EDITORIAL

EAU guidelines for prostate cancer: To screen or not to screen?∗
Guías de la EAU para el cáncer de próstata: ¿cribar o no cribar?

Since the implementation of serum prostate-specific antigen (PSA) as a screening tool revealed acceptable results in reducing prostate cancer specific mortality, demonstrated in the US Prostate, Lung, Colorectal and Ovarian cancer screening trial (PLCO) and the European Randomized Study of Screening for Prostate Cancer (ERSPC), substantial aspects of its utilization should be taken into closer consideration: As physicians are increasingly confronted with low-grade prostate cancer, there is a demand for distinct PSA cutoff values, adjusted to age- and disease-related risk groups, to guide patients to an individual suitable therapy concept, such as active surveillance. This concept implies the PSA to be a reliable marker for cancer progression and its prognosis as well as to demonstrate low rates of fluctuations in order to decrease the requirement of repeat- or even confirmatory biopsies.

Various data have been published on how far the initial PSA value correlates with pathological characteristics in low-grade prostate cancer, leading clinicians to increasingly confirm elevated laboratory PSA values by applying ultrasound guided biopsies. In terms of quaternary prevention, Resnick et al.² outline that patients who undergo serial biopsies harbor a significant risk for adverse pathologies. Especially the concept of active surveillance, once screened positively for an elevated PSA, encourages multiple repeat biopsies and reveals a potential undergrading and understaging in patients undergoing a radical prostatectomy after cancer progression.¹ Yet, inhomogeneous data have been published on how to follow low-grade prostate cancer patients, excluding the application of numerous control biopsies. Once the PSA-based diagnosis ‘prostate cancer’ has been made, despite a potential lack of sensitivity and specificity in differentiation of clinically significant cancers, there is no defensive therapy concept, which can minimize the risk of disease progression sufficiently, particularly in young patients with high Gleason scores. These coherences do not call a systemic screening into question, which incloses the power to detect prostate cancer at an early and curable stage – they would rather underline the need for satisfactory, evidence-based guidelines on how to proceed, once low-grade prostate cancers, which will probably never put patients’ health in jeopardy, have been detected.

References


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