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The Urologist's Perspective

N. Mottet, Dept. of Urology, University Hospital, Saint Etienne, FR

The widespread use of PSA has led to a significant increase in the number of prostate biopsies, a significant unnecessary biopsies leading to the discovery of insignificant lesions. Regarding biopsies, several progresses are on their way in the near future. The first one might be a better definition of patients at risk, either by a better use of the PSA or its derivatives.

Multiparametric MRI is associated with an extremely low risk of missing an aggressive lesion [1]. These MRI guided biopsies are associated with a clear improved pT classification or Gleason score [2]. This improvement is obtained with less cores. It is the first step before considering any form of focal treatment. In 2014 we are far from these findings. Sonography has a clear future and changes (either positive or negative) are to arrive soon. New targeting technologies such as elastography or histoscanning are under evaluation [3, 4]. Dedicated image fusion tools between MRI and sonography might become the future standard for targeted biopsy [5]. MRI interpretation reproducibility even using standardized tools remain a real issue, the inter-reader correlation being sometimes at best poor to moderate [6]. This must be confirmed outside expert centers and probably in each individual center before considering its systematic use.

The increasing infection related complications following biopsies [7] is a reality. It is linked to an increased resistance to antibiotics, specially those used for prophylaxis [8] and will soon represent a major issue. Decreasing the number of biopsies partly overcome this danger. The transperineal approach might be an alternative [9] but prospective trials are mandatory.

The use of PSA has led to an increased finding of small volume low grade lesions, many being considered as indolent while other are clearly under-evaluated. This is a limitation for active surveillance, specially in younger men. MRI will represent a major tool to solve this difficulty. Recently MRI has been shown to allow a better classification either globally [10] or for the extra-prostatic extension [11] and might even be the best predictive tool [12]. During follow up a standardized reporting might avoid confirmatory biopsies [13] and might simplifies follow up [14]. These results must be confirmed on large cohorts outside expert centers before being considered as standard. Senior adults represent a growing population with heavily undertreated lesions. Although the individual life expectancy is of paramount importance [15], its precise evaluation is lacking simple tools. Comorbidities are the main discriminating factors [16]. The G8 scale [17] represents a major improvement for patient stratification, combined with more specific tools [18]. These tools must be used to stop undretreating senior adults.

Surgery is a very effective treatment modality associated with some morbidity. It remains a demanding procedure with a long learning curve. Minimally invasive approaches have been suggested to be at least equivalent in term of functional outcome compared to the open ones [19, 20]. However the extra costs associated with this

approach will become a real issue. Cheaper robotic tools such as motorized needle holder or new 3D devices might become a viable alternative, particularly if we are mainly dealing with more advanced lesions, where the nerve protections will not be the priority compared to the required negative margins.

Finally the upcoming year will also see the start of a most awaited trial comparing surgery and radiotherapy in T3 prostate cancer (SPCG 15). Even if really difficult to conduct, this trial will be able to answer this major question: is any form of local treatment better ?

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