ACTIVE SURVEILLANCE OF PROSTATE CANCER

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ABOUT ME

- Board Certified Urologist
- In practice for 8 years
- Urology residency at University of Cincinnati, 2008-2013
  - Published one of the earliest papers on use of MRI for targeted prostate biopsy (2013)
- Fellowship in Genitourinary Trauma and Reconstruction at University of Minnesota, 2013-14
  - Gained extensive experience in Artificial Urinary Sphincter, Inflatable Penile Prosthesis implantation
  - Repair of radiation-induced injuries to urethra & bladder
- Current practice
  - Genitourinary cancers, including Prostate Cancer
    - MRI fusion biopsies, Active Surveillance, Transperineal biopsies
  - Robotic surgeries for prostate, kidney and bladder cancer (approx. 100/year)
  - Prosthesis

WHAT WE KNOW ABOUT PROSTATE CANCER

- Not all prostate cancers are lethal
  - Up to 30% are indolent, aka “lazy”
  - Typically “very low risk” and “low risk” prostate cancers – Gleason 6 & Gleason 3+4 or GG1 and GG2
- Treatment can have side effects
  - Sexual
  - Urinary
  - Can affect quality of life
- Treatment can be “overkill” in the case of “lazy” cancers

ACTIVE SURVEILLANCE – WHAT IS IT?

- Active monitoring of certain types of prostate cancer
  - "favorable risk" - Gleason 6 (GG1) and Gleason 3+4 (GG2)

  - Statistically not likely to worsen or spread outside the prostate **AS LONG AS CERTAIN PARAMETERS ARE MET**
    - **PSA density (PSA/Prostate Volume) less than 0.15[1]**
    - **Less than 20% of biopsy core involved with cancer [1]**
    - **MRI does not show any suspicion of cancer coming close to or getting outside prostate capsule**

  - Aim is to avoid treatment **WHILE MONITORING FOR ANY SIGNS OF WORSENING OF CANCER**
    - **Intervention at earliest sign of cancer becoming "unfavorable"**
    - **Intent is to cure**

- **Shared decision making between patient, partner and physician**

1. **Active Surveillance of Prostate Cancer is a Viable Option for Men Younger than 60 Years.** J Urol. 2019 Apr;201(4):721-727

ACTIVE SURVEILLANCE IN 2022

- Many more tools are available for monitoring and risk-stratification
  - PSA
  - MRI
  - Fusion biopsy (including transperineal)
  - Genomic testing
    - Prolaris, Decipher
- Lesser dependance on digital rectal examination
  - We are realizing that DRE can be inaccurate and misleading
- Able to offer AS to *some* patients with intermediate risk disease (Gleason 4+3 or GG3)
- Race & family history of prostate cancer **does not** disqualify a man from being AS candidate
- Awareness about mental health component of AS

ACTIVE SURVEILLANCE – HOW I DO IT

- Try to get MRI and do fusion biopsy upfront
  - Greater confidence in biopsy result
- If initial biopsy is without MRI, get MRI and perform “saturation biopsy”
  - Include region of interest but also biopsy rest of prostate
- Always encourage spouse/SO to be present when discussing biopsy results
- I do not use genomic testing **except** when doing AS for Gleason 3+4 disease
  - Genomic testing gives “probabilities”
  - PSA density, Gleason score and MRI can be used to arrive at same result
- I always ask the patient – “will you be able to sleep peacefully at night”?
  - It is important for the patient to feel comfortable with decision to do AS
  - Offer counseling
  - I emphasize that he can change his mind at any time and opt for treatment

ACTIVE SURVEILLANCE – HOW I DO IT

- PSA every 3 months for first 2 years
  - Will space it out to every 6 months if it remains stable after 2 years
  - If PSA goes up, recheck after 4-6 weeks
  - MRI and repeat biopsy if PSA goes up on recheck
- MRI yearly for 2 years, then every 2 years if PSA remains stable
  - MRI any time PSA rises
- Continue to monitor urinary symptoms, sexual function and mental health
  - If urinary symptoms due to enlarged prostate are getting worse, it may be time for treatment
  - If mental health is being affected, it may not be worthwhile

ACTIVE SURVEILLANCE – TAKE HOME MESSAGES

- It is safe in **well-selected** patients
  - May not be suitable for all
  - Risk of cancer metastasizing and becoming incurable is less than 1% in 5 years
- It is suitable for men of all ages
  - Younger men can maximize peak sexual function, but chances of needing treatment at some time is higher
  - Older men have the best chance of avoiding treatment altogether
- It is a shared decision-making
  - Onus is on you, as the patient, to ask if you are a candidate for AS
  - Get a second opinion, maybe even a third
  - Involve your life partner
- You can change your mind at any time!