INTRODUCTION AND OBJECTIVE: Obstructive sleep apnea (OSA) affects as many as 7% of adult men in the general population, higher in men with obesity and large neck sizes. OSA is associated with ED. No data to date has assessed EFR after RP in men with OSA. The objective of this study was to define EFR rates 2 years post-RP.

METHODS: Records of men who underwent RP with 24-month post-RP follow-up were reviewed. ADT and radiation therapy were exclusions. Men completed the OSA screening questionnaire, STOP-BANG (SB) pre-RP. Men were divided into OSA risk groups: high, intermediate, and low. EFR was recorded using IIEF-EFD score, with a score of at least 24 indicating recovery. Univariable and multivariable logistic regression analyses assessed predictors of EFR.

RESULTS: 454 men were analyzed. Mean age 62±7 years. Of the studied population, 12% had a history of OSA, 10% had diabetes, 12% were current smokers, and 37% were former smokers. The median STOP-BANG (SB) score was 2. High, intermediate, and low risk of OSA scores were 8%, 41% and 51% respectively. Mean baseline testosterone (T) was 495 ng/dL, PSA 7.4 ng/mL, and EFD score 22. Most men had a Gleason sum of 7 (87%). 73% of patients had bilateral or unilateral neurovascular bundle preservation. At the 2-year follow up, median EFD score in high, intermediate and low OSA risk groups: were 9, 16, and 18 respectively. The low OSA risk group was significantly more likely to recover (OR = 1.6, 1.1–2.4) than the moderate/high group.

CONCLUSIONS: In our cohort, at 2 years post-RP, increasing OSA risk is associated with poorer EFR in men post-RP.

Source of Funding: None

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Erectile Function/Dysfunction: Evaluation I

Moderated Poster 27

Saturday, September 11, 2021 10:30 AM-11:45 AM

MP27-01

IMPACTS OF NEOADJUVANT HORMONAL THERAPY PRIOR TO ROBOT-ASSISTED RADICAL PROSTATECTOMY ON POSTOPERATIVE HORMONAL- AND SEXUAL-RELATED QUALITY OF LIFE—ASSESSMENT BY PATIENT-REPORTED QUESTIONNAIRE

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INTRODUCTION AND OBJECTIVE: Neoadjuvant hormonal therapy (NHT) before radical prostatectomy (RP) is not recommended in current guidelines. Despite this recommendation, NHT before RP is sometimes conducted for a small portion of patients in a clinical practice. Not just side effects of hormonal therapy, degenerate post-operative quality life (QOL) remains the major problem even in the era of robot-assisted RP (RARP). In this study, we evaluated the impacts of NHT on hormonal- and sexual-related QOL in patients who underwent RARP.

METHODS: A total of 470 patients were enrolled. According to whether NHT was administered at least one time, patients were divided into two groups, the non-NHT group (n=408) and the NHT group (n=62). Hormonal- and sexual-related QOL was measured with the Japanese version of Expanded Prostate Index Composite (EPIC) questionnaire.

RESULTS: Hormonal summary scores at 6, 9 months (p=0.002 and 0.017, respectively), function scores before and 3, 6, 9 months after RARP (p=0.005, 0.031, 0.0009 and 0.008, respectively) and bother score at 6 months (p=0.025) in NHT group were statistically lower than those of non-NHT group. Decreased sexual function scores in NHT group was observed before and 6 months after RARP (p=0.027 and 0.021, respectively). Sexual function at 3 months in patients with >5 month-NHT duration significantly worse than that of ≤5 months (p=0.047). On the contrary, significantly worse sexual bother at 3 months was observed in patients with ≤5 month-NHT duration than that of >5 months (p=0.032). All of hormonal and sexual scores were not statistically significant between patients treated with anti-androgen monotherapy and luteinizing hormone-releasing hormone (LH-RH) agonists with/without anti-androgen drugs.

CONCLUSIONS: NHT prior to RARP should not be recommended in terms of not only oncological outcome but also the impacts on postoperative hormonal- and sexual-related QOL.

Source of Funding: None of the authors has any relevant financial interests, relationships, activities or affiliations pertaining to this study

MP27-02

DOES THE RISK OF OBSTRUCTIVE SLEEP APNEA (OSA) AFFECT ERECTILE FUNCTION RECOVERY (EFR) AFTER RADICAL PROSTATECTOMY (RP)?

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INTRODUCTION AND OBJECTIVE: Obstructive sleep apnea (OSA) affects as many as 7% of adult men in the general population, higher in men with obesity and large neck sizes. OSA is associated with ED. No data to date has assessed EFR after RP in men with OSA. The objective of this study was to define EFR rates 2 years post-RP.

METHODS: Records of men who underwent RP with 24-month post-RP follow-up were reviewed. ADT and radiation therapy were exclusions. Men completed the OSA screening questionnaire, STOP-BANG (SB) pre-RP. Men were divided into OSA risk groups: high, intermediate, and low. EFR was recorded using IIEF-EFD score, with a score of at least 24 indicating recovery. Univariable and multivariable logistic regression analyses assessed predictors of EFR.

RESULTS: 454 men were analyzed. Mean age 62±7 years. Of the studied population, 12% had a history of OSA, 10% had diabetes, 12% were current smokers, and 37% were former smokers. The median STOP-BANG (SB) score was 2. High, intermediate, and low risk of OSA scores were 8%, 41% and 51% respectively. Mean baseline testosterone (T) was 495 ng/dL, PSA 7.4 ng/mL, and EFD score 22. Most men had a Gleason sum of 7 (87%). 73% of patients had bilateral or unilateral neurovascular bundle preservation. At the 2-year follow up, median EFD score in high, intermediate and low OSA risk groups: were 9, 16, and 18 respectively. The low OSA risk group was significantly more likely to recover (OR = 1.6, 1.1–2.4) than the moderate/high group.

CONCLUSIONS: In our cohort, at 2 years post-RP, increasing OSA risk is associated with poorer EFR in men post-RP.

Source of Funding: None

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MP27-03

EVALUATING THE IMPACT OF TIME BETWEEN RADICAL PROSTATECTOMY (RP) AND ADJUVANT RADIATION THERAPY (RT) ON ERECTILE FUNCTION RECOVERY (EFR)

Jose M. Flores*, Nicole Benfante, Elizabeth Schofield, John P. Mulhall, New York City, NY

INTRODUCTION AND OBJECTIVE: RT post-RP in men with PSA recurrence improves survival. It is also associated with a higher rate of urinary incontinence and erectile dysfunction (ED). We attempted to evaluate if the time period between RP and adjuvant RT predicts EFR outcomes.

METHODS: Men who received RT post-RP with ≥2 years post-RP follow-up were analyzed. ADT and RT pre-RP were exclusions. Demographics, comorbidities and pathological parameters and IIEF erectile function domain (EFD) scores were recorded. We report median EFD scores and factors correlated with EFR ≥24 months post-RT. Factors included: patient age, comorbidities, smoking status, baseline pre-RT and pre-RT Testosterone (T), prostate specific antigen (PSA), baseline EFD score, Nerve-Vascular bundle (NVB) status, and time between RP and RT.

RESULTS: 126 men were included. Mean age at RP was 63±7 years. Mean pre-RP T was 390±222 ng/dL, PSA, 10.2±10.4 ng/mL and median EFD score were 27 (IQR=20–30). Median pre-RT T was 376.9±187 ng/dL, PSA 0.25±0.33 ng/mL, and median EFD score 9 (IQR=3–20). 54% of patients had bilateral NVB preservation, and 29.5% unilateral. 71% received ADT with their RT, the median duration of ADT exposure was 4.5 (IQR = 3–8.5) months. Median time between RP and RT was 14.9 months (IQR = 8.5–28.6) months; 41% had ≤1 year between RP and RT. 2 years post RP, median EFD was 9.5 (IQR = 3–22), 22% had a score ≥24. EFD score at follow-up was correlated with age at RP (r = 0.32, p < 0.001), and pre-RT EFD score (r = 0.56, p < 0.001). Time between RP and RT did not correlate with EFD score at follow up (r = 0.08, p = 0.39).