EDITORIAL COMMENT

UROLOGICAL ONCOLOGY

Prostate cancer: Improving lives by not "overtreating" patients

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INTRODUCTION

Overdiagnosis and overtreatment are considered significant problems in the era of PSA-based prostate cancer (PCa) screening. Active surveillance (AS) emerged as a common therapeutic solution to postpone side effects, i.e., erectile dysfunction, urinary incontinence, and bowel problems that reduce quality of life for men receiving treatment (surgery or radiotherapy) for low-risk PCa. Nowadays, AS remains a key management strategy for low-risk localized disease.

The approach involves closely monitoring the patient through regular prostate-specific antigen (PSA) testing, digital rectal examination, multiparametric magnetic resonance imaging (mpMRI) scans, and repeat biopsies to assess any changes in the disease. If signs of progression are detected, more aggressive treatment options, such as surgery or radiation, can be considered. Eastham and coauthors emphasize that AS should be individualized, with a thorough discussion about the potential risks and benefits, taking into account the patient's age, life expectancy, and overall health [1].

Eligibility for AS is generally based on well-defined clinical and pathological criteria. Most protocols include patients with low-risk PCa, characterized by a clinical stage T1c–T2a, a PSA of ≤10 ng/ml, a Gleason score of 6 (ISUP, Grade Group 1), and limited cancer involvement in biopsy cores (usually ≤2–3 cores with ≤50% cancer involvement per core) [2, 3]. Some protocols, developed by the European Association of Urology (EAU)/American Urological Association (AUA)/American Society for Radiation Oncology (ASTRO), cautiously extend eligibility to select patients with favorable intermediate-risk disease, particularly those with low-volume Gleason 3+4 (Grade Group 2) cancer, provided they are closely monitored. Risk stratification is critical in identifying appropriate candidates for AS. A significant advancement in AS protocols over the past decade has been the integration of mpMRI, which enhances both initial risk assessment and ongoing disease monitoring. The EAU and the British Association of Urological Surgeons

(BAUS) strongly recommend mpMRI at baseline to improve the detection of clinically significant prostate cancer and to guide targeted biopsy, thereby reducing the risk of underdiagnosis.

The evidence from the ProtecT trial, where men were randomized to treatment (radiotherapy/prostatectomy or AS), strongly supports that pathologic Grade Group 1 disease does not behave aggressively. Death from PCa occurred in 45 of 1,610 of men who were enrolled in the trial (2.7%): 17 (3.1%) in the AS group, 12 (2.2%) in the prostatectomy group, and 16 (2.9%) in the radiotherapy cohort. Among the 45 PCa-related deaths observed, none occurred in the 240 patients with pathologic Grade Group 1. Death from any cause occurred in 356 patients (21.7%), with a similar distribution across the three groups. Importantly, by the end of the 15-year follow-up, 133 men (24.4%) in the AS group were alive and had neither received radical treatment nor started ADT [4].

In the most recent study published in the "European Urology", Palmstedt et al. [5] reported long-term data from the GOTEBORG-1 trial regarding oncological outcomes for patients with low- or intermediate-risk PCa on AS. The authors found that many men in this cohort were able to avoid treatment for their disease, with as many as 55%, 35%, and 30% of men in the very low-risk, low-risk, and intermediate-risk groups, respectively, remaining free of treatment at 19 years after diagnosis. Importantly, oncological outcomes were very encouraging, and the PCa-specific survival rate at 25 years was 94%. There was a very low risk of PCa mortality at 22 years after diagnosis for men who initially opted for active surveillance of 1%, 8%, and 15% in the very low-risk, low-risk, and intermediate-risk groups, respectively.

In most of the European countries, around 30–40% of PCa patients with a localized disease are managed with active monitoring [6]. A review of the Polish medical literature revealed no original studies investigating AS. To our knowledge, most PCa patients in Poland are treated with either surgery or radiation. As a matter of fact, a substantial number of men still go through aggressive and costly treatment, e.g., robotic prostatectomy, that do not substantially affect survival.

Long-term data support AS as an effective strategy for PCa, and hopefully this approach would be more frequently adopted on Polish population. Although, according to Sosnowski et al. [7], there is still no perfect AS approach, we assume newly developed PCa biomarkers will be incorporated in the emerging protocols in the near future.

CONFLICT OF INTERESTS

The authors declare no conflict of interest.

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ETHICS APPROVAL STATEMENT

The ethical approval was not required.

References

1. Eastham JA, Auffenberg GB, Barocas DA, et al. Clinically Localized Prostate Cancer: AUA/ASTRO Guideline, Part II: Principles of Active Surveillance, Principles of Surgery, and Follow-Up. J Urol. 2022; 208: 19-25.
2. Chen RC, Rumble RB, Jain S. Active Surveillance for the Management of Localized Prostate Cancer (Cancer Care Ontario guideline): American Society of Clinical Oncology Clinical Practice Guideline Endorsement Summary. J Oncol Pract. 2016; 12: 267-269.
3. Deville C, Dess RT, Morgan TM, et al. Radiation Therapy Summary of the AUA/ASTRO Guideline on Clinically Localized Prostate Cancer. Pract Radiat Oncol. 2024; 14: 47-56.
4. Hamdy FC, Donovan JL, Lane JA, et al. Fifteen-Year Outcomes after Monitoring, Surgery, or Radiotherapy for Prostate Cancer. N Engl J Med. 2023; 388: 1547-1558.
5. Palmstedt E, Månsson M, Hugosson J, Arnsrud Godtman R. Active surveillance for screen-detected low- and intermediate-risk prostate cancer: extended follow-up up to 25 years in the GÖTEBORG-1 trial. Eur Urol 2025; 88: 373-380.
6. Mac Curtain BM, Daly K, Calpin G, et al. Reclassification of prostate cancer on first confirmatory prostate biopsy in men under active surveillance: A systematic review and meta-analysis. Cent European J Urol. 2025; 78: 125-136.
7. Sosnowski R, Kamecki H, Daneshmand S, et al. Active surveillance for low-risk prostate cancer – in pursuit of a standardized protocol. Cent European J Urol. 2020; 73: 123-126.