Project PROSPECT
PROState cancer Patient case ExChange Taskforce
Johnson & Johnson
SOUTHEAST ASIA

High-risk/high-volume mCSPC

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Case details and discussion plan

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Patient detailing

A high-risk/high-volume de novo mCSPC case was discussed. The patient was aged 64-year-old with active lifestyle, working individual with mild hypertension and no other health conditions. Additional parameters included:

- T3bN1M1b
- Gleason score 4 + 5 = 9 in all 8 scores
- 5 bone metastases on bone scan – left acetabular roof (3 cm), iliac crest x 2 (2 cm and 3 cm), dorsal right 7th rib (2 cm), T3 vertebral body (1 cm)
- mpMRI scan revealed extensive prostatic mass with left lateral extension into the seminal vesicle
- PSA 114 ng/mL, LDH 212 IU/L, ALP 72 IU/L, Hb 15.6 g/dL

Discussion: How would you treat this patient?

ADT monotherapy *OR* **ADT + abiraterone** *OR* **ADT + apalutamide or enzalutamide** *OR*

ADT + docetaxel *OR* **ADT + docetaxel + apalutamide or enzalutamide or abiraterone**

ADT: androgen-deprivation therapy; Hb: haemoglobin; LDH: lactate dehydrogenase; mCSPC: metastatic castrate-sensitive prostate cancer; mpMRI: multiparametric magnetic resonance imaging; PSA: prostate specific antigen

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Panelist insights

Experts shared regional insights about rational management of this case and choice of treatment for such patients.

A/Prof. Edmund Chiong

- As the patient is young, maximum intensification of therapy is a possibility.
- The patient could go either for ADT + Docetaxel alone, ADT + novel hormonal therapy or for AA + docetaxel + ADT.
- To conclude, ADT plus one of these therapies can be preferred.

Dr. Loh Chit Sin

- The patient certainly fits in with the various studies that has mentioned Abiraterone monotherapy.
- As the patient is young, the preferred therapy can be Docetaxel + AA or Docetaxel + AA + ADT.

A/Prof. Lee Lui Shiong

- A multidisciplinary team involving medical oncologists, neurologists will give insights into the course evidence and biology.
- There seems to be bias towards offering upfront chemotherapy because patients may be in a better position to tolerate Docetaxel initially than later.
- In Singapore, Abiraterone is accessible because it's launched generic.
- Discussion with the patient should always be considered.

The panelists agreed that:

- Choice of therapy depends on age, regional differences, reimbursement, and clinical data.
- ADT monotherapy is not the standard of care for patients with mCSPC.
- Discussing the pros and cons of the treatment with patient and a multi-disciplinary approach involving oncologist, radiologist, urologists is advisable.
- Panelists suggested the use of ADT + therapy intensification as the patient is young.
- Patient can be treated as per PEACE-1 data involving triplet therapy (ADT + Docetaxel + AA ± Radiotherapy).

A/Prof: Associate Professor; AA: Abiraterone acetate; ADT: androgen-deprivation therapy; mCSPC: metastatic castrate-sensitive prostate cancer

Clinical insights

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Trials/ Parameters	CHAARTED[1,2]	STAMPEDE[3,4,5,6]	LATITUDE[7,8]	STAMPEDE[4,9,10]	ENZAMET[11]	ARCHES[12]	TITAN[13,14]
Arms	ADT ± Doc	ADT ± Doc	ADT ± Abi	ADT ± Abi	ADT ± Enza	ADT ± Enza	ADT ± Apa
Docetaxel in expo. arm	100%	100%	0%	0%	45%	18%	11%
High vol./risk pts	65%	43%	100%	52%	52%	63%	63%
CRPC or PSA-/PFS	↑	↑	↑	↑	↑	↑	↑
OS	↑	↑	↑	↑	↑	↑	↑
HRQoL	-	↑	↑	↑	-	⇆	⇆

Abi: Abiraterone; ADT: androgen-deprivation therapy; Apa: Apalutamide; CRPC: castration-resistance prostate cancer; Doc: Docetaxel; Enza: Enzalutamide; Expo: exponential; HRQoL: health-related quality of life; OS: overall survival; PSA-PFA: prostate specific antigen progression-free survival

1. Kyriakopoulos CE, et al. J Clin Oncol. 2018;36:1080-87. 2. Sweeney CJ et al. N Engl J Med. 2015;373:737-46. 3. Morgans AK, et al. J Clin Oncol. 2018;36:1088-95. 4. Rush HL, et al. Oral presentation at ASCO GU 2020; abstract 14. 5. James ND, et al. Lancet. 2016;387:1163-77. 6. Clarke NW, et al. Ann Oncol. 2019;30:1992-2003. 7. Chi KN, et al. Lancet Oncol. 2018;19:194-206. 8. Fizazi K, et al. Lancet Oncol. 2019;20:686-700. 9. James ND, et al. N Engl J Med. 2017;377:338-51. 10. Hoyle AP, et al. Eur Urol. 2019;76:719-28. 11. Davis ID, et al. N Engl J Med. 2019;381:121-31. 12. Armstrong AJ, et al. J Clin Oncol. 2019;37:2974-86. 13. Chi KN, et al. N Engl J Med. 2019;381:13-24. 14. Chi KN, et al. Oral presentation at ASCO GU 2021; abstract 11.

↑ Better
⇆ No change

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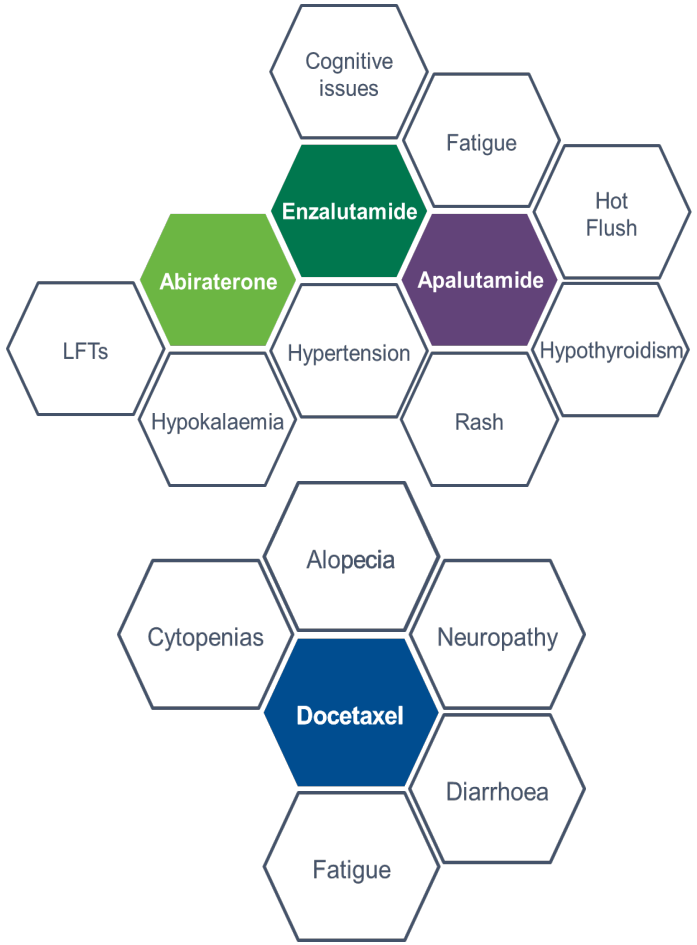
Discussion and Conclusion

- Chemotherapy is better in high volume and high-risk patients as confirmed by the expert panellists even though there is no comparative trial data in this regard.
- There seems to be bias towards offering upfront chemotherapy because patients may be in a better position to tolerate Docetaxel initially than later.
- In young mCSPC patients, maximum therapy intensification + ADT is a possibility after discussion with the patient and consensus with multi-disciplinary team.
- In ENZAMET, ARCHES and TITAN trials, both Enzalutamide and Apalutamide work, and it is not known which one is better as of now.
- Safety profile of the patients depended on the treatment administered. Docetaxel is associated with alopecia, cytopenia, neuropathy, diarrhoea and fatigue; whereas Apalutamide with rashes, moderate fatigue and cardiovascular issues and Abiraterone with LFTs, hypokalaemia.
- Clinical data suggests that PFS and OS were observed to be improved in all the clinical trials.
- HRQoL scores were better for STAMPEDE and LATITUDE trials and there was no change for ARCHES and TITAN.

Treatment-wise toxicity



ADT: androgen-deprivation therapy; HRQoL: health-related quality of life; LFT: liver-function test; mCSPC: metastatic castrate-sensitive prostate cancer; OS: overall survival; PFS: progression-free survival

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THANK YOU!

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