Poster Session 6: Oncology–Prostate (Part 2)
Friday, October 10, 2025 • 7:00–8:00 am

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Abstract #75

The impact of NCCN-compliant multidisciplinary conference on treatment decisions for men who are 70 years or older localized prostate cancer

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Introduction: We sought to investigate the impact of National Comprehensive Cancer Network (NCCN)-compliant multidisciplinary conference on the treatment decisions of men who are 70 years or older with prostate cancer.

Methods: Retrospective review of our database was performed. Patients who sought a second opinion at a comprehensive cancer center (2010–2023) were presented to the multidisciplinary Localized Prostate Cancer Conference (LPCC) that includes urologists, radiation oncologists, pathologists, and patient advocates. LPCC recommendations were compared with recommendations by the community urologists and the final treatment received by the patient. Cochrane Armitage test was used to examine trends over time.

Results: A total of 259 patients were identified (3% NCCN very low-risk, 17% low-risk, 21% intermediate favorable-, 30% intermediate unfavorable, 29% high/very high-risk); 34% were recommended AS, 33% were recommended surgery, and 70% were recommended radiation by the community as the preferred option compared to 49%, 31%, and 50%, respectively, by LPCC. AS, radiation, and surgery were elected by 49%, 20%, and 27%, respectively; 4% patients elected ADT.

Conclusions: For men who are 70 years or older, AS recommendation increased significantly over time by community urologists ($p<0.01$) and to a higher extent by NCCN-compliant multidisciplinary conference ($p=0.03$). The uptake of AS significantly increased within the same period ($p=0.01$) (Figure 1).

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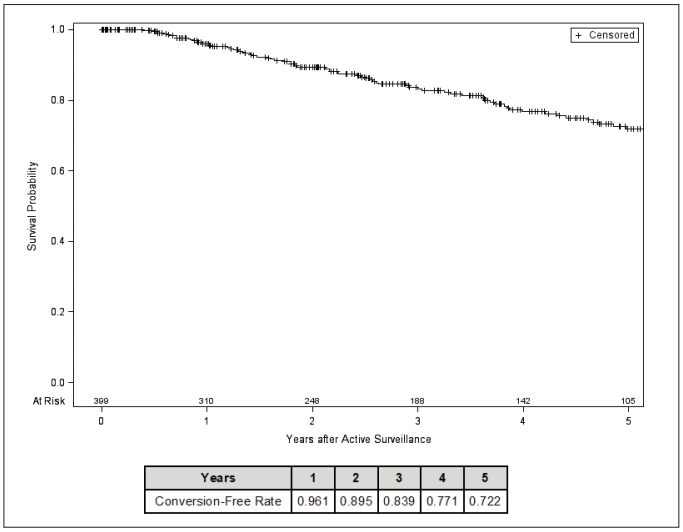

Years	1	2	3	4	5
Conversion-Free Rate	0.961	0.895	0.839	0.771	0.722

Abstract #75. Figure 1. Treatment conversion-free survival.

Abstract #76

Divergent recovery patterns in breast and prostate cancer screening following COVID-19 disruption: A retrospective analysis of over 600 000 eligible patients

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Introduction: This study sought to examine rates of breast and prostate cancer screening and evaluate changes pre-COVID pandemic, during the pandemic, and post-vaccination period, with attention to comparing trends across this timeframe.

Methods: For each quarter (Q) in 2017 Q1–2023 Q3, we used electronic health records data from a single, large health system to identify patients who were eligible for prostate and breast cancer screening. Eligible patients were assessed for whether they were screened using PSA lab records or mammography procedures. We collected patient information, including age, race, ethnicity, area deprivation index, rural-urban commuting area codes, insurance status, and the Charlson comorbidity index. First, we used multilevel, multivariable logistic regression to calculate case-mix adjusted probabilities of screening over time. Then, we used interrupted time series analysis on the probabilities to assess the effects of the COVID-19 pandemic on screening. We compared screening trends from pre-pandemic to the height of the pandemic (2020 Q2–2020 Q4) and to the COVID-19 vaccination period (2021 Q1–2023 Q3).

Results: Our study evaluated between 147 517–206 777 and 482 742–577 112 patients eligible to be screened per quarter for prostate and breast cancer, respectively. Patients had a 1.9% absolute decrease in probability of prostate cancer screening at the start of the pandemic ($p<0.05$). Absolute screening probability recovered in the vaccination period and was not significantly different from pre-pandemic; however, there was a statistically significant decrease in the slope of prostate cancer screening comparing pre-pandemic to post-vaccination. Patients had a 5.1% absolute decrease in probability of breast cancer screening at the start of the pandemic ($p<0.05$). For breast cancer, the absolute screening rate in the vaccination period was not significantly different from pre-pandemic, and there was not a statistically significant difference in the pre-pandemic to post-vaccination slope.

Conclusions: In a single, large health system, both breast and prostate cancer screening rates decreased with the COVID pandemic and recovered after vaccination. The trend of prostate cancer screening after the vaccination period is declining, while the slope of breast cancer screening is unchanged from pre-pandemic and continues to trend upwards.

Abstract #77

The association of previous cancer history with the incidence of prostate cancer harboring germline mutations

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Introduction: Prostate cancer (PCa) is the most common cancer in men and is the second leading cause of cancer-related mortality in men in the U.S. It is estimated that 10–15% of PCa cases are due to germline mutations. PCa with germline mutation is generally more biologically aggressive and is associated with worse clinical outcomes. Therefore, it is crucial to understand factors that may influence the risk of PCa with germline mutations. We assessed the impact of a prior cancer diagnosis.

Methods: Data were extracted from the Myriad Collaborative Research Registry (MCRR) for patients with a PCa diagnosis who received germline testing (MyRisk; starting September 2013) through Myriad Genetics. Variables included age of diagnosis, family and personal history of cancer, U.S. region, and germline mutation status. Patients were categorized based on whether they had no prior cancer diagnosis, one prior diagnosis, or 2+ prior diagnoses. A logistic regression model assessed the factors associated with a positive germline mutation.
Results: The total number of PCa patients included in the analysis was 42 643. Overall, 12.4% of PCa patients tested positive for a germline mutation; 10.5% of patients with no prior cancer history had a positive germline mutation, significantly less than the 15.1% of patients with one previous diagnosis ($p<0.001$) and 17.5% with 2+ previous diagnoses ($p<0.001$). The most significant difference was seen in patients with a history of colon cancer, where 8.6% of those with a positive germline mutation previously had colon cancer, while only 5.3% of those negative for a germline mutation did ($p<0.001$). In the logistic regression model, a prior diagnosis of ureteral cancer (OR 5.61, CI 2.33–13.5), bladder cancer (OR 1.53, CI 1.19–1.97), sarcoma (OR 2.51, CI 1.15–5.50), and colon cancer (OR 1.53, CI 1.37–1.72) was statistically significantly associated with a germline mutation.
Conclusions: PCa harboring germline mutations is associated with a prior diagnosis of cancer, specifically genitourinary cancers such as bladder and ureteral cancer, as well as colon cancer and sarcomas. These results emphasize the need to perform germline mutation testing in patients with a prior cancer history.

Abstract #78

Glucagon-like peptide-1 receptor agonists for the prevention of genitourinary cancers: A systematic review of observational studies

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Introduction: Glucagon-like peptide-1 receptor agonists (GLP-1 RAs) are drugs used to treat type 2 diabetes and obesity. Emerging evidence suggests potential anti-tumor properties on genitourinary cancers; however, no systematic reviews have synthesized evidence from observational studies investigating this potential link. Thus, this study aimed to systematically search and describe observational studies investigating the association between GLP-1 RAs and the incidence of genitourinary cancers.
Methods: We systematically searched MEDLINE, Embase, and Web of Science from January 1, 2005, through October 31, 2024. Eligible studies included English-language observational research assessing genitourinary cancer risks in GLP-1 RA users with relevant comparators.
Results: Six observational studies met the inclusion criteria, all involving patients with type 2 diabetes. Some studies compared GLP-1 RAs with multiple antihyperglycemic drug classes, such as metformin, sodium-glucose cotransporter-2 (SGLT-2) inhibitors, sulfonylureas, and insulin. Two studies focused on bladder cancer, one on kidney cancer, three on prostate cancer, and one on urothelial cancer. The reported hazard ratios (HRs) varied widely: for bladder cancer, HRs ranged from 0.85–1.10 (vs. metformin and SGLT-2 inhibitors, respectively); for kidney cancer, HRs ranged from 0.76–1.54 (vs. insulin and metformin, respectively); for prostate cancer, HRs ranged from 0.91–1.05 (vs. sulfonylureas); and for urothelial cancer: HR was 1.05 (vs. sulfonylureas). Variability in findings likely reflects heterogeneity in study designs, the choice of the comparators, and methodologic limitations, such as residual confounding and time-related biases.
Conclusions: This review highlights inconsistent findings on the link between GLP-1 RAs and genitourinary cancers. While emerging evidence suggests potential anti-tumor effects of GLP-1 RAs, additional well-designed, observational studies are needed to address methodologic challenges.

Abstract #79

Capsular abutment on MRI as a predictor of aggressive disease in prostate cancer

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Introduction: Multiparametric MRI is crucial for guiding prostate biopsies and detecting clinically significant prostate cancer, although its routine use in clinical staging is debated. Prior studies have examined MRI's role in detecting extraprostatic extension (EPE), with inconsistent results. While EPE indicates aggressive disease, capsular abutment on MRI has not been well-examined as a predictor of pathologic outcomes. We aimed to evaluate if capsular abutment serves as a prognostic marker for identifying aggressive prostate disease.
Methods: A retrospective review was conducted on patients who underwent robot-assisted laparoscopic radical prostatectomy (RP) with preoperative prostate MRI at a single institution from 2021–2023. MRI reports were assessed for capsular abutment, ECE, seminal vesicle invasion (SVI), and lymph node invasion. Demographic and clinical data and tumor characteristics, including ECE, SVI, lymph node metastasis, cribriform pattern, intraductal carcinoma, and positive margins, were recorded. Associations between capsular abutment, demographic and clinical factors, and tumor pathology were evaluated using univariate and multivariable logistic regression models.
Results: Among 128 patients, 45 (33.8%) exhibited capsular abutment on prostate MRI. This group had significantly higher PSA density (0.17 vs. 0.13, $p=0.007$) and a greater frequency of cribriform pattern on biopsy (44.4% vs. 26.8%, $p=0.04$). Gleason pattern 4 (GP4) percentage was also higher (52% vs. 30%, $p=0.03$). Capsular abutment was significantly correlated with MRI-detected ECE and SVI on MRI, with 81.2% of ECE and 100% of SVI cases exhibiting abutment. In 35.6% of cases with capsular abutment, ECE was undetected on MRI but confirmed on final pathology. Univariate analysis showed significant associations between capsular abutment and higher GP4 percentage (OR 5.08, 95% CI 1.19–21) and lymph node metastasis (OR 8.70, 95% CI 0.94–8.1), although these were not statistically significant in multivariable analysis. Seven patients with capsular abutment had biochemical recurrence (BCR), with a median time to BCR of 12.5 (4.1–22.63) months (Table 1).
Conclusions: Capsular abutment on MRI may indicate more aggressive tumor characteristics, such as cribriform pattern, increased GP4, and lymph node metastasis. While associations with GP4 and lymph node metastasis were significant in univariate analysis, they didn't hold in multivariable analysis. Capsular abutment may have potential as a marker for aggressive prostate cancer, warranting validation in larger cohorts.

Abstract #80

Evaluating disease volume in prostate biopsy as a predictor of adverse pathology: Comparison of bilateral disease and positive core count in prostate cancer

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Introduction: We aimed to evaluate the importance of volume of disease on positive prostate biopsy (PB) core count. We compared the presence of bilateral disease and number of positive core count to predict adverse pathology on radical prostatectomy (RP).
Methods: We reviewed patients who underwent robot-assisted RP between January 2021 and September 2023. Data was collected on demographic and surgical pathologic characteristics. Adverse pathologic features were defined as extraprostatic extension (EPE), seminal vesicle invasion, lymph node metastasis, cribriform, or intraductal carcinoma (IDC). We compared patients with bilateral vs. unilateral biopsy-detected PCa. We also evaluated the predictive power of adverse pathology for TR and TP biopsies. One hundred twenty-seven patients (67.9%) underwent TR and 60 patients (32.1%) underwent TP biopsy. Predictive accuracy was analyzed using ROC curve analysis. We further assessed through a multivariable logistic regression model. Based on the ROC analysis, we identified a cutoff of >7 positive biopsy cores as a threshold for increased risk of adverse pathology.
Results: Of 186 patients, 71 (38.2%) had bilateral PCa, and 82 (44.3%) had ≥7 positive biopsy cores. Patients with bilateral disease or ≥7 positive cores exhibited significantly higher preoperative PSA levels ($p=0.05$) and greater incidence of cribriform morphology ($p=0.001$). Higher GG was more frequently observed in

Abstract #79. Table 1. Patient demographics and clinical data, tumor characteristics

	Capsular abutment presence		
	Yes	No	P.
Total (%)	**45 (33.8)**	**83 (62.4)**	
Clinical Characteristics			
Continuous Varibles n , (1-3 IQR)			
Age(years)	68(61.5-70.5)	67(61-70)	0.58
BMI(Kg/m2)	30.1(27.1-32.7)	28.5 (25.9-31.7)	0.19
PSA (ng/ml)	7.2 (5.4-9.96)	6.3 (4.49-8.89)	0.39
PSAD	**0.17(0.13-0.31)**	**0.13(0.08-0.21)**	**0.007**
Categorical Variables n, (%)			
Race			0.72
White	41(35.9)	73 (64)	
Black	4(40)	6(60)	
Grade Group			0.07
2	24 (28)	61 (71.7)	
3	15 (48.3)	16 (51.6)	
4	6 (50)	6 (50)	
Bilateral Disease			0.79
yes	18(35.2)	33(64.7)	
No	27(35.5)	49(64.4)	
Biopsy Cribiform			**0.04**
yes	**20 (47.6)**	22 (52.38)	
No	25 (29.4)	60 (70.6)	
Imaging Characteristics n, (%)			
PIRADS Score			**0.0001**
0 - 3	1	38 (97.4)	
4 - 5	44 (49.4)	45 (50.5)	
Extracapsular Extension			**0.0001**
Yes	**13 (81.2)**	3 (18.75)	
No	29 (26.60)	80 (73.3)	
Seminal Vesicle Involvement			**0.01**
Yes	**3 (100)**	0	
No	42 (33.6)	83 (66.4)	
Lymph Node Involvement			0.24
Yes	2	1	
No	43 (34.4)	82 (65.6)	
Surgical Outcomes n, (%)			
RP Tumor percentage	0.10 (.10-.23)	0.10 (0.05-0.20)	0.1
GP4 percentage	**0.52 (0.20-0.70)**	**0.30(0.10-0.60)**	**0.03**
Extraprostatic Extension			0.15
Yes	24 (38)	38 (61.3)	
No	16 (27.1)	43 (72.8)	
Seminal Vesicle Extension			0.97
Yes	3	6	
No	37 (33)	75 (66.9)	
Lymph Node Metastasis			**0.02**
Yes	4 (80)	1 (20)	
No	36	0	
Cribiform on Path			0.1
Yes	33 (37)	56 (62.9)	
No	7 (21.2)	26 (78)	
Intraductal Carcinoma			0.09
Yes	16 (44.4)	20 (55.5)	
No	24 (28.9)	59 (71)	

patients with bilateral disease (p=0.03), compared to those with ≥7 positive cores (p=0.09). Multivariable analysis identified several factors independently associated with intraductal carcinoma (IDC) on final pathology, including GG (OR 2.87, 95% CI 1.66–4.96), ≥7 positive cores (OR 1.13, 95% CI 1.03–1.12), and bilateral disease (OR 2.6, 95% CI 1.23–5.46). Additionally, ≥7 positive cores was associated with EPE (OR 1.95, 95% CI 1.06–1.95), although bilateral disease did not show a significant association with EPE. Comparing biopsy methods, TR biopsy approach demonstrated superior performance in detecting EPE relative to TP biopsy (Table 1).

Conclusions: Disease volume in PB was a significant predictor of adverse pathology. Bilateral disease and a higher number of positive core count independently correlated with worse pathologic outcomes, such as IDC and EPE, regardless of GG. Notably, a greater number of positive core count was particularly effective in predicting EPE.

Abstract #80. Table 1. Presence of bilateral disease and number of positive core count categorized by clinical, imaging, and surgical characteristics

	Bilateral Disease			Number of Positive Cores		
	No	Yes	P	<=6	>=7	P
Total (%)	**115 (61.8)**	**71 (38.17)**		103(55.7)	82(44.3)	
Grade Group (%)			**0.03**			0.09
2	70 (57)	51 (42.2)		73(60)	48(39.6)	
3	35 (77.7)	10 (22.2)		23(52.2)	21(47.7)	
4	11 (52.3)	10 (47.6)		7(35)	13(65)	
Cribiform morphology (%)			**0.001**			**0.001**
No	88(75.9)	37(52.1)		79 (63.7)	45(36.2)	
Yes	27(23.3)	**34(47.9)**		23(38.3)	37 (61.6)	
Age (1-3 IQR)	67(61-71)	66(61-70)	0.58	67(60-70)	67(62-70)	0.48
BMI (1-3 IQR)	28.8(26.2-32.2)	29.2(26.9-32.7)	0.64	28.37 (25.8-32.4)	29.7 (27.3-32.7)	0.57
Size (1-3 IQR)	40(29-57.9)	36.5(29-48.2)	0.34	41 (28.6-57)	37 (29.2-49)	0.55
PSA (1-3 IQR)	**5.91(4.6-8.5)**	**7.25(5.4-10.6)**	**0.05**	**5.7 (4.5-8.3)**	**7.2 (5.5-10.6)**	**0.002**
PSAD (1-3 IQR)	0.15(0.10-0.21)	0.19(0.12-0.33)	0.2	0.15 (0.10-0.22)	0.19 (0.11-0.32)	0.14
Imaging						
MRI (%) Yes	77 (61.1)	49 (38.8)	0.63	69 (54.7)	57 (45.2)	0.61
PIRADS (%)			0.08			**0.005**
1 to 3	26(72)	10(27)		26 (74.3)	9 (25.7)	
4 to 5	48(57)	38(45.2)		40 (46.5)	46 (53.5)	
Extraprostatic Extension	7	9	0.12	7	9	0.32
Seminal Vesicle Invasion	1	2	0.33	2	1	0.71
Lymph Node Metastasis	2	1	0.82	3	0	0.12
Surgical Outcomes (1-3 IQR)						
Tumor Percentage	.10(0.05-0.20)	0.15(0.10-0.25)	0.12	**0.10 (0.05-0.20)**	**0.15 (0.10-0.30)**	**0.001**
Gleason 4 Percentage	0.30(0.18-0.70)	0.40(0.15-0.65)	0.94	0.30 (0.10-0.60)	0.40 (0.20-0.70)	0.06
Extraprostatic Extension (%)			**0.03**			**0.001**
No	58(50)	24(33.8)		64 (79)	17 (21)	
Yes	58(50)	47(66.2)		39 (37.5)	**65 (62.5)**	
Seminal Vesicle Invasion (%)			0.93			0.76
No	105(90.5)	64(90.1)		97 (57.7)	71 (42.2)	
Yes	11(9.5)	7(9.9)		6 (35.2)	11 (64.7)	
Lymph Node Metastasis (%)			0.1			0.19
No	109(94)	61(85.9)		97 (57.3)	72 (42.6)	
Yes	7(6)	9(12.7)		6(40)	9(60)	
Cribiform (%)			0.81			**0.02**
No	28(24.3)	87(75.7)		31 (70.4)	13 (29)	
Yes	16(22.9)	54(77.1)		71 (51)	68 (49)	
Intraductal Carcinoma (%)			**0.007**			**0.01**
No	86(74.1)	40(57.1)		77 (61.6)	48 (38.4)	
Yes	27(23.9)	30(42.9)		23 (41)	33 (59)	

Abstract #82

Comparing infection rate following transrectal and transperineal prostate biopsy

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Introduction: Transperineal prostate biopsy is a well-accepted alternative to transrectal biopsy, with similar cancer detection rates. It also allows for omission of antibiotic prophylaxis; however, recently published randomized control trials demonstrate conflicting results regarding post-biopsy infection rates. We sought to compare infection rate, severity, and timing following transperineal vs. transrectal prostate biopsy with a multisite cohort.

Methods: We conducted a multisite, retrospective cohort study of adult men who underwent transrectal prostate biopsy with antibiotic prophylaxis or trans-

perineal prostate biopsy without antibiotic prophylaxis from 2020-2021. Patients missing 30-day followup information were excluded. The primary outcomes were 30-day urinary tract infection rate and severity. Low severity infection was defined by fever, lower urinary tract symptoms with pyuria or bacteriuria treated outpatient. Moderate severity was defined as infection requiring hospital admission, or bacteremia not meeting sepsis criteria. High severity was defined as sepsis with sequential organ failure assessment score ≥2. Cox proportional hazard regression was performed to examine the effect of biopsy type on infection risk, adjusting for age, body mass index (BMI), race, biopsy type, and presence of diabetes.

Results: A total of 892 men were identified; 616 (69%) men underwent transrectal biopsy, 276 (31%) underwent transperineal biopsy. The overall infection rate was 5.2% in the transrectal group and 1.8% in the transperineal group. Of the 32 infections in the transrectal group, 15 (47%) were low-severity, 12 (38%) moderate-severity, and five (16%) high-severity. Of the five infections in the transperineal group, all were low-severity. The median time to infection was two days post-biopsy (IQR 1-5) in the transrectal group and six days (IQR 2.5-11.5) in the transperineal group. In the regression analysis, there was no significant difference in odds ratio for prostate biopsy type (odds ratio [OR] 0.47, 95% confidence interval [CI] [0.01-1.71]) (Table 1).

Conclusions: Our real-practice findings demonstrate no significant difference in infectious complications following transperineal vs. transrectal prostate biopsy with antibiotic prophylaxis, although transperineal biopsy had an overall lower infection rate and severity with zero septic events.

Abstract #82. Table 1. Regression analysis

	Odds of infection, OR (95% CI)	p
Age	0.970 (0.915, 1.029)	0.3054
BMI	1.053 (0.989, 1.115)	0.0912
Hospital		
Location 1	Ref	
Location 2	0.970 (0.353, 2.992)	0.9547
Location 3	0.440 (0.118, 1.582)	0.2046
Race (Non-white)	0.814 (0.213, 2.438)	0.7352
Smoking	1.209 (0.324, 3.545)	0.7503
Diabetes	1.585 (0.585, 3.852)	0.3320
Immunosuppression	0.784 (0.042, 4.158)	0.8186
Prior infection	3.424 (0.163, 25.653)	0.2963
Prior biopsy	0.667 (0.254, 1.569)	0.3763
Biopsy type	0.466 (0.095, 1.705)	0.2954
Antibiotics	2.042 (0.457, 11.225)	0.3734

P-values generated from logistic regression model.

Abstract #83

"Cancer care crossroads": The effect of rurality on patient attitudes and decision-making related to surgical prostate cancer care

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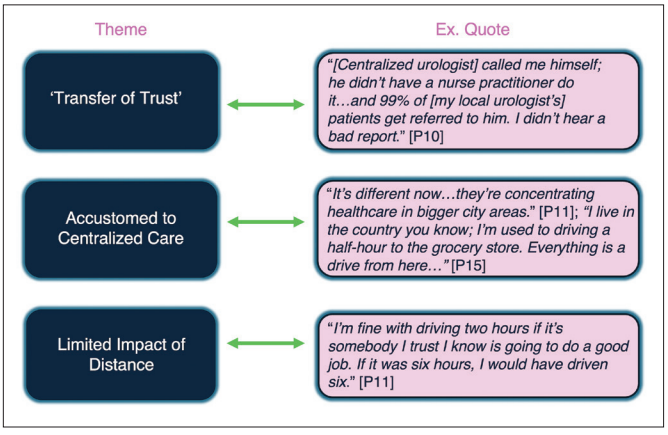
Introduction: Previous studies have shown that rurality significantly impacts treatment choice for prostate cancer, with patients in rural areas less likely to opt for surgery — citing distance from a treatment facility as influencing decision-making; however, the specific factors that influence patients' decision-making for prostate cancer treatment choice, during the narrow window of diagnosis to when a treatment plan is made, as well as patients' own meta-perceptions of rurality's impact on barriers to prostate cancer surgical care, is not well-understood. We use qualitative methodology as a flexible, granular research instrument to elucidate rural-urban patient perspectives related to prostate cancer surgical decision-making.

Methods: Patients receiving surgical prostate cancer care at a single National Cancer Institute Comprehensive Cancer Center, serving both urban/rural populations across Western Pennsylvania and its four neighboring states, were recruited from two high-volume surgeons at a centralized academic cancer center. We conducted 20 semi-structured interviews, recruiting up to thematic saturation, with 10 urban and 10 rural patients classified according to U.S. Census Tract/RUCA data. The interviews were then transcribed, de-identified, and coded with two independent coders using qualitative analysis software (NVivo 14.0), with thematic analysis using a hybrid deductive-inductive approach.

Results: The mean round-trip travel time was 152 minutes: 95 minutes for urban patients and 211 for rural patients. Themes included: 1) 'transfer of trust' from community to centralized providers; 2) the impact of centralization on patients' healthcare and driving distance; and 3) the limited impact of travel time on decision-making: "I'm fine with driving two hours, even six, if it's somebody I trust is going to do a good job." (P11) (Figure 1). Moreover, thematic analysis revealed current gaps in provider counseling, and aspects of treatment decision-making that helped patients feel a sense of agency and relief.

Conclusions: This is the first study, to our knowledge, that aims to understand qualitatively the impact and nuances of rurality on prostate cancer patient attitudes and surgical decision- making, laying the groundwork for exploring broader themes of inter-provider transfer of trust, sources of anxiety from time of diagnosis until a treatment plan is executed, patients' perceptions of the risks and benefits of prostate cancer treatment options, and provider referral patterns, among others.



Abstract #83. Figure 1. Themes.

Abstract #84

Objective evaluation of the quality of nerve-sparing at robot-assisted radical prostatectomy

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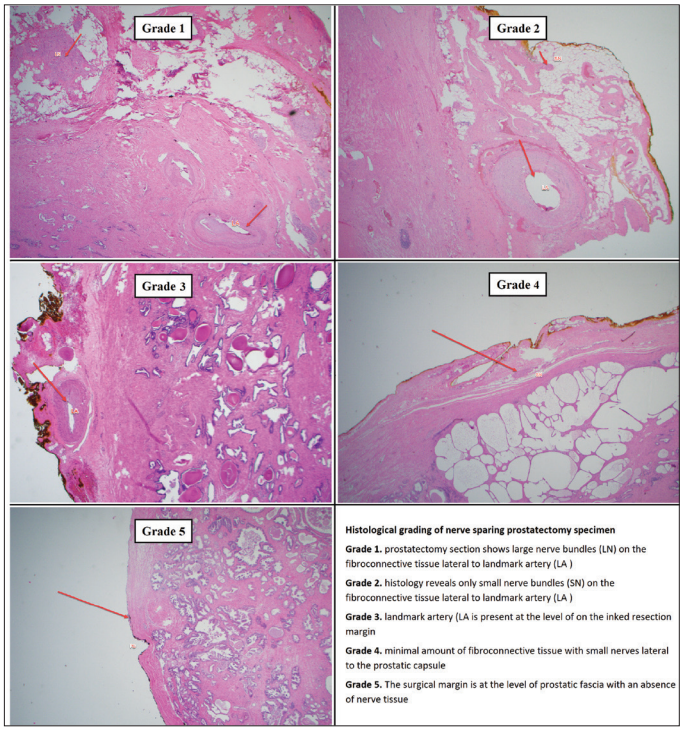
Introduction: We aimed to objectively evaluate the quality of nerve-sparing during robot-assisted radical prostatectomy (RARP) by analyzing post-radical prostatectomy histologic specimens for the presence of a neurovascular bundle.

Methods: Forty-four radical prostatectomy histologic specimens were retrospectively reviewed by an experienced genitourinary pathologist at Roswell Park Comprehensive Cancer Center, who was blinded to the patients' nerve-sparing status. Nerve-sparing status was assessed using a grading score ranging from 1–5 (1: no nerve-sparing, 5: 95% nerve-sparing). Adequate nerve-sparing was defined as grade 3 or higher. Concordance between surgeon-reported nerve-sparing and histologic nerve sparing was assessed using the Fisher exact test.

Results: Among the 44 specimens, six (13.5%) underwent non-nerve-sparing RARP, six (13.5%) underwent unilateral nerve-sparing, and 32 (73%) underwent bilateral nerve-sparing RARP yielding a total of 70 preserved nerves and 18 non-preserved. Among nerve-sparing sides, 44 (63%) were scored as grade ≥3 (at least 50% of nerves preserved). Among non-nerve-sparing sides, nine (50%) were scored as grade 1–2 nerve-sparing (Figure 1). Concordance for nerve-sparing achieved statistical significance (p=0.04); concordance for the non-nerve-sparing group was not significant (p=1.00).

Conclusions: Histologic evaluation of the quality of nerve-sparing is feasible and provides an objective means of evaluation of the quality of nerve-sparing.

Funding: Roswell Park Alliance Foundation.



Abstract #84. Figure 1. Histological grading of nerve-sparing prostatectomy specimen.

Abstract #85

The impact of NCCN-compliant multidisciplinary conference on the outcomes of active surveillance for men with localized prostate cancer

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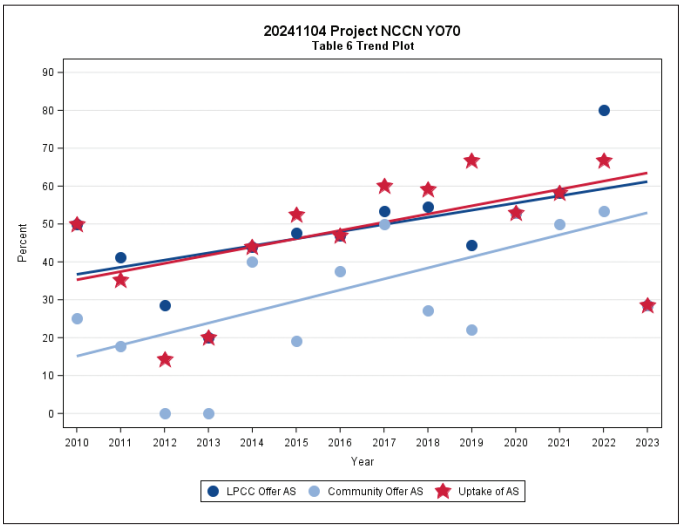
Introduction: We sought to investigate the impact of National Comprehensive Cancer Network (NCCN)-compliant multidisciplinary conference on the uptake and outcomes of active surveillance (AS) among eligible patients with prostate cancer.

Methods: Retrospective review of our AS database was performed. Patients who are eligible for AS who sought a second opinion at a comprehensive cancer center (2010–2023) were presented to the multidisciplinary Localized Prostate Cancer Conference (LPCC) that includes urologists, radiation oncologists, pathologists, and patient advocates. Kaplan-Meier analysis was used to depict treatment-free survival (TFS).

Results: A total of 593 patients were identified (18% NCCN very low-risk, 34% low-risk, and 48% intermediate favorable-risk); 46% were recommended AS as the preferred option by the community compared to 74% by LPCC, and 71% elected AS. Recommending AS significantly increased between 2010 and 2023 by the community (from 24% to 67%) and by LPCC (from 53% to 94%), while the proportion of men who received AS increased from 52% to 88% during the same period (p<0.0001 for all). Among those who elected AS, median followup was 3.64 (IQR 1.55–6.27) years. TFS was 90% and 72% at two and five years, respectively (Figure 1). Only one patient developed metastasis.

Conclusions: AS recommendation increased significantly over time by community urologists and to a higher extent by NCCN-compliant multidisciplinary conference. The uptake of AS significantly increased within the same period. At five years, the chance of discontinuing AS is 28%.

Funding: Roswell Park Alliance Foundation.



Abstract #85. Figure 1. Trend plot.