Round up

In this COVID-19 pandemic, patients who have recovered from the infection and present with a new onset of symptoms of frequency and urgency often ask if their symptoms could be related to the COVID-19 infection. It is interesting to read the article by Mumm et al.\(^1\) who report that between March and April 2020, 7 of 57 patients (12.2%) admitted in the COVID ward with fever, cough, and positive RT-PCR throat swab tests, showed significant new-onset symptoms of frequency and urgency of urine. The mean frequency was 13.7 micturition/day. All other reasons for frequency urgency such as urinary culture, prostatitis, and ureteric stones were excluded. They did not have residual urine or thickened bladder wall suggestive of bladder outlet obstruction.

Though none of the patients had SARS-CoV-2 RNA virus in urine, clinically all of them had features of viral cystitis. As one of the spike proteins of COVID-19 has predilection for angiotensin-converting enzyme 2 receptors, which are also present on the urothelial cell, it was postulated that viremia must have led to endothelitis and inflammation of the transitional cell lining. COVID-19 virus was detected in the serum of a few patients. This awareness could be useful to understand the new onset of frequency and urgency in the COVID-19 pandemic.

Another controversial issue worth discussing is the issue of shared decision-making (SDM) while recommending prostate-specific antigen (PSA) screening. Real-life practice disproves many guidelines. With contradictory recommendations on screening by the United States Preventive Task Force wherein health providers themselves are not clear about the utility of screening, then would SDM justify the recommendation for PSA screening?

Most of the updated PSA screening guidelines recommend SDM before advising PSA screening to a male of age 55–69. SDM is a dialog between the patient and the urologist to make the patient understand the clinical and epidemiological aspects of the prostate cancer and the risks and benefits associated with screening. The aim of SDM would depend on the ability of the patient to understand the science of prostate cancer, which could be called health literacy (HL). The article by Nguyen et al. discusses this relevant issue of the odds of getting PSA screening after SDM in men with different levels of HL.\(^2\) HL has been categorized into three levels, depending on the understanding of written information gleaned by the patients themselves. Contrary to the belief that higher HL would be associated with lower rates of screening, this study has shown contrary results. The odds of getting PSA screening, when SDM was present in men with the lowest HL, was much higher (3.94 [2.6–5.9]) than that in men with the highest literacy (2.2 [1.6–3]). Hence, in India, if the highest rate of screening among men is obtained, then would SDM justify the absence for SDM in our practice? This would be the question to be contemplated.

Locally advanced prostate cancer with adverse features such as pT3 disease, high Gleason grades, or positive surgical margins after radical prostatectomy (RP), is considered for adjuvant radiotherapy (ART). Radiotherapy after RP has significant side effects. The trend is toward offering salvage radiotherapy (SRT), that is, instead of immediate radiation, it is given when PSA starts rising after a nadir level. In the international, Phase 3, multicentric (138 centers), open-label, randomized controlled trial in prostate cancer (RADICALS) by Parker et al., 1396 patients were randomized to either have ART \((n = 699)\) within 6 months of RP or SRT \((n = 697).\(^3\) In the SRT arm, radiation was given on biochemical progression, when there was two or three consecutive rises in PSA from the nadir of 0.1 ng. It was given within 2 months of the PSA rise.

Interestingly, only 228 (33%) patients showed biochemical progression and required SRT within 5 years of RP. Had we given ART to start with, almost 67% would have got radiation unnecessarily with the added burden of side effects such as urinary incontinence and stricture. What if delay in radiation therapy may affect the survival? In the same data set, the 5-year biochemical recurrence-free survival was 85% with ART and 88% with SRT, based on an intention-to-treat analysis.

Hence, if a patient after RP with high-risk factors on histology agrees to have a vigilant follow-up, it would be better to delay the radiation without compromising survival. In this regard, a prospective meta-analysis collaboration (ARTISTIC) has been established to incorporate all the randomized trials of ART versus SRT to study the long-term survival.\(^4\)

There has been an increase in awareness among practicing urologists to order magnetic resonance imaging (MRI) before biopsy, in men suspected to have prostate cancer. MRI has a very high negative predictive value of identifying and characterizing lesions for local staging and is a useful adjunct for MR fusion biopsy. More often than not, as a reflex action, most of us write multi-parametric MRI (mpMRI), which
involves T2-weighted images (T2W), diffusion-weighted images (DWI), and dynamic contrast-enhanced images (DCE).

The question is, should we really get mpMRI in all men suspected with prostate cancer or switch over to bi-parametric MRI (bpMRI), that consists of only T2W and DWI images? In the article by Christophe et al., 92 patients who had MRI on a 3-Tesla system before having RP formed the study group. Four radiologists, including two with few months of experience, read both bpMRI and mpMRI imaging for location of the lesion, size of the lesion, PIRADS V2 scoring, and extracapsular extension. All radiologists interpreted the same set of MRIs at the interval of 4 weeks, first the images with the bpMRI protocol and then with the mpMRI protocol. It was concluded that the use of DCE (mpMRI) did not provide any benefit in all the parameters. Another noteworthy finding was that an inter-observer agreement was same for reading bpMRI or mpMRI. Though this study is on a small cohort of patients, it did raise an important question on the utility of adding DCE for prostate MRI. bpMRI would save not only time but also the cost of MRI contrast without compromising the result.

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