Conference Abstracts

Survival outcomes and characterization of patients (pts) with metastatic castration-sensitive prostate cancer (mCSPC) undergoing intensified androgen deprivation therapy (ADT) who do not achieve an optimal PSA response (PSA ≤0.2 ng/mL).

Nicolas Sayegh, MD¹, Nishita Tripathi¹, Beverly Chigarira¹, Yeonjung Jo¹, Taylor Ryan McFarland¹, Adam Kessel¹, Roberto Nussenzveig¹, Haoran Li², Clara Tandar², Divyam Goel¹, Kamal Kant Sahu¹, Benjamin Haaland¹, Benjamin L. Maughan¹, Umang Swami, MD³, Neeraj Agarwal¹

¹ University of Utah- Huntsman Cancer Institute

Keywords: prostate cancer, hormonal therapy, abstract conference

https://doi.org/10.53876/001c.38845

International Journal of Cancer Care and Delivery
Vol. 2, Issue Supplement 2, 2022

BACKGROUND

In pts with mCSPC undergoing intensified ADT, achieving a PSA nadir ≤0.2 ng/mL "anytime" after the start of treatment was associated with a significantly improved overall survival (OS) versus those with a PSA >0.2 ng/mL: HR 0.17 (95% CI, 0.13-0.23) (Chi AUA 2021, abstract 1281). Our objective was to validate these findings in a real-world population and characterize the clinical and tumor genomic landscape according to PSA response.

METHODS

In this IRB-approved study, patient-level data were collected retrospectively. Eligibility: presence of mCSPC undergoing intensified ADT with either docetaxel or novel hormonal therapy (NHT) started within 3 months of diagnosis, availability of PSA nadir, and availability of tumor comprehensive genomic profiling (CGP) prior to start of ADT. Variants of unknown significance and genomic aberrations present in <5% pts were excluded. Optimal PSA response (OR): PSA≤0.2 ng/mL. Study endpoints: PFS was calculated per PCWG-2 defined PSA progression or radiographic progression or clinical progression whichever occurred first; OS was defined as start of therapy to date of death or censored after last follow-up. The relationship between PSA nadir and both PFS and OS was assessed in the context of Cox proportional hazards. Gene prevalence was compared using a chi square test.

RESULTS

134 pts were eligible and included. Optimal responders (OR) (n=104) and non-OR (n=30); median age at diagnosis 65 vs 65 years; median PSA at ADT start 18.1 vs 74.5 ng/mL; high volume of disease 48% vs 77%. For OR and non-OR: median PFS, 60.6 vs 13.2 (P<0.001); median OS, 94.9 vs 35.2 months (P<0.001) respectively. Multivariate analysis is described in the table.

CONCLUSIONS

Only a minority of pts with mCSPC do not achieve an optimal PSA response with intensified ADT. Those non-OR have worse outcomes on treatment with intensified ADT. Herein we externally validate that achieving a PSA nadir ≤0.2 ng/mL is correlated with superior OS. Detailed genomic landscape of these pts will be presented in the meeting.