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How Does Active Surveillance for Prostate Cancer Affect Quality of Life? A Systematic Review

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Abstract

Context: The optimal management of screen-detected, localised prostate cancer remains controversial, related to overtreatment issues of screening and the nonrandomised evidence base. Active surveillance (AS) aims to delay or avoid curative therapy but may potentially harm patients' well-being through living with untreated prostate cancer.

Objective: To systematically review the literature on quality of life (QoL) in patients undergoing AS.

Evidence acquisition: Embase, Medline, Psychinfo, Cochrane Central, Web of Science, and PubMed databases were searched in May 2014 using *quality of life, active surveillance, prostate cancer*, their synonyms, and targeted manual searches. The psychological dimensions related to health-related QoL (HRQoL) outcomes were anxiety and depression, distress, decisional conflict, and mental health.

Evidence synthesis: Ten clinical and research-based AS studies worldwide measured HRQoL and related psychological facets in six cross-sectional studies and four cohorts (follow-up: 9–36 mo; published: 2006–2014). Six studies were linked to published AS cohorts. In total, 966 men undergoing AS (mean: 102 per study) were assessed (mean age: 66 yr). AS patients had good overall HRQoL scores, which were comparable or better than those of patients undergoing postradical treatment (comparator group in four studies), men's partners (one study) and population-based data (three studies). Anxiety and depression scores were favourable. Selection bias may be present, as none were randomised comparisons. Decreased psychological well-being may be partly predicted by AS patients' baseline and clinical characteristics.

Conclusions: Patients undergoing AS reported good QoL and did not appear to suffer major negative psychological impacts. Longer follow-up is required as well as investigation into which patients are predisposed to negative impact and leaving AS prematurely.

Patient summary: We reviewed the published evidence for quality-of-life impact on men with prostate cancer being monitored by active surveillance. The men who were on active surveillance usually reported good levels of well-being and did not appear to suffer major negative psychological impacts. The research findings suggest little presence of anxiety and depression and high overall quality of life related to their disease. However, there are few long-term studies, so more high-quality research is needed to make definitive recommendations.

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1. Introduction

The incidence of prostate cancer (PCa) worldwide is increasing as opportunistic screening becomes more widespread and average life expectancy rises [1]. A large randomised controlled trial showed disease-specific mortality benefits to population-based PCa screening in Europe [2,3] with less clear results in a similar trial in the United States [4], possibly due to the high rates of prostate-specific antigen (PSA) testing in their control group. However, both overdiagnosis and resulting overtreatment are problematic sequelae of PCa screening, due to the low diagnostic specificity of PSA levels and prostatic biopsies.

Active surveillance (AS) is an option for patients with favourable risk, localised PCa; AS aims to avoid or delay radical treatments without compromising long-term, disease-specific survival. AS involves regular monitoring by multimode imaging, PSA levels, and prostatic biopsies [5–7]. AS has existed for around 15 yr worldwide, although uptake has generally been modest outside established research cohorts such as the Prostate Cancer International Active Surveillance (PRIAS) study [8]. However, recent prominence of AS in American and European PCa management guidelines will potentially further increase use of this approach [9].

Radical treatment can have lifelong impact on patients' quality of life (QoL), including erectile, rectal, and urinary dysfunction [10]. Patients undergoing AS can potentially avoid these consequences of radical treatment but may suffer negative psychological effects due to living with an untreated cancer and the fear of disease progression [11–13]. If AS patients experience heightened distress and anxiety, they are potentially more likely to opt for radical treatment in advance of protocol-based recommendations [14].

The need to understand the potential psychological burden of AS was identified during an international AS conference in February 2014 in Amsterdam. This systematic review aimed to evaluate the published evidence on the health-related quality of life (HRQoL) and its related psychological dimensions in men undergoing AS, to help inform clinical practice and treatment decision making. Previous literature reviews in this area were nonsystematic [13–15], combined HRQoL studies of AS patients and of those undergoing passive observation without radical intervention (watchful waiting [WW]) for patients unsuitable for radical treatment [12], or were focused on the clinical outcomes of AS [5].

2. Evidence acquisition

This systematic review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines [16] with predefined search terms, inclusion and exclusion criteria, data collection, and analysis processes.

2.1. Study eligibility criteria

All study designs with quantitative HRQoL data from men with localised PCa receiving AS were eligible (without age

restriction). This review focused on overall HRQoL and on the psychological dimensions related to HRQoL, namely, anxiety, depression, decisional conflict, coping, distress, satisfaction, and mental health, as well as other psychological factors potentially related to AS as shown in previous qualitative studies (eg, uncertainty) and measured with standardised or validated questionnaires. Studies purely reporting on the physical aspects of HRQoL (eg, urinary or bowel symptoms or erectile function) were ineligible. Studies either with men receiving WW or where it was unclear if they were AS patients were excluded as QoL data, for data on men on WW are not comparable to that of men on AS, given the palliative aim of WW versus the curative intent of AS [9,17]. Full-text original articles in English were eligible without restriction on publication date. If multiple papers originated from one dataset, we included the one with the longest follow-up period.

2.2. Search strategy and study selection

Studies were identified by searching electronic databases and scanning reference lists of selected articles. In May 2014, Embase, Medline, Psycinfo, Cochrane Central, Web of Science, and PubMed (Supplement 1) were searched using *quality of life, active surveillance and prostate cancer* and their relevant synonyms. Reference lists were also searched for potentially eligible publications and previous literature reviews of QoL and AS [13–15]. Two authors (I.J.K., L.B.) independently screened all the titles and abstracts and the resulting reference list was compiled by a third author (J.A.L.) for full-text screening and data extraction. Disagreements were resolved by consensus.

2.3. Data collection

Three authors (J.A.L., I.J.K., L.B.) extracted data onto a form that was designed and piloted on six AS studies for one-third of the selected references. Two other authors (L.D.F.V., R.vd.B.) each checked one-half of the data extraction forms (randomly assigned) against the full-text papers. Data extracted included study design, setting, timing of HRQoL assessments, country, AS protocol, outcomes, follow-up duration, study population (clinical, research, or population registry), HRQoL data collection methods, inclusion and exclusion criteria, risk of bias, standardised and validated questionnaires, number of participants, response rates, responder and nonresponder characteristics, effect estimates for outcomes, and rates of leaving AS due to anxiety.

3. Evidence synthesis

The literature search identified 1157 unique citations (Fig. 1); 1087 citations were excluded as they were reviews, commentaries, abstracts, validation of questionnaires, or participants were on WW. Three citations were identified by searches of bibliographies, thus leaving 73 citations for a full-text screening. Of these, 63 citations were excluded. Major reasons for exclusion were that patients did not meet eligibility criteria for AS ($n = 27$), no mental QoL data were

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