

The Results of the First **Global** Prostate Cancer Consensus Conference for Developing Countries (PCCCDC)

Fernando Cotait Maluf

Associate Director – Oncology Center - Beneficência Portuguesa, São Paulo

Member of Steering Comitê – Oncology Center – Albert Einstein Hospital , São Paulo

Director – Oncology Center – Santa Lúcia Hospital, Brasília



Conflict of Interest

None for this talk

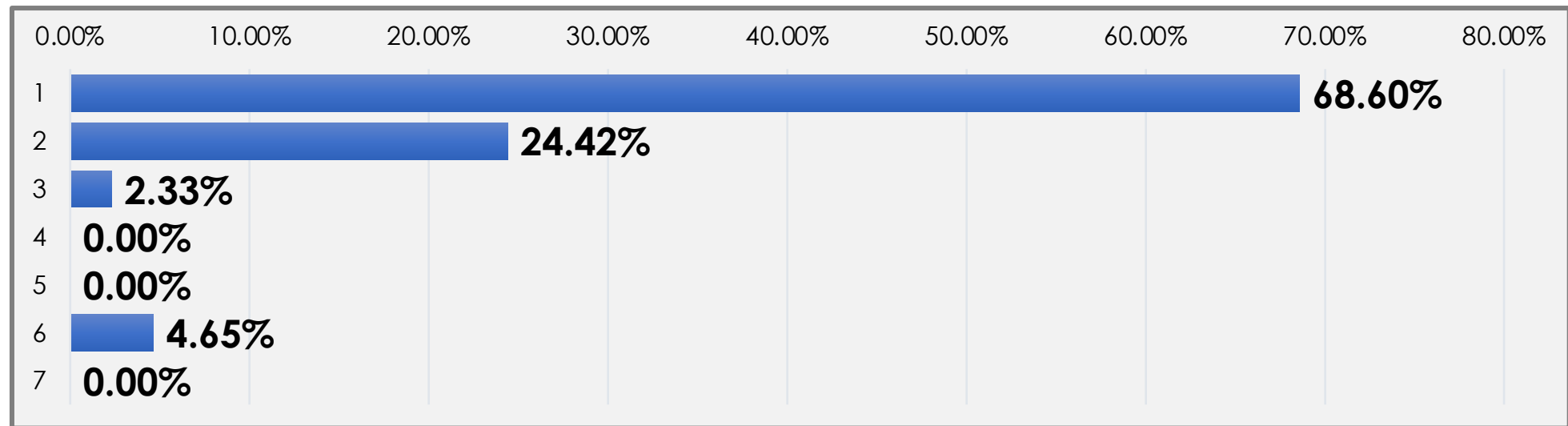
- This unique conference provided guidelines for the most frequent cancer in men specifically for areas of resources limitations (70-75% of the world's population).
- The methodology applied in the global consensus for developing countries was similar to one used for Advanced Prostate Cancer Consensus Conference (APC3C).

- Voting members included leader opinion physicians from different specialties: urologists, medical oncologists, radiation oncologists, radiologists and pathologists from developing countries in Latin America, Africa, Middle East, Asia and Eastern Europe.
- Physicians were generally aware of the costs of diagnostics, follow-up, and treatment tools
- For all the following questions that referred to an **area of limited resources** the recommendations should take into account cost-effectiveness as well as the possible therapies with easier and broader access.

2. LOCALIZED LOW-RISK (AND VERY LOW RISK) PROSTATE CANCER

2.2.4 What is your treatment recommendation for an otherwise healthy patient diagnosed with low risk prostate cancer in an area with **limited resources** ?

1. Active surveillance
2. Radical prostatectomy (only open approach is available)
3. External beam radiation (No IMRT available)
4. External beam radiation plus ADT (No IMRT available)
5. Some form of ADT (particularly if no local treatment is feasible)
6. All of the above
7. Abstain



2.2.17 In Institutions where there is no conformal external beam radiotherapy availability of IMRT technique, robotic/laparoscopic surgery nor focal therapy or brachytherapy, which treatment is recommended for patients with life expectancy of > 10-15 years, with low risk prostate cancer, who has declined active surveillance or who had disease progression on active surveillance?

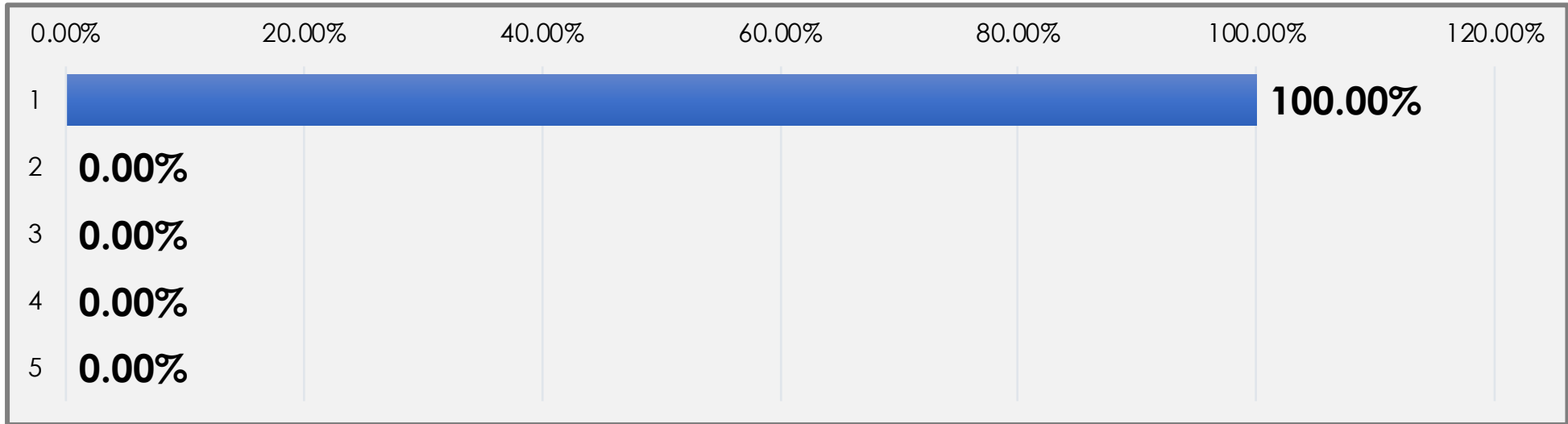
1. Radical prostatectomy (open only)

2. Hormonal therapy

3. Cobalt radiotherapy

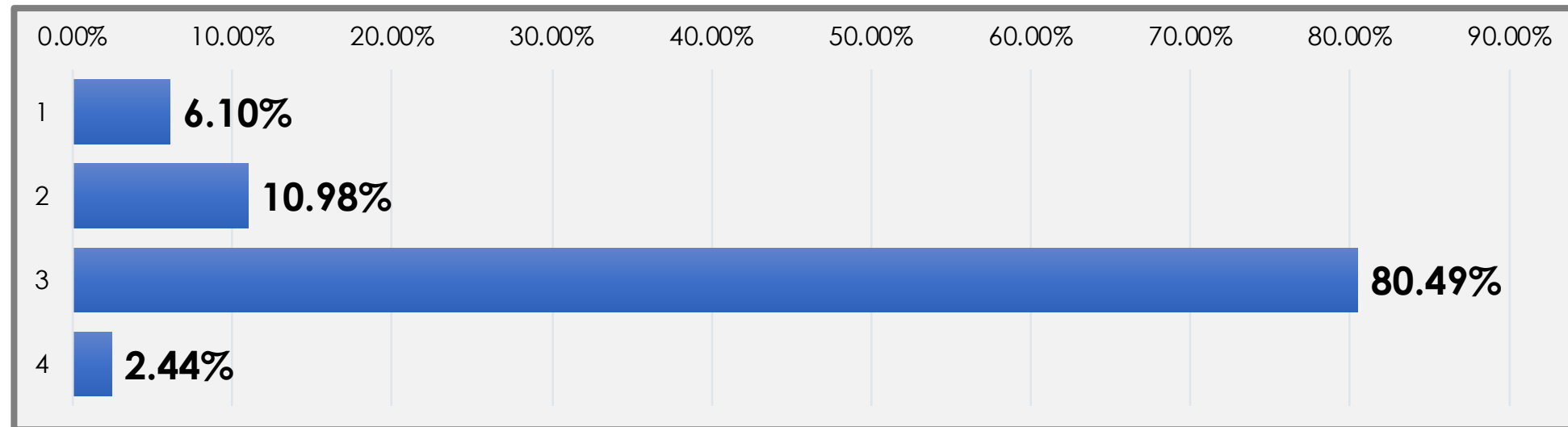
4. Combination of hormonal therapy and cobalt radiotherapy

5. Abstain
-



2.2.19 In Institutions where there is **only cobalt radiotherapy technique**, patients with prostate cancer can be treated with external radiotherapy?

1. Yes, the majority of patients
2. Yes, the minority of patients
3. No
4. Abstain

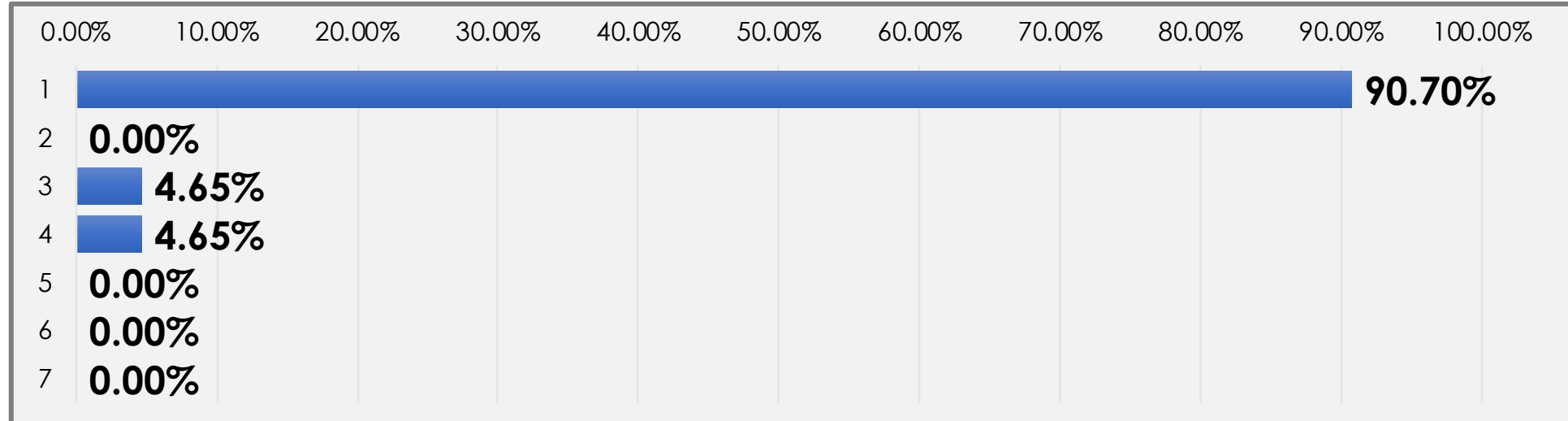


3. LOCALIZED INTERMEDIATE- RISK PROSTATE CANCER

(Consider intermediate favorable and intermediate)

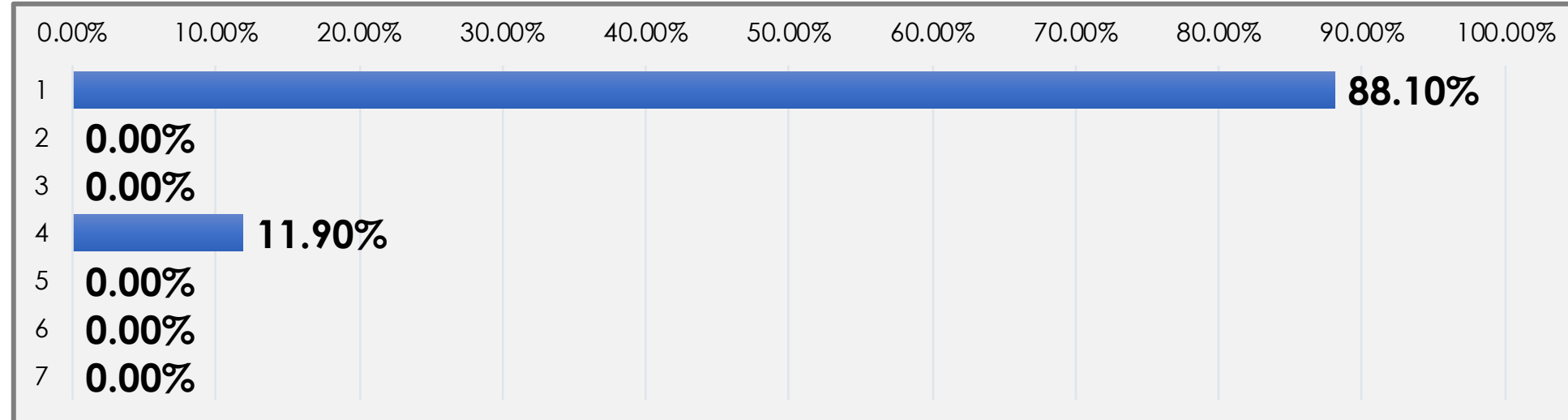
3.2.2 Which treatment is recommended for patients with life expectancy of > 10-15 years with the diagnosis of intermediate risk prostate cancer with Gleason score 3 + 4, PSA < 20ng/mL, and disease confined to the prostate in an area of **limited resources** ?

1. Radical prostatectomy (Robot platform not available)
2. Hormonal therapy alone
3. External beam radiotherapy alone (IMRT not available)
4. Combination of hormonal therapy and external beam radiotherapy (IMRT not available) +/- Brachytherapy
5. Brachytherapy
6. Active surveillance
7. Abstain



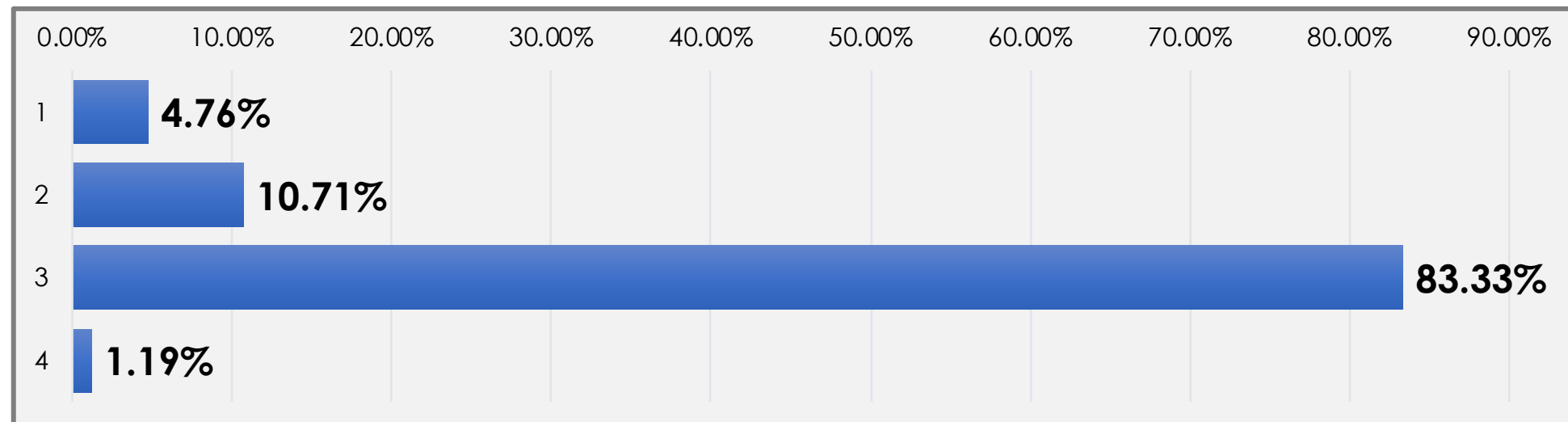
3.2.4 Which treatment is recommended for patients with life expectancy of > 10-15 years with the diagnosis of intermediate risk prostate cancer with Gleason score 4 + 3, PSA < 20ng/mL, and disease confined to the prostate in an area of **limited resources** ?

1. Radical prostatectomy (Robot platform not available)
2. Hormonal therapy alone
3. External beam radiotherapy alone (IMRT not available)
4. Combination of hormonal therapy and external beam radiotherapy (IMRT not available) +/- Brachytherapy
5. Brachytherapy
6. Active surveillance
7. Abstain



3.2.18 In Institutions where there is **only cobalt radiotherapy technique**, patients with intermediate-risk localized prostate cancer can be treated with external radiotherapy?

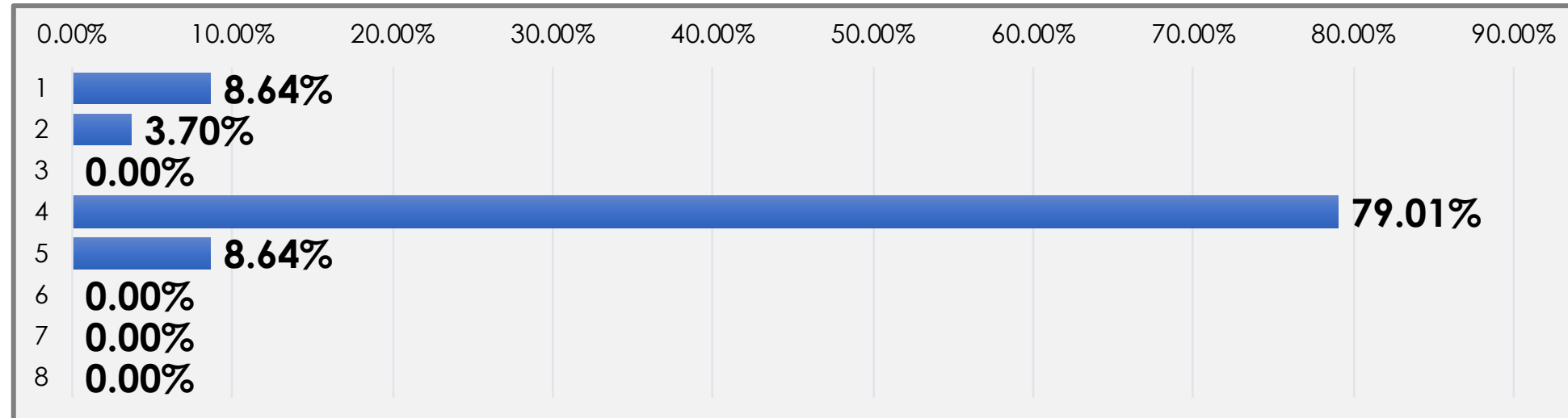
1. Yes, the majority of patients
2. Yes, the minority of patients
3. No
4. Abstain



4. HIGH-RISK AND LOCALLY ADVANCED PROSTATE CANCER

4.2.9 In Institutions where there is **no availability of IMRT technique**, what is your recommendation for patients with the diagnosis of high-risk prostate cancer with clinical T3/T4 and/or clinical N+?

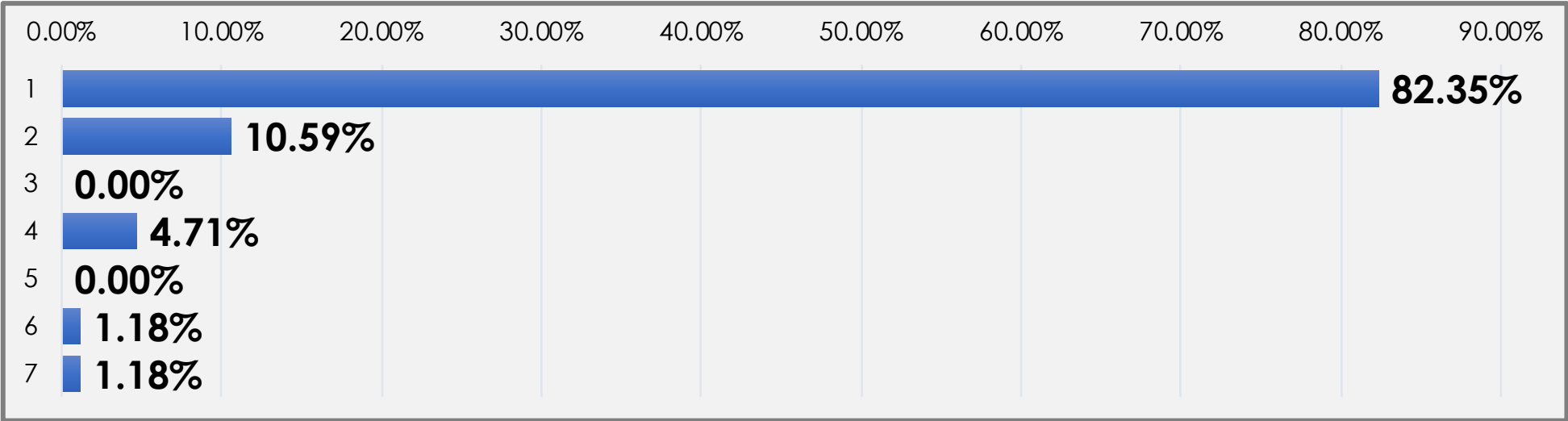
1. Radical prostatectomy + lymph node dissection
2. Hormonal therapy
3. Conformal external beam radiotherapy
4. Combination of hormonal therapy and conformal external beam radiotherapy
5. Combination of hormonal therapy, conformal external beam radiotherapy + brachytherapy
6. Active surveillance
7. No treatment and investigation only in case of symptoms suggesting progression of disease and then individualize treatment
8. Abstain



4.2.10 In Institutions where there is no availability of IMRT technique and conformal external beam radiotherapy, what is your recommendation for patients with the diagnosis of high-risk prostate cancer with Gleason score 8-10 and/or PSA > 20ng/mL and disease confined to the prostate?



- 1. Radical prostatectomy + lymph node dissection
- 2. Hormonal therapy
- 3. Cobalt radiotherapy
- 4. Combination of hormonal therapy and cobalt radiotherapy
- 5. Active surveillance
- 6. No treatment and investigation only in case of symptoms suggesting progression of disease
- 7. Abstain



4.2.11 In Institutions where there is **only conventional radiotherapy technique**, patients with high-risk disease confined prostate cancer can be treated with external radiotherapy?

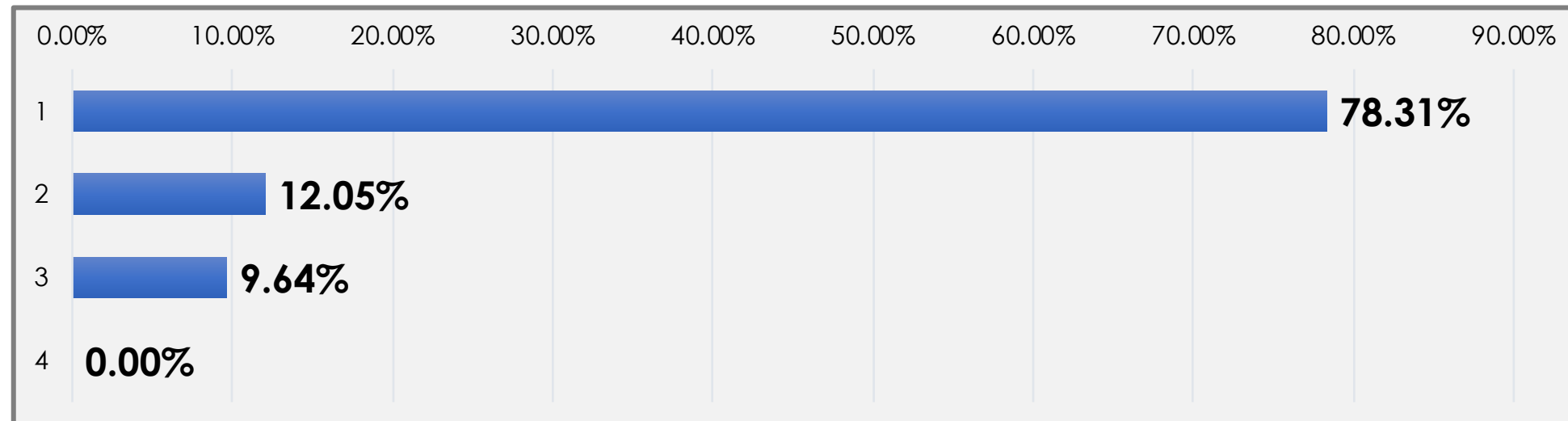
1. Yes, the majority of patients



2. Yes, the minority of patients

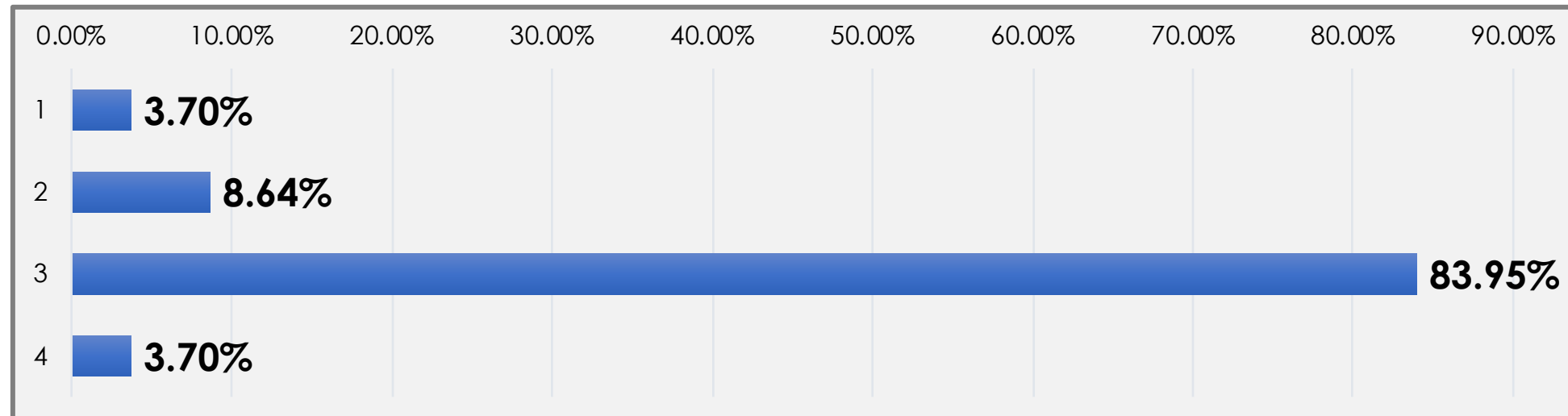
3. No

4. Abstain



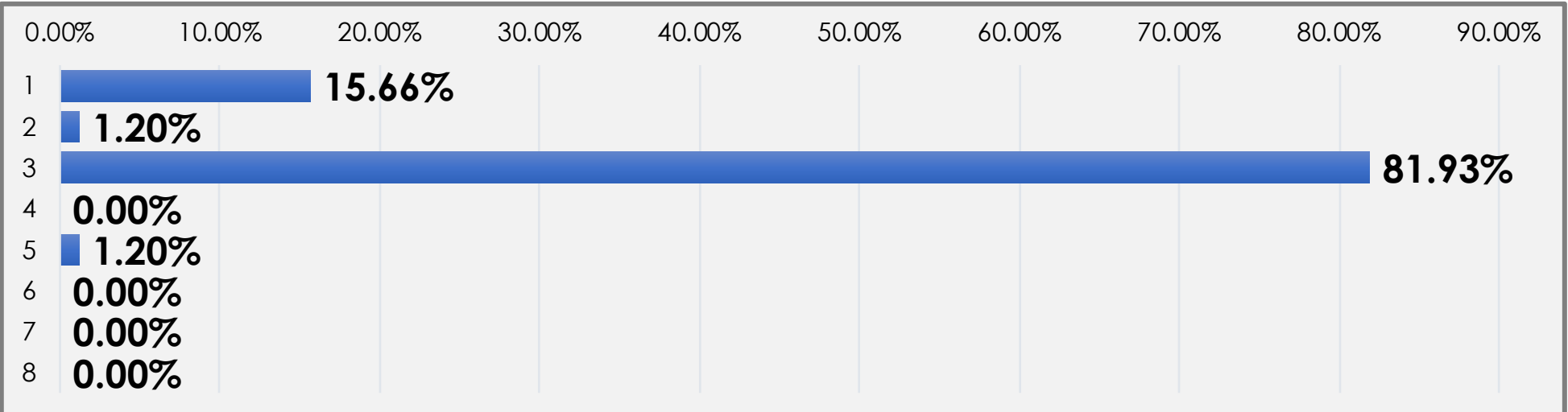
4.2.12 In Institutions where there is **only cobalt radiotherapy technique**, patients with high-risk disease confined prostate cancer can be treated with external radiotherapy ?

1. Yes, the majority of patients
2. Yes, the minority of patients
3. No
4. Abstain



4.2.28 In case the option for exclusive hormonal therapy is made for the treatment of high-risk prostate cancer with clinical T3/T4 and/or clinical N+, what would be your preference in an area of **limited resources** ?

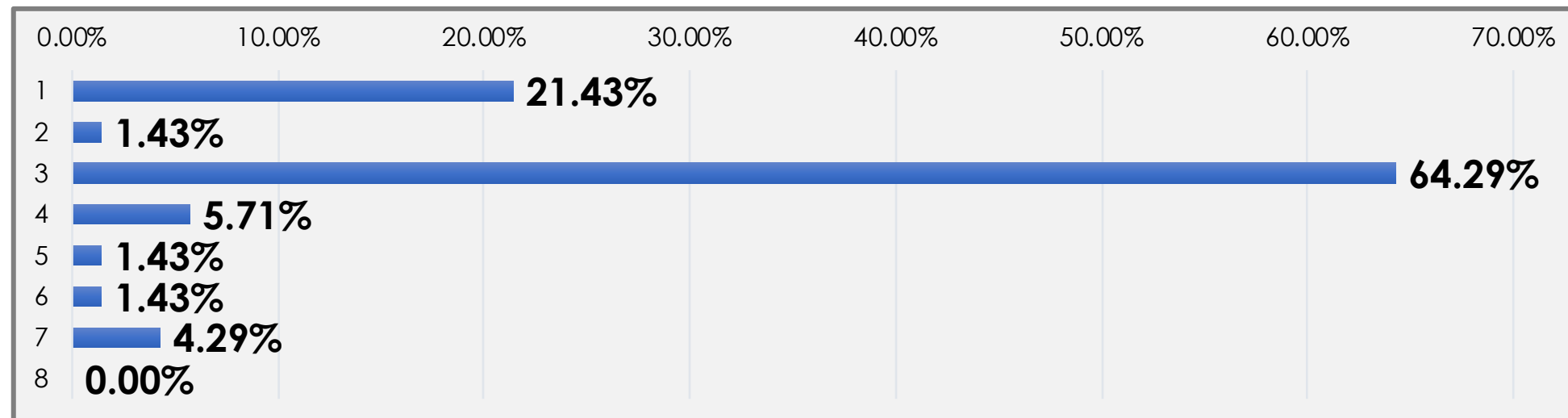
- 1. ADT by LHRH agonist alone (+/- first generation AR antagonist)
- 2. ADT by LHRH antagonist alone (+/- first generation AR antagonist)
- 3. ADT by Orchiectomy alone
- 4. ADT + abiraterone
- 5. Any form of intermittent ADT
- 6. Bicalutamide 50mg monotherapy
- 7. Bicalutamide 150mg monotherapy
- 8. Abstain



7. M1 CASTRATION-NAÏVE PROSTATE CANCER

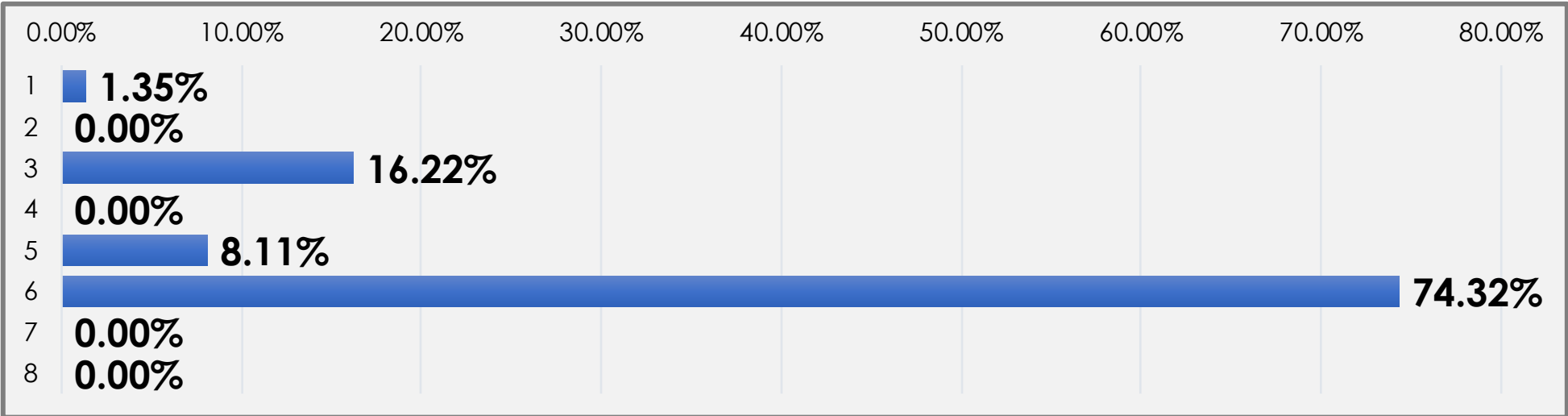
7.2.2 What hormone therapy scheme do you recommend in the majority of men presenting with de novo low-volume (as defined by CHARTED [no visceral metastases and no appendicular bone metastases]) metastatic castration-sensitive/naive prostate cancer in an area of **limited resources** ?

1. Continuous ADT by LHRH agonist alone (+/- first generation AR antagonist)
2. Continuous ADT by LHRH antagonist alone (+/- first generation AR antagonist)
3. ADT by Orchiectomy alone
4. Any form of intermittent ADT
5. Any form of continuous ADT plus abiraterone
6. Any form of continuous ADT plus docetaxel
7. Any form of continuous ADT (+/- first generation AR antagonist)
8. Abstain



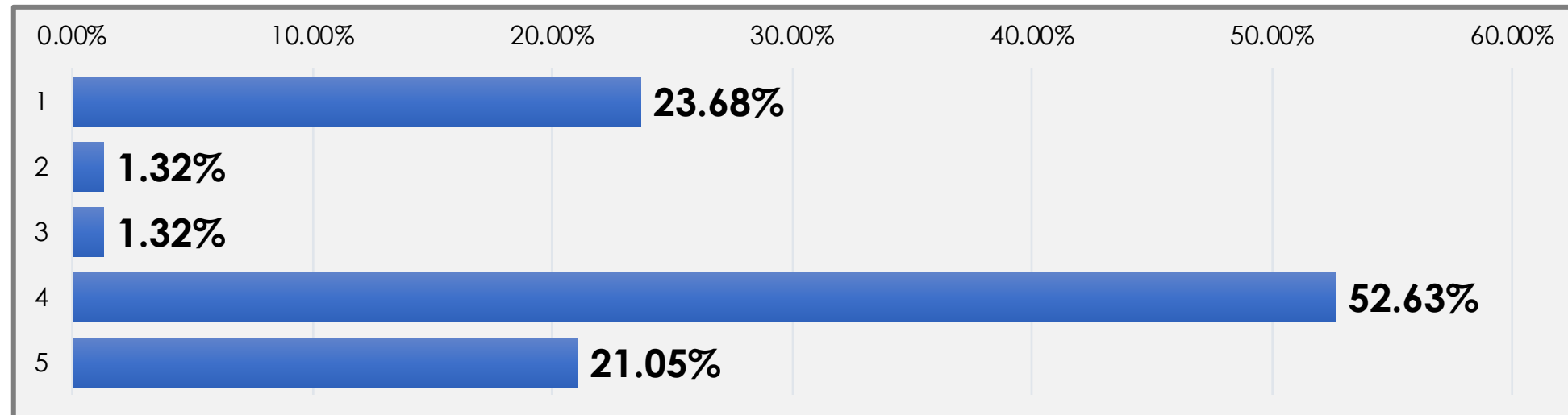
7.2.4 What hormone therapy scheme do you recommend in the majority of men presenting with de novo high-volume (as defined by CHAARTED [visceral metastases and/or ≥ 4 bone lesions with ≥ 1 beyond vertebral bodies and p  lvis]) metastatic castration-sensitive/naive prostate cancer in an area of **limited resources** ?

- 1. Continuous ADT by LHRH agonist alone (+/- first generation AR antagonist)
- 2. Continuous ADT by LHRH antagonist alone (+/- first generation AR antagonist)
- 3. ADT by Orchiectomy alone
- 4. Any form of intermittent ADT
- 5. Any form of continuous ADT plus abiraterone
- 6. Any form of continuous ADT plus docetaxel
- 7. Any form of continuous ADT (+/- first generation AR antagonist)
- 8. Abstain



7.2.16 If you use castration plus abiraterone in men with castration-sensitive/naive disease which abiraterone regimen do you recommend for the majority of patients in an area of **limited resources** ?

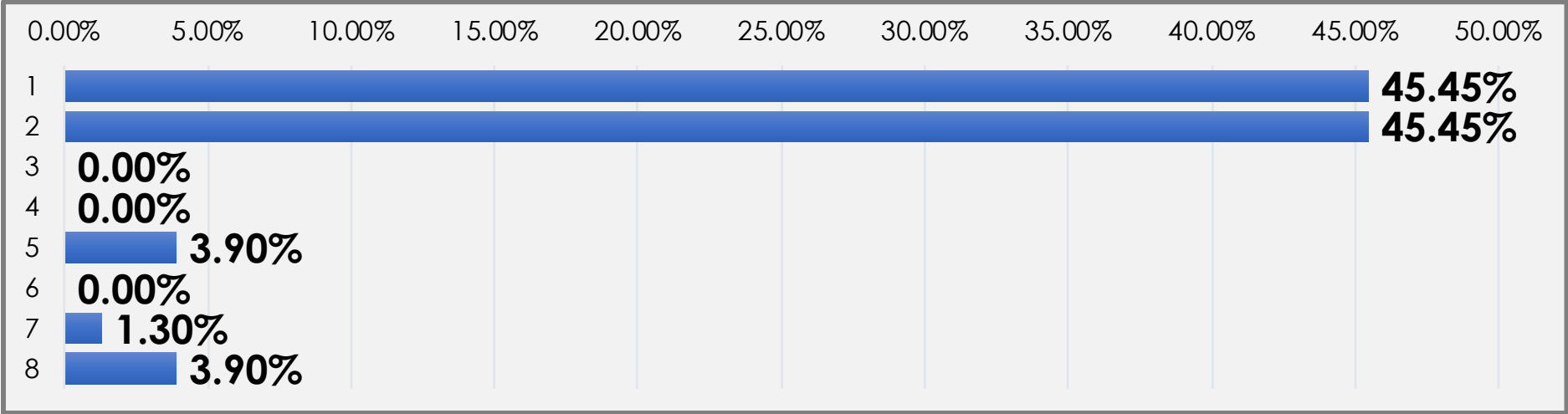
1. Abiraterone 1000mg plus prednisone 5mg/d
2. Abiraterone 1000mg plus prednisone 10mg/d
3. Abiraterone 250mg with fatty food plus prednisone 10mg/d
4. Abiraterone 250mg with fatty food plus prednisone 5mg/d
5. Abstain (including I do not use abiraterone in this situation)



8. M1 CASTRATION-RESISTANT PROSTATE CANCER

8.2.3 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/naive setting if full doses of abiraterone and enzalutamide as well as radium 223 are not available ?

- 1. Abiraterone 250mg with fatty foods
- 2. Docetaxel
- 3. Platinum based chemotherapy
- 4. Mitoxantrone
- 5. DES
- 6. Ketoconazole/prednisone
- 7. Corticosteroids
- 8. Abstain



8.2.4 What is your preferred treatment choice for second-line endocrine manipulation when Abiraterone and/or Enzalutamide are NOT available in this setting and you decide not to recommend chemotherapy?

1. First generation AR antagonist



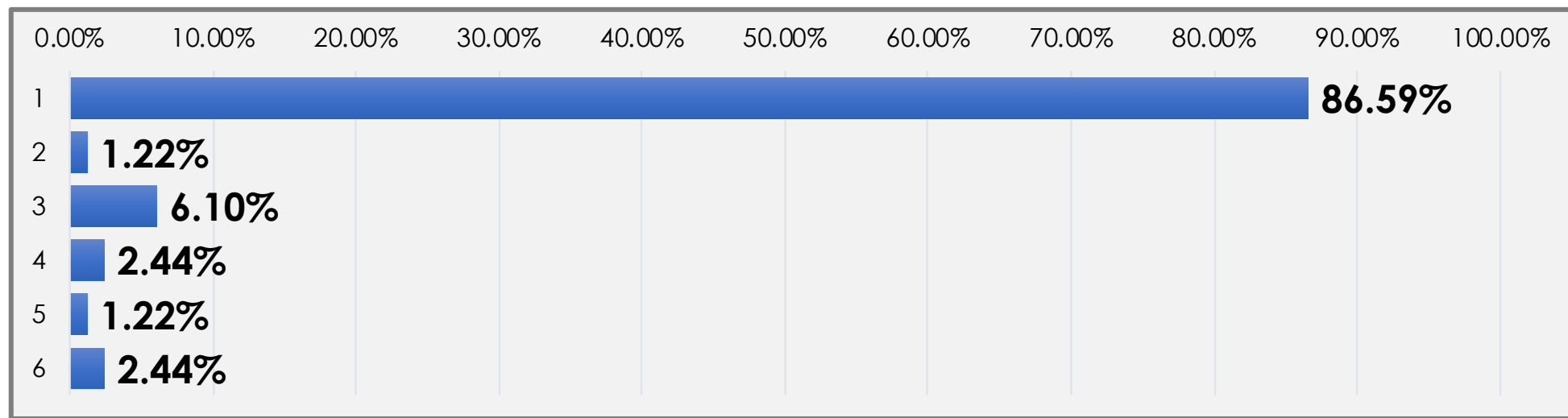
2. Ketoconazole

3. DES

4. Corticosteroids

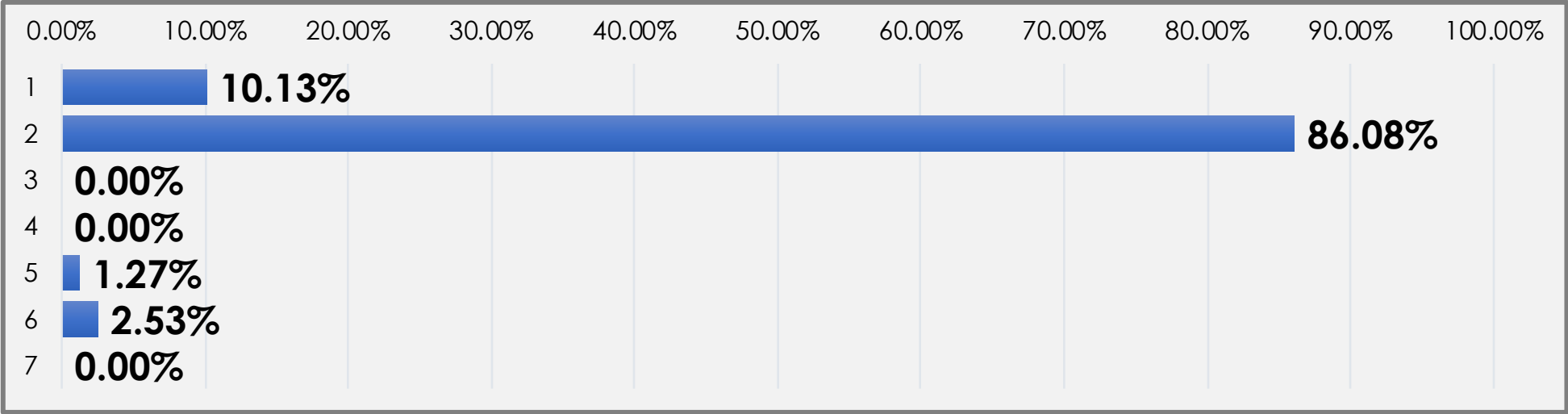
5. Other

6. Abstain



8.2.6 What is your preferred first-line mCRPC treatment option in the majority of symptomatic men who did NOT receive Docetaxel or Abiraterone in the castration-sensitive/naive setting if full doses of abiraterone and enzalutamide are not available ?

- 1. Abiraterone 250mg with fatty foods
- 2. Docetaxel
- 3. Mitoxantrone
- 4. DES
- 5. Ketoconazole/prednisone or Corticosteroids
- 6. Radium-223 if exclusively bone metastases
- 7. Abstain



8.2.25 Each of the following drugs is on the WHO essential medicines list and/or you are able to source them at an affordable price from generic manufacturer. Which would you consider to be appropriate treatment options in the setting of limited healthcare resources and in men with mCRPC who are progressing on or after Docetaxel?

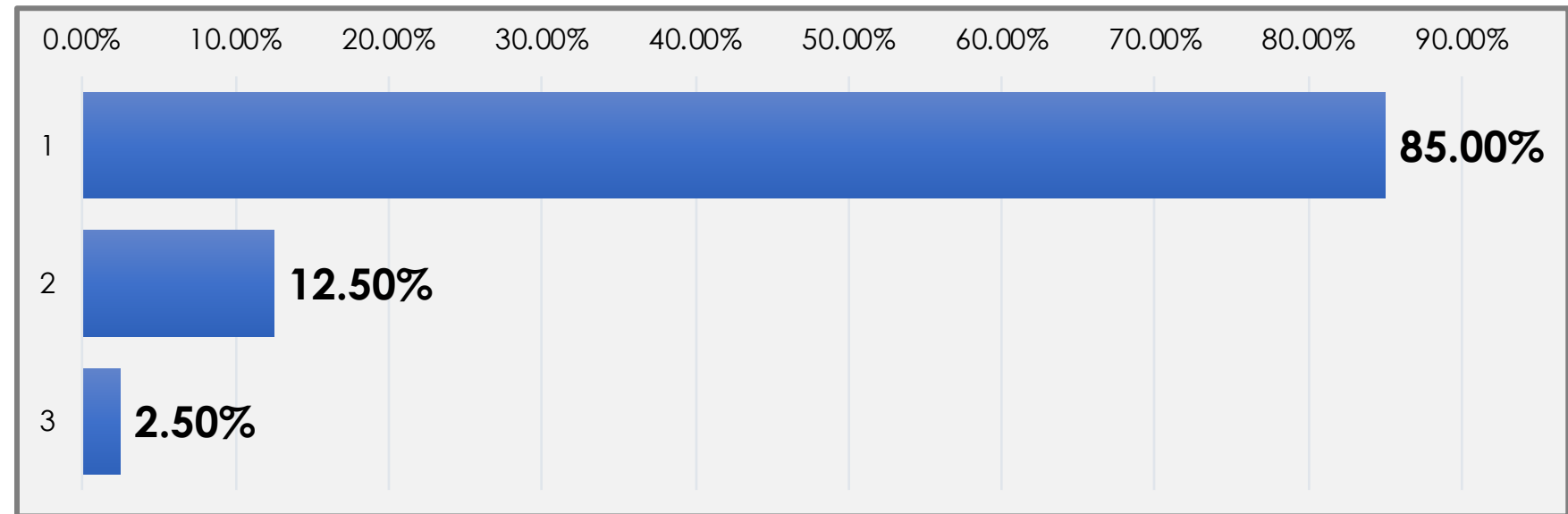
Mitoxantrone

1. Yes



2. No

3. Abstain



8.2.25 Each of the following drugs is on the WHO essential medicines list and/or you are able to source them at an affordable price from generic manufacturer. Which would you consider to be appropriate treatment options in the setting of limited healthcare resources and in men with mCRPC who are progressing on or after Docetaxel?

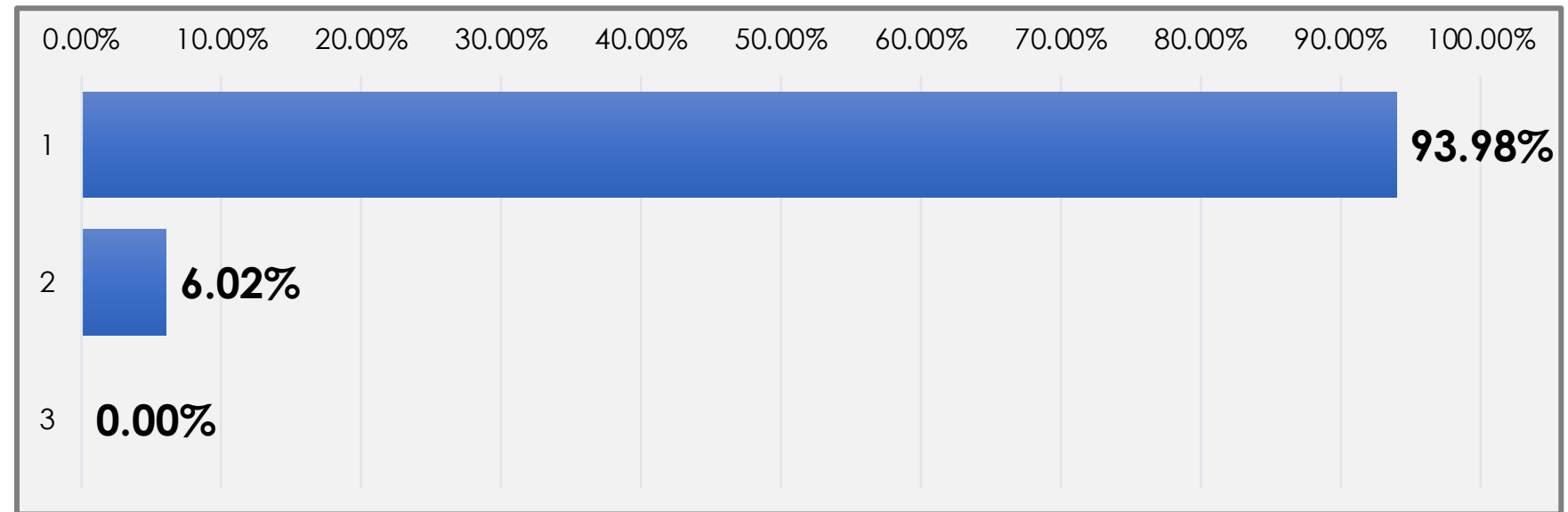
Abiraterone 250mg with fatty foods

1. Yes



2. No

3. Abstain



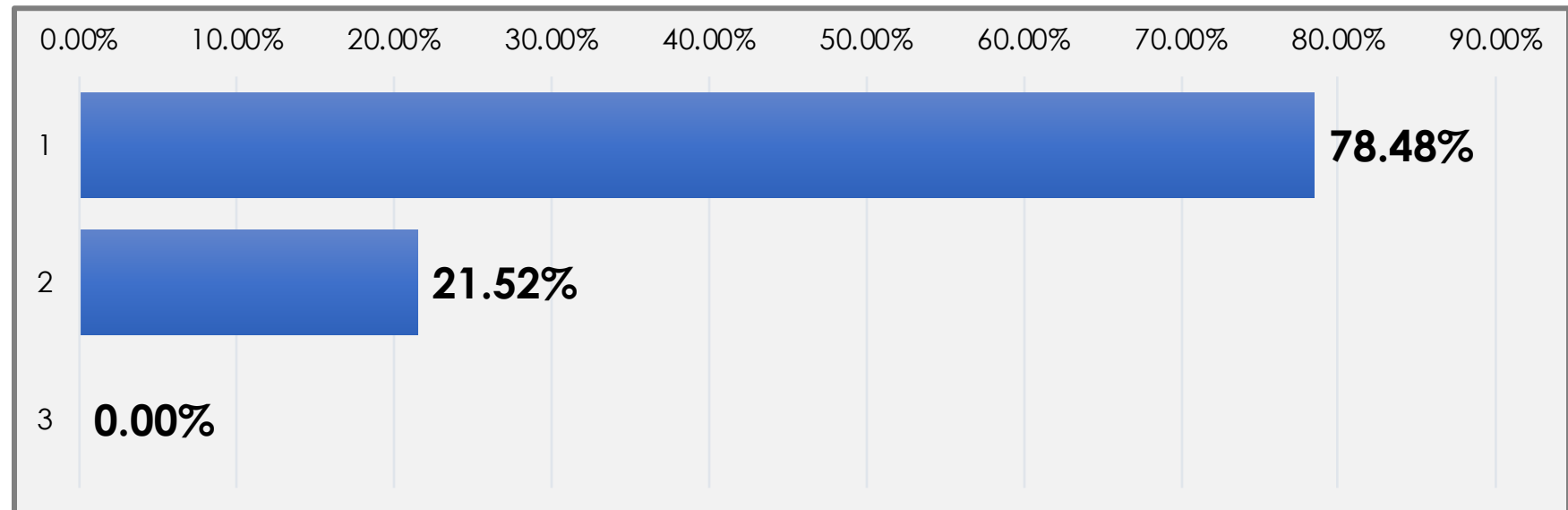
8.2.25 Each of the following drugs is on the WHO essential medicines list and/or you are able to source them at an affordable price from generic manufacturer. Which would you consider to be appropriate treatment options in the setting of limited healthcare resources and in men with mCRPC who are progressing on or after Docetaxel?

DES

1. Yes

2. No

3. Abstain



8.2.25 Each of the following drugs is on the WHO essential medicines list and/or you are able to source them at an affordable price from generic manufacturer. Which would you consider to be appropriate treatment options in the setting of limited healthcare resources and in men with mCRPC who are progressing on or after Docetaxel?

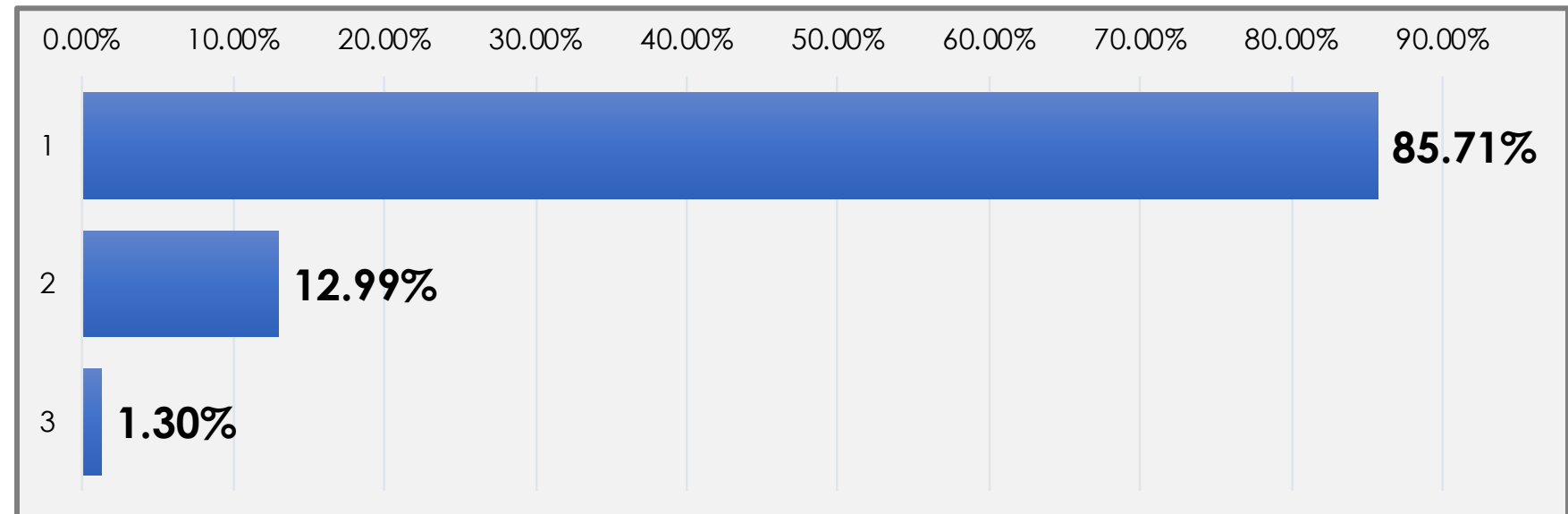
Ketoconazole/corticosteroids

1. Yes



2. No

3. Abstain



8.2.25 Each of the following drugs is on the WHO essential medicines list and/or you are able to source them at an affordable price from generic manufacturer. Which would you consider to be appropriate treatment options in the setting of limited healthcare resources and in men with mCRPC who are progressing on or after Docetaxel?

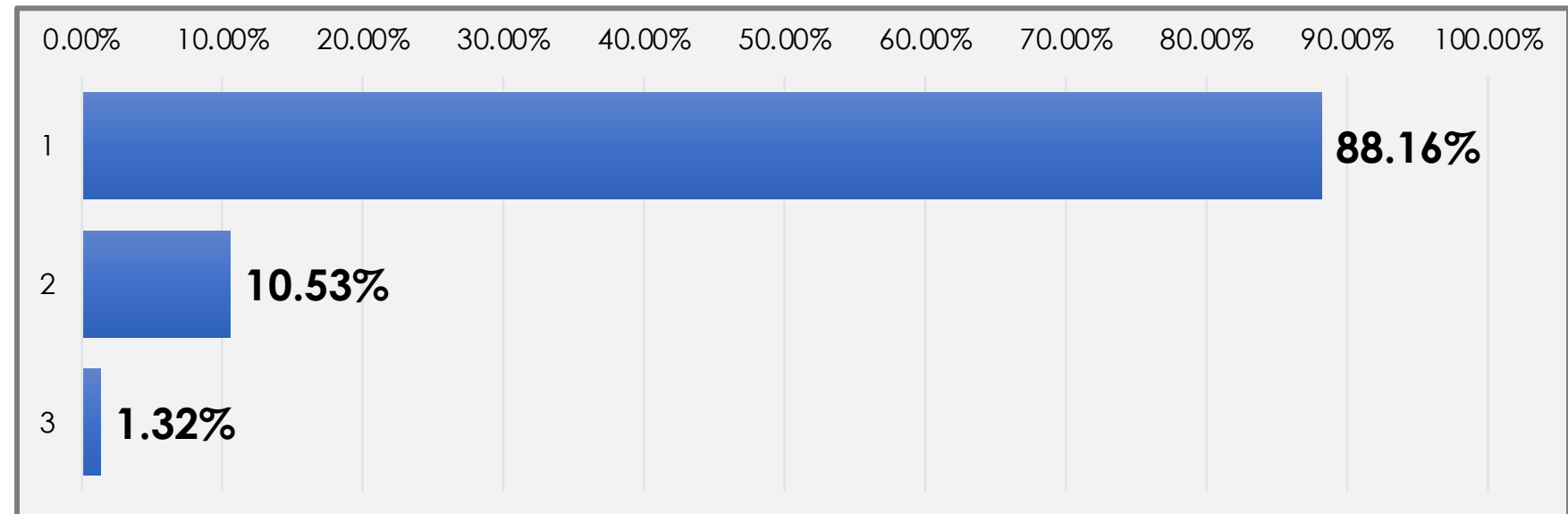
Corticosteroids

1. Yes



2. No

3. Abstain



8.2.25 Each of the following drugs is on the WHO essential medicines list and/or you are able to source them at an affordable price from generic manufacturer. Which would you consider to be appropriate treatment options in the setting of limited healthcare resources and in men with mCRPC who are progressing on or after Docetaxel?

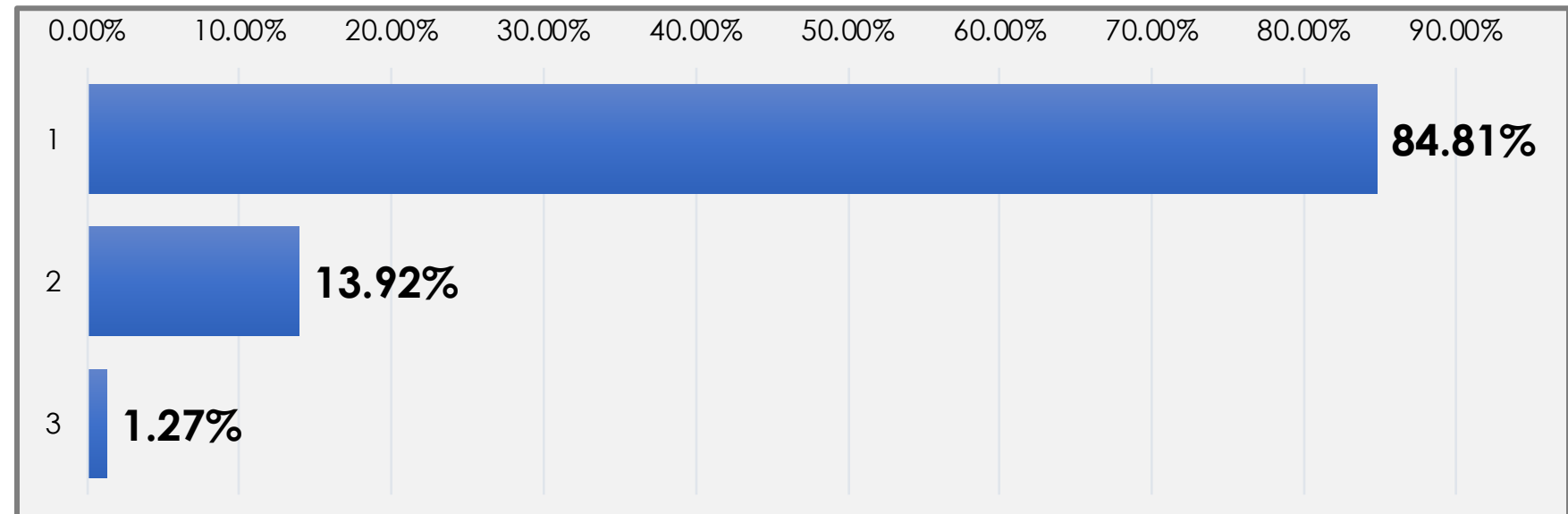
Bicalutamide 150mg

1. Yes



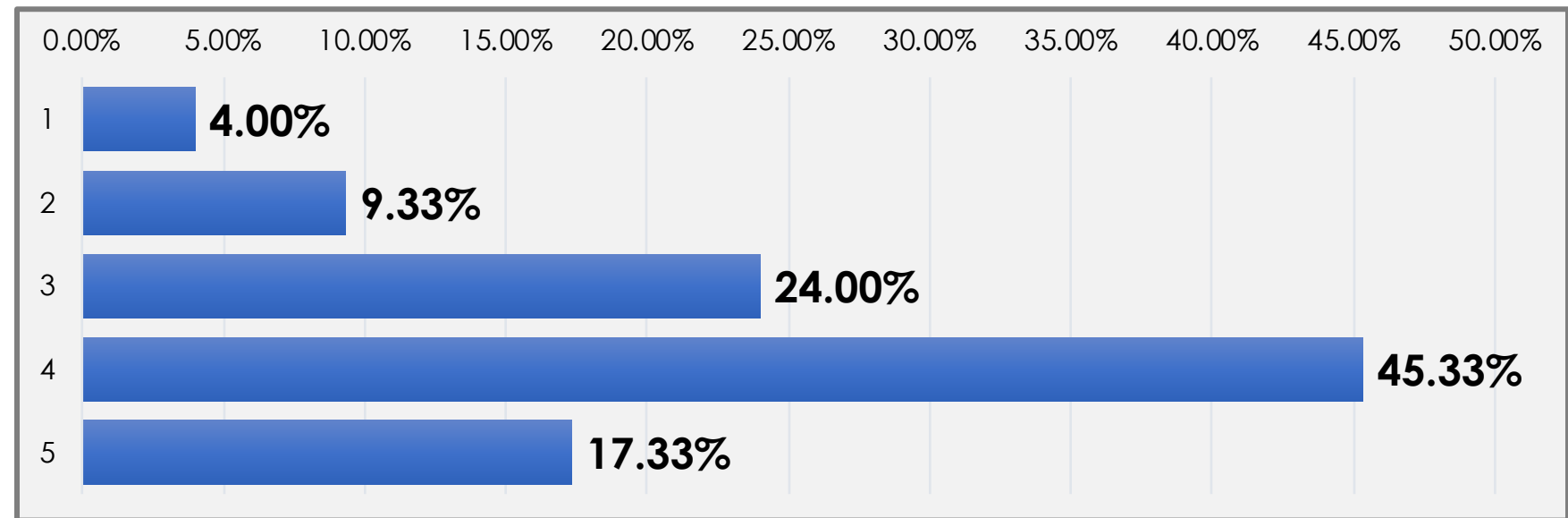
2. No

3. Abstain



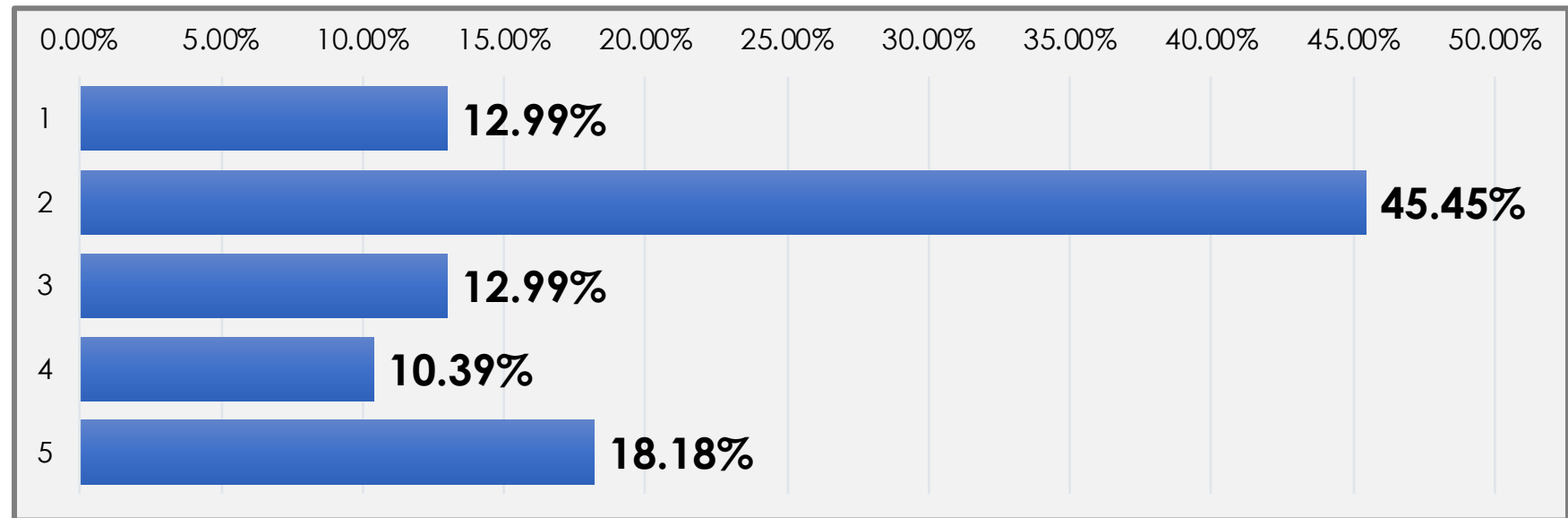
8.2.76 In men with mCRPC who have been treated with multiple agents and there is no clinical trial available, do you recommend best supportive care at what point ?

1. After second-line treatment
2. After third-line treatment
3. After fourth-line treatment
4. After fifth-line treatment
5. Abstain



8.2.77 In men with mCRPC who have been treated with multiple agents and there is no clinical trial available, do you recommend best supportive care at what point in an area of **limited resources** ?

1. After second-line treatment
2. After third-line treatment
3. After fourth-line treatment
4. After fifth-line treatment
5. Abstain



9.0 USE OF OSTEOCLAST-TARGETED THERAPY FOR SRE/SSE PREVENTION FOR ADVANCED PROSTATE CANCER (NOT FOR OSTEOPOROSIS/BONE LOSS)

9.11 Which osteoclast-targeted therapy do you recommend for men with mCRPC and bone metastases for SRE/SSE prevention in an area of **limited resources** ?

1. Zoledronic acid



2. Denosumab

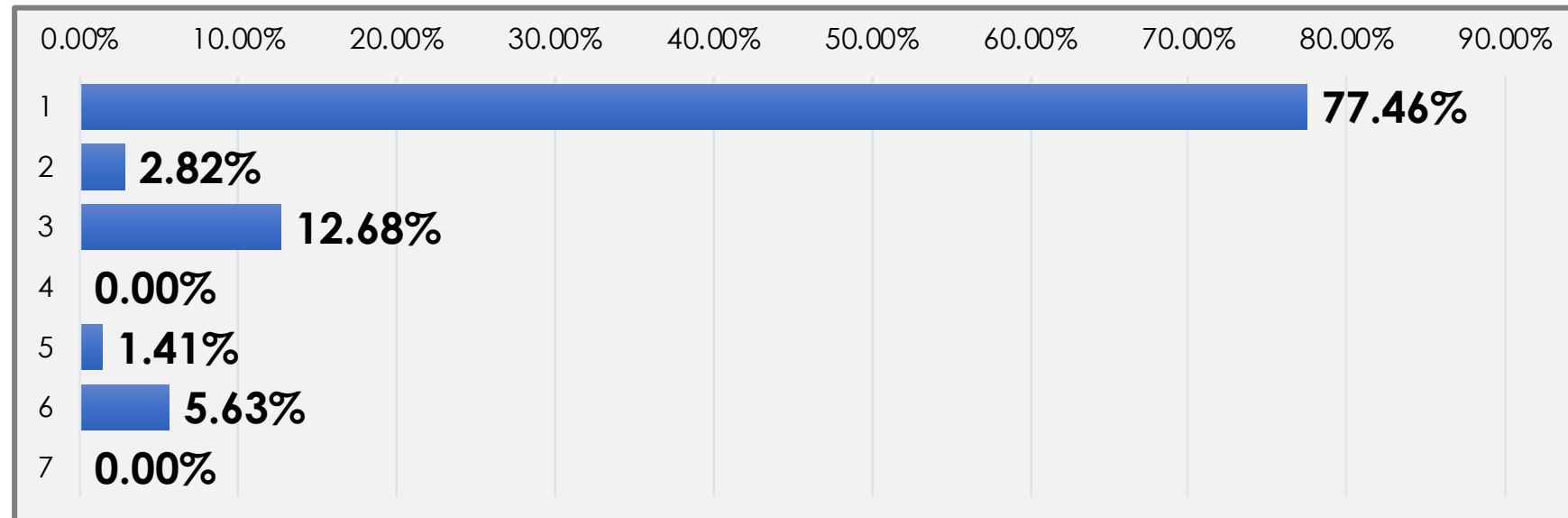
3. Either Zoledronic acid or Denosumab

4. Another osteoclast-targeted therapy

5. Vitamin D and calcium supplementation only

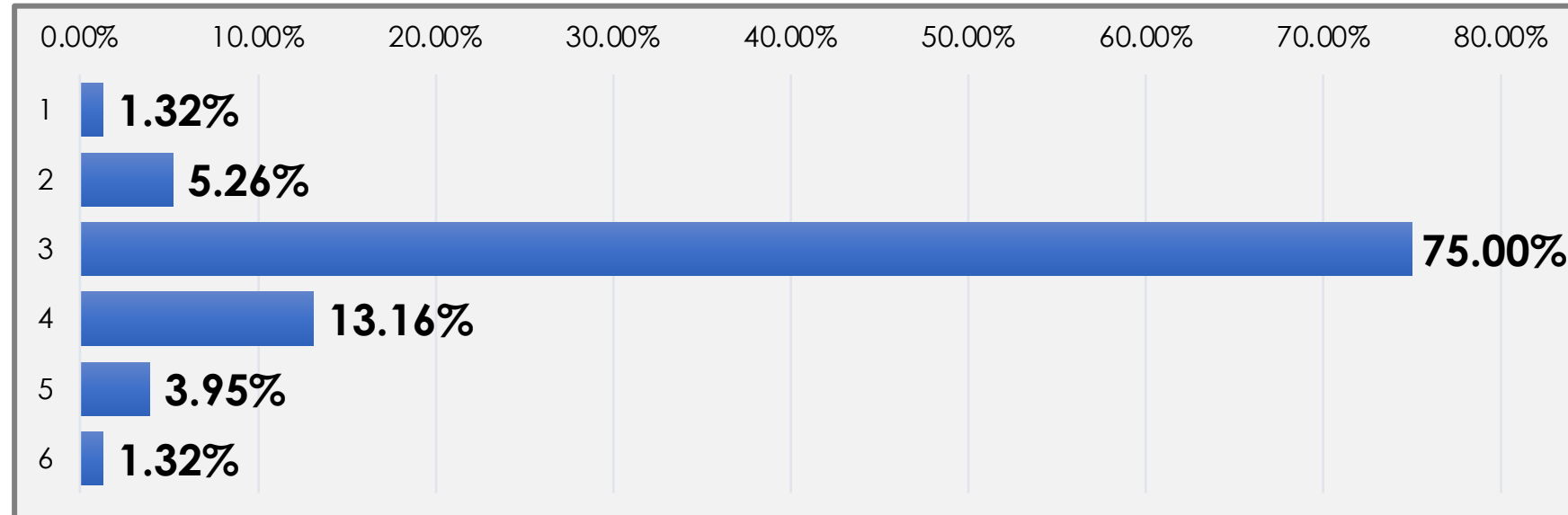
6. I do not use osteoclast-targeted therapy in this setting

7. Abstain



9.12 When you use osteoclast-targeted therapy (zoledronic acid or denosumab) in men with mCRPC, what treatment frequency do you recommend in an area of **limited resources** ?

1. Every 12 months
2. Every 6 months
3. Every 3 months
4. Every month
5. I do not use osteoclast-targeted therapy in this setting
6. Abstain



Conclusions/Recommendations in Areas of Limited Resources 1'

- Active surveillance is the preferred option in very low and low risk PC patients with higher life expectancy
- Radical prostatectomy is the preferred option for low risk PC who had progression on active surveillance or for intermediate risk disease (particularly when robotic surgery, IMRT, and conformal XRT are not available) (**consensus**)
- Cobalt radiation technique is not accepted as reasonable option for the treatment of localized and locally advanced disease (**consensus**)

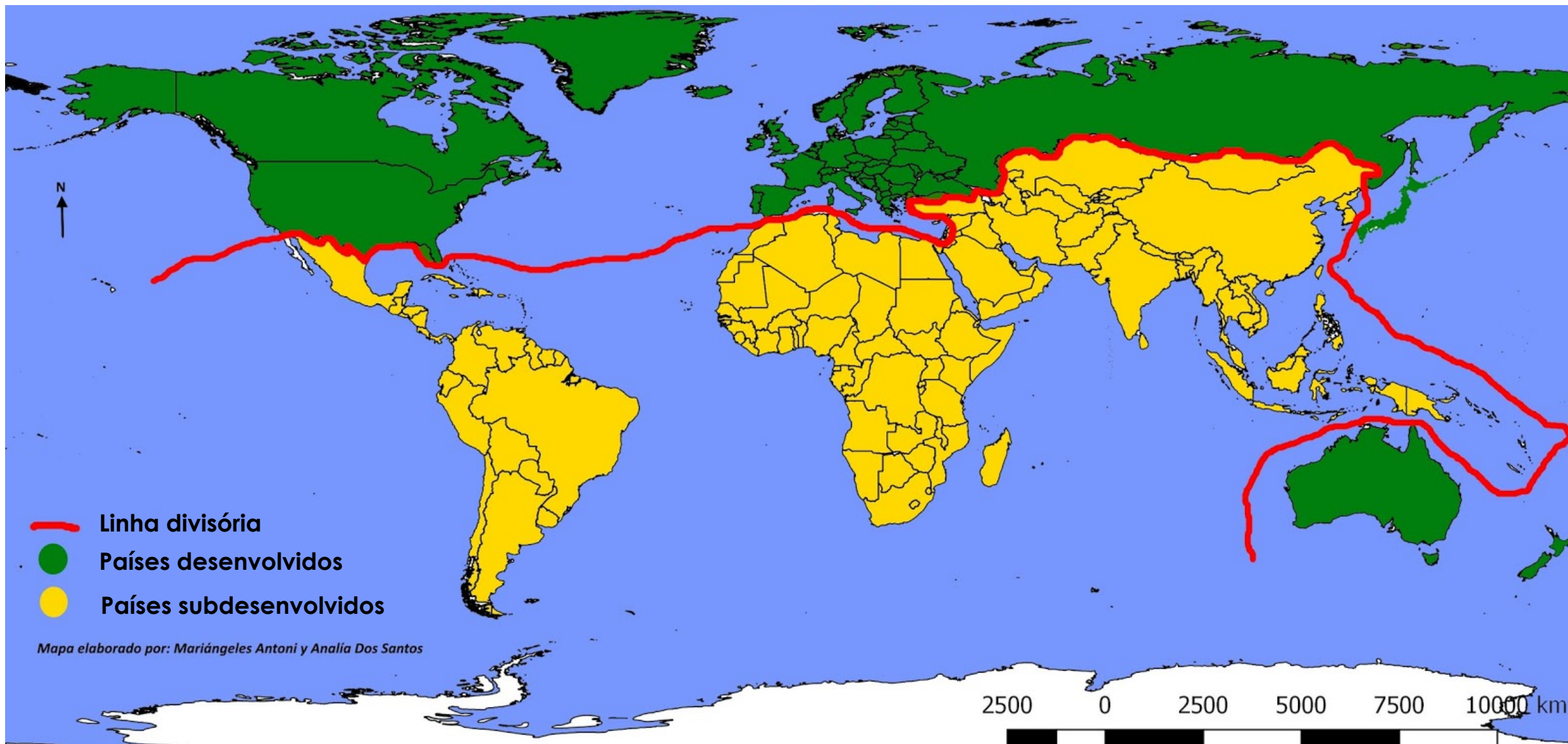
Conclusions/Recommendations in Areas of Limited Resources 2'

- Combination of hormonal therapy and conformal external beam radiotherapy (even if no IMRT available) is the preferred choice for high risk PC (clinical T3/T4 and/or N+) (**consensus**). Orchiectomy is preferred form of hormonal therapy (**consensus**)
- Radical prostatectomy is the preferred option for high-risk prostate cancer with Gleason score 8-10 and/or PSA > 20ng/mL and disease confined to the prostate when there is no availability of IMRT technique nor conformal external beam radiotherapy (**consensus**)
- Orchiectomy alone is the preferred option for metastatic castration sensitive low volume PC
- Orchiectomy associated with docetaxel is preferred option for metastatic castration sensitive high volume PC

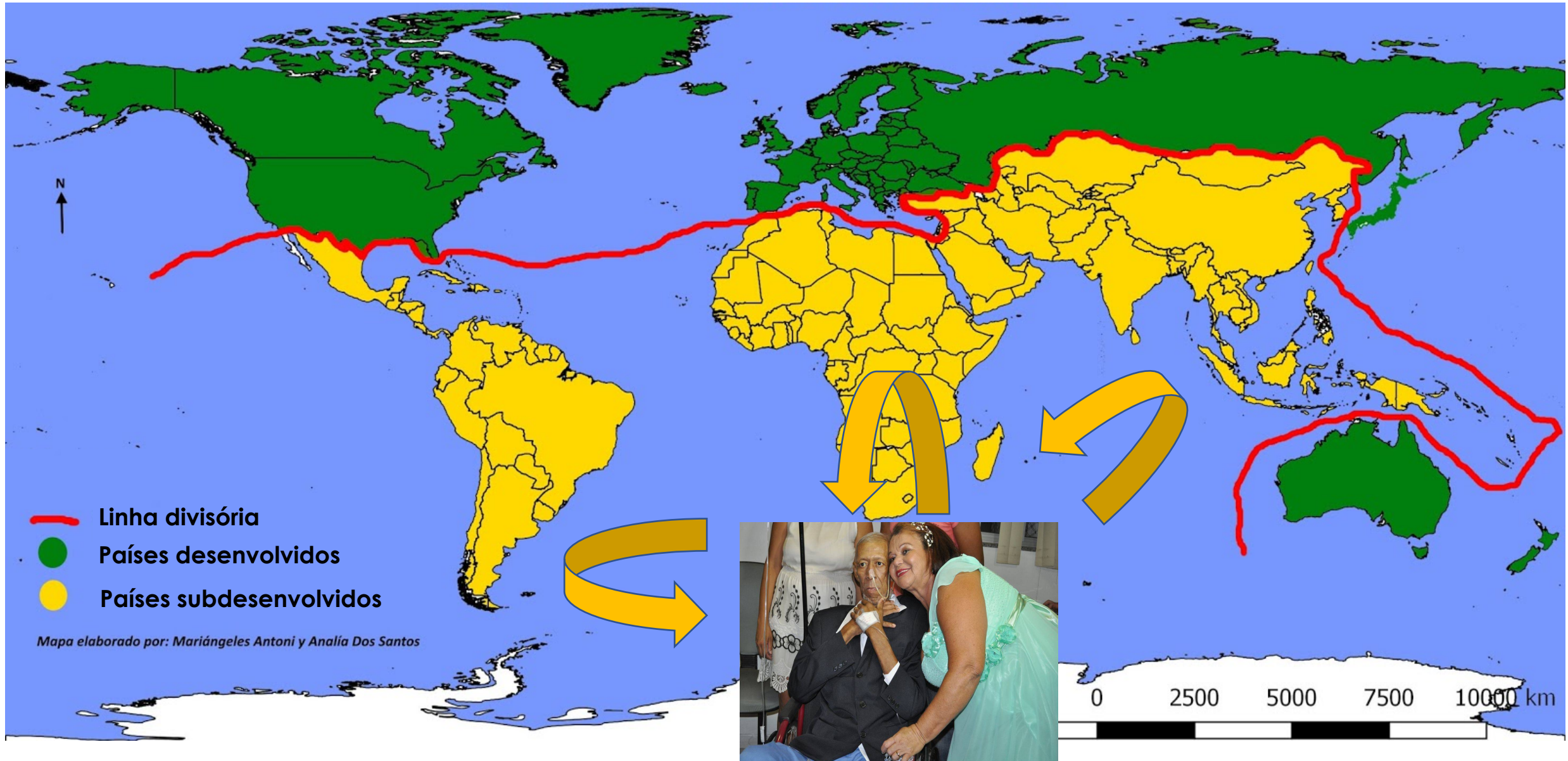
Conclusions/Recommendations in Areas of Limited Resources 3'

- Orchiectomy associated with docetaxel is preferred for metastatic castration resistant PC if abiraterone is not available (**consensus**)
- In the case low dose abiraterone is available either docetaxel or abiraterone 250mg QD are options to be considered
- Mitoxantrone, DES, high dose bicalutamide, and ketoconazole/corticosteroids are options to be considered if no life prolong agents are available for metastatic castration resistant PC (**consensus**)
- Zoledronic acid every 3 months is the preferred osteoclast-targeted therapy option for metastatic castration resistant PC with bone metastases to prevent SRE/SSE (**consensus**)

Developing vs Developed Countries



Developing vs Developed Countries



Thank you ! (maluffc@uol.com.br)

