Highlights of the Advanced Prostate Cancer Consensus Conference (APCCC) 2022

PROSCA
18. October 2022
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Conflicts of Interest AO

Advisory role (compensated, institutional):

Astra Zeneca, Astellas, Bayer, Janssen, Molecular Partners, MSD, Myriad, Pfizer, Roche, Sanofi Aventis (compensated, institutional)

Novartis, Janssen, Bayer, MSD, AstraZeneca, Merck, Astellas (compensated)

Research support (institutional):

TEVA, Janssen

Travel support:

Astellas, Bayer, Janssen, Sanofi Aventis

Speakers Bureau (compensated, institutional):

Astellas, Bayer, Janssen

This presentation reflects the opinion of the speaker and may contain information about a non-approved indication or product. Please do not use these oversimplified slides to make treatment recommendations in daily clinical practice, the accuracy or completeness of the information summarised in the slides can not be guaranteed. Some of the treatments mentioned on the slides are off-lable in Switzerland.

Conflicts of Interest SG

- **Personal honoraria** for participation in *advisory boards* from Amgen, MSD, Orion; *other honoraria* from Radio-televisione Svizzera Italiana (RSI), German-speaking European School of Oncology (DESO); *invited speaker* for ESMO, Swiss group for Clinical Cancer Research (SAKK), Swiss Academy of Multidisciplinary oncology (SAMO), Orikata academy research group, China Anti-Cancer Association Genitourinary Oncology Committee (CACA-GU); *Speaker's bureau* for Janssen Cilag; *travel grants* from ProteoMEdiX, Astra Zeneca
- **Institutional honoraria** for participation in *advisory boards or in Independent Data Monitoring Committees and Steering Committees* from AAA International, Amgen, Bayer, Bristol-Myers Squibb, Modra Pharmaceuticals, MSD, Novartis, Orion, Pfizer, Roche, Telixpharma Tolero Pharmaceutcials; *other honoraria* from Silvio Grasso Consulting.
- **Non-financial interests:** Menarini Silicon Biosystems; Aranda
- Co-inventor on patent application (WO 2009138392 A1) for a method for biomarker discover (granted in China, Europe, Japan and the US)
- Deputy of the ESMO guidelines committee for GU cancers, member of the scientific committee of ESMO guidelines, member of the EAU guideline panel for prostate cancer, past chair of the EORTC GU group; Member of the STAMPEDE trial management group

Why a Consensus Conference for Advanced Prostate Cancer

Several topics in this setting with:

- No evidence
- Sparse or low-level evidence
- Conflicting evidence
- Different interpretation of evidence
- Evidence generated only in a selected population

NOT Guidelines

Recommendations from experts for areas with no or only sparse evidence or conflicting evidence or different interpretation of evidence.

What is new at APCCC 2022

- More than 190 consensus questions have been developped by the APCCC expert panel

- For logistical reasons the voting took place prior to APCCC 2022

Topics of APCCC 2022

1. High-risk and locally advanced prostate cancer
2. Biochemical recurrence
3. Metastatic hormone-sensitive prostate cancer (mHSPC)
4. Non-metastatic, castration-resistant prostate cancer (nmCRPC)
5. Importance of lifestyle and prevention of complications in advanced prostate cancer
6. Management of metastatic CRPC
7. Oligometastatic and oligoprogressive prostate cancer

APCCC 2022 PANEL MEMBERS

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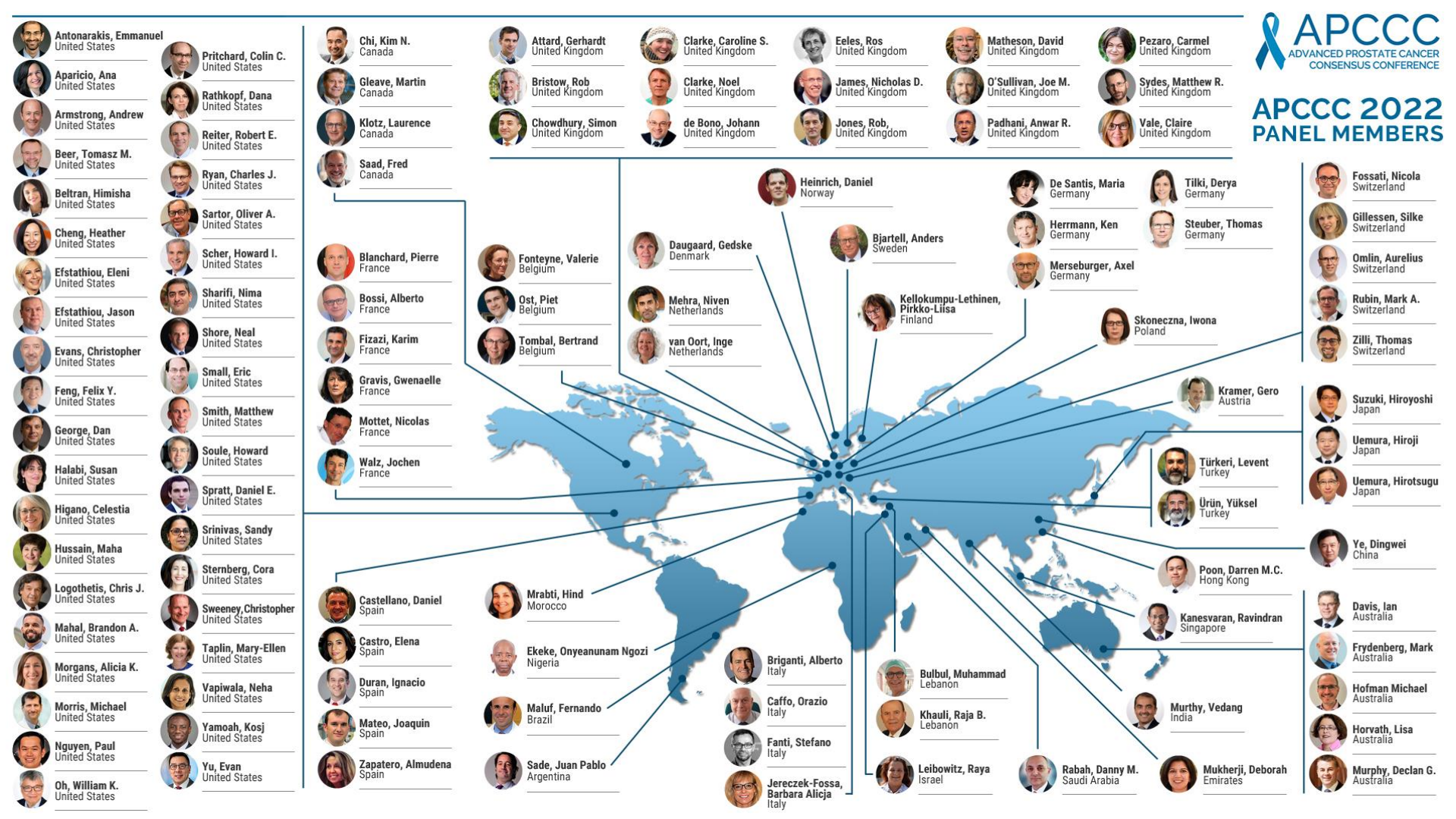

Antonarakis, Emmanuel — United States
Aparicio, Ana — United States
Armstrong, Andrew — United States
Beer, Tomasz M. — United States
Beltran, Himisha — United States
Cheng, Heather — United States
Efstathiou, Eleni — United States
Efstathiou, Jason — United States
Evans, Christopher — United States
Feng, Felix Y. — United States
George, Dan — United States
Halabi, Susan — United States
Higano, Celestia — United States
Hussain, Maha — United States
Logothetis, Chris J. — United States
Mahal, Brandon A. — United States
Morgans, Alicia K. — United States
Morris, Michael — United States
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Oh, William K. — United States
Pritchard, Colin C. — United States
Rathkopf, Dana — United States
Reiter, Robert E. — United States
Ryan, Charles J. — United States
Sartor, Oliver A. — United States
Scher, Howard I. — United States
Sharifi, Nima — United States
Shore, Neal — United States
Small, Eric — United States
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Srinivas, Sandy — United States
Sternberg, Cora — United States
Sweeney,Christopher — United States
Taplin, Mary-Ellen — United States
Vapiwala, Neha — United States
Yamoah, Kosj — United States
Yu, Evan — United States

Chi, Kim N. — Canada
Gleave, Martin — Canada
Klotz, Laurence — Canada
Saad, Fred — Canada

Attard, Gerhardt — United Kingdom
Bristow, Rob — United Kingdom
Chowdhury, Simon — United Kingdom
Clarke, Caroline S. — United Kingdom
Clarke, Noel — United Kingdom
de Bono, Johann — United Kingdom
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James, Nicholas D. — United Kingdom
Jones, Rob, — United Kingdom
Matheson, David — United Kingdom
O'Sullivan, Joe M. — United Kingdom
Padhani, Anwar R. — United Kingdom
Pezaro, Carmel — United Kingdom
Sydes, Matthew R. — United Kingdom
Vale, Claire — United Kingdom

Blanchard, Pierre — France
Bossi, Alberto — France
Fizazi, Karim — France
Gravis, Gwenaelle — France
Mottet, Nicolas — France
Walz, Jochen — France

Fonteyne, Valerie — Belgium
Ost, Piet — Belgium
Tombal, Bertrand — Belgium

Heinrich, Daniel — Norway
Daugaard, Gedske — Denmark
Mehra, Niven — Netherlands
van Oort, Inge — Netherlands
Bjartell, Anders — Sweden
Kellokumpu-Lethinen, Pirkko-Liisa — Finland

De Santis, Maria — Germany
Herrmann, Ken — Germany
Merseburger, Axel — Germany
Tilki, Derya — Germany
Steuber, Thomas — Germany

Skoneczna, Iwona — Poland

Fossati, Nicola — Switzerland
Gillessen, Silke — Switzerland
Omlin, Aurelius — Switzerland
Rubin, Mark A. — Switzerland
Zilli, Thomas — Switzerland

Kramer, Gero — Austria

Suzuki, Hiroyoshi — Japan
Uemura, Hiroji — Japan
Uemura, Hirotsugu — Japan

Türkeri, Levent — Turkey
Ürün, Yüksel — Turkey

Ye, Dingwei — China

Poon, Darren M.C. — Hong Kong

Kanesvaran, Ravindran — Singapore

Davis, Ian — Australia
Frydenberg, Mark — Australia
Hofman Michael — Australia
Horvath, Lisa — Australia
Murphy, Declan G. — Australia

Murthy, Vedang — India

Mukherji, Deborah — Emirates

Rabah, Danny M. — Saudi Arabia

Leibowitz, Raya — Israel

Bulbul, Muhammad — Lebanon
Khauli, Raja B. — Lebanon

Briganti, Alberto — Italy
Caffo, Orazio — Italy
Fanti, Stefano — Italy
Jereczek-Fossa, Barbara Alicja — Italy

Castellano, Daniel — Spain
Castro, Elena — Spain
Duran, Ignacio — Spain
Mateo, Joaquin — Spain
Zapatero, Almudena — Spain

Mrabti, Hind — Morocco
Ekeke, Onyeanunam Ngozi — Nigeria
Maluf, Fernando — Brazil
Sade, Juan Pablo — Argentina

APCCC Publications – available (open access)

Management of Patients with Advanced Prostate Cancer: Report of the Advanced Prostate Cancer Consensus Conference 2019

Eur Urol 2020 Apr;77(4):508-547. doi: 10.1016/j.eururo.2020.01.012. Epub 2020 Jan 27.

Lack of consensus identifies important areas for future clinical research: Advanced Prostate Cancer Consensus Conference (APCCC) 2019 findings

Eur J Cancer 2022 Jan;160:24-60. doi: 10.1016/j.ejca.2021.09.036

What Experts Think About Prostate Cancer Management During the COVID-19 Pandemic: Report from the Advanced Prostate Cancer Consensus Conference 2021

Eur Urol 2022 Feb 17;S0302-2838(22)01650-5. doi: 10.1016/j.eururo.2022.02.010.

Management of Patients with Advanced Prostate Cancer: Report from the Advanced Prostate Cancer Consensus Conference 2021

Eur Urol 2022 Apr 18;S0302-2838(22)01807-3. doi: 10.1016/j.eururo.2022.04.002.

Audience Vote

Do you have readily access to PSMA PET imaging (including reimbursement)?

- Yes
- No

Do you recommend a PSMA PET in the majority of patients with high-risk clinically localised prostate cancer?

1. Yes
2. No
3. Abstain/unqualified to answer

Do you recommend a PSMA PET in the majority of patients with intermediate unfavourable-risk clinically localised prostate cancer?

1. Yes
2. No
3. Abstain/unqualified to answer

Do you recommend a PSMA PET in the majority of patients with intermediate favourable-risk clinically localised prostate cancer?

1. Yes
2. No
3. Abstain/unqualified to answer

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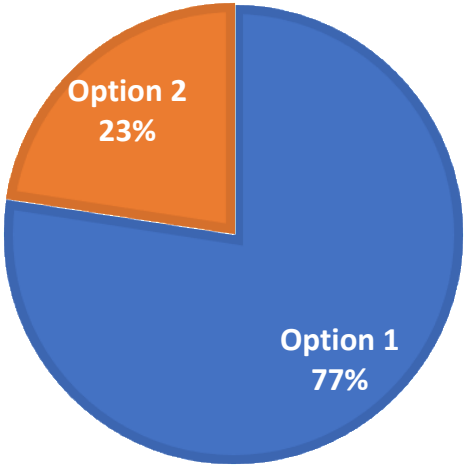
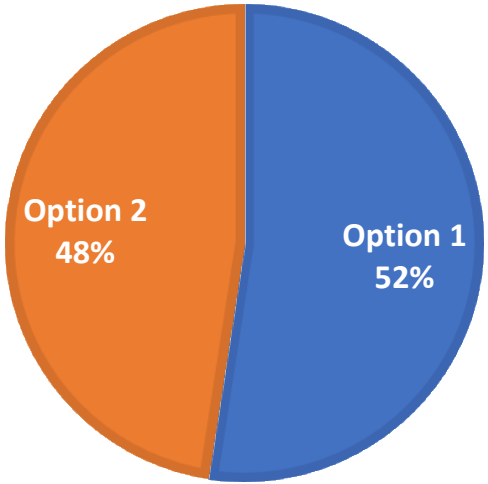
Q 2 - 4 Do you recommend a PSMA PET in the majority of patients with clinically localised prostate cancer?

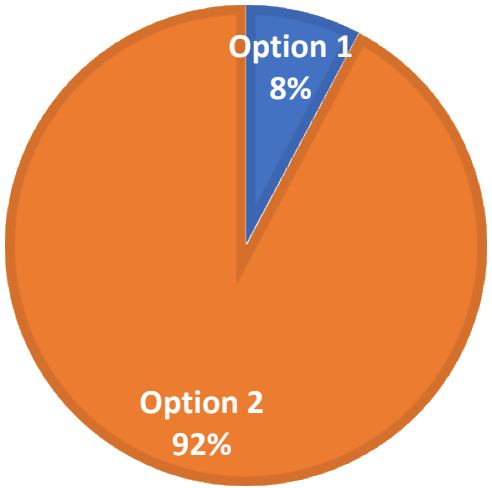
High-risk Localized



Intermediate unfavourable risk



Intermediate favourable risk



1. Yes
2. No
3. Abstain/unqualified to answer

Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2022

Q5 If you recommend a PSMA PET for systemic staging of clinically localised prostate cancer, what do you recommend (in addition to the MRI of the prostate)?

1. PSMA PET only after conventional imaging negative or indeterminate
2. Upfront PSMA PET with or without subsequent conventional imaging
3. Abstain/unqualified to answer (including: I do not recommend PSMA PET for staging)

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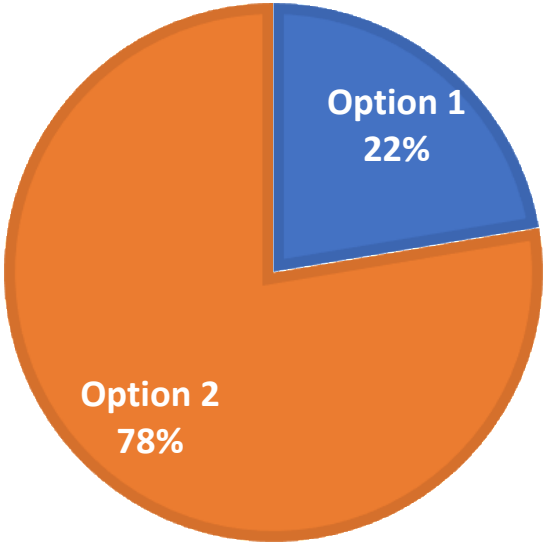

Option	Votes
Option 1	19
Option 2	66
Option 3	20
Total votes	105

Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2022

Discussion: Has PSMA PET imaging replaced conventional imaging for staging of localized prostate cancer?

Audience Vote

Do you have readily access to any of the AR pathway inhibitors (ARPI) for patients in the hormone-sensitive setting?

- Yes
- No

15. In the majority of patients with high-risk localised (STAMPEDE definition) prostate cancer (≥2 out of 3 criteria: cT3/T4, PSA ≥40, Gleason 8-10) and N0 M0 on next-generation imaging, what is your recommended systemic therapy in combination with local radiation therapy?

1. ADT alone for 2-3 years
2. ADT 2-3 years plus abiraterone for 2 years
3. ADT 2-3 years plus docetaxel 6 cycles
4. Abstain/unqualified to answer

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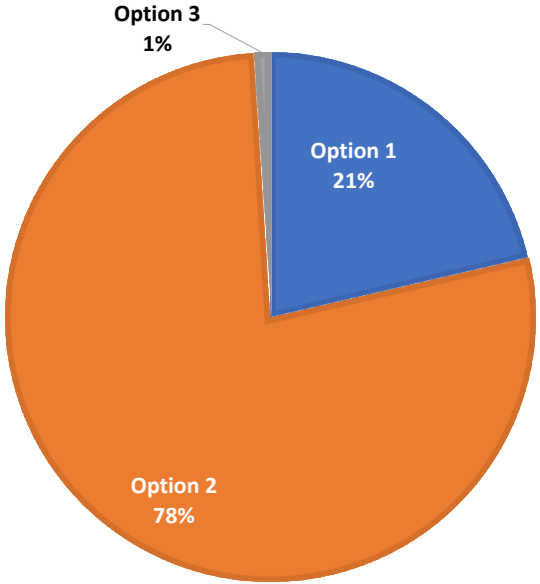

Option	Votes
Option 1	22
Option 2	80
Option 3	1
Option 4	2
Total votes	105

Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2022

Discussion: Are the data from STAMPEDE in M0 patients enough to change the SOC?

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23 and 24 For the majority of patients with 1 or 2 pathologically involved pelvic lymph nodes following radical surgery with extended PLND (pN1) without evidence of metastases on preoperative staging, with undetectable postoperative PSA and no high-risk features (ISUP grade group 4–5 or pT3 or positive margins), what is your recommendation provided the patient has regained continence?

1. Monitoring alone and salvage therapy in case of PSA rise
2. Adjuvant radiation therapy
3. Adjuvant radiation therapy plus systemic hormonal treatment
4. Systemic hormonal treatment alone
5. Abstain/unqualified to answer

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1. Monitoring alone and salvage therapy in case of PSA rise
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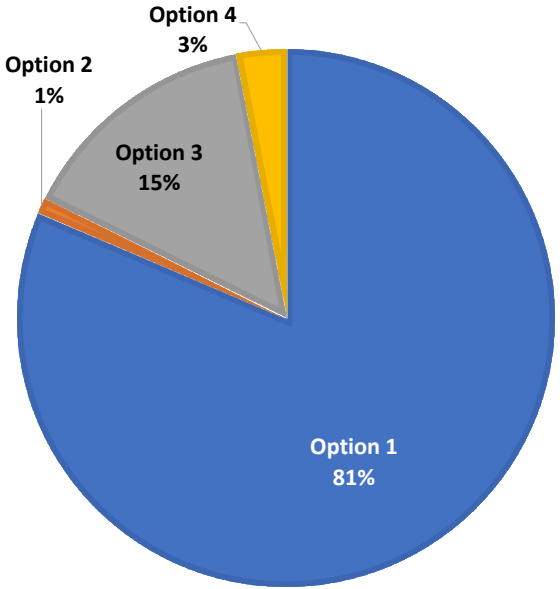
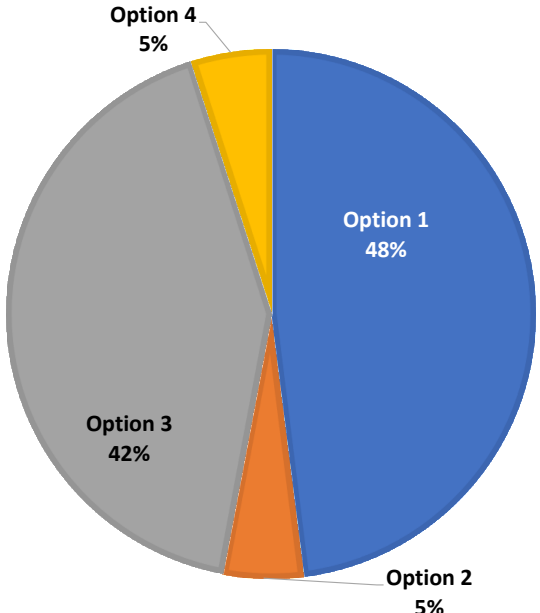
5. Abstain/unqualified to answer

No high-risk features (ISUP grade group 4–5 or pT3 or positive margins)



≥2 out of 3 high-risk features (ISUP grade group 4–5 or pT3 or positive margins)



Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2022

Discussion: Adjuvant radiation therapy for pN1?

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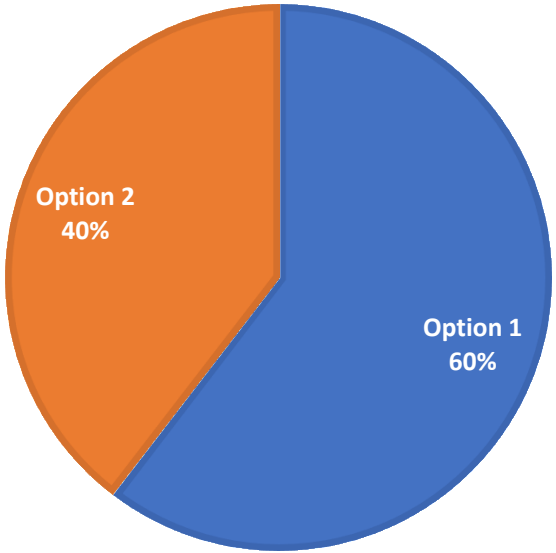
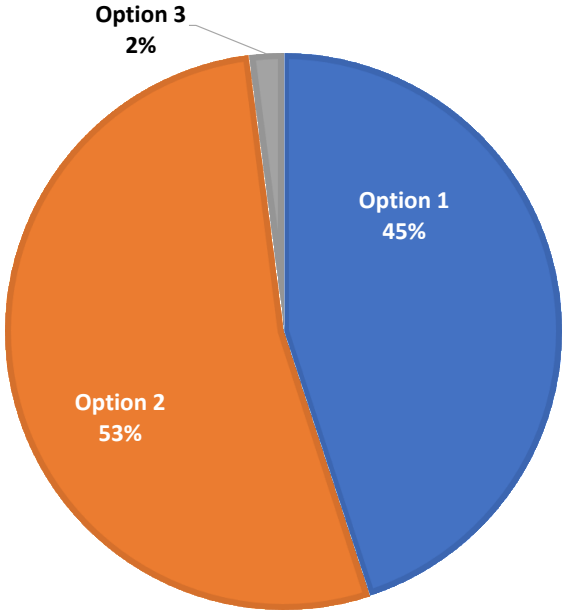
40 and 41 For the majority of patients with rising PSA after radical prostatectomy and PSA-DT <1 year OR pathological ISUP grade group 4–5 (EAU high-risk), what management do you recommend?

1. Salvage RT (+/- systemic therapy) as early as possible (i.e. before PSA <0.2)
2. Wait until PSA ≥0.2 and perform imaging
3. Systemic therapy alone
4. Abstain/unqualified to answer

WITH risk factors for local relapse (≥pT3b and/or R1)



WITHOUT risk factors for local relapse (≥pT3b and/or R1)



Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2022

Discussion: No consensus on salvage radiotherapy

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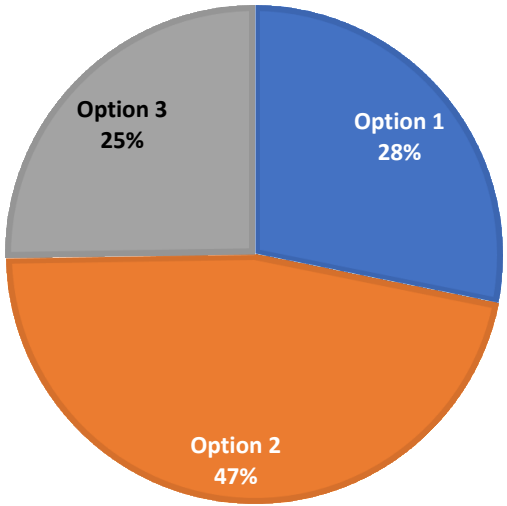
38. For the majority of patients with rising PSA after radical prostatectomy and PSA-DT >1 year and pathological ISUP grade group <4 (EAU low-risk) and a negative PSMA PET, what is your management recommendation?

1. Active monitoring and treat only in case of positive lesion on follow-up PSMA PET
2. Salvage RT plus/minus systemic therapy
3. Salvage RT plus/minus systemic therapy only in the context of additional adverse pathologic factors (e.g. R1, T3/T4, molecular classifier)
4. Abstain/unqualified to answer



Option	Votes
Option 1	29
Option 2	48
Option 3	26
Option 4	2
Total votes	105

Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2022

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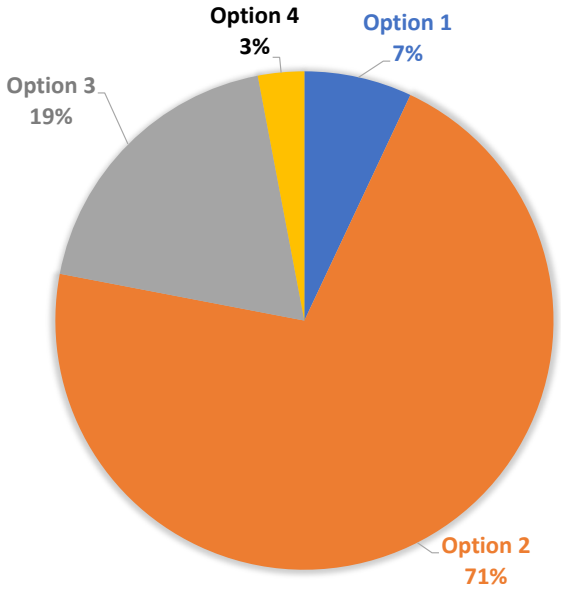
43. For the majority of patients with rising PSA after radical prostatectomy and PSA-DT <1 year OR pathological ISUP grade group 4–5 (EAU high-risk), and a negative PSMA PET, what is your management recommendation?

1. Active monitoring and treat only in case of positive lesion on follow-up PSMA PET
2. Salvage RT plus/minus systemic therapy
3. Salvage RT plus/minus systemic therapy only in the context of additional adverse pathologic factors (e.g. R1, T3/T4, molecular classifier)
4. Systemic therapy alone (including intermittent)
5. Abstain/unqualified to answer



Option	Votes
Option 1	7
Option 2	71
Option 3	19
Option 4	3
Option 5	5
Total votes	105

Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2022

Discussion

Discussion: Salvage radiation therapy alone, with 6 months or 24 months of ADT?

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72. What is your general treatment recommendation for the majority of patients with mHSPC?

1. **Combination therapy (ADT plus additional systemic therapy and/or local radiotherapy)**
2. ADT alone
3. Abstain/unqualified to answer

Option	Votes
Option 1	101
Option 2	3
Option 3	1
Total votes	105

Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2022

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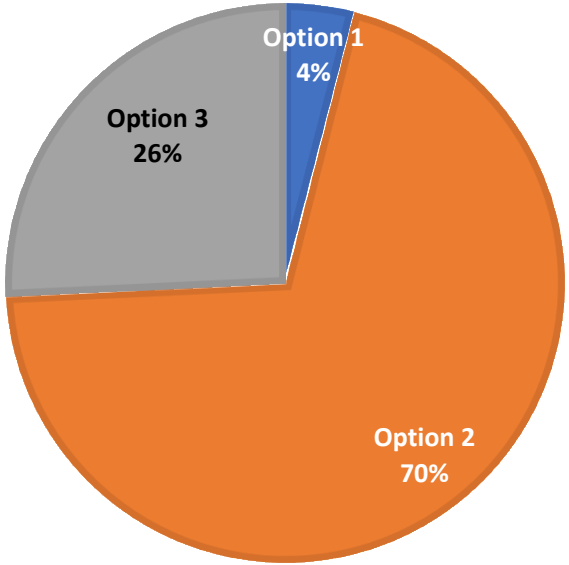
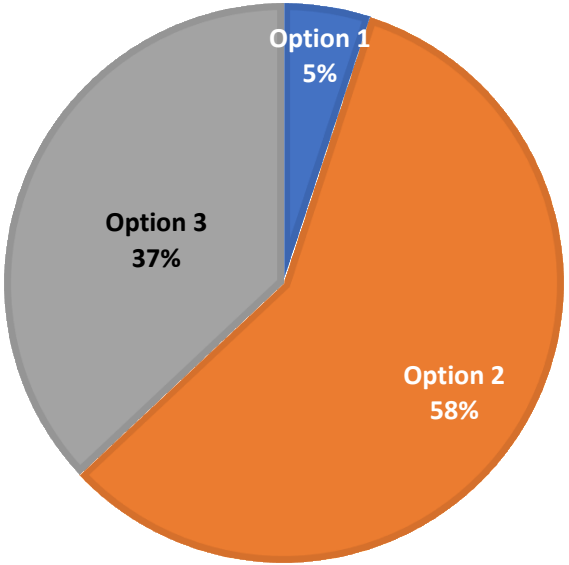
76 and 77 In which patients with mHSPC that are chemotherapy fit, do you recommend the triplet therapy ADT plus docetaxel plus AR pathway inhibitor?

1. In the majority of patients independent of disease volume
2. Only in high-volume patients
3. I usually do not recommend this combination
4. Abstain/unqualified to answer

Synchronous mHSPC



Metachronous mHSPC



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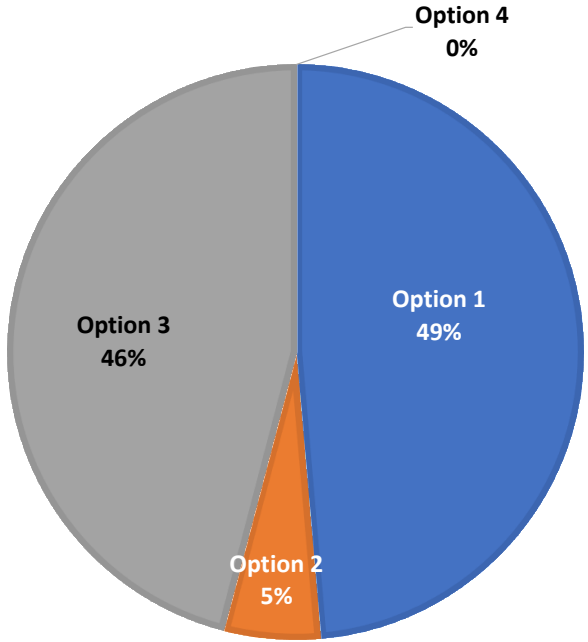
82. If you voted for triplet therapy in patients with synchronous mHSPC that are chemotherapy fit, which AR pathway inhibitor do you recommend for the majority of patients (in addition to ADT and docetaxel)?

1. Abiraterone
2. Apalutamide
3. Darolutamide
4. Enzalutamide
5. Abstain/unqualified to answer (including I did not vote for triplet therapy)



Option	Votes
Option 1	36
Option 2	4
Option 3	34
Option 4	0
Option 5	31
Total votes	105

Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2022

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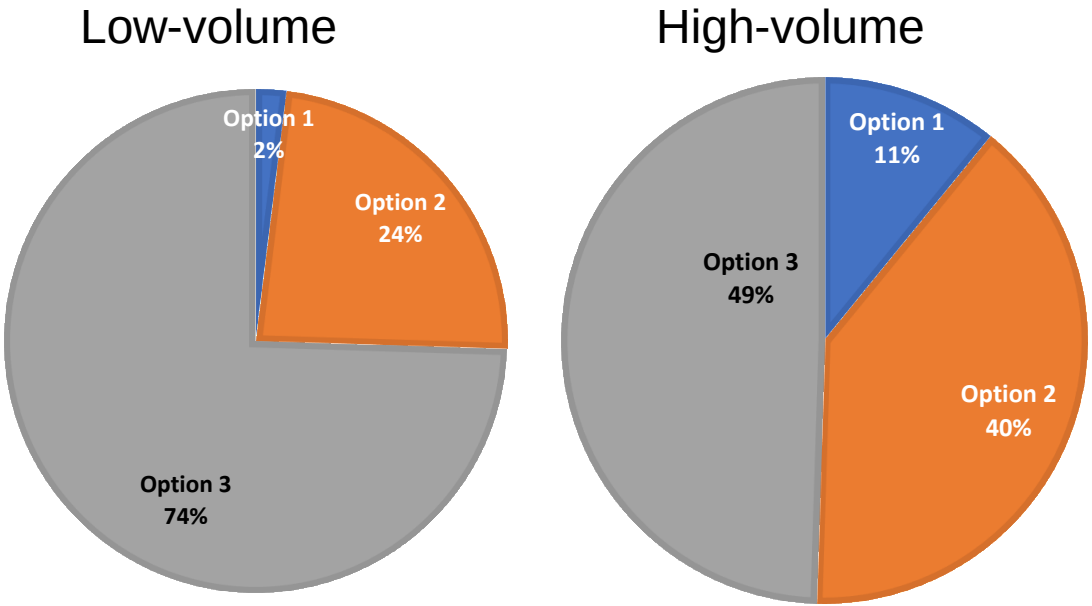
84. In patients with mHSPC, do you recommend the addition of docetaxel alone to ADT (assuming that AR pathway inhibitors are available)?

1. Yes, in the majority of patients
2. Yes, but only in a minority of selected patients
3. No
4. Abstain/unqualified to answer



Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2022

Discussion: Triplet therapy for mHSPC and the role of docetaxel?

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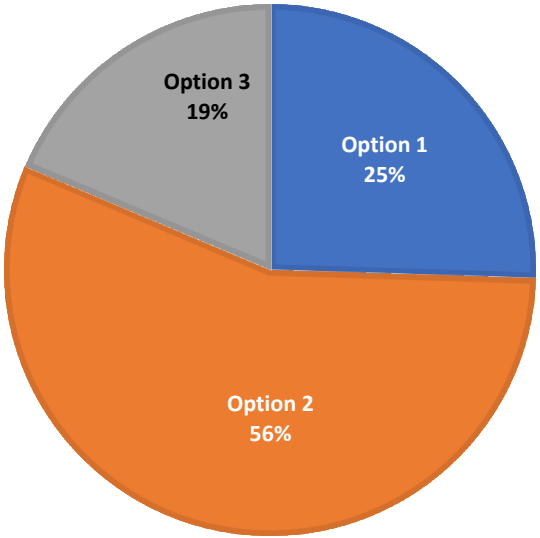
86. In patients with mHSPC who are ≥75 years old, do you recommend a geriatric assessment (assuming it is readily available) before choosing a treatment combination?

1. Yes, in the majority of patients
2. Yes, but only red flag issues are raised during consultation (frailty, cognitive issues, heart disease and significant comorbidity)
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	26
Option 2	57
Option 3	19
Option 4	3
Total votes	105

Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2022

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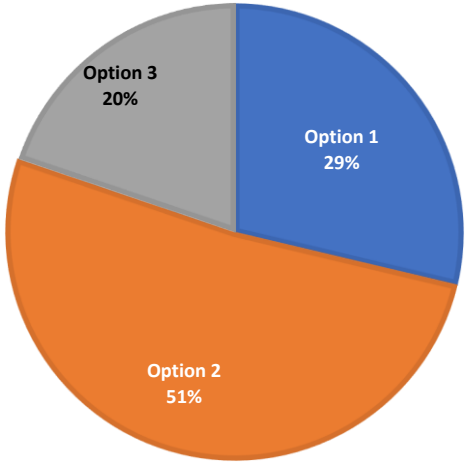
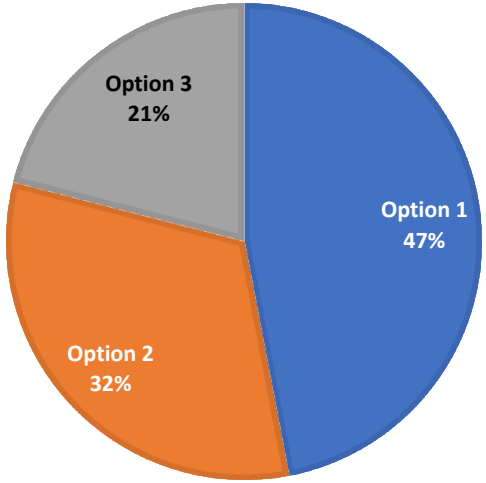
97. In patients with synchronous mHSPC, what is the minimal estimated non-cancer life expectancy for you to recommend a combination systemic therapy?

1. More than 1 year
2. More than 3 years
3. I don't base my decision on life expectancy estimation
4. Abstain/unqualified to answer

Low-volume



high-volume



Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2022

Discussion

Discussion: How to identify and manage vulnerable/frail patients?

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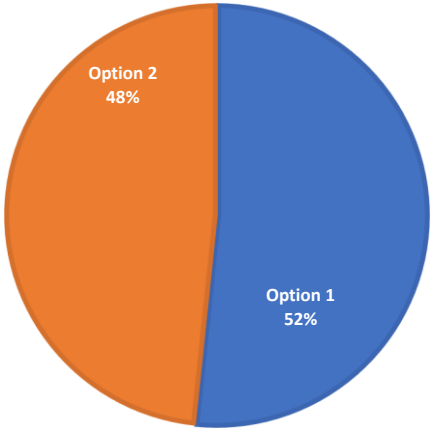
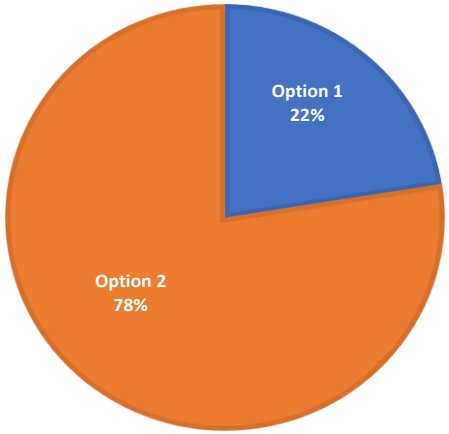
133, 134 and 135 In the majority of patients with mCRPC that are about to start an AR pathway inhibitor, do you recommend the combination with a PARP inhibitor as first-line therapy?

1. Yes
2. No
3. Abstain/unqualified to answer

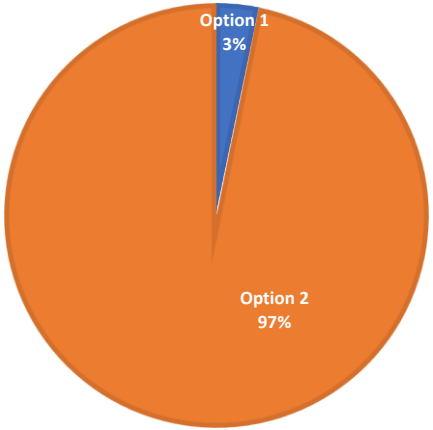
With a pathogenic BRCA1/2 alteration



With a pathogenic DNA repair gene alteration (NOT BRCA1/2)



Without a known DNA repair gene alteration



Results obtained April 2022 based on 104 voting epxerts.
For interpretation of results please check the paper, which will be published soon

Discussion

Discussion: PARP inhibition for molecularly selected patients only or for all-comers?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APCCC 2024
SAVE THE DATE
25 - 27 April 2024
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