

PD12-11
A DECADE OF URINARY AND SEXUAL FUNCTION OUTCOMES: STATEWIDE TRENDS AND PREDICTORS OF URINARY CONTINENCE AND ERECTILE FUNCTION RECOVERY FOLLOWING ROBOTIC RADICAL PROSTATECTOMY OVER THE PAST DECADE

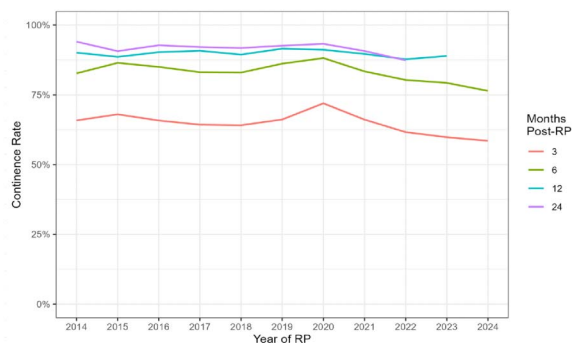
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INTRODUCTION AND OBJECTIVES: Robotic radical prostatectomy (RP) is a standard of care treatment option for localized prostate cancer, but postoperative urinary incontinence and erectile dysfunction significantly impact patient quality of life. Despite efforts to mitigate these effects, trends in recovery of continence and sexual function over the past decade remain unclear. This study evaluates these trends and factors influencing recovery post-RP using statewide data from the Michigan Urologic Surgery Improvement Collaborative (MUSIC).

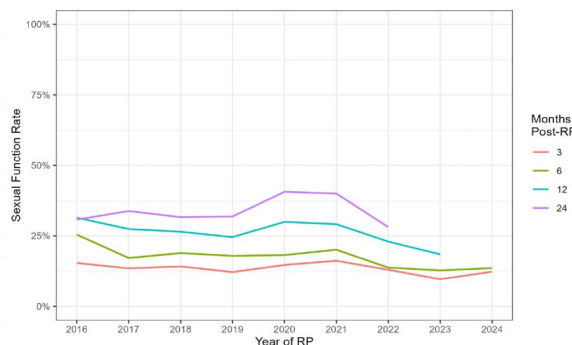
METHODS: We analyzed patient-reported outcomes (PRO) on urinary and sexual function for men undergoing RP from 2014-2024 in the MUSIC prostate cancer registry and included men with good baseline function. Social continence (SC) was defined as using 0-1 pads per day, and good sexual function (SF) was defined as erections firm enough for penetration. To assess changes over time, we compared proportions of patients with recovery of SC and good SF at 3, 6, 12, and 24 months postoperatively across the study period. Multivariable generalized estimating equations models were also used to identify factors associated with recovery of SC and SF.

RESULTS: There were 7,922 men with baseline SC and 3,507 men with good baseline SF, thus forming the primary two cohorts of our study. At 3, 6, 12, and 24 months, SC was regained in 65%, 84%, 90% and 92% of men, respectively. However, good baseline SF was only recovered in 13%, 17%, 26% and 34% of men at the same time intervals (Figure). We did not appreciate a significant change in SC or SF since 2014 (OR=0.95 per 5 years, $p=0.3$; and OR=0.94 per 5 years, $p=0.5$; respectively). Compared to no nerve sparing, bilateral nerve sparing was associated with better SC recovery (OR = 1.43, $p<0.001$), while both unilateral (OR = 1.71, $p = 0.007$) and bilateral nerve sparing (OR = 2.79, $p<0.001$) were associated with SF recovery. Higher T-stage was associated with poorer SF recovery: T3a (OR = 0.80, $p<0.017$) and T3b (OR = 0.61, $p = 0.008$) compared with T2 disease. T-stage was not associated with SC recovery (group $p=0.5$).

CONCLUSIONS: Despite efforts to improve SC and SF following RP, rates of recovery have not changed significantly over the past decade. Patients with SC have very high rates of recovery even by 6 months, but SF recovery has remained much more modest, even with those that have good baseline function.



A



B

Figure. Percentage of patients with social continence (A) and good erectile function (B) at 3, 6, 12 and 24 months postoperatively from 2014-2024.

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PD12-12
RESPONSE-ADAPTED NEOADJUVANT INTENSIFICATION WITH ABIRATERONE AND LHRH AGONIST ± DOCETAXEL BEFORE RADICAL PROSTATECTOMY IN HIGH-RISK LOCALIZED PROSTATE CANCER: A PROSPECTIVE COHORT STUDY EMULATING A TARGET TRIAL

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INTRODUCTION AND OBJECTIVES: The benefit of a response-adapted neoadjuvant therapy (NT) strategy prior to radical prostatectomy (RP) in high-risk localized prostate cancer needs robust evaluation.

METHODS: In this prospective cohort study, all eligible patients with high/very high-risk disease were counseled on the option of NT. Treatment assignment was based on patient choice, forming two groups: those who chose NT followed by RP, and those who opted for direct RP. The NT regimen consisted of abiraterone acetate, prednisone, and an LHRH agonist. Treatment response was assessed by MRI at 3 months; patients with suboptimal response were recommended to have chemotherapy (docetaxel) added to the ongoing NT regimen based on their physical status. This study had two primary endpoints: biochemical recurrence-free survival (BCR-FS) and event-free survival (EFS). To minimize confounding and account for competing risks, we constructed two balanced cohorts using Inverse Probability of Treatment Weighting (IPTW) and Propensity Score Matching (PSM). Treatment effects for the time-to-event endpoints were estimated using multivariable Fine-Gray competing risk regression to mitigate potential bias from competing events.

RESULTS: A total of 145 patients were included in the study, with 45 opting for NT and 100 proceeding directly to RP. After a median follow-up of 19.5 months, NT significantly improved both primary outcomes. For EFS, the adjusted subdistribution hazard ratio (sHR) in the IPTW cohort was 4.57 (95% CI, 1.77-11.8; $P=0.002$) and in the PSM cohort was 3.86 (95% CI, 1.48-10.1; $P=0.006$), favoring the NT