

Dr. Phillip Koo: First, wanted to start off by thanking PCF. PCF is a wonderful organization with decades of a proven track record of supporting groundbreaking research and it's also wonderful to see PCF supporting a lot of this patient education, which we all know makes a huge difference.

And thank you all for joining on this Saturday to learn more about prostate cancer. And as we all know, an informed patient is an empowered patient. And I think one of the many takeaways I learned this morning from Drs. Klassen and Ballas, is that it's really complicated. There is no one-size-fits-all solution. Even though it might be presented to you in that manner.

And in the end, I think the patients and the caregivers need to make it be well known to the physicians and APPs [advanced practice providers] taking care of you that these are the things that are important. These are your goals. This is what you need and use that to help craft what treatment plan is best for you and your family. So, really appreciate this time.

Now we're going to sort of jump into this idea of the topic of PSMA PET imaging. You know, we're really focusing on this idea of localized prostate cancer, but how do we know it's localized? And the truth is, we're never going to be 100% sure it's localized...we're going to talk about the sort of current FDA approvals for when you should use PSMA PET.

So the current indication, at initial diagnosis, is if there's a high suspicion for metastatic disease. So Dr. Ballas gave a wonderful overview of what that means. And according to those criteria, it's really about identifying those. If you've been identified with unfavorable intermediate-risk, high-risk, or very high-risk, that is an indication to go ahead and get a PSMA PET/CT. And then you have sort of other, you know, factors that we talked about. She talked about Decipher scores and other biomarkers that might place you in that higher-risk category of having metastatic disease. And again, this is one of those times in which a PSMA PET should be discussed and possibly obtained in that right clinical scenario.

One point I'd also like to recommend is the fact that if you are going to get a PSMA PET, you do not need to get a CT and a bone scan prior to that PSMA PET. Don't waste the time, don't waste your resources in getting something that we know is not going to perform as well as a PSMA PET.

So the image at the bottom, the reason why I included that, and for those of you who are fans of architecture, you'll recognize this house is Pierre Koenig's Case Study #21, and the reason I put it in was I wanted to sort of just emphasize that sometimes simple, less is

more, sometimes simple is better. And I know when you hear about—you go on the internet, you read about PSMA PET, you think, wow, this is amazing, wonderful.

I need this all the time. It might sound good, but that's not always true. So I think it's one of those times where you have to have a real open discussion and figure out when it makes the most sense for you in your management journey. You know, Dr. Klaassen gave a wonderful presentation on focal therapies. This is one of those burgeoning areas about—for PSMA PET, because there's a lot of discussions now about if you are going to get focal therapy, maybe you should get a PSMA PET prior to focal therapy to make sure you don't have any metastatic disease.

So again, this is one of those areas we're still learning a lot about. And that's why it's important for everyone to sort of stay tuned and keep up to date. Because I think we're going to learn more and more about this, especially in that focal therapy space as well...So to review when we talk about PSMA PET/CT, there's various different radionuclides or radiopharmaceuticals that could be injected into you in order to create that wonderful multicolored image that you guys often see.

One of the products is Pylarify.® One is Posluma. ® There's two others that are—have different isotopes called Illucix ® and Locametz. ® In the end, I don't think any of us can say with any convincing authority that one is better than the other. They all might have little subtle differences in how they're they distribute in your body. But I can't really give a convincing reason why you have to get one versus another.

Here's a very important point to recognize is that when you get a PSMA PET, when you're diagnosed, it is not perfect. It is not going to capture all of the disease that you have in your body, because the technology itself doesn't have that high resolution. And oftentimes you will get micro cells or small clumps of cells that cannot be detected by imaging, but they can be detected by a microscope.

That's why I sort of include this little picture saying that this does not replace the microscope. There's sort of two different levels of resolution that I would love to say PET could do it, but currently we can't compete with that microscope. The other point that's really important is if there is something seen on a PET that looks like metastatic disease, more often than not, and this is what we call specificity, it is going to be true and it's going to be metastatic.

So that's good from that perspective, that gives you confidence in what you're seeing on that imaging test...So, you know, let's just sort of talk through various scenarios. You're newly diagnosed with prostate cancer. Let's say you're unfavorable intermediate-risk. You sit down with your physician. You have a conversation. The decision is made to move forward with a PSMA PET/CT. Again, it doesn't matter which one they're injecting into your venous system. And one of the results that you might get is the PSMA PET comes back. It's negative. It's normal. You breathe a sigh of relief. Wonderful. This is the best scenario you could get. However, it's important to go back to what we talked about earlier that PSMA PET can miss micrometastatic disease.

And that's why we talk about the sensitivity only being in that 40 to 45% range. So even though we think that way, you should—if surgery was planned, you should still go on with surgery. And they should still stick with whatever plan they had before the imaging, just to make sure there aren't sort of other sites of disease that are below the resolution of PSMA PET.

So a good result doesn't mean it's perfect though. And that's sort of the take-home message. If the results come back positive, then it's really a question of how is it positive? Is it sort of in the nodes? Is it in the prostate? Where did it migrate to? Is it one lesion, two lesions, ten lesions, 20 lesions? And all of that will help inform the discussion about what to do next.

And we're not going to focus too much about this because this will be more for that advanced cancer prostate cancer, which will be for a different webinar later in the year. And the other scenario, which is unfortunate but occurs less often, is oftentimes it could be equivocal where there might be some questions or there might be some hedging on what the results mean, and sometimes you will it will be recommended to go on to additional imaging or maybe a biopsy to help clarify. And, you know, not ideal. But again, we need to know what these mean before we could actually go forward with the right treatment plan. So you know, Zach talked about this earlier. Hearing that “C-word.” You know, you're going through a lot of things in your mind.

You're feeling like “I got to take care of this immediately.” And, you know, start the process as soon as possible. We understand that. But it's also important to have the right information at the right time to make sure every decision afterwards is appropriate and best for your care. So that's all I have and welcome any questions. Thank you.

00:08:33:06 - 00:08:46:14

Dr. Zachary Klaassen: Thank you, Dr. Koo, that was outstanding and, great at the patient level. In the interest of time, we will move on to the next session. Thank you for that great presentation. So I'll bring Becky back on to introduce our next session, please.