Oh, it's really exciting.

Super, super exciting.

Thank you guys for being the kickoff.

Yeah, and who knew that September 6th was the day after Labor Day? OK.

Karen, I didn’t tell you yet.

I got covered over the weekend, so I’m COVID recovering now. You

are in the ranks of the proud

who who held out for that full 2 years before going down now.

With a really, really long Oh my goodness,
OK, we are live actually. OK.

Well, welcome everybody tonight to Smilo shares with primary care.

It's our kickoff. Wait just a few minutes so that people can join.

Before we get started, I see we have about 14 people did did. I see we have about 14 people did did.

Maybe you can answer the question and the answer.

Did anybody have a difficult have difficulty logging on?

Through the zoom link.

If anybody did, please please just give

us this the the feedback in the Q&amp;A.

And then if you might be asking the wrong people, I know. They got on.
00:02:27.470 --> 00:02:28.598 Is 16126 and

00:02:30.070 --> 00:02:33.416 Dan, can you go on mute please?

00:02:33.420 --> 00:02:35.380 Thanks. OK. All right, well,

00:02:35.380 --> 00:02:37.575 let’s get started because we

00:02:37.575 --> 00:02:40.600 have a lot going on tonight.

00:02:40.600 --> 00:02:42.160 My name is Anne Chang.

00:02:42.160 --> 00:02:46.840 and deputy CMO for Smilo,

00:02:46.840 --> 00:02:49.096 with Karen Brown and Ryan O’Connell.

00:02:49.096 --> 00:02:51.699 I’ll let you guys introduce yourselves.

00:02:51.700 --> 00:02:53.278 I’m a medical oncologist

00:02:53.278 --> 00:02:56.080 and primary care for Northeast Medical Group and

00:02:56.080 --> 00:02:58.612 I’m the medical director of primary

00:02:58.612 --> 00:03:01.063 care for Northeast Medical Group and

00:03:01.063 --> 00:03:03.492 thrilled to see this series get Off.
Ryan O'Connell, General Internist

at NE Medical Group

I think most everyone, but for those I haven’t met, thank you.

And really a special shout out to Ann Karen and to all the panelists who have really worked hard to make this really meaningful and highly educational.

I’m really excited.

Great. And Kevin Billinsley, who’s also our course director but is unable to attend today.

So first just to opening slide, if you can pull that up, please?

Telling you what this series is, it’s a monthly series.
It’s called smilo shares. Actually, it’s called with primary care for primary care. I think we ultimately decided with primary care and this month is focused on prostate cancer and each month it’s going to be a different topic. These are topics that both Karen and Ryan chose for primary care, not only for themselves, but thinking about and talking to other people. The designated audience is primary care clinicians. And our faculty,
we tried to choose people from a specific geographic region.

So today, we’re in Greenwich really, and focusing on prostate cancer. The idea is really to link and build relationships between primary care and EMG physicians. And this is going to be a monthly series just like that. Trust your gut so you can get used to it and put it on your calendar. It’s going to be the first Tuesday of the month from 5 to 6 virtually. And hopefully maybe this year we can do a few of these in person as well.
And the Big Y is really as we were talking about this that there’s just an explosion of information around cancer even for oncologists and I think for primary clinicians. This is an area where, you know, understanding the updated recommendations and some of the new approaches are really important to hear about and while there are lots of different, you know. Lectures around cancer, specifically this this format is
really focused on primary care.

And those questions that are most important to you and it'll be case based tonight we have three cases that are really going to highlight those what we thought would be very topical or very important questions that you run that you come across in clinic and to highlight the clinical pearls from our faculty.

So let's go to the next slide.

So we're going to do the the three case presentations.

We will have some time for
for a question to answer.
Each one will take about 15 minutes.
So we'll encourage you guys to
put your questions in the chat.
Some of those if if you want to hold them to the end,
we will hope to have a little bit of time at the end.
And then our terrific faculty is here.
Or you wanna introduce Aaron?
Or we have Aaron Culbert, who is an internist in the Greenwich region,
well respected by her colleagues and patients, and turns out to be quite
knowledgeable about prostate cancer.

How she’s a mother as well as a physician and has all sorts of athletic activities as well.

And next is Bruce Mcgibbon.

He’s already he’s been a radiation oncologist at Yale for 13 years, and he is the medical director of Rad ONC at Greenwich for the past three.

And he’s particularly interested in prostate cancer,

also very active and an owner of a new kitten he informed us last week.

And then my colleague Dan Petrovac, who’s a medical oncologist,

he’s a professor of medicine and leads
the Gu cancers for Yale and Smilo.

Uh, in New Haven. He’s been in Greenwich for for 10 years as well he is. Do you expert these develop new drugs he’s brought them to FDA approval really just known internationally and an amazing clinician and a clinical researcher and also very active in tennis and golf.

And then finally Jerry Portman who has been a urologist at Yale for 10 years in Greenwich for a year and he is you know he does generally urology but really focuses on urologic.
Ecology and he loves to travel.

In fact, he was participating on his vacation last week in planning of this event. So we’re going to get going and turn it right over to Aaron to start us off on the first case.

Thanks, Karen. All right. Thank you so much and thank you so much, Karen, for that kind introduction.

We’re going to start with our first case, pretty typical primary care, bread and butter.
We have our 47 year old white male. Non-smoker patient who presents today for a routine physical exam. When asked, he notes no urinary symptoms, unless of course he has coffee at night right before bedtime, which results in one to two episodes of nocturia. When we questioned him about family history, he relates his father was diagnosed with prostate cancer at the age of 61 and notes that his paternal grandfather was also diagnosed with prostate cancer. Not sure of the age for that. Uh, so um,
unless we count that coffee is asymptomatic for urinary symptoms.

He expresses concern to us about his family history of prostate cancer and says DOC, can I get screened for prostate cancer?

So we are going to talk uh to him. I think it’s easier to go through some of the screening recommendations utilizing our care signature pathway for prostate cancer screening.

This was a collaboration between our clinicians also involved review of a lot of the evidence that’s available as well.
NOTE Confidence: 0.898760204
00:09:50.942 --> 00:09:52.450 national recommendations,
NOTE Confidence: 0.898760204
00:09:52.450 --> 00:09:54.655 I think Mike Lehman was involved as
NOTE Confidence: 0.898760204
00:09:54.655 --> 00:09:57.142 well as our other affiliated urologists
NOTE Confidence: 0.898760204
00:09:57.142 --> 00:09:59.520 were involved in developing this pathway
NOTE Confidence: 0.898760204
00:09:59.520 --> 00:10:02.329 and keeping it as up to date as we
NOTE Confidence: 0.898760204
00:10:02.329 --> 00:10:04.273 can with the change in recommendations.
NOTE Confidence: 0.898760204
00:10:04.280 --> 00:10:06.408 Certainly since 2018 there’s
NOTE Confidence: 0.898760204
00:10:06.408 --> 00:10:09.114 been a lot of changes,
NOTE Confidence: 0.898760204
00:10:09.114 --> 00:10:12.558 especially with the Class C recommendation
NOTE Confidence: 0.898760204
00:10:12.558 --> 00:10:15.074 for prostate cancer screening for
NOTE Confidence: 0.898760204
00:10:15.074 --> 00:10:18.570 patients 55 to 69 and a lot of debate.
NOTE Confidence: 0.898760204
00:10:18.570 --> 00:10:19.998 Revolve revolving around the
NOTE Confidence: 0.898760204
00:10:19.998 --> 00:10:21.426 prostate specific antigen as
NOTE Confidence: 0.898760204
00:10:21.426 --> 00:10:23.348 well as digital rectal exams.
NOTE Confidence: 0.898760204
00:10:23.350 --> 00:10:26.266 So we’ll go through that as if you were
NOTE Confidence: 0.898760204
in the room talking to your patient, going through the pathway to evaluate his prostate cancer risk and go through the screening. So we have our test patient here. Karen’s kind enough to drive for me, so she’s going to open up that pathway. So this is how it would look if you were in doing your note. If you type in prostate, not prostate, uh, it will come up with the prostate cancer screening. Pathway or you wanna click on that initial screening pathway? And it will open up. Obviously the entire pathway,
Note: Confidence: 0.10259658
00:11:09.768 --> 00:11:13.100 she’s gonna fit it to our screen here.
Note: Confidence: 0.10259658
00:11:13.100 --> 00:11:16.439 So we’re gonna go through uh and see our,
Note: Confidence: 0.10259658
00:11:16.440 --> 00:11:17.907 our our case,
Note: Confidence: 0.10259658
00:11:17.907 --> 00:11:21.330 uh for today was 47 years old.
Note: Confidence: 0.10259658
00:11:21.330 --> 00:11:23.229 Karen, if you want to open up the authors,
Note: Confidence: 0.10259658
00:11:23.230 --> 00:11:25.732 I think you want to give full credit to
Note: Confidence: 0.10259658
00:11:25.732 --> 00:11:27.910 the contributors for the pathway content,
Note: Confidence: 0.10259658
00:11:27.910 --> 00:11:30.133 because I know this took a lot of work.
Note: Confidence: 0.10259658
00:11:30.140 --> 00:11:31.740 Uh, so there’s our list.
Note: Confidence: 0.10259658
00:11:31.740 --> 00:11:33.390 Mike Leitman up at the top,
Note: Confidence: 0.10259658
00:11:33.390 --> 00:11:35.315 an extra bacus who’s from
Note: Confidence: 0.10259658
00:11:35.315 --> 00:11:37.240 the Greenwich region as well,
Note: Confidence: 0.10259658
00:11:37.240 --> 00:11:39.478 Jerry Portman, who’s with us today,
Note: Confidence: 0.10259658
00:11:39.480 --> 00:11:41.886 Karen Brown who’s with us today,
Note: Confidence: 0.10259658
00:11:41.890 --> 00:11:43.500 as well as a host of others.
Note: Confidence: 0.10259658
So thank you very much for making this easy to use on the primary care side.

Alright. So we're going to go through the pathway. We're going to spend a little bit of time here because it does open up into some detail.

We're going to talk about some risk factors. Our patient is 47, he meets the criteria being above 40. So we'll give you a whole pathway overview here.

So our patient is 47, he meets the criteria being above 40. So we'll consider prostate
cancer screening for him.

It’s important to note this does not apply to patients who have a prior prostate biopsy with a high grade neoplasia or atypical cell proliferation.

We also want to double check that our patient has a greater than 10 year life expectancy.

Our patient is healthy, has no other medical comorbidities that we know of.

Uh, and he is younger than 75 years old.

So we’re gonna proceed down that pathway.

We’re gonna spend a little bit of time about certainly African American descent,
00:12:55.858 --> 00:12:57.846 we need to note.
NOTE Confidence: 0.873033107777778
00:12:57.850 --> 00:13:00.265 So on our initial case presentation slide,
NOTE Confidence: 0.873033107777778
00:13:00.270 --> 00:13:02.391 you know if he were African American
NOTE Confidence: 0.873033107777778
00:13:02.391 --> 00:13:04.681 that would be an additional risk factor
NOTE Confidence: 0.873033107777778
00:13:04.681 --> 00:13:07.258 on top of his family history and it
gives you the incidence rates as as well,
NOTE Confidence: 0.873033107777778
00:13:07.258 --> 00:13:09.690 but it it’s quite elevated.
NOTE Confidence: 0.873033107777778
00:13:11.310 --> 00:13:12.114 That population should definitely be
NOTE Confidence: 0.873033107777778
00:13:14.124 --> 00:13:16.551 screened at an earlier age greater
NOTE Confidence: 0.873033107777778
00:13:16.551 --> 00:13:19.428 than one or one or greater first
NOTE Confidence: 0.873033107777778
00:13:19.428 --> 00:13:22.146 degree relative within the history of
NOTE Confidence: 0.873033107777778
00:13:22.146 --> 00:13:24.876 prostate cancer on either side actually.
NOTE Confidence: 0.873033107777778
00:13:24.880 --> 00:13:27.164 So maternal and paternal
NOTE Confidence: 0.873033107777778
00:13:27.164 --> 00:13:30.019 diagnosed that less than 65.
NOTE Confidence: 0.873033107777778
00:13:30.020 --> 00:13:34.108 Family history of other cancers is important.
You want to consider not only prostate cancer, but you do want to consider breast cancer either male or female colorectal.

I think Melanoma is on that list or it was ovarian, pancreatic, uterine and then it expands down at the bottom if you have two or more first or second degree relatives with cancer at any age, so if you have multiple relatives. They will also count for you. So he does have a family history of prostate cancer and his father.
So we’re going to say, yes, he’s a high risk patient and then we’ll initiate shared decision making for him.

I’m going to come back to that.

There’s a bunch of resources there.

I did want to touch on the germline mutations and the genetic testing that’s available,

so not.

Not very common to talk about.

It’s something that Yale offers

for our patients, which is great.

If you click that hyperlink that says referral to cancer genetics,

it’ll automatically bring up to sign

off on that ambulatory referral to genetics,
00:14:47.940 --> 00:14:49.360 type in the referral reason,
00:14:49.360 --> 00:14:50.722 send it off.
00:14:50.722 --> 00:14:53.446 There’s also a Yale Generations project
00:14:53.446 --> 00:14:56.406 which you can offer to your patients,
00:14:56.410 --> 00:14:58.720 which is a DNA sequencing project
00:14:58.720 --> 00:15:00.520 that’s free to participate in,
00:15:00.520 --> 00:15:02.668 provides a lot of genetic screening.
00:15:02.670 --> 00:15:05.560 Uh, opportunities?
00:15:05.560 --> 00:15:07.660 And Karen just pull and pull
00:15:07.660 --> 00:15:09.840 up our our flyer for that.
00:15:09.840 --> 00:15:13.669 So that is definitely available to our
00:15:13.669 --> 00:15:16.380 patients either blood or saliva testing.
00:15:16.380 --> 00:15:18.510 And then patients will get that
00:15:18.510 --> 00:15:21.345 results and have a nice QR code they
00:15:21.345 --> 00:15:23.780 can scan to get involved with that.
So we can print that and give that to our patients or just click on that link and scan the QR code in the visit, which is nice.

In terms of genetic testing, BRCA gene testing is important. And then there’s additional.

Remind mutations that if you scroll down and click on, that germline mutations line up right above Karen.

There’s also additional testing related to Lynch syndrome.

I think the ATM gene, there’s a few genes that we know are linked to higher risk of prostate cancer.

So when it comes to shared decision making,
while I’m in the room with my patients, you can open this up. I know everybody has a different report with their patients, but basically the important thing is to let the patients know. What the recommendations are, what the testing is, as well as the risks of the testing. So there’s a lot of great handouts from the American Cancer Society resources from up to date that provide a great informational overview, especially with patients 47. He’s probably never had prostate
cancer screening before.

Would give them a great overview to know exactly what we're getting into because once you start screening. It's going to be continued most likely until they're 75 based on the current guidelines. So I would take this patient through, OK.

Yes, we should talk about prostate cancer screening.

Your dad had a history of prostate cancer.

These are the ways that we would screen.

PSA is is the most commonly used. We'll come back to other methods. There are risks of false positive.

Uh, if you Scroll down,
there is a list of the acute factors.
Yep, you got it.
That may alter PSA results.
So we’ll get into that.
But there is a nice smart phrase
you can put in your note.
It’s dot prostate cancer screening,
SDM’s shared decision making.
So you can put that into your note.
Get full credit for having that
lengthy shared decision making
conversation with your patient.
So you want to let the patient know,
you know, hey.
PSA is not a perfect test.
If you have some urinary retention instrumentation, vigorous physical activity or perineal trauma can sometimes raise the PSA. So if they say, OK, I understand they’re the risks involved with PSA, I want to proceed. You would then click on the screening PSA order either through Yale or LabCorp or through Quest and it’s going to look exactly like that if you see on the upper right hand side. So you can just hit accept and it will sign off on that screening PSA order. Yeah, there you go.
Perfect.

Alright. So say we sign off that our 47 year old male is otherwise pretty healthy.

It’s a week or two later, depending on whether he went to Quest or LabCorp, he should have gone to Yale. And then, uh,

as you go through the pathway, there’s Umm, if you go down to that 3rd result, Normal result discussion.

You can then go through that pathway and it literally takes you through step by step.

So Umm, we’re going to go through, we’re going to come back to the digital rectal exam.
I have a couple slides on that.

Umm, we'll talk about that in a minute.

If the PSA is greater than 10.

It should be repeated in about four to six weeks.

Uh, you want to make sure we weren't missing part of our history, some unknown instrumentation or unknown symptoms that they didn’t realize they had?

Uh, we also, uh,

wanna review what that repeat lab is.

If it’s still elevated, then that generates a reflex.

You can hit that refer to urology hyperlink up there on the right.

Yeah.
And at that point, we need to get your urology involved because that indicates more of a high risk probability if our young 47 year old has a PSA less than 10, which thankfully most of them do. We need to consider. Other factors so say he was 47 and on finasteride to help prevent hair loss. Umm, that’s your 5A reductase inhibitor. So there actually is a correction factor for that, something which I had to brush up on for this.
but if you do have a patient that's already on it, you really should double your PSA value. If the PSA increases while they’re already on a 5α reductase inhibitor, that also should be evaluated by urology. The reason for that is because higher grade lesions are more common when you’re on a 5α reductase inhibitor. So assuming he’s not on finasteride, which our patient was not, you can go by age category, even though the lab cut off will be 4.0 nanograms per milliliter. It really does go by age so that first decade.
00:20:59.070 --> 00:21:00.510 40 to 49, if it’s greater than two is considered abnormal,
00:21:00.510 --> 00:21:02.910 then 50 to 59 greater than three also considered abnormal,
00:21:02.910 --> 00:21:04.870 and then 60 and above.
00:21:04.870 --> 00:21:07.378 You can use that upper limit normal of the lab cut off at 4.
00:21:07.378 --> 00:21:10.350 So you can go through based on all of that.
00:21:10.350 --> 00:21:12.984 If his PSA was less than 2.0 nanograms per milliliter,
00:21:12.984 --> 00:21:25.200 and he would have a normal PSA,
00:21:25.200 --> 00:21:28.536 then you would go to the right
00:21:28.536 --> 00:21:30.680 and he would have a normal PSA,
00:21:30.680 --> 00:21:34.949 and actually it’ll break it down even further into when you should
00:21:34.949 --> 00:21:36.883
00:21:34.949 --> 00:21:36.754 be repeating the PSA numbers, 
NOTE Confidence: 0.8414475
00:21:36.760 --> 00:21:39.172 and you can actually go into 
NOTE Confidence: 0.8414475
00:21:39.172 --> 00:21:42.240 your health maintenance screen. 
NOTE Confidence: 0.8414475
00:21:42.240 --> 00:21:45.208 And you can update the modifier and 
NOTE Confidence: 0.8414475
00:21:45.208 --> 00:21:47.849 select the frequency that you want to. 
NOTE Confidence: 0.8414475
00:21:47.850 --> 00:21:51.036 I think you might have to hit edit modifier. 
NOTE Confidence: 0.8414475
00:21:51.040 --> 00:21:51.380 Yep. 
NOTE Confidence: 0.8374414
00:21:54.030 --> 00:21:55.118 Yeah, there it is. 
NOTE Confidence: 0.874907815
00:21:59.010 --> 00:22:02.220 Wonderful. And it should pop up. 
NOTE Confidence: 0.874907815
00:22:02.220 --> 00:22:06.748 Although. For us, it’s not. 
NOTE Confidence: 0.874907815
00:22:06.750 --> 00:22:09.414 So you should be able to edit that 
NOTE Confidence: 0.874907815
00:22:09.414 --> 00:22:11.966 modifier to be specific for the time 
NOTE Confidence: 0.874907815
00:22:11.966 --> 00:22:14.360 interval that you want to repeat. 
NOTE Confidence: 0.874907815
00:22:14.360 --> 00:22:16.979 You do not have to do it every year, 
NOTE Confidence: 0.874907815
00:22:16.980 --> 00:22:18.960 uh, but for higher risk patients, 
NOTE Confidence: 0.874907815
00:22:18.960 --> 00:22:21.036 uh, like our patient you should.
And then for lower risk patients, you can do every two to four years depending on how low their PSA is. And I think that about covers the more important points of the pathway.

If PSA is abnormal again, then you would refer to urology at that point. Thank you, Karen.

All right. Hopefully that health maintenance didn’t work because of the age.
problem solved and that will get fixed.

Yeah, we picked an older patient for testing.

All right. So I just want to draw some attention to the smart phrases.

There’s that shared decision making smart phrase.

And then if you want, rather than clicking on the hyperlinks in the pathway, if you felt like you wanted to do the prostate resources in your after visit summary, there is a smart phrase for that as well.

At the bottom, another key update, we need to circle back to the digital rectal exam.
It is no longer recommended for screening purposes, but it absolutely should be done. For diagnostic purposes, if our patient maybe didn’t drink the two cups of coffee before bedtime and still had those episodes of nocturia, you know, we may want to consider evaluating what’s going on. But for average screening purposes is not recommended in terms of when to start PSA screening for prostate cancer screening, if it is elevated risk.
you need to tell the patient that there are higher risk engage in that shared decision making. I know it takes a little bit of time, but it’s worth it. Because then they understand what they’re getting into and have better follow-up going forward. If there’s really no increased risk factors, you can start at 50. If we go to the next slide, I wanted to spend a little bit of time talking about that digital rectal exam,
everybody’s favorite test.

So I, I, you know, kind of had some trouble adjusting because I was kind of trained in medicine. If you could see it and touch it and it was right in front of you, you should check it.

But with the digital rectal exam that’s not necessarily the case. As I mentioned, definitely for symptoms, not so much for screening.

It does have a low sensitivity and low specificity.
The most generous estimate that I could find was that it had a 41% positive predictive value. But that was out of a meta analysis where when you broke it down into the individual studies did not have such great evidence backing it up. So that was probably overgenerous. They think the OR have shown that the digital rectal exam will increase the PSA a bit, you know, up to .4 nanograms per milliliter. And of course, just because of anatomy and physics.
making the earlier stages of prostate cancer undetectable based on just the Dre alone. So for that reason. You know, you know, looking at positive predictive value using abnormal digital rectal exam with a normal PSA.
that’s about a 10% positive predictive value.
And then there were additional studies looking at OK, well, if you.
Have a normal digital rectal exam but then you have an abnormal PSA.
Positive predictive value goes up to you know 25% a little bit more.
So there was you know, an advantage to using the PSA over just the digital rectal exam.
Certainly if you’re using the Dre for evaluating symptoms or if the patient says Doc, I can’t sleep tonight unless you check my prostate and you find
NOTE Confidence: 0.802824548125
00:26:43.674 --> 00:26:45.690 something nodule and duration.
NOTE Confidence: 0.802824548125
00:26:45.690 --> 00:26:46.612 It’s asymmetric.
NOTE Confidence: 0.802824548125
00:26:46.612 --> 00:26:49.839 Regardless of what the PSA level is,
NOTE Confidence: 0.802824548125
00:26:49.840 --> 00:26:51.982 you’re going to refer that patient
NOTE Confidence: 0.802824548125
00:26:51.982 --> 00:26:54.489 to urology to have that evaluated.
NOTE Confidence: 0.802824548125
00:26:54.490 --> 00:26:58.402 Alright, I think that’s all of my slides.
NOTE Confidence: 0.802824548125
00:26:58.402 --> 00:27:00.420 All right, Jerry, onto you.
NOTE Confidence: 0.802824548125
00:27:01.400 --> 00:27:01.890 All right.
NOTE Confidence: 0.818229185714286
00:27:01.900 --> 00:27:03.724 Good evening, everyone.
NOTE Confidence: 0.818229185714286
00:27:03.724 --> 00:27:07.616 So my patient is more your
NOTE Confidence: 0.818229185714286
00:27:07.616 --> 00:27:10.868 average patient that usually gets
NOTE Confidence: 0.818229185714286
00:27:10.868 --> 00:27:12.420 diagnosed with prostate cancer.
NOTE Confidence: 0.818229185714286
00:27:12.420 --> 00:27:15.204 So it’s a 57 year old
NOTE Confidence: 0.818229185714286
00:27:15.204 --> 00:27:17.647 asymptomatic man with PSA of 5.6.
NOTE Confidence: 0.818229185714286
00:27:17.647 --> 00:27:20.230 We always try to get a repeat PSA to
NOTE Confidence: 0.818229185714286
make sure that it wasn’t an aberration.

Re PSA’s basically the same.

And for almost all our patients at Yale, we try to get an MRI.

Before any biopsy because it increases and improves detection.

If we’re we have technology that helps target the specific areas on the MRI to make it a better biopsy.

So target biopsy was performed and it shows Gleason 3 + 4 prostate cancer and five out of 17 cores.

And these biopsies can be performed in the office under local, which most of us do, but also a lot of patients.
00:28:00.100 --> 00:28:01.820 have anxiety about this.

00:28:01.820 --> 00:28:03.860 So we do offer to do it in

00:28:03.860 --> 00:28:06.240 the OR under sedation as well.

00:28:06.240 --> 00:28:09.348 I would say 80% of my patients

00:28:09.348 --> 00:28:12.133 tolerated very well in the office

00:28:12.133 --> 00:28:15.304 because we could do a good prosthetic

00:28:15.397 --> 00:28:18.380 nerve block and about 20% have it

00:28:18.380 --> 00:28:21.340 done in the OR in terms of so the


00:28:23.630 --> 00:28:25.238 Go into the risk groups in a second,

00:28:25.240 --> 00:28:27.384 but it’s considered intermediate

00:28:27.384 --> 00:28:28.456 risk favorable.

00:28:28.460 --> 00:28:31.540 The two main treatment options that we offer.

00:28:31.540 --> 00:28:33.040 Active surveillance is usually for

00:28:33.040 --> 00:28:34.994 low risk and we offer radiation

NOTE Confidence: 0.818229185714286

45
and robotic surgery, which are standard of care treatments. There are also focal therapies that are considered newer treatments and don’t have as much data behind them. Prostate cancer is a very slow growing disease, so a therapy has to be around for 15 to 15 years. Before we know how well it works in terms of recurrence risk and then this question always comes up in terms of staging. For patients with prostate cancer, CAT scan and bone scan is recommended for grade Group 3 or higher,
NOTE Confidence: 0.818229185714286
00:29:07.990 --> 00:29:10.685 meaning Gleason 4 + 3 or higher.
NOTE Confidence: 0.818229185714286
00:29:10.690 --> 00:29:12.772 And there are instances where we
NOTE Confidence: 0.818229185714286
00:29:12.772 --> 00:29:15.689 use a newer PET scan called PSA PET,
NOTE Confidence: 0.818229185714286
00:29:15.690 --> 00:29:17.265 which Bruce McGibbon will go
NOTE Confidence: 0.818229185714286
00:29:17.265 --> 00:29:19.619 into a little bit in his slides.
NOTE Confidence: 0.640954106666667
00:29:22.120 --> 00:29:24.560 If we could go to next slide,
NOTE Confidence: 0.640954106666667
00:29:24.560 --> 00:29:26.776 so I just wanted to go over the
NOTE Confidence: 0.640954106666667
00:29:26.776 --> 00:29:28.035 risk stratification because we
NOTE Confidence: 0.640954106666667
00:29:28.035 --> 00:29:29.916 throw around these terms, low risk,
NOTE Confidence: 0.640954106666667
00:29:29.916 --> 00:29:31.068 intermediate risk, high risk.
NOTE Confidence: 0.640954106666667
00:29:31.070 --> 00:29:32.310 What do they mean?
NOTE Confidence: 0.640954106666667
00:29:32.310 --> 00:29:35.433 So very low risk is a small amount of
NOTE Confidence: 0.640954106666667
00:29:35.433 --> 00:29:38.198 leasing 6 basically with a low PSA.
NOTE Confidence: 0.640954106666667
00:29:38.200 --> 00:29:42.730 Gleason, Six is considered a very.
NOTE Confidence: 0.640954106666667
00:29:42.730 --> 00:29:45.060 Unaggressive and the chance of
NOTE Confidence: 0.640954106666667
it spreading outside of the prostate is extremely low. In most studies, both very low risk and low risk patients we usually recommend for active surveillance. Intermediate risk patients are split up into favorable and unfavorable, and that’s basically how much of the Gleason 4 component that they have. Also, it can be based on PSA. PSA is above 10. It’s also falls into intermediate risk. High risk is usually Gleason 4 + 4 or higher.
risk if there's evidence on MRI, if someone vascular invasion, noble disease, metastatic disease, or if the the top.

Component of the Gleason score is the Gleason 5.

So in terms of treatment for intermediate risk, robotic surgery and radiation are considered equally effective in prostate cancer treatment.

We haven't been able to prove that one is better than the other, so we usually go over the side effect profiles of each one and the
benefits and risks of each
NOTE Confidence: 0.7726194225
one and let the patient decide.
NOTE Confidence: 0.7726194225
Robotic surgery,
NOTE Confidence: 0.7726194225
usually it involves A1 day stay in the
NOTE Confidence: 0.7726194225
hospital and a catheter for one week.
NOTE Confidence: 0.7726194225
You it’s we we do a robotically,
NOTE Confidence: 0.7726194225
but it’s still a three to four week
NOTE Confidence: 0.7726194225
recovery radiation treatments,
NOTE Confidence: 0.7726194225
usually 5 or 28 treatments
NOTE Confidence: 0.7726194225
depending on the patient and
NOTE Confidence: 0.7726194225
cancer characteristics or let Bruce
NOTE Confidence: 0.7726194225
go over that a little bit more.
NOTE Confidence: 0.7726194225
The main effects of both radiation and
NOTE Confidence: 0.7726194225
surgery are on urinary and erectile function.
NOTE Confidence: 0.7726194225
Newer less proven therapies are the
NOTE Confidence: 0.7726194225
focal therapies and there are four
or five of these that depending on the institution. And I’ll go over one of the newer ones that we have here at Yale. Prior to radiation, patients usually undergo a procedure which is similar to a biopsy where we place gold markers into the prostate to help target the radiation and we place a space or gel and Bruce will have some slides on that and then the important thing is patients who are getting radiation treatment even for localized cancer, if it’s grade Group 3,
the NCCN guidelines recommend four to six months of androgen deprivation therapy and for great Group 4 to 5, the NCCN guidelines recommend at least 18 months for androgen deprivation therapy. This used to be two to three years. They’ve decreased it in the last two, To make it a little bit more tolerable, so to just go over some newer technologies, we have a. Yo. We, we have been using for the last 10 years the Artemis system to
help target MRI lesions.

We’ve just upgraded to the exact view, which is a very powerful ultrasound.

It’s 300% more powerful than standard ultrasound, which is 7 megahertz.

And on this ultrasound we could actually see prostate cancer lesions and that’s what the bottom right hand corner is showing.

It’s the ultrasound is so powerful that the the slide on the left is actually showing that you can actually see the previous needle tract through the prostate.
You can still do MRI fusion on these machines, which is very important because most of our patients get the MRI before the biopsy. And then one of these newer technologies that’s also available at Yale is the Tulsa Pro. And what this is is transurethral ultrasound ablation of the prostate. So the top device of the patient is asleep under anesthesia and it gets inserted into the urethra like a catheter. And the bottom device gets inserted into the rectal area for cooling. If you could go to the next slide.
And basically what this device does, it rotates and under MRI guidance it ablates the prostate in a circumferential fashion. Within 1 millimeter of the capsule, it's very precise. You can do focal therapy as shown on the slide on the left where you could just do 1/4 of the plot prostate, you could do 1/2 of the prostate or the entire thing. So there are two clinical trials right now at Yale investigating this. One is comparing it to surgery and one is just comparing. Is just the observational
study to see the the. It’s believed to be that the side effects with this are significantly lower than with surgery or radiation. Another area of interest for this treatment is in salvage treatment for patients who have undergone radiation and now have recurrence. And now I’ll turn it over to Bruce to discuss radiation treatment. Thanks, Jerry. So just want to break down some of the different scenarios where we do radiation and and give some. Some of the core details I think would be most interesting to you guys.
So for intact prostate, basically the two options, one is external beam radiation where patients lying on a table machine moves around at the distance and shoots X-rays and the others breakey therapy usually with seed implant. The vast majority of the gentleman these days in the US and really I think internationally get external beam breaking therapy still quite effective but in a much smaller percentage of the cases. Uh, and it’s less commonly available. So within external beam you have what’s
really considered traditional IRT, which is intensity modulated radiation therapy that I think most people are familiar with. That’s the nine week course, which is 40 to 45 treatments. We kind of rarely use that anymore. That’s really for guys who have very large process or have a lot of urinary issues where we’re trying to be very gentle per day. So most guys don’t need that. We’re mainly doing like Jerry referring to either the 28 treatments or the five. Treatments 20 actually can be 20 or 28 in the Yale system we we followed
the data most closely from the 28 fraction or treatment regimen. So that’s what we’ll see. It’s official title is moderately hypofractionated IRT, but for us it’s 28 treatments. The other is the five treatment option. This one has a lot of nicknames. There’s a lot of advertising around it. So I think it’s important to know that the core technique is SBRT or stereotactic body radiation therapy. This is the technique that the cyber knife. Sheen does, but other machines do as well. So our machine here at Greenwich
00:36:39.196 --> 00:36:40.982 is the true beam, for example,
NOTE Confidence: 0.83039534
00:36:40.982 --> 00:36:43.229 and a lot of machines like that,
NOTE Confidence: 0.83039534
00:36:43.230 --> 00:36:44.465 they’re high end machines that
NOTE Confidence: 0.83039534
00:36:44.465 --> 00:36:45.453 are capable of this,
NOTE Confidence: 0.83039534
00:36:45.460 --> 00:36:48.100 but Cyber net does it also sometimes called
NOTE Confidence: 0.83039534
00:36:48.100 --> 00:36:50.538 Saber in the Sloan Kettering system,
NOTE Confidence: 0.83039534
00:36:50.540 --> 00:36:50.926 excuse me,
NOTE Confidence: 0.83039534
00:36:50.926 --> 00:36:53.300 it’s referred to as precision RT.
NOTE Confidence: 0.83039534
00:36:53.300 --> 00:36:53.946 But anyway,
NOTE Confidence: 0.83039534
00:36:53.946 --> 00:36:56.207 important to know that a lot of
NOTE Confidence: 0.83039534
00:36:56.207 --> 00:36:57.718 machines do this technique.
NOTE Confidence: 0.83039534
00:36:57.720 --> 00:36:58.988 It is very focused.
NOTE Confidence: 0.83039534
00:36:58.988 --> 00:37:01.366 The cure rates are the same between
NOTE Confidence: 0.83039534
00:37:01.366 --> 00:37:02.146 these options.
NOTE Confidence: 0.83039534
00:37:02.146 --> 00:37:05.234 The bowel issues and urine issues are very,
NOTE Confidence: 0.83039534
00:37:05.240 --> 00:37:05.808 very similar.
There is some thought or hints that the five treatment option because it’s more intense per day might have a little more of an acute urinary side effect profile in the data that’s out there that actually looks very, very similar. But anecdotally I think some physicians especially urologist who follow the complications the most. Mostly feel like maybe there are sometimes some extra issues with that. For us, I think the big distinguisher is prostate size and baseline urinary
issues if you have a prostate size
NOTE Confidence: 0.83039534
under 60CC’s and really fairly
NOTE Confidence: 0.83039534
low urinary issues.
NOTE Confidence: 0.83039534
And I think these guys tend to
NOTE Confidence: 0.83039534
be a good candy for either one.
NOTE Confidence: 0.83039534
But if you’re anything beyond that,
NOTE Confidence: 0.815241292857143
I really strongly caution guys that
NOTE Confidence: 0.815241292857143
they kind of asking for trouble with
NOTE Confidence: 0.815241292857143
five and we should really do the 28,
NOTE Confidence: 0.815241292857143
which is a very solid track
NOTE Confidence: 0.815241292857143
record in terms of.
NOTE Confidence: 0.815241292857143
Pure and and toxicity breakey therapy
NOTE Confidence: 0.815241292857143
briefly mentioned that’s the seed
NOTE Confidence: 0.815241292857143
implant or sometimes temporary
NOTE Confidence: 0.815241292857143
catheters that are put in and then a
NOTE Confidence: 0.815241292857143
radioactive source is placed in and out.
I think this technique again very good especially for the low risk and favorable intermediate the jury was mentioning probably is the worst of the urinary staff profiles and can also be combined with external beam for high risk guys. But that’s a bit of a nuance that it’s probably not not so important for this chat. For post prostatectomy.

You’re sometimes asked to give radiation within about 6 to 12 months as adjuvant treatment. There’s some very risky looking
features that surgery pelvic nodes or
the PSA does not go to undetectable.
But most of what we’re doing these
days is called salvage radiation
therapy and that’s where the PC’s
gone undetectable and subsequently
risen typically to something like
.2 is our our most common cut
off and we see the guys there.
It’s about a 37 to 39 treatment course,
it’s about 8 weeks and.
There’s some developing data about,
including four to six months,
usually six months of engine
deprivation for these guys as well,
especially if they’re coming to
us with a little bit higher PSA or some other feature that’s a little riskier for Gleason.
And the third category which is I think definitely the new kid on the block and you know is really not as well known but it’s becoming really important is oligo metastatic.
So these are the guys who have, they do have metastatic disease based on whichever imaging we’ll talk in a later slide about that. But let’s say they have in the prostate and they have two bone sites. Should we treat this guy the same as
a guy who has 17 bone sites and some nodes in his chest and you know the most recent data says that really we should treat these guys differently if they have all of them. That disease we should treat the prostate as part of the case is not replace hormone therapy and other things that Dan will talk about. But in addition to that, treating the prostate has a survival benefit. And if we have again a limited number of bone sites, actually going after those bone sites can help to prevent additional bone sites from coming up and
create a longer PSA control.

Next slide please.

Just give a little more detail, Jerry’s mentioning.

We put in the the gold markers and the gel refer to the gel first.

So this is called the main product that’s available these days is called space or gel, a biodegradable gel.

So this is a biodegradable gel.

So it goes in, it lasts for three months and then dissolves back to water over another three months and just absorbed by the body.

And as you can appreciate in the
upper left in the cartoon and then
the real MRI pictures on the right,
it’s really trying to create this pad of
gel between the prostate and the ******.
And as I tell patients, it’s not.
It’s not a shield, it’s not absorbing
radiation in some magical way,
but it’s creating with that gap that’s
allowing us to drop the dose very quickly
between the process and the ****** and
it helps to reduce rectal side effects.
So not every guy is a
good candidate for this,
but most guys are.
And if there’s a nuance to it,
then we work with the urologist about,
you know, who’s a good candidate versus not.

So some guy who has posterior extension of
cancer on MRI that’s pretty pronounced,
may not be a good candidate for example,
but most guys are.

And so I think you’ll be hearing more
and more about guys who got gel on with
their markers with definitely a big helper.

There are different
fiducials that are possible.
I say the most common ones
and that we use are gold and
you can see a zoomed in view.
They they have a little bit of a
texture or rifling to them to help

stick in the prostate not migrate.

But there there are ceramic

versions of these.

There are long coiled versions.

There’s another one that has a a called

Calypso that has an electromagnetic.

Frequency is like an RF powered device that

can be checked multiple times a second.

So there are multiple types,

but I think you know the goal ones are

the most standard work really well.

The imaging on on the lower right is

what’s called a cone beam CT you know

when patients are asking us,

you know, how do you know that,
that the treatment is accurate?

You can’t see my prostate, but the treatment say,

every day before we treat you, we spin the machine around and we take an image that’s a cone beam CT. We overlay it with the real CAT scan that we get for planning.

So in this view here with this kind of quartered view, the upper left and the lower right is from the real CAT scan and the cone beam is the upper right and the lower left.
You can see that there’s some slight differences in how the tissues appear, but they’re really very robust and you can see with this red arrow what the gold markers like. So the gold markers are very easily distinguished and this is what helps us to have a high degree of confidence that we’re on target. Now some guys are not a candidate for this. They, you know, they’re on blood thinners and they. If we feel from primary care that you’re for their cardiologist that’s just not going to be safe.
00:42:53.512 --> 00:42:54.993 to go off blood thinners again
00:42:54.993 --> 00:42:56.401 or they simply don’t want another
00:42:56.401 --> 00:42:57.456 procedure or whatever it is.
00:42:57.460 --> 00:42:59.828 So we do have an option to not
00:42:59.828 --> 00:43:02.020 do gel and not do markers.
00:43:03.360 --> 00:43:05.292 If we’re going without markers,
00:43:05.292 --> 00:43:07.267 the margins that we use around
00:43:07.267 --> 00:43:09.245 the prostate are a little bit larger
00:43:09.245 --> 00:43:11.015 because we don’t have quite the same
00:43:11.020 --> 00:43:12.798 We can still take this comb beam
00:43:12.798 --> 00:43:14.559 image and see the soft tissues.
00:43:14.560 --> 00:43:16.416 So we can get very, very close,
00:43:16.416 --> 00:43:19.164 but the markers even even nicer.
00:43:19.170 --> 00:43:21.198 Next slide please.
00:43:21.200 --> 00:43:21.511 Uh,
NOTE Confidence: 0.850078931428571
00:43:21.511 --> 00:43:23.377 just a quick word about better
NOTE Confidence: 0.850078931428571
00:43:23.377 --> 00:43:24.310 imaging for prostate.
NOTE Confidence: 0.850078931428571
00:43:24.310 --> 00:43:26.291 So if we’re moving into that intermediate
NOTE Confidence: 0.850078931428571
00:43:26.291 --> 00:43:28.172 or high risk prostate cancer and
NOTE Confidence: 0.850078931428571
00:43:28.172 --> 00:43:30.128 above where we’re trying to staging,
NOTE Confidence: 0.850078931428571
00:43:30.130 --> 00:43:31.099 you know, convention,
NOTE Confidence: 0.850078931428571
00:43:31.099 --> 00:43:33.037 we’re getting an MMR and usually
NOTE Confidence: 0.850078931428571
00:43:33.037 --> 00:43:34.482 getting a CAT scan, abdomen,
NOTE Confidence: 0.850078931428571
00:43:34.482 --> 00:43:36.450 pelvis and bone scan.
NOTE Confidence: 0.850078931428571
00:43:36.450 --> 00:43:37.670 These are still good,
NOTE Confidence: 0.850078931428571
00:43:37.670 --> 00:43:38.585 still highly supported.
NOTE Confidence: 0.850078931428571
00:43:38.590 --> 00:43:40.930 Some insurance companies will still insist
NOTE Confidence: 0.850078931428571
00:43:40.930 --> 00:43:43.370 on getting those instead of a pet scan,
NOTE Confidence: 0.850078931428571
00:43:43.370 --> 00:43:45.302 but I think that the that
NOTE Confidence: 0.850078931428571
00:43:45.302 --> 00:43:46.590 the trend is definitely
to allow PET scans.

The first PET scan that we had access to around here was called Axemen.

The newer one, I think we have a little more confidence in.

It has some trade names like Polara 5,

It’s really a PSM, a pet CT,

We’re having a gentleman go up to New Haven,

we’ve having a gentleman go up to New Haven,

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we’re having a gentleman go up to New Haven,
Just a little little bird

I’m going to focus on, on the mid and bottom part of the slide.

So this this PSM, a pet can be used for gentleman with an initial diagnosis prostate cancer or if they’re post treatment either post prostatectomy or post radiation.

We’re seeing a PSA rise and we want to hunt down where the spot is or spots are. This is a a great study for that.

PSA is prostate specific membrane antigen.

So this is a little more specific to prostate cells is overexpressed and over 90% of prostate cancer cells and that’s really the magic
00:44:49.189 --> 00:44:50.498 of how we can make this work.

00:44:50.500 --> 00:44:52.588 So this is not a regular pet scan with glucose.

00:44:52.588 --> 00:44:57.459 This is really targeted to PSA and

00:44:57.459 --> 00:44:59.373 interestingly and hopefully it is has

00:44:59.373 --> 00:45:01.924 a high degree of expression with those

00:45:01.924 --> 00:45:04.014 higher leasing score, nastier tumors.

00:45:04.014 --> 00:45:05.430 Next slide please.

00:45:07.460 --> 00:45:08.009 Are you OK?

00:45:12.760 --> 00:45:13.810 Turn this over to Dan.

00:45:22.800 --> 00:45:24.014 Hi, Dan, I think you’re on mute still.

00:45:29.470 --> 00:45:31.213 I think it’s important to note that

00:45:31.213 --> 00:45:33.167 we’ve made a tremendous amount of

00:45:33.167 --> 00:45:34.707 progress in metastatic disease,

00:45:34.710 --> 00:45:36.666 not only in the earlier treatment

NOTE Confidence: 0.810822032

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of prostate cancer when we call the hormone sensitive state, which is what this patient is, but in the hormone resistant or castration resistant state. In fact, in 1991, my esteemed Lake colleague, Alan, you go to my published paper saying that patients only lived about a year with chemotherapy. Well, we’ve extended that out with all of our other treatments to about three years at this point and with good quality of life and for metastatic patients such as this five year survival to 7 year survival is not unexpected.
So this 82 year old male, very active develops lower back pain while playing tennis. He goes to see his internist, who does a series of L spine films, which demonstrate sclerotic bone metastases. He has a PSA of 1200. He’s referred for a biopsy of his prostate, which demonstrates at least nine adenocarcinoma. Imaging detects multiple bone metastases in the ribs and thoracic as well as lumbar sacral spine. So this is not the patient that Doctor Mcgibbon spoke about before.
This patient would not benefit from receiving radiation therapy to his prostate or to the metastases. Would really require systemic therapy. So this patient goes on androgen deprivation therapy with a drug called degarelix which rapidly reduces the testosterone levels within 24 to 48 hours to less than 50 nanograms per deciliter which is considered to be castrate and also he starts a drug called enzalutamide. Which is in next generation and antigen, which was originally approved for patients with resistant disease.
but now is being moved up front to these patients. So all these patients really deserve the chance of having what we call the best next generation agent. And drugs such as enzalutamide, apalutamide, abiraterone are all given to these patients in the early stages of metastases rather than the late stages where they originally approved. And we see that there’s more of a survival. Benefit in these patients with chemotherapy is also administered.
in this area as well,

so common complications that an internist may see in this disease include hot flushes,

osteoporosis, anemia, Impotence, fatigue, and weakness, muscle wasting.

That’s something we can do something about.

All of my patients with prostate cancer, I recommend that they maintain an active exercise program,

including lifting weights. They have to maintain the muscle mass because of course without testosterone we can have issues cardiovascular side effects of being newly identified. And these include a higher risk
00:48:19.296 --> 00:48:21.015 of a second myocardial infarction

00:48:21.015 --> 00:48:23.430 within six in a patient who’s had

00:48:23.430 --> 00:48:25.039 a myocardial infarction within

00:48:25.039 --> 00:48:27.613 six months of starting an engine

00:48:27.613 --> 00:48:28.471 deprivation therapy.

00:48:28.480 --> 00:48:30.280 And the guidelines for managing

00:48:30.280 --> 00:48:31.720 cardiovascular patients are really

00:48:31.720 --> 00:48:33.537 not as clear as we would like them

00:48:33.537 --> 00:48:35.328 to be at this particular point.


00:48:39.285 --> 00:48:42.108 at about half to 80% of men.

00:48:42.108 --> 00:48:44.303 It’s usually a sudden perceived

00:48:44.303 --> 00:48:45.620 increase in temperature,

00:48:45.620 --> 00:48:46.950 accompanied by reading of the

00:48:46.950 --> 00:48:48.014 skin and profuse sweating.
And this is usually spontaneous, changes in body position or ingestion of hot liquids can also cause this particular problem, environmental changes as well.

So what do we do about hot flashes? We generally will ask the patient try to try soy products because they do have phytoestrogens and that tends to counteract that.

Additionally, drugs such as Effexor, Clonidine are also effective in these patients. We generally will reserve that for severe hot flushes.
Osteoporosis is really a more recognized problem in men over the last several years, and about 25 to 30% of all osteoporotic hip fractures do occur in men. By 2025 we expect about 1.1 million cases, and as one would expect with a patient zoning going ancient deprivation therapy, the major causes hypogonadism. Women can also experience this who are on LHRH agonists for endometriosis, and that’s why. The use is usually limited to about six months.
after age 35, zero .5 to 1% of their bone mineral density per year. That’s accelerated in the patient on androgen deprivation therapy to 1.4% to 2.6% per year and compared to age matched controls. Men on energy deprivation therapy have a 6.5% to 7070.3% risk of higher bone loss and the rates of fractures are higher. So in the hormone sensitive state the patient we would consider giving calcium and vitamin D2. And we see this is in a patient who’s head does not have bone metastases, who’s treated for more than six months.
This is 218 patients. A 6% fracture rate is seen and the median time to fracture is 28 months. Next slide.

So we generally as I said before in a metastatic patient, I generally don’t do dextra scans. But in a patient that we’re treating with the urologist as well as radiation oncologist who may be on angi and deprivation therapy who don’t have metastatic disease, we do dextra scans and then treat the patient accordingly depending upon the level of bone density loss at baseline.
Great. That was terrific.

Dan, really, can we stop sharing?

This means we actually have a decent amount of time for questions and the Q&A which is wonderful.

So folks who are listening, please type in your questions in the Q&A.

I know that there are a number of people who had questions already for each other.

So I'm going to allow Aaron to start off.

Alright. I guess dance, since you finished most recently, uh, I wanted to ask if there a recommendation for how often to check, uh, bone density testing on
those patients who receive androgen deprivation therapy?

It’s usually every two years we check it, OK?

OK, I figured that with the, uh, I guess the 28 month marker there that you gave the average bone loss.

OK, and have you had any experience with gabapentin helping with hot flashes for your patients with?

But I’ve not really tried it.

I’ve used predominantly Effexor.

But anyway some literature that does use it.
You know, The funny thing is that that the soil products do actually work. Not. Soy milk, which has very little soy but tofu soy cheese. It will least reduce the the frequency or actually the intensity of the hot flashes may make not make them go away completely, but makes it a little more tolerable. Do you have any soy products you recommend? I have a lot of patients who like supplements, tofu, tofu. Sounds tasty to me. Here’s a question from Beth Allard. Can you address PSA testing and patient on on testosterone replacement,
the frequency and cut offs for referral?

Yeah, that’s a great question.

UM, to my knowledge, when I looked at the most recent guidelines, there was not a strong relationship between testosterone and worsening of prostate cancer outcomes.

So I think the guidelines are still the same for.

But Dan, correct me if I’m wrong.

At Harvard, they’ve actually been looking into that question.

They do have a number grammar 7 adjustment.
And I’m blanking on the author’s name.

If I think of it, I’ll put it in the chat but they have it.

Looking at this particular issue interestingly I thought the other question would be should a man with prostate cancer go on androgen, androgen supplementation.

And in fact we’re actually using high dose testosterone in some patients for right with resistant disease and about a third of those patients will respond to that.
So that testosterone is a very poorly understood hormone. And you know, again, I think you really should consult with your physician before embarking on any of those particular supplements. Ryan, were you going to add to that? No, sorry, I was just responding. I was since the best question was answered, I just took it out of the queue. I'm sorry. Let's see another question from the chat. If a Dre is abnormal and the PSA within normal, what is the next step maybe going to Jerry?
Yeah, so I would have probably recommend referring to the urologist at that point. Because I think we, you know. It’s rare for me to call a Dr abnormal unless I, you know, truly feel something. Because of the the sensitivity and specificity that Aaron quoted, usually the PSA is 15 to 20 and those patients as well. There are rare instances when that’s not the case. And there are some instances where the patient is older.
and doesn’t have a PSA level. So if the Dre is abnormal and we were very concerned, I would get a PSA on that patient and. There have been patients that have stopped PSA screening because of their age and the Dre was very concerning. Yeah, but I think it’s important. If the DVR is abnormal it needs a second opinion. Yeah, but I think it’s important. If the DVR is abnormal it needs a second opinion. I agree.
hot flashes and flashes?

Keep these questions coming in.

They’re fantastic.

No, not that I found. Dan anything?

I’ve not found that either. I found mixed experiences with it.

And then why stop PSA at 75 years old?

How proud here this is actually. Pretty controversial, uh?

The AUA guidelines actually recommend 55 to 70.

I did have a discussion with my patients at age 75.

And we discussed the harms of continuing to test.

The problem is when you can.
When you tell a patient to consider life expectancy, that’s not something that they want to consider. It’s difficult to stop testing at 75 because most patients will. I’ve had a lot of patients who’ve come to see me who were told by their previous urologist that they’re going to die anyway. Why test your PSA? And they don’t like hearing that, so, uh, it. If the patient is on Plavix and...
aspirin and has had three stents, you know, the chance that you’re gonna increase their lifespan with PSA testing is pretty low. Most prostate cancer that’s intermediate risk probably takes anywhere from 7 to 10 years to actually metastasize. That’s why the 10 year life expectancy is a good rule as well. Got it. We were talking about Dre also earlier in the planning and it is something that many of us are have grown up in a certain way and it marks their dates us I guess.
Karen Ryan, any thoughts on the Dre and how things have changed recommendations over time?

So I was going to ask a different question, but a quick story. Remember, I once told the patient, this is 20 years ago, back when it was still a standard of care to do a digital rectal exam. And he said, oh, they’re digital now. True story, true story.

No, I think you know what. What we find, and I’ll be really interested in Karen’s perspective as well, is
that, you know, old habits
die hard and,
it’s hard to convince
we find that, you
Conversations like this or presentations like this are ways in which we can share best
evidence and evolve practice.
But you know for the record when I trained it was the standard of care and I’m wrapping my head around it.
So Karen, I don’t know
more thoughtful answer than mine.
I mean the answer that
I mean Aaron presented some of the statistics we do get a lot of false positives and urology consultation I still consider a precious resource and so you know I want to make sure that most of the people who most need to get there do and the reality is and it’s kind of funny because ten years ago we weren’t saying this, but the blood test does work remarkably well. It’s not perfect, but I think most of us have really decreased our rectal exams, and we increased our PSA and
01:00:21.090 --> 01:00:24.490 so on a kind of summary level,
NOTE Confidence: 0.890008486666667

01:00:24.490 --> 01:00:25.408 you know, my,
NOTE Confidence: 0.890008486666667

01:00:25.408 --> 01:00:27.550 my guess is that we're finding more
NOTE Confidence: 0.890008486666667

01:00:27.616 --> 01:00:30.178 prostate cancer and being more sensitive.
NOTE Confidence: 0.890008486666667

01:00:30.180 --> 01:00:31.360 I mean I, I,
NOTE Confidence: 0.882029092857143

01:00:31.360 --> 01:00:32.860 I offered every man, I said,
NOTE Confidence: 0.882029092857143

01:00:32.870 --> 01:00:35.612 you know, I don't, I'm not required to
NOTE Confidence: 0.882029092857143

01:00:35.612 --> 01:00:37.540 do a rectal exam anymore, but I'm happy
NOTE Confidence: 0.922311652857143

01:00:37.550 --> 01:00:39.377 to do one if you would like.
NOTE Confidence: 0.922311652857143

01:00:39.380 --> 01:00:41.420 And I find that actually most patients
NOTE Confidence: 0.922311652857143

01:00:41.420 --> 01:00:43.850 are far more happy to give it up than
NOTE Confidence: 0.922311652857143

01:00:43.850 --> 01:00:46.930 if I phrased it any other way. Uh, but
NOTE Confidence: 0.818237412

01:00:48.060 --> 01:00:50.972 you know. I mean, everything we do,
NOTE Confidence: 0.818237412

01:00:50.972 --> 01:00:53.059 there's always a risk of missing something
NOTE Confidence: 0.817327743

01:00:53.170 --> 01:00:56.176 and and so everything we do just has to
NOTE Confidence: 0.817327743

01:00:56.176 --> 01:00:58.886 be with the greatest good in mind and and
what we can do routinely for everybody. Just want to make one point. I think it’s great that you having that discussion. Going back to the preventative task force, there was a study that was done at ASCO presented at Asco Gu this year where they look state by state at the development of metastatic disease and there’s been a 28% increase in metastatic disease since that task force made that recommendation. So I’m glad that we’re getting back to having shared discussions because
clearly we want to move to a curable situation rather than incurable situation.

And that's go ahead, Chris. I was just going to add to that that Jerry and Dan and I are managing these days really a really high number of gentlemen in their late, mid to late 70s to early 80s who have Gleason 8-9 disease and no Mets and I think these guys are gentlemen where they don’t all need treatment but I think quite a few of them really do benefit from treatment you know they and I
what the this part of the discussion

I have with guys is that you know

long before prostate cancer kills you.

If it spreads it creates a considerable reduction in your quality of life

But as maybe even before that with

that older gentleman it’s hey can

I can I keep you from being on long term manager deprivation having

bone Mets with pain a fracture.

And I think these are all really important discussions to have so I think.

You know being more flexible and you
know individualized with PSA screening

We're just seeing a lot of these
doctors these days who fit that that
description and and if we pick some
don't all need treatment.

But again there are a lot of these guys,
the higher grade disease that I
think need need attention.

I think that actually
that attitude that’s allowed us
to feel more comfortable with more
PSA screening, I mean it there.
There was a point where it felt a little bit like if you had an elevated PSA, you know, the people may be getting unnecessary care. And with the better risk stratification and attention to the kind of geriatric and comorbid medical concerns that, you know, I feel like even if there is a PSA that’s mildly elevated. People get the right care, you know, on both ends of the urology primary care spectrum. And have you had that same kind of ability to let go and feel more comfortable doing it?
No, it’s definitely added to, I think my comfort as well as my patients knowing that there’s you know, a procedure, there’s great specialists who are highly involved. There’s so much to offer these patients now versus you know 20 years ago we just haven’t had this explosion in. And tech and and options. And I think that shared decision making is employed is it’s what we’re doing today too. So in the Smiler shares with primary care. So we have run out of time unfortunately. It’s been fantastic discussion, a few more questions that maybe
we can answer after the fact,
but really appreciate all of the panelists.
Karen Ryan are really pleased
with the attendance and tell your
friends we’ll be back next month.
Thanks so much. OK.
Thanks, everybody. Thank you.