EAU 26th Congress Updates

I. Prostate cancer screening: Where are we in 2026?
We know that screening can save lives.

This year, confirmation comes from 30 years of data collected in the longest-running prostate cancer screening trial.

This research demonstrates minimal harm and is essential for future progress.

There was also a higher incidence of prostate cancer in the screening group.

The beneficial effect on cancer mortality increases with time.

MRI and risk stratification have now surpassed overdiagnosis.

Using MRI in accordance with the PRISM recommendations could detect significant prostate cancers.

Risk-based approach reduces MRI referrals for prostate cancer by up to 60%.

Pilot sites rely on either PSA density or the Rotterdam RPCRC.

Centers implementing the RPCRC alongside transrectal ultrasound achieve the most significant decrease in unnecessary MRIs.

In PRAISE-U, only patients at higher prostate cancer risk receive MRI scans.

Contemporary screening programs carry minimal psychological risks.

PRAISE-U assesses stress and anxiety at various points to identify stages of heightened psychosocial burden.

More member states have started pilot programs for risk-based PCa screening in recent times, and even more countries are likely to introduce such initiatives soon.

All data will be ultimately integrated into UroEvidenceHub, creating a centralized resource that supports high quality monitoring, evaluation and research on population -based Pca screening.

II. Treatment de-intensification in mHSPC

This is not a myth or reality, but a working hypothesis meant to balance survival with quality of life. Continuous MAB is still the standard.

The “De-Escalate” trial questions whether more treatment is always beneficial for all patients.

If intermittent therapy proves non-inferior for deep responders, it could reduce patients' risks of chronic hypogonadism and cardiovascular disease while conserving healthcare resources.

This approach allows the body to recuperate during rest, supporting the sustained effort needed for survival, particularly in the early stages for patients who have responded positively to treatment.

There continue to be several outstanding challenges in the management of patients with mHSPC.

In case of high-volume mHSPC no data exist to support RP here, in low volume burden for selected

Furthermore, the results (e.g., AMPLITUDE, CAPItello-281 and PSMAddition) could further complicate the already complex therapeutic landscape in this setting.

III. PSMA-PET enhances staging precision as in the proPSMA study published in The Lancet. However, patient outcomes rely on thorough biological assessment and a consistent treatment approach.

In cT3b, ISUP grade group 5 disease with PSMA-positive nodes, systemic risk should be assumed and addressed early.

Mesorectal/perirectal nodal involvement lies outside standard surgical templates and represents an emerging marker of advanced locoregional disease.

RT-based multimodal treatment combined with long-term ADT improves metastasis-free and OS in locally advanced PCa.

The central challenge of the PSMA-PET is aligning sophisticated imaging with equally sophisticated, multidisciplinary strategy.

In cases of N1 prostate cancer, escalation of therapy beyond androgen deprivation treatment (ADT) is advised, as this strategy is supported by robust evidence. The clinical benefit provided by enzalutamide remains relatively modest.

IV. Five surprising truths about AI reading your prostate MRI scans.:

1.In the PI-CAI study, AI outperformed in diagnostic accuracy.

2.AI failed to beat radiologists with the full clinical picture

3.AI´s hidden superpower is reducing harm by 50% fewer false positives.

4. The real breakthrough is Human-AI collaboration.

5. AI is a precision tool, not a ready-made solution.

AI scaling without deliberate workforce planning risks long waits, variable MRI quality.

Irregular reporting reduced clinicians' and public confidence.

AI is not a substitute for radiologists in organized screening today.

V. Key take-home messages of ProBio:

1. Probio is a circulating tumor DNA (ctDNA) platform trial to improve precision systematic therapy selection in mPCa
2. ProBio now covers mHSPC, using both escalation and de-escalation approaches.
3. De-escalation compares ADT+darolutamide versus darolutamide monotherapy.

VI. Metastasis-Directed Therapy (MDT):

MDT can significantly impact the course of treatment for well-selected patients by postponing systemic therapy, supporting intermittent treatment approaches, or extending the effectiveness of ongoing systemic regimens.

The strongest evidence supporting MDT comes from patients with metachronous oligometastatic HSPC. Both the primary tumor and existing metastases can seed new metastases. Metastatic cells can cycle back to the primary tumor or self-seed.

The ARTO trial is the first randomized study showing OS benefit with MDT.

Understanding underlying metastatic biology better can instruct rationale design of combination systemic and local therapy for metastatic disease.

High-risk mutational signature genes predict response to PARPI.

VII. Classic triple: ADT, DARO, DOC.

Likely beneficial compared to ADT/ARSI doublet for aggressive tumor types, such as high tumor volume, significant local burden, and low-PSA secretors.

Biomarkers are currently being developed, including APIC, Decipher PTEN, RB1, SPOP, and others.

New Schedules:

More tolerable and significantly more effective.

Is the DARO triple regimen superior to Abi?

Novel Triples (PSMAdd, Capitello , Amplitude), any role for the classic one?

VIII. Developing approaches for lymph node management:

Research shows that PLND during RP increases complication risk but improves nodal staging accuracy in PCa patients. Such added value of PLND on nodal staging seems to decline as PSMA PET provides superior staging performance. Especially in patients with intermediate-risk disease, the added value of PLND above PSMA PET seems marginal. It is important to identify if a subset of patients with localized PCa will benefit more than risk additional complications.

Ongoing trials will determine if PLND offers oncological benefits.

IX. Radioligand therapy:

The PSMA fore trial is the largest phase 3 open-label study of RLT in chemotherapy-naïve mCRPC patients, with 468 participants.

Pre-plant secondary endpoint: time to deterioration of FACT-P at the time of the third data cutoff.

Pluvicto delayed deterioration in health-related QoL versus ARPI change: 4,3 months after ARPI change (N=199) and 7,5 months after Pluvicto.(N=187).