APPENDIX

GURC Canadian Consensus Forum members by specialty and region

Fred	**Saad**	QC	Urologist	Core Scientific Group
Kim	Chi	BC	Medical Oncologist	
Tony	Finelli	ON	Urologist	
Sebastien	Hotte	ON	Medical Oncologist	
Christina	Canil	ON	Medical Oncologist	
Alan	So	BC	Urologist	
Shawn	Malone	ON	Radiation Oncologist	
Bobby	Shayegan	ON	Urologist	
Lorne	Aaron	QC	Urologist	GURC Panel
Naveen	Basappa	AB	Medical Oncologist	
Henry	Conter	ON	Medical Oncologist	
Brita	Danielson	AB	Radiation Oncologist	
Geoffrey	Gotto	AB	Urologist	
Robert	Hamilton	ON	Urologist	
Jason	Izard	ON	Urologist	
Anil	Kapoor	ON	Urologist	
Michael	Kolinsky	AB	Medical Oncologist	
Aly-Khan	Lalani	ON	Medical Oncologist	
Jean-Baptiste	Lattouf	QC	Urologist	
Chris	Morash	ON	Urologist	
Scott	Morgan	ON	Radiation Oncologist	
Tamim	Niazi	QC	Radiation Oncologist	
Krista	Noonan	BC	Medical Oncologist	
Michael	Ong	ON	Medical Oncologist	
Ricardo	Rendon	NS	Urologist	
Sandeep	Sehdev	ON	Medical Oncologist	
Jeffrey	Spodek	ON	Urologist	

GURC practice recommendations arising from earlier study of prostate cancer specialists

Biochemical recurrence

1. In general, absolute prostate-specific antigen should be used to guide when to initiate androgen deprivation therapy (ADT) after biochemical recurrence following local radical treatment.
2. Intermittent ADT should generally be used for patients with no documented metastatic disease and prostate-specific antigen (PSA)-only recurrence following local radical treatment.
3. On average, PSA should be measured every 3–4 months for PSA recurrence after local radical therapy.

Non-metastatic castration-resistant prostate cancer (nmCRPC)

4. For the majority of patients, a PSA doubling time (PSADT) of $\leq$10 months should be used as the threshold to start second-generation androgen receptor (AR) therapy for patients with nmCRPC.
5. For the majority of patients, a PSADT of $\leq$10 months should be used as the threshold to start second-generation AR therapy for patients with nmCRPC and PSA 10–20 ng/mL.
6. For patients with nmCRPC on conventional imaging and PSADT $\leq$10 months, treatment should be initiated with nmCRPC agents, such as apalutamide or darolutamide.
7. For the majority of patients with nmCRPC on conventional imaging, metastases on positron-emission tomography (PET)-based imaging, and PSADT $\leq$10 months, treatment with nmCRPC agents, such as apalutamide or darolutamide, is recommended.
8. Surrogate endpoints likely correlated with overall survival, such as metastasis-free survival, provide sufficient evidence for treatment decision-making in nmCRPC.

Metastatic castration-sensitive prostate cancer (mCSPC)

9. For the majority of men presenting with high-volume mCSPC, ADT treatment in the form of luteinizing hormone-releasing hormone (LHRH) agonist alone (± short course first-generation AR antagonist) AND adjuvant systemic therapies, such as docetaxel, apalutamide, abiraterone acetate/prednisone, or enzalutamide, are recommended.
10. For the majority of patients with de novo low-volume mCSPC who are not symptomatic from the primary tumor, treatment of the primary tumor is recommended, in addition to systemic therapy described in (9).

11. For the majority of patients with de novo low-volume mCSPC, radiation therapy is the preferred form of treatment of the primary tumor.
12. In men with de novo high-volume mCSPC who are not symptomatic from the primary tumor, treatment of the primary tumor, in addition to systemic therapy, is not recommended.

Sequencing of treatments across the disease spectrum

13. In patients who receive apalutamide for nmCRPC and subsequently progress to mCRPC, docetaxel is recommended for first-line treatment of mCRPC (with or without stereotactic body radiotherapy).
14. In patients who receive enzalutamide for nmCRPC and subsequently progress to mCRPC, docetaxel is recommended for first-line treatment of mCRPC (with or without stereotactic body radiotherapy).
15. For the majority of asymptomatic or minimally symptomatic men who received docetaxel in the castration-sensitive setting, abiraterone acetate + prednisone or enzalutamide is the preferred first-line treatment option for mCRPC.
16. For the majority of asymptomatic or minimally symptomatic men who received abiraterone acetate + prednisone in the castration-sensitive setting, docetaxel is the preferred first-line treatment option for mCRPC.
17. For the majority of symptomatic men who received abiraterone acetate + prednisone in the castration-sensitive setting, docetaxel is the preferred first-line treatment option for mCRPC.
18. For the majority of asymptomatic men who were treated with abiraterone acetate + prednisone or enzalutamide for first-line mCRPC and who had an initial response followed by PSA-only progression (secondary acquired resistance), continuation on current therapy is recommended.
19. For the majority of asymptomatic men who were treated with abiraterone acetate + prednisone or enzalutamide for first-line mCRPC and who had initial response followed by radiological + PSA progression (secondary acquired resistance), docetaxel is the preferred second-line treatment.
20. For the majority of symptomatic men who were treated with abiraterone acetate + prednisone or enzalutamide for first-line mCRPC and who had an initial response followed by progression, docetaxel is the preferred second-line treatment.
21. For the majority of men with mCRPC who are progressing on or after docetaxel for mCRPC, abiraterone acetate + prednisone, or enzalutamide is the preferred second-line treatment for men without prior abiraterone acetate + prednisone or enzalutamide treatment.
22. In asymptomatic men with mCRPC and PSA-only progression on abiraterone acetate + prednisone, a steroid switch to dexamethasone is recommended.

Metastatic castration-resistant prostate cancer (mCRPC)

23. For the majority of asymptomatic or minimally symptomatic men with mCRPC who did not receive docetaxel or abiraterone acetate + prednisone in the castration-sensitive setting, abiraterone acetate + prednisone or enzalutamide is the preferred first-line treatment for mCRPC.
24. Chemotherapy used after initial ARAT therapy is not felt to restore sensitivity to further ARAT use.
25. In the mCRPC setting, fatigue related to enzalutamide was treated with a dose reduction of enzalutamide.

Genetic testing

26. In men with DNA repair defects (germline or somatic) who progress early on ADT to mCRPC, first-line mCRPC should be treated with standard options.
27. In men with newly diagnosed metastatic (M1) prostate cancer, genetic counselling and testing is recommended in a minority of selected patients.
28. In men with newly diagnosed metastatic (M1) prostate cancer, genetic counselling and testing is recommended for men with a positive family history for prostate cancer/breast cancer/ovarian cancer.
29. In men with newly diagnosed metastatic (M1) prostate cancer, genetic counselling and testing is recommended for men with a positive family history for other cancer syndromes (e.g., hereditary breast cancer and ovarian cancer syndrome and/or pancreatic cancer, or Lynch syndrome).

Imaging

30. For the majority of men with mCSPC, computed tomography (CT) and bone scintigraphy is the recommended imaging modality.
31. For men with CSPC who have received local treatment with curative intent (± salvage radiation therapy), PET-CT (PSMA, choline or FACBC [fluciclovine]) imaging is the modality recommended, if available, to diagnose an oligometastatic recurrent state. The best management of such a state if subject to clinical trials.