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Best Practices in Shared Decision Making: Selection of the Optimal ADT Regimen in mHSPC Based on Patient Preferences

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

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Dr. McKay:
This is CME on ReachMD, and I'm Rana McKay, a genitourinary medical oncologist at the University of California in San Diego. Today, we're going to be talking about best practices and shared decision-making and the selection of the optimal ADT regimen in mHSPC based on patient preference.

We're going to review our case of a 59-year-old gentleman who initially presented with back pain, was seen by his primary care doctor, and ultimately ended up undergoing imaging, which identified sclerotic lesions throughout his bones. This prompted a PSA check and further imaging, which demonstrated a PSA of 134 and staging scans with diffuse sclerotic osseous metastases throughout his skeleton. He had a biopsy that was performed that confirmed prostatic adenocarcinoma, and ultimately, the patient was diagnosed with high-volume de novo metastatic hormone-sensitive prostate cancer.

There are many decisions to factor in when selecting an oral versus injectable formulation of an LHRH analog with patients with metastatic hormone-sensitive prostate cancer. From a medical standpoint and clinical standpoint, for those individuals that have significant symptoms related to their disease, may have obstructive urinary symptoms, any signs or symptoms of cord compression, or individuals that really just warrant a rapid and immediate decline in testosterone, those are generally individuals that are better served with a GnRH antagonist as opposed to an agonist.

Now, with regards to selection of oral versus injectable, a lot of this depends on patient choice and patient preference regarding whether they elect to be on another oral agent or whether they elect to do an injectable form of treatment. Many patients may be traveling, they may be doing various things that may preclude them from physically coming into the clinic, particularly if they're getting a once-a-month injection, or some patients just may not desire to get an injectable, may desire to receive therapy with an oral agent.

In the context of individuals that are on continuous treatment, there are different preferences. In this scenario with this patient with high-volume de novo metastatic disease, it's unlikely that he'll ever have a period where we may discontinue the ADT backbone of therapy, and that may also factor into somebody's decision around oral therapy versus an injectable.

So I think it's critically important, when you have a patient before you, to highlight the different options that are out there for treatment and really align the patient's goals with the goals of therapy in selecting the form of ADT that may be utilized, because now the list of agents that can be utilized is expanding with different options for patients to be considered.

Thank you for listening today.

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