EAU-EANM-ESTRO-ESUR-SIOG GUIDELINES ON PROSTATE CANCER

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N. Mottet (Chair), P. Cornford (Vice-chair), R.C.N. van den Bergh, E. Briers (Patient Representative), M. De Santis, S. Fanti, S. Gillessen, J. Grummet, A.M. Henry, T.B. Lam, M.D. Mason, T.H. van der Kwast, H.G. van der Poel, O. Rouvière, I.G. Schoots, D. Tilki, T. Wiegel
Guidelines Associates: T. Van den Broeck, M. Cumberbatch, N. Fossati, G. Gandaglia, N. Grivas, M. Lardas, M. Liew, L. Moris, D.E. Oprea-Lager, P-P.M. Willemse

Introduction

Prostate cancer (PCa) is a complex disease, in which 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 second most common cancer in males. 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 (stage based on digital rectal examination [DRE] only)		
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 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	
	T3a	Extracapsular extension (unilateral or bilateral)
	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 (pelvic) Lymph Nodes[1]		
NX	Regional lymph nodes cannot be assessed	
N0	No regional lymph node metastasis	
N1	Regional lymph node metastasis	

M - Distant Metastasis[2]	
M0	No distant metastasis
M1	Distant metastasis
M1a	Non-regional lymph node(s)
M1b	Bone(s)
M1c	Other site(s)

[1] *Metastasis no larger than 0.2 cm can be designated pNmi.*
[2] *When more than one site of metastasis is present, the most advanced category is used. (p)M1c is the most advanced category.*

Pathological staging (pTNM) is based on histopathological tissue assessment and largely parallels the clinical TNM, except for clinical stage T1c and the T2 substages. All histopathologically confirmed organ-confined PCas after radical prostatectomy (RP) are pathological stage T2 and the current UICC no longer recognises pT2 substages.

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 (any ISUP grade) cT3-4 or cN+
Localised			**Locally advanced**

GS = Gleason score; ISUP = International Society for Urological Pathology; PSA = prostate-specific antigen.

The International Society of Urological Pathology (ISUP) World Health Organization (WHO) 2014 grade groups have been adopted which allow patients to better understand the behaviour of their diagnosed prostate carcinoma, while separating GS 7 adenocarcinoma into two prognostically very distinct categories; grade group 2 for GS 7(3+4) and grade group 3 for GS 7(4+3) (see Table 3).

Table 3: ISUP 2014 grade

Gleason score	ISUP grade
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 screening and early detection	Strength rating
Do not subject men to prostate-specific antigen (PSA) testing without counselling them on the potential risks and benefits.	Strong
Offer an individualised risk-adapted strategy for early detection to a well-informed man and a life-expectancy of at least 10 to 15 years.	Weak
Offer early PSA testing to 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; • men of African descent > 45 years of age; • men carrying *BRCA2* mutations > 40 years of age.	Strong

Offer a risk-adapted strategy (based on initial PSA level), with follow-up intervals of 2 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 8 years in those not at risk.	Weak
Stop early diagnosis of PCa based on life expectancy and performance status; men who have a life-expectancy of < 15 years are unlikely to benefit.	Strong

Diagnostic Evaluation

Clinical diagnosis

Prostate cancer is usually suspected on the basis of DRE and/or PSA levels. Definitive diagnosis depends on histopathological verification of adenocarcinoma in prostate biopsy cores, 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. Diagnostic procedures that will not affect the treatment decision can usually be avoided.

Guidelines for diagnostic imaging	Strength rating
Recommendations for all patients	
Do not use multi-parametric magnetic resonance imaging (mpMRI) as an initial screening tool.	Strong

Adhere to PI-RADS guidelines for mpMRI acquisition and interpretation and evaluate mpMRI results in multidisciplinary meetings with pathological feedback.	Strong
Recommendations in biopsy-naïve patients	
Perform mpMRI before prostate biopsy.	Strong
When mpMRI is positive (i.e. PI-RADS ≥ 3), combine targeted and systematic biopsy.	Strong
When mpMRI is negative (i.e., PI-RADS ≤ 2), and clinical suspicion of PCa is low, omit biopsy based on shared decision making with the patient.	Weak
Recommendations in patients with prior negative biopsy	
Perform mpMRI before prostate biopsy.	Strong
When mpMRI is positive (i.e. PI-RADS ≥ 3), perform targeted biopsy only.	Weak
When mpMRI is negative (i.e., PI-RADS ≤ 2), and clinical suspicion of PCa is high, perform systematic biopsy based on shared decision making with the patient.	Strong

Pathology of prostate biopsies

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 (GS) per biopsy site and global GS. Reporting of a RP specimen includes type of carcinoma, global ISUP grade, pathological stage and surgical margin status

Recommendations for the clinical diagnosis	Strength rating
Perform transrectal prostate needle biopsies under antibiotic protection.	Strong
Use a local anaesthetic by peri-prostatic infiltration for prostate needle biopsies.	Strong

Do not offer non-targeted transition zone sampling at initial biopsies due to low detection rates.	Weak
Ensure that prostate core biopsies from different sites are submitted separately for processing and pathology reporting.	Strong

Guidelines for staging of PCa

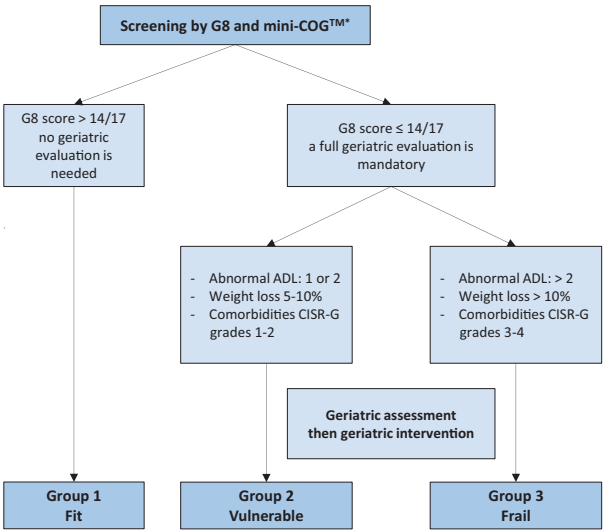
Any risk group staging	**Strength rating**
Use pre-biopsy mpMRI for staging information.	Weak
Low-risk localised PCa	
Do not use additional imaging for staging purposes.	Strong
Intermediate-risk PCa	
In ISUP grade ≥ 3, include at least a cross-sectional abdominopelvic imaging and bone-scan for metastatic screening.	Weak
High-risk localised PCa/locally advanced PCa	
Perform metastatic screening including at least cross-sectional abdominopelvic imaging and a bone-scan.	Strong

Evaluating health status and life expectancy

Recommendations	**Strength rating**
Use individual life expectancy, health status, and comorbidity in PCa management.	Strong
Use the Geriatric-8 and mini-COG tools for health status screening.	Strong
Perform a full specialist geriatric evaluation in patients with a G8 score ≤ 14.	Strong

Consider standard treatment in vulnerable patients with reversible impairments (after resolution of geriatric problems) similar to fit patients, if life expectancy is > 10 years.	Weak
Offer adapted treatment to patients with irreversible impairment.	Weak
Offer symptom-directed therapy alone to frail patients.	Strong

Figure 1: Decision tree for health status screening (men > 70 years)*



Mini-COG™ = Mini-COG™ cognitive test; ADLs = activities of daily living; CIRS-G = Cumulative Illness Rating Score - Geriatrics; CGA = comprehensive geriatric assessment.

*For Mini-COG™, a cut-off point of ≤ 3/5 indicates a need to refer the patient for full evaluation of potential dementia.
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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 comorbidity and a limited life expectancy, treatment of localised PCa may be deferred to avoid loss of quality of life (QoL).

General guidelines for active treatment of PCa

Recommendations	Strength rating
Inform patients that no active treatment modality has shown superiority over any other active management options or deferred active treatment in terms of overall- and PCa-specific survival for clinically localised disease.	Strong
Offer a watchful waiting policy to asymptomatic patients with a life expectancy < 10 years (based on comorbidities).	Strong
Inform patients that all active treatments have side effects.	Strong
Surgical treatment	
Inform patients that no surgical approach (open-, laparoscopic- or robotic radical prostatectomy) has clearly shown superiority in terms of functional or oncological results.	Weak

When a lymph node dissection (LND) is deemed necessary, perform an extended LND template for optimal staging.	Strong
Do not perform nerve-sparing surgery when there is a risk of ipsilateral extracapsular extension (based on cT stage, ISUP grade, nomogram, multiparametric magnetic resonance imaging).	Weak
Do not offer neoadjuvant androgen deprivation therapy before surgery.	Strong
Radiotherapeutic treatment	
Offer intensity-modulated radiation therapy (IMRT) or volumetric arc external-beam radiotherapy (VMAT) for definitive treatment of PCa by external-beam radiation therapy.	Strong
Offer moderate hypofractionation (HFX) with IMRT/VMAT, including image-guided radiation therapy to the prostate, to carefully selected patients with localised disease.	Strong
Ensure that moderate HFX adheres to radiotherapy protocols from trials with equivalent outcome and toxicity, i.e. 60 Gy/20 fractions in 4 weeks or 70 Gy/28 fractions in 6 weeks.	Strong
Active therapeutic options outside surgery and radiotherapy	
Only offer cryotherapy and high-intensity focused ultrasound within a clinical trial setting or well-designed prospective cohort study.	Strong
Only offer focal therapy within a clinical trial setting or well-designed prospective cohort study.	Strong

Guidelines for first-line treatment of various disease stages

Recommendations		Strength rating
Low-risk disease		
Active surveillance (AS)	Offer AS to patients with a life expectancy > 10 years and low-risk disease.	Strong
	If a patient has had upfront multiparametric magnetic resonance imaging (mpMRI) followed by systematic and targeted biopsies there is no need for confirmatory biopsies.	Weak
	Patients with intraductal and cribiform histology on biopsy should be excluded from AS.	Strong
	If required, perform mpMRI before a confirmatory biopsy.	Strong
	Take both targeted biopsy (of any PI-RADS $\geq$ 3 lesion) and systematic biopsy if confirmatory biopsy performed.	Strong
	Perform serum prostate-specific antigen (PSA) assessment every 6 months.	Strong
	Perform digital rectal examination (DRE) every 12 months.	Strong

	Repeat biopsy should be performed if there is evidence of PSA progression, clinical progression on DRE or radiological progression on mpMRI.	Strong
	During follow-up, if mpMRI is negative (i.e., PI-RADS ≤ 2), and clinical suspicion of PCa progression is low (e.g. low PSA velocity, long PSA doubling time [DT]), omit biopsy based on shared decision making with the patient.	Weak
	Counsel patients about the possibility of needing further treatment in the future.	Strong
Active treatment	Offer surgery and radiotherapy (RT) as alternatives to AS to patients suitable for such treatments and who accept a trade-off between toxicity and prevention of disease progression.	Weak
Pelvic lymph node dissection (PLND)	Do not perform a PLND (estimated risk for pN+ ≤ 5%).	Strong

Radiotherapy	Offer low-dose rate (LDR) brachytherapy to patients with low-risk PCa, without a previous transurethral resection of the prostate (TURP), with a good International Prostatic Symptom Score (IPSS) and a prostate volume < 50 mL.	Strong
	Use intensity-modulated radiation therapy (IMRT) with a total dose of 74-80 Gy or moderate hypofractionation (60 Gy/20 fx in 4 weeks, or 70 Gy/28 fx in 6 weeks), without androgen deprivation therapy (ADT).	Strong
Other options	Only offer whole gland treatment (such as cryotherapy, high-intensity focused ultrasound [HIFU], etc.) or focal treatment within a clinical trial setting or well-designed prospective cohort study.	Strong
Intermediate-risk disease		
Active surveillance	Offer AS to highly selected patients (< 10% Gleason pattern 4) accepting the potential increased risk of further metastases.	Weak
Radical prostatectomy (RP)	Offer RP to patients with intermediate-risk disease and a life expectancy > 10 years.	Strong
	Offer nerve-sparing surgery to patients with a low risk of extracapsular disease.	Strong

Extended pelvic lymph node dissection (ePLND)	Perform an ePLND in intermediate-risk disease if the estimated risk for positive LNs exceeds 5%.	Strong
Radiotherapy	Offer LDR brachytherapy to selected patients; patients without a previous TURP, with a good IPSS and a prostate volume < 50 mL.	Strong
	For EBRT, use a total dose of 76-78 Gy or moderate hypofractionation (60 Gy/20 fx in 4 weeks or 70 Gy/28 fx in 6 weeks), in combination with short-term neoadjuvant plus concomitant ADT (4 to 6 months).	Strong
	In patients not willing to undergo ADT, use an escalated dose of EBRT (76-80 Gy) or a combination with brachytherapy.	Weak
Other therapeutic options	Only offer whole-gland ablative therapy (such as cryotherapy, HIFU, etc.) or focal ablative therapy for intermediate-risk disease within a clinical trial setting or well-designed prospective cohort study.	Strong
	Do not offer ADT monotherapy to intermediate-risk asymptomatic men unable to receive any local treatment.	Weak

High-risk localised disease		
Radical prostatectomy (RP)	Offer RP to selected patients with high-risk localised PCa, as part of a potential multi-modal therapy.	Strong
Extended pelvic lymph node dissection	Perform an ePLND in high-risk PCa.	Strong
	Do not perform a frozen section of nodes during RP to decide whether to proceed with, or abandon, the procedure.	Strong
Radiotherapy	In patients with high-risk localised disease, use ERBT with 76-78 Gy in combination with long-term ADT (2 to 3 years).	Strong
	In patients with high-risk localised disease, use EBRT with brachytherapy boost (either HDR or LDR), in combination with long-term ADT (2 to 3 years).	Weak
Other options	Do not offer either whole gland or focal therapy to high-risk patients.	Strong
	Do not use ADT monotherapy in asymptomatic patients.	Strong
Locally-advanced disease		
Radical prostatectomy	Offer RP to highly selected patients with cT3b-T4 N0 or any cN1 disease only as part of multi-modal therapy.	Strong

Extended pelvic lymph node dissection	Perform an ePLND in high-risk PCa.	Strong
Radiotherapy	In patients with locally advanced cN0 disease, offer RT in combination with long-term ADT.	Strong
	Offer long-term ADT for at least 2 years.	Weak
Other options	Do not offer whole gland treatment or focal treatment to high-risk patients.	Strong
	Only offer ADT monotherapy to those patients unwilling or unable to receive any form of local treatment if they have a PSA-DT < 12 months, and either a PSA > 50 ng/mL, a poorly-differentiated tumour or troublesome local disease-related symptoms.	Strong
	Offer patients with cN1 disease a local treatment (either RP or EBRT) plus long-term ADT.	Weak
Adjuvant treatment after radical prostatectomy		
	Do not prescribe adjuvant ADT in pN0 patients.	Strong
	Offer adjuvant EBRT to the surgical field to highly selected patients.	Strong

	Discuss three management options with patients with pN+ disease after an ePLND, based on nodal involvement characteristics: 1. Offer adjuvant ADT; 2. Offer adjuvant ADT with additional radiotherapy; 3. 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.	Weak
Non-curative or palliative treatments in a first-line setting		
Localised disease		
Watchful waiting (WW)	Offer WW to asymptomatic patients not eligible for local curative treatment and those with a short life expectancy.	Strong
Localised advanced disease		
Watchful waiting	Offer a deferred treatment policy using ADT monotherapy to M0 asymptomatic patients with a PSA-DT > 12 months, a PSA < 50 ng/mL and well-differentiated tumour, who are unwilling or unable to receive any form of local treatment.	Strong

Persistent PSA after RP	
Offer a prostate-specific membrane antigen (PSMA) positron emission tomography (PET) scan to men with a persistent PSA > 0.2 ng/mL to exclude metastatic disease.	Weak
Treat men with no evidence of metastatic disease with salvage radiotherapy and additional hormonal therapy.	Weak

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 tumour tissue. After an undetectable PSA is obtained following RP, a PSA > 0.4 ng/mL and rising, best predicts further metastases.
- After RT, an increase in PSA > nadir + 2 ng/mL best predicts further metastases.
- Palpable nodules and increasing serum PSA are often signs of local recurrence.

Recommendations for follow-up	Strength rating
Routinely follow up asymptomatic patients by obtaining at least a disease-specific history and serum prostate-specific antigen (PSA) measurement. These should be performed at 3, 6 and 12 months after treatment, then every 6 months until 3 years, and then annually.	Strong
At recurrence, only perform imaging to detect local recurrence if the outcome will affect treatment planning.	Strong

Only offer bone scans and other imaging modalities to men with biochemical recurrence or symptoms suggestive of progression without signs of biochemical relapse.	Strong

Guidelines for metastatic disease, second-line and palliative treatments

Recommendations	Strength rating
Metastatic disease in a first-line setting	
Offer immediate systemic treatment with androgen deprivation therapy (ADT) to palliate symptoms and reduce the risk for potentially serious sequelae of advanced disease (spinal cord compression, pathological fractures, ureteral obstruction) to M1 symptomatic patients.	Strong
Offer luteinising hormone-releasing hormone (LHRH) antagonists, especially to patients with an impending spinal cord compression or bladder outlet obstruction.	Weak
Offer surgery and/or local radiotherapy (RT) to any patient with M1 disease and evidence of impending complications such as spinal cord compression or pathological fracture.	Strong
Offer immediate systemic treatment also to M1 patients asymptomatic from their tumour.	Weak

Discuss deferred ADT with well-informed M1 patients asymptomatic from their tumour since it lowers the treatment-related side-effects, provided the patient is closely monitored.	Weak
Offer short-term administration of an older generation androgen receptor (AR) antagonist to M1 patients starting LHRH agonist to reduce the risk of the 'flare-up' phenomenon.	Weak
Do not offer AR antagonists monotherapy to patients with M1 disease.	Strong
Offer ADT combined with chemotherapy (docetaxel) to patients whose first presentation is M1 disease and who are for docetaxel.	Strong
Offer ADT combined with abiraterone acetate plus prednisone or apalutamide or enzalutamide to patients whose first presentation is M1 disease and who are fit enough for the regimen.	Strong
Offer ADT combined with prostate RT to patients whose first presentation is M1 disease and who have low volume of disease by CHAARTED criteria.	Strong
Do not offer ADT combined with any local treatment (RT/surgery) to patients with high volume (CHAARTED criteria) M1 disease outside of clinical trials (except for symptom control).	Strong

Recommendations for imaging in biochemical recurrence	Strength rating
Prostate-specific antigen (PSA) recurrence after radical prostatectomy	
Perform prostate-specific membrane antigen positron emission tomography/computed tomography (PSMA PET/CT) if the PSA level is > 0.2 ng/mL and if the results will influence subsequent treatment decisions.	Weak
In case PSMA PET/CT is not available, and the PSA level is ≥ 1 ng/mL, perform fluciclovine PET/CT or choline PET/CT imaging if the results will influence subsequent treatment decisions.	Weak
PSA recurrence after radiotherapy	
Perform prostate mpMRI to localise abnormal areas and guide biopsies in patients fit for local salvage therapy.	Weak
Perform PSMA PET/CT (if available) or fluciclovine PET/CT or choline PET/CT in patients fit for curative salvage treatment.	Strong

Recommendations for second-line therapy after treatment with curative intent		Strength rating
Biochemical recurrence after treatment with curative intent		
Biochemical recurrence after radical prostatectomy (RP)	Offer PSA monitoring to patients with biochemical recurrence with low-risk features at relapse who may not benefit from intervention.	Weak
	Offer salvage radiotherapy (SRT) to patients with a PSA rise from the undetectable range. Once the decision for SRT has been made, SRT (at least 66 Gy) should be given as soon as possible.	Strong
	Offer hormonal therapy in addition to SRT to men with biochemical recurrence.	Weak
Biochemical recurrence after RT	Treat highly selected patients with localised PCa and a histologically proven local recurrence with salvage RP (SRP).	Weak
	Salvage RP should only be performed in experienced centres.	Weak
	Only offer salvage high intensity focused ultrasound, salvage cryosurgical ablation and salvage brachytherapy to patients with proven local recurrence within a clinical trial setting or well-designed prospective cohort study.	Strong

Systemic salvage treatment	Do not offer ADT to M0 patients with a PSA-DT > 12 months.	Strong
Life-prolonging treatments of castration-resistant disease		
Ensure that testosterone levels are confirmed to be < 50 ng/dL, before diagnosing castration-resistant PCa (CRPC).		Strong
Counsel, manage and treat patients with metastatic CRPC (mCRPC) in a multidisciplinary team.		Strong
Treat patients with mCRPC with life-prolonging agents. Base the choice of first-line treatment on the performance status (PS), symptoms, comorbidities, location and extent of disease, patient preference, and on the previous treatment for hormone-sensitive metastatic PCa (HSPC) (alphabetical order: abiraterone, cabazitaxel, docetaxel, enzalutamide, radium-223, sipuleucel-T).		Strong
Cytotoxic treatments of castration-resistant disease		
Offer patients with mCRPC who are candidates for cytotoxic therapy docetaxel with 75 mg/m^2 every 3 weeks.		Strong
Offer patients with mCRPC and progression following docetaxel chemotherapy further life-prolonging treatment options, which include abiraterone, cabazitaxel, enzalutamide and radium-223.		Strong
Base further treatment decisions of mCRPC on pre-treatment PS, response to previous treatment, symptoms, comorbidities, extent of disease and patient preference.		Strong
Offer cabazitaxel to patients previously treated with docetaxel and progressing within 12 months of treatment with abiraterone or enzalutamide.		Strong

Supportive care of castration-resistant disease	
Offer bone protective agents to patients with mCRPC and skeletal metastases to prevent osseous complications.	Strong
Monitor serum calcium and offer calcium and vitamin D supplementation when prescribing either denosumab or bisphosphonates.	Strong
Treat painful bone metastases early on with palliative measures such as EBRT and adequate use of analgesics.	Strong
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.	Strong
Non-metastatic castrate-resistant disease	
Offer apalutamide, darolutamide or enzalutamide to patients with M0 CRPC and a high risk of developing metastasis (PSA-DT < 10 months) to prolong time to metastases.	Strong

Follow-up after treatment with life-prolonging treatments

Recommendations for follow-up during hormonal treatment	**Strength rating**
Evaluate patients at 3 to 6 months after the initiation of treatment.	Strong
The follow-up strategy must be individualised based on stage of disease, prior symptoms, prognostic factors and the treatment given.	Strong

In patients with stage M0 disease, schedule follow-up at least every 6 months. As a minimum requirement, include a disease-specific history, serum prostate-specific antigen (PSA) determination, as well as liver and renal function in the diagnostic work-up.	Strong
In patients with stage M1 disease, schedule follow-up every 3 to 6 months. As a minimum requirement, include an initial FRAX-score assessment, disease-specific history, digital rectal examination (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. Pay attention to symptoms associated with metabolic syndrome as a side effect of androgen deprivation therapy (ADT). Phospholipid profiles and glucose levels should be checked and treated if abnormal.	Strong
Counsel patients (especially with M1b status) about the clinical signs suggestive of spinal cord compression.	Strong
When disease progression is suspected, adapt/individualise follow up.	Strong
In patients with suspected progression, assess the testosterone level. By definition, castration-resistant PCa requires a testosterone level < 50 ng/dL (< 1 mL/L).	Strong
Do not offer routine imaging to otherwise stable asymptomatic patients.	Strong

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 (QoL)'. 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 can be 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 978-94-92671-07-3), available to all members of the European Association of Urology at their website: http://www.uroweb.org/guidelines/.