Author reply 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 thank our esteemed readers for their interest in our recent manuscript and their insightful comments on the same.[1] We deeply appreciate the compliments expressed for our attempt to present indigenously derived data on this vexing topic of active surveillance (AS) for prostate cancer (CaP) in India.

While we agree that many centers use the more restrictive Epstein criteria for advising AS, the very fact that this modality finds mention in all major guidelines (European Association of Urology, National Comprehensive Cancer Network etc.) as the preferred option for all low risk disease and as a valid option for favorable intermediate risk disease as well, implies that it reflects the recommended practice in the real world.[2-4] In this light, we believe that our study adds an important word of caution on the implementation of these guidelines in the Indian scenario. The decision for lymph node dissection in each low risk case was taken on the surgeon's discretion and perhaps reflects the lingering suspicion in our minds that some of these patients are likely to be upgraded or upstaged a fact that actually bears out in the final analysis.

We agree with our esteemed reader that screening is likely to help diagnose CaP earlier in our country and may increase the likelihood of a successful AS strategy. However, as in the west, this has to be weighed against the problems of overdiagnosis and overtreatment and is a separate matter of debate altogether. Being a retrospective analysis, with the limitations that we have acknowledged in the manuscript, it is not possible for us to give figures for screen detected versus symptomatic patients in our study. As suggested, a prospective longitudinal study on patients undergoing AS is definitely the way forward, and we hope that our manuscript will provide impetus to our colleagues for the same. At the same time, we would like to defend the title of our study with the acknowledged caveat that this represents only the first step in the quest for an answer to the role of AS for CaP in India, and that the extrapolation and interpretation of the same needs the requisite amount of caution.

We would also like to clarify that all patients underwent an magnetic resonance imaging (MRI) prior to radical prostatectomy in our cohort, thereby providing the most accurate preoperative clinical stage possible and almost eliminating the possibility of misattribution of stage. This is in stark contrast to the western world where MRI and bone scan is not even recommended for low risk disease and AS is recommended based on prostate biopsy findings, prostate-specific antigen, and clinical examination alone.[5] A misattribution of grade indeed is very much possible due to sampling errors and pathological misinterpretation and is the very reason why we recommend caution in implementing AS protocols in India. While we agree that targeted biopsy can definitely eliminate sampling errors, its use is currently limited due to factors related to accessibility and cost. As acknowledged as a limitation in our manuscript, in our cohort, a large proportion of the biopsies were performed outside our center and only the slides were reviewed by our pathologists. Hence, it was not possible to standardize biopsy protocols and implement targeted biopsy in every case. We would also like to clarify that all cases were performed by a single surgical team

led by a single surgeon at a single institution. The second institution mentioned is the current affiliation of the first author and not the place where this study was conducted.

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