HealthManagement
Promoting Management and Leadership

Moving Evidence into Practice

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Inspire2Live has been created to empower people to convert the sense of powerlessness, caused by cancer, into one of strength. Inspire2Live is founded on the absolute belief that one can attain the greatest possible satisfaction by putting their heart and soul into helping others. Its motto is “Never, ever quit!”.

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On 11 November 2021, Inspire2Live organised a congress in Amsterdam to determine the best patient screening, diagnosis, and treatment techniques for prostate cancer and how we can offer them to everyone. How can we quickly implement evidence-based innovations to improve quality of life for all patients with prostate cancer? Implementation still happens far too slowly on a too limited scale which, in turn, harms patients.

Evidence is important, but not enough. For screening, there is still some resistance to the prostate-specific antigen (PSA) test, because it leads to many unnecessary biopsies and overdiagnosis, often resulting in overtreatment. In the case of an elevated PSA, using a qualitatively correct MRI as a second test is clearly the right choice. MRI reduces not only unnecessary tissue damage but also overdiagnosis. MRI is also more accurate and prevents the unnecessary and painful ‘12 needles in the anus’ for a diagnostic biopsy. Even though this new method is included in the Dutch guidelines on prostate carcinoma, a strong lobby is still required among professional groups and government bodies to become standard practice for all patients. Rapid implementation of this protocol, both in the Netherlands and internationally, is necessary to ensure that every man with an increased risk of prostate cancer receives a routine MRI and, if necessary, an MRI-targeted tissue biopsy rather than a ‘blind’ biopsy which is still not the case everywhere.

The discussion about screening for early detection of prostate cancer is too emotionally driven and should be conducted based on evidence. We need to apply the results from the large European Randomized Study of Screening for Prostate Cancer (ERSPC). After all, we can combine the current knowledge about MRI-guided diagnostics and the change in the active surveillance policy with the existing ERSPC data and deduce the effects of modern screening. In this way, we wouldn’t have to wait decades for outcomes from randomised clinical trials, with and without MRI, and the patient would quickly benefit from the new strategy.

Good information about prostate cancer and the role of PSA and MRI can help to accelerate the speed of implementation. There is currently a huge variation in practice in having PSA determined, which is both undesirable and harmful for patients. It is important that patient advocates take the lead in this. We have to make it our problem because otherwise, it will take a long time before these new techniques finally benefit patients. In other words: '*It's our problem, and therefore we have to be in the driving seat'* .

After diagnosis, treatment is required. Our congress showed that there had been progress on this front as well. In terms of new and innovative treatment, the combination of MRI and radiotherapy looks like a promising path to take. Hundreds of patients have already been treated in trials. The precision that can be achieved with this technique reduces unpleasant side effects such as impotence and incontinence. New technological developments, such as combining MRI and radiation in one device (MR-LINAC), must be compared quickly and reliably with existing techniques. Only this way can we work on a future in which we will always be able to offer the best therapy for every patient. The same applies to introducing treatments faster than usual: '*It's our problem, and therefore we have to be in the driving seat'* .

Changes in diagnostics and treatment mean that there will be shifts of responsibility between the various healthcare professionals, e.g., between urologists and radiologists and between urologists and radiation therapists. One can imagine that this will create some resistance which will almost certainly delay implementation, so, at the risk of repeating myself, '*It's our problem, and therefore we have to be in the driving seat'* .

Evidence is important, but not enough. There is sufficient evidence for performing early diagnostics with PSA, MRI, and treatment with MRI-guided radiation. We can and must continue to collect more evidence, but we cannot afford to wait any longer. Doctors should already know that this is the best route to diagnosis and treatment. We patients want to have these options.

We must also create an improved learning environment. What is good now will be even better in a few years and hopefully perfect in the future. However, patients do not have the luxury of waiting. Every delay leads to more serious illness, a greater chance of unpleasant side effects and increased mortality. In addition, healthcare costs become significantly higher, which society cannot afford either.

Creating awareness among patients and caregivers is essential, and training specialists is necessary. General practitioners and urologists should not be left behind, and radiologists should constantly be looking beyond daily practice. Science provides many new evidence-based technological possibilities for diagnostics and treatment, so patients need to receive the right information. This is a combined responsibility for patient advocates and professional groups.

Only when patients, caregivers, scientists, payers, and politicians join forces will we be able to bring the latest proven evidence into daily practice, thereby providing the best of help for patients. The thresholds are too high for us to reach individually, and only by sitting together in the driving seat can we live up to the title of our congress: Moving evidence into practice. And that's what we're going to do.

Peter Kapitein,

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