Urology CHEAT SHEETS by RAEU GRUPO DE RESIDENTES Y JÓVENES URÓLOGOS
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ACTIVE SURVEILLANCE IN PROSTATE CANCER

DEFINITION: Active surveillance (AS) aims to avoid unnecessary treatment in men with clinically localized prostate cancer (PCa) who do not require immediate treatment, but at the same time find the right time for curative treatment in those who ultimately need it.

- **AS differs from watchful waiting** in that AS seeks not to lose the patient's curative window.
- **Up to 45%** of patients diagnosed with PCa **are candidates for an AS program.**
- **15-year mortality** in patients with **ISUP 1-2 PCa** diagnosed by PSA is around 7%.

* DIFFERENCES BETWEEN AS AND WATCHFUL WAITING

	ACTIVE SURVEILLANCE	WATCHFUL WAITING
THERAPEUTIC INTENTION	Curative	Palliative
TRACING	Pre-defined scheme	Patient oriented
TESTS	PSA, digital rectal examination (DRE), mpMRI , re-biopsies	Not predefined
LIFE EXPECTANCY	> 10 years	<10 years
OBJECTIVE	Minimize overtreatment without compromising survival	Minimize the adverse effects of treatments
COMMENTS	Aimed at patients with low or favorable intermediate-risk PCa	Aimed at patients with many comorbidities and limited life expectancy

PUBLISHED RESULTS OF PROSPECTIVE SERIES SHOW:

- **OVERALL SURVIVAL AT 10 YEARS: 98-100%**
- **CANCER-SPECIFIC SURVIVAL AT 10 YEARS: 99-100%**
- **METASTASIS-FREE SURVIVAL AT 10 YEARS: 99%**
- **Equivalent oncological outcomes in patients treated with immediate radical treatment after diagnosis compared to those who went through active surveillance before radical treatment** (https://pubmed.ncbi.nlm.nih.gov/23321581/)

INCLUSION CRITERIA low-risk

Most used criteria:
- ISUP 1 (Gleason 6)
- Clinical stage T1c o T2a
- PSA <10ng/ml
- PSA density <0.15
- There is no limit of positive cores but not recommended for high volume bilateral disease.

INCLUSION CRITERIA favorable intermediate-risk

- ISUP 2 (Gleason 7, 3+4)
- PSA <20ng/ml
- Clinical stage T1c
- Low volume (1 or 2 with less than 50% of tumor)
- Less than 10-20% of pattern 4

EXCLUSION CRITERIA

- ISUP 3-5
- Extensive bilateral disease
- Presence of intraductal carcinoma, sarcomatoid, small cell, or cribiform pattern.
- Perineal invasión, extra-prostatic invasión, linfovascular invasion.
- Life expectancy <10 years*

* You can use the Lee- Schonberg calculator (https://eprognosis.ucsf.edu/leeschonberg.php)

FOLLOW-UP

There are **different follow-up protocols,** but in general terms the most accepted is:
- **PSA EVERY 3 TO 6 MONTHS**
- **DRE EVERY 6 TO 12 MONTHS**
- **REPEAT BIOPSY IN THE FIRST 6-12 MONTHS** (confirmation biopsy) , ideally with previous mpMRI and fusion biopsy .
- **RE-BIOPSY IN CASE OF PROGRESSION IN DRE, PSA OR RADIOLOGICAL (PIRADS)**
- **ASSESS RE-BIOPSY IN PATIENTS WHO DO NOT MEET ANY PROGRESSION CRITERIA IF THEY HAVE NOT BEEN BIOPSIED IN A LONG PERIOD OF TIME (≥3-4 YEARS)**

ref: DETECTIVE study consensus (PMID : 31587989)

WHEN TO GO FOR RADICAL TREATMENT?

- **HISTOLOGICAL PROGRESSION IN RE-BIOPSY MEETING EXCLUSION CRITERIA** (30 to 40% of patients in active surveillance will be re-classified during follow-up)
- **PATIENT ANXIETY OR STRESS**
- **PATIENTS WHO DO NOT WISH TO CONTINUE IN ACTIVE SURVEILLANCE** due to discomfort or inability to adherence to the protocol

* Active treatment should not be switched to exclusively due to isolated changes in PSA, digital rectal examination, magnetic resonance imaging or number of positive cylinders , the set of all characteristics should be assessed

DOES ACTIVE SURVEILLANCE WORSE LONG-TERM OUTCOMES VERSUS RADICAL TREATMENT ?

Multiple published series have shown that all oncological and surgical outcomes are equivalent in both groups

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ISUP= International society of urological pathology
mpMRI= Multi-parametric magnetic resonance imaging
PSA= Prostate specific antigen