Real-world Tactics to Address Health Inequities in Prostate Cancer Care

CMEO Podcast Transcript

Edith Mitchell, MD, MACP, FCPP, FRCP:

Good evening. I am Dr. Edith Mitchell, and on behalf of CME Outfitters, I would like to welcome you to today's educational activity, which is entitled *Real-world Tactics to Address Health Inequities in Prostate Cancer Care*. Today's activity is brought to you by CME Outfitters, an award-winning jointly accredited provider of continuing medical education for clinicians worldwide and is supported by an educational grant from the Johnson and Johnson Institute and the Johnson and Johnson family of companies. Now let me introduce our faculty for tonight's presentation. Again, I'm Dr. Edith Mitchell, and I'm Clinical Professor of Medicine and Medical Oncology in the Department of Medical Oncology at the Sydney Kimmel Medical School at Thomas Jefferson University. I am also Director of the Center to Eliminate Cancer Disparities, and Associate Director for Diversity Affairs at the Sydney Kimmel Cancer Center at Jefferson. This is all in Philadelphia, Pennsylvania. I am also the 116th President of the National Medical Association.

Joining me tonight is my colleague, Dr. Quoc Trinh, who is Co-Director of the Dana-Farber/Brigham and Women's Prostate Cancer Program. He is Director of Clinical Operations, Division of Urological Surgery, and Associate Professor of Surgery at Harvard Medical School in Boston. So let's take a moment and discuss the learning objectives for today's session. After participating in today's activities, clinicians should be better able to describe the impact of health inequities on patients with prostate cancer and develop individual treatment strategies for patients with prostate cancer. So at this time, Dr. Trinh, if you would like to begin and start the discussion. Also, I think you have a patient that you would like to describe to our audience today. So, could you tell us about the outcomes, and specifically, related to patients with prostate cancer? Please go ahead, Dr. Trinh.

Quoc-Dien Trinh, MD, MBA:

So good evening and thank you, Dr. Mitchell for the caring introduction. So today we're going to talk about racial disparities in prostate cancer outcomes. We know that racial and ethnic minorities experience worse outcomes and lower quality of care across a variety of conditions, of chronic conditions. That's true for heart disease, and it's true for many cancers including bladder cancer, and specifically here tonight, prostate cancer. What's especially concerning is that there is a different level of a gap across different cancers, and that gap is particularly concerning for prostate and breast cancer, as you can see here.

What's also important to know is that for breast cancer, there are potential biological explanations of the gap, triple negative breast cancer, etc., etc. But for prostate cancer, such differences are not as clearly understood. What is also concerning is that if you look at this paper that was published a couple years ago, the gap that is seen across racial minorities and White patients has narrowed over time for many racial groups, whether it is Hispanic [patients], for example, or Asian [patients], but it has not for African American [patients], and specifically in the world of prostate cancer.

The other concept that I think is important to mention here is that setting of care matters, because in many circumstances in U.S. healthcare, when you have equal access, those disparities that we describe are mitigated, and potentially, completely go away. Let's talk about some examples, two of them specifically. If you look at this paper that we published in JAMA Oncology in 2016, we looked at racial differences in surgical care of Medicare beneficiaries with localized prostate cancer. What's different about this paper is that we're looking at a population of individuals who are all insured, because everybody above 65 has Medicare. We're looking at only those who had surgical care because there are compelling data suggesting that African American men are less likely to get treatment for prostate cancer, and we're only looking here at localized prostate cancer. So, only individuals who present with non-metastatic disease, because there's a lot of discussion, for example, that Black men present with more aggressive disease at presentation.

But, if you take away these differences in insurance, in terms of receipt of treatment and stage at presentation, you come to realize that there are actually no survival gaps between Black and White patients, and this is true for overall, as well as prostate cancer-specific mortality. Another example is data coming from the military health system, because in the military, it doesn't matter what race you are, income level, education level, everybody gets access to healthcare, either the direct healthcare system, Walter Reed Hospitals and such, or in Veterans Affair Hospitals for veterans. There are data from the military that when you look at racial disparities, whether in wait time to receive a biopsy or survival among those where on active surveillance, again, there are potentially no differences between Black and White men with prostate cancer.

If we continue down that road, this is a paper that was published a couple years ago that was named by the Prostate Cancer Foundation as one of the “most provocative” papers of that year. Which, if you look at unadjusted outcomes, you find that, again, Black men have worse survival over time compared to White men by a factor 2.5x, if you look at the literature. But the more you account for these factors, whether it is demographics, access to treatment, cancer characteristics, that difference potentially goes away to a point that, in this paper, when everything is accounted for, Black men seem to do even slightly better. This is one of many papers that came out around that time to have demonstrated a similar relationship, which is that when you are able to account for access to care, the receipt of care, those differences that we often describe seem to be mitigated and potentially go away.

So, if we talk today about our case, our case is about Curtis, who is a 68-year-old Black man with a number of health conditions, hypertension, hyperlipidemia, obesity, type 2 diabetes, and he has an elevated PSA. He is referred to a urologist, but due to personal issues, there has been a delay in scheduling appointments. This issue is real, because although there are differences in the receipt of PSA screening between Black and White men, there are recent data to suggest that that difference is even more important among those with an elevated PSA that need referral to urology. There seems to be quite a gap in terms of those who do receive care and those who don't. In any case, 10 months after referral, Curtis' PSA has increased, and it is now 22 [ng/mL]. Finally, he gets a prostate biopsy, and it shows Gleason grade 4, Gleason 4 + 4, 8, in 8 of 12 cores. Again, there are delays. Finally, he receives a radical prostatectomy four months later. This is an important concept because, as I alluded to earlier, Black men are less likely to be treated for prostate cancer. Then you could argue, well, wait a minute, many of the prostate cancers can be safely monitored as part of active surveillance protocols. But what the data suggests, and this is a paper that we published a couple years ago, is that those who really need treatment, those with intermediate and high-risk prostate cancer, that is where the gap is most pronounced. The gap is even more pronounced when you look at high-risk disease, where it is absolutely clear-cut that men with high-risk prostate cancer should be treated. That gap, that disparity, has not improved over time, and this is what this paper has shown.

Edith Mitchell:

Dr. Trinh? Can you tell us, or describe to us, what are the components of high-risk prostate cancer? What do we mean? Are there components that we can actually check or measure?

Quoc-Dien Trinh:

Yes. So high-risk prostate cancer is determined based on a number of criteria. It is based on physical exam, so clinical T-staging. It is based on the Gleason score. Six is the lowest Gleason score, and that can go up to 10. Then it is also based on the PSA level.

Edith Mitchell:

Thank you. Thank you.

Quoc-Dien Trinh:

Going back to our case, the final pathology here showed pT3b disease, which is invasion into the seminal vesicle. When a prostate is removed and the treatment was successful, we expect the PSA to go down to 0, because there's no prostate that will produce any PSA. However, unfortunately for Curtis, his first PSA after surgery was .11, suggesting persistent disease. Therefore, the patient is planned for adjuvant radiation therapy with hormonal androgen deprivation, but the patient does miss a few radiation sessions due to outside factors. This is also an important concept because, as I move along the continuum of care, we talked about disparities in screening, disparities in getting a biopsy. We talked about disparities in receiving a treatment, but these disparities continue down to spectrum, and there are also differences in treatment for recurrence between Black and White men. So, for example, if you look at this paper that was published recently, despite similar access to treatment, White men received more ADT compared to Black men. And as we know, ADT is a critical component of salvage radiation and hormonal treatments for men with recurrent prostate cancer after surgery.

Another important aspect is that when Black men recur for prostate cancer, there seems to be, also, disparities in treatment intensification when the disease persists despite standard of care treatments. In this study, for example, that was published not too long ago, treatment intensification occurs less frequently for Black men compared to non-Hispanic White patients, as shown in this figure. Going back to our case, less than a year after completing salvage treatments, the PSA is rising again, and unfortunately this time around the PSMA PET shows oligometastatic disease to the bone. There are a number of treatment options that are available at this point in time, but we do want to emphasize, here, the role for germline genetic testing, as well as clinical trials, as many options are emerging in this space for recurrent prostate cancer.

So, a small word to talk about clinical trial participation, and we know that this is a huge, huge issue. One of the issues that will arise is that, as we know, prostate cancer disproportionally affects Black men, yet Black men are disproportionately less involved in clinical trials, especially for prostate cancer. These data have been demonstrated again and again in the number of studies, including the one that I am showing here. This is a huge problem, because if we are trying to treat everybody equitably, and we want to devise the right treatment for all individuals, the whole promise of personalized medicine, and one racial subgroup, Black men, are disproportionately affected with prostate cancer, we need them to participate in trials so that we are offering the right treatment for Black men, not a treatment that was developed largely on a population of non-Black men. What's really interesting in this space of advanced prostate cancer is that there are emerging data in the last 3-4 years that have shown that Black men who actually make it to these clinical trials, who are actually receiving these advanced prostate cancer treatments, seem to do pretty well for it.

For example, in this study that was published by Dr. George et al, this large retrospective study shows that Black men with chemotherapy-naïve, metastatic, castrate-resistant prostate cancer may have better overall survival with abiraterone or enzalutamide than White patients, regardless of subsequent treatment. That is really, really interesting, especially based on the fact that, as we know, mortality of Black men with prostate cancer is allegedly worse than White men. Another study that has shown something similar, in this case, another study by Dr. George et al, showed that the response to abiraterone acetate and prednisone was greater and longer lasting in Black men compared to White men. So again, interesting evidence about the treatment of advanced prostate cancer and how, in this case, getting Black men to treatment and receiving the state-of-the-art treatment may provide more durable response and outcomes.

Just a couple words to talk a little bit about. I have shown as part of this presentation the many access to care issues that minority populations face when dealing with a complex disease like prostate cancer. But how do we really understand what are the dimensions of access to care and how can we make a difference? So, if we go quickly around the table here and we talk about this conceptual model that was described, actually, many decades ago, we can look at one component at a time, and one of them is travel burden. There is pretty interesting data suggesting that Black men have to travel more than White men to receive care. Maybe it's something about where these hospitals are located, where clinical trials are available, and as a result, this results in a disparity. You also have to consider the travel burden is not the same as travel distance. Sometimes a Black man may reside really close to a hospital, but getting to that hospital, the metro lines, the bus lines to get there, are so complicated that ultimately it is more of a travel burden compared to the White men that may have a direct line or access to that given hospital. So, what's the solution here? Well, potentially using outreach clinics that are actually implemented in communities of color, in the areas that are serving minority populations, would potentially help with this issue.

Affordability, we know, is a huge issue. Financial toxicity, one in three Americans put off medical treatment because of cost. How can we address this? Well, there are obviously policy decisions that can be made to make medication more affordable, to make health insurance more affordable and more accessible, and that is a potential barrier to access to care as well. Availability is also another important aspect. Availability is a little bit like travel burden, but addresses different things. we're talking about availability of clinical trials, availability of primary care, cancer screening. We need to bring this care to these communities, and different solutions can be implemented, but among other things, is bring the care to minoritized populations and potentially providing institutions that deal with minorities with block grants and more funding to address the needs of our communities.

Acceptability, I think, is also an extremely important aspect of the access to care issues. Acceptability as an understanding, and health literacy, as to what is being offered and what is right for a given patient and their families. But also, the question of medical mistrust and not necessarily trusting institutions that have, for example, for a long time taken care of affluent White patients now being asked to take care of minority patients, who are especially, for example, seeking access to a specific clinical trial. Leveraging patient navigation, I think, is key to addressing this issue. Also, initiatives to really engage patients into such institutions. Finally, accommodation. Accommodation is an important aspect here, because patients may have difficulty with clinic visits, the time, the hours that are provided, the formulations of the drugs that are being given. Again, navigation is an important aspect to address this, but also adjusting clinical hours and making ourselves available to provide equitable care.

So, what we discussed today is that while there are racial differences in prostate cancer incidence and mortality, there are clear disparities which connotates injustice in access to prostate cancer treatment. In fact, when prostate cancer care is applied equitably to all racial groups, the disparities in outcomes are mitigated, or go away. How do we address these issues? We can apply the SMART Goals: specific, measurable, attainable, relevant, and timely. We want to apply guideline-concordant care to all patients. We want to listen to a patient's specific treatment needs and concerns. We want to involve patient navigators where possible, because providing equitable care is not providing the same care for everyone, but giving extra help for those who are in need. We want to encourage our minority populations to participate in clinical trials, because we want these treatments work for everyone, not for a specific racial group. Thank you for your time, and happy to engage in a conversation in the coming weeks.

Edith Mitchell:

Thank you so much for that outstanding presentation, Dr. Trinh. I would like to reemphasize your recommendations and make sure that clinicians include in their history collection and information regarding the patient, in terms of taking the patient history, is that we include the social determinants of health so that we have a guide and understanding of the difficulty for the patient to come to the center, finding out where their primary care physician is located, because that may allow for some sharing of data collection. Find out what the patient's work schedule is and whether they may come during regular hours or if they need assistance in alternative hours. As you mentioned, making sure that we extend the hours of our clinical healthcare facility to accommodate those patients. So again, applying the guidelines for therapeutic intervention as well as diagnostic criteria. Listen to the patients regarding their specific needs, and sometimes we need to also include their family needs. Make sure that we involve patient navigators if they are available, and then encourage clinical trial participation.

It is well recognized that African American men have less participation in clinical trials, but yet when you ask the patients and collect patient reported data, the patients say that they were not asked to participate in a clinical trial. So, we need to make sure that we are offering that. Then, I always say precision oncology and genomic testing, really very important in the African American population, because there is less information on the data related to tumors in Black patients. So, I thank you so much for that outstanding presentation, and I want to say to our audience that we will want you to participate in clinical trials for your patients. I say sometimes, not the patient participating in the clinical trial, but it is the clinician making available the clinical trial information.

Our audience, I thank you for participating in this event tonight. To receive CME credit for today's program, please complete the post-test and evaluation, and you will be able to download and print your certificate immediately after completion of these tasks. Lastly, please visit the CME Outfitters Oncology Hub to access additional activities on relevant oncology topics and the Diversity and Inclusion Hub for discussions of disparities in healthcare as well as resources, patient education materials. You can also follow us on Twitter: @CMEOutfitters. Again, thank you so much, Dr. Trinh, for our discussion, and thank you to the audience for your joining us today. Thank you very much, and good night.

