EAU-ESTRO-ESUR-SIOG GUIDELINES ON PROSTATE CANCER

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Introduction

Prostate cancer (PCa) is a complex disease, and, aside from disease characteristics, age, comorbidities and individual patient preference will impact treatment choice. All available management options need to be discussed, in full, with the patient.

Epidemiology and Risk Prevention

Prostate cancer is the most common cancer in males in Europe. It is a major health concern, especially in developed countries due to the greater proportion of elderly men in the general population, and the potential risk of over-treatment following early diagnosis. There are three well-established risk factors for PCa: increasing age, ethnic origin, and genetic predisposition. There is currently no high-level evidence that preventative measures may reduce the risk of PCa.

Classification and Staging Systems

The 2017 Tumour Node Metastasis (TNM) classification is used for staging (Table 1).

Table 1: 2017 TNM classification

T - Primary Tumour		
TX	Primary tumour cannot be assessed	
T0	No evidence of primary tumour	
T1	Clinically inapparent tumour that is not palpable	
	T1a	Tumour incidental histological finding in 5% or less of tissue resected
	T1b	Tumour incidental histological finding in more than 5% of tissue resected
	T1c	Tumour identified by needle biopsy (e.g. because of elevated PSA)
T2	Tumour that is palpable and confined within the prostate	
	T2a	Tumour involves one half of one lobe or less
	T2b	Tumour involves more than half of one lobe, but not both lobes
	T2c	Tumour involves both lobes
T3		Tumour extends through the prostatic capsule[1]
	T3a	Extracapsular extension (unilateral or bilateral) including microscopic bladder neck involvement
	T3b	Tumour invades seminal vesicle(s)
T4	Tumour is fixed or invades adjacent structures other than seminal vesicles: external sphincter, rectum, levator muscles, and/or pelvic wall	
N - Regional Lymph Nodes[2]		
NX	Regional lymph nodes cannot be assessed	
N0	No regional lymph node metastasis	
N1	Regional lymph node metastasis	

M - Distant Metastasis[3]		
M0	No distant metastasis	
M1	Distant metastasis	
	M1a	Non-regional lymph node(s)
	M1b	Bone(s)
	M1c	Other site(s)

[1] Invasion into the prostate apex or into (but not beyond) the prostate capsule is not classified as T3, but as T2.

[2] T2a to c only exist for clinical T2 (cT2). For pathological T2 they are no longer present in the 2017 TNM. Only pT2 exists.

[2] Metastasis no larger than 0.2 cm can be designated pNmi.

[3] When more than one site of metastasis is present, the most advanced category is used. (p)M1c is the most advanced category.

Table 2: EAU risk groups for biochemical recurrence of localised and locally advanced prostate cancer

Definition			
Low-risk	**Intermediate-risk**	**High-risk**	
PSA < 10 ng/mL and GS < 7 (ISUP grade 1) and cT1-2a	PSA 10-20 ng/mL or GS 7 (ISUP grade 2/3) or cT2b	PSA > 20 ng/mL or GS > 7 (ISUP grade 4/5) or cT2c	any PSA any GS cT3-4 or cN+ Any ISUP grade
Localised			**Locally advanced**

GS = Gleason score; PSA = prostate-specific antigen.

Recommendations for screening and early detection	LE	GR
Do not subject men to prostate-specific antigen (PSA) testing without counselling on the potential risks and benefits.	3	B
Offer an individualised risk-adapted strategy for early detection to a well-informed man with a good performance status and a life expectancy of at least ten to fifteen years.	3	B
Offer early PSA testing in well-informed men at elevated risk of having PCa: • men > 50 years of age; • men > 45 years of age and a family history of PCa; • African-Americans > 45 years of age; • men with a PSA level of > 1 ng/mL at 40 years of age; • men with a PSA level of > 2 ng/mL at 60 years of age.	2b	A
Offer a risk-adapted strategy (based on initial PSA level), with follow-up intervals of two years for those initially at risk: • men with a PSA level of > 1 ng/mL at 40 years of age; • men with a PSA level of > 2 ng/mL at 60 years of age. Postpone follow-up to eight years in those not at risk.	3	C
Decide on the age at which early diagnosis of PCa should be stopped based on life expectancy and performance status; men who have a life-expectancy of < 15-years are unlikely to benefit.	3	A

Diagnostic Evaluation

Clinical diagnosis

Prostate cancer is usually suspected on the basis of digital rectal examination (DRE) and/or PSA levels. Definitive diagnosis depends on histopathological verification of adenocarcinoma in prostate biopsy cores or unexpected discovery in specimens from transurethral resection of the prostate (TURP) or prostatectomy for benign prostatic enlargement.

The decision whether to proceed with further diagnostic or staging work-up is guided by which treatment options are available to the patient, taking the patient's life expectancy into consideration. Procedures that will not affect the treatment decision can usually be avoided.

A biopsy pathology report includes the type of carcinoma and parameters describing its extent (e.g. proportion of positive cores, percentage or mm of carcinoma involvement per core) as well as Gleason score per biopsy site and global Gleason score. Reporting of a radical prostatectomy (RP) specimen includes type of carcinoma, global Gleason score, pathological stage and surgical margin status. The International Society of Urological Pathology (ISUP)-World Health Organization (WHO) 2014 grade groups were adopted which allow patients to better understand the behaviour of their diagnosed prostate carcinoma, while separating Gleason score 7 adenocarcinoma into two prognostically very distinct categories; grade group 2 for Gleason score 7 (3 + 4) and grade group 3 for Gleason score 7 (4 + 3) (see Table 3).

Table 3: ISUP 2014 grade groups

Gleason score	Grade group
2-6	1
7 (3 + 4)	2
7 (4 + 3)	3
8 (4 + 4 or 3 + 5 or 5 + 3)	4
9-10	5

Recommendations for the clinical diagnosis of prostate cancer	LE	GR
Do not use transurethral resection of the prostate as a tool for cancer detection.	2a	A
Use the International Society of Urological Pathology (ISUP) 2014 Gleason grading system for grading of PCa.	2a	A
In symptomatic men, base the initial decision to perform a biopsy on prostate-specific antigen (PSA) testing and digital rectal examination (DRE).	2b	A
Use the additional diagnostic options in asymptomatic men with a normal DRE and a PSA between 2.0 and 10 ng/mL (risk calculator, or an additional serum or urine-based test [e.g. Prostate Health Index, 4Kscore or prostate cancer gene 3] or imaging).	3	C
Do not initially offer transition zone biopsies due to low detection rates.	2b	B
For initial diagnosis, perform a core biopsy of ten to twelve systematic transrectal or transperineal peripheral zone biopsies under ultrasound guidance.	2a	B

Perform transrectal prostate needle biopsies under antibiotic protection.	1b	A
Use a local anaesthetic by periprostatic infiltration for transrectal prostate needle biopsies.	1a	A
Ensure that prostate core biopsies from different sites are submitted separately for processing and pathology reporting.	3	A
Adhere to the 2014 ISUP consensus meeting Guidelines for processing and reporting of prostatectomy specimens.	3	A
Perform one set of repeat biopsies for persistent indications for PCa (abnormal DRE, elevated PSA or histopathological findings suggestive of malignancy at initial biopsy).	2a	B

Recommendations for processing prostatectomy specimens	**LE**	**GR**
Ensure total embedding, by conventional (quadrant) or whole-mount sectioning.	3	C
Ink the entire surface before cutting, to evaluate the surgical margin.	3	A
Examine the apex and base separately, using the cone method with sagittal or radial sectioning.	3	A

Recommendations for imaging - repeat biopsy	**LE**	**GR**
Before repeat biopsy, perform multiparametric magnetic resonance imaging (mpMRI) when clinical suspicion of PCa persists in spite of negative biopsies.	1a	A
During repeat biopsy include systematic biopsies and targeting of any mpMRI lesions seen.	2a	B

Guidelines for staging of PCa

Any risk group staging	LE	GR
Do not use computed tomography and transrectal ultrasound for local staging.	2a	A

Low-risk localised PCa	LE	GR
Do not use additional imaging for staging purposes.	2a	A

Intermediate-risk PCa	LE	GR
In predominantly Gleason pattern 4 (ISUP grade 3), include at least cross-sectional abdomino-pelvic imaging and a bone-scan for metastatic screening.	2a	A*
In predominantly Gleason pattern 4 (ISUP grade 3), use prostate multiparametric magnetic resonance imaging (mpMRI) for local staging.	2b	A

High-risk localised PCa/High-risk locally advanced PCa	LE	GR
Use prostate mpMRI for local staging.	2b	A
Perform metastatic screening including at least cross-sectional abdominopelvic imaging and a bone-scan.	2a	A

**Upgraded following panel consensus.*
ISUP = International Society of Urological Pathology.

Disease Management

Deferred treatment

Many men with localised PCa will not benefit from definitive treatment, and 45% of men with PSA-detected PCa may be candidates for deferred management. In men with co-morbidity and a limited life expectancy, treatment of localised PCa may be deferred to avoid loss of quality of life (QoL).

Guidelines overview - Primary treatment of PCa

General recommendations	GR
Discuss several treatment modalities (active surveillance [AS], surgery and radiotherapy) with patients suitable for such treatments.	A*
In patients who are surgical candidates for radical prostatectomy (RP), discuss all approaches (i.e. open, laparoscopic or robotic) as acceptable treatment options since none have clearly shown superiority in terms of functional or oncological results.	A
Offer external beam radiotherapy (EBRT) to all risk groups of non-metastatic PCa.	A
Offer intensity-modulated radiation therapy (IMRT) for definitive treatment of PCa by EBRT.	A
Moderate hypofractionation (HFX) with IMRT including image-guided radiation therapy (IGRT) to the prostate can only be offered to carefully selected patients with localised disease.	A
Moderate HFX should adhere to radiotherapy-protocols from trials with equivalent outcome and toxicity, i.e. 60 Gy/20 fractions in four weeks or 70 Gy/28 fractions in six weeks.	A

Recommendations		GR
Low-risk PCa		
Active surveillance	Offer active surveillance (AS) to patients with the lowest risk of cancer progression: > 10 years life expectancy, cT1/2, prostate-specific antigen (PSA) ≤ 10 ng/mL, biopsy Gleason score ≤ 6 , ≤ 2 positive biopsies, minimal biopsy core involvement (≤ 50% cancer per biopsy).	A
	Base follow up on digital rectal examination (DRE), PSA and repeated biopsies.	A
	Counsel patients about the possibility of needing further treatment in the future.	A
Radical prostatectomy	Offer both radical prostatectomy (RP) and radiotherapy (RT) in patients with low- and intermediate-risk PCa and a life expectancy > 10 years.	A
	Do not perform a lymph node dissection (LND) in low-risk PCa.	A
Radiotherapy	In low-risk PCa, use a total dose of 74 to 78 Gy for external beam radiotherapy (EBRT).	A
	In patients with low-risk PCa, without a previous transurethral resection of the prostate (TURP) and with a good International Prostate Symptom Score (IPSS) and a prostate volume < 50 mL, offer low-dose-rate (LDR) brachytherapy.	A

Cryotherapy, HIFU	Only offer cryotherapy and high-intensity focused ultrasound (HIFU) within a clinical trial setting. The lack of long-term efficacy compared to standard modality must be discussed with patients.	A
Focal treatment	Do not offer focal therapy of PCa as a therapeutic alternative outside clinical trials.	A
Androgen suppression	Unsuitable.	A
Watchful waiting	Offer watchful waiting (WW) to patients not eligible for local curative treatment and with a short life expectancy.	A
Intermediate-risk PCa		
Active surveillance	Not an option.	A
Radical prostatectomy	Offer both RP and RT in patients with low- and intermediate-risk disease and a life expectancy > 10 years.	A
	Offer nerve-sparing surgery in patients with a low risk of extracapsular disease (refer to nomograms).	B
	Use multiparametric magnetic resonance imaging (mpMRI) as a decision tool to select patients for nerve-sparing procedures.	B
	Perform an extended LND (eLND) if the estimated risk for positive lymph nodes (LNs) exceeds 5%.	B
	Do not perform a limited LND.	A

	In patients with pT3,N0M0 PCa and an undetectable PSA following RP, discuss adjuvant EBRT because it at least improves biochemical-free survival.	A
	Inform patients with pT3,N0M0 PCa and an undetectable PSA following RP about salvage irradiation as an alternative to adjuvant irradiation when PSA increases.	A
	Do not offer adjuvant hormonal therapy (HT) after RP for pN0 disease.	A
Radiotherapy	In intermediate-risk PCa use a total dose of 76-78 Gy, in combination with short-term androgen deprivation therapy (ADT) (four to six months).	A
	In selected intermediate-risk patients, without a previous TURP and with a good IPSS and a prostate volume < 50 mL, offer LDR brachytherapy.	A
Androgen suppression monotherapy	No place in asymptomatic patients.	A
Watchful waiting	Offer WW to patients not eligible for local curative treatment and with a short life expectancy.	A
High-risk PCa		
Watchful waiting	**High risk localised:** Offer WW to patients not eligible for local curative treatment and with a short life expectancy.	A

	High risk locally advanced: In locally advanced M0 patients unwilling or unable to receive any form of local treatment, offer a deferred treatment policy to asymptomatic patients with a PSA-DT > 12 months and a PSA < 50 ng/mL and non-poorly differentiated tumour.	A
Active surveillance	Not appropriate.	A
Radical prostatectomy	Do not offer neoadjuvant hormonal therapy (NHT) before RP.	A
	Offer RP in selected patients with locally advanced (cT3a) disease and a life expectancy > 10 years only as part of multi-modal therapy	A
	Offer nerve-sparing surgery in patients with a low risk of extracapsular disease (refer to nomograms).	A
	Perform an eLND in high-risk PCa.	A
	High risk localised: Offer RP in patients with high-risk localised PCa and a life expectancy of > 10 years only as part of multi-modal therapy.	A
	In high-risk disease, use mpMRI as a decision-making tool to select patients for nerve-sparing procedures.	B

	High risk locally advanced: Offer RP in highly selected patients with (cT3b-T4 N0 or any T N1) only as part of multi-modal therapy.	C
	In patients with pT3,N0M0 PCa and an undetectable PSA following RP, discuss adjuvant EBRT because it at least improves biochemical-free survival.	A
	Inform patients with pT3,N0M0 PCa and an undetectable PSA following RP about salvage irradiation as an alternative to adjuvant irradiation when PSA increases.	A
Radiotherapy	Inform patients with an undetectable PSA following RP about salvage irradiation as an alternative to adjuvant irradiation when PSA increases (see Section 6.9.5.1).	A
	In patients with high-risk localised PCa and locally advanced cN0 PCa, use EBRT to a dose of 76-78 Gy, or combined EBRT with brachytherapy boost (either high-dose rate [HDR] or LDR). Radiotherapy should be given in combination with long-term ADT (two to three years).	A
	In patients with locally advanced cN0 PCa, offer RT in combination with long-term ADT (two to three years is recommended).	A

Androgen suppression monotherapy	Reserved for those patients unwilling or unable to receive any form of local treatment and that are either symptomatic or asymptomatic with a PSA-DT < 12 months and a PSA > 50 ng/mL and a poorly differentiated tumour.	A
	Do not offer ADT to patients with a PSA-DT > 12 months	A
N1 patients		
cN1	In patients with cN+ PCa, offer pelvic external beam irradiation in combination with immediate long-term ADT.	B
pN1 after extended lymph node dissection (eLND)	Offer adjuvant ADT for node-positive (pN+).	B
	Offer adjuvant ADT with additional radiotherapy.	A
	Offer observation (expectant management) to a patient after eLND and ≤ 2 nodes with microscopic involvement, and a PSA < 0.1 ng/mL and absence of extranodal extension.	B
Metastatic PCa		
Active surveillance	Unsuitable.	A
Radical prostatectomy	Unsuitable outside clinical trial.	A
Radiotherapy to the prostate	Unsuitable outside clinical trial.	A

Androgen suppression	Offer surgical or medical castration (luteinising-hormone-releasing hormone [LHRH] agonist or antagonist) as androgen deprivation therapy.	A
	Offer castration combined with chemotherapy (docetaxel) to all patients whose first presentation is M1 disease and who are fit enough for chemotherapy.	A
	Offer castration alone, with or without an anti-androgen, to patients unfit for, or unwilling to consider, castration combined with chemotherapy.	A
	Do not prescribe abiraterone acetate or enzalutamide outside of a clinical trial.	A
	In M1 symptomatic patients, offer immediate castration to palliate symptoms and reduce the risk for potentially catastrophic sequelae of advanced disease (spinal cord compression, pathological fractures, urethral obstruction, extra-skeletal metastases).	A
	In M1 asymptomatic patients, offer immediate castration to defer progression to a symptomatic stage and prevent serious disease progression-related complications.	A

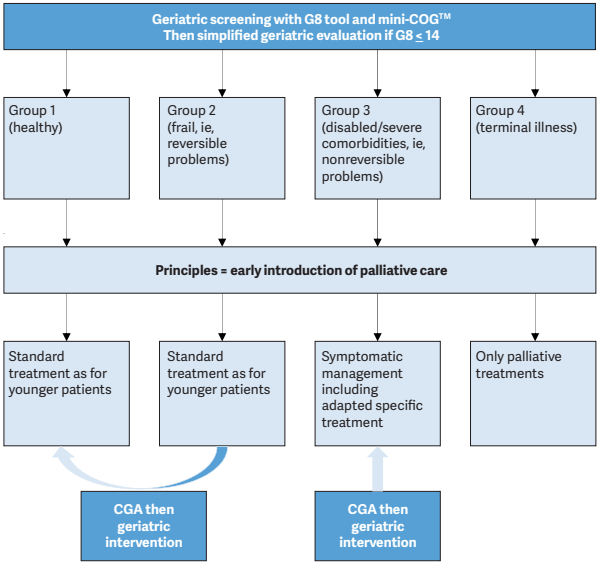
	In M1 asymptomatic patients, discuss deferred castration with a well-informed patient since it lowers the treatment side effects, provided the patient is closely monitored.	B
	Do not routinely offer ADT to asymptomatic men with biochemical recurrence.	A
	In M1 patients treated with an LHRH agonist, offer short-term administration of anti-androgens to reduce the risk of the 'flare-up' phenomenon.	A
	Start anti-androgens used for 'flare-up' prevention on the same day as an LHRH analogue is started or for up to seven days before the first LHRH analogue injection if the patient has symptoms). Treat for four weeks.	A
	Do not offer anti-androgen monotherapy in M1 patients.	A
	Offer LHRH antagonists, especially in patients with an impending spinal cord compression or bladder outlet obstruction.	B
	In asymptomatic M1 patients, offer intermittent treatment to highly motivated patients, with a major PSA response after the induction period.	B

	In M1 patients follow the schedules used in published clinical trials on timing of intermittent treatment. Stop treatment when the PSA level is < 4 ng/mL after six to seven months of treatment. Resume treatment when the PSA level is > 10-20 ng/mL (or back to the original level, if < 20 ng/mL).	C

Guidelines for the treatment of senior adults (> 70 years of age)

Recommendations for assessment	GR
Perform systematic health status screening in senior adults with localised PCa.	A
Use the G8 screening tool for health status screening.	A
Perform a full specialist geriatric evaluation in patients with G8 score ≤ 14.	A
Treatment options for senior adults according to their health status: 1. offer standard treatment to fit or healthy older men; 2. offer standard treatment to frail patients (reversible impairment) after resolution of geriatric problems; 3. offer adapted treatment to disabled patients (irreversible impairment); 4. offer only symptomatic palliative treatment to patients who are too sick with terminal illness.	B

Figure 1: Decision-making based on health status assessment*



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Mini-COG™ = mini-COG™ cognitive test;
CGA = comprehensive geriatric assessment.

Recommendations for treatment	LE	GR
Localised disease		
Offer standard treatment to fit and frail senior adults (after status optimisation) with a life expectancy > 10 years.	2b	A
Offer individualised treatment based on life expectancy, symptoms and risk factors to senior adults with a life expectancy < 10 years.	2b	A
In disabled or 'too–sick' senior adults, offer immediate androgen deprivation therapy only for symptom palliation.	1b	A
Offer minimally invasive energy-ablative therapies only to selected fit and frail senior adults with intermediate-risk disease.	3	B
Advanced disease (locally advanced/metastatic disease)		
Evaluate bone mineral status and prevent osteo-porosis-related fractures in senior adults.	2b	A
Offer new chemotherapeutic and hormonal agents to fit and frail adults.	1b	B

Follow-up after treatment with curative intent

- After RP, PSA should be undetectable (< 0.1 ng/mL). A PSA of > 0.1 ng/mL after RP is a signal of residual prostate tissue. After an undetectable PSA is obtained following RP, a PSA > 0.2 ng/mL and rising, is associated with recurrent disease.
- After RT, an increase in PSA > 2 ng/mL above the nadir, rather than a specific threshold value, is the most reliable sign of recurrence.
- Palpable nodules and increasing serum PSA are often signs of local recurrence.

Recommendations for follow-up after treatment with curative intent	GR
Routinely follow-up asymptomatic patients, by obtaining a disease-specific history and prostate-specific antigen (PSA) measurement supplemented by digital rectal examination (DRE). These should be performed at three, six and twelve months after treatment, then every six months until three years, and then annually.	B
Imaging to detect local recurrence is only recommended if it affects treatment planning. Biopsy is usually not necessary before second-line therapy.	B
Do not routinely offer bone scans and other imaging modalities to asymptomatic patients if there are no signs of biochemical relapse. In case patients have bone pain or other symptoms of progression, re-staging should be considered irrespective of serum PSA level.	B

Recommendations for follow-up during hormonal treatment	GR
Evaluate patients at three to six months after the initiation of treatment.	A
As a minimum, tests should include serum prostate-specific antigen (PSA) measurement, digital rectal examination (DRE), serum testosterone, and careful evaluation of symptoms in order to assess the treatment response and side effects.	A
In patients undergoing intermittent androgen deprivation, monitor PSA and testosterone at fixed intervals during the treatment pause (monthly or at three-month intervals).	A

Adapt follow-up to the individual patient, according to stage of disease, prior symptoms, prognostic factors and the treatment given.	A
In patients with stage M0 disease with a good treatment response, schedule follow-up every six months. As a minimum requirement, include a disease-specific history, DRE and serum PSA determination in the diagnostic work-up.	A
In patients with stage M1 disease with a good treatment response, schedule follow-up every three to six months. As a minimum requirement, include a disease-specific history, DRE, serum PSA, haemoglobin, serum creatinine and alkaline phosphatase measurements in the diagnostic work-up. The testosterone level should be checked, especially during the first year.	A
Counsel patients (especially with M1b status) about the clinical signs suggestive of spinal cord compression.	A
When disease progression occurs, or if the patient does not respond to treatment, adapt/individualise follow up.	A
In patients with suspected progression, assess the testosterone level. By definition, castration-resistant PCa requires a testosterone level < 50 ng/mL (< 1 mL/L).	B
Do not offer routine imaging to otherwise stable patients.	B

Second-line therapies (salvage treatment)

Modality	Recommendations	GR
Active surveillance	In case of biochemical recurrence after RP, offer patients with a prostate-specific antigen (PSA) rise from the undetectable range and favourable prognostic factors (≤ pT3a, time to bio-chemical recurrence > 3 year, PSA-doubling time [DT] > 12 months, Gleason score ≤ 7) active surveillance and possibly delayed salvage radiotherapy (RT).	B
Salvage radical prostatectomy	Treat highly selected patients with localised PCa and a histologically proven local recurrence with salvage radical prostatectomy (SRP).	B
	Due to the increased rate of side effects, perform SRP in experienced centres.	A
Salvage Brachy-therapy **Salvage HIFU** **Salvage Cryo**	Discuss high intensity focused ultrasound, cryosurgical ablation and salvage brachytherapy with patients without evidence of metastasis and with histo-logically proven local recurrence. Inform patients about the experimental nature of these approaches.	B

Salvage lymph node dissection	Discuss salvage lymph node dissection (LND) with men experiencing nodal recurrence after local treatment but it should be considered experimental and biochemical recurrence after salvage LND occurs in the majority of cases.	C
Salvage androgen deprivation therapy	If salvage androgen deprivation therapy (ADT) (post-primary RT) is started, offer intermittent therapy to responding patients.	A

Castrate Resistant PCa

No definitive strategy regarding first treatment choice (which drug/drug family first) can be devised. Castrate testosterone levels are to be maintained (see Section 6.10.3.1 of the PCa Guidelines)

Recommendations	LE	GR
Ensure that testosterone levels are confirmed to be < 50 ng/mL, before diagnosing castration-resistant PCa (CRPC).	4	A
Do not treat patients for non-metastatic CRPC outside of a clinical trial.	3	A
Counsel, manage and treat patients with metastatic (m)CRPC in a multidisciplinary team.	3	A
Treat patients with mCRPC with life-prolonging agents. Base the choice of first-line treatment on the performance status, symptoms, comorbidities, location and extent of disease (alphabetical order: abiraterone, docetaxel, enzalutamide, radium-223, sipuleucel-T).	1b	A

Offer patients with mCRPC who are candidates for cytotoxic therapy docetaxel with 75 mg/m^2 every three weeks.	1a	A
In patients with mCRPC and progression following docetaxel chemotherapy offer further life-prolonging treatment options, which include cabazitaxel, abiraterone, enzalutamide and radium-223.	1a	A
Base second-line treatment decisions of mCRPC on pre-treatment performance status, comorbidities and extent of disease.		B

Guidelines for Supportive Care of mCRPC

These recommendations are in addition to appropriate systemic therapy.

Recommendations	LE	GR
Offer bone protective agents to patients with metastatic castration-resistant PCa (mCRPC) and skeletal metastases to prevent osseous complications.	1a	B
Offer calcium and vitamin D supplementation when prescribing either denosumab or bisphosphonates.	1b	A
Treat painful bone metastases early on with palliative measures such as external beam radiotherapy, and adequate use of analgesics.	1a	B
In patients with spinal cord compression start immediate high-dose corticosteroids and assess for spinal surgery followed by irradiation. Offer radiation therapy alone if surgery is not appropriate.	1b	A

Quality of Life

Treating PCa can affect an individual both physically and mentally, as well as his close relations and his work or vocation. These multifaceted issues all have a bearing on his perception of 'quality of life'. Prostate cancer care should not be reduced to focusing on the organ in isolation. Taking QoL into consideration relies on understanding the patient's wishes and preferences so that optimal treatment proposals can be formulated and discussed. There is clear evidence of unmet needs and ongoing support requirements for some men after diagnosis and treatment for PCa.

This short booklet text is based on the more comprehensive EAU Guidelines (ISBN 978-90-79754-91-5), available to all members of the European Association of Urology at their website: http://www.uroweb.org/guidelines/.