Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/frontlines-prostate-cancer/advances-in-prostate-cancer-care-genetic-testing-teamwork-and-arpis/32212/

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Advances in Prostate Cancer Care: Genetic Testing, Teamwork, and ARPIs

Announcer:
Welcome to *On the Frontlines of Prostate Cancer* on ReachMD. On this episode, we'll hear from Dr. Neal Shore, who will be discussing the latest treatments for prostate cancer. Dr. Shore is the Medical Director of the Carolina Urologic Research Center in Myrtle Beach, South Carolina. Let's hear from him now.

Dr. Shore:
There have been a multitude of advances. First, the importance of performing genetic testing. Both germline and somatic has now had a dramatic impact on the prostate cancer landscape. It's absolutely essential that we perform germline testing for our patients diagnosed with prostate cancer because we have FDA-approved therapies for HRR mutation in the form of PARP inhibitors in the castration-resistant population. We also have tumor agnostic indications if we do somatic testing for patients who have TMB-high, MSI-high, or MLH as well as HER2-positivity. Regarding germline testing—what we refer to as informing family members or cascade family testing—if a patient is BRCA-positive, his offspring, his siblings, and their offspring need to be tested. We can pick up potentially localized breast, ovarian, pancreatic cancer, or endometrial cancers before they present as metastatic. Unfortunately, there's a tremendous underutilization of both germline and somatic testing in the uro-oncologic community. I think medical oncologists have done a much better job because of their familiarity with outside of GU oncology.

Other important advances has been the multidisciplinary team: urologists, radiation oncologists, medical oncologists, and nuclear medicine radiologists—specifically with nuclear medicine radiology and the use of radiopharmaceuticals as well as interpreting PSMA PET scans. The complexity of approvals at the imaging level, the biomarker level, and the therapeutic level absolutely mandates the effective collaboration of a multiple disciplinary team.

The newer androgen receptor pathway inhibitors, specifically enzalutamide, apalutamide, darolutamide, and the androgen biosynthesis inhibitor abiraterone, are marked improvements from the first-generation AR pathway inhibitors flutamide, nilutamide, and bicalutamide. I never use those first-generation ARPIs. The newer generation are much more competitive inhibitors of the AR, and when you look at the clinical trial landscape going from resistant disease—whether it's before or after exposure to chemotherapy or in the nonmetastatic CRPC state, which was historically using conventional imaging—moving proximally to metastatic hormone-sensitive prostate cancer—whether it's low volume or high volume—and now with biochemical recurrence after prostatectomy or radiation or both, and even in high-risk patients who are undergoing radiation therapy with ADT, adding an ARPI is the standard of care. And the ARPIs, depending upon the clinical trial and the specific stage of the landscape, are going to be the newer-generation ARPIs. It's obvious and clear that there's Level 1 evidence for that, so it's incumbent upon healthcare providers to have the appropriate shared decision-making conversation. Essentially, monotherapy ADT is almost never the standard of care any longer.

Announcer:
That was Dr. Neal Shore discussing advancements in the prostate cancer treatment landscape. To access this and other episodes in our series, visit *On the Frontlines of Prostate Cancer* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!