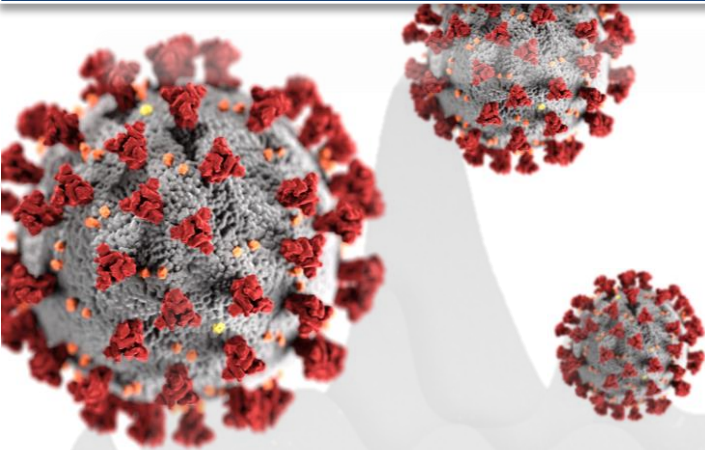




Managing Prostate Cancer Beyond the Acute Phase of COVID-19



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- CMA Code of Ethics and Professionalism (Update 2004, last reviewed March 2018)
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- Bayer and Sanofi manufacture products in therapeutic categories that will be discussed in this program; specific product mentions include: cabazitaxel (Sanofi), darolutamide (Bayer), and radium-223 (Bayer)



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Agenda

Learning Objectives

Sources of Guidance

Considerations for Developing Local Cancer Management Plans

Considerations for Prostate Cancer Management

Localized, Prostate Cancer

Locally Advanced Prostate Cancer

Metastatic Hormone-Sensitive Prostate Cancer (mHSPC)

Castration-resistant prostate cancer (CRPC)

Closing Discussion

Learning Objectives

Participants will examine and discuss guidance regarding prostate cancer management in the environment of COVID-19 infection.

By the end of this program, participants will be able to:

- Contribute to formulating management plans for patients with prostate cancer in their local practices appropriate to a chronic phase of the COVID-19 pandemic
- Manage patients with prostate cancer with consideration for increasing or decreasing access to local resources resulting from an evolving COVID-19 environment

Sources of Guidance

CUOG-CUA	Kokorovic A, et al. Canadian framework for managing prostate cancer during the COVID-19 pandemic: Recommendations from the Canadian Urologic Oncology Group and the Canadian Urological Association. Can Urol Assoc J. 2020 Apr 28. doi: 10.5489/cuaj.6667.
Canadian GU Med Onc Panel	Lalani A-K A, et al. Prioritizing systemic therapies for genitourinary malignancies: Canadian recommendations during the COVID-19 pandemic. Can Urol Assoc J 2020;14(5):E154-8. http://dx.doi.org/10.5489/cuaj.6595
EAU	Ribal MJ, et al. EAU Guidelines Office Rapid Reaction Group: An organisation-wide collaborative effort to adapt the EAU guidelines recommendations to the COVID-19 era. https://uroweb.org/guideline/covid-19-recommendations/
BC Cancer	BC Cancer. Provincial Cancer Clinical Management Guidelines in Pandemic Situation (COVID-19). Apr. 20, 2020. http://www.bccancer.bc.ca/health-professionals-site/Documents/provincial_cancer_clinical_management_guidelines_pandemic_situation_covid19_april20_2020.pdf
OH-CCO	Ontario Health - Cancer Care Ontario: COVID-19 Supplemental Clinical Guidance for Patients with Cancer. March 29, 2020. https://www.ontariohealth.ca/COVID-19
MSSS	Sante et Services sociaux Quebec. Recommandations pour la priorisation des patients en contexte de pandémie de COVID-19 – Volet Cancers urologiques. April 15, 2020. https://msss.gouv.qc.ca/professionnels/documents/coronavirus-2019-ncov/PJ2_Recommandations_cancers-urologiques_200415.pdf
INESSS	COVID-19 : Revue des lignes directrices et recommandations pour la prise en charge des cancers urologiques en contexte de pandémie. May 4, 2020. https://www.inesss.qc.ca/fileadmin/doc/INESSS/COVID-19/COVID-19_INESSS_cancer_urologique.pdf

Considerations for Developing Local COVID-19 Cancer Management Plans

Providing Cancer Care During an Evolving COVID-19 Environment: General Principles

- Treatment prioritization must take into account regional differences in infection rates, resource capacity, and mitigation efforts¹
- The risk of serious morbidity resulting from SARS-CoV-2 infection may outweigh the competing risk of prostate cancer in many men¹
- Appropriate patient counselling and shared decision-making is strongly encouraged¹
- Prioritization must be given to limiting exposures of patients and healthcare workers to SARS-CoV-2

COVID-19 in Canada (June 7, 2020)²

Hospitalized cases		16%
Deaths		8%
Age Group	Proportion of Cases	Proportion of Deaths
40-59	31%	3%
60-79	18%	25%
80+	18%	72%
Gender		
Male	43%	46%

1. Lalani A-K A, et al. Can Urol Assoc J 2020;14(5):E154-8. <http://dx.doi.org/10.5489/cuaj.6595>

2. PHAC. COVID-19 Daily Epidemiology Update. June 7, 2020. <https://www.canada.ca/content/dam/phac-aspc/documents/services/diseases/2019-novel-coronavirus-infection/surv-covid19-epi-update-eng.pdf>

Planning in an Evolving COVID-19 Environment

- The source guidance documents provide recommendations for cancer patient management during the acute phase of a pandemic
- Hanna and colleagues propose a conceptual framework for prioritizing cancer treatment focusing on 3 scenarios:¹
 1. Preparedness (no confirmed cases)
 2. Moderate healthcare resource limitations
 3. Severe healthcare resource limitations
- Limited guidance exists currently for the chronic phase



Treatment Goals During COVID-19 Phases

- Do not delay cancer treatment if at all possible, but if resources limit availability of care, prioritization is necessary
- The goal is to make sure that everyone can receive the most adequate treatment possible despite the crisis¹
- When the pandemic is over and activities resume a normal rhythm, the priorities of patients waiting for treatment should be respected in the interest of fairness¹

Multidisciplinary case conferences remain important venues to prioritize the care of complex patients and to continuously review policies in a rapidly changing context.²

1. Sante et Services sociaux Quebec. Recommandations pour la priorisation des patients en contexte de pandémie de COVID-19 – Volet Cancers urologiques. Apr.15, 2020
2. Hanna TP, et al. Nat Rev Clin Oncol. 2020. <https://doi.org/10.1038/s41571-020-0362-6>

Considerations for Prostate Cancer Management in a COVID-19 Environment

Surgery Considerations: Risks and Resource Utilization

Consider surgery-related risks

- Serious complications
- Increased risk of SARS-CoV-2 exposure to patients and healthcare professionals
- Robotic-assisted laparoscopic prostatectomy or laparoscopic RP may increase exposure to aerosolized virus
- Precautions necessary with minimally invasive surgery, eg, use of filter devices

Assess hospital resource utilization

- Access to operating theatre
- Anaesthesiology services
- Hospital equipment
- Hospital/intensive care beds

RP = radical prostatectomy

1. Kokorovic A, et al. Can Urol Assoc J. 2020 Apr 28. doi: 10.5489/cuaj.6667.
2. Sante et Services sociaux Quebec. Recommandations pour la priorisation des patients en contexte de pandémie de COVID-19 – Volet Cancers urologiques. 2020 Apr.15.

Recommendations Regarding Risk of COVID-19 Transmission During Minimally Invasive Surgery (MIS)

- Concern regarding risk of exposure from CO2 created during MIS procedures
- Lack of definitive data demonstrating active COVID-19 virus present in CO2 aerosol
- Efforts to protect operating room staff should be implemented to decrease exposure to surgical smoke, including:
 - Pre-operative testing in all patients scheduled for MIS surgery
 - Comprehensive personal protective equipment for staff
 - Reducing the production of surgical plume and filtration of CO2 through approved filters

Radiation Therapy (RT) Considerations: Risks and Resource Utilization

- Treatment-related risks:
 - Brachytherapy carries risk of serious complications
 - Increased risk of SARS-CoV-2 exposure to patients and healthcare professionals
 - External beam RT mitigates some risk, but requires multiple hospital visits
- Hospital resource utilization
 - Anaesthesiology services
 - Hospital equipment
 - Hospital beds

Many RT groups have instituted short-course interim policies leaning on SBRT techniques

1. Kokorovic A, et al. Can Urol Assoc J. 2020 Apr 28. doi: 10.5489/cuaj.6667.

2. Sante et Services sociaux Quebec. Recommandations pour la priorisation des patients en contexte de pandémie de COVID-19 – Volet Cancers urologiques. 2020 Apr.15.

Systemic Therapy Considerations: Risks and Resource Utilization

Treatment	Considerations
Chemotherapy	- Frequent hospital resource utilization¹ - Toxicities eg, neutropenia risk^{1,2} – <i>consider G-CSF support</i> - Higher risk for severe illness³ - Consider reducing number of cycles or lengthening intervals²
ARAT	- Use home monitoring programs to avoid unnecessary hospital/clinic visits*³ - For patients progressing on abiraterone, consider switch from prednisone to dexamethasone to delay time to chemotherapy (<i>Ph 2 SWITCH study</i>)³
ADT	- Consider longer-acting depots, eg, q 3-6 monthly LHRH analogs^{†‡3,4} - Home injection programs³

*Maintain ongoing awareness of transmission risks associated with local home care services. Canadian home care guidance can be found at: <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/infection-prevention-control-covid-19-interim-guidance-home-care-settings.html>

[†]Degarelix may still be indicated in men with contraindications to GNRH depot injections and/or who require rapid testosterone suppression because of symptomatic disease burden.

[‡]6-month formulations available in Canada include leuprolide acetate and triptorelin injectable suspensions.

ADT = Androgen deprivation therapy; ARAT = androgen receptor axis therapy; GNRH = gonadotropin-releasing hormone; LHRH = luteinizing hormone-releasing hormone.

1. Lalani A-K A, et al. Can Urol Assoc J 2020;14(5):E154-8.

2. Sante et Services sociaux Quebec. Recommandations pour la priorisation des patients en contexte de pandémie de COVID-19 – Volet Cancers urologiques. 2020 Apr.15.

3. Kokorovic A, et al. Can Urol Assoc J. 2020 Apr 28. doi: 10.5489/cuaj.6667.

4. BC Cancer. Provincial Cancer Clinical Management Guidelines in Pandemic Situation (COVID-19). 2020 Apr.20.

Systemic Therapy Considerations: Risks and Resource Utilization *cont.*

Treatment	Considerations
Bone-targeted supportive therapies	• Encourage self-injection where possible¹ • Consider frequency of laboratory monitoring¹ • Temporarily discontinue therapy if laboratory monitoring is not possible¹ • Consider longer treatment intervals¹; eg, extending q 4 weekly denosumab to q 12 weekly² • Consider denosumab over zoledronic acid², or deferring therapies such as zoledronic acid³

Other considerations:

- Drug access via private insurance / occupational instability³
- Use standard of care protocols vs. compassionate access program⁴

1. Kokorovic A, et al. Can Urol Assoc J. 2020 Apr 28. doi: 10.5489/cuaj.6667.

2. Ontario Health – Cancer Care Ontario. COVID-19 Supplemental Clinical Guidance for Patients with Cancer. March 29, 2020.

3. BC Cancer. Provincial Cancer Clinical Management Guidelines in Pandemic Situation (COVID-19). Apr.20, 2020.

Systemic Therapy Considerations: Risks and Resource Utilization *cont.*

Treatment	Considerations
Corticosteroids	• Consider avoiding or delaying treatments requiring corticosteroids, and discontinuing those in progress¹ • Glucocorticoids should be minimized as an adjunct to systemic therapies; use lowest effective dose²

- Advice from WHO and CDC to avoid corticosteroids is based on concerns that viral replication might be prolonged and clearance delayed (largely extrapolated from data on MERS-CoV and influenza)³
- Currently no evidence that corticosteroid therapy in cancer patients increases the risk of COVID-19 infection or leads to worse clinical outcomes in confirmed cases³
- Benefit or detriment of corticosteroid use may be influenced by intended use, timing of use relative to viral infection, dose, duration, and comorbidities
- The risk of viral infections at physiological steroid doses would appear low for patients with progressive prostate cancer³

Take Home Message:

- A risk-benefit analysis should be performed for each patient on the use of steroids in cancer care³

1. Sante et Services sociaux Quebec. Recommandations pour la priorisation des patients en contexte de pandémie de COVID-19 – Volet Cancers urologiques. Apr.15, 2020.

2. Lalani A-K A, et al. Can Urol Assoc J 2020;14(5):E154-8.

3. Waterhouse JV, et al. Eur Urol. 2020;78. [https://www.europeanurology.com/article/S0302-2838\(20\)30259-1/fulltext](https://www.europeanurology.com/article/S0302-2838(20)30259-1/fulltext)

Imaging Guidance: Prioritization of Oncology Patients

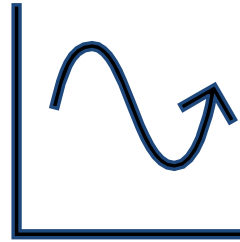
- Conduct “timed” imaging examinations during active phase of treatment (eg, assessment of response)
- Consider deferring surveillance imaging for recurrence

Modality	Considerations
CT and MRI	• Book per existing scheduling • Patients with neo/adjuvant indications with modest survival benefits could be considered for deferral
PET	• Perform imaging if new therapy is being considered • Consider deferring in patients with relatively indolent malignancies that will not be treated or therapy will not be altered during pandemic
BMD	• To be deferred unless expressly requested by oncology
Ultrasound	• Proceed as required for ongoing clinical management of cancer patients according to planning priority
Interventional Radiology	• Proceed as required for ongoing clinical management of cancer patients according to planning priority • Consider deferring prostate biopsy for non-high-risk patients

Priority levels: A – deemed critical; B – cancer patients requiring systemic/radiation treatment; C – generally healthy, non-life-threatening condition).

Discussion: What resource limitations are anticipated locally over the next 6 months?

- Surgery
- Radiation therapy
- Systemic therapy
- Imaging



Localized Prostate Cancer

Localized Low-Risk PC

(very-low, low- and favorable-intermediate risk [FIR])

Source	Guidance
CUOG-CUA (Kokorovic et al. Can Urol Assoc J. 2020)	General • <u>In-person</u> consult <u>not recommended</u> • <u>Diagnostic investigations</u> (imaging, biopsy) <u>not recommended</u> Patients on or choosing active surveillance • <u>Short-term suspension</u> of active surveillance where appropriate, including in-person clinic visits, DRE, PSA, imaging, repeat biopsy Patients choosing RP or RT • <u>Consider delay</u> of RP/RT • <u>Do not use NADT</u> to bridge the COVID-19 Patients on ongoing surveillance following definitive therapy • Consider decreasing frequency of PSA testing and deferring in-office appointments, particularly for patients >1 year since surgery or RT

Localized High-Risk PC

(unfavorable-intermediate risk [UIR], high-risk [HR], very high-risk [VHR])

Source	Guidance
CUOG-CUA (Kokorovic et al. Can Urol Assoc J. 2020)	New consults • <u>Proceed with diagnostic interventions and staging investigations</u> pending resource availability Patients choosing RT • <u>Begin NADT</u> per current best practice; 4-6 months of ADT is appropriate for UIR patients • Consider <u>hypofractionated protocols</u> to minimize centre visits Patients proceeding with RP • UIR, HR, and VHR patients require special consideration in centres deferring non-emergent surgical cases due to COVID-19; a <u>delay of 3 months</u> may be considered • <u>NADT prior to RP not recommended</u> outside of a clinical trial – If prolonged surgical delays are expected for a patient with UIR, HR, or VHR, NADT may be considered

Localized High-Risk PC

(unfavorable-intermediate risk [UIR], high-risk [HR], very high-risk [VHR])

Source	Guidance
CUOG-CUA (Kokorovic et al. Can Urol Assoc J. 2020)	Patients on surveillance following definitive therapy • <u>Conduct ongoing PSA testing and imaging if needed</u> to assess for recurrence • Consider <u>decreased frequency of testing</u> in men who have been <u>disease-free ≥2 yrs</u> • Transition to <u>telehealth</u>

Discussion: Managing localized prostate cancer in the chronic phase of COVID-19

- **What will we continue to implement from the acute phase?**
- **How should deferred treatments be managed/prioritized?**

Locally-Advanced Prostate Cancer

Locally-Advanced PC

Source	Guidance
CUOG-CUA (Kokorovic et al. Can Urol Assoc J. 2020)	Newly diagnosed advanced PC • <u>In-person clinic consultations</u> recommended • <u>Full staging evaluation</u>, including lab testing and imaging recommended Patients with high-risk features post-RP • <u>Early salvage RT</u> is recommended <u>over upfront adjuvant RT</u> • Consider <u>hypofractionated RT</u> protocols • Men with <u>biochemical recurrence (BCR) and no evidence of metastases</u> should have <u>ongoing PSA testing and imaging</u>; frequency dictated by disease-risk and PSADT Newly diagnosed node-positive PC (without evidence of further metastasis) • Prescribe <u>ADT</u> and <u>consider EBRT</u> per best practice • Consider <u>hypofractionated RT</u> protocols • <u>Abiraterone</u> has shown benefit; consider requirement for <u>lab monitoring</u> and <u>physical examination</u> – recommend <u>delay</u> of abiraterone up to 6 months from diagnosis

Discussion: Managing locally advanced prostate cancer in the chronic phase of COVID-19

- **What will we continue to implement from the acute phase?**
- **Which treatment modifications are still required?**
- **How are/should deferred treatments being managed/prioritized?**

Metastatic Hormone-Sensitive Prostate Cancer (mHSPC)

Source	Guidance
CUOG-CUA (Kokorovic et al. Can Urol Assoc J. 2020)	Newly diagnosed mHSPC • <u>Recommend ARAT over docetaxel chemotherapy in addition to ADT</u> • Concerns with chemotherapy: higher risk for severe illness, more intense resource use and risk exposure Oligometastatic HSPC • Require ADT and may benefit from EBRT to prostate (with or without an ARAT) • Recommend <u>delaying RT</u> • If RT is administered, consider a <u>hypofractionated course</u>
Canadian GU Recommendations (Lalani et al. Can Urol Assoc J. 2020)	mHSPC • [per recommendations for newly diagnosed mHSPC above] • <u>ARAT initiation can be delayed up to 6 months post-initiation of ADT</u> (assuming castration resistance has not emerged)

Discussion: Managing mHSPC in the chronic phase of COVID-19

- **What will we continue to implement from the acute phase?**
- **How are/should deferred treatments being managed/prioritized?**

Castration-Resistant Prostate Cancer (CRPC)

Non-Metastatic Castration-Resistant Prostate Cancer (nmCRPC)

Source	Guidance
CUOG-CUA (Kokorovic et al. Can Urol Assoc J. 2020)	Newly diagnosed high-risk (PSADT <10 mo) nmCRPC - Consider apalutamide, enzalutamide, darolutamide per current SOC* nmCRPC with prolonged PSADT - Consider decreasing the frequency of imaging

Metastatic Castration-Resistant Prostate Cancer (mCRPC)

Source	Guidance
CUOG-CUA (Kokorovic et al. Can Urol Assoc J. 2020)	Patients with mCRPC not previously treated with an ARAT • Recommend <u>ARAT</u> over chemotherapy • Consider <u>radium-223</u> in men with bony metastases Patients with painful bone metastases or bone metastases at high risk of fracture (eg, vertebra/pelvis/femur) • Refer to radiation oncology for short course of palliative RT
Canadian GU Recommendations (Lalani et al. Can Urol Assoc J. 2020)	First-line mCRPC • Recommend <u>ARAT</u> when not used previously • If ARAT used for nmCRPC or HSPC and chemotherapy would be treatment choice, consider: 1) whether chemotherapy can be safely delayed; 2) individual risks of COVID-19; 3) hospital resource constraints • Consider <u>radium-223</u> over chemotherapy in patients with bone-only mCRPC

Radium-223 supply from the manufacturer has not been impacted during the pandemic.

mCRPC – Second Line

Source	Guidance
Canadian GU Recommendations (Lalani et al. Can Urol Assoc J. 2020)	Second-line mCRPC • Recommend ARAT when not used previously • If ARAT used previously and chemotherapy would be treatment choice, consider: – whether chemotherapy can be safely delayed – individual risks of COVID-19 – hospital resource constraints • Consider radium-223 over chemotherapy in patients with bone-only mCRPC

Radium-223 supply from the manufacturer has not been impacted the pandemic.

mCRPC – Third Line

Source	Guidance
Canadian GU Recommendations (Lalani et al. Can Urol Assoc J. 2020)	Third-line mCRPC - Recommend alternate ARATs over alternate chemotherapy - Level 1 data support alternate chemotherapy, however hospital constraints may preclude IV chemotherapy and adverse event management - If ARAT used previously and chemotherapy would be treatment choice, consider: - whether chemotherapy can be safely delayed; - individual risks of COVID-19; - hospital resource constraints - Consider radium-223 over chemotherapy in patients with bone-only mCRPC

Discussion: Managing CRPC in the chronic phase of COVID-19

- **What will we continue to implement from the acute phase?**
- **What treatment preferences/modifications are still required?**
- **How are/should deferred treatments being managed/prioritized?**

Final Discussion: Managing prostate cancer in the chronic phase of COVID-19

- **What will we continue to implement from the acute phase?**
 - Telehealth
 - Patient support services (eg, home injection, bloodwork, blood pressure) where local home care providers are able to maintain a high level of COVID-19 safety
 - More thoughtful reasoning of optimal timing and choice of anticancer therapy to maximize risk/benefit ratio
- **What treatment preferences/modifications are still required?**
- **How are/should deferred treatments being managed/prioritized?**
 - In consultation with patient and family
 - In a multidisciplinary fashion
 - By taking into account the likelihood of progression and the impact of deferral, delay or sub-optimal therapy on patient prognosis
 - By prioritizing patients at highest risk of being negatively impacted by delay/deferral of treatment

Managing Prostate Cancer Beyond the Acute Phase of COVID-10

- **Key insights and takeaways from the acute phase:**
 - Telehealth can be used effectively in many circumstances
 - Treatment options with lower risk of complications should be considered during periods of increased risk/resource limitations
- **Considerations for the chronic phase:**
 - Maintain capacity in the system
 - Routinely review local policies
 - Discuss implications of COVID-19 environment on prostate cancer management with patients and family

End

APPENDIX

- EAU guidelines
- BC Cancer guidelines
- OH-CCO guidance
- MSSS recommendations

EAU Guidelines

Localized Low-Risk PC

Source	Guidance
EAU Guidelines (Ribal et al. 2020 uroweb.org)	Low risk – active surveillance • Postpone confirmatory rebiopsy as well as DRE • PSA can be postponed for up to 6 months Low risk – active treatment • Postpone and encourage patients to have treatment deferred for 6-12 months

Localized Intermediate-Risk PC

Source	Guidance
EAU Guidelines (Ribal et al. 2020 uroweb.org)	Intermediate risk – active surveillance (G3+4) - DRE and repeated biopsy when medical resources allow Intermediate risk – RP - RP can be <u>postponed</u> until after pandemic <u>Do not use NADT</u> Intermediate risk – EBRT - For EBRT, use moderate <u>hypofractionation</u> (20x3 Gy) starting with <u>NADT</u> that might be prolonged for up to 6 months <u>Avoid invasive procedures</u> such as fiducial insertion and/or rectal spacers Intermediate risk – brachytherapy <u>Postpone or consider an alternative</u> modality (invasive procedures carry higher risk of COVID-19 transfer)

Localized High-Risk PC

Source	Guidance
EAU Guidelines (Ribal et al. 2020 uroweb.org)	RP • Postpone until after pandemic • If patient anxious, consider ADT + EBRT EBRT • Use immediate NADT for up to 6 months followed by EBRT and long-term ADT • Do not use fiducials or spacers

Locally-Advanced PC

Source	Guidance
EAU Guidelines (Ribal et al. 2020 uroweb.org)	Locally-Advanced PC (including cN1) RP • Do not use NADT to postpone RP • Consider long term ADT + EBRT as an alternative to surgery EBRT • Start immediate NADT if symptomatic, followed by EBRT 6-12 months later • Avoid invasive procedures (eg, fiducial insertion, rectal spacers)

Follow-up After Treatment with Curative Intent

Source	Guidance
EAU Guidelines (Ribal et al. 2020 uroweb.org)	General • Offer telemedicine as often as possible • Only patients in absolute need of clinical exam should have it Persistently elevated PSA • Postpone PET imaging • If treatment deemed necessary, start ADT and postpone further work-up and potential EBRT later PSA relapse after local treatment • Defer imaging • After RP: Offer salvage EBRT for patients with EAU high-risk BCR if available; if not consider ADT with EBRT after pandemic • After EBRT: If salvage needed, offer ADT initially if PSADT <12 months

Source	Guidance
EAU Guidelines (Ribal et al. 2020 uroweb.org)	Low-volume mHSPC – if clinical harm unlikely if postponed 6 months - When ADT + prostate EBRT is considered, <u>postpone EBRT</u> mHSPC – if clinical harm is very likely if postponed >6 weeks - Offer immediate treatment with <u>ADT plus (alphabetically) abiraterone acetate + prednisone (consider 5 mg QD) OR apalutamide OR enzalutamide</u> - Avoid ADT with docetaxel based on risk for neutropenia and frequent hospital visits

Source	Guidance
EAU Guidelines (Ribal et al. 2020 uroweb.org)	• Treat patients with life-prolonging agents • Base the choice of first-line treatment on: – PS – Symptoms – Comorbidities – Location and extent of disease – Patient preference – Previous treatment for HSPC – Use of medical resources – Specific risk during COVID-19 pandemic • <u>Avoid chemotherapy</u> as much as possible; if absolutely needed: use docetaxel 75 mg/m² q 3 weekly with G-CSF to avoid a higher number of visits or 50 mg/m² q 2 weekly • Give cabazitaxel 20 mg/m² with G-CSF if indicated and no other treatment option is available • <u>Abiraterone + prednisone</u> 10 mg daily might be reconsidered (steroid use)

BC Cancer Guidelines

Localized Low-Risk PC

(low-risk or favorable-intermediate risk disease)

Source	Guidance
 BC Cancer April 20, 2020 (bccancer.bc.ca)	General • Most low-risk and intermediate-risk PC patients can be deferred or converted to EBRT during a prioritization phase

Localized High-Risk PC

(unfavourable-intermediate risk or high-risk disease)

Source	Guidance
 BC Cancer April 20, 2020 (bccancer.bc.ca)	RT • Consider EBRT as alternative for patients already on RT if long delay to brachytherapy is anticipated • If patient has completed/due to complete EBRT component of brachytherapy boost protocol, boost should occur within 10 days of EBRT for HDR, and within 5 weeks of EBRT for LDR if capacity allows and patient is infection category 1 (asymptomatic, not in isolation) • For patient pending an HDR boost, consider switch to LDR boost to minimize operating room and anesthesia time

Source	Guidance
 BC Cancer April 20, 2020 (bccancer.bc.ca)	• Patients considered for radium-223 should be assessed for their goals relative to the state of the pandemic, and alternate methods of symptom control may be appropriate • Patients on a course of radium-223 should be evaluated by phone for symptoms and progression; there should be a lower threshold than usual for deferring or cancelling treatment

Radium-223 supply from the manufacturer has not been impacted during the pandemic.

OH-CCO Guidance

Source	Guidance
 Ontario Health – Cancer Care Ontario March 29, 2020 (ontariohealth.ca)	mHSPC • Continue ADT • ARATs are preferred over docetaxel but currently not funded; abiraterone and apalutamide may be obtained through manufacturer compassionate supply

Localized High-Risk PC

(unfavourable-intermediate risk or high-risk disease)

Source	Guidance
 Ontario Health – Cancer Care Ontario March 29, 2020 (ontariohealth.ca)	• If decision is to treat rather than delay therapy using ADT, consider • a 5 fraction SBRT approach (PACE study) or • a 7 fraction IMRT/VMAT strategy (HYPO-RT-PC trial)

Non-Metastatic Castration-Resistant Prostate Cancer (nmCRPC)

Source	Guidance
 Ontario Health – Cancer Care Ontario March 29, 2020 (ontariohealth.ca)	nmCRPC • Apalutamide (funded) or enzalutamide are options* *Darolutamide received Health Canada approval (Feb. 20, 2020) for the treatment of patients with nmCRPC.

Source	Guidance
 Ontario Health – Cancer Care Ontario March 29, 2020 (ontariohealth.ca)	• Goal is to avoid taxane or chemotherapy • Treat with an ARAT if no prior use • If good response to a prior ARAT, recommend another ARAT over chemotherapy • Radium-223 should be given precedence over chemotherapy (less immunosuppressive); consider nuclear medicine resource availability

Radium-223 supply from the manufacturer has not been impacted during the pandemic.

MSSS Recommendations

Localized Low-Risk PC

(low-risk or favorable-intermediate risk disease)

Source	Guidance
 MSSS Recommendations April 15, 2020 (msss.gouv.qc.ca)	General • All treatments can be postponed for a period of 3 to 6 months with follow-up appropriate • Recommended therapeutic alternatives (taking into account resource availability): – Active surveillance - favoured approach – RT - if RT is necessary, use a hypofractionated or ultra-hypofractionated regimen, provided this approach is safe for the patient; without NADT

Localized High-Risk PC

(unfavourable-intermediate risk or high-risk disease)

Source	Guidance
 MSSS Recommendations April 15, 2020 (msss.gouv.qc.ca)	RP • Perform only if very high-risk disease General • All other treatments should be postponed for a period of 3 months if possible • Recommended therapeutic alternatives (taking into account resource availability): – RT: when necessary, use a hypofractionated regimen, provided this approach is safe for the patient – Begin NADT while awaiting definitive treatment

Managing Recurrent Disease

Source	Guidance
 MSSS Recommendations April 15, 2020 (msss.gouv.qc.ca)	Recurrent disease post-prostatectomy • Delay salvage RT • If recurrent disease is high risk, start hormone therapy while waiting to administer RT

Metastatic Prostate Cancer

Source	Guidance
 MSSS Recommendations April 15, 2020 (msss.gouv.qc.ca)	Metastatic Prostate Cancer • Begin first-line treatment as soon as possible • Give preference to ADT plus ARAT over chemotherapy (according to the clinical situation) • Avoid or limit use of corticosteroids • Delay or avoid radiotherapy for oligometastatic disease • Treatment considerations – When chemotherapy is necessary, limit the number of cycles and consider dose reduction (<i>and/or use of G-CSF</i>) – Give preference to apalutamide- and enzalutamide-based treatment – Give preference to radium-based treatment over chemotherapy for second-line or later treatment • Consider more frequent (<i>virtual</i>) follow-up to avoid unplanned hospitalization and emergency department visits