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Winning the Battle Against Side Effects: Adverse Event Management in HSPC

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Dr. Taplin:
This is CE on ReachMD, and I am Dr. Mary-Ellen Taplin. I'm here with Dr. Scott Tagawa.

Dr. Tagawa, how do you approach team-based management of adverse events associated with the intensified therapy that we're using in our patients with hormone-sensitive prostate cancer?

Dr. Tagawa:
Thanks for the question. I think it's very important. I'd say there's a couple of aspects that are there. One is what I would call multidisciplinary approach to patients, as well as recognizing and potentially intervening on some of the adverse events that we see with our therapies, because just because they live longer, we also would prefer that they live better to the extent that we can.

So I don't think it has the overall management of any patient with probably any disease—but let's just talk about prostate cancer—has to fall on one specialty, whether it's a medical oncologist or urologist, or kind of that core team, which might include an advanced practice provider.

Certainly, we have additional specialties that are out there that may help us with that.

I think an aspect that does fall on the kind of the core medical team is the initial decision for which drugs might be employed. And then initial counseling and assessment to intervene early, because finding an adverse event at a low grade and intervening is one of the main ways we prevent that from becoming higher grade. And as was talked about in prior episodes, sometimes comorbidities will help steer us in one direction or another as we're picking a doublet or triplet type of therapy.

So for instance, underlying cardiovascular disease. So all of the ARPIs have a risk of cardiovascular disease, mostly because of hypertension across the board with all 4. But we believe that abiraterone probably has the highest cardiovascular risk. And while I'm saying that, probably the highest liver risk. So that's something I'll think about when picking these, and it also is given with the corticosteroids. So if someone has diabetes, I might want to steer away from that.

Differences in terms of fatigue and falls, we'd say the androgen receptor inhibitors probably have that a little bit more, particularly enzalutamide, although a lot of the data come from APMR, or castrate-resistant disease.

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Rashes, maybe a little bit more with apalutamide, as well as thyroid alterations, whether it is hyper- or hypothyroidism, it's something that we want to monitor there.

And then across the board, particularly if we're using ADT, are drug–drug interactions. But those are all clear factors that will come into the decision in terms of which type of an ARPI we're going to add.

And, to throw in an additional specialist that I didn't mention before, that may be the pharmacist. And I think we can gain additional help there, besides looking up drug–drug interactions in terms of the clinic.

Generically, I think that the combination of diet and exercise is quite important overall, not just because of the potential changes in metabolism and weight gain, with more fat and less muscle overall. But when it comes to fatigue, the general recommendation is for exercise, but we should be mindful that not every patient should be on the same dose of all of our drugs. So sometimes another factor that is important and can be helpful is an adjustment in the dose, sometimes holding a dose temporarily and then restarting or just reducing the dose. Essentially all of the ARPIs can be effective at slightly lower doses. So I think it's an important factor to consider.

Dr. Taplin:
To summarize, I would say number 1, it's important to understand our patients' underlying health and physiology; and number 2, to understand the potential side effects of the drugs we're prescribing, and to convene a multidisciplinary team or approach to ensuring that every patient on our prostate cancer therapy has the best quality of life that they can.

So thank you very much for this great discussion. Thanks for listening.

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