APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

Consensus Questions APCCC 2019

For all questions:

Unless stated otherwise, it is assumed that:

1. All treatments and diagnostic procedures are readily available.
2. There are no treatment contraindications.
3. There are no options to participate in clinical trials.
4. For next-generation imaging: All resources for acquisition and interpretation are available

Unless stated otherwise, recommendations apply only to non-frail patients and patients with adenocarcinoma.

Recommendations should serve as a basis for discussion with patients as part of shared decision-making.

Definitions:

Castration-sensitive/naïve prostate cancer (CNPC): Newly diagnosed metastatic, without prior systemic therapy apart from (neo)/adjuvant hormones. (After APCCC the term hormone-sensitive prostate cancer (mHSPC) was used based on the voting results).

Chemo-hormonal therapy: Addition of six planned cycles of docetaxel to ADT within 3-4 months of starting ADT.

First-generation non-steroidal AR antagonist (NSAA): Bicalutamide, flutamide, nilutamide.

M0: non metastatic as per TNM

High-volume metastatic disease: Visceral metastases or ≥4 bone lesions, with ≥1 bone lesion beyond the vertebral bodies and pelvis.

High-risk metastatic disease: Newly diagnosed M1 disease with at least 2 of the following criteria: Gleason score ≥8; ≥3 bone metastases; visceral metastases.

Synchronous metastatic disease: De-novo M1 disease, no prior local treatment of the prostate.

Metachronous metastatic disease: M1 disease after local treatment of the prostate (RT or surgery).

Definitions (continued):

For nmCPRC (M0 CRPC): Unless stated otherwise the questions relate to patients with a PSA doubling time of 10 months or less during continuous ADT and a total PSA level of 2 ng per milliliter or greater.

ADT: Androgen deprivation therapy by either LHRH agonist (plus/minus short-course of first-generation non-steroidal AR antagonist (NSAA)) or LHRH antagonist or orchiectomy.

Abiraterone: In case that abiraterone is mentioned, it is assumed that treatment is given as a combination of abiraterone plus prednisone/prednisolone.

Survival-prolonging therapy for mCRPC: Abiraterone, cabazitaxel, docetaxel, enzalutamide, radium 223, sipuleucel-T.

First-line therapy for mCRPC: First use of a survival-prolonging agent (see above) in the mCRPC setting.

Next-generation imaging for prostate cancer: PET-CT with the following tracers of choice: PSMA, choline, and FACBC (fluciclovine) and/or whole-body morphologic and diffusion-weighted MRI.

Rules for voting:

In case of a follow-up question, if you did ***not*** vote “yes” to the preceding question(s), please choose “Abstain.”

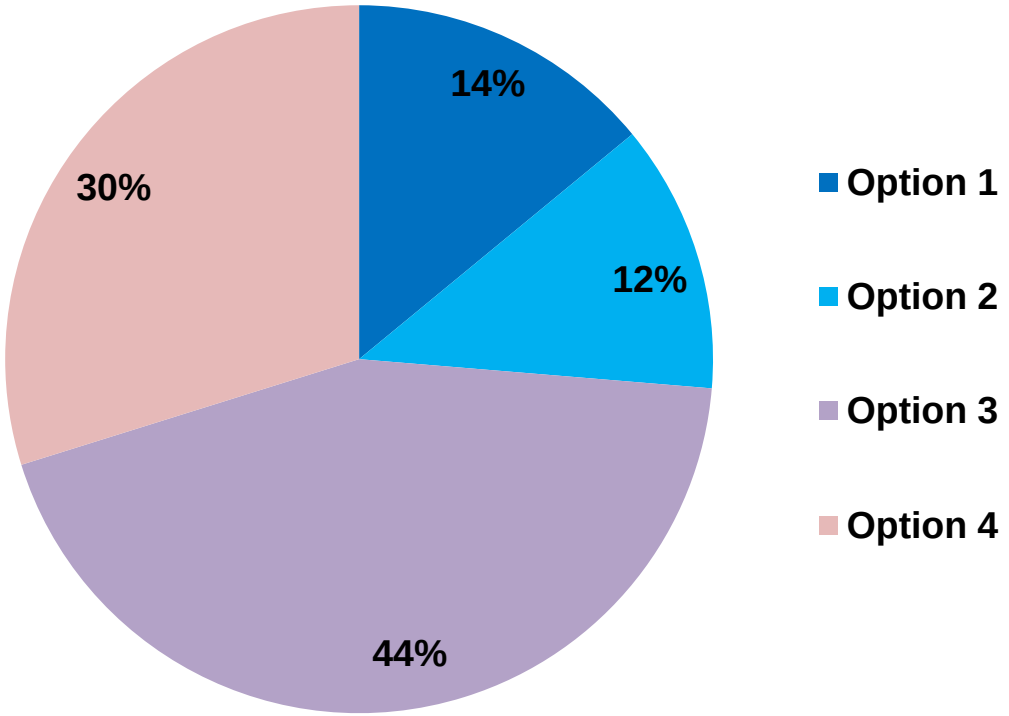
Panellists should also choose “Abstain” if they:

- Have no clear best answer choice
- Have relevant conflicts of interest
- Feel that they are not an expert for this specific question

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

What is your medical speciality?

1. Clinical Oncology
2. Radiation therapy
3. Medical Oncology
4. Urology



Option	Votes	Percent
Option 1	8	14
Option 2	7	12
Option 3	25	44
Option 4	17	30
Total votes	57	

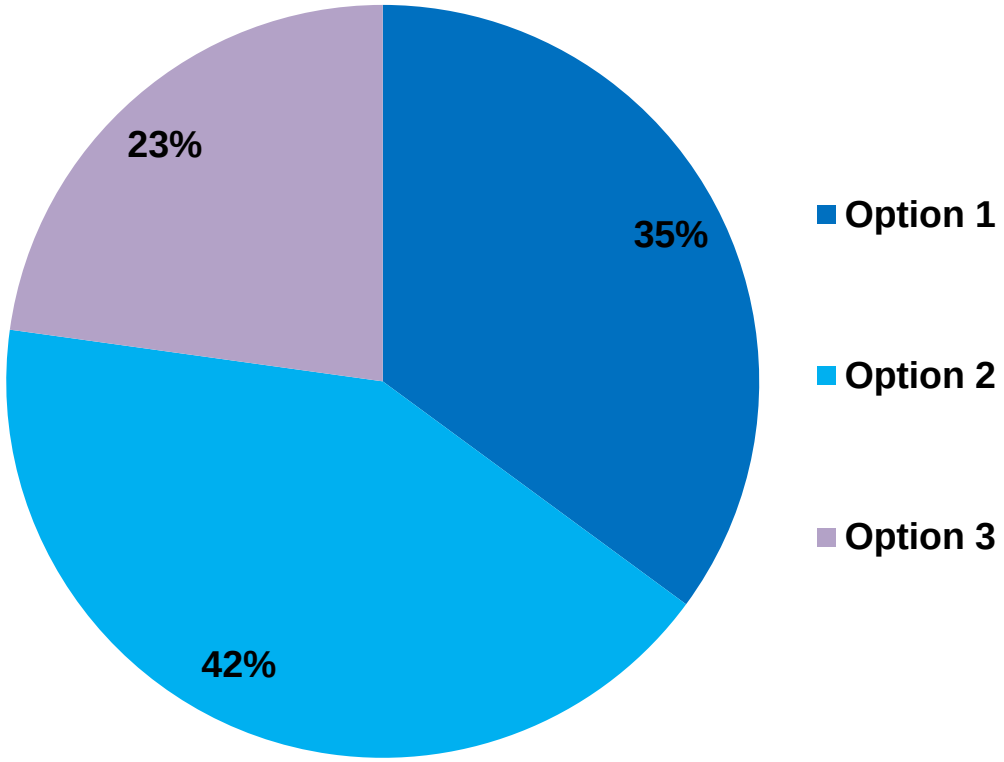
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

Which region do you come from?

1. Europe
2. North-America
3. Other



Option	Votes	Percent
Option 1	20	35
Option 2	24	42
Option 3	13	23
Total votes	57	

Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

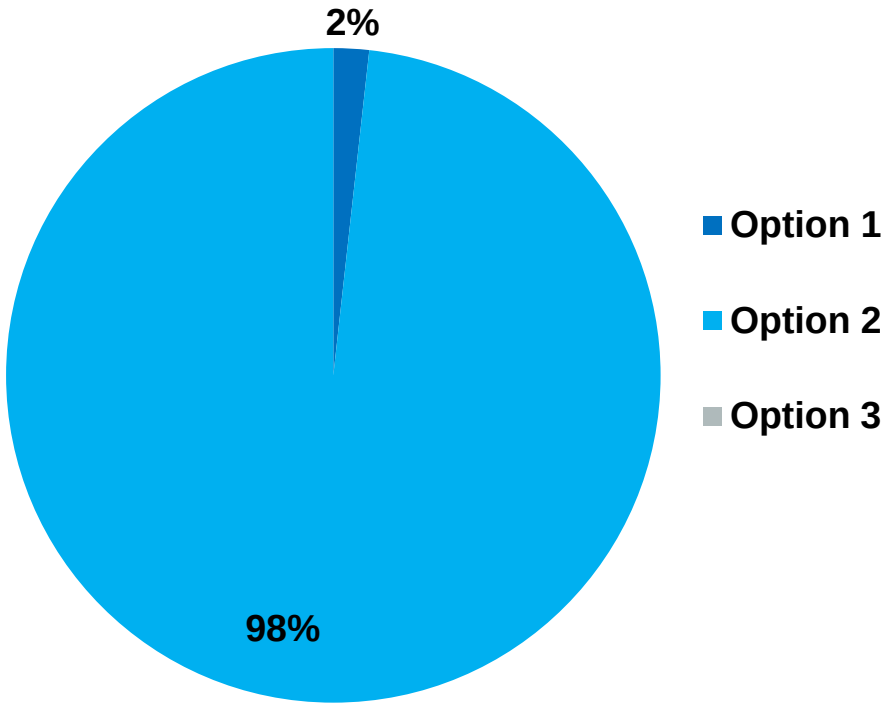
1. Locally advanced prostate cancer

1.1 Newly diagnosed clinical N1 (**cN1**, pelvic lymph nodes), M0 (non-metastatic) prostate cancer

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

1. What is your preferred treatment recommendation for the majority of patients with newly diagnosed **cN1** (pelvic lymph nodes), M0 prostate cancer?

1. Systemic therapy alone without loco-regional therapy
2. Radical loco-regional treatment plus/minus systemic therapy
3. Abstain



Option	Votes	Percent
Option 1	1	2
Option 2	56	98
Abstain	0	0
Total votes	57	

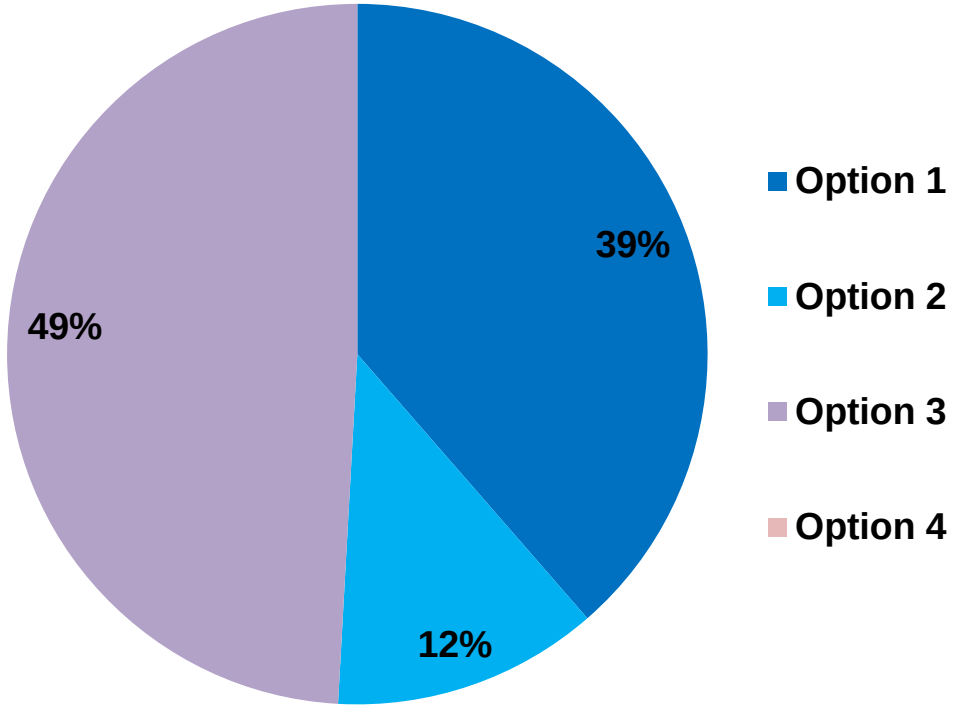
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

2. If you recommend radical loco-regional treatment in **cN1** (pelvic lymph nodes), M0 prostate cancer, what is your preferred primary loco-regional treatment option?

1. Radiation therapy
2. Surgery
3. Either radiation therapy or surgery
4. Abstain



Option	Votes	Percent
Option 1	22	39
Option 2	7	12
Option 3	28	49
Abstain	0	0
Total votes	57	

Published in European Urology 2020 open access:

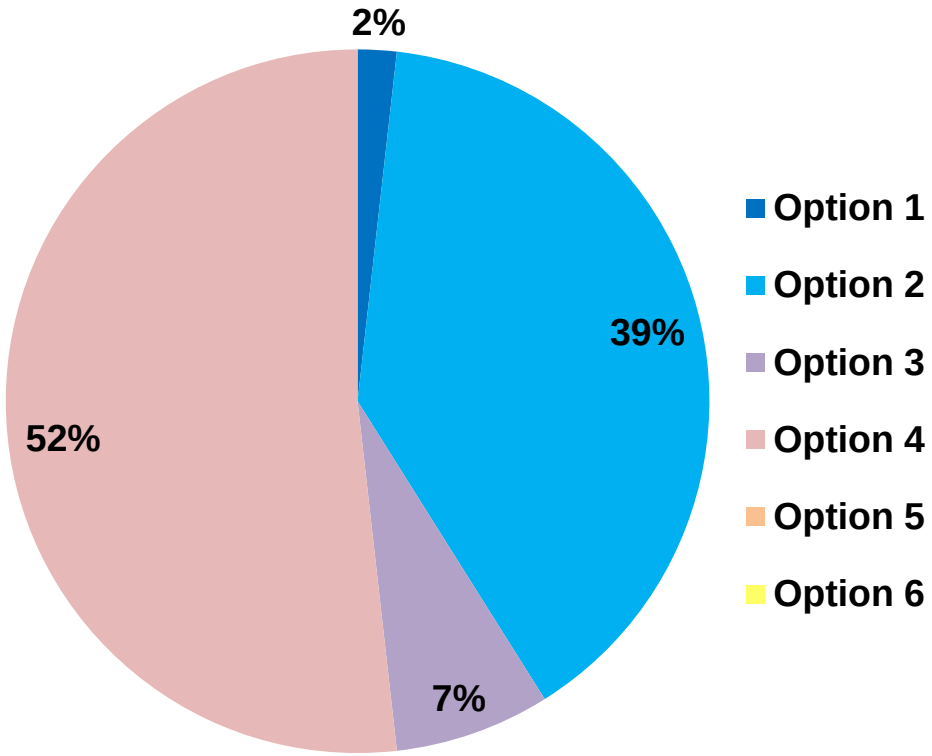
https://doi.org/10.1016/j.eururo.2020.01.012

Question 3 pertains to patients with M0 prostate cancer with **cN1** disease who are fit for additional treatment with docetaxel and/or abiraterone (i.e. who have no contraindications) in cases where there are no regulatory limitations.

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

3. For patients with M0 prostate cancer with **cN1** disease who are receiving radical loco-regional treatment with radiation therapy, which systemic therapy do you recommend?

1. No systemic treatment
2. ADT alone
3. ADT plus docetaxel
4. ADT plus abiraterone
5. ADT plus docetaxel plus abiraterone
6. Abstain



Option	Votes	Percent
Option 1	1	2
Option 2	22	39
Option 3	4	7
Option 4	29	52
Option 5	0	0
Abstain	0	0
Total votes	56	

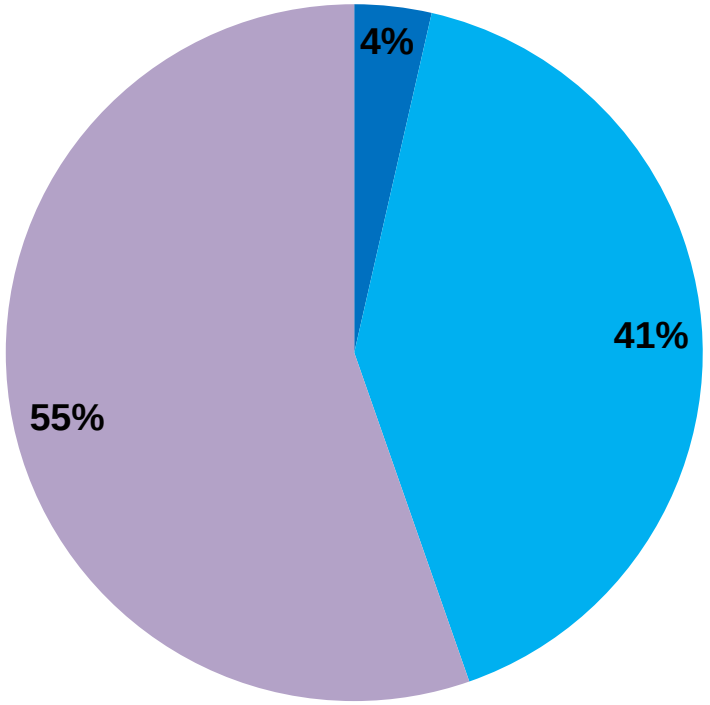
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

4. For patients with cN1, cM0 prostate cancer who are receiving radiation therapy as radical loco-regional treatment, which duration of ADT do you recommend?

1. ADT short-term (4-12 months)
2. ADT mid-term (>12 - 24 months)
3. ADT long-term (>24-36 months)
4. ADT lifelong
5. Abstain



Option	Votes	Percent
Option 1	2	4
Option 2	23	41
Option 3	31	55
Option 4	0	0
Abstain	0	0
Total votes	56	

Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

1.2 Newly diagnosed pathological N1 (**pN1**, pelvic lymph nodes, adequate sampling) M0 (non-metastatic) prostate cancer following radical surgery

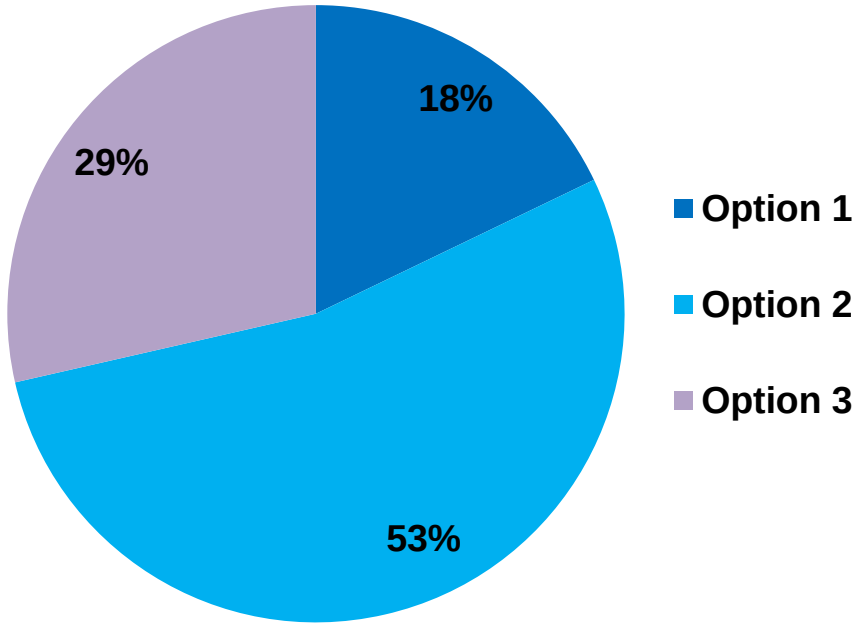
Questions 5-6:

For patients with undetectable postoperative PSA who have recovered urinary continence, do you recommend adjuvant radiation therapy (whole pelvis and prostate bed) in cases of:

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

5. For patients with undetectable postoperative PSA who have recovered urinary continence, do you recommend adjuvant radiation therapy (whole pelvis and prostate bed) in cases of: **pN1 disease of ≤2 lymph nodes and no pT4 and negative margins?**

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	10	18
Option 2	30	53
Option 3	16	29
Abstain	1	NA
Total votes	57	

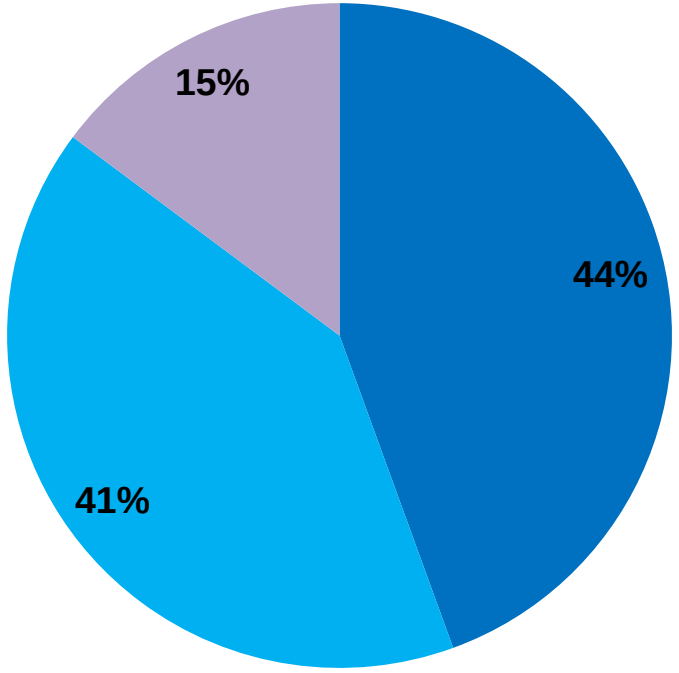
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

6. For patients with undetectable postoperative PSA who have recovered urinary continence, do you recommend adjuvant radiation therapy (whole pelvis and prostate bed) in cases of: **pN1 disease of 3 or more lymph nodes and no pT4 and negative margins?**

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	24	44
Option 2	22	41
Option 3	8	15
Abstain	0	0
Total votes	54	

Published in European Urology 2020 open access:

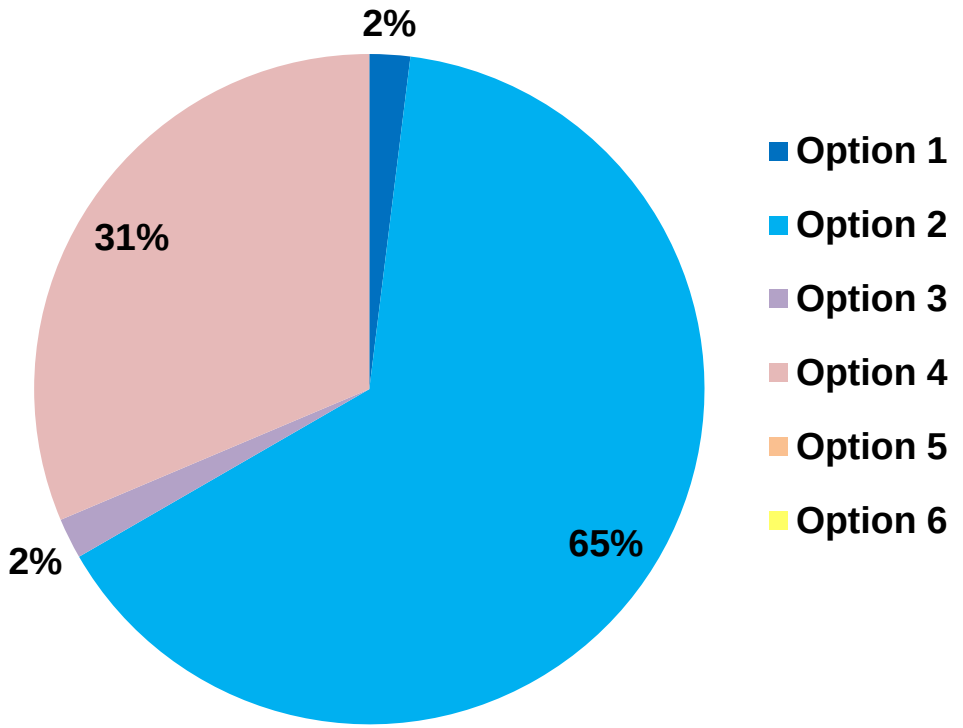
https://doi.org/10.1016/j.eururo.2020.01.012

Question 7 pertains to patients with M0 prostate cancer with pN1 disease who are fit for additional treatment with docetaxel and/or abiraterone (i.e. who have no contraindications) in cases where there are no regulatory limitations.

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

7. If you recommend adjuvant radiation therapy in patients with pN1 disease, which systemic therapy do you recommend?

1. No systemic treatment
2. ADT alone
3. ADT plus docetaxel
4. ADT plus abiraterone
5. ADT plus docetaxel plus abiraterone
6. Abstain



Option	Votes	Percent
Option 1	1	2
Option 2	33	65
Option 3	1	2
Option 4	16	31
Option 5	0	0
Abstain	5	NA
Total votes	56	

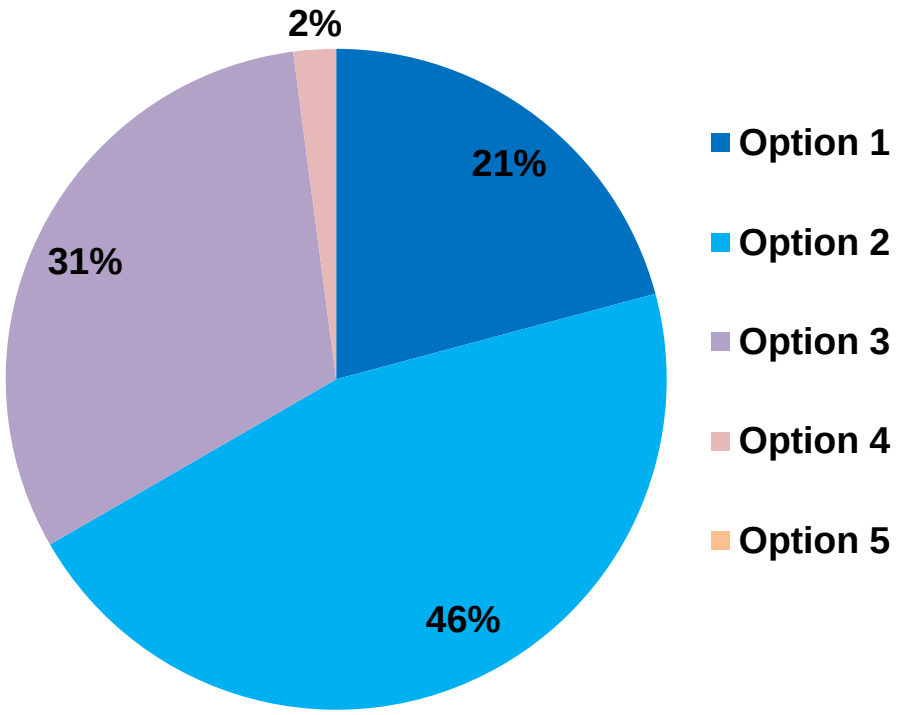
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

8. If you recommend adjuvant radiation therapy and ADT in the majority of patients with pN1 disease, which duration of ADT do you recommend?

1. ADT short-term (4-12 months)
2. ADT mid-term (>12-24 months)
3. ADT long-term (>24-36 months)
4. ADT lifelong
5. Abstain



Option	Votes	Percent
Option 1	10	21
Option 2	22	46
Option 3	15	31
Option 4	1	2
Abstain	8	NA
Total votes	56	

Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

2. Biochemical recurrence after local therapy

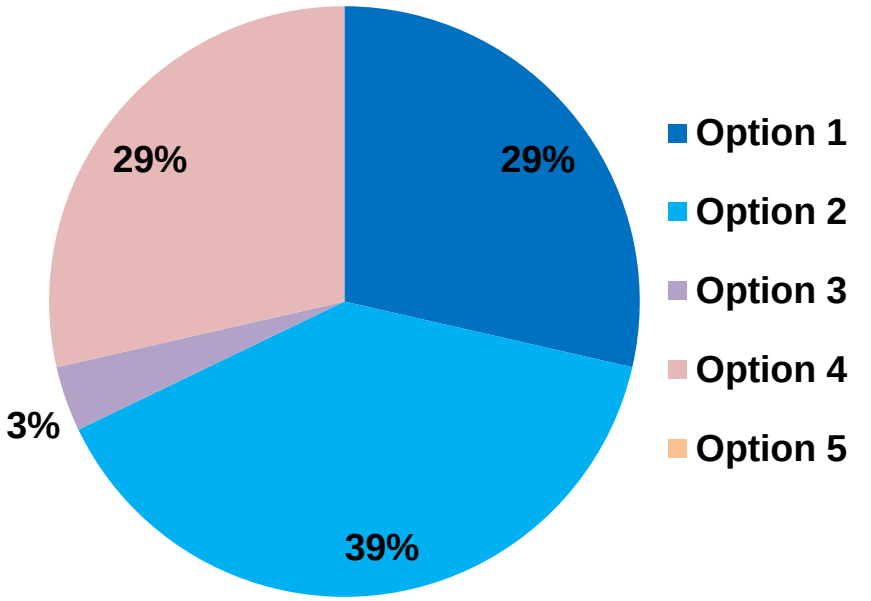
2.1 PSA recurrence after radical radiation therapy

For questions regarding imaging it is assumed that all resources for acquisition and interpretation are available

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

9. At what confirmed PSA level do you recommend imaging for asymptomatic patients with rising PSA after radical (definitive) radiation therapy?

1. Rising PSA but <2ng/mL above nadir
2. ≥2 ng/mL above nadir (Phoenix criteria)
3. ≥2 ng/mL above nadir with PSA doubling time <12 months
4. I do not recommend imaging based only on PSA value or PSA kinetics alone but e.g. based on PSA doubling-time and ISUP grade
5. Abstain



Option	Votes	Percent
Option 1	16	29
Option 2	22	39
Option 3	2	3
Option 4	16	29
Abstain	0	0
Total votes	56	

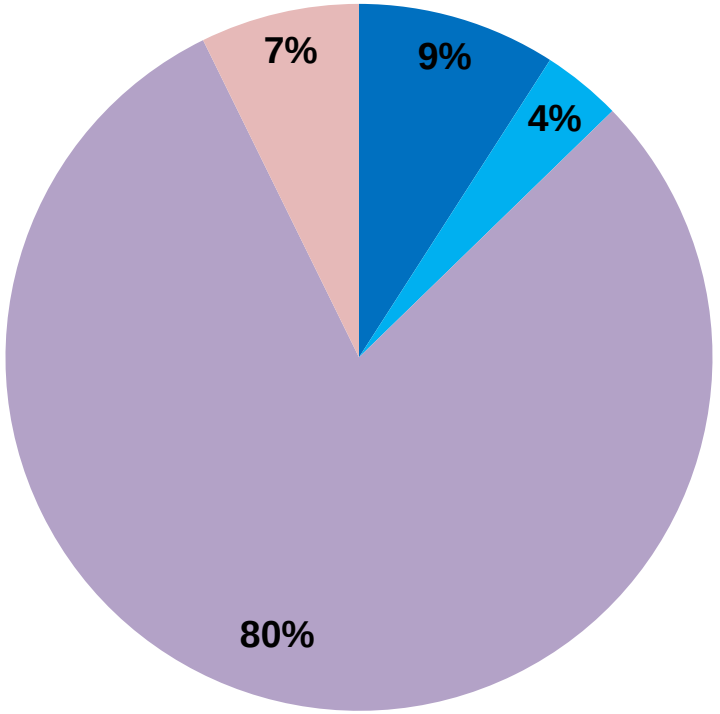
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

10. Which imaging modality(ies) do you recommend for patients with rising PSA after radical radiation therapy of the prostate?

1. CT and/or bone scintigraphy (plus/minus pelvic MRI)
2. Whole-body MRI alone (plus/minus pelvic MRI)
3. PSMA PET CT/MRI (plus/minus pelvic MRI)
4. Fluciclovine or choline PET CT/MRI (plus/minus pelvic MRI)
5. Abstain



Option	Votes	Percent
Option 1	5	9
Option 2	2	4
Option 3	44	80
Option 4	4	7
Abstain	0	0
Total votes	55	

Published in European Urology 2020 open access:

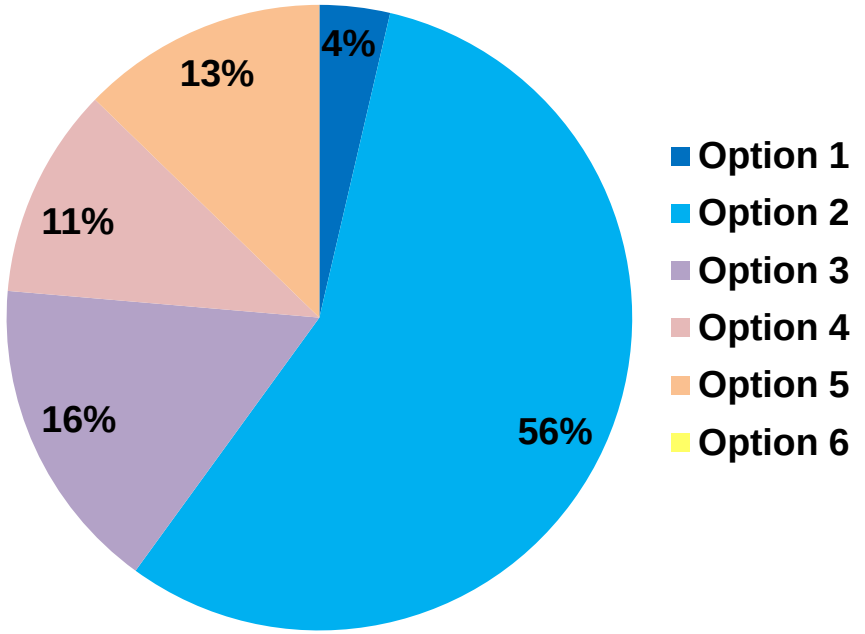
https://doi.org/10.1016/j.eururo.2020.01.012

2.2 PSA recurrence after radical prostatectomy

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

11. For patients with rising PSA after radical prostatectomy, at what confirmed rising PSA level do you usually recommend imaging?

1. PSA below 0.2 ng/mL
2. PSA >0.2 – 0.5 ng/mL
3. PSA >0.5-1.0 ng/mL
4. PSA >1 ng/mL
5. I do not recommend imaging based on PSA value or PSA kinetics alone but e.g. based on PSA doubling-time and ISUP grade
6. Abstain



Option	Votes	Percent
Option 1	2	4
Option 2	31	56
Option 3	9	16
Option 4	6	11
Option 5	7	13
Abstain	0	0
Total votes	55	

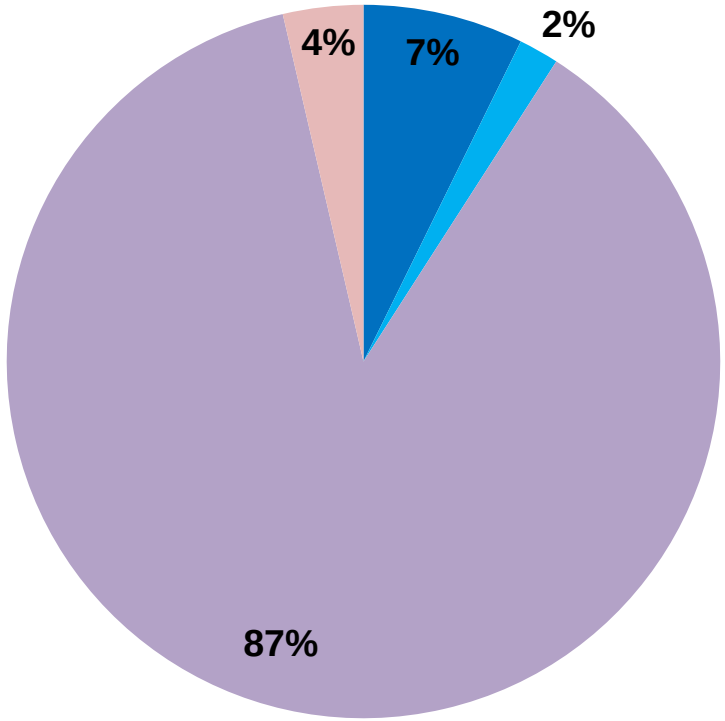
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

12. Which imaging modality(ies) do you recommend for patients with rising PSA after radical prostatectomy?

1. CT and/or bone scintigraphy (plus/minus pelvic MRI)
2. Whole-body MRI alone (plus/minus pelvic MRI)
3. PSMA PET CT/MRI (plus/minus pelvic MRI)
4. Fluciclovine or choline PET CT/MRI (plus/minus pelvic MRI)
5. Abstain



Option	Votes	Percent
Option 1	4	7
Option 2	1	2
Option 3	48	87
Option 4	2	4
Abstain	0	0
Total votes	55	

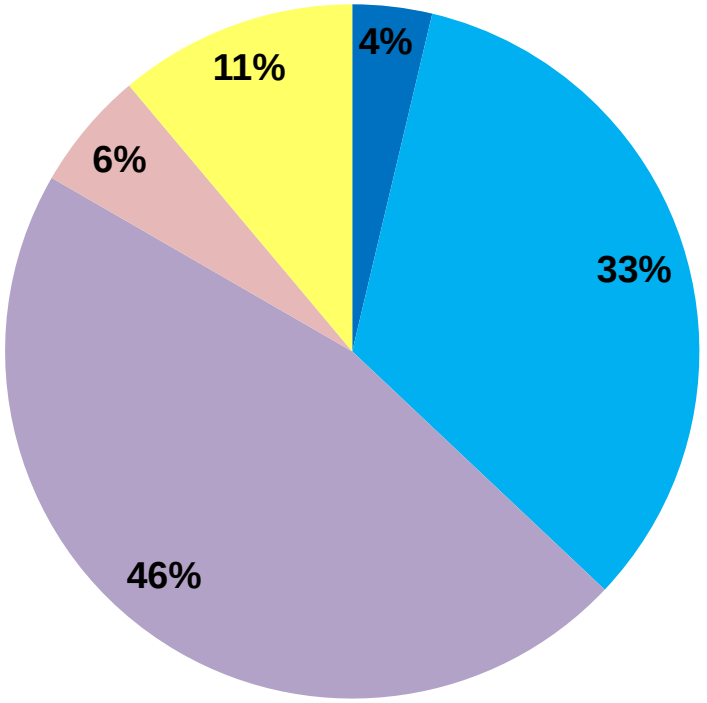
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

13. For the **majority of post-prostatectomy patients** with isolated rising PSA only, if salvage RT is planned, at what confirmed upper PSA level do you recommend starting salvage radiation therapy?

1. Before PSA reaches 0.1 ng/mL
2. Before PSA reaches 0.2 ng/mL
3. Before PSA reaches 0.5 ng/mL
4. Before PSA reaches 1.0 ng/mL
5. Only after PSA reaches ≥1.0 ng/mL
6. I do not recommend salvage RT based only on PSA value alone but e.g. based on PSA doubling-time and ISUP grade
7. Abstain



Option	Votes	Percent
Option 1	2	4
Option 2	18	33
Option 3	25	46
Option 4	3	6
Option 5	0	0
Option 6	6	11
Abstain	3	NA
Total votes	57	

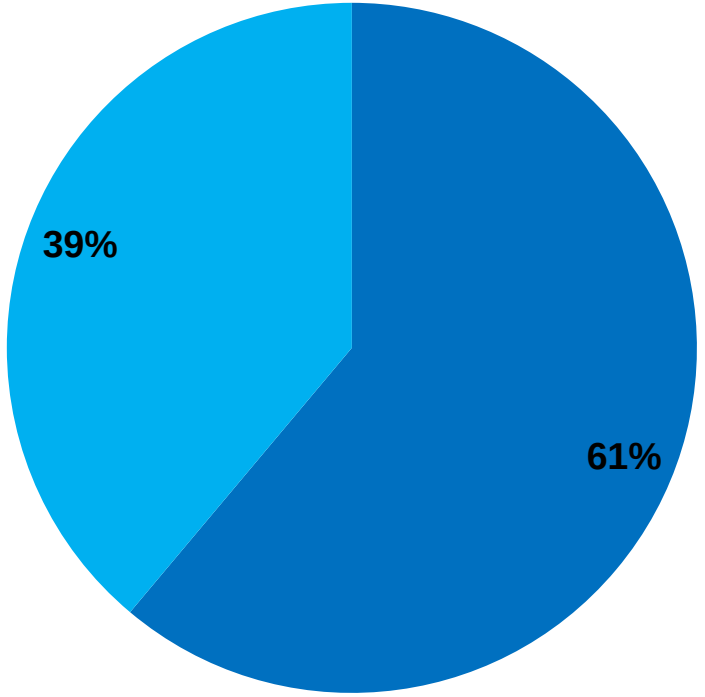
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

14. Do you recommend systemic hormonal treatment in combination with salvage radiation therapy for patients with PSA recurrence after radical prostatectomy?

1. Yes, in the majority of patients
2. In a minority of selected patients (e.g. based on PSA value or PSA kinetics or characteristics of the primary tumour)
3. No
4. Abstain



Option	Votes	Percent
Option 1	33	61
Option 2	21	39
Option 3	0	0
Abstain	1	NA
Total votes	55	

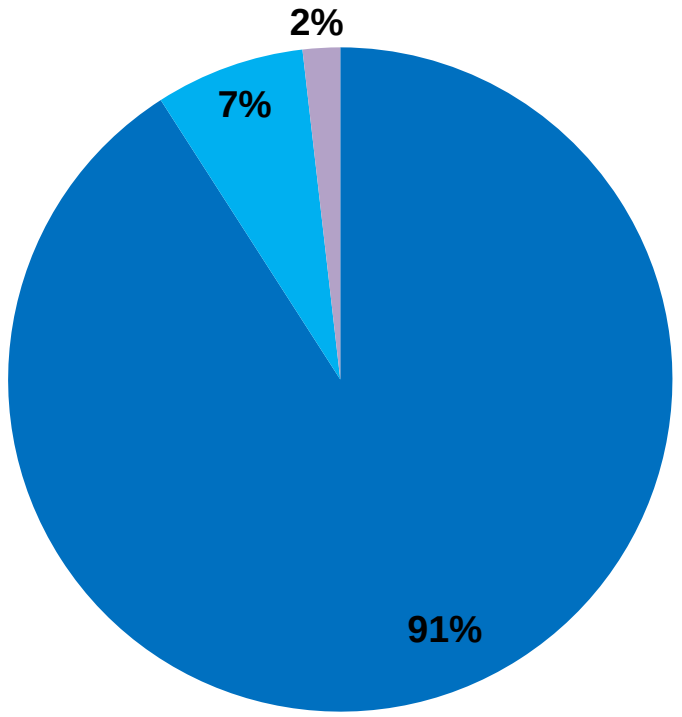
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

15. If you recommend systemic hormonal therapy in combination with salvage radiation therapy for a patient, what do you recommend?

1. LHRH agonist or antagonist
2. Bicalutamide 150mg daily
3. Bicalutamide 50mg daily
4. Another hormonal therapy
5. Abstain



Option	Votes	Percent
Option 1	50	91
Option 2	4	7
Option 3	1	2
Option 4	0	0
Abstain	0	0
Total votes	55	

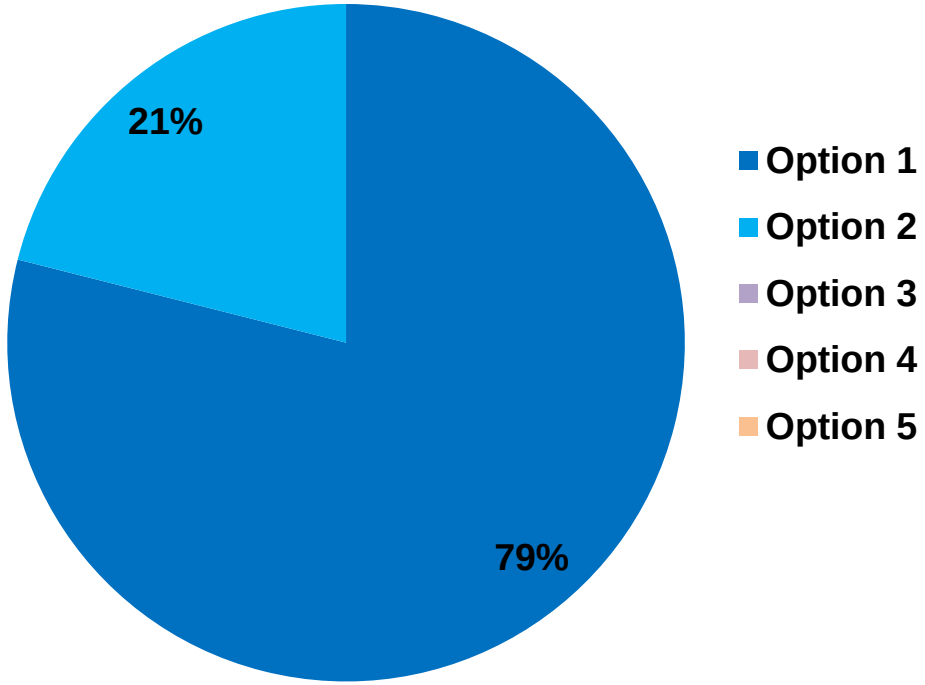
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

16. If you recommend systemic hormonal treatment in combination with salvage radiation therapy for a patient, which duration of AR blockade do you recommend for the majority of patients?

1. Short-term (4-12 months)
2. Mid-term (>12-24 months)
3. Long-term (>24-36 months)
4. Lifelong
5. Abstain



Option	Votes	Percent
Option 1	45	79
Option 2	12	21
Option 3	0	0
Option 4	0	0
Abstain	0	0
Total votes	57	

Published in European Urology 2020 open access:

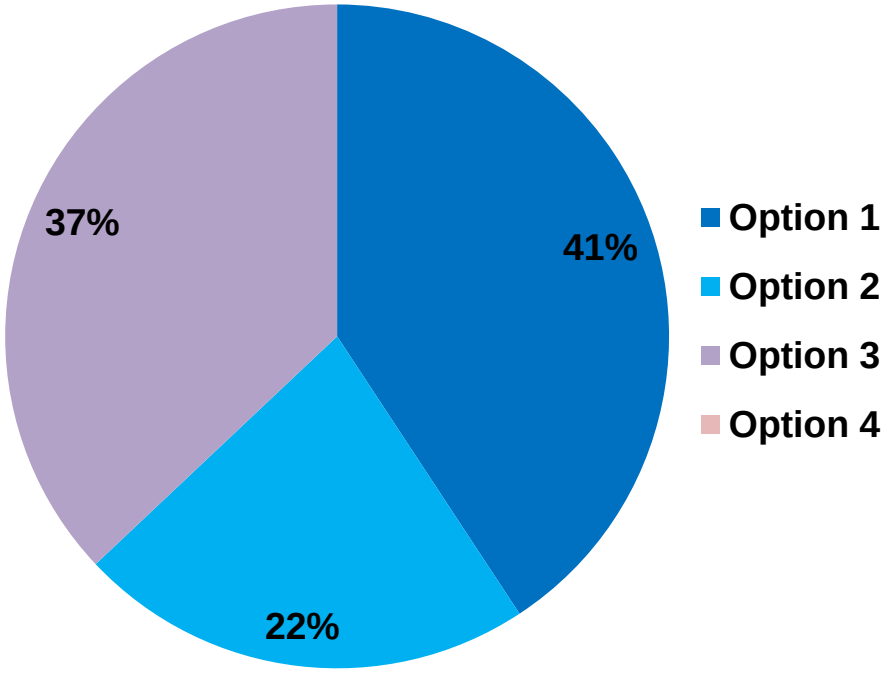
https://doi.org/10.1016/j.eururo.2020.01.012

2.3 PSA persistence after radical prostatectomy

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

17. Do you recommend repeating imaging (negative pre-operative imaging) for an asymptomatic pN0 patient with **PSA persistence** four to six weeks after radical prostatectomy (EAU guideline definition: confirmed ≥0.1 ng/mL)?

1. Yes
2. Yes, but only in the presence of other adverse factors (e.g. positive surgical margins)
3. No
4. Abstain



Option	Votes	Percent
Option 1	22	41
Option 2	12	22
Option 3	20	37
Abstain	1	NA
Total votes	55	

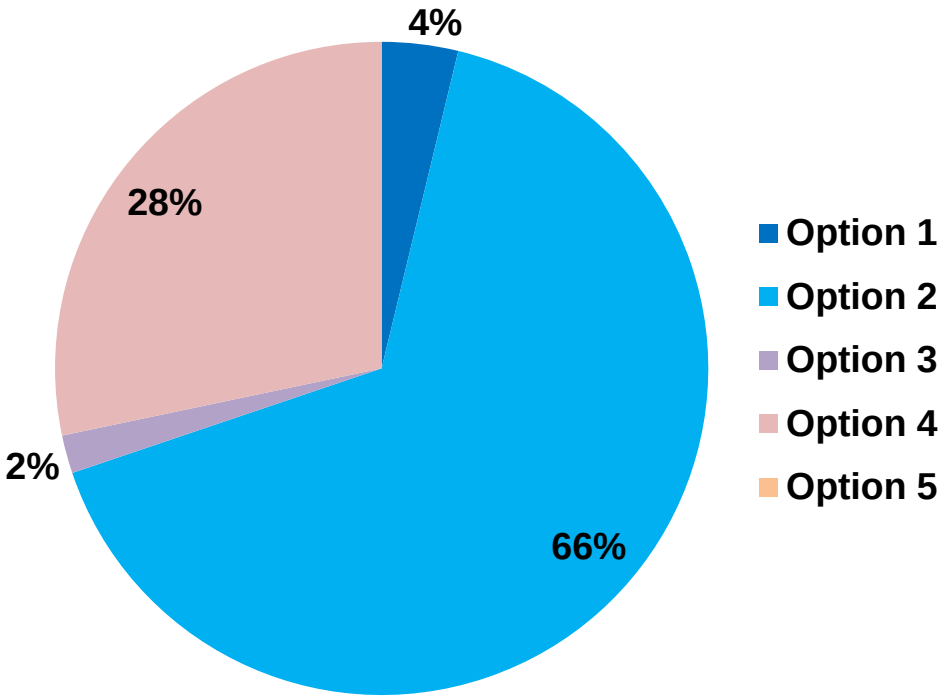
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

18. If you recommend repeat imaging and there is no evidence of macroscopic disease by your preferred imaging modality, which treatment do you recommend for an asymptomatic pN0 patient with **PSA persistence** (≥0.1 ng/mL and confirmed not to be falling) four to eight weeks after radical prostatectomy?

1. Salvage radiation therapy
2. Salvage radiation therapy plus systemic hormonal treatment
3. Systemic hormonal treatment alone
4. No immediate active treatment, PSA surveillance
5. Abstain



Option	Votes	Percent
Option 1	2	4
Option 2	35	66
Option 3	1	2
Option 4	15	28
Abstain	4	NA
Total votes	57	

Published in European Urology 2020 open access:

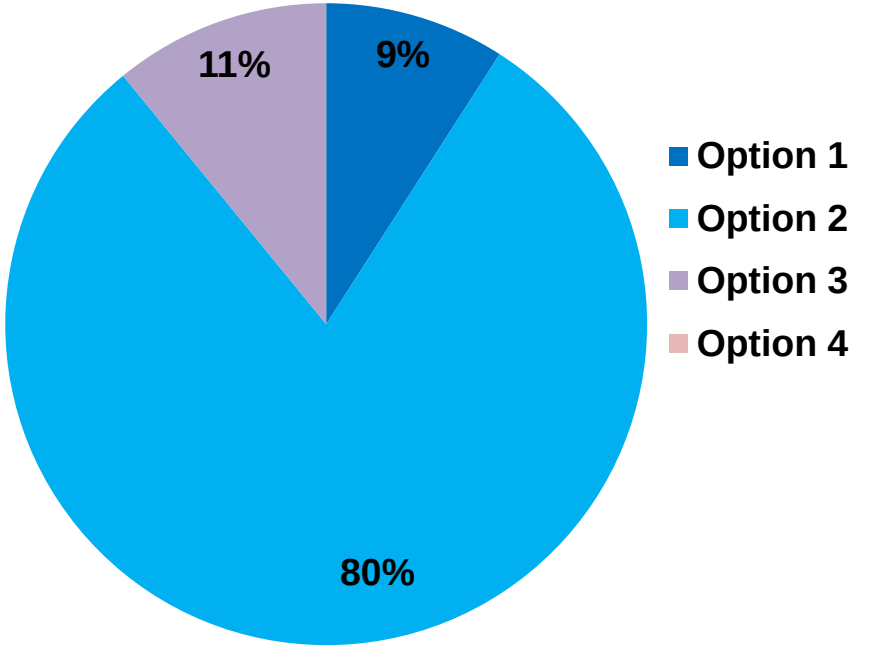
https://doi.org/10.1016/j.eururo.2020.01.012

2.4 Rising PSA non-metastatic disease

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

19. In men with non-metastatic disease and confirmed rising PSA (post-local therapy plus/minus salvage local RT), do you recommend starting long-term ADT?

1. Yes, in the majority of patients
2. In a minority of selected patients e.g. PSA ≥4ng/ml and rising, with PSA doubling time ≤6 months OR PSA ≥20ng/ml (STAMPEDE inclusion criteria)
3. No, I only recommend ADT after detection of metastatic disease
4. Abstain
5. Unqualified to answer



Option	Votes	Percent
Option 1	5	9
Option 2	44	80
Option 3	6	11
Abstain	1	NA
Total votes	56	

Published in European Urology 2020 open access:

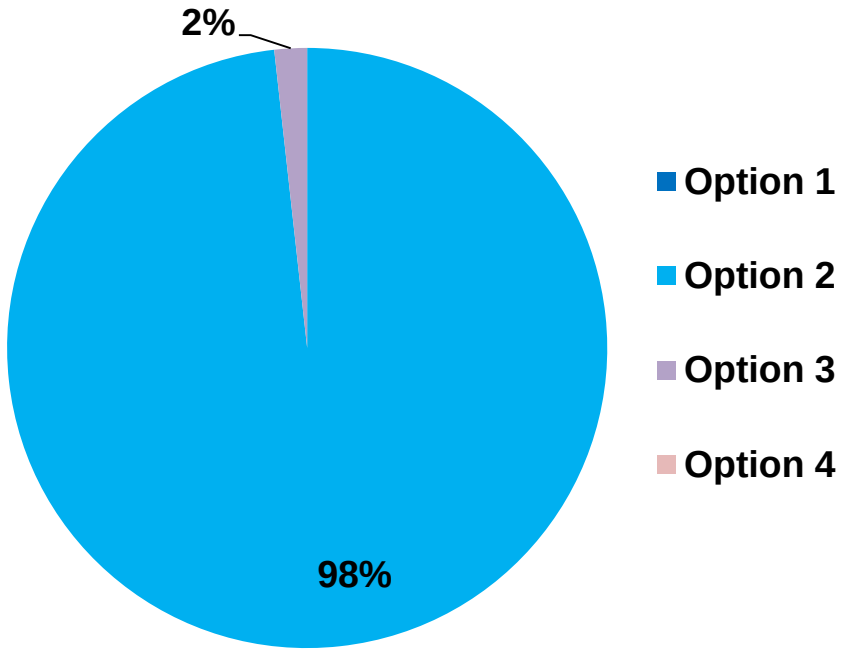
https://doi.org/10.1016/j.eururo.2020.01.012

3. Management of the primary tumour in the metastatic setting

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

20. Based on the current literature, do you think that local treatment of the primary tumour has an overall survival benefit in:

1. Majority of patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC) regardless of metastatic volume
2. Only patients with low-volume/burden newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)
3. No clear benefit in any patients
4. Abstain



Option	Votes	Percent
Option 1	0	0
Option 2	56	98
Option 3	1	2
Abstain	0	0
Total votes	57	

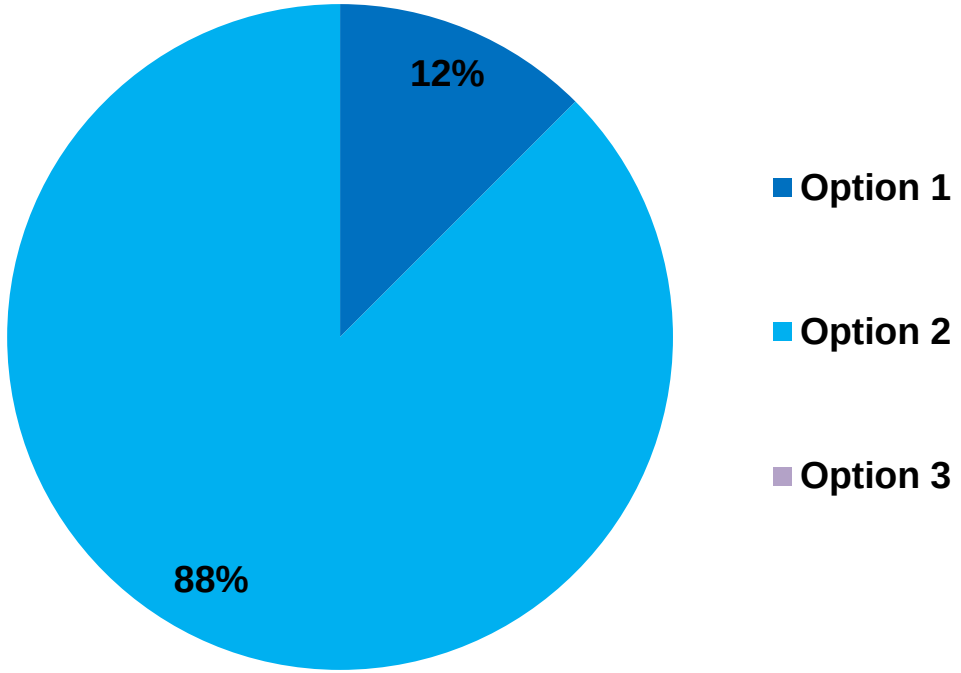
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

21. For patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC), is it appropriate to extrapolate data from STAMPEDE (radiation therapy of the prostate) to radical surgery of the prostate?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	7	12
Option 2	49	88
Abstain	1	NA
Total votes	57	

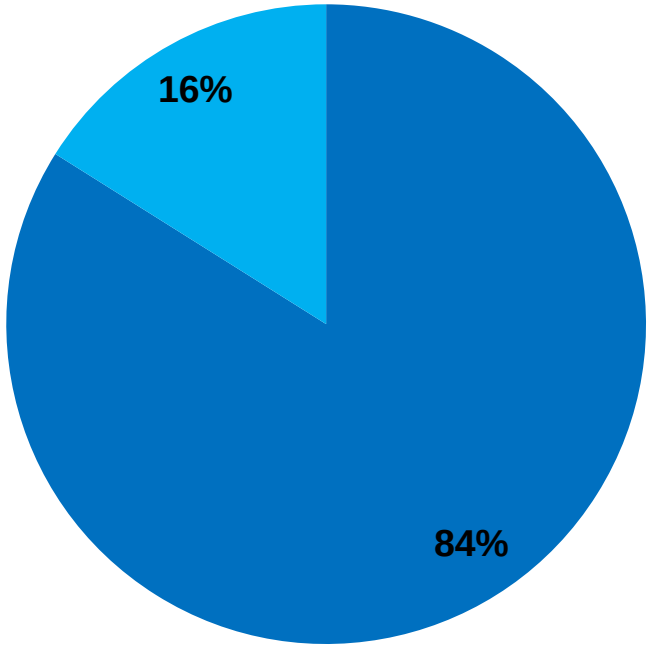
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

22. If you recommend treatment of the prostate in patients with newly diagnosed **low-volume/burden** metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC), what is your preferred treatment option in the majority of these patients?

1. Radiation therapy to the prostate
2. Prostatectomy
3. Abstain



Option	Votes	Percent
Option 1	47	84
Option 2	9	16
Abstain	1	NA
Total votes	57	

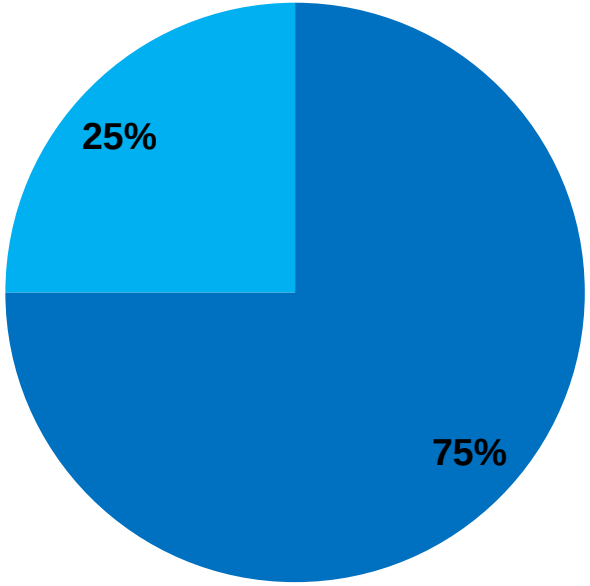
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

23. If you recommend RT of the primary tumour in patients with newly diagnosed **low-volume/burden metastatic** (M1) castration-sensitive/ naïve prostate cancer (CNPC) who also have clinical pelvic N1 disease, do you recommend that radiation treatment volume encompasses the pelvic lymph nodes?

1. Yes (radiation therapy of the primary and pelvic lymph nodes)
2. No (radiation therapy only of the primary)
3. Abstain



Option	Votes	Percent
Option 1	39	75
Option 2	13	25
Abstain	3	NA
Total votes	55	

Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

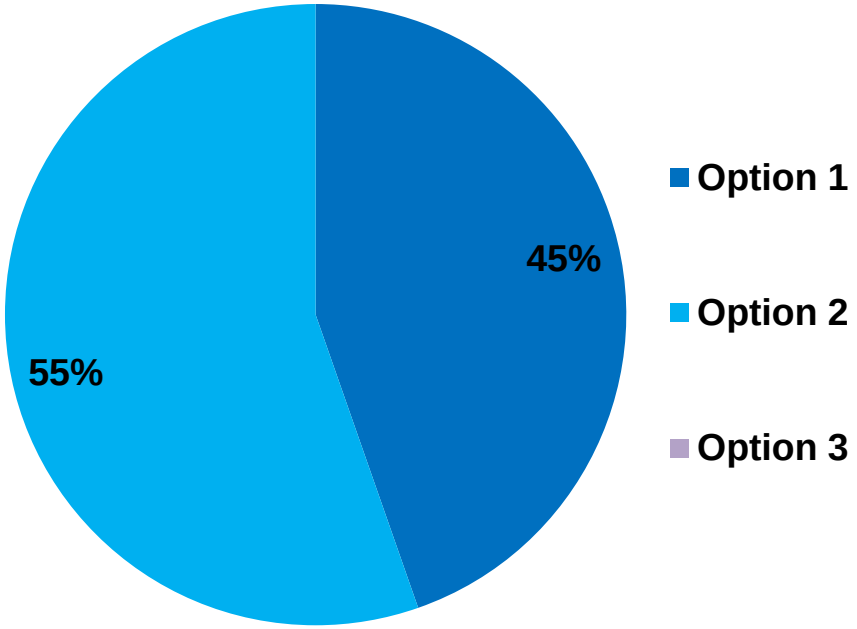
4. Systemic treatment of newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)

4.1 Terminology: Newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

24. Do you recommend avoiding the term **"castration"** for patients with advanced prostate cancer?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	25	45
Option 2	31	55
Abstain	0	0
Total votes	56	

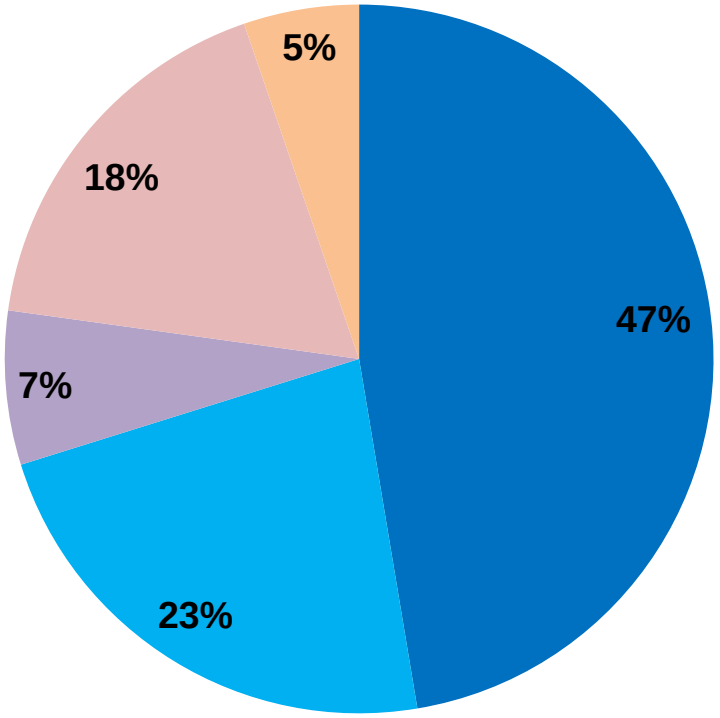
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

25. In your opinion, which terminology best describes metastatic prostate cancer in patients who are about to start ADT?

1. Hormone-naïve metastatic prostate cancer
2. Hormone-sensitive metastatic prostate cancer
3. Metastatic prostate cancer receiving first-line (define) systemic therapy
4. Castration-naïve metastatic prostate cancer
5. Castration-sensitive metastatic prostate cancer
6. Abstain



Option	Votes	Percent
Option 1	27	47
Option 2	13	23
Option 3	4	7
Option 4	10	18
Option 5	3	5
Abstain	0	0
Total votes	57	

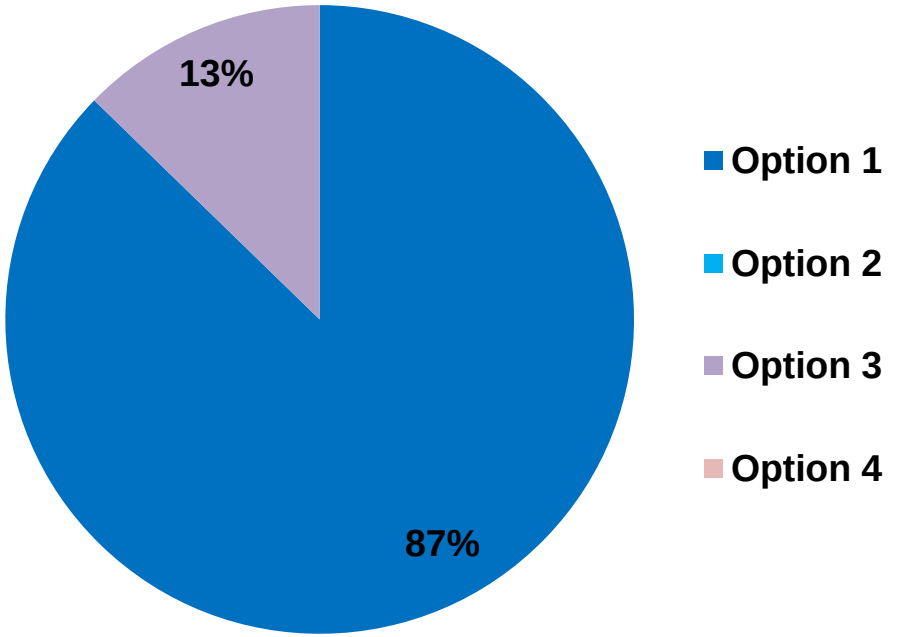
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

26. In your opinion, which terminology best describes patients with metastatic prostate cancer who are progressing (testosterone level <50ng/mL)?

1. Castration-resistant prostate cancer (CRPC)
2. Progressing hypogonadal prostate cancer
3. Metastatic prostate cancer progressing after (define) systemic therapy
4. Abstain



Option	Votes	Percent
Option 1	48	87
Option 2	0	0
Option 3	7	13
Abstain	0	0
Total votes	55	

Published in European Urology 2020 open access:

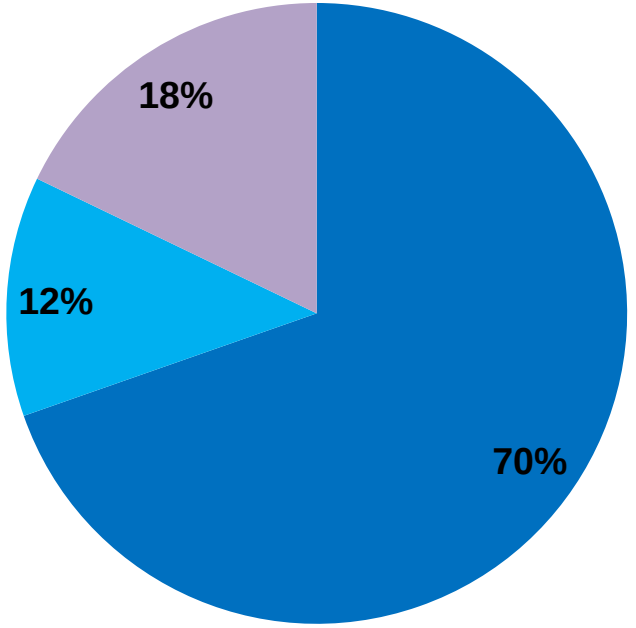
https://doi.org/10.1016/j.eururo.2020.01.012

4.2 Management of newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

27. Do you recommend measuring total testosterone level before starting first-line treatment with ADT?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	39	70
Option 2	7	12
Option 3	10	18
Abstain	1	NA
Total votes	57	

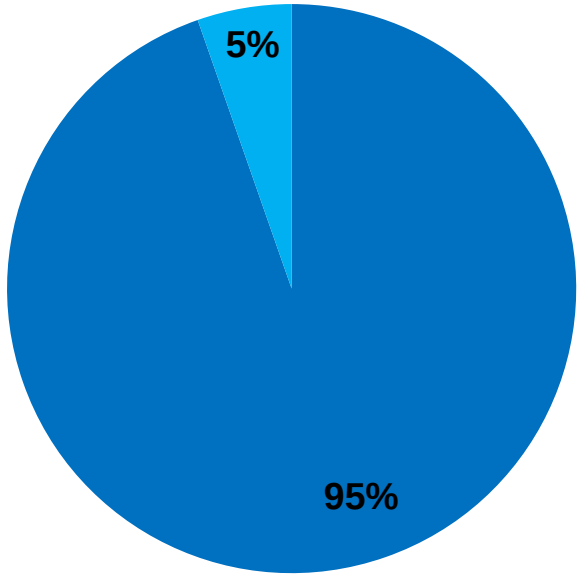
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

28. In patients with high suspicion of metastatic prostate cancer (based on PSA, imaging) do you recommend **histopathological confirmation** of prostate cancer (either before or after initiation of ADT)?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	53	95
Option 2	3	5
Option 3	0	0
Abstain	0	0
Total votes	56	

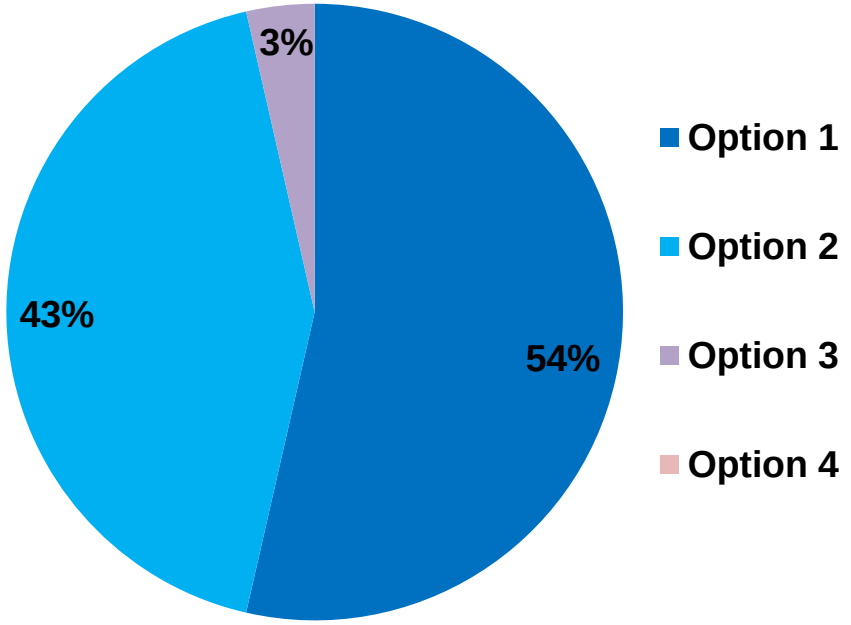
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

29. In symptomatic patients with high suspicion of metastatic prostate cancer (PSA, imaging) do you initiate ADT before histopathological confirmation of prostate cancer?

1. Yes, in the majority of symptomatic patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	30	54
Option 2	24	43
Option 3	2	3
Abstain	0	0
Total votes	56	

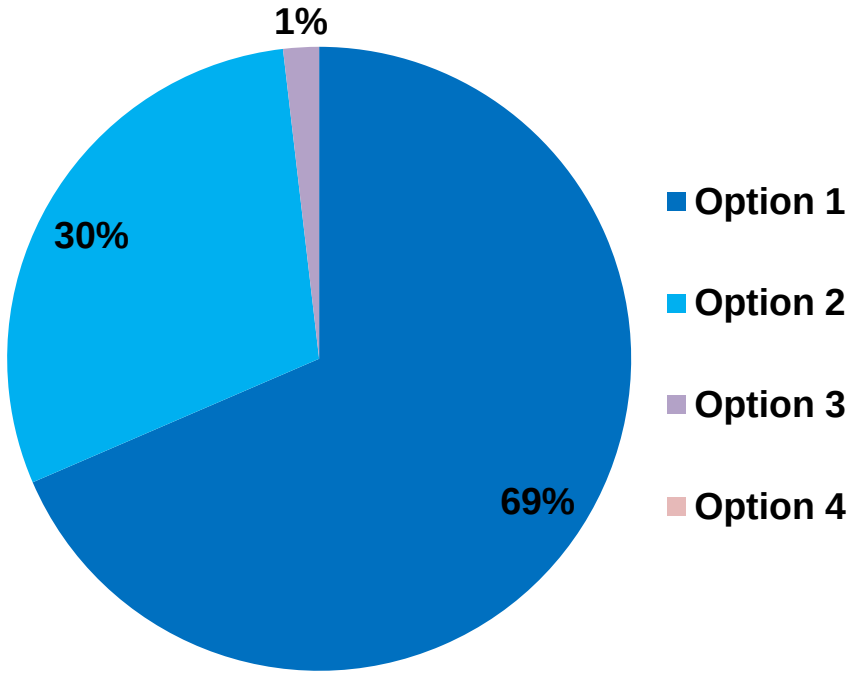
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

30. If you initiate GnRH agonist therapy in patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC), do you recommend a short course of a first-generation non-steroidal AR antagonist (NSAA) as flare protection?

1. Yes, in the majority of patients
2. Yes, but only if there is a risk of harm from disease flare
3. No
4. Abstain (including I do not initiate ADT with a GnRH agonist)



Option	Votes	Percent
Option 1	37	69
Option 2	16	30
Option 3	1	1
Abstain	2	0
Total votes	56	NA

Published in European Urology 2020 open access:

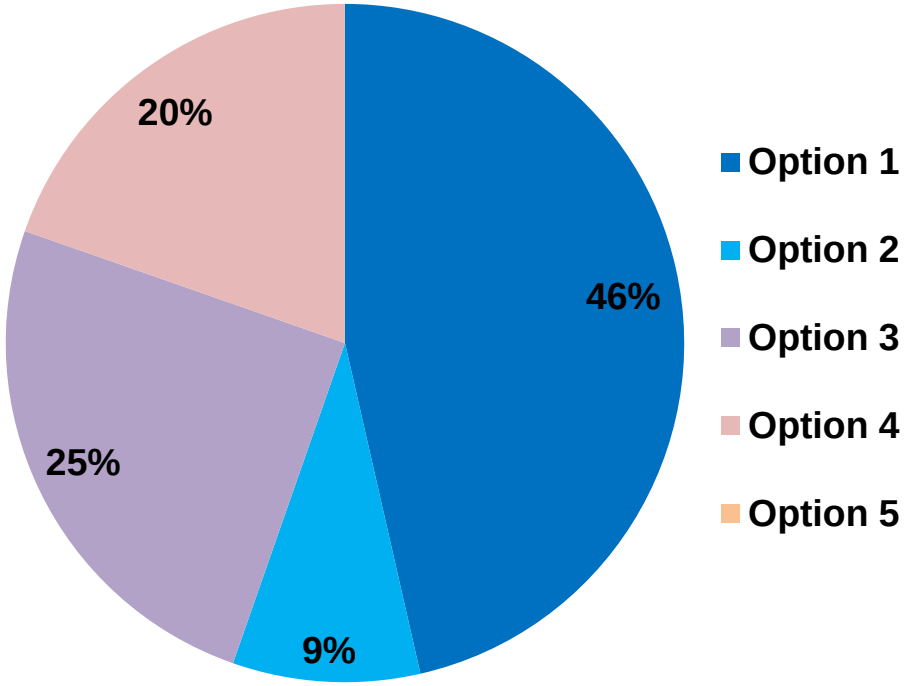
https://doi.org/10.1016/j.eururo.2020.01.012

Questions 31-41 pertain to patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC) who are fit for additional treatment with docetaxel or abiraterone or enzalutamide or apalutamide (i.e. who have no contraindications) in cases where there are no regulatory limitations.

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

31. Which definition do you recommend using to guide treatment selection of **docetaxel** in addition to ADT in patients with castration-sensitive/naïve prostate cancer (CNPC)?

1. High/low-volume disease
2. High/low-risk disease
3. Either one of these definitions
4. Neither of these definitions
5. Abstain



Option	Votes	Percent
Option 1	26	46
Option 2	5	9
Option 3	14	25
Option 4	11	20
Abstain	0	0
Total votes	56	

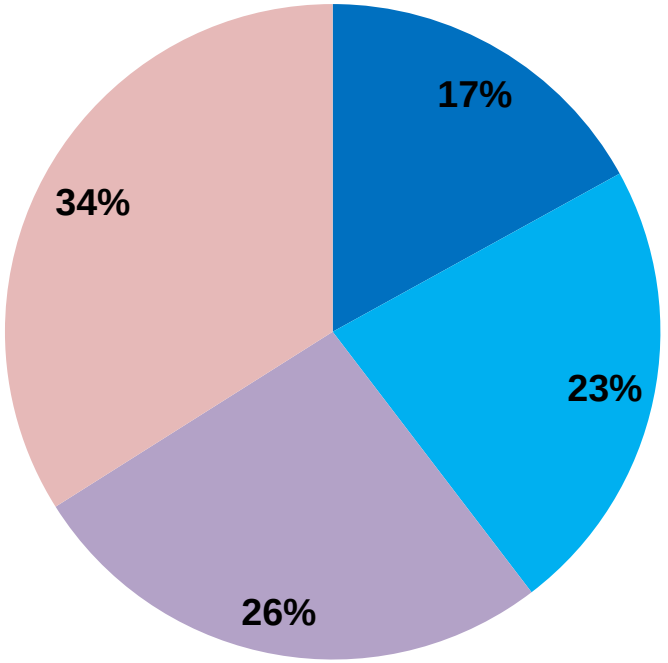
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

32. Which definition do you recommend using to guide treatment selection of **abiraterone** in addition to ADT in patients with castration-sensitive/naïve prostate cancer (CNPC)?

1. High/low-volume disease
2. High/low-risk disease
3. Either one of these definitions
4. Neither of these definitions
5. Abstain



Option	Votes	Percent
Option 1	9	17
Option 2	12	23
Option 3	14	26
Option 4	18	34
Abstain	0	0
Total votes	53	

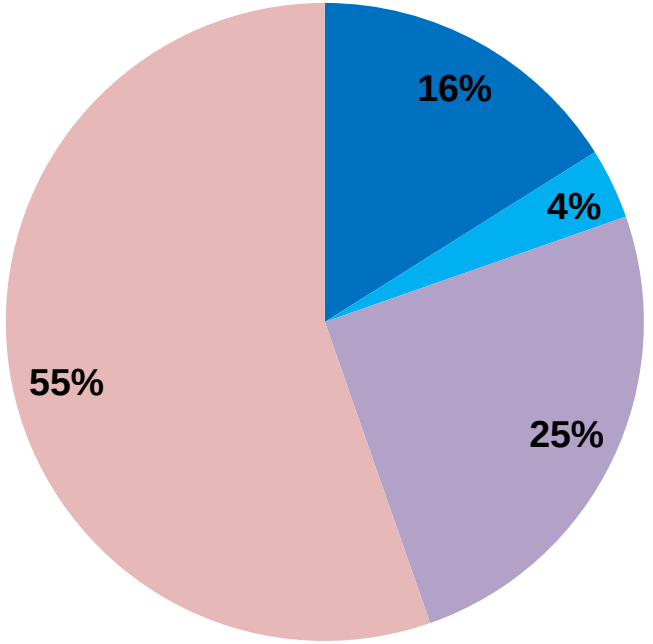
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

33. Which definition do you recommend using to guide treatment selection of **enzalutamide or apalutamide** in addition to ADT in patients with castration-sensitive/naïve prostate cancer (CNPC)?

1. High/low-volume disease
2. High/low-risk disease
3. Either one of these definitions
4. Neither of these definitions
5. Abstain



Option	Votes	Percent
Option 1	9	16
Option 2	2	4
Option 3	14	25
Option 4	31	55
Abstain	0	0
Total votes	56	

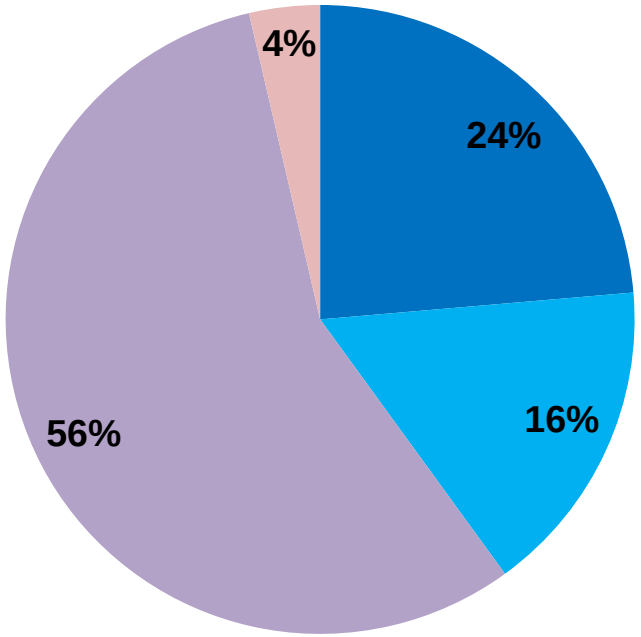
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

34. What is your **preferred** treatment in addition to ADT in patients with **de-novo high-volume** metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC) without symptoms from the primary tumour?

1. AR pathway inhibitor (abiraterone or apalutamide or enzalutamide) as sole additional therapy
2. Docetaxel as sole additional therapy
3. Any one of docetaxel or abiraterone or apalutamide or enzalutamide as sole additional therapy
4. Docetaxel plus an AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
5. ADT alone, no additional treatment
6. Abstain



Option	Votes	Percent
Option 1	13	24
Option 2	9	16
Option 3	31	56
Option 4	2	4
Option 5	0	0
Abstain	0	0
Total votes	55	

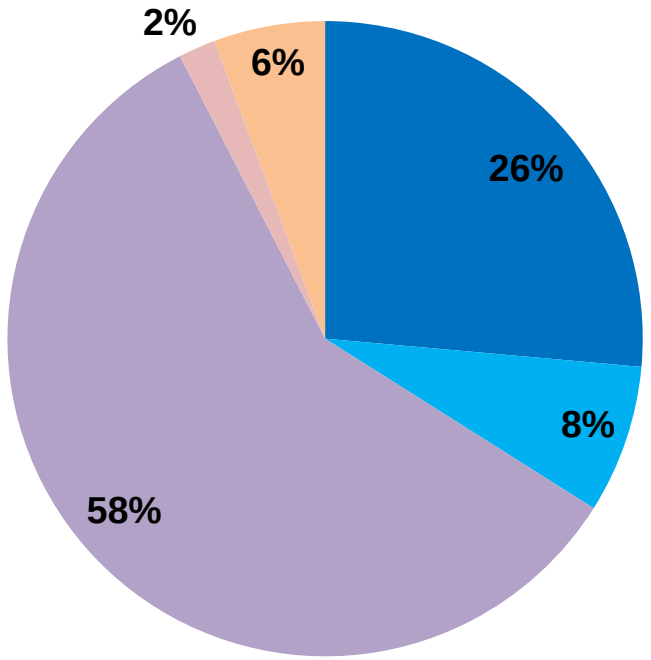
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

35. What is your preferred treatment in addition to ADT in patients with newly diagnosed **high-volume metastatic** (M1) castration-sensitive/naïve prostate cancer (CNPC) **relapsing after local treatment of the primary tumour**?

1. AR pathway inhibitor (abiraterone or apalutamide or enzalutamide) as sole additional therapy
2. Docetaxel as sole additional therapy
3. Any one of docetaxel or abiraterone or apalutamide or enzalutamide as sole additional therapy
4. Docetaxel plus an AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
5. ADT alone, no additional treatment
6. Abstain



Option	Votes	Percent
Option 1	14	26
Option 2	4	8
Option 3	31	58
Option 4	1	2
Option 5	3	6
Abstain	0	0
Total votes	53	

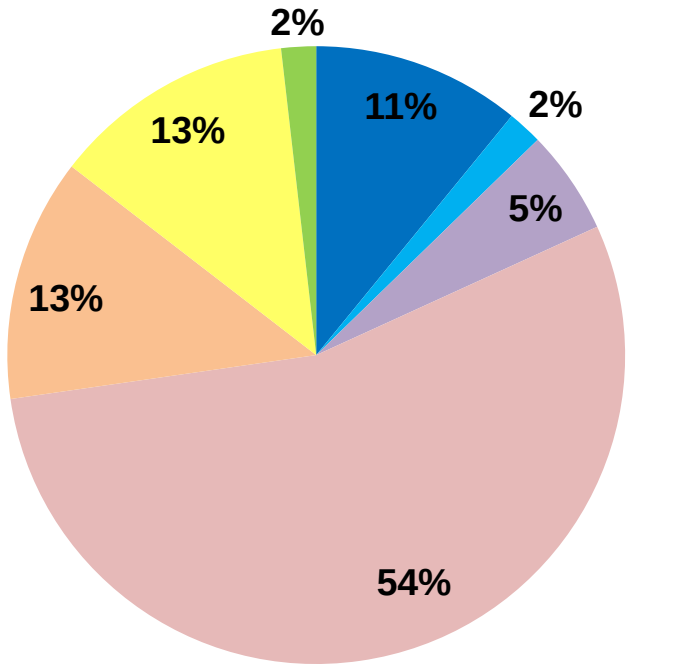
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

36. What is your preferred treatment in addition to ADT in patients with **de-novo low-volume metastatic** (M1) castration-sensitive/naïve prostate cancer (CNPC) without symptoms from the primary tumour?

1. AR pathway inhibitor (abiraterone or apalutamide or enzalutamide) as sole additional therapy
2. Docetaxel as sole additional therapy
3. Any one of docetaxel or abiraterone or apalutamide or enzalutamide as sole additional therapy
4. AR pathway inhibitor (abiraterone or apalutamide or enzalutamide) plus treatment of the primary
5. Docetaxel plus treatment of the primary tumour
6. Treatment of the primary alone
7. ADT alone, no additional treatment
8. Abstain



Option	Votes	Percent
Option 1	6	11
Option 2	1	2
Option 3	3	5
Option 4	30	54
Option 5	7	13
Option 6	7	13
Option 7	1	2
Abstain	0	NA
Total votes	55	

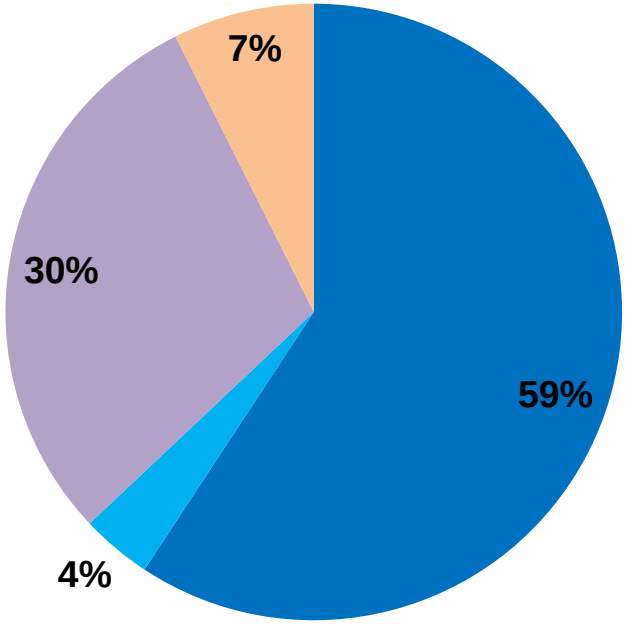
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

37. What is your preferred treatment in addition to ADT in patients with newly diagnosed **low-volume** metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC) relapsing after **local treatment of the primary tumour**?

1. AR pathway inhibitor (abiraterone or apalutamide or enzalutamide) as sole additional therapy
2. Docetaxel as sole additional therapy
3. Any one of docetaxel or abiraterone or apalutamide or enzalutamide as sole additional therapy
4. Docetaxel plus an AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
5. ADT alone, no additional treatment
6. Abstain



Option	Votes	Percent
Option 1	32	59
Option 2	2	4
Option 3	16	30
Option 4	0	0
Option 5	4	7
Abstain	1	NA
Total votes	55	

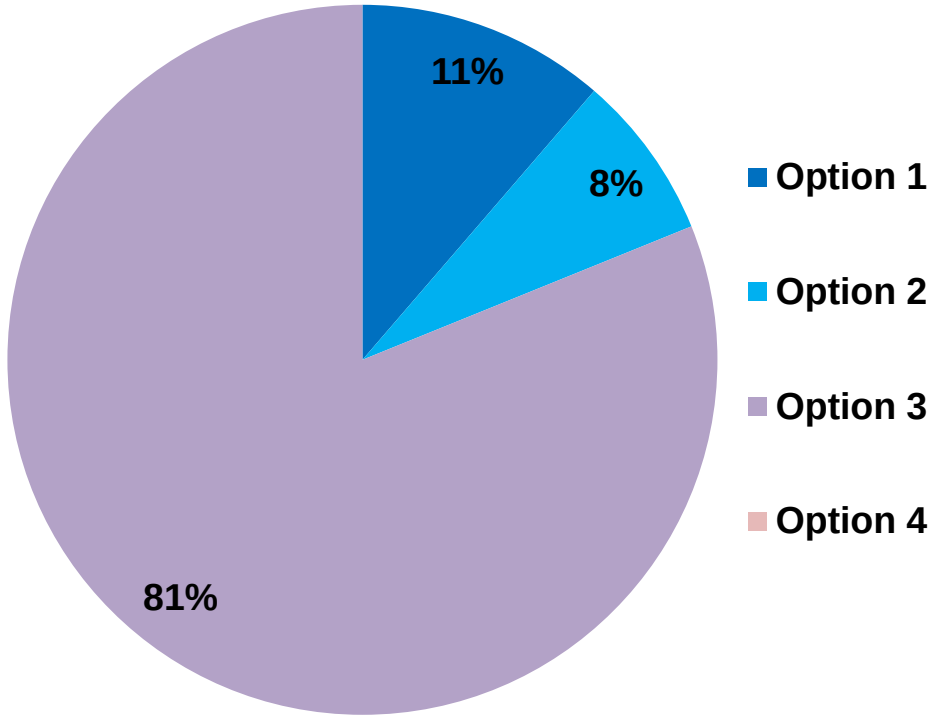
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

38. If you recommend **docetaxel plus an AR pathway inhibitor** (abiraterone or apalutamide or enzalutamide) in addition to ADT in a patient with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC), what is your **preferred** strategy?

1. Sequential administration (docetaxel first)
2. Concurrent administration
3. I do not recommend this combination
4. Abstain



Option	Votes	Percent
Option 1	6	11
Option 2	4	8
Option 3	43	81
Abstain	4	NA
Total votes	57	

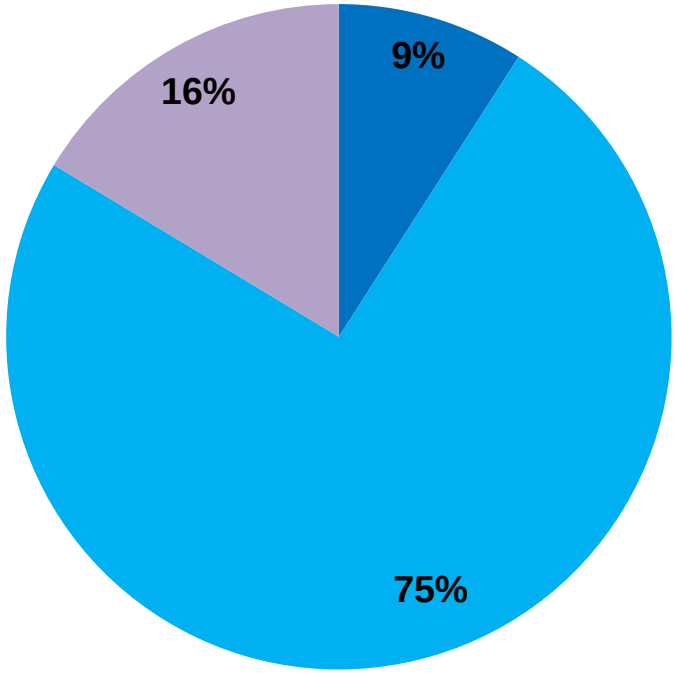
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

39. For a patient with **de novo high-volume** and/or **high-risk** metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC), Gleason score ≥9, **multiple** liver metastases and/or **lytic** bone metastases, and a low PSA value (<20) but no histopathological evidence of small cell carcinoma, what do you recommend in addition to ADT?

1. AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
2. Docetaxel
3. Platinum-based combination therapy
4. PARP inhibitor
5. ADT alone, no additional treatment
6. Abstain



Option	Votes	Percent
Option 1	5	9
Option 2	41	75
Option 3	9	16
Option 4	0	0
Option 5	0	0
Abstain	1	NA
Total votes	56	

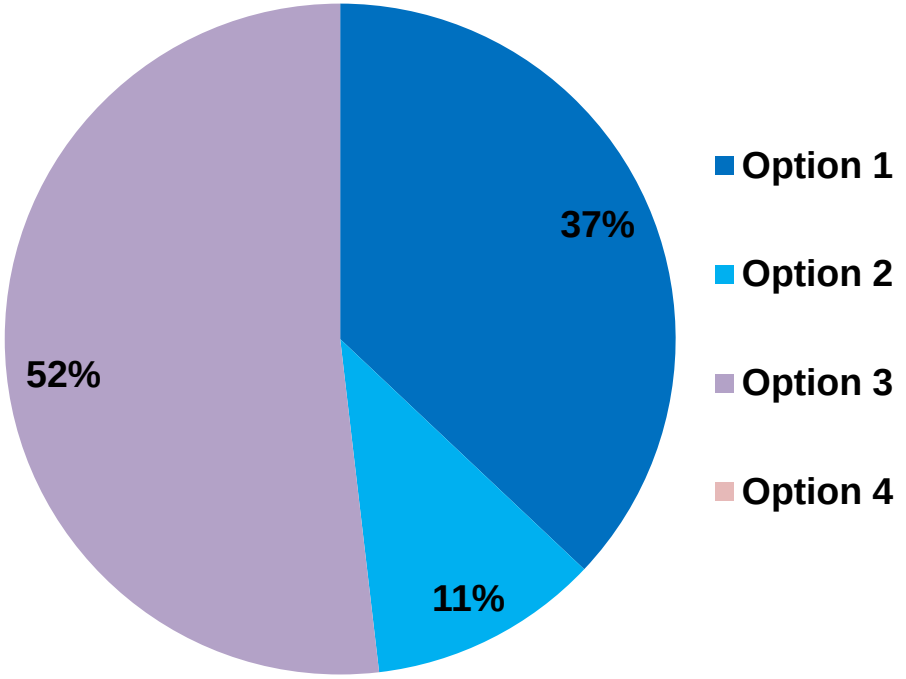
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

40. What is your **preferred** AR pathway inhibitor (abiraterone or apalutamide or enzalutamide) in addition to ADT for the majority of patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)?

1. Abiraterone
2. Novel AR antagonist (enzalutamide or apalutamide)
3. Any of these options
4. Abstain



Option	Votes	Percent
Option 1	20	37
Option 2	6	11
Option 3	28	52
Abstain	1	NA
Total votes	55	

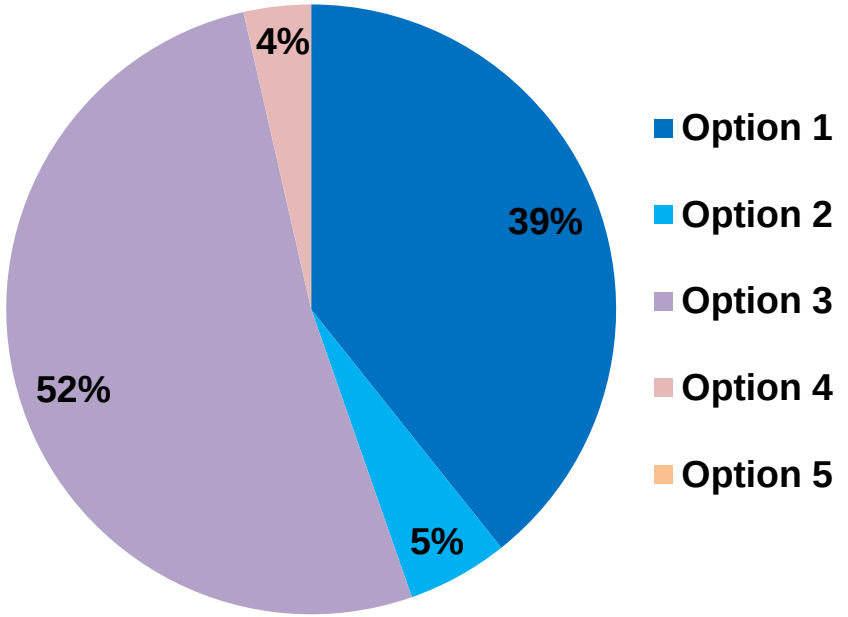
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

41. What glucocorticoid regimen do you recommend when starting abiraterone in patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)?

1. Prednisone/prednisolone at 5mg twice daily
2. Prednisone/prednisolone at 10mg once daily
3. Prednisone/prednisolone at 5mg once daily
4. Dexamethasone at 0.5mg to 1mg once daily
5. Abstain



Option	Votes	Percent
Option 1	22	39
Option 2	3	5
Option 3	29	52
Option 4	2	4
Abstain	1	NA
Total votes	57	

Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

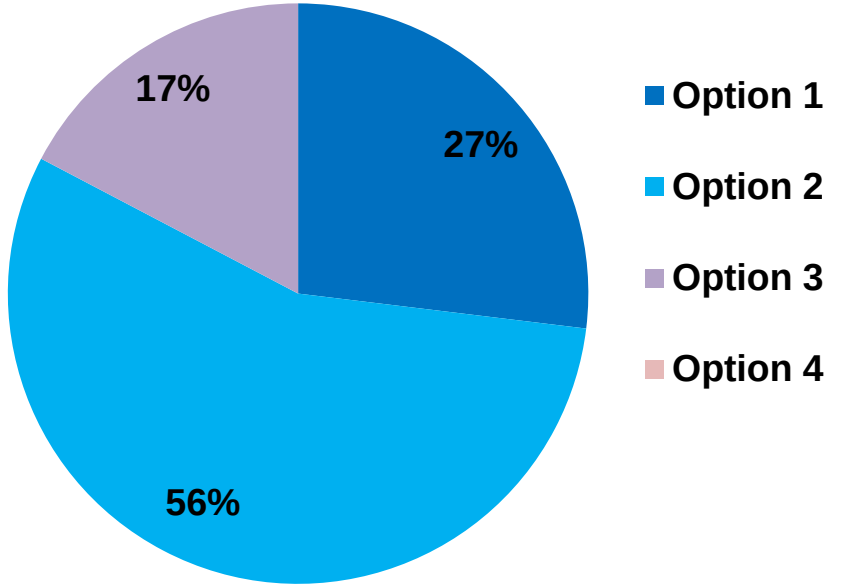
4.3 General imaging

For these questions, assume that you have access to ALL imaging modalities and interpretation/expertise.

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

42. What monitoring by imaging, do you recommend for the majority of patients with **newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)**?

1. Baseline imaging → monitor PSA alone → further imaging at progression
2. Baseline imaging → follow-up imaging at 6-12 months or at best response → monitor PSA alone → further imaging at progression
3. Baseline imaging → follow-up imaging every 3-6 months
4. Abstain



Option	Votes	Percent
Option 1	14	27
Option 2	29	56
Option 3	9	17
Abstain	2	NA
Total votes	54	

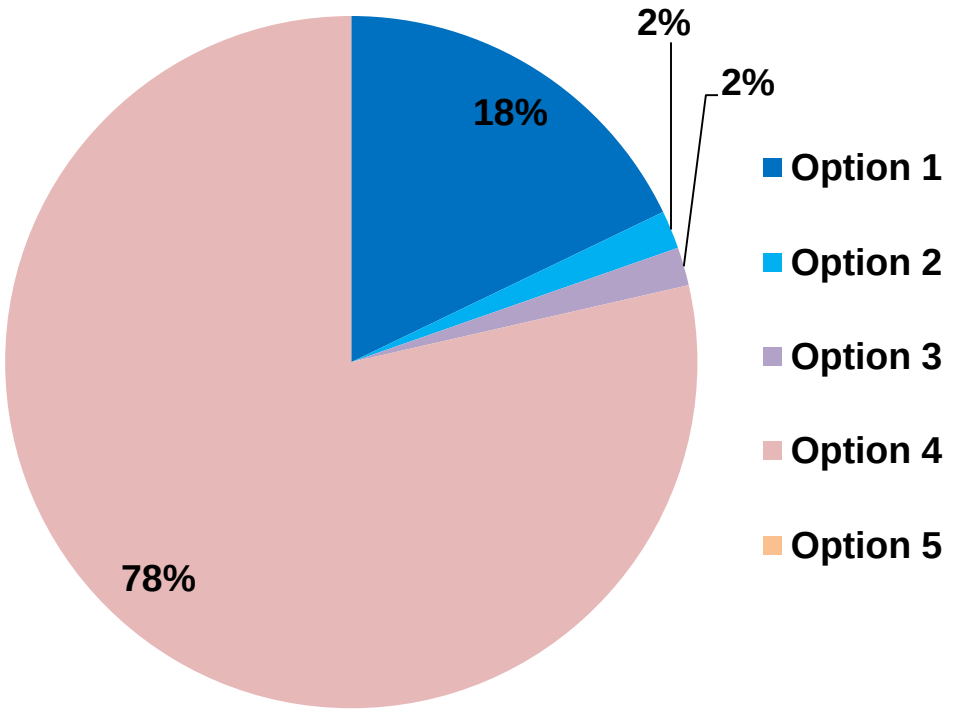
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

43. For the **majority of patients** with newly diagnosed high-volume metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC) based on CT and bone scintigraphy, what **additional imaging modalities** do you recommend?

1. PSMA PET CT/MRI
2. Fluciclovine or Choline PET CT/MRI
3. Whole-body MRI without PET
4. No further imaging, CT and bone scintigraphy are sufficient
5. Abstain



Option	Votes	Percent
Option 1	10	18
Option 2	1	2
Option 3	1	2
Option 4	44	78
Abstain	0	0
Total votes	56	

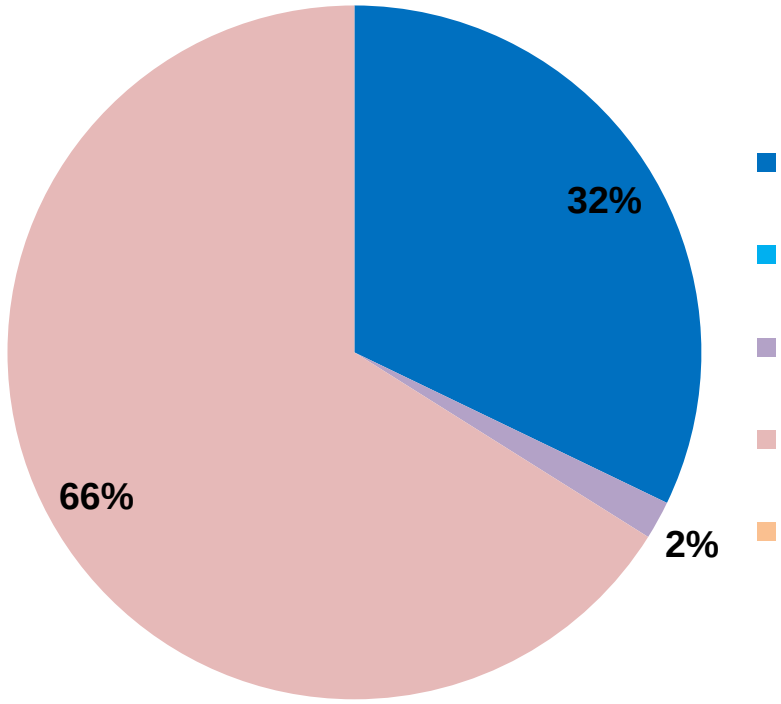
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

44. For the majority of patients with newly diagnosed **low-volume metastatic (M1)** castration-sensitive/naïve prostate cancer (CNPC) based on CT and bone scintigraphy, what **additional imaging modalities** do you recommend?

1. PSMA PET CT/MRI
2. Fluciclovine or choline PET CT/MRI
3. Whole-body MRI without PET
4. No further imaging, CT and bone scintigraphy are sufficient
5. Abstain



Option	Votes	Percent
Option 1	18	32
Option 2	0	0
Option 3	1	2
Option 4	37	66
Abstain	0	0
Total votes	56	

Published in European Urology 2020 open access:

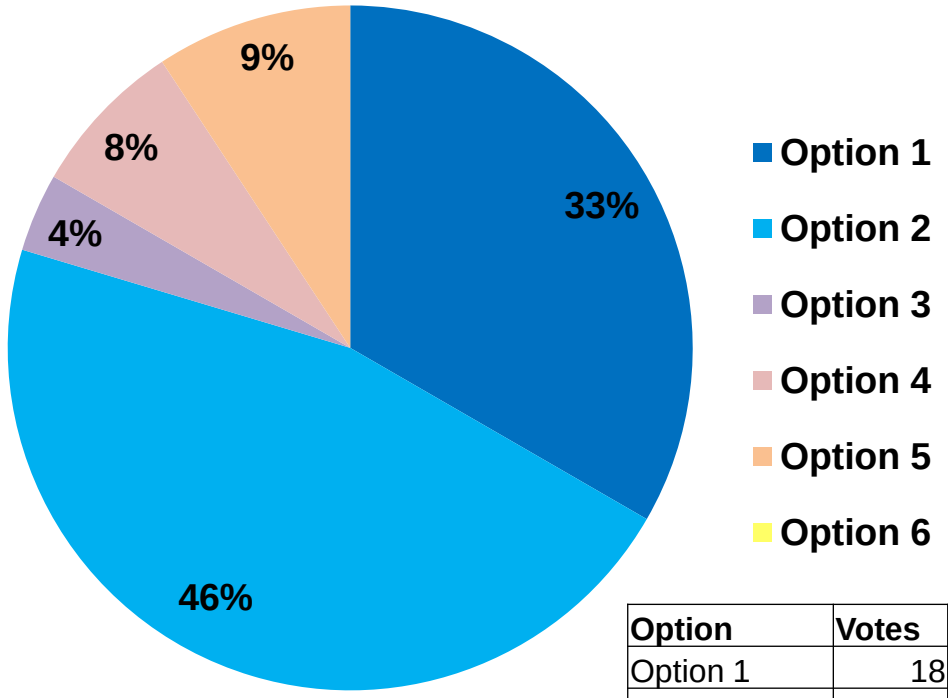
https://doi.org/10.1016/j.eururo.2020.01.012

4.4 Oligometastatic prostate cancer (no prior systemic therapy for metastatic disease)

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

45. Which definition of oligometastatic prostate cancer is **useful to guide treatment selection** for local treatment of all lesions plus/minus systemic therapy?

1. Patients with a limited number of any synchronous or metachronous metastases, including visceral metastases, that all can be treated with local therapy
2. Patients with a limited number of synchronous or metachronous bone and/or lymph node metastases, excluding visceral metastases, that all can be treated with local therapy
3. Patients with a limited number of any metachronous metastases, including visceral metastases, that all can be treated with local therapy
4. Patients with a limited number of metachronous bone and/or lymph node metastases, excluding visceral metastases, that all can be treated with local therapy
5. I do not believe oligometastatic prostate cancer exists as a clinically meaningful entity
6. Abstain



Option	Votes	Percent
Option 1	18	33
Option 2	25	46
Option 3	2	4
Option 4	4	8
Option 5	5	9
Abstain	1	NA
Total votes	55	

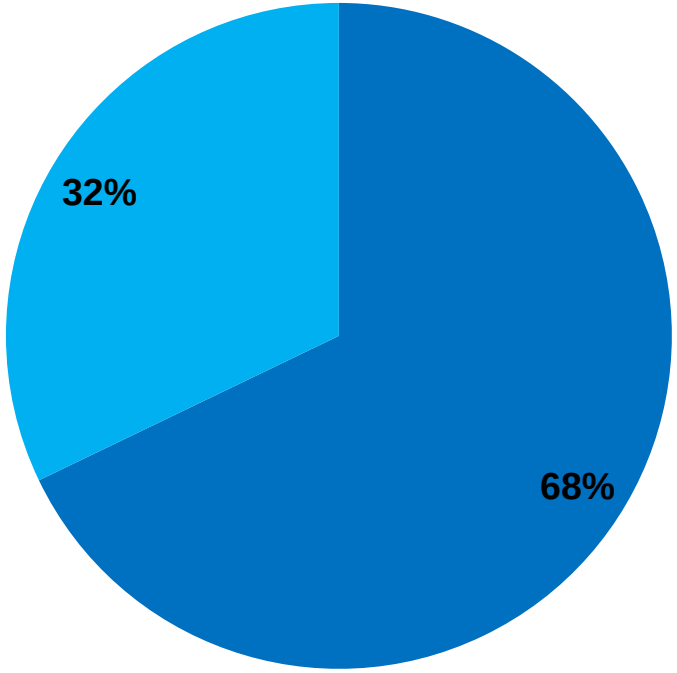
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

46. For treatment decisions is it important to distinguish **de-novo treatment-naïve (synchronous)** oligometastatic prostate cancer from oligometastatic prostate cancer **recurring** after local therapy **(metachronous)**?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	38	68
Option 2	18	32
Abstain	1	NA
Total votes	57	

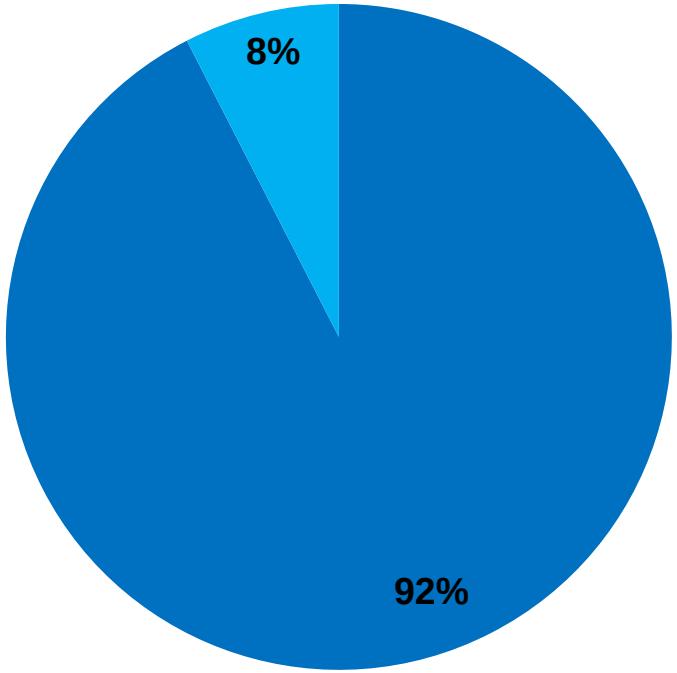
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

47. For treatment decisions in untreated de-novo oligometastatic prostate cancer, is it important to distinguish **lymph node-only** disease (including distant lymph node metastases) from disease that includes metastatic lesions at other sites?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	49	92
Option 2	4	8
Abstain	2	NA
Total votes	55	

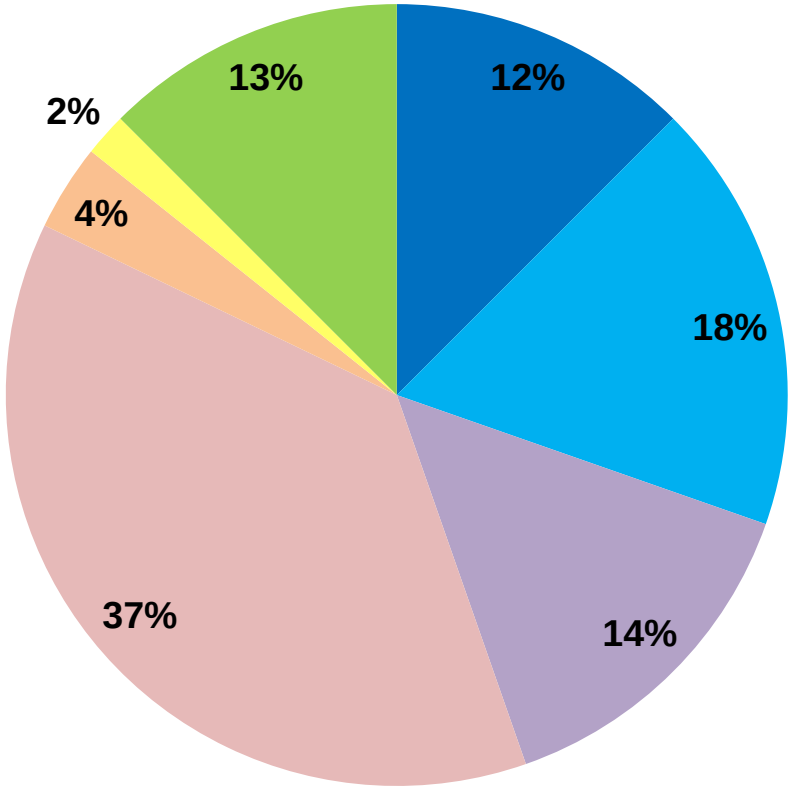
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

48. What is your treatment goal when recommending **local treatment of all lesions instead of systemic therapy** in oligometastatic prostate cancer?

1. Delay start of ADT
2. Prolongation of progression-free survival
3. Prolongation of overall survival
4. All three of the above
5. Cure
6. None of the above
7. I do not recommend local treatment of all lesions in oligometastatic prostate cancer
8. Abstain



Option	Votes	Percent
Option 1	7	12
Option 2	10	18
Option 3	8	14
Option 4	21	37
Option 5	2	4
Option 6	1	2
Option 7	7	13
Abstain	0	0
Total votes	56	

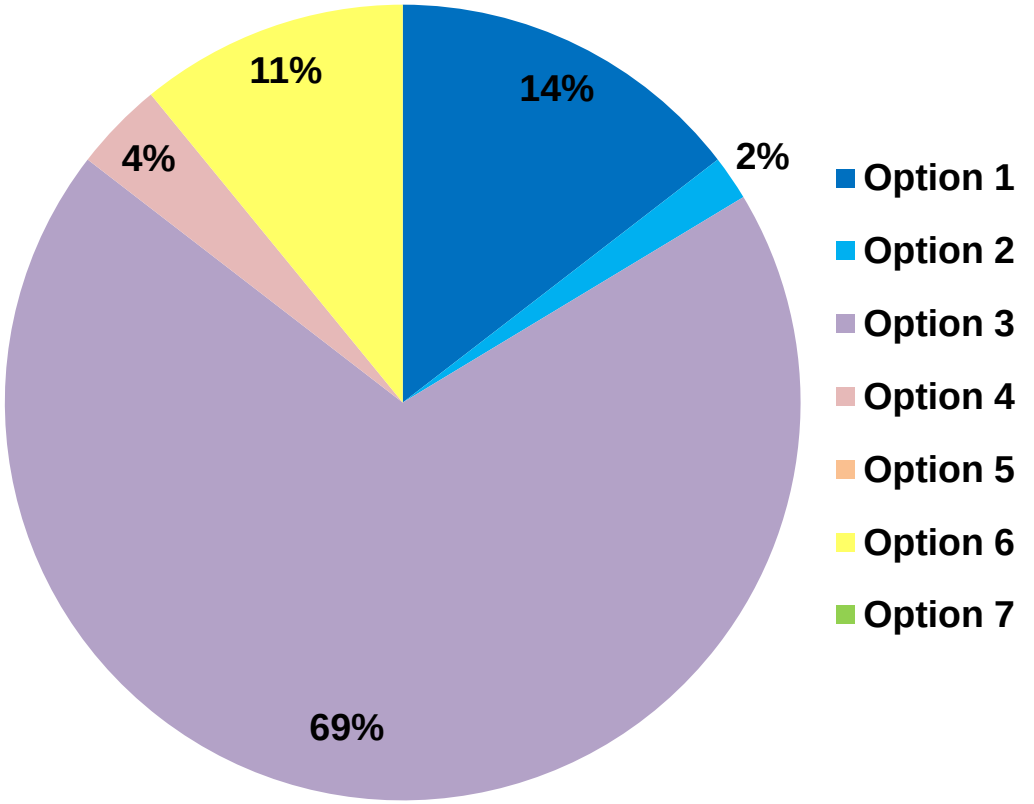
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

49. What is your treatment goal when recommending adding **local treatment of all lesions to systemic treatment** in oligometastatic prostate cancer?

1. Prolongation of progression-free survival
2. Prolongation of overall survival
3. Prolongation of both PFS and OS
4. Cure
5. None of the above
6. I do not recommend local treatment of all lesions in oligometastatic prostate cancer
7. Abstain



Option	Votes	Percent
Option 1	8	14
Option 2	1	2
Option 3	38	69
Option 4	2	4
Option 5	0	0
Option 6	6	11
Abstain	0	0
Total votes	55	

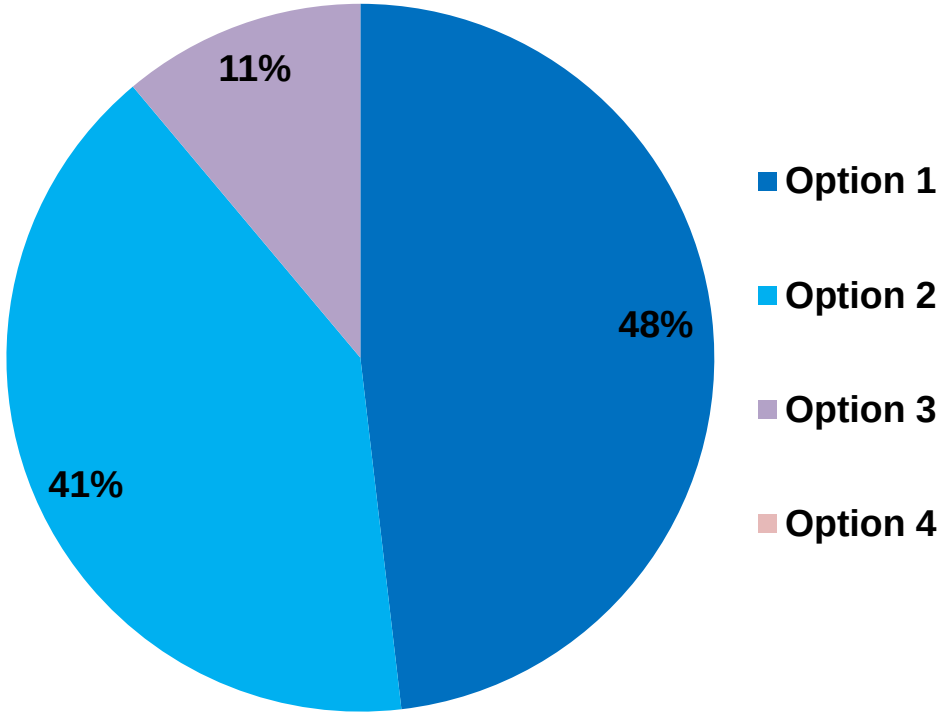
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

50. What is your cut-off for the number of metastases when considering prostate cancer to be oligometastatic?

1. ≤3 metastases
2. ≤5 metastases
3. No cut-off, any number that can be safely treated with ablative intent
4. Abstain



Option	Votes	Percent
Option 1	26	48
Option 2	22	41
Option 3	6	11
Abstain	1	NA
Total votes	55	

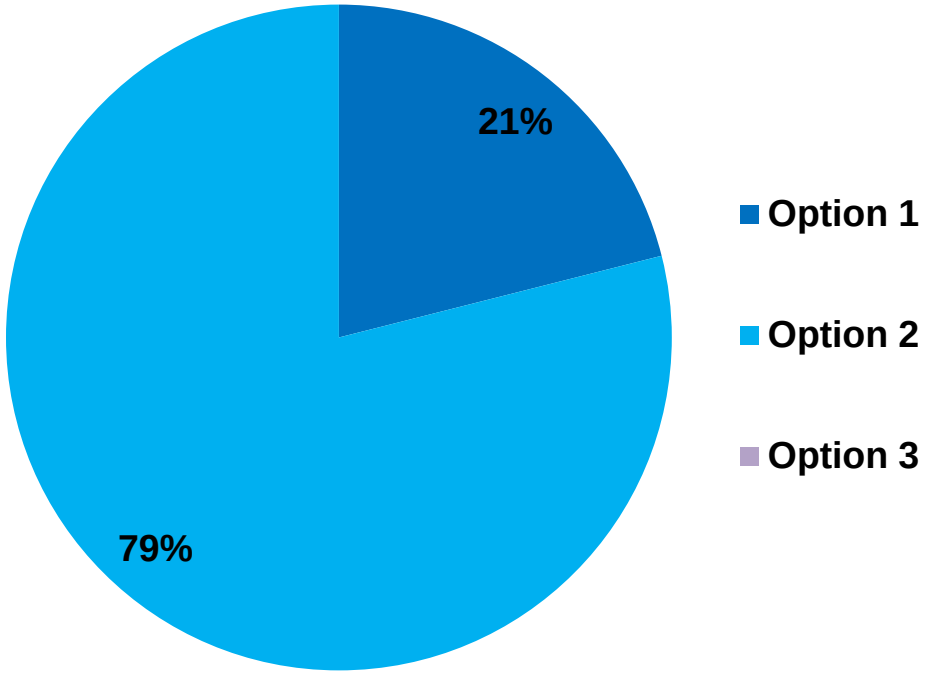
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

51. Is imaging by CT and bone scintigraphy sufficient to define the oligometastatic state for treatment planning?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	12	21
Option 2	45	79
Abstain	0	0
Total votes	57	

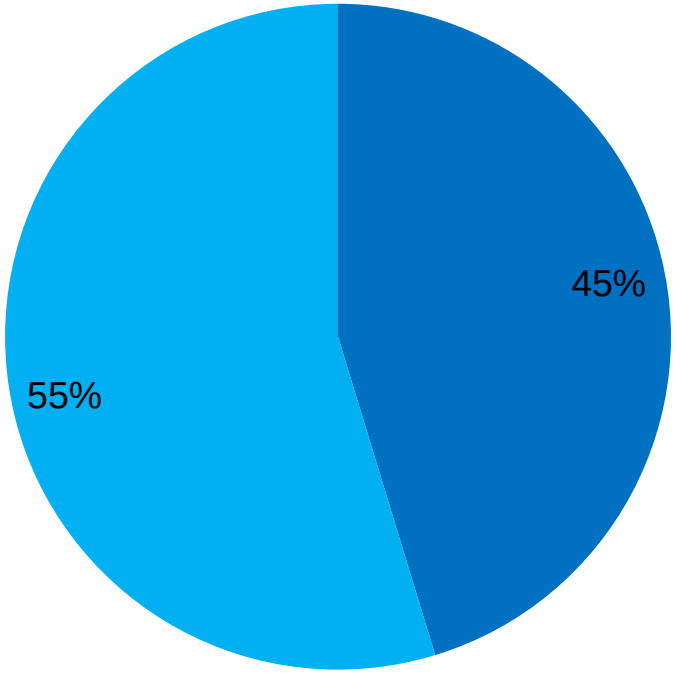
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

52. Should low volume disease defined by PET or MRI, but not evident on CT or bone scintigraphy, be treated the same as low volume disease by conventional definitions (CT and bone scintigraphy)?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	24	45
Option 2	29	55
Abstain	2	NA
Total votes	55	

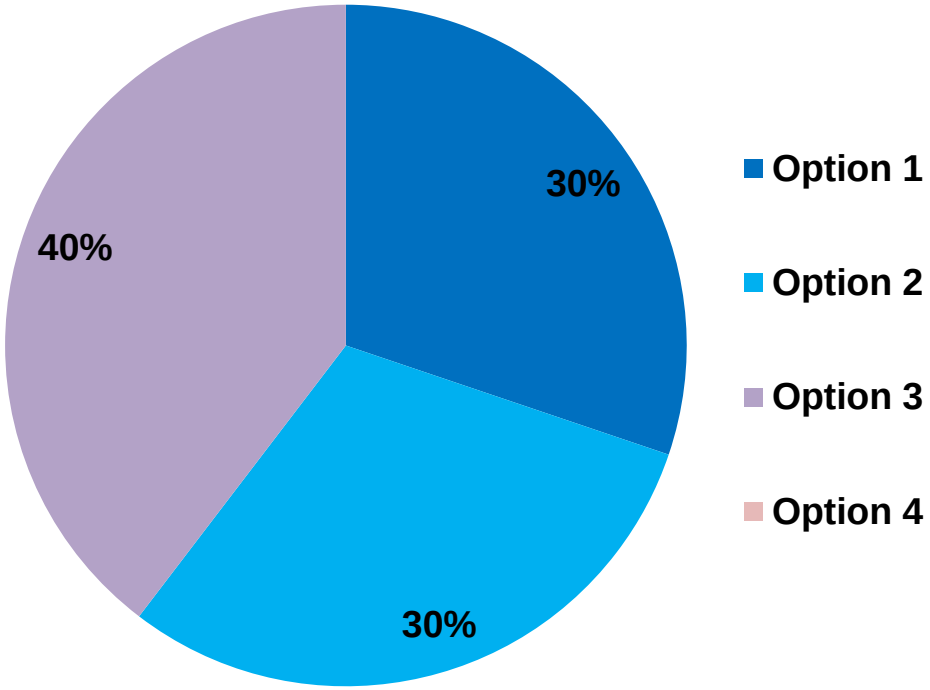
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

53. When planning local treatment of all lesions plus/minus systemic therapy in de-novo oligometastatic prostate cancer, do you recommend **confirmatory imaging approximately 8-12 weeks after initial diagnosis** to confirm an oligometastatic state before starting this treatment?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	16	30
Option 2	16	30
Option 3	21	40
Abstain	3	NA
Total votes	56	

Published in European Urology 2020 open access:

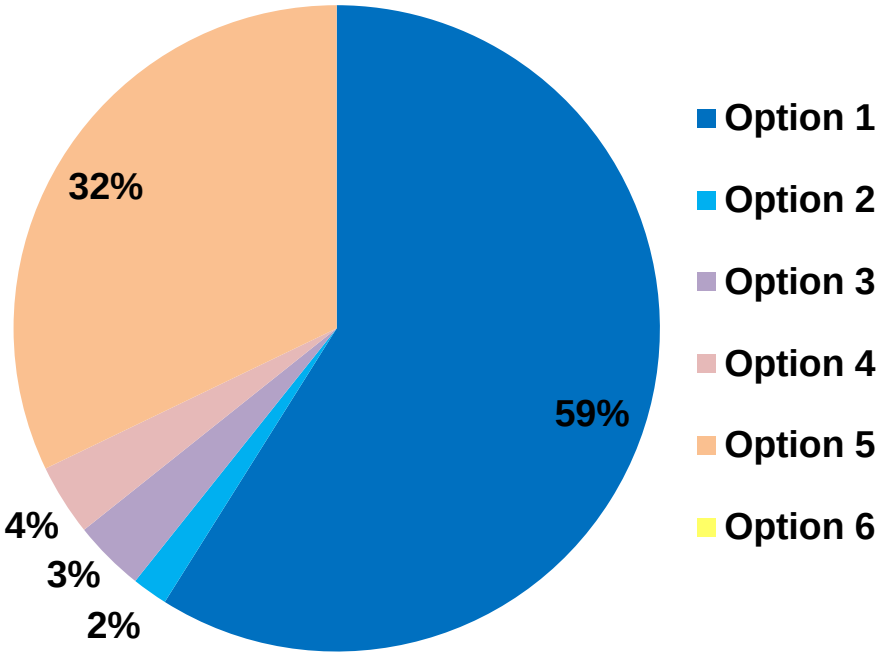
https://doi.org/10.1016/j.eururo.2020.01.012

4.5 Management of de-novo (synchronous) oligometastatic prostate cancer (no prior metastatic disease or prior treatment for prostate cancer)

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

54. For patients with **de-novo (synchronous)** oligometastatic disease on CT and bone scintigraphy, which confirmatory imaging modality(ies) do you recommend (apart from local staging)?

1. PSMA PET-CT/MRI
2. Fluciclovine or Choline PET-CT/MRI
3. Whole-body MRI without PET
4. A combination of two next-generation imaging methods
5. No additional imaging
6. Abstain



Option	Votes	Percent
Option 1	33	59
Option 2	1	2
Option 3	2	4
Option 4	2	3
Option 5	18	32
Abstain	0	0
Total votes	56	

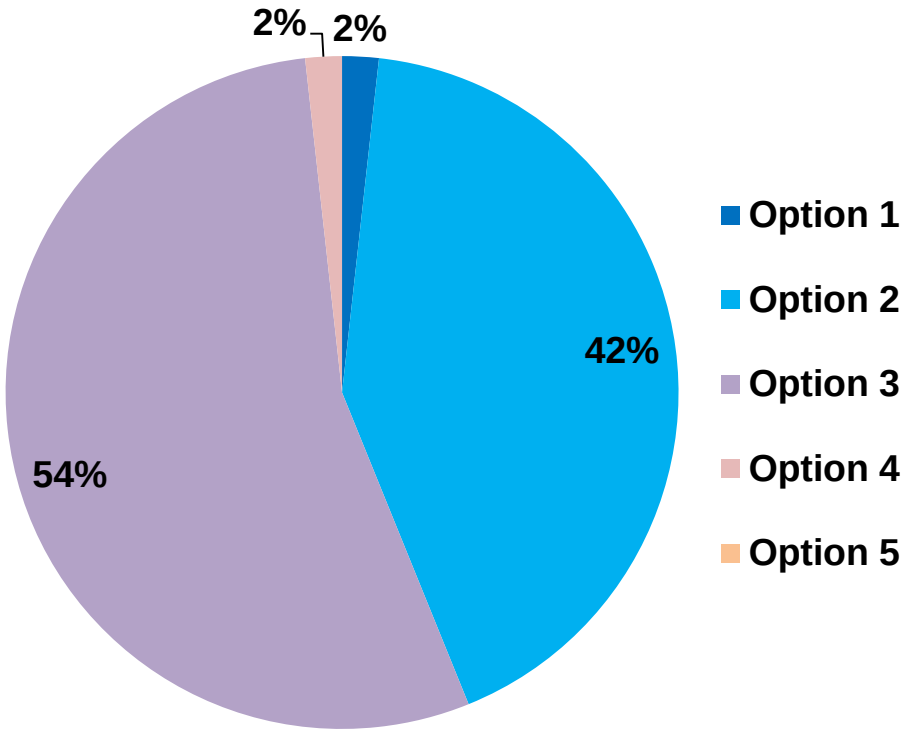
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

55. Which treatment do you recommend for the majority of patients with **de-novo (synchronous)** oligometastatic prostate cancer based on conventional imaging who have an untreated primary tumour?

1. Systemic therapy only
2. Systemic therapy plus treatment of the primary tumour
3. Systemic therapy plus treatment of the primary tumour and focal treatment of all lesions
4. Treatment of the primary tumour and focal treatment of all lesions without systemic therapy
5. Abstain



Option	Votes	Percent
Option 1	1	2
Option 2	24	42
Option 3	31	54
Option 4	1	2
Abstain	0	0
Total votes	57	

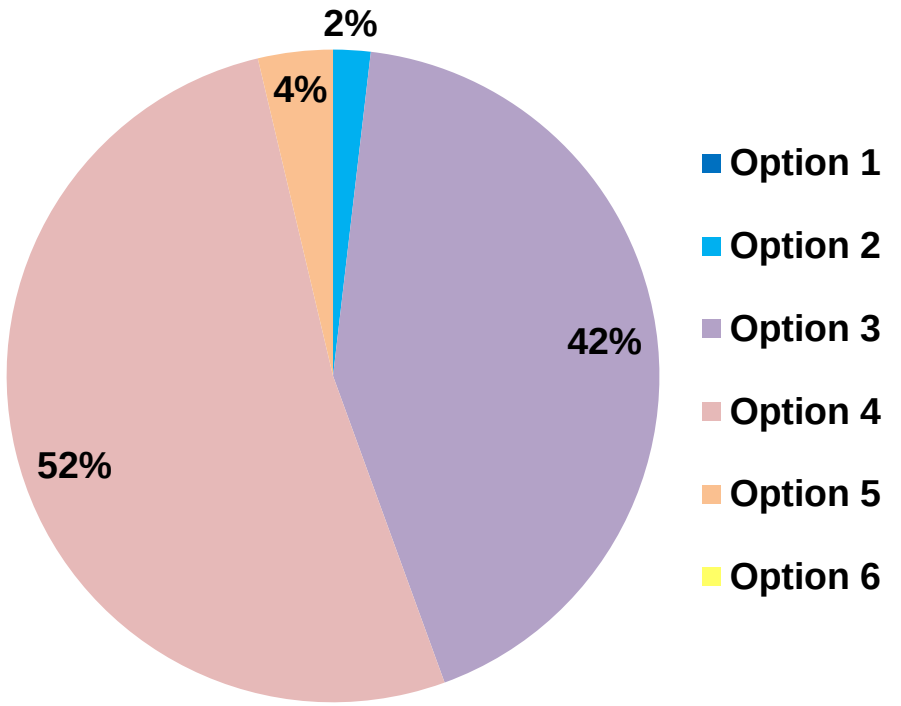
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

56. Which treatment do you recommend for the majority of patients with **de-novo (synchronous)** oligometastatic prostate cancer on novel imaging (but no metastases on conventional imaging) who have an untreated primary tumour?

1. Systemic therapy only
2. Local/regional therapy only
3. Systemic therapy plus treatment of the primary tumour
4. Systemic therapy plus treatment of the primary tumour and focal treatment of all lesions
5. Treatment of the primary tumour and focal treatment of all lesions without systemic therapy
6. Abstain



Option	Votes	Percent
Option 1	0	0
Option 2	1	2
Option 3	23	42
Option 4	28	52
Option 5	2	4
Abstain	1	NA
Total votes	55	

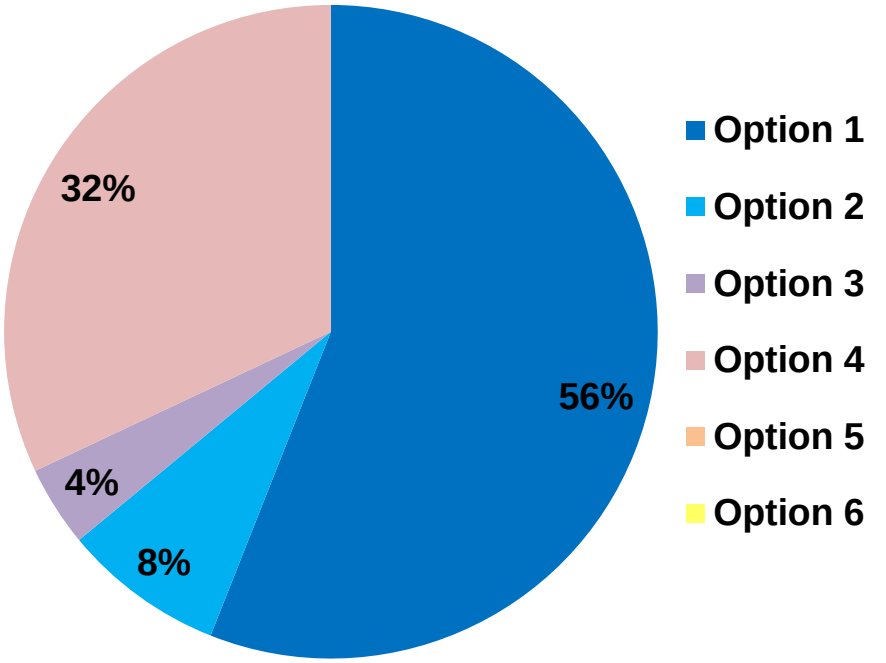
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

57. For patients with **de-novo (synchronous)** oligometastatic prostate cancer and an untreated primary tumour, if you perform radical local treatment of the primary **and** of all lesions, **what systemic therapy** do you usually recommend in addition to ADT?

1. AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
2. Docetaxel
3. Docetaxel plus an AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
4. I do not recommend additional systemic therapy to ADT in these patients
5. No systemic therapy, also no ADT
6. Abstain



Option	Votes	Percent
Option 1	28	56
Option 2	4	8
Option 3	2	4
Option 4	16	32
Option 5	0	0
Abstain	4	NA
Total votes	54	

Published in European Urology 2020 open access:

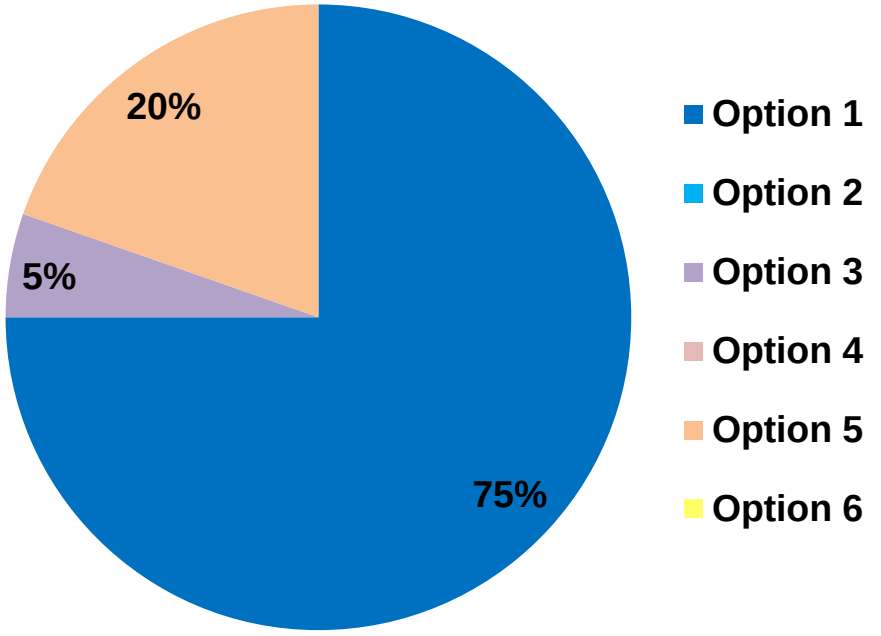
https://doi.org/10.1016/j.eururo.2020.01.012

4.6 Newly diagnosed oligorecurrent (metachronous) oligometastatic disease after local treatment (EBRT or radical prostatectomy ± EBRT) with curative intent (plus/minus salvage radiation therapy)

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

58. Which imaging modality(ies) do you recommend in patients with a rising PSA after radical treatment to confirm a diagnosis of oligorecurrent (metachronous) oligometastatic prostate cancer if detected on CT and bone scintigraphy?

1. PSMA PET-CT/MRI
2. Fluciclovine or choline PET-CT/MRI
3. Whole-body MRI without PET
4. A combination of two next-generation imaging methods
5. No additional imaging
6. Abstain



Option	Votes	Percent
Option 1	42	75
Option 2	0	0
Option 3	3	5
Option 4	0	0
Option 5	11	20
Abstain	1	NA
Total votes	57	

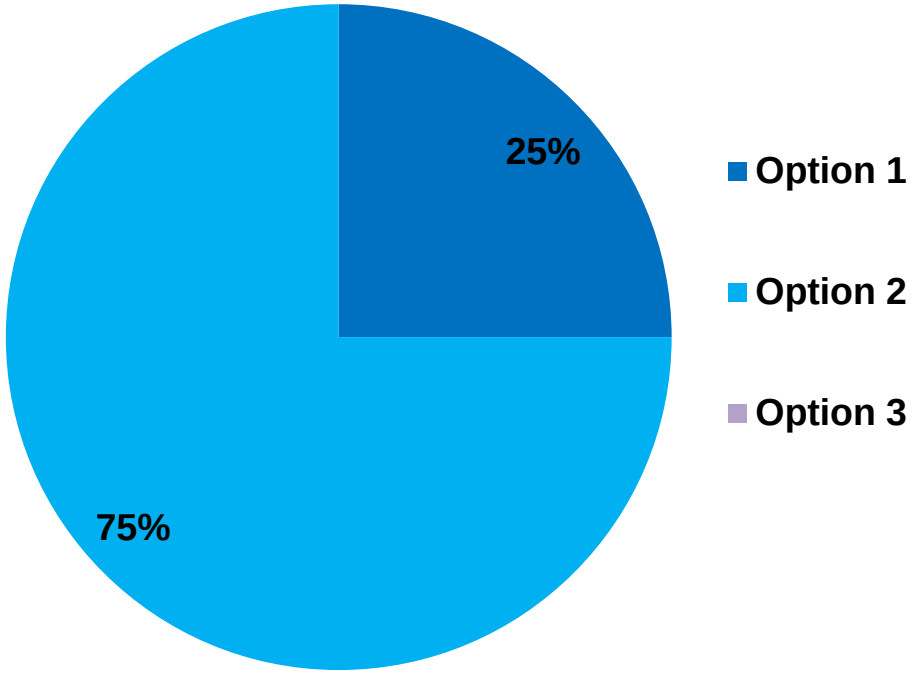
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

59. Which treatment do you recommend for the majority of patients with oligorecurrent (metachronous) oligometastatic prostate cancer?

1. Systemic therapy alone
2. Systemic therapy and local treatment of all lesions
3. Abstain



Option	Votes	Percent
Option 1	14	25
Option 2	42	75
Abstain	0	0
Total votes	56	

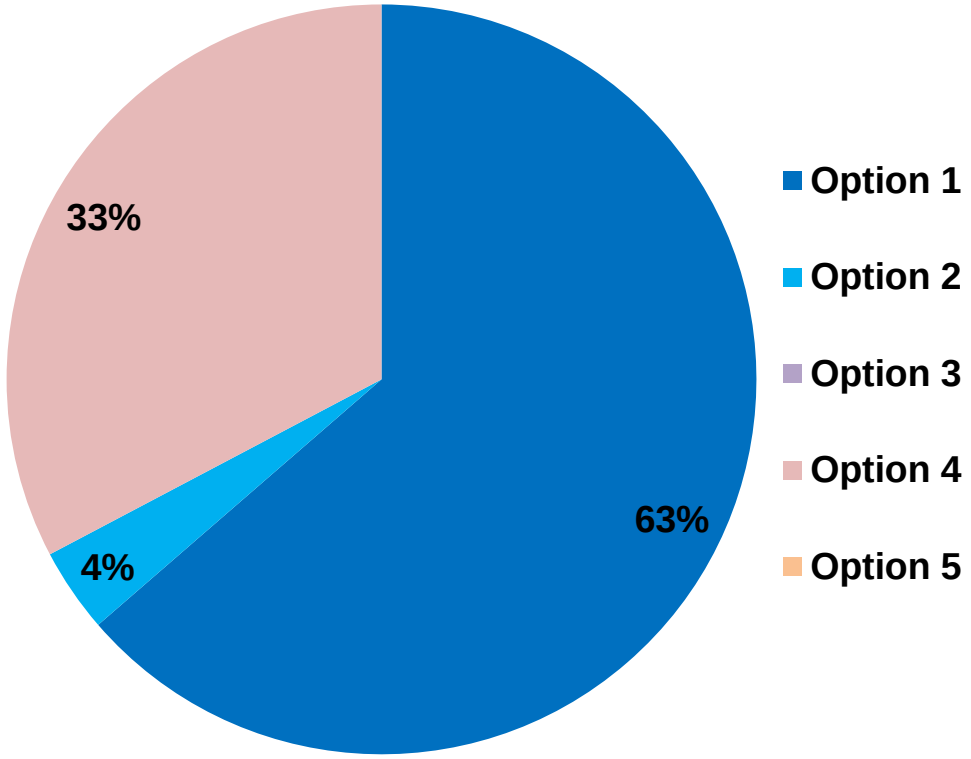
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

60. If you perform radical local treatment of all lesions in patients with oligorecurrent (metachronous) oligometastatic prostate cancer, which systemic therapy do you usually recommend in addition to ADT?

1. AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
2. Docetaxel
3. Docetaxel plus an AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
4. I do not recommend additional systemic therapy to ADT in these patients
5. Abstain



Option	Votes	Percent
Option 1	35	63
Option 2	2	4
Option 3	0	0
Option 4	18	33
Abstain	1	NA
Total votes	56	

Published in European Urology 2020 open access:

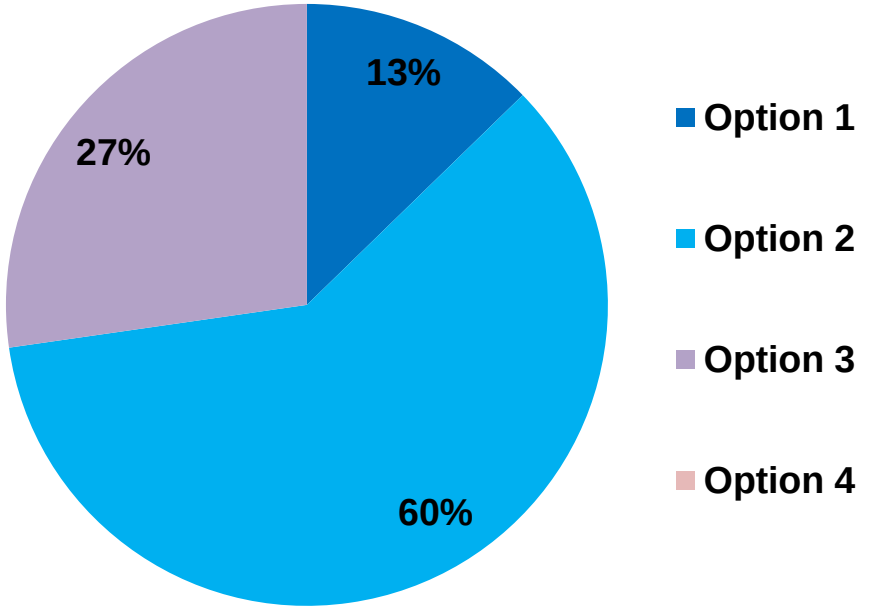
https://doi.org/10.1016/j.eururo.2020.01.012

4.7 Oligoprogressive (not oligometastatic) CRPC

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

61. What is the most useful definition of oligoprogressive prostate cancer?

1. A single progressing pre-existing or new lesion in a patient with metastatic disease that is otherwise stable/treatment-responsive
2. A limited number of progressing pre-existing or new lesion(s) in a patient with metastatic disease that is otherwise stable/treatment-responsive
3. I do not believe that oligoprogressive prostate cancer is a meaningful clinical entity
4. Abstain



Option	Votes	Percent
Option 1	7	13
Option 2	33	60
Option 3	15	27
Abstain	1	NA
Total votes	56	

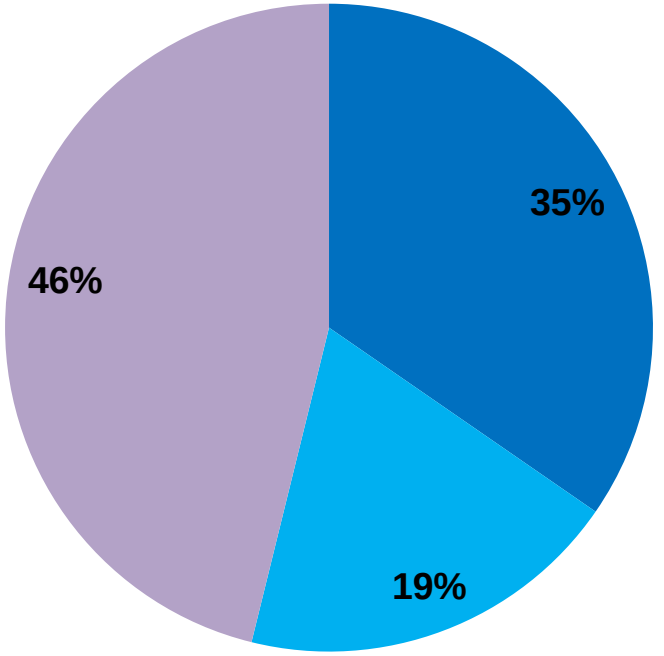
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

62. For patients with oligoprogressive metastatic chemotherapy-naïve CRPC, how do you recommend treating if there is disease progression (no visceral metastases) on a combination of ADT plus AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)?

1. Switch from current AR pathway inhibitor to another systemic therapy
2. Switch from current AR pathway to another systemic therapy and perform local treatment of all progressing lesions
3. Do not change systemic therapy; perform local treatment of all progressing lesions
4. Abstain



Option	Votes	Percent
Option 1	18	35
Option 2	10	19
Option 3	24	46
Abstain	4	NA
Total votes	56	

Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

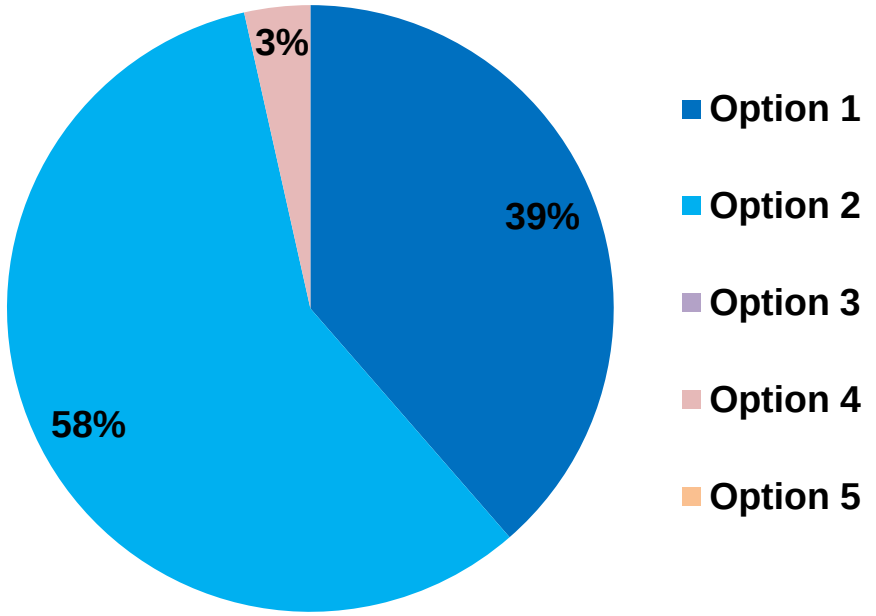
5. Management of non-metastatic CRPC (M0 CRPC)

For nmCPRC (M0 CRPC): Unless stated otherwise the questions relate to patients with a PSA doubling time of 10 months or less during continuous ADT and a total PSA level of 2 ng per milliliter or greater.

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

63. What imaging do you recommend for the majority of patients with CRPC and rising PSA with no metastatic disease documented on past imaging?

1. CT and/or bone scintigraphy
2. PSMA PET-CT/MRI
3. Fluciclovine or Choline PET-CT/MRI
4. Whole-body MRI without PET
5. Abstain



Option	Votes	Percent
Option 1	22	39
Option 2	33	58
Option 3	0	0
Option 4	2	2
Abstain	0	0
Total votes	57	

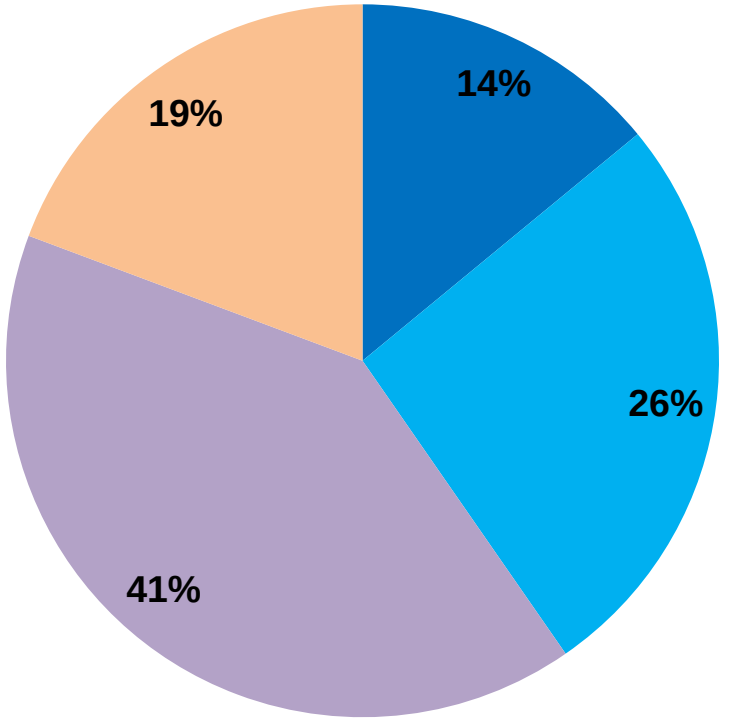
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

64. For asymptomatic nmCRPC (M0 CRPC) patients (no metastatic disease documented on past imaging) on ADT who have rising PSA and PSA doubling time <10 months, at what confirmed total PSA level do you recommend imaging?

1. PSA <1
2. PSA ≥1-2
3. PSA >2-10
4. PSA ≥10
5. I do not use absolute PSA values to guide imaging
6. I do not recommend imaging these patients
7. Abstain



Option	Votes	Percent
Option 1	8	14
Option 2	15	26
Option 3	23	41
Option 4	0	0
Option 5	11	19
Option 6	0	0
Abstain	0	0
Total votes	57	

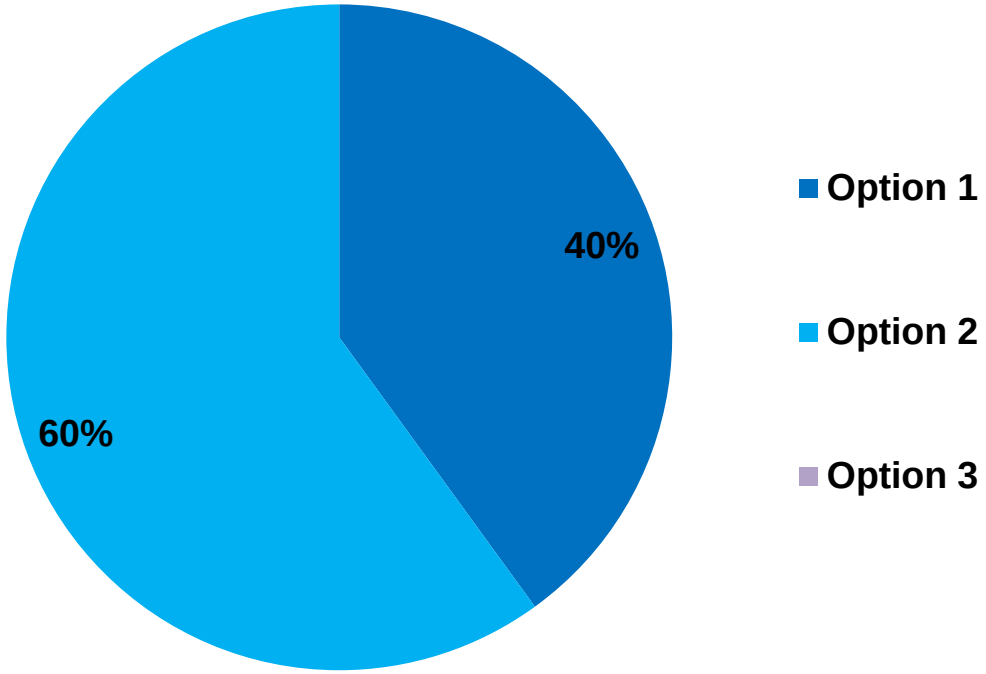
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

65. Is it appropriate to extrapolate data from ARAMIS, PROSPER, and SPARTAN to abiraterone?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	22	40
Option 2	33	60
Abstain	2	NA
Total votes	57	

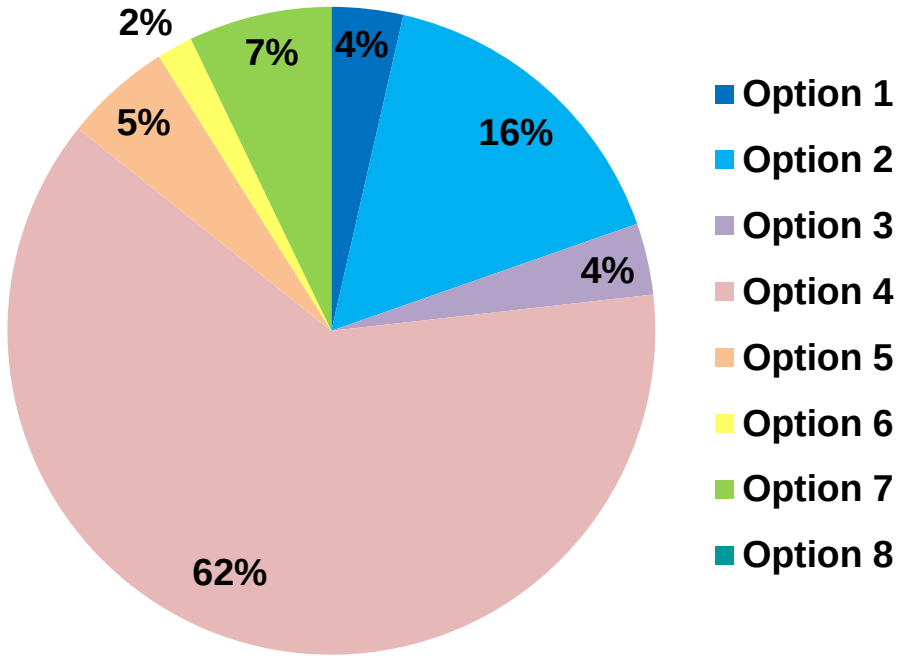
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

66. In the majority of nmCRPC (M0 CRPC) patients who have PSA ≥2 ng/mL and PSA doubling time ≤10 months, what is your preferred treatment choice in addition to ADT?

1. Apalutamide
2. Darolutamide
3. Enzalutamide
4. Any AR antagonist mentioned above
5. Abiraterone
6. Steroids (dexamethasone, prednisolone)
7. No additional treatment; continue ADT alone
8. Abstain



Option	Votes	Percent
Option 1	2	4
Option 2	9	16
Option 3	2	4
Option 4	35	62
Option 5	3	5
Option 6	1	2
Option 7	4	7
Abstain	0	0
Total votes	56	

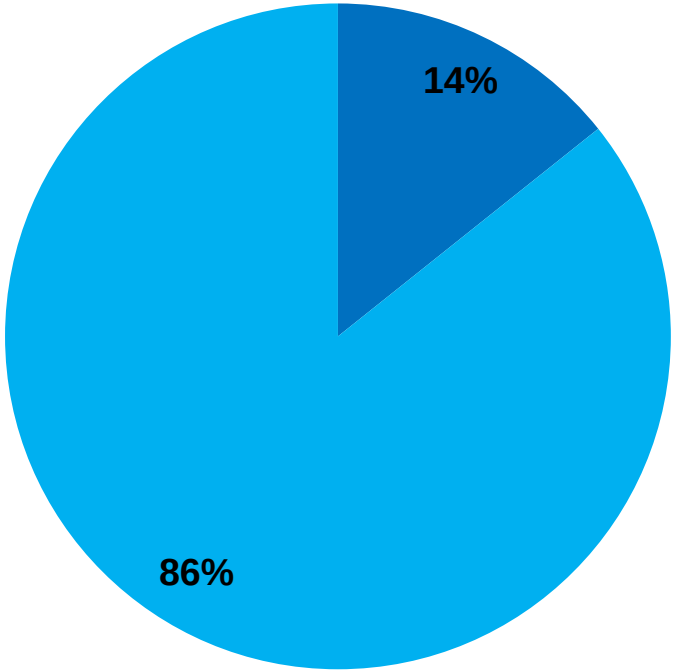
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

67. Is it appropriate to extrapolate data from ARAMIS, PROSPER, and SPARTAN to patients with nmCRPC (M0 CRPC) who have PSA doubling time >10 months?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	8	14
Option 2	48	86
Abstain	1	NA
Total votes	57	

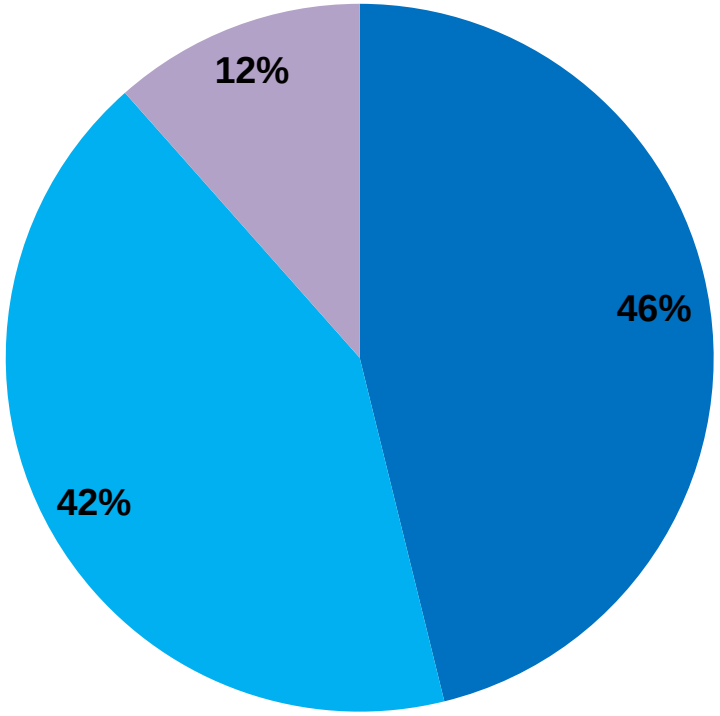
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

68. For patients with nmCRPC (M0 CRPC), an **untreated primary tumour**, and no evidence of disease outside the prostate, do you recommend radical (definitive) local therapy instead of systemic therapy if local disease is confirmed?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	24	46
Option 2	22	42
Option 3	6	12
Abstain	1	NA
Total votes	53	

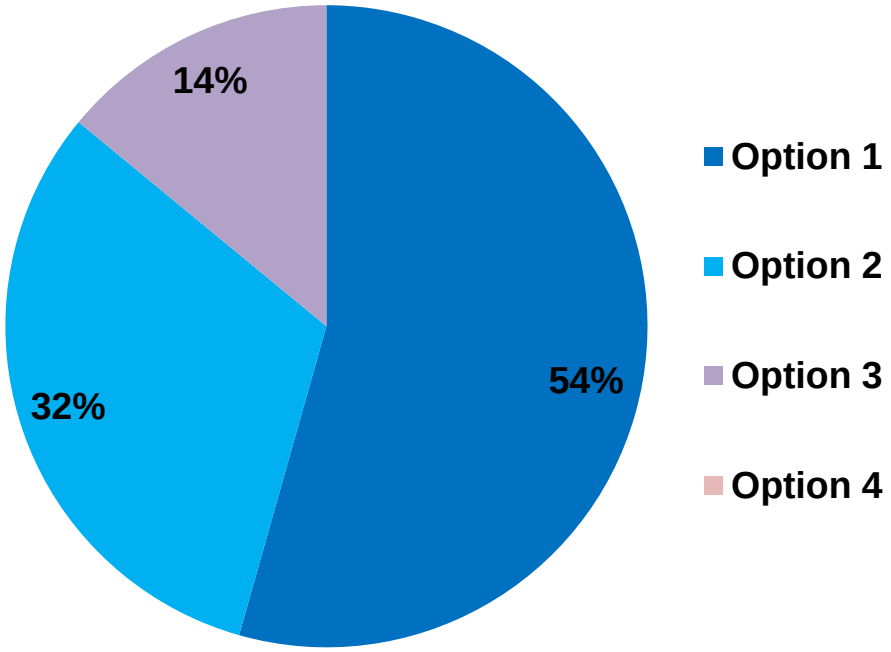
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

69. For patients with nmCRPC (M0 CRPC) and no evidence of disease outside the prostate bed who have received **previous radical prostatectomy but no prior local radiation therapy**, do you recommend salvage radiation therapy instead of systemic therapy if recurrence in the prostate bed is confirmed?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	31	54
Option 2	18	32
Option 3	8	14
Abstain	0	0
Total votes	57	

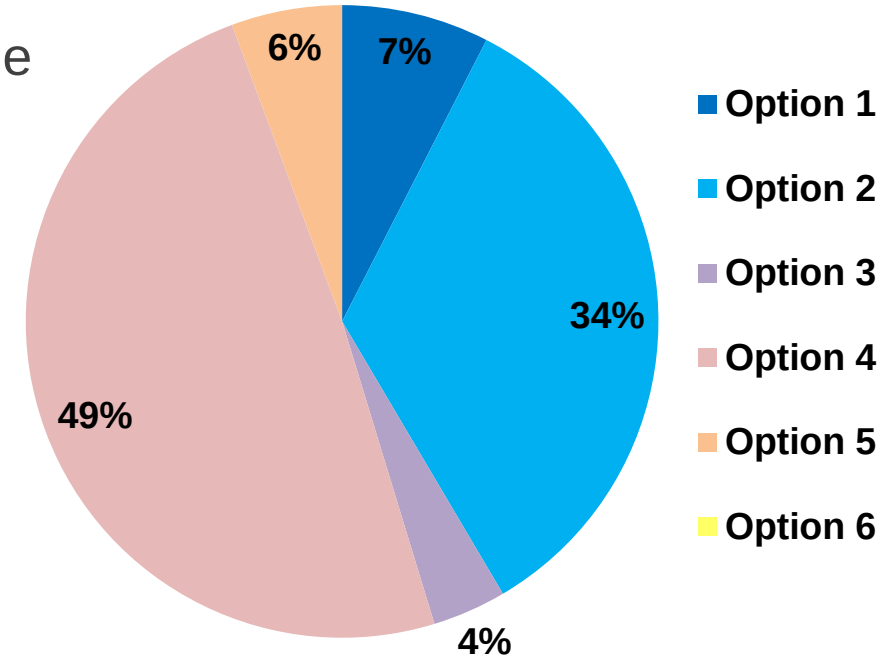
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

70. If you treat a patient with an AR pathway inhibitor (apalutamide or darolutamide or enzalutamide) for nmCRPC (M0 CRPC), when do you recommend changing treatment apart from ADT (excluding treatment changes for toxicity)?

1. PSA rise (as per PCWG3 criteria) alone
2. Occurrence of metastases alone
3. Symptomatic progression alone
4. Two out of the three criteria above
5. All three criteria
6. Abstain (including I do not give these treatments in this situation)



Option	Votes	Percent
Option 1	4	7
Option 2	18	34
Option 3	2	4
Option 4	26	49
Option 5	3	6
Abstain	4	NA
Total votes	57	

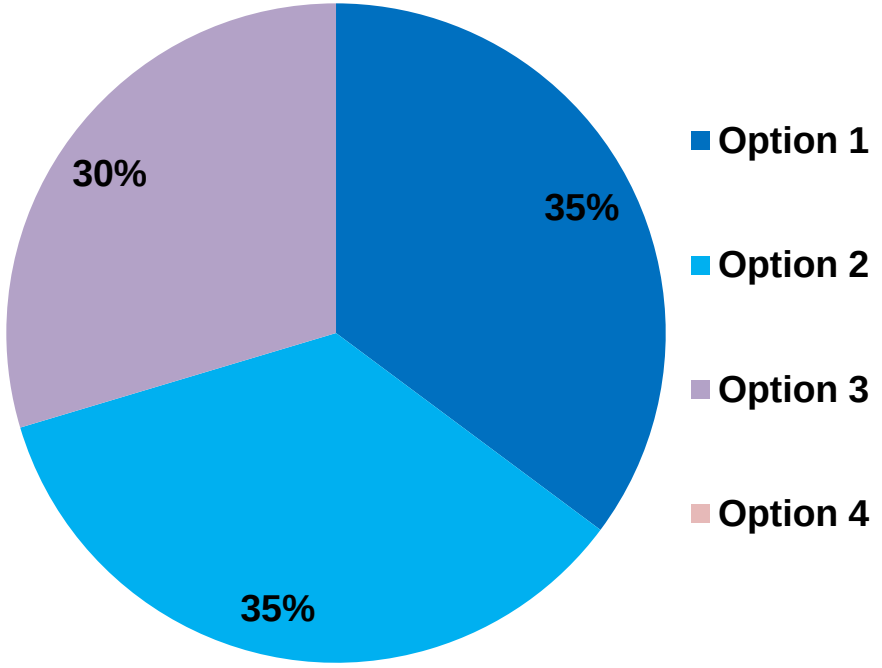
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE www.apccc.org

71. If you treat a patient with an AR pathway inhibitor (apalutamide or darolutamide or enzalutamide) for nmCRPC (M0 CRPC), what ongoing monitoring by imaging do you recommend for the majority of patients who are receiving AR pathway inhibitors?

1. Baseline imaging → monitor PSA alone → further imaging at progression
2. Baseline imaging → follow-up imaging at 6-12 months or at best response → monitor PSA alone → further imaging at progression
3. Baseline imaging → follow-up imaging every 3-6 months
4. Abstain



Option	Votes	Percent
Option 1	19	35
Option 2	19	35
Option 3	16	30
Abstain	2	NA
Total votes	56	

Published in European Urology 2020 open access:

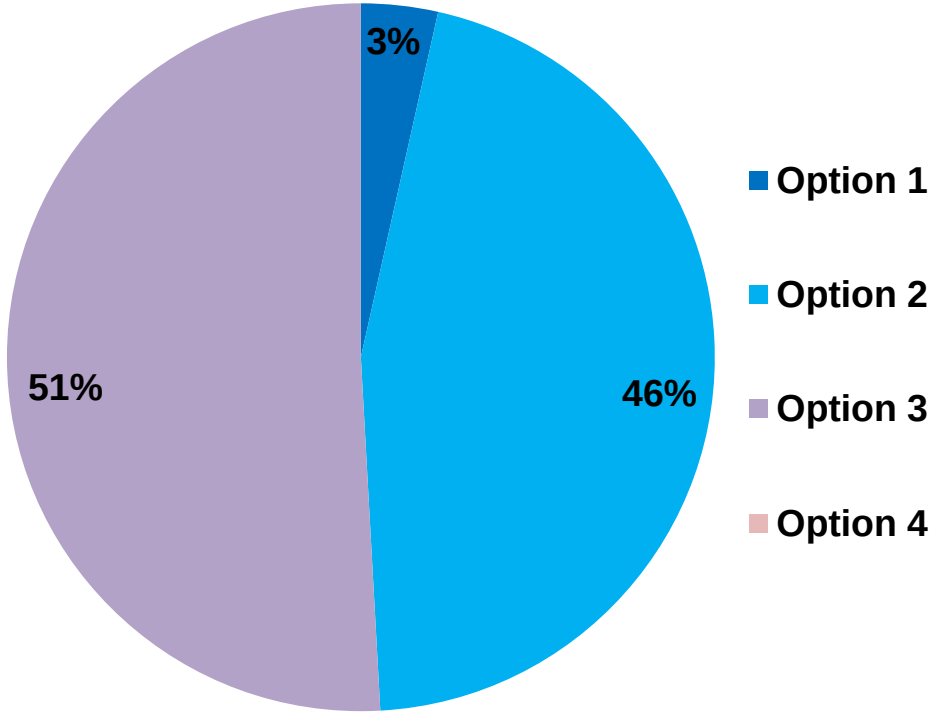
https://doi.org/10.1016/j.eururo.2020.01.012

6. Management of mCRPC

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

72. Do you recommend switching treatment for mCRPC at PSA progression alone (in the absence of other examinations)?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	2	3
Option 2	26	46
Option 3	29	51
Abstain	0	0
Total votes	57	

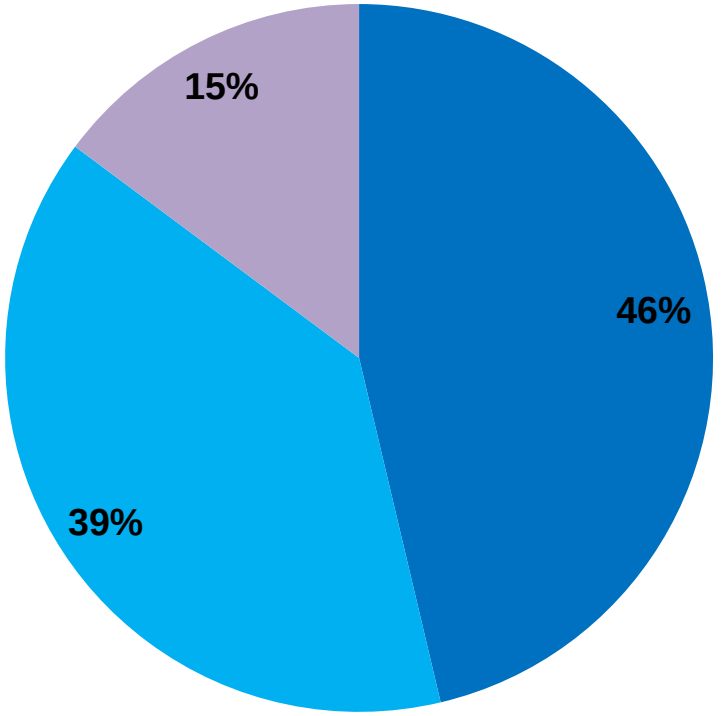
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

73. Do you recommend switching treatment for mCRPC in the case of unequivocal **progression on next-generation imaging** (wb-MRI, PET/CT with different tracers) alone (no PSA or clinical progression)?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	25	46
Option 2	21	39
Option 3	8	15
Abstain	1	NA
Total votes	55	

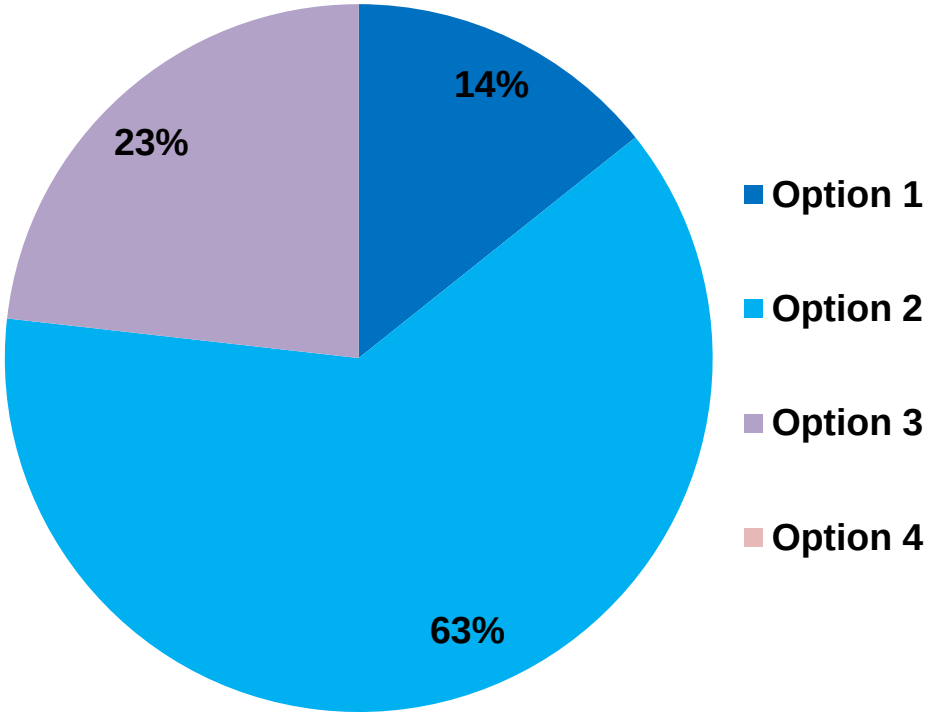
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

74. Do you recommend enzalutamide for patients **progressing on** treatment with abiraterone in cases where there are no regulatory limitations?

1. Yes, in the majority of patients
2. In a minority of selected patients (e.g. response ≥6 months to treatment with abiraterone)
3. No
4. Abstain



Option	Votes	Percent
Option 1	8	14
Option 2	35	63
Option 3	13	23
Abstain	0	0
Total votes	56	

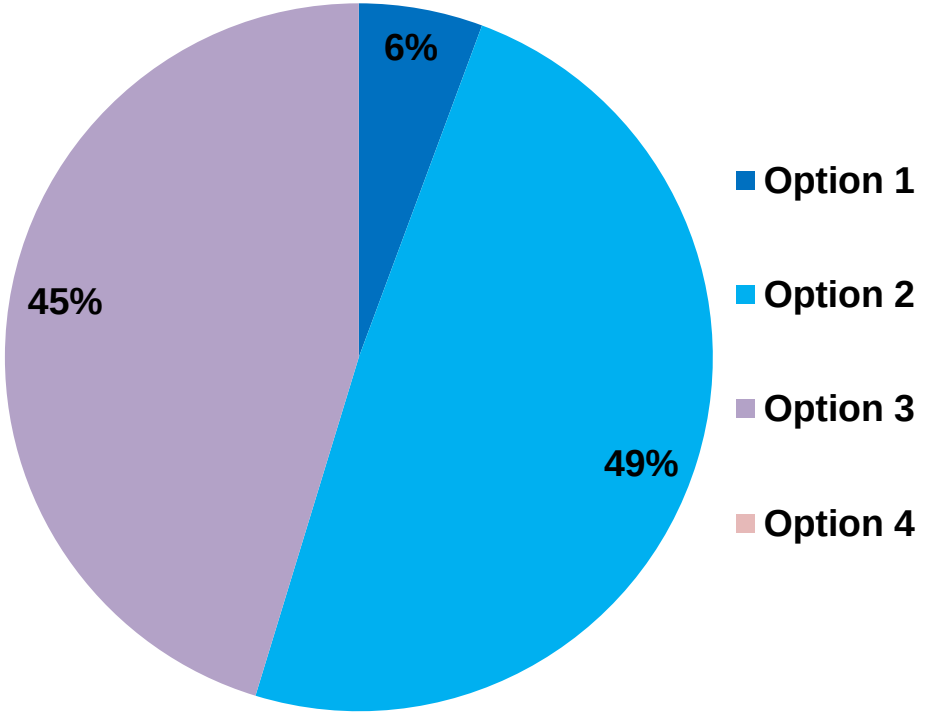
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

75. Do you recommend abiraterone for patients **progressing on** treatment with enzalutamide in cases where there are no regulatory limitations?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	3	6
Option 2	26	49
Option 3	24	45
Abstain	1	NA
Total votes	54	

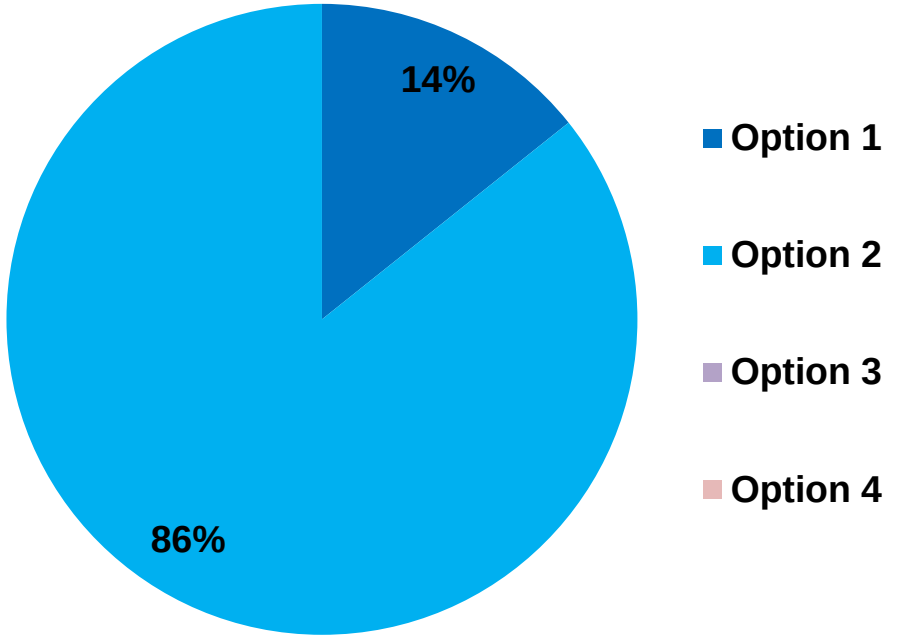
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

76. When discontinuing abiraterone or chemotherapy, what do you recommend regarding steroid therapy?

1. Stopping steroids at the last administration of abiraterone/chemotherapy
2. Taper steroids over a course of some weeks
3. Continuation of same dose of steroids
4. Abstain



Option	Votes	Percent
Option 1	8	14
Option 2	48	86
Option 3	0	0
Abstain	0	0
Total votes	56	

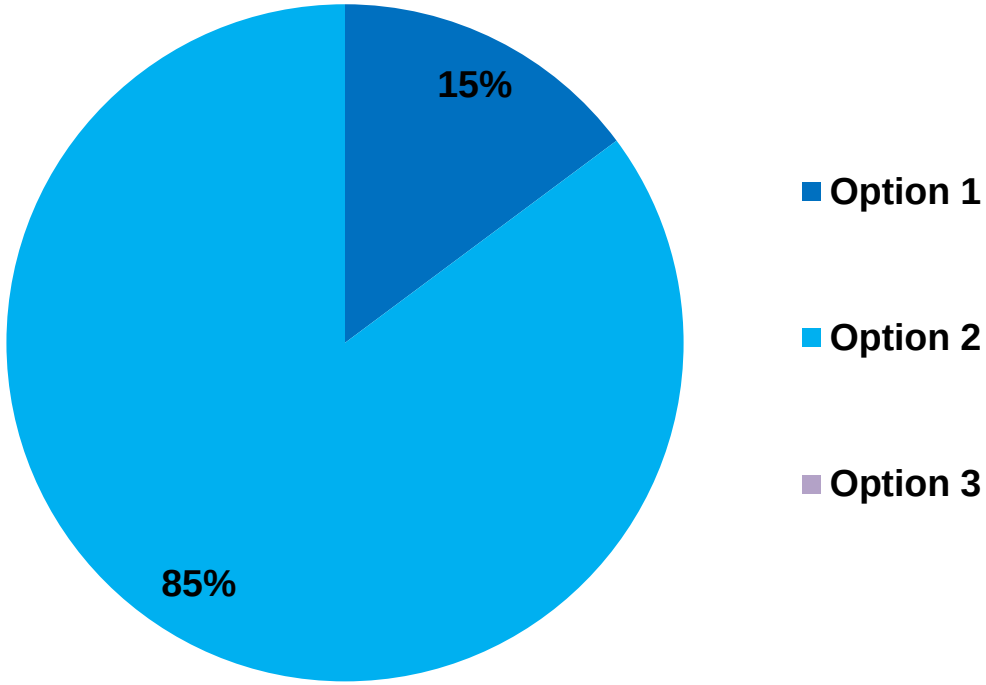
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

77. Do you recommend **AR-V7 testing** to select candidates for abiraterone after enzalutamide (or vice versa)?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	8	15
Option 2	46	85
Abstain	1	NA
Total votes	55	

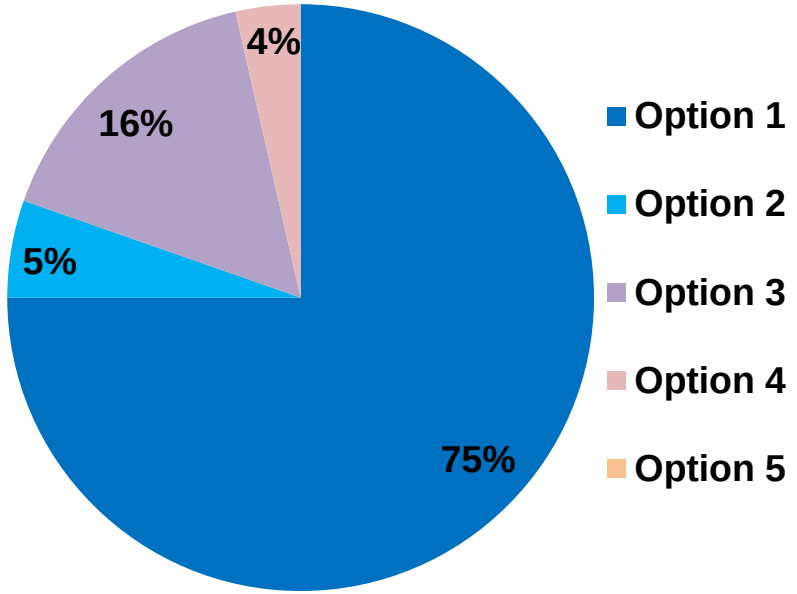
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

78. What glucocorticoid regimen do you recommend when starting abiraterone in patients with mCRPC?

1. Prednisone/prednisolone at 5mg twice daily
2. Prednisone/prednisolone at 10mg once daily
3. Prednisone/prednisolone at 5mg once daily
4. Dexamethasone at 0.5mg to 1mg once daily
5. Abstain



Option	Votes	Percent
Option 1	42	75
Option 2	3	5
Option 3	9	16
Option 4	2	4
Abstain	0	0
Total votes	56	

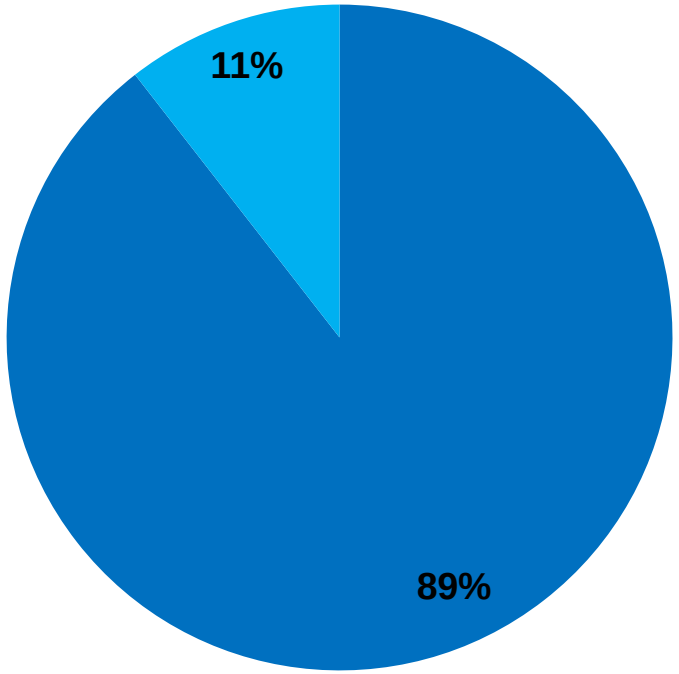
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

79. For patients with metastatic prostate cancer in the context of limited resources (patient or system), is it appropriate to prescribe a lower dose of abiraterone (250mg) given with food?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	51	89
Option 2	6	11
Abstain	0	0
Total votes	57	

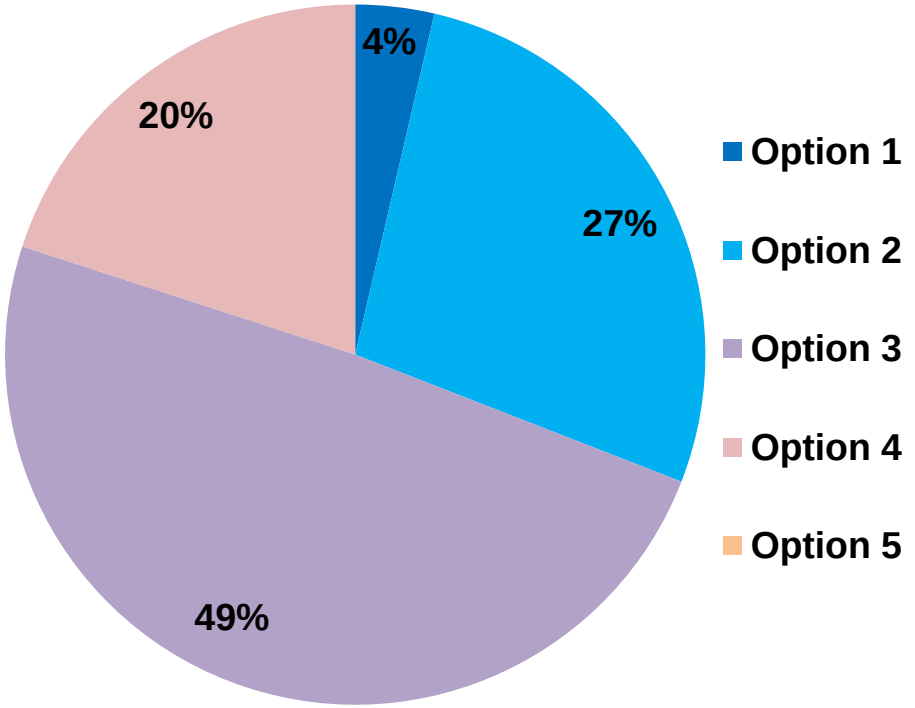
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

80. Is there a role for the use of bicalutamide as sole additional therapy to ADT in patients with mCRPC?

1. Yes, routinely in the majority of patients
2. In a minority of selected patients
3. Only in the context of limited resources
4. No
5. Abstain



Option	Votes	Percent
Option 1	2	4
Option 2	15	27
Option 3	27	49
Option 4	11	20
Abstain	0	0
Total votes	55	

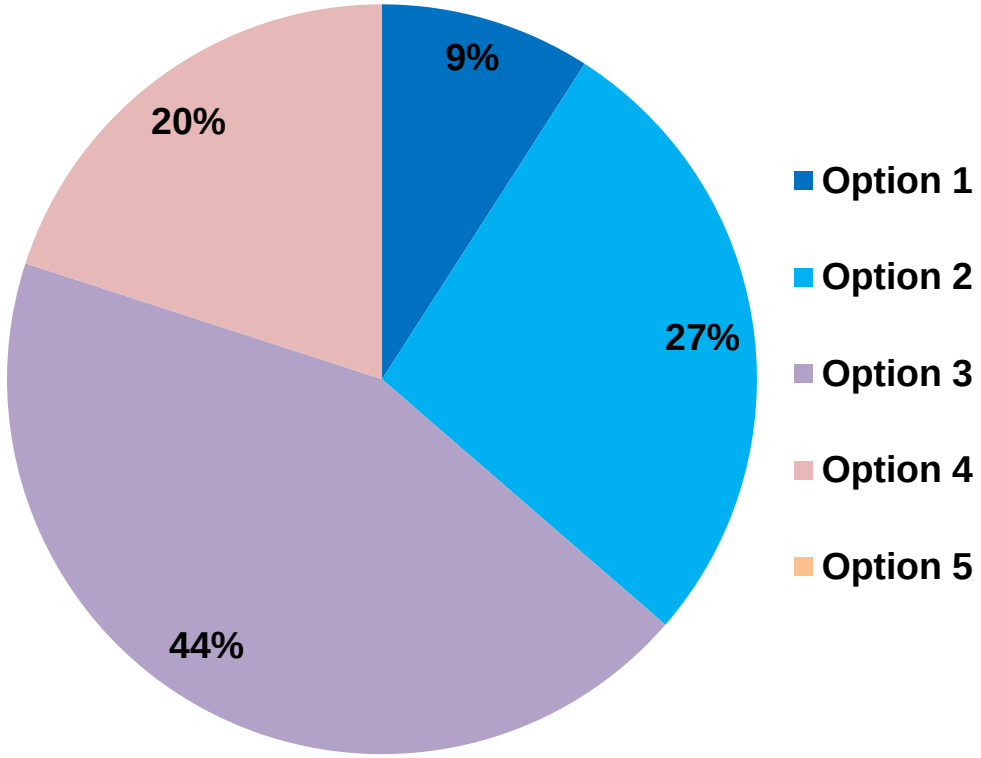
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

81. Is there a role for the use of low-dose dexamethasone as sole additional therapy to ADT in patients with mCRPC?

1. Yes, routinely in the majority of patients
2. In a minority of selected patients
3. Only in the context of limited resources
4. No
5. Abstain



Option	Votes	Percent
Option 1	5	9
Option 2	15	27
Option 3	24	44
Option 4	11	20
Abstain	1	NA
Total votes	56	

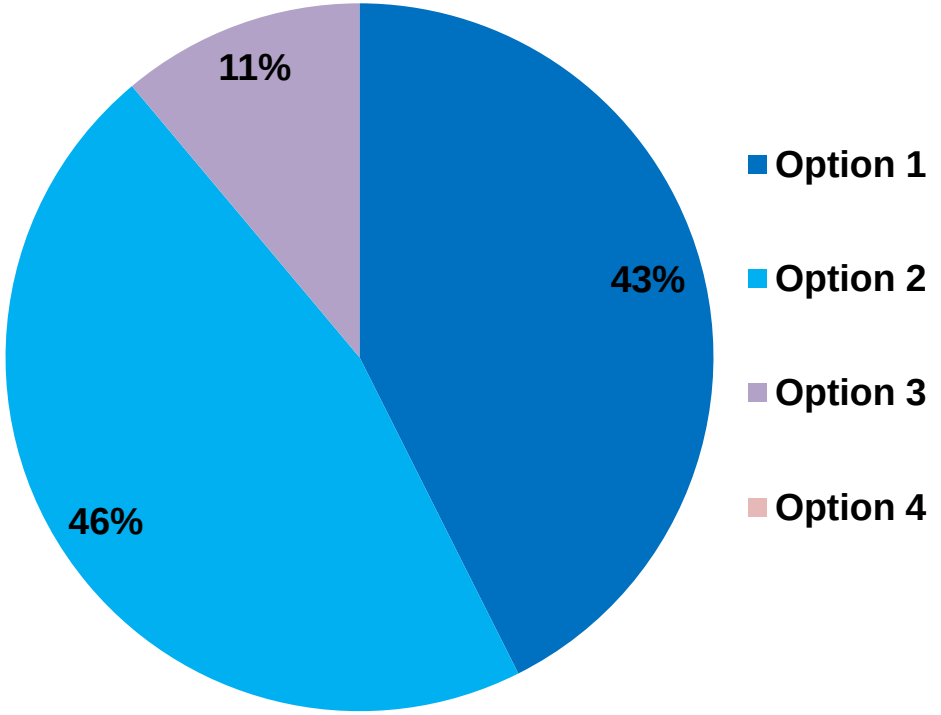
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

82. Do you recommend Lutetium-PSMA therapy for patients with PSMA imaging-positive mCRPC who have **exhausted approved treatments** and cannot enrol in a clinical trial?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	23	43
Option 2	25	46
Option 3	6	11
Abstain	1	NA
Total votes	55	

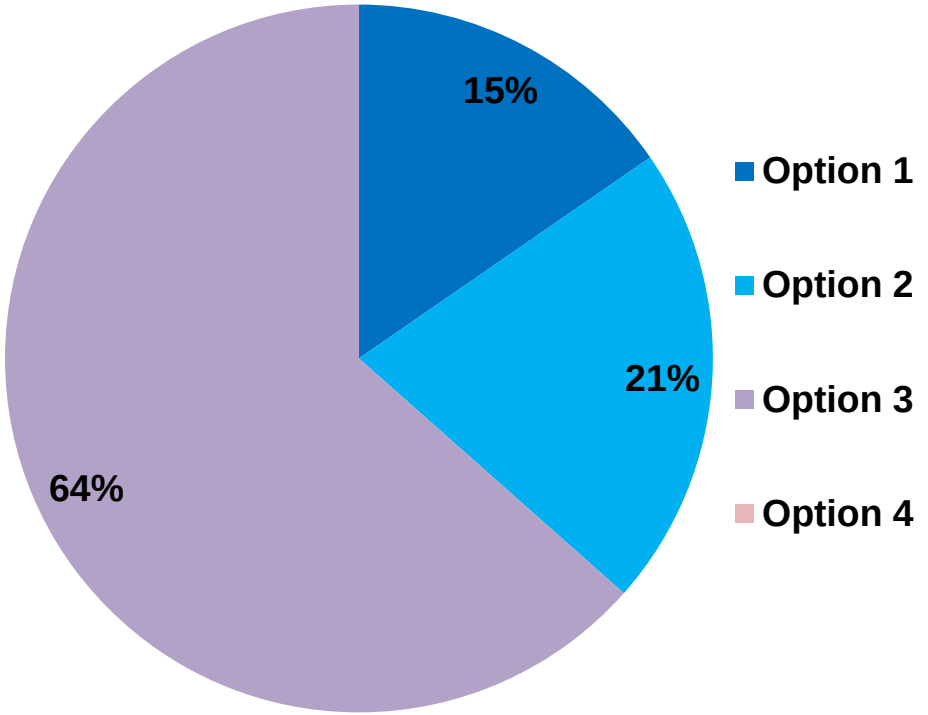
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

83. Which imaging do you recommend to select patients for Lutetium-PSMA therapy?

1. PSMA PET/CT alone
2. PSMA PET/CT plus standard imaging
3. PSMA PET/CT plus FDG PET/CT plus/minus standard imaging
4. Abstain



Option	Votes	Percent
Option 1	8	15
Option 2	11	21
Option 3	33	64
Abstain	3	NA
Total votes	55	

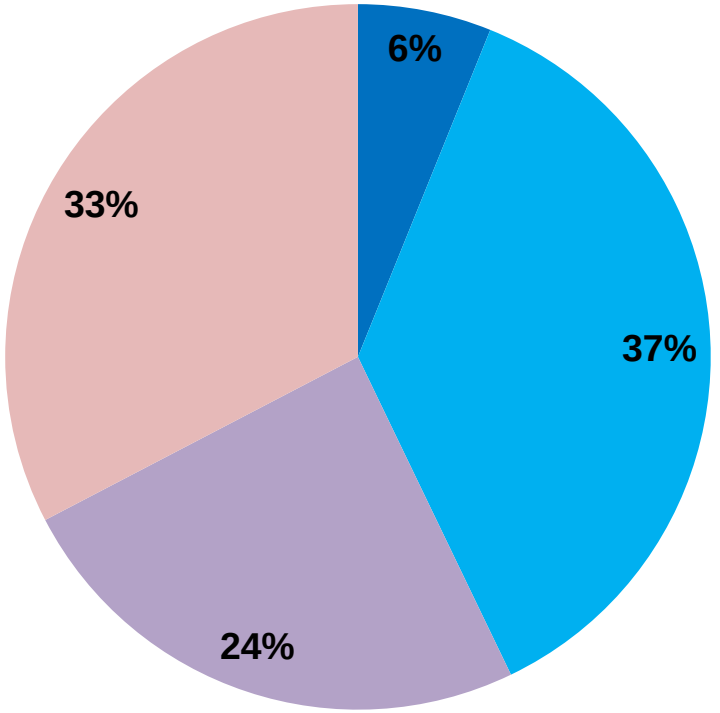
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

84. Which imaging do you recommend for monitoring response to Lutetium-PSMA therapy?

1. Standard imaging alone
2. PSMA PET/CT alone
3. PSMA PET/CT plus standard imaging
4. PSMA PET/CT plus FDG PET/CT plus/minus standard imaging
5. Abstain



Option	Votes	Percent
Option 1	3	6
Option 2	18	37
Option 3	12	24
Option 4	16	33
Abstain	5	NA
Total votes	54	

Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

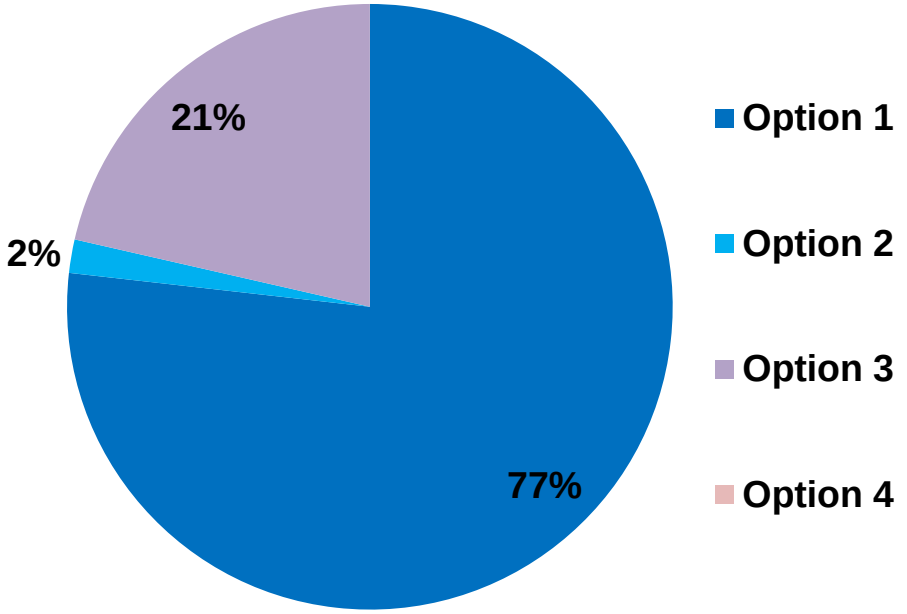
APCCC
ADVANCED PROSTATE CANCER
CONSENSUS CONFERENCE
www.apccc.org

7. Bone and bone metastases

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

85. Do you routinely screen for **osteoporosis risk factors** (e.g. current/history of smoking, corticosteroids, family history of hip fracture, personal history of fractures, rheumatoid arthritis, >3 alcohol units/day, BMI) in patients with prostate cancer starting on long-term ADT?

1. Yes, in the majority of patients
2. Only in patients with bone-metastatic disease
3. No
4. Abstain



Option	Votes	Percent
Option 1	43	77
Option 2	1	2
Option 3	12	21
Option 4	0	0
Total votes	56	

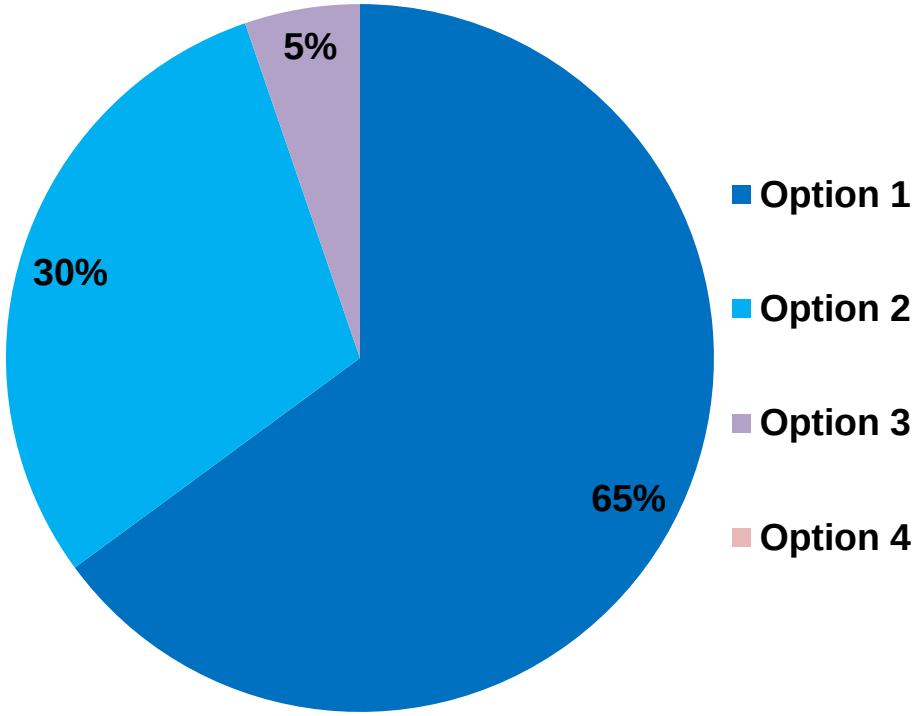
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

86. Do you routinely recommend measurement of bone mineral density in patients with prostate cancer starting on long-term ADT?

1. Yes, in the majority of patients
2. Only in patients with risk factors
3. No
4. Abstain



Option	Votes	Percent
Option 1	37	65
Option 2	17	30
Option 3	3	5
Abstain	0	0
Total votes	57	

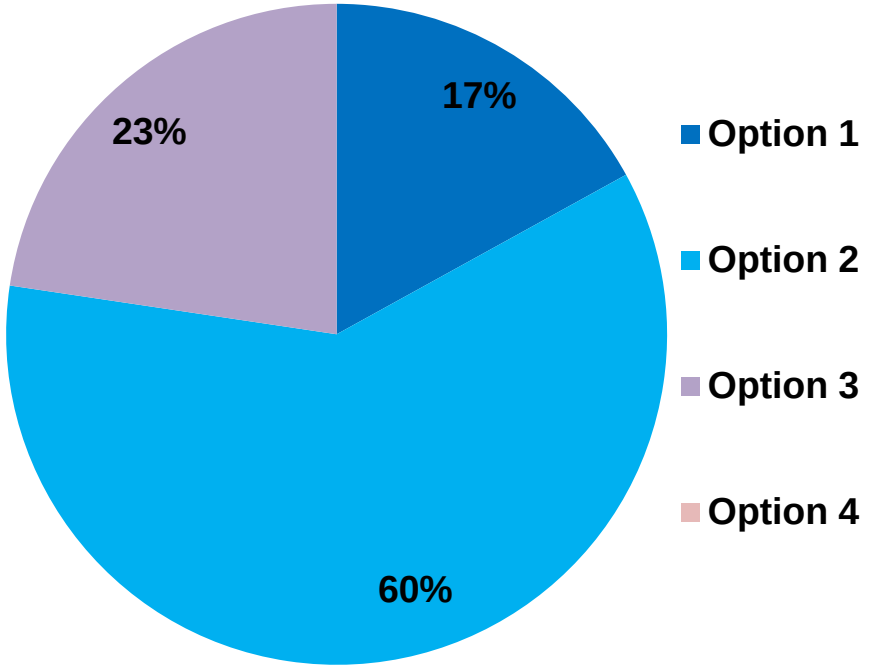
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

87. Is it appropriate to **start an osteoclast-targeted therapy** at the dose and schedule used for osteoporosis in order to prevent cancer treatment-induced bone loss (CTIBL)/fractures in patients with prostate cancer starting on long-term ADT **without a bone mineral density measurement**?

1. Yes, in the majority of patients
2. Only in patients with an increased risk of fractures (e.g. 10-year FRAX risk of ≥3% for hip fractures and/or ≥20% for all major fractures)
3. No
4. Abstain



Option	Votes	Percent
Option 1	9	17
Option 2	32	60
Option 3	12	23
Abstain	0	0
Total votes	53	

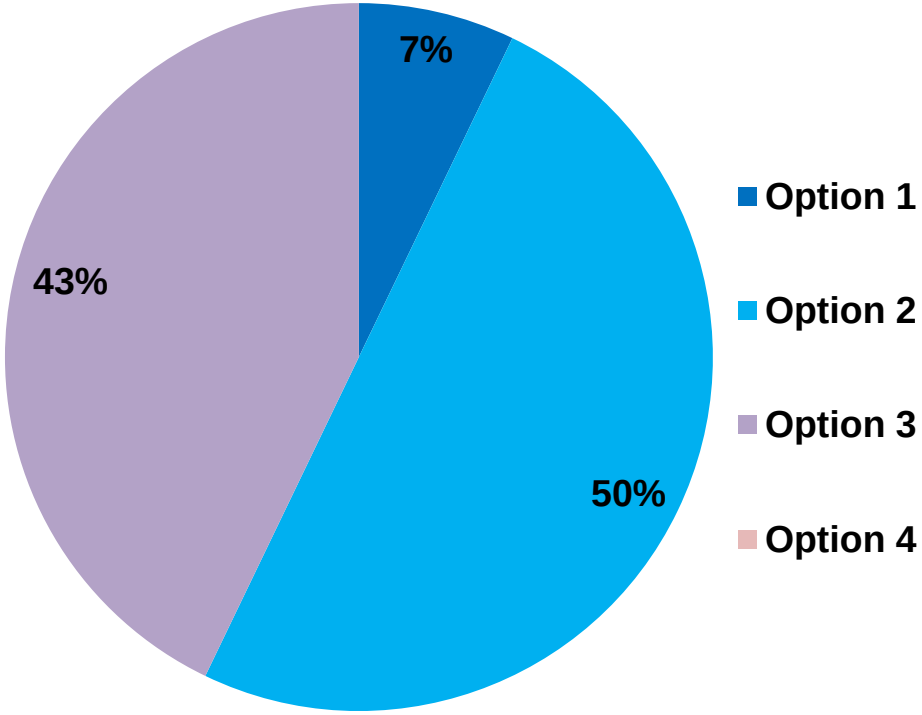
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

88. For prostate cancer patients starting on long-term ADT who have **NO documented osteoporosis on bone mineral density measurement**, do you routinely recommend initiating denosumab or a bisphosphonate at the dose and schedule used for osteoporosis, in order to prevent cancer treatment-induced bone loss (CTIBL)/ fractures?

1. Yes, in the majority of patients
2. Only in patients with an increased risk of fractures (e.g. 10-year FRAX risk of ≥3% for hip fractures and/or ≥20% for all major fractures)
3. No
4. Abstain



Option	Votes	Percent
Option 1	4	7
Option 2	28	50
Option 3	24	43
Abstain	0	0
Total votes	56	

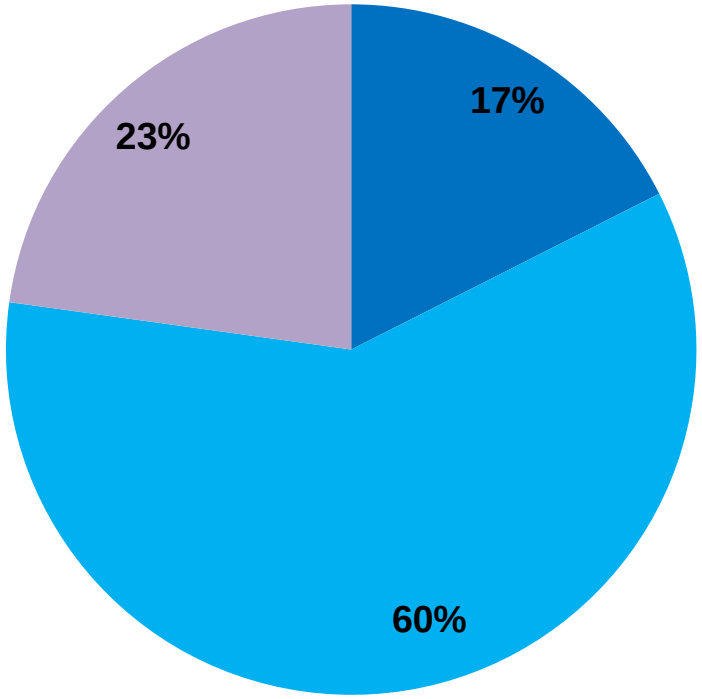
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

89. For patients starting on long-term ADT **plus abiraterone/prednisone** who have **NO** documented osteoporosis, do you routinely recommend initiating denosumab or a bisphosphonate at the dose and schedule used for osteoporosis, in order to prevent cancer treatment-induced bone loss (CTIBL)/ fractures?

1. Yes, in the majority of patients
2. Only in patients with an increased risk of fractures (e.g. 10-year FRAX risk of ≥3% for hip fractures and/or ≥20% for all major fractures)
3. No
4. Abstain



Option	Votes	Percent
Option 1	10	17
Option 2	34	60
Option 3	13	23
Abstain	0	0
Total votes	57	

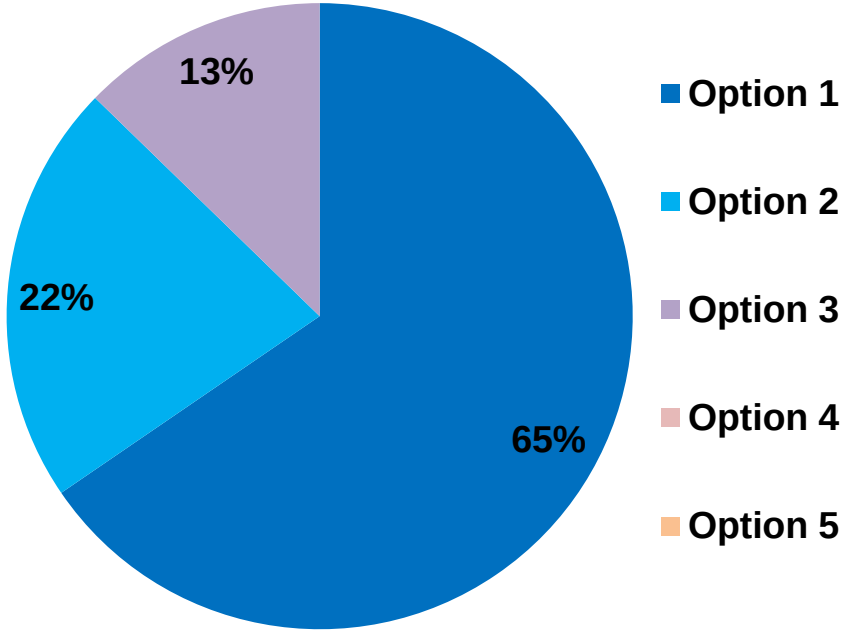
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

90. Do you recommend osteoclast-targeted therapy (zoledronic acid or denosumab) at the higher dose and more frequent schedule used for reducing the risk of SRE (skeletal-related events) in patients with CRPC and bone metastases?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No, dose and schedule for osteoporosis are sufficient
4. No, I do not recommend osteoclast-targeted therapy in these patients
5. Abstain



Option	Votes	Percent
Option 1	36	65
Option 2	12	22
Option 3	7	13
Option 4	0	0
Abstain	1	NA
Total votes	56	

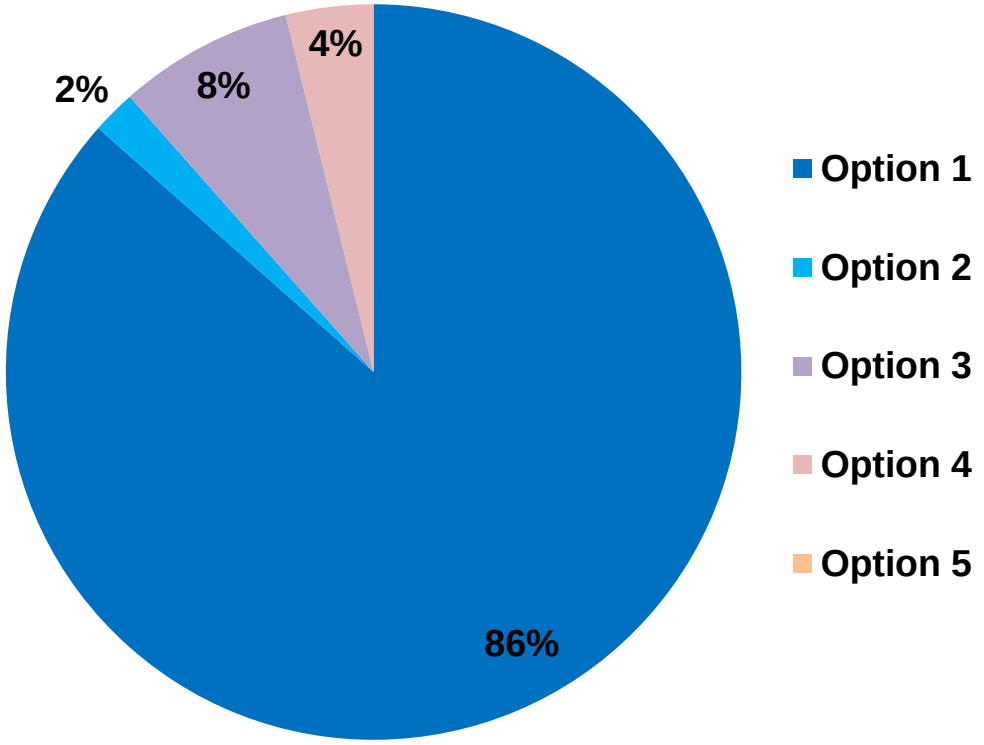
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

91. When treatment with radium-223 is planned in patients with mCRPC, do you recommend osteoclast-targeted therapy at the higher dose and more frequent used for reducing the risk of SRE?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No, dose and schedule for osteoporosis are sufficient
4. No, I do not recommend osteoclast-targeted therapy in these patients
5. Abstain



Option	Votes	Percent
Option 1	45	86
Option 2	1	2
Option 3	4	8
Option 4	2	4
Abstain	4	NA
Total votes	56	

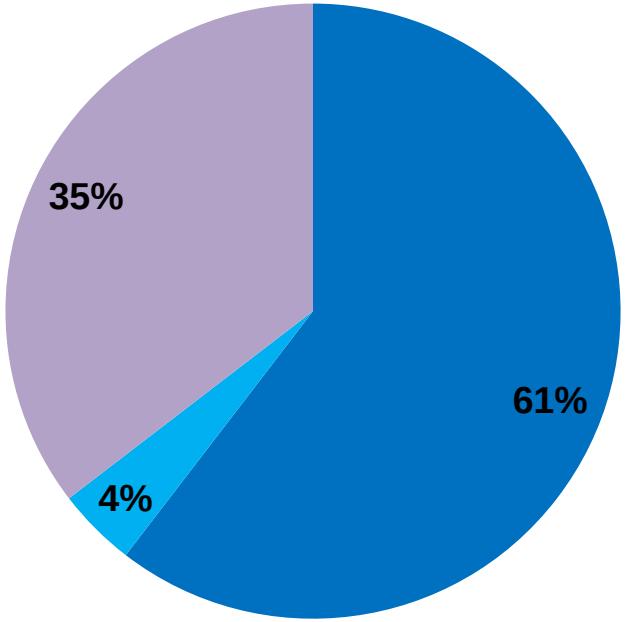
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

92. When you use osteoclast-targeted therapy at the higher dose and more frequent used for reducing the risk of SRE in patients with mCRPC and bone metastases, what treatment duration do you recommend?

1. Approximately 2 years and then stop
2. Approximately 5 years and then stop
3. Indefinitely
4. Abstain



Option	Votes	Percent
Option 1	29	60
Option 2	2	4
Option 3	17	35
Abstain	8	NA
Total votes	56	

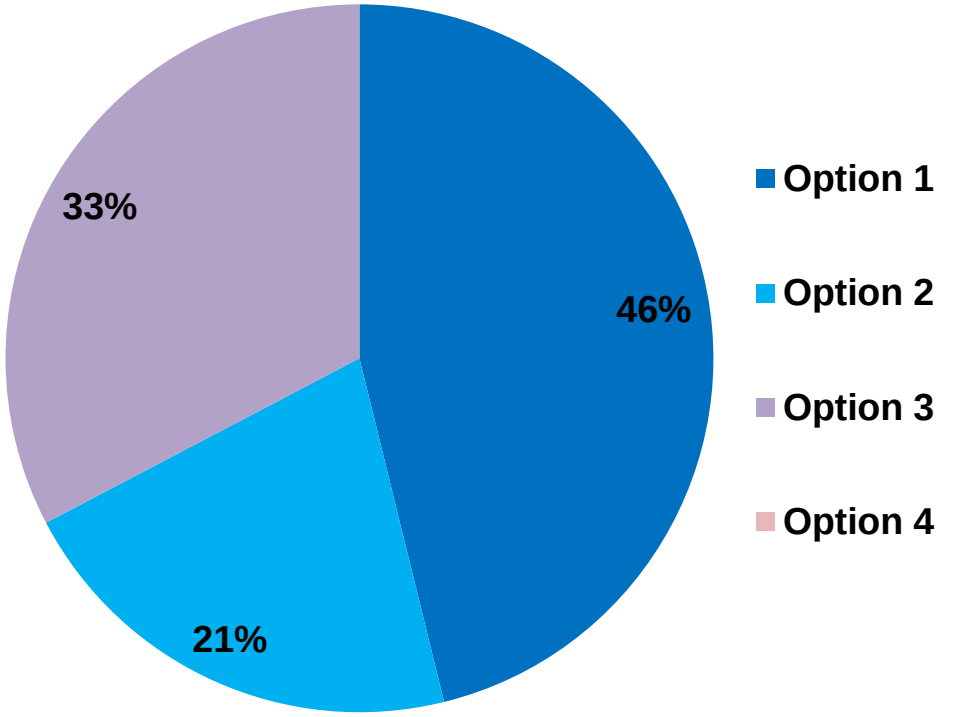
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

93. When you use osteoclast-targeted therapy at the dose and schedule used for reducing the risk of SRE in patients with mCRPC and bone metastases, what treatment frequency do you recommend?

1. Every 4 weeks
2. Every 4 weeks for the first two years and then reduce frequency
3. Every 12 weeks
4. Abstain



Option	Votes	Percent
Option 1	24	46
Option 2	11	21
Option 3	17	33
Abstain	4	NA
Total votes	56	

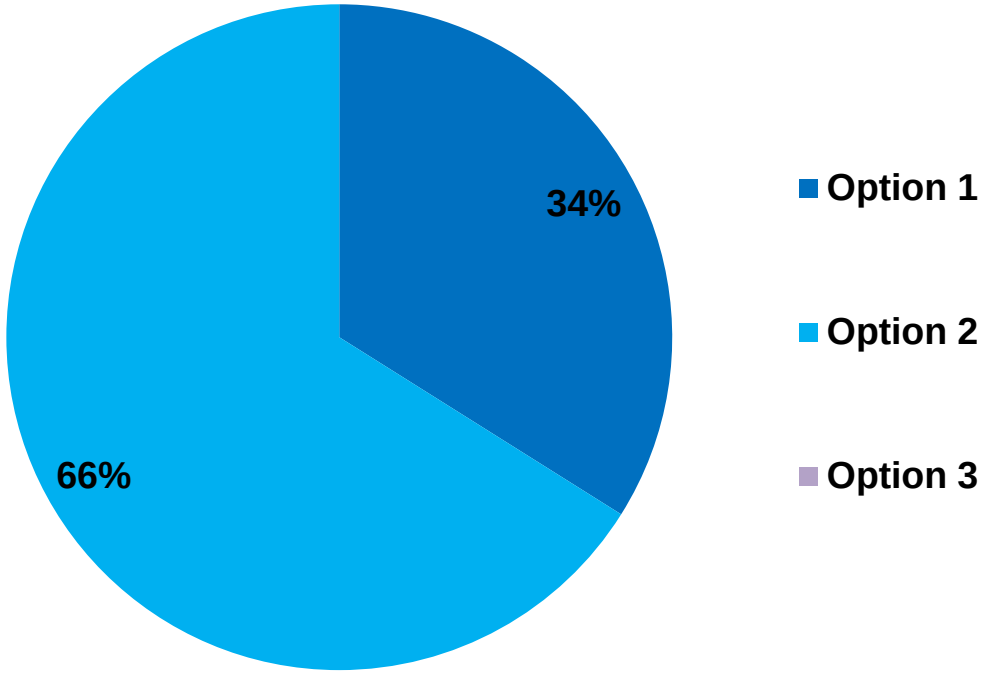
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

94. Do you support the statement that mCRPC patients should receive radium-223 only after receiving two prior treatments for mCRPC or if they cannot receive other treatments?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	19	34
Option 2	37	66
Abstain	0	0
Total votes	56	

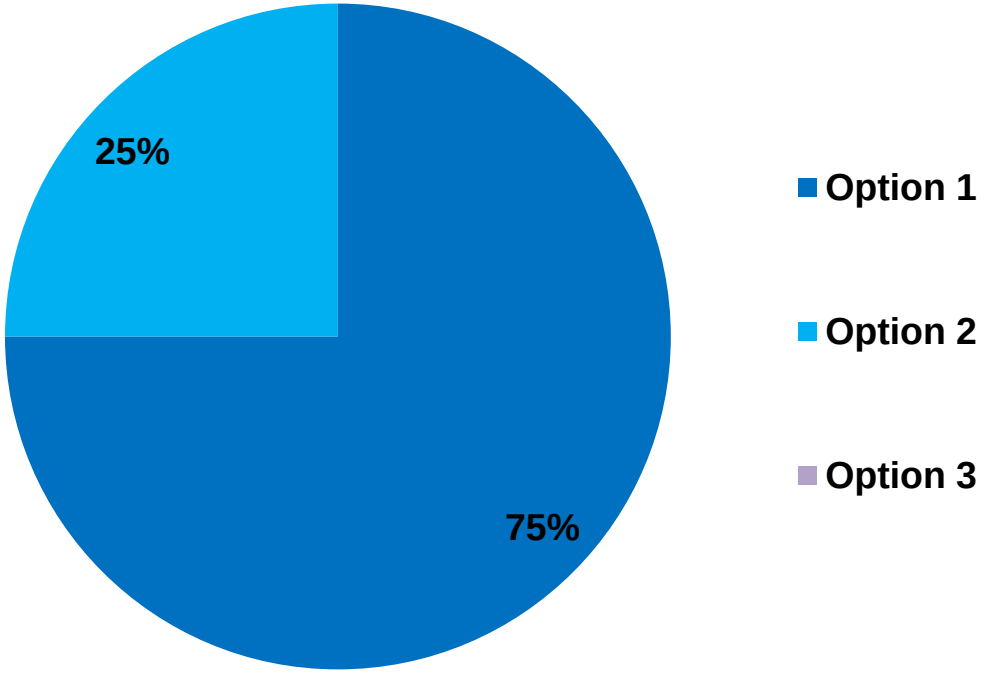
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

95. Do you recommend that the majority of patients with mCRPC receive cabazitaxel sometime during their disease course?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	42	75
Option 2	14	25
Abstain	0	0
Total votes	56	

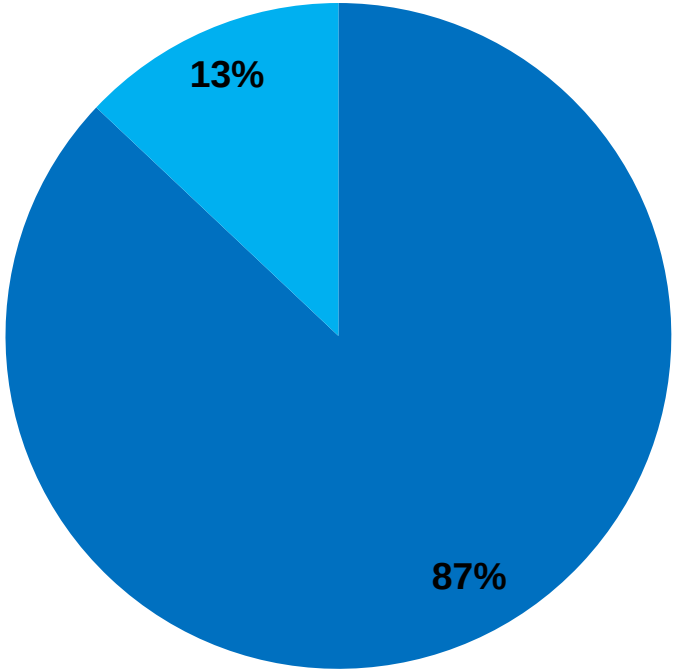
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

96. Do you recommend that the majority of symptomatic patients with mCRPC and predominant bone metastases (without visceral disease and bulky lymph node disease) receive radium-223 sometime during their disease course?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	47	87
Option 2	7	13
Abstain	2	NA
Total votes	56	

Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

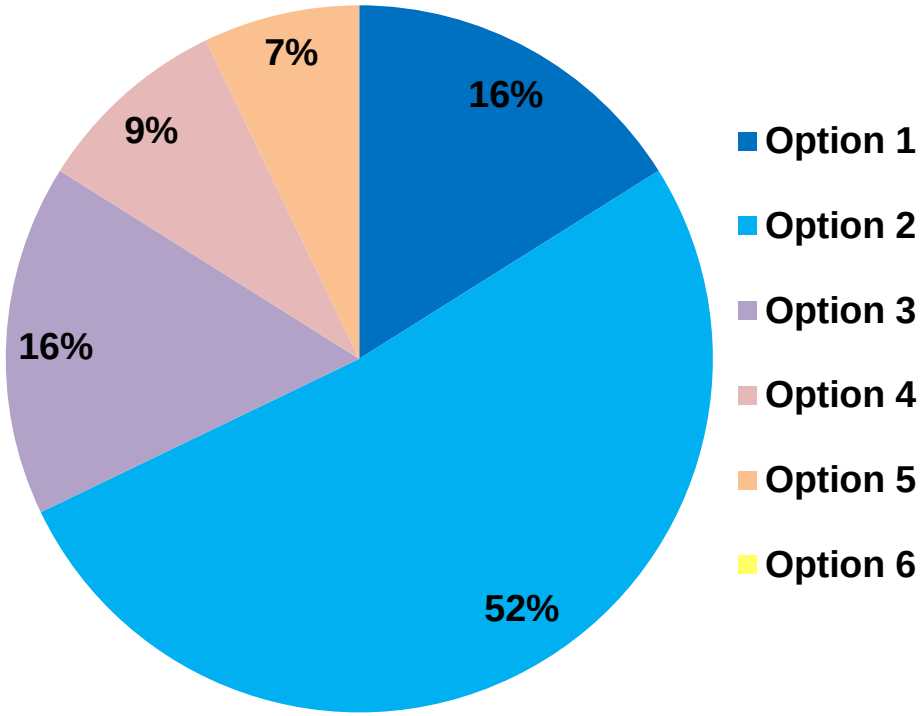
8. Molecular characterization: Tissue and blood

8.1 Tumour genomic testing

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

97. When do you first recommend **tumour** genomic testing?

1. At diagnosis of high-risk localized disease
2. At first diagnosis of metastatic disease
3. After at least one line of chemotherapy and at least one AR pathway inhibitor
4. After all standard treatment options are exhausted
5. I do not routinely recommend tumour genomic testing
6. Abstain



Option	Votes	Percent
Option 1	9	16
Option 2	29	52
Option 3	9	16
Option 4	5	9
Option 5	4	7
Abstain	1	NA
Total votes	57	

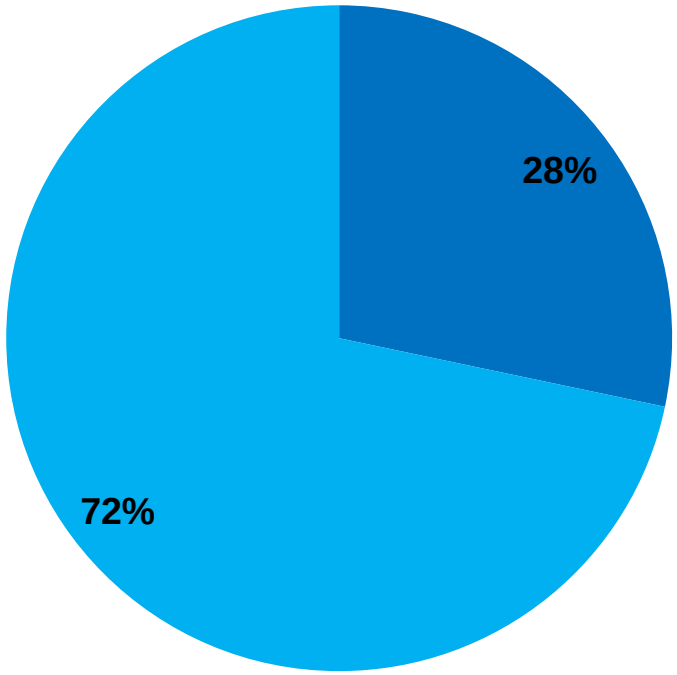
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

98. If you recommend **tumour** genomic testing, which tests do you consider **relevant** in patients with metastatic prostate cancer outside of a clinical trial?

1. DNA repair defects, including mismatch repair evaluation (MSI high)
2. Prostate cancer-specific larger panel testing, including for example homologous recombination deficiency (BRCA1, BRCA2, PALB2, RAD51), PTEN, PI3K, SPOP, CDK12, ATM, mismatch repair evaluation (MSI high), tumour mutation burden
3. Abstain



Option	Votes	Percent
Option 1	15	28
Option 2	38	72
Abstain	3	NA
Total votes	56	

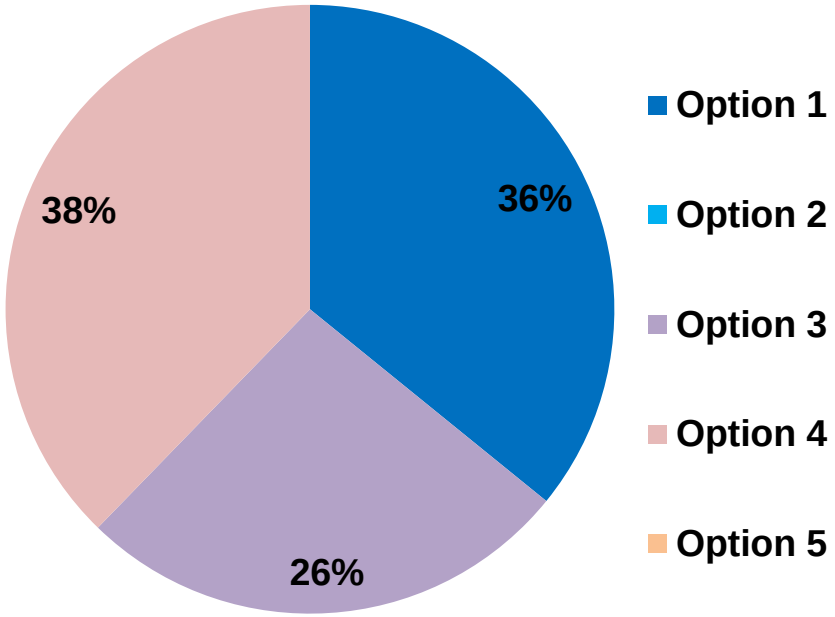
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

99. Does the presence of a **tumour** BRCA1/2 aberration in patients with **intermediate or high-risk localized prostate cancer** influence your treatment decision?

1. Yes, I recommend radical prostatectomy over radiation therapy
2. Yes, I recommend radiation therapy over radical prostatectomy
3. No, I make the standard treatment recommendation
4. No, I make the standard treatment recommendation but more intense monitoring
5. Abstain



Option	Votes	Percent
Option 1	19	36
Option 2	0	0
Option 3	14	26
Option 4	20	38
Abstain	2	NA
Total votes	55	

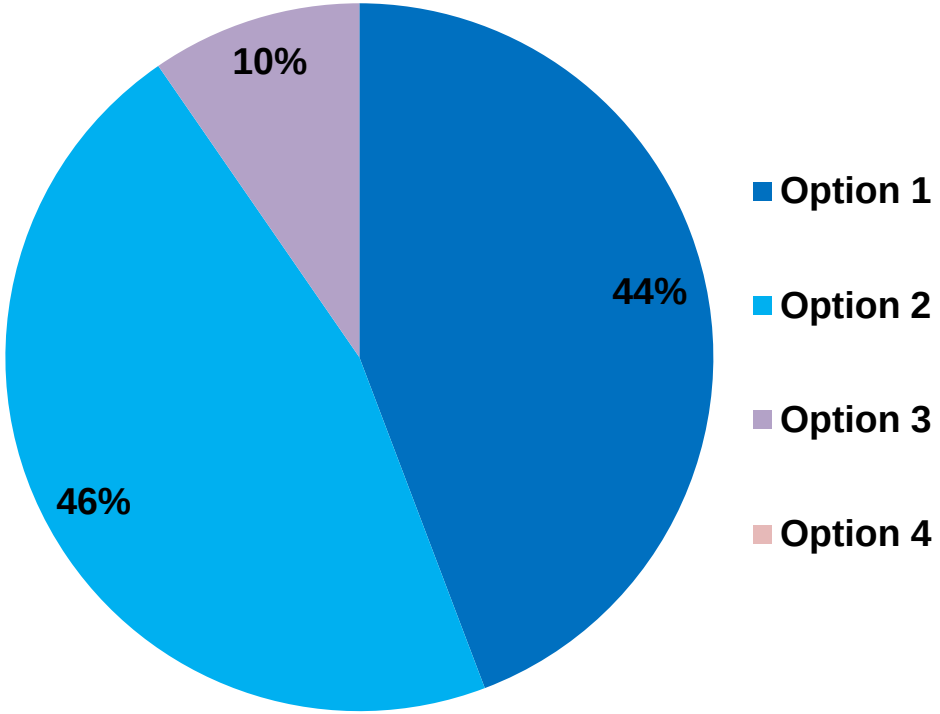
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

100. Do you recommend that the **majority** of metastatic prostate cancer patients get their **tumours** tested for **BRCA1/2** aberrations?

1. Yes
2. Yes, but only metastatic castration-resistant patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	23	44
Option 2	24	46
Option 3	5	10
Abstain	4	NA
Total votes	56	

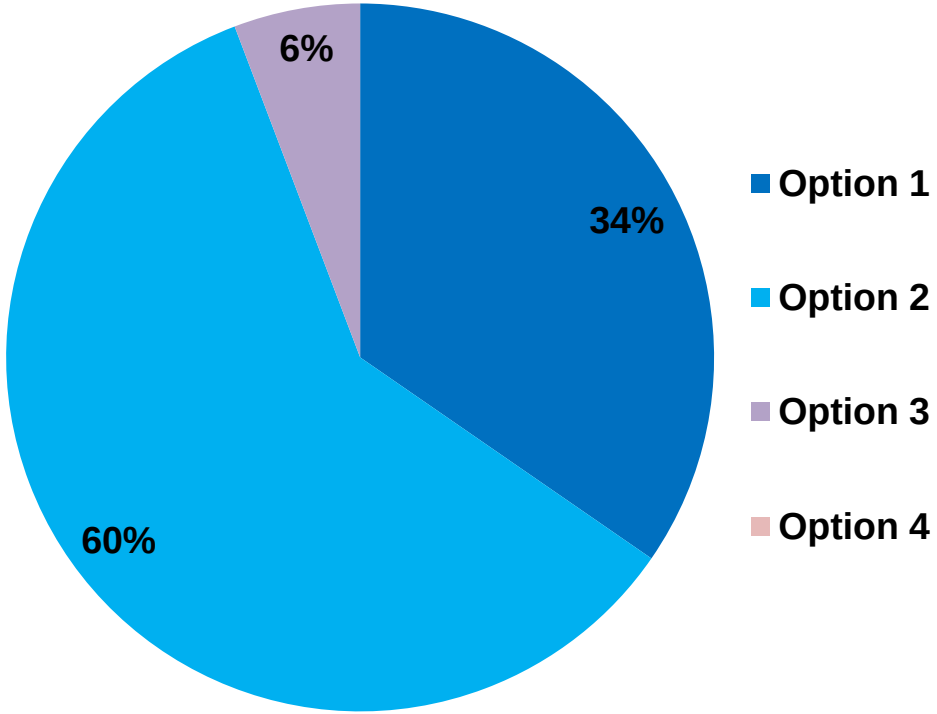
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

101. Do you recommend that the **majority** of metastatic prostate cancer patients get their **tumours** tested for **mismatch repair defects (MSI high)**?

1. Yes
2. Yes, but only metastatic castration-resistant patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	18	34
Option 2	31	60
Option 3	3	6
Abstain	4	NA
Total votes	56	

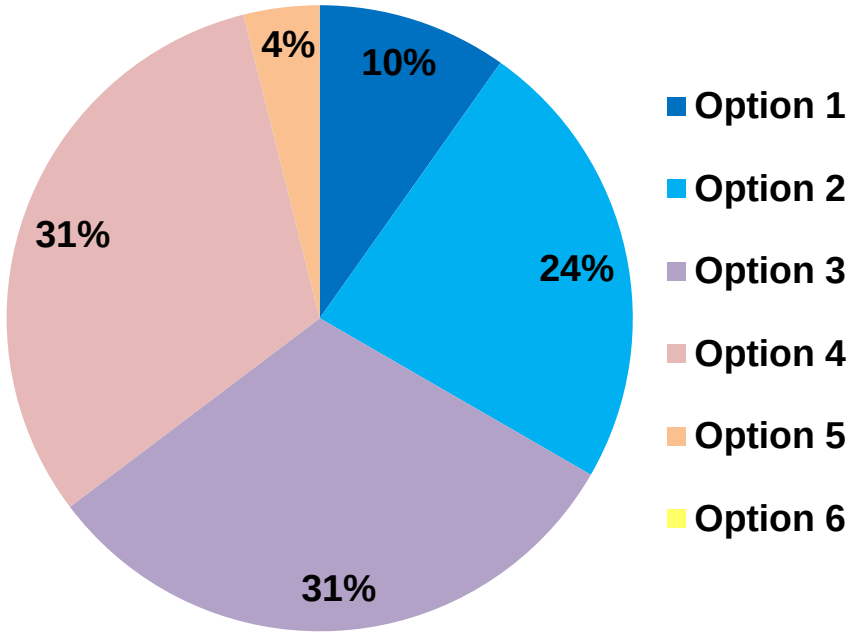
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

102. Do you recommend anti-PD1 therapy for patients with metastatic prostate cancer and a **mismatch repair defect (MSI high)** outside of a clinical trial?

1. Yes, at first diagnosis of metastatic disease, at start of ADT
2. Yes, after progression on ADT (first-line mCRPC)
3. Yes, after at least one line of chemotherapy and at least one AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
4. Only after all standard treatment options are exhausted
5. No, I do not recommend an anti-PD1 therapy for these patients
6. Abstain



Option	Votes	Percent
Option 1	5	10
Option 2	12	24
Option 3	16	31
Option 4	16	31
Option 5	2	4
Abstain	4	NA
Total votes	55	

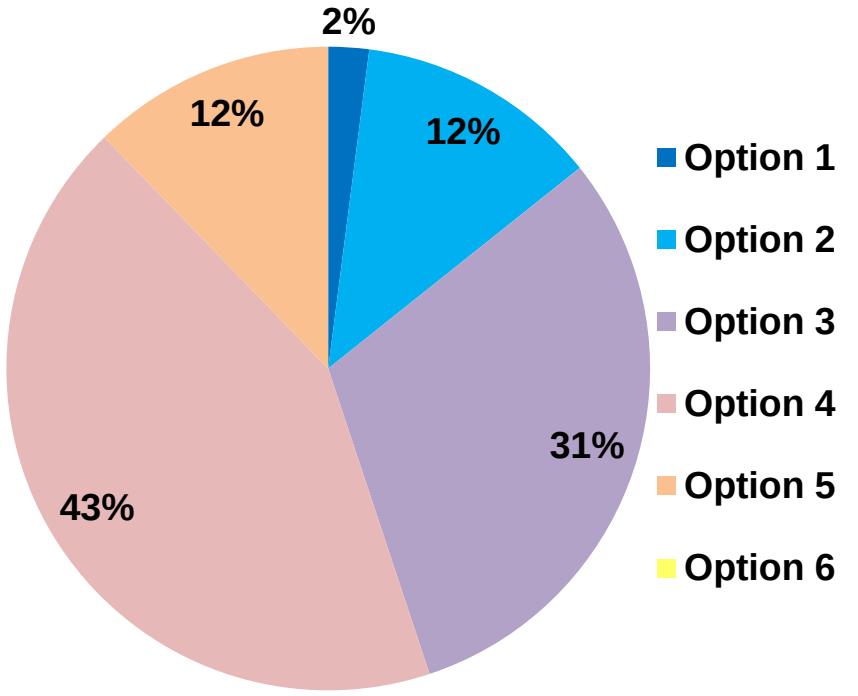
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

103. Do you recommend anti-PD1 therapy for patients with metastatic prostate cancer and biallelic CDK12 loss outside of a clinical trial?

1. Yes, at first diagnosis of metastatic disease, at start of ADT
2. Yes, after progression on ADT (first-line mCRPC)
3. Yes, after at least one line of chemotherapy and at least one AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
4. Only after all standard treatment options are exhausted
5. No, I do not recommend an anti-PD1 therapy for these patients
6. Abstain



Option	Votes	Percent
Option 1	1	2
Option 2	6	12
Option 3	15	31
Option 4	21	43
Option 5	6	12
Abstain	6	NA
Total votes	55	

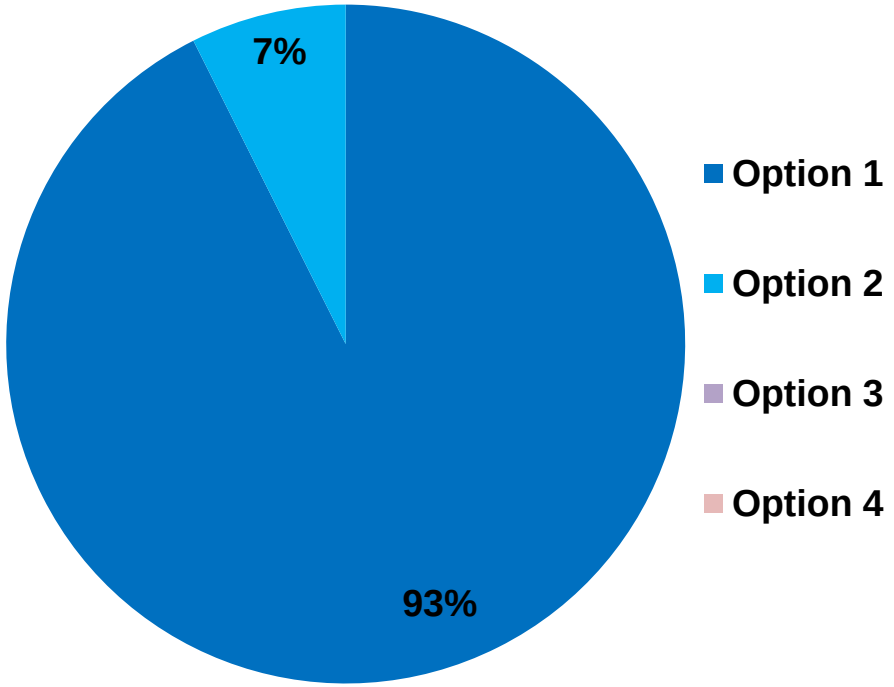
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

104. Do you recommend that the **majority** of metastatic prostate cancer patients with a deleterious **germline** BRCA1/2 mutation receive a PARP inhibitor or platinum therapy during their disease course outside of a clinical trial if none is available?

1. Yes
2. Yes, but only a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	50	93
Option 2	4	7
Option 3	0	0
Abstain	2	NA
Total votes	56	

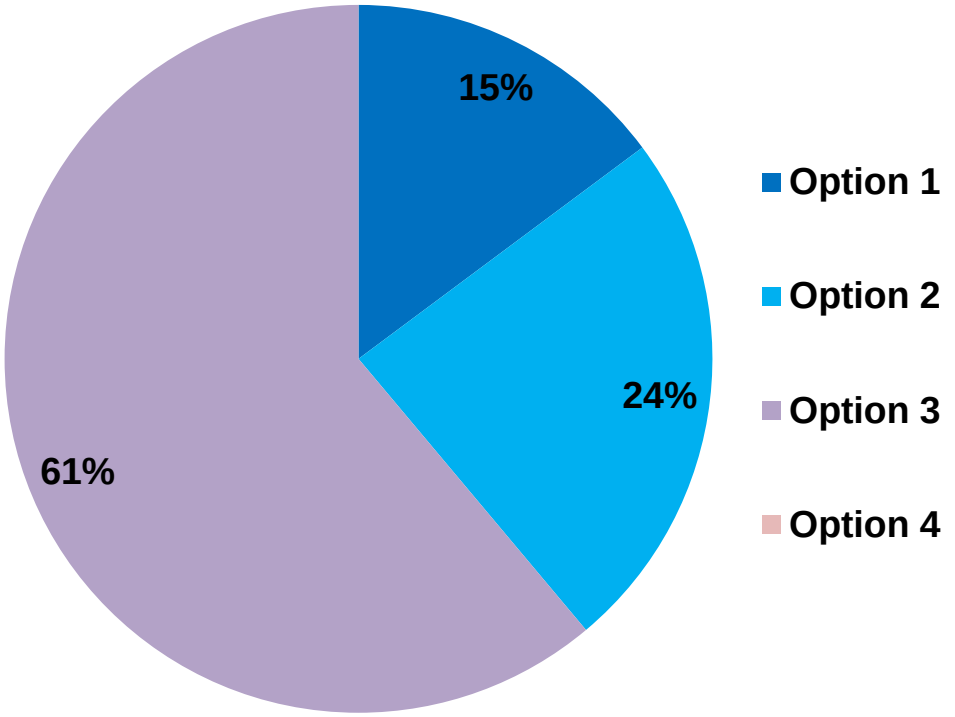
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

105. Do you recommend PARP inhibitor or platinum therapy for patients with metastatic prostate cancer and **a strong family history** of BRCA-associated cancers but no documented somatic and germline aberrations?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	8	15
Option 2	13	24
Option 3	33	61
Abstain	1	NA
Total votes	55	

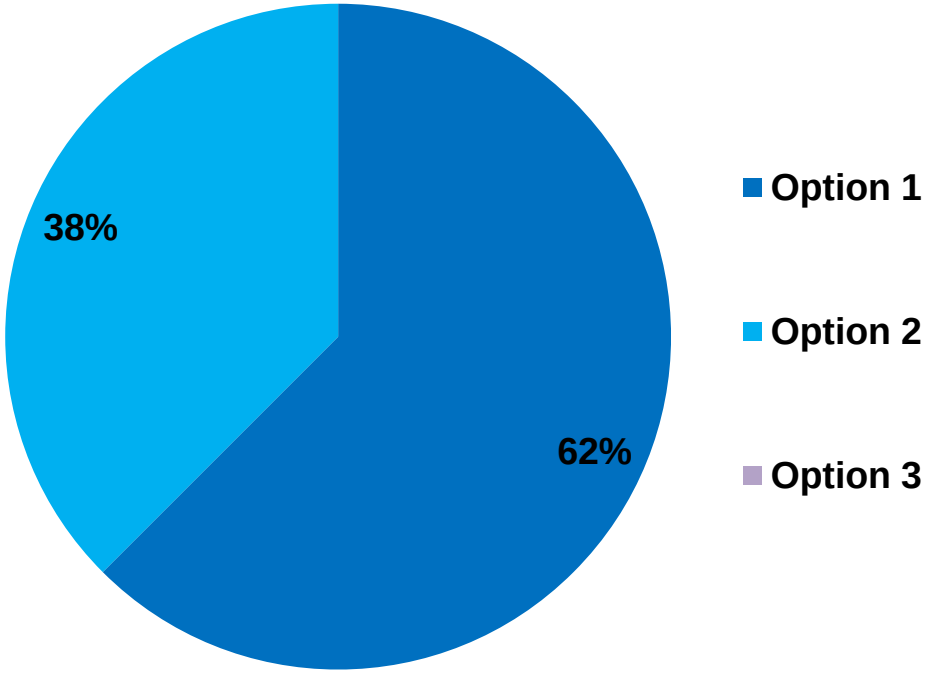
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

106. When (in which cases) do you recommend a PARP inhibitor or platinum therapy for patients with metastatic prostate cancer with a BRCA1/2 aberration (somatic and/or germline)?

1. Only for biallelic loss
2. Monoallelic loss is sufficient
3. Abstain



Option	Votes	Percent
Option 1	30	62
Option 2	18	38
Abstain	8	NA
Total votes	56	

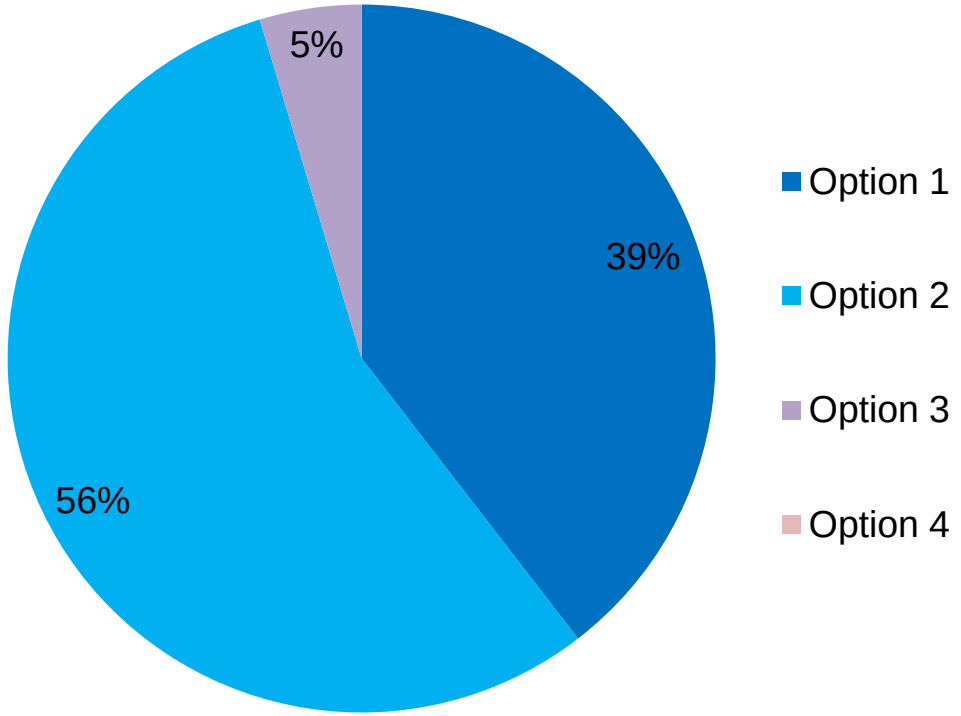
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

107. Do you recommend platinum-based therapy in patients with metastatic prostate cancer and pathogenic BRCA1/2 aberrations (somatic and/or germline) who progressed on or after a PARP inhibitor therapy?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	17	39
Option 2	24	56
Option 3	2	5
Abstain	12	NA
Total votes	55	

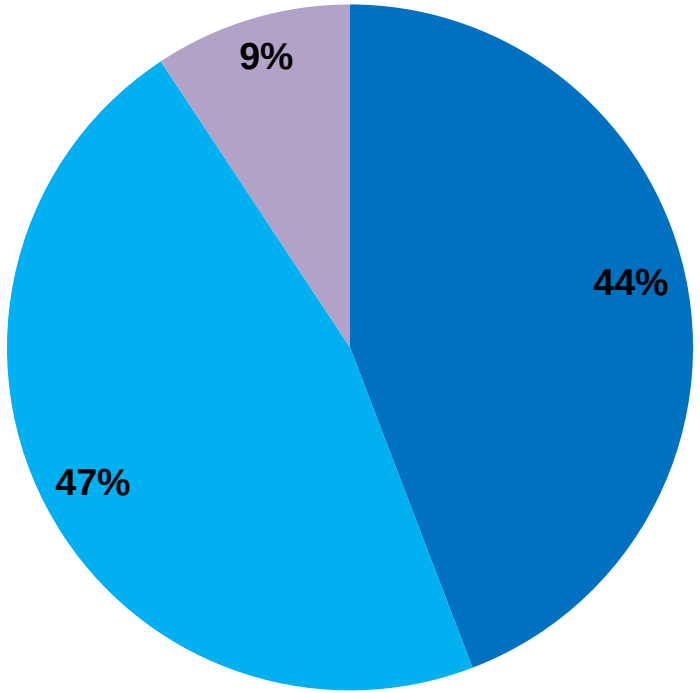
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

108. Do you recommend PARP inhibitor therapy in patients with metastatic prostate cancer and pathogenic BRCA1/2 aberrations (somatic and/or germline) who progressed on or after a platinum-based therapy?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	19	44
Option 2	20	47
Option 3	4	9
Abstain	8	NA
Total votes	51	

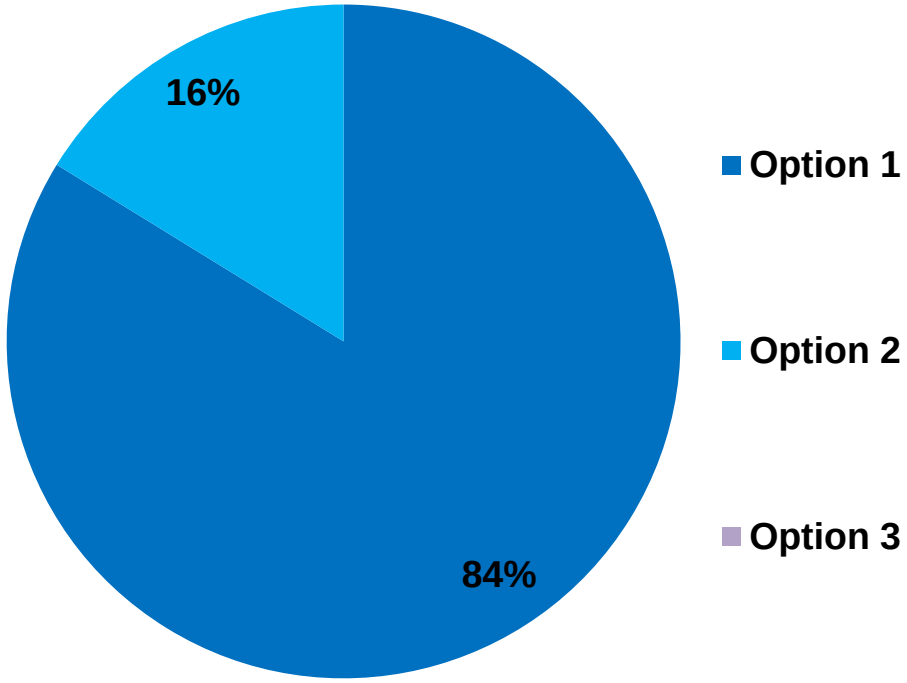
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

109. If you ever recommend carboplatin therapy (monotherapy or combination), which schedule do you routinely recommend?

1. 3-weekly carboplatin, AUC 4-5
2. Weekly carboplatin, AUC 2-3
3. Abstain



Option	Votes	Percent
Option 1	31	84
Option 2	6	16
Abstain	18	NA
Total votes	55	

Published in European Urology 2020 open access:

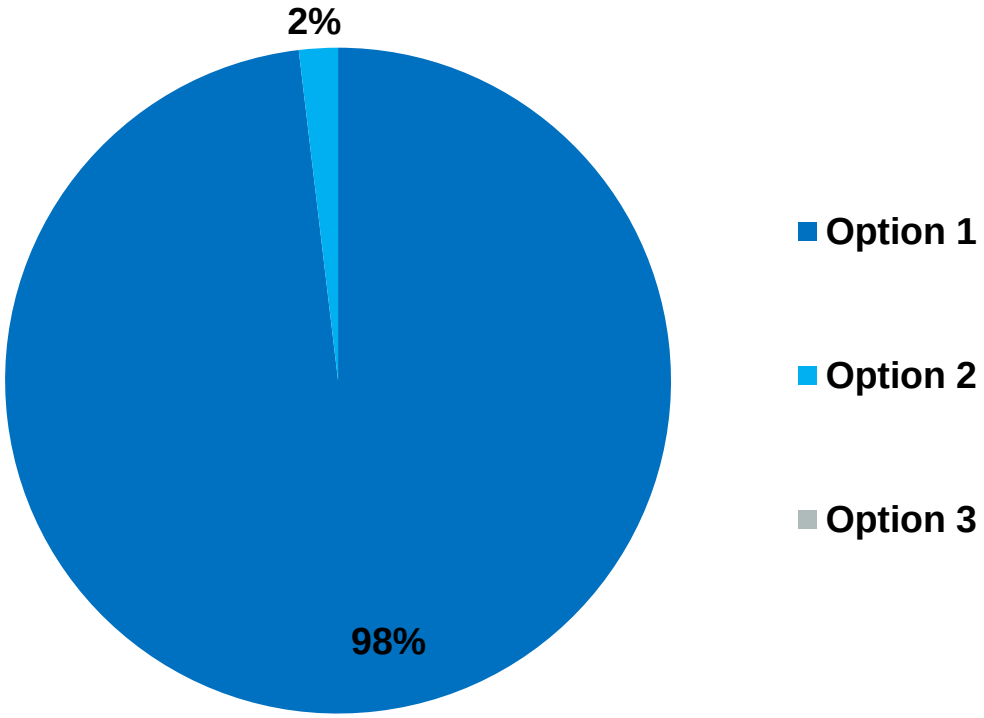
https://doi.org/10.1016/j.eururo.2020.01.012

8.2 Genetic counselling and germline testing in daily clinical practice

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

110. Do you recommend collecting a **detailed family history** of cancer for all patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	52	98
Option 2	1	2
Abstain	0	0
Total votes	53	

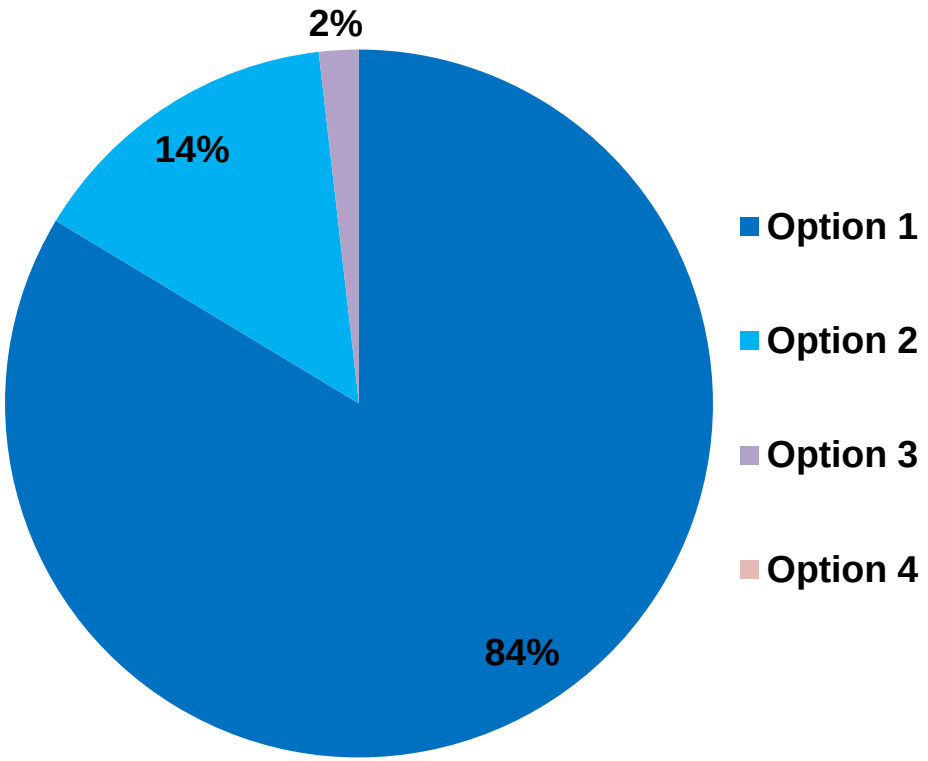
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

111. Do you recommend genetic counselling and/or **germline** DNA testing for patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	46	84
Option 2	8	14
Option 3	1	2
Abstain	0	0
Total votes	55	

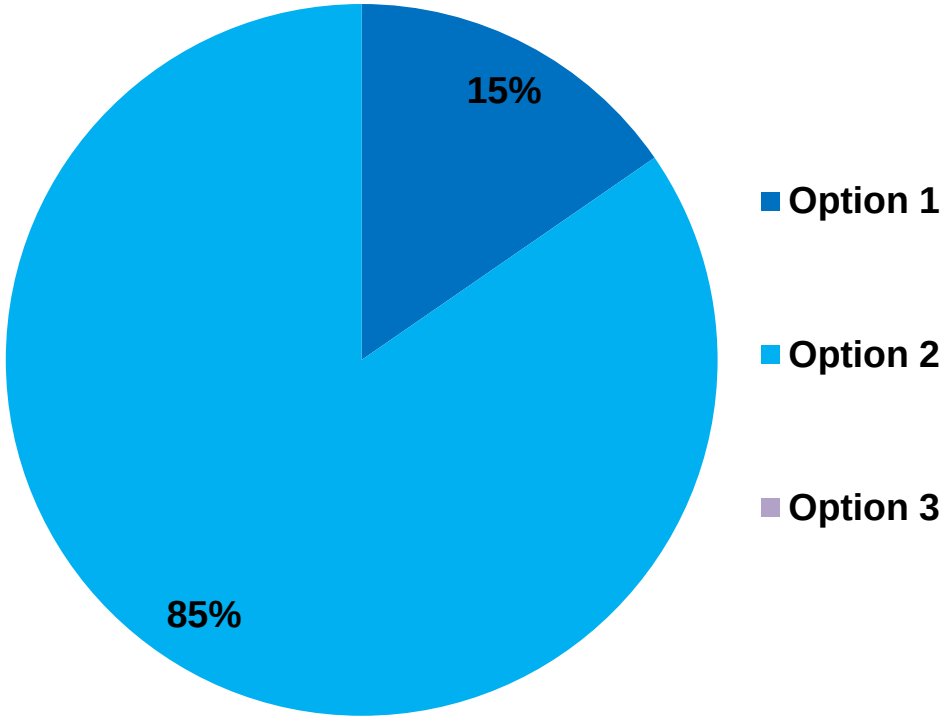
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

112. If you recommend **germline** DNA testing, what do you test in patients with prostate cancer?

1. BRCA1 and BRCA2 only
2. Extended panel testing, including homologous recombination DNA repair
3. Abstain



Option	Votes	Percent
Option 1	8	15
Option 2	44	85
Abstain	3	NA
Total votes	55	

Published in European Urology 2020 open access:

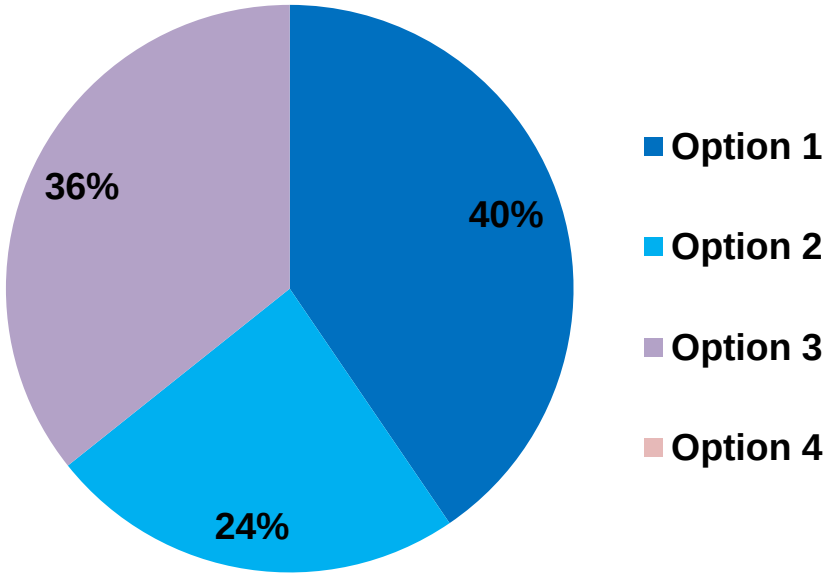
https://doi.org/10.1016/j.eururo.2020.01.012

9. Heterogeneity of patients with prostate cancer (ethnicity, elderly)

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

113. If you treat a patient of East Asian ethnicity with taxane chemotherapy for mCRPC, how do you initiate treatment?

1. Start with standard dose (75mg/m2), with dose reductions in subsequent cycles as indicated
2. Start with reduced dose (e.g. 60mg/m2), with dose reductions in subsequent cycles as indicated
3. Start with reduced dose, and escalate dose in the absence of relevant side effects
4. Abstain



Option	Votes	Percent
Option 1	17	40
Option 2	10	24
Option 3	15	36
Abstain	15	NA
Total votes	57	

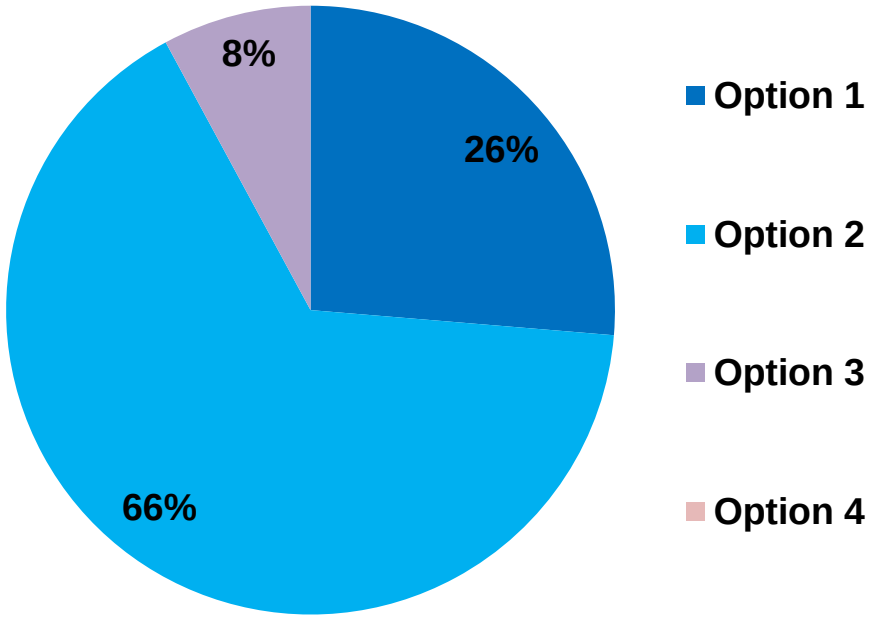
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

114. If you treat patients who are highly obese, what is your preferred strategy for dose calculation?

1. Treat at full dose according to actual body surface area
2. Cap the dose at an arbitrary BSA (e.g. 2.0 m/2) or cytotoxic dose
3. Use actual BSA but reduce the mg/m2 dose
4. Abstain



Option	Votes	Percent
Option 1	10	26
Option 2	25	66
Option 3	3	8
Abstain	18	NA
Total votes	56	

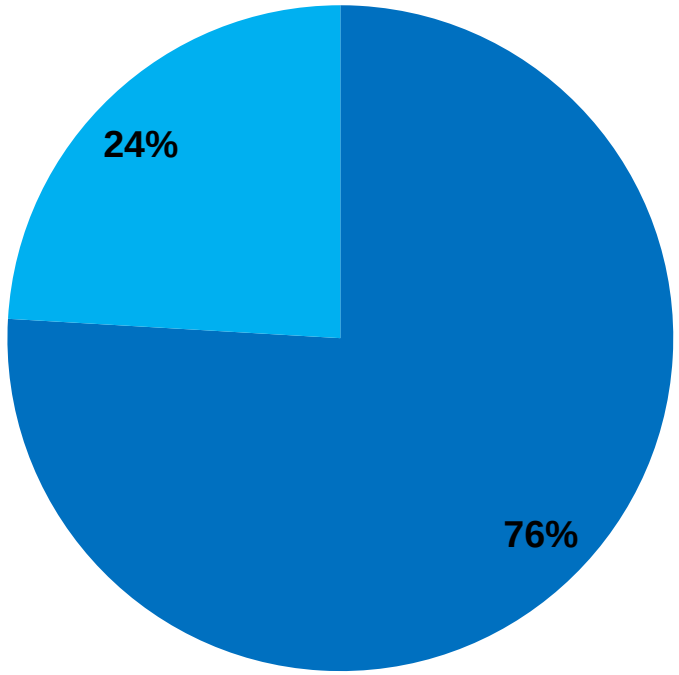
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

115. Can we extrapolate mCRPC clinical trial data **regarding efficacy** to the treatment of **patients who are older** than the majority of patients enrolled in these trials?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	41	76
Option 2	13	24
Abstain	2	NA
Total votes	56	

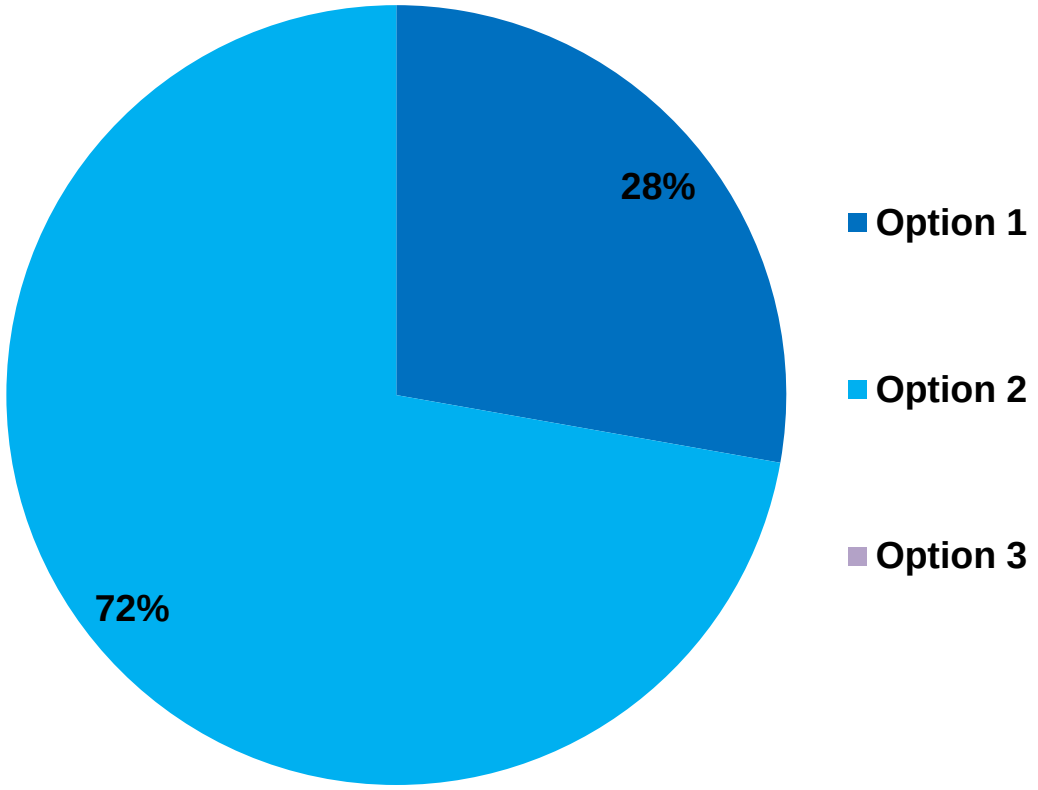
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

116. Can we extrapolate mCRPC clinical trial data **regarding toxicity** to the treatment of **patients who are older** than the majority of patients enrolled in these trials?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	15	28
Option 2	39	72
Abstain	1	NA
Total votes	55	

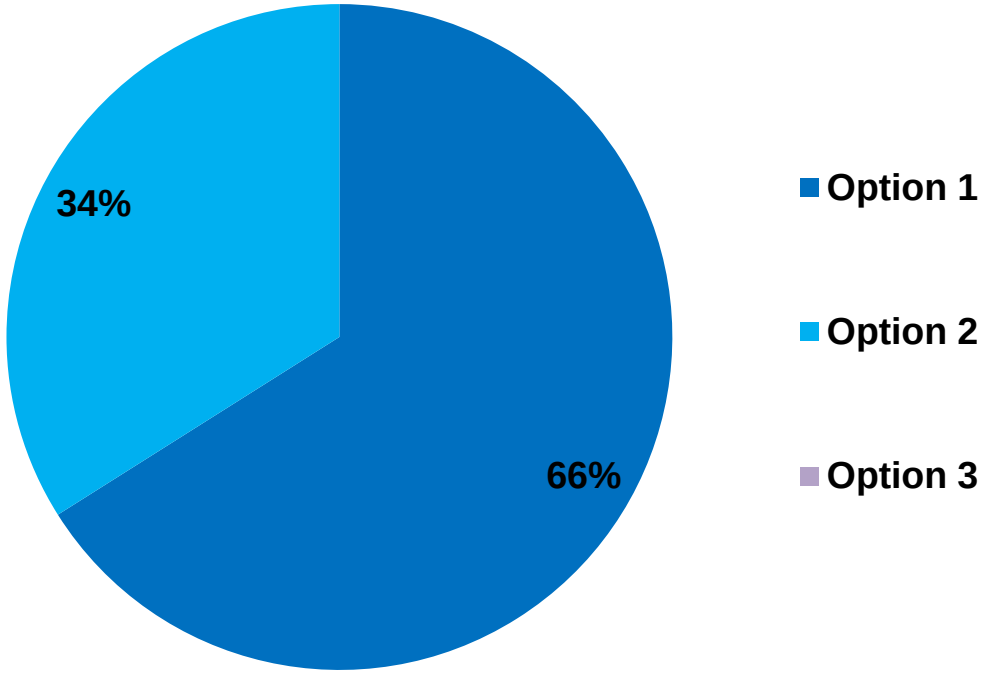
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

117. Can we extrapolate mCRPC clinical trial data **regarding efficacy** to the treatment of **patients of other ethnicities** than the majority of patients enrolled in these trials?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	35	66
Option 2	18	34
Abstain	3	NA
Total votes	56	

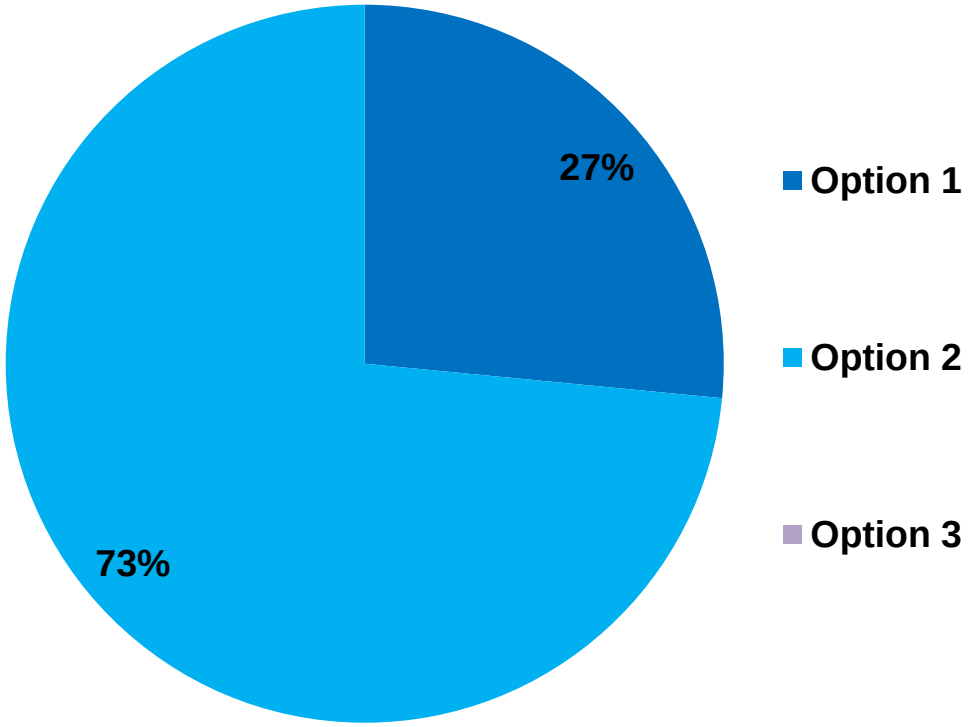
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

118. Can we extrapolate mCRPC clinical trial data **regarding toxicity** to the treatment of **patients of other ethnicities** than the majority of patients enrolled in these trials?

1. Yes
2. No
3. Abstain



Option	Votes	Percent
Option 1	13	27
Option 2	36	73
Abstain	4	NA
Total votes	53	

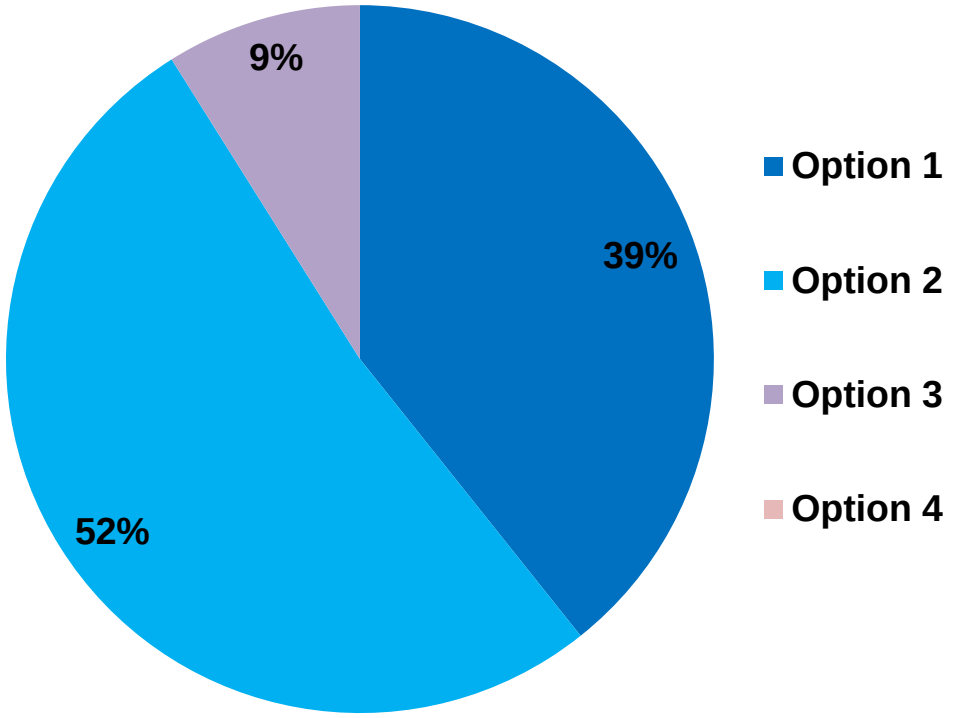
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

119. Do you recommend a health status assessment prior to treatment selection in patients with advanced prostate cancer who are ≥70 years old?

1. Yes, in the majority of patients
2. In a minority of selected patients
3. No
4. Abstain



Option	Votes	Percent
Option 1	22	39
Option 2	29	52
Option 3	5	9
Abstain	0	0
Total votes	56	

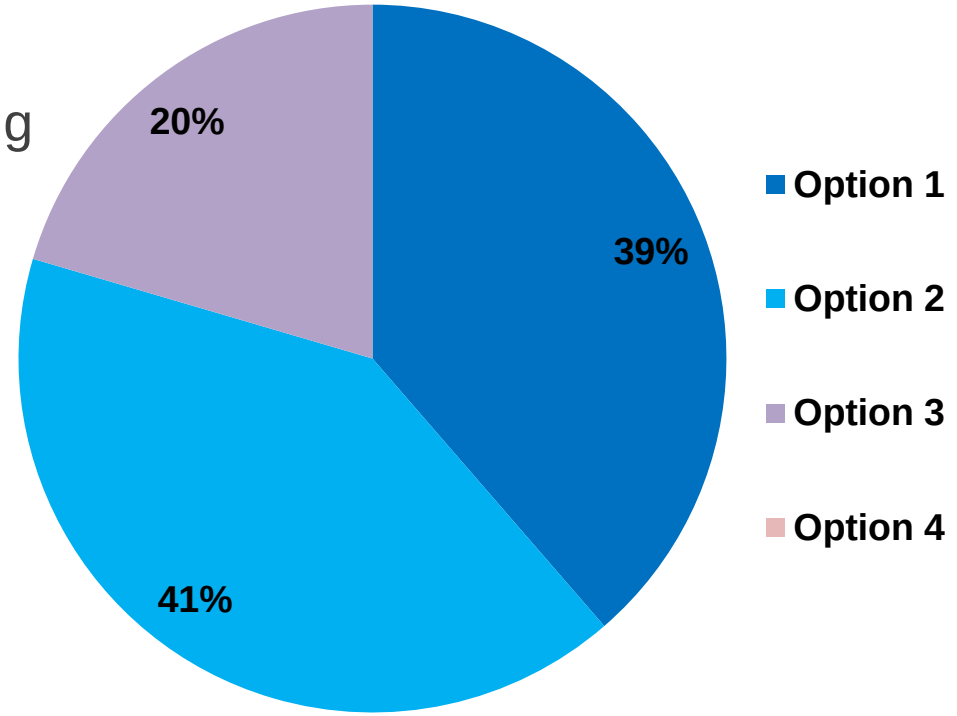
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

120. If you recommend a health status assessment in patients with advanced prostate cancer who are ≥70 years old, which one do you recommend?

1. Extended assessment by treating physician
2. Referral to geriatrician
3. Referral to other healthcare professional
4. Abstain



Option	Votes	Percent
Option 1	17	39
Option 2	18	41
Option 3	9	20
Abstain	8	NA
Total votes	52	

Published in European Urology 2020 open access:

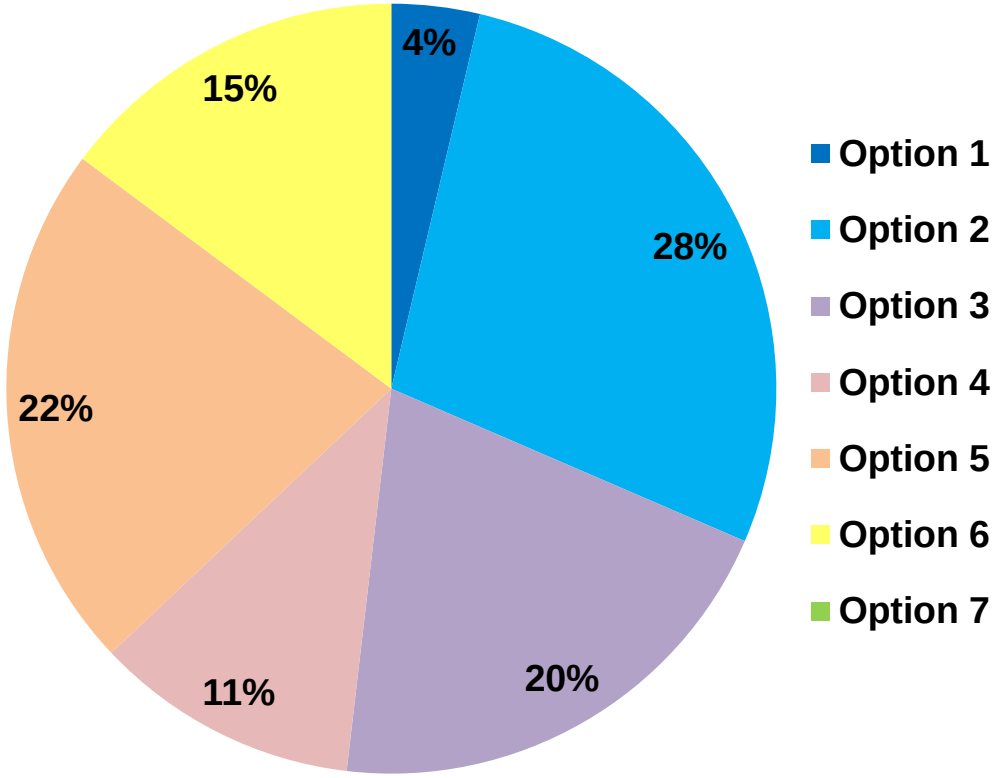
https://doi.org/10.1016/j.eururo.2020.01.012

10. Side effects of hormonal treatments and their management

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

121. What is your **preferred** first management option for patients on ADT with frequent or bothersome **hot flushes**?

1. Gabapentin
2. Venlafaxine
3. Cyproterone acetate
4. Medroxyprogesterone
5. Complementary approaches e.g. acupuncture
6. Other
7. Abstain



Option	Votes	Percent
Option 1	2	4
Option 2	15	28
Option 3	11	20
Option 4	6	11
Option 5	12	22
Option 6	8	15
Abstain	1	NA
Total votes	55	

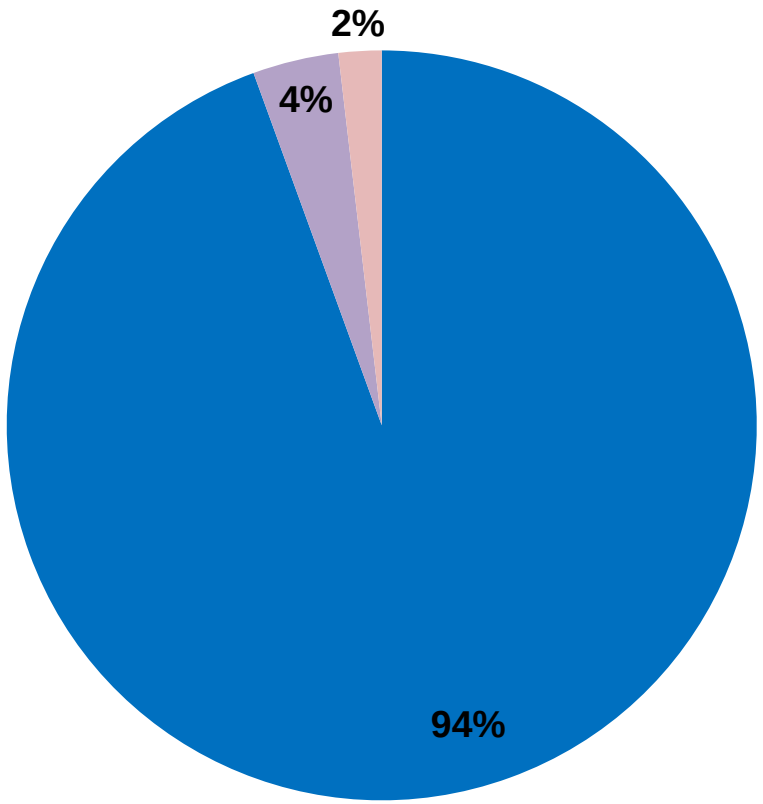
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

122. What is your **preferred** first management option **to reduce fatigue** in patients receiving systemic therapy for prostate cancer (apart from therapy dose reduction if possible)?

1. Resistance and aerobic exercise
2. Methylphenidate therapy
3. Caffeine
4. Other
5. Abstain



Option	Votes	Percent
Option 1	51	94
Option 2	0	0
Option 3	2	4
Option 4	1	2
Abstain	0	0
Total votes	54	

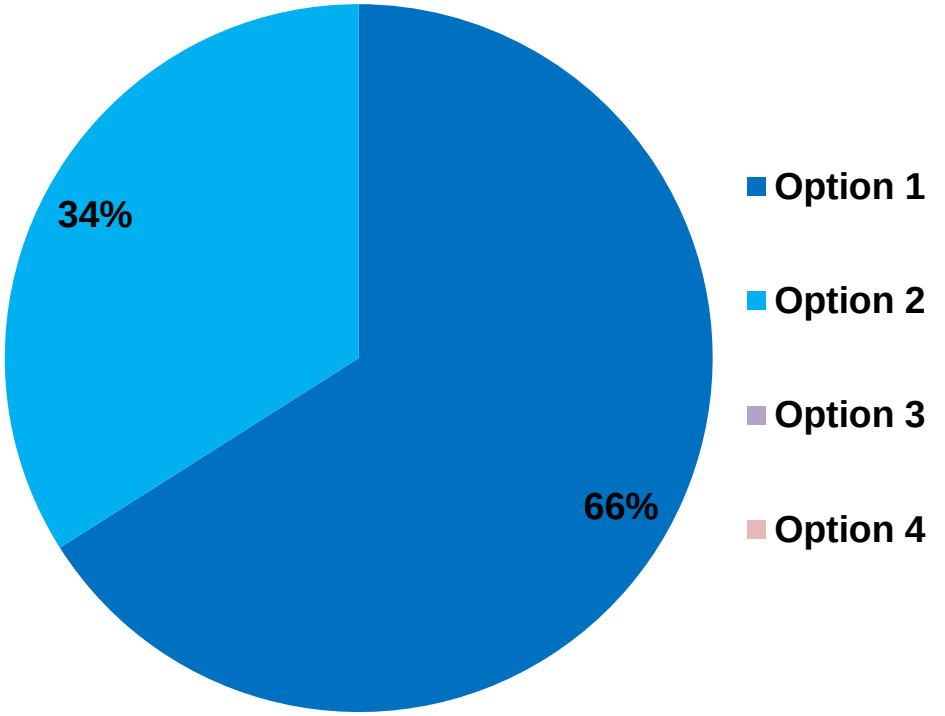
Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012

APCCC
ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE
www.apccc.org

123. What is your **preferred** first management option for patients who develop clinically **significant cognitive impairment** on enzalutamide or apalutamide?

1. Switch to abiraterone
2. Reduce enzalutamide/apalutamide dose
3. Add methylphenidate therapy
4. Abstain



Option	Votes	Percent
Option 1	33	66
Option 2	17	34
Option 3	0	0
Abstain	6	NA
Total votes	56	

Published in European Urology 2020 open access:

https://doi.org/10.1016/j.eururo.2020.01.012