Active Surveillance: Not Your Father's Watchful Waiting

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Active surveillance is becoming a very reasonable and appropriate “treatment” strategy for men with low-risk localized prostate cancer, as Large and Eggener eloquently describe in this review article. It is important to recognize that active surveillance is not what was once referred to as “watchful waiting,” which I believe many patients interpret as “watching and waiting to die."

As the name implies, active surveillance is an active approach to prostate cancer (as opposed to the more passive nature of watchful waiting) that includes numerous diagnostic interventions to ensure that the tumor is behaving in a relatively benign manner, minimizing the possibility that the patient will experience adverse clinical outcomes due to prostate cancer.

Patient Perspective

The real challenge for health-care providers is dealing with patients’ preconceived notions surrounding prostate cancer and reassuring them that active surveillance is a reasonable approach. The key to this, in my opinion, is properly explaining the rationale for the approach. To this end, Large and Eggener may have understated the argument in support of active surveillance. A critical point is to reassure patients that there is a lengthy lead time associated with prostate-specific antigen (PSA) screening and that a significant number of screen-detected prostate cancers are clinically indolent. It is likely that the 5- to 8-year time frame and the 23% to 42% overdiagnosis rate mentioned in the article are conservative estimates. Using data from the Rotterdam site of the recently completed European Randomized Study of Screening for Prostate Cancer, Schroder[1] estimated the lead time associated with PSA screening to be 10.3 years and the overdiagnosis rate to be an astonishing 54%. As providers, we need to explain this to patients in simple terms and reassure them that, if their tumor shows any sign of biochemical or pathologic progression during follow-up, aggressive intervention can be undertaken safely at that time with little risk.

One of the possible adverse effects of active surveillance is increased anxiety, which Large and Eggener mention as a predictor of receipt of aggressive intervention. Interestingly, a recent prospective study of 150 prostate cancer survivors who entered the Prostate Cancer Research International: Active Surveillance (PRIAS) study in the Netherlands indicated that active surveillance was associated with decreased general and prostate cancer–related anxiety and less uncertainty with decision-making, compared to a reference population.[2] Of course, these findings are likely related to selection bias, as the study was not randomized, but by the same token, these patients had to be properly counseled to agree to enroll in the active surveillance program. This is really the key to patient acceptance of active surveillance—comprehensive counseling with detailed explanation of the risks and benefits of the approach. If a patient understands what active surveillance entails and knowingly wishes to pursue this approach, the data presented in this review article indicate that it is probably a safe and appropriate option.

Unanswered Questions

This is not to say that all the questions surrounding active surveillance are answered. While Large and Eggener recommend a rebiopsy prior to undertaking active surveillance, this is not the accepted standard of care, nor is it my personal approach. Like the investigators in the PRIAS study mentioned above[3] and those from the Prostate Testing for Cancer and Treatment (ProtecT) study, a randomized clinical trial comparing surgery, radiation, and active surveillance,[4] I prefer to rebiopsy the patient roughly 6 to 12 months after the original diagnosis. Even if the patient has occult aggressive disease that was missed on first biopsy, the lead time associated with PSA screening
makes it unlikely that the window of curability will close by omitting an immediate repeat biopsy and just performing a surveillance biopsy within 1 year.

The real problem is that we do not have data to suggest the optimal follow-up schedule in active surveillance, and there is little consensus on the topic. In fact, as evidenced in Table 3 of the Large and Eggener review, we are not even in agreement on the appropriate inclusion criteria for active surveillance programs or how best to define progression. These issues need to be the focus of clinical research in the future.

Conclusion

In summary, active surveillance is an acceptable therapeutic approach to low-risk prostate cancer in properly selected, well-counselled patients. In 2009, it should not be reserved for older men or men with multiple comorbid conditions only, although it is certainly appropriate in many of these patients. We know that a considerable number of younger and healthy patients have indolent disease and may benefit from the active surveillance approach.

Having said that, I must acknowledge something that my late colleague and friend John Stein used to say—that even if 1 in 3 patients with screen-detected prostate cancer has clinically meaningless disease, we can’t identify which ones are harmless and, therefore, we are better off overtreating a third of patients than undertreating two-thirds. While I did not agree with him on this point, we both agreed that there remains a pressing need for novel biomarkers of disease aggressiveness that will allow us to better predict the course of prostate cancer. Once these new biomarkers are identified, I am certain that the utilization of active surveillance will appropriately increase and may even rival surgery or radiation as primary therapy in localized disease.

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