

# Consensus Questions APCCC 2024

Advanced Prostate Cancer Consensus Conference 2024  
25-27 April 2024  
Lugano, Switzerland



## **Unless stated otherwise, it is assumed that:**

- All treatments and diagnostic procedures are readily available.
- There are no treatment contraindications.
- There are no options to participate in clinical trials.
- Unless stated otherwise, recommendations apply only to non-frail patients and patients with prostate acinar adenocarcinoma.

## **Answer Options**

- If someone did not feel expert in a specific topic, they could choose: abstain/unqualified to answer

## **Levels of consensus are defined as follows:**

≥75% agreement on an answer option: Consensus

≥90% agreement on an answer option: Strong consensus

For certain questions we have predefined to pool answer options with similar intent

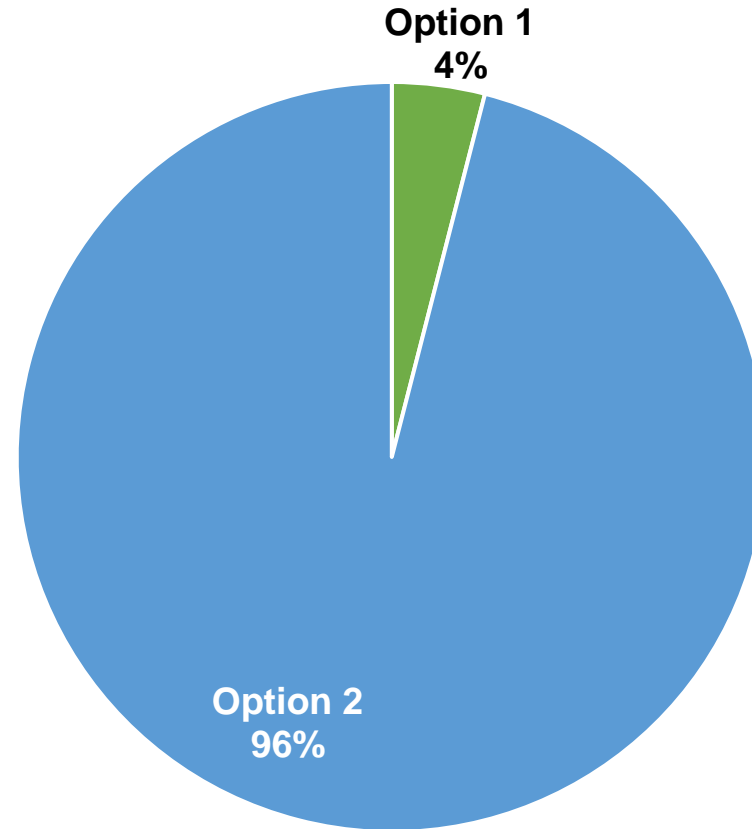
**Unlike other consensus approaches, APCCC does not aim to reach consensus for a specific answer option but we concentrate on reaching consensus on the phrasing of the questions/answer options**

# 1. High-risk localised and locally advanced prostate cancer

## 1.1. General questions

1. In the majority of patients with localised prostate cancer and clinically T2 (DRE positive) cN0 cM0 and ISUP  $\geq 3$  carcinoma and clear evidence of T3 disease on MRI, what do you recommend?

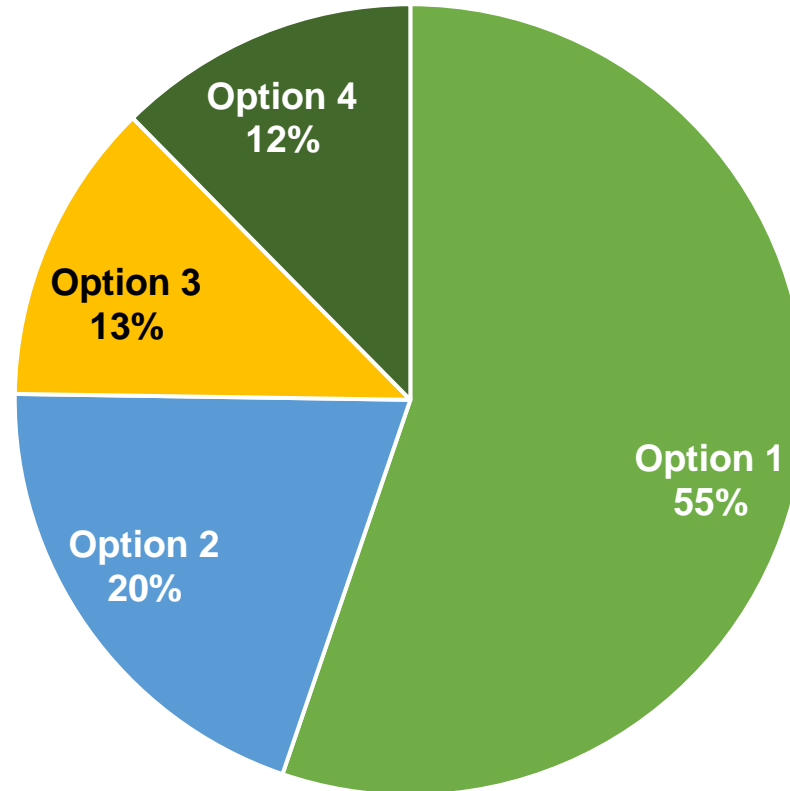
1. Treat as T2
2. **Treat as T3**
3. Abstain/unqualified to answer



Option	Votes
Option 1	4
Option 2	96
Abstain	6

2. In the majority of patients with clinically high-risk localised or locally advanced prostate cancer and one PSMA PET positive bone lesion WITHOUT a correlate on the CT component of the initial PSMA PET, what do you recommend as next investigation?

1. Correlative conventional imaging (e.g., MRI, X-rays or bone scintigraphy)
2. Biopsy if feasible
3. No further investigation, treat as M0
4. No further investigation, treat as M1
5. Abstain/unqualified to answer (including: I do not recommend PSMA PET imaging in this situation)

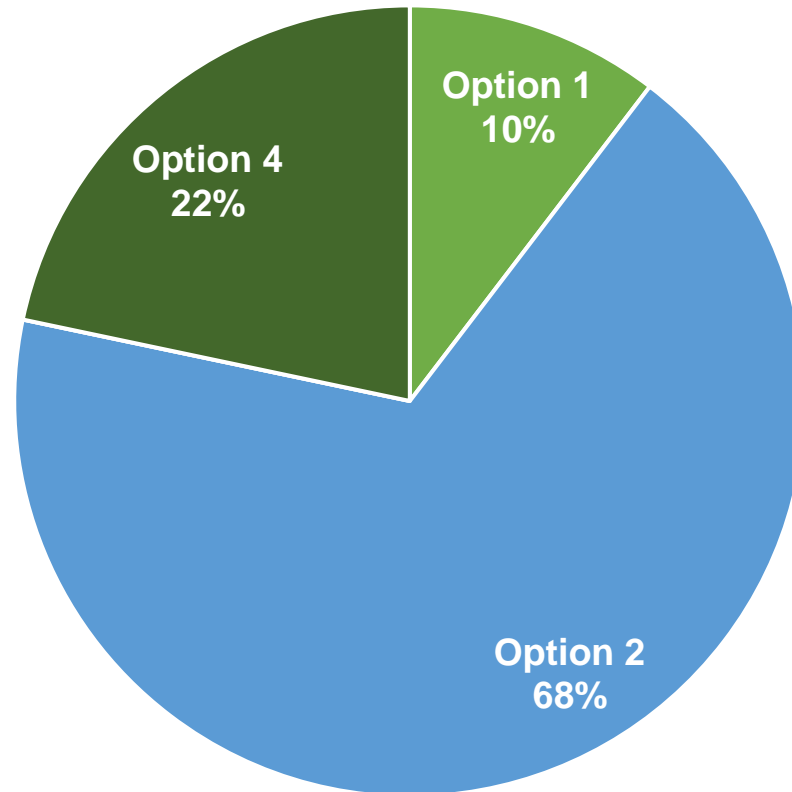


Option	Votes
Option 1	58
Option 2	21
Option 3	13
Option 4	13
Abstain	1

1. High-risk localised and locally advanced prostate cancer
- 1.2. Treatment of high-risk localised/locally advanced prostate cancer

3. In the majority of patients with high-risk localised/locally advanced prostate cancer (STAMPEDE definition) N0 M0 on next-generation imaging, what is your recommended treatment?

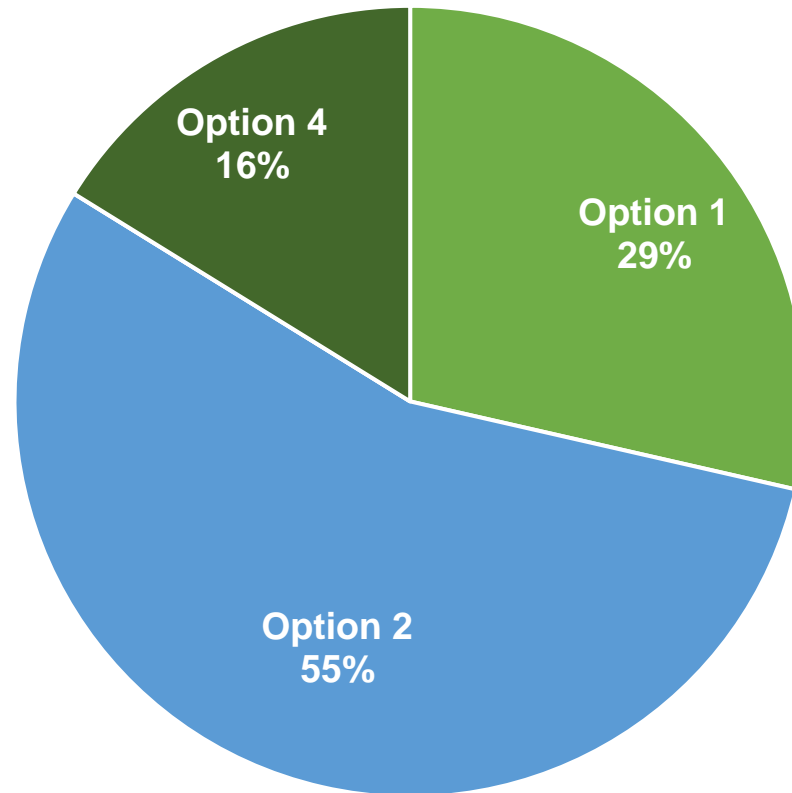
1. Radiation plus long-term ADT alone
2. Radiation plus long-term ADT plus abiraterone for 2 years
3. Radiation plus long-term ADT plus docetaxel
4. Surgery, recognising that it may be part of a multimodality approach
5. Abstain/unqualified to answer



Option	Votes
Option 1	11
Option 2	72
Option 3	0
Option 4	23
Abstain	0

4. In the majority of patients with very high-risk localised prostate cancer (NCCN definition) and NOT high-risk localised/locally advanced prostate cancer (STAMPEDE definition) N0 M0 on next-generation imaging, what is your recommended treatment?

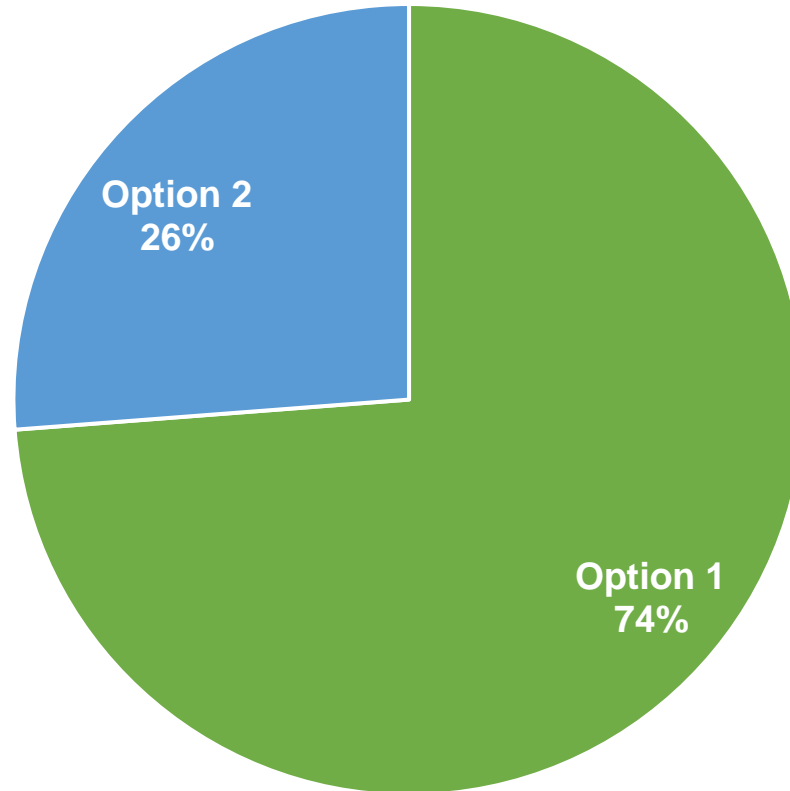
1. Radiation plus long-term ADT alone
2. Radiation plus long-term ADT plus abiraterone for 2 years
3. Radiation plus long-term ADT plus docetaxel
4. Surgery, recognising that it may be part of a multimodality approach
5. Abstain/unqualified to answer



Option	Votes
Option 1	30
Option 2	58
Option 3	0
Option 4	17
Abstain	1

5. For patients with high-risk localised or locally advanced prostate cancer that you would like to treat with radiation therapy plus long-term ADT plus abiraterone for 2 years (M0 disease) and in case the patient is not eligible for abiraterone, is it appropriate to substitute abiraterone with one of the novel AR antagonists (Apa, Daro, Enza)?

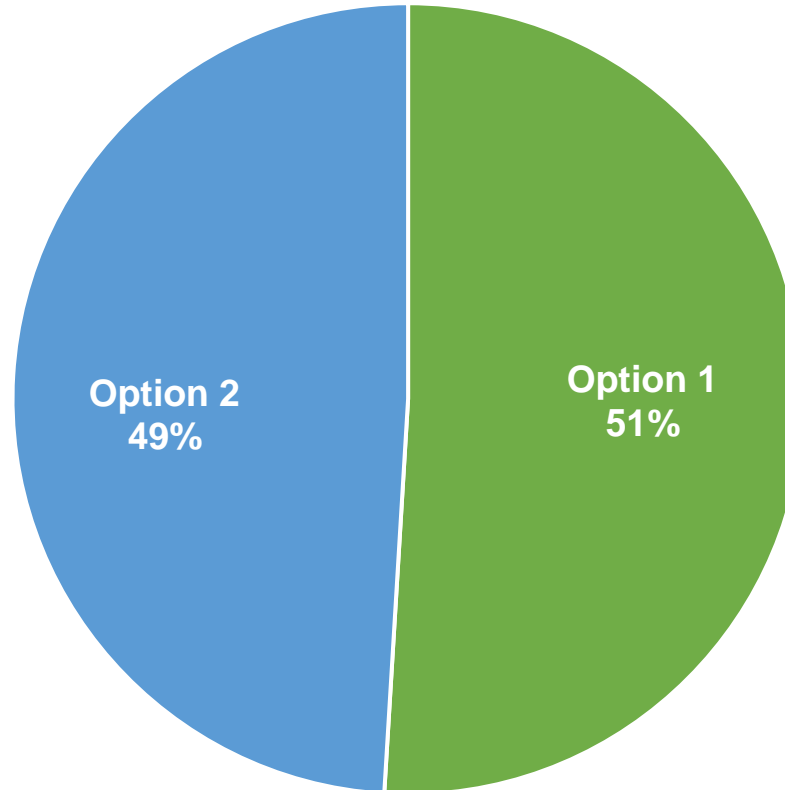
- 1. Yes
- 2. No
- 3. Abstain/unqualified to answer (including I do not use this regimen)



Option	Votes
Option 1	76
Option 2	27
Abstain	3

6. In general, is it appropriate for the majority of patients also if they are eligible for abiraterone to substitute abiraterone with one of the novel AR antagonists (Apa, Daro, Enza) in combination with radiation plus long-term ADT in M0 disease?

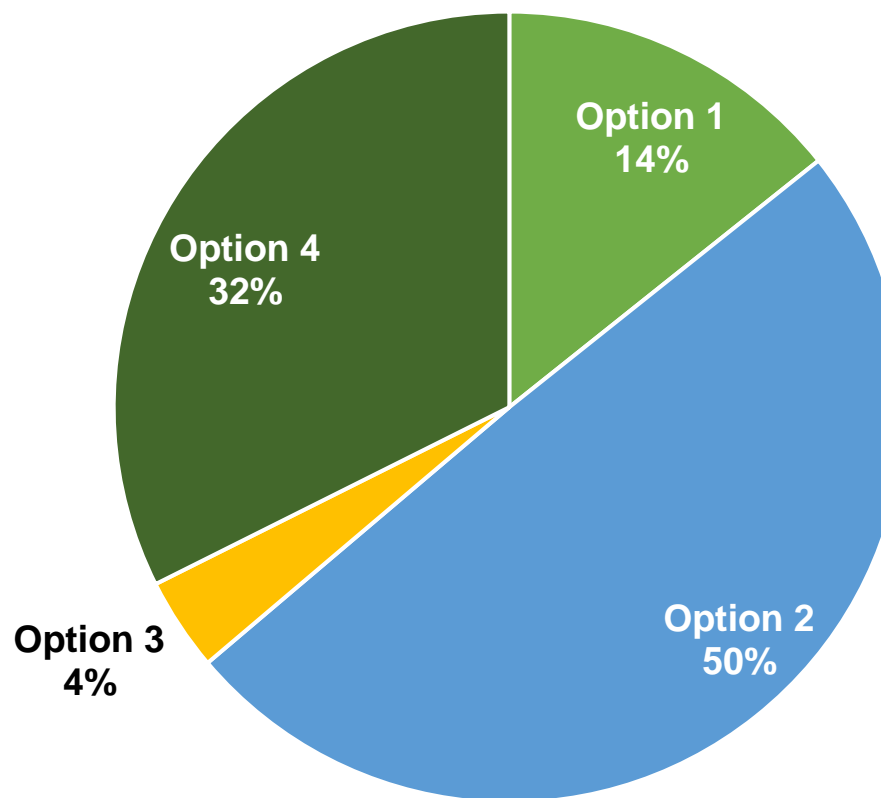
1. Yes
2. No
3. Abstain/unqualified to answer (including I do not use this regimen)



Option	Votes
Option 1	53
Option 2	51
Abstain	2

7. In the majority of patients with high-risk localised/locally advanced prostate cancer cT3, Gleason 8-10 (no evidence of small cell carcinoma) and low PSA (e.g. <3ng/mL) what do you recommend?

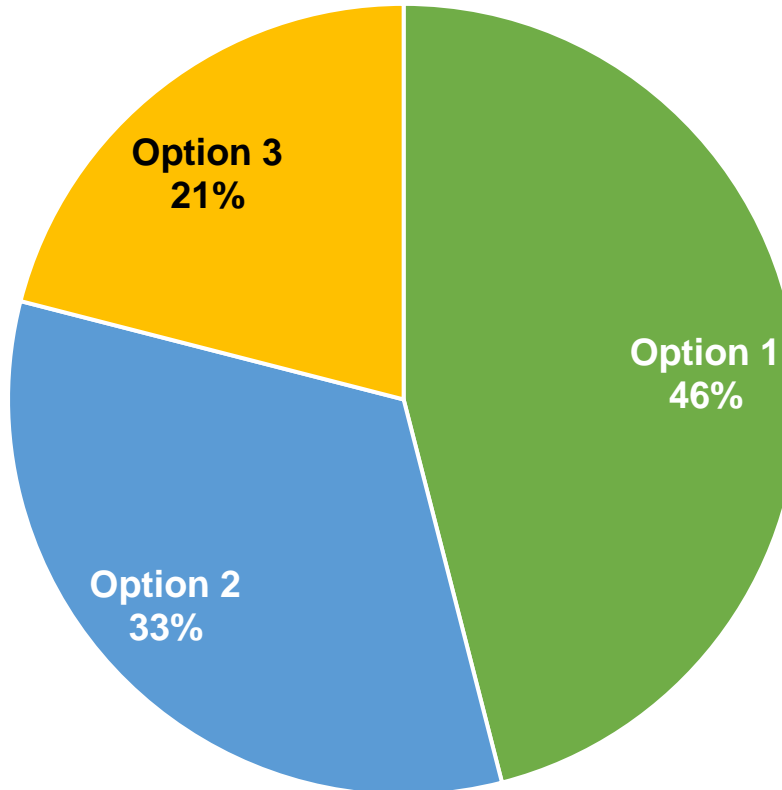
1. Radiation plus long-term ADT alone
2. Radiation plus long-term ADT plus abiraterone for 2 years
3. Radiation plus ADT plus 4-6 cycles of docetaxel
4. Surgery, recognising that it may be part of a multimodality approach
5. Abstain/unqualified to answer



Option	Votes
Option 1	15
Option 2	52
Option 3	4
Option 4	34
Abstain	1

8. In patients with high-risk localised/locally advanced prostate cancer planned for radiation therapy do you recommend neoadjuvant systemic therapy (3-9 months ADT ± ARPI) before start of radiation therapy?

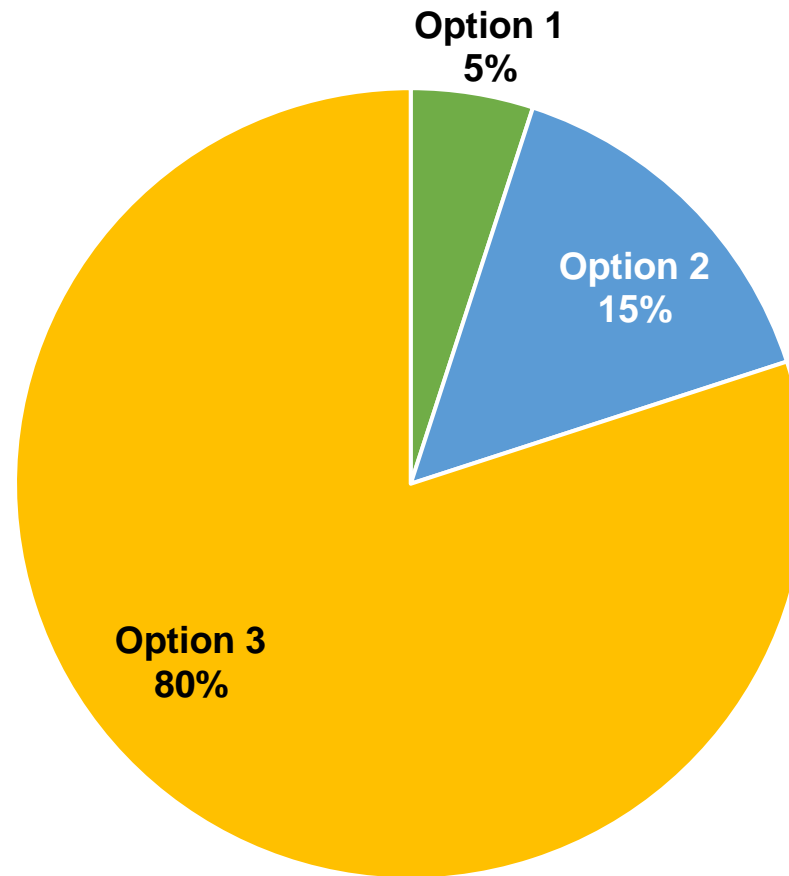
1. Yes, in the majority of patients
2. Yes, in selected patients for downstaging or for logistical reasons (e.g. long waiting time)
3. No
4. Abstain/unqualified to answer (including I do not recommend radiation in this situation)



Option	Votes
Option 1	46
Option 2	33
Option 3	21
Abstain	6

9. In patients with high-risk localised/locally advanced prostate cancer planned for radical prostatectomy do you recommend neoadjuvant systemic therapy (ADT ± ARPI) before surgery?

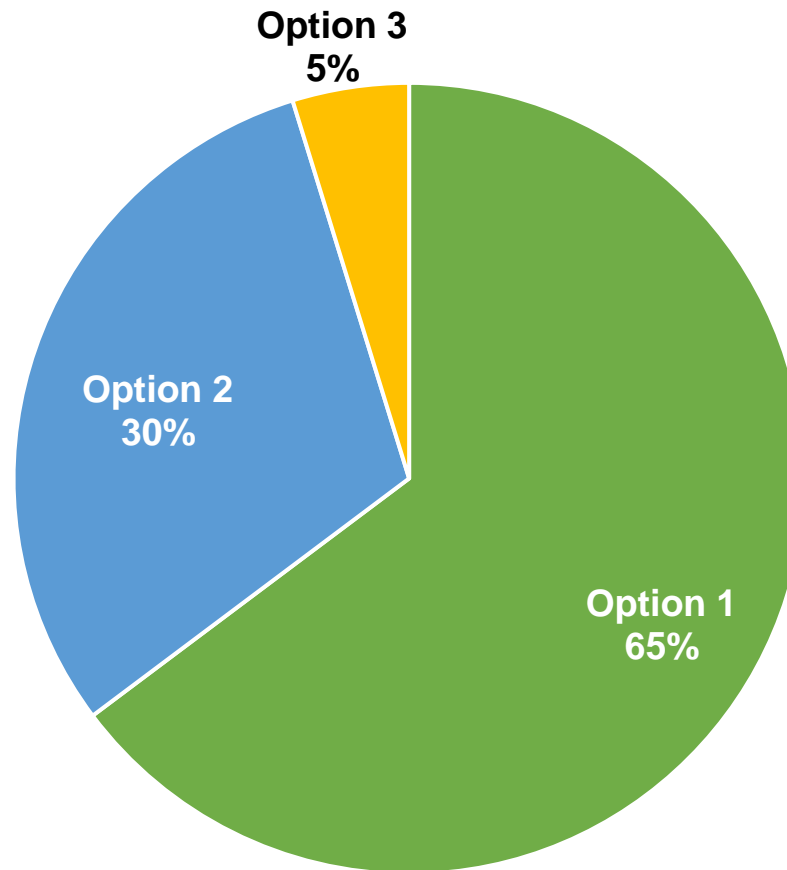
1. Yes, in the majority of patients
2. Yes, in selected patients for downstaging or for logistical reasons (e.g. long waiting time)
- 3. No**
4. Abstain/unqualified to answer (including I do not recommend radiation in this situation)



Option	Votes
Option 1	5
Option 2	15
Option 3	80
Abstain	6

10. In patients with high-risk localised/locally advanced prostate cancer that you treat with radiation therapy plus long-term ADT plus abiraterone for 2 years and with no relevant toxicity, is it appropriate to stop also the ADT after two years instead of after 3 years?

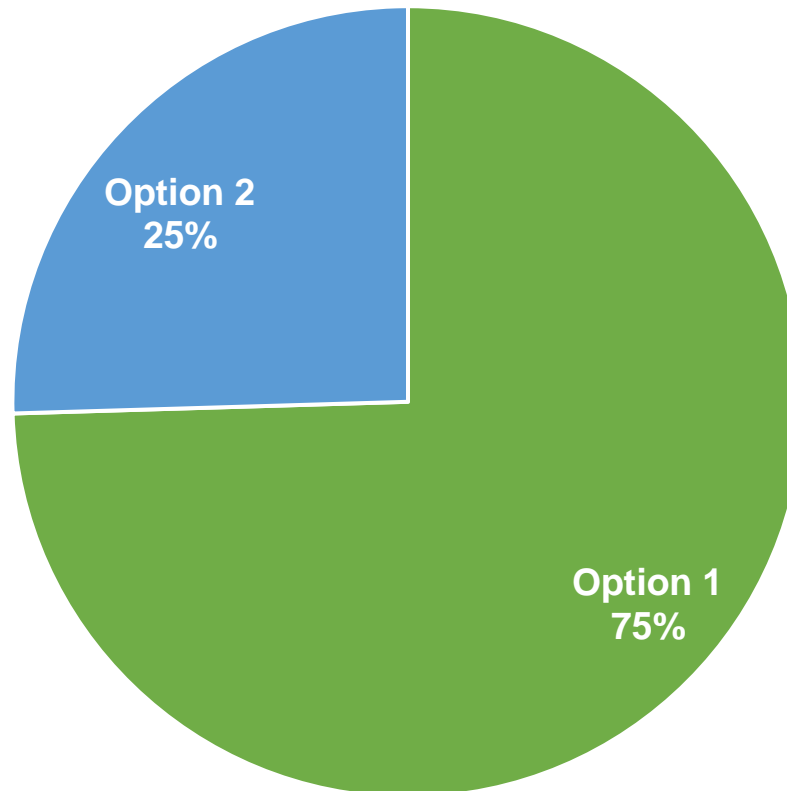
1. Yes, in the majority of patients
2. Yes, in selected patients (e.g. with a relevant cardiovascular history)
3. No
4. Abstain/unqualified to answer (including I do not use this regimen)



Option	Votes
Option 1	68
Option 2	32
Option 3	5
Abstain	1

11. For the majority of patients with high risk localised/locally advanced prostate cancer who are about to start ADT ( $\pm$  ARPI) do you recommend baseline testosterone measurement before starting systemic therapy?

- 1. Yes
- 2. No
- 3. Abstain/unqualified to answer



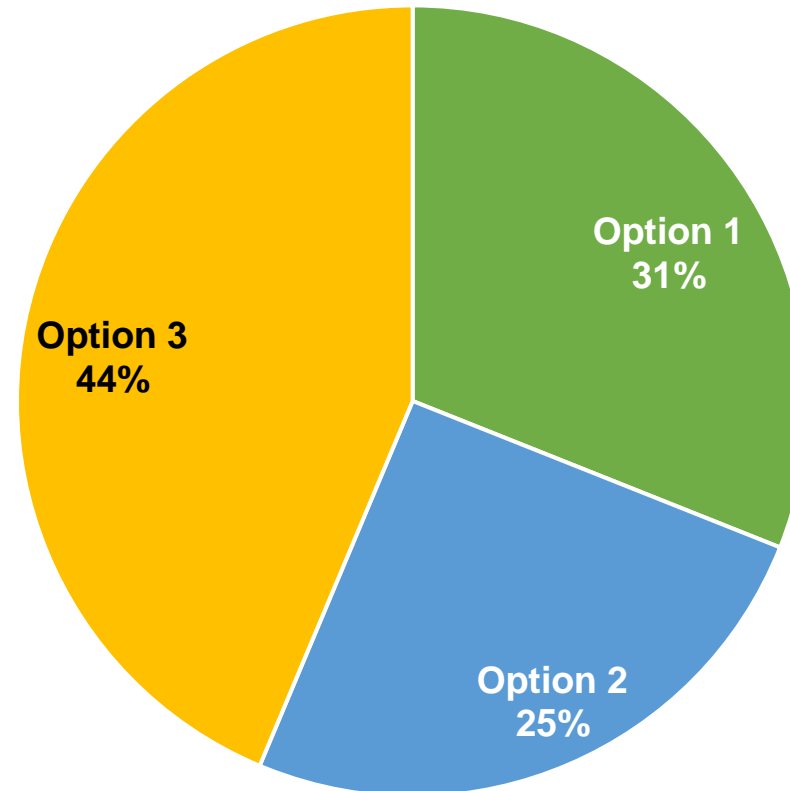
Option	Votes
Option 1	79
Option 2	27
Abstain	0

# 1. High-risk localised and locally advanced prostate cancer

## 1.3. Lymphadenectomy in localised prostate cancer

12. In patients with unfavourable intermediate-risk localised prostate cancer (NCCN definition) for whom radical prostatectomy is planned, and who have a negative PSMA PET (N0 M0), do you recommend an extended pelvic lymphadenectomy (ePLND)?

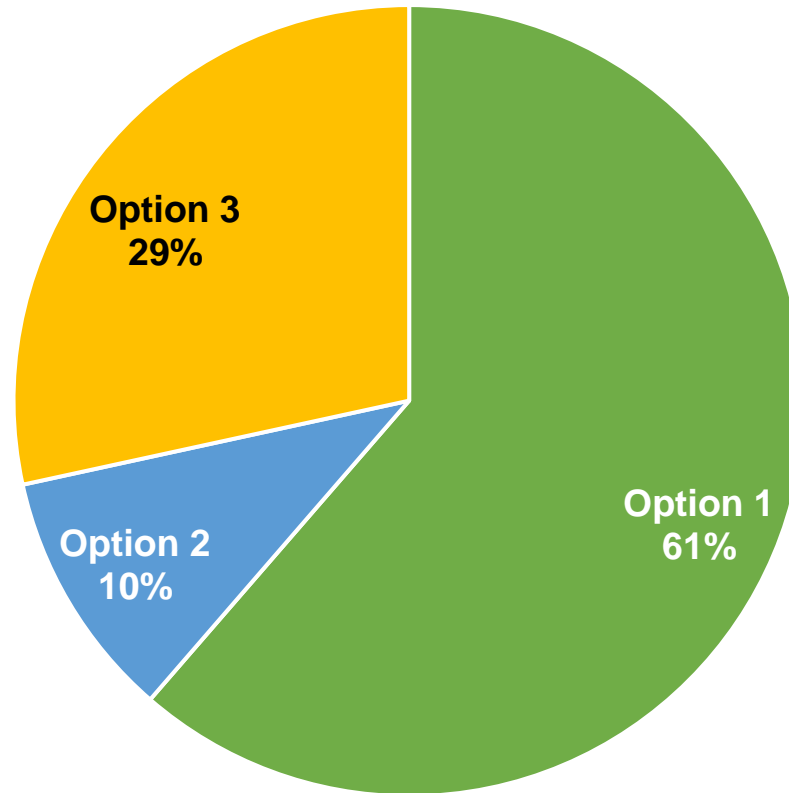
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	27
Option 2	22
Option 3	38
Abstain	19

13. In patients with high-risk localised prostate cancer (NCCN definition) for whom radical prostatectomy is planned, and who have a negative PSMA PET (N0 M0), do you recommend an extended pelvic lymphadenectomy (ePLND)?

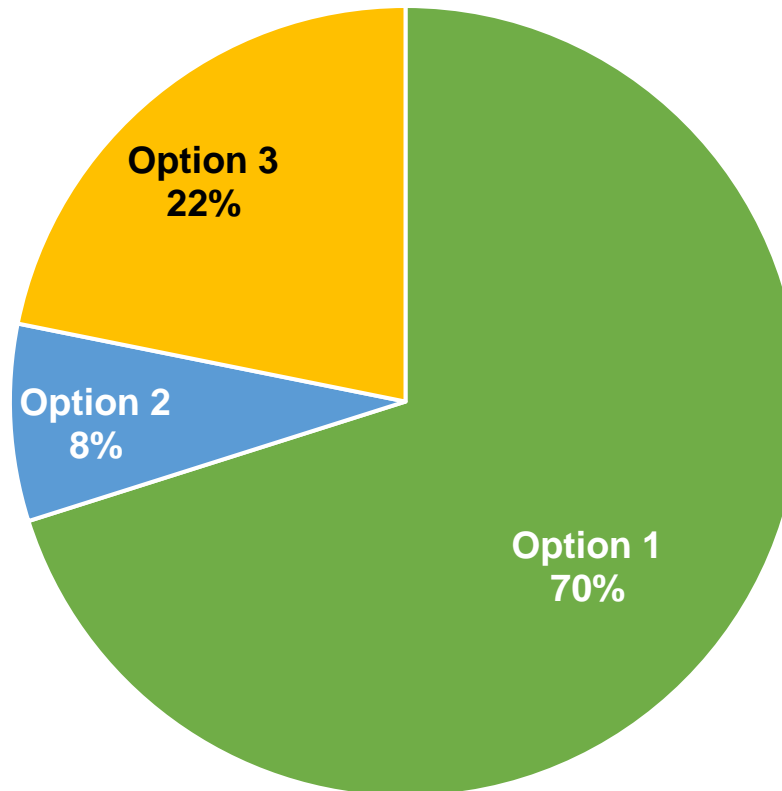
- 1. Yes, in the majority of patients
- 2. Yes, but only in selected patients
- 3. No
- 4. Abstain/unqualified to answer



Option	Votes
Option 1	54
Option 2	9
Option 3	25
Abstain	18

14. In patients with very high-risk localised prostate cancer (NCCN definition) for whom radical prostatectomy is planned, and who have a negative PSMA PET (N0 M0), do you recommend an extended pelvic lymphadenectomy (ePLND)?

1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



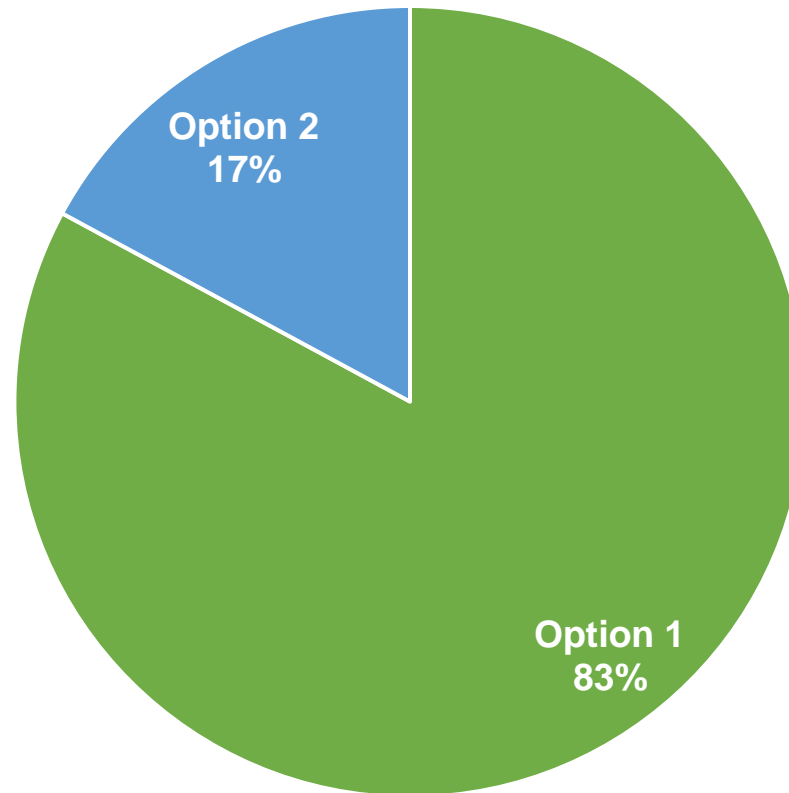
Option	Votes
Option 1	61
Option 2	7
Option 3	19
Abstain	19

# 1. High-risk localised and locally advanced prostate cancer

## 1.4. Radiation therapy in high-risk localised and locally advanced prostate cancer

15. In the majority of patients with high-risk localised/locally advanced prostate cancer undergoing radiation therapy to the prostate in combination with long-term ADT do you recommend a radiation therapy dose escalation (with an equivalent total dose of approximately 80Gy in 2Gy fractions)?

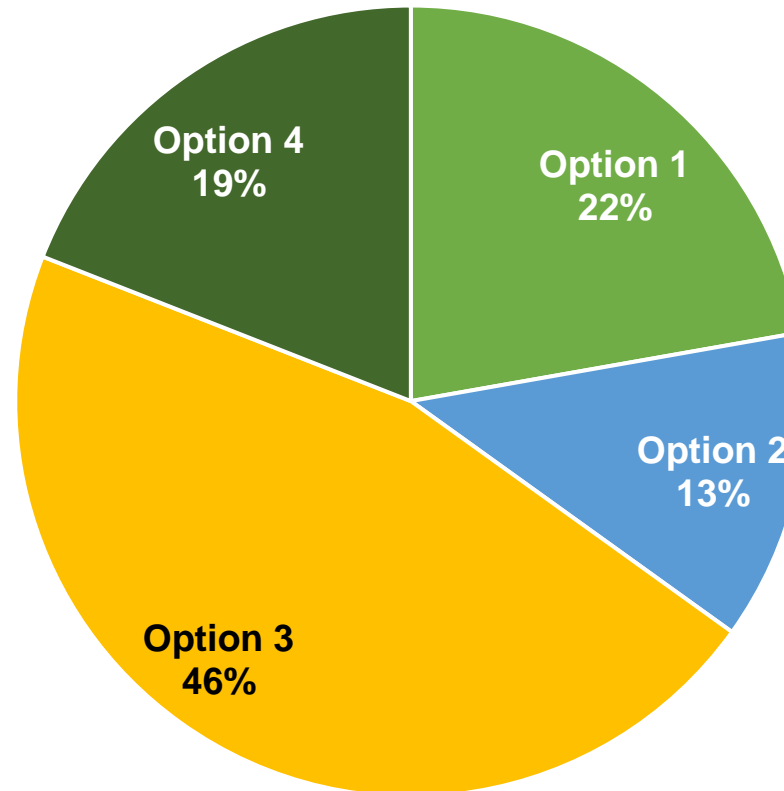
- 1. Yes
- 2. No
- 3. Abstain/unqualified to answer



Option	Votes
Option 1	63
Option 2	13
Abstain	30

## 16. In the majority of patients with high-risk localised/locally advanced prostate cancer undergoing RT to the prostate, which dose escalation modality do you recommend?

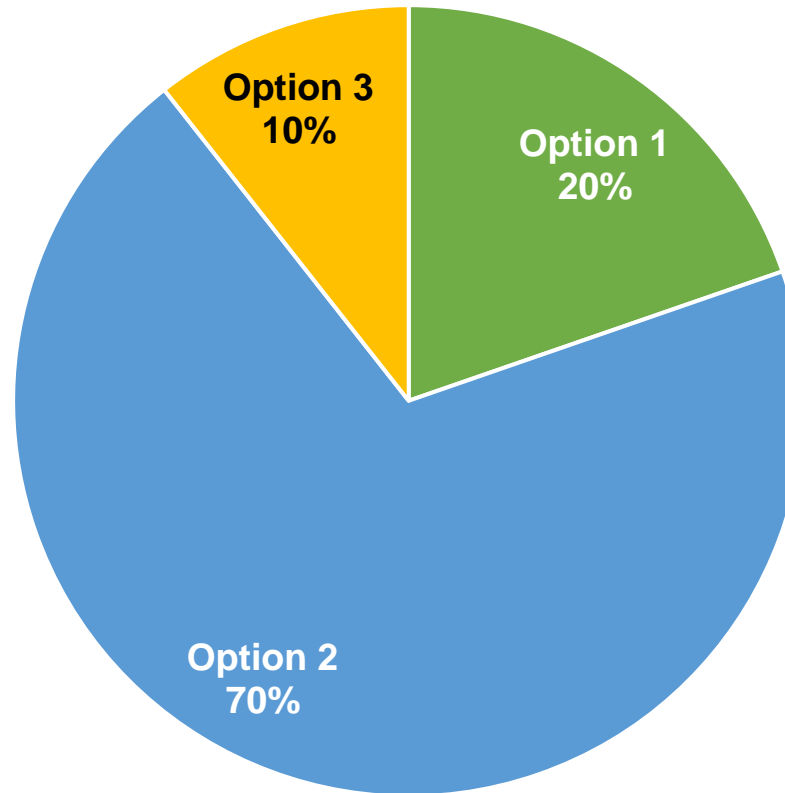
1. Combination of EBRT (45-50 Gy) + brachytherapy boost
2. Whole prostate radiation therapy with standard fractionation (e.g. 80Gy in 40 fractions)
3. Whole prostate radiation therapy with moderate hypofractionation (e.g. 62Gy in 20 fractions equivalent to 80Gy in 40 fractions)
4. Focal boost to the intraprostatic tumour (e.g. 95Gy/35 fractions or 67Gy/20 fractions or equivalent)
5. Abstain/unqualified to answer (including I do not recommend dose escalation)



Option	Votes
Option 1	14
Option 2	8
Option 3	29
Option 4	12
Abstain	43

17. In the majority of patients with high-risk localised/locally advanced prostate cancer undergoing radiation therapy to the prostate, what fractionation do you recommend?

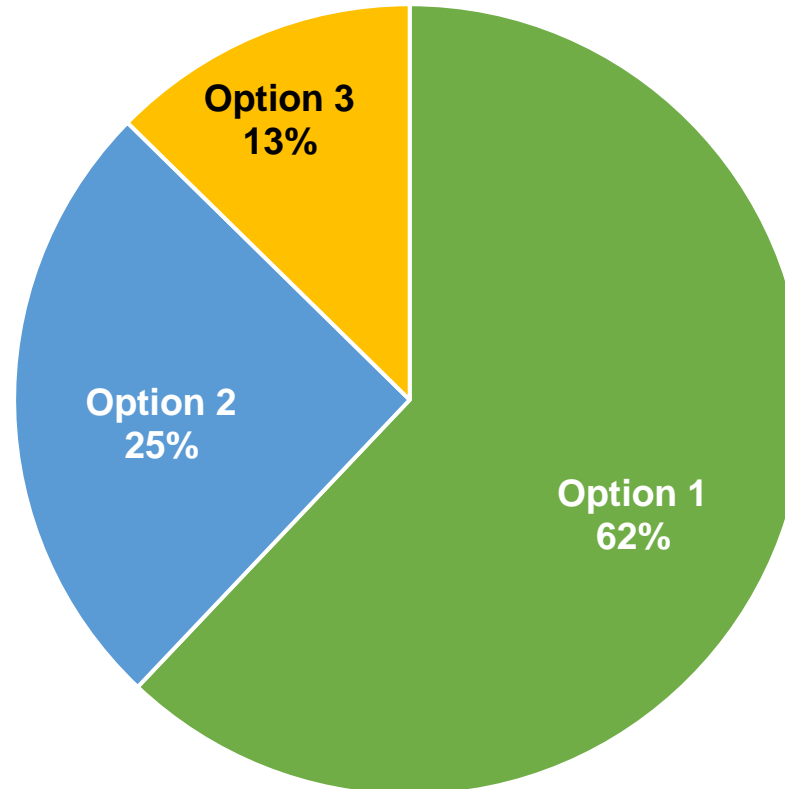
1. Conventional (1.8-2 Gy/fractions)
2. Moderate hypofractionation (2.5-3.0/Gy fractions)
3. Ultrahypofractionation/SBRT (>6 Gy/fractions)
4. Abstain/unqualified to answer



Option	Votes
Option 1	13
Option 2	46
Option 3	7
Abstain	40

18. In patients with high-risk localised/locally advanced prostate cancer undergoing RT to the prostate, who have had conventional imaging only and are cN0, do you recommend radiation therapy to pelvic nodes?

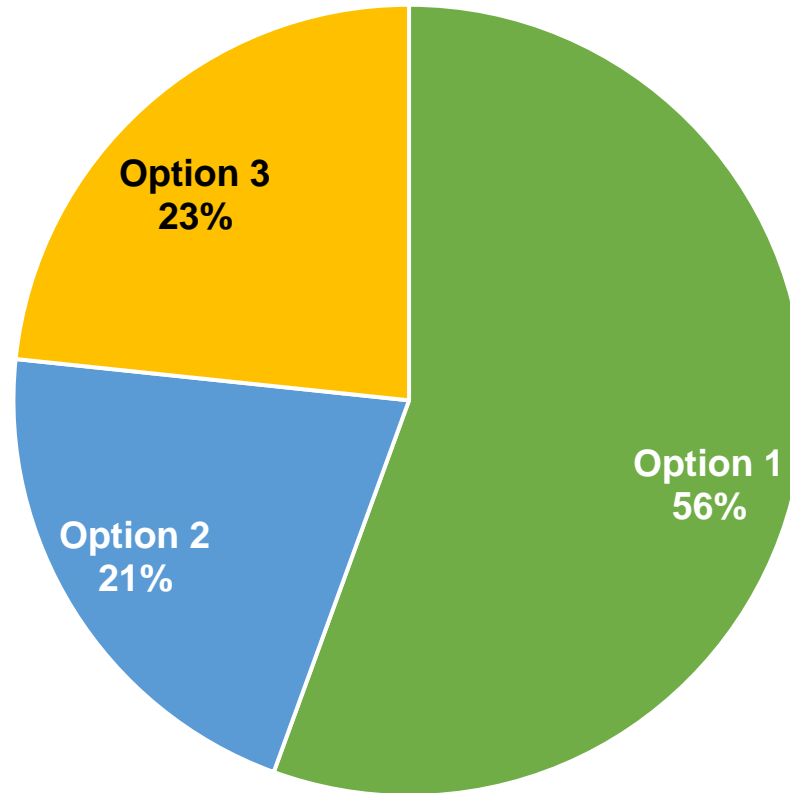
1. Yes, in the majority of patients
2. Yes, but only in selected patients based on risk factors
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	54
Option 2	22
Option 3	11
Abstain	19

19. In patients with high-risk localised/locally advanced prostate cancer undergoing RT to the prostate, who have had a PSMA PET and are cN0, do you recommend radiation therapy to the pelvic nodes?

1. Yes, in the majority of patients
2. Yes, but only in selected patients based on risk factors
3. No
4. Abstain/unqualified to answer



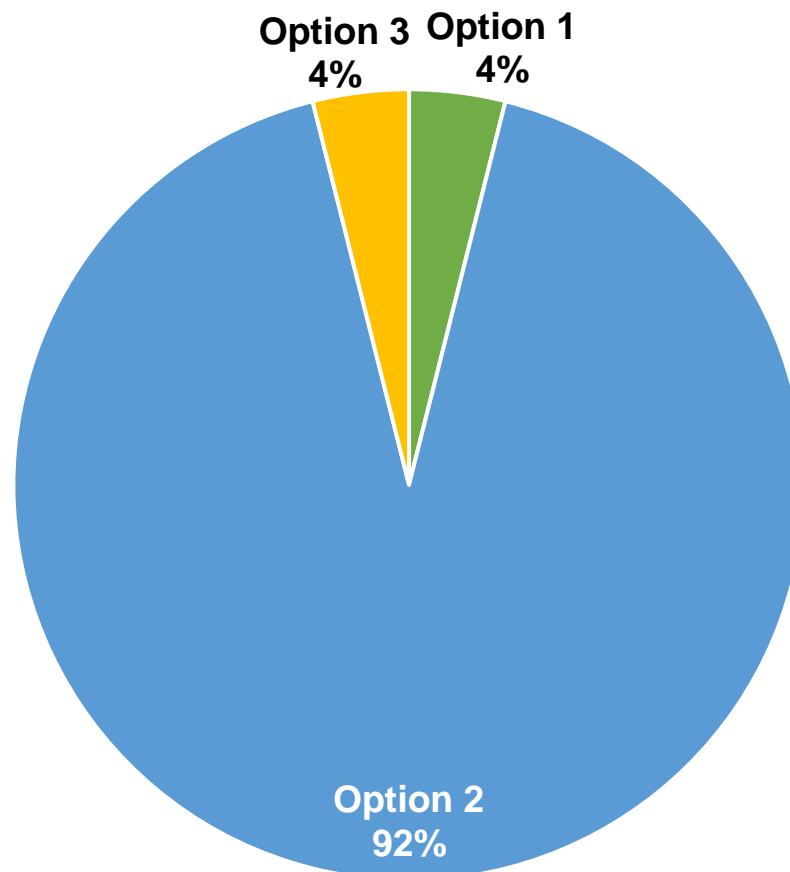
Option	Votes
Option 1	50
Option 2	19
Option 3	21
Abstain	16

# 1. High-risk localised and locally advanced prostate cancer

## 1.5. Treatment of cN1 disease

20. What is your preferred treatment recommendation for the majority of patients with prostate cancer with newly diagnosed cN1 (pelvic lymph nodes) on conventional imaging and no distant lesions (M0)?

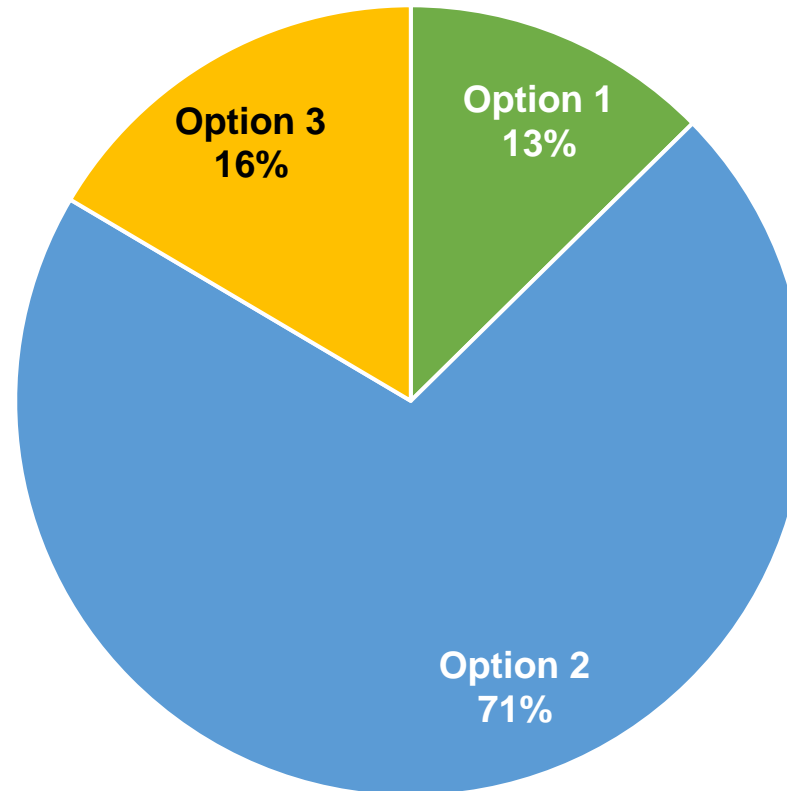
1. Radiation therapy prostate plus pelvis plus long-term ADT
2. **Radiation therapy prostate plus pelvis plus long-term ADT plus abiraterone for 2 years**
3. Surgery, recognising that it may be part of a multimodality approach
4. Abstain/unqualified to answer



Option	Votes
Option 1	4
Option 2	94
Option 3	4
Abstain	4

21. What is your preferred treatment recommendation for the majority of prostate cancer patients with cN0 on conventional imaging and positive pelvic lymph nodes on PSMA PET imaging but no distant lesions (M0) and otherwise NOT meeting the STAMPEDE (high-risk, locally advanced M0) definition?

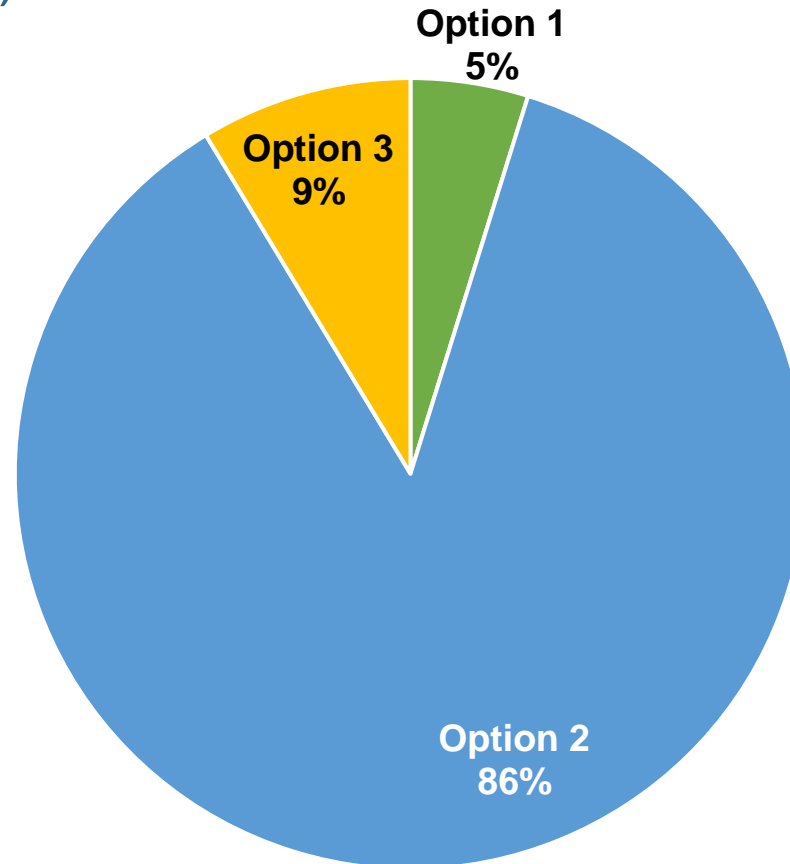
1. Radiation therapy prostate plus pelvis plus long-term ADT
2. Radiation therapy prostate plus pelvis plus long-term ADT plus abiraterone for 2 years
3. Surgery, recognising that it may be part of a multimodality approach
4. Abstain/unqualified to answer



Option	Votes
Option 1	13
Option 2	73
Option 3	17
Abstain	3

22. What is your preferred treatment recommendation for the majority of prostate cancer patients with cN0 on conventional imaging but positive pelvic lymph nodes on PSMA PET but no distant lesions (M0) and meeting also the STAMPEDE (high-risk, locally advanced M0) definition?

1. Radiation therapy prostate plus pelvis plus long-term ADT
- 2. Radiation therapy prostate plus pelvis plus long-term ADT plus abiraterone for 2 years**
3. Surgery, recognising that it may be part of a multimodality approach
4. Abstain/unqualified to answer



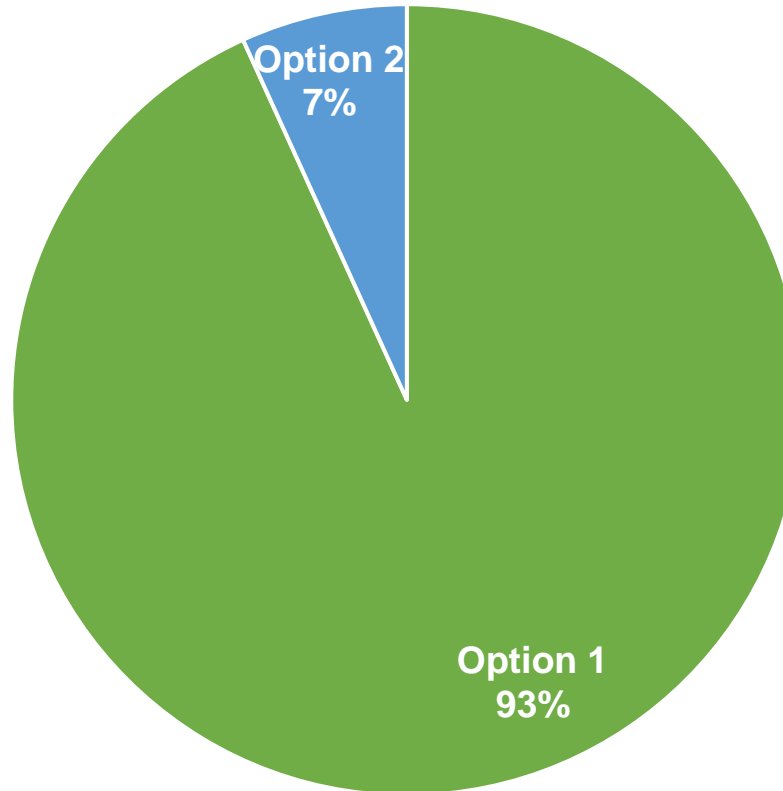
Option	Votes
Option 1	5
Option 2	90
Option 3	9
Abstain	2

## 1. High-risk localised and locally advanced prostate cancer

### 1.6. Adjuvant treatment considerations in node negative disease (pN0)

23. For the majority of patients with pT3b pN0 following radical prostatectomy with extended PLND and ISUP grade group 4-5 and R0 and with undetectable postoperative PSA, what is your recommendation provided the patient has regained continence?

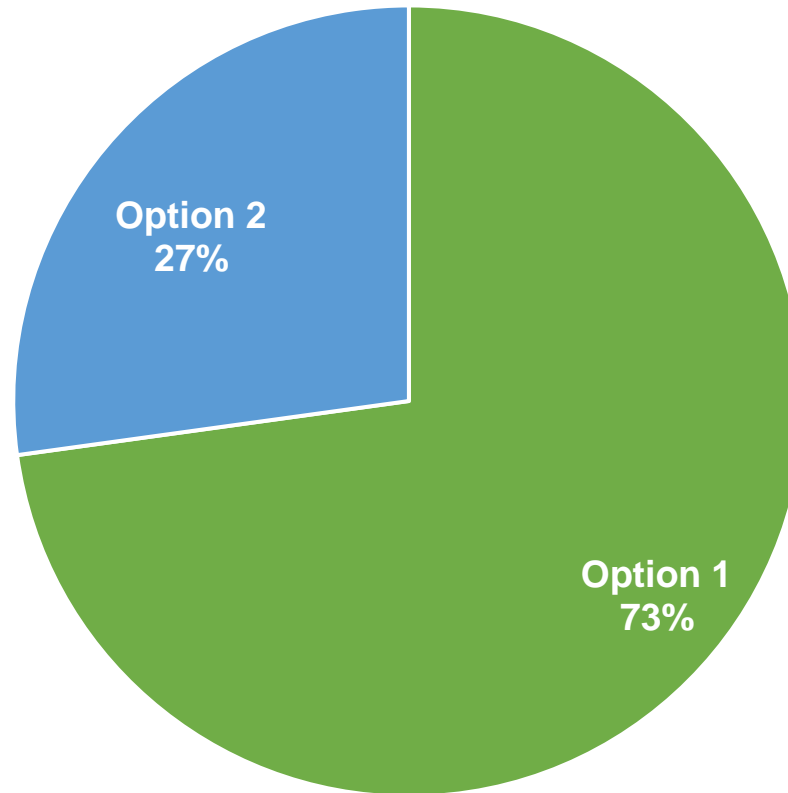
1. **Monitoring and early salvage therapy (RT or systemic therapy or both) in case of a confirmed PSA rise**
2. Adjuvant therapy (RT or systemic therapy or both)
3. Abstain/unqualified to answer



Option	Votes
Option 1	96
Option 2	7
Abstain	3

24. For the majority of patients with pT3b pN0 following radical prostatectomy with extended PLND and ISUP grade group 4-5 and R1 and with undetectable postoperative PSA, what is your recommendation provided the patient has regained continence?

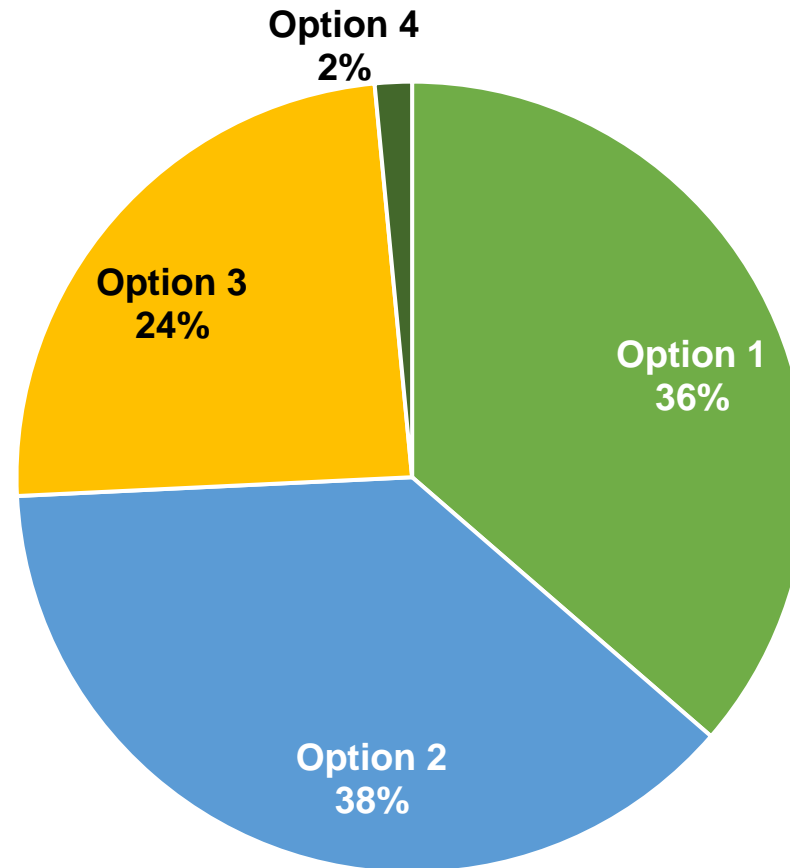
1. Monitoring and early salvage therapy (RT or systemic therapy or both) in case of a confirmed PSA rise
2. Adjuvant therapy (RT or systemic therapy or both)
3. Abstain/unqualified to answer



Option	Votes
Option 1	75
Option 2	28
Abstain	3

25. If you recommend adjuvant therapy in a patient with pT3b pN0 following radical prostatectomy with extended PLND and ISUP grade group 4-5 and R1 and with undetectable postoperative PSA what is your recommendation regarding systemic therapy?

1. Adjuvant radiation therapy alone
2. Adjuvant radiation therapy plus short-term (e.g. 6 months) of systemic hormonal therapy
3. Adjuvant radiation therapy plus long-term (e.g. 24 months) of systemic hormonal therapy
4. Systemic therapy alone
5. Abstain/unqualified to answer (including I never recommend adjuvant therapy)



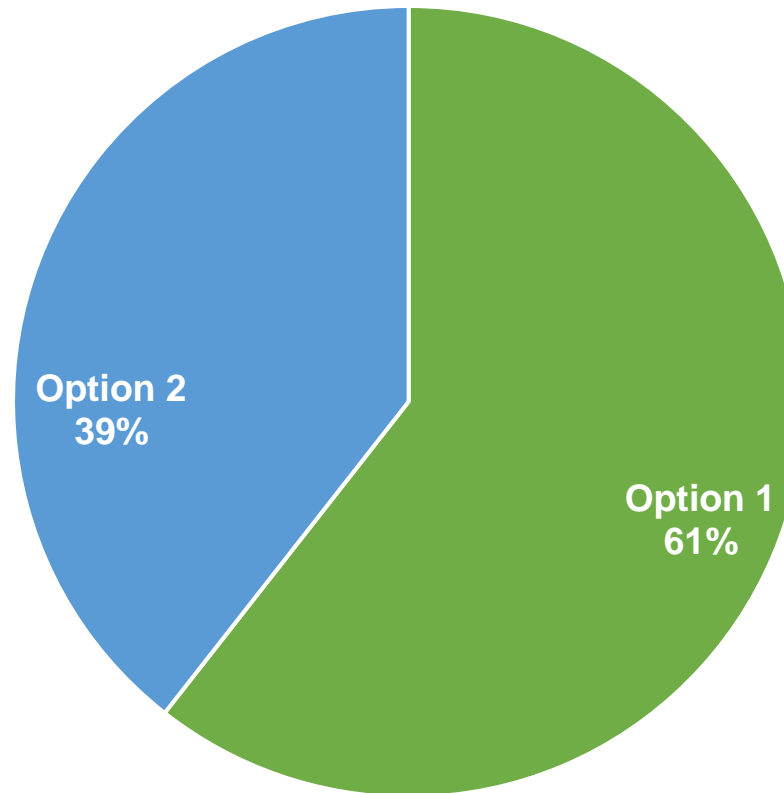
Option	Votes
Option 1	24
Option 2	25
Option 3	16
Option 4	1
Abstain	40

# 1. High-risk localised and locally advanced prostate cancer

## 1.7. Adjuvant treatment considerations in node positive disease (pN1)

26. For the majority of patients with pT3b and 1-2 pathologically involved pelvic lymph nodes (pN1) following radical prostatectomy with extended PLND and ISUP grade group 4-5 and with undetectable postoperative PSA, what is your recommendation provided the patient has regained continence?

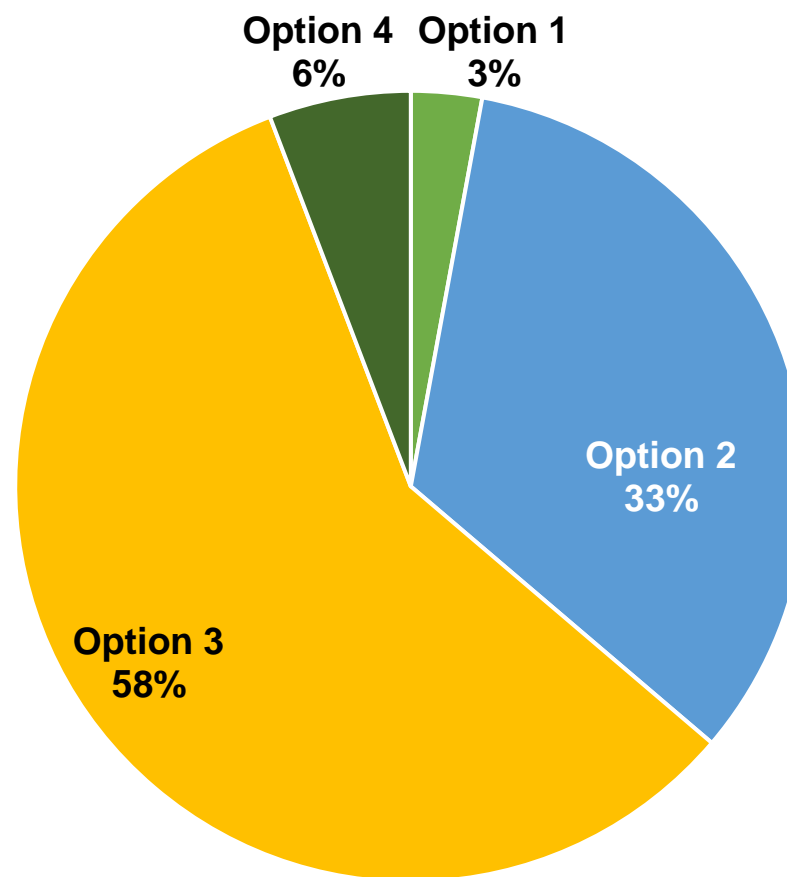
1. Monitoring and early salvage therapy (RT or systemic therapy or both) in case of a confirmed PSA rise
2. Adjuvant therapy (RT or systemic therapy or both)
3. Abstain/unqualified to answer



Option	Votes
Option 1	63
Option 2	41
Abstain	2

27. If you recommend adjuvant therapy in a patient with pT3b and 1-2 pathologically involved pelvic lymph nodes (pN1) following radical prostatectomy with extended PLND and ISUP grade group 4-5 and with undetectable postoperative PSA what is your recommendation regarding systemic therapy?

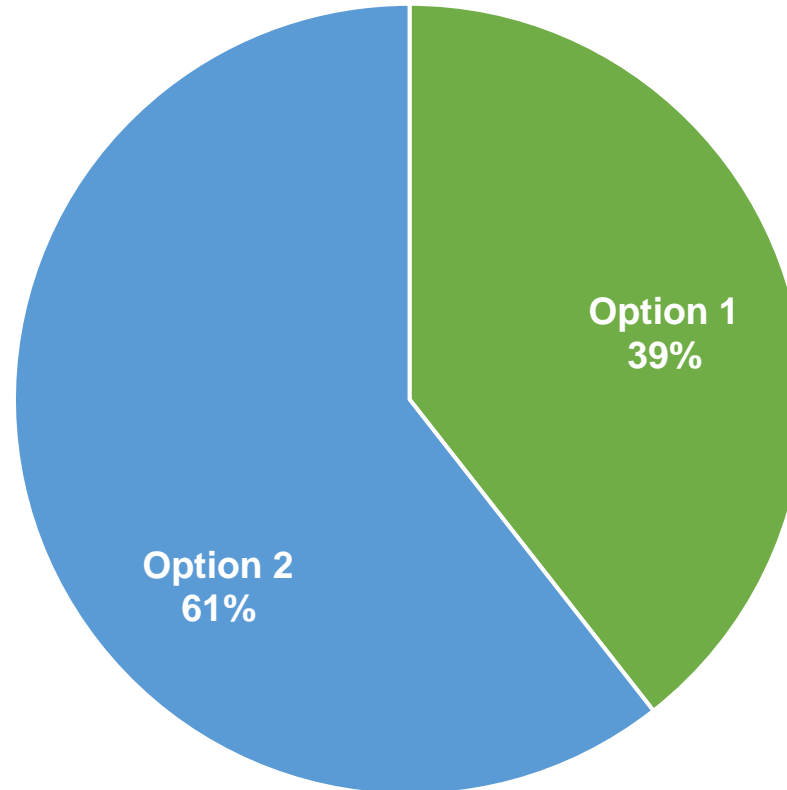
1. Adjuvant radiation therapy alone
2. Adjuvant radiation therapy plus short-term (e.g. 6 months) of systemic hormonal therapy
3. Adjuvant radiation therapy plus long-term (e.g. 24 months) of systemic hormonal therapy
4. Systemic therapy alone
5. Abstain/unqualified to answer (including I never recommend adjuvant therapy)



Option	Votes
Option 1	2
Option 2	23
Option 3	40
Option 4	4
Abstain	37

28. For the majority of patients with pT3b and 3 or more pathologically involved pelvic lymph nodes (pN1) following radical prostatectomy with extended PLND and ISUP grade group 4-5 and with undetectable postoperative PSA, what is your recommendation provided the patient has regained continence?

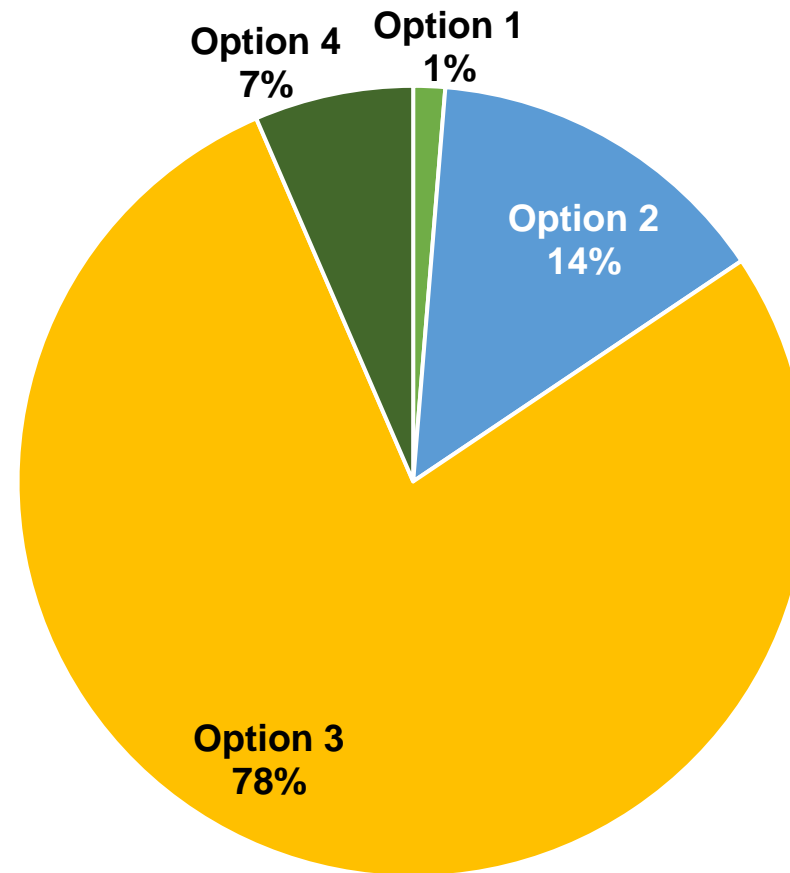
1. Monitoring and early salvage therapy (RT or systemic therapy or both) in case of a confirmed PSA rise
2. Adjuvant therapy (RT or systemic therapy or both)
3. Abstain/unqualified to answer



Option	Votes
Option 1	41
Option 2	63
Abstain	2

29. If you recommend adjuvant therapy in a patient with pT3b and 3 or more pathologically involved pelvic lymph nodes (pN1) following radical prostatectomy with extended PLND and ISUP grade group 4-5 and with undetectable postoperative PSA what is your recommendation regarding systemic therapy?

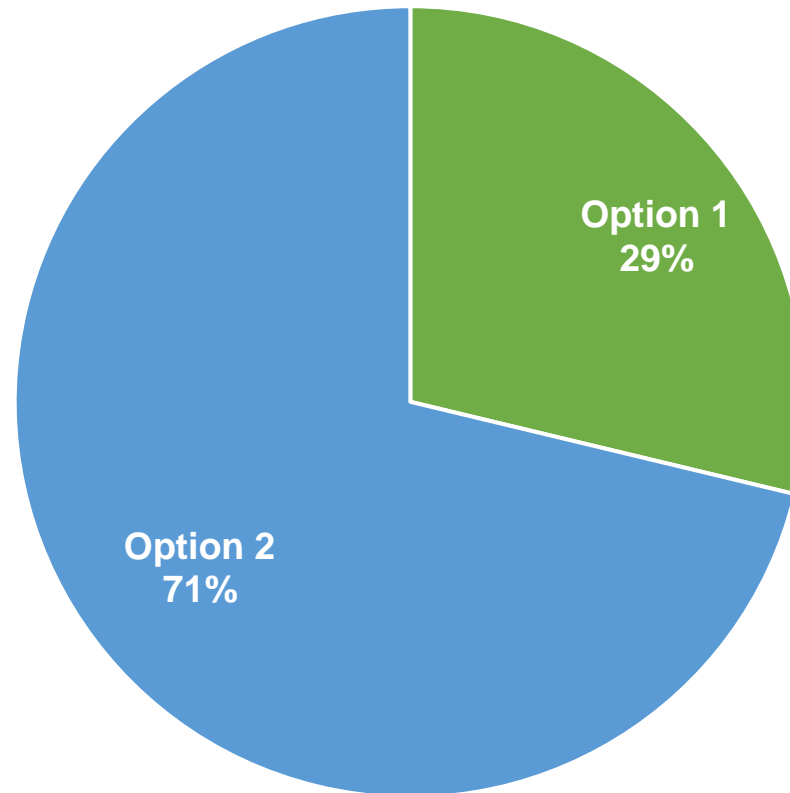
1. Adjuvant radiation therapy alone
2. Adjuvant radiation therapy plus short-term (e.g. 6 months) of systemic hormonal therapy
- 3. Adjuvant radiation therapy plus long-term (e.g. 24 months) of systemic hormonal therapy**
4. Systemic therapy alone
5. Abstain/unqualified to answer (including I never recommend adjuvant therapy)



Option	Votes
Option 1	1
Option 2	11
Option 3	60
Option 4	5
Abstain	29

30. For the decision to use adjuvant therapy if adverse features are present post radical prostatectomy do you recommend using a genomic classifier (e.g., Decipher) in the majority of patients?

1. Yes
2. No
3. Abstain/unqualified to answer (including I do not use a genomic classifier in this situation)



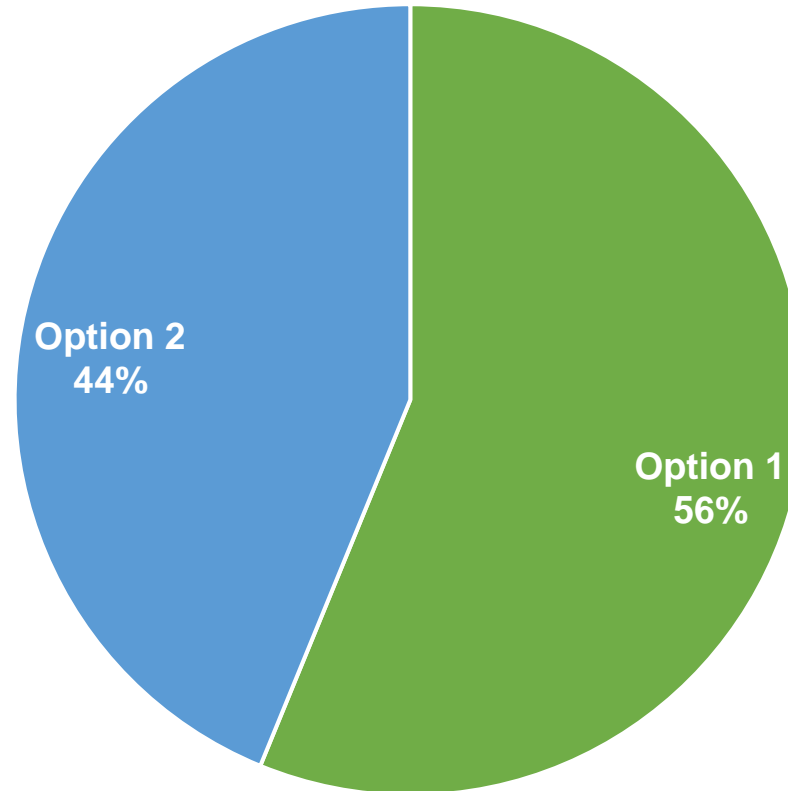
Option	Votes
Option 1	23
Option 2	57
Abstain	26

## 2. PSA Persistence and Biochemical Recurrence

### 2.1. PSA Persistence

31. What do you recommend for a patient with PSA persistence with a PSA value around 0.2 ng/mL post RP and pN0 on extended PLND and no evidence of risk factors (Risk factors: R1, pT3, ISUP grade group 4-5) and a negative postoperative PSMA PET, provided the patient has regained continence?

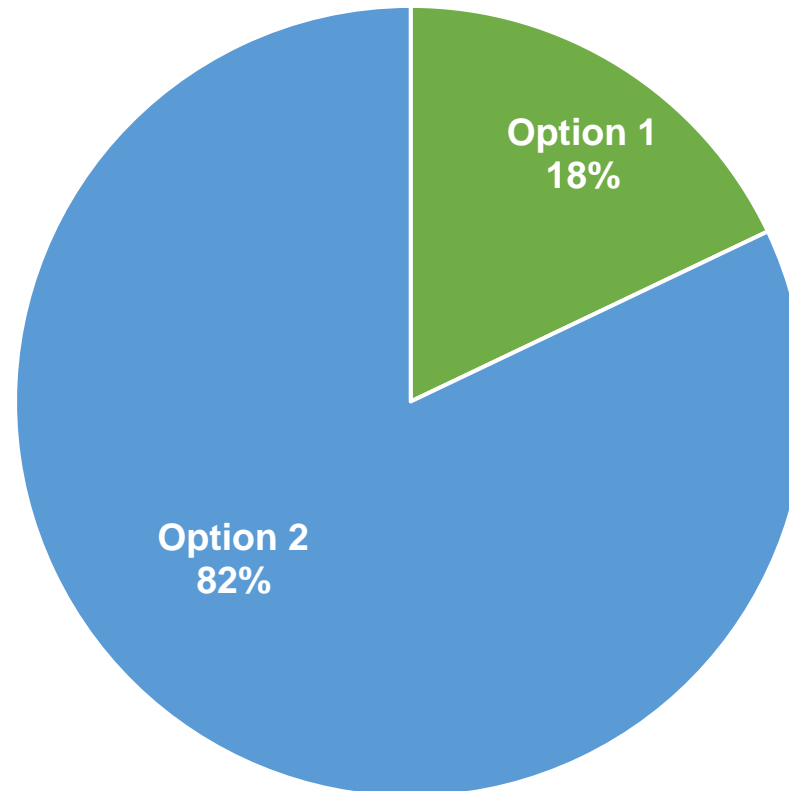
1. Monitoring (including imaging) and salvage therapy in case of further PSA rise
2. Immediate therapy (RT or systemic therapy or both)
3. Abstain/unqualified to answer



Option	Votes
Option 1	59
Option 2	46
Abstain	1

32. What do you recommend for a patient with PSA persistence with a PSA value around 0.7 ng/mL post RP and pN0 on extended PLND and no evidence of risk factors (Risk factors: R1, pT3, ISUP grade group 4-5) and a negative postoperative PSMA PET, provided the patient has regained continence?

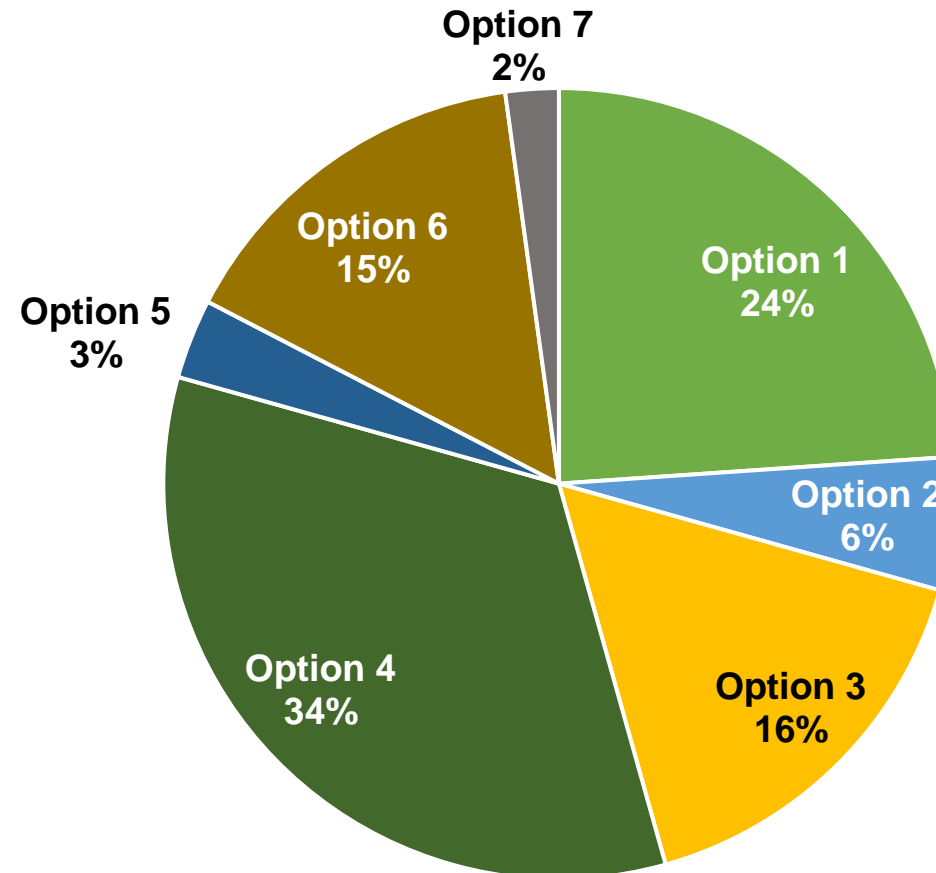
1. Monitoring (including imaging) and salvage therapy in case of further PSA rise
2. **Immediate therapy (RT or systemic therapy or both)**
3. Abstain/unqualified to answer



Option	Votes
Option 1	19
Option 2	87
Abstain	0

33. For patients with PSA persistence post RP and pN0 on extended PLND and no evidence of risk factors (Risk factors: R1, pT3, ISUP grade group 4-5) and a negative postoperative PSMA PET that you treat with immediate therapy what do you recommend?

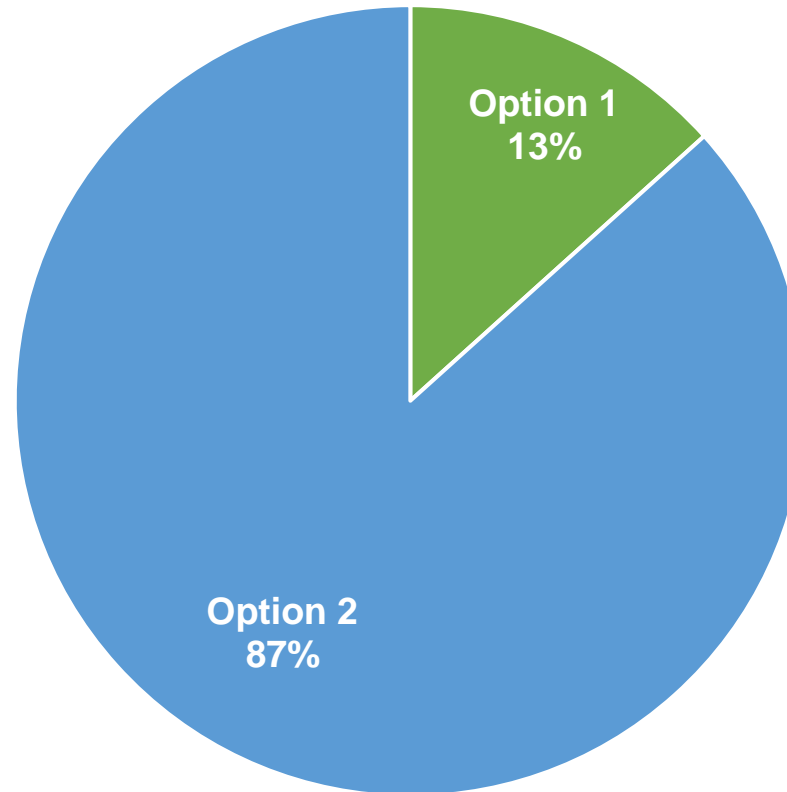
1. Radiation therapy prostate bed alone
2. Radiation therapy prostate bed plus pelvis
3. Radiation therapy prostate bed plus short-term systemic therapy
4. Radiation therapy prostate bed plus pelvis plus short-term systemic therapy
5. Radiation therapy prostate bed plus long-term systemic therapy
6. Radiation therapy prostate bed plus pelvis plus long-term systemic therapy
7. Systemic therapy alone
8. Abstain/unqualified to answer (including I do not recommend immediate therapy)



Option	Votes
Option 1	22
Option 2	5
Option 3	15
Option 4	31
Option 5	3
Option 6	14
Option 7	2
Abstain	14

34. What do you recommend for a patient with PSA persistence post RP, pN0 on extended PLND and 2 or more risk factors (Risk factors: R1, pT3, ISUP grade group 4-5) and a negative postoperative PSMA PET, provided the patient has regained continence?

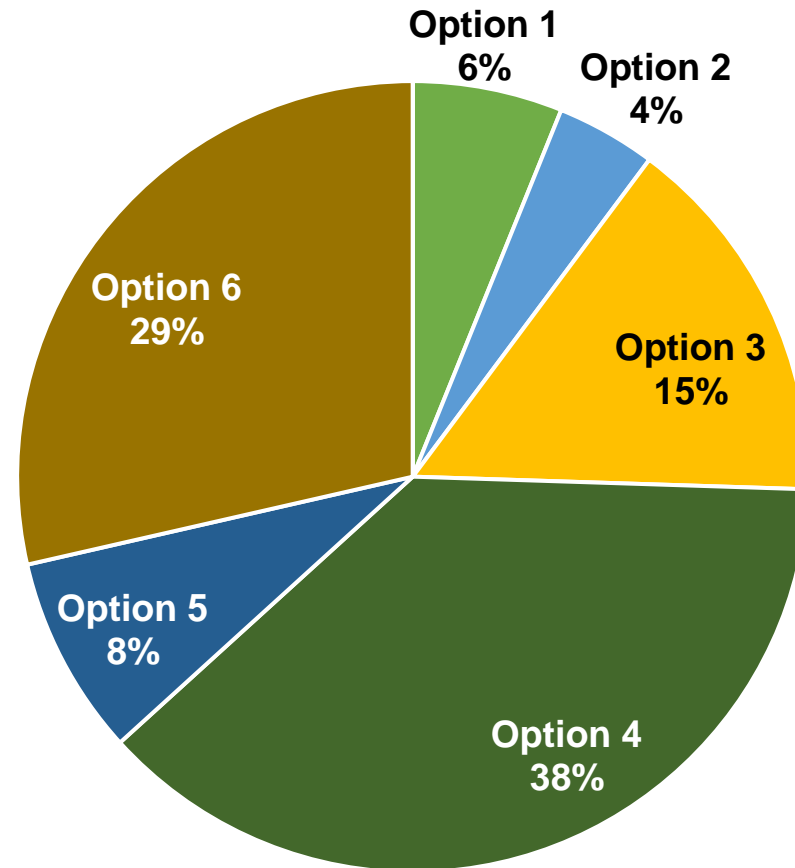
1. Monitoring (including imaging) and salvage therapy in case of further PSA rise
2. **Immediate therapy (RT or systemic therapy or both)**
3. Abstain/unqualified to answer



Option	Votes
Option 1	14
Option 2	91
Abstain	1

35. For patients with PSA persistence post RP, pN0 on extended PLND and 2 or more risk factors (Risk factors: R1, pT3, ISUP grade group 4-5) and a negative postoperative PSMA PET that you treat with immediate therapy what do you recommend?

1. Radiation therapy prostate bed alone
2. Radiation therapy prostate bed plus pelvis
3. Radiation therapy prostate bed plus short-term systemic therapy
4. Radiation therapy prostate bed plus pelvis plus short-term systemic therapy
5. Radiation therapy prostate bed plus long-term systemic therapy
6. Radiation therapy prostate bed plus pelvis plus long-term systemic therapy
7. Systemic therapy alone
8. Abstain/unqualified to answer (including I do not recommend immediate therapy)



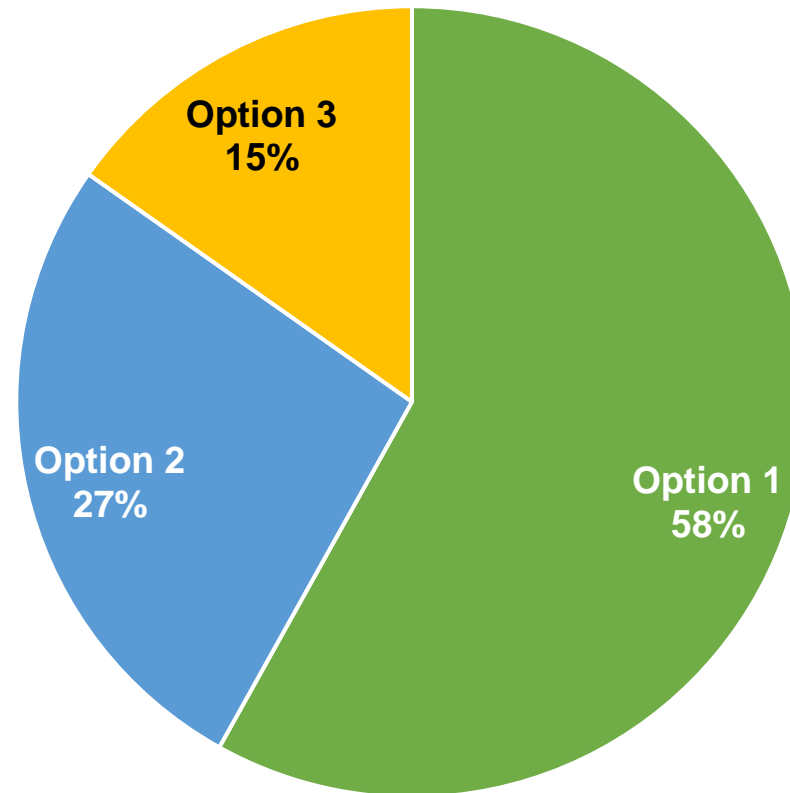
Option	Votes
Option 1	6
Option 2	4
Option 3	15
Option 4	37
Option 5	8
Option 6	28
Option 7	0
Abstain	8

## 2. PSA Persistence and Biochemical Recurrence

### 2.2. Biochemical recurrence after RP

36. For the majority of patients with slowly rising PSA (total PSA value 0.2 ng/mL) after radical prostatectomy and PSA-DT >1 year AND pathological ISUP grade group <4 do you recommend PSMA PET imaging?

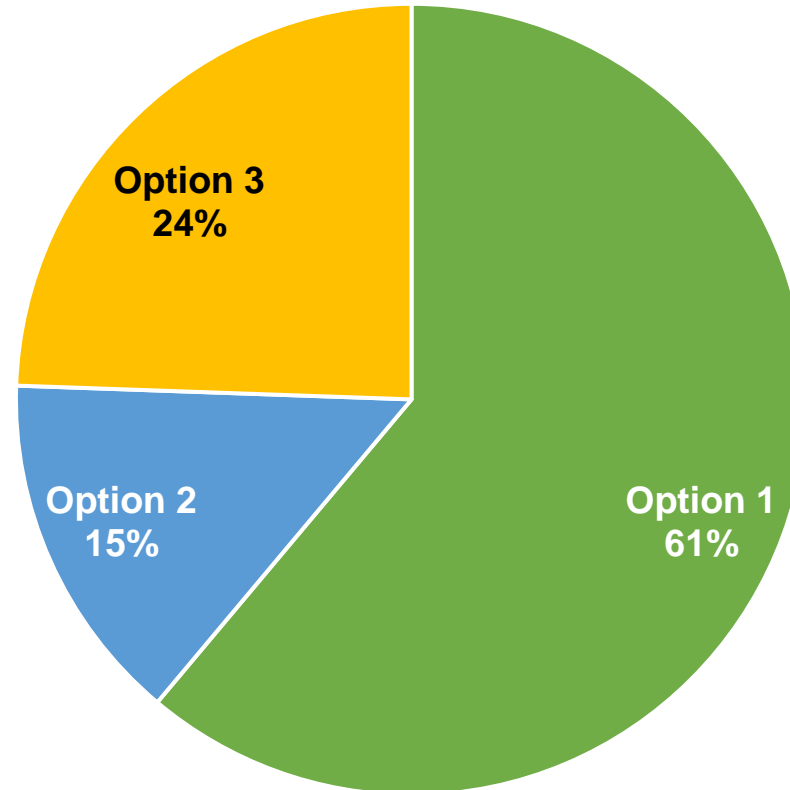
1. Yes
2. No, PSA monitoring
3. No, early salvage therapy without PSMA PET imaging
4. Abstain/unqualified to answer



Option	Votes
Option 1	61
Option 2	28
Option 3	16
Abstain	1

37. For the majority of patients with slowly rising PSA (total PSA value 0.2 ng/mL) after radical prostatectomy and PSA-DT >1 year AND pathological ISUP grade group <4 if you recommended PSMA PET imaging and PSMA PET is negative what do you recommend?

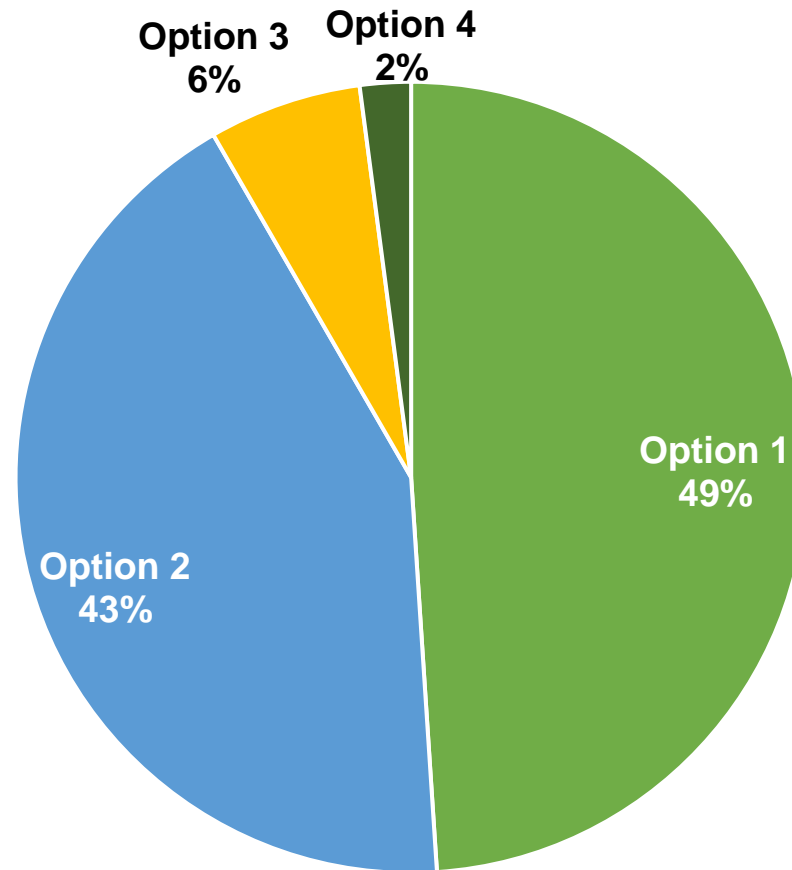
1. Early salvage therapy (RT ± systemic therapy)
2. Regular imaging e.g. every 4-12 months
3. Repeat PSMA PET every time PSA doubles
4. Abstain/unqualified to answer (including I did not recommend PSMA PET imaging)



Option	Votes
Option 1	55
Option 2	13
Option 3	22
Abstain	16

38. For the majority of patients with a confirmed rising PSA after radical prostatectomy and PSA-DT >1 year AND pathological ISUP grade group <4 and no or negative PSMA PET imaging, what is your management recommendation regarding salvage therapy?

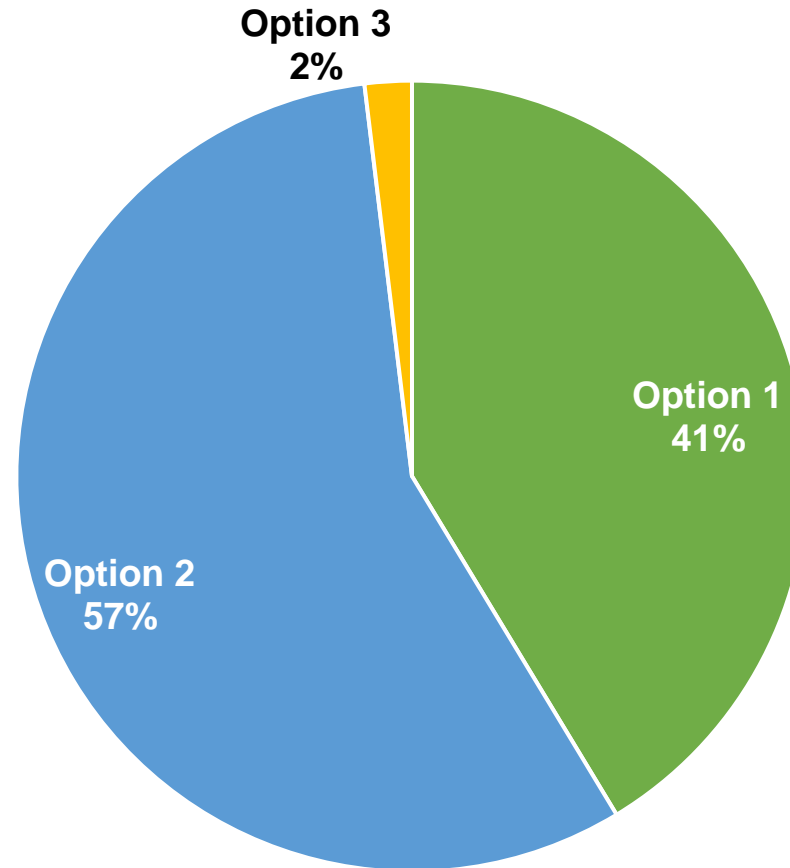
1. Radiation therapy alone
2. Radiation therapy plus short-term (e.g. 6 months) of systemic hormonal therapy
3. Radiation therapy plus long-term (e.g. 24 months) of systemic hormonal therapy
4. Systemic therapy alone
5. Abstain/unqualified to answer (including I did not vote for salvage therapy)



Option	Votes
Option 1	47
Option 2	41
Option 3	6
Option 4	2
Abstain	10

39. For the majority of patients with a confirmed rising PSA after radical prostatectomy (WITHOUT risk factors for local relapse  $\geq$ pT3b and/or R1) and PSA-DT <1 year OR pathological ISUP grade group 4–5 (EAU high-risk), what management do you recommend?

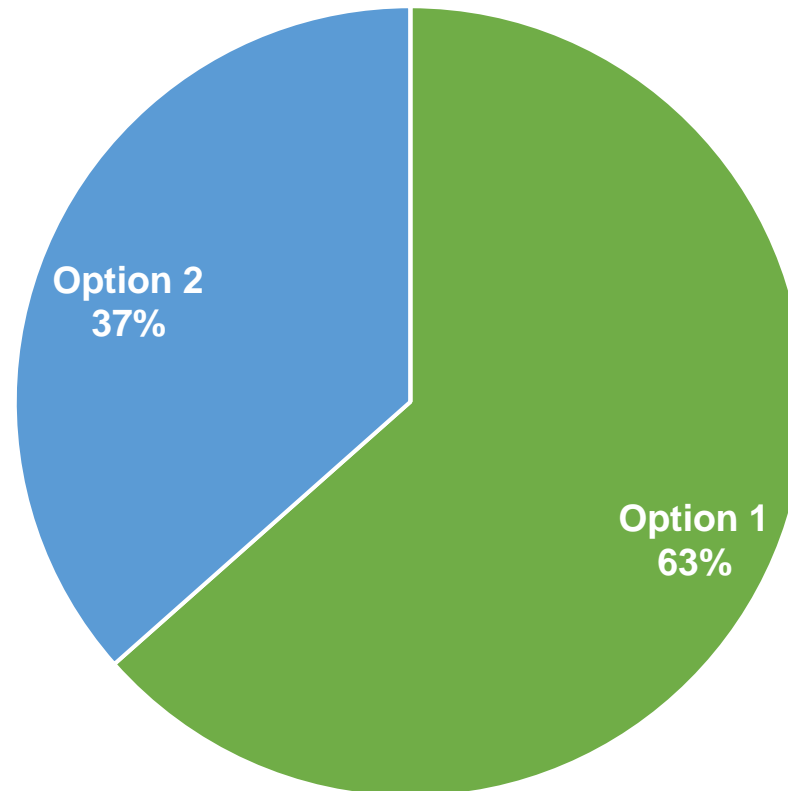
1. Salvage RT (+/- systemic therapy) as early as possible (i.e. PSA <0.2 ng/mL)
2. Wait until PSA is approximately 0.2 and perform PSMA PET
3. Systemic therapy alone
4. Abstain/unqualified to answer



Option	Votes
Option 1	43
Option 2	59
Option 3	2
Abstain	2

40. For the majority of patients with a confirmed rising PSA after radical prostatectomy (WITH risk factors for local relapse  $\geq$ pT3b and/or R1) and PSA-DT <1 year OR pathological ISUP grade group 4–5 (EAU high-risk), what management do you recommend?

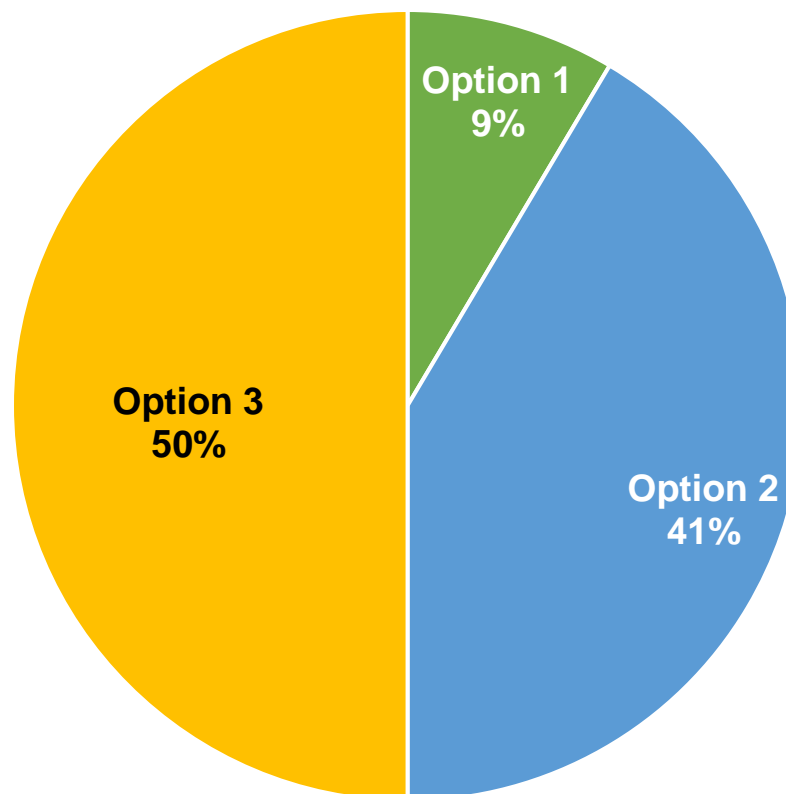
1. Salvage RT (+/- systemic therapy) as early as possible (i.e. PSA <0.2 ng/mL)
2. Wait until PSA is approximately 0.2 ng/mL and perform PSMA PET
3. Systemic therapy alone
4. Abstain/unqualified to answer



Option	Votes
Option 1	66
Option 2	38
Option 3	0
Abstain	2

41. If you recommend salvage RT in a patient with a confirmed rising PSA but a PSA <0.2 ug/l after radical prostatectomy and PSA-DT ≤1 year or pathological ISUP grade group 4 or 5 WITH risk factors for local relapse (≥pT3b and/or R1) at what PSA value do you recommend initiating salvage therapy?

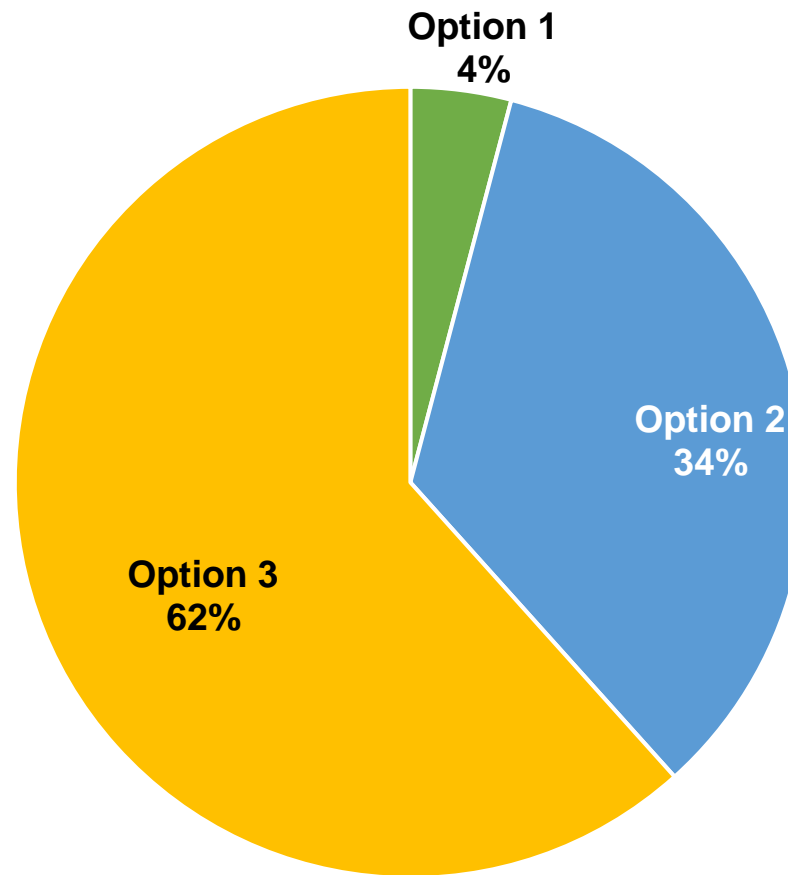
1. PSA <0.1 ng/mL
2. PSA 0.1 – 0.15 ng/mL
3. PSA >0.15 - <0.2 ng/mL
4. Abstain/unqualified to answer (including I do not recommend salvage therapy in patients with a PSA <0.2 ng/mL)



Option	Votes
Option 1	7
Option 2	34
Option 3	41
Abstain	24

42. If you recommend salvage RT in a patient with a confirmed rising PSA but a PSA <0.2 ug/l after radical prostatectomy and PSA-DT ≤1 year or pathological ISUP grade group 4 or 5 WITHOUT risk factors for local relapse (≥pT3b and/or R1) at what PSA value do you recommend initiating salvage therapy?

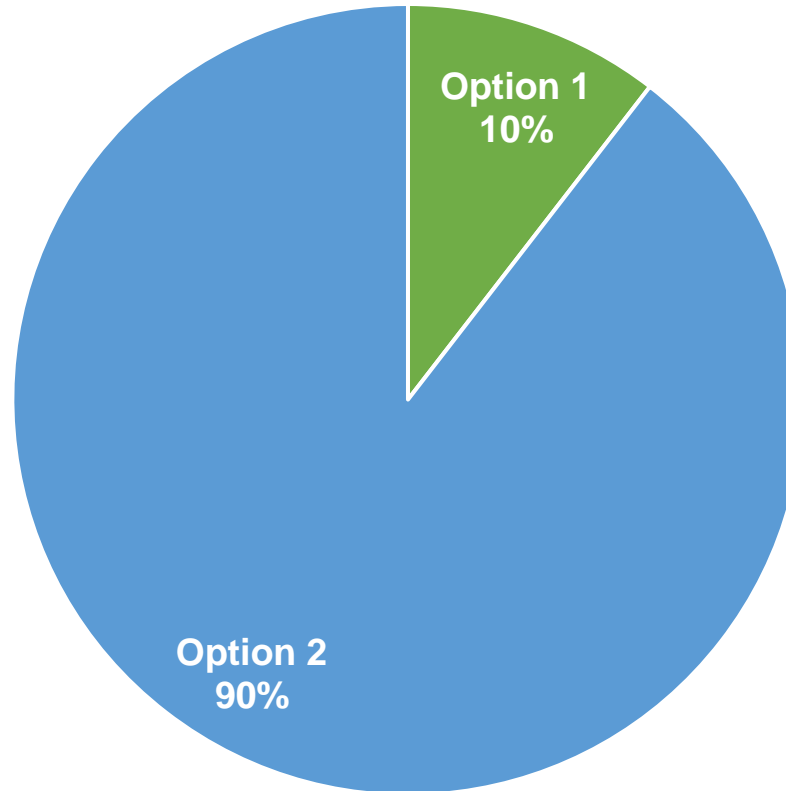
1. PSA <0.1 ng/mL
2. PSA 0.1 – 0.15 ng/mL
3. PSA >0.15 - <0.2 ng/mL
4. Abstain/unqualified to answer (including I do not recommend salvage therapy in patients with a PSA <0.2 ng/mL)



Option	Votes
Option 1	3
Option 2	25
Option 3	45
Abstain	33

43. For the majority of patients with a confirmed rising PSA after radical prostatectomy and PSA-DT  $\leq 1$  year or pathological ISUP grade group 4 or 5 and no or negative PSMA PET imaging, what is your management recommendation?

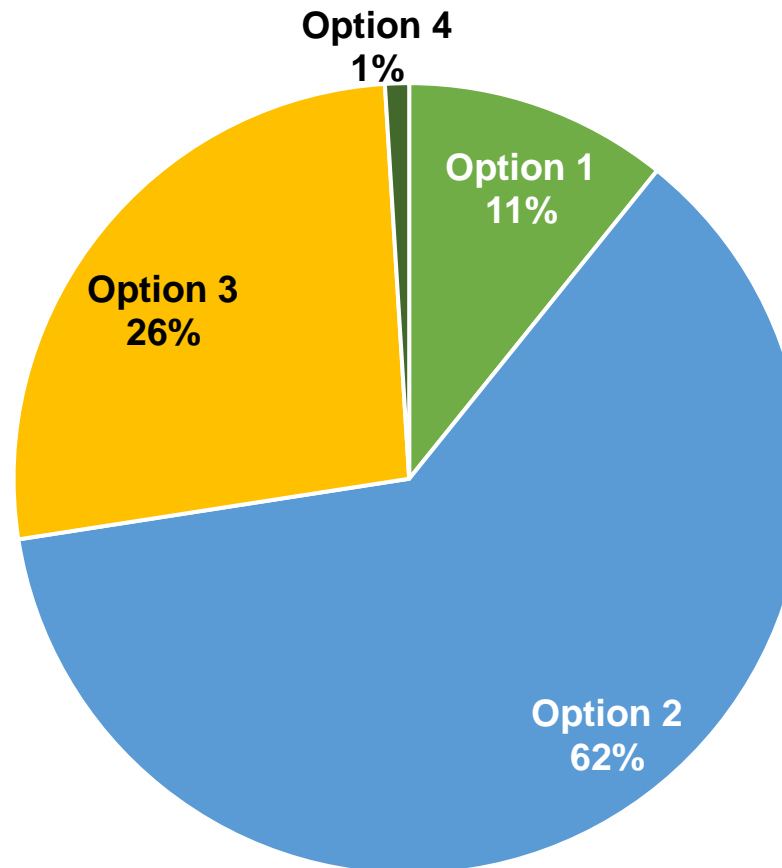
1. Monitoring
2. **Salvage therapy (RT or systemic therapy or both)**
3. Abstain/unqualified to answer



Option	Votes
Option 1	11
Option 2	94
Abstain	1

44. For the majority of patients with a confirmed rising PSA after radical prostatectomy and PSA-DT  $\leq$  1 year or pathological ISUP grade group 4 or 5 and no or negative PSMA PET imaging, what is your management recommendation regarding salvage therapy?

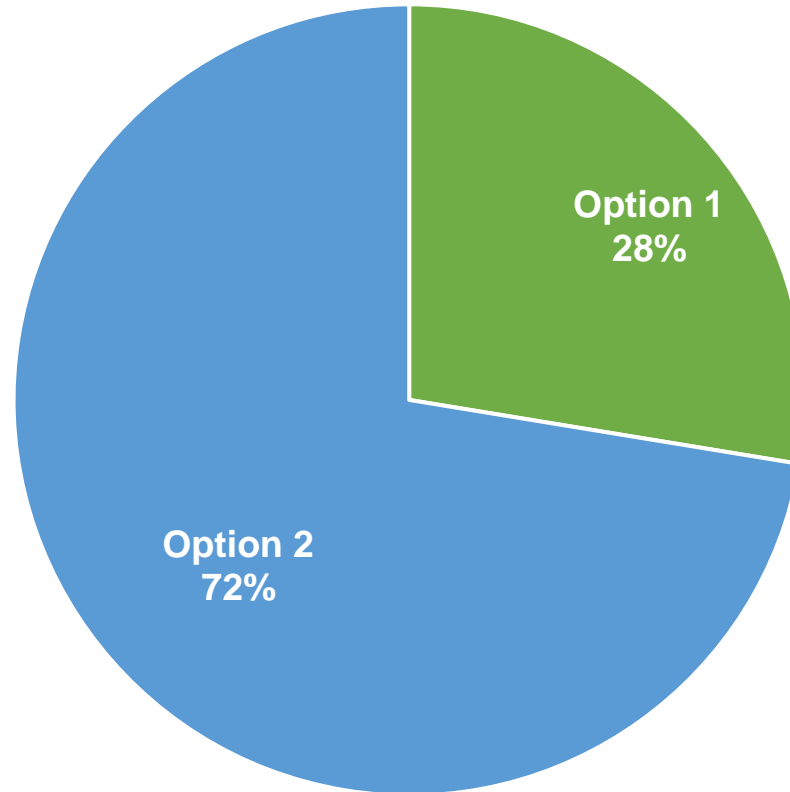
1. Radiation therapy alone
2. Radiation therapy plus short-term (e.g. 6 months) of systemic hormonal therapy
3. Radiation therapy plus long-term (e.g. 24 months) of systemic hormonal therapy
4. Systemic therapy alone
5. Abstain/unqualified to answer (including I do not recommend salvage therapy)



Option	Votes
Option 1	11
Option 2	63
Option 3	27
Option 4	1
Abstain	4

45. For the majority of patients with an early rise of PSA after RP do you recommend using a molecular classifier (e.g., Decipher) for the decision to add systemic hormonal therapy to salvage radiation therapy?

1. Yes
2. No
3. Abstain/unqualified to answer (including I do not use a molecular classifier routinely in this situation)



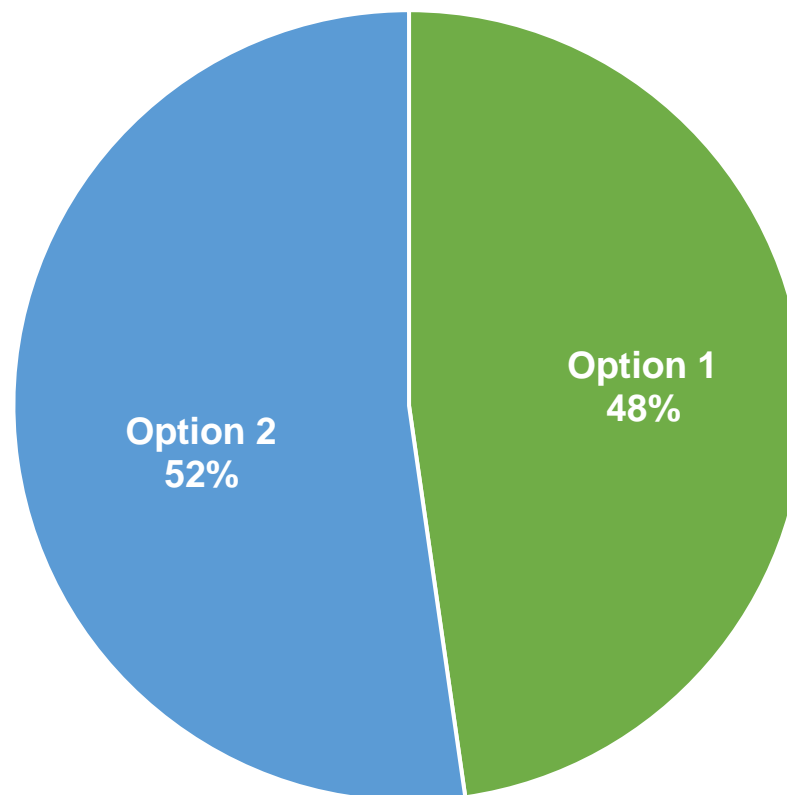
Option	Votes
Option 1	24
Option 2	63
Abstain	19

## 2. PSA Persistence and Biochemical Recurrence

### 2.3. Radiation therapy field in patients with biochemical recurrence

46. For the majority of patients with an early rise of PSA after RP and extended PLND (pN0) and PSA-DT  $\leq 1$  year or pathological ISUP grade group 4 or 5 and a negative PSMA PET in which you recommend salvage radiation therapy, what is your preferred approach regarding the RT field?

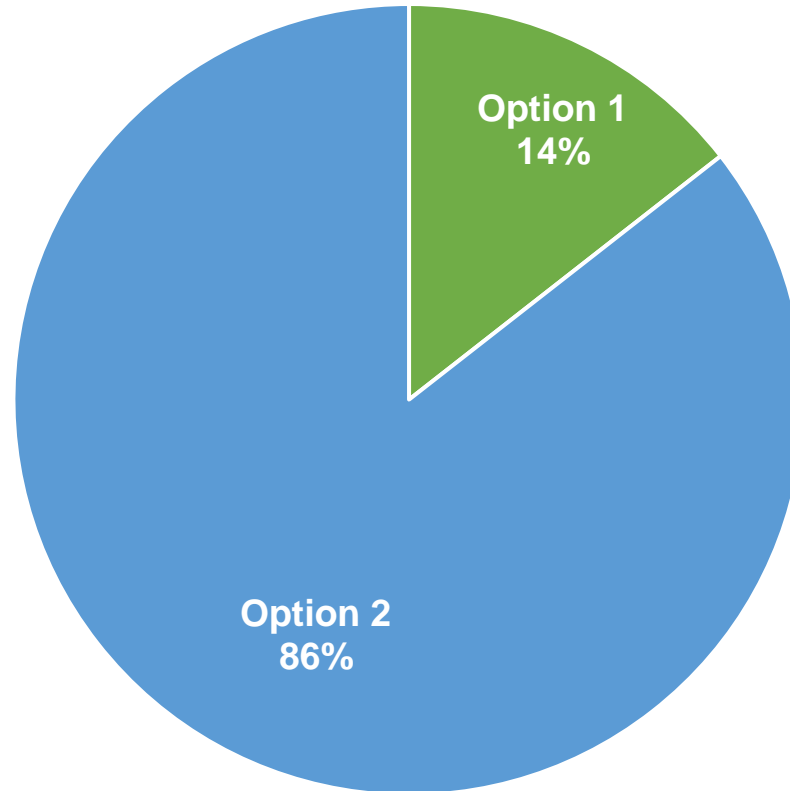
1. Prostate bed radiation therapy alone
2. Prostate bed plus pelvic lymph nodes
3. Abstain/unqualified to answer



Option	Votes
Option 1	42
Option 2	46
Abstain	18

47. For the majority of patients with an early confirmed rise of PSA after RP without PLND and PSA-DT  $\leq 1$  year or pathological ISUP grade group 4 or 5 and a negative PSMA PET in which you recommend salvage radiation therapy, what is your preferred approach regarding the RT field?

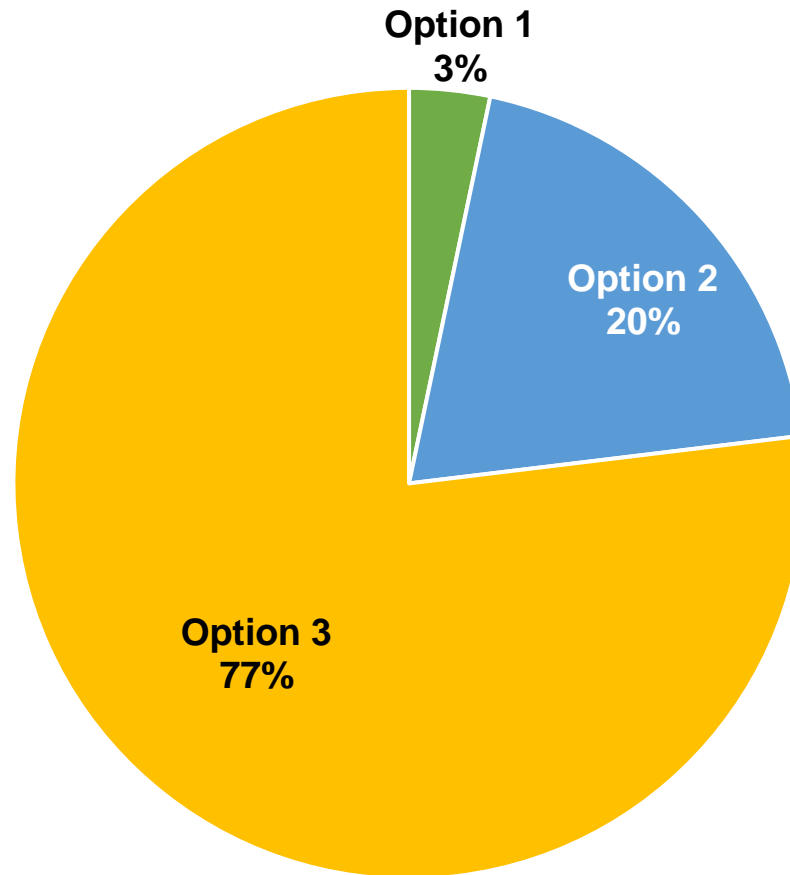
1. Prostate bed radiation therapy alone
- 2. Prostate bed plus pelvic lymph nodes**
3. Abstain/unqualified to answer



Option	Votes
Option 1	13
Option 2	77
Abstain	16

48. In the majority of patients with a confirmed PSA rise after radical prostatectomy without prior salvage RT and PSA-DT  $\leq 1$  year or pathological ISUP grade group 4 or 5 and 1-3 positive lymph nodes in the pelvis alone on PSMA PET, what is your treatment recommendation regarding the radiation therapy?

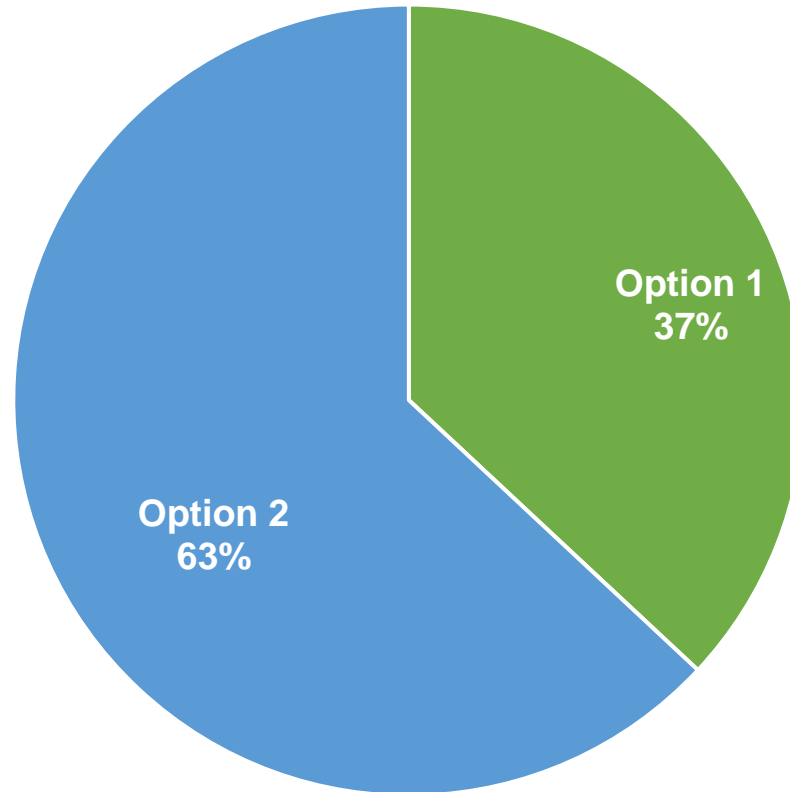
1. SBRT of positive nodes alone
2. Whole pelvis RT plus/minus boost to positive nodes
- 3. Radiation therapy prostate bed plus whole pelvis plus/minus boost to positive nodes**
4. Abstain/unqualified to answer



Option	Votes
Option 1	3
Option 2	18
Option 3	70
Abstain	15

49. In the majority of patients with a confirmed PSA rise after radical prostatectomy with prior salvage RT to the prostate bed and PSA-DT  $\leq 1$  year or pathological ISUP grade group 4 or 5 and 1-3 positive lymph nodes in the pelvis alone on PSMA PET, what is your treatment recommendation regarding the radiation therapy?

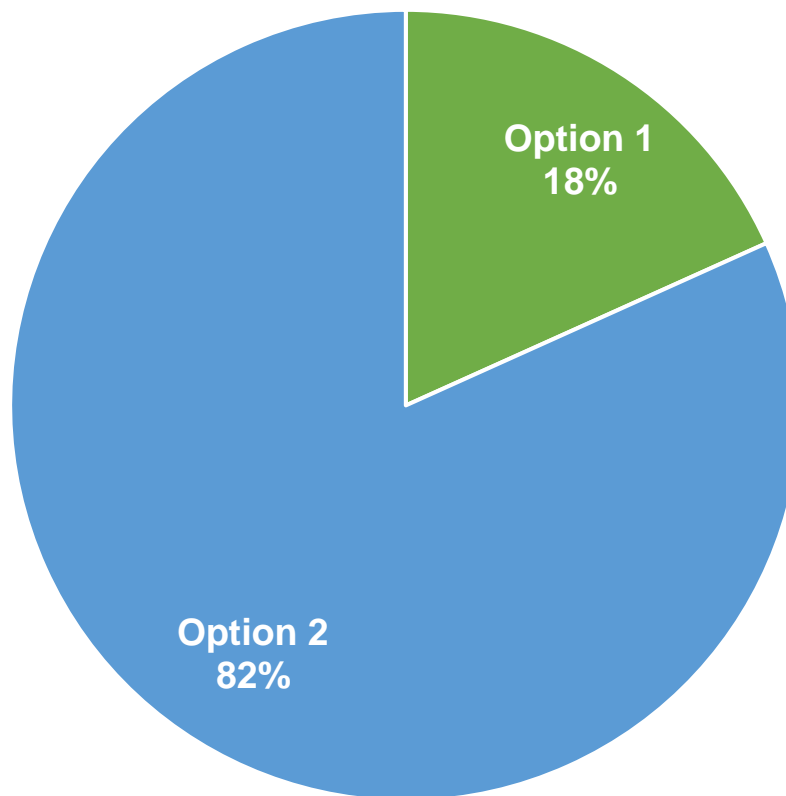
1. SBRT of positive nodes alone
2. Whole pelvis RT plus/minus boost to positive nodes
3. Abstain/unqualified to answer



Option	Votes
Option 1	34
Option 2	58
Abstain	14

50. In the majority of patients with a confirmed PSA rise after radical prostatectomy with PSA-DT >1 year AND pathological ISUP grade group <4 and a local relapse in the prostate bed detected on MRI and/or PSMA PET and N0 M0 (no prior local salvage RT) do you recommend a biopsy?

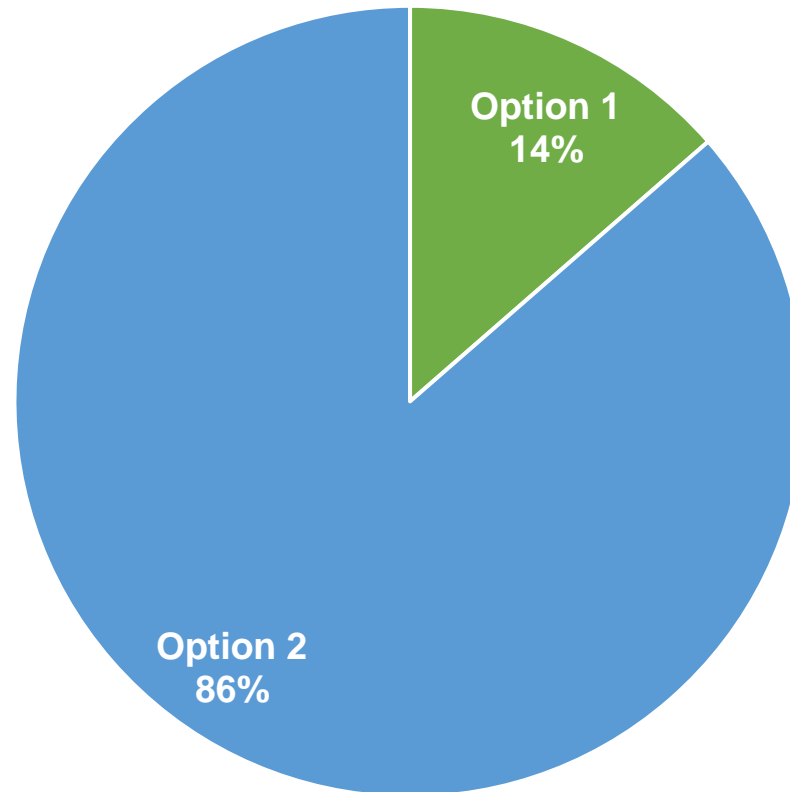
- 1. Yes
- 2. **No**
- 3. Abstain/unqualified to answer



Option	Votes
Option 1	19
Option 2	85
Abstain	2

51. In the majority of patients with PSA rise after radical prostatectomy with PSA-DT ≤1 year or pathological ISUP grade group 4 or 5 and a local relapse in the prostate bed detected on MRI and/or PSMA PET and N0 M0 (no prior local salvage RT) do you recommend a biopsy?

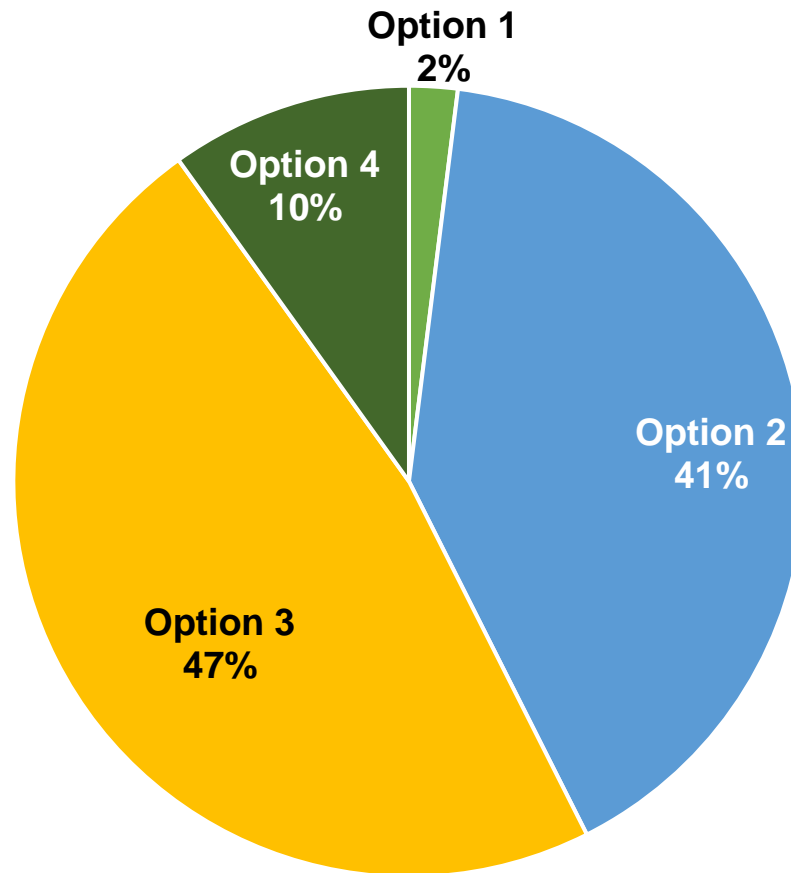
1. Yes
2. **No**
3. Abstain/unqualified to answer



Option	Votes
Option 1	14
Option 2	89
Abstain	3

52. In the majority of patients with a confirmed PSA rise after radical prostatectomy and a local relapse in the prostate bed detected on MRI and/or PSMA PET and N0 M0 (no prior local salvage RT) confirmed by biopsy and a PSA-DT >1 year AND pathological ISUP grade group 1-3 what do you recommend?

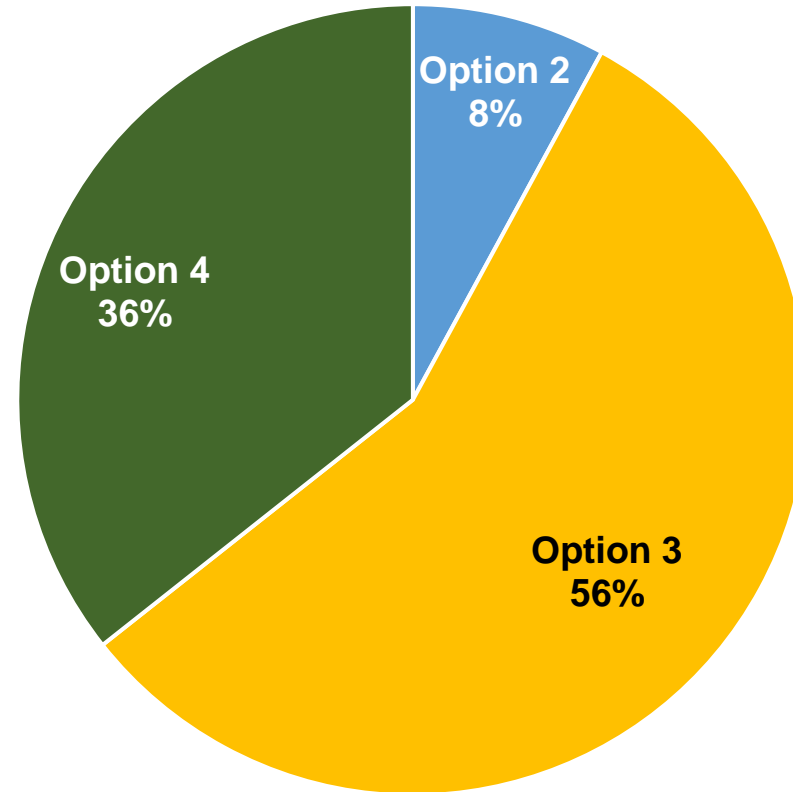
1. Monitoring
2. Radiation therapy of the prostatic bed +/- boost to the lesion
3. Radiation therapy of the prostatic bed +/- boost the lesion plus short-term (e.g. 6 months) of systemic therapy
4. Radiation therapy of the prostatic bed +/- boost the lesion plus long-term (e.g. 24 months) of systemic therapy
5. Abstain/unqualified to answer



Option	Votes
Option 1	2
Option 2	41
Option 3	48
Option 4	10
Abstain	5

53. In the majority of patients with PSA rise after radical prostatectomy and a local relapse in the prostate bed detected on MRI and/or PSMA PET (no prior local salvage RT) confirmed by biopsy and a PSA-DT  $\leq 1$  year or pathological ISUP grade group 4 or 5 what do you recommend?

1. Monitoring
2. Radiation therapy of the prostatic bed +/- boost to the lesion +/- pelvis
3. Radiation therapy of the prostatic bed +/- boost the lesion +/- pelvis plus short-term (e.g. 6 months) of systemic therapy
4. Radiation therapy of the prostatic bed +/- boost the lesion +/- pelvis plus long-term (e.g. 24 months) of systemic therapy
5. Abstain/unqualified to answer



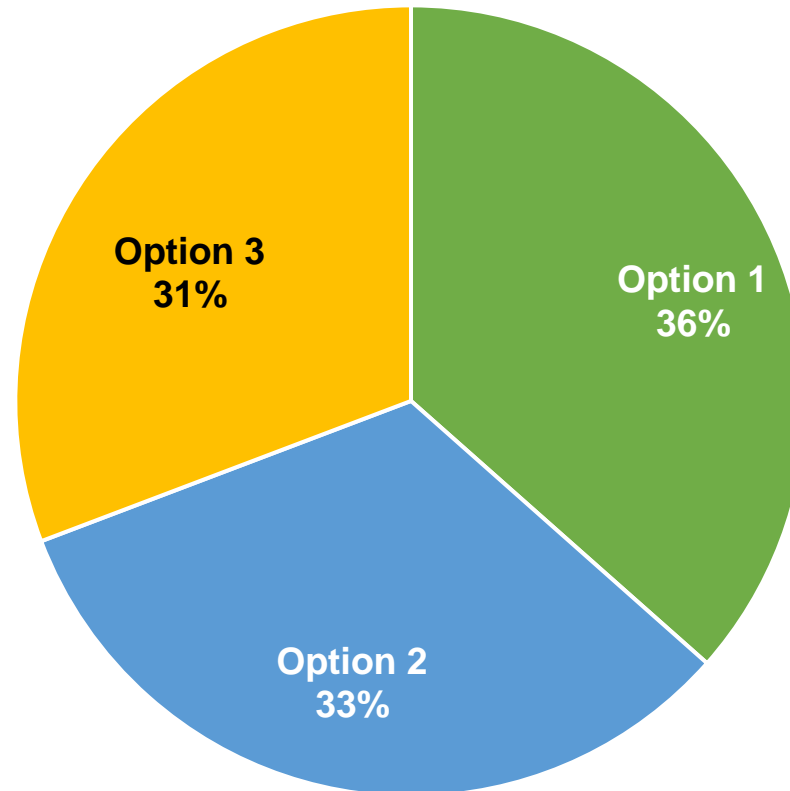
Option	Votes
Option 1	0
Option 2	8
Option 3	57
Option 4	36
Abstain	5

## 2. PSA Persistence and Biochemical Recurrence

### 2.4. Biochemical recurrence after radical RT of the prostate

54. In patients with high-risk localised/locally advanced prostate cancer who have received radical RT plus systemic therapy (ADT ± ARPI) at what point do you recommend imaging in case of a rising PSA from a nadir of <0.2ng/mL in the context of recovering testosterone?

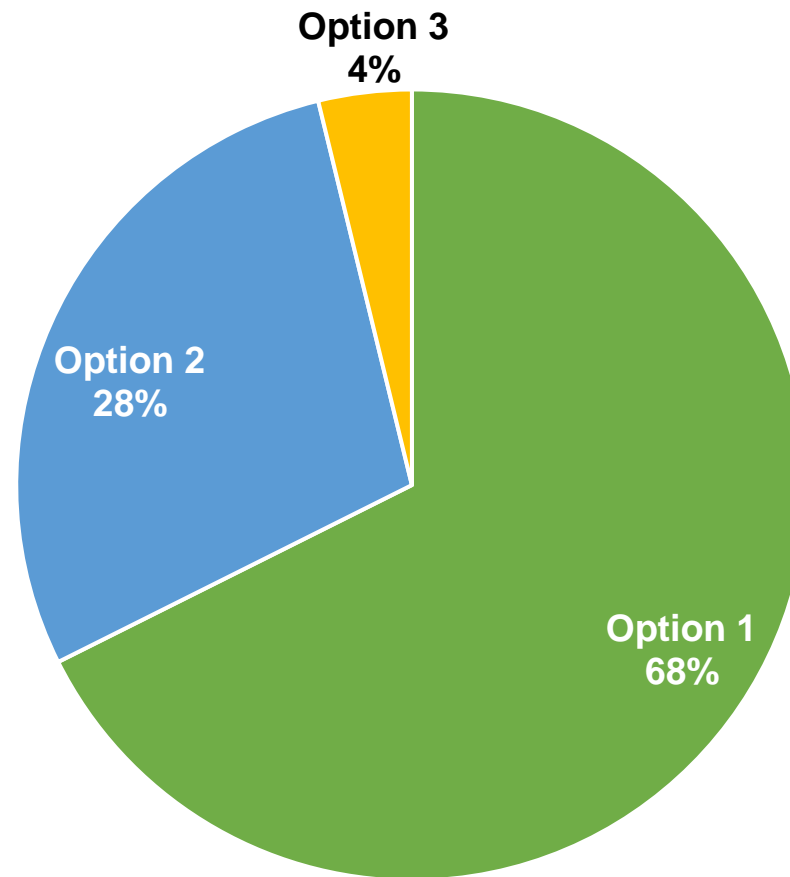
1. At PSA ≥2 ng/mL above nadir
2. At PSA 1-2 ng/mL above nadir and with rapidly rising PSA
3. At PSA 1-2 ng/mL irrespective of PSA kinetics
4. Abstain/unqualified to answer (including I do not recommend imaging at imaging at all in this setting)



Option	Votes
Option 1	38
Option 2	34
Option 3	32
Abstain	2

55. What do you recommend for the majority of patients with a confirmed local recurrence in the prostate after radical RT (interval to biochemical failure <18 months and/or ISUP grade group 4–5) and a PSA-DT ≤9 months and no detectable metastases on imaging?

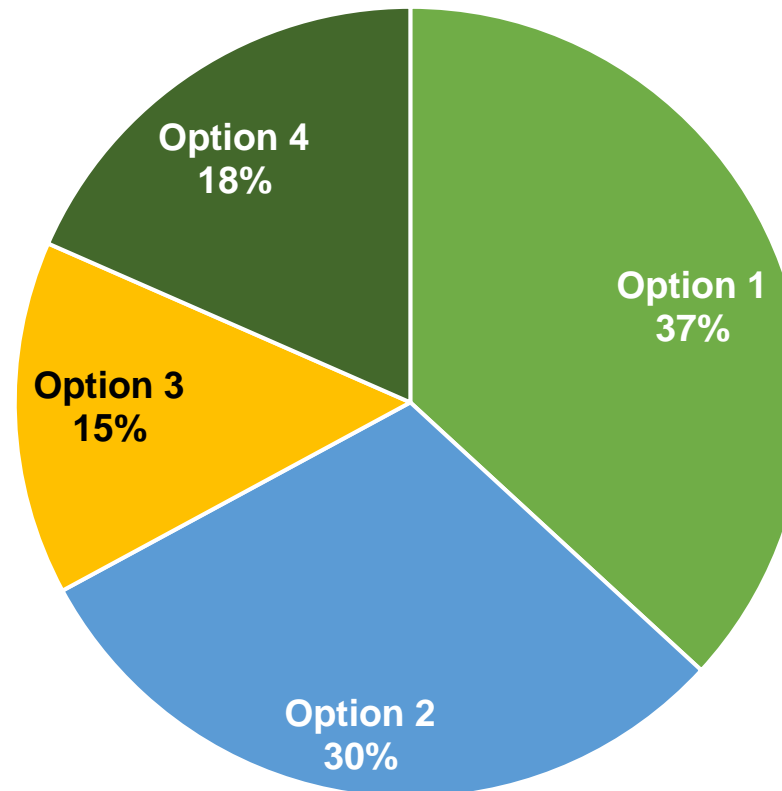
1. Local salvage therapy (± systemic therapy)
2. Systemic therapy alone
3. Monitoring
4. Abstain/unqualified to answer



Option	Votes
Option 1	71
Option 2	30
Option 3	4
Abstain	1

56. If you use local salvage therapy in a patient with a confirmed local recurrence in the prostate after radical RT (interval to biochemical failure <18 months and/or ISUP grade group 4–5) and a PSA-DT  $\leq 9$  months and no detectable metastases on imaging, what do you recommend?

1. Salvage prostatectomy
2. SBRT re-irradiation
3. Brachytherapy alone
4. Other local therapy, such as HIFU or cryotherapy or irreversible electroporation (IRE)
5. Abstain/unqualified to answer (including I do not recommend a local salvage therapy)



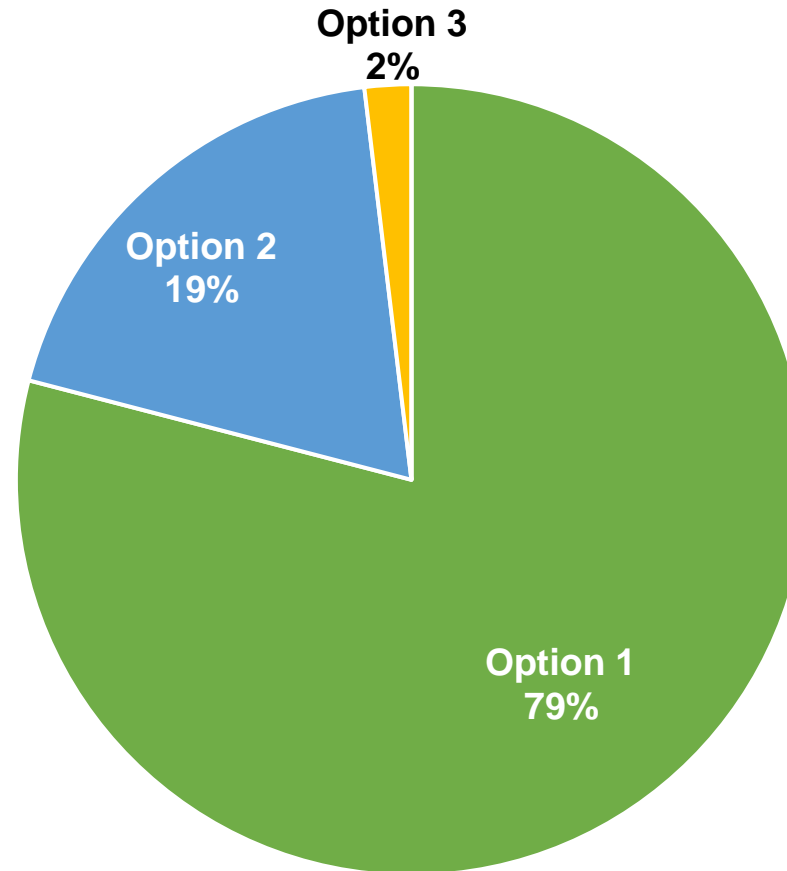
Option	Votes
Option 1	28
Option 2	23
Option 3	11
Option 4	14
Abstain	30

## 2. PSA Persistence and Biochemical Recurrence

### 2.5. High-risk biochemical recurrence (nmHSPC on conventional imaging)

57. For the majority of patients with a confirmed rising PSA ( $\geq 1$  ng/mL after RP) and no prior salvage RT and PSA-DT  $\leq 9$  months and normal testosterone and negative conventional imaging, what do you recommend?

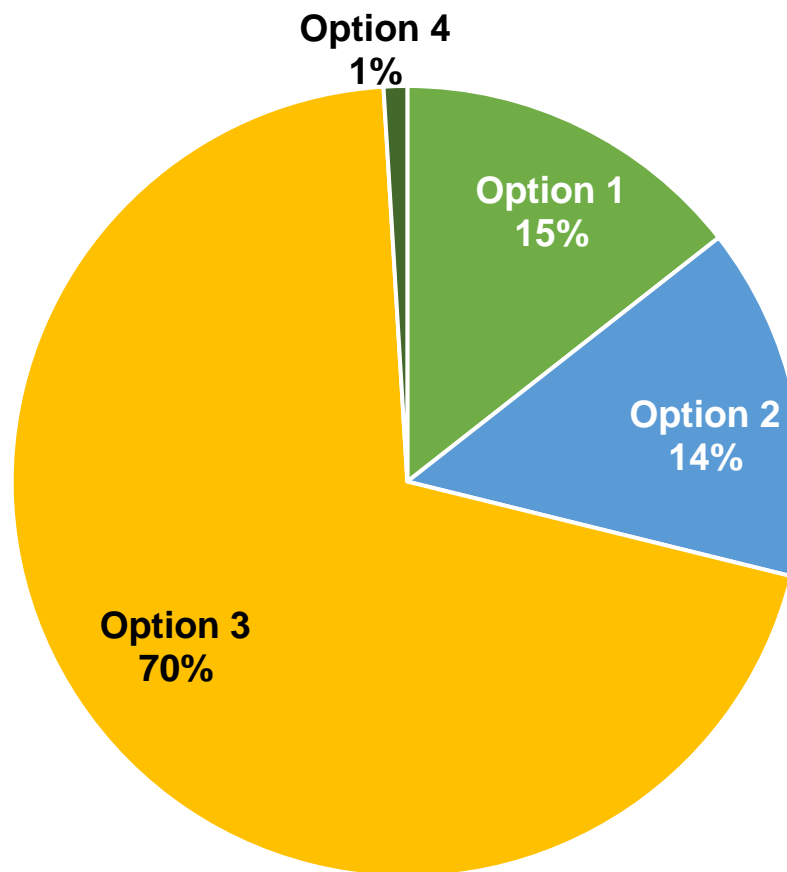
1. PSMA PET imaging
2. Salvage RT  $\pm$  systemic therapy
3. Immediate systemic therapy
4. Monitoring only, and deferred treatment
5. Abstain/unqualified to answer



Option	Votes
Option 1	83
Option 2	20
Option 3	2
Option 4	0
Abstain	1

58. For the majority of patients with high-risk nmHSPC and oligometastatic disease on PSMA PET imaging, what do you recommend?

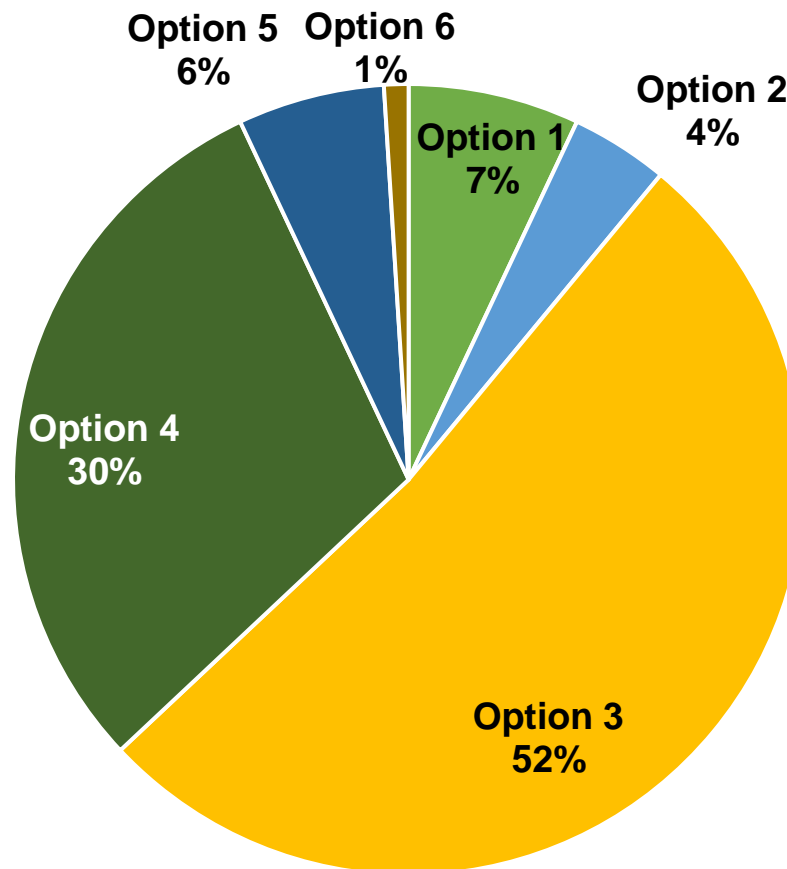
1. Immediate systemic therapy
2. Immediate metastases directed therapy
3. Immediate combination of both options above
4. Monitoring only and deferred treatment
5. Abstain/unqualified to answer



Option	Votes
Option 1	15
Option 2	15
Option 3	73
Option 4	1
Abstain	2

59. For the majority of patients high-risk nmHSPC and oligometastatic disease on PSMA PET imaging, what do you recommend for systemic therapy?

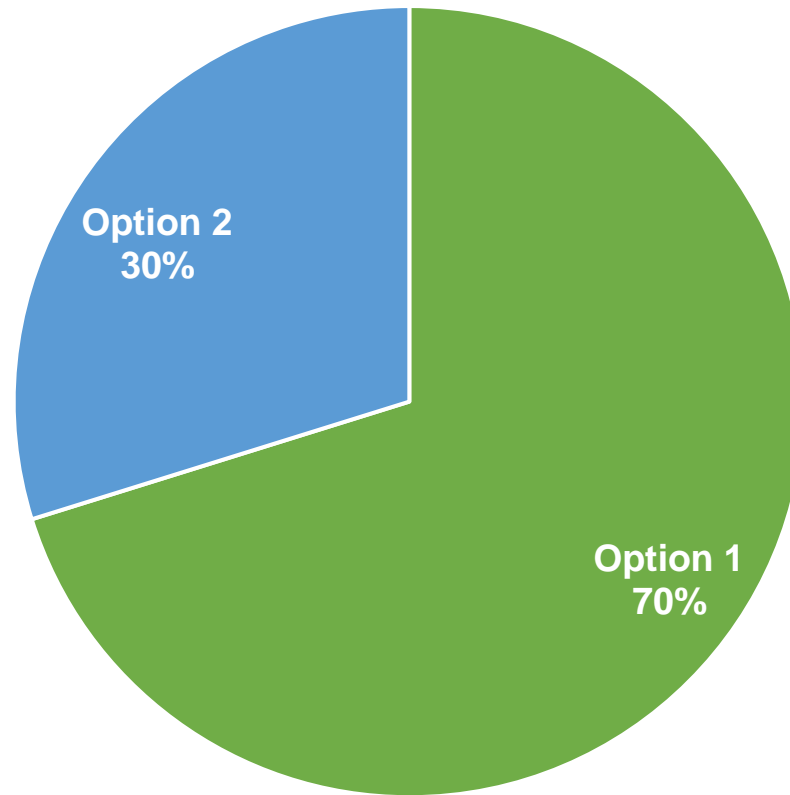
1. ADT alone, intermittent therapy
2. ADT alone, continuous therapy
3. ADT plus ARPI, intermittent therapy
4. ADT plus ARPI, continuous therapy
5. ARPI alone, intermittent therapy
6. ARPI alone, continuous therapy
7. Abstain/unqualified to answer (Including I do not recommend systemic therapy in this situation)



Option	Votes
Option 1	7
Option 2	4
Option 3	52
Option 4	30
Option 5	6
Option 6	1
Abstain	6

60. For the majority of patients with high-risk nmHSPC and negative PSMA PET imaging, what do you recommend?

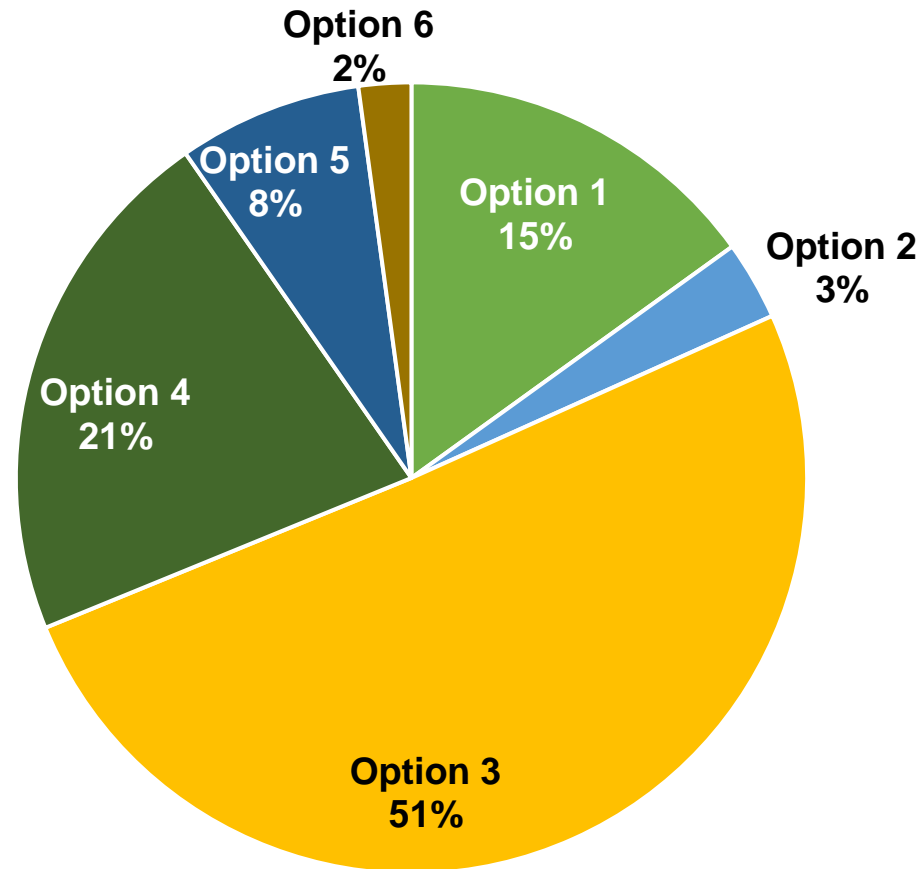
1. Immediate systemic therapy
2. Monitoring and deferred treatment
3. Abstain/unqualified to answer



Option	Votes
Option 1	73
Option 2	31
Abstain	2

61. For the majority of patients with high-risk nmHSPC and negative PSMA PET imaging, what do you recommend for systemic therapy?

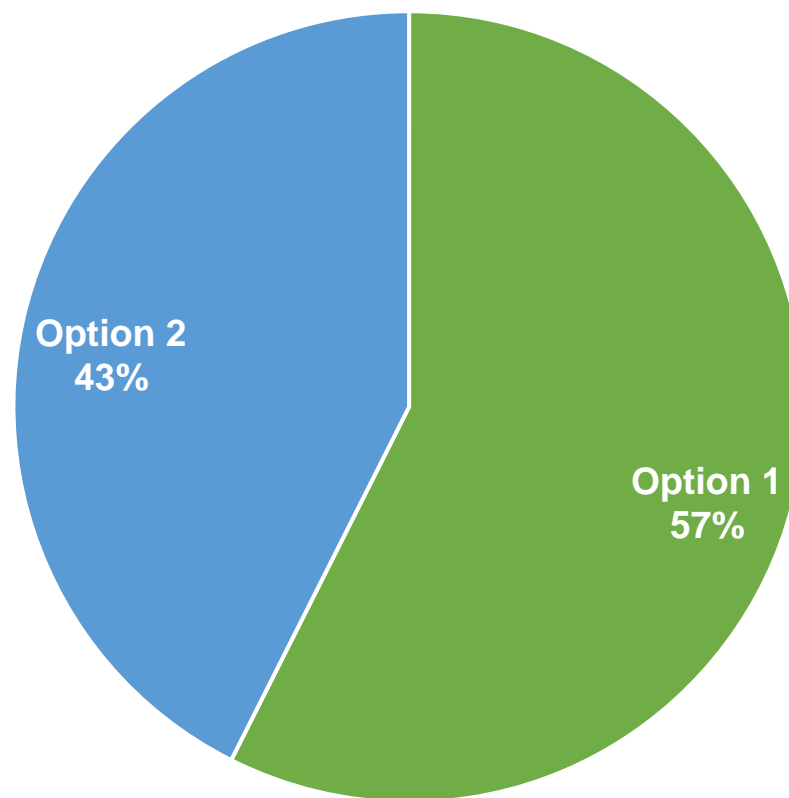
1. ADT alone, intermittent therapy
2. ADT alone, continuous therapy
3. ADT plus Enza, intermittent therapy
4. ADT plus Enza, continuous therapy
5. Enza alone, intermittent therapy
6. Enza alone, continuous therapy
7. Abstain/unqualified to answer (including I do not recommend systemic therapy in this situation)



Option	Votes
Option 1	14
Option 2	3
Option 3	47
Option 4	20
Option 5	7
Option 6	2
Abstain	13

62. Is it appropriate to extrapolate the data generated by the EMBARK trial with enzalutamide to other ARPI (Apalutamide and Darolutamide for monotherapy, Apalutamide, Darolutamide and Abiraterone for combination therapy)?

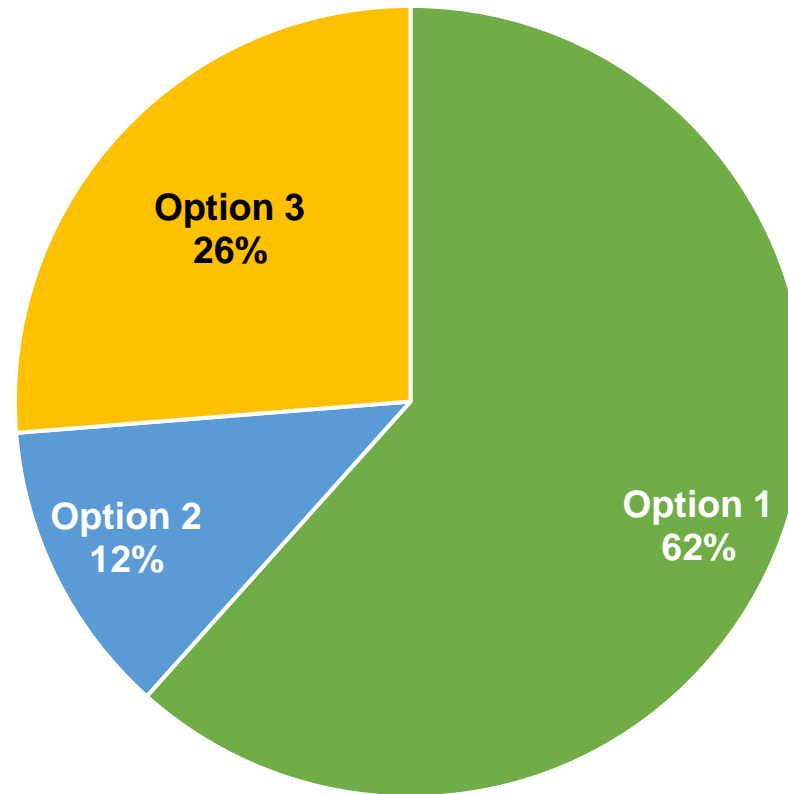
1. Yes
2. No
3. Abstain/unqualified to answer



Option	Votes
Option 1	58
Option 2	43
Abstain	5

63. For the majority of patients progressing on an AR antagonist (Apa, Daro, Enza) monotherapy without ADT, what is your treatment recommendation in case of unequivocal radiographic progression (not eligible for metastases directed therapy)?

1. Continue the AR antagonist monotherapy and start ADT
2. Discontinue the AR antagonist and start ADT monotherapy
3. Discontinue the AR antagonist and start ADT plus an additional systemic treatment
4. Abstain/unqualified to answer



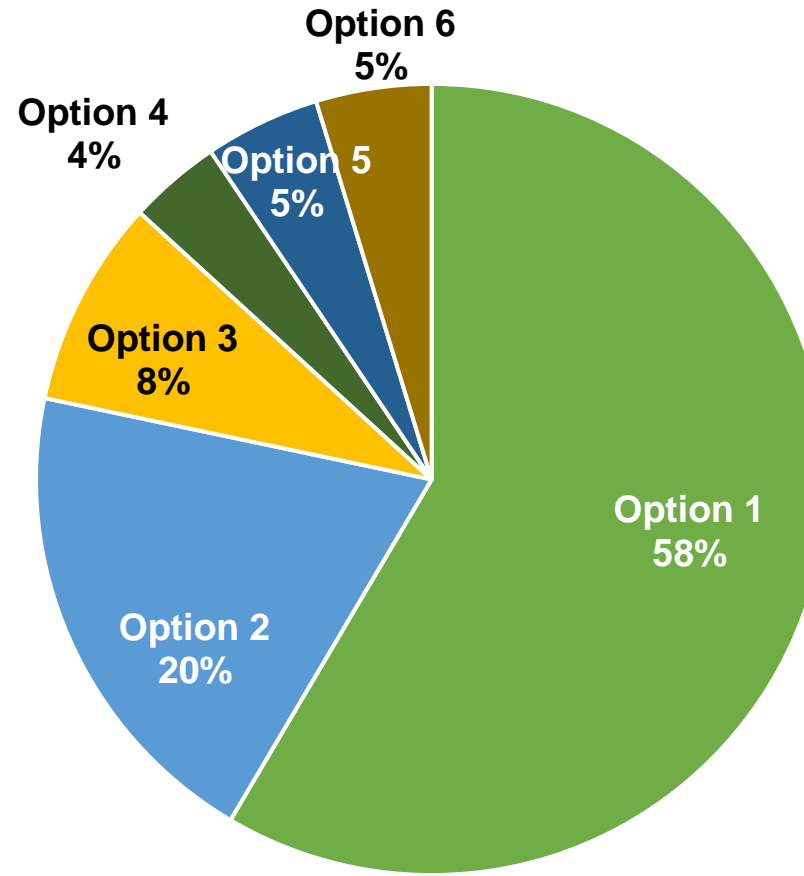
Option	Votes
Option 1	61
Option 2	12
Option 3	26
Abstain	7

## 3. mHSPC

### 3.1. Terminology

## 64. What terminology do you recommend using for the drugs abiraterone, apalutamide, enzalutamide and darolutamide?

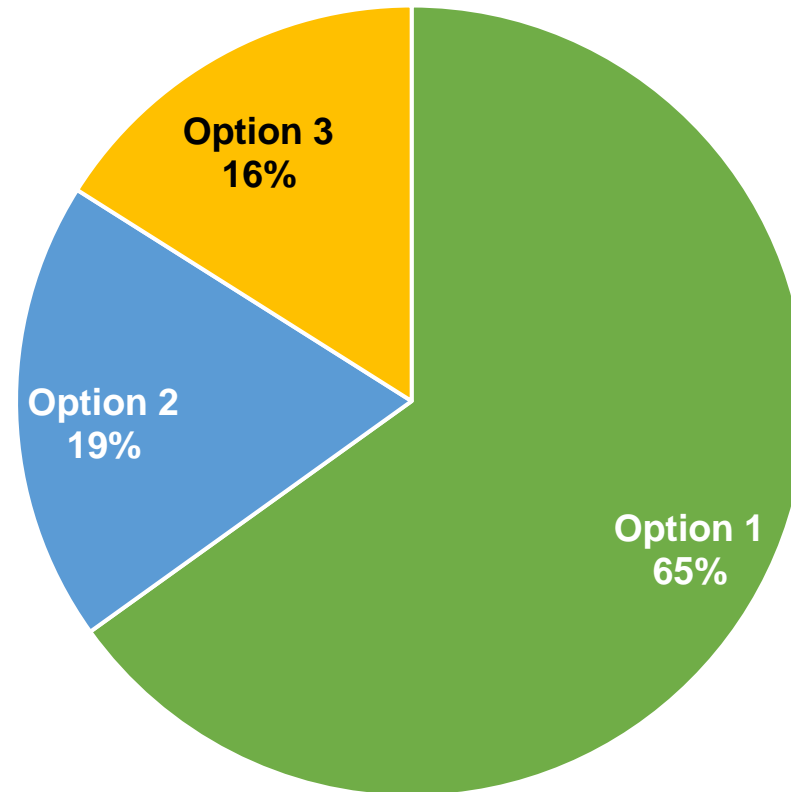
1. Androgen receptor pathway inhibitors (ARPI)
2. Androgen receptor signalling inhibitors (ARSI)
3. Androgen receptor-targeted agents (ARTA)
4. Second generation ARPIs (SARPI)
5. New hormonal agents (NHA)
6. Novel hormonal therapies (NHT)
7. Abstain/unqualified to answer



Option	Votes
Option 1	62
Option 2	21
Option 3	9
Option 4	4
Option 5	5
Option 6	5
Abstain	0

## 65. Which terminology do you recommend for newly diagnosed metastatic disease?

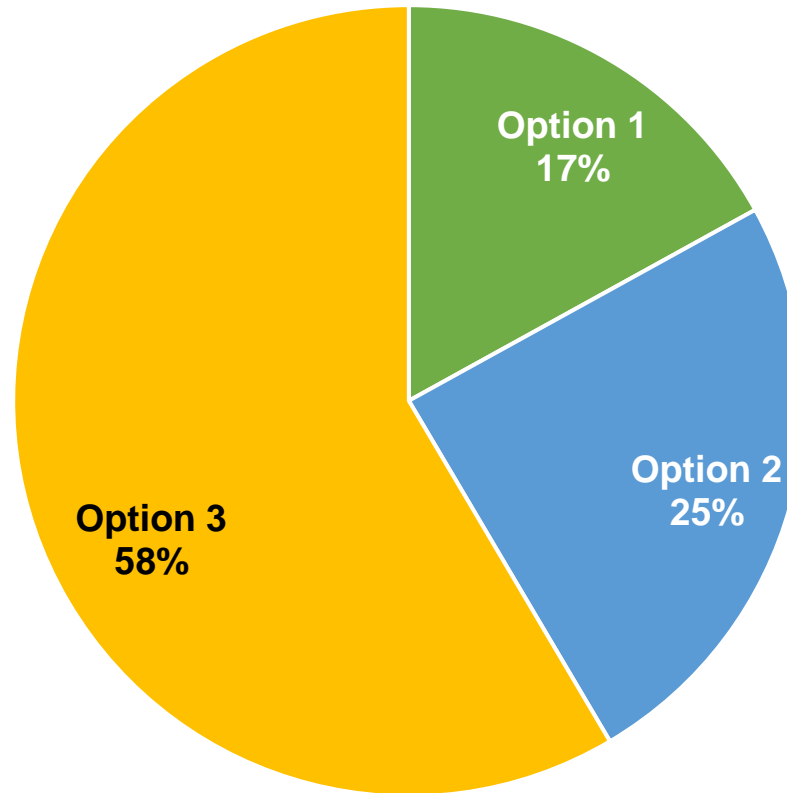
1. Metastatic hormone sensitive prostate cancer (mHSPC)
2. Metastatic hormone naïve prostate cancer (mHNPC)
3. Metastatic castration sensitive prostate cancer (mCSPC)
4. Abstain (including I recommend another term)



Option	Votes
Option 1	69
Option 2	20
Option 3	17
Abstain	0

## 66. Which terminology do you recommend using in patients with mHSPC that receive ADT plus an additional systemic therapy?

1. Combination systemic therapy
2. Systemic treatment intensification
3. Doublet or triplet therapy
4. Abstain (including I recommend another term)



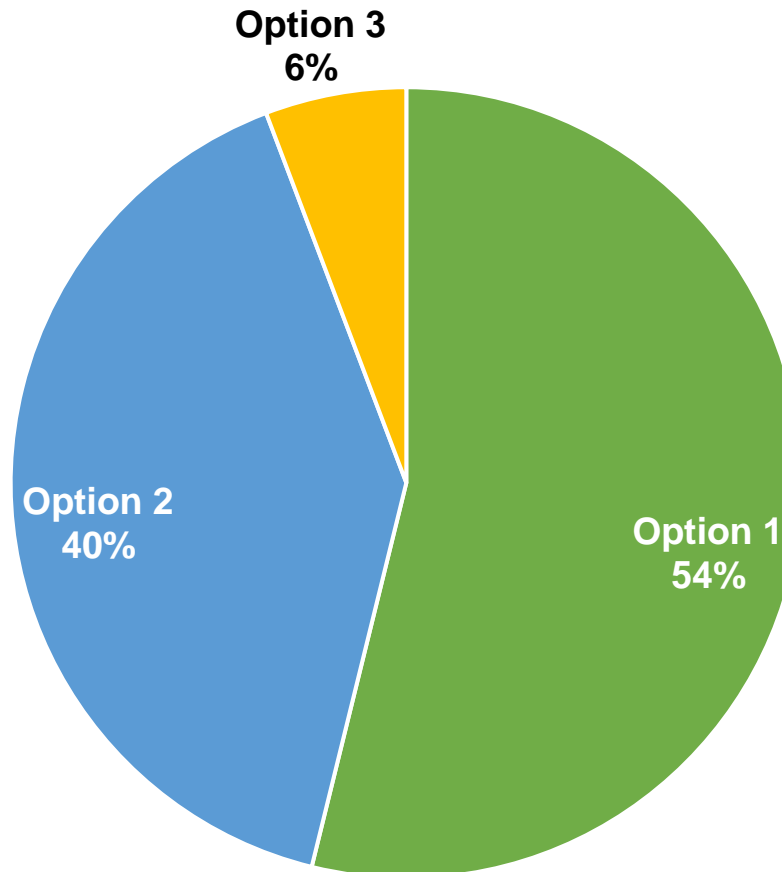
Option	Votes
Option 1	18
Option 2	26
Option 3	62
Abstain	0

## 3. mHSPC

### 3.2. Triplet therapy

67. In patients with high-burden mHSPC that are chemotherapy fit, do you recommend the triplet therapy ADT plus docetaxel plus ARPI?

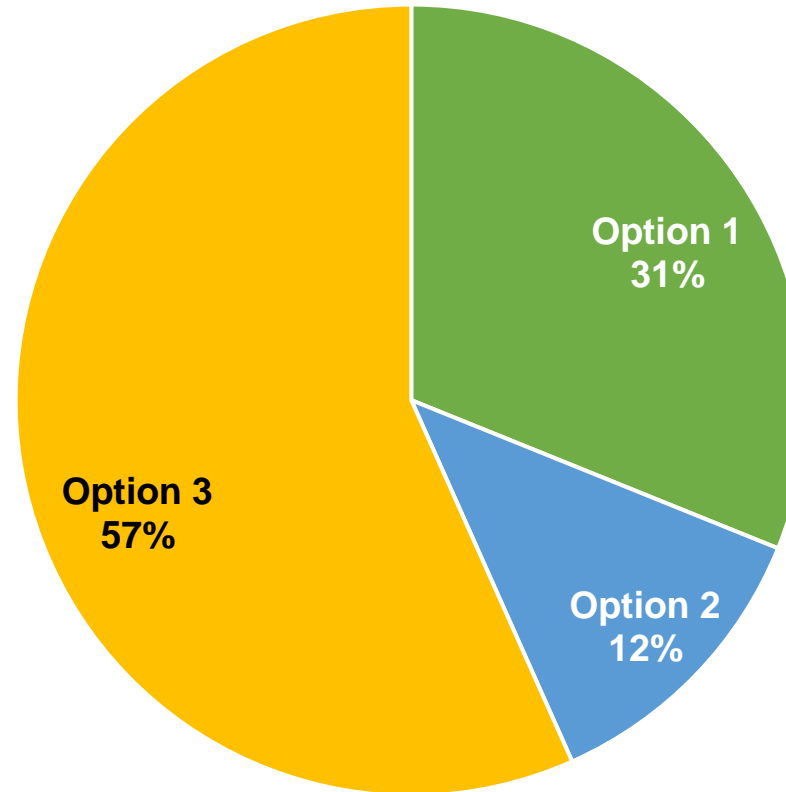
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No, I usually do not recommend this combination
4. Abstain/unqualified to answer



Option	Votes
Option 1	56
Option 2	42
Option 3	6
Abstain	2

## 68. If you use the triplet therapy (ADT plus docetaxel plus ARPI) only in selected patients, what is most important factor for your decision to use triplet therapy?

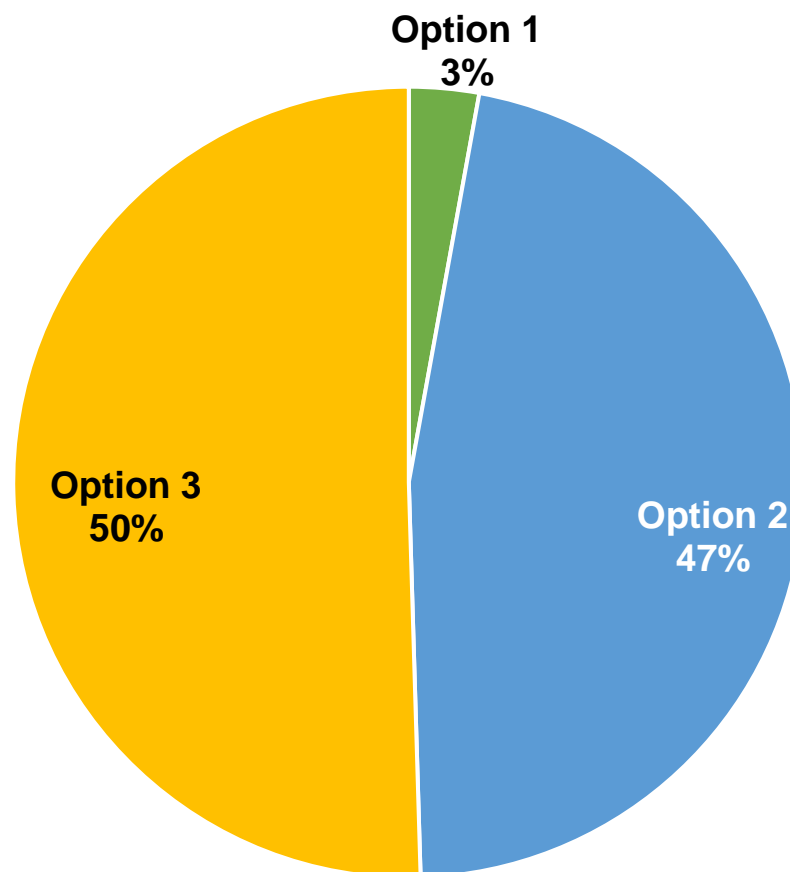
1. Synchronous disease (versus metachronous)
2. Age (biological)
3. High volume disease (versus low volume)
4. Abstain/unqualified to answer (I did not vote for triplet therapy in selected patients)



Option	Votes
Option 1	28
Option 2	11
Option 3	51
Abstain	16

69. In patients with synchronous low-burden mHSPC that are chemotherapy fit, do you recommend the triplet therapy ADT plus docetaxel plus ARPI?

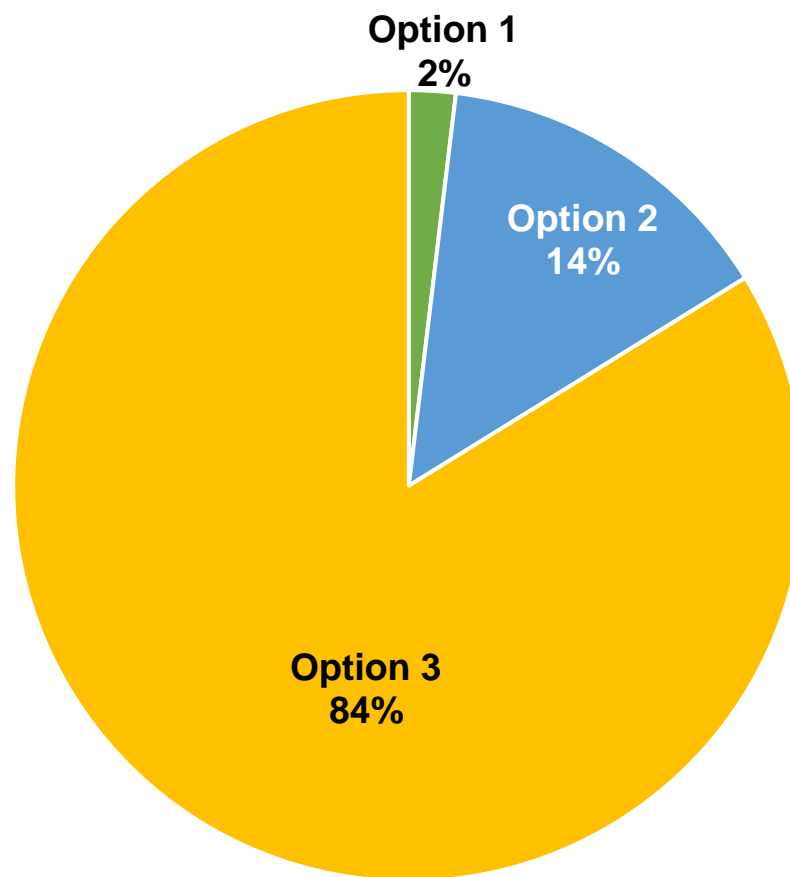
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	3
Option 2	49
Option 3	53
Abstain	1

70. In patients with metachronous low-burden mHSPC that are chemotherapy fit, do you recommend the triplet therapy ADT plus docetaxel plus ARPI?

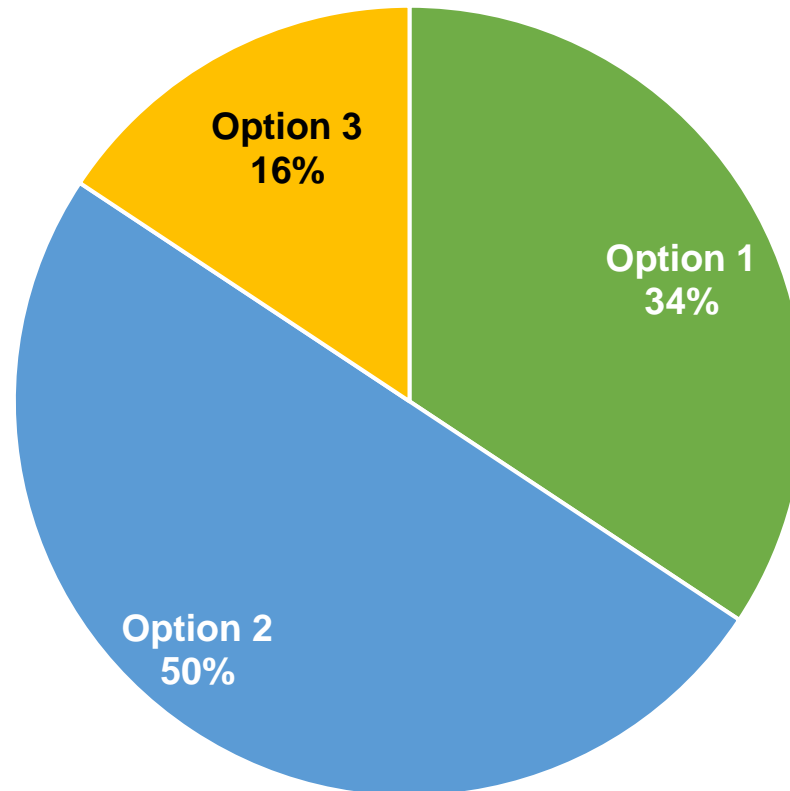
1. Yes, in the majority of patients
2. Yes, but only in selected patients
- 3. No**
4. Abstain/unqualified to answer



Option	Votes
Option 1	2
Option 2	15
Option 3	88
Abstain	1

71. In patients with metachronous high-burden mHSPC that are chemotherapy fit, do you recommend the triplet therapy ADT plus docetaxel plus ARPI?

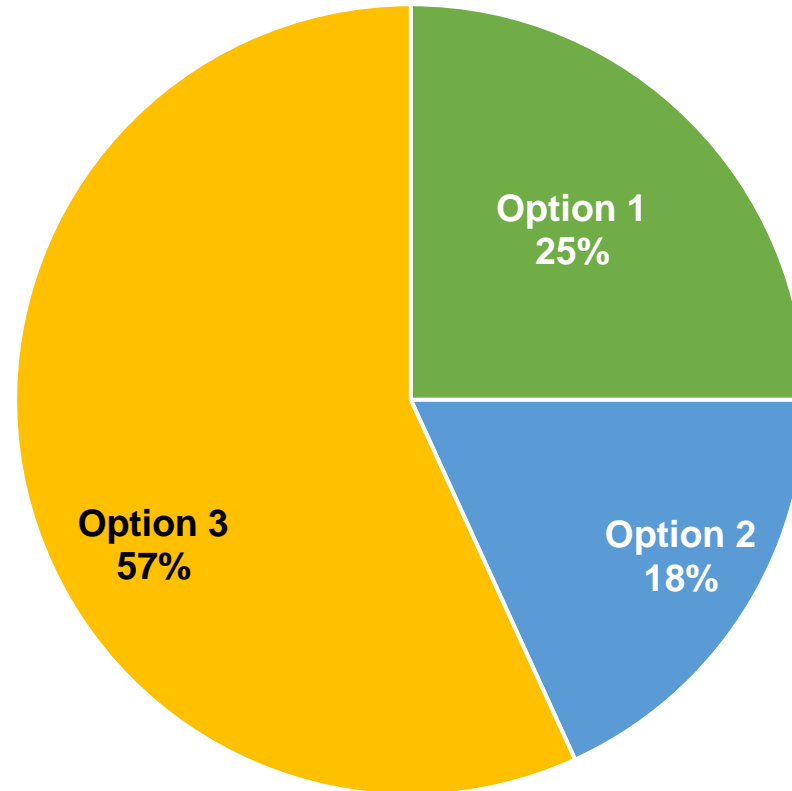
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	35
Option 2	51
Option 3	16
Abstain	4

72. For patients with mHSPC that receive triplet therapy (ADT plus docetaxel plus ARPI) do you routinely recommend primary G-CSF prophylaxis?

1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



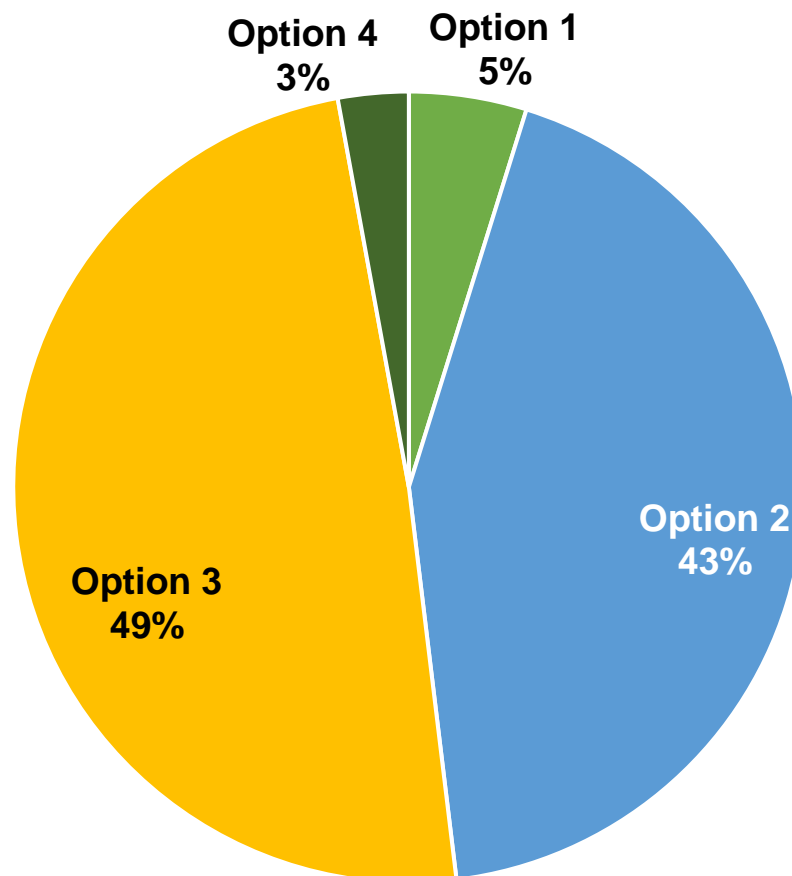
Option	Votes
Option 1	22
Option 2	16
Option 3	50
Abstain	18

## 3. mHSPC

### 3.3. Low-burden mHSPC

73. For the majority of patients with low-burden synchronous mHSPC with PSMA PET positive retroperitoneal lymph nodes what is your treatment recommendation?

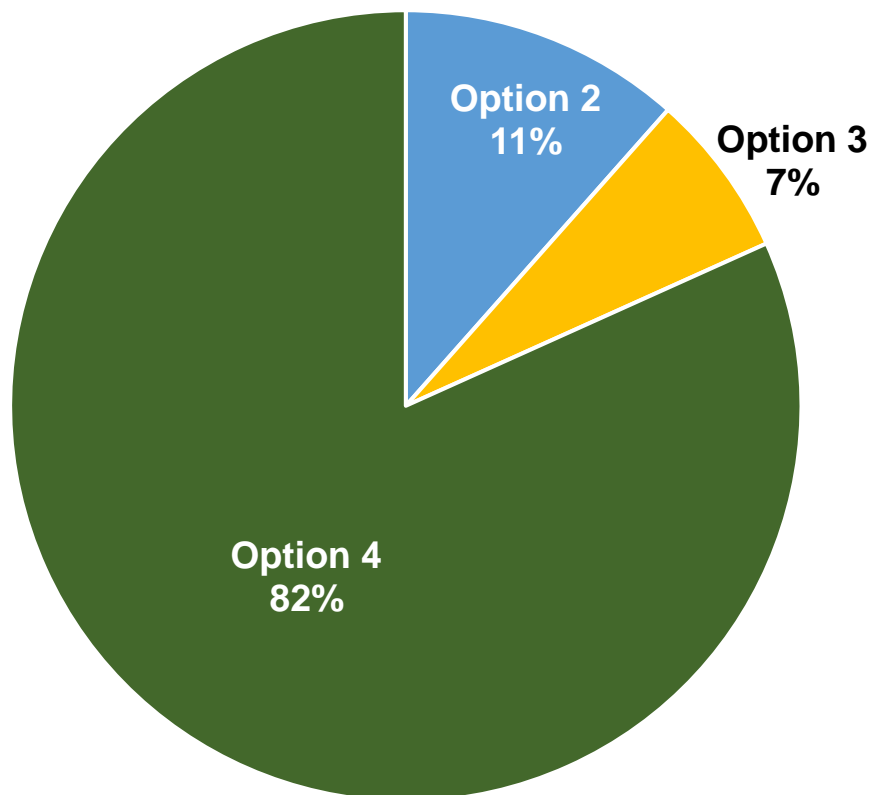
1. Systemic therapy alone
2. Systemic therapy plus RT of the primary
3. Systemic therapy plus RT of the primary and metastases directed therapy (MDT)
4. RT of the primary and MDT without systemic therapy
5. Abstain/unqualified to answer



Option	Votes
Option 1	5
Option 2	45
Option 3	51
Option 4	3
Abstain	2

74. In the majority of patients with synchronous low-burden mHSPC on conventional imaging, what is your treatment recommendation (regardless of the decision about metastases-directed therapy and regardless of the addition of docetaxel)?

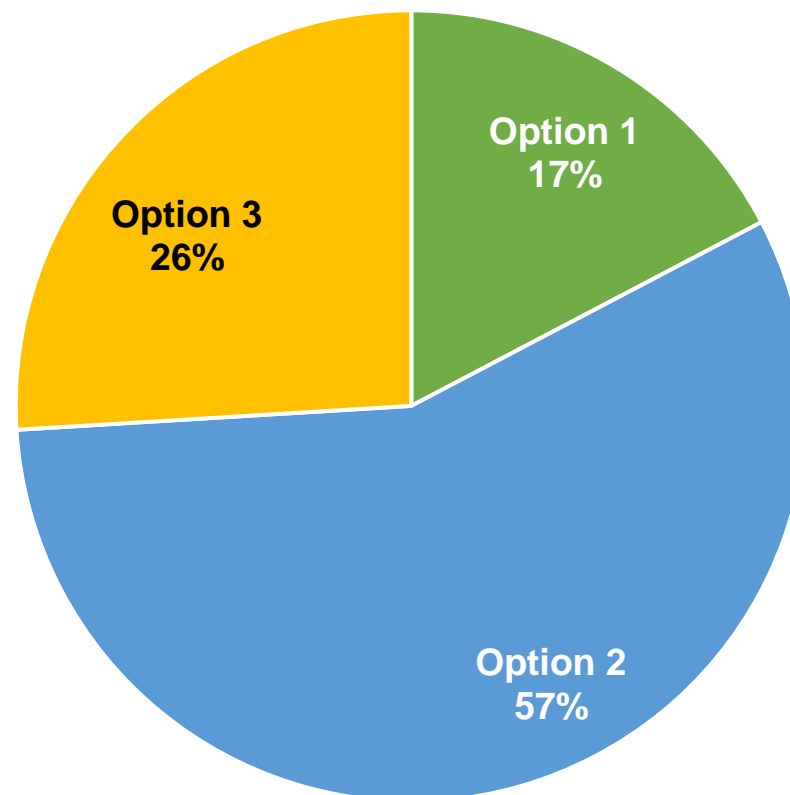
1. ADT alone
2. ADT plus ARPI
3. ADT plus RT of the primary tumour
4. **ADT plus ARPI plus RT of the primary tumour**
5. Abstain/unqualified to answer



Option	Votes
Option 1	0
Option 2	12
Option 3	7
Option 4	85
Abstain	2

75. In the majority of patients with synchronous low-burden mHSPC on conventional imaging, do you recommend additional metastases directed therapy (if technically feasible) of all lesions?

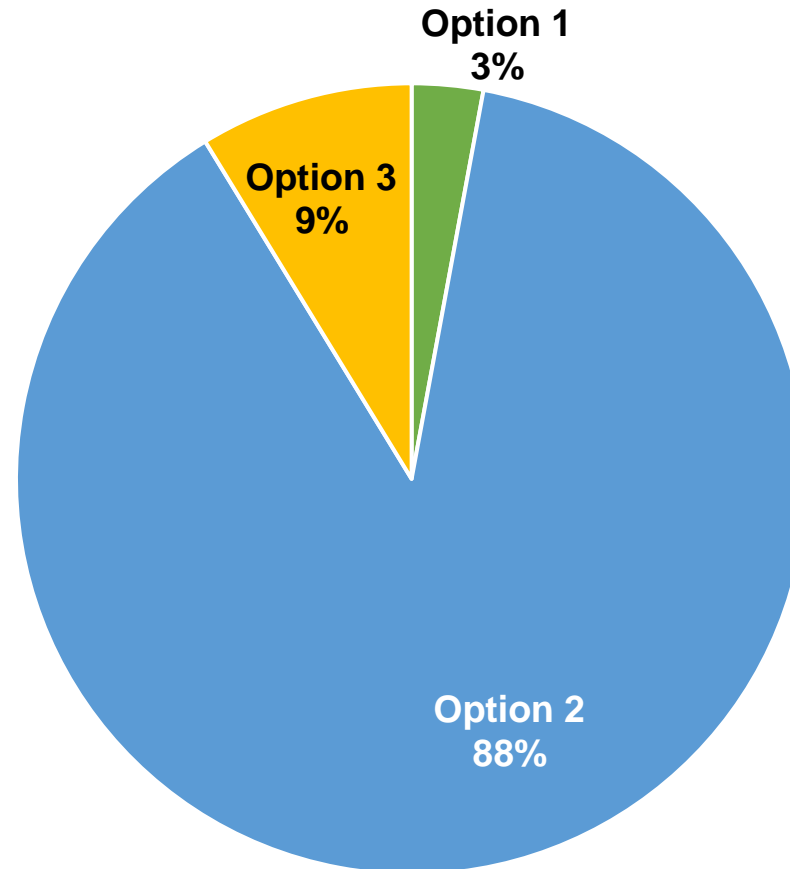
1. Yes
2. Yes, but only if no relevant additional and/or untreatable lesions confirmed by next-generation imaging
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	18
Option 2	59
Option 3	27
Abstain	2

76. In the majority of patients with synchronous low-burden mHSPC on next-generation imaging and negative on conventional imaging, what is your treatment recommendation (regardless of the decision about metastases-directed therapy and regardless of the addition of docetaxel)?

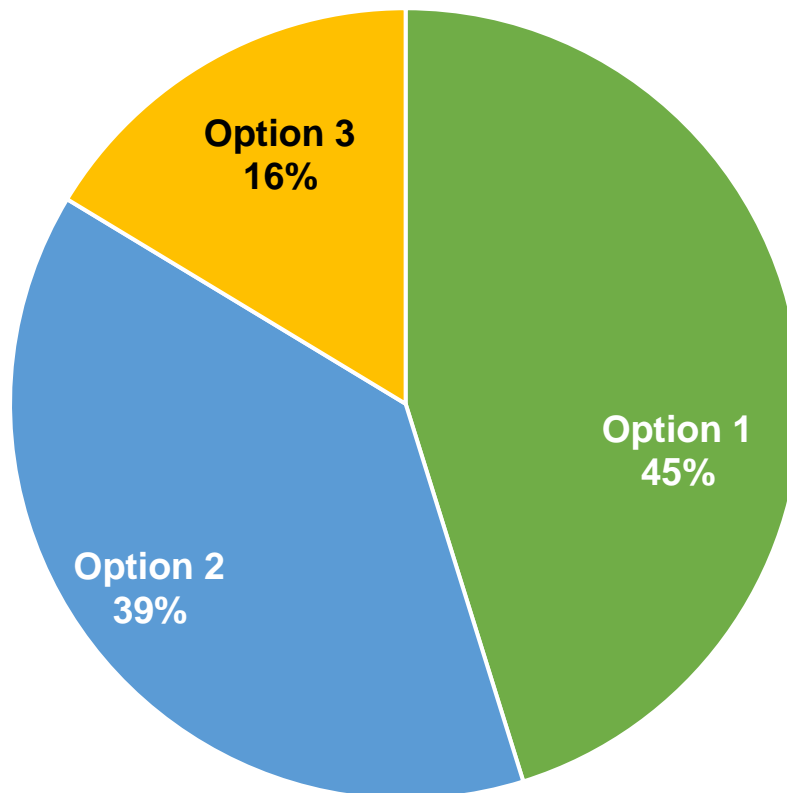
1. ADT ± ARPI
2. **ADT plus RT of the primary tumour ± ARPI**
3. Treat as M0
4. Abstain/unqualified to answer



Option	Votes
Option 1	3
Option 2	91
Option 3	9
Abstain	3

77. In patients with synchronous low-burden mHSPC on next-generation imaging and negative on conventional imaging, do you recommend additional metastases directed therapy (if technically feasible) of all lesions?

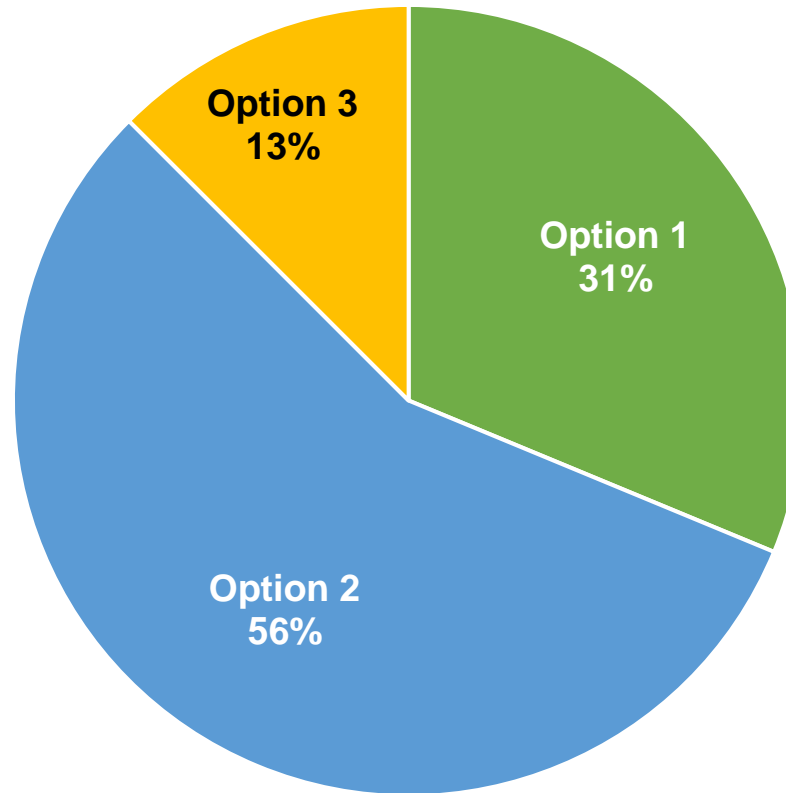
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	47
Option 2	40
Option 3	17
Abstain	2

78. In patients with synchronous low-burden mHSPC on conventional imaging and if you use metastases-directed therapy what is your recommendation regarding the duration of systemic therapy?

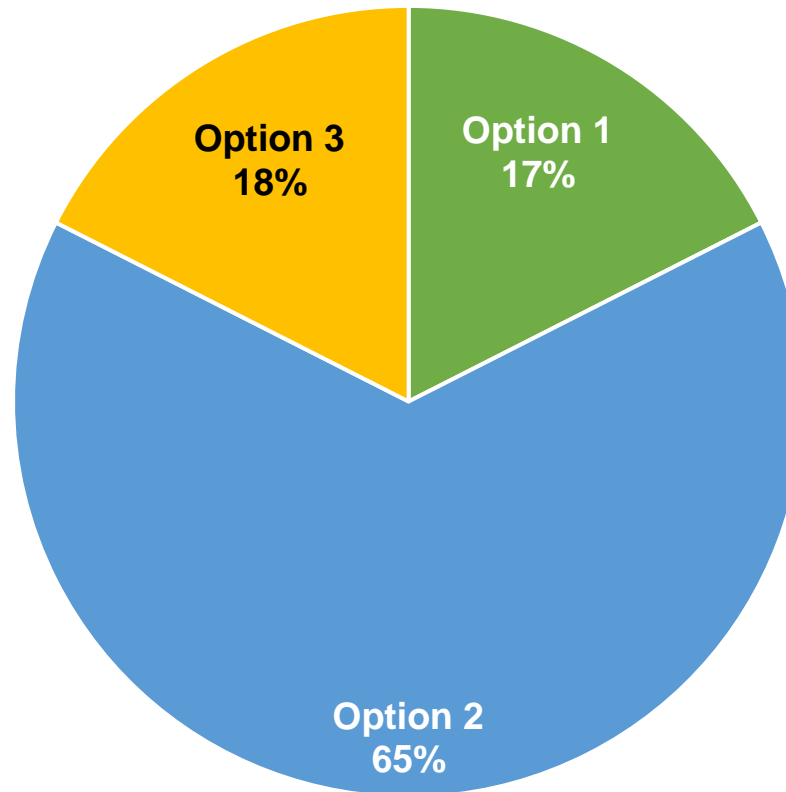
1. Continuous lifelong treatment of ADT ± ARPI
2. Continuous treatment of ADT ± ARPI for 2-3 years
3. Intermittent (e.g., interrupt after 6-12 months if PSA <0.2 ng/mL)
4. Abstain/unqualified to answer (including I did not vote for metastases-directed therapy or I do not use systemic therapy in this situation)



Option	Votes
Option 1	30
Option 2	54
Option 3	12
Abstain	10

79. In patients with synchronous low-burden mHSPC on next-generation imaging and negative on conventional imaging and if you use metastases-directed therapy what is your recommendation regarding the duration of systemic therapy?

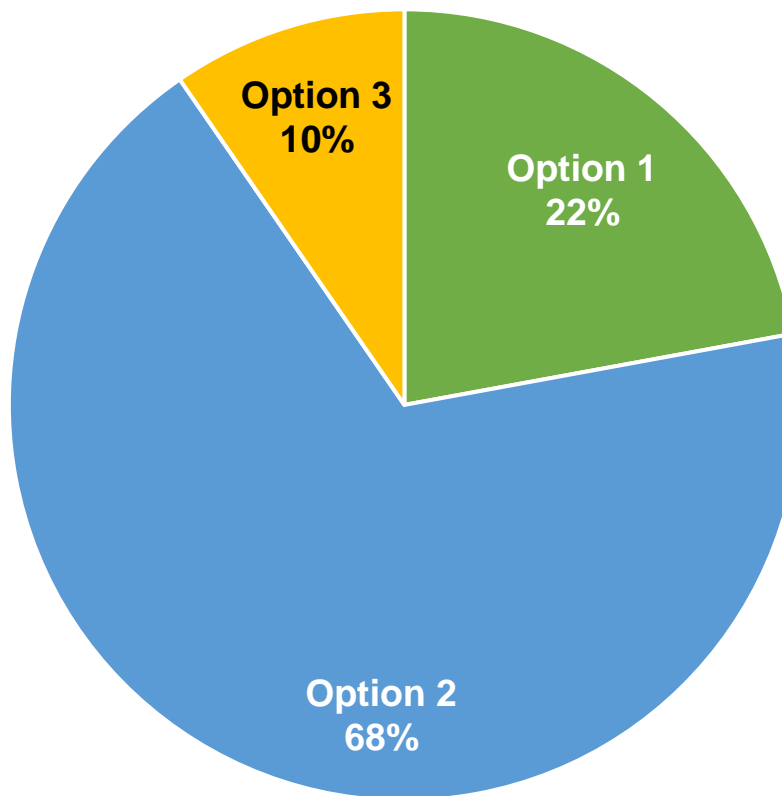
1. Continuous lifelong treatment of ADT ± ARPI
2. Continuous treatment of ADT ± ARPI for 2-3 years
3. Intermittent (e.g., interrupt after 6-12 months if PSA <0.2 ng/mL)
4. Abstain/unqualified to answer (including I did not vote for metastases-directed therapy or I do not use systemic therapy in this situation)



Option	Votes
Option 1	17
Option 2	63
Option 3	17
Abstain	9

80. In the majority of patients with metachronous low-burden mHSPC on conventional imaging, what is your treatment recommendation?

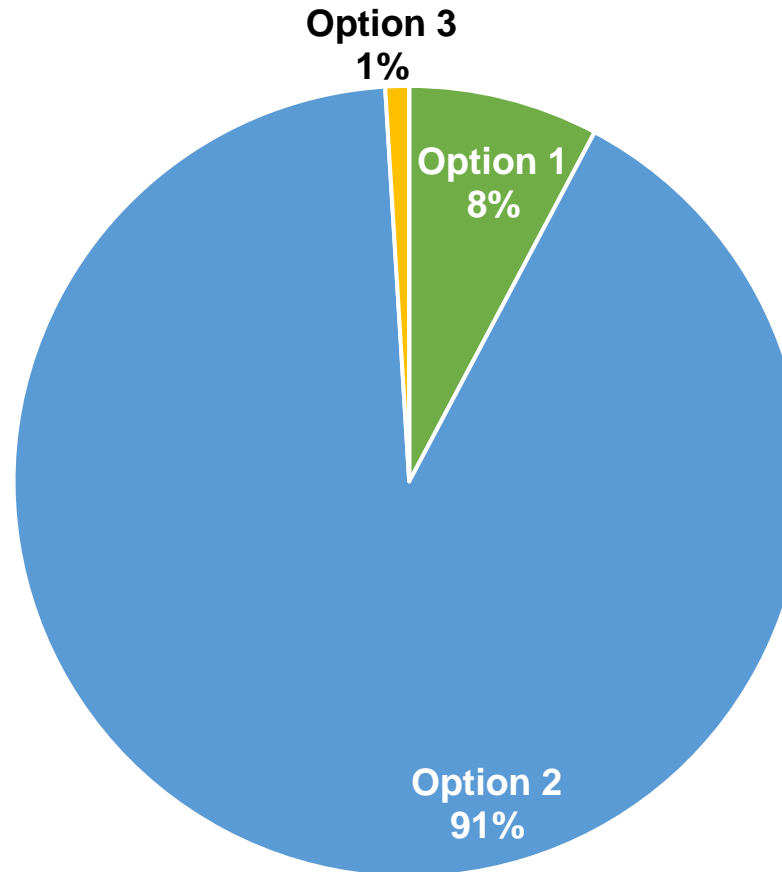
1. Systemic therapy alone
2. Systemic therapy plus metastases directed therapy
3. Metastases directed therapy alone
4. Abstain/unqualified to answer



Option	Votes
Option 1	23
Option 2	71
Option 3	10
Abstain	2

81. If you recommend systemic therapy in a patient with metachronous low-burden mHSPC on conventional imaging, what type of systemic therapy do you recommend?

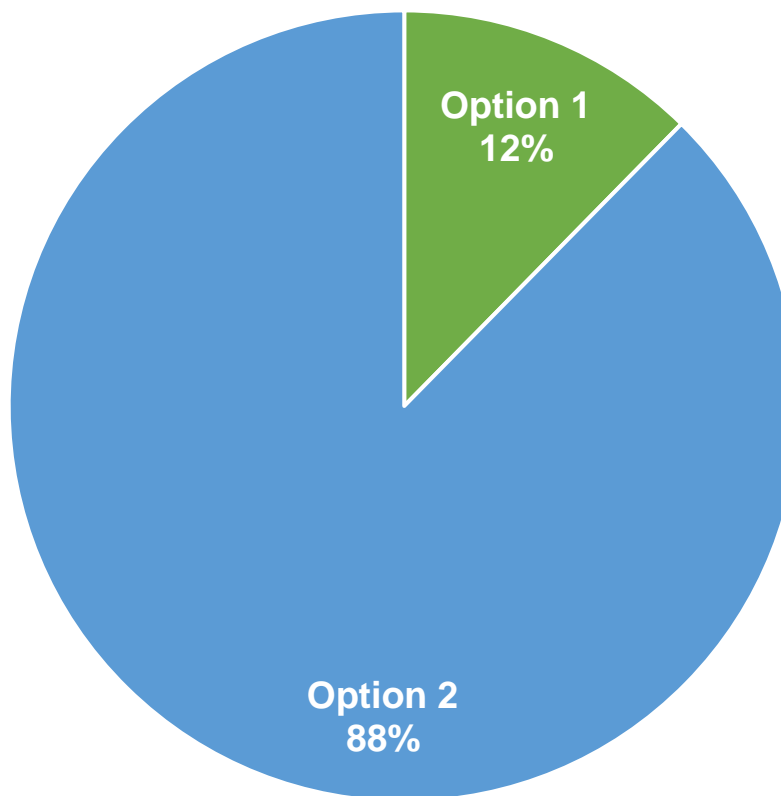
1. ADT alone
2. ADT plus ARPI
3. ARPI alone
4. ADT plus ARPI plus docetaxel
5. Abstain/unqualified to answer (Including I do not use systemic therapy in this situation)



Option	Votes
Option 1	8
Option 2	94
Option 3	1
Option 4	0
Abstain	3

82. If you recommend metastases directed in a patient with metachronous low-burden mHSPC on conventional imaging, what do you recommend?

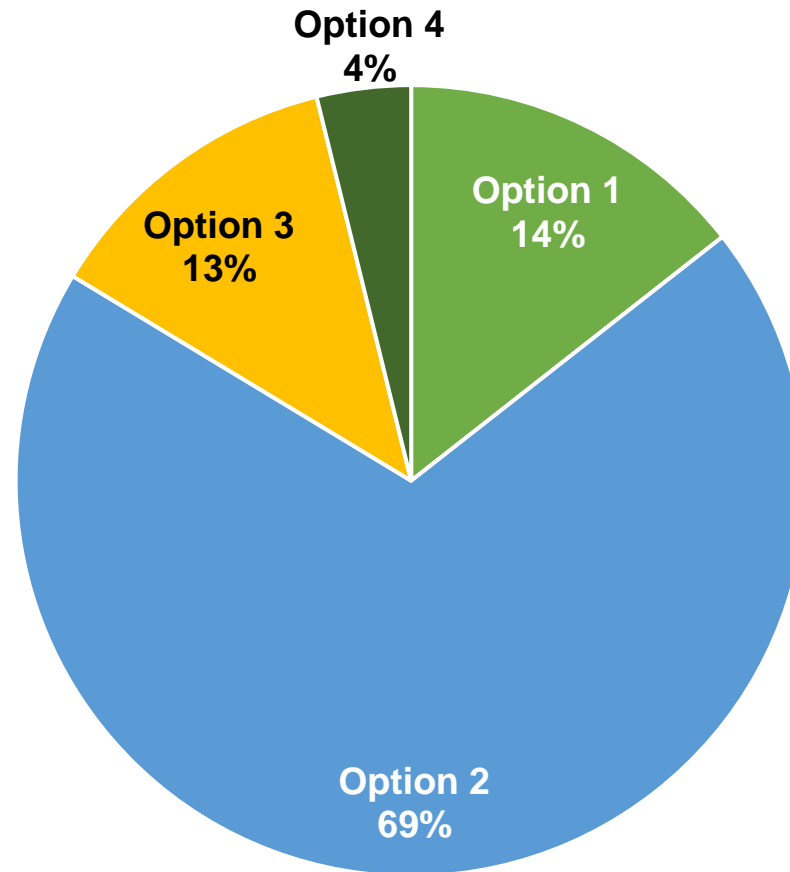
1. Treat based on conventional imaging
2. Treat only if no relevant additional and/or untreatable lesions confirmed by next-generation imaging
3. Abstain/unqualified to answer (including I do not recommend metastases directed therapy in this situation)



Option	Votes
Option 1	11
Option 2	78
Abstain	17

83. In the majority of patients with metachronous low-burden mHSPC on next-generation imaging and negative on conventional imaging, what is your treatment recommendation?

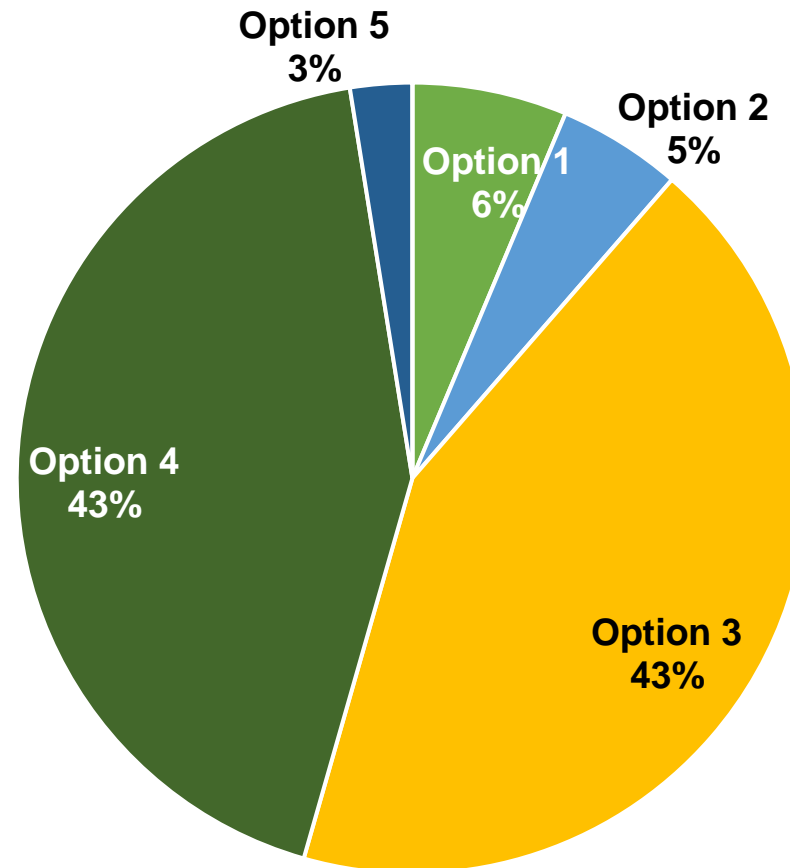
1. Systemic therapy alone
2. Systemic therapy plus metastases directed therapy
3. Metastases directed therapy alone
4. Monitoring and no immediate treatment
5. Abstain/unqualified to answer



Option	Votes
Option 1	15
Option 2	72
Option 3	13
Option 4	4
Abstain	2

84. If you recommend systemic therapy alone in a patient with metachronous low-burden mHSPC on next-generation imaging and negative on conventional imaging, what is your treatment recommendation?

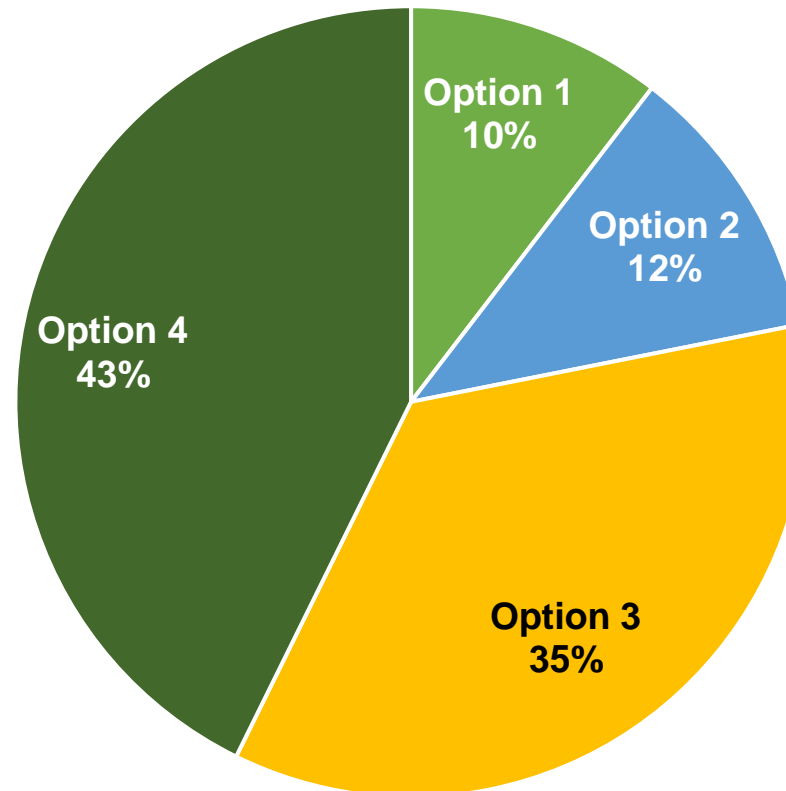
1. ADT alone, intermittent therapy
2. ADT alone, continuous therapy
3. ADT plus ARPI, intermittent therapy
4. ADT plus ARPI, continuous therapy
5. ARPI alone, intermittent therapy
6. ARPI alone, continuous therapy
7. Abstain/unqualified to answer (including I do not recommend systemic therapy alone in this situation)



Option	Votes
Option 1	5
Option 2	4
Option 3	34
Option 4	34
Option 5	2
Option 6	0
Abstain	27

85. If you recommend metastases-directed therapy in a patient with metachronous low-burden mHSPC on next-generation imaging and negative on conventional imaging, what is your recommendation regarding systemic therapy?

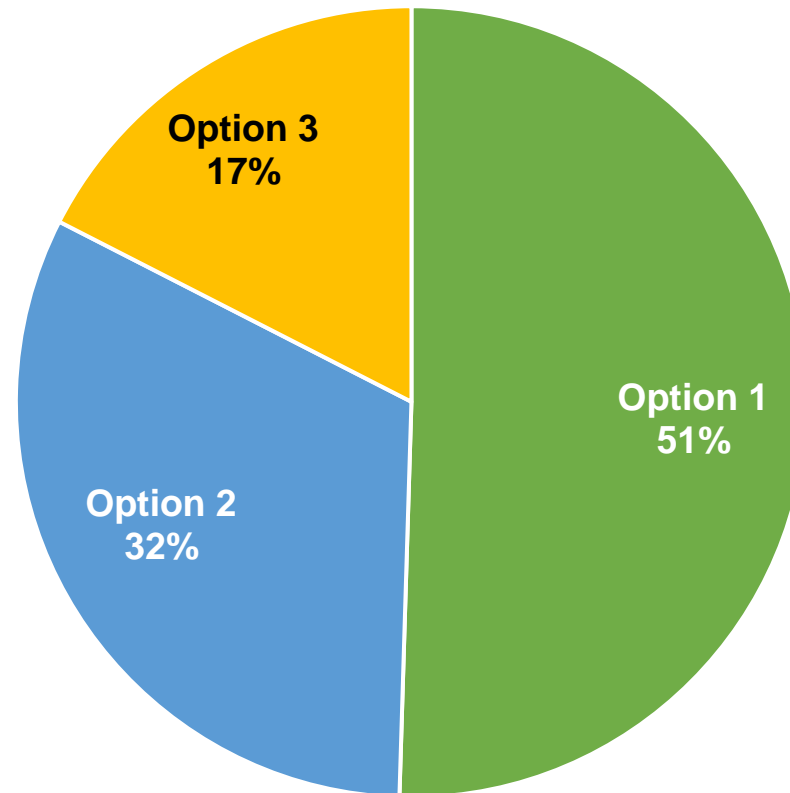
1. No systemic therapy
2. Continuous lifelong treatment of ADT ± ARPI or ARPI alone
3. Continuous treatment of ADT ± ARPI or ARPI alone for 2-3 years
4. Intermittent ADT ± ARPI or ARPI alone (e.g., interrupt after 6-12 months if PSA <0.2 ng/mL)
5. Abstain/unqualified to answer (including I do not use metastases-directed therapy)



Option	Votes
Option 1	10
Option 2	11
Option 3	34
Option 4	41
Abstain	10

86. If you recommend systemic therapy in a patient with metachronous low-burden mHSPC on conventional imaging, what is your recommendation regarding systemic therapy?

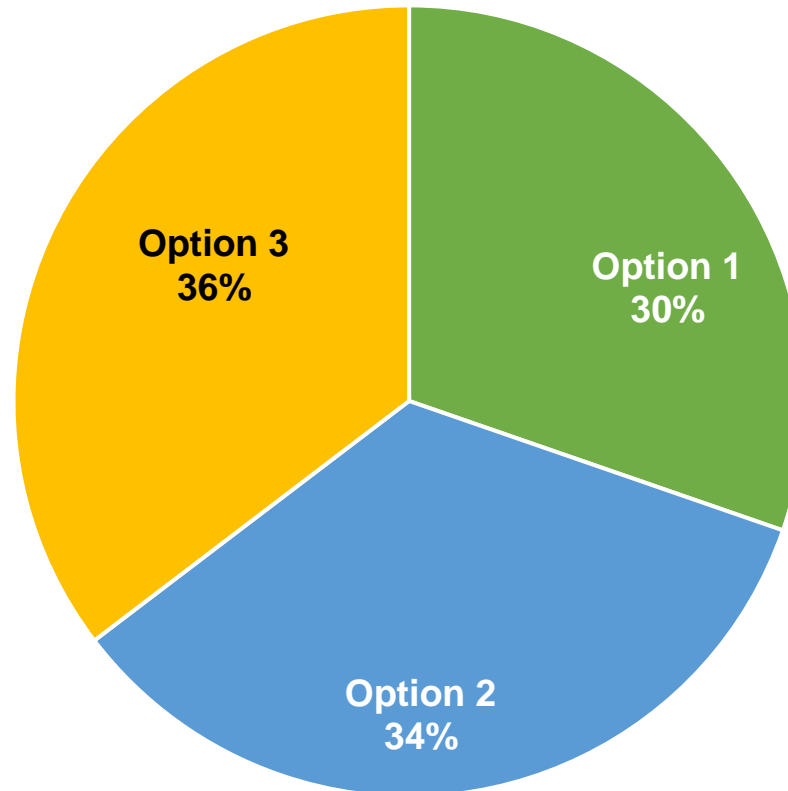
1. Continuous lifelong treatment of ADT ± ARPI or ARPI alone
2. Continuous treatment of ADT ± ARPI or ARPI alone for 2-3 years
3. Intermittent ADT ± ARPI or ARPI alone (e.g., interrupt after 6-12 months if PSA <0.2 ng/mL)
4. Abstain/unqualified to answer (including I do not recommend metastases-directed therapy or I do not use systemic therapy in this situation)



Option	Votes
Option 1	52
Option 2	33
Option 3	18
Abstain	3

87. If you recommend systemic therapy in patients with metachronous low-burden mHSPC on next-generation imaging and negative on conventional imaging, what is your recommendation regarding systemic therapy?

1. Continuous lifelong treatment of ADT ± ARPI or ARPI alone
2. Continuous treatment of ADT ± ARPI or ARPI alone for 2-3 years
3. Intermittent ADT ± ARPI or ARPI alone (e.g., interrupt after 6-12 months if PSA <0.2 ng/mL)
4. Abstain/unqualified to answer (including I do not recommend metastases-directed therapy or I do not use systemic therapy in this situation)



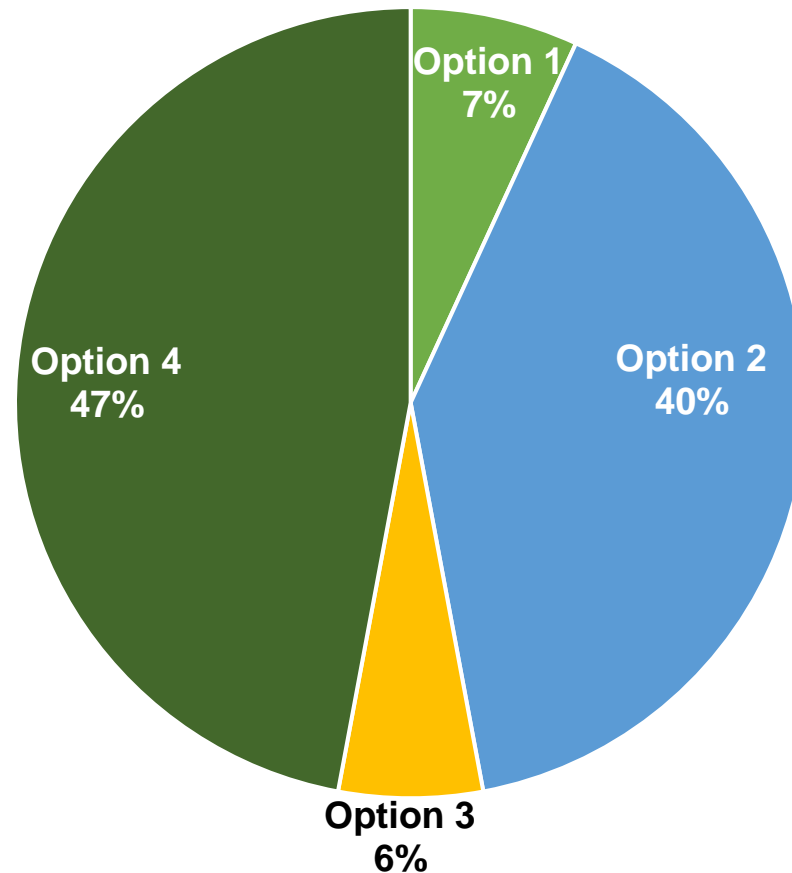
Option	Votes
Option 1	30
Option 2	34
Option 3	35
Abstain	7

## 3. mHSPC

### 3.4. Treatment de-escalation

88. For the majority of patients with mHSPC with deep remission to systemic therapy (e.g., PSA <0.2 ng/mL) and complete radiological response of measurable lesions (PCWG3 criteria), and no relevant side-effects, do you recommend treatment interruption?

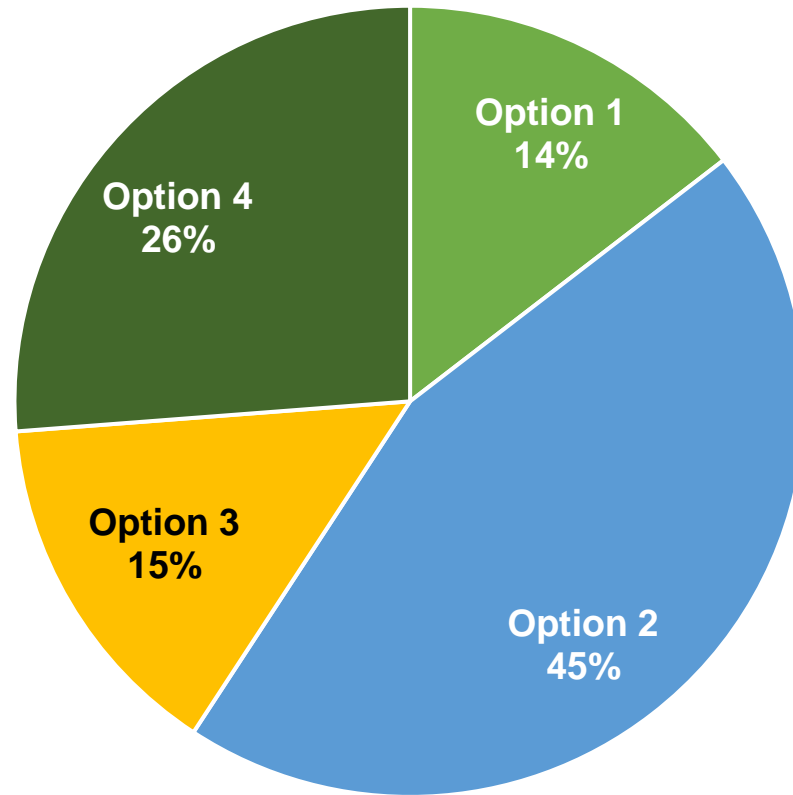
1. Yes, after 6-12 months
2. Yes, after 24-36 months
3. Yes, after >36 months
4. No, I recommend continuous therapy
5. Abstain/unqualified to answer



Option	Votes
Option 1	7
Option 2	41
Option 3	6
Option 4	48
Abstain	4

89. For the majority of patients with mHSPC with deep remission to systemic therapy (e.g., PSA <0.2 ng/mL), and no relevant side-effects, do you discuss the option of treatment interruption?

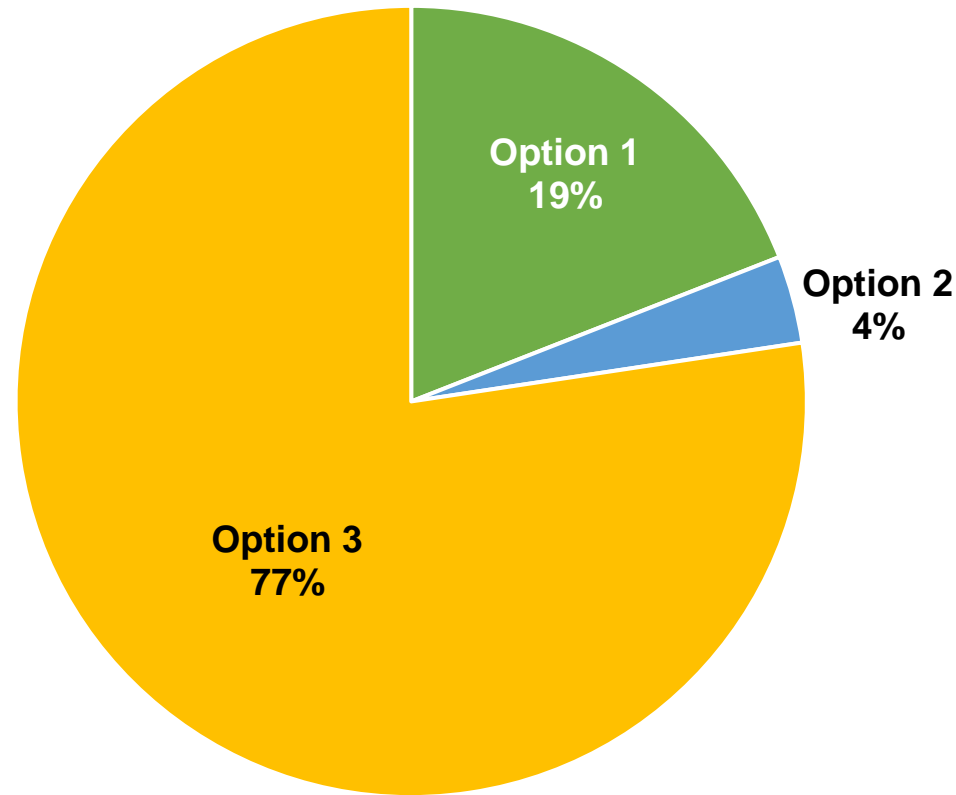
1. Yes, after 6-12 months
2. Yes, after 24-36 months
3. Yes, after >36 months
4. No, I recommend continuous therapy
5. Abstain/unqualified to answer



Option	Votes
Option 1	15
Option 2	46
Option 3	15
Option 4	27
Abstain	3

90. If you use treatment interruption in patients with mHSPC with deep remission to systemic therapy (e.g., PSA <0.2 ng/mL) what is your recommendation regarding systemic therapy?

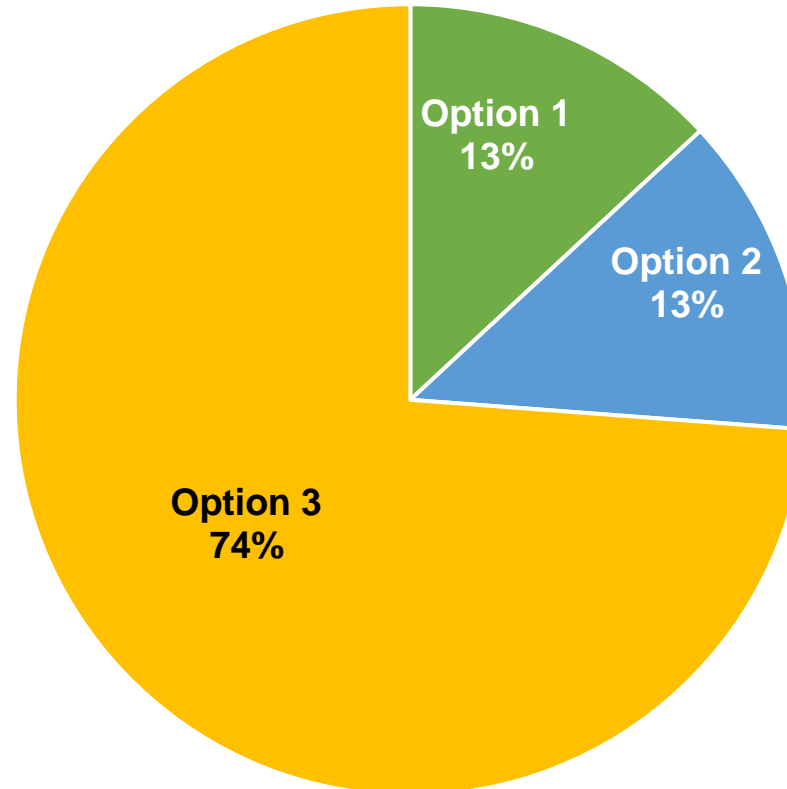
1. Suspend the ARPI
2. Suspend ADT
- 3. Suspend both ADT and the ARPI**
4. Abstain/unqualified to answer (including I did not vote for interruption)



Option	Votes
Option 1	16
Option 2	3
Option 3	65
Abstain	22

91. If you use treatment interruption in patients with mHSPC with deep remission to systemic therapy (e.g., PSA <0.2 ng/mL) what is your trigger to re-start systemic therapy in the absence of clinical progression and in the context of recovered testosterone?

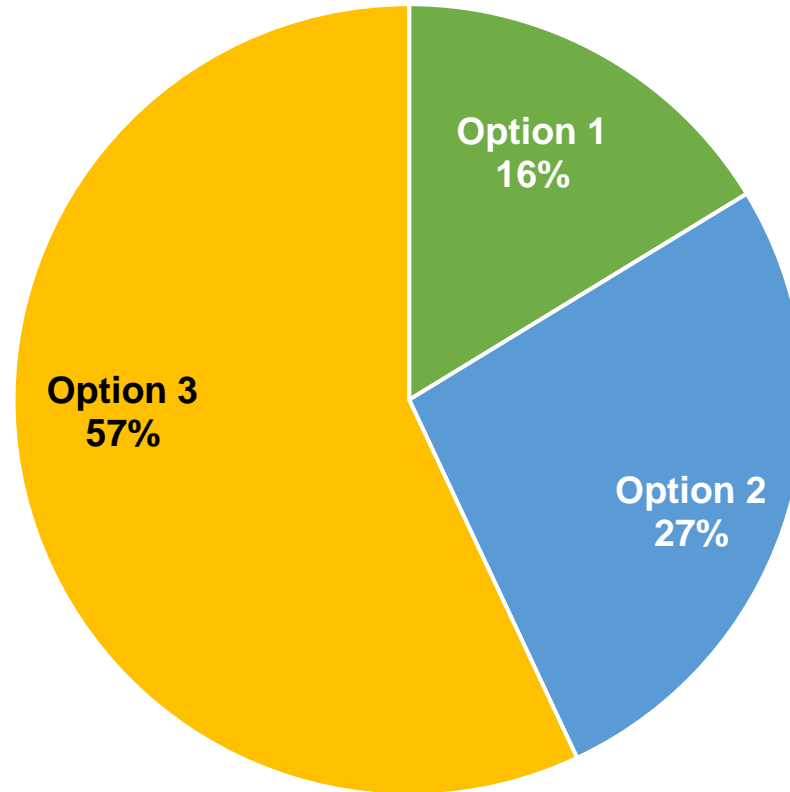
1. Based on PSA rise
2. Based on imaging with or without PSA rise
3. Based on PSA rise or imaging progression, whichever occurs first
4. Abstain/unqualified to answer (including I did not vote for interruption)



Option	Votes
Option 1	11
Option 2	11
Option 3	62
Abstain	22

92. If you use treatment interruption in patients with mHSPC with deep remission to systemic therapy (e.g., PSA <0.2 ng/mL) and if on a PSMA PET during treatment interruption oligo-progressive disease is identified, what is your recommendation in the context of recovered testosterone?

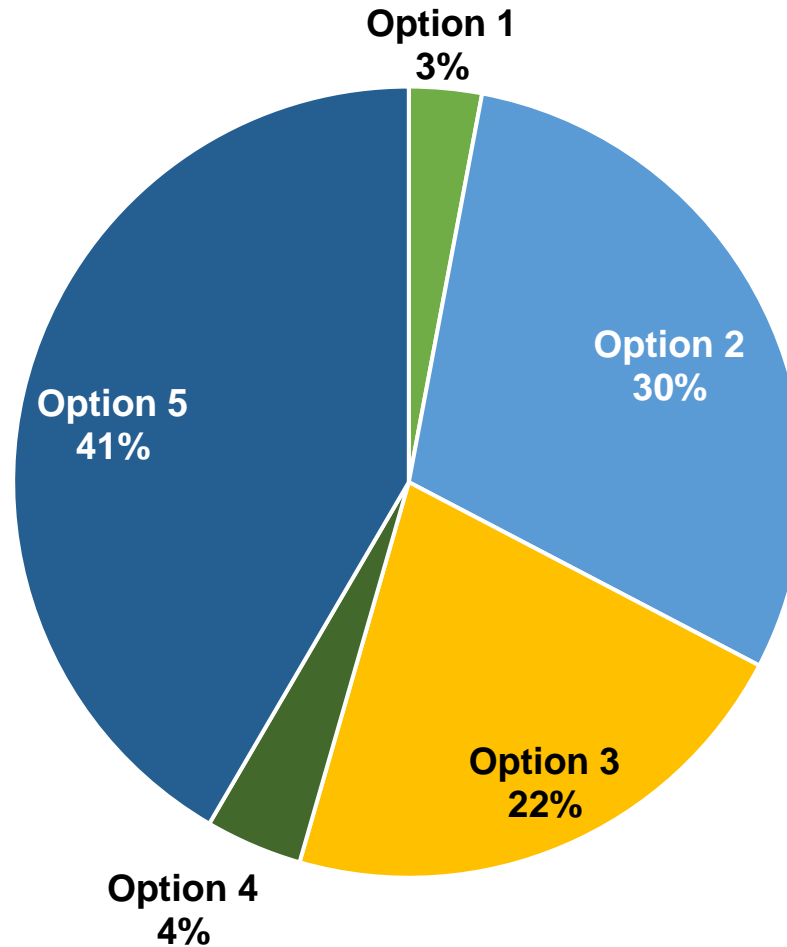
1. Re-start systemic therapy
2. Metastases-directed therapy
3. Both of the above
4. Abstain/unqualified to answer (including I did not vote for interruption)



Option	Votes
Option 1	14
Option 2	23
Option 3	49
Abstain	20

93. For the majority of patients with mHSPC with deep remission on ADT + ARPI (e.g., PSA <0.2 ng/mL), and bothersome side-effects (fatigue, cognitive decline, falls, hot flashes), what is your recommendation regarding systemic therapy?

1. No change in systemic therapy
2. ARPI dose reduction (ADT continued)
3. Suspend the ARPI (ADT continued)
4. Suspend ADT (ARPI continued)
5. Suspend both ADT and the ARPI
6. Abstain/unqualified to answer



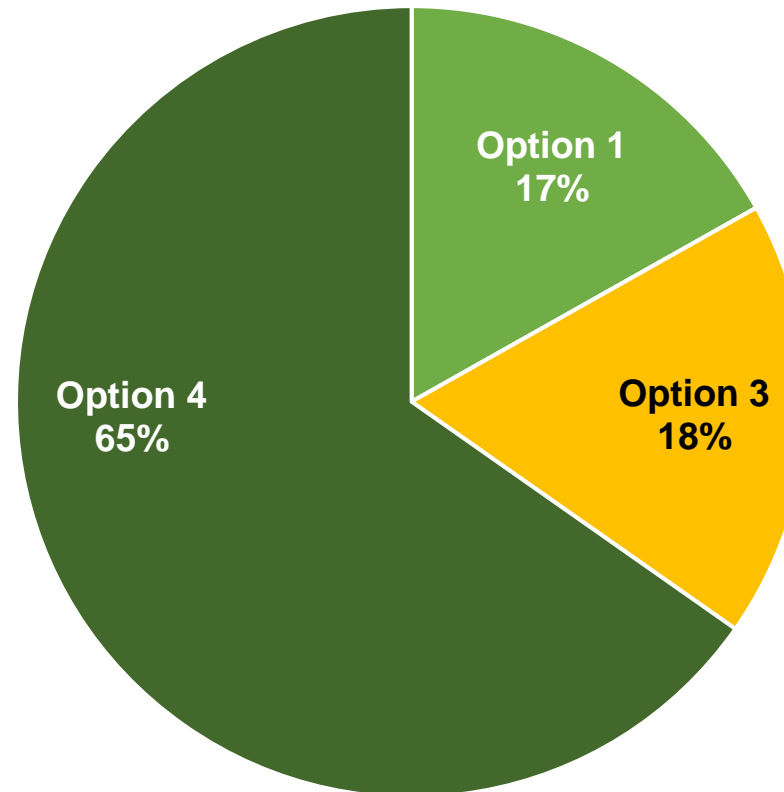
Option	Votes
Option 1	3
Option 2	30
Option 3	22
Option 4	4
Option 5	42
Abstain	5

## 3. mHSPC

### 3.5. Special situations

94. In patients with synchronous mHSPC and presence of a pathogenic BRCA alteration, does this information change your treatment recommendation for the patient?

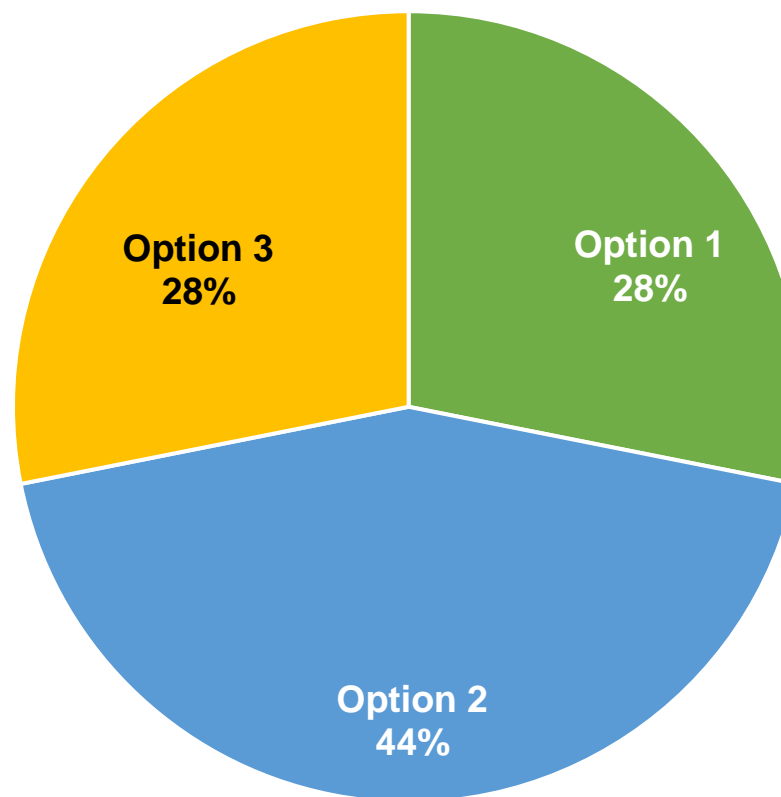
1. Yes, I recommend ADT + ARPI + Docetaxel triplet systemic therapy over ADT + ARPI doublet systemic therapy regardless of disease burden
2. Yes, I add a platinum chemotherapy to systemic therapy regardless of disease burden
3. Yes, I add a PARP inhibitor to systemic therapy regardless of disease burden
4. No
5. Abstain/unqualified to answer



Option	Votes
Option 1	16
Option 2	0
Option 3	17
Option 4	62
Abstain	11

95. For the majority of patients with mHSPC if there is histological evidence of a relevant neuroendocrine component (not pure small cell carcinoma) will it change your clinical management?

1. Yes, I recommend docetaxel as part of the initial treatment regimen
2. Yes, I recommend a platinum ( $\pm$  taxane) as part of the initial treatment regimen
3. No
4. Abstain/unqualified to answer



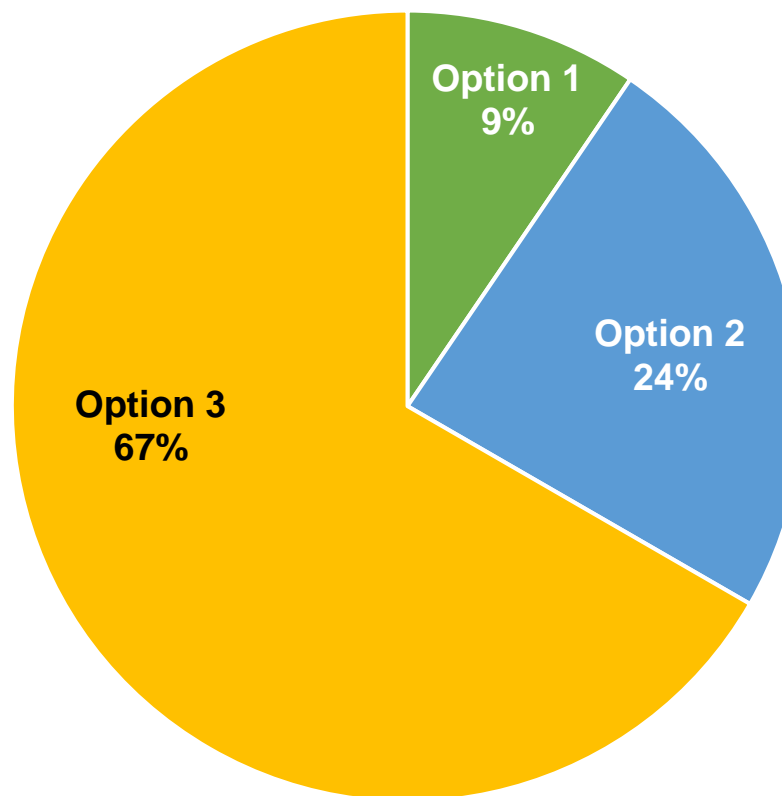
Option	Votes
Option 1	27
Option 2	42
Option 3	27
Abstain	10

## 3. mHSPC

### 3.6. Radiation of the primary tumour in mHSPC

96. In patients with high-volume synchronous mHSPC without relevant local symptoms, do you recommend local radiation therapy of the primary in addition to systemic therapy?

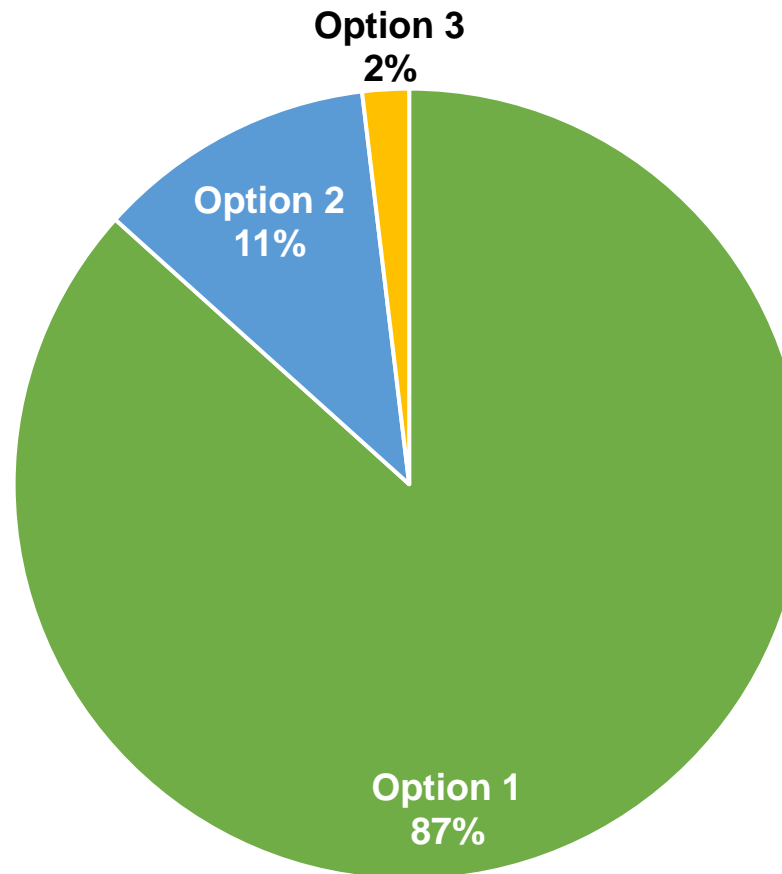
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No, I usually do not recommend RT in this situation
4. Abstain/unqualified to answer



Option	Votes
Option 1	10
Option 2	25
Option 3	70
Abstain	1

97. In patients with low-volume synchronous mHSPC without relevant local symptoms that receive ADT plus an ARPI, do you recommend local radiation therapy of the primary in addition to systemic therapy?

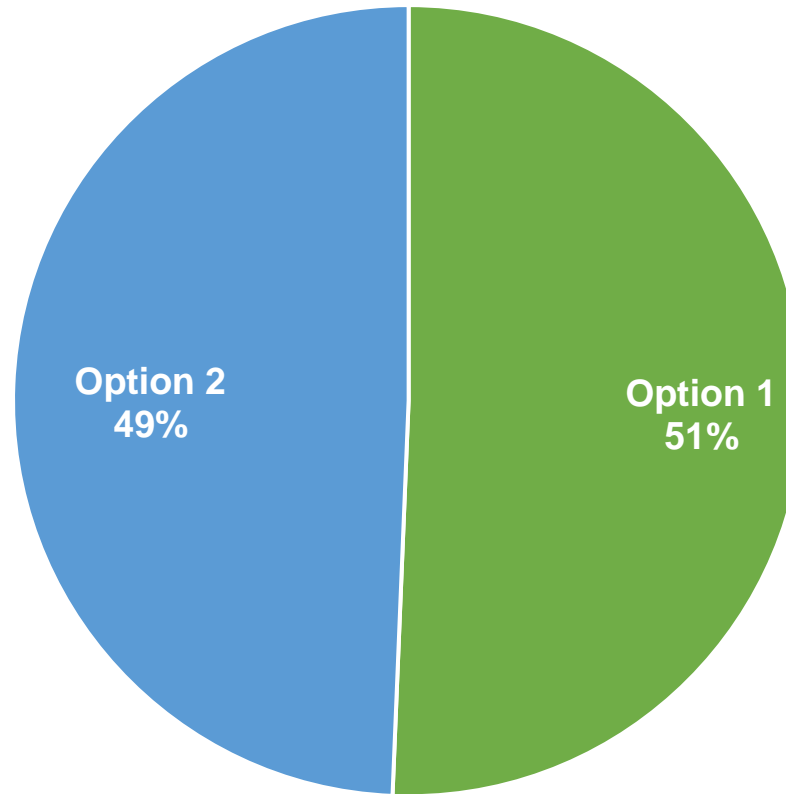
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No, I usually do not recommend RT in this situation
4. Abstain/unqualified to answer



Option	Votes
Option 1	91
Option 2	12
Option 3	2
Abstain	1

## 98. For the majority of patients with synchronous mHSPC who are planned for local radiation therapy what is your recommended radiation schedule?

1. A dose escalated RT dose e.g. 74 – 80 Gy in 37-40 fractions (or equivalent hypofractionated schedules such as 60-70 Gy in 20-28 fractions or ultrahypofractionation in 5 fractions): Full definitive dosing as used in localized prostate cancer
2. A lower RT dose e.g. 55 Gy in 20 fractions or 36 Gy in six fractions as used in STAMPEDE
3. Abstain/unqualified to answer (including I do not decide on radiation prescription schedules)



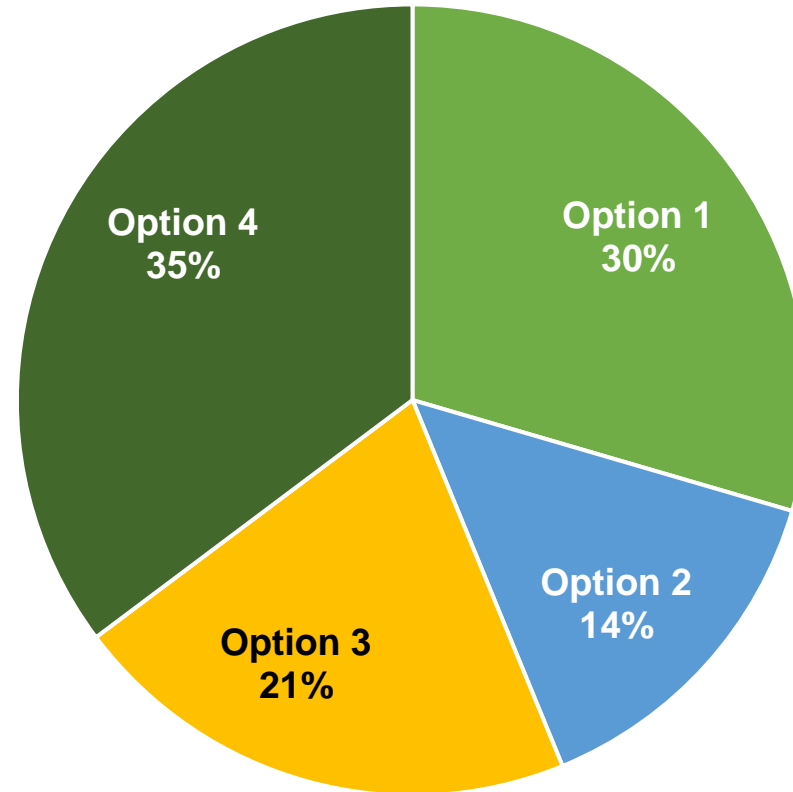
Option	Votes
Option 1	39
Option 2	38
Abstain	29

## 3. mHSPC and mCRPC

### 3.6. Genetics

99. For the majority of patients with high-risk localised/locally advanced prostate cancer do you routinely recommend genetic evaluation?

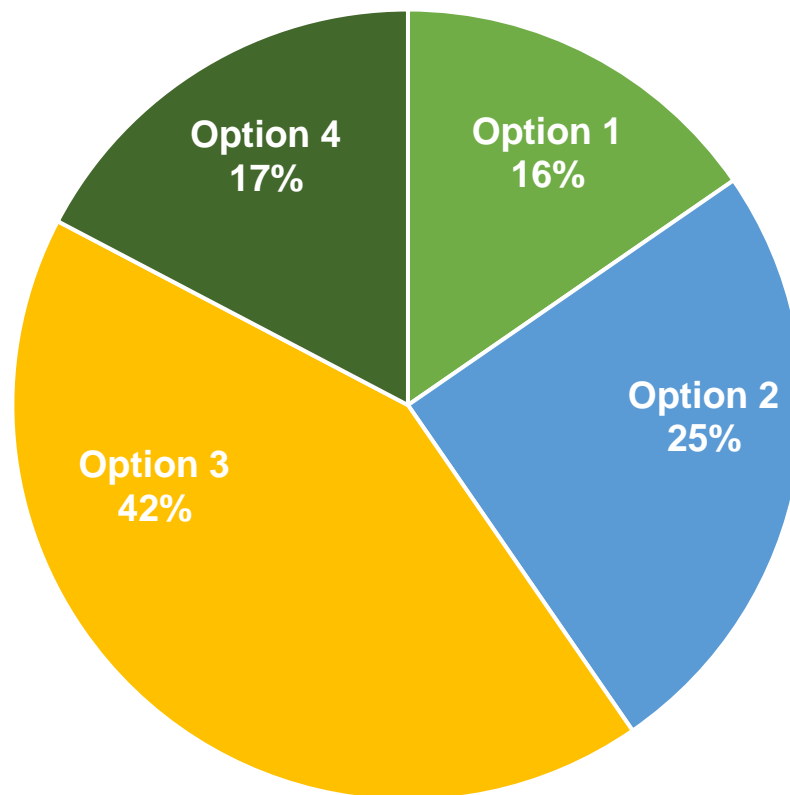
1. Yes, germline testing
2. Yes, somatic testing plus/minus germline testing only in case of relevant somatic alterations
3. Yes, both germline and somatic testing, independent of findings in somatic testing
4. No
5. Abstain/unqualified to answer



Option	Votes
Option 1	31
Option 2	15
Option 3	22
Option 4	37
Abstain	1

# 100. For the majority of patients with mHSPC, do you routinely recommend genetic evaluation (if not performed earlier)?

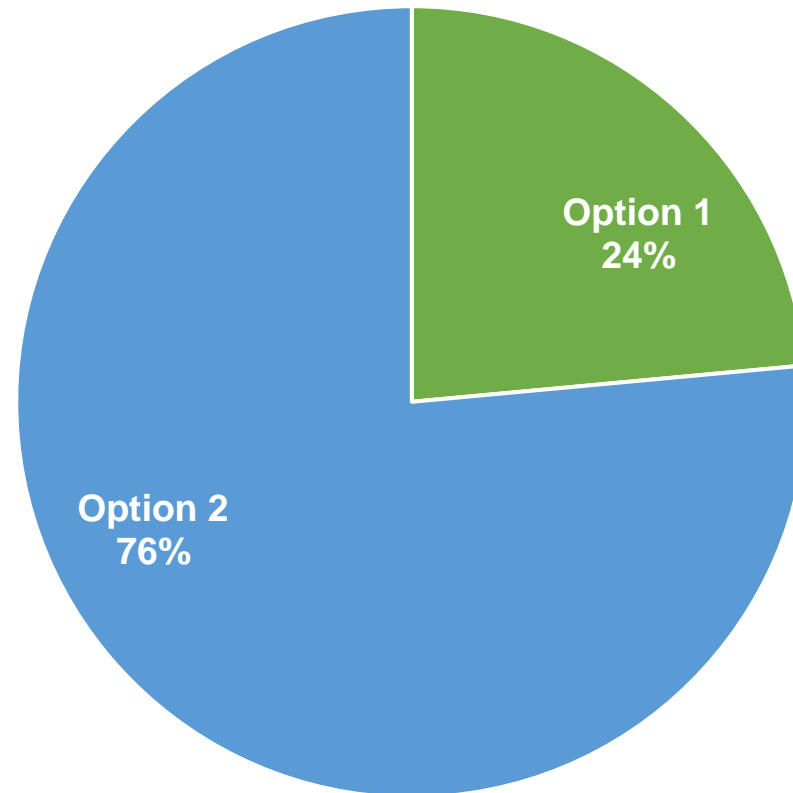
1. Yes, germline testing
2. Yes, somatic testing plus/minus germline testing only in case of relevant somatic alterations
3. Yes, both germline and somatic testing, independent of findings in somatic testing
4. No
5. Abstain/unqualified to answer



Option	Votes
Option 1	16
Option 2	26
Option 3	44
Option 4	18
Abstain	2

101. Outside a clinical trial, does the information of genetic evaluation (germline and/or somatic) influence your decision for first-line treatment of mHSPC in the majority of patients (if testing is available without restrictions)?

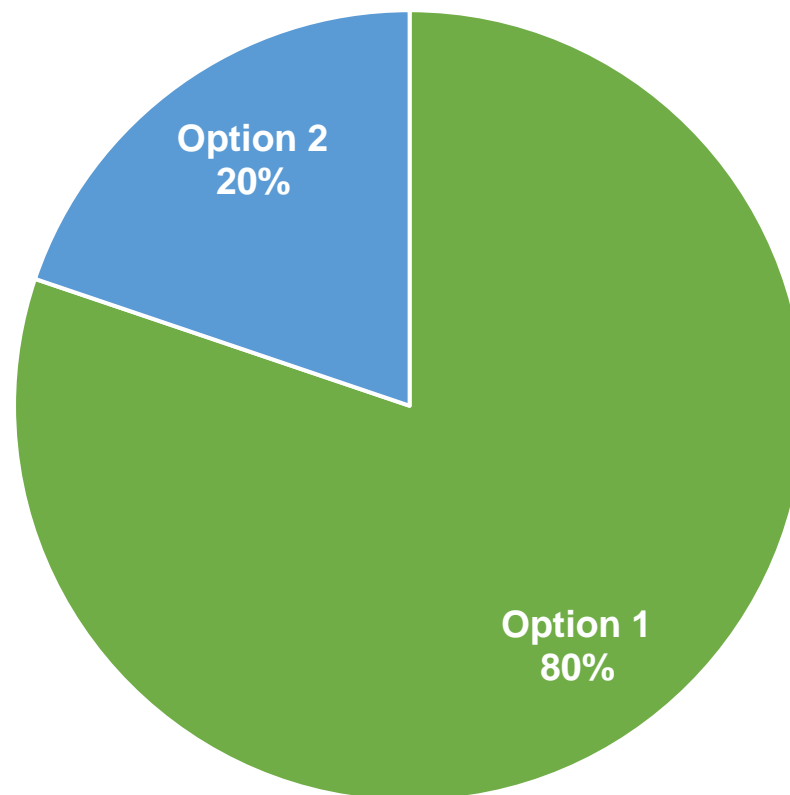
1. Yes
- 2. No**
3. Abstain/unqualified to answer



Option	Votes
Option 1	24
Option 2	78
Abstain	4

102. Outside a clinical trial, does the information of genetic evaluation (germline and/or somatic) influence your decision for first-line treatment of mCRPC in the majority of patients (if testing is available without restrictions)?

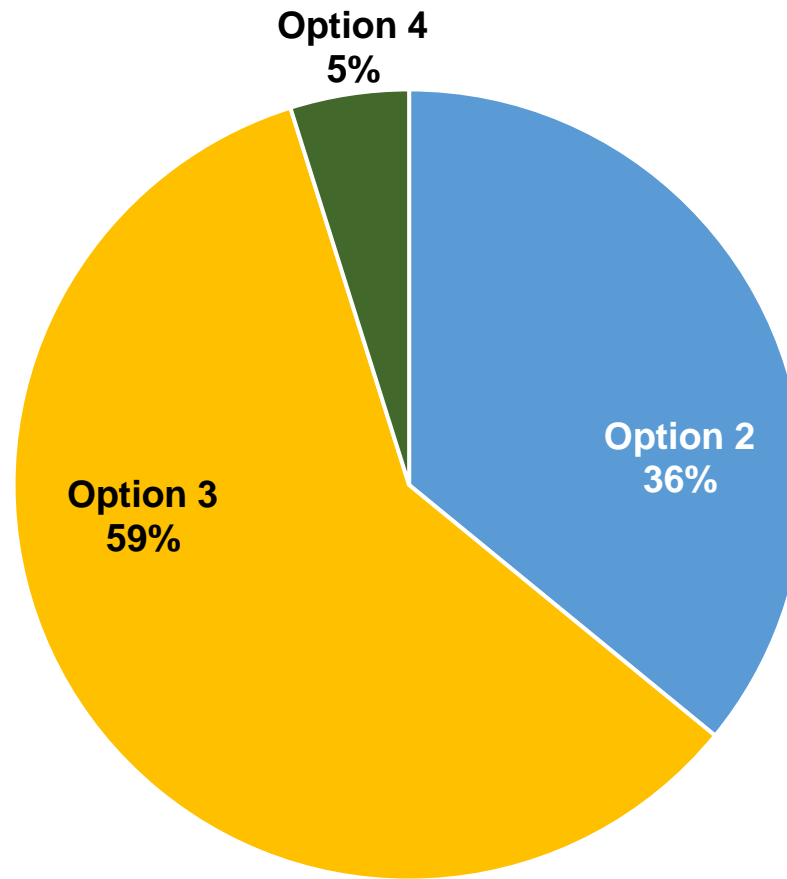
- 1. Yes
- 2. No
- 3. Abstain/unqualified to answer



Option	Votes
Option 1	81
Option 2	20
Abstain	5

# 103. For the majority of patients with mCRPC, do you routinely recommend genetic evaluation (if not performed earlier)?

1. Yes, germline testing
2. Yes, somatic testing plus/minus germline testing only in case of relevant somatic alterations
3. Yes, both germline and somatic testing, independent of findings in somatic testing
4. No
5. Abstain/unqualified to answer



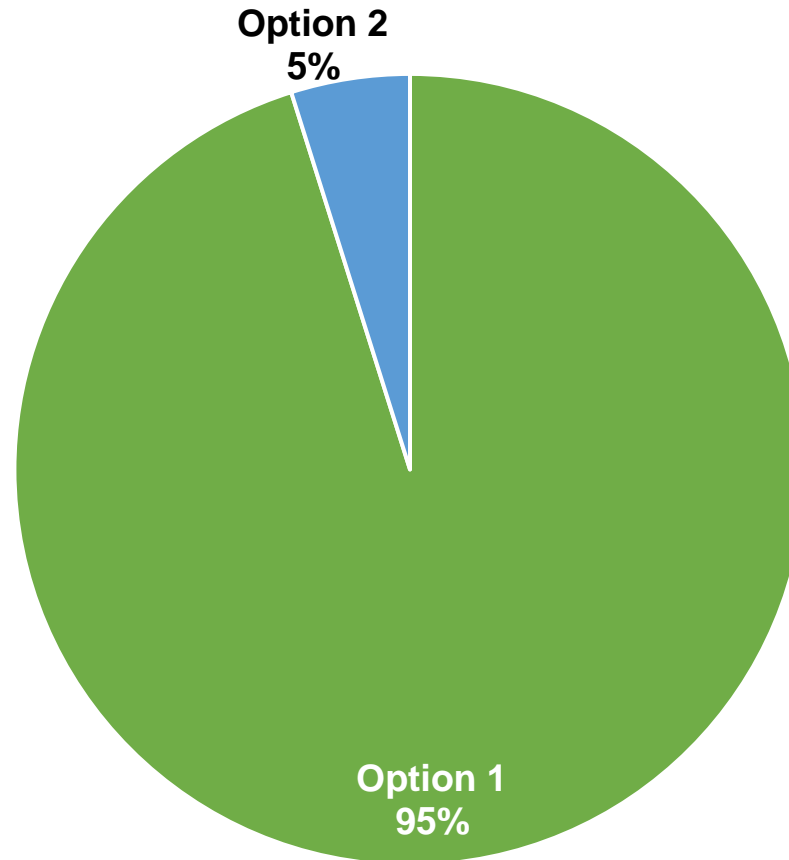
Option	Votes
Option 1	0
Option 2	37
Option 3	61
Option 4	5
Abstain	3

## 4. mCRPC

### 4.1. mCRPC general

104. Do you recommend somatic genetic testing for DDR genes before recommending a PARP inhibitor and ARPI combination treatment for first-line mCRPC?

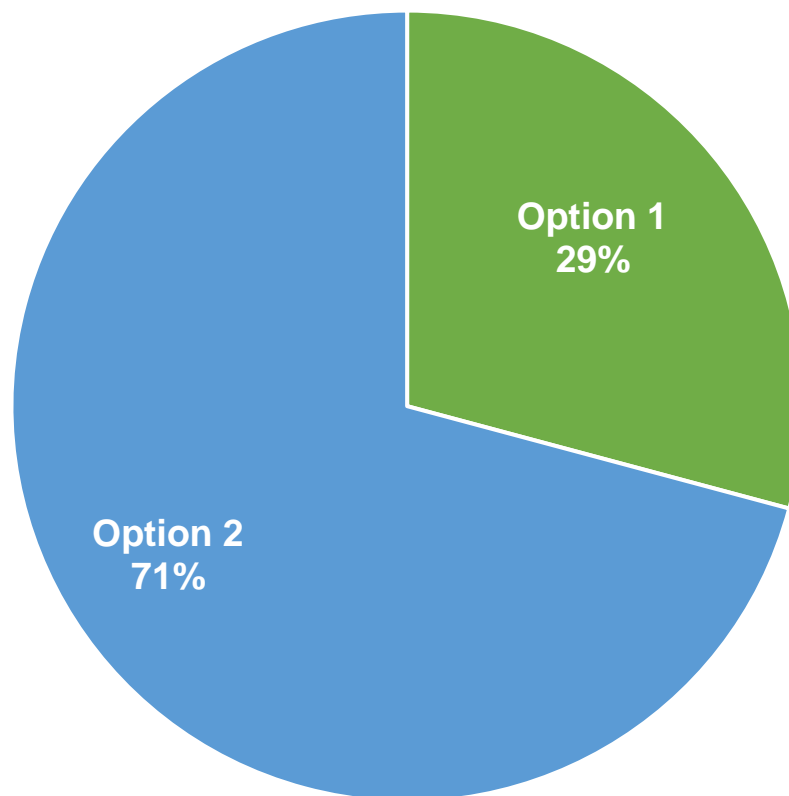
- 1. Yes
- 2. No
- 3. Abstain/unqualified to answer



Option	Votes
Option 1	98
Option 2	5
Abstain	3

105. If you use a combination of ARPI plus PARP inhibitor, is it appropriate to combine any ARPI with any PARP inhibitor for first-line mCRPC?

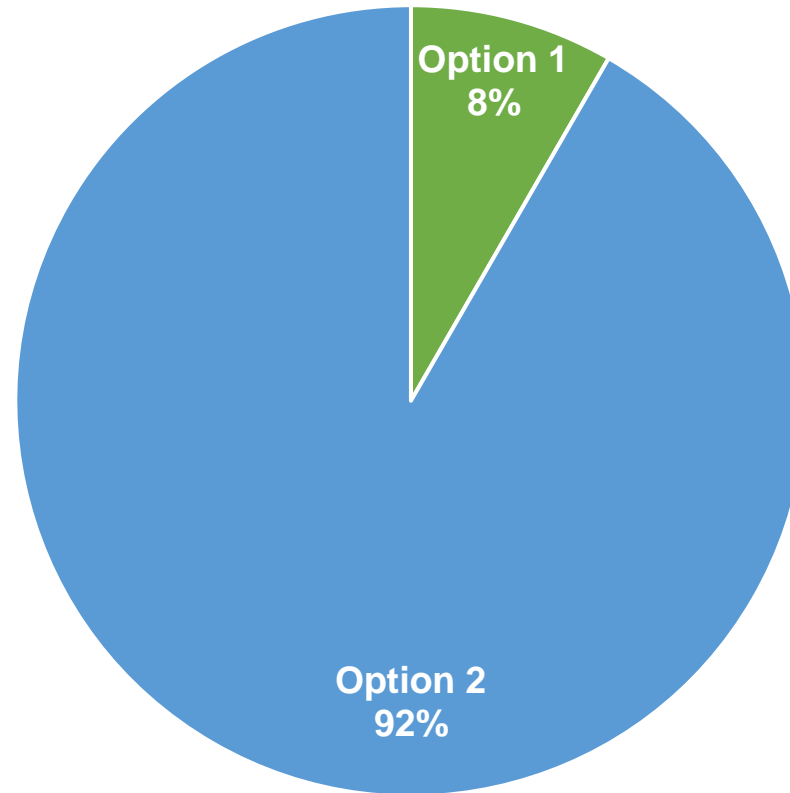
1. Yes
2. No
3. Abstain/unqualified to answer



Option	Votes
Option 1	28
Option 2	68
Abstain	10

106. In the majority of patients with mCRPC progressing on ADT plus an ARPI (either started for mHSPC or CRPC) do you recommend cabozantinib and atezolizumab if they are fit for chemotherapy or <sup>177</sup>Lu-PSMA therapy?

1. Yes
2. **No**
3. Abstain/unqualified to answer



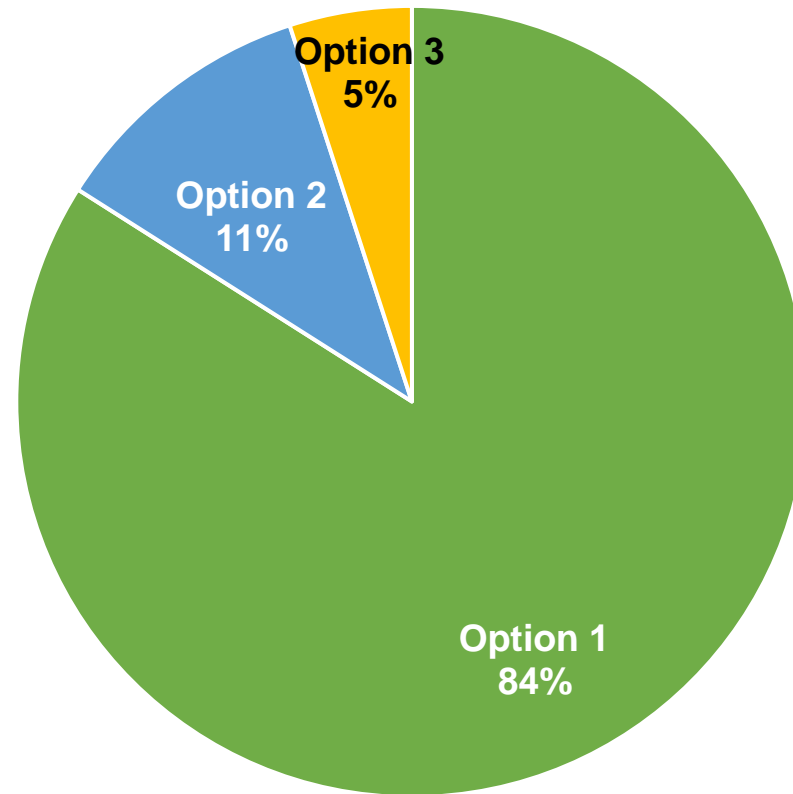
Option	Votes
Option 1	8
Option 2	88
Abstain	10

## 4. mCRPC

### 4.2. mCRPC no somatic genetic profiling done

107. For the majority of patients with mCRPC with somatic genetic testing not available what is your treatment recommendation in the first-line setting when they received ADT ( $\pm$  docetaxel) for mHSPC?

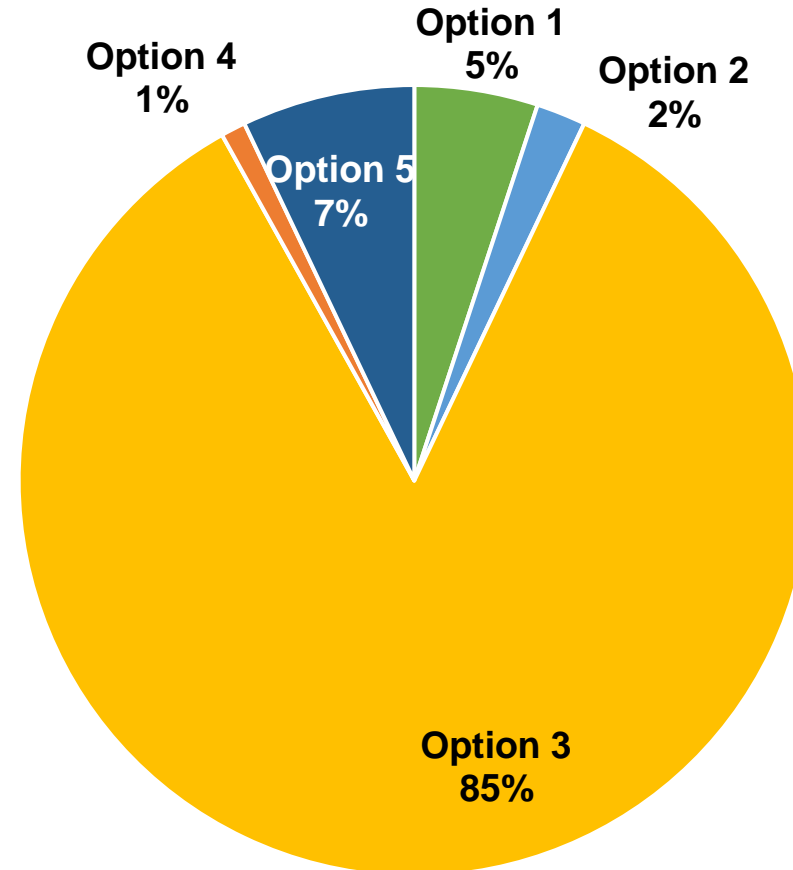
1. ARPI
2. ARPI plus PARP inhibitor
3. Other option e.g. taxane or <sup>177</sup>Lu-PSMA according to appropriate treatment criteria
4. Abstain/unqualified to answer



Option	Votes
Option 1	84
Option 2	11
Option 3	5
Abstain	6

108. For the majority of patients with mCRPC and somatic genetic testing not available what is your treatment recommendation in the first-line setting when they received ADT+ARPI for mHSPC?

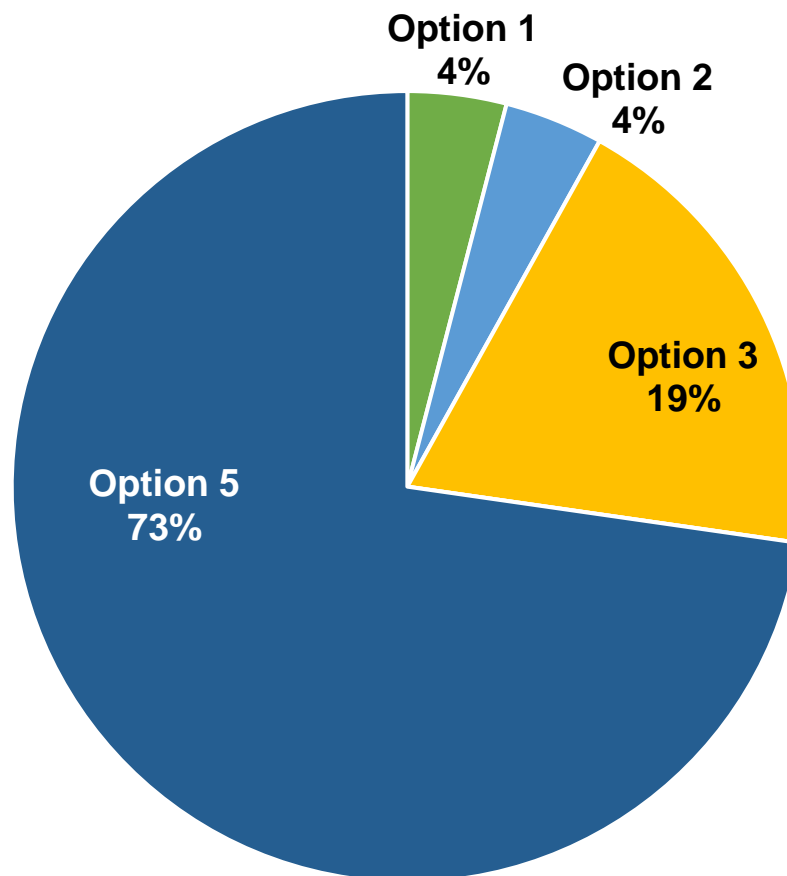
1. Alternate ARPI
2. Add PARP inhibitor to current therapy or change to alternate ARPI plus PARP inhibitor
- 3. Docetaxel**
4. Radium-223
5. <sup>177</sup>Lu-PSMA
6. Abstain/unqualified to answer



Option	Votes
Option 1	5
Option 2	2
Option 3	84
Option 4	1
Option 5	7
Abstain	7

109. For the majority of patients with mCRPC and somatic genetic testing not available, what is your treatment recommendation in the first-line setting when they received ADT + ARPI and docetaxel for mHSPC?

1. Alternate ARPI
2. Add PARP inhibitor to current therapy or change to alternate ARPI plus PARP inhibitor
3. Taxane
4. Radium-223
5. <sup>177</sup>Lu-PSMA
6. Abstain/unqualified to answer



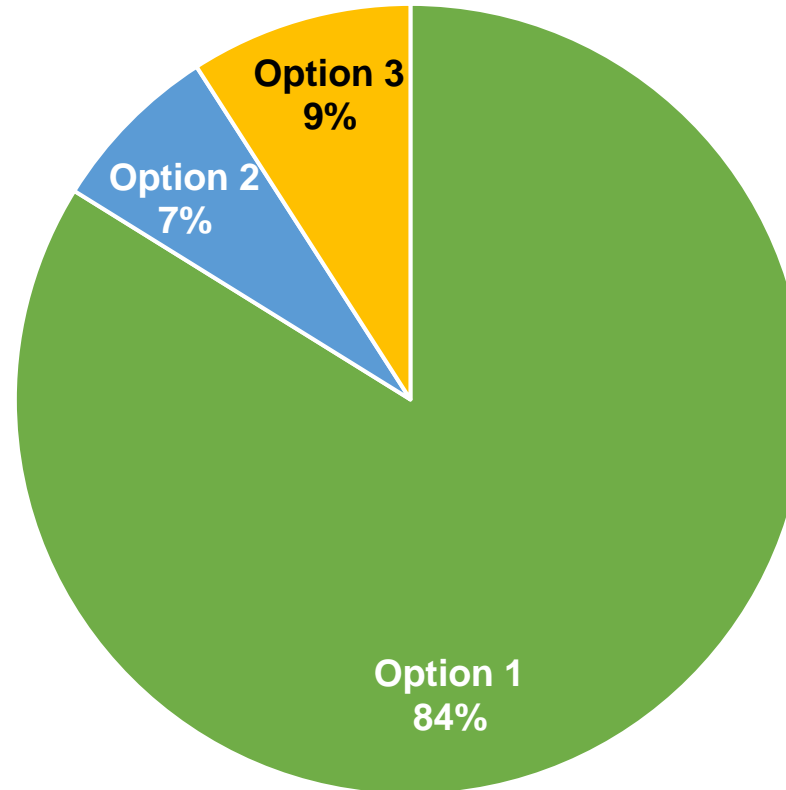
Option	Votes
Option 1	4
Option 2	4
Option 3	19
Option 4	0
Option 5	72
Abstain	7

## 4. mCRPC

### 4.3. mCRPC tumour genetic profiling: Tested and no DDR alterations identified

110. For the majority of patients with mCRPC who have been tested and no DDR alteration was identified what is your treatment recommendation in the first-line setting when they received ADT ( $\pm$  docetaxel) for mHSPC?

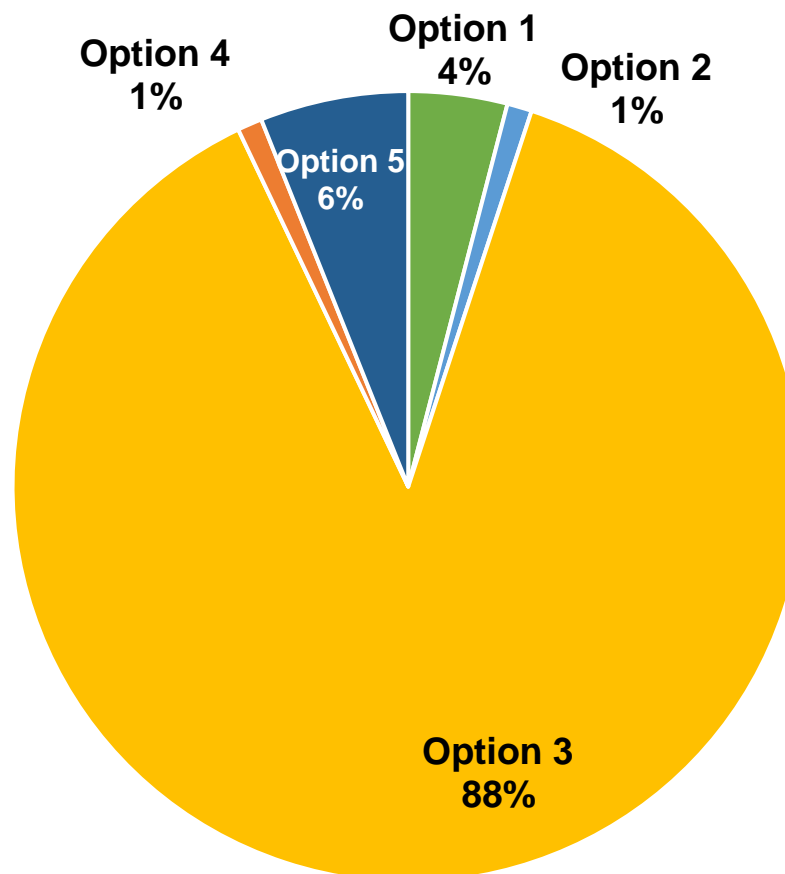
1. ARPI
2. ARPI plus PARP inhibitor
3. Other option e.g. taxane or  $^{177}\text{Lu}$ -PSMA therapy according to appropriate treatment criteria
4. Abstain/unqualified to answer



Option	Votes
Option 1	83
Option 2	7
Option 3	9
Abstain	7

111. For the majority of patients with mCRPC who have been tested and no DDR alteration was identified what is your treatment recommendation in the first-line setting when they received ADT+ ARPI for mHSPC?

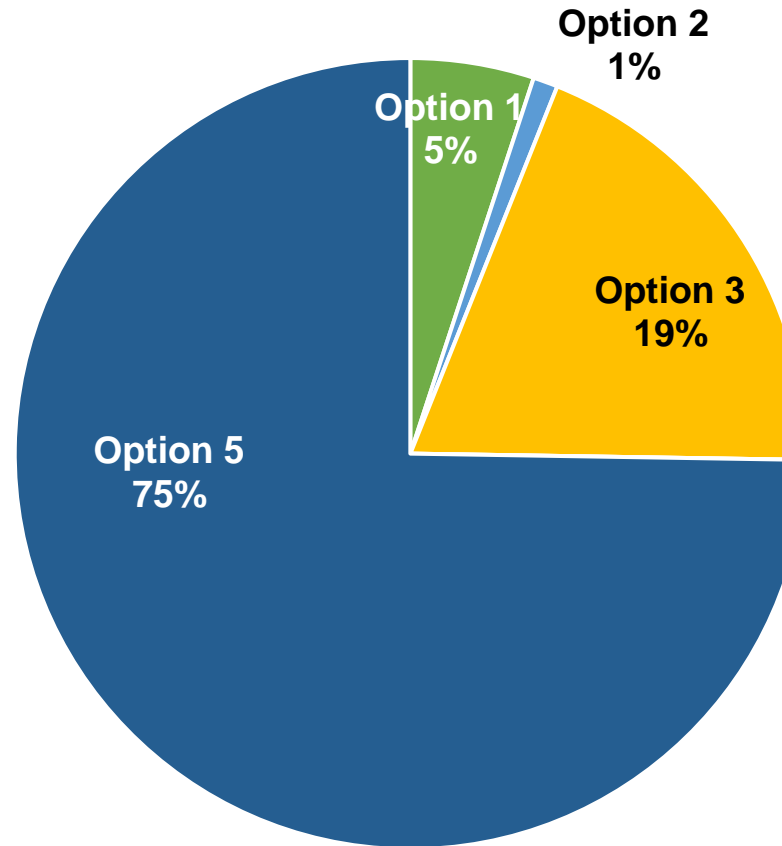
1. Alternate ARPI
2. Add PARP inhibitor to current therapy or change to alternate ARPI plus PARP inhibitor
3. **Docetaxel**
4. Radium-223
5. <sup>177</sup>Lu-PSMA
6. Abstain/unqualified to answer



Option	Votes
Option 1	4
Option 2	1
Option 3	87
Option 4	1
Option 5	6
Abstain	7

112. For the majority of patients with mCRPC who have been tested and no DDR alteration was identified what is your treatment recommendation in the first-line setting when they received ADT+ ARPI + docetaxel for mHSPC?

1. Alternate ARPI
2. Add PARP inhibitor to current therapy or change to alternate ARPI plus PARP inhibitor
3. Taxane
4. Radium-223
5. **<sup>177</sup>Lu-PSMA**
6. Abstain/unqualified to answer



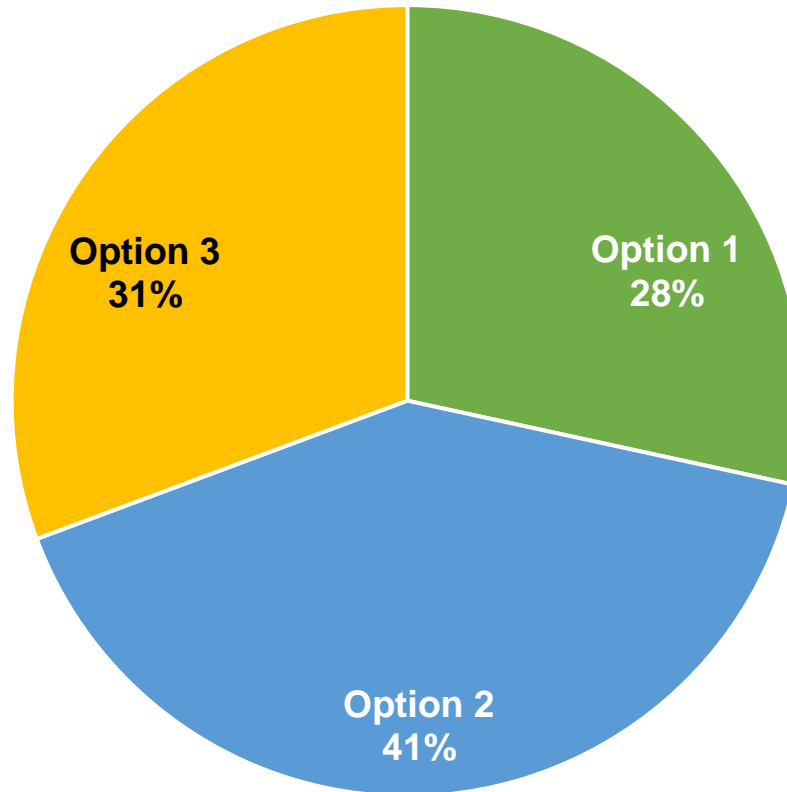
Option	Votes
Option 1	5
Option 2	1
Option 3	19
Option 4	0
Option 5	74
Abstain	7

## 4. mCRPC

4.4. mCRPC tumour genetic profiling: DDR alteration (NOT BRCA2) detected as only HRR

113. In the majority of patients with mCRPC and a pathogenic **ATM alteration**, do you recommend treatment with a PARP inhibitor (monotherapy or combination with ARPI depending on where the patient is in the course of the disease)?

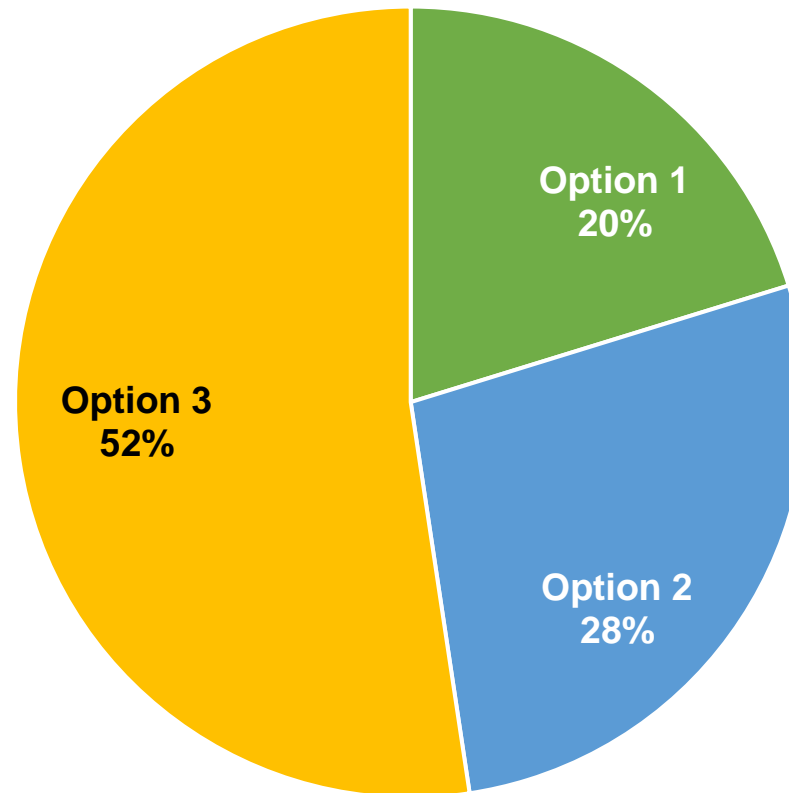
1. Yes, in the same indication as for patients with BRCA2 alteration
2. Yes, but at a later stage of the disease compared to patients with BRCA2 alteration
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	25
Option 2	36
Option 3	27
Abstain	18

114. In the majority of patients with mCRPC and a pathogenic ATR alteration, do you recommend treatment with a PARP inhibitor (monotherapy or combination with ARPI depending on where the patient is in the course of the disease)?

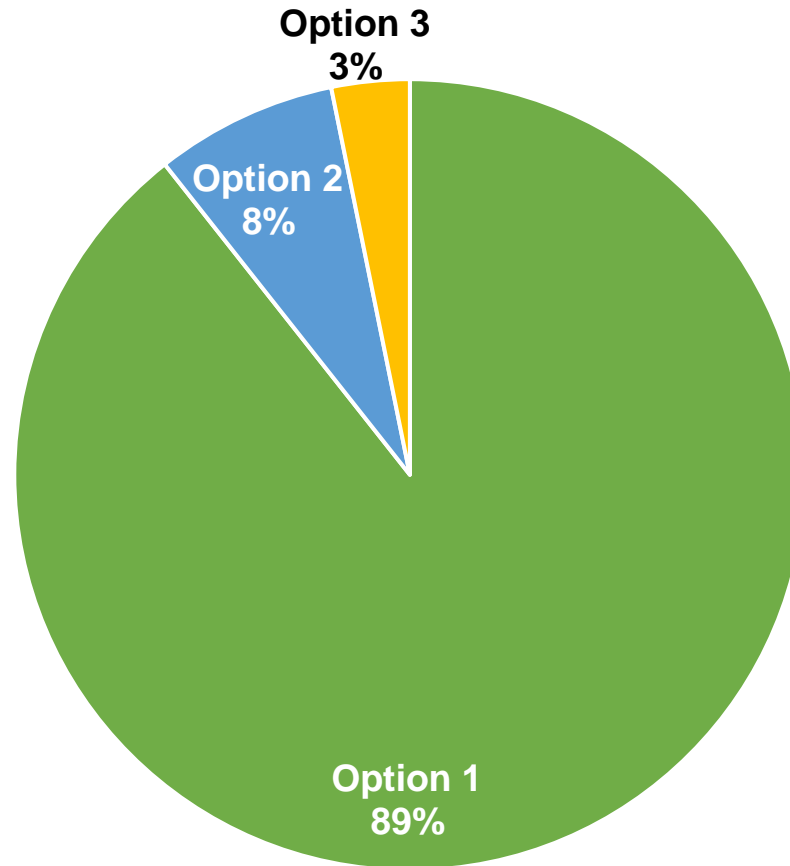
1. Yes, in the same indication as for patients with BRCA2 alteration
2. Yes, but at a later stage of the disease compared to patients with BRCA2 alteration
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	17
Option 2	23
Option 3	44
Abstain	22

115. In the majority of patients with mCRPC and a pathogenic **BRCA1 alteration**, do you recommend treatment with a PARP inhibitor (monotherapy or combination with ARPI depending on where the patient is in the course of the disease)?

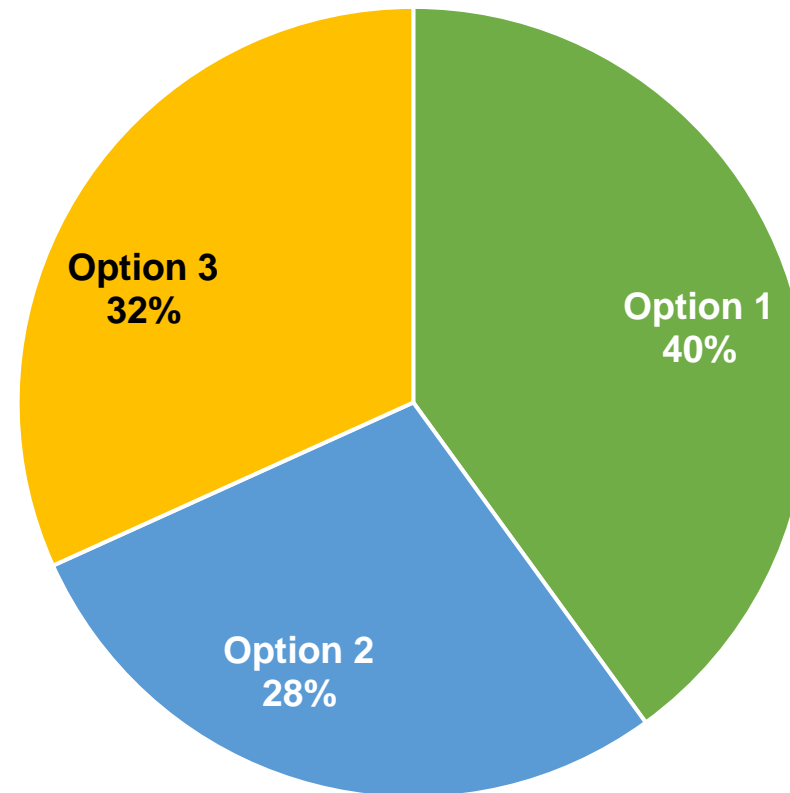
1. **Yes, in the same indication as for patients with BRCA2 alteration**
2. Yes, but at a later stage of the disease compared to patients with BRCA2 alteration
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	84
Option 2	7
Option 3	3
Abstain	12

116. In the majority of patients with mCRPC and a pathogenic **FANCA alteration**, do you recommend treatment with a PARP inhibitor (monotherapy or combination with ARPI depending on where the patient is in the course of the disease)?

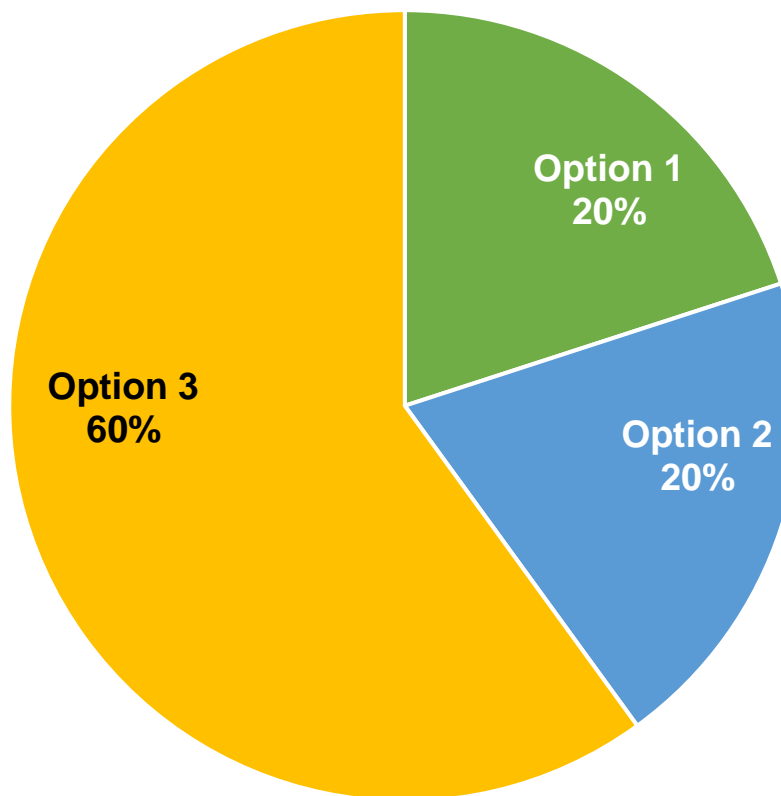
1. Yes, in the same indication as for patients with BRCA2 alteration
2. Yes, but at a later stage of the disease compared to patients with BRCA2 alteration
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	34
Option 2	24
Option 3	27
Abstain	21

117. In the majority of patients with mCRPC and a pathogenic **MLH1 alteration**, do you recommend treatment with a PARP inhibitor (monotherapy or combination with ARPI depending on where the patient is in the course of the disease)?

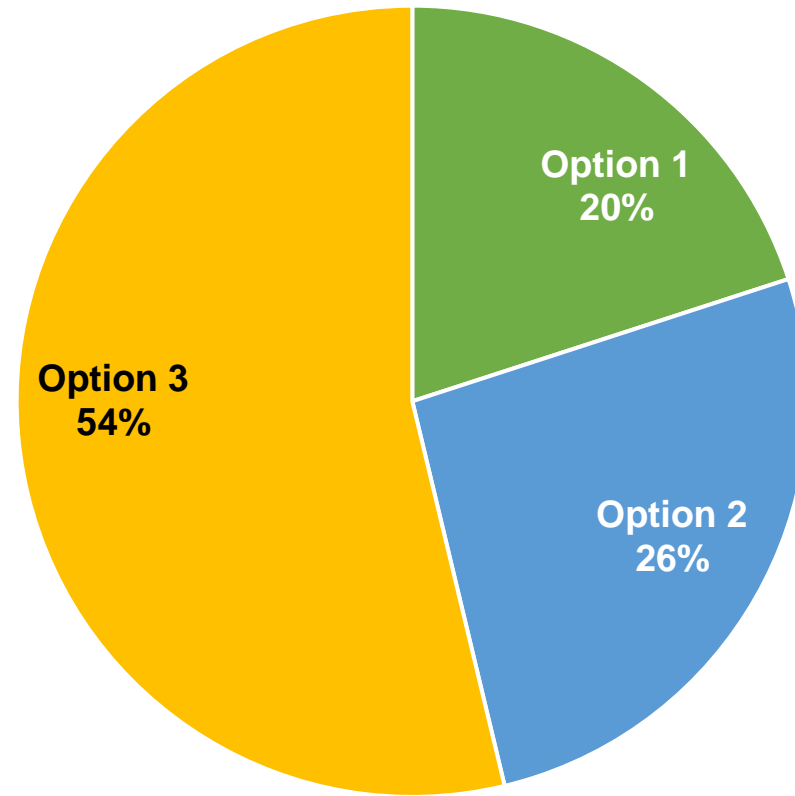
1. Yes, in the same indication as for patients with BRCA2 alteration
2. Yes, but at a later stage of the disease compared to patients with BRCA2 alteration
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	17
Option 2	17
Option 3	51
Abstain	21

118. In the majority of patients with mCRPC and a pathogenic **MRE11A alteration**, do you recommend treatment with a PARP inhibitor (monotherapy or combination with ARPI depending on where the patient is in the course of the disease)?

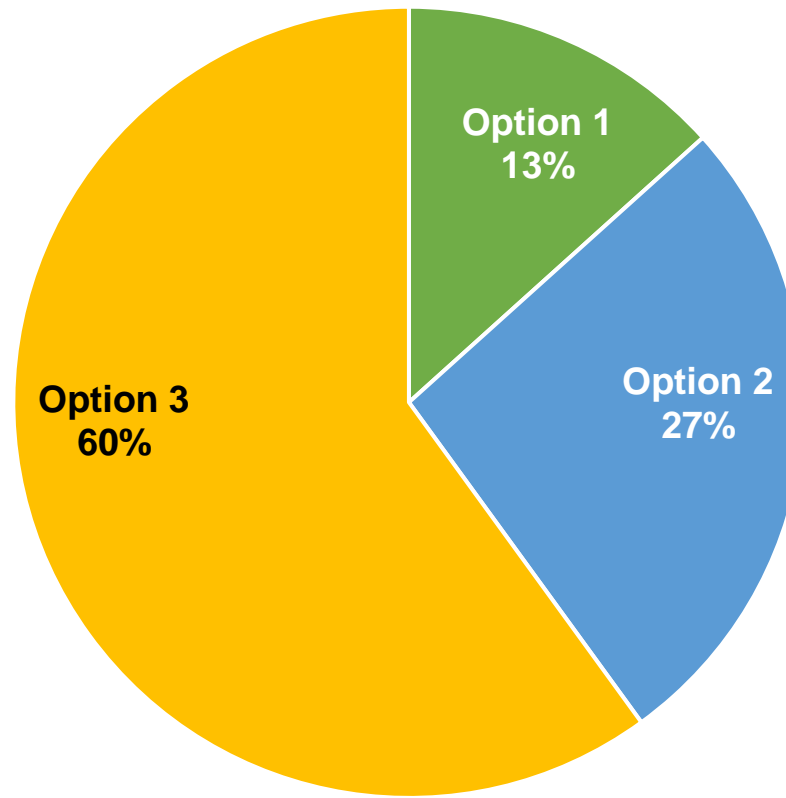
1. Yes, in the same indication as for patients with BRCA2 alteration
2. Yes, but at a later stage of the disease compared to patients with BRCA2 alteration
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	16
Option 2	21
Option 3	43
Abstain	26

119. In the majority of patients with mCRPC and a pathogenic **NBN alteration**, do you recommend treatment with a PARP inhibitor (monotherapy or combination with ARPI depending on where the patient is in the course of the disease)?

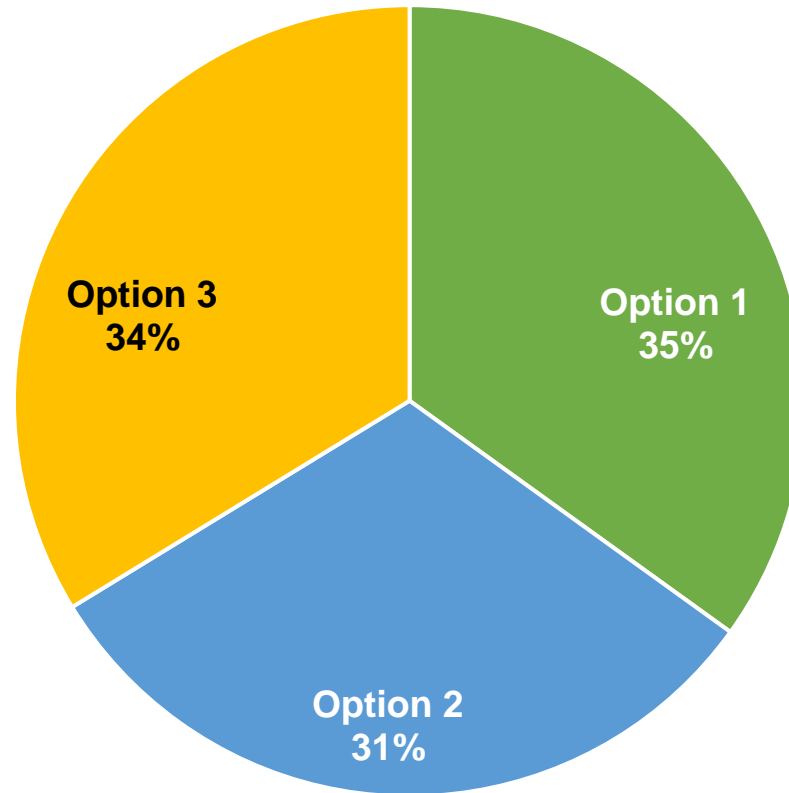
1. Yes, in the same indication as for patients with BRCA2 alteration
2. Yes, but at a later stage of the disease compared to patients with BRCA2 alteration
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	10
Option 2	20
Option 3	45
Abstain	31

120. In the majority of patients with mCRPC and a pathogenic **RAD51C alteration**, do you recommend treatment with a PARP inhibitor (monotherapy or combination with ARPI depending on where the patient is in the course of the disease)?

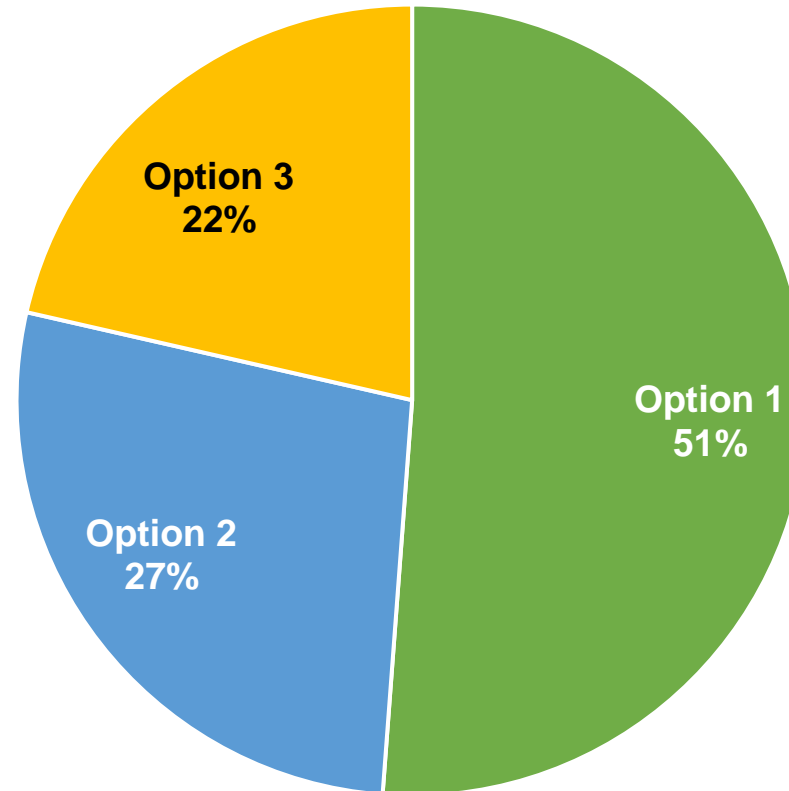
1. Yes, in the same indication as for patients with BRCA2 alteration
2. Yes, but at a later stage of the disease compared to patients with BRCA2 alteration
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	29
Option 2	26
Option 3	28
Abstain	23

121. In the majority of patients with mCRPC and a pathogenic **PALB2 alteration**, do you recommend treatment with a PARP inhibitor (monotherapy or combination with ARPI depending on where the patient is in the course of the disease)?

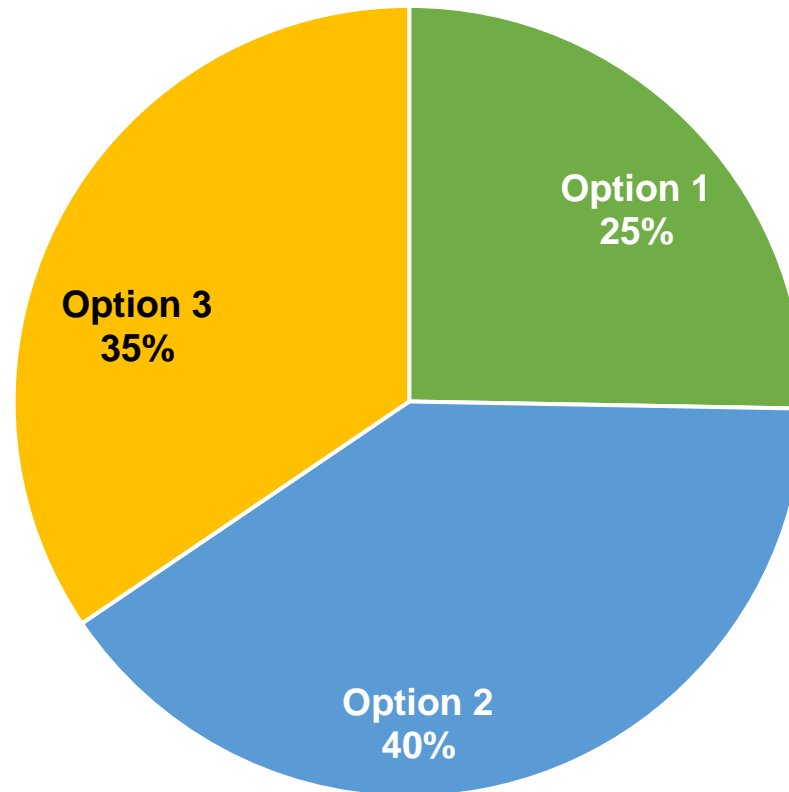
1. Yes, in the same indication as for patients with BRCA2 alteration
2. Yes, but at a later stage of the disease compared to patients with BRCA2 alteration
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	43
Option 2	23
Option 3	18
Abstain	22

122. In the majority of patients with mCRPC and an inactivating CDK12 alteration, do you recommend treatment with a PARP inhibitor (monotherapy or combination with ARPI depending on where the patient is in the course of the disease)?

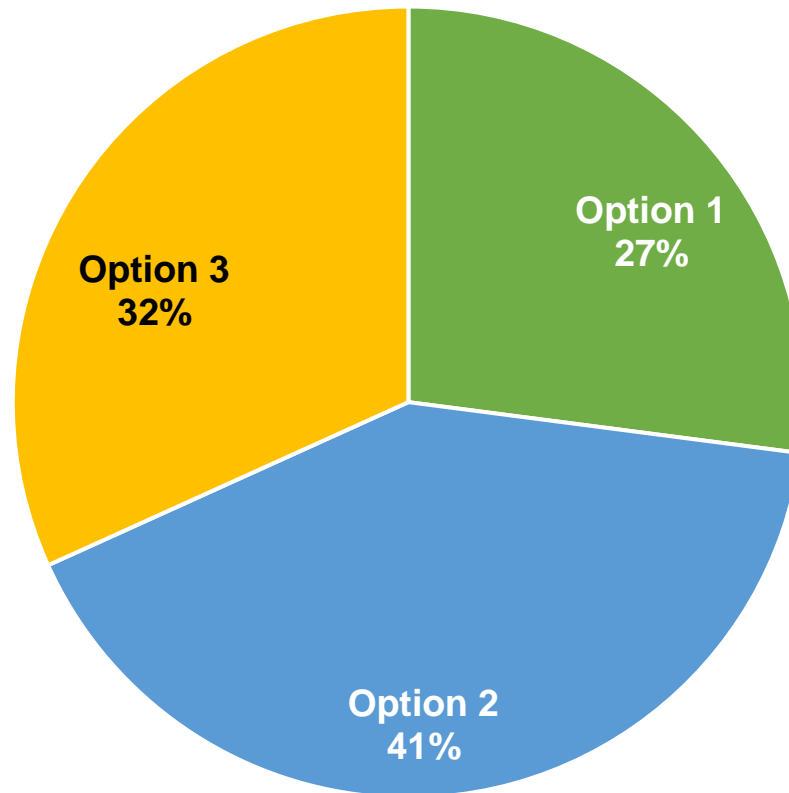
1. Yes, in the same indication as for patients with BRCA2 alteration
2. Yes, but at a later stage of the disease compared to patients with BRCA2 alteration
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	22
Option 2	35
Option 3	30
Abstain	19

123. In the majority of patients with mCRPC and a pathogenic **CHEK2 alteration**, do you recommend treatment with a PARP inhibitor (monotherapy or combination with ARPI depending on where the patient is in the course of the disease)?

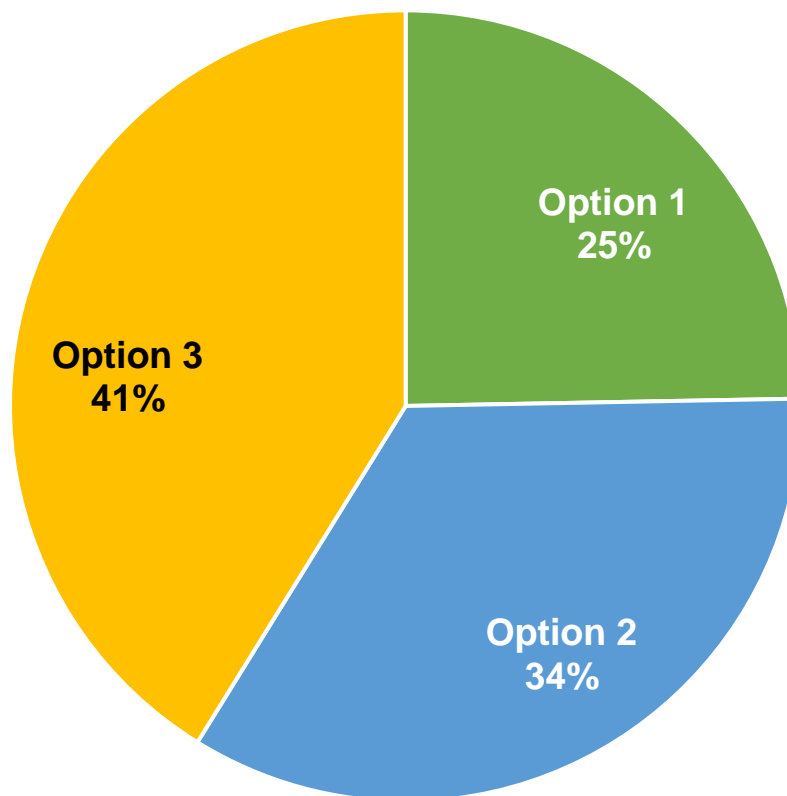
1. Yes, in the same indication as for patients with BRCA2 alteration
2. Yes, but at a later stage of the disease compared to patients with BRCA2 alteration
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	23
Option 2	35
Option 3	27
Abstain	21

124. In patients with mCRPC progressing on or after an ARPI and with an inactivating CDK12 alteration, do you recommend treatment with a checkpoint inhibitor in preference to a standard mCRPC option?

1. Yes
2. Yes, but only if also TMB-high
3. No
4. Abstain/unqualified to answer



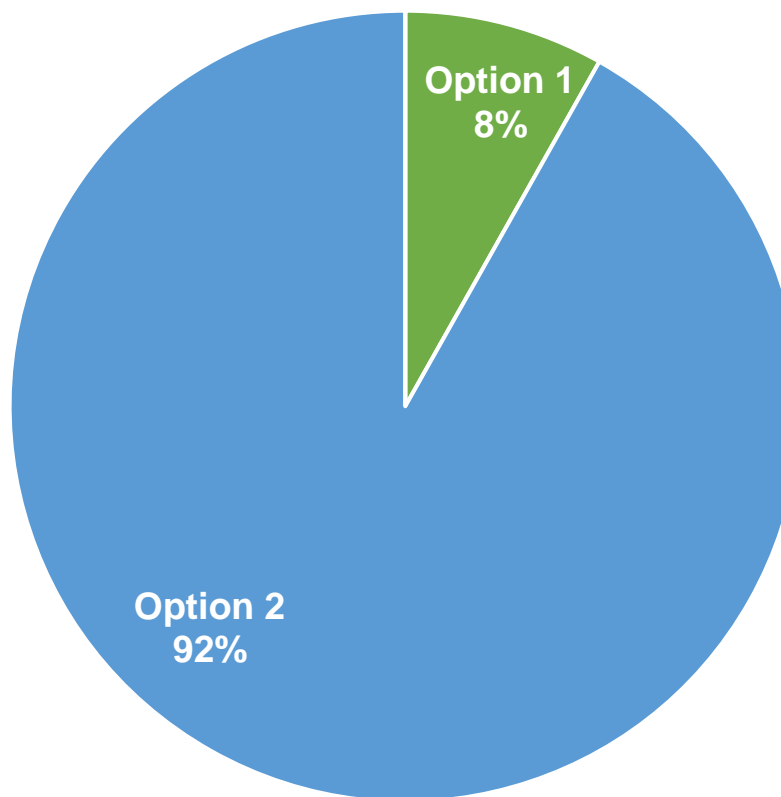
Option	Votes
Option 1	21
Option 2	29
Option 3	35
Abstain	21

## 4. mCRPC

### 4.5. mCRPC tumour genetic profiling with evidence of BRCA2 alteration

125. For the majority of patients with mCRPC with a pathogenic alteration in **BRCA2** what is your treatment recommendation in the first-line mCRPC setting when they received ADT ( $\pm$  docetaxel) for mHSPC?

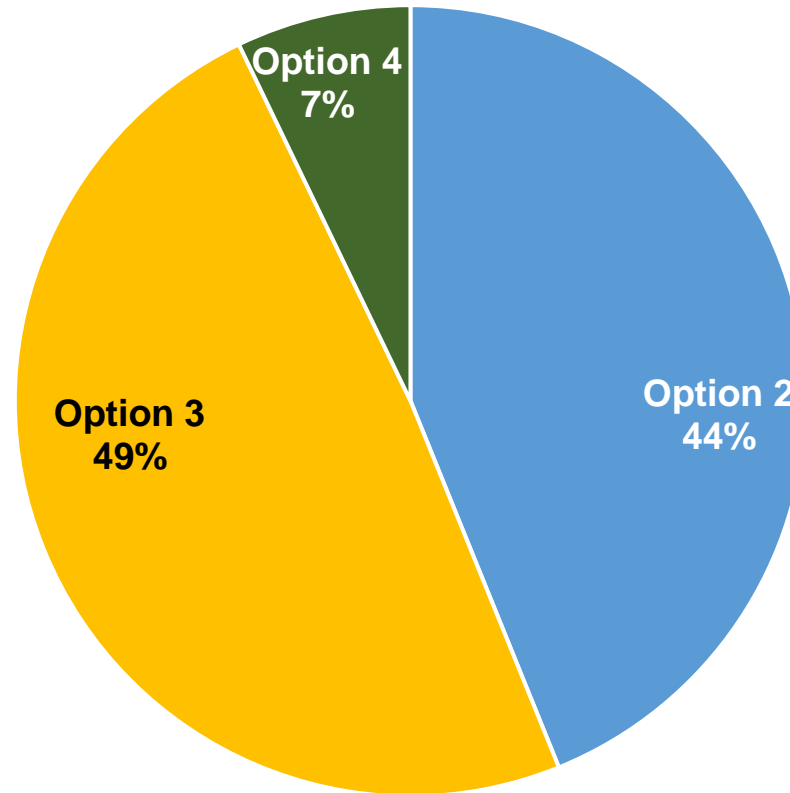
1. ARPI
2. **ARPI plus PARP inhibitor**
3. Other option e.g. taxane or  $^{177}\text{Lu}$ -PSMA therapy according to appropriate treatment criteria
4. Abstain/unqualified to answer



Option	Votes
Option 1	8
Option 2	90
Option 3	0
Abstain	8

126. For the majority of patients with mCRPC with a pathogenic alteration in BRCA2 what is your treatment recommendation in the first-line mCRPC setting when they received ADT+ ARPI for mHSPC?

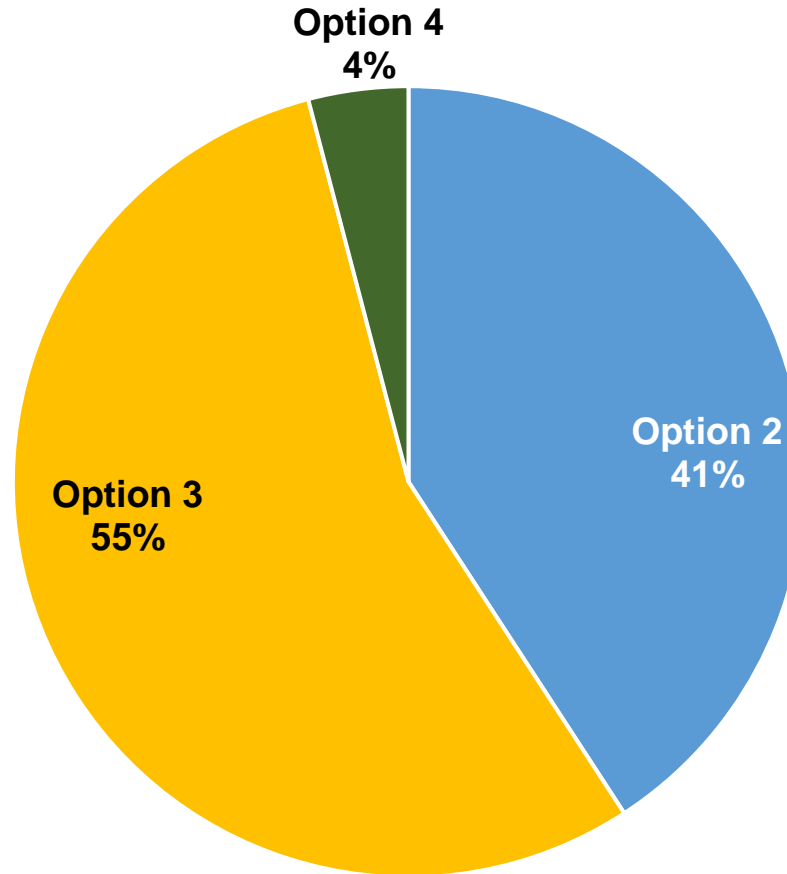
1. Alternate ARPI
2. Add PARP inhibitor to current therapy or change to alternate ARPI plus PARP inhibitor
3. PARP inhibitor monotherapy
4. Other treatment options including: docetaxel, radium-223 or <sup>177</sup>Lu-PSMA therapy
5. Abstain/unqualified to answer



Option	Votes
Option 1	0
Option 2	43
Option 3	48
Option 4	7
Abstain	8

127. For the majority of patients with mCRPC with a pathogenic alteration in BRCA2 what is your treatment recommendation in the first-line mCRPC setting when they received ADT+ ARPI + docetaxel for mHSPC?

1. Alternate ARPI
2. Add PARP inhibitor to current therapy or change to alternate ARPI plus PARP inhibitor
3. PARP inhibitor monotherapy
4. Other treatment options including: taxane, radium-223 or <sup>177</sup>Lu-PSMA therapy
5. Abstain/unqualified to answer

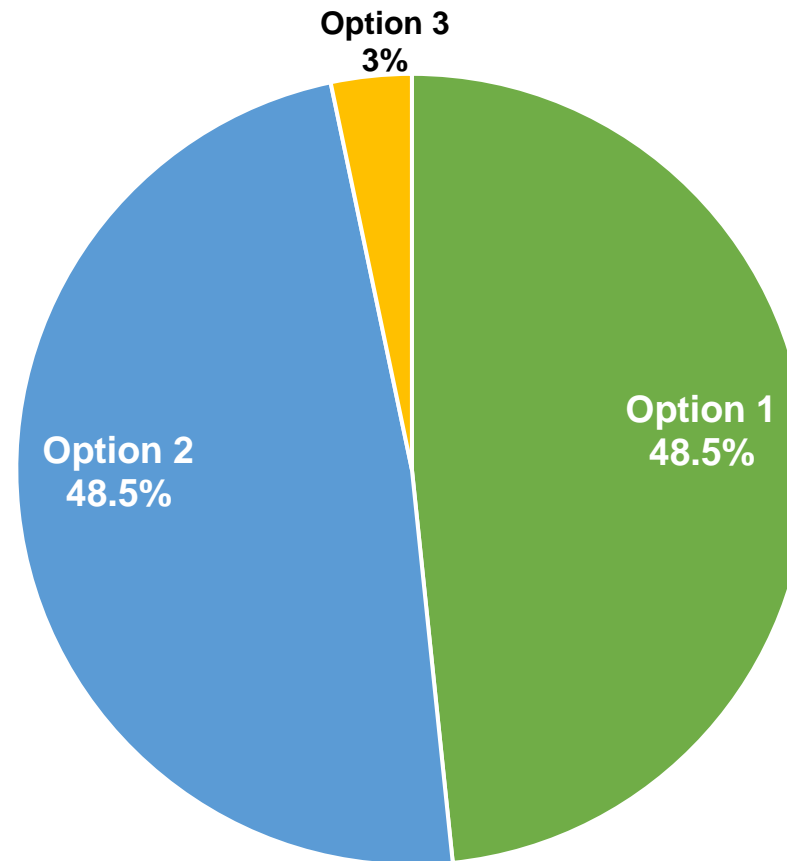


Option	Votes
Option 1	0
Option 2	40
Option 3	54
Option 4	4
Abstain	8

128. Question deleted

129. In patients with a confirmed pathogenic BRCA2 alteration (germline/somatic or somatic alone) and in the case where you do not have access to a PARP inhibitor, do you recommend treatment with a platinum-based therapy instead (monotherapy or combination)?

1. Yes, before a taxane chemotherapy
2. Yes, but only after a taxane chemotherapy
3. No
4. Abstain/unqualified to answer



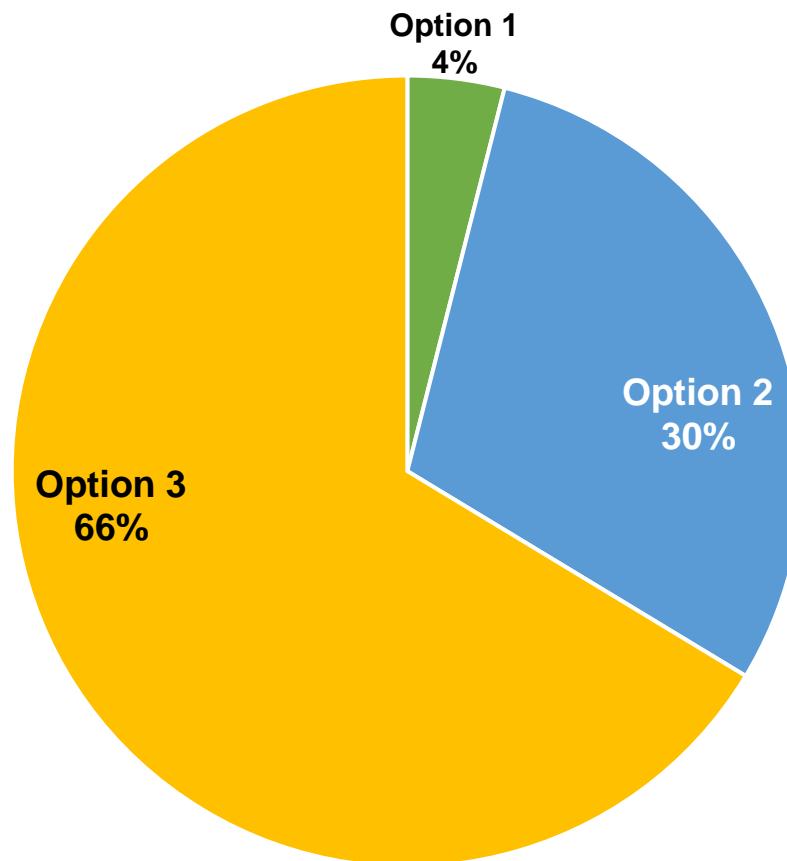
Option	Votes
Option 1	44
Option 2	44
Option 3	3
Abstain	15

## 4. mCRPC

### 4.6. ARPI switch

# 130. Do you recommend a direct switch to abiraterone in patients whose cancer is progressing on an AR antagonist (Apa/Daro/Enza)?

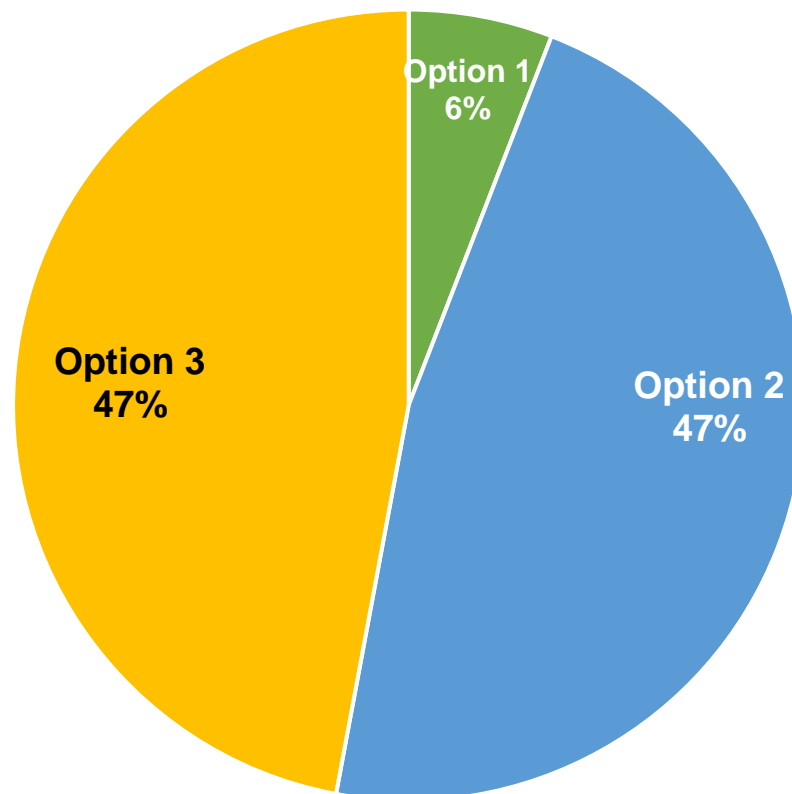
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	4
Option 2	30
Option 3	67
Abstain	5

# 131. Do you recommend a direct switch to an AR antagonist (Apa/Daro/Enza) in patients whose cancer is progressing on abiraterone?

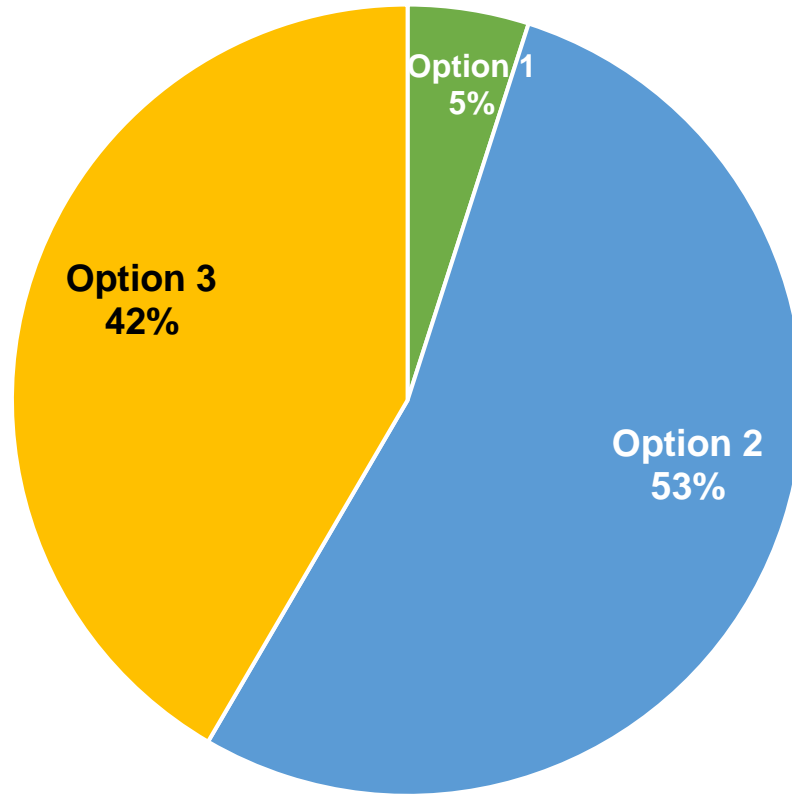
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	6
Option 2	48
Option 3	48
Abstain	4

## 132. Do you recommend an alternate ARPI as monotherapy anytime in the treatment sequence in patients who have received a prior ARPI treatment?

1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



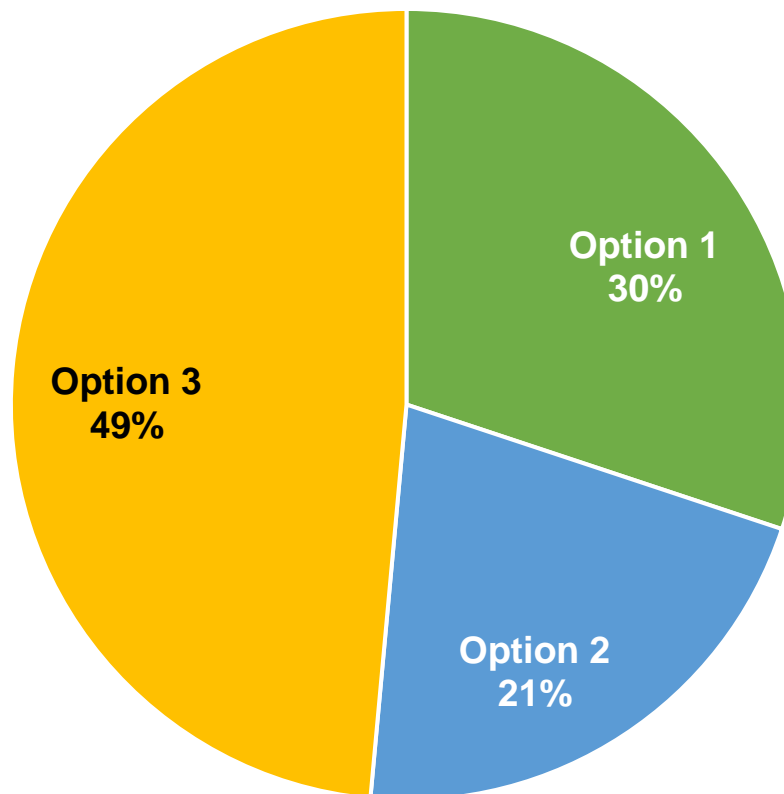
Option	Votes
Option 1	5
Option 2	54
Option 3	42
Abstain	5

## 4. mCRPC

### 4.7. Radiation therapy in mCRPC

133. For the majority of patients with multiple metastases and only oligoprogressive mCRPC (max. 3 progressing lesions) what do you recommend?

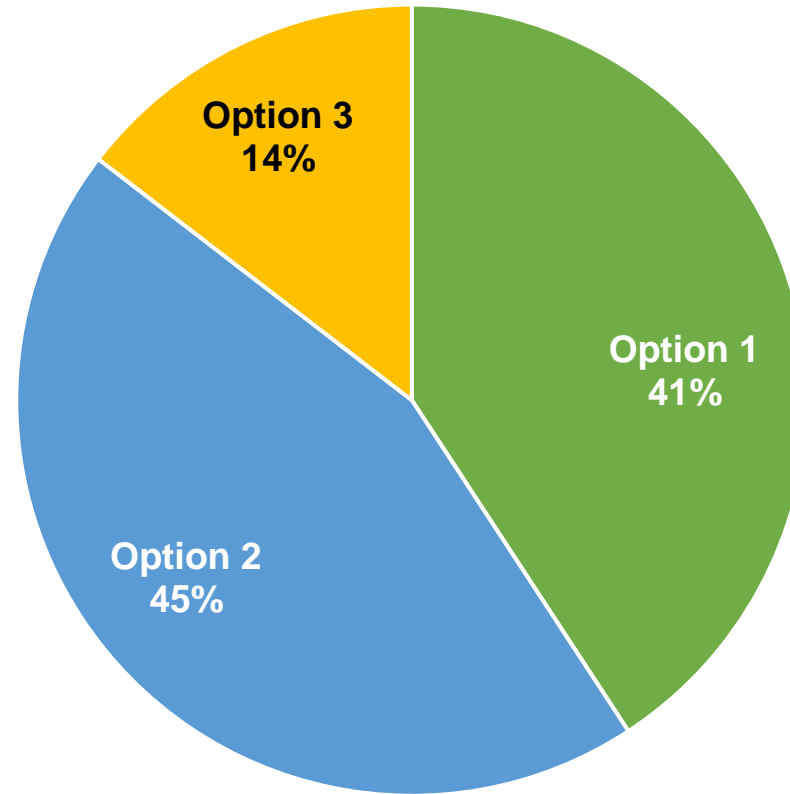
1. Switch systemic therapy
2. Switch to another systemic therapy **and** perform MDT of all progressing lesions
3. Do not change systemic therapy; perform MDT of all progressing lesions
4. Abstain/unqualified to answer



Option	Votes
Option 1	31
Option 2	22
Option 3	50
Abstain	3

134. For the majority of patients with oligometastatic first-line mCRPC (max. 3-5 lesions) what do you recommend?

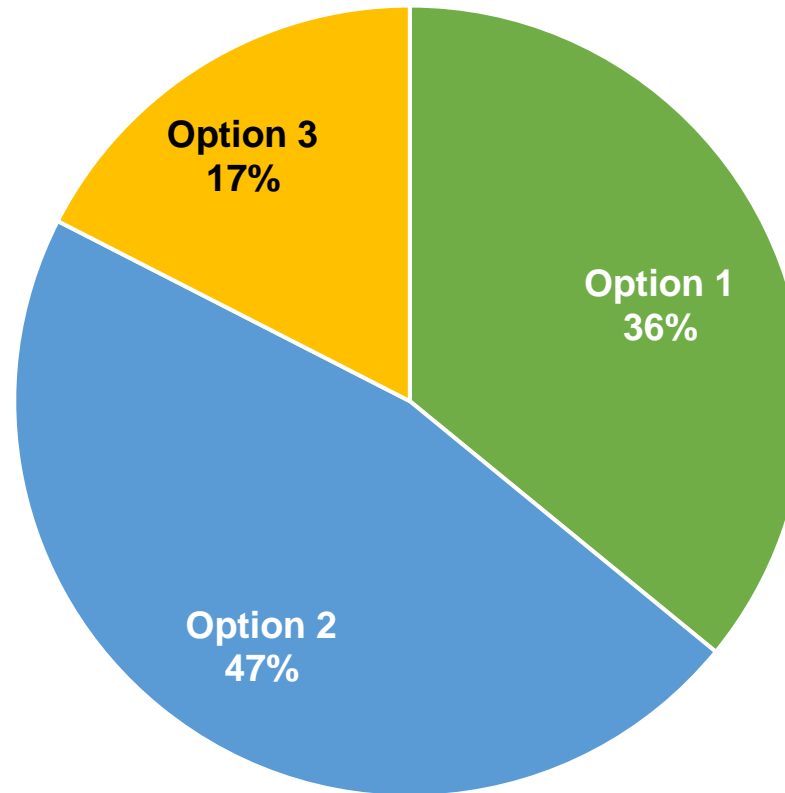
1. Add/switch systemic therapy
2. Add/switch systemic therapy **and** perform MDT of all lesions
3. Perform MDT of all lesions alone
4. Abstain/unqualified to answer



Option	Votes
Option 1	42
Option 2	46
Option 3	15
Abstain	3

135. For the majority of asymptomatic patients with mCRPC with progressing high-risk bone lesions do you recommend prophylactic radiation therapy to reduce the risk of SRE?

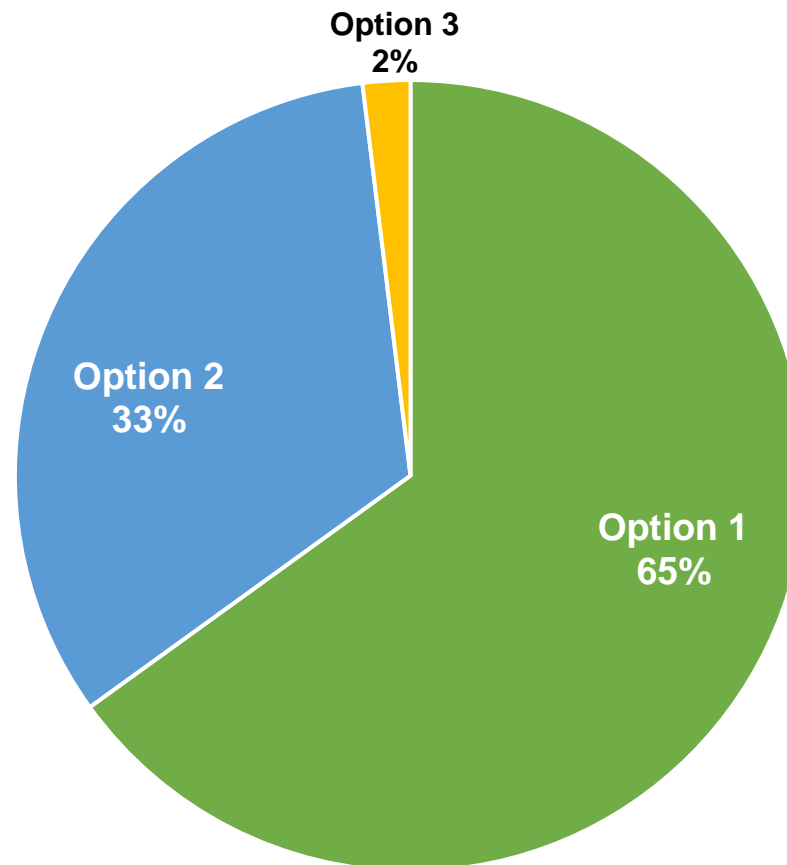
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	37
Option 2	48
Option 3	18
Abstain	3

136. For the majority of asymptomatic patients with mCRPC with disease progression in the spine with epidural soft tissue component do you recommend prophylactic radiation therapy to reduce the risk of symptomatic spinal cord compression?

1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



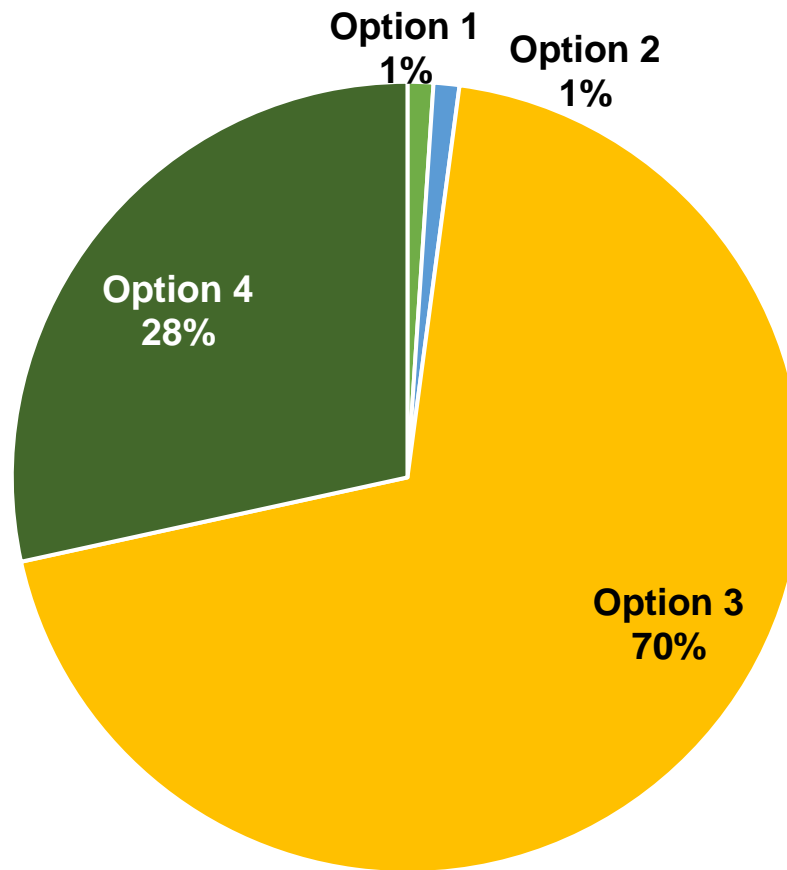
Option	Votes
Option 1	67
Option 2	34
Option 3	2
Abstain	3

## 5. Lutetium-177-PSMA Therapy

### 5.1. Sequencing of $^{177}\text{Lu}$ -PSMA therapy

137. For the majority of chemotherapy fit asymptomatic patients with PSMA imaging-positive mCRPC who meet PET criteria for <sup>177</sup>Lu-PSMA therapy and have received one line of ARPI and no chemotherapy, what is your preferred treatment option assuming treatments are readily available and there is no actionable molecular alteration?

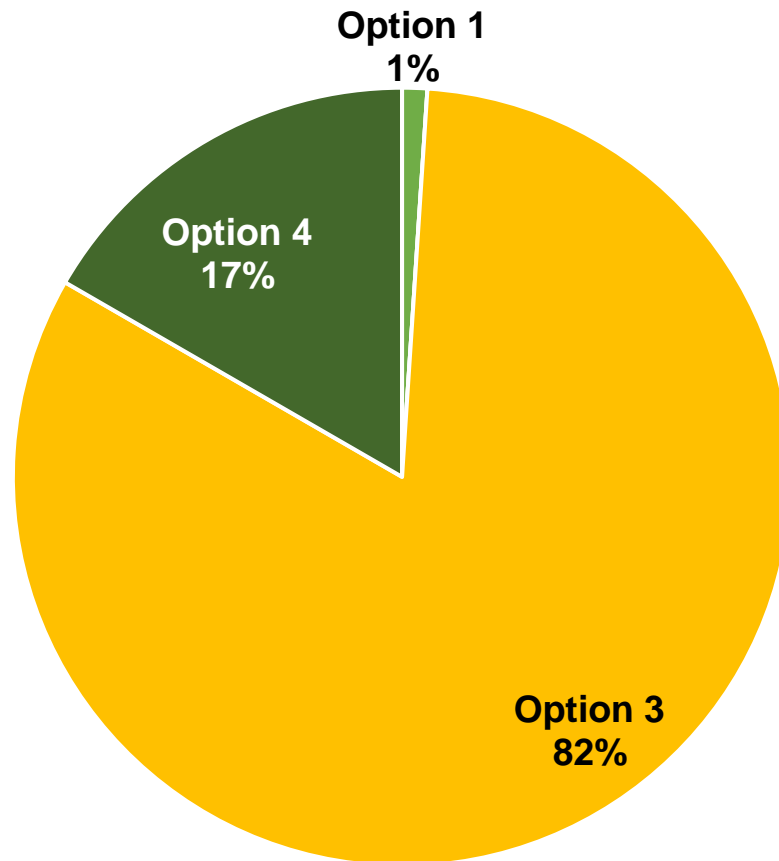
1. Alternate ARPI
2. ARPI + PARPi
3. Docetaxel
4. <sup>177</sup>Lu-PSMA
5. Abstain/unqualified to answer



Option	Votes
Option 1	1
Option 2	1
Option 3	66
Option 4	27
Abstain	11

138. For the majority of chemotherapy fit symptomatic patients with PSMA imaging-positive mCRPC who meet relevant PET criteria for <sup>177</sup>Lu-PSMA therapy, who have received one line of ARPI and no chemotherapy, what is your preferred treatment option assuming treatments are readily available and there is no actionable molecular alteration?

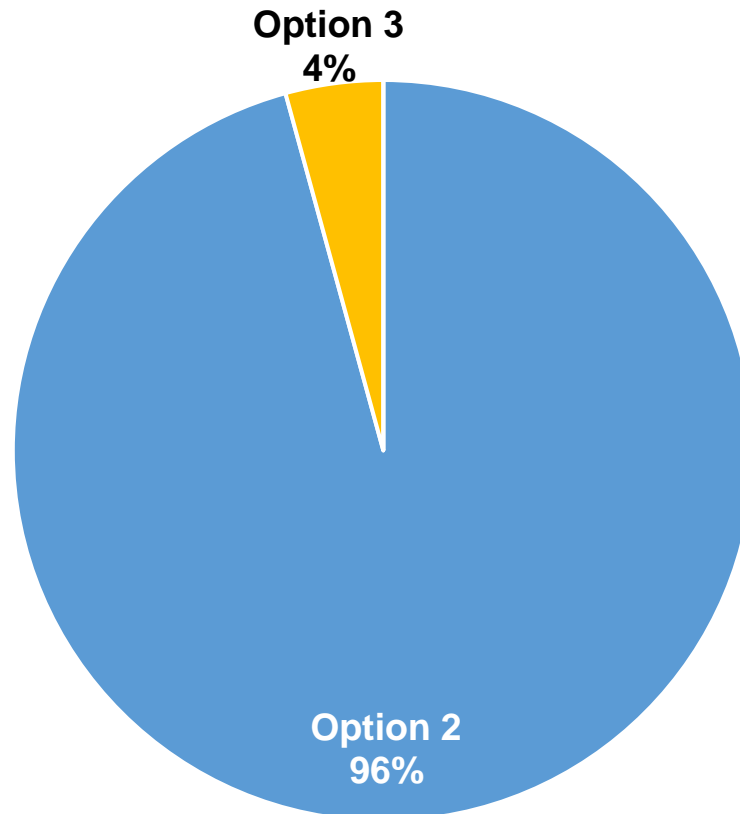
1. Alternate ARPI
2. ARPI + PARPi
- 3. Docetaxel**
4. <sup>177</sup>Lu-PSMA
5. Radium-223
6. Abstain/unqualified to answer



Option	Votes
Option 1	1
Option 2	0
Option 3	79
Option 4	16
Option 5	0
Abstain	10

139. For the majority of chemotherapy fit patients with PSMA imaging-positive mCRPC who meet relevant PET criteria for <sup>177</sup>Lu-PSMA therapy, who have received one line of ARPI and one line of taxane-based chemotherapy, what is your preferred treatment option assuming treatments are readily available and there is no actionable molecular alteration?

1. Alternate ARPI
- 2. <sup>177</sup>Lu-PSMA**
3. Cabazitaxel
4. Radium-223
5. Abstain/unqualified to answer



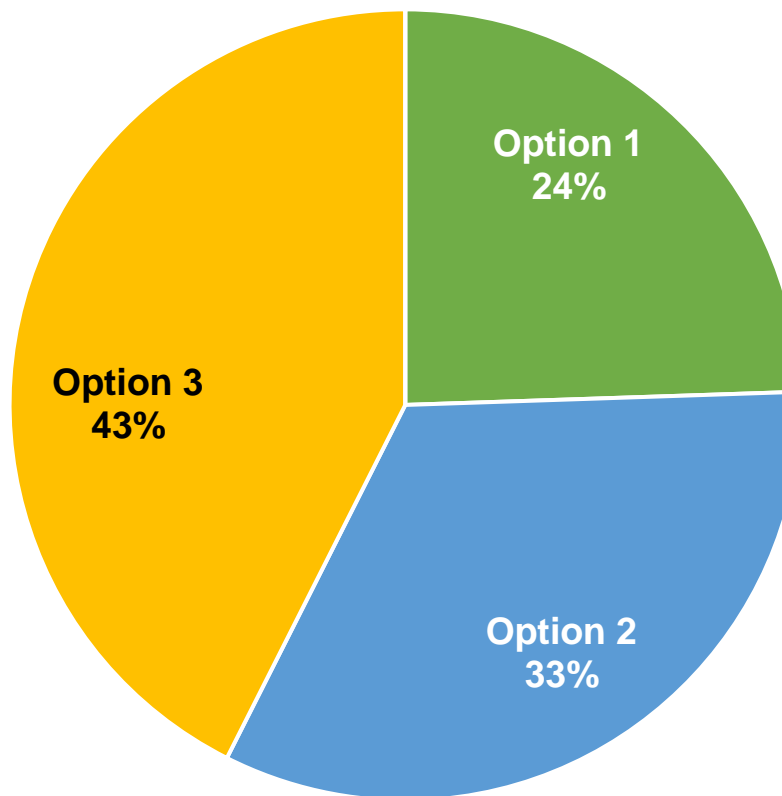
Option	Votes
Option 1	0
Option 2	90
Option 3	4
Option 4	0
Abstain	12

## 5. Lutetium-177-PSMA Therapy

### 5.2. Patient selection and monitoring

140. In the majority of patients that you evaluate for <sup>177</sup>Lu-PSMA therapy eligibility, what imaging do you routinely recommend assuming all scans are readily available?

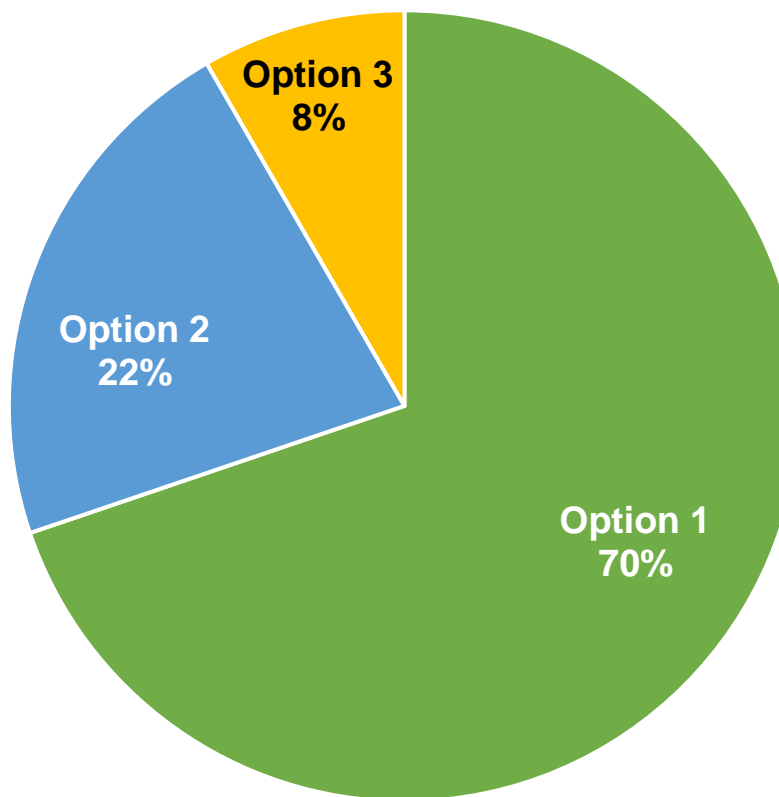
1. PSMA PET plus FDG PET (like in the TheraP study)
2. PSMA PET and bone scintigraphy (like in the VISION study)
3. PSMA PET and add FDG PET selectively for equivocal cases
4. No PSMA PET imaging needed
5. Abstain/unqualified to answer



Option	Votes
Option 1	23
Option 2	31
Option 3	40
Option 4	0
Abstain	12

141. In the majority of patients on treatment with  $^{177}\text{Lu}$ -PSMA do you recommend imaging for response monitoring during  $^{177}\text{Lu}$ -PSMA treatment in the absence of clinical progression?

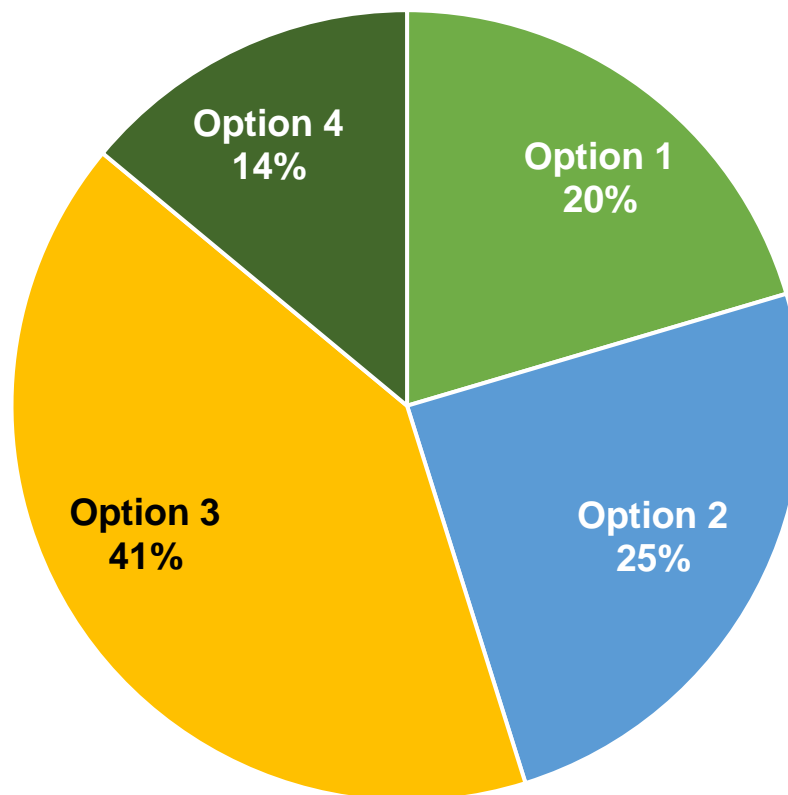
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	67
Option 2	21
Option 3	8
Abstain	10

142. In the majority of patients on treatment with <sup>177</sup>Lu-PSMA which imaging modality do you recommend for response monitoring?

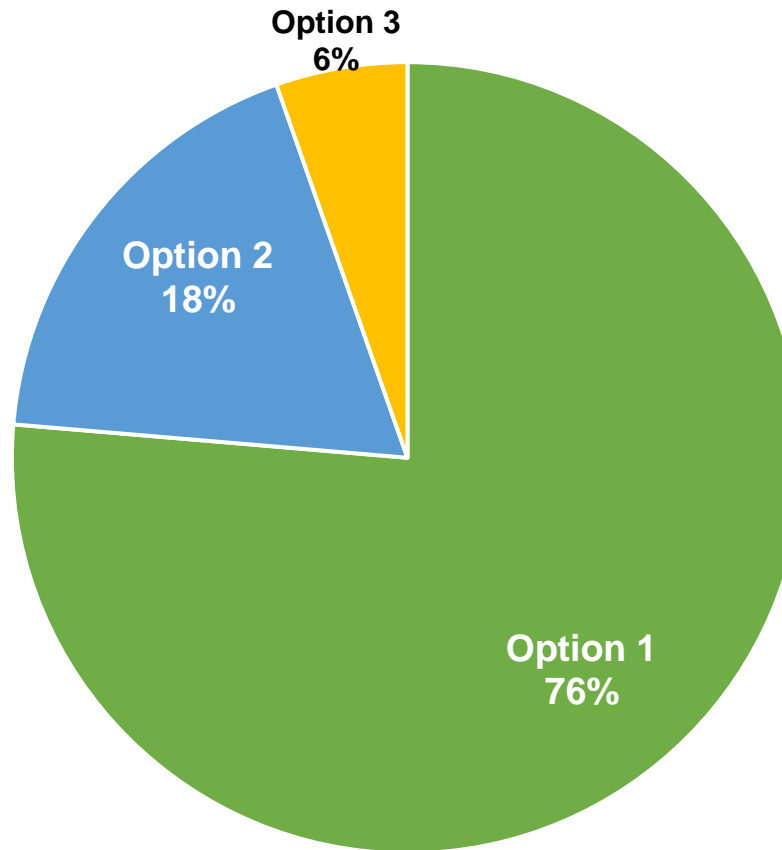
1. Conventional imaging
2. PSMA PET (no iodine iv contrast)
3. PSMA PET plus diagnostic CT (with iv iodine contrast)
4. LuPSMA SPECT/CT
5. Abstain/unqualified to answer



Option	Votes
Option 1	19
Option 2	23
Option 3	38
Option 4	13
Abstain	13

143. In the majority of patients with response (PSA and/or clinical and/or radiological) to <sup>177</sup>Lu-PSMA therapy after 4 cycles, do you recommend completion of the 6 cycles if PSMA-based imaging shows significant remaining uptake (as defined by the treating physician)?

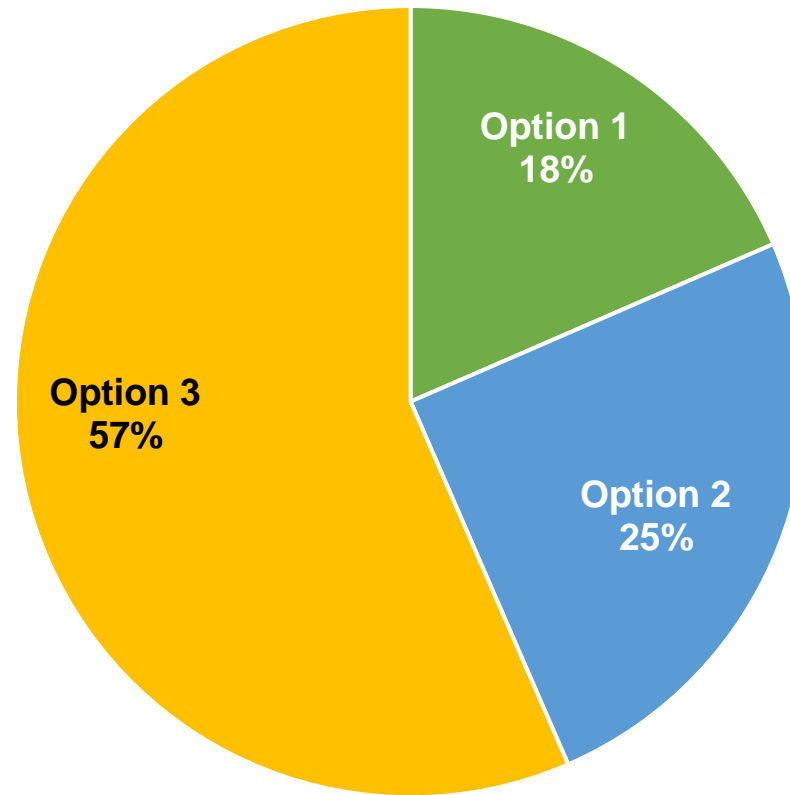
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	71
Option 2	17
Option 3	5
Abstain	13

144. In the majority of patients with response (PSA and/or clinical and/or radiological) to <sup>177</sup>Lu-PSMA therapy after 4 cycles, do you recommend completion of the 6 cycles if PSMA-based imaging shows no remaining uptake (as defined by the treating physician)?

1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



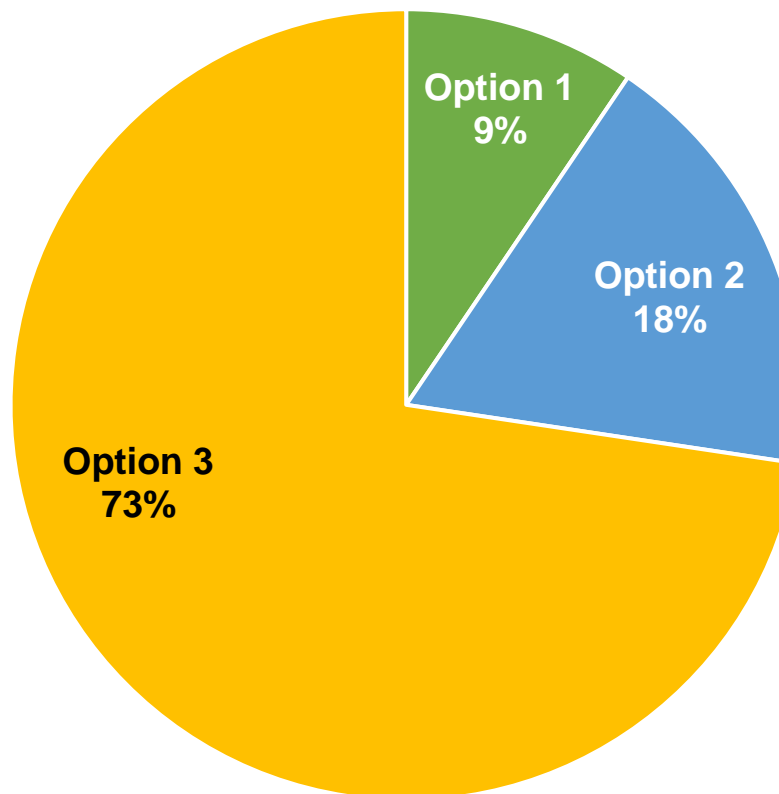
Option	Votes
Option 1	17
Option 2	23
Option 3	52
Abstain	14

## 5. Lutetium-177-PSMA Therapy

### 5.3. General RLT questions

145. For the majority of patients treated with <sup>177</sup>Lu-PSMA in the mCRPC setting post ARPI and post-chemotherapy, do you recommend the combination with the alternate ARPI?

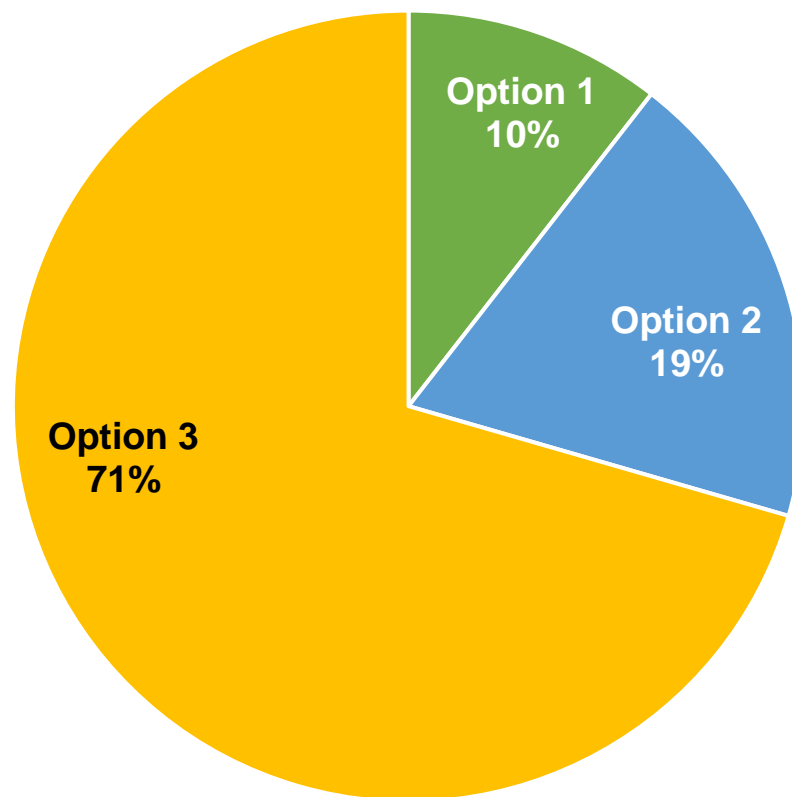
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	9
Option 2	17
Option 3	69
Abstain	11

146. For the majority of patients treated with <sup>177</sup>Lu-PSMA in the mCRPC setting post ARPI and no prior chemotherapy, do you recommend the combination with the alternate ARPI?

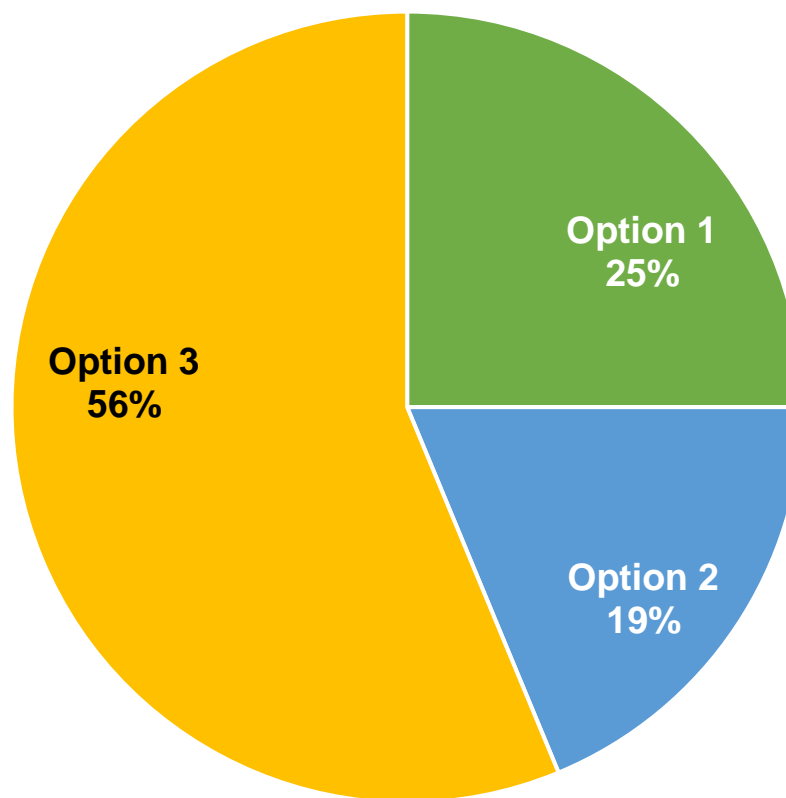
1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	10
Option 2	18
Option 3	67
Abstain	11

## 147. Can the data generated by PSMAfore and VISION with Lutetium-PSMA-617 be extrapolated to Lutetium-PSMA with alternate PSMA ligands?

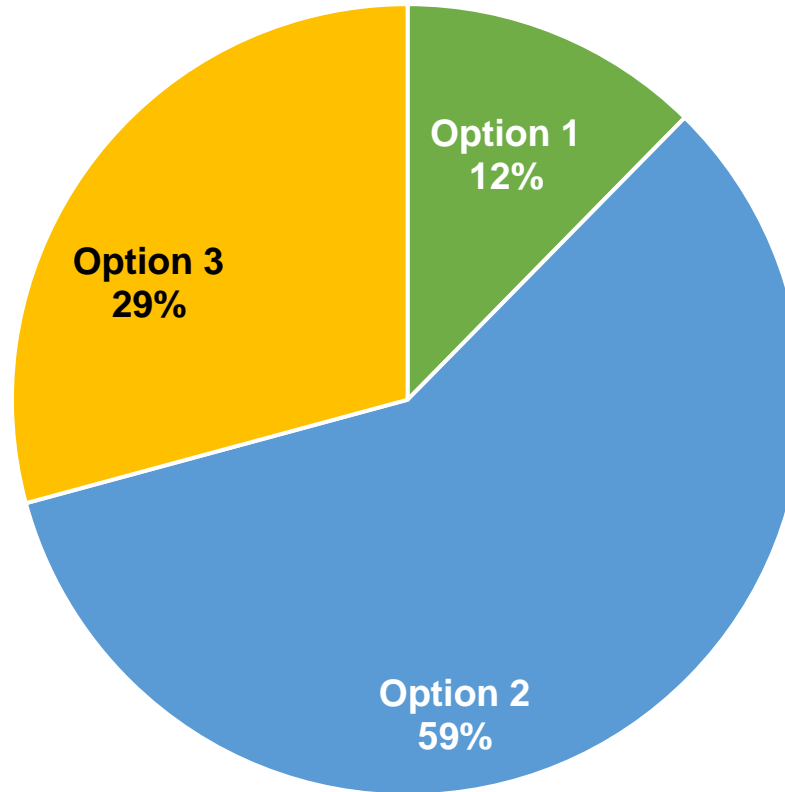
1. Yes, for all PSMA ligands
2. Yes, but only for PSMA-I&T
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	20
Option 2	15
Option 3	45
Abstain	26

148. Do you recommend re-treatment with Lutetium-PSMA (if relevant PET criteria are met) in the disease course in patients who have previously responded to 6 cycles of <sup>177</sup>Lu-PSMA treatment?

1. Yes
2. Yes, but only if response of >6 months
3. No
4. Abstain/unqualified to answer



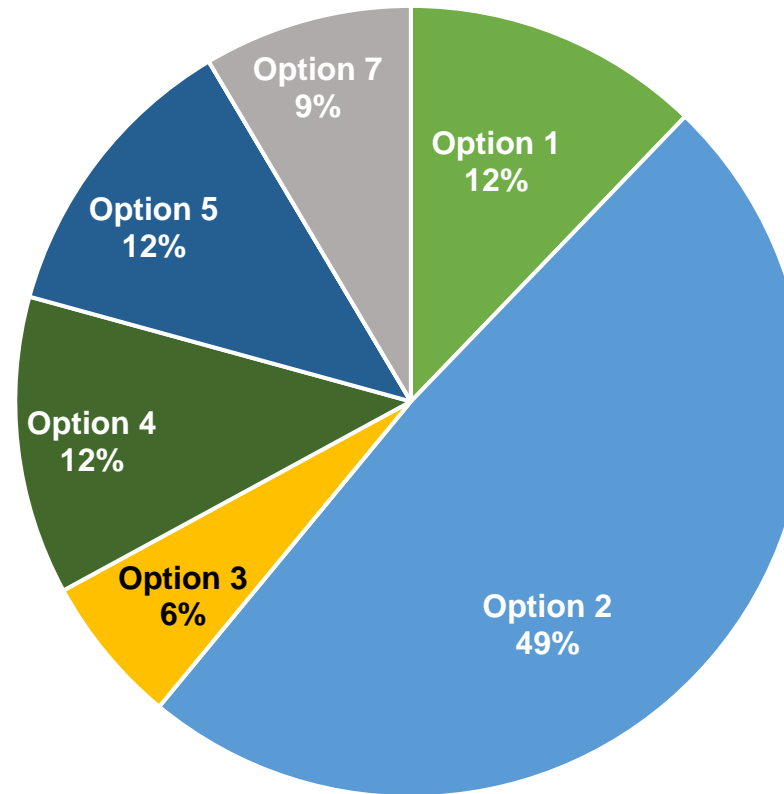
Option	Votes
Option 1	11
Option 2	52
Option 3	26
Abstain	17

## 5. Lutetium-177-PSMA Therapy

### 5.4. RLT treatment in patients with impaired bone marrow or renal function

149. In the majority of patients with mCRPC (no DDR alteration) progressing on or after an ARPI and relevant impaired bone marrow function (haemoglobin <90 g/L and/or neutrophils <1.5 x10<sup>9</sup>/L and/or platelets <100 x10<sup>9</sup>/L), what do you recommend?

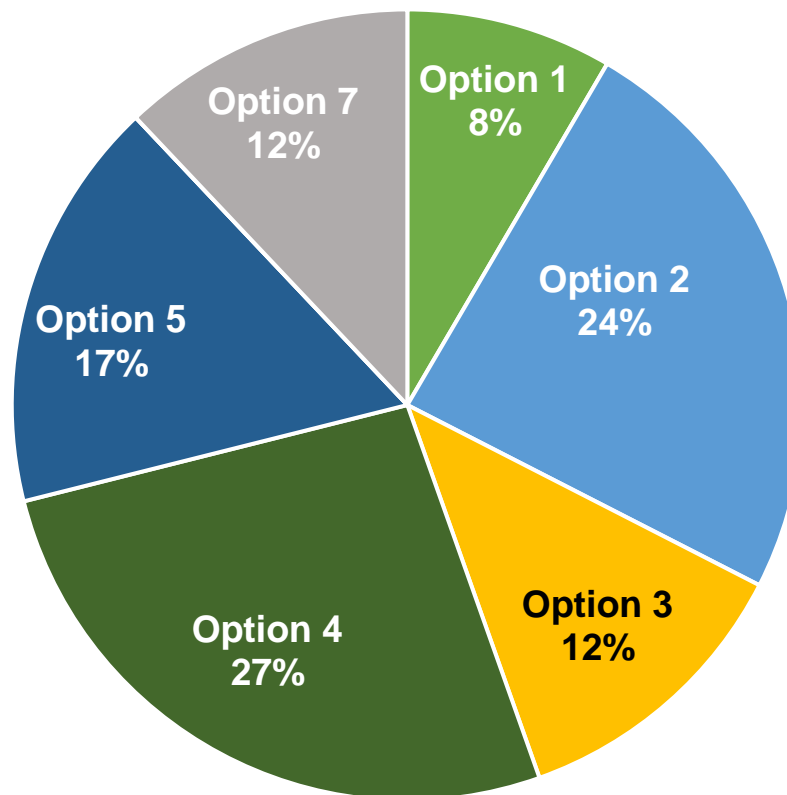
1. Docetaxel 3-weekly
2. Docetaxel weekly or 2-weekly
3. <sup>177</sup>Lu-PSMA
4. <sup>177</sup>Lu-PSMA reduced administered activity
5. Alternate ARPI
6. Radium-223
7. Best supportive care
8. Abstain/unqualified to answer



Option	Votes
Option 1	10
Option 2	40
Option 3	5
Option 4	10
Option 5	10
Option 6	0
Option 7	7
Abstain	24

150. In the majority of patients with mCRPC (no DDR alteration) progressing on or after an ARPI and docetaxel and relevant impaired bone marrow function (haemoglobin <90 g/L and/or neutrophils <1.5 x10<sup>9</sup>/L and/or platelets <100 x10<sup>9</sup>/L), what do you recommend?

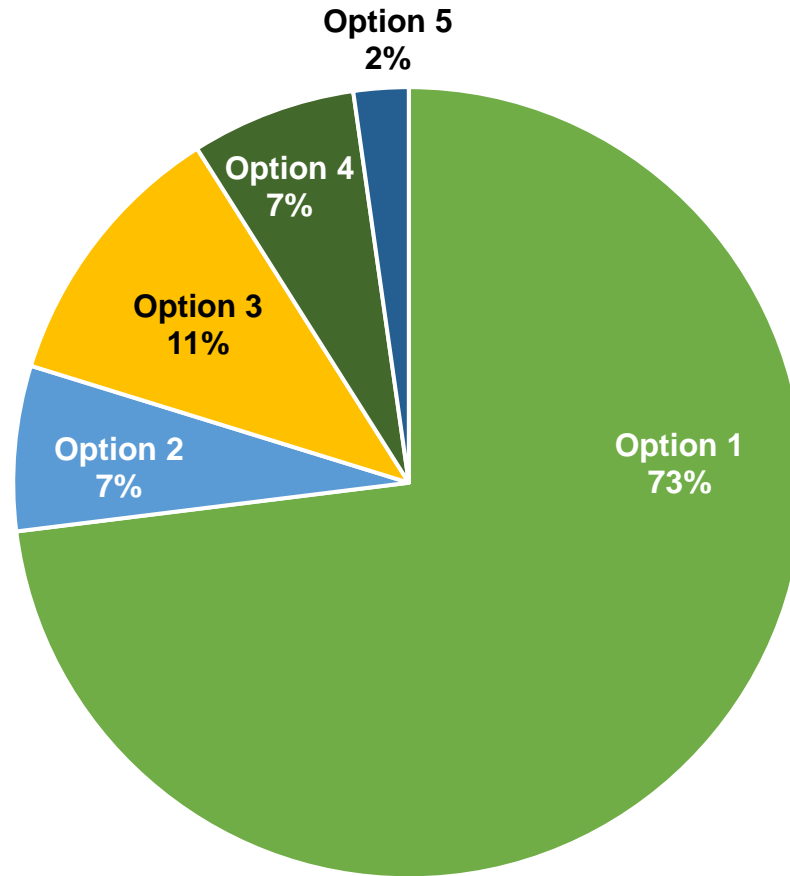
1. Cabazitaxel 3-weekly
2. Cabazitaxel weekly or 2-weekly
3. <sup>177</sup>Lu-PSMA
4. <sup>177</sup>Lu-PSMA reduced administered activity
5. Alternate ARPI
6. Radium-223
7. Best supportive care
8. Abstain/unqualified to answer



Option	Votes
Option 1	7
Option 2	20
Option 3	10
Option 4	22
Option 5	14
Option 6	0
Option 7	10
Abstain	23

151. In the majority of patients with mCRPC (no DDR alteration) progressing on or after an ARPI and impaired renal function (GFR 30-49mL/min), what do you recommend?

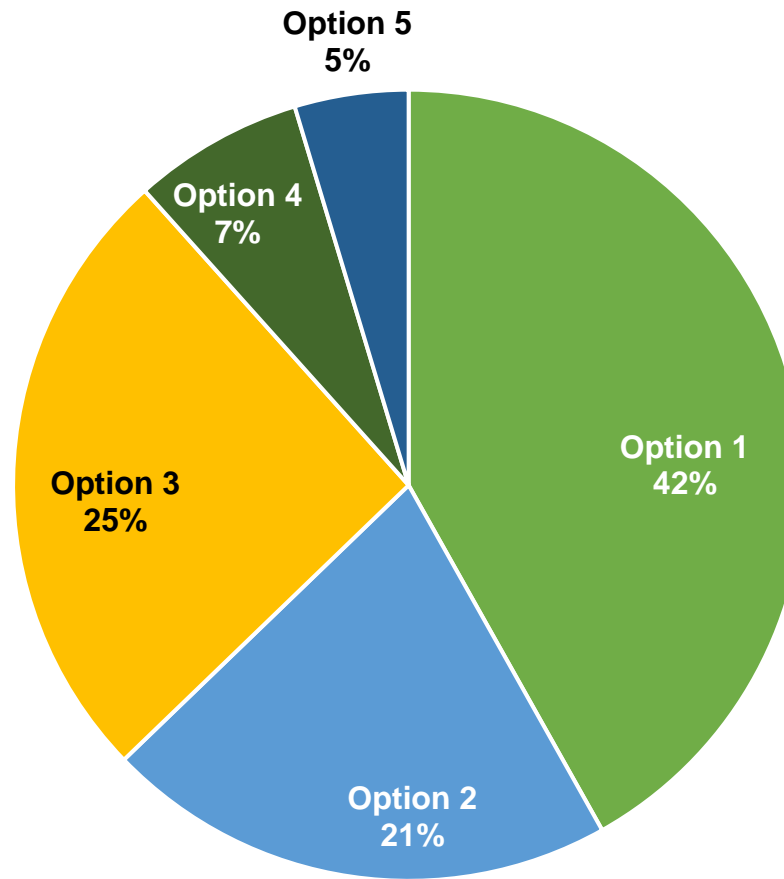
1. Docetaxel
2. <sup>177</sup>Lu-PSMA
3. <sup>177</sup>Lu-PSMA reduced administered activity
4. Alternate ARPI
5. Radium-223
6. Abstain/unqualified to answer



Option	Votes
Option 1	65
Option 2	6
Option 3	10
Option 4	6
Option 5	2
Abstain	17

152. In the majority of patients with mCRPC (no DDR alteration) progressing on or after an ARPI and docetaxel and impaired renal function (GFR 30-49mL/min) what do you recommend?

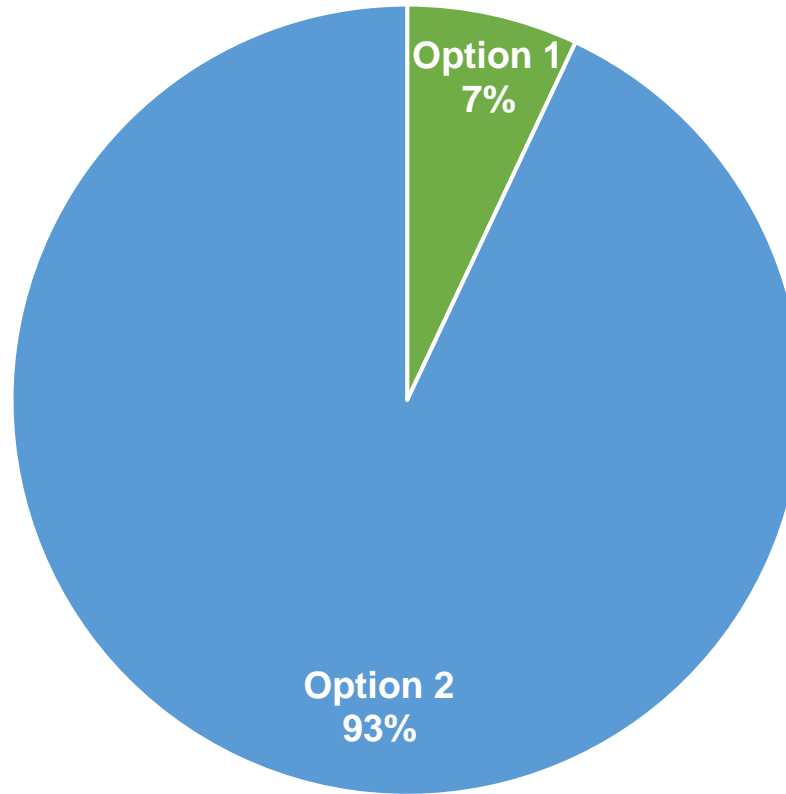
1. Cabazitaxel
2. <sup>177</sup>Lu-PSMA
3. <sup>177</sup>Lu-PSMA reduced administered activity
4. Alternate ARPI
5. Radium-223
6. Abstain/unqualified to answer



Option	Votes
Option 1	36
Option 2	18
Option 3	22
Option 4	6
Option 5	4
Abstain	20

# 153. Is it appropriate to recommend Lutetium-PSMA therapy in patients with mHSPC outside of a clinical trial?

- 1. Yes
- 2. **No**
- 3. Abstain/unqualified to answer



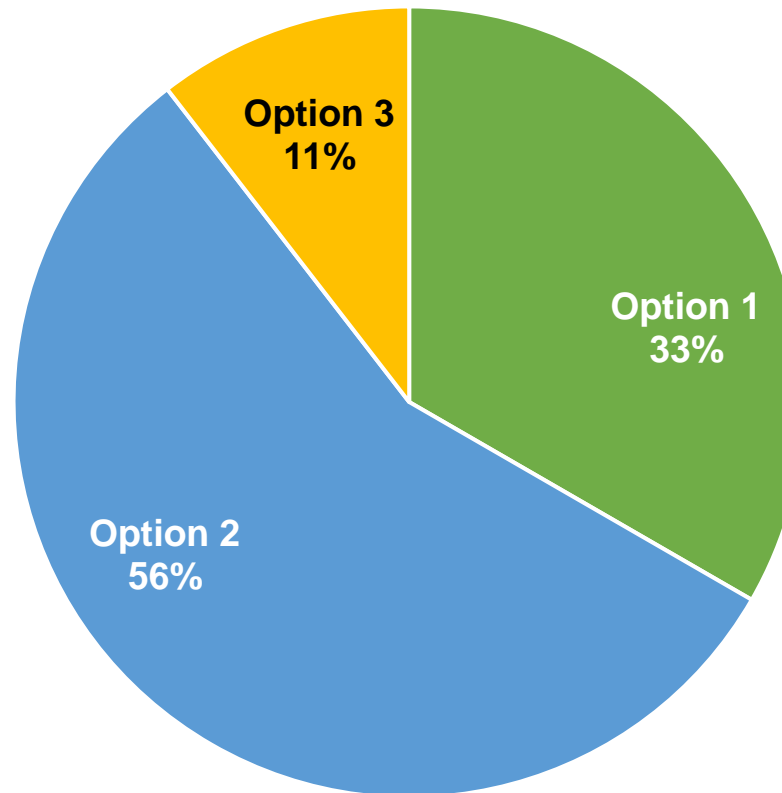
Option	Votes
Option 1	7
Option 2	93
Abstain	6

## 6. Side effects

### 6.1. Cardiovascular risk assessment and monitoring

154. Do you recommend a cardiovascular risk assessment (e.g. ESC, ASCVD, U-prevent...) in patients with advanced prostate cancer starting systemic therapy (ADT ± ARPI)?

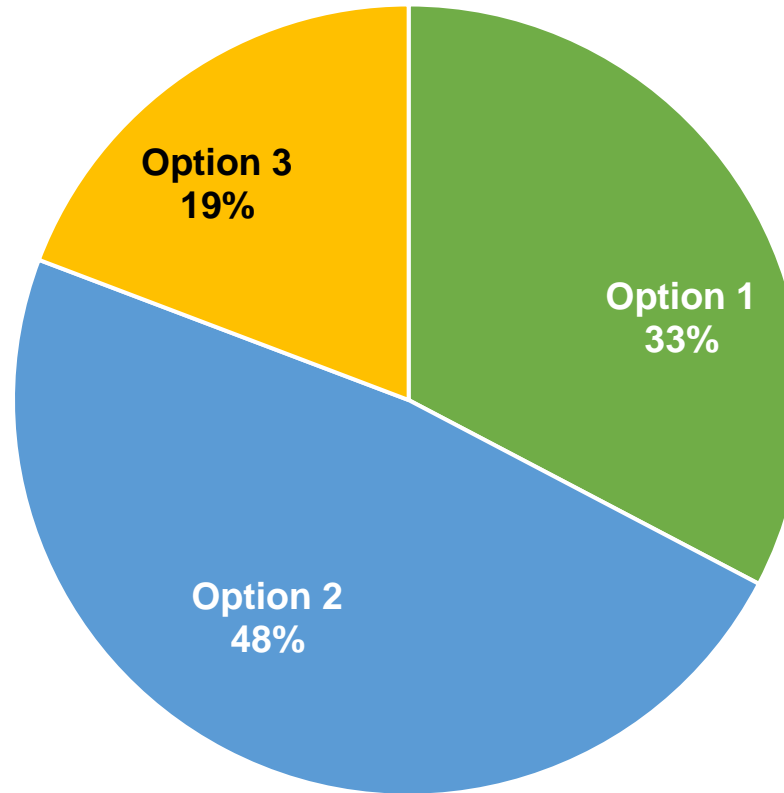
1. Yes, in the majority of patients
2. Yes, but only in selected patients with a history of a major adverse cardiac event (MACE) or other risk factors for cardiac disease
3. No, standard clinical assessment
4. Abstain/unqualified to answer



Option	Votes
Option 1	35
Option 2	59
Option 3	11
Abstain	1

## 155. Do you recommend a baseline ECG before start of systemic hormonal therapy (ADT ± ARPI)?

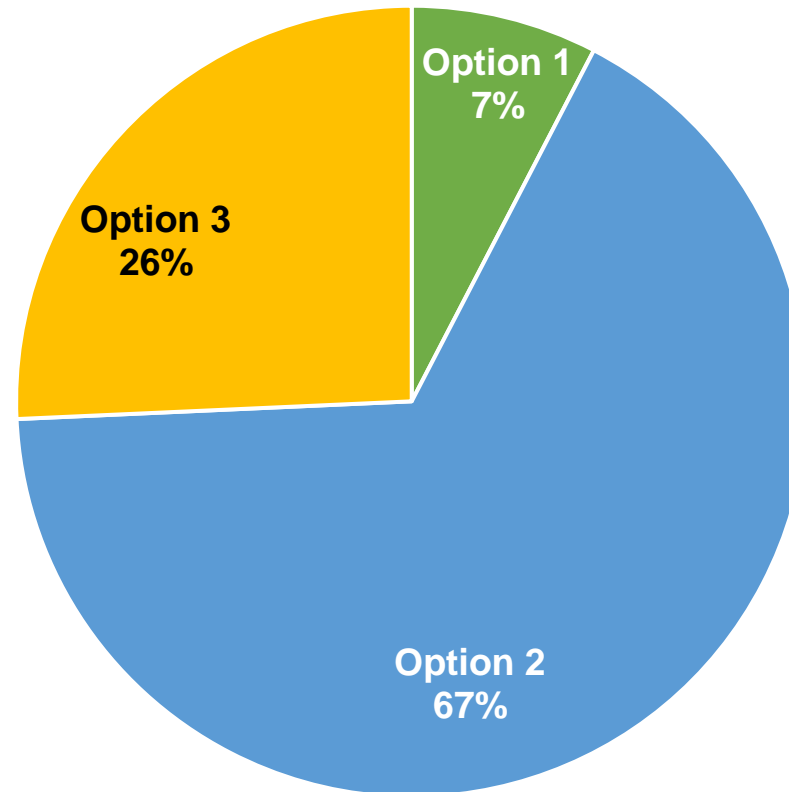
1. Yes, in the majority of patients
2. Yes, but only in selected patients with a history of a major adverse cardiac event (MACE) or other risk factors for cardiac disease
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	34
Option 2	50
Option 3	20
Abstain	2

156. Do you recommend a cardiac evaluation (for example stress test and/or echocardiography in addition to ECG) before start of ADT?

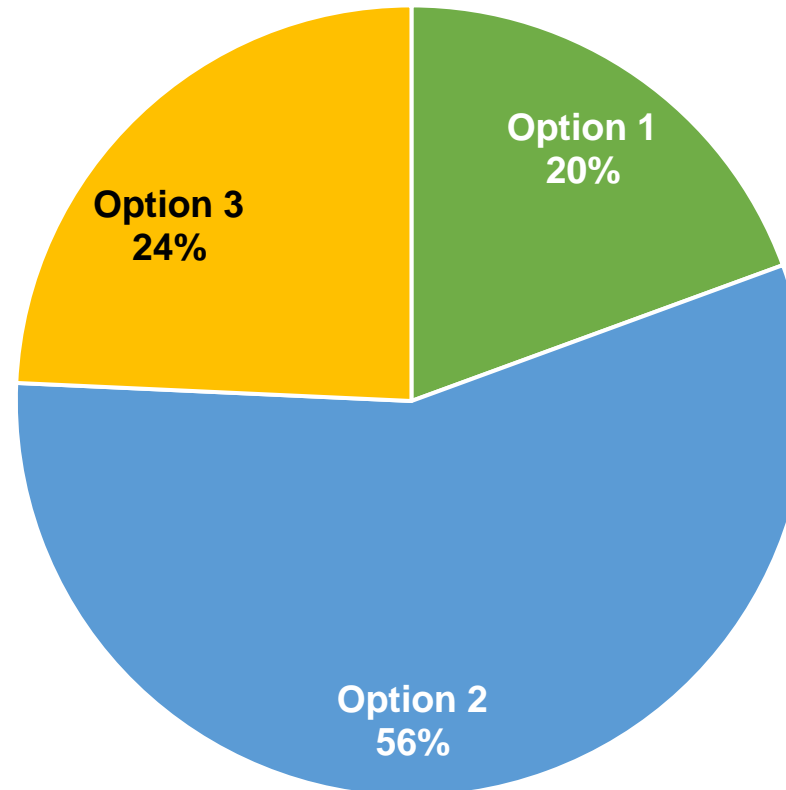
1. Yes, in the majority of patients
2. Yes, but only in selected patients with a history of a major adverse cardiac event (MACE) or other risk factors for cardiac disease
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	8
Option 2	70
Option 3	27
Abstain	1

157. Do you recommend a cardiac evaluation (for example echocardiography and/or stress test in addition to ECG) before start of abiraterone in addition to ADT?

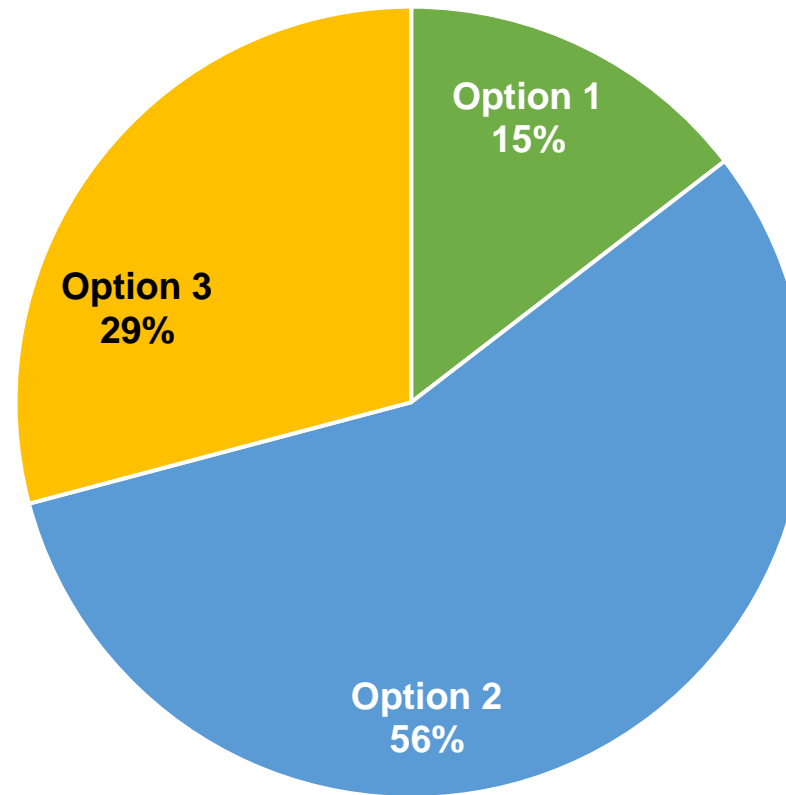
1. Yes, in the majority of patients
2. Yes, but only in selected patients with a history of a major adverse cardiac event (MACE) or other risk factors for cardiac disease
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	20
Option 2	58
Option 3	25
Abstain	3

158. Do you recommend a cardiac evaluation (echocardiography and/or stress test in addition to ECG) before start of an AR antagonist (Apa, Daro, Enza) in addition to ADT?

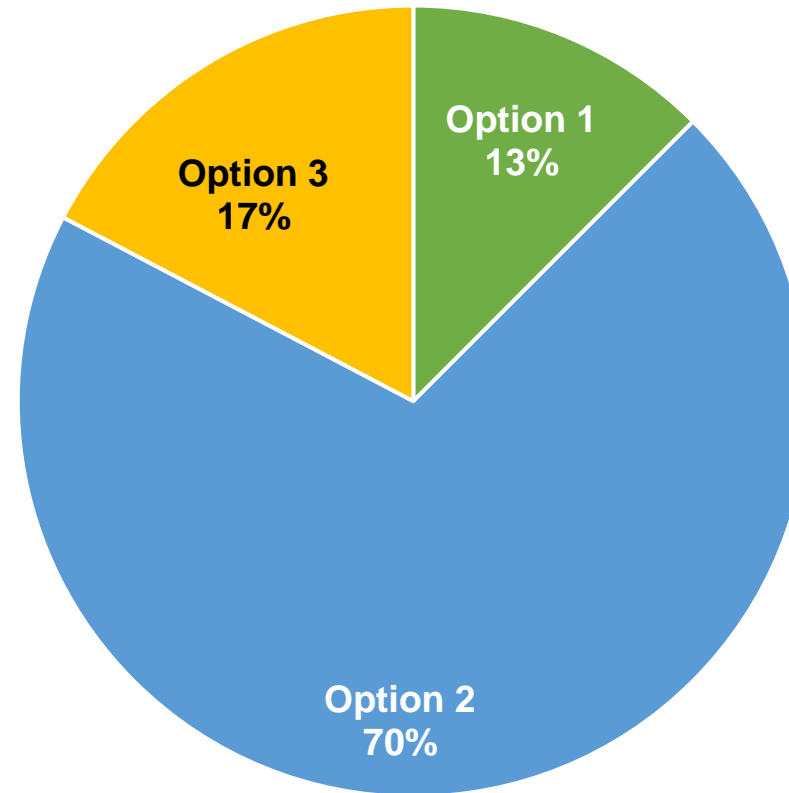
1. Yes, in the majority of patients
2. Yes, but only in selected patients with a history of a major adverse cardiac event (MACE) or other risk factors for cardiac disease
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	15
Option 2	58
Option 3	30
Abstain	3

159. For the majority of patients starting systemic hormonal therapy (ADT ± ARPI) do you recommend monitoring lipid-profiles?

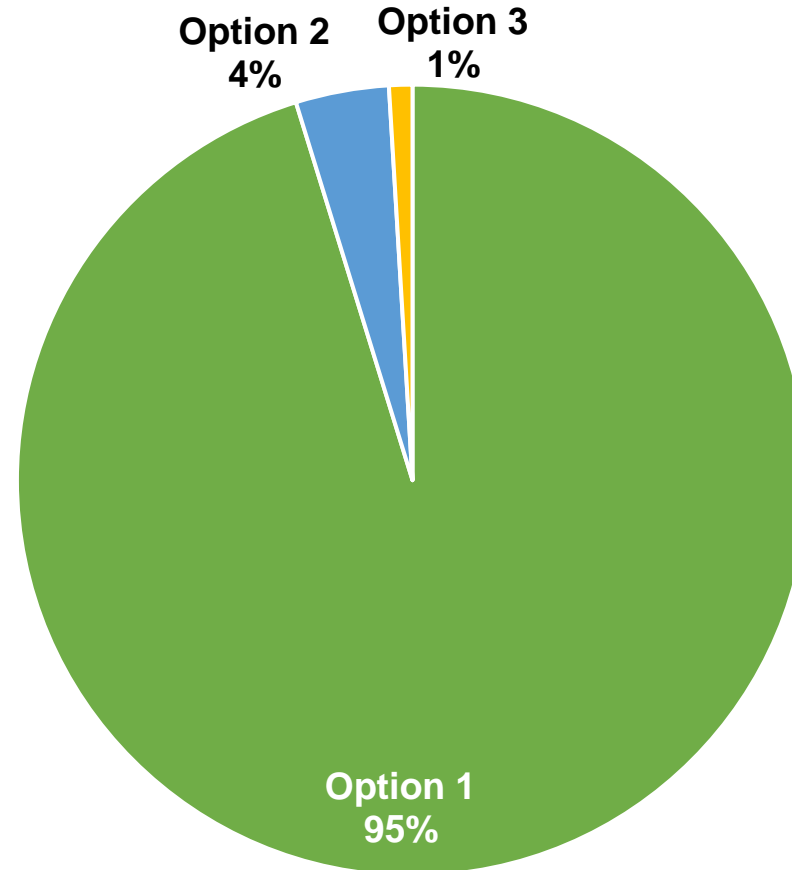
1. Yes baseline
2. Yes, baseline and regularly e.g. every 6-12 months
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	13
Option 2	73
Option 3	18
Abstain	2

# 160. Do you recommend blood pressure monitoring in patients on abiraterone therapy?

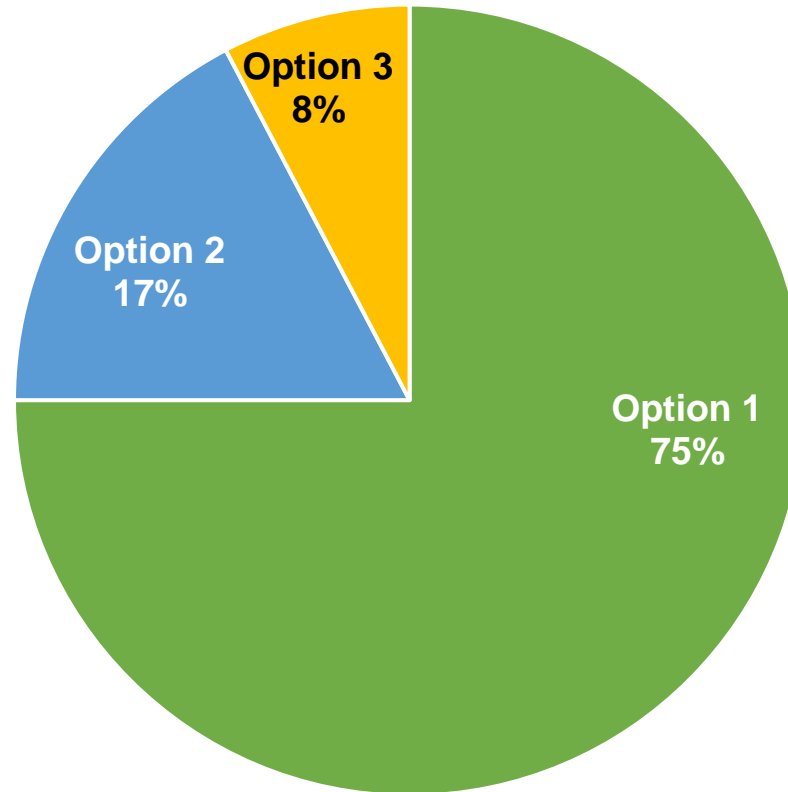
1. **Yes, in the majority of patients**
2. Yes, but only in selected patients with a history of a major adverse cardiac event (MACE) or other risk factors for cardiac disease
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	100
Option 2	4
Option 3	1
Abstain	1

# 161. Do you recommend blood pressure monitoring in patients on AR antagonist (Apa, Daro, Enza) therapy?

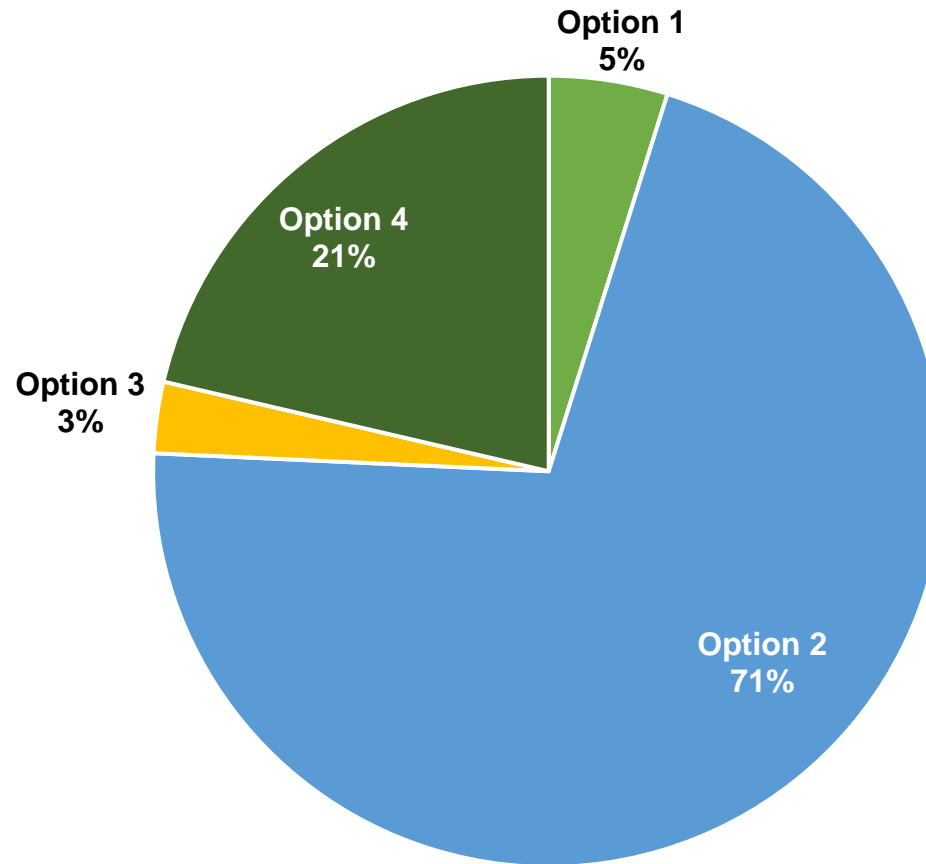
1. **Yes, in the majority of patients**
2. Yes, but only in selected patients with a history of a major adverse cardiac event (MACE) or other risk factors for cardiac disease
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	78
Option 2	18
Option 3	8
Abstain	2

162. For the majority of patients with advanced prostate cancer with a recent history of major adverse cardiac event (MACE) with an indication for ADT, what is your preferred GnRH analogue?

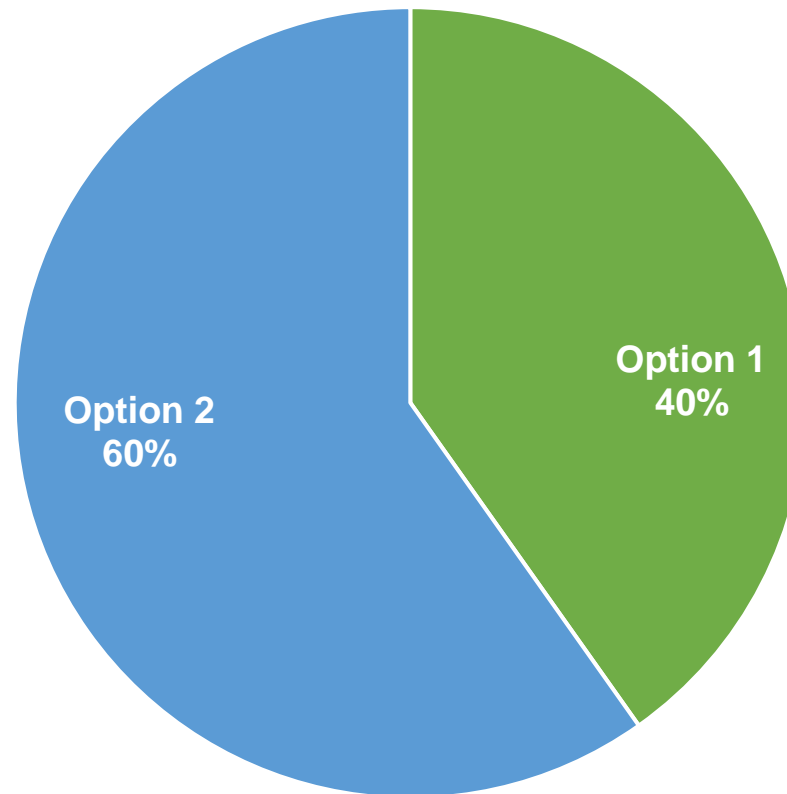
1. LHRH agonist
2. LHRH antagonist
3. Orchiectomy
4. Either one of the options above
5. Abstain/unqualified to answer



Option	Votes
Option 1	5
Option 2	73
Option 3	3
Option 4	22
Abstain	3

163. For patients with metastatic prostate cancer on permanent ADT, should health-care systems recommend switching from LHRH agonist/antagonists to bilateral subcapsular orchiectomy to spare health care resources?

1. Yes
2. No
3. Abstain/unqualified to answer



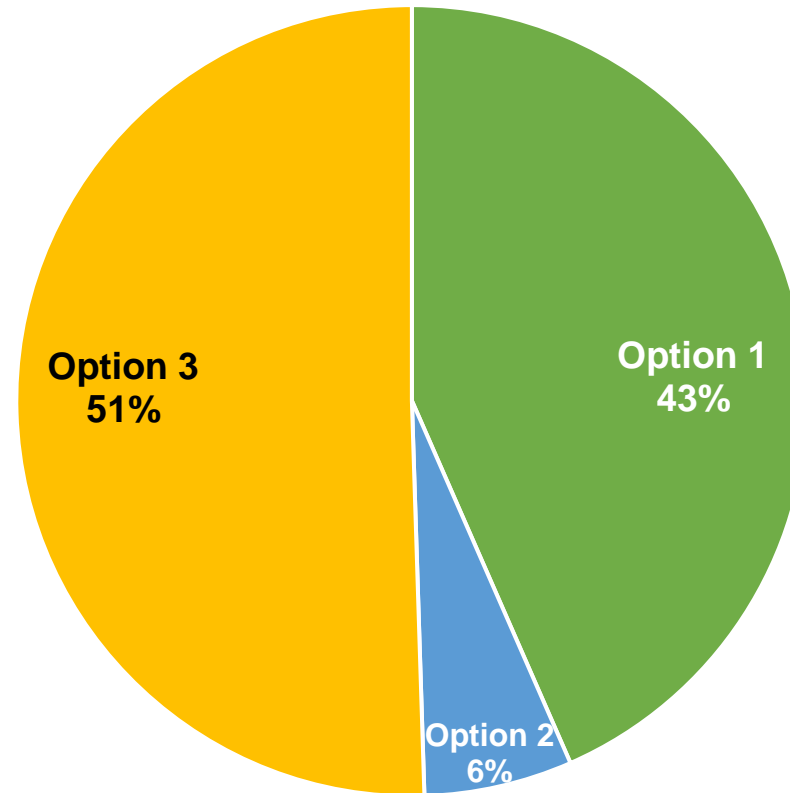
Option	Votes
Option 1	41
Option 2	61
Abstain	4

## 6. Side effects

### 6.2. Hot flushes

164. For the majority of patients, what do you recommend as non-drug management options for frequent or bothersome hot flushes in addition to lifestyle changes?

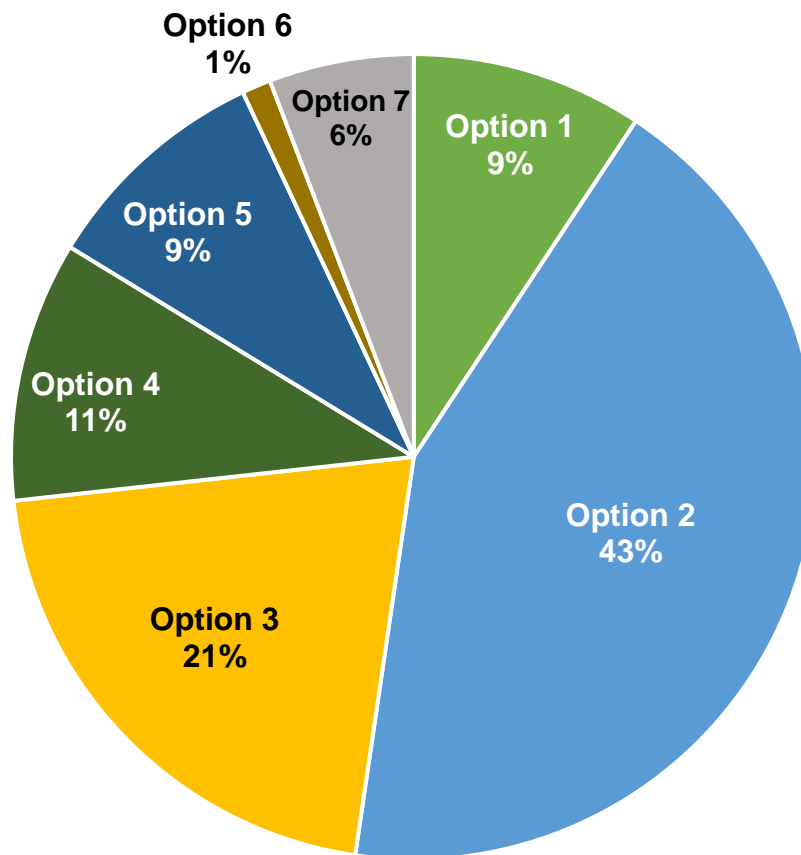
1. Exercise
2. Acupuncture
3. Both of the above
4. Abstain/unqualified to answer



Option	Votes
Option 1	43
Option 2	6
Option 3	50
Abstain	7

165. For the majority of patients, what is your preferred drug management option for frequent or bothersome hot flushes in addition to lifestyle changes?

1. Gabapentin
2. Venlafaxine
3. Cyproterone acetate
4. Megestrol acetate
5. Oxybutynin
6. Fezolinetant
7. Low-dose oestrogens
8. Abstain/unqualified to answer



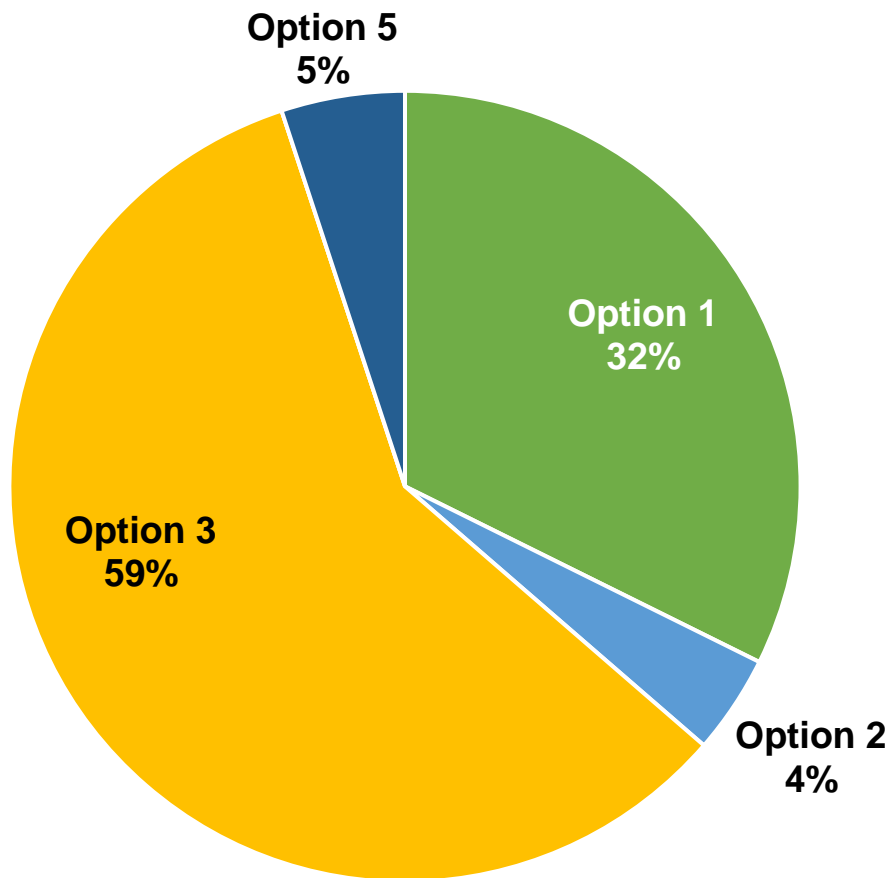
Option	Votes
Option 1	8
Option 2	37
Option 3	18
Option 4	9
Option 5	8
Option 6	1
Option 7	5
Abstain	20

## 6. Side effects

### 6.3. ARPI selection in special situations

166. For the majority of patients with advanced prostate cancer and a history of falls, what is your preferred ARPI (any treatment line, assuming all options are available)?

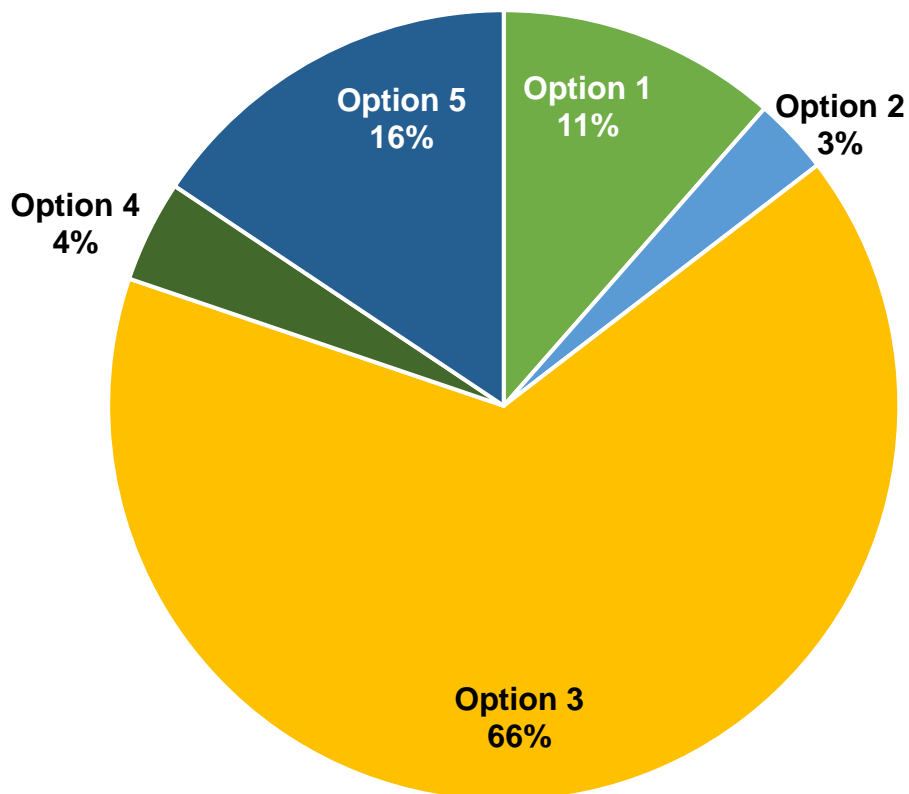
1. Abiraterone
2. Apalutamide
3. Darolutamide
4. Enzalutamide
5. Any of the above
6. Abstain/unqualified to answer



Option	Votes
Option 1	32
Option 2	4
Option 3	58
Option 4	0
Option 5	5
Abstain	7

167. For the majority of patients with advanced prostate cancer and a history of coronary artery disease and currently on oral anticoagulants and a statin what is your preferred ARPI (any treatment line, assuming all options are available)?

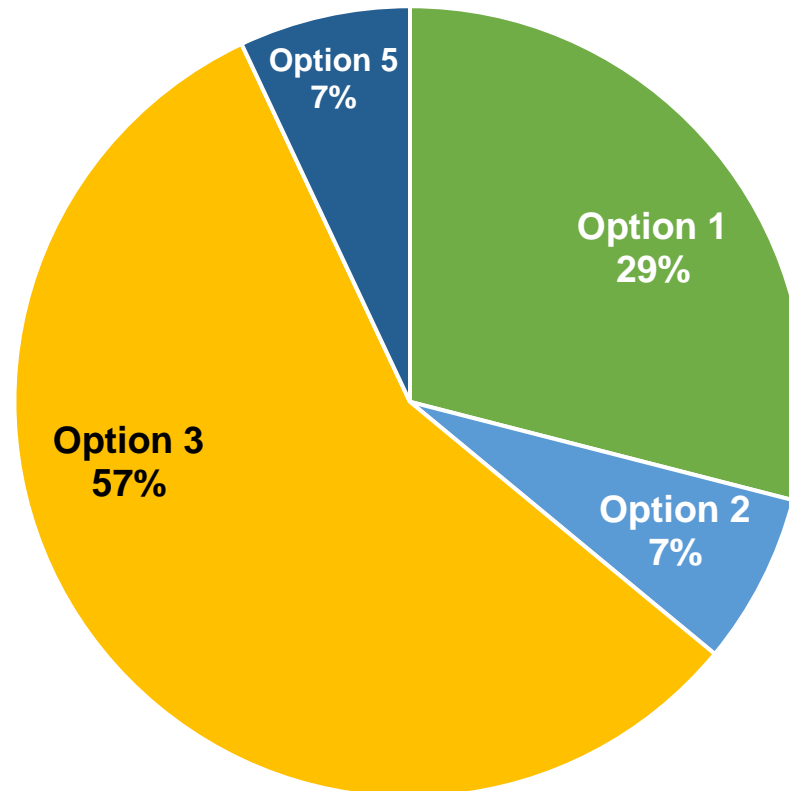
1. Abiraterone
2. Apalutamide
3. Darolutamide
4. Enzalutamide
5. Any of the above
6. Abstain/unqualified to answer



Option	Votes
Option 1	11
Option 2	3
Option 3	63
Option 4	4
Option 5	15
Abstain	10

168. For the majority of patients with advanced prostate cancer and a history of cognitive impairment what is your preferred ARPI (any treatment line, assuming all options are available)?

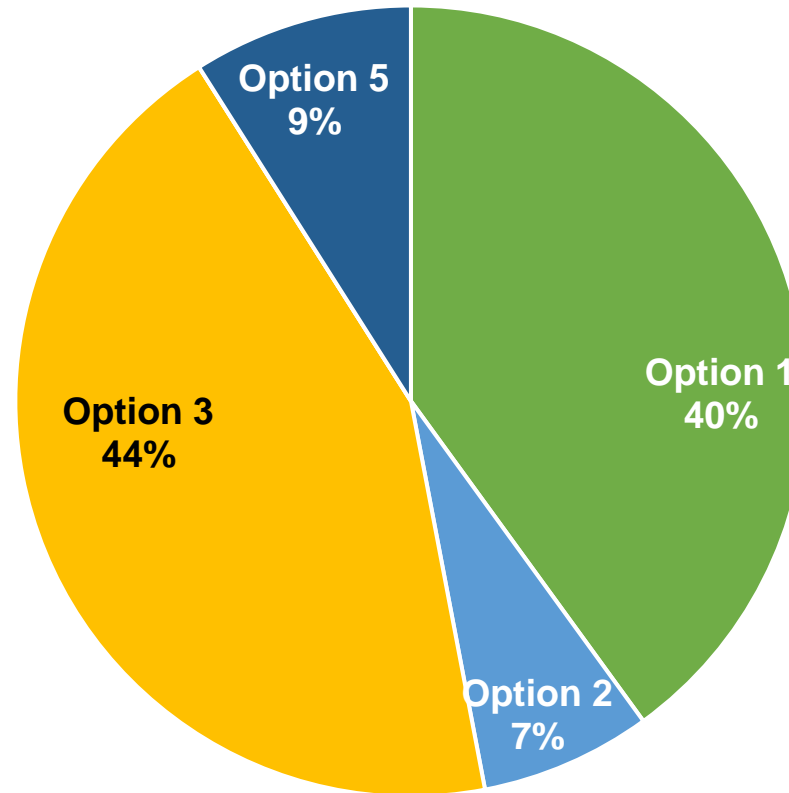
1. Abiraterone
2. Apalutamide
3. Darolutamide
4. Enzalutamide
5. Any of the above
6. Abstain/unqualified to answer



Option	Votes
Option 1	29
Option 2	7
Option 3	57
Option 4	0
Option 5	7
Abstain	6

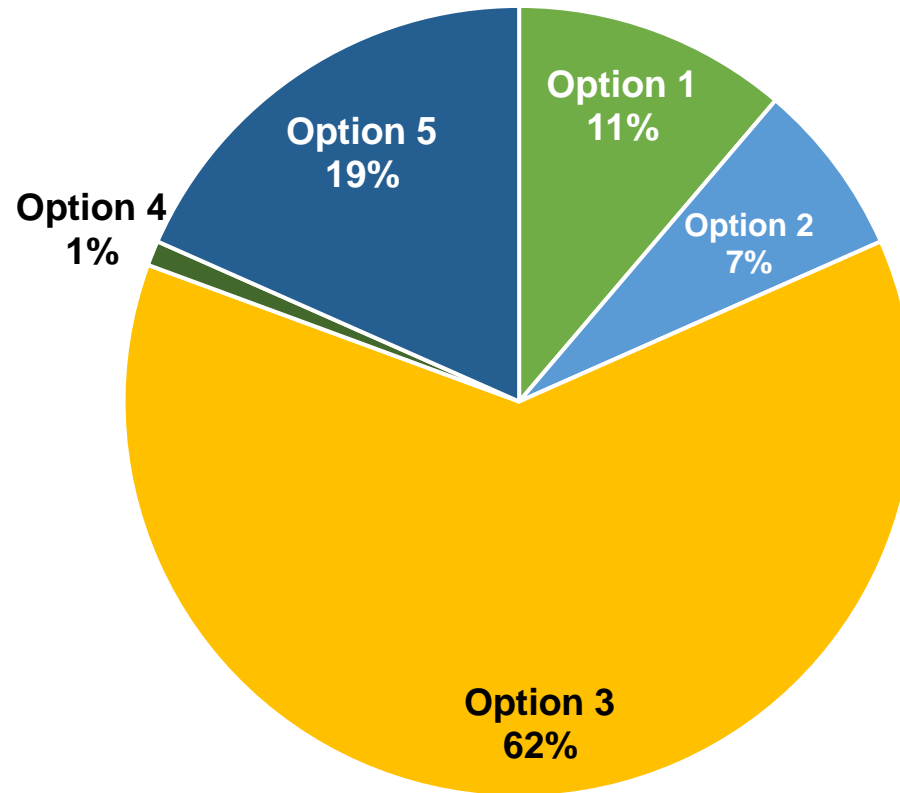
169. For the majority of patients with advanced prostate cancer and a history of relevant fatigue what is your preferred ARPI (any treatment line, assuming all options are available)?

1. Abiraterone
2. Apalutamide
3. Darolutamide
4. Enzalutamide
5. Any of the above
6. Abstain/unqualified to answer



Option	Votes
Option 1	40
Option 2	7
Option 3	44
Option 4	0
Option 5	9
Abstain	6

170. For the majority of patients with mHSPC  $\geq 75$  years of age, what is your ARPI of choice in any line with regards to efficacy and the safety profile in this patient population assuming all options are available?

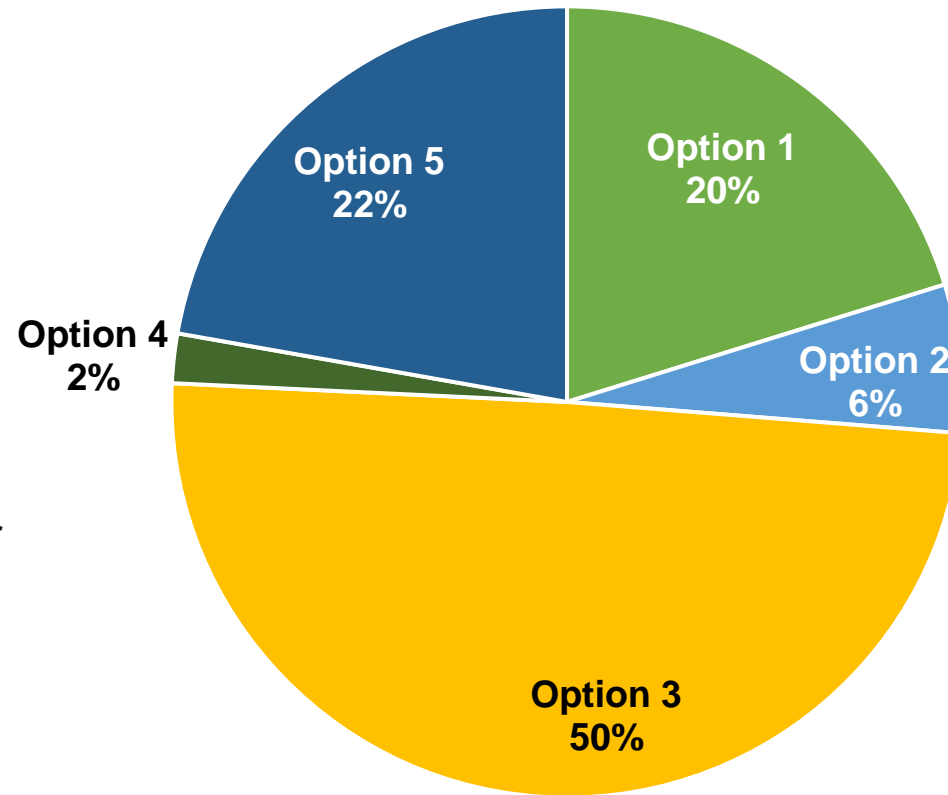


1. Abiraterone
2. Apalutamide
3. Darolutamide
4. Enzalutamide
5. Any of the above
6. Abstain/unqualified to answer

Option	Votes
Option 1	11
Option 2	7
Option 3	61
Option 4	1
Option 5	18
Abstain	8

171. For the majority of patients with mCRPC ≥75 years of age, what is your ARPI of choice in any line with regards to efficacy and the safety profile in this patient population assuming all options are available?

1. Abiraterone
2. Apalutamide
3. Darolutamide
4. Enzalutamide
5. Any of the above
6. Abstain/unqualified to answer



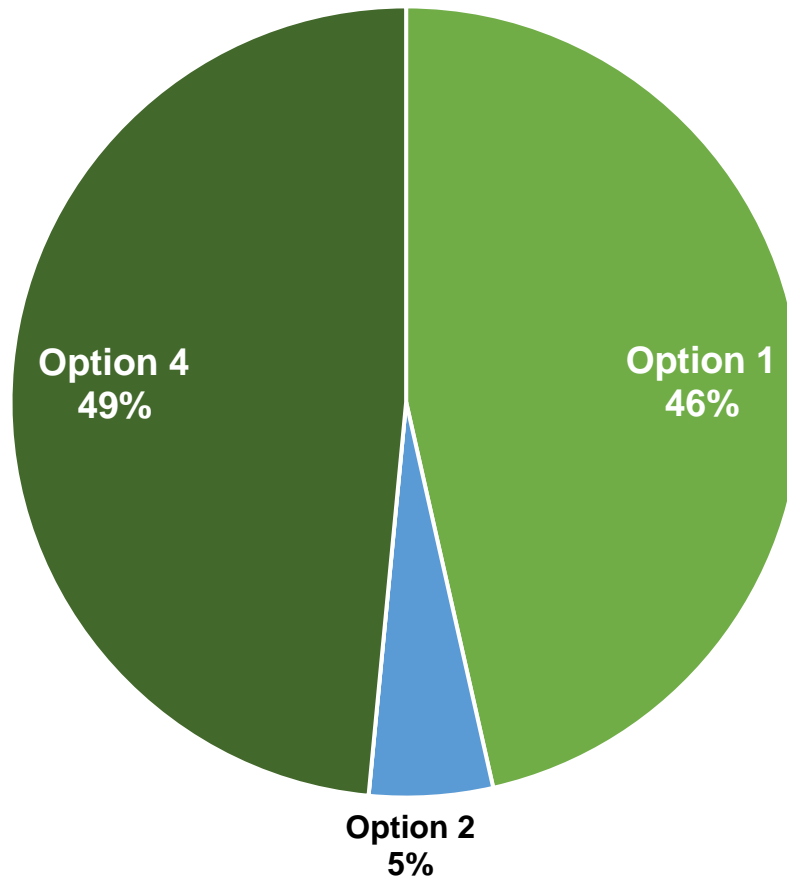
Option	Votes
Option 1	20
Option 2	6
Option 3	49
Option 4	2
Option 5	22
Abstain	7

## 6. Side effects

### 6.4. AR antagonist monotherapy

172. For the majority of patients who receive enzalutamide or bicalutamide monotherapy (150mg OD), do you recommend a primary prophylaxis for gynaecomastia?

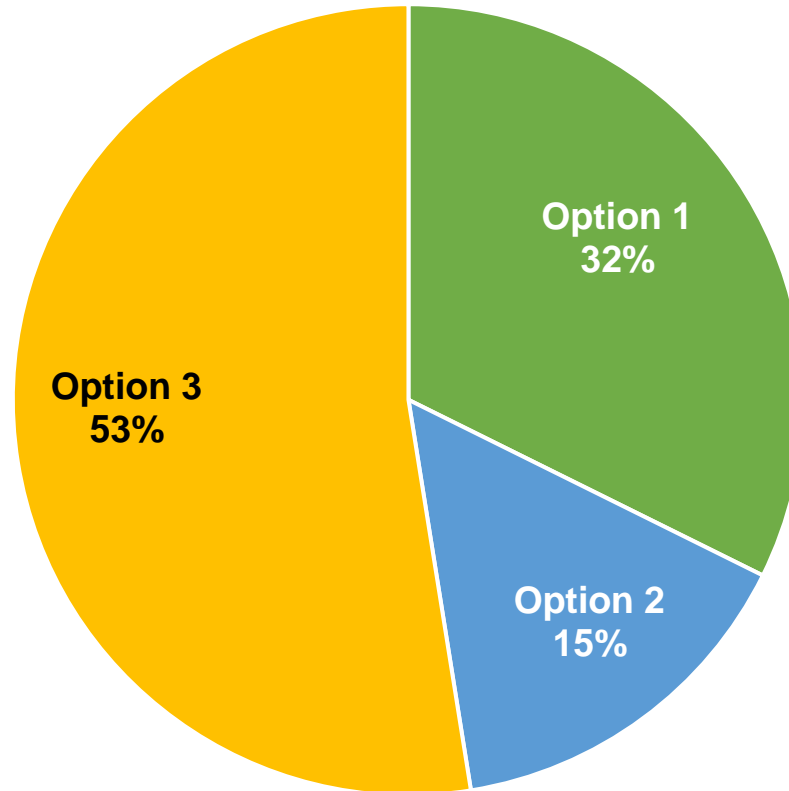
1. Yes, breast bud irradiation
2. Yes, tamoxifen
3. Yes, subareolar mastectomy
4. No
5. Abstain/unqualified to answer



Option	Votes
Option 1	46
Option 2	5
Option 3	0
Option 4	48
Abstain	7

173. For the majority of patients who receive enzalutamide or bicalutamide monotherapy (150mg OD) and who develop relevant gynecomastia, what further investigations do you recommend?

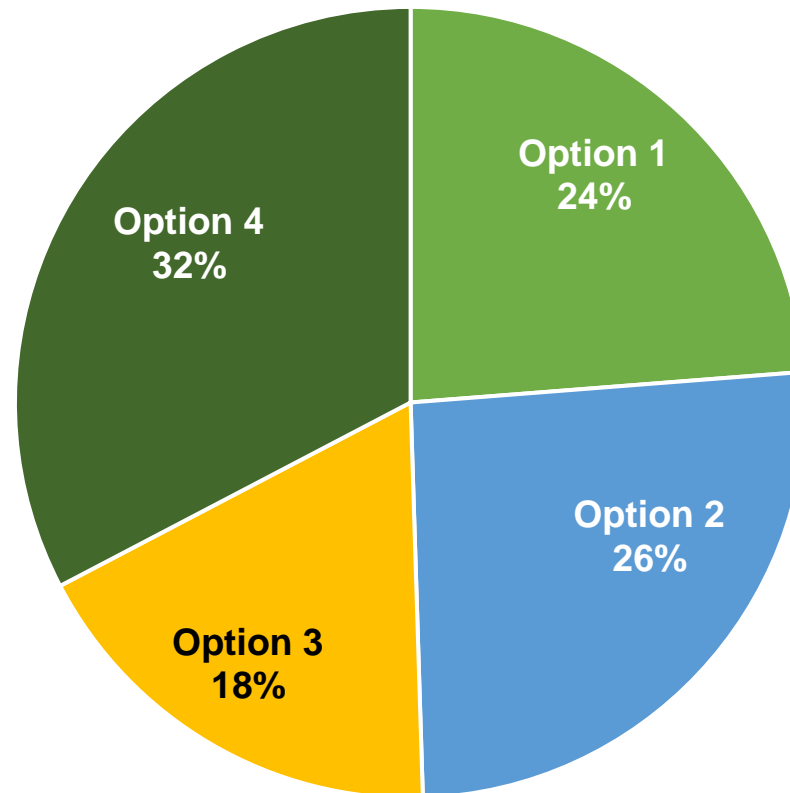
1. Ultrasound
2. Mammography
3. None
4. Abstain/unqualified to answer



Option	Votes
Option 1	32
Option 2	15
Option 3	52
Abstain	7

174. For the majority of patients who receive enzalutamide or bicalutamide monotherapy (150mg OD) and who develop bothersome gynecomastia, what is your preferred treatment?

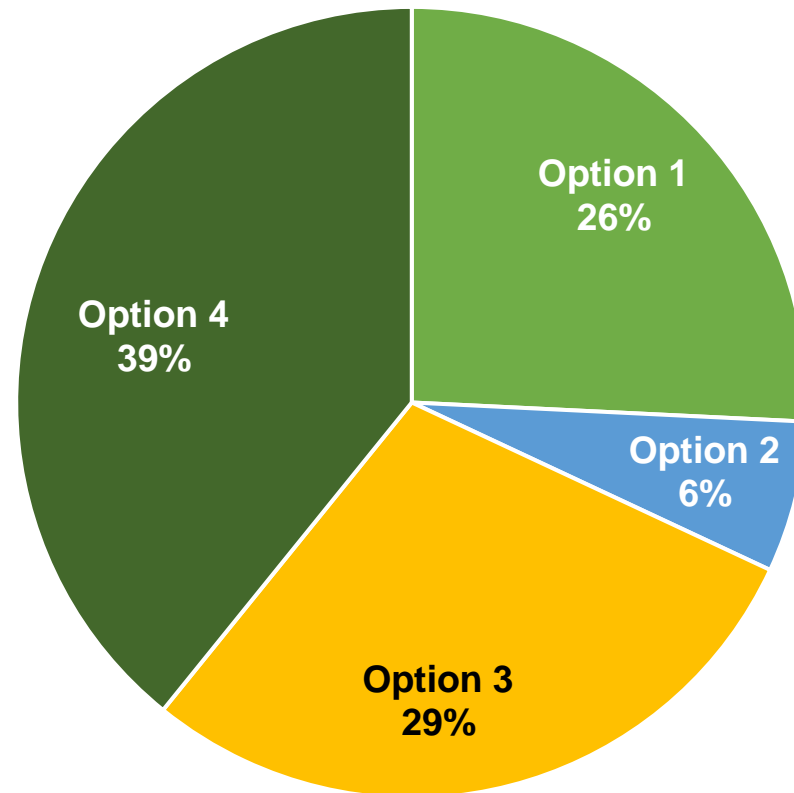
1. Breast bud irradiation
2. Surgery
3. Medical therapy (e.g., tamoxifen)
4. None of the above, supportive measures (including drug discontinuation)
5. Abstain/unqualified to answer



Option	Votes
Option 1	24
Option 2	26
Option 3	18
Option 4	33
Abstain	5

175. For the majority of patients who receive enzalutamide or bicalutamide monotherapy (150mg OD) and who develop bothersome mastodynia what is your preferred treatment?

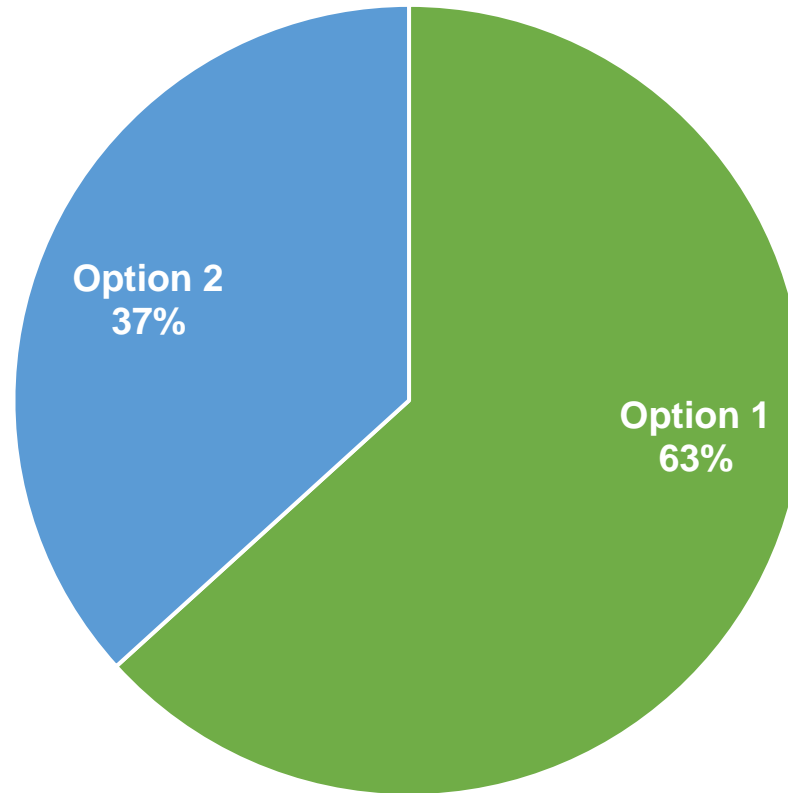
1. Breast bud irradiation
2. Surgery
3. Medical therapy (e.g., tamoxifen)
4. None of the above, supportive measures (including drug discontinuation)
5. Abstain/unqualified to answer



Option	Votes
Option 1	25
Option 2	6
Option 3	28
Option 4	38
Abstain	9

176. Is it appropriate to extrapolate the data generated with bicalutamide 150mg on prophylaxis of gynaecomastia to the AR antagonists (Apa, Daro, Enza)?

1. Yes
2. No
3. Abstain/unqualified to answer



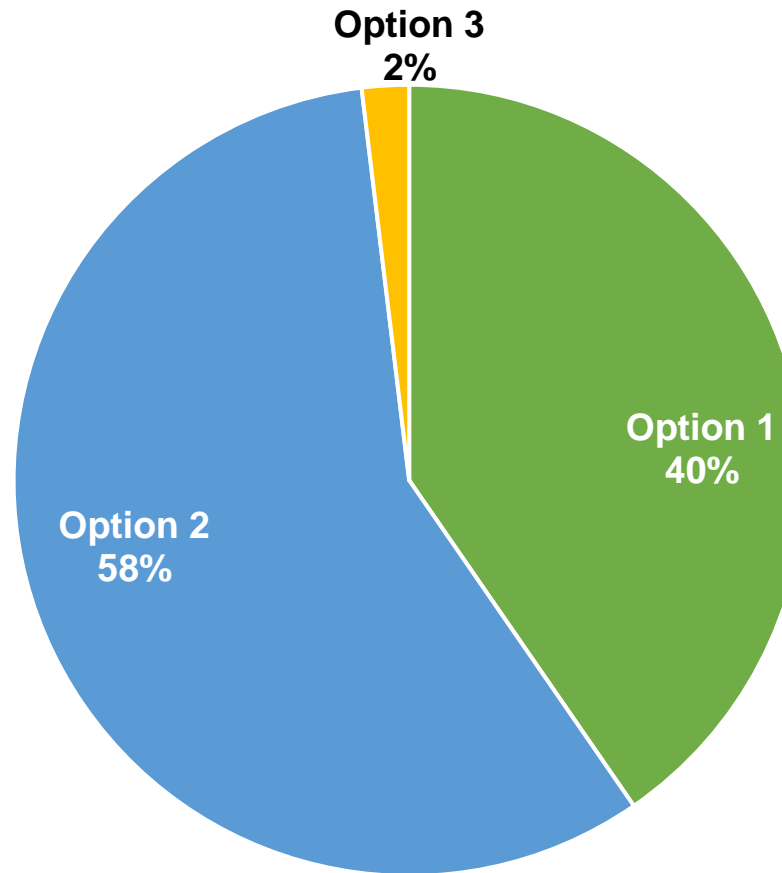
Option	Votes
Option 1	62
Option 2	36
Abstain	8

## 7. Bone protection in advanced prostate cancer

### 7.1. HSPC

177. In patients with mHSPC on long term continuous ADT based therapy, do you recommend initiating therapy for prevention of cancer treatment induced bone loss other than calcium, vitamin D3 and exercise?

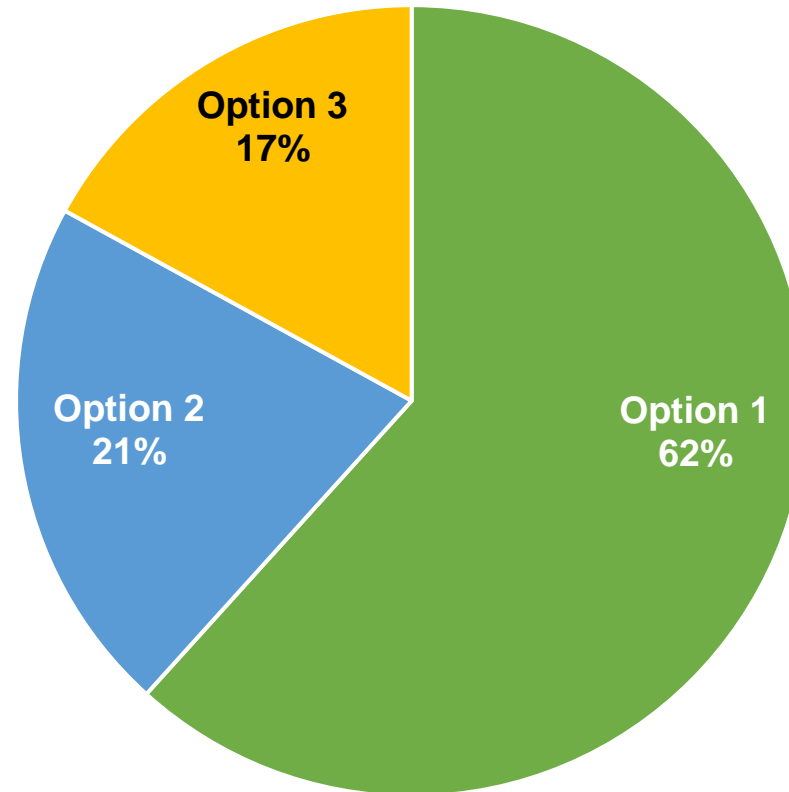
1. Yes, in the majority of patients
2. Yes, in selected patients (e.g., according to ESMO or NCCN guideline or bone mineral density scan)
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	42
Option 2	60
Option 3	2
Abstain	2

178. If you recommend antiresorptive therapy in a patient with mHSPC on continuous ADT based therapy, what do you recommend?

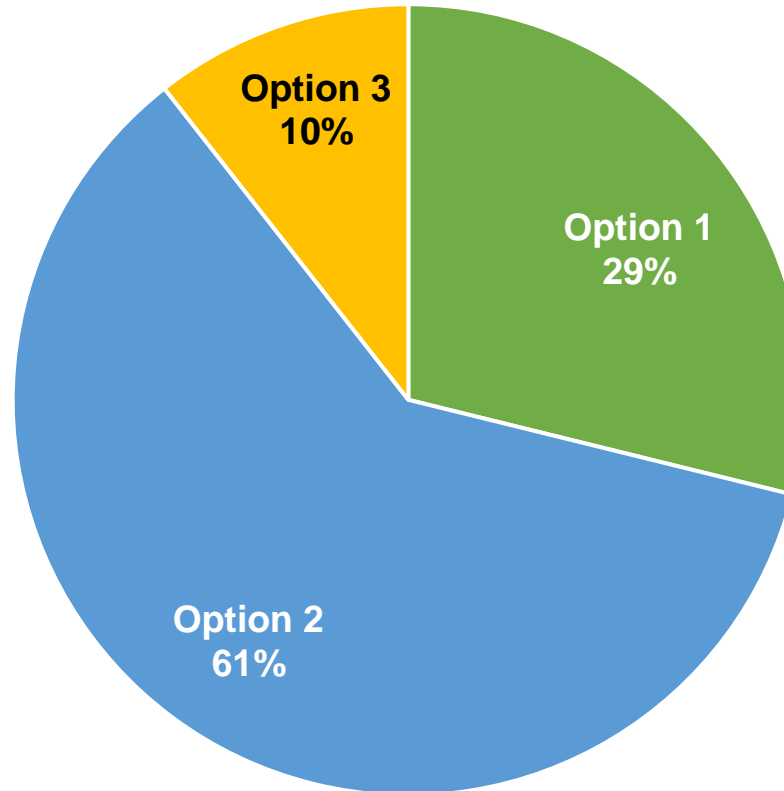
1. Denosumab 60mg q6 months subcutaneously
2. Bisphosphonate q12 months intravenously
3. Oral bisphosphonate
4. Abstain/unqualified to answer (including I do not recommend antiresorptive therapy in these patients)



Option	Votes
Option 1	58
Option 2	20
Option 3	16
Abstain	12

179. In patients with high-risk localised/locally advanced prostate cancer on ADT based therapy for 2-3 years, do you recommend initiating therapy for protection of cancer treatment induced bone loss other than calcium, vitamin D3 and exercise?

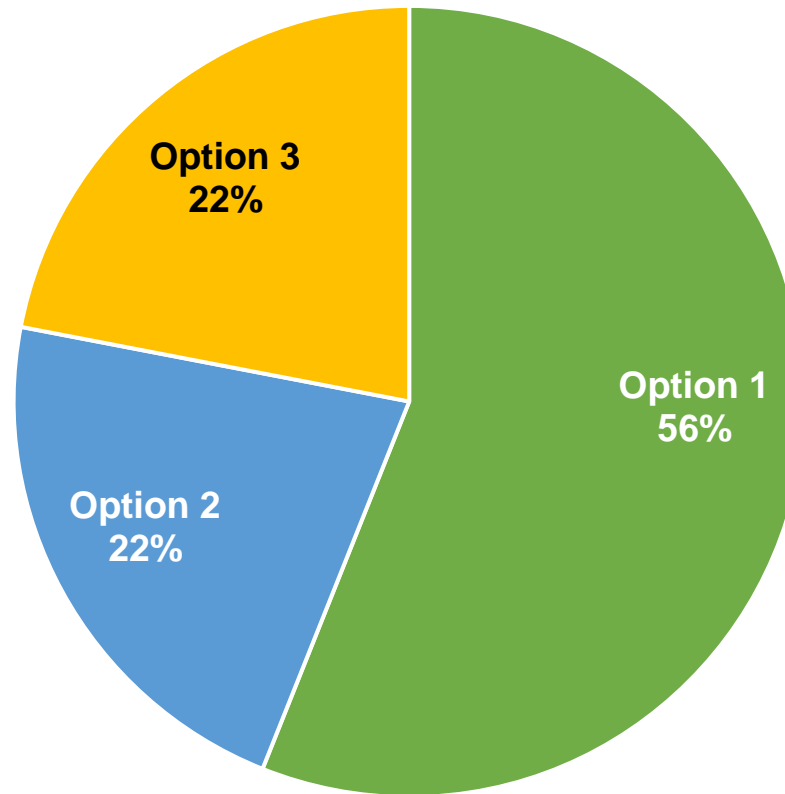
1. Yes, in the majority of patients
2. Yes, in selected patients (e.g., according to ESMO or NCCN guideline or bone mineral density scan)
3. No
4. Abstain/unqualified to answer



Option	Votes
Option 1	30
Option 2	63
Option 3	11
Abstain	2

180. If you recommend antiresorptive therapy in a patient with high-risk localised/locally advanced prostate cancer on ADT based therapy for 2-3 years, what do you recommend?

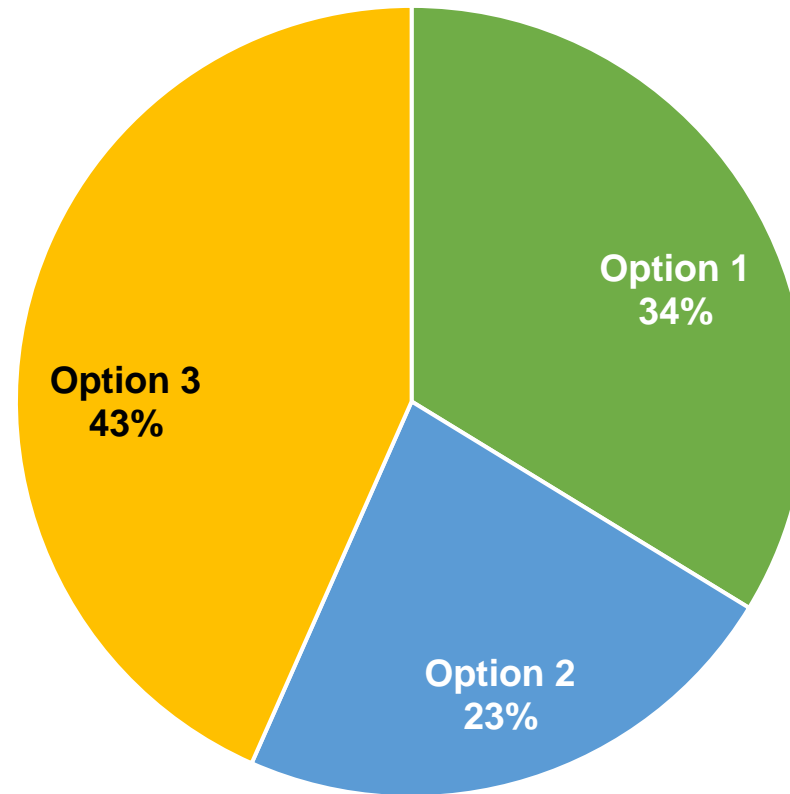
1. Denosumab 60mg q6 months subcutaneously
2. Bisphosphonate q12 months intravenously
3. Oral bisphosphonate
4. Abstain/unqualified to answer



Option	Votes
Option 1	51
Option 2	20
Option 3	20
Abstain	15

181. For the majority of patients with HSPC on denosumab (2x/year) who have to stop treatment with denosumab, do you recommend a consolidating dose of zoledronic acid to prevent bone loss upon discontinuation of denosumab?

1. Yes, in the majority of patients
2. Yes, but only in selected patients
3. No
4. Abstain/unqualified to answer (including: I do not recommend denosumab in this situation)



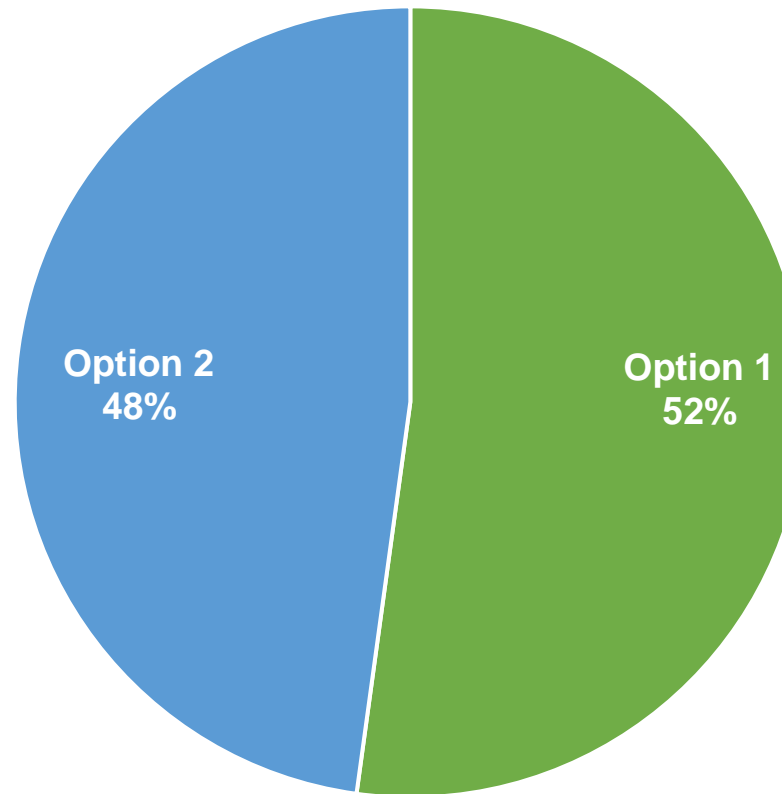
Option	Votes
Option 1	28
Option 2	19
Option 3	36
Abstain	23

## 7. Bone protection in advanced prostate cancer

### 7.2. CRPC

182. For the majority of patients with mCRPC and bone metastases what do you recommend regarding dose/frequency when starting of bone targeting agents?

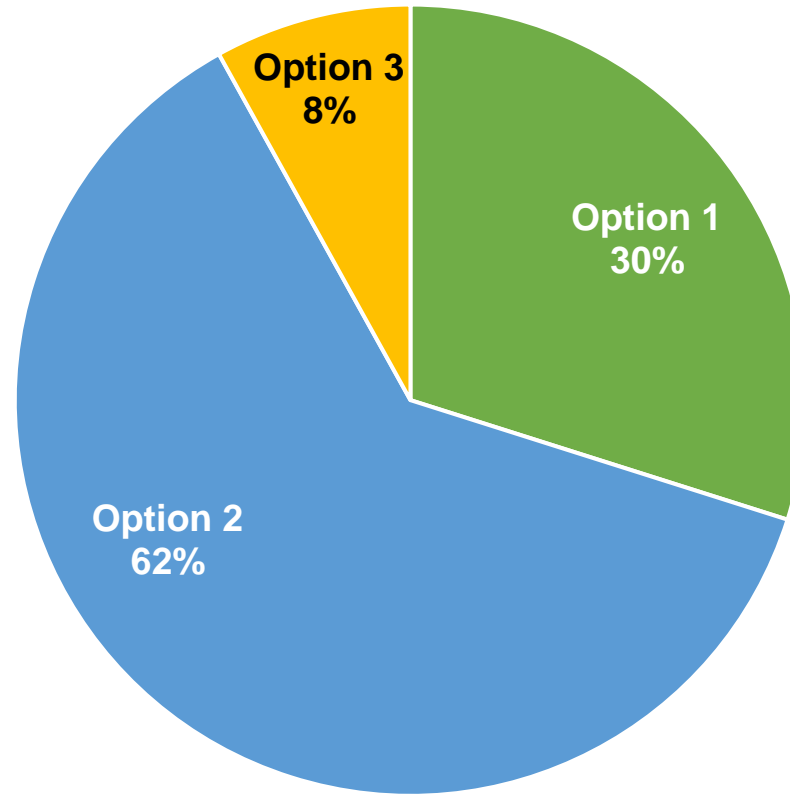
1. Monthly administrations
2. Three monthly administrations ( $\pm$  loading phase)
3. Abstain/unqualified to answer



Option	Votes
Option 1	48
Option 2	44
Abstain	14

183. For the majority of patients with mCRPC and bone metastases on monthly denosumab or zoledronic acid what do you recommend in the absence of toxicity?

1. Stop bone targeting agent after 2 years
2. Continue bone targeting agent after 2 years and reduce frequency of administration
3. Continue bone targeting agent monthly also after 2 years
4. Abstain/unqualified to answer



Option	Votes
Option 1	26
Option 2	54
Option 3	7
Abstain	19