

⁶⁸Ga-prostate-specific membrane antigen positron emission tomography/computed tomography for patients with favorable intermediate-risk prostate cancer

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Abstract

Introduction: Current guidelines don't support the use of pretreatment imaging in patients with favorable intermediate-risk prostate cancer. ⁶⁸Ga-prostate-specific membrane antigen positron emission tomography/computed tomography (PSMA PET/CT) is more accurate than conventional imaging for preoperative staging. We aimed to evaluate whether pretreatment ⁶⁸Ga-PSMA PET/CT is beneficial for identifying pathological lymph node involvement (LNI) and adverse pathology among patients with favorable intermediate-risk prostate cancer.

Methods: We reviewed 88 patients with favorable intermediate-risk prostate cancer who underwent ⁶⁸Ga-PSMA PET/CT prior to radical prostatectomy and lymph node dissection from 2016–2020. The primary endpoint was the presence of pathological LNI. Association between pretreatment characteristics and outcomes were evaluated.

Results: Preoperative ⁶⁸Ga-PSMA PET/CT showed suspicious uptake in lymph nodes in 4/88 patients (5%), hence, 20 patients would need to be scanned to identify a patient with a positive lymph node on imaging. Two patients had pathological LNI, only one of whom showed ⁶⁸Ga-PSMA PET/CT uptake prior to surgery. The sensitivity, specificity, positive predictive value, and negative predictive values of ⁶⁸Ga-PSMA PET/CT for identifying LNI were 50%, 97%, 25%, and 99%, respectively. After surgery, four patients had evidence of prostate-specific antigen (PSA) persistence. The rate of PSA persistence was higher among patients with LNI on preoperative ⁶⁸Ga-PSMA PET/CT (2/4, 50% vs. 2/84, 2%, p=0.009).

Conclusions: Preoperative imaging of favorable intermediate-risk prostate cancer patients using ⁶⁸Ga-PSMA PET/CT showed a low yield for identifying patients at higher risk. Consistent with current guidelines, our findings do not support the routine use of PET/CT in this group of patients. Future prospective studies are needed to validate our findings.

Introduction

Pretreatment imaging of patients diagnosed with prostate cancer is aimed at identifying lymph node involvement and distant metastases which are more common in patients with higher tumor stage and grade and influence treatment options.^{1,2} Pretreatment staging recommendations intend to reduce routine imaging in men with low-risk of distant disease; therefore, current guidelines do not recommend the use of routine conventional imaging for staging men with favorable intermediate-risk prostate cancer.^{3–5} However, data regarding the diagnostic yield of imaging in the pre-treatment setting for prostate cancer are based mainly on studies utilizing CT scans of the abdomen and pelvis and bone scintigraphy.^{6,7}

⁶⁸Ga-PSMA PET/CT is evolving as a more accurate method for staging prostate cancer.^{8,9} Several studies evaluated the preoperative use of ⁶⁸Ga-PSMA PET/CT within the context of high-risk patients, supporting its role in disease staging with a higher accuracy compared to conventional imaging.¹⁰ Consistent with these findings the FDA has approved the use of PSMA PET CT for the staging of high-risk patients. Less is known regarding the role of ⁶⁸Ga-PSMA PET/CT for the pretreatment staging of patients with intermediate-risk disease, especially in men diagnosed with favorable intermediate-risk prostate cancer.

In the current study we investigate the role of preoperative ⁶⁸Ga-PSMA PET/CT in a group of patients with favorable intermediate-risk prostate cancer who underwent radical prostatectomy and lymph node dissection. Specifically, we aimed to evaluate whether this novel modality can accurately identify patients who harbor higher risk or more advanced disease, justifying its use in this subgroup of prostate cancer patients.

Methods

After obtaining Institutional Review Board approval we identified 117 patients with NCCN favorable intermediate-risk prostate cancer who underwent ⁶⁸Ga-PSMA PET/CT prior to treatment with radical prostatectomy between the years 2016 - 2020. According to the NCCN definition of favorable intermediate-risk prostate cancer,³ all patients had no high-risk and very-high-risk features and had one of the following intermediate risk factors – clinical stage T2b or T2c, Gleason Grade Group 2 cancer and a PSA value of 10-20 ng/ml. In addition, all patients had <50% positive biopsy cores. Patients with multiple intermediate risk factors were not included in the cohort. Twenty-nine patients who did not undergo pelvic lymph node dissection at time of radical prostatectomy were excluded from the study cohort leaving a total of 88 patients for further analyses.

Baseline patient and tumor characteristics were collected including age, clinical stage based on digital rectal examination, pre-biopsy PSA score (ng/mL), biopsy Gleason Grade Group, total number of biopsy cores obtained and number of positive biopsy cores. The risk

of lymph node involvement (LNI) at radical prostatectomy was calculated for each patient using the nomogram developed by Gandaglia et al.¹¹ which included preoperative PSA, clinical T-stage, biopsy Gleason Grade Group, percentage of cores with highest-grade PCa, and percentage of cores with lower-grade disease.

Prior to treatment, all patients underwent a PET/CT scan with ⁶⁸Ga-PSMA-11 (⁶⁸Ga-HBED-CC) used as the PSMA ligand. PET images were reconstructed by means of an ordered-subsets expectation-maximization algorithm. CT data were used for attenuation correction. Images were reported by high-volume dedicated nuclear medicine readers. Lesions with increased tracer uptake above background were considered positive. We obtained data regarding the number of men identified with PET-positive lymph node on imaging. In patient with positive lymph nodes, we noted the number of positive nodes and the short axis diameter (cm) of the largest lymph node.

All patients underwent robotic assisted radical prostatectomy and bilateral pelvic lymph node dissection. None of the patients received neoadjuvant treatment. Surgical specimens were reviewed by a dedicated genitourinary pathologist and the pathological Gleason Grade Group, presence of extra-capsular extension, seminal vesical invasion and surgical margin status were reported. The total number of lymph nodes obtained, and number of positive nodes were also collected. After surgery patients were followed with serial PSA measurements. PSA persistence was defined as a PSA of ≥ 0.1 ng/mL within 4 to 8 weeks after radical prostatectomy.

The primary study endpoint was the presence of pathologic LNI. Secondary endpoint included adverse pathology at surgery and PSA persistence. Descriptive statistics were used to report baseline clinical characteristics, ⁶⁸Ga-PSMA PET/CT results and findings at radical prostatectomy. The median and interquartile range (IQR) were used for continuous variable. Categorical variables were reported as number and percent. The sensitivity, specificity, and accuracy of ⁶⁸Ga-PSMA PET/CT for the detection of LNI were calculated on a per patient basis with pathologic LNI as the standard reference. Univariable logistic regression analyses were performed to evaluate the association between baseline clinical and pathological characteristics including age, clinical T-stage, PSA, biopsy Gleason Grade Group, percent positive biopsy cores and LNI on ⁶⁸Ga-PSMA PET/CT and the presence of one or more adverse outcomes at radical prostatectomy (pathologic Gleason Grade Group ≥ 3 , extracapsular extension, seminal vesicle invasion, LNI, and PSA persistence). P-values for the univariable logistic regression analyses were adjusted using the Bonferroni method due to multiple testing. Receiver operating characteristic (ROC) curve analyses were performed to evaluate the diagnostic performance of ⁶⁸Ga-PSMA PET/CT and the Gandaglia et al. nomogram in predicting LNI and the areas under the ROC curves were obtained and compared using the DeLong test.¹² All statistical analyses were two-sided, and significance was defined as $P < 0.05$. All analyses were conducted using R Statistical Software (version 3.5.1; R Foundation for Statistical Computing, Vienna, Austria).

Results

The study cohort included a total of 88 men at a median age of 66 years (IQR 61, 69). Clinical stage was T1c in 58/88 patients (66%) and T2a in 30/88 (34%). Median PSA value

was 6.30 (IQR 5.18, 8.50). Most patients (78/88, 89%) had Gleason Grade Group 2 tumors on prostate biopsy. The median estimated risk of LNI at surgery was 2% (IQR 2%, 3%). Patient and biopsy characteristics are reported in Table 1.

Preoperative ⁶⁸Ga-PSMA PET/CT showed uptake in all of the primary prostate lesions and suspicious uptake in lymph nodes in 4/88 patients (5%). Among the 4 patients with suspected node involvement, the median number of suspicious nodes was 1.50 (IQR 1.00, 2.00) and median short axis diameter of suspicious nodes was 8.00mm (IQR 5.50, 10.75), (Table 1). The event rate of a positive finding on ⁶⁸Ga-PSMA PET/CT in our cohort of favorable intermediate-risk patients was 0.05 (4 divided by 88); since the event rate in patients who do not undergo PET-PSMA is zero, on average (number needed to scan = $1/0.05 = 20$) 20 patients would need to be scanned to identify a patient with a positive lymph node on ⁶⁸Ga-PSMA PET/CT.

Surgical pathologic findings are reported in Table 2. The sensitivity, specificity, positive, and negative predictive value for seminal vesicle invasion were 53%, 98%, 70%, 92%, respectively (Table 3). Two patients had pathologic LNI, only one of whom showed ⁶⁸Ga-PSMA PET/CT uptake prior to surgery. The sensitivity, specificity, positive predictive value, and negative predictive value of ⁶⁸Ga-PSMA PET/CT for identifying LNI at radical prostatectomy were 50%, 97%, 25% and 99%, respectively (Table 3) and the area under the ROC curve was 0.73. The area under the ROC curve for the detection of LNI using the predictive nomogram was 0.69 ($p=0.87$ using the DeLong test, Figure 1). After surgery, 4 patients had evidence of PSA persistence. The rate of PSA persistence was higher among patients with LNI on preoperative ⁶⁸Ga-PSMA PET/CT (2/4, 50% vs. 2/84, 2%, $p=0.009$).

Univariable logistic regression analyses did not show an association between the preoperative predictors age, clinical stage, PSA, Gleason Grade Group on prostate biopsy, percent positive biopsy cores and LNI on ⁶⁸Ga-PSMA PET/CT and any adverse outcome at radical prostatectomy after adjusting the p-value due to multiple testing (Table 4).

Discussion

In the current study we evaluated the role of preoperative ⁶⁸Ga-PSMA PET/CT imaging for patients diagnosed with favorable intermediate-risk prostate cancer who underwent radical prostatectomy with lymph node dissection. The rate of positive LNI on imaging was 5%; thus, 20 patients were needed to undergo a scan to identify a positive finding. Moreover, we found a low positive predictive value of 25% for pathologic LNI and a small non-significant increase in the area under the ROC curve compared to preoperative nomogram findings, further questioning the utility of the preoperative scan in this risk group.

Pre-treatment staging for patients diagnosed with prostate cancer is evolving with the advent of improved imaging modalities. Findings from the randomized, multi-center, proPSMA trial support replacing conventional imaging using bone scan and abdominopelvic CT with more sensitive imaging modalities for the initial staging of patients with high-risk PCa. In the trial, ⁶⁸Ga-PSMA PET/CT had higher sensitivity (85% vs. 38%) and specificity (98% vs. 91%) than conventional imaging, translating to a 92% vs. 65% AUC for accuracy, thus favoring ⁶⁸Ga-PSMA PET/CT as the preferred imaging modality. This benefit was consistent for the detection of both pelvic nodal involvement and distant metastases.¹⁰ When

evaluated in the high-risk setting, ⁶⁸Ga-PSMA PET/CT had a good sensitivity and specificity for LNI, possibly impacting clinical decision making. In a contemporary meta-analysis investigating the role of ⁶⁸Ga-PSMA PET/CT for primary staging, the sensitivity and specificity of ⁶⁸Ga-PSMA PET/CT were 77% and 97%, respectively.¹³

The role of ⁶⁸Ga-PSMA PET/CT in the evaluation of patients with lower risk disease is less studied as most publications evaluating the incremental value of ⁶⁸Ga-PSMA PET/CT included mostly high risk prostate cancer patients.^{8,13} Even among studies that included small numbers of intermediate risk patients, they were all diagnosed with unfavorable characteristics,¹⁰ or were recognized only as intermediate risk patients without further data regarding subclassification to favorable or unfavorable risk.¹⁴ None of these published studies reported data or presented the diagnostic characteristics of ⁶⁸Ga-PSMA PET/CT specifically among men with intermediate-risk disease and especially in a group of patients with favorable intermediate-risk prostate cancer. Due to the extensive use of ⁶⁸Ga-PSMA PET/CT in our center we were able to evaluate the performance of ⁶⁸Ga-PSMA PET/CT when used preoperatively in a consecutive cohort of men with favorable intermediate-risk prostate cancer according to the NCCN criteria. In our cohort the sensitivity for LNI was 50%, lower than previously published in cohorts of high-risk disease, and a low positive predictive value was observed (25%), possibly due to the low number of patients who are expected to have nodal involvement given the favorable risk of this group of patients. In addition, as published previously, it is difficult to identify extracapsular extension using ⁶⁸Ga-PSMA PET/CT alone and none of the patients in our cohort were suspected to have a T3a disease preoperatively.¹⁵

Pelvic lymph node dissection based on predefined anatomical templates remains the gold standard for the detection of nodal metastases. Given the potential morbidity associated with this procedure,^{16–18} it should be considered only in men with an increased risk of LNI. AUA guidelines recommend lymph node dissection in every man with unfavorable-intermediate or high risk prostate cancer.⁴ The EAU and NCCN guidelines recommend the use of predictive models to help identify patients with high probability of LNI and use various cut-offs for selecting the appropriate candidates for lymph node dissection.^{3,5} In our cohort, we used the nomogram developed by Gandaglia et al. to evaluate preoperative risk of LNI. The area under the ROC curves of the nomogram and ⁶⁸Ga-PSMA PET/CT did not differ significantly and no benefit was noted when using PET/CT.

In medicine, the concept of number needed to treat is well established, unlike the concept of number needed to image which is less utilized when describing the benefit obtained from an imaging modality.¹⁹ The concept of number needed to image should be further developed to define how many negative imaging tests can be allowed for 1 positive finding, both from the perspective of optimal patient care as well as from the perspective of cost-effective imaging, especially when the positive predictive value is low.²⁰ Physicians aim to avoid advanced imaging in the setting of a low clinical suspicion of finding abnormalities. From a clinical standpoint, according to our findings, ⁶⁸Ga-PSMA PET/CT does not improve the ability to identify patients at a higher risk of LNI, and its implementation in the clinical practice would not substantially alter the number of patients destined to undergo lymph node dissection. Our results demonstrate that currently available nomograms to predict the risk of

LNI are relatively accurate and still play an important role in guiding treatment decisions, and the value of ⁶⁸Ga-PSMA PET/CT in patients with favorable intermediate-risk prostate cancer is questionable.

The study limitations include the small cohort size and the retrospective nature of the study. There was likely a selection bias in patients who had favorable intermediate-risk prostate cancer and underwent ⁶⁸Ga-PSMA PET/CT prior to surgery. This selection bias may explain, in part, the relatively high rate of extracapsular extension observed in our cohort. In addition, the ⁶⁸Ga-PSMA PET/CT scans and biopsy Gleason scores included in the study did not undergo central review; however, they were performed by experienced readers and dedicated genitourinary pathologists. Finally, in the current study we did not have a comparison group of patients who did not undergo imaging, or who underwent imaging using conventional modalities; thus, we were unable to assess the incremental value of ⁶⁸Ga-PSMA PET/CT. However, given the diagnostic characteristics of ⁶⁸Ga-PSMA PET/CT in patients with favorable-intermediate disease, it is unlikely this benefit will be substantial.

Conclusions

Preoperative imaging of favorable intermediate-risk prostate cancer patients using ⁶⁸Ga-PSMA PET/CT showed a low yield for identifying patients with LNI and adverse pathology at prostatectomy. Our findings do not support the routine use of ⁶⁸Ga-PSMA PET/CT in patients with favorable intermediate-risk prostate cancer. Future prospective studies are needed to validate our results.

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Figures and Tables

Figure 1. Receiver operating characteristic (ROC) curves evaluating the diagnostic performance of ⁶⁸Ga-PSMA PET/CT (blue) and the Gandaglia et al nomogram (green) in predicting LNI at radical prostatectomy and pelvic lymph node dissection with the appropriate areas under the curves. AUC: area under the curve; LNI: lymph node involvement.

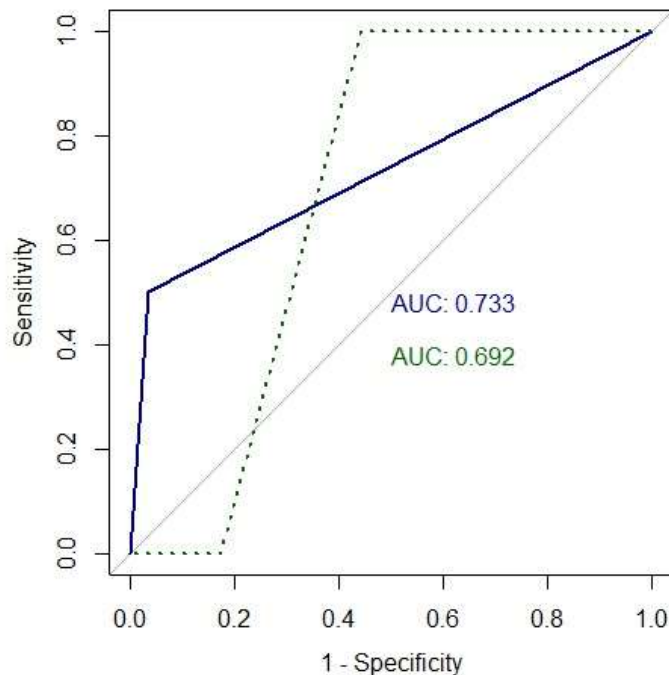


Table 1. Clinical, pathological, and imaging characteristics of the study cohort prior to radical prostatectomy and lymph node dissection (n=88)

Variable		Finding
Age (years)		66.00 (61.00, 69.00)
Clinical stage	T1c	58 (65.9)
	T2a	30 (34.1)
PSA (ng/mL)		6.30 (5.18, 8.50)
Biopsy Gleason grade group	1	10 (11.4)
	2	78 (88.6)
Number of biopsy cores		12.00 (12.00, 14.25)
Number of positive biopsy cores		3.00 (3.00, 5.00)
Percent positive biopsy cores (%)		25 (19, 42)
Estimated risk of lymph node involvement* (%)		2.00 (2.00, 3.00)
Lymph node involvement on PET-PSMA	No	84 (95.5)
	Yes	4 (4.5)
Number of involved nodes on PET-PSMA**		1.50 (1.00, 2.00)

Largest diameter of involved nodes on PET-PSMA (mm)**		8.00 (5.50, 10.75)
Suspected extra-capsular extension on PET-PSMA	No	88
	Yes	0
Suspected seminal vesicle invasion on PET-PSMA	No	80
	Yes	8

Continuous variables are reported as median and interquartile range and categorical variables as number and percent. *Calculated based on the nomogram by Gandaglia et al.¹¹

** Among 4 patients with positive lymph nodes on PET-PSMA. PET: positron emission tomography; PSA: prostate-specific antigen; PSMA: prostate specific membrane antigen.

Table 2. Pathological findings at radical prostatectomy and lymph node dissection (n=88)		
Variable		Finding
Gleason Grade group at radical prostatectomy	1	2 (2.3)
	2	57 (64.8)
	3	29 (33.0)
Extra-capsular extension	No	44 (50.0)
	Yes	44 (50.0)
Seminal vesical invasion	No	77 (87.5)
	Yes	11 (12.5)
Positive surgical margins	No	79 (89.8)
	Yes	9 (10.2)
Pathologic lymph node involvement	No	86 (97.7)
	Yes	2 (2.3)
Total number of lymph nodes obtained at prostatectomy		12.50 (11.00, 16.00)
PSA persistence after surgery	No	84 (95.5)
	Yes	4 (4.5)

Continuous variables are reported as median and interquartile range and categorical variables as number and percent. PSA: prostate-specific antigen.

Table 3. Diagnostic characteristics of PET-PSMA in detecting seminal vesicle invasion and lymph node involvement

	Sensitivity (%)	Specificity (%)	Positive predictive value (%)	Negative predictive value (%)
Seminal vesicle invasion	53	98	70	92
Lymph node involvement	50	97	25	99

PET: positron emission tomography; PSMA: prostate-specific membrane antigen.

Table 4. Univariable logistic regression analyses evaluating the association between pre-operative clinical characteristics and adverse outcomes at radical prostatectomy, including one or more of the following findings: Gleason Grade Group >2, extracapsular extension, seminal vesicle invasion, lymph node involvement, and/or PSA persistence

Variable		OR	95% CI		p	Adjusted p*
Age (per 1 year)		1.074	1.011	1.149	0.027	0.161
Clinical stage	T1c	Ref.			0.528	1
	T2a	0.751	0.307	1.838		
PSA (per 1 ng/mL)		0.954	0.831	1.09	0.481	1
Biopsy Gleason grade group	1	Ref.			0.59	1
	2	1.437	0.372	5.565		
Percent positive biopsy cores (per 1%)		1.176	0.865	1.615	0.304	1
Lymph node involvement on PET-PSMA	No	Ref.			0.743	1
	Yes	0.714	0.082	6.185		

*P-values were adjusted using the Bonferroni method. CI: confidence interval; OR: odds ratio; PET: positron emission tomography; PSA: prostate-specific antigen; PSMA: prostate-specific membrane antigen; Ref: reference.