UTILIDAD REAL DE NOMOGRAMAS EN UROLOGÍA

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Nomograma

- Representación gráfica que permite realizar con rapidez cálculos numéricos aproximados.

Probabilidad de Órgano-confinación = 100 – [100 / (1 + e^{-z})]

e = número e

z = -3,5616 + 0,7430(Estadio T1c) + 1,6838(Estadio T2a-b) + 2,4246(Estadio T2b) + 4,5900(Estadio T3a-b) + 1,498 (Gleason 7) + 1,7213(Gleason 8-10) + 1,0200(PSA 4,01-10) + 1,5317(PSA 10,01-20) + 2,0595(PSA 20,01-30) + 2,9769(PSA >30)

PSA preop. (ng./mL.) / Estadio clínico	0 – 4	4,01 – 10	10,01 – 20	20,01 – 30	> 30
Suma de Gleason de la biopsia: 2 – 6					
T1a – T1b	97	93	88	82	64
T1c	94	86	78	68	46
T2a – T2b	87	70	58	45	25
T2c	76	53	40	28	14
T3a – T3b	26	11	7	4	2
Suma de Gleason de la biopsia: 7					
T1a – T1b	89	74	63	50	29
T1c	79	57	45	32	16
T2a – T2b	59	35	23	16	7
T2c	41	20	13	8	3
T3a – T3b	7	3	2	1	0
Suma de Gleason de la biopsia: 8 - 10					
T1a – T1b	86	69	58	44	24
T1c	75	52	39	28	13
T2a – T2b	54	30	20	13	6
T2c	36	17	11	7	3
T3a – T3b	6	3	1	1	0

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T2c	76	53	40	28	14
T3a – T3b	26	11	7	4	2
Suma de Gleason de la biopsia: 7					
T1a – T1b	89	74	63	50	29
T1c	79	57	45	32	16
T2a – T2b	59	35	23	16	7
T2c	41	20	13	8	3
T3a – T3b	7	3	2	1	0
Suma de Gleason de la biopsia: 8 - 10					
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T3a – T3b	6	3	1	1	0

TABLA I. Probabilidad de órgano-confinación tumoral (pT2).

Borque-Fernández, J., et al. Vigencia actual de los nomogramas en la estadificación del Cáncer de Próstata. Arch. Esp. Urol., 59, 10 (989-1.000), 2006.

Nomogramas en Urología

Requisitos
Calibración
Discriminación
Utilidad clínica

Tipos
Diagnóstico
De estadificación
Pronóstico

Nomogramas en Urología: Cáncer de vejiga no músculo invasivo.

- Nuevos diagnósticos 75-85% no invaden la capa muscular.
- Riesgo de recurrencia y progresión.

Risk category	Definition
Low-risk tumours	Primary, solitary, TaG1 (PUNLMP, LG[*]), < 3 cm, no carcinoma *in situ* (CIS)
Intermediate risk tumours	All tumours not defined in the two adjacent categories (between the category of low and high risk).
High-risk tumours	Any of the following: • T1 tumour; • G3 (HG[**]) tumour; • CIS; • Multiple, recurrent and large (> 3 cm) TaG1G2/LG tumours (all features must be present).
Subgroup of highest-risk tumours	
T1G3/HG associated with concurrent bladder CIS, multiple and/or largeT1G3/HG and/or recurrent T1G3/HG, T1G3/HG with CIS in the prostatic urethra, some forms of variant histology of urothelial carcinoma lymphovascular invasion.	
BCG failures	

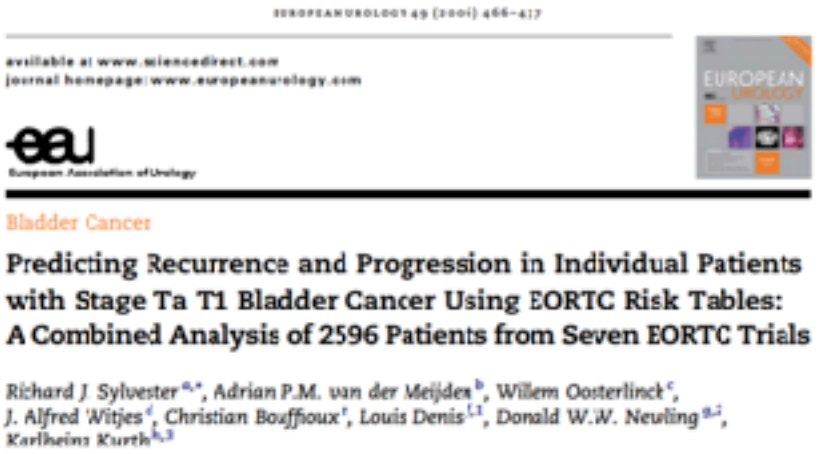
Babjuk, M., et al. EAU guidelines on non–muscle-invasive urothelial carcinoma of the bladder: update 2016. *European urology*, 2017, vol. 71, no 3, p. 447-461

Nomogramas en Urología: Cáncer de vejiga no músculo invasivo.

- EORTC (European Organisation for Research and Treatment of Cancer).
  - **Risk Tables for Predicting Recurrence and Progression in Individual Patients with Stage Ta T1 Bladder Cancer.**

Al año
Recurrencia 15-61%
Progresión 1-17%

A los 5 años
Recurrencia 31-78%
Progresión 1-45%


EUROPEAN UROLOGY 49 (2006) 466–477

available at www.sciencedirect.com
journal homepage: www.europeanurology.com

EUROPEAN UROLOGY

Bladder Cancer

Predicting Recurrence and Progression in Individual Patients with Stage Ta T1 Bladder Cancer Using EORTC Risk Tables: A Combined Analysis of 2596 Patients from Seven EORTC Trials

Richard J. Sylvester[a,*], Adrian P.M. van der Meijden[b], Willem Oosterlinck[c], J. Alfred Witjes[d], Christian Bouffioux[e], Louis Denis[f,1], Donald W.W. Neuling[g,2], Karlheinz Kurth[h,3]

Sylvester, R.J., et al. Predicting recurrence and progression in individual patients with stage Ta T1 bladder cancer using EORTC risk tables: a combined analysis of 2596 patients from seven EORTC trials. Eur Urol, 2006. 49: 466.

EORTC Risk Tables for Predicting Recurrence and Progression in Individual Patients with Stage Ta T1 Bladder Cancer

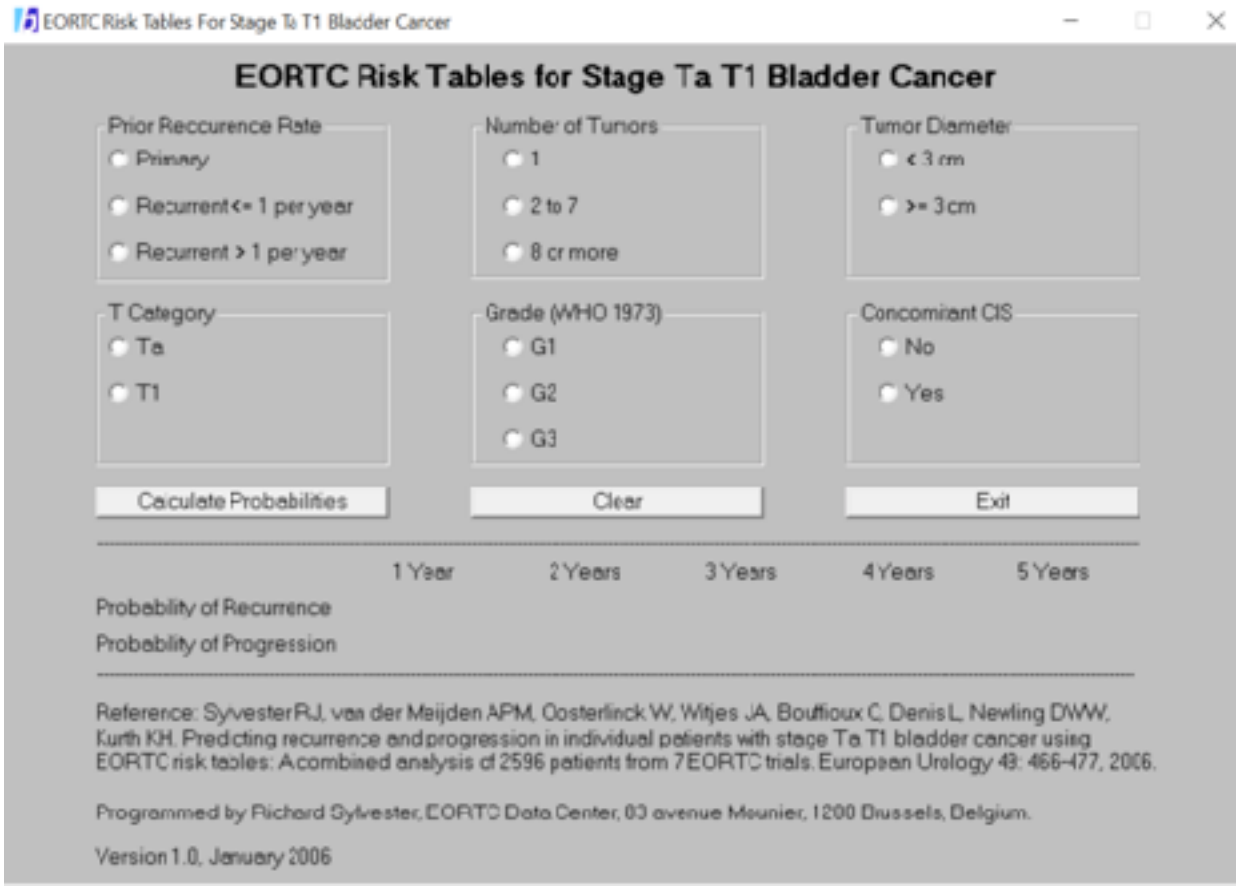
Factor	Recurrence	Progression
Number of tumours		
Single	0	0
2-7	3	3
≥ 8	6	3
Tumour diameter		
< 3 cm	0	0
≥ 3	3	3
Prior recurrence rate		
Primary	0	0
≤ 1 recurrence/year	2	2
> 1 recurrence/year	4	2
Category		
Ta	0	0
T1	1	4
Concurrent CIS		
No	0	0
Yes	1	6
Grade		
G1	0	0
G2	1	0
G3	2	5
Total Score	0-17	0-23

Recurrence score	Probability of recurrence at 1 year		Probability of recurrence at 5 years	
	%	(95% CI)	%	(95% CI)
0	15	(10-19)	31	(24-37)
1-4	24	(21-26)	46	(42-49)
5-9	38	(35-41)	62	(58-65)
10-17	61	(55-67)	78	(73-84)

Progression score	Probability of progression at 1 year		Probability of progression at 5 years	
	%	(95% CI)	%	(95% CI)
0	0.2	(0-0.7)	0.8	(0-1.7)
2-6	1	(0.4-1.6)	6	(5-8)
7-13	5	(4-7)	17	(14-20)
14-23	17	(10-24)	45	(35-55)

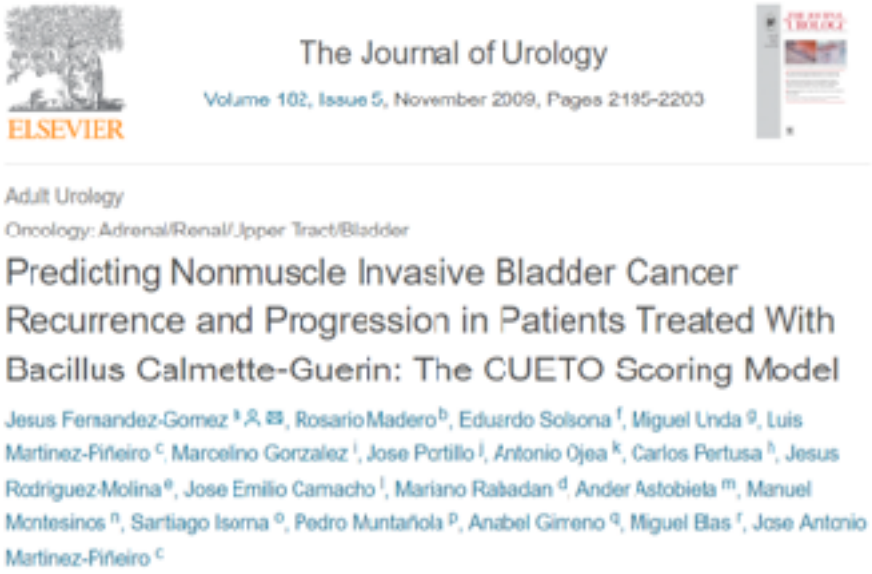
Sylvester, R.J., et al. Predicting recurrence and progression in individual patients with stage Ta T1 bladder cancer using EORTC risk tables: a combined analysis of 2596 patients from seven EORTC trials. Eur Urol, 2006. 49: 466.

EORTC Risk Tables for Predicting Recurrence and Progression in Individual Patients with Stage Ta T1 Bladder Cancer



- http://www.eortc.be/tools/bladdercalculator/

Modelo CUETO de puntuación (Predicción de recurrencia y Progresión de Tumor Vesical No Músculo-Invasivo tratado con Bacilo de Calmette-Guerin).



ELSEVIER

The Journal of Urology

Volume 182, Issue 5, November 2009, Pages 2195-2203

Adult Urology

Oncology: Adrenal/Renal/Upper Tract/Bladder

Predicting Nonmuscle Invasive Bladder Cancer Recurrence and Progression in Patients Treated With Bacillus Calmette-Guerin: The CUETO Scoring Model

Jesus Fernandez-Gomez [a], Rosario Madero [b], Eduardo Solsona [f], Miguel Unda [g], Luis Martinez-Piñeiro [c], Marcelino Gonzalez [i], Jose Portillo [j], Antonio Ojea [k], Carlos Pertusa [h], Jesus Rodriguez-Molina [e], Jose Emilio Camacho [l], Mariano Rabadan [d], Ander Astobieta [m], Manuel Montesinos [n], Santiago Isorna [o], Pedro Muntañola [p], Anabel Girreno [q], Miguel Blas [r], Jose Antonio Martinez-Piñeiro [c]

Fernandez-Gomez, J., et al. Predicting nonmuscle invasive bladder cancer recurrence and progression in patients treated with bacillus Calmette-Guerin: the CUETO scoring model. J Urol, 2009. 182: 2195.

Predicción de Recurrencia y Progresión de Tumor Vesical No Músculo Invasivo Tratado con Bacilo de Calmette Guerin: El Modelo CUETO de Puntuación English

Factor		Puntuación Recurrencia	Puntuación Progresión
Sexo	Hombre	0	0
	Mujer	3	0
Edad (años)	Menor que 60	0	0
	De 60 a 70	1	0
	Mayor que 70	2	2
Tumor recurrente	No	0	0
	Si	4	2
Nº tumores	Menor o igual a 3	0	0
	Mayor que 3	2	1
Categoria T	Ta	0	0
	T1	0	2
Tis asociado	No	0	0
	Si	2	1
Grado	G1	0	0
	G2	1	2
	G3	3	6
Puntuaciones totales		0	0

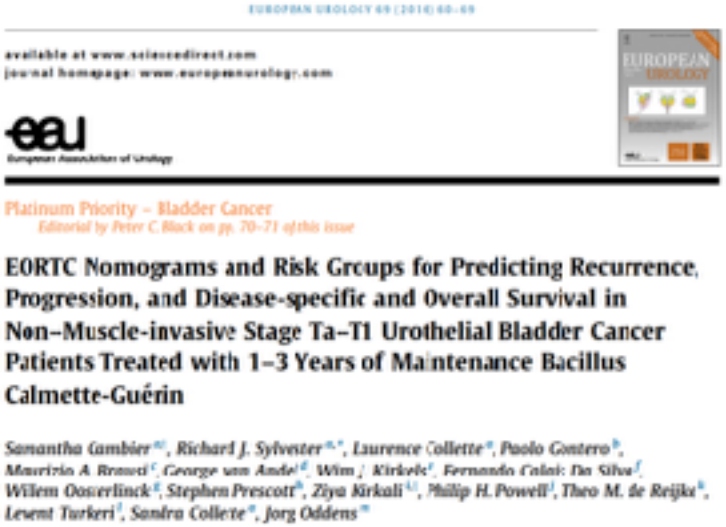
Probabilidad de recurrencia y progresion a 1, 2 y 5 años por puntuación total

Tiempo	Recurrencia (0 4) Prob. (%)	Recurrencia (0 4) I.C. 95% (I..Inf-I..Sup)	Progresión (0 4) Prob. (%)	Progresión (0 4) I.C. 95% (I..Inf-I..Sup)
1 año	8.24	(5.91 10.57)	1.17	(0.15 2.19)
2 años	12.60	(9.76 15.44)	2.16	(0.77 3.55)
5 años	20.98	(17.33 24.63)	3.76	(1.90 5.62)

http://www.aeu.es/Cueto.html

EORTC Nomograms and Risk Groups for Predicting Recurrence, Progression, and Disease-specific and Overall Survival in Non-Muscle-invasive Stage Ta-T1 Urothelial Bladder Cancer Patients Treated with 1-3 Years of Maintenance Bacillus Calmette-Guérin.

- Los pacientes NMIBC tratados con 1-3 años de mantenimiento con BCG tienen un pronóstico heterogéneo.
- Los pacientes con alto riesgo de recurrencia y / o progresión tienen un rendimiento bajo en los programas de mantenimiento actualmente recomendados.
- Se requieren tratamientos alternativos con urgencia.



Cambier, S., et al. EORTC Nomograms and Risk Groups for Predicting Recurrence, Progression, and Disease-specific and Overall Survival in Non-Muscle-invasive Stage Ta-T1 Urothelial Bladder Cancer Patients Treated with 1-3 Years of Maintenance Bacillus Calmette-Guérin. Eur Urol. 2016 Jan;69(1):60-9. doi: 10.1016/j.eururo.2015.06.045. Epub 2015 Jul 23.

EAU Guidelines on Non-muscle-invasive Bladder Cancer (TaT1 and CIS)

M. Babjuk (Chair), M. Burger (Vice-Chair), E. Compérat, P. Gontero, A.H. Mostafid, J. Palou, B.W.G. van Rhijn, M. Rouprêt, S.F. Shariat, R. Sylvester, R. Zigeuner
Guidelines Associates: O. Capoun, D. Cohen, V. Hernández, V. Soukup

Recommendations	GR
Apply the EORTC risk tables and calculator for the prediction of the risk of tumour recurrence and progression in different intervals after transurethral resection of the bladder, in individual patients.	B
Use the CUETO risk tables and the new EORTC risk groups for the prediction of the risk of tumour recurrence and progression in individual patients treated with bacillus Calmette-Guérin.	B

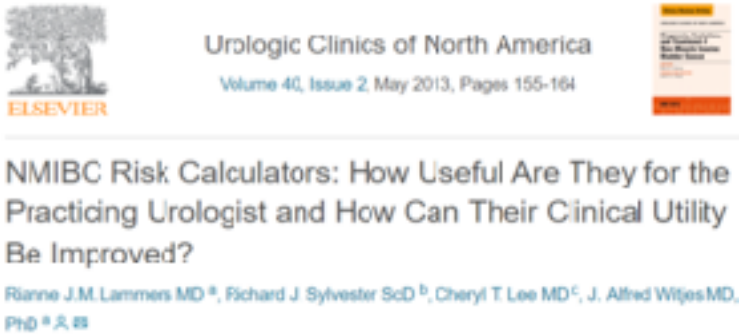
Babjuk, M., et al. EAU guidelines on non–muscle-invasive urothelial carcinoma of the bladder: update 2016. *European urology*, 2017, vol. 71, no 3, p. 447-461.

Nomogramas predictivos de recurrencia y progresión de Cáncer vesical no músculo invasivo

- Pueden ayudar en el proceso de toma de decisiones y potencialmente mejorar los resultados clínicos de los pacientes con Cáncer vesical no músculo invasivo.

Nomogramas predictivos de recurrencia y progresión de Cáncer vesical no músculo invasivo

- Pueden ayudan en el proceso de toma de decisiones y potencialmente mejorar los resultados clínicos de los pacientes con Cáncer vesical no músculo invasivo.
- Lammers et al. reportó que estos modelos proporcionaron un bajo VPP para progresión, especialmente en la enfermedad de alto grado (EORTC: 21%, CUETO: 24%).



Nomogramas predictivos de recurrencia y progresión de Cáncer vesical no músculo invasivo

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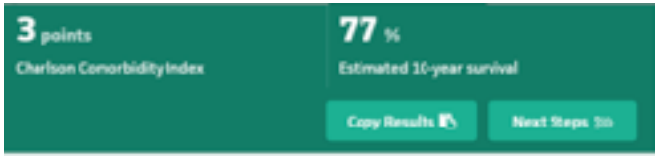
- Lammers et al. reportó que estos modelos proporcionaron un bajo VPP para progresión, especialmente en la enfermedad de alto grado (EORTC: 21%, CUETO: 24%).

- Xylinas et al., han validado externamente la utilidad de ambos modelos (cohorte multicéntrica de 4689 pacientes), indicando que las tablas de riesgo de EORTC y el modelo de puntuación CUETO mostraron una discriminación deficiente para recurrencias (índices c 0.597 y 0.523) y progresión (índices c 0.662 y 0.616). Ambos modelos sobreestimaron el riesgo de progresión, especialmente en pacientes NMIBC de alto riesgo.

Cáncer de Próstata. Indice de Comorbilidad de Charlson

Number of points	Conditions
1 point	50-60 years
	Myocardial infarction
	Heart failure
	Peripheral vascular insufficiency
	Cerebrovascular disease
	Dementia
	Chronic lung disease
	Connective tissue disease
	Ulcer disease
	Mild liver disease
	Diabetes
2 points	61-70 years
	Hemiplegia
	Moderate to severe kidney disease
	Diabetes with organ damage
	Tumours of all origins
3 points	71-80 years
	Moderate to severe liver disease
4 points	81-90 years
5 points	> 90 years
6 points	Metastatic solid tumours
	AIDS

Recommendations	LE	GR
Offer an individualised risk-adapted strategy for early detection to a well-informed man with a good performance status and a life-expectancy of at least ten to fifteen years.	3	B
Decide on the age at which early diagnosis of PCa should be stopped based on life expectancy and performance status; men who have a life-expectancy of < 15 years are unlikely to benefit.	3	A

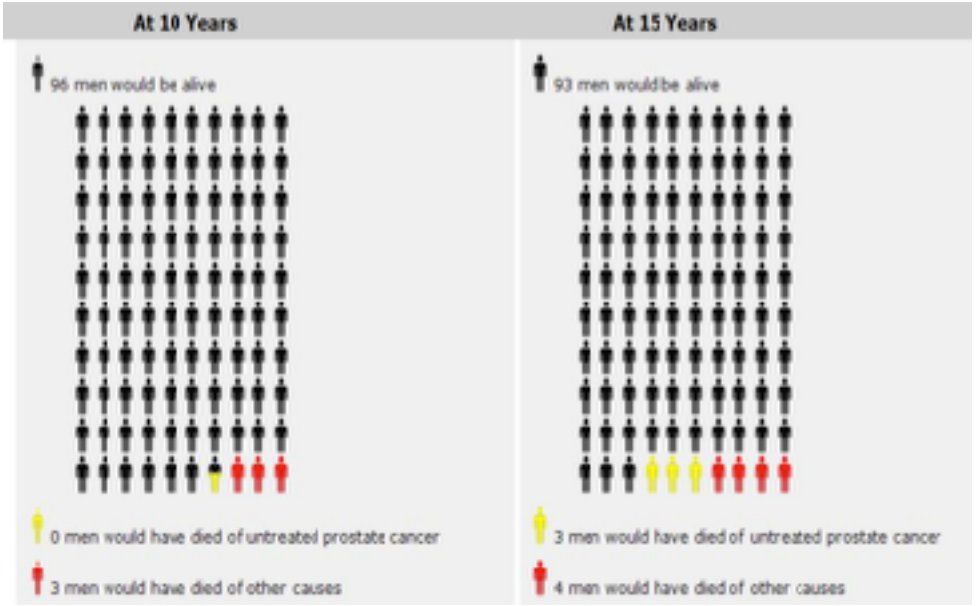


https://www.mdcalc.com/charlson-comorbidity-index-cci

-Mottet, N., et al. EAU-ESTRO-SIOG guidelines on prostate cancer. Part 1: screening, diagnosis, and local treatment with curative intent. *European urology*, 2017, vol. 71, no 4, p. 618-629.
-Charlson, M.E., et al. A new Method of Classifying Prognostic Comorbidity in Longitudinal Studies: Development and Validation. Journal of Chronic Diseases 40:373-383

Esperanza de vida a los 10-15 años específica para Cáncer de Próstata

Memorial Sloan Kettering Cancer Center



https://webcore.mskcc.org/survey/surveyform.aspx?&preview=true&excelsurveylistid=4

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Cáncer de Próstata

- Las calculadoras de riesgos pueden ser útiles para ayudar a determinar de forma individual el riesgo potencial de cáncer, reduciendo así la cantidad de biopsias innecesarias.
  - PCPTRC 2.0.
  - ERSCP

Mottet, N., et al. EAU-ESTRO-SIOG guidelines on prostate cancer. Part 1: screening, diagnosis, and local treatment with curative intent. *European urology*, 2017, vol. 71, no 4, p. 618-629.

Cáncer de Próstata

- Prostate Cancer Prevention Trial Risk Calculator Version
  - Seguimiento de 5519 hombre durante 7 años.
  - PSA <3ng/ml.
  - Tacto rectal y PSA anual.
  - Biopsia prostática transrectal a los 7 años.
  - Conclusión: El PSA, los antecedentes familiares, los hallazgos del DRE y los antecedentes de una biopsia de próstata negativa previa proporcionaron un valor predictivo independiente para el cálculo del riesgo de una biopsia que mostró presencia de cáncer.

Schmitz-Dräger, B.J., et al. The Prostate Cancer Prevention Trial (PCPT). Relevance for clinical practice. Urologe A. 2007 Oct;46(10):1364, 1366-8, 1370.

Cáncer de Próstata

- **Prostate Cancer Prevention Trial Risk Calculator Version 2.0**

Schmitz-Dräger, B.J., et al. The Prostate Cancer Prevention Trial (PCPT). Relevance for clinical practice. Urologe A. 2007 Oct;46(10):1364, 1366-8, 1370.

http://myprostatecancerrisk.com/

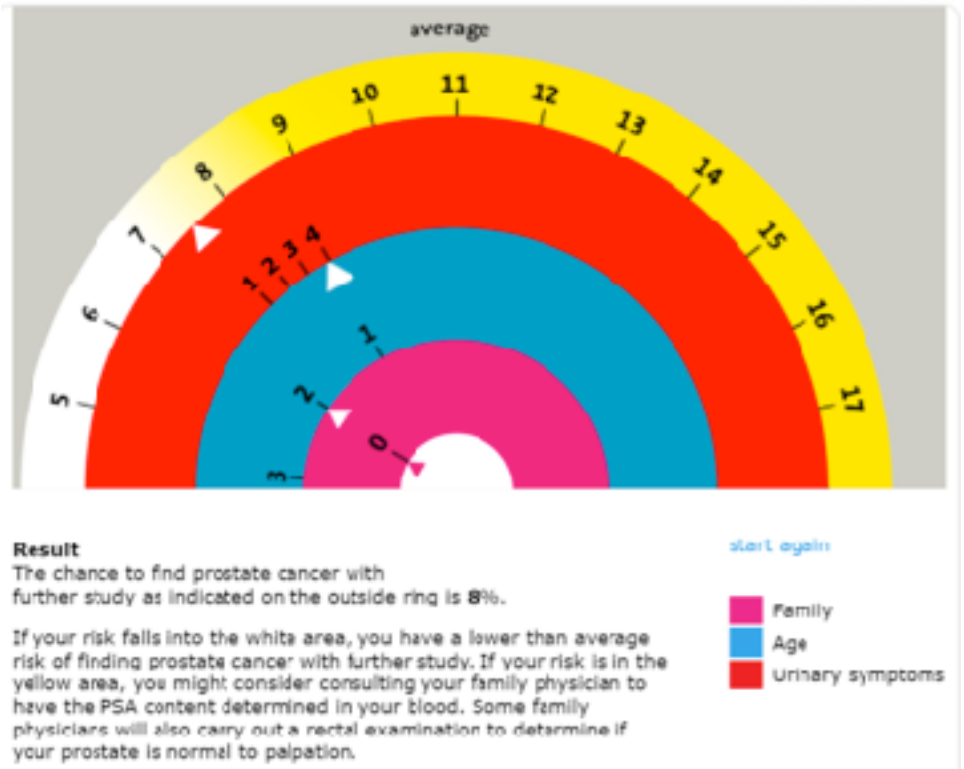
Cáncer de Próstata

- **European Randomised Study of Screening for Prostate Cancer (ERSPC) risk calculators significantly outperform the Prostate Cancer Prevention Trial (PCPT) 2.0 in the prediction of prostate cancer: a multi-institutional study.**

  - **Conclusiones:** El rendimiento de las calculadoras de riesgo en la presente cohorte muestra que ERSPC-RC es una herramienta superior en la predicción del CaP; sin embargo el rendimiento del ERSPC-RC en esta población aún no justifica su uso en la práctica clínica.

Foley, R.W., et al. European Randomised Study of Screening for Prostate Cancer (ERSPC) risk calculators significantly outperform the Prostate Cancer Prevention Trial (PCPT) 2.0 in the prediction of prostate cancer: a multi-institutional study. BJU Int. 2016 Nov;118(5):706-713. doi: 10.1111/bju.13437. Epub 2016 Feb 29.

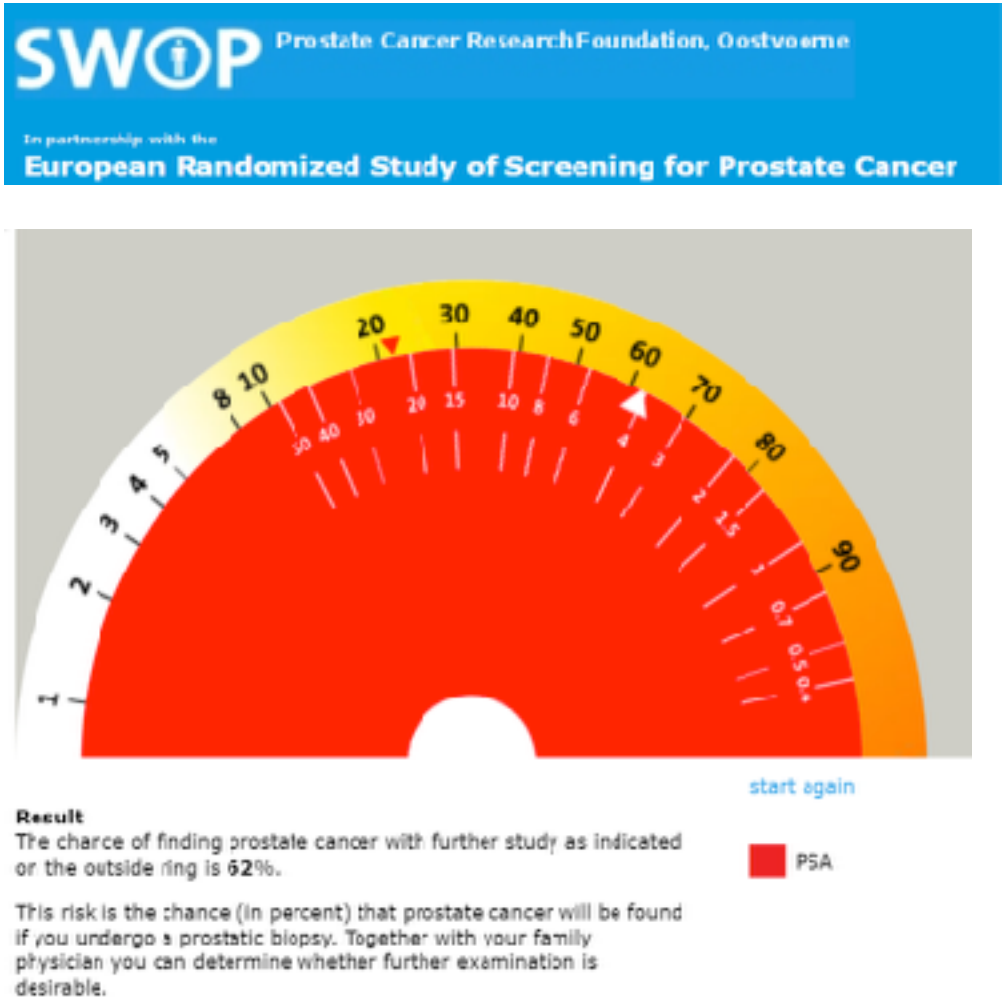
Cáncer de Próstata



- Calculador de riesgo 1.
  - Probabilidad de Ca de Próstata según datos clínicos.

http://www.prostatecancer-riskcalculator.com

Cáncer de Próstata



- Calculador de riesgo 2.
  - Probabilidad de Ca de Próstata mediante la cuantificación del PSA.

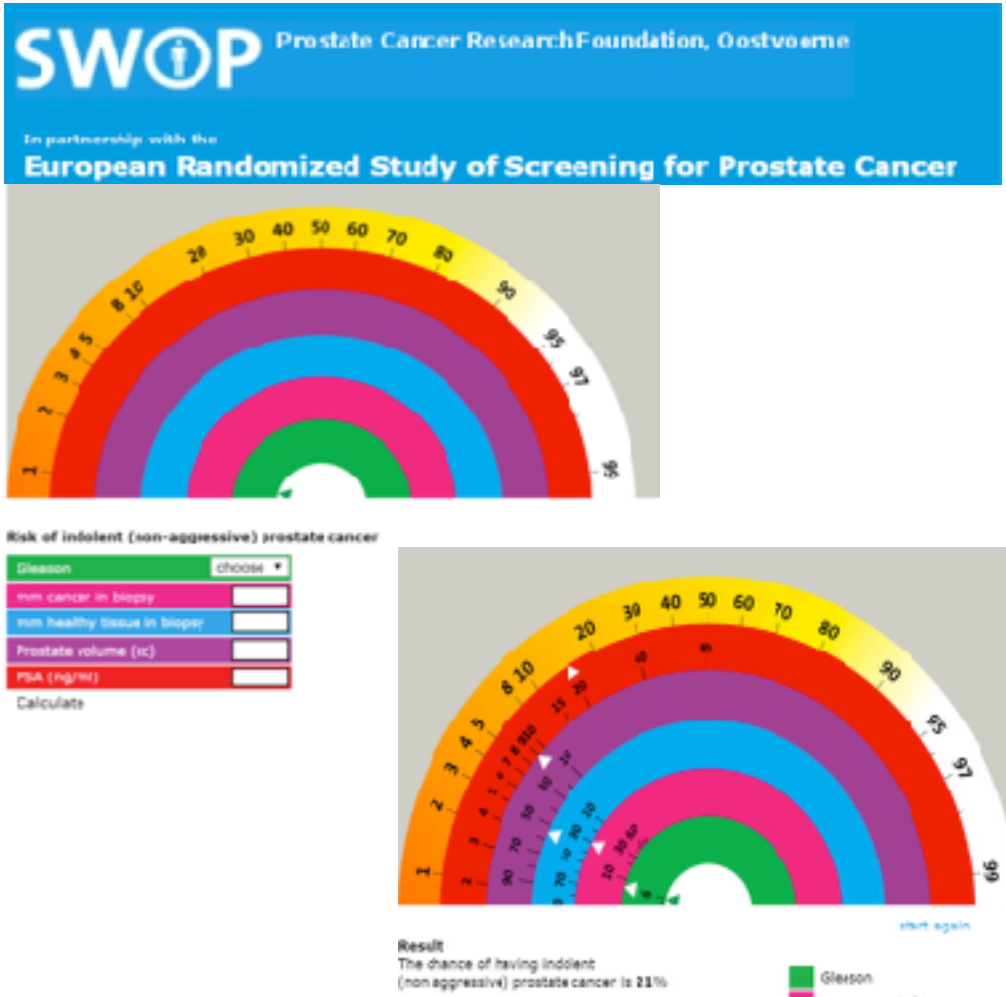
http://www.prostatecancer-riskcalculator.com

Cáncer de Próstata

- Calculador de riesgo 3-4:
  - Calcula la probabilidad de tener una biopsia positiva.

http://www.prostatecancer-riskcalculator.com

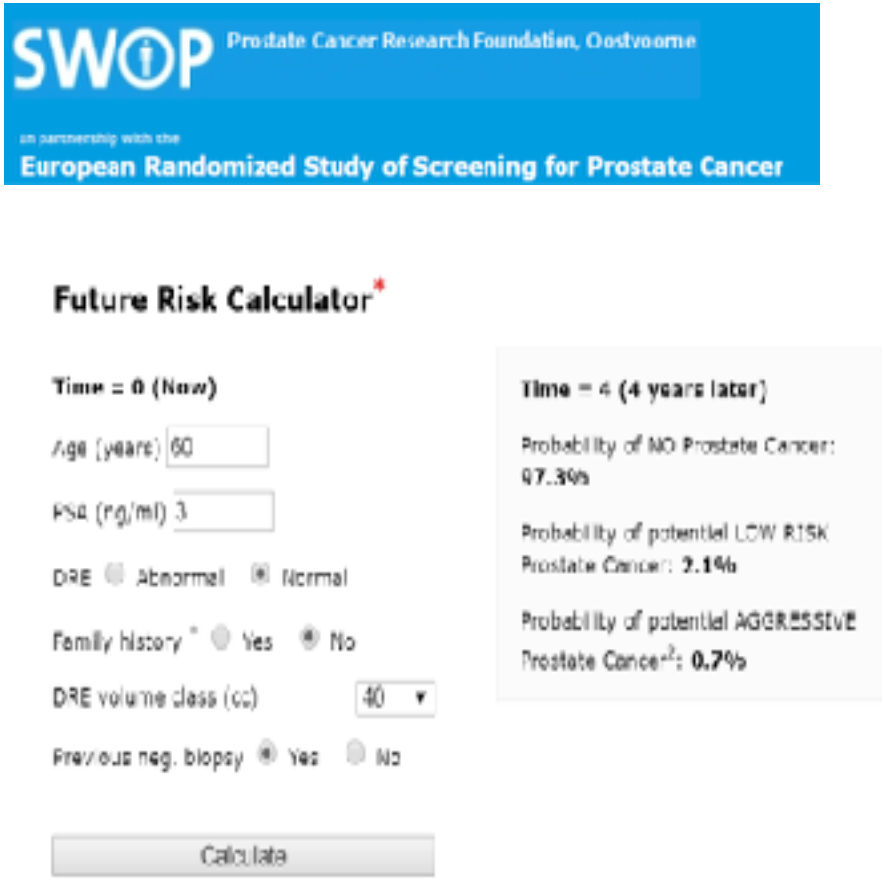
Cáncer de Próstata



- Calculador de riesgo 5:
  - Probabilidad de presentar un Ca de próstata indolente que puede no requerir tratamiento inmediato.

http://www.prostatecancer-riskcalculator.com

Cáncer de Próstata



- Calculador de riesgo 6:
  - Calcula el riesgo de oadecer Ca de Próstata en los próximos 4 años.
  - Valora edad, PSA, tacto rectal, historia familiar, volume prostático, y biopsia previa si la tuviera.

http://www.prostatecancer-riskcalculator.com

EAU – ESTRO – ESUR – SIOG Guidelines on Prostate Cancer

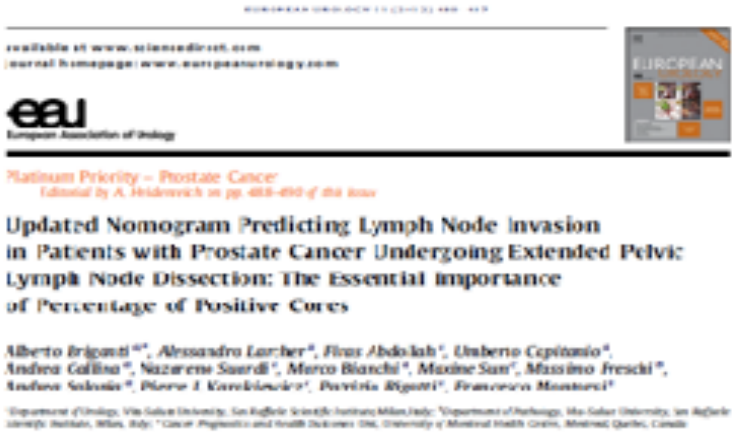
N. Mottet (Chair), J. Bellmunt, E. Briers (Patient Representative), M. Bolla, L. Bourke, P. Cornford (Vice-chair), M. De Santis, A.M. Henry, S. Joniau, T.B. Lam, M.D. Mason, H.G. van der Poel, T.H. van der Kwast, O. Rouvière, T. Wiegel
Guidelines Associates: N. Arfi, R.C.N. van den Bergh, T. van den Broeck, M. Cumberbatch, N. Fossati, T. Gross, M. Lardas, M. Liew, P. Moldovan, I.G. Schoots, P.M. Willemse

Recommendations	LE	GR
In order to avoid unnecessary biopsies, offer further risk-assessment to asymptomatic men with a prostate specific antigen level between 2-10 ng/mL prior to performing a prostate biopsy. Use one of the following tools: • risk-calculator; • an additional serum or urine-based test (e.g. Prostate Health Index test [PHI], four kallikrein [4K]score or Prostate cancer gene 3 [PCA3]) or imaging.	3	C

Mottet, N., et al. EAU-ESTRO-SIOG guidelines on prostate cancer. Part 1: screening, diagnosis, and local treatment with curative intent. *European urology*, 2017, vol. 71, no 4, p. 618-629.

Ca de Próstata: Nomograma de Briganti.

- Invasión ganglionar presente entre 1-26%.
- Usando un corte del 5%:
  - Falsos negativos 1,5%.
  - Sensibilidad 87,3%.
  - Especificidad 70,3%.
  - VPN 98,4%
- Se evita linfadenectomía en 2/3 de los pacientes.



Platinum Priority – Prostate Cancer

Updated Nomogram Predicting Lymph Node Invasion in Patients with Prostate Cancer Undergoing Extended Pelvic Lymph Node Dissection: The Essential Importance of Percentage of Positive Cores

Briganti, A., et al. Updated nomogram predicting lymph node invasion in patients with prostate cancer undergoing extended pelvic lymph node dissection: the essential importance of percentage of positive cores. Eur Urol. 2012 Mar;61(3):480-7. doi: 10.1016/j.eururo.2011.10.044. Epub 2011 Nov 7.

Ca de Próstata: Nomograma de Briganti.

Probabilidad de invasión de ganglios linfáticos en pacientes sometidos a Linfadenectomía Pélvica Extendida (LPE) basada en el Nomograma de Briganti (NB)

PSA	0	*(decimales con punto)*
Estadio clínico	Seleccionar	
Grado primario de Gleason	Seleccionar	
Grado secundario de Gleason	Seleccionar	
% de cilindros positivos	0	
Puntos totales	0	
Probabilidad de invasión	0	%

Nota: punto de corte en el 5%

Fuente: Probability prediction of lymph nodes invasion (LNI) in patiens undergoing extended pelvic lymphadenectomy
www.europeanurology.com/article/S0302-2838%281%2901231-9/

http://www.pixelhive.net/nomograma_briganti/

EAU – ESTRO – ESUR – SIOG Guidelines on Prostate Cancer

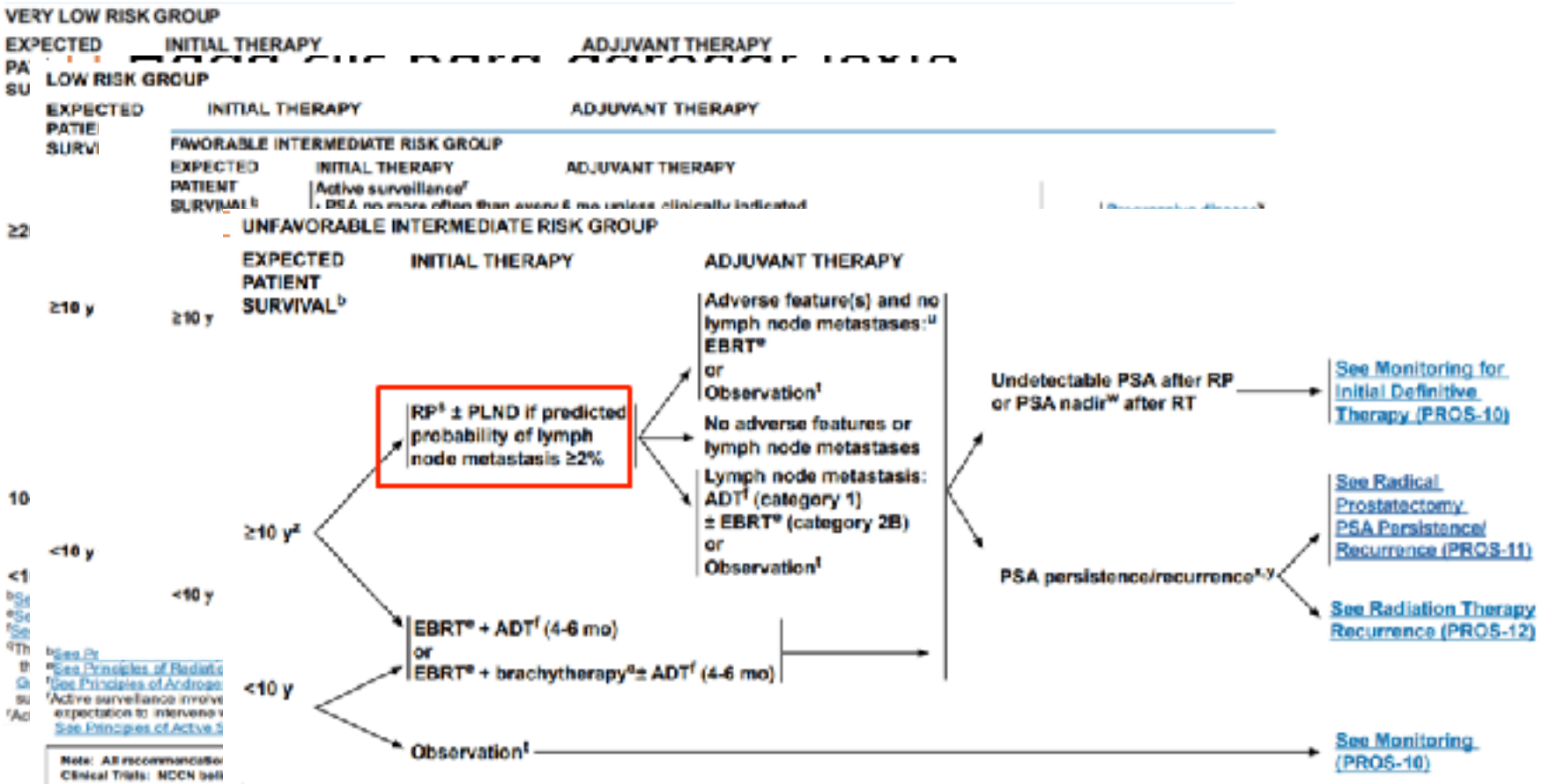
N. Mottet (Chair), J. Bellmunt, E. Briers (Patient Representative), M. Bolla, L. Bourke, P. Cornford (Vice-chair), M. De Santis, A.M. Henry, S. Joniau, T.B. Lam, M.D. Mason, H.G. van der Poel, T.H. van der Kwast, O. Rouvière, T. Wiegel
Guidelines Associates: N. Arfi, R.C.N. van den Bergh, T. van den Broeck, M. Cumberbatch, N. Fossati, T. Gross, M. Lardas, M. Liew, P. Moldovan, I.G. Schoots, P.M. Willemse

Recommendations	LE	GR
Do not perform a lymph node dissection (LND) in low-risk PCa.	2b	A
Perform an extended(e)LND in intermediate-risk PCa if the estimated risk for positive lymph nodes exceeds 5%.	2b	B
Perform an eLND in high-risk PCa.	2a	A
Do not perform a frozen section of nodes during radical prostatectomy (RP) to decide whether to proceed with, or abandon, the procedure.	2a	A
Do not perform a limited LND.	2a	A

Mottet, N., et al. EAU-ESTRO-SIOG guidelines on prostate cancer. Part 1: screening, diagnosis, and local treatment with curative intent. *European urology*, 2017, vol. 71, no 4, p. 618-629.

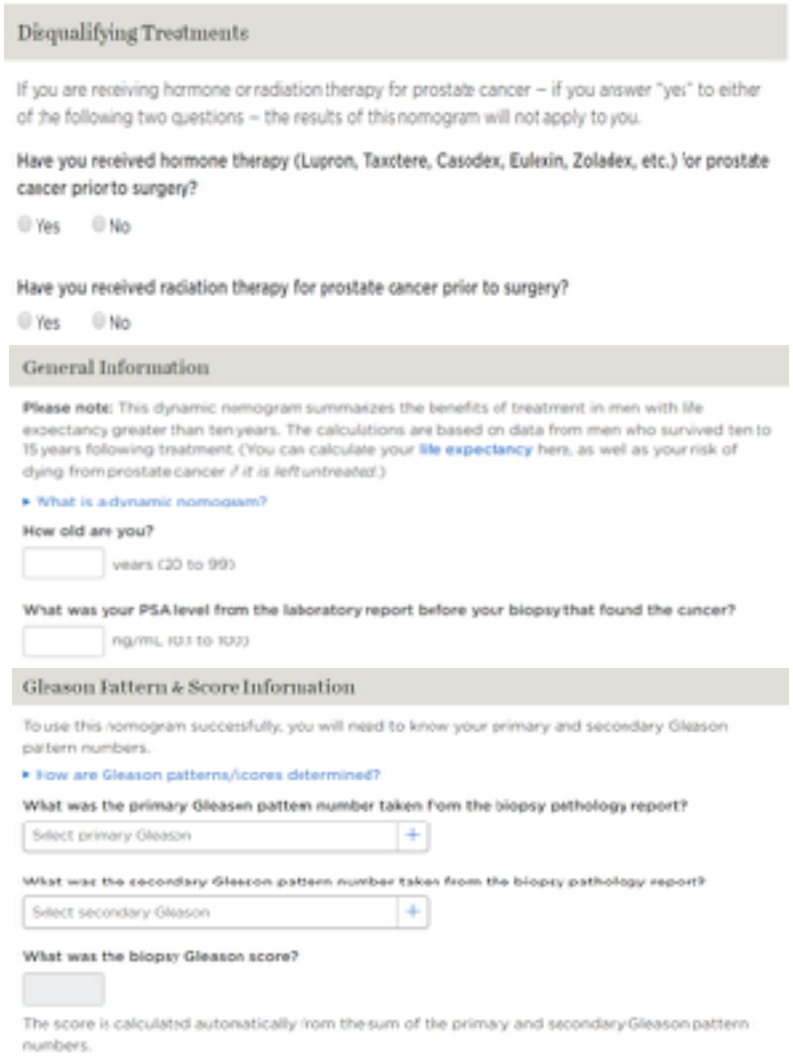
National Comprehensive Cancer Network®

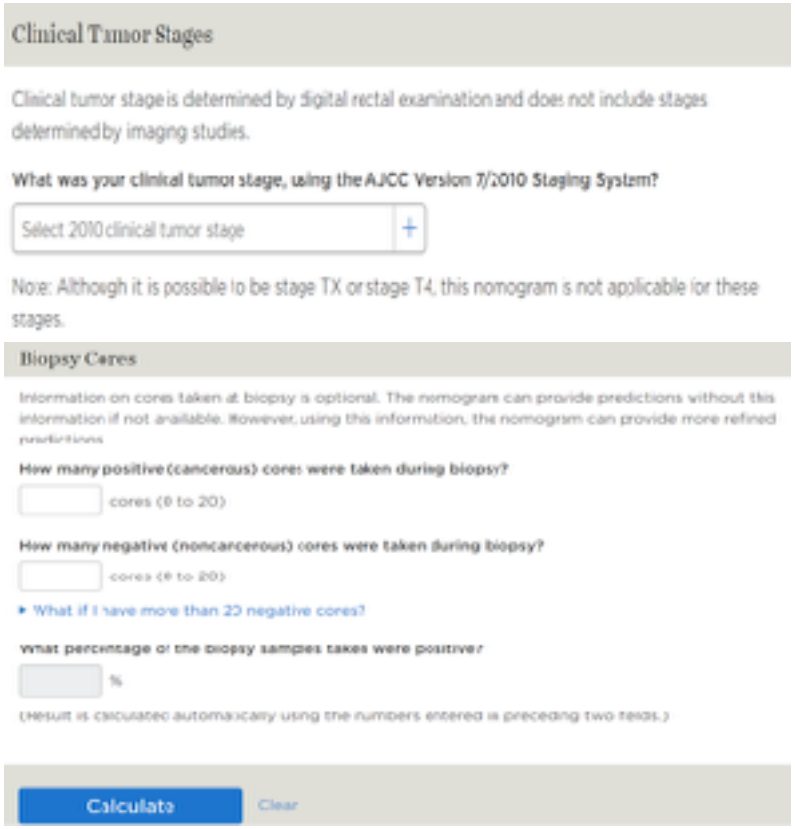
NCCN Guidelines Version 1.2018
Prostate Cancer



[b] See Principles of Life Expectancy Estimation (PROS-A).
[e] See Principles of Radiation Therapy (PROS-D).
[f] See Principles of Androgen Deprivation Therapy (PROS-F).
[q] See Principles of Surgery (PROS-E).
[f] Observation involves monitoring the course of disease with the expectation to deliver palliative therapy for the development of symptoms or a change in exam or PSA that suggests symptoms are imminent. See Principles of Active Surveillance and Observation (PROS-C).
[u] Adverse laboratory/pathologic features include: positive margin(s), seminal vesicle invasion, extracapsular extension, or detectable PSA.
[w] PSA nadir is the lowest value reached.
[x] PSA persistence/recurrence after RP is defined as failure of PSA to fall to undetectable levels (PSA persistence) or undetectable PSA after RP with a subsequent detectable PSA that increases on 2 or
[y] RTOG-ASTRO (Radiation Therapy Oncology Group - American Society for Therapeutic Radiology and Oncology) Phoenix Consensus: 1) PSA increase by 2 ng/mL or more above the nadir PSA is the standard definition for PSA persistence/recurrence after EBRT with or without HT; and 2) A recurrence evaluation should be considered when PSA has been confirmed to be increasing after radiation even if the increase above nadir is not yet 2 ng/mL, especially in candidates for salvage local therapy who are young and healthy. Retaining a strict version of the ASTRO definition allows comparison with a large existing body of literature. Rapid increase of PSA may warrant evaluation (prostate biopsy) prior to meeting the Phoenix definition, especially in younger or healthier men.

Nomograma MSKCC Pre-prostatectomía radical





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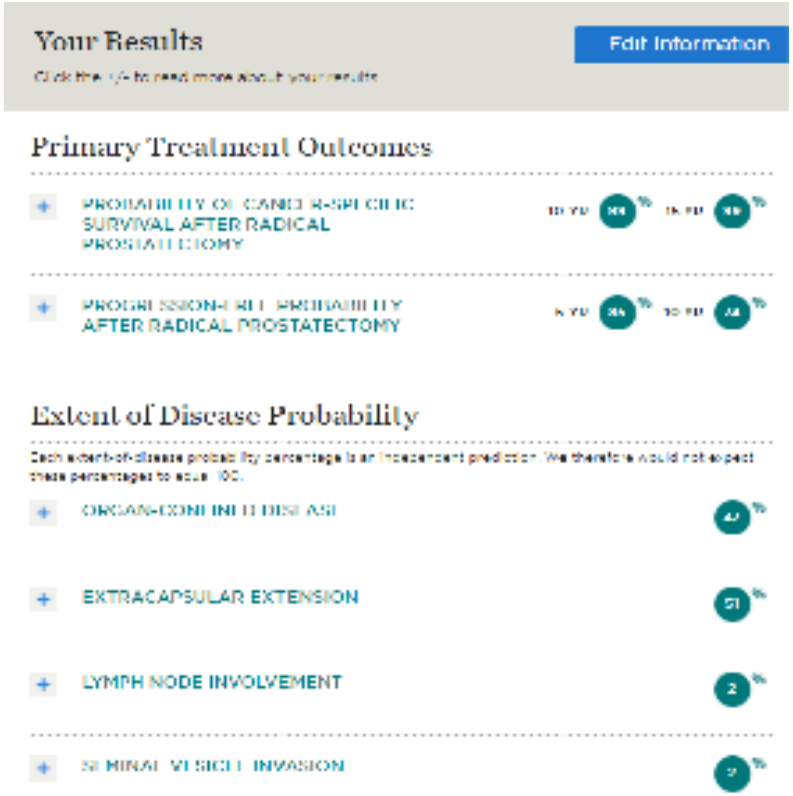
Nomograma MSKCC Pre-prostatectomía radical



https://www.mskcc.org/nomograms/prostate/pre_op

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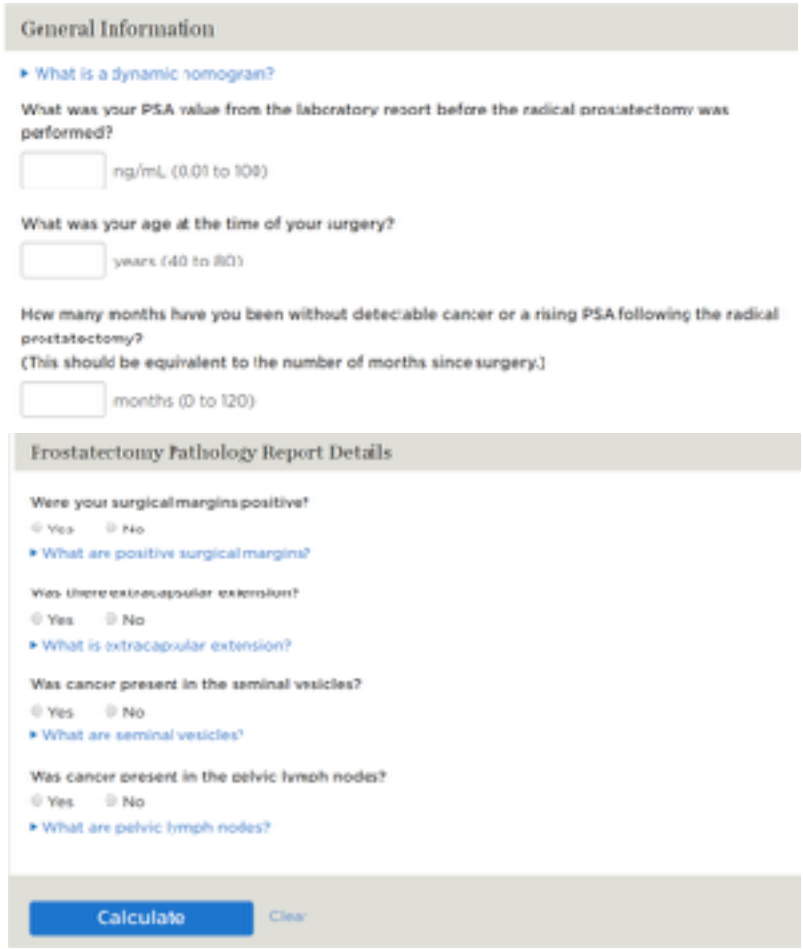
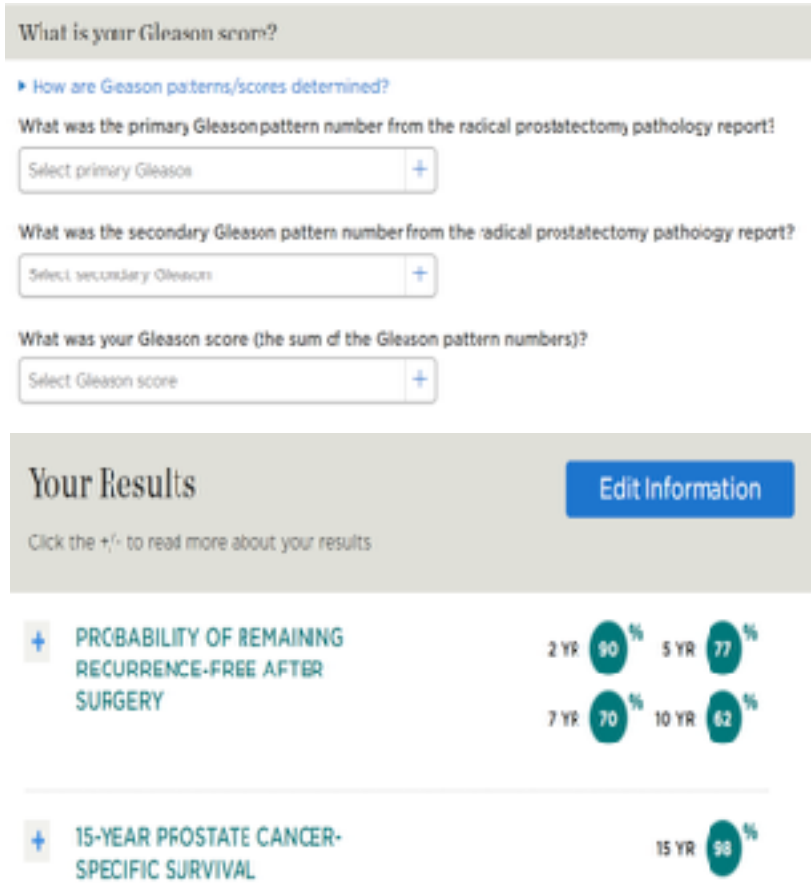
Nomograma MSKCC Postprostatectomía radical





https://www.mskcc.org/nomograms/prostate/post_op

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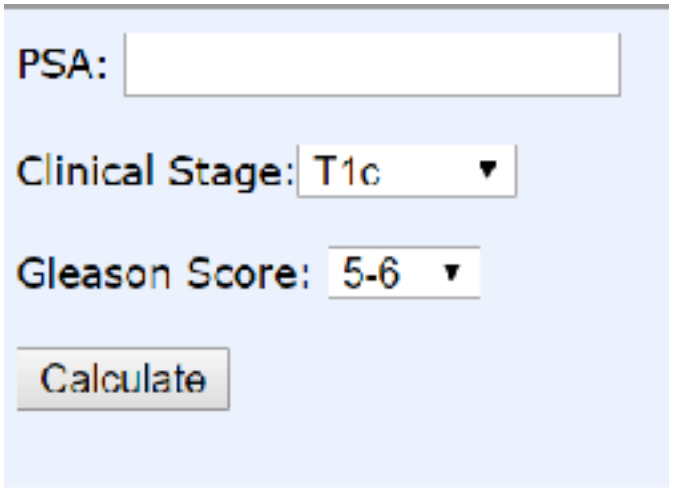
Tablas de Partín



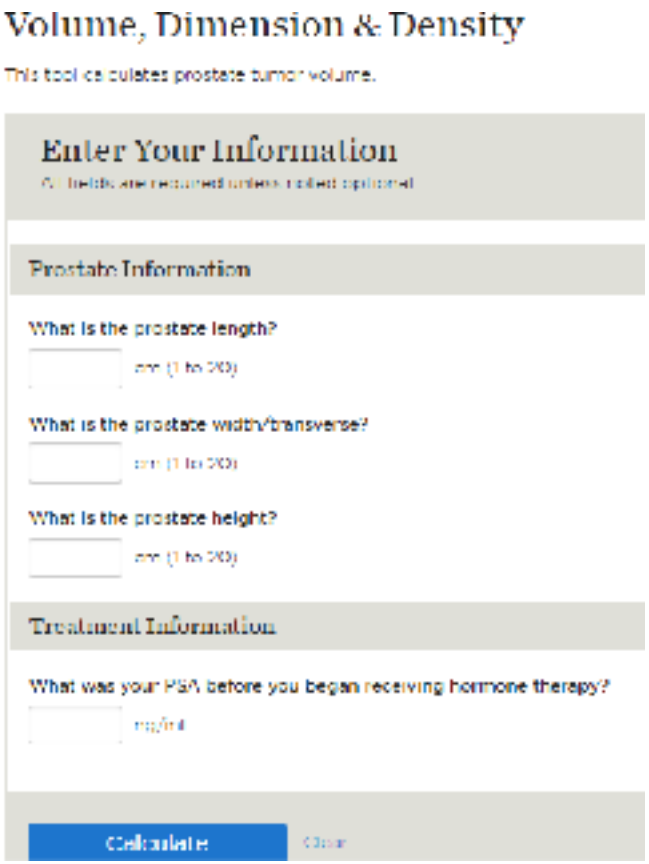
PSA:6 **Clinical Stage**:'T2b/T2c' **Gleason Score**:'3+4'

Organ confined: [34%(27.8%-41.1%)]
Extraprostatic extension: [40%(33.3%-47%)]
Seminal Vesicle Invasion: [18.9%(12.5%-27%)]
Lymph Node Invasion: [7.1%(3.6%-12%)]

All numbers represent predictive probabilities with a 95 percent confidence interval

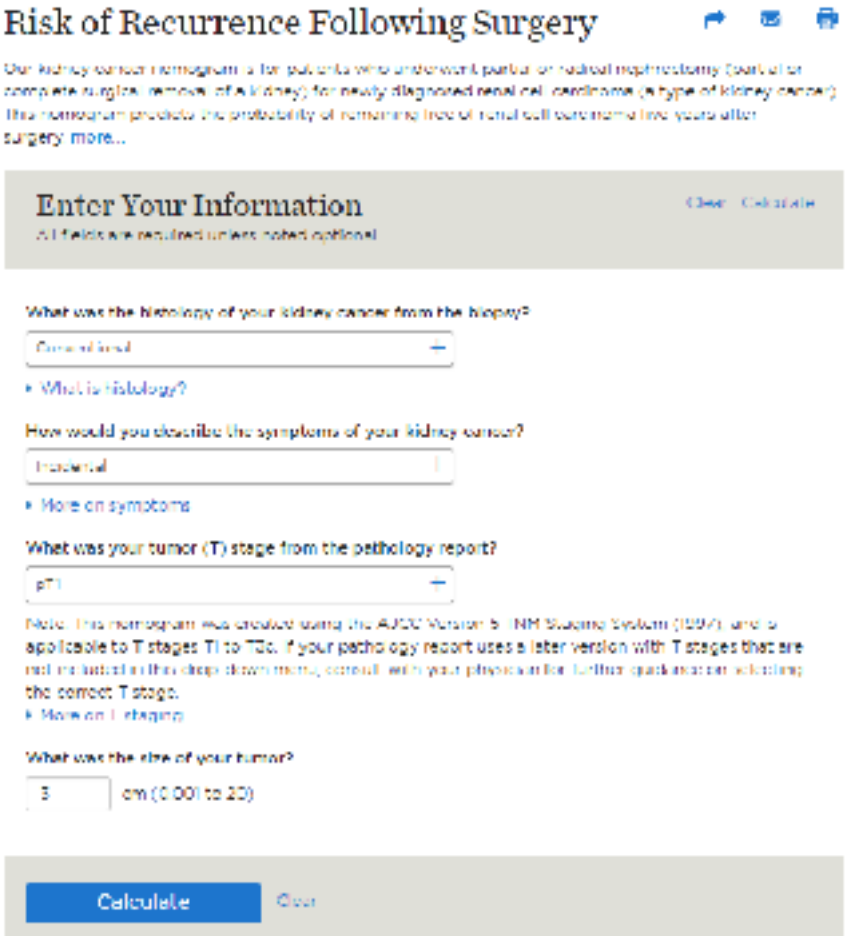
http://urology.jhu.edu/support/partinTables.php

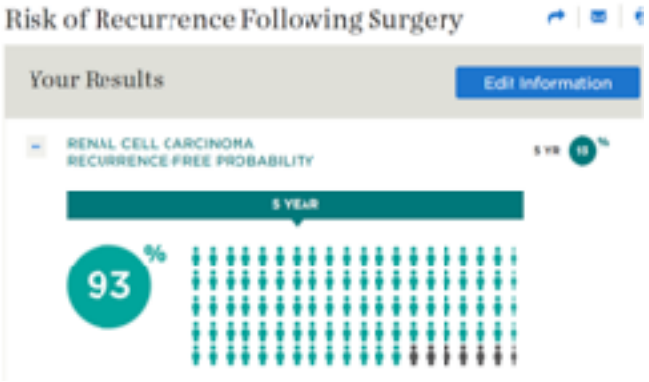
Volumen prostático y densidad del PSA



https://www.mskcc.org/nomograms/prostate/volume

Ca renal. Riesgo de recurrencia tras cirugía de Ca renal





https://www.mskcc.org/nomograms/renal

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- **Indice de comorbilidad de Charlson.**
  - https://www.mdcalc.com/charlson-comorbidity-index-cci
- **Supervivencia a los 10-15 años MSKCC**
  - webcore.mskcc.org/survey/surveyform.aspx?&preview=true&excelsurveylistid=4
- **PCPTRC 2.0 (riesgo de cáncer de próstata pre-biopsia).**
  - http://myprostatecancerrisk.com/
- **ERSCP (riesgo de cáncer de próstata pre-biopsia).**
  - http://www.prostatecancer-riskcalculator.com
- **Nomograma de Briganti**
  - http://www.pixelhive.net/nomograma_briganti/
- **Nomograma pre-prostatectomía radical MSKCC.**
  - https://www.mskcc.org/nomograms/prostate/pre_op
- **Nomograma post-prostatectomía radical MSKCC.**
  - https://www.mskcc.org/nomograms/prostate/post_op
- **Tablas de Partin**
  - http://urology.jhu.edu/support/partinTables.php
- **Riesgo de recurrencia tras cirugía de Ca Renal.**
  - https://www.mskcc.org/nomograms/renal

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GRACIAS