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Guideline Updates for ADT: Best Practices for Treating Advanced Prostate Cancer

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Hello, I'm Dr. Tanya Dorff. Today, we'll look at the NCCN Guideline updates for androgen deprivation therapy in advanced prostate cancer.

Dr. Dorff:
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The NCCN Guidelines panel has now incorporated the use of pretty much any of the available testosterone-lowering agents in the context of metastatic hormone-sensitive prostate cancer. Even though most clinical trials still utilized the older LHRH agonist, often in the depot formulations, really the ability of the LHRH antagonists, either oral or injected, have been shown to lower testosterone in ways that should make them interchangeable, and therefore, in the guidelines now, there's a list of all of the available agents.

There had been some concerns about especially the oral antagonist drug, and physicians should still use their judgment and check for drug-drug interactions. That's something we didn't have to worry about with the injections. However, there have been some real-world datasets that have not identified any concerns in combining the oral LHRH antagonist with our other forms of hormone therapy or other treatments that we utilize in prostate cancer. And furthermore, prospective registry data will be forthcoming that will provide further insights on how this oral agent performs in combination with various therapies.

Another issue that used to be of concern was compliance. We went away from providing the injection and knowing that our patient was getting their treatment to trusting that a patient would take a pill every day, knowing that it's important to maintain low levels of testosterone in order for the treatment to be effective. Hence, there was some concern that if patients could not be compliant, there would be testosterone breakthrough, which would impact the efficacy of their treatment.

However, in the modern practice, where we are using doublet therapy for most patients with metastatic hormone-sensitive prostate cancer, we're now relying on patients to take an oral agent anyway. And I think in part because of that, we're getting more comfortable with the fact that our patients can be compliant, and adding that oral antagonist, which is one pill once a day, doesn't seem to be a prohibitive barrier when added on top of the androgen receptor pathway inhibitor oral agents.

Retrospective datasets, again, support both compliance as well as a lack of immediate testosterone breakthrough if patients do occasionally omit a dose, thus we don't appear to compromise efficacy by utilizing a fully oral regimen. In our own experience, which was published in *The Oncologist*, there were 21 patients taking relugolix concurrent with androgen receptor pathway inhibitors, and no new safety signals were identified. Compliance was good, with only 7 patients reporting having missed any doses. And in our unpublished experience, when we do have patients who admit to missing a dose here and there, we're not seeing testosterone breakthrough, and we do regularly measure that.

Therefore, for metastatic hormone-sensitive prostate cancer, we now have multiple options as far as how we lower testosterone,

whether we use an injection or an oral agent, an agonist or an antagonist of the LHRH pathway.

Our time is up. Thanks for tuning in.

Announcer:
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