

in post-treatment surveillance is unclear. In our cohort, we observed a substantial initial PSA reduction at 3 months and subsequent stabilization for most patients. More importantly, we defined the difference in PSA drop between focal and hemi-gland ablation. This significant difference highlights need to consider the extent of treatment zone when assessing PSA kinetics post-IRE.

<https://doi.org/10.1016/j.urolonc.2024.12.195>

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POST-OPERATIVE SENTIMENT IN PATIENTS AFTER MRI-GUIDED TRANSURETHRAL ULTRASOUND ABLATION (TULSA) OF LOCALIZED PROSTATE CANCER: QUANTIFYING REGRET AND CORRELATING PATIENT-REPORTED REGRET WITH FUNCTIONAL OUTCOMES

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Introduction: Focal therapy for prostate cancer provides an attractive option for patients interested in balancing treatment related side effects on urinary and erectile function with oncologic control. MR-guided transurethral ultrasound ablation (TULSA) has emerged as a focal therapy technique for localized prostate cancer that may be able to achieve acceptable oncologic outcomes while maximizing functional outcomes important to patients. Here we share patient-reported outcomes after TULSA, including satisfaction and treatment regret metrics.

Methods: We conducted a retrospective survey of men currently enrolled in a single-center, prospective study utilizing TULSA to treat localized prostate cancer. The survey was sent via patient portal to those treated with TULSA between October 2020 and December 2023. Surveys contained 4 sections based on validated questionnaires, including questions regarding urinary and erectile symptoms and feelings of satisfaction and regret. Each section contained dynamic questions that collected further information depending on patient responses. Survey responses were analyzed. Patients were then grouped into regret and non-regret cohorts based on responses to the prompt “I regret the choice that was made.” Those who answered “disagree” and “strongly disagree” were grouped into the non-regret cohort and all others were assigned to the regret cohort. Those who selected any option other than “strongly disagree” were prompted to quantify the extent that 10 symptoms contributed to their inability to select “strongly disagree.”

Results: In total, 162 surveys were sent, and 83 surveys were fully completed and subsequently analyzed. Most (89.2%) patients agreed or strongly agreed TULSA was the right decision, they would choose TULSA again (84.3%), and they would recommend TULSA to family (88.0%). Responding to the prompt “I regret the choice that was made,” patients reported: strong disagreement 56 (67.5%), disagreement 17 (20.5%), neutrality 5 (6.0%), agreement 3 (3.6%), and strong agreement 2 (2.4%). As a result, 10 patients were assigned to the regret cohort. Compared to the non-regret cohort, those in the regret cohort were significantly more likely to endorse worst postoperative erections compared to preoperative erections and were less likely to have erections with self-stimulation (Figure 1). A distribution of the 10 symptoms contributing to patient sentiment is shown in Figure 2. Erectile dysfunction (88.9%) and ejaculatory issues (70.4%) were the most cited reasons for not selecting “strongly disagree.”

Conclusions: Our findings identify a significant relationship between post-TULSA decision regret and erectile function. Our data shows that overall satisfaction with TULSA is high and functional outcomes may be more favorable than radical treatment options. However, our findings also support that variability in outcomes may significantly impact patient-reported treatment regret. Further work is needed to identify the relationships between patient selection, intraoperative techniques and functional outcomes to further refine which patient populations may experience the best functional outcomes and the highest treatment satisfaction after TULSA.

<https://doi.org/10.1016/j.urolonc.2024.12.196>

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PATIENT-REPORTED FUNCTIONAL DECLINE FOLLOWING RADICAL PROSTATECTOMY (RP) OR EXTERNAL BEAM RADIATION WITH ANDROGEN DEPRIVATION THERAPY (EBRT W/ ADT) FOR UNFAVORABLE-RISK PROSTATE CANCER

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Introduction: In the primary analysis of the Comparative Effectiveness Analysis of Surgery and Radiation (CEASAR) study, most comparative patient-reported functional differences between treatments for localized cancer attenuated within five years (JAMA 331(4):302 2024). This secondary analysis describes clinically meaningful functional decline after treatment of unfavorable-risk prostate cancer to better inform patients' expectations.

Methods: Participants diagnosed with localized prostate cancer between 2011-2012 were prospectively enrolled from 5 US Surveillance, Epidemiology and End Results Program Sites. The validated 26-item Expanded Prostate Index Composite questionnaire (range, 0-100) was administered at baseline and at 1-, 3-, 5-, and 10 years. Functional change from baseline was calculated at each time point. Established thresholds for clinically meaningful functional decline (CMFD) were used: 10 sexual function (fxn), 6 urinary incontinence (Uincon); 5 urinary irritative (Uirr); 4 bowel fxn. Descriptive statistics report function and problems for participants with unfavorable-risk (prostate-specific antigen 10 ng/mL, Grade Group 3-5, and/or cT3a) prostate cancer selecting a specific treatment. Unadjusted analyses were performed; results should not be compared across treatment groups.

Results: Among 446 men with unfavorable-risk prostate cancer, 294 were treated with RP and 152 with EBRT w/ ADT, and completed the baseline and at least 1 postbaseline survey. Median [interquartile range] age, 66 [61-71] years; 72% non-Hispanic white. Most EBRT was IMRT (89%) with IGRT (87%) and 84% of RP was nerve-sparing with 61% bilateral nerve-sparing. The proportion of participants with CMFD in each functional domain and with “moderate to big problem” (MTBP) with sexual, urinary, and bowel function at each time point are reported in the table below. Fewer patients reported a MTBP with function than those reporting CMFD.

Conclusions: Our findings highlight long-term clinically meaningful functional declines and problems following different treatments for unfavorable-risk prostate cancer. Patients should be informed about potential long-term functional risks to manage treatment expectations effectively.

<https://doi.org/10.1016/j.urolonc.2024.12.197>

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BACK TO BASICS - DIGITAL RECTAL EXAMINATION IN THE ERA OF ADVANCED IMAGING: IS IT STILL ESSENTIAL FOR PROSTATE CANCER DETECTION?

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Introduction: Over the years, digital rectal examination (DRE) has been recommended for annual prostate cancer (PCa) screening in men over 50. Recently, the American Urological Association (AUA) guidelines have been amended to consider digital rectal examination (DRE) optional in patients undergoing PCa screening. Screening plays a crucial role in preventing deaths and detecting metastatic PCa cases. While PSA testing and imaging studies are the cornerstone diagnostic modalities, DRE remains a clinically valuable and cost-effective tool that can aid in the evaluation of these patients and should not be overlooked.