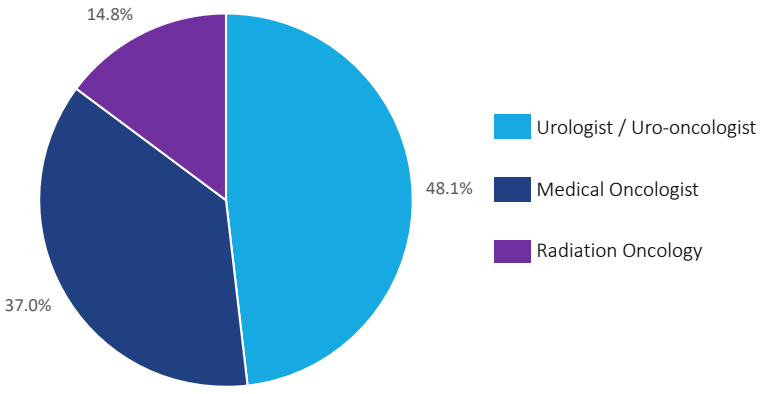
GURC
Genitourinary Research Consortium

GURC Canadian Consensus Forum Results December 2018

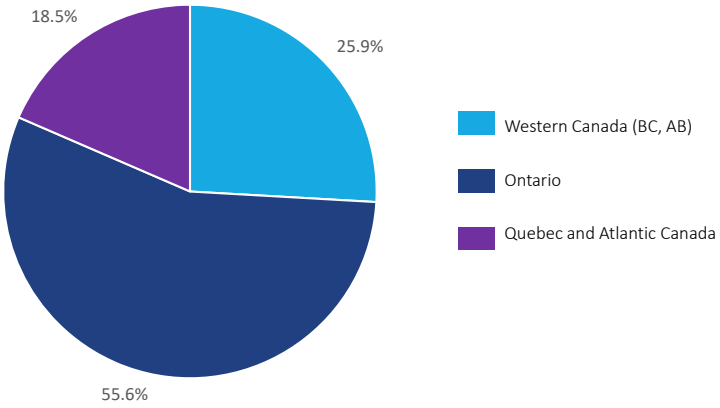
1. Please indicate your area of specialty.

Opt	Votes
	13
	10
	4



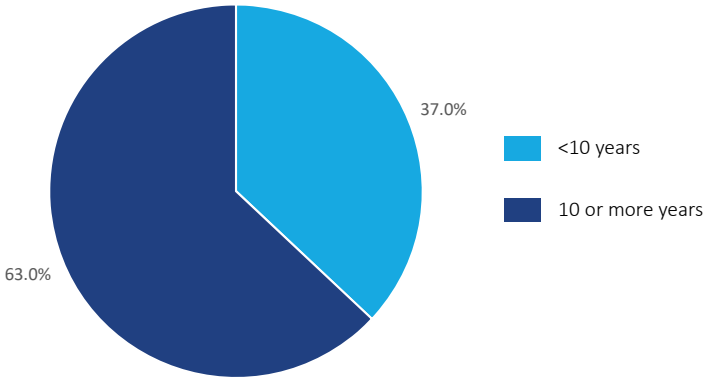
2. Please indicate your region of practice.

Opt	Votes
	7
	15
	5

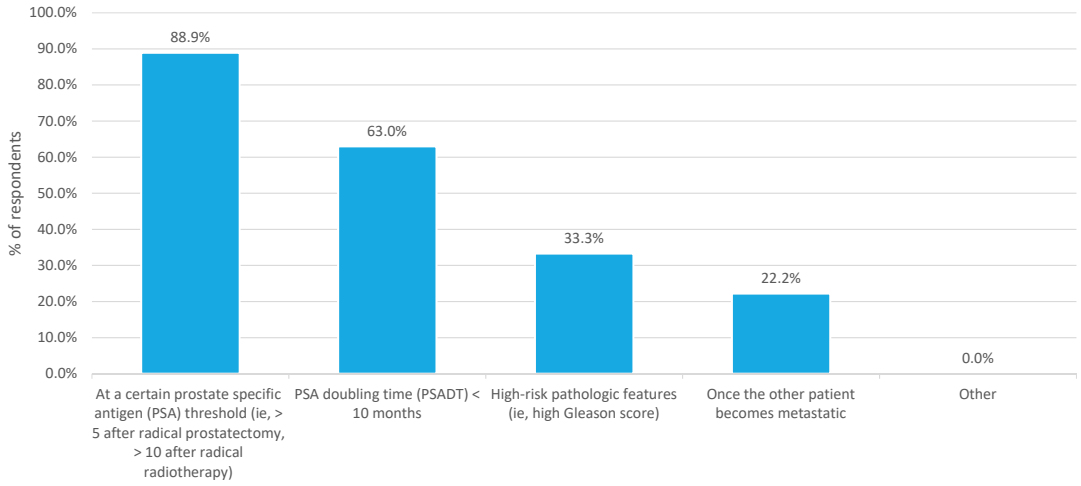


3. Please indicate the number of years you have been in practice.

Opt	Votes
	10
	17



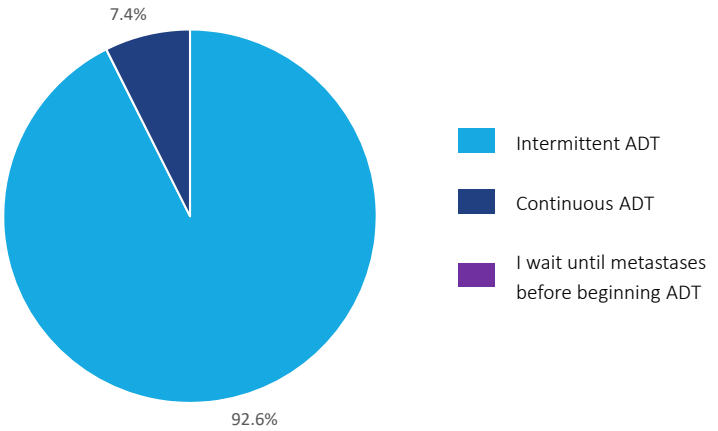
4. In general, when do you recommend initiating treatment with androgen deprivation therapy (ADT) following biochemical recurrence after local radical treatment? Choose all that apply.



Opt	1	2	3	4	5
Votes	24	17	9	6	0

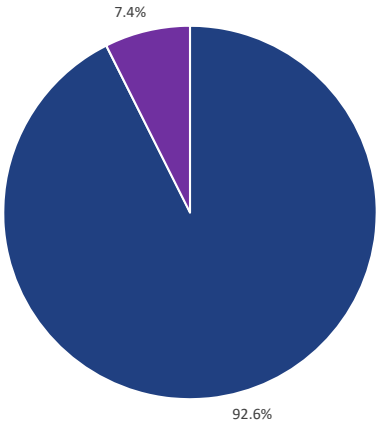
5. Do you generally initiate intermittent or continuous ADT for PSA-only recurrence following local radical treatment in patients with no documented metastatic disease?

Opt	Votes
	25
	2
	0

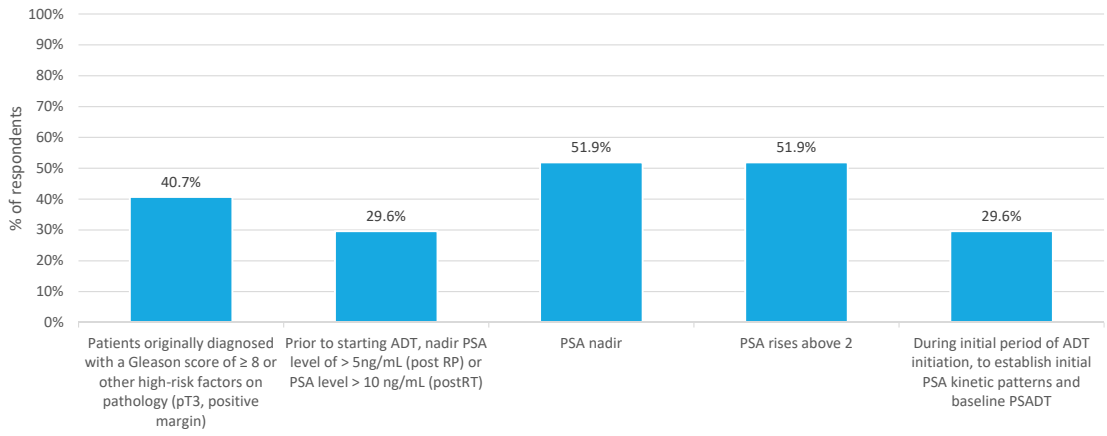


6. On average, how often do you measure PSA for patients on ADT for PSA recurrence after local radical therapy?

Opt	Votes
	0
	25
	2
	0
	0



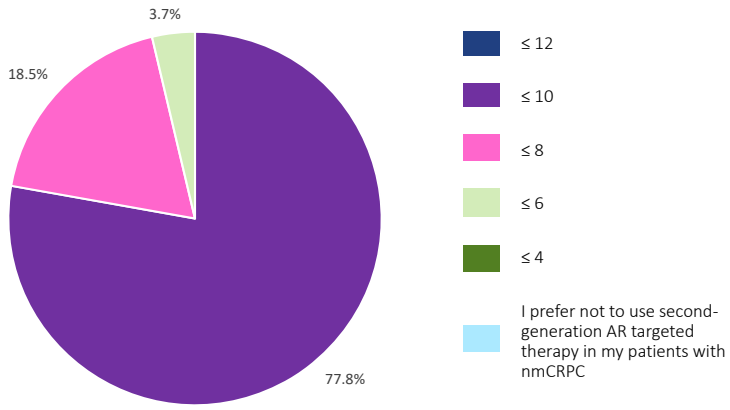
7. In patients on ADT for PSA only recurrence following local radical therapy, when should PSA be tested more frequently (≤ 3 months)? Choose all that apply.



Opt	1	2	3	4	5
Votes	11	8	14	14	8

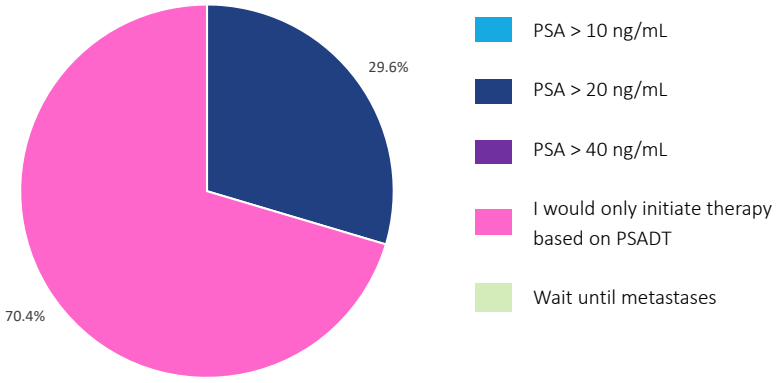
8. What PSADT threshold do you use to start second-generation AR therapy for the majority of your patients with nmCRPC?

Opt	Votes
≤ 14	0
≤ 12	0
≤ 10	21
≤ 8	5
≤ 6	1
≤ 4	0
I prefer not to use second-generation AR targeted therapy in my patients with nmCRPC	0



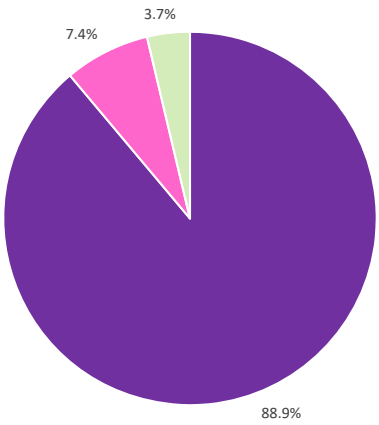
9. In a patient with nmCRPC and PSADT > 10 months, is there an absolute value of PSA that you use to trigger initiation of second generation antiandrogen (ie, apalutamide or enzalutamide)?

Opt	Votes
PSA > 10 ng/mL	0
PSA > 20 ng/mL	8
PSA > 40 ng/mL	0
I would only initiate therapy based on PSADT	19
Wait until metastases	0



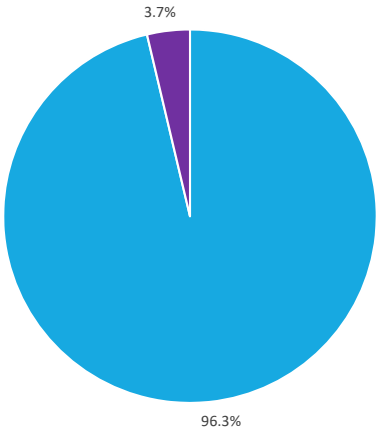
10. For your nmCRPC patients with PSA 10–20 ng/mL, what PSADT threshold do you use in the majority of these patients to initiate second generation AR targeted therapy (apalutamide or enzalutamide)?

Opt	Votes
≤ 14	0
≤ 12	0
≤ 10	24
≤ 8	2
≤ 6	1
≤ 4	0
I prefer not to use second-generation AR targeted therapy in my patients with nmCRPC	0



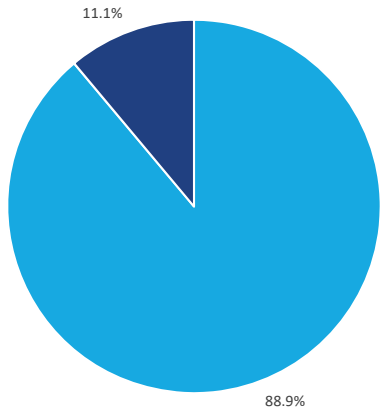
11. For patients with nonmetastatic CRPC on conventional imaging and PSADT ≤ 10 months, what do you do?

Opt	Votes
Treat with nmCRPC agents such as apalutamide or enzalutamide	26
Treat with ADT alone	0
Treat with ADT alone with careful monitoring and increased frequency of PSA measurements and imaging	1
Wait for metastasis to present	0



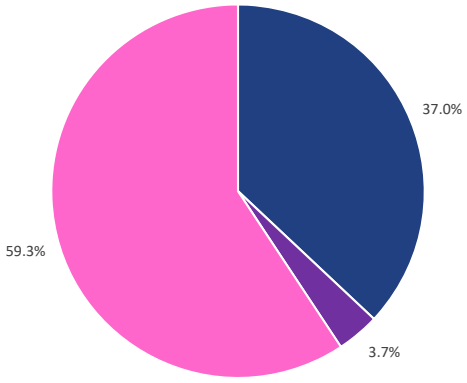
12. What systemic treatment approach do you recommend for the majority of your CRPC patients with PSADT ≤ 10 months, who are nonmetastatic on conventional imaging and have metastases on advanced imaging?

Opt	Votes
	24
	3
	0
	0



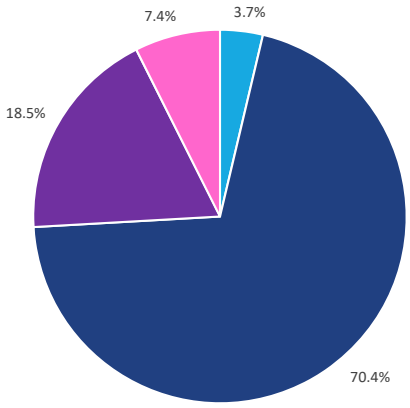
13. In the nmCRPC setting, if a patient initiates treatment with apalutamide or enzalutamide, at what threshold do you recommend switching to subsequent treatment?

Opt	Votes
	0
	10
	1
	16
	0



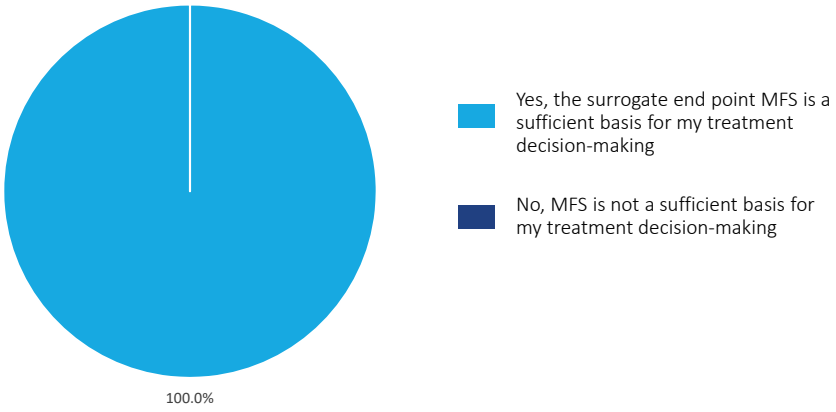
14. In the nmCRPC setting, what do you do if a patient treated with apalutamide or enzalutamide presents with asymptomatic oligometastatic disease?

Opt	Votes
	1
	19
	5
	2
	0



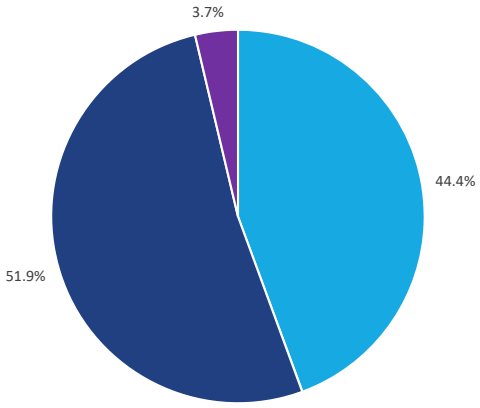
15. Do you feel that surrogate end points correlated with overall survival (OS), such as metastasis-free survival (MFS), provide sufficient evidence for treatment decision-making in nmCRPC?

Opt	Votes
	27
	0



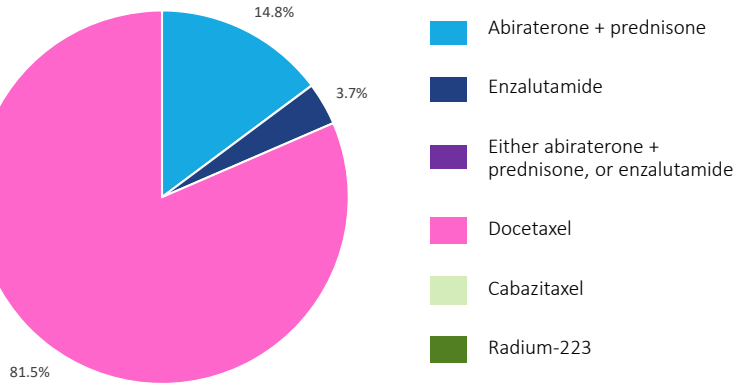
16. Does the PFS2 end point in SPARTAN provide evidence that treating earlier in disease with apalutamide does not negatively impact subsequent therapy for mCRPC?

Opt	Votes
	12
	14
	1



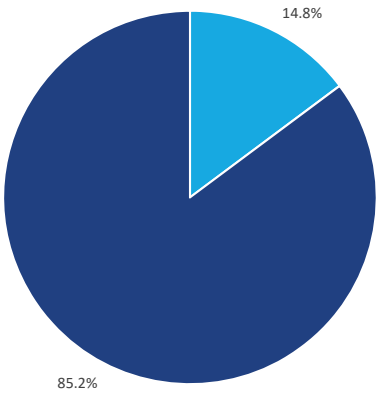
17. In patients who receive apalutamide for nmCRPC and subsequently progress to mCRPC, what do you recommend for first-line treatment of mCRPC (with or without SBRT)?

Opt	Votes
	4
	1
	0
	22
	0
	0



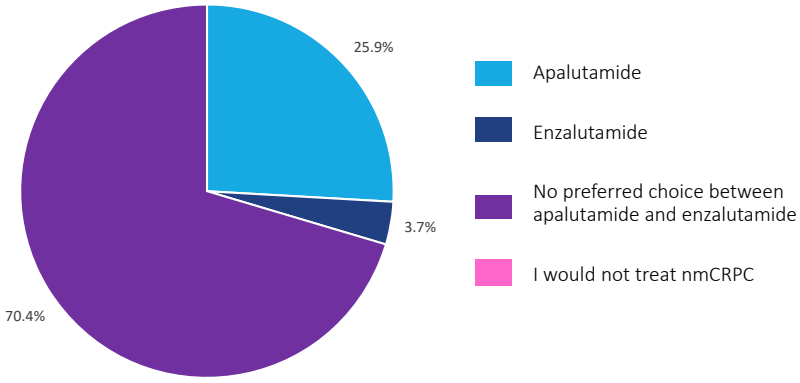
18. In patients who receive enzalutamide for nmCRPC and subsequently progress to mCRPC, what next line of treatment do you recommend for first-line treatment of mCRPC (with or without SBRT)?

Opt	Votes
	4
	23
	0
	0



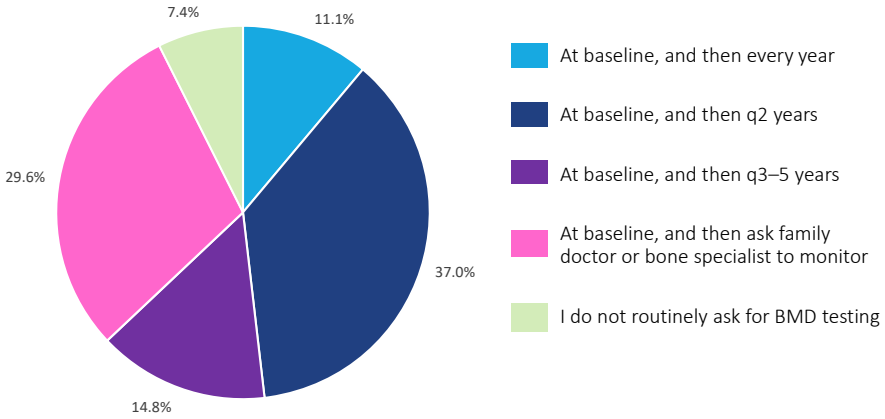
19. What treatment would you recommend for patients with nmCRPC with no contraindication to either apalutamide of enzalutamide and if you had equal access to both?

Opt	Votes
	7
	1
	19
	0



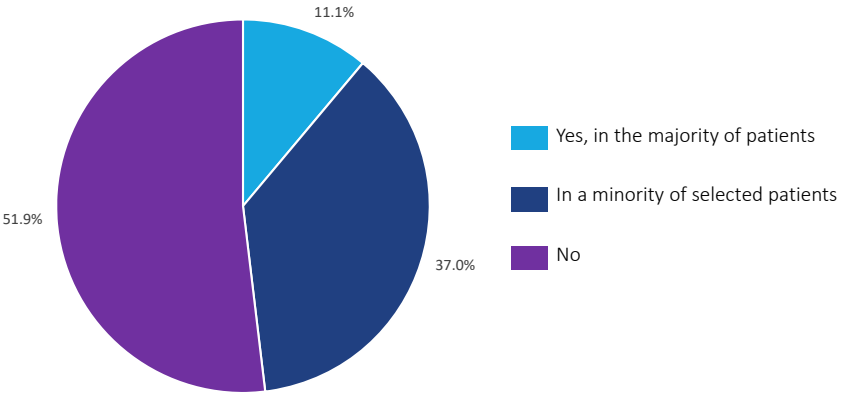
20. In general, how often do you monitor bone mineral density (BMD) for patients on long term ADT?

Opt	Votes
	3
	10
	4
	8
	2



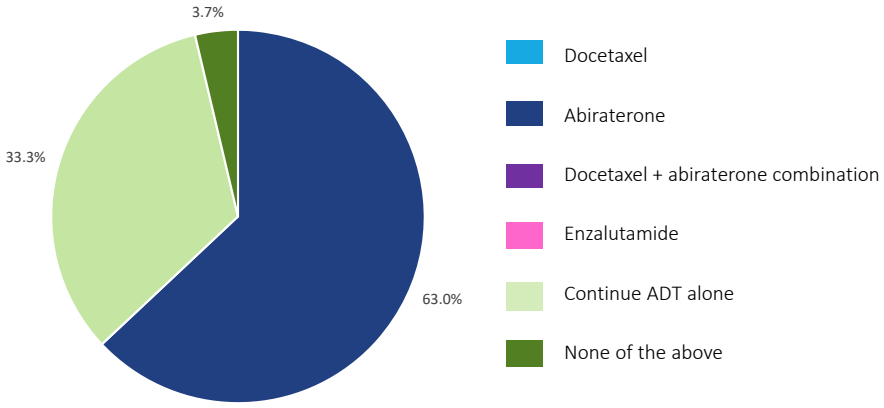
21. Do you prescribe osteoporotic fracture preventative treatment with bisphosphonate or denosumab in your nmCRPC patients who are not known to be osteoporotic?

Opt	Votes
	3
	10
	14



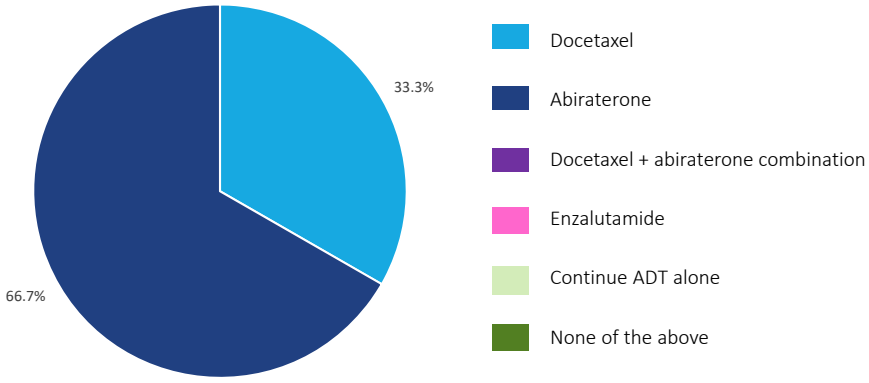
22. For men who are suitable for all options, what is your preferred treatment in addition to ADT in most patients with low volume / low-risk metastatic castration-sensitive prostate cancer (mCSPC)?

Opt	Votes
	0
	17
	0
	0
	9
	1



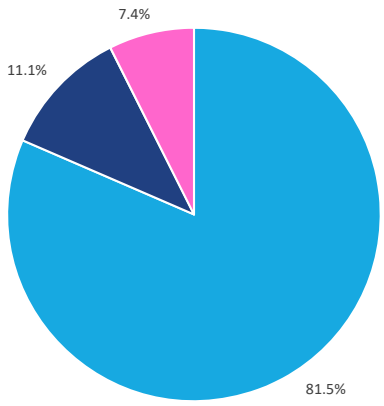
22b. For men who are suitable for all options, what is your preferred treatment in addition to ADT in most patients with high volume / high-risk metastatic castration-sensitive prostate cancer (mCSPC)?

Opt	Votes
	9
	18
	0
	0
	0
	0



23. In general, what form of ADT do you recommend in the majority of men presenting with high-volume mCSPC?

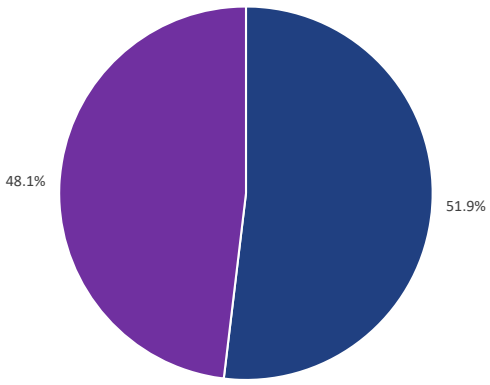
Opt	Votes
	22
	3
	0
	2
	0



- Continuous ADT by luteinizing hormone-releasing hormone (LHRH) agonist alone (+/- short course first-generation androgen receptor [AR] antagonist)
- LHRH antagonist
- Orchiectomy
- Continuous complete androgen blockade (LHRH analog + first-generation AR antagonist)
- Intermittent ADT

24. How long after starting ADT do you recommend starting docetaxel in men where you plan to add docetaxel to ADT?

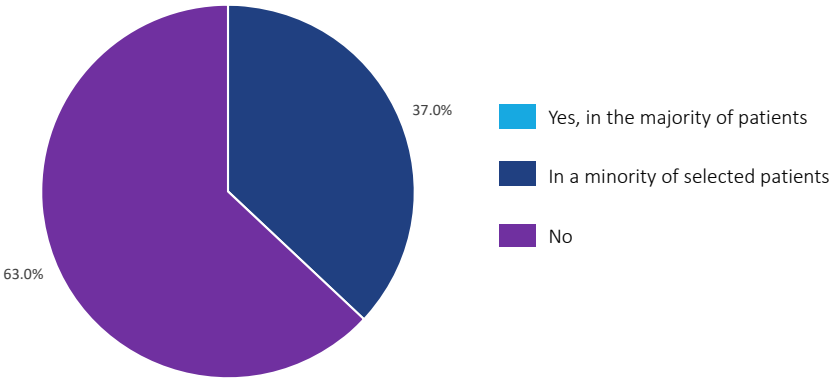
Opt	Votes
	0
	14
	13
	0
	0



- Within 2–4 weeks after starting ADT
- Within 1–3 months after starting ADT
- Within 4 months after starting ADT
- Within 6 months after starting ADT
- I do not prescribe docetaxel in this setting

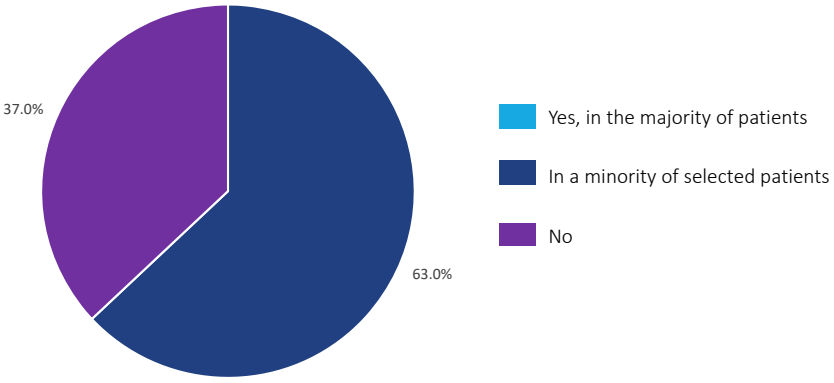
25. Do you recommend docetaxel in addition to ADT in men with castration-sensitive N1 M0 prostate cancer?

Opt	Votes
	0
	10
	17



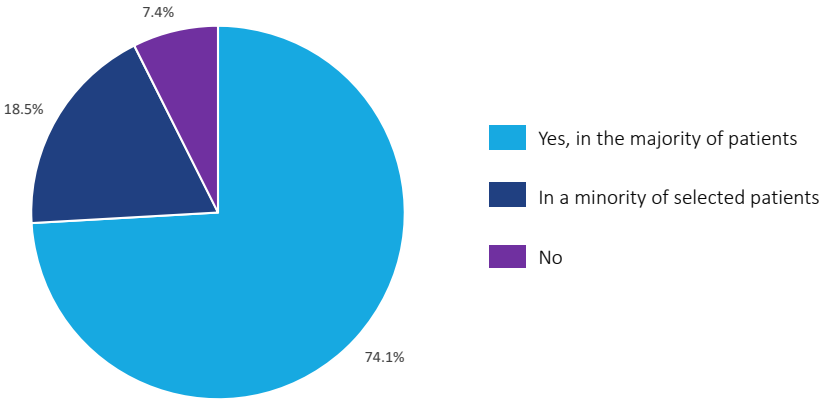
26. Do you recommend abiraterone in addition to ADT in men with castration-sensitive N1 M0 prostate cancer?

Opt	Votes
	0
	17
	10



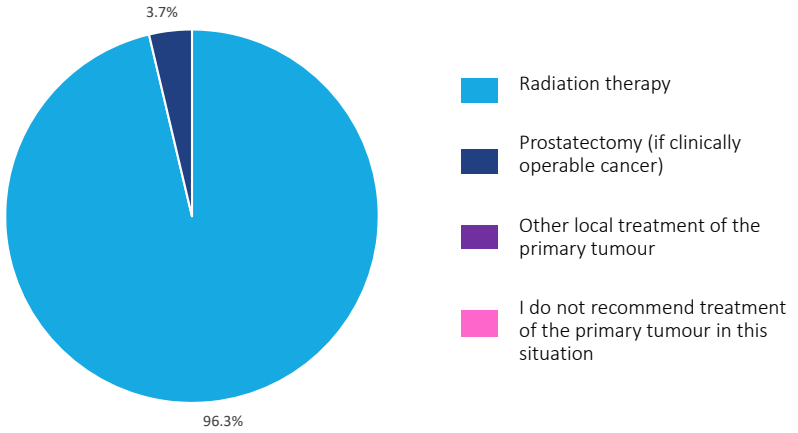
27. In men with de novo metastatic castration-sensitive low-volume prostate cancer, who are not symptomatic from the primary tumour, do you recommend treatment of the primary tumour in addition to systemic therapy?

Opt	Votes
	20
	5
	2



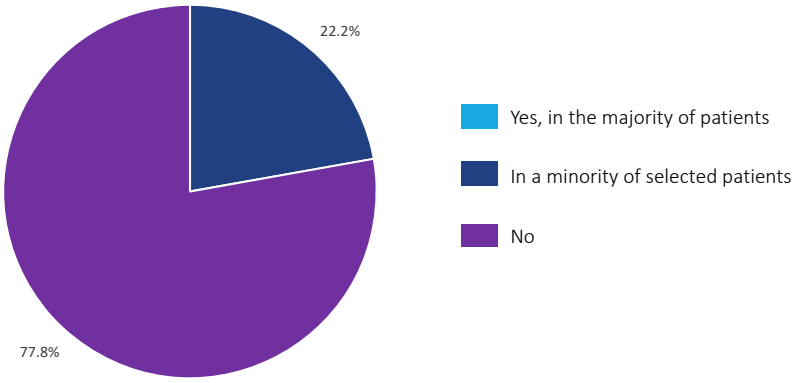
28. In de novo metastatic low-volume prostate cancer, what is your preferred treatment of the primary tumour in the majority of men?

Opt	Votes
	26
	1
	0
	0



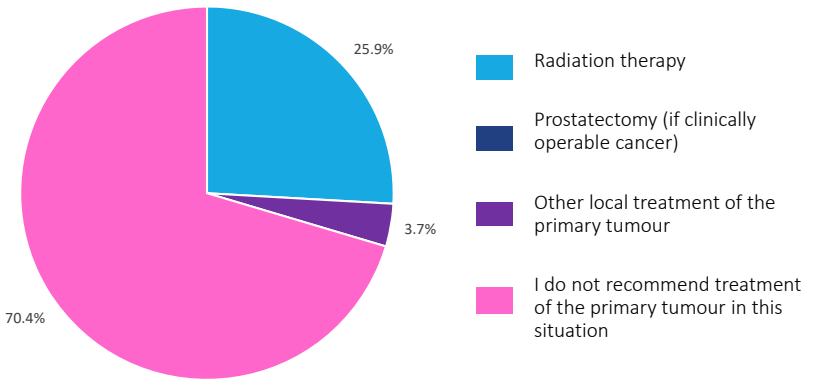
29. In men with de novo metastatic castration-sensitive high-volume prostate cancer, who are not symptomatic from the primary tumour, do you recommend treatment of the primary tumour in addition to systemic therapy?

Opt	Votes
	0
	6
	21



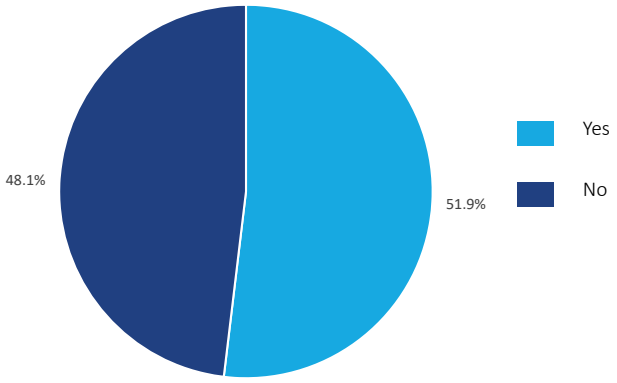
30. In de novo metastatic high-volume prostate cancer, what is your preferred treatment of the primary tumour in the majority of men?

Opt	Votes
	7
	0
	1
	19



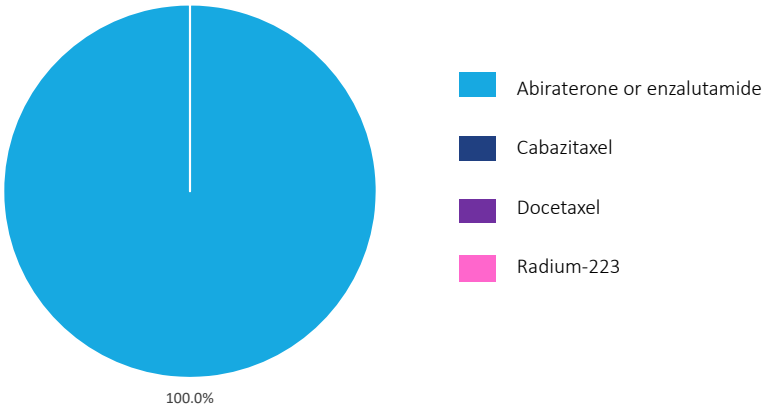
31. Do you recommend using the high-volume (CHAARTED) and high-risk (LATITUDE) disease definitions in mCSPC interchangeably in clinical practice?

Opt	Votes
	14
	13



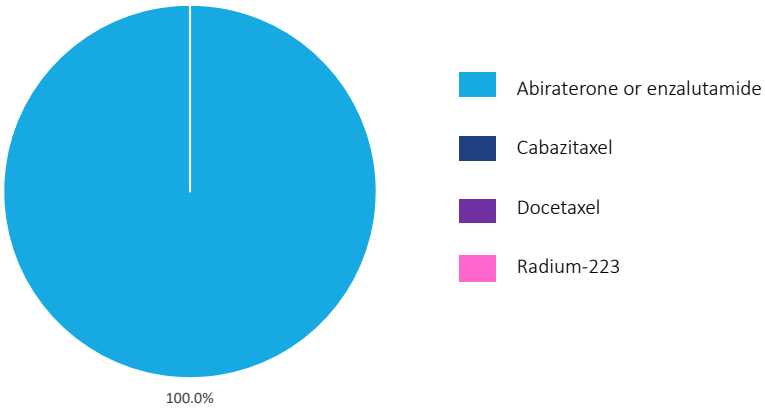
32. What is your preferred first-line mCRPC treatment option in the majority of asymptomatic or minimally symptomatic men who received docetaxel in the castration-sensitive/naïve setting?

Opt	Votes
	26
	0
	0
	0



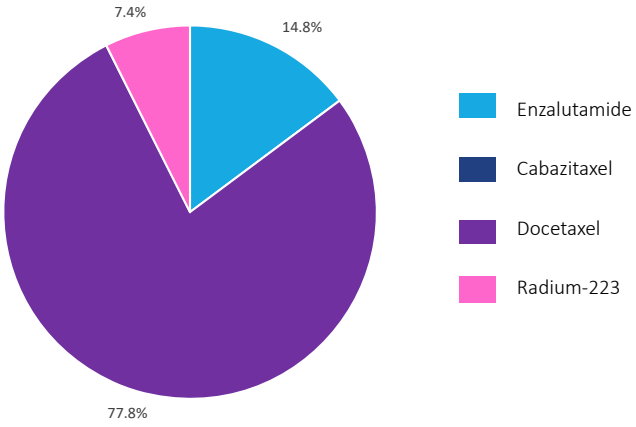
33. What is your preferred first-line mCRPC treatment option in the majority of asymptomatic or minimally symptomatic men who did NOT receive docetaxel or abiraterone in the castration-sensitive/-naïve setting?

Opt	Votes
	27
	0
	0
	0



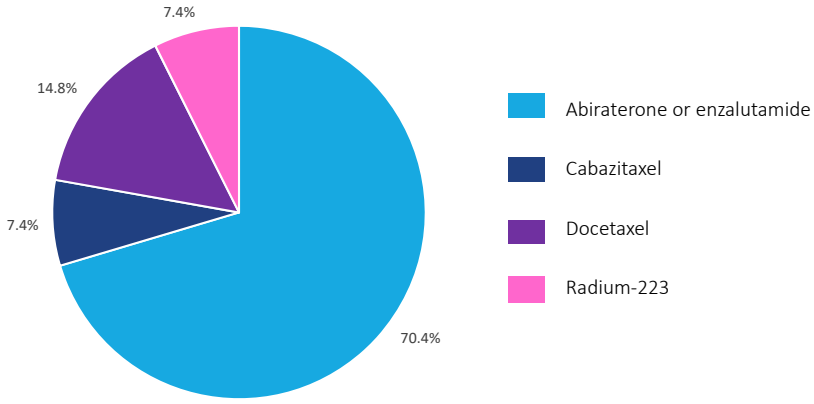
34. What is your preferred first-line mCRPC treatment option in the majority of asymptomatic or minimally symptomatic men who received abiraterone in the castration-sensitive/-naïve setting?

Opt	Votes
	4
	0
	21
	2



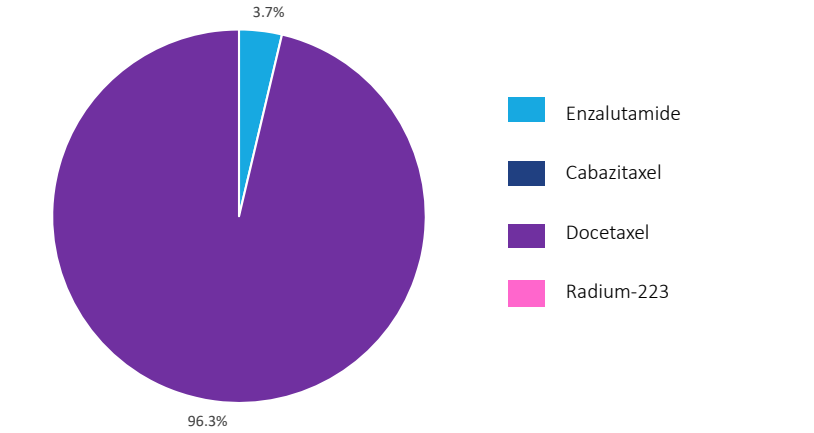
35. What is your preferred first-line systemic mCRPC treatment option in the majority of symptomatic men who received docetaxel in the castration-sensitive/-naïve setting?

Opt	Votes
	19
	2
	4
	2



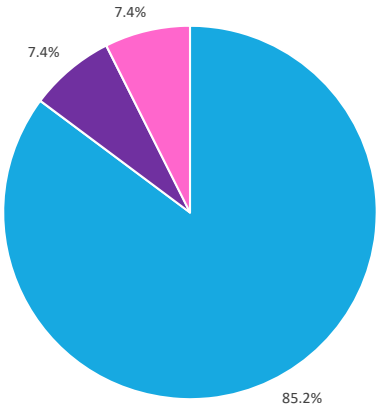
36. What is your preferred first-line mCRPC treatment option in the majority of symptomatic men who received abiraterone in the castration-sensitive/-naïve setting?

Opt	Votes
	1
	0
	26
	0



37. In men with mCRPC who are asymptomatic and have rising PSA on abiraterone plus prednisone, do you recommend a steroid switch to dexamethasone?

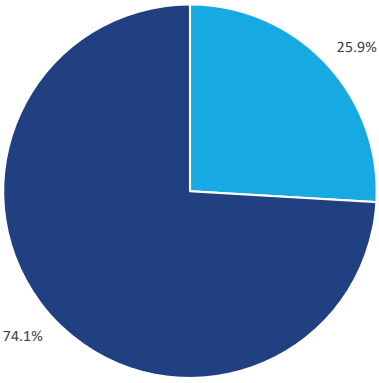
Opt	Votes
	23
	0
	2
	2
	0



- Yes, when progression is PSA progression alone
- Yes, when progression is PSA progression plus clinical and/or radiographic progression
- Yes, regardless of type of progression
- Continue with abiraterone plus prednisone with no switch to dexamethasone
- No, discontinue abiraterone and start a different systemic therapy

38. Do you believe that chemotherapy re-sensitizes to further ARAT therapy?

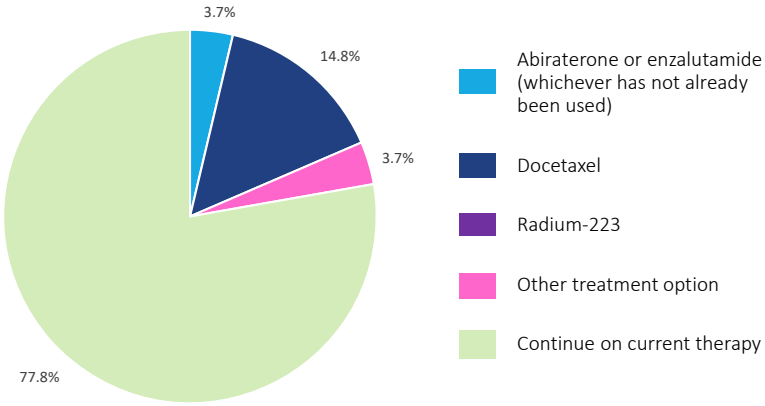
Opt	Votes
	7
	20



- Yes
- No

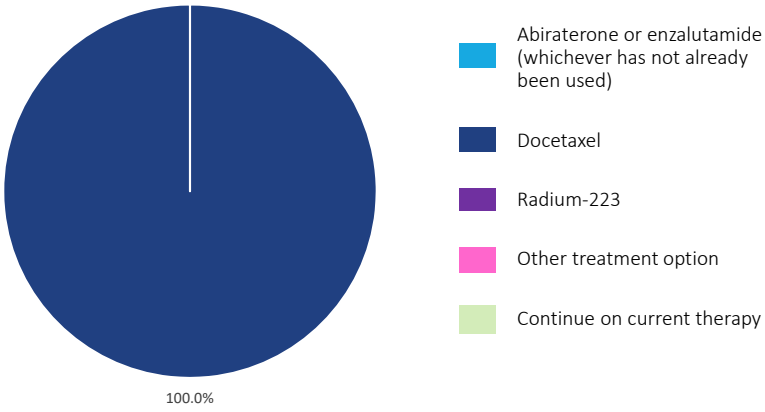
39. In men treated with abiraterone or enzalutamide for first-line asymptomatic mCRPC who have an initial response followed by PSA only progression (secondary [acquired] resistance), what is your preferred second-line treatment for the majority of men?

Opt	Votes
	1
	4
	0
	1
	21



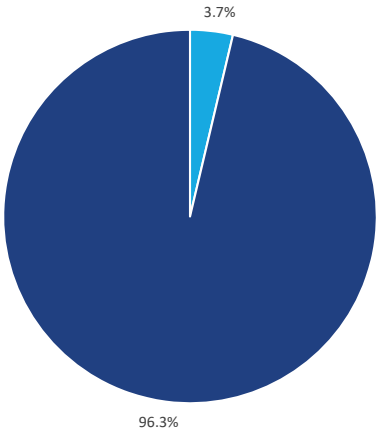
40. In men treated with abiraterone or enzalutamide for first-line asymptomatic mCRPC who have an initial response followed by radiologic + PSA progression secondary [acquired] resistance), what is your preferred second-line treatment for the majority of men?

Opt	Votes
	0
	27
	0
	0
	0



41. In men progressing with symptoms after an initial response to treatment with abiraterone or enzalutamide for first-line mCRPC, what is your preferred second-line treatment for the majority of men?

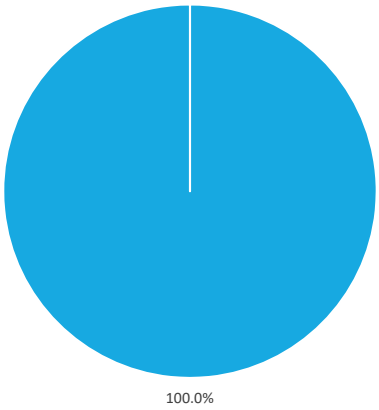
Opt	Votes
	1
	26
	0
	0
	0



- Abiraterone or enzalutamide (whichever has not already been used)
- Docetaxel
- Radium-223
- Other treatment option
- Continue on current therapy

42. What is your preferred second-line mCRPC treatment option in the majority of men progressing on or after docetaxel for mCRPC (without prior abiraterone or enzalutamide)?

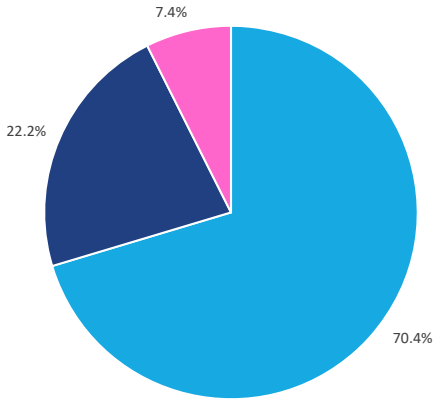
Opt	Votes
	27
	0
	0
	0
	0
	0



- Abiraterone or enzalutamide
- Cabazitaxel
- Radium-223
- Re-challenge with docetaxel if greater than 12 months since last treatment
- Other treatment option
- Continue on current therapy

43. In the mCRPC setting, do you recommend attempting a dose reduction of enzalutamide if a patient experiences adverse effects?

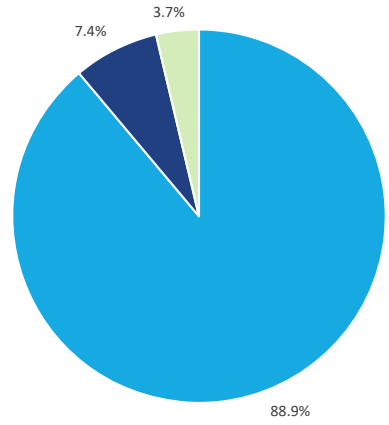
Opt	Votes
	19
	6
	0
	2



- Yes, in the majority of my patients
- Yes, in a select minority of my patients
- No, I maintain the original dose
- No, I switch to abiraterone/prednisone

44. In the mCRPC setting, how do you treat fatigue related to enzalutamide?

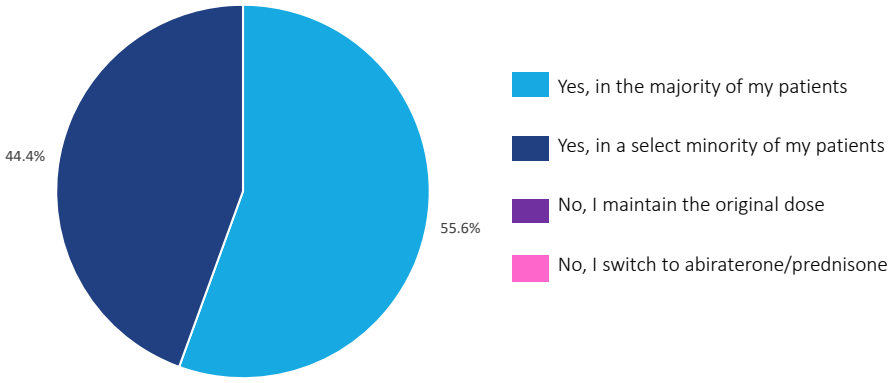
Opt	Votes
	24
	2
	0
	0
	1



- Dose reduction of enzalutamide ± lifestyle recommendations (diet, exercise)
- Addition of prednisone ± lifestyle recommendations (diet, exercise)
- Discontinuation and switch to another agent ± lifestyle recommendations (diet, exercise)
- No action
- Lifestyle recommendations (diet, exercise) alone

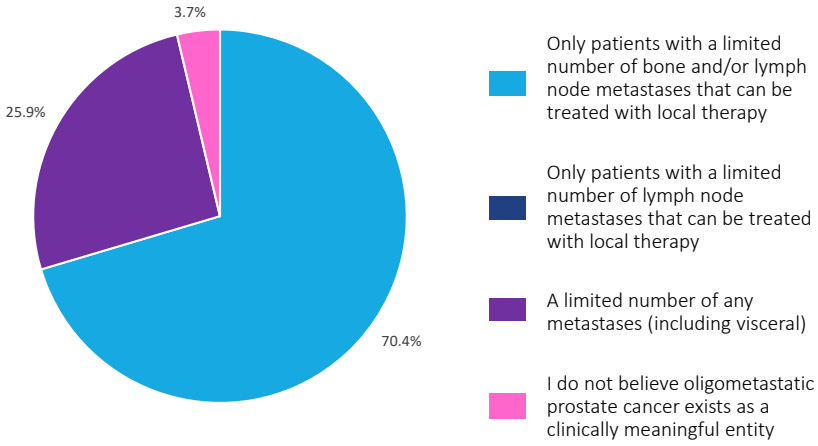
45. In the mCRPC setting, do you recommend attempting a dose reduction to abiraterone + prednisone if a patient experiences adverse effects (other than elevated liver enzyme tests)?

Opt	Votes
	15
	12
	0
	0



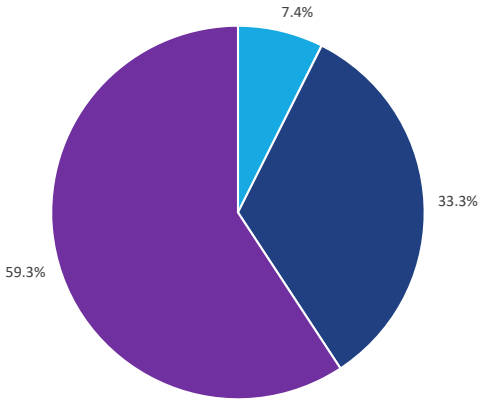
46. A clinically meaningful definition of oligometastatic prostate cancer that influences treatment decision (local treatment of all lesions +/- systemic therapy) includes:

Opt	Votes
	19
	0
	7
	1



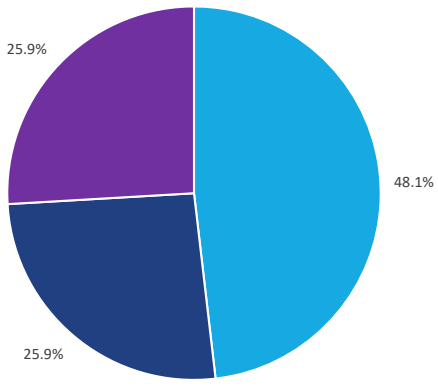
47. What is your cut-off for the number of metastases to consider a patient as oligometastatic?

Opt	Votes
≤ 2 metastases	2
≤ 3 metastases	9
≤ 5 metastases	16
I do not believe that oligometastatic prostate cancer is a clinically meaningful entity	0



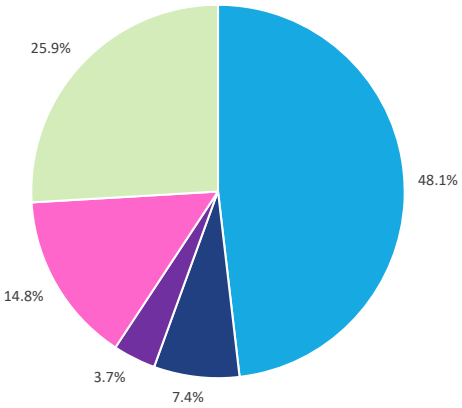
48. Which treatment do you recommend in healthy men with newly-diagnosed oligometastatic castration-sensitive prostate cancer with an untreated primary tumour?

Opt	Votes
ADT +/- docetaxel +/- abiraterone +/- radiation to the primary	13
Radical local treatment of all lesions including the primary lesion (surgery or RT) + ADT 24-36m +/- docetaxel +/- abiraterone	7
Radical local treatment of all lesions including the primary lesion (surgery or RT) + lifelong ADT +/- docetaxel +/- abiraterone	7
I do not believe that oligometastatic prostate cancer is a clinically meaningful entity	0



49. What treatment do you recommend in the majority of asymptomatic men developing oligometastatic recurrent CSPC after local treatment of the primary with curative intent (+/- salvage radiation therapy)?

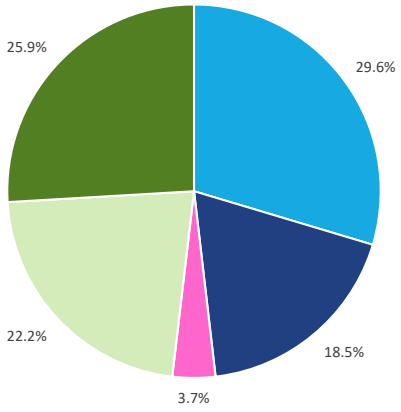
Opt	Votes
	13
	2
	1
	4
	7



- Lifelong ADT +/- docetaxel +/- abiraterone
- Radical local treatment of all lesions (surgery or RT) without ADT
- Radical local treatment of all lesions (surgery or RT) + ADT 6–12m
- Radical local treatment of all lesions (surgery or RT) + ADT 24–36m
- Radical local treatment of lesions (surgery or RT) + lifelong ADT +/- docetaxel +/- abiraterone

50. What treatment do you recommend if you are considering metastasis-directed therapy in men with oligometastatic recurrent CSPC that is limited to lymph node metastases in the pelvis after local treatment with curative intent (+/- salvage radiation therapy)?

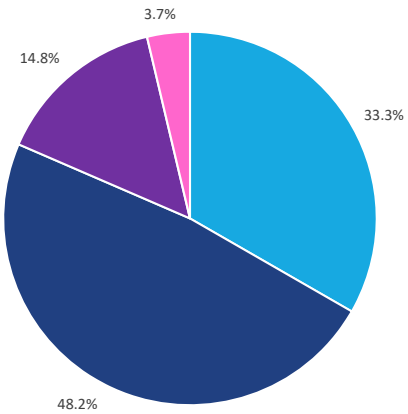
Opt	Votes
	8
	5
	0
	1
	6
	7
	0



- ADT
- Salvage lymph node dissection
- Salvage lymph node dissection + whole pelvis radiotherapy
- Focal radiotherapy to the suspicious nodes
- Stereotactic body radiation therapy (SBRT)
- Whole pelvis radiotherapy +/- boost to the suspicious nodes
- I do not believe that the oligometastatic recurrent state is a clinically meaningful entity

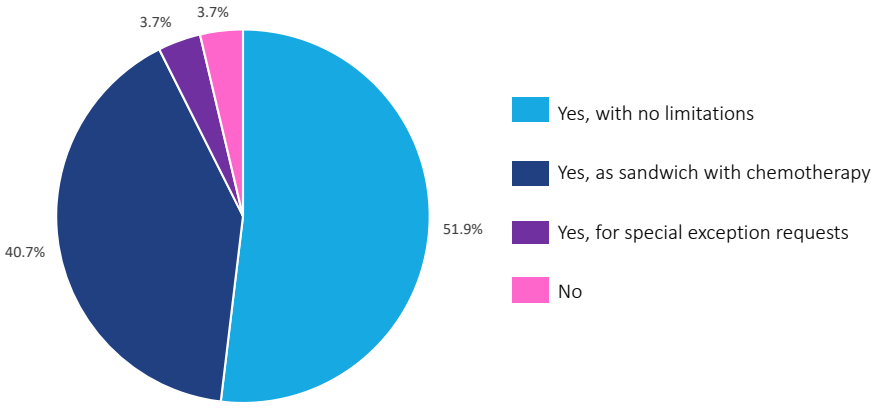
51. Would you recommend provincial funding for use of a second AR agent in patients with mCRPC?

Opt	Votes
	9
	13
	4
	1



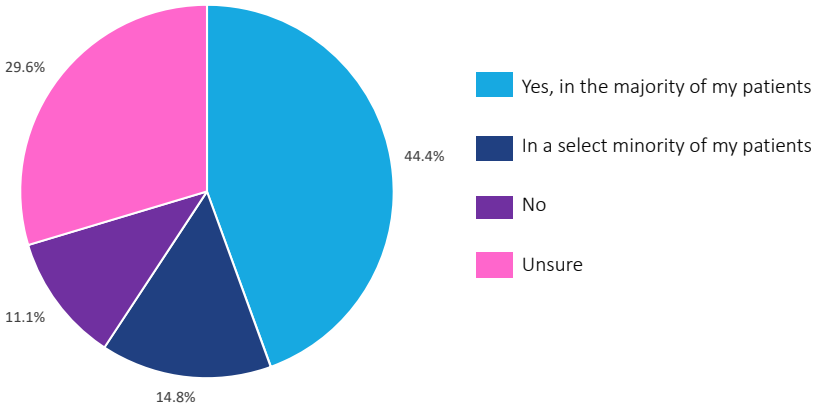
52. Would you recommend provincial funding for use of a second AR agent in patients with mCRPC (after mCSPC or after nmCRPC)?

Opt	Votes
	14
	11
	1
	1



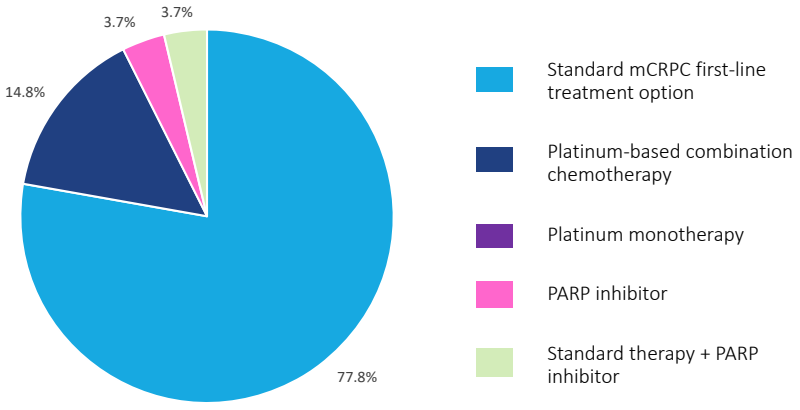
53. If access was available, would you recommend treatment with PARP inhibitor in men with mCRPC and presence of DNA repair defects (germline or somatic)?

Opt	Votes
	12
	4
	3
	8



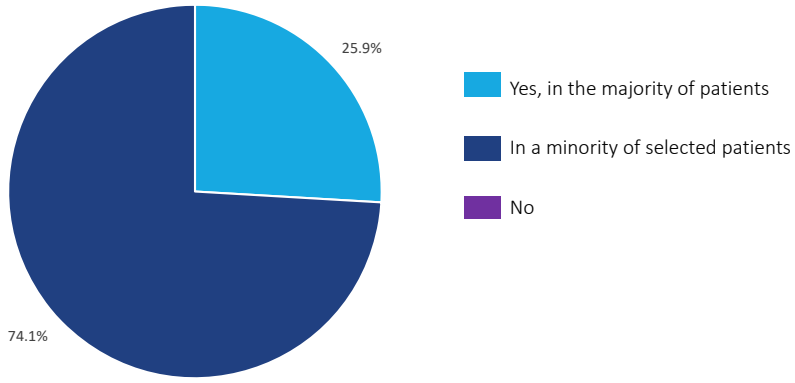
54. In men with mCRPC and a presence of DNA repair defects (germline or somatic) progressing early on ADT (castration-resistance), which first-line mCRPC treatment do you recommend?

Opt	Votes
	21
	4
	0
	1
	1

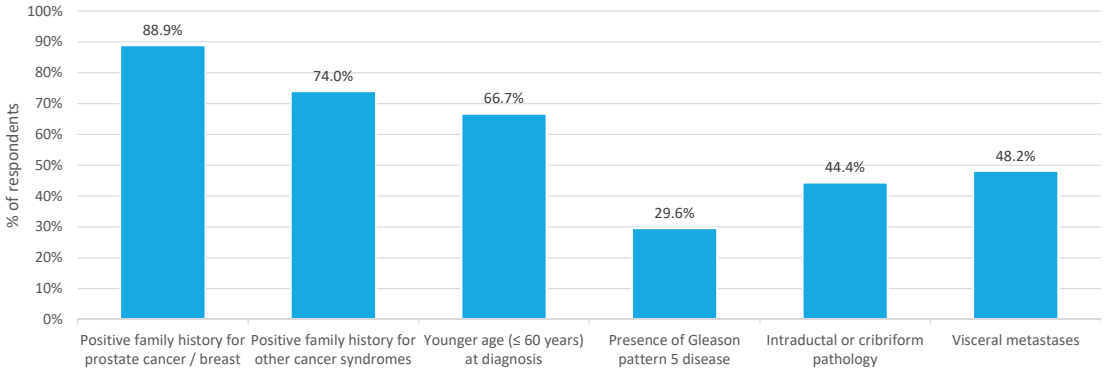


55. Would you recommend genetic counselling and testing for men with newly diagnosed metastatic (M1) prostate cancer?

Opt	Votes
	7
	20
	0



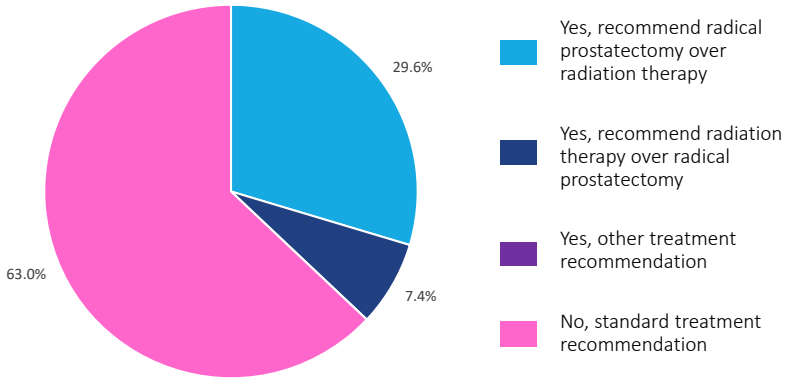
56. If you voted for a minority of selected patients in the previous question, which factors influence your selection? Choose all that apply.



Opt	1	2	3	4	5	6
Votes	24	20	18	8	12	13

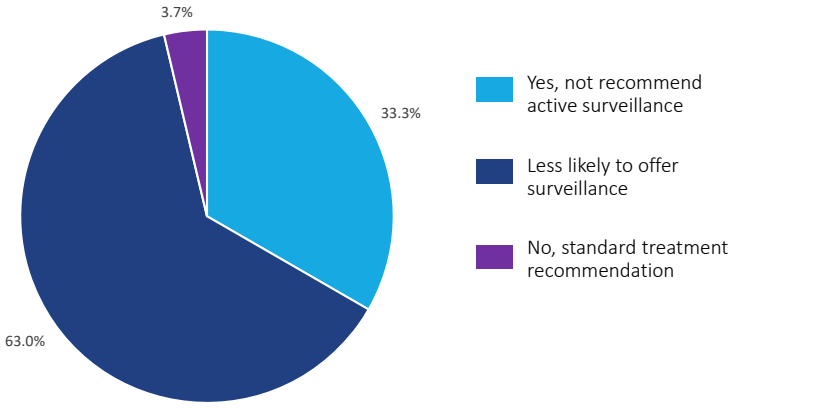
57. Does the presence of a germline BRCA1, BRCA2, or ATM mutation in men with intermediate or high-risk localized prostate cancer influence your treatment decision?

Opt	Votes
	8
	2
	0
	17



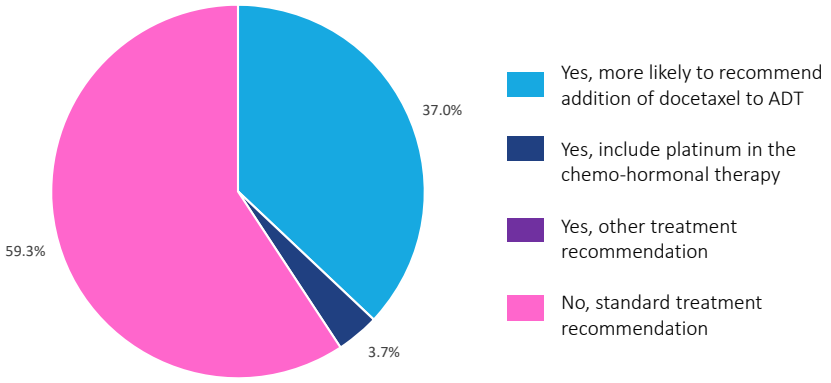
58. Does the presence of a germline BRCA1, BRCA2, or ATM mutation in men with low-risk localized prostate cancer influence your treatment decision?

Opt	Votes
	9
	17
	1



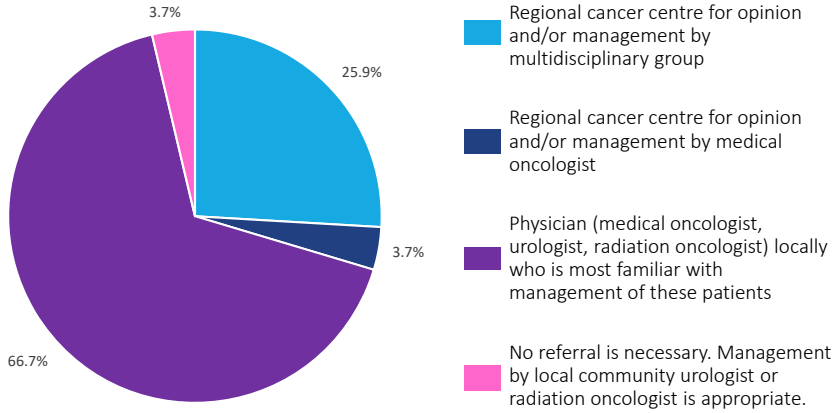
59. Does the presence of DNA repair defects (germline or somatic) in men with newly-diagnosed metastatic castration-sensitive/-naïve prostate cancer influence your upfront treatment decision for men with metastatic disease?

Opt	Votes
	10
	1
	0
	16



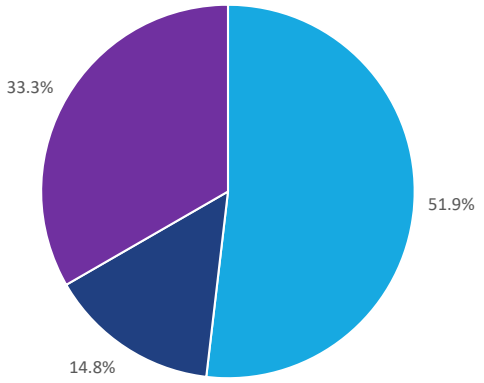
60. Patients with nmCRPC should be referred to:

Opt	Votes
	7
	1
	18
	1



61. Patients with mCSPC should be referred to:

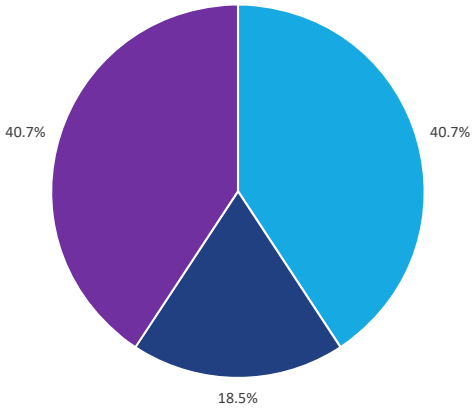
Opt	Votes
	14
	4
	9
	0



- Regional cancer centre for opinion and/or management by multidisciplinary group
- Regional cancer centre for opinion and/or management by medical oncologist
- Physician (medical oncologist, urologist, radiation oncologist) locally who is most familiar with management of these patients
- No referral is necessary. Management by local community urologist is appropriate

62. Patients with mCRPC should be referred to:

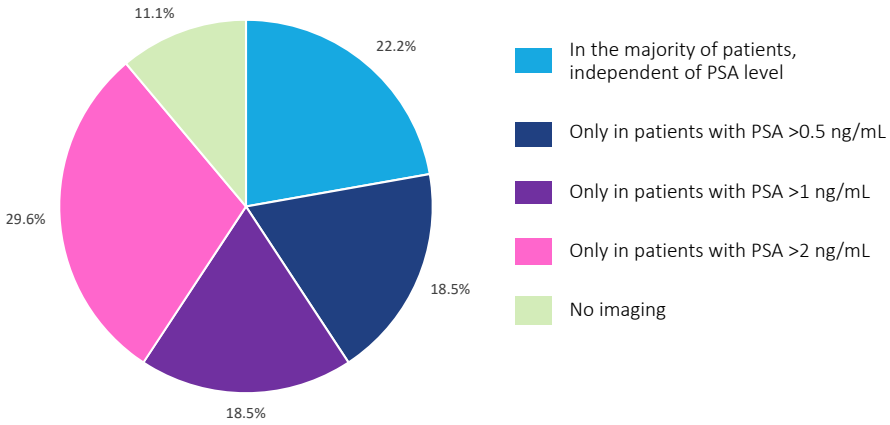
Opt	Votes
	11
	5
	11
	0



- Regional cancer centre for opinion and/or management by multidisciplinary group
- Regional cancer centre for opinion and/or management by medical oncologist
- Physician (medical oncologist, urologist, radiation oncologist) locally who is most familiar with management of these patients
- No referral is necessary. Management by local community urologist is appropriate

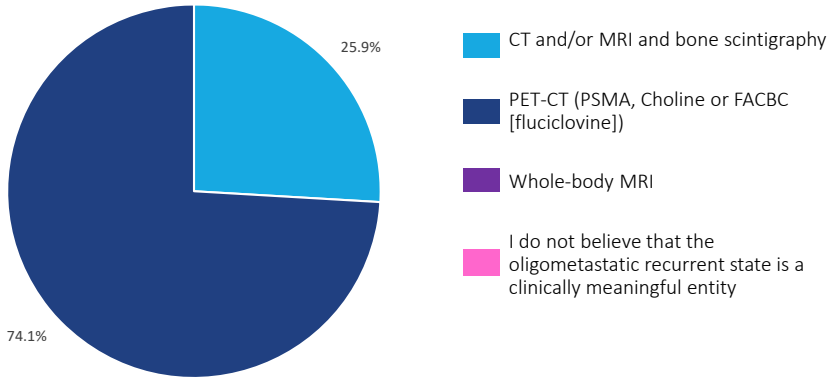
63. In which men with isolated rising PSA alone after prostatectomy do you recommend imaging (including next generation imaging) before starting salvage radiation therapy?

Opt	Votes
	6
	5
	5
	8
	3



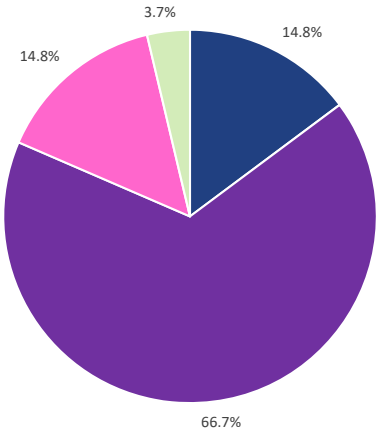
64. What imaging modality do you recommend to diagnose the oligometastatic recurrent state for men with CSPC after local treatment with curative intent (+/- salvage radiation therapy)?

Opt	Votes
	7
	20
	0
	0



65. How do you image your patients with mCSPC (assume all options available)?

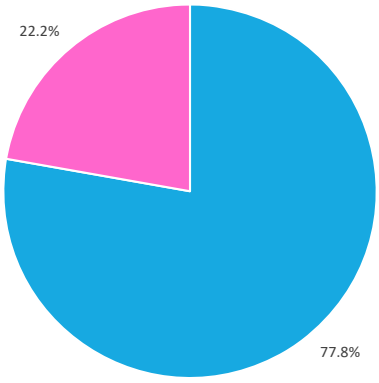
Opt	Votes
	0
	4
	18
	4
	1



- Baseline imaging and regular monitoring by imaging every 3–6 months
- Baseline imaging and regular monitoring by imaging every 6–12 months
- Baseline imaging and follow-up imaging at PSA nadir and again at progression (confirmed PSA rise and/or clinical progression)
- Baseline imaging only and monitoring by PSA alone and imaging at progression
- Another option

66. What kind of imaging do you recommend for the majority of men with mCSPC?

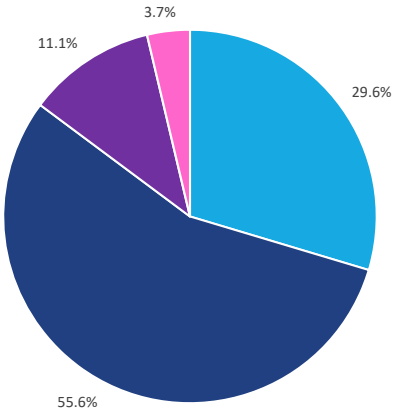
Opt	Votes
	21
	0
	0
	6



- CT and bone scintigraphy
- CT alone
- Bone scintigraphy alone
- Next-generation imaging for prostate cancer if available

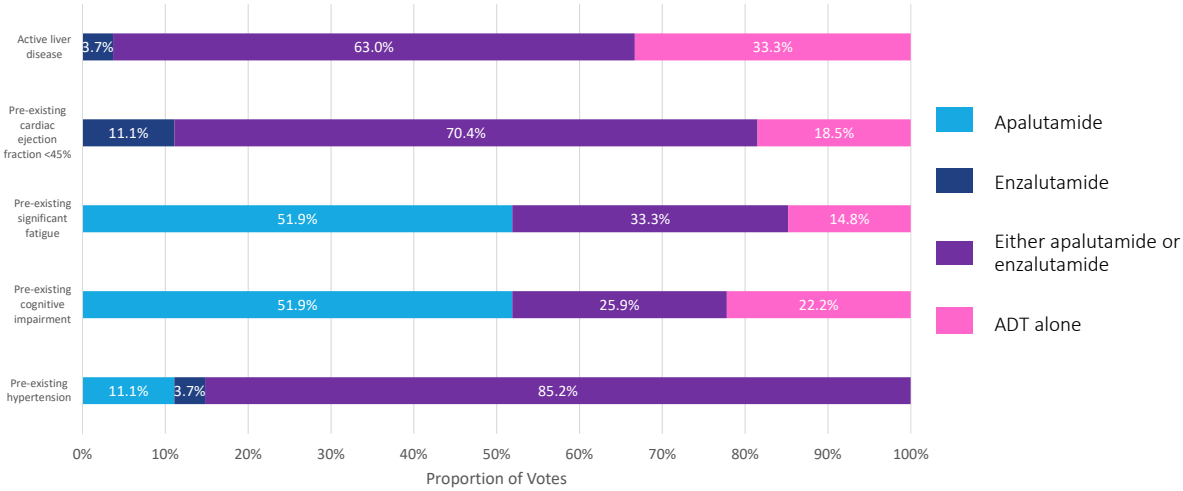
67. How do you image the majority of your patients on first-line mCRPC therapy (assuming all options available)?

Opt	Votes
	8
	15
	3
	1

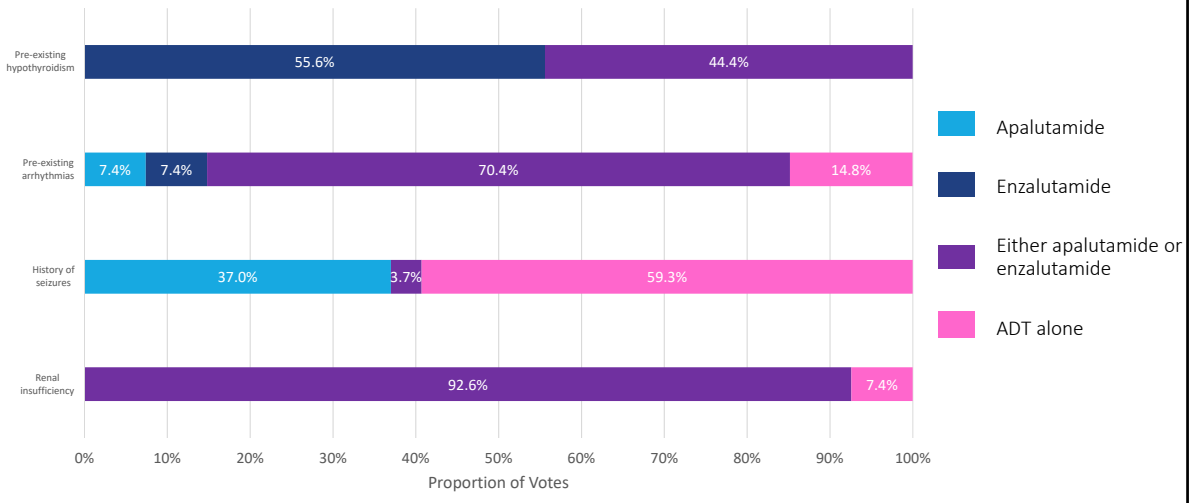


- Baseline imaging and regular monitoring by imaging every 3–6 months
- Baseline imaging and follow-up imaging at PSA nadir and again at progression (confirmed PSA rise and/or clinical progression)
- Baseline imaging only and monitoring by PSA alone and imaging at progression
- Another option

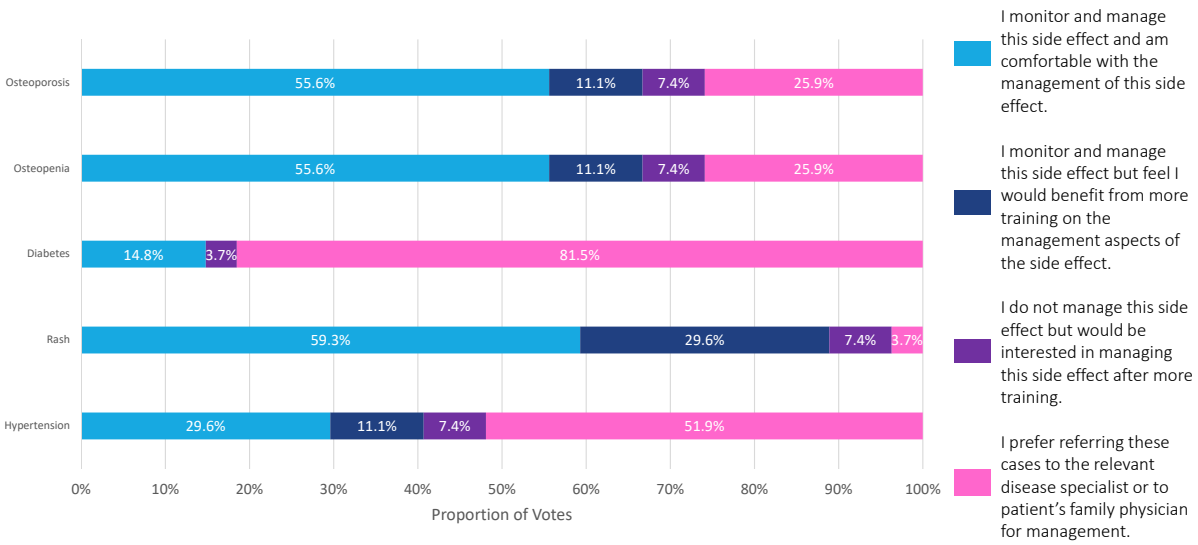
Exploratory Q1. What treatment do you recommend for nmCRPC among patients with the following?



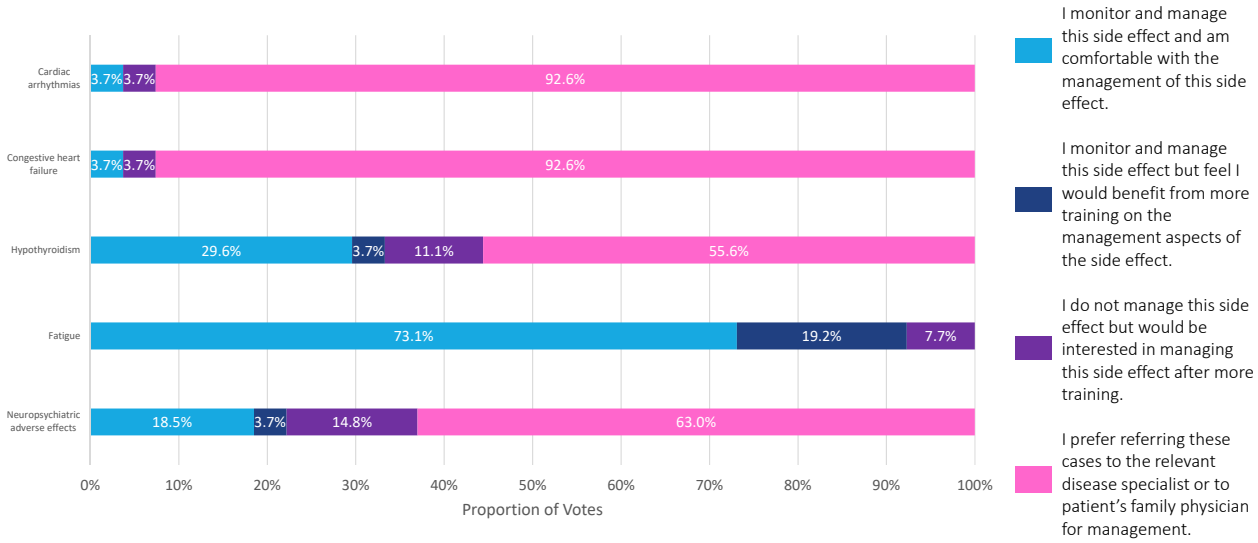
Exploratory Q1 Continued. What treatment do you recommend for nmCRPC among patients with the following?



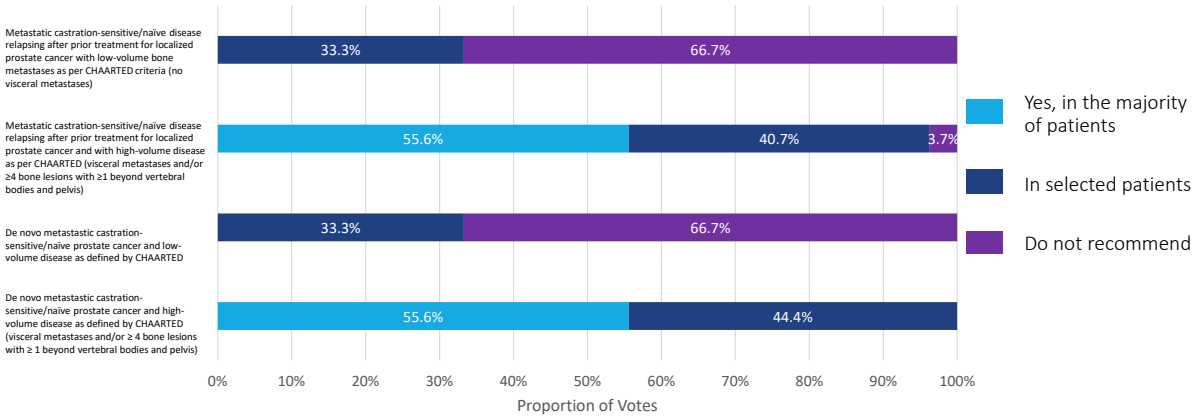
Exploratory Q2. Do you feel comfortable managing the following side effects related to AR therapy?



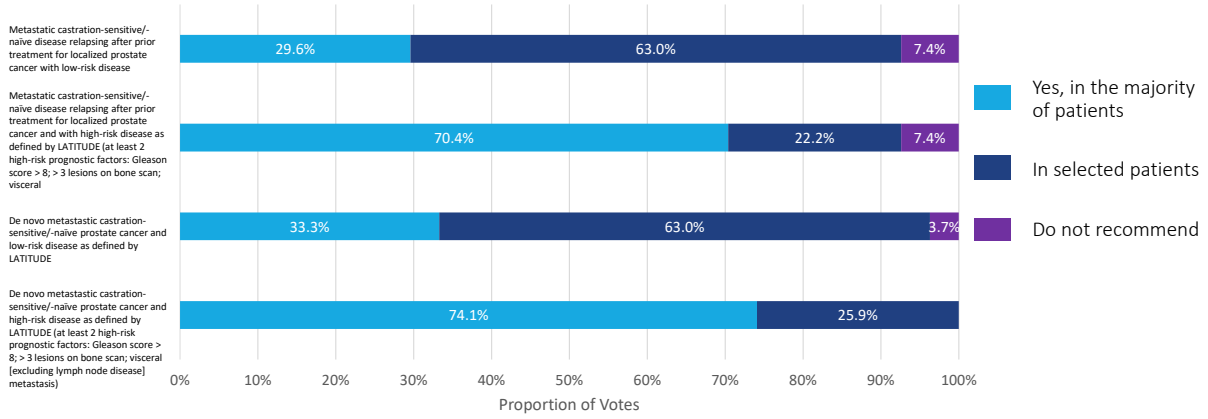
Exploratory Q2 Continued. Do you feel comfortable managing the following side effects related to AR therapy?



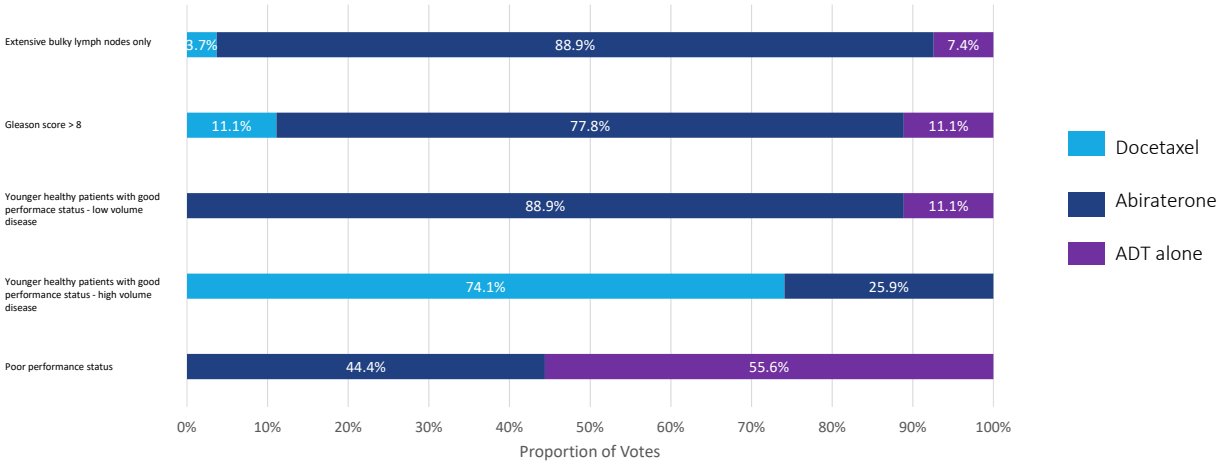
Exploratory Q3. For men who are suitable for all treatment options, do you recommend docetaxel in addition to ADT in men in the following situations?



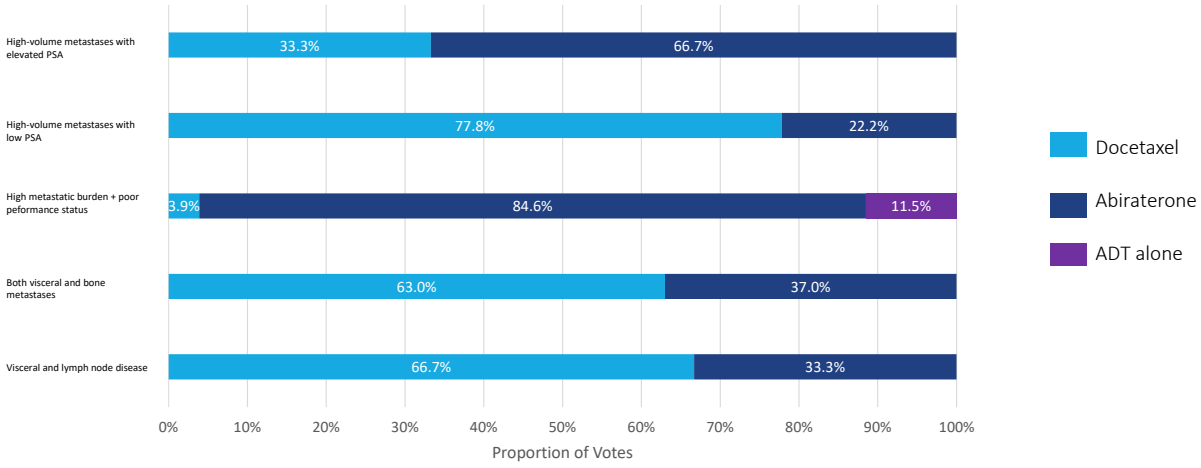
Exploratory Q4. For men who are suitable for all treatment options, do you recommend abiraterone in addition to ADT in men in the following situations?



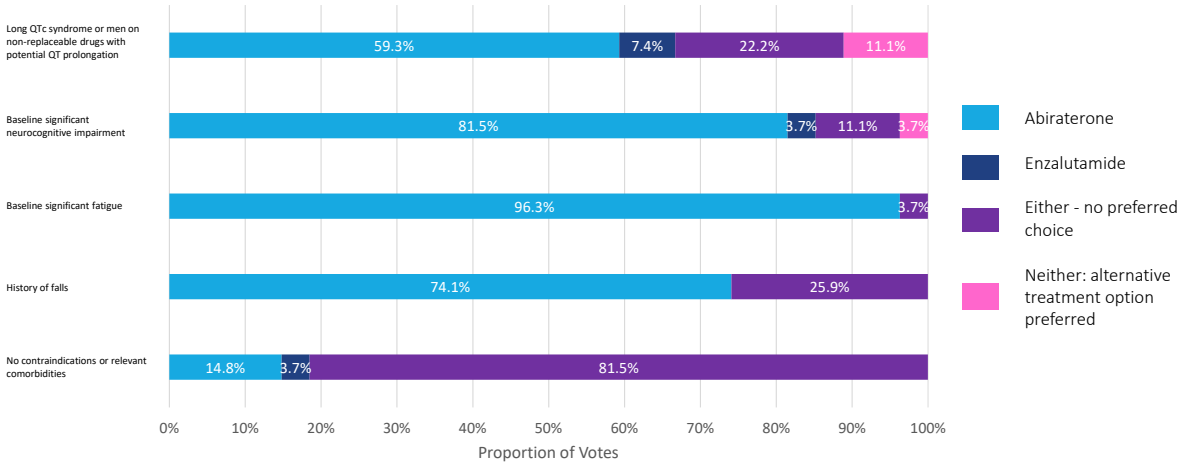
Exploratory Q5. What do you generally recommend for treatment of mCSPC in the following patient subgroups (assuming no other contraindication to treatment)?



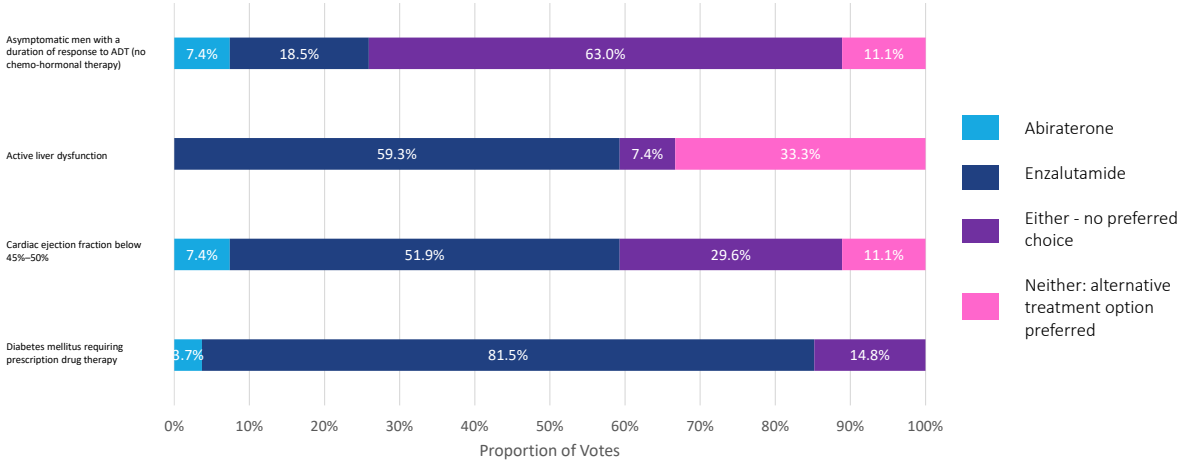
Exploratory Q5 Continued. What do you generally recommend for treatment of mCSPC in the following patient subgroups (assuming no other contraindication to treatment)?



Exploratory Q6. What is your preferred choice between abiraterone and enzalutamide at any time in the treatment sequence in men with mCRPC if all options are available in the following medical situations?



Exploratory Q6 Continued. What is your preferred choice between abiraterone and enzalutamide at any time in the treatment sequence in men with mCRPC if all options are available in the following medical situations?



Exploratory Q7. On average, how often do you request imaging for patients who are being treated with apalutamide or enzalutamide for nmCRPC?