American Cancer Society®

NATIONAL PROSTATE CANCER ROUNDTABLE

Managing Special Care Considerations in the Treatment of Advanced Prostate Cancer

March 5, 2026
3:00 – 4:00 PM ET

Thank You to Our Sponsors!

Pfizer has provided funding to ACS in support of the launch of “Change the Odds: Uniting to Improve Cancer Outcomes™,” a new initiative to start creating change where it is most urgently needed: in communities disproportionately impacted by breast and prostate cancer.

Ground Rules

1 **Nonpartisan Commitment & Discussion Guidelines**

ACS/ACS CAN is a nonprofit, nonpartisan organization. We believe everyone should have a fair and just opportunity to prevent, detect, treat, and survive cancer. We therefore ask that you avoid partisan topics and opinions today.

2 **ACS National Roundtable Rules for Engagement**

Rules for engagement clarify the expectations for participation by members and representatives of the ACS NPCRT. Members are expected to respect and comply with these Rules and all other applicable ACS policies.

3 **Confidentiality**

This webinar is being recorded. Please be mindful of our conversation and respectful of others' privacy. Do not identify or discuss specific patients by name.

General Webinar Housekeeping

This webinar will be archived on the ACS NPCRT website.

You will be muted with your video turned off when you join the webinar.

This webinar takes place on the Zoom platform. To review Zoom's privacy policy, please visit https://www.zoom.com/en/trust/terms/

Questions? Type them in the Question-and-Answer box at the bottom of your screen. We also encourage you to ask questions as they arise in the chat.

Previously on ACS NPCRT…

Our September 2025 webinar discussed the current landscape of clinical care for advanced prostate cancer, setting the stage for our Summit on special considerations and barriers to care. Today's webinar shares some of the themes discussed at the Summit, which the Roundtable has integrated into its Strategic Roadmap.

https://npcrt.org/resource/webinar-replay-recent-advances-in-the-clinical-management-of-metastatic-prostate-cancer-september-3-2025/

1) Learn about best practices in treating older or frail patients with prostate cancer

2) Learn how systemic therapy for prostate cancer can cause cardiovascular issues in some patients, and how to manage them

3) Understand the effect of prostate cancer therapy on bone health and how to minimize fracture risk in patients with advanced disease

American Cancer Society®

NATIONAL PROSTATE CANCER ROUNDTABLE

Learning Objectives

ACS NPCRT Team Members

Sarah Shafir, MPH
VP, National Roundtables and Coalitions

Lucas Brand, PhD
Strategic Director, ACS NPCRT

Michelle Chappell
Program Manager, National Roundtables and Coalitions

Pre-Test Poll

Meet The Experts

Alicia Morgans, MD, MPH
Associate Professor of Medicine
Medical Director, Survivorship Program
Dana-Farber Cancer Institute

Meet The Experts

Chuck Ryan, MD

GU Medical Oncologist

Memorial Sloan Kettering Cancer Center

Meet The Experts

Avirup Guha, MD

Assistant Professor, Cardiology

Medical College of Georgia

Disclosures

Alicia Morgans, MD, MPH

Honoraria for consulting: AAA, AstraZeneca, Astellas, Bayer, BMS, Curium, Johnson & Johnson, Exact Sciences, Exelixis, Merck, Sumitomo Pharma Inc, Pfizer, Novartis, Lantheus, Telix, Tolmar
Research funding and collaboration: Astellas, Bayer, BMS, Sumitomo Pharma Inc, Pfizer, Exact Sciences, Novartis, Johnson & Johnson, Lantheus, Telix

Chuck Ryan, MD

Honoraria: Johnson and Johnson, Bayer
Consulting: Tolmar, Novartis, Arsenal Bio, Bayer
Podcast support : Lilly

Avirup Guha, MD

No relevant disclosures to report

Special Considerations for Treating Advanced Prostate Cancer In Older Adult Populations

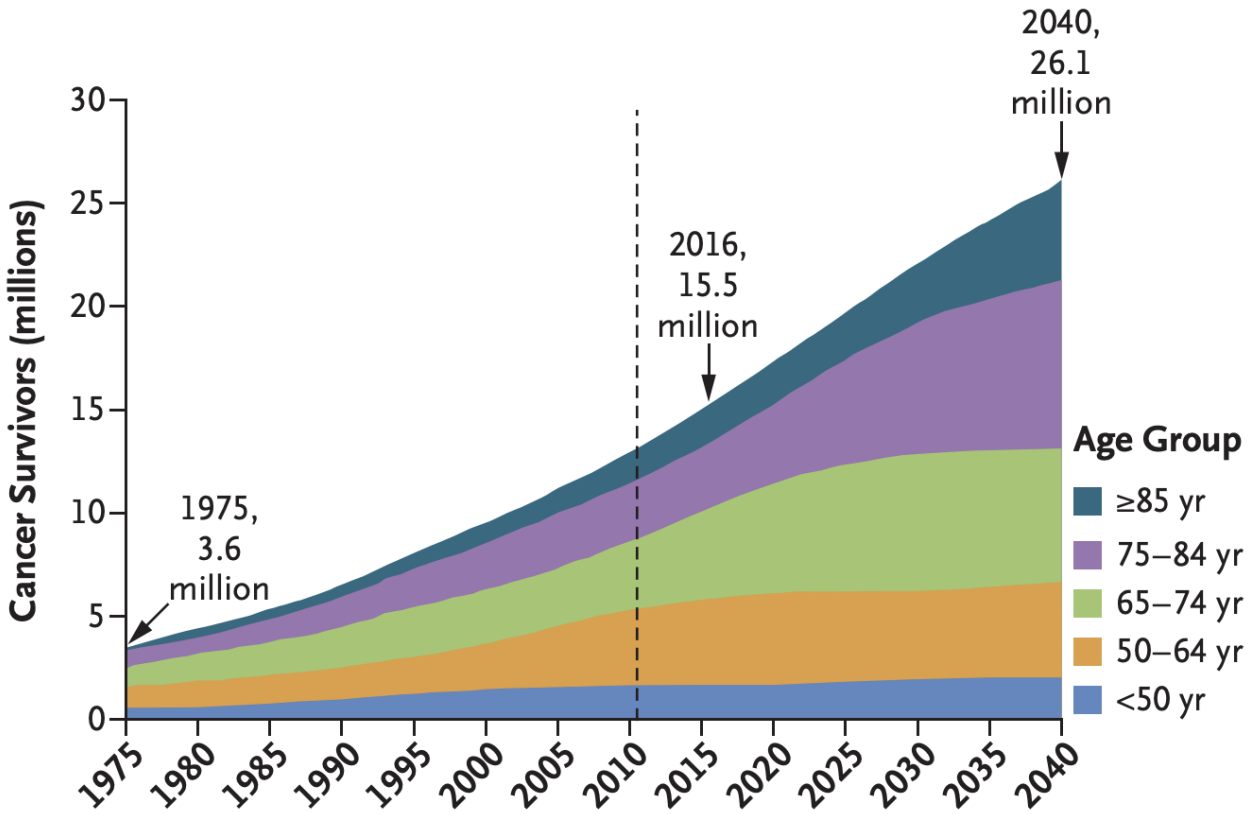
Alicia Morgans, MD, MPH
Associate Professor of Medicine
Harvard Medical School
Director, Survivorship Program
Dana-Farber Cancer Institute

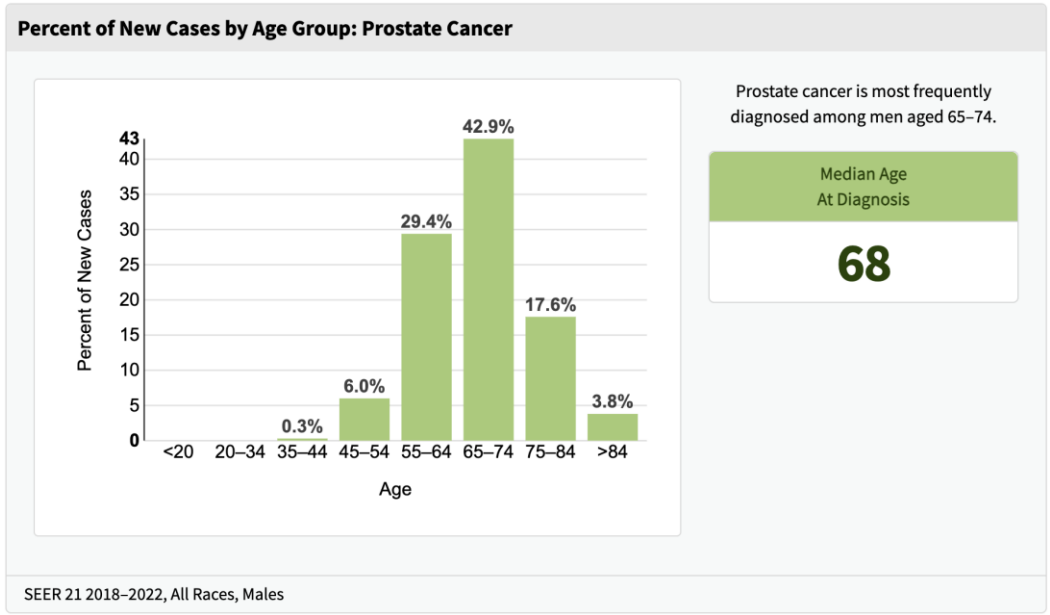
Dana-Farber
Cancer Institute

Disclosures

- Honoraria for consulting: AAA, AstraZeneca, Astellas, Bayer, BMS, Curium, Johnson & Johnson, Exact Sciences, Exelixis, Merck, Sumitomo Pharma Inc, Pfizer, Novartis, Lantheus, Telix, Tolmar
- Research funding and collaboration: Astellas, Bayer, BMS, Sumitomo Pharma Inc, Pfizer, Exact Sciences, Novartis, Johnson & Johnson, Lantheus, Telix

Older Adult Cancer Survivor Population Increasing

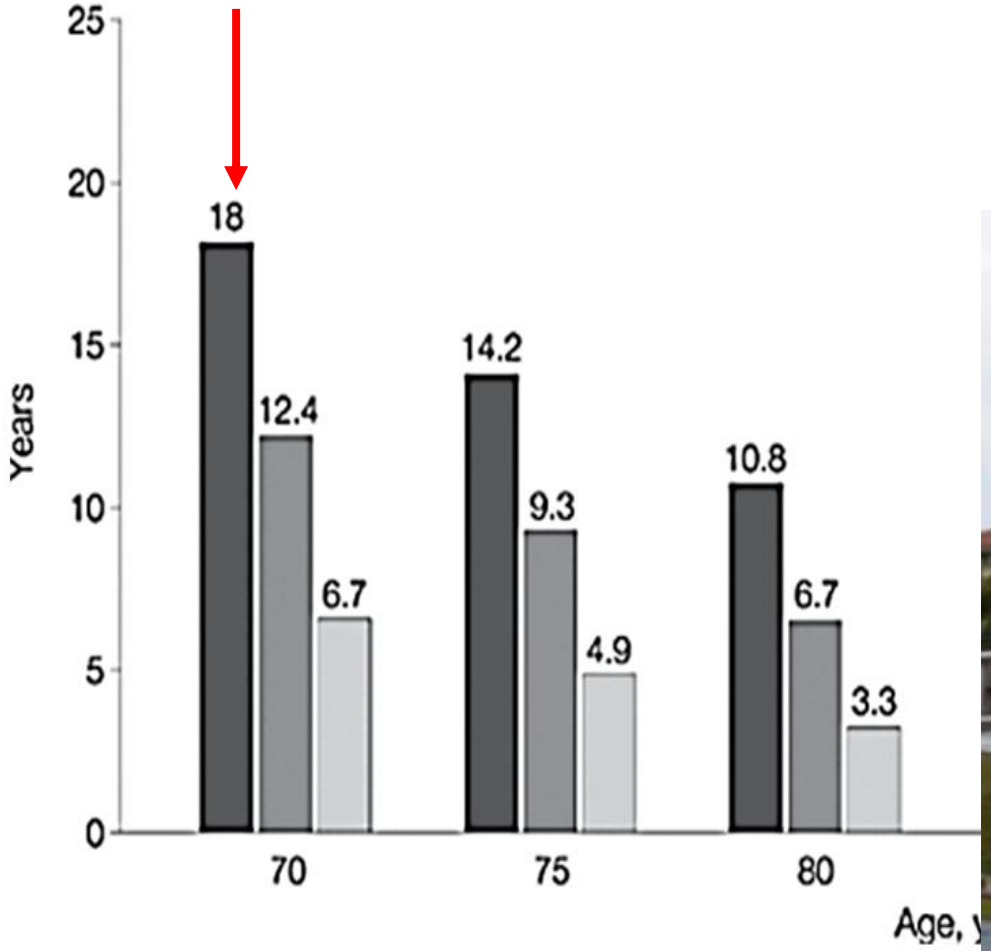




Shapiro CL. New Engl J Med 2018.
https://seer.cancer.gov/statfacts/html/prost.html [Accessed Sept 21, 2025]

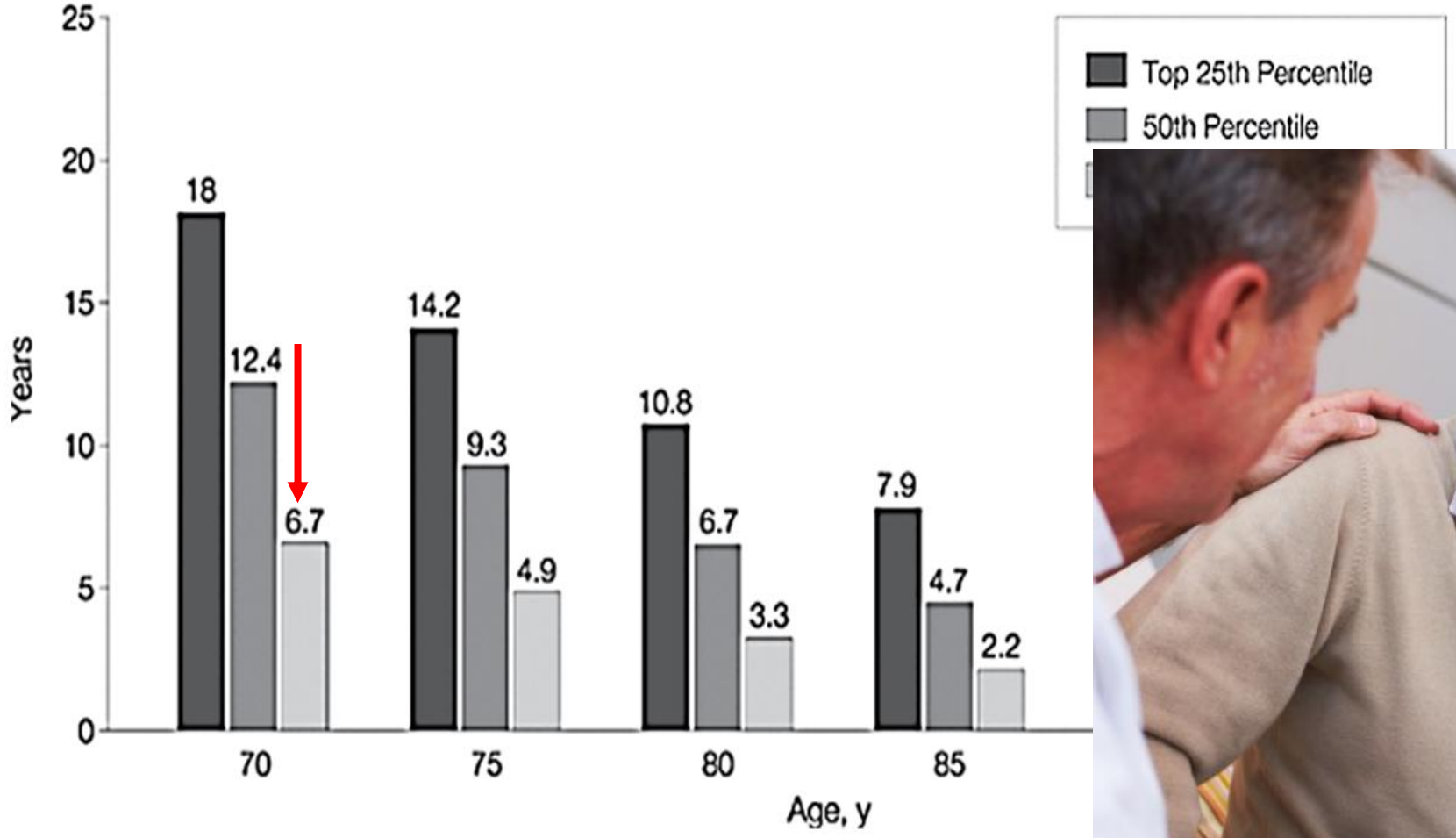
Chronologic and Biologic Age are NOT the same

Consider Life Expectancy When Determining Treatment



Walter LC. JAMA, 2001.

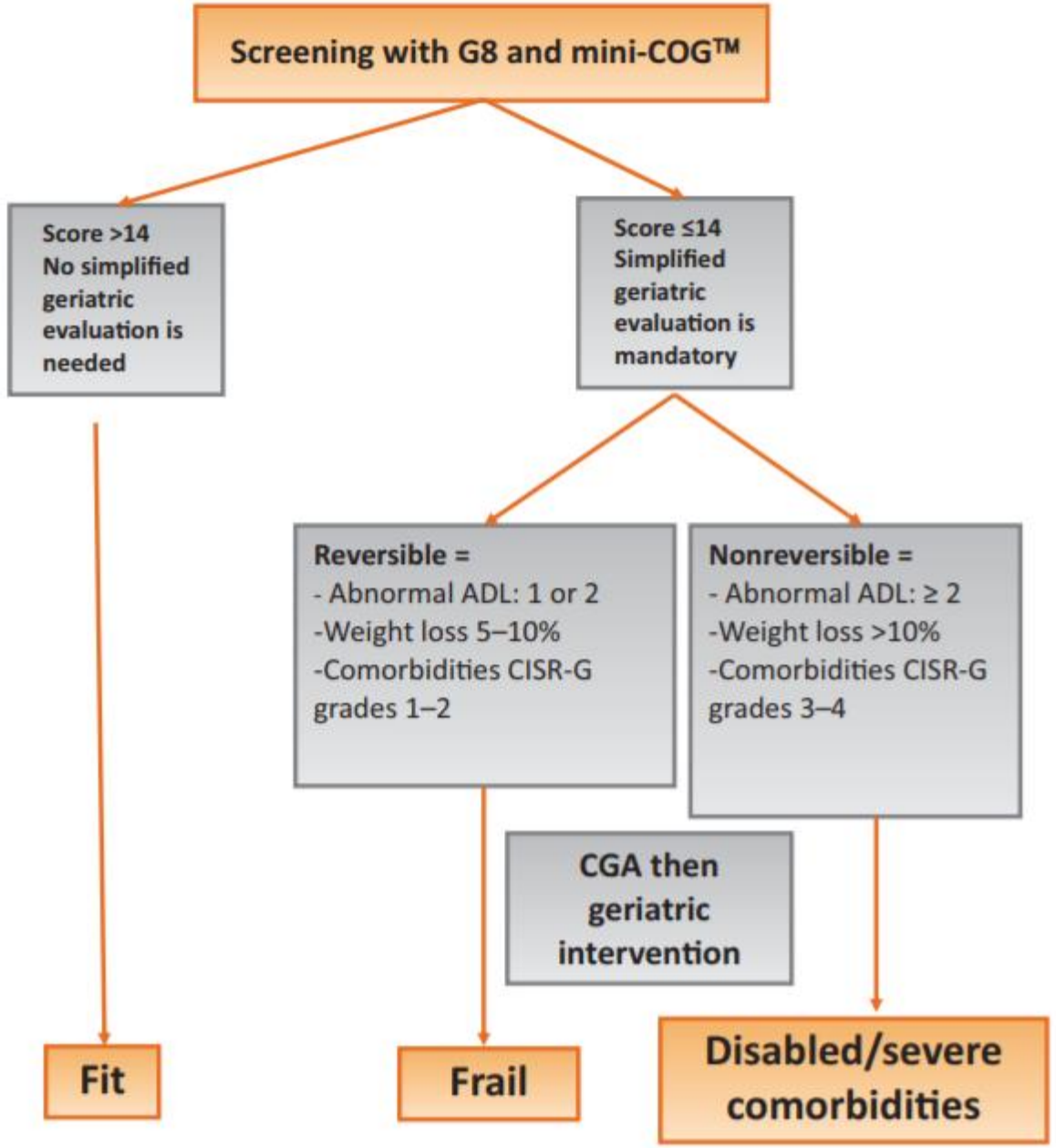
Consider Life Expectancy When Determining Treatment



Walter LC. JAMA, 2001.

International Society of Geriatric Oncology Guidelines

Stratification of patient fitness allows clinicians to **tailor supportive measures** and effectively **inform treatment decisions**



Droz JP, et al. Eur Urol, 2017.

G8 Screening Tool

Table 2. G8 Screening Tool

Item	Score
1. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing, or swallowing difficulties?	0 = severe reduction in food intake 1 = moderate reduction in food intake 2 = normal food intake
2. Weight loss during the last 3 months	0 = weight loss > 3 kg 1 = does not know 2 = weight loss between 1 and 3 kg 3 = no weight loss
3. Mobility	0 = bed or chair bound 1 = able to get out of bed/chair but does not go out 2 = goes out
4. Neuropsychological problems	0 = severe dementia or depression 1 = mild dementia or depression 2 = no psychological problems
5. BMI (weight in kg/height in m^2)	0 = BMI < 19 1 = 19 ≤ BMI < 21 2 = 21 ≤ BMI < 23 3 = BMI ≥ 23
6. Takes more than 3 medications per day	0 = yes 1 = no
7. In comparison with other people of the same age, how does the patient consider his/her health status?	0.0 = not as good 0.5 = does not know 1.0 = as good 2.0 = better
8. Age	0 = > 85 years 1 = 80-85 years 2 = < 80 years

Abbreviation: BMI, body mass index.

Kenis C, et al. J Clin Oncol, 2014.

Systemic Treatment Considerations –

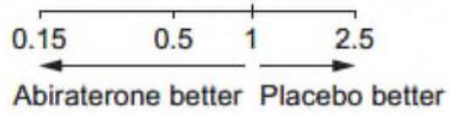
ARPIs Generally Work Similarly in Older Adults

Latitude Subgroup Analyses

- **OS benefit similar** for abiraterone acetate when analyzed by age

Supplementary Figure S2. Overall Survival Subgroup.

Subgroup	Abiraterone	Placebo	Hazard Ratio (95% CI)
	Median (mo)		
All patients	NR	34.7	0.63 (0.51–0.76)
Age			
<65 yr	NR	33.7	0.62 (0.45–0.84)
≥65 yr	NR	35.1	0.64 (0.49–0.82)
≥75 yr	NR	NR	0.82 (0.53–1.27)
ECOG			
0	NR	38.2	0.64 (0.48-0.86)
1-2	NR	31.3	0.61 (0.46-0.79)
Visceral disease			
Yes	NR	32.3	0.51 (0.33–0.79)
No	NR	35.1	0.66 (0.53–0.83)
Gleason score			
<8	NR	NR	0.62 (0.18–2.11)
≥8	NR	34.7	0.63 (0.51–0.77)
Bone lesions			
≤10	NR	NR	0.65 (0.45–0.96)
>10	NR	31.3	0.60 (0.47–0.75)
Above median PSA			
Yes	NR	36	0.68 (0.51–0.89)
No	NR	33.9	0.58 (0.44–0.77)
Above median LDH			
Yes	NR	33.9	0.74 (0.56–0.96)
No	NR	36.7	0.51 (0.38–0.69)
Region			
Asia	NR	NR	0.73 (0.42–1.27)
East Europe	NR	30.5	0.50 (0.36–0.69)
West Europe	NR	38.1	0.75 (0.51–1.09)
Rest of world	NR	31	0.70 (0.45–1.09)



Chi et al (2019) *N Engl J Med 381*: 13-24

TITAN Subgroup Analyses

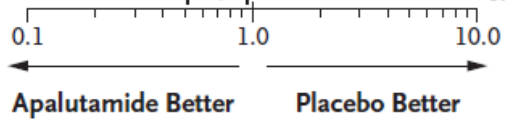
- **OS benefit similar** for apalutamide when analyzed by age

Chi KN, et al N Engl J Med, 2019.

Overall Survival

B Subgroup Analysis

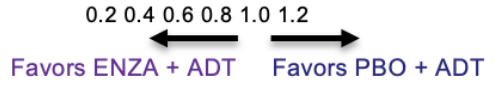
Subgroup	Apalutamide no. of events/no. of patients	Placebo no. of events/no. of patients	Apalutamide median overall survival (mo)	Placebo median overall survival (mo)	Hazard Ratio for Death (95% CI)
All patients	83/525	117/527	NE	NE	0.68 (0.51–0.90)
Bone metastasis only at baseline					
Yes	28/289	53/269	NE	NE	0.47 (0.30–0.75)
No	55/236	64/258	NE	NE	0.88 (0.61–1.26)
Visceral disease and bone metastasis at baseline					
Yes	20/56	25/72	NE	26.6	0.99 (0.55–1.77)
No	63/469	92/455	NE	NE	0.63 (0.46–0.87)
Gleason score at diagnosis					
≤7	21/174	34/169	NE	NE	0.56 (0.33–0.97)
>7	62/351	83/358	NE	NE	0.73 (0.52–1.01)
Previous docetaxel use					
Yes	11/58	9/55	NE	NE	1.27 (0.52–3.09)
No	72/467	108/472	NE	NE	0.63 (0.47–0.85)
Age					
<65 yr	21/149	43/182	NE	NE	0.56 (0.33–0.94)
65–74 yr	42/243	51/232	NE	NE	0.73 (0.48–1.10)
≥75 yr	20/133	23/113	NE	NE	0.74 (0.41–1.35)
Baseline PSA above median					
Yes	58/285	66/241	NE	NE	0.68 (0.48–0.97)
No	25/240	51/286	NE	NE	0.56 (0.35–0.91)
Baseline LDH above ULN					
Yes	18/60	25/60	NE	NE	0.68 (0.37–1.24)
No	62/443	86/442	NE	NE	0.69 (0.49–0.95)
Baseline ALP above ULN					
Yes	40/177	61/180	NE	NE	0.63 (0.42–0.93)
No	43/346	56/345	NE	NE	0.73 (0.49–1.09)
Disease volume					
High	69/325	97/335	NE	NE	0.68 (0.50–0.92)
Low	14/200	20/192	NE	NE	0.67 (0.34–1.32)
Metastasis stage at initial diagnosis					
M0	7/85	11/59	NE	NE	0.40 (0.15–1.03)
M1	71/411	101/441	NE	NE	0.72 (0.53–0.98)



Similar OS Benefit: Enzalutamide in mHSPC in ARCHES by Age

- **OS benefit similar** for enzalutamide when analyzed by age

Subgroup	ENZA + ADT / PBO + ADT No. (events)	ENZA + ADT / PBO + ADT Median (mo)	HR (95 % CI)
All subgroups	574 (191)/576 (223)	NR/NR	0.70 (0.58–0.85)
Age < 65 years	148 (46)/152 (55)	86.4/NR	0.63 (0.42–0.93)
Age 65–74 years	256 (73)/255 (96)	NR/NR	0.65 (0.48–0.89)
Age ≥ 75 years	170 (72)/169 (72)	69.6/58.9	0.83 (0.60–1.15)
Geographic region			
Europe	341 (123)/344 (140)	86.4/75.7	0.76 (0.60–0.97)
North America	86 (28)/77 (29)	83.1/NR	0.57 (0.34–0.97)
Rest of the world	147 (40)/155 (54)	NR/NR	0.65 (0.43–0.97)
Hispanic or Latino	46 (16)/37 (17)	NR/41.0	0.47 (0.23–0.93)
Not Hispanic or Latino	504 (164)/514 (195)	86.4/NR	0.72 (0.58–0.88)
Gleason score < 8	171 (45)/187 (55)	NR/NR	0.75 (0.50–1.11)
Gleason score ≥ 8	386 (136)/373 (162)	86.4/52.7	0.65 (0.52–0.82)
ECOG PS 0	448 (139)/443 (161)	NR/NR	0.70 (0.56–0.88)
ECOG PS 1	125 (52)/133 (62)	83.1/47.7	0.73 (0.50–1.06)



Armstrong A, et al. ASCO 2025.

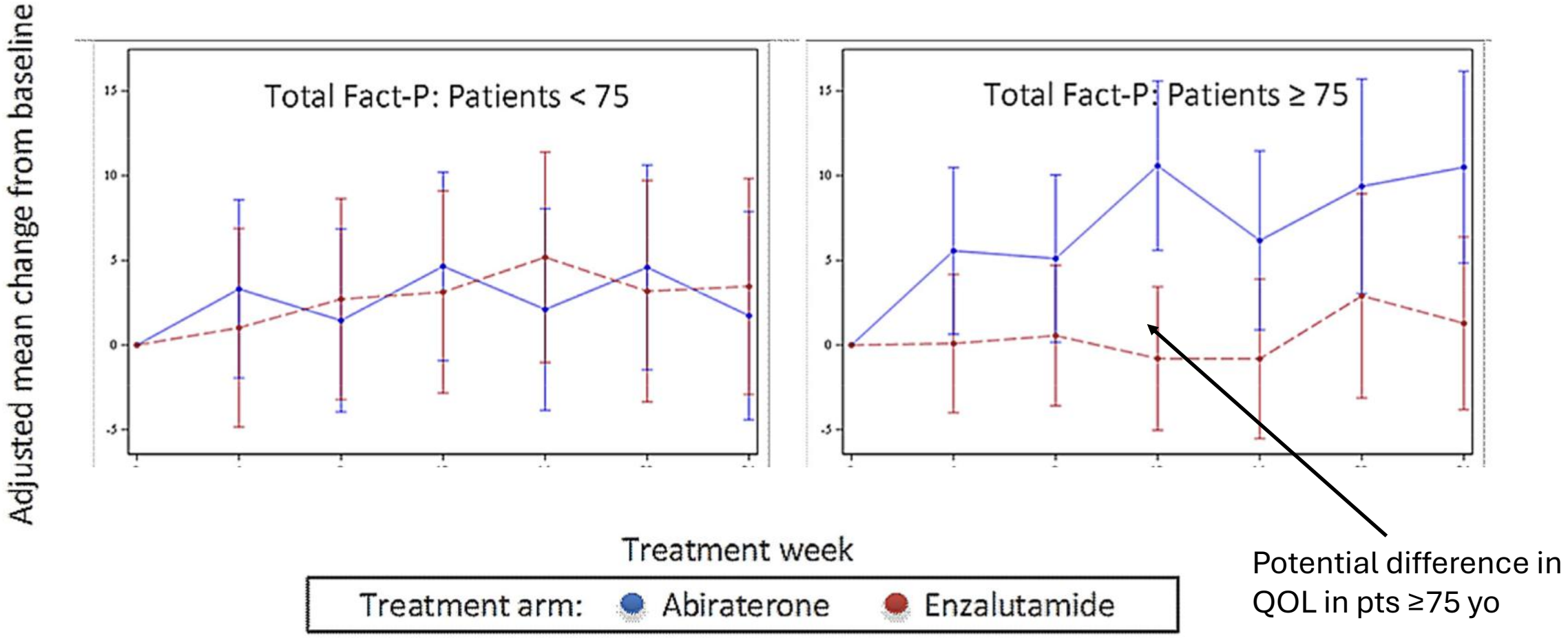
Reduced Survival Benefit of Abiraterone in Older Adults vs AR Inhibitors?

		PFS	OS	PCSS*
Younger age groups (<75)	Abiraterone trial data	~25%	~16%	~17%
	Amide (± abi) trial data	~27%	~18%	?
Oldest age group (75+)	Abiraterone trial data	~8%	~0%	~9%
	Amide (± abi) trial data	~27%	~19%	?

*Prostate Cancer Specific Survival

David Fisher, ASCO-GU 2025, Abstract #20

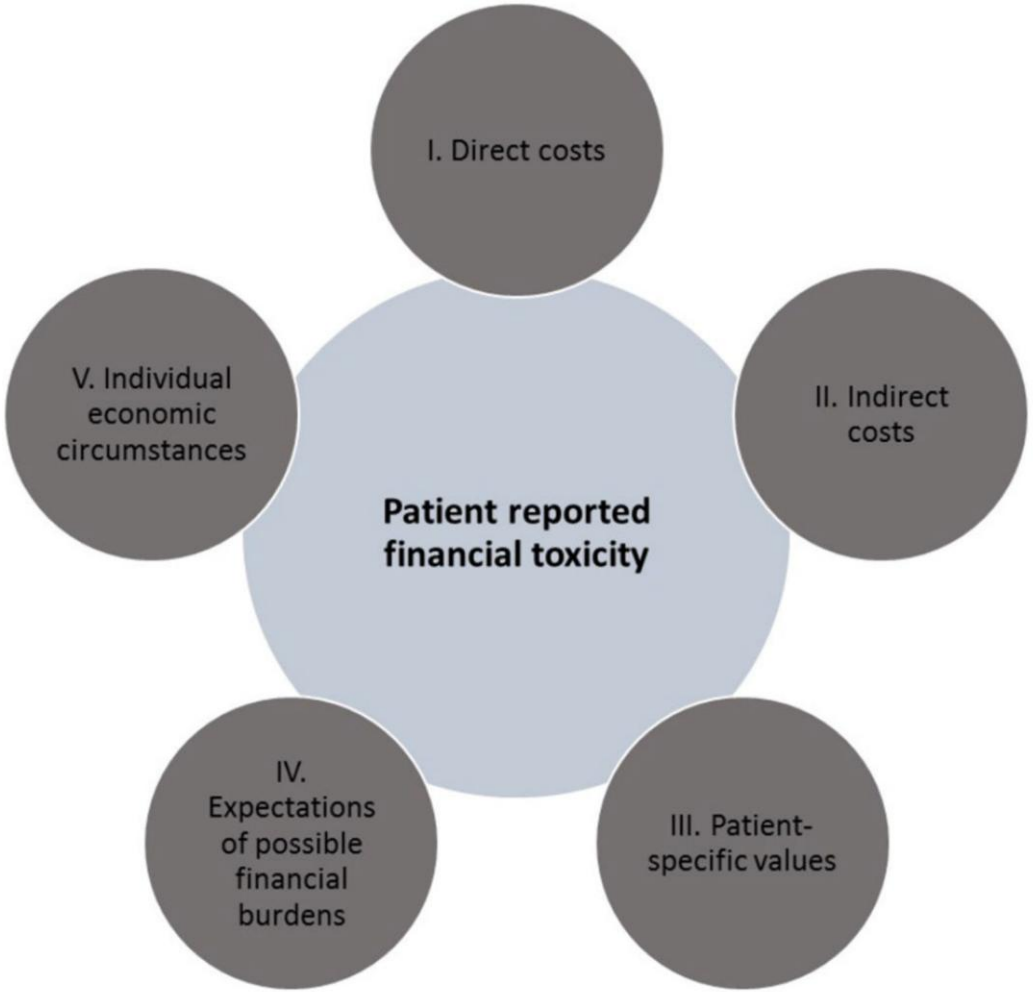
QOL Difference? Abiraterone and Enzalutamide QOL in mCRPC



Khalaf DJ, et al. Eur Urol, 2018.

Financial Toxicity in Older Adults

- Study of 536 patients with advanced cancer ≥ 70 years
- 18.3% reported financial toxicity
- Financial toxicity associated with increased depression, anxiety, distress, and poorer QOL



Imber BS, et al. Nat Rev Urol. 2021. Arastu A, et al. JAMA Network Open. 2020.

Summary

- Prostate cancer disproportionately affects the elderly, and the older adult cancer survivor population is growing worldwide
- Older adults should have assessments that properly define their risks of complications and **identify reversible areas for supportive interventions** that enable them to undergo effective treatment
- **Disease control** and **quality of life** outcomes suggest similar benefits for older patients if we can treat them safely
- **Financial toxicity** should be considered as a source of potential distress and opportunity for intervention

Bone Health
Unanswered Questions

- Charles J Ryan MD
  Member

- March 5, 2026

Memorial Sloan Kettering
Cancer Center

Bone Directed Therapies

Why we need it….

1. Bony Morbidity –> Mortality

2. Symptomatic events → loss of function and pain

3. Treatment related adverse event –> Osteoporosis.

4. Prednisone and other steroid use is common

5. *We have reasonably effective treatment approaches to prevent events, preserve function and maintain QOL. We just need to make sure they are used*

…What we have

1. Calcium and Vitamin D Supplementation - Recommended
2. Zoledronic Acid

    Zometa 4 mg IV q3-12 weeks -- SRE prevention –

    Reclast (Zoledronic Acid 5 mg IV annually) --for Osteoporosis Treatment

3. Denosumab

    XGEVA - For SRE Prevention. –

    Prolia – For osteoporosis treatment

For Osteoporosis Treatment. –

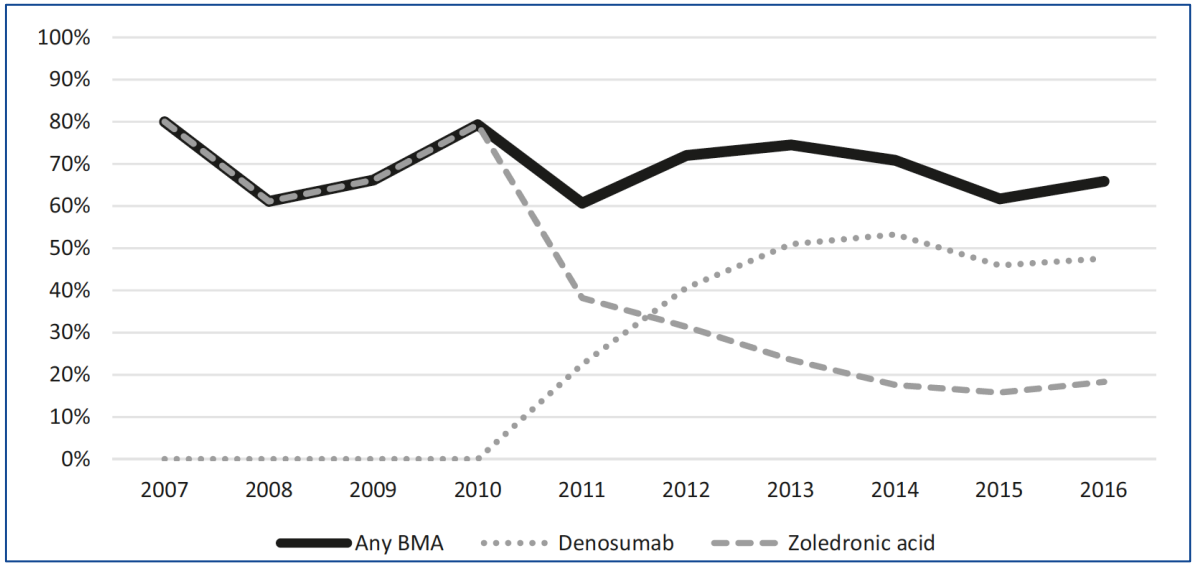
Radium 223?

Other RLT?

BMA Use is Not Optimal

BMA appropriate use (mCRPC)

Proportion receiving BMA within 180 days of initiating CRPC-defining therapy



Mitchell et al, *Prostate Cancer and Prostatic Disease* 2022

Barriers to appropriate BMA use

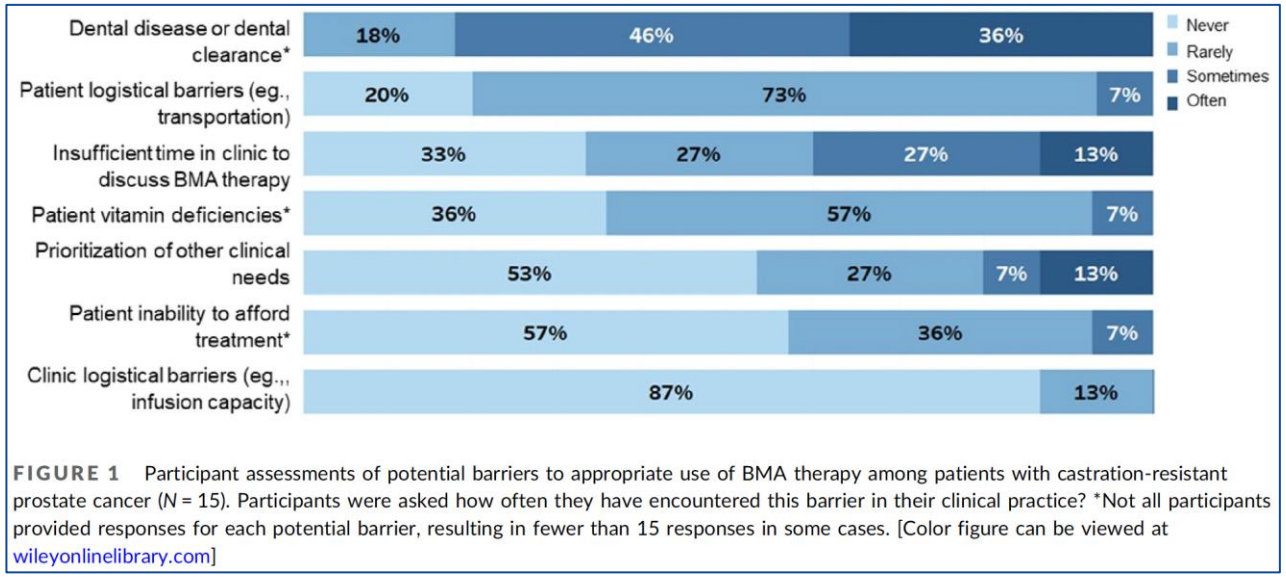
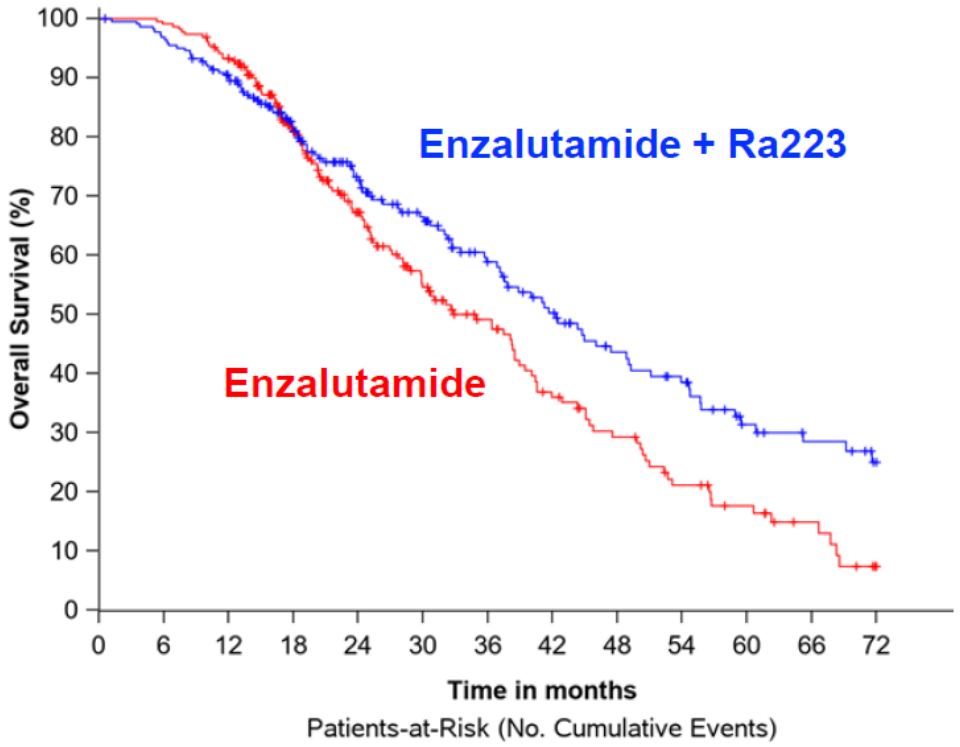


FIGURE 1 Participant assessments of potential barriers to appropriate use of BMA therapy among patients with castration-resistant prostate cancer ($N = 15$). Participants were asked how often they have encountered this barrier in their clinical practice? *Not all participants provided responses for each potential barrier, resulting in fewer than 15 responses in some cases. [Color figure can be viewed at wileyonlinelibrary.com]

Mitchell et al, *The Prostate* 2023

Anti-tumor effective BMA? - PEACE 3 – Adding Radium to Enzalutamide in CRPC improves OS



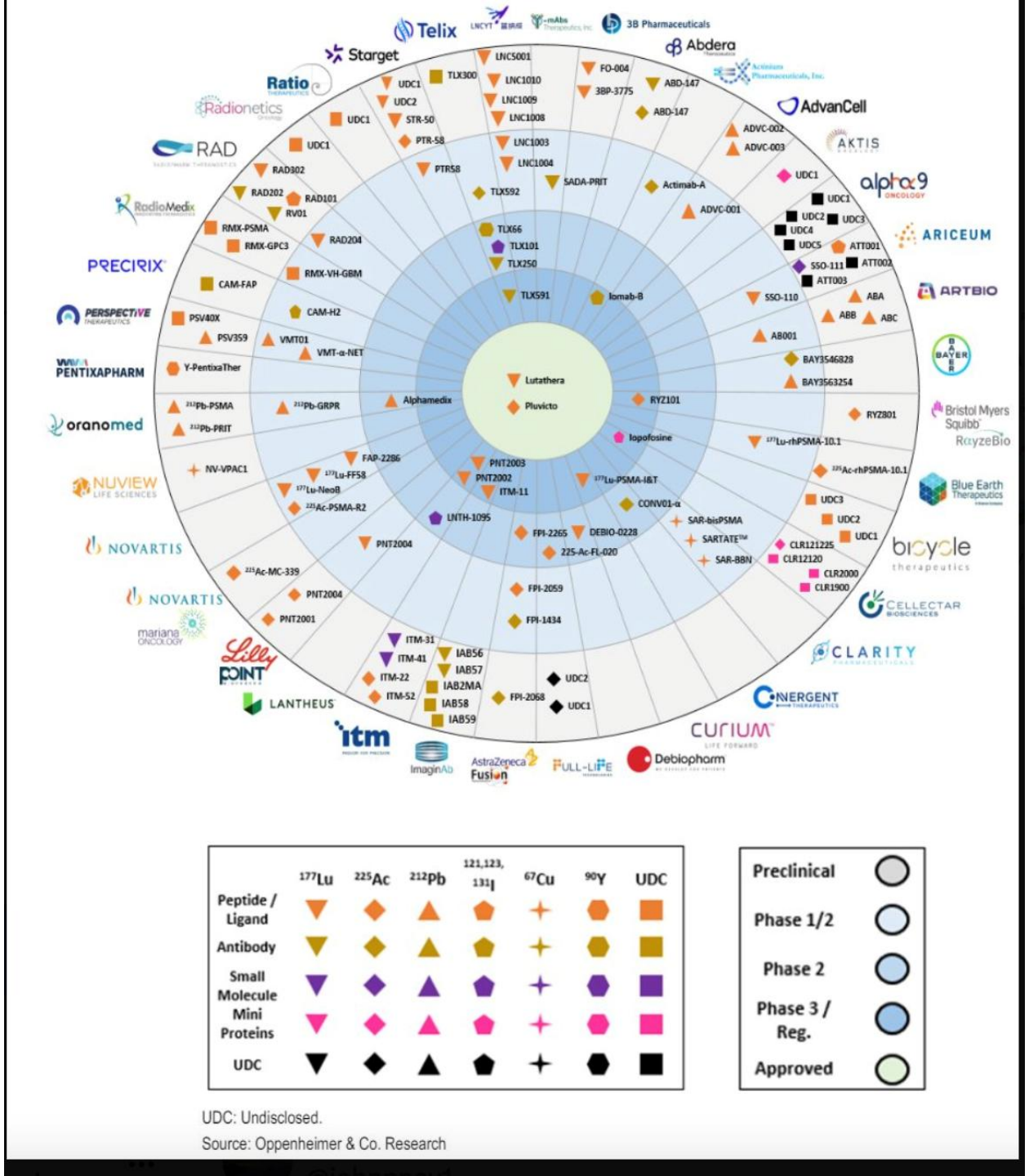
Arm	n/N	Median (95%CI)
Enzalutamide + Ra223	110/222	**42.3** (36.8-49.1) mo
Enzalutamide	129/224	**35.0** (28.8-38.9) mo
HR (95%CI)	**0.69** (0.52-0.90)	
Log-Rank p-value	**0.0031**	<0.0034

- Pre-set level of significance for interim analysis was ≤ 0.0034
- Due to non-proportional hazards plus lack of unequivocal significance for RMST (restricted mean survival time) sensitivity analysis, study will continue to final OS analysis

Saad F. Mini Oral Session ESMO 2024 (Late-Breaking, Oral)

A dizzying array of radiopharmaceuticals is coming

In prostate and other tumor types



UDC: Undisclosed.

Source: Oppenheimer & Co. Research

Address barriers to Optimal Care and Use of Bone Agents

Education

- Awareness of potential benefits / costs of skeletal morbidity
- Integration into clinical pathways and EHR treatment plans
- Survivorship recommendations in NCCN
- Supportive care recommendations in NCCN and other guidelines
- Oncologists don't generally get granular morbidity reports on their 'cases' like surgeons do. Should we?
- Eg review all SRES in a practice over time?

Research

Integration into clinical trials - as 'required' (like continuing ADT)

Organ dysfunction strategies.

Promote /propose strategies for assessing BTT Use in patients with low CrCL or other comorbidities.

Address the role of BTT in RLT treated patients

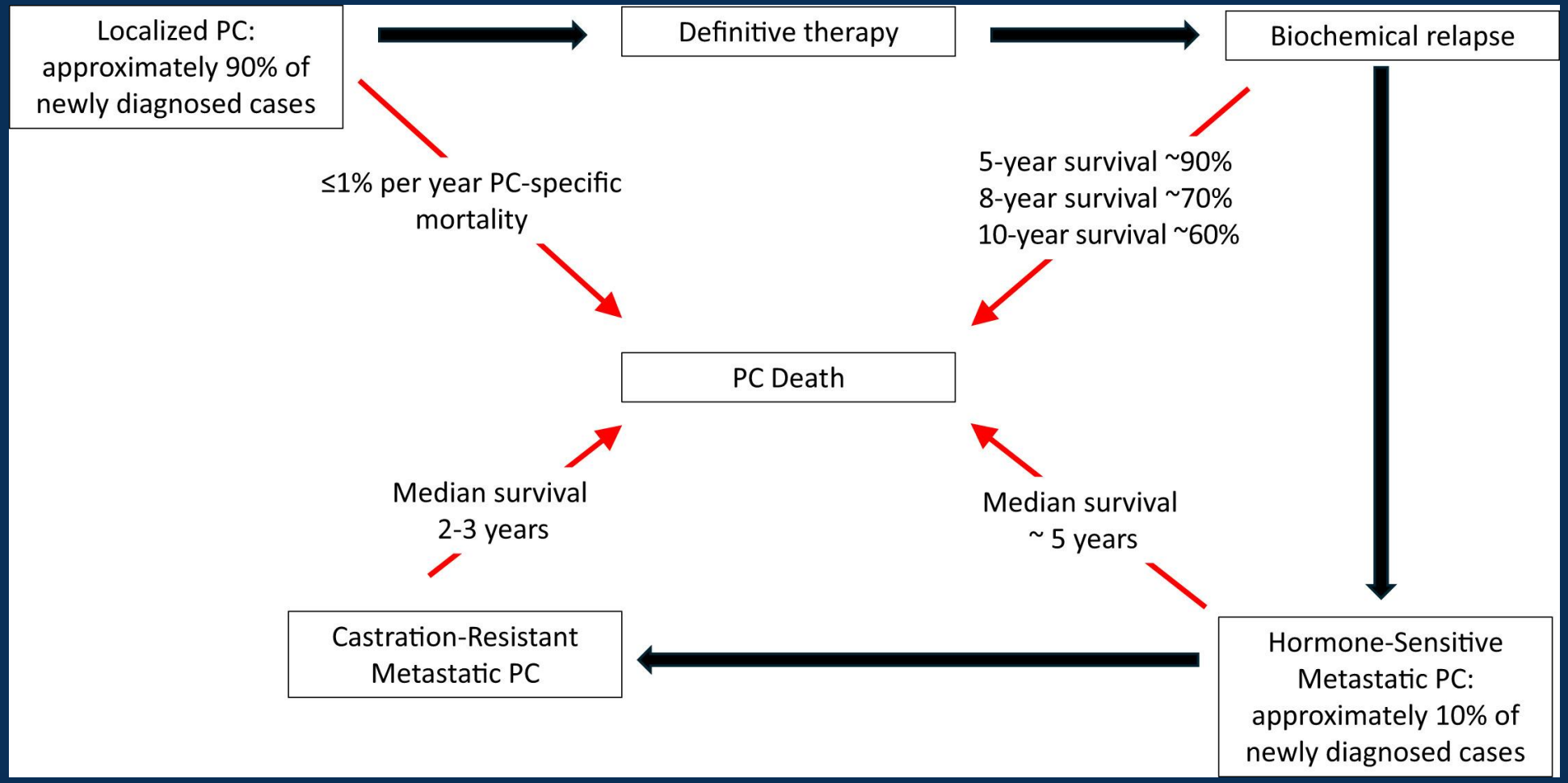
Educate clinicians about optimal use strategies.


Memorial Sloan Kettering
Cancer Center

Cardiovascular Health in Advanced Prostate Cancer

Avirup Guha, MBBS, MPH, FACC, FESC, FAHA, FICOS
Director of Cardio-Oncology, Georgia Cancer Center
Medical College of Georgia at Augusta University
Augusta, GA, USA
X - @avirupguha

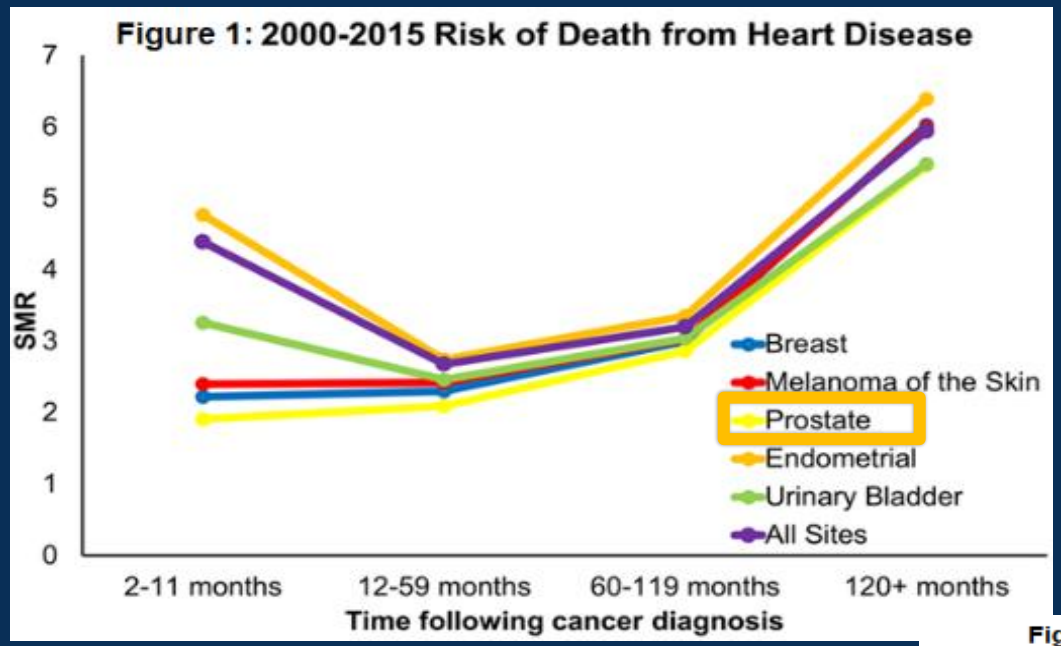
Natural History of Prostate Ca

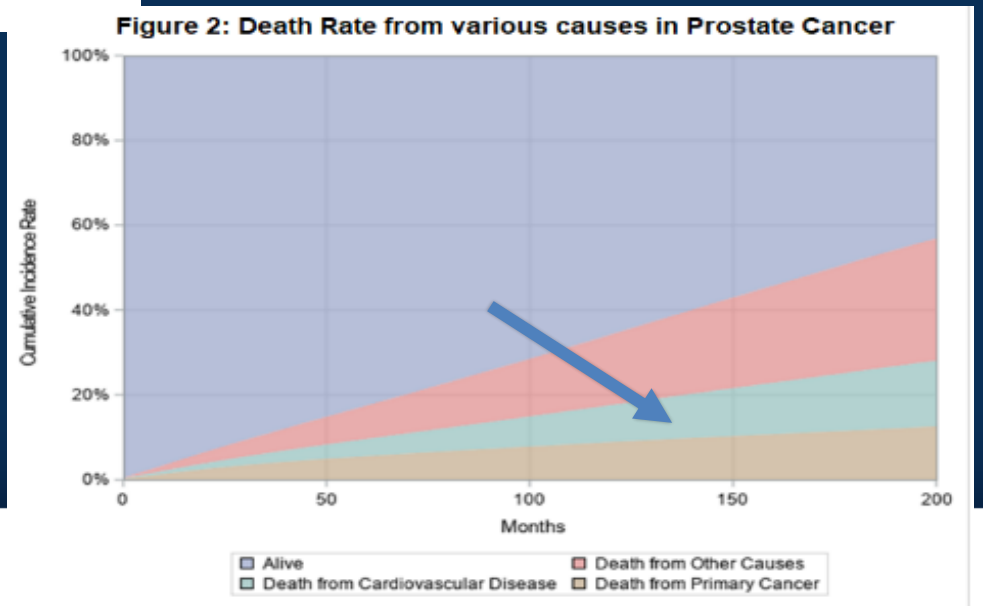


Leong DP, et al. JACC CardioOncol. 2024;6(6):835-846.

JACC CardioOncology

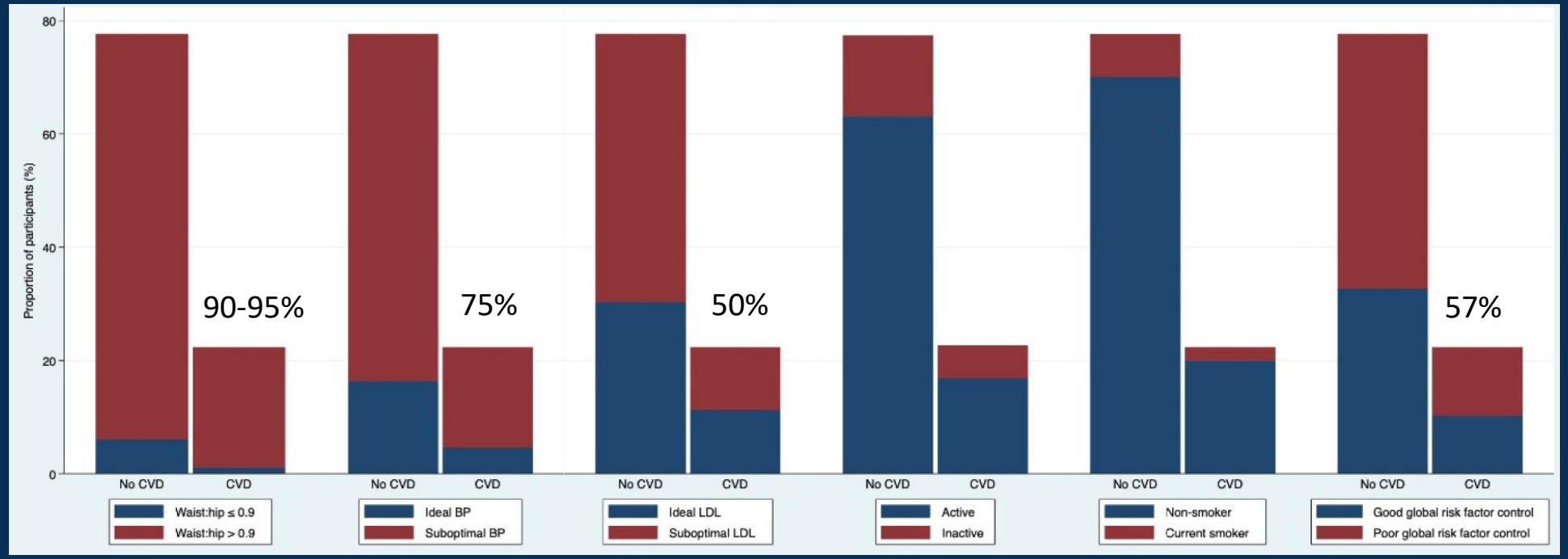
Death from CVD in PC





Sturgeon KM et al. European Heart Journal. 2019;40(48):3889-3897.

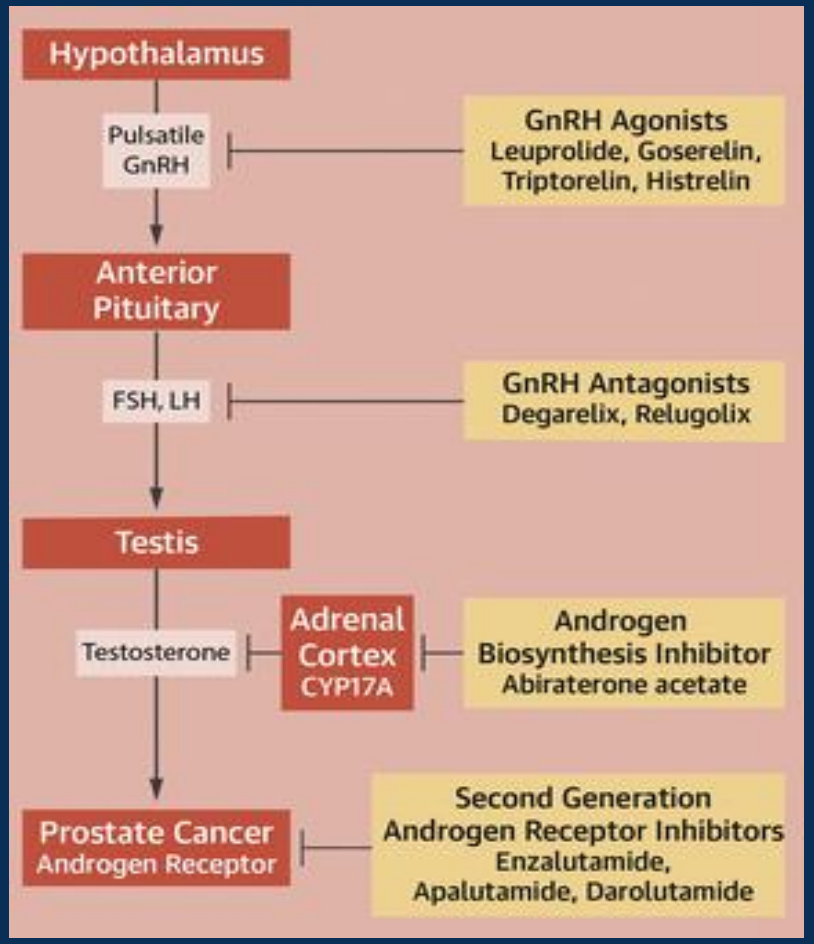
CV risk factors in PC



- 2,618 consecutive men (mean age 68 years) with PC - 8.2% had metastatic PC, 22% had known CVD
- 99% had ≥ 1 uncontrolled CV risk factor
- 57% had poor global risk factor control

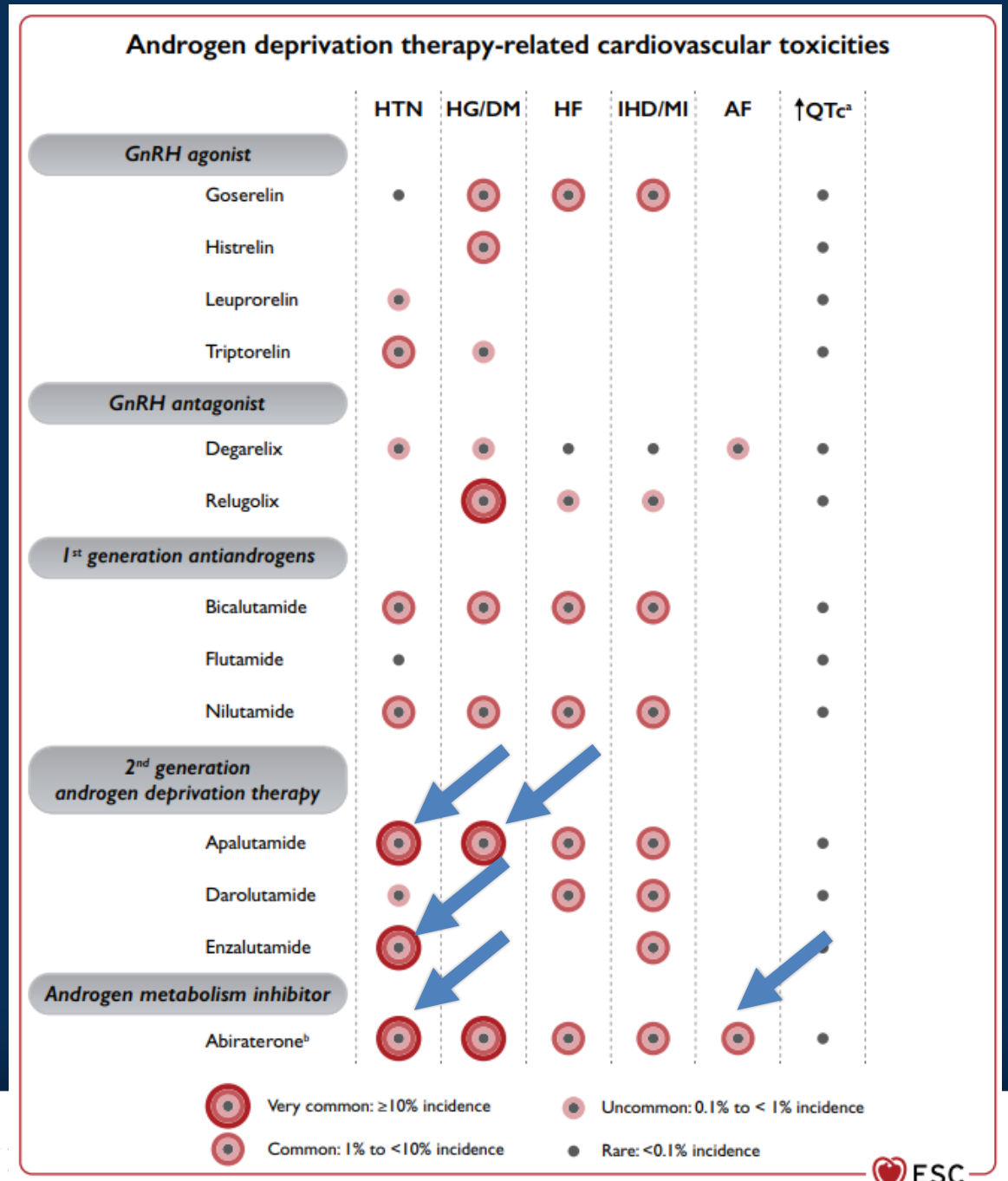
Klimis H, et al. J Am Coll Cardiol CardioOnc. 2023 Feb, 5 (1) 70–81

ADT – Increases risk of CVD/CVD RF



- ADT: ↑ CV risk (HTN, DM, dyslipidemia, obesity, sarcopenia)
- AR pathway inhibitors (enzalutamide, apalutamide, abiraterone): improve OS but add metabolic/cardiac stress
- Triplet regimens (ADT + docetaxel + ARPI): prolong OS but raise CV risk burden
- PARPi and novel IO/VEGF combos: emerging therapies with CV event signals

Narayan V. et al. J Am Coll Cardiol CardioOnc. 2021 Dec, 3 (5) 737–741
Lyon, A. R et al, EHJ 2022. 23(10), e333-e465.



Lyon, A. R et al. EHJ 2022; 23(10), e333-e465.

ADT – Agonist vs Antagonist

Pronounce

vs.

HERO

End point	Patients with eventsn (%) degarelix vs leuprolide	Hazard ratio (95% CI)*	*P* value†
Primary efficacy			
Time from randomization to first adjudicated MACE	15 (5.5) vs 11 (4.1)	1.283 (0.589–2.794)	0.5294

Cumulative Incidence of MACE at End of Wk 48 (95% CI)

percent

Leuprolide	5.6 (3.5–8.9)
Relugolix	2.8 (1.8–4.5)

Hazard ratio with relugolix, 0.46 (95% CI, 0.24–0.88)

3.6% (3 of 84 patients) in the Relugolix group and 17.8% (8 of 45 patients)

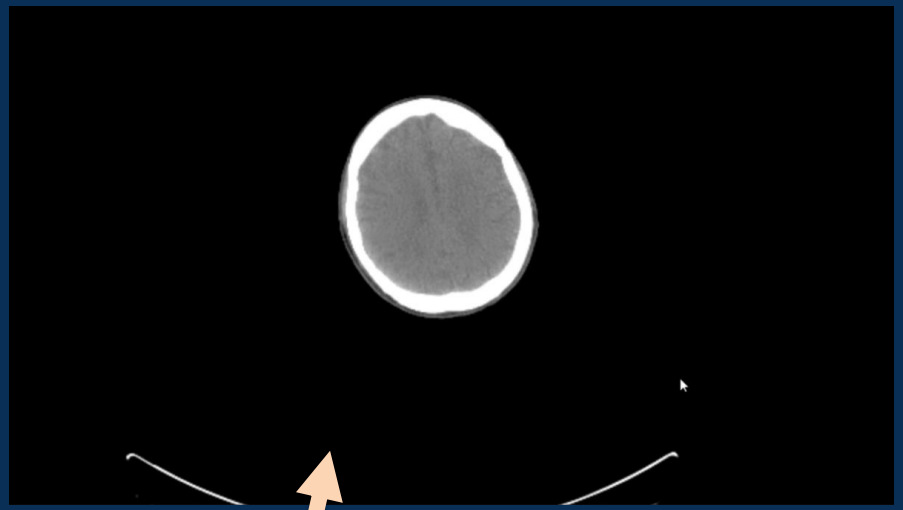
JACC CardioOncology

A Journal of the American College of Cardiology

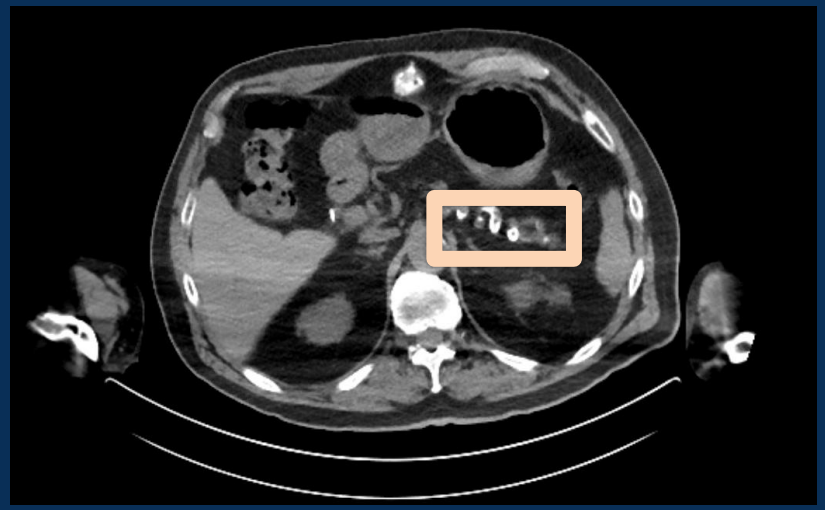
A GnRH antagonist should be considered in patients with pre-existing symptomatic CAD[f] who require ADT.[341,342]	IIa	B

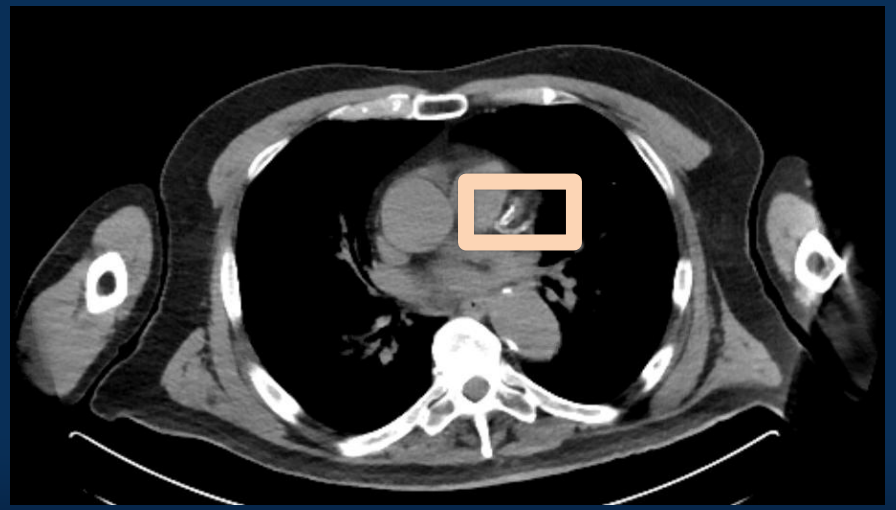
Lopes, R. E et al, Circulation. 2021;144:1295–1307;
Shore ND, N Engl J Med 2020; 382:2187-2196
Lyon, A. R et al, EHJ 2022. 23(10), e333-e465.

Biological Predictors- **PSMA PET – correction CT**

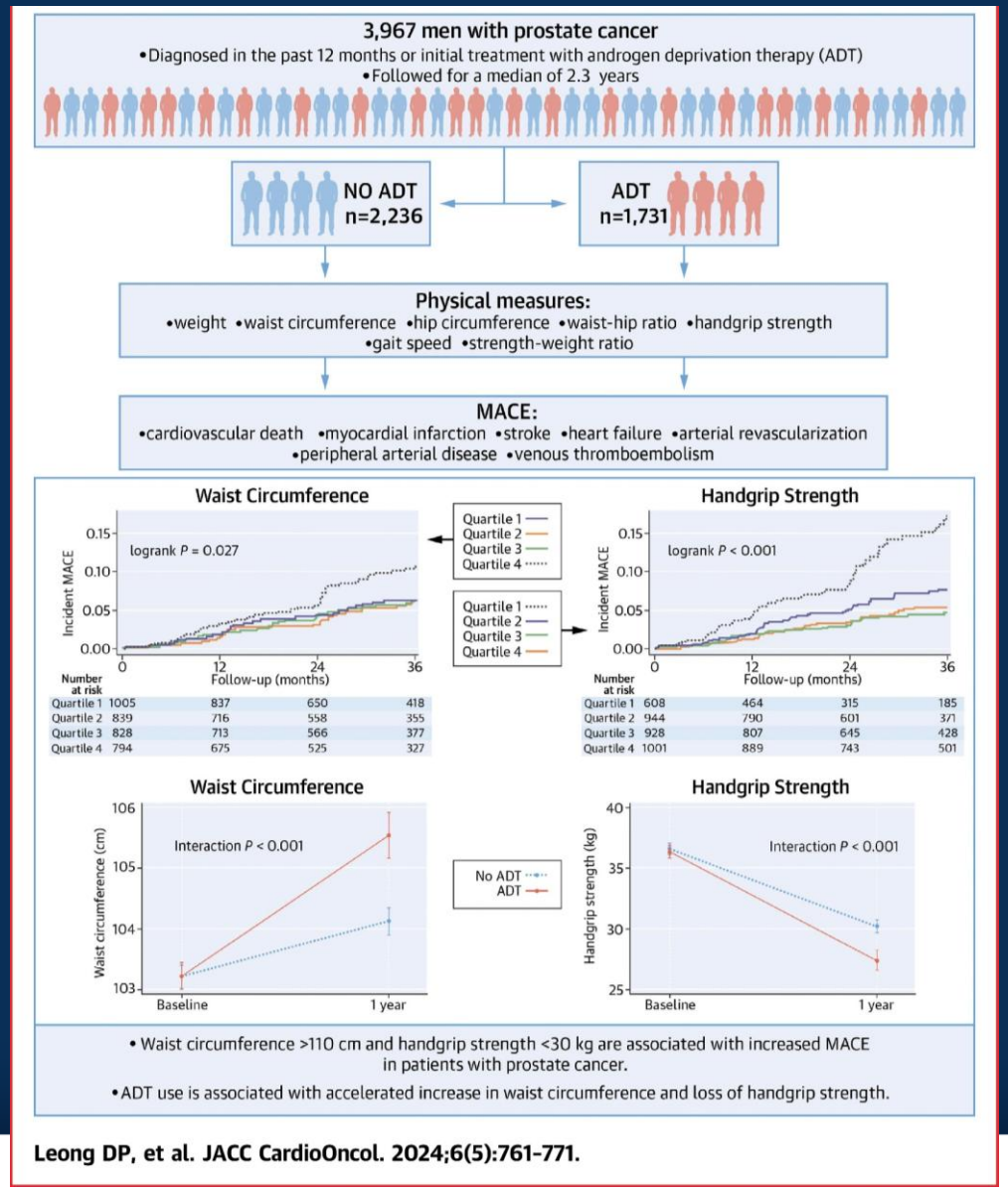


Skeletal muscle





Skeletal muscle



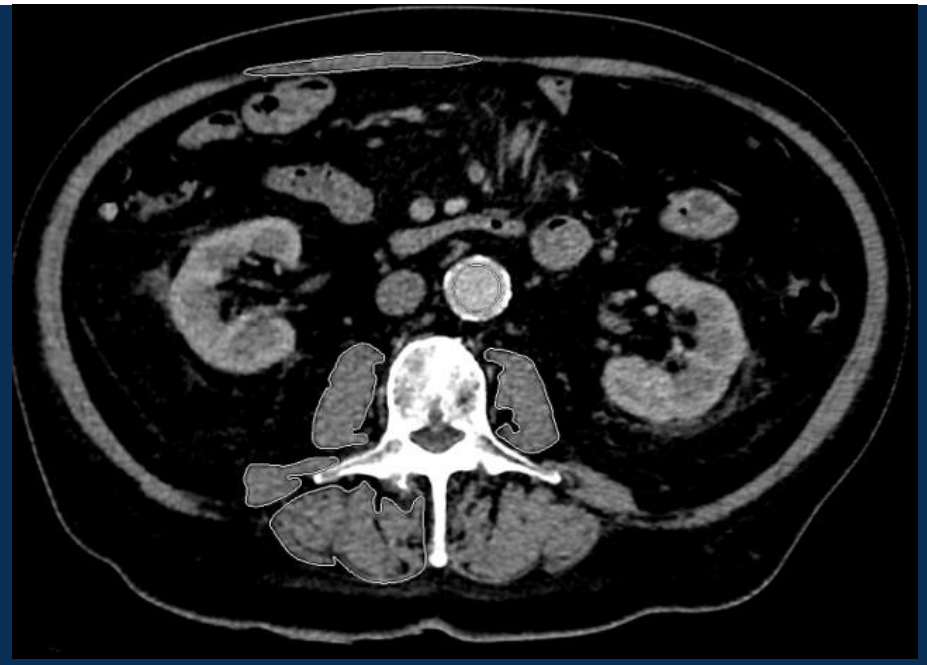
Leong DP, et al. JACC CardioOncol. 2024;6(5):761-771.

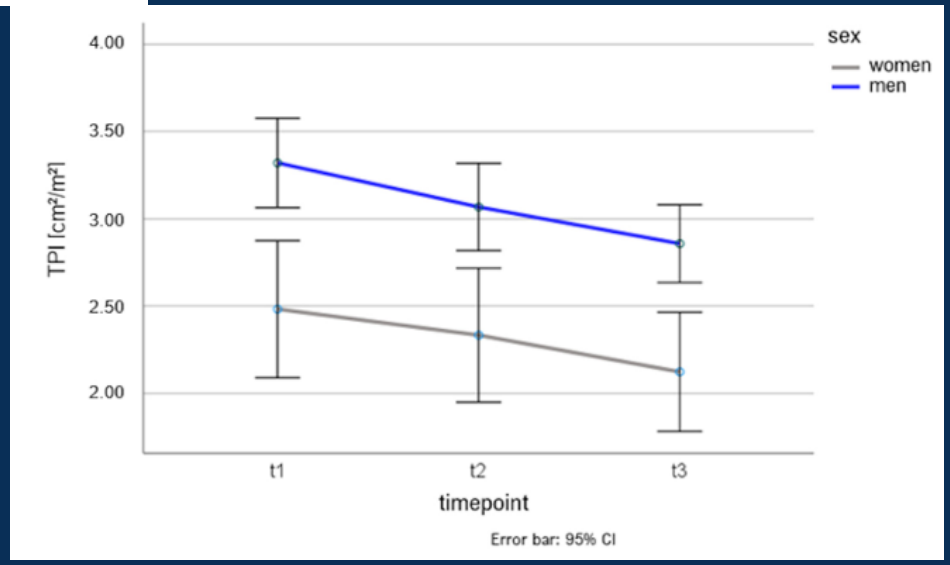
Each quartile reduction in strength was associated with adjusted hazard ratio (95% CI) 1.24 (1.01-1.52)

Article

Applicability of the CT Radiomics of Skeletal Muscle and Machine Learning for the Detection of Sarcopenia and Prognostic Assessment of Disease Progression in Patients with Gastric and Esophageal Tumors

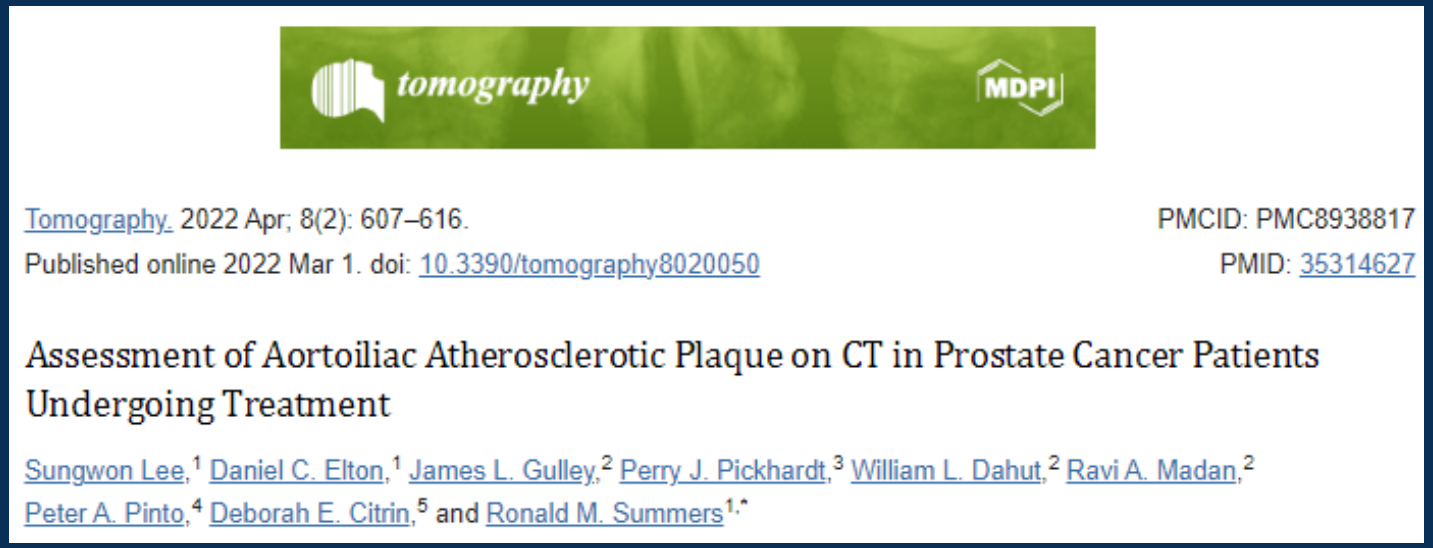
Daniel Vogele [1,*], Teresa Mueller [1], Daniel Wolf [1,2,3], Stephanie Otto [4], Sabitha Manoj [1,3], Michael Goetz [1,3], Thomas J. Ettrich [5,6,†] and Meinrad Beer [1,6,7,†]





CT radiomics and machine learning can be used to detect sarcopenia and assess disease progression in patients with gastric and esophageal tumors, finding significant predictive capabilities for sarcopenia.

CAC score



tomography

MDPI

Tomography. 2022 Apr; 8(2): 607–616.
Published online 2022 Mar 1. doi: 10.3390/tomography8020050
PMCID: PMC8938817
PMID: 35314627

Assessment of Aortoiliac Atherosclerotic Plaque on CT in Prostate Cancer Patients Undergoing Treatment

Sungwon Lee,[1] Daniel C. Elton,[1] James L. Gulley,[2] Perry J. Pickhardt,[3] William L. Dahut,[2] Ravi A. Madan,[2] Peter A. Pinto,[4] Deborah E. Citrin,[5] and Ronald M. Summers[1,*]

- The study evaluates the link between aortoiliacatherosclerotic plaque and prostate cancer in treated patients.
- No notable correlation was found between the plaque and prostate cancer biomarkers.
- Agatston scores of abdominal plaques showed a good correlation with patient age and Framingham risk scores.

CAC score

Volume 43, Issue Supplement_2 October 2022

JOURNAL ARTICLE

Prognostic impact of coronary artery calcifications in patients with newly diagnosed prostate cancer FREE

N Stoedkilde-Joergensen, A Bugge Tinggaard, S Winther, J A Ejlersen, M Boettcher

European Heart Journal, Volume 43, Issue Supplement_2, October 2022, ehac544.2593, https://doi.org/10.1093/eurheartj/ehac544.2593

Published: 03 October 2022

PDF Split View Cite Permissions Share

- Coronary artery calcium (CAC) scores are obtained from non-ECG-gated CT scans at the time of prostate cancer (PCa) diagnosis.
- CAC scores can predict the occurrence of major adverse cardiac events (MACE) in PCa patients.
- Higher CAC scores are associated with a greater risk of MACE.
- Early detection of CAC can help direct preventive treatment -> PCa

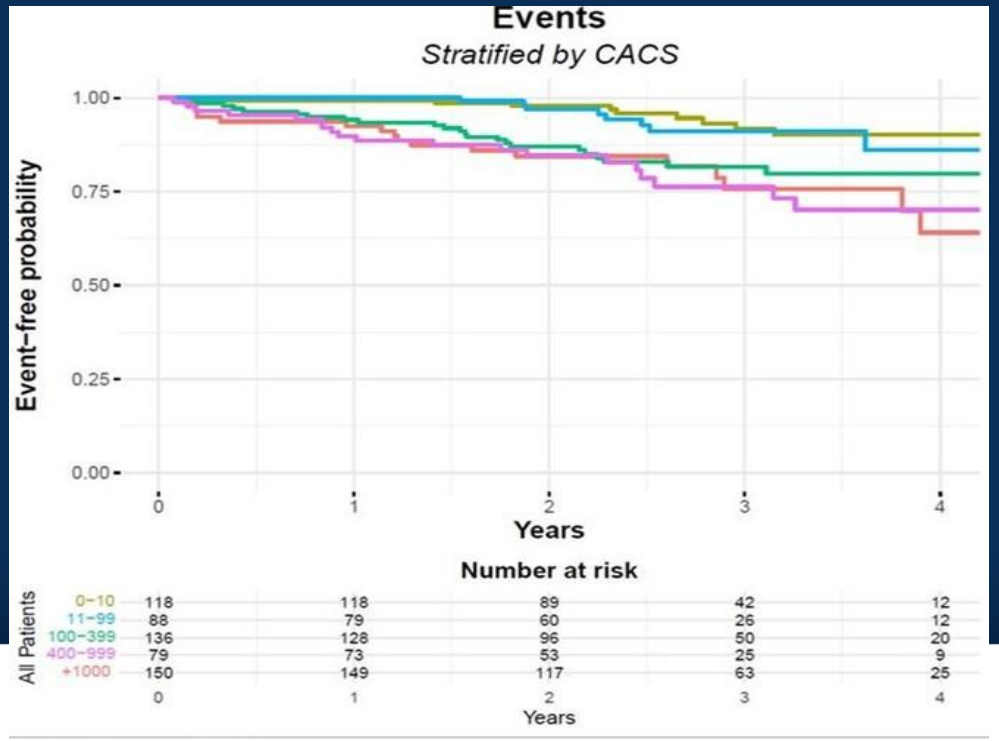
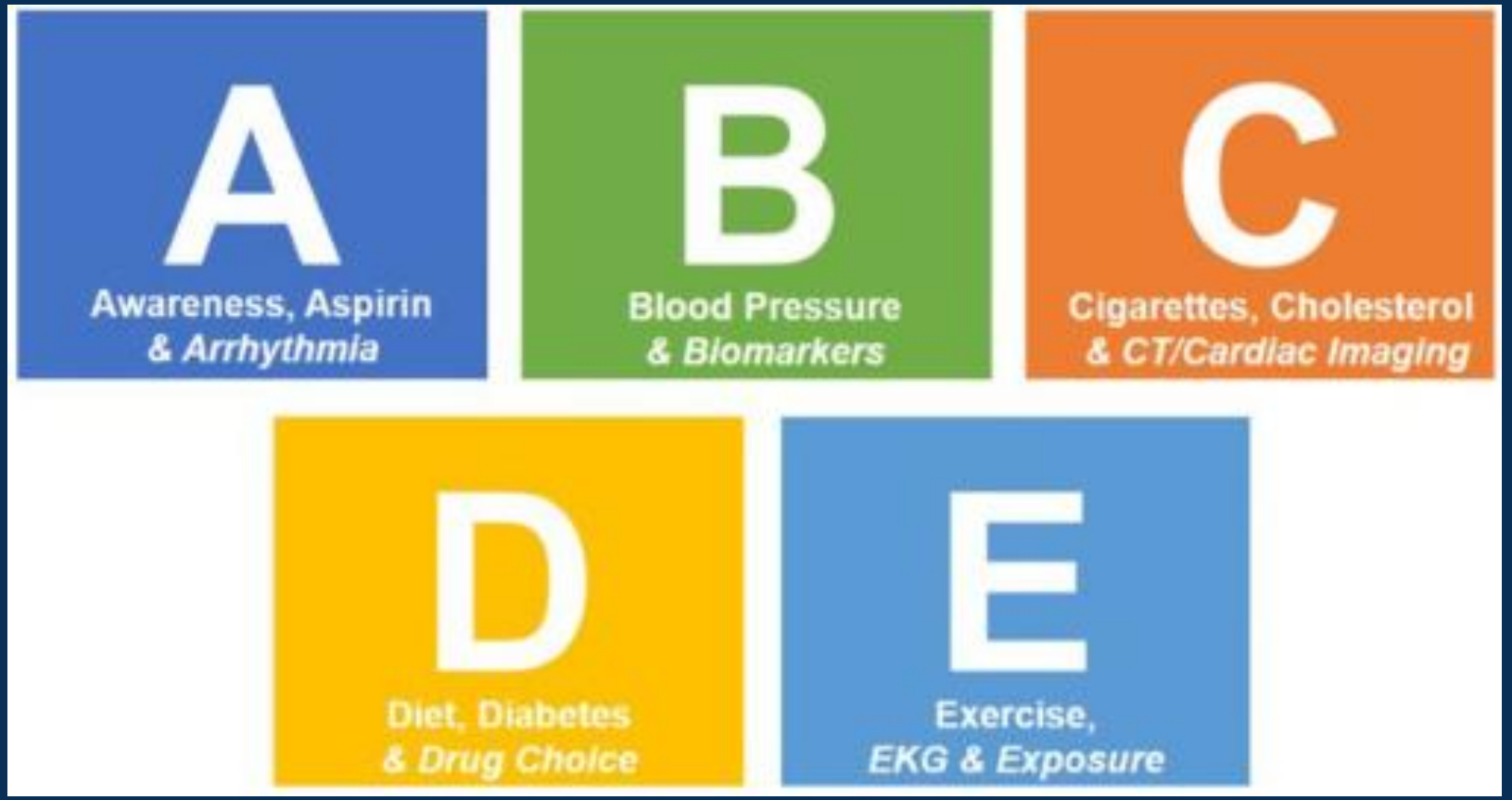


Figure 1

EHJ

AUGUSTA UNIVERSITY

Management and Gaps



- Fragmented care between oncology, cardiology, and primary care

Guha et al. Curr Treat Options Cardio Med 22, 69 (2020)

Path Forward

- Baseline CV risk stratification: ASCVD, IC-OS, biomarkers, imaging
- Integrated care models: oncology + cardiology + primary care
- Lifestyle & exercise interventions: mitigate obesity, sarcopenia, hypertension
- What Should be the Strategic priorities for ACS NPCRT?

American Cancer Society

NATIONAL PROSTATE CANCER ROUNDTABLE

Q&A

Post-Test Poll

LEARNING OPPORTUNITY

Improving Treatment in Advanced Prostate Cancer ECHO

The expertly designed curriculum of this ECHO program was developed to help address the challenges many oncologists and multidisciplinary team members face when providing care for patients with advanced prostate cancer.

American Cancer Society®

Recordings Available

- 10 sessions, originally ran from **December 2024–September 2025**
- Recordings are **FREE** and **OPEN TO ALL**

https://echo.cancer.org/program/improving-treatment-in-advanced-prostate-cancer-echo/

If you're an MD, DO, NP, or PA in oncology or urology who cares for prostate cancer patients, this program is for you.

Stay Connected with ACS NPCRT

- **Website:** npcrt.org
- **LinkedIn:** American Cancer Society National Prostate Cancer Roundtable
- **Newsletter:** Sign up at npcrt.org/about-us/

American Cancer Society®

NATIONAL PROSTATE CANCER ROUNDTABLE

Thank You

Npcrt.org