Results: Of 160 pts with HRRm mCRPC (mean age: 68 yrs; mean follow-up post-mCRPC: 2.1 yrs), 151 (94%) were treated with ≥ 1 LOT (121 [76%], 94 [59%], 60 [38%], and 41 [26%] with ≥ 2, ≥ 3, ≥ 4, and ≥ 5 LOTs, respectively) during follow-up. The main tx class used in 1L was new hormonal agent (NHA; 54%; Table). The most commonly selected first line (1L) tx were abiraterone (29% of pts with 1L; observed median tx duration: 4.5 mo), enzalutamide (24%; 6.1 mo), docetaxel (17%; 3.5 mo); for 2L were enzalutamide (23% of pts with 2L; 5.7 mo), abiraterone (16%; 5.7 mo), docetaxel (15%; 3.5 mo); for 3L were docetaxel (16% of pts with 3L; 3.6 mo), abiraterone (15%; 2.9 mo), enzalutamide (13%; 3.5 mo). There was a plethora of LOT sequences (Table). In pts with ≥ 2 LOTs, the most common LOT sequence by class was 1L NHA → 2L NHA (20%; median 15.9 mo from 1L start to 2L end; Table); in pts with ≥ 3 LOTs, it was 1L NHA → 2L NHA→ 3L Chemo (12%; median 19.3 mo from 1L start to 3L end).

Conclusions: This real-world study identified poor outcomes on standard of care tx for HRRm+ mCRPC pts. The study also illustrates the lack of tx harmonization for these pts with known poor prognosis, suggesting a need for future tx optimization.

Editorial acknowledgement: Editorial assistance was provided by Mona Lisa Chanda, an employee at Analysis Group in Montréal, Quebec, Canada.

Legal entity responsible for the study: Merck & Co., Inc. and Analysis Group, Inc.

Funding: This study was funded by Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc., Kenilworth, NJ, USA and by AstraZeneca.

Disclosure: N. Shore: Honoraria (self), Advisory/Consultancy, Travel/Accommodation/Expenses: Amgen, Astellas, AstraZeneca, Bayer, BMS, Dendreon, Fergene, Ferring, Janssen, Merck, Myovant, Nymox, Pfizer, Sanofi, Tolmar; Speaker Bureau/Expert testimony: Astellas, Bayer, Janssen; Leadership role: LUGPA, BCAN Boards; Research grant/Funding (institution): Astellas, Bayer, Tolmar. R. Ionescu-Ittu: Research grant/Funding (institution), I am an employee of Analysis Group, a consulting company which has received funding from Merck: Merck & Co, Inc.; Full/Part-time employment, Analysis Group has provided paid consulting services to various clients in the biomedical arena: Analysis Group, Inc. F. Laliberté: Research grant/Funding (institution), I am an employee of Analysis Group, a consulting company which has received funding from Merck: Merck & Co, Inc.; Full/Part-time employment, Analysis Group has provided paid consulting services to various clients in the biomedical arena: Analysis Group, Inc. L. Yang: Honoraria (self), Honoraria (institution), Travel/Accommodation/Expenses, Shareholder/Stockholder/Stock options, Full/Part-time employment: Merck & Co, Inc. A. Gayle: Full/Part-time employment: AstraZeneca. S. Payne: Full/Part-time employment, Full-time employee: AstraZeneca. M. Mahendran: Research grant/Funding (institution), I am an employee of Analysis Group, a consulting company which has received funding from Merck: Merck & Co, Inc.; Full/Part-time employment, Analysis Group has provided paid consulting services to various clients in the biomedical arena: Analysis Group, Inc. S. Amin: Shareholder/Stockholder/Stock options, Full/Part-time employment: AstraZeneca. D. Lejeune: Research grant/Funding (institution), I am an employee of Analysis Group, a consulting company which has received funding from Merck: Merck & Co, Inc.; Full/Part-time employment, Analysis Group has provided paid consulting services to various clients in the biomedical arena: Analysis Group, Inc. J.E. Burgents: Shareholder/Stockholder/Stock options, Full/Part-time employment, Spouse/Financial dependant, Regarding spouse/financial dependent, my wife works at Merck: Merck & Co, Inc. M.S. Duh: Research grant/Funding (institution), I am an employee of Analysis Group, a consulting company which has received funding from Merck: Merck & Co, Inc.; Full/Part-time employment, Analysis Group has provided paid consulting services to various clients in the biomedical arena: Analysis Group, Inc. L. Yu: Research grant/Funding (institution), I am an employee of Analysis Group, a consulting company which has received funding from Merck: Merck & Co, Inc.; Full/Part-time employment, Analysis Group has provided paid consulting services to various clients in the biomedical arena: Analysis Group, Inc. S. Ghate: Shareholder/Stockholder/Stock options, Full/Part-time employment: Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc.

https://doi.org/10.1016/j.annonc.2020.08.913

655P Prognostic significance of docetaxel (D) plus androgen-deprivation therapy (ADT) in patients (p) with metastatic castration-sensitive prostate cancer (mCSPC) according to extent of disease: A study of real-world data

L. Notario[1], J.M. Piulats[2], N. Sala[3], U. Ferrándiz[1], A. González[1], O. Etxániz[1], S. Villà[4], O. Buisan[5], A. Boladeras[6], L. Heras[2], L. Del Carpio[2], A. Roselló[7], P. Barretina[3], C. Fina[3], J.C. Pardo[1], J.M. Suárez[8], J. Comet[9], X. Garcia del Muro[2], A. Esteve[1], A. Font[1]

[1]Medical Oncology Department, Institut Català d'Oncologia Badalona, Barcelona, Spain; [2]Medical Oncology Department, Institut Català d'Oncologia Hospitalet, Barcelona, Spain; [3]Medical Oncology Department, Institut Català d'Oncologia Girona, Girona, Spain; [4]Radiation Oncology Department, Institut Català d'Oncologia Badalona, Barcelona, Spain; [5]Urology Department, Hospital Germans Trias i Pujol, Barcelona, Spain; [6]Radiation Oncology Department, Institut Català D'Oncologia Hospitalet, Barcelona, Spain; [7]Radiation Oncology Department, Institut Català D'Oncologia Girona, Girona, Spain; [8]Urology Department, Hospital de Bellvitge, Barcelona, Spain; [9]Urology Department, Hospital Josep Trueta, Girona, Spain

Background: Clinical trials have reported conflicting findings on the role of D plus ADT in p with mCSPC according to extent of disease. We have retrospectively analyzed the impact of extent of disease on progression-free survival (PFS) and overall survival (OS) in p with mCSPC treated with D plus ADT or ADT alone in clinical practice.

Methods: Between 2015 and 2019, 160 p with mCSPC were treated at centers of the Catalan Institute of Oncology (Catalunya, Spain). For the present study, we have classified these p according to extent of disease. Those with ≥five bone metastases and/or visceral metastases were defined as "high-volume" (HV; n=87), and all other p were defined as "low-volume" (LV; n=73).

Results: One hundred p (60 HV; 40 LV) received D plus ADT and 60 p (27 HV; 33 LV) received ADT alone. Median age was 69.5 years; 79% of p were ECOG PS 0-1; 81% had Gleason 8-10. Bone, lymph node, and visceral metastases were present in 87%, 66%, and 15% of p, respectively. p receiving ADT alone were older with poorer ECOG PS than p receiving D plus ADT. 95 p (59%) progressed to castration-resistant prostate cancer, 74% of whom were then treated with abiraterone or enzalutamide and 24% with D or cabazitaxel. Median PFS was 18.9 months (m) in the 100 p treated with D plus ADT and 13.4 m in the 60 p treated with ADT alone (P=0.01). Among LV p, PFS was longer in those receiving D plus ADT than those receiving ADT alone (29.6 m vs 15.0 m; P=0.002). In contrast, in HV p, no differences in PFS according to treatment were observed. Although OS was slightly longer in p treated with D plus ADT (39.2 m vs 35.7 m, p=0.26), the difference was not significant either in HV p (P=0.41) or LV p (P=0.11). Multivariate analyses identified advanced age, PS 2, HV, and ADT alone as markers of shorter PFS and only PS 2 as a marker of shorter OS.

Conclusions: Despite the limitations inherent in a retrospective, non-randomized study, our findings suggest a benefit in PFS for D plus ADT in LV p but not in HV p. A longer follow-up and marginal structural modeling are warranted to determine the impact on OS in both HV and LV p.

Legal entity responsible for the study: The authors.

Funding: Has not received any funding.

Disclosure: All authors have declared no conflicts of interest.

https://doi.org/10.1016/j.annonc.2020.08.914

656P Divergent results between Advanced Prostate Cancer Consensus Conference (APCCC) panelist (P) and global non-panelist (NP) survey respondents

C.J. Ryan[1], A. Prizment[2], M. Oyenuga[3], K. Sacco[4], G. Carithers[4], A.G. Omlin[3], S. Gillessen[5]

[1]Division of Hematology, Oncology and Transplantation, University of Minnesota, Minneapolis, MN, USA; [2]Department of Oncology/Hematology , University of Minnesota, Minneapolis, MN, USA; [3]Medical Oncology and Haematology Department, Kantonsspital St. Gallen, St. Gallen, Switzerland; [4]Department of Oncology/Hematology, UroToday, Berkeley, CA, USA; [5]Department of Oncology/Hematology , The Christie NHS Foundation Trust, Manchester, UK

Background: The 2019 APCCC consensus statements reflect opinions of global clinical experts who treat a high volume of prostate cancer patients, engage in research and education. We hypothesized that NonPanelist's (NP) consensus will differ from expert panelist clinician (P) consensus across a variety of domains. The current study compares P to NP consensus from 225 clinicians globally who were presented a choice of APCCC questions.

Methods: 20 representative questions posed at APCCC2019 were posted on Urotoday.com, a global urologic oncology education site from 9/8/2019 until 18/1/20 (prior to dissemination of APCCC results) with email solicitations going out to several national societies and groups. NP was defined as clinicians treating >10 but <100 unique prostate cancer annually. The questionnaire was reviewed by the Investigational Review Board at the University of Minnesota. The primary endpoint is concordance of the most frequently chosen answers (either A-E, or Y/N) among P vs NP.

Results: Region for P/NP was Europe, North America or Other for 35/21, 42/33 and 23/46% (p=0.003). NP respondents were Urologists (35%), Medical Oncologists (46%), Clinical Oncologists (3%), Radiation Oncologists (7%) and 9% other (including nurses and trainees). For 12/20 analyzed APCCC guideline questions, there was little disagreement. In 8/20, disparate responses between NP and P (adjusted p<0.05) were observed. Questions with the greatest divergence between P and NP dealt with recommendation for germline testing in M1 castration sensitive disease (84% vs 34% of P and NP do so in a majority of pts, respectively, p=0.0007); Use of anti-PD1 therapy in MSI high disease (96% of P use outside of clinical trial vs 69% of NP, p=0.0007) and treatment of the primary tumor in patients with metastatic disease (98% of P recommend in low volume only vs 77% of NP, p<0.0008).

Conclusions: While agreement was noted on a majority of questions, the survey identified knowledge and practice gaps that may be useful for further educational and training efforts. Most gaps reflected relatively recent and sometimes controversial data (e.g. use of immune checkpoint inhibitors).

Legal entity responsible for the study: The authors.

Funding: Has not received any funding.

Disclosure: All authors have declared no conflicts of interest.

https://doi.org/10.1016/j.annonc.2020.08.915