



Letter to the Editor

Re: Anna Bill-Axelson, Hans Garmo, Lars Holmberg, et al. Long-term Distress After Radical Prostatectomy Versus Watchful Waiting in Prostate Cancer: A Longitudinal Study from the Scandinavian Prostate Cancer Group-4 Randomized Clinical Trial. *Eur Urol* 2013;64:920–8.

We were glad to see the article on long-term distress after radical prostatectomy versus watchful waiting in prostate cancer [1]. This paper highlights a number of problems experienced worldwide with follow-up of this cohort and the lack of available holistic care facilities.

Prostate cancer is one of the most frequently diagnosed cancers in men [2]. Due to improvements in diagnosis and treatment, the number of survivors is increasing [3]. This often results in overbooked clinics, with patients only receiving treatment of acute medical conditions with no support for accompanying physical and psychological conditions [4].

Taking this into account, we developed a new model. Once patients with prostate cancer have entered the so-called survivorship phase, they are offered the option of entering the prostate cancer survivorship programme. Patients are not followed up in clinic, but their prostate-specific antigen (PSA) numbers are entered into a central database. Patients are also allocated a specialist nurse as a key worker should their clinical situation change or as a way of informing patients to attend the clinic regarding PSA changes triggered from the database.

To coordinate such large figures, a specialist software programme was developed, with the trust information technology (IT) automatically generating follow-up, depending on PSAs, surgery, and radiotherapy. To support this, a team was established with commissioners, psychologists, project managers, and IT input. This is supplemented by survivorship conferences including access to professionals advising on identified patient issues (eg, psychological care, health promotion, research, finance, and welfare).

There are 630 patients in the database, 10 having undergone brachytherapy, 315 radiotherapy, and 288 following surgery. This study is worthwhile conducting because it is envisaged that the follow-up will facilitate easier access to reliable information, improve support for patients and their families, and ease the health care burden.

This also allows a holistic approach while enabling us to monitor patients for recurrence. The aim of the programme is a continuing user-led system according to patient risk stratification that is applicable across all tumour sites. The next step is to develop the programme further for patients on hormone therapy or active surveillance.

Not only is this a good approach for patients, as proven by these results, but it is also essential for managing patients given that there are 260 000 prevalent cases now and there will be an estimated 600 000 cases by 2030. There is no current room for secondary care follow-up, which also is not desirable because most patients can be managed through a community-based follow-up approach.

Sadly, despite the large figures throughout the world for this cohort, there are no set guidelines for survivorship care, especially prostate survivorship care. We were very glad to see a step has been made in the right direction, with members of the European Association of Urology acknowledging survivorship as a category within prostate cancer treatment at their congress. We hope guidelines will follow.

Conflicts of interest: The authors have nothing to disclose.

References

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