Re; Singh S, Patil S, Tamhankar AS, Ahluwalia P, Gautam G. Low-risk prostate cancer in India: Is active surveillance a valid treatment option? Indian J Urol 2020;36:184-90

We read with great interest the article by Singh *et al*. entitled "Low-risk prostate cancer in India: Is active surveillance a valid treatment option?"[1] We congratulate the authors for generating evidence regarding upstaging and upgrading of low-risk carcinoma prostate following radical prostatectomy (RP). We wish to highlight few points worth consideration regarding interpretation of the data in this study.

The authors have followed NCCN guidelines for active surveillance (AS) in low-risk carcinoma prostate (T1-T2a, Gleason score GS ≤6, prostate-specific antigen PSA <10 ng/ml). However, the majority of centers and the European Association of Urology guidelines follow a restrictive approach, offering AS to patients who fulfill the Epstein criteria (GS ≤6, with no more than 2 positive cores and no core having more than 50% of tumor).[2,3] The mean biopsy core positivity in the current study is 3.2 (1–8) with 50% of enrolled patients had ≥3 positive cores. The prostate biopsy cores taken were also variable raging 5–16 cores and there was no mention about percentage positivity of individual cores. Thus, it may be prudent to say that majority of patients enrolled in the current study were already not the preferred candidates for offering AS as per the restrictive approach. The authors themselves considering RP over AS in this subset of patients is in itself reflective of the same. Furthermore, the authors performed pelvic lymph node dissection in 16/46 (34%) patients of which 7/16 (43%) underwent extended pelvic lymph node dissection. It would be interesting to know the rationale behind performing lymph node dissection in these patients. In the current study, biopsy upgrading after RP occurred in 23 patients (50%). The upgrading has been reported in contemporary studies to the tune of 38%–72%.[4] Stackhouse *et al*. have reported that GS sum of <7 is itself an independent predictor of under grading of prostate biopsy.[5]

Furthermore, there is no mention about whether these enrolled patients were screen detected prostate cancer patients or not. The authors themselves state that "delayed diagnosis of the disease in our part of the world, attributable to the absence of a routine screening practice, or a more aggressive disease profile could be the possible reason. This emphasizes the need to practice caution while adopting Western standards for AS in Indian men." Rather than stating "adoption of western standards and a different tumour biology" as reason for upgrading, the study results serve as reminder to strengthen PSA screening program in our country.

The authors acknowledge that this is a single center retrospective study with limited number of patients ($n = 46$) and with no central pathology biopsy review. A better study design to answer the query raised by the title would be a prospective longitudinal study on patients undergoing AS or on patients who underwent RP among cohort who are already undergoing AS. Hence, the title of the article and its extrapolation to entire population of India is not valid as the authors themselves acknowledged that their patient cohort may not represent prostate cancer at the population level and the results must be interpreted with extreme caution.

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Received: 04.07.2020, **Accepted:** 23.08.2020, **Published:** 01.10.2020

Financial support and sponsorship: Nil.

Conflicts of interest: There are no conflicts of interest.

Access this article online

Quick Response Code:

Website: www.indianjurol.com

DOI: 10.4103/iju.IJU_386_20

How to cite this article: Sharma AP, Chaudhary K, Devana SK. Re; Singh S, Patil S, Tamhankar AS, Ahluwalia P, Gautam G. Low-risk prostate cancer in India: Is active surveillance a valid treatment option? Indian J Urol 2020;36:184-90. Indian J Urol 2020;36:331-2.