

**Std 1.12 Public Reporting of Outcomes - 2018**

During the November Saint Agnes Cancer Committee meeting, members determined the focus for 2018 public reporting should be to share the findings of our physician led study on prostate cancer management which was undertaken to ensure the delivery of care is provided in compliance with evidence based national guidelines. In addition to showcasing the study findings, the committee directed that the posting should offer prostate cancer awareness information as a means to provide public education on this important subject.

***Who gets Prostate Cancer? Only men!***

***A man will be diagnosed with prostate cancer every 3 minutes.***

Prostate cancer is the second-most common cancer in U.S. men. About 1 man in 9 will be diagnosed with prostate cancer during his lifetime. Prostate cancer develops mainly in older men and in African-American men. Of particular concern, African-American men are 2.4 times more likely to die of prostate cancer than Caucasian men**.** About 6 cases in 10 are diagnosed in men aged 65 or older, and it is generally rare before age 40. The average age at the time of diagnosis is about 66.

***African-American men are 74% more likely to develop***

***prostate cancer than any other ethnicity!***

The Saint Agnes Cancer Program is committed to providing high quality comprehensive cancer care right here in the Central Valley. The multidisciplinary team of cancer professionals at Saint Agnes Medical Center and Saint Agnes' Cancer Center, newly named 'cCARE at Saint Agnes' are able to offer the same advances in prostate cancer management, including the latest technology, personalized medicine and treatment protocols used in larger metropolitan areas. For example, most recently Saint Agnes acquired the UroNav Fusion Biopsy System (fused MRI and ultrasound guided biopsy) which is a tool that allows physicians to look at the prostate, in real-time. The 3-D image clearly displays areas of suspicion that require biopsy. This clarity and precision helps eliminate the need to take multiple random biopsies. It also allows the physician to pin-point exactly where they need to biopsy. Additionally, it can also help detect aggressive tumors that may have otherwise been missed.

***Did you know that the BRCA gene most related to breast cancer***

***is also related to prostate cancer?***

We strongly encourage our readers, ***no matter who you are or what your age****,* to pay particular attention to the nationally recognized prostate cancer screening and early detection guidelines which we have **included below** to emphasize the facts you need to know.

***It's a fact that prostate cancer***

***is 100% treatable if detected early!***

**Saint Agnes Medical Center**

**Monitoring Compliance with Evidence Based National Treatment Guidelines**

**Stage I Prostate Cancer (N=18)**

During Cancer Committee meeting held 8/6/18, the Commission on Cancer (CoC) 2017 Cancer Quality Improvement Program Report (CQIP version March 2018), 2017 SAMC Site Table and CoC/NCDB CP3R cancer program performance measures as well as General Tumor Board case presentation information was utilized for consideration to determine the site/topic for the 2018 Cancer Committee physician led study as outlined in CoC Standard 4.6.

Praneetha Narahari, MD, FACS, Cancer Liaison Physician (CLP) and Committee Chair, proposed that we review prostate cancer management due to concerns highlighted in the current CQIP Report which demonstrated that in all areas Saint Agnes Medical Center reflected similar outcomes to comparisons; however, the data for First Course Treatment for Stage I & II Prostate Cancer indicated the use of radiation only for Stage I prostate cancer in 64.7% of patients. By comparison, the average for all CoC approved cancer programs (N=1500) for radiation only was 20.8% (see graph). This finding was also in stark contrast to the 2014 cancer committee physician study that reported 100% (13) of Stage I prostate cancer cases underwent surgery only at Saint Agnes during 2013. Committee agreed that the CLP's observations warranted investigation. Recommendation was made that the data be reviewed by cCARE Radiation Oncologists to ensure appropriateness of patient selection and adherence to national treatment guidelines.

To that end, Cancer Registry data for the year in question, 2015, as well as appropriate medical records were made available to Cancer Committee physician designees, Drs. Sukhjeet Batth and Christine Chang-Halpenny, for their analysis and recommendations. As part of their review AJCC TNM Staging assignments and pre-treatment risk stratification elements were confirmed.

For the year 2015 there were a total of (70) Analytic Prostate Cancer cases. Of those, 26% (18) were Stage I, and the subject of our study; 63% (44) were Stage II and 11% (8) comprised Stage III and IV.

Of the (18) Stage I cases, 50% (9) were diagnosed elsewhere and referred to Saint Agnes for all/or part of their first course treatment.

Age distribution noted (1) 40-44, (1) 45-49, (2) 50-54, (2) 55-59, (3) 60-64, (2) 65-69, (6) 70-79 and (1) 80-84. Racial/ethnic breakdown included (13) Caucasian, (4) Hispanic and, (1) African American gentleman (age 74) who was subsequently diagnosed with a Stage IV adenocarcinoma of the stomach (age 75) and the only one of this group to have expired during the approximately three year interval.

Clinical assessment noted (13) had PSAs of less than 10 and each underwent appropriate work-up that included digital rectal exam and imaging/transrectal ultrasound. There were (5) men for which clinical work-up was not obtained due to unsuspected finding of prostate cancer on transurethral resection of the prostate (TURP) performed for symptom relief, ie. urinary retention. Pathologic evaluation of prostate biopsies and transurethral resection specimens confirmed Gleason 3+3, score 6, indicating 100% were low risk.

As noted, (5) men underwent TURP with incidental finding of prostate cancer, each meeting very low or low risk criteria, and were appropriately selected for active surveillance. Two patients were treated by robotic radical prostatectomy. One of the two, (age 52) also received pre-operative hormonal treatment. Pathologic evaluation of the resected specimens noted both had no adverse features, Gleason 3+3, low risk disease.

Eleven patients (11) were treated by radiation only. Radiation modalities included (5) external beam (EBRT) and (6) low dose rate brachytherapy I-125 interstitial seed implant including (1) of whom was treated with combined external beam and implant. Records review indicated appropriate patient selection per criteria for the treatment delivered for 100% of the patients in this group.

Although genetics was not specifically analyzed within the scope of our study, a diagnosis of cancer brings up many questions and concerns regarding one's personal or family history of cancer which may warrant consultation with a genetic counsellor. For example, one man within the study cohort received his prostate cancer diagnosis at age 40 and had a reported family history of prostate cancer in a paternal uncle and paternal grandfather which is suggestive of consideration for genetic consultation based on general National Comprehensive Cancer Network (NCCN) Guidelines. However, recently updated NCCN guidelines with specific implications for those diagnosed with prostate cancer are provided for our reader's benefit:

According to the NCCN guidelines for Genetic/Familial High-risk Assessment Breast and Ovarian (version 2.2019), the committee recommends genetics evaluation for men meeting the following criteria:

1) metastatic prostate cancer at any age irrespective of family history

2) high-grade prostate cancer (Gleason score ≥ 7) at any age in men of Ashkenazi Jewish ancestry irrespective of family history

3) high-grade prostate cancer (Gleason score ≥ 7) at any age in men with family history of ≥1 close blood relative with ovarian cancer, pancreatic cancer, metastatic prostate cancer at any age or breast cancer <50 years

4) high-grade prostate cancer (Gleason score ≥ 7) at any age in men with family history of ≥2 close blood relatives with breast cancer or prostate cancer (any stage) at any age

*\*\* close blood relatives include first-, second-, and third-degree relatives in the maternal or paternal lineage*

Following case review, the data showed our low risk early stage prostate cancer patients are offered all treatment options, including active surveillance, radiation, and radical prostatectomy if their life expectancy is at least 10 years. Although our registry data may show a disproportionately higher number of patients received radiation compared to national averages, we believe that this is due to a limited sample size, and the inherent limitations of hospital based cancer registry data collection. **Overall the study demonstrates adherence to national treatment guidelines in accordance with NCCN, American Urologic Association (AUA), and American Society for Radiation Oncology (ASTRO) criteria.** Our recommendation at this time would be to encourage utilization of the newly revised NCCN guidelines for Genetic/Familial High-risk Assessment to identify prostate cancer patients that may be at increased risk of a hereditary cancer predisposition syndrome and may benefit from genetic consultation and testing for better patient care.

***There is a lack of awareness that men can be screened for prostate cancer simply with a blood test.***

**American Cancer Society Recommendations for Prostate Cancer Early Detection**

The American Cancer Society (ACS) recommends that men have a chance to make an informed decision with their health care provider about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks, and potential benefits of prostate cancer screening. Men should not be screened unless they have received this information. The discussion about screening should take place at:

* **Age 50 for men who are at average risk** of prostate cancer and are expected to live at least 10 more years.
* **Age 45 for men at high risk** of developing prostate cancer. This includes African Americans and men who have a first-degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger than age 65).
* **Age 40 for men at even higher risk** (those with more than one first-degree relative who had prostate cancer at an early age).

After this discussion, men who want to be screened should be tested with the prostate-specific antigen (PSA) blood test. The digital rectal exam (DRE) may also be done as a part of screening.

If, after this discussion, a man is unable to decide if testing is right for him, the screening decision can be made by the health care provider, who should take into account the man’s general health preferences and values.

If no prostate cancer is found as a result of screening, the time between future screenings depends on the results of the PSA blood test:

* Men who choose to be tested who have a PSA of less than 2.5 ng/mL may only need to be retested every 2 years.
* Screening should be done yearly for men whose PSA level is 2.5 ng/mL or higher.

Because prostate cancer often grows slowly, men without symptoms of prostate cancer who do not have a 10-year life expectancy should not be offered testing since they are not likely to benefit. Overall health status, and not age alone, is important when making decisions about screening.

Even after a decision about testing has been made, the discussion about the pros and cons of testing should be repeated as new information about the benefits and risks of testing becomes available. Further discussions are also needed to take into account changes in a man’s health, values, and preferences.

Sources:

* American College of Surgeons' Commission on Cancer; [www.facs.org](http://www.facs.org)

*\*Saint Agnes Cancer Program has been approved by the CoC since 1986. Through our Commission on Cancer accreditation we are able to compare our provision and timeliness of care and improve performance based on nationally recognized quality measures and standards of cancer care.*

* + National Cancer Data Base (NCDB)
	+ Cancer Quality Improvement Program Report (CQIP)
* American Cancer Society [www.cancer.org/cancer/prostate-cancer/early-detection.html](http://www.cancer.org/cancer/prostate-cancer/early-detection.html)
	+ Recommendations for Prostate Cancer Early Detection
	+ ACS Cancer Facts & Figures 2018
* Prostate Cancer Foundation [www.stepup.pcf.org](http://www.stepup.pcf.org)
* Saint Agnes Medical Center [www.samc.com](http://www.samc.com)
* SAMC Cancer Registry database

*\*This report is developed from our hospital based registry experience which is not ‘population based’ data*.

Analytic Caseload comprised Class of Case 00 – 22. Discrepancy, CoC/NCDB reported Cancer Program Total Case Volume, 2015 My Facility (68).

* Family Health Portrait has been made available for your use at [www.samc.com/genetic-counseling](http://www.samc.com/genetic-counseling)

***\*Telling your doctor your family history is a first step to find out if you may be at increased risk. It will also guide you and your doctor in deciding what tests you need, when to start, and how often to be tested. Knowing your family history also helps you and your doctor decide if genetic counseling or testing may be right for you. These services are available through Saint Agnes Medical Center. Arrangements for Genetics consultation can be made by calling 450-5500 (Saint Agnes Cancer Support Service).***