Urologo dal 2002, ha studiato presso la scuola di Napoli – Federico II, FEBU, PhD

Urologia oncologica e Urologia Funzionale , le grandi passioni

>170 articoli su riviste nazionali ed internazionali

h-index : 46

Urologo ASL Abruzzo 2, direttore UOS Urologia Robotica

Aree di interesse: chirurgia minininvasiva, Green Light Laser, RIRS, neurourologia, urooncologia, CRPC

Dr Luca Cindolo

Thermocline Otto Dix, oil on canvas 2017
A. Annino

Il paziente metastatico resistente alla castrazione: identificazione e trattamento

Dr. Luca Cindolo

Numero crescente di articoli

= interesse crescente

Quale farmaco?

Quando trattare?

Trattare o non trattare?

Neoplasia prostatica

Terapia ormonale

Sviluppo M0 CRPC

Progressione a M1 CRPC

Decisione terapeutica


JOURNAL OF CLINICAL ONCOLOGY SPECIAL ARTICLE

Trial Design and Objectives for Castration-Resistant Prostate Cancer: Updated Recommendations From the Prostate Cancer Clinical Trials Working Group 3

Come seguire il paziente?

Quando lo shift?

Quando sospendere?

Non è meglio l'invio all'oncologo?

ELSEVIER

UROLOGIC ONCOLOGY

Urologic Oncology: Seminars and Original Investigations 35 (2017) S1–S13

Original article

Navigating the evolving therapeutic landscape in advanced prostate cancer

E. David Crawford, M.D.[a], Daniel Petrylak, M.D.[b,c], Oliver Sartor, M.D.[d,e,*]

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[b] Department of Medicine (Medical Oncology), Yale (Smilow) Cancer Center, New Haven, CT
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[d] Department of Medicine, Tulane Cancer Center, New Orleans, LA
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Received 1 June 2016; received in revised form 13 January 2017; accepted 26 January 2017

mCRPC Treatment: The Right Treatment for the Right Patient at the Right Time: EVERYDAY UROLOGY- Full Text Article

Everyday Urology-Oncology Insights: Volume 1, Issue 4

EURURO-7792; No. of Pages 12

ARTICLE IN PRESS

EUROPEAN UROLOGY XXX (2018) XXX–XXX

available at www.sciencedirect.com
journal homepage: www.europeanurology.com

European Association of Urology

Platinum Priority – Review – Prostate Cancer

Editorial by XXX on pp. x–y of this issue

Update on Systemic Prostate Cancer Therapies: Management of Metastatic Castration-resistant Prostate Cancer in the Era of Precision Oncology

Philipp Nuhn[a], Johann S. De Bono[b], Karim Fizazi[c], Stephen J. Freedland[d,e], Maurizio Grilli[f], Philip W. Kantoff[g], Guru Sonpavde[h], Cora N. Sternberg[i], Srinivasan Yegnasubramanian[j,k], Emmanuel S. Antonarakis[j,k,]*

Online version at http://www.minervamedica.it

Minerva Urologica e Nefrologica 2018 February;70(1):22-41
DOI: 10.23736/S0393-2249.17.02976-9

REVIEW

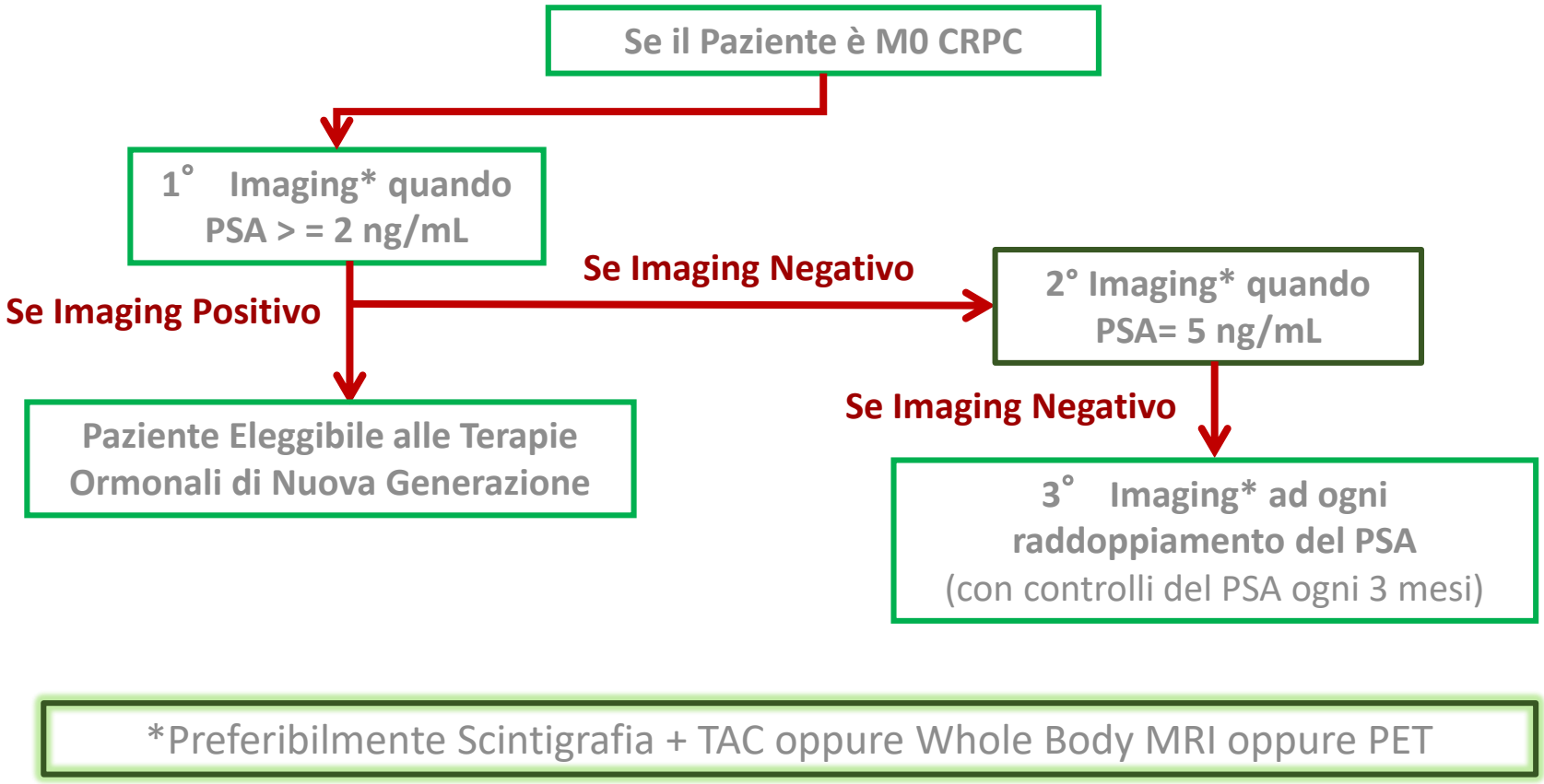
Castration-resistance prostate cancer: what is in the pipeline?

Cosimo DE NUNZIO[1,*], Fabrizio PRESICCE[1], Silvana GIACINTI[2], Maria BASSANELLI[2,3], Andrea TUBARO[1]

Our challenge in the near future will be to identify the right treatment or better the right combination and sequencing of treatments that should be used to manage patients with CRPC or even with advanced prostate cancer.

Si fa presto a dire tailoring

EAU Guidelines
Il Metodo RADAR



Crawford et al, UROLOGY 2014
Linee guida EAU 2015

Molecole

Paziente

Esperienza clinica

Molecole

Treatment	Trial	Reference	Survival (mos)	Survival gain (mos)
Docetaxel/prednisone vs mitoxantrone/predn.	TAX-327[1]	Tannock 2004	18.9 vs 16.5	**2,4**
Sipuleucel vs placebo		Kantoff 2010	25.8 vs 21.7	**4.1**
Abiraterone/prednisone vs Placebo/prednisone	COU-AA-302[3]	Ryan 2014	34.7 vs 30.3	**4,4**
Enzalutamide vs placebo	PREVAIL[4]	Beer 2014	35.3 vs 31.3	**4,0**
Radium-223 vs placebo/BSC	ALSYMPCA[5]	Parker 2013	14.9 vs 11.3	**3,6**

[1]Tannock et al. N Engl J Med. 2004 ; [2]Kantoff et al.N Engl J Med. 2010; [3]Ryan C et al. Lancet Oncol.2015
[4]Beer et al. European Urology 2016; [5]Parker et al.N Engl J Med. 2013

EURURO-7792; No. of Pages 12
ARTICLE IN PRESS
EUROPEAN UROLOGY XXX (2018) XXX–XXX

available at www.sciencedirect.com
journal homepage: www.europeanurology.com

European Association of Urology

Platinum Priority – Review – Prostate Cancer
Editorial by XXX on pp. x–y of this issue

Update on Systemic Prostate Cancer Therapies: Management of Metastatic Castration-resistant Prostate Cancer in the Era of Precision Oncology

Philipp Nuhn [a], Johann S. De Bono [b], Karim Fizazi [c], Stephen J. Freedland [d,e], Maurizio Grilli [f], Philip W. Kantoff [g], Guru Sonpavde [h], Cora N. Sternberg [i], Srinivasan Yegnasubramanian [j,k], Emmanuel S. Antonarakis [j,k,]*

Molecole

Table 1 – Current therapies in mCRPC

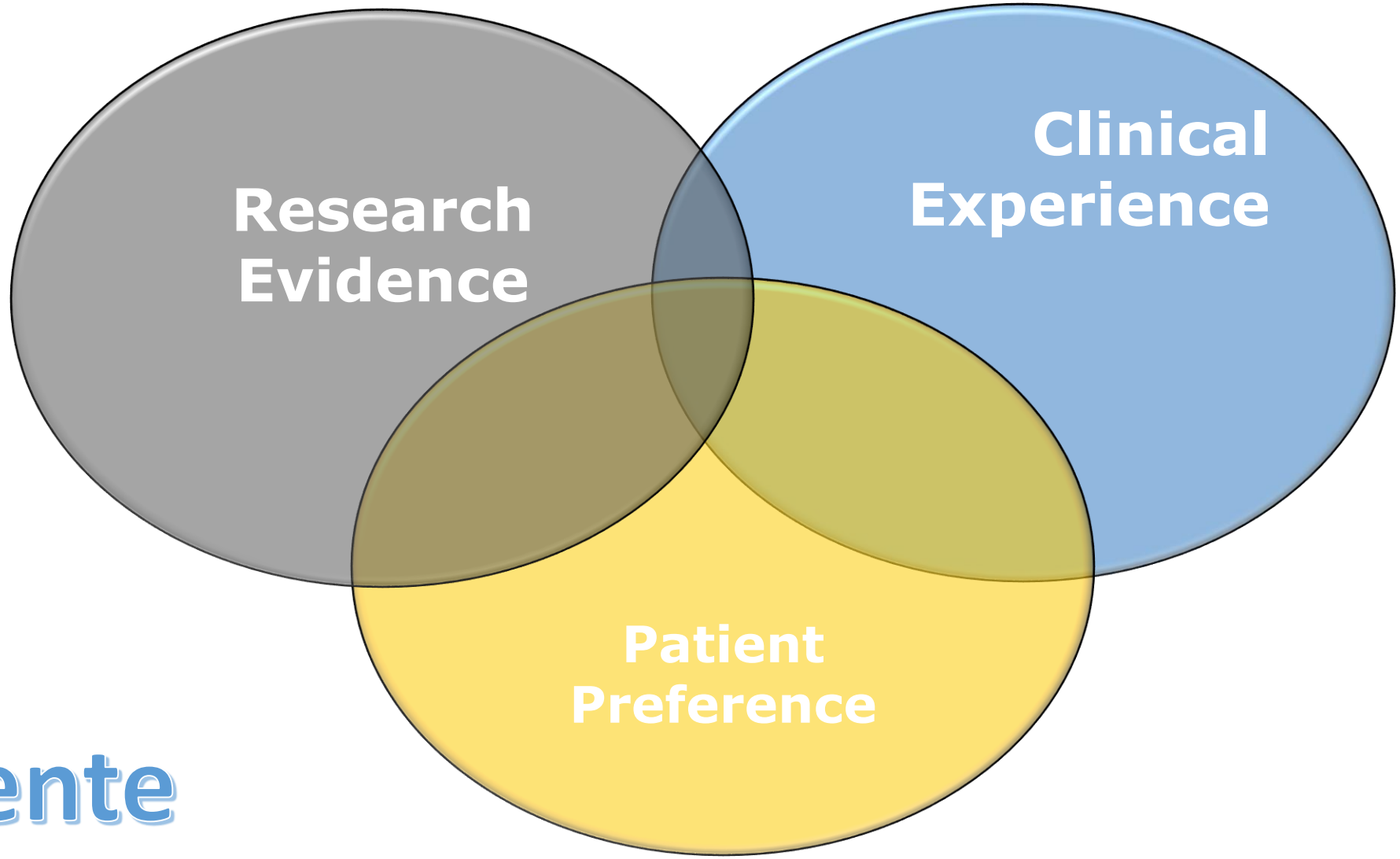
AR-targeted therapy		
Abiraterone	CYP17A1 inhibitor	Approved
Enzalutamide	AR antagonist	Approved
Orteronel (TAK-700)	CYP17A1 inhibitor	Under clinical evaluation
Seviteronel (VT-464)	CYP17A1 inhibitor	Under clinical evaluation
Apalutamide (ARN-509)	AR antagonist	Under clinical evaluation
Darolutamide (ODM-201)	AR antagonist	Under clinical evaluation
Chemotherapy		
Docetaxel	Taxane	Approved
Cabazitaxel	Taxane	Approved
Immunotherapy		
Sipuleucel-T	Therapeutic vaccine	Approved
PROSTVAC-VF	Therapeutic vaccine	Under clinical evaluation
Ipilimumab (MDX-010)	CTLA-4 inhibitor	Under clinical evaluation
Nivolumab	PD-1 inhibitor	Under clinical evaluation
Pembrolizumab	PD-1 inhibitor	Under clinical evaluation
Atezolizumab	PD-L1 inhibitor	Under clinical evaluation
Avelumab	PD-L1 inhibitor	Under clinical evaluation
Bone-targeted therapy		
Bisphosphonates		Approved
Denosumab	RANKL inhibitor	Approved
Radium-223	Radionuclide	Approved
PARP inhibitors		
Olaparib	PARP inhibitor	Under clinical evaluation
Veliparib	PARP inhibitor	Under clinical evaluation
Rucaparib	PARP inhibitor	Under clinical evaluation
Niraparib	PARP inhibitor	Under clinical evaluation
Talazoparib	PARP inhibitor	Under clinical evaluation
Other emerging therapies and novel therapeutic targets		
Selinexor	XPO-1 inhibitor	Under clinical evaluation
SM88	Agent combination	Under clinical evaluation
Cabozantinib	Tyrosine kinase inhibitor	Under clinical evaluation
Tasquinimod	Small-molecule inhibitor	Negative
^{177}Lu-PSMA-617	PSMA-targeted therapies	Under clinical evaluation

Molecole

Paziente

Esperienza clinica

Evidence Based Medicine



Paziente

Sackett BMJ 1996

Clinical Therapeutics/Volume 39, Number 4, 2017

Patients' Preferences for the Treatment of Metastatic Castrate-resistant Prostate Cancer: A Discrete Choice Experiment

Lina Eliasson, PhD[1]; Hayley M. de Freitas, MSc[1]; Lindsay Dearden, MSc[2]; Brian Calimlim, DrPH[3]; and Andrew J. Lloyd, DPhil[1]

(N = 285)

Completo controllo del dolore
(OR = 12.069 [95% CI, 10.555–13.800])

Trattamenti che ritardano la chemio
(OR, 1.727 [95% CI, 1.548–1.927])

Trattamenti che compromettono meno memoria e funzioni cognitive
(OR, 2.115 [95% CI, 1.849–2.420]),

Trattamenti che hanno basso rischio di fatigue
(OR, 1.365 [95% CI 1.219-1.528])

Trattamenti con minori accessi ospedalieri
(OR, 1.245 [95% CI 1.111-1.397])

Limitazioni di cibo... Poco rilevanti!

Paziente

LA PATIENTS' SATISFACTION CON ABIRATERONE È RISULTATA "MOLTO MIGLIORATA" NEL 36,1% DEI PAZIENTI E "MIGLIORATA" NEL 32,4% DEI PAZIENTI.

Caratteristiche demografiche e patologiche dei pazienti al basale

Caratteristiche	Valore
Età media (SD), anni	76,7 (7,1)
ECOG Performance Status, n (%)	
0-1	119 (93)
>2	9 (7)
ALT mediana al basale (range), U/L	20 (8-87)
AST mediano al basale (range), U/L	18,5 (6-309)
Comorbidità, n (%)	
Nessuna	26 (20)
Solo cardiovascolari	47 (36,4)
Solo metaboliche	11 (8)
Solo neurologiche	4 (3)
Solo neoplasia pregressa	1 (0,7)
Multiple	26 (20)
Altro	14 (11,9)

Tabella 1 di Rif.5
Abbreviazioni: ALT = alanina aminotransferasi;
AST = Aspartato aminotransferasi;
ECOG = Eastern Cooperative Oncology Group

Sopravvivenza libera da progressione e soddisfazione del trattamento

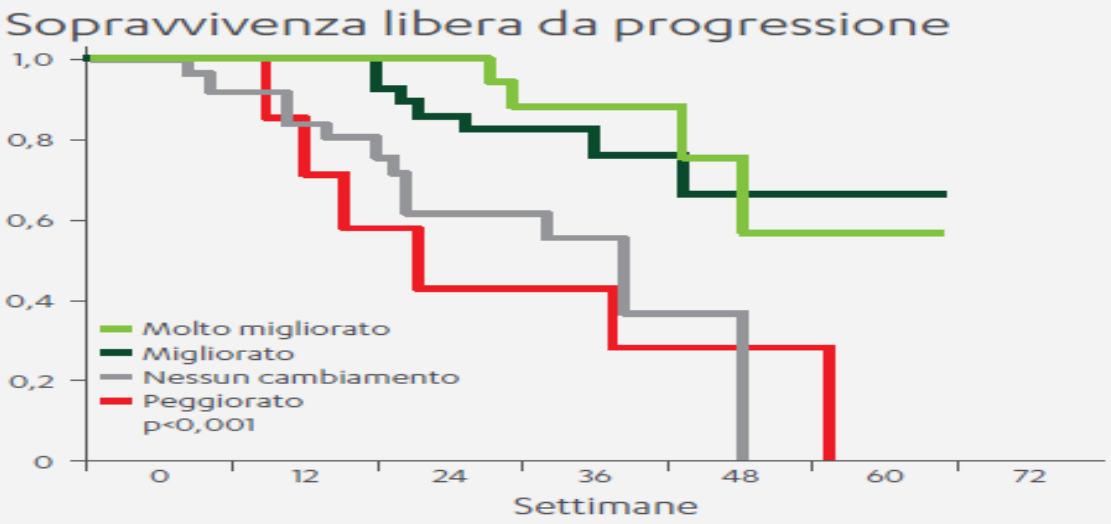


Figura 1 di Rif.5

La *Patient's Satisfaction* e' un predittore di malattia libera da progressione (PFS)

Paziente

Cindolo L et al. Clinical Genitourinary Cancer 2017 ; 15(5): 520-525.

STUDIO AQUARIUS Studio osservazionale, prospettico, attualmente ongoing.

PRO			Month 1	Month 2	Month 3	Month 4-6
FACT-Cog	1.	Perceived cognitive impairments (+)	3.25 [1.09-5.40]	4.73 [2.25-7.22]	5.44 [2.50-8.37]	4.22 [1.51-6.93]
	2.	Comments from others (+)	0.76 [0.25-1.26]	0.71 [0.20-1.22]	0.95 [0.30-1.60]	0.58 [0.00-1.17]
	3.	Perceived cognitive abilities (+)	[illegible]	2.55 [0.23-4.86]	-0.65 [-3.30-2.00]	1.67 [-0.88-4.22]
	4.	Impact on QoL (+)	0.74 [-0.28-1.75]	0.09 [illegible]	[illegible]	0.28 [-0.65-1.21]
BFI	1.	Your fatigue right now (-)	-0.71 [-1.31 to -0.11]	-0.82 [-1.50 to -0.14]	-0.99 [-1.74 to -0.23]	-0.08 [-0.79-0.63]
	2.	Your usual level of fatigue (-)	-0.70 [-1.30 to -0.10]	-1.04 [-1.70 to -0.37]	-1.24 [-2.02 to -0.46]	-0.32 [-0.96-0.32]
	3.	Your worst level of fatigue (-)	-0.89 [-1.51 to -0.27]	-1.00 [-1.74 to -0.25]	-1.32 [-2.10 to -0.53]	-0.09 [-0.82-0.63]
	4.	Fatigue interference (-)	-0.33 [-0.84-0.19]	-0.71 [-1.25 to -0.18]	-0.90 [-1.56 to -0.24]	-0.35 [-0.94-0.24]
BPI	1.	Pain at its worst (-)	0.06 [-0.63-0.76]	-0.54 [-1.29-0.21]	-0.66 [-1.46-0.14]	-0.05 [-0.75-0.65]
	2.	Pain at its least (-)	-0.13 [-0.68-0.41]	-0.58 [-1.15 to -0.01]	-0.50 [-1.09-0.08]	-0.30 [-0.89-0.28]
	3.	Pain on the average (-)	0.29 [-0.24-0.83]	-0.64 [-1.25 to -0.04]	-0.66 [-1.32 to -0.01]	-0.04 [-0.71-0.63]
	4.	Pain right now (-)	-0.08 [-0.67-0.52]	-0.34 [-0.97-0.30]	-0.24 [-0.83-0.36]	-0.21 [-0.81-0.39]
	5.	Pain interference (-)	-0.13 [-0.65-0.40]	-0.12 [-0.72-0.47]	-0.53 [-1.23-0.16]	0.06 [-0.60-0.72]
QLQ-C30	1.	Physical functioning (+)	2.37 [-1.64-6.38]	1.30 [-3.26-5.87]	6.80 [1.81-11.80]	3.75 [-1.07-8.56]
	2.	Role functioning (+)	6.33 [-0.95-13.61]	8.95 [1.99-15.91]	9.20 [1.78-16.62]	2.28 [-5.72-10.29]
	3.	Emotional functioning (+)	4.55 [0.36-8.75]	1.33 [-4.19-6.86]	7.05 [2.88-11.23]	2.71 [-1.80-7.22]
	4.	Cognitive functioning (+)	4.25 [0.55-7.95]	[illegible]	[illegible]	[illegible]
	5.	Social functioning (+)	4.20 [-1.75-10.16]	6.74 [0.77-12.70]	9.02 [2.78-15.26]	4.00 [-2.47-10.47]
	6.	Fatigue (-)	-10.58 [-15.92 to -5.24]	-7.95 [-13.90 to -1.99]	-15.35 [-22.69 to -8.00]	-7.27 [-13.92 to -0.62]
	7.	Nausea and vomiting (-)	[illegible]	-1.25 [-5.26-2.76]	-5.67 [-9.71 to -1.62]	[illegible]
	8.	Pain (-)	-3.16 [-9.37-3.05]	-3.73 [-11.26-3.79]	-9.79 [-16.98 to -2.61]	-0.51 [-7.58-6.56]
	9.	Dyspnea (-)	-0.65 [-6.15-4.86]	-1.52 [-8.18-5.14]	-1.41 [-8.33-5.51]	0.69 [-6.78-8.17]
	10.	Insomnia (-)	-3.83 [-10.70-3.04]	4.08 [-3.09-11.24]	-1.88 [-9.75-5.99]	6.86 [0.14-13.58]
	11.	Appetite loss (-)	-10.06 [-16.01 to -4.11]	-5.55 [-12.43-1.34]	-13.51 [-20.59 to -6.42]	-7.84 [-14.63 to -1.05]
	12.	Constipation (-)	-4.31 [-10.86-2.24]	1.46 [-5.78-8.69]	-4.48 [-11.57-2.60]	-2.73 [-10.01-4.55]
	13.	Diarrhea (-)	-1.02 [-7.02-4.99]	-3.97 [-9.82-1.88]	-2.42 [-7.97-3.12]	3.21 [-2.00-8.41]
	14.	Financial difficulties (-)	0.65 [-3.30-4.60]	-2.37 [-6.74-1.99]	-0.73 [-4.44-2.98]	-1.91 [-5.86-2.04]
	15.	Global health status/QoL (+)	0.22 [-5.14-5.58]	6.94 [0.52-13.37]	6.51 [-0.44-13.47]	1.94 [-3.73-7.62]

Significant difference in favor of AAP | Trend in favor of AAP | Trend in favor of ENZ | Significant difference in favor of ENZ

Interpretation of the PRO items: for FACT-Cog, higher scores are favorable; for EORTC QLQ-C30 functional scales and global health status/QoL, higher scores are favorable, for EORTC QLQ-C30 symptom scales, lower scores are favorable; for BPI-SF and BFI-SF, lower scores are favorable.

Initial Results From AQUARiUS, a Prospective, Observational, Multi-Centre Phase 4 Study Assessing Patient-Reported Outcomes in Metastatic Castration-Resistant Prostate Cancer Patients Treated With Abiraterone Acetate Plus Prednisone or Enzalutamide

Scopo dello studio: analizzare i Patient Report Outcomes (PRO) nei pazienti che iniziano un trattamento in prima linea con Abi o con Enza.

Nella maggior parte dei casi si può osservare come a 6 mesi quasi tutti gli items rimangano a favore del trattamento con Abiraterone.

Paziente

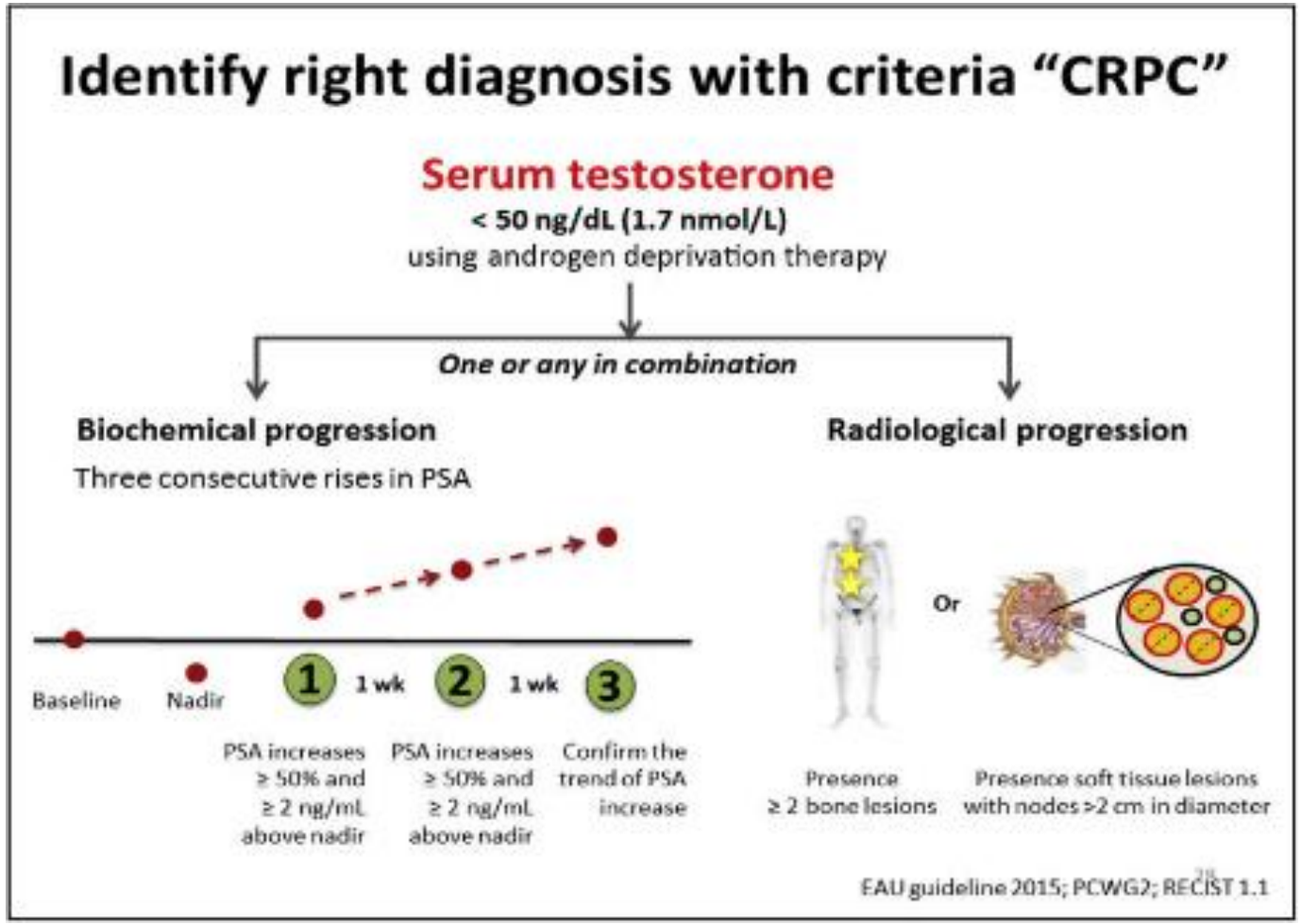
Thiery-Vuillemin A, et al. Poster at ASCO 2018, Abstract 5058

Molecole

Paziente

Esperienza clinica

Esperienza clinica



Varietà quadri clinici
Sviluppo di lesioni ossee 90%

eventi scheletrici

mCRPC basso volume, asintomatici, ottima QoL

mCRPC alto volume, alto rischio, sintomi rilevanti e significativi (dolore)

mCRPC rapidamente progressivi, alto volume

«...aim of therapy in patients with mCRPC is to match the appropriate strength therapy to the appropriate level of patient symptoms and disease burden». Ryan JC 2018

Esperienza clinica

Safety and efficacy of abiraterone acetate in chemotherapy-naive patients with metastatic castration-resistant prostate cancer: an Italian multicenter "real life" study

Luca Cindolo, Clara Natoli, Cosimo De Nunzio, Michele De Tursi, Maurizio Valeriani, Silvana Giacinti, Salvatore Micali, Mino Rizzo, Giampaolo Bianchi, Eugenio Martorana, Marcello Scarcia, Giuseppe Mario Ludovico, Pierluigi Bove, Anastasia Laudisi, Oscar Selvaggio, Giuseppe Carrieri, Maida Bada, Pietro Castellan, Stefano Boccasile, Pasquale Ditonno, Paolo Chiodini, Paolo Verze, Vincenzo Mirone and Luigi Schips

BMC Cancer 2017 **17**:753
https://doi.org/10.1186/s12885-017-3755-x
Received: 13 January 2017 | **Accepted:** 6 November 2017 | **Published:** 10 November 2017

Discussion

In the current study, we have depicted a representative snapshot regarding the efficacy of AA in an unselected patient population as in a "real life" scenario. Herein, with a mid term follow-up, we confirmed that AA plus prednisone is an effective treatment with excellent patient satisfaction ("greatly improved/improved": 69.2%) and with a good safety profile (Grade 3 and 4 toxicity recorded in 11.7%). However, in a different setting (real life vs RCT) of different mCRPC patients (older patients, with lower value of baseline PSA, and shorter follow-up) we obtained results in terms of survival outcomes comparable with those reported in the COU-302 trial [6]. In particular, we observed a median

Therapeutic Advances in Urology *Systematic Review*

Abiraterone in chemotherapy-naive patients with metastatic castration-resistant prostate cancer: a systematic review of 'real-life' studies

Ther Adv Urol
2018, Vol. 10(10) 305–315
DOI: 10.1177/1756287218786160

Michele Marchioni, Petros Sountoulides, Maida Bada, Sebastiano Rapisarda, Cosimo De Nunzio, Fabiola Raffaella Tamburro, Luigi Schips and Luca Cindolo

Esperienza clinica

Therapeutic Advances in Urology — *Systematic Review*

Abiraterone in chemotherapy-naive patients with metastatic castration-resistant prostate cancer: a systematic review of 'real-life' studies

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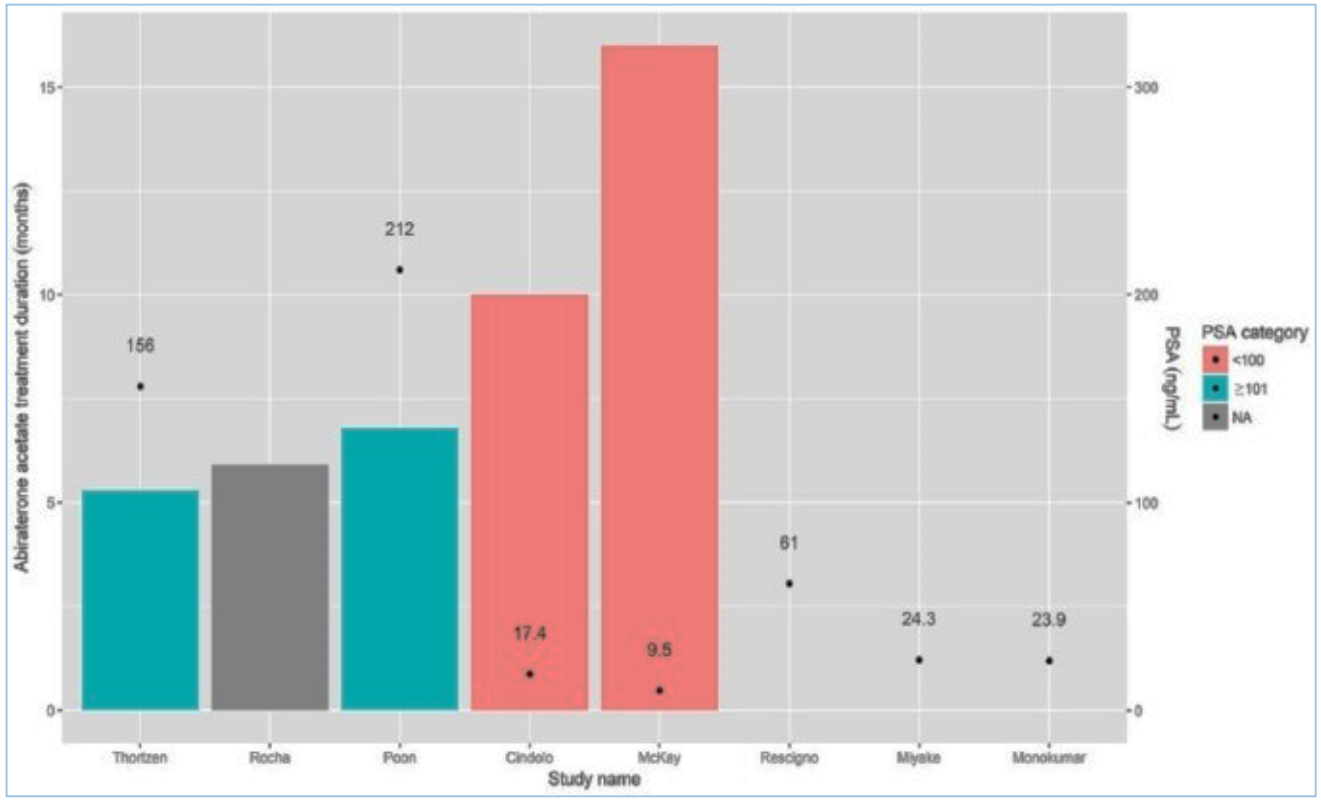


8 studi - 801 pazienti
PSA tra 9.5 e 212.0 ng/ml
Terapia con AA più lunga se PSA più basso

OS tra 14 e 36.4 mesi
% Tossicità ≥G3 tra 4.4 e 15.5%

Alta eterogeneità dei pazienti trattati
AA assicura buoni risultati sopravvivenza in setting 'real-life' setting

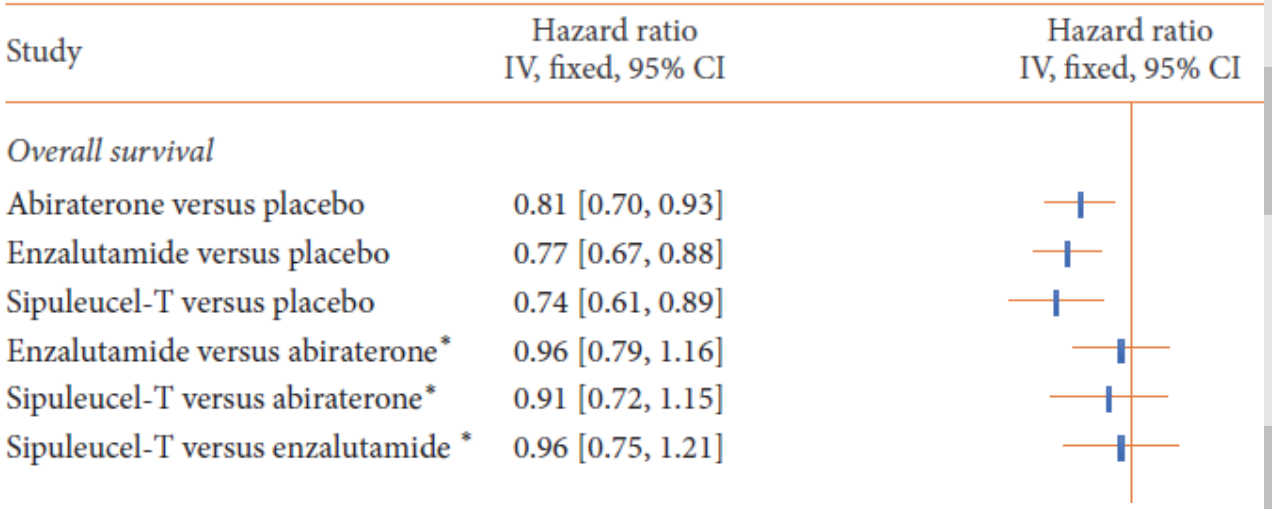
Quale scelta terapeutica nelle mani dell'urologo ?

BioMed Research International
Volume 2017, Article ID 3941217, 10 pages
https://doi.org/10.1155/2017/3941217

Review Article

Safety and Efficacy of First-Line Treatments for Chemotherapy-Naive Metastatic Castration-Resistant Prostate Cancer: A Systematic Review and Indirect Comparison

Haofeng Zheng, Jialiang Chen, Wenhan Qiu, Sijie Lin, Yanxiong Chen, Guancan Liang, and Youqiang Fang



	COU-AA-302 (n = 542) %	PREVAIL (n = 871) %
Any adverse event	99	98
Any serious adverse event	33	34
Discontinuation owing to adverse event	10	8
Adverse event leading to death	4	3

EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

EudraVigilance

Banca dati europea delle segnalazioni di sospette reazioni avverse ai farmaci

Settembre 2018

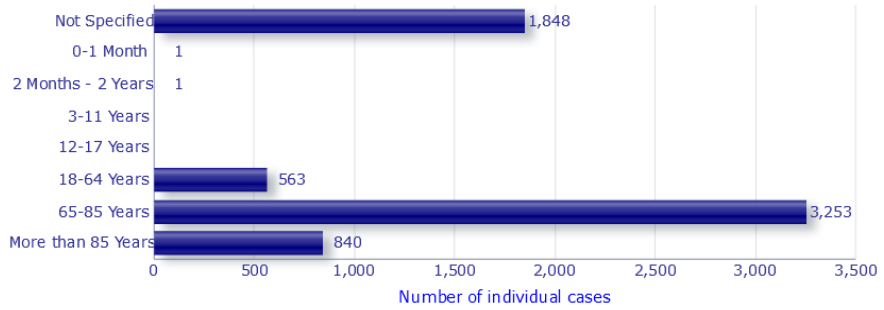
www.adrreports.eu/it/eudravigilance.html

Number of individual cases identified by Age Group in EudraVigilance for Zytiga is 6.506 (up to sept. 2018)

The number of individual cases identified in EudraVigilance for **ZYTIGA** is **6,506** (up to Sep 2018)

Number of individual cases by Age Group

Age Group	Cases	%
Not Specified	1,848	28.4%
0-1 Month	1	0.0%
2 Months - 2 Years	1	0.0%
3-11 Years	0	
12-17 Years	0	
18-64 Years	563	8.7%
65-85 Years	3,253	50.0%
More than 85 Years	840	12.9%
Total	**6,506**	**100.0%**

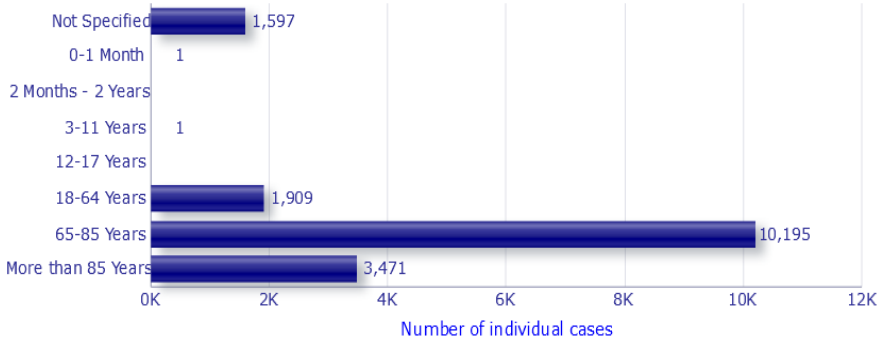


Number of individual cases identified by Age Group in EudraVigilance for Xtandi is 17.174 (up to sept. 2018)

The number of individual cases identified in EudraVigilance for **XTANDI** is **17,174** (up to Sep 2018)

Number of individual cases by Age Group

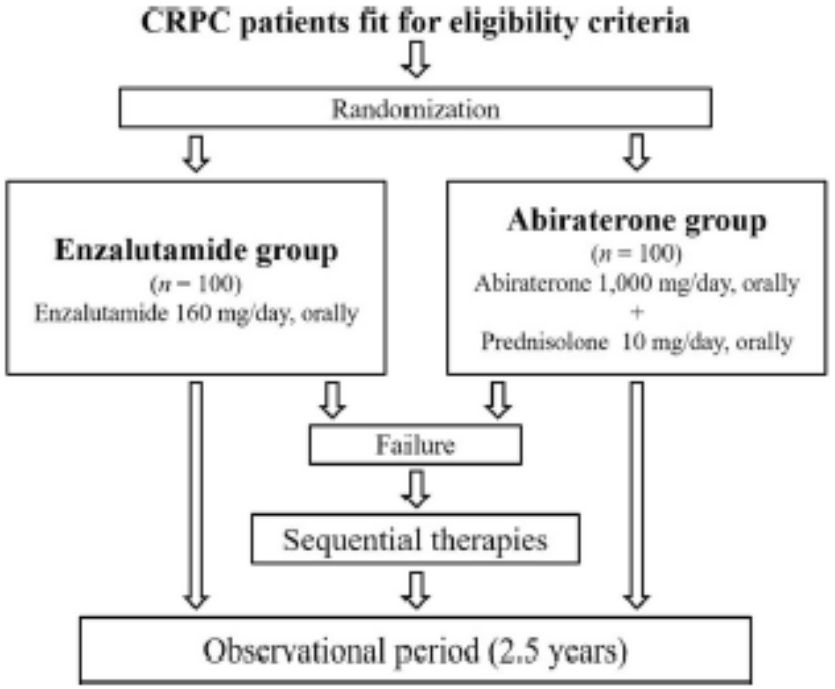
Age Group	Cases	%
Not Specified	1,597	9.3%
0-1 Month	1	0.0%
2 Months - 2 Years	0	
3-11 Years	1	0.0%
12-17 Years	0	
18-64 Years	1,909	11.1%
65-85 Years	10,195	59.4%
More than 85 Years	3,471	20.2%
Total	**17,174**	**100.0%**

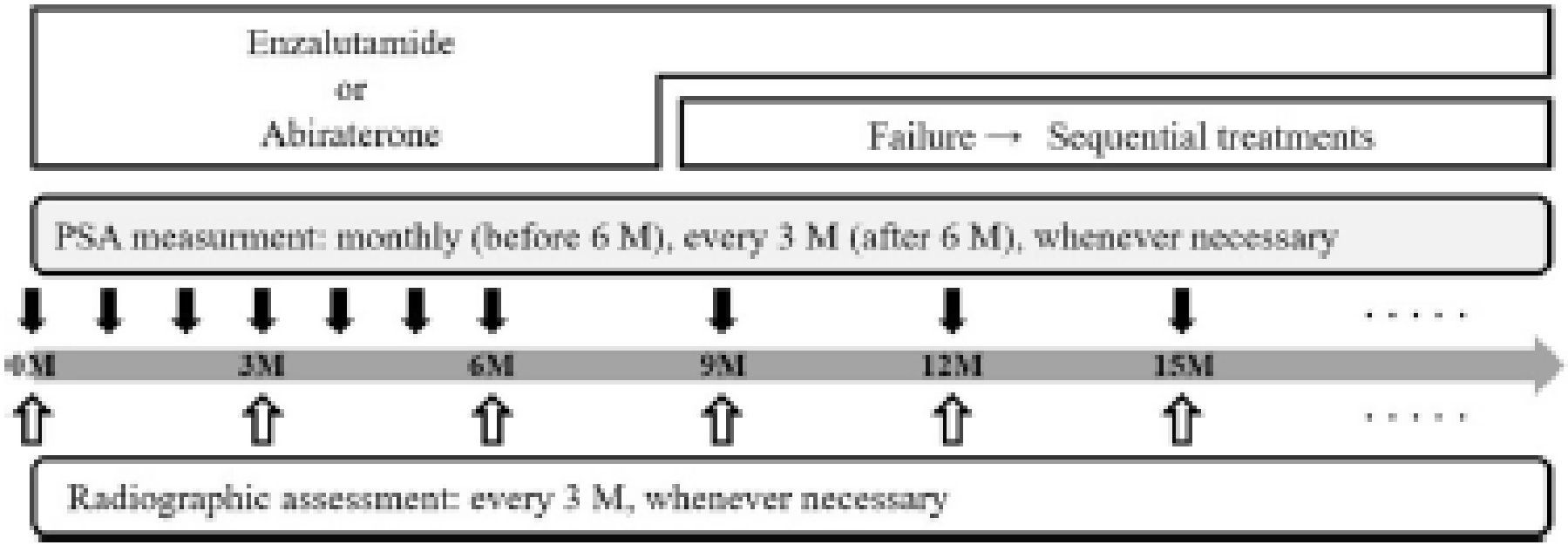


STUDY PROTOCOL Open Access

Enzalutamide versus abiraterone as a first-line endocrine therapy for castration-resistant prostate cancer (ENABLE study for PCa): a study protocol for a multicenter randomized phase III trial

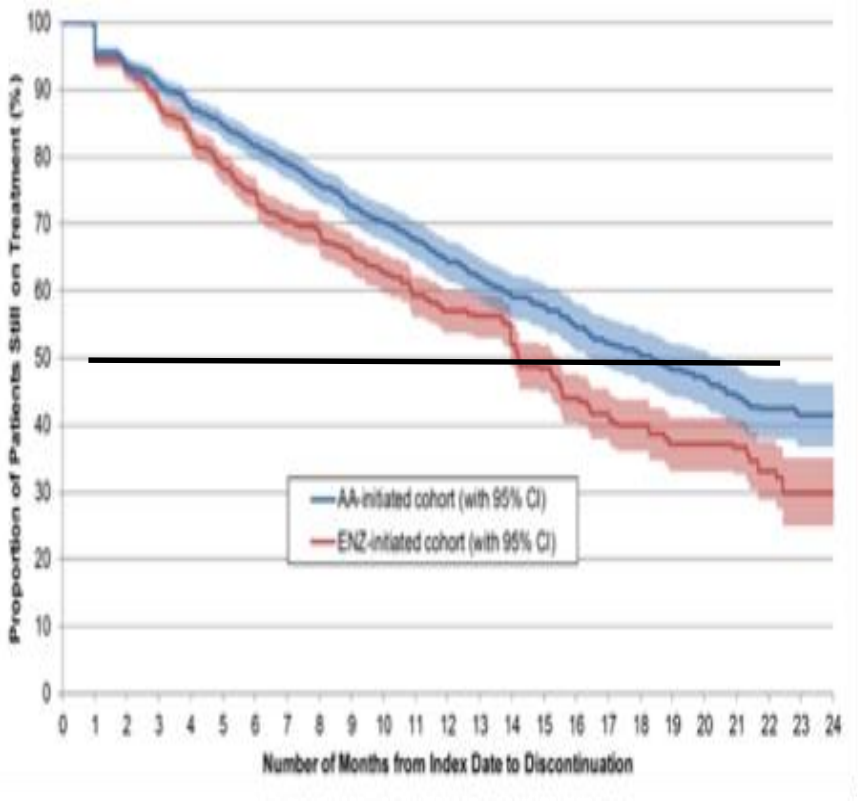
Kouji Izumi[1*], Atsushi Mizokami[1], Mikio Namiki[1], Shogo Inoue[2], Nobumichi Tanaka[3], Yuko Yoshio[4], Kei Ishibashi[5], Manabu Kamiyama[6], Noriyasu Kawai[7], Hideki Enokida[8], Takashi Shima[9] and Shizuko Takahara[10]

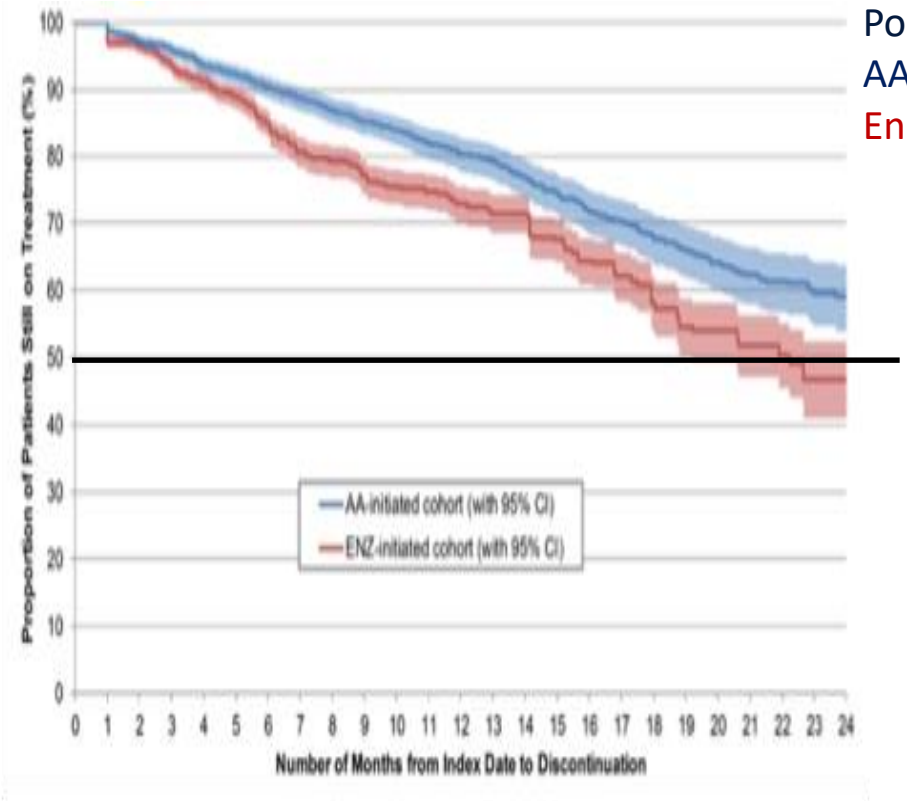




Izumi K, BMC Cancer 2017

La scelta del primo trattamento post ADT influenza la durata complessiva del trattamento





Popolazione ponderata:
AA initiated cohort= 1718
Enza initiated cohort= 1680

Durata trattamento singolo iniziando con:
- **Abiraterone 18,3 mesi**
- **Enza 14,2 mesi**

Durata mediana di tutto il trattamento per CRPC iniziando con:
- **Abiraterone non ancora raggiunta**
- **Enzalutamide 22,2 mesi**

Pilon et al. Journal of Managed Care & Specialty Pharmacy 2017

Take Home Messages

- **Scelta del trattamento fondata su RCT, real-life evidence, esperienza clinica**

- **Esperienza clinica Italia >17000 pazienti**

- **Studi real-life = efficacia ABI rispetto a RCT**
  anche in popolazioni particolari

- **QoL = preservata**

- **Fatigue e aspetti cognitivi a favore di ABI**

A prospective real life study evaluating Abiraterone Acetate plus Prednisone (AAP) for metastatic Castration Resistant Prostate Cancer (mCRPC) (Abitude Study)

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BACKGROUND AND OBJECTIVES

- Abiraterone acetate is a selective inhibitor of androgen biosynthesis that potently and irreversibly blocks CYP17, a crucial enzyme in testosterone synthesis, resulting in virtually undetectable serum and intratumoral androgens and antitumor activity in patients with metastatic castration-resistant prostate cancer (1,2,3).
- According to an emerging need to investigate effectiveness in routine clinical practice, the ABITUDE study was designed to evaluate Abiraterone Acetate plus Prednisone (AAP) in a real-world setting on chemotherapy-naïve patients with metastatic Castration-Resistant Prostate Cancer (mCRPC). Here we present the main results of the first interim analysis.

METHODS

- ABITUDE is a prospective, observational cohort study. Patients were consecutively enrolled in 49 Italian centers at the beginning of AAP and are being followed for 3 years.
- The primary objective is to evaluate PSA decline rate, radiographic progression-free survival (rPFS) and clinical benefit maintenance according to PCWG3 during AAP. Patient's quality of life and pain were measured every 6 months with the Functional Assessment of Cancer Therapy–Prostate (FACT-P; score range: 0-[illegible]) and Brief Pain Inventory (BPI; score range: [illegible]) questionnaire.

- Among 48 [illegible] for analysis [illegible] centers, wh[illegible] radiotherapy
- The median [illegible] 12.2). Main ba[illegible]
- The most rele[illegible] urological cent[illegible] hormonal therap[illegible] [illegible]eated in [illegible] time in standard [illegible] beginning of AAP.

Table 1: Demographics and clinical characteristics at baseline

	Total	Urology	Radiotherapy	Oncology
Centers n (%)	49 (100%)	10 (20,5%)	6 (12,2%)	33 (67,3%)
Patients n (%)	453 (94,2%)	65 (13.5%)	58 (12.1%)	330 (68,6%)
Age (years)				
mean	75.9	75.1	75.6	76.2
≥75 years	267 (58,9%)	33 (50.8%)	34 (58.6%)	200 (60.6%)
PSA (ng/mL)				
Median	15.0	8.1	10.5	16.5
Extent of disease				
Bones	318 (70.2%)	43 (66.2%)	35 (60.3%)	240 (72.7%)
Lymphnodes	230 (50.8%)	29 (44.6%)	35 (60.3%)	166 (50.3%)
Visceral	38 (8,4%)	4 (6.2%)	0 (0%)	34 (10,3%)
Prostatic bed	16 (3,5%)	11 (16.9%)	3 (5.2%)	2 (0,6%)
Bone mets ≥10 n(%)	62 (19.6%)	6 (14%)	7 (20%)	49 (20.5%)
Time from castration to AAP (median)	34.7 m	51 m	41.1 m	31.1 m
ECOG PS, n(%)				
0	250 (56.4%)	19 (30.6%)	27 (48.2%)	204 (62.8%)
1	170 (38.4%)	32 (51.6%)	25 (44.6%)	113 (34.8%)
≥2	23 (5.2%)	11 (17.7%)	4 (7.1%)	8 (2.5%)
NK	10	3	2	5
Comorbidities, n (%)				
0	146 (32.2%)	23 (35.4%)	12 (20.7%)	111 (33.6%)
1	145 (32%)	28 (43.1%)	24 (41.4%)	93 (28.2%)
≥2	162 (35.8%)	14 (21.5%)	22 (37.9%)	126 (38.2%)

ECOG:European Cooperative Oncology Group
NK= Not Known

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[1]Attard G, Reid AH, A'Hern R, et al. Selective inhibition of CYP17 with abiraterone acetate is highly active in the treatment of castration-resistant prostate cancer. J Clin Oncol 2009; 27: 3742–48.
[2]Fizazi, Karim, et al. "Abiraterone acetate for treatment of metastatic castration-resistant prostate cancer: final overall survival analysis of the COU-AA-301 randomised, double-blind, placebo-controlled phase 3 study." The lancet oncology 13.10 (2012): 983-992.
[3]Ryan, Charles J., et al. "Abiraterone acetate plus prednisone versus placebo plus prednisone in chemotherapy-naive men with metastatic castration-resistant prostate cancer (COU-AA-302): final overall survival analysis of a randomised, double-blind, placebo-controlled phase 3 study." The Lancet Oncology 16.2 (2015): 152-160.

RESULTS (II)

- At baseline more than half of the patients (56.1%) showed cardiovascular disorders, of which hypertension was the most frequent (48,3%) (figure 1).
- The most common reason for abiraterone treatment was PSA progression and radiographic progression (56,3%) and 81 (17.9%) started AAP due to PSA progression only (figure 2).

Figure 1: Patients with ongoing comorbidities

Efficacy results

- At the time of first planned interim analysis , 90,6% of the patients were alive and only 70 (15%) developed metastases (figure 3).

Figure 3: Kaplan-Meier Plot of Time to rPFS

* Patients who experienced radiographic desease progression or death during the follow-up period.

- Patients achieving PSA decline (≥50%) from baseline within 3 months of AA treatment were 151 (37.6%) but during the treatment the patients that achieved the ≥50% PSA decline increased to 242 (60.3%) (table 2). This is a further evidence demonstrating that the treatment should not be interrupted based on the lack of PSA response.

Table 2: patients with PSA response

	N=(401)*
PSA response rate (≥50%) after 3 months of AA treatment	151 (37.6%)
PSA response rate (≥50%) from baseline	242 (60.3%)

* Analysis subset for PSA

RESULTS (III)

Quality of life

- At enrolment, median (25th-75th percentile) FACT-P total score was 110 (95; 120) points (N=421); during observation period, 218 patients (71.9%) did not show functional decline (N=303)(data not shown).
- Median (25th-75th percentile) baseline BPI worst pain score was 2 points (0-4; N=388). After 6 months the median scores of BPI scale halved (table 3). Patients with moderate or extreme pain/discomfort at baseline also experienced an improvement (table 4).
- EQ-5D-3L questionaire indicate an improvement of general healty status (table 4).

Table 3: Pain assessment – BPI questionnaire results

	N	25th percentile	Median	75th percentile
[illegible]	173	0.0	1.0	3.0
[illegible]	54	0.0	0.3	2.5
[illegible]	[illegible]	0.0	2.0	4.0
[illegible]		0.0	1.0	4.0
[illegible]		0.0	0.4	3.0
[illegible]		0.0	0.2	1.9

[illegible]s Quality of Life – EQ-5D-3L questionnaire

		Baseline (N=453)	Follou up 6 months (N=453)
Mobility	I have no problems in walking about	275 (61.7%)	221 (68.4%)
	I have some problems in walking about	165 (37.0%)	100 (31.0%)
	I am confined to bed	6 (1.3%)	2 (0.6%)
	missing	7	130
Self-care	I have no problems with self-care	364 (81.8%)	273 (84.5%)
	I have some problems washing or dressing myself	73 (16.4%)	45 (13.9%)
	I am unable to wash or dress myself	8 (1.8%)	5 (1.5%)
	missing	8	130
Usual activities	I have no problems with performing my usual activities	307 (69.6%)	242 (74.9%)
	I have some problems with performing my usual activities	113 (25.6%)	70 (21.7%)
	I am unable to perform my usual activities	21 (4.8%)	11 (3.4%)
	missing	12	130
Pain/ Discomfort	I have no pain or discomfort	235 (53.4%)	202 (62.9%)
	I have moderate pain or discomfort	197 (44.8%)	114 (35.5%)
	I have extreme pain or discomfort	8 (1.8%)	5 (1.6%)
	missing	13	132
Anxiety/ Discomfort	I am not anxious or depressed	263 (59.5%)	201 (62.6%)
	I am moderately anxious or depressed	159 (36.0%)	110 (34.3%)
	I am extremely anxious or depressed	20 (4.5%)	10 (3.1%)
	missing	11	132

Note. Percentages were calculated over number of patients with non-missing response.

Safety

- Adverse reaction occurred in 10% of patients, the vast majority being non serious (9,4%).

CONCLUSIONS

- These data suggest that AAP was active and safe in a real world study population with baseline comorbidities.
- AAP delay functional decline and improve HRQoL and pain palliation.
- Further analyses with a longer follow up are awaited.

lunedì 15 ottobre 8 - 9.30
Sala Salvatore Luria

Studio ABITUDE

- Studio osservazionale prospettico in chemonaive ABI
- Analisi ad interim (durata 36m)
- 10 urologie coinvolte
- 65 pazienti seguiti da urologi/481 pazienti totali