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Head-to-head Comparison of Transrectal Ultrasound-guided Prostate Biopsy Versus Multiparametric Prostate Resonance Imaging with Subsequent Magnetic Resonance-guided Biopsy in Biopsy-naïve Men with Elevated Prostate-specific Antigen: A Large Prospective Multicenter Clinical Study

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Abstract

Background: There is growing interest to implement multiparametric magnetic resonance imaging (mpMRI) and MR-guided biopsy (MRGB) for biopsy-naïve men with suspected prostate cancer.

Objective: Primary objective was to compare and evaluate an MRI pathway and a transrectal ultrasound-guided biopsy (TRUSGB) pathway in biopsy-naïve men with prostate-specific antigen levels of ≥ 3 ng/ml.

Design, setting, and population: A prospective, multicenter, powered, comparative effectiveness study included 626 biopsy-naïve patients (from February 2015 to February 2018).

Intervention: All patients underwent prebiopsy mpMRI followed by systematic TRUSGB. Men with suspicious lesions on mpMRI also underwent MRGB prior to TRUSGB. MRGB was performed using the in-bore approach.

Outcome measurements and statistical analysis: Clinically significant prostate cancer (csPCA) was defined as grade group ≥ 2 (Gleason score ≥ 3 + 4) in any core. The main secondary objectives were the number of men who could avoid biopsy after nonsuspicious mpMRI, the number of biopsy cores taken, and oncologic follow-up. Differences

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Keywords: Prostate cancer Transrectal ultrasound-guided biopsy Multiparametric magnetic resonance imaging Prostate Imaging Reporting and Data System Magnetic resonance-guided biopsy

1. Introduction

International guidelines recommend systematic 12-core transrectal ultrasound-guided biopsy (TRUSGB) in biopsy-naïve men with elevated prostate-specific antigen (PSA) serum levels of $>$3 ng/ml [1,2]. However, TRUSGB has limitations. First, clinically insignificant prostate cancer (insignPCa) is unnecessarily detected. Second, many men undergo TRUSGB and never have prostate cancer (PCa) diagnosed. Biopsies can lead to complications such as bleeding and infections, leading to increased healthcare costs [3]. Third, clinically significant prostate cancer (csPCa) can be missed. Fourth, multiple risk stratification errors occur, contributing to treatment failures for men undergoing active surveillance for presumed low-risk PCa.

Compared with TRUSGB, multiparametric magnetic resonance imaging (mpMRI) has been reported to reduce the detection of insignPCa while increasing the detection of csPCa [4–6]. The opportunity to selectively localize csPCa enables MR-directed biopsy and in so doing use fewer cores. This has improved the diagnostic pathway for men with suspected PCa. It has been shown that if mpMRI is nonsuspicious, immediate TRUSGB can be safely avoided [7,8]. Multiple single- and multicenter randomized trials have confirmed the superiority of mpMRI and MR-directed biopsy to TRUSGB [9–14]. However, these studies lacked sufficient standardization of MRI reporting, central quality control review of mpMRI acquisition and reading, central pathology review of biopsies, and adequate oncologic follow-up. In addition, many studies have not performed a comparison of TRUSGB and mpMRI + MR-guided biopsy (MRGB) in the same patients.

Therefore, we conducted a prospective, multicenter, clinical effectiveness study that compared head-to-head mpMRI + MRGB (MRI pathway) with the TRUSGB pathway in biopsy-naïve men at a risk of PCa.

2. Patients and methods

2.1. Study population

Between February 2015 and February 2017, 699 consecutive biopsy-naïve men, aged 50–75 yr with a PSA level of $>$3 ng/ml were recruited in this prospective multicenter comparative effectiveness study (Supplementary Fig. 1). Patients were enrolled from four medical centers in the Netherlands: Radboudumc Nijmegen (coordinating, central center; n = 169) and three nonuniversity hospitals—Ziekenhuis Groep Twente (n = 357), Maasstad Hospital Rotterdam (n = 152), and Andros Men's Health Institutes (n = 21).

Exclusion criteria were age $<$50 or $>$75 yr, a history of previous prostate biopsy or PCa, general contraindications for MRI, use of medications known to affect serum PSA levels, symptoms of urinary tract infection, and a history of invasive treatments for benign prostate hyperplasia. The central ethical review board approved this study, and written informed consent was obtained from all patients. The study was registered in the Dutch Trial register under identifier NTR5555.

2.2. Multiparametric MRI

All patients underwent mpMRI performed at 3 T (Magnetom Skyra, Siemens Healthineers, Erlangen, Germany) compliant with the Prostate Imaging Reporting and Data System version 2 (PI-RADS v2) standards (Supplementary Fig. 2)[15,16]. The protocol consisted of T2-weighted imaging in three planes, diffusion-weighted imaging with calculation of apparent diffusion coefficient (ADC) maps, high $b$-value images ($b > 1400$ s/mm$^2$), and dynamic contrast enhanced imaging (Supplementary Table 1). The images were
analyzed by trained radiologists using the PI-RADS v2 to score all detected lesions. A central review before biopsy was performed by two central-center radiologists (J.B. and M.v.d.L., 25 and 5 yr of experience with prostate MRI, respectively) for each case. For patients enrolled in the central center, the images were analyzed independently by these two radiologists. When PI-RADS scores were discordant, a consensus assessment decided on the need for MRGB. Multiparametric MRI was categorized as suspicious in the presence of PI-RADS 3–5 lesion(s). PSA density (PSD) was calculated by dividing serum PSA level by MRI prostate volume.

2.3. Biopsy

Men with a suspicious mpMRI scan underwent in-bore MRGB (using 18G needles with sampling length of 17 mm) followed by a 12-core systematic TRUSGB (using 18G needles with sampling length of 17 mm) preferably the same day, performed by a urologist blinded to the imaging results. MRGB was performed using a commercially available transrectal in-bore MR biopsy device (Invivo, Gainesville, FL, USA). Nonuniversity radiologists received training for the MRGB procedure. Each PI-RADS 3–5 lesion was biopsied using two to four cores. The lowest signal areas on ADC maps within a suspicious region were used to target biopsies.

TRUSGB was performed according to international guidelines [17]. Where a lesion was visible at TRUS, it was targeted by using the core for the relevant prostate zone (no additional cores were performed). Men with nonsuspicious mpMRI (PI-RADS 1–2) underwent TRUSGB only.

2.4. Histopathology

All biopsies were centrally reviewed at the central center by an experienced uropathologist (C.A.H.K., 25 yr of experience) independent of the results of the nonuniversity pathologists and the mpMRI results. TRUSGB and MRGB of each patient were evaluated separately from each other and blinded to the individual results. TRUSGB cores adjacent to lesions sampled by MRGB were called “perilesional.” For cores containing cancer, grade group (GG) and Gleason score (GS) were determined using the 2014 International Society of Urologic Pathology (ISUP) criteria [18]. Any prostatectomy specimens after radical prostatectomy were analyzed by the experienced general pathologists.

2.4.1. Definition of clinically significant PCa

Recent EAU guidelines use the definition of GG ≥ 2 (GG 3 + 3) for csPCa [17,19]. This matches with the newly introduced ISUP scoring system, where no separation is made between large and small GG 1 (GS 3 + 3) PCa. Therefore, our initial definition of csPCa that included large GG 1 (GS 3 + 3) PCa was changed to GG ≥ 2 (GG 3 + 4). Additional analyses for the two other csPCA definitions, large GG 1 (GS 3 + 3) and GG ≥ 3 (GS ≥ 4 + 3) were performed.

2.5. Outcome measurements

The primary outcomes comprised the overall detection rates of csPCA and insignPCA for both pathways. The secondary outcomes were the proportion of men in the MRI pathway who did not undergo MRGB after a nonsuspicious scan result, the number of csPCA missed in this group (detected by immediate TRUSGB and 1-yr follow-up), histopathologic details of biopsy and radical prostatectomy specimens, the number of biopsy cores per biopsy session, MRI and histopathology reader performance, biopsy complications, and oncologic follow-up.

2.6. Follow-up

A “safety net” was provided to all patients without csPCA at TRUSGB with either nonsuspicious mpMRI or suspicious mpMRI without a csPCA at MRGB. This included a minimum follow-up of 1 yr, with repeated PSA levels every 6 mo. In case of increased or persistent elevated PSA, repeat mpMRI and/or biopsy was performed.

2.7. Statistical analysis

Statistical analyses were performed using R (version 3.5.0; R Foundation for Statistical Computing, Vienna, Austria). Descriptive statistics were used to present clinical and mpMRI characteristics. Continuous variables were presented as median (interquartile range) and categorical variables as numbers with percentages. In patients with multiple lesions on mpMRI, the index lesion with the highest PI-RADS score was used.

To compare the proportions of csPCA and insignPCA in both pathways, McNemar’s tests were used. Adjusted Wald confidence intervals (CIs) for differences of proportions with matched pairs were calculated. Multiparametric MRI and histopathology reader agreement was calculated using Gwet’s agreement coefficient (AC) [20].

3. Results

3.1. Patient data and mpMRI results

Data of 626 patients were analyzed (Fig. 1). Patient characteristics and mpMRI scores are summarized in Table 1. The mpMRI was scored PI-RADS 1–2, 3, 4, and 5 in 49%, 6%, 22%, and 23%, respectively. Cancer detection rate (CDR) of the combined pathways was 334/626 (53%). Overall detection rates (without follow-up) were 190/626 (30%) for csPCA and 144/626 (23%) for insignPCA. Table 1 and Supplementary Table 10 show the results of two alternate definitions of csPCA.

3.2. MRGB and TRUSGB results

MRGB was performed in 317/626 (51%) patients. TRUSGB was performed in all patients. Biopsy core analysis details are presented in Table 2. Detection rates of csPCA increased with increasing PI-RADS categories. Differences of csPCA detection between TRUSGB and MRGB for PI-RADS 5 lesions were minimal (2%). These differences were higher for PI-RADS 3–4 lesions (12%; Table 2 and Supplementary Fig. 3).

3.3. Clinical performance of MRI and TRUSGB pathways

The overall CDR in the MRI pathway was 247/626 (39%) compared with 301/626 (48%) in the TRUSGB pathway. Immediate results, without follow-up, showed that the TRUSGB pathway found csPCA in 146/626 (23%) and the MRI pathway in 159/626 (25%) patients (difference of 2%; 95% CI: −1 to 5); insignPCA was found in 155/626 (25%) and 88/626 (14%) patients, respectively (difference of 11%; 95% CI: 7–14). Relative sensitivity of the MRI pathway compared with the TRUSGB pathway was 1.09 for csPCA and 0.57 for insignPCA (Table 3).

The diagnostic impact of biopsy strategies is presented in Fig. 2. Restricting biopsy to patients with suspicious mpMRI (PI-RADS 3–5; n = 317) reduced the number of men requiring a biopsy by 309/626 (49%). Not performing biopsy in PI-RADS 1–2 cases resulted in missing 10/309 (3%) of csPCA. Nine patients had a GG 2 (GS 3 + 4) and one a GG 3
In patients with nonsuspicious mpMRI, TRUSGB overdetected insignPCa in 63/309 (20%). If systematic TRUSGB would be performed in patients with nonsuspicious mpMRI and PSAD/C21 \(0.15 \text{ ng/ml/ml} \) (\(n = 55\)), three cases of csPCa would have been found. This would lower the underdetected rate to 2%, at the cost of 9% more insignPCa. If biopsy would be performed only in patients with PI-RADS 3 and PSAD/C21 \(0.15 \text{ ng/ml/ml} \), four csPCa cases including one GG 3 and one GG 5 would go undetected.

The utility of the MRI pathway alone versus the MRI pathway plus systematic 12-core TRUSGB (combined pathway) was also evaluated. Additional 7\% (21/317) csPCa cases were detected with the combined biopsy approach (Fig. 2, Supplementary Fig. 4B, and Supplementary Table 3). In 20 of these 21 patients, the csPCa cases detected by TRUSGB were recognized on mpMRI as suspicious lesions. In the remaining patient, the csPCa diagnosed by TRUSGB (GG 5; GS 4 + 5) was missed by all readers (therefore not specifically targeted) but was retrospectively visible. In the 20 patients with visible lesions diagnosed as csPCa only by TRUSGB cores, the TRUSGB cores were obtained from the abnormal mpMRI lesion area or from neighboring perilesional TRUSGB areas. In total 72 (peri)lesional TRUSGB cores were taken, yielding 15 patients with GG 3 and one with GG 4 + 3 PCa. Thus, the average number of TRUSGB cores was 4 (72/20) to diagnose each extra csPCa.

3.3.1. MRI reader performance
MRI reader performance concordance analysis for PI-RADS score was performed between first nonuniversity center and second central-center reading. The agreement for both readers was 88\% (399/456; Gwet’s AC = 0.84; 95\% CI: 0.80–0.88) and the agreement for decision whether to perform an MRGB was 94\% (428/456; Gwet’s AC = 0.88; 95\% CI: 0.83–0.92; Supplementary Table 4).

Fig. 1 – Flow diagram of study design and participants. mpMRI = multiparametric magnetic resonance imaging; MRGB = magnetic resonance-guided biopsy; PI-RADS = Prostate Imaging Reporting and Data System; PSA = prostate-specific antigen; TRUSGB = transrectal ultrasound-guided biopsy.
In 131 patients, radical prostatectomy was performed.  

### 3.4. Prostatectomy results

In total, 6% (41/626) of patients had complications: 3% had a complicated urinary tract infection (UTI/urosepsis) and 3% had other complications including lower urinary tract symptoms \( n = 9 \), bleeding \( n = 8 \), vasovagal episode \( n = 3 \), and transient ischemic attack after discontinuation of anticoagulant medication \( n = 1 \). Fifty percent (20/41) of these complications occurred in patients who underwent only TRUSGB in the nonsuspicious mpMRI group, including 2.9% (nine of 309) with complicated UTI/urosepsis.

### 4. Discussion

The major strength of this study is its quality-controlled, multicenter, head-to-head design. It confirms the larger body of research and clinical experience on combined mpMRI and MRGB for the detection and localization of csPca in biopsy-naive patients [9–14,21–23]. This paper makes multiple contributions to existing literature where there is controversy regarding its use for biopsy-naive men. Our study provides level 1a evidence that the mpMRI pathway is noninferior to the TRUSGB pathway in biopsy-naive men with regard to significant disease detection but is superior for detecting fewer insignificant cancers, and supports the “no immediate biopsy approach” after nonsuspicious mpMRI scans. Similar to other studies, we show that TRUSGB yields of csPca in nonsuspicious mpMRI patients are low (4%) [7,8]. Furthermore, not performing TRUSGB in these patients results in avoidance of complicated UTI/urosepsis in 2.9%.

The proportion of men avoiding biopsy is almost twice that reported by the PROMIS and PRECISION trials—27% and 28%, respectively [9,10]. In the PROMIS study, this was at the cost of underdetection of csPca of 24% (38/158) found on template mapping biopsy using the csPca definition of Gg \( \geq 2 \) (Gg \( \geq 3 + 4 \)) [9]. However, for TRUSGB the csPca yield in nonsuspicious mpMRI cases was only 5.1% (H.U.)
Table 2 – Biopsy core analysis details for TRUSGB and MRGB

<table>
<thead>
<tr>
<th></th>
<th>TRUSGB</th>
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<th>MRGB</th>
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<tr>
<td></td>
<td>Total n (%)</td>
<td>PI-RADS 1–2 n (%)</td>
<td>PI-RADS 3 n (%)</td>
<td>PI-RADS 4 n (%)</td>
<td>PI-RADS 5 n (%)</td>
<td>Total n (%)</td>
<td>PI-RADS 3 n (%)</td>
<td>PI-RADS 4 n (%)</td>
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<tr>
<td><strong>Biopsy outcome</strong></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>No PCa</td>
<td>325 (52)</td>
<td>236 (76)</td>
<td>23 (58)</td>
<td>50 (37)</td>
<td>16 (11)</td>
<td>70 (22)</td>
<td>26 (65)</td>
<td>38 (28)</td>
</tr>
<tr>
<td>insignPCa</td>
<td>155 (25)</td>
<td>63 (20)</td>
<td>11 (28)</td>
<td>52 (38)</td>
<td>29 (21)</td>
<td>88 (28)</td>
<td>7 (18)</td>
<td>44 (32)</td>
</tr>
<tr>
<td>csPCa</td>
<td>146 (23)</td>
<td>10 (3)</td>
<td>6 (15)</td>
<td>34 (25)</td>
<td>96 (68)</td>
<td>159 (50)</td>
<td>7 (18)</td>
<td>54 (40)</td>
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<tr>
<td><strong>Grade group/Gleason score</strong></td>
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<tr>
<td>GG 1/3+2</td>
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<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (0.1)</td>
<td>0 (0)</td>
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<tr>
<td>GG 1/3+3</td>
<td>155 (25)</td>
<td>63 (20)</td>
<td>11 (28)</td>
<td>52 (38)</td>
<td>29 (21)</td>
<td>87 (27)</td>
<td>7 (18)</td>
<td>44 (32)</td>
</tr>
<tr>
<td>GG 2/3+4</td>
<td>70 (11)</td>
<td>9 (3)</td>
<td>3 (8)</td>
<td>21 (15)</td>
<td>37 (26)</td>
<td>89 (28)</td>
<td>10 (4)</td>
<td>40 (30)</td>
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<td>GG 3/4+3</td>
<td>30 (5)</td>
<td>1 (&lt;1)</td>
<td>1 (3)</td>
<td>8 (6)</td>
<td>20 (14)</td>
<td>28 (9)</td>
<td>2 (5)</td>
<td>7 (5)</td>
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<td>GG 4/4+4</td>
<td>14 (2)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>2 (2)</td>
<td>12 (9)</td>
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<td>2 (1)</td>
</tr>
<tr>
<td>GG 4/3+5</td>
<td>3 (&lt;1)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (&lt;1)</td>
<td>2 (1)</td>
<td>5 (2)</td>
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<tr>
<td>GG 5/4+5</td>
<td>2 (&lt;1)</td>
<td>0 (0)</td>
<td>0 (0)</td>
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<tr>
<td>GG 5/5+4</td>
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<td>1 (3)</td>
<td>0 (0)</td>
<td>15 (11)</td>
<td>18 (6)</td>
<td>0 (0)</td>
<td>1 (&lt;1)</td>
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<tr>
<td>GG 5/5+5</td>
<td>7 (1)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1 (&lt;1)</td>
<td>6 (4)</td>
<td>6 (2)</td>
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<td><strong>Biopsy cores</strong></td>
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<td></td>
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</tr>
<tr>
<td>Total cores sampled</td>
<td>7512 (100)</td>
<td>3708 (50)</td>
<td>480 (13)</td>
<td>1632 (48)</td>
<td>1692 (52)</td>
<td>849 (42)</td>
<td>105 (16)</td>
<td>356 (42)</td>
</tr>
<tr>
<td>Total positive cores</td>
<td>1259 (17)</td>
<td>157 (4)</td>
<td>50 (10)</td>
<td>292 (18)</td>
<td>760 (45)</td>
<td>584 (68)</td>
<td>34 (12)</td>
<td>206 (58)</td>
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<td>Median cancer core length (mm, IQR)</td>
<td>4.6 (2.7–7)</td>
<td>2.1 (1–3)</td>
<td>3.0 (1–6)</td>
<td>3.3 (2–5)</td>
<td>6.2 (4.5–9)</td>
<td>6.3 (5–9)</td>
<td>4.0 (3–6)</td>
<td>5.0 (4–7)</td>
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<td>Percentage PCa of positive core length (%)</td>
<td>37</td>
<td>16</td>
<td>27</td>
<td>26</td>
<td>46</td>
<td>57</td>
<td>37</td>
<td>45</td>
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</tbody>
</table>

csPCa = clinically significant prostate cancer; GG = grade group; insignPCa = clinically insignificant prostate cancer; IQR = interquartile range; MRGB = magnetic resonance-guided biopsy; PCa = prostate cancer; PI-RADS = Prostate Imaging Reporting and Data System; TRUSGB = transrectal ultrasound-guided biopsy. Definition of csPCa: grade group ≥2 (Gleason score ≥3 + 4). Percentages may not total 100 because of rounding.

Table 3 – Pathway yield and relative sensitivity for different definitions of clinically significant prostate cancer

<table>
<thead>
<tr>
<th></th>
<th>TRUSGB pathway (n = 626)</th>
<th>MRI pathway (n = 309)</th>
<th>Relative sensitivity of MRI versus TRUSGB pathway</th>
<th>p value</th>
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<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>(%, 95% CI)</td>
<td>No biopsy (n = 309)</td>
<td>MRGB (n = 317)</td>
</tr>
<tr>
<td><strong>Grade group ≥2 (GS ≥ 3 + 4)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Prevalence csPCa:</td>
<td>200 (32.0, 28–36)</td>
<td>csPCa</td>
<td>146 (23.3, 20–27)</td>
<td>159 (25.4, 22–29)</td>
</tr>
<tr>
<td>insignPCa</td>
<td>155 (24.8, 21–28)</td>
<td>insignPCa</td>
<td>88 (14.1, 11–17)</td>
<td>0.57</td>
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<tr>
<td><strong>Other definitions for csPCa</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>“Larger” grade group ≥1 (GS ≥ 3 + 3)”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence csPCa:</td>
<td>286 (45.7, 42–50)</td>
<td>csPCa</td>
<td>215 (34.3, 31–38)</td>
<td>229 (36.6, 33–40)</td>
</tr>
<tr>
<td>insignPCa</td>
<td>86 (13.7, 11–17)</td>
<td>insignPCa</td>
<td>18 (2.9, 2–4)</td>
<td>0.20</td>
</tr>
<tr>
<td><strong>Grade group ≥3 (GS ≥ 3 + 4)</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence csPCa:</td>
<td>97 (15.5, 13–19)</td>
<td>csPCa</td>
<td>76 (12.1, 10–15)</td>
<td>70 (11.2, 9–14)</td>
</tr>
<tr>
<td>insignPCa</td>
<td>225 (35.9, 32–40)</td>
<td>insignPCa</td>
<td>177 (28.3, 25–32)</td>
<td>0.79</td>
</tr>
</tbody>
</table>

CI = confidence interval; csPCa = clinically significant prostate cancer; GG = grade group; GS = Gleason score; insignPCa = clinically insignificant prostate cancer; MRGB = magnetic resonance-guided biopsy; MRI = magnetic resonance imaging; TRUSGB = transrectal ultrasound-guided biopsy. Relative sensitivity is the sensitivity (ie, true positive rate) ratio between the MRI pathway and the TRUSGB pathway for each definition of csPCa. A value of 1 shows equal sensitivity. Values >1 indicate greater sensitivity for the MRI pathway, whereas values below 1 show lower sensitivity. Higher relative sensitivity is desirable for csPCa, and lower for the detection of insignPCa. The p values were calculated with McNemar’s test for paired nominal data.

Definitions of csPCa:
* Prevalence of csPCa of both pathways included 1-yr follow-up. MRGB/TRUSGB: GG ≥ 2 (GS ≥ 3 + 4) in any core.
** MRGB: GG 1 (GS 3 + 3) with total tumor core length ≥6 mm or GG ≥ 2 (GS ≥ 3 + 4) in any core. TRUSGB: GG 1 (GS 3 + 3) with three or more biopsy cores or GG ≥ 2 (GS ≥ 3 + 4) in any core.
*** MRGB/TRUSGB: GG ≥ 3 (GS ≥ 4 + 3) in any core.
Ahmed, personal communication). Pokorny et al. [11] showed that biopsy could be avoided in 36% (81/223), with an underdiagnosis of csPCa in 11% (9/81) found on TRUSGB. The low prevalence of csPCa in this study (30%) compared with contemporary cohorts (38–47%) could contribute to the high number of nonsuspicious MRI scans [9,10,21,24], which are in line with the MRI screening study of Grenabo Bergdahl et al. [25]. Another more important explanation for the higher proportion of nonsuspicious mpMRI scans than in other studies may be the high-quality standards achieved in image acquisition and reading. In our study, all mpMRI scans were performed on 3 T scanners, adhering to the PI-RADS v2 protocols, undertaken by trained prostate-MRI technologists. We also attained high quality in mpMRI readings using double expert consensus readings. These high standards helped minimize the proportion of “uncertain” (PI-RADS 3) diagnoses. PI-RADS 3 was present in 6% in our study, versus 28%, 21%, and 15% in the PROMIS, PRECISION, and Pokorny et al’s studies [9–11], respectively. That nonuniversity radiologists can perform high-quality reading after appropriate training is illustrated by their high agreement with the central-center radiologists.

This study design can also address the debate regarding the appropriate biopsy action in men with suspicious mpMRI scans: MRGB alone or MRGB + TRUSGB? In agreement with the literature, addition of systematic TRUSGB to MRGB leads to higher rates of csPCa and insignPCa [6,26]. The majority of csPCa missed by MRGB appears to be sampling errors related to intratumor heterogeneity. “Focal saturation” by additional four perilesional cores showed to improve csPCa detection when sampling with MRGB.

Some limitations should be discussed. First, reproducing these findings outside expert centers may be a challenge, but as shown in this study, it is not impossible. A well-designed training program can achieve high inter-reader agreements for PI-RADS score allocations as well as for biopsy decision making.

Second, MRGB and TRUSGB were undertaken in sequence on the same day. The visible MRGB needle track could have influenced the urologist in TRUSGB needle placements. Moreover, when TRUSGB was abnormal, a needle targeted to the abnormality was undertaken in lieu of the sextant core. This could inflate the PCA detection rates of TRUSGB, although biopsy hemorrhage from MRGB may partly negate this effect.

Third, even though this study used in-bore MRGB, which is considered the optimal MR-targeting technique for smaller lesions, a recent review showed that in-bore MRGB...
and MR-TRUS-fusion–guided biopsy are equally accurate, and results are potentially transferable to MR-TRUS-fusion–guided biopsies [27].

Fourth, some investigators have noted that selective sampling of the most aggressive part of a cancer by MRGB may lead to risk-stratification errors and can potentially lead to overtreatments of csPCa detected by MRGB [28]. However, a comparison of TRUSGB and MRGB with prostatectomy specimens within this study did not show marked differences between histologic down- and upgrading.

Finally, the low rate of infection-related complications could be further reduced by utilizing transperineal template mapping biopsies instead of the transrectal sampling route used in this study [9].

An "MRI-first" pathway in biopsy-naïve men has implementation challenges. The recommendation for "no immediate biopsy" requires a robust follow-up regimen to minimize missing csPCa that emerge in follow-up. Our approach for a “safety net” is to perform 6-monthly PSA tests and repeated mpMRI, MRGB, or TRUSGB when clinical suspicion persists. Panebianco et al. [8] have shown that such a safety net detects most interval cancers after non-suspicious MRGB and that emerging csPCa are curable at that time (Panebianco, personal communication) [29]. Furthermore, an education program and quality control for prostate-MRI technologists, MRGB physicians, and radiologists are needed, to deliver optimized quality of care for men with suspected PCa.

Finally, implementation of all new technologies is always connected with costs; although the MRI pathway, especially when using in-bore MRGB, is initially more expensive, extra costs are compensated for by reduced delays in diagnoses, ommittance of biopsies and subsequent biopsy-related morbidities, and treatment costs [30–32].

5. Conclusions

In biopsy-naïve men, the MRI pathway compared with the TRUS pathway results in an identical detection rate of csPCa, with significantly fewer cases of insignPcA. In this high-quality standard study, almost half of men have non-suspicious MRGB, which is higher compared with other studies. Not performing immediate TRUS biopsy after negative MRI is at the cost of missing csPCa only in 4%.

Author contributions: Jelle O. Barentsz had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

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Appendix A. Supplementary data

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References


