**Supplemental Appendix 1.** Questions and Expert Responses (N=38) From USPCC Sessions on mCRPC and Aggressive Variant/Neuroendocrine Prostate Cancer

**6. Aggressive Variant/Neuroendocrine Prostate Cancer**

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| --- | --- | --- |
| **6.1** Do you use platinum-based chemotherapy for patients with mCRPC in the absence of DNA repair gene alterations? | | |
| **Answer** | **#** | **%** |
| Yes | 18 | 50 |
| No | 11 | 31 |
| Abstain | 7 | 19 |

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| --- | --- | --- |
| **6.2** Do you use histologic features to select patients for platinum-based chemotherapy? | | |
| **Answer** | **#** | **%** |
| Yes | 31 | 86 |
| No | 2 | 6 |
| Abstain | 3 | 8 |

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| **6.3** Which histologic features do you use to select patients for platinum-based chemotherapy? | | |
| **Answer** | **#** | **%** |
| Small-cell carcinoma | 7 | 19 |
| Small-cell carcinoma or any features of neuroendocrine prostate cancer (NEPC) on biopsy | 23 | 64 |
| Other histologic features | 0 | 0 |
| I do not use histologic features to select patients for platinum-based chemotherapy | 1 | 3 |
| Abstain | 5 | 14 |

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| **6.4** Do you use the clinical features listed below to select platinum-based chemotherapy for patients with CRPC (1st or 2nd line CRPC) for whom biopsy does not show small-cell carcinoma or NEPC? | | | | | | |
| **Answer** | **Yes** | | **No** | | **Abstain** | |
| **#** | **%** | **#** | **%** | **#** | **%** |
| Liver metastases | 26 | 72.2 | 5 | 13.9 | 5 | 13.9 |
| Low PSA ≤ 10 ng/mL plus ≥ 20 bone metastases on initial presentation or CRPC progression | 15 | 41.7 | 14 | 38.9 | 7 | 19.4 |
| Radiographic progression with PSA ≤ 1 ng/mL | 23 | 63.9 | 10 | 27.8 | 3 | 8.3 |
| Lytic bone metastases | 22 | 61.1 | 11 | 30.6 | 3 | 8.3 |
| Elevated serum neuroendocrine markers (eg, CEA, LDH) | 15 | 41.7 | 14 | 38.9 | 7 | 19.4 |
| Bulky ≥ 5 cm lymphadenopathy or high-grade tumor mass in prostate/pelvis | 14 | 38.9 | 18 | 50 | 4 | 11.1 |
| Short response to initial AR therapy ≤ 6 months | 13 | 36.1 | 16 | 44.4 | 7 | 19.4 |
| Lung metastases | 8 | 22.2 | 21 | 58.3 | 7 | 19.4 |

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| **6.5** Do you use genomic features (other than DNA repair aberrations) to select platinum-based chemotherapy for patients with CRPC when the biopsy does not show small-cell carcinoma or NEPC? | | |
| **Answer** | **#** | **%** |
| Yes | 22 | 61 |
| No | 9 | 25 |
| Abstain | 5 | 14 |

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| **6.6** Which genomic features (other than DNA repair aberrations) do you use to select platinum-based chemotherapy for patients with CRPC when the biopsy does not show small-cell carcinoma or NEPC? | | |
| **Answer** | **#** | **%** |
| RB1 deletion or mutation | 2 | 6 |
| TP53 mutation or deletion | 1 | 3 |
| PTEN deletion | 1 | 3 |
| Concurrent RB1 and TP53 loss of function | 4 | 11 |
| Loss of 2 of 3: RB1, TP53, PTEN | 12 | 33 |
| I do not use genomic features to select patients for platinum-based chemotherapy | 9 | 25 |
| Abstain | 7 | 19 |

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| **6.7** In which of the following situations do you consider doing a biopsy to look for small-cell carcinoma/NEPC? | | | | | | |
| **Answer** | **Yes** | | **No** | | **Abstain** | |
| **#** | **%** | **#** | **%** | **#** | **%** |
| When the development of new liver metastases in setting of low or nonrising PSA occurs? | 35 | 97.2 | 0 | 0 | 1 | 2.8 |
| In the case of PSMA-negative soft tissue or visceral lesions on PSMA-PET/CT? | 30 | 83.3 | 3 | 8.3 | 3 | 8.3 |
| When the development of parenchymal brain metastases occurs? | 22 | 61.1 | 8 | 22.2 | 6 | 16.7 |
| For any patient with CRPC? | 6 | 16.7 | 26 | 72.2 | 4 | 11.1 |

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| **6.8** If small-cell carcinoma/NEPC is suspected, what is the **minimum** evaluation(s) of metastatic biopsies you would complete? | | |
| **Answer** | **#** | **%** |
| Only morphology is required (eg, small cell, large cell, mixed, adenocarcinoma, poorly differentiated) | 0 | 0 |
| Morphology plus immunohistochemistry (IHC) for classical NE markers (eg, SYP, chromogranin, INSM1) | 10 | 28 |
| Morphology plus IHC for PSA and AR | 6 | 17 |
| All of the above | 19 | 53 |
| Abstain | 1 | 3 |

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| **6.9** Do you recommend repeat genomic sequencing in a patient with small-cell/NEPC if they already had genomic sequencing of a prior CRPC biopsy? | | |
| **Answer** | **#** | **%** |
| Yes | 26 | 72 |
| No | 7 | 19 |
| Abstain | 3 | 8 |

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| **6.10** A 69-year-old patient with mCRPC has progression after abiraterone, docetaxel, and cabazitaxel and has undergone a PSMA-PET/CT for consideration of treatment with 177Lu-PSMA-617. His PSA has risen 5 ng/mL to &gt; 9 ng/mL and multiple new PSMA-negative liver metastases are identified, in addition to new PSMA-positive bone metastases. What would you do next? | | |
| **Answer** | **#** | **%** |
| FDG PET | 2 | 6 |
| FDG PET and a biopsy of the liver lesion | 11 | 31 |
| Biopsy of the liver lesion | 15 | 42 |
| Analysis of circulating tumor DNA to look for RB1/TP53/PTEN alterations | 0 | 0 |
| 177Lu-PSMA-617 | 1 | 3 |
| Platinum-based chemotherapy | 4 | 11 |
| None of the above | 0 | 0 |
| Abstain | 3 | 8 |

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| **6.11** What is the preferred nomenclature for a patient with CRPC who develops new liver metastases with PSA < 1 ng/mL and has a liver biopsy that is read as poorly differentiated carcinoma with neuroendocrine features (by morphology and IHC)? | | |
| **Answer** | **#** | **%** |
| Neuroendocrine prostate cancer | 5 | 14 |
| Small cell neuroendocrine prostate carcinoma (SCNPC) | 7 | 19 |
| Aggressive variant prostate cancer (AVPC) | 18 | 50 |
| AR-indifferent prostate cancer | 2 | 6 |
| CRPC | 1 | 3 |
| Not sure | 1 | 3 |
| Abstain | 2 | 6 |

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| **6.12** Which of the following treatments would you use for a patient with CRPC and treatment-emergent small-cell carcinoma/NEPC after progression on ADT plus abiraterone followed by docetaxel with new liver metastases? Serum PSA is < 1 ng/mL. Liver biopsy shows pure small-cell carcinoma, AR-negative, PSA-negative by IHC. A TMPRSS2-ERG gene fusion is detected by DNA sequencing. | | |
| **Answer** | **#** | **%** |
| Carboplatin plus etoposide | 7 | 19 |
| Carboplatin plus etoposide, plus atezolizumab, followed by atezolizumab maintenance | 8 | 22 |
| Carboplatin plus cabazitaxel | 9 | 25 |
| Cabazitaxel | 0 | 0 |
| Other | 1 | 3 |
| Abstain | 11 | 31 |

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| **6.13** What is preferred treatment for a patient with CRPC who develops new liver lesions and has a PSA < 1 ng/mL after progression on ADT plus abiraterone followed by docetaxel? A biopsy shows poorly differentiated adenocarcinoma that is AR-positive and PSA-negative. | | |
| **Answer** | **#** | **%** |
| Carboplatin plus etoposide | 3 | 8 |
| Carboplatin plus etoposide and atezolizumab, followed by atezolizumab maintenance | 2 | 6 |
| Carboplatin plus cabazitaxel | 18 | 50 |
| Cabazitaxel | 2 | 6 |
| PSMA PET and Lu-PSMA-617, if PSMA positive | 3 | 8 |
| Other |  |  |
| Abstain | 8 | 22 |

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| **6.14** Do you recommend brain MRI for patients with treatment-emergent pure small-cell carcinoma/NEPC for staging in the absence of neurological symptoms? | | |
| **Answer** | **#** | **%** |
| Yes | 18 | 50 |
| No | 15 | 42 |
| Abstain | 3 | 8 |

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| --- | --- | --- |
| **6.15** Which of the following therapies would you use as the next line of therapy (off trial) for a fit patient with treatment emergent small-cell carcinoma/NEPC after progression on therapy with carboplatin plus etoposide? | | |
| **Answer** | **#** | **%** |
| Lurbinectedin | 6 | 17 |
| Pembrolizumab | 5 | 14 |
| Taxane | 5 | 14 |
| Other | 5 | 14 |
| Hospice | 1 | 3 |
| Abstain | 14 | 39 |

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| **6.16** Which of the following treatments would you use as the next line of therapy (off trial) for a patient who has AVPC without features of small-cell carcinoma/NEPC after progression on therapy with carboplatin plus cabazitaxel and is PSMA-negative on PET? | | |
| **Answer** | **#** | **%** |
| Lurbinectedin | 5 | 14 |
| Pembrolizumab | 4 | 11 |
| Mitoxantrone | 1 | 3 |
| Other | 8 | 22 |
| Hospice | 3 | 8 |
| Abstain | 15 | 42 |

**7. mCRPC (1 of 3)**

|  |  |  |
| --- | --- | --- |
| **7.1** Can further manipulation of the androgen receptor axis result in clinical meaningful benefit in patients who have received next-generation galeterone analogs (NGGA)? | | |
| **Answer** | **#** | **%** |
| Yes | 17 | 46 |
| No | 2 | 5 |
| Not sure | 12 | 32 |
| Abstain | 6 | 16 |

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| --- | --- | --- |
| **7.2** Does the use of docetaxel in mHSPC, but not mCRPC in the castration-sensitive state, mean that it should not be used in the hormone-sensitive state? | | |
| **Answer** | **#** | **%** |
| No, I do not use docetaxel for mCRPC | 1 | 3 |
| Yes, I would docetaxel for mCRPC | 7 | 19 |
| Yes, I would use docetaxel for mCRPC, but only if PFS at least 12 months post docetaxel for mHSPC | 19 | 51 |
| Not sure | 2 | 5 |
| Abstain | 8 | 22 |

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| --- | --- | --- |
| **7.3** Would you use ARIs for patients with mCRPC if they were previously used for the patients when they had mHSPC? | | |
| **Answer** | **#** | **%** |
| Yes | 26 | 70 |
| No | 8 | 22 |
| Abstain | 3 | 8 |

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| --- | --- | --- |
| **7.4** Do you believe that existing checkpoint inhibitors will ever demonstrate sufficient activity in mCRPC? | | |
| **Answer** | **#** | **%** |
| Yes | 8 | 22 |
| No | 13 | 35 |
| Not sure | 15 | 41 |
| Abstain | 1 | 3 |

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| --- | --- | --- |
| **7.5** Where is the optimal place in the timeline of CRPC to test a novel agent? | | |
| **Answer** | **#** | **%** |
| After all approved therapies have been tried | 2 | 5 |
| First-line mCRPC | 12 | 32 |
| After at least 1 androgen receptor pathway inhibitors (ARPI) and a taxane | 13 | 35 |
| After at least 1 ARPI, a taxane, and 177Lu-PSMA-617 (in eligible patients) | 4 | 11 |
| Not sure | 3 | 8 |
| Abstain | 3 | 8 |

**8. mCRPC—PARPis**

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| --- | --- | --- |
| **8.1** Should PARPi monotherapy be only offered to men with mCRPC who harbor BRCA1/2 mutations? | | |
| **Answer** | **#** | **%** |
| Yes | 17 | 46 |
| No | 15 | 41 |
| Not sure | 2 | 5 |
| Abstain | 3 | 8 |

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| --- | --- | --- |
| **8.2** Should PARPi monotherapy be offered to men with mCRPC who have non-BRCA HRR gene mutations? | | |
| **Answer** | **#** | **%** |
| Yes | 14 | 38 |
| No | 14 | 38 |
| Not sure | 6 | 16 |
| Abstain | 3 | 8 |

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| --- | --- | --- |
| **8.3** Can ctDNA testing alone (without tissue testing) be used to identify and select men for treatment with a PARPi? | | |
| **Answer** | **#** | **%** |
| Yes | 22 | 59 |
| No | 4 | 11 |
| Not sure | 7 | 19 |
| Abstain | 4 | 11 |

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| --- | --- | --- |
| **8.4** Do you recommend rechallenge with another PARPi if the disease progresses on 1 PARPi? | | |
| **Answer** | **#** | **%** |
| Yes | 2 | 5 |
| No | 25 | 68 |
| Not sure | 6 | 16 |
| Abstain | 4 | 11 |

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| --- | --- | --- |
| **8.5** In men with mCRPC with HRR gene alterations, should PARPi monotherapy be preferably offered before or after docetaxel? | | |
| **Answer** | **#** | **%** |
| Before | 29 | 78 |
| After | 1 | 3 |
| Not sure | 5 | 14 |
| Abstain | 2 | 5 |

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| **8.6** Given the potential of marrow toxicities, should there be a defined and fixed duration of treatment with PARPi in those men who continue to respond to PARPi beyond 1-2 years? | | |
| **Answer** | **#** | **%** |
| Yes | 10 | 27 |
| No | 13 | 35 |
| Not sure | 11 | 30 |
| Abstain | 3 | 8 |

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| --- | --- | --- |
| **8.7** Would you consider intermittent PARPi therapy in patients who achieve a deep response to PARPi? | | |
| **Answer** | **#** | **%** |
| Yes | 15 | 41 |
| No | 5 | 14 |
| Not sure | 15 | 41 |
| Abstain | 2 | 5 |

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| --- | --- | --- |
| **8.8a** For men with BRCA altered mCRPC, would you offer PARPi + ARPi? | | |
| **Answer** | **#** | **%** |
| Yes | 31 | 84 |
| No | 0 | 0 |
| Not sure | 2 | 5 |
| Abstain | 4 | 11 |

|  |  |  |
| --- | --- | --- |
| **8.8b** If toxicities lead to discontinuation of a PARPi (without disease progression on the first PARPi), do you feel treatment with another PARPi with nonoverlapping toxicities should be offered? | | |
| **Answer** | **#** | **%** |
| Yes | 20 | 54 |
| No | 5 | 14 |
| Not sure | 10 | 27 |
| Abstain | 2 | 5 |

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| --- | --- | --- |
| **8.9** For men with mCRPC and no pathogenic alterations of HRR, would you offer PARPi + ARPi? | | |
| **Answer** | **#** | **%** |
| Yes | 10 | 27 |
| No | 16 | 43 |
| Not sure | 9 | 24 |
| Abstain | 2 | 5 |

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| --- | --- | --- |
| **8.10** Which PARPi ARPi combinations would you consider offering today if it were FDA approved? Select all that apply | | |
| **Answer** | **#** | **%** |
| Olaparib + abiraterone | 27 | 73 |
| Talazoparib + Enzalutamide | 21 | 57 |
| Niraparib + Abiraterone | 10 | 27 |
| Not sure | 2 | 5 |
| Abstain | 3 | 8 |

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| --- | --- | --- |
| **8.11** For men with BRCA altered mCRPC, would you offer PARPi + ARPi to men who have progressed on a prior ARPi? | | |
| **Answer** | **#** | **%** |
| Yes | 18 | 49 |
| No | 13 | 35 |
| Not sure | 4 | 11 |
| Abstain | 2 | 5 |

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| **8.12** Setting aside regulatory decisions about approval of PARPi ARPi combinations, will you recommend a combinations that improves rPFS but falls short of statistical significance for improving OS? | | |
| **Answer** | **#** | **%** |
| Yes | 23 | 62 |
| No | 6 | 16 |
| Not sure | 5 | 14 |
| Abstain | 3 | 8 |

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| --- | --- | --- |
| **8.13** Should carboplatin be presented to patients with HRRm disease as a less-expensive alternative to PARPi? | | |
| **Answer** | **#** | **%** |
| Yes | 13 | 35 |
| No | 6 | 16 |
| Not sure | 2 | 5 |
| Only for those who cannot afford a PARPi or who are ineligible for a PARPi | 12 | 32 |
| Abstain | 4 | 11 |

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| --- | --- | --- |
| **8.14** If initial NGS testing of the primary tumor reveals no deleterious alterations in HRR genes, do you recommend repeating NGS when the disease progresses to mCRPC? | | |
| **Answer** | **#** | **%** |
| Yes | 30 | 81 |
| No | 4 | 11 |
| Not sure | 1 | 3 |
| Abstain | 2 | 5 |

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| **8.15** Assuming a patient was eligible for PARP inhibitor and radium 223, how would you sequence the two? | | |
| **Answer** | **#** | **%** |
| PARP before radium 223 | 21 | 57 |
| PARP after radium 223 | 2 | 5 |
| PARP in combination with radium 223 | 3 | 8 |
| It depends (open ended response) | 9 | 24 |
| Abstain | 2 | 5 |

**9. mCRPC—Theranostics**

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| **9.1** What are the minimum requirements for PSMA PET in patient selection for 177Lu-PSMA-radioligand therapy (RLT) in the VISION population? | | |
| **Answer** | **#** | **%** |
| No PSMA PET imaging is necessary for patient selection in postchemo population with limited options | 0 | 0 |
| Any PSMA uptake > background in any lesion | 3 | 8 |
| PSMA SUV mean > 10 | 2 | 6 |
| PSMA > liver in some active lesions (but a minority can be PSMA low/negative) | 7 | 19 |
| VISION study protocol (≥ 1 PSMA-positive metastatic lesion [PMSA > liver parenchyma in ≥ 1 metastatic lesion of any size in any organ system] and no PSMA-negative lesions) | 16 | 44 |
| TheraP study protocol (≥ 1 site with SUV max ≥ 20, no FDG+/PSMA- | 2 | 6 |
| PSMA SUV mean > 10 |  |  |
| Not sure | 4 | 11 |
| Abstain | 2 | 6 |

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| --- | --- | --- |
| **9.2** Does it matter which PSMA PET agent is utilized? | | |
| **Answer** | **#** | **%** |
| Yes | 0 | 0 |
| No | 34 | 94 |
| Abstain | 2 | 6 |

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| --- | --- | --- |
| **9.3** Should both PSMA and FDG PET be used in patient selection for 177Lu-PSMA-RLT? | | |
| **Answer** | **#** | **%** |
| Yes | 5 | 14 |
| No | 21 | 58 |
| Not sure | 9 | 25 |
| Abstain | 1 | 3 |

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| --- | --- | --- |
| **9.4** Should most patients being treated in the VISION setting receive combination therapy with ARPI? | | |
| **Answer** | **#** | **%** |
| Yes | 11 | 31 |
| No | 11 | 31 |
| Not sure | 13 | 36 |
| Abstain | 1 | 3 |

|  |  |  |
| --- | --- | --- |
| **9.5** Should patients who have PSMA positive mCRPC who are naïve to chemotherapy receive 177Lu-PSMA-RLT? | | |
| **Answer** | **#** | **%** |
| Yes | 1 | 3 |
| Yes, if they are unfit for chemo | 7 | 19 |
| Yes, if they have balanced discussion and refuse chemo | 2 | 6 |
| Not until full data for randomized trials are released | 17 | 47 |
| Not until guidelines are stated are in favor | 1 | 3 |
| Not until FDA approval | 5 | 14 |
| Never | 0 | 0 |
| Only on trial | 1 | 3 |
| Not sure | 0 | 0 |
| Abstain | 2 | 6 |

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| --- | --- | --- |
| **9.6** What is the minimum pretreatment hemoglobin level used in patient selection for 177Lu-PSMA-RLT? | | |
| **Answer** | **#** | **%** |
| 10 g/dL | 3 | 8 |
| 9 g/dL | 7 | 19 |
| 8 g/dL | 13 | 36 |
| 7 g/dL | 1 | 3 |
| Doesn’t matter if due to marrow infiltration | 5 | 14 |
| Not sure | 6 | 17 |
| Abstain | 1 | 3 |

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| --- | --- | --- |
| **9.7** What is the minimum pretreatment platelet count used in patient selection for 177Lu-PSMA-RLT? | | |
| **Answer** | **#** | **%** |
| 100 x 10^9/L | 9 | 25 |
| 75 x 10^9/L | 12 | 33 |
| 50 x 10^9/L | 5 | 14 |
| 25 x 10^9/L | 0 | 0 |
| Doesn’t matter if due to marrow infiltration | 3 | 8 |
| Not sure | 6 | 17 |
| Abstain | 1 | 3 |

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| --- | --- | --- |
| **9.8** What is the minimum pretreatment neutrophil count used in patient selection for 177Lu-PSMA-RLT? | | |
| **Answer** | **#** | **%** |
| 1.5 x 10^9/L | 12 | 33 |
| 1 x 10^9/L | 10 | 28 |
| Doesn’t matter if due to marrow infiltration | 4 | 11 |
| Not sure | 8 | 22 |
| Abstain | 2 | 6 |

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| --- | --- | --- |
| **9.9** What is the maximum pretreatment serum creatinine used in patient selection for 177Lu-PSMA-RLT? | | |
| **Answer** | **#** | **%** |
| Upper limit of normal (ULN) | 0 | 0 |
| 1.5 x ULN | 18 | 50 |
| 2.5 x ULN | 3 | 8 |
| 3 x ULN | 0 | 0 |
| Doesn’t matter as long as other parameters are OK | 2 | 6 |
| Not sure | 11 | 31 |
| Abstain | 2 | 6 |

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| **9.10** Should anyone receive less than 7.4 GBq (200 mCi) of 177Lu-PSMA-617 in cycle 1 (ie, should there be initial “dose” reductions)? | | |
| **Answer** | **#** | **%** |
| Yes | 4 | 11 |
| No | 16 | 44 |
| Not sure | 14 | 39 |
| Abstain | 2 | 6 |

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| --- | --- | --- |
| **9.11** Should we calculate normal organ dose limits with prior lifetime radiation exposure prior to dosing with therapeutic radionuclide therapy? | | |
| **Answer** | **#** | **%** |
| Yes, I would not treat even if organ function was adequate | 1 | 3 |
| Yes, I would adjust radioactivity dose even if organ function was adequate | 9 | 25 |
| No, I would ignore prior exposure as long as organ function was adequate | 13 | 36 |
| Not sure | 9 | 25 |
| Abstain | 4 | 11 |

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| --- | --- | --- |
| **9.12** Should most patients undergo regular postinfusion SPECT after each treatment with standard of care 177Lu-PSMA-RLT? | | |
| **Answer** | **#** | **%** |
| Yes, with most or all doses | 8 | 22 |
| Yes, at least once per course | 6 | 17 |
| No, only for research | 14 | 39 |
| Not sure | 7 | 19 |
| Abstain | 1 | 3 |

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| --- | --- | --- |
| **9.13** Should patients have serial PSMA PET during treatment with standard of care 177Lu-PSMA-RLT? | | |
| **Answer** | **#** | **%** |
| Yes, PSMA PET is standard imaging to assess response/progression | 5 | 14 |
| Yes, most patients should have at least 1 follow-up PSMA PET | 14 | 39 |
| No, only for research | 14 | 39 |
| Not sure | 2 | 6 |
| Abstain | 1 | 3 |

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| --- | --- | --- |
| **9.14** Should patients with excellent response (>95% PSA reduction, no symptoms of disease, favorable imaging) stop therapy early (less than planned treatment course outside of a study) with planned restart of treatment upon progression? | | |
| **Answer** | **#** | **%** |
| Yes, with up to 1 consolidation cycle | 6 | 17 |
| Yes, only if excellent response is accompanied by PSMA low/negative imaging | 13 | 36 |
| No, in the absence of toxicity, patients should complete their treatment course | 12 | 33 |
| Not sure | 3 | 8 |
| Abstain | 2 | 6 |

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| **9.15** In your opinion, after clinical trials have been completed, what will be the optimal disease state for 177Lu-PSMA-RLT? | | |
| **Answer** | **#** | **%** |
| Postchemo mCRPC | 3 | 8 |
| Prechemo mCRPC | 20 | 56 |
| Overtly (conventional imaging) metastatic noncastrate PC | 6 | 17 |
| Biochemically recurrent PSMA PET plus PC | 1 | 3 |
| High-risk nonmetastatic PC in combination with local therapy | 2 | 6 |
| Not sure | 3 | 8 |
| Abstain | 1 | 3 |

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| --- | --- | --- |
| **9.16** Do you believe that targeted alpha particles will be better than beta particles? | | |
| **Answer** | **#** | **%** |
| Yes | 5 | 14 |
| Yes for efficacy, but I worry about toxicity | 17 | 47 |
| Yes for safety, but I worry about efficacy in the setting of bulky disease | 4 | 11 |
| No, overall therapeutic index of betas will prove more acceptable | 0 | 0 |
| No | 0 | 0 |
| Not sure | 9 | 25 |
| Abstain | 1 | 3 |

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| --- | --- | --- |
| **9.17** Should we use PROs instead of CTCAE to assess nonlaboratory toxicity? | | |
| **Answer** | **#** | **%** |
| Yes | 6 | 17 |
| Yes, for subjective items such as dry mouth | 13 | 36 |
| No, not until there is a validated instrument | 9 | 25 |
| No | 1 | 3 |
| Not sure | 5 | 14 |
| Abstain | 2 | 6 |
| Yes | 6 | 17 |