



## Letter to the Editor

**Re: Alberto Briganti, Nicola Fossati, James W.F. Catto, et al. Active Surveillance for Low-risk Prostate Cancer: The European Association of Urology Position in 2018. Eur Urol 2018;74:357–68**

We read the recent paper by Briganti et al. [1] with great interest, in which they conclude that active surveillance (AS) is becoming a widely adopted strategy for patients with low-risk prostate cancer (PC). However, they seem too optimistic about the application context for AS in actual clinical practice. In our opinion, AS may remain an option that is “more easily said than done” in the next decade, and what is currently important is to prioritize education on PC and AS before pushing AS in clinical practice.

Radical prostatectomy or radiotherapy has commonly been the treatment of choice for localized PC for decades. Accumulating evidence suggests that conservative treatments such as observation and AS have excellent long-term results, especially in terms of all-cause and PC-specific mortality in the localized PC setting [1,2]. We believe that in the future, overtreatment will be effectively reduced for this patient population and that more medical resources can then be directed towards those who really need them. Nonetheless, in our opinion, this will not be an easy road to travel. In fact, patients commonly have a negative and defensive perspective on AS [3], as do many urologists. This lack of confidence among patients and the potential for progression may be the two crucial factors that could impede more widespread adoption of AS, even though these concerns are somewhat unfounded.

First, patients are frequently unwilling to accept AS [3]. A lack of effective medical education, psychological fears, and inadequate understanding of cancer among patients compel most of them to only accept radical therapies. This fear and lack of understanding in relation to cancer are longstanding and deep-rooted. For many, a cancer diagnosis is considered catastrophic and only means a short-term life full of suffering. Therefore, there may be poor acceptance of a recommendation for no surgical treatment and only AS while living with a cancer, especially a localized cancer with a low probability of being recommended for radical treatment. In such cases,

repeated suggestions for other available treatments are usually rejected. Second, internal and international migration leads to a lack of treatment compliance [4] and the frequency of migration is increasing because of worldwide economic and cultural exchanges. Loss to follow-up means a lack of continuous observation of disease. Thus, a greater risk of potential cancer progression may exist, so urologists and patients may be unwilling to opt for AS. Regions may differ slightly, but these two concerns appear to apply globally. Taking China as an example, the situation is more complicated. Despite the two factors mentioned above, 42% of Chinese urologists are worried about AS-associated medical disputes and their potential negative effects, which has affected Chinese clinical practice. Third, renaming Gleason score 6 PC as “not cancer” [5] may represent a big step forwards.

Education of patients and urologists is vital and is likely to lead to change. Until then, AS remains “more easily said than done” and still has a long way to go.

**Conflicts of interest:** The authors have nothing to disclose.

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