American Urological Association

Journal of Urology®

The PINK JUICE Is Worth the Squeeze: The Cost of Open and Why It's Worth Every Penny

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I’m About to Go a Little Rogue…

- But I promise you, it’s worth it
- “This is how we’ve always done it…”
- Open peer review got me thinking → open, transparent, accessible, engaging
- How do we involve as many people as possible in our processes?
- Open is the right thing to do, but it’s not always the cheapest or the easiest!
- Because this is the GW Ethics Conference, and we are talking about the right thing to do!

A CLOSER LOOK AT OUR PUBLICATIONS

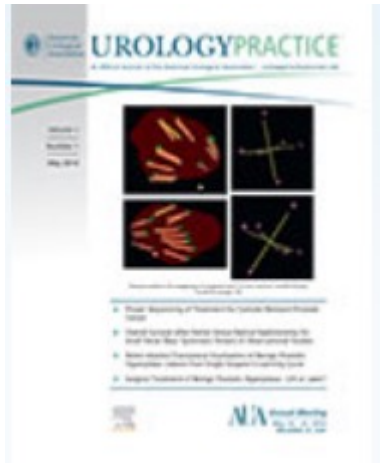
- 3 Peer-reviewed journals (JU, UPJ, JUOP)
- JU is our flagship journal
- 1 CME product (Update Series)
- 1 Member newsletter/digital ecosystem (*AUANews*)
- 4 Annual Meeting products (Annual Meeting Program Book, JU abstracts, *AUA Daily News*, AUA Awards Dinner program)
- Internal AUA messaging – emails, reports, presentations

WHERE WE WERE

- *The Journal of Urology*® launched in 1917
- Very little Editorial Board engagement
- COVID-19 and Jennifer Regala both arrive in 2020
- Dr. Robert Siemens selected as Editor in fall 2020

What Did Our Publications Look Like 3 Years Ago?

From Crusty and Dusty to Best in Class



American Urological Association

Publications

WHERE WE ARE

- Excellent leaders are not afraid of change
- Greater Editorial Board engagement = more opportunity for voices to be heard
- Expanding the size of the table gives more people a seat
- Creating an environment where innovation and inclusion are expected
- Talking often within and beyond our Editorial Boards
- Our Editors of our four scholarly publications have a bond like none I've ever seen

WHERE WE'RE GOING

- We will remember that DEI is NOT a box to be checked
- We understand that meaningful DEI efforts are never exclusive
- We will learn from each other and from others
- We will use the resources other organizations have provided as a roadmap
- We will provide transparent and consistent reporting
- We will collaborate our efforts with other journals

OPEN PEER REVIEW

- Historically, single-anonymous peer review has been used by *The Journal of Urology®*
- Double-anonymous peer review? NO, here's why…
- Open peer review launched as of November 1, 2021
- But wait. How are we defining open peer review? And how will it evolve?
- Goals: transparency, inclusivity, education
- Negative effects? Decline in review acceptances?
- Almost 2 years in, what's next?

ANATOMY OF OPEN PEER REVIEW

THE JOURNAL of UROLOGY®

- Peer Review Report -

Original Submission:

Reviewer #1:

Major:

This is a single-institution retrospective analysis of local recurrence after penile sparing surgery for localized penile cancer with specific emphasis on evaluation of the role of PeIN at the surgical margin. This is interesting and important work, and you should be commended on your efforts. While overall, I have no other major methodological concerns, I am interested in the pathologic staging as described by the authors. Given the start of the series in 2006 and follow-up ending in 2020 the TNM staging for penile cancer has undergone revision, most recently in 2018 with important stratification for the T1 group based on presence of LVI. In this analysis, patients are presented as being T1 overall, T1a and T1b - while certainly the original staging in 2006 did not make this characterization, this pathological distinction was made based on prognostic data and the patients in this cohort should be re-stratified to reflect this. If this data is not available for some patients, this should be mentioned in the text and discussed in limitations.

Minor:

Results line 3 should read "PeIN was introduced at our centre after".

Discussion line 15 should read "imiquimod and 5-fluorouracil or YAG and CO2 laser".

Conclusion Spell out the abbreviations not introduced in paper surgical margin and local recurrence.

Reviewer #2:

This concise report of single-institution data associating PeIN at the margin of resection after penile-sparing surgery with higher local recurrence rates highlights a void in the literature describing outcomes after surgical management of PeIN and may inform follow up and surveillance strategies as well as raise debate regarding the role of adjuvant topical therapy after resection.

Were patients prior to 2016, when standardization of PeIN reporting commenced, excluded? If so, would be more accurate to state that this cohort included patients treated between 2016-2020 in the methods and results.

In the methods, please clarify whether PeIN at the margin was diagnosed on final pathologic specimens or could have been diagnosed intraoperatively. Have you correlated intraoperative frozen diagnosis of PeIN with confirmation on final path, as this may further inform surgical strategy and the role of frozen section confirmation of negative margins during penile-sparing surgery.

Please also expand upon clinical follow up (physical exam vs utilization of cross-sectional imaging for surveillance) and define criteria for local recurrence in the methods. Was local recurrence confirmed

THE JOURNAL of UROLOGY®

- Peer Review Report -

pathologically in all patients or diagnosed based solely on physical exam or imaging?

Recommend reporting the prevalence of PeIN overall in addition to PeIN at the surgical margin. Was the presence of PeIN also associated with local recurrence or only if it was noted at the margin?

Would also report HPV status as this is associated with undifferentiated PeIN and could be represent a confounder of recurrence.

With 41 recurrence events, the multivariable model is at risk of being overfit to examine this many variables. G1/2 could be combined to reflect low-grade. It is unclear and unexpected based on prior data why higher grade tumors would have a lower recurrence risk. Please comment on this in the discussion.
Did you examine differences in PFS, CSS, or OS? Given the risk of progression in the setting of local recurrence, a difference in these outcomes would further emphasize the clinical implications of this data.
The discussion overstates "that PeIN is probably the only or at least the most important risk factor for local recurrence" based on single-institution retrospective data.

Minor corrections:
Results line 1 - correct penile cancers to its pleural form.

Correct spelling of Kaplan Meier in Figure 1 legend. Also recommending removing gridlines and clarifying unit (months) to time on x-axis.

Maintain consistency in the capitalization of PeIN throughout the manuscript (correct in Results paragraph 2, line 1 and Table 1).

Reviewer #3:

You present a retrospective analysis on the local recurrence rate for men with a + PeIN at the surgical post penile-sparing surgery. Local recurrence rate was higher in PeIN at the surgical vs those with a negative margin. Given that a positive margin is widely considered a risk factor for recurrence, I do not find this paper to add further insight into penile cancer care.

Reviewer #4:

You provide a retrospective review of nearly 1000 men who underwent penile sparing surgery at single quaternary care center in England. 15% of men had a positive surgical margin for PeIN which was associated with a twofold increase in local recurrence. This data suggests that patients with PeIN positive surgical margins would likely benefit from closer surveillance and potentially adjuvant therapy.

ANATOMY OF OPEN PEER REVIEW

THE JOURNAL of UROLOGY

- Peer Review Report -

A few brief questions/comments:

1. Do you have information on HPV status? If so can this be included.

2. Do you have information on presence of LVI and primary surgical treatment stratified by recurrence? Did these factors impact recurrence rates?

3. Did patients with PeIN+ margins receive any adjuvant therapies (topical, laser etc) or were they all just surveilled until recurrence?

4. Can you provide information on stage/grade of recurrence. Where these patients able to be treated with penile sparing therapies at time of recurrence or did they require penectomy, groin dissection, etc.

Editor's Comments:

We appreciate this submission on a poorly investigated topic. You are to be commended. In addition to the comments from external reviewers, we would ask for you to pay careful attention to reporting guidelines for statistics (Assel et al, PMID 30537407) and figures/tables (Vickers et al, PMID 32441187) to ensure appropriate reporting overall, although the submission is generally well reported throughout common issues include lack of consideration of guidelines 2.4, 2.5, 4.1 and 4.2.

Revision 1:

Reviewer #5: Guidelines for Reporting of Statistics for Clinical Research in Urology: https://www.auajournals.org/doi/10.1097/JU.0000000000000001

Guidelines for Reporting of Figures and Tables for Clinical Research in Urology: https://www.auajournals.org/doi/full/10.1097/JU.0000000000001096

1. Please refer to the guidelines for reporting of statistics linked above. Specifically please refer to guidelines 4.11, 4.12, 4.13, 4.14, and 4.15 and revise accordingly.

2. How were missing data handled in the Cox regression?

3. "After a median followup of 2.8 years, men with PeIN had an earlier risk of local recurrence compared to men without PeIN (median of 14 years compared median not reached, p=0.027, figure 1). I think this means: median followup in those without PeIN was 14 years, median follow up in those with PeIN was 2.8 years. If so, please revise to make the sentence more clear. I'm not sure to what "median not reached" is referring. If the p-value is coming from the log-rank test, please clarify and interpret it accordingly.

4. Be more specific about how patients are being censored. Are deaths being censored? Censoring at time of death may violate the assumption of the noninformative censoring and may lead to bias.

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- Peer Review Report -

Consider treating death as a competing risk. See Guideline 4.13.

5. Please report the date of last followup.

6. I was expecting to see p-values in Table 1 based on language in the "Statistical analysis" section. Please add p-values or revise the language.

Chief Statistician:

1. Don't split table 1 by relapse (a time-dependent outcome), consider instead splitting by PeIN surgical margins.

2. A hazard ratio of 2 doesn't mean a doubling of risk, please update your language.

3. Please do not superimpose p-values onto the KM figures and update the x-axis label (see guideline 3.7.7 and 3.7.27; https://www.auajournals.org/doi/10.1097/JU.0000000000001096).

Revision 2:

Reviewer #5: Thank you for performing a competing risk analysis of this data and revising the statistical methods accordingly. Please resolve the following minor items.

1. Specify that you conducted a complete-case analysis for the Fine Gray model (removed patients who had missing data) in the "statistical analysis" section.

2. It is not clear to me whether the median of 2.8 years of follow-up is specific to those who had recurrence or the entire cohort. Please report median follow-up time for those without an event. See Guideline 4.12.

3. "In 7/2021" makes it sound like all events happened in this one month. Consider removing the date from that sentence and adding the specific dates (date of first surgery and date of last follow-up) to the section "Follow-up".

Chief Statistician: Please update the statistical methods section per guideline 4.13.

Consultants and Editors contributing to the peer review process for this article were Melissa Assel, Peter E. Clark, Maria Masotti, Bogdana Schmidt, D. Robert Siemens, and three anonymous reviewers.

ENCOURAGEMENT OF OPEN DISCUSSION

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www.auajournals.org/journal/juro

Special Article

JU Insight

AUA Diversity & Inclusion Task Force: Blueprint and Process for Justice, Equity, Diversity and Inclusion

Simone Thavaseelan, Arthur L. Burnett II, Sam Chang et al.

Correspondence: Simone Thavaseelan (email: simonethavaseelan@gmail.com).

Full-length article available at auajournals.org/10.1097/JU.0000000000002813.

Study Need and Importance: Urologists have a duty to provide high urological quality care to all patients. A growing body of evidence demonstrates that individuals from marginalized groups experience inequities in all areas of health. Such disparities begin with inadequate access to urological care and extend through experiences within the health care system, all of which ultimately widen gaps in morbidity and mortality for entire communities. As a leading professional organization in urology, the American Urological Association (AUA) has a duty to recognize the scope of these issues related

ongoing AUA D&I initiatives and reports on the 14 recommendations made within the framework of the 5 focus areas of Just and Inclusive Environment, Diversity in the Workforce, Structural Competency, Advocacy and Research (see Figure).

Limitations: The AUA D&I Task Force recognizes that this list of recommendations is not exhaustive and represents only the start of an ongoing process of pursuing diversity, equity and inclusion within the AUA. In order for these Task Force recommendations to be effective, our organization will need to

ENCOURAGEMENT OF OPEN DISCUSSION

JU Forum

THE JOURNAL of UROLOGY®
www.auajournals.org/journal/juro

Taking a Stand: No Conferences in Anti-abortion States

Key Words: ethics; abortion, legal

After the fall of Roe v. Wade, there has been growing concern over the impact of restrictive abortion laws in various states across the United States. These laws have significantly limited women's access to reproductive health care services, including safe and legal abortion. Amidst this backdrop, it is crucial to examine the ethical implications of hosting our professional meetings in states where such access is severely restricted or even nonexistent. The impact on female physicians attending these meetings deserves attention, as they face challenges to their well-being and professional advancement. As we look towards the American Urological Association and Society of Urologic Oncology meetings scheduled for San Antonio and Dallas, Texas, in 2024 this is especially relevant.

In Texas on August 25, 2022, the "Human Life Protection Act" took effect which provides that a "person may not knowingly perform, induce, or attempt an abortion unless the mother has a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places her at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced."[1] As issued by the Attorney General of Texas, "a person who violates the Act commits a first-degree felony if an unborn child dies as a result, a second-degree felony if the child lives, incurs civil penalties of no less than $100,000 for each violation, and may lose his or her professional license."[1]

These laws have far-reaching implications for the citizens of Texas, and for potential visitors to the state. The vaguely worded abortion ban has created confusion and fear among patients, physicians, and hospitals leading to long-term health consequences and threatening women's lives. In a lawsuit filed in Texas, 13 patients and 2 obstetricians have sued the state after patients were denied timely abortion care despite developing complications leading to nonviable pregnancies.[2] In these cases, patients were forced to wait until they developed septic shock to receive what was previously deemed standard of care or travel out of state to protect their lives and future fertility.

The urologic workforce is increasingly female, growing from 7.7% of all practicing urologists in 2014 to 11.6% in 2022.[3] The majority of this growth is unsurprisingly within the youngest demographics; women represent 24.5% of all practicing urologists under 45 years of age compared with 13.1% of those 45-54 years of age, 5.6% of those 55-64 years of age, and only 1.3% of those 65 years or older.[3] Given that the majority of the female workforce is of childbearing age, conducting meetings in states with stringent reproductive laws assumes heightened significance. Data from a study published in *JAMA Surgery* demonstrated a higher likelihood of major pregnancy complications among female surgeons compared to nonsurgeons, with 48.3% of female surgeons developing a major complication compared to 27.2% of their nonsurgeon counterparts.[4] Notably, 42% of female surgeons experienced a pregnancy loss and among these, 84.4% experienced this loss at less than 10 weeks' gestation, 31.8% between 10 and 20 weeks' gestation, and 3.8% experienced a loss at 20 weeks or later.[4] These data highlight the potential for sudden, devastating, and catastrophic events to occur at any point during the pregnancy, emphasizing the absolute requirement for uninterrupted access to appropriate reproductive care.

Conferences serve a crucial function for professional development and are especially important in the early stages of career development. Simply asking female urologists to not attend because they would be unable to access necessary medical care is an unreasonable expectation. Meetings facilitate networking, knowledge sharing, and allow for the presentation of novel research. As the vast majority of women in urology are in the earlier stages of their careers, these meetings are especially meaningful for cementing of collaborations and creating a professional research reputation. Moreover, there are overwhelming data on the lack of female presenter representation in meetings and so hosting meetings in challenging locations will only exacerbate this underrepresentation.[5] For women to have to choose between their potential well-being and their professional

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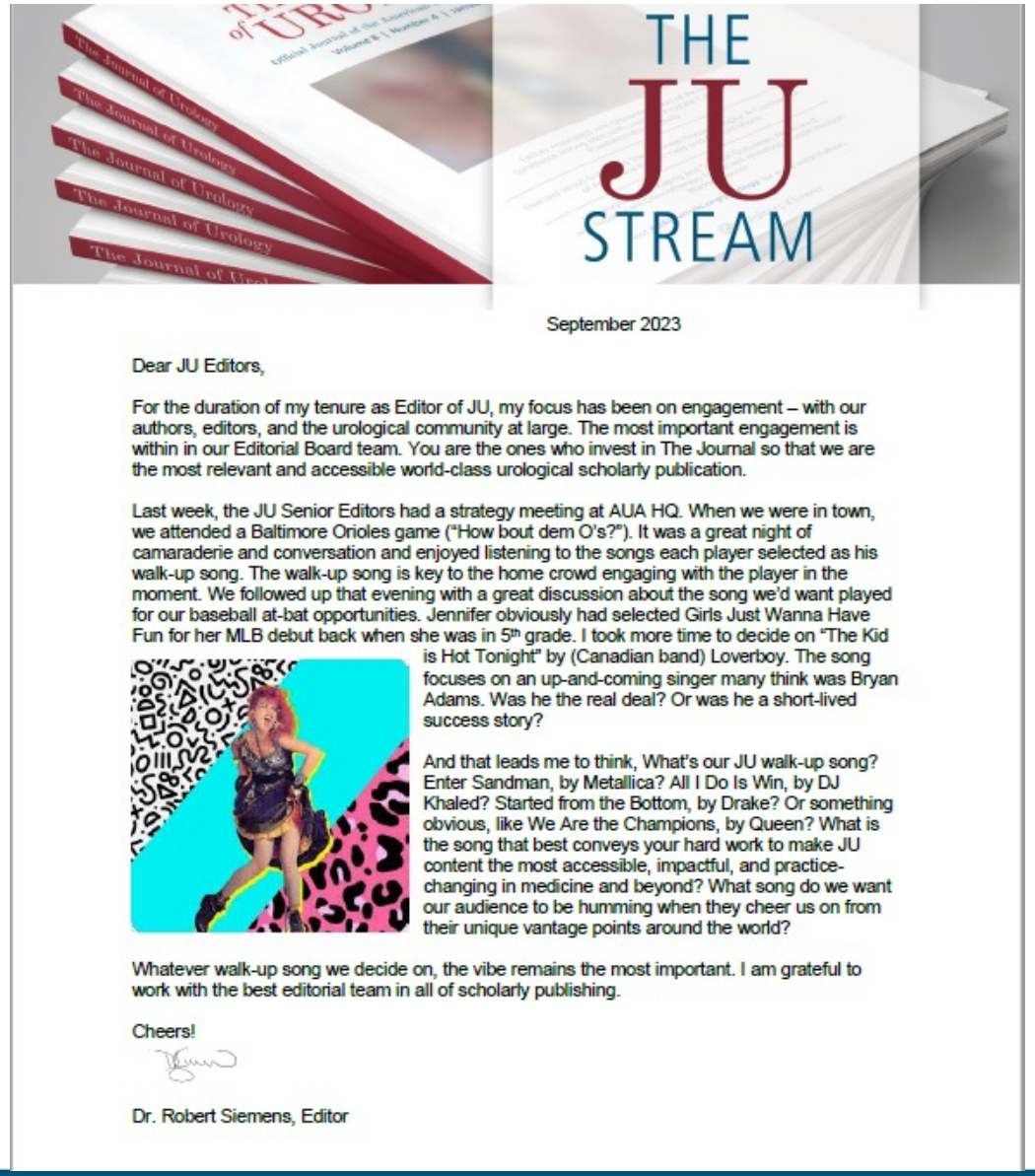
THE JU FANNY PACK

- More than just a fanny pack
- Community building
- Accessibility
- Tangible outcomes: pre-submission inquiries, more reviewers, more interest in editorial leadership



EDITORIAL BOARD ENGAGEMENT

- Editorial Board newsletter – boring stats with fun tidbits (JU Pet of the Month and more)
- In-person meeting 1x/year; Zoom the rest of the year
- Senior Editors meet in person for a strategy meeting 2x/year
- Small group meetings (including the HEAD Table)
- Engagement extends to other journals in the AUA family

EARLY CAREER EDITORS

- **WHO are the ECEs?** “Early career” urologists serving in major topic areas plus online content promotion
- **WHY did you start this program?** Editorial Board training, cultivation of diverse voices, representation of all career levels
- **WHEN are they selected/how long do they serve?** January 1; 2-year term, not renewable
- **WHERE do the ECEs fit in on the Ed Board?** They fit into all aspects of EB life: policy decisions, EB meetings, strategic thinking
- **WHAT do they do?** Editorial consultations, peer review training, ambassadors for the journal, other JU-related speaking engagements
- **HOW do we train them?** Mentorship, frequent small group meetings, individual training, lots of time with our EiC, and inclusion as true team members

Health Equity And Diversity Table

Short-Term Goals

- All Ed Board members invited and included; inclusion extended past Ed Board
- Editorial co-written by HEAD Table members to announce efforts
- Self-reported data on Editorial Board diversity
- In the short term, the Table will serve as another layer of review for health equity-/DEI-related papers
- Collection of self-reported peer review data assessing gender, geography, race/ethnicity, and expertise of authors, reviewers, and submitters
- Submitters: Is this paper related to DEI/disparities? Track acceptance rates separately

Long-Term Goals

- Study open peer review data: Who is choosing to have their name published? Other relevant trends
- Transparency and reporting of peer review data/Ed Board representation/open peer review, both in front matter and in research format articles
- Training of Table, Ed Board, Ed Office staff from experts in urology and beyond
- Use social media as an ongoing tool to engage discussion on DEI and JU
- Reassess the aims of scope of JU. “What is a JU paper?”
- New section and Associate Editor for a “DEI and Health Disparities” section of the journal

Health Equity And Diversity Table

Spaceship Idea

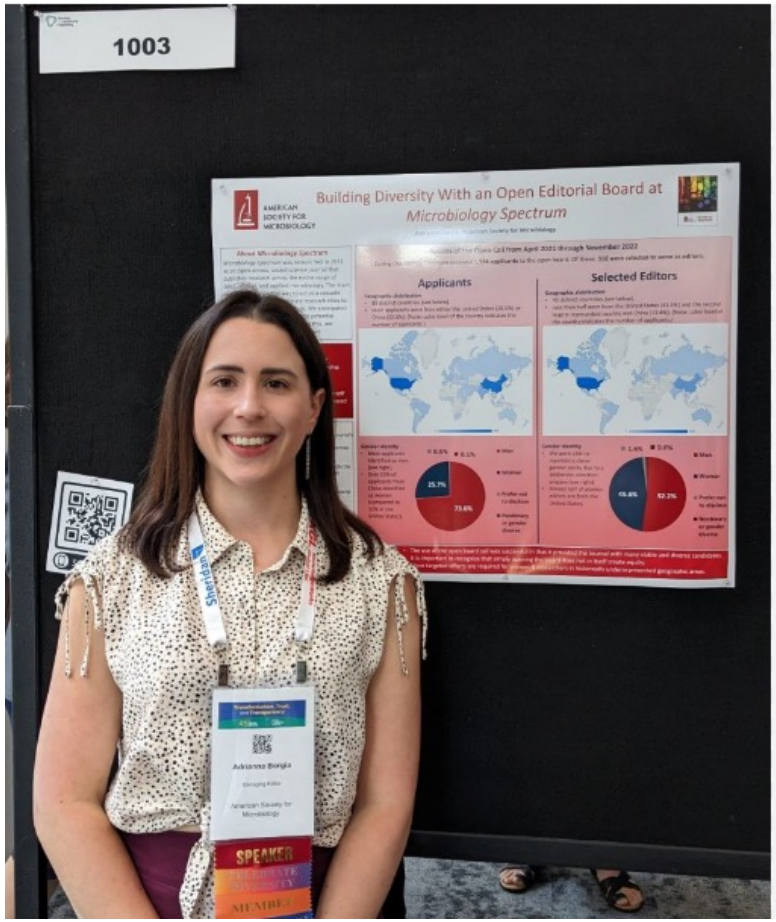
To create a collaborative DEI/healthy equity-focused pool of peer reviewers across all urology publications

LOOKING BEYOND UROLOGY

- What is happening in scholarly publishing at large?
- Two non-urologists are voting members of our Publications Committee
- The Journal of Urology DEI in Scholarly Publishing Series: DEI Success Stories
- Miranda Walker, Jonathan Schultz, and more!

OPEN CALLS FOR EDITORS

- Thank you to Adrianna Borgia
- Our journals ALL hold open calls for editors not
- We have met candidates who would never have been considered before
- Open, transparent, inclusive
- Takes A LOT of time – but it's worth it



ON THE HORIZON

- Lighting the Table of Contents on fire
- Reimagining the Urological Review Survey
- JU Patient Summaries, read-aloud JU Insights
- Using our *AUANews* platform and Extras boxes to continue reimagination of content
- WHY? Diversity of voices and continued accessibility and reach of content

TAKING ON THE ELEPHANT ONE BITE AT A TIME

- Get the buy-in of your Editorial Boards
- Don’t be afraid to try new things
- Identify opportunities that are do-able to start
- Your work will never be done – but don’t stop trying

Using the *AUANews* Digital Ecosystem to Its Full Potential

- Since 2020, we have tripled our content
- In April 2021, we published our first "Celebrating Diversity with the AUA" focus issue; this annual issue doubled in size in 2022 and feature an open call for submissions in 2023
- In September 2022, we launched a second monthly release, *AUANews*Extra, to double our issues from 12 to 24 annually
- In December 2022, we launched the AUANews.net stand-alone site
- We welcomed our new Editor, Dr. Stacy Tanaka, in 2023 (first ever female EiC at the AUA)
- How do we use *AUANews* as a tool of Open Access and accessibility?

The Voice of Urology

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UROLOGY PRACTICE®

JU | Open Plus

AUANews

Extending Our Community Globally

- We utilize the brands of our publications, particularly JU, to engage international members
- International Member Committee – *AUANews* contributions, Editorial Board involvement
- Our Publications are prominently displayed as part of the AUA's show displays at EAU, CUA, etc. (pictured here are JU Editor Dr. Robert Siemens and Editorial Board member Dr. Carme Mir of Spain)
- WHY? We are making our publications accessible and attainable to the world

QUESTIONS?