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European Association of Urology

Letter to the Editor

Re: Stephanie Guillaumier, Max Peters, Manit Arya, et al. A Multicentre Study of 5-year Outcomes Following Focal Therapy in Treating Clinically Significant Nonmetastatic Prostate Cancer. Eur Urol 2018;74:422–9

We read the article by Guillaumier et al. [1] with great interest. The article presents extraordinary results and we have some questions for the authors.

The indication for focal therapy for prostate cancer is not yet well established. According to a 2015 expert consensus [2], focal therapy is suitable for low-risk and especially intermediate-risk prostate cancer. The cases in this study were mainly intermediate- and high-risk prostate cancer, and some patients had stage T3 cancer. These cases may have had lymph node metastasis. Is focal therapy suitable for the cases in this study?

Multiparametric magnetic resonance imaging (mpMRI) combined with targeted and systematic biopsies was used for lesion localisation for some of the cases. The question arises as to how the specific range of focal therapy was determined. For patients with a positive mpMRI-targeted biopsy but negative systematic biopsy, if wide local ablation or hemiablation is based on the range defined by MRI alone, even by treating known areas of cancer with a margin, the requirement for complete ablation of the index lesion still cannot be achieved. By analysing whole-mount sections, Priester et al. [3] found that MRI underestimates the size of prostate cancers, as foci had an average diameter 11 mm longer and a volume three times greater than the MRI contours.

Two patients in the study developed rectourethral fistulae. This type of complication is very difficult to treat. We would like to know the key considerations in terms of the indications and intraoperative treatment for use of focal therapy to avoid or reduce this complication.

Conflicts of interest: The authors have nothing to disclose.

References

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