Case 3

Dr Simone Albisinni

CASE 3

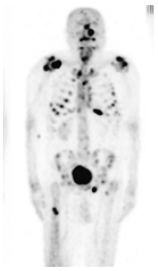
- 75 yo male

- PSA 26ng/ml
- DRE: highly suspicious, ±80cc
- Mp-MRI: PiRADS 5/5
- Biopsies: 8/12 +; Gleason 7(4+3)

- PMH: Hypertension; atrial fibrillation (anticoagulated by rivaroxaban), knee arthritis
- **G8 score**:16/17

CASE 3

- CT scan:
  - Thorax: negative
  - Abdomen: negative
- Bone scan:
  - Multiple bone lesions
  - No pain
  - ALP: 88 UI/L

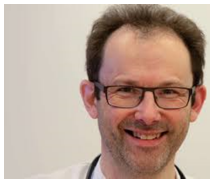


WHAT TO DO?

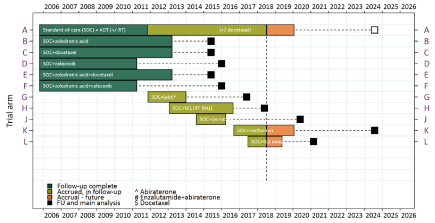
1. ADT
2. ADT+docetaxel
3. ADT+Abi/P
4. Local Radiotherapy+ADT
5. ADT, if response → prostatectomy
6. Whole body MRI
7. PSMA PET/CT
8. Inclusion in protocol

CASE 3

- The view of the Medical Oncologist and of the Radiation Oncologist



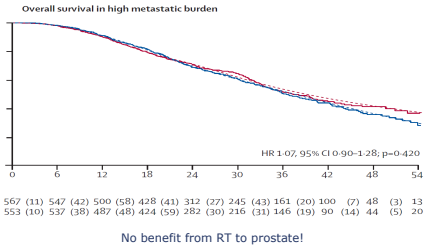
STAMPEDE TRIAL



http://www.stampedetrial.org/ 6

iridium kankernetwerk

RT to the primary does not prolong OS in high-volume mHSPC

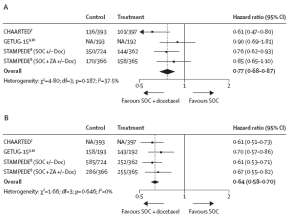


No benefit from RT to prostate!

Parker C. et al. Lancet 2018.

CHU de Liège

Addition of docetaxel or bisphosphonates to standard of care in men with localised or metastatic, hormone-sensitive prostate cancer: a systematic review and meta-analyses of aggregate data



Effect of the addition of docetaxel in M1 patients

A: on OS

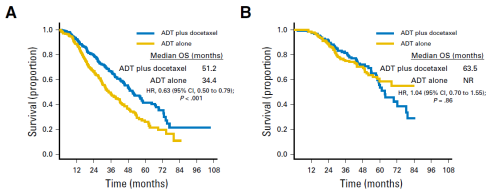
B: on DFS

Vale et al, Lancet Oncol, 2016, 17, 243-56

CHU de Liège

mHNPC : Docetaxel and volume disease in CHAARTED

Addition of docetaxel to ADT benefits high-volume disease ONLY



Sweeney et al, N Engl J Med, 2015, 373, 737-46
Kyriakopoulos et al, J Clin Oncol, 2018, 36, 1080-7

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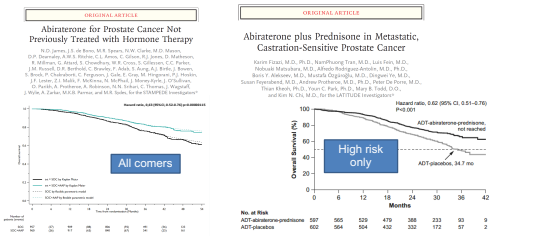
mHNPC : WHAT WE KNOW FOR ABIRATERONE!

- 2 randomised controlled trials and 1 meta-analysis

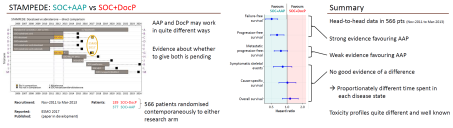


James N, et al. N Engl J Med. 2017, 377, 338-51
Fizazi K, et al. N Engl J Med. 2017, 377, 352-60

CHU de Liège

ABIRATERONE OR DOCETAXEL ?

- **Docetaxel**
  - **Toxicity**
  - **Short**
  - **Cheap**
- **Abiraterone**
  - **Well-tolerated**
  - **Long lasting**
  - **Expensive**



Sydes et al, Ann Oncol, 2018, 29, 1235-48

CASE 3

Hôpital Erasme ULB

- Patient is treated by **ADT+Docetaxel (6x)**
- 6 months: PSA 0.6ng/ml (iPSA 26ng/ml)
- 12 months: 0.4ng/ml
- 24months:0.4ng/ml
- 36months: 0.5ng/ml
  - Hot flushes
  - Fatigue
  - Abdominal circumference increased by 9cm (110cm)
  - Patient (now 79 yo) would like to interrupt ADT

WHAT TO DO?

1. Continue ADT
2. Intermittent ADT
3. Restaging
4. Local radiotherapy
5. Prostatectomy

CASE 3

- The view of the Urologist

INSTITUT JULES BORDET INSTITUUT

Available Data - Cytoreductive Prostatectomy / Multimodal approach

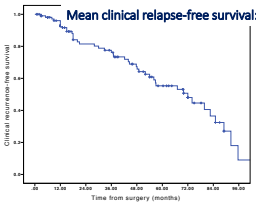
Heidenreich J Urol 2015: Surgery (n=23) vs SOC (n=38). Similar PSA and tumor burden.
Time to CRPC: 40 vs 29 mo, p=0.04
PFS: 38.6 vs 26.5, p=0.03
Cancer specific survival 95.6% vs 84.2%, p=0.04

Heidenreich ASCO-GU 2017: Multicentric - 113 men with metastatic PCa
Cytoreductive Prostatectomy even in high volume metastatic setting

Mean age	61 (42-69) years
Mean follow-up	53.0 (13-96) months
Median follow-up	45.7 (13-96) months
Lymph node metastases	10/113 (8.8%)
Low volume skeletal metastases	85/113 (75.2%)
High volume skeletal metastases	25/113 (22.1%)
Visceral metastases	4/113 (3.5%)
No/limited/extended pLAD	1.8%/8.8%/89.4%
Neoadjuvant ADT	80/113 (70.8%

Margin status	Positive	57 (54.3)
	Negative	48 (45.7)
postoperative T stage	T0/Tx	2 (1.9)
	T2	21 (19.8)
	T3a	14 (13.2)
	T3b	57 (53.8)
	T4	12 (11.3)
postoperative N stage	Nx	4 (3.8)
	N0	26 (24.5)
	N1	76 (71.7)

Available Data - Cytoreductive Prostatectomy / Multimodal approach



Heidenreich ASCO-GU 2017

AGE!

Significant difference in bRFS if PSA<1;1-4; >4ng/ml (p<0,0004)

- Low vs high volume disease (7.1% vs 32.1%)
- PSA < 4ng/ml vs PSA > 4 ng/ml (6.1% vs 47.8%)
- neoadjuvant vs no neoadjuvant therapy (8.75% vs 24.2%)

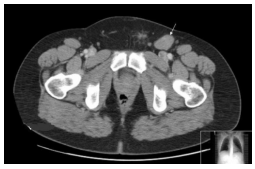
Clavien-Dindo IIIB (p < 0.05)

CASE 3

- Restaging

Bone scan: 2 residual lesions: L1 and right ileum

CT scan: left inguinal lymphadenopathy



Patient is asymptomatic

He just hates his hormonal implants….

WHAT TO DO?

1. Continue ADT
2. Intermittent ADT
3. Stereotaxic radiotherapy on oligomets ± ADT
4. Local radiotherapy+stereotaxic on oligomets ± ADT
5. Prostatectomy+stereotaxic radiotherapy on oligomets ± ADT

CASE 3

- The view of the Medical Oncologist

Intermittent treatment	
In asymptomatic M1 patients, only offer intermittent treatment to highly motivated men, with a major prostate-specific antigen (PSA) response after the induction period.	Strong
• In M1 patients, follow the schedules used in published clinical trials on timing of intermittent treatment. • Stop treatment when the PSA level is < 4 ng/mL after six to seven months of treatment. • Resume treatment when the PSA level is > 10-20 ng/mL (or returned to the initial level of < 20 ng/mL).	Weak
Do not use castration combined with any local treatment (radiotherapy/surgery) outside an investigational setting except for symptom control.	Strong

Mottet N et al, EAU guidelines 2018
retrieved from https://uroweb.org/guideline/prostate-cancer/ accessed 02.12.2018

CASE 3

- Patient was continued on ADT
- Osteoporotic fracture Th7 after 48months (80 yo) on ADT
- Died at 82yo after a fall → subdural hematoma
- PSA 1 month before: 0.9ng/ml