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SPECIAL ARTICLE

How will focal therapy fit in with existing treatments?☆

M. Emberton[a], F. Gómez-Veiga[b,*], H. Ahmed[a], L. Dickinson[a]

[a] *Division of Surgery and Interventional Science, University College London, Londres, United Kingdom*
[b] *Servicio de Urología, Complexo Hospitalario Universitario de A Coruña, A Coruña, Spain*

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KEYWORDS
Prostate cancer;
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Abstract
Context: The current management of localized prostate cancer is a therapeutic challenge with different options including active radicals or active follow-up. The aim of this paper is to analyze the feasibility and validity of the ''Focal'' active treatment versus the concept of active follow-up or Radical Treatment.
Evidence acquisition: We reviewed the literature on the various diagnostic methods, advantages, and difficulties of active follow-up and Radical Treatment, versus focal therapy with the possibilities of defining characteristics of aggressiveness and patient selection.
Evidence synthesis: The mesh biopsy techniques along with multiparametric magnetic resonance imaging and association of factors such as tumor size, length of affected cylinder and Gleason are parameters that allow us to define location and definition of clinically significant tumors and subsidiary of focal therapies.
Conclusions: The definition, location and aggressiveness of prostate cancer in low-intermediate risk tumors can be defined avoiding radical therapies with their side effects or the risks of underestimating tumors as in active follow-up without the minimum side effects.

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* Corresponding author.
E-mail address: fgveiga@telefonica.net (F. Gómez-Veiga).

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PALABRAS CLAVE
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¿Cómo encajará la terapia focal en los tratamientos existentes?

Resumen
Contexto: El manejo actual del cáncer de próstata localizado supone un reto terapéutico con diferentes opciones, incluyendo las activas radicales o el seguimiento activo. El objetivo de este trabajo es analizar la posibilidad y validez del tratamiento activo «focal» frente al concepto de seguimiento activo o tratamiento radical.
Adquisición de evidencia: Realizamos una revisión de la literatura sobre los diferentes métodos diagnósticos, ventajas o dificultades del seguimiento activo y tratamiento radical frente a la terapia focal, con las posibilidades de definición de características de agresividad y selección de pacientes.
Síntesis de evidencia: Las técnicas de biopsia con rejilla junto con la resonancia nuclear magnética nuclear multiparamétrica y la asociación de factores como el tamaño del tumor, la longitud del cilindro afecto y Gleason son parámetros que nos permiten afinar en la localización y definición de tumores clínicamente significantes y subsidiarios de terapias focales.
Conclusiones: La definición, localización y agresividad del cáncer de próstata en tumores de riesgo bajo-intermedio puede ser definida evitando las terapias radicales con sus efectos secundarios, o los riesgos de subestimar tumores como en el seguimiento activo con los mínimos efectos secundarios.

Puntos comunes: active surveillance and focal therapy

Active surveillance (AS) and focal therapy (FT)-directing therapy to cancer instead of to prostate-share a significant common denominator: the idea that men, given an acceptable cancer risk, they generally prefer to keep their prostate. Physicians recommend preservation strategies of tissues through AS and FT hoping to minimize some of the harms associated with overdiagnosis. While the diagnosis cannot be reversed, we can present to the newly diagnosed man a procedure associated with reduced levels of damage in a group of patients who probably have little opportunity to benefit from treatment. In recommending the preservation of tissues, the doctor gives one of the two strategies that the patient can consider as an alternative to whole-gland radical therapy in its many forms.

Strategy one

AS provides a containment strategy: ''Mr. John, you have prostate cancer, but we are pretty sure that it is unimportant. I think that it is unlikely you will be affected if we do not touch it. We will survey it and will treat it in case we see changes.''

Strategy two

FT provides a risk reduction strategy: ''Mr. John, you have prostate cancer. We have identified the worse part of it. We should be able to treat the cancer and to preserve most of your prostate''.

Both strategies overlap considerably; however, one of them focuses on the period final, and the other one on the beginning. Both try to refer men with low-risk prostate cancer, who can safely avoid a whole-gland radical therapy. AS procedure assesses over time the situation of low risk by submitting the patient to a test that lacks precision. After every review, some patients are newly classified because they exceed the upper level of risk and they leave the AS; usually whole-gland radical therapy is offered to them.[1] Finally, a depurated group of patients with low-risk status, who have not been reclassified histologically, are considered free of ''progression''.

When offering FT, location, extent and risk (according to the cancer degree and the maximum length of the nucleus of cancer) have to be established in advance and in order to define the disease's topography. These three parameters determine the completion of treatment. In order to rule out cancer clinically important, accuracy is required not only in the therapy field (high specificity) but also in the volume of the tissue that has to be preserved (high sensitivity). Traditional diagnostic tests are not up to the job. Focal therapist must adopt a sampling strategy that could fulfill both requirements.

For the physician, recommending a strategy for preservation of tissue implies significantly different challenges from those that arise when treating the whole gland. The doctor treating the entire gland in the most basic level requires at least a diagnosis of prostate cancer. A Gleason of 3 + 3 mm is enough to decide to carry out the treatment. A question still remains: if the cancer is aggressive or lethal.[2] This aspect is unimportant for the surgeon or for the radiation oncologist who plan patient's IMRT, because the treatment for the organ-confined disease does not depend on the size, the cancer grade and localization. For everyone the goal, in a certain manner, is the prostate, not the cancer.

When recommending AS, the physician requires more information. A strategy of prostate preservation will never