



19^e Congrès
National
D'Urologie

16, 17 et 18
janvier 2025
Hôtel El Aurassi, Alger

Enzalutamide dans le traitement du cancer de la Prostate métastatique hormono-sensible (mHSPC)

M. OUKKAL

Oncologie Médicale – CHU Béni Messous

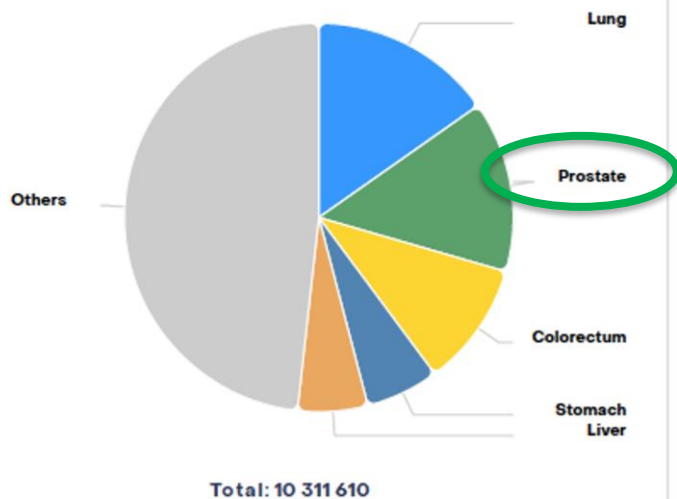


Introduction

- Le plus fréquent des cancers de l'homme de plus de 50 ans
- Incidence en augmentation (plus de 1,4 M de nouveaux cas/an dans le monde en 2022)
- 5^{ème} cause de mortalité par cancer chez l'homme (\approx 400 mille décès par an dans le monde en 2022)
- Progrès considérables dans le traitement du cancer de la prostate (Intérêt des RCP).
- Problème de santé publique

Epidémiologie

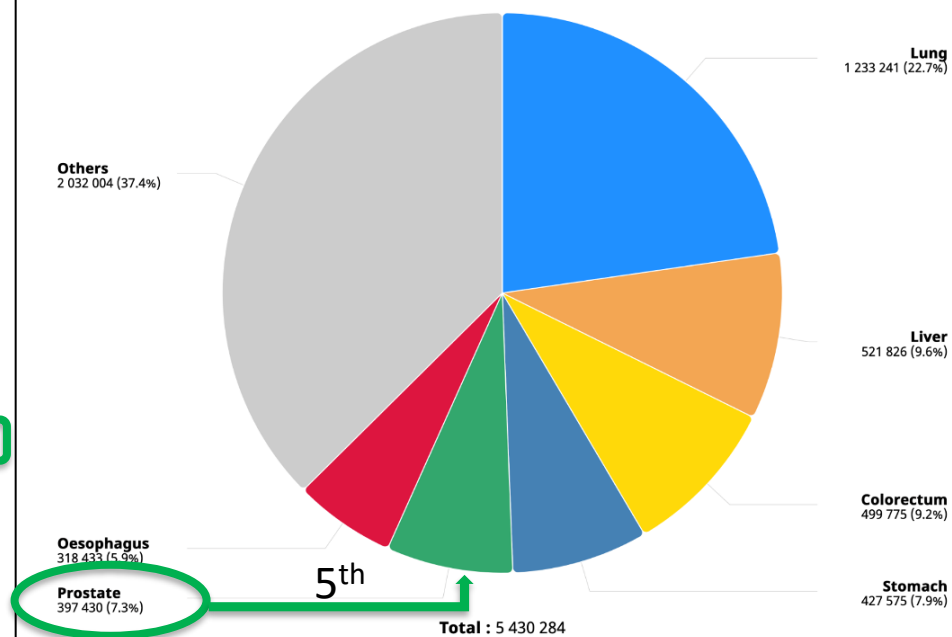
Incidence



Rank	Cancer site	Number of cases	Percent
1st	Lung	1 572 045	15.2%
2nd	Prostate	1 467 854	14.2%
3rd	Colorectum	1 069 446	10.4%
4th	Stomach	627 458	6.1%
5th	Liver	600 676	5.8%
-	Others	4 974 131	48.2%

Number of new cases in 2022, males, all ages

Mortalité





Réseau National des Registres du Cancer

5 principales localisations - Hommes



Localisations	Nouveaux cas	Taux bruts/100 000	Age médian
Poumon	3076	16,2	62
Colorectum	3022	15,9	57
Prostate	2619	13,8	67
Vessie	1864	9,8	65
Estomac	970	5,1	60

Réseau National des Registres des cancers 2019

Prostate Cancer Clinical States

HORMONE-SENSITIVE

CASTRATION-RESISTANT

Deaths From Disease

26,730

Clinically
Localized
Disease

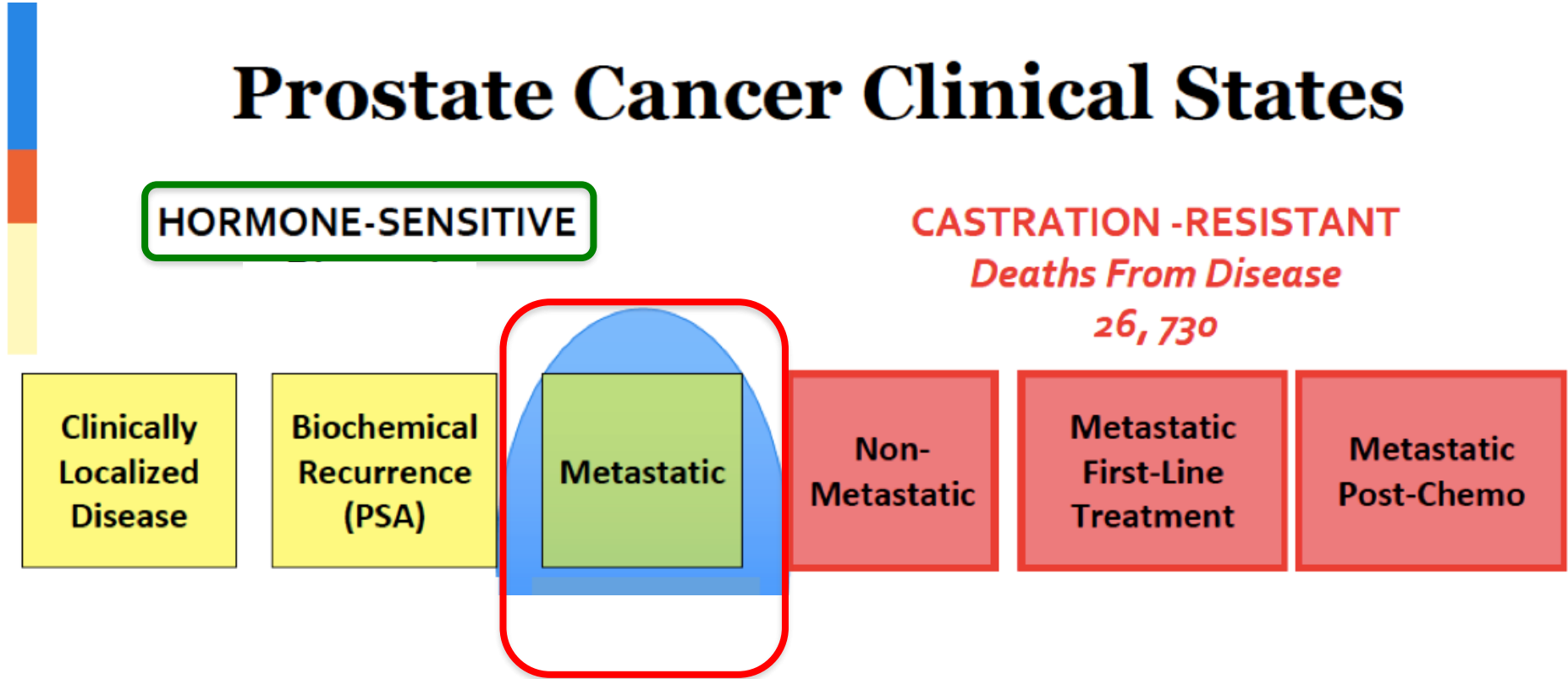
Biochemical
Recurrence
(PSA)

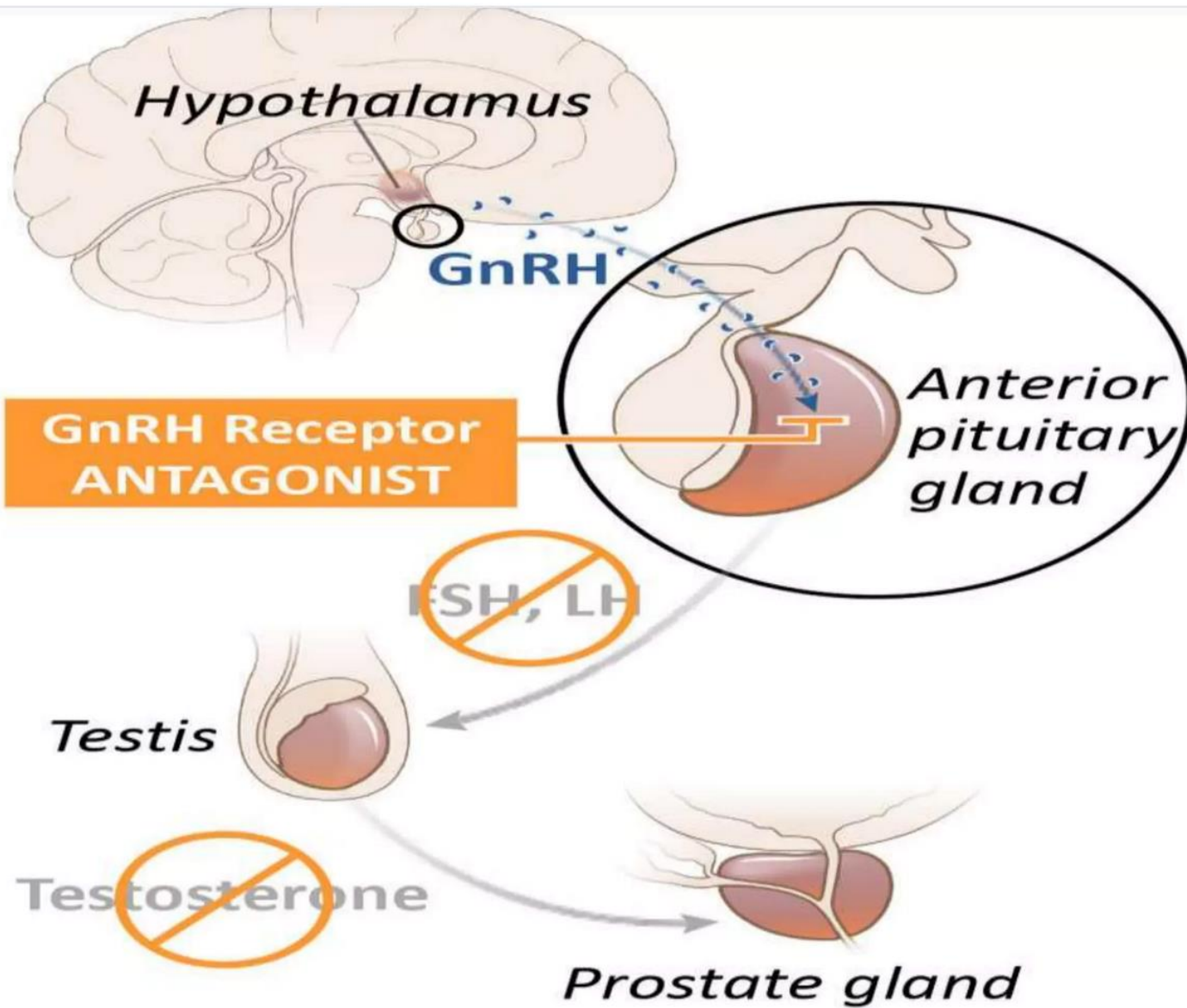
Metastatic

Non-
Metastatic

Metastatic
First-Line
Treatment

Metastatic
Post-Chemo





Androgen Deprivation Therapy

EFFECT OF ORCHIECTOMY AND IRRADIATION ON CANCER OF THE PROSTATE*

CHARLES HUGGINS, M.D.

CHICAGO, ILL.

* Read before the American Surgical Association, Cleveland, Ohio, April 6-8, 1942.



Charles Huggins:
Nobelprize Medicine 1966

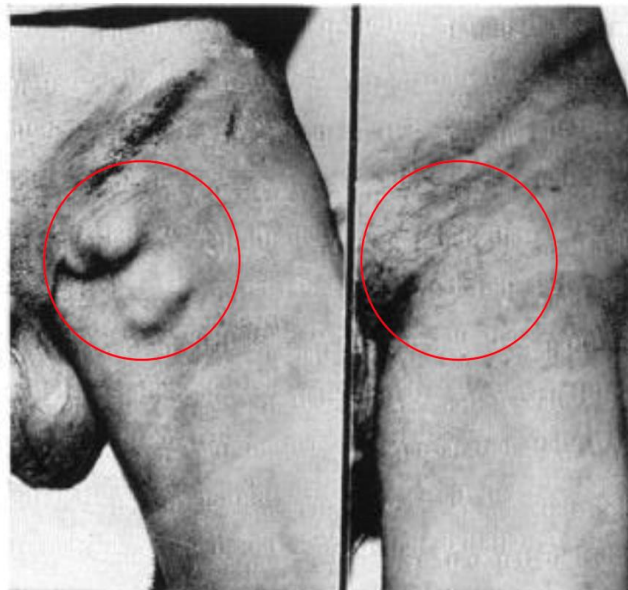
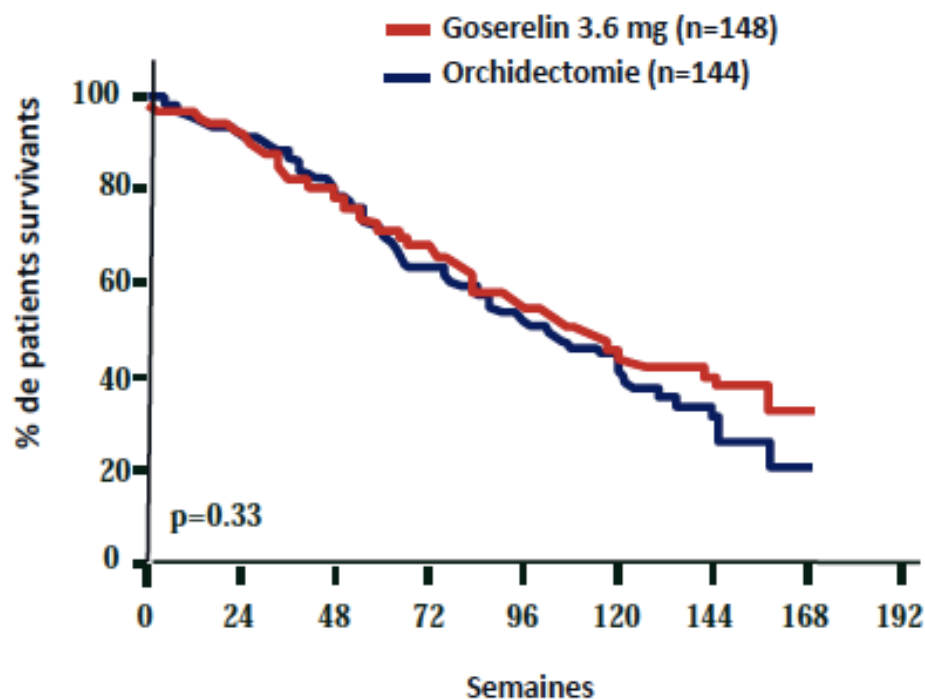


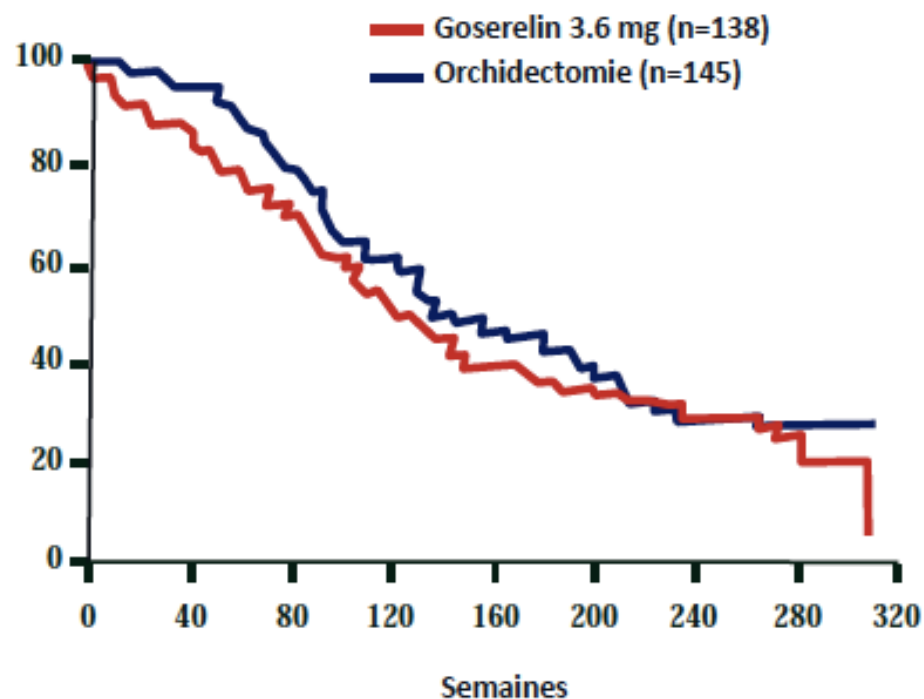
FIG. 4.—M. C. (a patient of Dr. W. S. Grant). Metastatic adenocarcinoma of the prostate in inguinal nodes on the left; the same region 107 days after orchiectomy is shown on the right

Hormonothérapie des formes métastatiques

Agonistes de la LHRH
= Castration chirurgicale



Kaisary et al (1991)



Vogelzang et al (1995)

What can we expect from ADT alone?

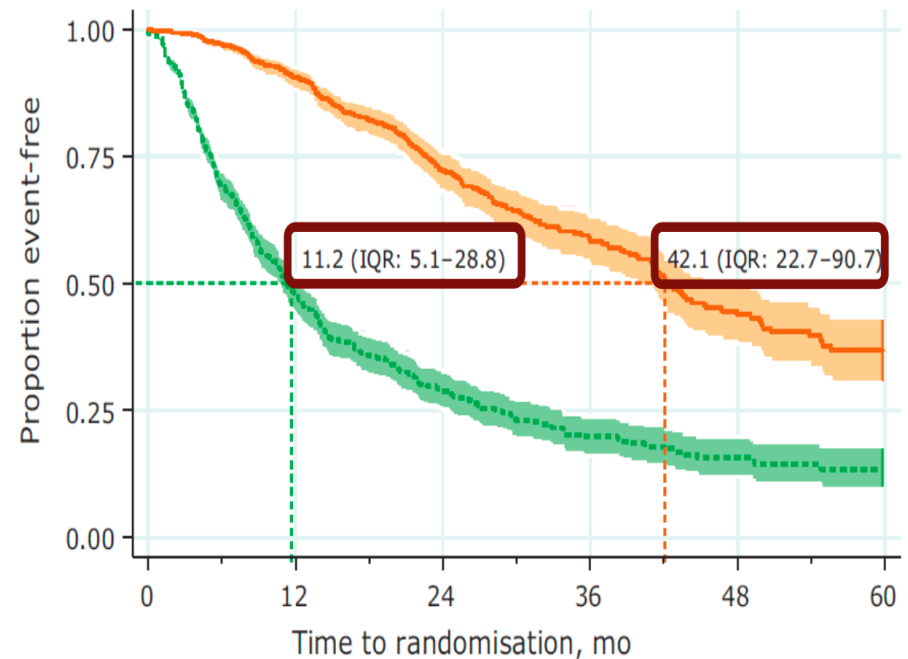
917 patients with *de novo* M1 PCa
(2005-2014) treated by ADT alone
(STAMPEDE randomized trial control arm)

Median FFS: **11 mo**

Median OS: **42 mo**

Patient Characteristics:

Age: 66y
PSA: 112
Bone only 62%
Liver 2%
Lung 4%



At risk, no.

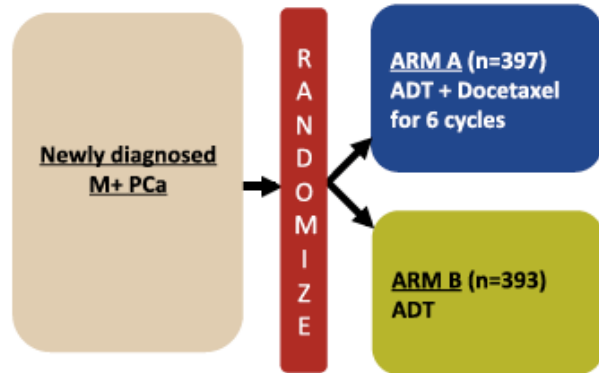
FFS event	917	(369)	272	(93)	107	(28)	50	(8)	25	(3)	8
Death	917	(61)	523	(90)	283	(43)	148	(30)	71	(9)	20



Intensification : Doublets

Chemohormonal Therapy in Metastatic Hormone-Sensitive Prostate Cancer

Christopher J. Sweeney, M.B., B.S., Yu-Hui Chen, M.S., M.P.H.,



Primary endpoint:
Overall survival

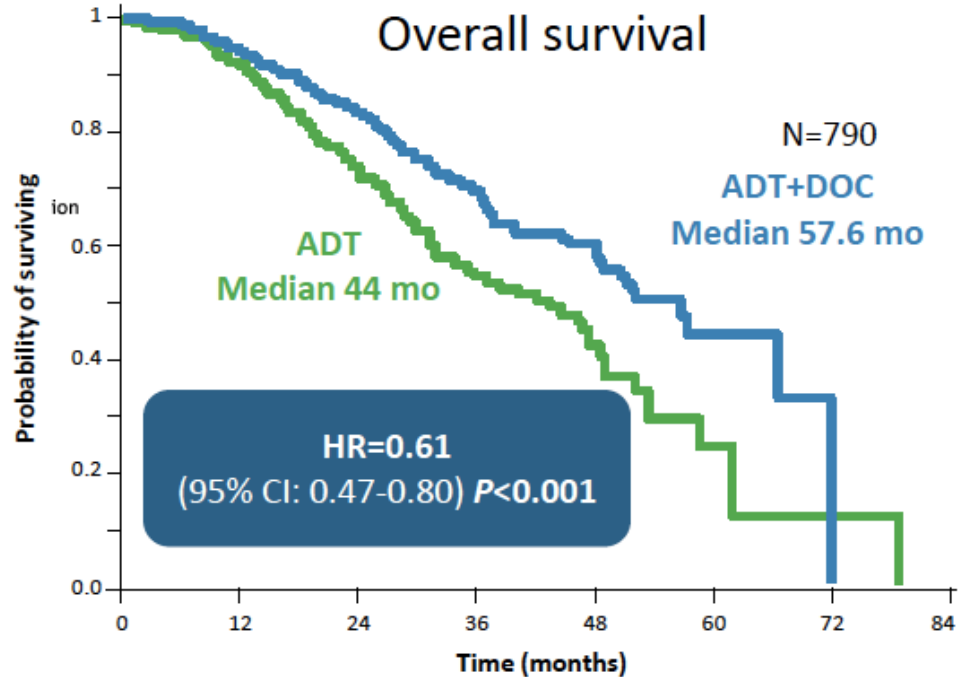
Stratification

- Extent of mets : high vs low
- Age: >70 vs < 70
- ECOG 0-1 vs 2

ADT allowed up to 120 days prior to randomization
Intermittent ADT not allowed

Docetaxel 75mg/m² 6 cycles

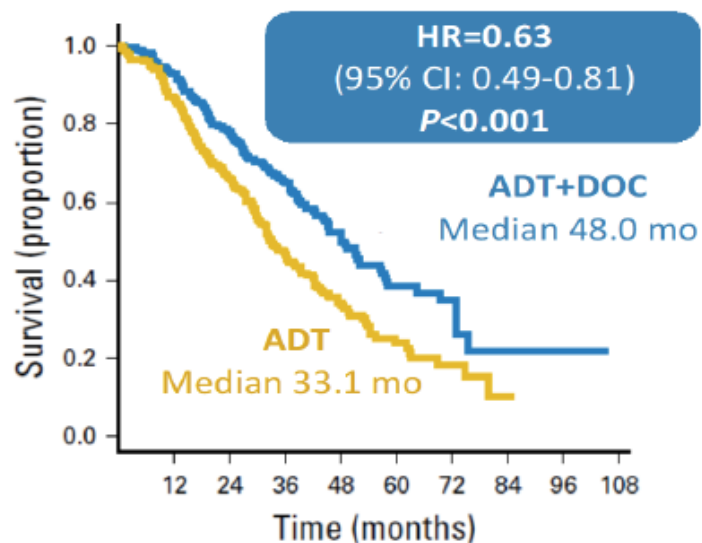
80% of ADT patients received at PD docetaxel !



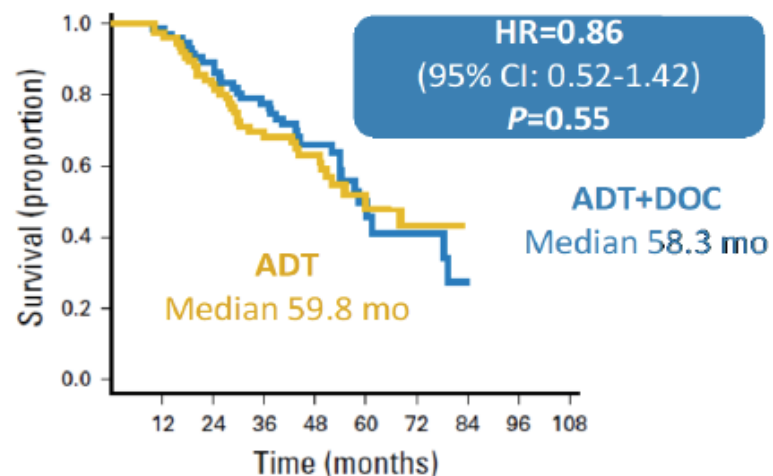
High volume metastatic disease

- visceral metastases and/or
- 4 or more bone metastases
(with at least 1 beyond pelvis and vertebral column)

High-volume* (N=421)



Low-volume (N=154)



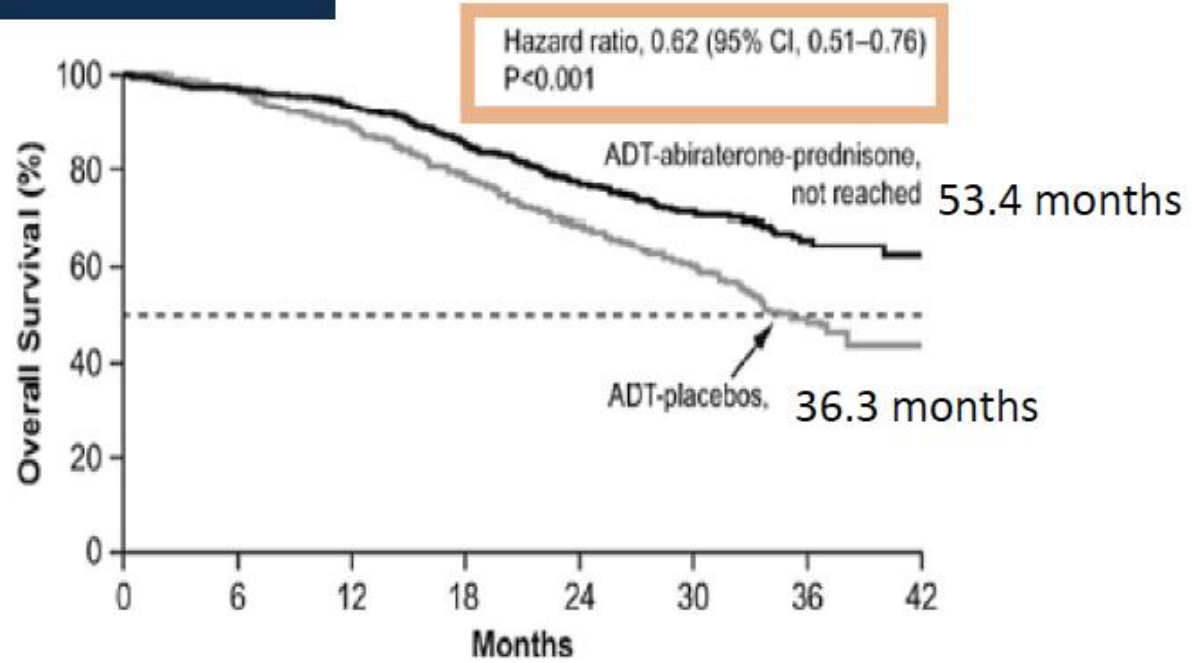
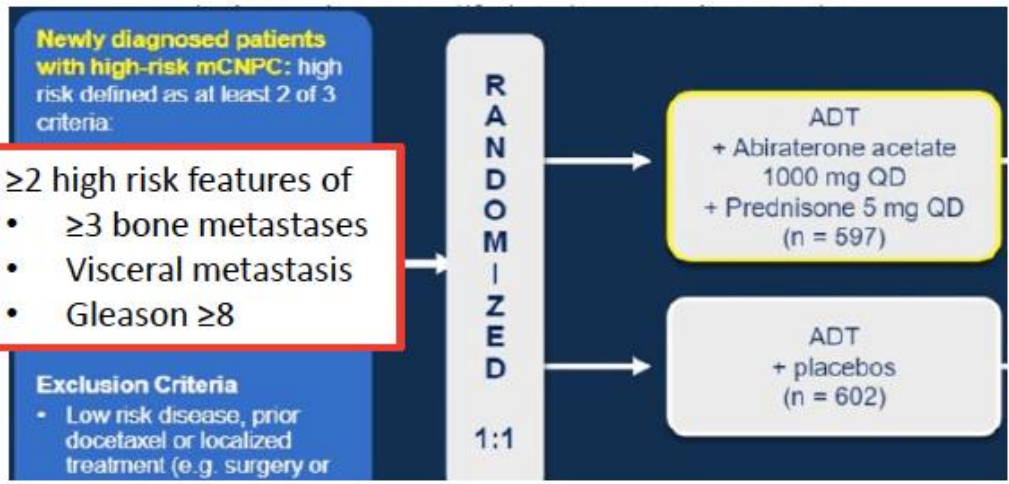
Strong rationale for using chemo in HIGH VOLUME

On BONE SCAN and Thoraco-Abdo CT

Abiraterone plus Prednisone in Metastatic, Castration-Sensitive Prostate Cancer

LATITUDE Trial

Karim Fizazi, M.D., Ph.D., NamPhuong Tran, M.D., Luis Fein, M.D.,

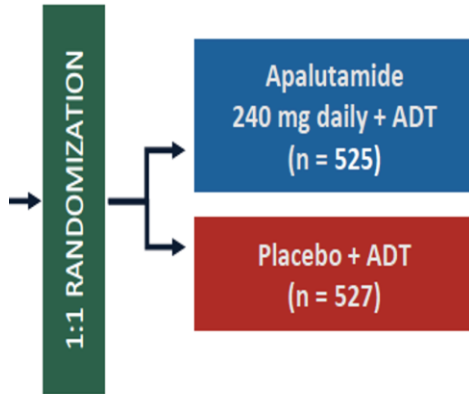


New SoC in mHSPC High Risk

TITAN : Apalutamide vs placebo le CaP métastatique hormonosensible

N = 1052

Dec 2015 –
Jul 2017



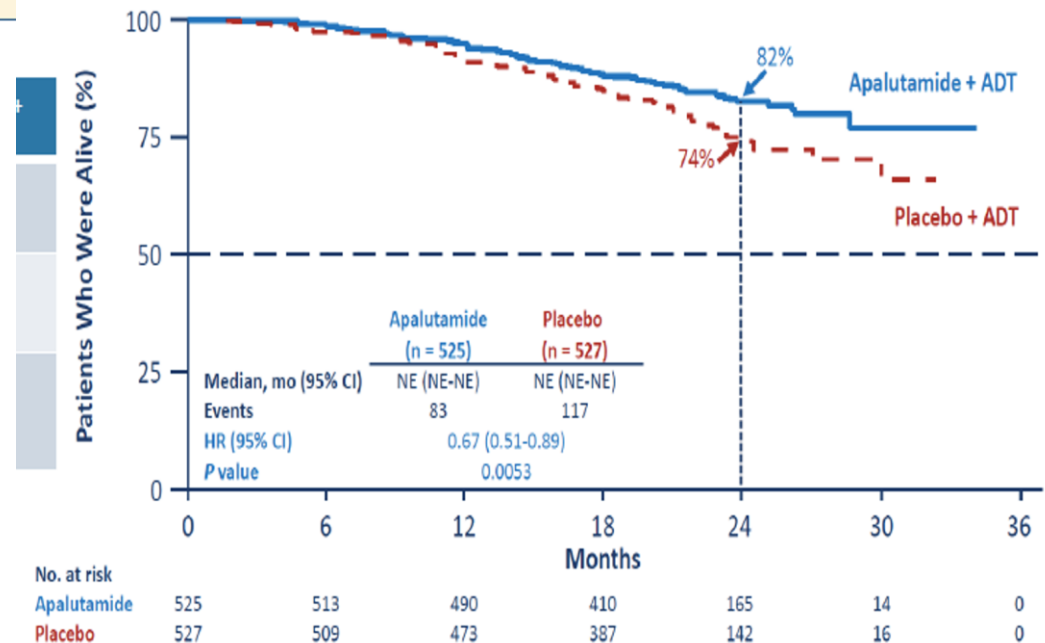
Dual primary end points

- OS
- rPFS

Secondary end points

- Time to cytotoxic chemotherapy
- Time to pain progression
- Time to chronic opioid use
- Time to skeletal-related event

TITAN : Survie globale (co-critère principal)
33% de diminution du risque de décès

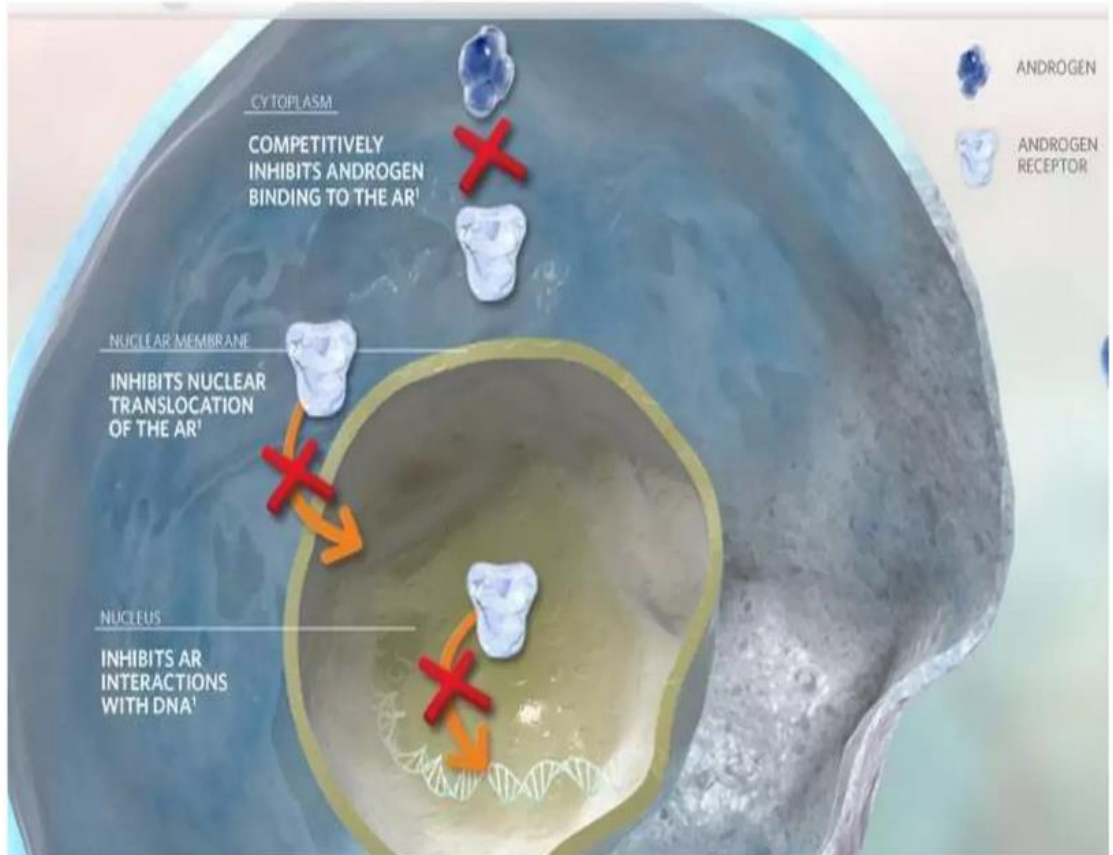


Apalutamide for castration sensitive prostate cancer NEJM 2019

Enzalutamide

- **MOA**

- Androgen receptor inhibitor
- Competitively inhibits androgen binding to receptors and inhibits androgen receptor nuclear translocation and interaction with DNA



ENZAMET : étude de phase III en ouvert mHSPC enzalutamide versus antiandrogène non stéroïdien (+ suppression androgénique)

Study population

- Prostatic adenocarcinoma with metastases on CT, bone scanning or both
- ECOG: 0-2
- Prior randomization: ADT initiated up to 12 weeks and 2 cycles docetaxel*
- Previous ADT for up to 24 months was allowed if the treatment had been completed > 12 months earlier.

Stratification

Volume of metastases

- High vs low

Planned early Doc

- Yes vs no

ECOG PS score

- 0-1 vs 2

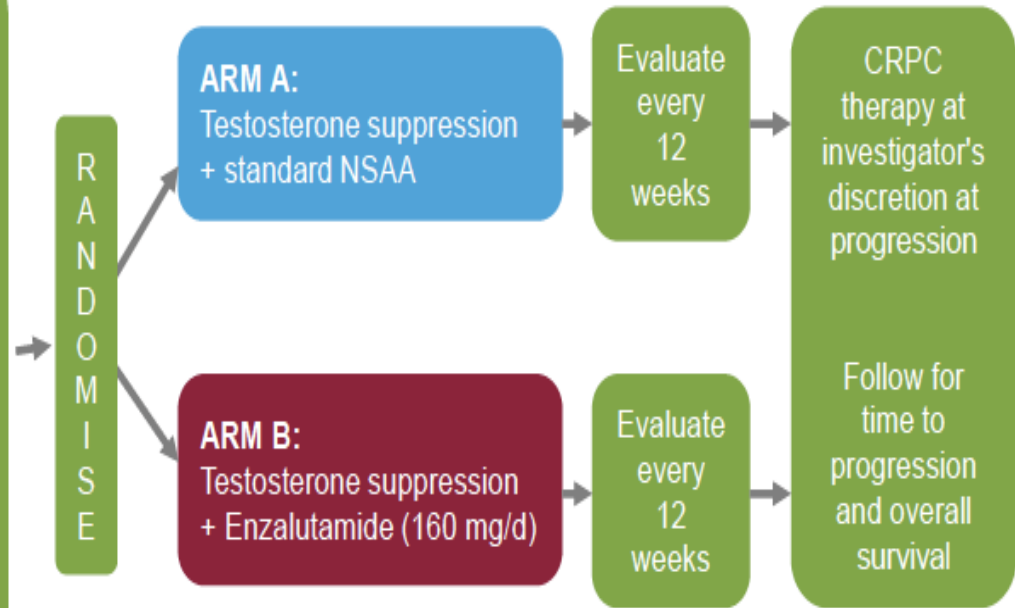
Anti-resorptive therapy

- Yes vs no

Comorbidities

ACE-27** : 0-1 vs 2-3

Study site



Critère principal : Survie globale

* High volume: Visceral metastases and/or ≥ 4 bone metastases (≥ 1 beyond pelvis and vertebral column).

* **After the enrollment of 88 patients, the early administration of docetaxel with testosterone suppression was permitted** in protocol version 2 as a stratification factor before randomization, according to evidence showing improved survival with this approach. The decision to initiate early treatment with docetaxel was left up to the individual patients and their physicians. If docetaxel was administered, the regimen consisted of 75 mg/m², without prednisone or prednisolone, given every 3 weeks for a maximum of six cycles. Up to two cycles of docetaxel were permitted before randomization.

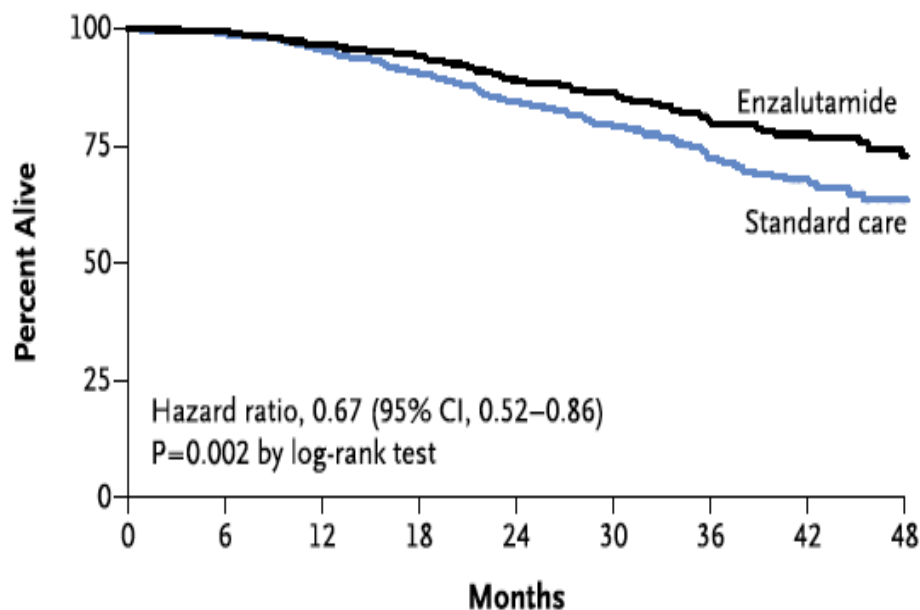
ENZAMET: Baseline Characteristics

Characteristic	Enzalutamide (n = 563)	NSAA (n = 562)
Median age, yrs (IQR)	69.2 (63.2-74.5)	69.0 (63.6-74.5)
Australian, n (%)	324 (58)	321 (57)
ECOG PS 0/1/2, %	72/27/1	72/27/1
Planned early docetaxel*, n (%)	254 (45)	249 (44)
Disease volume, n (%)		
▪ High	291 (52)	297 (53)
▪ Low	272 (48)	265 (47)
ACE-27 score 0/1, n (%)	422 (75)	419 (75)
Treatment for prostate cancer, n (%)		
▪ Planned treatment for SRE	55 (10)	58 (10)
▪ Prior local prostatectomy or radiotherapy	238 (42)	235 (42)
▪ Prior adjuvant ADT	58 (10)	40 (7)
▪ Prior docetaxel	95 (17)	83 (15)

*Early docetaxel: 61% of high volume, 27% of low volume
 Sweeney. ASCO 2019. Abstr LBA2. Davis. NEJM. 2019;[Epub].

ENZAMET : Survie globale (critère principal)

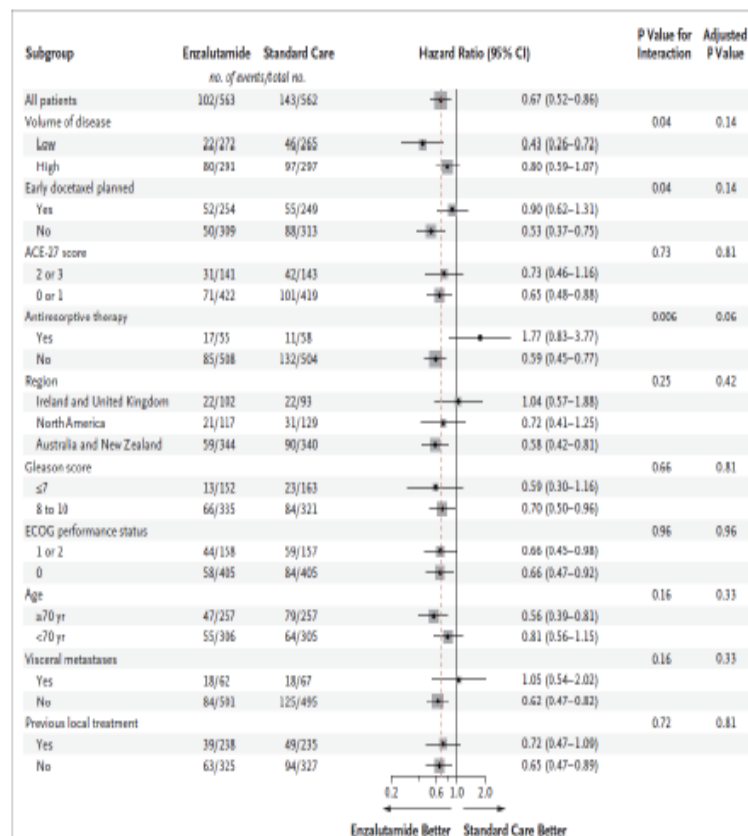
33 % de diminution du risque de décès



No. at Risk

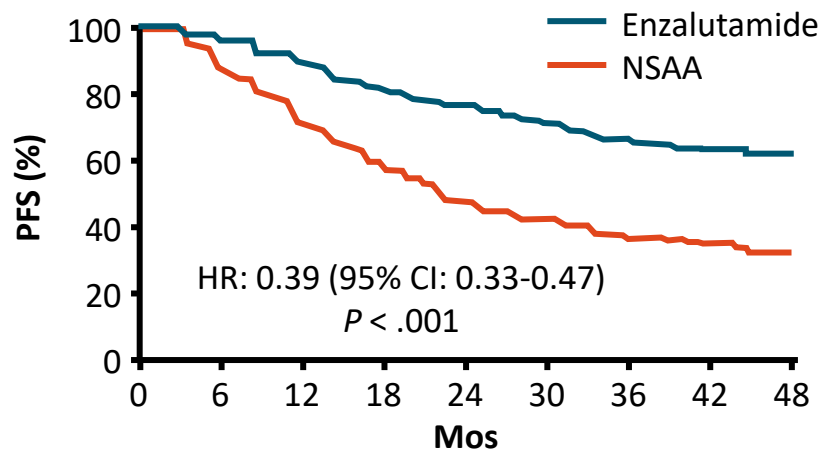
	0	6	12	18	24	30	36	42	48
Enzalutamide	563	558	541	527	480	340	189	106	45
Standard care	562	551	531	501	452	311	174	86	32

Durée médiane de suivi : 34 mois

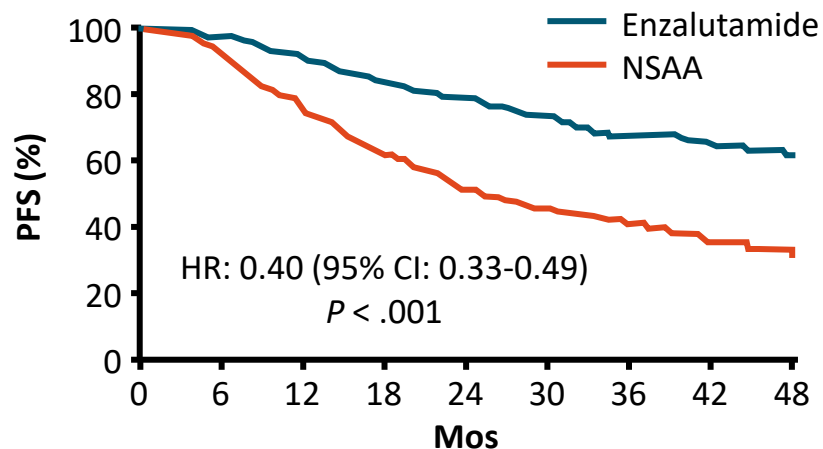


ENZAMET: PFS

Time to PSA increase, clinical progression, or death



Time to Clinical Progression



Patients at Risk,										
n	563	543	500	455	411	269	146	77	34	
Enzalutamide	562	486	395	322	249	161	78	44	17	
NSAA										

Patients at Risk, n										
	563	547	507	468	424	284	156	84	36	
Enzalutamide	563	547	507	468	424	284	156	84	36	
NSAA	562	512	418	346	272	182	96	50	17	

Sweeney. ASCO 2019. Abstr LBA2. Davis. NEJM. 2019;[Epub]. Reproduced with permission.

ENZAMET: Conclusions

- Enzalutamide demonstrated improved survival compared with standard NSAA in patients with mHSPC
 - 36-mo OS: 80% for enzalutamide vs 72% for NSAA (HR: 0.67; $P = .002$)
 - Similar OS benefit in patients with low and high volume of metastases
- Increased toxicity was shown with the addition of enzalutamide, as expected
 - Patients who were also treated with docetaxel experienced more chemotherapy-related toxicity
- The study investigators concluded that enzalutamide is an appropriate option for men with mHSPC starting on ADT

ARCHES : Enzalutamide vs placebo le CaP métastatique hormonosensible

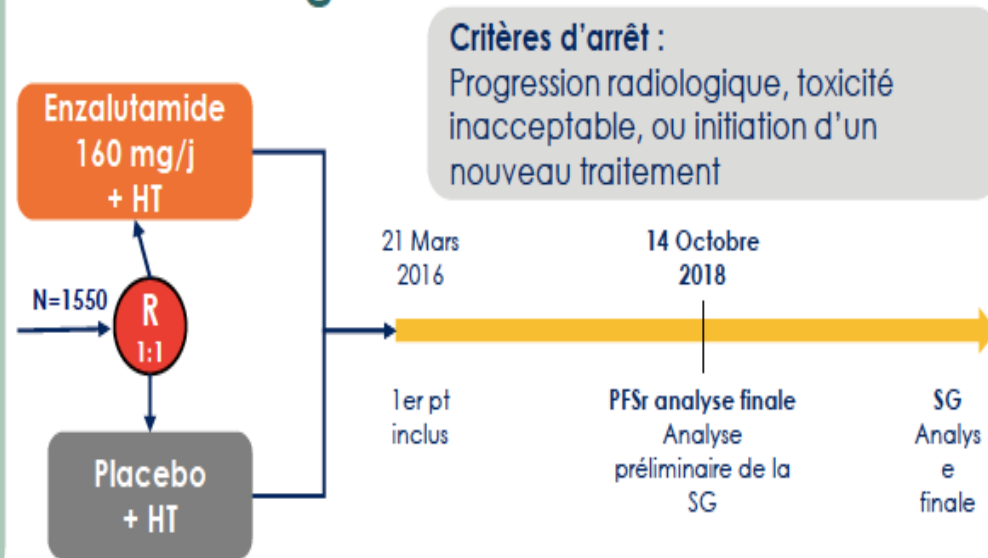
Critères d'éligibilité

- CaPm HS (confirmé par CT; Scinti os ou IRM)
- Adénocarcinome confirmé sur le plan histologique
- ECOG Performance Status 0 to 1
- Déprivation hormonale ≤ 3 mois sauf si post docetaxel, alors ≤ 6 mois

Facteurs de stadification

- Volume tumoral (low vs high*)
- Prior docetaxel therapy for CaPm HS (aucun, 1-5, or 6 cycles)

Design



Critère principal :

Délai à la progression radiologique (revue centralisée) ou décès quelle que soit la cause

*Métastases dans les viscères, ou en l'absence de lésions viscérales, >4 lésions osseuses, dont >1 située au-dessus du rachis et du pelvis

Baseline Patient Characteristics (ITT, n=1150)

- After study unblinding, **184 patients (31.9%)** randomized to placebo plus ADT remained progression-free and gave informed consent to **cross over**, 180 (31.3%) of whom received treatment with enzalutamide plus ADT. Median time to crossover was **21.5 months**

Characteristic	Enzalutamide + ADT (n=574)	Placebo + ADT (n=576)	Placebo + ADT crossover (n=184)
Median age, years (range)	70 (46–92)	70 (42–92)	69 (51–89)
Geographic region, n (%)			
Asia-Pacific	104 (18.1)	113 (19.6)	49 (26.6)
Europe	341 (59.4)	344 (59.7)	102 (55.4)
North America	86 (15.0)	77 (13.4)	18 (9.8)
ECOG PS 0, n (%)	448 (78.0)	443 (76.9)	155 (84.2)
High disease volume, n (%)	354 (61.7)	373 (64.8)	92 (50.0)
Gleason score ≥8 at initial diagnosis, n (%)	386 (67.2)	373 (64.8)	108 (58.7)
Localization of confirmed metastases at screening, n (%)			
Lymph node only ^a	74 (12.9)	80 (13.9)	41 (22.8)
Bone disease, with or without lymph node	432 (75.3)	432 (75.0)	122 (67.8)
Visceral disease, with or without bone or lymph node	64 (11.1)	64 (11.1)	17 (9.4)
Distant metastasis at initial diagnosis, n (%)	402 (70.0)	365 (63.4)	107 (58.2)
Prior therapy, n (%)			
Docetaxel	103 (17.9)	102 (17.7)	29 (15.8)
ADT	535 (93.2)	514 (89.2)	162 (88.0)
Median PSA, ng/mL	5.4 (0–4823.5)	5.1 (0–19,000.0)	4.05 (0.0–3192.0)

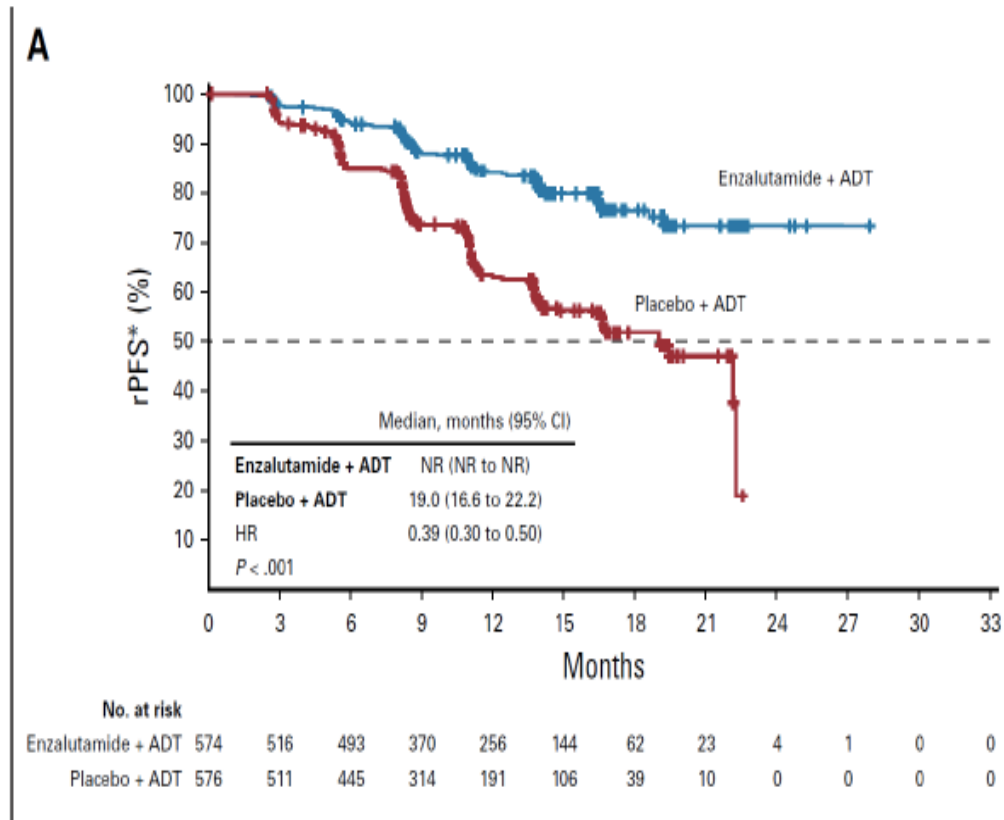
^aLymph node metastases or unconfirmed metastatic disease.
ADT=androgen deprivation therapy; ECOG PS=Eastern Cooperative
Oncology Group performance status; ITT=intent-to-treat; PSA=prostate-
specific antigen.
Slides are property of the author. Permission required for reuse.

- Patients in the placebo plus ADT crossover group generally had a more favorable prognosis at baseline, with fewer high volume, more node only, and fewer *de novo* M1 patients**

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PFS radiologique (rPFS – critère principal)

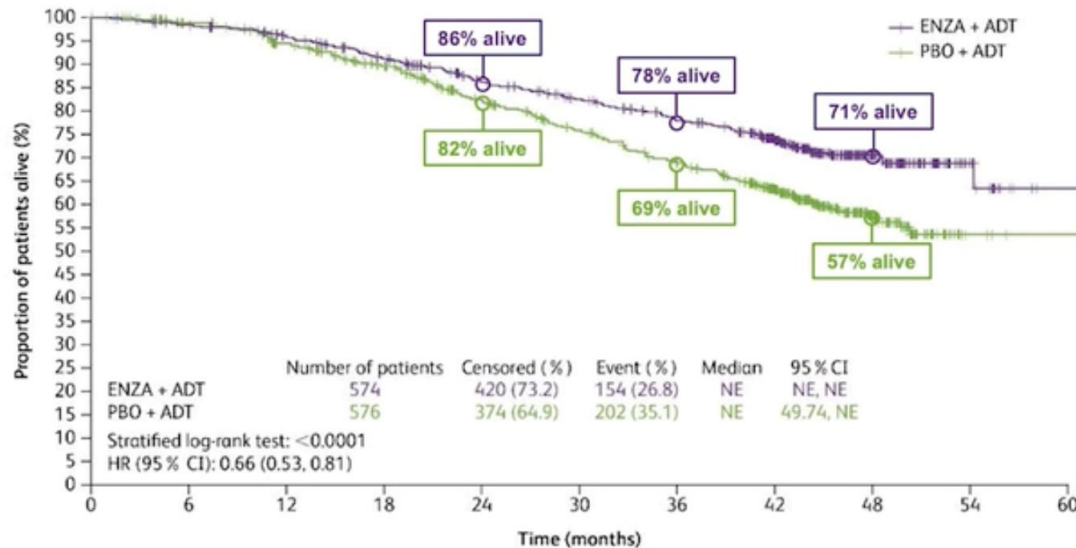
61 % de diminution du risque de progression radiographique ou de décès



Durée médiane de suivi : 14,4 mois

ARCHES : OS

Overall Survival (ITT)



- As of May 28, 2021: 356 deaths (enzalutamide plus ADT, 154; placebo plus ADT, 202) were observed
- Median follow-up time: 44.6 mo
- Median treatment duration:
 - Enzalutamide plus ADT: 40.2 mo
 - Placebo plus ADT: 13.8 mo
 - Placebo plus ADT crossover: 23.9 mo

Patients at risk

	0	6	12	18	24	30	36	42	48	54	60
ENZA + ADT	574	559	535	498	457	427	396	316	120	17	1
PBO + ADT	576	548	511	468	404	363	322	232	80	4	1

- Enzalutamide plus ADT significantly improved overall survival by 34% vs placebo plus ADT

Treatment-emergent Adverse Events

Event, n (%)	Enzalutamide + ADT (n=572)		Placebo + ADT (n=574)		Placebo + ADT crossover (n=180)	
	All grades	Grade 3–4	All grades	Grade 3–4	All grades	Grade 3–4
Any TEAE	520 (90.9)		504 (87.8)		149 (82.8)	
Any TEAE leading to treatment withdrawal	79 (13.8)		32 (5.6)		13 (7.2)	
Any study drug-related TEAE leading to death	0		1 (0.2) ^b		0	
Any TEAE of special interest	All grades	Grade 3–4	All grades	Grade 3–4	All grades	Grade 3–4
Convulsions	3 (0.5)	3 (0.5)	3 (0.5)	2 (0.3)	1 (0.6)	0
Hypertension	82 (14.3)	29 (5.1)	39 (6.8)	13 (2.3)	14 (7.8)	6 (3.3)
Decreased neutrophil count	8 (1.4)	4 (0.7)	4 (0.7)	2 (0.3)	2 (1.1)	1 (0.6)
Cognitive/memory impairment	38 (6.6)	4 (0.7)	15 (2.6)	0	12 (6.7)	0
Ischemic heart disease	26 (4.5)	7 (1.2)	11 (1.9)	8 (1.4)	6 (3.3)	4 (2.2)
Other selected cardiovascular events	25 (4.4)	10 (1.7)	10 (1.7)	4 (0.7)	4 (2.2)	3 (1.7)
Posterior reversible encephalopathy syndrome	0	0	0	0	0	0
Fatigue	184 (32.2)	16 (2.8)	118 (20.6)	11 (1.9)	43 (23.9)	4 (2.2)
Renal disorders	11 (1.9)	2 (0.3)	4 (0.7)	0	0	0
Second primary malignancies	23 (4.0)	16 (2.8)	11 (1.9)	7 (1.2)	3 (1.7)	2 (1.1)
Falls	58 (10.1)	7 (1.2)	19 (3.3)	3 (0.5)	13 (7.2)	2 (1.1)
Fractures	77 (13.5)	20 (3.5)	31 (5.4)	9 (1.6)	12 (6.7)	2 (1.1)
Loss of consciousness	15 (2.6)	9 (1.6)	2 (0.3)	1 (0.2)	2 (1.1)	0
Thrombocytopenia	3 (0.5)	0	3 (0.5)	0	0	0
Musculoskeletal events	223 (39.0)	14 (2.4)	171 (29.8)	17 (3.0)	41 (22.8)	5 (2.8)
Severe cutaneous adverse reactions	1 (0.2)	0	1 (0.2)	0	0	0
Angioedema	10 (1.7)	1 (0.2)	1 (0.2)	0	0	0
Rash	22 (3.8)	0	10 (1.7)	0	6 (3.3)	1 (0.6)
Hepatic disorder	34 (5.9)	8 (1.4)	35 (6.1)	4 (0.7)	7 (3.9)	4 (2.2)



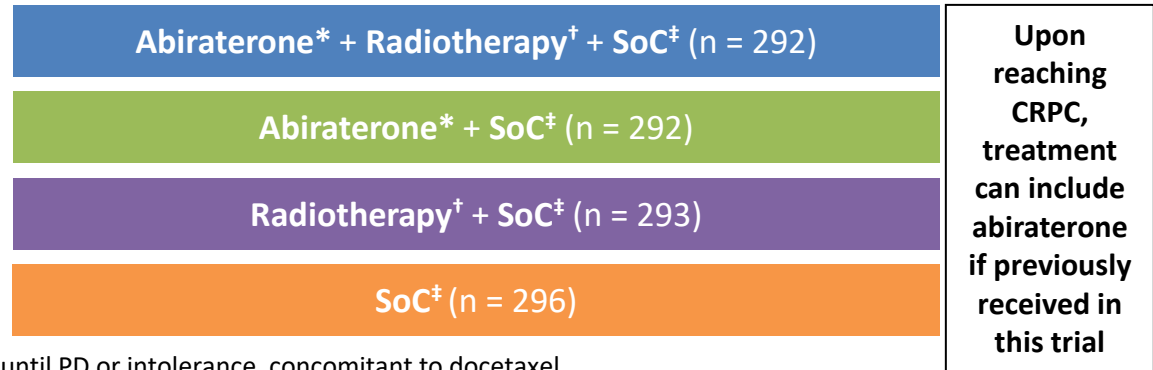
Intensification : Triplets

PEACE-1: Study Design

- Multicenter, randomized, open-label phase III trial^{1,2}

Stratified by ECOG PS (0 vs 1/2), metastatic site (LN vs bone vs visceral), type of castration (surgical vs LHRH agonist vs LHRH antagonist), docetaxel (yes vs no)

Patients with de novo mCSPC;
distant mets by ≥ 1 lesion on bone scan and/or CT scan; ECOG PS 0-2;
continuous on-study ADT; ADT for ≤ 3 mo before enrollment permitted
(N = 1173)

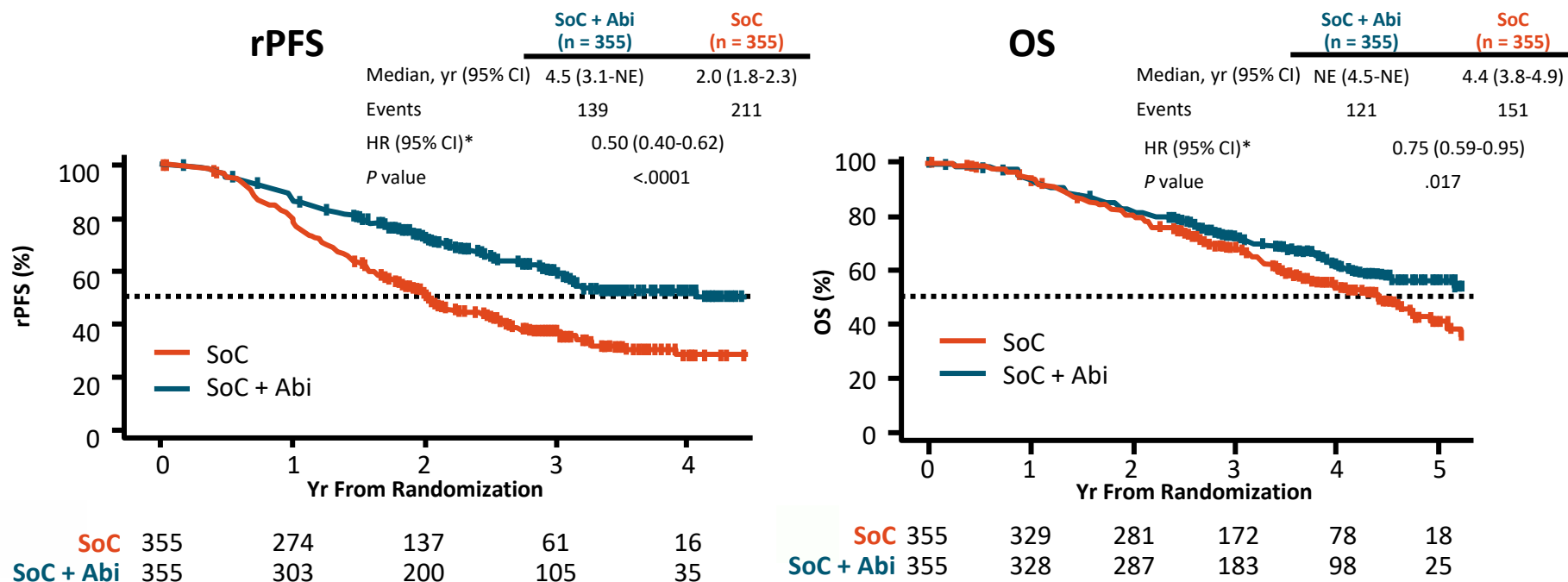


*Abiraterone 1000 mg/day + prednisone 5 mg BID until PD or intolerance, concomitant to docetaxel.

†74 Gy in 37 fractions after completion of docetaxel. ‡Continuous ADT \pm docetaxel 75 mg/m² Q3W x 6 cycles.

- **Coprimary endpoints:** rPFS and OS with 2x2 factorial design and hierarchical testing¹
- **Key secondary endpoints:** castration resistance-free survival, time to next SRE, PSA response rate, time to pain progression, QoL, safety¹

PEACE-1: rPFS and OS With Abiraterone in the Docetaxel (\pm Radiotherapy) Population



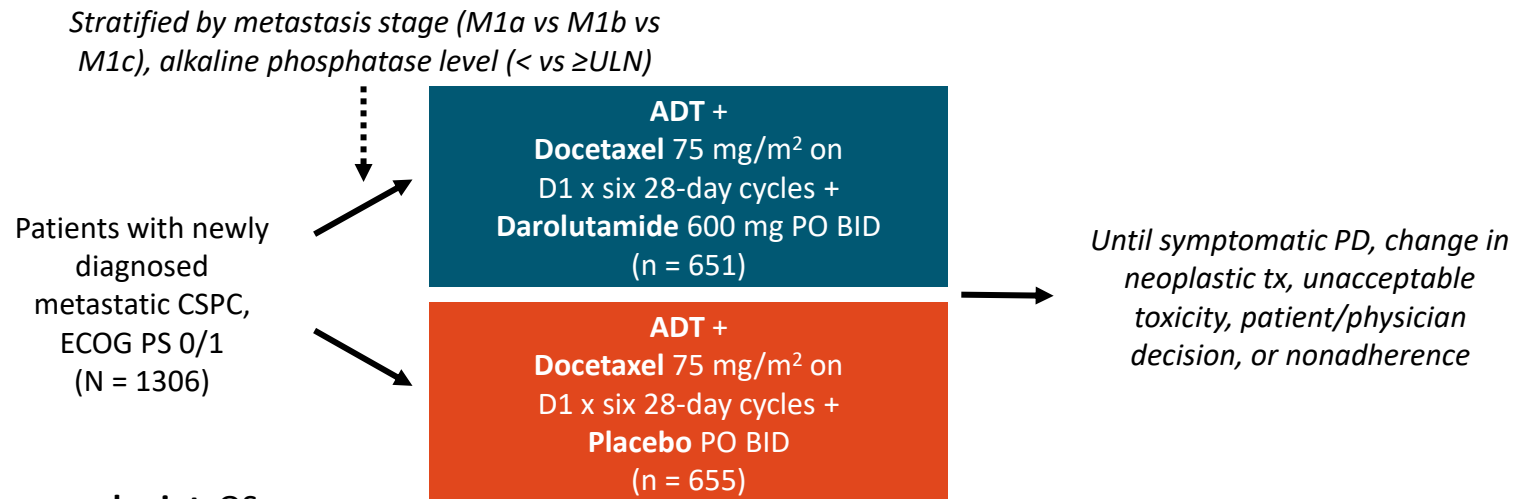
*Adjusted on stratification parameters (RXT, PS, type of castration, metastatic burden).

PEACE-1: Grade 3-5 AEs Reported in ADT + Docetaxel Population

Grade 3-5 AEs, n (%)	Abiraterone + SoC (± Radiotherapy) (n = 346)	SoC (± Radiotherapy) (n = 350)
Neutropenia	34 (10)	32 (9)
Febrile neutropenia	18 (5)	19 (5)
Liver	20 (6)	2 (1)
Hypertension	76 (22)	45 (13)
Hypokalemia	11 (3)	1 (0)
Cardiac	6 (2)	5 (1)
Fatigue	10 (3)	15 (4)
Gastrointestinal	14 (4)	18 (5)
Grade 5	7 (2)	3 (1)

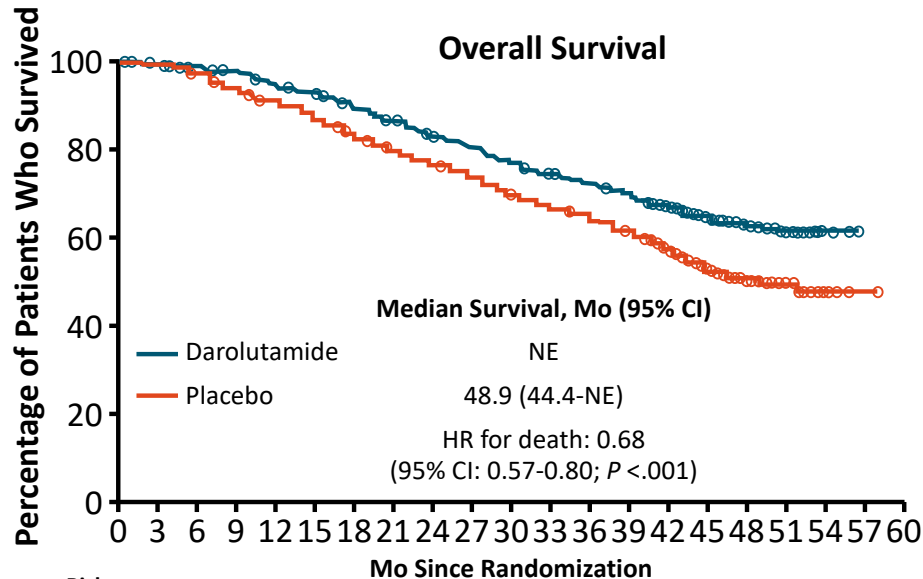
Phase III ARASENS Trial: Darolutamide in mCSPC

- International, randomized, double-blind, placebo-controlled trial in 286 sites in 23 countries



- Primary endpoint:** OS
- Secondary endpoints tested hierarchically in this order:** time to CRPC, time to pain progression, SSE-free survival, time to first SSE, time to initiation of subsequent anticancer therapy, time to worsening of physical symptoms, time to first opioid use, safety

ARASENS: Primary Endpoint (Overall Survival), Safety



Patients at Risk, n

Mo	0	3	6	9	12	15	18	21	24	27	30	33	36	39	42	45	48	51	54	57	60
Darolutamide	651	645	637	627	608	593	570	548	525	509	486	468	452	436	402	267	139	56	9	0	0
Placebo	654	646	630	607	580	565	535	510	488	470	441	424	402	383	340	218	107	37	6	1	0

- Addition of darolutamide to ADT + docetaxel significantly lowered risk of death by 32.5% vs placebo

Safety Outcome, n (%)	ADT + Docetaxel + Darolutamide (n = 652)	ADT + Docetaxel + Placebo (n = 650)
Any AE	649 (99.5)	643 (98.9)
Serious AE	292 (44.8)	275 (42.3)
AE leading to permanent d/c of trial agent		
▪ Darolutamide or placebo	88 (13.5)	69 (10.6)
▪ Docetaxel	52 (8.0)	67 (10.3)

- Comparable rates between treatment arms of any-grade, grade 3-5, and serious AEs
- Most common grade 3/4 AEs in darolutamide arm included neutropenia (33.7%), febrile neutropenia (7.8%), hypertension (6.4%), and anemia (4.8%)
- Similar rates of death due to treatment-emergent AEs (darolutamide arm, 4.1%; placebo arm, 4.0%)

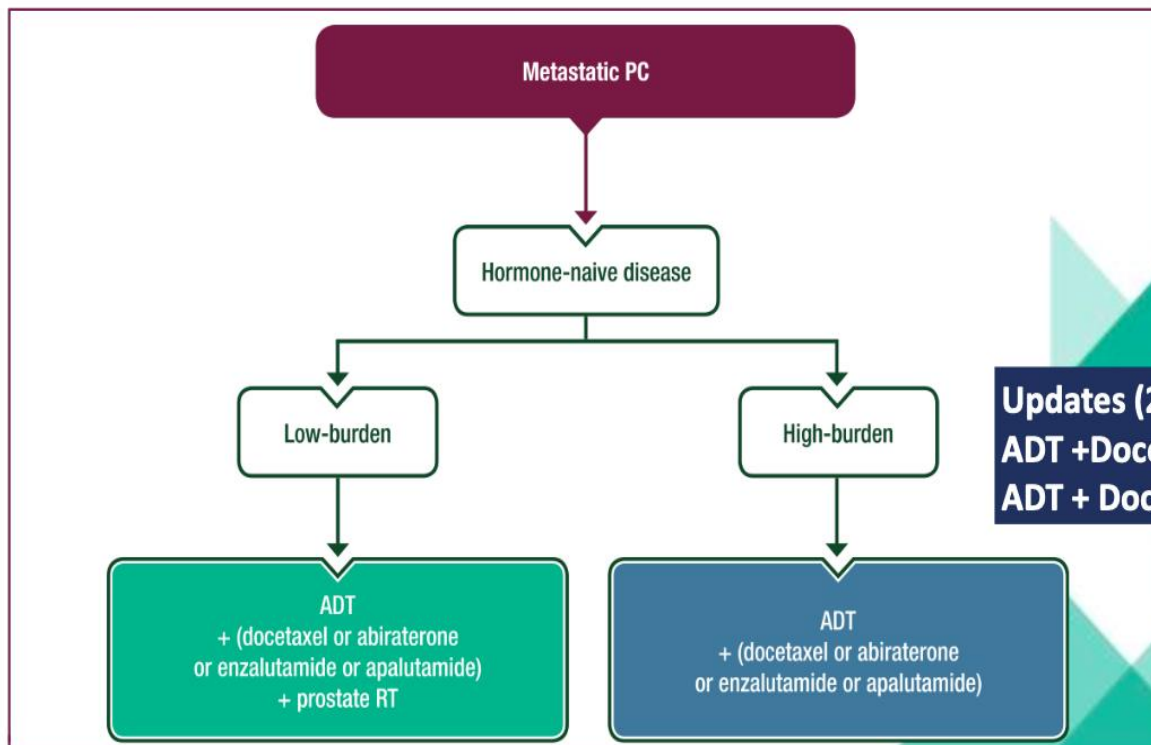
Smith. NEJM. 2022;[Epub].

Recommandations 2022-2024

Recommandations	Grade
Une intensification du traitement systémique par l'ajout d'une HTNG est recommandée chez tout patient M1 (SAd + HTNG)	Fort
Il n'y a plus d'indication à intensifier la suppression androgénique par le docétaxel seul (SAd + docétaxel), sans association avec une HTNG	Fort
La combinaison SAd + HTNG + docétaxel (triplet) est recommandée pour des patients éligibles à la chimiothérapie, préférentiellement en cas de maladie M1 <i>de novo</i> et à haut volume L'HTNG sera alors soit l'abiratérone, soit le darolutamide (ordre alphabétique)	Fort
Une radiothérapie prostatique à dose curative peut être proposée en cas de maladie M1 de faible volume	Fort
La radiothérapie dirigée sur les métastases (en dehors du contexte symptomatique) n'a pas fait preuve de son efficacité oncologique et doit être proposée dans le cadre d'essais cliniques	Fort

ESMO GUIDELINES: REAL WORLD CASES

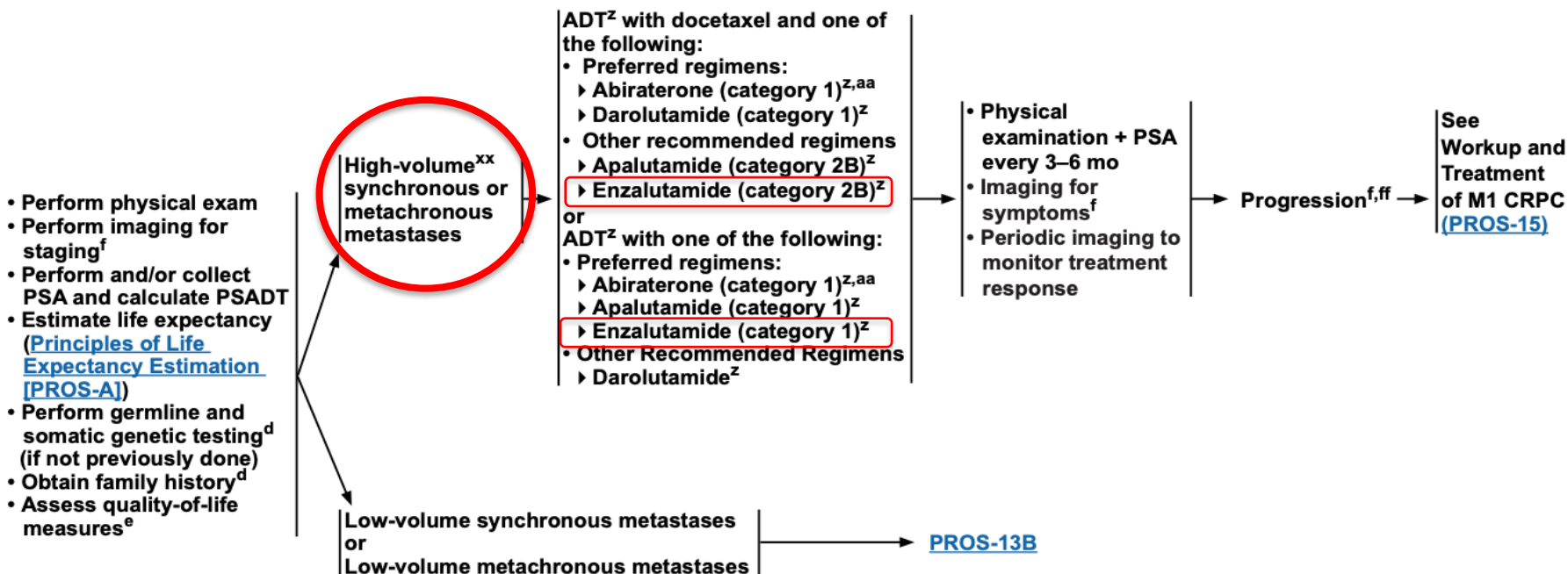
ESMO GUIDELINES (2020+2023 E- UPDATE)



Updates (2023) : Triplets
ADT + Docetaxel + Abiraterone
ADT + Docetaxel + Darolutamide

WORKUP AND TREATMENT OF M1 CSPC^{c,rr,ss,tt,uu,vv}

WORKUP FOR METASTASES^{ww}



Note: All recommendations are category 2A unless otherwise indicated.

[Workup and Treatment of M1 CSPC Footnotes \(PROS-13C\)](#)



WORKUP AND TREATMENT OF M1 CSPC^{c,rr,ss,tt,uu,vv}

WORKUP FOR METASTASES^{ww}

High-volume^{xx} synchronous or metachronous metastases

[PROS-13A](#)

Low-volume
synchronous
metastases

- ADT^z with one of the following:
- Preferred regimens:
 - Abiraterone (category 1)^{z,aa}
 - Apalutamide (category 1)^z
 - Enzalutamide (category 1)^z
 - Other Recommended Regimens
 - Darolutamide (category 2B)^z
- or
- ADT^z with docetaxel and one of the following:
- Abiraterone (category 2B)^{z,aa}
 - Apalutamide (category 2B)^z
 - Darolutamide (category 2B)^z
 - Enzalutamide (category 2B)^z
- or
- ADT^z with EBRT^s to the primary tumor^{yy} alone or with one of the following:
- Abiraterone^{z,aa}
 - Apalutamide (category 2B)^z
 - Docetaxel (category 2B)^z
 - Enzalutamide (category 2B)^z

Low-volume
metachronous
metastases

- ADT^z with one of the following:
- Preferred regimens:
 - Abiraterone (category 1)^{z,aa}
 - Apalutamide (category 1)^z
 - Enzalutamide (category 1)^z
 - Other Recommended Regimens
 - Darolutamide (category 2B)^z

- Physical examination + PSA every 3–6 mo
- Imaging for symptoms^f
- Periodic imaging to monitor treatment response

Progression^{f,ff}

See
Workup and
Treatment
of M1 CRPC
([PROS-15](#))

Note: All recommendations are category 2A unless otherwise indicated.

[Workup and Treatment of M1 CSPC Footnotes \(PROS-13C\)](#)



Les Guides Thérapeutiques en Oncologie Médicale

III.2.C. Cancer de la prostate métastatique hormono-naïf

Métastases synchrones

Haut volume/ Haut risque

STANDARDS

- Suppression androgénique immédiate et continue associée à l'acétate d'abiratérone ou enzalutamide.
- Suppression androgénique immédiate et continue associée au docétaxel.
- Traitement local non recommandé.
- Médicament ciblant l'os non recommandé.

OPTIONS

- Antiandrogène de première génération lors de la première injection d'agoniste LHRH pour prévention du flare up si forte masse tumorale.
- Blocage androgénique complet par un analogue LH-RH associé à un antiandrogène de première génération.
- Docétaxel en plus de l'association SAd + HTNG peut être discuté pour les patients.

Bas volume/ Bas risque

STANDARDS

- Suppression androgénique immédiate et continue associée à l'acétate d'abiratérone ou enzalutamide.
- Radiothérapie prostatique.
- Médicament ciblant l'os non recommandé.

OPTION

- Traitement local des métastases si maladie oligométastatique.

Métastases métachrones

STANDARDS

- Hormonothérapie immédiate et continue associée à l'enzalutamide.
- Médicament ciblant l'os non recommandé.

OPTIONS

- Hormonothérapie immédiate et continue associée à l'acétate d'abiratérone.
- Hormonothérapie intermittente si pauci-symptomatique, asymptomatique, informé, PSA < 4 ng/mL après 6-9 mois d'hormonothérapie.
- Traitement local des métastases en cas de maladie oligométastatique.

Conclusion

- Le cancer de la prostate est un problème de santé son incidence est en constante augmentation.
- Le traitement médicamenteux a connu d'importants progrès ces derniers années.
- Le traitement du cancer de la prostate métastatique hormonosensible par suppression androgénique seule n'est plus suffisant.
- Un traitement par un doublet (suppression androgénique plus HTNG) au moins est indispensable.
- Une trithérapie (suppression androgénique + HTNG + Taxane) est discutée chez certains patients (de novo et haut volume).
- Intérêt des réunions de concertation pluridisciplinaires (RCP) pour des décisions collégiales adaptées à chaque patient.