

Dr. Zachary Klaassen: So really this conversation over the next eight minutes is really what is focal therapy, and are you a candidate, and more importantly, are you not a candidate. And I think what this really is, is partial treatment of the prostate gland, only treating exactly where the prostate cancer is, and historically, this has been related with images that are seen on the MRI scan.

So why is this even an option? And really it comes down to what Dr. Ballas already said in terms of side effects of local therapy. We know that whether it's radiation or surgery is going to cause erectile dysfunction, urinary incontinence or leakage of urine.

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And so this has led to a multitude of types of local into including HIFU, which is high intensity focal ultrasound, cryoablation, laser ablation, a rather newer option called NanoKnife or irreversible electroporation, and many others as well...

So are you a candidate? Really, this is coming down to the prostate cancer-specific factors which include less than or equal to Gleason 4+3 or greater than or equal to 3+4 prostate cancer.

So a very tight window of patients that may be candidates for prostate cancer has to only be on one side of the prostate gland. Otherwise, it's going to be a whole gland therapy, which would be better candidate for radiation or surgery. And ideally, the prostate cancer correlates with a spot that we can see on the MRI. There's also some important additional things that we should consider if we're considering focal therapies that are outside of the prostate cancer itself.

And this is understanding that long term follow-up and some of the data is much less mature than we have for radical prostatectomy or radiation therapy. You have to be willing to undergo serial follow up MRIs, and you have to be willing to undergo additional biopsies of the prostate gland as well...And again, as important as patients understanding—who are not a candidate for—are appropriate candidate for focal therapy.

So this includes bilateral disease. So both sides of the prostate equal to or greater than Gleason 3+4. Anywhere that there's 4+4 in the entire prostate, this is a high risk prostate cancer. It should not be treated with focal therapy. Unable to see the prostate cancer, an MRI being able to see it allows us to directly treat that specific spot.

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So having it line up with where the biopsy is and where the MRI spot is is very important. Not being comfortable with the lack of long term follow up data. As we mentioned, prostate –prostatectomy and radiation therapy have excellent long-term, follow-up data, whereas the focal therapy is much less usually in the realm of 4 to 5 years at most.

And additionally, as I mentioned previously, unwilling to undergo the appropriate follow-up, which we highlighted on the previous slide. So I'll leave it to, Leslie to follow up with some additional questions. Thank you.

Dr. Leslie Ballas: Thank you so much. I think that was a really great introduction to focal therapy. One question I have, and I think you've kind of really touched on it, I think in your slides, but just to make sure that, you know, families and patients understand, when I laid out the options for prostate cancer, I said, active surveillance, surgery, radiation plus or minus hormones. I didn't list focal therapy. Why is this considered separate or distinct from these standard treatments?

Dr. Zachary Klaassen: I think it's a great question, but I think the reason it probably isn't is because it doesn't have the long-term data.

And that doesn't mean that it's not the right treatment for the right patient, but it's immaturity of data in terms of follow up. We're not treating the entire prostate gland like we are with radiation or surgery. And so I think that that sort of is an important delineation between sort of what we call standard of care treatment or standard treatment of the entire prostate versus the select group of men that may be a candidate for just treating that one specific area of the prostate gland.

Dr. Leslie Ballas: When we're dealing with something that doesn't have as long of follow-up, like you're stating, how can patients evaluate or find a qualified doctor for this treatment since it's relatively new?

Dr. Zachary Klaassen: Yeah, that's a great question. I think the importance is that the patients and their families have to understand that there is people that have their—not their best interests in mind, but have their best cancer interests in mind.

And those that may be doing this on maybe patients that may not be as appropriate. And that's sort of the dark truth in some of these situations, and I think finding somebody that has a reputable track record, certainly has great experience with it. Having ability to have a

follow-up protocol, not just treating the patient and being done with it, but following with serial MRIs and biopsies.

And so it's—it can be tricky to find those patients—or find those physicians. I don't think there's a perfect answer for it. But doing research on who's doing it, who's been doing it for a while, and really asking pointed questions about their follow-up plan is important.

Dr. Leslie Ballas: Thank you. I think that does help patients a lot understand how to find just the right physician to treat them.

Dr. Zachary Klaassen: Yeah.

Dr. Leslie Ballas: You've laid out, both in this discussion and in your slides, that the follow-up protocol is essential. And I think part of that is understanding what options patients have after focal therapy. You know, God forbid their cancer is not completely controlled or they have a recurrence on the other side of the gland. Can you have surgery? Can you have treatments after focal therapy?

Dr. Zachary Klaassen: Yeah, absolutely. I think this is, honestly, it's hard to summarize this in a sort of overview. I think it's a case-by-case basis. The general answer is yes. I think it depends on the type of focal therapy that was used. Was it a half of the gland or just a part of that one half of the gland?

We're really worried about tissue changes if we're thinking about taking out the prostate after this type of therapy. And that can make it more difficult. You know, quite honestly, and I think MRIs are helpful with maybe seeing some of those planes and evaluating. I certainly think radiation is still relatively easy to do after focal therapy. I think surgery is probably a case-by-case basis, but it is feasible. I think it's a case-by-case situation., though.

Dr. Leslie Ballas: Thank you so much for explaining that. I see Becky's back to introduce our next session.