Joint Implementation Statement

The British Association of Urological Surgeons (BAUS) welcome the National Institute for Clinical Excellence (NICE) prostate cancer guideline and are keen to work with NICE in supporting its implementation. Since its publication BAUS and NICE have had discussions to ensure that there is clarity over some of the recommendations in order to support the implementation of the guideline. It has been decided that a joint statement should be added to the implementation support documents.

The statement applies to:

The management of patients with low risk prostate cancer
It is expected that men with low risk prostate cancer suitable for radical treatment will be told about a range of treatment options including active surveillance, radiotherapy and surgery. This is to ensure that a fully informed joint decision on future care is made by the patient and his doctor. For patients choosing active surveillance, the decision about when and whether to carry out a re-biopsy should be made in consultation with the multi-disciplinary team.

Hormonal therapy for biochemical relapse after primary treatment
In asymptomatic men with biochemical progression after radical treatment, because of long lead times and difficulty in accurately measuring PSA doubling times, hormonal treatment should normally be deferred until PSA doubling times are around 3 months and account should be taken of the actual level of PSA.

In men with symptomatic recurrence or with bone metastases, hormone therapy should normally be started at the time these problems are detected.

Bisphosphonates and osteoporosis
The use of bisphosphonates to prevent or reduce the complications of bone metastases in men with hormone-refractory prostate cancer is not recommended. Bisphosphonates for pain relief may be considered for men with hormone-refractory prostate cancer when other treatments (including analgesics and palliative radiotherapy) have failed. The oral or intravenous route of administration should be chosen according to convenience, tolerability and cost. Strontium-89 should be considered for men with hormone-refractory prostate cancer and painful bone metastases, especially those men who are unlikely to receive myelosuppressive chemotherapy

Bisphosphonates should not be used routinely to prevent osteoporosis in men with prostate cancer receiving androgen withdrawal therapy. However because long term androgen deprivation is associated with osteoporosis, before men start androgen deprivation therapy assessment should

normally be made of their individual risk. Local protocols should be developed which prior to androgen deprivation would include measurement of bone density, and assessment of risk based on site of metastases and which would include triggers for starting chemo-preventative treatment to reduce risk of future bone complications.

Follow up of men with localised prostate cancer.

Healthcare professionals should discuss the purpose, duration, frequency and location of follow-up with each man with localised prostate cancer, and if he wishes, his partner or carers. Men with prostate cancer should be clearly advised about potential longer term adverse effects of treatment and when and how to report them. If agreed between doctor, patient and GP, then men with prostate cancer who have chosen a watchful waiting regimen with no curative intent should normally be followed up in primary care in accordance with protocols agreed by the local urological cancer MDT and the relevant primary care organisation(s). Their PSA should be measured at least once a year.

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