Managing Castrate Resistant Metastatic Prostate Cancer

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There have been some game-changers in terms of disease management. A new monoclonal antibody will be coming out, denosumab. Provenge would be desirable in the pre-chemotherapy state, but patients who are calling to be put on the waiting list already have had chemo and their PSA is very high. Asymptomatic and minimally symptomatic men fall usually within the pre-chemotherapy space. Abiraterone, an AR modulator, will likely be a positive study, and it is yet to be determined as pre- or post-chemo. Carbazitaxel is newly approved for use.

The thing which confuses me in clinical trials is how do you define castrate resistant disease? One group defined endpoints which put a patient into this castrate resistant category: PSA minimum of 2 ng/mL; rising PSA at least one week apart; lymph nodes greater than 2 cm; and two or more lesions on bone scan. Management includes the supportive aspect: get the DEXA scan, and give calcium and vitamin D. Standard of care still is zoledronic acid; we worry about renal function, ONJ, but we want to try to minimize or prevent the skeletal related complications. We want to determine how to get PSA to not rise, even with bone mets, before starting chemotherapy. We can try Casodex; ketoconazole; steroids; DES with Coumadin; and consider a clinical study.

Provenge is exciting in a biological sense. Our center in Michigan is one of only 50 sites in the U.S. allowed access to Provenge. Our waiting list continues to grow: this is without publicity, patients just know. People are coming from Germany; they are willing to pay cash for a noncurative therapy. The company cannot keep up. Most concern is to try to make treatment more effective and less toxic.