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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Best Practices in Shared Decision-Making: Discussing ADT Regimens in mHSPC With Your Patient

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. McKay:
Hello, this is CME on ReachMD, and I'm Dr. Rana McKay, a genitourinary medical oncologist at the University of California in San Diego. Today, we're going to be discussing best practices and shared decision-making and discussing ADT regimens in the metastatic hormone-sensitive prostate cancer setting for your individual patient.

To kick us off with a discussion, we're going to be starting with a case. I'm going to highlight a story about a gentleman, 59-year-old man without any really significant past medical history, who presented with back pain to his primary care physician. Ultimately, ended up getting diagnostic imaging performed that showed sclerotic lesions throughout his skeleton and got a PSA that was drawn that demonstrated his PSA was 134.

He had a biopsy that was performed of the metastatic lesions that confirmed prostatic adenocarcinoma and had complete staging scans, including a bone scan and a CT chest, abdomen, and pelvis imaging that demonstrated the presence of diffuse osseous metastases throughout the skeleton and an enlarged prostate with some pelvic adenopathy. This patient has high-volume metastatic hormone-sensitive prostate cancer, and there's a lot of decisions that come into play with regards to selecting the choice of therapy for this individual.

These patients are typically initiated on androgen deprivation therapy, and the use of an antagonist versus agonist in this context largely depends on the presence of clinical symptoms. And in most scenarios, patients can be initiated on an agonist agent as opposed to antagonist, though this is dependent on clinical decisions such as whether the patient has obstructive urinary symptoms, any signs of cord compression, where you're really worried about immediate testosterone flare with an agonist agent.

What we've come to see from a series of landmark studies is that treatment intensification in the metastatic hormone-sensitive setting has really been associated with improved outcomes for patients. We've demonstrated initially with the results of the CHAARTED and the GETUG studies, that really catapulted us into an era of treatment intensification for mHSPC, is that adding additional treatments to the ADT backbone improves outcomes.

We have a series of clinical trials that looked at adding next-generation androgen receptor pathway inhibitors such as apalutamide, enzalutamide, and also abiraterone, and more recently from the ARANOTE study, also darolutamide was associated with improved outcomes for patients. There's also several studies that looked at the role of triple therapy utilizing the backbone of ADT docetaxel with abiraterone, as was done in PEACE-1, and with darolutamide, as was done in the ARASENS trial.

So whenever you have a patient before you, all patients should be initiated on ADT and likely also an ARSI, and then the decision to add

chemotherapy is largely dependent on clinical parameters as we don't have level 1 evidence regarding the treatment decision between ADT/ARSI versus ADT/ARSI plus docetaxel.

In my clinical practice, the decisions that I factor in into determining whether I select doublet treatment with ADT/ARSI versus triplet therapy with ADT/ARSI, plus docetaxel is largely dependent on clinical parameters. It's dependent on the timing of metastatic disease, whether patients have de novo or metachronous disease, the presence of visceral metastases, particularly liver metastases, the presence of high- or low-volume disease, also patient performance status. Sometime genomic alterations may factor in if patients have a more biologically aggressive tumor.

With regards to selection of the choice of ARSI, this is largely also dependent on patient factors, patient comorbidities, the different drugs they may be on, as the different ARSI agents, including abiraterone, which requires concurrent prednisone and is associated with the syndrome of mineralocorticoid excess, is associated with the unique clinical phenotype when used.

With regards to the antiandrogens, the next-generation antiandrogens, like enzalutamide and apalutamide, drug-drug interaction is certainly something that we need to monitor for. And also, key side effects of fatigue, falls, cognitive issues can play into effect with regards to patients' comorbidities.

So at the end of the day, for our 59-year-old patient with high-volume de novo metastatic hormone-sensitive prostate cancer, I would tend to favor a treatment with triple therapy with ADT and ARSI plus docetaxel for this patient to improve his long-term outcomes. Many factors at the end of the day get taken into account when deciding on any one given regimen for a patient with metastatic hormone-sensitive disease.

Thank you for listening.

Announcer:
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