



14 October 2020

Professor Nick Talley
Editor-in-Chief
The Medical Journal of Australia
via email mja@mja.com.au

Dear Professor Talley,

Re: MJA Article - “Differences in treatment choices for localised prostate cancer diagnosed in private and public health services”

We are writing in response to the recently published article by Te Marvelde et. al. titled “Differences in treatment choices for localised prostate cancer diagnosed in private and public health services”. The authors of this study concluded that in Victoria prostate cancer treatment choices differ substantially between men diagnosed in private and public health systems. Members of USANZ, as the society representing Australian and New Zealand urologists, have a number of concerns regarding the validity of this study, the methodology and the conclusions reached.

In this retrospective study, the proportions of men in public and private health services receiving radical prostatectomy and curative external beam radiation therapy were examined in a multivariable logistic regression which only included age, ISUP tumour grade and comorbidity. The authors made additional sub-analyses using the same covariables.

From urologists’ perspective the decision to treat men with newly diagnosed prostate cancer and the treatment modality are influenced by a number of patient related, cancer related as well as surgeon related factors. Ultimately, treatment is delivered after a comprehensive informed consent process, which engages the patients and their families throughout the decision-making process. Unfortunately, the Te Marvelde study does not acknowledge the decision-making process and does not make any attempts to address various factors involved in treatment planning.

There are a number of important cancer features impacting on treatment modality, including the PSA level, the T-stage and ISUP grade. In this study, Te Marvelde et. al. only uses the ISUP grade in their predictor model. This is a major flaw in this study and is a failure of the peer-review process to highlight this major deficiency. This error significantly impacts the results and subsequent conclusions reached in this study.

Another important factor influencing treatment modality is patient comorbidity. In this study VAED data for the year preceding the prostate cancer diagnosis and up to 30 days after diagnosis were assessed to identify comorbid conditions other than cancer according to the Charlson Comorbidity Index, categorised as 0 or at least 1. This variable provided very little discriminatory power (3% vs. 6%), and yet this was the only surrogate variable which accounted for comorbidity in this study’s key multivariable analyses. Additionally, the OR for this variable in these analyses were not reported. It should be noted that 38% of this study’s population were older than 70 years, and yet only 3.8% scored one or more on the VAED derived Charlson Comorbidity Index. This demonstrates that the method used in this study to account for co-morbidity is not adequately robust to provide an accurate picture of patients’ general health status.

The inaccuracy and limitations of administrative datasets in recording details such as comorbid conditions or medication lists are well established. The authors clearly identify comorbidity as a factor influencing treatment, however, fail to assess and account for this variable in a reliable way. This oversimplification of influence of co-morbidity in treatment planning is demonstrative of authors' lack of clinical expertise in managing newly diagnosed prostate cancer.

The authors also cite the ProTect trial to suggest no major differences between active treatment options exist, however they completely fail to identify the vast differences in the disease characteristics of men in that trial to those included in their current study (77% ISUP 1, 2% ISUP 4/5 vs. 35% ISUP 1 and 18% ISUP 4/5).

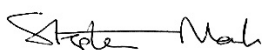
The authors do not address the issues related to comparatively limited access to minimally invasive (Robot Assisted Laparoscopic Prostatectomy, RALP) surgery in the public system. The majority of Prostate cancers in private are treated robotically which likely results in more rapid return to baseline function. In fact, access to RALP may be the sole reason some men pursue private care.

Another important factor which the authors failed to address is the clinical outcomes. The ultimate aim of any treatment is optimal longterm functional and oncological results. This study did not make any attempt to review or even acknowledge these significant clinical endpoints. Te Marvelde et. al. have not presented any evidence that the supposed variation in treatment modalities between public and private services has had any negative impact on the final clinical outcome.

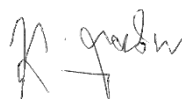
Outcomes data, similar to what is used in Te Marvelde et. al. study can be helpful in identifying systematic shortcomings, inequities and barriers to just healthcare. However, the authors missed the opportunity to highlight these issues. They concluded that treatment of people with cancer should be consistent, safe, of high quality and evidence-based, however do not show any evidence that the current practice is to the contrary.

USANZ formally requests the right of reply in order to provide a balanced view to your readers.

Your sincerely,



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UROLOGICAL SOCIETY
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