AUA 2026 MAY 15-18 Washington, DC

Prostate Cancer Active Surveillance: The New Normal?

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No disclosures

What is Active Surveillance?

- Close monitoring of low risk (Gleason 3+3) and select low-intermediate risk (Gleason 3+4) prostate cancer
- Utilization of PSA (density <0.15 ng/mL/cc), MRI, and biopsy
- Potential use of genomic testing such as Oncotype DX, Decipher, and Prolaris in conjunction with routine methods of assessment

AUA recommendations for AS candidates

EB1

For patients with low-risk prostate cancer, clinicians should recommend active surveillance as the preferred management option. (Strong Recommendation; Evidence Level: Grade A)

In asymptomatic patients with prostate cancer and limited life expectancy (determined on a patient-specific basis), clinicians should recommend watchful waiting. (Strong Recommendation; Evidence Level: Grade A)

For patients with favorable (3+4, < 50% cores) intermediate-risk prostate cancer, clinicians should discuss active surveillance, radiation therapy, and radical prostatectomy. (Strong Recommendation; Evidence Level: Grade A)

Clinicians should inform patients with intermediate-risk prostate cancer considering whole gland or focal ablation that there is a lack of high-quality data comparing ablation outcomes to radiation therapy, surgery, and active surveillance. (Expert Opinion)

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EB1 A "Strong Recommendation" with "Grade A" evidence signifies the highest level of confidence in clinical guidelines, indicating that benefits substantially outweigh risks. It is based on consistent data from high-quality sources like multiple randomized controlled trials (RCTs) or meta-analyses, implying that further research is unlikely to change this confidence.

Only one without this is the intermediate risk, vague guidance
Elizabeth Bucher, 3/15/2026

EB2

Candidates for AS

- Early-stage (T1–T2a)- disease contained within the prostate
- Low risk Gleason score 6 (3+3) or very low-volume 7 (3+4)
  - Pattern 4 < 10% of tissue on biopsy
  - Low tumor volume
  - Absence of adverse pathological features such as intraductal carcinoma or cribriform patterns
- PSA: Typically less than 10 ng/mL

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Wait… I thought this was called Watchful Waiting?

All patients with prostate CA can potentially do watchful waiting

Typical criteria include any patient with prostate CA with limited life expectancy EB3 or potential for exacerbation of comorbidity or severe side effect risk/complication from treatment.

Slide 5

EB2 Volume of grade II disease is important
Elizabeth Bucher, 3/9/2026

Slide 6

EB3 Types of patients
Life limiting illnesses- dialysis, oxygen dependent etc
- life expectancy < 10 years (PSA not recommended for these patients)
- have utilized when prostate CA is incidentally identified by PCP checking PSA, etc.
Elizabeth Bucher, 2/18/2026

AS vs WW

EB4

Low risk or select intermediate risk patients	All patients
Combo monitoring approach including repeat biopsy at specified intervals	Combo monitoring approach, typically not including repeat biopsy-> less regimented
Recommended to continue indefinitely unless life expectancy changes, i.e. other CA diagnosis, etc.	May discontinue at any time based on patient's health or other factors

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MRI prostate- What is the purpose?

- Use of PI-RADS rating system to determine risk of high grade prostate CA
- Multi purpose- Used as "map" for repeat biopsy vs tool to determine need for repeat biopsy versus continued PSA surveillance

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EB4 PSA, MRI, and/or biopsy
MRI is not a replacement for bx
Elizabeth Bucher, 3/8/2026

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Genomic testing

Newer options to help with risk stratification especially for intermediate risk PC

Usually minimal cost for patient- financial assistance, cost based on income, bill to government and commercial insurance

EB5

Utilization of tissue from prostate biopsy- no further testing is needed

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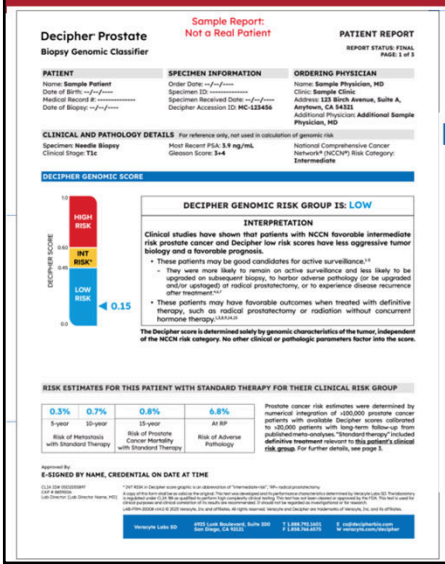

Decipher Prostate
Biopsy Genomic Classifier

Sample Report: Not a Real Patient

PATIENT REPORT

DECIPHER GENOMIC RISK GROUP IS: LOW

INTERPRETATION

Clinical studies have shown that patients with NCCN favorable intermediate risk prostate cancer and Decipher low risk scores have less aggressive tumor biology and a favorable prognosis.

- These patients may be good candidates for active surveillance.
  - They were more likely to remain on active surveillance and less likely to be upgraded on subsequent biopsy, to harbor adverse pathology (or be upgraded and/or upstaged) at radical prostatectomy, or to experience disease recurrence after treatment.
- These patients may have favorable outcomes when treated with definitive therapy, such as radical prostatectomy or radiation without concurrent hormone therapy.

The Decipher score is determined solely by genomic characteristics of the tumor, independent of the NCCN risk category. No other clinical or pathologic parameters factor into the score.

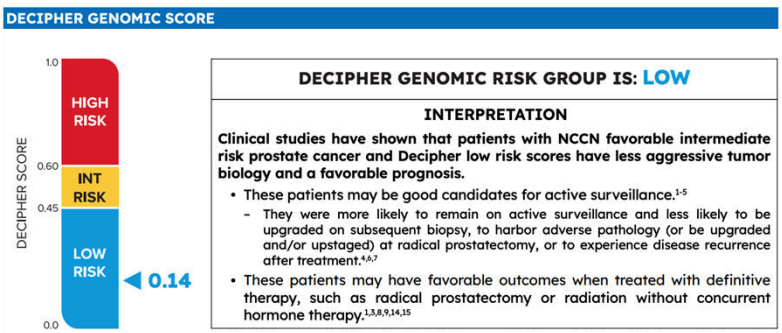
RISK ESTIMATES FOR THIS PATIENT WITH STANDARD THERAPY FOR THEIR CLINICAL RISK GROUP

0.3%	0.7%	0.8%	6.8%
5-year	10-year	15-year	At RP
Risk of Metastasis with Standard Therapy		Risk of Prostate Cancer Mortality with Standard Therapy	Risk of Adverse Pathology

E-SIGNED BY NAME, CREDENTIAL ON DATE AT TIME

EB6

Decipher



Slide 9

EB5 Huge pro, nothing more invasive etc.
Elizabeth Bucher, 3/15/2026

Slide 10

EB6 Only test included in NCCN guidelines
Helps to determine how “active” AS should be
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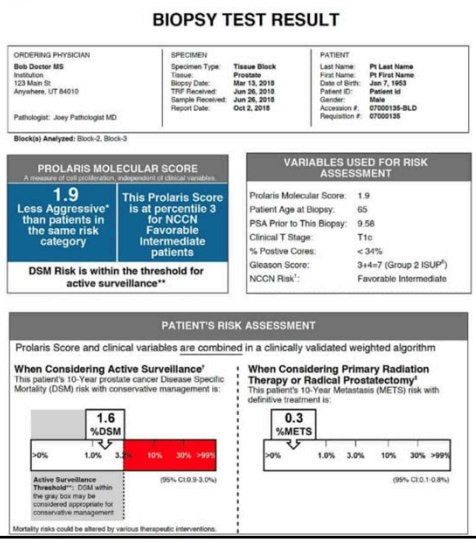
EB7

Prolaris



BIOPSY TEST RESULT

ORDERING PHYSICIAN
Bob Doctor MS
Institution
123 Main St
Anywhere, UT 84010
Pathologist: Joey Pathologist MD

SPECIMEN
Specimen Type: Tissue Block
Tissue: Prostate
Biopsy Date: Mar 13, 2018
TRF Received: Jun 26, 2018
Sample Received: Jun 26, 2018
Report Date: Oct 2, 2018

PATIENT
Last Name: Pt Last Name
First Name: Pt First Name
Date of Birth: Jan 7, 1953
Patient ID: Patient Id
Gender: Male
Accession #: 07000135-BLD
Requisition #: 07000135

Block(s) Analyzed: Block-2, Block-3

PROLARIS MOLECULAR SCORE
A measure of cell proliferation, independent of clinical variables.

1.9
Less Aggressive* than patients in the same risk category

This Prolaris Score is at percentile 3 for NCCN Favorable Intermediate patients

DSM Risk is within the threshold for active surveillance**

VARIABLES USED FOR RISK ASSESSMENT

Prolaris Molecular Score:	1.9
Patient Age at Biopsy:	65
PSA Prior to This Biopsy:	9.58
Clinical T Stage:	T1c
% Postive Cores:	< 34%
Gleason Score:	3+4=7 (Group 2 ISUP[2])
NCCN Risk[1]:	Favorable Intermediate

PATIENT'S RISK ASSESSMENT

Prolaris Score and clinical variables are combined in a clinically validated weighted algorithm

When Considering Active Surveillance[1]
This patient's 10-Year prostate cancer Disease Specific Mortality (DSM) risk with conservative management is:
1.6 %DSM
>0% 1.0% 3.1% 10% 30% >99%
Active Surveillance Threshold**: DSM within the gray box may be considered appropriate for conservative management
(95% CI:0.9-3.0%)

When Considering Primary Radiation Therapy or Radical Prostatectomy[1]
This patient's 10-Year Metastasis (METS) risk with definitive treatment is:
0.3 %METS
>0% 1.0% 3.0% 10% 30% >99%
(95% CI:0.1-0.8%)

Mortality risks could be altered by various therapeutic interventions.

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A measure of cell proliferation, independent of clinical variables.

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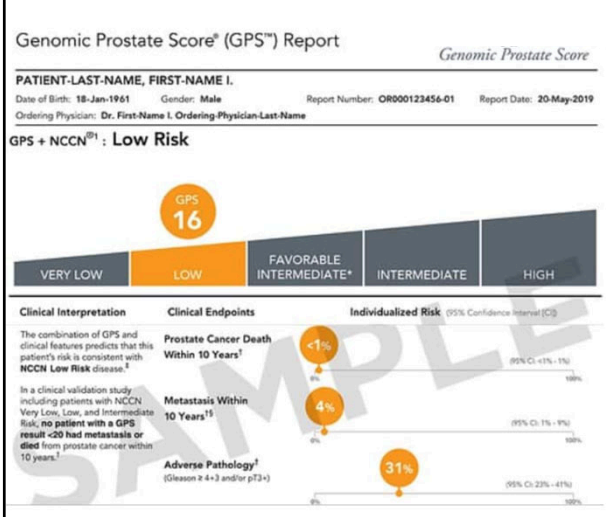
EB8

Oncotype DX Genomic Prostate Score Test



Genomic Prostate Score® (GPS™) Report

Genomic Prostate Score

PATIENT-LAST-NAME, FIRST-NAME I.
Date of Birth: 18-Jan-1961 Gender: Male Report Number: OR000123456-01 Report Date: 20-May-2019
Ordering Physician: Dr. First-Name I. Ordering-Physician-Last-Name

GPS + NCCN®[1] : Low Risk

GPS 16

VERY LOW | LOW | FAVORABLE INTERMEDIATE* | INTERMEDIATE | HIGH

Clinical Interpretation	Clinical Endpoints	Individualized Risk (95% Confidence Interval [CI])
The combination of GPS and clinical features predicts that this patient's risk is consistent with NCCN Low Risk disease.[1]	Prostate Cancer Death Within 10 Years[1]	<1% (95% CI: <1% - 1%)
In a clinical validation study including patients with NCCN Very Low, Low, and Intermediate Risk, no patient with a GPS result <20 had metastasis or died from prostate cancer within 10 years.[1]	Metastasis Within 10 Years[1,5]	4% (95% CI: 1% - 9%)
	Adverse Pathology[1] (Gleason ≥ 4+3 and/or pT3+)	31% (95% CI: 23% - 41%)

SAMPLE

12

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EB7 analysis of 46 gene expressions to determine risk of metastasis and mortality

Also
Elizabeth Bucher, 3/15/2026

Slide 12

EB8 determine risk of aggressiveness of cancer i.e. risk of metastasis as well as appropriateness of AS vs treatment
Elizabeth Bucher, 3/15/2026

EB9

AUA recommendations for AS

1. Patients managed with active surveillance should be monitored with serial PSA values and repeat prostate biopsy. (Expert Opinion)
2. In patients selecting active surveillance, clinicians should utilize mpMRI to augment risk stratification, but this should not replace periodic surveillance biopsy. (Expert Opinion)

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The Art of Active Surveillance

- No set schedule
- Recommend PSA every 3-6 months, potentially sooner
- Digital rectal exam (DRE) EB10
- Utilization of genomic testing
- MRI is helpful for follow up biopsies to aid in focused tissue sampling, more sensitive at identifying higher risk types of prostate CA
  - **Not a replacement for biopsy**
- Repeat biopsy- 12m-36m

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EB9 Very vague, multiple guidelines
Bottom line is close monitoring is key
Utilization of shared decision making
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Slide 14

EB10 Further risk stratification based on DNA analysis of the prostate tissue to determine risk for increase in Gleason score or future metastasis

If unable to use MRI utilization of genomic testing may be of even more benefit
Elizabeth Bucher, 2/18/2026

UCSF- Capra score

- Developed at University of California San Francisco
- Does not require use of MRI findings
- CAPRA score is can be used in all prostate CA diagnoses to determine an individual's likelihood of metastasis, cancer-specific mortality, and overall mortality

Variable	Specific patient's level	Points to be assigned
Age at diagnosis	Under 50	0
	50 or older	1
PSA at diagnosis (ng/ml)	less than or equal to 6	0
	between 6.1 and 10	1
	between 10.1 and 20	2
	between 20.1 and 30	3
	more than 30	4
Gleason score of the biopsy (primary/secondary)	no pattern 4 or 5	0
	secondary pattern 4 or 5	1
	primary pattern 4 or 5	3
Clinical stage (T-stage)	T1 or T2	0
	T3a	1
Percent of biopsy cores involved with cancer (positive for cancer)	less than 34 percent	0
	34 percent or more	1

Capra Scoring

0 to 2 L*ow-risk*
3 to 5 *intermediate-risk*
6 to 10 *high-risk*

Low risk amenable to AS

STRATified CANcer Surveillance (STRATCANS)

EB11

Model that risk-stratifies patients with prostate cancer on AS three tiers based on their risk of disease progression with use of NICE Cambridge Prognostic Group (CPG)

NICE Cambridge Prognostic Group (CPG)	Criteria
1	Gleason score 6 (Grade Group 1) **AND** PSA < 10 ng/ml **AND** Stage T1–T2
2	Gleason score 3 + 4 = 7 (Grade Group 2) **OR** PSA 10–20 ng/ml **AND** Stage T1–T2
3	Gleason score 3 + 4 = 7 (Grade Group 2) **AND** PSA 10–20 ng/ml **AND** Stage T1–T2 **OR** Gleason 4 + 3 = 7 (Grade Group 3) **AND** Stage T1–T2
4	One of Gleason score 8 (Grade Group 4) **OR** PSA > 20 ng/ml **OR** Stage T3
5	Any combination of Gleason score 8 (Grade Group 4), PSA > 20 ng/ml or Stage T3 **OR** Gleason score 9–10 (Grade Group 5) **OR** Stage T4

Table 1 - Criteria of the NICE Cambridge Prognostic Groups (NG131)

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EB11 Developed in UK
Allows for more specific monitoring approach, standardized
Utilization of MRI is a must
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Benefits of use of risk stratification

Study in 2025 that EB12ed Stratcans criteria to 7578 men on AS from the Michigan Urological Surgery Improvement Collaborative registry. 4009, 2732, and 837 patients were in STRATCANS 1, 2, and 3, respectively. The risk of progression to ≥GG3 was 13%, 33%, and 53% for patients in STRATCANS 1, 2, and 3, respectively.

Survival rates in men with CPG1 and CPG2 are very similar over a 10-year lifespan with marginal gains from immediate radical therapy-> Quality of life!

Men in CPG3 gain most from radical intervention with a 4-fold reduction in mortality compared to a policy of conservative management.

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Why not just treat the patient?

EB13

- Trend towards prostate CA becoming more of a chronic illness vs acute disease (exceptions include younger patients or high risk/high grade disease Gleason 8+)
- Risk of side effects/complications from treatment
- Potential for other diseases to be more acute and require timely treatment

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EB12 The rate of any biopsy upgrading was approximately 50% at 3 years across all STRATCANS tiers. STRATCANS tiers were also significantly associated with time to definitive treatment, with 16%, 28%, and 35% of men in STRATCANS 1, 2, and 3, respectively, receiving definitive treatment by 36 months.
Elizabeth Bucher, 3/11/2026

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EB13 Incontinence
ED
Rectal bleeding
Elizabeth Bucher, 2/18/2026

EB14

How to discuss AS with our patients

- AS is NOT doing nothing. It is an active management plan that is flexible
- Discuss the facts. We have good evidence to state that monitoring these patients is reasonable and will allow for progressive disease to be identified in a timely manner with initiation of treatment
- Not for all patients even if they meet criteria. May not feel comfortable, high anxiety, etc. We need to be empathetic with these patients and support them

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Questions?

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EB14 This is where we as APPs thrive, good relationship with patients and strong communication. Patients need to be able to trust this process. The word “cancer” has never previously been associated with an active surveillance approach
Elizabeth Bucher, 3/11/2026

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