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## Letter to the Editor

**Re: Taimur T. Shah, Max Peters, David Eldred-Evans, et al. Early-Medium-Term Outcomes of Primary Focal Cryotherapy to Treat Nonmetastatic Clinically Significant Prostate Cancer from a Prospective Multicentre Registry. Eur Urol 2019;76:98–105**

As an organ-preserving treatment modality, focal therapy not only is effective in control of prostate cancer (PC) but also avoids complications such as urinary incontinence and sexual dysfunction caused by radical prostatectomy. Studies have demonstrated that focal therapy has satisfactory treatment outcomes in low- and intermediate-risk PC [1,2]. High-risk PC has high rates of local progression, metastasis, and mortality, so some treatment modalities for this PC setting are controversial. The article by Shah et al. [3] suggests that focal cryotherapy for high-risk PC results in good rates of cancer control and low rates of treatment-related side effects. Because of the above factors, the indication for focal therapy is a meaningful topic. Several issues warrant consideration for a better understanding of the application of focal therapy.

Effective detection and evaluation of lesions with a relatively high degree of malignancy in the prostate are a prerequisite for focal therapy. Transperineal mapping biopsy and multiparametric magnetic resonance imaging targeting with standard transrectal ultrasound biopsy can be used in preoperative evaluation before focal therapy. Transperineal mapping biopsy is a dense template-assisted sampling procedure with access via the perineum. The biopsy needle interval is 0.5 cm. This method can detect clinically significant lesions in the prostate. It has been reported that the average number of biopsy needles for transperineal mapping biopsy can reach 64 [4]. In the study by Shah et al., 92.6% of patients underwent a transperineal mapping biopsy before treatment. However, the results in Table 1 in their article [3] show that the median number of biopsy needles was only 25, which raises the question why so few biopsy needles were used for transperineal mapping biopsy.

The results reported by Shah et al suggest that focal therapy for medium- to high-risk PC has a satisfactory therapeutic effect and a relatively low incidence of complications. However, the patients with high-risk disease selected in the study mainly had stage T3a PC. Patients with prostate-specific antigen >20 ng/ml and Gleason score ≥8 were in the minority. The range of cryotherapy is generally >1 cm beyond the target area, which is helpful for the treatment of PC with capsule invasion [5]. In addition, the PC lesions for patients in the study cohort were mainly located in the anterior half of the prostate, which is far from the neurovascular bundles on both sides of the organ. Focal therapy for lesions in the anterior half of the prostate can cause less damage to the neurovascular bundles, and thus has better potential for avoiding the occurrence of postoperative erectile dysfunction. These may be the reasons why focal therapy of high-risk PC in this study had satisfactory treatment outcomes. For high-risk PC, endocrine therapy is generally recommended after radical treatment. Thus, another relevant question is whether endocrine therapy was used for patients with high-risk PC undergoing focal therapy in the study.

***Conflicts of interest:*** The author has nothing to disclose.

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