CASE PRESENTATION #1: BCR IN A HIGH-RISK PATIENT

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CASE HISTORY

- 64 yo healthy man undergoes RALP/ePLND for Gleason 4+4 pT3bR1N0 adenocarcinoma
- PMH/PSH: non-contributory

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CASE CONTINUED

- PSA increases from initially undetectable to 0.14 ng/ml 9 months after prostatectomy (repeat 0.16 ng/ml)
  - (-) systemic/constitutional complaints
  - (-) incontinence

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QUESTIONS FOR DISCUSSION

- Has this patient met AUA definition of BCR?
  - How characterize risk for subsequent metastases?
- Further evaluation needed (imaging)?
- Salvage RT – consider at this time?
  - If so, should concurrent ADT be given? If so, for how long?
- Would salvage systemic therapy be an option?
  - What are pro's/con's?

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Case Discussion #2- Genetic Testing

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Patient DW

- 68yo man with OSA and HTN
- Dec 2010 had a PSA of 4.5, biopsy showed Gleason 3+4=7 prostate cancer in 3/12 cores
  - Favorable intermediate risk
- Jan 2011 he completed EBRT (no ADT), PSA nadir of 1.1 Dec 2011
- PSA 2012 was 1.3, but by 2013 his PSA was 26.7
  - Bone scan negative, CT with 1.8cm L common iliac LN
- Feb 2014 PSA was up to 48.6
  - LN biopsy was +Pca, started ADT (Lupron)
- Reached nmHRPC in 2016 and started on bicalutamide
  - PSA became undetectable

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Patient RW

- Switched to enzalutamide in 2018 for rising PSA
  - PSA response to <0.5
- Slow rise in PSA over next 8 years with negative CT and bone scans
- Feb 2026 PSA 2.74, PSMA PET with pelvic nodal uptake and 1 osseous metastasis
- Received **Tempus** testing- no clinically significant variants noted
- March 2026 initiated sipuleucel-T

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Questions

- What genetic testing is available for patients with advanced prostate cancer?
- When should genetic testing be performed?
- What information is gleaned from somatic and/or germline testing?
- What genes of interest are actionable and what therapies are approved in this setting?

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Case Based Roundtable Discussion
Case #3

M1 HSPC - Oligometastatic

David F Jarrard, MD

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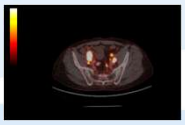
Case #2: Healthy 53yo with pelvic adenopathy and bone metastasis

- Presents with urinary obstruction
- PSA 35 and GG5 tumor right (T2b)
- Large pelvic lymph nodes and a metastasis to humerous (N1 M1b)



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Case #3 (Oligometastatic HSPC)

Discussion:

- How do we define oligometastatic?
- What clinical and radiological features are important for the management of these patients? Additional studies
- What treatment options are available for oligometastatic HSPC?
- What are the goals and outcomes of treatment?

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Case #4:
Metastatic Hormone Sensitive Prostate Cancer

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- 69 yo man, ECOG 1
- SH: current EToH use of about 2.0 standard drinks of alcohol per week.
- PMH: CAD on aspirin/clopidogrel
- FH: Father dx w/ prostate cancer / Mother dx with breast cancer

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Oncologic Summary

11/15/24 - prostatic adenocarcinoma, acinar type, Gleason score 7 (3+4), Grade Group 2.
07/2025 - Completed definitive XRT without ADT in July 2023 in CCF (compliance issues)
05/2024 - Rising PSA 32
6/24/24 - Bone metastases detected in PSMA PET (confirmed in CT/Bone) – high volume

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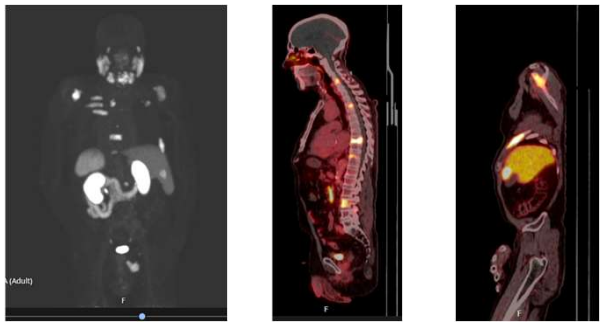

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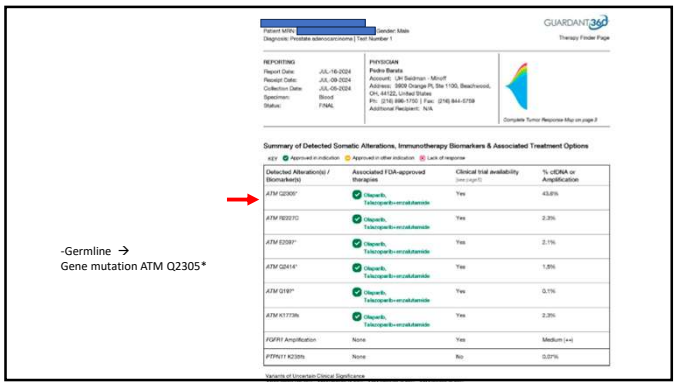

-Germline →
Gene mutation ATM Q2305*

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Questions

- Would you recommend ADT + ARPI alone or triplet therapy with docetaxel in this patient?
- Would the presence of high-volume disease, age, cardiovascular comorbidities, and patient preference influence your recommendation?
- Would you consider PARP inhibitor-based therapy in this patient with germline *ATM mutation*, and if so, at what point in the disease course?

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Case Presentation #5

M1 CRPC Minimally Symptomatic

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Case #5

- 65-year-old gentleman is referred for a rising PSA.
- Previously underwent RALP for Gl 8 prostate cancer (PSA 12, 0/7 LNs, Margins +)
- Received radiation therapy 6 months post-op
- After 5 years of follow-up he was started on ADT for rising PSA and suspicious pelvic lymph nodes. He had an excellent response for several years.
- However, his PSA has increased on ADT over the last year:
  - 0.41 -> 1.06 -> 1.54

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Case #5 (Continued)

- Has no pain or symptoms and excellent performance status
- Testosterone is castrate (<20 mg/dL)
- LDH, Hgb, alkaline phosphatase normal
- CT Scan and bone scan obtained
  - CT scan showed stable pelvic nodes
  - Bone scan shows new lesions in the ribs and spine

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Is there a role for Next Generation Imaging?

What are his options for treatment in this setting?

What side effects should we be aware of?

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CASE PRESENTATION #6: M1 CRPC – DDR First Line

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Case History

- 72 y/o healthy male with mCRPC
  - Radical prostatectomy: pT3aN0M0, GG5, PSM RA +RB
    - PSA < 0.1 but… BCR 12 months later
  - CT and bone scan negative
  - Salvage XRT + 6 mos ADT
    - PSA < 0.1 but… BCR 24 months later
  - PSMA PET with small volume metastases
  - ADT + Abiraterone + Prednisone

Family History
- Prostate cancer in father, brother
- Lethal breast cancer in sister

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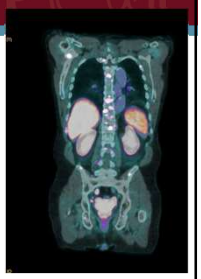
Case History

- **Germline testing**
  - **BRCA2 mutation**

RESULT: POSITIVE

- Initial PSA response, with subsequent rise
  - <0.1 → 0.19 → 0.19 → 0.42 → 1.14
  - Testosterone < 12
- **PSMA PET → Progressive metastatic**



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Case History

- 72 y/o M with mCRPC and BRCA2 mutation
  - ARPI in mHSPC
- Asymptomatic
- ECOG 0-1

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Questions for Discussion

- What defines mCRPC?
- Who do you order germline and somatic testing in and why?
- What are treatment options for newly diagnosed mCRPC?
- How do you decide which treatment for newly diagnosed mCRPC?

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Case 7

M1 CRPC: First and Second Line Treatment Options

Alicia K. Morgans, MD, MPH, FASCO

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PATIENT CASE

- Mr. SR is a 68 year old AA man with osteoarthritis, coronary artery disease, HTN, and hyperlipidemia
- He presented to his PCP with lower back pain that was not responsive to stretches and NSAIDs. Lumbar spine x-rays were concerning for metastatic cancer in multiple vertebral bodies.
- PSA was 46. He was referred to a urologist for work up.
- Prostate MRI suggested two PI-RADs 5 on the right with likely ECE and multiple enlarged pelvic lymph nodes. Prostate biopsy demonstrated GG 5 prostate adenocarcinoma in 6/12 template cores and the target lesion biopsies.
- He undergoes staging studies including CT c/a/p and bone scan that demonstrate multiple vertebral, pelvic, and rib metastases (~15 sites of bone metastases)

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PATIENT CASE

- He starts treatment with ADT + enzalutamide for high volume mHSPC as he prefers a non-chemotherapy containing regimen. PSA responds and nadirs at 1.2 ng/mL after 9 months.
- After approximately 14 months of relatively stable PSA values, his PSA started to rise steadily with a current level of 12.1 ng/mL.
- Patient is symptomatic with increased lower back pain and notes an unintentional 8-pound weight loss

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PATIENT CASE

- What additional tests should be performed?
- Which treatments for prostate cancer have been shown to prolong overall survival in this scenario?
- What treatment is recommended by the AUA for this patient?

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