The utility of provincial AS guidelines

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In this issue of *CUAJ*, Cancer Care Ontario (CCO) (via Program in Evidence Based Care initiative) releases its active surveillance (AS) guidelines for the management of localized prostate cancer.[1] These guidelines are a welcome addition to the host of recent recommendations around early prostate cancer detection and management.[2] There are no other evidence-based jurisdictional guidelines in existence, and arguably given the healthcare delivery contrasts between the United States and Canada, a local perspective is preferable for Canadian practitioners. AS has its roots in Canada,[3] and for a variety of reasons has found early support here. AS mitigates the harms of over treatment and uncouples diagnosis from radical treatment.

Although adoption of AS has been increasing since its introduction,[4] there are still barriers to its implementation. Concerns around AS relate to the potential of missing a window of curability due to either misclassification at diagnosis, or unrecognized evolution of favourable risk cancer to a more aggressive phenotype over the course of surveillance.[5] Other concerns include the lack of consensus as to which patients are appropriate candidates, as well as which tests with what frequency should be carried out. The threshold for intervention with radical therapy is also variable. The lack of consensus in AS protocols[6] has contributed both to slow adoption and poor compliance to protocols, which in turn has hampered prospective data collection.

These guidelines address many of these concerns using available evidence to codify and standardize an AS protocol. In this guideline, the authors recommend AS for low-risk patients (defined as Gleason ≤6) as a standard. For intermediate-risk patients (defined as Gleason 7) active therapy is recommended. Select patients with low volume Gleason 3+4 (no more than 10% pattern 4) can also be considered for AS. The recommended AS protocol is consistent with current practice. It includes serial prostate-specific antigen/digital rectal examinations, confirmatory 12–14 core biopsies within 6 to 12 months of initial biopsy, and serial biopsies every 3 to 5 years thereafter. Indication for progressing to active therapy is grade change on re-biopsy, or increased volume of Gleason 6. These guidelines dovetail nicely with recently released CCO Prostate Cancer Treatment Pathway[7] and provide evidence-based guidance for the spectrum of prostate cancer management.

There are several areas in which the authors do not find enough evidence to make strong recommendations, but offer guidance. Evidence around the utility of magnetic resonance imaging is evolving and some guidance is offered regarding its use. The use of 5-alpha reductase inhibitors in AS is unclear at this time, but they may have a role.

While the authors have done a balanced job given the paucity of high level evidence on which to make recommendations, there are some refinements that may make their way into the next guideline. This guideline uses Gleason score alone for stratification. Risk groups are increasingly being refined for more granular stratification. In future iterations of surveillance guidelines, other models of risk groups, such as the Cancer of the Prostate Risk Assessment (CAPRA)[8] Kattan or other nomograms, may be used. Many promising biogenetic or genetic markers will help to stratify indolent from aggressive phenotypes of prostate cancer and should be part of AS protocols.

These guidelines are an excellent start, and opportunities become immediately apparent. The ability to gather data using a standard provincial AS protocol is an opportunity to consider creating a provincial registry. AS usage rates across jurisdictions are variable. There may be an opportunity to examine regional differences in AS usage as a quality metric. As factors allowing for discrimination of indolent from aggressive disease, as well better markers for progression become evident, these markers will need to be incorporated into AS guidelines. Undoubtedly, having a provincial evidence-based AS guideline will encourage more widespread adoption and hence improve the care of prostate cancer patients.

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