080 SURECAP: Survey and Evaluation of Castration Resistant Prostate Cancer (CRPC) in Germany

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INTRODUCTION

The objective of this project was an assessment of the current status quo in the diagnosis and treatment of CRPC facing the plurality of novel treatment options, involved institutions and specialties in the clinical reality in Germany.

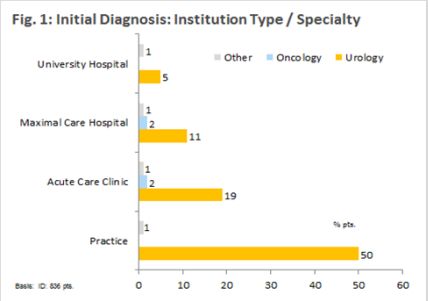
METHODS

In this healthcare research project clinical and epidemiological data from patients with CRPC and a therapy decision in Q3/4 2014 were retrospectively and anonymously reported in a representative sample of centers on the basis of the patient files. Based on the structural healthcare research from 2014 the distribution of treated CRPC prevalence within respective institutions was assumed as within university hospitals (4%), certified Prostate Cancer Centers (16%), other non-university hospitals (12%), office based urologists (33%) and office based oncologists (35%). The sample of participating sites (n=79, hospitals 35%, office based urologists 36%, office based oncologists 25%, respectively) and reported CRPC pts. (836 pts. eligible for the analysis after quality checks) reflects this distribution. The participating sites reported all pts. meeting the inclusion criteria: CRPC diagnosis, treatment decision regarding CRPC in Sept 1 – Dec 31 2014. The treatment decision was defined as start, adjustment or end of a treatment. Progression of disease was used as an approximation for the end of a treatment line. The patient record contained the entire treatment history back from the reporting period to the initial diagnosis. The data was reported online in the EDC program secuTrial™ (iAS GmbH, Berlin). The completeness and plausibility checks were performed in 100% pts. in two steps: online in real time during the data capture and by central clinical monitors in the completed data set.

RESULTS

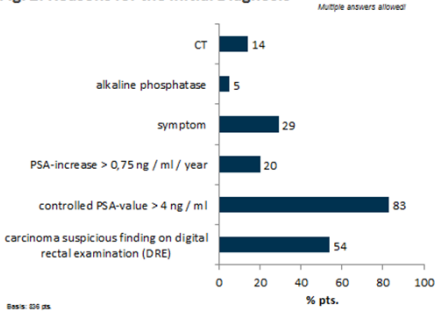
Half of all prostate cancer diagnoses were obtained by office based urologists (50%), 36% by hospital based urologists and 4% by hospital based oncologists. (Fig.1)

Fig. 1: Initial Diagnosis: Institution Type / Specialty



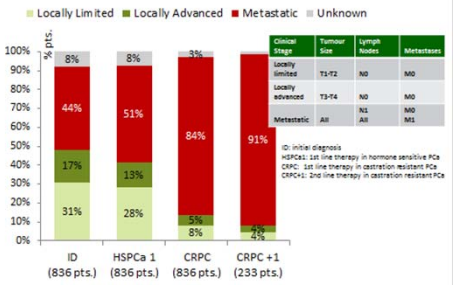
Elevated PSA-values (83%), pathological digital rectal examis (DRE) (54%) or clinical symptoms (29%) were the most frequent reasons for the diagnosis of prostate cancer.(Fig.2)

Fig. 2: Reasons for the Initial Diagnosis



At time of initial diagnosis 44% pts. presented with metastatic, 17% with local advanced and 31% with local limited stage of disease. This distribution of initial disease stages may in part reflect the study design enrolling only patients with developed CRPC. (Fig.3)

Fig. 3: Clinical Staging in the Course of Disease



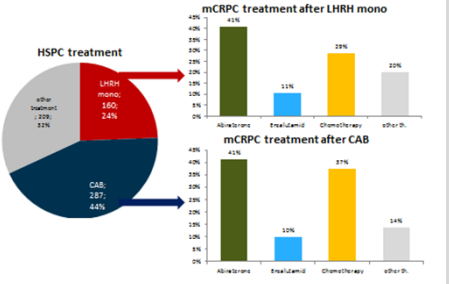
The most frequent symptoms leading to the reevaluation of the clinical staging were bone pain or pathological fractures (26%), decline of performance status (23%) or micturition disorders (11%). The diagnosis of castration resistance was defined by biochemical PSA progress (86%) or by radiological progress (65%) or by clinical symptoms (41%) under the current treatment.

Patient characteristics at CRPC diagnosis (n=836 pts.)

Age	73 y. median
ECOG	1 median
PSA level in serum	13,6 ng/dl median
Testosterone level in serum	0,35 ng/dl median
Skeletal metastases	602/836 (72%) pts
Lymph nodes metastases	351/836 (42%) pts.
Visceral metastases	125/836 (15%) pts.

After the relapse of primary LHRHa therapy (median treatment duration 21,5 months) and the diagnosis of CRPC (in accordance with EAU Guidelines from 2014) 41% pts were treated with Abiraterone acetate + Prednisone, 11% pts. received Enzalutamide or 29% chemotherapy, 20% pts were treated with any other therapy. (Fig. 4)

Fig. 4 Treatment Sequence in mCRPC pts.
(n=656 mCRCP pts./846 CRPC pts.)



In 1st line mCRPC after relapse of primary LHRHa treatment and CAB (complete androgen blockade) 41% pts. received Abiraterone acetate + prednisone, 10% Enzalutamide or a chemotherapy regimen (37%). (Fig. 4)

The most frequent use of chemotherapy (46%) in CRPC patients was reported in 1st line after diagnosis of castration resistance (=1st relapse). (Fig. 5)

The novel endocrine therapies were adopted very fast in the 1st line CRPC treatment. (Fig. 5)

Fig. 5: 1st Line CRPC Treatment by the Time of CRPC Diagnosis

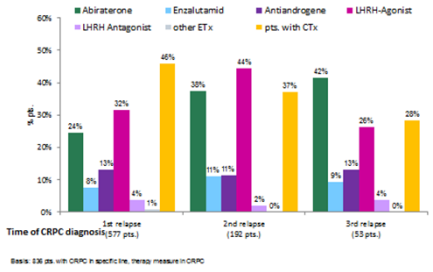
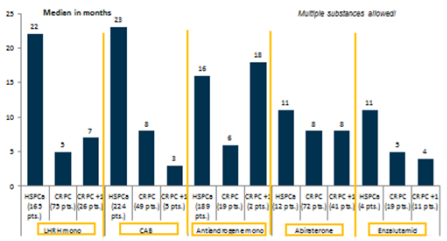
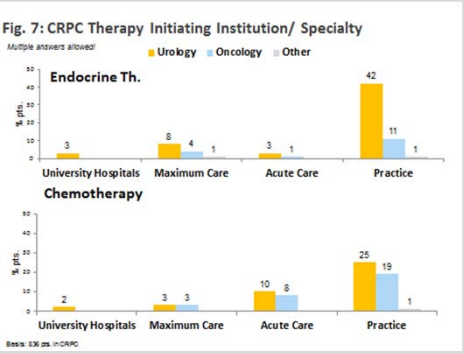


Fig. 6: Median Duration of Endocrine Th.
(completed treatment in the reporting period only)



Most treatments of CRPC were supervised by urologists: 42% of endocrine therapies and 25% of chemotherapies in the 1st line CRPC were initiated by urologists in a office based practice. (Fig. 7)

Fig. 7: CRPC Therapy Initiating Institution/ Specialty



LIMITATIONS

The methodology of this healthcare survey did not allow an access to the patient files for the source data verification of the reported data. Therefore no on-site monitoring was performed. The plausibility and completeness was warranted by 100% online and centralized data check. The reporting period was limited to Q3-Q4 2014 and therefore long term follow up data was not available.

CONCLUSIONS

- This healthcare survey provides further supporting data to reflect the clinical reality in Germany in this high risk patient population.
- In Germany the main care provider in CRPC is the urologists (Fig. 1 and Fig. 7)
- 44% of patients who developed a CRPC presented metastases at initial diagnosis
- A quarter of mCRPC patients received modern antihormonal therapies such as AA+P or E directly after failure of LHRHa therapy without previous CAB according to current EAU guideline definition of castration resistance in prostate cancer.
- Modern AHT treatments are accepted treatment options beside C in first line mCRPC in routine clinical practice

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