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Quality of life in men living with advanced and localised prostate cancer: A United Kingdom population-wide patient-reported outcome study of 30,000 men

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Research in context

Evidence before this study

Ovid databases (MEDLINE, Embase, PsychINFO) were searched for articles relating to health-related quality of life (HRQL) and “localised”, “advanced”, “metastatic”, “stage” and “prostate cancer” or “prostatic neoplasms” up to June 2018. Most articles relate to men with localised disease, with good quality evidence collected in the setting of clinical trials and observational studies of specific cohorts. Few studies have focused on those diagnosed with locally advanced or metastatic prostate cancer (PCa). In the small number of studies separating results by stage, poorer HRQL has been associated with later stage of disease. However, sample sizes tend to be small. Therefore, little is known about the impacts of PCa in men living with and beyond a diagnosis of advanced disease, especially in comparison to men with non-metastatic disease.

Added value of the study

This is first study able to compare, at scale, the HRQL and functional outcomes of men living with localised and advanced PCa. Data were collected on 35,823 men, with diagnostic stage available on 30,733 of whom 23.4% had stage III disease and 12.8% stage IV. The population-based approach enables true definition of the quality of survival of the increasingly prevalent group of men living with and beyond PCa. We identified that men with stage III and IV disease reported more problems, including those generic to health and those related to treatment, particularly androgen deprivation therapy (ADT). Poor sexual function was reported by most men, regardless of stage, and the majority (56.5%) reported not being offered any intervention or support for this. Despite specific functional morbidities, many men with PCa self-reported their overall health to be similar to men in general population studies and a substantial proportion of men with stage IV disease (23.5%) reported no problems on any EQ-5D dimension. These results highlight areas of unmet need and will be vital in helping men make informed decisions about their treatment.

Implications of all the available evidence

Most men living 18-42 months after a diagnosis of PCa can expect to experience as good HRQL as men in the general population, including those with stage III and a substantial proportion of those with stage IV disease. Although significant sexual morbidity is common, the majority of men are not offered helpful intervention or support. The evidence suggests that there are subgroups of men who would benefit from service improvements around sexual rehabilitation and measures to minimise the use of ADT. These include wider use of intermittent ADT (versus continuous use), the avoidance of unnecessary ADT (i.e. for non-metastatic disease) and the use of shorter neoadjuvant courses (reduced from 3 years to 1 year). This study collected data from men living up to a maximum of 42 months beyond diagnosis. Those with stage IV disease are likely to experience deterioration in their HRQL at some point following this. Further evidence is needed to inform appropriate service provision for them in these later years.

Abstract

Background: Little is known about the health-related quality of life (HRQL) of men living with advanced prostate cancer. We report for the first time population-wide functional outcomes and HRQL in men with advanced or localised disease.

Methods: Men diagnosed 18-42 months previously were identified across the United Kingdom. Functional outcomes (EPIC-26 plus interventions for sexual dysfunction) and generic HRQL (EQ-5D-5L & self-assessed health) were assessed through a postal survey. Diagnostic stage was obtained through cancer registration records and treatment was self-reported.

Findings: 35,823 (60.8%) men responded. Stage was known for 85.8%; 19,599 (63.8%) stage I/II, 7,209 (23.4%) stage III, 3,925 (12.8%) stage IV. Men with stage III and IV disease reported more problems, including those generic to health and those related to treatment. Poor sexual function was common (81.0%), regardless of stage. Over half of men (56.5%) received no intervention for this. Differences in urinary and bowel morbidity were greater with respect to treatment than stage. Androgen deprivation therapy (ADT) was associated with poorer HRQL, hot flushes, weight gain and lack of energy. Overall self-assessed health was similar in men with stage I-III disease, and whilst reduced in those with stage IV cancer, 23.5% with metastatic disease reported no problems on any EQ-5D dimension.

Interpretation: Men diagnosed with advanced disease do not report markedly different HRQL outcomes to those diagnosed with localised disease, although significant problems with hormonal function and fatigue are reported amongst men treated with ADT. Sexual dysfunction is common and the majority of men are not offered helpful intervention or support. Service improvements around sexual rehabilitation and measures to reduce the impact of ADT are required.

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Background

The number of prostate cancer (PCa) survivors has increased rapidly over recent decades. According to population-based cancer registry data, 10-year survival has tripled in the last 40 years in the United Kingdom (UK)¹. In England, there are an estimated 325,000 men alive having been diagnosed with PCa between 1995 and 2015². A principal challenge for healthcare is to understand the needs of this growing group of men, in particular the problems and challenges faced by those living with advanced disease (30% of men with distant metastases now survive at least five years³). The quality of survival experienced, with definition of the specific impacts of the disease and its treatment, must be robustly determined to facilitate appropriate care provision⁴.

Significant sexual, urinary and bowel morbidities have been identified following treatment of localised PCa, with the pattern and severity of morbidity varying according to the type and intensity of treatment received⁵⁻⁸. Most intelligence originates from randomised controlled trials and observational studies of specific cohorts, often reporting outcomes following surgery compared to radiotherapy and surveillance in men with localised PCa⁹. Evidence for the UK has not been generated at an unselected population level. In addition, few studies have reported outcomes in men with locally advanced or metastatic disease. Such studies tend to be small and are mostly clinical trials comparing specific treatment types¹⁰⁻¹².

The Life After Prostate Cancer Diagnosis (LAPCD) study adopts an established approach to the measurement of population-level health-related quality of life (HRQL), previously used in a national population of colorectal cancer survivors¹³, and extends this to men living with all stages of PCa 18-42 months post diagnosis. An internationally recommended series of outcome measures has been utilised to facilitate comparison and interpretation, with specific enquiry as to the impact of interventions offered for sexual dysfunction¹⁴. Here we report the functional outcomes (urinary, bowel, sexual and vitality/hormonal) and HRQL of men with PCa,

in order to a) quantify and compare outcomes across all disease stages and treatment groups, and b) identify implications for healthcare delivery.

Methods

The LAPCD methodology has been reported in full¹⁵ but is outlined below.

Participants

All National Health Service (NHS) Hospital Trusts/Health Boards treating PCa were approached. In England, 111 of 136 Trusts participated; 21 declined and 4 were involved in overlapping studies (Supplementary figure 1). All Trusts/Health Boards in Northern Ireland (NI; $n=5$), Scotland ($n=14$) and Wales ($n=6$) participated. Men alive 18-42 months after a PCa diagnosis (ICD10¹⁶ C61) in participating Trusts/Boards were identified from national population-based cancer registries in England, NI and Wales. In Scotland, due to privacy restrictions, men were identified through hospital activity data and verified through the cancer registry. Approximately 82% of eligible men with PCa across the UK were invited to participate.

Data collection

Men were sent a postal survey (Supplementary file 1) from their treating Trust/Board. Men consented by returning completed surveys and declined by not returning them, returning them unanswered or opting out via a free-phone helpline. Up to two reminders were sent to non-responders.

Functional outcomes and HRQL were assessed using the items defined in the International Consortium on Health Outcome Measurement (ICHOM) minimum outcome dataset¹⁴: the Expanded Prostate cancer Index Composite short form (EPIC-26)¹⁷; items on use of interventions to improve sexual function; and EQ-5D-5L¹⁸. The survey included other measures covering social difficulties, decision regret, emotional well-being and others, which will be reported elsewhere.

Patient involvement

A User Advisory Group, including 6 PCa survivors, was chaired by HB (co-investigator and PCa survivor). The group has been involved in all stages of the study from design through to interpretation and dissemination of results.

Data handling

Stage at diagnosis was obtained from national cancer registration records. Stage I and II were combined into a 'localised disease' group and compared to stage III and IV separately. An area-based measure of socio-economic deprivation (split into quintiles) was derived using postcode of residence¹⁹⁻²². Age, presence of other long-term conditions and treatments received were derived from the survey data. Age (question 78) was categorised as <55, 55-64, 65-74, 75-84, and ≥85 years. Where missing, this was supplemented by cancer registration data (accounting for the lag between diagnosis and survey). Other long-term conditions (question 84) were counted and categorised as none, 1, 2, 3, ≥4. Treatments (question 8) were categorised into single therapies (e.g. surgery alone or external beam radiotherapy [EBRT] alone) or combinations therapies (e.g. EBRT and androgen deprivation therapy [ADT]) (Supplementary file 2).

EPIC-26 measures function across five domains (urinary incontinence, urinary irritation and obstruction, bowel, sexual, vitality/hormone), using 26 items. Domain scores range from 0-100, with 100 representing best possible function. Where one item in a domain was missing, this was substituted with the mean of the available items, as per the scoring guidance²³. In addition to mean scores, individual item responses were used to derive the proportion reporting a moderate/big problem (or equivalent), as per Watson et al²⁴.

The ICHOM dataset includes two items assessing use of medications and devices for erectile dysfunction²⁵. These were amended to avoid drug/trade names (Supplementary file 1, questions 25-26). An extra item on use of specialist services to help with sex life was included

(Supplementary file 1, question 27). The possible response categories were grouped as 'not offered', 'offered but did not want/try it', 'offered but did not help', 'offered and it helped'.

EQ-5D-5L records information on five dimensions (mobility, self-care, usual activities, pain/discomfort, anxiety/depression), plus a rating of self-assessed health (SAH) based on "how good or bad your health is today" (valued 0-100, where 100 represents best possible health). The proportion of respondents reporting any problem, regardless of severity, in each dimension separately and across all five dimensions was derived. Mean SAH ratings were calculated.

Statistical analysis

Log-linear regression was used to model the continuous outcomes (EPIC-26 functional domain scores and the EQ-5D SAH score), as this approach provided a better fit to the data than a linear one. Binary logistic regression models were developed for each individual EPIC-26 item (with moderate/big problems, or equivalent, as the outcome) and each EQ-5D dimension (with reporting of any problem as the outcome). To generate results by stage and treatment, these variables were added separately to the models. Each model included adjustment for age (as a linear term), socio-economic deprivation and number of other long-term conditions. Subgroup analyses by age group were adjusted for socio-economic deprivation and other long-term conditions. Resulting model coefficients were used to predict the mean scores and proportions for each stage and treatment group, taking account of the different case-mix profiles of each group. Analysis of the use of interventions for sexual dysfunction was based on the raw survey responses, in order to reflect 'real world' provision of sexual support to men with prostate cancer. In all analyses, men with missing responses were excluded on a question-by-question basis, thus all proportions and mean values refer to the men who responded to that question. Due to the large number of men included in the study, statistical significance can be achieved with only small differences in outcomes, and these may not be clinically relevant. As such, results are presented alongside previously

estimated minimally important differences (MIDs), where available²⁶⁻²⁸. Analyses were performed using Stata version 15.0 (StataCorp, TX, USA).

Role of the funding source

The funders of the LAPCD study had no role in the design of the study, the data collection, analysis and interpretation, the writing of the manuscript or the decision to submit for publication. Anonymised study data were available to AD and SW. The corresponding author had full access to the anonymised data and had final responsibility to submit the article for publication.

Results

Sample size and response rates

Initially, 59,990 eligible men were identified; 1,060 (1.8%) died during the study period, giving a final sample of 58,930. Of these, 35,823 returned completed questionnaires (60.8% response) (Supplementary figure 1). Men aged under 55 (51.8% response) or over 85 (36.9% response), from non-white ethnic groups (38.0% response) and those living in the most socio-economically deprived areas (48.3% response) were less likely to participate (Supplementary table 1). By stage, response rates were highest in the men diagnosed with stage III cancer (65.7%) and lowest in those diagnosed with stage IV disease (58.1%). Within the completed questionnaires, levels of missing data were generally low e.g. <3% missing for EQ-5D (Supplementary table 2). EPIC-26 items were less well completed and domain scores could not be calculated in 9-18% of cases. Completion was highest for the sexual function domain and lowest for the urinary irritation domain.

Characteristics of the population

Nearly half (46.4%) of the cohort were aged 65-74 at survey (median 71 years, IQR 67-77) (Table 1). A quarter (26.3%) of the men lived in the least socio-economically deprived areas

and 10.1% lived in the most deprived. Most men (71.0%) reported at least one other long-term condition, with 7.2% reporting four or more.

Stage at diagnosis was known for 85.8% (30,733) of respondents, of whom 63.8% (19,599) had stage I or II disease, 23.4% (7,209) stage III, and 12.8% (3,925) stage IV. Table 1 details the characteristics of each stage group, including those with unknown stage. The men diagnosed with stage IV disease (median age 73 years, IQR 68-79) were older than those with stage I/II disease (median age 71 years, IQR 66-76). The median age of the group with unknown stage was 73 (IQR 67-79). The socio-economic deprivation and long-term condition profiles were similar across the known stage groups, whilst a higher proportion of the group with unknown stage lived in the least socio-economically deprived areas ($p < 0.001$).

The treatments reported by the men are detailed in Table 1. Across the whole cohort, 20.9% reported receiving combined EBRT and ADT, with a further 19.7% reporting having surgery alone (Table 1). Of those diagnosed with stage I/II disease, 20.3% reported being on a monitoring regime (active surveillance (AS) or watchful waiting) and 23.5% reported having surgery alone. Most men diagnosed with stage IV cancer were receiving ADT, either alone (28.4%) or in combination with EBRT and/or other systemic therapy (chemotherapy, Abiraterone, Enzalutamide) (40.7%).

Specific functional outcomes

EPIC-26 domain scores

Mean adjusted EPIC-26 domain scores were high, indicating good function, except for sexual function where scores were much lower (24.0) (Table 2). Urinary and bowel function were similar across all disease stages (<3 point difference), whereas vitality/hormone and sexual function were substantially reduced in men with stage III and IV PCa compared to those with localised disease (8-16 point difference for hormone function and 12-17 point difference for sexual function). Men treated surgically reported more urinary incontinence, whilst those on ADT reported worse hormonal and sexual function.

Urinary function

Needing to urinate frequently was the most common urinary symptom (adjusted proportion: 18.6% reported a moderate/big problem), followed by leaking at least once per day (adjusted proportion: 12.7%). There were only small differences in the reporting of urinary symptoms by stage (Figure 1a). Men who underwent surgery reported high levels of urinary incontinence (adjusted proportions: 23.4% leaked at least once per day and 31.4% used one or more pads per day in the surgery alone group) (Supplementary table 3). Problems with urinary frequency and weak stream/incomplete emptying were less of a problem in the 'surgery alone' group than in other treatment groups.

Bowel function

Problems with bowel function were relatively infrequent compared to other domains and varied little by stage of disease (Figure 1a). Bowel urgency was the most common bowel problem (adjusted proportion: 8.8% reported a moderate/big problem). Bowel problems were more frequent following EBRT, alone or in combination. For example, 11.4% of the 'EBRT alone' group reported moderate/big problems with bowel urgency compared to 4.4% in the 'surgery alone' group (adjusted proportions: Supplementary table 3).

Vitality/hormone function

Problems with lack of energy, hot flushes and weight gain were most commonly reported (Supplementary table 3). There were much larger differences in the reporting of these symptoms by stage than was seen for urinary and bowel function (Figure 1a), however, this is related to the treatment received. Men treated with ADT, alone or in combination with other therapy, reported much higher rates of problems with hormonal function and fatigue. For example, 30.7% of men treated with ADT reported moderate/big problems with hot flushes (compared to 5.4% in the no-ADT group) and 29.4% of men treated with ADT reported problems with lack of energy (compared to 14.7% in the no-ADT group) (Figure 1b). There was a smaller difference in the reporting of depression between the ADT and no-ADT groups (11.4% and 6.6% reporting moderate/big problems).

Sexual function

Problems with sexual function were more common than issues in other domains: poor/very poor erections (81.5%), poor/very poor ability to reach orgasm (76.6%) and poor/very poor overall sexual function (81.0%) (adjusted proportions: Supplementary table 3). In men with localised disease, 75.0% reported poor/very poor sexual function, as did 90.4% of men with stage III and 96.0% of men with stage IV cancer (adjusted proportions: Figure 2a). By treatment, just over half of men on AS (51.1%) reported poor/very poor overall sexual function, increasing to 83.7% of men who had surgery alone and 93.6% receiving ADT alone (adjusted proportions: Supplementary table 3).

Looking across the age groups, just over half (54.5%) of the men aged <55 reported poor/very poor sexual function and this increased sharply with age (Figure 2b). A substantial proportion of men (45.2% overall) perceived their (lack of) sexual function to be a moderate/big problem; however, this decreased slightly with age.

Use of interventions to improve sexual function

Across the cohort, 41.4% reported being offered medications to aid or improve erections, 22.6% were offered devices to aid erections and 14.8% were offered specialist services to help with sex life (Supplementary table 4). Over half (56.5%) were not offered any of these interventions. Younger men were more likely to report having been offered intervention: however, even in the youngest age group (<55 years), 23.5% were not offered medications, 48.9% were not offered devices and 76.0% were not offered access to specialist services (Figure 3). By stage, similar proportions of men with stage I/II (46.7%) and stage III (47.7%) disease were offered interventions compared to 26.9% with stage IV (not shown).

Amongst men offered any of the three interventions, 37.2% did not want them or did not try them, 23.8% found they did not help, and 39.0% reported at least one of them being helpful (Supplementary table 4). Of those offered medications, 34.2% reported them being helpful.

Of those offered devices, 28.3% reported them as helpful. For those offered specialist services, 18.9% found them helpful.

Health-related quality of life

The overall mean adjusted SAH score was 76.3 (Table 2). SAH was 5.7 points lower in men with stage IV disease compared to men with localised cancer (mean adjusted scores: 71.7 and 77.4 respectively). Men with stage III disease reported a mean adjusted SAH score of 76.3. When looking across the age groups, the difference in SAH between stage I/II and stage IV was greater in the younger men (Figure 4a). A similar pattern was seen when looking at the effect of ADT use by age (Figure 4b).

Respondents were most likely to report problems (of any level) with 'pain/discomfort' (41.7%) and least likely to report problems with 'self-care' (11.5%) (adjusted proportions: Table 2). Men with stage IV cancer reported more problems in each dimension, and this was highest for 'pain/discomfort' (54.6%) and 'usual activities' (53.3%). Nearly a quarter (23.5%) of those with stage IV PCa reported no problems in any EQ-5D dimension (compared to 40.2% stage I/II and 35.3% stage III). In the stage IV group, mean adjusted SAH was 85.1 in the men reporting no problems and 67.3 in those who reported ≥ 1 problem.

Discussion

This population-based study of functional outcomes and HRQL of over 30,000 men living 18-42 months beyond PCa diagnosis represents the largest patient-reported outcome series to date. It includes 11,000 men living with locally advanced or metastatic disease, an increasingly prevalent cohort of cancer survivors, frequently excluded from study. The data show that the majority of men with stage III disease and approximately 25% of those with stage IV disease report good overall HRQL. However, sexual morbidity is high, irrespective of stage of disease, and over half of men reported they had not been offered intervention to help with this. More than other treatments, ADT is associated with reduced overall HRQL.

Function

Approaching 80% of the cohort reported poor or very poor sexual function and this was consistently high across the disease stages. A recent study of older men in the general population found that 48% reported poor sexual function²⁹. In this study, 51% of men on active surveillance reported poor sexual function. Sexual issues in these men are unlikely to be related to the diagnosis of PCa as they have not received any active treatment. Hence, whilst sexual dysfunction is common in the general population, the levels reported by men treated for PCa are considerably higher. Overall, 57% reported not being offered access to medications, devices or specialist services to address this, and only 40% of those offered help found it to be beneficial. The extent of failure to receive support has not previously been described. This intelligence would suggest clinical services need to proactively address this and ensure that sexual support is routinely offered to all men. However, it must be acknowledged that not all men see their lack of sexual function as a problem and some will not want intervention to address this. In particular, these data suggest that older men see their lack of sexual function as less of a problem than younger men.

Overall levels of urinary and bowel problems in men with PCa are relatively low; however, there are subgroups with increased levels of dysfunction. For example, men treated surgically reported higher levels of urinary incontinence with 30% reporting using pads daily, a finding which supports previous research^{5,8}. These men are between 18 and 42 months post-diagnosis and there may be some recovery in function with longer follow-up⁵.

In general, those with stage III and IV disease reported a higher level of problems, but in many cases these differences were small and were less than previously estimated MIDs for urinary and bowel function²⁸. Larger impacts on sexual function, hormonal function, fatigue and depression were seen and will, in part, be driven by treatment with ADT. The majority of men with stage III or IV PCa will be on long-term or indefinite ADT. There may be some recovery in those who stop ADT, with a corresponding reduction in symptoms, but testosterone levels may never recover to pre-treatment levels. Longer-term follow-up of men would be required

to assess recovery of sexual function, levels of fatigue and other ADT-related effects. The results suggest that clinicians should pursue treatment approaches that preserve testosterone function when possible and minimise ADT use. Steps to reduce ADT-related morbidity might include wider use of intermittent ADT (versus continuous use), the avoidance of unnecessary ADT (i.e. for non-metastatic disease) and the use of shorter neoadjuvant courses (reduced from 3 years to 1 year).

Health-related quality of life

Despite significant sexual dysfunction, urinary difficulties and hormonal issues in some groups, this cohort of men living with and beyond the diagnosis of PCa report similar SAH to men in the general population^{29,30} (Table 3). Differences in SAH amongst the overall LAPCD and general population samples are small, less than 3 points, with minimally important differences in EQ-5D SAH ratings having previously been estimated at being in the region of 7 points^{26,27}. This apparent “resilience” of men with PCa may be accounted for by the “Gap Hypothesis” of quality of life, with the diagnosis of a life-threatening illness and subsequent experience of undergoing treatment leading to re-calibration of expectations and values³¹.

This study is the first at-scale attempt to describe the outcomes of men living with locally advanced and metastatic PCa. Overall the SAH of men with stage III disease is not markedly different from those with localised disease or UK general population surveys. Whilst scores from those with stage IV disease are 6 points lower than those with localised disease, this may not equate to a clinically meaningful difference. A quarter of men with stage IV PCa report no problems in any EQ-5D domain. Not all men with Stage IV PCa experience similar clinical trajectories, with some living for prolonged periods and others living significantly shorter periods from diagnosis. Sub-groups of men, such those with oligometastatic disease, may experience few problems whilst others experience diminished HRQL. This study did not capture the detailed clinical information needed to investigate subtypes of disease. The absence of other at-scale studies of the outcomes of men living with stage III and IV disease prevent comparison with other studies. Further investigation into the outcomes of men living

with metastatic disease is required, particularly over a longer time period, as many will only develop symptoms a number of years after diagnosis.

Strengths

Through whole population sampling, potential recruitment or clinical trial intervention bias has been avoided. In addition, all disease stages and treatments have been included, adding important new data on men living with and beyond diagnoses of advanced disease who have been largely omitted from previous quality of life outcome studies. Utilisation of a standardised set of accepted outcome measures enables future international benchmarking.

Data collection at this scale, from all centres in NI, Scotland and Wales and 111 of 136 NHS Trusts in England, has allowed us to produce datasets for individual Trusts, Cancer Alliances and regional health boards. Internet-based tools will be made available to support service improvement, and in parallel, a public-facing electronic tool will provide an information and decision-making resource for men and their families, through identification of expected outcomes based on robust unselected data.

Limitations

The response rate of 61% is comparable to a similar survey of colorectal cancer survivors in England (63%)¹³. Comparison of rates with other PCa trials and cohort studies is difficult due to different identification and recruitment methods. Our response rate is reported without exclusion or screening of eligible individuals. Non-respondents were more likely to be older, Black, Asian or minority ethnic and live in more socio-economically deprived areas. These are groups who may be expected to potentially experience poorer HRQL. Variation in response rate by stage was identified, with those with stage III disease having the highest response rates and those with stage IV disease at diagnosis the lowest. We do not know if patients with worse health status were less likely to respond. Data completeness was high for the majority of questions. Records with missing data were excluded from analysis, which assumes that those who did not respond to the question have similar outcomes to those who

did. This assumption cannot be validated using the available data. Men were less likely to avoid questions on sexual function than they were for some of the other domains, which is perhaps counter-intuitive but could indicate a real concern in this otherwise healthy-feeling group.

Staging information was taken from national cancer registration data at diagnosis and was available for 86% of respondents. The cancer registry uses a variety of data sources, including pathology reports and treatment databases, to capture stage information. Some groups of men are less likely to appear in a treatment or pathology dataset near the time of diagnosis (for instance, those on watchful waiting are less likely to have a biopsy). At the time when men in this study were diagnosed, there was less access to multi-disciplinary team systems to capture staging information, though this has now improved. Treatment information was self-reported, due to limited data in cancer registries on types of monitoring and difficulties in capturing hormone therapies administered through primary care prescriptions (Public Health England, Personal Communication). However, some respondents had difficulty reporting the treatments they received (e.g. distinguishing between types of radiotherapy) and these groups had to be excluded from some analyses.

Conclusions

Most men living 18-42 months after diagnosis of PCa can expect to experience as good HRQL as men in the general population. Those diagnosed with locally advanced and metastatic disease do not report markedly different HRQL outcomes to those diagnosed with localised disease, although significant problems with hormonal function and fatigue are reported as a result of ADT. However, it should be recognised that this study covers a limited window of time and HRQL in those with metastatic disease may deteriorate over a longer time period. Sexual dysfunction is common across all disease stages, with notably poor provision of sexual support. Our results suggest that there are subgroups of men who would benefit from service improvements around sexual rehabilitation and measures to reduce the impact of ADT. This study shows that outcomes for men with PCa are more strongly linked with the treatments

received than disease stage itself, although clearly the two are intertwined. These results allow clinicians to present very positive goals for quality of survival 18-42 months after diagnosis, including for a substantial proportion of men with metastatic disease.

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Ethical approval

The study received the following approvals: Newcastle & North Tyneside 1 Research Ethics Committee (15/NE/0036), Confidentiality Advisory Group (15/CAG/0110), NHS Scotland Public Benefit and Privacy Panel (0516-0364) and NHS R&D approval from Wales, Scotland and Northern Ireland.

Authors' contributions

AG and AWG are co-Principal Investigators and designed the study together with co-investigators AD, PW, LH, PS, EW, RW, PK and HB. RM, MA and TK managed the study and data collection. AD and SW analysed the data. JC, WC, MM, LS, DW, EM, GV and DH are members of the Clinical & Scientific Advisory Group (chaired by PS) which provided study oversight and advised on interpretation of the data. DD, DB, EMcN and DH advised on study design, data collection and interpretation of data from the devolved nations. AD wrote the initial draft of the paper. All authors contributed to critically revising the paper and approved the final version.

Declaration of interests

All authors declare no conflicts of interest.

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Table 1: Characteristics of the study sample split by stage at diagnosis

	All men		Stage I/II		Stage III		Stage IV		Stage unknown		
	n	%	n	%	n	%	n	%	n	%	
Total	35,823	100.0	19,599	54.7	7,209	20.1	3,925	11.0	5,090	14.2	
Treatment	Active surveillance	2,928	8.2	2,320	11.8	0	0.0	0	0.0	457	9.0
	Watchful waiting	2,292	6.4	1,666	8.5	182	2.5	164	4.2	993	19.5
	Brachytherapy alone	1,208	3.4	940	4.8	62	0.9	13	0.3	294	5.8
	Surgery alone	7,054	19.7	4,606	23.5	1,323	18.4	132	3.4	193	3.8
	Surgery + EBRT/ADT	2,349	6.6	853	4.4	801	11.1	339	8.6	548	10.8
	EBRT alone	2,536	7.1	1,533	7.8	573	7.9	136	3.5	431	8.5
	EBRT + ADT	7,488	20.9	3,688	18.8	2,359	32.7	658	16.8	783	15.4
	ADT alone	3,116	8.7	965	4.9	487	6.8	1,116	28.4	356	7.0
	Systemic + ADT	630	1.8	71	0.4	37	0.5	450	11.5	72	1.4
	Systemic + EBRT (+/- ADT)	513	1.4	84	0.4	128	1.8	237	6.0	64	1.3
	Other treatment groups	5,709	15.9	2873	14.7	1257	17.4	680	17.3	899	17.7
Age at survey	<55 years	661	1.8	447	2.3	92	1.3	45	1.1	77	1.5
	55-64 years	5,594	15.6	3,366	17.2	1,026	14.2	473	12.1	729	14.3
	65-74 years	16,638	46.4	9,420	48.1	3,406	47.2	1,712	43.6	2,100	41.3
	75-84 years	11,082	30.9	5,670	28.9	2,391	33.2	1,326	33.8	1,695	33.3
	85+ years	1,842	5.1	696	3.6	294	4.1	369	9.4	483	9.5
	Unknown	6	0.02	0	0.0	0	0.0	0	0.0	6	0.1
Socio-economic deprivation quintile	1 - least deprived	9,408	26.3	5,128	26.2	1,802	25.0	962	24.5	1,516	29.8
	2	9,289	25.9	5,186	26.5	1,889	26.2	1,000	25.5	1,241	24.4
	3	7,381	20.6	4,082	20.8	1,504	20.9	869	22.1	926	18.2
	4	5,266	14.7	2,846	14.5	1,084	15.0	596	15.2	740	14.5
	5 - most deprived	3,620	10.1	1,955	10.0	786	10.9	421	10.7	458	9.0
	Unknown	859	2.4	402	2.1	144	2.0	77	2.0	236	4.6
No. of other long-term conditions	0	10,405	29.0	5,740	29.3	2,087	28.9	1,131	28.8	1,447	28.4
	1	12,527	35.0	6,910	35.3	2,594	36.0	1,316	33.5	1,707	33.5
	2	7,154	20.0	3,827	19.5	1,432	19.9	807	20.6	1,088	21.4
	3	3,174	8.9	1,708	8.7	605	8.4	391	10.0	470	9.2
	≥4	2,563	7.2	1,414	7.2	491	6.8	280	7.1	378	7.4

EBRT: External beam radiotherapy; ADT: Androgen deprivation therapy; Systemic therapy includes chemotherapy/Abiraterone/Enzalutamide.

Table 2: Functional and HRQL outcomes in men diagnosed with prostate cancer 18-42 months previously

	EPIC-26 domain (adjusted mean score*: 100 = best possible function)					EQ-5D dimension (adjusted % reporting any level of problem*)					EQ-5D Overall HRQL*	
	Urinary incontinence n=31,827	Urinary irritation n=29,274	Bowel function n=30,861	Hormone function n=31,746	Sexual function n=32,525	Mobility n=35,411	Self-care n=35,470	Usual activities n=35,416	Pain/ discomfort n=35,349	Anxiety/ depression n=35,310	≥1 problem (%) n=34,769	Mean SAH rating n=35,003
All men	82.6	85.9	88.9	79.9	24.0	33.8	11.5	36.5	41.7	33.0	63.2	76.3
Stage												
I/II	82.9	86.0	89.6	83.6	28.5	29.7	9.8	32.0	38.9	31.0	59.8	77.4
III	81.2	86.2	87.4	75.3	16.4	34.8	11.6	38.5	42.3	33.9	64.7	76.3
IV	83.2	84.7	88.1	68.0	11.9	49.8	18.9	53.3	54.6	43.0	76.5	71.7
Treatment												
AS	87.6	83.0	93.1	90.0	44.6	24.3	7.4	23.9	34.5	30.8	57.3	78.7
WW	87.1	85.2	93.1	88.0	41.3	31.6	10.4	31.6	36.7	30.9	59.0	77.2
Brachy alone	89.2	84.1	88.8	89.3	37.6	20.7	5.9	22.9	36.4	25.2	52.6	79.6
Surg alone	73.5	90.0	93.4	89.6	22.1	23.9	7.6	29.1	33.5	27.3	54.6	79.5
Surg + EBRT/ADT	73.1	86.1	86.2	76.9	14.9	34.0	11.6	40.0	42.9	35.5	66.1	76.0
EBRT alone	86.7	86.1	86.2	80.7	25.6	32.8	10.2	33.4	41.2	28.4	59.7	77.6
EBRT + ADT	86.8	85.5	84.4	72.2	19.1	34.4	10.7	38.0	44.6	34.3	64.8	76.2
ADT alone	86.4	84.6	90.9	69.3	15.3	43.0	15.9	47.6	46.5	41.0	74.3	72.0
Syst + ADT	86.2	84.6	90.7	66.9	11.5	55.1	19.5	59.3	57.2	46.4	81.8	70.4
Syst + EBRT	85.1	83.4	83.8	66.2	12.4	59.5	25.5	62.2	61.7	45.6	82.4	68.3

*Adjusted for age at survey, socio-economic deprivation and number of other long-term conditions.

AS: Active surveillance; WW: Watchful waiting; Brachy: Brachytherapy; Surg: Surgery; EBRT: External beam radiotherapy; ADT: Androgen deprivation therapy; Syst: Systemic therapy (Chemotherapy/Abiraterone/Enzalutamide); SAH: Self-assessed health.

Due to the large number of men included in the study, statistical significance can be achieved with only small differences in outcomes, and these may not be clinically relevant. Results should be considered alongside previously estimated minimally important differences. For EPIC-26: Urinary incontinence (6-9 points); Urinary irritation/obstruction (5-7 points); Bowel function (4-6 points); Vitality/hormone function (4-6 points); Sexual function (10-12 points). For EQ-5D Self-assessed health (7 points).

Table 3: Comparison of self-assessed health ratings in the LAPCD cohort and general population surveys (men aged 60 and over)

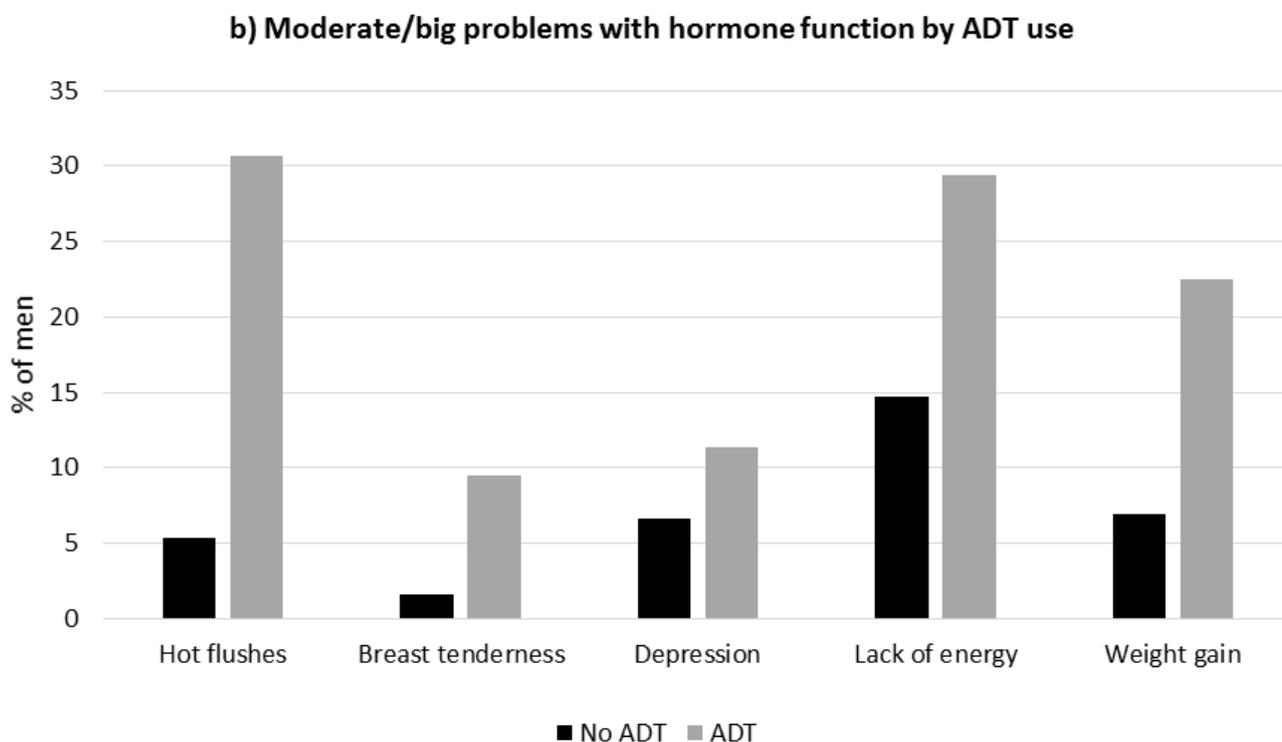
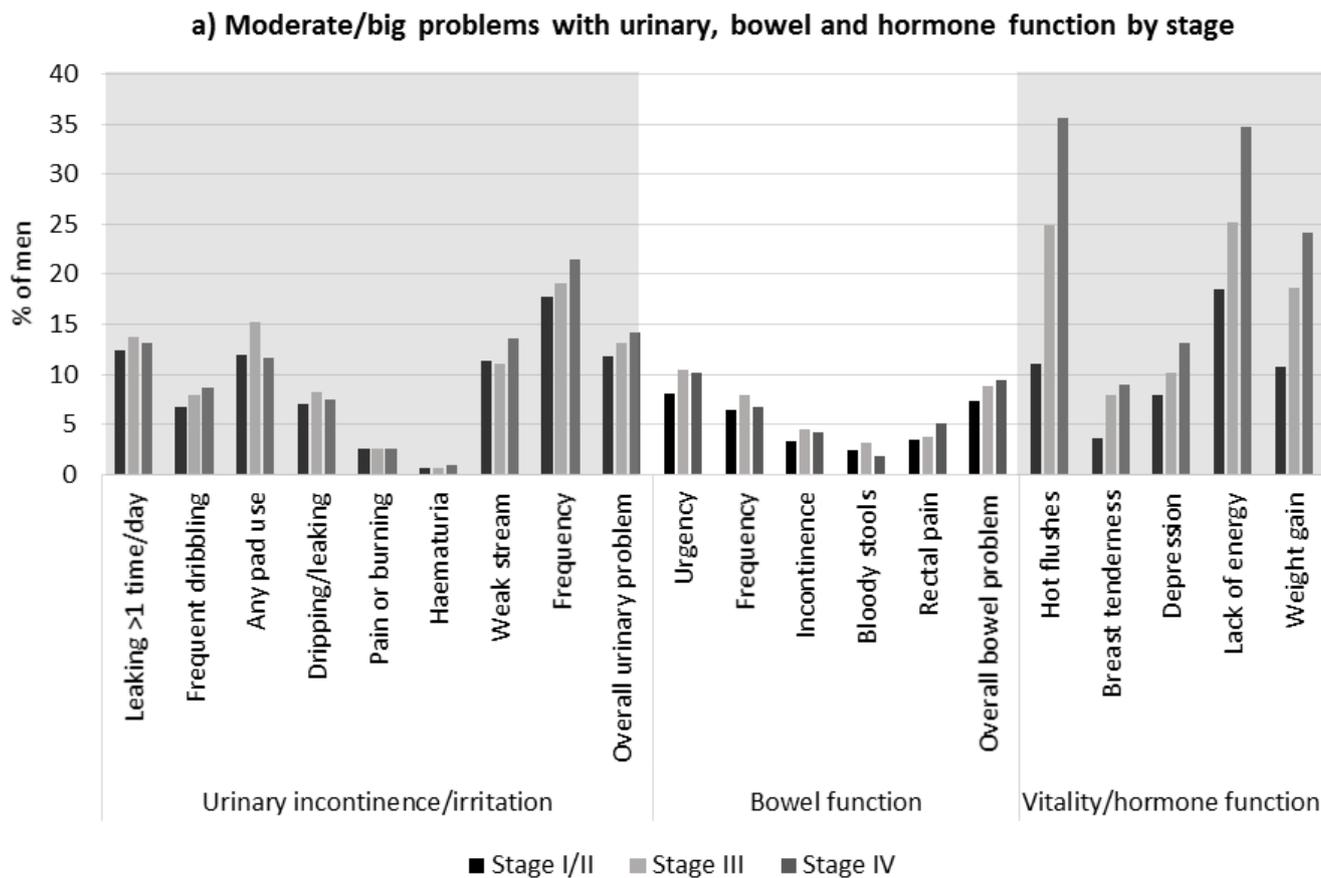
	<i>n</i>	Mean SAH
<i>LAPCD</i>		
Stage I/II	18,055	77.8
Stage III	6,792	76.6
Stage IV	3,759	71.7
Overall	33,370	76.5
<i>General population</i>		
Northern Ireland, 2016 ¹	2,597	77.2
Health Survey for England, 2012 ²	1,016	74.2

SAH: Self-assessed health

¹Northern Ireland General population survey (Donnelly et al. Urinary, bowel and sexual health in older men from Northern Ireland. *BJU Int* 2018. doi: 10.1111/bju.14182).

²Health Survey for England 2012 (NHS Digital. Available from <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/health-survey-for-england-2012>).

Figure 1: Urinary, bowel and vitality/hormone function in men diagnosed with prostate cancer 18-42 months previously



Figures represent predicted adjusted proportions (adjusted for age, socio-economic deprivation and no. of other long-term conditions)

Figure 2: Sexual function in men diagnosed with prostate cancer 18-42 months previously

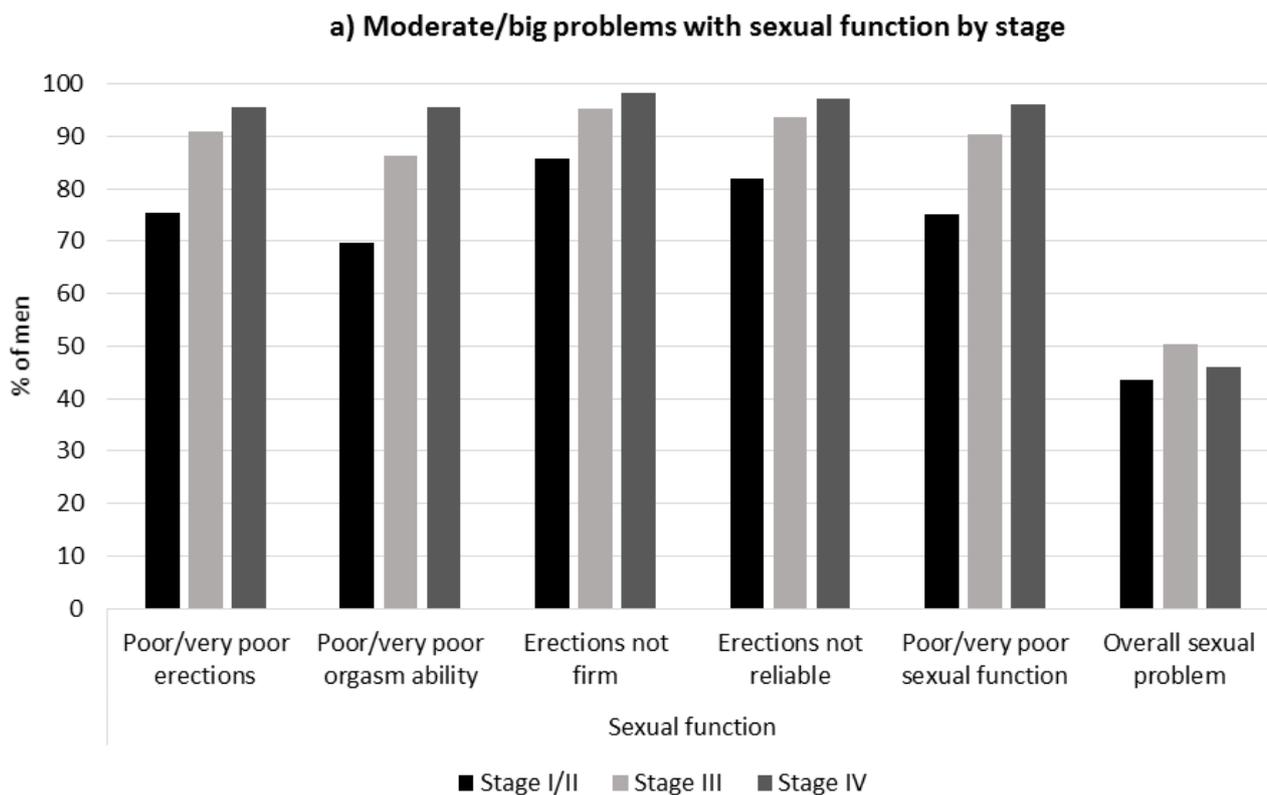


Figure 2a represents predicted adjusted proportions (adjusted for age, socio-economic deprivation and no. of other long-term conditions)

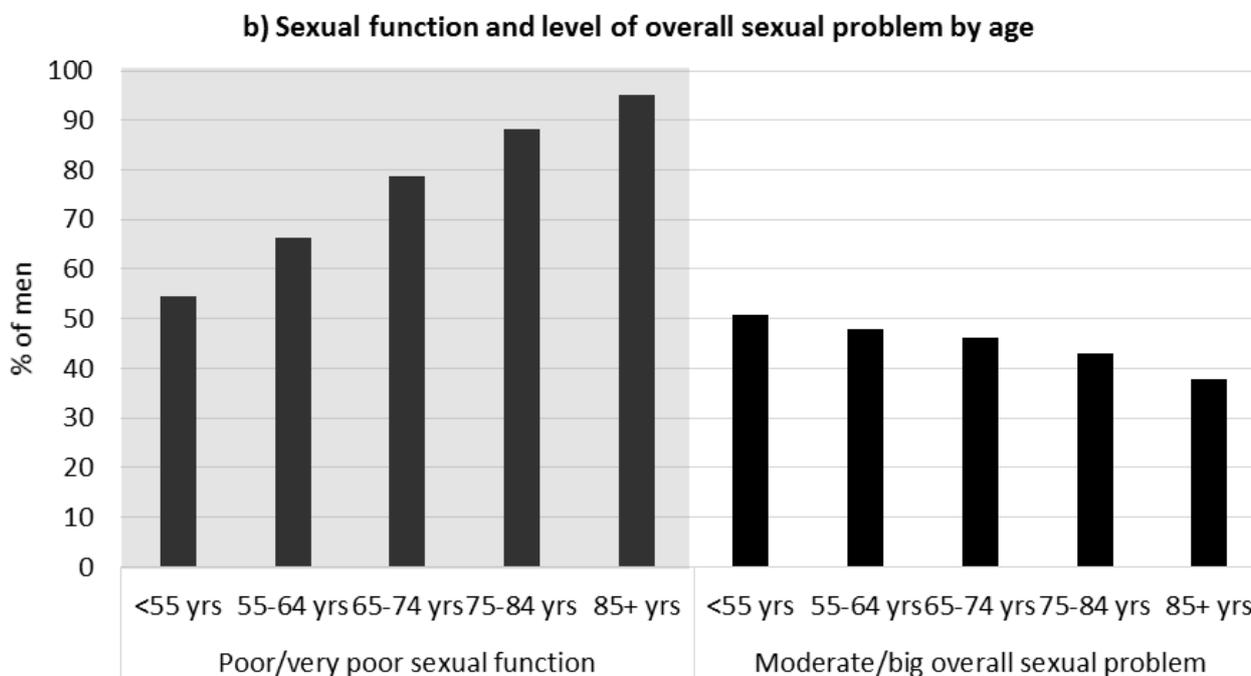
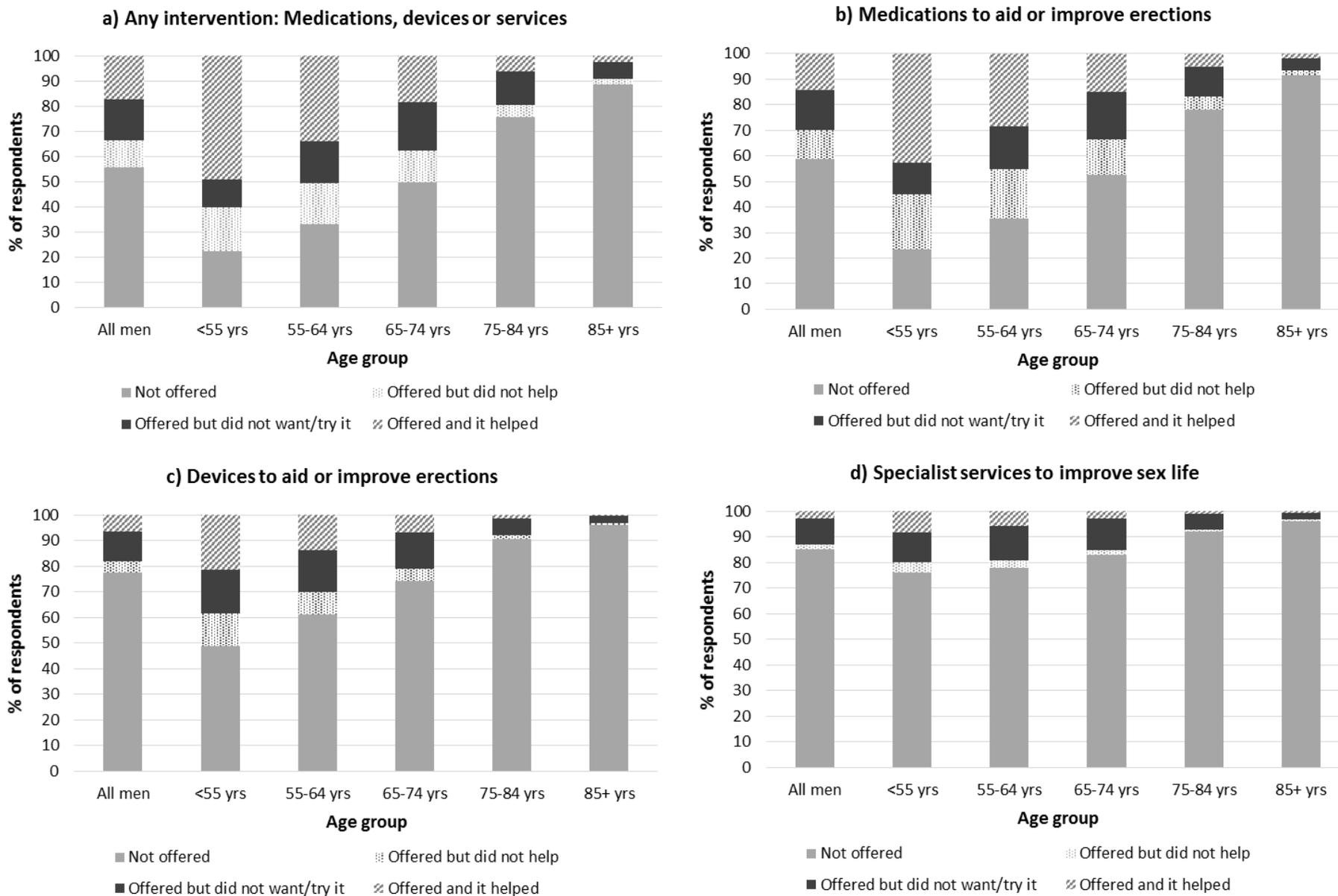


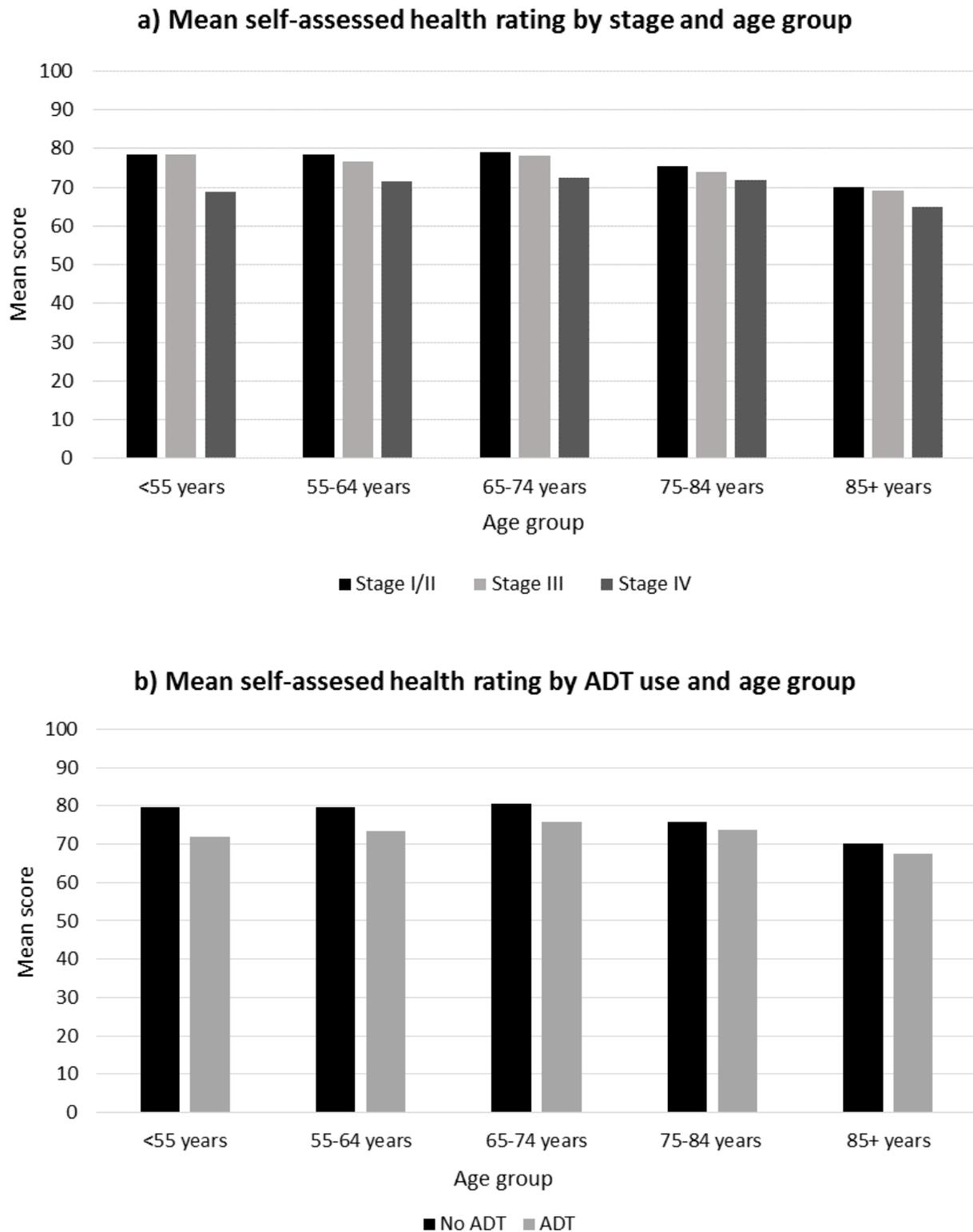
Figure 2b represents predicted adjusted proportions (adjusted for socio-economic deprivation and no. of other long-term conditions)

Figure 3: Use of interventions to improve sexual function by men diagnosed with prostate cancer 18-42 months previously



Figures represent unadjusted proportions

Figure 4: Self-assessed health ratings in men diagnosed with prostate cancer 18-42 months previously



Figures represent predicted adjusted mean scores (adjusted for socio-economic deprivation and no. of other long-term conditions)

ADT: Androgen deprivation therapy

Results should be considered alongside the previously estimated minimally important difference for EQ-5D Self-assessed health (7 points).