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Discontinuation of Active Surveillance Without Risk Reclassification Prior to Treatment

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INTRODUCTION AND OBJECTIVE: Guideline organizations support the use of active surveillance (AS) for all men with low risk (LR) and select men with favorable intermediate risk (FIR) prostate cancer (PC). Although encouraging AS as the initial approach for favorable-risk PC is an important first step in reducing overtreatment, this strategy is incomplete as it ignores another source of overtreatment: delayed treatment of men on AS who have not had risk reclassification. We evaluated the proportion of men that transitioned from AS to treatment without risk reclassification.

METHODS: We reviewed the Michigan Urological Surgery Improvement Collaborative (MUSIC) registry for men diagnosed with NCCN LRPC and FIRPC that underwent treatment after a period of AS to identify the proportion of men that did not have risk reclassification prior to treatment. Reclassification was defined as meeting any criteria for NCCN FIRPC for men initially diagnosed with LRPC and any criteria for NCCN unfavorable intermediate risk PC for men initially diagnosed with FIRPC.

RESULTS: From 2013 to 2021, 2118 men in MUSIC underwent treatment after initial AS, of which 741 (35%) did not have risk reclassification prior to treatment. A higher proportion of men with FIRPC underwent treatment without risk reclassification compared with LRPC (50% vs. 29%, $p<0.001$). The proportion of men with LRPC undergoing delayed treatment decreasing from 60% in 2013 to 23% in 2021 (Fig. 1). Alternatively, the proportion of men with FIRPC treated without risk reclassification has remained stable.

CONCLUSIONS: The overall percent of patients leaving AS for treatment without risk reclassification has declined in MUSIC, likely due to an increasing acceptance and comfort with AS for favorable-risk PC. The proportion of men with FIRPC undergoing treatment without risk reclassification has remained relatively stable, which may be explained by the clinical uncertainty regarding a treatment threshold for these men on AS. While there remains uncertainty regarding when patients with FIRPC on AS should be treated, there are QI opportunities to reduce overtreatment in men with LRPC on AS, a group for which the urologic community has coalesced around the use of AS as the preferred approach.

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