Becky Campbell: So without further ado, I want to introduce our wonderful co-hosts, Dr. Oliver Sartor and Dr. Neal Shore.

So, Dr. Oliver Sartor is a medical oncologist at the Mayo Clinic. He's an internationally recognized expert in prostate cancer, has published more than 500 peer-reviewed publications, and has led four pivotal multi-institutional trials leading to FDA approvals. He also serves as Vice Chair of the GU Cancer Committee for NRG oncology.

Next, I'd like to introduce Dr. Neal Shore. He's medical director at the Carolina Urologic Research Center. He is an internationally recognized expert in therapies for patients with advanced urologic cancers, has conducted more than 400 clinical trials and more than 350 peer-reviewed publications, and serves as an editorial board member of multiple journals.

I'd like to welcome Dr. Sartor and Dr. Shore. They're going to start off by talking about the landscape of advanced prostate cancer and define what that is. Then they'll get into more details about treatment options for metastatic hormone-sensitive prostate cancer. So, welcome Dr. Sartor and Dr. Shore.

Dr. Neal Shore: Well, thank you so much, Becky. And, I just want to say, I think I speak for Dr. Sartor and our other faculty that are coming on that PCF does an amazing job of bringing forward patient, digestible, authentic material in a very fair and balanced way. It's sort of my “go-to” website resource for my patients when they're newly diagnosed, regardless of the stage. And this has been multiple decades of great work.

The website and the materials are curated and updated regularly from therapeutics, diagnostics strategies to how to deal with cancer, as well as for their family members. So, it's a great honor to be here. And great to always do a program to start off with my dear friend and colleague, Dr. Oliver Sartor. So, let's go to our first slide, please.

And I'm going to go through in a pretty rapid succession. The journey for prostate cancer. And, you know, it's remarkable what's happened. And the key and the title here is over the decades, patients are diagnosed sometimes with advanced disease, we say oftentimes “advanced,” I think, meaning the disease is outside the prostate. But the first red box, when it's localized or confined to the prostate, a very significant percentage of patients don't require anything.

We've learned a lot about the importance of active surveillance, and we've been somewhat guilty, I think, as urologists in particular, and maybe radiation oncologists, too - is overtreatment. We've learned a lot, but there's still a significant percentage, probably more than half who have more aggressive disease. And then that's what's meant by definitive therapy, whether it's surgical or radiation. And then when I get to the next slide, it'll go over some of those options.

We don't always cure everyone, unfortunately, with definitive therapy or an active treatment, and then we see oftentimes the PSA starts to go up, which we've sometimes referred to as biochemical recurrence.

The PSA doubling time, PSA velocity, or the rate of rise of the PSA becomes very important. We'll talk a little more about that. Imaging, identifying whether it's low volume, only a few lesions, or a multiple lesions, what we sometimes call "high volume." And that leads us to disease within the pelvis, outside the pelvis, it could be in bones, it can be in soft tissue, it can be in the lungs, the liver. And then a decision is made at a certain point in time, whether it's "BCR," the biochemically recurrent, or the metastatic, about starting testosterone suppression therapies as well as oral androgen receptor pathway drugs. And then the second half of our program, we're going to get into what happens when you go from having sensitive disease versus what we call "resistant disease." Next slide please.

So, this gets a little more into the weeds. I'm not going to go through every one of these for purposes of time. And I want to have a discussion with Dr. Sartor. But we're focusing on here in that first left box is: right, there's a spectrum from active surveillance, which doesn't mean we ignore the disease we monitor. Maybe there's a repeat biopsy. How is the patient doing regarding any local symptoms?

And of course, monitoring the PSA. Interventional treatments are listed here, sometimes with or without systemic therapies. And there's an evolving burgeoning area of focal therapy. It's been with us for several decades. A couple of things are listed here, but it's an area that is very ripe for a lot of different technologies. Sometimes that can create some confusion for patients, but it is important to recognize we're making advances. When you get to have definitive or active treatment and you develop biochemical recurrence, as one can see in the black box subsumed under the biochemical recurrence, all these different things and different approaches.

And I think one of the things that's really important today is the multidisciplinary team and inclusive of that, meaning, what does the urologist, the medical oncologist, the radiation oncologist. How is the pathologist weighing in from genetic standpoint? The nuclear medicine radiologist, the nursing team?

And of course, the family. And that's where shared decision-making is an incredibly important theme for all of our patients who are listening today, their caregivers. We're moved away from this kind of paternalistic, approach where, I, doctor will tell you what you must do.

There's really now an opportunity for a lot of discussion and shared decision making. I think this is remarkably important. And, well, that'll be a theme, I think, throughout this entire two-hour program.