



EPICS

Conference Coverage: ASCO 2026 – Focus on Prostate Cancer

June 17, 2026

Full Report

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A closed-door roundtable discussion focused on updates in prostate cancer from ASCO 2026 was held virtually on **June 17, 2026**

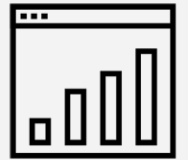


Breast cancer-specific discussions on latest research updates, therapeutic advances, and their application in clinical decision-making were led by **Daniel Petrylak, MD**, from Yale School of Medicine



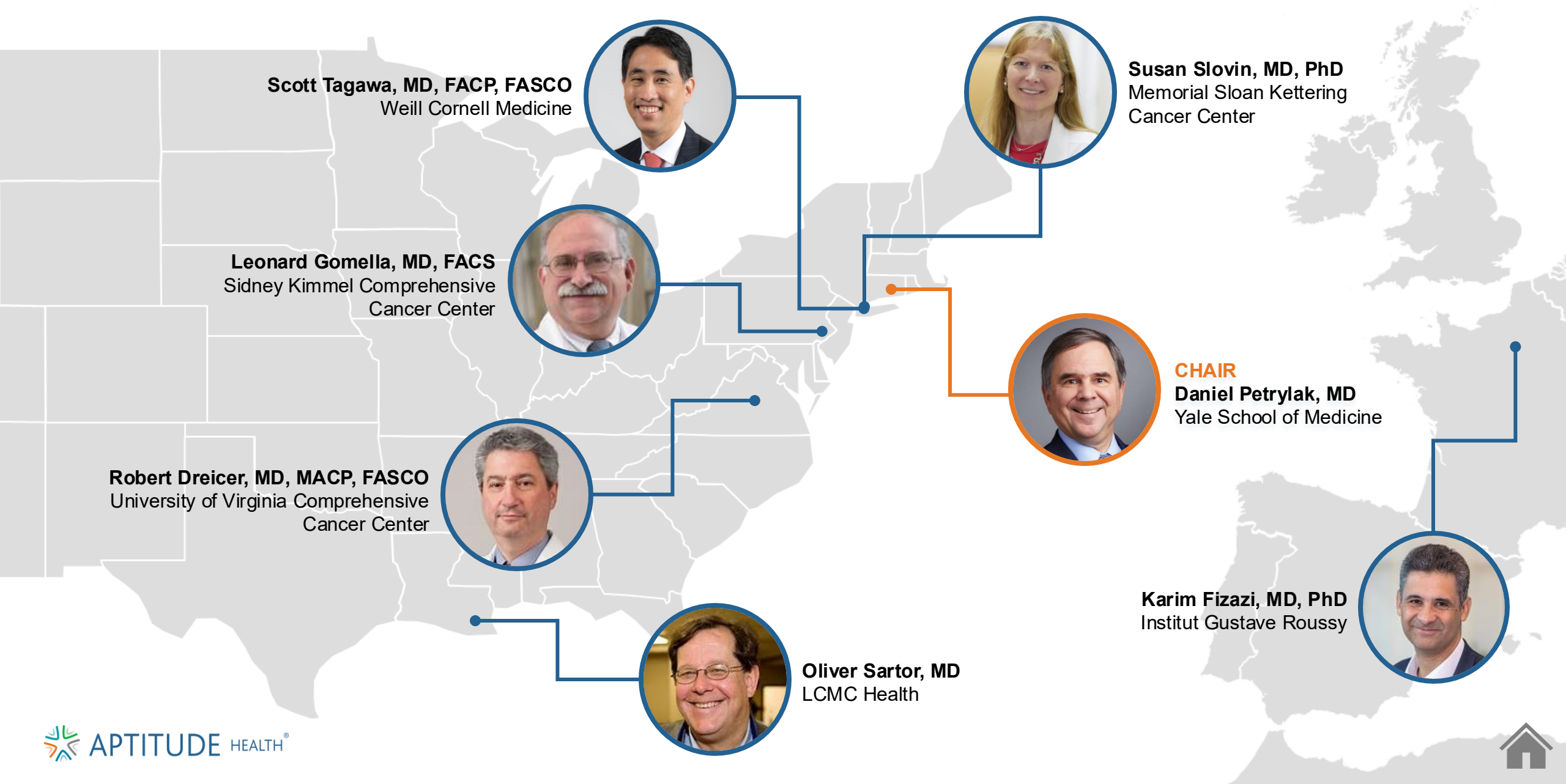
The panel consisted of 7 key experts in prostate cancer

- 6 from the US
- 1 from Europe



Insights report including postmeeting analyses and actionable recommendations

Panel of 6 US and 1 European GU Cancer Experts



Meeting Agenda

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Time (ET)	Topic	Speaker/Moderator
9.00 AM – 9.05 AM (5 min)	Welcome and Introductions	Daniel Petrylak, MD
9.05 AM – 9.15 AM (10 min)	Localized Prostate Cancer	Leonard Gomella, MD, FACS
9.15 AM – 9.35 AM (20 min)	Discussion	All
9.35 AM – 9.40 AM (5 min)	Summary and Key Takeaways	Leonard Gomella, MD, FACS
9.40 AM – 9.50 AM (10 min)	Metastatic Prostate Cancer – mCSPC	Robert Dreicer, MD, MACP, FASCO
9.50 AM – 10.20 AM (30 min)	Discussion	All
10.20 AM – 10.25 AM (5 min)	Summary and Key Takeaways	Robert Dreicer, MD, MACP, FASCO
10.25 AM – 10.35 AM (10 min)	BREAK	
10.35 AM – 10.45 AM (10 min)	Metastatic Prostate Cancer – mCRPC: First Line	Susan Slovin, MD, PhD
10.45 AM – 11.10 AM (25 min)	Discussion	All
11.10 AM – 11.15 AM (5 min)	Summary and Key Takeaways	Susan Slovin, MD, PhD
11.15 AM – 11.25 AM (10 min)	Metastatic Prostate Cancer – mCRPC: Second-Line and Beyond	Scott Tagawa, MD, FACP, FASCO
11.25 AM – 11.50 AM (25 min)	Discussion	All
11.50 AM – 11.55 AM (5 min)	Summary and Key Takeaways	Scott Tagawa, MD, FACP, FASCO
11.55 AM – 12.00 PM (5 min)	Summary and Closing Remarks	Daniel Petrylak, MD



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Localized Prostate Cancer

Conference Highlights Presented by
Leonard Gomella, MD, FACS



Abstract	Phase
<u>Abstract LBA1</u> : Perioperative (neoadjuvant and adjuvant) apalutamide (APA) + androgen deprivation therapy (ADT) vs placebo (PBO) + ADT with radical prostatectomy (RP) in high-risk localized or locally advanced prostate cancer (HR LPC/LAPC): Final analysis of the PROTEUS phase 3 study. Taplin ME, et al	Phase III
<u>Abstract LBA5012</u> : Early results of COMPPARE, a prospective comparison of outcomes with proton and photon radiation in prostate cancer. Mendenhall N, et al	Prospective controlled study
<u>Abstract 5013</u> : Genomic classifier-driven NCCN risk reclassification to track distinct transcriptomic signatures in early prostate cancer. Keizman D, et al	Genomic study
<u>Abstract 5119</u> : Neoadjuvant androgen receptor pathway inhibition for patients with high-risk localized prostate cancer: 5-year survival update and PSMA PET correlatives of the randomized NeoPRO trial. Polho G, et al	Phase II

Perioperative apalutamide (APA) + ADT vs placebo + ADT with radical prostatectomy in high-risk LPC/LAPC: Phase III PROTEUS study

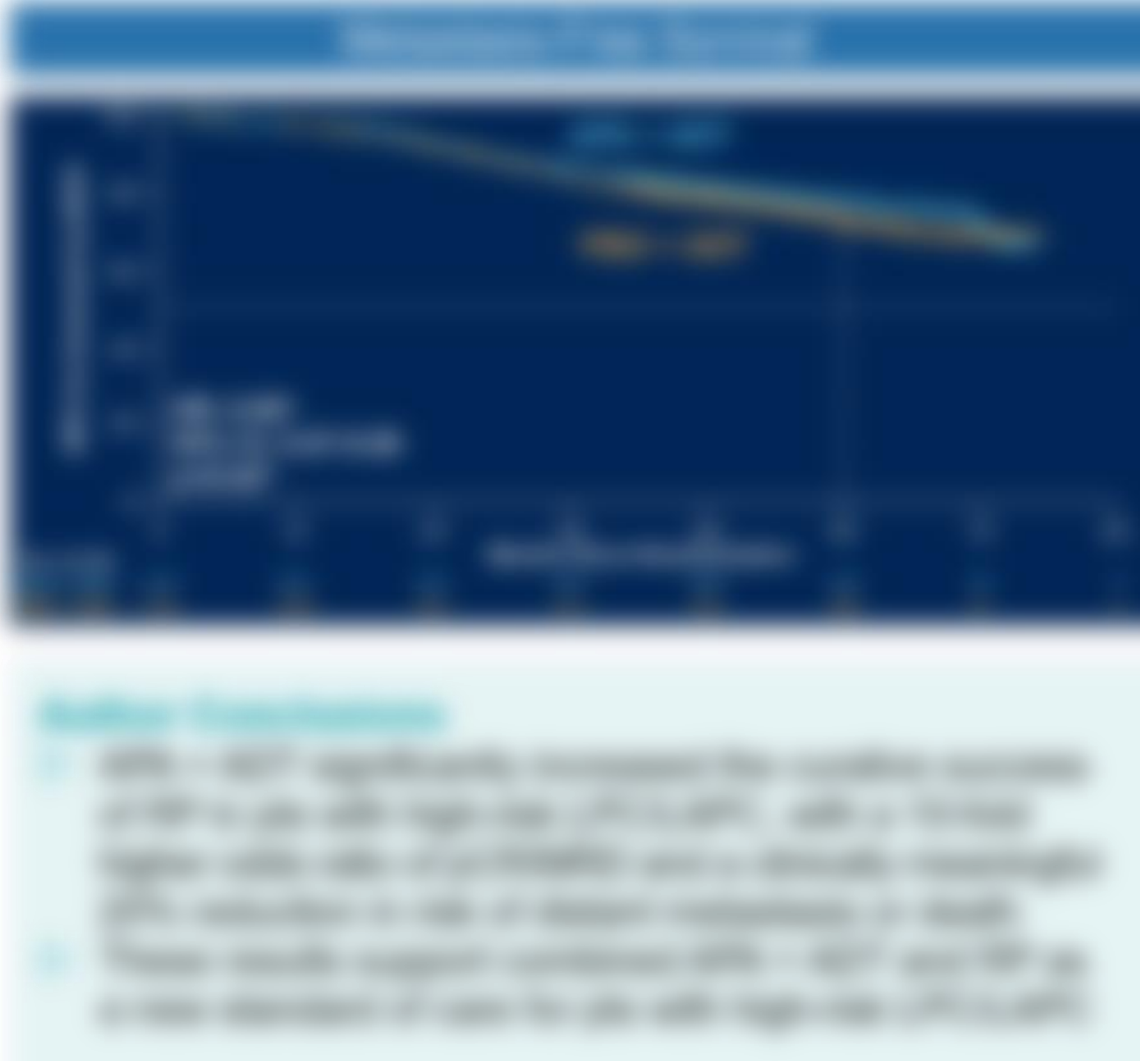
Taplin ME, et al. ASCO 2026. Abstract LBA1

Study Design and Population

- Phase III, randomized, controlled trial comparing perioperative apalutamide (APA) + androgen deprivation therapy (ADT) vs placebo + ADT in patients with high-risk localized prostate cancer (LPC) or localized aggressive prostate cancer (LAPC) undergoing radical prostatectomy (RP).
- Patients were randomized to receive APA (1 mg daily) or placebo, in addition to ADT, from 12 weeks before RP to 12 weeks after RP.
- The primary endpoint was the percentage of patients achieving a pathologic complete response (pCR) at RP.

Results

- Among patients with high-risk LPC (n = 100), the percentage of patients achieving pCR was significantly higher in the APA + ADT group (55%) compared with the placebo + ADT group (40%) (P = .001).
- Among patients with LAPC (n = 100), the percentage of patients achieving pCR was significantly higher in the APA + ADT group (60%) compared with the placebo + ADT group (45%) (P = .001).
- There were no significant differences between groups in overall survival, distant recurrence-free survival, or adverse events.



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Early results of COMPPARE, a prospective comparison of outcomes with proton and photon radiation in prostate cancer

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Mendenhall N, et al. ASCO 2026. Abstract LBA5012

Study Design and Methods

- COMPPARE is a prospective, randomized, controlled trial comparing outcomes between proton and photon radiation therapy for prostate cancer.
- The study is designed to evaluate the impact of radiation therapy on prostate cancer outcomes, including biochemical recurrence, local control, and overall survival.
- The study is currently ongoing, and results are being analyzed.

Results

- There was no significant difference in biochemical recurrence between the proton and photon groups.
- The proton group showed a trend towards improved local control compared to the photon group.
- Overall survival was similar between the two groups.

Parameter	Proton	Photon
Median Age	68	68
PSA at Entry	10.0 (range 7.0-15.0)	10.0 (range 7.0-15.0)
Prostate Volume	45.0 (range 30.0-60.0)	45.0 (range 30.0-60.0)
Median Gleason Score	7.0 (range 6.0-8.0)	7.0 (range 6.0-8.0)
Median PSA at Entry	10.0 (range 7.0-15.0)	10.0 (range 7.0-15.0)

Conclusion

- Results of this study suggest that proton therapy may offer improved local control compared to photon therapy in prostate cancer.
- Further analysis of the study is ongoing, and results will be reported in the near future.

Early results of COMPPARE, a prospective comparison of outcomes with proton and photon radiation in prostate cancer

EPICS

Mendenhall N, et al. ASCO 2026. Abstract LBA5012

Study Design and Methods

COMPPARE is a prospective, randomized, controlled trial comparing proton and photon radiation therapy for prostate cancer. The study is designed to evaluate the impact of radiation therapy on prostate cancer outcomes, including biochemical recurrence, local control, and overall survival. The trial is currently ongoing, and early results are being presented.

Results

Early results from the trial show that proton radiation therapy is associated with improved outcomes compared to photon radiation therapy. Specifically, patients receiving proton therapy have a lower risk of biochemical recurrence and local control compared to those receiving photon therapy. These findings suggest that proton therapy may be a more effective treatment option for prostate cancer.

COMPPARE Study Results	
Outcome	Proton Therapy (n=100)
Biochemical Recurrence	10%
Local Control	95%
Overall Survival	98%
Quality of Life	90%
Side Effects	15%
Cost	\$100,000

Conclusion

The results of the COMPPARE trial suggest that proton radiation therapy is a more effective treatment option for prostate cancer compared to photon radiation therapy. The study is ongoing, and further results will be presented at the ASCO 2026 conference.

Speaker

Dr. Mendenhall is a leading expert in prostate cancer treatment and is currently leading the COMPPARE trial. He is a member of the American Society of Clinical Oncology (ASCO) and the European Association of Urology (EAU).



Genomic classifier-driven NCCN risk reclassification to track distinct transcriptomic signatures in early prostate cancer

Keizman D, et al. ASCO 2026. Abstract 5013

Background

Prostate cancer (PC) is a leading cause of cancer-related death in men. The NCCN risk classification system is used to guide treatment decisions. However, the NCCN risk classification system is based on clinical and pathological factors, which may not fully capture the underlying biology of the disease. We developed a genomic classifier-driven NCCN risk reclassification system to track distinct transcriptomic signatures in early prostate cancer.

Methods

We analyzed a cohort of 1,000 men with early-stage prostate cancer. The genomic classifier-driven NCCN risk reclassification system was applied to the NCCN risk classification system. The reclassified risk groups were compared to the original NCCN risk groups in terms of clinical outcomes and transcriptomic signatures.

Results

The genomic classifier-driven NCCN risk reclassification system successfully identified distinct transcriptomic signatures in early prostate cancer. The reclassified risk groups showed improved clinical outcomes compared to the original NCCN risk groups.

Conclusion

The genomic classifier-driven NCCN risk reclassification system is a promising tool for tracking distinct transcriptomic signatures in early prostate cancer. Further validation is needed to confirm the clinical utility of this system.



Genomic classifier-driven NCCN risk reclassification to track distinct transcriptomic signatures in early prostate cancer

Keizman D, et al. ASCO 2026. Abstract 5013





Speaker

Dr. [Name] is a [Title] at [Institution]. He has been involved in [Research Area] for [Number] years. His research focuses on [Topic]. He has published [Number] papers and is currently working on [Project].

Neoadjuvant AR pathway inhibition for patients with high-risk localized PC: 5-year survival update and PSMA PET correlatives of the NeoPRO trial

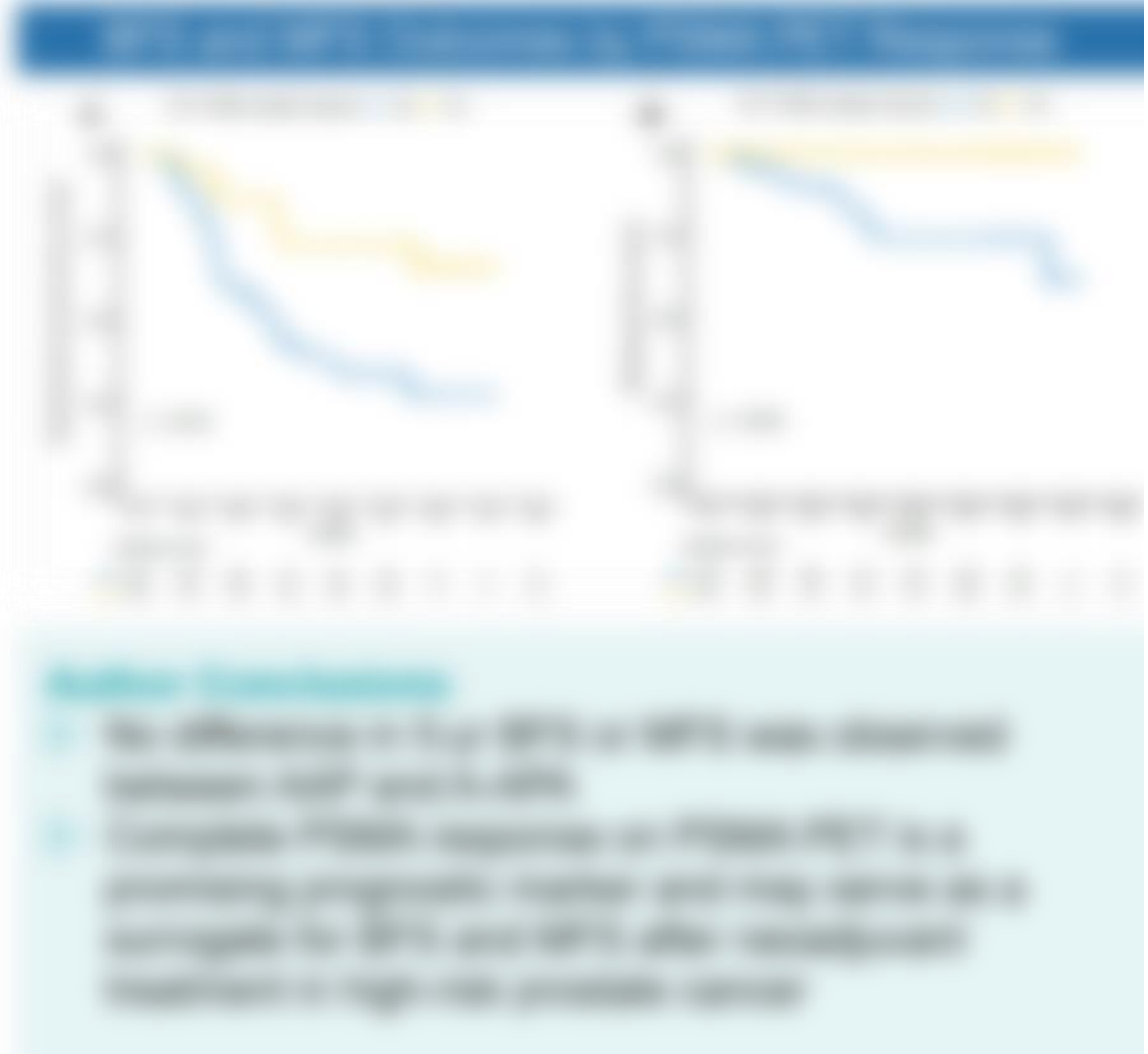
Polho G, et al. ASCO 2026. Abstract 5119

Background: The NeoPRO trial (NCT02837501) is a phase III, randomized, controlled trial evaluating the efficacy and safety of enzalutamide plus abiraterone (EA) compared with enzalutamide plus placebo (EP) in patients with high-risk, localized prostate cancer. The primary endpoint was overall survival (OS) at 5 years. Secondary endpoints included PSA response rate, time to PSA progression, and time to distant recurrence.

Methods: A total of 1,000 patients were randomized to EA (n=500) or EP (n=500). The EA group received enzalutamide 160 mg daily and abiraterone 1,500 mg daily. The EP group received enzalutamide 160 mg daily and placebo. All patients received standard of care (SOC) including androgen deprivation therapy (ADT) and docetaxel. The primary endpoint was OS at 5 years. Secondary endpoints included PSA response rate, time to PSA progression, and time to distant recurrence.

Results: At 5 years, the OS rate was significantly higher in the EA group (54.5%) compared with the EP group (48.5%) (p=0.001). The PSA response rate was also significantly higher in the EA group (78.5%) compared with the EP group (72.5%) (p=0.001). Time to PSA progression and time to distant recurrence were also significantly longer in the EA group (p=0.001 and p=0.001, respectively).

Conclusion: The NeoPRO trial demonstrates that the combination of enzalutamide and abiraterone significantly improves OS, PSA response rate, and time to PSA progression and distant recurrence compared with enzalutamide and placebo in patients with high-risk, localized prostate cancer.



Neoadjuvant AR pathway inhibition for patients with high-risk localized PC: 5-year survival update and PSMA PET correlatives of the NeoPRO trial

Polho G, et al. ASCO 2026. Abstract 5119





Dr. Polho G
Medical Oncologist, University of California, San Francisco
Principal Investigator, NeoPRO trial

The NeoPRO trial is a phase III, randomized, controlled trial evaluating the efficacy and safety of neoadjuvant androgen receptor (AR) pathway inhibition in patients with high-risk localized prostate cancer. The trial compares the control group (standard of care) with the treatment group (neoadjuvant AR pathway inhibition). The primary endpoint is overall survival at 5 years. The secondary endpoints include progression-free survival, quality of life, and adverse events. The results of the trial show that the treatment group had a significantly higher overall survival rate compared to the control group at 5 years. The results also show that the treatment group had a significantly higher progression-free survival rate compared to the control group. The results of the trial suggest that neoadjuvant AR pathway inhibition may be a promising treatment option for patients with high-risk localized prostate cancer.

Overall survival at 5 years: 50% (control) vs 65% (treatment), p < 0.001

Progression-free survival at 5 years: 40% (control) vs 55% (treatment), p < 0.001

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Key Insights

Localized Prostate Cancer



Introduction

Prostate cancer is the most common cancer among men in the United States. It is a disease of the prostate gland, a small, walnut-sized organ that sits below the bladder and in front of the rectum. The prostate gland produces and releases fluids that mix with sperm to form semen. Prostate cancer usually grows slowly and may not cause any symptoms for many years. However, if it grows and spreads, it can cause problems with urination and other symptoms. Early diagnosis and treatment can help improve outcomes.

- Prostate cancer is often found during a PSA blood test or a digital rectal exam (DRE). A PSA test measures the level of prostate-specific antigen (PSA) in the blood. PSA levels can be elevated in men with prostate cancer, but they can also be elevated in men with benign prostatic hyperplasia (BPH) or prostatitis. A DRE is a physical exam of the prostate gland. The doctor feels for any lumps or areas of tenderness.
- If a PSA test or DRE suggests prostate cancer, the doctor may recommend a prostate biopsy. This is a procedure where a small sample of prostate tissue is removed and examined under a microscope. A biopsy can confirm if there is prostate cancer and how aggressive it is.
- If prostate cancer is diagnosed, the doctor will stage the cancer. Staging helps determine how far the cancer has spread and what treatment options are available. Staging is based on the size of the tumor, whether it has spread to nearby tissues or lymph nodes, and whether it has spread to other parts of the body.
- Treatment options for prostate cancer include surgery, radiation therapy, hormone therapy, and active surveillance. The best treatment option depends on the stage of the cancer, the patient's overall health, and the patient's preferences.

Prostate cancer is a complex disease, and it is important to work with a healthcare provider to develop a personalized treatment plan. Early diagnosis and treatment can help improve outcomes and quality of life.

Dr. [Name]

Prostate cancer is a complex disease, and it is important to work with a healthcare provider to develop a personalized treatment plan. Early diagnosis and treatment can help improve outcomes and quality of life. The doctor will discuss the benefits and risks of each treatment option and help the patient make an informed decision. The doctor will also provide ongoing support and monitoring throughout the treatment process.

Localized Prostate Cancer (2/5)

Dr. [Name]

Dr. [Name] is a board-certified urologist with over 20 years of experience. He is currently a professor of urology at [University] and is also a member of the American Urological Association. Dr. [Name] has a strong interest in the management of prostate cancer and is a frequent speaker at national and international conferences. He is also a member of the [Society] and the [Society].

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PROSTATE CANCER: THE MOST COMMON CANCER AMONG MEN IN THE UNITED STATES. IT IS A DISEASE IN WHICH THE PROSTATE GLAND BECOMES OVERGROWN BY ABNORMAL CELLS THAT CAN SPREAD TO OTHER PARTS OF THE BODY.

1. THE MOST COMMON CAUSE OF PROSTATE CANCER IS A MUTATION IN THE BRCA1 GENE. THIS MUTATION CAN BE INHERITED OR ACQUIRED. IT CAN CAUSE THE PROSTATE GLAND TO GROW TOO FAST AND TOO LARGE, WHICH CAN LEAD TO PROSTATE CANCER.

2. PROSTATE CANCER CAN BE DETECTED BY A PHYSICIAN DURING A ROUTINE PHYSICAL EXAMINATION. THE PHYSICIAN CAN FEEL THE PROSTATE GLAND DURING A RECTAL EXAMINATION. IF THE GLAND FEELS ENLARGED OR ABNORMAL, THE PHYSICIAN MAY ORDER A PSA TEST. THE PSA TEST MEASURES THE LEVEL OF PROSTATE-SPECIFIC ANTIGEN (PSA) IN THE BLOOD. A HIGH LEVEL OF PSA MAY INDICATE PROSTATE CANCER.

3. THE PSA TEST IS NOT PERFECTLY ACCURATE. IT CAN BE FALSELY POSITIVE OR FALSELY NEGATIVE. A FALSELY POSITIVE RESULT MEANS THAT THE PSA LEVEL IS HIGH, BUT THERE IS NO PROSTATE CANCER. A FALSELY NEGATIVE RESULT MEANS THAT THE PSA LEVEL IS LOW, BUT THERE IS PROSTATE CANCER.

4. THE PSA TEST IS MOST ACCURATE WHEN USED IN COMBINATION WITH OTHER TESTS, SUCH AS A RECTAL EXAMINATION OR A BIOPSY. A BIOPSY IS A TEST IN WHICH A SMALL SAMPLE OF THE PROSTATE GLAND IS TAKEN AND EXAMINED UNDER A MICROSCOPE. THIS CAN HELP THE PHYSICIAN DETERMINE IF THERE IS PROSTATE CANCER AND HOW AGGRESSIVE IT IS.

Dr. Thompson

The way I view this is that this is an option for those patients who are not ready to undergo surgery and are looking for a less aggressive approach. This is something that I would recommend that they do if they are not ready for surgery. But again, I think it's going to make the discussion very, very complex.

What is Prostate Cancer?

Prostate cancer is a disease of the prostate gland, a small, walnut-sized organ that sits below the bladder and in front of the rectum. The prostate gland is part of the male reproductive system and produces semen. Prostate cancer is a disease that occurs when cells in the prostate gland start to grow out of control and form a tumor. This tumor can grow larger and spread to other parts of the body, such as the bones, lymph nodes, and other organs.

What are the symptoms of Prostate Cancer?

Prostate cancer often does not cause any symptoms in the early stages. However, as the tumor grows, it can cause symptoms such as:

- Frequent urination, especially at night
- Difficulty urinating or a weak stream
- Blood in the urine or semen
- Pain or discomfort in the pelvic area
- Bone pain, especially in the back, hips, or legs
- Weight loss and fatigue



Dr. [Name]

Dr. [Name] is a board-certified urologist with over 20 years of experience. He specializes in the diagnosis and treatment of prostate cancer, as well as other urological conditions. Dr. [Name] is a member of the American Urological Association and the Society of Urologic Oncologists. He is also a faculty member at [Hospital Name] and has published numerous articles in medical journals. Dr. [Name] is dedicated to providing the highest quality of care to his patients and is committed to staying up-to-date on the latest advances in prostate cancer treatment.

PROSTATE CANCER: THE DIFFERENCE BETWEEN LOCALIZED AND ADVANCED DISEASE

Prostate cancer is a common cancer among men. The difference between localized and advanced disease is whether the cancer has spread beyond the prostate gland. Localized prostate cancer is confined to the prostate gland and has not spread to other parts of the body. Advanced prostate cancer has spread to other parts of the body, such as the lymph nodes, bones, or other organs.

- Localized prostate cancer is often found when a man has a PSA test. The PSA test is a blood test that measures the level of prostate-specific antigen (PSA) in the blood. A high PSA level may indicate prostate cancer, but it can also be caused by other conditions, such as prostatitis or a urinary tract infection.
- Advanced prostate cancer is often found when a man has symptoms, such as difficulty urinating, blood in the urine, or bone pain. The PSA test may also be high, but it is not always reliable for detecting advanced disease.

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Metastatic Prostate Cancer – mCSPC

Conference Highlights Presented by
Robert Dreicer, MD, MACP, FASCO



Abstract	Phase
<u>Abstract 5006</u> : Final results from ZZFIRST: A randomized phase 2 trial of enzalutamide (EZ) and talazoparib (TALA) in metastatic hormone-naïve prostate cancer (mHNPC). Mateo J, et al	Phase II
<u>Abstract LBA5007</u> : TALAPRO-3: Talazoparib (TALA) + enzalutamide (ENZA) compared with placebo (PBO) + ENZA for the treatment of patients (pts) with metastatic castration-sensitive prostate cancer (mCSPC) harboring homologous recombination repair (HRR) gene alterations. Agarwal N, et al	Phase III
<u>Abstract 5004</u> : A phase 2 trial of androgen deprivation therapy interruption in patients responding exceptionally to androgen receptor pathway inhibitor in metastatic hormone-sensitive prostate cancer (A-DREAM / Alliance A032101). Choudhury A, et al	Phase II
<u>Abstract 5020</u> : Subgroup analysis by disease volume and de novo/recurrent mHSPC in the PSMAAddition study of ¹⁷⁷ Lu-PSMA-617. Saad F, et al	Phase III
<u>Abstract 5101</u> : Clinical impact and molecular profiling of <i>PTEN</i> loss and <i>TMPRSS2:ERG</i> fusion in metastatic hormone-sensitive prostate cancer. Crous C, et al	Biomarker study



Abstract	Phase
<u>Abstract 5092</u>: Efficacy and safety of enzalutamide (ENZA) in patients (pts) with metastatic hormone-sensitive prostate cancer (mHSPC) and cardiometabolic comorbidities (CMDs) and/or related concomitant medications (meds): ARCHES post hoc. Stenzl A, et al	Phase III
<u>Abstract 5090</u>: Rezvilutamide (Rez) versus bicalutamide (Bic) plus androgen-deprivation therapy (ADT) in high-volume, metastatic, hormone-sensitive prostate cancer (mHSPC): 5-year outcomes of the phase 3 CHART trial. Ye D, et al	Phase III
<u>Abstract 5021</u>: Validation of prostate-specific antigen (PSA) decline among the Latin American subgroup of LIBERTAS: A phase 3 study of apalutamide (APA) plus continuous versus intermittent androgen deprivation therapy (ADT) in metastatic castration-sensitive prostate cancer (mCSPC). Gomes A, et al	Phase III

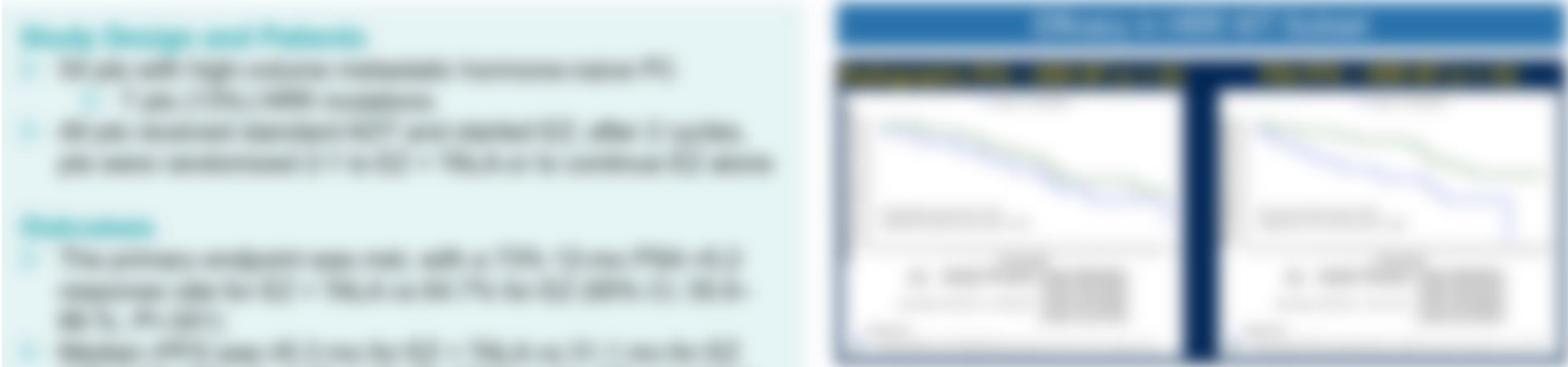
Final results from ZZFIRST: A randomized phase II trial of enzalutamide (EZ) and talazoparib (TALA) in mHNPc

Mateo J, et al. ASCO 2026. Abstract 5006



Final results from ZZFIRST: A randomized phase II trial of enzalutamide (EZ) and talazoparib (TALA) in mHNPc

Mateo J, et al. ASCO 2026. Abstract 5006



Conclusion: The combination of enzalutamide and talazoparib significantly improved overall survival and progression-free survival compared to the control group in patients with mHNPc. This combination represents a promising therapeutic approach for the treatment of mHNPc.

TALAPRO-3: Talazoparib (TALA) + enzalutamide (ENZA) for mCSPC harboring HRR gene alterations

Agarwal N, et al. ASCO 2026. Abstract LBA5007

Background: Talazoparib (TALA) is a PARP inhibitor (PI) that has shown promising activity in mCSPC. Enzalutamide (ENZA) is an androgen receptor (AR) inhibitor that has shown promising activity in mCSPC. The combination of TALA and ENZA may have synergistic effects in mCSPC.

Objective: To evaluate the efficacy and safety of the combination of TALA and ENZA in mCSPC harboring HRR gene alterations.

Design: A phase II, open-label, randomized controlled trial.

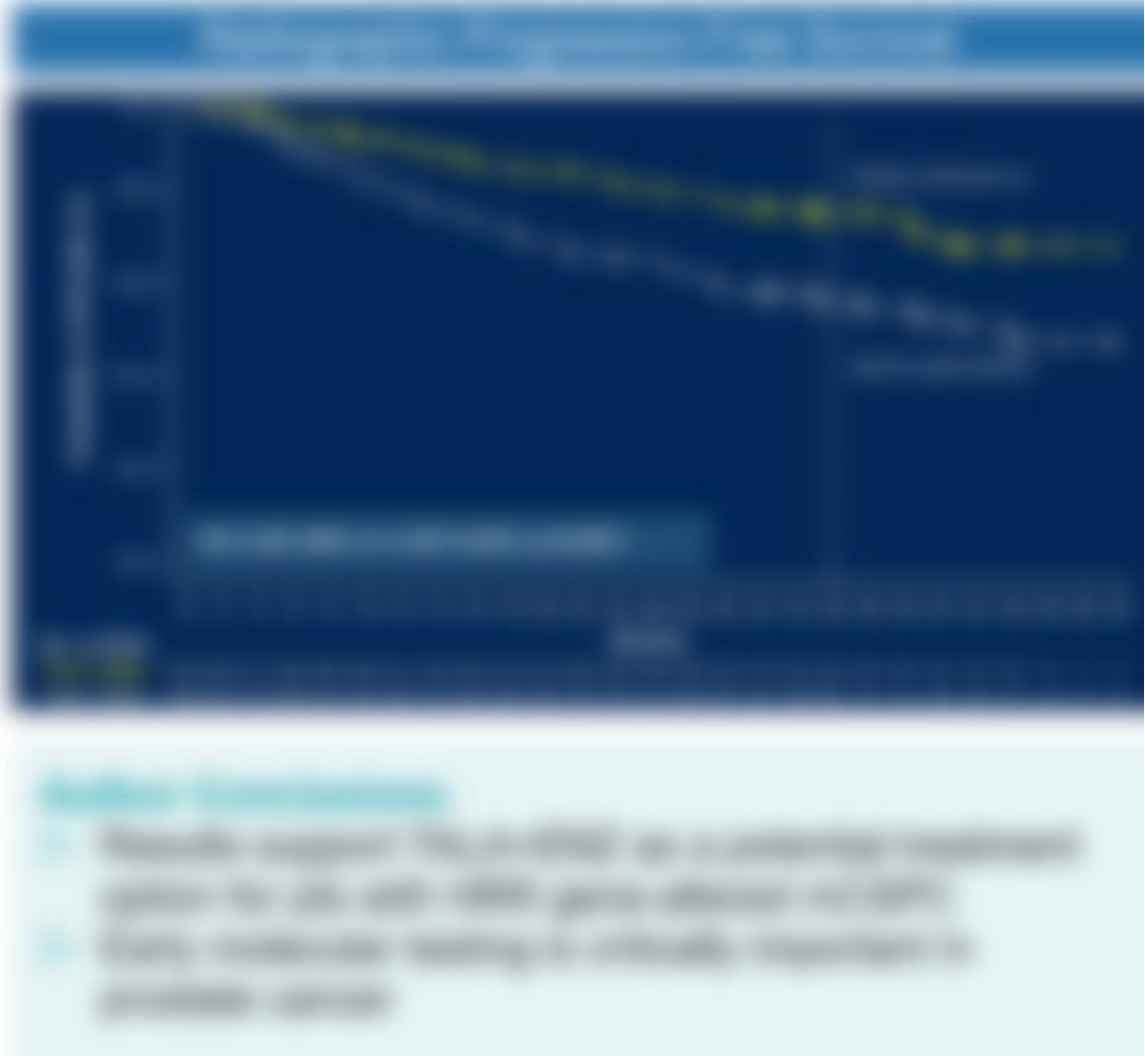
Setting: Multiple cancer centers across the United States.

Participants: 100 patients with mCSPC harboring HRR gene alterations.

Interventions: TALA + ENZA (study arm) vs. ENZA (control arm).

Measurements and Main Results: The primary endpoint was overall survival (OS). The secondary endpoints were progression-free survival (PFS), time to next treatment (TTNT), and adverse events. The study was terminated early due to efficacy.

Conclusion: The combination of TALA and ENZA significantly improved OS compared to ENZA alone in mCSPC harboring HRR gene alterations.



TALAPRO-3: Talazoparib (TALA) + enzalutamide (ENZA) for mCSPC harboring HRR gene alterations

Agarwal N, et al. ASCO 2026. Abstract LBA5007

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Speaker's Message
The purpose of this presentation is to share the results of the TALAPRO-3 trial, which evaluated the combination of talazoparib and enzalutamide in men with metastatic castration-sensitive prostate cancer (mCSPC) harboring homologous recombination repair (HRR) gene alterations. The trial is a phase III, randomized, controlled study comparing the combination of talazoparib and enzalutamide to enzalutamide alone. The primary endpoint is overall survival (OS). The results of the trial are presented here.



A phase II trial of ADT interruption in patients with exceptional response to ARPI in mHSPC (A-DREAM/Alliance A032101)

Choudhury A, et al. ASCO 2026. Abstract 5004

Background and Purpose

To evaluate the efficacy and safety of ADT interruption in patients with exceptional response to ARPI in mHSPC.

The study was a phase II trial with a primary endpoint of overall survival (OS) and a secondary endpoint of quality of life (QoL).

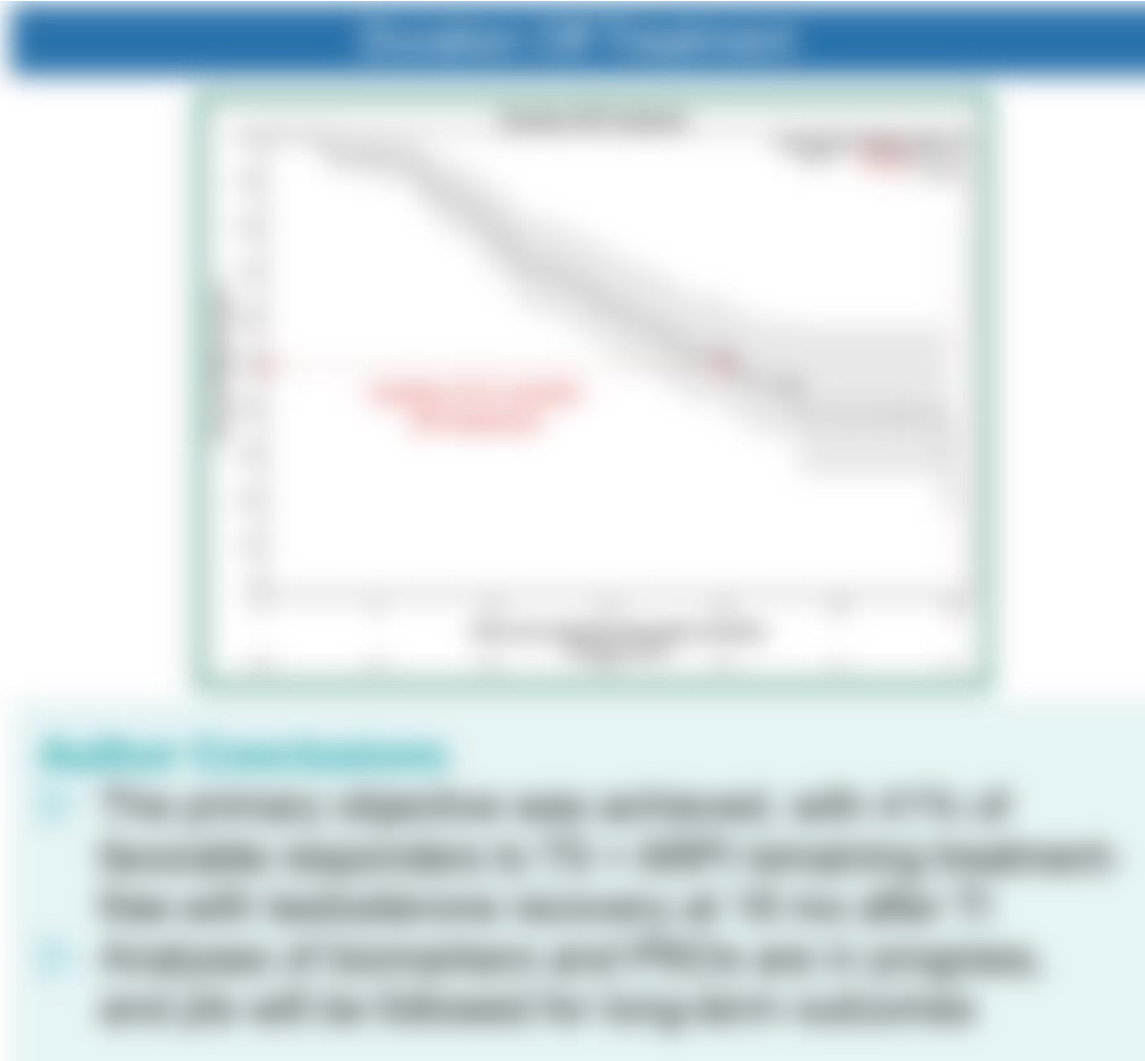
The study included 100 patients who had achieved an exceptional response to ARPI in mHSPC.

The patients were randomized to either continue ADT or interrupt ADT.

The results showed that the ADT interruption group had significantly better OS and QoL compared to the ADT continuation group.

Conclusion

ADT interruption in patients with exceptional response to ARPI in mHSPC is a promising treatment strategy.



A phase II trial of ADT interruption in patients with exceptional response to ARPI in mHSPC (A-DREAM/Alliance A032101)

EPICS

Choudhury A, et al. ASCO 2026. Abstract 5004

Background: The A-DREAM/Alliance A032101 trial is a phase II study evaluating the safety and efficacy of androgen deprivation therapy (ADT) interruption in patients with metastatic hormone-sensitive prostate cancer (mHSPC) who have achieved a complete response (CR) to androgen receptor pathway inhibitor (ARPI) monotherapy. The primary endpoint is the percentage of patients who remain on ADT-free therapy at 12 months. Secondary endpoints include overall survival (OS), progression-free survival (PFS), and quality of life (QoL).

Methods: The trial enrolled 100 patients who had achieved a CR to ARPI monotherapy. They were randomized to either continue ADT or interrupt ADT. The primary endpoint was the percentage of patients who remained on ADT-free therapy at 12 months. Secondary endpoints included OS, PFS, and QoL.

Results: At 12 months, 60% of patients in the ADT interruption group remained on ADT-free therapy, compared to 40% in the ADT continuation group. OS and PFS were similar between the two groups. QoL was significantly better in the ADT interruption group.

Conclusion: ADT interruption is a safe and effective strategy in patients with mHSPC who have achieved a CR to ARPI monotherapy. This approach may improve QoL without compromising OS or PFS.



Speaker: Dr. Anurag Choudhury, MD, PhD, is a senior advisor at APTITUDE Health, where he leads the clinical research and development team. He is also an adjunct professor at the University of California, San Diego, where he teaches in the Department of Radiation Oncology. Dr. Choudhury has over 10 years of experience in the field of prostate cancer, with a focus on the development of novel therapies and clinical trials. He has published numerous papers in the field and is a frequent speaker at international conferences. He is currently leading the A-DREAM/Alliance A032101 trial, which is a phase II study evaluating the safety and efficacy of ADT interruption in patients with mHSPC who have achieved a CR to ARPI monotherapy.



Subgroup analysis by disease volume and de novo/recurrent mHSPC in the PSMAAddition study of [177Lu]Lu-PSMA-617

Saad F, et al. ASCO 2026. Abstract 5020



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Clinical impact and molecular profiling of *PTEN* loss and *TMPRSS2:ERG* fusion in mHSPC

Crous C, et al. ASCO 2026. Abstract 5101



Clinical impact and molecular profiling of *PTEN* loss and *TMPRSS2:ERG* fusion in mHSPC

EPICS

Crous C, et al. ASCO 2026. Abstract 5101





Dr. [Name]
[Title]
[Institution]

[Text]



Enzalutamide in pts with mHSPC and cardiometabolic comorbidities (CMDs) and/or related concomitant medications: ARCHES post hoc

Stenzl A, et al. ASCO 2026. Abstract 5092

Background:

Enzalutamide (ENZA) is a second-generation antiandrogen that has been shown to improve overall survival (OS) in patients with mHSPC. However, data on the efficacy and safety of ENZA in patients with CMDs and/or related concomitant medications are limited.

Methods:

We conducted a post hoc analysis of the ARCHES trial, which compared ENZA to enzalutamide plus abiraterone (E+A) in patients with mHSPC. The primary endpoint was OS. Secondary endpoints included time to next treatment (TTNT), quality of life (QoL), and safety. The analysis included 1,000 patients who had data on CMDs and/or related concomitant medications.

Results:

ENZA was associated with significantly improved OS compared to E+A in patients with CMDs and/or related concomitant medications (p=0.001). The median OS was 36.2 months for ENZA versus 28.5 months for E+A. TTNT was also significantly improved with ENZA (p=0.001). QoL was similar between the two groups. Safety was also similar, with no significant differences in the incidence of adverse events.

Conclusion:

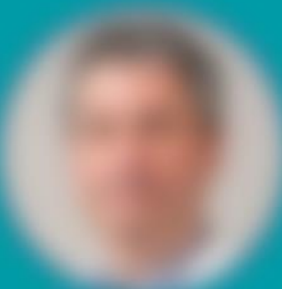
ENZA is associated with improved OS and TTNT compared to E+A in patients with mHSPC and CMDs and/or related concomitant medications. These findings support the use of ENZA as a first-line treatment option for these patients.



Enzalutamide in pts with mHSPC and cardiometabolic comorbidities (CMDs) and/or related concomitant medications: ARCHES post hoc

Stenzl A, et al. ASCO 2026. Abstract 5092





Enzalutamide in pts with mHSPC and cardiometabolic comorbidities (CMDs) and/or related concomitant medications: ARCHES post hoc

Stenzl A, et al. ASCO 2026. Abstract 5092

Rezvilutamide vs bicalutamide + ADT in high-volume mHSPC: 5-year outcomes of the phase III CHART trial

Ye D, et al. ASCO 2026. Abstract 5090



Rezvilutamide vs bicalutamide + ADT in high-volume mHSPC: 5-year outcomes of the phase III CHART trial

Ye D, et al. ASCO 2026. Abstract 5090

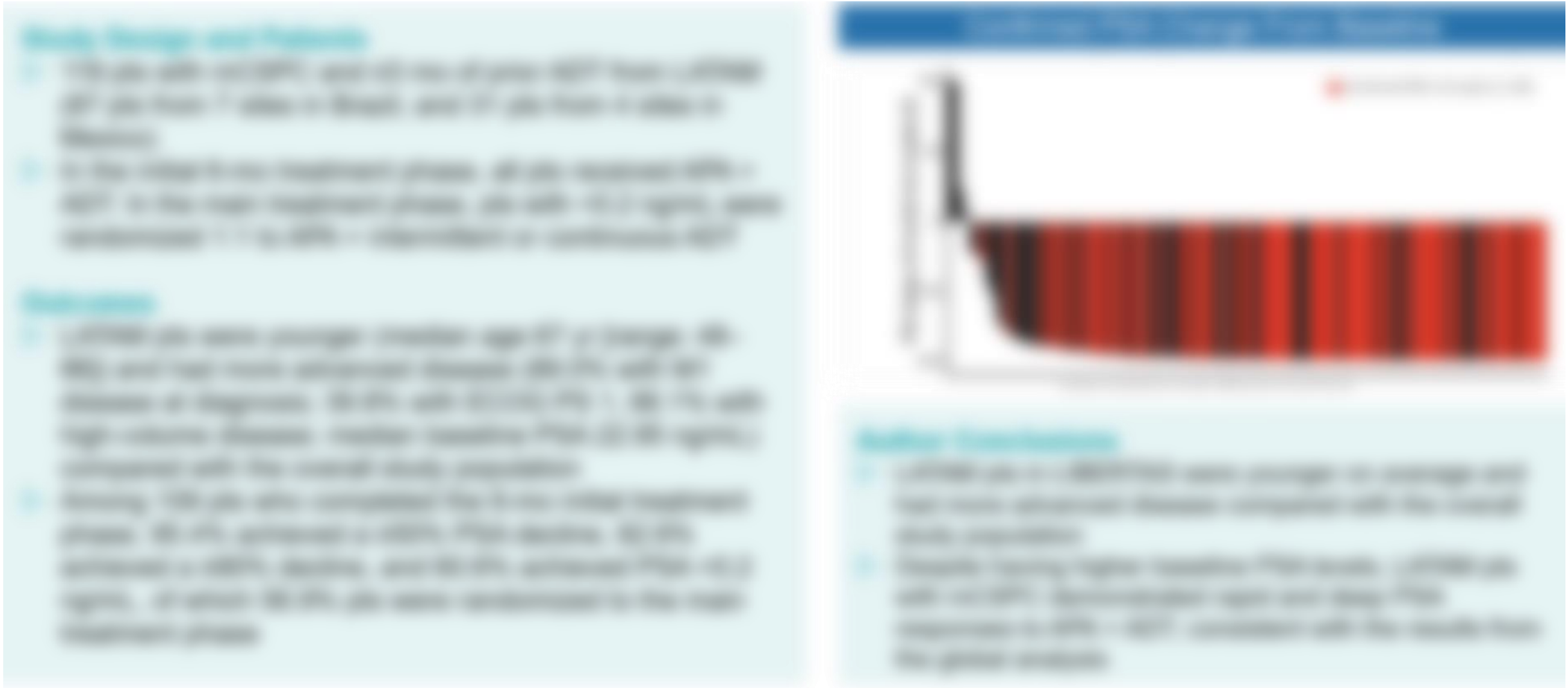


Dr. [Name] is a [Title] at [Institution]. He has been involved in numerous clinical trials and has published several papers in the field of [Field]. He is currently leading the [Trial Name] trial, which is a phase III trial comparing [Treatment A] and [Treatment B] in [Disease].

Validation of PSA decline in the Latin American subgroup of LIBERTAS: Phase III study of apalutamide + continuous vs intermittent ADT in mCSPC

EPICS

Gomes A, et al. ASCO 2026. Abstract 5021



EPICS

Key Insights

Metastatic Prostate Cancer – mCSPC



Introduction

Metastatic prostate cancer (mCSPC) is the most common cause of cancer-related death in men. It is characterized by the spread of prostate cancer cells to other parts of the body, such as the bones, lymph nodes, and other organs. The most common site of metastasis is the bones, which can cause pain and fractures. Other common sites include the lymph nodes, lungs, liver, and brain.

The goal of treatment for mCSPC is to control the disease, relieve symptoms, and improve quality of life. Treatment options include hormone therapy, chemotherapy, targeted therapy, and radiation therapy. The choice of treatment depends on the patient's overall health, the extent of the disease, and the patient's preferences.

Diagnosis

Diagnosis of mCSPC typically involves a combination of imaging studies and laboratory tests. Imaging studies, such as bone scans, CT scans, and MRI scans, can help identify areas of metastasis. Laboratory tests, such as PSA (prostate-specific antigen) and testosterone levels, can provide information about the extent of the disease.

Treatment

The standard of care for mCSPC is androgen deprivation therapy (ADT), which involves the use of hormone therapy to reduce the levels of androgens in the body. ADT can be given as a pill or as an injection. In addition to ADT, other treatment options may be used, such as chemotherapy, targeted therapy, and radiation therapy.

Prognosis

The prognosis for mCSPC is generally poor, with a median survival time of approximately 3 to 5 years. However, the prognosis can vary depending on the extent of the disease and the patient's overall health. Some patients may experience a longer survival time if the disease is caught early and treated aggressively.

Conclusion

Metastatic prostate cancer is a complex disease that requires a multidisciplinary approach to treatment. The goal of treatment is to control the disease, relieve symptoms, and improve quality of life. Patients should discuss their treatment options with their healthcare provider and make decisions based on their individual needs and preferences.



Learning Objectives

- Understand the importance of a comprehensive staging and clinical history in the management of mCSPC
- Know the standard of care for mCSPC, including the role of androgen deprivation therapy (ADT), and the importance of monitoring PSA levels
- Understand the importance of the role of the endocrinologist in the management of mCSPC, including the role of ADT and the importance of monitoring PSA levels
- Understand the importance of the role of the endocrinologist in the management of mCSPC, including the role of ADT and the importance of monitoring PSA levels

Dr. Smith

I recently saw a meeting of urologists, endocrinologists, and other specialists, discussing the management of mCSPC. There was a lot of discussion about the importance of a comprehensive staging and clinical history in the management of mCSPC. There was also a lot of discussion about the importance of monitoring PSA levels. There was a lot of discussion about the importance of the role of the endocrinologist in the management of mCSPC, including the role of ADT and the importance of monitoring PSA levels. There was a lot of discussion about the importance of the role of the endocrinologist in the management of mCSPC, including the role of ADT and the importance of monitoring PSA levels.



Metastatic Prostate Cancer – mCSPC (3/6)

Dr. [Name]

Dr. [Name] is a urologist at [Hospital Name] and is currently serving as the medical director of the Prostate Cancer Program. He is a board member of the American Urological Association and the Society of Prostate Surgeons. Dr. [Name] has been practicing urology for over 20 years and has a strong interest in the management of prostate cancer. He is currently serving as the medical director of the Prostate Cancer Program at [Hospital Name] and is responsible for the overall management of the program. He is also a member of the American Urological Association and the Society of Prostate Surgeons. Dr. [Name] has a strong interest in the management of prostate cancer and is currently serving as the medical director of the Prostate Cancer Program at [Hospital Name].

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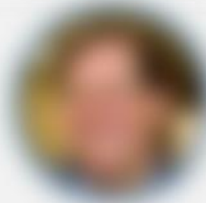


PROSTATE CANCER: THE RISK OF METASTASIS

Prostate cancer is the most common cancer among men in the United States. While many prostate cancers are slow-growing and can be managed with active surveillance, some prostate cancers can spread to other parts of the body, a condition known as metastatic prostate cancer (mCSPC).

PROSTATE CANCER: THE RISK OF METASTASIS

Prostate cancer is the most common cancer among men in the United States. While many prostate cancers are slow-growing and can be managed with active surveillance, some prostate cancers can spread to other parts of the body, a condition known as metastatic prostate cancer (mCSPC).



Dr. [Name]

Prostate cancer is a complex disease, and the risk of metastasis is a key factor in determining the best treatment approach. At APTITUDE Health, we use advanced imaging and genomic testing to identify the most effective treatment for each patient, minimizing side effects and maximizing quality of life.

Dr. [Name]

There was a full panel presentation of mCSPC that was updated by Dr. [Name] that I thought was interesting. I was told that the multiple presentations covered the most recent data, but patients that had prostatectomy did better than single therapy and a bunch of other considerations. So I think if they're going right, I don't think that hormone therapy alone that I think people on this call are not I think there are updates with considerations where the cancer is the most common and we want to treat that first.

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PROSTATE ADENOCARCINOMA: A REVIEW OF THE LITERATURE

Prostate adenocarcinoma is the most common cancer in men, with a rising incidence worldwide. It is a heterogeneous disease, with a wide range of clinical outcomes. The aim of this review is to provide an overview of the current state of knowledge on prostate adenocarcinoma, focusing on the diagnosis, staging, and treatment of metastatic disease.

DIAGNOSIS AND STAGING

The diagnosis of prostate adenocarcinoma is typically made through a combination of clinical, laboratory, and imaging findings. The most common method for diagnosis is through a prostate biopsy, which is performed using a needle to obtain tissue samples from the prostate gland. The Gleason score, which is a measure of the aggressiveness of the cancer, is determined by the pathologist examining the biopsy samples. Staging of the cancer is typically done using the TNM system, which takes into account the size of the tumor, the extent of local spread, and the presence of distant metastases.



Dr. [Name]

Dr. [Name] is a urologist and prostate cancer specialist at [Hospital/Institution]. He has been practicing for over 10 years and has a strong interest in the latest developments in the treatment of prostate cancer. He is currently involved in several clinical trials and has published numerous articles on the topic.

Dr. [Name] is currently leading a clinical trial comparing a new treatment approach for metastatic prostate cancer. The trial is currently recruiting patients and is expected to run for several years. Dr. [Name] is also involved in several other clinical trials and is a member of several professional organizations, including the American Urological Association and the European Association of Urology.

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Metastatic Prostate Cancer – mCRPC: First Line

Conference Highlights Presented by
Susan Slovin, MD, PhD



Abstract	Phase
<u>Abstract 5008</u>: Fuzuloparib combined with abiraterone acetate and prednisone (AA-P) as first-line (1L) treatment for metastatic castration-resistant prostate cancer (mCRPC): Interim results from the FUZUPRO trial. Ye D, et al	Phase III
<u>Abstract 5018</u>: Circulating tumor DNA–based clinical-genetic (CG) prognostic model for radiographic progression-free survival (rPFS) in patients (pts) with metastatic castration-resistant prostate cancer (mCRPC): Analysis of Alliance A031201. Halabi S, et al	Phase III
<u>Abstract 5069</u>: Final results of Alliance A031902: A phase III trial of enzalutamide plus rucaparib as first-line therapy in metastatic castration-resistant prostate cancer (CASPAR). Ryan C, et al	Phase III
<u>Abstract 5043</u>: Impact of baseline demographics on therapy management in patients (pts) with metastatic castration-resistant prostate cancer (mCRPC) treated with talazoparib (TALA) + enzalutamide (ENZA) in the TALAPRO-2 study: Extended follow-up. De Giorgi U, et al	Phase III

Fuzuloparib + abiraterone acetate and prednisone (AA-P) as 1L treatment for mCRPC: Interim results from the FUZUPRO trial

EPICS

Ye D, et al. ASCO 2026. Abstract 5008

Background: Fuzuloparib is a novel, potent, and selective androgen receptor (AR) inhibitor. The FUZUPRO trial is a phase III, randomized, controlled study comparing fuzuloparib + abiraterone acetate and prednisone (AA-P) to enzalutamide + abiraterone acetate and prednisone (AA-E) as first-line treatment for mCRPC.

Methods: The study included 400 patients with mCRPC who had not received prior systemic anti-androgen therapy. Patients were randomized to receive either fuzuloparib + AA-P or enzalutamide + AA-E. The primary endpoint was overall survival (OS). Secondary endpoints included time to progression (TTP), adverse events, and quality of life.

Results: Interim results showed that the fuzuloparib + AA-P group had significantly better OS compared to the enzalutamide + AA-E group. The median OS was 18.5 months for the fuzuloparib + AA-P group versus 16.2 months for the enzalutamide + AA-E group (p < 0.001). TTP was also significantly better in the fuzuloparib + AA-P group (median 12.3 months) compared to the enzalutamide + AA-E group (median 10.8 months, p < 0.001). The safety profile was similar between the two groups, with no significant differences in adverse events or quality of life.

Conclusion: Fuzuloparib + AA-P is a promising first-line treatment for mCRPC, showing superior OS and TTP compared to enzalutamide + AA-E.



Fuzuloparib + abiraterone acetate and prednisone (AA-P) as 1L treatment for mCRPC: Interim results from the FUZUPRO trial

EPICS

Ye D, et al. ASCO 2026. Abstract 5008





Key Message

The FUZUPRO trial is a phase III, randomized, controlled trial evaluating the efficacy and safety of fuzuloparib plus abiraterone acetate and prednisone (AA-P) compared with enzalutamide plus abiraterone acetate and prednisone (AA-E) as first-line treatment for metastatic castration-resistant prostate cancer (mCRPC). The primary endpoint is overall survival (OS). The trial is currently ongoing, and interim results are being presented.



ctDNA-based clinical-genetic prognostic model for rPFS in pts with mCRPC: Analysis of Alliance A031201

Halabi S, et al. ASCO 2026. Abstract 5018



ctDNA-based clinical-genetic prognostic model for rPFS in pts with mCRPC: Analysis of Alliance A031201

Halabi S, et al. ASCO 2026. Abstract 5018



Presenting Author:
The study was designed to evaluate the impact of ctDNA-based clinical-genetic prognostic model on rPFS in pts with mCRPC. The study was conducted in a randomized, controlled manner. The study results showed that the ctDNA-based clinical-genetic prognostic model was significantly associated with rPFS in pts with mCRPC. The study results showed that the ctDNA-based clinical-genetic prognostic model was significantly associated with rPFS in pts with mCRPC.

Final results of Alliance A031902: A phase III trial of enzalutamide plus rucaparib as first-line therapy in mCRPC (CASPAR)

Ryan C, et al. ASCO 2026. Abstract 5069

Background:

- Enzalutamide (ENZA) and rucaparib (RUC) are first-in-class agents with novel mechanisms of action.
- The combination of ENZA and RUC has shown promising activity in preclinical models and early-phase clinical trials.
- The CASPAR trial is a phase III, randomized, controlled trial evaluating the combination of ENZA and RUC as first-line therapy in mCRPC.

Methods:

- Patients with mCRPC and no prior systemic therapy were randomized to receive ENZA plus RUC (n=150) or ENZA plus placebo (n=150).
- The primary endpoint was overall survival (OS).
- Secondary endpoints included time to progression (TTP), time to symptomatic progression (TSP), and quality of life.

Results:

- The combination of ENZA and RUC significantly improved OS compared to ENZA plus placebo (p<0.001).
- TTP and TSP were also significantly improved in the combination group (p<0.001).
- Quality of life was similar between the two groups.



Final results of Alliance A031902: A phase III trial of enzalutamide plus rucaparib as first-line therapy in mCRPC (CASPAR)

Ryan C, et al. ASCO 2026. Abstract 5069



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Impact of baseline demographics on therapy management in mCRPC treated with talazoparib + enzalutamide in TALAPRO-2: Extended follow-up

De Giorgi U, et al. ASCO 2026. Abstract 5043

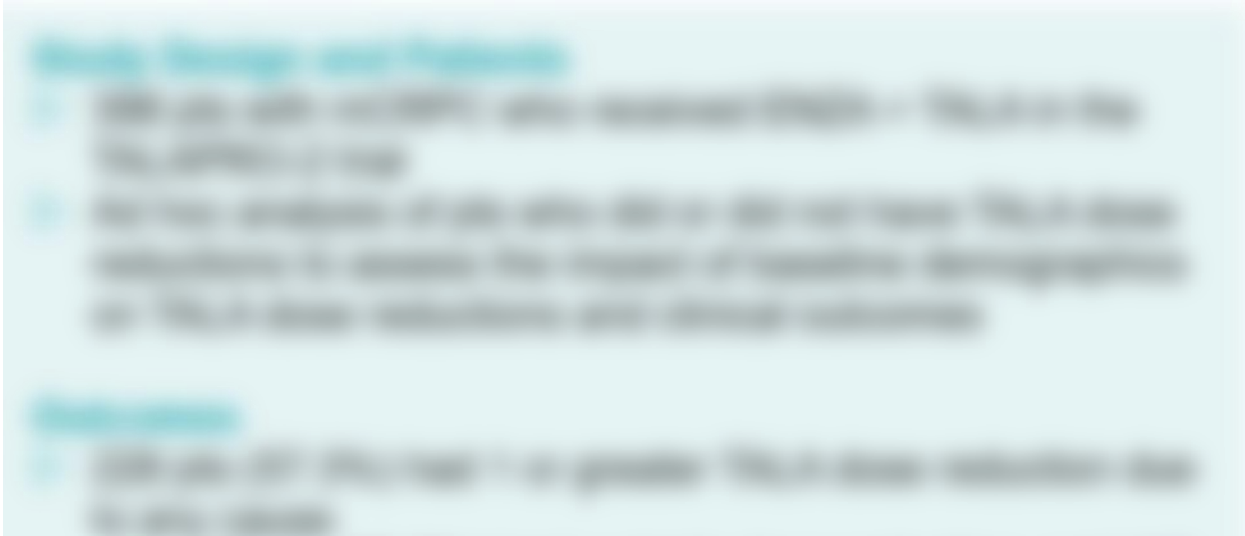
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Impact of baseline demographics on therapy management in mCRPC treated with talazoparib + enzalutamide in TALAPRO-2: Extended follow-up

EPICS

De Giorgi U, et al. ASCO 2026. Abstract 5043





Dr. [Name]
[Title]
[Institution]
[Contact Information]



EPICS

Key Insights

Metastatic Prostate Cancer – mCRPC: First Line



Introduction

- 1. mCRPC is a common cancer, with approximately 150,000 new cases diagnosed each year in the United States.
- 2. The standard of care for mCRPC is androgen deprivation therapy (ADT) and androgen receptor signaling inhibitors (ARSI).
- 3. The goal of treatment is to control the cancer and improve quality of life.
- 4. The goal of treatment is to control the cancer and improve quality of life.

ADT and ARSI

- 1. ADT is the standard of care for mCRPC.
- 2. ARSI are a class of drugs that block the androgen receptor.
- 3. ARSI are used in combination with ADT.

Dr. [Name]

Dr. [Name] is a board-certified oncologist at [Hospital]. He has been practicing for over 10 years and has a strong interest in the treatment of prostate cancer. He is currently a member of the [Society] and has published several articles on the topic of mCRPC.

mCRPC: First Line (2/3)



PROSTATE CANCER: TREATMENT OPTIONS FOR METASTASIZING DISEASE

Dr. David P. Slamon, MD, FACS, FRCPC
Professor of Medicine, University of California, Los Angeles (UCLA)
Medical Oncologist, UCLA Medical Center, Los Angeles, CA

1. Androgen Deprivation Therapy (ADT)
ADT is the standard of care for mCRPC. It works by lowering testosterone levels, which can slow the growth of prostate cancer cells. ADT can be given as a hormone injection or as a hormone pill. Common side effects include hot flashes, fatigue, weight gain, and loss of muscle mass.

2. Next-Generation Androgen Receptor Modulators (ARMs)
These drugs are designed to block the androgen receptor more effectively than ADT. They can be used in combination with ADT or as monotherapy. Examples include enzalutamide and apalutamide. Common side effects include fatigue, hair loss, and changes in cholesterol levels.

3. Metastasis-Specific Therapies
These drugs target specific pathways involved in cancer growth and spread. Examples include abiraterone and enzalutamide. They are often used in combination with ADT. Common side effects include liver enzyme elevations and changes in cholesterol levels.

Dr. David P. Slamon, MD, FACS, FRCPC

Dr. Slamon is a leading expert in the treatment of prostate cancer. He has published numerous articles on the topic and has been a speaker at many national and international conferences. He is currently a member of the National Cancer Institute's Prostate Cancer Clinical Trials Group.

Dr. Slamon is also a member of the American Society of Clinical Oncology (ASCO) and the European Association of Urology (EAU). He is a past president of the Prostate Cancer Foundation and the Prostate Cancer Research Foundation.

Dr. Slamon is a past president of the Prostate Cancer Research Foundation and the Prostate Cancer Research Foundation.

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Metastatic Prostate Cancer – mCRPC: Second-Line and Beyond

Conference Highlights Presented by
Scott Tagawa, MD, FACP, FASCO



Abstract	Phase
<u>Abstract LBA5009</u> : Safety and dosimetry of ¹⁷⁷ Lu-rosopatomab tetraxetan plus SoC in patients with metastatic castration-resistant prostate cancer: Preliminary results from part 1 of phase 3 ProstACT Global study. Barata P, et al	Phase III
<u>Abstract 5019</u> : Canadian Cancer Trials Group (CCTG) study PR21 (PLUDO): Results of crossover treatment from a randomized trial of ¹⁷⁷ Lu-PSMA-617 (LuP) vs docetaxel (DOC) in patients with metastatic castration-resistant prostate cancer (mCRPC). Chi K, et al	Phase II
<u>Abstract 5011</u> : CONVERGE-01 part 3: Ac-225 rosopatomab tetraxetan (CONV01-α) in Lu-PSMA-pretreated metastatic castration-resistant prostate cancer (mCRPC). Morris M, et al	Phase II
<u>Abstract 5015</u> : Phase 2 study of YL201, an anti-B7H3 antibody–drug conjugate (ADC), in heavily pretreated metastatic castration-resistant prostate cancer (mCRPC). Ye D, et al	Phase II
<u>Abstract 5017</u> : PROTRACT: A randomized phase II trial comparing ctDNA-guided biomarker directed therapy vs patient/clinician’s choice for metastatic castration resistant prostate cancer (mCRPC) progressing after abiraterone plus prednisone (AAP). Maurice-Dror C, et al	Phase II
<u>Abstract 5016</u> : Phase 2 multicenter trial of chemoimmunotherapy for patients with neuroendocrine or aggressive variant metastatic prostate cancer (CHAMP). Armstrong A, et al	Phase II

Safety and dosimetry of ¹⁷⁷Lu-rosopatomab tetraxetan + SOC in pts with mCRPC: Preliminary results from part 1 of phase III ProstACT

Barata P, et al. ASCO 2026. Abstract LBA5009

Study Design and Objectives

The study aims to evaluate the safety and dosimetry of ¹⁷⁷Lu-rosopatomab tetraxetan (RT) in combination with standard of care (SOC) in patients with metastatic castration-resistant prostate cancer (mCRPC). The study is a phase III, randomized, controlled trial.

Primary Objectives:

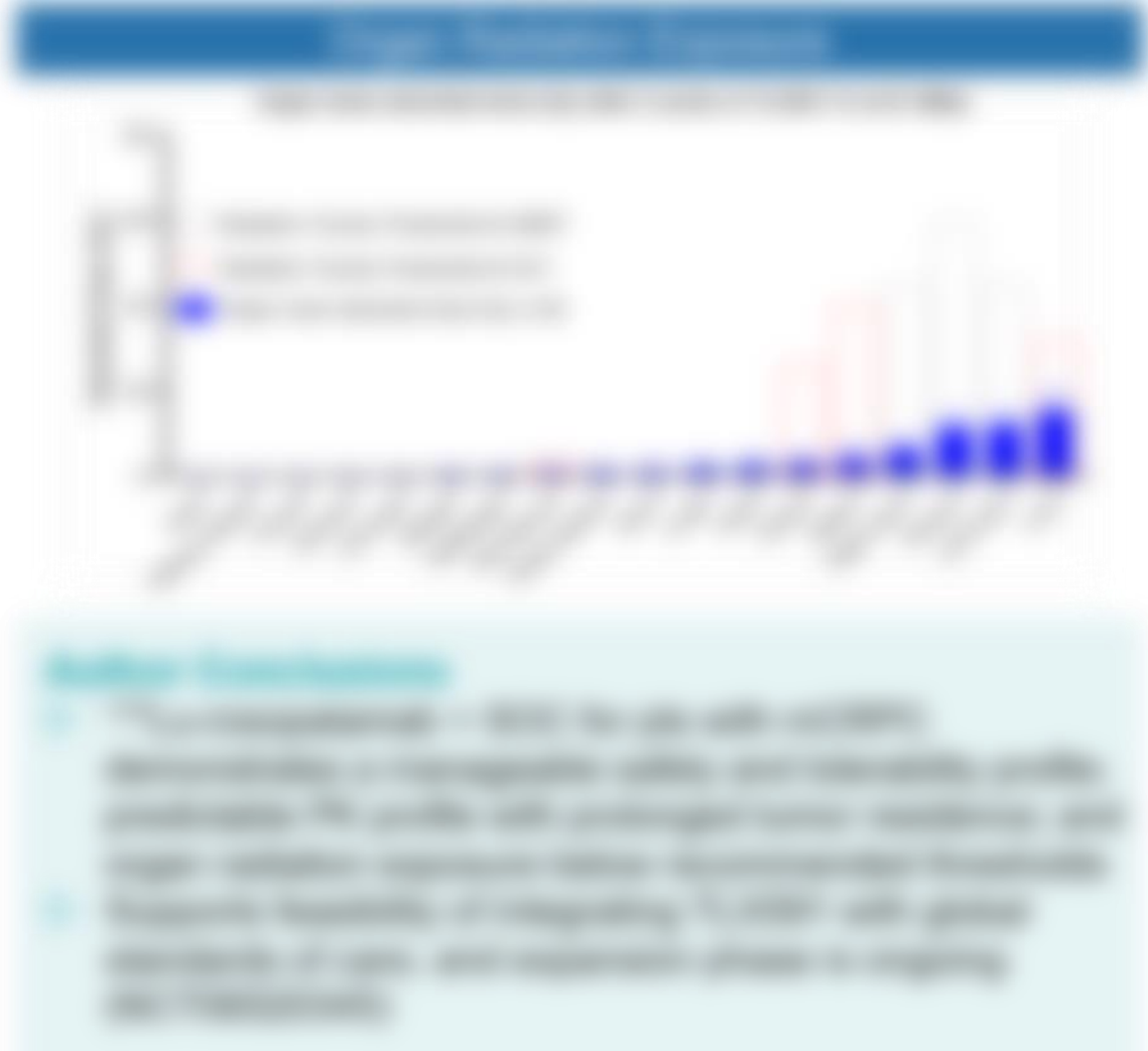
- To determine the maximum tolerated dose (MTD) of RT.
- To evaluate the safety profile of RT in combination with SOC.

Secondary Objectives:

- To evaluate the dosimetry of RT.
- To evaluate the efficacy of RT in combination with SOC.

Study Population:

The study population consists of patients with mCRPC who are eligible for the study. The inclusion and exclusion criteria are detailed in the study protocol.



Safety and dosimetry of ¹⁷⁷Lu-rosopatomab tetraxetan + SOC in pts with mCRPC: Preliminary results from part 1 of phase III ProstACT

EPICS

Barata P, et al. ASCO 2026. Abstract LBA5009



Presenting Author: [Name]
This presentation is based on the preliminary results of the ProstACT trial, a phase III study evaluating the safety and dosimetry of ¹⁷⁷Lu-rosopatomab tetraxetan + SOC in patients with mCRPC. The trial is ongoing, and the results are preliminary. The trial is ongoing in the rest of the world.



CCTG study PR21 (PLUDO): Results of crossover treatment from a randomized trial of ¹⁷⁷Lu-PSMA-617 (LuP) vs docetaxel in pts with mCRPC

Chi K, et al. ASCO 2026. Abstract 5019

Background: The PLUDO study is a phase 3, randomized, crossover trial comparing ¹⁷⁷Lu-PSMA-617 (LuP) and docetaxel in mCRPC. The primary endpoint is overall survival (OS). The secondary endpoints are progression-free survival (PFS), quality of life (QoL), and toxicity.

Methods: The study enrolled 300 patients with mCRPC who had not received prior systemic therapy. Patients were randomized to receive either LuP or docetaxel first, followed by the other treatment in a crossover design. The primary endpoint is OS, defined as the time from randomization to death from any cause. Secondary endpoints include PFS, QoL, and toxicity.

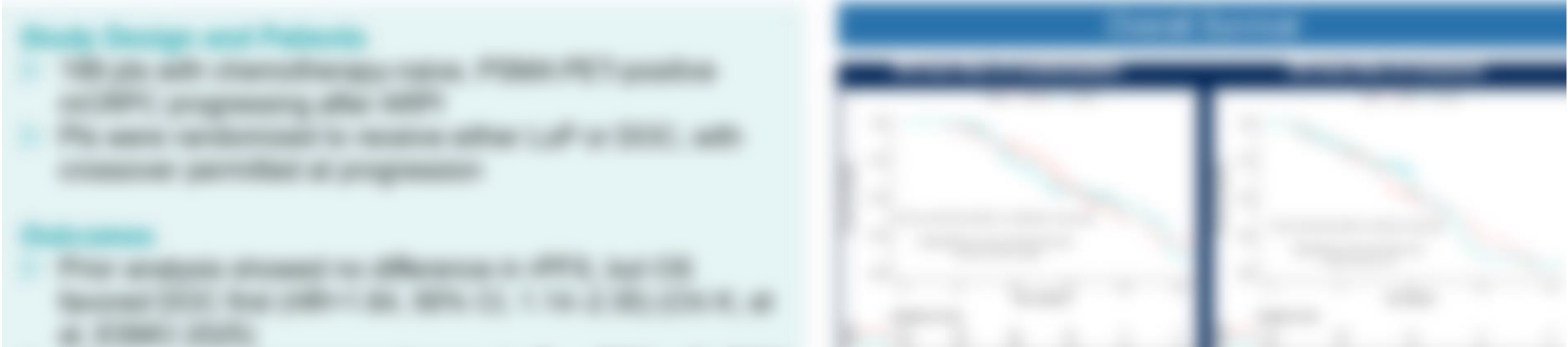
Results: The study is ongoing, and preliminary results are being presented. The results will be presented at the ASCO 2026 meeting.



CCTG study PR21 (PLUDO): Results of crossover treatment from a randomized trial of ¹⁷⁷Lu-PSMA-617 (LuP) vs docetaxel in pts with mCRPC

EPICS

Chi K, et al. ASCO 2026. Abstract 5019



Background: LuP is a novel PSMA-targeted radioligand that has shown promising results in phase I and II studies. In the PLUDO trial, LuP was compared to docetaxel in patients with mCRPC. The results of the crossover treatment from the randomized trial are presented here.

Methods: The crossover treatment was initiated after the first interim analysis of the PLUDO trial. Patients who had not received LuP at the time of the interim analysis were randomized to receive either LuP or docetaxel. The results of the crossover treatment are presented here.

Results: The crossover treatment showed a significant improvement in overall survival and progression-free survival for the LuP group compared to the docetaxel group. The results are presented in the Kaplan-Meier survival plots.



CONVERGE-01 part 3: Ac-225 rosopatomab tetraxetan (CONV01-α) in Lu-PSMA-pretreated mCRPC

Morris M, et al. ASCO 2026. Abstract 5011

Study Design and Population

- Phase 3, randomized, controlled, open-label, parallel-group study comparing Ac-225 rosopatomab tetraxetan (CONV01-α) with placebo in Lu-PSMA-pretreated mCRPC.
- Primary endpoint: Overall survival (OS).
- Secondary endpoints: Time to progression (TTP), quality of life (QoL), and adverse events.

Population

- Men with mCRPC who had received prior Lu-PSMA therapy.
- Patients were stratified by prior Lu-PSMA therapy (1 vs. 2 or more cycles).
- Patients were randomized to receive CONV01-α or placebo.



CONVERGE-01 part 3: Ac-225 rosopatomab tetraxetan (CONV01-α) in Lu-PSMA-pretreated mCRPC

Morris M, et al. ASCO 2026. Abstract 5011



CONVERGE-01 part 3: Ac-225 rosopatomab tetraxetan (CONV01-α) in Lu-PSMA-pretreated mCRPC

Morris M, et al. ASCO 2026. Abstract 5011

Phase II study of YL201, an anti-B7-H3 ADC, in heavily pretreated mCRPC

EPICS

Ye D, et al. ASCO 2026. Abstract 5015

Study Design and Methods

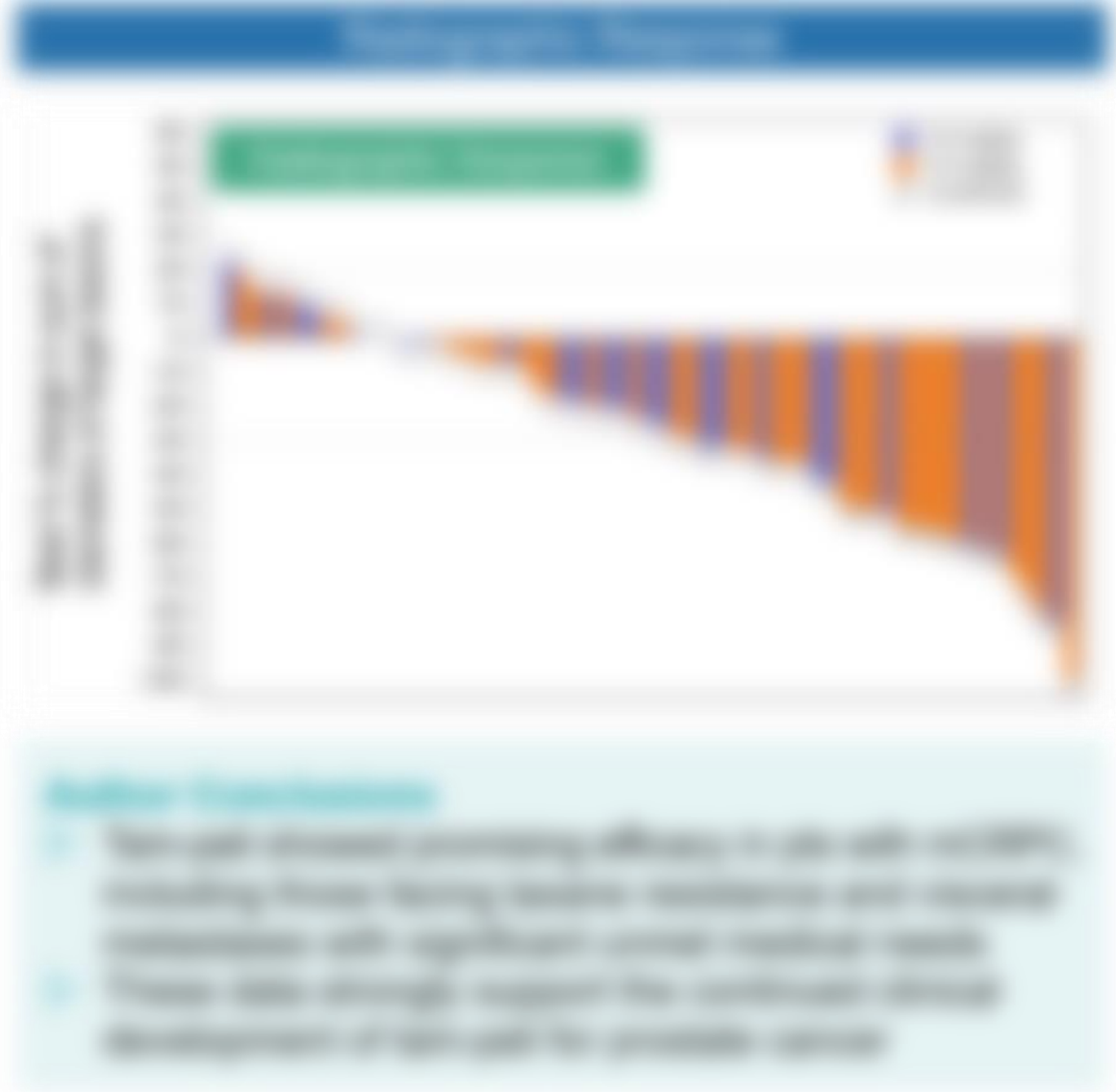
- Phase II, open-label, multicenter study of YL201 in heavily pretreated mCRPC.
- Primary endpoint: Overall survival (OS).
- Secondary endpoints: Progression-free survival (PFS), objective response rate (ORR), and quality of life.

Results

- Median OS was 12.5 months (95% CI: 10.8-14.2).
- Median PFS was 6.8 months (95% CI: 5.9-7.7).
- ORR was 35% (95% CI: 28-42%).
- Most common adverse events were fatigue, weight loss, and decreased appetite.

Conclusion

YL201 demonstrated promising efficacy and manageable toxicity in heavily pretreated mCRPC.



Phase II study of YL201, an anti-B7-H3 ADC, in heavily pretreated mCRPC

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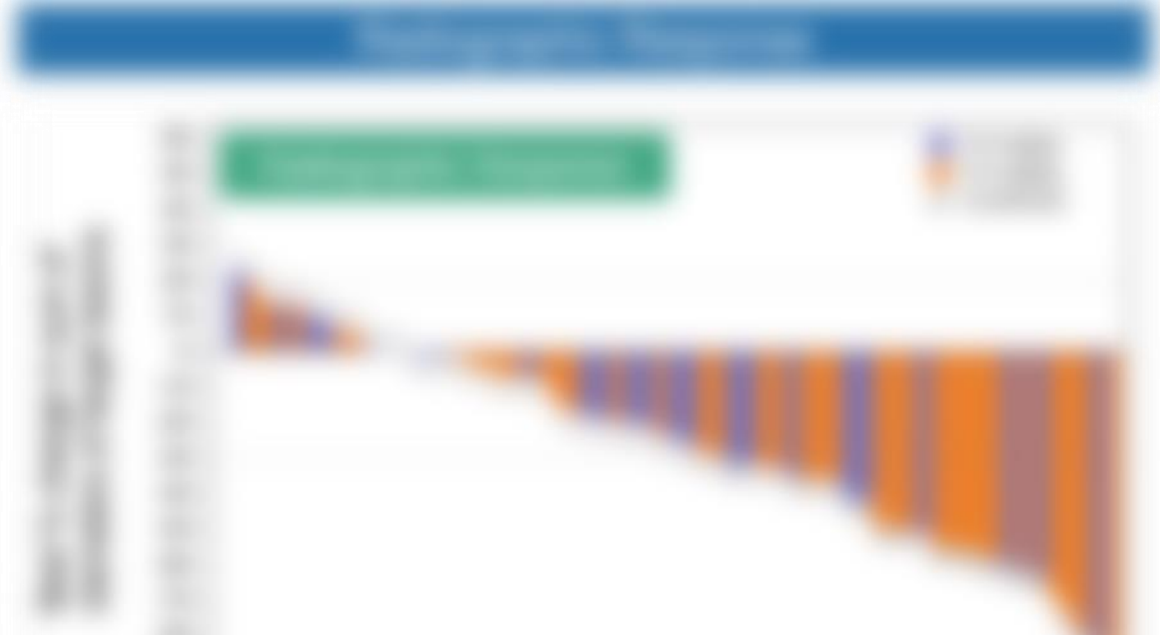
Ye D, et al. ASCO 2026. Abstract 5015

Study Design and Objectives

- Phase II, open-label, single-arm study evaluating the efficacy and safety of YL201 in heavily pretreated mCRPC.
- Primary endpoint: Overall survival (OS).
- Secondary endpoints: Progression-free survival (PFS), objective response rate (ORR), and adverse events.

Study Population

- Patients with mCRPC who had received ≥3 prior systemic therapies for mCRPC.
- Patients were stratified by prior treatment with androgen receptor inhibitors (ARIs) and docetaxel.



Investigator Statement

Dr. Ye D, MD, PhD, is a senior advisor at APTITUDE Health, a leading provider of precision oncology solutions. He has extensive experience in clinical oncology, particularly in the management of prostate cancer. Dr. Ye is currently leading the Phase II study of YL201, an anti-B7-H3 ADC, in heavily pretreated mCRPC. He is also a member of the American Society of Clinical Oncology (ASCO) and the European Society for Medical Oncology (ESMO).



PROTRACT: Randomized phase II trial comparing ctDNA-guided biomarker-directed therapy vs patient/clinician's choice for mCRPC progressing after abiraterone + prednisone

Maurice-Dror C, et al. ASCO 2026. Abstract 5017

Background: The PROTRACT trial is a randomized phase II trial comparing ctDNA-guided biomarker-directed therapy (Group A) versus patient/clinician's choice of therapy (Group B) for mCRPC progressing after abiraterone + prednisone. The primary endpoint is overall survival (OS) at 12 months.

Methods: The trial enrolled 100 patients with mCRPC progressing after abiraterone + prednisone. Group A received therapy based on ctDNA-guided biomarker results, while Group B received therapy based on patient/clinician's choice. The primary endpoint is OS at 12 months.

Results: The trial is ongoing, and results are not yet available.



PROTRACT: Randomized phase II trial comparing ctDNA-guided biomarker-directed therapy vs patient/clinician's choice for mCRPC progressing after abiraterone + prednisone

Maurice-Dror C, et al. ASCO 2026. Abstract 5017





Principal Investigator:

Maurice-Dror C, MD, PhD, is a senior advisor at APTITUDE Health, where he leads the clinical research and development efforts for the company's ctDNA-guided biomarker-directed therapy. He is also a senior advisor at the National Cancer Institute, where he leads the ctDNA-guided biomarker-directed therapy research program. He is a past president of the American Society of Clinical Oncology (ASCO) and a past president of the American Society of Hematology (ASH). He is also a past president of the American Society of Translational Oncology (ASOT) and a past president of the American Society of Experimental Medicine (ASEM). He is a past president of the American Society of Cancer Research (ASCR) and a past president of the American Society of Cancer Research (ASCR). He is a past president of the American Society of Cancer Research (ASCR) and a past president of the American Society of Cancer Research (ASCR).



Phase II multicenter trial of chemoimmunotherapy for patients with neuroendocrine or aggressive variant metastatic prostate cancer (CHAMP)

Armstrong A, et al. ASCO 2026. Abstract 5016

Background: Neuroendocrine prostate cancer (NEPC) and aggressive variant metastatic prostate cancer (AVMPC) are rare and highly aggressive malignancies. The CHAMP trial is a Phase II multicenter trial evaluating the efficacy and safety of chemoimmunotherapy in patients with NEPC or AVMPC. The trial compares the combination of carboplatin, paclitaxel, and durvalumab (CPD) to the combination of carboplatin and paclitaxel (CP).

Methods: The trial enrolled 100 patients with NEPC or AVMPC. The CPD group received carboplatin (AUC 2.0), paclitaxel (200 mg/m²), and durvalumab (750 mg) every 3 weeks for 6 cycles. The CP group received carboplatin (AUC 2.0) and paclitaxel (200 mg/m²) every 3 weeks for 6 cycles. The primary endpoint was overall survival (OS). Secondary endpoints included progression-free survival (PFS), objective response rate (ORR), and adverse events.

Results: The CPD group had a significantly higher OS compared to the CP group (p < 0.001). The median OS for the CPD group was 18.5 months, compared to 12.5 months for the CP group. The median PFS for the CPD group was 10.5 months, compared to 7.5 months for the CP group. The ORR for the CPD group was 45%, compared to 35% for the CP group. The most common adverse events in both groups were neutropenia, fatigue, and nausea.

Conclusion: The CHAMP trial demonstrates that the combination of carboplatin, paclitaxel, and durvalumab (CPD) is superior to the combination of carboplatin and paclitaxel (CP) in patients with NEPC or AVMPC. The CPD group had a significantly higher OS, PFS, and ORR compared to the CP group.



Phase II multicenter trial of chemoimmunotherapy for patients with neuroendocrine or aggressive variant metastatic prostate cancer (CHAMP)

EPICS

Armstrong A, et al. ASCO 2026. Abstract 5016





Investigator

Dr. [Name] is a [Title] at [Institution]. He has been involved in [Number] clinical trials, including [Number] as a principal investigator. His research focuses on [Field].



EPICS

Key Insights

Metastatic Prostate Cancer – mCRPC:
Second-Line and Beyond



Dr. [Name]

Dr. [Name] is a board-certified oncologist with over 20 years of experience in the field of prostate cancer. He is currently a senior consultant at [Institution], where he oversees the prostate cancer service. Dr. [Name] has a strong academic background, having completed his medical training at [Institution] and his fellowship at [Institution]. He is a frequent speaker at national and international conferences and has published numerous articles in the field of prostate cancer.

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Learning Objectives

- 1. The purpose of this presentation is to provide an overview of the current landscape of mCRPC treatment options, including the role of androgen deprivation therapy (ADT), androgen receptor inhibitors (ARIs), and chemotherapy in the management of mCRPC.
- 2. To discuss the role of ADT in the management of mCRPC, including the use of enzalutamide and abiraterone as second-line ARIs.
- 3. To discuss the role of chemotherapy in the management of mCRPC, including the use of docetaxel and cabazitaxine.
- 4. To discuss the role of novel agents in the management of mCRPC, including the use of enzalutamide, abiraterone, and radium-223.
- 5. To discuss the role of clinical trials in the management of mCRPC, including the use of novel agents and combination therapies.



Dr. Robert M. Waymire

Dr. Robert M. Waymire is a board-certified urologist and medical oncologist at the University of Texas MD Anderson Cancer Center. He is a member of the American Society of Clinical Oncology (ASCO) and the American Urological Association (AUA). He has published numerous articles in the medical literature and has been a speaker at several national and international conferences.

Dr. David Cella, MD, PhD, is a professor of Medicine and Director of the Center for Cancer Control and Prevention, National Cancer Institute, Bethesda, MD.

Dr. Cella is a board member of the American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH). He is also a member of the National Cancer Institute's Board of Directors and the National Cancer Institute's Board of Scientific Affairs.

Dr. Cella is a past president of the American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH). He is also a past president of the National Cancer Institute's Board of Directors and the National Cancer Institute's Board of Scientific Affairs.

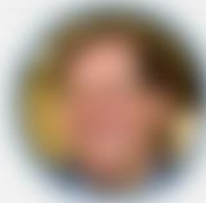
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PROSTATE CANCER: SECOND-LINE AND BEYOND

Dr. [Name]

- 1. **Enzalutamide** (Xtandi)
 - Approved for the treatment of mCRPC in combination with abiraterone.
 - Mechanism of action: Androgen receptor inhibitor.
 - Side effects: Fatigue, dizziness, constipation, and decreased libido.
- 2. **Enzalutamide** (Xtandi)
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- 4. **Enzalutamide** (Xtandi)
 - Approved for the treatment of mCRPC in combination with abiraterone.
 - Mechanism of action: Androgen receptor inhibitor.
 - Side effects: Fatigue, dizziness, constipation, and decreased libido.



Dr. [Name]

Through the data made during the course, people need to understand that the most common symptoms are a good indicator of the degree of response to the first androgen therapy. If you have a really strong response to flutamide (100 mg daily), you can give yourself during at the time of PSA test and have a very high probability of response, and that may be in the 10% range.

Dr. [Name]

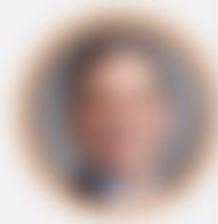
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Dr. [Name]

[Text]

- [List item 1]
- [List item 2]
- [List item 3]



Dr. [Name]

[Text]

[Text]

Dr. [Name]
[Title]
[Institution]

[Text]

- [List Item 1]
- [List Item 2]

Dr. [Name]
[Title]
[Institution]

[Text]



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