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Non- Metastatic Prostate Cancer- Panel Discussion

Dr Sujana Priya V MD;DNB; FRCR (UK)
Senior Consultant Radiation Oncologist
AIG Hospitals, Hyderabad

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Panelists

- Dr Kanhu Charan Patro- Radiation Oncologist
- Dr Vivek Anand- Radiation Oncologist
- Dr Rohit Malde- Radiation Oncologist
- Dr Manish Chandra- Radiation Oncologist
- Dr Amit Kumar- Medical Oncologist
- Dr Aditya Pradhan- Uro Oncologist
- Dr Gaurav Kumar- Uro Oncologist
- Dr Yuvaraja T B- Uro Oncologist

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Case capsule

- 65-year-old, Incidentally detected rising S.PSA
- S.PSA-5.34 ng/ml
- Mp-MRI Prostate- cT2No PIRADS-5 Lesion

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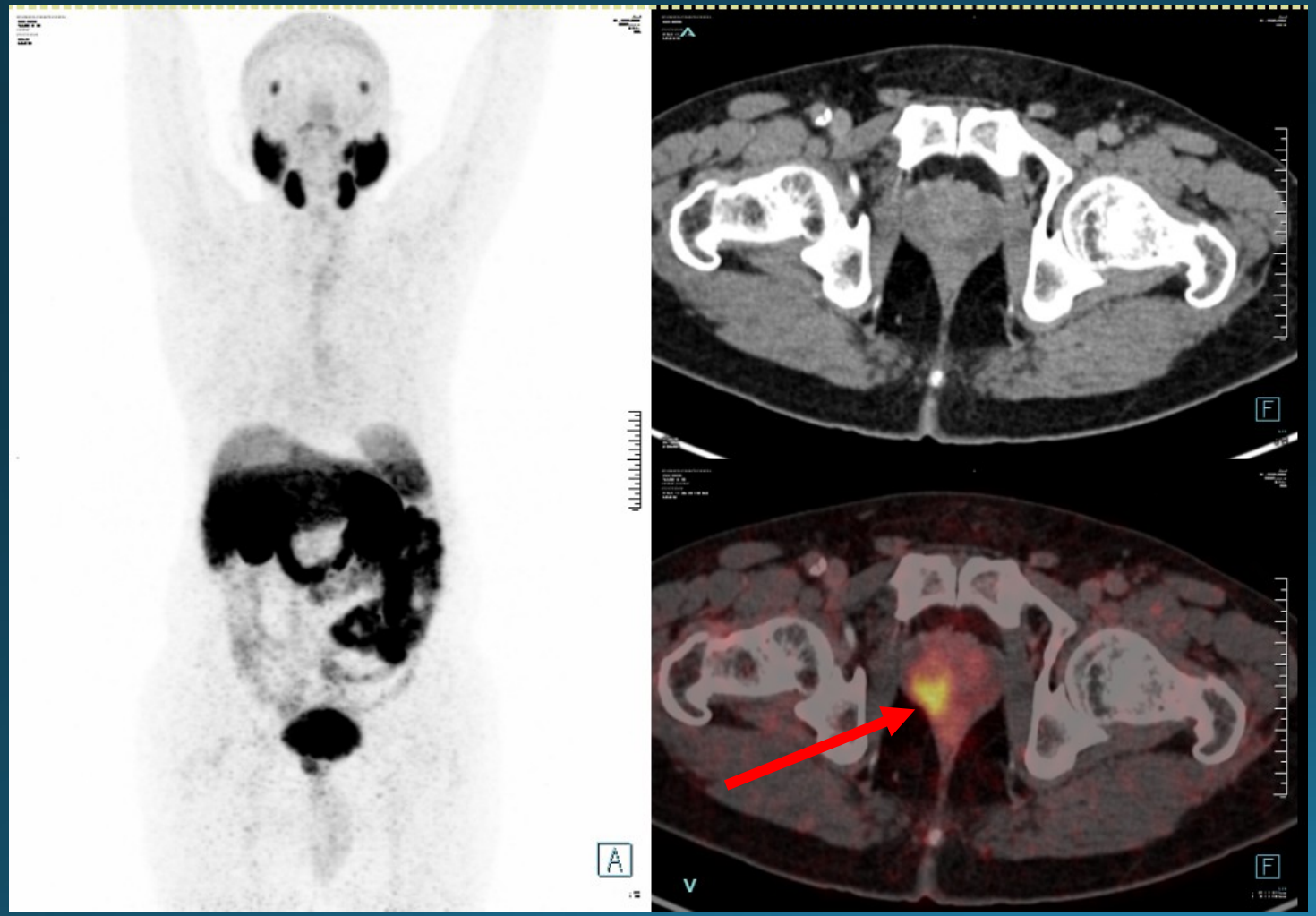
PSMA PET-CT



- PSMA Avid lesion in the PZ of mid & apex of prostate on right side
- No nodes

- TRUS Guided Biopsy-
- Adenocarcinoma, GS 3+4=7, GG2
- MDT Discussion-
- Surgery vs Radiation- Went ahead with Surgery

- What Surgery would you like to perform?
- Role of Nodal Dissection- Limited vs ePLND
- What is your Current Practice?
- Has your practice changed from 2021 to 2025?

2021

EUROPEAN UROLOGY ONCOLOGY 4 (2021) 532–539

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

European Association of Urology

No difference in rates of BCR in limited vs ePLND

Priority Article

Editorial by Gaëtan Devos, Andries Wynckaert, Gert De Meerleer and Steven Joniau pp. 540–542 of this issue

Limited versus Extended Pelvic Lymph Node Dissection for Prostate Cancer: A Randomized Clinical Trial

Karim A. Touijer [a,], Daniel D. Sjoberg [b], Nicole Benfante [a], Vincent P. Laudone [a], Behfar Ehdaie [a], James A. Eastham [a], Peter T. Scardino [a], Andrew Vickers [b]*

[a] *Urology Service, Department of Surgery, Memorial Sloan Kettering Cancer Center, New York, NY, USA;* [b] *Department of Epidemiology and Biostatistics, Memorial Sloan Kettering Cancer Center, New York, NY, USA*

BCR rate (HR 1.05, 95% CI 0.97–1.13; p = 0.3)

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2024

European Association of Urology

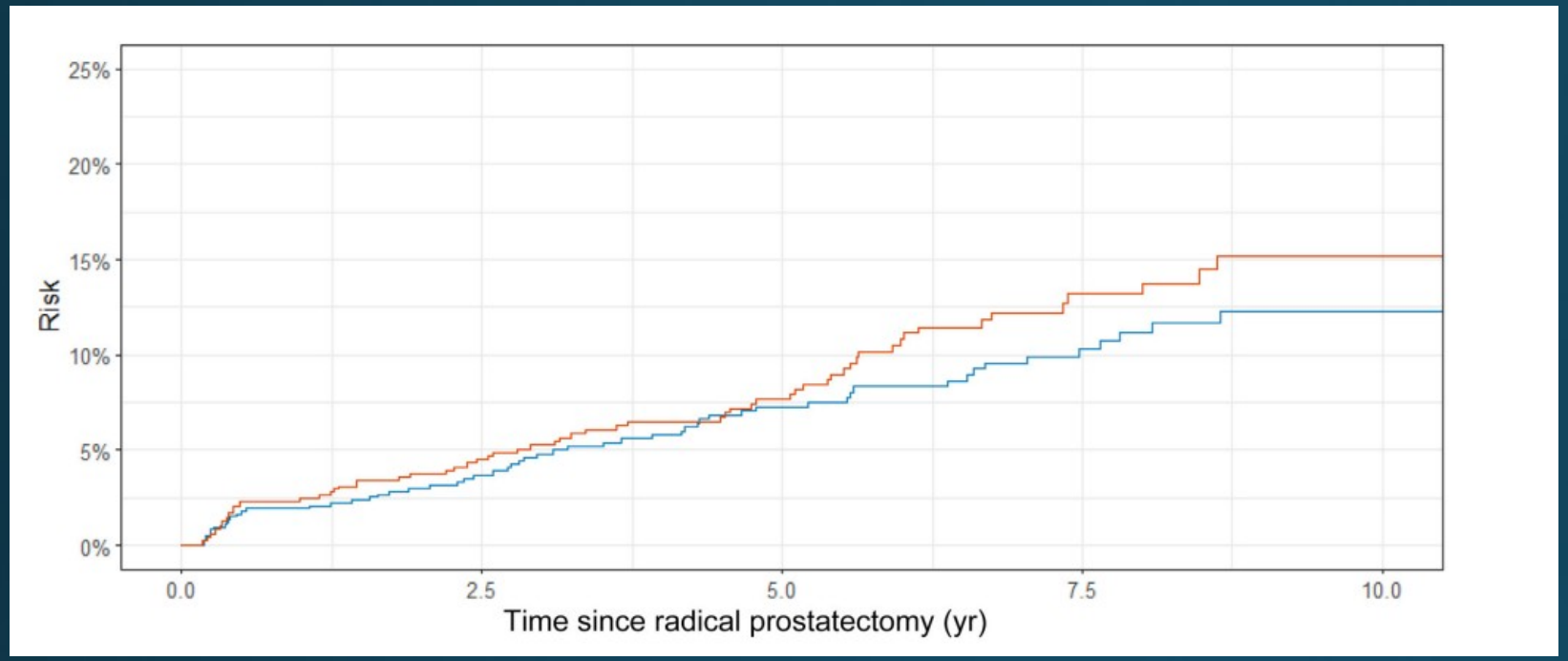
Original Article
Editorial by Matthew J. Roberts, Philip Cornford, Derya Tilki on pp. 261–263 of this issue

Pelvic Lymph Node Dissection in Prostate Cancer: Update from a Randomized Clinical Trial of Limited Versus Extended Dissection

Karim A. Touijer[a,], Emily A. Vertosick[b], Daniel D. Sjoberg[b], Nicole Liso[a], Sunny Nalavenkata[a], Barbara Melao[a,c], Vincent P. Laudone[a], Behfar Ehdaie[a], Brett Carver[a], James A. Eastham[a], Peter T. Scardino[a], Andrew J. Vickers[b]*

[a] *Urology Service, Department of Surgery, Memorial Sloan Kettering Cancer Center, New York, NY, USA;* [b] *Department of Epidemiology and Biostatistics, Memorial Sloan Kettering Cancer Center, New York, NY, USA;* [c] *Department of Urology, University of Sao Paolo, Sao Paulo, Brazil*

- RCT (Single center)
- N=1432
- Median f/u 5.2 years



Cumulative incidence of Metastases in extended and Limited PLND

MFS in ePLND- 88% (p=0.003) vs 85% (p< 0.001) PLND

- What are the Clinical & patient factors which drive your surgical planning?

- What imaging do you rely on before scrubbing in?

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JAMA Network | Open

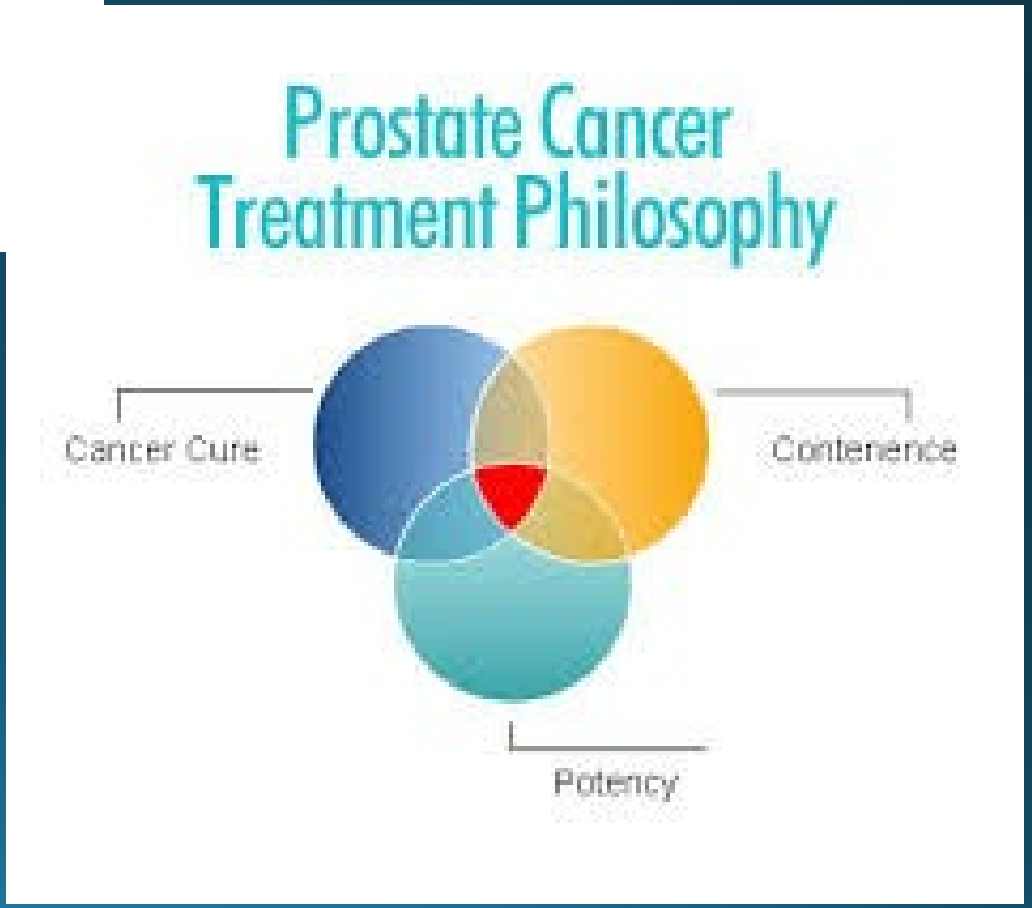
Original Investigation | Urology

Trifecta Outcomes After Use of 3-Dimensional Digital Models for Planning of Robotic Prostatectomy

A Secondary Analysis of a Randomized Clinical Trial

Joseph D. Shirk, MD; Robert E. Reiter, MD, MBA; Eric M. Wallen, MD; Raymond W. Pak, MD; Thomas Ahlering, MD; Ketan K. Badani, MD; James R. Porter, MD

N=92

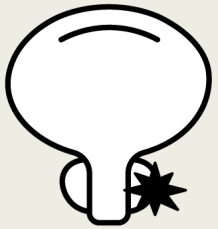


JAMA Network Open

RCT: Trifecta Outcomes After Use of 3-Dimensional Digital Models for Planning Robotic Prostatectomy

POPULATION

92 Men



Adult men with localized prostate cancer undergoing robotic-assisted radical prostatectomy (RALP)

Mean age, 62, y

INTERVENTION

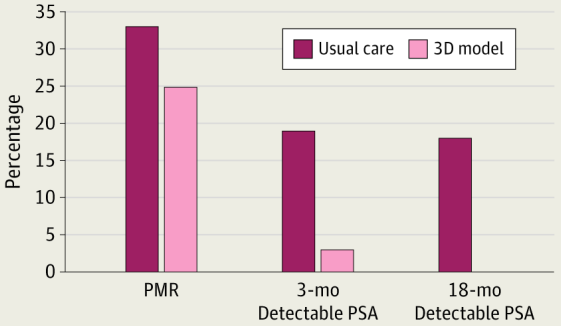
92 Patients randomized

41 RALP planned with 3-dimensional (3D) model Surgeon review of biopsy results and a 3D model created from magnetic resonance imaging

51 RALP planned with usual care Surgeon review of biopsy results and magnetic resonance imaging only

FINDINGS

The detectable prostate-specific antigen (PSA) rate was significantly lower in the 3D model group vs the usual care group; the positive margin rate (PMR) was similar between groups



Detectable PSA:

3D model: 3 mo, 3%; 18 mo, 0% (PMR, 25.0%)

Usual care: 3 mo, 19%; 18 mo, 18% (PMR, 32.7%)

Absolute difference: 17.9% (95% CI, 1.8%-31.8%); *P* = .01

SETTINGS / LOCATIONS

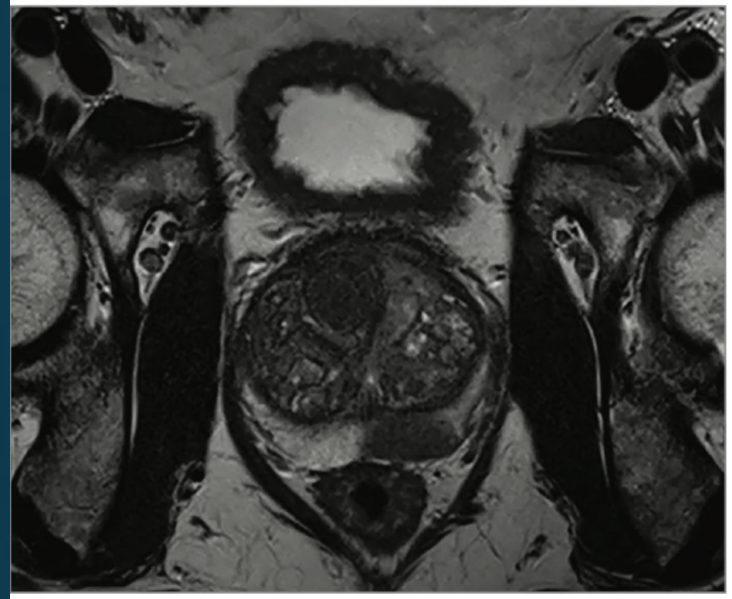
6 Academic institutions in the US

PRIMARY OUTCOME

Oncologic outcomes after RALP immediately postoperatively, at 3-6 mo, and at 18-24 mo

Shirk JD, Reiter RE, Wallen EM, et al. Trifecta outcomes after use of 3-dimensional digital models for planning robotic prostatectomy: a secondary analysis of a randomized clinical trial. *JAMA Netw Open*. 2024;7(9):e2434143. doi:10.1001/jamanetworkopen.2024.34143

A Prostate lesion



B Sample biopsy report

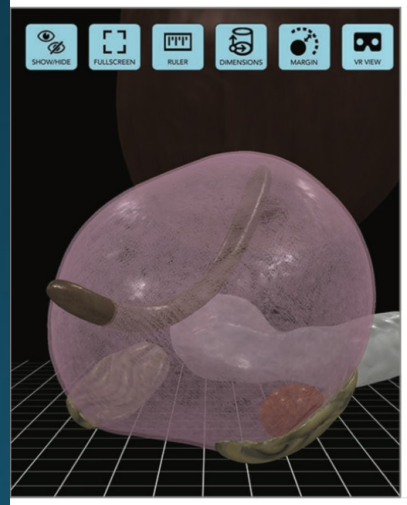
1. Left lateral mid

Prostatic adenocarcinoma
Prostate cancer grading:
Primary Gleason grade: 4
Secondary Gleason grade: 4
Total Gleason score: 8
Grade group: 4

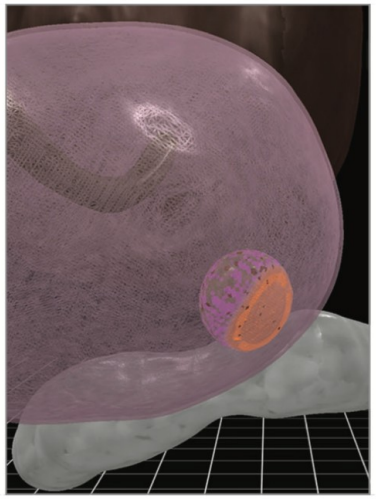
2. Left lateral apex

Prostatic adenocarcinoma
Prostate cancer grading:
Primary Gleason grade: 4
Secondary Gleason grade: 3
Total Gleason score: 7
Grade group: 3

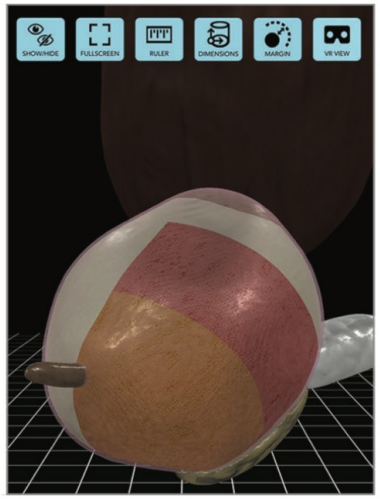
C Lesion proximity to neurovascular bundle



D Lesion contact with capsule



E Biopsy cores



A, Magnetic resonance image of a prostate with lesion. B, Sample patient biopsy report. C, Three-dimensional model of a prostate showing the proximity of the lesion (orange) to the neurovascular bundle (brown). D, Three-dimensional model with the neurovascular bundle hidden, showing wide contact of the lesion (orange) with the capsule (pink). E, Three-dimensional model of a prostate showing color-coded biopsy cores (Grade Group 3 is orange, and Grade Group 4 is red).

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Table 1. Baseline Characteristics Between Groups Who Underwent RALP With and Without 3D Digital Models[a]

Characteristic	Intervention group (n = 41)	Control group (n = 51)
Pathological stage		
T2	26 (63.4)	27 (52.9)
T3a	11 (26.8)	18 (35.3)
T3b	4 (9.8)	6 (11.8)

Table 2. Comparative Outcomes Between the Intervention and Control Groups Who Underwent RALP With and Without 3D Digital Models

Outcome	Intervention group (n = 41)[a]	Control group (n = 51)[a]	Absolute difference, % (95% CI)	*P* value
Oncologic				
Margin status				
Negative	30 (75.0)	33 (67.3)	7.7 (−11.3 to 26.7)	.42
Positive	10 (25.0)	16 (32.7)		
PSA, ng/mL				
3 mo				
Undetectable	32 (96.9)	29 (80.6)	16.3 (1.3 to 31.5)	.03
Detectable	1 (3.1)	7 (19.4)		
18 mo				
Undetectable	32 (100)	32 (82.1)	17.9 (1.8 to 31.8)	.01
Detectable	0	7 (17.9)		
RT with or without ADT by 18 mo				
Yes	1 (3.1)	12 (31.6)	28.5 (10.1 to 46.7)	.002
No	31 (96.9)	26 (68.4)		
Sexual				
18 mo				
Mean (SD)	16.8 (8.7)	9.8 (7.7)	7.0 (2.6 to 11.4)	.002
<17	9 (36.0)	21 (70.0)	34.0 (7.5 to 60.4)	.01
≥17	16 (64.0)	9 (30.0)		

Limitations

Overall Margin positive rate	Comparable in both the arms
SHIM Score (Sexual Health Inventory for Men)	Affected by higher rates of RT+ADT in Control arm
Comparable clinical parameters?	Higher stage patients in the control arm
Sample size	Small sample size to determine adequate effect size
Trifecta	BCR & SHIM are significant, the 3rd arm for Urinary continence -NS

BJU Int 2024; **133:** 742–751 doi:10.1111/bju.16295

BJUI
BJU International

Original Article

Can nerve monitoring during radical prostatectomy improve functional outcomes? A randomised trial

Alexander B. Nolsøe[1,2], Peter Busch Østergren[1,2], Henrik Jakobsen[1], Christian Fuglesang S. Jensen[1], Niels Henrik Bruun[3], Jens Sønksen[1,2] and Mikkel Fode[1,2]

[1]*Department of Urology, Copenhagen University Hospital, Herlev and Gentofte Hospital, Herlev,* [2]*Institute for Clinical Medicine, University of Copenhagen, Copenhagen, and* [3]*Aalborg University Hospital, Aalborg, Denmark*

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N=82

RARP + Nerve stimulation

Standard RARP

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ICIQ-UI Short Form

Initial number ☐☐☐☐☐☐☐ CONFIDENTIAL Today's date (DAY ☐☐ MONTH ☐☐ YEAR ☐☐)

Many people leak urine some of the time. We are trying to find out how many people leak urine, and how much this bothers them. We would be grateful if you could answer the following questions, thinking about how you have been, on average, over the PAST FOUR WEEKS.

1 **Please write in your date of birth:** ☐☐ DAY ☐☐ MONTH ☐☐ YEAR

2 **Are you** *(tick one)*: Female ☐ Male ☐

3 **How often do you leak urine?** *(Tick one box)*

never ☐	0
about once a week or less often ☐	1
two or three times a week ☐	2
about once a day ☐	3
several times a day ☐	4
all the time ☐	5

4 **We would like to know how much urine you think leaks.**
How much urine do you usually leak (whether you wear protection or not)?
(Tick one box)

none ☐	0
a small amount ☐	2
a moderate amount ☐	4
a large amount ☐	6

5 **Overall, how much does leaking urine interfere with your everyday life?**
Please ring a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 **10**
not at all — a great deal

ICIQ score: sum scores 3+4+5 ☐☐

6 **When does urine leak?** *(Please tick all that apply to you)*

- never – urine does not leak ☐
- leaks before you can get to the toilet ☐
- leaks when you cough or sneeze ☐
- leaks when you are asleep ☐
- leaks when you are physically active/exercising ☐
- leaks when you have finished urinating and are dressed ☐
- leaks for no obvious reason ☐
- leaks all the time ☐

Thank you very much for answering these questions.

Follow-up	Continence rates for all patients, %			
	ProPep	Control	Difference (95% CI)	P
3 months	31	23	8 (−13 to 29)	0.47
6 months	63	44	19 (−3 to 41)	0.09
12 months	63	63	0 (−21 to 21)	1.00

The primary outcome -difference in the ICIQ-SF score between the groups at the 12-month f/u

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- 65-year-old, Incidentally detected rising S.PSA
- S.PSA-5.34 ng/ml
- Mp-MRI Prostate- cT2No PIRADS-5 Lesion

- Patient not keen on surgery-
- What do you advise?

Option 1- SBRT
Option 2- Conventional RT
Option 3- Convince for Surgery

- What factors do you consider before deciding?

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

European Association of Urology

Original Article – Editor's choice

Editorial by Markus Graefen, Alberto Bossi on pp. 577–578 of this issue

Radical Prostatectomy Versus Stereotactic Radiotherapy for Clinically Localised Prostate Cancer: Results of the PACE-A Randomised Trial

Nicholas van As [a,b,], Binnaz Yasar [a,b], Clare Griffin [b], Jaymini Patel [b], Alison C. Tree [a,b], Peter Ostler [c], Hans van der Voet [d], Daniel Ford [e], Shaun Tolan [f], Paula Wells [g], Rana Mahmood [h], Mathias Winkler [i], Andrew Chan [j], Alan Thompson [a], Chris Ogden [a], Olivia Naismith [a,k], Julia Pugh [b], Georgina Manning [b], Stephanie Brown [b], Stephanie Burnett [b], Emma Hall [b]*

[a] *The Royal Marsden Hospital, London, UK;* [b] *The Institute of Cancer Research, London, UK;* [c] *Mount Vernon Cancer Centre, Northwood, UK;* [d] *The James Cook University Hospital, Middlesbrough, UK;* [e] *University Hospitals Birmingham, Birmingham, UK;* [f] *The Clatterbridge Cancer Centre, Liverpool, UK;* [g] *St. Bartholomew's Hospital, London, UK;* [h] *Colchester General Hospital, Colchester, UK;* [i] *Charing Cross Hospital, London, UK;* [j] *University Hospitals Coventry & Warwickshire, Warwickshire, Coventry, UK;* [k] *Radiotherapy Trials QA Group, London, UK*

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N=123

N=63 SBRT

N=60
Surgery

Co-Primary End-points-
Urinary & Bowel Toxicity

Secondary End-points-
Sexual functioning/ PRO/ Clinician RO

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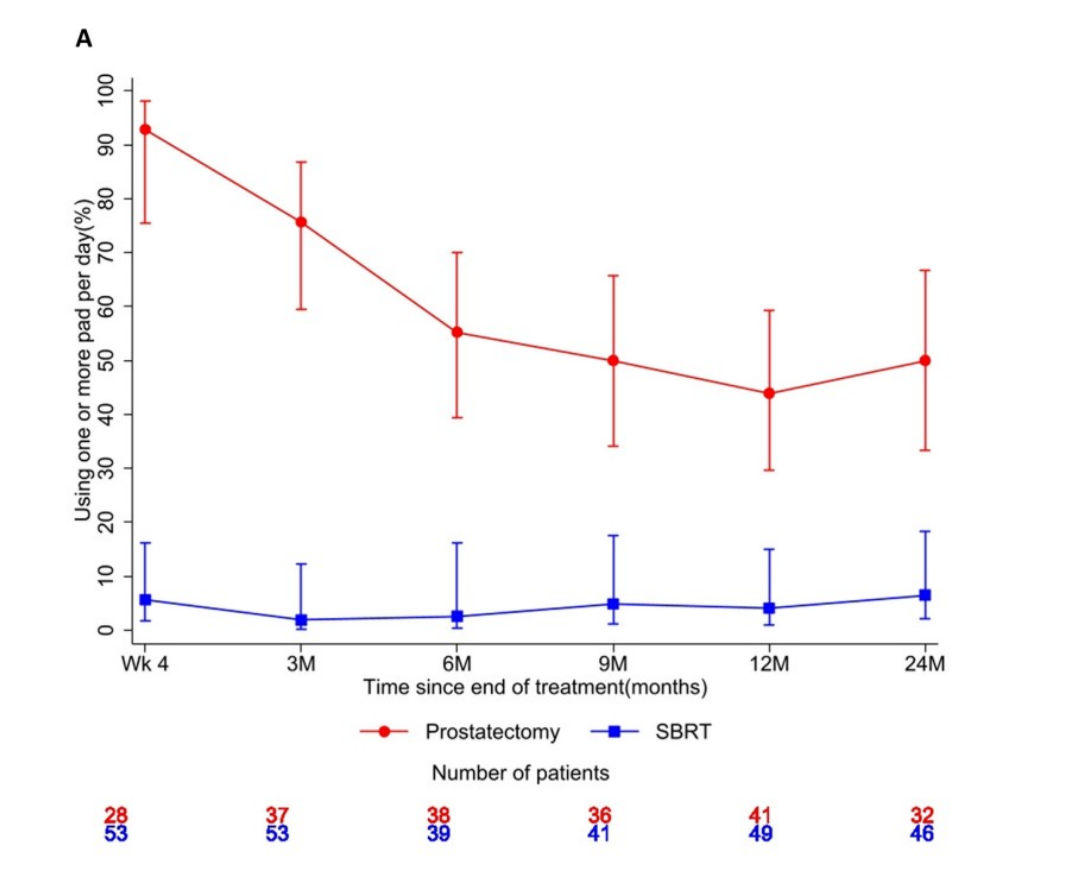
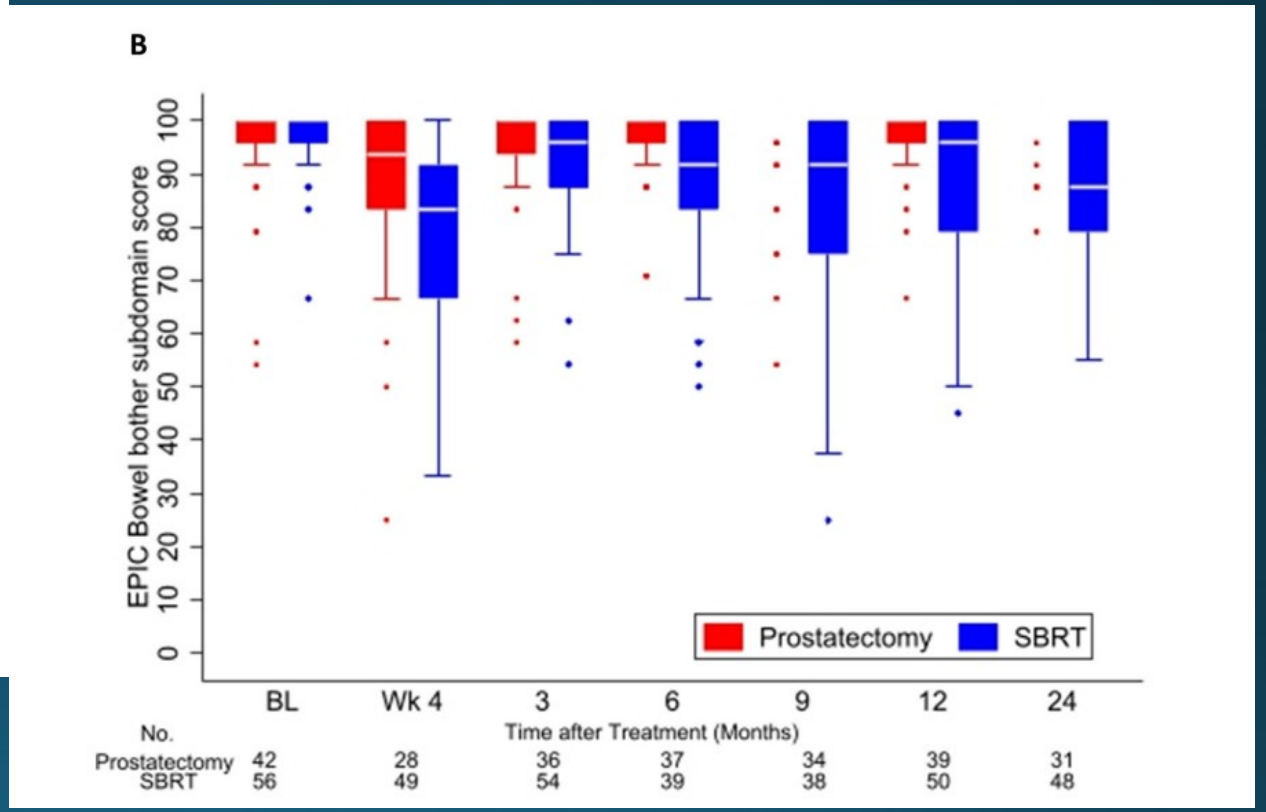


Proportion of patients requiring Urinary pads at -2yrs



EPIC Bowel Sub Domain score

- 65-year-old, Incidentally detected rising S.PSA
- S.PSA-25.34 ng/ml
- Mp-MRI Prostate- cT3aN0 PIRADS-5 Lesion

- MDT Discussion
- What do you advise?

Option 1- SBRT
Option 2- Mod Hypo fx RT
Option 3- Convince for Surgery

- What factors do you consider before deciding?

Emulated RCT

PROSTATE CANCER - LOCALIZED

Check for updates

309

Oral Abstract Session

Radical prostatectomy (RP) versus radiotherapy (RT) in high-risk prostate cancer (HR-PCa): Emulated randomized comparison with individual patient data (IPD) from two phase III randomized trials (RCTs).

Soumyajit Roy, Yilun Sun, James Andrew Eastham, Martin Gleave, Himisha Beltran, Amar Upadhyaya Kishan, Angela Y Jia, Nicholas George Zaorsky, Jorge A. Garcia, Eric J. Small, Paul L. Nguyen, Gerhardt Attard, Rana R. McKay, Alton Oliver Sartor, Seth A. Rosenthal, Susan Halabi, Felix Y Feng, Michael J. Morris, Howard M. Sandler, Daniel Eidelberg Spratt; Rush University Medical Center, Chicago, IL; Case Western Reserve University, Cleveland, OH; Memorial Sloan Kettering Cancer Center, New York, NY; University of British Columbia, Vancouver, BC, Canada, Vancouver, BC, Canada; Dana-Farber Cancer Institute, Boston, MA; Department of Radiation Oncology, University of California, Los Angeles, Los Angeles, CA; University Hospitals Seidman Cancer Center, Case Western Reserve University, Cleveland, OH; Division of Solid Tumor Oncology, University Hospitals Seidman Cancer Center, Case Comprehensive Cancer Center, Case Western Reserve University, Cleveland, OH; University of California San Francisco, San Francisco, CA; Brigham and Women's Hospital, Boston, MA; Institute of Cancer Research, University College, London, United Kingdom; Moores Cancer Center at UC San Diego Health, La Jolla, CA; Mayo Clinic, Rochester, MN; Department of Radiation Oncology, Sutter Medical Group, Sacramento, CA; Department of Biostatistics and Bioinformatics, Duke Cancer Institute Center for Prostate and Urologic Cancers, Duke University School of Medicine, Durham, NC; Radiology School of Medicine, University of California, San Francisco, San Francisco, CA; Cedars-Sinai Medical Center, Los Angeles, CA

Emulated RCT

N=557
RTOG 521

N=733
CALGB 90203

IPTW cumulative incidence of distant metastasis (DM)- Primary EP

Death after DM- Atrributing Pca was considered

Cumulative incidence of DM low in RT vs RP 16% vs 23% (p=0.01)

RT has significant number of deaths without DM

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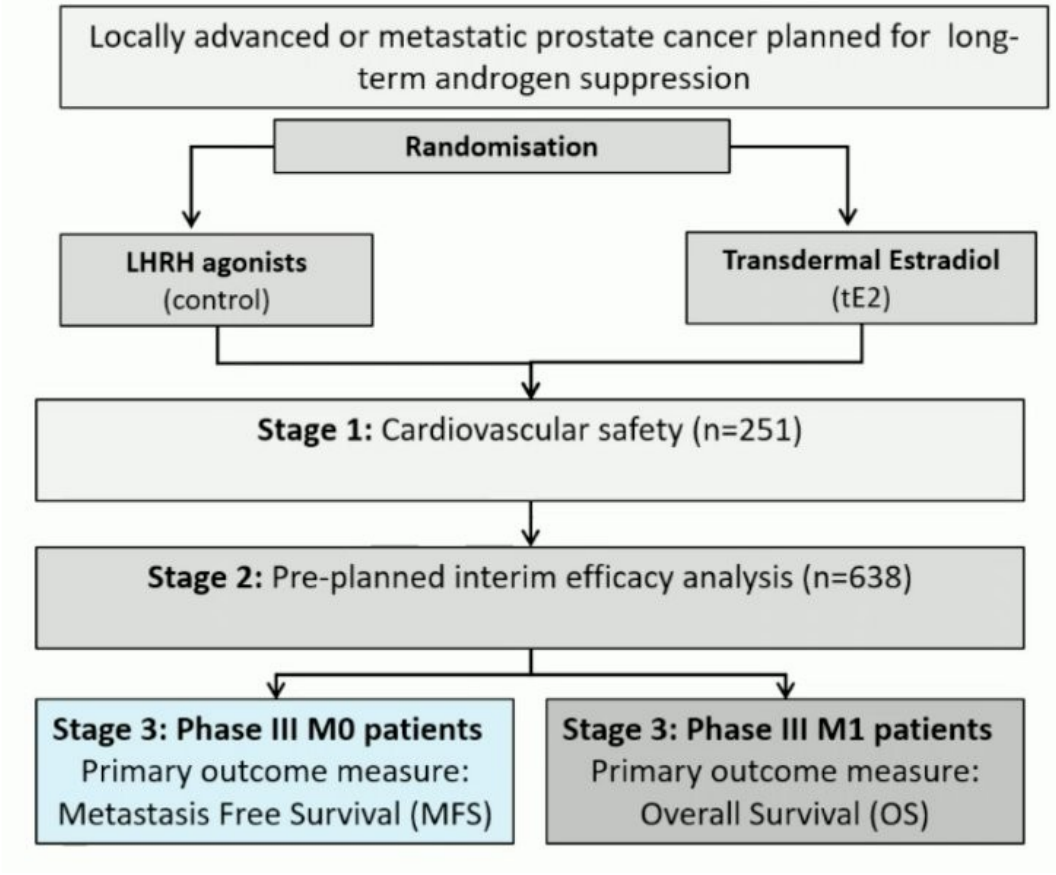
ESMO 2024: Prostate Cancer Efficacy Results from a Randomized Phase 3 Evaluation of Transdermal Estradiol Versus LHRH Agonists for Androgen Suppression in M0 Prostate Cancer

- What would be the choice of ADT in this patient?
- What factors would you consider in deciding the drugs?



Side effects	LHRH	Estradiol
Gynecomastia	42%	85%
Hot flushes	89%	44%
Bone mineral density		✓
CardioVascular Toxicity		✓
QOL		✓

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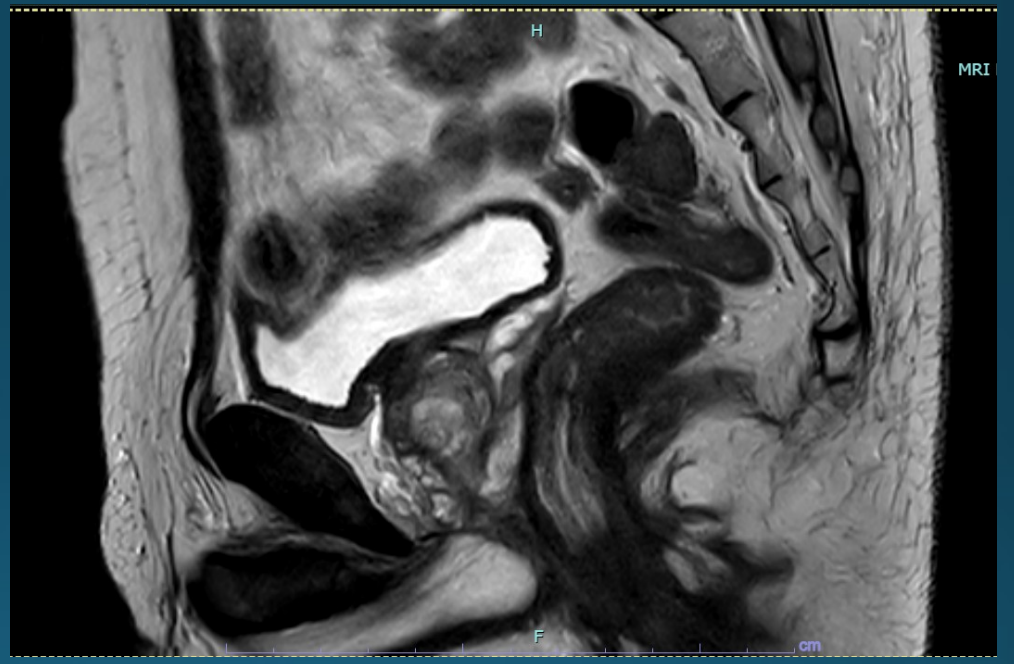

You have the option of Photon vs Proton, what do you choose?

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LBA 01

Prostate Advanced Radiation Technologies Investigating Quality of Life (PARTIQoL): Phase III Randomized Clinical Trial of Proton Therapy vs. IMRT for Localized Prostate Cancer

N=450

IMRT 70Gy/28fx
N=224

PBT 79.2Gy/44fx
N=226

Health care software bowel score Mean (Std Dev)	PBT (N=221)	IMRT (N=216)	p-value
Baseline	93.7 (7.8)	93.5 (7.9)	
24 mo	91.8 (11.1)	91.9 (8.6)	
Change	-2.4 (9.7)	-2.2 (9.1)	0.836

Median follow-up was 60.3

no difference in PFS (93.4% vs 93.7% at 60m

no difference in any QOL domain

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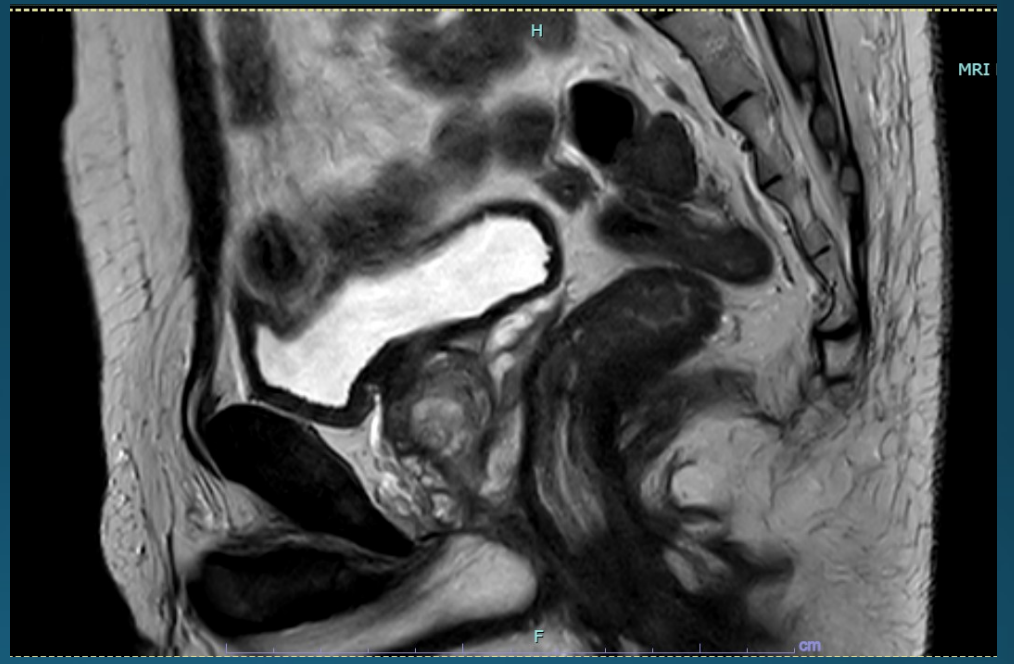

Patient developed a local relapse, would you send for surgery or do a re-irradiation?

Re-SBRT after previous definitive or salvage radiotherapy (RE-START). A study on behalf of AIRO

Giulio Francolini[1], Fabio Matrone[2], Alessandra Donofrio[2], Giulia Marvaso[3,4], Barbara Alicja Jereczek-Fossa[5], Liliana Belgioia[6], Elisa D'angelo[7], Rosario Mazzola[8], Rossana Ingargiola[9], Antonella Fontana[10], Alberto Cacciola[11], Esmeralda Scipilliti[12], Marcin Miszczyk[13], Vanessa Di Cataldo[1], Lorenzo Livi[14]

[1]Azienda Ospedaliero Universitaria Careggi, Radiation Oncology Unit, Oncology Department, Florence, Italy. [2]Centro di Riferimento Oncologico-Istituto di Ricovero e Cura a Carattere Scientifico (CRO-IRCCS), Aviano, Department of Radiation Oncology, Aviano, Italy. [3]IEO European Institute of Oncology IRCCS, Division of Radiation Oncology, Milan, Italy. [4]University of Milan, Department of Oncology and Hemato-Oncology, Milan, Italy. [5]IEO European Institute of Oncology, Division of Radiation Oncology, Milan, Italy. [6]IRCCS Ospedale Policlinico San Martino, Department of Radiotherapy, Genova, Italy. [7]Azienda Ospedaliero Universitaria di Modena, Radiotherapy Unit, Modena, Italy. [8]IRCCS Sacro Cuore Don Calabria Hospital, Advanced Radiation Oncology Department, Negrar, Verona, Italy. [9]National Center for Oncological Hadrontherapy, Radiation Oncology Unit, Clinical Department, Pavia, Italy. [10]Santa Maria Goretti Hospital, Radiotherapy Department, Latina, Italy. [11]University of Messina, Radiation Oncology Unit, Department of Biomedical, Dental Science and Morphological and Functional Images, Messina, Italy. [12]Istituto Nazionale Tumori-IRCCS-Fondazione G. Pascale, Department of Radiation Oncology, Naples, Italy. [13]Maria Skłodowska-Curie National Research Institute of Oncology, Gliwice branch, III(rd) Radiotherapy and Chemotherapy Department, Gliwice, Poland. [14]University of Florence, Department of Biomedical, Experimental and Clinical Sciences "M. Serio", Florence, Italy

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- Ambispective registry
- N= 302
- Structural relapse in Prostate or PB
- SBRT Median 30/2-5 fx
- bRFS, MFS, OS Endpoints

bRFS /MFS/OS

Variable	Univariate bRFS	Multivariate bRFS
High risk disease	=0.01	=0.01
Time to BCR <36 months	<0.001	<0.001
Concomitant ADT	<0.001	<0.001
PSA </=1 ng at relapse	<0.001	<0.001

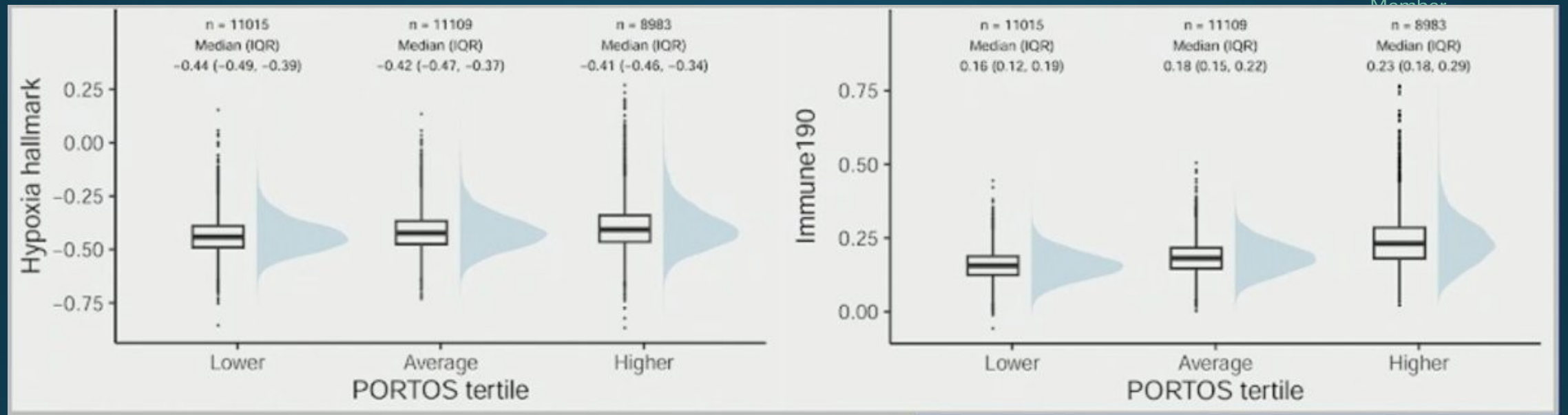
- None of above factors affected – MFS
- Time between end of Radiotherapy to relapse <36 months –OS p=0.02

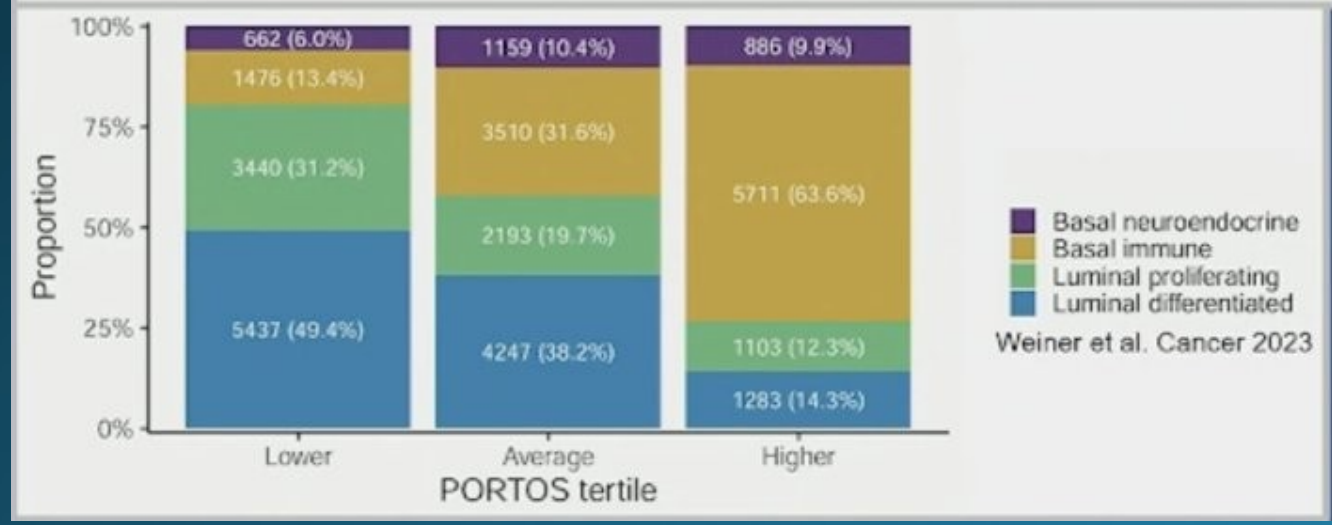
Toxicities

Toxicity	ACUTE	LATE
GI	11.2%	20.2%
GU	22.5%	38.4%

Gene signature predictor of dose-response to prostate radiation: Validation of PORTOS in phase III trials.

Shuang Zhao, Hyunnam Monica Ryu, James A. Proudfoot, Elai Davicioni, Jeff M. Michalski, Daniel Eidelberg Spratt, Stefanie Hayoz, Jeffry Simko, Howard M. Sandler, Alan Pollack, Matthew Parliament, Ian S. Dayes, Rohann Jonathan Mark Correa, Theodore Karrison, William Adrian Hall, Daniel M. Aebersold, Felix Y Feng, Pirus Ghadjar, Phuoc T. Tran, Alan Dal Pra; Department of Human Oncology, University of Wisconsin-Madison, Madison, WI; Veracyte, Inc., San Francisco, CA; Veracyte, Inc., South San Francisco, CA; Veracyte, Inc., San Diego, CA; Washington University School of Medicine in St. Louis, St. Louis, MO; University Hospitals Seidman Cancer Center, Case Western Reserve University, Cleveland, OH; Swiss Group for Clinical Cancer Research (SAKK), Bern, Switzerland; University of California, San Francisco, San Francisco, CA; Cedars-Sinai Medical Center, Los Angeles, CA; University of Miami Health System, Miami, FL; Division of Radiation Oncology, Cross Cancer Institute, Department of Oncology, University of Alberta, Edmonton, AB, Canada; Juravinski Cancer Centre, Hamilton, ON, Canada; London Health Science Centre, London, ON, Canada; NRG Oncology Statistics and Data Management Center, Philadelphia, PA; Medical College of Wisconsin, Milwaukee, WI; University of Bern, Bern, Switzerland; Helen Diller Family Comprehensive Cancer Center, University of California, San Francisco, San Francisco, CA; Charité Universitätsmedizin Berlin, Berlin, Germany; University of Maryland, Baltimore, MD; University of Miami, Miami, FL


n = 11015
Median (IQR)
-0.44 (-0.49, -0.39)
n = 11109
Median (IQR)
-0.42 (-0.47, -0.37)
n = 8983
Median (IQR)
-0.41 (-0.46, -0.34)
Hypoxia hallmark
0.25
0.00
-0.25
-0.50
-0.75
Lower
Average
Higher
PORTOS tertile
n = 11015
Median (IQR)
0.16 (0.12, 0.19)
n = 11109
Median (IQR)
0.18 (0.15, 0.22)
n = 8983
Median (IQR)
0.23 (0.18, 0.29)
Immune190
0.75
0.50
0.25
0.00
Lower
Average
Higher
PORTOS tertile


Proportion
100%
75%
50%
25%
0%
662 (6.0%)
1476 (13.4%)
3440 (31.2%)
5437 (49.4%)
1159 (10.4%)
3510 (31.6%)
2193 (19.7%)
4247 (38.2%)
886 (9.9%)
5711 (63.6%)
1103 (12.3%)
1283 (14.3%)
Lower
Average
Higher
PORTOS tertile
Basal neuroendocrine
Basal immune
Luminal proliferating
Luminal differentiated
Weiner et al. Cancer 2023

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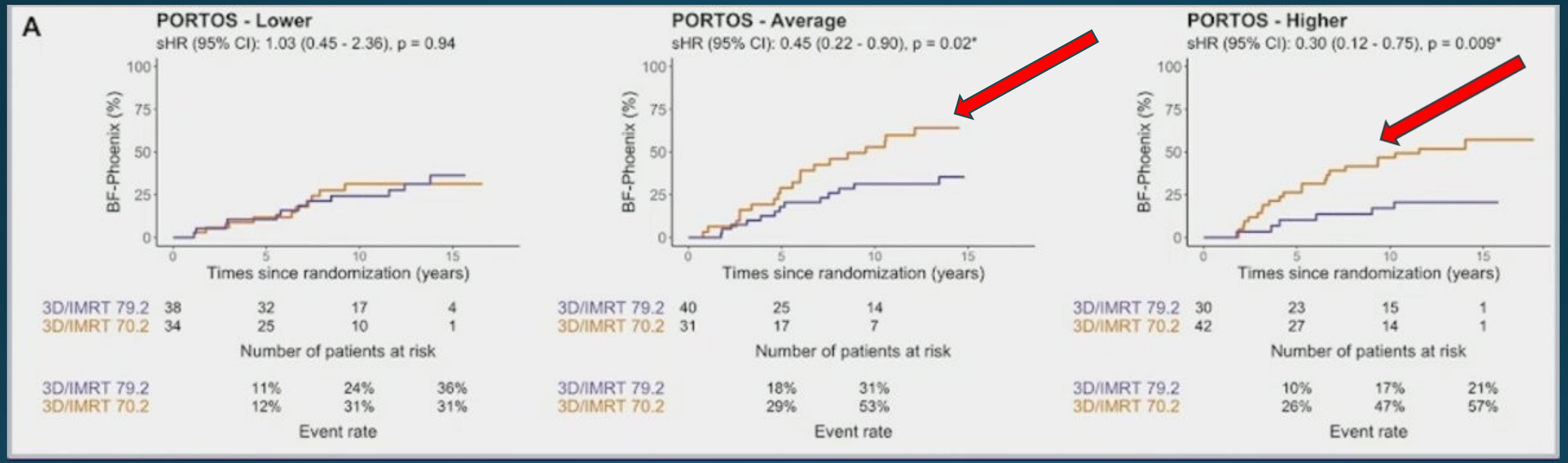
Results for RTOG-126



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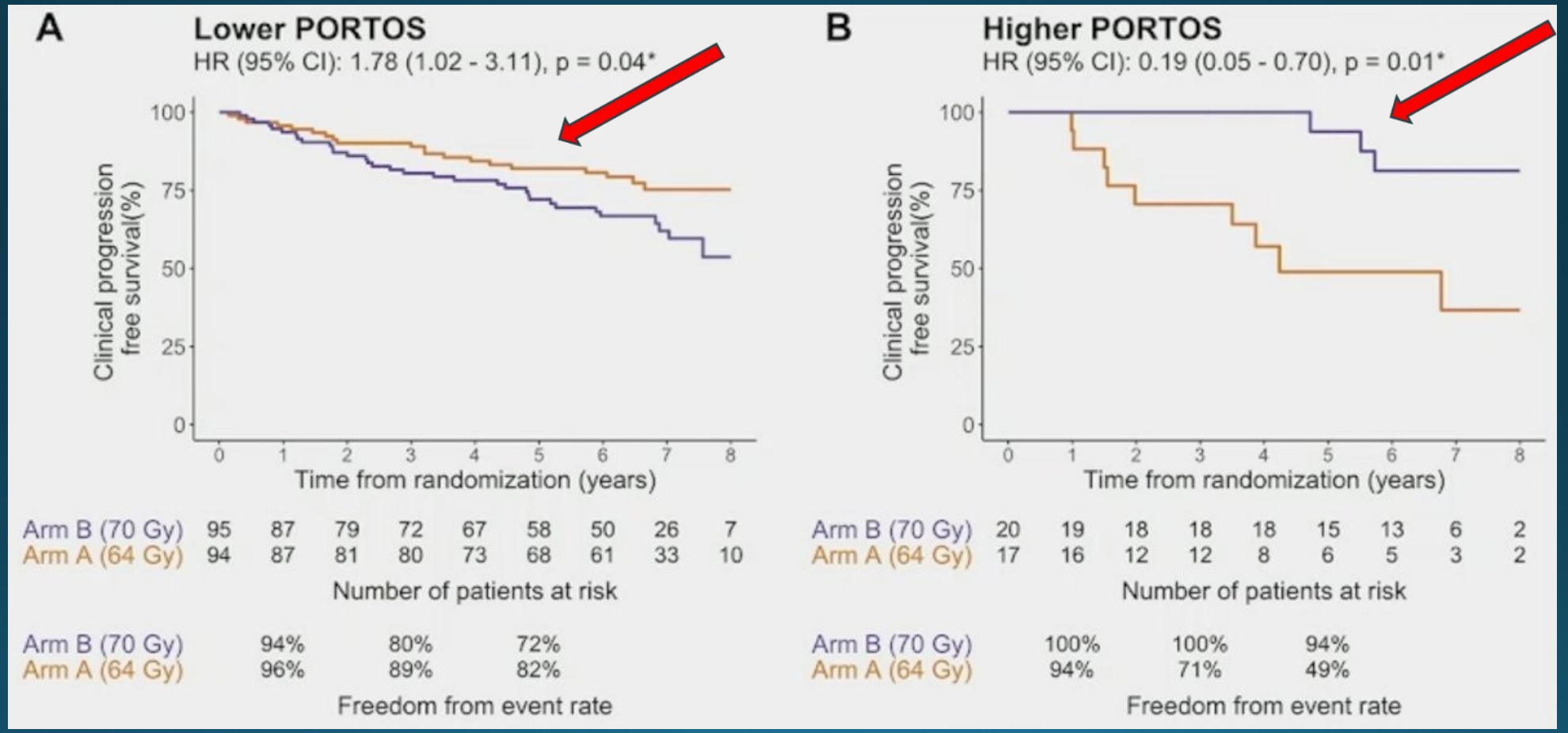
SAKK 9/10



PORTOS gene signature as a predictor of risk of adverse events after dose-escalated vs. lower-dose prostate radiation therapy in NRG/RTOG 0126.

Karen E. Hoffman, Sophia C. Kamran, Hyunnam Monica Ryu, James A. Proudfoot, Elai Davicioni, Paul L. Nguyen, Stephanie L. Pugh, Daniel Eidelberg Spratt, Jeff M. Michalski, Matthew Parliament, Ian S. Dayes, Rohann Correa, John M Robertson, Elizabeth Gore, Desiree E. Doncals, Eric Vigneault, Luis Souhami, Felix Y Feng, Phuoc T. Tran, Shuang Zhao; The University of Texas MD Anderson Cancer Center, Houston, TX; Massachusetts General Hospital, Harvard Medical School, Boston, MA; Veracyte, Inc., San Francisco, CA; Veracyte, Inc., South San Francisco, CA; Veracyte, Inc., San Diego, CA; Brigham and Women's Hospital, Boston, MA; NRG Oncology, Philadelphia, PA; University Hospitals Seidman Cancer Center, Case Western Reserve University, Cleveland, OH; Washington University School of Medicine in St. Louis, St. Louis, MO; University of Alberta, Edmonton, AB, Canada; Juravinski Cancer Centre, Hamilton, ON, Canada; London Health Sciences Centre, London, ON, Canada; Beaumont CCOP, Royal Oak, MI; Milwaukee VAMC and the Medical College of Wisconsin, Milwaukee, WI; Summa Health Medical Group, Akron, OH; CHU de Quebec, Quebec, QC, Canada; McGill University Health Centre, Montreal, QC, Canada; Radiology School of Medicine, University of California, San Francisco, San Francisco, CA; University of Maryland, Baltimore, MD; University of Wisconsin Carbone Cancer Center, Madison, WI

Higher PORTOS scores associated with higher AE's

To Recapitulate…

- ePLND improves MFS, should be considered based on current evidence
- Several evidence limitations to use the 3D Models for Sx planning, waiting before implementing reasonable
- Intraoperative nerve monitoring did not improve functional outcomes
- SBRT vs RP, Urinary & Sexual functioning better at 2 years, Bowel toxicity worse with SBRT
- Newer Trial designs like emulated RCT should be interpreted carefully

To Recapitulate…

- Robust RCT, should we reinvent the wheel for ADT?
- No difference in QOL or outcomes for IMRT vs PBT
- Personalized & predictive medicine is the way to go forward in decision making

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THANK YOU