85% of younger patients. The vast majority of cT3 patients received radiotherapy in combination with hormonal therapy, regardless of age. However, in the eldest patients (≥80 years) hormonal monotherapy was applied most frequently (>60%). In the patients with cT4/N+/M+ PC, the use of hormonal therapy as monotherapy increased strongly with increasing age. The 5-year relative survival decreased with increasing age: 92% for the patients aged <70 years, 87% for patients aged 70-80 years, and 68% for patients aged ≥80 years. The 5-year relative survival of low stage PC appeared to be similar for patients aged <70 years versus ≥70, whereas the survival of advanced PC (≥T3) was worse for older patients: 5-year relative survival is 97% versus 91% for the cT3 patients and 53% versus 43% for the cT4/N+/M+, respectively for patients aged <70 years versus ≥70 years.

CONCLUSIONS: Elderly men with PC are more often diagnosed with advanced disease, possibly as a result of patients' or doctors' delay. After adjusting for disease stage, older patients have a worse prognosis than younger patients. Further research should elucidate whether elderly PC patients are treated optimally while taking the increased life expectancy and the trade-off between the beneficial effects and adverse events of the treatments into account.

PD47-06
LOWER RISK OF PROSTATE CANCER IN ASIAN MEN: FROM LESS SCREENING OR TRUE RACIAL DIFFERENCES?

Tom Feng*, Alexis Freedland, Los Angeles, CA; Lauren Howard, Durham, NC; Adriana Vidal, Los Angeles, CA; Daniel Moreira, Chicago, IL; Ramiro Castro-Santamaria, King of Prussia, PA; Gerald Andriole, St. Louis, MO; Stephen Freeland, Los Angeles, CA

INTRODUCTION AND OBJECTIVES: Global prostate cancer incidence rates are lower in Asian men than white men. To what degree this relates to less aggressive screening in Asian men or inherent differences by race remains to be determined. Our aim was to determine whether Asian race was associated with lower prostate cancer diagnosis in a study of all men who received prostate-specific antigen (PSA) screening and systematic prostate biopsies independent of PSA levels.

METHODS: REDUCE was a 4-year, multicenter, randomized, double-blind, placebo-controlled study that followed biopsy-negative men with protocol-dictated PSA-independent biopsies at 2- and 4-years. Eligible men were aged 50-75 years, had serum PSA between 2.5-10 ng/mL, and a prior negative prostate biopsy. We tested the association between race and receipt of prostate biopsy as well as race and prostate cancer diagnosis using multivariable logistic regression.

RESULTS: Of 8,122 men in REDUCE, 7,296 were of white or Asian race and had complete data for analysis. Asian men had lower BMI (24.8 vs 26.9, p<0.001) and smaller prostate volumes (34.2 vs 43.4 cc, p<0.001) but were similar in baseline age, PSA, family history of prostate cancer, and digital rectal exam findings compared to white men. There was no difference in rate of receiving a prostate biopsy between Asian and white men (p=0.634). After adjusting for various clinical and demographic characteristics, Asian men were less likely to be diagnosed with cancer during the 4-year study compared to white men (OR 0.56, p=0.011). When testing for differences in cancer grade, Asian race was significantly associated with decreased risk of low-grade cancer compared to white race (OR 0.43, p=0.016). This risk reduction was also observed for high-grade cancer (OR 0.63, p=0.290) though the association was not statistically significant.

CONCLUSIONS: Among men with a negative pre-study biopsy who all underwent biopsies largely independent of PSA, Asian race was associated with reduced risk of prostate cancer diagnosis. These data suggest less screening among Asian men globally cannot completely explain the lower risk of prostate cancer among Asian men. Further studies are needed to explore the inherent differences attributed by race in prostate cancer diagnosis.

PD47-07
THE EFFECT OF A PREFERENCE SENSITIVE ONLINE DECISION AID ON LOCALIZED PROSTATE CANCER TREATMENT: FIRST RESULTS OF A RANDOMIZED CLUSTER CONTROLLED TRIAL

Romy Lamers*, Maarten Cuypers, Tilburg, Netherlands; Marieke de Vries, Nijmegen, Netherlands; Lonneke vd Poll-Franse, Tilburg, Netherlands; Ruud Bosch, Utrecht, Netherlands; Paul Kil, Tilburg, Netherlands

INTRODUCTION AND OBJECTIVES: Decision aids (DAs) support shared decision making for the treatment of localized prostate cancer by providing balanced evidence based information, eliciting preferences and by structuring the decision making process. Studies have shown that the use of a DA may increase minimal/non-invasive treatment options. However, the current literature is uncertain about the effect on treatment choice in localized prostate cancer using DAs. Our objective is to study the effect of a preference sensitive web based DA on treatment decision making.

METHODS: A randomized cluster controlled trial was performed among 18 hospitals between 2014-2016. In the intervention arm (nine hospitals) the DA was offered following diagnosis (N=332). Patients in the control arm (another nine hospitals) received care and information as usual (N=128). After treatment decision-making but before treatment start, patients in both arms received a questionnaire measuring treatment choice, decisional conflict and knowledge. Analyses were performed using t-tests, ANOVA and Pearson correlations.

RESULTS: Response rate was 72% (intervention N=273, control N=109). No differences were found in PSA and Gleason score between groups. The decision aid led to more patients choosing active surveillance (AS) in comparison with standard information (28% vs. 17%, P=0.03). In the control arm we found significantly more external beam radiotherapy (EBRTx) (16% vs 8%, P=0.02) and brachytherapy (BT) (33% vs. 19%, P=0.005). No differences were found in decisional conflict and knowledge. One in five patients indicated to prefer a decision aid in a paper form instead of online.

CONCLUSIONS: Patients made different treatment choices after DA use. The online DA supported shared decision making and this may lead to significantly more AS. More radiotherapy was found in the control arm. The decision aid did not lead to more decisional conflict. However, a minority of the patients prefers a paper form of the decision aid. The most optimal DA form needs to be determined. We currently collect post-treatment measures to determine regret and treatment satisfaction levels.

PD47-08
VARIATION AND TRENDS IN PROSTATE CANCER CARE AT COMMISSION ON CANCER DESIGNATED FACILITIES

Björn Löppenberg*, Akshay Sood, Deepansh Dalela, Patrick Karabon, Detroit, MI; Jesse Sammon, Portland, ME; Malte Vetterlein, Detroit, MI; Joachim Noldus, Herne, Germany; James Peabody, Detroit, MI; Quoc-Dien Trinh, Boston, MA; Mani Menon, Firas Abdollah, Detroit, MI

INTRODUCTION AND OBJECTIVES: Contemporary treatment trends for prostate cancer show increased rates of active surveillance. However, nationwide applicability of these reports is limited. Additionally, the impact of Commission on Cancer facility type on prostate cancer treatment patterns is unknown.

METHODS: We used the National Cancer Data Base between 2004 and 2013 to identify men diagnosed with prostate cancer. Our cohort was stratified based on the National Comprehensive Cancer Network prostate cancer risk-classes. Cochran-Armitage tests evaluated temporal trends. Random effects hierarchical logit models assessed treatment variation at Commission on Cancer-facility and institution level.