Urological Society for American Veterans

Veterans Affairs Urological Forum

AUA National Meeting 2017

MAY 14, 2017

1:00 PM – 8:00 PM

APPETIZERS • BEVERAGES

EVENING PROGRAM w DINNER

DOUGLASS ROOM
WESTIN BOSTON WATERFRONT
425 SUMMER STREET
BOSTON, MA

AGENDA:

1:00-1:15 REGISTRATION, REFRESHMENTS, EXHIBITS

1:15 - 1:20 PM: WELCOME
- Jeffrey A. Jones, President USAV (MEDVAMC, Houston, TX)

1:20 -1:30 PM: VA UROLOGY ORGANIZATIONAL STRUCTURE
- Mark G. Garzotto, Chairman, Urology Surgical Advisory Board
  (Portland VAMC, Portland, OR)

1:30 - 1:40 PM: "Bladder Cancer Diagnosis" (INDUSTRY SPONSORED)
- Jennifer M. Taylor (MEDVAMC, Houston, TX)

1:40 - 2:00 PM: PRESENTATIONS OF VA-FUNDED UROLOGY PROJECTS
- John Leppert
- Danil Makarov
- Florian Schroeck
- Jeremy Shelton
- Ted Skolarus

2:05- 2:10 PM: BREAK

2:10– 2:20 PM: "Yale VA experience: MRI-US Fusion Prostate Biopsy" (Industry Sponsored)
- Preston Sprenkle, Yale VA MC, West Haven, CT

2:20 PM: INTRODUCTION TO ACADEMIC SESSION
- Danil V. Makarov, Scientific Program Chair (VANYHHS, New York, NY)

2:25 - 3:50 PM: SCIENTIFIC ABSTRACT PRESENTATIONS AND AWARDS
- 4 min presentations
- 2 min discussion
- Moderators: Robert Grubb & Justin Parker

3:50 - 4:45 PM: BUSINESS MEETING (ALL ATTENDEES ARE WELCOME)

4:45 - 5:30 PM: NETWORKING—DISCUSSION WITH EXHIBITORS

5:30 - 7:30 PM: AVAHO PANEL SESSION—GENETIC AND GENOMIC TESTING- IMPACT ON TREATMENT FOR VETERANS WITH PROSTATE CANCER (DINNER INCLUDED)
- Julie Lynch, VAMC Salt Lake City, Utah

ABSTRACTS:

Final outcomes of a phase II trial of MRI-ultrasound fusion biopsy guided prostate cancer focal therapy by bipolar radiofrequency ablation

Samir S. Taneja , Richard Huang, Fang-Ming Deng, and Andrew Rosenkrantz

INTRO: We report the outcomes of prostate cancer (PCa) focal therapy (FT) using a novel bipolar radiofrequency ablation (bRFA) device guided by results of MRI-ultrasound fusion-targeted (MRF-TB) and systematic (SB) biopsy .

METHODS: 21 men with stage ≤T2a, GS ≤ 7(3+4) PCa were enrolled in a Phase II trial of FT (clinicaltrials.gov # NCT02303054) if PSA <10, ≤ 2 MRI suspicious regions (mSR), MRF-TB,, and PCa spatially concordant on MRF-TB and SB. Follow-up included postop day (POD) 7 and 6 month MRI and 6 month MRF-TB/SB. Residual cancer was defined as in field, in margin (target adjacent), or out of field. Adverse events (AE), quality of life, sexual, and urinary outcomes were assessed.

RESULTS: 21 men (Mean age 63.9. Mean baseline PSA 5.1) completed treatment and follow-up biopsy in either 1 (n=15) or 2 (n=6) mSR. Compared with the 6 month biopsy, post-op MRI was not a significant predictor of residual PCa ($\chi(2) = 5.162$, $p = .076$). Negative targeted biopsy was noted in 16/21 (76%) men and 20/25 (80%) lesions. Residual PCa was noted in field in 5 (24%), in margin in 6 (28%), and out of field in 7 (33%) men. AE were mild and transient. There was no measured reduction in QOL after treatment.

CONCLUSION: Focal bRFA is a novel highly targeted method of FT when guided by MRF-TB/SB. Tumor clearance was achieved in 76% of men with minimal effects of QOL, but residual PCa was noted in the region of the ablation in 43%, suggesting need for improved targeting and margin control.

Funding: Trod Medical, St Petersburg, Florida (study sponsor); Joseph and Diane Steinberg Charitable Trust, New York, New York (research sponsor)

OPTIMIZING THE NUMBER OF TARGETED CORES DURING PROSTATE MRI-FUSION TARGET BIOPSY (MRF-TB)

Alexander P. Kenigsberg, Marc A. Bjurlin, Andrew Rosenkrantz, Hasan Dani, Xiaosong Meng, Fang-Ming Deng, Richard Huang, James Wysock, William Huang, Herbert Lepor, Samir S. Taneja

INTRODUCTION: The study objective is to characterize the value of additional MRF-TB cores on biopsy.

METHODS: For men undergoing MRF-TB between 2015 and 2016, 4 cores were directed to each MRI-targeted lesion. The MRI-targeted core in which the highest Gleason Score (GS) was first encountered was defined as the first highest Gleason core (FHGC). The first MRI-targeted core to provide diagnosis of clinically significant (CS) cancer (GS ≥ 3+4) was defined as the first CS core (FCSC). We analyzed the frequency of a FCSC on cores 3 or 4 and determined differences in pre-procedure characteristics between FHGC in cores 1,2 or 3,4.

RESULTS: 318 patients underwent MRF-TB, with 457 lesions biopsied. 261 lesions had cancer on MRF-TB. Among those, the FHGC was found on core 1 in 154 (59.0%), core 2 in 56 (21.5%), core 3 in 31 (11.9%), and core 4 in 20 (7.7%) men. Of the 51 instances in which the FHGC was encountered on cores 3 or 4, only in 24 lesions (9.2% of total cancer lesions) were these cores the FCSC. Relative to cores 1-3, core 4 represented the first CS core in 9 (3.4%) cases. There was no significant difference in pre-procedure characteristics between groups.

CONCLUSIONS: The FHGC was found in cores 1 or 2 over 80% of the time and cores 3 or 4 only contributed to the identification of CS cancer in 9.2%. Lesion size, visibility on ultrasound, and suspicion score may influence the necessity for >2 cores in targeting of MRI suspicious regions.

BURDEN OF INAPPROPRIATE IMAGING AMONG MEN WITH INCIDENTAL LOW-INTERMEDIATE RISK PROSTATE CANCER

Siri Drangsholt, Walter, Abbey Lepor, Erica Sedlander, Caitlin Curnyn, Stacy Loeb, Patrick Malloy, Danil V. Makarov

Introduction: According to current National Comprehensive Cancer Network (NCCN) guidelines, routine imagining for staging low-risk prostate cancer is not recommended. However, extensive overuse of inappropriate imaging continues to persist. Rates of incidental findings versus false positive diagnoses from inappropriate imaging are poorly understood and have yet to be quantified for low-intermediate risk prostate cancer patients.

Objective: To determine the frequency of incidental and false positive radiologic findings in patients with low-intermediate risk prostate cancer during initial staging.

Methods: We retrospectively reviewed all low to intermediate risk prostate cancer patients medical records from the VA NY Harbor Healthcare System from 2005-2015 who underwent inappropriate staging imaging.

Results: Of 517 cases, 417 men were classified as low risk prostate cancer and underwent inappropriate staging imaging, 277 (66%) had CT scans, 379 (91%) had a bone scan and 18 (4%) had an MRI. Of these 417 men, 178 (43%) had follow up imaging for positive findings. We calculated an incidental finding rate of 13% and a false positive rate of 46% for patients. 7 patients had findings suggestive of advanced or metastatic disease.

Conclusion: Despite guideline recommendations, overuse remains an issue for low-risk prostate cancer patients. The false positive rate found in this analysis is alarmingly high at 46%, this use of scans is burdensome to the healthcare system, patients and likely contributes to delayed treatment. This study highlights the frequency of inappropriate imaging and negative consequences.

Black men in the Veterans Health Administration (VHA) are more likely to receive definitive prostate cancer treatment

Temitope L. Rude, Dawn Walter, Ted Skolarus, Cary P. Gross, John Leppert, Steven B. Zeliadt, Daniel Becker, Joseph Ravenell, Aisha Langford, Stacy Loeb, Danil V. Makarov

Introduction: Black men with prostate cancer in SEER-Medicare are less likely to undergo definitive treatment than whites; however, Black men treated in the VHA demonstrate parity in prostate cancer mortality. We studied whether the receipt of curative therapy for VHA patients was influenced by race and likelihood of benefit.

Methods: We performed a retrospective cohort study of veterans diagnosed with prostate cancer in 2011-13 from the VHA Corporate Data Warehouse. We examined treatment patterns within clinical benefit groups based on D'Amico risk and life expectancy. We used logistic regression to model receipt of definitive treatment as a function of race.

Results: 4,987 men were identified who received all of their care within the VA system. Race, clinical benefit group, age and region ($p<0.01$) were associated with receiving curative treatment. When we introduced the interaction between race and clinical benefit, race did not impact treatment in the high or low benefit groups; however, for intermediate benefit patients, black men were treated at the same rate as high risk non-black men (OR 0.85, 95% CI 0.56-1.31), while non-black men were less likely to receive treatment than their high risk non-black counterparts (OR 0.32, 95% CI 0.22-0.47).

Conclusions: In the VHA, black patients are more likely to receive curative treatment in clinically complex situations. This bias toward treatment in Black men likely reflects an appropriate treatment difference and speaks to the success of the VHA in overcoming disparity in access to care.

MORTALITY WITHIN ONE YEAR OF PROSTATE CANCER DIAGNOSIS: HIGH RATE OF CANCER-SPECIFIC MORTALITY IN THE ELDERLY

Alex Arnouk, Cynthia Smith; Barry Stein

INTRODUCTION: The 2013 AUA guidelines on the early detection of prostate cancer recommend against routine PSA screening in men 70+ years of age. This is based on the absence of evidence that screening in this population shows benefit, and the clear evidence that the ratio of harm to benefit increases with age. It is believed that competing co-morbidities are more likely to cause mortality before prostate cancer. We sought to evaluate characteristics of patients at our institution who were diagnosed with prostate cancer and subsequently died within 1 year of diagnosis.

METHODS: After obtaining IRB approval, we retrospectively identified the records of all patients diagnosed with prostate cancer at the Stratton Veterans Affairs Medical Center, in Albany New York between January 1, 2000 and December 31, 2009. A total of 563 patients were identified from our tumor registry. Demographic data were collected, including initial PSA, stage of disease, Gleason Grade, follow-up visits, and treatment plan. Patients who were diagnosed with prostate cancer and subsequently died within 1 year of diagnosis were identified. A determination of their prostate cancer risk stratification was performed using D'Amico criteria. Death records were utilized to determine cause of death and verified through review of the electronic medical record.

RESULTS: We identified 31 patients who were diagnosed with prostate cancer and subsequently died within 1 year of diagnosis. Mean follow-up was 206 days. A total of 24/31 (77.4%) were age 70+, 22/24 (91.2%) of this age group had high risk disease, and none underwent potentially curative therapy (surgery, radiation with or without androgen deprivation therapy, active surveillance). For comparison, high risk disease was noted in 4/7 (57.1%) of patients age <70, and 2/7 (28.6%) of this age group underwent potentially curative therapy. Prostate cancer was found to be the cause of death in 17/24 (70.8%) of patients age 70+ versus 2/7 (28.6%) of patients age <70.

CONCLUSIONS: In our cohort of prostate cancer patients, this disease was not innocuous in the elderly. Of those patients age 70+, prostate cancer was found to be the cause of death in 70.8%, and these patients were virtually all in the D'Amico high risk category. There is a tendency to consider that elderly men will die of other co-morbidities, and not of prostate cancer. These results support the idea that men with prostate cancer should be evaluated base on physiologic rather than chronologic age when determining screening and treatment options.

Understanding the implications of de-implementation of chemical castration among men with prostate cancer on bone health surveillance

Ted A. Skolarus, MD, MPH; Tudor Borza, MD, MSc; Vahakn Shahinian, MD, MS; Timothy P. Hofer, MD, MSc; Kyle Kepreos, MS; Jennifer Davis, MS; Brent K. Hollenbeck, MD, MS; Sarah T. Hawley, PhD, MPH; Anne E. Sales, RN, PhD

Introduction
Although some prostate cancer patients benefit from ADT, chemical castration is also performed when there is no high-level evidence for use and despite iatrogenic harms (e.g., osteoporosis) creating opportunities for de-implementation. For these reasons, we determined the extent to which ADT and bone density testing varied across VA facilities.

Methods
Using VA cancer registry and administrative data, we identified 50,969 men diagnosed with prostate cancer from 2005 through 2008. We characterized facility-level rates of ADT and bone density testing (BDT) use, and used a Multilevel Endogenous Switch Model to determine factors influencing both ADT and BDT use.

Results
21,329 (42%) men received ADT as a prostate cancer treatment across 130 facilities. After adjustment for patient and facility characteristics, we found significant variation in facility-level rates for both ADT and bone density testing use (Figure). We found no significant effect of ADT use upon the probability of a patient receiving a bone density test ($p = 0.361$).

Conclusion
We found significant variability in ADT and BDT use among VA facilities treating prostate cancer patients, however no relationship between the two. These findings suggest de-implementation of lower value ADT may have limited downstream implications for bone health surveillance, implying a further need to implement adequate surveillance coupled with de-implementation of ADT.

Challenges and Opportunities in Prostate Cancer Research at the ME DeBakey VA Medical Center

JA Jones, MD, J Taylor, MD, C Pettaway, MD, W. Lowrance, MD, A. Jones, G Gonzales, PhD, JD Franklin, M Irizarry, M Ittmann, MD

Introduction: Management of prostate cancer continues to be a large clinical load for every VA urology section. Both patients & providers struggle with decision-making on how best to manage low to intermediate risk disease, while many of the patients with high risk disease, despite aggressive intervention, develop metastatic disease which often progresses to the castrate resistant state. African American (AA) veterans are perceived to have a higher rate of aggressive prostate cancer, with many potential contributing factors, however adequately powered & well controlled studies to delineate the role of biomarkers to make predictions for prostate cancer progression & mortality, in this racial cohort, are lacking. Conducting clinical trials within the VA system has significant obstacles but also has significant strengths to be employed. Obstacles include added federal regulatory hurdles, unique provisions in IRB consent forms required by VA R&D committees, difficulties in employment of dedicated clinical research associates at VA facilities, & patients with large number of substantial co-morbidities that render them ineligible due to exclusion criteria. Strengths include the presence of the HVAREF to assist in financial negotiations with the industry sponsors, & the wide ethnic & racial diversity of the veterans, allowing more representative population sampling.

Methods: The MEDVAMC is currently participating in 2 multi-center clinical trials to help shed light on both the issue of decision-making in localized cancer (Myriad URO-005- Prolaris genomic analysis) & in defining the factors & biomarkers in African American men which may lead to a suboptimal clinical outcome. In the Myriad study, prostate biopsies were sent for genomic testing before therapeutic decision-making in men with low to intermediate risk & volume prostate cancer. In the POPCAP study, demographic information, total PSA, % free PSA, 2 pro-PSA, & PHI were collected in AA men & compared with biopsy results (POPCAP).

Results: During the first year of the POPCAP study being opened, the MEDVAMC enrolled 151 AA patients, while during the first 6 months 47 were enrolled on the Myriad URO-005 study. 11 of the 47 had insufficient RNA to analyze, & 10/11 with insufficient RNA, the biopsy cores were left in formalin > 48 hours before paraffin embedding. Of the 151 AA men enrolled on POPCAP, 7 had blood & urine collected but decided not to undergo the prostate biopsy leaving 144 evaluable patients. These were compared to 60 non-VA, AA patients. Despite that mean of all measures of PSA being higher in the non-VA group, TotPSA-19.1 vs 10.2, %fPSA – 16.7 vs 14.9, PHI- 71.4 vs 49.4, the rate of cancer 51.1% vs 64.8% & Gleason score >/= 4+3 - 23.5% vs 35.3% were higher in the VA population . Of the PSA measures, PHI had the highest sensitivity 80.5% & specificity 76%.

Conclusions: Conducting clinical trials can be challenging in the VA system, however these challenges can be overcome by proper trial selection for the veteran population. The racial diversity in the VA provides an important opportunity for clinical discovery. AA veterans may have more aggressive prostate cancers than non-VA AA's. Further studies will look into the potential role of Agent Orange exposure & other contributing factors in veterans.

PHENAZOPYRIDINE: AN EASIER WAY TO IDENTIFY URETERAL ORIFICES

Alexandra Rehfuss MD[1], Joseph Mahon MD[1], Igor Sorokin MD[2], Cynthia Smith[3], Barry S. Stein MD[3]
[1]Albany Medical Center, [2]UT Southwestern, [3]Stratton VA Medical Center

Introduction

Intravenous methylene blue is commonly used to identify ureteral orifices (UOs). However, it can increase operating time, and at high doses induce methemoglobinemia and interfere with pulse oximetry. Phenazopyridine discolors the urine orange, can be administered orally pre-operatively and is safe for short term use. We evaluated the utility of phenazopyridine in identifying the UOs.

Methods

Adult patients undergoing urological endoscopic procedures at the Stratton VA were prospectively enrolled. Preoperative metabolic panels were reviewed. Exclusion criteria included: renal insufficiency (CrCl<50ml/min), severe hepatitis or severe liver disease, G6PD deficiency, previous hypersensitivity to phenazopyridine, or pregnancy. In Phase 1, patients undergoing office flexible cystoscopy were administered 200mg phenazopyridine the morning of the procedure. In Phase 2, patients took 200mg phenazopyridine at 7pm the night before surgery. Upon entry into the bladder, UOs were identified and urine color was graded (0=no dye, 1=weak, 2=moderate, 3=strong). Patients were assessed post-operatively for side effects.

Results

17 patients met inclusion criteria. 12 patients were enrolled in Phase 1 and 100% had excretion of orange urine (grade 3) from the UOs. This strong efflux of orange urine made it difficult to visualize the bladder and required several irrigations to clear the colored urine. Therefore, we transitioned to Phase 2. Five patients have currently completed Phase 2 and 100% had excretion of orange urine (grade 2). No adverse events were reported.

Conclusion

Phenazopyridine can successfully identify UOs at time of endoscopic procedure. Given the robust orange color produced, we recommend administration the evening prior to procedure.

PRELIMINARY EXPERIENCE WITH ACTIVE SURVEILLANCE OF SMALL RENAL MASSES IN THE VETERAN POPULATION

Robert G. Moore, Debora K. Moore, K.C. Balaji-Salisbury VA Medical Center, Salisbury, NC

Introduction: The urological literature has demonstrates that SRM can safely undergo active surveillance with serial imaging with a very low rate of progression and/or metastatic disease. However, data from active surveillance of SRM in the veteran population is lacking in the medical literature. We present our preliminary experience with active surveillance in the veteran population.

METHODS: All SRM less than or equal to 4 cm and renal masses greater than 4 cm that refused therapy were prospectively followed with serial imaging (4-12 months). Criteria for Intervention includes A) greater than 5 mm lesion growth per year, B) Renal lesions greater than 4 cm, C) patient preference for treatment and D) symptomatic lesions

RESULTS: A total of 132 veterans with SRM were followed with serial imaging with 37(28%) patients crossing over the intervention arm. Indications for intervention (A) grow > 5mm/year-59.7%, (B) Lesion>4 cm (27%) and patient preference (13, 5%). Seventy eight percent of the intervention had confirmed malignancy compared to 22% benign lesions of the 37 veterans in the intervention arm. Rate of malignancy for the indication for intervention was (A) 86.4%, (B) 70% and (C) 60%. A single patient with a 3 cm lesion developed metastatic disease (<0.7% of surveillance series).

CONCLUSION: Active surveillance of SRM in the veteran population is safe with only 28% of the patients needing surgery. The best predictor of malignancy is >5mm of renal lesion growth per year.

OUTCOMES OF DISTAL URETERECTOMY FOR HIGH GRADE UROTHELIAL CARCINOMA OF THE DISTAL URETER: A MULTI-INSTUTIONAL EXPERIENCE

Varun Vijay[1], Brian Chao[1], Xiaosong Meng[1], Hayley Silver[1], Ezra J. Margolin[2], Justin T. Matulay[2], Ojas Shah[2], Christopher B. Anderson[2], Marc A. Bjurlin[1] and William C. Huang[1]

[1]New York University Langone Medical Center, Department of Urology, New York, NY
[2]Columbia University Medical Center, Department of Urology, New York, NY

Introduction: Our objective is to compare oncologic outcomes between nephroureterectomy (NU) and distal ureterectomy (DU). NU is the gold standard of surgical management for upper tract urothelial carcinoma (UTUC), while DU is a nephron sparing option for distal ureter disease.

Methods: We retrospectively reviewed the records of 175 patients who underwent extirpative surgery for high grade (HG) UTUC at our institutions from 2000 to 2016. Preoperative patient characteristics and postoperative pathologic characteristics were collated. Progression-free survival (PFS) was defined as no evidence of systemic disease and estimated using the Kaplan-Meier method.

Results: In our cohort, 16% (n=28) of patients underwent DU and 85% (n=147) underwent NU. Median follow-up was 22 months.

36% patients treated with DU recurred in the ipsilateral moiety with a median time to recurrence of 6 months. 43% of patients undergoing NU had multi-focal disease on final pathology.

There was a significantly higher percentage of patients with organ-confined disease on DU (75% vs 46%, p=0.006). However, there was no difference in bladder recurrence (p=0.14) or PFS (p=0.460).

Conclusions: DU is a feasible option in patients with HG UTUC of the distal ureter when compared to NU. There are no significant differences in PFS or bladder recurrence, however patients undergoing DU require close surveillance given a high rate of ipsilateral recurrence.

PREDICTION OF HIGH RISK PATHOLOGIC FEATURES AND PROGNOSTIC SIGNIFICANCE OF HYDRONEPHROSIS IN UPPER TRACT UROTHELIAL CARCINOMA (UTUC)

Brian Chao[1], Varun Vijay[1], Xiaosong Meng[1], Hayley Silver[1], Ezra J. Margolin[2], Justin T. Matulay[2], Ojas Shah[2], Christopher B. Anderson[2], Marc A. Bjurlin[1] and William C. Huang[1]

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[2]Columbia University Medical Center, Department of Urology, New York, NY

Introduction: Preoperative hydronephrosis (PH) has been shown to predict adverse pathologic features and may identify potential cohorts likely to benefit from aggressive treatment. We aimed to assess PH as a predictor of pathologic features and progression free-survival (PFS) in upper tract urothelial carcinoma (UTUC).

Methods: We retrospectively reviewed the charts of 151 patients who were treated for UTUC at two institutions between January 2000 and February 2016. PH was defined as any dilation within the ureter or collecting system ipsilateral to known disease. PFS was defined as the time (in months) following initial treatment without evidence of systemic disease. Pathologic data was compared using Chi-squared and unpaired T-tests; logistic regression was used for multivariate analysis.

Results: Overall, 56% of patients had PH. Of this group, 84% had high grade disease on final pathology, 58% had muscle-invasive disease, and 13% had lymph nodes positive for metastasis. Of the patients with high grade disease, 57% presented with PH. On univariate analysis, patients with PH were more likely to have disease in the ureter ($p<0.01$) and muscle-invasive disease on final pathology ($p=0.04$). On multivariate analysis adjusting for age, gender, and location, patients with PH were more likely to have muscle-invasive disease ($p=0.01$). However, no difference was found with regard to PFS between patients with and without PH.

Conclusions: Despite no difference in PFS, the presence of PH was an independent predictor of muscle-invasive disease on final pathology. Patients with UTUC who present with hydronephrosis may want to consider aggressive treatment (e.g. chemotherapy) prior to definitive surgery.

LEVERAGING BIG DATA TO STUDY BLADDER CANCER CARE

Florian R. Schroeck[1, 2, 3, 4], Brenda Sirovich[1,4], John D. Seigne[2,3], Douglas J. Robertson,[1,4] Philip P. Goodney[1,4]

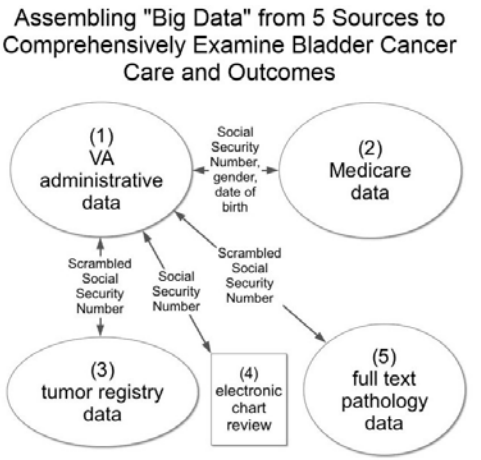
White River Junction VA Medical Center, White River Junction, VT[1]; Section of Urology[2] and Norris Cotton Cancer Center[3], Dartmouth Hitchcock Medical Center, Lebanon, NH; The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth College, Hanover, NH[4]

Introduction: Despite its high prevalence, research on optimal bladder cancer care is limited. We assembled and validated "big data", enabling us to assess real-world care and outcomes across a large number of patients.

Methods: Combining data from 5 sources (Figure), we validated the use of administrative data to identify patients with newly diagnosed bladder cancer who received care in VA. We compared (1) the diagnosis dates (administrative versus tumor registry) and receipt of bladder cancer care in VA assessing (2) administrative data versus chart review and (3) those who did versus who did not have bladder pathology reports available.

Results: Among 11,323 patients with tumor registry data, 90% had a difference ≤90 days between diagnosis dates from administrative and registry data. Comparing administrative data to chart review, 58 of 59 patients who received bladder cancer care in VA were correctly identified (sensitivity 98%, specificity 90%). Receipt of bladder cancer care in VA was more common among those who had bladder pathology reports available versus those who had not (96% versus 43%, p<0.001).

Conclusion: We successfully combined and validated data from 5 sources. These data now make it possible to better understand how bladder cancer care is provided and how intensity of care impacts outcomes such as tumor recurrence and progression.



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Notes:

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