

ADT and node inclusion improves salvage radiation

Salvage therapy with prostate bed radiotherapy (PBRT) is recommended for most men with prostate cancer who have sustained increases in serum prostate-specific antigen (PSA) levels after prostatectomy. Now, data from the phase III NRG Oncology/RTOG 0534 SPPORT trial, recently published in *The Lancet*, show that the addition of short-term androgen deprivation therapy (ADT) and pelvic lymph node radiotherapy (PLNRT) to PBRT improves freedom from progression in this setting.

In the NRG Oncology/RTOG 0534 SPPORT trial, men with serum PSA levels of 0.1–2 ng/ml after prostatectomy were randomly allocated to receive PBRT alone (group 1; $n=592$), PBRT plus ADT for 4–6 months (group 2; $n=602$) or PBRT plus PLNRT and ADT (group 3; $n=598$). The primary end point was 5-year freedom from progression (defined as serum PSA ≥ 2 ng/ml over the nadir, clinical failure or death).

At a median follow-up duration of 8.2 years, 5-year freedom from progression was 70.9%, 81.3% and 87.4% in groups 1, 2 and 3, respectively. The differences between group 1 and either group 2 or group 3 were statistically significant ($P < 0.001$), as was the difference between groups 2 and 3 ($P = 0.003$).

Several secondary end points were also assessed, with mixed results.

These include overall survival, which was not significantly different between groups according to these data, although such an effect might only become apparent at longer follow-up durations.

Acute toxicities (≤ 3 months after radiotherapy) were more frequent in groups 2 (36% and 7% of patients had grade ≥ 2 and ≥ 3 toxicities, respectively) and 3 (44% and 11%) than in group 1 (18% and 3%; all $P \leq 0.012$). The incidence of grade ≥ 2 late toxicities was 57%, 58% and 62% in groups 1, 2 and 3, respectively, and that of grade ≥ 3 late toxicities was 12%, 16% and 17%.

These results indicate that men who receive salvage PBRT can derive further clinical benefit not only from the addition of ADT, but also from the inclusion of pelvic lymph nodes in the radiotherapy field.

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ORIGINAL ARTICLE Pollak, A. et al. The addition of androgen deprivation therapy and pelvic lymph node treatment to prostate bed salvage radiotherapy (NRG Oncology/RTOG 0534 SPPORT): an international, multicentre, randomised phase 3 trial. *Lancet* **399**, 1886–1901 (2022)

RELATED ARTICLE Zaorsky, N. G. et al. Salvage therapy for prostate cancer after radical prostatectomy. *Nat. Rev. Urol.* **18**, 643–668 (2021)

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Road for inclusion and caring in urology starts at AUA 22

After 2 years of virtual conferences, members of the urology community finally met in person in New Orleans for the 117th edition of the American Urological Association (AUA) annual meeting, from 13 to 16 May 2022.

A varied programme encompassing basic, translational and clinical research was designed to satisfy the interest of a broad-spectrum audience.

A number of guideline updates were presented: guidelines for the diagnosis and management of priapism, updated for the first time in >20 years with a focus on flexible and personalized treatment approaches; updated guidelines for clinically localized prostate cancer, in which the most substantial change was the recommendation of active surveillance as the preferred approach in the management of patients with low-risk prostate cancer; and guidelines for the evaluation and treatment of localized renal cancer, introducing and expanding on topics such as genetic counselling, adjuvant therapy and imaging.

Debated topics in prostate cancer included focal ablation therapy as opposed to active surveillance for patients with low-risk or intermediate-risk prostate cancer, object of different talks and a moderated debate during a plenary session.

Patient quality of life was an important topic throughout the conference. Encouraging results from an ongoing clinical trial including patients with prostate cancer who underwent prostatectomy showed benefits of penile traction therapy in preserving erectile function, which, if validated, could considerably improve patient quality of life. In another session, new exchange methods to improve renal transplantation globally increasing the number of matched kidney donor–recipient pairs was presented.

A strong need to promote inclusion and diversity in urology

emerged during the conference, from talks focused on racial disparities in urology, to a panel discussion around caring for transgender patients. Panellists provided useful advice for urologists to create a safe environment for transgender patients and manage gender-affirming surgery complications. Gender disparity is also a strongly felt issue in urology. Initiatives such as a panel discussion during plenary sessions and the meeting organized by the Society of Women in Urology put the spotlight on this topic. The general feeling was that a lot of progress has been made but much remains to be done, especially in terms of pay gap and women representation in leadership positions.

Lastly, COVID-19 was reflected in many of the talks. The effect of the COVID-19 pandemic on diagnosis and management of patients with urological tumours was discussed. Indirect effects of the pandemic were also the focus of a point–counterpoints debate about telemedicine in reproductive urology. Dr James Smith highlighted the benefits of telemedicine for patients struggling with infertility, mainly consisting of the possibility to be visited in the comfort of their home, and without needing to travel or leave work. Dr James Dupree argued that telemedicine cannot substitute a physical examination and that personal connection with the patient might be lost with this approach. The debate moderator Dr Jay Sandlow recognized the limits of online visits to deliver sensitive information but supported the use of telemedicine in follow-up visits.

Only one topic reached unanimous consensus: online conferences are possible and convenient, but the value of handshakes, social moments and live discussions outside conference rooms is irreplaceable.

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