

mCSPC

# Case details and discussion plan

## Patient detailing



### The 66-year-old healthy working male patient with: Feb 2020

- Hypothyroid on T4
- Takes Tamsulosin for BPH (benign prostatic hyperplasia)
- Benign testicular lesion
- c/o Swollen foreskin
- No urinary symptoms
- DRE nodule left lobe
- PSA: 12
- mpMRI: PIRADs 5, EPE, no enlarged lymph node, no regional bone metastasis
- Biopsy: Gleason 4+4, GPC 100%, TPC 70%
- Clinical stage: T3a, N0, M0

### Treatment offered

- Surgery (as part of multimodal treatment)
  - Retzius-sparing RALRP (left nerve sacrificed), BPLND, discharged on day 3
- EBRT as an option

## Case progression - Post-metastasis phase

### May 2020

- PSA: 0.54
- Advised PSMA PET CT – deferred by patient
- Progress: 8 Aug 2020
- Started ADT (Triptorelin)
- Discussed Titan study with patient

**8th Aug 2020:** Prostatectomy done; started ADT

**17 Aug 2020:** Started on Apalutamide 240mg od

**29 Aug 2020:** Slight tiredness on exercise after the apalutamide; otherwise totally well and working fulltime

**20 Oct 2020:** PSA <0.01

**21 May 2021:** Reported maculo-papular rash; Apalutamide stopped for 1 month

**25 June 2021:** PSA <0.01; Skin much better

**27 July 2021:** PSA <0.01

**26 Aug 2021:** On Enzalutamide 1 month; PSA 0.01; no rash, mild tiredness; Rpt PSMA PET CT – all lesions resolved



## Discussion

- How would you treat this patient?
- Would you prefer radiation to surgery given that it is locally advanced?
- Would you agree that PSMA PET CT is good to be considered here?
- At some point the patients' PSA is going to become detectable again and start to rise in this scenario we don't have a definition for CRPC as opposed to ADT alone patients. Do you have any guidelines at all as to what would constitute resistance to treatment and to start consider alternative therapy?

# Panelist insights

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



A/Prof. Edmund Chiong

- At initial presentation, surgery (radical prostatectomy), radiation therapy with hormonal therapy (ADT) are options.
- At post treatment biochemical recurrence, I would have done a PSMA PET CT scan at the time as well. There is some reason to intensify treatment if mCSPC.
- Depends on whether we think the patient clinically still benefits from the current treatment or not. Two parameters are looked at before consider changing therapy (based on PCWG recommendations): see new lesions on the imaging plus PSA and the clinical symptoms.



Prof. Axel S. Merseburger

- An option of radiation with ADT for three years or radical prostatectomy.
- PSMA PET CT is suggested. Radiation of the prostate bed is still recommended (As Declan Murphy proposes don't wait until we have metastatic disease or till PSA is 5). Schedule the patient for salvage radiation in this case you may even call it adjuvant radiation.
- The further course of treatment with ADT and apalutamide is a good plan.
- In the case, the patient has a high Gleason score, so abiraterone would not be a good combination with corticoid steroids., this would have an impact on his body after several years. Apalutamide will be good alone.
- Patient can experience rash as we know from TITAN study. Restart the patient on Apalutamide. Consult dermatologist for the rash. Start with low dose corticosteroid and stop again. If the rash develops again, consider changing to another NHT. Consider giving either AR receptor blocker or enzalutamide as there would be no need to prescribe prednisone.

## Panelist insights *cont...*

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



Dr. Loh Chit Sin

- Many of these patients are good candidate for lutetium trial.
- PSMA PET CT scan will not show any lesion until PSA reach about 0.5. Due to biochemical recurrence, I would wait until PSA exceeds 0.5 before considering imaging. That way lesions can be seen when PSA is much lower and the treatment can be initiated much earlier.



A/Prof. Lee Lui Shiong

- After prostatectomy when his PSA was below 0.5. The PSMA PET CT would have been poor. The patient chose well saving himself the morbidity of salvage radiation.
- The patient is highly functioning so whether it's a choice between apalutamide, abiraterone or just ADT alone is a discussion with the patients. Some patients with apalutamide get fatigue and maybe even cognitive impairment but abiraterone is seen to spare that cognitive impairment bit more.
- It is going to be a PSA driven follow-up. Where imaging comes in at some point the threshold of PSA progression will be known and they would have to consider quantifying the disease – whether it's just PSA that's moving or it's a detectable disease. That can then bring up the discussion of changing therapeutics.

## Conclusion

- At post-treatment biochemical recurrence, PSMA PET CT scan is suggested as soon as PSA exceeds 0.5 as that way lesions can be seen when PSA is much lower and earlier – treatment can be initiated.
- The patient is highly functioning therefore discussing the pros and cons of the treatment with patient and a multi-disciplinary approach involving oncologist, radiologist, urologists is advisable.
- Two parameters are looked at before considering changing the therapy (based on PCWG recommendations): see abnormalities (new lesions) on the images plus PSA and the clinical symptoms.

**THANK YOU!**