EAU GUIDELINES 2026 UPDATE

The EAU26 Guidelines: What's Changed?

EAU-EANM-ESTRO-ESUR-ISUP-SIOG
Prostate Cancer Guidelines 2026

A reference guide for clinical teams

The 2026 EAU Prostate Cancer Guidelines confirm a fundamental shift in managing hormone-sensitive disease at every stage — from high- risk biochemical recurrence to metastatic HSPC. Building on EMBARK,[2,3] PEACE-1,[4] ARASENS,[5] and AMPLITUDE,[6] the updated guidance formalises **ADT as the irreplaceable, continuous backbone** of all combination strategies, while opening new biomarker-selected pathways for the first time.[1]

EMBARK — KEY DATA (NCT02319837)[2,3]
Phase III trial in high-risk biochemical recurrence (BCR) prostate cancer

63% **MFS risk reduction**
Enzalutamide + leuprolide vs leuprolide alone (HR0.37;95%CI0.25–0.57;p<0.0001)[2]

78.9% **8-yr OS — combination arm**
vs 69.5% leuprolide alone (HR0.60;95%CI0.44–0.80;p=0.0006)[3]

For healthcare professionals only.
Use alongside full EAU 2026 Guidelines and approved SmPC.
MFS=metastasis-free survival; OS=overall survival; BCR=biochemical recurrence; PSADT=PSA doubling time; ADT=androgen deprivation therapy; ARPI=androgen receptor pathway inhibitor.

References: see reverse.

EAU 2026 — KEY GUIDELINE CHANGES

Four Practice-Changing Updates concerning ADTs

The2026 EAUPCa Guidelinespresenttargetedrevisionsto Sections 6.4.7 (second-linetherapy after curative intent) and 6.6.8 / 6.6.4.b.2 (mHSPC first-line treatment and new biomarker-guided pathways).[1]

Guideline Revision — M0 High-Risk BCR (Sec. 6.4.7)[1]

EAU 2026

Enzalutamide monotherapy is **no longer the preferred approach** for M0 patients.
No significant OS benefit was demonstrated with monotherapy (HR 0.83; p=0.19 vs leuprolide).[3]
The **enzalutamide + leuprolide combination** is the only arm to demonstrate statistically significant OS benefit (HR 0.60; p=0.0006).[3]

MHSPC — SEC. 6.6.8

ADT:TheContinuousBackbone of Combination Therapy

Stronger emphasis on ADT as the backbone across all hormone-sensitive metastatic disease. All combination strategies — doublet, triplet, biomarker-guided - are explicitly built upon continuous ADT. The 2026 update reinforces that ADT should not be considered optional background therapy, but the foundation upon which combination regimens are built.[1]

EAU 2026 Sec. 6.6.8

UPDATED — SEC. 6.6.4.B.2

TripletTherapy:NewDedicated Subsection

The 2026 update introduces a new dedicated subsection **formalising ADT + docetaxel + abiraterone (PEACE-1)[4]** and **ADT + docetaxel + darolutamide (ARASENS)[5]** as structured pathways for fit patients with high-volume/synchronous mHSPC. The recommendation to offer triplet therapy was already established in the 2025 guideline; the 2026 revision provides a distinct structural home for these regimens. ARASENS demonstrated a 32.5% reduction in risk of death vs ADT + docetaxel doublet (OS HR 0.68; 95% CI 0.57–0.80; p<0.001)[5]; PEACE-1 showed OS HR 0.75 with triplet vs doublet (95.1% CI 0.59–0.95; p=0.017).[4]

EAU 2026 Sec. 6.6.4.b.2

NEW — SEC. 6.6.4.B.2

HRR Testing Might Be Considered in mHSPC

Systematic somatic or germline **HRR testing might be considered in all mHSPC patients (weak recommendation)**.[1] Results directly determine eligibility for ADT + abiraterone + niraparib (AMPLITUDE).[6] Patients with BRCA mutations achieved median rPFS not reached vs 26.0 months on standard doublet (HR 0.52; p<0.0001).[6] Testing at diagnosis is now essential to unlock this pathway.

EAU 2026 Sec. 6.6.4.b.2 (AMPLITUDE)

Revised Section — SEC. 6.6.4.B.2

NEWSUBSECTIONTOSEC.6.6.4.B.2 PTEN-Deficient Disease: AKT Inhibition

CAPItello-281 now incorporated:[7] ADT + abiraterone + capivasertib introduced as a biomarker-selected pathway in PTEN-deficient mHSPC, built upon the ADT + ARPI backbone. PTEN loss activates the PI3K/AKT pathway — a key resistance mechanism. Deeper PTEN loss (>99%) showed an OS HR of 0.77 (95% CI 0.61–0.98; p=0.03), suggesting enriched benefit with stringent biomarker selection.[7]

EAU 2026 Sec. 6.6.4.b.2 (CAPItello-281)

CONSIDER TO TEST MHSPC PATIENTS
Somatic/germline HRR testing is now a formal EAU 2026 recommendation[1] — results define PARPi eligibility.[6]

ADT IS NON-NEGOTIABLE
No doublet, triplet, or biomarker-guided regimen is guideline-validated without continuous ADT as foundation.[1]

MDT DISCUSSION REQUIRED
All mHSPC patients should be discussed in a multidisciplinary team before treatment initiation (strong recommendation).[1]

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EAU 2026 — MHSPC TREATMENT FRAMEWORK & EVIDENCE

Selecting the Right Combination: All Pathways Start with ADT

PerEAU 2026Sec. 6.6.8,continuousADTisthe mandatoryfoundationacross all mHSPC treatment.[1] Intensification partner selection is guided by disease volume, fitness for chemotherapy, and — now formally — tumour biomarkers.

▶ **STEP 1: Continuous ADT** — Mandatory backbone in all mHSPC pathways (EAU 2026, Sec. 6.6.8)[1]

STEP 2 - FITNESS & VOLUME ASSESSMENT → DOUBLET OR TRIPLET

HIGH-VOLUME / DOCETAXEL-FIT PATIENTS

Triplet Therapy(EAU 2026Sec.6.6.4.b.2) [1]

- ADT + Docetaxel + Abiraterone *(PEACE-1)*[4]
- ADT + Docetaxel + Darolutamide *(ARASENS)*[5]

Regulatoryapproval status fortripletcombinationsvaries bycountry and by individual product. Prescribers should consult the locally approved SmPC before initiating therapy.

ANY VOLUME / DOCETAXEL-UNFIT PATIENTS

Doublet ARPI (EAU 2026 Sec. 6.6.8)[1]

- ADT + Enzalutamide / Apalutamide / Abiraterone — strong recommendation[1]
- ADT + Darolutamide — weak recommendation[1]

STEP 3 - BIOMARKER TESTING: CONSIDER TO [1]TEST ALL MHSPC PATIENTS (EAU 2026 SEC. 6.6.4.B.2)[1]

SYSTEMATIC SOMATIC OR GERMLINE HRR + PTEN TESTING — EAU 2026 FORMAL RECOMMENDATION[1]

HRR Altered — **ADT + Abiraterone + Niraparib** — AMPLITUDE:[6] rPFS HR 0.52 in BRCA-mutated patients (95% CI 0.37–0.72; p<0.0001); HR 0.63 in overall HRR-mutated population (95% CI 0.49–0.80; p=0.0001).

PTEN Loss — **ADT + Abiraterone + Capivasertib** — CAPItello-281:[7] AKT inhibition added to ADT + ARPI backbone in PTEN-deficient mHSPC. Deeper PTEN loss enriches for benefit.

SUPPORTING TRIPLET EVIDENCE - PEACE-1 & ARASENS

PEACE-1 — ADT + DOCETAXEL + ABIRATERONE[4]

rPFS HR **0.50** vs ADT + docetaxel (median 4.46 vs 2.03 yr; p<0.0001)

OS HR **0.75** vs ADT + docetaxel (95.1% CI 0.59–0.95; p=0.017)

Greatest OS benefit in high-volume disease

ARASENS - ADT + DOCETAXEL + DAROLUTAMIDE[5]

OS HR **0.68**vs ADT+docetaxel (95%CI 0.57–0.80;p<0.001)

Risk of death reduced by 32.5%; benefit across high- and low-volume subgroups

REFERENCES

1. Cornford P et al. EAU-EANM-ESTRO-ESUR-ISUP-SIOG Guidelines on Prostate Cancer 2026. uroweb.org, March 2026.

2. Freedland SJ et al. Improved Outcomes with Enzalutamide in BCR Prostate Cancer (EMBARK). N Engl J Med 2023;389:1453–65.

3. Shore ND, de Almeida Luz M, De Giorgi U, et al. Improved survival with enzalutamide in biochemically recurrent prostate cancer. N Engl J Med. Published online 19 October 2025. doi:10.1056/NEJMoa2510310.

4. Fizazi K et al. Abiraterone plus docetaxel in de novo mHSPC (PEACE-1). Lancet 2022;399:1695–707.

5. Smith MR et al. Darolutamide, ADT, and docetaxel in mHSPC (ARASENS). N Engl J Med 2022;386:1132–42.

6. Attard G et al. Niraparib + abiraterone + ADT in HRR-deficient mHSPC (AMPLITUDE). Nature Medicine 2025;31:4109–18.

7. Fizazi K et al. Capivasertib + abiraterone in PTEN-deficient mHSPC (CAPItello-281). Ann Oncol 2026;37:53–68

ADT AND HIGH-RSK BCR

THE EMBARK LENS

All EAU 2026 combination pathways now mandate continuous ADT.[1]

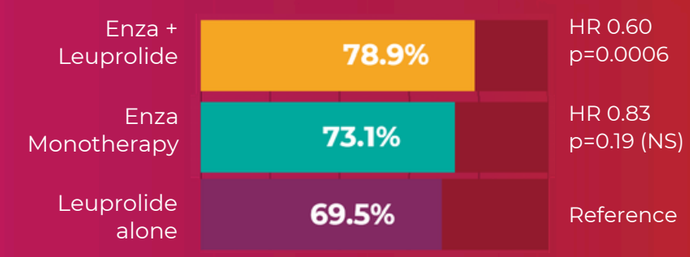
LHRH Agonist — Leuprolide Acetate

EMBARK ADT

EMBARK was a Phase III randomised trial in M0 high-risk biochemical recurrence (BCR) prostate cancer (PSADT ≤9 months; non-metastatic on conventional imaging). Patients were randomised 1:1:1 to enzalutamide + leuprolide, enzalutamide monotherapy, or leuprolide alone.[2]

Leuprolide was the only ADT used across all arms of EMBARK.[2] The leuprolide combination arm is the sole regimen to demonstrate statistically significant OS benefit in EMBARK (HR 0.60; p=0.0006).[3]

EMBARK — 8-YEAR OVERALL SURVIVAL[3]



NS = not statistically significant. Only the combination arm demonstrated a significant OS benefit. Data: Shore ND et al. 2025.[3]

EMBARK (NCT02319837) — GUIDELINE FOUNDATION

Phase III RCT in high-risk BCR after local therapy (PSADT ≤9 months; M0 on conventional imaging).[2] Randomised 1:1:1 to **enzalutamide 160 mg daily + leuprolide acetate 22.5** mg every 12 weeks, enzalutamide monotherapy, or leuprolide acetate 22.5 mg every 12 weeks alone. Leuprolide acetate 22.5 mg (an LHRH agonist) **was the sole validated ADT partner** across all EMBARK arms. Patients achieving PSA <0.2 ng/mL at week 36 entered a treatment suspension period — a key de-intensification feature. The combination OS benefit at 8 years[3] directly informs the EAU 2026 Sec. 6.4.7 strong recommendation,[1] and underlines why the ADT partner identity matters.