West of Scotland Cancer Network

Urological Cancers
Managed Clinical Network
Primary Care Cancer Network

Prostate Cancer

Regional Follow-up Guidelines

Prepared by	M Underwood/G Oades
Approved by	Urological Cancers MCN and PCCN Steering Groups/ RCCLG / RCAG
Issue date	October 2016
Review date	October 2021
Version	2.0

Prostate Cancer Regional Follow-up Guidelines Review

The purpose of the prostate cancer regional follow-up guidelines is to ensure consistency of practice across the West of Scotland and the principles of any revision to the follow-up guideline will continue to ensure that management of patients after initial treatment for prostate cancer are:

- Patient-centred;
- Aligned to recognised current best practice;
- Equitable across the region;
- Clinically safe and effective; and
- Efficiently delivered.

The guidelines continue to be developed on the basis that the key aims underpinning the purpose of follow-up are to:

- Manage and treat symptoms and complications;
- Provide psychological and supportive care; and
- Detect and treat recurrent disease.

Follow-up practice has to be patient centred and, ideally, supported by empirical evidence of improved outcomes and survival. In the absence of good quality evidence, care should be tailored to the needs and preference of patients. The construction of appropriate follow-up guidance requires balancing perceived patient needs with effective utilisation of resources.

A review of the existing regional prostate cancer guidelines commenced in September 2015, led by Mr Mark Underwood, Consultant Urologist, NHS Greater Glasgow and Clyde and Mr Gren Oades, Consultant Urologist, NHS Greater Glasgow and Clyde and Clinical Lead, Urological Cancers MCN.

A review of evidence and guidance on the management of follow-up was undertaken and the West of Scotland Prostate Cancer Follow-up Guidelines updated to reflect contemporary practice. The National Institute for Clinical Excellence (NHS England) Clinical Guideline (175) Prostate Cancer: diagnosis and treatment, January 2014 and the European Association of Urology Prostate Cancer Guidelines, March 2015 were utilised to inform changes.

This updated guideline reflects the need to combine the previous sections "Post radical treatment with stable PSA and locally advanced prostate cancer with stable PSA" into a new section, entitled "Follow-up after treatment with curative intent; this includes surgery, brachytherapy, radiotherapy and adjuvant hormone therapy." This specific change will mean that an end date for patients in respect of curative intent is introduced for the first time. There will be a modest reduction in the numbers of visits overall in this section, with a change in emphasis meaning that more patients may be seen in the secondary care environment, although there is provision for follow-up in either primary (General Practitioners) or community (Clinical Nurse Specialists) care environment as per local agreement e.g. NHS Forth Valley.

The changes will also mean a modest decrease in the frequency of follow-up in active surveillance for patients with stable PSA. There is also provision for follow-up in primary care/community care as per local agreement.

These regional guidelines are recommended by the Urological Cancers MCN and the Primary Care Cancer Network 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.

Prostate Cancer Follow-up Guidelines

1) Watchful Waiting with stable PSA

Location	Frequency	Duration
Secondary Care	6 monthly	Year 2
Primary/ Community Care as per local agreement	Annual	Year 3 onwards – Consider End date 5 years

A PSA doubling time of less than 18 months is suggestive of disease progression and these men require more frequent assessment.

2) Active Surveillance patients with stable PSA

<table>
<tr><th>Location</th><th>Frequency</th><th>Duration</th></tr>
<tr><td>Secondary Care</td><td>4 monthly</td><td>Year 1</td></tr>
<tr><td>Secondary Care</td><td>6 monthly</td><td>Year 2</td></tr>
<tr><td colspan="3">If after 2 years there is a shared care option the patients can be discharged to primary/community care for annual PSA.</td></tr>
<tr><td>Secondary Care or Primary/ Community Care as per local agreement</td><td>6 monthly</td><td>Year 10
if radical treatment with curative intent not feasible</td></tr>
</table>

At enrolment in active surveillance: multiparametric MRI if not previously performed. Every 6–12 months, perform a DRE. At 12 months, the patient should have a: prostate re-biopsy

3) Follow-up after treatment with curative intent; this includes surgery, brachytherapy, radiotherapy and adjuvant hormone therapy.

<table>
<tr><th>Location</th><th>Frequency</th><th>Duration</th></tr>
<tr><td>Secondary Care</td><td>4 monthly</td><td>Year 1</td></tr>
<tr><td>Secondary Care</td><td>6 monthly</td><td>Years 2-3</td></tr>
<tr><td colspan="3">If after 3 years there is a shared care option the patients can be discharged to primary care/ community care for annual PSA.</td></tr>
<tr><td>Secondary Care or Primary/Community Care as per local agreement</td><td>Annually</td><td>Years 4-10, follow-up to cease at the end of year 10</td></tr>
</table>

After Radical Prostatectomy, PSA should be undetectable (<0.1ng/ml). A PSA of >0.2ng/ml and rising is associated with recurrent disease. After DXT +/- Hormones, a PSA increase of >2ng/ml above the nadir is a valuable sign of recurrence.

4) Metastatic prostate cancer with stable PSA

Location	Frequency	Duration
Secondary Care	3 monthly year 1, 6 monthly year 2	Years 1-2
Primary Care	6 monthly	Potential for shared care from year 3 onwards – no end date
Secondary Care	6 monthly	Patients on second line or third line treatment remain in secondary care – no end date

References:

The National Institute for Clinical Excellence (NHS England) Clinical Guideline (175) Prostate Cancer: diagnosis and treatment, January 2014

European Association of Urology Prostate Cancer Guidelines, March 2015