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ADT Intensification: The Evidence You Can't Afford to Miss

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Dr. Taplin:
This is CE on ReachMD, and I'm Dr. Mary-Ellen Taplin. I'm pleased to be joined today by Dr. Scott Tagawa.

Scott, how should we interpret the clinical trial evidence for supporting ADT intensification in metastatic hormone-sensitive prostate cancer?

Dr. Tagawa:
Thanks very much, Dr. Taplin, for the question. I think it's a very important topic for the patients that are sitting in front of us. And I would say on a very high level, we clearly have data that more than 1 systemic therapy is going to benefit most patients that walk in the door with metastatic disease.

We started off—really, it's been a while now—with the addition of docetaxel to the backbone of ADT with the CHAARTED trial, followed by the STAMPEDE trial, both showing a difference in overall survival adding docetaxel. And that was followed by a number of different trials that added an ARPI or androgen receptor pathway inhibitor, either an androgen synthesis inhibitor, a CYP17 inhibitor or androgen receptor inhibitor.

And the summary is that they all will lead to benefit, initially with abiraterone and prednisone or prednisolone in STAMPEDE, and then in the LATITUDE trial.

And these were followed by a number of different trials that added to the backbone, mostly of ADT, but some also out of the backbone of ADT and docetaxel in that they either allowed a run-in period in a small minority or had that ongoing, such as in the PEACE-1 trial.

But again, what they showed overall was that, whether it is a CYP17 inhibitor or an androgen receptor inhibitor, there was a survival benefit, which was very nice.

And if we speak specifically, we have apalutamide that was studied in the TITAN trial. We have enzalutamide studied in the ARCHES trial, as well as previously going against an antiandrogen in the cooperative group ENZAMET trial. And then we have darolutamide that was initially studied in addition to ADT and docetaxel, but then subsequently studied alone ADT, with or without the AR inhibitor darolutamide.

And, again, what they showed overall in total is a benefit. What we have, in summary—and this is reflected in essentially every single guideline—is that we want to have a doublet for virtually all patients; patients that are at least healthy enough to receive these, we want to have ADT and an ARPI.

However, we do not know the benefit of docetaxel in this setting when added to an ARPI, because of just the order of how these happened. As you know, Mary-Ellen, this is being studied in 2 studies in the cooperative group system, either adding them at the beginning, or for those who don't have a PSA that nadirs at less, or at least within 6 months, at less than 0.2, then adding in docetaxel.

So I think we'll have an answer to that question in the relatively near future. But right now, I think we're left with looking at: are they presenting with de novo disease? Are they presenting with especially high-volume de novo disease? And [if] they're healthy enough to receive docetaxel, then I think it's reasonable, outside of a clinical trial, to add docetaxel. Although I would encourage everyone that has access to answer these questions in a clinical trial, because we really don't know.

So I'd say overall we're going to have a doublet for the majority of patients, occasionally triplet. There is a triplet that is, I would say, prime time for this current era, which is specifically in patients with BRCA2 alterations, germline and/or somatic, which is the addition of niraparib to ADT and abiraterone and prednisone.

So there are molecularly selected subsets that may benefit, but otherwise we're talking about ADT and ARPI with some patients that may also benefit from docetaxel.

Dr. Taplin:
Thank you, Dr. Tagawa. That was a very helpful review of a lot of rich prospective data in metastatic hormone-sensitive prostate cancer.

I would say the conclusion is that all patients with metastatic hormone-sensitive prostate cancer, unless their life expectancy is limited by underlying medical issues or their goals of their healthcare steer them in a different way, all patients should be considered for doublet therapy that includes an androgen receptor pathway inhibitor. And then, higher-volume patients or patients with specific genomic alterations, such as BRCA2 mutations, should be considered for triplet therapy. And as you noted, there's different types of triplet therapy, ADT, ARPI, plus chemotherapy and ADT, ARPI, plus a PARP inhibitor, and there may be more to come in the near future regarding other options for triplet therapy.

So thank you very much for that review. Our time is up. See you at the next episode.

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