WEST MIDLANDS CANCER ALLIANCE

Prostate Standards of Care

November 2025

West Midlands Cancer Alliance

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Document Purpose	The aim of this document is to provide recommendations for streamlining the prostate cancer MDT and does not represent clinical guidelines.	
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Version Control

Version	Date	Amendments
0.1	June 2025	Created by The Royal Wolverhampton NHS Trust (RWT) led by Mr David Mak.
0.2	August 2025	Encompasses comments from the Urology EAG on the 3rd of June 2025.
0.3	October 2025	Encompasses comments from the Urology EAG on the 9th September 2025.
1.0	November 2025	Ratified by WMCA Urology EAG and WMCA Clinical Cabinet.

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1.Introduction

The multi-disciplinary team (MDT) has been the cornerstone of cancer care delivery since the Calman-Hine report in 1995 and National Cancer Plan in 2000. Although it was originally mandated that all patients with cancer would be discussed by an MDT, the cancer landscape has changed with the demand for more personalised treatments to a higher volume of patients with more case complexity.

With the ever-increasing burden and workload on MDTs, there is a need to optimise case discussions to derive the full benefit of MDT meetings and provide input where it is needed. In line with guidance published from NHS England and NHS Improvement on streamlining MDT meetings, Standards of Care (SoC) have been introduced in various institutions to good effect with up to 25% of pelvic uro-oncology cases being streamlined and MDT discussion avoided.

There is a requirement for SoCs to be introduced as a routine part of the Urology MDT meetings to stratify patients into those that require full multidisciplinary discussion and those that can be listed but not discussed in the MDT meeting when the patient needs are met by a SoC.

Implementation of SoCs will require more work outside of the MDT meeting, including after the MDT for audit purposes, as well as support from and increased responsibility and input of all clinicians (benign or malignant) whether involved in MDT meeting discussions or not.

A regional SoC is required to decrease the variability in patient management. The West Midlands Cancer Alliance (WMCA) Urology Expert Advisory Group (EAG) had the task to review and agree the proposed SoC document. This was based on the MDT streamlining document by Mr David Mak, Consultant Urologist at RWT based on multiple sources, which are referenced below. A summary of the recommendations made during the EAG is included in the post-EAG meeting minutes document, which can be obtained on request from the WMCA.

This document outlines the various processes around the Urology MDT to facilitate streamlining with the objective of maximising MDT management discussion for patients with complex urological cancer disease that requires a full multidisciplinary approach while protocolising the management of patients with less complex disease for which national guidance (EAU and NICE) is sufficient for decision making.

2. Listing for Cases for MDT

The primary responsibility of listing patients for formal discussion at MDT lies with the responsible clinician.

Requests for formal discussion at MDT must include a valid clinical question. The role of the MDT is to provide recommendations for treatment, in addition to oversight of clinical governance of cancer patient management. The responsibility of the final treatment choice lies with both the patient and responsible clinician.

When cases are listed for MDT, it must be indicated whether histology review, radiology review or both are required.

As outlined in this document, each of the organ site specific standards of care should be adhered to and guides whether patients are to be formally discussed at MDT or protocoled.

New diagnoses of urological malignancy will be listed on MDT, but not all will be formally discussed in line with the standards of care. Those cases that conform to a SoC will be protocoled.

Patients with benign histopathology will not be formally discussed at MDT unless the responsible clinician detects discrepancies. The responsible clinician must review these results and request MDT discussion if warranted. Benign histology includes – benign prostate biopsies, benign bladder biopsies/TURBT specimens and benign renal biopsies.

All tertiary referrals will be formally discussed at MDT. It is essential that all investigations have been received at the tertiary centre before listing and review. The referring clinical team must ensure all relevant information is provided and indicate the investigations that require review. If tertiary referrals are incomplete and further information is required, the case will not be listed at MDT and sent back to the referring clinical team.

Surveillance scans and investigations will not be routinely discussed at MDT. The responsible clinician must review the result of investigations of those patients following a surveillance protocol to determine if formal MDT discussion is required.

All patients who may be eligible for a clinical trial will be listed and discussed at the MDT.

Re-discussion of patients who are already being managed under an agreed MDT plan can be warranted if they are complex or if new pertinent information arises that requires discussion by more than one discipline. Patients that require discussion only by one discipline should not be discussed at MDT, but within their own directorate.

Clinicians could request formal discussion of cases if the criteria outlined in the SoC guidance are not fulfilled and if formal MDT discussion is warranted.

When patients are listed for formal MDT discussion, the relevant minimum datasets must be provided by the referring clinician as outlined in the specific organ site guidance detailed below. This will facilitate detailed and accurate discussion of cases. If minimum datasets are not complete, the responsible clinician will be requested to provide the necessary information before listing on MDT.

Whenever possible, all relevant investigations (particularly radiological investigations) should be completed before listing at the MDT, unless a particular initial investigation may alter management or latter investigations would not change a potential MDT outcome.

Note that for review of imported radiological investigations from other Trusts, the image reports must be available for MDT discussion. Cases from other Trusts will not be listed when the image reports are not available.

Table 1 – Summary of criteria for listing at MDT

New diagnosis of urological malignancy	Listed for MDT • Protocoled if standard of care can be applied, • Formally discussed as per SoC guidance,
Tertiary referrals	All cases listed and formally discussed at MDT
Benign histology	Not listed for MDT Responsible clinician to request MDT discussion if warranted after clinical review.
Surveillance investigations	Not listed for MDT Responsible clinician to request MDT discussion if warranted after clinical review.
Eligible for clinical trial	All cases to be listed and formally discussed at MDT

3. Prostate Cancer

3.1 Risk stratification of newly diagnosed prostate cancer patients

Patients will be risk stratified using the following essential data:

- Serum PSA,
- Clinical stage
- Gleason score in alignment with NICE Guidelines (percentage of Gleason 4 pattern and association with cribriform/intraductal variants)
- Other histology if not adenocarcinoma (e.g. Lymphoma, NED)
- Cambridge Prognostic Group (CPG) should be recorded for all patients.
- Patients will be further characterised according to life expectancy and performance status.

Criteria for mandatory discussion at MDT include:

- All high risk localised prostate cancers (CPG 4 and 5) need to be discussed at MDT
- Metastatic prostate cancer disease

Low risk and intermediate risk prostate cancer cases (CPG 1-3) will be protocolised according to the potential treatment options (as per EAU and NICE guidelines) and not formally discussed at the MDT.

Patients with prostate cancer of any risk (excluding metastatic prostate cancer) with marked comorbidity and not suitable for radical therapy will be protocolised and not formally discussed at the MDT.

Patients with prostate cancer of any risk suitable for recruitment in a clinical trial should be discussed at the MDT.

Patients that do not fit the criteria as outlined in Table 2 can be discussed in full at the MDT at the request of the responsible clinician.

Table 2 – Standards of Care for Newly Diagnosed Prostate Cancer Patients

Risk Group	Standard of Care Guidelines
Cambridge Prognostic Group 1: ***Low risk prostate cancer*** Gleason score 6 (grade 1) <u>AND</u> PSA <10 ng/ml <u>AND</u> Stages T1-T2	**Standard of Care** Recommend active surveillance as the favoured treatment choice in accordance with locally agreed active surveillance protocol. Consider treatment defined by the MDT, if: • Patient rejects active surveillance following multidisciplinary counselling or if patient life expectancy >20 years. Radical treatment should be discouraged as benefits of surveillance maybe most in younger men. • Bulky disease on MRI likely to have been under-sampled should be evaluated with early MRI at 6-12 months followed by biopsy (consider immediate template biopsy or fusion targeted biopsy) *[Follow up – F2F OP Prostate Team – Priority 2]*

Cambridge Prognostic Group 2: ***Low-intermediate risk prostate cancer*** Gleason score 3+4 =7 (grade group 2) <u>OR</u> PSA 10-20 ng/ml <u>AND</u> Stages T1-T2	**Standard of Care** Active surveillance in accordance with locally agreed active surveillance protocol. Consider treatment defined by the MDT if life expectancy >10 years. Active surveillance if patient rejects treatment defined by the MDT. Patient should be informed that there is a slightly higher risk of metastasis (circa 8%) over the next 10-15 years. Consideration of intraductal or cribriform pattern 4 histology on biopsy should be considered, in favour of treatment over active surveillance in such cases. The proportion of Gleason pattern 4 histology on biopsy should also be considered when offering active surveillance or radical treatment. A percentage of < 5-10 % could favour active surveillance (the percentage of pattern 4 should be reported).

	[Follow up – F2F OP Prostate Team – Priority 2]
Cambridge Prognostic Group 3: ***Intermediate risk prostate cancer*** Gleason score 3+4 =7 (grade group 2) <u>AND</u> PSA 10-20 ng/ml <u>AND</u> Stages T1-T2 <u>OR</u> Gleason score 4+3 =7 (grade group 3) <u>AND</u> Stages T1-T2	**Standard of Care** Recommend treatment defined by the MDT, if life expectancy >10 years Active surveillance if has low volume disease (Gleason 3+4 – grade group 2) on prostate biopsy and small or no visible lesion on MRI, if patient rejects radical treatment. Patient should be informed that there is a slightly higher risk of metastasis (circa 8%) over the next 10-15 years. Consideration of intraductal or cribriform pattern 4 histology on biopsy should be taken into account in patients with low volume disease (Gleason 3+4 – grade group 2) on prostate biopsy if considering active surveillance, favouring active treatment. *[Follow up – F2F OP Prostate Team – Priority 2]*
Cambridge Prognostic Group 4: ***High risk prostate cancer*** One of the following: Gleason score 8 (grade group 4) <u>OR</u> PSA >20 ng/ml <u>OR</u> Stage T3	**Discuss all cases at MDT** Recommend treatment defined by MDT.

Cambridge Prognostic Group 5: ***High risk prostate cancer*** Any combination of: Gleason score 8 (grade group 4) PSA >20ng/ml Stage T3 <u>OR</u> Gleason score 9-10 (grade group 5) <u>OR</u> Stage T4	**Discuss all cases at MDT** Recommend treatment defined by MDT.
Any risk (excluding metastatic) prostate cancer cases with significant co-morbidities making ineligible for radical therapy	**Standard of Care** Recommend watchful waiting in accordance to locally agreed protocol. *[Follow up – F2F OP Any – Priority 2]*
Metastatic prostate cancer	**Discuss all cases at MDT** Recommend treatment defined by MDT. Systemic treatment – chemotherapy and/or AR targeted therapy. Referral to oncology team and to be reviewed by oncology within 12 weeks of commencing LHRHa. For low volume metastatic disease (oligometastatic disease of 3 or less bone metastases) advise high dose palliative radiotherapy to the prostate.

Note: In patients where androgen deprivation therapy is indicated (e.g. radical radiotherapy), LHRHa should be started at the point of treatment decision, unless there are contraindications based on comorbidity or frailty (e.g. significant ischaemic cardiac disease), in which case patients should remain on androgen receptor antagonists (e.g. bicalutamide).

The trusts that are not using CPG for risk stratification and are using the NICE criteria (based on D'Amico and later EAU risk stratification) should use the table below (extract from the GIRFT document) to accurately stratify the disease.

NICE risk group	NICE criteria	CPG category*	CPG criteria	Risk stratification for treatment	Treatment option
Low-risk disease	Gleason score ≤ 6 *AND* PSA < 10 ng/ml *AND* stages T1-T2a	1	Gleason score 6 (Grade Group 1) *AND* PSA < 10 ng/ml *AND* stages T1-T2*	Lower risk prostate cancer	For men with lower risk prostate cancer recommend active surveillance. Record on FDS as starting active surveillance at the point the patient is informed of diagnosis.
Intermediate-risk disease	Gleason score 7 *OR* PSA 10-20 ng/ml *OR* Stage T2b	2	Gleason score 3 + 4 = 7 (Grade Group 2) *OR* PSA 10-20 ng/ml *AND* stages T1-T2*	Intermediate risk prostate cancer where active surveillance is an option	Most men with Cambridge Prognostic Score 2 & some with CPG 3 will be suitable for active surveillance. Men with ≥ Gleason 3 + 4 should be recorded on FDS as having started active surveillance, whilst also offering discussion of active treatment.
		3	Gleason score 3 + 4 = 7 (Grade Group 2) *AND* PSA 10-20 ng/ml *AND* stages T1-T2* *OR* Gleason score 4 + 3 = 7 (Grade Group 3) *AND* stages T1-T2*	Intermediate risk prostate cancer where active surveillance is not advisable * see note	Offer timely review (2 – 4 weeks) for consideration of radical treatment, in a joint clinic setting where appropriate. Commence hormone therapy in those patients who will require neo-adjuvant treatment as part of their SOC.
High-risk or locally advanced disease	Gleason score 8 – 10 *OR* PSA > 20 ng/ml *OR* Stage ≥T2c	4	*One of:* Gleason score 8 (Grade Group 4) *OR* PSA > 20 ng/ml *OR* Stage T3	Higher risk localised prostate cancer	Offer timely review (2 – 4 weeks) for consideration of radical treatment, in a joint clinic setting where appropriate. Commence hormone therapy in those patients who will require neo-adjuvant treatment as part of their SOC.
		5	*Any combination of:* Gleason score 8 (Grade Group 4) PSA > 20nb/ml or Stage T3 *OR* Gleason score 9-10 (Grade group 5) *OR* Stage T4		

Note: Where higher risk features are present including Gleason 4 + 3, cribriform and intraductal pathology, or larger tumour volume seen on MRI or biopsy.

*** CPG categories do not use sub-categories of stage T2.**

3.2 Risk stratification of prostate patients for diagnostic clinical review

Patients will be risk stratified according to their PIRADS/Likert score in alignment with European Association of Urology (EAU) Guidelines (Table 3).

By default, MRI scans of patients on the suspected prostate cancer pathway will not be formally discussed at MDT. The decision to undertake prostate biopsies will be undertaken by the responsible clinician after diagnostic clinical review in accordance with the standard of care guidelines as outlined in Table 3.

The responsible clinician can request formal MDT discussion of MRI scans prior to proceeding with prostate biopsies, only if there is a valid clinical reason and if patients do not fit the criteria

outlined in Table 3. These requests will be reviewed by a core member of the MDT prior to listing.

Use the 'Risk stratification of prostate cancer with MRI and prostate-specific antigen density-based tool for personalized decision making.'

	csPCa prevalence relative to PI-RADS score		csPCa prevalence in the PSA density risk groups					
Total	**ISUP ≥2 Ca prevalence**		**Low (PSA density <0.10)**		**Intermediate-low (PSA density 0.10-0.15)**		**Intermediate-high (PSA density 0.15-0.20)**		**High (PSA density ≥0.20)**	
ALL PI-RADS	623/2055	(30.3%)	65/790	(8.2%)	133/576	(23.1%)	118/269	(43.9%)	307/420	(73.1%)
PI-RADS 1-2	34/1113	(3.1%)	7/602	(1.2%)	9/341	(2.6%)	9/100	(9.0%)	9/70	(12.9%)
PI-RADS 3	36/206	(17.5%)	8/76	(10.5%)	9/63	(14.3%)	10/40	(25.0%)	9/27	(33.3%)
PI-RADS 4-5	553/736	(75.1%)	50/112	(44.6%)	115/172	(66.9%)	99/129	(76.7%)	289/323	(89.5%)

Very low	0%-5% csPCa (below population risk)	No biopsy
Low	5%-10% csPCa (acceptable risk)	No biopsy
Intermediate-low	10%-20% csPCa	Discuss biopsy
Intermediate-high	20%-30% csPCa	Recommend biopsy
High	30%-40% csPCa	Perform biopsy
Very high	>40% csPca	Perform biopsy

Table 3 – Standards of Care Guidelines for Prostate Patients

Risk Group	Standard of Care Guidelines
PI-RADS or Likert 1-2 with PSA density < 0.2	**Standard of care** No biopsy required. Discharge to primary care, recommending PSA follow up. Ensure an ad personum PSA is provided for re-referral based on patient's volume and PSAD 0.2.
PI-RADS or Likert 3 with PSA density ≤ 0.12	**Diagnostic clinical review** No biopsy required usually. Inform patient of the low likelihood of clinically significant prostate cancer (1-2%). Prostate biopsy can be advised if there are other risk factors (e.g. family history, ethnicity, genetic disorders). Ensure an ad personum PSA is provided for re-referral based on patient's volume and PSAD 0.12.
PI-RADS 3 or Likert 3 with PSA density > 0.12 **OR**	**Diagnostic clinical review** Discuss role of prostate biopsy (10-15% risk of clinically significant prostate cancer) If patient declines biopsy, allow PIFU if they reconsider.

PIRADS or Likert 1-2 with PSA density >0.2	
PI-RADS or Likert 4-5	**Standard of care** Recommend prostate biopsy due to risk of clinically significant prostate cancer.
Radiological imaging indicating metastatic prostate cancer in patients with good PS (0-2)	**Standard of care** If good performance status, then proceed with prostate biopsy with intention to commence hormone therapy and refer to oncology. Subsequent formal discussion at MDT with prostate biopsy and radiology review as per standards of care guidelines for newly diagnosed prostate cancer patients (Table 1).
Radiological imaging indicating metastatic prostate cancer in patients with poor PS (3)	**Diagnostic clinical review** If poor performance status, then consider formal discussion at MDT to review need for prostate biopsies.

3.3 Negative (benign) prostate biopsies

Patients on the suspected prostate cancer pathway, who have undergone an MRI prostate and a prostate biopsy that does not demonstrate any evidence of malignancy, will not be formally discussed at MDT.

An assessment of the risk of a missed cancer will be made by the responsible clinician taking into consideration:

- The type of prostate biopsy (TRUS / TP); targeted versus non-targeted
- Location of visible lesion on MRI prostate (e.g. anterior lesion)
- PIRADS score
- Presence of ASAP / HGPIN

The need for formal MDT discussion will be identified by the responsible clinician after diagnostic clinical review in accordance with the standard of care guidelines as outlined in Table 4.

Patients that do not fit the criteria as outlined in Table 4 can be discussed in full at the MDT at the request of the responsible clinician.

Table 4 – Standards of Care Guidelines for Prostate Patients with Negative Biopsy

Risk Group	Standard of Care Guidelines
Low Risk of Missed Cancer PIRADS 3 or less on MRI No significant abnormality on MRI (e.g. bone signal, lymphadenopathy, T3 appearances) Satisfied that any identifiable lesions on MRI have been targeted	**Standard of care** Discharge to GP Establish personalised PSA threshold for referral and frequency according to local policy (e.g. PSA velocity or PSA threshold= volume x PSA density)
Medium Risk of Missed Cancer **PIRADS 4/5 on MRI** **Concern for 'missed target' on biopsy** **Significant findings on MRI ((e.g. bone signal, lymphadenopathy, T3 appearances)**	**Diagnostic Clinical Review** Consider full discussion at MDT if significant concern for possible missed cancer on biopsy. At MDT discussion, consider: • 'missed target' at biopsy. • Lesion could be downgraded to lower suspicion. • Acute inflammation or granulomatous prostatitis mimicking prostate cancer appearances on MRI. Recommend re-biopsy (6-12 weeks) or repeat MRI in 6-12 months taking into account PSA kinetics.
HGPIN	**Standard of care** Discharge to GP Establish personalised PSA threshold for referral and frequency according to local policy
ASAP	**Diagnostic Clinical Review** Consider full discussion at MDT if significant concern for possible missed cancer on biopsy. Recommend re-biopsy (6-12 weeks) or repeat MRI in 6-12 months taking into account PSA kinetics.

3.4 Risk stratification of prostate cancer patients under surveillance

Prostate cancer patients established on active surveillance will not be formally discussed at MDT. MRI scans, PSA blood tests and prostate biopsies undertaken as part of active surveillance protocols will be protocolised.

It is the duty of the responsible clinician to review investigations performed and request formal MDT discussion if a change in treatment strategy is warranted and in accordance with the guidance detailed in Table 5. In line with EAU recommendations, change in treatment strategy should be based on biopsy progression, not on progression on MRI and/or PSA.

Patients that do not fit the criteria as outlined in Table 4 can be discussed in full at the MDT at the request of the responsible clinician.

Table 5 – Standards of Care Guidelines for Prostate Patients under Active Surveillance

Risk Group	Standard of Care Guidelines
Stable MRI and stable PSA kinetics	**Standard of Care** Continue following active surveillance protocol. *[Follow up – Responsible clinician to action appropriate outcome]*
New MRI appearances/progression and/or change in PSA kinetics (e.g. PSA DT < 2 years)	**Diagnostic Clinical Review** Recommend prostate biopsies to guide change in treatment strategy.
Histological progression on biopsy	**Discuss all cases at MDT**
Patient request to change treatment strategy	**Standard of Care** Responsible clinician to discuss treatment options with patient.

3.5 Risk stratification of postoperative histology in radical prostatectomy patients

The histology of patients who have undergone a radical prostatectomy will be reviewed by the operating surgeon. The pathological stage (T- and N-stage), Gleason score and surgical margin status of radical prostatectomy specimens will be recorded. Formal discussion of postoperative histology will be based on these parameters as outlined by Table 6.

Patients that do not fit the criteria as outlined in Table 6 can be discussed in full at the MDT at the request of the responsible clinician.

Table 6 – Standards of Care Guidelines for Radical Prostatectomy Patients

Risk Group	Standard of Care Guidelines
Negative surgical margin – Pathological Stage T2-T3	**Standard of Care** Routine postoperative surgical follow up – telephone or f2f outpatient appointment to be organised with operating surgeon.
Positive surgical margin – focal (<3mm)	**Standard of Care** Routine postoperative surgical follow up – telephone or f2f outpatient appointment to be organised with operating surgeon.
Positive surgical margin - >3mm	**All cases to be discussed at MDT**
Pathological Stage T4	**All cases to be discussed at MDT**
Pathological N1 disease	**All cases to be discussed at MDT**
Eligible for clinical trial	**All cases to be discussed at MDT**

3.6 Minimum clinical dataset for prostate patients discussed at MDT

When a patient is added to the MDT irrespective of whether the patient's case is protocoled or formally discussed, the data items outlined in Table7 (the minimum clinical dataset) must be provided.

Table 7 - Minimum clinical dataset for prostate patients discussed at MDT

Required minimum clinical dataset
Patient age
Is patient aware of diagnosis
Co-morbidity – listed in words
Performance status (WHO)
PSA at diagnosis
TNM staging
Number of positive biopsy cores / Number of total cores
Gleason score
CPG risk stratification
Imaging performed to date [MRI, Bone Scan, CT, PET Scan]
Is patient eligible for a clinical trial
Family history

Ethnicity
Lower urinary tract symptoms (IPSS)
Sexual function if sexually active (SHIM or IIEF) iief.pdf SHIM.pdf
Type of MDT Discussion held – Standard of Care or Full MDT Discussion
Recommendation / Management Plan

3.7 Auditing the results

All units who wish to audit the protocolised patients will use the provided excel spreadsheet.
What dataset should be included in auditing SoC?