CUA 2022 Annual Meeting Abstracts – Podium Session 3: Oncology – Prostate

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POD-3.1

The carbon footprint of travel to Canadian Urological Association conferences

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Introduction: Global warming has emerged as one of the greatest threats to habitats and human health in the coming years. Exacerbations of urological conditions, such as urolithiasis and infertility, have been linked to this manmade problem. The significance of the challenge is forcing governments, organizations, and individuals to re-examine policies and habits that address this issue. Pre-pandemic, Canadian Urological Association (CUA) conferences were held annually, alternating between an eastern, central, or western location across Canada. The goal of this study is to examine the carbon footprint of travel to the CUA conference, and whether this is impacted by location.

Methods: Anonymized registrant information was obtained for the attendees of the 2016 (Vancouver), 2018 (Halifax), and 2019 (Quebec City) CUA conferences. Registrant institution was used to estimate the distance that attendees traveled. Industry attendees and registrants without institutional city of origin information were excluded from the analysis. It was assumed that attendees from institutions <3 hours from the conference traveled by car (midrange vehicle, fuel efficiency: 8.42 L/100 km). All other registrants were assumed to have flown (round-trip, economy class, no layovers). Carbon footprint was calculated using an online calculator in tons of CO_2 (tCO_2). Total attendees, number of attendees driving, number of attendees flying, mean distance traveled per attendee (km, round-trip), total carbon footprint, and average carbon footprint were calculated for each conference. Mean carbon footprint, and mean distance traveled were compared using one-way ANOVA, with a Tukey's multiple comparisons test (α=0.05).

Results: Vancouver had the largest number of attendees (n=473; 407 flying, 66 driving), followed by Halifax (n=382; 331 flying, 51 driving), and Quebec City (n=362; 265 flying, 97 driving). The mean distance traveled by attendees was greatest for the Vancouver CUA (6041 km/roundtrip) compared to Quebec City (3096 km/roundtrip, p<0.0001) and Halifax (2985 km/roundtrip, p<0.0001). There was no difference in mean distance traveled between Halifax and Quebec City (p=0.95). The highest total carbon footprint was seen in Vancouver (tCO_2=447.76), followed by Quebec City (tCO_2=217.04), and Halifax (tCO_2=182.22). The average footprint per attendee was significantly higher in Vancouver (mean tCO_2=1.08) compared to both Quebec City (mean tCO_2=0.62, p<0.0001) and Halifax (mean tCO_2=0.52, p<0.0001). There was no difference in the average footprint between Halifax and Quebec City (p=0.63).

Conclusions: The location of a CUA conference has a significant impact on its carbon footprint. While engagement of the entire membership in a large country is a worthy goal when considering the site of CUA conferences, we submit that the environmental impact of such meetings should also be a consideration.

POD-3.2

Effect of ^{18}F-DCFPyL prostate-specific membrane antigen-positron emission tomography/computed tomography on the management of suspected limited residual/recurrent disease following radical prostatectomy: A prospective, multicenter registry trial in Ontario

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Introduction: We aimed to assess disease detection rate of ^{18}F-DCFPyL positron emission tomography/computed tomography (PET/CT) and management changes directed by PET results in patients with suspected limited residual or recurrent disease following radical prostatectomy (RP).

Methods: A total of 1289 patients from six Ontario cancer centers were enrolled, including 487 post-RP. Cohort 1 (C1) (n=72) were node-positive or had prostate-specific antigen (PSA) >0.1 ng/ml post-RP. Cohort 2 (C2) (n=415) had biochemical failure (BCF) post-RP, with 0–4 disease sites on CT and/or bone scan. Management intent (curative or palliative) was collected both pre- and post-prostate-specific membrane antigen (PSMA) PET/CT.

Results: PSMA-PET detected disease in 39/72(54.2%) in C1 and 188/415(45.3%) in C2. In C1 patients with node-positive disease post-RP and PSA <0.1, the detection rate was 16.7% (1/6). For C1 on PET, 22/72(30.6%) had locoregional failure, 11 (15.3%) were oligometastatic, and six (8.3%) had extensive disease. For C2, the respective data were 122/188 (29.4%), 51 (12.3%), and 15 (3.6%). Overall, management change was recorded in 212/487 (43.5%). In 91/474 men (19.2%), there was a management intent change ("intent" data unavailable in 13). In C1, 13% changed from curative to palliative intent and 10.1% from palliative to curative. For C2, 5.4% changed from curative to palliative and 13.1% from palliative to curative intent. The most common management changes for both cohorts were: 1) conversion from observation or systemic therapy to salvage radiation or surgery for locoregional disease (68/487,13.9%); and 2) addition of node-directed therapy (65/487, 13.3%).

Conclusions: Compared with standard imaging, PSMA-PET detected additional disease sites in approximately 50% of patients with BCF and suspected low-volume metastatic disease, often resulting in management change. Significantly, PSMA-PET led to therapeutic intent change in 20% of men. Long-term followup will determine if PSMA-PET will impact eventual disease outcome in patients with suspected limited residual/recurrent disease following RP.

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POD-3.3

Predictors of adverse outcomes for patients with high-risk and very high-risk prostate cancer undergoing radical prostatectomy: Results from the Canadian High-risk Prostate Cancer Collaboration

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Introduction: Radical prostatectomy (RP) for the management of patients with localized prostate cancer (PCa) has varied outcomes depending on initial clinical risk group. Even within the same risk groups, the short- and long-term outcomes for patients undergoing treatment for high- and very high-risk diseases are very variable. We describe predictors of adverse outcomes in patients undergoing RP for high- and very high-risk PCa.

Methods: This multi-institutional, retrospective study describes outcomes of patients from seven Canadian academic institutions who underwent RP for high-/very high-risk PCa. Primary endpoints were postoperative detectable prostate-specific antigen (PSA) (≥0.1 ng/mL), pathologic stage ≥T3a, lymph node disease, development of metastases, and castrate-resistant prostate cancer (CRPC). Logistic regression and Cox proportional-hazards models were used to identify prognostic indicators.

Results: A total of 702 patients who underwent RP between 2005 and 2016 were evaluated. Preoperative characteristics are shown in Table 1. Short-term outcomes included postoperative detectable PSA, pathological T stage ≥3a, and lymph node involvement. Predictors of postoperative detectable PSA and pathological lymph node involvement are shown in Figures 1 and 2, respectively. Postoperatively, 17.7 % of patients were no longer high-/very high-risk; 38.9% of Gleason scores were downgraded, while 18.7 % were upgraded. Postoperative outcomes are shown in Table 2. Undetectable PSA was achieved in 72.6% (510) of patients, development of metastases occurred in 10.4%, and development of CRPC in 5.7%, with 5.3% all-cause mortality at a median followup of 3.6 years. Development of metastases was predicted by clinical node involvement (hazard ratio [HR] 4.39, p<0.05), pathological node involvement (HR 2.08, p<0.05), and detectable postoperative PSA (HR 5.79, p<0.001). The same features were predictive of CRPC, with clinical node involvement being the strongest predictor (HR 10.7, p<0.01).

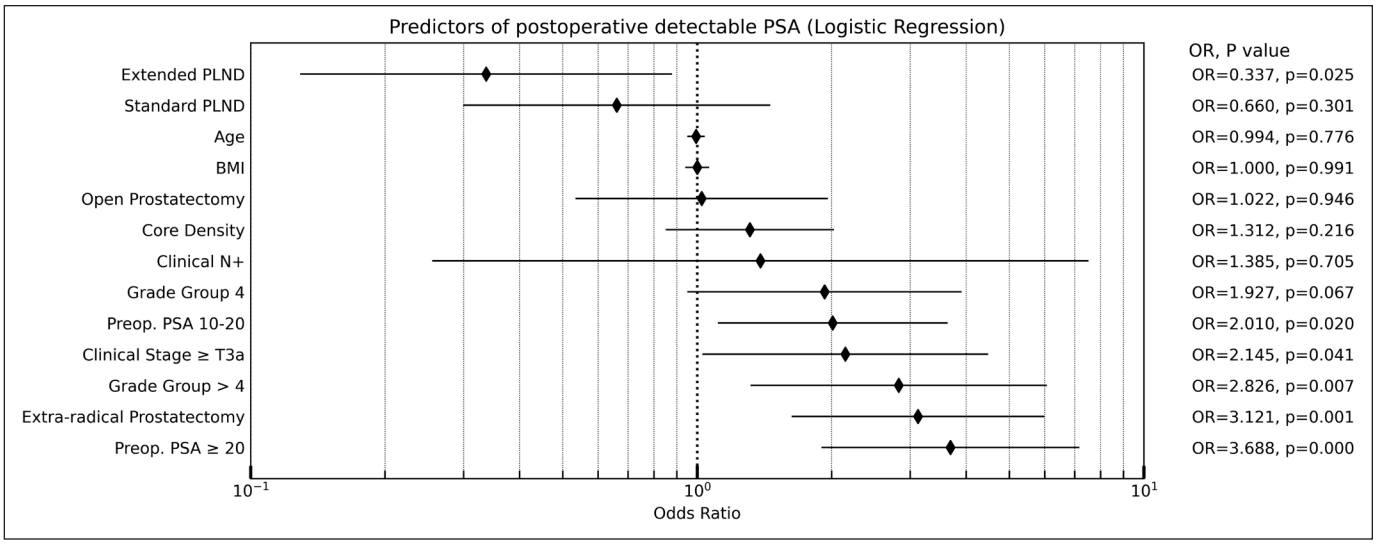
Conclusions: When evaluating patients preoperatively, PSA ≥20 ng/mL is the biggest risk factor for detectable postoperative PSA. Extended pelvic lymph node dissection was protective against postoperative detectable PSA. Clinical and pathological node-positive status, as well as detectable postoperative PSA, are strongly predictive for the development of metastases and CRPC. We hypothesize that in the era of novel therapies, patients with these risk factors should be considered for escalated treatment.

POD-3.3. Table 1. Preoperative characteristics

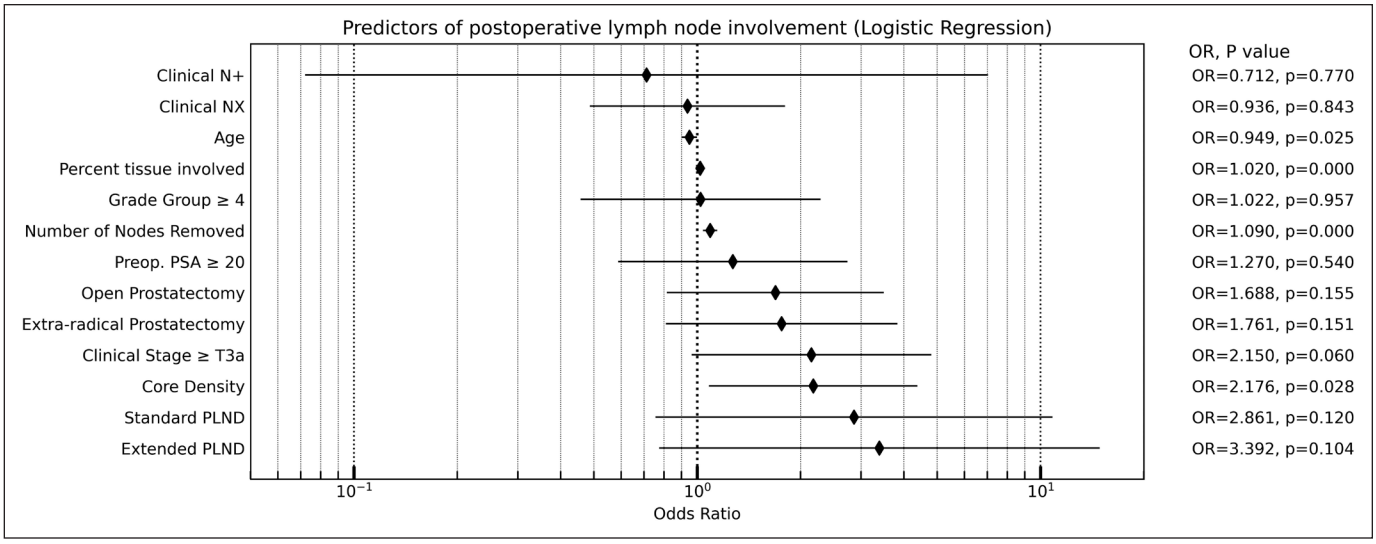
	Total (n=702)
Age (mean & range)	63.4 (41–80)
BMI (mean & range)	28.6 (17.0–42.8)
Grade group	
<4	176 (25.1%)
4	349 (49.7%)
>4	172 (24.5%)
Preoperative PSA	
Preop. PSA <10	388 (55.3 %)
Preop. PSA 10–20	148 (21.1 %)
Preop. PSA ≥20	163 (23.2 %)
Clinical T stage	
T1–T2a	452 (64.4%)
T2b–T2c	153 (21.8%)
T3a	61.0 (9.0%)
>T3a	12 (1.7%)
Clinical N stage	
cN0	400 (57.0%)
cN+	11 (1.6%)
cNX	291 (41.5%)
Biopsy cores	
Percentage tissue involved (mean)	41.18
Core density (mean)	0.53
Surgical approach	
Open prostatectomy	258 (36.8%)
Robotic prostatectomy	297 (42.3%)
Extra-radical prostatectomy	118 (16.8%)
Pelvic lymph node dissection	
No PLND	96 (13.7%)
Standard PLND	494 (70.4%)
Extended PLND	107 (15.2%)
Nodes removed (mean & range)	8.3 (0–48)
Complications	
Any complications	135 (19.2%)
Clavien ≥3	72 (10.3%)

POD-3.3. Table 2. Postoperative outcomes

Outcome	Total (n=702)
PSA	
<0.1	510 (72.6%)
≥0.1	165 (23.5%)
Unknown	27 (3.8%)
Gleason score	
7	382 (54.4)
8–10	299 (42.6%)
Pathologic T stage	
T2	169 (24.1%)
T3a	311 (44.3%)
>T3a	190 (27.1%)
Pathologic N stage	
N0	526 (74.9%)
N+	84 (12.0%)
NX	92 (13.1%)
Surgical positive margins	272 (38.7%)



POD-3.3. Figure 1. Predictors of postoperative detectable PSA. Preoperative PSA ≥20 ng/mL, grade group >4, and clinical T stage ≥3a were highly predictive of a postoperative detectable PSA. Extended pelvic lymph node dissection was a protective factor against postoperative detectable PSA.



POD-3.3. Figure 2. Predictors of postoperative lymph node involvement. Percentage of tissue involved on biopsy and core density on biopsy were predictive of lymph node involvement. Number of nodes removed during pelvic lymph node dissection was also predictive of lymph node involvement. Lymph node disease preoperatively identified on CT was not a good predictor of pathologic lymph node involvement.

POD-3.4

A urinary exosome assay interrogating small non-coding RNAs accurately identifies and stratifies prostate cancer into low-, intermediate-, or high-risk disease

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Introduction: The miR Sentinel® Test measures the expression of 442 small non-coding RNAs (sncRNAs) extracted from urinary exosomes to differentiate patients with no molecular evidence of prostate cancer (NMEPCa) from those with molecular evidence of prostate cancer (MEPCa). The test further classifies men with MEPCa into low-, intermediate- or high-risk disease. We compared the results of the miR Sentinel® PCC4 Test to systematic and magnetic resonance imaging (MRI)-guided core needle biopsy in men at risk for prostate cancer undergoing biopsy.

Methods: A total of 763 biopsy-naive men over 45 years of age undergoing systematic and/or targeted biopsy were recruited. sncRNAs were isolated from urinary exosomes and interrogated by RT-qPCR on a custom-designed OpenArray platform.

Results: The molecular classification was compared to the biopsy grade group (Table 1). Sensitivity for NPEPC or grade group (GG) 1 vs. GG 2–5 was (75+18+4+105=203)/221=92.2% and the negative predictive value for absence of GG 2–5 PCa was (221+64+12+123=420)/(238+200=420)=96%. The apparent false-positive rate for GG 2–5 cancer was (34+35+32+22=(123)/(543)=23%. A total of 208 patients had discordant systematic and targeted biopsies; 29 of these had a negative systematic biopsy and a positive targeted

POD-3.4. Table 1. Sentinel Test cross-validation study vs. grade group

Pathology-based classification systematic/MRI guided biopsy	Total participants		Sentinel risk classification frequency counts			
			NMEPCa	Low	Intermediate	High
NPEPCa	354	543	221	64	34	35
GG1	189		12	123	32	22
GG2	97	220	0	4 (2%)	75	18
GG3-GG5	123		5 (2.1%)	9 (4.5%)	4	105
Total	763		238	200	145	180

POD-3.4. Table 2. Results of the Sentinel score among 47 patients with discordant results between their systematic and targeted biopsies

		Sentinel risk classification frequency counts			
	Number	NMEPCa	Low	Intermediate	High
A. Systematic negative; MRI-guided positive					
GG1	14	2	8	3	1
GG2	7	0	0	7	0
GG3-GG5	8	0	1	0	7
Total	29	2	9	10	8
B. Systematic positive; MRI-guided negative					
GG1	14	0	8	3	3
GG2	3	0	0	3	0
GG3-GG5	1	0	0	0	1
Total	18	0	8	6	4

biopsy (Table 2). The molecular test predicted the targeted biopsy outcome in 27/29=93.1% overall, and in 14/15 (93%) of the cases with GG 2–5 cancer. In the 18 patients with positive systematic and negative MRI-targeted biopsies, the test result predicted the positive biopsy in 100%.

Conclusions: The miR Sentinel Test offers an accurate, non-invasive means to accurately identify the presence or absence of prostate cancer and classify risk status to predict pathological grade on biopsy. The high predictive accuracy of the test in patients whose systematic and targeted biopsies were discordant suggests that the 23% discordance between the negative biopsy result and the positive Sentinel Test result was, in most cases, due to false-negative biopsies.

POD-3.5

Prostate Cancer-Patient Empowerment Program (PC-PEP) randomized clinical trial: Results of a six-month intervention designed to reduce the burden of mental health among patients with curative disease

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Introduction: Curative prostate cancer often co-occurs with poor mental health and elevated side-effects.[1,2] Here, we examined the effects of a six-month, online, home-based intervention, Prostate Cancer–Patient Empowerment Program (PC-PEP), on reducing psychological distress and need for treatment among men with curative disease treated with radical prostatectomy or radiation therapy.

Methods: A randomized controlled trial was conducted involving 128 men with biopsy-proven prostate adenocarcinoma. Men were randomly assigned to receive the PC-PEP intervention (n=66) or standard of care (n=62) for six months. Non-specific psychological distress measured at baseline and at six months, measured using Kessler Psychological Distress Scale, was the primary outcome. Total and cuffoff (≥20) scores were assessed in covariate-adjusted analyses

Results: All 128 men completed the study (Table 1). Statistically significant interactions (time by condition) on non-specific psychological distress revealed that patients who received the intervention had significantly lower psychological distress than controls at six months (Figure 1). Patients in the control condition had 3.35 (95% confidence interval 1.06–10.52) times higher odds of screening positive for clinical non-specific psychological distress and need for treatment than men who received the intervention.

Conclusions: Results support the integration of PC-PEP to complement the standard of care and help reduce the burden of mental health of patients with curative disease.

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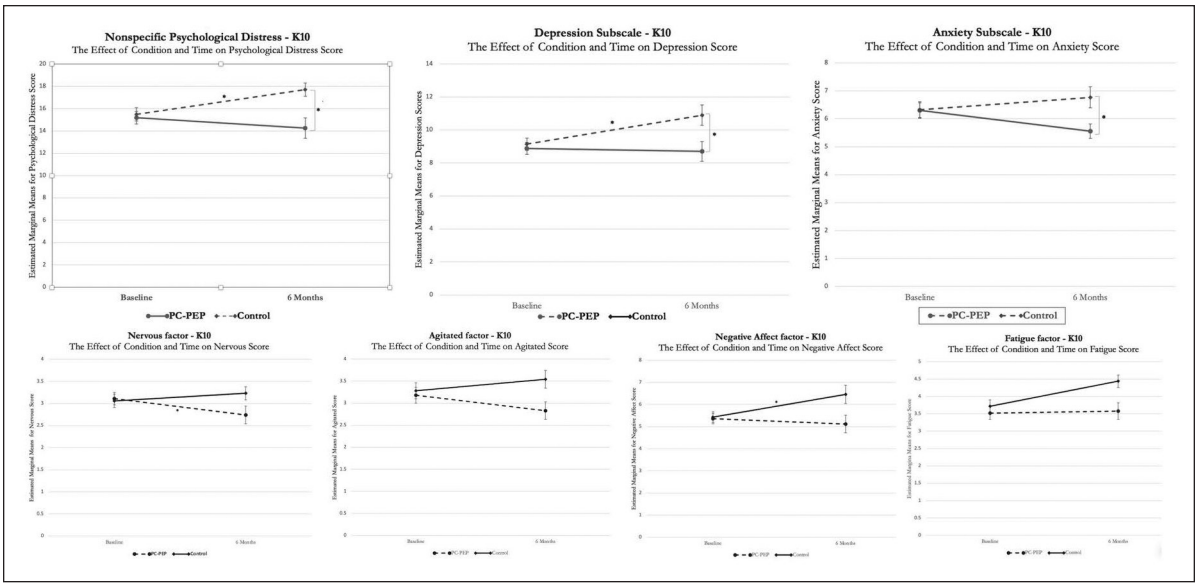

POD-3.5. Figure 1. Effects of PC-PEP interaction on non-specific psychological distress, depression and anxiety subscales, and factors showing the specific makeup of a patient's psychological distress (nervous, agitated, fatigue, and negative affect) from baseline to 6 months among 128 curative prostate cancer patients treated in Nova Scotia, Canada. Note: *p<0.05. Standard error bars are shown. Covariates appearing in the model are evaluated at the following values: currently on prescribed mediation for depression, anxiety, or both at baseline=0.1484, Charlson Comorbidities Index age adjusted at baseline=2.5469, time between randomization and treatment (days)=67.2734, treatment modality= 1.5156, relationship status at baseline=0.94.

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POD-3.6

Prostate cancer of Indigenous men in Canada — identifying differences in diagnosis and treatment within a universal healthcare system

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Introduction: In Canada, Indigenous Peoples have higher morbidity rates and a lower life expectancy than non-Indigenous Canadians.[1] Prostate cancer (PCa) detection occurs less often and with worse overall survival in Indigenous men than other Canadians.[2] Data from the Alberta Prostate Cancer Research Initiative (APCaRI) shows ~1% of men diagnosed and treated for PCa in Alberta are Indigenous, despite Indigenous Peoples comprising 5.1% of Alberta's population. The objective of this study was to identify differences in PCa diagnosis and treatment between Indigenous and non-Indigenous men.

Methods: Men were prospectively enrolled in the APCaRI registry between June 2014 and July 2021. We compared the age, prostate-specific antigen (PSA), and Gleason grade group (GGG) at diagnosis, time from biopsy to treatment decision, treatment choices, and number of patients with metastases between Indigenous and non-Indigenous men with PCa in Alberta. Statistics were calculated using SPSS version 25 (Armonk, NY: IBM Corp.).

Results: A total of 64 Indigenous patients and 6242 non-Indigenous patients had data available for analysis. The mean age was 63.7 (standard deviation [SD] 7.2) vs. 64.3 (SD 7.8) years (p=0.26), and the median PSA was 8.7 vs. 7.4 ng/mL (p=0.02) between Indigenous and non-Indigenous men, respectively. Time from biopsy to treatment decision was 10.7 (SD 6.6) vs. 12.1 (SD 9.6) weeks (p=0.33). GGG stratification revealed 20.4% vs. 36.7% GGG 1, and 79.6% vs. 63.3% GGG 2–5 (p=0.01), respectively. Active surveillance was less common (18.4% vs. 30.5%), while radiation therapy was more common (44.9% vs. 28.7%) in Indigenous men, with pooled analysis of treatment choices significantly differing between groups (p<0.01). Indigenous men were more than twice as likely to be diagnosed with metastases (odds ratio 2.25, 95% confidence interval 1.11–4.60).

Conclusions: PCa diagnosis and treatment differ between Indigenous and non-Indigenous men. Indigenous men present with higher-grade tumors and increased rates of metastasis. Despite similar age, Indigenous men presented with higher median PSA at the time of PCa diagnosis. These data suggest potential differences in rates of PCa screening between Indigenous and non-Indigenous men.

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POD-3.5. Table 1. Sample characteristics at baseline between the Prostate Cancer–Patient Empowerment Program (PC-PEP) intervention and control wait-list groups, among 128 prostate cancer patients undergoing curative-intent treatment in Nova Scotia, Canada

	Overall (n=128)	PC-PEP Intervention (n=66)	Control (n=62)
Age, n, mean (SD)	128, 66.22 (7.05)	66, 65.42 (6.84)	62, 67.06 (7.23)
Body mass index, n, mean (SD)	128, 28.62 (4.98)	66, 28.78 (4.96)	62, 28.45 (5.04)
Household Income, >30 000 CAD/past year, n, %	106, 82.8%	54, 81.8%	52, 83.9%
Race, White, n, %	121, 94.5%	60, 90.9 %	61, 98.4%
Education, university or above, n, %	68, 53.1%	31, 47.0%	37, 59.7
Relationship status (married/currently in a relationship), n, %	120, 93.8%	59, 89.4%	61, 98.4%
Stage of cancer at randomization			
Risk category (RP+primary RT±HT)*, n, %			
Low	3, 2.3%	1, 1.5%	2, 3.2%
Intermediate	82, 64.1%	42, 63.6%	40, 64.5%
High	31, 24.2%	13, 19.7%	18, 29.0%
PSA at time of relapse (salvage RT), mean (SD)	12, 8.71 (3.49)	10, 9.02 (3.77)	2, 7.19 (0.30)
Post-COVID** enrolment, n %	101, 78.9%	51, 77.3%	50, 80.6%
Prescribed ADT n, %	48, 37.5%	27, 40.9%	21, 33.9%
Treatment modality			
Radical prostatectomy	62, 48.4%	29, 43.9%	33, 53.2%
Radiation therapy	54, 42.2%	27, 40.9%	27, 43.5%
Radiation therapy (salvage)	12, 9.4%	10, 15.2%	2, 3.3%
Charlson Comorbidity Index age adjusted, n, mean (SD)	128, 2.55 (1.07)	66, 2.45 (1.13)	62, 2.64 (1.03)
Current cigarette smoker, n, %	8, 6.3%	5, 7.6%	3, 4.8%
Time between randomization and treatment (days), n, mean (SD)	128, 67.27 (38.52)	66, 64.41 (36.68)	62, 70.32 (40.45)
Currently taking medication for depression, anxiety or both at baseline, n, %	19, 14.8%	12, 18.2%	7, 11.3%
No evidence of cancer recurrence at 6 months after randomization, n, %	121, 94.5%	63, 95.5%	58, 93.3%

Note: There were no statistically significant differences between the two arms at baseline for any of the sociodemographic or medical covariates. *National Comprehensive Cancer Network (NCCN). **The COVID pandemic restrictions began in the Canadian Maritime Provinces: Nova Scotia, New Brunswick, and Prince Edward Island on March 16, 2020. HT: hormone therapy; PC-PAP: Prostate Cancer-Patient Empowerment Program: RP: radical prostatectomy; RT: radiation therapy.