Best practice in active surveillance for prostate cancer: A consensus guideline for health professionals

Contents:
Introduction ................................................................. 1
Our guidelines for health professionals ........ 2
  1) Who should be offered active surveillance? .............. 2
  2) Who shouldn’t be offered active surveillance? .......... 2
  3) Decision-making ...................................................... 2
  4) Follow-up and support ............................................. 2
  5) When to stop active surveillance ......................... 3
Expert Reference Group .............................................. 4
References used in the review ................................. 5

Introduction
We have developed guidelines on best practice in active surveillance in prostate cancer. These are based on:
• a review of all the available research
• an audit of current practice in the UK and other countries
• research into how men with prostate cancer feel about active surveillance.


They include guidance for health professionals on:
• who should be offered active surveillance
• who shouldn’t be offered active surveillance
• decision-making
• follow-up and support
• when to stop active surveillance.

Our guidelines have been developed for health professionals in centres using pre-biopsy multi-parametric magnetic resonance imaging (mpMRI) scans to help diagnose prostate cancer.

If you have prostate cancer
These guidelines outline what we believe is best practice in active surveillance, however, your hospital may do things slightly differently. If you have prostate cancer and are thinking of going on active surveillance you can read more about what it involves, the advantages and disadvantages and what to expect on our website at prostatecanceruk.org/active-surveillance
For general information about prostate cancer, visit prostatecanceruk.org/information
Our guidelines for health professionals

1) Who should be offered active surveillance?

Active surveillance is suitable for men whose prostate cancer is contained inside the prostate (localised prostate cancer) and isn’t likely to spread (low-risk prostate cancer).

Men with a Gleason score of 6 (3+3) should be offered active surveillance as a first management approach.

Active surveillance may also be suitable for some men with prostate cancer who have all of the following:

- a Gleason score of 7 (3+4)
- an mpMRI scan that shows a T stage of T2* or lower
- the biopsy results match the MRI results (they both show signs of prostate cancer in the same areas)
- a PSA density value of 0.2ng/ml² or lower
- should be well enough to have treatments such as surgery or radiotherapy.

For more information about tests and test results, visit prostatecanceruk.org/tests

2) Who shouldn’t be offered active surveillance?

Active surveillance is not suitable for men with prostate cancer who have any of the following:

- a Gleason score of 7 (4+3) or higher where Gleason grade 4 is found in more than two biopsy samples
- an mpMRI scan that shows a T stage of T3a** or higher
- more than 5mm of cancer in any of their biopsy samples.

Men with a Gleason score of 7 (4+3) where Gleason grade 4 is found in only one or two biopsy samples, or who have less than 5mm cancer in all of their biopsy samples, can be offered another biopsy if they are interested in active surveillance.

3) Decision-making

Men who are offered active surveillance should be given easy-to-understand information and support to help them decide whether to go on active surveillance or have treatment straight away.

This should include a discussion about what’s important to them, all other suitable treatment options, and the risks, benefits and side effects of each treatment.

4) Follow-up and support

Support for men

Men on active surveillance should have access to a clinical nurse specialist (CNS).

They should be offered and have access to support and counselling at any time while they are on active surveillance.

Year one of active surveillance

All men who choose active surveillance should be given an active surveillance plan that is tailored to them and their cancer by their consultant urologist.

The plan should tell them how often they should have a PSA test, and the PSA level that means they need to see a consultant again (PSA threshold). The active surveillance plan should be shared with their GP.

Men should have regular PSA tests (as set out in their active surveillance plan). How often a man has a PSA test will depend on their:

- previous PSA levels
- mpMRI scan results
- PSA density.
If a man’s PSA level goes above their personal PSA threshold, their GP should test for a urine infection and, if no infection is found, do another PSA test after six weeks. If the PSA level is still above their personal PSA threshold, then the man should be referred to the hospital for further tests.

Men on active surveillance should also have an mpMRI scan 12 months after their previous (baseline) scan. If a man can’t have an mpMRI scan, then they should have a DRE at 12 months instead.

They should then have a biopsy if their mpMRI scan results show changes to their cancer or if their PSA level has risen above their personal PSA threshold.

A routine biopsy after 12 months can be delayed if other tests suggest the cancer is unlikely to spread, for example if the man’s mpMRI scan results and PSA level haven’t changed. However, men may choose to have a biopsy after 12 months, even if their mpMRI scan results and PSA level suggest their cancer hasn’t changed.

**Year two of active surveillance and onwards**
The following guidelines are for men who are in their second year (or later) on active surveillance. They should be used every year until a man begins a treatment like surgery or radiotherapy, or moves on to watchful waiting.

If a man stays on active surveillance, their consultant should update their active surveillance plan. This updated plan should be shared with their GP. The plan should still tell men how often they should have a PSA test and what their personal PSA threshold is.

Men should have regular PSA tests (as set out in their active surveillance plan). How often a man has a PSA test will depend on their:
- previous PSA levels
- mpMRI scan results
- PSA density.

If a man’s PSA level goes above their personal PSA threshold, their GP should test for a urine infection and, if no infection is found, do another PSA test after six weeks. If the PSA level is still above their personal PSA threshold, then the man should be referred to the hospital for further tests.

Men may have an mpMRI scan in their second year (or later) of active surveillance if cancer was visible on their first (baseline) mpMRI scan, or if their PSA level goes above their PSA threshold. Their GP, consultant or CNS may also decide to do a DRE.

If a man can’t have an mpMRI scan, then they should have a DRE instead.

Men should then have a biopsy if their mpMRI scan results show changes to their cancer. Men may also choose to have a biopsy, even if their mpMRI scan results and PSA level suggest their cancer hasn’t changed.

Men’s general health should be checked regularly to make sure they are still fit enough to receive other treatments, like surgery or radiotherapy, if they need them.

**5) When to stop active surveillance**
A man should be able to stop active surveillance at any time to either have treatment to get rid of the cancer, such as surgery or radiotherapy, or go on to watchful waiting.

The decision should only be made after discussion with their GP, CNS or consultant, and should consider the man’s personal preferences and whether their cancer has grown. Doctors will also look at men’s general health and any other health problems they have when deciding whether treatment or watchful waiting would be more suitable.

Read more about active surveillance on our website at prostatecanceruk.org/active-surveillance
Expert Reference Group

These guidelines have been developed and agreed by the following Expert Reference Group:

- Mark Ashworth, School of Population Health and Environmental Sciences, King’s College London.
- Robert Bradley, Consultant Radiologist, Sheffield Teaching Hospitals NHS Foundation Trust.
- Keith Cass, Founder of The Red Sock Campaign and Board member and Trustee of Tackle Prostate Cancer.
- Philip Cornford, Consultant Urological Surgeon, Royal Liverpool University Hospital NHS Trust.
- William Cross, Consultant Urological Surgeon, St James University Hospital, Leeds.
- Vincent Gnanapragasam, Academic Urology Group, Department of Surgery and Oncology, University of Cambridge.
- Liz Hetherington, Researcher, Pattern Research Ltd.
- Julian Keanie, Clinical Radiologist, Western General Hospital NHS Trust, Edinburgh.
- Scott Little, Clinical Nurse Specialist, Western General Hospital NHS Trust, Edinburgh.
- Ken Mastris, Vice-Chairman and Secretary of Tackle Prostate Cancer.
- Samuel Merriel, Exeter Medical School, University of Exeter.
- Caroline Moore, Consultant Urological Surgeon, University College London Hospitals NHS Foundation Trust.
- Adam Nairn, Expert Patient Representative, Scotland.
- Jon Oxley, Consultant Histopathologist, North Bristol NHS Trust.
- Chris Parker, Consultant Clinical Oncologist, Royal Marsden Hospital.
- Amit Patel, Department of Radiology, Lister Hospital, Hertfordshire.
- Lucy Powell, Uro-Oncology Clinical Nurse Specialist, Colchester Hospital University Foundation Trust and British Association of Urological Nurses (BAUN) Trustee.
- Jonathan Richenberg, Consultant Radiologist, Department of Radiology, Royal Sussex County Hospital, Brighton, and Brighton and Sussex Medical School.
- Martin Roland, Emeritus Professor of Health Services Research, University of Cambridge.
- Monique Roobol, Erasmus University Medical Centre, Department of Urology, Rotterdam, The Netherlands.
- Murali Varma, Consultant Histopathologist, Cardiff and Vale University Health Board, Wales.
- Deborah Victor, Uro-oncology Clinical Nurse Specialist, Royal Cornwall Hospitals NHS Trust.
- Clare Waymont, Urology Advanced Nurse Practitioner, Royal Wolverhampton Hospitals NHS Trust, UK and British Association of Urological Nurses (BAUN) Trustee.
PROFESSIONAL SUPPORT

prostatecanceruk.org/professional-support
professionals@prostatecanceruk.org
020 3310 7000