Supplementary

Appendix 1

The list of APCCC 2019 questions used in the conference. The numbers of question are corresponded to the numbers at APCCC 2019

2. Biochemical recurrence after local therapy

2.1 PSA recurrence after radical radiation therapy

Q10. Imaging modality(ies) for patients with rising PSA after radical radiation therapy of the prostate

1. CT and/or bone scintigraphy (plus/minus pelvic MRI)
2. Whole-body MRI alone (plus/minus pelvic MRI)
3. PSMA PET CT/MRI (plus/minus pelvic MRI)
4. Fluciclovine or choline PET CT/MRI (plus/minus pelvic MRI)
5. Abstain

2.2 PSA recurrence after radical prostatectomy

Q12. Imaging modality(ies) for patients with rising PSA after radical prostatectomy

1. CT and/or bone scintigraphy (plus/minus pelvic MRI)
2. Whole-body MRI alone (plus/minus pelvic MRI)
3. PSMA PET CT/MRI (plus/minus pelvic MRI)
4. Fluciclovine or choline PET CT/MRI (plus/minus pelvic MRI)
5. Abstain

4. Systemic treatment of newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)

4.6 Newly diagnosed oligorecurrent (metachronous) oligometastatic disease after local treatment (EBRT or radical prostatectomy ± EBRT) with curative intent (plus/minus salvage radiation therapy)

Q58. Recommended imaging modalities in patients with rising PSA after radical treatment to confirm a diagnosis of oligorecurrent (metachronous)

1. PSMA PET-CT/MRI
2. Fluciclovine or choline PET-CT/MRI
3. Whole-body MRI without PET
4. A combination of two next-generation imaging methods
5. No additional imaging
6. Abstain

4. Systemic treatment of newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)

4.4 Oligometastatic prostate cancer (no prior systemic therapy for metastatic disease)

Q45. Which definition of oligometastatic prostate cancer is useful to guide treatment selection for local treatment of all lesions plus/minus systemic therapy?

1. Patients with a limited number of any synchronous or metachronous metastases, including visceral metastases, that all can be treated with local therapy
2. Patients with a limited number of synchronous or metachronous bone and/or lymph node metastases, excluding visceral metastases, that all can be treated with local therapy
3. Patients with a limited number of any metachronous metastases, including visceral metastases, that all can be treated with local therapy
4. Patients with a limited number of metachronous bone and/or lymph node metastases, excluding visceral metastases, that all can be treated with local therapy
5. I do not believe oligometastatic prostate cancer exists as a clinically meaningful entity
6. Abstain

https://dx.doi.org/10.21037/tau-22-396

Q48. What is your treatment goal when recommending local treatment of all lesions instead of systemic therapy in oligometastatic prostate cancer?
1. Delay start of ADT
2. Prolongation of progression-free survival
3. Prolongation of overall survival
4. All three of the above
5. Cure
6. None of the above
7. I do not recommend local treatment of all lesions in oligometastatic prostate cancer
8. Abstai

Q49. What is your treatment goal when recommending adding local treatment of all lesions to systemic treatment in oligometastatic prostate cancer?
1. Prolongation of progression-free survival
2. Prolongation of overall survival
3. Prolongation of both PFS and OS
4. Cure
5. None of the above
6. I do not recommend local treatment of all lesions in oligometastatic prostate cancer
7. Abstain

Q50. What is your cut-off for the number of metastases when considering prostate cancer to be oligometastatic?
1. ≤3 metastases
2. ≤5 metastases
3. No cut-off, any number that can be safely treated with ablative intent
4. Abstain

5. Management of non-metastatic CRPC (M0 CRPC)

Q66. In the majority of nmCRPC (M0 CRPC) patients who have PSA ≥2 ng/mL and PSA doubling time ≤10 months, what is your preferred treatment choice in addition to ADT?
1. Apalutamide
2. Darolutamide
3. Enzalutamide
4. Any AR antagonist mentioned above
5. Abiraterone
6. Steroids (dexamethasone, prednisolone)
7. No additional treatment; continue ADT alone
8. Abstain

Q67. Is it appropriate to extrapolate data from ARAMIS, PROSPER, and SPARTAN to patients with nmCRPC (M0 CRPC) who have PSA doubling time >10 months?
1. Yes
2. No
3. Abstain

Q68. For patients with nmCRPC (M0 CRPC), an untreated primary tumour, and no evidence of disease outside the prostate, do you recommend radical (definitive) local therapy instead of systemic therapy if local disease is confirmed?
1. Yes, in the majority of patients

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2. In a minority of selected patients
3. No
4. Abstain

3. Management of primary tumour in the metastatic setting

Q20. Based on the current literature, do you think that local treatment of the primary tumour has an overall survival benefit in:
1. Majority of patients with newly diagnosed metastatic (M1) castration- sensitive/naïve prostate cancer (CNPC) regardless of metastatic volume
2. Only patients with low-volume/burden newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)
3. No clear benefit in any patients
4. Abstain

Q21. For patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC), is it appropriate to extrapolate data from STAMPEDE (radiation therapy of the prostate) to radical surgery of the prostate?
1. Yes
2. No
3. Abstain

Q23. If you recommend RT of the primary tumour in patients with newly diagnosed low-volume/burden metastatic (M1) castration-sensitive/ naïve prostate cancer (CNPC) who also have clinical pelvic N1 disease, do you recommend that radiation treatment volume encompasses the pelvic lymph nodes?
1. Yes (radiation therapy of the primary and pelvic lymph nodes)
2. No (radiation therapy only of the primary)
3. Abstain

4. Systemic treatment of newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)

4.1 Terminology: Newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)

Q25. In your opinion, which terminology best describes metastatic prostate cancer in patients who are about to start ADT?
1. Hormone-naïve metastatic prostate cancer
2. Hormone-sensitive metastatic prostate cancer
3. Metastatic prostate cancer receiving first-line (define) systemic therapy
4. Castration-naïve metastatic prostate cancer
5. Castration-sensitive metastatic prostate cancer
6. Abstain

4.2 Management of newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC)

Q34. What is your preferred treatment in addition to ADT in patients with de-novo high-volume metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC) without symptoms from the primary tumour?
1. AR pathway inhibitor (abiraterone or apalutamide or enzalutamide) as sole additional therapy
2. Docetaxel as sole additional therapy
3. Any one of docetaxel or abiraterone or apalutamide or enzalutamide as sole additional therapy
4. Docetaxel plus an AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
5. ADT alone, no additional treatment
6. Abstain

Q36. What is your preferred treatment in addition to ADT in patients with de-novo low-volume metastatic (M1) castration-

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sensitive/naïve prostate cancer (CNPC) without symptoms from the primary tumour?

1. AR pathway inhibitor (abiraterone or apalutamide or enzalutamide) as sole additional therapy
2. Docetaxel as sole additional therapy
3. Any one of docetaxel or abiraterone or apalutamide or enzalutamide as sole additional therapy
4. AR pathway inhibitor (abiraterone or apalutamide or enzalutamide) plus treatment of the primary
5. Docetaxel plus treatment of the primary tumour
6. Treatment of the primary alone
7. ADT alone, no additional treatment
8. Abstain

Q37. What is your preferred treatment in addition to ADT in patients with newly diagnosed low-volume metastatic (M1) castration-sensitive/naïve prostate cancer (CNPC) relapsing after local treatment of the primary tumour?

1. AR pathway inhibitor (abiraterone or apalutamide or enzalutamide) as sole additional therapy
2. Docetaxel as sole additional therapy
3. Any one of docetaxel or abiraterone or apalutamide or enzalutamide as sole additional therapy
4. Docetaxel plus an AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
5. ADT alone, no additional treatment
6. Abstain

6. Management of mCRPC

Q76. When discontinuing abiraterone or chemotherapy, what do you recommend regarding steroid therapy?

1. Stopping steroids at the last administration of abiraterone/chemotherapy
2. Taper steroids over a course of some weeks
3. Continuation of same dose of steroids
4. Abstain

Q80. Is there a role for the use of bicalutamide as sole additional therapy to ADT in patients with mCRPC?

1. Yes, routinely in the majority of patients
2. In a minority of selected patients
3. Only in the context of limited resources
4. No
5. Abstain

9. Heterogeneity of patients with prostate cancer (ethnicity, elderly)

Q113. If you treat a patient of East Asian ethnicity with taxane chemotherapy for mCRPC, how do you initiate treatment?

1. Start with standard dose (75mg/m2), with dose reductions in subsequent cycles as indicated
2. Start with reduced dose (e.g. 60mg/m2), with dose reductions in subsequent cycles as indicated
3. Start with reduced dose, and escalate dose in the absence of relevant side effects
4. Abstain

8. Molecular characterization: Tissue and blood

8.1 Tumour genomic testing

Q100. Do you recommend that the majority of metastatic prostate cancer patients get their tumours tested for BRCA1/2 aberrations?

1. Yes
2. Yes, but only metastatic castration-resistant patients
3. No

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4. Abstain

Q101. Do you recommend that the majority of metastatic prostate cancer patients get their tumours tested for mismatch repair defects (MSI high)?
1. Yes
2. Yes, but only metastatic castration-resistant patients
3. No
4. Abstain

Q102. Do you recommend anti-PD1 therapy for patients with metastatic prostate cancer and a mismatch repair defect (MSI high) outside of a clinical trial?
1. Yes, at first diagnosis of metastatic disease, at start of ADT
2. Yes, after progression on ADT (first-line mCRPC)
3. Yes, after at least one line of chemotherapy and at least one AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
4. Only after all standard treatment options are exhausted
5. No, I do not recommend an anti-PD1 therapy for these patients
6. Abstain

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