MRO.ART
MODERN RADIATION ONCOLOGY
36° RESIDENTIAL COURSE

Gemelli
Fondazione Policlinico Universitario Agostino Gemelli IRCCS
Università Cattolica del Sacro Cuore

G-ART
Advanced Radiation Therapy



Genitourinary malignanices

Post-operative radiotherapy management: when and how to choose between adjuvant and salvage

Thomas ZILLI

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Bellinzona, 09.10.2026

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Università della Svizzera italiana

Conflict of Interest Disclosure

I have the following potential conflict(s) of interest to report:

- Honoraria / Travel costs — Janssen, Amgen, Ferring, Debiopharm, Bayer, Astellas, Telix, Accord, Recordati, Ipsen, Johnson & Johnson
- Research Grants — Varian Medical Systems, Astellas
- Advisory Boards — Janssen, Accord, Astellas, Recordati

The patient



- 72-year old men
  - asymptomatic
  - sexually active
  - no major comorbidities
  - no positive familial history

- PSA 02/2026: 14 ng/mL (10 ng/mL 05/2021)
- DRE: cT2b, mid right lobe
- mpMRI: mrT3a signs of extracapsular invasion, node negative
- Targeted + systematic biopsies: prostate adenocarcinoma Gleason 4+3 (ISUP GG 3) on the right prostate

03/2026 **Robotic radical prostatectomy with eLND**

Prostate adenocarcinoma GS 4+3 (ISUP GG 3), pT3a pN0 (0/16) R1 (1mm apex, GG3)

6-week PSA after RP: 0.02 ng/mL

1.Optimal treatment: node negative

- Prostate adenocarcinoma GS 4+3, ***pT3a pN0 (0/16) R1*** (1 mm apex)
- 6-week PSA after RP: 0.02 ng/mL

What would you like to do?

1. Androgen deprivation (ADT)
2. Observation ± salvage radiotherapy ± ADT
3. Adjuvant radiotherapy ± ADT
4. Genomic testing



Adjuvant RT and undetectable PSA

Clinical context

- **Adjuvant radiotherapy (ART)** after radical prostatectomy (RP)
- No evidence of disease status post RP (undetectable PSA)
- Consider RT in selected patients at high risk of recurrence to improve local control and prevent metastatic progression.

What is an undetectable PSA?

- Typically defined as **PSA <0.1 ng/mL** in most contemporary studies.

Definition of biochemical recurrence (BCR) after RP

- EAU 2026: **No definitive PSA cut-off** defines BCR after RP.
- A confirmed rising PSA indicates disease recurrence.
- **PSA >0.4 ng/mL and rising** best predicts subsequent metastases.

Evidence and risk considerations

- Rising PSA = high risk: **two consecutive rises ≥0.1 ng/mL** or **three consecutive rises** at any PSA level (RADICALS-RT).
- Threshold for adjuvant/salvage RT depends on individual risk; for high-risk patients, a **single PSA ≥0.05 ng/mL** may be considered.

References
EAU Guidelines on Prostate Cancer 2026 | Morgan et al. J Urol. 2024 | Parker et al. Lancet. 2020 | Mir et al. Eur Urol. 2014

The natural history after radical prostatectomy

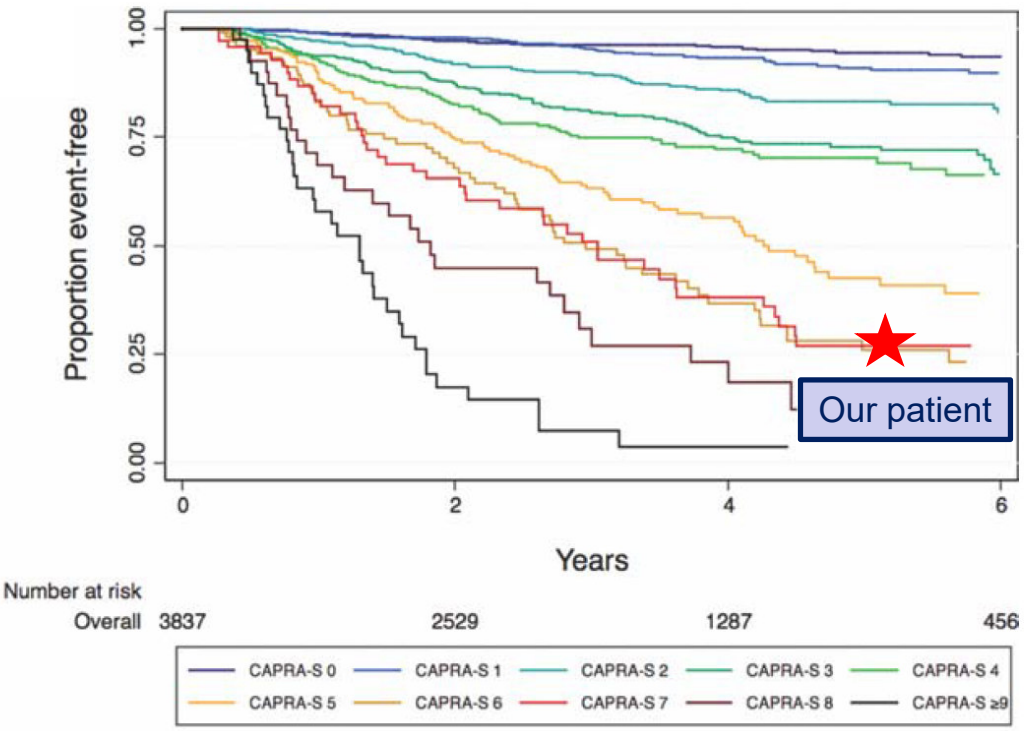
The CAPRA-S Score

A Straightforward Tool for Improved Prediction of Outcomes After Radical Prostatectomy

Matthew R. Cooperberg, MD, MPH[1]; Joan F. Hilton, MPH, ScD[1,2]; and Peter R. Carroll, MD, MPH[1]

Variable	Level	Points	Variable	Level	Points
PSA	0-6	0	Gleason	2-6	0
	6.01-10	1		3+4	1
	10.01-20	2		4+3	2
	>20	3		8-10	3
SM	Negative	0	ECE	No	0
	Positive	2		Yes	1
SVI	No	0	LNI	No	0
	Yes	2		Yes	1

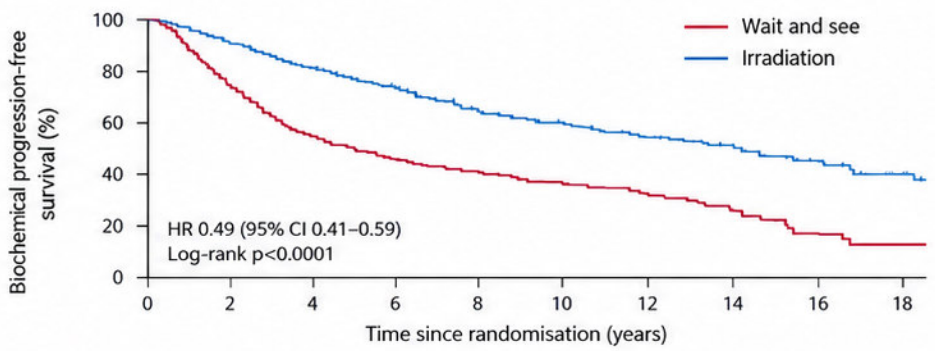
Our patient: CAPRA-S = 7



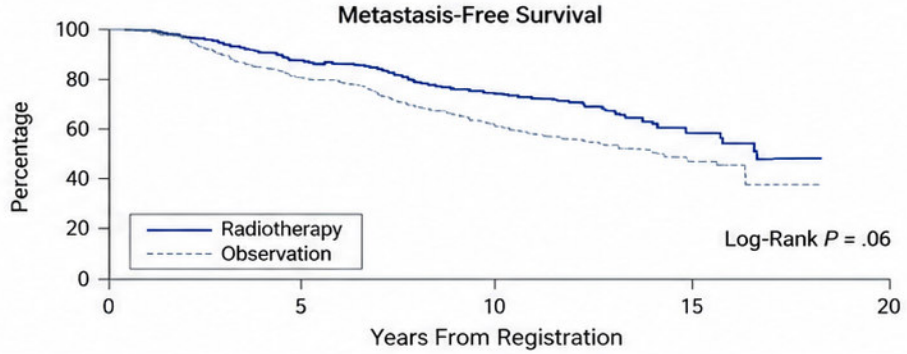
Cooperberg *et al.* Cancer 2011

Adjuvant RT *vs* Observation (pT3a/b and/or R1 pN0)

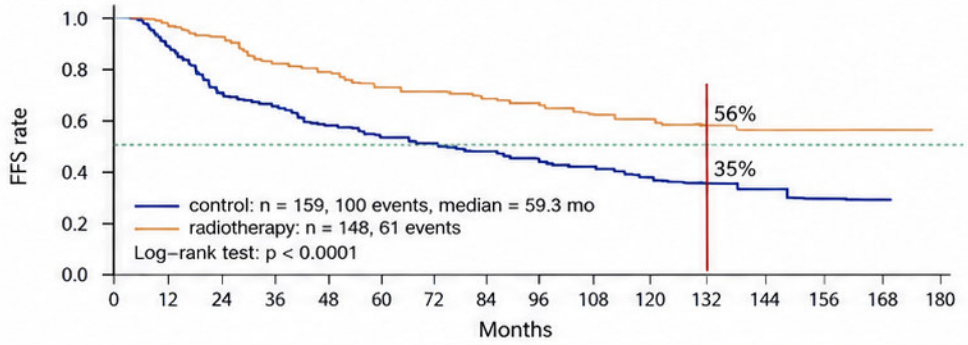
EORTC 22911 trial *(Bolla, Lancet 2012)*



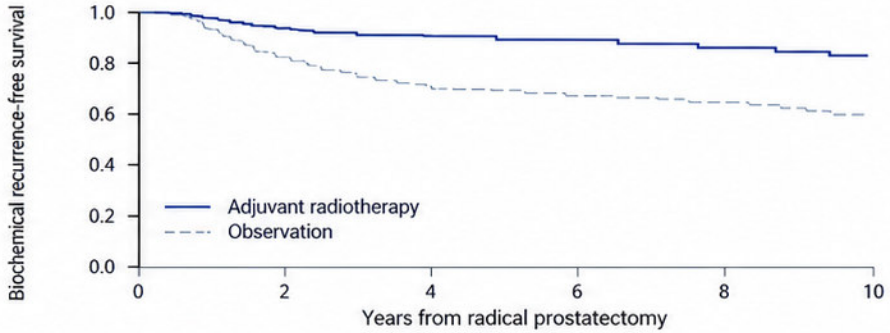
SWOG 8794 trial *(Thompson, J Urol 2009)*



ARO 96-02 trial *(Wiegel T, Eur Urol 2014)*



FinnProstate Group 2019 trial *(Hackman, Eur Urol 2019)*



Adjuvant RT: better biochemical control, but no impact on survival (except SWOG 8794)…

Adjuvant radiotherapy trials: limitations

Study (year)	n	Inclusion criteria	Randomisation	Definition of BCR PSA (ng/mL)	Median FU (mo.)	Biochemical Progression-free survival	Overall survival
SWOG 8794 (2009) [962]	431	pT3 cN0 ± involved SM	60–64 Gy vs. observation	> 0.4	152	10 yr.: 53% vs. 30% (p < 0.05)	**10 yr.: 74% vs. 66%** Median time: 15.2 vs. 13.3 yr., p = 0.023
EORTC 22911 (2012) [963]	1,005	pT3 ± involved SM pN0 pT2 involved SM pN0	60 Gy vs. observation	> 0.2	127	10 yr.: 60.6% vs. 41% (p < 0.001)	**81% vs. 77%** n.s.
ARO 96-02 (2014) [948]	388	pT3 (± involved SM) pN0 PSA post-RP undetectable	60 Gy vs. observation	> 0.05 + confirmation	112	10 yr.: 56% vs. 35% (p = 0.0001)	**10 yr.: 82% vs. 86%** n.s.
FinnProstate Group (2019) [964]	250	pT2,R1 / pT3a	66.6 Gy vs. observation (+ SRT)	> 0.4 (in 2 successive measurements)	112 vs. 103 (patients alive)	10 yr.: 82% vs. 61% (p < 0.001)	**10 yr.: 92% vs. 87%** n.s.

**See Section 6.3.5 for delayed (salvage) post-radical prostatectomy external irradiation.*
BCR = biochemical recurrence; FU = follow-up; mo. = months; n = number of patients; n.s. = not significant; PSA = prostate-specific antigen; RP = radical prostatectomy; SM = surgical margin; SRT = salvage radiotherapy.

But… limitations of these trials

- **Old studies** recruiting in 1990–early 2000 (before ultra-sensitive PSA), with **30%** of patients with **persistent PSA**
- **No standardized** follow-up imaging
- Use of salvage RT (20% SWOG vs 33% EORTC): **impact of early vs late SRT**
- Risk of **overtreatment** in many patients
- **Debatable MFS and OS benefit** of the SWOG trial
- **Impact on toxicity and QoL** of adjuvant RT

Cornford P *et al.* EAU guidelines 2026

Early salvage radiotherapy reduce the death risk

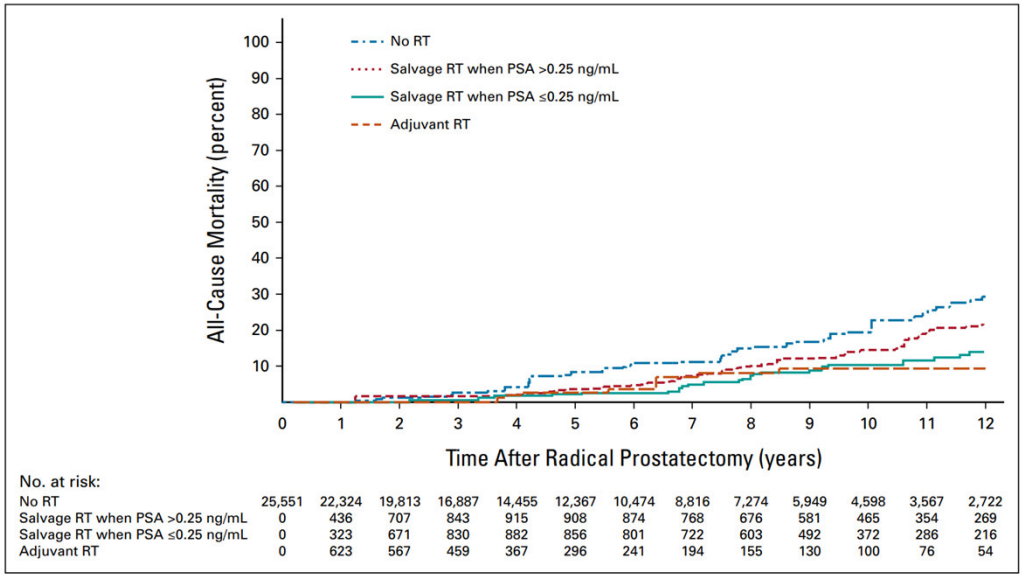


TABLE 3. AHR for ACM When sRT(t) is Delivered Above the Prespecified PSA Cutpoint After RP Compared With PSA Levels at or Below the PSA Cutpoint

PSA Cutpoint in ng/mL	No. of Men	No. of Deaths	No. of PC Deaths	AHR (95% CI)	P
>0.10	2,897	179	55	0.88 (0.56 to 1.36)	.55
≤0.10	336	23	8		
>0.15	2,579	164	53	1.11 (0.77 to 1.58)	.58
≤0.15	654	38	10		
>0.20	2,190	150	50	1.28 (0.93 to 1.76)	.14
≤0.20	1,043	52	13		
>0.25	1,677	134	45	1.49 (1.11 to 2.00)	.008
≤0.25	1,556	68	18		
>0.30	1,362	117	39	1.45 (1.09 to 1.92)	.01
≤0.30	1,871	85	24		
>0.35	1,167	105	36	1.46 (1.10 to 1.94)	.008
≤0.35	2,066	97	27		
>0.40	985	97	32	1.58 (1.19 to 2.09)	.001
≤0.40	2,248	105	31		
>0.45	864	89	29	1.53 (1.16 to 2.04)	.003
≤0.45	2,369	113	34		
>0.50	737	79	27	1.61 (1.21 to 2.14)	.001
≤0.50	2,496	123	36		

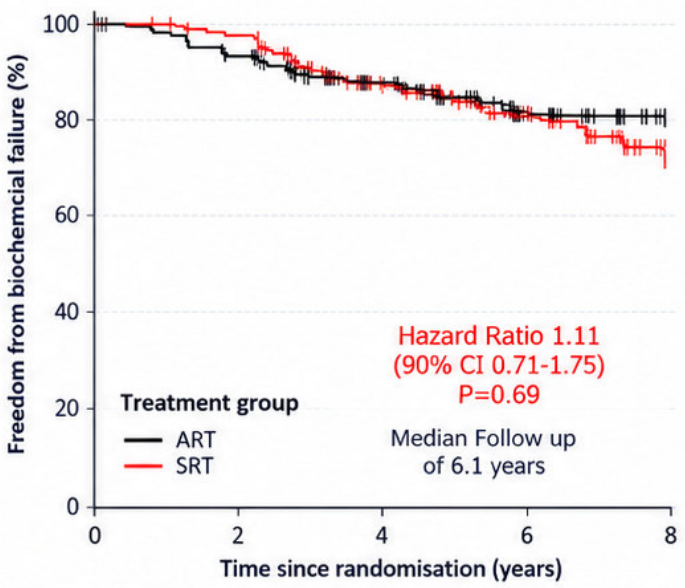
25,551 pT2-4 N0 or NxM0 PCa patients with at least 1 risk factor (pT3/4 or GS 8-10)

Initiating sRT above a PSA level of 0.25 ng/mL is associated with increased ACM-risk in pts with ≥ 1 high-risk factor

Tilki D *et al.* JCO 2023

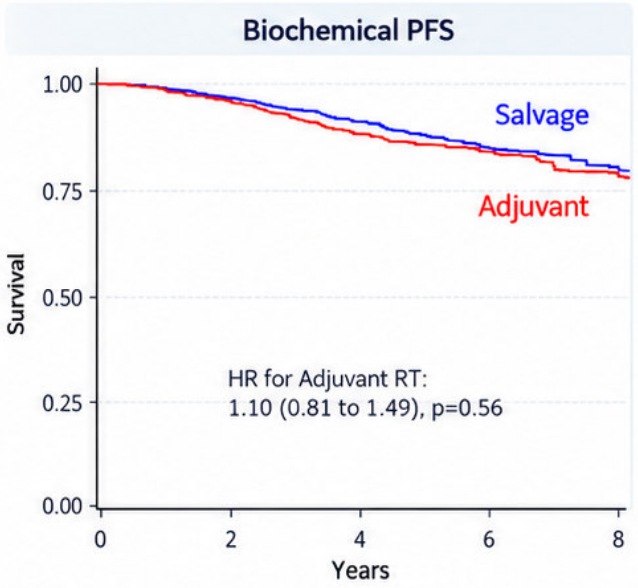
Adjuvant *vs* early salvage RT: same question, same answer

RAVES
Kneebone et al.



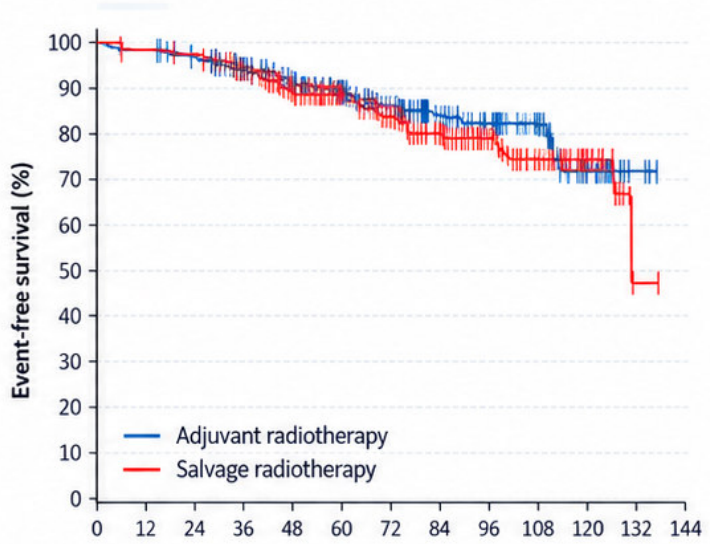
No. at risk (No. censored)	0	2	4	6	8
ART	166 (0)	151 (5)	111 (37)	73 (71)	21 (120)
SRT	167 (0)	160 (4)	119 (30)	76 (68)	21 (117)

RADICALS-RT
Parker et al.



N	0	2	4	6	8
Def	699 (29)	601 (29)	378 (17)	165 (5)	42
Imm	697 (28)	596 (42)	361 (11)	154 (5)	36

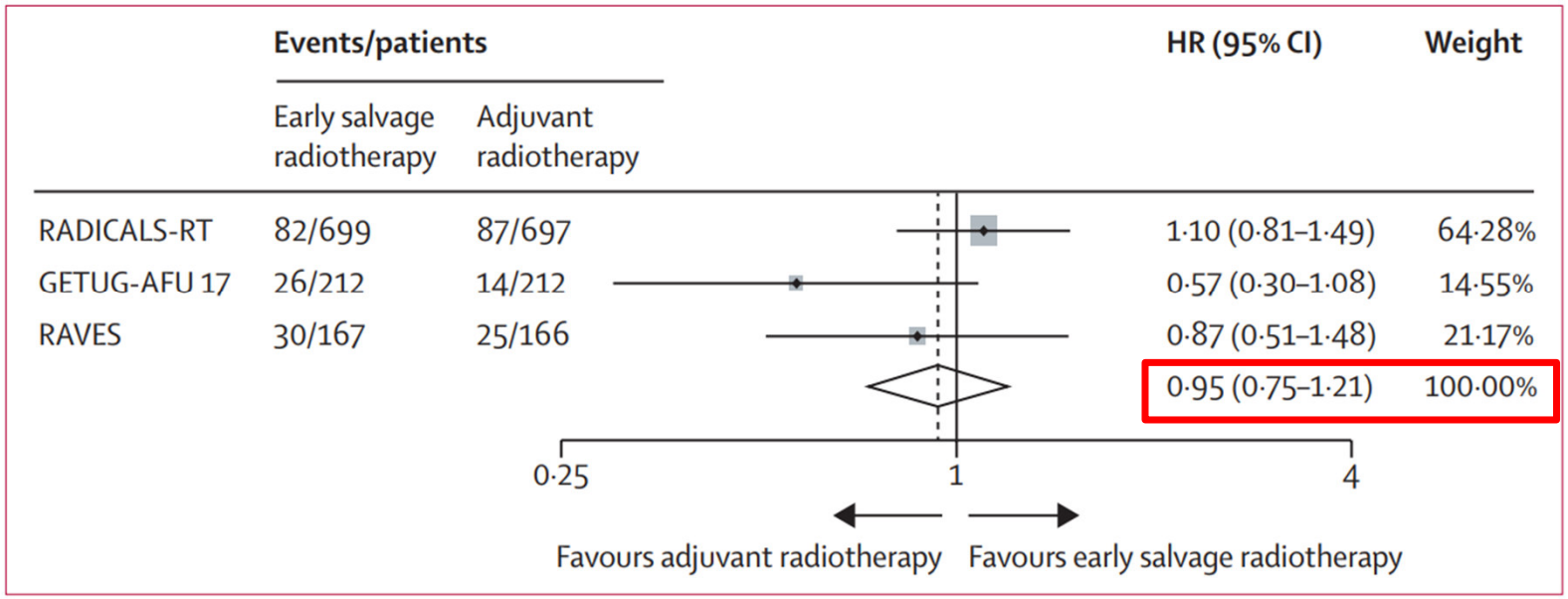
GETUG-AFU 17
Sargos et al.



Number at risk (number censored)	0	12	24	36	48	60	72	84	96	108	120	132	144
Adjuvant radiotherapy	212 (0)	196 (12)	148 (51)	101 (92)	52 (139)	8 (179)	...						
Salvage radiotherapy	212 (0)	203 (5)	158 (38)	105 (81)	54 (127)	8 (172)	...						

Kneebone *et al.* Lancet Oncol 2020; Parker *et al.* Lancet 2020; Sargos *et al.* Lancet Oncol 2020

Adjuvant *vs* early salvage RT: the ARTISTIC meta-analysis



Three independent randomized trials, prospectively pooled at the individual-patient level.

This is not the absence of a difference. It is the presence of equivalence.

Vale *et al.* Lancet 2020

Adjuvant *vs* early salvage RT: the impact on side effects

RADICALS-RT

Late RTOG events (≥ 2 years) · Grade 1–2

Event	Salvage RT (n = %)	Adjuvant RT (n = %)	p value
Diarrhoea	9%	**18%**	<0.001
Proctitis	6%	**13%**	<0.001
Cystitis	7%	**14%**	0.001
Haematuria	5%	**15%**	<0.001
Urethral stricture	3%	**7%**	<0.001

Higher G3 haematuria with adjuvant: 5% vs 1%.
RADICALS-RT, Table 3.

Patient-reported outcomes · Adjusted for baseline

ICS urinary incontinence — Higher = worse

YEAR 1	YEAR 5	YEAR 10
p = 0.001	p = 0.037	p = 0.381

Vaizey faecal incontinence — Higher = worse

YEAR 1	YEAR 5	YEAR 10
p < 0.001	p = 0.029	p = 0.017

All figures favour Salvage-RT.
RADICALS-RT, Figure 7.

Parker *et al.* Lancet 2020

The guidelines

EAU guidelines · 2026
European Association of Urology

- Offer **early salvage intensity-modulated RT** to men with two consecutive PSA rises (strong). Do not for a PSA treshold.
- Offer **monitoring** to EAU Low-risk BCR (weak).
- Offer **ADJUVANT RT** for ISUP GG 4-5 and pT3 (weak).

NCCN · 2026
National Comprehensive Cancer Network

- **Salvage RT** graded **Category 1.**
- **Adjuvant radiation** may be reasonable for patients with **multiple adverse features**.

ESMO guidelines · 2026
European Society for Medical Oncology

- **Early salvage RT** for patients with BCR if there is a risk of metastatic progression (Cat III, B).
- **Surveillance** for BCR and low risk of metastatic progression (Cat III, B).

The ARTISTIC meta-analysis: what early salvage RT does not cover

Characteristic	RADICALS-RT		GETUG-AFU 17		RAVES	
	Adjuvant radiotherapy (n = 697)	Early salvage radiotherapy (n = 699)	Adjuvant radiotherapy (n = 212)	Early salvage radiotherapy (n = 212)	Adjuvant radiotherapy (n = 166)	Early salvage radiotherapy (n = 167)
Median follow-up, months*	60 (range 2–132)	60 (range 2–132)	75 (range 0–130)	75 (range 0–130)	78 (range 1–122)	78 (range 1–122)
Median age, years	65 (60–68)	65 (60–68)	64 (60–68)	64 (59–68)	64 (60–68)	64 (50–68)
Median preoperative PSA, ng/mL	7.8 (5.8–11.4)	8.0 (5.6–11.6)	Not available	Not available	7.4 (5.5–10.2)	7.4 (5.3–10.4)
Pathological stage						
pT2	163 (23%)	176 (25%)	0	0	37 (22%)	39 (23%)
pT stage 3a/b	529 (76%)	519 (74%)	208 (99%)	206 (98%)	129 (78%)	128 (77%)
pT4	5 (1%)	4 (1%)	3 (1%)	5 (2%)	0	0
Gleason score						
≤6	48 (7%)	48 (7%)	21 (10%)	22 (10%)	8 (5%)	8 (5%)
7	527 (77%)	528 (76%)	174 (82%)	167 (78%)	132 (80%)	124 (80%)
≥8	112 (16%)	123 (17%)	17 (8%)	23 (11%)	26 (16%)	25 (15%)
Positive margins	439 (63%)	443 (63%)	211 (100%)	210 (100%)	110 (66%)	113 (68%)
Seminal vesicle involvement						
Yes	129 (19%)	132 (19%)	44 (21%)	46 (22%)	31 (19%)	33 (20%)
No	568 (81%)	567 (81%)	167 (79%)	165 (78%)	135 (81%)	134 (80%)
Unknown	0	0	1 (<1%)	1 (<1%)	0	0
Extracapsular extension						
Yes	492 (71%)	483 (69%)	212 (100%)	212 (100%)	129 (78%)	128 (77%)
No	205 (29%)	215 (31%)	0	0	37 (22%)	39 (23%)
Unknown	0	1 (<1%)	0	0	0	0
Lymph node involvement						
Involved	38 (5%)	28 (4%)	0	0	1 (1%)	0
Not involved	335 (48%)	374 (54%)	212 (100%)	212 (100%)	165 (99%)	167 (100%)
Nx	324 (47%)	297 (43%)	0	0	0	0
CAPRA-S risk group†						
Low (0–2)	38 (8%)	55 (8%)	..	..	22 (13%)	21 (13%)
Intermediate (3–5)	382 (55%)	384 (55%)	..	..	100 (60%)	98 (59%)
High (≥6)	257 (37%)	260 (37%)	..	..	44 (27%)	48 (29%)

Patients with adverse features (ISUP grade 4–5, pT3b) represented a minority (15–20%)

Vale *et al.* Lancet 2020

What early salvage RT does not cover



Adapted from Ost P APCCC 2026

Room for a selected adjuvant policy?

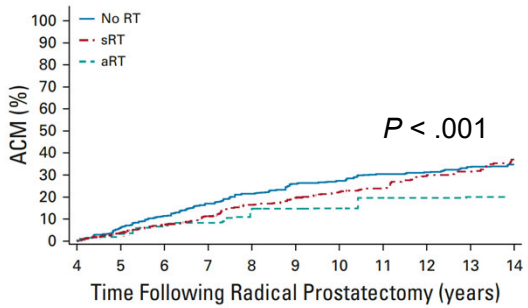
Adjuvant Versus Early Salvage Radiation Therapy for Men at High Risk for Recurrence Following Radical Prostatectomy for Prostate Cancer and the Risk of Death

Derya Tilki, Ming-Hui Chen, Jing Wu, Hartwig Huland, Markus Graefen, Thomas Wiegel, Dirk Böhmer, Osama Mohamad, Janet E. Cowan, Felix Y. Feng, Peter R. Carroll, Bruce J. Trock, Alan W. Partin, Anthony V. D'Amico, et al.

26,118 patients
treated with RP + LND
(1989–2016)

FU = 8.2 years

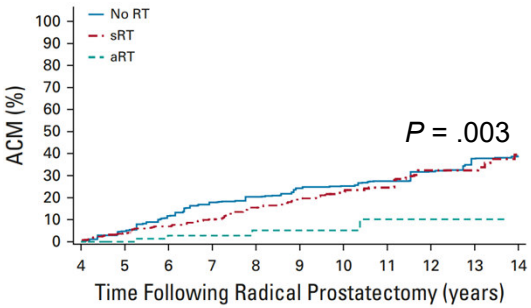
A All pts with adverse pathology (including pN1)



No. at risk:

No RT	1,102	853	652	521	426	356	307	262	224	181	156
sRT	895	740	600	469	347	268	192	146	103	75	57
aRT	427	327	259	199	130	86	62	44	25	13	8

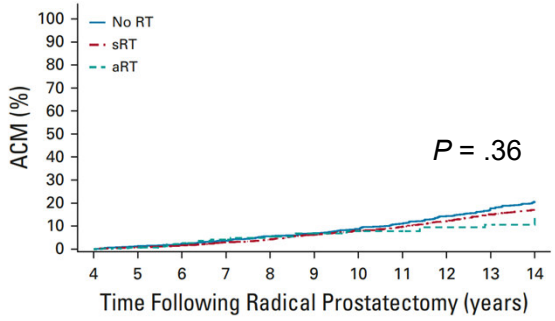
B pN0 pts with adverse pathology



No. at risk:

No RT	438	343	274	224	194	167	141	124	106	81	70
sRT	387	332	285	240	189	153	113	88	59	42	32
aRT	108	81	68	52	38	26	21	14	10	5	3

C All pts without adverse pathology



No. at risk:

No RT	21,089	18,196	15,633	13,353	11,253	9,466	7,859	6,620	5,422	4,367	3,483
sRT	2,217	2,248	2,206	2,084	1,859	1,620	1,351	1,138	936	745	595
aRT	388	325	269	229	185	144	107	84	59	43	27

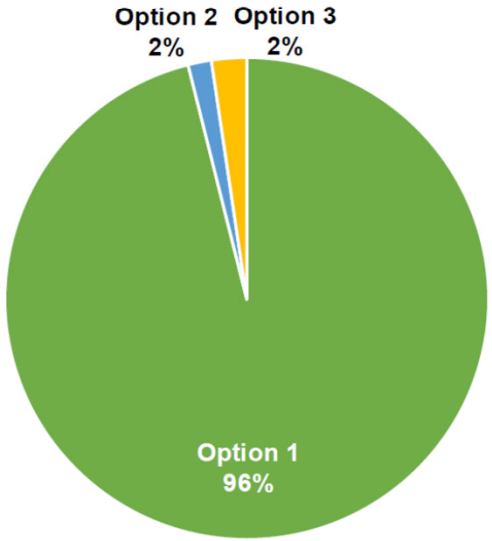
Adjuvant RT can reduce the all cause-mortality risk in men with pN1 or Gleason score 8 to 10 and pT3/4 prostate cancer

Tilki D *et al.* JCO 2021

The APCCC 2026 consensus meeting

High-risk localised and locally advanced prostate cancer

36. For the majority of patients with pT3 pN0 following radical prostatectomy with extended PLND and ISUP grade group 4-5 and R0 and with undetectable postoperative PSA, what is your recommendation provided the patient has regained continence?

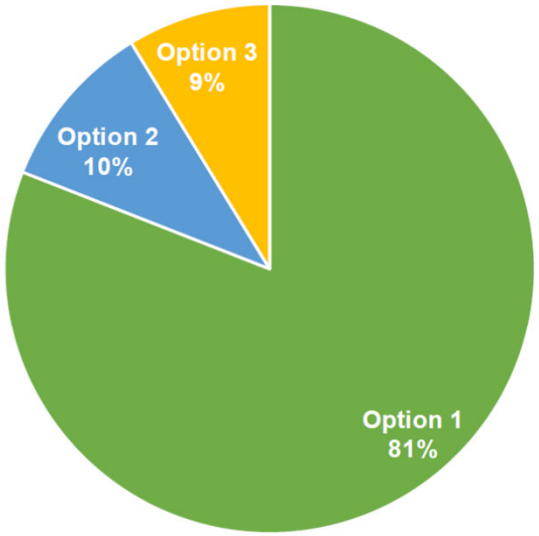


		Votes
Option 1	Monitoring and early salvage therapy (RT or systemic therapy or both) in case of a confirmed PSA rise	123
Option 2	Adjuvant RT	2
Option 3	Adjuvant RT plus systemic hormonal therapy	3
Abstain	Abstain/unqualified to answer	5

The APCCC 2026 consensus meeting

High-risk localised and locally advanced prostate cancer

37. For the majority of patients with pT3 pN0 following radical prostatectomy with extended PLND and ISUP grade group 4-5 and R1 and with undetectable postoperative PSA, what is your recommendation provided the patient has regained continence?

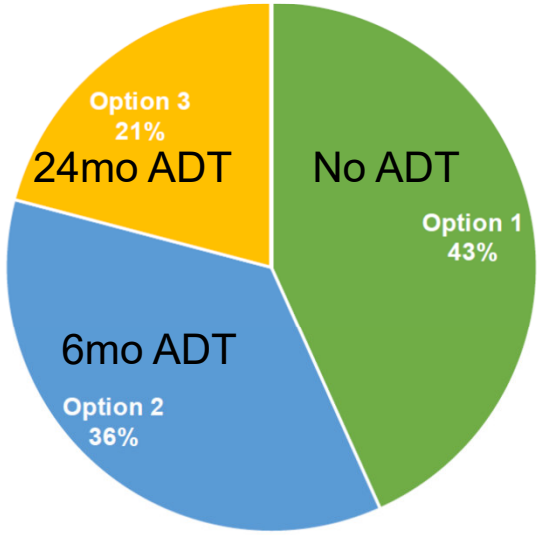


		Votes
Option 1	Monitoring and early salvage therapy (RT or systemic therapy or both) in case of a confirmed PSA rise	102
Option 2	Adjuvant RT	13
Option 3	Adjuvant RT plus systemic hormonal therapy	11
Abstain	Abstain/unqualified to answer	7

The APCCC 2026 consensus meeting

High-risk localised and locally advanced prostate cancer

38. If you recommend adjuvant therapy in a patient with pT3 pN0 following radical prostatectomy with extended PLND and ISUP grade group 4-5 and with undetectable postoperative PSA what is your recommendation regarding systemic therapy?



		Votes
Option 1	Adjuvant radiation therapy alone	29
Option 2	Adjuvant radiation therapy plus short-term (e.g. 6 months) of systemic hormonal therapy	24
Option 3	Adjuvant radiation therapy plus long-term (e.g. 24 months) of systemic hormonal therapy	14
Option 4	Systemic hormonal therapy alone	0
Abstain	Abstain/unqualified to answer (including I do not recommend adjuvant therapy in this setting)	66

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE

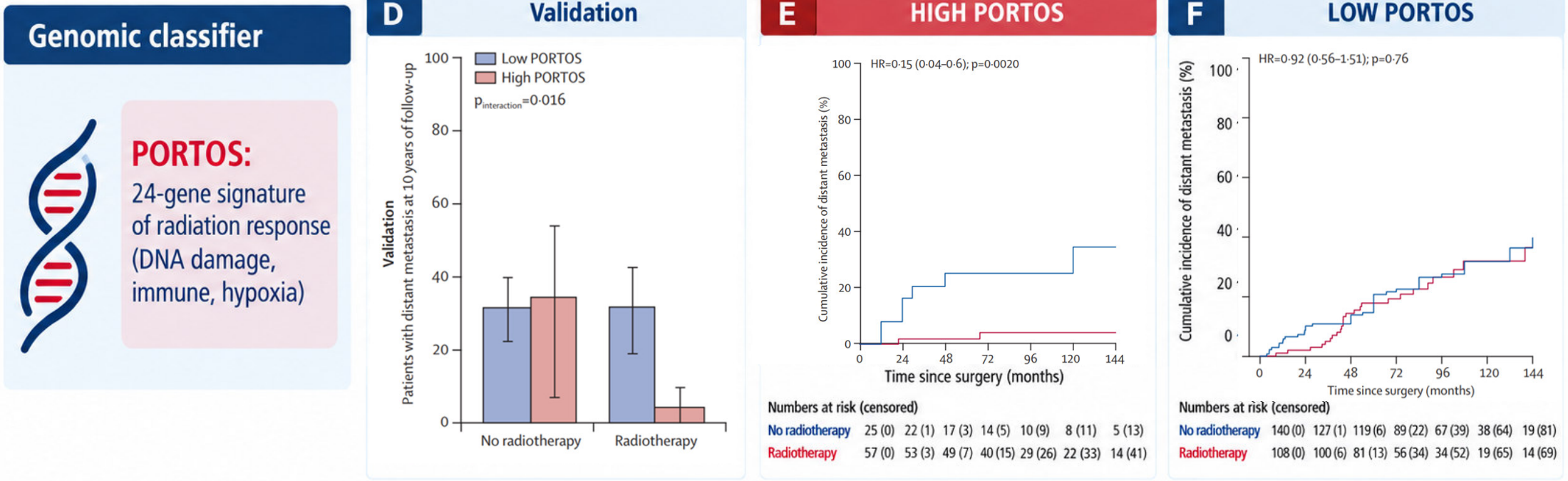
Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2026 © APC Society (apccc.org)

Consensus questions APCCC 2026

Genomic classifier: RT timing (adjuvant RT *vs* Observation)

Development and validation of a 24-gene predictor of response to postoperative radiotherapy in prostate cancer: a matched, retrospective analysis

Shuang G Zhao, S Laura Chang*, Daniel E Spratt, Nicholas Erho, Menggang Yu, Hussam Al-Deen Ashab, Mohammed Alshalalfa, Corey Speers, Scott A Tomlins, Elai Davicioni, Adam P Dicker, Peter R Carroll, Matthew R Cooperberg, Stephen J Freedland, R Jeffrey Karnes, Ashley E Ross, Edward M Schaeffer, Robert B Den, Paul L Nguyen†, Felix Y Feng†*

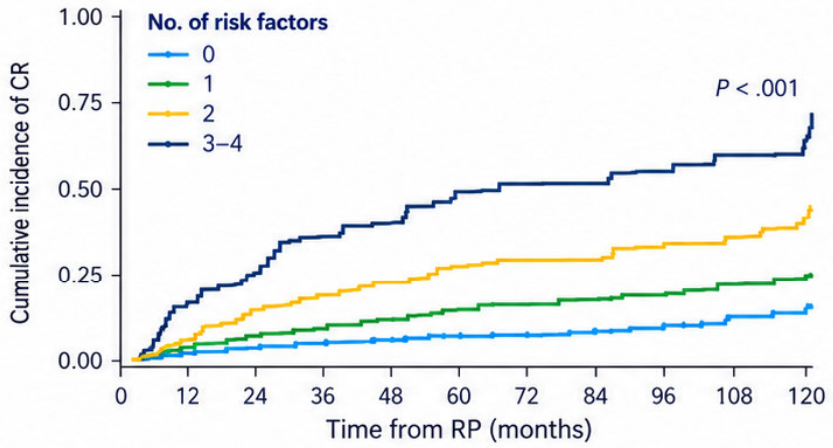


Zhao SG *et al.* Lancet Oncol 2016

Genomic classifier: RT timing (adjuvant RT *vs* Observation)

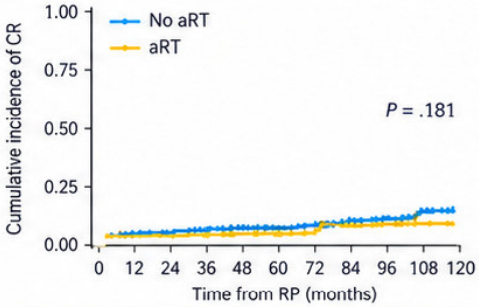
Clinical recurrence risk rises with the number of risk factors | **Risk factors:** pT3b/T4 stage • Gleason score 8–10 • pN1 • Decipher score >0.6

Cumulative incidence of clinical recurrence (CR) by number of risk factors



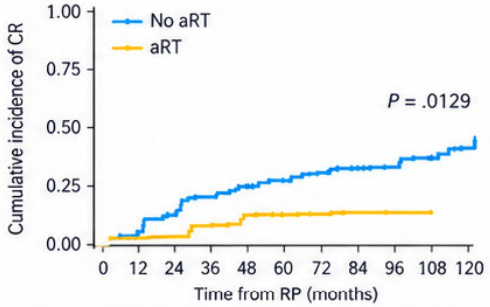
Risk factors	n (%)	CR at 60 mo (%) (95% CI)	CR at 120 mo (%) (95% CI)
0	239 (16.1)	4.8 (2.0–9.2)	7.4 (4.0–11.8)
1	482 (32.5)	9.3 (6.9–12.6)	14.4 (11.5–18.1)
2	391 (26.4)	16.4 (12.7–21.4)	27.5 (21.7–36.0)
3–4	287 (19.3)	46.4 (38.7–59.5)	67.4 (56.3–76.2)

A < 2 risk factors



No significant difference observed

B ≥ 2 risk factors



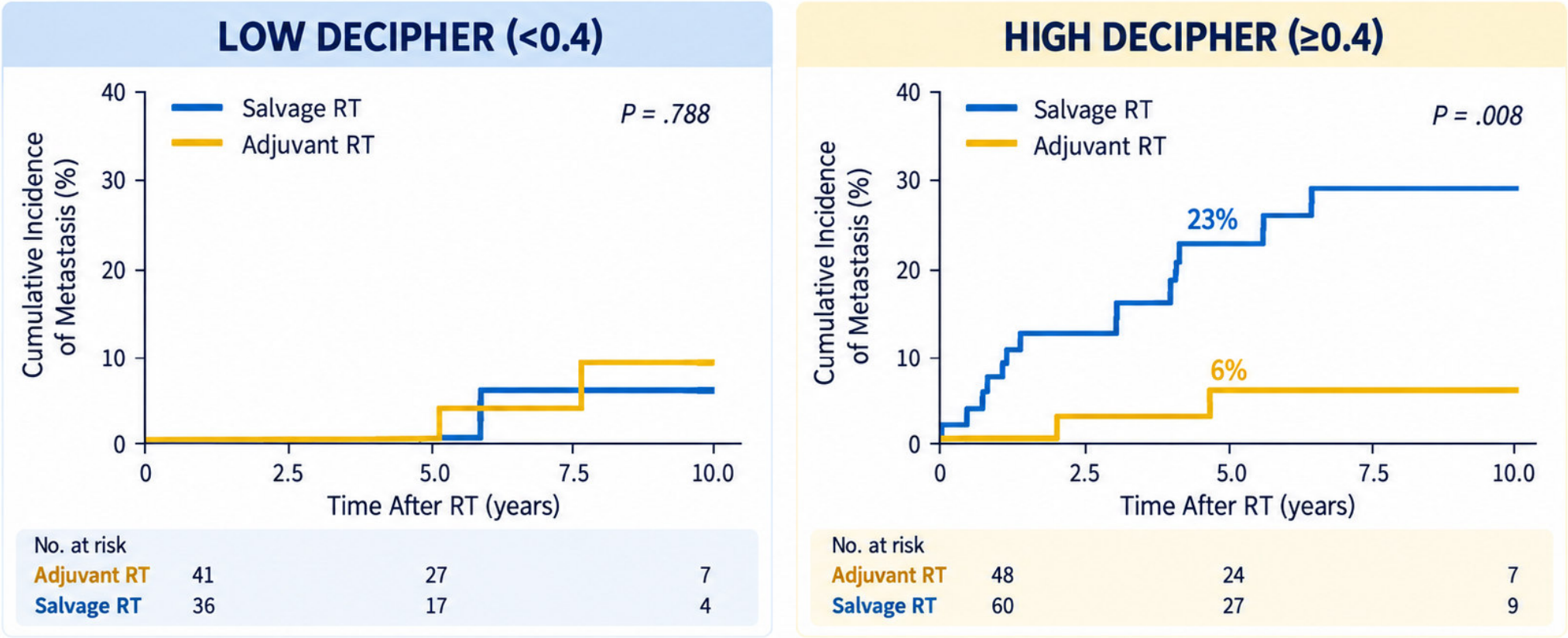
Lower clinical recurrence with aRT

Study cohort

- **512** patients treated with radical prostatectomy at 4 US academic centers (1990–2010)
- All had pT3a disease, positive surgical margins, and/or pathologic lymph-node invasion
- **21.9%** received adjuvant RT
- Median follow-up among censored patients: 8.3 years
- Multivariable Cox regression assessed predictors including Decipher score to develop a risk-stratification tool.

Dalela D *et al. J Clin Oncol.* 2017

Genomic classifier: RT timing (adjuvant RT *vs* salvage RT)



188 PCa patients with pT3 and/or R1 (96 treated with aRT; 89 with SRT)

Den *R et al.* JCO 2015

2. Optimal treatment: node positive

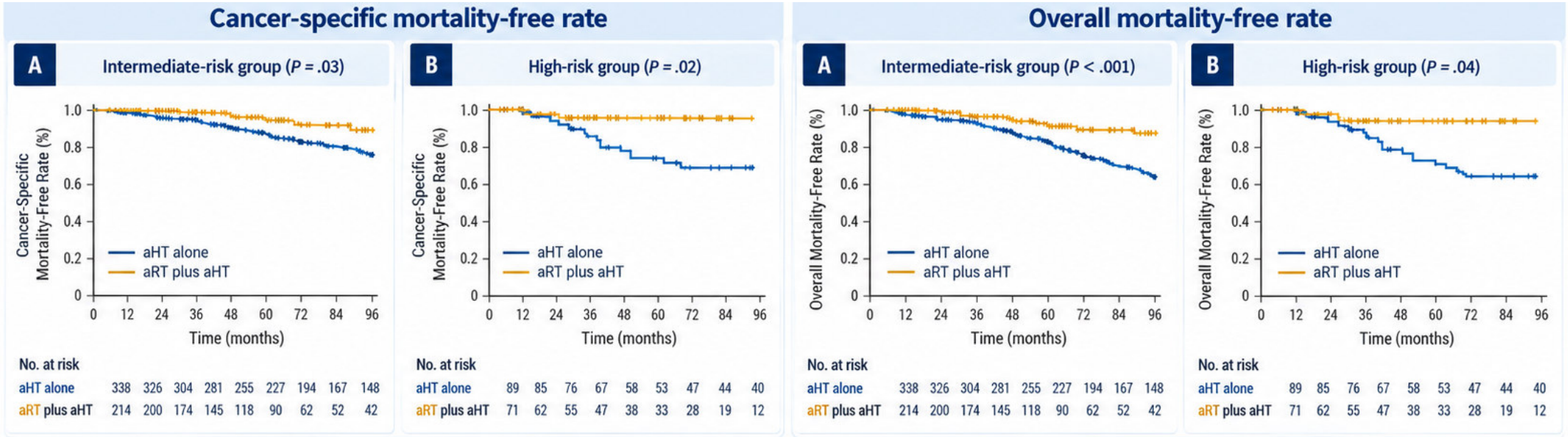
- Prostate adenocarcinoma GS 4+3, **pT3a pN1 (2/16) R1** (1 mm apex)
- 6-week PSA after RP: 0.02 ng/mL

What would you like to do?

1. Androgen deprivation (ADT)
2. Observation ± salvage radiotherapy ± ADT
3. Adjuvant radiotherapy ± ADT



Adjuvant RT *vs* ADT for pN1 disease



1,107 pN1 patients treated with RP (1988–2010); adjuvant ADT ± adjuvant RT (35%)

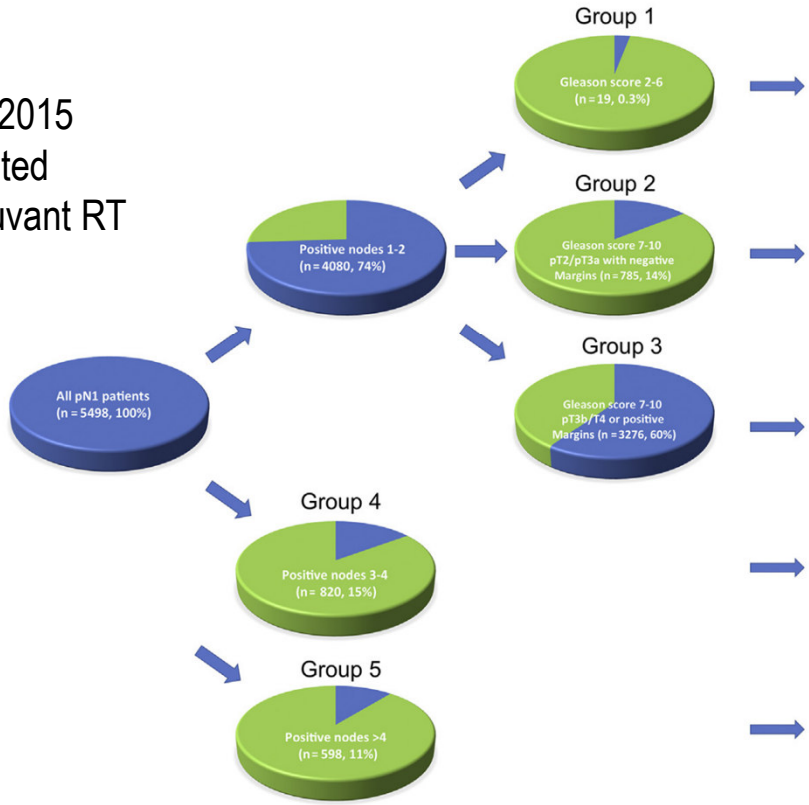
- **Intermediate-risk:** ≤ 2 PLNs, GS 7 to 10, and pT3b/pT4 stage or R1 disease
- **High-risk:** 3 to 4 PLNs

Adjuvant **RT plus ADT** compared to adjuvant ADT alone **improves CSS and OS** in men with pN1 prostate cancer

Abdollah F *et al.* JCO 2014

Adjuvant RT *vs* ADT for pN1 disease

- NCDB database 2004-2015
- 5498 pN1 PCa pts treated with ADT or ADT + adjuvant RT



8-year Overall survival in entire cohort; % (95% CI)	8-year overall survival in ADT only; % (95% CI)	8-year overall survival in aRT plus ADT; % (95% CI)	P – value
77 % (42-92)	76 % (33-94)	80 % (20-97)	0.7
80 % (75-85)	83 % (76-87)	75 % (63-84)	0.2
67 % (64-70)	64 % (60-68)	71 % (66-76)	<0.001
55 % (48-62)	49 % (40-58)	70 % (56-80)	0.003
55 % (46-64)	55 % (44-75)	56% (38-70)	0.5

pN1 (1-2 nodes)
GS 7-10
pT3b/pT4 or R1

pN1 (3-4 nodes)

Abdollah F *et al.* Eur Urol 2018

Adjuvant RT *vs* Early Salvage RT for pN1 disease

17,913 pT2c–4, **N0 or N1, M0** prostate cancer treated with RP and pelvic LN assessment

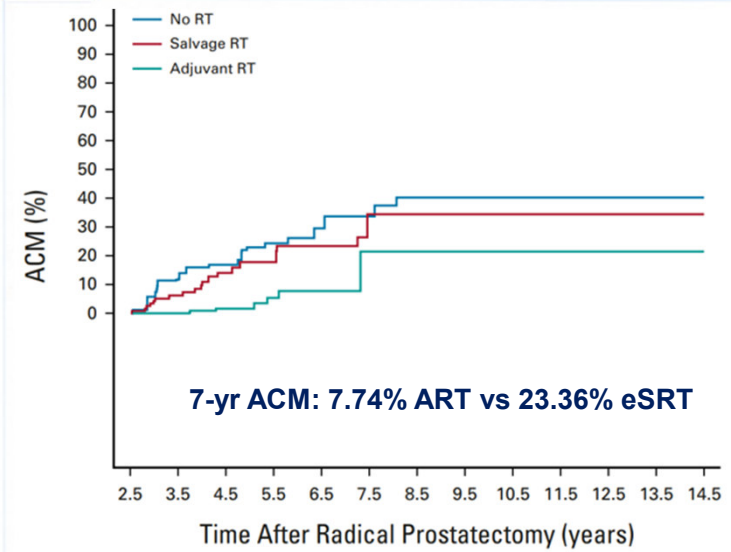
- 16,299 pN0
- 1,323 pN1 (1–3)
- 291 pN1 (≥4)

Median FU: 7.2 yr

aRT vs eSRT
ACM (all-cause mortality) reduction

HR: 0.92; 95% CI, 0.85–0.99; *P* = .03

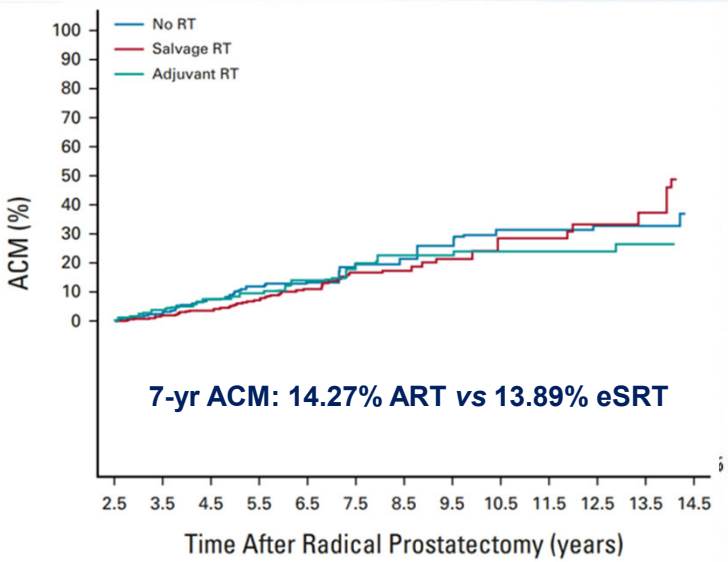
A **pN1 (≥ 4 nodes)**



No. at risk:

No RT	93	65	52	34	18	14	8	5	3	2	0	0	0
Salvage RT	112	75	43	28	19	12	7	3	1	1	1	1	1
Adjuvant RT	86	65	44	31	23	13	7	5	3	3	2	0	0

B **pN1 (1–3 nodes)**



No. at risk:

No RT	543	389	274	174	115	79	59	50	34	29	23	19	11
Salvage RT	454	400	333	255	190	116	80	52	36	29	18	12	8
Adjuvant RT	326	245	186	148	109	68	43	31	22	11	5	4	2

Adjuvant RT compared to eSRT **reduces all-cause mortality risk** in men with pN1 prostate cancer **(reduction increased by 8% with each additional positive pelvic LN)**

Tilki D et *al.* JCO 2022

The guidelines for pN1

EAU - EANM - ESTRO - ESUR - ISUP - SIOG Guidelines on

Prostate Cancer

In pN1 patients, after an extended lymph node dissection (eLND), discuss three management options, based on nodal involvement characteristics: 1. Offer adjuvant ADT. 2. Offer adjuvant ADT with additional IMRT/VMAT plus IGRT. 3. Offer observation (expectant management) to a patient after eLND and ≤ 2 nodes and an undetectable PSA.	Weak

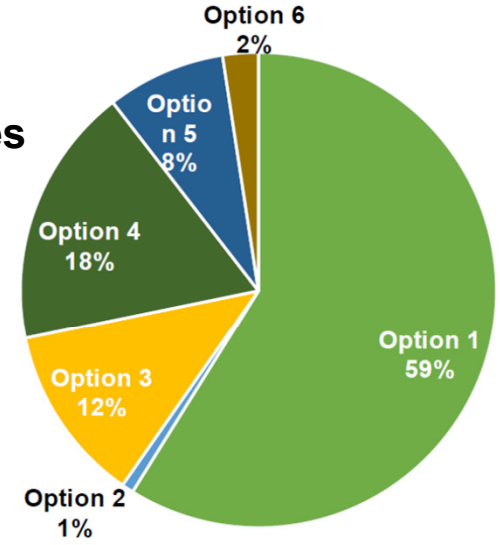
Conrford P *et al.* EAU guidelines 2026

The APCCC consensus meeting

High-risk localised and locally advanced prostate cancer

39. For the majority of patients with pT3 and 1-2 pathologically involved pelvic lymph nodes (pN1) following radical prostatectomy with extended PLND and ISUP grade group 4-5 and with undetectable postoperative PSA, what is your recommendation provided the patient has regained continence?

aRT +/- ADT in 39% of the cases



		Votes
Option 1	Monitoring and early salvage therapy (RT or systemic therapy or both) in case of a confirmed PSA rise	73
Option 2	Adjuvant radiation therapy alone	1
Option 3	Adjuvant radiation therapy plus short-term (e.g. 6 months) of systemic hormonal therapy	15
Option 4	Adjuvant radiation therapy plus long-term (e.g. 24 months) of systemic hormonal therapy	22
Option 5	Adjuvant radiation therapy plus long-term (e.g. 24 - 36 months) of ADT plus abiraterone for 24 months	10
Option 6	Systemic therapy alone	3
Abstain	Abstain/unqualified to answer	9

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE

Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2026 © APC Society (apccc.org)

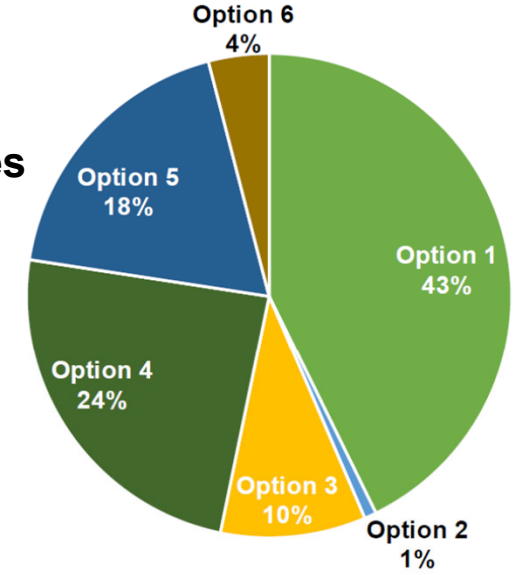
Consensus questions APCCC 2026

The APCCC consensus meeting

High-risk localised and locally advanced prostate cancer

40. For the majority of patients with pT3 and 3 or more pathologically involved pelvic lymph nodes (pN1) following radical prostatectomy with extended PLND and ISUP grade group 4-5 and with undetectable postoperative PSA, what is your recommendation provided the patient has regained continence?

aRT +/- ADT in 53% of the cases



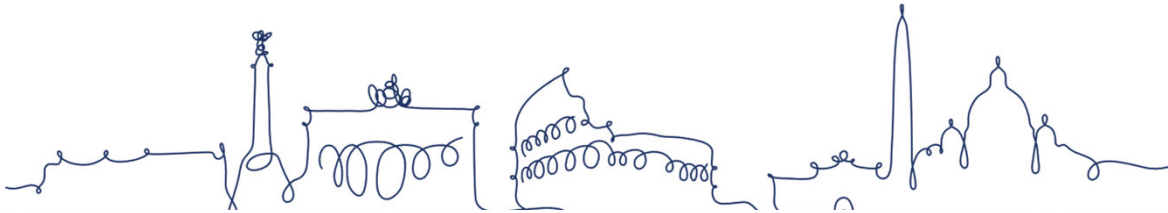
		Votes
Option 1	Monitoring and early salvage therapy (RT or systemic therapy or both) in case of a confirmed PSA rise	53
Option 2	Adjuvant radiation therapy alone	1
Option 3	Adjuvant radiation therapy plus short-term (e.g. 6 months) of systemic hormonal therapy	12
Option 4	Adjuvant radiation therapy plus long-term (e.g. 24 months) of systemic hormonal therapy	30
Option 5	Adjuvant radiation therapy plus long-term (e.g. 24 - 36 months) of ADT plus abiraterone for 24 months	23
Option 6	Systemic therapy alone	5
Abstain	Abstain/unqualified to answer	9

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE

Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2026 © APC Society (apccc.org)

Consensus questions APCCC 2026

Take home messages



1. In pN0 pts with undetectable PSA, **salvage RT** remains the **first option**, but **patient selection** is essential **(some patients can just be observed)**.
2. **Early salvage RT (PSA < 0.5 ng/mL)** provides the best outcome results.
3. **Adjuvant RT +/- ADT** may be considered in **selected patients with very high-risk features** (pT3-4, GS 8-10, pN1).
4. **Molecular imaging** and **genomic classifiers** will define the future of postoperative RT.
5. **Multidisciplinary discussion** and inclusion in **clinical trials or registries** is recommended.

Gemelli GART

MRO.ART MODERN RADIATION ONCOLOGY

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