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/redefining-mhspc-treatment-from-monotherapy-to-triplet-therapy-regimens/32220/

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Redefining mHSPC Treatment: From Monotherapy to Triplet Therapy Regimens

Announcer:
Welcome to *On the Frontlines of Prostate Cancer* on ReachMD. On this episode, we'll hear from Dr. Daniel George, who's not only the Eleanor Easley Distinguished Professor of Medicine, Surgery, and Urology at Duke University, but he's also an American Cancer Society Impact Research Professor and practicing GU oncologist at Duke Cancer Institute. He'll be discussing the role of monotherapy versus combination therapy for the treatment of metastatic hormone-sensitive prostate cancer, or mHSPC for short. Here's Dr. George now.

Dr. George:
I think real-world oncologists like myself—and I like to think of myself as practicing in the real world even though I'm at an academic center—we should be thinking of combination therapy—ADT and ARPi—as the standard of care. The exception should be the patient who gets ADT alone. There should be some reason, either the disease volume, biology, or the patient's comorbidities, that suggests that adding the ARPi is unnecessary upfront. And then I think we should be thinking about, who are the chemotherapy-eligible patients? And if a patient is chemotherapy eligible, we should be thinking about using chemotherapy and an ARPi and ADT upfront because that is probably associated with the greatest benefit for chemotherapy. It's only six cycles. There's no prednisone. Docetaxel is pretty well tolerated. These patients haven't had years of hormonal therapy first. So to me, this is the best use of that in the patients who are chemo eligible.

And then I think the last piece we should be thinking about is precision medicine. We have a number of studies now evaluating genetic alterations like BRCA2 and other homologous recombinant repair defects. We have a study and a press release out there around the loss of PTEN and using an Akt inhibitor reporting top-level positive results for radiographic progression-free survival with abiraterone, and we have a study with using PSMA for selection of patients to receive an ARPi and ADT with or without Pluvicto. And I think these are emerging approaches to be thinking about in how we select patients for that additional combination. So right now, without any of that, to me that's docetaxel, but in the future, we may be thinking about other combinations that we'd want to consider based on either the biology of the imaging, the genetics of the tumor, or the expression by immunohistochemistry on tumor samples. So these are I think the next generation of combinations we'll look for in the future.

Announcer:
That was Dr. Daniel George talking about when we should use monotherapy versus combination therapy for mHSPC. 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!