

## Screening:

Before conditions can be treated, they need to be diagnosed, of course. In the GU cancer area, particularly prostate cancer, the issue of screening has recently become somewhat controversial.

Twice in the past several years, panels that review PSA screening (the primary diagnostic for prostate cancer), specifically the U.S. Preventive Services Task Force, have altered their recommendations for PSA screening, Dr. Abern said.

First, in 2011, the group changed its screening guidelines for men 55-69 from “C” (when the patient consults with his physician whether to undergo periodic testing) to “D” (screening is not recommended).

The 2011 change was made, Dr. Abern said, because some cancers were “over-diagnosed” or did not threaten patients’ lives, so the treatment itself became a downside to screening for some patients. But in 2018 the group reversed its decision, returning its recommendation for men 55-69 to “C.”

“They’d already begun to see the repercussions from lack of screening,” Dr. Abern said. In addition, he noted, national screening guidelines for cancer simply have not addressed higher-risk patient groups — people of color, those of lower socioeconomic status or who have less access to health insurance, and those who may be affected by environmental factors.

“What all the task forces and committees that establish guidelines for screening and have changed their recommendations twice in the past decade have acknowledged is that we don’t have a lot of good information about how screening helps high-risk populations,” Dr. Abern said.

“We live in a high-risk community here in Chicago, so we’ve never believed there should be less screening; in fact, we think there should be more screening,” he said.

“We don’t know exactly why these disparities exist, but we believe the variables that contribute to the South and West Sides of the city, where prostate cancer mortality rates are three times the national average, may play a part. And there are not a lot of specific data on these groups and their risk factors, so we’re doing a lot of research in this area.”

In urban health settings like Chicago, he added, race and ethnicity, access to reliable transportation, and having public or no insurance versus private insurance can contribute to patients missing appointments or losing touch with the healthcare system, factors he and Dr. Moreira have documented in a paper published in the *Journal of Community Health* (<https://www.ncbi.nlm.nih.gov/pubmed/28551861>) and which the navigator program is designed to address.

## Research and Clinical Trials:

The fourth most common cancer in men, and a condition that affects many women, bladder cancer and treatment for it have a unique history at UIC. Tice Bacillus Calmette-Guérin (BCG), the most common strain used for treatment, was invented at the UIC Institute for Tuberculosis research in 1950 (<https://pharmacy.uic.edu/research/discoveries>).

Getting appropriate access to BCG has become more challenging recently because the treatment drug faces global shortages at least through this year, Dr. Abern noted.

This shortage has made it extremely difficult for some physicians to treat their patients. But an ongoing UI clinical trial of BCG in high-grade invasive bladder cancer is providing resources other hospitals and physicians simply cannot, he said.

“Having this trial open ensures our patients get access to BCG in order to maximize the chances patients get to obtain treatment of bladder cancer, and reduce their risk of reoccurrence,” said Dr. Abern, the primary investigator of the trial at UIC.

“Our national clinical trial offers preferred access to that drug, which is the gold standard for care,” Dr. Abern added.

Other research efforts, Dr. Abern noted, are targeted toward improving early detection of prostate cancer with new imaging technologies. Dr. Abern was recently awarded a grant from the UI Cancer Center to develop a new MRI protocol for improving detection of prostate cancer.

This study will offer a novel MRI technique optimized for prostate cancer detection to men with elevated PSA and no prior biopsy. Then, these images can be combined with ultrasound to guide biopsies.

The study will also use artificial intelligence machine learning approaches to help determine how the cancer’s visual fingerprint can be found with the MRI protocol. The ultimate goal is to reserve invasive biopsy for those who really need them and improve the accuracy when they are needed,” he added. Even in cases that are far advanced, Dr. Abern noted, UI Urology’s approach can make a significant impact on the lives of patients.

“We’re offering treatment people cannot get elsewhere, including for patients in late-stage, even incurable phases of cancer. There’s still medical treatment available for maintaining quality of life, extending life in a meaningful way, and helping people reach life milestones: graduations, weddings, birthdays,” he added.

“The options we offer — no matter the stage of the condition — make a vital difference.”