**Welcome to AnCan After Hours**

**You have questions……………. Dr. Greene has answers.**

*Some attendees to our Dec. 30 webinar with Kirsten Greene, MD, chair of urology at the University of Virginia, had follow-up questions. AC After Hours shared the questions with Dr. Greene, who graciously responded.*

**AnCan: Dr. Greene, you conceded that many men with very low-risk prostate cancer may go without treatment for the rest of their lives. Are there any statistics on that percentage? What do you base the statement on? How long do men on active surveillance typically defer treatment if they have low-risk or intermediate-risk prostate cancer?**

**Dr. Greene:** Regarding the issue of deferring treatment vs avoiding treatment, this goes to the heart of active surveillance vs watchful waiting. For people who believe they are avoiding treatment forever, perhaps they are on watchful waiting.

It is at least worth a conversation with their urologist to see which one they are really on and why. Sometimes we(physicians) are not great about communicating why we think someone "will never need treatment in your lifetime." Maybe it isn't so much about the prostate cancer risk as it is about patient age and competing comorbidities.

Patients may think that the cancer just isn't that dangerous while the physician is thinking about competing health risks vs the cancer. This is why I stressed so strongly that patients should know if they are on AS or WW and to be sure it is the one they want.

I am basing this statement on all of the long-term active surveillance trials and cohorts which have been published as well as my participation in one of them (UCSF) and my experience as a urologic oncologist.

Regarding the statistics for this, I would urge patients to read the publications from these trials and I have attached the most recent publication of the Johns Hopkins active surveillance cohort.

This cohort is one of the most conservative, meaning that low-risk and very low-risk patients were included but very few or no intermediate-risk. [See: https://www.sciencedirect.com/science/article/abs/pii/S0302283819309613?via%3Dihub]

So this answers the question about how likely men are to be treated in these categories.

The treatment rates at each time point. 35% were treated at 5 years, 48% by 10 years, and 52% by 15 years.

The converse is the answer to the question of what percentage of men avoid treatment for each time point. This paper, along with the other trials, is also the source of my answer regarding GG1 [Gleason Grade 1, or Gleason 6] disease metastasizing. The rate is certainly <1% and maybe less than 0.1%.

**AnCan: Why not just do transperineal procedures and abandon the transrectal biopsy to avoid sepsis?**

**Dr. Greene:** The SUO [Society of Urologic Oncology] just had a whole session on this, including a debate. I tried to present the pros and cons of each during our presentation rather than advocating for either.

…It isn't that simple or clear-cut, and I'm not going to tell patients that TP is the only or best option if it is a more complex issue. IF someone is concerned only about sepsis and nothing else, then he should have a transperineal biopsy. This is a hotly debated issue right now in the U.S., and TP definitely has a lower sepsis rate. It is more painful and may have a higher risk of urinary retention. This commonly requires anesthesia or sedation, but some patients are able to tolerate this in the office. It is being increasingly adopted in the U.S. and is the way biopsies are done in England, Australia, Germany, etc.

**AnCan: We've been told that it's easier to get the anterior samples with transperineal. Is that true?**

**Dr. Greene:** Yes. It is easier to get anterior and apical cores although experienced urologists can get these areas with TR as well.

**AnCan: Why not just do transperineal procedures since they essentially avoid the sepsis and infection issues?**

**Dr. Greene:** Yes, sepsis is lower, pain and retention are higher. If sepsis is your only concern, then TP is the way to go.

**AnCan:** **Sepsis is a concern among these men. Do some urologists do a better job of avoiding it than others?**

**Dr. Greene:** Yes, and it has to do with antibiotic resistance profiles in that region, prophylaxis, cultures, etc. There are ways to decrease the sepsis rate.

**AnCan: Why don't urologists simply get retrained and do transperineal biopsies? Or is it not that simple?**

**Dr. Greene**: It really isn't that simple. Think about the fact that urologists take care of many patients other than just those having prostate biopsies. If our only job in urology was doing prostate biopsies, then it would make sense to take the time, money, effort, lost work to get completely retrained, buy all new equipment, retrain all of our staff, change all of the sterilization equipment, and requirements for the new equipment, change office schedules to allow for this longer procedure. Maybe buy double the equipment to run multiple biopsy rooms to make up for the fact you can do fewer in a day, etc. Maybe wait times for patients would be longer since fewer biopsies could be done each day. Think about your own work for a second and a major change that would impact a critical workflow in one area of many that you do. Even if you wanted to make a change, it impacts a lot of people and processes and it would take months at best to ramp one thing down and ramp another up.

**AnCan: Is this a time/compensation issue?**

**Dr. Greene:** Yes, partly. it takes maybe double the time to do a TP than a TR and likely longer if you are doing this in an operating room. Compensation is the same for TP and TR approaches.

**AnCan: How steep is the learning curve for urologists?**

**Dr. Greene:** Not that steep if the patient is under anesthesia but it is trickier if the patient is awake. We don't want to hurt or traumatize people during a biopsy, especially since this is an important part of surveillance.

**AnCan: How much longer do transperineal biopsies take compared with transrectal biopsies in experienced hands?**

**Dr. Greene:** It depends on the team and not just the urologist. Maybe double the time best-case scenario.

**AnCan: Would it be more equitable and acceptable to urologists if Medicare and other payors paid more for transperineal biopsies?**

**Dr. Greene:** Yes, that would definitely help. But it isn't just the urologist to consider. If you are doing this in the OR, then the facility costs are very high (have to pay anesthesia, nursing staff, cleaning staff, central sterile supply, etc). OR time is one of the highest costs in all of health care, up to $100 or more a minute. So while the urologist may be getting paid double for the professional fees, if the hospital/ambulatory surgery center/outpatient clinic is still getting paid the same amount you can see how urologists may not be allowed to do this approach because it would be a money loser for an institution or private practice.

A**nCan: You mentioned the issue of pacemakers and shrapnel with MRIs. What about artificial hips, which are common in this audience. Can MRIs be done safely on men with hip replacements? How common is this?**

**Dr. Greene:** To be clear, there are no contraindications to orthopedic hardware in any location and MRI.

**AnCan: An attendee said he had favorable PI-RADS from his MRIs and then had high reading of PI-RADS 4. He said he discussed this with his radiologist and they decided to “discount” that reading. Can we discount PI-RADS 4 or 5 in some cases?**

**Dr. Greene:** I don't advise discounting PI-RADS 4 or 5 readings. Data is still data. Remember, MRIs don't diagnose prostate cancer. There are likely to be areas of prostate cancer and an MRI fusion biopsy confirms this (or rules it out). Simply put, you may have a PIRADS 4 or 5 lesion and it may not be cancer. It's imaging and not pathology, remember. If patients think that they are more well informed on how to read their MRI than the radiologist who is reading it, then this may be a reason for them to consider asking for an overread (this means a second opinion reading) of their MRI at a high volume prostate cancer center. Don't go it alone.

**AnCan: Have you heard of MRIs causing tinnitus? Can going in feet first help?**

**Dr. Greene:** Yes, MRIs are loud. No, I have not heard of long-term hearing damage from this. Patients may ask for headphones or earplugs or bring earplugs. I don't think feet first helps, but headphones or earplugs will. Some places offer music.