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Insights Into Prostate Cancer

September 13, 2025

Chicago, IL

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Click to move to topic of interest or ARS supporting data

Click to return to previous slide

Report Contents

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Quick Links

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Report Snapshot

Report Snapshot: Session Overview

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Disease state and data presentations were led on **September 13, 2025,** by **Ulka Vaishampayan, MD,** from the University of Michigan, with content developed in conjunction with the Aptitude Health scientific team

The objectives of the meeting were to gain advisors' perspectives on the following

- Use/barriers to use of androgen receptor (AR) inhibitors and potential radioligand therapies for management of metastatic hormone-sensitive prostate cancer (mHSPC)
- Use/barriers to use of radioligand therapy for management of metastatic castration-resistant prostate cancer (mCRPC)
- Perceptions of evolving clinical data and their impact on therapy choice in mHSPC and mCRPC

Data collection was accomplished through use of **audience response system (ARS)** questioning and **moderated discussion**

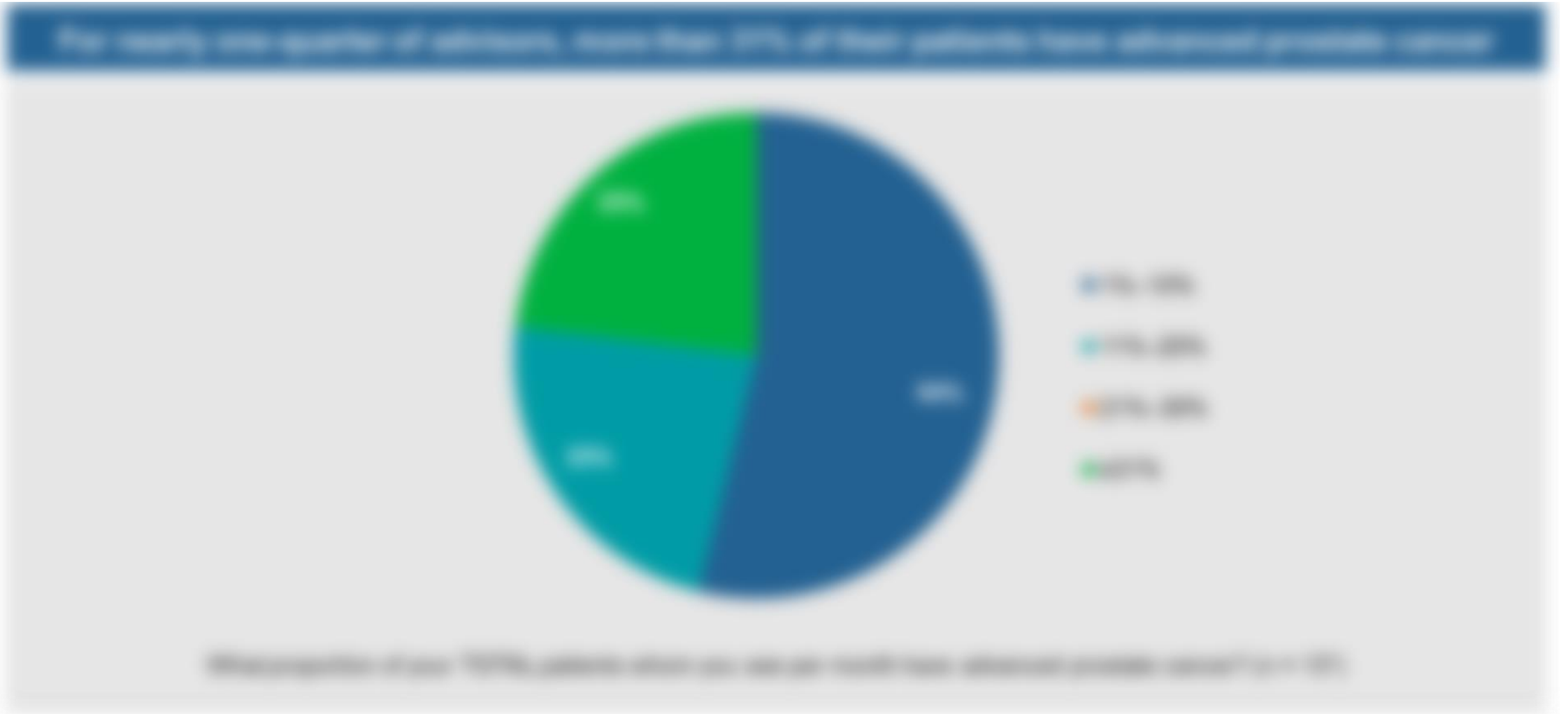
Insights on the management of prostate cancer were obtained from **15 community oncologists** from the Midwest region

Report Snapshot: Session Agenda

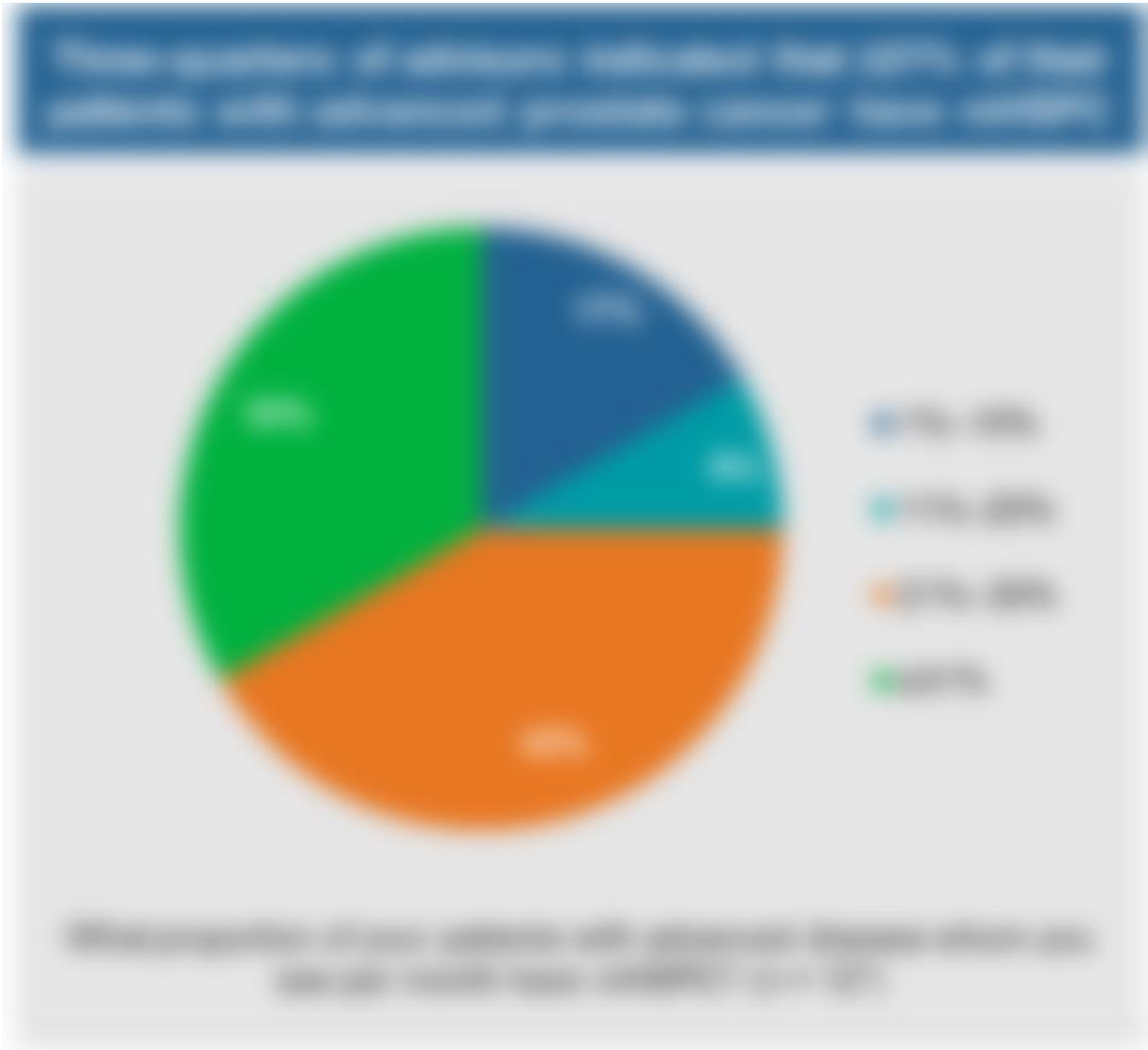
Time	Topic
9.00 AM – 9.15 AM (15 min)	**Introduction** > Program overview > Round-robin introductions
9.15 AM – 10.25 AM (10-min ARS; 25-min presentation; 35-min discussion)	**Management of mHSPC** > ARS questions > Overview of current data > Reaction and discussion
10.25 AM – 10.35 AM (10 min)	**Break**
10.35 AM – 11.45 AM (10-min ARS; 25-min presentation; 35-min discussion)	**Management of mCRPC** > ARS questions > Overview of current data > Reaction and discussion
11.45 AM – 12.00 PM (15 min)	**Key Takeaways and Meeting Evaluation**

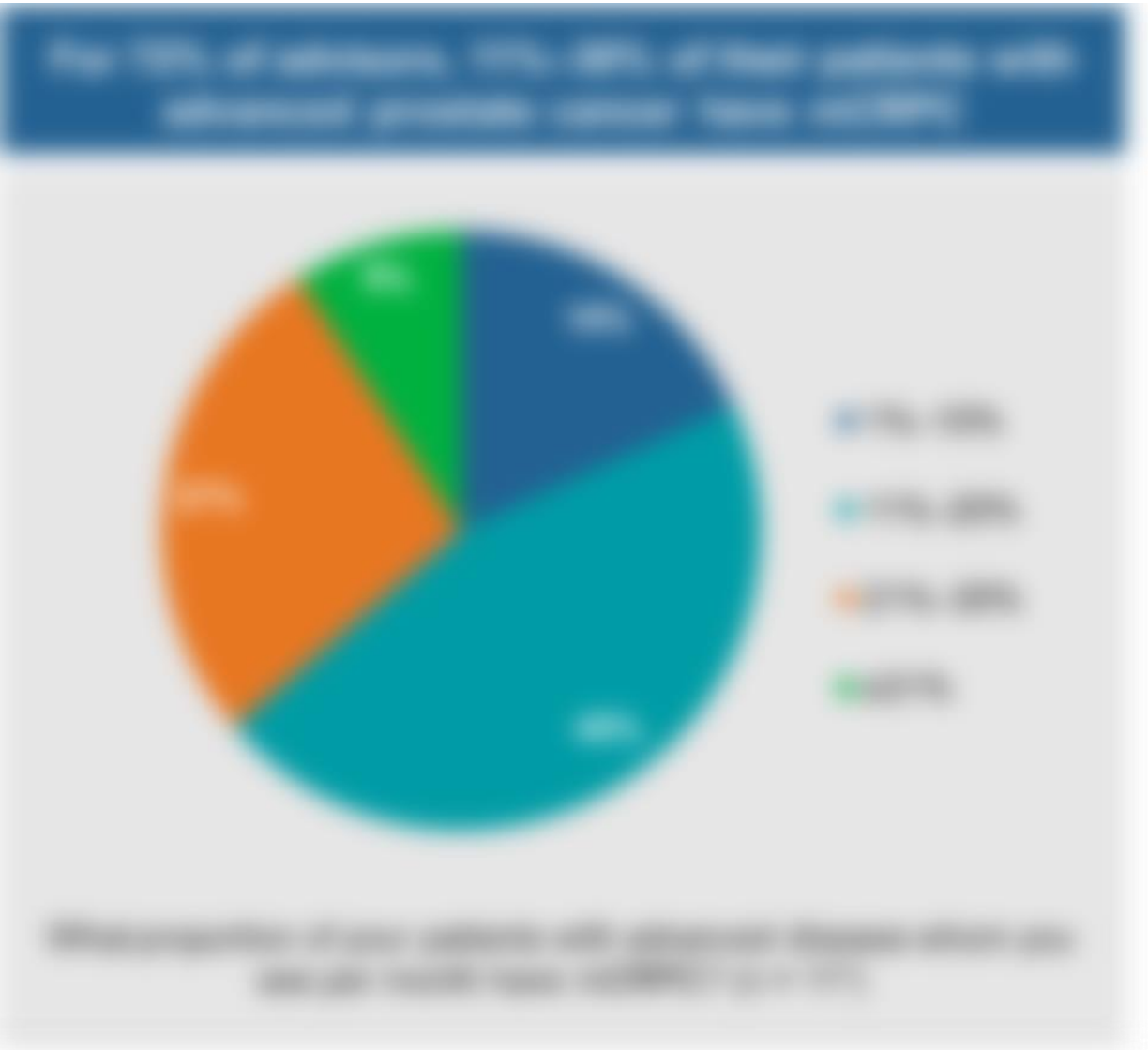
Report Snapshot: Attendee Overview

Report Snapshot: Attendee Demographics (1/2)



Report Snapshot: Attendee Demographics (2/2)





Scope of the Report

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Topline Takeaways

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Detailed Insights and Strategic Recommendations

Objective 1: Detailed Insights

Objective 1: Supportive Quotes From Discussion (1/4)

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OBJECTIVE 1: Understand advisors' perspectives on current treatment practices in, and understanding of, HER2+ mBC

Topic	Advisor Statements
Choosing between TAP and T-DM1 plus pertuzumab	"I think the HR-negative patients with visceral disease, bulky disease, where you really are worried about getting a response and you wouldn't be able to use the PATRAK, that's probably the patient I would think about it for." "I think even though the T-DM1 trial wanted you to be at least 6 months from your last trastuzumab-based therapy, I'd probably favor more T-DM1 if you're between 6 and 12 months, as opposed to trying CLEOPATRA again." "I forget the breakdown for age, but for DBOS, I thought that age actually crossed the midline for our spot for elderly patients." "Underlying pulmonary comorbidities."
Tucatinib-based regimen	"I used tucatinib and very well tolerated. And also in NCCN Guidelines, it's in third-line treatment tucatinib. But you can use in brain metastases second-line treatment. So I have used it and modified the dose of capecitabine sometimes, and it's very well tolerated." "I've used it on the third line. I actually had this come up interestingly recently for a patient, not because of CNS mets, but she, like, basically blew through her CLEOPATRA, and she had really bulky pulmonary metastases, required supplemental oxygen. And in the second line, I gave her these 2 options and said you're really, you're high risk for ILD because of your existing pulmonary mets. So it's probably a better treatment for you. And then I also offered HERCLAB, and she ultimately chose T-DM1. And I just got her first scans, and they look amazing. Her oxygen requirements have decreased. So it was a risk, but I think it was the right choice, hopefully."

Objective 1: Supportive Quotes From Discussion (2/4)

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Topic	Advisor Statements
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Objective 1: Supportive Quotes From Discussion (3/4)

Topic	Advisor Statements
Perspectives on DESTINY-Breast09	"Yeah, but the data speaks, hazard ratio of 0.36 and 95% confidence interval 0.44 to 0.71. And look at the Kaplan-Meier curves. They're separating . . . Very impressive data . . . Which you showed us." "And then when you brought up the impressive results for their control arm, I think we had this study open and what was remarkable, at least in our site, was there was a significant discordance between central review of HER2 and local. And it was a fair amount of patients, like almost all of the patients had discordance. So we actually didn't have a fair amount that was not eligible for DESTINY-Breast09 because of that. I wonder if that's something that just sort of, I guess, concentrated the HER2 population for this, and maybe patients did better. I don't know if that was discussed at all in this." "I mean, they're very impressive results. I'm sure we'll get into the major criticism of the study, which is that the THP CLEOPATRA regimen is so tolerable once you get to the maintenance phase. And I know there are ongoing studies about doing sort of an induction style followed by maintenance. So I think that's what I'm really excited to see. T-DM1 is, I think, well tolerated in general, but it's a lot of monitoring. I'm doing scans every 8 weeks, more or less, to look for ILD. And that's just a lot on patients, especially in long responders. Sometimes I don't restage them for 6 months or do their echoes for 6 months. So it just is like the intensity has increased, for sure." "I think the other factor with this control arm doing better than CLEOPATRA is the volume of patients that did not get trastuzumab or pertuzumab, because half of the patients were de novo. That means the other half had therapy for breast cancer in the past. That's probably not something we saw."

Objective 1: Supportive Quotes From Discussion (4/4)

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Topic	Advisor Statements
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[redacted]	[redacted]

Objective 1: Strategic Recommendations

Objective 2: Detailed Insights

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OBJECTIVE 2: Gain insight into current treatment practices in HR+ HER2- mBC

Topline Takeaway: Advisors prioritize efficacy, safety, and quality of life in HR+ HER2- mBC, with ribociclib as the most preferred CDK4/6i. Advisors currently prefer fulvestrant-based regimens for second-line therapy in the absence of actionable mutations, but they noted a preference for alpelisib in patients with *PIK3CA* mutations and elacestrant in the case of *ESR1* mutations. Advisors found SERENA-6 compelling and were optimistic regarding its future incorporation in HR+ mBC, though concerns remain regarding lead time bias and testing costs.

When discussing HR+ disease, advisors emphasized that safety, toxicity management, quality of life, and efficacy outcomes guide treatment decisions

- Ribociclib is the most preferred CDK4/6i for HR+ mBC, with half of advisors recommending ribociclib as their first-line choice, while 42% of advisors said it depends on the patient
  - Advisors pointed to efficacy results and toxicity profiles as the leading reasons behind their choice of CDK4/6 inhibitor; physicians also consider NCCN Guidelines in their preference
- According to advisors, palbociclib is more appealing for frail patients, while abemaciclib remains effective for higher-risk disease

Following progression on first-line letrozole plus abemaciclib, most advisors would recommend fulvestrant plus ribociclib for a patient with HR+ HER2 mBC in the absence of any actionable mutations

- During discussion, advisors noted that they typically use alpelisib for their patients with *PIK3CA* mutations, citing that it came first as their main rationale for its selection over capivasertib
- Advisors discussed using single-agent elacestrant for their patients with *ESR1*-mutated HR+ mBC

Advisors found the data from SERENA-6 and INAVO120 highly compelling and expressed interest in the EMBER-3 and VERITAC-2 trials to expand the arsenal of available treatments for HR+ mBC

- Physicians cite lead time bias and the potential cost of repeated *ESR1* testing as challenges for incorporation of SERENA-6, but they remain optimistic and noted that many patients desire additional testing
  - One advisors raised a question on how to proceed for patients who test positive for *ESR1* mutations at low allele fractions

Objective 2: Supportive Quotes From Discussion (1/4)

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OBJECTIVE 2: Gain insight into current treatment practices in HR+, HER2 – mBC

Topic	Advisor Statements
Perceptions of SERENA-6	"This is a landmark trial. It came in ASCO. … Plenary session. … Also in New England Journal of Medicine." "We are doing circulating tumor DNA and next-generation sequencing in all metastatic disease. … I think it's a practice-changing data. It's very, very important. The question is, how often you will do it? It means every 3 months, every 6 months. Other thing, PIK3CA mutation. If you found it's a very bad mutation as compared to ESR1 mutation, I will treat with PIK3CA inhibitor initially, because that's a worse mutation as compared to ESR1 mutation. Here you can wait a little bit. But I think this is very important data, which you showed us, and it's a practice-changing. But I don't think camizestrant is available in US yet, this camizestrant with cyclin-D kinase. I think it should be implemented in patient care after 6 months and every 3 to 6 months, check for ESR1 mutation, and change the treatment." "I think the question comes, are we using second line early? Is it a lead time bias also? I think that was another discussion." "Do we know a median time to detect an ESR1 alteration in those that were detected? So, we screened about 3,000 patients or maybe 300 patients. Obviously, at the time, they detected the first ESR1 alteration got randomized. Was that 6 months? Was that a year? Do we know?" "I was skeptical because of the potential for, excuse me, lead time bias as well. And checking every 2 to 3 months certainly is going to increase the cost of what we're doing. But this time to the quality-of-life measure actually sort of changed my mind a little bit. Although I can see what you're saying about the psychological impact. But I don't know how to explain it other than clinical benefit is important, so."

Objective 2: Supportive Quotes From Discussion (2/4)

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Topic	Advisor Statements
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Objective 2: Supportive Quotes From Discussion (3/4)

Objective 2: Supportive Quotes From Discussion (4/4)

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Objective 2: Strategic Recommendations

Objective 3: Detailed Insights

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Objective 3: Supportive Quotes From Discussion (1/3)

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Topic	Advisor Statements
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Objective 3: Supportive Quotes From Discussion (2/3)

Topic	Advisor Statements
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Objective 3: Supportive Quotes From Discussion (3/3)

Objective 3: Strategic Recommendations

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Attendee Key Takeaways

Attendee Key Takeaways (1/5)

Attendee Key Takeaways (2/5)

Attendee Key Takeaways (3/5)

Attendee Key Takeaways (4/5)

Attendee Key Takeaways (5/5)

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ARS Data

The Majority of Advisors Refer >50% of Their Patients With mHSPC for Genetic Testing

While 47% of Advisors Do Not Encounter Any Barriers to AR Inhibitor Use in Treating mHSPC, Another 47% Reported Delays in Authorization as a Key Impediment

Patient Case 1

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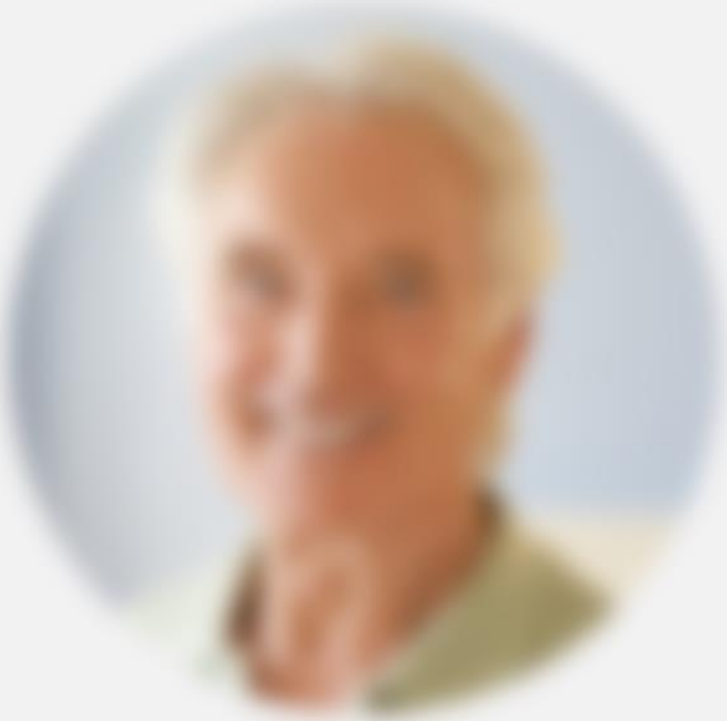

What would be your preferred therapy for a patient with mHSPC with the following characteristics?

- Bone and visceral (lung) metastases, PSMA PET positive
- Symptomatic disease
- ECOG PS 1
- High-volume synchronous metastases
- No known targetable genetic mutations/aberrations

Nearly All Advisors Selected Triplet Therapy With Darolutamide for Treatment of a Patient With High-Volume mHSPC

Patient Case 2

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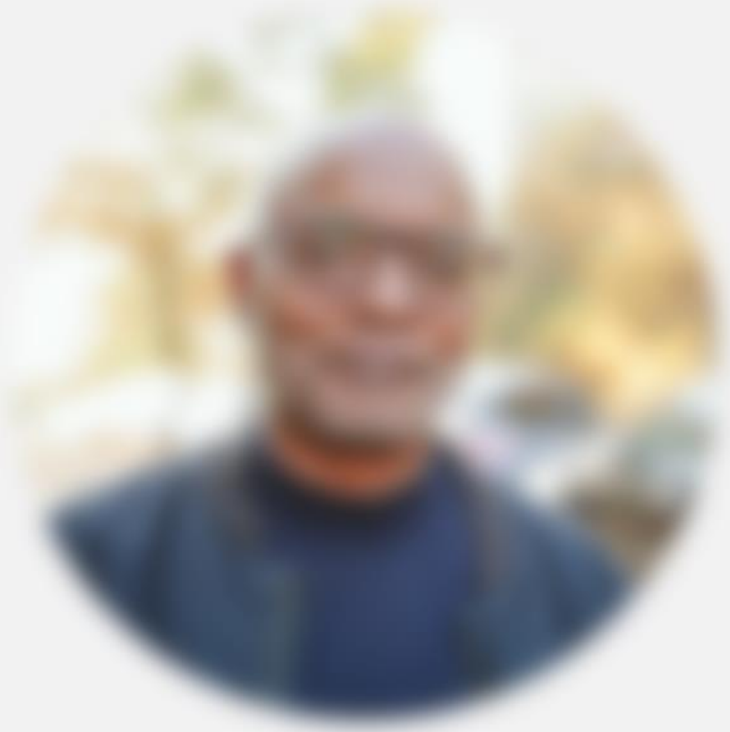

What would be your preferred therapy for a patient with mHSPC with the following characteristics?

- Bone and lymph node metastases, PSMA PET positive
- Mildly symptomatic disease
- ECOG PS 1
- Low-volume synchronous metastases
- No known targetable genetic mutations/aberrations

The Preferred Treatment for a Patient With Low-Volume mHSPC Was Doublet Therapy With Either Darolutamide (33%), Apalutamide (20%), or Enzalutamide (13%)

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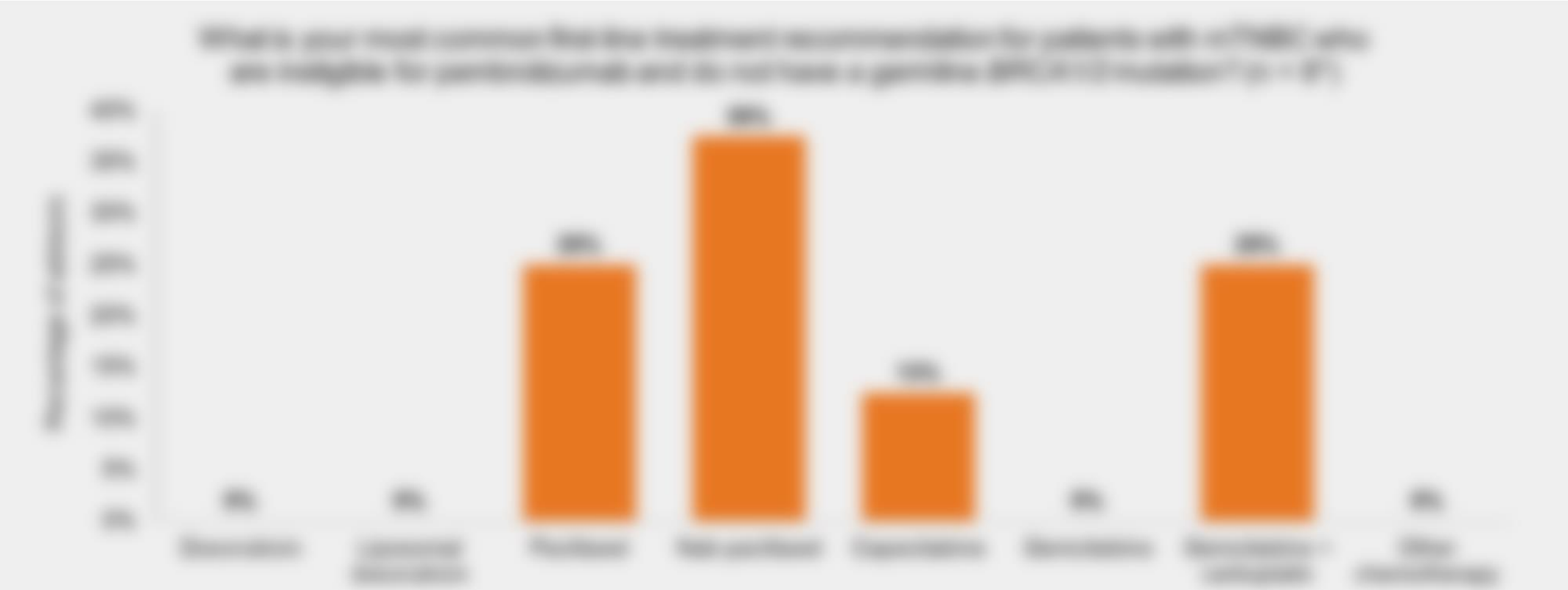
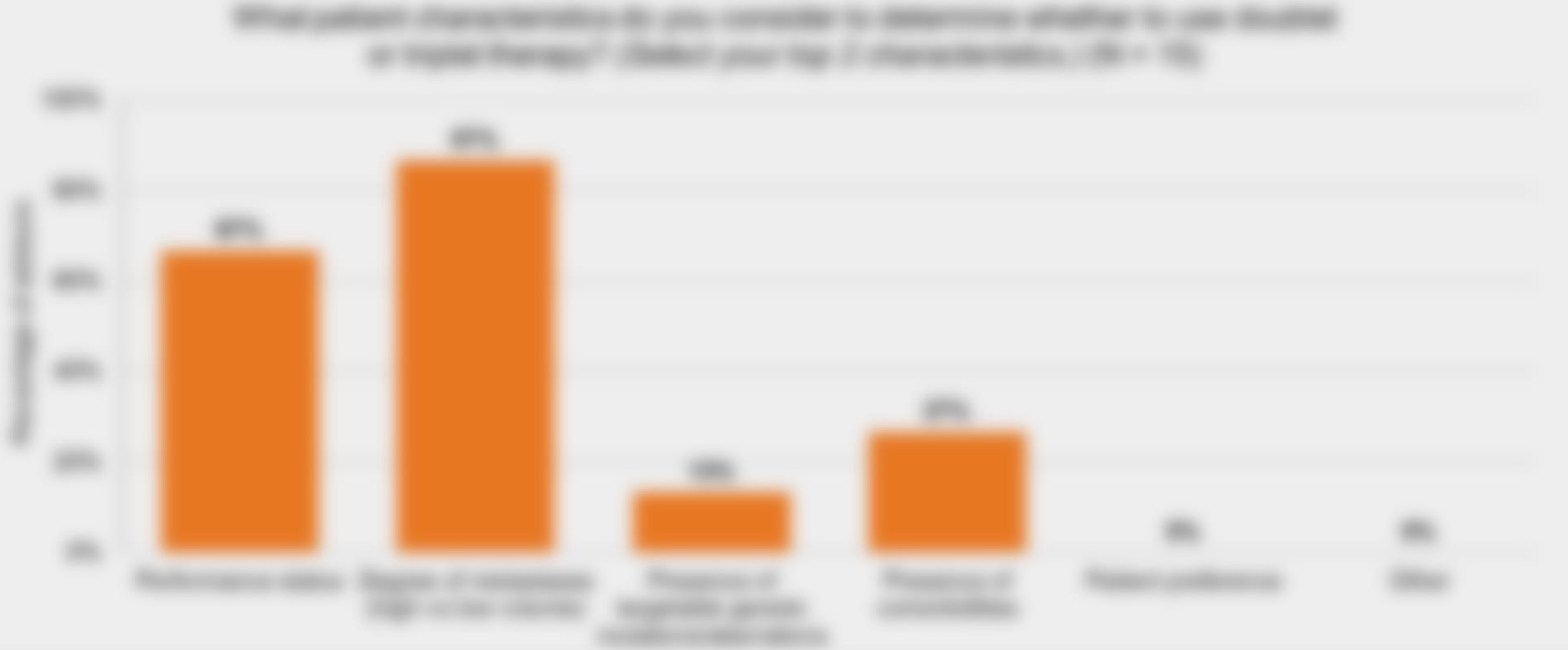


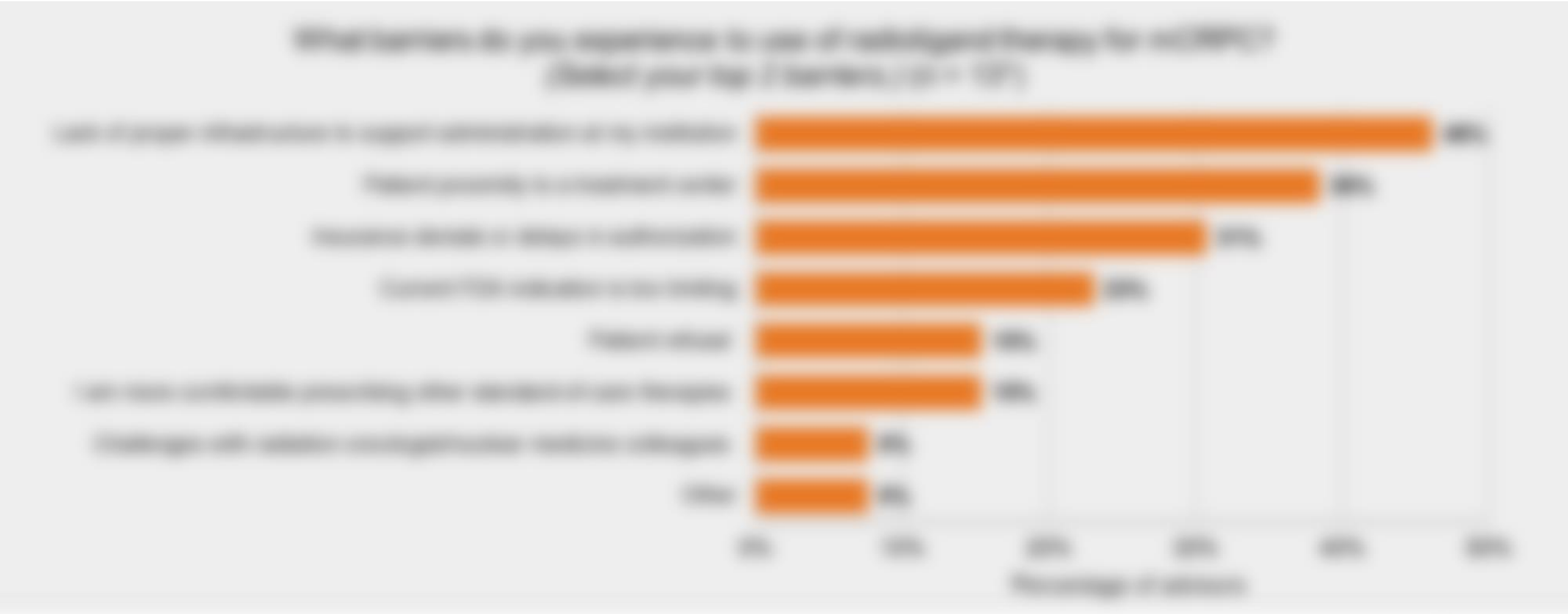
Degree of Metastases, Followed by Patient Performance Status, Are Top Factors in Determining Treatment Intensification



Nearly All Advisors Refer the Majority of Their Patients With mCRPC for Genetic Testing

While Over Half of Advisors Have Access to Multiple Treatment Service Lines, Only 15% Can Access a Hot Lab/Theranostics Department at Their Institution

Lack of Proper Infrastructure, Patient Proximity to Treatment Centers, and Insurance Issues Are The Most Frequent Hurdles to Use of Radioligand Therapy for mCRPC



Patient Case 3

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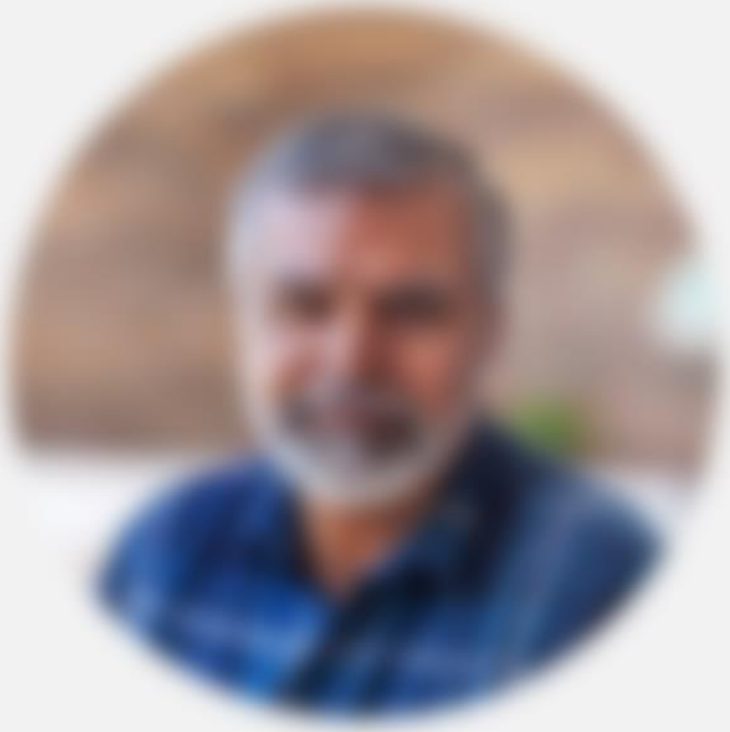

What would be your preferred therapy for a patient with mCRPC with the following characteristics?

- Bone and visceral (lung) metastases, PSMA-PET positive
- Symptomatic disease
- ECOG PS 1
- Prior ADT + AR-targeted therapy (enzalutamide) + docetaxel
- Unknown genetic mutations

Over Three-Quarters of Advisors Selected ^{177}Lu-PSMA-617 Treatment for a Symptomatic Patient With mCRPC Who Received Prior Triplet Therapy (with enzalutamide)

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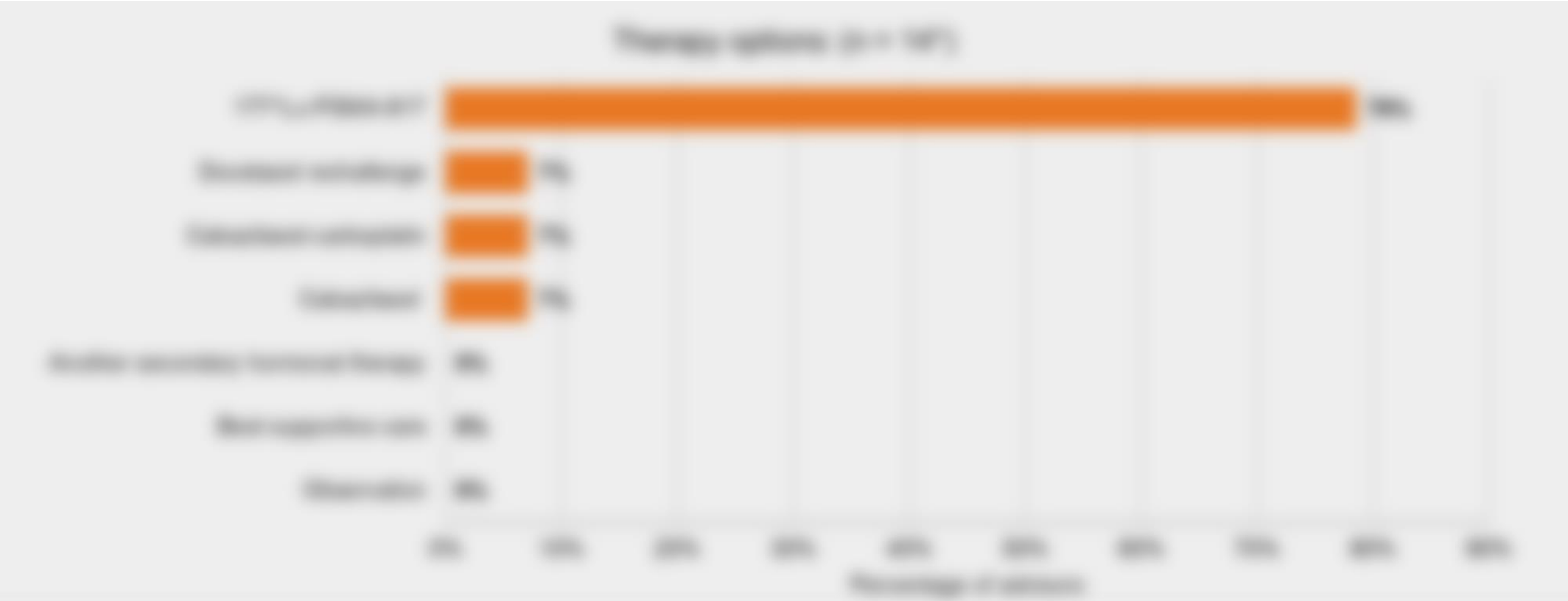

Patient Case 4

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What would be your preferred therapy for a patient with mCRPC with the following characteristics?

- Bone and lymph node metastases, PSMA PET positive
- Mildly symptomatic disease
- ECOG PS 1
- Prior enzalutamide and docetaxel
- Known *BRCA* mutation

All Advisors Preferred a PARP Inhibitor for a Mildly Symptomatic Patient With mCRPC and Known *BRCA* Mutation, Who Previously Received Enzalutamide + Docetaxel

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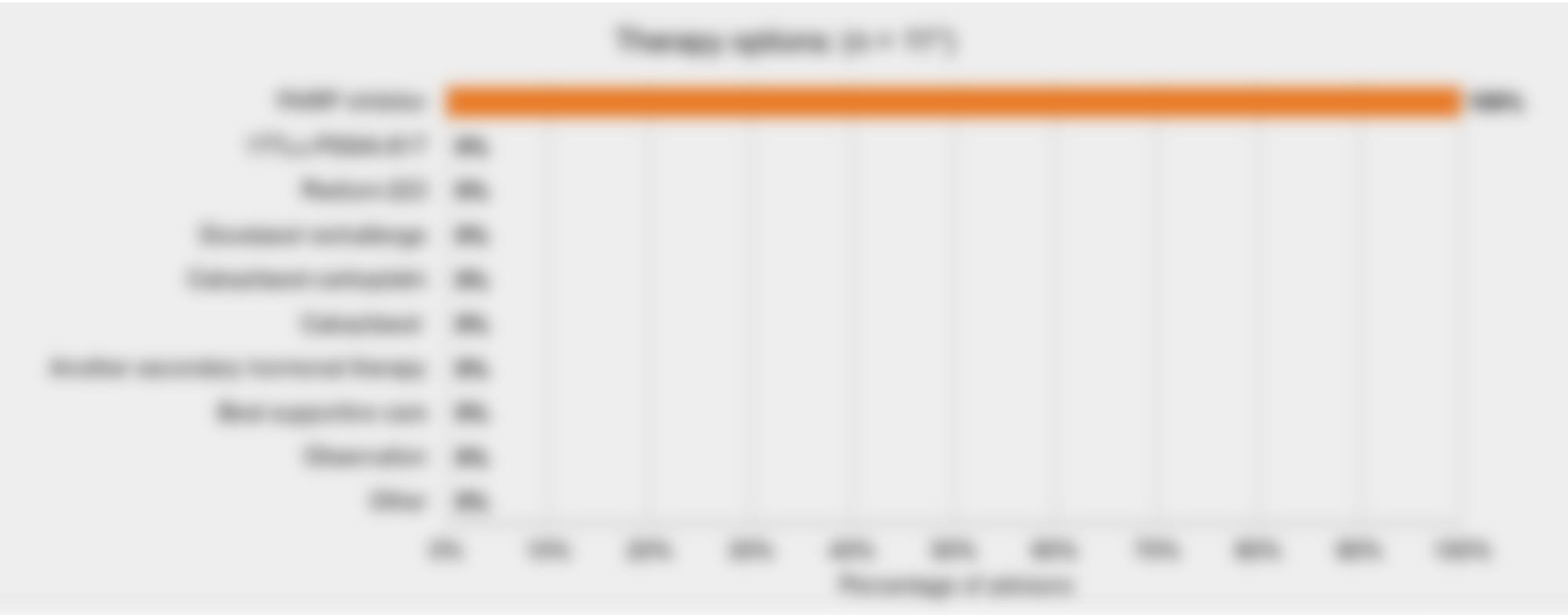

Patient Case 5

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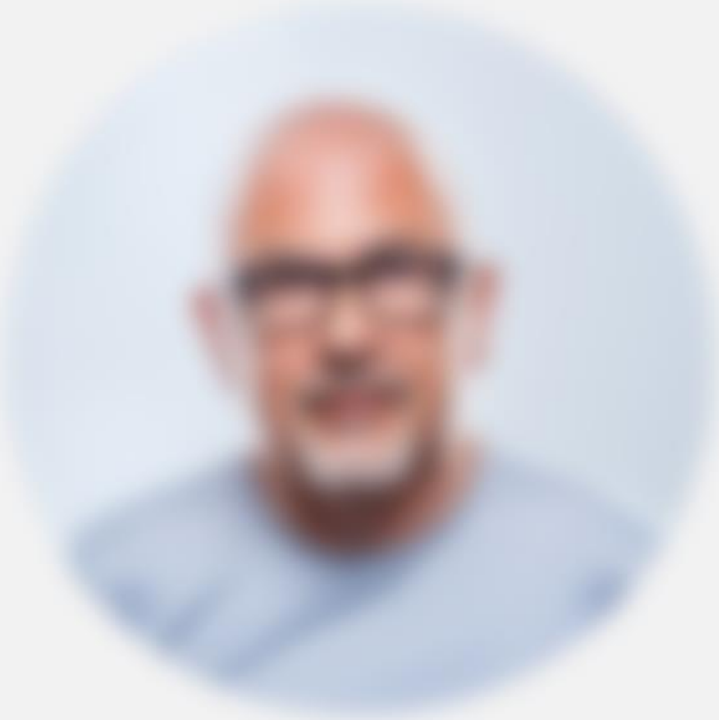

What would be your preferred therapy for a patient with mCRPC with the following characteristics?

- Bone metastases, PSMA PET positive
- Asymptomatic
- ECOG PS 0
- Prior AR-targeted therapy
- No actionable genetic mutations

64% of Advisors Favored ^{177}Lu-PSMA-617 Treatment for a Patient With Asymptomatic mCRPC and Prior AR-Targeted Therapy; Another 14% Preferred Docetaxel

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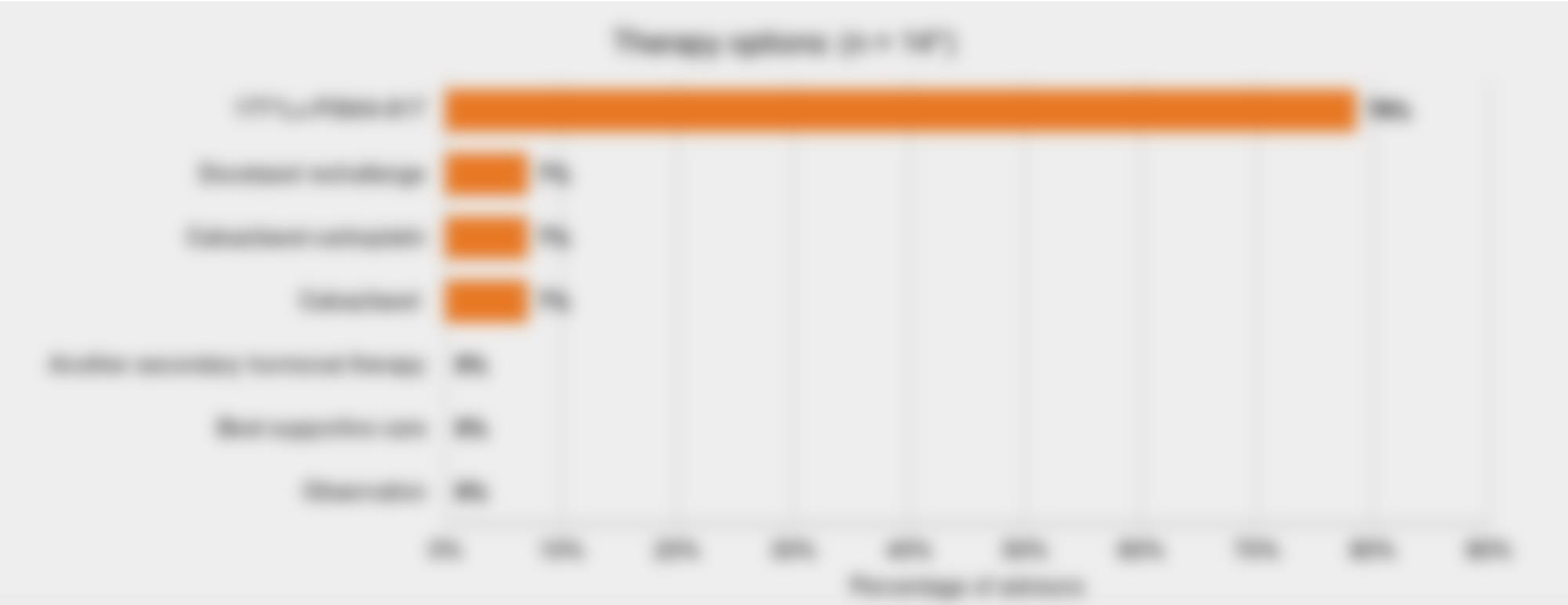

Patient Case 6

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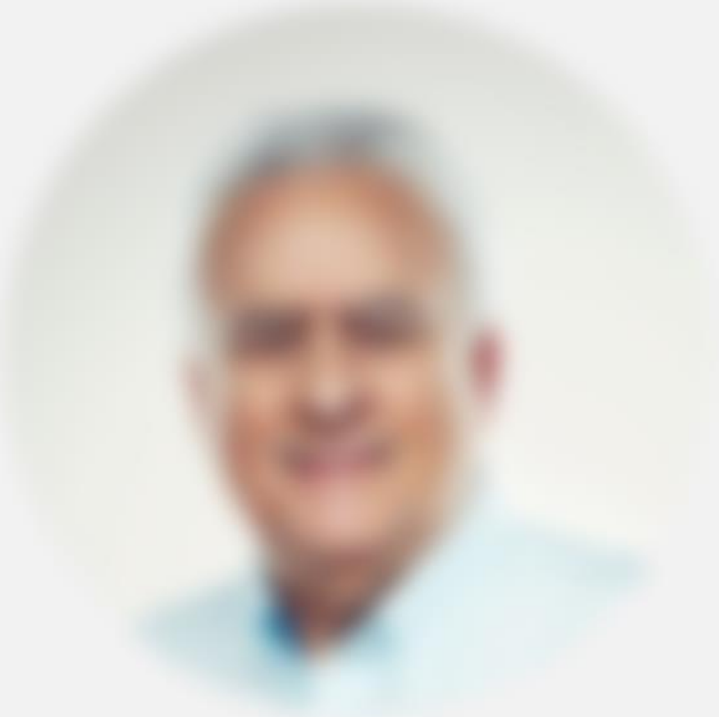
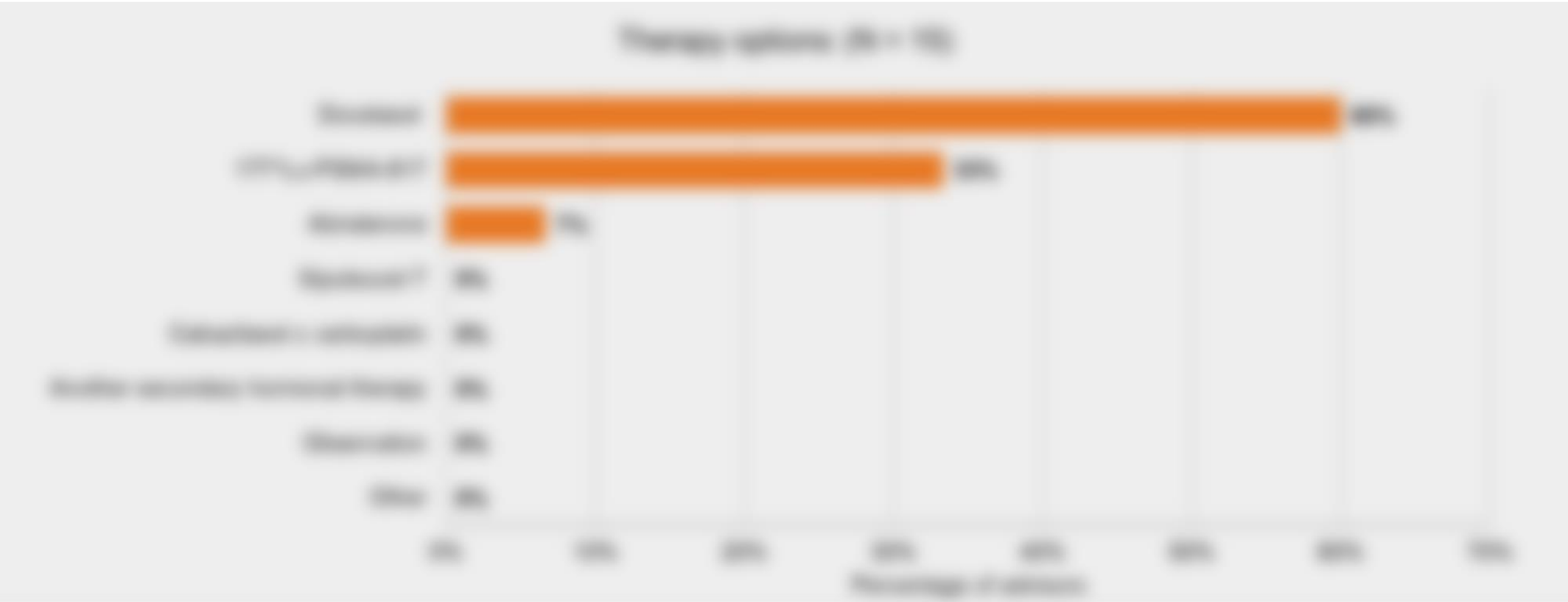


What would be your preferred therapy for a patient with mCRPC with the following characteristics?

- Bone and visceral metastases, PSMA PET positive
- Symptomatic disease
- ECOG PS 1
- Prior ADT + AR-targeted therapy (enzalutamide)
- No actionable genetic mutation

Although the Majority of Advisors Chose Docetaxel Treatment for a Symptomatic Patient With Prior Doublet Therapy (with enzalutamide), 33% Preferred ^{177}Lu-PSMA-617



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US 5901-B Peachtree Dunwoody Road
Suite 415, Atlanta, GA 30328, US

EU Laan van Nieuw Oost-Indië 133 F
2593 BM The Hague, the Netherlands

UK 6th Floor, 2 Kingdom Street
London, W2 6BD, United Kingdom

aptitudehealth.com