

ORIGINAL ARTICLE

# Docetaxel and Estramustine Compared with Mitoxantrone and Prednisone for Advanced Refractory Prostate Cancer

Daniel P. Petrylak, M.D., Catherine M. Tangen, Dr.P.H., Maha H.A. Hussain, M.D., Primo N. Lara, Jr., M.D., Jeffrey A. Jones, M.D., Mary Ellen Taplin, M.D., Patrick A. Burch, M.D., Donna Berry, Ph.D., R.N., Carol Moinpour, Ph.D., Manish Kohli, M.D., Mitchell C. Benson, M.D., Eric J. Small, M.D., Derek Raghavan, M.D., Ph.D., and E. David Crawford, M.D.

## ABSTRACT

### BACKGROUND

Mitoxantrone-based chemotherapy palliates pain without extending survival in men with progressive androgen-independent prostate cancer. We compared docetaxel plus estramustine with mitoxantrone plus prednisone in men with metastatic, hormone-independent prostate cancer.

### METHODS

We randomly assigned 770 men to one of two treatments, each given in 21-day cycles: 280 mg of estramustine three times daily on days 1 through 5, 60 mg of docetaxel per square meter of body-surface area on day 2, and 60 mg of dexamethasone in three divided doses before docetaxel, or 12 mg of mitoxantrone per square meter on day 1 plus 5 mg of prednisone twice daily. The primary end point was overall survival; secondary end points were progression-free survival, objective response rates, and post-treatment declines of at least 50 percent in serum prostate-specific antigen (PSA) levels.

### RESULTS

Of 674 eligible patients, 338 were assigned to receive docetaxel and estramustine and 336 to receive mitoxantrone and prednisone. In an intention-to-treat analysis, the median overall survival was longer in the group given docetaxel and estramustine than in the group given mitoxantrone and prednisone (17.5 months vs. 15.6 months,  $P=0.02$  by the log-rank test), and the corresponding hazard ratio for death was 0.80 (95 percent confidence interval, 0.67 to 0.97). The median time to progression was 6.3 months in the group given docetaxel and estramustine and 3.2 months in the group given mitoxantrone and prednisone ( $P<0.001$  by the log-rank test). PSA declines of at least 50 percent occurred in 50 percent and 27 percent of patients, respectively ( $P<0.001$ ), and objective tumor responses were observed in 17 percent and 11 percent of patients with bidimensionally measurable disease, respectively ( $P=0.30$ ). Grade 3 or 4 neutropenic fevers ( $P=0.01$ ), nausea and vomiting ( $P<0.001$ ), and cardiovascular events ( $P=0.001$ ) were more common among patients receiving docetaxel and estramustine than among those receiving mitoxantrone and prednisone. Pain relief was similar in both groups.

### CONCLUSIONS

The improvement in median survival of nearly two months with docetaxel and estramustine, as compared with mitoxantrone and prednisone, provides support for this approach in men with metastatic, androgen-independent prostate cancer.

From Columbia University, Herbert Irving Comprehensive Cancer Center, New York (D.P.P., M.C.B.); Southwest Oncology Group Statistical Center, Seattle (C.M.T., C.M.); the University of Michigan Comprehensive Cancer Center, Ann Arbor (M.H.A.H.); the University of California, Davis, Sacramento (P.N.L.); Baylor College of Medicine, Houston (J.A.J.); the University of Massachusetts Medical Center, Worcester (M.E.T.); the Mayo Clinic, Rochester, Minn. (P.A.B.); Biobehavioral Nursing and Health Systems, University of Washington, Seattle (D.B.); the University of Arkansas for Medical Science, Little Rock (M.K.); the University of California, San Francisco, Cancer Center, San Francisco (E.J.S.); the Cleveland Clinic Foundation, Cleveland (D.R.); and the University of Colorado Health Science Center, Denver (E.D.C.). Address reprint requests to the Southwest Oncology Group (S9916) Operations Office, 14980 Omicron Dr., San Antonio, TX 78245-3217, or at pubs@swog.org.

N Engl J Med 2004;351:1513-20.

Copyright © 2004 Massachusetts Medical Society.

**M**EN WITH NEWLY DIAGNOSED METASTATIC prostate cancer have a rapid response to surgical or medical castration, with improvement in bone pain, regression of soft-tissue metastases, and a decline in serum prostate-specific antigen (PSA) levels.<sup>1</sup> Nevertheless, in virtually all patients the tumor ultimately becomes androgen-independent a median of 18 to 24 months after castration.<sup>1,2</sup> During this terminal phase in the natural history of prostate cancer, approximately 29,900 affected men in the United States will die of the disease in 2004.<sup>3</sup> Patients with metastatic androgen-independent prostate cancer have a progressive and morbid disease with a median survival of 10 to 12 months; currently, no treatment offers a survival advantage. Chemotherapy for androgen-independent prostate cancer is ineffective<sup>4</sup>: mitoxantrone plus prednisone or hydrocortisone, the current standard of care, palliates bone pain in approximately 30 percent of patients but does not improve survival.<sup>5,6</sup>

Immunohistochemical studies have demonstrated that the antiapoptotic protein Bcl-2 is increased in metastatic cells from androgen-independent prostate tissue.<sup>7</sup> Docetaxel, a taxane used to treat a variety of solid tumors, phosphorylates Bcl-2 in vitro, leading to its inactivation and to eventual cell death by apoptosis.<sup>8</sup> Estramustine,<sup>9</sup> which disrupts microtubule-associated proteins in vitro, has synergistic activity with docetaxel against human prostate-cancer cell lines.<sup>10,11</sup> Phase 1 and 2 studies of docetaxel plus estramustine in men with androgen-independent prostate cancer demonstrated a decline in serum PSA levels of at least 50 percent in 68 to 84 percent of patients, a measurable disease response in 28 to 55 percent, and a median survival of up to 23 months.<sup>11-14</sup> These data provided the foundation for this prospective, randomized, phase 3 trial (Southwest Oncology Group [SWOG] Intergroup protocol 99-16), which we conducted to determine whether docetaxel plus estramustine improves survival over that afforded by mitoxantrone plus prednisone in men with androgen-independent prostate cancer.

## METHODS

### PATIENTS

Patients were enrolled by institutions affiliated with SWOG, Cancer and Leukemia Group B, the North Central Cancer Treatment Group, the Clinical Trials

Support Unit, and the extended participation project program through the National Cancer Institute. Eligibility required pathologically confirmed adenocarcinoma of the prostate and progressive metastatic disease (stage D1 or D2) despite androgen-ablative therapy and cessation of antiandrogen treatment. Criteria for progressive disease were progression of a bidimensionally measurable lesion, as assessed within 28 days before study registration; progression of disease that could be evaluated but not measured (e.g., by bone scanning), as assessed within 42 days before registration; or an increase in the serum PSA level over the baseline level in at least two consecutive samples obtained at least 7 days apart.<sup>15</sup> Antiandrogen therapy was discontinued before registration, at least six weeks before in the case of nilutamide or bicalutamide and four weeks before in the case of flutamide or other secondary hormonal therapy. To ensure continued androgen ablation, patients continued taking luteinizing-hormone-releasing hormone agonists throughout study treatment. Patients were required to discontinue bisphosphonates at least 28 days before registration. Prior radiotherapy (to less than 30 percent of the bone marrow only) or one prior systemic therapy (except with estramustine, taxanes, anthracyclines, or mitoxantrone) was permitted if at least four weeks had elapsed since the completion of that therapy. Adequate renal, hepatic, and cardiac function and a SWOG performance-status score of 0 to 2 (a performance status of 3 was allowed if the score was due to bone pain) were also required. Patients were ineligible if they had received prior radioisotope or anticoagulant therapy (excluding aspirin), had active thrombophlebitis or hypercoagulability, had a history of pulmonary embolus, or pleural effusions or ascites.

### STRATIFICATION

Patients were classified at registration according to the following factors: type of progression (i.e., progression of disease that could be measured or evaluated vs. increasing PSA level alone), grade of bone pain according to the Common Terminology Criteria of the National Cancer Institute (grade 1 [mild, not interfering with function] vs. grade 2 [moderate pain interfering with function but not interfering with the activities of daily life], grade 3 [severe pain, severely interfering with the activities of daily living], or grade 4 [disabling pain]), and SWOG performance-status score (0 or 1 vs. 2 or

3).<sup>16</sup> All patients provided written informed consent, and the study was approved by the institutional review board of each participating institution.

#### TREATMENT

Patients were randomly assigned to one of two treatments, each given in 21-day cycles: 280 mg of estramustine (Emcyt, Pfizer) three times daily one hour before or two hours after meals on days 1 through 5 plus 60 mg of docetaxel (Taxotere, Aventis) per square meter of body-surface area intravenously on day 2, preceded by 60 mg of dexamethasone orally in three divided doses, starting the night before docetaxel, or 12 mg of mitoxantrone (Novantrone, OSI) per square meter intravenously on day 1 plus 5 mg of prednisone twice daily. Doses of docetaxel and mitoxantrone were increased to 70 mg per square meter and 14 mg per square meter, respectively, if no grade 3 or 4 adverse events were observed during the first cycle. A report that prophylactic anticoagulation decreased estramustine-associated vascular effects prompted an amendment of the protocol on January 15, 2001, to include daily warfarin (2 mg) plus aspirin (325 mg) in the group assigned to receive estramustine.<sup>16</sup> Treatment continued until disease progression or unacceptable adverse effects occurred or until a maximum of 12 cycles of docetaxel and estramustine or 144 mg of mitoxantrone per square meter had been administered.

#### EVALUATION

The pretreatment evaluation included a history taking, a physical examination in which weight and performance status were recorded, computed tomography (CT) of the abdomen and pelvis, bone scanning, nuclear ventriculography (multiple gated acquisition [MUGA] scanning), a complete blood count, and measurement of serum PSA, serum creatinine, and serum testosterone. MUGA scans were repeated every four cycles among patients in the group given mitoxantrone and prednisone. At every cycle, the pretreatment evaluation was repeated (excluding MUGA scanning, measurement of serum testosterone, and baseline imaging studies). Adverse events were evaluated by means of the Common Toxicity Criteria of the National Cancer Institute, version 2.0. Imaging studies were repeated every six cycles; if positive, they were repeated every three cycles.

Objective responses were defined on the basis

of the sum of bidimensional measurements of metastatic lesions. Confirmed objective responses required a follow-up scan (a minimum of four weeks later) that demonstrated a continued response. Progression was defined by one of the following: a 50 percent increase or an increase of 10 cm<sup>2</sup>, whichever was smaller, in the sum of measurements of metastatic lesions over the sum at baseline; a clear worsening of nonmeasurable disease; reappearance of any lesion that had disappeared; appearance of any new lesion; or death.

A confirmed partial response of nonmeasurable disease was defined as a reduction by more than 50 percent over baseline in two or more PSA measurements obtained at least four weeks apart, with no evidence of disease progression on imaging. Progressive disease was defined as a 25 percent increase in the serum PSA level — to at least 5 ng per milliliter — over the last preregistration measurement, with confirmation of the increase at least four weeks later. For patients with a decrease in serum PSA levels during the trial, progressive disease was defined as a confirmed increase of 25 percent, to at least 5 ng per milliliter over the nadir.<sup>14</sup>

#### STATISTICAL ANALYSIS

The primary objective of the study was to compare overall survival in the two groups. Assuming an exponential distribution of survival times, 3.5 years for accrual, an additional year of follow-up, and a sample size of 310 patients per group, this study had a statistical power of 0.80 to detect an improvement of 33 percent in median survival in the group given docetaxel and estramustine, as compared with the group given mitoxantrone and prednisone, with the use of a one-sided log-rank test at a P value of 0.025. Interim analyses were to be conducted when half the patients had been enrolled and again when enrollment was complete. The null and alternative hypotheses were to be tested at a one-sided P level of 0.0025 at each analysis. The significance level for the final analysis, performed one year after study closure, was specified as a one-sided P value of 0.02. However, in accordance with the policy of the *Journal*, only two-sided P values are reported. Secondary end points included progression-free survival, the objective-response rate, the rate of PSA response (defined as a decline in the serum PSA level of at least 50 percent), and adverse events. The data set was locked and analyzed on March 9, 2004.

Kaplan–Meier curves were used to estimate rates

of overall survival and progression-free survival. Survival was defined from the date of randomization to the date of death from any cause or censored at the date of last contact. Progression-free survival was defined as the time from randomization to the first occurrence of objective or PSA progression or death from any cause. The general chi-square test was used to compare rates of response (objective and PSA) and adverse events between the two treatment groups. All analyses were performed with the use of SAS software, version 9.0.

The study was designed by the Genitourinary

Committee of SWOG and was approved by the Cancer Treatment and Evaluation Program of the National Cancer Institute. The SWOG Statistical Center received funding from Aventis Pharmaceuticals for the additional cost of collecting data on the quality of life. Aventis was allowed to review the protocol and make comments before enrollment began. Aventis had no access to the data but received a semiannual summary of enrollment and adverse events.

## RESULTS

### CHARACTERISTICS OF THE PATIENTS

A total of 770 patients were enrolled between October 1999 and January 2003. Ninety-six patients (12 percent) were found to be ineligible: 30 owing to the lack of adequate withdrawal of antiandrogen or other hormonal therapy, 11 because of missing documentation, 31 because of inadequate baseline laboratory studies, 17 because of rising PSA levels without evidence of metastatic disease, and 7 for miscellaneous reasons. The baseline characteristics of the 674 eligible patients in both treatment groups were similar (Table 1). The sole evidence of disease progression was a rising PSA level in 18 percent of patients.

### TREATMENT

There were 11 major protocol deviations. Six patients in the group given docetaxel and estramustine and four patients in the group given mitoxantrone and prednisone did not receive the assigned treatment and were not included in the evaluation of adverse events. One patient in the latter group who received intermittent radiotherapy while receiving the assigned treatment, a major protocol deviation, was included in the evaluation of adverse events. Six patients who discontinued treatment within one week after starting mitoxantrone and prednisone (four men) or docetaxel and estramustine (two men) were not included in the evaluation of adverse events; however, in the case of all these men, the reported results and statistical analyses are based on the treatment group to which the patients were assigned.

### RESPONSE AND SURVIVAL

During a median follow-up of 32 months, 217 of the 338 patients in the group given docetaxel and estramustine died (64 percent), as did 235 of the 336 patients in the group given mitoxantrone and

**Table 1. Baseline Characteristics of the Patients.**

Characteristic	Docetaxel and Estramustine	Mitoxantrone and Prednisone
No. randomized	386	384
No. eligible	338	336
Age (yr)		
Median	70	70
Range	47–88	43–87
Race or ethnic group (%)*		
White	86	82
Black	12	15
Hispanic	7	6
Asian	1	1
Unknown	1	1
SWOG performance-status score (%)		
0 or 1	90	88
2 or 3	10	12
Type of progression (%)		
Measurable or able to be evaluated	81	82
Increased PSA only	19	18
PSA (ng/ml)		
Median	84	90
Range	0.1–10,820	0.1–8378
Sites of disease (%) *		
Bone	84	88
Soft tissue		
Lymph node	24	26
Liver	8	9
Lung	10	10
Bone pain (%)		
Grade <2	64	64
Grade ≥2	36	36

\* Patients could be included in more than one category. Race or ethnic group was self-reported.

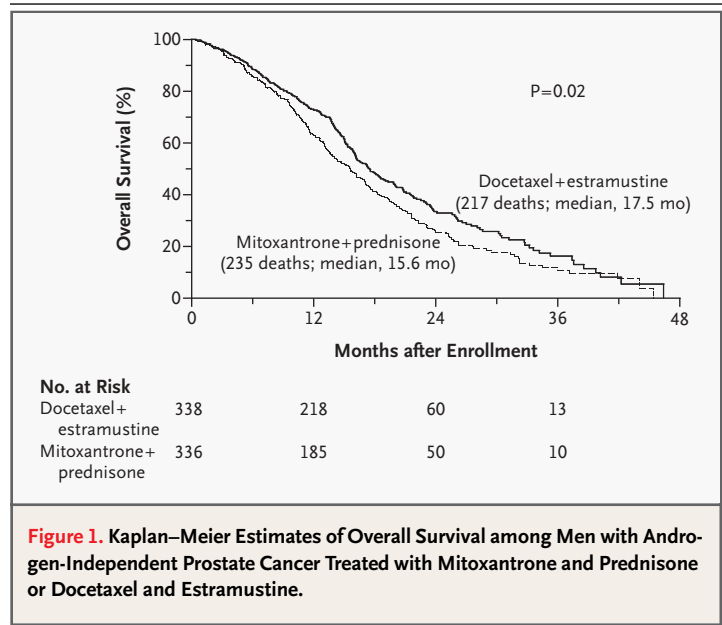
prednisone (70 percent). According to the intention-to-treat analysis, the median survival was 17.5 months among the patients assigned to docetaxel and estramustine and 15.6 months among the patients assigned to mitoxantrone and prednisone ( $P=0.02$ ) (Fig. 1); the corresponding hazard ratio for death was 0.80 (95 percent confidence interval, 0.67 to 0.97). The median time to progression was 6.3 months in the group given docetaxel and estramustine and 3.2 months in the group given mitoxantrone and prednisone ( $P<0.001$ ) (Fig. 2).

Declines in serum PSA levels of at least 50 percent occurred more frequently after treatment with docetaxel and estramustine (155 of 309 patients, or 50 percent) than after treatment with mitoxantrone and prednisone (82 of 303 patients, or 27 percent;  $P<0.001$ ). A partial response in measurable disease occurred in 17 percent of patients in the group given docetaxel and estramustine (17 of 103, 4 unconfirmed) and 11 percent of patients in the group given mitoxantrone and prednisone (10 of 93, 4 unconfirmed). This difference was not significant ( $P=0.30$ ). Patients with an inadequate assessment were assumed to have had no response. There was no significant difference in pain relief, as reported by the patients, between the two groups (data not shown).

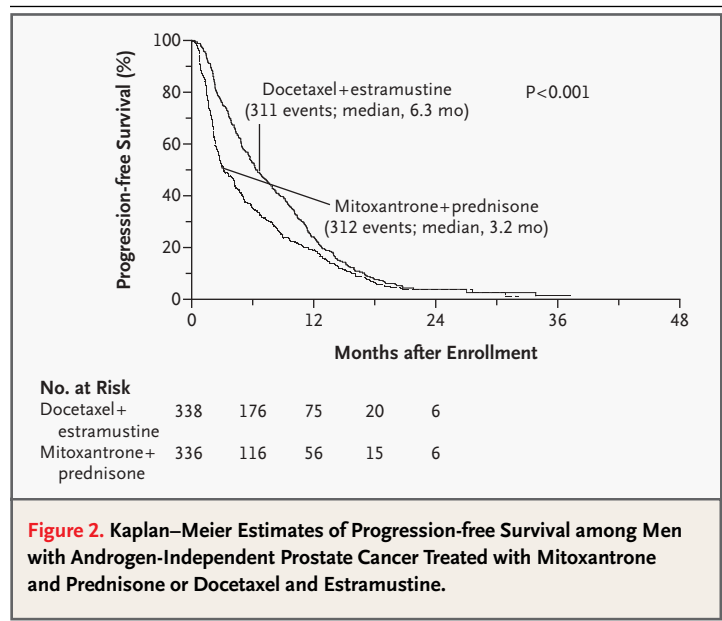
**ADVERSE EVENTS**

As of December 2003, all surviving patients had stopped the protocol treatment. Adverse events led to the withdrawal of 54 patients in the group assigned to docetaxel and estramustine (16 percent) and 32 patients in the group assigned to mitoxantrone and prednisone (10 percent). The rates of severe or life-threatening (grade 3 or 4) and fatal (grade 5) adverse events are summarized in Table 2. The rate of grade 3, 4, or 5 neutropenia in the group given mitoxantrone and prednisone did not differ significantly from that in the group given docetaxel and estramustine (12.5 percent vs. 16.1 percent,  $P=0.22$ ). As compared with the group given mitoxantrone and prednisone, the group given docetaxel and estramustine had significantly higher rates of grade 3 or 4 neutropenic fevers (5 percent vs. 2 percent,  $P=0.01$ ), cardiovascular events (15 percent vs. 7 percent,  $P=0.001$ ), nausea and vomiting (20 percent vs. 5 percent,  $P<0.001$ ), metabolic disturbances (6 percent vs. 1 percent,  $P<0.001$ ), and neurologic events (7 percent vs. 2 percent,  $P=0.001$ ). There were eight treatment-related deaths in the group given docetaxel and estramustine: three are still

under review, a fourth was due to gastrointestinal bleeding thought to be due to aspirin, a fifth was caused by sepsis arising from necrotic prostate tissue, a sixth (due to liver and renal failure, atrial fibrillation, and pulmonary edema) occurred within a week after treatment was started, a seventh was associated with granulocytopenia and neutropenia, and the eighth was caused by a respiratory tract in-



**Figure 1. Kaplan–Meier Estimates of Overall Survival among Men with Androgen-Independent Prostate Cancer Treated with Mitoxantrone and Prednisone or Docetaxel and Estramustine.**



**Figure 2. Kaplan–Meier Estimates of Progression-free Survival among Men with Androgen-Independent Prostate Cancer Treated with Mitoxantrone and Prednisone or Docetaxel and Estramustine.**

fection. Four patients had grade 5 adverse events attributed to mitoxantrone and prednisone. Three died within 30 days of receiving protocol treatment, and another died from a respiratory tract infection and grade 4 anorexia. Vascular complications and their relationship to prophylactic warfarin treatment in the group given docetaxel and estramustine are shown in Table 3; these findings are observational and were not part of the planned primary analysis.

## DISCUSSION

This randomized trial demonstrated that the treatment of androgen-independent metastatic prostate cancer with estramustine and docetaxel results in a longer median survival than treatment with mitoxantrone and prednisone (17.5 months vs. 15.6 months,  $P=0.02$ ). The hazard ratios for death

(0.80 and 0.76, respectively) and median survival rates (17.5 months and 18.9 months, respectively) were similar in our docetaxel group and the group given docetaxel every three weeks in the study reported by Tannock et al.<sup>17</sup> elsewhere in this issue of the *Journal*. Although we did not meet our primary aim of detecting a 33 percent improvement in median survival with estramustine and docetaxel, this trial had reasonable power to detect smaller differences in survival. Relative to mitoxantrone and prednisone, docetaxel and estramustine reduced the mortality rate by 20 percent (95 percent confidence interval, 3 to 33 percent). The rates of reduced PSA levels and progression-free survival were significantly higher in the group given docetaxel and estramustine than in the group given mitoxantrone and prednisone. The survival estimate of the group given estramustine and docetaxel in our trial fell

**Table 2. Adverse Events.**

Type or Site of Adverse Event	Docetaxel and Estramustine (N=330)			Mitoxantrone and Prednisone (N=328)			P Value*
	Grade 3	Grade 4	Grade 5	Grade 3	Grade 4	Grade 5	
	<i>number of patients</i>						
Drug reaction	0	0	3	0	0	3	1.00
Cardiovascular	37	10	1	16	6	0	0.001
Clotting	2	0	0	0	0	0	0.50
Dermatologic	1	0	0	1	0	0	1.00
Endocrine	0	0	0	1	0	0	0.50
Influenza-like symptoms	29	3	0	20	2	0	0.20
Nausea and vomiting	61	5	0	16	1	0	<0.001
Hematologic	17	47	1	18	33	0	0.18
Hemorrhage	11	2	1	6	0	0	0.11
Immunologic	3	0	0	0	0	0	0.25
Infection	36	7	2	20	2	0	0.004
Liver	9	1	1	11	1	0	0.84
Lung	12	2	1	8	1	1	0.42
Metabolic	14	6	0	2	0	0	<0.001
Musculoskeletal	8	0	0	1	2	0	0.22
Neurologic	21	2	0	5	0	0	0.001
Pain	34	1	0	18	5	0	0.13
Renal or bladder	8	0	1	3	0	0	0.14
Maximal grade of any adverse event†	114	62	8	63	46	4	<0.001

\* P values were calculated by means of a two-sided Fisher's exact test and are for the comparison of the percentage of patients in each treatment group with grade 3 or 4 adverse events with the percentage of patients with grade 1 or 2 adverse events; there was no adjustment for multiple comparisons.

† The maximal grade of adverse event was 0, 1, or 2 in 146 patients in the group given docetaxel and estramustine and 215 patients in the group given mitoxantrone and prednisone.

within the confidence intervals of smaller phase 1 and 2 studies of this combination.<sup>11-14</sup>

The median survival of 15.6 months among patients treated with mitoxantrone and prednisone is longer than that reported by Tannock et al. (12 months),<sup>5</sup> Kantoff et al. (12.3 months),<sup>6</sup> or Ernst et al. (11.5 months).<sup>18</sup> The median survival was similar to that reported in the current study by Tannock et al. (16.5 months). This difference may be due in part to the use of different eligibility criteria, in particular the requirement for symptomatic disease in the studies by Tannock et al. and Ernst et al. In contrast, in a randomized trial of 101 asymptomatic men with a rising serum PSA level, Berry et al. found a nonsignificant 4-month difference in median survival: 23 months among men treated with mitoxantrone and prednisone, as compared with 19 months among men treated with prednisone alone.<sup>19</sup> In our trial, 18 percent of patients had an increase in PSA but were asymptomatic with metastatic disease. The median PSA level at entry (87 ng per milliliter) was somewhat lower than in the studies by Kantoff et al. (150 ng per milliliter),<sup>6</sup> Tannock et al. (158 ng per milliliter),<sup>5</sup> and Ernst et al. (150 ng per milliliter),<sup>18</sup> but pretreatment PSA levels do not predict survival in this patient population, although they probably reflect tumor burden.

Crossover treatment may also partially account for the small difference in survival between the two

treatment groups. Of all the patients we treated, about half received at least one other antineoplastic regimen after having had no response to the assigned treatment. It is difficult to judge the effect of these additional treatments on overall survival, because multiple variables influence response and survival after crossover treatment.

Continuous corticosteroid treatment can reduce serum PSA levels by at least 50 percent in 20 to 74 percent of men with hormone-refractory prostate cancer,<sup>20</sup> but the regimen of premedication with dexamethasone (60 mg every three weeks) that we used is unlikely to have affected the results. In a phase 2 study, the same dose and schedule of dexamethasone that we used were employed until the serum PSA level rose at least 25 percent over baseline levels or clinical progression occurred, at which point docetaxel and estramustine were given. None of the patients treated with dexamethasone had a decline in PSA of at least 50 percent (the level actually increased by a median of 47 percent). After progression during dexamethasone therapy, 92 percent of patients treated with docetaxel and estramustine had a decline in serum PSA levels of at least 50 percent.<sup>21</sup>

In phase 2 studies, estramustine was associated with an increased risk of nausea, thromboembolic events, and cardiovascular events.<sup>11-14,22</sup> In our trial, cardiovascular and gastrointestinal events were

**Table 3. Adverse Events among Patients Receiving Docetaxel and Estramustine, According to Whether They Were Receiving Prophylactic Anticoagulation.**

Adverse Event	No Anticoagulation (N=111)			Prophylactic Anticoagulation (N=218)		
	Grade 3	Grade 4	Grade 5	Grade 3	Grade 4	Grade 5
	<i>number of patients (percent)</i>					
Abnormal troponin T level	0	1 (1)	0	0	0	0
Cardiac ischemia or myocardial infarction	3 (3)	2 (2)	0	0	1 (1)	0
Cardiovascular accident	1 (1)	0	0	0	2 (1)	0
Thrombosis or embolism	3 (3)	3 (3)	0	0	8 (4)	0
Epistaxis	0	0	0	0	0	0
Melena or gastrointestinal bleeding	4 (4)	1 (1)	1 (1)	0	1 (1)	0
Hematochezia	0	0	0	0	1 (1)	0
Hematemesis	0	1 (1)	0	0	0	0
Hemoptysis	0	0	0	0	0	0
Hematuria	2 (2)	0	0	3 (1)	0	0
Increase in partial-thromboplastin time	0	0	0	2 (1)	0	0
Increase in prothrombin time	0	0	0	1 (1)	0	0

more frequent among patients given docetaxel and estramustine than among those given mitoxantrone and prednisone. However, this difference was not associated with an increased rate of treatment-related deaths or discontinuation of treatment in the former group.

In conclusion, treatment with estramustine and docetaxel moderately increases survival at the cost of an increased rate of adverse events. These factors must be balanced when one is considering the use of docetaxel and estramustine as first-line therapy for men with metastatic androgen-independent prostate cancer.

Supported in part by grants (CA38926, CA32102, CA37135, CA25224, CA46441, CA37981, CA45808, CA27057, CA12644,

CA68183, CA22433, CA35261, CA58861, CA20319, CA46113, CA58882, CA76447, CA04919, CA16385, CA35090, CA03096, CA67663, CA45450, CA35431, CA45807, CA58416, CA14028, CA45377, CA63845, CA42777, CA46136, CA11083, CA35119, CA58658, CA46282, CA76129, CA46368, CA35176, CA86780, CA46462, CA35192, CA35178, CA67575, CA63844, CA12213, CA74647, CA35128, CA35996, CA58686, CA13612, CA45461, CA58723, CA63848, CA35281, CA63850, CA76132, and CA74811) from the National Cancer Institute, Department of Health and Human Services, and by Aventis.

Drs. Petrylak and Taplin report having received grant support, lecture fees, and consulting fees from Aventis; Dr. Hussain consulting fees and lecture fees from and having equity in Aventis; Dr. Lara lecture fees from Aventis and AstraZeneca; Dr. Benson lecture fees from Aventis; Drs. Small and Raghavan consulting fees from Aventis; Dr. Crawford consulting fees and lecture fees from Aventis; and Dr. Moinpour consulting fees from AstraZeneca.

We are indebted to Dr. Robert Fine and Dr. Karen Antman for helpful comments during the preparation of this manuscript.

## REFERENCES

- Crawford ED, Eisenberger MA, McLeod DG, et al. A controlled trial of leuprolide with and without flutamide in prostatic carcinoma. *N Engl J Med* 1989;321:419-24. [Erratum, *N Engl J Med* 1989;321:1420.]
- Eisenberger MA, Blumenstein BA, Crawford ED, et al. Bilateral orchiectomy with or without flutamide for metastatic prostate cancer. *N Engl J Med* 1998;339:1036-42.
- Jemal A, Tiwari RC, Murray T, et al. Cancer statistics, 2004. *CA Cancer J Clin* 2004; 54:8-29.
- Yagoda A, Petrylak D. Cytotoxic chemotherapy for advanced hormone-resistant prostate cancer. *Cancer* 1993;71:1098-109.
- Tannock IF, Osoba D, Stockler MR, et al. Chemotherapy with mitoxantrone plus prednisone or prednisone alone for symptomatic hormone-resistant prostate cancer: a Canadian randomized trial with palliative end points. *J Clin Oncol* 1996;14:1756-64.
- Kantoff PW, Halabi S, Conaway M, et al. Hydrocortisone with or without mitoxantrone in men with hormone-refractory prostate cancer: results of the Cancer and Leukemia Group B 9182 study. *J Clin Oncol* 1999; 17:2506-13.
- McDonnell TJ, Navone NM, Troncoso P, et al. Expression of bcl-2 oncoprotein and p53 protein accumulation in bone marrow metastases of androgen independent prostate cancer. *J Urol* 1997;157:569-74.
- Haldar S, Chintapalli J, Croce CM. Taxol induces bcl-2 phosphorylation and death of prostate cancer cells. *Cancer Res* 1996;56: 1253-5.
- Benson R, Hartley-Asp B. Mechanisms of action and clinical uses of estramustine. *Cancer Invest* 1990;8:375-80.
- Kreis W, Budman DR, Calabro A. Unique synergism or antagonism of combinations of chemotherapeutic and hormonal agents in human prostate cancer cell lines. *Br J Urol* 1997;79:196-202.
- Petrylak DP, Macarthur R, O'Connor J, et al. Phase I/II studies of docetaxel (Taxotere) combined with estramustine in men with hormone-refractory prostate cancer. *Semin Oncol* 1999;26:Suppl 17:28-33.
- Savarese DM, Halabi S, Hars V, et al. Phase II study of docetaxel, estramustine, and low-dose hydrocortisone in men with hormone-refractory prostate cancer: a final report of CALGB 9780. *J Clin Oncol* 2001; 19:2509-16.
- Kreis W, Budman D. Daily oral estramustine and intermittent intravenous docetaxel (Taxotere) as chemotherapeutic treatment for metastatic, hormone-refractory prostate cancer. *Semin Oncol* 1999;26:Suppl 17:34-8.
- Petrylak DP, Macarthur RB, O'Connor J, et al. Phase I trial of docetaxel with estramustine in androgen-independent prostate cancer. *J Clin Oncol* 1999;17:958-67.
- Bubley GJ, Carducci M, Dahut W, et al. Eligibility and response guidelines for phase II clinical trials in androgen-independent prostate cancer: recommendations from the Prostate-Specific Antigen Working Group. *J Clin Oncol* 1999;17:3461-7. [Erratum, *J Clin Oncol* 2000;18:2644.]
- Sinibaldi VJ, Carducci MA, Moore-Cooper S, Laufer M, Zahurak M, Eisenberger MA. Phase II evaluation of docetaxel plus one-day oral estramustine phosphate in the treatment of patients with androgen independent prostate carcinoma. *Cancer* 2002; 94:1457-65.
- Tannock IF, de Wit R, Berry WR, et al. Docetaxel plus prednisone or mitoxantrone plus prednisone for advanced prostate cancer. *N Engl J Med* 2004;351:1502-12.
- Ernst DS, Tannock IF, Winquist EW, et al. Randomized, double-blind, controlled trial of mitoxantrone/prednisone and clodronate versus mitoxantrone/prednisone and placebo in patients with hormone-refractory prostate cancer and pain. *J Clin Oncol* 2003;21:3335-42.
- Berry W, Dakhil S, Modiano M, Gregurich M, Asmar L. Phase III study of mitoxantrone plus low dose prednisone versus low dose prednisone alone in patients with asymptomatic hormone refractory prostate cancer. *J Urol* 2002;168:2439-43.
- Fakih M, Johnson CS, Trump DL. Glucocorticoids and treatment of prostate cancer: a preclinical and clinical review. *Urology* 2002;60:553-61.
- Weitzman AL, Shelton G, Zuech N, et al. Dexamethasone does not significantly contribute to the response rate of docetaxel and estramustine in androgen independent prostate cancer. *J Urol* 2000;163:834-7.
- Hudes G, Einhorn L, Ross E, et al. Vinblastine versus vinblastine plus oral estramustine phosphate for patients with hormone-refractory prostate cancer: a Hoosier Oncology Group and Fox Chase Network phase III trial. *J Clin Oncol* 1999;17:3160-6.

Copyright © 2004 Massachusetts Medical Society.