderurologie,
Thomas-Alexander Vögeli	Medac	Sanofi, Lilly, Takeda, Aventis, Farco Pharma	nein	nein	nein	nein	DGU	nein	Medizinisches Zentrum Städteregion Aachen, Universität Düsseldorf,
Lothar Weißbach	Der Urologe, Uro-News, Stiftung Warentest, BMG	Vorträge Lilly, Akademie der DGU	Gazprom Germania	nein	Gazprom Germania	nein	DGU	nein	Stiftung Männergesundheit, Berlin
Frederik Wenz	nein	Sanofi, Astra-Zeneca, Elekta, Zeiss, Lilly, Novartis	Forschungs-kooperationen mit den genannten Fir-	nein	nein	nein	DEGRO, BVDST	nein	Universität Heidelberg, Universitätsmedizin Mannheim,

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwend-ungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre
			men						
Nicolas Wernert	nein	nein	nein	nein	nein	nein	Deutsche Gesellschaft für Pathologie	nein	Universität Bonn
Thomas Wiegel	Bayer-Schering, Ipsen, Takeda, Novartis, Amgen, AstraZeneca	Ipsen, Takeda, Novartis	nein	nein	nein	nein	DEGRO	nein	UK Ulm,
Manfred P. Wirth	Akademie der Dt. Urologen, Amgen, Apogepha, Astellas, AstraZeneca, Ferring, GlaxoSmithKline, Novartis, Orion, Pfizer, Pharmion, Sanofi Aventis, Takeda, TRM Oncology	Akademie der Dt. Urologen, Amgen, Apogepha, Astellas, AstraZeneca, Ferring, GlaxoSmithKline, Novartis, Orion, Pfizer, Pharmion, Sanofi Aventis, Takeda, TRM Oncology	nein	nein	nein	nein	DGU, BDU	nein	UK Dresden
Bernhardt Wörmann	nein	nein	nein	nein	nein	nein	DGHO	nein	Klinikum Braunschweig bis 2009, DGHO sein 2010, Charite Berlin seit 2011

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwend-ungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre
Johannes M Wolff.	Advisory Board: AstraZeneca (beendet), Sanofi, Janssen-Cilag, Ferring, Amgen	AstraZeneca (beendet), Sanofi, Janssen-Cilag, Ferring, Amgen, Astellas, Takeda, GSK	nein	nein	nein	nein	DGU, BDU, DKG-AUO	nein	AKH Viersen GmbH, Viersen
Jens-Peter Zacharias	BPS (Der BPS wird zu 50% durch Spenden finanziert. Davon kommen 3,5 % von der Arzneimittelindustrie. 95% sind Projektförderungen der Dt. Krebshilfe und der Krankenkassen.	nein	nein	nein	nein	nein	BPS Vorstand	nein	Rentner

Abkürzungen: AOK = Allgemeine Ortskrankenkasse, ASCO = American Society of Clinical Oncology, AUA = American Urological Association, BDN = Berufsverband Deutscher Neurologen, BDU = Bundesverband der deutschen Urologen, BMG = Bundesministerium für Gesundheit, BMS = Bristol-Myers Squibb, BPS = Bundesverband Prostatakrebs Selbsthilfe, BUG = Berliner Urologische Gesellschaft, BVDST = Berufsverbandes Deutscher Strahlentherapeuten, DAK = Deutsche Angestellten Krankenkasse, DEGRO = Deutsche Gesellschaft für Radioonkologie, DGHO = Deutsche Gesellschaft für Hämatologie und Onkologie, DGN = Deutsche Gesellschaft für Nuklearmedizin, DGU = Deutsche Gesellschaft für Urologie, DKG = Deutsche Krebsgesellschaft, DGK-AUO = Arbeitsgemeinschaft Urologische Onkologie der Deutschen Krebsgesellschaft, DKV = Deutsche Krankenversicherung, EAU = European Association of Urology, EqualEstro = Independent Quality Assurance for Therapeutic Radiology and Oncology, ESTRO = European Society for Therapeutic Radiology and Oncology, ESUR = European Society for Urological Research, G-BA = Gemeinsamer Bundesausschuss, IBCN = International Bladder Cancer Network, MVZ = Medizinisches Versorgungszentrum, NRWGU = Nordrhein-Westfälische Gesellschaft für Urologie, SIU = Société Internationale d'Urologie, UK = Universitätsklinikum, URS = Urological Research Society

12.9.2. Interessenkonflikterklärungen 2013/2014

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwendungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre	*Selbsteinschätzung, ob Interessenkonflikt besteht*
Albrecht Clemens	Nein	Nein	Nein	Nein	Ja: MIG Fonds ~ 50.000 Euro	Nein	Ja: DEGRO	Nein	Gemeinschaftspraxis für Strahlentherapie	Nein
Andreas Blana	Nein	Ja: Referententätigkeit: Conmed / Linvatec, EDAP TMS, Janssen	Nein	Nein	Nein	Nein	Ja: DGU, EAU, Bayerisch österreichische Urologenvereinigung	Nein	Klinikum Fürth	Nein

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Alfred Böcking, *(Beobachter)*	Nein	Nein	Nein	Nein	Nein	Nein	Nein	Ja: 80 wissenschaftliche Publikationen zur diagnostischen/prognostischen DNA-Bildzytometrie. Entwicklung von Applikationssoftware zusammen mit dem Lehrstuhl für Bildverarbeitung an der RWTH Aachen, Prof. Dr. D. Meyer-Ebrecht	Emeritierter Hochschulprofessor seit 2010, Konsiliarius am Institut für Pathologie des Krankenhauses Düren	Nein
Dirk Böhmer	Nein	Ja: Takeda Pharma Vortragstätigkeiten	Ja: Varian Medical Systems Schulungskurs (4 x pro Jahr)	Nein	Nein	Ja: Hr. J. Schröder, Fa. BrachySolution	Ja: DKG, DEGRO, ARO	Nein	Charite Universitätsmedizin Berlin	Nein
Christof Börgermann,	Nein	Nein	Nein	Nein	Nein	Nein	Ja: BDU	Nein	Krankenhaus Düren	Nein

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Burchardt, Martin	Nein	Nein	Nein	Nein	Nein	Nein	Nein	Nein	Universitätsmedizin Greifswald	Nein
Carl, Ernst-Günther	Nein	Nein	Nein	Nein	Nein	Nein	Ja: BPS Schatzmeister	Nein	Im Ruhestand seit 2008	Nein
Dietz, Josef	Nein	Nein	Nein	Nein	Nein	Nein	Nein	Nein	Als Rentner bin ich seit 6 Jahren als SHG-Leiter Mitglied im BPS e.V. und stellv. Vorstand im Landesverband Prostatakrebs Selbsthilfe Baden-Württemberg g.V. ehrenamtlich und gemeinnützig landes- und bundesweit engagiert.	Nein

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Doehn, Christian	Ja: Advisory Boards: Roche, Pfizer, Bayer, GSK, Novartis, Janssen Cilag, Sanofi	Ja: Vorträge/Schulungen: Roche, Bayer, GSK, Novartis, Takeda	Ja: Olympus	Nein	Ja: Astra-Zeneca	Nein	Ja: DGU, BDU, EAU, AUA, ASCO, DKG	Nein	UKSH (Uni Lübeck) bis 05/2011 seitdem Freiberufler	Nein
Donner-Banzhoff, Norbert	Nein	Nein	Ja: Arriba-pro, AOK BaWü, AOK Bundesverband 150.000 €	Nein	Nein	Ja: Ehefrau leitende Angestellte bei Novartis Vaccines & Diagnostics	Ja: Deutscher Hausärzteverband, DEGAM	Nein	Philipps-Universität Marburg Abteilung für Allgemeinmedizin	Nein

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Egidi, Günther	Ja: 1000 € vom Profil-Institut für die Teilnahme an einem Experten-Workshop zu Patienten-relevanten Endpunkten in der Diabetes-Therapie	Ja: 1000 € von der AOK Bremen für die Erarbeitung eines Vortragsmoduls zu umsatzstarken Arzneimitteln.	Nein	Nein	Nein	Nein	Ja: Gesellschaft für Allgemeinmedizin und Familienmedizin (DEGAM)	Ja: Ich bin strenger Anhänger einer auf klinisch relevante Endpunkte orientierten evidenzbasierten Medizin und habe mich wiederholt kritisch gegenüber einem PSA-Screening geäußert.	selbständig	Ja: Aus meiner kritischen Grundhaltung gegen ein PSA-Screening ergibt sich vorab ein Interessenkonflikt, der m.E. nicht gegen meine Mitarbeit in der Leitliniengruppe spricht, sondern der nur gewusst und beachtet werden sollte.
Enders, Paul	Nein	Nein	Nein	Nein	Nein	Nein	Ja: Bundesverband Prostatakrebs Selbsthilfe e.V.	Nein	n/a	Nein
Fiebrandt, Hanns-Jörg	Nein	Nein	Nein	Nein	Nein	Nein	Ja: BPS	Nein	Rentner seit 2004	Nein

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Fornara, Paolo	Nein	Nein	Nein	Nein	Nein	Nein	Ja:	Nein	MLU Universität Halle-Wittenberg Ernst-Grube-Str. 40 06120 Halle	Nein
Fröhner, Michael	Nein	Ja: Vortragshonorare erhalten von GlaxoSmithKline, Novartis.	Nein	Nein	Nein	Ja: Organisation eines Live-OP-Seminars mit der Firma Wolff im Rahmen des Mitteldeutschen Urologenkongresses 2013.	Ja: Deutsche Gesellschaft für Urologie	Nein	Universitätsklinikum Dresden A.ö.R.	Nein
Ganswindt, Ute	Nein	Ja: Gelegentlich Vortragshonorar oder Reisekostenunterstützung durch MERCK, TAKEDA, HEXAL	Nein	Nein	Nein	Nein	Ja: Marburger Bund, DEGRO, ESTRO, ASTRO, DKG	Nein	LMU München . Klinikum der Universität	Nein

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Göckel-Beining, Bernt	Nein	Nein	Nein	Nein	Nein	Nein	Ja: Leitlinienbeauftragter des BDU	Nein	Selbständig	Nein
Graefen, Markus	Nein	Nein	Nein	Nein	Nein	Nein	Ja: DGU	Nein	Martini-Klinik, Universitätsklinik, Hamburg-Eppendorf	Nein
Grimm, Marc-Oliver	Ja: Pfizer Pharma (Berater), Astellas Pharma (Berater), GlaxoSmithKline Pharma (Berater), Bayer HealthCare (Berater)	Ja: Bayer HealthCare (Referent) Pfizer Pharma (Referent), Sanofi Aventis (Referent), Hexal AG (Referent), Novartis (Referent), Takeda (Referent), Janssen Cilag (Referent), Apogepha (Referent), AMS (Gastoperateur)	Ja: Novartis Pharma GmbH	Nein	Nein	Nein	Ja: Deutsche Ges. für Urologie, Berufsverband der Deutschen Urologen, Deutsche Krebsgesellschaft, European Association of Urology, American Urological Association, Thüringer Krebsgesellschaft, Arbeitskreis Urologische Onkologie Thüringen	Nein	Universitätsklinikum Jena Bachstr. 8 07740 Jena	Nein
Grün, Arne	Nein	Nein	Nein	Nein	Nein	Nein	Ja: DEGRO, DEG	Nein	Charité-Klinik für Radio-Onkologie	Nein

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Hakenberg, Oliver	Nein	Nein	Nein	Nein	Nein	Nein	Ja: DGU, BDU	Nein	Universitätsmedizin Rostock	Nein
Hartmann, Arndt	Ja: Advisory Board Zylomed	Nein	Nein	Nein	Nein	Nein	Ja: Deutsche Gesellschaft für Pathologie, Bundesverband Deutscher Pathologen	Nein	Universitätsklinikum Erlangen	Nein
Heidenreich, Axel	Ja: Amgen, Astellas, IPSEN, Janssen Cilag, Sanofi Aventis	Ja: Amgen, Astellas, Ferring, IPSEN, Janssen Cilag, Sanofi Aventis, Takeda, Myriad	Ja: Astellas, Sanofi Aventis	Nein	Nein	Nein	Nein	Nein	Uniklinik Aachen	Nein
Henkel, Thomas-Oliver	Ja: Advisory Board Duodart/Firma GSK	Ja: Schulung für Ärzte: Brachytherapie Kurse Firma Bebig	Nein	Nein	Nein	Ja: Dr. Rainer Ott, Firma TEVA	Nein	Nein	Selbstständig	Nein
Höcht, Stefan	Nein	Nein	Nein	Nein	Nein	Nein	Ja: Vorstand ARO, Vorstand DEGRO	Nein	Selbstständig tätig	Nein
Hoffmann, W.	Nein	Nein	Nein	Nein	Nein	Nein	Ja: DEGRO-Vorstandmitglied	Nein	Klinikum-Braunschweig	Nein

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Hölscher, Tobias	Ja: klinische Qualitätskontrolle für Bestrahlung im Rahmen klinischer Studien; EQUAL-ESTRO; 3600 €/Jahr	Nein	Nein	Nein	Nein	Nein	Ja: Mitgliedschaft DEGRO, ESTRO, Bundesverband Strahlentherapie., DGU	Nein	Klinik und Poliklinik für Strahlentherapie und MVZ für Strahlentherapie am Universitätsklinikum Dresden	Nein
Klein, Tobias	Nein	Ja: Dozent "Fachpflege Onkologie" im Rahmen der "Weiterbildung Onkologie für MFA Urologie" durch medac GmbH/DGU	Nein	Nein	Nein	Nein	Ja: KOK Beirat (Konferenz Onkologischer Kranken- & Kinderkrankenpflege) -> eine AG de DKG e.V.	Nein	DRK-Schwesternschaft Hamburg e.V. (Angestellter)	Nein
Kotzerke, Jörg	Nein	Nein	Nein	Nein	Nein	Nein	Ja: Präsident der deutschen Gesellschaft für Nuklearmedizin	Nein	Freistaat Sachsen	Nein

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Krause, Bernd	Nein	Nein	Nein	Nein	Nein	Nein	Ja: Mitglied im Vorstand d. Deutschen Ges. für Nuklearmedizin , Task Group Coordinator der DGN, ist mit der Erstellung sämtlicher Leitlinien der DGN. Sei es im Sinne der Erstellung für die bei der AWMF einzustellenden Leitlinien der DGN oder eigene Leitlinien befasst, die entsprechend auch publiziert werden. Ist im Vorstand der European Association of Nuclear Medicine (EANM), Wien, als Committee Koordinator tätig. Daraus ergibt sich ebenfalls eine Involvierung in Leitlinienerstellungen der EANM.	Nein	Universitätsmedizin Rostock	Nein

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Kristian-Glen	Nein	Ja: Vorträge Uro-Update	Nein	Nein	Nein	Nein	Ja: Mitglied: Deutsche Gesellschaft für Pathologie (DGP), Berufsverband deutscher Pathologen (BV)	Nein	Universitätsklinikum Bonn/Universität Bonn (seit 5/2011) Universität Zürich (2007-2011)	Nein
Lein, Michael	Ja: Advisory Board Novartis (2012 beendet), Meeting mit Fa. Amgen (Beratung)	Ja: Vortrag Fa. Amgen	Ja: VEG-Studie, Fa. GlaxoSmithKline; FINA007-Studie, Fa. Galenus	Nein	Nein	Nein	Nein	Nein	Klinikum Offenbach GmbH	Nein

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Loch, Tillmann	Ja. Fresenius Kabi Deutschland (Honorar), Theranostic (Honorar)	Ja: Vortrags- und Schulungstätigkeit, Takeda Pharma, GSK, Farco, etc. (nach Anfrage); Kongressvorträge a. Anfrage (i.d. Regel nicht produktbezogen)	Ja: Leihgeräte BK Medical, Olympus	Ja: Erfinder/Entwickler Ultraschalldiagnostikverfahren (Keine Zahlungen!)	Nein	Nein	Ja: DGU, EAU, Guideline Office, AK Bildgebende Systeme der Akademie, ESUV; Mitglied: AUA, DGU, BDU, DEGUM, EAU,	Nein	Diakonissenkrankenhaus Flensburg	Nein
Loertzer, Hagen	Nein	Nein	Nein	Nein	Nein	Nein	Ja: DGU, DBU	Nein	Westpfalz-Klinikum Kaiserslautern, Universitätsklinikum Göttingen	Nein
Luboldt, Hans-Joachim	Nein	Nein	Nein	Nein	Nein	Nein	Ja: DGU, BDU, AUA, SIU, EAU	Nein	Selbstständig	Nein

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Lümmen, Gerd	Ja: FARCO Pharma GmbH, Köln; Innovacell Biotechnologie AG, Innsbruck, Österreich	Nein	Nein	Nein	Nein	Nein	Ja: DGU, BDU	Nein	St. Josef-Hospital Troisdorf	Nein
Machtens, Stefan	Ja: Advisory Board Tätigkeit für Sanofi, Pfizer, Bayer	Ja: Bezahlte Vortragstätigkeit für Sanofi, BARD, Pfizer, GSK, Astellas, Bayer, Amgen	Ja: Drittmittel für Study Nurse durch Fa. BARD	Nein	Nein	Nein	Ja: Mitglied in DGU	Nein	Chefarzt in der Abteilung für Urologie und Kinderurologie am Marienkrankenhaus Bergisch Gladbach; Dr.-Robert-Koch-Str. 18; 51465 Bergisch Gladbach	Nein
Martin, Thomas	Nein	Ja: Vortragshonorare von Roche Pharma	Nein	Nein	Nein	Nein	Ja: DEGRO, ARO	Nein	Ambulanz Bremen GmbH, MVZ Sektion Radioonkologie; Klinikum Bremen-Mitte, Klinik für Strahlentherapie	Nein

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Miller, Kurt	Ja: Amgen, Novartis, Astellas, Janssen-Cilag, Ferring, Sanofi-Aventis, GSK, BMS, Roche	Ja: Amgen, Novartis, Astellas, Janssen-Cilag, Ferring, Sanofi-Aventis, GSK, BMS, Roche	Ja: Novartis	Nein	Nein	Nein	Ja: DGU, DKG	Nein	Charité	Nein
Moser, Lutz	Nein	Nein	Nein	Nein	Nein	Nein	Ja: Mitglied der DEGRO, Deutsche Gesellschaft der Radioonkologen	Nein	Charité Berlin Universitätsmedizin	Nein

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Mueller-Lisse, Ulrich	Nein	Ja: Vorträge / Seminare für Bracco Deutschland GmbH, Konstanz (Hersteller von Kontrastmitteln für die Radiologie) und für Saegeling Medizintechnik GmbH, Heidenau (Medizinprodukte-hersteller, Vertrieb und Service)	Nein	Nein	Nein	Nein	Ja: Mitglied und Vertreter der Deutschen Röntgengesellschaft e.V. (Berlin), Vorsitzender der Arbeitsgemeinschaft Urogenitale Radiologie der Deutschen Röntgengesellschaft e.V.	Nein	Klinikum der Universität München (fortlaufend seit 07/1993)	Nein
Otto, Ullrich	Nein	Nein	Nein	Nein	Nein	Nein	Nein	Nein	Klinikum Hartenstein, Bad Wildungen	Nein
Palmedo, Holger	Nein	Nein	Nein	Nein	Nein	Nein	Ja: DGN	Nein	freiberuflich	Nein

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Pummer, Karl	Ja: Astellas, Takeda, Janssen (jeweils Advisory Board)	Ja: Astellas, Takeda, Ferring, Novartis, Janssen (jeweils Vorträge)	Ja: Takeda (Studien-Protokoll: Millenium C21004)	Nein	Nein	Nein	Nein	Nein	Medizinische Universität Graz Auenbruggerplatz 5/6 8036 Graz	Nein
Rohde, Volker	Nein	Ja: Vorträge für Firmen: Hexal, Apogepha, Medac, Jansen (keine Zusammenhänge zu Produkten)	Nein	Nein	Nein	Nein	Nein	Nein	Eigenständige Praxisführung	Nein
Roth, Wilfried	Nein	Nein	Nein	Nein	Nein	Nein	Ja: DGP, BV Deutscher Pathologen	Nein	Universitätsklinikum Heidelberg DKFZ Heidelberg	Nein
Rübben, Herbert	Ja: DKV, AOK, Innovacell	Nein	Nein	Nein	Nein	Nein	Ja: DGU, BDU	Nein	Land NRW	Nein

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Schmitz-Dräger, Bernd Jürgen	Ja: Novartis: Studientätigkeit, Referent, Advisory Board; Takeda: Referent; Hexal: Referent, Advisory Board	Ja: Novartis Pharma, Astra-Zenaca	Ja: Novartis Pharma	Nein	Nein	Nein	Ja: EAU, International Bladder Cancer Network (IBCN)	Nein	Selbstständig	Nein
Schostak, Prof. Dr. med. Martin	Ja: Berater für die Firma EDAP-TMS	Ja: Vortragender für EDAP-TMS	Nein	Nein	Nein	Nein	Ja: Mitglied DGU	Nein	Universitätsklinikum Magdeburg seit 06/2011 Charité Berlin 1994-2011	Nein
Schrader, Prof. Mark	Nein	Nein: Astellas, Bayer, Pierre Fabre	Ja: Janssen	Nein	Nein	Nein	Nein	Nein	aktuell: Universitätsklinikum Ulm vorher: Charité	Nein

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwendungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre	*Selbsteinschätzung, ob Interessenkonflikt besteht*
Sedlmayer, Felix	Nein	Ja: firmengetragene Wissenschafts-Symposien (je 1x) Takeda, Astellas, Sandoz	Ja: Forschungskooperation mit d. Firmen Elekta, C-Re (Medizintechnikhersteller)	Nein	Nein	Nein	Ja: ÖGRO, DEGRO	Nein	Land Salzburg	Nein
Seitz, Gerhard *(Beobachter)*	Nein	Nein	Nein	Nein	Nein	Nein	Ja: DGP	Nein	Niedergelassen als Pathologe, Chefarzt in Teilzeit (13 h) der Sozialstiftung Bamberg	Nein

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Semjonow, Axel	Ja: Beckman-Coulter, Janssen-Cilag	Ja: Abbott, Astellas, Beckman-Coulter, Dr. Pfleger, Fering, GlaxoSmithKline, Ipsen, Novartis, Pfizer, Roche, Siemens, Takeda, TEVA	Ja: Beckman-Coulter, Protagen, Roche	Ja: Patent "Method for characterizing primary tumors" DE102171 02A1, DE102171 02B4, EP1497657 A2, US20060147911, US20090035774 A1, WO2008 0307405	Nein	Ja: Familiäre Beziehung: Medical Director Philips Healthcare	Ja: Arbeitskreis Labordiagnostik, DGU; European Group on Tumor Maker (EGTM); National Academy of Clinical Biochemists (NACB)	Nein	UK Münster, Prostatazentrum	Nein

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwendungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre	*Selbsteinschätzung, ob Interessenkonflikt besteht*
				A2, WO2003087405 A3						
Steuber, Thomas	Ja: Advisory-Board Aktivität bei Janssen, Amgen, Sanofi-Aventis	Ja: Honorarvorträge (Sat-Symposien) für Amgen und Janssen	Nein	Nein	Nein	Nein	Nein	Nein	Martini-Klinik am UKE GmbH	Nein
Stöckle, Michael	Nein	Nein	Ja: Prostata-Ca Studie, Janssen, Studienleiter Dr. Oltmann	Nein	Ja: 50 Aktien von intuitive surgical	Nein	Ja: Präsident DGU	Ja: Robotischer Operateur (Da-Vinci Operationen)	Uniklinikum des Saarlandes	Nein
Vögeli, Thomas-Alexander	Nein	Ja: Vortragstätigeit: Medac, Takeda, Lilly, Sanofi, Teleflex	Nein	Nein	Nein	Nein	Ja: DGU, AUA, SIU, EAU	Nein	Medizinisches Zentrum Städteregion Aachen	Nein

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwendungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre	*Selbsteinschätzung, ob Interessenkonflikt besteht*
Wagner, Sigrid	Nein	Nein	Nein	Nein	Nein	Nein	Nein	Nein	Bis 2011 Uni Halle, Ernst-Gruber-Str. 40, 06120 Halle Ab 2011 Klinikum Ingolstadt GmbH	Nein
Wedding, Ulrich	Nein	Ja: Novartis, Roche, Janssen-Cilag, Amgen, Pro.. (nicht lesbar), Cephalon, Pfizer, Chugai, Sanofi	Nein	Nein	Ja: Bayer AG 50 Aktien	Nein	Ja: DGHO, DGP, DGIM, DKG, AIO, DGG	Nein	Universitätsklinikum Jena	Nein
Weißbach, Lothar	Ja: Wissenschaftlicher Beirat Hexal	Ja: Vortragshonorare Fa. Lilly	Ja: Fa. Gazprom für die HAROW-Studie; Fa. Janssen für die I-BuTu-Studie	Nein	Nein	Nein	Nein	Nein	Ja: Novartis, Roche, Janssen-Cilag, Amgen, Pro.. (nicht lesbar), Cephalon, Pfizer, Chugai, Sanofi	Nein

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwendungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre	*Selbsteinschätzung, ob Interessenkonflikt besteht*
Wenz, Frederik	Ja: Elekta, Berater Zeiss, Berater	Ja: Vortragshonorare Celegene, Elekta, Zeiss, Roche, Amgen, Novartis	Ja: Forschungskooperation Elekta, Zeiss	Nein	Nein	Nein	Ja: DEGRO, DGU, ARO, BVDST	Nein	Universitätsmedizin Mannheim	Nein
Wernert, Nicolas *(Berater)*	Nein	Nein	Nein	Nein	Nein	Nein	Ja: Deutsche Gesellschaft für Pathologie	Nein	Universität Bonn/Universitätsklinikum Bonn	Nein
Wiedemann, Andreas	Nein	Ja: Vortragstätigkeit: FA. Pfizer, Fa. Dr. Pfleger, Fa. Berlin-Chemie	Ja: AMS-Deutschland	Nein	Nein	Nein	Ja: Deutsche Gesellschaft für Geriatrie Vorsitz AG Inkontinenz	Nein	Ev. Krankenhaus Witten gGmbH	Nein
Wiegel, Thomas	Ja: Advisory Board Ipsen, Siemens	Ja: Ferring, Hexal, Takeda, Siemens, Ipsen, Janssen	Nein	Nein	Nein	Nein	Ja: DEGRO	Nein	Land Baden-Württemberg	Nein

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwendungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre	*Selbsteinschätzung, ob Interessenkonflikt besteht*
Wirth, Manfred	Ja: Amgen GmbH, Apogepha Arzneimittel GmbH, AstraZeneca GmbH, Bayer Vital GmbH, Dendreon Cooperation, Ferring Arzneimittel GmbH, Janssen Cilag GmbH, Orion Pharma GmbH, Sanofi-Aventis Deutschland GmbH, Siemens AG, Takeda Pharma	Ja: Amgen GmbH, Apogepha Arzneimittel GmbH, AstraZeneca GmbH, Bayer Vital GmbH, Dendreon Cooperation, Ferring Arzneimittel GmbH, Janssen Cilag GmbH, Orion Pharma GmbH, Sanofi-Aventis Deutschland GmbH, Siemens AG, Takeda Pharma	Nein	Nein	Nein	Nein	Ja: Mitglied der DGU und des BDU	Nein	Universitätsklinikum Carl Gustav Carus Dresden	Nein
Wolff, Johannes M.	Ja: Astra Zeneca, Amgen, Bayer, Ferring, Janssen, Sanofi	Ja: Astra Zeneca, Astellas, Bayer, Ferring, Hexal, Ipsen, Janssen, Sanofi, Takeda	Nein	Nein	Nein	Nein	Ja: DGU, BDU, DGHO, DKG	Nein	AKH Viersen Heesstraße 10 41751 Viersen	Nein

Name	1. Berater- bzw. Gutachtertätigkeit oder bezahlte Mitarbeit	2. Honorare für Vortrags- und Schulungstätigkeiten oder bezahlte Autorenschaften	3. Finanzielle Zuwendungen (Drittmittel)	4. Eigentümerinteresse	5. Besitz von Geschäftsanteilen, Aktien, Fonds	6. Persönliche Beziehungen	7. Mitglied relevanter Fachgesellschaften	8. Politische, akademische, wissenschaftliche oder persönliche Interessen	9. Gegenwärtiger Arbeitgeber, relevante frühere Arbeitgeber der letzten 3 Jahre	*Selbsteinschätzung, ob Interessenkonflikt besteht*
Wörmann, Bernhard	Nein	Nein	Nein	Nein	Nein	Nein	Ja: Deutsche Gesellschaft für Hämatologie und Medizinische Onkologie (DGHO), verantwortlich für Leitlinien	Nein	Deutsche Gesellschaft für Hämatologie und Medizinische Onkologie (DGHO); Charité Berlin	Nein
Zacharias, Jens-Peter	Nein	Nein	Nein	Nein	Nein	Nein	Ja: BPS Vorstandsmitglied, Vertreter im G-BA (siehe Geschäftsbericht)	Ja: ebm Fördermitglied, Vertreter des BPS	Rentner	Ja: Wegen der Interessenlage wurde ich eingeladen.
Zastrow, Stefan	Ja: Sanofi-Aventis, Pfizer, Apogepha	Ja: Janssen, Sanofi-Aventis, Pfizer, Apogepha	Nein	Nein	Nein	Nein	Ja: DGU	Nein	Universitätsklinikum Dresden	Nein
Zips, Daniel	Nein	Nein	Ja: Bayer Pharma Berlin Forschungskooperation	Nein	Nein	Nein	Ja: ESTRO	Nein	Klinikum Tübingen seit 04/2012, zuvor Uniklinikum Dresden	Nein

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