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Centers of Excellence: What are Realistic Goals?

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This issue of *European Urology* contains a provocative manuscript with a proposal from the European Association of Urology Prostate Cancer Centre Consensus Meeting on European prostate cancer centers of excellence [1]. Composed of recognized European leaders in urologic oncology, the group argues in favor of three "steps" to define centers of excellence and a regulatory approach to ensure adherence to the inclusion criteria. What exactly are the authors attempting to do and are they likely to achieve their goals?

The specific aim of this project is to identify "European centers characterized by high-quality cancer care, research and education." Who will benefit from this designation: the authors themselves, patients, governments, universities, public health professionals, insurance carriers? The abstract for the manuscript lists "outcome measurements" and enumerates required criteria in three domains: clinics, research, and education. The authors specifically state that they are not trying to establish minimal standards for prostate cancer management, since the European Society of Oncology has already identified prostate cancer units. Then what are the authors trying to achieve?

Under the "clinical step" the authors list five items: a core team, associated services, a multidisciplinary approach, a diagnostic pathway, and a therapeutic pathway. Most institutions currently host a web site that usually lists the first three items. This hardly requires a regulatory framework. Proposing standardized diagnostic and therapeutic pathways is a much more complex and difficult task. Prostate cancer diagnosis in 2019 usually depends on the decision to screen for prostate-specific antigen (PSA). This is still controversial in both the USA and Europe. Many guidelines suggest that physicians should have a conversation about the risks and benefits of PSA testing for men aged 55–70 yr [2]. It is unclear how one would define a "center of excellence" based on an institution's diagnostic pathway evaluating patient age, medical history, co-morbidities, previous PSA values, and discussion results to decide to screen and perform a prostate biopsy.

Perhaps the authors only wish to evaluate diagnostic and therapeutic pathways after prostate cancer diagnosis. Again this is problematic. In the discussion section of the manuscript the authors focus on the idea that evaluation of life expectancy is a critical factor when considering treatment. The recent update of the Scandinavian Prostate Cancer Group 4 study confirms that prostate cancer is a chronic disease that can progress over three decades [3]. After 29 yr of follow up, 52% of the men randomized to watchful waiting have died of causes other than their prostate cancer, while 31% have died from prostate cancer. For men undergoing radical prostatectomy, 54% have died from other causes and 20% have died from prostate cancer. The authors have shown that radical prostatectomy results in an absolute risk reduction of 11% for prostate cancer mortality and increases life expectancy by a median of 2.9 yr. This gain was primarily experienced by men younger than 65yr at diagnosis and those with intermediate-grade disease. Since most of the men in this study were diagnosed with clinical disease and PSA testing probably introduces a 10-yr lead time, these outcomes are optimistic for contemporary men aged >65 yr at diagnosis because of competing medical risks. Entry criteria for the study mandated that men had to be younger than 75 yr, have life expectancy of >10 yr, and have no other cancer that was considered likely to shorten survival. Men outside these criteria in 2019 are lucky if they experience a similar benefit from treatment. Therefore, how much additional value does a formal comorbidity assessment or formal geriatric assessment yield? What evidence do we have of a tool that can accurately measure life expectancy of 10–15 yr? The heterogeneity in treatment

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recommendations noted by the authors stems from our lack of understanding of the natural history of well and poorly differentiated disease and the relative impact of treatment, not on our ability to assess longevity.

The authors state that one of the important benefits of this project is standardization of reporting methods and the establishment of data systems. I absolutely agree, but the obvious question is why has this not already happened? The last two decades have seen important strides in the development of tools such as the Expanded Prostate Cancer Index Composite to measure quality of life following prostate cancer treatment and the International Index of Erectile Function to measure sexual dysfunction [4,5]. Pathologic criteria have been established to standardize readings for prostate biopsies and prostatectomy specimens [6]. Institutions need only customize their electronic medical records to record this information. The hurdle stems from the costs of capturing baseline data and the additional expense of tracking long-term outcomes. This is why high-quality randomized trials such as ProtecT are so extraordinarily expensive to conduct [7]. Few institutions have the funds necessary to accomplish the clinical goals envisioned by the authors.

Finally, the authors propose that centers of excellence should be involved in research and education. This is classically the role of academic medical centers. How do academic medical centers achieve these goals? They conduct and publish research and train the next generation of physicians. Research and education cost money. Historically this has come from government grants and private philanthropy, which often have criteria for evaluating study proposals. While being labeled a “center of excellence” might impact the success of an institution's grant proposals, most granting bodies have their own methods for assessing an institution's infrastructure and capabilities.

Truly excellent centers are distinguished by their ability to explore new frontiers and identify and evaluate new diagnostic and therapeutic tools. Any regulatory approach that tries to define such centers often devolves into a list of criteria that describes qualified institutions. For European urologists this is the role served by the European Board of Urology examinations. The quality improvement goals envisioned by the authors are laudable, but I am afraid that the costs of implementing many of the changes demanded of participating institutions will far exceed the funds available. Fortunately these costs keep falling for us all and therefore we should all work towards achieving them without needing a seal of approval.

Conflicts of interest: The author has nothing to disclose.

References

[1] Wirth M, Fossati N, Albers P, et al. The European Prostate Cancer Centres of Excellence: a novel proposal from the European Association of Urology Prostate Cancer Centre Consensus Meeting. Eur Urol 2019;76:179–86.

[2] Carter HB, Albertsen PC, Barry MJ, et al. Early detection of prostate cancer: AUA guideline. J Urol 2013;190:419–26.

[3] Bill-Axelson A, Holmberg L, Garmo H, et al. Radical prostatectomy or watchful waiting in prostate cancer—29 year follow up. N Eng J Med 2018;379:2319–29.

[4] Wei JT, Dunn RL, Litwin MS, et al. Development and validation of the Expanded Prostate Index Composite (EPIC) for comprehensive assessment of health related quality of life with prostate cancer. Urology 2000;56:899–905.

[5] Roson RC, Riley A, Wagner G, et al. The International Index of Erectile Function (IIEF): a multidimensional scale for assessment of erectile dysfunction. Urology 1997;49:822–30.

[6] Epstein JI, Allsbrook Jr WC, Amin MB, et al. The 2005 International Society of Urological Pathology (ISUP) consensus conference on Gleason grading of prostatic carcinoma. Am J Surg Pathol 2005;29:1228–42.

[7] Hamdy FC, Donovan JL, Lane JA, et al. 10-Year outcomes after monitoring, surgery or radiotherapy for localized prostate cancer. N Eng J Med 2016;375:1415–24.