Prostate cancer (PCa) is a disease that exhibits heterogeneity in terms of its clinical behavior [1]. Therefore, it is not surprising that heterogeneity also affects the way we treat PCa.

Radical treatments such as radical prostatectomy (RP) and radiation therapy (RT) have for years been considered the standard of care for most men with non-metastatic PCa [2,3]. During the last 120 years, many changes regarding surgical and radiation techniques have arisen to reduce morbidity and improve oncological and functional outcomes [4]. However, despite all of the effort behind these advances, the negative effects on sexual, urinary and bowel function remain unsolved [5].

Active surveillance (AS) emerged in the early 2000s, to address this issue, offering a significant number of patients the option to avoid or delay treatment. Unfortunately, only those with low and favorable intermediate-risk PCa can benefit from this approach [6].

Aside from AS and whole-gland treatment, focal therapy (FT) has been developed over the past 20 years with the aim of improving functional outcomes without compromising metastasis and cancer specific survival for men with localized PCa who are not suitable for AS.

In 2023, oncological outcomes following FT remain a challenge mainly due to a lack of both well-designed trials and long-term follow-up which is essential given the good prognosis of low and favorable intermediate localized PCa, with 10-year distant metastasis rates <10% [7]. However, many studies have already demonstrated significant functional benefits, with a low impact on continence and erectile function [8]. These findings suggest that further research and development of FT as an alternative treatment for PCa is warranted.

Over time, improvements in diagnostic accuracy—using magnetic resonance imaging (MRI) and targeted biopsies (TBx) [9] which are essential for selecting appropriate candidates for FT—have contributed to the rapid evolution of FT. In addition, the number of energy sources—high-intensity focused ultrasound (HIFU), irreversible electroporation (IRE), cryoablation, focal laser
Ablation (FLA), focal brachytherapy, photodynamic therapy (PDT), and radiofrequency ablation (RFA), among others—has increased significantly in recent years, and the selection of the most appropriate option has been refined with clinical experience [10]. Nevertheless, the process of obtaining robust oncological results with FT has lagged behind these advancements.

As FT continues to evolve, it has been used on a diverse patient population with varying treatment strategies and a growing number of energy sources [11]. Furthermore, relapse criteria, follow-up protocols, and the reporting of outcomes are not standardized.

In this context, where there is a high degree of heterogeneity in terms of selection, treatment, and follow-up, the utilization of Delphi consensus may be highly useful in guiding our practice and advancing our understanding in the near future, especially in situations where more robust evidence is still pending.

CONTROVERSIAL ASPECTS OF FOCAL THERAPY

There are multiple controversial points in FT that explain the existing diversity in patient selection, treatment, and follow-up.

1. Accuracy of diagnosis

The multifocality of PCa is a significant challenge in the application of FT for PCa. Despite the detection of multiple lesions on MRI and bilateral positive biopsies, FT for PCa is focused on treating the lesion that is deemed the most clinically significant and likely to influence the progression of the cancer [12].

Accurate diagnosis is crucial for the success of FT. MRI and biopsies have played a significant role in the development of this treatment. Since 2017, several studies have demonstrated that MRI-TBx can improve the detection of clinically significant PCa (csPCa) while reducing the detection of insignificant PCa [13]. The Trio Study found that the percentage of upgrading after RP was lower with combined biopsies (7%) compared to target biopsies alone (18%) or systematic biopsies alone (30%) [14]. These findings highlight the importance of using MRI together with target and systematic biopsies in the diagnosis of PCa for optimal planning of FT treatment.

Nevertheless, diagnosis of PCa using MRI-TBx together with systematic biopsies may not be sufficient for planning FT, and the optimal number of biopsy cores to take outside the index lesion is not yet clear. Lee et al [15] showed that the detection rate of csPCa increased with the number of biopsy cores taken. In their study, using a systematic biopsy that only included cores not within the lesions identified on MRI (non-targeted systematic saturation biopsy), the csPCa detection rate was 21% with a median of 22 cores. However, when the number of cores was reduced to 14, the csPCa detection rate decreased to 16%. The proportion of men who needed to change their treatment plans also increased as the number of biopsy cores taken increased, with most of the cases showing an increase in the FT ablation zone. Ganzer et al [16] analyzed 155 patients who underwent RP following MRI-TBx followed by 12 systematic biopsies and observed that the concordance with prostatectomy histopathology was >75% for the unilateral csPCa, stage pT2, or no International Society for Urological Pathology (ISUP) grade group (GG) upgrading. However, when all these parameters were considered together, accuracy decreased to 54%–64%. Interestingly, the authors found that the concordance was slightly higher when cases of ISUP GG3 PCa were evaluated, compared to cases of ISUP ≤GG2 PCa.

High PI-RADS scores and index lesion volumes have been linked to worse oncological outcomes [17]. Meng et al [18] found that 18% of patients with PI-RADS ≥4 abnormalities on MRI had no cancer on MRI-guided biopsies. Nevertheless, in most cases, a repeat MRI revealed less aggressive lesions, but when it did not, repeat MRI-guided biopsy was positive in over 60% of patients. Hence, when a patient has multiple lesions on MRI and only one is positive on MRI-guided biopsy, a re-evaluation of the MRI and even repeat biopsies may be recommended before proceeding with FT [19].

When considering FT, it is essential to make sure that the diagnosis is as accurate as possible, and it appears that using MRI alone may not provide enough precision. Moreover, the quality of MRI and the interpretation of those images in clinical practice has largely been questioned. To address this issue, the Prostate Imaging Quality (PI-QUAL) score was proposed in 2020 as a standardized scoring system to evaluate multiparametric MRI quality using a 5-point Likert scoring system. This is crucial as PI-QUAL scores <3 have been linked to higher rates of upstaging from organ-confined to locally advanced PCa, lower detection rates for PI-RADS 5 lesions and extra prostatic extension,
and fewer suspicious lesion detections [20].

It has been shown that Gallium-68 prostate-specific membrane antigen (PSMA) positron emission tomography (PET) has a greater sensitivity and specificity than conventional imaging for patients with high-risk PCa before curative-intent surgery or radiotherapy [21]. The benefit of PSMA-PET in this context is a matter of debate, as the potential effect of adapted treatment is uncertain in terms of oncological outcomes. Even more questionable is the impact that PSMA-PET may have on oncological outcomes for patients with intermediate-risk PCa who undergo FT. Eiber et al [22] explored the role of simultaneous 68Ga-PSMA PET/MRI on the localization of primary PCa and observed that each technique detected tumor-involved areas that were negative in the other modality, concluding that a combined image improves diagnostic accuracy for PCa localization compared with both MRI and PET imaging alone. Furthermore, some authors have identified a significant correlation between the tumor-maximum standardized uptake value and Gleason score [23]. In conclusion, PSMA PET/MRI might help to increase the chances of finding the most clinically significant lesion when planning FT.

Finally, when MRI is not possible for clinical or other reasons, FT may not be completely contraindicated. In such cases, an alternative approach may be a transperineal template-mapping biopsy using a 5 to 10 mm sampling frame, as proposed in the CHRONOS trial [24].

2. Patient selection

The inclusion criteria for FT treatment are not consistent among centers. The threshold for prostate-specific antigen (PSA) level, clinical stage based on digital rectal examination or MRI, ISUP grade, number of visible lesions on MRI, and volume limit of the index lesion, among other variables, are debated and vary among study protocols. Table 1 summarizes several trials on FT for PCa, demonstrating the significant variability in inclusion criteria deemed acceptable for the success of this treatment [24-30].

Among all the variables mentioned above, the ISUP grade may be considered one of the most controversial. As with every experimental technique, FT initially focused on low-risk PCa due to uncertainty about the effects on cancer control. In this sense, the first and only randomized control trial (RCT) on FT that began enrolling patients in 2011 only included those with low-risk PCa. This study compared Vascular-targeted PDT to AS and found that FT was linked to fewer conversions to radical treatments, but also had a higher rate of complications [31].

It has been established that AS is effective for patients at low risk of developing metastases, making FT for ISUP GG1 PCa an unnecessary treatment with possible adverse effects [3]. Consequently, nowadays Gleason 7 (3+4) seems to be accepted as the best candidate for FT, but the question of whether the treatment indication should be extended to ISUP GG3 PCa is still being debated [32].

Additionally, the intraductal and cribriform patterns have been deemed as an aggressive Gleason 4 subtype with unfavorable oncological outcomes after RP and thus are exclusion criteria for AS. It remains unclear if they should also be considered as an exclusion criteria for FT [33].

Reddy et al [34] analyzed data from 1,379 patients recorded in the HIFU Evaluation and Assessment of Treatment (HEAT) registry from 13 UK centers. The study found that more than 50% of men treated with FT had ISUP GG2 PCa, while 16% had ISUP GG3 PCa. Additionally, 17 patients with high-risk PCa underwent FT. As expected, the failure-free survival rate (FFS), which includes whole-gland salvage treatment, a third FT treatment, systemic treatment, and/or the development of PCa metastases and/or PCa-specific death, was lower for patients with D’Amico intermediate and high-risk PCa. The study also found significant differences in FFS between ISUP GG2 and GG3 patients. A longer follow-up is needed to determine whether salvage treatment following FT is able to control disease progression to metastatic PCa, but the study found 7-year metastasis-free and PCa-specific survival rates greater than 99% [34]. In a recent study, Scheltema et al [35] published a median 5-year outcome of primary IRE for localized PCa. Once again, most of the patients included in the study harbored ISUP GG2 PCa, but 16% of patients harbored ISUP GG3 PCa. Despite the short follow-up time, the study found no significant differences in terms of FFS—defined as no need for radical treatment and/or nodal/distant PCa after initial IRE treatment with one re-treatment of IRE allowed—per ISUP grade.

It is also important to note that for patients with ISUP>GG2 PCa, lymph node control may be necessary during RT or RP [3]. Thus, the requirement for
Table 1. Trials on focal therapy for localized prostate cancer and inclusion criteria regarding PSA, ISUP score, presence of MRI lesions outside of the treatment field, presence of positive biopsies outside the index lesion, clinical stage, and index tumor volume

<table>
<thead>
<tr>
<th>Study</th>
<th>ClinicalTrials.gov Identifier</th>
<th>Type of study</th>
<th>Objective of the study</th>
<th>PSA</th>
<th>ISUP</th>
<th>Inclusion criteria</th>
<th>Positive biopsies outside the index lesion</th>
<th>Clinical stage</th>
<th>Index tumor volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparative healthcare research outcomes of novel surgery in prostate cancer (IP4-CHRONOS): a prospective, multi-centre therapeutic phase II parallel randomised control trial [24]</td>
<td>NCT04049747</td>
<td>RCT</td>
<td>HIFU or cryotherapy vs. whole gland treatment</td>
<td>≤20 ng/mL</td>
<td>ISUP GG1 provided ≥6 mm cancer core length in any one core or ISUP GG2 or GG3 of any length or ISUP GG4 in some cores but where the overall Gleason score is 7</td>
<td>Pathology must be reviewed and confirm the presence of inflammation or atrophy</td>
<td>Not contraindication if ISUP GG1 ≤5 mm outside of the treatment field</td>
<td>≤ctT3a</td>
<td>≤cT2b</td>
</tr>
<tr>
<td>Prostate cancer IRE study (PRIS): a randomized controlled trial comparing focal therapy to radical treatment in localized prostate cancer [25]</td>
<td>NCT05513443</td>
<td>RCT</td>
<td>IRE vs. whole gland treatment</td>
<td>≤20 ng/mL</td>
<td>ISUP GG2 or GG3 without any Gleason grade 4 in systematic biopsies outside of the target</td>
<td>Only single MRI-visible lesion allowed</td>
<td>ISUP GG1 outside of target lesion allowed</td>
<td>≤ctT2b</td>
<td>&lt;1.5 cm³ lesion volume</td>
</tr>
<tr>
<td>Evaluation of HIFU hemiablation and short term androgen deprivation therapy combination to enhance prostate cancer control (ENHANCE) [26]</td>
<td>NCT03845751</td>
<td>Phase II trial. Single Arm</td>
<td>Evaluation of short-term hormone therapy together with HIFU</td>
<td>≤15 ng/mL</td>
<td>ISUP GG2</td>
<td>Not contraindication for FT</td>
<td>Not contraindication if ISUP GG1 ≤1 mm</td>
<td>≤ctT2b</td>
<td>Not defined</td>
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<tr>
<td>Focal MR-guided focused ultrasound treatment of localized intermediate risk prostate lesions [27]</td>
<td>NCT01657942</td>
<td>Phase II trial. Single Arm</td>
<td>Evaluation of safety and effectiveness of HIFU</td>
<td>≤20 ng/mL</td>
<td>ISUP GG2 or GG3 with no more than 15 mm cancer in maximal linear dimension in any single core</td>
<td>Only single MRI-visible lesion allowed</td>
<td>Not contraindication if ISUP GG1</td>
<td>≤ctT2b</td>
<td>Not defined</td>
</tr>
</tbody>
</table>
Table 1. Continued

<table>
<thead>
<tr>
<th>Study</th>
<th>ClinicalTrials.gov Identifier</th>
<th>Type of study</th>
<th>Objective of the study</th>
<th>PSA</th>
<th>ISUP</th>
<th>Inclusion criteria</th>
<th>Clinical stage</th>
<th>Index tumor volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pivotal study of the NanoKnife system for the ablation of prostate</td>
<td>NCT04972097</td>
<td>Phase II trial. Single Arm</td>
<td>Evaluation of safety and effectiveness of IRE</td>
<td>PSA ≤15 ng/mL or PSA density &lt;0.2 if PSA is &gt;15 ng/mL</td>
<td>ISUP GG2 or GG3</td>
<td>Not defined</td>
<td>≤cT2b</td>
<td>Not defined</td>
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<td>tissue (PRESERVE) [28]</td>
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<td>Positive biopsies outside the index lesion</td>
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<tr>
<td>Focal brachytherapy in patients with selected “low-risk” prostate</td>
<td>NCT02391051</td>
<td>Phase II trial. Single Arm</td>
<td>Evaluation of safety and effectiveness of focal brachytherapy</td>
<td>≤10 ng/mL</td>
<td>ISUP GG1</td>
<td>Not defined</td>
<td>Not defined</td>
<td>≤cT2a</td>
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<td>cancer – a phase-II-trial (FOKAL-BT) [29]</td>
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<tr>
<td>A multicenter, randomized, single-blind, 2-arm intervention study</td>
<td>NCT01835977</td>
<td>RCT</td>
<td>Focal vs. extended ablation in localized PCa with IRE</td>
<td>PSA &lt;15 ng/mL or PSA &gt;15 ng/mL counseled with caution</td>
<td>ISUP GG1 or GG2</td>
<td>Not defined</td>
<td>Not defined</td>
<td>Not defined</td>
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<tr>
<td>evaluating the adverse events and quality of life after irreversible</td>
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<tr>
<td>electroporation for the ablation of localized low-intermediate risk</td>
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<tr>
<td>prostate cancer [30]</td>
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</tbody>
</table>

This table presents some of the ongoing studies on focal therapy for prostate cancer, highlighting the variability in inclusion criteria, which reflects the lack of consensus regarding patient selection. RCT: randomized control trial, PCa: prostate cancer, PSA: prostate-specific antigen, ISUP: International Society for Urological Pathology, GG: grade group, MRI: magnetic resonance imaging, RP: radical prostatectomy, HIFU: high-intensity focused ultrasound, IRE: irreversible electroporation.
lymph node treatment should be carefully evaluated when considering PT as an alternative treatment for this group of patients [36]. The questions of timing and methodology remains unresolved, which may result in even greater heterogeneity in PT treatment [2,3].

The issue of multiplicity may be the second most debated aspect in patient selection, after ISUP grade. The decision to consider patients with multiple lesions on MRI for PT is not clear, as it might depend on factors such as lesion location, size, correspondence with positive biopsies, and biopsy grade. For instance, the PRIS trial only included patients with single lesions on MRI, while the CHRONOS trial may allow patients with multiple lesions after reviewing the pathology [24].

3. Energy selection

Since the 1990s, several energy sources for PCa tissue ablation have been developed but no comparative studies have been conducted [8].

Treatment choice recommendations, such as an à la carte approach [10], have attempted to propose specific types of energy to be used based on the location of the lesion, but this approach is not universally accepted and only HIFU, cryotherapy and brachytherapy were considered. In a recent study by Stabile et al [37], it was observed that both HIFU and cryotherapy for PCa likely achieve similar medium-term oncologic results regardless of PCa location. They also found that lesions on the prostatic base were associated with a higher rate of salvage treatment. On the other hand, even though brachytherapy is proposed as the energy to be used, apical lesions remain a problem when using it [38].

Blazevsuki et al [39] evaluated the efficacy of IRE for treating apical PCa. With a median follow-up of 44 months, 50 patients with PCa lesions within 3 mm of the apical capsule were treated with IRE. Only one patient experienced incontinence 12 months after treatment and one had in-field residual disease on repeat biopsy. The results suggested that using IRE for distal apex PCa is safe and feasible.

Lastly, the lack of a standardized set of tools and equipment for FT in each center, has resulted in a continued problem, as it is unclear whether all energies provide similar results.

4. Treatment considerations

The uncertainty surrounding the selection of patients and the type of energy to be used is further complicated by the ongoing debate on how to perform the treatment.

For instance, there is an open discussion about the benefit of MRI-guided versus ultrasound-guided HIFU treatment. MRI-guided HIFU allows to monitor the therapy in real time with magnetic resonance thermometry thermal feedback and evaluate the ablated tissue immediately following treatment. Nevertheless, the hypothetical benefit that this new technology may have in terms of functional or oncological results is still unknown [27].

Concerning the extent of the ablated area, it may be debated whether it should be limited to the lesion, the region, or the lobe. de la Rosette et al [30] found in a 2-arm intervention study that intermediate PCa patients receiving local IRE treatment had the same oncological outcomes as those receiving extensive IRE treatment. However, more patients in the extended treatment arm experienced sexual function impairment, despite no differences in urinary symptoms.

If a focal approach is selected, the importance of margins becomes critical. In 2015, Le Nobin et al [40] compared the boundaries of prostate tumors on MRI and those observed during RP histological examination, proving that MRI underestimated tumor size with a maximal discrepancy between imaging and histological boundaries of an average of 1.99±3.1 mm. They also observed that maximum distance between radiological and anatomopathological boundaries was significantly greater for high suspicion lesions and for high grade lesions. A simulated treatment volume based on a 9 mm treatment margin achieved complete histological tumor destruction in 100% of patients. More recently, Aslim et al [41] also studied the correlation between the size of lesions on MRI and the whole mount histopathology. They found that for tumors up to 12 mm, a 6-mm margin would achieve complete ablation of high-grade tumors. They also noted that larger tumors and those with Gleason 4–5 components were more likely to be underestimated in size. Based on this, they concluded that the optimal tumor size for FT was less than 12 mm, and the optimal treatment margin was 5 to 6 mm. In the same lines, Brisbane et al [42] observed that biopsies taken from a 10-mm radius area surrounding MRI lesions contain most cores of csPCa that are not present within the lesion. These results leave the debate open as to whether a margin of 5 or 10 mm should be considered when planning a FT treatment. Probably the
answer must be adapted to the characteristics of the lesion and the energy used.

5. Follow-up

Contrast enhanced MRI, PSA, and biopsies are crucial for identifying patients suitable for FT and also for monitoring their progress post-treatment.

The percentage of PSA reduction has been identified as an independent predictor of any additional treatment following FT. In the context of a median time of 5 months to reach the PSA nadir, a decrease of at least 50% in PSA levels may be used as an indicator of the effective quality and efficacy of treatment. This also corresponds to a 20% chance of requiring additional radical treatment within 5 years of FT [43].

The appropriate level of PSA that should trigger further testing is uncertain. While MRI has been proposed as a more effective method than PSA testing in identifying remaining tumor tissues after FT [44], its ability to evaluate the results after FT is also limited due to its low sensitivity (less than 50%) in detecting csPCa (55). These limitations have not been overcome by newer techniques such as PSMA-PET [45].

In this scenario, it is crucial that post-treatment biopsies are not skipped to ensure proper monitoring of the disease. The timing and method remain a subject of debate.

CONSENSUS AS A STRONG MOVEMENT TO UNIFY CRITERIA

To address the aforementioned gaps in our knowledge of the effectiveness of FT as an alternative treatment for localized PCa, several RCTs are underway as shown in Table 2 [24,25,46-49]. However, it will likely take several more years to obtain the first results from these studies.

While we await the results of these RCTs, it is important to standardize the way in which FT is performed to ensure consistent, high-quality care. This

<table>
<thead>
<tr>
<th>Title</th>
<th>ClinicalTrials.gov Identifier</th>
<th>Country</th>
<th>Experimental comparator</th>
<th>Active comparator</th>
<th>Primary outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparative healthcare research outcomes of novel surgery in prostate cancer (IP4-CHRONOS): a prospective, multi-centre therapeutic phase II parallel randomised control trial [24]</td>
<td>NCT04049747</td>
<td>United Kingdom</td>
<td>HIFU or cryotherapy</td>
<td>Whole gland treatment</td>
<td>Progression-free survival</td>
</tr>
<tr>
<td>Evaluation of HIFU in treatment of localized prostate cancer and of recurrence after radiotherapy (HIFI) [46]</td>
<td>NCT04307056</td>
<td>France</td>
<td>HIFU</td>
<td>RP</td>
<td>Recurrence-free survival</td>
</tr>
<tr>
<td>Phase 3, multicenter, randomized study, evaluating the efficacy and tolerability of focused HIFU (high intensity focused ultrasound) therapy compared to active surveillance in patients with significant low risk prostate cancer (HIFUSA) [47]</td>
<td>NCT03531099</td>
<td>France</td>
<td>HIFU</td>
<td>AS</td>
<td>Patient proportion who needed radical treatment</td>
</tr>
<tr>
<td>Focal prostate ablation versus radical prostatectomy (FARP) [48]</td>
<td>NCT03668652</td>
<td>Norway</td>
<td>HIFU</td>
<td>RP</td>
<td>Treatment failure</td>
</tr>
<tr>
<td>Partial prostate ablation versus radical prostatectomy [49]</td>
<td>ISRCTN99760303</td>
<td>United Kingdom</td>
<td>HIFU or IRE</td>
<td>RP</td>
<td>Treatment failure</td>
</tr>
<tr>
<td>Prostate cancer IRE study (PRIS): a randomized controlled trial comparing focal therapy to radical treatment in localized prostate cancer [25]</td>
<td>NCT05513443</td>
<td>Sweden</td>
<td>IRE</td>
<td>RP (PRIS1)</td>
<td>Urinary continence (PRIS1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RT (PRIS2)</td>
<td>Irritative urinary symptoms (PRIS2)</td>
</tr>
</tbody>
</table>

This table presents a compilation of ongoing RCTs comparing FT with radical treatments such as RP or RT, as well as AS. It is important to note that unlike in the past, the comparators for FT are now primarily whole-gland treatments instead of AS. HIFU followed by cryotherapy and IRE are the main energy modalities used in current RCTs.

may involve establishing guidelines for patient selection, treatment planning, and follow-up care.

According to the recommendations of the Agency for Health Care Policy and Research, Delphi techniques are considered to provide the lowest level of evidence [50]. However, at present, they are the only scientific tools available for generating consensus on the use of the utilization of new diagnostic methods, treatments, or monitoring tools.

Over the last decade, at least 10 consensuses on FT have been published, covering a range of topics such as definitions, patient selection, biomarker use, and follow-up protocols [51]. However, many of these consensuses had relatively small respondent pools, with less than 100 people participating, and a majority of these respondents being urologists and experts on the field.

At this stage, the primary approach to improving the quality of consensus and promoting adherence to its results is to involve a considerable and diverse range of participants. The ongoing Falcon project, a broad Delphi consensus on FT, aims to enhance the current body of literature by engaging a significant number of potential participants from different fields of specialization, encompassing diverse backgrounds and healthcare practices across multiple countries. Furthermore, this project aims to address all the aforementioned controversies pertaining to FT, ranging from patient selection to patient follow-up.

In a situation characterized by uncertainty and ongoing skepticism surrounding FT, it is hopeful that this project will successfully accomplish its objective of providing updated, robust, and consensus-driven guidance in the treatment of patients with PCa suitable for FT.

Conflict of Interest

All the authors of this manuscript have direct involvement with the Falcon Project. A Delphi consensus on focal therapy financially supported by Angiodynamics.

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Author Contribution

Conceptualization: LRS, ME, TR, PS, BM, FB, JLDE, AL, RSS. Data/Information curation: LRS. Supervision: RSS. Validation: ME, TR, PS, BM, FB, JLDE, AL, RSS. Visualization: ME, TR, PS, BM, FB, JLDE, AL, RSS. Writing – original draft: LRS. Writing – review & editing: LRS. All authors prepared the manuscript and/or figures; all authors approved the submitted manuscript.

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