



Letter to the Editor

Re: Henk G. van der Poel, Roderick C.N. van den Bergh, Erik Briers, et al. Focal Therapy in Primary Localised Prostate Cancer: The European Association of Urology Position in 2018. Eur Urol 2018;74:84–91

We would like to raise some issues concerning the article by van der Poel et al. [1].

First, this paper seems to reflect only their position as we find no evidence that the authors sought to investigate the opinion of the European Association of Urology (EAU). A recent survey conducted by the EAU Young Academic Urologists aiming to do so demonstrated that the actual position is widely divergent with 52% of respondents currently suggesting focal therapy (FT) to eligible patients.

Second, the authors are in danger of allowing the extraordinary to become enemy of the valuable. Their provocative stance, which has no precedent in being applied to any other prostate cancer (PCa) intervention states that for FT to be adopted, the following conditions need to be fulfilled: (1) survival efficacy at least equivalent to standard of care (SOC), (2) fewer complications and functional side effects compared with SOC, (3) reliable follow-up, and (4) salvage treatment not impaired by primary FT.

Taking each of these elements in turn, estimating survival benefit of FT against a comparator is going to be challenging given that it was not possible to demonstrate survival benefit of existing treatments versus no treatment over 10 yr [2].

Robust evidence relying on patient-reported outcome measures shows that genitourinary toxicity and serious complications after FT are significantly lower than those after radical treatments [3,4]. This is no longer a matter of debate.

The inability of imaging to identify all high-risk cancers should be considered for any tissue-preserving approach, including active surveillance (AS), which in contrast to FT, is considered SOC by the EAU. Also, the unreliability and the variability of follow-up and the lack of an explanatory randomised controlled trial (RCT) in the field are limitations applicable to AS also. The two RCTs available for AS were only recently published, although AS has been contemplated in the EAU guidelines for a decade [2,3]. Partial

nephrectomy was recommended by the EAU based on cohort outcomes before any RCT data. We now have 5-yr median follow-up for FT in PCa showing high rates of cancer control [5]. The goalposts should not be changed.

Finally, it is a well-known phenomenon that salvage prostatectomy after radiotherapy is difficult and has very poor functional and oncological outcomes. These facts are not used in guidelines or position papers to recommend against radiotherapy. It seems rather inconsistent to invoke them here. The presence of scar tissue after any primary surgery may make the subsequent procedure more challenging. The real matters of debate are the trade-offs that patients are willing to make, the number of patients who would fail and would actually require salvage treatment, and the relative loss of function compared to primary surgery.

In conclusion, whilst we respect all our colleagues' opinions, it is important that these are not misrepresented as being those of the wider membership. We must take care that we do not embark on an exercise of cognitive dissonance that denies our patients a legitimate strategy that many will want to know about and accept as an alternative treatment option.

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