Motexafin Lutetium-Photodynamic Therapy of Prostate Cancer: Short- and Long-Term Effects on Prostate-Specific Antigen

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Abstract Purpose: The time course of serum prostate-specific antigen (PSA) response to photodynamic therapy (PDT) of prostate cancer was measured. Experimental Design: Seventeen patients were treated in a phase I trial of motexafin lutetium-PDT. PDT dose was calculated in each patient as the product of the ex vivo measured pre-PDT photosensitizer level and the in situ measured light dose. Serum PSA level was measured within 2 months before PDT (baseline), and at day 1; weeks 1 to 3; months 1, 2, and 3; months 4 to 6; and months 7 to 11 after PDT. Results: At 24 hours after PDT, serum PSA increased by 98% ± 36% (mean ± SE) relative to baseline levels (P = 0.007). When patients were dichotomized based on median PDT dose, those who received high PDT dose showed a 119% ± 52% increase in PSA compared with a 54% ± 27% increase in patients treated at low PDT dose. Patients treated with high versus low PDT dose showed a median biochemical delay of 82 versus 43 days (P = 0.024), with biochemical delay defined as the length of time between PDT and a nonreversible increase in PSA to a value greater than or equal to baseline. Conclusions: Results show PDT to induce large, transient increases in serum PSA levels. Patients who experienced high PDT dose showed greater short-term increase in PSA and a significantly more durable PSA response (biochemical delay). These data strongly promote the need for individualized delivery of PDT dose and assessment of treatment effect in PDT of prostate cancer. Information gained from such patient-specific measurements could facilitate the introduction of multiple PDT sessions in patients who would benefit.

Prostate cancer is the most frequently diagnosed cancer in men in the United States and the second leading cause of cancer deaths in men (1). Prostate cancer is a multifocal disease, and control requires treatment of the entire gland (2). Since the introduction of prostate-specific antigen (PSA) monitoring as a screening tool, more patients are diagnosed at early stage of disease. Standard therapy options for local control of prostate cancer include radiation therapy by brachytherapy or external beam radiation, prostatectomy, and androgen deprivation. Unfortunately, treatment of patients with local recurrence after radiation therapy is challenging (3). Surgery after radiation therapy is limited by significant morbidity with high incidence of urinary incontinence, rectal injury, and impotence due to postradiation fibrosis (4, 5). Androgen deprivation therapy is not curative and is poorly tolerated (3). New treatment approaches are needed for patients with locally recurrent prostatic disease.

Photodynamic therapy (PDT) involves the administration of photosensitizer followed by local activation of this drug with specific wavelengths of light. The activated photosensitizer leads to the formation of reactive oxygen species, which will damage tumor or normal cells located at the site of its production (6, 7). PDT is Food and Drug Administration approved for superficial and obstructing non–small cell lung cancer, obstructing esophageal cancer, and Barrett’s esophagus with high-grade dysplasia. It has been investigated for treatment of locally recurrent prostate cancer after radiation therapy (2, 6, 8–12), and trials of Tookad-mediated PDT for prostate cancer are currently open in Canada4 and in the United Kingdom.5 One of the largest advantages that PDT offers to the treatment of prostate cancer is that it can typically be used to treat tissues already exposed to a maximal dose of radiation therapy (10). Moreover, PDT itself can be repeated several times if necessary (10).

In our recently closed phase I clinical trial of motexafin lutetium (MLu) PDT for prostate cancer, we treated patients (n = 17) who experienced locally recurrent disease after radiation therapy (13). Patients were treated with increasing doses of MLu (0.5-2 mg/kg), decreasing time interval to light delivery (3-24 hours), and increasing light fluence (25-150 J/cm²). Light was delivered to a prescribed dose that was directly measured within the gland by interstitially inserted isotropic detectors. Illumination of the entire prostate was accomplished by using a brachytherapy template to position the interstitially placed treatment fibers 1 cm apart. This distance was chosen based on studies of canine prostate, which found fiber spacing at distances of 1 cm to provide effective and safe light distribution (13, 14).

The primary findings of the MLu-PDT prostate trial have included reports of considerable intrapatient and interpatient heterogeneity in light distribution, photosensitizer uptake, oxygenation, and tissue optical properties within the prostate (15, 16). Although these results are not dissimilar from that found in other studies of PDT (15–19), this heterogeneity makes treatment dosimetry challenging. Integrated treatment dosimetry that uses real-time measurement of fluence rate and tissue optical properties, together with photosensitizers concentration, oxygenation and/or blood flow, has been proposed as a method toward optimizing PDT (9, 12). In addition to these methods for physical dose or efficacy monitoring, the rapid assessment of biological response could significantly improve patient care by providing a means for the early identification of those who would benefit from additional treatment sessions. In the treatment of prostate cancer, prostate-specific antigen response may provide a simple, inexpensive monitoring tool with the potential to rapidly report on treatment effect, thereby facilitating the identification of patients who should be further considered, e.g., through prostate biopsy, for subsequent photodynamic therapy treatment sessions.

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**Translational Relevance**

Treatment options for locally recurrent prostate cancer after radiation therapy are limited. Photodynamic therapy is an attractive experimental modality because it offers the possibility of repeat treatments and minimal morbidity. Yet, there is considerable intrapatient and interpatient variability in all aspects of photodynamic therapy dosimetry including drug concentration, fluence rate, and optical properties. Therefore, the ability to perform individualized, *in situ* measurement of photodynamic therapy dose is valuable, but the rapid assessment of biological response could significantly improve patient care by providing a means for the early identification of those who would benefit from additional treatment sessions. In the treatment of prostate cancer, prostate-specific antigen response may provide a simple, inexpensive monitoring tool with the potential to rapidly report on treatment effect, thereby facilitating the identification of patients who should be further considered, e.g., through prostate biopsy, for subsequent photodynamic therapy treatment sessions.

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**Materials and Methods**

**Patient selection.** Eighteen patients were enrolled on a phase I clinical trial of interstitial MLu-mediated PDT for prostate cancer at the University of Pennsylvania. Seventeen patients went on to receive MLu and interstitial light (PDT), and these 17 patients are considered for the present analysis. The details of patient characteristics and the clinical trial were previously reported (13, 15, 28) and are summarized here. Data on MLu tissue concentration have been previously presented (13), as has serum PSA levels for one patient (13), but in the present report, we uniquely consider these data in relation to each other. The phase I clinical trial was done according to protocol approved by the Institutional Review board of the University of Pennsylvania, the Clinical Trials and Scientific Monitoring Committee of the University of Pennsylvania Cancer Center, and the Cancer Therapy Evaluation Program of the National Cancer Institute. The study of MLu-mediated PDT was conducted on patients with biopsy-proven locally recurrent prostate carcinoma after radiation therapy. Each patient signed the informed consent and underwent a history and physical, magnetic resonance imaging of the prostate, bone scan, urological evaluation, and laboratory studies including complete blood count, biochemistry profile, lipid panel, and PSA levels. Seventeen patients were treated, eight with recurrence after external beam radiation therapy, and nine after brachytherapy. Exclusion criteria included any evidence of distant metastasis or extracapsular invasion, primary T1 or T2 tumors, prostate volume of >50 cc, PSA of >20 ng/mL, history of grade III or IV genitourinary or gastrointestinal toxicity with previous therapy, and inadequate renal, hepatic, or hematologic function. One patient was found to have extracapsular extension of disease after being enrolled on the protocol and did not receive PDT.

**Prostate PDT.** PDT was administered as reported earlier (13, 15, 28). Briefly, using images collected by transrectal ultrasound at 2 wk before PDT, a treatment plan was developed in Multimedia Medical System software for interstitial fiber placement. Cylindrical diffusing fibers of varying lengths were used as light sources, spaced 1 cm apart at positions determined by the treatment plan to cover the entire length of the prostate at a particular position. Within 24 h before light delivery, 0.5 to 2 mg/kg MLu (Cancer Therapy Evaluation Program-National Cancer Institute) was administered i.v., within 5 to 10 min, as a sterile, pyrogen-free 2 mmol/L (2.3 mg/mL) solution in 5% mannitol/water (see dose escalation in Table 1). After an interval of 3 to 24 h, 732-nm light was delivered (Laser Model 730, 15-W diode; Diomed, Ltd.) at a fluence rate of 150 mW/cm², with light fluence...
from 25 to 150 J/cm² (see Table 1). PDT was done in a surgical suite with precautions to prevent unplanned photosensitizer activation, including filtered operating room lighting and covering of the patient’s exposed skin.

**M Lu measurement.** Under ultrasound guidance, needle biopsies were collected from each prostate quadrant at times both before and after light administration. Biopsy specimens were frozen on dry ice, protected from light, and transported to the laboratory for storage at -80°C. At time of analysis, biopsy tissue was thawed and multiple biopsy samples were combined as needed to obtain a total of 5 to 25 mg. Only biopsies collected at the same time point, i.e., either pre-PDT or post-PDT, were combined. If more than one appropriately sized sample was available for analysis, then the resulting data were averaged to provide a single photosensitizer value for the tissue of each patient at each time point. Specimens were placed in a 2-mL capped polypropylene tube and homogenized (Polytron 1200) in 400 µL of phosphate buffer (24 mmol/L; pH 7.5). Homogenates were mixed with 400 µL of chloroform, then 400 µL of methanol was added. After centrifugation (3,500 rpm; 15 min), the organic layer was collected, and 200 µL was transferred to a cuvette. The fluorescence of the homogenized sample was measured by a spectrophuorometer (FluoroMax-3; Jobin Yvon, Inc.) with λex of 474 nm and λem of 740 nm (emission scan range from 650-850 nm). M Lu concentration in the tissue was calculated based on the change in fluorescence resulting from addition of a known amount of M Lu to each sample after its initial reading. Data are presented as nanograms of M Lu per milligram of tissue (16). The effect of PDT on tissue photosensitizer level was calculated from these data as the ratio of post-PDT to pre-PDT photosensitizer concentration.

**PSA measurement.** Baseline PSA was defined as the serum PSA value closest to the time of PDT within –2 mo before treatment. Postprocedure serum PSA was drawn at 1 day after completion of PDT and analyzed at Hospital of University of Pennsylvania using standard procedure. Subsequent PSA levels were drawn at each follow up visit, which by protocol were scheduled at 2 wk after discharge, monthly for 3 mo, then every 3 mo for up to 2 y. These visits actually provided PSA values for the following time ranges after PDT: day 1, weeks 1 to 3 (day 4-24), month 1 (day 26-55), month 2 (day 60-95), month 3 (day 102-126), month 4 to 6 (day 129-206), and month 7 to 11 (day 211-297). A small amount of leeway was allowed in the actual number of days encompassed by each protocol-defined follow-up interval to ensure that sequential measurements on patients were placed in their intended time course. If a patient had more than one PSA measurement within the indicated time frame, then the reported value is the average of all collected samples. Percent change in PSA was defined as ([post-PDT - pre-PDT]/pre-PDT) × 100%, using the pre-PDT PSA value closest to the start of PDT treatment.

**Statistical analysis.** Continuous outcomes were characterized by descriptive statistics, e.g., the mean, median, SE, and range. Interpatient variability was evaluated by the coefficient of variation, calculated as the [(SD/mean) × 100]. Patients were dichotomized into low and high PDT dose groups based on values less than and equal to or greater than the median delivered PDT dose, respectively. The nonparametric Wilcoxon signed-ranks test was used to compare pre-PDT and post-PDT PSA level within patients. The biochemical delay was defined as the time from PDT to a nonreversible increase in PSA to a level equal to or greater than baseline. In other words, the PDT-induced increase in PSA was excluded from this analysis because it was a temporary, reversible phenomenon, and data were analyzed for a increase in PSA after their posttherapy minimum. Biochemical delay was estimated by the Kaplan-Meier method, and group comparisons were assessed by the log-rank test. Patients who did not experience this event were censored on the date of their final PSA measurement within the time frame of this study (up to 297 d after PDT). The coefficient of determination (R²) was used to assess the magnitude of the correlation between tissue photosensitizer concentration and the percent change in PSA at 24 h after PDT. All P values are two-sided. All analyses were conducted with SPSS 14 (SPSS, Inc.) or JMP 5.1 (SAS Institute).

**Results.** Seventeen patients were treated on a phase I trial of M Lu-PDT for cancer of the prostate. Although toxicity of treatment was a primary study end point, data on serum PSA and tumor photosensitizer uptake were collected before and after light treatment.

| Table 1. Treatment variables and early PSA response in patients receiving M Lu-PDT of prostate cancer |
|-------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Patient no. | M Lu dose (mg/kg) | Drug-light interval (h) | Fluence (J/cm²) | Pre-PDT M Lu (ng/mg) | P DT dose (ng/mg) × J/cm² | Pre-PDT PSA (ng/mL) | Day 1 to 3 post-PDT | Weeks 1 to 3 post-PDT | Month 1 post-PDT |
| 1 | 0.5 | 24 | 25 | 0.28 | 7 | ND | — | — | — |
| 2 | 0.5 | 24 | 25 | 0.34 | 9 | 10 | NA | 12 | 10 |
| 3 | 0.5 | 24 | 25 | 0.42 | 11 | 12 | 12.3 | NA | 10.2 |
| 4 | 1 | 24 | 25 | 0.77 | 19 | 12.1 | 14.4 | 10.8 | 14.1 |
| 5 | 1 | 24 | 25 | 0.65 | 16 | 6.4 | 11.4 | 8.3 | 6.5 |
| 6 | 1 | 24 | 25 | 0.52 | 13 | 3.4 | 7.3 | 4.5 | 4.9 |
| 7 | 1 | 24 | 25 | 0.47 | 12 | 5.1 | NA | 5.8 | 7.2 |
| 8 | 2 | 6 | 25 | 3.03 | 76 | ND | — | — | — |
| 9 | 2 | 6 | 50 | 2.32 | 116 | 5.9 | 4.4 | 6.3 | 5.3 |
| 10 | 2 | 6 | 100 | 4.8 | 480 | 6.7 | 5.6 | 5.7 | 5.7 |
| 11 | 2 | 3 | 25 | 4.65 | 116 | 1.8 | 6.4 | 2.3 | — |
| 12 | 2 | 3 | 50 | 3.55 | 177 | 8.4 | 11.9 | 8.9 | 6.7 |
| 13 | 2 | 3 | 100 | NA | -* | 3.4 | 7 | 5.5 | 4.7 |
| 14 | 2 | 3 | 100 | 6.73 | 673 | 4 | 5.2 | 6.1 | 5.4 |
| 15 | 2 | 3 | 150 | 1.71 | 257 | ND | — | — | — |
| 16 | 2 | 3 | 100 | 7.83 | 783 | 6.4 | 31.7 | 37.9 | 5.1 |
| 17 | 2 | 3 | 150 | 5.46 | 819 | 15.4 | 41.2 | 11.4 | 2.7 |

Abbreviations: ND, not detectable; NA, not available.

*Although insufficient sample size prevented ex vivo measurement of prostate M Lu concentration in patient 13, drug concentration measured by in vivo absorption spectroscopy, a technique that has been validated relative to the ex vivo spectrofluorometric measurements in these patients (16), indicates that patient 13 experienced a PDT dose that was ≥140 ng/mg × J/cm² (15).
Table 1 summarizes the PDT conditions and early PSA response of these patients. Photosensitizer doses of 0.5 mg/kg (n = 3 patients), 1.0 mg/kg (n = 4), or 2 mg/kg (n = 10) were used in combination with drug-light intervals of 3, 6, or 24 hours. Pre-PDT prostate photosensitizer levels (mean ± SE) corresponding to these injected doses were 0.35 ± 0.04 ng/mg at 0.5 mg/kg (24 hours; n = 3), 0.65 ± 0.07 ng/mg at 1 mg/kg (24 hours; n = 3), 0.47 ng/mg at 1 mg/kg (6 hours; n = 3), 3.38 ± 0.74 ng/mg at 2 mg/kg (6 hours; n = 3), and 4.99 ± 0.90 ng/mg at 2 mg/kg (3 hours; n = 6). All patients who received low drug doses (0.5 or 1 mg/kg) were treated with low fluence (25 J/cm²), whereas patients who received a 2 mg/kg dose were treated at fluences of 25 (n = 2), 50 (n = 2), 100 (n = 4), or 150 J/cm² (n = 2). This lead to delivered PDT (product of photosensitizer level and fluence) < 20 ng/mg/cm² for patients treated with low (0.5 or 1.0 mg/mg MLU) photosensitizer doses, whereas patients who received 2 mg/kg MLU experienced delivered PDT doses of 76 to 819 ng/mg/cm². The median delivered PDT dose was 116 ng/mg/cm².

Fourteen of the 17 treated patients were PSA evaluable, meaning that PSA levels were detectable in the pre-PDT samples. Among these 14 patients, pre-PDT serum PSA values ranged from 1.8 to 15.4 ng/mL (median, 6.4 ng/mL). PSA levels could be expected to exhibit two types of changes after PDT: (a) an increase in PSA levels shortly after PDT insult on the prostatic tissue and (b) a decline in PSA levels at times more removed from treatment could result from a reduction in tumor burden. Figure 1A displays the time course of the change in serum PSA levels in a patient treated with high dose PDT (150 J/cm², 2 mg/kg MLU, 3-hour drug-light interval). PDT was immediately followed by a large increase in PSA, which rapidly dropped to levels below the baseline measurement. Among all of the patients, PSA values generally reached their maximum within 1 day to 3 weeks after PDT, although one patient (#7) experienced a peak at his 1-month follow-up and one patient (#10) did not experience an increase in PSA levels within the short term after PDT.

To summarize the effect of PDT on PSA, the change in PSA was calculated for each patient in multiple post-PDT time frames: day 1, weeks 1 to 3, month 1, month 2, month 3, month 4 to 6, and months 7 to 11 (Fig. 1B). On average (mean ± SE), serum PSA levels significantly increased by 98% ± 36% within 1 day after PDT (P = 0.007), and remained elevated (53% ± 37%) through the following 1 to 3 weeks. However, there was substantial interpatient variability in percent change in PSA at both time intervals, as indicated by coefficient of variation values of 127% and 253% at day 1 and week 1 to 3, respectively. On average, within 26 to 55 days (month 1) after PDT serum PSA levels dramatically declined to a level indistinguishable from baseline (mean ± SE, 1% ± 10%). This decline was followed by a steady increase in PSA levels as disease progressed, and PSA levels significantly exceeded their pre-PDT values within 129 to 206 days (month 4-6) after treatment. Overall, these data show that early and substantial increases in serum PSA levels may be one of the first indications of treatment effect in interstitial PDT of prostate cancer.

Strong temporal changes in PSA response to PDT are apparent in the data of Fig. 1B regardless of the fact that these responses are averaged over patients who experienced a very broad range of PDT doses (see Table 1). To more closely examine the effect of PDT dose on PSA response, patients were divided into approximately equal-sized groups, defined as those who received PDT doses less than the median value of 116 ng/mg/cm² versus those who received PDT doses equal to or greater than this value. Figure 2 shows striking differences in the first month of PSA responses in patients who received high versus low PDT dose. The percent increase (mean ± SE) in PSA at day 1 was greater in patients who received high (119% ± 52%) than low (54% ± 27%) PDT dose, with only the high-dose patients experiencing an increase in serum PSA levels over baseline that closely approached statistical significance (P = 0.055). Furthermore, at their 1-month follow-up, high-PDT-dose patients tended toward a decrease in PSA levels relative to their baseline (-11% ± 15%), whereas low-PDT-dose patients continued to exhibit PSA levels that on average were slightly higher than baseline (15% ± 10%). Differences in PSA response as a function of PDT dose disappeared by the conclusion of 2 months after PDT, with both groups of patients demonstrating a ~10% increase in PSA levels.

The duration of biochemical delay, the length of time between PDT and a nonreversible increase in PSA to a value
equal to or greater than baseline was calculated for the high- and low-PDT-dose groups. It should be noted that: (a) baseline PSA level was similar in patients treated at high versus low PDT dose (mean ± SE, 6.5 ± 1.5 ng/mL versus 8.2 ± 1.5 ng/mL, respectively) and (b) time to the minimum PSA value after PDT was also similar in high- and low-PDT-dose patients (mean ± SE, 33 ± 7 days versus 45 ± 9 days, respectively). In contrast, the duration of biochemical delay was longer for the high-PDT-dose group compared with the low-PDT-dose group (median, 82 days versus 43 days, respectively; P = 0.024; Fig. 3). Between 19 and 160 days after PDT, all 6 patients in the low-PDT-dose group experienced a PSA value greater than or equal to baseline. The patient whose biochemical delay was noted to be 160 days did not adhere to the follow-up schedule and a shorter delay is quite likely. In contrast, 3 patients in the high-dose group failed to reach their respective pre-PDT PSA levels in follow-ups that extended through 123 to 283 days. However, although the high-dose-PDT patients did show a significantly greater biochemical delay, all patients did ultimately experience biochemical failure, as defined by an increase in PSA to a value at least 0.5 ng/mL greater than the minimum post-PDT value in 3 consecutive follow-up visits. Substantial variability in time to biochemical failure existed among patients, which masked any difference between the high and low dose groups.

Due to the design of this clinical trial, high PDT doses generally incorporated both high drug dose and high light fluence, whereas low PDT doses generally incorporated both low drug dose and low light fluence (see Table 1). Therefore, the increase in PSA levels at high PDT doses could, in fact, be driven by an association between PSA level and either drug dose or fluence individually. We explored these possibilities, finding no association between PSA and the fluence of light delivery (data not shown). There did appear to be a weak positive correlation between percent change in PSA at 1 day after PDT and the pre-PDT tissue MLu concentration (R² = 0.29; P = 0.09; Fig. 4A), which emphasizes that the effects photosensitizer content may be dominant over effects of light dose in the relationship between PDT dose and PSA response under the conditions studied.

If pre-PDT prostate photosensitizer concentration is dominant in the effect of PDT dose on PSA response, then it also becomes relevant to examine how changes in prostate photosensitizer concentration during PDT are related to PSA response. Change in MLu concentration during PDT was calculated as the ratio of post-PDT to pre-PDT tissue concentration. A decrease in MLu was in detected 11 of 16 evaluable patients, whereas an increase in MLu concentration was found in 5 patients. Figure 4B summarizes the change in prostate MLu concentration in each patient as a function of injected dose.

The relationship between the post-PDT/pre-PDT tissue concentration and the maximum PDT-induced increase in PSA was considered for 12 patients who exhibited a short-term increase in PSA after PDT. Patients were divided into two groups, those who showed a decrease in drug level with PDT and those who showed an increase. Among those patients who experienced a decrease in prostate photosensitizer concentration during PDT, the average (± SE) maximum change in PSA was 136% ± 60% (P = 0.008), whereas the maximum change was only modest (52% ± 23%) among patients who did not show a decrease in prostate MLu concentration (Fig. 5).

### Discussion

Treatment options for locally recurrent prostate cancer after radiation therapy are limited. PDT is an attractive experimental modality because it offers the possibility of repeat treatments and minimal morbidity (10). Therefore, a means for early assessment of patient response to prostate PDT would be a valuable tool in planning patient care. Other modalities that treat the prostate can result in large but transient increases in serum PSA levels (22, 25). Furthermore, these elevated PSA

![Fig. 2](image-url) The average (mean ± SE) percent change in PSA, a function of time after PDT in patients who experienced a PDT dose less than (open bars) or greater than or equal to (closed bars), the median dose of 116 mg cm². PDT dose was calculated as the product of tissue photosensitizer concentration and light dose; n = 4 to 6 (open bars) or 7 to 8 (closed bars). +, = P < 0.05 for Wilcoxon signed-rank test comparing post-PDT PSA values to baseline measurement in the same patient.

![Fig. 3](image-url) Kaplan-Meier estimation of biochemical delay in the PSA response in patients treated with a PDT dose less than or greater than or equal to the median dose of 116 mg cm². Duration of biochemical delay was defined as the length of time between PDT and a nonreversible (i.e., not PDT induced) increase in PSA to a value greater than or equal to baseline. n = 6 and 8 for low- and high-dose PDT, respectively.


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levels were found to correlate with treatment dose (energy) in laser-mediated electrovaporization of the prostate (26). In the present study, we report that (a) MLu-PDT of human prostate cancer results in a significant short-term increase in serum PSA levels and (b) the change in PSA is related to PDT dose, as well as to PDT effect on photosensitizer concentration in the treated tissue.

Several clinical studies of PDT for prostate have been reported, including treatments that used the drugs hematoporphyrin derivative, aminolevulinic acid, meso-tetrahydroxyphenyl chlorin, and Tookad (2, 6, 10). Although some reports do document PSA response at roughly 1 month after PDT (8, 11, 29), to our knowledge, the present study is the first to evaluate PSA within 1 day to several weeks of treatment. A short-term increase in PSA after treatment of the prostate can be caused by cellular damage, leading to the release of PSA into the circulation (25). We found such an increase after MLu-PDT despite the limitation that damage was not sufficient to control disease progression, i.e., ultimately all patients experienced biochemical failure. Nevertheless, a ~2-fold difference in PSA response at 24 hours after PDT was noted in patients treated at high versus low PDT dose, which suggests that higher, more effective PDT doses will lead to even greater PSA release. In some instances, a time lapse of 2 months occurred between baseline PSA doses and PDT; thus, disease progression over time may contribute to the increase in PSA after PDT. However, the average (± SE) absolute change in PSA at 1 day after PDT (6.1 ± 2.7 ng/mL) greatly exceeded the increase in PSA (1.8 ± 0.4 ng/mL) over an average (± SE) of 160 ± 33 days immediately preceding baseline measurement in patients (n = 13) who were not on hormone therapy before the baseline blood draw. These data strongly suggest that increases in PSA after PDT were predominantly a result of treatment, with less effect from disease progression in a potential ~60 day window. PSA values (average ± SE) after PDT increased to 13.2 ± 3.3 ng/mL (range 4.4-41.2 ng/mL) on day 1 and 9.7 ± 2.5 ng/mL (range, 2.3-37.9 ng/mL) in weeks 1 to 3. Because these levels are far below those reported after prostate cryosurgery (average maximum of 155 ng/mL; range, 18.9-490.5 ng/mL; ref. 25), it is likely that more effective PDT protocols will lead to greater PSA release.

The magnitude of increases in serum PSA after therapy necessarily will be a function of not only the severity of prostate damage but also the presence of functional vasculature to deliver PSA to the systemic circulation. Therefore, specific trends in PSA response to PDT may differ among photosensitizers and protocols that alter the balance of direct cell kill versus vascular damage. For example, preclinical investigations in subcutaneous human prostate tumor xenografts found Tookad PDT to lead to immediate (within 7 hours) declines in PSA levels (30). This response could be a result of the rapid vascular shutdown found during Tookad PDT, which is a
purely vascular treatment (31). It is also likely a function of the animal model studied, and PSA levels in humans cannot be expected to change as rapidly because PSA half-life is longer in humans (30). Nevertheless, the present study found significant PDT-induced increases in PSA after MLu-PDT conditions that are considered to be predominantly vascular targeting, i.e., a short drug-light interval. Therefore, it is not unreasonable to expect that PDT with more cellular-acting drugs such as ALA and meso-tetrahydroxyphenyl chlorin will also lead to PSA increases.

Because prostatic manipulation, including biopsy collection (24), can lead to release of PSA, there is reason to believe that the process of interstitial fiber placement for PDT will cause a spike in serum PSA. However, in the present report, all patients experienced the same process for interstitial placement of the treatment fibers so this factor cannot explain the difference in PSA response as a function of PDT dose. On the other hand, patients treated at higher PDT dose also had slightly longer treatment times and theoretically prolonged procedural trauma. The possible effect of treatment time on PSA response can be assessed from the relationship between treatment fluence, i.e., treatment time, and PDT-induced change in PSA levels. No association between fluence and PSA response was found, suggesting that the duration of interstitial probe placement did not affect PSA response over the range of exposure times used in this trial.

Subsequent to treatment-induced increases in PSA, its serum levels will decline if therapy was sufficient to reduce disease burden and prostate volume, thereby decreasing the number of cells releasing PSA (11, 24). A correlation between reduction in prostate volume and decreasing serum PSA levels has been found at 6 weeks after electrovaporization therapy (22), and a correlation between the extent of prostatic necrosis and the percent change in PSA was found at 4 and 12 weeks after PDT (32). In our patients, PSA response at 1 month after PDT is similar to that which has been found in other PDT trials: some patients experienced a reduction in PSA levels to below baseline, but generally, this was followed by steadily increasing levels (8, 11). However, a PSA response lasting up to 6 months after PDT (the length of the study) was reported by Trachtenberg et al. (29) in the majority of men who experienced a necrosis volume >20% after localized illumination of the prostate with Tookad-mediated PDT.

In conclusion, photodynamic therapy is under evaluation for the treatment of locally recurrent prostate cancer after radiation therapy. PDT provides minimally invasive treatment with few adverse effects, and further studies are warranted to evaluate efficacy and improve therapy delivery. There is considerable intrapatient and interpatient variability in all aspects of PDT dosimetry including drug concentration, fluence rate, and optical properties. Thus, the ability to perform individualized,
in situ measurement of PDT dose is valuable, as would be a means for the rapid individualized assessment of PDT effect. The data of the present report strongly promote the need for individualized measures of PDT delivery, e.g., that reported by in vivo light dosimetry, and individualized measures of PDT effect, e.g., that reported by serum PSA levels, to be incorporated into clinical trials of prostate cancer.

References