West of Scotland Cancer Network

Urological Cancers
Managed Clinical Network

Prostate Cancer

Regional Watchful Waiting Guidance

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Introduction

These regional guidelines are supported by the Urological Cancers MCN whose members also recognise that specific needs of individual patients may require to be met by an alternative approach and that this will be provided where necessary and documented in the patient notes.

- The purpose of the prostate cancer regional watchful waiting (WW) guidance is to align effective patient-centred practices across the West of Scotland to recognised best practice including the principles of realistic medicine [1, 9]
- Ensure WW programmes are clinically safe and effective
- Ensure WW programmes are efficiently delivered in the context of each health board's model of delivering care for the diverse cohorts of men living with prostate cancer

Prostate Cancer Watchful Waiting

The Scottish Cancer Network Clinical Management Pathway (SCN CMP) published 18 June 2025 defines watchful waiting (WW) as follows:

> Watchful Waiting (WW) is a way of monitoring, through a non-curative pathway, prostate cancer that isn't causing any symptoms or signs of advanced disease.
>
> - Patients should be fully counselled as to the 'non-radical' intent of WW, as opposed to the 'radical' intent of Active Surveillance prior to enrolment.
> - Suitability for WW will be case by case dependent on advancing age and comorbidities.
> - A WW protocol will generally involve a 6-12 monthly PSA test through the GP practice with the results monitored in secondary care and further investigation initiated when PSA is rising quickly on consecutive testing, or patient is symptomatic of metastatic disease.
> - Treatment should be initiated when advanced disease is demonstrated
>   - or PSA doubling time is <3 months, or metastases are evident on imaging (bone scan or CT; no role for MRI in these patients).
> - Treatment will be in the form of hormonal therapy which can be initiated on specialist advice in either primary or secondary care.

At the Urological Cancers MCN Advisory Board meeting on 03/02/2025, it was agreed that the CMP guidance would be enhanced with regional guidance to specifically address common issues arising during MDT discussions for patients on watchful waiting. These include:

1. The initial diagnostic approach, incorporating the principles of realistic medicine from the outset.
2. Examples of watchful waiting schedules.
3. The transition pathway for patients moving from Active Surveillance (AS) to WW due to changes in their clinical status, including potential exit points.

Following recent Advisory Board discussions, the updated guidance should also consider key factors for managing patients on WW, such as when to recommend repeat imaging (e.g., based on doubling times), assessment of symptoms, and patient fitness for treatment according to performance status. Additionally, a stop mechanism should be included—such as a symptom-triggered review after five years.

1. Approach from Initial Diagnosis

Watchful waiting (WW) is an appropriate strategy for patients with prostate cancer who are considered too frail or have significant comorbidities that limit life expectancy, making them unlikely to benefit from curative local therapies [9]. Unlike active surveillance (AS)—which involves regular PSA testing, digital rectal examinations (DRE), and MRI scanning with a view to radical treatment if/when any significant change is noted—watchful waiting typically involves less intensive follow-up. Patients are often monitored in urology outpatient clinics and instructed to alert their GP, urologist, or cancer nurse if concerning (red flag) symptoms emerge. The European Association of Urology (EAU) provides a clear comparison between AS and WW, as shown in the table below [9].

Entry Points for Watchful Waiting

Watchful waiting may be suitable for men with:

- Limited life expectancy and
- Slow-growing, low-risk, asymptomatic, organ-confined prostate cancer
- In some circumstances, patients with asymptomatic locally advanced or low volume metastatic disease might be suitable for a period of WW

Assessment tools to evaluate frailty should be utilized to support this decision [5, 9]. The goal is to prioritise **quality of life** over curative intent, recognising that many prostate cancers progress slowly, and patients often succumb to other health issues before the cancer becomes clinically significant [2, 3, 9]. WW is typically recommended when:

- The prostate cancer is unlikely to affect the patient's lifespan
- The patient is frail or has significant comorbidities
- Treatment is unlikely to improve overall survival
- Life expectancy is estimated to be less than 10 years [3, 9]

Initial counselling at the point of referral from primary care can help identify patients suitable for WW, potentially avoiding unnecessary imaging or prostate biopsies based on a clinical diagnosis alone [5].

a) Exit Points from Watchful Waiting

i. Symptom progression (Red Flags):

Key symptoms that may indicate disease progression include:

- Unexplained weight loss, fatigue
- New or worsening bone/back pain (possible metastases)
- Urinary symptoms such as frequency, straining, weak stream, or incomplete voiding (possible local invasion)
- Signs of ureteric obstruction (e.g. renal failure, back pain)
- Symptoms of malignant spinal cord compression: new-onset bowel/bladder dysfunction, worsening mobility, or severe back pain [2–5]

If such symptoms emerge, treatment, typically in the form of androgen deprivation therapy (ADT) after MDT discussion—may be initiated. As described by the Johns Hopkins Urology Department, WW focuses on "tracking symptoms, not test results," thereby avoiding unnecessary interventions [2, 3]. Other possible treatments at this stage include palliative radiotherapy or transurethral resection of the prostate (TURP) to manage symptoms [9], and less likely SACT in such a cohort.

ii. PSA kinetics:
A rapidly rising PSA - particularly a doubling time of less than 3 months, should prompt imaging +/- initiation of hormone therapy. A PSA doubling time of less than 12 months should prompt consideration of updated imaging (CT and bone scan) and initiation of hormone therapy if clinically indicated.

iii. Scheduled review (5-year checkpoint):
After 5 years of asymptomatic status with stable PSA kinetics, continued monitoring may no longer be necessary. Discontinuing follow-up at this point could reduce patient anxiety and should be a shared decision.

2. Watchful Waiting Schedules

WW schedules can vary by health board. For instance, NHS Ayrshire and Arran has its own framework [6]. Generally, WW protocols are **less prescriptive and intensive** than AS.

- PSA testing is typically performed every 6–12 months, either in urology clinics or through primary care, depending on local arrangements.
- In severely frail or homebound patients (e.g., nursing home residents), routine PSA testing shouldbe omitted. In these cases, hormone therapy would be initiated **only if symptoms develop** [6].
- For less frail individuals with stable PSA over 3–5 years, discharge from outpatient care may be considered. GPs should be advised to re-refer if symptoms emerge or if PSA rises rapidly [6].

Format of Follow-Up

Follow-up should be **individualised**. Options include:

- In-person or telephone consultations via urology clinics
- Alternating appointments between primary care and urology
- Letter-only slots for PSA blood test results
- Some health boards (e.g., NHS Ayrshire & Arran, NHS Forth Valley) use **cancer specialist nurses** to oversee WW follow-up, while others retain oversight in consultant-led clinics.
- Prostate Cancer UK supports ‘Personalised Stratified Follow-Up (PSFU)’, also called patient-initiated/open-access follow-up. Used in some UK Trusts like Guy’s and St Thomas’ and similar to the West of Scotland’s digital model, patients get PSA tests every six months with results mailed. A nurse-led helpline is available for symptom reporting, shifting routine follow-up from clinics to remote monitoring [7-8]

Differences between active surveillance and watchful waiting, EAU guidelines [9]

Aspect	Active Surveillance	Watchful Waiting
Treatment intent	Curative	Palliative
Follow-up	Pre-defined schedule	Patient-specific
Assessment/markers used	DRE, PSA, re-biopsy, imaging (MRI)	• None (wait for symptoms); or • Annual/biannual PSA (consider DRE if significant PSA-rise or imaging if metastases suspected)
Life expectancy	> 10 years	< 10 years
Aim	Minimise curative treatment-related toxicity without compromising survival, as the PCa is so indolent that it is unlikely to cause symptoms even with long life expectancy	Minimise palliative treatment-related (ADT) toxicity without compromising survival, PCa is unlikely to affect lifespan.
Eligible patients	Low- and selected intermediate-risk patients	Can apply to patients in all risk groups

3.Transitioning from Active Surveillance to Watchful Waiting

Men with organ-confined prostate cancer and a life expectancy of over 10 years are typically managed under an **AS** protocol, with a view to instigating radical management if there are any signs of significant progression. However, as clinical circumstances change, due to increasing age or the development of significant comorbidities, these patients may become more suitable for **WW**. In such cases, the entry criteria for WW should be revisited, and detailed counselling offered to support a shared decision-making process [9].

Any change in management strategy should be documented at the **multidisciplinary team (MDT)** meeting to ensure alignment across care providers. A Swedish study found that **48% of men** with very low-risk prostate cancer on AS transitioned to WW over their lifetime, with the likelihood of transition increasing with age at the time of AS initiation [10].

Where a transition to WW is anticipated, it may be prudent to formally register this **prior to requesting a surveillance MRI**, as the need for intensive monitoring may no longer be justified. Delaying this decision could lead to unnecessary investigations, contributing to avoidable resource use.

Some patients may find the transition from regular AS follow-up to the less intensive WW model unsettling, highlighting the need for clear explanation and reassurance. As nearly half of AS patients eventually move to WW, clinical teams in the West of Scotland should audit this group, given the potential impact on outpatient and imaging demands. Ultimately, this transition is a key shift in prostate cancer care and should be guided by clinical reassessment, patient needs, and shared decision-making [1, 2, 8–11].

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