

Active Surveillance for Prostate Cancer: Are We Failing Latino Patients at a Large Safety Net Hospital?

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Abstract

We sought to determine whether non-clinical trial patients adhere to active surveillance (AS) protocols and to discover how many were lost to follow-up (LTFU) at 2 institutions in California. Patients on AS from lower socioeconomic status strata were more often LTFU, and LTFU was significantly different between the 2 institutions. Multivariable analysis revealed that the main determinant of LTFU was socioeconomic status.

Introduction: Active surveillance (AS) is one recommended option for low-risk prostate cancer and involves close follow-up and monitoring. Our objective was to determine whether non-clinical trial patients adhere to AS protocols and how many are lost to follow-up (LTFU). **Patients and Methods:** Retrospective chart review was performed for patients with nonmetastatic prostate cancer who initiated AS at Los Angeles County Hospital (LAC) and University of Southern California Norris Comprehensive Cancer Center (Norris) between January 1, 2008, and January 1, 2015. Competing-risks regression analyses examined the difference in LTFU rates of AS patients in the 2 institutions and examined the association between LTFU and patient characteristics. We used California Cancer Registry data to verify if patients LTFU were monitored and/or treated at other LAC medical facilities. **Results:** We found 116 patients at LAC and 98 at Norris who met the AS criteria for this study. Patients at LAC and Norris had similar tumor characteristics but differed in median income, race, primary language spoken, distance residing from hospital, and socioeconomic status (SES). LTFU was significantly different between the institutions: $57 \pm 7\%$ at LAC and $32 \pm 6\%$ at Norris at 5 years ($P < .001$). By multivariable analysis, the main determinant of LTFU was SES ($P = .045$). By 5 years, the chance of an LAC patient remaining on AS was $8 \pm 6\%$ compared to $20 \pm 6\%$ for a Norris patient ($P < .001$). **Conclusion:** Successful AS implementation relies on patient follow-up. We found that patients on AS from lower SES strata are more often LTFU. Identifying barriers to follow-up and compliance among low SES patients is critical to ensure optimal AS.

Clinical Genitourinary Cancer, Vol. ■, No. ■, ■-■ © 2018 Elsevier Inc. All rights reserved.

Keywords: Active monitoring, Health care disparities, Low-risk prostate cancer, Socioeconomic status, Watchful waiting

Introduction

Prostate cancer (PCa) is the leading cancer diagnosis in men, with approximately 181,000 men diagnosed annually.¹ Active surveillance (AS) is an option for men with low-risk (LR) PCa because it

allows deferment of treatment until progression, potentially indefinitely. Although AS eliminates the morbidity and decreased quality of life associated with definitive PCa treatments, it may increase anxiety in men who worry about untreated cancer.²⁻⁵ AS enrollment in 2010-2013 was approximately 40%,^{6,7} indicating that most men with LR-PCa still elect to undergo treatment.

The available data suggest that AS is a safe alternative to definitive therapy for LR-PCa. Two randomized controlled trials demonstrated that PCa-specific mortality does not differ between AS and definitive treatment.⁸⁻¹⁰ However, most men in these studies were non-Hispanic white (NHW) men.^{11,12} There remains a dearth of data on the outcomes among ethnic minorities and/or those from lower socioeconomic status (SES).

Monitoring plans are important components of AS; they detect disease progression in time for curative treatment. The risk of

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Submitted: Oct 26, 2017; Revised: Jan 25, 2018; Accepted: Jan 27, 2018

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disease progression with LR-PCa necessitates rigorous follow-up for patients on AS. Social determinants of health contribute to health access barriers, thus emphasizing the importance of investigating AS in vulnerable populations.^{13,14}

This retrospective study investigated the implementation of AS in a real-world setting. We addressed the utilization of therapy and monitoring of minorities and lower SES populations. The primary objectives of the study were to evaluate the probability of patients being lost to follow-up (LTFU) and the compliance with AS.

Methods

Patient Selection

A retrospective institutional review board—approved chart review of the electronic medical record was conducted at Los Angeles County Hospital (LAC), one of the largest safety net hospitals in the country, and University of Southern California Norris Comprehensive Cancer Center (Norris), a university-based private cancer hospital that is a National Cancer Institute—designated comprehensive cancer center, largely staffed by the same physicians. We obtained a list of patients diagnosed or treated with PCa between January 1, 2008, and December 31, 2014, patients treated in the Los Angeles County Cancer Surveillance Program, and patients with data in the Los Angeles registry (part of the National Cancer Institute's Surveillance, Epidemiology, and End Results [SEER] cancer registry program). We reviewed the electronic medical records and excluded patients with metastatic disease at presentation, incidental PCa diagnosed at cystoprostatectomy, treatment received elsewhere after diagnosis, or treatment after January 1, 2015. The remaining patients were categorized according to the initial treatment (within 6 months of diagnosis) chosen: surgery, radiotherapy, or AS (Figure 1).

Data Collection

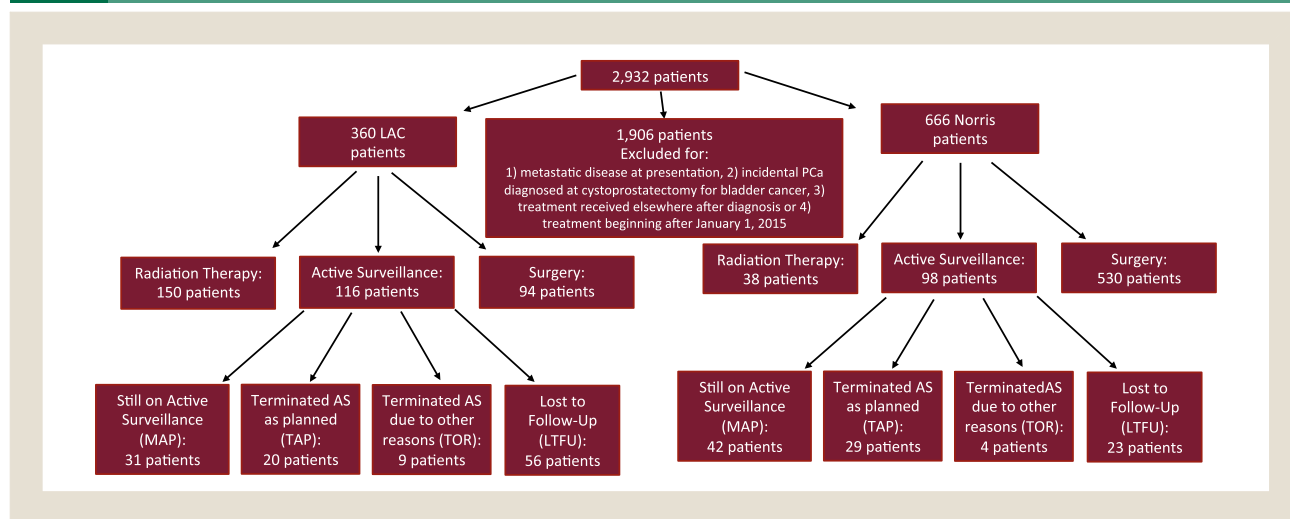
We abstracted demographic patient-level data (age, race/ethnicity, primary language spoken, zip code, SES, and distance from hospital), tumor-specific data (clinical T stage, Gleason score, number of positive biopsy cores, percentage of biopsy core positive,

presence of perineural invasion, and prostate-specific antigen [PSA] values), and clinical data (specialties seen before choosing therapy, whether treatment options were discussed using the patient's primary language, and whether an interpreter was used) on all patients. The California Cancer Registry provided the ecologic SES variable based on the patient's census tract residence at diagnosis. This derived variable combines 7 census indicator variables that capture education, income, and occupation in order to develop a single variable.¹⁵ SES is reported as quintiles (1-5, with 1 being the lowest).¹⁶

For patients who chose AS, we collected data on the duration of monitoring and frequency of monitoring visits, repeat PSAs, and biopsies. For a patient to be categorized as selecting AS, the medical record needed to record that all treatment options were presented to the patient and that he or she chose AS. Patient data were abstracted through December 31, 2015, to determine whether they terminated AS as planned (disease progression that required treatment or patient choice) (TAP), terminated AS due to other reasons (short life expectancy, significant comorbidities, moved, transferred care) (TOR), LTFU, or were still on AS and receiving monitoring as planned. We considered patients LTFU if they missed 2 consecutive follow-up visits and failed to return to the clinic, where they opted for AS (approximately 94% of AS patients were seen only by urology). We also recorded whether patients continued to visit clinics other than those for their PCa. If patients failed to return to PCa clinics but returned for other physician appointments, we deemed them LTFU for their PCa.

To evaluate patients LTFU, we obtained information on subsequent positive biopsy results received from other institutions (within Los Angeles County) by screening electronic pathology (epath) reports by the Cancer Surveillance Program. In California, hospitals and independent pathology laboratories are required to report all cancer cases to a regional cancer registry. Epath data are reviewed to document incidental cancer diagnoses. We identified subsequent positive biopsy samples from the LTFU group, and we recoded patients with subsequent positive biopsy samples from LTFU to TAP (if the pathology was from a surgical specimen), or TOR.

Figure 1 Flowchart Illustrating Patient Selection



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