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Expert Panel: Selecting Treatment in mHSPC: Which Treatment for Which Patient?

Announcer:
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Dr. Moses:
Hello, and thank you for joining us for this discussion on selecting treatment and metastatic hormone-sensitive prostate cancer, which treatment for which patient? I'm Kelvin Moses at Vanderbilt University Medical Center, and I'm joined by Dr. Alicia Morgans at Dana Farber in Boston. Welcome.

Dr. Morgans:
Thank you so much for having me.

Dr. Moses:
Thank you. So let's jump right into it. When we're talking about metastatic hormone-sensitive prostate cancer, tell me about the sort of the definition and also about volume of disease and how that changes our thinking about metastatic prostate cancer.

Dr. Morgans:
Sure. So I think just to remind everyone, metastatic disease in metastatic hormone-sensitive prostate cancer is defined using conventional imaging strategies still at this point in time. So things like bone scans, CTs, and MRIs, rather than defining volume in metastatic disease by PSMA or other forms of PET, though we know that those are now in our world and in our domain, we just don't do that at this point in time.

And it's really important, as we're seeing new patients with mHSPC, to think about whether they have de novo metastatic disease, so right out of the gate, metastatic disease when they're first diagnosed, or recurrent metastatic disease that has come back after maybe a prostatectomy or radiation to the prostate in the past. These distinctions help us to understand how aggressive the cancer is, what the prognosis might be, with de novo having a more aggressive prognosis, and also help us choose treatments, because we think that de novo metastatic disease may be one that may be helped by chemotherapy, perhaps more so in some settings than recurrent disease, though, every patient, of course, is an individual.

And of course, you mentioned also low- and high-volume disease, again defined on our standard old-fashioned imaging of bone scan, CTs, and MRIs, with high-volume disease really being patients having at least 4 bone metastases with at least 1 outside of the axial skeleton, or visceral disease. And anyone who has less disease burden than that, having low-volume disease. And this distinction again, really important because high-volume disease seems to be certainly more aggressive disease with a poor prognosis, but a disease setting where we may again be more inclined to use chemotherapy and a chemo-hormonal or even triplet approach, because we think that this may be more effective there, than it may be in the low-volume setting.

Also, of course, we remember for patients with de novo metastatic disease, if they have not had treatment to the primary prostate and

they have low-volume, hormone-sensitive metastatic disease, we would also radiate the prostate in that setting for a survival advantage.

Dr. Moses:
Yeah, that's a great point and some of that data comes from Stan P. that you just mentioned. You also mentioned doublet and triplet therapy, and I think that's a relatively new topic, especially with the recent PEACE-1 and ARASENS trials. Talk about those type of combinations and in whom would you consider that?

Dr. Morgans:
Absolutely. So doublets are our tried and true ADT plus an androgen receptor signaling inhibitor, really this backbone is the standard of care for prostate cancer patients with metastatic hormone-sensitive disease. And we think about intensifying that to a triplet in some patients, that doublet therapy has been really standard since LATITUDE, ARCHES, ENZAMET, TITAN, all of these studies, including STAMPEDE, which showed that ADT alone was really inferior in terms of overall survival.

So PEACE-1 and ARASENS used a backbone of ADT and docetaxel chemotherapy for 6 cycles, and added darolutamide in ARASENS, or abiraterone in PEACE-1, to compare the triplet of ADT docetaxel and the ARSI, versus ADT/docetaxel, which had been a standard of care. What both of these studies showed is that particularly in patients with high-volume disease, the ADT, docetaxel, abiraterone, or ADT, docetaxel, darolutamide actually was associated with a survival advantage, versus ADT plus docetaxel chemotherapy. So at this point in time for chemofit patients, high-volume patients, de novo metastatic patients, if we can use chemotherapy, it's really important to offer that triplet combination for them.

Dr. Moses:
Absolutely. And that's really new and exciting data because we've seen a survival benefit with the combinations with a tolerable adverse event profile.

As we wrap up, can you talk about how we use either biomarkers or genetic information to make treatment decision-making briefly?

Dr. Morgans:
Sure. So we definitely use our imaging as a biomarker to make sure that we're identifying high- versus low-volume disease which is critical. And things like PSA are not really guiding our treatment decision-making at this point, though we do follow it. Germline genetic testing is certainly recommended for all patients with mHSPC

Dr. Moses:
Excellent. Well thank you for all the information. I hope everyone enjoyed this presentation, and we look forward to the questions.

Dr. Morgans:
Thank you.

Announcer:
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