Evidenze attuali nel campo della sorveglianza attiva/vigile attesa

G. Ciccone

Epidemiologia clinica e valutativa

AO Città della Salute e della Scienza di Torino e CPO Piemonte

CPO

Centro di Riferimento per l'Epidemiologia e la Prevenzione Oncologica in Piemonte

Azienda Ospedaliera Città della Salute e della Scienza di Torino

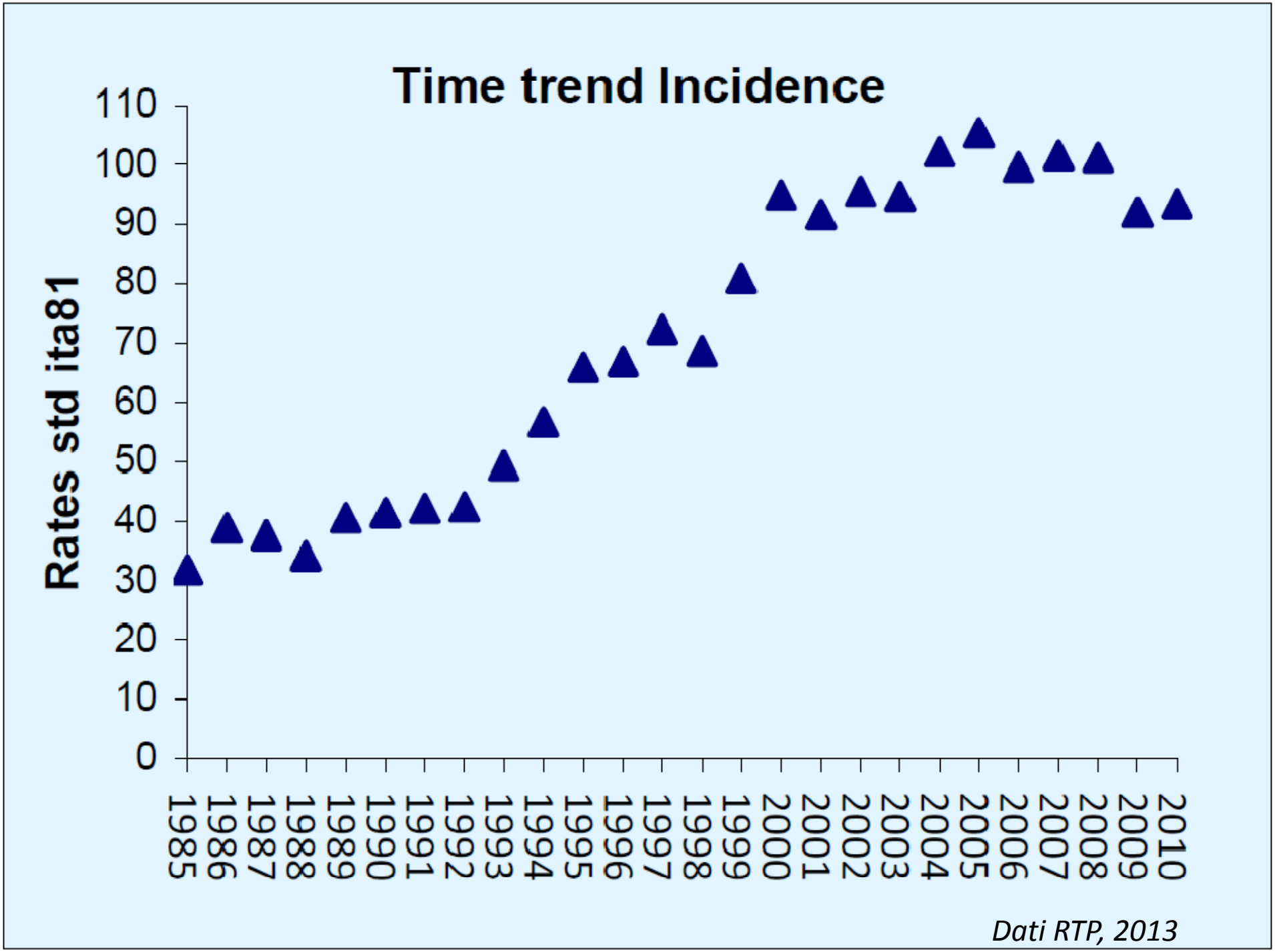
Argomenti

1. Razionale della sorveglianza attiva (SA) e della vigile attesa (VA)
2. Progetto di SA per la Rete Oncologica
3. Stima dell'impatto economico della SA nella Rete Oncologica

1. Razionale della sorveglianza attiva (SA) e della vigile attesa (VA)

Aspetti epidemiologici

- L'epidemiologia del t. della prostata (TP) è profondamente cambiata nel corso degli ultimi 2 decenni
- La diffusione del test con PSA ha causato un forte aumento dell'incidenza e, apparentemente, della sopravivenza, senza modificare sostanzialmente la mortalità
- Con il test PSA (e successiva biopsia) si identificano molti soggetti con lesioni in stadio precoce e a basso rischio di evolvere in modo clinicamente significativo anche in assenza di trattamento (**sovra-diagnosi**)
- Il **sovra-trattamento** di questi pazienti comporta conseguenze negative sulla loro qualità di vita e sul SSN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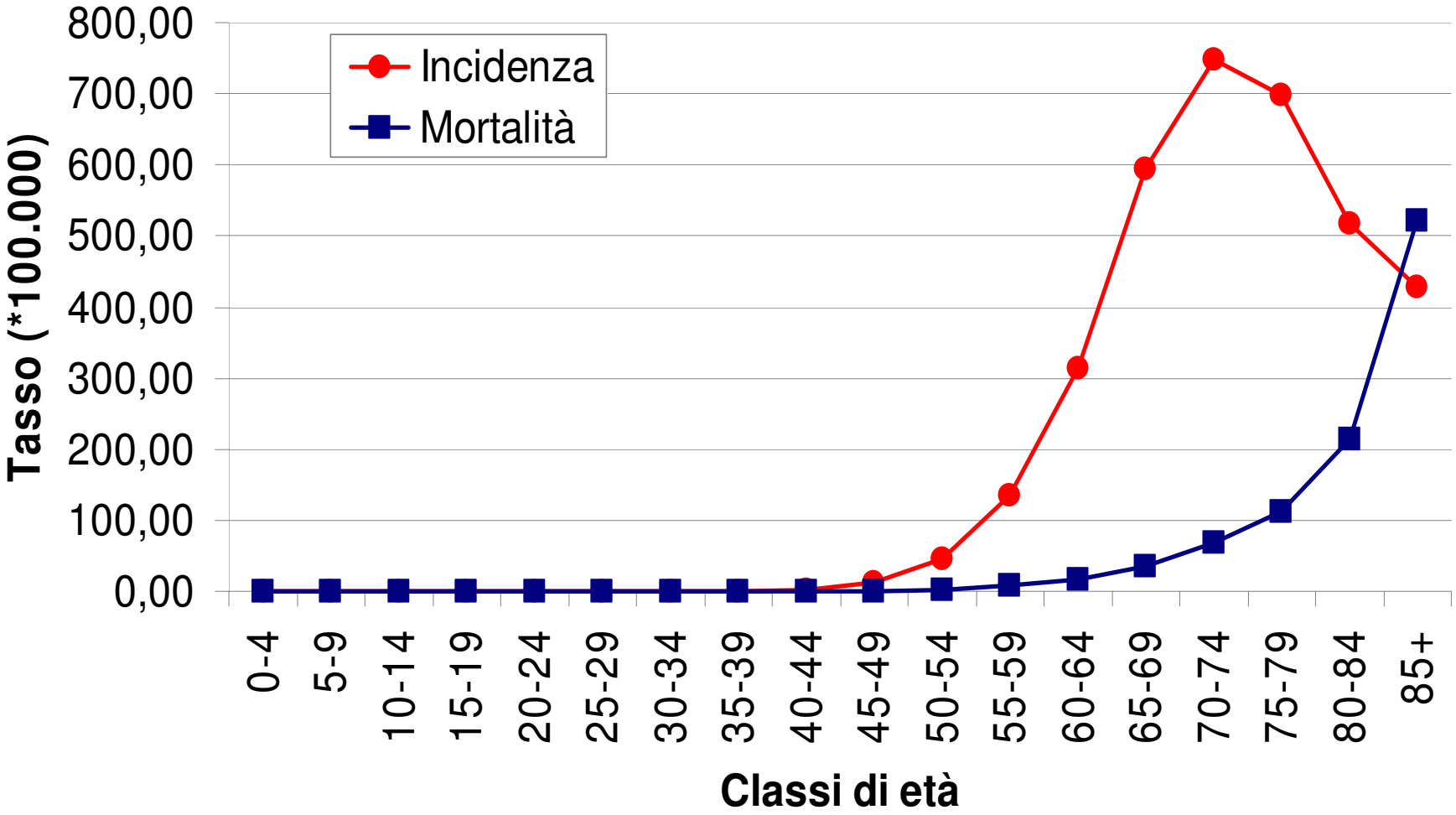
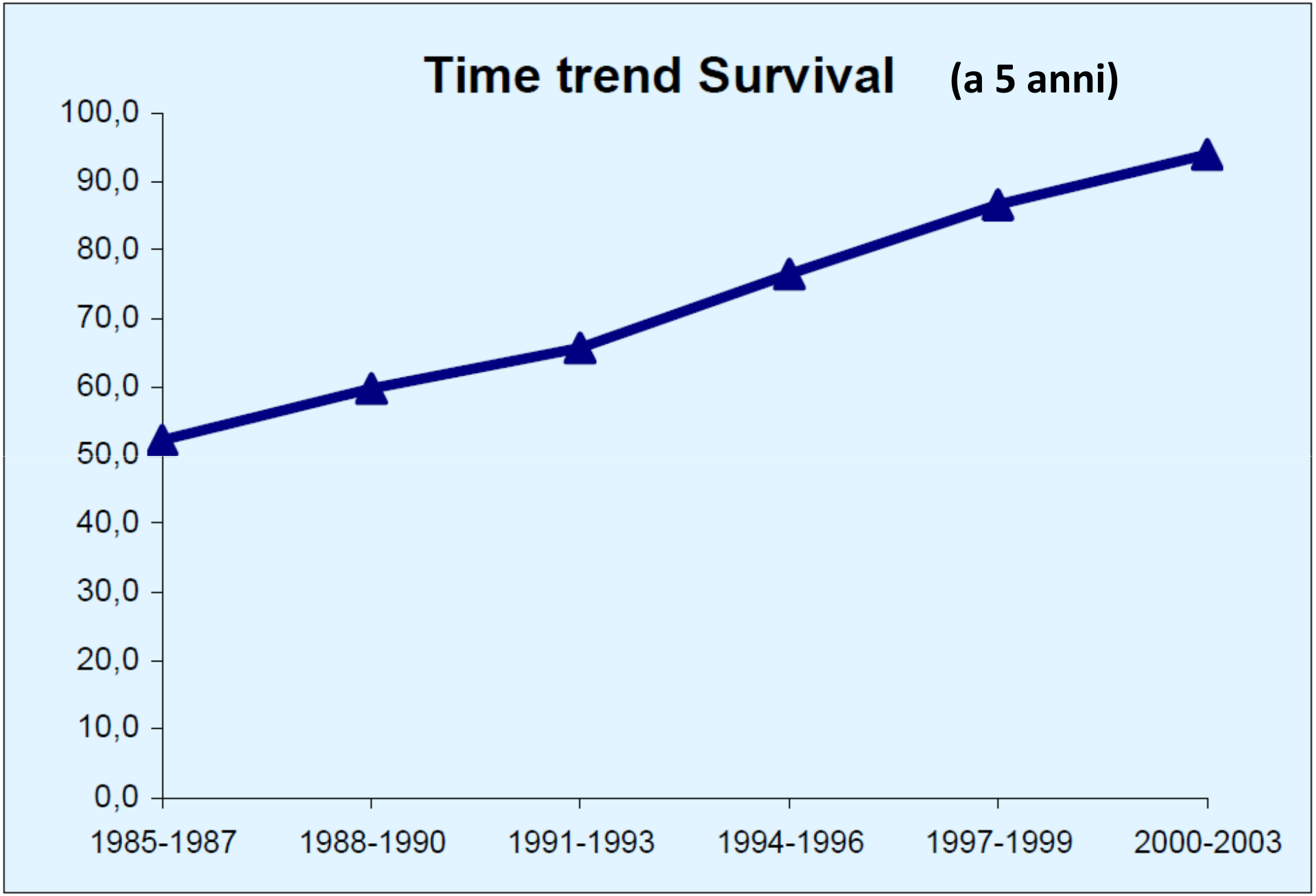
Dati RTP, 2013

Tasso di incidenza e di mortalità per età (RTP 2008-2010)





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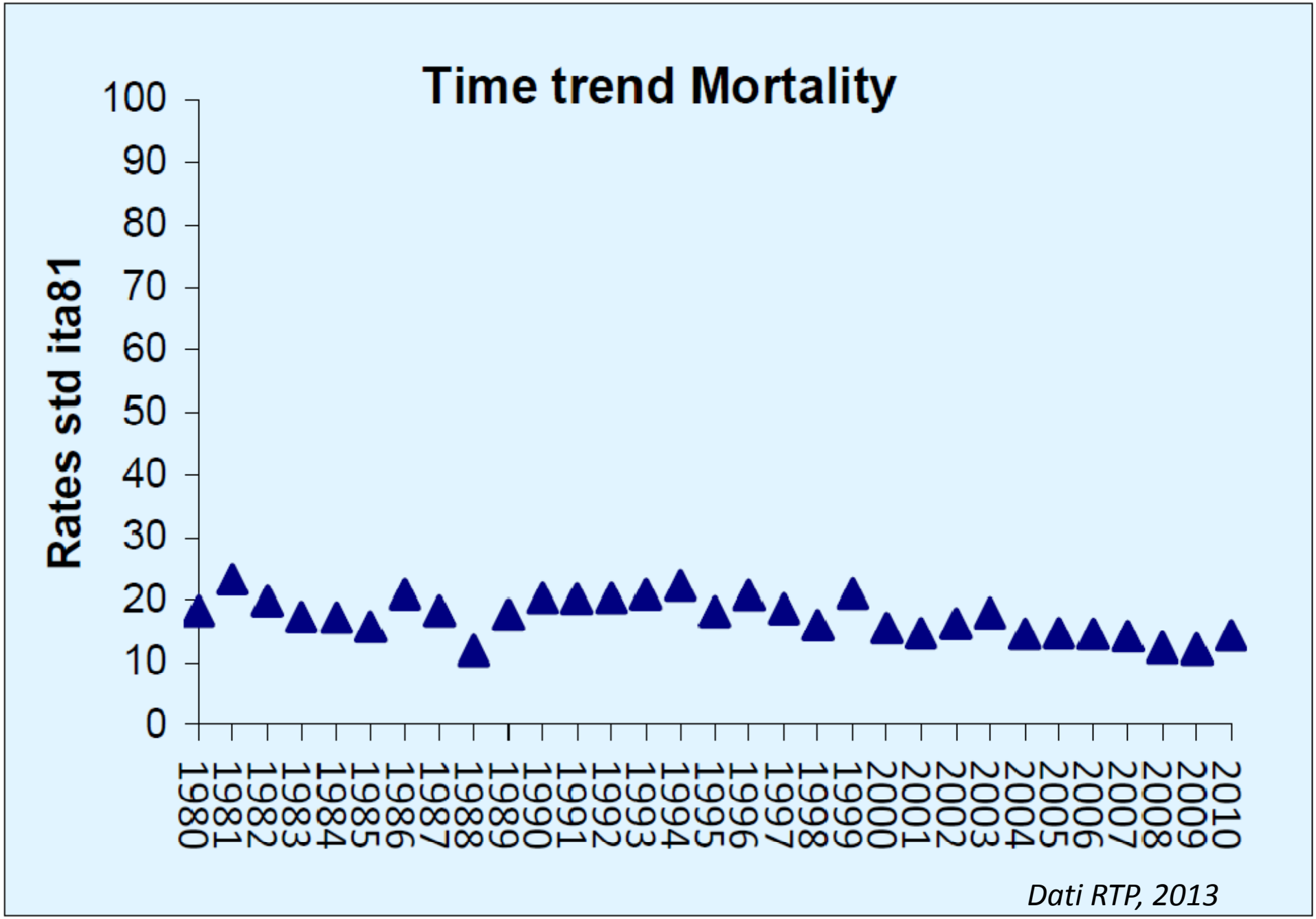
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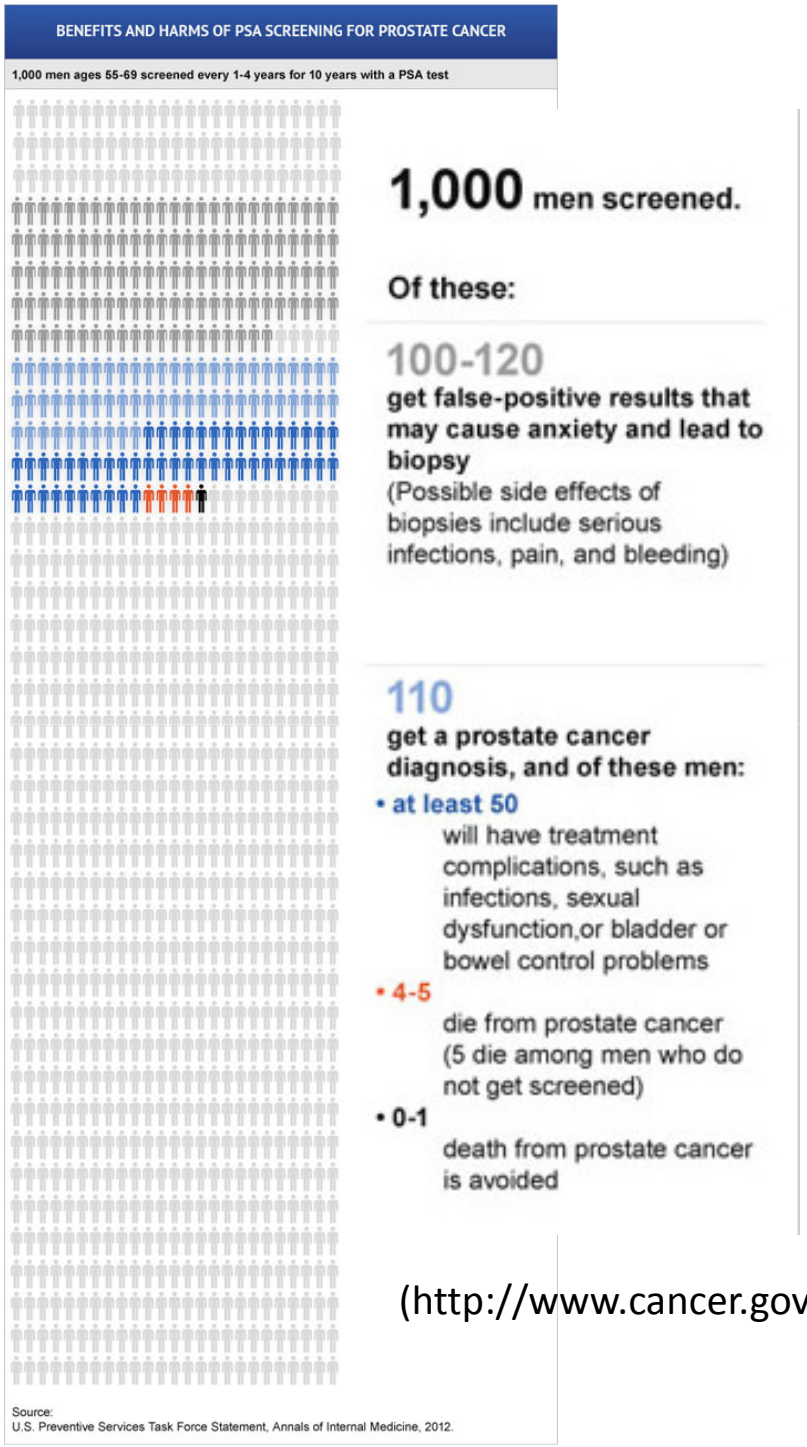

(http://www.cancer.gov/cancertopics/factsheet/detection/PSA)

REVIEW | Annals of Internal Medicine

Active Surveillance in Men With Localized Prostate Cancer

A Systematic Review

Issa J. Dahabreh, MD, MS; Mei Chung, PhD, MPH; Ethan M. Balk, MD, MPH; Winifred W. Yu, PhD, MS; Paul Mathew, MD; Joseph Lau, MD; and Stanley Ip, MD

Background: Active surveillance (AS) and watchful waiting (WW) have been proposed as management strategies for low-risk, localized prostate cancer.

Purpose: To systematically review strategies for observational management of prostate cancer (AS or WW), factors affecting their utilization, and comparative effectiveness of observational management versus immediate treatment with curative intent.

Data Sources: MEDLINE and Cochrane databases (from inception to August 2011).

Study Selection: Screened abstracts and reviewed full-text publications to identify eligible studies.

Data Extraction: One reviewer extracted data, and another verified quantitative data. Two independent reviewers rated study quality and strength of evidence for comparative effectiveness.

Data Synthesis: Sixteen independent cohorts defined AS, 42 studies evaluated factors that affect the use of observational strategies, and 2 evidence reports and 22 recent studies reported comparisons of WW versus treatment with curative intent. The most common eligibility criteria for AS were tumor stage (all cohorts), Gleason score (12 cohorts), prostate-specific antigen (PSA) concentration (10 cohorts), and number of biopsy cores positive for cancer (8 cohorts). For monitoring, studies used combinations of periodic PSA testing (all cohorts), digital rectal examination (14 cohorts), and rebiopsy (14 cohorts). Predictors of receiving no active treatment included older age, comorbid conditions, lower Gleason score, tumor stage, PSA concentration, and favorable risk group. No published studies compared AS with immediate treatment with curative intent. Watchful waiting was generally less effective than treatment with curative intent; however, applicability to contemporary patients may be limited.

Limitations: Active surveillance and WW often could not be differentiated in the reviewed studies. Published randomized trials have assessed only WW and did not enroll patients diagnosed by PSA screening.

Conclusion: Evidence is insufficient to assess whether AS is an appropriate option for men with localized prostate cancer. A standard definition of AS that clearly distinguishes it from WW is needed to clarify scientific discourse.

Primary Funding Source: Agency for Healthcare Research and Quality.

Ann Intern Med. 2012;156:582-590. www.annals.org

For author affiliations, see end of text.

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Annals of Internal Medicine | CONFERENCE

National Institutes of Health State-of-the-Science Conference: Role of Active Surveillance in the Management of Men With Localized Prostate Cancer

Patricia A. Ganz, MD; John M. Barry, MD; Wylie Burke, MD, PhD; Nananda F. Col, MD, MPP, MPH; Phaedra S. Corso, PhD, MPA; Everett Dodson; M. Elizabeth Hammond, MD; Barry A. Kogan, MD; Charles F. Lynch, MD, PhD, MS; Lee Newcomer, MD, MHA; Eric J. Seifter, MD; Janet A. Tooze, PhD, MPH; Kasisomayajula Viswanath, PhD; and Hunter Wessells, MD*

National Institutes of Health (NIH) Consensus and State-of-the-Science Statements are prepared by independent panels of health professionals and public representatives on the basis of 1) the results of a systematic literature review prepared under contract with the Agency for Healthcare Research and Quality, 2) presentations by investigators working in areas relevant to the conference questions during a 2-day public session, 3) questions and statements from conference attendees during open discussion periods that are part of the public session, and 4) closed deliberations by the panel during the remainder of the second day and morning of the third. This statement is an independent report of the panel and is not a policy statement of NIH or the U.S. government.

The statement reflects the panel's assessment of medical knowledge available at the time the statement was written. Thus, it provides a "snapshot in time" of the state of knowledge on the conference topic. When reading the statement, keep in mind that new knowledge is inevitably accumulating through medical research. The following statement is an abridged version of the panel's report, which is available in full at http:

diate treatment with surgery or radiation. These therapeutic strategies are associated with short- and long-term complications, including impotence and urinary incontinence. Only a few men choose observational strategies, thereby delaying the initiation of curative therapy or avoiding it completely. Given the high prevalence of low-risk prostate cancer, the roles of active surveillance and other observational strategies as alternatives to immediate treatment need to be clarified.

The National Cancer Institute, the Centers for Disease Control and Prevention, and the NIH Office of Medical Applications of Research convened a State-of-the-Science Conference on 5 to 7 December 2011 to assess the available scientific evidence about active surveillance for men with localized prostate cancer. The conference, which addressed 5 key questions, was informed by a formal evidence report commissioned through the Agency for Healthcare Research and Quality, data presented by speakers, and input from attendees.

Active surveillance

- Active surveillance is appropriate in men with disease that is believed to be indolent who do not require immediate therapy.
- Patients are monitored closely, often with a multifactorial follow-up, including periodic PSA testing, digital rectal examination (DRE), prostate imaging, and prostate biopsy.
- These patients are treated with surgery or radiation on evidence of biochemical, histologic, or anatomical progression, or at the patient's discretion.
- In practice, AS is generally used in relatively younger men with low-risk cancer who are otherwise healthy and may benefit from and tolerate aggressive therapies that are offered with curative intent upon cancer progression.

Watchful waiting (WW)

- Watchful waiting is typically a more passive strategy, with interventions— often palliative—triggered by symptomatic progression.
- Watchful waiting is usually reserved for older men with localized cancer or major comorbid conditions who are not likely to benefit from or tolerate aggressive curative treatment.
- Active surveillance and WW often could not be differentiated in the reviewed studies.
- **Published randomized trials have assessed only WW and did not enroll patients diagnosed by PSA screening**.

Sintesi delle evidenze (1)

- No completed randomized clinical trials have assessed whether patients who undergo active surveillance have better or worse outcomes than those who receive immediate curative treatment.
- The PIVOT trial compared watchful waiting with radical prostatectomy. With a median follow-up of 10 years, prostate cancer and all-cause mortality did not significantly differ between groups.
- The ProtecT trial is under way in the United Kingdom, but results will not be available for 5 to 10 years.
- 2 RCT of WW vs RP and 1 RCT of WW vs RT reported long term results. The applicability of these RCT findings to contemporary patients with prostate cancer is limited because most enrolled patients were not diagnosed with PSA screening.

Sintesi delle evidenze (2)

- 16 noncomparative cohort studies are examining active surveillance in men with low-risk disease.
- Differences in:
  - Patient selection criteria
  - Follow-up protocols
  - Triggers for intervention
- Early results demonstrate disease-free and survival rates that compare favorably with those reported for curative therapy.
- **For disease-specific quality of life, patients who undergo radical prostatectomy or radiation therapy experience worse urinary and sexual functioning than patients following an observation strategy. These differences persist over time.**

Prospettive di ricerca

- Future clinical studies are needed to determine the optimal AS protocol and provide information on the comparative effectiveness of AS versus immediate active treatment.
- These studies will require large sample sizes and long-term follow-up.
- Basic and clinical research to uncover better molecular, clinical, or imaging markers of indolent versus aggressive disease (particularly potentially fatal biological forms of newly diagnosed prostate cancer among patients with low-risk disease, according to current criteria) are necessary to better inform which patients are most likely to benefit from observational management versus active treatment.
- Combining such markers into predictive scores can improve our ability to identify patients who are most likely to benefit from immediate active treatment

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European Association of Urology

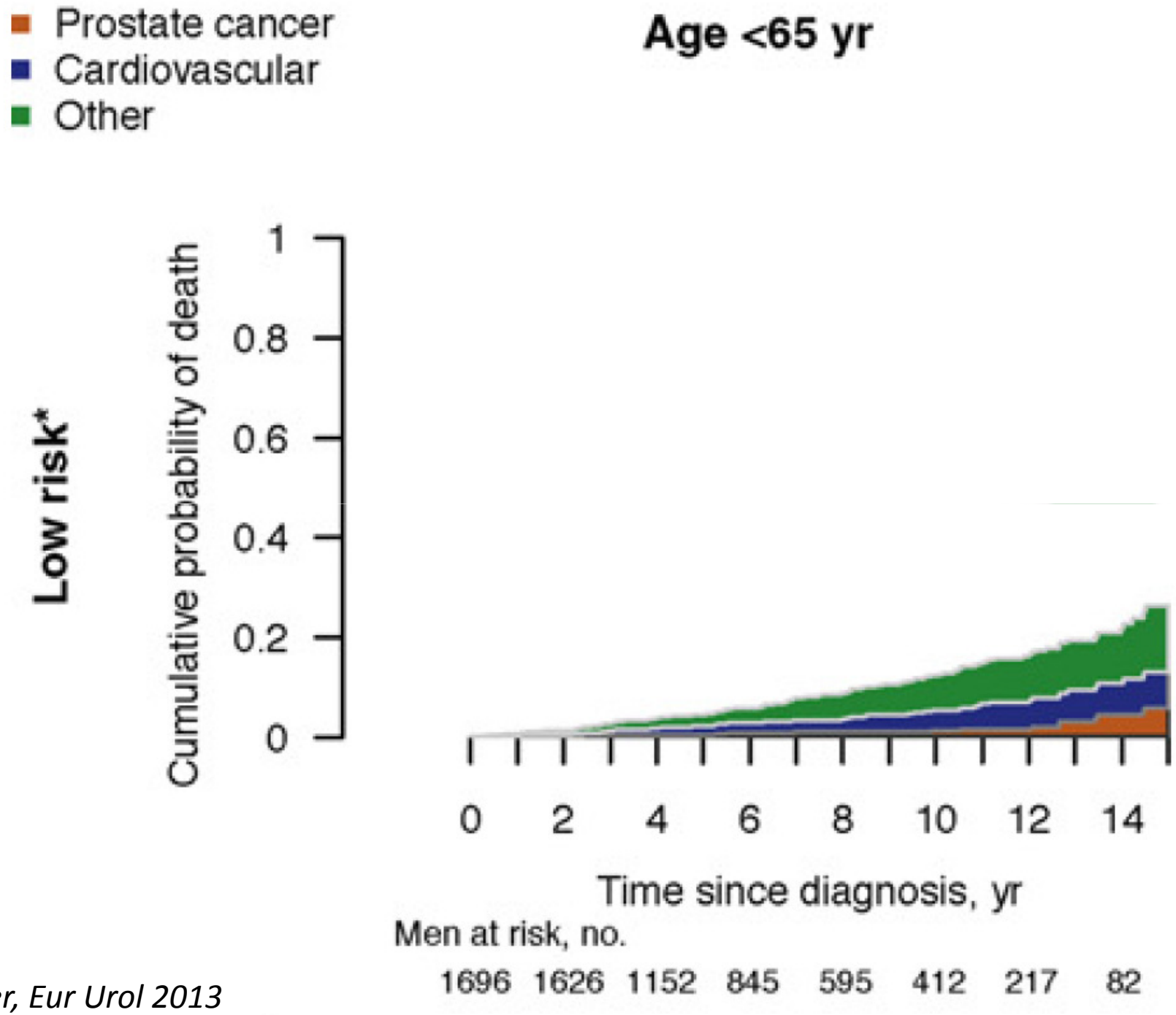
Platinum Priority – Prostate Cancer

Editorial by Urs E. Studer and Peter C. Albertsen on pp. 97–99 of this issue

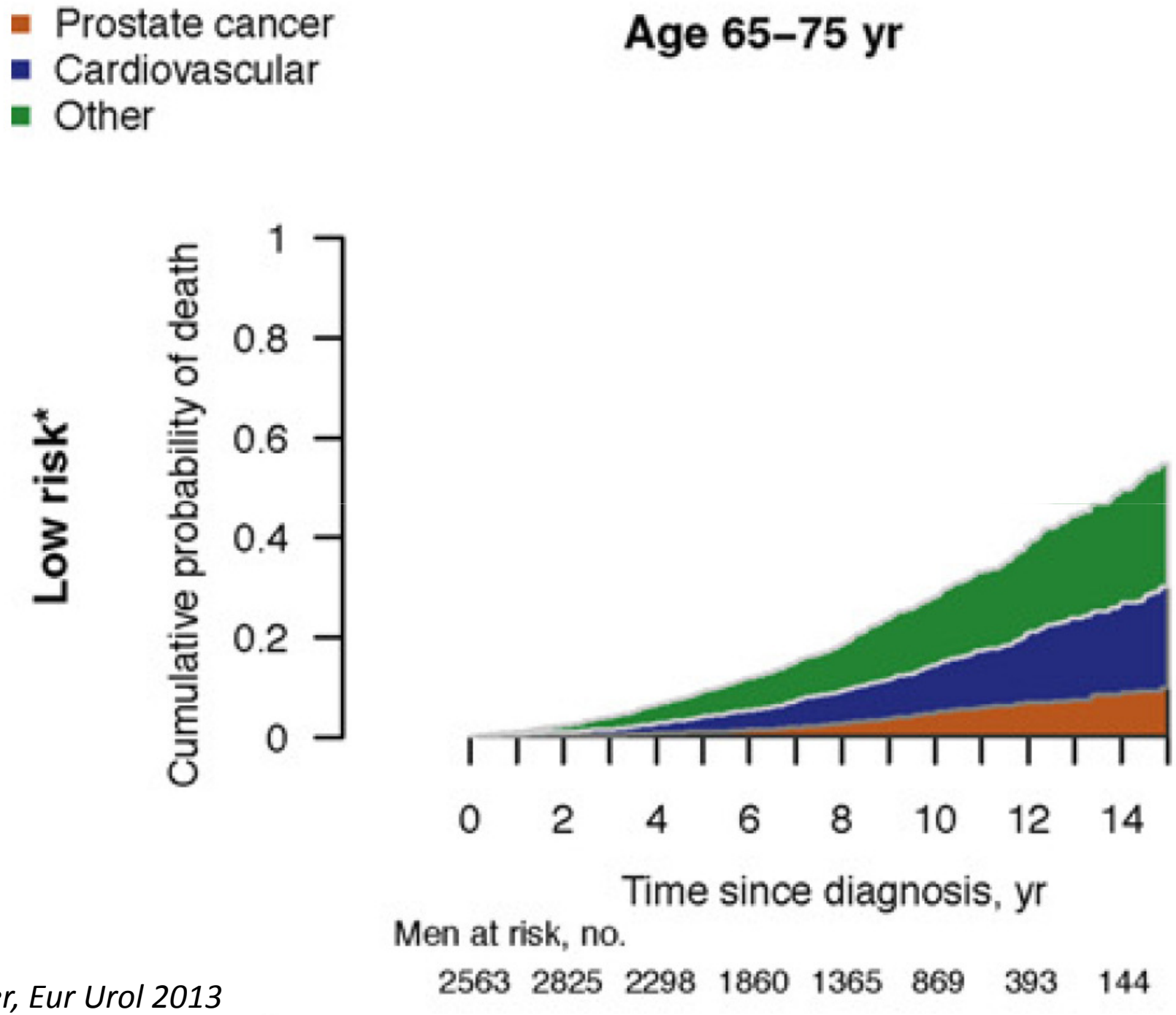
Long-term Outcomes Among Noncuratively Treated Men According to Prostate Cancer Risk Category in a Nationwide, Population-based Study

Jennifer R. Rider[a,*], *Fredrik Sandin*[b], *Ove Andrén*[c], *Peter Wiklund*[d], *Jonas Hugosson*[e], *Pär Stattin*[f]

[a] *Channing Laboratory, Department of Medicine, Brigham and Women's Hospital and Harvard Medical School; and Department of Epidemiology, Harvard School of Public Health, Boston, MA, USA;* [b] *Regional Cancer Center, Uppsala, Sweden;* [c] *Department of Urology, Örebro University Hospital, Örebro, Sweden;* [d] *Department of Molecular Medicine and Surgery, Division of Urology, Karolinska Institute, Stockholm, Sweden;* [e] *Department of Urology, Institute of Clinical Sciences, Sahlgrenska Academy at University of Göteborg, Göteborg, Sweden;* [f] *Department of Surgical and Perioperative Sciences, Urology, and Andrology, Umeå University, Umeå, Sweden; and Department of Surgery, Urology Service, Memorial Sloan-Kettering Cancer Center, New York, NY, USA*



Rider, Eur Urol 2013



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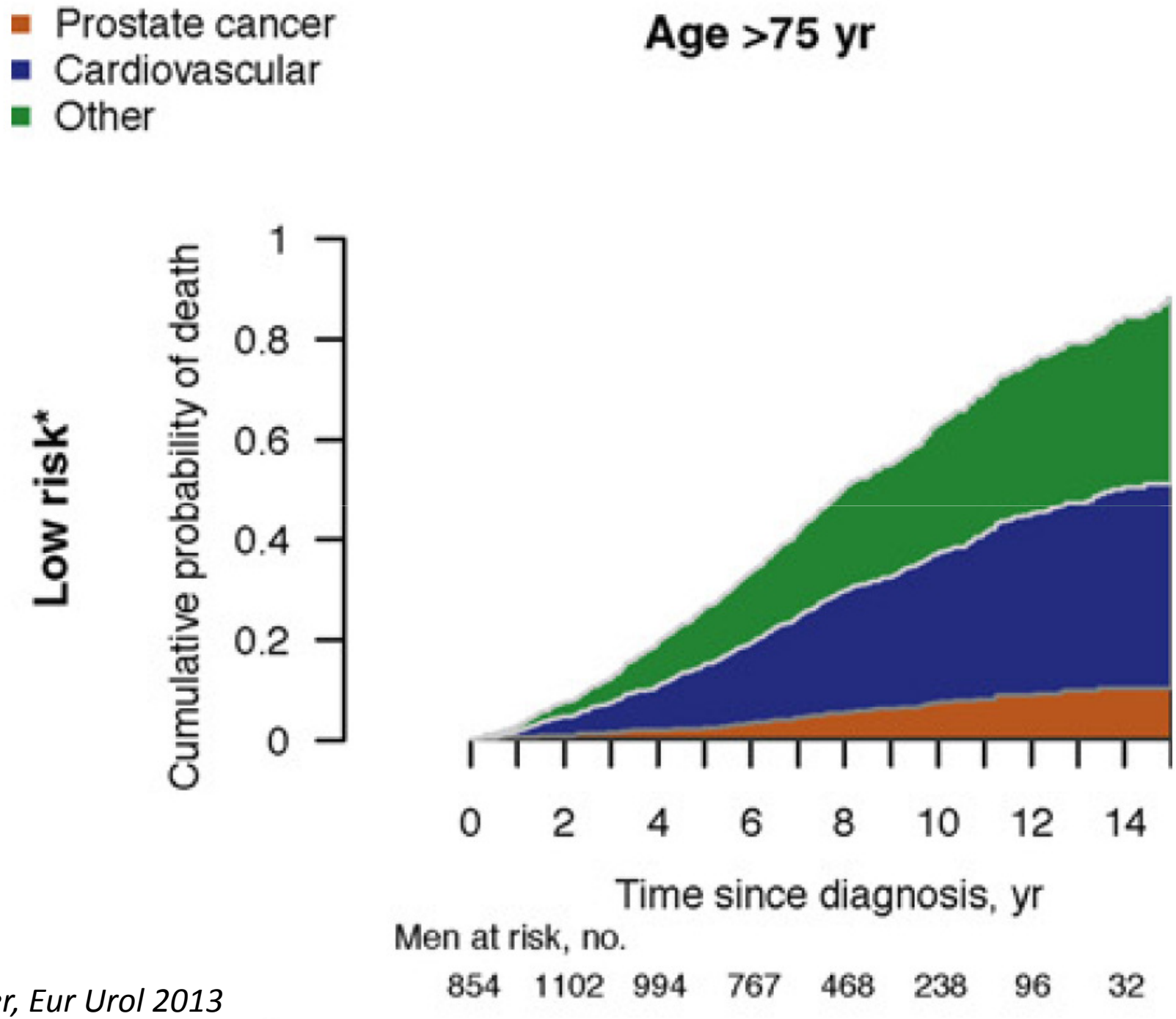

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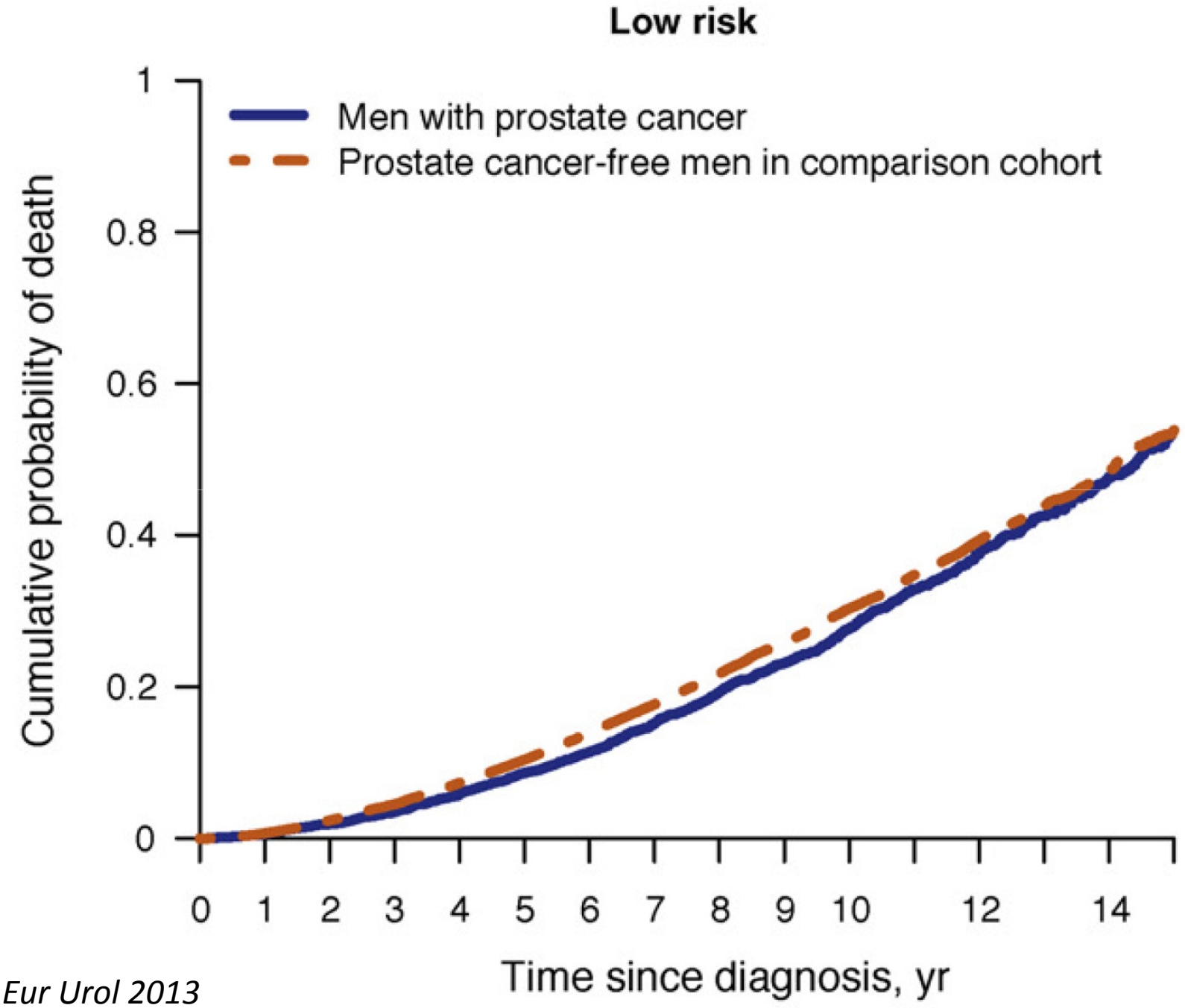

Rider, Eur Urol 2013

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European Association of Urology

Platinum Priority – Prostate Cancer

Editorial by Markus Graefen and Thorsten Schlomm on pp. 604–605 of this issue

Active Surveillance for Low-Risk Prostate Cancer Worldwide: The PRIAS Study

Meelan Bul[a,], Xiaoye Zhu[a], Riccardo Valdagni[b], Tom Pickles[c], Yoshiyuki Kakehi[d], Antti Rannikko[e], Anders Bjartell[f], Deric K. van der Schoot[g], Erik B. Cornel[h], Giario N. Conti[i], Egbert R. Boevé[j], Frédéric Staerman[k], Jenneke J. Vis-Maters[l], Henk Vergunst[m], Joris J. Jaspars[n], Petra Strölin[o], Erik van Muilekom[p], Fritz H. Schröder[a], Chris H. Bangma[a], Monique J. Roobol[a]*

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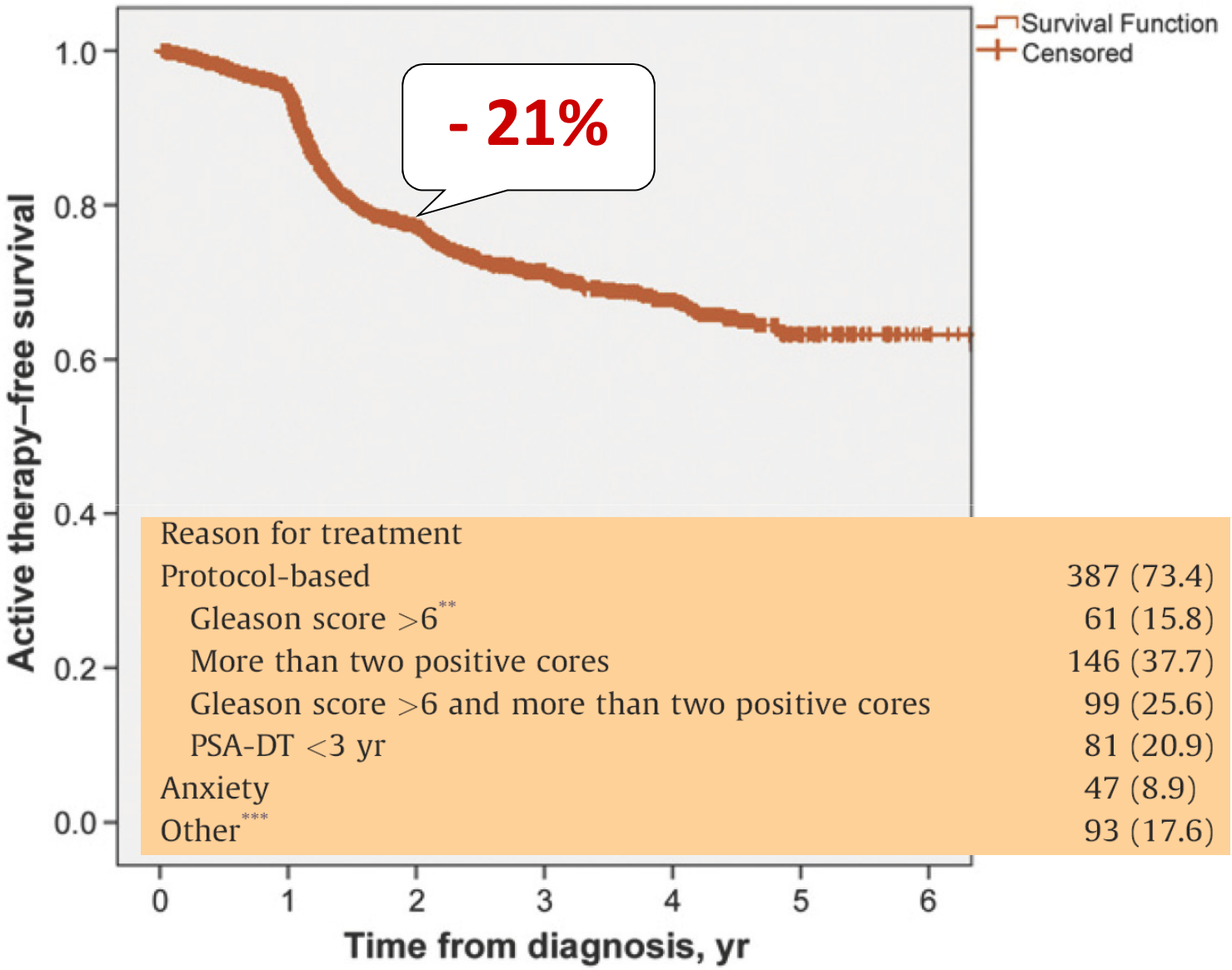
- **Periodo di arruolamento: 2006 - 2012**
- **Paesi partecipanti: 17**
- **N° centri attivi: >100**
- **N° pz arruolati (maggio 2012): 2494**
  - **da centri Italiani: 364 (14.6%)**
- **Follow-up mediano: 1.6 mesi**



Reason for treatment	
Protocol-based	387 (73.4)
Gleason score >6**	61 (15.8)
More than two positive cores	146 (37.7)
Gleason score >6 and more than two positive cores	99 (25.6)
PSA-DT <3 yr	81 (20.9)
Anxiety	47 (8.9)
Other***	93 (17.6)

Fig. 1 – Active therapy–free survival over time.

Bul, Eur Urol 2013

Table 5 – Association of baseline characteristics with deferred active treatment over time

Baseline characteristics	Deferred active therapy, $n = 527$	
	HR (95% CI)	p value
Age at diagnosis	1.0 (0.98–1.01)	0.62
PSA	1.0 (0.92–1.02)	0.22
PSA-D†	2.1 (1.68–2.70)	<0.001*
Clinical stage		
T1C	Ref.	Ref.
T2	1.1 (0.86–1.34)	0.55
Total biopsy cores	0.95 (0.91–0.98)	0.002*
Positive cores		
1	Ref.	Ref.
2	1.7 (1.43–2.04)	<0.001*

HR = hazard ratio; CI = confidence interval; PSA = prostate-specific antigen; PSA-D = prostate-specific antigen density; Ref = reference group.

† HR for PSA-D is reported per 0.10-U increase.

* Significant results ($p < 0.05$).

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European Association of Urology

Platinum Priority – Prostate Cancer

Editorial by Laurence Klotz on pp. 108–110 of this issue

Outcome Following Active Surveillance of Men with Screen-detected Prostate Cancer. Results from the Göteborg Randomised Population-based Prostate Cancer Screening Trial

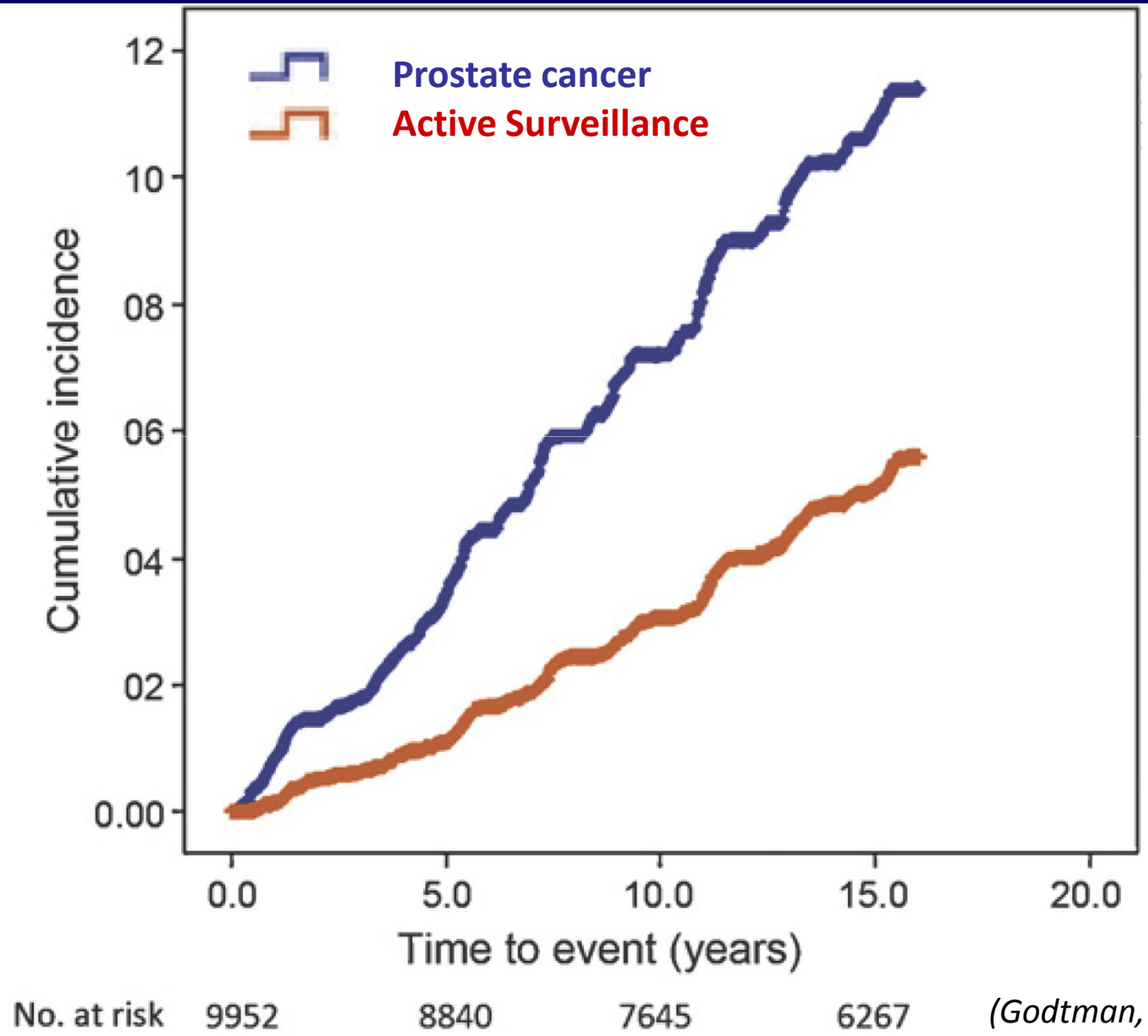
Rebecka Arnsrud Godtman [a,*], *Erik Holmberg* [b], *Ali Khatami* [a], *Johan Stranne* [a], *Jonas Hugosson* [a]

[a] *Department of Urology, Institute of Clinical Sciences, Sahlgrenska Academy at the University of Göteborg, Göteborg, Sweden;* [b] *Department of Oncology, Institute of Clinical Sciences, Sahlgrenska Academy at the University of Göteborg, Göteborg, Sweden*

Caratteristiche della coorte

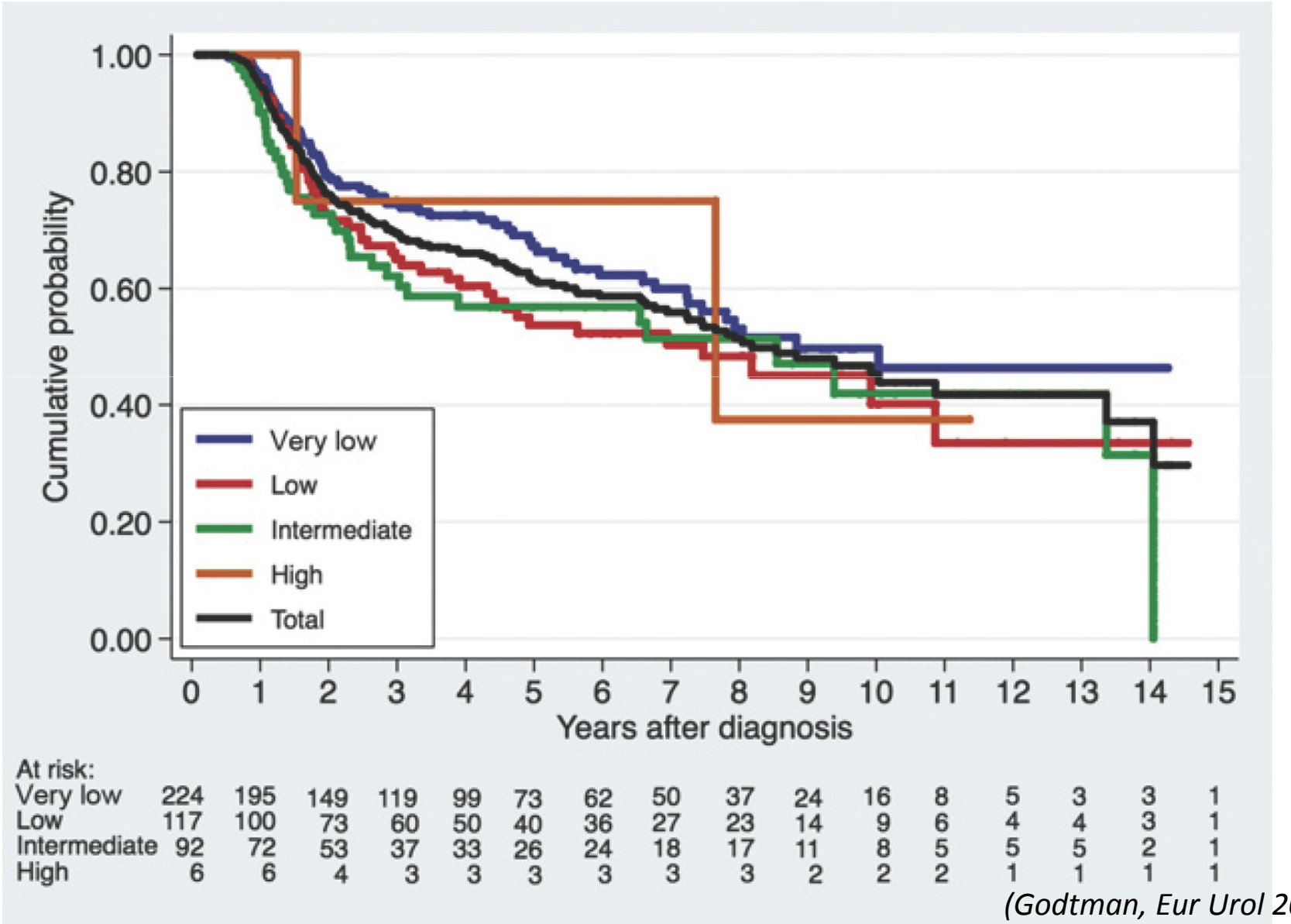
- 968 casi diagnosticati con lo screening tra il 1995 e il 2010 su 10000 soggetti randomizzati al braccio screening
- Il 46% (442 su 968 casi) è stato inizialmente gestito con SA
- Distribuzione per livello di rischio dei pz in SA (sec. Epstein, 1994):
  - **51.0% - very low risk**
  - **26.7% - low risk**
  - 21.9% - intermediate risk
  - 1.4% - high risk
- Tempo mediano di follow-up in SA: 8.2 anni

Cumulative incidence of screen-detected prostate cancer and active surveillance



(Godtman, Eur Urol 2013)

Treatment-free survival for the various risk groups



(Godtman, Eur Urol 2013)

Influence of risk group and age at diagnosis on overall survival

Covariate	HR, multivariate model	*p* value
Risk group		
Very low (*n* = 224)	1.0	–
Low (*n* = 117)	1.1 (0.6–2.0)	0.87
Intermediate (*n* = 92)	1.6 (0.9–3.0)	0.13
High (*n* = 6)	4.5 (1.1–19.1)	0.04
Age	1.1 (1.0–1.2)	0.002

HR = hazard ratio.
Within parentheses: 95% confidence interval.

For the large group of men with very low-risk and low risk PCa, AS appears safe. There were no deaths from PCa, and no man developed metastatic disease during a median follow-up of 6 yr.

(Godtman, Eur Urol 2013)

The NEW ENGLAND JOURNAL of MEDICINE

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Radical Prostatectomy versus Observation for Localized Prostate Cancer

Timothy J. Wilt, M.D., M.P.H., Michael K. Brawer, M.D., Karen M. Jones, M.S., Michael J. Barry, M.D., William J. Aronson, M.D., Steven Fox, M.D., M.P.H., Jeffrey R. Gingrich, M.D., John T. Wei, M.D., Patricia Gilhooly, M.D., B. Mayer Grob, M.D., Imad Nsouli, M.D., Padmini Iyer, M.D., Ruben Cartagena, M.D., Glenn Snider, M.D., Claus Roehrborn, M.D., Ph.D., Roohollah Sharifi, M.D., William Blank, M.D., Parikshit Pandya, M.D., Gerald L. Andriole, M.D., Daniel Culkin, M.D., and Thomas Wheeler, M.D., for the Prostate Cancer Intervention versus Observation Trial (PIVOT) Study Group

ABSTRACT

BACKGROUND

The effectiveness of surgery versus observation for men with localized prostate cancer detected by means of prostate-specific antigen (PSA) testing is not known.

METHODS

From November 1994 through January 2002, we randomly assigned 731 men with localized prostate cancer (mean age, 67 years; median PSA value, 7.8 ng per milliliter) to radical prostatectomy or observation and followed them through January 2010. The primary outcome was all-cause mortality; the secondary outcome was prostate-cancer mortality.

RESULTS

During the median follow-up of 10.0 years, 171 of 364 men (47.0%) assigned to radical prostatectomy died, as compared with 183 of 367 (49.9%) assigned to observation (hazard ratio, 0.88; 95% confidence interval [CI], 0.71 to 1.08; P=0.22; absolute risk reduction, 2.9 percentage points). Among men assigned to radical prostatectomy, 21 (5.8%) died from prostate cancer or treatment, as compared with 31 men (8.4%) assigned to observation (hazard ratio, 0.63; 95% CI, 0.36 to 1.09; P=0.09; absolute risk reduction, 2.6 percentage points). The effect of treatment on all-cause and prostate-cancer mortality did not differ according to age, race, coexisting conditions, self-reported performance status, or histologic features of the tumor. Radical prostatectomy was associated with reduced all-cause mortality among men with a PSA value greater than 10 ng per milliliter (P=0.04 for interaction) and possibly among those with intermediate-risk or high-risk tumors (P=0.07 for interaction). Adverse events within 30 days after surgery occurred in 21.4% of men, including one death.

CONCLUSIONS

Among men with localized prostate cancer detected during the early era of PSA testing, radical prostatectomy did not significantly reduce all-cause or prostate-cancer mortality, as compared with observation, through at least 12 years of follow-up. Absolute differences were less than 3 percentage points. (Funded by the Department of Veterans Affairs Cooperative Studies Program and others; PIVOT ClinicalTrials.gov number, NCT00007644.)

From the Center for Chronic Disease Outcomes Research, Minneapolis Veterans Affairs (VA) Health Care System, and Section of General Medicine, University of Minnesota School of Medicine, Minneapolis (T.J.W.); Urologic IDEA, Seattle (M.K.B.); the VA Cooperative Studies Program Coordinating Center, Perry Point (K.M.J.), and the Agency for Healthcare Research and Quality, Rockville (S.F.) — both in Maryland; the General Medicine Division, Massachusetts General Hospital, Boston (M.J.B.); VA Medical Center, Greater Los Angeles Healthcare System, Los Angeles (W.J.A.), and VA Medical Center, Long Beach (P.I.) — both in California; Richmond VA Medical Center, Richmond, VA (B.M.G.); the Department of Urology, University of Pittsburgh, and VA Pittsburgh Health Care System, Pittsburgh (J.R.G.); the University of Michigan, Ann Arbor (J.T.W.); the VA New Jersey Health Care System, East Orange (P.G.); VA Medical Center Syracuse, Syracuse (I.N.), Brooklyn VA Medical Center, Brooklyn (W.B.), and VA Western New York Health System, Buffalo (R.C.) — all in New York; Louis A. Johnson VA Medical Center, Clarksburg, WV (G.S.); the Department of Urology, Southwestern Medical Center, University of Texas Dallas, Dallas (C.R.), Temple VA Medical Center, Temple (P.P.), and Baylor College of Medicine, Houston (T.W.) — all in Texas; Jesse Brown VA Medical Center, Chicago (R.S.); Washington University, St. Louis (G.L.A.); and the University of Oklahoma, Norman (D.C.). Address reprint requests to tim.wilt@va.gov.

This article was updated on July 19, 2012, at NEJM.org.

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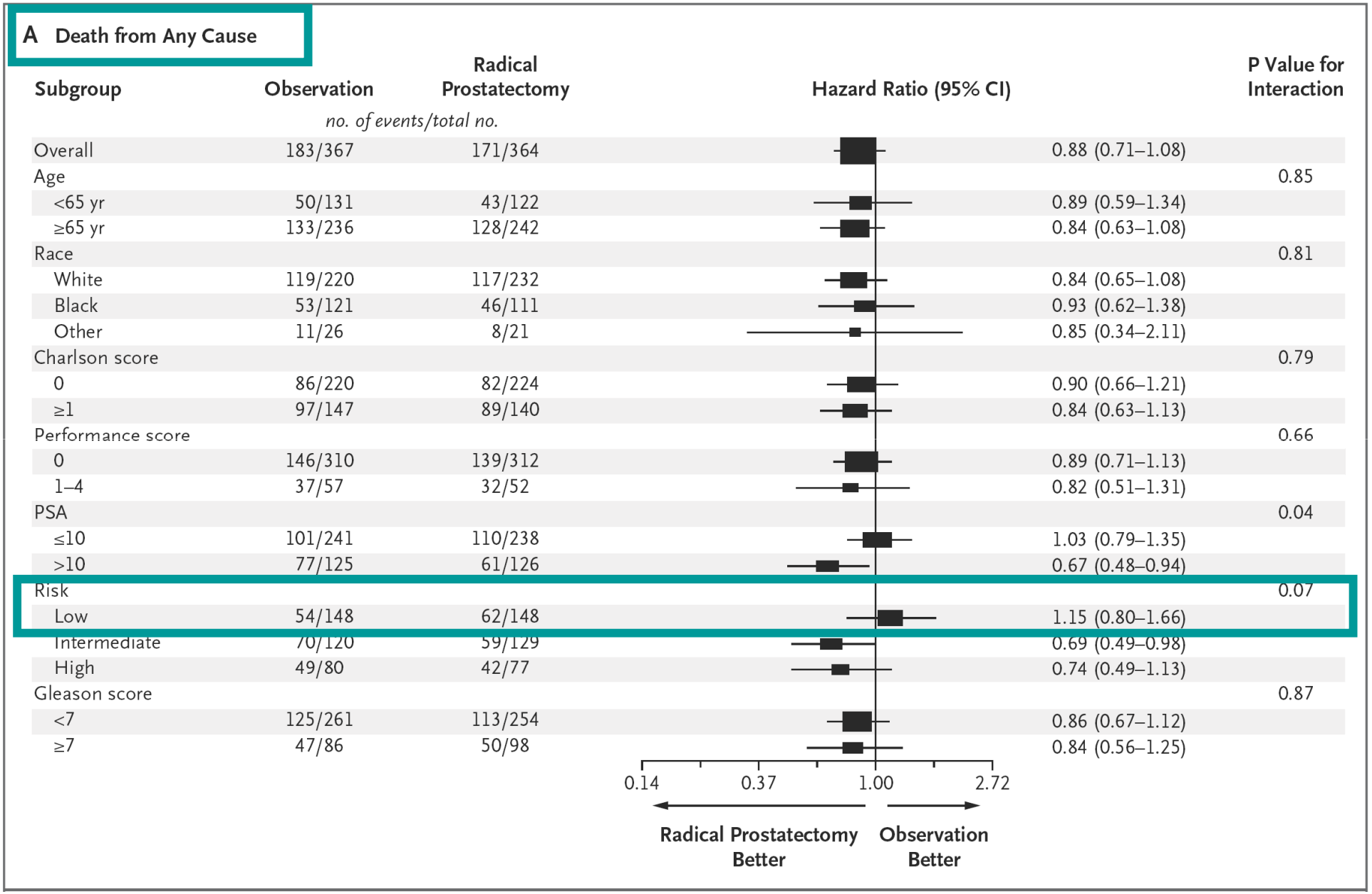
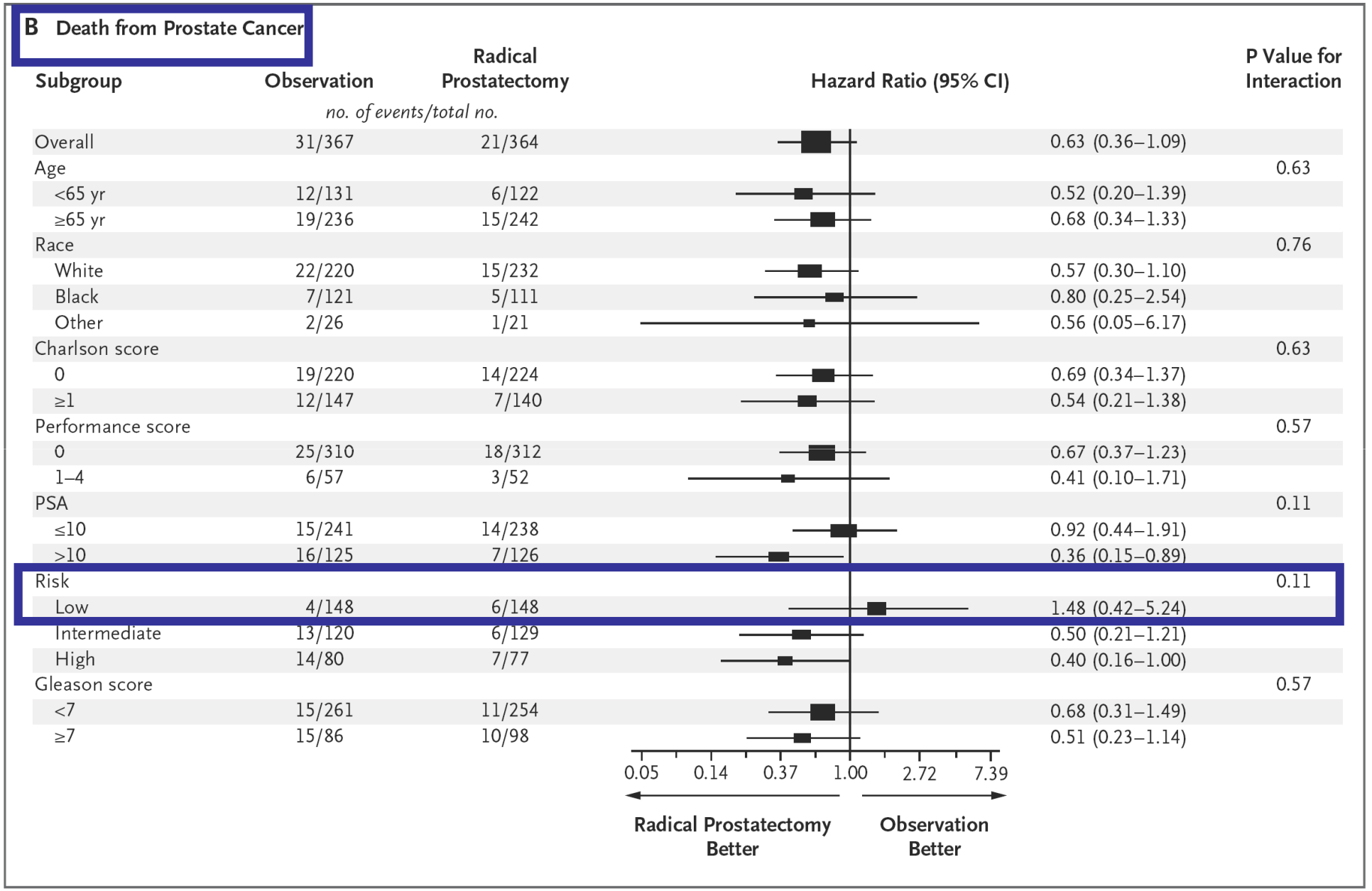


Wilt, NEJM 2012



Wilt, NEJM 2012

2. Progetto di SA per la Rete Oncologica

Premessa

- **Bozza di progetto** elaborata nel corso del 2012-2013 da un **gruppo di lavoro** istituito dalla Rete Oncologica al quale hanno partecipato urologi, radioterapisti, oncologi, patologi ed epidemiologi
- Il progetto è attualmente in attesa dell'esito di **domanda di finanziamento** al Ministero della Salute (ricerca finalizzata 2011-2012) e alla Compagnia di San Paolo

Background -1

- La **sorveglianza attiva (SA)** è considerata una delle opzioni appropriate da proporre a pazienti selezionati con nuova diagnosi di tumore della prostata
- Nonostante la SA sia **raccomandata dalle Linee Guida regionali (2009)** e da molte altre LG internazionali, è **ancora poco utilizzata** nella pratica assistenziale per diverse ragioni:
  - timori del paziente e/o del medico (psicologici, clinici, medico-legali, interessi economici, …)
  - assenza di una proposta di SA "di sistema"
  - presenza di disincentivi (economici, professionali, di valutazione di produttività, …)
  - difficoltà organizzative
  - assenza di un contesto di valutazione su compliance, esiti, costi, …

Background -2

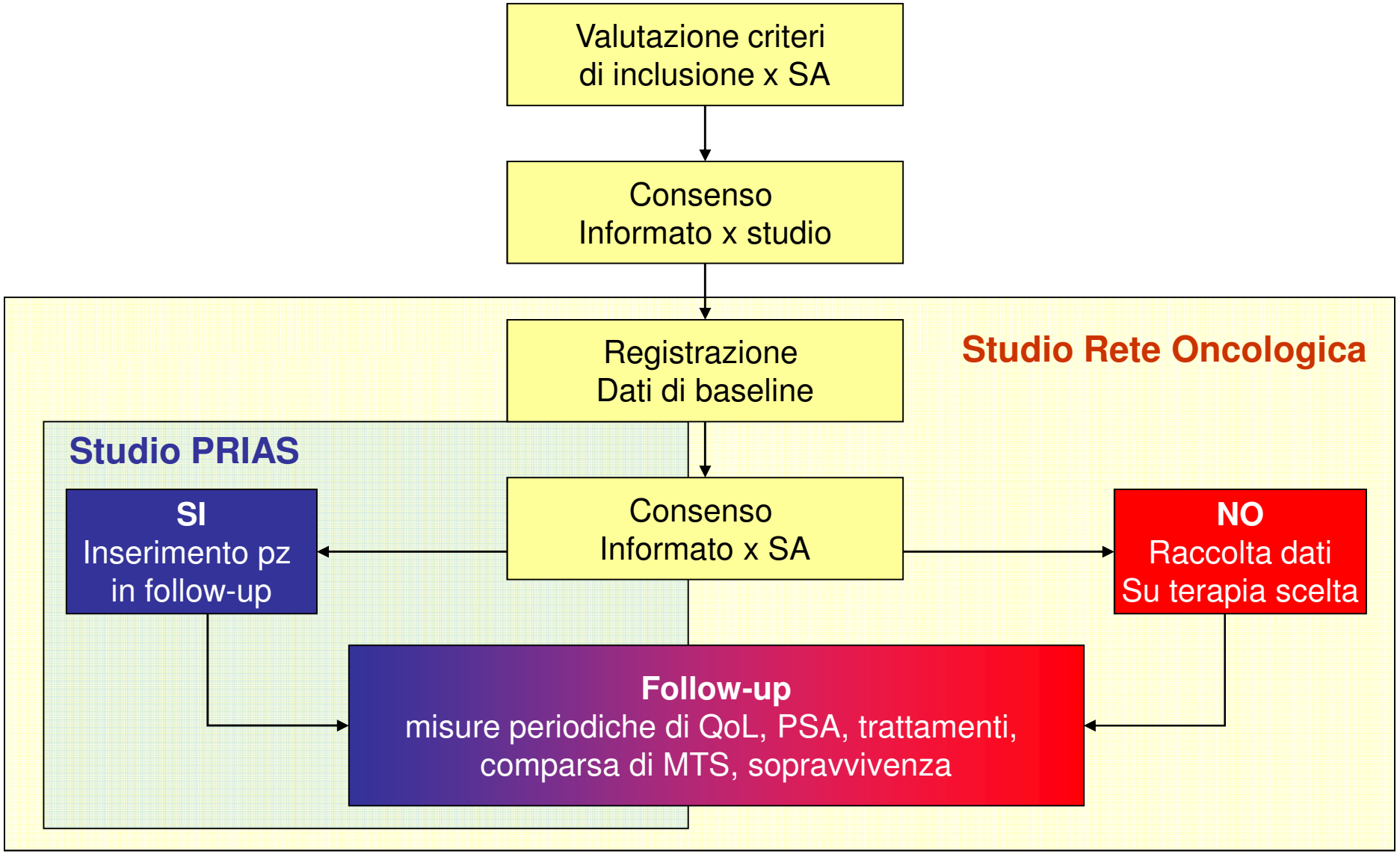
- La conoscenza della **SA come possibile opzione di trattamento si sta diffondendo** anche tra i medici non specialisti, i pazienti, nell'opinione pubblica
- La diffusione della SA nella pratica assistenziale potrebbe essere molto favorita nell'ambito di un **contesto di ricerca clinica** perché ciò potrebbe ridurre alcuni rischi (es. medico-legali) e offrire maggiori garanzie di sicurezza e qualità (standardizzazione dell'organizzazione, raccolta dati e valutazione)
- Il principale fattore che condiziona il successo/l'insuccesso di una iniziativa di ricerca di questo tipo è l'ampiezza e la sistematicità dell'**adesione "di rete"** degli specialisti maggiormente coinvolti (urologi, radioterapisti)

Metodi (1): criteri di inclusione

- Principali **criteri di selezione**:
  - tumori localizzati a basso rischio
  - potenziale eligibilità del paziente a trattamenti radicali
  - assenza di controindicazioni (psicologiche, organizzative)
- In discussione i criteri di inclusione di **PRIAS:**

1. Men should:
   – Have histologically proven adenocarcinoma of the prostate
   – Be fit for curative treatment
   – Be willing to attend the follow-up visits
   – Not have received former therapy for prostate cancer
2. Clinical stage is T1C or T2
3. Gleason score is $\leq$6 and $\leq$2 biopsy cores are invaded with prostate cancer
4. PSA is $\leq$10 ng/ml and PSA density is $\leq$0.2 ng/ml/ml

Metodi (2): disegno di studio



Metodi (3): obiettivi

- Stimare, a livello di popolazione:
  - la proporzione di nuovi **casi eligibili** a SA
  - la proporzione di nuovi **casi che accettano** la SA
  - la proporzione di **casi che abbandonano** la SA x:
    - motivi clinici
    - altri motivi (psicologici, ecc…)
- Identificare le **caratteristiche** dei pazienti e del setting assistenziale associate ad accettazione/rifiuto della SA (confronto con pazienti che scelgono la chirurgia, la RT o altre terapie) o ad abbandono della SA (confronto con pz che restano in SA)
- **Confrontare**, con opportune tecniche statistiche, i gruppi di pazienti che scelgono **la SA vs altri trattamenti** all'esordio per **outcome clinici, di qualità di vita e di costo**

Metodi (4): raccolta dati

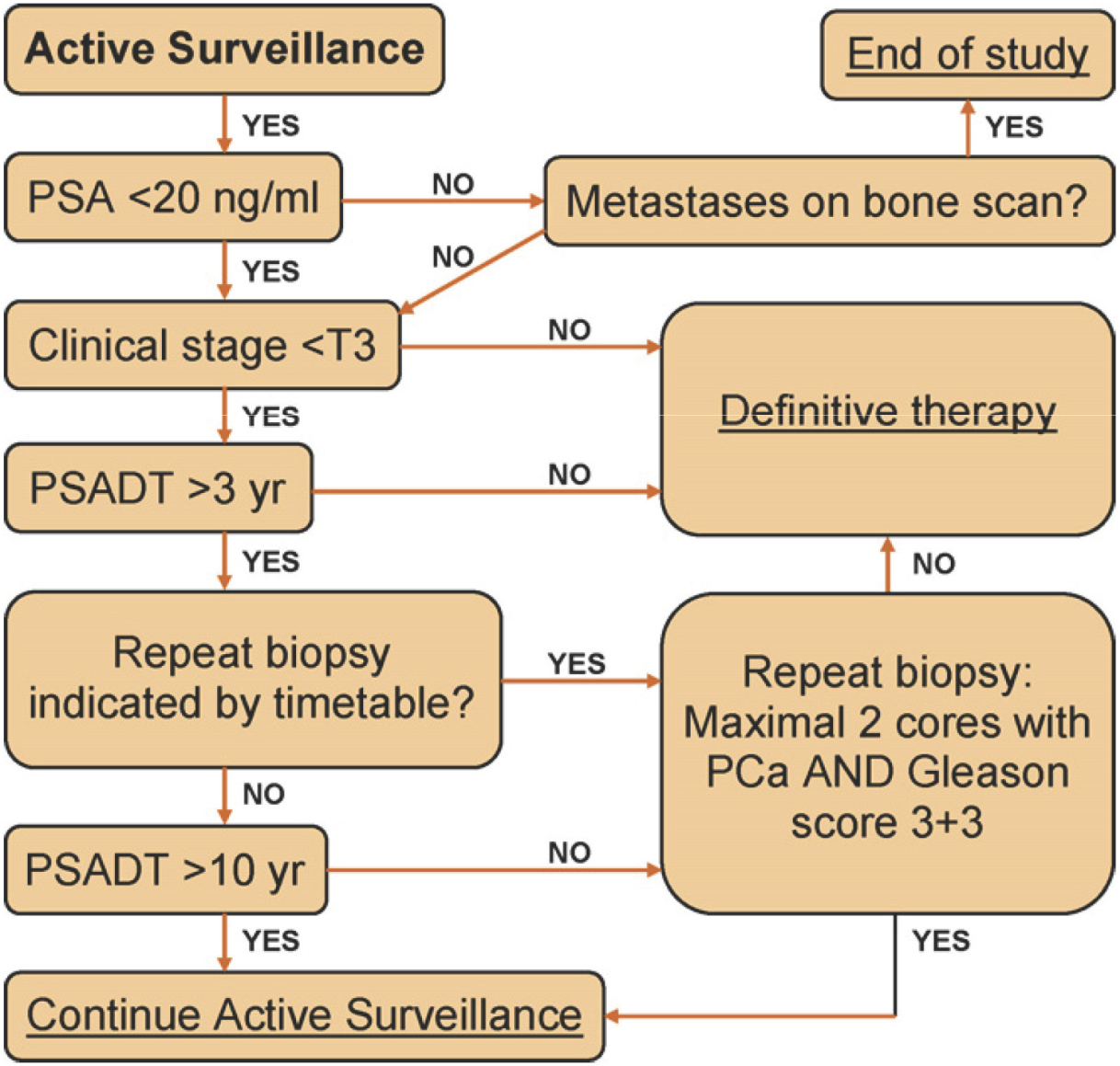
- Arruolamento di **(tutti) i casi eligibili x SA in (almeno) 3 anni** in Piemonte e Valle d'Aosta (circa 15-20% dei nuovi casi, pari a circa 750/4250 casi/anno, per un totale di 2250 in 3 anni)
- Colloquio con **informazioni** (verbali e scritte) x i pazienti e per il medico di famiglia e richiesta **consenso** (solo x studio, anche per SA)
- Raccolta di **informazioni cliniche e sociodemografiche** alla diagnosi su database predisposto per i trials dal CPO su web (www.epiclin.it)
- Raccolta di **informazioni sulla scelta terapeutica** (SA, chirurgia, RT, altro)
- Inserimento dei pazienti in **follow-up** (con reminders via SMS secondo calendario predefinito per quelli in SA) e registrazione dati su esito dei controlli e degli outcome

Metodi (5):
es. di calendario del follow-up (PRIAS)

Year	1					2				3		4		5		6		7	
Month	0	3	6	9	12	15	18	21	24	30	36	42	48	54	60	66	72	78	84
PSA-test	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DRE	✓		✓		✓		✓		✓		✓		✓		✓		✓		✓
Biopsy	✓				✓								✓						✓
Evaluation	✓		✓		✓		✓		✓		✓		✓		✓		✓		✓

* Repeat biopsy:
a) Standard after 1, 4, 7 en 10 year and subsequently every 5 years.
b) If indicated by the PSA DT, except for years when a standard repeat biopsy is scheduled.
No more than 1 biopsy per year should be performed
** Time of diagnosis

Metodi (6):
es. di criteri per interruzione della SA (PRIAS)



Metodi (7): organizzazione

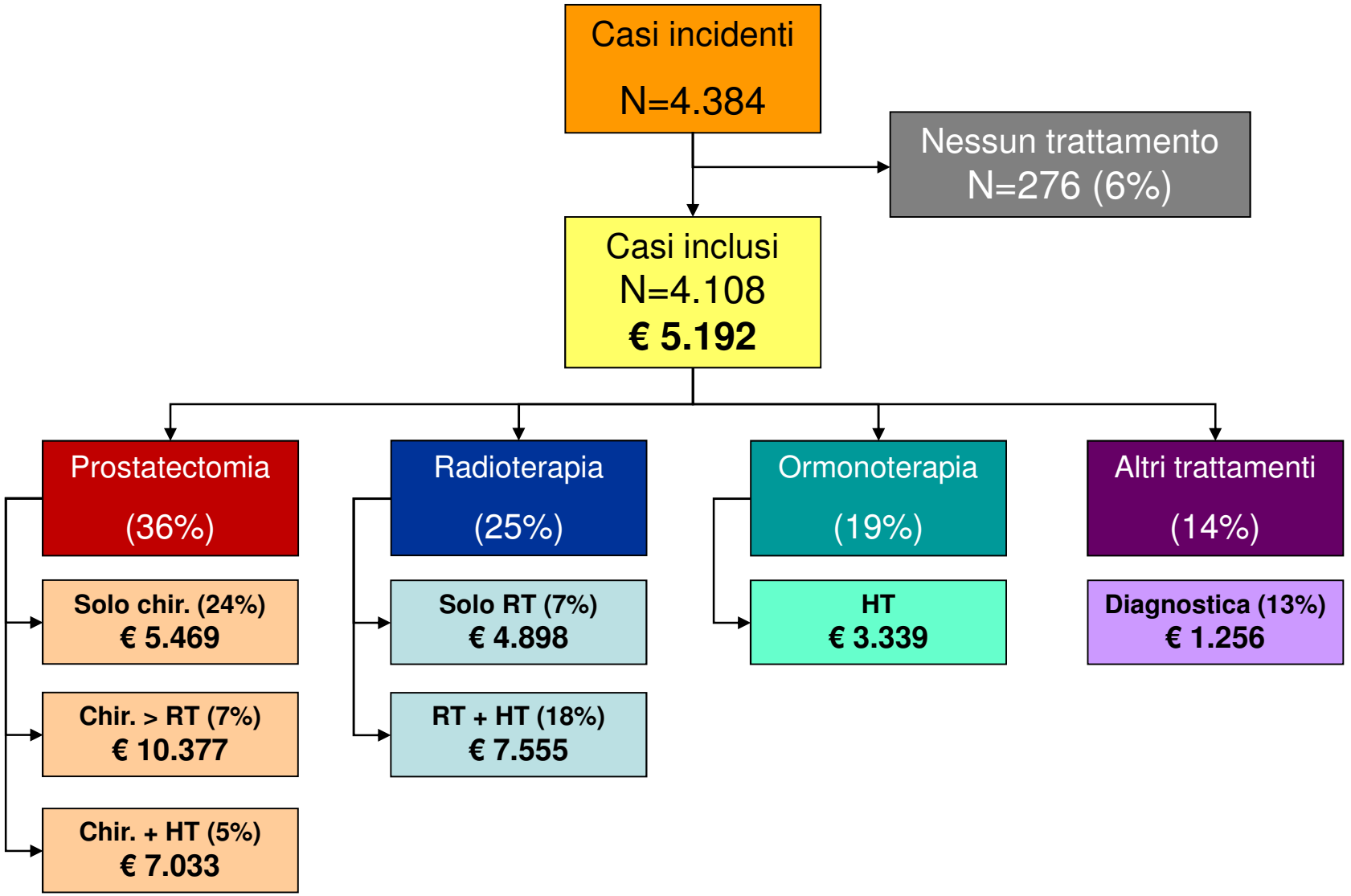
- Raccolta **adesioni** da urologie e radioterapie
- Definizione del **protocollo** di studio (cfr PRIAS)
- Approvazione da parte dei **comitati etici**
- Predisposizione degli **strumenti** e del **materiale informativo**:
  - opuscolo per pazienti, medici di famiglia
  - diffusione del progetto (articoli, interviste, locandine, ecc…)
  - sviluppo database su web con sistema interattivo di guida alle decisioni in corso di follow-up secondo protocollo e segnalazione automatica via SMS degli appuntamenti per i pazienti
- Predisposizione del sistema di **revisione delle diagnosi istologiche** e delle biopsie in corso di follow-up
- Predisposizione di una **banca di campioni biologici**???

3. Stima dell’impatto economico della SA nella Rete Oncologica

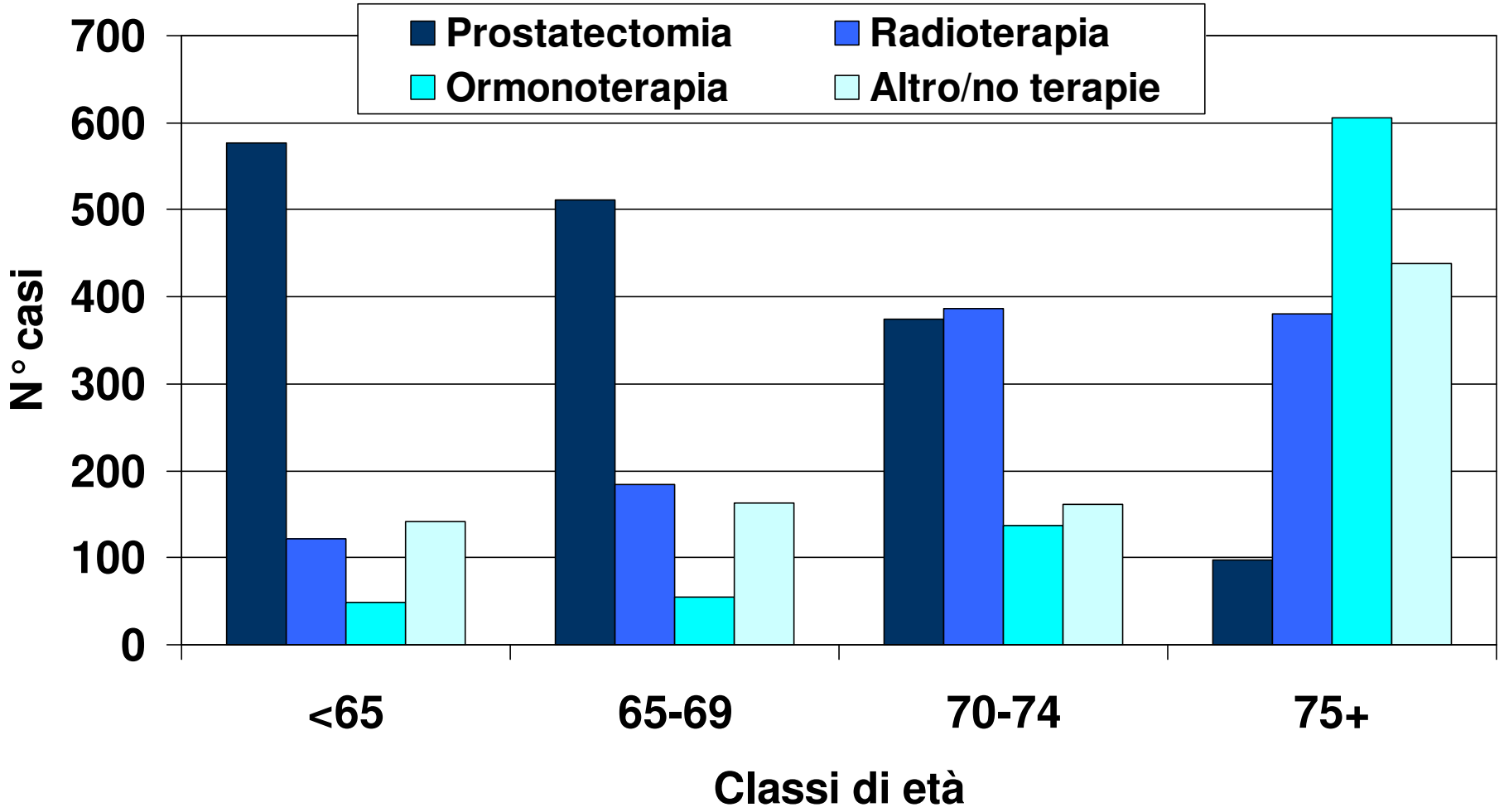
Ricostruzione del trattamento del T. della prostata a Torino

- Identificazione di tutti i **casi incidenti** nel periodo 2005-2010 a Torino (dati CPO-Registro Tumori)
- Ricostruzione **percorso di trattamento nel primo anno** dopo la diagnosi tramite record linkage con:
  - SDO (interventi, biopsie)
  - Prestazioni ambulatoriali di RT, diagnostica, follow-up
  - Prescrizioni farmacologiche
- Stima del **costo di ciascun percorso** terapeutico
- Stima del **numero di pazienti eligibili per Sorveglianza Attiva**
- **Stima dell'impatto economico** dell'introduzione della SA su scala regionale (**Budget Impact Analysis, BIA**)

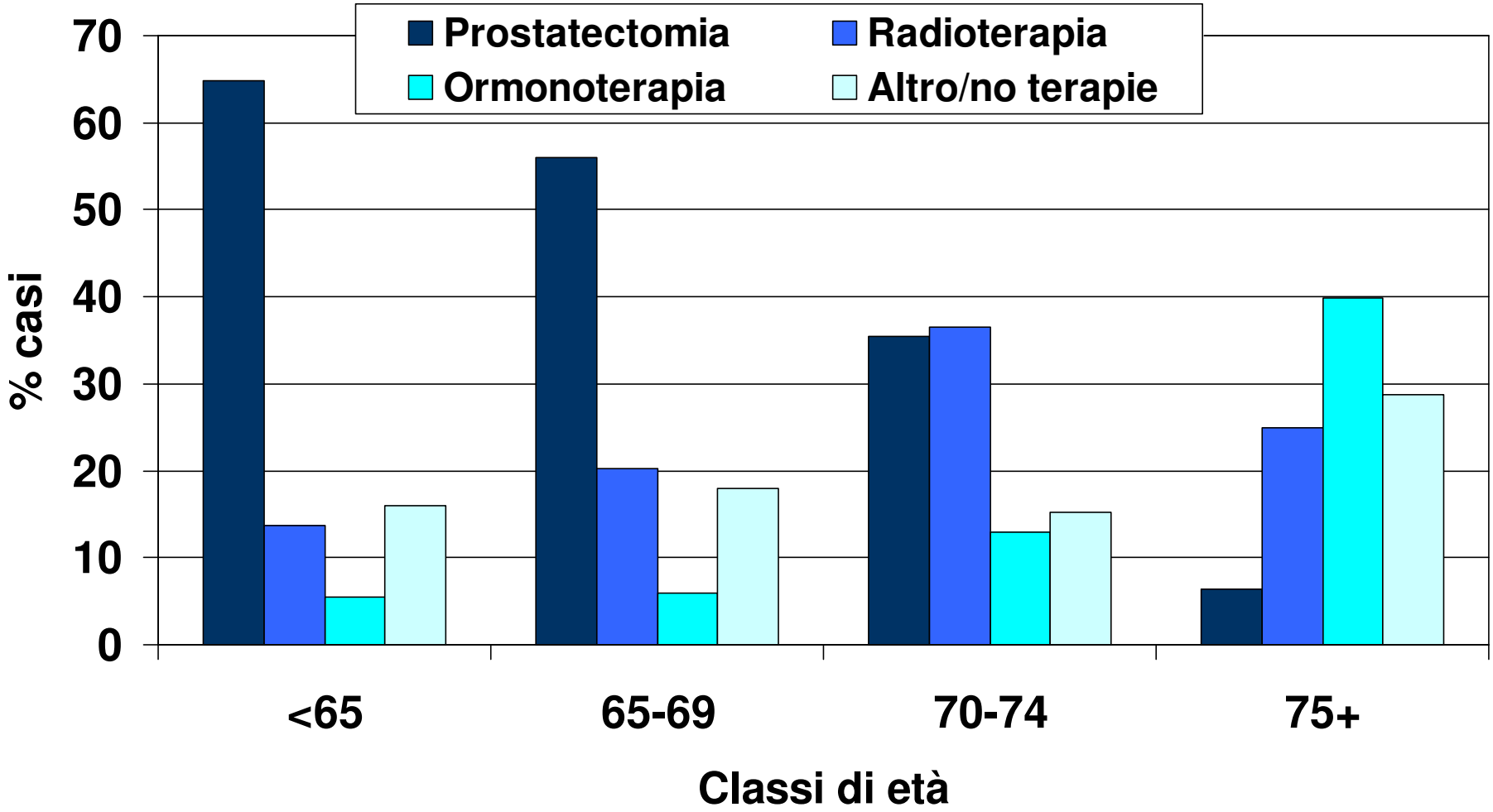
Percorso terapeutico e costi per tumore della prostata a Torino (2005-2009)



Trattamento iniziale per tumore della prostata. Torino, 2005-2009



Trattamento iniziale per tumore della prostata. Torino, 2005-2009



Implementazione della SA su scala regionale: stima di BIA (1° anno di F-UP, dati preliminari)

- Stima casi incidenti anno 2015 (fonte RTP): **4.241**
- Casi eligibili per SA: 35%
- Accettazione: 50%
- No. pazienti gestiti con SA: **763**
- Abbandono durante il 1° anno di follow-up: 7%

Costi SA: follow-up	↑	**+**	432.626 €
Costi SA: switch a chirurgia/radioterapia	↑	**+**	284.596 €
Costi prostatectomia	↓	**-**	3.130.907 €
Costi radioterapia	↓	**-**	934.749 €
SALDO potenziale da implementazione	↓	**-**	**3.348.434 €**

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EDITORIALS

Too much medicine; too little care

Time to wind back the harms of overdiagnosis and overtreatment

Paul Glasziou *professor* [1], Ray Moynihan *senior research fellow*[1], Tessa Richards *analysis editor*[2], Fiona Godlee *editor in chief*[2]

"Too much testing of well people and not enough care for the sick worsens health inequalities and drains professionalism, harming both those who need treatment and those who don't." Margaret McCartney.[1]