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EDITORIAL COMMENT

In the treatment paradigm for prostate cancer, the pendulum has swung towards increasing use of active surveillance (AS) for lower risk disease, reflected by the most recent guidelines from the American Urological Association.[1] These recommendations are supported largely by level-1 evidence from the PIVOT and ProtecT trials, which revealed similar mortality outcomes between observation and primary treatment for patients with clinically localized disease.[2,3] In the present study, the authors characterize the management patterns of a unique, sizable cohort of patients with very low, low, or intermediate risk prostate cancer diagnosed in one of several large community practices distributed geographically across multiple states. Although the biopsies were conducted before the most recent American Urological Association guidelines were released, the results encouragingly reveal that nearly three-fourths and half of community practices were adhering to current guideline recommendations regarding pursuit of AS as the initial treatment strategy for very low and low-risk disease, respectively. This adherence is to be applauded, as this approach theoretically is the least financially rewarding management strategy.

Undoubtedly, there are a multitude of factors that may impact treatment decisions in community practices compared to academic settings, and the authors note practice-level variation, which was similarly mirrored in a study from the Michigan Urological Surgery Improvement Collaborative.[4] Although reasons for pursuing primary treatment instead of AS are not captured in this study, patient preference may be driven by factors such as anxiety, need for repeat surveillance biopsies, and distance to treatment facility, among others. While older age was predictably associated with increased use of AS, the authors surprisingly did not find a significant association of race with AS, even though African Americans have a higher risk of adverse pathologic features and progression.[5]

Considering the impact that adherence to guidelines have on healthcare delivery and reducing financial burden, this article nicely assesses the prevalent practices and adoption of AS in prostate cancer management in the community setting. The data presented reflect the practices 5+ years ago, and indeed we have witnessed a considerable shift in the evaluation of prostate cancer patients since then. In our current era, reliance on multiparametric MRI, targeted biopsies, and genomic testing has largely supplemented the traditional approach of random systematic biopsies, especially when contemplating AS in patients with presumably lower risk disease. While these approaches are increasingly becoming standard practice at many large hospitals and academic centers, such technology may not be readily available in community practices, and an updated cohort would provide interesting insight into management trends over time in light of emerging technologies.

Undoubtedly, the decision to treat or observe prostate cancer is complex and relies on an individualized approach that involves a shared decision between the provider and the patient after considering life expectancy, underlying risk factors, competing comorbidities, and patient concerns. For a field that is rapidly evolving, we must do our diligence as clinicians to stay abreast the wealth of emerging knowledge, appreciate the latest guidelines, and educate our patients in order to pursue the optimal management strategy.

CONFLICT OF INTEREST

Authors declare no conflict of interest.

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