

13° CONGRESSO NAZIONALE AIOM GIOVANI

2019 NEWS IN ONCOLOGY



SEQUENZA TERAPEUTICA IN PAZIENTE AFFETTO DA TUMORE DELLA PROSTATA METASTATICO ALL'ESORDIO

Chiara Casadei

S.S. Oncologia Medica Genitourinaria

- Start from clinics:

Uomo di 67 anni

28.03.2018 TC addome con mdc:

multiple linfoadenomegalie in sede retroperitoneale, lungo il decorso dell'aorta e degli assi vascolari iliaci, il maggiore in sede para-aortica sinistra di circa 48 x 40 mm all'altezza della vena renale.

Prostata aumentata di dimensioni (55 x 45 mm), disomogenea, con impronta sul pavimento vescicale da parte del lobo medio.

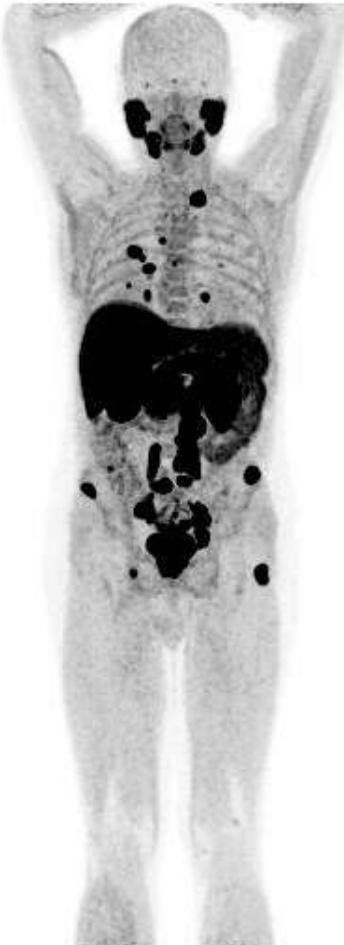
A livello del secondo forame sacrale sinistro si apprezza formazione tissutale con densità dei tessuti molli disomogeneamente ipodensa, con dismogenea e minima impregnazione post-contrastografica, lievemente maggiore in fase tardiva, di circa 45 x 35 mm. La neoformazione descritta determina aumento del calibro del forame sacrale, senza tuttavia determinare grossolani fenomeni erosivi sulla corticale ossea.

 Comparsa di **reazione allergica a mezzo di contrasto**, con sintomi respiratori.

09.05.2018 biopsia prostatica: adenocarcinoma prostatico di alto grado, Gleason Score 10 (5+5)

PSA 2.29 ng/mL

• Start from clinics:



PET-colina:

- noduli polmonari
- multiple linfoadenopatie sovra e sotto-diaframmatiche
- iperaccumulo del radiofarmaco a livello della prostata con estensione alle vescichette seminali
- plurime lesioni ossee (ala iliaca, emisacro dx, ischio dx, grande trocantere sn)

05.06.2018 fibrobroncoscopia →

quadro compatibile con metastasi di adenocarcinoma

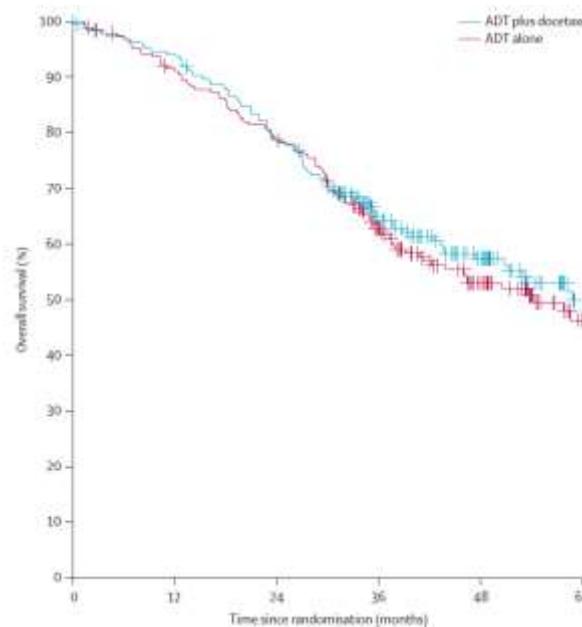
What about literature?



• Chemotherapy

Androgen-deprivation therapy alone or with docetaxel in non-castrate metastatic prostate cancer (GETUG-AFU 15): a randomised, open-label, phase 3 trial

Gérardine Gréville, Xavier Fournier, Florence Jobé, Stéphane Oxford, Frédéric Pivaud, Benjamin Esteva, Jérôme Lutz, Christophe Remy, Hervé Delfosse, Jean-Eustache Boulle, Brigitte Lagrange, Frédéric Polard, Christelle Théodore, Gaëtan Delpech, Jean-Marc Ferrant, Danièle Pouyssegur, Luc Mancini, Philippe Brunel, Sylvie Zerbe, Muriel Hachulla, Jean-François Bertrand, Jeanne Gauthier, Alain-Jean Faucheu, Christian Platzer, Claude Lounisier, Jean-Luc Labeyrie, Jean-Pascal Machado, Claude El-Khoury, Alain Rousset, Etienne Sozzi, Jean Christophe Eyraud, Ali Hachem, Gauthier Bouqueré, Michel Seckler



Median OS was
58.9 months
in the group given ADT + docetaxel
VS
54.2 months
in that given ADT alone.

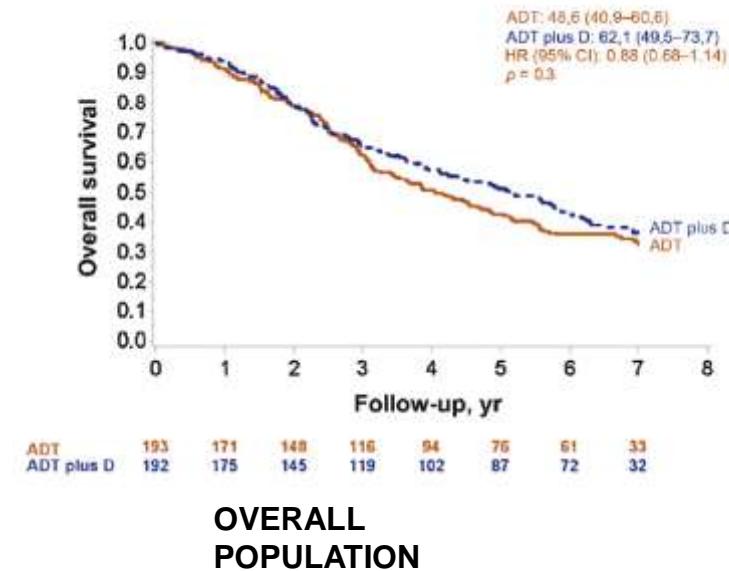
Lancet Oncol 2013; 14: 149–58

available at www.sciencedirect.com
journal homepage: www.europeanurology.com



Platinum Priority ~ Prostate Cancer
Editorial by Julian S. Stiller and Christopher J. Stenwig on pp. 253–254 of this issue

Androgen Deprivation Therapy (ADT) Plus Docetaxel Versus
ADT Alone in Metastatic Non castrate Prostate Cancer:
Impact of Metastatic Burden and Long-term Survival
Analysis of the Randomized Phase 3 GETUG-AFU15 Trial



EUROPEAN UROLOGY 70 (2016) 256–262

• Chemotherapy

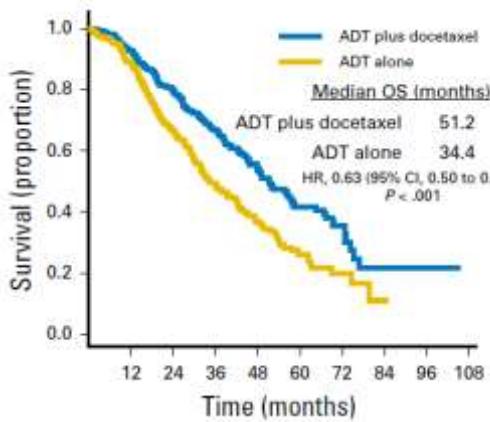
VOLUME 36 • NUMBER 11 • APRIL 10, 2018

JOURNAL OF CLINICAL ONCOLOGY

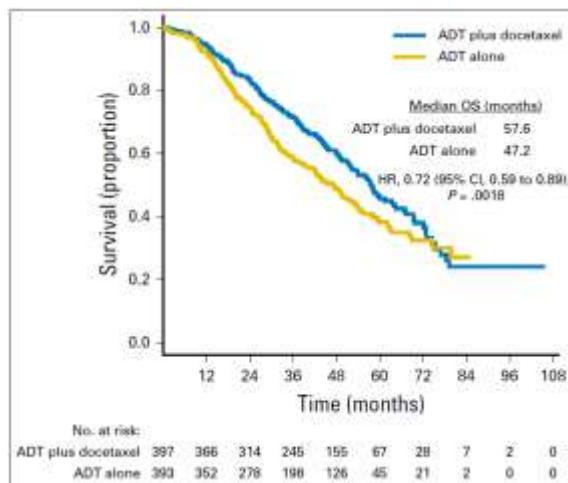
ORIGINAL REPORT

Chemohormonal Therapy in Metastatic Hormone-Sensitive Prostate Cancer: Long-Term Survival Analysis of the Randomized Phase III E3805 CHAARTED Trial

Christen E. Kyriakopoulos, Yu-Hui Chen, Michael A. Camacho, Glenn Liu, David F. Harland, Noah M. Hahn, Daniel H. Sherrin, Robert Dreyfus, Maha Hussain, Mario Eisenberger, Munish Kohli, Elizabeth R. Plimack, Nicholas J. Vigliangolo, Joel Picos, Matthew M. Crowley, Jorge A. Garcia, Robert S. DiPietro, and Christopher J. Sweeney

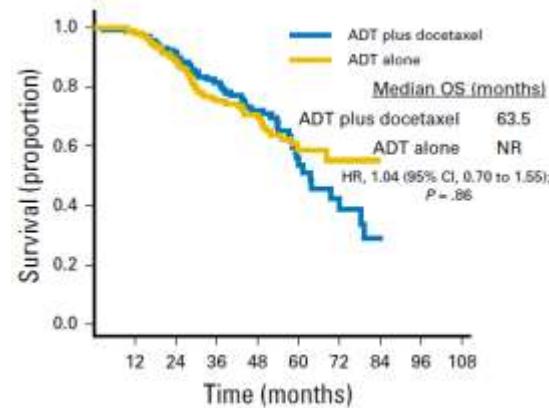


**HIGH VOLUME
DISEASE**



CHAARTED definition of high-volume disease:

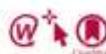
- Visceral metastases or
- ≥ 4 bone lesions with ≥1 beyond the vertebral body and pelvis



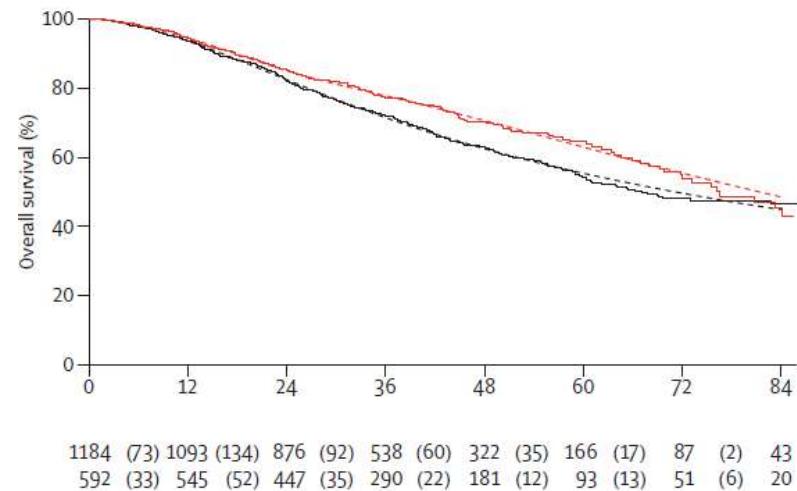
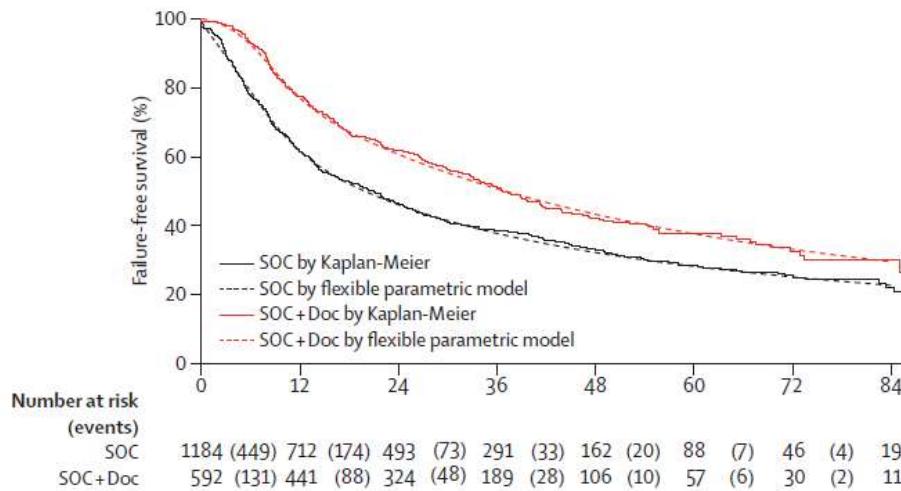
**LOW VOLUME
DISEASE**

• Chemotherapy

Addition of docetaxel, zoledronic acid, or both to first-line long-term hormone therapy in prostate cancer (STAMPEDE): survival results from an adaptive, multiarm, multistage, platform randomised controlled trial



Nicholas D James, Matthew R Sydes, Noel W Clarke, Malcolm D Mason, David P Drummond, Melissa R Spears, Alastair W S Ritchie, Christopher C Parker, J Martin Russell, Gerhardt Attard, Johann de Bono, William Cross, Rob J Jones, George Thalassara, Claire Amies, David Matheson, Robin Millman, Mymoona Alzubei, Sharon Beesley, Alison J Birtle, Sosannah Brock, Richard Cathomar, Prasir Chakraborti, Simon Chowdhury, Audrey Cook, Tony Elliott, Joanne Gale, Stephanie Gibbs, John D Graham, John Hetherington, Robert Hughes, Robert Liang, Fiona McKenna, Duncan B McLaren, Joe M O'Sullivan, Omi Parkh, Clive Peedell, Andrew Protheroe, Angus J Robinson, Niranjanan Sridhar, Rajapandu Srinivasan, John Staffurth, Santanum Sutar, Shuan Tolan, David Tsang, John Wagstaff, Mahesh E B Parmar, for the STAMPEDE investigators*



Median OS
71 months (IQR 32 - not reached) for SOC-only
VS
81 months (41 - not reached) for SOC + Doc
(HR 0.78, 95% CI 0.66–0.93; p=0.006)

Lancet 2016; 387: 1163-77

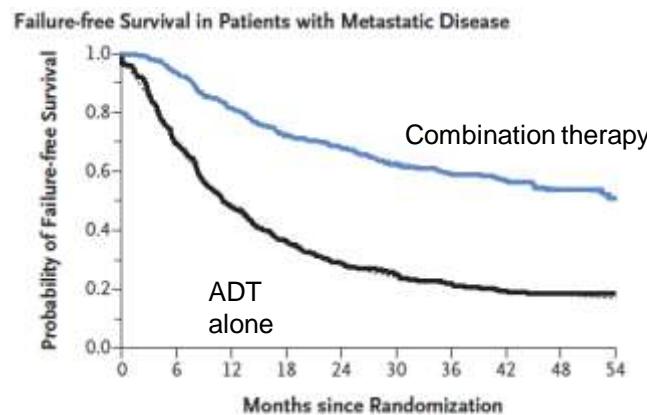
• Hormone therapy

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

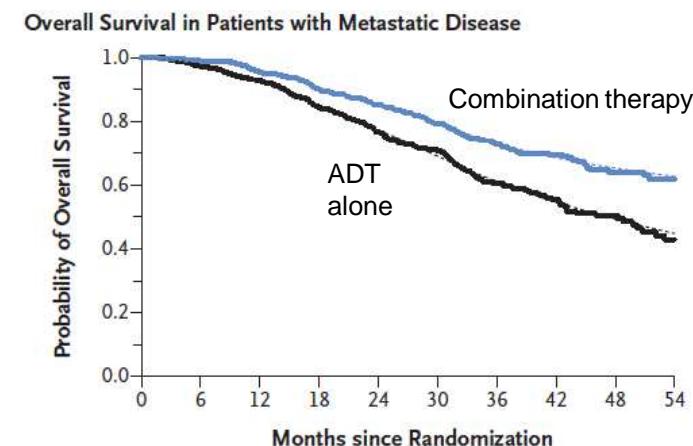
Abiraterone for Prostate Cancer Not Previously Treated with Hormone Therapy

N.D. James, J.S. de Bono, M.R. Spears, N.W. Clarke, M.D. Mason, D.P. Dearnaley, A.W.S. Ritchie, C.L. Amos, C. Gilson, R.J. Jones, D. Matheson, R. Millman, G. Attard, S. Chowdhury, W.R. Cross, S. Gillessen, C.C. Parker, J.M. Russell, D.R. Berthold, C. Brawley, F. Adab, S. Aung, A.J. Birtle, J. Bowen, S. Brock, P. Chakraborti, C. Ferguson, J. Gale, E. Gray, M. Hingorani, P.J. Hoskin, J.F. Lester, Z.I. Malik, F. McKinna, N. McPhail, J. Money-Kyrie, J. O'Sullivan, O. Parikh, A. Protheroe, A. Robinson, N.N. Srihari, C. Thomas, J. Wagstaff, J. Wylie, A. Zarkar, M.K.B. Parmar, and M.R. Sydes, for the STAMPEDE Investigators[#]



No. of Patients (no. of treatment-failure events)									
Combination therapy	500	(92)	399	(65)	326	(40)	202	(11)	63
ADT alone	502	(258)	236	(93)	139	(33)	83	(9)	23

3-year survival
83% in the ADT+ Abiraterone group
VS
76% in the ADT-alone group
(HR for death, 0.63; 95% CI 0.52-0.76;
 $p<0.001$)



No. of Patients (no. of deaths)									
Combination therapy	500	(22)	469	(50)	415	(57)	256	(18)	81
ADT alone	502	(35)	460	(80)	371	(73)	215	(23)	60

• Hormone therapy

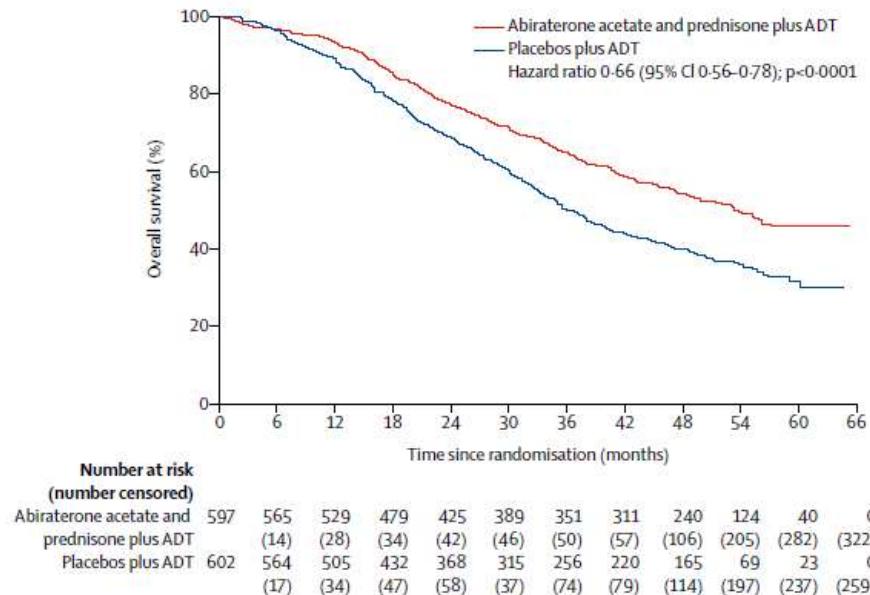


Abiraterone acetate plus prednisone in patients with newly diagnosed high-risk metastatic castration-sensitive prostate cancer (LATITUDE): final overall survival analysis of a randomised, double-blind, phase 3 trial

Kamran Fizazi, Nam-Phuong Tran, Luis Fehn, Nobuyuki Matsubara, Alfredo Rodriguez-Antolin, Boris V Alekseev, Mustafa Ozgurel, Dingwei Ye, Susan Feyereisen, Andrew Pruthouse, Giri Sudar, Yesenia Lina, Susan Li, Suneele Mundie, Klein N Chi

High risk defined as meeting at least 2 of 3 high risk criteria:

- Gleasone score ≥ 8
- Presence of ≥ 3 lesions on bone scan
- Presence of measurable visceral lesion



median OS 53.3 months vs 36.5 months

What is better for hormone-sensitive patients?

Starting chemotherapy or hormone-therapy?

• Abiraterone or Docetaxel?:



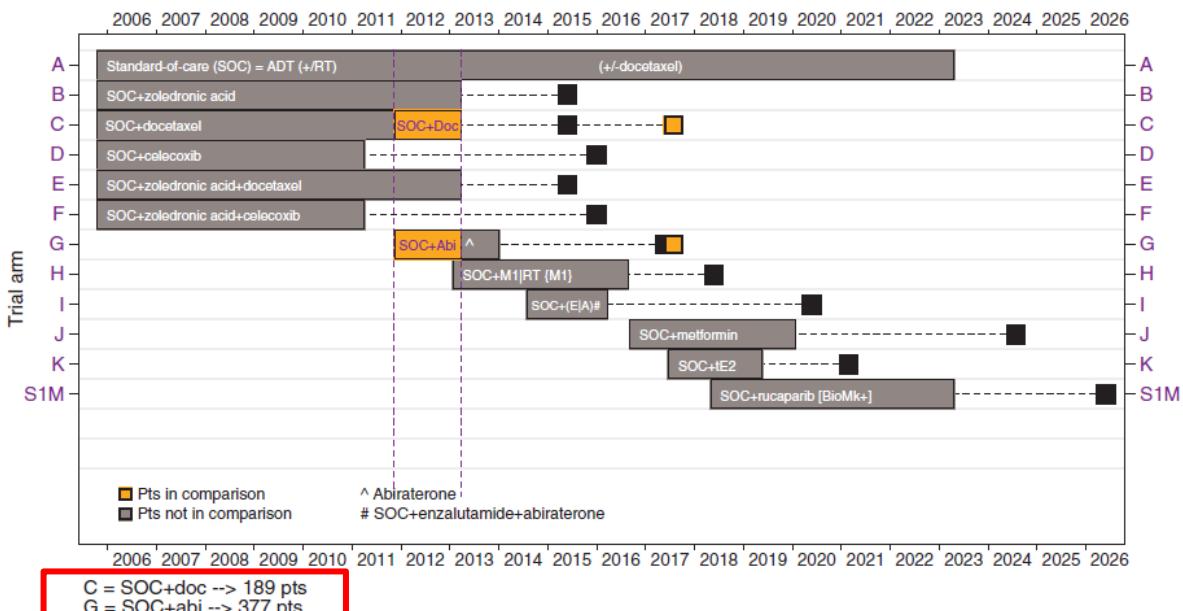
Annals of Oncology 29: 1229–1240, 2018
doi:10.1093/annonc/mdy077
Published online 26 February 2018

ORIGINAL ARTICLE

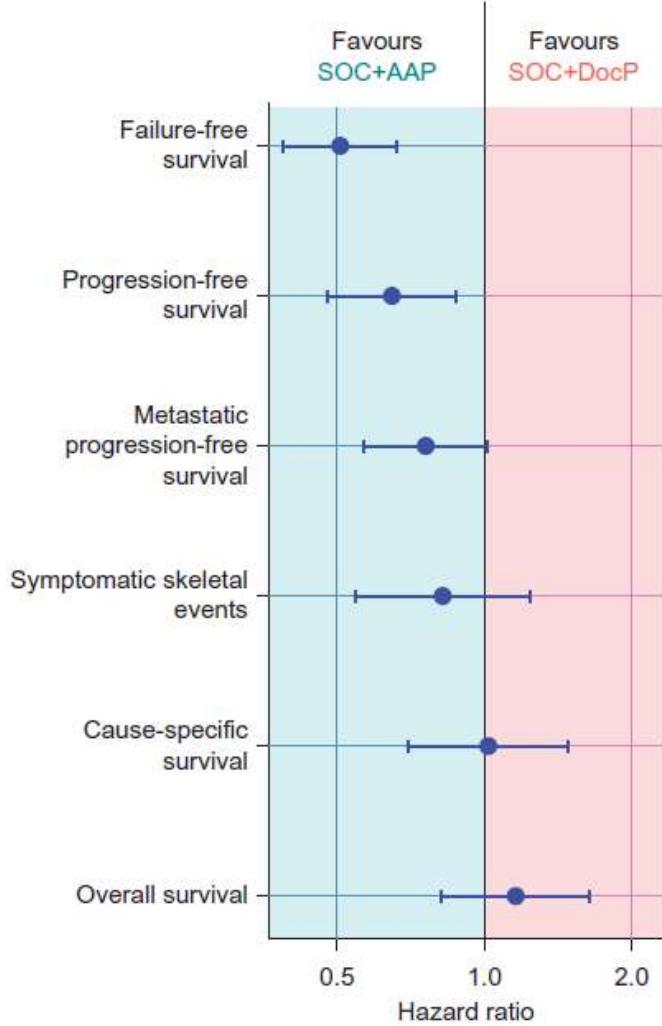
Adding abiraterone or docetaxel to long-term hormone therapy for prostate cancer: directly randomised data from the STAMPEDE multi-arm, multi-stage platform protocol

M. R. Sydes¹, M. R. Spears¹, M. D. Mason², N. W. Clarke³, D. P. Dearnaley⁴, J. S. de Bono⁵, G. Attard⁶, S. Chowdhury⁶, W. Cross⁷, S. Gillessen^{8,9,10}, Z. I. Malik¹¹, R. Jones^{12,13}, C. C. Parker^{6,14}, A. W. S. Ritchie¹, J. M. Russell^{12,15}, R. Millman¹, D. Matheson¹⁵, C. Amos¹, C. Gilson¹, A. Birte¹⁶, S. Brock¹⁷, L. Capaldi¹⁸, P. Chakraborty¹⁹, A. Choudhury^{20,21,22}, L. Evans²³, D. Ford²⁴, J. Gale²⁵, S. Gibbs²⁶, D. C. Gilbert²⁷, R. Hughes²⁸, D. McLaren²⁹, J. F. Lester³⁰, A. Nikapota³¹, J. O'Sullivan^{12,31}, O. Parkh³², C. Feedell¹⁰, A. Protheroe³³, S. M. Rudman⁶, R. Shaffer³⁷, D. Sheehan¹⁰, M. Simms²⁹, N. Srihari⁴⁰, R. Strebler^{31,41}, S. Sundar⁴³, S. Tolani¹, D. Tsang⁴⁴, M. Varughese⁴⁵, J. Wagstaff⁴⁶, M. K. B. Parmar¹⁴, N. D. James^{47*}, & The STAMPEDE Investigators

STAMPEDE: Docetaxel vs abiraterone -- direct comparison



• Abiraterone or Docetaxel?:



Worst adverse events

	SOC + Doc (n = 189)	SOC + AAP (n = 377)
Safety population		
Number of patients included in analysis ^a	172	373
Patients with an adverse event—no. (%)		
Grade 1–5 adverse event	172 (100)	370 (99)
Grade 3–5 adverse event	86 (50)	180 (48)
Grade 3–5 adverse events—no. (%)		
Endocrine disorder	15 (9)	49 (13)
Febrile neutropenia	29 (17)	3 (1)
Neutropenia (neutrophils)	22 (13)	4 (1)
General disorder	18 (10)	21 (6)
Fatigue	7 (4)	8 (2)
Oedema	1 (1)	2 (1)
Musculoskeletal disorder	9 (5)	33 (9)
Cardiovascular disorder	6 (3)	32 (9)
Hypertension	0 (0)	12 (3)
Myocardial infarction	2 (1)	4 (1)
Cardiac dysrhythmia	1 (1)	5 (1)
Gastrointestinal disorder	9 (5)	28 (8)
Hepatic disorder	1 (1)	32 (9)
Increased AST	0 (0)	6 (2)
Increased ALT	1 (1)	23 (6)
Respiratory disorder	12 (7)	11 (3)
Dyspnoea	4 (2)	1 (1)
Renal disorder	5 (3)	20 (5)
Lab abnormalities	9 (5)	11 (3)
Hypokalaemia	0 (0)	3 (1)

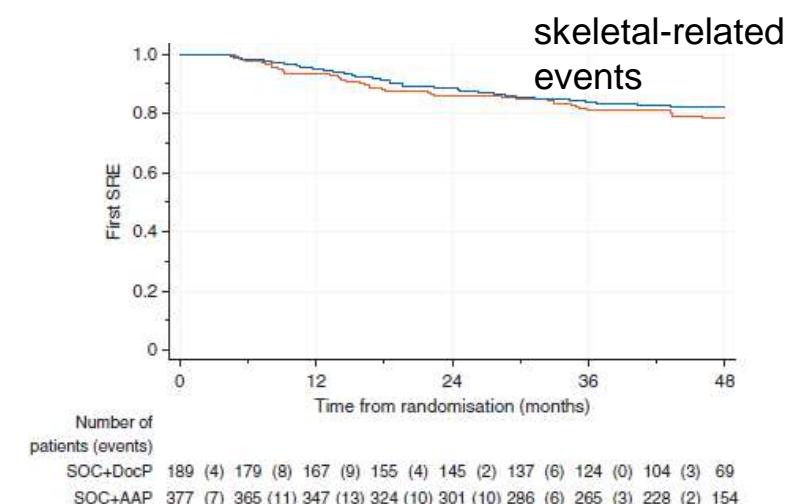
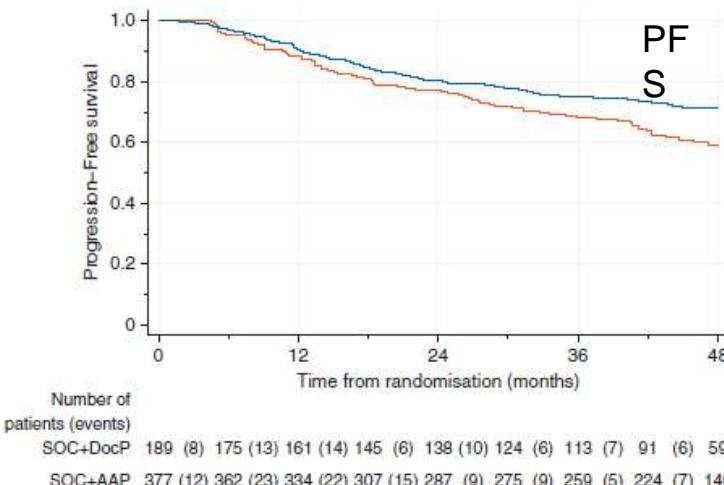
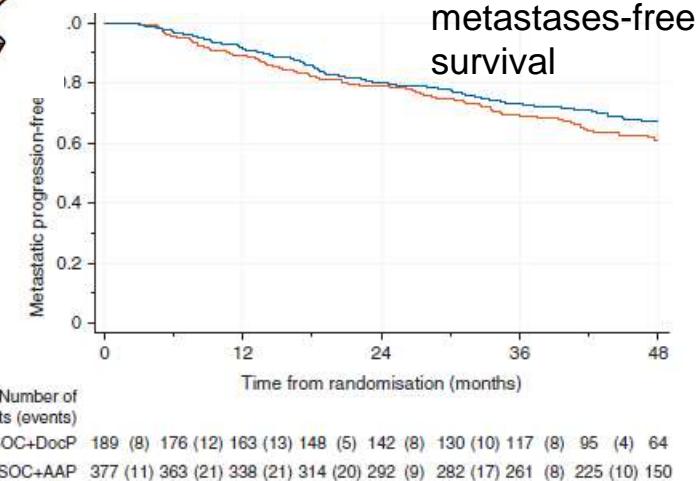
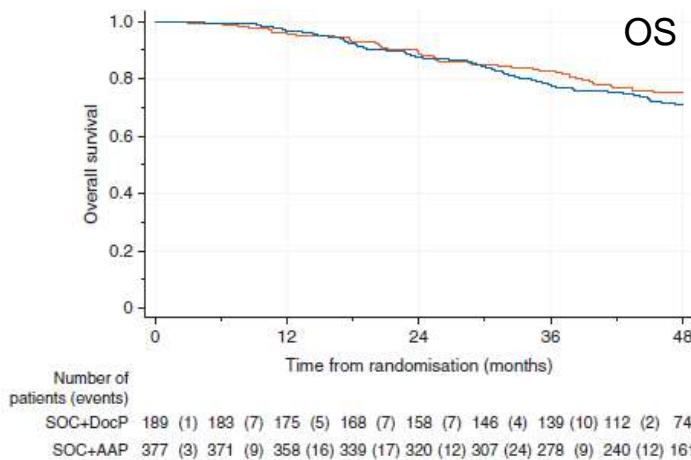
^aThe safety population includes patients who started their allocated treatment.

This is not a true randomized trial (only a part)

• Abiraterone or Docetaxel



SOC+DocP
SOC+AAP



• mHSPC trial

summaries:

	ETUG-AFU 15	CHAARTED	STAMPEDE (arm G)	LATITUDE	ENZAMET	TITAN
DRUG	Docetaxel	Docetaxel	Abiraterone	Abiraterone	Enzalutamide	Apalutamide
PATIENTS	385	790	1917	1199	1125	1052
INTERVENTION (1:1)	ADT+ DOCE Vs ADT	ADT+ DOCE vs ADT	ADT+ ABI/P vs ADT + placebo	ADT+ ABI/P vs ADT + placebo	ADT+ ENZA vs ADT+ NSAA	ADT+ APA vs ADT + placebo
KEY I/E	<ul style="list-style-type: none"> Newly diagnosed (de novo) and metastatic (prior local therapy) ADT or chemo for neoadjuvant/adjuvant discontinued ≥ 12 months prior to enrollment ADT initiation for metastatic disease ≤ 2 months before enrollment No prior chemo for metastatic disease 	<ul style="list-style-type: none"> Newly diagnosed (de novo) and metastatic (prior local therapy) ADT for adjuvant up to 24 months and progression > 12 months after completion ADT for metastatic disease, if initiated, < 120 days prior to randomization and no progression 	<ul style="list-style-type: none"> Newly diagnosed (de novo) and metastatic (prior local therapy) High risk locally advanced: <ul style="list-style-type: none"> -T3 or T4 - GS 8-10 - PSA ≥40 ng/mL High risk relapsed disease: <ul style="list-style-type: none"> -PSA ≥4 ng/mL and PSADT < 6 months - PSA ≥ 20 ng/mL - nodal/metastatic relapse -ADT exposure < 12 months total and > months without treatment 	<ul style="list-style-type: none"> Newly diagnosed (de novo) only High risk: <ul style="list-style-type: none"> -GS ≥ 8 -Bone lesions 3 -Measurable visceral metastasis ADT exposure < 3 months 	<ul style="list-style-type: none"> Newly diagnosed (de novo) and metastatic (prior local therapy) ECOG 0-1 ≥ 1 bone lesion ADT exposure < 3 months Up to 6 cycles of Docetaxel within 2 months of enrollment (SD post-docetaxel) RT, surgery and up to 6 months ADT allowed for met disease ADT for neoadjuvant/adjuvant < 36 months of duration and ≥ 12 months before enrollment EXCLUDED if visceral met are the only site of metastasis 	<ul style="list-style-type: none"> Newly diagnosed (de novo) and metastatic (prior local therapy) ECOG 0-1 ≥ 1 bone lesion ADT exposure < 3 months Up to 6 cycles of Docetaxel within 2 months of enrollment (SD post-docetaxel) RT, surgery and up to 6 months ADT allowed for met disease ADT for neoadjuvant/adjuvant < 36 months of duration and ≥ 12 months before enrollment EXCLUDED if visceral met are the only site of metastasis

• Hormone therapy: latest

ENZAMET Treatment

STRATIFICATION

Volume of metastases*

-High vs Low

Planned Early Docetaxel

Yes vs No

ECOG PS

-0-1 vs 2

Anti-resorptive therapy

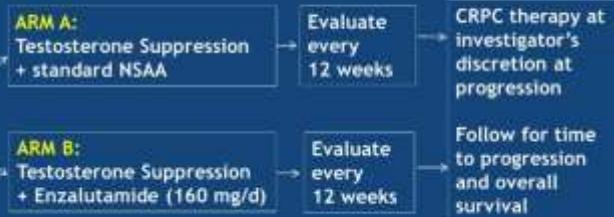
-Yes vs No

Comorbidities

ACE-27**: 0-1 vs 2-3

Study Site

R
A
N
D
O
M
I
Z
E

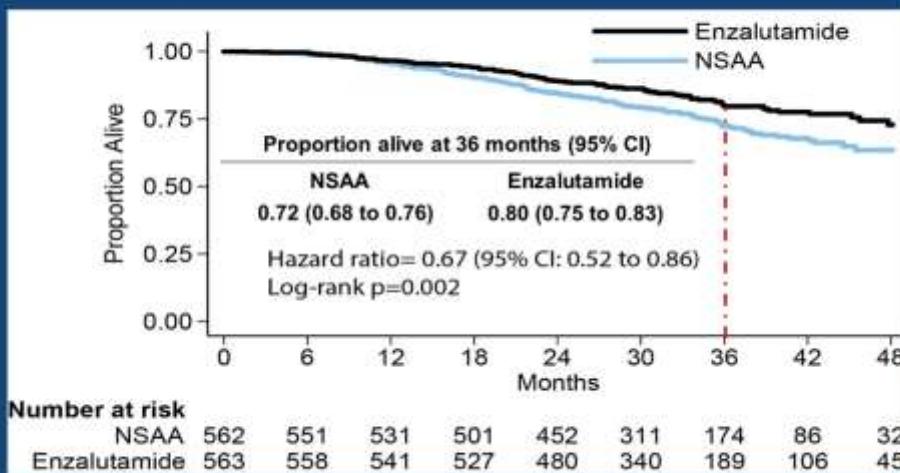


- Prior to randomization testosterone suppression up to 12 weeks and 2 cycles of docetaxel was allowed.
- Intermittent ADT and cyproterone were not allowed
- NSAA: bicalutamide; nilutamide; flutamide
- *High volume: visceral metastases and/or 4 or more bone metastases (at least 1 beyond pelvis and vertebral column)
- **Adult Co-morbidity Evaluation-27

PRESENTED AT: 2019 ASCO ANNUAL MEETING #ASCO19

PRESENTED BY: Christopher Sweeney, MD

Primary endpoint: Overall survival



PRESENTED AT: 2019 ASCO ANNUAL MEETING #ASCO19

PRESENTED BY: Christopher Sweeney, MD

Presented By Christopher Sweeney at 2019 ASCO Annual Meeting

- Hormone therapy: latest news

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ANNUAL MEETING

TITAN Study Design

"All-comer" patient population

Key Eligibility Criteria

Castration sensitive

Distant metastatic disease by ≥ 1 lesion
on bone scan

ECOG PS 0 or 1

On-Study Requirement

Continuous ADT

Permitted

Prior docetaxel

ADT ≤ 6 mo for mCSPC or ≤ 3 yr for local disease

Local treatment completed ≥ 1 yr prior

Stratifications

Gleason score at diagnosis (≤ 7 vs ≥ 8)

Region (NA and EU vs all other countries)

Prior docetaxel (yes vs no)

N = 1052

Dec 2015 –
Jul 2017

→ 1:1 RANDOMIZATION

Apalutamide
240 mg daily + ADT
(n = 525)

Placebo + ADT
(n = 527)

Dual primary end points

- OS
- rPFS

Secondary end points

- Time to cytotoxic chemotherapy
- Time to pain progression
- Time to chronic opioid use
- Time to skeletal-related event

Exploratory end points

- Time to PSA progression
- Second progression-free survival (PFS2)
- Time to symptomatic progression

ECOG PS, Eastern Cooperative Oncology Group performance status;

NA, North America; PSA, prostate-specific antigen; rPFS, radiographic progression-free survival.

PRESENTED AT:
2019 ASCO[®]
ANNUAL MEETING

#ASCO19
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PRESENTED BY: Kim N. Chi, MD

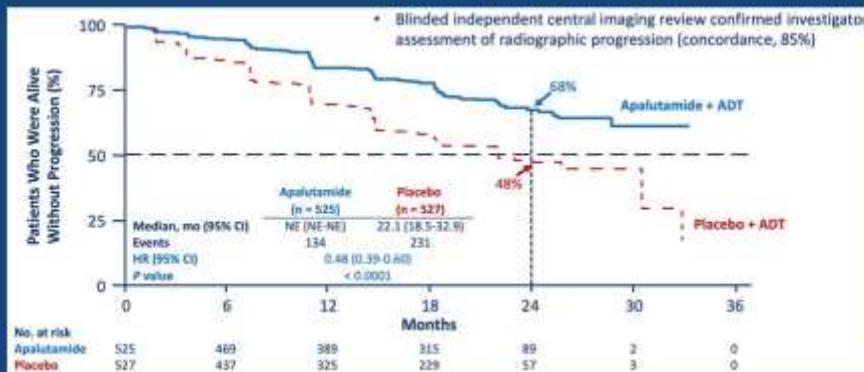
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Presented By Kim Chi at 2019 ASCO Annual Meeting

• Hormone therapy: latest news

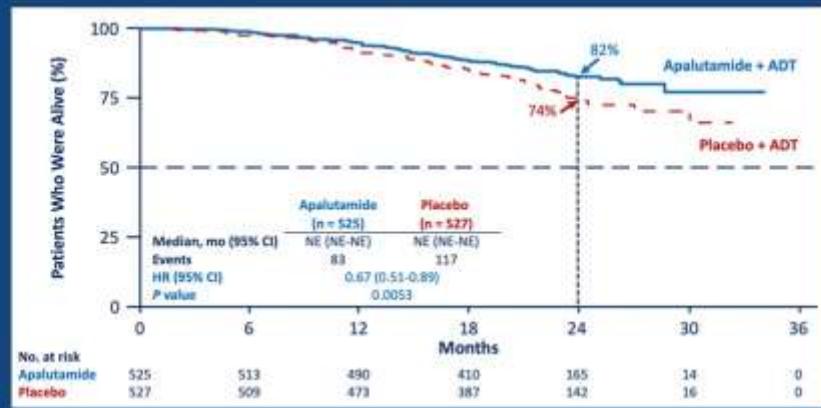
Results

rPFS



- 20% difference in rPFS at 2 years
- Reduced risk of radiographic progression by 52%

OS



- 8% difference in OS at 2 years
- Reduced risk of death by 33%

More rash, fatigue, hypothyroidism, fracture with apalutamide

• Clinical practice



M1^{dd,ee,qq} → **ADT^u and docetaxel 75 mg/m² for 6 cycles^{ss} (category 1)**
or
ADT^u and abiraterone with prednisone (category 1)
or
ADT^u and EBRT^q to the primary tumor for low-volume M1
or
ADT^{u,rr}
or
ADT^u and abiraterone with methylprednisolone (category 2B)

Qualità dell'evidenza SIGN	Raccomandazione	Forza della raccomandazione clinica
Alta	Nei pazienti metastatici alla diagnosi, specie in quelli con malattia ad alto rischio, dovrebbe essere presa in considerazione la possibilità di associare alla terapia androgeno-deprivativa upfront, un trattamento con Abiraterone acetato e prednisone o prednisolone ^{139,140} .	Positiva forte
QUESITO GRADE: Nei pazienti con malattia metastatica (M1) ormono-sensibile, "high volume" alla diagnosi secondo i criteri CHARTED, che non abbiano controindicazioni alla chemioterapia, è raccomandabile l'associazione del Docetaxel up-front alla terapia androgeno-soppressiva?		
RACCOMANDAZIONE: Nei pazienti con malattia metastatica (M1) ormono-sensibile, "high volume" alla diagnosi secondo i criteri CHARTED, l'associazione up-front di Docetaxel (6 cicli) alla terapia androgeno-soppressiva dovrebbe essere presa in considerazione.		
Forza della raccomandazione: POSITIVA FORTE		



	Recommendation
Offer surgical or medical castration (luteinizing-hormone-releasing hormone agonist or antagonist) as androgen deprivation therapy	Strong
Offer castration combined with chemotherapy (docetaxel) to all patients whose first presentation is M1 disease and who are fit enough for chemotherapy	Strong
Offer castration combined with abiraterone acetate + prednisone to all patients whose first presentation is M1 disease and who are fit enough for the regimen	Strong
Offer castration, with or without an antiandrogen, to patients unfit for a combination with docetaxel or abiraterone acetate + prednisone, or who are unwilling to consider it	Strong

- Clinical characteristics:



- Newly diagnosed metastatic prostate cancer
- Gleason Score 10
 - 5 bone lesions
 - visceral lesions



High volume and high risk disease



- Start from clinics:

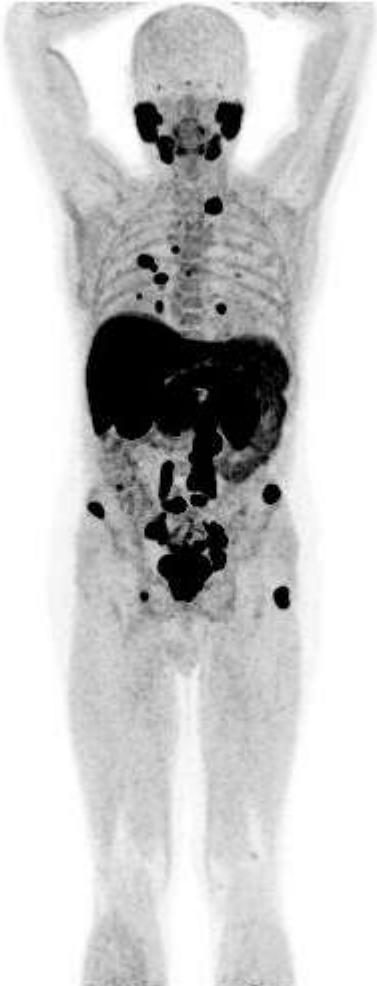
11.06.2018 avvio di Enantone 11.25 mg ogni 3 mesi + Bicalutamide 50 mg per 1 mese

Dal 10.07.2018 effettuati 6 cicli di **Docetaxel** 75 mg/mq, con ottima tolleranza

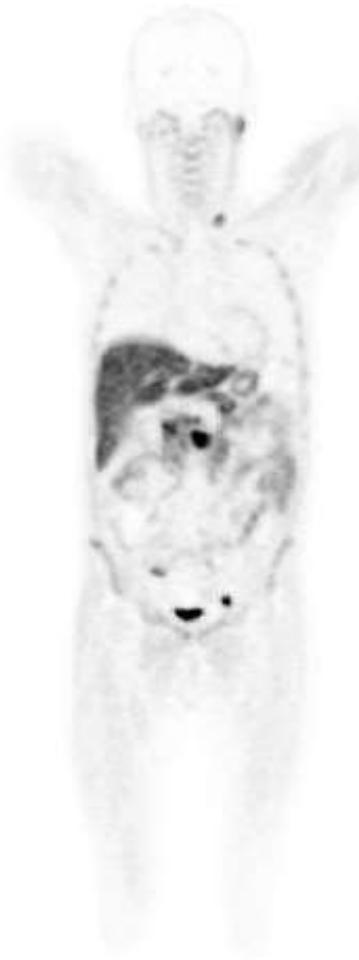
23.11.2018 **PSA 1.28 ng/mL**

05.12.2018 PET- colina

- Start from clinics:



31/05/2018



24/11/2018

- riduzione del gradiente metabolico in corrispondenza delle lesioni polmonari e linfonodali;
- lieve riduzione nella captazione di alcune lesioni scheletriche, persistenza di altre



Follow-up con:

- esame clinico
- dosaggio periodico di PSA e testosterone
- PET-colina (paziente allergico a mdc TC)

- Start from clinics: follow-up

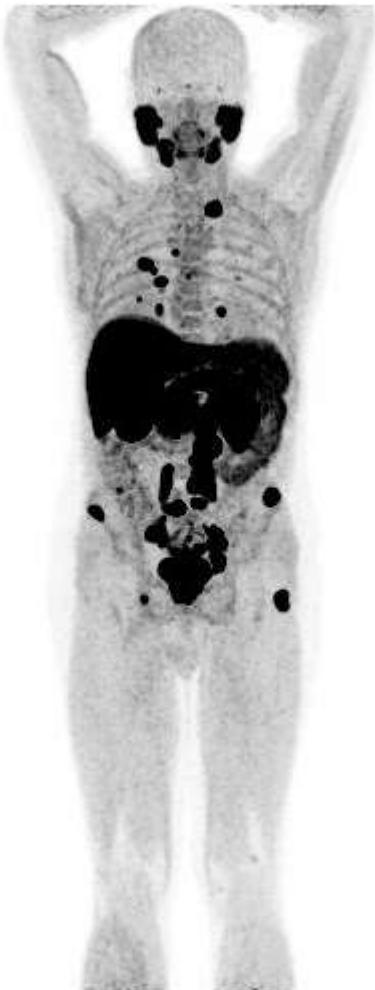
28.01.19 PSA 0.45 ng/mL , testosterone 0.09 nmoli/L

05.02.2019 rialzo della creatinina (1.57 mg/dL) con successivo riscontro ecografico di idroureteronefrosi sinistra

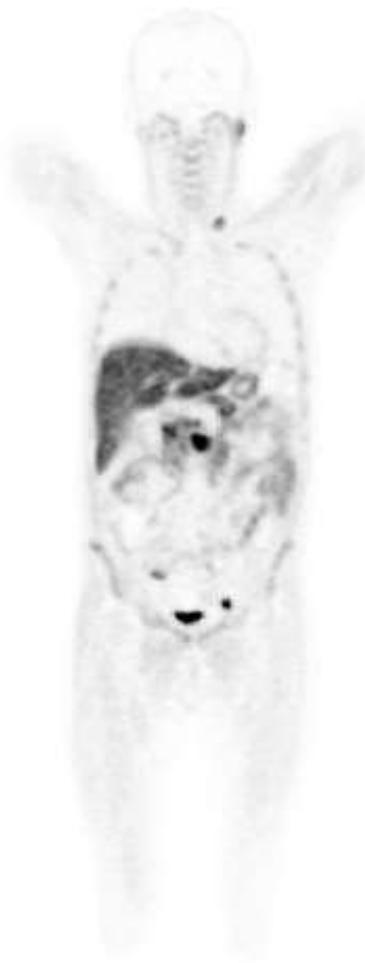
13.02.2019 posizionamento di nefrostomia sinistra

29.03.2019 PET-colina

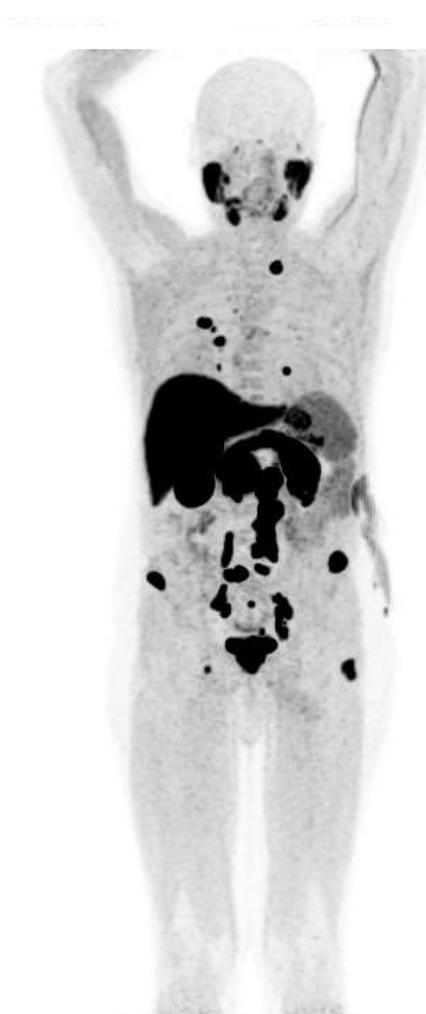
- Start from clinics:



31/05/2018



24/11/2018



29/03/2019

A

- Start from clinics:

10.04.2019 PSA 1.1 ng/mL, testosterone 0.09 nmoli/L

12.04.2019 visita oncologica:

comparsa di dolore a livello dell'emibacino sinistra, con necessità di avviare terapia con Ossicodone



• Castration resistance:

La definizione di **malattia resistente alla castrazione** si applica a un gruppo di pazienti piuttosto eterogeneo, sia dal punto di vista clinico che biologico:

- affetti prevalentemente da malattia localmente avanzata o metastatica,
- in progressione dopo un trattamento di prima linea con deprivazione androgenica (ADT),
- purchè sia presente una condizione di soppressione gonadica “ottimale” ($\text{testosterone} \leq 0.5 \text{ ng/mL}$)

...decidiamo di iniziare una nuova terapia...

What about sequences?



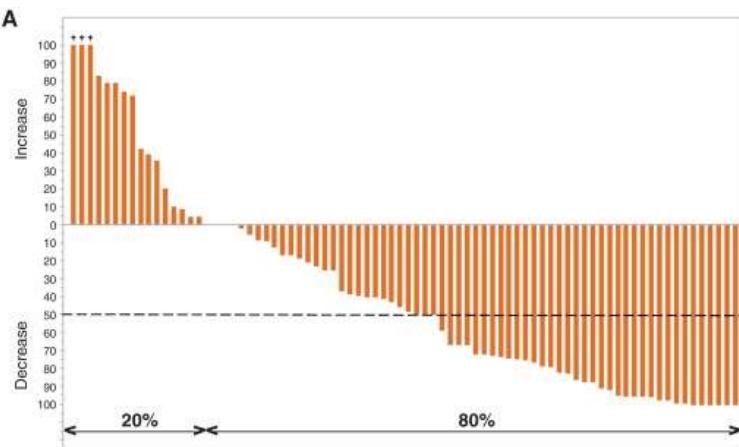
• What about sequences?

available at www.sciencedirect.com
journal homepage: www.europeanurology.com



Platinum Priority – Prostate Cancer
Editorial by Herrlinger Tombal on pp. 704–705 of this issue

Anticancer Activity and Tolerance of Treatments Received Beyond Progression in Men Treated Upfront with Androgen Deprivation Therapy With or Without Docetaxel for Metastatic Castration-naïve Prostate Cancer in the GETUG-AFU 15 Phase 3 Trial

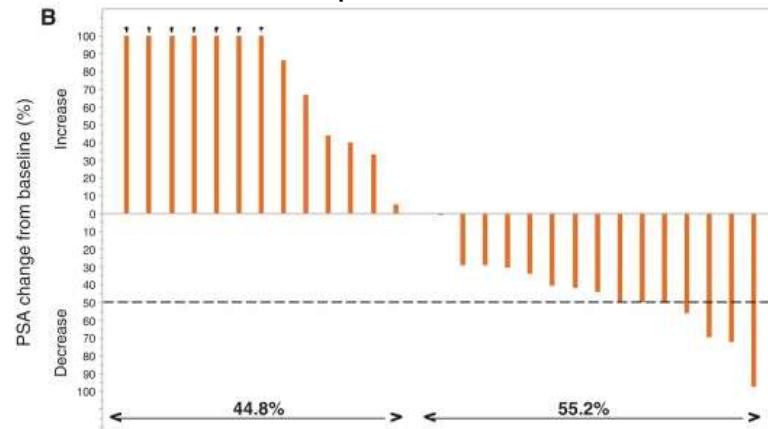


Docetaxel in ADT alone arm (GETUG 15)

First-line: 66 pts, $\geq 50\%$ PSA decline in 38%
First+second-line: 80 pts, $\geq 50\%$ PSA decline in 45%

Docetaxel rechallenge in ADT + docetaxel arm (GETUG 15)

First-line: 20 pts, $\geq 50\%$ PSA decline in 20%
First+second-line: 29 pts, $\geq 50\%$ PSA decline 14%



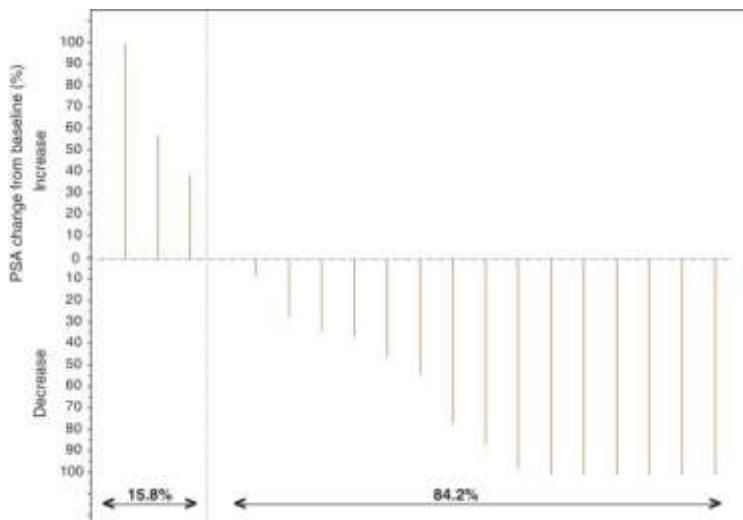
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ABI/ENZA in ADT+docetaxel arm (GETUG 15)
First+second-line: 19 pts, $\geq 50\%$ PSA decline in 53%

- In pts treated upfront with ADT+docetaxel for mHSPC, docetaxel «rechallenge» in mCRPC did not give unexpected toxicity but limited efficacy ($\geq 50\%$ PSA decline 14%)
- preliminary data about the use of AA/ENZA for mCRPC support maintained efficacy
- Is there any room for cabazitaxel as first-line treatment in this sub-group of pts?

• What about sequences?

hypothesis

Metastatic
Hormone-Sensitive
prostate cancer

Metastatic
Castration-
resistance prostate
cancer I line

Metastatic
Castration-
resistance prostate
cancer II line

Metastatic
Castration-
resistance prostate
cancer III line

Riutilizzo di una terapia attiva
vs

Stessa strategia con un farmaco
più potente

ADT
+
Docetaxel

Strategia
differente

Docetaxel

Cabazitaxel

?

Abiraterone

Enzalutamid
e

Abi/Enza

Cabazitaxel

Abiraterone

Enzalutamid
e

?

Abi/Enza

Cabazitaxel

Cabazitaxel

Abi/Enza



• What about sequences?

hypothesis

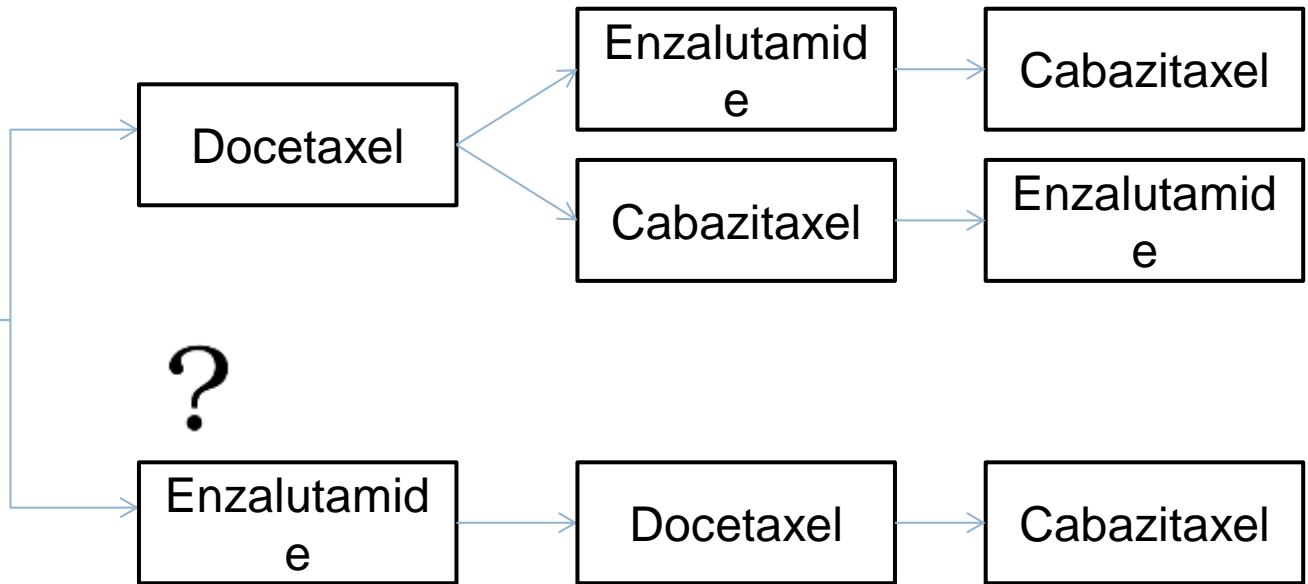
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Metastatic
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cancer III line

ADT
+
Abiraterone**



** Abiraterone non è al momento rimborsato in Italia per tale indicazione!

• The best choice...

- Al momento, nessuna evidenza supporta la superiorità di un farmaco rispetto all'altro
- La scelta dipende da:



sintomi

ECOG PS

comorbidità

qualità della vita

aspettativa di vita

tumor burden

localizzazione delle metastasi

- Start from clinics:

23.04.2019 avviata terapia con:

- Enzalutamide 160 mg/die
- Acido zoledronico 4 mg q28

Effettuata inoltre valutazione multidisciplinare di osteo-oncologia:

- non indicazione ad ortesi
- non indicata radioterapia

A breve in programma rivalutazione strumentale, tuttavia possiamo dire di aver ottenuto, ad oggi:

- beneficio clinico: riduzione del dolore con successivo, graduale svezzamento da oppiacei
- PSA stabile

• Take home message

- Docetaxel and Abiraterone improve survival in hormone naïve newly diagnosed patients with metastatic high volume disease
- Enzalutamide and Apalutamide also improve survival in hormone naïve newly diagnosed patients with metastatic disease in phase 3 studies
- Docetaxel should be considered for routine practice in suitable men with newly-diagnosed high volume metastatic disease
- Abiraterone should be considered for routine practice in suitable men with newly-diagnosed high risk metastatic disease
- Treatments should be tailored on patients' characteristics

GRAZIE PER L'ATTENZIONE