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based on interval prostate specific antigen (PSA) and magnetic resonance imaging (MRI) testing, reflex or for cause biopsy, and rates of secondary treatments. There would be little disagreement that PGA achieved oncological control if men avoided whole gland treatment and did not develop metastasis or lethal disease. We will not know if PGA achieves these outcomes for decades. One of end-points for expressing oncological control in the present study was avoidance of whole gland treatment. The FDA approves of this end point since it is clinically meaningful and measureable. With a median follow up of only 30 months, only 9% of men underwent whole gland salvage treatment. So, may we conclude PGA with HIFU achieves intermediate oncological control? It is my experience that most men who are attracted to PGA will not undergo whole gland treatment under any circumstance. The surgeon can also heavily influence decisions how to manage in or out of field occurrence. For these reasons, I am hesitant to conclude that avoidance of whole gland salvage treatment at a median of 30 months indicates intermediate oncological control was achieved. The early validation studies of AS performed reflex biopsies at regular intervals to confirm oncological control. I strongly believe the absence of demonstrable disease should become the gold standard for assessing oncological control following PGA. Hopefully, we will ultimately demonstrate that PSA velocity or mpMRI individually, or in combination, can be reliable surrogates for oncological control. Identifying high volume GGG 1 or any Gleason pattern 4 in or out of field should be considered an oncological failure since this represents indication for treatment. Unfortunately, the authors did not prospectively mandate interval PSA and MRI testing and reflex biopsy in order to validate that noninvasive tests are reliable surrogates of oncological control.

Finally, it is imperative to set realistic expectations for oncological control following PGA. Approximately, 10%, 25%, 50%, and 65% of men with biopsy GGG 1, 2, 3, and 4 disease will develop biochemical recurrences at 8 years following RP, respectively. Therefore, we must anticipate and accept oncological failures following PGA. "Treatment failures" following RP are associated with modest rates of incontinence and high rates of sexual dysfunction. Oncological failures following PGA are associated with virtually no adverse functional outcomes. Men experiencing PGA treatment failures may opt for AS, secondary PGA, or whole gland treatment. As a surgeon who offers PGA to men with only clinically significant PCa, it is my conviction that while we may not cure the disease in some men, we will not compromise metastasis free and overall survival, providing we are vigilant in assessing and treating oncological failures in its early stages. The investigators did not discuss compliance with follow-up in their series. I believe the biggest challenge toward preventing metastatic and lethal disease following PGA will not be failure of treatment alone, but rather failure of vigilant follow-up.

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EDITORIAL COMMENT



There is a lack of high-level evidence validating opinions how to best assess oncological outcome following partial gland ablation (PGA). Oncological outcome following PGA has been reported

AUTHOR REPLY



We agree with the important points raised in this commentary. There is indeed a lack of evidence as to what constitutes optimal