Androgen deprivation therapy as backbone therapy in the management of prostate cancer

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Abstract: Androgen deprivation therapy (ADT) is well established as a backbone therapy for metastatic prostate cancer (mPCA), and both European and American guidelines emphasize the importance of maintaining ADT after progression to metastatic castration-resistant prostate cancer (CRPC). However, the use of ADT varies widely in clinical practice despite these recommendations. Both research and development of increasingly precise assay technologies have improved our understanding of androgen production and signaling, and the recent data have suggested that a new serum testosterone cutoff value of <0.7 nmol/L should be employed. Most clinical trials to date have used the historical 1.7 nmol/L cutoff, but the <0.7 nmol/L cutoff has been associated with improved patient outcomes. Combining agents with different mechanisms of action to achieve intense androgen blockade may improve survival both before and after progression to CRPC. Data suggest that this intensive approach to androgen deprivation could delay the transition to CPRC and hence improve survival dramatically. Various combinations of backbone ADT with chemotherapy or radiotherapy are under investigation. Administration of ADT is established in patients with intermediate or high-risk localized prostate cancer (PCA) receiving radiotherapy with curative intent. This article reviews the current and potential role of ADT as backbone therapy in both hormone-sensitive PCA and CRPC with a focus on mPCA.

Keywords: prostate cancer, androgen deprivation therapy, ADT, chemotherapy, radiotherapy, treatment guidelines

Introduction

The androgen sensitivity of prostate cancer (PCa) is well established,¹ and androgen deprivation therapy (ADT) has become a cornerstone of treatment, with the potential to halt, or at least slow, the disease progression.² Surgical castration remains the gold standard for ADT, but its effects are permanent, continuous and irreversible.³ Nonsurgical treatments have become a more popular choice for ADT, because they allow intermittent therapy and have a lower psychological impact than surgical castration. The National Comprehensive Cancer Network (NCCN) now states that medical castration is as effective as bilateral orchiectomy.⁴

ADT can delay metastatic PCa (mPCA) progression for around 2 years on average, but most patients will eventually develop castration-resistant PCa (CRPC).⁵ PCa growth remains dependent on androgen receptor (AR) signaling, even after the development of CRPC, highlighting the need to maintain ADT.⁶

This review outlines the importance of ADT as backbone therapy in CRPC and considers its continued use with existing and new treatment modalities in CRPC.
### Treatment guidelines

There is a clear consensus on the role of ADT, among current treatment guidelines published by the European Association of Urology, the American Urological Association and the NCCN. ADT is recommended in addition to radiotherapy (intermediate and high-risk disease) and for selected patients with biochemical failure (defined as rising prostate-specific antigen [PSA] values). Guidelines agree that ADT is the gold standard treatment for mPCa and that hormone therapy should remain a backbone of treatment following the transition from castration-sensitive disease to CRPC.

### Adherence to guidelines

Despite consistent guidance to maintain backbone ADT in CRPC, there is a wide variation in actual clinical practice. Cross-sectional survey data from 3,477 patients with CRPC in five countries (France, Germany, Italy, Spain and the UK) revealed that between 19% and 45% (in the UK and Italy, respectively) of patients received chemotherapy alone with no ADT. The reasons for this divergence between guidelines and clinical practice are unclear, and this study reported no consistent link between years of practice and likelihood of continuing ADT in CRPC. However, this apparent tendency for some clinicians to overlook the need for continued ADT may expose patients to unnecessary risk.

### Defining medical castration with ADT

In defining ADT, regulatory authorities recommend the historical castration cutoff value of <1.7 nmol/L (<50 ng/dL) testosterone, based on early tests that could only detect testosterone above this level. However, modern assays, with improved sensitivity, have revealed that the mean testosterone level following bilateral orchiectomy is 0.5 nmol/L (15 ng/dL), and a lower cutoff at <0.7 nmol/L testosterone may be beneficial. A 6-month retrospective study of 73 men with non-mPCa found that any recorded testosterone peak above 1.1 nmol/L (32 ng/dL) was associated with significantly impaired survival free of androgen independent progression (88 months [95% CI, 55–121] versus 137 months [95% CI, 104–170], respectively; P<0.03). In addition, rising PSA levels are commonly used to diagnose CRPC in the clinic, with a minority of oncologists and urologists citing testosterone levels as an additional marker, according to a European survey. Clinical trials have continued to use the <1.7 nmol/L testosterone cutoff, although some studies are starting to explore lower cutoff values.

Data from 626 patients with PCa with baseline serum testosterone levels above 5.0 nmol/L, more than 12 months after completing definitive radiotherapy in the PR-7 trial, have shown that testosterone values below 0.7 nmol/L are associated with delayed progression to CRPC and cancer-related death, compared with values above 0.7 nmol/L. Patients whose testosterone values reached a nadir below 0.7 nmol/L had a median time to CRPC of 10 years, versus 7.21 years and 3.62 years with testosterone nadirs between 0.7 nmol/L and 1.7 nmol/L, respectively (hazard ratio [HR], 1.62 and 1.90; P=0.015). Median and maximum testosterone levels below 0.7 nmol/L were also associated with significantly longer times to CRPC, compared with testosterone levels between 0.7 nmol/L and 1.7 nmol/L, and >1.7 nmol/L, respectively.

This link between very low testosterone levels and improved outcomes corresponds to the observation that lower PSA levels predict longer survival, even to the point of any detectable PSA being linked to worsened outcomes.

### Optimizing treatment regimens in hormone-sensitive PCa

The optimal timing of ADT, whether as monotherapy or in combination with other agents, remains a subject of
metastatic hormone-sensitive PCa

- 178 patients with CRPC, which is progressing on ADT

- Randomized, double-blind

Neoadjuvant treatment, localized hormone-sensitive PCa

- Randomized, open-label

mPCa or unresectable PCa

- Randomized, open-label

mPCa

- Randomized, double-blind

Debate, and research is ongoing to optimize ADT regimens (Tables 1–3). Studies have tested androgen blockade using different agents alone or in combination, and whether adding chemotherapy to backbone ADT before transition to CRPC can improve the overall survival (OS) for patients with mPCa (Table 1).

### Intense androgen blockade for hormone-sensitive mPCa

The European Organization for Research and Treatment of Cancer (EORTC) conducted two Phase III studies using intense androgen blockade in mPCa, with apparently conflicting results. The EORTC GU Group Trial 30843 compared maximal androgen blockade using a luteinizing hormone-releasing hormone (LHRH) agonist plus cyproterone acetate versus standard LHRH monotherapy or bilateral orchietomy. Investigators reported no significant difference between survival times, response rates or times to progression in all three treatment groups. In contrast, the EORTC Phase III trial 30853 found that an intensive androgen-blocking regimen using LHRH plus flutamide was associated with significantly improved outcomes compared with bilateral orchietomy. Time to death due to malignant disease, time to first progression, progression-free survival (PFS) and duration of survival were significantly better in patients receiving intense androgen blockade compared with bilateral orchietomy (P=0.008, P=0.009, P=0.02, and P=0.04, respectively). The HR for overall progressions between survival times, response rates or times to progression in all three treatment groups.

<table>
<thead>
<tr>
<th>Study no/name</th>
<th>No of Pts</th>
<th>Design</th>
<th>Treatments</th>
<th>Pts, end points/planned completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT01946165</td>
<td>69</td>
<td>Randomized, open-label</td>
<td>Abiraterone acetate + LHRH agonist vs abiraterone acetate + LHRH agonist and enzalutamide for 6 months</td>
<td>Pts with PSA at high risk of recurrence. Difference in pathological stage ≤ pT2 at prostatectomy over 6 months. Proportion of Pts with ≤ pT2 (October 2021)</td>
</tr>
<tr>
<td>NCT01751451</td>
<td>120</td>
<td>Randomized, open-label, parallel group</td>
<td>Abiraterone acetate only vs abiraterone acetate + degarelix vs degarelix only</td>
<td>Pts with PCa with a rising PSA or a rising PSA and nodal disease following definitive radical prostatectomy. Primary: PFS (undetectable PSA), soft tissue complete response. Secondary: PSA response, percentage with a non-castrate level of testosterone, overall QoL, non-hematological adverse events, LH recovery rates (October 2016)</td>
</tr>
<tr>
<td>NCT02077634</td>
<td>70 (recruiting)</td>
<td>Randomized, open-label</td>
<td>Abiraterone acetate + prednisone ± LHRH therapy</td>
<td>Pts with PSA progression after prostatectomy and/or radiotherapy. Pts with PSA progression will enter crossover phase Primary: PSA-free survival (PSA &lt;0.1 ng/mL) at 12 months after treatment (February 2017)</td>
</tr>
<tr>
<td>NCT02640534</td>
<td>168 (to start recruiting, June 2016)</td>
<td>Randomized, open-label, active comparator, parallel assignment</td>
<td>Enzalutamide ± metformin</td>
<td>Pts with progressive chemotherapy-naive CRPC (October 2016)</td>
</tr>
</tbody>
</table>

**Table 2** Summary of ongoing Phase II clinical studies with ADT as backbone therapy in PCa

<table>
<thead>
<tr>
<th>Study no/name</th>
<th>No of Pts</th>
<th>Design</th>
<th>Treatments</th>
<th>Pts, end points/planned completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT00309985 (CHAARTED)</td>
<td>780</td>
<td>Randomized, open-label</td>
<td>LHRH alone vs LHRH + abiraterone acetate + prednisone</td>
<td>Pts with PSA progression after prostatectomy and/or radiotherapy. Pts with PSA progression will enter crossover phase Primary: PSA-free survival (PSA &lt;0.1 ng/mL) at 12 months after treatment (February 2017)</td>
</tr>
<tr>
<td>NCT01786265</td>
<td>200</td>
<td>Randomized, open-label, crossover</td>
<td>LHRH alone vs LHRH + abiraterone acetate + prednisone</td>
<td>Pts with PSA progression after prostatectomy and/or radiotherapy. Pts with PSA progression will enter crossover phase Primary: PSA-free survival (PSA &lt;0.1 ng/mL) at 12 months after treatment (February 2017)</td>
</tr>
<tr>
<td>NCT01946165</td>
<td>69</td>
<td>Randomized, open-label</td>
<td>Abiraterone acetate + LHRH agonist vs abiraterone acetate + LHRH agonist and enzalutamide for 6 months</td>
<td>Pts with PCa at high risk of recurrence. Difference in pathological stage ≤ pT2 at prostatectomy over 6 months. Proportion of Pts with ≤ pT2 (October 2021)</td>
</tr>
<tr>
<td>NCRN322 (TERRAIN)</td>
<td>375</td>
<td>Randomized, open-label</td>
<td>Abiraterone acetate only vs abiraterone acetate + degarelix vs degarelix only</td>
<td>Pts with PCa with a rising PSA or a rising PSA and nodal disease following definitive radical prostatectomy. Primary: PFS (undetectable PSA), soft tissue complete response. Secondary: PSA response, percentage with a non-castrate level of testosterone, overall QoL, non-hematological adverse events, LH recovery rates (October 2016)</td>
</tr>
</tbody>
</table>

**Abbreviations:** ADT, androgen deprivation therapy; mPCa, metastatic PCa; PCa, prostate cancer; PFS, progression-free survival; PSA, prostate-specific antigen; Pts, patients; QoL, quality of life.
<table>
<thead>
<tr>
<th>Study no/name</th>
<th>No of Pts/estimated enrollment</th>
<th>Design</th>
<th>Treatments</th>
<th>Pts, end points/planned completion</th>
</tr>
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<tbody>
<tr>
<td>NCT01715285</td>
<td>1,209</td>
<td>Randomized, double-blind, parallel-group</td>
<td>Abiraterone acetate + low-dose prednisone + ADT vs ADT alone + low-dose prednisone</td>
<td>Pts with newly diagnosed high-risk, metastatic hormone-naive PCa. OS up to 60 months, rPFS. Time to next SRE, time to PSA progression (August 2018)</td>
</tr>
<tr>
<td>NCT00268476</td>
<td>2,962</td>
<td>Randomized, open-label</td>
<td>ADT alone vs ADT + zoledronic acid, docetaxel, prednisolone, celecoxib, abiraterone, enzalutamide and/or radiotherapy</td>
<td>Pts with locally advanced or mPCa. Primary: OS. Secondary: failure-free survival, cost effectiveness, QoL, toxicity, SREs (September 2017)</td>
</tr>
<tr>
<td>NCT02003924</td>
<td>1,560</td>
<td>Randomized, double-blind, parallel group</td>
<td>Enzalutamide vs placebo (with ongoing ADT in both groups)</td>
<td>Pts with non-mPCa while receiving ADT. Primary: MFS. Secondary: OS, time to pain progression, time to opiate use for pain, time to first use of cytotoxic chemotherapy, time to first use of new antineoplastic, time to PSA progression, QoL (2017–2019)</td>
</tr>
<tr>
<td>NCT01946204</td>
<td>1,200</td>
<td>Randomized, double-blind, parallel group</td>
<td>ARN-509 vs placebo (with ongoing ADT in both groups)</td>
<td>Pts with non-mPCa while receiving ADT. Primary: MFS. Secondary: OS, time to symptomatic progression, time to initiation of cytotoxic chemotherapy, time to metastasis, QoL (2016–2019)</td>
</tr>
<tr>
<td>NCT02531516</td>
<td>1,500</td>
<td>Randomized, double-blind, parallel assessment</td>
<td>GnRH agonist + radiotherapy + ARN-509 + bicalutamide</td>
<td>Subjects with high-risk, localized or locally advanced PCa receiving primary radiation therapy. Primary: MFS. Secondary: time to local–regional recurrence, time to CRPC, time to distant metastasis, OS (December 2022 to January 2026)</td>
</tr>
<tr>
<td>NCT02200614</td>
<td>1,500 (recruiting)</td>
<td>Randomized, double-blind, placebo-controlled, parallel assignment</td>
<td>ADT + BAY1841788 (ODM-201)</td>
<td>Men with high-risk non-mCRPC, already receiving ADT. Primary: MFS. Secondary: OS, time to first SSE, time to initiation of first cytotoxic chemotherapy, time to pain progression (March 2018 to June 2020)</td>
</tr>
<tr>
<td>NCT02489318</td>
<td>1,000 (recruiting)</td>
<td>Randomized, double-blind, placebo-controlled, parallel assignment</td>
<td>ADT + ARN-509</td>
<td>Men with low-volume metastatic hormone-sensitive PCa. Primary: rPFS, OS. Secondary: time to pain progression, time to SRE, time to chronic opioid use, time to initiation of cytotoxic chemotherapy (February to December 2022)</td>
</tr>
<tr>
<td>NCT02257736</td>
<td>960 (recruiting)</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Abiraterone + prednisone + ARN-509</td>
<td>Pts with chemotherapy-naïve mCRPC. Primary: rPFS. Secondary: OS, time to chronic opioid use, time to initiation of cytotoxic chemotherapy, time to pain progression (December 2018)</td>
</tr>
<tr>
<td>NCT01957436</td>
<td>916</td>
<td>Randomized, open-label, parallel-group</td>
<td>ADT ± local radiotherapy ± abiraterone acetate and prednisone</td>
<td>Pts with metastatic hormone-naïve PCa. Primary: OS and PFS. Secondary: PSA response rate, PCA-specific survival, time to pain progression, time to next SRE, time to chemotherapy, time to severe local symptoms, toxicity, rPFS (2016–2023)</td>
</tr>
<tr>
<td>NCT02043678</td>
<td>800</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Abiraterone acetate and prednisone/prednisolone ± radium-223 dichloride</td>
<td>Asymptomatic or mildly symptomatic chemotherapy naïve, with bone-predominant mCRPC. Primary: symptomatic skeletal event-free survival. Secondary: OS, time to opiate use for cancer pain, time to pain progression, time to cytotoxic chemotherapy, rPFS, number of participants with adverse events (2017–2020)</td>
</tr>
<tr>
<td>Study ID</td>
<td>Participants</td>
<td>Design</td>
<td>Treatments</td>
<td>Outcomes</td>
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<tr>
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<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------</td>
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<tr>
<td>NCT02446444</td>
<td>800 (recruiting)</td>
<td>Randomized, open-label, parallel assignment, active comparator</td>
<td>LHRHA and radiotherapy + enzalutamide + LHRHA and radiotherapy + conventional NSAA</td>
<td>Hormone-sensitive localized PCa at high risk for recurrence deemed suitable for external beam radiation therapy. Primary: OS time. Secondary: cause-specific survival time, PSA, PFS time, clinical PFS time, time to subsequent hormonal therapy (restarting ADT), time to castration-resistant disease (PCWG2 criteria), MFS, adverse events, health-related QoL, health outcomes relative to costs (incremental cost-effectiveness ratio) (September 2021) High-risk non-mPCa progressing after radical prostatectomy or radiotherapy or both. Primary: MFS. Secondary: OS, proportion of Pts per group who remain treatment-free 2 years after suspension of study drug treatment at week 37 due to undetectable PSA, time to castration resistance, PCa-specific survival, time to first symptomatic skeletal event, composite of safety (December 2020) First-line ADT for newly diagnosed mPCa. Primary: OS time. Secondary: PSA PFS time, clinical PFS time, adverse events, health-related QoL, health care resource cost-effectiveness (December 2020)</td>
</tr>
<tr>
<td>NCT02319837</td>
<td>1,860 (recruiting)</td>
<td>Randomized, double-blind, parallel-assessment, active comparator and placebo-controlled</td>
<td>Enzalutamide monotherapy + Leuproline + placebo</td>
<td>High-risk non-mPCa progressing after radical prostatectomy or radiotherapy or both. Primary: MFS. Secondary: OS, proportion of Pts per group who remain treatment-free 2 years after suspension of study drug treatment at week 37 due to undetectable PSA, time to castration resistance, PCa-specific survival, time to first symptomatic skeletal event, composite of safety (December 2020) First-line ADT for newly diagnosed mPCa. Primary: OS time. Secondary: PSA PFS time, clinical PFS time, adverse events, health-related QoL, health care resource cost-effectiveness (December 2020)</td>
</tr>
<tr>
<td>NCT02446405</td>
<td>1,100 (recruiting)</td>
<td>Randomized, open-label, active-comparator, parallel assignment</td>
<td>Standard LHRA or surgical castration (standard of care) + enzalutamide</td>
<td>First-line ADT for newly diagnosed mPCa. Primary: OS time. Secondary: PSA PFS time, clinical PFS time, adverse events, health-related QoL, health care resource cost-effectiveness (December 2020)</td>
</tr>
<tr>
<td>NCT02495974</td>
<td>1,930 (recruiting)</td>
<td>Observational (case-only), prospective</td>
<td>Enzalutamide as part of standard clinical practice</td>
<td>mCRPC Pts prescribed enzalutamide as part of standard clinical practice. Primary: TTF, time from baseline (treatment initiation) to treatment discontinuation of enzalutamide for any reason. Secondary: time to PSA progression, time from the initiation of enzalutamide to the date of PSA progression, PSA response, time to disease progression, time from the initiation of enzalutamide to the date of radiographic progression, PSA progression or clinical progression according to the investigator's assessment, OS (France only), time from the initiation of enzalutamide to death or Pt survival at the end of the study, treatment duration, reason for the initiation of treatment with enzalutamide, reason for enzalutamide discontinuation, subsequent anti-neoplastic therapy for mCRPC, time to opiate use, pain assessed by BPI-SF, QoL of participants assessed using EQ-5D-5L, QoL of participants assessed using FACT-P, number of participants hospitalized, number of visits to health care professionals, safety assessed by reported adverse events, safety assessed by modification of treatment with enzalutamide as a response to adverse events, number of deaths due to any cause (July 2018)</td>
</tr>
<tr>
<td>NCT02288247</td>
<td>650 (recruiting)</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Docetaxel + prednisolone + enzalutamide</td>
<td>Chemotherapy-naive Pts with progressive mCRPC. Primary: OS, rPFS. Secondary: time to first SRE, time to initiation of cytotoxic chemotherapy, time to PSA progression, percentage of Pts with PSA response 50%, best overall soft tissue response (September 2013) mCRPC. Primary: OS. Secondary: Grade 3 or higher toxicity profile, decline in PSA, PFS, objective response rate, rPFS, tumor burden and bone activity (December 2019)</td>
</tr>
<tr>
<td>NCT01212991</td>
<td>1,717 (recruiting)</td>
<td>Randomized, double-blind, placebo-controlled, parallel assessment</td>
<td>Enzalutamide monotherapy</td>
<td>Chemotherapy-naive Pts with progressive mCRPC. Primary: OS, rPFS. Secondary: time to first SRE, time to initiation of cytotoxic chemotherapy, time to PSA progression, percentage of Pts with PSA response 50%, best overall soft tissue response (September 2013) mCRPC. Primary: OS. Secondary: Grade 3 or higher toxicity profile, decline in PSA, PFS, objective response rate, rPFS, tumor burden and bone activity (December 2019)</td>
</tr>
<tr>
<td>NCT01949337</td>
<td>1,224 (recruiting)</td>
<td>Randomized, open-label, parallel assignment</td>
<td>Enzalutamide monotherapy + abiraterone + prednisone</td>
<td>Chemotherapy-naive Pts with progressive mCRPC. Primary: OS, rPFS. Secondary: time to first SRE, time to initiation of cytotoxic chemotherapy, time to PSA progression, percentage of Pts with PSA response 50%, best overall soft tissue response (September 2013) mCRPC. Primary: OS. Secondary: Grade 3 or higher toxicity profile, decline in PSA, PFS, objective response rate, rPFS, tumor burden and bone activity (December 2019)</td>
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(Continued)
Table 3 (Continued)

<table>
<thead>
<tr>
<th>Study no/name</th>
<th>No of Pts/estimated enrollment</th>
<th>Design</th>
<th>Treatments</th>
<th>Pts, end points/planned completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT01995513 (PLATO)</td>
<td>509</td>
<td>Randomized, double-blind, placebo-controlled Phase IV safety/efficacy study</td>
<td>Abiraterone + prednisolone + enzalutamide</td>
<td>Chemotherapy-naive mCRPC. Primary: PFS. Secondary: time to PSA progression, PSA response (December 2016)</td>
</tr>
<tr>
<td>NCT0 (UPWARD)</td>
<td>424</td>
<td>Open-label, post-marketing safety study (Phase IV)</td>
<td>Enzalutamide + ongoing ADT</td>
<td>mCRPC with disease progression; at least one risk factor for seizures. Proportion of evaluable subjects with at least one confirmed seizure (February to October 2016)</td>
</tr>
</tbody>
</table>

Abbreviations: ADT, androgen deprivation therapy; BPI-SF, Brief Pain Inventory Short Form; CRPC, castration-resistant PCa; EQ-SD-5L, EuroQol5 dimension 5 level health state utility index – 5L; FACT-P, Functional Assessment of Cancer Therapy – Prostate; GnRH, gonadotropin-releasing hormone; LHRH, luteinizing hormone-releasing hormone; LHRHA, luteinizing hormone-releasing hormone analog; mCRPC, metastatic CRPC; MFS, metastasis-free survival; mPCa, metastatic PCa; NSAA, nonsteroidal anti-androgen; OS, overall survival; Pts, patients; QoL, quality of life; rPFS, radiographic PFS; SRE, skeletal-related event; SSE, symptomatic skeletal event; TTF, time to treatment failure.

Another Phase II trial found that intense ADT plus abiraterone acetate was more effective than intense ADT alone in patients with localized PCa (Table 1).28

Intense androgen blockade with novel agents for localized PCa

Ongoing Phase III trials such as the Study of Abiraterone Acetate Plus Low-Dose Prednisone Plus Androgen Deprivation Therapy (ADT) versus ADT Alone in Newly Diagnosed Participants with High-Risk, Metastatic Hormone-Naive Prostate Cancer (TITAN) and the Phase III MACE (Metastatic Acronym) trial are assessing the clinical outcomes in localized PCa (ClinicalTrials.gov: NCT01547299, NCT00924469). A Phase II study comparing neoadjuvant therapy with the AR inhibitor enzalutamide and the dihydrotestosterone blocker dutasteride found lower tissue testosterone levels and a higher rate of pathologically complete response after 6-month combination therapy including ADT, compared with enzalutamide alone (Table 1).28

One group analysis of both trials suggested that intense androgen blockade might be more beneficial for patients with good prognosis compared with those whose prognosis was poor. There were very few patients with a good prognosis (95% CI, 0.57-0.95).28

A subgroup analysis of both trials suggested that intense androgen blockade might be more beneficial for patients with good prognosis compared with those whose prognosis was poor. There were very few patients with a good prognosis (95% CI, 0.57-0.95).28

The investigators concluded that intense androgen blockade might be more beneficial for patients with good prognosis compared with those whose prognosis was poor. There were very few patients with a good prognosis (95% CI, 0.57-0.95).28
Two Phase III trials are also investigating intense androgen blockade for patients with hormone-sensitive non-mPCa: Enzalutamide in Androgen Deprivation Therapy With Radiation Therapy for High Risk, Clinically Localized, Prostate Cancer (ENZARAD; ClinicalTrials.gov: NCT02446444) and Safety and Efficacy Study of Enzalutamide Plus Leuprolide in Patients With Nonmetastatic Prostate Cancer (EMBARK; NCT02319837).

Chemotherapy in metastatic hormone-sensitive PCA
An increasing body of evidence suggests that adding chemotherapy to ADT may improve survival in patients with hormone-sensitive mPCa. Studies have generated apparently conflicting results, and these trials, such as the intensive androgen blockade studies described earlier, have also identified subsets of patients who seem most likely to benefit from this treatment approach.

The CHAARTED trial
The Eastern Cooperative Oncology Group ChemoHormonal Therapy versus Androgen Ablation Randomized Trial for Extensive Disease in Prostate Cancer (ECOG-CHAARTED) demonstrated a significant survival benefit for patients who received six cycles of docetaxel at the start of ADT compared with ADT alone (Figure 2). A significant OS survival benefit was seen in patients with high-volume disease (defined as having visceral metastases or ≥4 bone lesions, including at least one outside the vertebrae and pelvis); median OS was 49.2 months versus 32.2 months, respectively, for combined treatment or ADT monotherapy; HR for death, 0.60; 95% CI, 0.45–0.81; P<0.001. It is interesting that there was such a strong survival advantage for adding docetaxel to ADT in early phase mPCa, even though 147 of the 287 patients who progressed to CRPC in the ADT-only group subsequently received docetaxel. The frequency of Grade 3 or higher adverse events in the combined therapy group was comparable with frequencies reported in the docetaxel summary of product characteristics.

The GETUG-AFU 15 trial
In contrast, investigators on the smaller androgen deprivation therapy alone or with docetaxel in non-castrate mPCa (GETUG-AFU 15) trial concluded that docetaxel should not be used in the first-line treatment regimens for patients with hormone-sensitive mPCa. PFS was significantly longer in the ADT-plus-docetaxel group, versus ADT alone: 22.9 months versus 12.9 months; HR, 0.72; P=0.005 (biological PFS; clinical PFS was also significantly different), but there was no significant OS advantage for combination therapy (Table 1). Common toxic effects in the ADT plus docetaxel group included neutropenia (50% vs 3% on ADT monotherapy), anemia (72% vs 22% on ADT monotherapy), sensory neuropathy (29% vs 4% on ADT monotherapy) and fatigue (74% vs 20% on ADT monotherapy).

Mean quality of life scores were also significantly poorer...
on combined therapy compared with ADT alone, at both 3- and 6-month follow-up.\(^{15}\)

These contrasting results have stimulated debate on the value of adding docetaxel to ADT in hormone-sensitive mPCa, and the GETUG-AFU 15 investigators performed a subset analysis, at a mean follow-up of 82.9 months, to assess whether the different outcomes were due to different case mixes in their patient populations.\(^{16,22}\) This new analysis found no significant difference in OS between groups receiving ADT plus docetaxel, or ADT alone, neither for the whole study population nor for the subgroup of high-volume disease (using the same definitions as the CHAARTED study), although the authors noted that their subsets were underpowered for this retrospective analysis.\(^{22}\)

The STAMPEDE trial

The ongoing Systemic Therapy in Advancing or Metastatic Prostate cancer: Evaluation of Drug Efficacy (STAMPEDE) trial is already generating clear evidence on whether to add docetaxel – or other agents – to ADT in early/hormone-naive PCa.\(^{23,24}\) STAMPEDE is comparing ADT monotherapy versus ADT plus chemotherapy, anti-androgen treatment and/or radiotherapy, and has recruited more than 7,000 patients to date (Table 3).\(^{23,25,26}\) Results are now available for 2,962 patients randomized to four arms (control/ADT monotherapy, ADT plus six cycles of 75 mg/m\(^2\) docetaxel [with 10 mg prednisolone], ADT plus zoledronic acid, or ADT plus docetaxel and zoledronic acid).\(^{26}\) Adding docetaxel (but not zoledronic acid) to ADT significantly improved OS, with a 10-month extension in median survival from 71 months on ADT alone to 81 months on ADT plus docetaxel (Table 4).\(^{26}\) There was no benefit for zoledronic acid on either survival or skeletal-related events, despite good compliance with therapy.\(^{26}\)

Conclusion from STAMPEDE and CHAARTED trials for patients with high-risk PCa

The result of STAMPEDE is consistent with the findings of the CHAARTED study, but, interestingly, STAMPEDE data suggest that docetaxel may be of benefit in both metastatic and non-mPCa.\(^{16,26}\) The investigators reported that estimated treatment effects of docetaxel in both PCa-specific survival and failure-free survival were comparable in both patient groups, although the relatively low population size and smaller number of deaths (compared with men who presented with metastatic disease) meant that the non-metastatic subgroup was underpowered to demonstrate improved survival.\(^{26}\) STAMPEDE will generate long-term data on these four arms.\(^{26}\) The authors concluded that “Standard of care should be updated to include docetaxel chemotherapy in suitable patients with metastatic disease, and docetaxel may be considered for men with high-risk non-metastatic prostate cancer with or without radiotherapy.”\(^{26}\)

Future STAMPEDE publications will also report on similar comparisons for celecoxib, abiraterone, combination therapy using enzalutamide plus abiraterone and prostate radiotherapy.\(^{26}\)

It is interesting to note that an earlier study of 589 men with advanced PCa, of whom 46% had locally advanced T3 or T4 disease and 52% had metastatic disease, also found a similar benefit of intensive androgen blockade in both groups.\(^{26}\) The authors reported a nonsignificant improvement in survival when they added flutamide to LHRH therapy in patients who were hormone naïve.\(^{27}\)

Optimizing therapy in CRPC

A number of clinical studies have investigated the benefit of combining ADT with various other agents, including enzalutamide, abiraterone acetate, chemotherapy, radium-223 and novel agents, following the development of CRPC (Table 1 and Figure 3).\(^{29–37}\) Figure 3 shows the findings of Phase III trial in patients with previously untreated mPCa that tested hypothesis that three 8-week cycles of ketoconazole and doxorubicin alternating with vinblastine and estramustine, given in addition to standard androgen deprivation, would delay the appearance of castration-resistant disease.
ADT during radium-223

Radium-223 has been associated with significantly improved survival, versus placebo: in an interim analysis (n = 809) of a Phase III trial of men with metastatic CRPC (mCRPC), the median OS was 14.0 months versus 11.2 months on placebo; HR 0.70 (95% CI, 0.58–0.83); \( P = 0.002 \). This study applied a pragmatic approach, allowing clinicians to prescribe best standard of care, at their own discretion, throughout the study, meaning that the results may be more applicable to clinical practice than other trials. It is unclear how many of these patients received ADT during the study, although they were required to continue their maintenance treatment.

Abiraterone acetate

Abiraterone acetate has demonstrated the efficacy in Phase III trials when added to ADT for men with progressive mCRPC, both before and after receiving chemotherapy. The COU-AA-301 study revealed a significant survival benefit of abiraterone acetate in 1,195 men with mCRPC, which had progressed following docetaxel. Median OS was 15.8 months in the abiraterone acetate plus prednisone group versus 11.2 months on prednisone plus placebo, after a median follow-up of 20.2 months (HR, 0.74; 95% CI, 0.64–0.86; \( P < 0.0001 \)). This OS benefit was consistent across subgroups (according to prespecified analyses). Median radiographic PFS (rPFS) was 5.6 months and 3.6 months on abiraterone acetate and placebo, respectively (HR, 0.66; 95% CI, 0.58–0.76; \( P < 0.0001 \)).

In the COU-AA-302 study, abiraterone acetate (with prednisone) was linked with significantly improved survival versus placebo (plus prednisone) in 1,088 patients with mCRPC who were asymptomatic or minimally symptomatic and had received no prior chemotherapy. There were 147 deaths in the abiraterone-treated group (n = 546; 27%) and 186 deaths in the prednisone-only group (n = 542; 34%), at a median follow-up of 22.2 months. HRs for OS and rPFS were 0.75 (95% CI, 0.61–0.93; \( P = 0.01 \)) and 0.53 (95% CI, 0.45–0.62; \( P < 0.001 \)), respectively. Abiraterone showed a consistent benefit across subgroups.

Enzalutamide

Adding the oral AR inhibitor enzalutamide to ongoing ADT also significantly improves survival in CRPC, according to two large Phase III studies. Both trials (Safety and Efficacy Study of MDV3100 in Patients With Castration-Resistant Prostate Cancer Who Have Been Previously Treated With Docetaxel-based Chemotherapy [AFFIRM] and Safety and Efficacy Study of Oral MDV3100 in Chemotherapy-Naive Patients With Progressive Metastatic Prostate Cancer [PREVAIL]) included patients with progressive mCRPC, and serum testosterone levels of 1.7 nmol/L (50 ng/dL) or less, maintained with regular hormonal ADT (unless they...
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had previously undergone orchietomy.34,39 The AFFIRM study investigators recruited patients who had previously received docetaxel, while the PREVAIL trial included patients who had not received chemotherapy.34,39 Both studies were stopped after interim analyses that revealed significant survival benefits of treatment.34,39

AFFIRM included 1,199 patients who were randomized to receive either enzalutamide (n=800) or placebo (n=399) with backbone ADT and bisphosphonate therapy.34 Median OS was 18.4 months in the enzalutamide group versus 13.6 months on placebo (HR, 0.63; 95% CI, 0.53–0.75; P<0.001).34 All secondary end points also showed significant improvements on enzalutamide, including time to PSA progression (HR, 0.25; 95% CI, 0.20–0.30; P<0.001) and rPFS (HR, 0.40; 95% CI, 0.45–0.47; P<0.001).34 Adverse event rates were similar in the enzalutamide and placebo groups, even though the observation period for enzalutamide was more than double that of the placebo group.34

Chemotherapy-naïve patients entering the PREVAIL study were also randomized to receive either enzalutamide (n=872) or placebo (n=845) in combination with ongoing ADT.39 Enzalutamide-treated men had better OS than controls, with an estimated median survival time of 32.4 months versus 30.2 months on placebo (HR, 0.71; 95% CI, 0.60–0.84; P<0.001).36,39 The HR for rPFS was 0.19 (95% CI, 0.15–0.23; P<0.001).39 Several ongoing Phase III trials are comparing different therapeutic approaches to mCRPC, as summarized in Table 3.

Non-mCRPC

Optimizing management of non-mCRPC could dramatically improve survival for many thousands of men with PCa. A recent large-scale data analysis reported a total PCa prevalence of 2,219,280 in the USA in 2009, with an annual all-cause mortality of 168,290.40 The authors estimated an mCRPC incidence of only 36,100 (1.6%), but this group contributed 34,525 annual deaths (20.5% of total deaths in men with PCa).40 Optimal treatment at the non-mCPRC stage could delay progression to metastatic disease, in which this model predicted to be 34% each year.40 Annual all-cause mortality in mCPRC was 56%, and 86% of mCPRC had progressed from non-mCPRC.40 Reducing annual progression from non-mCPRC to mCPRC by 11.5% could prevent 3,694 deaths per year, according to this model.40

Results of four large-scale Phase III trials with a total planned population over 5,800 patients with non-mCRPC are due to become available over the next 1–10 years (Table 3). Tables 2 and 3 summarize some key ongoing Phase II and III randomized clinical trials investigating the efficacy and safety of abiraterone, enzalutamide or ARN-509, with or without ADT and other treatments, in both metastatic and non-mPCAs.

Future developments

Accumulating evidence for the benefits of combining ADT with chemotherapy, at least using docetaxel, may encourage many clinicians to adopt this approach. This could substantially increase OS in a large population of men with PCa. Enzalutamide or abiraterone acetate may potentially be used before CRPC develops, either as an alternative to ADT or in combination with ADT (Tables 2 and 3).

The optimal approach to treating patients with non-mCRPC remains an open question. Limited data availability and the small number of ongoing studies (notably PROSPER, SPARTAN and ARAMIS; Table 3) means these decisions may remain uncertain, although there are encouraging preliminary results from the ongoing STAMPEDE trial. There is a clear need for more research in this area, to allow clinicians to make informed decisions for this group of patients, which could transform outcomes in PCa. Increased numbers of reliable biomarkers and genetic profiling may help to determine which patients to treat, with which type of treatment and by when. Personalized/individualized medicine in PCa will become a reality as more treatment options/combinations that include ADT become available which are supported by clinical data.

Conclusion

Clinical studies to date have shown the benefit of maintaining ADT as backbone therapy in combination with other treatment modalities in mPCa, but data are limited. Further studies are needed to determine the most appropriate use of backbone ADT therapy in CRPC. The safety and tolerability of chemotherapy regimens are not markedly changed by continuing ADT as backbone treatment. The key question is whether continuing ADT following the development of CRPC, irrespective of the additional treatments given, prolongs survival for patients with an acceptable level of side effects.

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