ADT should not be started until metastatic disease has developed

The NO

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Conflicts of interest

• PI or member steering committee: Amgen, Astellas, Bayer, Medivation, Ferring, Sanofi-Genzyme

• Paid Advisor or Consultant for: Amgen, Bayer, Astellas, Ferring, Sanofi-Genzyme
yes  maybe  no
ADT should not be started until metastatic disease has developed.

1. The definition of “metastatic” is technology dependent.
What imaging?

EAU, AUA, NCCN guidelines

PCWG2 (3?)

Is it accurate?
The detection of bone metastases in patients with high-risk prostate cancer: $^{99m}$Tc-MDP planar bone scintigraphy, single- and multi-field-of-view SPECT, $^{18}$F-Fluoride PET, and $^{18}$F-fluoride PET/CT


- In a prospective study, BS and $^{18}$F-Fluoride PET/CT were performed on the same day in 44 patients with high-risk PCa. In 20 of the latter patients, planar BS was followed by single field-of-view SPECT and in 24 patients by multi-FOV SPECT of the axial skeleton.

<table>
<thead>
<tr>
<th>Modality</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>PPV</th>
<th>NPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>$^{99m}$Tc BS</td>
<td>57 (35)</td>
<td>57(95)</td>
<td>59 (89)</td>
<td>55(44)</td>
</tr>
<tr>
<td>$^{99m}$Tc BS/SPECT</td>
<td>78 (39)</td>
<td>67(86)</td>
<td>72(75)</td>
<td>74(31)</td>
</tr>
<tr>
<td>$^{18}$F-Fluoride PET</td>
<td>100 (48)</td>
<td>62 (95)</td>
<td>74(92)</td>
<td>100(63)</td>
</tr>
<tr>
<td>$^{18}$F-Floride PET/CT</td>
<td>100 (87)</td>
<td>100(100)</td>
<td>100(100)</td>
<td>100(87)</td>
</tr>
</tbody>
</table>

*Analysis considering equivocal results as positive for malignancy. In parentheses, analysis considering equivocal results as negative for malignancy.
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2. Delaying until Tc\textsuperscript{99m} turn positive = actively monitoring a lot of patients

- 1,352 men PSA recurrence after surgery; divided into an early HT group in which patients (355) received HT after PSA only recurrence but before clinical metastasis and a late HT group for patients (997) who received no HT before clinical metastasis or by current follow-up.
Immediate versus deferred initiation of androgen deprivation therapy in prostate cancer patients with PSA-only relapse. An observational follow-up study


- 2096 eligible patients with PSA recurrence 69% RP and d 31% EBRT
- Deferred treatment: ADT when symptoms, M1, short PSA doubling time or 2 years after inclusion.

Fig. 2. Overall (A) and prostate cancer-specific (B) survival, standardised for baseline and time-varying variables, for immediate versus deferred androgen deprivation therapy (ADT), Cancer of the Prostate Strategic Urologic Research Endeavour (CaPSURE) 1974–2013.
Timing of androgen-deprivation therapy in patients with prostate cancer with a rising PSA (TROG 03.06 and VCOG PR01-03 [TOAD]): a randomised, multicentre, non-blinded, phase 3 trial.


- 261 PSA relapse after previous attempted curative therapy and 32 PCa not suitable for curative treatment
- Randomized to immediate ADT or to delayed ADT with a recommended interval of at least 2 years unless clinically contraindicated
Timing of androgen-deprivation therapy in patients with prostate cancer with a rising PSA (TROG 03.06 and VCOG PR01-03 [TOAD]): a randomised, multicentre, non-blinded, phase 3 trial.
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Figure 6: Global health-related quality of life over the first 2 years. Error bars show 95% CIs. ADT = androgen-deprivation therapy.
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2. Delaying until Tc\textsuperscript{99m} turn positive = actively monitoring a lot of patients.
3. We have now good evidence that patients with a rapid rise in PSA will benefit from early ADT.
Whole body MRI (WB-MRI) assessment of metastatic spread in prostate cancer: Therapeutic perspectives on targeted management of oligometastatic disease. 


| Table I: Distribution of Metastatic Disease According to the Target Organ (Bones, Nodes, Both) in 96 Metastatic PCa Patients (46 mHNPC and 50 mCRPC) |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|
| Site                           | All patients    | ≤3 metastases   |                 |                 |
|                                | mHNPC | mCRPC | mHNPC | mCRPC |
| Lymph nodes only               | 13 (28%) | 17 (34%) | 3 (6.5%) | 11 (22%) |
| Bone only                      | 14 (29%) | 16 (32%) | 7 (15%) | 11 (22%) |
| Lymph nodes and bone           | 19 (41%) | 17 (34%) | 3 (6.5%) | 3 (6%) |
| Total                          | 46     | 50    | 13     | 25    |
Whole body MRI (WB-MRI) assessment of metastatic spread in prostate cancer: Therapeutic perspectives on targeted management of oligometastatic disease.

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2. Delaying until Tc$^{99m}$ turn positive = actively monitoring a lot of patients.
3. We have now good evidence that patients with a rapid rise in PSA will benefit from early ADT.
4. New imaging technologies may changes our view on that very important timing question