Informed Prostate Cancer Support Group Inc.
"A 501 C 3 CORPORATION ID # 54-2141691"

FEBRUARY 2024 NEWSLETTER

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Phone: 619-890-8447 Web: http://ipcsg.org

Wednesday, February 14,

Volume 17 Issue 02

Next Meeting Saturday, February 17, 2024 IPCSG—10:00am—Noon PDT.

- **Roundtable**—Three members of the IPCSG group will share stories about their journey with Prostate Cancer. Dennis Hickey; Don Wang; Karla Going—President North County Cancer Fitness - .This is your chance to get all your questions answered by people who have **"been there, done that".**
  - As always, spouses/partners and caregivers are welcome and encouraged to attend!
  - After the meeting a light lunch will be served in the foyer outside the meeting room
- **For links to further Reading: https://ipcsg.blogspot.com/ (includes member suggested links)**
- **If you have Comments, Ideas or Questions,** email to Newsletter@ipcsg.org

IPCSG Meeting at Sanford Burnham Prebys Auditorium, January 20, 2024

Speakers

- **Dr. A.J. Mundt** opens with an overview of the Advances in Radiation Treatments over the past year. Then he introduces the speakers below.
- **Dr. Tyler Seibert** is an Assistant Professor in the Division of Radiation Oncology and a member of the RMAS Center for Precision Radiation Medicine (CPRM)
- **Dr. James Urbanic** professor of Clinical Radiation Medicine and Applied Sciences UCSD
- **Brent Rose MD** is the Chief of the Genitourinary (GU) Disease Team, specializing in novel approaches for the treatment of prostate cancer.

Dr. A.J. Mundt opens with an overview of the Advances in Radiation Treatments over the past year.

Radiation Oncology in Prostate Cancer Treatment: External and Internal Beam Approaches

Radiation oncology is one of the three pillars in the treatment of prostate cancer, with external beam and internal beam (brachytherapy) being the two main types of radiation. External beam radiation involves the use of photons or protons, which are energy waves or particles, respectively. While photons continue to fade as they move into the body, protons give off their energy and stop, making proton therapy useful in sparing healthy tissues.

The choice between photon and proton therapy depends on the patient's individual needs, considering factors such as tumor location and the presence of nearby critical structures. Brachytherapy, on the other hand, involves placing radioactive sources inside the body. This can be done permanently (low-dose-rate brachytherapy) or tem-

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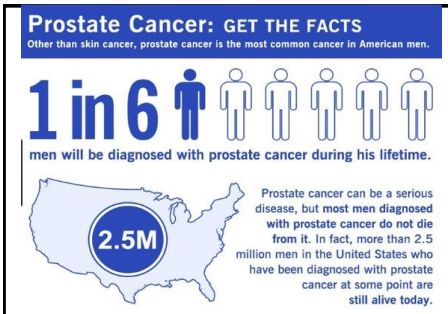

Organization

a 501c3 non-profit organization - all positions are performed gratis

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NEWSLETTER
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PROSTATE CANCER—*2 WORDS, NOT A SENTENCE*

What We Are About

Our Group offers the complete spectrum of information on prevention and treatment. We provide a forum where you can get all your questions answered in one place by men that have lived through the experience. Prostate cancer is very personal. Our goal is to make you more aware of your options before you begin a treatment that has serious side effects that were not properly explained. Impotence, incontinence, and a high rate of recurrence are very common side effects and may be for life. Men who are newly diagnosed with PCa are often overwhelmed by the frightening magnitude of their condition. Networking with our members will help identify what options are best suited for your life style.

Join the IPCSG TEAM

If you consider the IPCSG to be valuable in your cancer journey, realize that we need people to step up and HELP. Call **President** Bill Lewis @ (619) 591-8670 "bill@ipcsg.org"; or **Director** Gene Van Vleet @ 619-890-8447.

From the Editor

In this issue:

For further articles see the blog at https://ipcsg.blogspot.com/ . First we have an AI generated summary of last months brief on radiation therapy by Dr. AJ Mundt and his colleagues from UCSD. Unfortunately the audio for Q&A wasn't good enough to be included. Some important items of interest this month:

1. *Adding Apalutamide Boosts PSA Control in Prostate Cancer—New ERLEADA® (apalutamide) Analysis Demonstrates Rapid, Deep Prostate-Specific Antigen (PSA) Response in Patients with Metastatic Castration-Sensitive Prostate Cancer (mCSPC)*
2. *2023 Top Story in Prostate Cancer: PARP Inhibition Moves Forward | PracticeUpdate— what's a PARP inhibitor? Gives hope to advanced cases.*
3. *Top 10 prostate cancer stories in 2023: urologytimes.com—a lot of progress last year! - some of the biggest:*
   FDA approves enzalutamide for nonmetastatic CSPC;
   ProtecT trial shows AS yields same outcomes as RP surgery;
   177Lu-PNT2002 safe and effective in mCRPC;
4. *Cardiovascular risks of androgen receptor targeted agents in prostate cancer: a systematic review and meta-analysis—ADT may keep you alive from cancer long enough so you'll die from a heart attack!*

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porarily (high-dose-rate brachytherapy). In both cases, the goal is to deliver a high dose of radiation directly to the tumor while minimizing exposure to surrounding tissues.

When undergoing radiation therapy, treatment is typically delivered in smaller doses over time (fractionation). Conventional fractionation typically consists of daily treatments over several weeks. More recently, hypofractionation has gained popularity, in which the total number of treatments is reduced, leading to a higher dose per treatment. However, careful consideration is needed when using hypofractionation, as higher doses per treatment can have implications for the surrounding tissues, such as the bladder and rectum. The total biological dose remains the same with both conventional and hypo-fractionated treatments, but their effects on tissues differ due to the difference in dose distribution and timing.

Dr. Tyler Seibert is an Assistant Professor in the Division of Radiation Oncology and a member of the RMAS Center for Precision Radiation Medicine (CPRM)

Focal Boost Treatment Reduces Cancer Recurrence and Spread in Prostate Cancer

A phase three randomized trial in the Netherlands published in 2020 compared treating men with intermediate or high-risk prostate cancer using either the whole prostate based on a CT scan or targeting just the part of the prostate showing the most aggressive tumor on an MRI. The trial found that the focal boost group had 67% less local recurrence and 44% less spread to lymph nodes or other parts of the body. Additionally, there was no increase in toxicity or side effects between the two groups. However, despite the clear benefits of this focal boost treatment, a survey of radiation oncologists around the world found that only 42% of them are using it routinely, even in high-income countries. The reasons for the low adoption rate include the difficulty of aligning the MRI with the CT scan, the challenge of training staff to plan treatment with the focal boost, and the difficulty of obtaining high-quality MRI scans. To address these issues, researchers at UC San Diego have developed a program called Precision Pro RT that aligns the MRI with the CT scan, shows the tumor on MRI, and overlay it on the CT scan for treatment planning. The use of MRI should also be encouraged for making decisions about biopsies, planning biopsies, predicting nerve-sparing during surgery, and for focal therapy in radiation therapy.

Dr. James Urbanic professor of Clinical Radiation Medicine and Applied Sciences UCSD

Innovative Proton Therapy for Improved Cancer Imaging and Treatment

In this segment, Dr. Urbanic discusses the advancements in proton therapy, a type of radiation treatment that uses protons instead of traditional x-rays. The speaker highlights their organization's innovation, AC way, which enables them to focus on cancer using MRI and sophisticated computer software to process color pictures. They have also developed a universal image processing system that allows for high-quality images from any location, enhancing accessibility and efficiency. An essential aspect of proton therapy is its potential for better imaging and higher resolution compared to conventional treatments, especially in detecting escaped cancer cells in processes like lymph nodes or bones. However, further research and funding are required to provide concrete evidence of these advantages. The speaker, a radiation oncologist, explains three categories of patients they treat, namely those requiring radiation as a definitive treatment, post-surgery treatment to prevent recurrence, and symptom management. The doctor emphasizes the importance of selecting the right radiation oncologist, one who can offer a wide range of treatment options. The segment also touches upon proton therapy basics, such as its origins and the process through which protons are acquired. The speaker highlights the unique benefits of proton therapy, including the ability to minimize damage to surrounding tissues and organs due to the energy delivery mechanism of protons. Overall, this segment highlights the advancements and potential of proton therapy, emphasizing the need for further research and the importance of choosing a radiation oncologist with diverse treatment options for optimal patient care.

Proton Beam Therapy: Revolutionizing Cancer Treatment

Proton beam therapy is a cutting-edge cancer treatment that offers several advantages over traditional X-ray radiation. With the ability to control the beam from soup to nuts using magnets, proton therapy can scan the beam in three different directions, filling the target and adjusting the energy and time the beam sits at any one place. This allows for more precise targeting of cancer cells, minimizing damage to surrounding healthy tissue. Proton therapy is currently used in 40 or so centers across the United States, with more on the East Coast than the West Coast.

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The newest proton centers have compacted the size of the center down nicely, and treat patients using similar technology to traditional radiation therapy. One of the major advantages of proton therapy is the reduced exposure to radiation in the rest of the body, as it gets rid of the exposure to the rest of the patient's body. However, it's harder to tell if there is a huge delta in side effects or cure rate between proton treatment and traditional radiation therapy. Proton therapy is also particularly useful for treating pediatric tumors, as it reduces the risk of secondary cancers in the long term. The latency time for secondary cancer from radiation treatment is at least a decade, making it a significant issue for adult cancer patients as well. In summary, proton beam therapy is a promising cancer treatment that offers more precise targeting of cancer cells, reduced exposure to radiation, and lower risk of secondary cancers. While it is not yet clear if there is a significant difference in side effects or cure rate compared to traditional radiation therapy, proton therapy is a valuable tool in the fight against cancer.

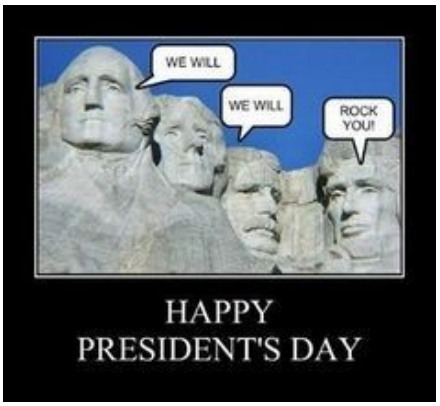
Brent Rose MD is the Chief of the Genitourinary (GU) Disease Team, specializing in novel approaches for the treatment of prostate cancer.

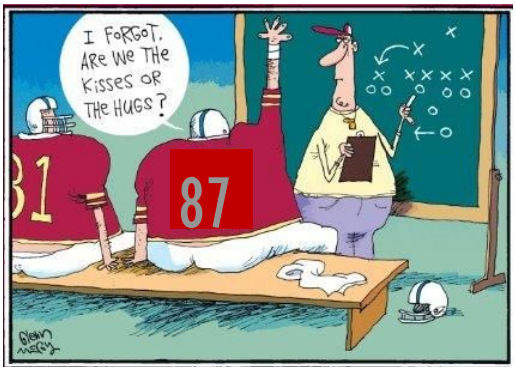
Personalized Approach to Understanding Prostate Cancer

In this passage, Dr. Rose discusses the importance of understanding prostate cancer, particularly for those who have received a new diagnosis. The primary goal of the session is to educate attendees so they can make informed decisions about their treatment. Since prostate cancer has a wide range of aggressiveness levels, it's crucial to know the specifics of each case. The session covers prostate anatomy and the function of prostate-specific antigen (PSA) in screening, diagnosis, and treatment monitoring. The speaker emphasizes that PSA is not a perfect test, and its interpretation can be influenced by various factors. The most significant takeaway from this passage is the importance of a personalized approach to understanding prostate cancer based on individual needs and circumstances. This approach involves informed decision-making, active participation in the process, and awareness of the various factors that can influence the diagnostic and treatment journey. It's crucial not to rely solely on a PSA value of 4 as the critical threshold for PSA and instead consider age, lifestyle, and other relevant factors in interpreting test results. Ultimately, this personalized approach aims to empower individuals with the knowledge and tools necessary to navigate the complexities of prostate cancer.

Full video of the presentations and member Q&A is on youtube at:
https://www.youtube.com/watch?v=LkHjT6Np9dA

On The Lighter Side





Adding Apalutamide Boosts PSA Control in Prostate Cancer

medscape.com
Deepa Varma

TOPLINE:
A new study revealed that the addition of apalutamide to androgen deprivation therapy (ADT), with or without abiraterone acetate plus prednisone, prolongs prostate-specific antigen (PSA) progression-free survival in patients with biochemically recurrent prostate cancer.

METHODOLOGY:
- Intensification of androgen blockade is known to improve survival in nonmetastatic castration-resistant prostate cancer as well as metastatic castration-sensitive disease. This approach, when used for a finite duration, can also benefit patients with high-risk biochemically recurrent prostate cancer who are at a risk for distant metastases.
- In the open-label, phase 3 PRESTO trial, researchers evaluated 503 patients who had undergone radical prostatectomy and experienced biochemical recurrence with a minimum PSA level of 0.5 ng/mL and PSA doubling time of 9 months or less.
- The patients were randomly assigned 1:1:1 to receive ADT alone, ADT plus apalutamide, or ADT plus apalutamide, abiraterone acetate, and prednisone.
- The primary endpoint was PSA progression-free survival during a 1-year treatment duration.

Secondary outcome measures included PSA progression-free survival in the testosterone-recovered population (a subgroup of patients who achieved serum testosterone to > 50 ng/dL during the study follow-up), medium time to testosterone recovery (a level > 50 ng/dL), and safety.

TAKEAWAY:
- At a median follow-up of 21.5 months, ADT plus apalutamide significantly prolonged median PSA progression-free survival compared with ADT monotherapy (24.9 vs 20.3 months; hazard ratio [HR], 0.52). ADT plus apalutamide, abiraterone acetate, and prednisone improved median PSA progression-free survival compared with ADT alone (26 vs 20.3 months; HR, 0.48).
- Compared with ADT monotherapy, the time to testosterone recovery to > 50 ng/dL was not significantly different in the ADT plus apalutamide (3.9 vs 3.8 months, respectively). In the ADT plus apalutamide, abiraterone acetate, and prednisone group, there was longer time (4.7 months) to testosterone recovery, which did not meet statistical significance.

Serious adverse events occurred in 8% of patients in the ADT monotherapy group, 9% in the ADT plus abiraterone group, and 17% in the ADT plus apalutamide, abiraterone acetate, and prednisone group, respectively. The most common were hypertension, dyspnea, and falls.

IN PRACTICE:
Despite finding that intensified ADT significantly improved PSA progression-free survival vs ADT alone, experts in an accompanying editorial cautioned that by treating biochemical recurrence, "we are treating largely asymptomatic men, many of whom will live for years without encountering any disease-related consequences and for whom the toxicity of therapy may exacerbate underlying comorbidities, potentially increasing the risk of nonprostate cancer death."

SOURCE:
This research was led by Rahul Aggarwal, MD, from University of California San Francisco, and was published online on January 23, 2024, in the *Journal of Clinical Oncology*.

2023 Top Story in Prostate Cancer: PARP Inhibition Moves Forward | PracticeUpdate

practiceupdate.com

Ishita A. Basera et al.,

The inhibition of PARP enzymes using olaparib or rucaparib monotherapy was FDA-approved in 2020 for selected patients with homologous recombination repair (HRR) gene–mutated metastatic castrate-resistant prostate cancer (mCRPC). Thus, PARP inhibitors have been a part of the armamentarium for advanced prostate cancer for more than 3 years; but, in 2023, much more data became available and much more was learned.

The TRITON3 trial[1] reported mature data on radiographic progression–free survival (rPFS) outcomes in patients with BRCA1, BRCA2, or ATM mutations. More than 4800 patients were screened to randomize 405 patients. All patients had mCRPC and progression despite prior treatment with a second-generation androgen-receptor pathway inhibitor (ARPI) such as abiraterone, enzalutamide, darolutamide, or apalutamide. In TRITON3, patients were randomized to a second ARPI or docetaxel (physician's choice; control) or rucaparib. The PARP inhibitor regimen was superior to the control regimen, whether using an ARPI or the taxane. ATM and BRCA mutations were separately analyzed. In the intention-to-treat (ITT) analysis, the trial was positive; but, when the ATM- and BRCA-mutant populations were analyzed separately, it was apparent that the BRCA-mutant population substantially benefited from PARP inhibition (rPFS HR, 0.50; 95% CI, 0.36–0.69) whereas the ATM-mutant population did not. Overall survival (OS) also trended positively (HR, 0.81; 95% CI, 0.58–1.12) in the BRCA-mutant population when treated with rucaparib. When the control arm choices were analyzed in the BRCA-mutant population, it was apparent that rucaparib was superior to docetaxel as well as the second ARPI. Of note, taxane-treated patients had an rPFS of 8.3 months, providing valuable prospective docetaxel data in this population.

Three important PARP inhibitor trials evaluated a PARP inhibitor and ARPI combination in patients with mCRPC. Both niraparib and olaparib were evaluated in combination with abiraterone/prednisone, and talazoparib was evaluated in combination with enzalutamide.

The most controversial trial was PROpel.[2] Abiraterone/prednisone was given with or without olaparib in the first-line mCRPC setting (no prior ARPI allowed). This setting is rapidly disappearing in the current therapeutic landscape. All-comers were treated, and patients were retrospectively allocated to HRR-mutated status or not based on either tissue or circulating-tumor DNA analyses. The key to understanding this trial is in the ITT versus the subset analysis. The rPFS but not OS among ITT all-comers suggested a benefit of the PARP inhibitor/abiraterone combination. The subsets were extremely revealing. The rPFS (HR, 0.23; 95% CI, 0.12–0.43) and OS (HR, 0.29; 95% CI, 0.14–0.56) were strikingly positive in the BRCA-mutated subset, but other patients with HRR-mutated disease and those with non–HRR-mutated disease had little evidence of benefit. The FDA opined similarly, and the abiraterone/prednisone/olaparib combination is now FDA-approved in the first line in patients with BRCA-mutated mCRPC. This is a strong and positive confirmation of the importance of olaparib in combination with abiraterone/prednisone for patients with a BRCA mutation.

Similar conclusions were reached after analysis of the MAGNITUDE trial,[3] which evaluated abiraterone/prednisone with or without niraparib in the first-line mCRPC setting. Patients were prospectively subdivided into HRR-mutated and non–HRR-mutated subsets. The primary endpoint was rPFS, and a variety of secondary endpoints were also included. The Data Monitoring Committee noted futility in the non–HRR-mutated subset and terminated accrual to that portion of the trial after an interim analysis. The BRCA-mutated subset clearly benefited, as measured by rPFS (HR, 0.55; 95% CI, 0.39–0.78) and more, and the FDA has now approved the abiraterone/prednisone/niraparib combination in the front-line setting in

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patients with BRCA-mutated mCRPC.

Next up was the TALAPRO-2 study.[4] In this case, enzalutamide with or without talazoparib was assessed in the front-line setting in patients with mCRPC. Patients were prospectively assessed for HRR gene alterations (BRCA1, BRCA2, PALB2, ATM, ATR, CHEK2, FANCA, RAD51C, NBN, MLH1, MRE11A, and CDK12) and then stratified by the HRR gene alteration status (deficient, nondeficient, or unknown). In TALAPRO-2, the outcomes scenario was somewhat different than that observed in MAGNITUDE and in PROpel. The BRCA-mutated subset truly benefited, and the rPFS hazard ratio was a striking 0.23 (95% CI, 0.10–0.53) for combination therapy in that subset. Perhaps surprising was the finding that the non–BRCA-mutated HRR-mutant population also had a positive trend for rPFS (HR, 0.66; 95% CI, 0.39–1.12). Dose reductions for talazoparib were common, and 19.1% of the patients discontinued talazoparib because of adverse events. Clearly, talazoparib-treated patients need to be carefully monitored. Given the totality of the evidence, the FDA approval for the enzalutamide/talazoparib combination included a relatively broad label, including mutations in ATM, ATR, BRCA1, BRCA2, CDK12, CHEK2, FANCA, MLH1, MRE11A, NBN, PALB2, and RAD51C.

A phase I trial in mCRPC using PARP inhibition in combination with prostate-specific membrane antigen (PSMA)–targeted lutetium-177 (^{177}Lu) was also reported for the first time.[5] Using an intermittent olaparib approach combined with the standard doses of ^{177}Lu-PSMA-617, provocative data were presented at the 2023 annual ASCO meeting. Efficacy data were interesting when looking at prostate-specific antigen declines, and adverse events were more limited than might be expected. These data pave the path forward for PARP inhibitors to be used in the future in combination with other DNA-damaging agents. Such combinations might involve ^{177}Lu and/or various targeted alpha emitters, including using lead-212, astatine-211, and/or actinium-225.

So, what do we learn overall in 2023? The risk/benefit ratio of PARP inhibitors in non-selected patients is not sufficient to justify their use, but the activity of a PARP inhibitor in combination with an ARPI is quite substantial for the front-line treatment of patients with mCRPC with a BRCA mutation. In fact, the observed hazard ratios for rPFS are among the best ever reported in prospective trials. Precision medicine works when patients are properly selected.

What next? Multiple trials are now evaluating PARP inhibitors in mCRPC. These trials include talazoparib and niraparib but not rucaparib or olaparib. Olaparib patents will expire soon, and more investments are not being made in that asset. The TRITON3 trial was positive with rucaparib, but the sponsor went bankrupt anyway. Bankruptcy is a major impediment to additional trial sponsorship!

Newer PARP inhibitors are under development. Selective PARP-1 inhibitors[6] have much less myelosuppression. More trials are needed to prove the point, but less myelosuppression may be particularly welcomed when being used in combination with DNA-damaging agents such as PSMA-targeted isotopic therapy. The saga will continue, and additional studies with DNA repair inhibitors in prostate cancer will continue for many years to come.

Top 10 prostate cancer stories in 2023:

urologytimes.com
Hannah Clarke

As the year comes to a close, we revisit some of this year's top content on prostate cancer.
There's been an abundance of news surrounding prostate cancer advances over the last year. In honor of these breakthroughs, *Urology Times*® is highlighting our top content on prostate cancer from 2023.

(Continued on page 8)

FDA approves enzalutamide for nonmetastatic CSPC

In November 2023, the FDA approved enzalutamide (Xtandi) for use with or without a GnRH analog therapy for the treatment of patients with nonmetastatic castration-sensitive prostate cancer with biochemical recurrence at high risk for metastasis. The approval was based on findings from the phase 3 EMBARK trial (NCT02319837), which showed that enzalutamide plus leuprolide reduced the risk of metastasis or death by 58% compared with placebo plus leuprolide in this patient population (HR, 0.42; 95% CI, 0.30-0.61; *P* < .001). Read more on the approval here.

ProtecT trial researchers: Active monitoring yields same outcomes as radical treatment in prostate cancer

In an interview with Urology Times, **Freddie C. Hamdy, FRCS, FMedSci**, and **Jenny L. Donovan, PhD, FMedSci**, shared the 15-year clinical and patient-reported outcomes from the ProtecT trial (NCT02044172), which suggest that many patients with localized prostate cancer can delay surgery or radiation without increasing their mortality risk. Read their full discussion here.

177Lu-PNT2002 shows initial safety and efficacy in mCRPC

Reported topline results from the phase 3 SPLASH trial (NCT04647526) show initial safety and efficacy of 177Lu-PNT2002, an investigational prostate-specific membrane antigen (PSMA)-targeted radioligand therapy, in patients with metastatic castration-resistant prostate cancer who have progressed following treatment with androgen receptor pathway inhibitor (ARPI). Overall, 177Lu-PNT2002 demonstrated a median radiographic progression-free survival of 9.5 months, compared with 6.0 months among patients in the control arm, who were treated with an ARPI. Read more on the initial findings here.

EpiSwitch Prostate Screening blood test launches on US market

In September 2023, the EpiSwitch Prostate Screening (PSE) blood test was clinically validated and became available to men in the US being screened for prostate cancer. The PSE test was shown to improve the predictive accuracy of a standard PSA test from 55% to 94%. Read more here.

Dr. Dallos discusses emerging treatments in the mCRPC paradigm

At the 16th Annual Interdisciplinary Prostate Cancer Congress® and Other Genitourinary Malignancies, **Matthew Dallos, MD** of Memorial Sloan Kettering Cancer Center, discussed emerging treatment options for patients with metastatic castration-resistant prostate cancer (mCRPC). Antibody-drug conjugates, including those targeting PSMA, are among the next wave of treatment advances in mCRPC, Dallos noted. Read more on the session here.

Minimizing incontinence after radical prostatectomy: Lessons learned

Ricardo Soares, MD, discusses the techniques he and other experts employ to minimize incontinence after radical prostatectomy. Soares is a urologist with Northwestern Medicine in Chicago (Western suburbs), Illinois. Read his full discussion here.

Plant-based diets linked to lower risk of prostate cancer progression and recurrence

Findings shared during the 2023 ASCO Genitourinary Cancers Symposium showed that patients with prostate cancer whose diets included the highest amounts of plants had a lower risk of disease progression and recurrence. Data showed that plant-based diets were associated with improved outcomes, as the group of patients with the highest consumption of plant-based foods had a 52% lower risk of disease progression compared with the group of patients with diets that included the lowest amounts of plants (HR, 0.48; p-trend < .001). Read more on the findings here.

Study evaluates patient experiences with biopsy-based genomic testing during active surveillance

Michael S. Leapman, MD, MHS, discusses a qualitative descriptive study comprised of in-depth, semi-structured interviews of patients with low- or favorable-intermediate-risk prostate cancer undergoing active surveillance. The interviews were designed to gain an understanding of the patients' experiences with biopsy-based genomic testing as they made decisions regarding the management of their prostate cancer. Read the full interview here.

Monitoring, feedback, and financial incentives improve uptake of active surveillance

Badar M. Mian, MD, discusses a report from the Michigan Urologic Surgery Improvement Collaborative (MUSIC) that describes the results of a previously deployed initiative to define and implement quality metrics and improve active surveillance (AS) utilization rates in patients with favorable risk prostate cancer. The authors compared AS rates from the MUSIC registry with those from the national Surveillance, Epidemiology, and End Results (SEER) program. Read the full discussion here.

Phase 3 ARASTEP study to investigate darolutamide plus ADT for hormone-sensitive prostate cancer

In March 2023, the phase 3 ARASTEP study was initiated to investigate the efficacy of darolutamide (Nubeqa) plus androgen deprivation therapy (ADT) vs ADT alone in hormone-sensitive prostate cancer. The randomized trial is expected to enroll 750 patients with hormone-sensitive prostate cancer. Read more on the study here.
You can view all of our content surrounding advances in prostate cancer here.

Cardiovascular risks of androgen receptor targeted agents in prostate cancer: a systematic review and meta-analysis

Chloe Shu Hui Ong, Yu Xi Terence Law, Lin Kyaw, Qi Yang Lim, Tim Loke, Qing Hui Wu, Ho Yee Tiong & Edmund Chiong

Prostate Cancer and Prostatic Diseases (2024)Cite this article

Abstract

Introduction Androgen receptor targeted agents (ARTA) have increasingly been incorporated into treatment regimens for various stages of prostate cancer. Patients are living longer with prostate cancer, and thus have a higher cumulative exposure to the treatment and its accompanying side effects, especially those of cardiovascular disease. We aim to assess the differences in the incidence of cardiac-related adverse events after treatment of prostate cancer with ARTA versus placebo.

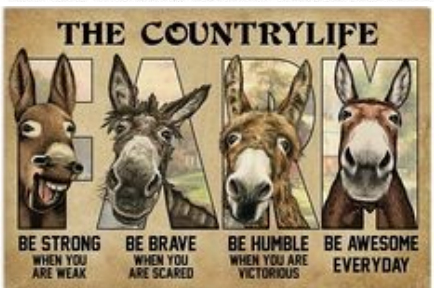
Methods Three databases were thoroughly searched for relevant articles. The PICOS model was used to frame our clinical question, with which 2 independent authors went through several rounds of screening to select the final included studies. Meta-analysis was done using the Cochran-Mantel-Haenszel Method. Quality assessment was carried out with the Cochrane Risk of Bias tool RoB 2.

Results The use of ARTA in prostate cancer increases the incidence of cardiac-related adverse events (RR: 1.56, 95% CI: 1.29–1.90, $p < 0.00001$), such as hypertension (RR: 1.69, 95% CI: 1.46–1.97, $p < 0.00001$), ischaemic heart disease (RR: 1.84, 95% CI: 1.36–2.50, $p < 0.0001$), and arrhythmia (RR: 1.38, 95% CI: 1.11–1.71, $p = 0.004$), although this did not manifest in an increased incidence of cardiac arrests/deaths (RR: 1.28, 95% CI: 0.87–1.88, $p = 0.21$).

Discussion ARTA increases the risk of cardiac-related adverse events, hypertension, ischaemic heart disease and arrhythmia. Armed with this knowledge, we will be better poised to manage cardiac risks accordingly and involve a cardiologist as required when starting patients on ARTA

On the Lighter Side

WE'D LIKE TO SPEAK TO YOU ABOUT YOUR PREDICTION



NOAH KNEW THERE WOULDN'T BE ANOTHER FLOOD, YET HIS ARK REFLEX REMAINED HEIGHTENED FOR YEARS TO COME

NETWORKING

Please help us in our outreach efforts. Our speakers bureau consisting of Gene Van Vleet and Bill Lewis is available to speak to organizations of which you might be a member. Contact Gene 619-890-8447 or gene@ipcsg.org or Bill 619-591-8670 (bill@ipcsg.org) to coordinate.

Member John Tassi is the webmaster of our website and welcomes any suggestions to make our website simple and easy to navigate. Check out the Personal Experiences page and send us your story. Go to: https://ipcsg.org/personal-experience

FINANCES

We want to thank those of you who have made special donations to IPCSG. Remember that your gifts are tax deductible because we are a 501(c)(3) non-profit organization.

We again are reminding our members and friends to consider giving a large financial contribution to the IPCSG. This can include estate giving as well as giving in memory of a loved one. You can also have a distribution from your IRA made to our account. We need your support. We will, in turn, make contributions from our group to Prostate Cancer researchers and other groups as appropriate for a non-profit organization. Our group ID number is 54-2141691. Corporate donors are welcome!

DIRECTIONS TO MEETINGS

Directions to Sanford-Burnham-Prebys Auditorium
10905 Road to the Cure,
San Diego, CA 92121

- Take I-5 (north or south) to the Genesee exit (west).
- Follow Genesee up the hill, staying right.
- Genesee rounds right onto North Torrey Pines Road.
- **Do not turn into the Sanford-Burnham-Prebys Medical Discovery Institute or Fishman Auditorium**
- Turn right on Science Park Road. Watch for our sign here.
- Turn Left on Torreyana Road. Watch for our sign here.
- Turn Right on Road to the Cure (formerly Altman Row). Watch for our sign here.