DEFINING THE PATH FOR

Comprehensive Care of Prostate Cancer Patients Receiving ADT

A road map for Healthcare Professionals

Your patient is starting androgen deprivation therapy (ADT) What comes next ▶
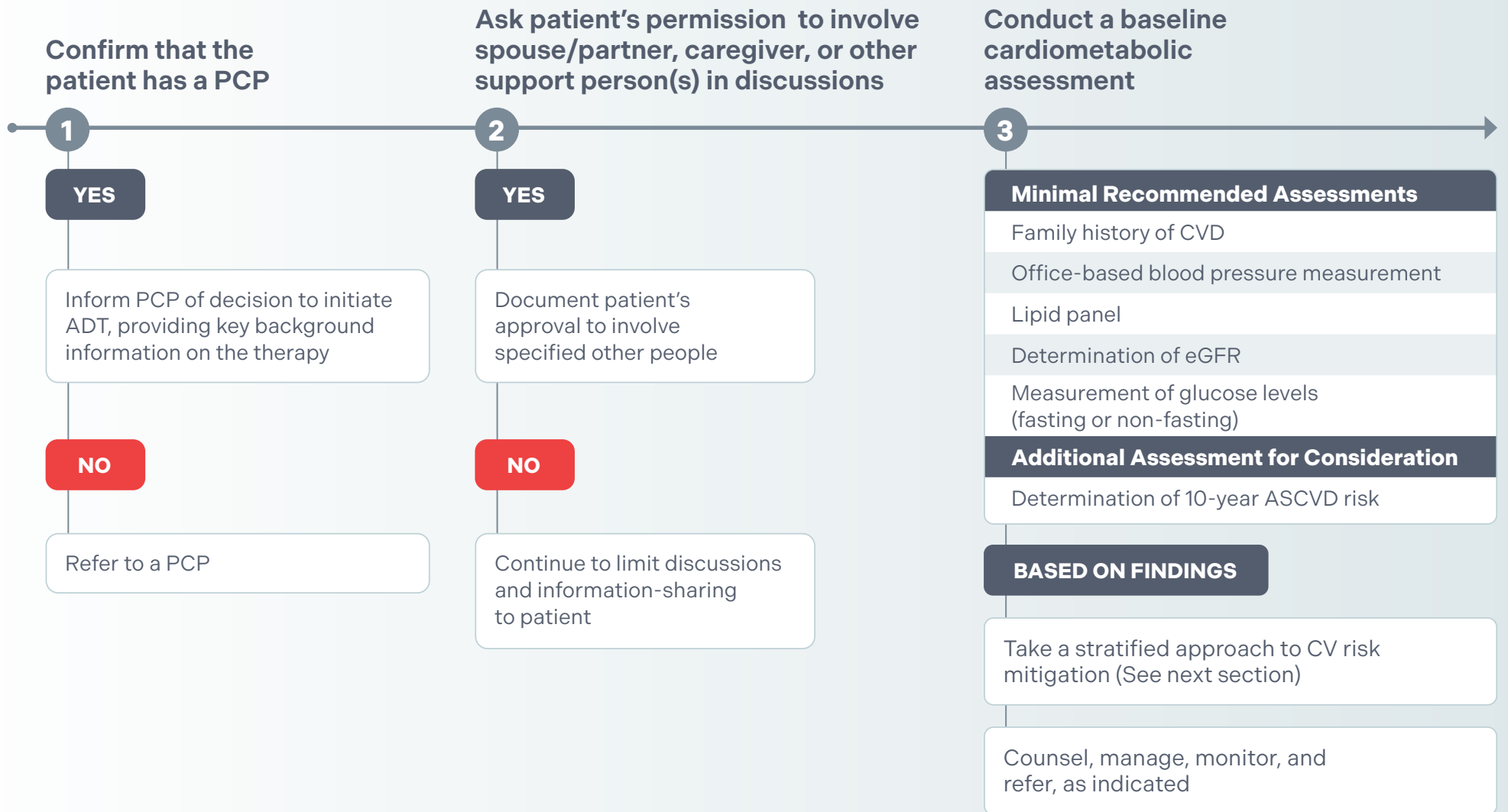
This roadmap was created to provide busy clinicians with a comprehensive, efficient approach to evaluating, managing, and counseling patients prior to initiating ADT and throughout the course of ADT treatment.

The roadmap was developed by a multispecialty and multidisciplinary panel that included urology, medical oncology, endocrinology, and primary care physicians; a nursing professional; exercise physiologist; dietitian; psychologist; and patient advocates.

For more information about the Prostate Cancer 360 initiative and its resources for clinicians and patients, visit prostatecancer360.com.

Prostate Cancer 360

Defining the Path for Comprehensive Care of Men on Androgen Deprivation Therapy

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Prior to Initiating ADT

EVALUATION AND REFERRAL

Confirm that the patient has a PCP

(1)

YES

Inform PCP of decision to initiate ADT, providing key background information on the therapy

NO

Refer to a PCP

Ask patient's permission to involve spouse/partner, caregiver, or other support person(s) in discussions

(2)

YES

Document patient's approval to involve specified other people

NO

Continue to limit discussions and information-sharing to patient

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Conduct a baseline cardiometabolic assessment

(3)

Minimal Recommended Assessments

Family history of CVD

Office-based blood pressure measurement

Lipid panel

Determination of eGFR

Measurement of glucose levels (fasting or non-fasting)

Additional Assessment for Consideration

Determination of 10-year ASCVD risk

BASED ON FINDINGS

Take a stratified approach to CV risk mitigation (See next section)

Counsel, manage, monitor, and refer, as indicated

ASCVD, atherosclerotic cardiovascular disease; BMD, bone mineral density; CV, cardiovascular; CVD, cardiovascular disease; eGFR, estimated glomerular filtration rate; PCP, primary care provider; PHQ-2, Patient Health Questionnaire-2; PHQ-9, Patient Health Questionnaire-9.

Take a stratified approach to CV risk mitigation

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Borderline
- No uncontrolled dyslipidemia, hypertension, diabetes, or metabolic syndrome
- No obesity
- No other risk-enhancing factors

Provide counseling on CV risk, importance of maintaining follow up with PCP, and healthy lifestyle interventions, including physical activity, nutrition, and weight maintenance

Intermediate
- Uncontrolled diabetes, dyslipidemia, or hypertension
- Metabolic syndrome, obesity, current smoking or any other risk-enhancing factor

In addition to counseling, initiate or refer for treatment of uncontrolled risk factors. Consider ordering or referring for coronary artery calcium testing

High
≥3 intermediate risk factors OR any of the following:
- Preexisting ASCVD, heart failure, valvular disease, arrythmia, or angina
- History of myocardial infarction or stroke

In addition to counseling and management of uncontrolled risk factors, consider referral to cardiology or cardio-oncology

Determine statin-use status

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Patient is taking a statin
Reinforce benefits of statin therapy

Patient is not taking a statin and does not have a contraindication to statin therapy
Counsel on benefits of statin therapy, as well as potential adverse effects

Initiate or refer for initiation of statin

Patient is not taking a statin and has an established contraindication to statin therapy
Counsel on importance of controlling CV risk factors

Perform a baseline fracture risk and BMD assessment

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Calculate 10-year fracture risk
Refer for elevated baseline fracture risk

Determine vitamin D status
Prescribe vitamin D or refer for further evaluation/prescribing, if indicated

Consider using a brief depression screen

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Administer the PHQ-2 or another brief depression screen
Refer to mental health professional, if indicated

Consider recommending patient self-assessment with PHQ-9 or another validated tool
Counsel patient on how to act on results

Assess sexual health

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Assess the patient's sexual health

- Provide pre-emptive counseling for patients and their partners regarding ADT-related erectile dysfunction and reduced sexual desire
- Review ways in which sexual relationships can be maintained while on ADT (eg, through nonpenetrative sexual activity)
- Refer to relevant medical or mental health professionals, as indicated

Assess physical activity level

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Use a validated tool such as the Godin Leisure-Time Exercise Questionnaire or the International Physical Activity Questionnaire Short Form (IPAQ-SF)
(https://sites.google.com/view/ipaq)

- Prescribe physical activity for all patients on ADT
- Consider referring inactive or sedentary patients to an exercise physiology program

COUNSELING
Take a stratified approach to CV risk mitigation

▼

Treatment Rationale

- What ADT is
- How ADT works
- Why you are prescribing ADT/ intended benefits

Potential Consequences

- Cardiovascular health
- Bone health
- Potential weight gain/changes in body composition
- Vasomotor symptoms/fatigue/ sleep disturbances
- Emotional/mental health and cognition
- Sexual health
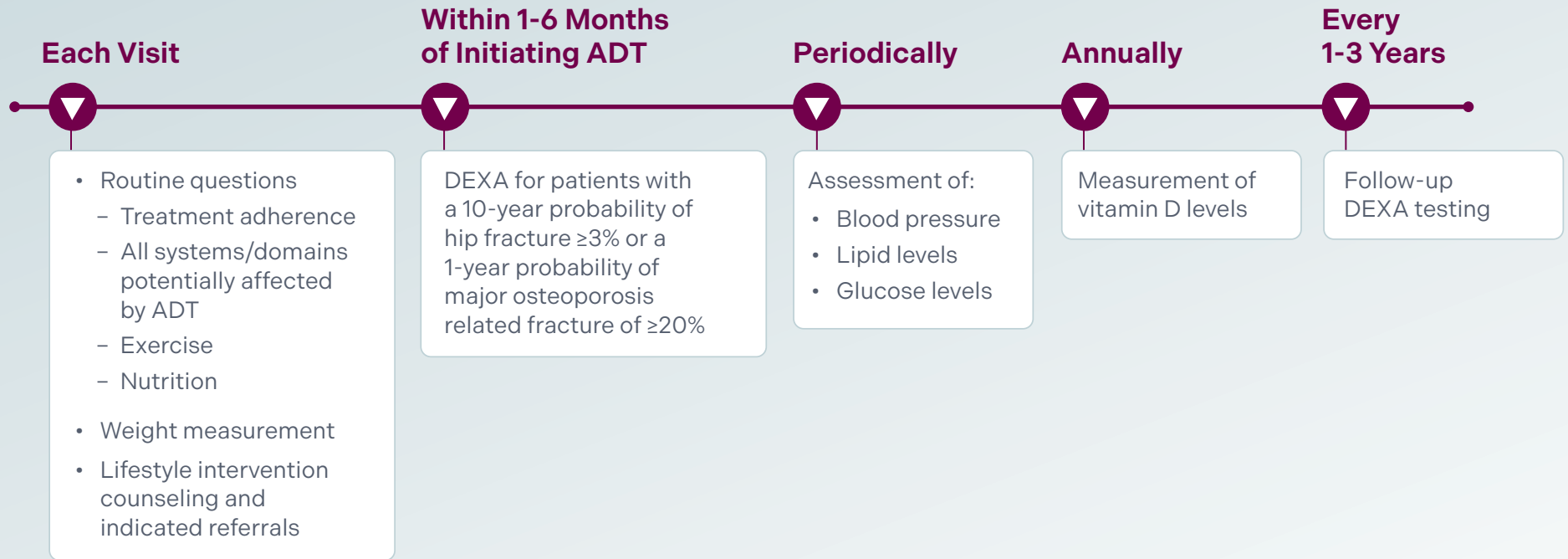
Importance of Lifestyle Changes

- Nutrition
- Physical activity

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After Initiating ADT

Each Visit

- Routine questions
  - Treatment adherence
  - All systems/domains potentially affected by ADT
  - Exercise
  - Nutrition
- Weight measurement
- Lifestyle intervention counseling and indicated referrals

Within 1-6 Months of Initiating ADT

DEXA for patients with a 10-year probability of hip fracture ≥3% or a 1-year probability of major osteoporosis related fracture of ≥20%

Periodically

Assessment of:
- Blood pressure
- Lipid levels
- Glucose levels

Annually

Measurement of vitamin D levels

Every 1-3 Years

Follow-up DEXA testing

DEXA, dual-energy X-ray absorptiometry.

Please visit prostatecancer360.com for other resources.

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