Utilisation des nouvelles hormonothérapies

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Limoges

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Actualités dans la prise en charge des cancers urologiques

Liens d’intérêts

- Aucun

HTNG augmentent la survie au stade métastatique

survie globale augmentée vs ADT & ADT + DOCETAXEL

HTNG + ADT > ADT

- AAP + ADT (LATITUDE, STAMPEDE)
- APA + ADT (TITAN)
- ENZA + ADT (ARCHES)

HTNG + ADT + DOC > ADT + DOC

- ENZA + ADT +/- DOC (ENZAMET)
- AAP + ADT + DOC (PEACE-1)
- DARO + ADT + DOC (ARASENS)

ADT + DOC> ADT

- GETUG-12, CHAARTED, STAMPEDE

Bénéfice : haut volume / bas volume

HTNG augmentent OS pour tout fardeau tumoral

(tableau : Pr Pierre Blanchard)

Essai	Population globale OS, HR (95% CI)	Population haut volume OS, HR (95% CI)	Population bas volume OS, HR (95% CI)
LATITUDE AAP + ADT vs PBO + ADT (100% *de novo*; N=1199)	0.66 (0.56, 0.78)	0.62 (0.52, 0.74)	0.72 (0.47, 1.10)
STAMPEDE AAP AAP + SOC vs SOC (94% *de novo*; N=1003)	0.62 (0.53, 0.73)	0.54 (0.43, 0.69)	0.55 (0.41, 0.76)
ENZAMET ENZA + ADT vs NSAA + ADT (45% concurrent DOC; N=1125)	0.70 (0.58, 0.84)	0.79 (0.63, 0.98)	0.54 (0.39, 0.74)
TITAN APA + ADT vs PBO + ADT (10% prior DOC; N=1052)	0.65 (0.53, 0.79)	0.70 (0.56, 0.88)	0.52 (0.35, 0.79)
ARCHES ENZA + ADT vs PBO + ADT (18% prior DOC; N=1150)	0.66 (0.53, 0.81)	0.66 (0.52, 0.83)	0.66 (0.43, 1.03)
ARASENS DARO + ADT + DOC vs PBO + ADT + DOC (100% DOC; N=1306)	0.68 (0.57, 0.80)	0.69 (0.57, 0.82)	0.68 (0.41, 1.13)

ajout HTNG : référence en 1L métastatique

AFU 2022-2024

l'intensification se discute selon âge, comorbidités, traitements et caractéristiques de la maladie

Recommendation Table 2 Systemic intensification at mHSPC stage.

Recommendations	Level
Intensification of systemic therapy by adding an NHA is recommended for all M1 patients (ADT + NHA)	High
There is no longer an indication to intensify androgen suppression with docetaxel alone (ADT + docetaxel), without combining with an NHA	High
The ADT + NHA + docetaxel (triplet) combination is recommended for patients eligible for chemotherapy, preferably in cases of *de novo* and high-volume M1 disease The NHA would then be either abiraterone or darolutamide (in alphabetical order)	High

CaP localisé (très) haut risque-STAMPEDE

(2 facteurs parmi 3) ou **N+**

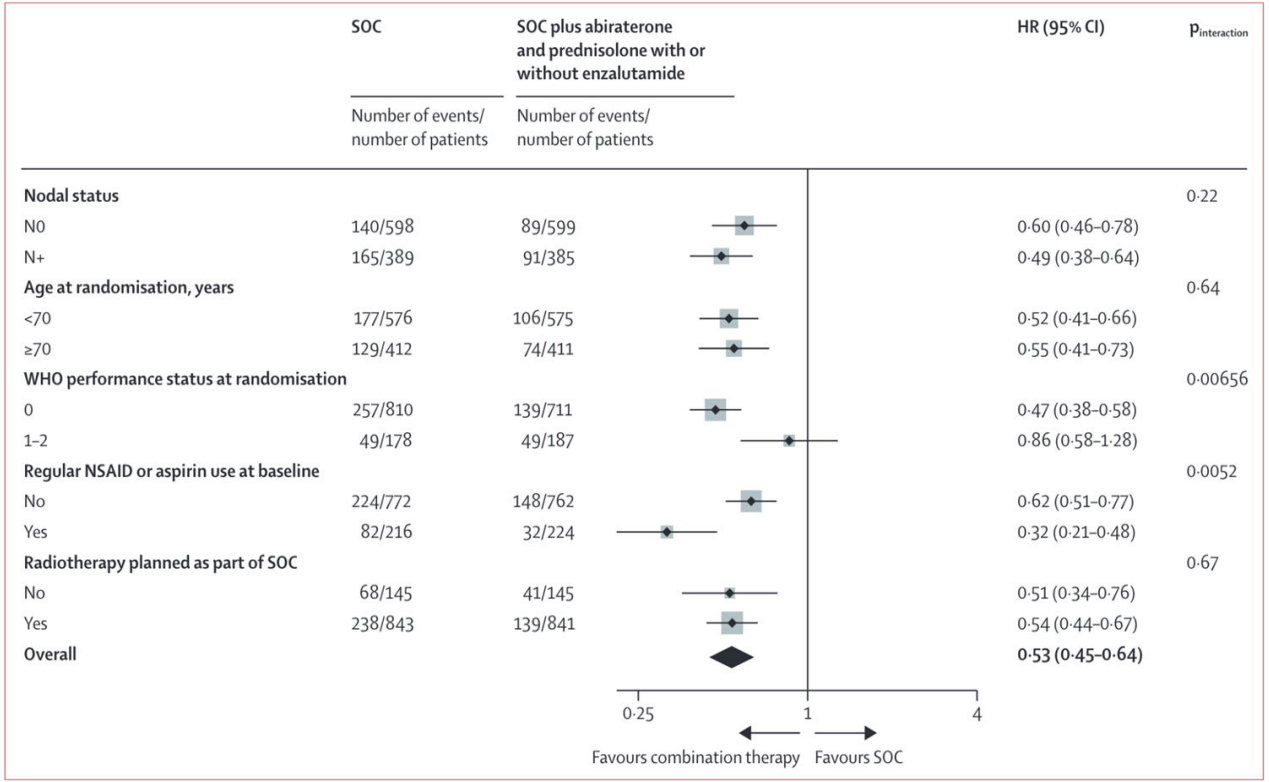
PSA >
40 ng/ml

T3-T4

ISUP
4-5

ajout HTNG : si localisé très haut risque

MFS HR 0.53 (0.45 - 0.64)



	SOC	SOC plus abiraterone and prednisolone with or without enzalutamide	HR (95% CI)	$p_{interaction}$
	Number of events/ number of patients	Number of events/ number of patients		
Nodal status				0·22
N0	140/598	89/599	0·60 (0·46–0·78)	
N+	165/389	91/385	0·49 (0·38–0·64)	
Age at randomisation, years				0·64
<70	177/576	106/575	0·52 (0·41–0·66)	
≥70	129/412	74/411	0·55 (0·41–0·73)	
WHO performance status at randomisation				0·00656
0	257/810	139/711	0·47 (0·38–0·58)	
1–2	49/178	49/187	0·86 (0·58–1·28)	
Regular NSAID or aspirin use at baseline				0·0052
No	224/772	148/762	0·62 (0·51–0·77)	
Yes	82/216	32/224	0·32 (0·21–0·48)	
Radiotherapy planned as part of SOC				0·67
No	68/145	41/145	0·51 (0·34–0·76)	
Yes	238/843	139/841	0·54 (0·44–0·67)	
Overall			**0·53 (0·45–0·64)**	

Attard G et al Lancet 2022

ajout HTNG : si localisé très haut risque

consensus des référentiels majeurs : AFU, ESTRO, NCCN

Risque	AFU-GETUG 2022	ESTRO-ACROP 2023	NCCN 2023
Faible	aucune	aucune	aucune
Intermédiaire (bas)*	aucune	4 - 6 mois	aucune
Intermédiaire (haut)	6 mois	4 - 6 mois	4 - 6 mois *Option : 0 si curiethérapie*
Haut	18 - 36 mois ADT *Option : 12 - 18 mois si curiethérapie*	2 - 3 ans ADT	2 - 3 ans ADT
Très haut	2 - 3 ans (ABI 2 + ADT 3)	2 - 3 ans (ABI 2 + ADT 3)	2 - 3 ans (ABI 2 + ADT 3)

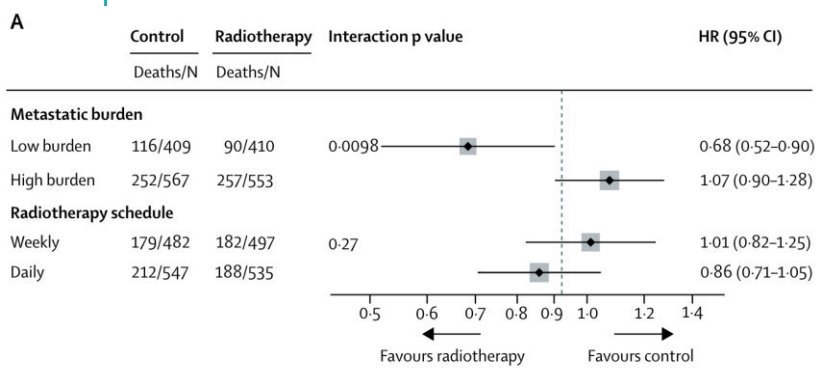
HTNG : irradiation du primitif ?

ADT + RT prostate
augmente OS
si métastatique *bas-volume*
STAMPEDE Parker & al Lancet 2018

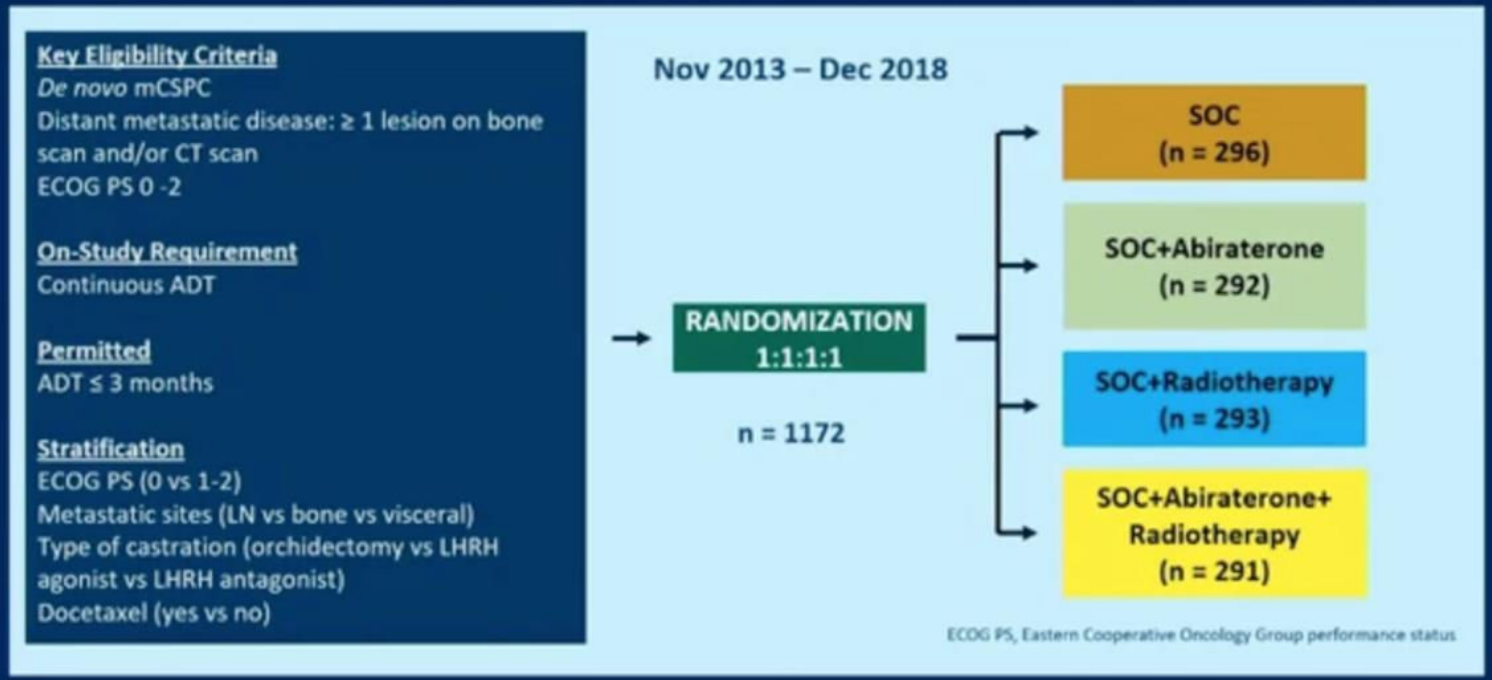
OS HR 0.68 (0.52 - 0.90)

ADT + HTNG
+/- RT prostate ?

Bénéfice ?



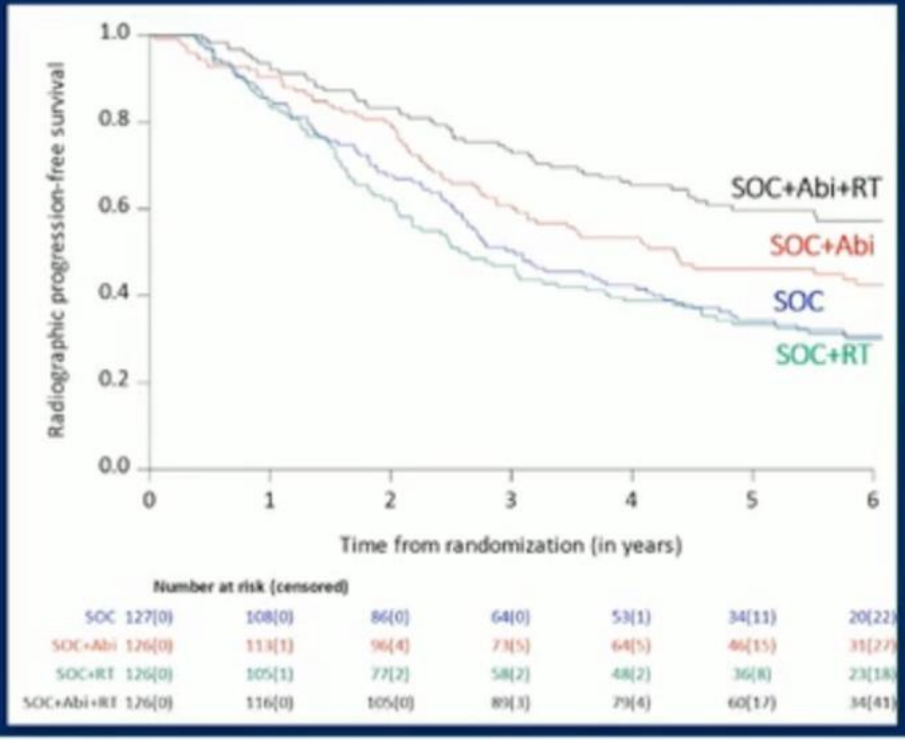
Design of PEACE-1



2023 ASCO ANNUAL MEETING #ASCO23 Alberto Bossi

ASCO KNOWLEDGE CONQUERS CANCER

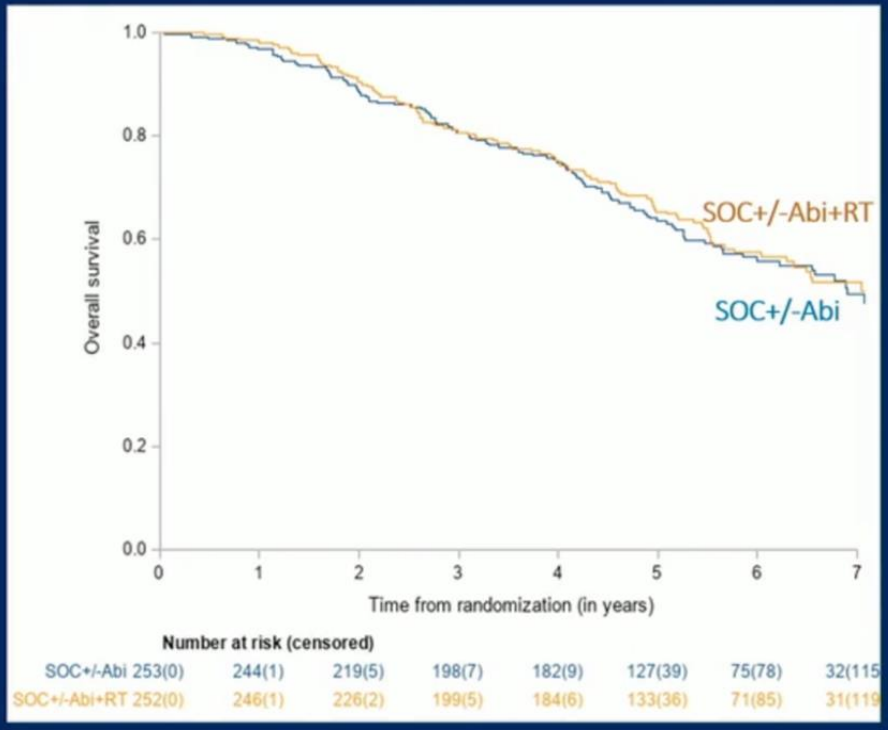
rPFS (low volume population)



	SOC (n=127)	SOC+RT (n=126)	SOC+Abi (n=126)	SOC+Abi+RT (n=126)
Median, yrs. (99.9% CI)	3.0 (2.3-4.8)	2.6 (1.7-4.6)	4.4 (2.5-7.3)	7.5 (4.0-NE)
Events, n.	87	89	74	55
HR (99.9%CI)*	Ref	1.11 (0.67-1.84)	0.76 (0.45-1.28)	0.50 (0.28-0.88)
Global p-value	<0.0001			
HR (99.9% CI)*	Ref	1.08 (0.65-1.80)	Ref	0.65 (0.36-1.19)
P-values arms w/wo Abi	0.61		0.02	

*Adjusted on stratification factors (PS, type of castration, docetaxel)

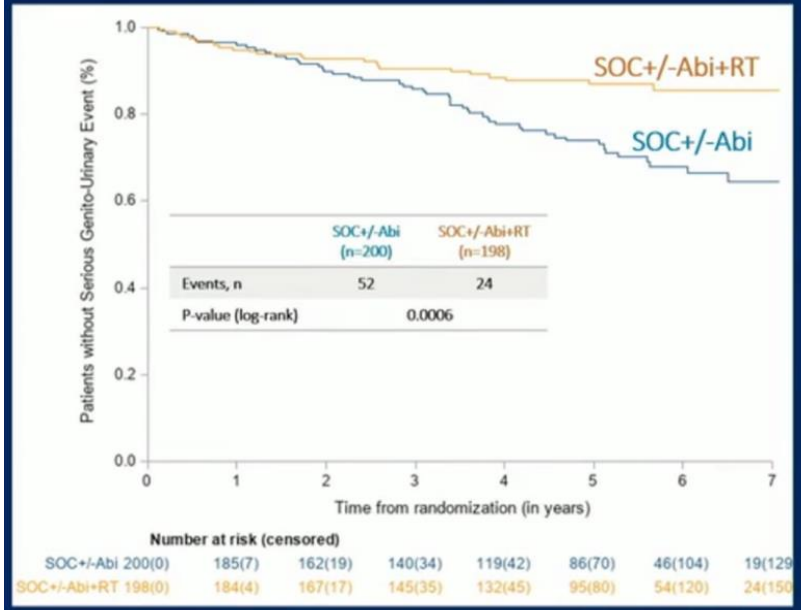
OS (low volume population)

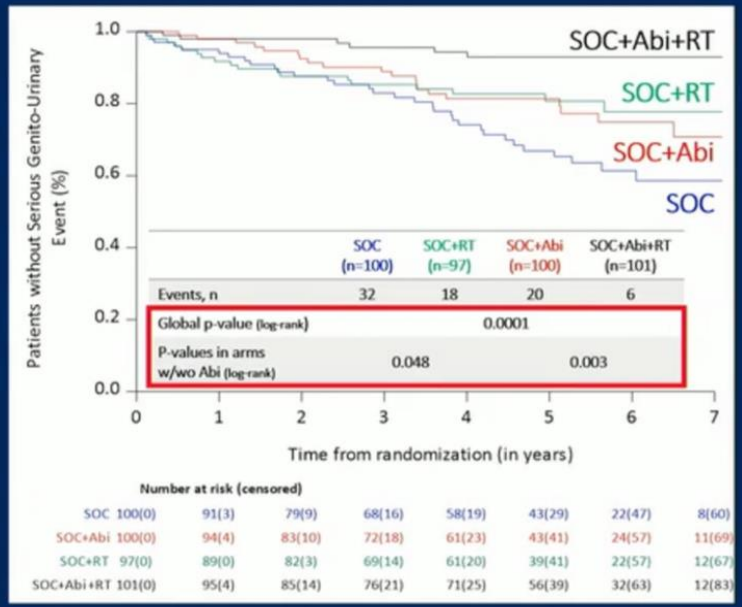


	SOC+/Abi (n=253)	SOC+/-Abi++RT (n=252)
Median, ys. (95.1% CI)	6.9 (5,9-7,5)	7,5 (6-NE)
Events, n	111	104
HR*	Ref	0,98 (0.74-1.28)
p-value	0.86	

*Adjusted on Abitraterone and stratification factors (PS, type of castration, docetaxel)

Time to Serious Genito-Urinary events (low volume pop.)

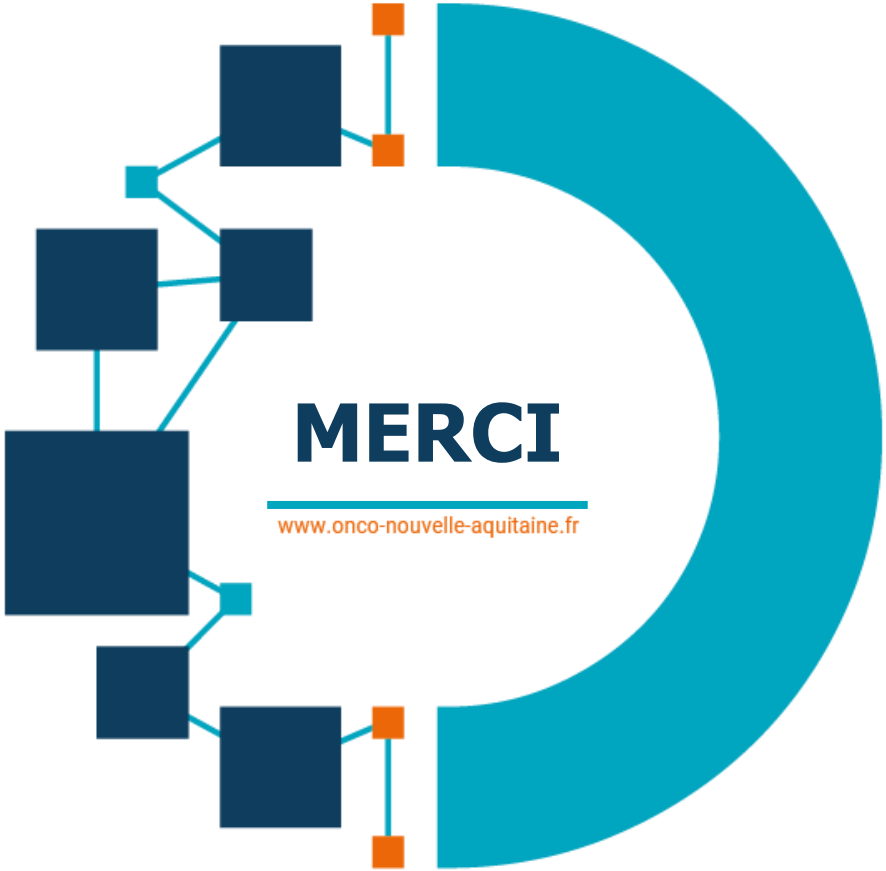




Résumé

HTNG nouveau standard en 2023 si :

- Localisé haut risque (N+ ou 2 FDR parmi ISUP4-5, PSA>40, T3-4)
- Métastatique homono sensible
- Y compris si DOXETAXEL (AAP + ADT + DOC > ADT + DOC)
- Données de tolérance rassurantes
- ADT simple se discute si comorbidités / âge / PS > 2
- RT sur primitif si bas volume métastatique (PEACE-1) :
  - Gain en os remis en cause par HTNG ?
  - Intérêt pour prévenir symptômes urinaires ?
- HTNG +/- RT oligométastases = question (PEACE-8 / GETUG 43)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