FRIDAY THE 13TH
GENITOURINARY CANCERS (GU)
CANCER EDUCATION DAYS

# Resource Package

## Friday, November 13, 2026

This package includes resources as well as specific supports pertaining to the care of Genitourinary (GU) Cancer patients. We invite you to explore the various sections of the package to learn more.

## Questions and Answers

Thank you for your questions during Cancer Education Day: Genitourinary (GU) Cancers. Below is a summary of the questions asked and answers from the speakers during the event.

| Question | Answer |
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| **PROSTATE CANCER** | |
| **Screening, Symptoms & PSA Testing – Dr. Karim Marzouk** | |
| How to differentiate between BPH and prostate cancer since PSA can be elevated in both conditions. | 1. Although the population-based evidence does not largely support rectal examination, as a urologist and a surgeon who operates on prostates, I can get a lot of information from a rectal exam.<br>2. We rely on MRI imaging. If PSA is elevated and you can't tell if it is BPH or prostate cancer, we would rely on MRI, rectal examinations, PSA density, and PSA velocity.<br>3. If still unsure after the above steps are taken, next would be a prostate biopsy if strong clinical suspicion warrants this to be undertaken. |
| We have many men who want testing but would prefer not to have a DRE. What is the conversation to have here? | From a population-based standpoint, the DRE has kind of been debunked. Largely, there is not a lot of great data to show that it is a very powerful tool to use for PSA screening. As a urologist, I can get a lot of information from a DRE, especially a DRE that is very abnormal, which would prompt me to skip the MRI altogether and go immediately to a prostate biopsy. As a urologist, that is part of my day-to-day assessment. In the community, from a primary care standpoint, how helpful would it be? I would say not a lot of great data to support, so if you don't want to do it and the patient does not want to do it, I don't think anyone would fault you on that. If a patient is referred to me for an elevated PSA, as a urologist, this would be a mandatory part of my evaluation. |

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| Would you do an MRI instead of a transrectal ultrasound? | 1. Sure. However, I think our resources will largely not support that. This is a very limited resource, as MRI is used for many other organs, so the wait-time is excessively long and so adding more strain on the system by taking every man for a prostate MRI may not be practical and pragmatic for our healthcare system.<br>2. MRI is as good as your MRI device, so a 3 Tesla MRI is better than a 1.5 Tesla MRI, but also highly subjective and really depends on the expertise of the radiologist. The better quality, and more experience and comfort of the reading radiologist will provide a better interpretation.<br>3. I would limit the use of MRI to elevated PSA, patients who warrant further investigation for assessment of risk of prostate cancer. Widespread use of MRI in the patient population is likely not feasible. |
| We don't typically screen with DRE but asking for PSA just order? | Yes, I agree. In the community setting, if you don't feel comfortable with the DRE or the patient is not inclined, we can rely on just a PSA. |
| Any value of Pmax value given on ultrasound? | In my opinion, probably not. I don't have great data in terms of assessing the estimated predicted PSA values should be based on the volume of the prostate. Not a lot of contemporary showing that is significant or reliable. What is very helpful is the actual volume, so when we get that, we take that into consideration with calculating other metrics such as the PSA density. There can be some interobserver variability depending on where the calipers are placed around the prostate, so for me personally I think the volume of the prostate would be the most important information to take away on an ultrasound. |
| **Radiation Treatment for Prostate Cancer – Dr. Adrian Cozma** | |
| In terms of the fractionation you addressed, hypofractionation, so the 5 radiation sessions for prostate cancer versus standard fractionation of the 33, strictly based on disease aggressiveness, so we don't treat high-risk or high-grade disease with hypofractionated doses? | Historically, the way we have done it, because patients that are more favorable tend to have better outcomes to begin with, there is more potential for us to trial and try to reduce the number of treatments for that patient population because we are likely to be successful in either indication. Much of the work in reducing the number of treatments initially happened with lower, more favorable risk prostate cancer patients. In the UK there is a trial that compared hypofractionated, which is 20 treatments of radiation, versus 5 fractions of SBRT delivered every other day. That particular clinical trial showed us that delivering radiation every other day over 5 treatments was actually equally successful from an oncologic perspective without a significant increase in toxicity. A lot of the data for SBRT or ultra-hypofractionated is from the low/favorable to intermediate risk category. More clinical trials now are increasingly using it in unfavorable intermediate risk and high-risk, and that is something that we are developing at our centre as well. It has primarily been the more favorable indications and now it is expanding to more aggressive |

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| | indications as well. Some centres are now exploring the possibility of doing brachytherapy, which is single implant plus 5 treatments of SBRT, which would be a total treatment duration of 6, versus 25 or in the past 39. We are really getting more and more comfortable with reducing the number of treatments, but that is based primarily on more favorable indications first and now expanding to the high-risk categories as well. |
| **Hereditary Cancer Risk in GU Oncology – Mrs. Sarah Muir** | |
| Would a male person be eligible for HCT testing if their maternal side grandfather and uncle both have prostate cancer? | Whether there is history on the maternal or paternal side, is equally weighted. There is no preference if somebody's maternal grandfather versus paternal grandfather (for example) had prostate cancer. Genetically, men and women are equally at risk to inherit these pathogenic variants generally in the cancer space. If the patient themselves are unaffected but have family members with a cancer history, more information would be required (such as pathology of the prostate cancer). The patient would certainly be eligible for a referral to genetics for assessment, but likely the individual who has had the cancer themselves is going to be the best first person in the family to have that genetic testing because they would be the one most likely (if there is the germline mutation) be the place to find it first. Then there could be more targeted testing offered for the rest of the family. |
| Can we assume that cancer patients seen through WRCC have had available genetic testing? | Not necessarily. Information about when a referral to Genetics, or when genetic testing is indicated, is circulated and shared with the Cancer Program, oncologists and other providers. Often, they will be appropriately assessed, but not always, especially if somebody was seen in the past, criteria does change over time for who is eligible. If somebody is going through active cancer treatments, generally evaluation for the need of genetic testing is something that would be done during their course here. However, if their course has finished and they haven't had any genetic testing, but you as their primary care provider may still be suspicious that they might meet criteria or they want that genetics evaluation, I would always encourage a referral to the Cancer Genetics Program. We can confirm if any testing was done or if it needs to be done. |
| **KIDNEY CANCER** | |
| **Management of Renal Malignancies – Dr. Haider Abed** | |
| No questions were asked. | |
| **Bosniak Classification of Renal Cystic Masses Imaging and Follow-up – Dr. Youssef Almalki** | |
| We encounter patient populations that are elderly, they have very poor kidney function with a low eGFR and sometimes struggle when we find indeterminate findings on an ultrasound. Any advice or tips for this patient | 1. The debate about whether contrast actually should matter in terms of renal function. We are incrementally moving away from using renal function to determine who can get contrast and who doesn't. With an eGFR of 20 and not on dialysis, we might actually give contrast if you're interested |

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| population (let's say they have an eGFR of 20, as this is quite common). What should we do here? | in characterizing it more and it is going to make a difference in terms of management.<br>2. You could do ultrasound as surveillance in six months to see if it changes at all. It depends on the look of the mass. If it looks like it is a II or a IIF on ultrasound, we are going to be less concerned. If it is a looking like a III or a IV, then we are going to be talking about imaging options or biopsy. |
| I find personally there is a lot of heterogeneity in terms of the reporting (diagnosers versus describers). I find people are moving away from the Bosniak classification system, when it's indeterminate. Any comments? This classification seems fairly clear-cut but a lot of subjectivity so sometimes we get reports describing thickening and partial enhancement but do not provide a score. What is being disseminated now to radiologists in terms of the classification and are these more suggestions or should we really be sticking to numerically categorizing? | Nothing is cookie-cutter. We were always taught to beware of the radiologist with a ruler. There is variability in terms of measurement. Communicate back to the radiologist when you feel it is not clear, as opposed to just leaving it. You can ask if the radiologist feels it is Urology worthy or follow-up worthy. |
| **BLADDER CANCER** | |
| **Presentation, Epidemiology & Risk Factors – Dr. Christopher Langley** | |
| What can we do as family practitioners to assist with workup? For example, for microscopic hematuria. | The important thing is making sure they actually have microscopy. Although the incidence of cancer is not incredibly high, you don't want to miss those patients. If I receive 100 referrals a month, I can't narrow it down to who actually truly has microscopic hematuria. I usually send something back asking for microscopy and cytology. If the microscopy or cytology is positive then refer the patient back. Approximately 50% of the time they will have the microscopy done and it's actually negative and no need for referral. Including a creatinine is also helpful, as these patients are usually older and are going to need a CT scan and would need a creatinine. Having a cytology is helpful as well. A patient with a positive cytology will likely go directly to a scope and be booked within a few weeks without having to be seen in the office first.<br><br>We recognize that it's getting harder to get CT scans, especially the CT Urogram being the gold standard for evaluating the upper tracts. In patients with microscopic hematuria that have low risk factors, a renal ultrasound will do, but having all of these investigations done beforehand really can help expedite the workup and bring the patient to cysto.<br><br>If the patient has gross hematuria, you can order CT Urogram but do not delay referral to a urologist while waiting for results. |

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| From a DI point of view CTU is very table-time intensive. | We have been asked by our radiology colleagues if we can skip one of the phases, but unfortunately, it's the delayed phase that is the most important to the urologists. In the higher-risk patient population is really makes all the difference. In order for us to confidently tell the patient that everything is fine. If the CT looks clean and the scope is clear then we can reassure our patients that there is minimal risk from a malignancy standpoint. |
| **Systemic Therapy in Bladder Cancer Treatment – Dr. Sindu Kanjeekal** | |
| Are the endocrine side effects, such as diabetes (insulin dependent), reversible once you come off immunotherapy? | It is variable. If you recognize it sooner rather than later you can treat with usually steroids for immunotherapy related. Usually, the treatment is anti-immunosuppressives. Sometimes it can resolve completely and it goes away, other times it remains; especially endocrine ones. I find diabetes is not so common but I would say hypothyroidism is very common and some people need to be on a small amount of thyroid replacement. |
| We obviously see the efficacy and very impressive results we can get with immunotherapy in bladder cancer, in terms of eligibility in patient subpopulations that may already have some autoimmune disease (such as Crohn's, rheumatoid arthritis, psoriatic arthritis), what is the appetite from the medical oncologist point of view in terms of initiating this patient population on biotherapies? | We used to think of it as almost a contraindication and say that we can't do it, but now as we have had so much experience with the drugs, I think it not an absolute contraindication. If somebody would really benefit from immunotherapy, I think most of us would assess how severe the underlying autoimmune disease is, is it under good control? I would speak with our rheumatologist to indicate my thoughts on starting this, ask their opinion, and often I think we would give it a try if it was important enough. |
| For our primary care colleagues, what would you like to see as they are about to start immunotherapy? Should they be followed a bit more closely and what are things they should be looking for? | We need to work on better communication with our primary care partners. The primary care teams are way better at managing diabetes, thyroid disorders, hypertension, cardiovascular risk factors more than an oncologist. We really need primary care involved and I think we could do a better job of sharing what we need you to focus on and spend time with those patients. |
| **Post-Treatment Care for Urologic Cancer Patients – Dr. Victoria Turnbull** | |
| We get a lot of post-treatment care referrals for patients post-prostatectomy or post-radiation therapy for prostate cancer. What kind of ancillary support services would you feel would be best served for prostate cancer patients? Are there services in London that we may like to see here in the Windsor-Essex County region? | One of the services we have in London is a dedicated pelvic floor physiotherapist, who is a male, which I do think helps male patients feel a little more comfortable in an uncomfortable environment. His entire focus is post-radical prostatectomy and pelvic floor physiotherapy. Patients get in quickly, and are provided with a really good plan. We all have an idea of what the exercise plan looks like, what the routine is and when we expect the patient to start doing better. Having this service and expertise is important.<br><br>Another service would be an intracavernosal injection teaching program. Providing an expedient way for patients to learn ICI therapy. Being able to have that teaching on-hand quickly and |

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| | easily is a nice way to facilitate care and make them feel a little less uncomfortable.<br><br>Another one thing we are still missing as part of survivorship is a post-cancer treatment sexual counselling expert. We are lacking this in our region. As urologists we aren't very good at that, we are mostly surgical, and we are asked to oversee some of these. |

## Erie St. Clair Region Cancer Clinic Webpages

- The cancer clinics below provide exceptional cancer care to residents of Sarnia-Lambton, Chatham-Kent and Windsor-Essex:
  - Bluewater Health Cancer Clinic
  - Chatham-Kent Health Alliance Cancer Clinic
  - Erie Shores HealthCare – Satellite Site
  - Windsor Regional Cancer Centre
    - To refer a patient to the Windsor Regional Cancer Centre, complete the New Patient Referral Form and **fax to 519-253-5364**.
- My Cancer Journey has been developed by patients, family members, and our care team to guide your patients through the cancer experience. It includes directions to the Windsor Regional Cancer Centre, important phone numbers, what to bring, and community resources in addition to other helpful information.

## Prostate Cancer

Prostate cancer is the abnormal growth of cells in the prostate gland, a small walnut-sized organ that produces semen. It is the most common cancer among men in Canada, primarily affecting older adults. Most early-stage prostate cancers grow slowly and are often treatable if caught early.

**Canadian Cancer Society:**

- What is prostate cancer? | Canadian Cancer Society
- Symptoms of prostate cancer | Canadian Cancer Society
- Diagnosis of prostate cancer | Canadian Cancer Society
- Grading prostate cancer | Canadian Cancer Society
- Stages of prostate cancer | Canadian Cancer Society
- Prognosis and survival for prostate cancer | Canadian Cancer Society
- Treatments for prostate cancer | Canadian Cancer Society
- Supportive care for prostate cancer | Canadian Cancer Society

**Cancer Care Ontario:**

- Prostate Cancer Diagnosis Pathway Map
- Prostate Cancer Treatment Pathway Map
- Prostate Cancer Follow-Up Pathway Map

**Ontario Men's Health:**

- Prostate Cancer in Canada and PSA Testing - Ontario Men's Health

**Prostate Cancer Foundation Canada:**

- Prostate Cancer Foundation Canada

## Erie St. Clair Regional Cancer Program – Cancer Genetics Program

Genetic testing for genitourinary (GU) cancers, including prostate, bladder, and kidney cancers, helps identify hereditary predispositions, guides targeted therapies like PARP inhibitors, and determines the risk for family members.

**Erie St. Clair Regional Cancer Program – Cancer Genetics Program:**

- Genetics_Referral_Form_July_2026.pdf
- Referral Guidance for Hereditary Cancer Genetic Assessment
    - This program offers genetic counselling and testing for families at risk for inherited forms of cancer.
    - If you think that your patient's personal and/or family history of cancer may be genetic, please complete the referral form and **fax it to 519-255-8688**.
    - Please be advised that the Cancer Genetics Program **does not accept self-referrals**. All referrals must be received from a physician or nurse practitioner.

**Why Genetic Testing Matters in Genitourinary Cancers:**

- Prostate Cancer: Germline testing (often utilizing genes such as *BRCA1*, *BRCA2*, and *ATM*) is recommended for those with metastatic or high-risk disease. Positive results unlock specific targeted therapies and prompt earlier screening for family members.
- Bladder and Upper Tract Urothelial Cancers: Testing can identify mutations in DNA damage repair genes, which may guide personalized treatment options and influence immunotherapy response.
- Kidney Cancer (Renal Cell Carcinoma): Testing identifies hereditary syndromes such as von Hippel-Lindau (VHL) disease or Birt-Hogg-Dubé syndrome, allowing for specialized, proactive surveillance of other organ systems.

## Kidney Cancer

Kidney cancer is a disease where abnormal cells in the kidneys grow uncontrollably to form a tumor. The most common type is renal cell carcinoma (RCC). Because the kidneys are deep within the abdomen, early-stage kidney cancer rarely causes noticeable symptoms.

**Canadian Cancer Society:**

- What is kidney cancer? | Canadian Cancer Society
- Symptoms of kidney cancer | Canadian Cancer Society
- Diagnosis of kidney cancer | Canadian Cancer Society
- Grading kidney cancer | Canadian Cancer Society
- Stages of kidney cancer | Canadian Cancer Society
- Prognosis and survival for kidney cancer | Canadian Cancer Society
- Treatments for kidney cancer | Canadian Cancer Society
- Supportive care for kidney cancer | Canadian Cancer Society

**Cancer Care Ontario:**

- Kidney Cancer | Cancer Care Ontario
- ORN | Ontario Renal Network

**Kidney Cancer Canada:**

- Main Home | Kidney Cancer Canada
- Free resources for patients and caregivers | Kidney Cancer Canada

**Bosniak Classification:**

- CUA_guideline_on_the_management_of_cystic_renal_lesions.pdf

## Bladder Cancer

Bladder cancer starts when cells in the lining of the bladder grow out of control, eventually forming tumors. The most common warning sign is blood in the urine, making it critical to seek medical evaluation if you notice this.

**Canadian Cancer Society:**

- What is bladder cancer? | Canadian Cancer Society
- Symptoms of bladder cancer | Canadian Cancer Society
- Diagnosis of bladder cancer | Canadian Cancer Society
- Grading bladder cancer | Canadian Cancer Society
- Stages of bladder cancer | Canadian Cancer Society
- Prognosis and survival for bladder cancer | Canadian Cancer Society
- Treatments for bladder cancer | Canadian Cancer Society
- Supportive care for bladder cancer | Canadian Cancer Society

**Cancer Care Ontario:**

- Bladder Cancer | Cancer Care Ontario
- CCOBladderPathwayMap.pdf

**Bladder Cancer Canada:**

- Bladder Cancer Information | Bladder Cancer Canada
- Upper Tract Urothelial Carcinoma | Bladder Cancer Canada

## Testicular Cancer

Testicular cancer begins when cells in the testicle grow abnormally, usually forming a painless lump. It is the most common cancer in young adults, but it is highly curable and treatable if detected early.

**Canadian Cancer Society:**

- What is testicular cancer? | Canadian Cancer Society
- Risks for testicular cancer | Canadian Cancer Society
- Symptoms of testicular cancer | Canadian Cancer Society
- Diagnosis of testicular cancer | Canadian Cancer Society
- Stages of testicular cancer | Canadian Cancer Society
- Prognosis and survival for testicular cancer | Canadian Cancer Society
- Treatments for testicular cancer | Canadian Cancer Society
- Supportive care for testicular cancer | Canadian Cancer Society

**Testicular Cancer Canada:**

- Testicular Cancer Canada

**Thank you for joining us for Cancer Education Day: GU Cancers!**
**We hope to see you at our next event on Friday, February 12, 2027, focused on Breast Cancers.**