Invited correspondence

Response to THELANCET-D-17-00627 by Salami S.S., et al.

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We thank Salami and colleagues for raising these three issues.

First, the primary role of a triage test is to rule out clinically significant prostate cancer and by doing so help the patient avoid an unnecessary biopsy. If the MRI does happen to reveal an abnormality with a high probability of prostate cancer it will need targeting. PROMIS did not address the issue of targeting as it was a blinded study. Other studies have done this and several others are currently recruiting [1].

Second, we disagree that the performance of mpMRI parallels that of PSA. In PROMIS, PSA was non-contributory in terms of its ability to predict clinically

significant prostate cancer. In contrast, MRI derived Likert score was closely correlated.

Finally, we agree that our prevailing assumptions about clinically significant prostate cancer should be questioned. Nonetheless, there is an increasing realisation that Gleason 6 lesions do not harbour hallmarks of malignancy [2] and that many Gleason 3+4=7 cancers do well without immediate treatment [3], whether diagnosed initially or even if missed by a TRUS-biopsy [4]. One of the most striking attributes of MRI within PROMIS was the complete absence of any misclassification of cancers with Gleason Grade Group III, IV or V.

References

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