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GUARD INTERNATIONAL SYMPOSIUM

GU-Alliance for Research and Development

PRESENCIAL RETRANSMITIDO EN DIRECTO
FACE-TO-FACE AND LIVE STREAMING



16-18 SEPTIEMBRE 2026

Espacio Maldonado, Madrid

**Actualización en el manejo del mHSPC
oligometastásico. ¿Cómo implementar el uso
de la PET con PSMA en esta población?**

Nick James

Institute of Cancer Research and Royal Marsden Hospital, London

Overview

Defining oligo-metastatic disease

Impact of new generation imaging on staging

- PSMA-PET
- Whole body MRI

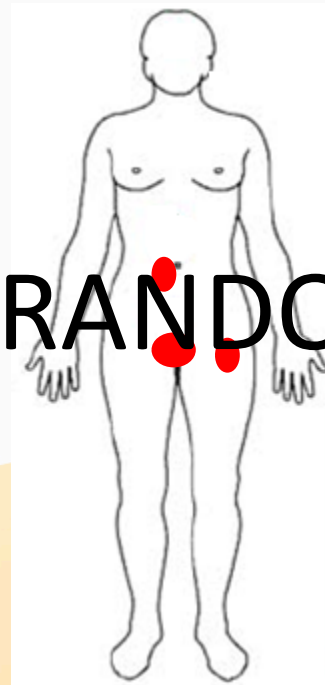
How should we use PSMA PET in the rapidly changing modern landscape

Minimal residual disease – a new therapeutic space?

Defining Oligometastatic Subtypes

Synchronous Oligometastasis/low volume

A clinical scenario in which oligometastatic disease is detected at the time of diagnosis of the primary tumour.



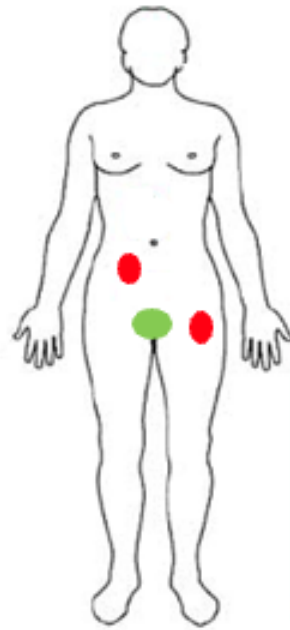
- Untreated Distant Metastasis
- Untreated Primary Lesion

NO RANDOMISED TRIAL DATA

Defining Oligometastatic Subtypes

Oligo-Recurrent or Metachronous Oligometastasis/low volume

The development of oligometastatic disease after treatment of the primary tumour.

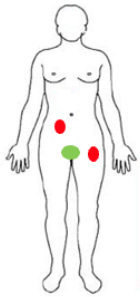


- Untreated Distant Metastasis
- Treated Primary Lesion

Defining Oligometastatic Subtypes

Oligo-Recurrent or Metastatic
volume

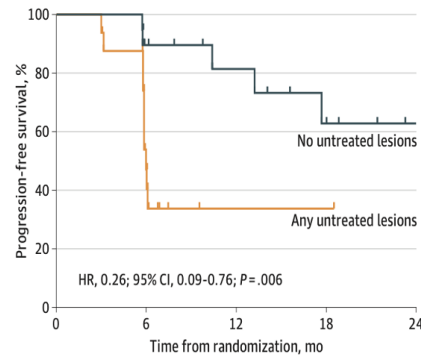
The development of oligometastatic disease from a primary tumour.



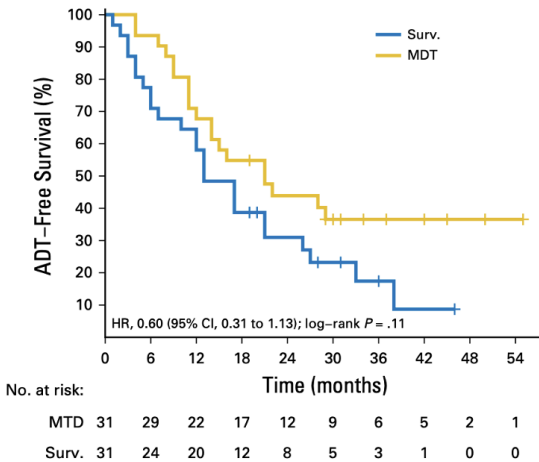
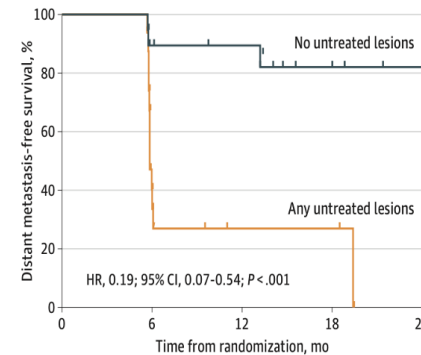
● Untreated
● Treated

ORIOLE and STOMP

C PFS stratified by presence of untreated lesions



D DMFS stratified by presence of untreated lesions



- Progression at 6 months was 5% with no untreated lesions and 38% with untreated lesions

- Median ADT-free survival of 21m vs 13m with MDT
- Median time to PSA progression 10m v 6m with MDT

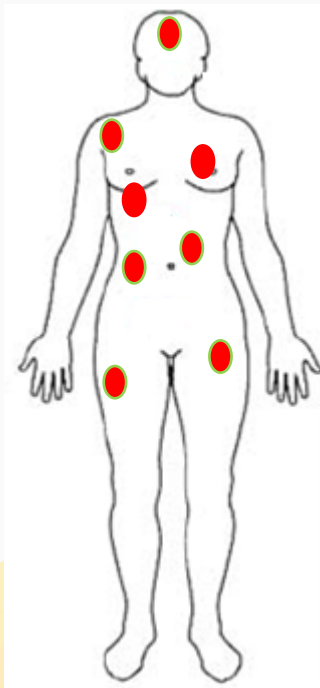
Phillips *et al.*, *JAMA Oncol.* 2020

Ost *et al.*, *JCO*, 2020

Defining Oligometastatic Subtypes

Oligo-persistent Metastasis:

Most sites disappear, some persist with therapy

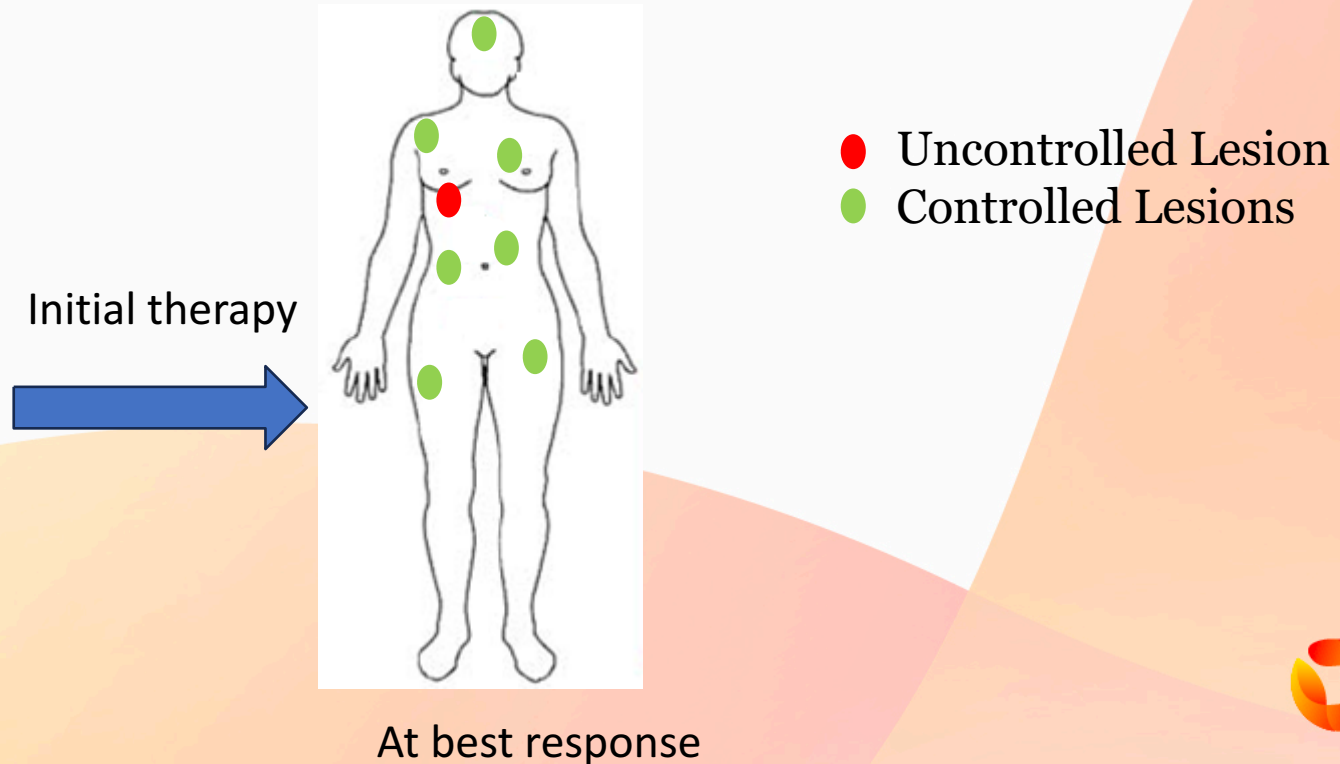


- Uncontrolled Lesion
- Controlled Lesions

Defining Oligometastatic Subtypes

Oligo-persistent Metastasis:

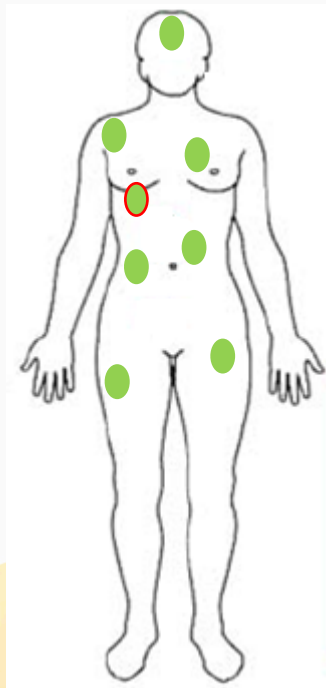
Most sites disappear, some persist with therapy



Defining Oligometastatic Subtypes

Oligo-progressive Metastasis:

Most sites disappear, some persist with therapy

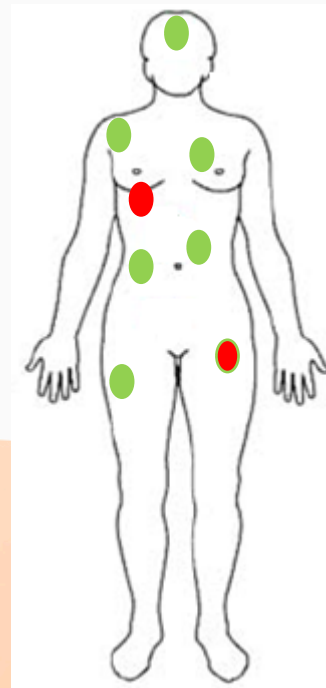


- Uncontrolled Lesion
- Controlled Lesions

Defining Oligometastatic Subtypes

Oligo-progressive Metastasis:

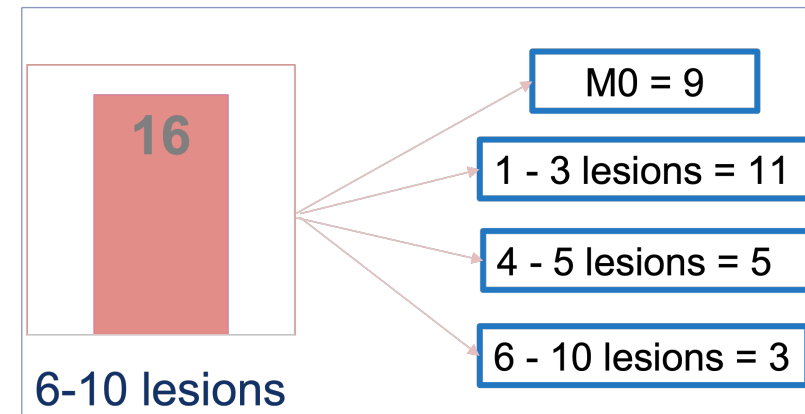
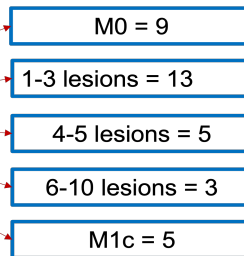
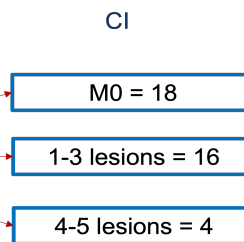
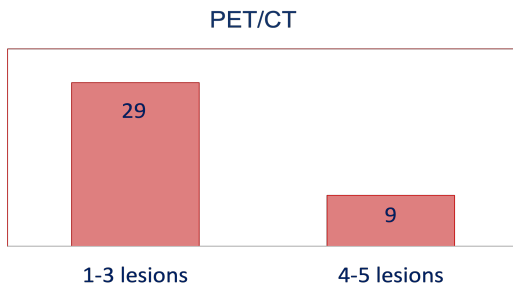
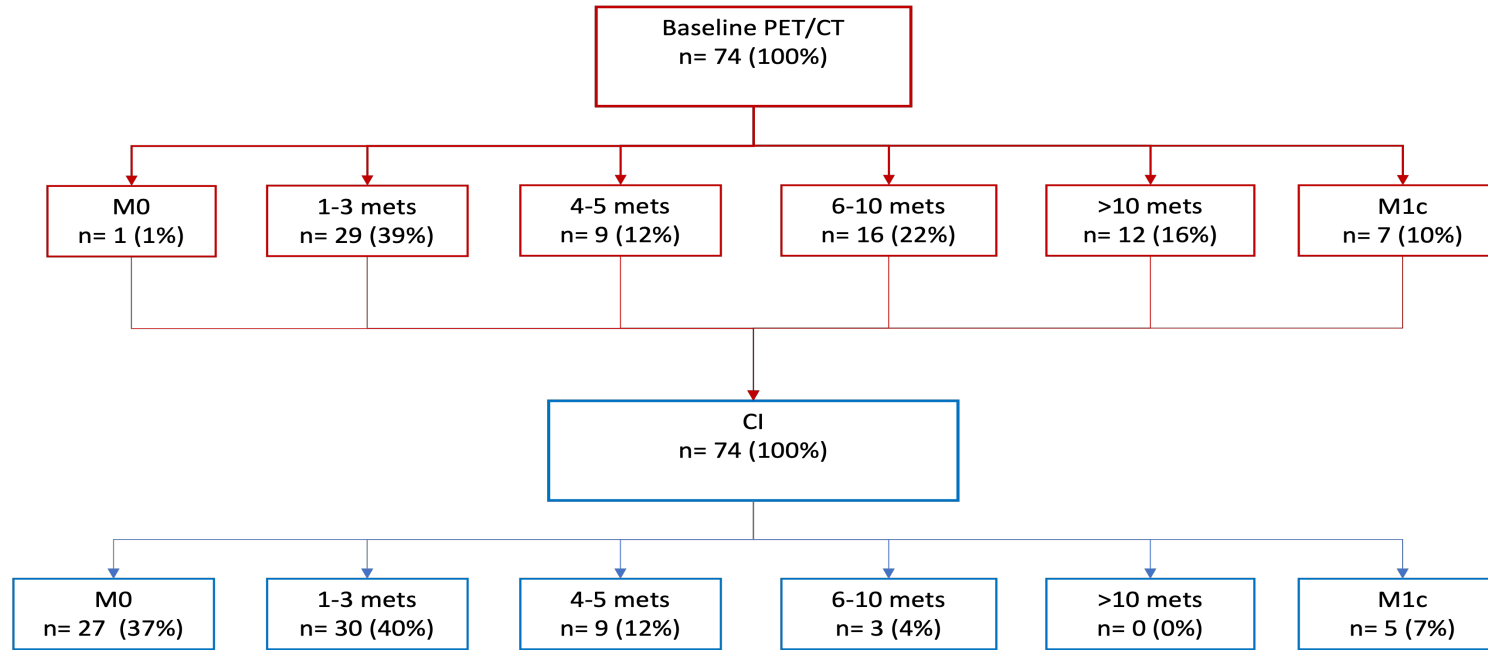
Most sites disappear, some persist with therapy



- Uncontrolled Lesion
- Controlled Lesions

At disease progression

**HOW DOES CONVENTIONAL STAGING
RELATE TO PSMA-PET?**



62.5% OMD on CI
31% M0 on CI

1 3 Implications

Many previous M0 patients will be staged as M1 with PSMA-PET

Treat as M1?

- May be undertreating the primary

Treat as M0?

- May be undertreating the metastases

Low burden M1 patients will be staged as high burden with PSMA-PET

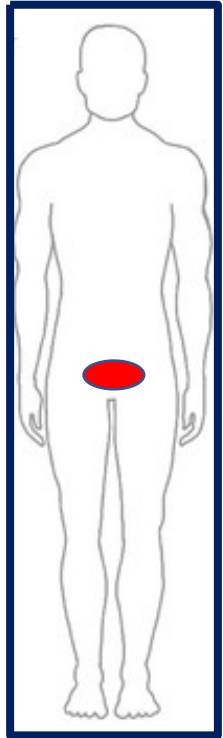
Treat as low burden

- may omit docetaxel inappropriately

Treat as high burden

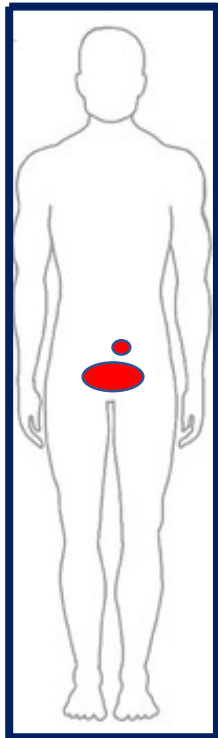
- may overtreat with chemotherapy
- May undertreat the primary

De novo prostate cancer therapy



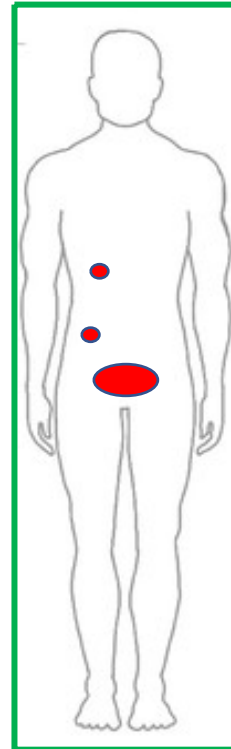
PRIMARY
DISEASE

ADT + Prostate
RT



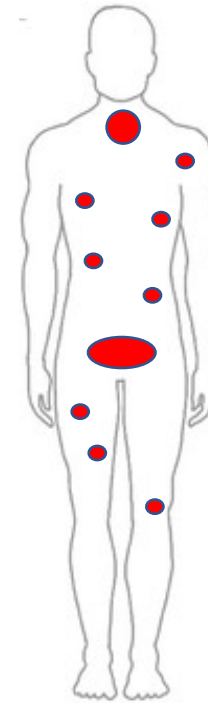
NODE+
DISEASE

ADT + Prostate
+ nodal RT



LOW-VOLUME
< 4 bone lesions

ADT+ ARTI +
Prostate RT
? Add MDT



HIGH-VOLUME CHARTED
≥ 4 bone lesions

ADT + Docetaxel +
ARTI

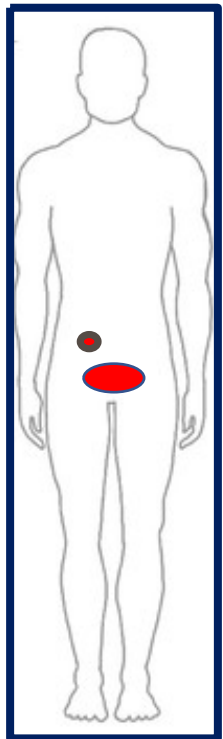
STANDARD IMAGING
(BONE SCAN + CT scan)

Low risk localized



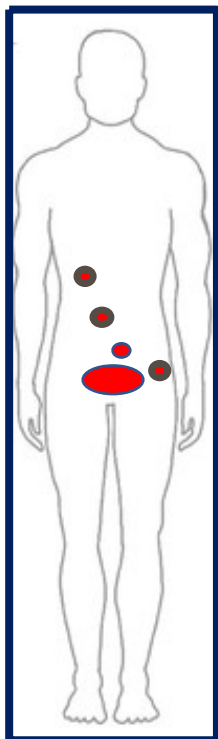
Full blown metastatic

The stage migration in the *de-novo* setting



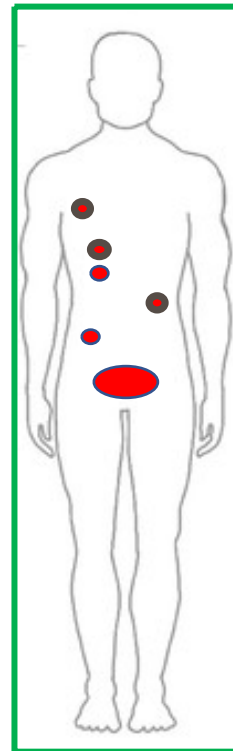
PRIMARY
DISEASE

ADT + Prostate
RT ?+ nodal RT



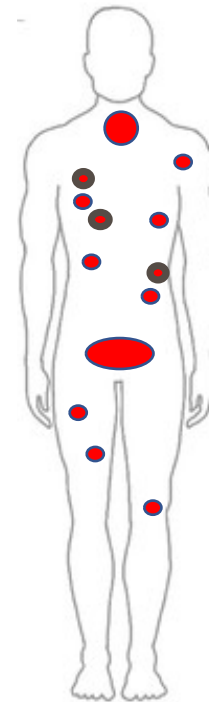
NODE+
DISEASE

ADT + Prostate
+ nodal RT
?+ PA Nodal RT



LOW-VOLUME
< 4 bone lesions

ADT+ ARTI +
~~Prostate RT~~
~~?Add MDT~~



HIGH-VOLUME CHARTED
≥ 4 bone lesions

ADT + Docetaxel +
ARTI

STANDARD IMAGING
(BONE SCAN + CT scan)

+ PSMA-PET

Low risk localized

NEXT-GENERATION IMAGING (PSMA PET-CT)

Full blown metastatic

Implications for practice

Much of the literature no longer informative

Need to do trials to test the predictive benefit of new generation imaging

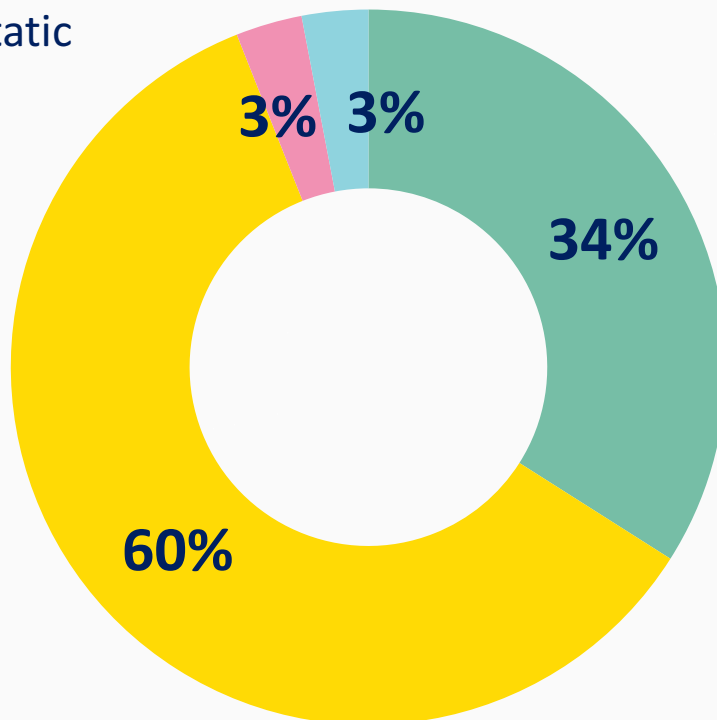
**DOES BASELINE IMAGING PREDICT
RESPONSE OR RELAPSE?**

Patterns of response vs disease volume

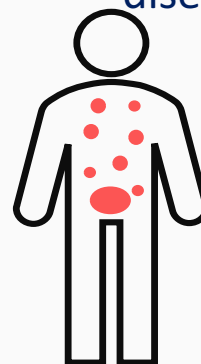
A) Oligometastatic disease



n= 35/99 (35%)



B) Polymetastatic disease



n= 39/85 (46%)

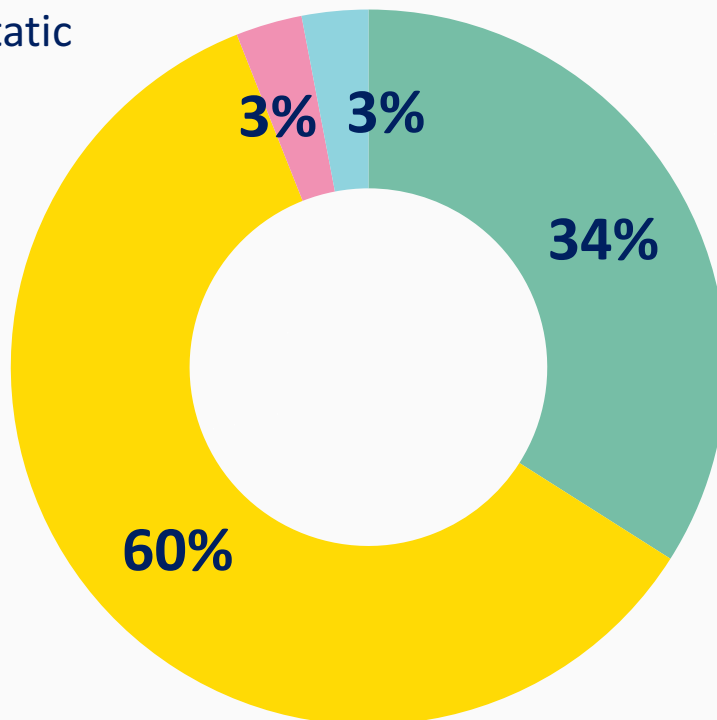
■ Complete response ■ Partial response ■ Stable disease ■ Not evaluable

Patterns of response vs disease volume

A) Oligometastatic disease



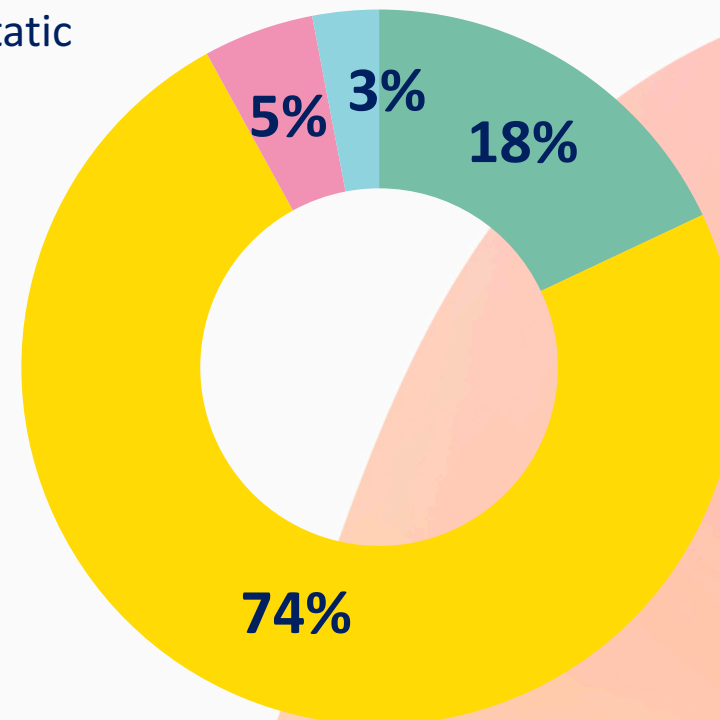
n= 35/99 (35%)



B) Polymetastatic disease



n= 39/85 (46%)



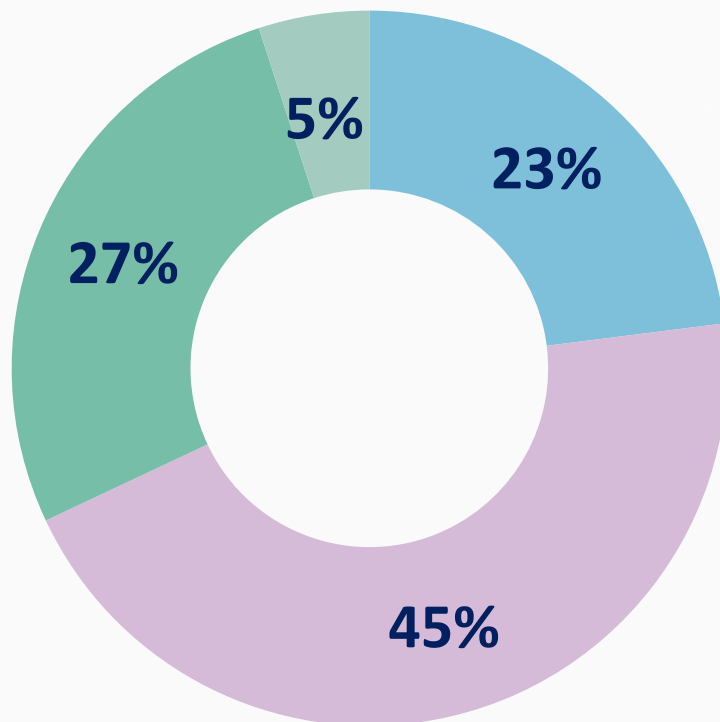
■ Complete response ■ Partial response ■ Stable disease ■ Not evaluable

Patterns of relapse vs disease volume

A) Oligometastatic disease



n= 22/99 (22%)



B) Polymetastatic disease

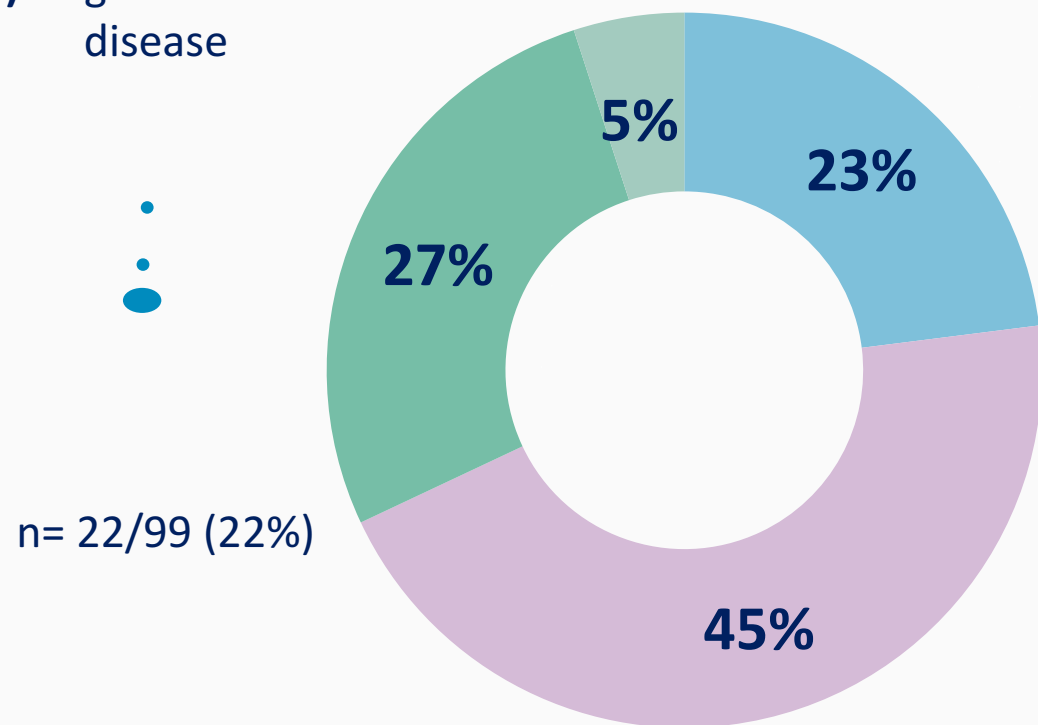


n= 37/85 (44%)

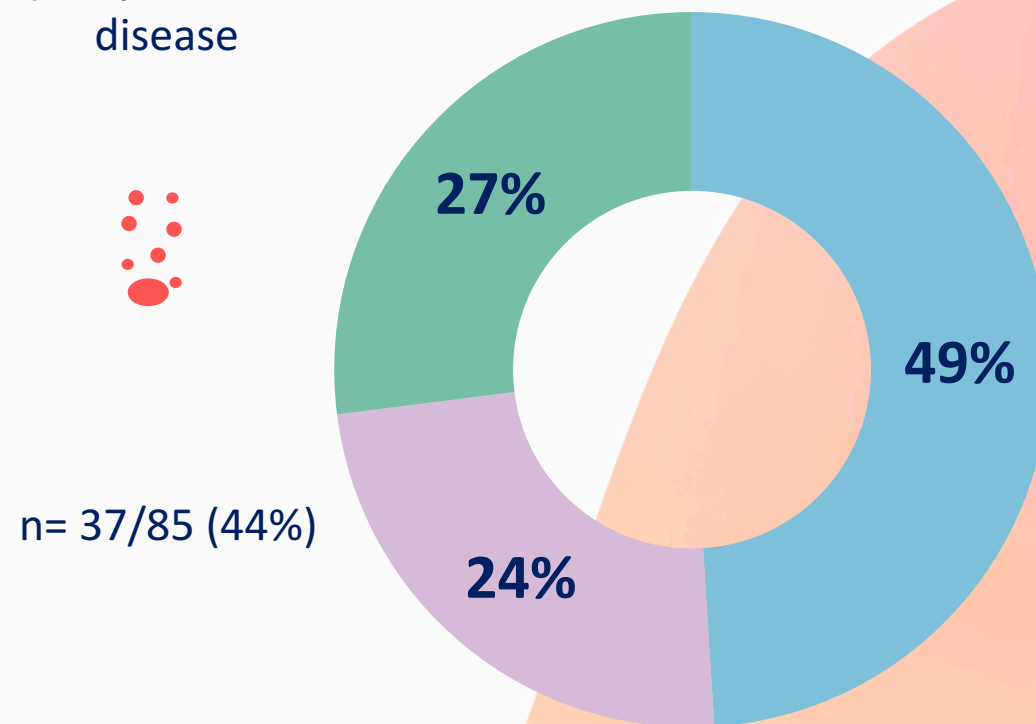
■ Same sites ■ New sites ■ Mixed sites ■ Not evaluable

Patterns of relapse vs disease volume

A) Oligometastatic disease



B) Polymetastatic disease



■ Same sites ■ New sites ■ Mixed sites ■ Not evaluable

Implications for practice

Oligometastatic disease may never recur at site of presentation without need for ablative therapy

At progression lesions frequently appear at completely new sites

Therefore

- 1. Cannot assume upfront SBRT is of benefit**
- 2. Trials needed in oligo-persistent and oligo-progressive settings**

Can we extend the envelope of cure to low volume metastatic patients

STAMPEDE2 (James), PEARLS (Murray), STARTRAP (Murray)

All comparing non-curative standard of care (SOC) with SOC + SBRT to sites of metastasis.

STAMPEDE2 (bone metastasis focus) and PEARLS (nodal metastasis only) – radiotherapeutic intensification at presentation

SOC vs SOC + RT to metastases

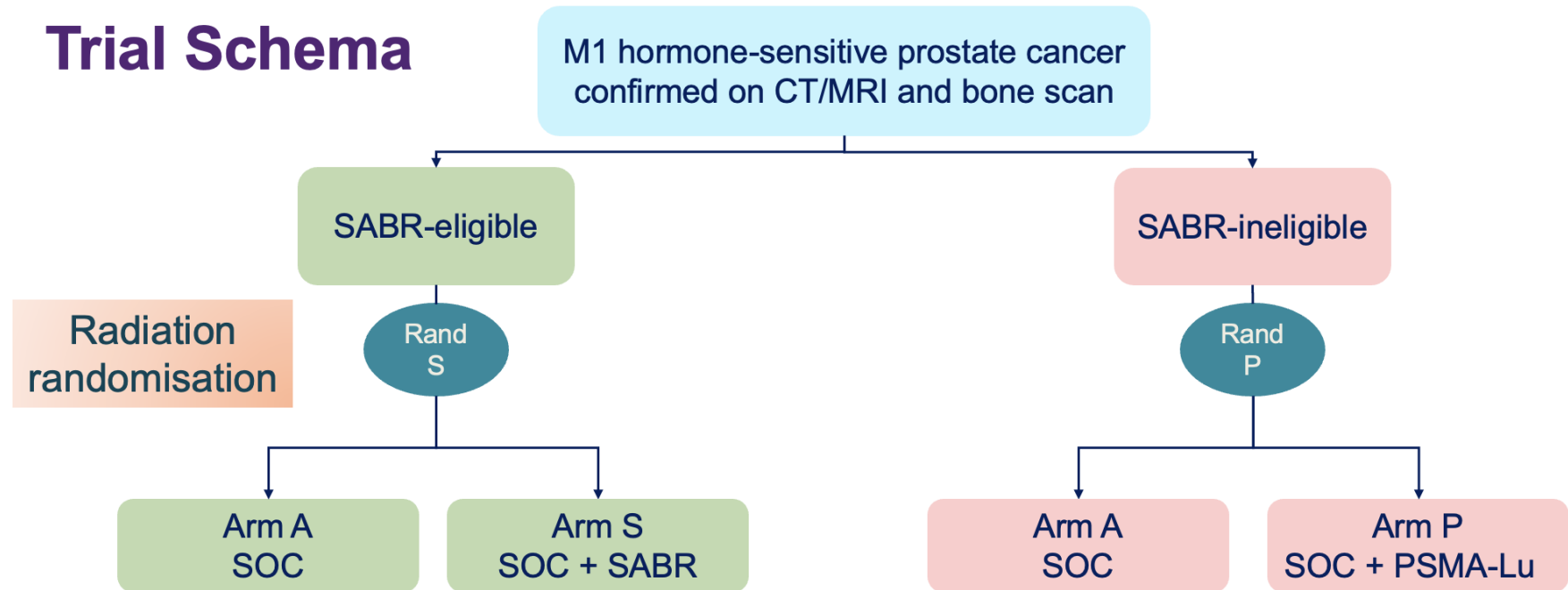
Integrated simultaneous international meta-analysis

STARTRAP – targeting best response intensification or maintenance

Randomised secondary intensification with SBRT to oligometastatic disease at best response and first relapse vs systemic therapy

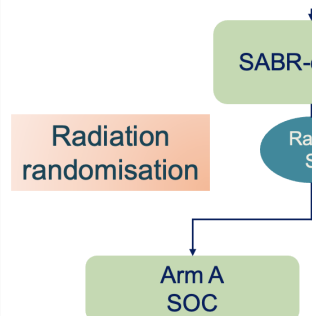
STAMPEDE2

Trial Schema



STAMPEDE2 – de novo oligometastasis

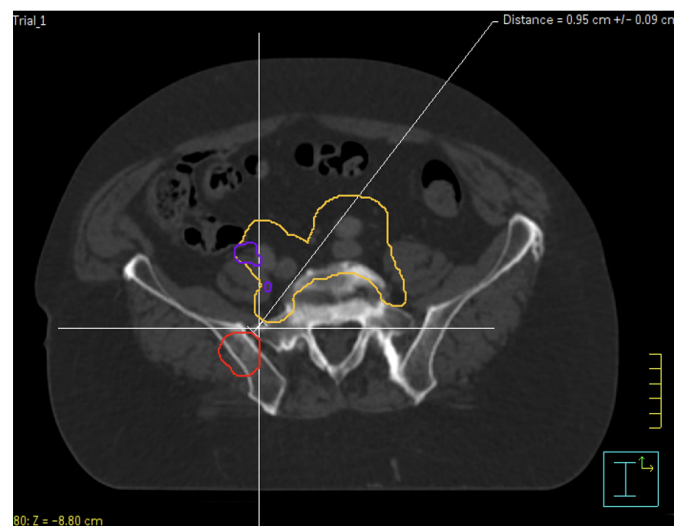
Trial Schema



Example Cases Arm S



Case 3



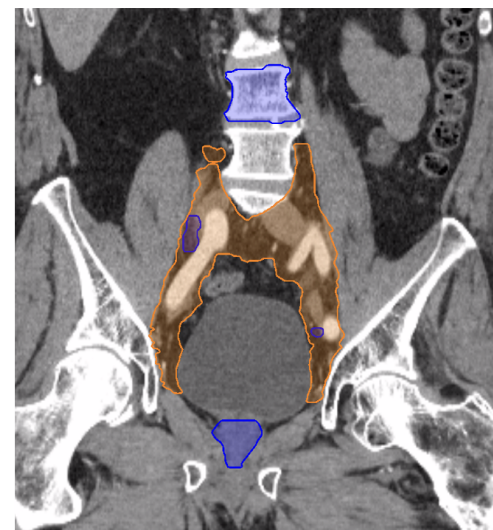
20# to treat prostate, pelvic lymph node and neighbouring bone mets



MRC
Clinical
Trials Unit



Case 4

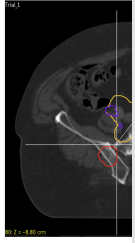


Prostate and pelvic lymph node field extending to L4/5 to include proximal C.I lymph nodes. L3 vertebral mets can be treated with extended PLN field or SABR provided there is at least 2cm gap between PTVs

PEARLS – de novo para-aortic nodal metastasis

Example

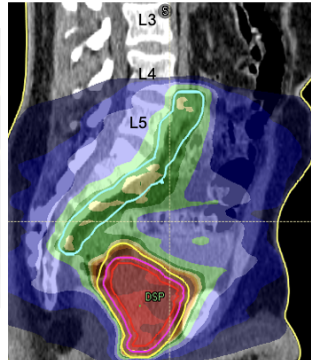
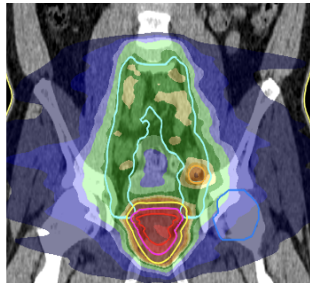
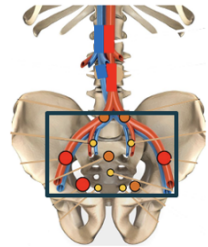
Case 3



20# to treat prostate
neighbouring bone



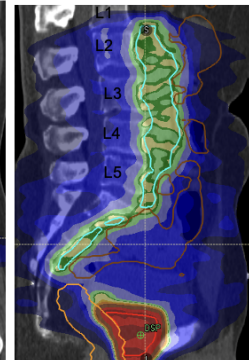
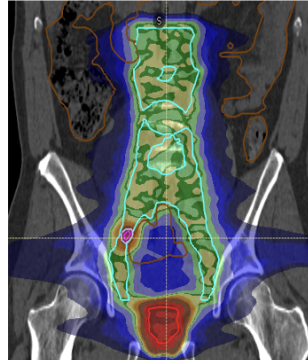
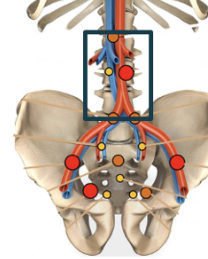
Pelvic lymph node cohort
(PSMA avid lymph nodes
below the L4/L5 interspace)



IMRT
Prostate 60Gy
Pelvic lymph nodes 44Gy
Boost to involved lymph nodes 51Gy

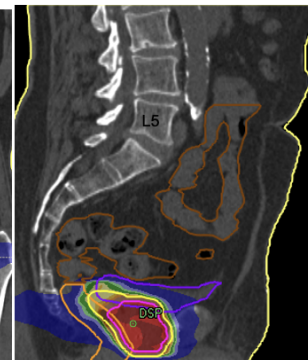
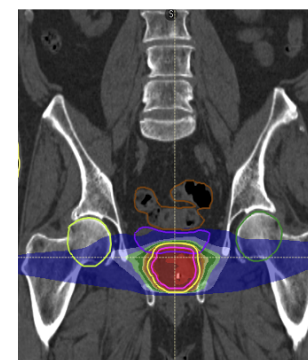
**CONTROL ARM – STANDARD
FIELD**

PA node cohort
(Above the L4/L5 interspace up
to L1/L2 interspace)



IMRT
Prostate 60Gy
Pelvic and para-aortic lymph nodes 44Gy
Boost to involved lymph nodes 51Gy

**EXPERIMENTAL ARM – EXTENDED
FIELD**

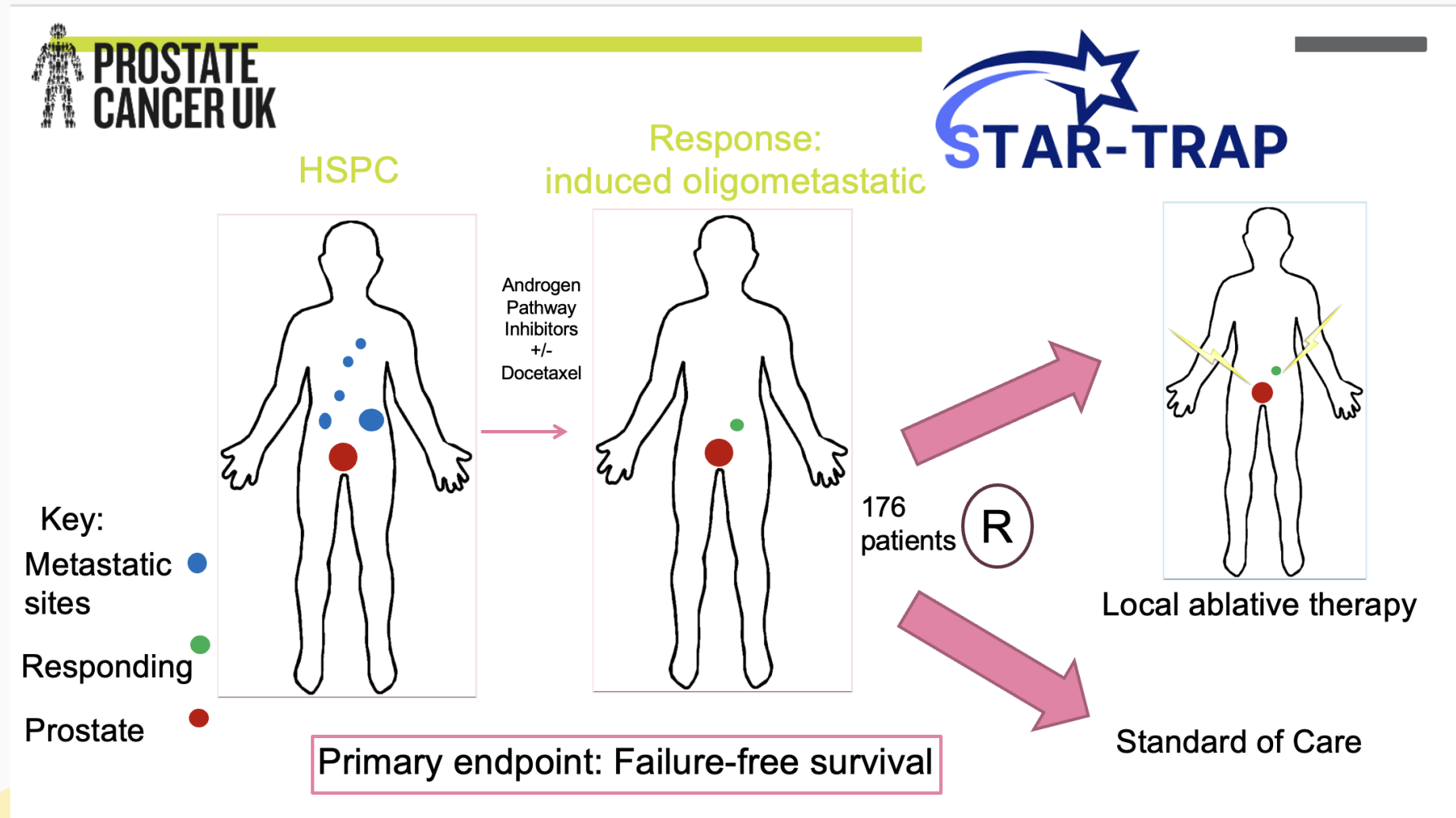


IMRT
Prostate 60Gy
**CONTROL ARM – STANDARD
FIELD**

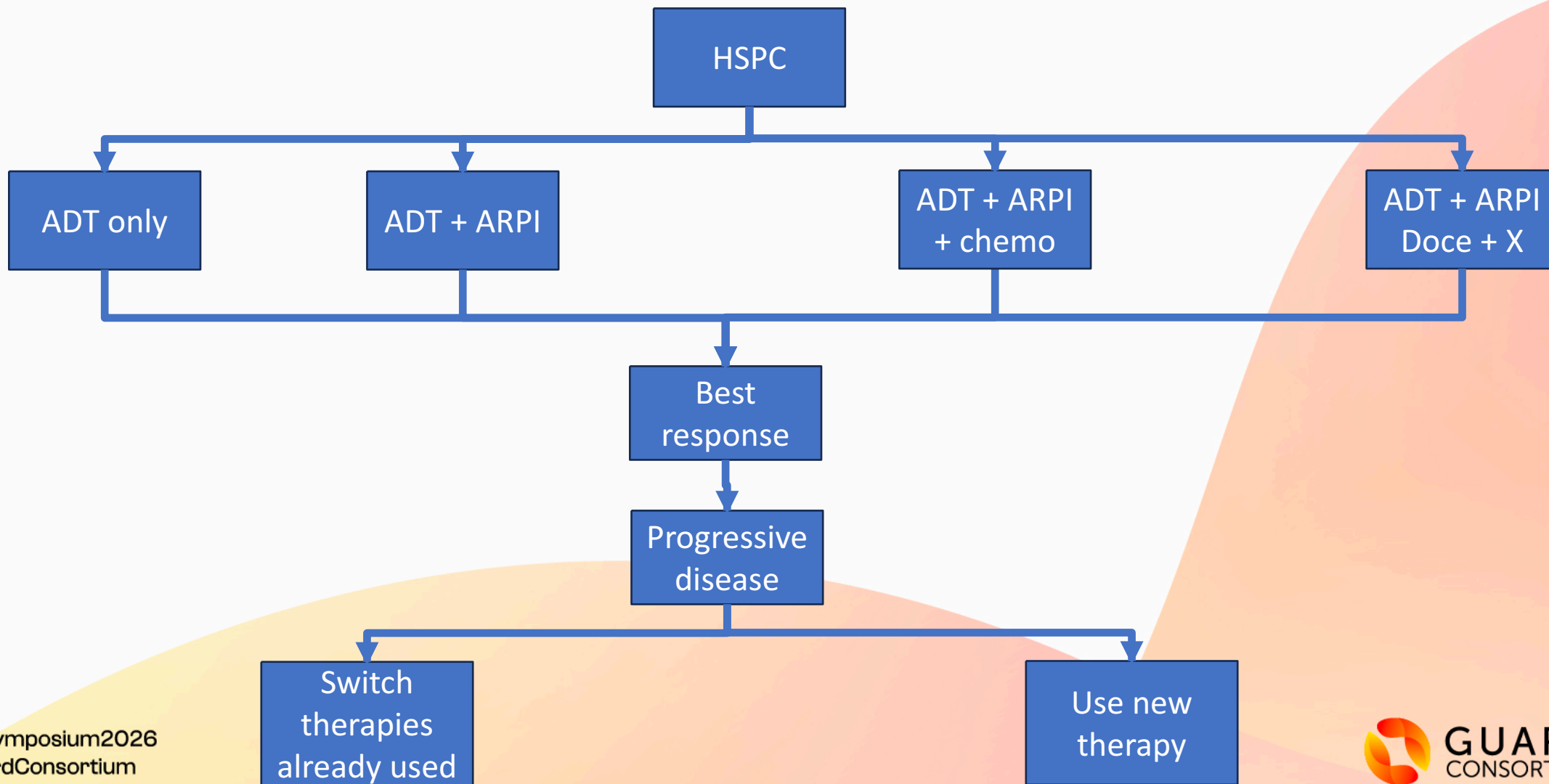


3

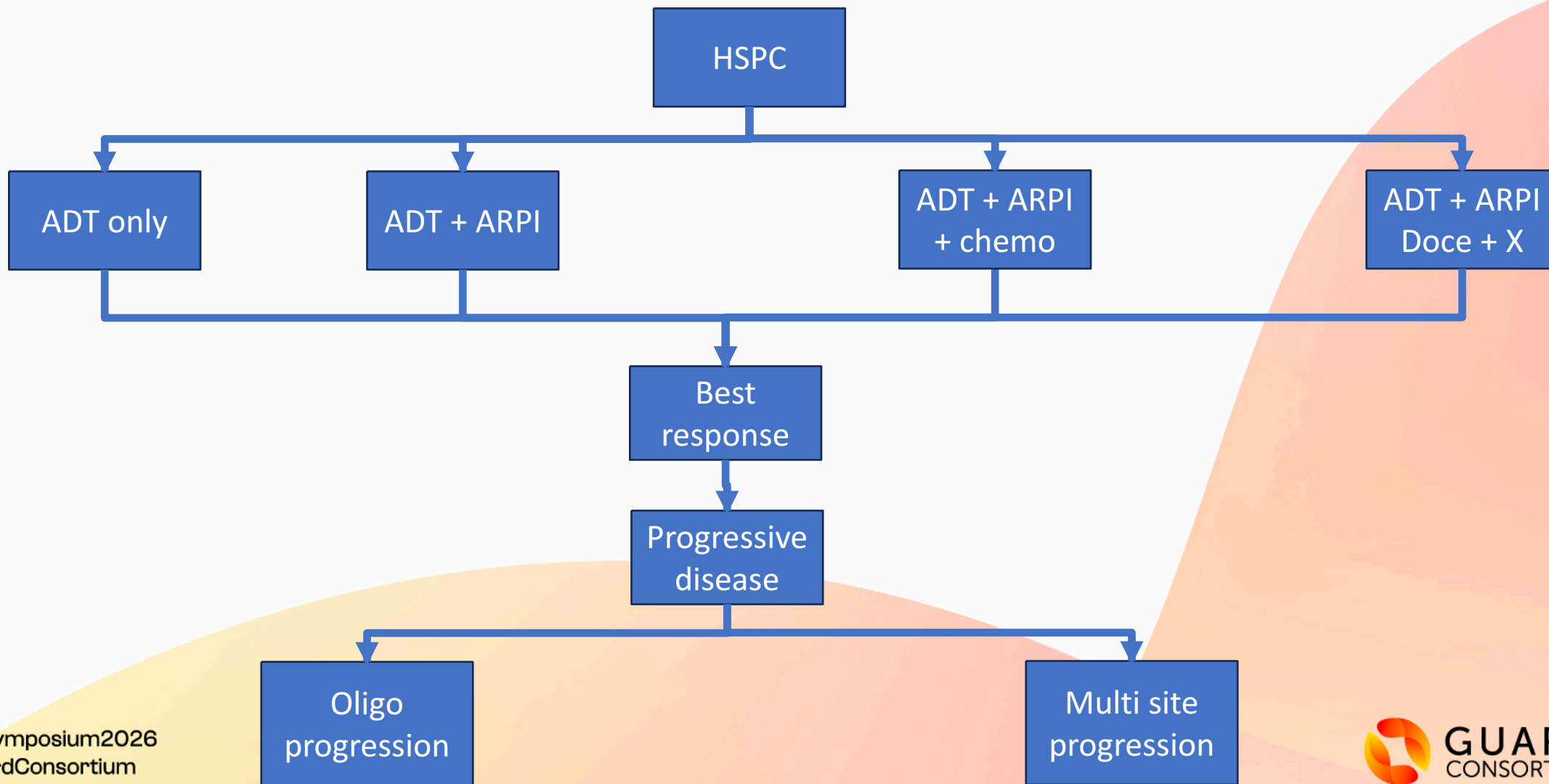
STARTRAP – oligopersistent and oligoprogressive



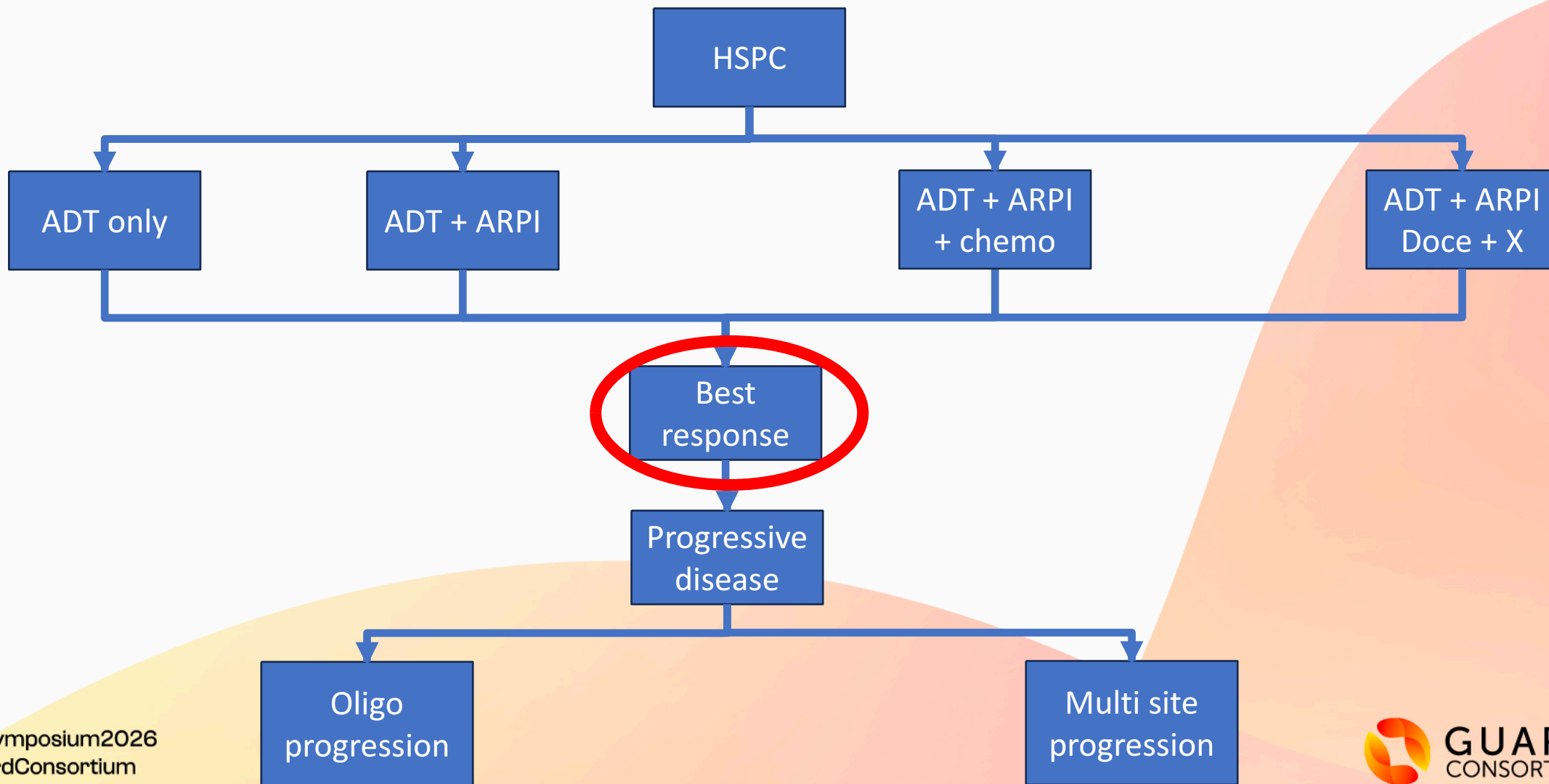
Current approach to relapse therapy



Current approach to relapse therapy



Targeting residual disease



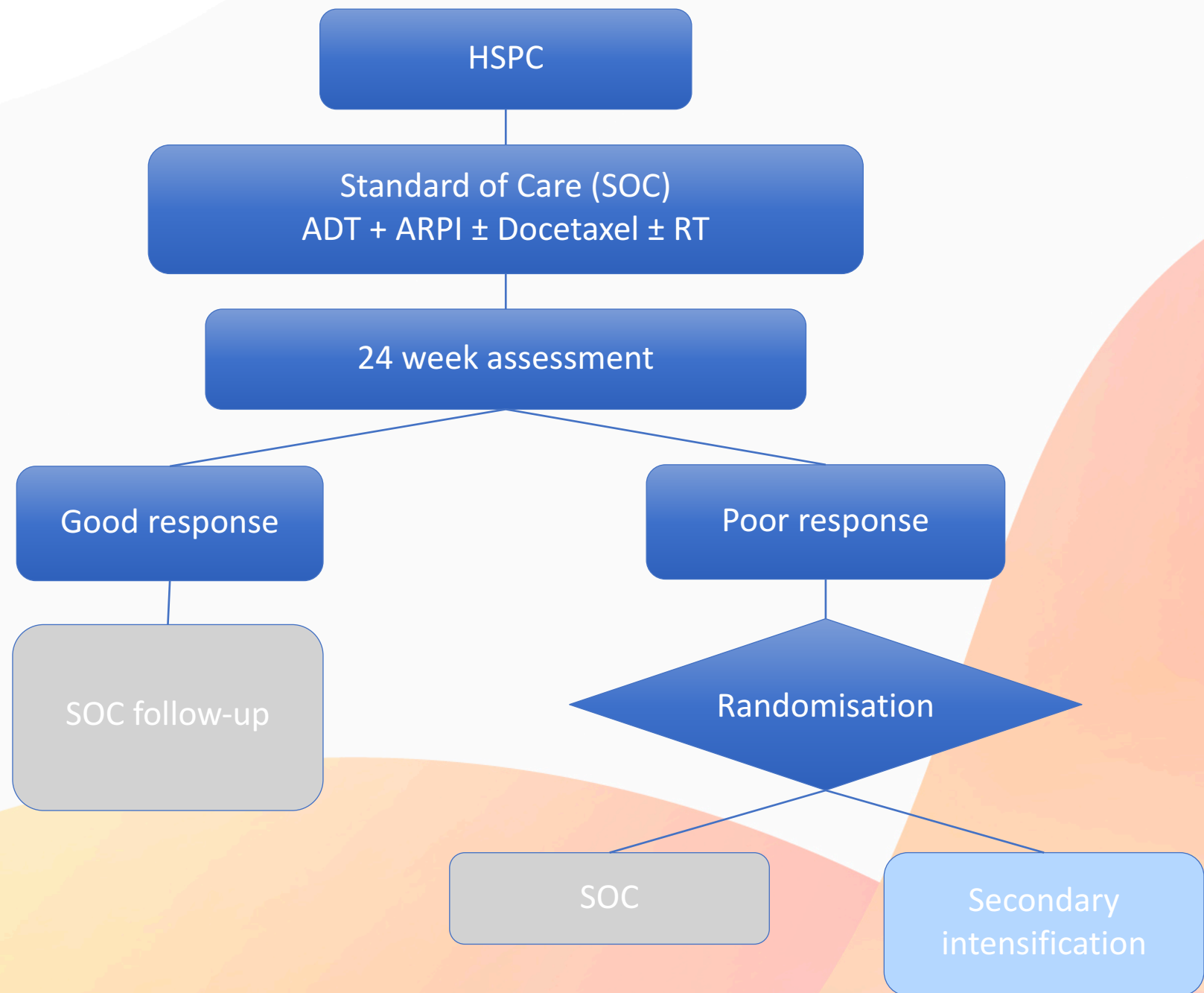
Targeting residual disease

Potentially new area for trials

Can offer metastasis directed therapy

Biopsy and targeted molecular therapy

Can envisage trial platform where randomize vs standard of care.



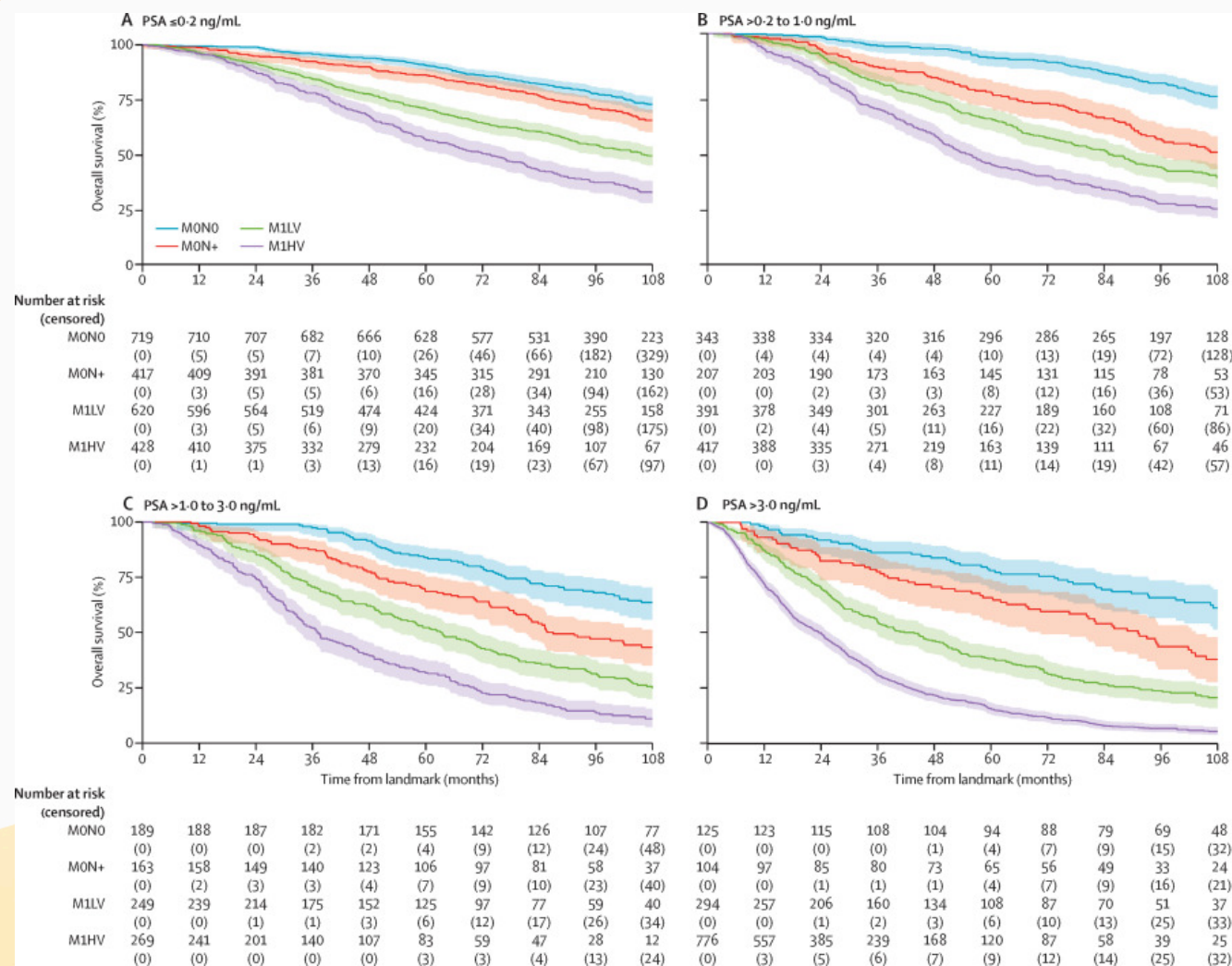
How to define poor response?

PSA

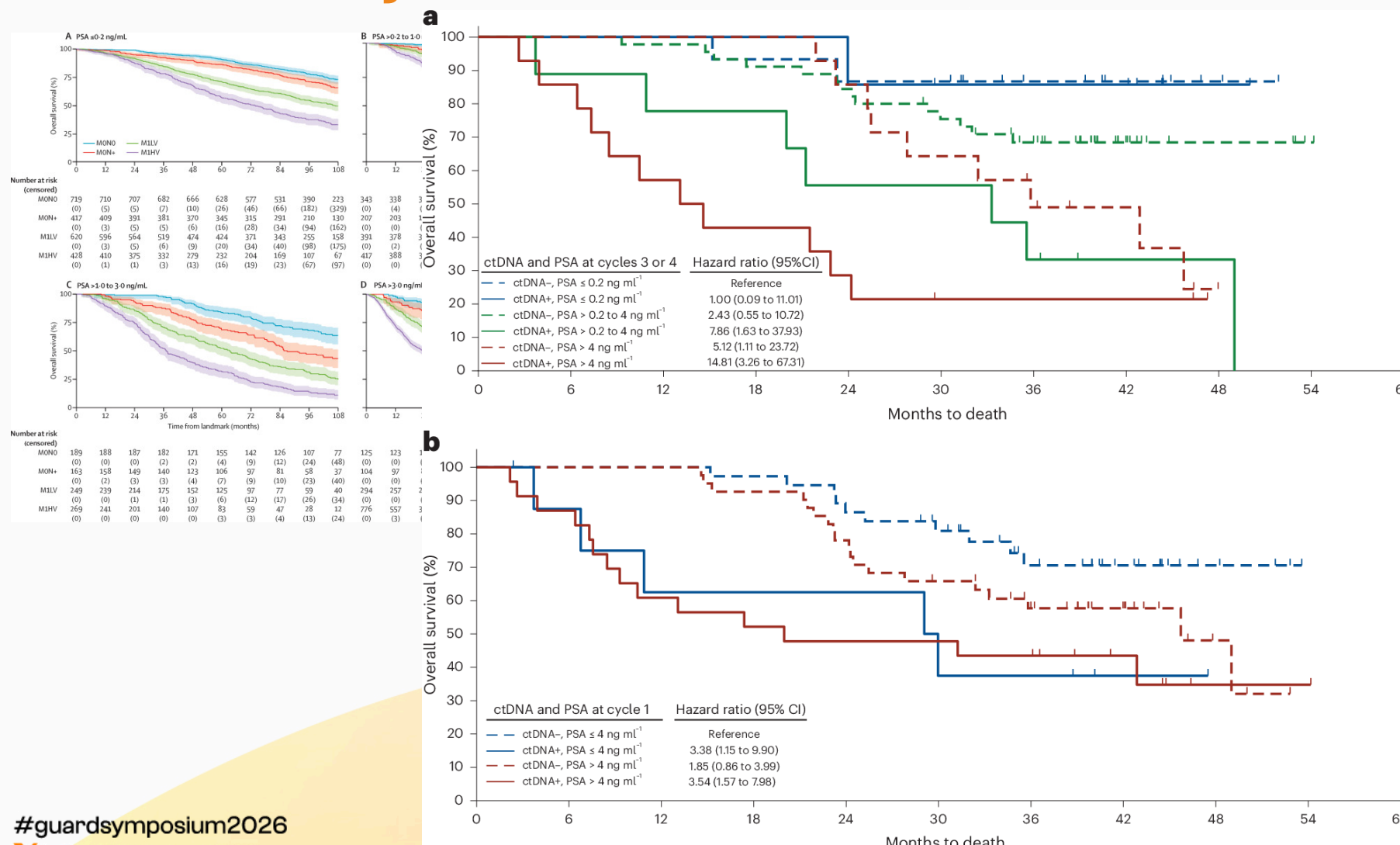
ctDNA

Imaging

PSA nadir, ctDNA and overall survival

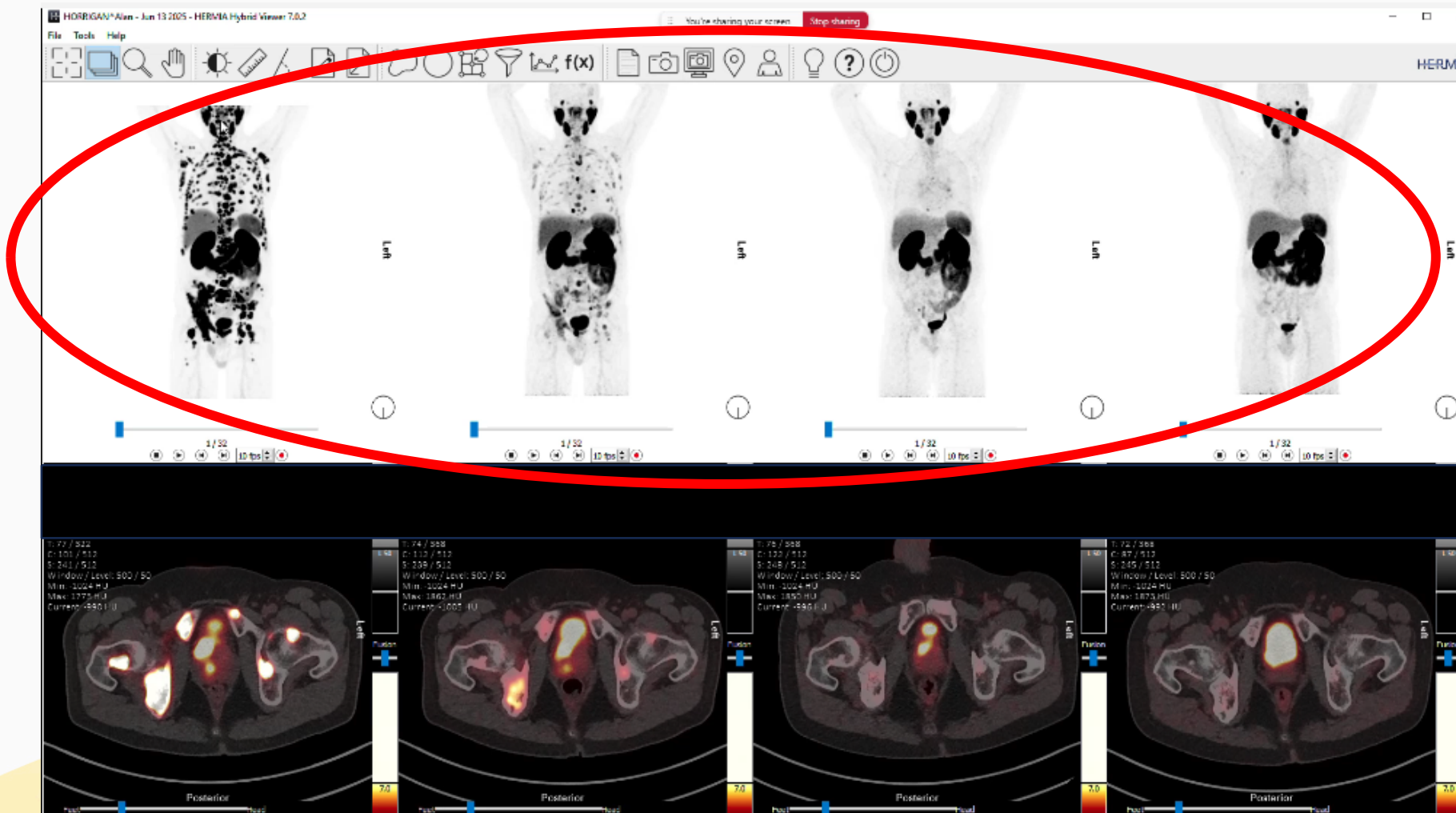


PSA nadir, ctDNA and overall survival



STAMPEDE2 Imaging

Imaging –
near
complete
response



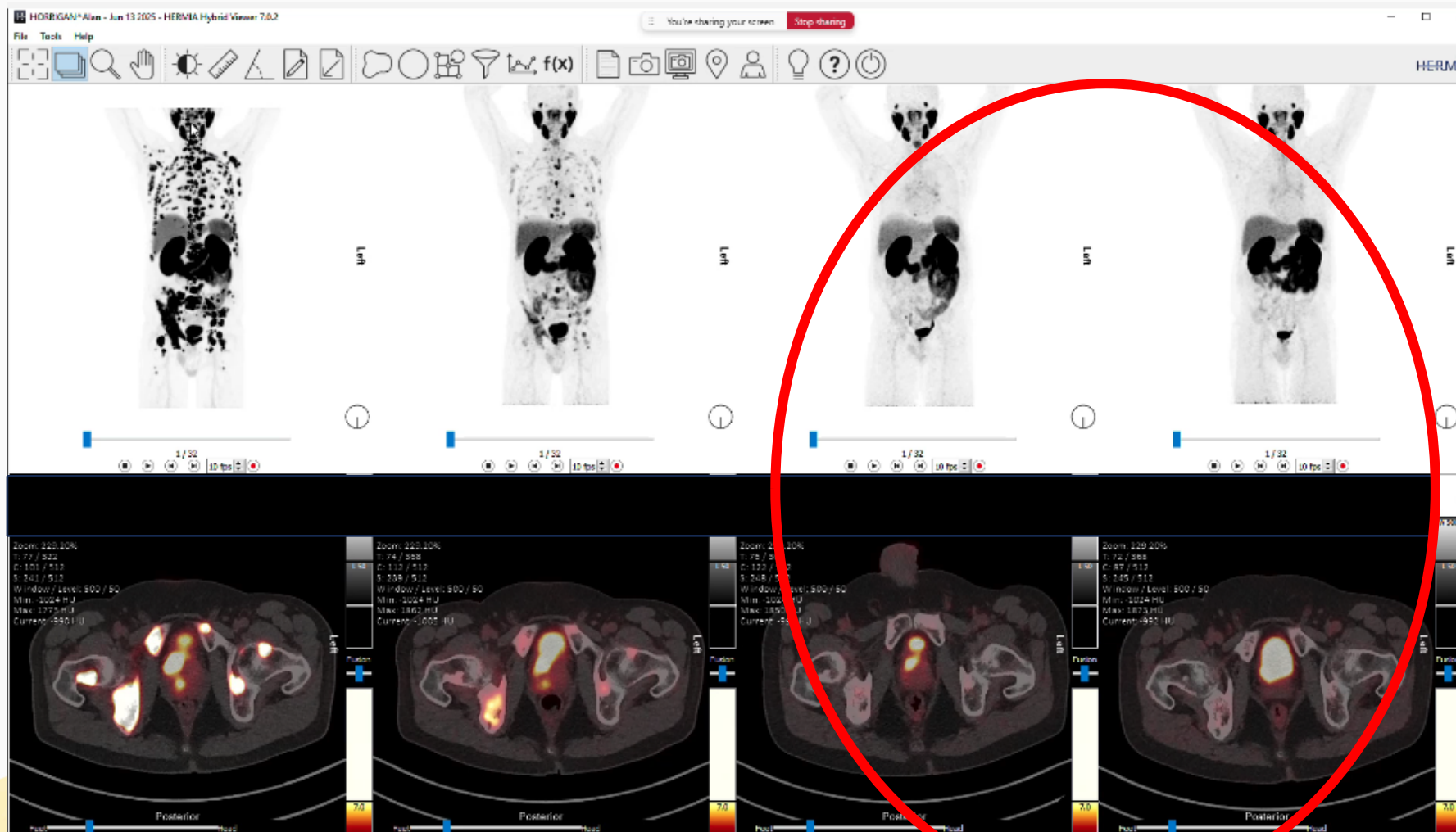
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STAMPEDE2 Imaging

Imaging –
residual
prostate
disease

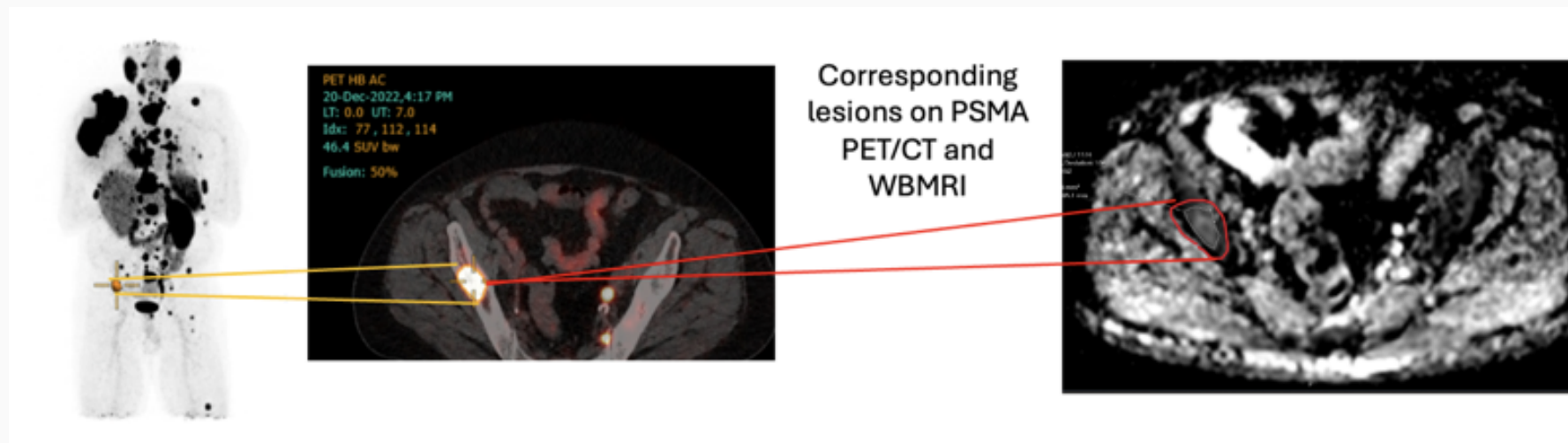


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Targeted biopsies of residual disease



PSMA-PET

MRI

Key points

- MRI gives detailed information on sites with viable tumor
- We have in house expertise on targeted biopsy of bone lesions

Conclusions

New generation imaging is problematic with respect to treatment guidelines

BUT

Exciting new interventions and trial design opportunities opening up

Can we start to cure oligometastatic disease?

¡Gràcias!