POSTER #B9

Patterns of Management and Multidisciplinary Care in High/Very High and Intermediate Risk Prostate Cancer: A Population-Based Study in Ontario, Canada

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Introduction

- Prostate cancer (PCa) is a heterogeneous disease with prognosis determined by clinical risk stratification.
- Patients with high- or very high-risk (H/vHR) disease face substantially higher risks of recurrence, metastasis, and prostate cancer–specific mortality compared with those with intermediate-risk (IR) disease.[1,2]
- Optimal management requires coordinated multidisciplinary care involving urology, radiation oncology, and medical oncology.

Objectives

- This study aims to characterize current management practices and multidisciplinary care patterns among patients with high/very high-risk and intermediate-risk prostate cancer in Ontario, Canada.
- The focus is on evaluating consultation rates, treatment approaches, and coordination of care during the initial diagnosis and the first-year post-diagnosis.

Methods

- A retrospective, population-based cohort study was conducted using province-wide linked administrative data from Ontario.
- The cohort included patients diagnosed with H/vHR PCa and 16,650 with IR disease between 2010 and 2021.
- Descriptive analyses summarized consultation patterns with urology, radiation oncology, and medical oncology, both prior to treatment and within the first year after diagnosis.
- Comparisons between groups were performed using standardized differences and p-values.

Results

- Between 2010 and 2021, 12,939 patients diagnosed with H/vHR PCa and 16,650 with IR disease were identified.
- Most patients in both groups visited a urologist (H/vHR: 97.8%; IR: 94%; p<0.001) (**Table 1**).
- However, fewer high-risk patients had radiation oncology consultations before treatment (H/vHR: 41.2%; IR: 62.5%; p<0.001).
- Among those undergoing radical prostatectomy, about 40% had prior radiation oncologist consultations, with no significant difference across risk groups.
- Medical oncology consultations were rare (~2%) in both groups.
- Within the first year, approximately one-third of patients met only with a urologist, but over 65% met with both urologists and radiation oncologists.
- Notably, only 40% of high-risk and 32% of IR patients received coordinated multidisciplinary care involving urology, radiation, and medical oncology.

Limitations

- Due to the administrative data sources used, only formal consultations were identified. Informal multi-specialty consultation would not have been noted and thus these data may under-estimate multi-disciplinary care.

Table 1. Physician Management among Patients who Received Treatment after PCa Diagnosis, by Localized Prostate Cancer (LPC) Risk

	Total	Intermediate Risk	High and very high risk	P value	Standardized Difference
Urologist visits between index and first treatment among patients with PCa specific treatments	28,438 (96.1%)	16,278 (97.8%)	12,160 (94.0%)	<.0001	0.191
Radiation oncologist visits between index and first treatment among patients with PCa specific treatments	15,741 (53.2%)	10,412 (62.5%)	5,329 (41.2%)	<.0001	0.437
Medical oncologist visits between index and first treatment among patients with PCa specific treatments	639 (2.2%)	343-347*	292-296*	0.2401	0.014
Urologists only visit in the first year after index among all patients	8,895 (30.06%)	5,424 (32.58%)	3,471 (26.83%)	<.0001	0.126
Medical Oncologist visits between first treatment and castration resistance among patients who received PC specific treatments and developed castration-resistant prostate cancer (CRPC)	340 (27.3%)	70 (24.6%)	270 (28.1%)	0.2357	0.081
Multi-D (Urologist + Radiation Oncologist + Medical Oncologist) visits care between index and death (limit to patients who died during study period)	2,397 (36.75%)	905 (32.30%)	1,492 (40.10%)	<.0001	0.163

*Exact numbers suppressed to preserve patient anonymity based on ICES privacy regulations

Key Takeaways

Despite guideline recommendations, **multidisciplinary** care remains inconsistently delivered in localized prostate cancer, particularly among **high-risk** patients.

Improving coordinated, team-based care is essential to optimize treatment decisions and outcomes.

Conclusions

Despite the importance of multidisciplinary management, significant gaps exist in the coordination of care for prostate cancer patients, especially among high-risk groups.

Strengthening collaborative approaches is crucial to enhance treatment decision-making and improve clinical outcomes.

Future efforts should focus on optimizing multidisciplinary pathways to ensure comprehensive, patient-centered care, particularly in the context of emerging data for systemic treatment intensification for these patients.

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Poster

https://www.congresshub.com/Oncology/GU2026/Apalutamide/Wallis

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Disclosures
Author disclosures can be found on the ASCO GU website.

References
1. Freedland SJ, Nair S, Lin X, Karsh L, Pieczonka C, Potluri R, et al. AUS real-world study of treatment patterns and outcomes in localized or locally advanced prostate cancer patients. World J Urol. 2023 Dec 1;41(12):3535–42. 2. Eastham JA, Auffenberg GB, Barocas DA, Chou R, Crispino T, Davis JW, et al. Clinically Localized Prostate Cancer: AUA/ASTRO Guideline, Part II: Principles of Active Surveillance, Principles of Surgery, and Follow-Up. The Journal of Urology [Internet]. 2022 Jul [cited 2025 Jun 2]; Available from: https://www.auajournals.org/doi/10.1097/JU.0000000000002758 3. Mohler JL, Antonarakis ES. NCCN Guidelines Updates: Management of Prostate Cancer. J Natl Compr Canc Netw. 2019 May 1;17(5.5):583–6.

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