Informed Prostate Cancer Support Group Inc.
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NOVEL CORONAVIRUS PROTECT YOURSELF

Thursday, September 16, 2021

SEPTEMBER 2021 NEWSLETTER

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STREAMING ONLINE LIVE

Volume 14 Issue 09

• Saturday, Sept 18, 2021 IPCSG - Live-Stream Event, 10:00am PT
Transrectal v. Transperineal Biopsy Alternative

- Richard J. Szabo, MD is a clinical associate professor in the Department of Urology at University of California, Irvine and is on staff at Kaiser Permanente Orange County and Riverside, California. He has written extensively about the new transperineal approach and has a special interest in teaching "free-hand" transperineal prostate biopsy under local anesthesia to his colleagues and informing the general public of the technique's advantages over the transrectal approach.
- Due to COVID-19, no in-person meetings at the Sanford Burnham Prebys Medical Discovery Institute will take place until further notice. This meeting will be live-streamed and will also be available on DVD.
- **For further Reading: https://ipcsg.blogspot.com/**
- **For Comments, Ideas and Questions,** email to Newsletter@ipcsg.org

• Saturday, August 28, 2021 IPCSG - Live-Stream Event, 10:00am PT
Jane Shellhouse - Nutrition and lifestyle strategies for all ages, that support growth, development, and healthy aging.

Summary by Bill Lewis

Jane Shellhouse, C.N., CNM is a healthcare practitioner in Placentia CA who focuses on a patient-centered, personalized approach to preventative care that takes into account physical, mental and emotional aspects, including beliefs, attitudes and motivations that play a major role in overall wellness. She is a 20-year survivor of colon cancer, with no radiation treatments – only surgeries – and using functional medicine.

She offers hope and programs that help with the multiple problems people often have. Many people buy over-the-counter supplements, but 20% absorption is typical. She uses specially formulated nutraceuticals that have 80% absorption.

She recommends finding a "clinical nutritionist," that can offer needed testing to get at the root of what the patient really needs. She is available for meetings via Zoom to discuss concerns.

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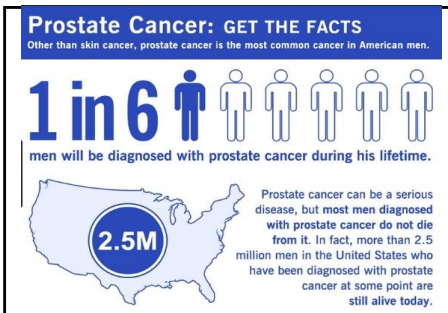

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a 501c3 non-profit organization - all positions are performed gratis

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Stephen Pendergast ..... Editor

NEWSLETTER

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PROSTATE CANCER—*2 WORDS, NOT A SENTENCE*

What We Are About

Our Group offers the complete spectrum of information on prevention and treatment. We provide a forum where you can get all your questions answered in one place by men that have lived through the experience. Prostate cancer is very personal. Our goal is to make you more aware of your options before you begin a treatment that has serious side effects that were not properly explained. Impotence, incontinence, and a high rate of recurrence are very common side effects and may be for life. Men who are newly diagnosed with PCa are often overwhelmed by the frightening magnitude of their condition. Networking with our members will help identify what options are best suited for your life style.

Meeting Video DVD's

DVD's of our meetings are available for purchase on our website at https://ipcsg.org/purchase-dvds and are generally available by the next meeting date.

Join the IPCSG TEAM

If you consider the IPCSG to be valuable in your cancer journey, realize that we need people to step up and HELP. Call **President** Bill Lewis @ (619) 591-8670 ; or **Director** Gene Van Vleet @ 619-890-8447.

From the Editor

Due to COVID-19, no in-person meetings will be held until further notice. We will continue to post and distribute the newsletter in the interim. Our speaker this month will be broadcast via the IPCSG website at https://ipcsg.org/live-stream and can be watched by scrolling down and clicking on the "WATCH THE PRESENTATION" button. The broadcast will begin approximately 10 minutes before to the listed start time.

In this issue:

First, we have Bill Lewis's great summary of the last talk by Jane Shellhouse, followed by Articles of Interest

- *A Proclamation on National Prostate Cancer Awareness Month, 2021 President* Joe Biden describes the national significance of PCa. He follows with a description of what men can do, and some re-sources available. There is a lengthy discussion of research efforts to cure PCa.
- *The challenge of finding new tools to fight prostate* cancer Firstly de-scribes how PCa can be either relatively harmless and typically overtreated, or deadly and incurable; genome sequencing technol-ogy is now able to classify it.
- Comparison between 18F-*DCFPyL PET and MRI for the detection of transition zone prostate cancer* Looks back at MpMRI versus F18 PET/MRI imaging in localizing PCa tumors, and determines that the later is more effective. It is the first FDA-approved / commercially available PSMA PET imaging agent for prostate cancer, and is called Pylarify or simply Pyl.

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In her office, she offers nutritional testing through a "plethysmography" (body composition, including how well you digest and absorb your food, hydrate at the cell level, red blood cell lifespan, and caloric burn rate) method, blood and urine testing, stool testing and stress testing (cortisol level) using saliva. She always works in the office of an MD or (currently) a Chiropractor to be able to order all the needed tests, and is not able to take insurance. Due to a CA mandate, she is not a diagnostician, but someone who teaches prevention and avoidance of recurrence. She is approved by Health Savings Plans.

Case studies were discussed. One patient was sent to Dr. Duke Bahn in Ventura for scans, prior to a recommended prostatectomy. Dr. Bahn found that surgery might not be needed, and did repeat scans over time that confirmed the cancer was not aggressive. Jane provided him with zinc of two types, Vitamin D with K1 and K2 for absorption, magnesium buffered chelate, a highly-absorbably multivitamin without iron or copper (a chelated version by Albion Labs), Vitamin C, DIM (diindolylmethane, which keeps testosterone from converting into estrogens, to keep aromatase issues under control), and Oncoplex (a product developed by Johns Hopkins Hospital, and sold exclusively through one of her suppliers). After 10 years, the cancer was almost non-existent.

Dr. Bahn has retired, but his replacements are Dr. Benjamin Johnson, M.D. and Dr. Jamil Muasher, M.D., still in Ventura, CA – at 805-585-3082. Color Doppler ultrasound scans are also offered at Prostate Oncology Specialists, in Marina del Rey.

Food suggestions: Avoid beer, because hops promote prostate cancer growth. Red wine would be better, but all alcohol turns effectively to sugar, which is bad for cancer. She recommends fatty fish, such as salmon or mackerel (despite some mercury contamination), very limited red meat (which increases testosterone, which then can convert to undesirable estrogens, and also promotes diabetes), chicken or turkey and fresh organic eggs (up to 2 daily). She doesn't like dairy foods, since most of the protein molecules are large and hard to break down. Goat or sheep milk products are much easier to digest. Avoid processed foods, luncheon meats (except from Trader Joe's). She recommends a plant-based diet (greens and fruit and moderate carbohydrate starches), but considers plant-based protein drinks that have the essence of the plants in them to be an acceptable alternative for those who really cannot stick with the whole-plant approach. Nutritionists can get them for you, since they are not available in regular stores. Freshly.com offers nutritious prepared meals. She likes a protein bar called a One Bar that has 20 grams of protein, and only one gram of sugar, and comes in many flavors.

Balance is very important.

Glutamine, an essential amino acid, crosses the blood-brain barrier and decreases dopamine levels. It can thus help reduce cravings for sugar and the compulsions of alcoholics or cigarette smokers. She recommends ¾ teaspoon of powder once or twice a day (from Sprouts, Trader Joe's, or a health food store).

She has handouts that she uses for in-person talks, that you may request from her.

Questions:

What about multi-day fasting? She believes that people need to eat good foods throughout the day, but should stop eating early in the evening. Most people with cancer appear to be nutritionally deficient, so should eat regularly. Eating only one meal a day tends to promote conversion to fat.

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What about whey protein powder after exercising? Pea and rice-based powders may be better. But she does like protein after exercising.

How many eggs? They are a perfect protein. One or two a day would be fine, unless you have a cholesterol problem.

What about caffeine with protein powder? She would just use coffee, but no more than two cups a day.

What about barley malt or blackstrap molasses instead of sugar? She considers the molasses healthy, but the barley malt less so. She often recommends organic honey or maple syrup, but using it in small quantities. What about agave? A little is OK, but honey seems to be healthier. Sweeteners should only be used in very small amounts.

Is your nutritional advice also applicable after a prostatectomy and subsequent recurrence? Yes, there's a lot you can do nutritionally to help yourself.

What about fat-free milk? She feels that 2% is fine, relatively speaking, but as previously noted, the proteins in cow's milk are difficult for us to break down.

What about processed food, such as meat-substitute products? She does not like them. And she has many patients avoid gluten, because then their test results improve, and they feel better.

Regarding glutamine, would you take it daily, or only when you feel a sugar craving? It's part of her nutritional program, and is taken every day. It really helps to restore the lining of the gut if taken for a long period of time.

Comments on different types of fish? She has a handout from the environmental defense fund. Wild-caught salmon is best, albacore tuna, atlantic mackerel, etc.

Catfish and falafia? Catfish is a bottom feeder, and falafia is imported, so both are likely unhealthy.

Postscript: Three things that Jane notes are very bad for prostate cancer; Highly saturated food, alcohol, and multiple sex partners. Who knew?

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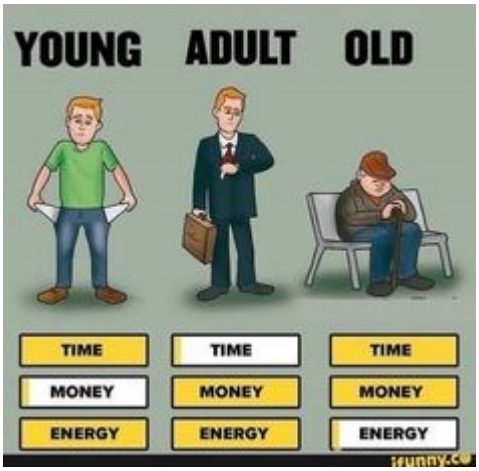
We recommend that you watch the video online for more definitive information about the talk and slides: https://www.youtube.com/watch?v=cx6NtQLj33U

A DVD of the talk and Jane Shellhouse's slides will be available for purchase from the IPCSG about one month after the meeting.

On the Lighter Side



Articles of Interest

A Proclamation on National Prostate Cancer Awareness Month, 2021

In 2021, over 248,500 Americans have been diagnosed with prostate cancer. Even as we make tremendous advancements in cancer research and treatment, prostate cancer is the second most commonly diagnosed cancer and the second-leading cause of cancer deaths among our Nation's fathers, sons, husbands, and brothers. Today, one in eight men in the United States will be diagnosed with prostate cancer in his lifetime — often without any previous signs or symptoms. During National Prostate Cancer Awareness Month, we rededicate ourselves to supporting those diagnosed with prostate cancer through research, education, and access to prevention, treatment, and follow-up care and support. Together, we can increase awareness of this cancer, and improve the care and well-being of those impacted by this disease.

Awareness of the risk factors of prostate cancer can help men make informed choices about their health with their primary health care providers — especially for men over the age of 65, men who have a family history of prostate cancer, and Black men who have a higher chance of developing and suffering from prostate cancer. I encourage all men and their families to learn the latest information on prostate cancer at www.cancer.gov/types/prostate and www.cdc.gov/cancer/prostate. I also encourage every American to get recommended cancer screenings, check-ups, and treatments from your health care providers. Most importantly, talk to your doctor about your risks for developing prostate cancer.

My Administration continues to push for groundbreaking discoveries and innovative treatments to end cancer as we know it. That is why I am working to create an Advanced Research Projects Agency for Health at the National Institutes of Health — or ARPA-H — which would invest 6.5 billion dollars to develop breakthroughs that prevent, detect, and treat cancer and other deadly diseases.

I am also committed to funding research to expand prevention and treatment of prostate cancer specifically. Today, researchers funded by the National Cancer Institute are working to advance our understanding of how to prevent, detect, and treat prostate cancer. The National Institutes of Health and partners in the private sector have launched the largest-ever coordinated research effort to investigate environmental and genetic factors related to prostate cancer to better understand why it disproportionately impacts Black men. And we are working on methods to prepare more advanced early detection tests and clinical trials to develop and enhance treatments for all men.

My Administration will also continue to protect and fight to build on the Affordable Care Act (ACA) and the important protections it provides for all Americans, including for men with prostate cancer. The ACA prohibits insurance companies from restrictive annual dollar limits on benefits, and it prohibits insurers from denying coverage or charging higher premiums to patients with prostate cancer — or any other pre-existing medical condition. The ACA also helps ensure that every man with prostate cancer receives quality health care.

Our Nation has made exceptional progress in the fight against cancer, and I am committed to doing everything I can to bring together the knowledge, as well as the human and financial resources necessary to advance that progress. We owe every person who has lost their battle with this disease, every person living with this disease, and every person who may one day be diagnosed with it, our continued work to defeat it. During National Prostate Cancer Awareness Month, let us renew our efforts to save lives and spare suffering by accelerating our work to end cancer as we know it.

NOW, THEREFORE, I, JOSEPH R. BIDEN JR., President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim September 2021 as National Prostate Cancer Awareness Month. I encourage citizens, government agencies, private businesses, nonprofit organizations, and other interested groups to join in activities that will increase awareness of what Americans can do to prevent and cure prostate cancer.

IN WITNESS WHEREOF, I have hereunto set my hand this
thirty-first day of August, in the year of our Lord two thousand twenty-one, and of the Independence of the United States of America the two hundred and forty-sixth.

JOSEPH R. BIDEN JR.

The challenge of finding new tools to fight prostate cancer

. arstechnica.com

Erin Biba - 9/9/2021, 5:30 AM

What's next —

Why prostate cancer is so hard to study—and how researchers are overcoming that.

In the US, September is National Prostate Cancer Awareness Month. This feature highlights why catching prostate cancer early can be critical, and what researchers are doing to improve the odds of controlling the disease once it's found.

Prostate cancer is a paradox. It has one of the highest early-stage survival rates of any cancer, yet it's the second most common cause of cancer death in the US among people with a prostate (behind only lung cancer). Localized prostate cancer, only found in the organ itself, is highly curable. But once it becomes metastatic, spreading beyond the prostate, it is incurable and leads to death.

This makes studying it complicated. How do you understand something that is at once easy and impossible to cure? Researchers tackling the paradox are harnessing technologies like imaging, genetic sequencing, big data, and artificial intelligence to work toward changing outcomes for patients across the spectrum of cancer severity. From understanding what makes the cancer develop in the first place to identifying new drugs and new methods of treatment—each innovation is an opportunity to save lives. Here's a look at just a few of the countless projects in progress around the world that could one day change the treatment landscape for prostate cancer.

Quantifying the paradox

The 10-year life expectancy for localized prostate cancer is around 98 percent. It's remarkably curable. Many prostate tumors are so slow-growing and nonthreatening, they're not even treated—they're simply monitored to make sure they stay nonthreatening. "You're more likely to die with prostate cancer than of prostate cancer," says Dr. Isla Garraway, director of research in the Department of Urology at the University of California, Los Angeles (UCLA).

But once the cancer becomes metastatic, that prognosis changes completely. Treatments can improve a patient's quality of life and increase their lifespan, but eventually the cancer will become resistant to all treatments and turn fatal. According to Dr. Yaw Nyame, an attending physician and assistant professor of urology at the University of Washington: "For most [prostate] cancers, when you are diagnosed because you have symptoms it's oftentimes a sign that your disease is really advanced. If you have pain, or blood in the urine, or difficulty emptying your bladder, it's likely you have advanced cancers." In other words, the danger is compounded by the fact that there are no symptoms until it's too late to cure.

Meanwhile, the prevalence of the disease is staggering. About 1 in 8 people with a prostate (depending on who you ask) will be diagnosed in their lifetime. So far in 2021, the US has seen roughly 248,530 new cases and about 34,130 deaths.

Estimates of the percentage of metastatic cancers run from 5 to 10 percent, but the huge number of overall cases means that even the low-end estimate will ultimately mean a lot of cancer that resists treatment.

And the CDC says the percentage is on the rise, which means it's more important than ever for science to solve the problem of incurable metastatic prostate cancer.

Understanding the underlying causes

"For cancer researchers in general, we're always seeking out the origins. Where does it start, what cells does it start in, how is it co-opting the processes of normal cells to evade the immune system or invade areas where it shouldn't be?" says UCLA's Dr. Garraway. "Just like other cancers, the whole idea is to understand the biology of the prostate tumors better so you can find the Achilles heel of that tumor."

The challenge, Garraway tells Ars, is that for a long time, research into what causes prostate cancer growth was focused on the indolent (or slow-moving) versions of the disease that were curable. More surgeries removed slow-growing tumors, leaving researchers with more access to these tissue samples. Metastatic patients were less likely to undergo surgery because their cancers had spread to other parts of their body, so those samples were studied less often.

"For those 10 percent or so who are destined to have this metastatic disease, at least half of them already had spreading of their cancer at diagnosis," she says. "They weren't surgical candidates, so we weren't capturing their tissues. And it's a challenge to get enough tissue from a metastatic lesion."

Recent advances in technology have changed that reality. Over the past decade, Garraway says next-gen genome sequencing technology has allowed scientists to classify and analyze minuscule amounts of tissue. Doctors can now use a small needle to collect "a very tiny little piece of tissue," creating a paradigm shift in the study of lethal prostate cancer.

A look at prostate stem cells

It's now possible to ask whether there are factors that mark high-risk tumors early on. Garraway compares these tiny samples of metastatic tumor cells to non-cancerous prostate tissue, hoping they can provide a clue as to the cause of the former's aggressive behavior.

She does this by focusing on the stem cells normally found in the prostate, which can generate any cell type in this tissue (though, unlike embryonic stem cells, they can't generate any other tissues). But stem cells show up in prostate tumors, too. Garraway hypothesizes that these prostate-specific stem cells might have features that make tumors more dangerous. Comparing the genes that are active in both prostate stem cells and cancers "gave us ideas about how these more aggressive cancers are co-opting benign stem cell traits. The stem cell's primitive embryonic-type properties can facilitate infestation and spreading," she says.

Because prostate stem cells can generate new glands, they're really good at moving around and invading other parts of the body. "And they're more hardy. They can survive things differentiated cells can't survive," Garraway says. "They're resistant to radiation and chemotherapy, and they can survive damage to their DNA. We think activating these survival mechanisms supports tumor initiation."

Garraway and her collaborators took healthy prostate tissue samples, sorting the cells by the different proteins they make, and identified if the cells have traits like the ability to regenerate prostate tissue. The results were compared to ones generated using the stem cells found in the metastatic tumor samples. "This is where it gets interesting," says Garraway. It turned out that both benign tissue and the tumor cells expressed a protein called Keratin 13. That protein was very rare in most healthy tissues, but, "we almost always saw [it] in biopsies that had metastatic disease," she says.

Before this, the researchers thought Keratin 13 was what Garraway called a "run of the mill" protein that simply helped give a cell shape and stiffness. But they knew some keratins can also play a role in the signaling needed when cells migrate. "So now what we're focused on is what it can do," Garraway tells Ars. They've started by removing Keratin 13, which results in incapacitating the cells. "We were surprised cells that express Keratin 13 can no longer metastasize. It suggests it has a functional role in the metastatic process."

This research is still in the very early stages. Garraway calls it "an example of how research and discovery is done, but it shouldn't be considered a potential new therapy for now."

Even if it doesn't lead to treatments, the research she and her colleagues are doing will still contribute to the overall science of prostate cancer. "Our bigger focus is in understanding the tumor biology of these aggressive cells," she tells Ars. "Prostate cancer that is metastatic is incurable. We have to understand who and why and how."

onlinelibrary.wiley.com

Comparison between 18F-DCFPyL PET and MRI for the detection of transition zone prostate cancer

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Yachao Liu MD, Yanliang Dong BD, Jiajin Liu BD, Xiaojun Zhang MD, Mu Lin MD, Baixuan Xu MD,

First published: 13 September 2021

Abstract

Background

We aimed to compare the diagnostic performance of ^{18}F-DCFPyL positron emission tomography (PET) and multiparameter magnetic resonance imaging (mp-MRI) in detecting transition zone (TZ) prostate cancer (PCa).

Methods

This retrospective study included 20 patients who underwent ^{18}F-DCFPyL PET/MRI and 32 patients who underwent ^{18}F-DCFPyL PET/CT and MRI from January 2019 to June 2020. All patients had TZ lesions and underwent prostate biopsies. One senior (reader 1) and one junior (reader 2) nuclear medicine physician evaluated each TZ lesion independently, according to the molecular imaging prostate-specific membrane antigen scoring system and the Prostate Imaging Reporting and Data System version 2.1 (PI-RADS v2.1). The histologic diagnosis of prostate biopsy was used as the reference standard. The diagnostic performance of the two methods was compared in terms of inter-reader agreement and area under the receiver operating characteristic (AUC-ROC) curve.

Results

Of the 52 patients, 43 had TZ PCa. For inter-reader agreement, the kappa value was 0.883 for ^{18}F-DCFPyL PET and 0.393 for mp-MRI. For PET, both readers had the same diagnostic sensitivity, specificity, and accuracy of 93.0%, 77.8%, and 90.4%, respectively. For mp-MRI, the diagnostic sensitivity, specificity, and accuracy was 67.4%, 33.3%, and 61.5% for reader 1, and 51.2%, 44.4%, and 51.9% for reader 2, respectively. PET outperformed mp-MRI for both readers with an AUC of 0.872 for PET versus 0.584 for mp-MRI, $p = .0209$ for reader 1, and an AUC of 0.860 for PET versus 0.505 for mp-MRI, $p = .0213$ for reader 2. Among the 43 patients with TZ PCa, ^{18}F-DCFPyL PET detected a distant bone metastasis missed by the CT in one case and two small lymph node metastases missed by the CT and MRI in another case.

Conclusions

These results suggest that ^{18}F-DCFPyL PET, which was almost independent of the experience of the readers, was more objective in the evaluation of TZ lesions, and had higher diagnostic value than mp-MRI.

news.cancerresearchuk.org

Hormone therapy gets green light for advanced prostate cancer

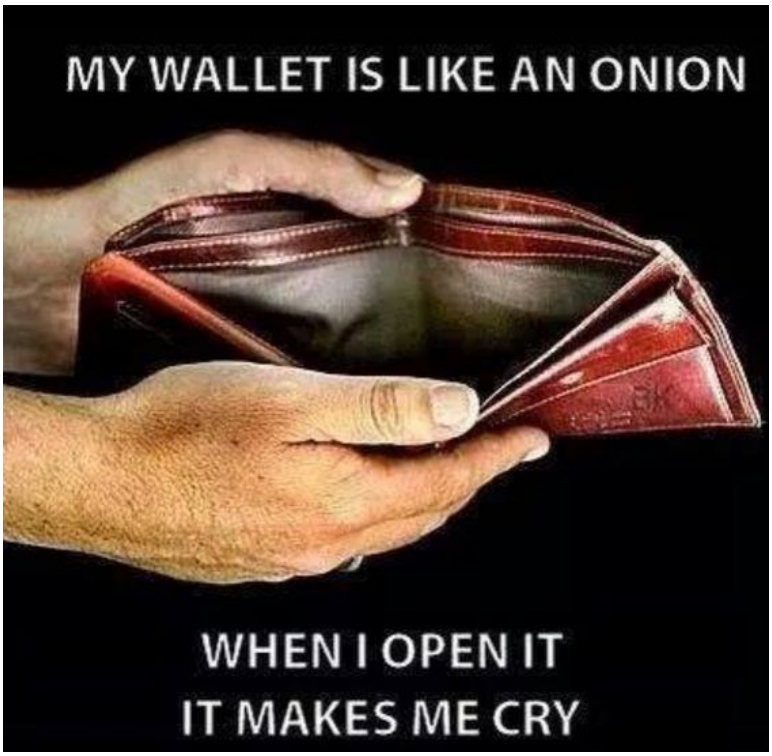
NETWORKING

Please help us in our outreach efforts. Our speakers bureau consisting of Gene Van Vleet is available to speak to organizations of which you might be a member. Contact Gene 619-890-8447 or gene@ipcsg.org to coordinate.

Member John Tassi is the webmaster of our website and welcomes any suggestions to make our website simple and easy to navigate. Check out the Personal Experiences page and send us your story. Go to: https://ipcsg.org/personal-experience

Our brochure provides the group philosophy and explains our goals. Copies may be obtained by mail or email on request. Please pass them along to friends and contacts.

FINANCES



We want to thank those of you who have made special donations to IPCSG. Remember that your gifts are tax deductible because we are a 501(c)(3) non-profit organization.

We again are reminding our members and friends to consider giving a large financial contribution to the IPCSG. This can include estate giving as well as giving in memory of a loved one. You can also have a distribution from your IRA made to our account. We need your support. We will, in turn, make contributions from our group to Prostate Cancer researchers and other groups as appropriate for a non-profit organization. Our group ID number is 54-2141691. Corporate donors are welcome!

While our monthly meetings are suspended, we still have continuing needs, but no monthly collection. If you have the internet you can contribute easily by going to our website, http://ipcsg.org and clicking on "Donate" Follow the instructions on that page. OR just mail a check to: IPCSG, P. O. Box 420142, San Diego CA 92142

Continued Editors Notes:

• *Hormone therapy gets green light for advanced prostate cancer* Describes how the British NHS has determined that ADT plus apalutamide is a reasonable alternative to chemo with docetaxel with ADT.

• *Active Surveillance for Prostate Cancer: Switch After 4 Years Study* found that overall, a growing fraction of men with low/medium risk PCa were put on AS, 69% in 2014. However, the study also found that half of the men put on active surveillance had switched to treatment after a median follow-up of 4 years.

• *Which Prostate Biopsy Is Best: Transrectal or Transperineal?* A lot of debate among urologists

• *The role of histopathological and biochemical parameters for predicting metastatic disease on 68Ga-PSMA-11 PET in prostate cancer* In this study, 68Ga-PSMA-11 PET positivity was significantly higher in the high-risk patient group than in the low-intermediate risk groups.

• *Efficacy of systemic therapies in men with metastatic castration resistant prostate cancer harboring germline ATM versus BRCA2 mutations* Conventional therapies can be effective in gATM carriers and should be considered before PARPi, which shows limited efficacy in this group.

• *9/11 First Responders Face Higher Cancer Risk 20 Years Later* researchers found that increased risks of prostate cancer began showing up surprisingly early

• *Prebys Cancer Center Opens at Scripps Mercy Hospital San Diego* A comprehensive cancer care facility opened its doors on the campus of Scripps Mercy Hospital

• *Impact of enzalutamide on patient-reported fatigue in patients with prostate cancer: data from the pivotal clinical trials* The levels of fatigue were greater in mCRPC and lower in earlier states of disease. In all trials, patients reported a small increase in fatigue for the first 13–17 weeks after starting enzalutamide or placebo, with slightly greater fatigue with enzalutamide

• *Prostate Cancer Surgeries Plummeted for Black Men in 2020* During the initial COVID-19 lockdown, the odds of Black men undergo-ing surgery for untreated nonmetastatic prostate cancer dropped by 94%, but for White men, there was no change.

The National Institute for Health and Care Excellence (NICE) has approved apalutamide (Erleada) in combination with a hormone treatment for some prostate cancer patients in England.

The hormone therapy will now be an option for adults with advanced hormone-sensitive prostate cancer that's spread to other parts of the body.

According to NICE, the drug could help stop the spread of prostate cancer and should be used if the chemotherapy docetaxel is not suitable or can't be tolerated.

Kruti Shrotri, head of policy development at Cancer Research UK said: "This is good news for people affected by this type of prostate cancer. Many patients can't tolerate or choose not to have chemotherapy due to its impact on their quality of life, and they will now have another potentially life-extending treatment option available to them."

A new combination

Apalutamide works by blocking the effect of testosterone on prostate cancer cells and will be available for some 8,000 people in England.

In the TITAN clinical trial, patients who were given apalutamide and androgen deprivation therapy (ADT) were found to live longer than those treated with a dummy drug (placebo) plus ADT.

Studies also found that apalutamide with ADT is more effective than using ADT alone. Although no trials directly comparing the two have been done, indirect analysis of the data by researchers has shown that the apalutamide treatment combination was better tolerated than docetaxel plus ADT.

Additional treatment options

Patients have gradually seen more treatments become accessible – often a combination therapy involving ADT, chemotherapy and steroids.

Until this year, many people with few or no symptoms of prostate cancer may have chosen to take ADT alone. Despite the long-term benefits of docetaxel, their decision is often based on the belief that the medicine worsens quality of life.

In June this year, the committee green-lit enzalutamide (Xtandi) plus ADT, as a treatment option for patients with this type of prostate cancer.

And during the COVID-19 pandemic a new option was added, as NHS England published interim guidance, allowing patients to be treated with the medicines abiraterone and prednisone plus ADT. However, due to the cost of abiraterone, the treatment is only used for people who cannot tolerate enzalutamide plus ADT.

Following the latest NICE decision, patients will also have access to a 'valuable' new treatment option, which patient experts noted is generally better tolerated than chemotherapy.

NICE decisions are usually adopted in Wales and Northern Ireland, while Scotland has a separate process for reviewing drugs.

A campaign for change

Cost played a role in apalutamide's journey to approval.

In draft guidance published earlier this year, NICE decided against recommending apalutamide due to uncertainties in the clinicial trial results – because patients could switch medication from the placebo to apalutamide during trials. However, they also concluded that cost estimates were uncertain and too high to be considered an acceptable use of NHS resources.

The decision prompted a Prostate Cancer UK campaign calling on NICE and the medicine's manufacturer Janssen to give patients access to apalutamide. This latest decision comes as the pharmaceutical company has agreed an undisclosed discount on the drug for the NHS.

"We are very pleased that Janssen has been able to work with us to address the uncertainties in the evidence identified by the committee in the previous draft guidance," said Meindert Boysen, NICE deputy chief executive and director of the centre for health technology evaluation. "This means that we are able to produce final draft guidance recommending apalutamide as an effective and valuable additional treatment option for people with these types of prostate cancer."

Active Surveillance for Prostate Cancer: Switch After 4 Years

Sharon Worcester

medscape.com

Active surveillance instead of immediate aggressive treatment has become a standard of care for men with low-risk prostate cancer, and this initial management strategy has become increasing popular in recent years, show new data from a real-world study.

The study examined data on 17,000 men diagnosed with low-risk prostate cancer in Ontario, Canada between January 1, 2008 and December 31, 2014.

It found that overall, half (51%) of these men were put on active surveillance as their initial management strategy, but it also showed that this proportion increased significantly over time, from 38% in 2008 to 69% in 2014.

However, the study also found that half of the men put on active surveillance had switched to treatment after a median follow-up of 4 years.

The new data are reported by Narhari Timilshina, MPH, of the University Health Network and the University of Toronto, Canada, and colleagues. The paper was published online in the *Journal of Urology* and will appear in the October issue.

Several factors were associated with the discontinuation of active surveillance in favor of definitive treatment for low-risk prostate cancer, the team comments. These include younger age at diagnosis, a higher number of comorbidities, and certain adverse cancer-specific characteristics such as higher prostate-specific antigen (PSA) level.

For example, the hazard ratios for active surveillance (AS) discontinuation were 0.83 for those aged 56-65 years ($P < .001$) and 0.70 for those aged 66-75 years (P

< .001) compared with those aged 55 years or less. The HRs were 1.29 and 1.31 for those with PSA of 4.01-10 ng/mL (P < .001) and 10.01 ng/mL or greater (P < .004), respectively, compared with those with PSA 0-4.

Discontinuation of AS was also more common when care was provided at academic institutions and by higher volume physicians and institutions, the team writes.

The median time to AS discontinuation was 16 months, and treatment-free survival among the AS patients at was 85% at 1 year, 58% at 3 years and 52% at 5 years.

"The results of this study are important to patients, providers, and policy," the investigators write, adding that "[t]here is a dire need to develop robust tests such as biomarkers and advanced imaging to move the field beyond nonspecific measures (ie, PSA) and invasive prostate biopsy."

They further recommend combining competing health risks and patient characteristics with disease-specific traits to better select patients for inclusion.

"The practice would benefit from the development of quality indicators, targeted continuing education for physicians, and patient education with shared decision-making at the onset of AS," they conclude.

Writing in a related editorial, Michael S. Sessine, MD, and Jeffrey J. Tosoian, MD, MPH, of Rogel Cancer Center, University of Michigan, Ann Arbor, note that some prospective AS programs are reporting increases in the proportion of men remaining on AS over time.

This is "likely the result of better initial patient selection in the modern era (ie, less undersampling), with more patients exposed to MRI and targeted biopsies during diagnostic and confirmatory testing."

The lower treatment-free survival observed in the current study could be attributable to initial undersampling for the same reasons, they suggests.

In addition, the reason for switching to definitive treatment in the current study was unknown in 30% of cases, making it "difficult to know with certainty the root of these differences."

"Regardless, Timilshina et al have added to the growing body of AS literature and provided potential risk factors for treatment that can be used to better educate and counsel patients initiating AS," they conclude.

Which Prostate Biopsy Is Best: Transrectal or Transperineal?

medpagetoday.com

Howard Wolinsky,

Meeting Coverage > AUA

— Advocates for one may face uphill battle, debate at AUA meeting suggests

by Contributing Writer, MedPage Today September 13, 2021

If the Crossfire debate at the American Urological Association (AUA) virtual annual meeting is any indication, advocates for transperineal (TP) biopsies face an uphill battle in persuading U.S. urologists to adopt the practice.

The issue of transrectal versus TP biopsies has been simmering worldwide in recent years. The European Association of Urology not long ago adopted a guideline that designated TP as the preferred biopsy method. Transrectal biopsies have already lost favor in Norway, much of the U.K., Australia, and other countries, as urologists hope to prevent infections and potentially deadly biopsies and find more prostate cancers.

AUA, however, is just starting to address new guidelines on prostate biopsies. Only about 2.5% of prostate biopsies in the U.S. are done with TP approaches through disinfected skin between the anus and the testicles.

In the Crossfire, two American urologists took the transrectal side: Arvin George, MD, a surgeon at the University of Michigan in Ann Arbor, who specializes in diagnosis and management of genitourinary cancers; and Thomas Polascik, MD, director of surgical technology at the Duke Prostate and Urological Cancer Center in Durham, North Carolina.

Two international physicians were recruited to take the side of TP biopsies: Peter Chiu, MD, an associate professor at Prince of Wales Hospital in Australia, and of the Chinese University of Hong Kong; and Hashim Ahmed, BCh, chair of urology at Imperial College London.

Ahmed threw down the gauntlet with the "myself, my family, and my friends test."

"If you're all being honest with yourself, you would not want to have [a transrectal biopsy]. You would not want your father, or your uncle, or your grandfather to have this [biopsy]. You would choose transperineal biopsy," he said.

He stressed that the transrectal approach is really a "transfecal" approach.

"We are putting a needle through the rectum and through feces and inoculating bacteria into the prostate, and therefore risking sepsis," Ahmed said. "Even with an enema to clear out the back passage, there is still going to be feces left inside the rectum."

Polascik argued that the transrectal ultrasound (TRUS) biopsy remains the gold standard for biopsies. "It is fast, easy, and effective," he said, adding that TRUS is the model for workflow efficiency.

He said that with proper technique, post-TRUS biopsy infection hospitalization rates can be reduced to zero.

George said, "There are greater non-infectious hospitalizations with transperineal biopsy. At least that is what we see in the state of Michigan."

Is TP more painful?

Chiu said pain tolerance is "actually quite good" using free-hand TP biopsy and local anesthesia. "Usually, the most painful part is the local anesthetic injections."

But George, director of the Michigan Urological Surgery Improvement Collaborative's (MUSIC) prostate cancer quality improvement initiatives, said MUSIC's research on more than 1,200 patients has found that TP biopsies are more painful. "There's no denying that. And anybody who's done both TP and transrectal biopsy is not going to argue that point. It's driven by a significant difference in anesthetic administration," he said.

Is TP with $200 disposables and $40,000 in set-up costs acceptable?

Chiu insisted that TP biopsies are "affordable." He said there are ways around expensive disposables.

But George countered that "transperineal biopsies take significantly longer, especially when you're early on in your learning curve. We all know that [with] transrectal biopsies, you can get in and out in 3 minutes and you are done."

Neither side took up the fact that TP biopsies have easier access to the apex, where 30% or more of prostate cancers occur, and, hence, the TP technique offers the possibility of detecting more cancers.

Matthew Allaway, MD, founder and president of Perineologic, who pioneered a freehand tool for guidance of TP biopsies, said, "To quote Henry Ford: 'If I had asked people what they wanted, they would have said faster horses.'" Perhaps, in the context of this debate, the answer would be better antibiotics.

"The evolution from TR [transrectal] to TP is inevitable," Allaway continued. "Change is difficult, but if we don't learn from history, we are bound to repeat. Changing antibiotics has a marginal short-term gain, but will not move the needle on complications long term. Modern TP approaches using effective devices and methodologies are showing notable improvements in cancer detection. And finally, shouldn't the decision be the patients on how they want to be biopsied?"

The AUA Crossfire is just the opening salvo of an issue that could impact urology for years to come as American men increasingly demand TP biopsies.

The AUA is exploring its options in new guidelines, the association noted.

Raymond Wezik, JD, the AUA's director of Policy and Advocacy, told the advocacy group Active Surveillance Patients International that the guidelines panel is "finalizing the scope" of its investigation.

"The panel are researching a number of questions related to transperineal versus transrectal to look into both clinical benefit (i.e., cancer detection) as well as the associated harms of each and the need for/harms of anesthesia associated with the procedure," Wezik said. "Keep in mind that this process takes careful research, so the peer-review portion will likely be available closer to 2023."

Howard Wolinsky is a Chicago-based medical freelancer. He recently covered the emerging debate on transrectal versus transperineal biopsy in his blog about his cancer journey, which he has written for MedPage Today *since 2016.*

The role of histopathological and biochemical parameters for predicting metastatic disease on 68Ga-PSMA-11 PET in prostate cancer

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Uğuray Aydos MD

Abstract

Background

The aim of this study was to evaluate the role of histopathological and biochemical parameters in the prediction of the presence and number of PSMA positive

lesions consistent with the metastatic spread of prostate cancer on ^{68}Ga-PSMA PET images.

Methods

Biochemical, histopathological and imaging data of 302 prostate cancer patients who underwent ^{68}Ga-PSMA -11 PET/CT or PET/MR imaging for primary staging were retrospectively analyzed. Patients were divided into two groups as "PET positive" and "PET negative" according to the presence of pathologic extraprostatic PSMA involvement. "PET positive" patients were additionally divided into two groups: oligometastatic (1-3 metastatic lesion) and multimetastatic (>3 metastatic lesions).

Results

The mean age of patients was 66.8 ± 7.6 years. Imaging modality was PET/MR in 223 (73.8%) and PET/CT in 79 (26.2%) of patients. Total PSA, PSA density (PSAD), ALP, and tumor ratio in biopsy specimens were found to be significantly higher in "PET positive" group compared to "PET negative" group and in multimetastatic group compared to oligometastatic group. PET positivity was observed in 3.8% of the low-intermediate risk groups (ISUP 1-3 and total PSA ≤ 20 ng/ml and PSAD < 0.15 ng/ml/cc). This ratio was 46% in the high-risk group (ISUP 4-5 or total PSA > 20 ng/ml or PSAD ≥ 0.15 ng/ml/cc) with a relative risk of 12 ($p < .001$). The prediction models to predict the PET positivity and the presence of distant metastasis had AUCs of 0.901 and 0.925, respectively; with ALP, total PSA, and tumor ratio in needle biopsy specimen as significant independent predictors ($p < .05$).

Conclusions

In this study, ^{68}Ga-PSMA-11 PET positivity was significantly higher in the high-risk patient group than in the low-intermediate risk groups. The prediction models used for predicting the PET positivity and the presence of distant metastasis on PET imaging were successful with high discriminatory powers. In addition to total PSA and ISUP GG, ALP and tumor ratio in biopsy specimens can be used to identify high-risk patients.

Efficacy of systemic therapies in men with metastatic castration resistant prostate cancer harboring germline ATM versus BRCA2 mutations

onlinelibrary.wiley.com

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First published: 13 September 2021

Abstract

Background

Among men with metastatic prostate cancer, about 10% have germline alterations in DNA damage response genes. Most studies have examined *BRCA2* alone or an aggregate of *BRCA1/2* and *ATM*. Emerging data suggest that *ATM* mutations may have distinct biology and warrant individual evaluation. The objective of this study is to determine whether response to prostate cancer systemic therapies differs between men with germline mutations in *ATM* (*gATM)* and *BRCA2* (*gBRCA2)*.

Methods

This is an international multicenter retrospective matched cohort study of men with prostate cancer harboring *gATM* or *gBRCA2*. PSA_{50} response (≥50% decline in prostate-specific antigen) was compared using Fisher's exact test.

Results and Limitations

The study included 45 *gATM* and 45 *gBRCA2* patients, matched on stage and year of germline testing. Patients with *gATM* and *gBRCA2* had similar age, Gleason grade, and PSA at diagnosis. We did not observe differences in PSA_{50} responses to abiraterone, enzalutamide, or docetaxel in metastatic castration resistant prostate cancer between the two groups; however, 0/7 with *gATM* and 12/14 with *gBRCA2* achieved PSA_{50} response to PARPi ($p < .001$). Median (95% confidence interval) overall survival from diagnosis to death was 10.9 years (9.5-not reached) versus 9.9 years (7.1-not reached, $p = .07$) for the *gATM* and *gBRCA2* cohorts, respectively. Limitations include the retrospective design and lack of mutation zygosity data.

Conclusions

Conventional therapies can be effective in *gATM* carriers and should be considered before PARPi, which shows limited efficacy in this group. Men with *gATM* mutations warrant prioritization for novel treatment strategies.

9/11 First Responders Face Higher Cancer Risk 20 Years Later

webmd.com

By Amy Norton *HealthDay Reporter*

MONDAY, Sept. 13, 2021 (HealthDay News) -- Twenty years on, responders to the World Trade Cen-

ter attacks in New York City are showing increased risks of certain cancers, two new studies confirm.

Researchers found higher-than-average rates of prostate cancer among firefighters, medics and other workers who toiled at the disaster site on and after Sept. 11, 2001.

And compared with firefighters from other major U.S. cities, those exposed to the 9/11 disaster had higher risks of both prostate and thyroid cancers.

It's been known that World Trade Center rescue and recovery workers have above-average rates of certain cancers.

But the new studies help clarify the picture further, experts said.

In one, researchers found that increased risks of prostate cancer began showing up surprisingly early — a little over five years after responders' exposure to the twin tower site and the toxic dust cloud that enveloped it.

"We were not expecting the latency period to be that short," said senior researcher Charles Hall, a professor at Albert Einstein College of Medicine in New York City.

Often, cancer has a long latency — meaning it develops many years after a person's initial exposure to a carcinogen.

Hall said the new findings suggest "we should not assume all cancers have a long latency period."

And that, he said, could inform medical follow-up of responders to other large-scale disasters, such as major wildfires.

"This implies that when we have a disaster like this, we may want to establish surveillance sooner," Hall said.

The other study compared New York City firefighters who responded on 9/11 with firefighters in other big U.S. cities. It found that compared with their colleagues, 9/11 firefighters had a 13% higher risk of developing any type of cancer over the next 15 years.

Two specific cancers stood out: New York City firefighters had more than double the risk of thyroid cancer, and a 39% higher risk of prostate cancer. They were also typically about four years younger when diagnosed with cancer, the researchers reported.

Hall also worked on that study. He said the findings bolster the case that exposures on 9/11 — and not only the general occupational exposures of being a firefighter — are contributing to cancers in some responders.

Both studies were published Sept. 10 in the journal *Occupational and Environmental Medicine*.

A federal law passed in 2010 created the World Trade Center Health Program to provide health care to 9/11 responders and civilian survivors of the attack. Among its benefits are cancer screenings.

Dr. Geoffrey Calvert, senior medical advisor to the health program, said the new findings add to the understanding of responders' cancer risks.

He agreed that the period between exposure and increased risk of prostate cancer was shorter than expected.

As it stands, though, there are no special screening recommendations for World Trade Center responders or survivors. They're "identical" to what's advised for the public in general, said Calvert, who wrote an editorial published with the studies.

When it comes to prostate cancer screening, men aged 55 to 69 are generally advised to talk to their doctor about whether it's right for them.

In the new study that focused on prostate cancer, Hall's team looked at data on nearly 54,400 men who responded to the World Trade Center disaster — including firefighters, police, paramedics, construction workers, volunteers and clean-up workers.

Overall, 1,120 men were diagnosed with prostate cancer through 2015. Up until 2006, responders' risk of the disease was no greater than that of New York State men in general.

But that changed starting in 2007, when their risk rose to be 24% higher than the norm. And firefighters who'd arrived the morning of 9/11 appeared to be at greater risk than workers who arrived later.

Hall said that's suggestive of a "real effect" of exposure to the toxic plume at the site. The massive cloud is known to have contained cancer-causing substances such as dioxins, asbestos, benzene and polychlorinated biphenyls (PCBs), Hall noted.

He advised 9/11 responders to get into the health monitoring program if they haven't already. "There's no reason not to, even if you're healthy — or especially if you are," Hall said.

Calvert said the program "remains steadfast in its mission."

"Among the [program's] successes are its efforts to ensure excellence and efficiency in the delivery of medical monitoring and treatment, for both physical and mental health conditions related to 9/11 exposures," he said.

More information

The U.S. Centers for Disease Control and Prevention has more on the World Trade Center Health Program.

SOURCES: Charles Hall, PhD, professor, department of epidemiology and population health, Albert Einstein College of Medicine, New York City; Geoffrey Calvert, MD, senior medical advisor, World Trade Center Health Program, U.S. National Institute for Occupational Safety and Health, Washington, D.C.; *Occupational and Environmental Medicine*, Sept. 10, 2021, online

timesofsandiego.com

Prebys Cancer Center Opens at Scripps Mercy Hospital San Diego

The new$59 million Prebys Cancer Center. Courtesy Scripps Health

A comprehensive cancer care facility opened its doors on the campus of Scripps Mercy Hospital San Diego Monday.

Prebys Cancer Center is part of Scripps MD Anderson Cancer Center, a clinically integrated cancer care program that treats patients throughout San Diego County.

The $59 million center is the second of two regional cancer hubs offered as part of the partnership between Scripps Health and MD Anderson Cancer Center in Houston. The other hub, located on the Torrey Pines Mesa, serves the northern region.

The new outpatient center is slated to offer a range of advanced cancer treatments and patient support services. The 40,000-square-foot, four- story facility is named for the late Conrad Prebys, who earlier donated $25 million to support the facility and an endowed medical director position at Scripps MD Anderson.

"The opening of Prebys Cancer Center represents a pivotal step in our journey to provide advanced, individualized cancer care to the residents of San Diego County and the Southern California region," said Scripps President and CEO Chris Van Gorder. "Patients will find this to be a truly exceptional facility in every sense, from the sophisticated medical technology and collaborative approach to care, to the comforting environment and personal supportive services we offer."

Prebys Cancer Center is now open for physician appointments for new and existing patients. Additional patient care services are expected to begin at the new facility in the coming weeks, including radiation therapy and immunotherapy, targeted therapy and chemotherapy infusion.

The center is equipped with radiation therapy technology, including two linear accelerators that can deliver external beam radiation treatments with "exceptional accuracy," a statement from Scripps reads. The technology allows doctors to shape the radiation beam so it tightly conforms to each tumor's unique contours, while its motion management system enables the beam to follow tumors that move as a patient breathes during treatment. Both of these features are intended to spare normal tissues around the tumor from the damaging effects of radiation.

Prebys Cancer Center also houses a 20-chair infusion center, where chemotherapy, targeted therapy, immunotherapy and other treatments will be administered.

The new facility also contains a physician clinic area with 20 patient exam rooms, two minor surgical procedure rooms and collaboration spaces for treatment planning conferences with patients and their multidisciplinary physician teams. Additionally, it includes a large multipurpose room for health education seminars and other community events, along with offices for physicians, care teams and support staff. A new 140-space parking garage adjoins the center.

Support services at the new center soon will be permanently consolidated at the nearby Woltman Family College Building, a structure at Scripps Mercy San Diego expected to open in January 2022, when restoration is completed.

"Prebys Cancer Center is perfectly suited to our multidisciplinary team approach to cancer care, where we bring physicians, caregivers and services around the patient," said Dr. Thomas Buchholz, medical director of Scripps MD Anderson Cancer Center and a Scripps Clinic radiation oncologist. "Our patients also will have access to novel clinical trials, which aim to advance current standards of care."

In 2011, Conrad Prebys donated $45 million toward the Prebys Cardiovascular Institute on the campus of Scripps Memorial Hospital La Jolla. He also made a $10 million donation in 2006 to support construction of the Conrad Prebys Emergency and Trauma Center at Scripps Mercy Hospital San Diego.

–City News Service

nature.com

Impact of enzalutamide on patient-reported fatigue in patients with prostate cancer: data from the pivotal clinical trials

Saad, Fred

Abstract

Background

Fatigue is a multifactorial symptom commonly reported by patients with prostate cancer as a result of disease and treatment. This study assesses the impact enzalutamide has on patient-reported fatigue ("fatigue") by using patient-reported outcomes from four pivotal, placebo-controlled trials of enzalutamide (ARCHES (NCT02677896), PROSPER (NCT02003924), PREVAIL (NCT01212991), and AFFIRM (NCT00974311)).

Methods

Fatigue was assessed in the individual studies using the Functional Assessment of Cancer Therapy–Prostate item GP1 at baseline, weeks 13 or 17, and every 12 weeks until disease progression. Longitudinal changes were assessed using mean scores and mixed-model repeated measures.

Results

The fatigue rates at baseline were higher in patients with later-stage disease (metastatic and/or castration-resistant prostate cancer (CRPC)) and among patients who had already received prior treatment lines; rates ranged between 58% in PROSPER (nonmetastatic CRPC) and 86% in AFFIRM (post-docetaxel metastatic CRPC). Irrespective of disease state, initiation of enzalutamide or placebo resulted in an early increase of fatigue (by weeks 13 or 17), with fatigue levels stabilizing thereafter. At last assessment, ≥55% of patients reported fatigue improvement or stabilization in all trials compared to baseline. More patients reported fatigue worsening by ≥1 or ≥2 units with enzalutamide plus androgen deprivation therapy (ADT) than with placebo plus ADT in ARCHES, PROSPER, and PREVAIL, but the between-group difference was <10% in all trials.

Conclusions

The levels of fatigue were greater in mCRPC and lower in earlier states of disease. In all trials, patients reported a small increase in fatigue for the first 13–17 weeks after starting enzalutamide or placebo, with slightly greater fatigue with enzalutamide in all studies except AFFIRM, but fatigue stabilized or improved thereafter. This suggests a role for clinical management of fatigue to help patients cope early in treatment.

Prostate Cancer Surgeries Plummeted for Black Men in 2020

medscape.com

Marcia Frellick

During the initial COVID-19 lockdown, the odds of Black men undergoing surgery for untreated nonmetastatic prostate cancer dropped by 94%, but for White men, there was no change, new data show.

Before the pandemic, "there was no difference between White and Black patients" in terms of getting the surgery, said Adrien Bernstein, MD, a urologic oncology fellow at Fox Chase Cancer Center in Philadelphia.

He and his colleagues conducted a retrospective, multi-institution cohort study comparing prostatectomy rates during the first COVID wave (March to May 2020) with rates during the same months in 2019.

They used the Pennsylvania Urologic Regional Collaborative (PURC) — which gathers data from academic and private institutions in urban and rural settings — to evaluate men diagnosed with nonmetastatic prostate cancer.

Of the 647 men with localized prostate cancer, 269 received care during the 2020 study period and 378 received care during the 2019 period, Bernstein reported at the American Urological Association 2021 Annual Meeting.

In 2020, surgery was significantly less likely for Black than for White men (1.3% vs 25.9%; *P* < .001), despite similar COVID-19 risk factors, biopsy grade, and comparable 2019 surgery rates (17.7% vs 19.1%; *P* = .75).

On regression analysis, after adjustment for covariates, the odds of prostatectomy for Black men dropped to 6% in 2020 (odds ratio [OR], 0.06; 95% CI, 0.007 - 0.43; *P* = .006), with no change for White patients (OR, 1.41, 95% CI, 0.89 - 2.21; *P* = .142).

"In a multivariable analysis, adjusted for the presence of high-risk disease and age, White men were 31 times more likely to receive surgical care during the lockdown period than Black patients," Bernstein said.

Early in the pandemic, many resources were diverted from cancer care to COVID care, leaving many patients, including those with prostate cancer, with limited or no access to surgery, he explained.

Although localized prostate cancer does not require immediate treatment, the study highlights systemic inequities, the team writes in their abstract.

Surgical Volume Varied by Site

"The degree to which sites reduced surgery during the first wave varied substantially," with some sites increasing surgical volume by 33% and others shutting down completely, said Bernstein. "Notably, sites that cared for more Black patients were those most impacted by the lockdown."

"Lessons from the study are applicable to all patients and should drive efforts to recognize and offset the implications of our pandemic-related decisions by prioritizing care in underserved communities," he said.

Another glaring racial gap was revealed in a study presented at the meeting by Ali Mouzannar, MD, a urology resident with the University of Miami.

Although the US Food and Drug Administration approved sipuleucel-T (Provenge) as the first and only immunotherapy treatment for metastatic castration-resistant prostate cancer in 2010, the increase in use of the novel agent — from 3.8% in 2010 to 39.8% in 2013 — was mainly seen in White men. Black and Hispanic patients saw a disproportionately low increase and were more likely to continue with chemotherapy.

10-20 ng/mL: pathological outcome analysis of a population-level database

nature.com

Cooperberg, Matthew R.

Abstract

Background

Active surveillance (AS) is generally recognized as the preferred option for men with low-risk prostate cancer. Current guidelines use prostate-specific antigen (PSA) of 10–20 ng/mL or low-volume biopsy Gleason grade group (GG) 2 as features that, in part, define the favorable intermediate-risk disease and suggest that AS may be considered for some men in this risk category.

Methods

We identified 26,548 men initially managed with AS aged <80 years, with clinically localized prostate cancer (cT1-2cN0M0), PSA ≤ 20 ng/mL, biopsy GG ≤ 2 with percent positive cores ≤33% and who converted to treatment with radical prostatectomy from the surveillance, epidemiology, and end results prostate with the watchful waiting database. Multivariable logistic regression was performed to determine predictors of adverse pathology at RP according to PSA level (<10 vs 10–20 ng/mL) and GG (1 vs 2).

Results

Of 1731 men with GG 1 disease and PSA 10–20 ng/mL, 382 (22.1%) harbored adverse pathology compared to 2340 (28%) of 8,367 men with GG 2 and a PSA < 10 ng/mL who had adverse pathology at RP. On multivariable analysis, the odds of harboring adverse pathology with a PSA 10–20 ng/mL (odds ratio [OR] 1.87, 95% confidence interval [CI] 1.71–2.05, $p < 0.001$) was less than that of GG 2 (OR 2.56, 95%CI 2.40–2.73, $p < 0.001$) after adjustment.

Conclusions

Our results support extending AS criteria more permissively to carefully selected men with PSA 10–20 ng/mL and GG 1 disease.

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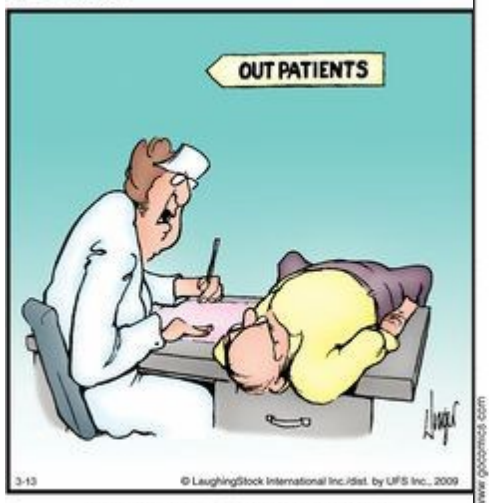

"His hospital insurance runs out in 15 minutes."

"Surely you must know if you have health insurance..."

"If it doesn't itch, don't worry about it."