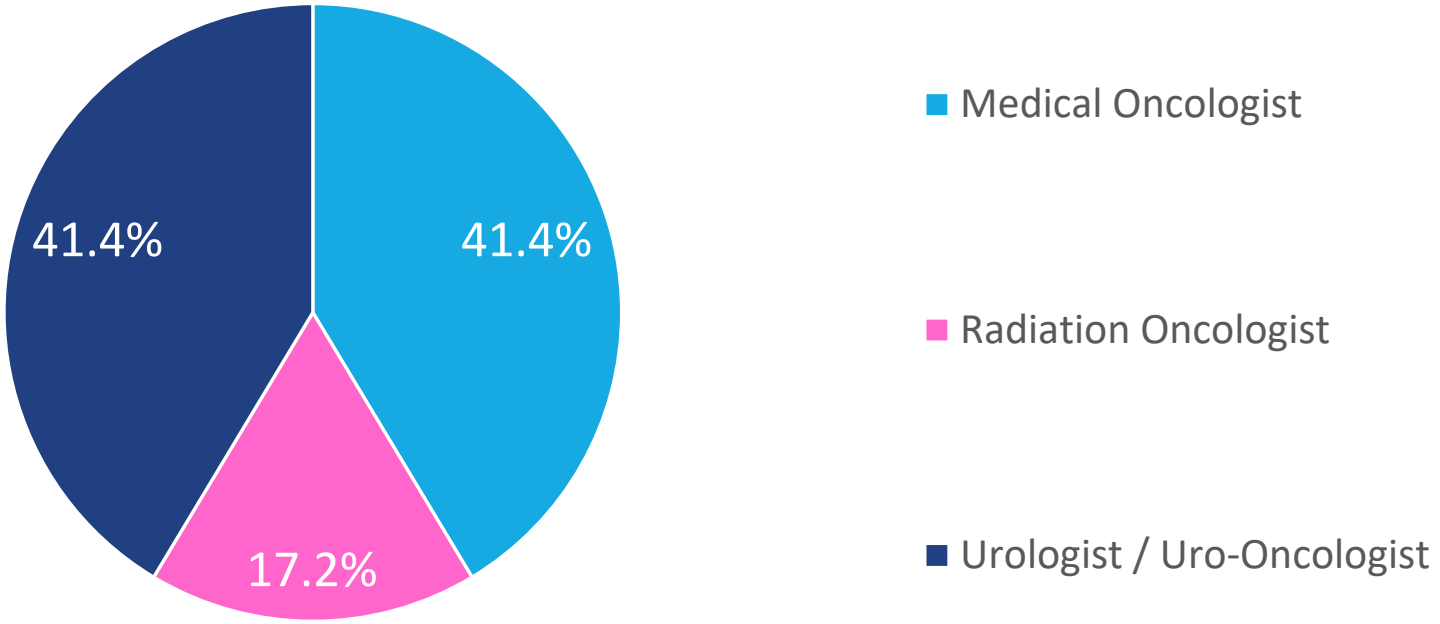
APPENDIX B

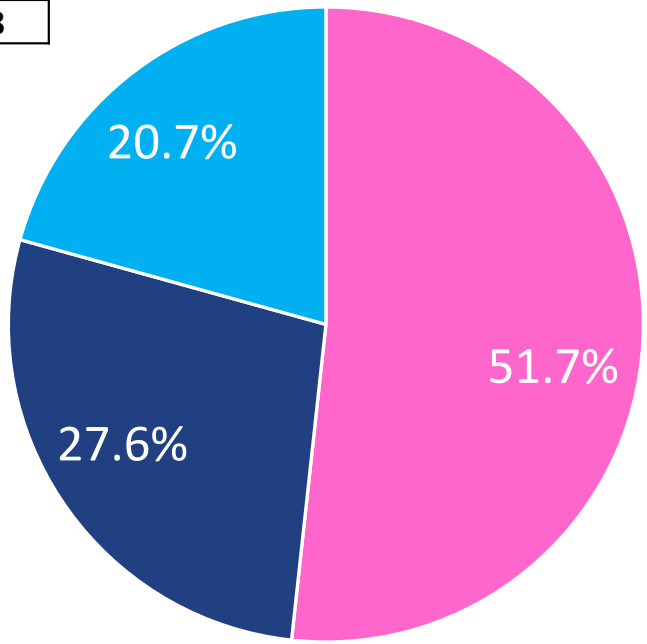
Question 0A: Please indicate your area of specialty

Opt	Votes
	12
	5
	12



Question 0B: Please indicate your region of practice

Opt	Votes
	15
	6
	8



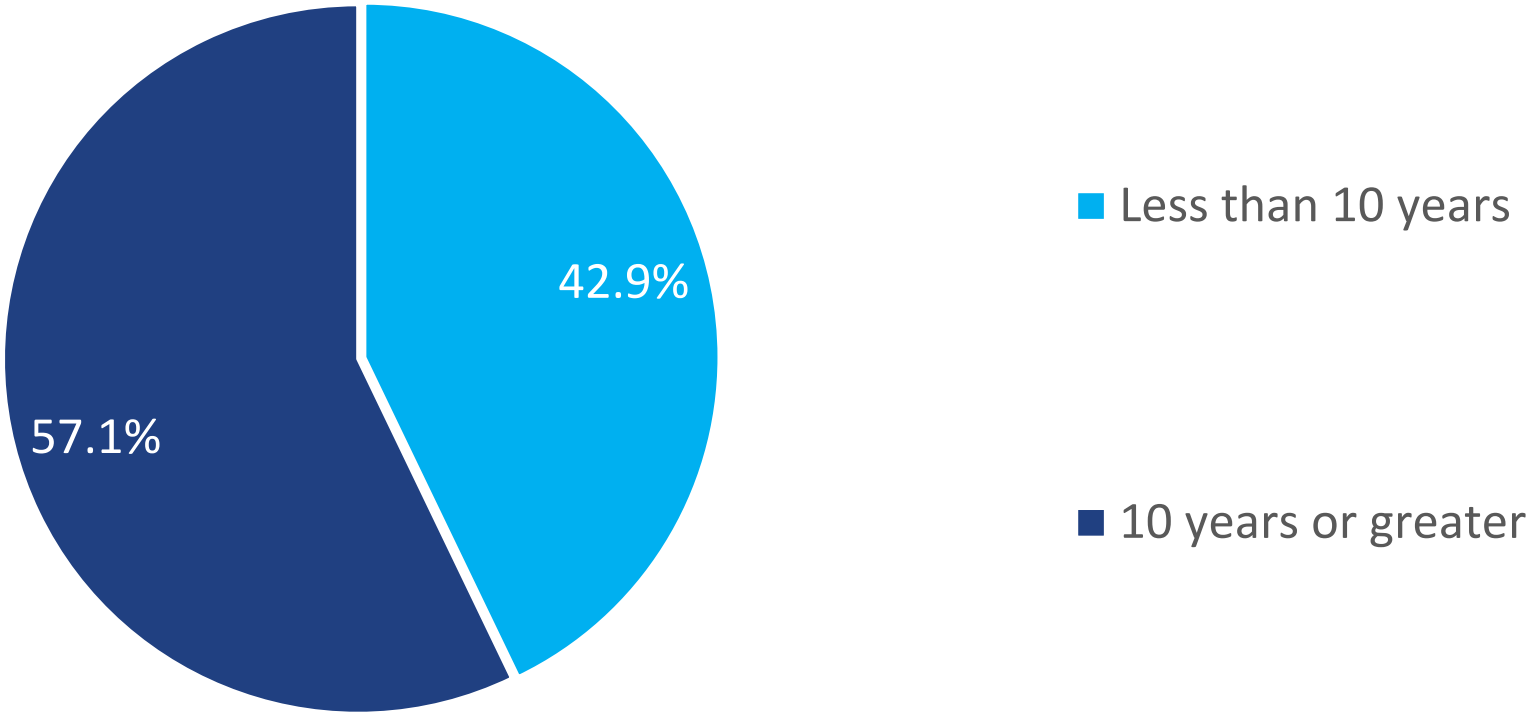
Ontario

Western Canada (BC, AB)

Quebec and Atlantic Canada

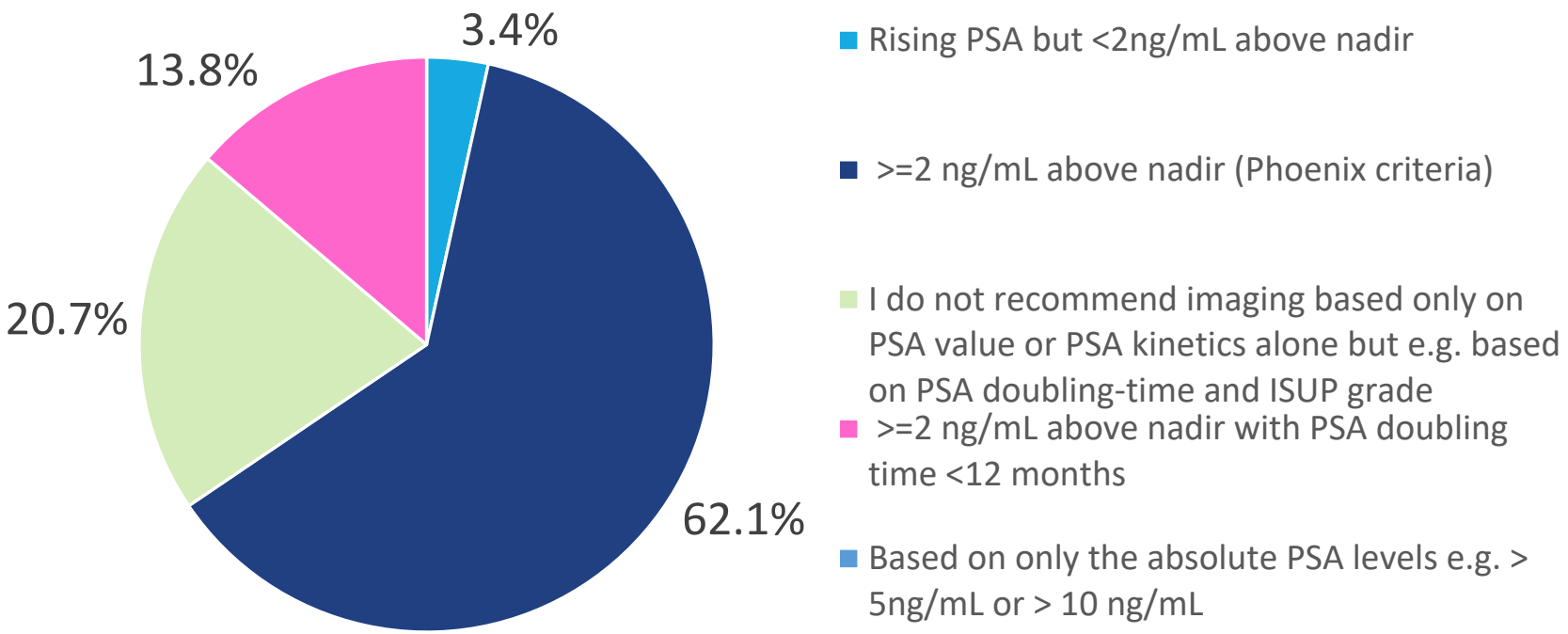
Question 0C: Please indicate the number of years you have been in practice

Opt	Votes
	16
	12



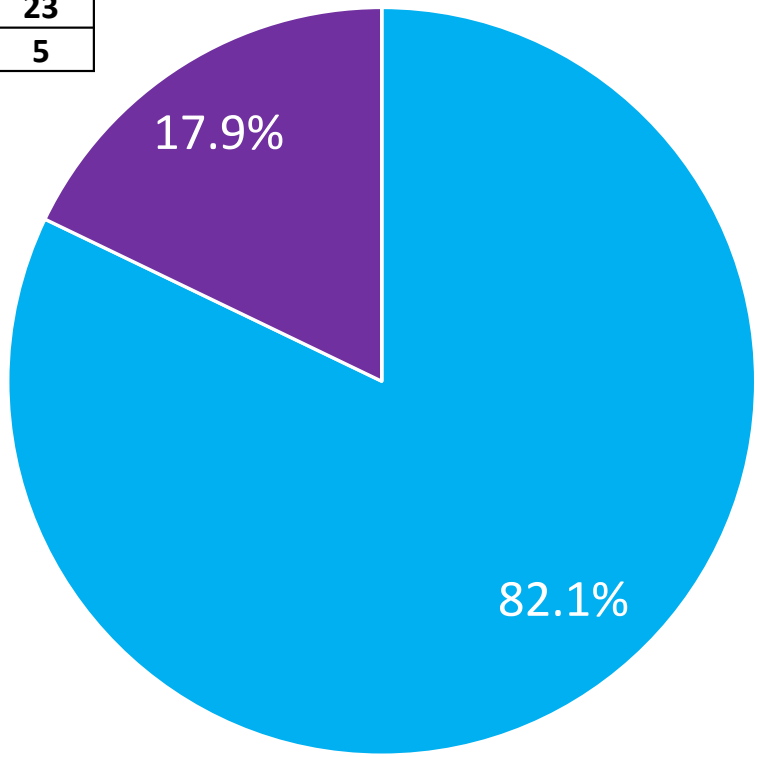
Question 1: At what confirmed PSA level do you recommend imaging for asymptomatic patients with rising PSA after radical (definitive) radiation therapy?

Opt	Votes
	1
	18
	6
	4



Question 2: Which imaging modality(ies) do you most often use for patients with rising PSA after radical prostatectomy?

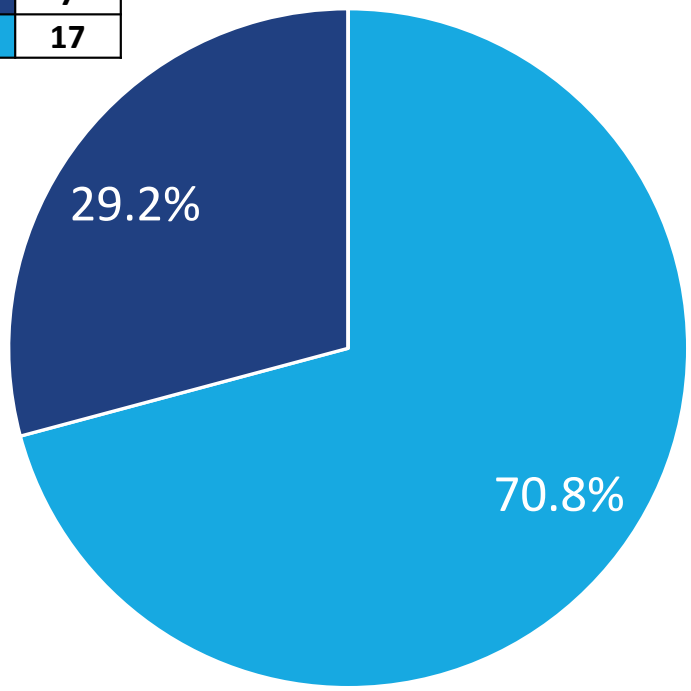
Opt	Votes
	23
	5



- CT and bone scintigraphy (plus/minus pelvic MRI)
- PSMA PET CT/MRI (plus/minus pelvic MRI)
- Whole-body MRI alone (plus/minus pelvic MRI)

Question 3: Do positive findings on PSMA PET after reaching biochemical recurrence change your management approach for a patient?

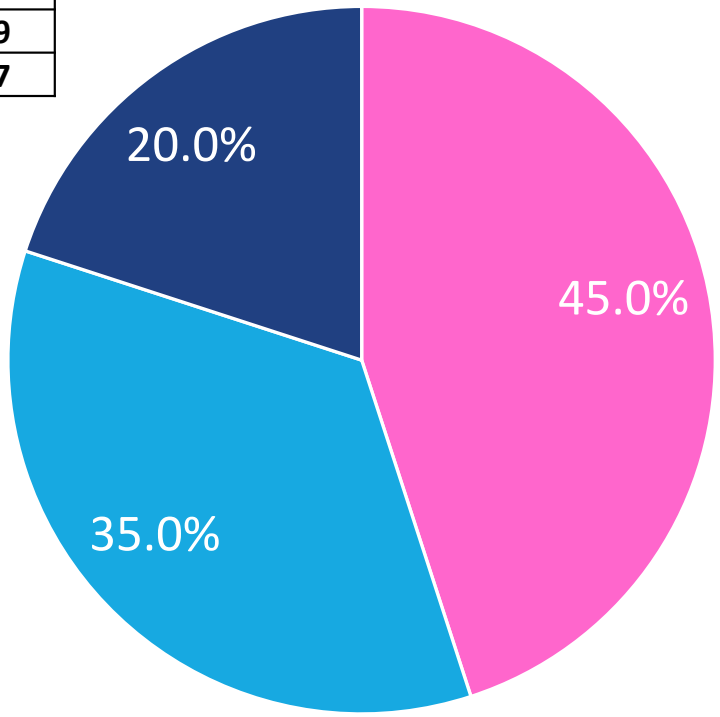
Opt	Votes
	7
	17



- It changes my treatment and monitoring plan
- It changes only my treatment plan
- It changes only my monitoring plan
- It rarely changes my treatment or management approach

Question 4: Do you recommend repeating imaging (negative pre-operative imaging) for an asymptomatic pN0 patient with PSA persistence (>=0.1 ng/mL) four to six weeks after radical prostatectomy?

Opt	Votes
	4
	9
	7

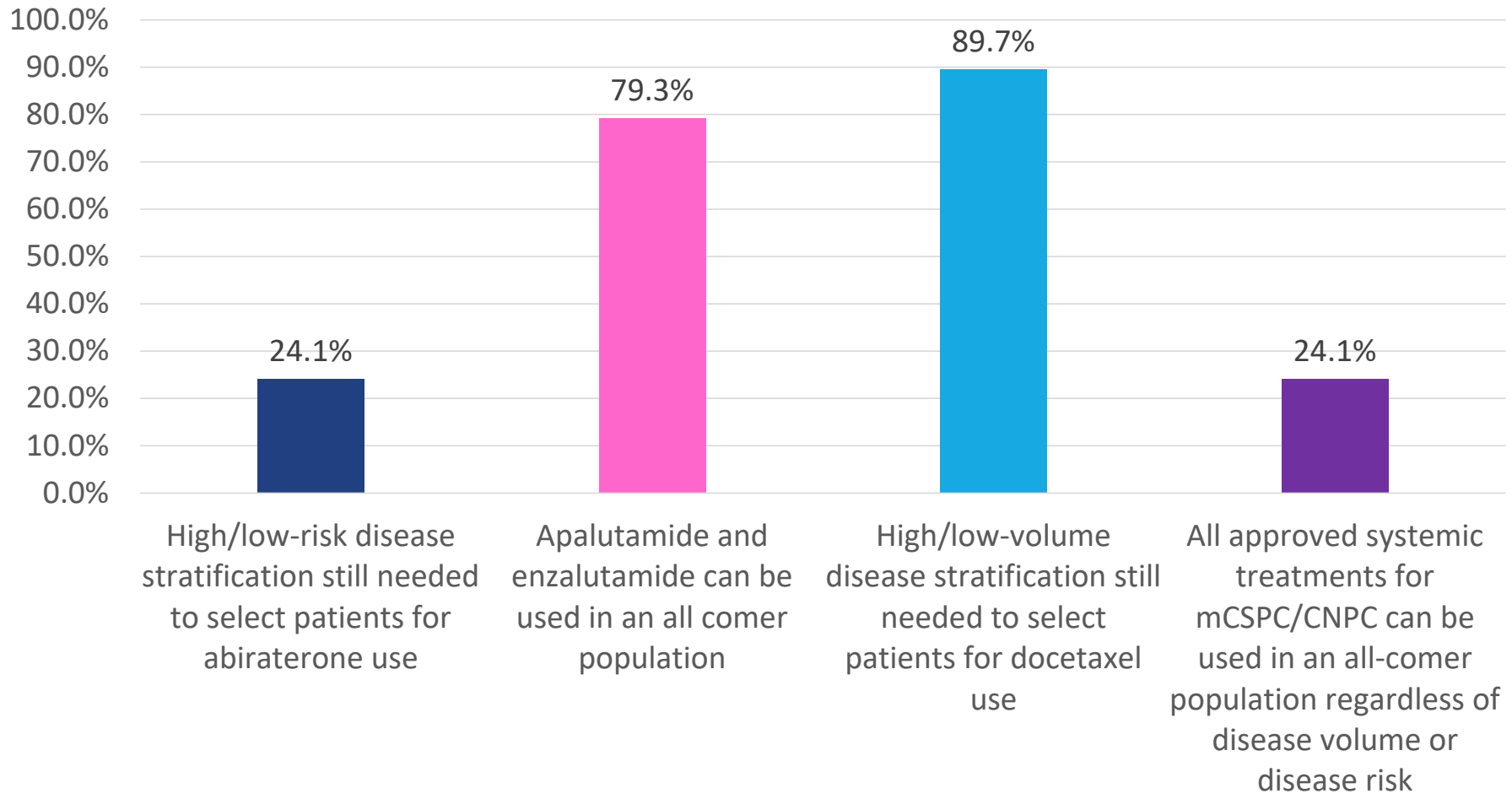


- No
- Yes, to establish a new baseline following radical prostatectomy
- Yes, but only in the presence of other adverse factors (e.g. Gleason score, intraductal etc.)

LYY[N1

Question 5: Should mCSPC/CNPC patients still be stratified as high/low volume and high/low risk to inform treatment decision making or can we consider this as an all comer population?

Opt	Votes
	7
	7
	26
	23

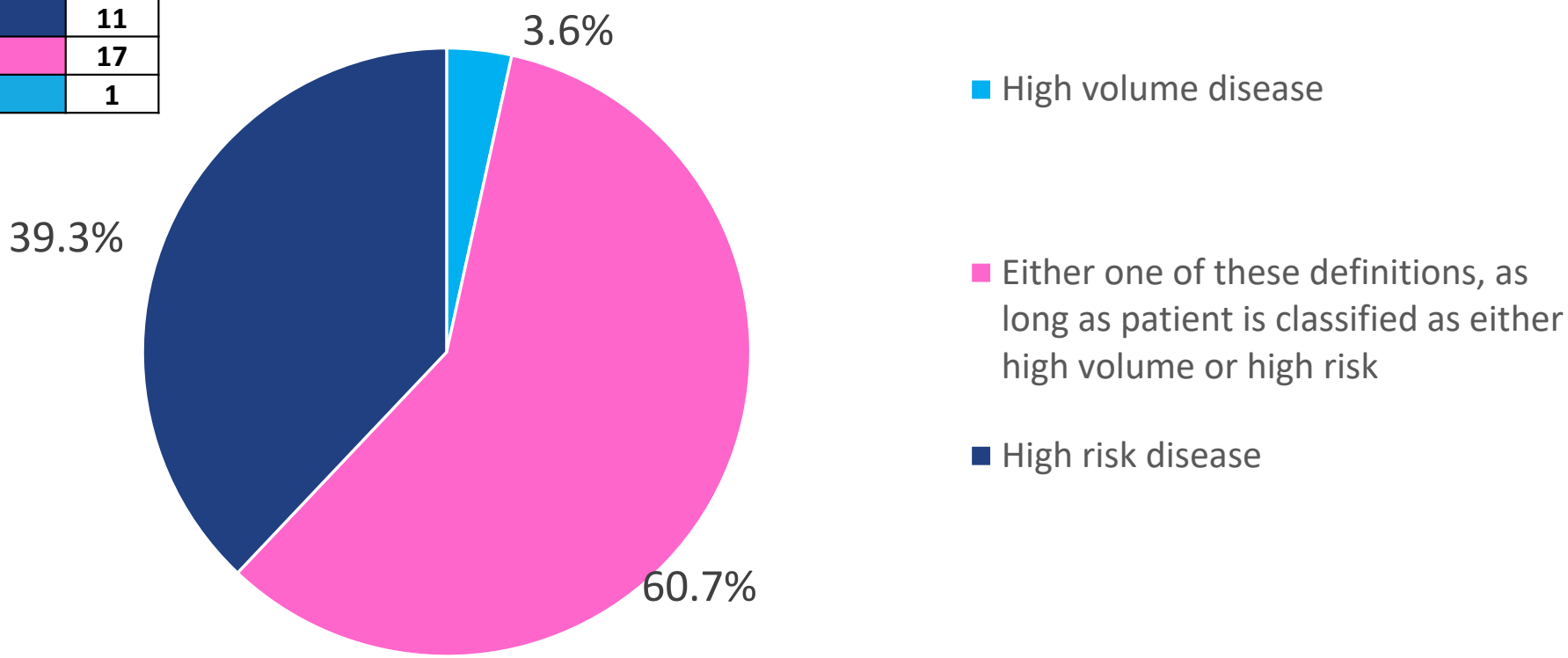


LYY[N1 Yang's calculation

Li, Yang Yun [JOICA NON-J&J], 2021-03-11

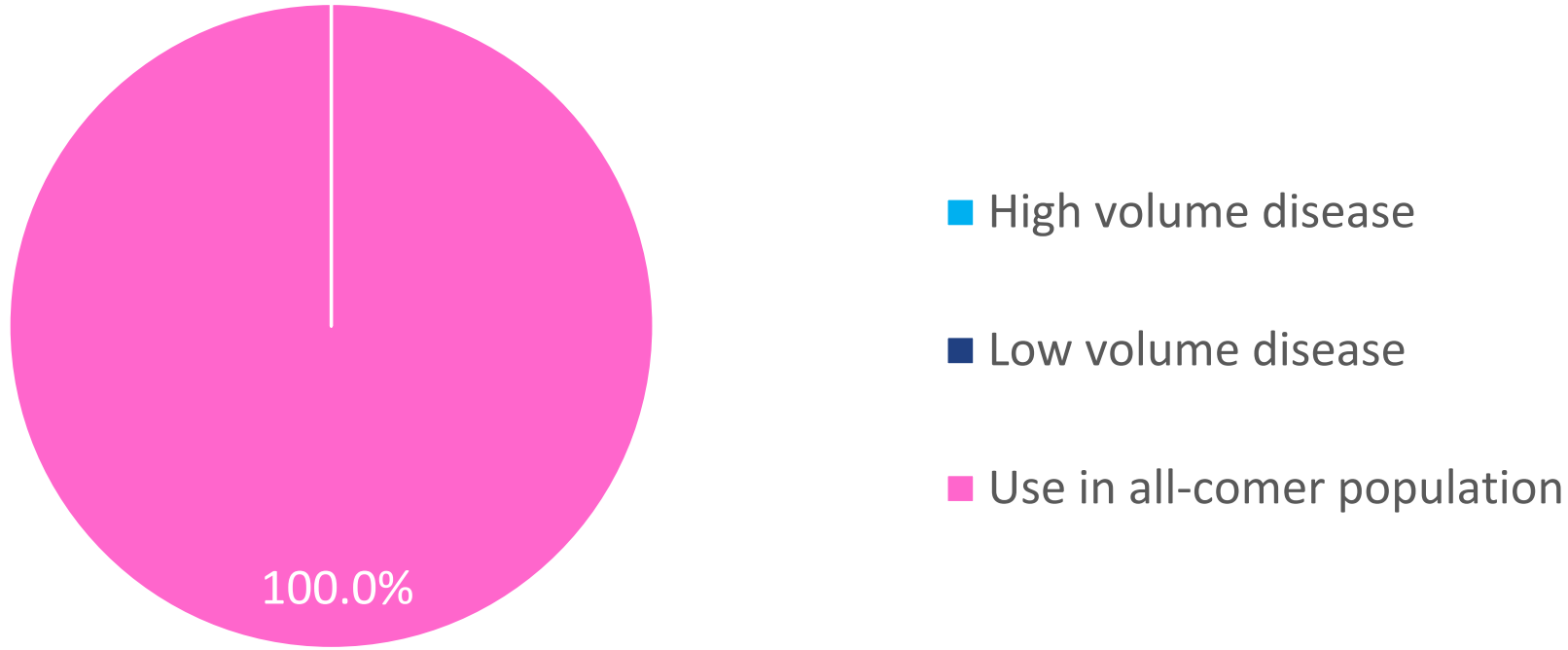
Question 6: Which definition do you currently use to guide treatment selection of abiraterone acetate plus prednisone in addition to ADT in patients with metastatic castration-sensitive/naïve prostate cancer (CSPC/CNPC)?

Opt	Votes
	11
	17
	1



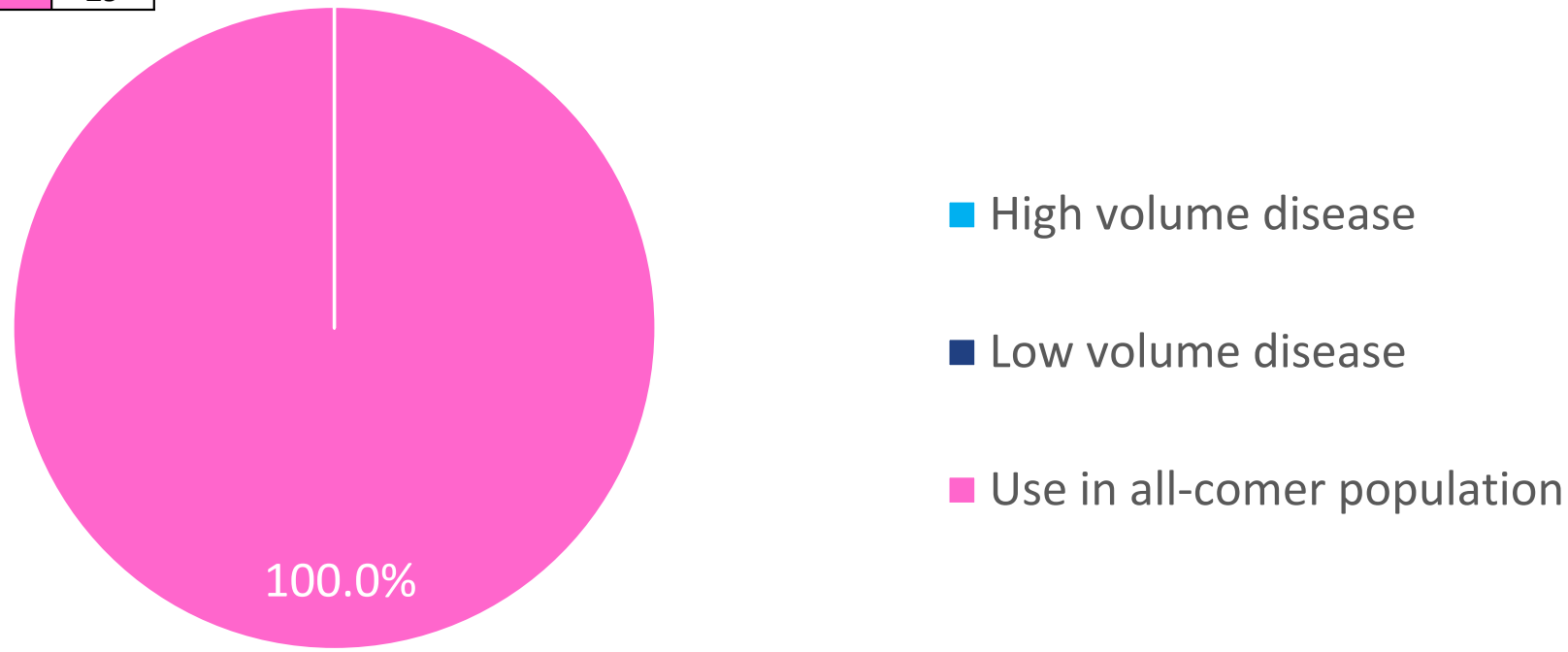
Question 7: Which patient population do you recommend for use of enzalutamide in addition to ADT in patients with metastatic castration-sensitive/naïve prostate cancer (CSPC/CNPC)?

Opt	Votes
	29



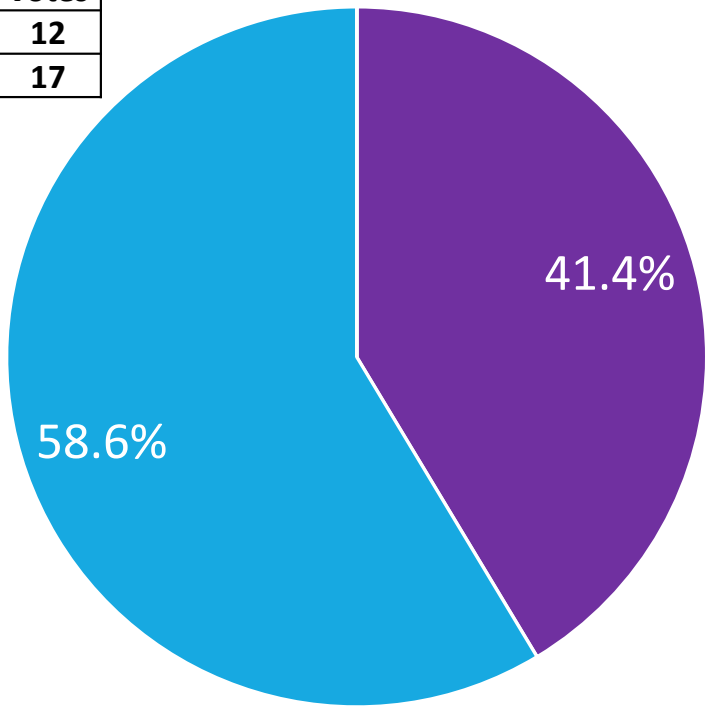
Question 8: Which patient population do you recommend for use of apalutamide in addition to ADT in patients with castration-sensitive/naïve prostate cancer (CSPC/CNPC)?

Opt	Votes
	29



Question 9: What is your preferred treatment in addition to ADT in patients with de-novo high-volume metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC) without symptoms from the primary tumour?

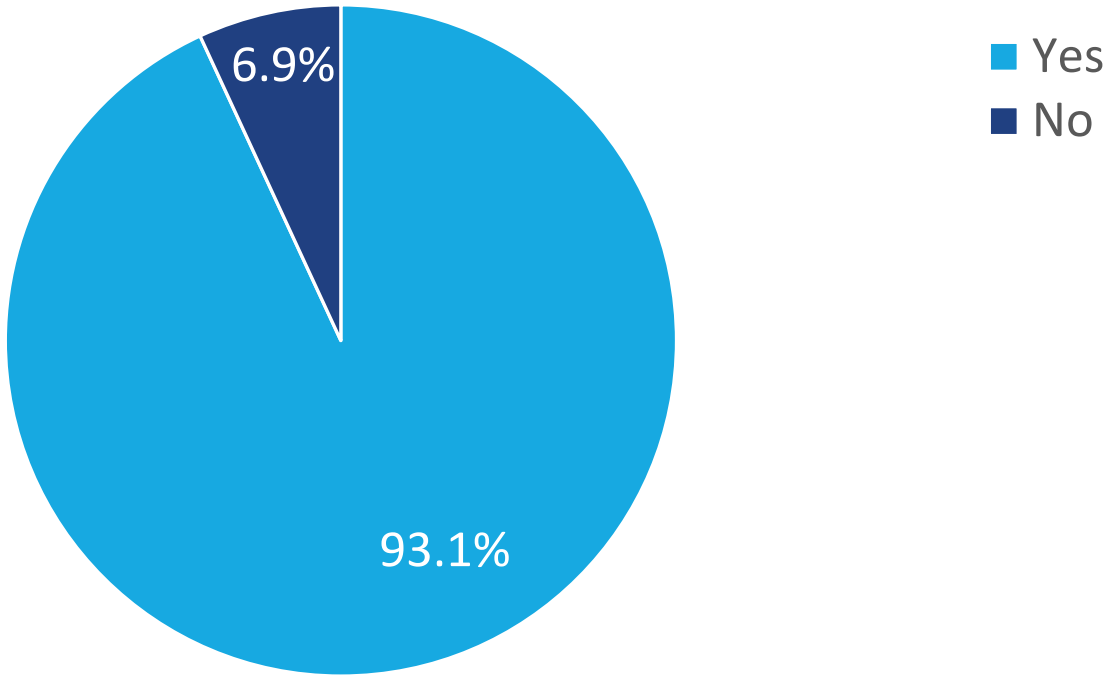
Opt	Votes
	12
	17



- Any one of docetaxel or abiraterone or apalutamide or enzalutamide
- AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
- Docetaxel
- Docetaxel plus AR pathway inhibitor (abiraterone or apalutamide ore enzalutamide)
- NSAA
- No additional treatment

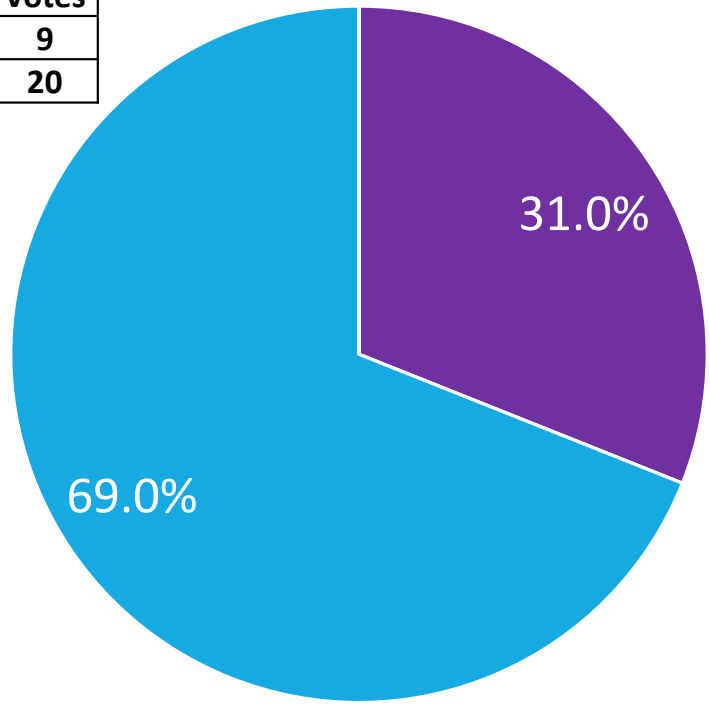
Question 9a: Is docetaxel still an option in patients with de-novo high-volume metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC) without symptoms from the primary tumour?

Opt	Votes
	2
	27



Question 10: What is your preferred treatment in addition to ADT in patients with high-volume metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC) relapsing after local treatment of the primary tumour?

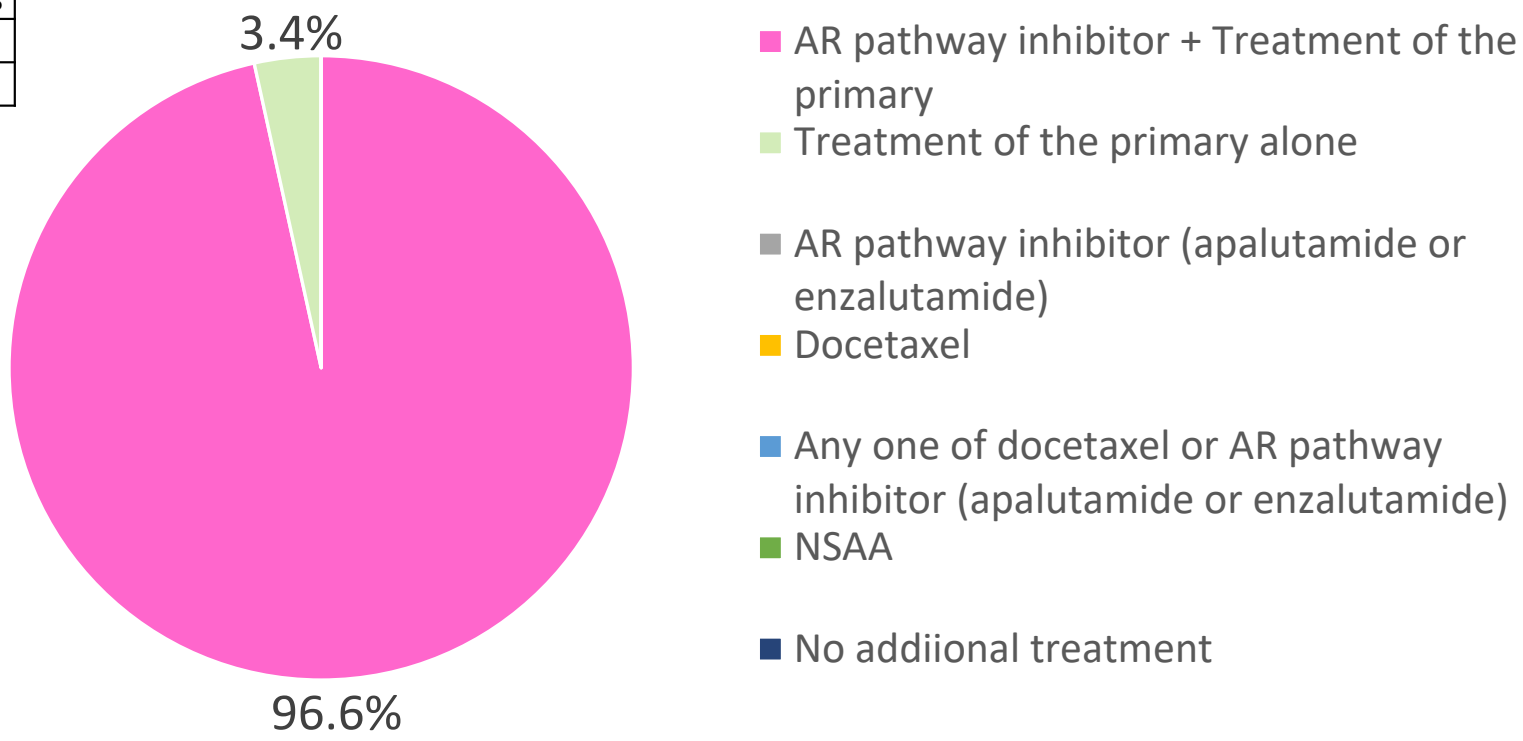
Opt	Votes
	9
	20



- Any one of docetaxel or abiraterone or apalutamide or enzalutamide
- AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)
- Docetaxel
- Docetaxel plus AR pathway inhibitor (abiraterone or apalutamide ore enzalutamide)
- NSAA

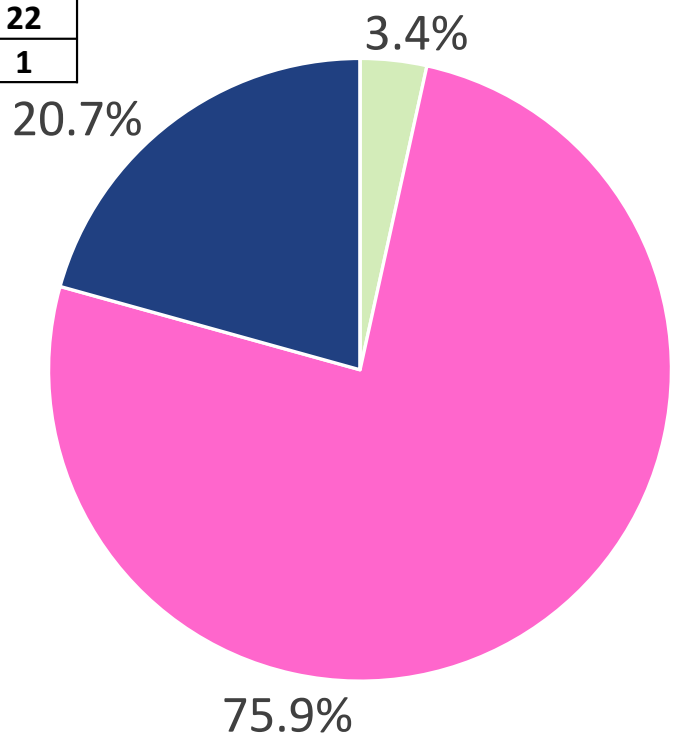
Question 11: What is your preferred treatment in addition to ADT in patients with de-novo low-volume metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC) without symptoms from the primary tumour?

Opt	Votes
	1
	28



Question 12: Do you recommend using docetaxel followed by AR pathway inhibitor in patients with mCNPC or mCSPC?

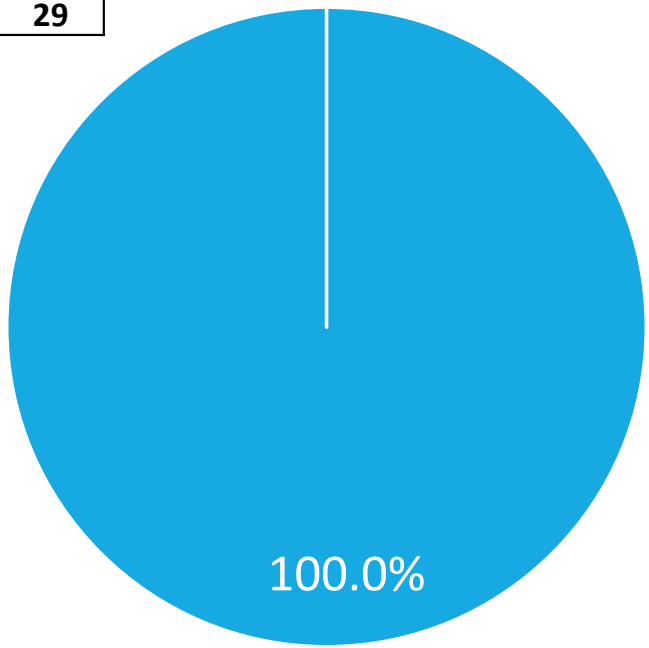
Opt	Votes
	6
	22
	1



- Yes, in select patients who do not reach undetectable PSA (<0.2) within 6 months of initiating docetaxel
- No
- Yes, in select patients, aligned to criteria from TITAN and ARCHES (docetaxel up to 6 cycles followed by AR pathway inhibitor in patients with no evidence of progression)
- Yes, in the majority of patients

Question 13: What is your preferred treatment in addition to ADT in patients with low-volume metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC) relapsing after local treatment of the primary tumour?

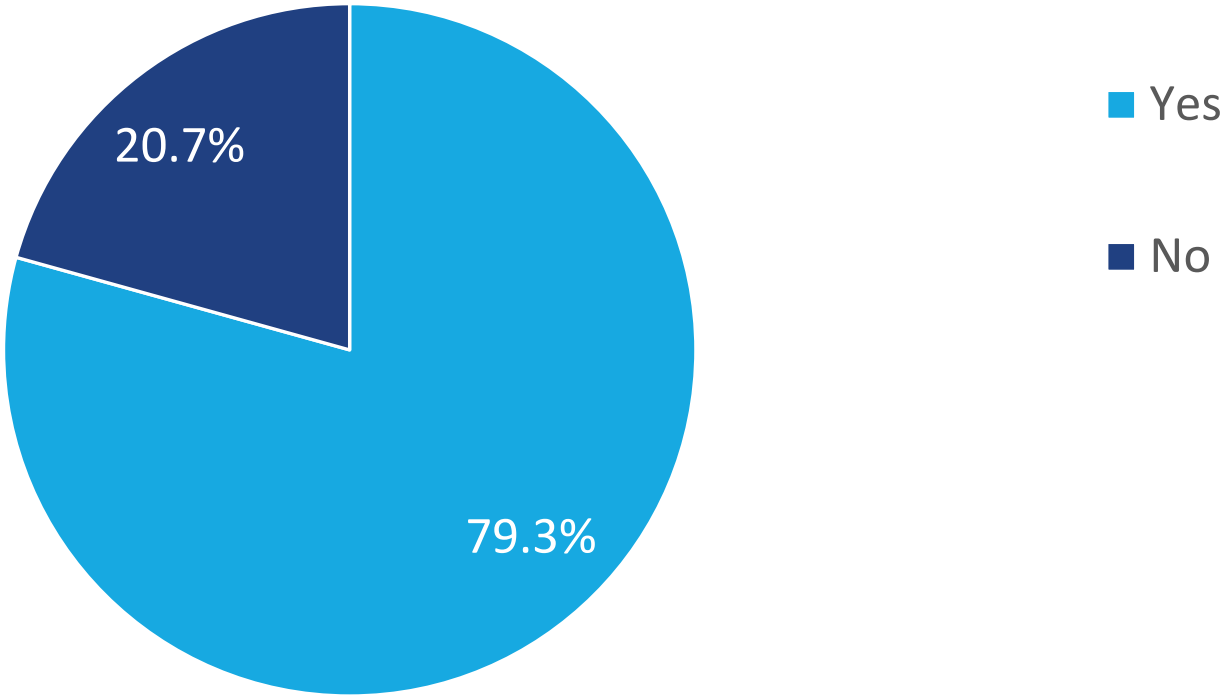
Opt	Votes
	29



- AR pathway inhibitor (e.g. apalutamide or enzalutamide)
- Docetaxel
- Any one of docetaxel or AR pathway inhibitor
- Docetaxel plus an AR pathway inhibitor
- NSAA
- No additional treatment

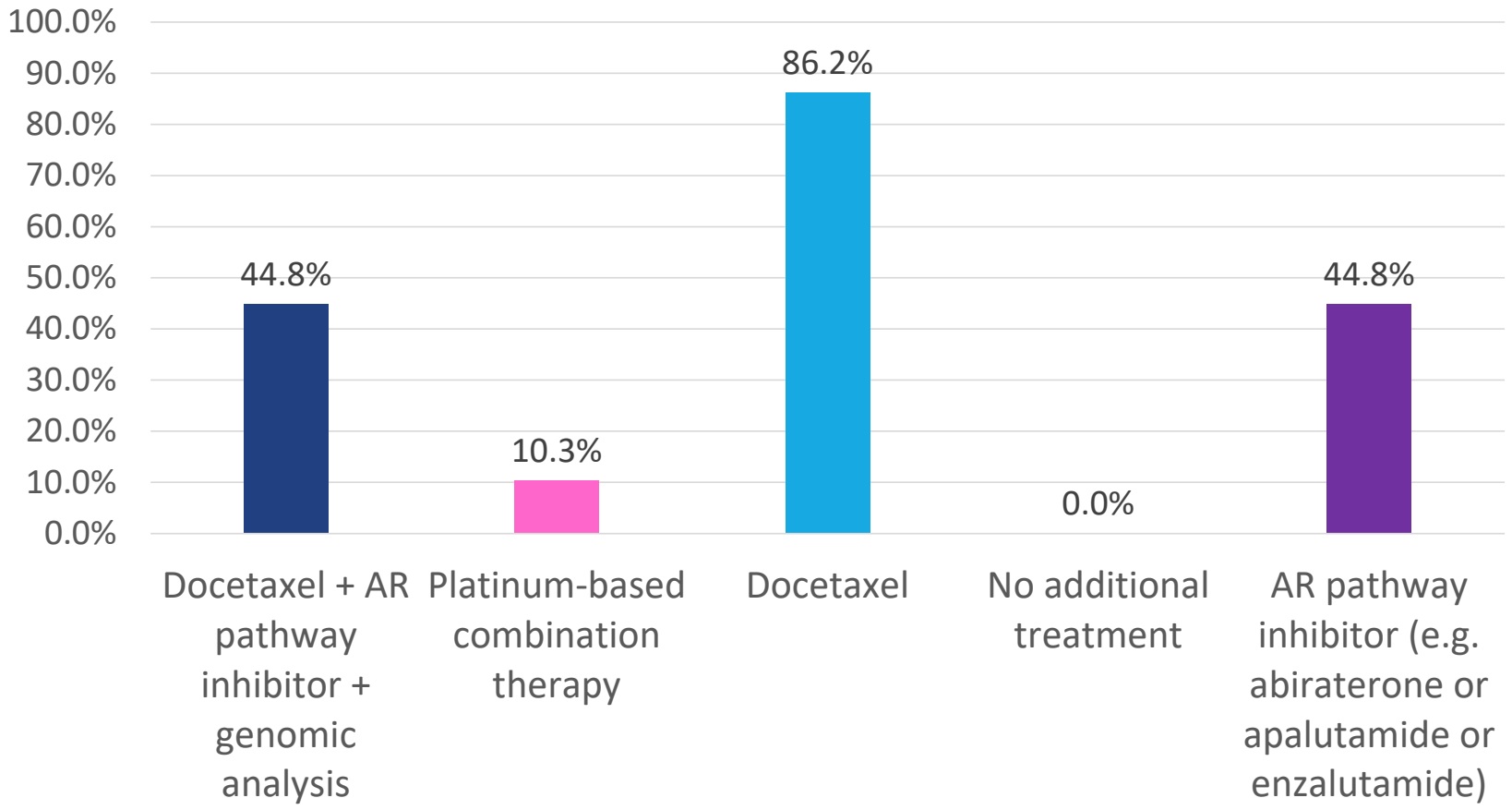
Outside of clinical trials would you consider metastases directed therapy in low volume patients particularly if they are having lots of symptoms from their ARATs or systemic therapies?

Opt	Votes
	6
	23



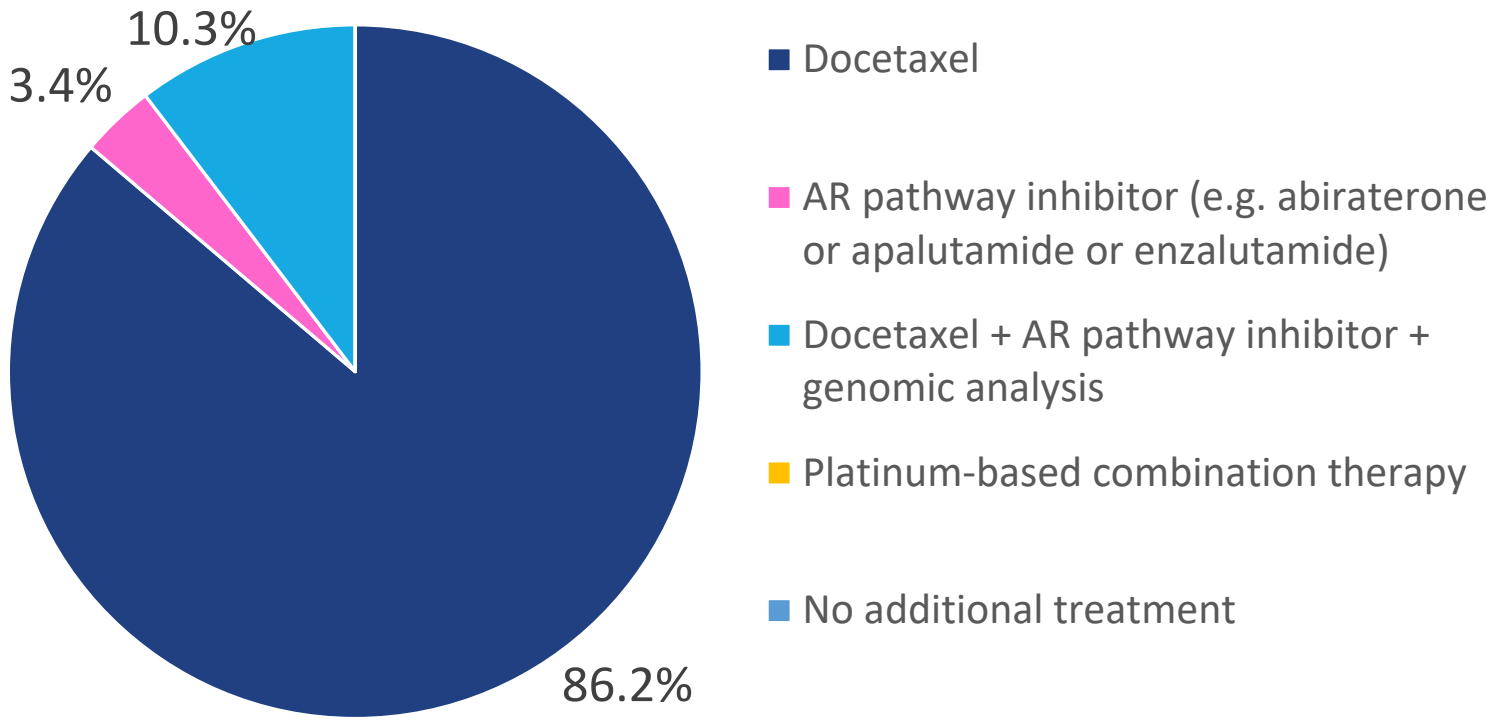
Question 14: For a patient with de novo high-volume and/or high-risk metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC), Gleason score =9, multiple liver metastases and/or lytic bone metastases, and a low PSA value (<20) but no histopathological evidence of small cell carcinoma, what do you recommend in addition to ADT?

Opt	Votes
	13
	13
	25
	10



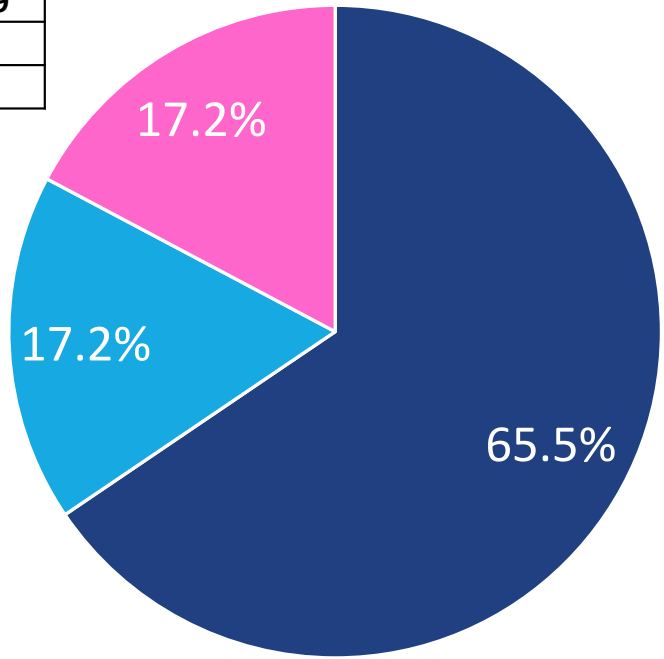
Question 14a: For a patient with de novo high-volume and/or high-risk metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC), Gleason score =9, multiple liver metastases and/or lytic bone metastases, and a low PSA value (<20) but no histopathological evidence of small cell carcinoma, what is your preferred treatment option?

Opt	Votes
	25
	1
	3



Question 15: When do you monitor patients who are receiving treatment for newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC)?

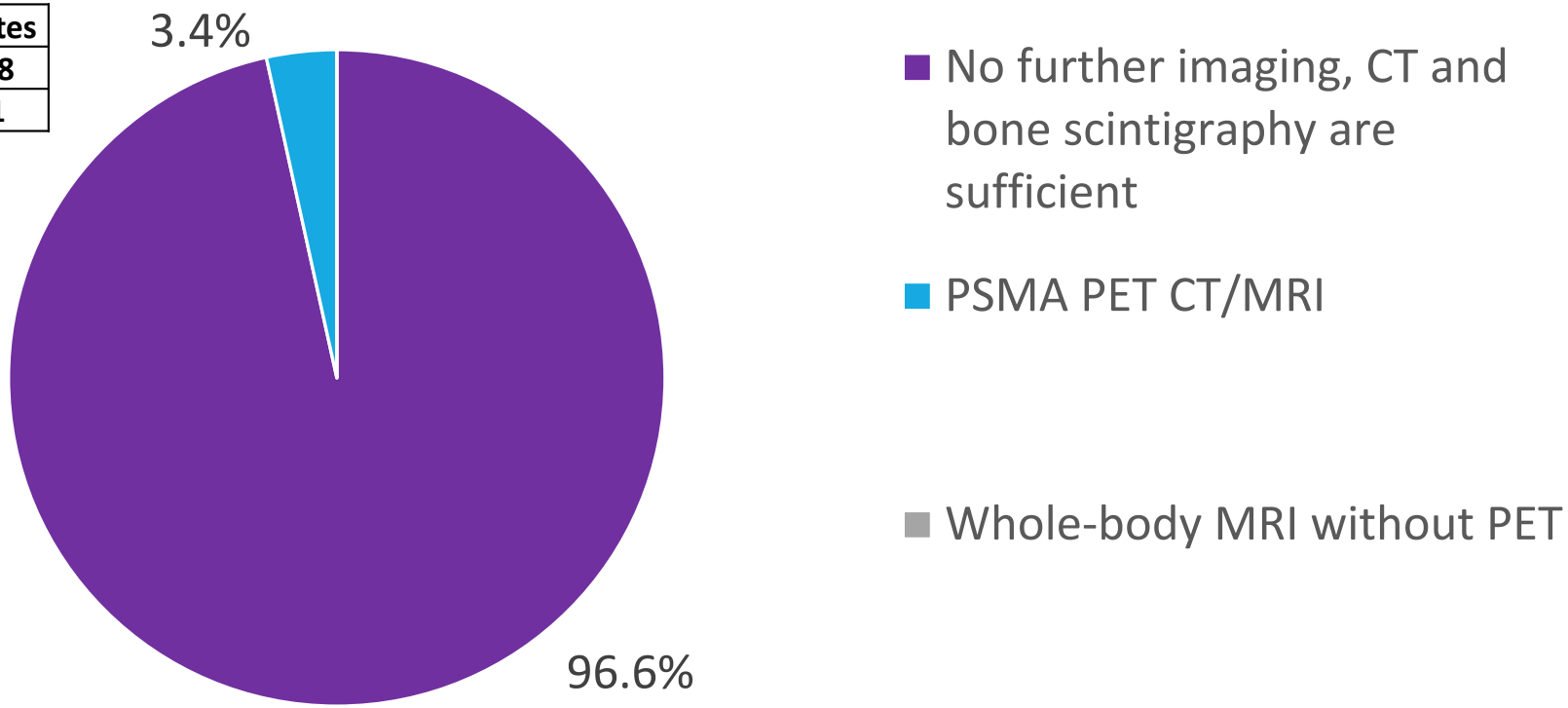
Opt	Votes
	19
	5
	5



- Baseline imaging, followed by imaging at best response (i.e. 6-12 months), PSA monitoring for progression, further imaging at progression
- Baseline imaging, followed by imaging every 3-6 months, monitoring of PSA for progression
- Baseline imaging, followed by PSA monitoring for progression, further imaging only at progression

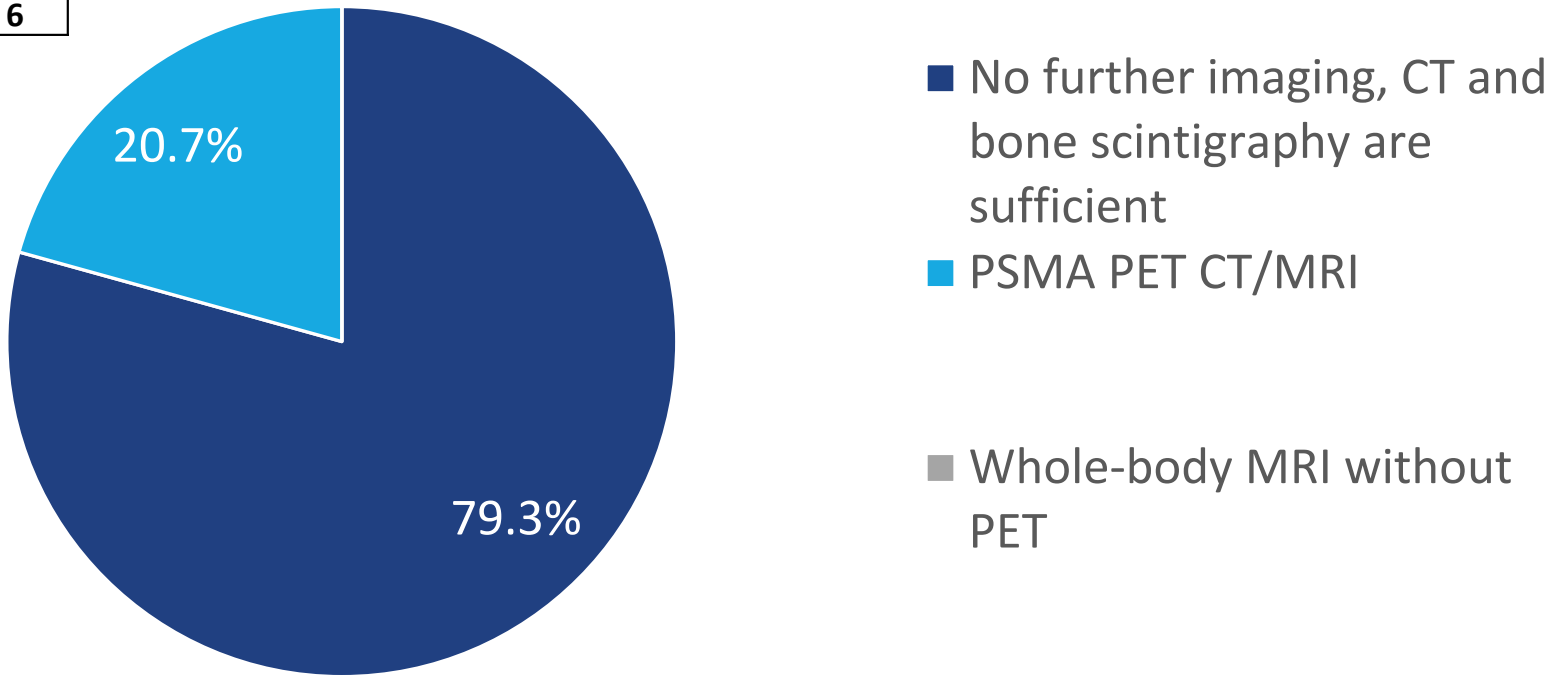
Question 16: For the majority of patients with newly diagnosed low-volume metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC) based on conventional imaging, what additional imaging modalities do you use to guide the decision to treat the primary?

Opt	Votes
	28
	1



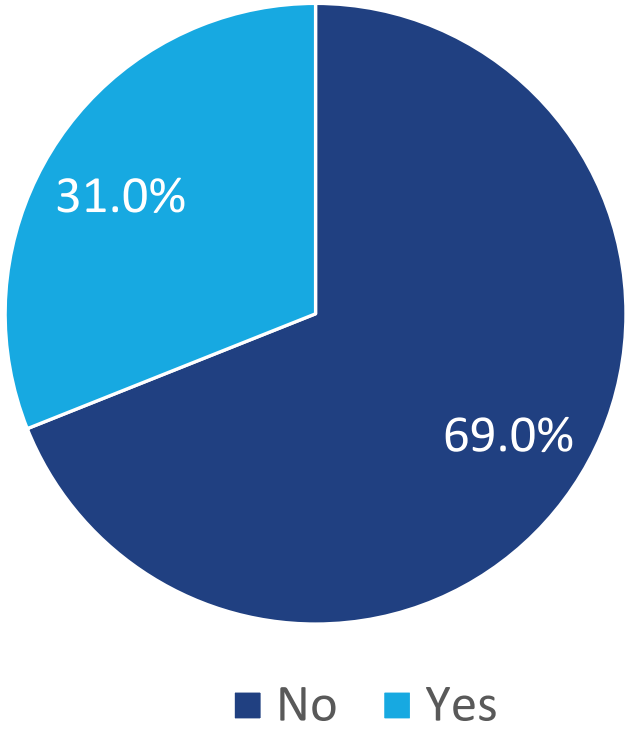
Question 17: Which definition of oligometastatic prostate cancer is useful to guide metastasis-directed ablative therapy?

Opt	Votes
	23
	6



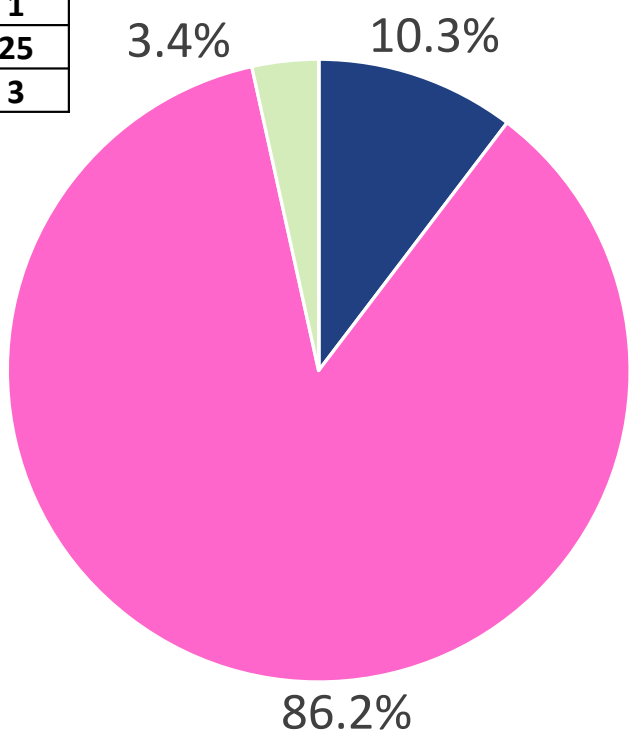
Question 18: For treatment decisions, is it important to distinguish de-novo treatment-naïve (synchronous) oligometastatic prostate cancer from oligometastatic prostate cancer recurring after local therapy (metachronous)?

Opt	Votes
	20
	9



Question 19: In addition to ADT, what is your recommended treatment approach for the majority of patients with oligometastatic CNPC/CSPC with an untreated primary?

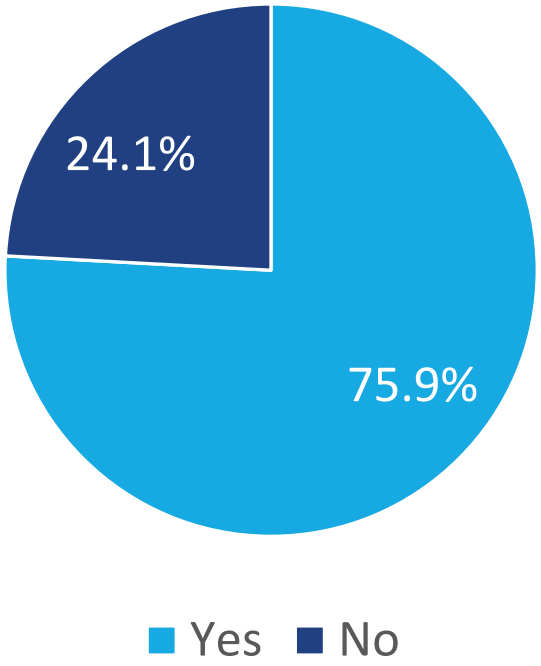
Opt	Votes
	1
	25
	3



- AR pathway inhibitor + Treatment of the primary + Metastasis-directed ablative treatment of all lesions
- AR pathway inhibitor + Treatment of the primary
- Treatment of the primary alone
- AR Pathway inhibitor (apalutamide or enzalutamide)
- Treaetment of the primary + Metastasis-directed ablative tratment of all lesions
- No additional treatment

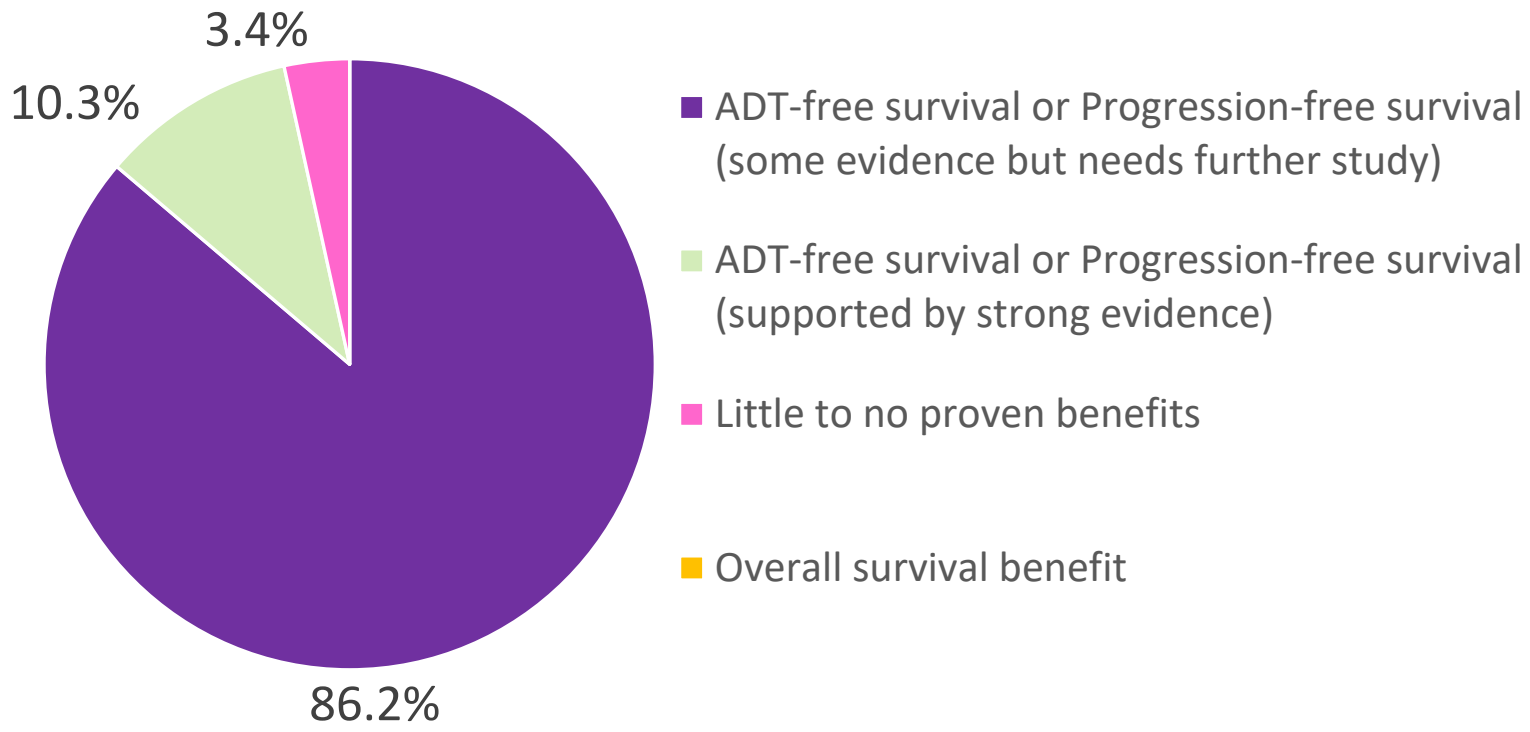
Question 20: For treatment decisions in untreated de-novo oligometastatic prostate cancer, is it important to distinguish lymph node-only disease from disease that includes metastatic lesions at other sites?

Opt	Votes
	7
	22



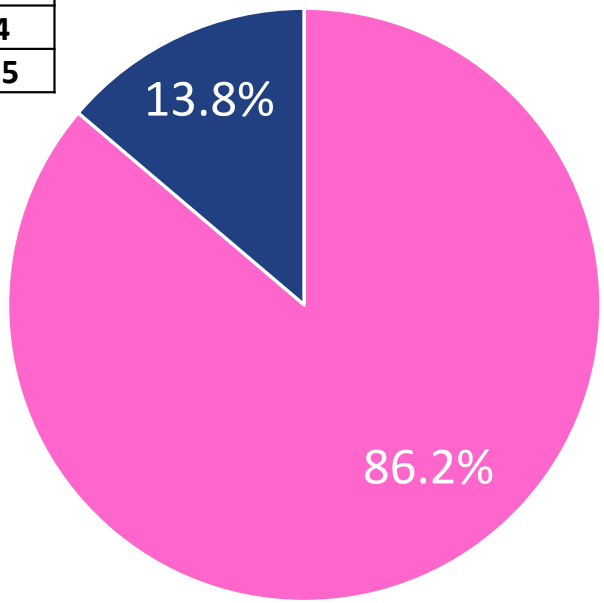
Question 21: Based on the current evidence, do you think that local treatment of metastatic lesions (metastasis directed therapy) in treatment-naïve oligometastatic prostate cancer confers?

Opt	Votes
	1
	25
	3



Question 22: Do you recommend metastasis-directed ablative treatment of all lesions instead of systemic therapy (ADT +/- ARAT) in oligometastatic prostate cancer (no prior systemic treatment)?

Opt	Votes
	4
	25



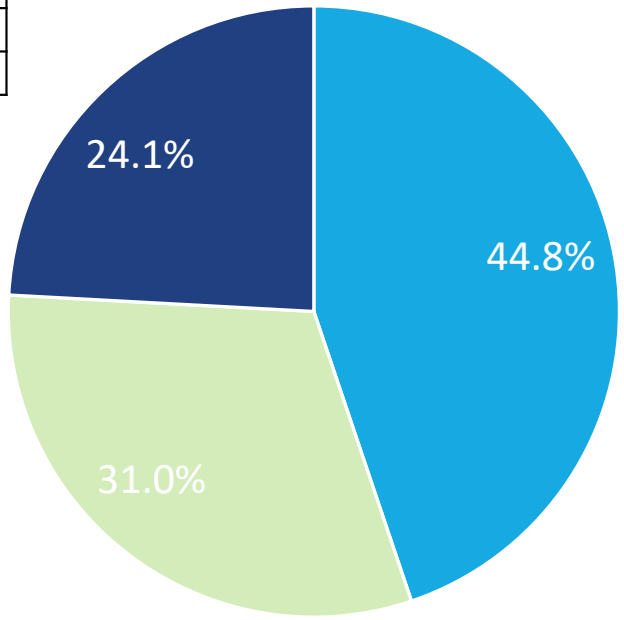
No or very rarely

Yes, in a minority of patients

Yes, in the majority of patients

Question 23: What is your treatment goal when recommending metastasis-directed ablative treatment of all lesions instead of systemic therapy (ADT+/-ARAT) in oligometastatic prostate cancer (no prior systemic therapy)?

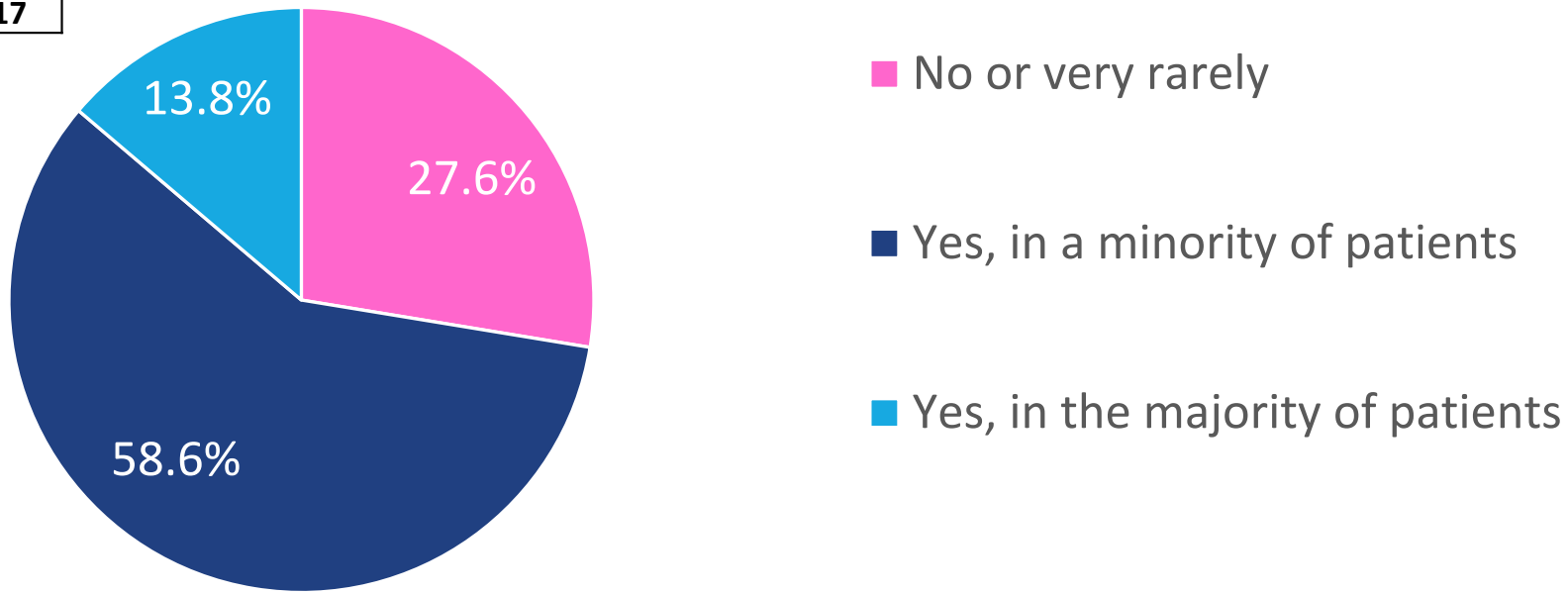
Opt	Votes
	13
	9
	7



- Delay start of ADT
- I do not recommend, or only rarely recommend, metastases-directed treatment of all lesions instead of systemic therapy in oligometastatic prostate cancer
- Prolongation of progression-free survival
- Cure
- Prolongation of overall survival

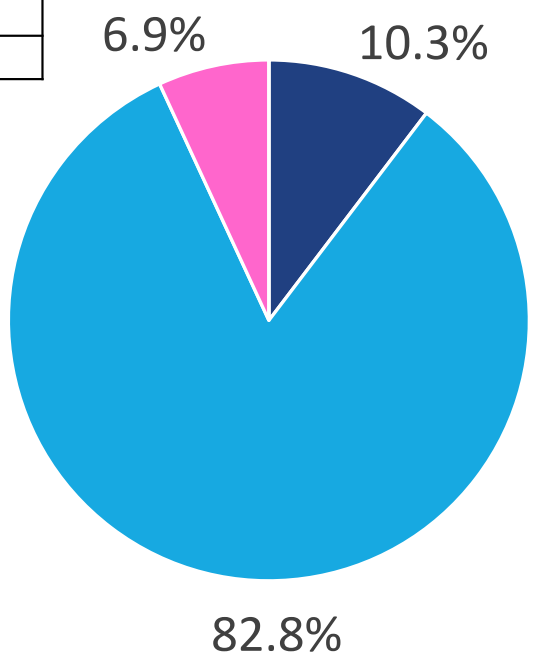
Question 24: Do you recommend metastasis-directed ablative treatment of all lesions in addition to systemic therapy (ADT+/-ARAT) in oligometastatic prostate cancer (no prior systemic treatment)?

Opt	Votes
	4
	8
	17



Question 25: What is your treatment goal when recommending adding metastasis-directed ablative treatment of all lesions to systemic treatment (ADT+/-ARAT) in oligometastatic prostate cancer?

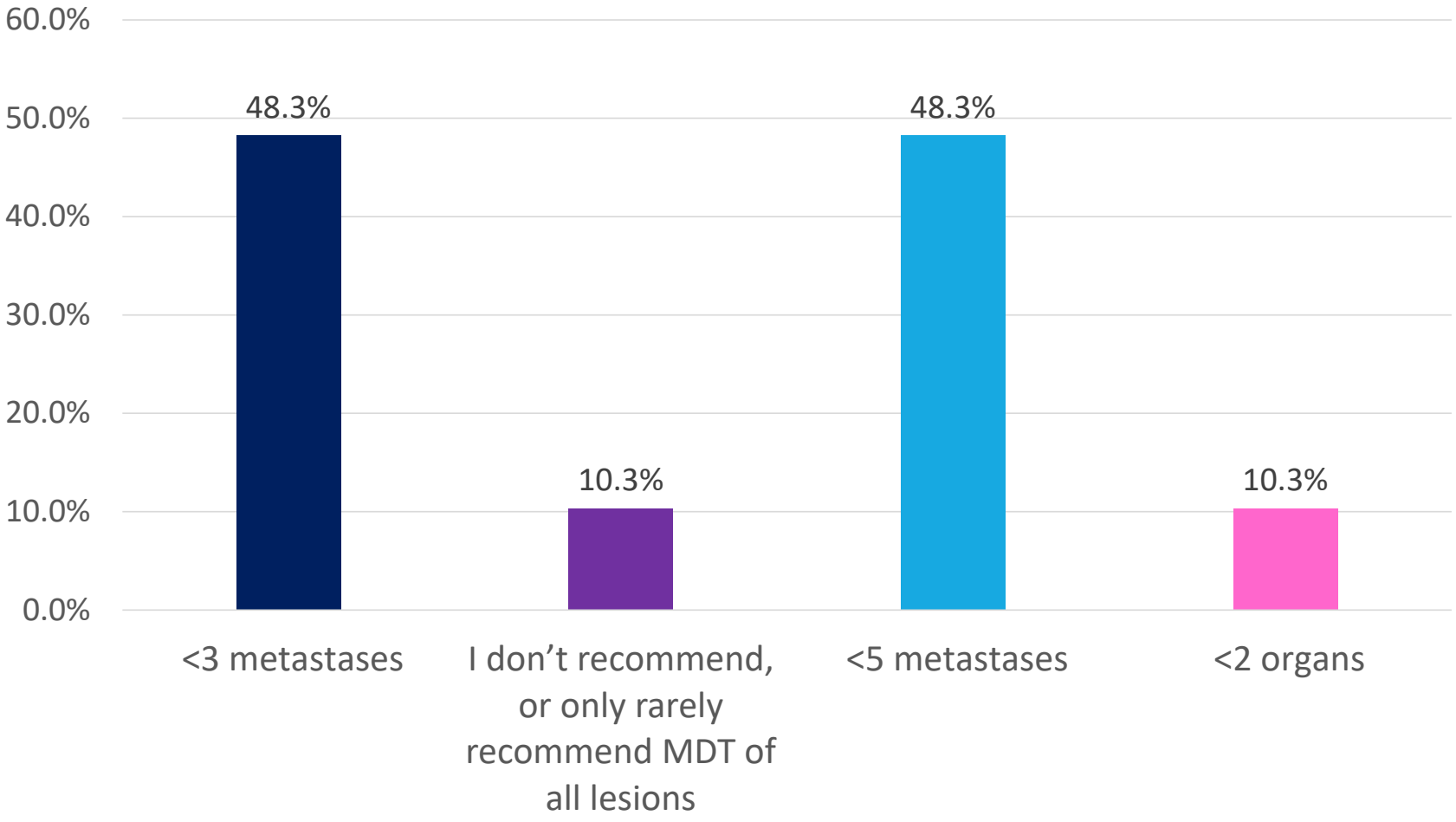
Opt	Votes
	24
	2
	3



- Prolongation of overall survival
- Prolongation of progression-free survival
- I do not recommend, or only rarely recommend, metastasis-directed treatment of all lesions in oligometastatic prostate cancer
- Cure

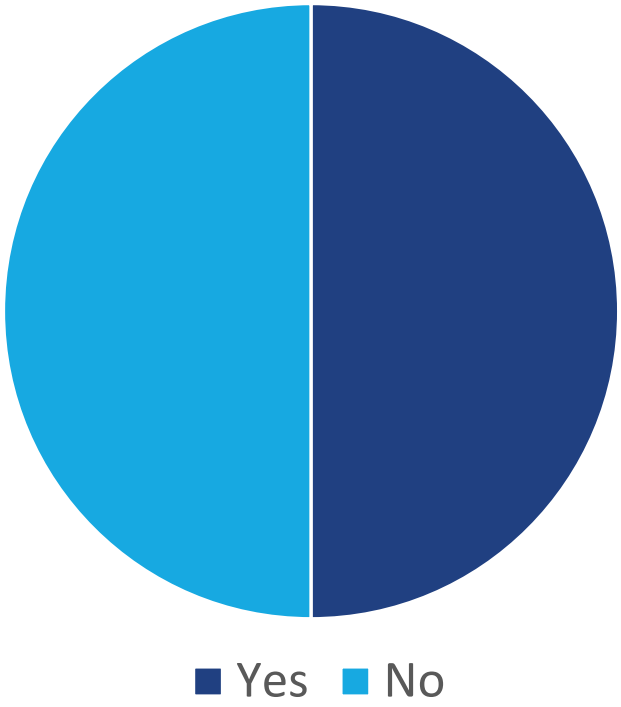
Question 26: What is your cut-off for the number of metastases when considering prostate cancer to be oligometastatic to guide treatment decisions regarding metastasis-directed ablative treatment of all lesions? Does location of metastatic lesions impact your decision? Please choose all correct responses.

Opt	Votes
	14
	3
	14
	3



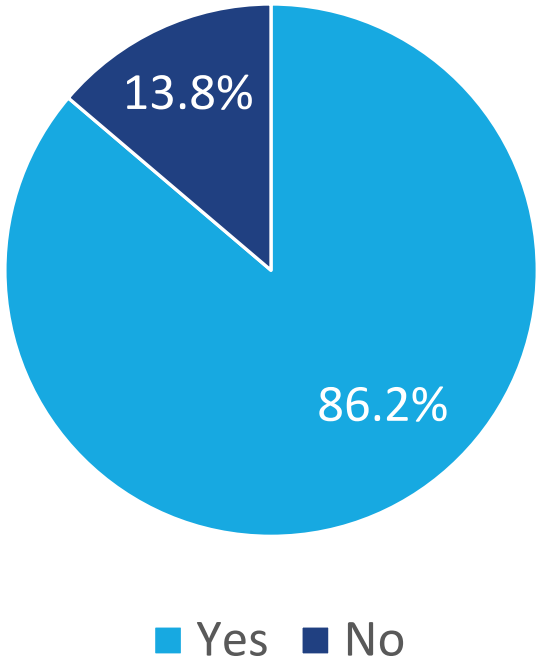
Question 27: Is imaging by CT and bone scintigraphy sufficient to define the oligometastatic state for treatment planning?

Opt	Votes
	14
	14



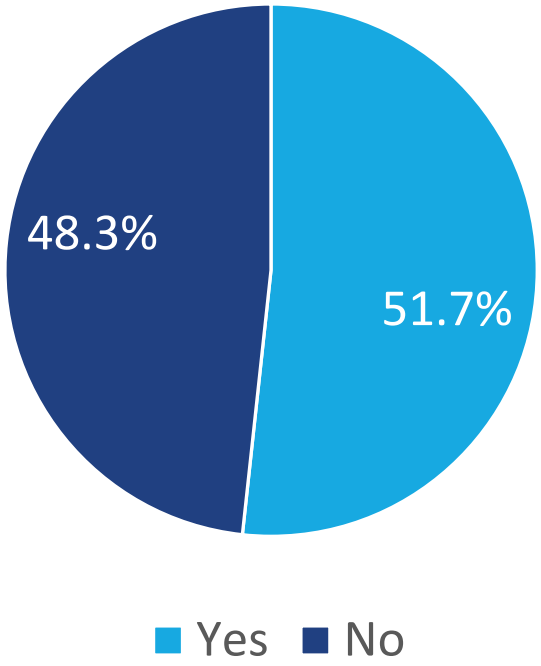
Question 28: Does your management strategy change if you have a PSMA PET positive result that shows low volume metastatic disease for a patient who is negative for metastases on conventional imaging (CT/Bone Scan) result?

Opt	Votes
	4
	25



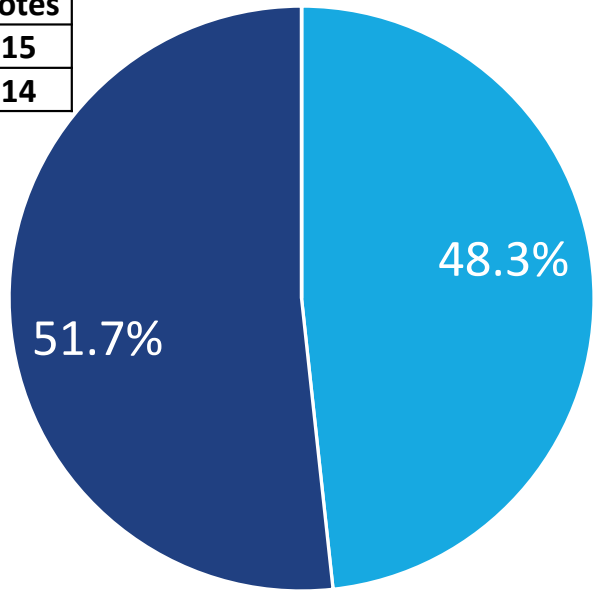
Question 29: Does your management strategy change if you have a PSMA PET result that shows high volume metastatic disease for a patient with low volume metastatic disease on conventional imaging (CT/Bone Scan)?

Opt	Votes
	14
	15



Question 30: If patients with low volume disease based on conventional imaging undergoes advanced imaging, with results that are consistent with high volume disease criteria, how do you select systemic therapy for the majority of those patients?

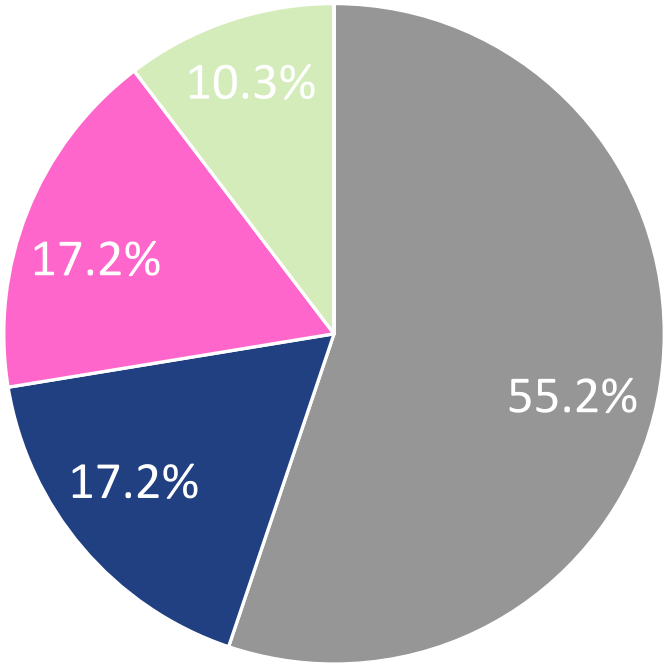
Opt	Votes
	15
	14



- Treat patient as high-volume disease
- Treat patient as low-volume disease
- Treat patient as all-comer population. Advanced imaging doesn't change my treatment
- Treat with ADT alone

Question 31: In addition to ADT, what is your recommended treatment approach for the majority of patients with an untreated primary, who is non-metastatic based on conventional imaging, but has de novo oligometastatic prostate cancer on advanced imaging (PET)?

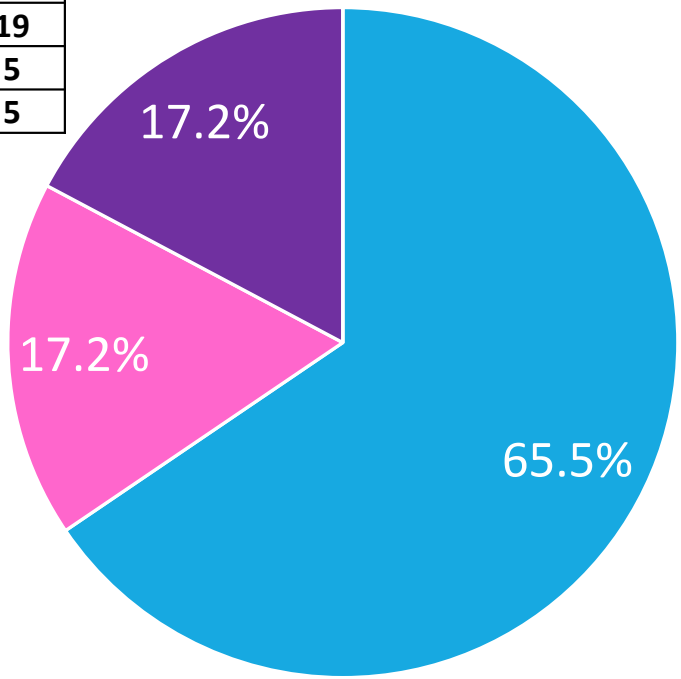
Opt	Votes
	5
	16
	3
	5



- AR pathway inhibitor + Treatment of the primary
- Treatment of the primary alone
- AR pathway inhibitor + Treatment of the primary + Metastasis-directed ablative treatment of all lesions
- Treatment of the primary + Metastasis-directed ablative treatment of all lesions
- AR pathway inhibitor (apalutamide or enzalutmaide)

Question 32: For patients with oligometastatic disease (synchronous or metachronous) on CT and bone scintigraphy, which confirmatory imaging modality(ies) do you use (apart from local staging) to guide planning for metastasis-directed therapy?

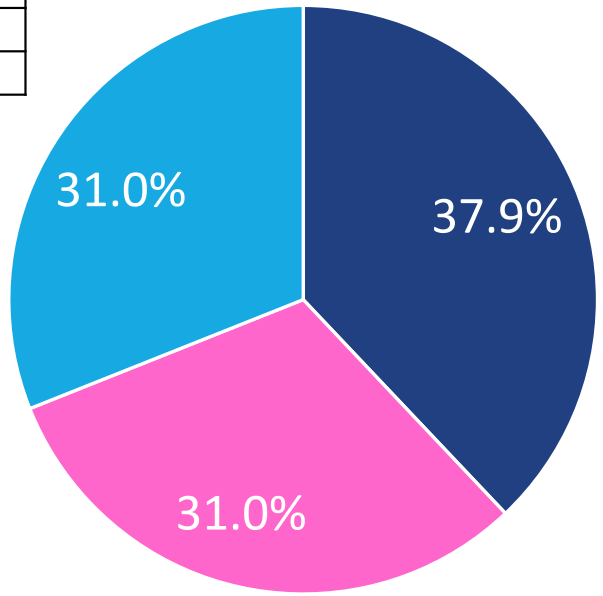
Opt	Votes
	19
	5
	5



- PSMA PET-CT/MRI
- No additional imaging
- I do not use, or only rarely use metastasis-directed therapy
- Whole-body MRI without PET

Question 33: Does PET change your decision to treat the primary tumour in a patient originally classified as low-volume on conventional imaging now appears to be high volume?

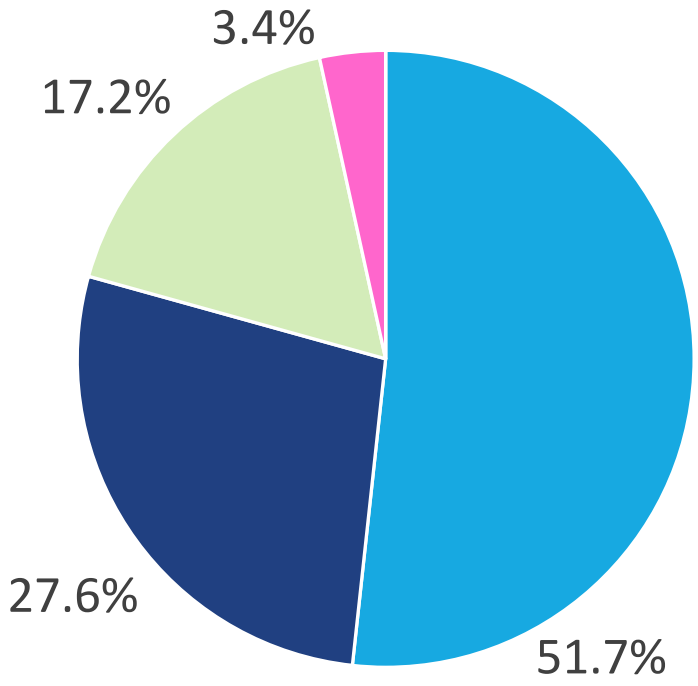
Opt	Votes
	9
	9
	11



- Yes, in a minority of patients
- No or very rarely
- Yes, in the majority of patients

Question 34: What is your recommended treatment approach for the majority of patients with oligorecurrent (metachronous) oligometastatic prostate cancer?

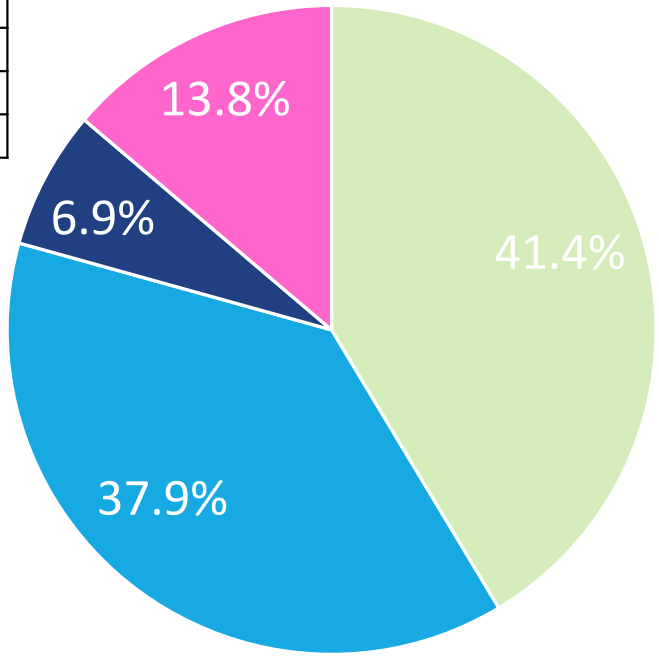
Opt	Votes
	8
	5
	1
	15



- AR pathway inhibitor + ADT
- AR pathway inhibitor + Metastasis-directive ablative therapy of lesions + ADT
- Metastasis-directed ablative therapy of lesions + ADT
- Metastasis directed ablative therapy alone to delay ADT
- ADT alone

Question 35: What is your recommended treatment approach for the majority of patients with oligorecurrent oligometastatic disease, who is non-metastatic based on conventional imaging, but has low-volume oligorecurrent oligometastatic prostate cancer on advanced imaging (PET or MRI)?

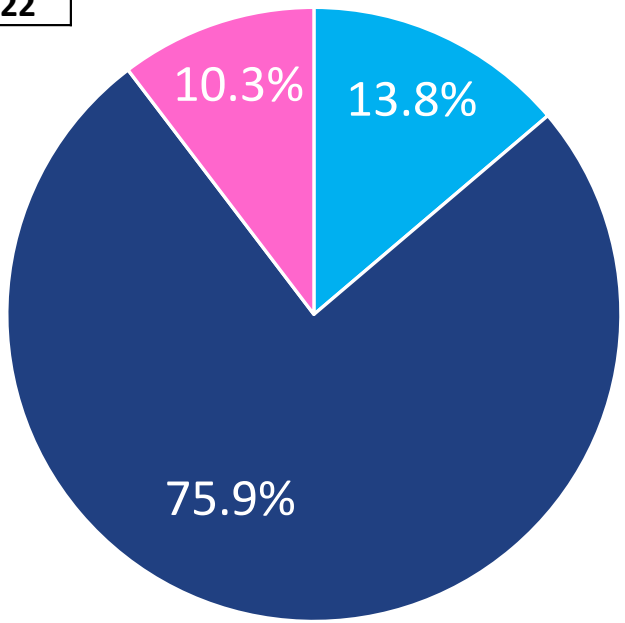
Opt	Votes
	2
	12
	4
	11



- Metastasis-directed ablative therapy of lesions + ADT
- AR pathway inhibitor + ADT
- AR pathway inhibitor + Metastasis-directive ablative therapy of lesions + ADT
- ADT alone

Question 36: What is the most useful definition of oligoprogressive prostate cancer?

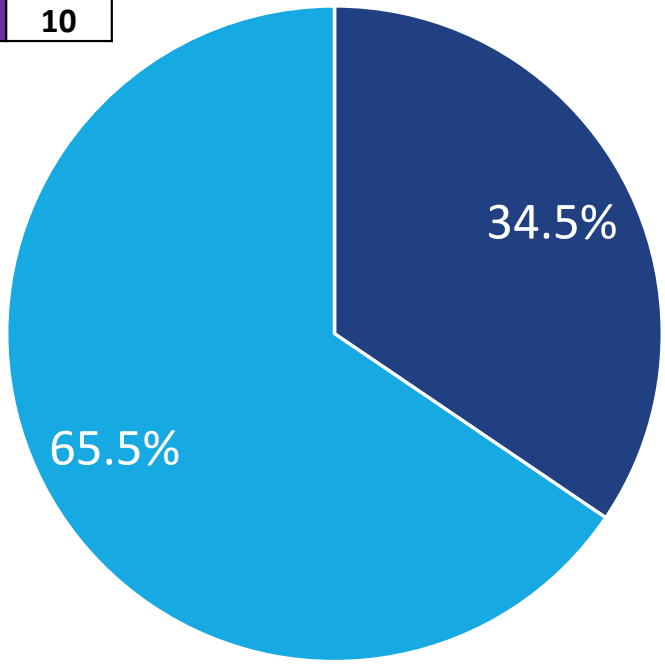
Opt	Votes
	3
	4
	22



- I do not believe that oligoprogressive prostate cancer is a meaningful clinical entity
- A limited number of progressing pre-existing or new lesion(s) in a patient with metastatic disease that is otherwise stable/treatment-responsive
- A single progressing pre-existing or new lesion in a patient with metastatic disease that is otherwise stable/treatment-responsive

Question 37: For patients with oligoprogressive metastatic chemotherapy-naïve CRPC, how do you recommend treating if there is disease progression (no visceral metastases) on a combination of ADT plus AR pathway inhibitor (abiraterone or apalutamide or enzalutamide)?

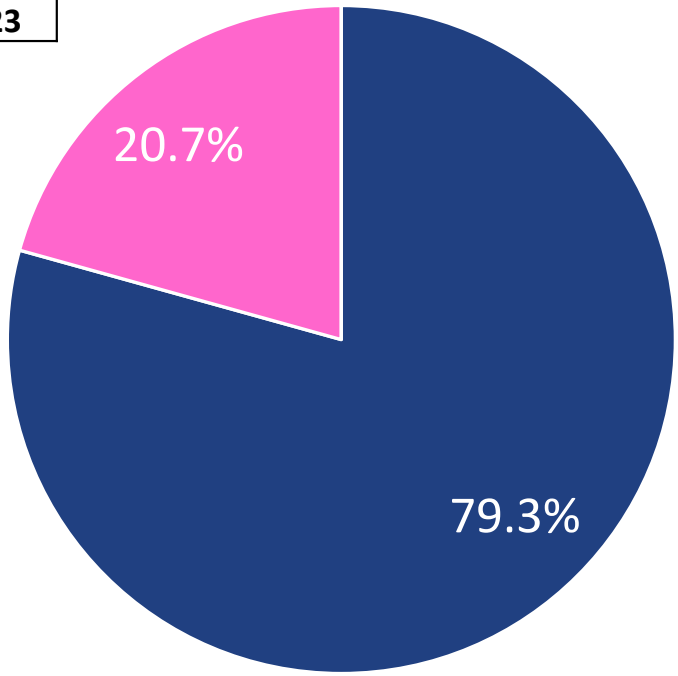
Opt	Votes
	19
	10



- Do not change systemic therapy; perform MDT of all progressing lesions
- Switch from current AR pathway inhibitor to another systemic therapy
- Switch from curent AR pathway to another systemic herapy and perform metastasis-directed ablative treatment of all progressive lesions

Question 38: Is there a role for AR pathway inhibitor to AR pathway inhibitor (back to back) sequencing from mCNPC/mCSPC to mCRPC, assuming no regulatory or access limitations?

Opt	Votes
	6
	23



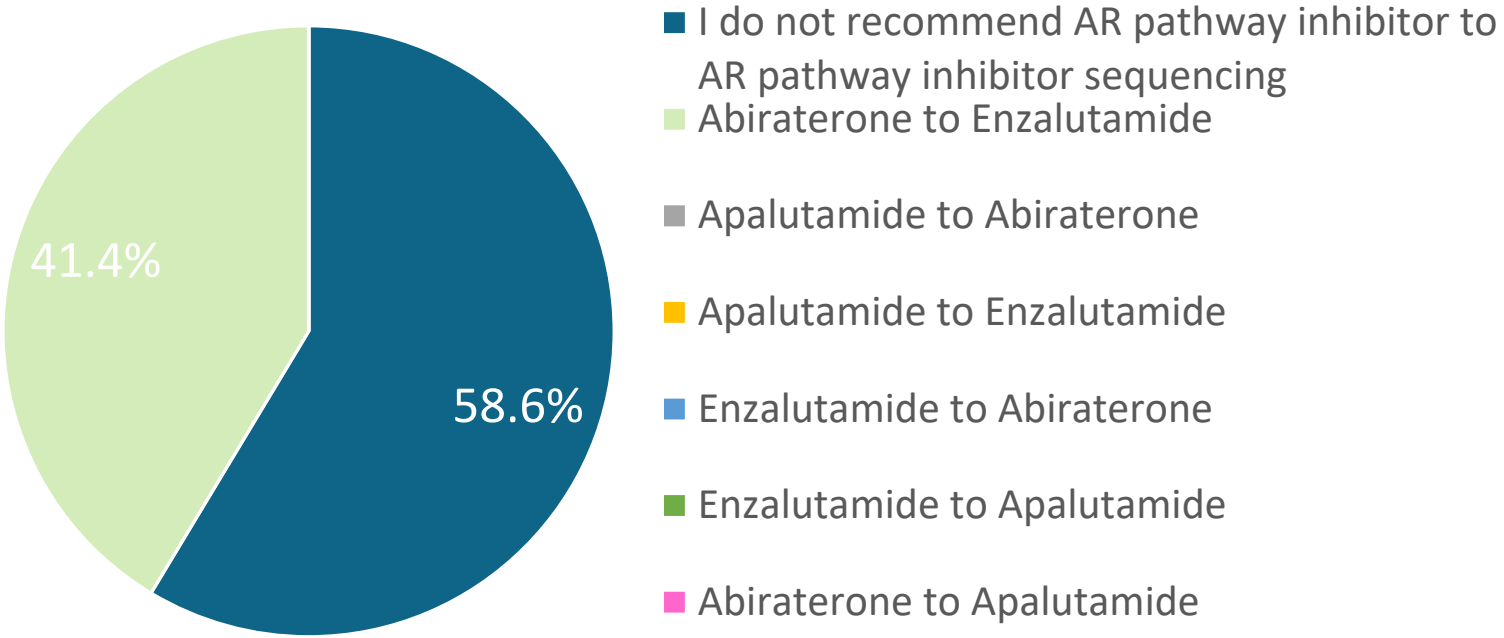
Yes, in a minority of patients (i.e. who are ineligible or refuse other options)

No

Yes, in a majoity of patients

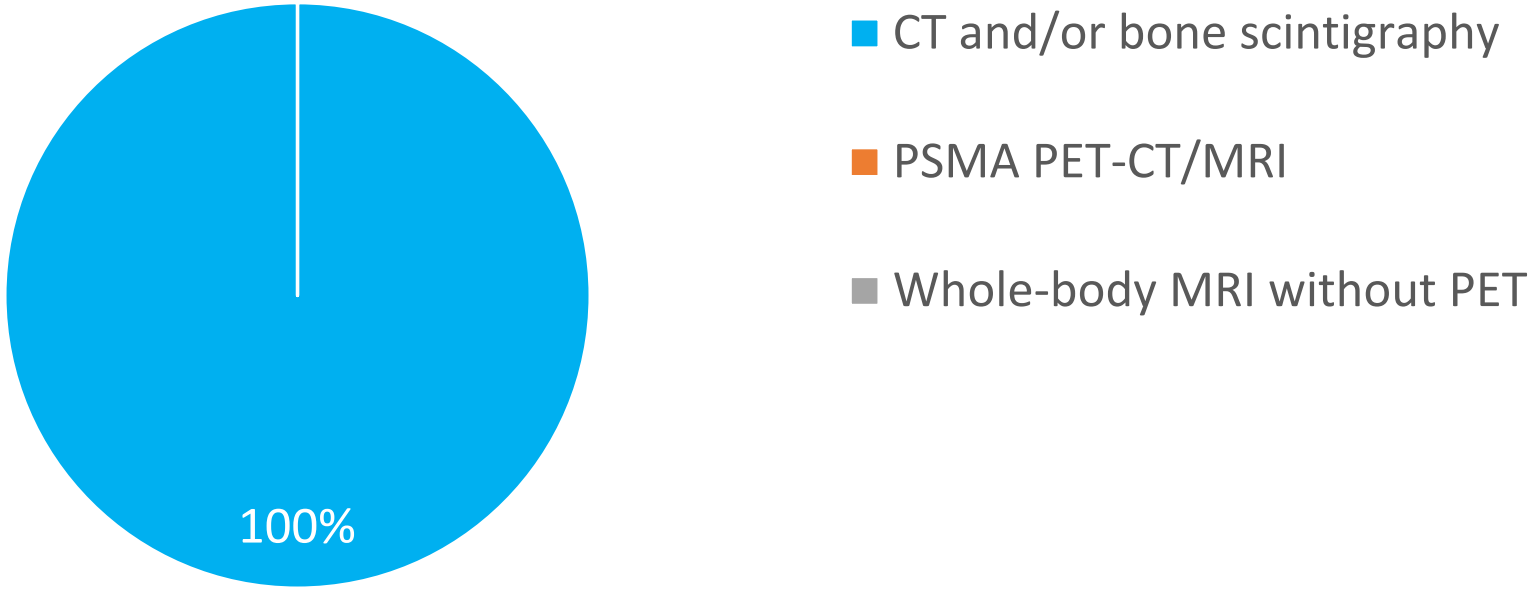
Question 39: What is your preferred AR pathway inhibitor to AR pathway inhibitor sequencing strategy for patients who progress from mCNPC/mCRPC to mCRPC?

Opt	Votes
	12
	17

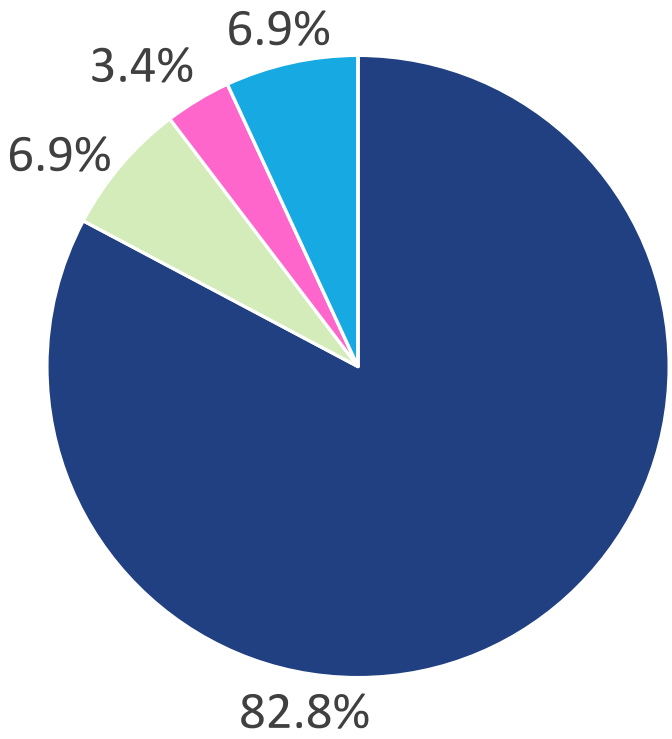


Question 40: What imaging do you use for the majority of patients to guide treatment decisions for the majority of patients with recent onset of CRPC and rising PSA in order to determine if patient is nmCRPC or mCRPC?

Opt	Votes
	29



Question 41: For asymptomatic nmCRPC (M0 CRPC) patients (no metastatic disease documented on past imaging) on ADT who have rising PSA and PSA doubling time <=10 months, at what confirmed total PSA level do you recommend imaging?

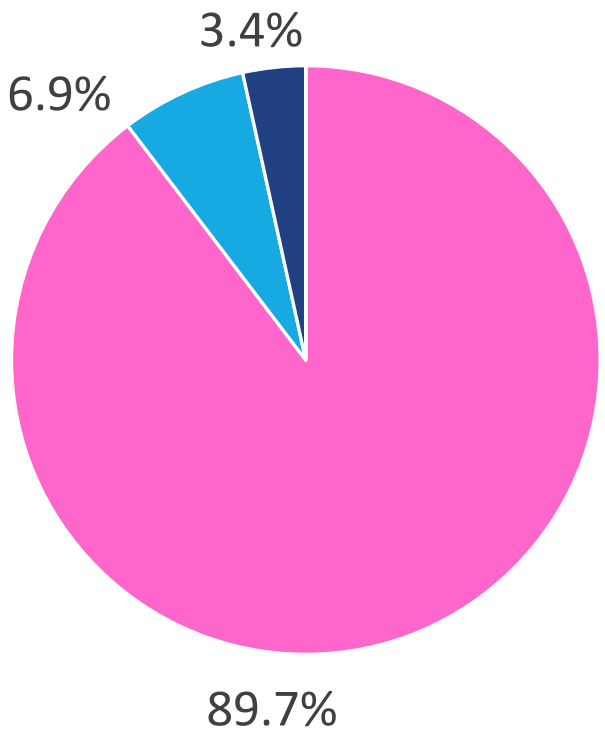


Opt	Votes
	24
	1
	2
	2

- PSA >2 ng/mL
- PSA >1 ng/mL
- PSA >5 ng/mL
- PSA >10 ng/mL
- I do not use absolute PSA values to guide imaging
- I do not recommend imaging these patients

Question 42: In the majority of nmCRPC (M0 CRPC) patients who have PSA >2 ng/mL and PSA doubling time <10 months, what is your preferred treatment choice in addition to ADT?

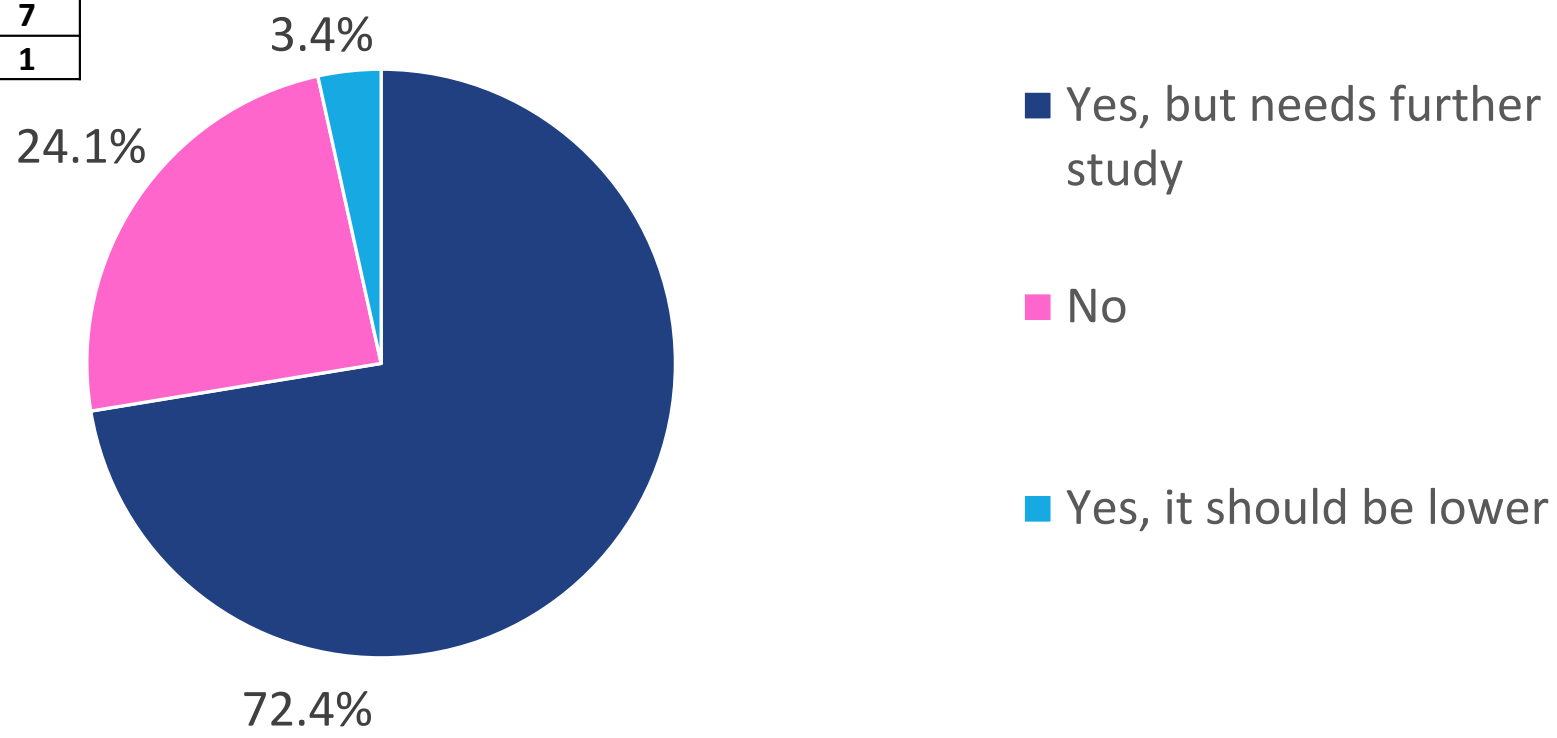
Opt	Votes
	1
	26
	2



- Any AR antagonist mentioned above
- Apalutamide
- Darolutamide
- Enzalutamide
- NSAA (i.e. bicalutamide)
- No additional treatment: continue ADT alone

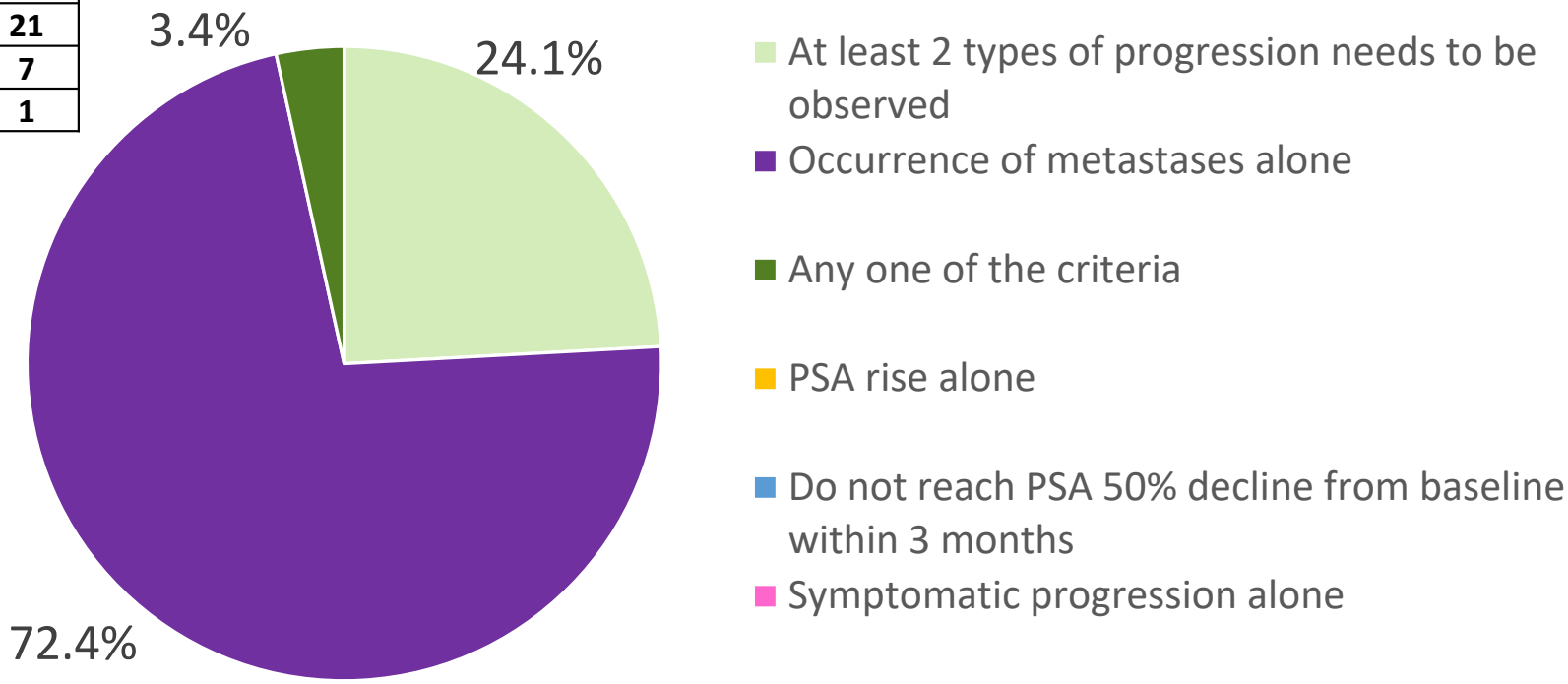
Question 43: The definition of CRPC includes an absolute PSA threshold of 2 ng/mL or greater. Is there a rationale to consider a lower PSA threshold that is lower than 2ng/mL to define CRPC?

Opt	Votes
	21
	7
	1



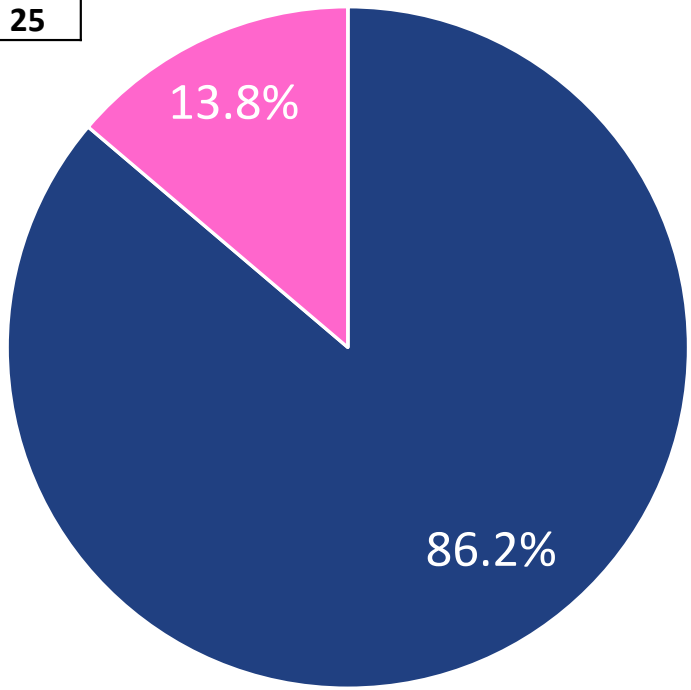
Question 44: If you treat a patient with an AR pathway inhibitor (apalutamide or darolutamide or enzalutamide) for nmCRPC (M0 CRPC), at what threshold do you recommend changing treatment apart from ADT (excluding treatment changes for toxicity)?

Opt	Votes
	21
	7
	1



Question 45: In there a role for AR pathway inhibitor to AR pathway inhibitor (back to back) sequencing from nmCRPC to mCRPC, assuming no regulatory or access limitations?

Opt	Votes
	4
	25



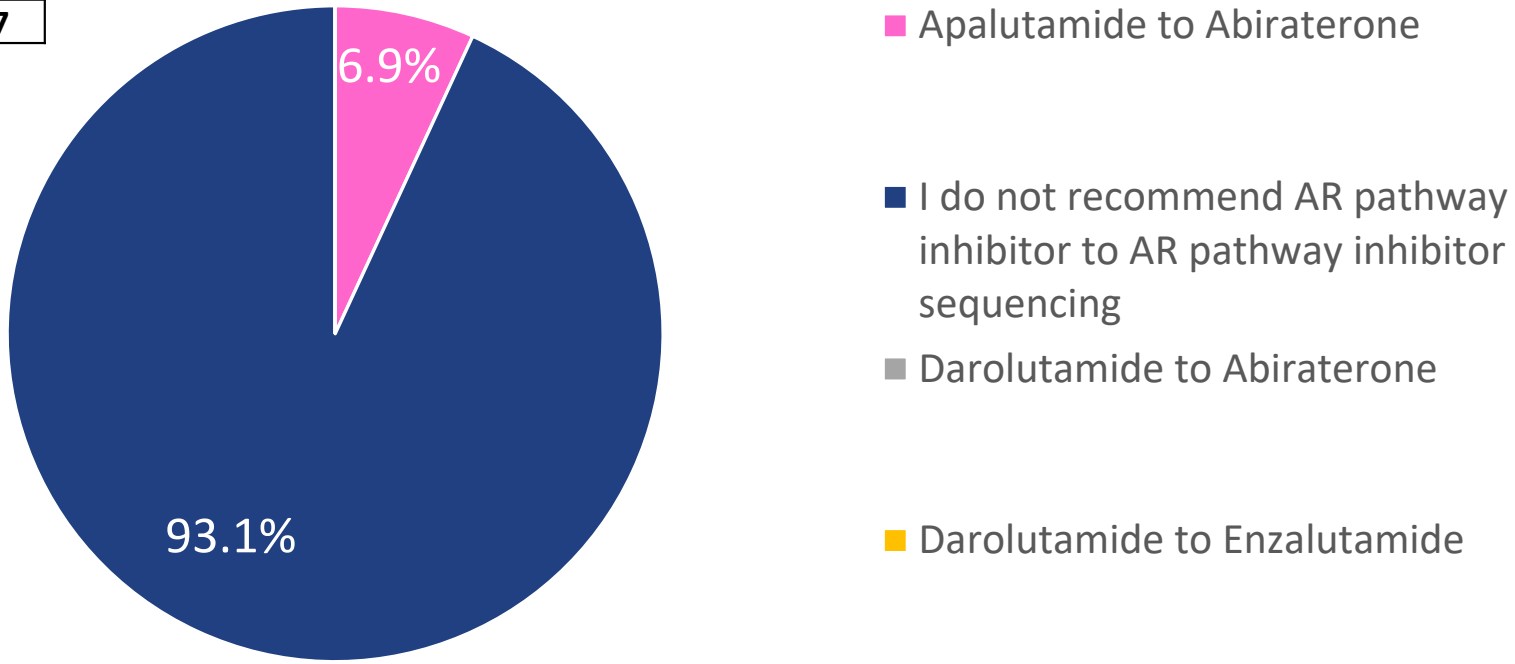
Yes, in a minority of patients (i.e. who are ineligible, refuse other options, etc.)

No

Yes, in the mjority of patients

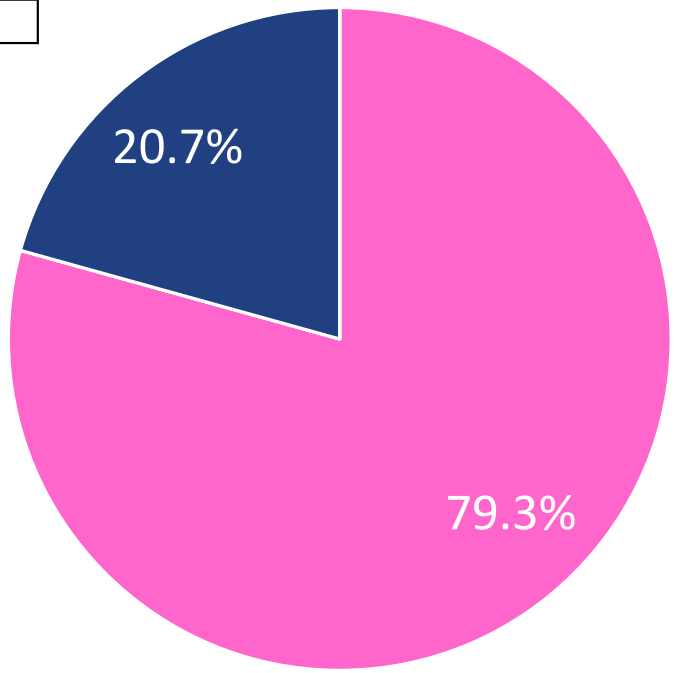
Question 46: What is your preferred AR pathway inhibitor to AR pathway inhibitor sequencing strategy for patients who progress from nmCRPC to mCRPC?

Opt	Votes
	2
	27



Question 47: Do you recommend switching treatment in patients with mCRPC at PSA progression alone (in the absence of other signs of progression)?

Opt	Votes
	23
	6



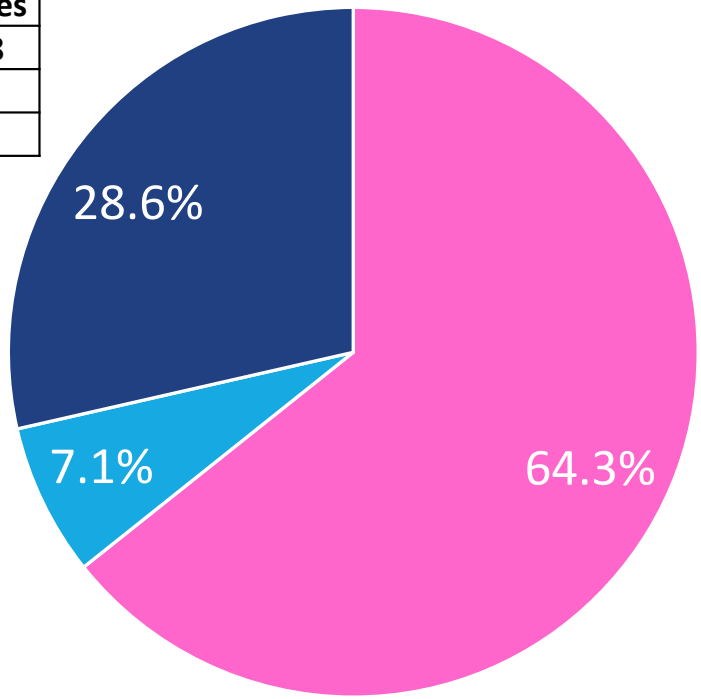
No

Yes, in selected patients

Yes, in the majority of patients

Question 48: Do you recommend switching treatment in patients with mCRPC in the case of unequivocal progression on next-generation imaging (wb-MRI, PET/CT with different tracers) alone (without PSA or clinical progression)?

Opt	Votes
	18
	2
	8



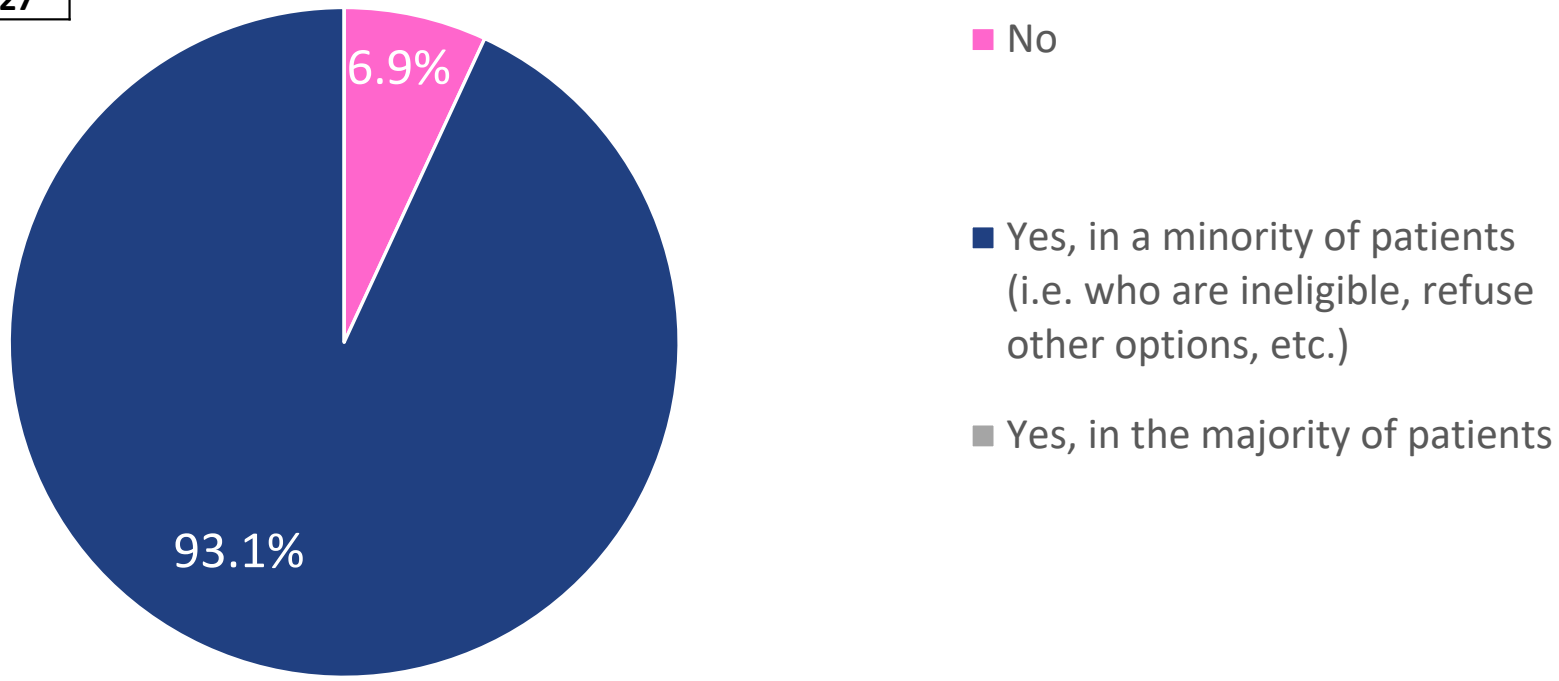
No

Yes, in the majority of patients

Yes, in a minority of patients

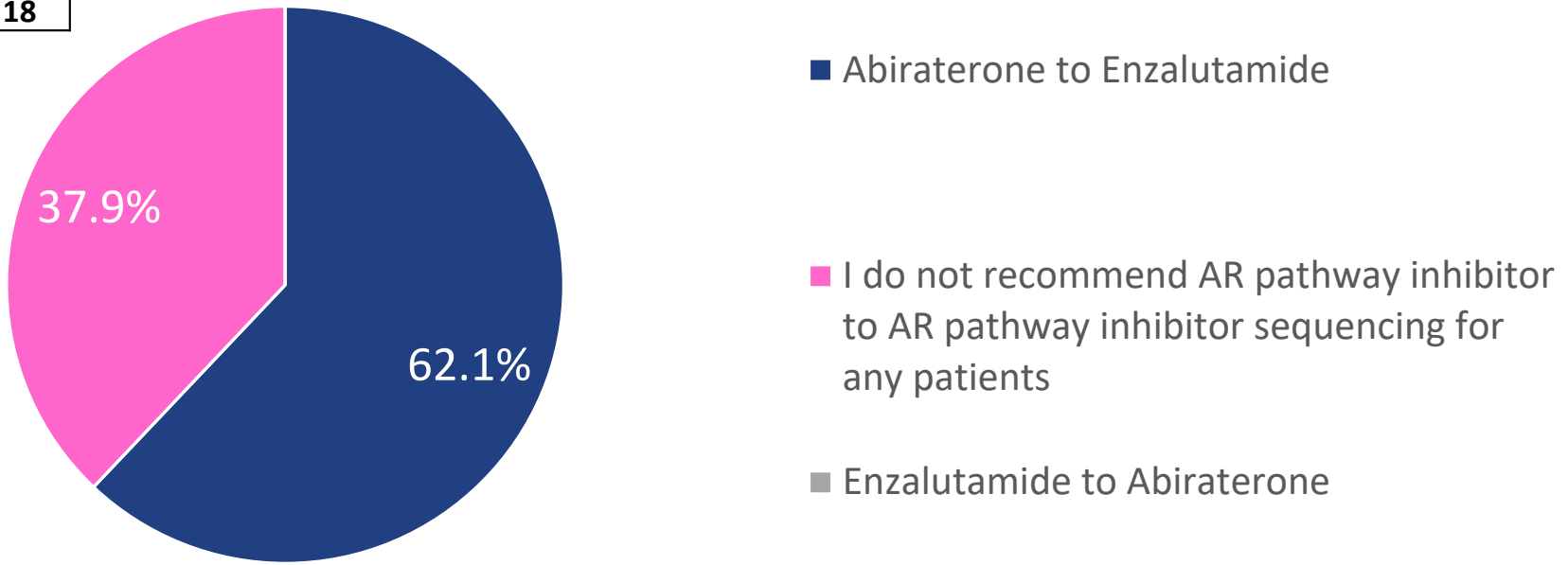
Question 49: Is there a role for AR pathway inhibitor to AR pathway inhibitor (back to back) sequencing within the mCRPC setting, assuming no regulatory or access limitations?

Opt	Votes
	2
	27



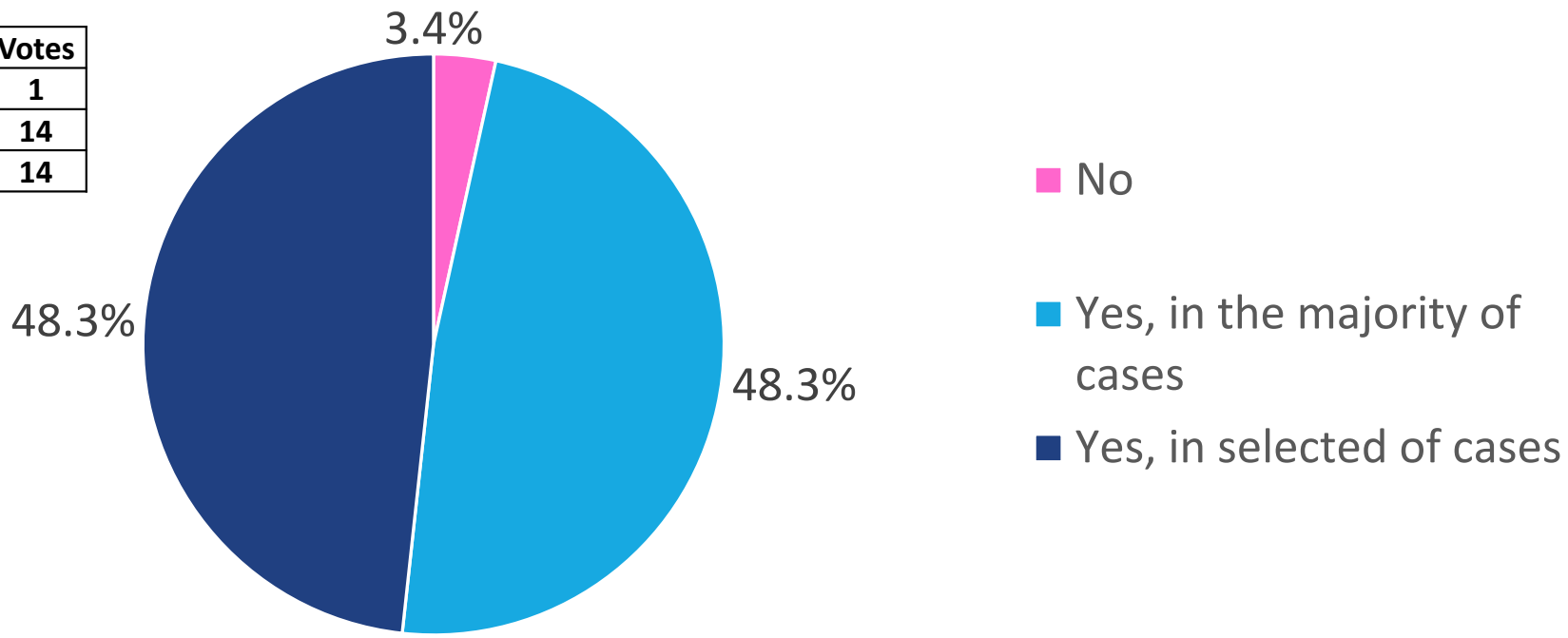
Question 50: What is your preferred AR pathway inhibitor to AR pathway inhibitor sequence in the mCRPC setting?

Opt	Votes
	11
	18



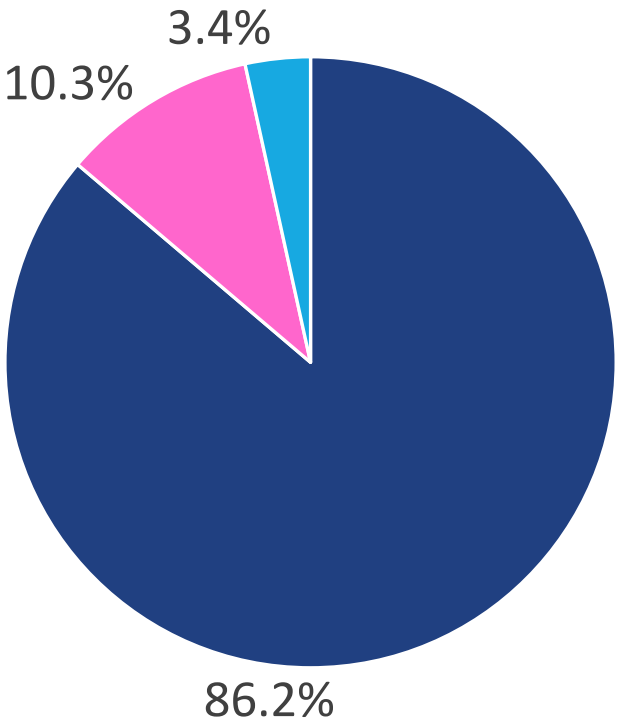
Question 51: Is there a role for biomarker testing as an approach to select candidates who may potentially respond to a second AR pathway inhibitor at some point later in the treatment continuum?

Opt	Votes
	1
	14
	14



Question 52: For patients starting on long-term ADT plus abiraterone/prednisone with mCSPC who have NO documented osteoporosis, do you routinely recommend initiating denosumab or a bisphosphonate at the dose and schedule used for osteoporosis, in order to prevent cancer treatment-induced bone loss (CTIBL)/ fractures?

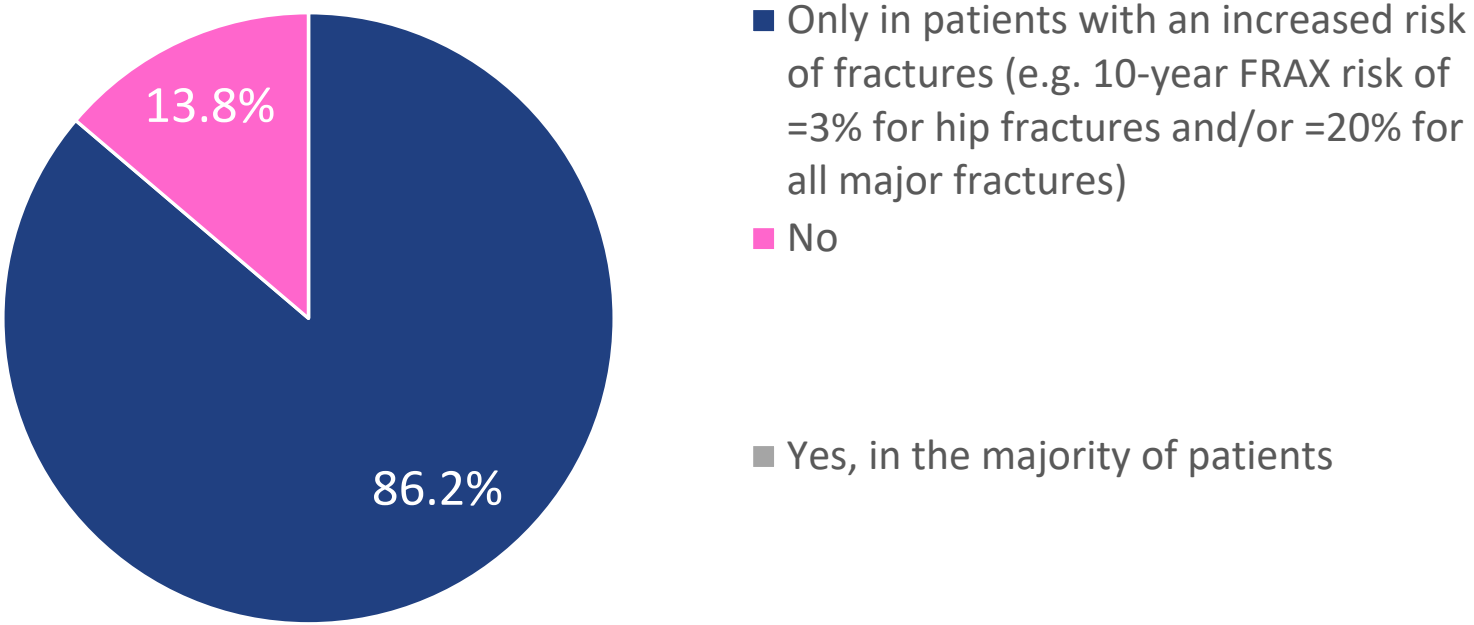
Opt	Votes
	3
	1
	25



- Only in patients with an increased risk of fractures (e.g. 10-year FRAX risk of =3% for hip fractures and/or =20% for all major fractures)
- No
- Yes, in the majority of patients

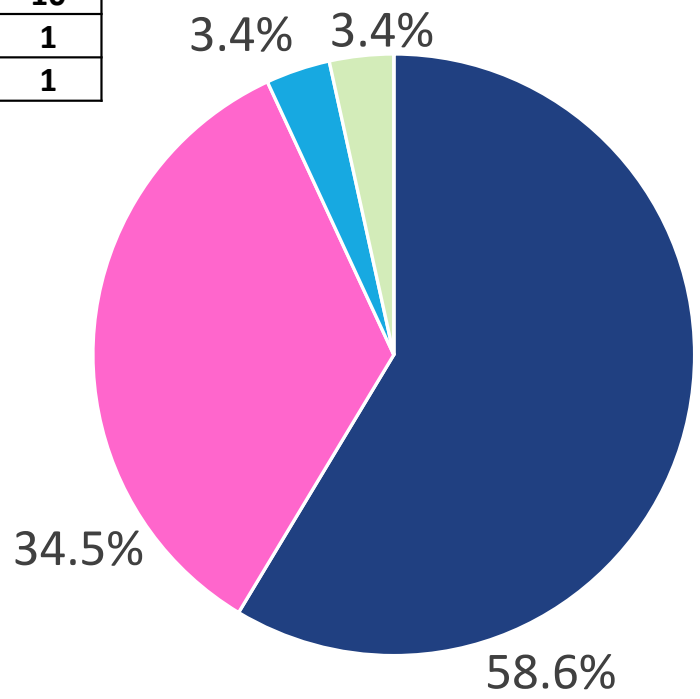
Question 53: For patients with nmCRPC starting receiving ADT plus AR pathway inhibitors, who have NO documented osteoporosis, do you routinely recommend initiating denosumab or a bisphosphonate at the dose and schedule used for osteoporosis, in order to prevent cancer treatment-induced bone loss (CTIBL)/ fractures?

Opt	Votes
	4
	25



Question 54: When do you first recommend tumour genomic testing?

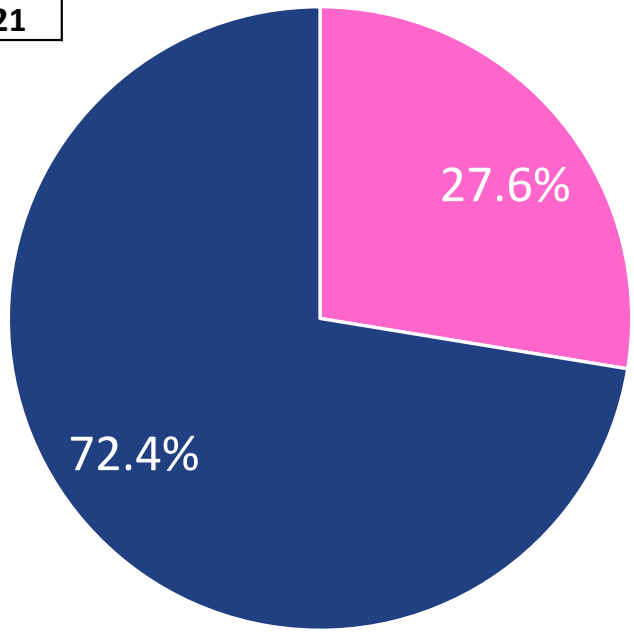
Opt	Votes
	17
	10
	1
	1



- At first diagnosis of metastatic disease
- After at least one line of chemotherapy and at least one AR pathway inhibitor
- At diagnosis of high-risk localized disease
- I do not routinely recommend tumour genomic testing
- Afer all standard treatment options are exhausted

Question 55: If you recommend tumour genomic testing, which tests do you consider relevant in patients with metastatic prostate cancer outside of a clinical trial?

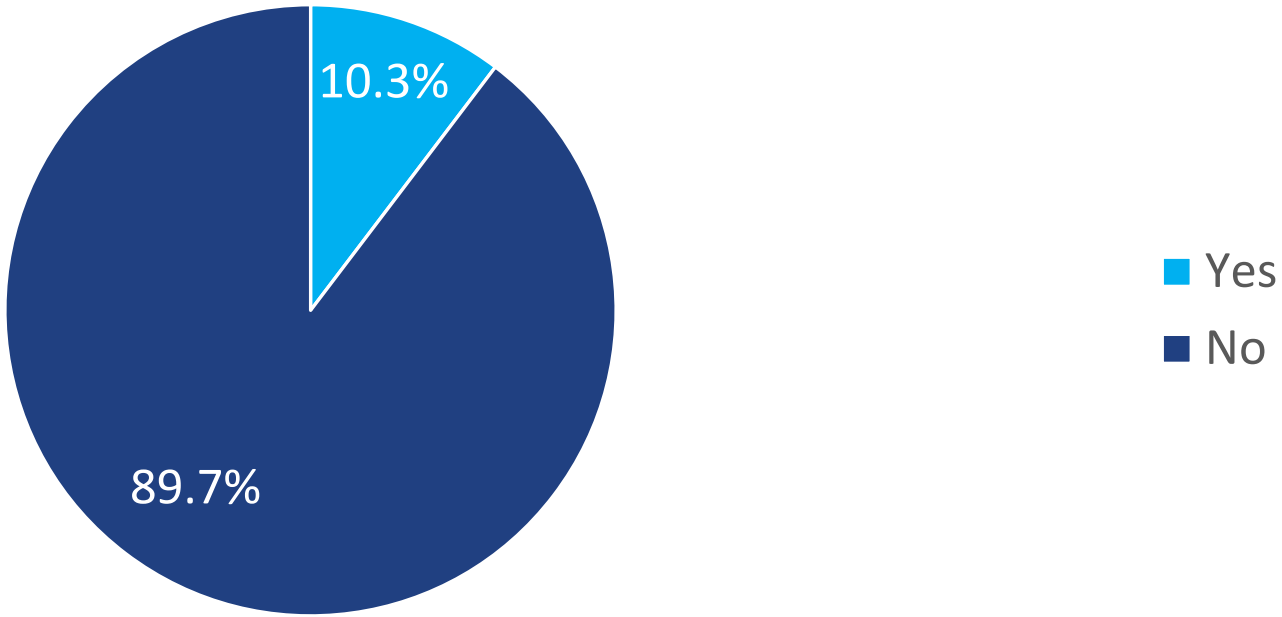
Opt	Votes
	8
	21



- DNA repair defects, including mismatch repair evaluation (MSI high)
- Prostate cancer-specific larger panel testing, including for example homologous recombination deficiency (BRCA1, BRCA2, PALB2, RAD51), PTEN, PI3K, SPOP, CDK12, ATM, mismatch repair evaluation (MSI high), tumour mutation burden

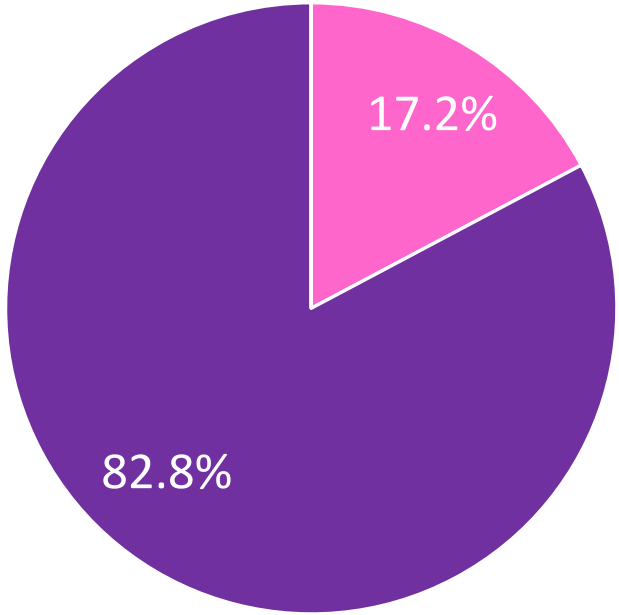
Question 55a: Do you have access to genomic testing outside of clinical trials?

Opt	Votes
	3
	26



Question 56: Does the presence of a tumour BRCA1/2 germline aberration in patients with low-risk localized prostate cancer influence your treatment decision?

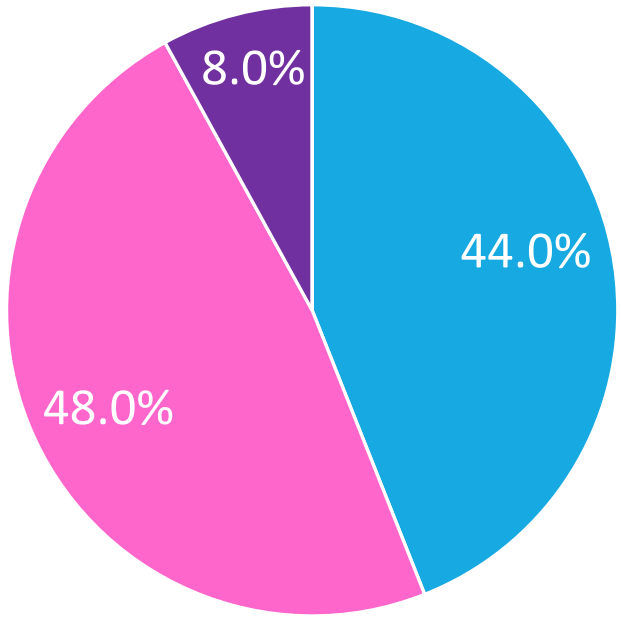
Opt	Votes
	5
	24



- No, patients continue with active surveillance but more intense monitoring
- Yes, I recommend radical therapy (either surgery or radiation) instead of surveillance
- Yes, I recommend radical prostatectomy over radiation therapy
- Yes, I recommend readiation therapy over radical prostatectomy

Question 57: Does the presence of a tumour BRCA1/2 germline aberration in patients with intermediate or high-risk localized prostate cancer influence your treatment decision?

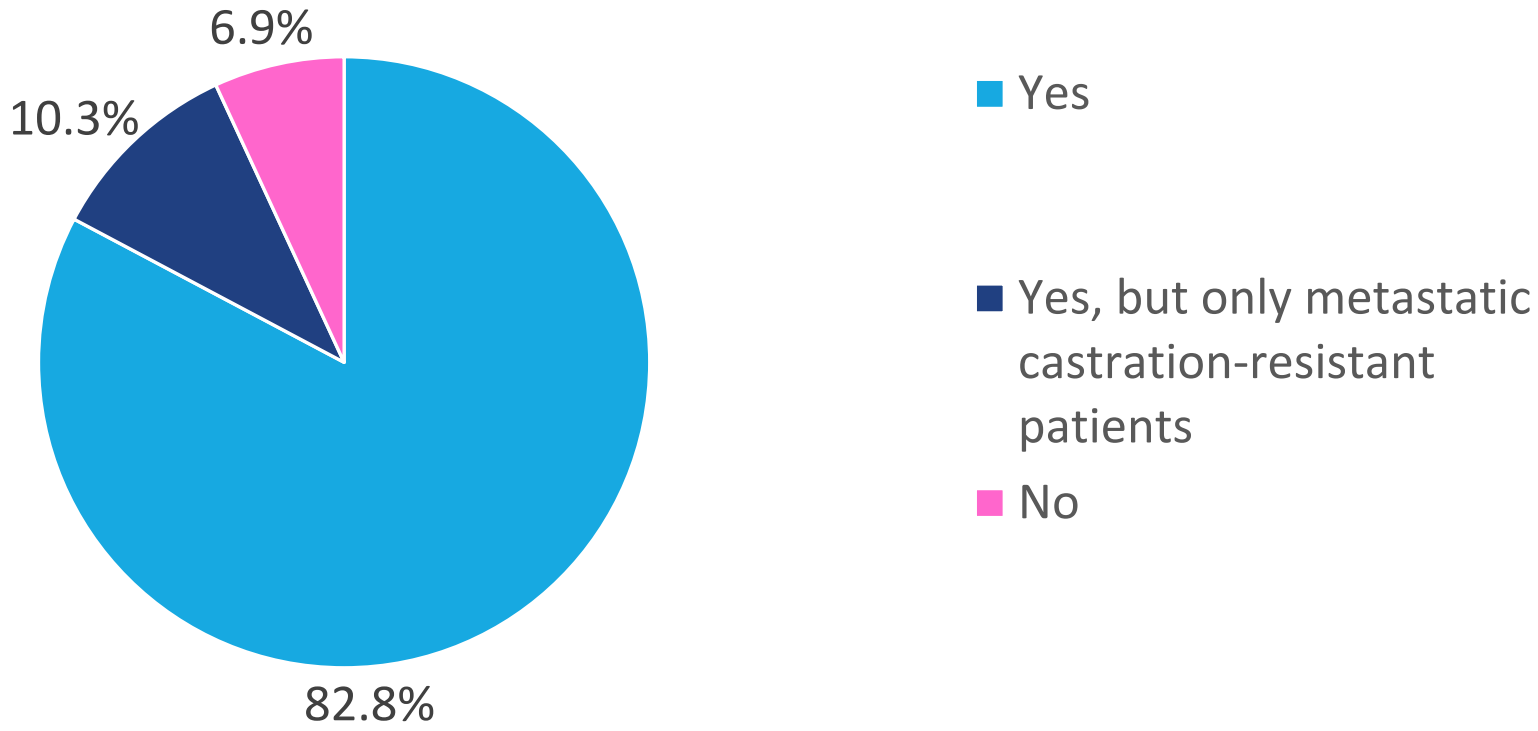
Opt	Votes
	2
	11
	12



- Yes, I recommend radical prostatectomy over radiation therapy
- No, I make the standard treatment recommendation but more intense monitoring
- No, I make the standard treatment recommendation
- Yes, I recommend radiation therapy over radical prostatectomy

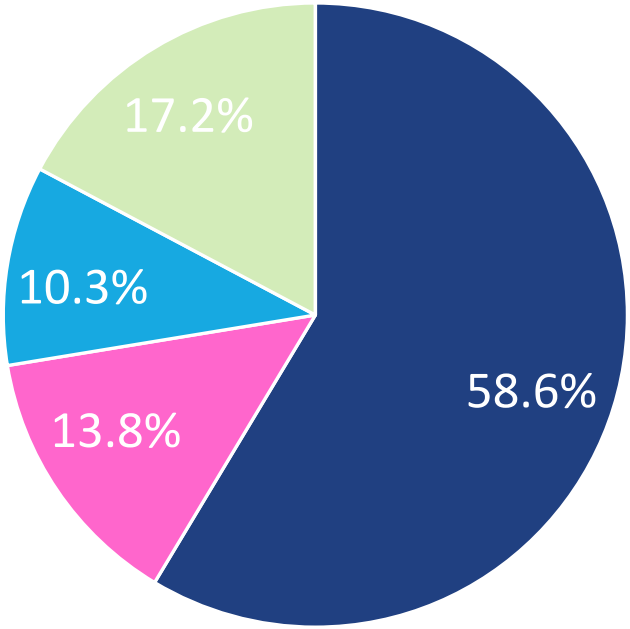
Question 58: Do you recommend that the majority of metastatic prostate cancer patients get their tumours tested for BRCA1/2 aberrations?

Opt	Votes
	2
	24
	3



Question 59a: Who and when should patients be tested for BRCA 1/2 mutation? (somatic)

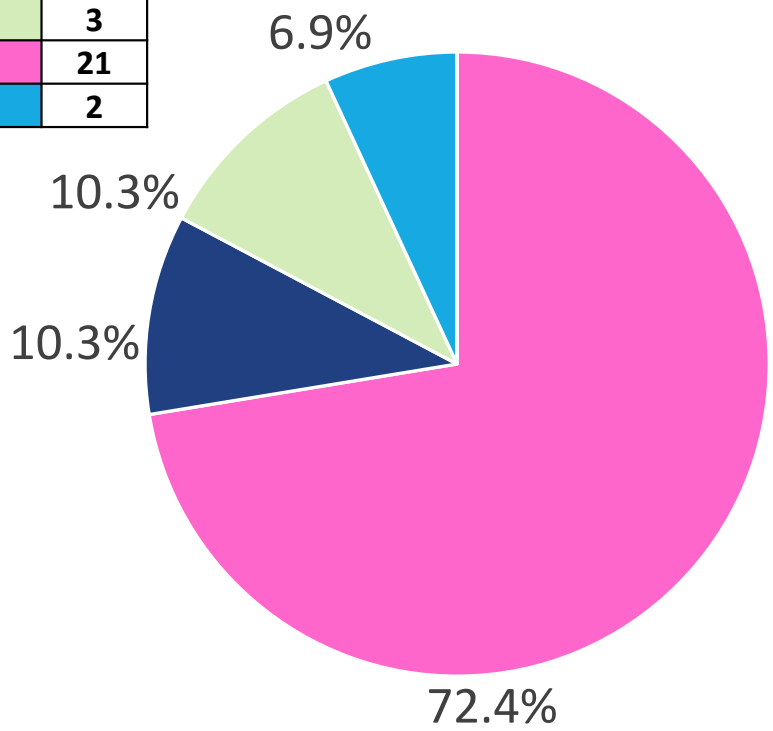
Opt	Votes
	17
	5
	4
	3



- PCa patients with mCNPC/mCSPC
- Any PCa patients with a strong family history of BRCA-associated concerns and undocumented somatic and germline aberration
- PCa patients with high/very high-risk localized disease
- PCa patients with mCRPC
- I don't think a positive BRCA1/2 test result will change my treatment decision making

Question 59b: Who and when should patients be tested for BRCA 1/2 mutation? (germline)

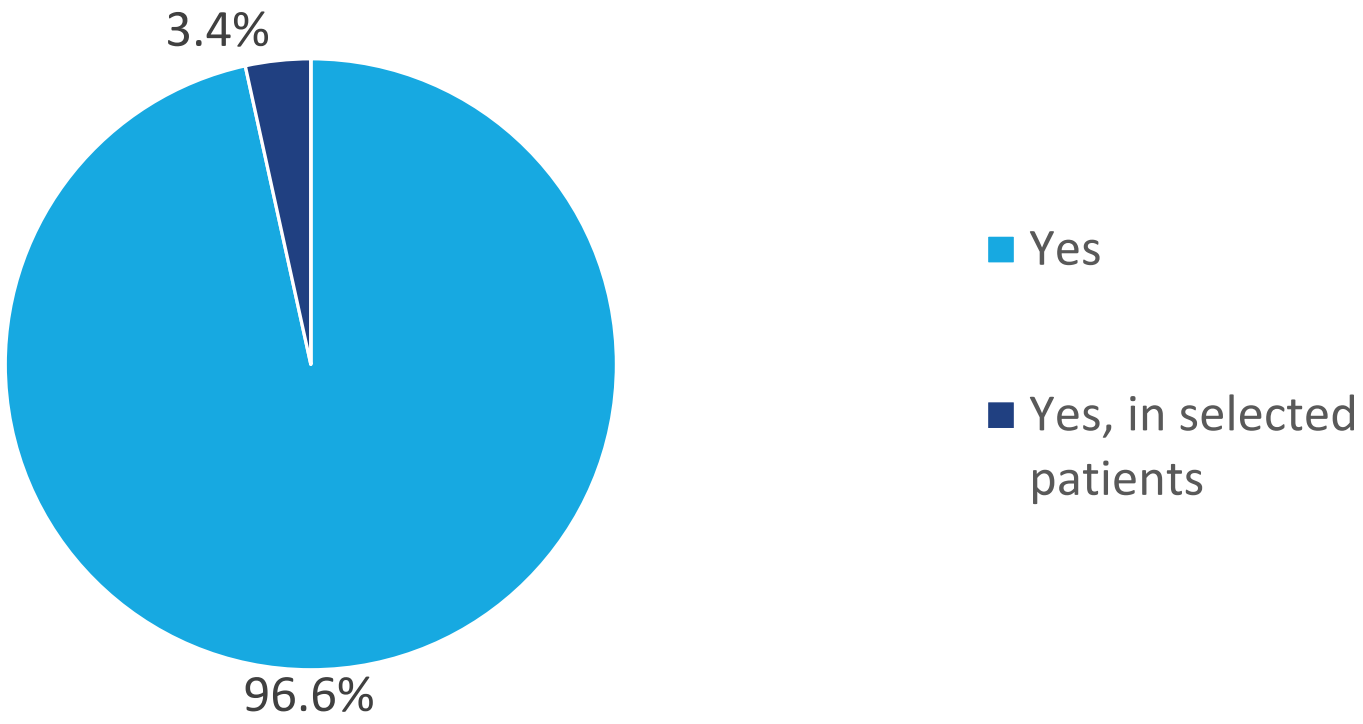
Opt	Votes
	3
	3
	21
	2



- Any PCa patients with a strong family history of BRCA-associated concerns and undocumented somatic and germline aberration
- PCa patients with mCRPC
- PCa patients with mCNPC/mCSPC
- PCa patients with high/very high-risk localized disease
- I don't think a posstive BRCA1/2 test result will change my treatment decision making

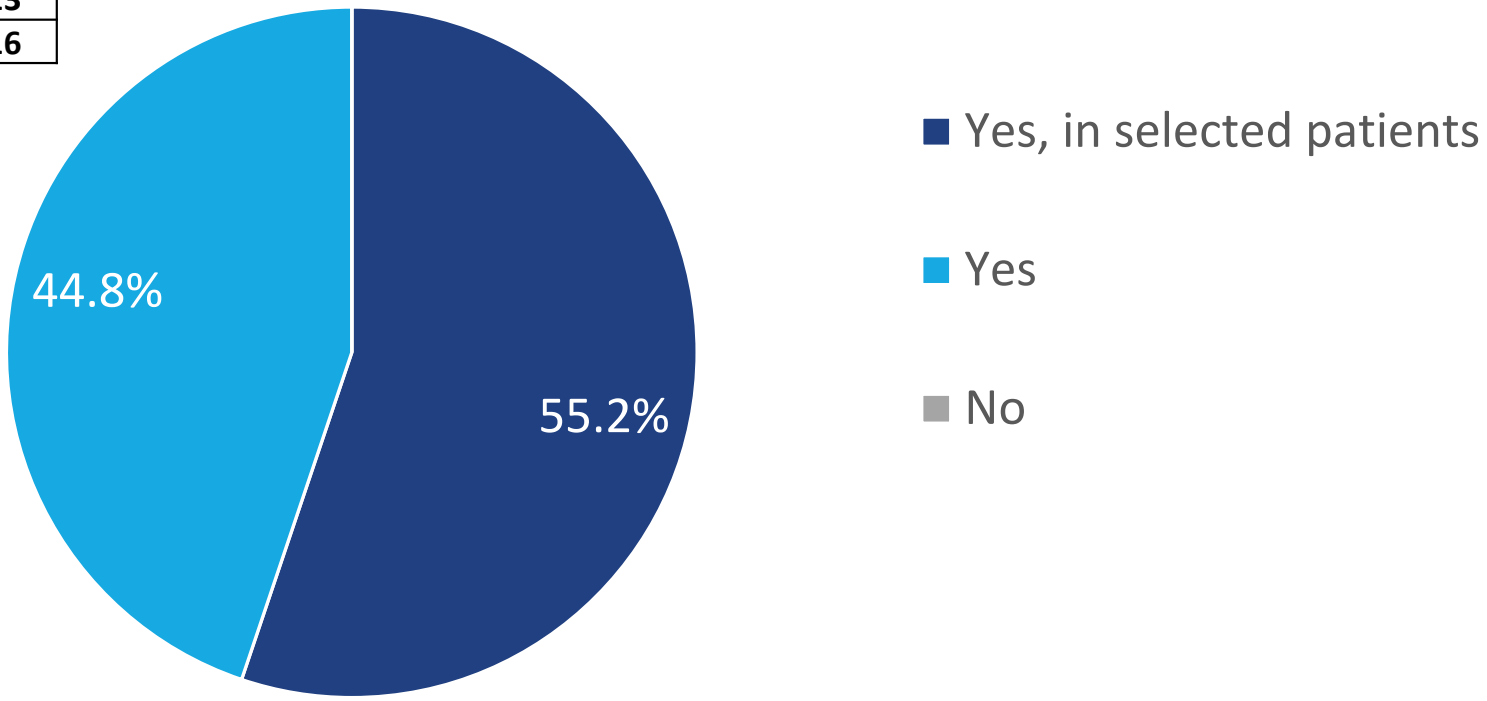
Question 60: Do you recommend that the majority of metastatic prostate cancer patients with a deleterious germline BRCA1/2 mutation receive a PARP inhibitor during their disease course outside of a clinical trial if none is available?

Opt	Votes
	28
	1



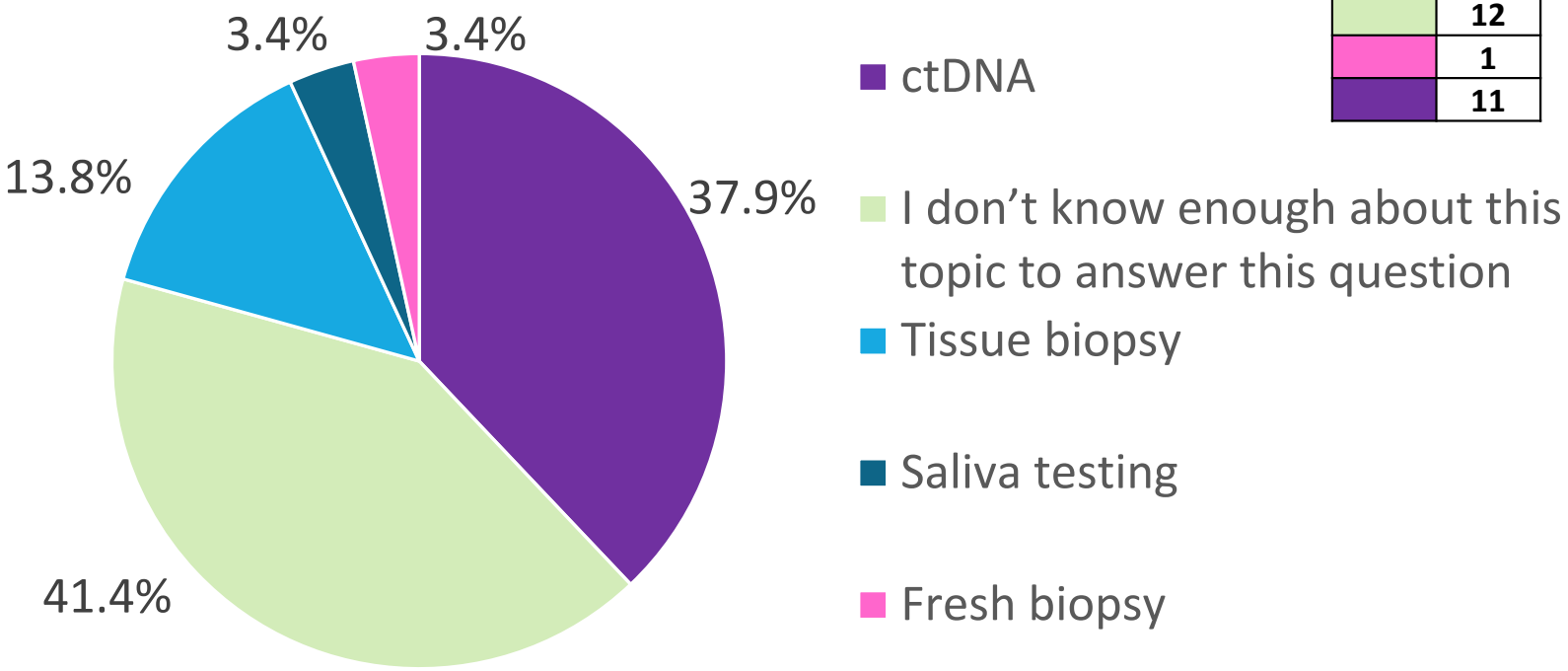
Question 61: Do you recommend that the majority of metastatic prostate cancer patients with a deleterious germline BRCA1/2 mutation receive platinum therapy during their disease course outside of a clinical trial if no trials are available?

Opt	Votes
	13
	16



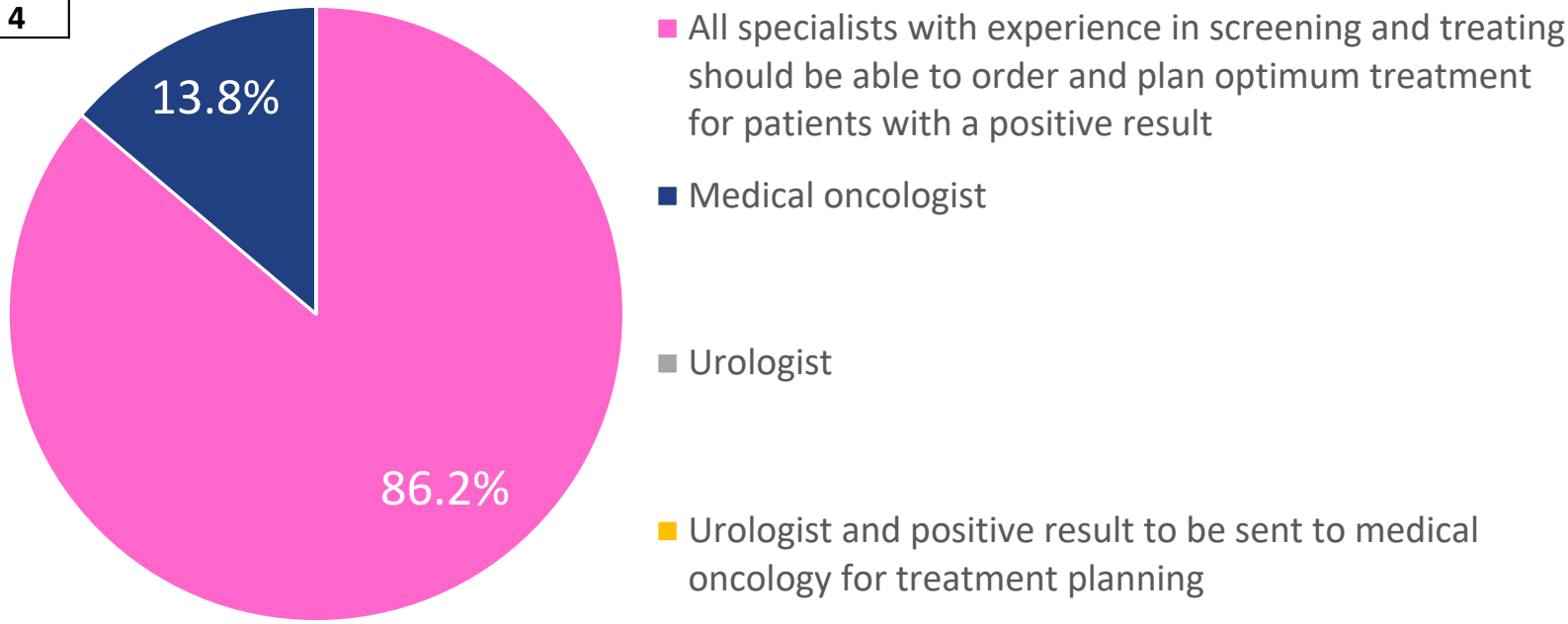
Question 62: What do you believe is the best way to test for BRCA 1/2 mutations in prostate cancer patients?

Opt	Votes
	4
	1
	12
	1
	11



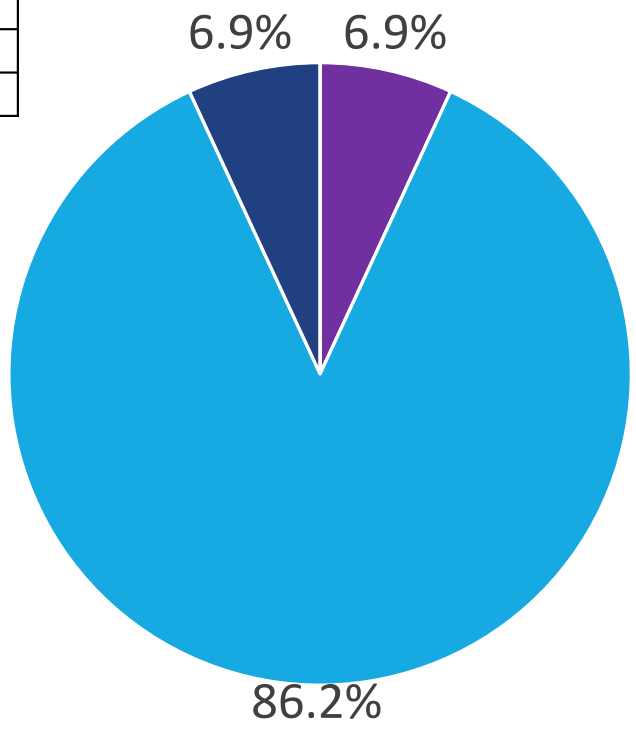
Question 63: Which specialty do you recommend ordering the BRCA 1/2 genetic testing and leading the treatment planning for patients with positive result?

Opt	Votes
	25
	4



Question 64: What is your treatment recommendation for metastatic prostate cancer with a pathogenic BRCA 1/2 aberration (somatic and/or germline)?

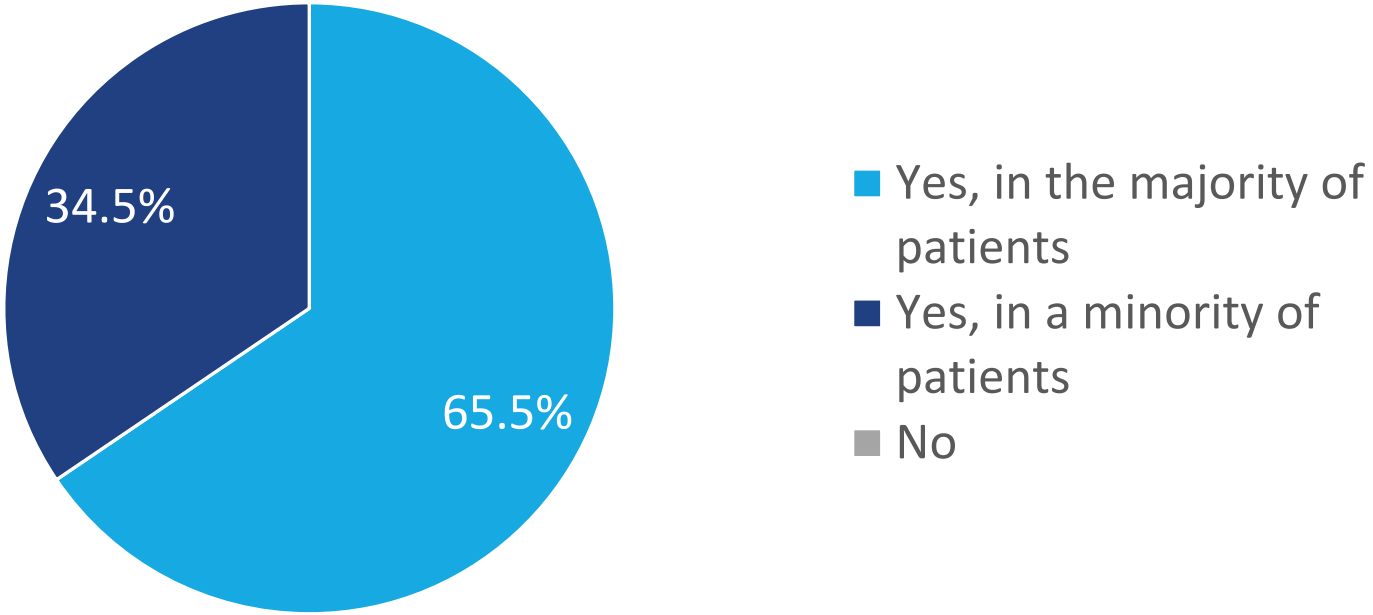
Opt	Votes
	2
	2
	25



- PARP inhibitor or platinum therapy + AR pathway inhibitor therapy
- PARP inhibitor or platinum therapy during their disease course when available
- PARP inhibitor + AR pathway inhibitor therapy
- I don't believe in he PARPi daa for Pca patients yet

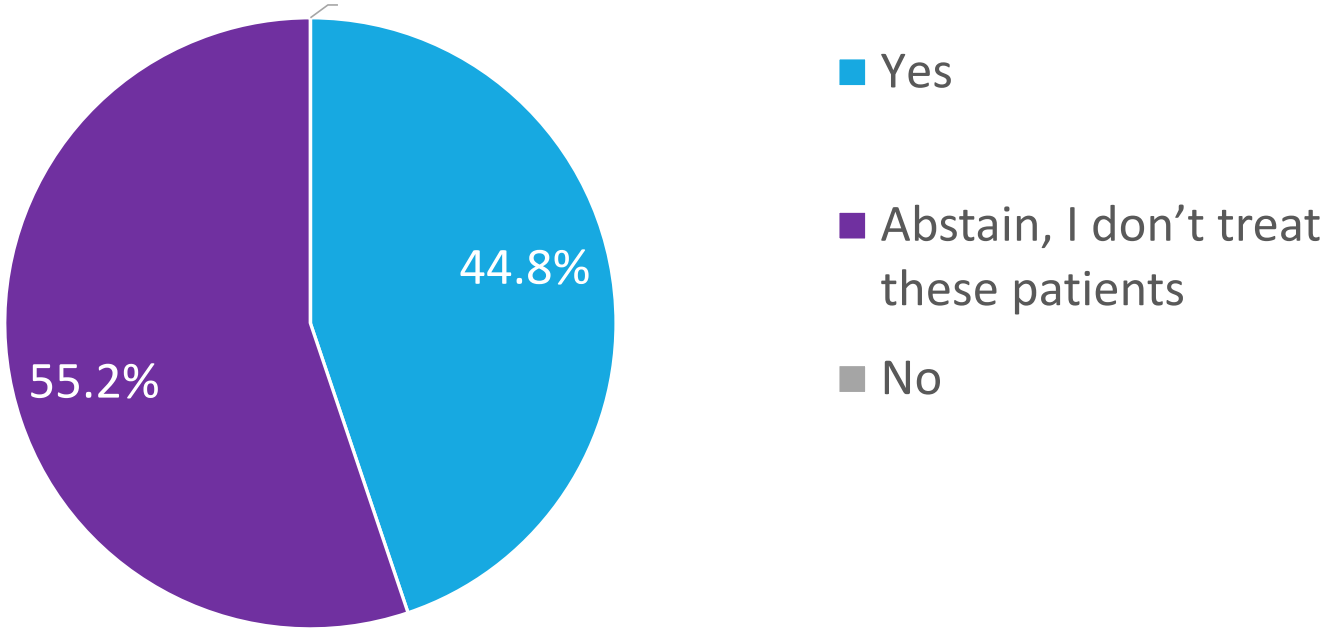
Question 65: Do you recommend genetic counselling and/or germline DNA testing for patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC)?

Opt	Votes
	19
	10



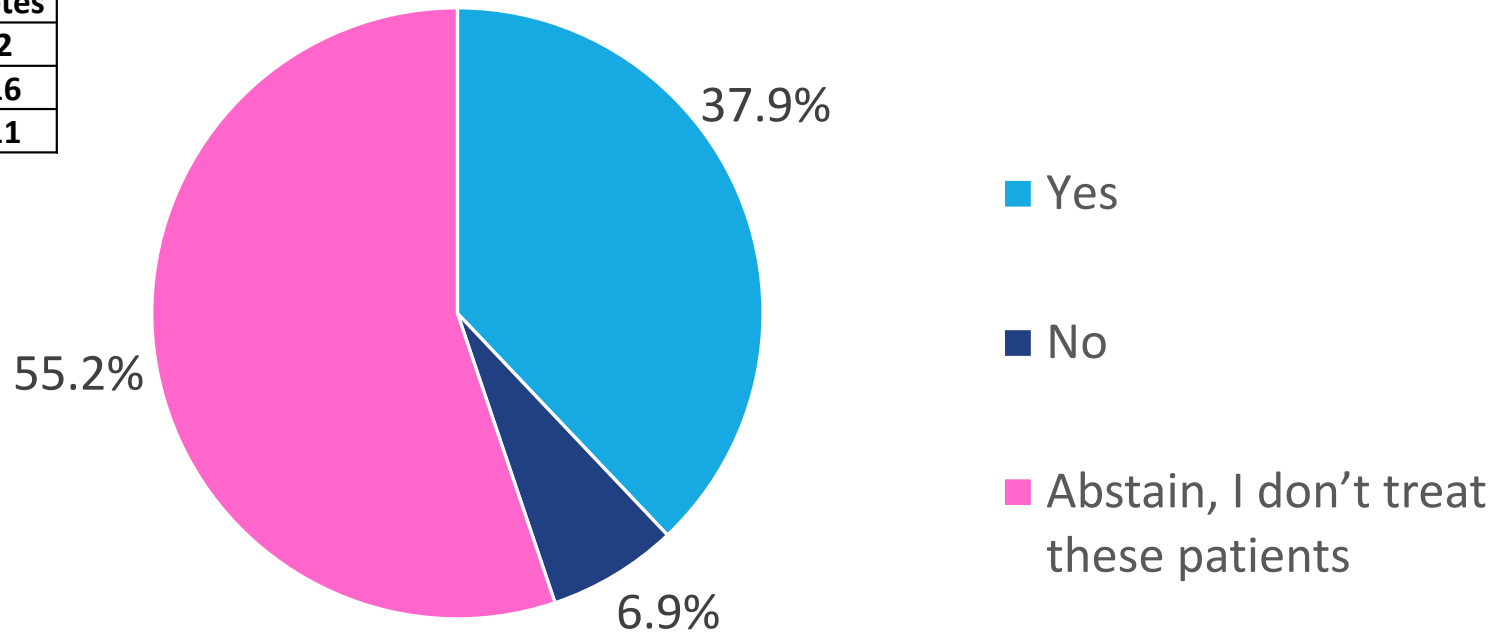
S1: For patients with cN1, cM0 prostate cancer who are receiving radiation therapy as radical loco-regional treatment, do you recommend approximately 24 months duration of ADT for the majority of your patients?

Opt	Votes
	13
	16



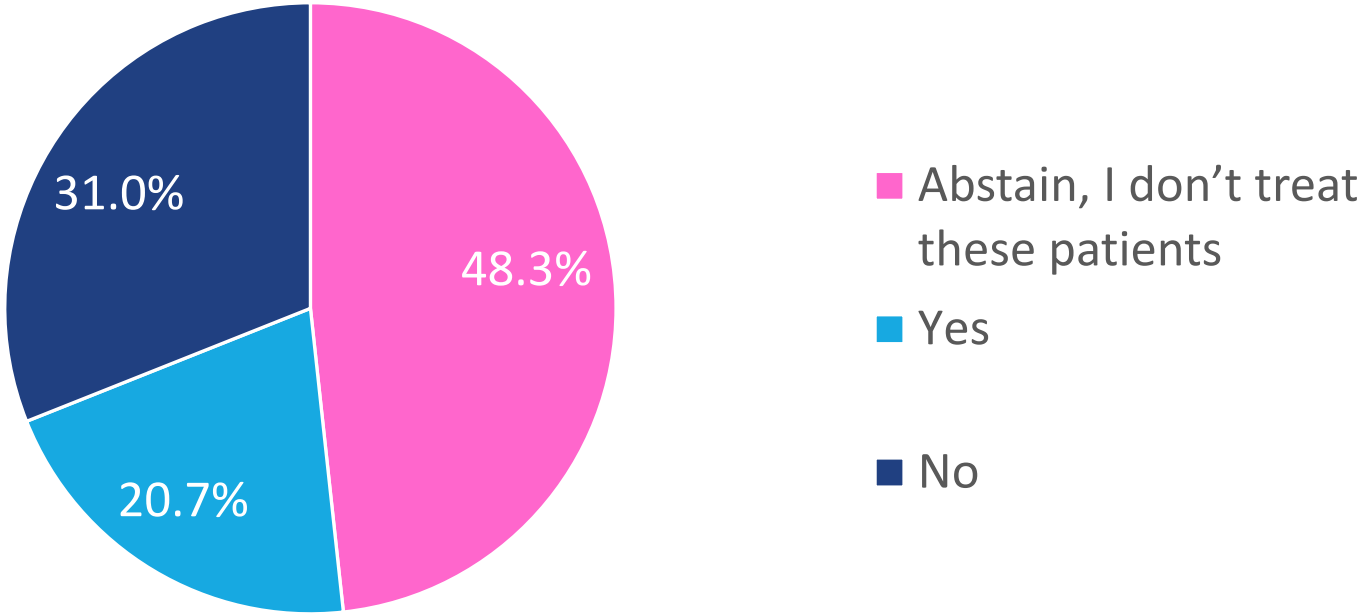
S2: For patients with pN1 disease receiving adjuvant radiation therapy, do you recommend approximately 24 months duration of ADT for the majority of your patients?

Opt	Votes
	2
	16
	11



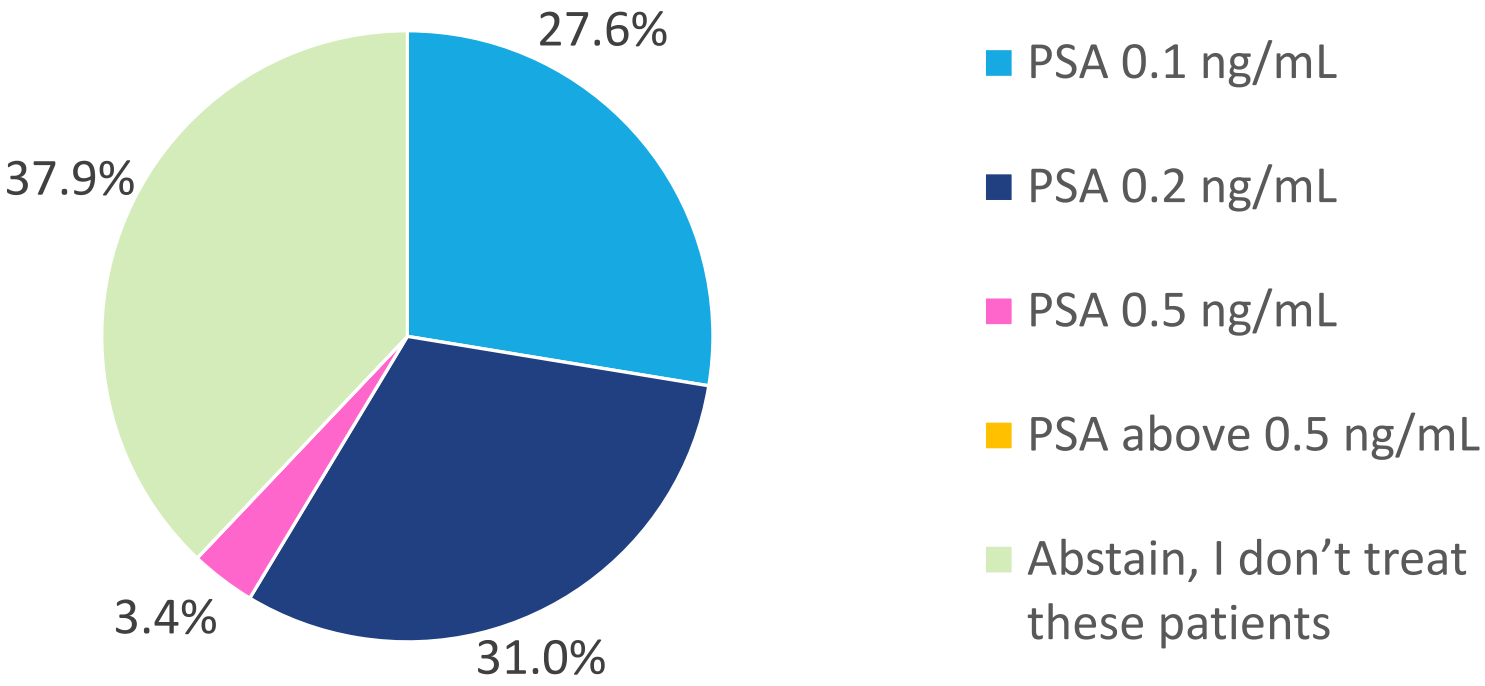
S3: For patients receiving salvage radiation therapy following surgery, do you recommend approximately 12 months duration of ADT for the majority of your patients?

Opt	Votes
	9
	14
	6



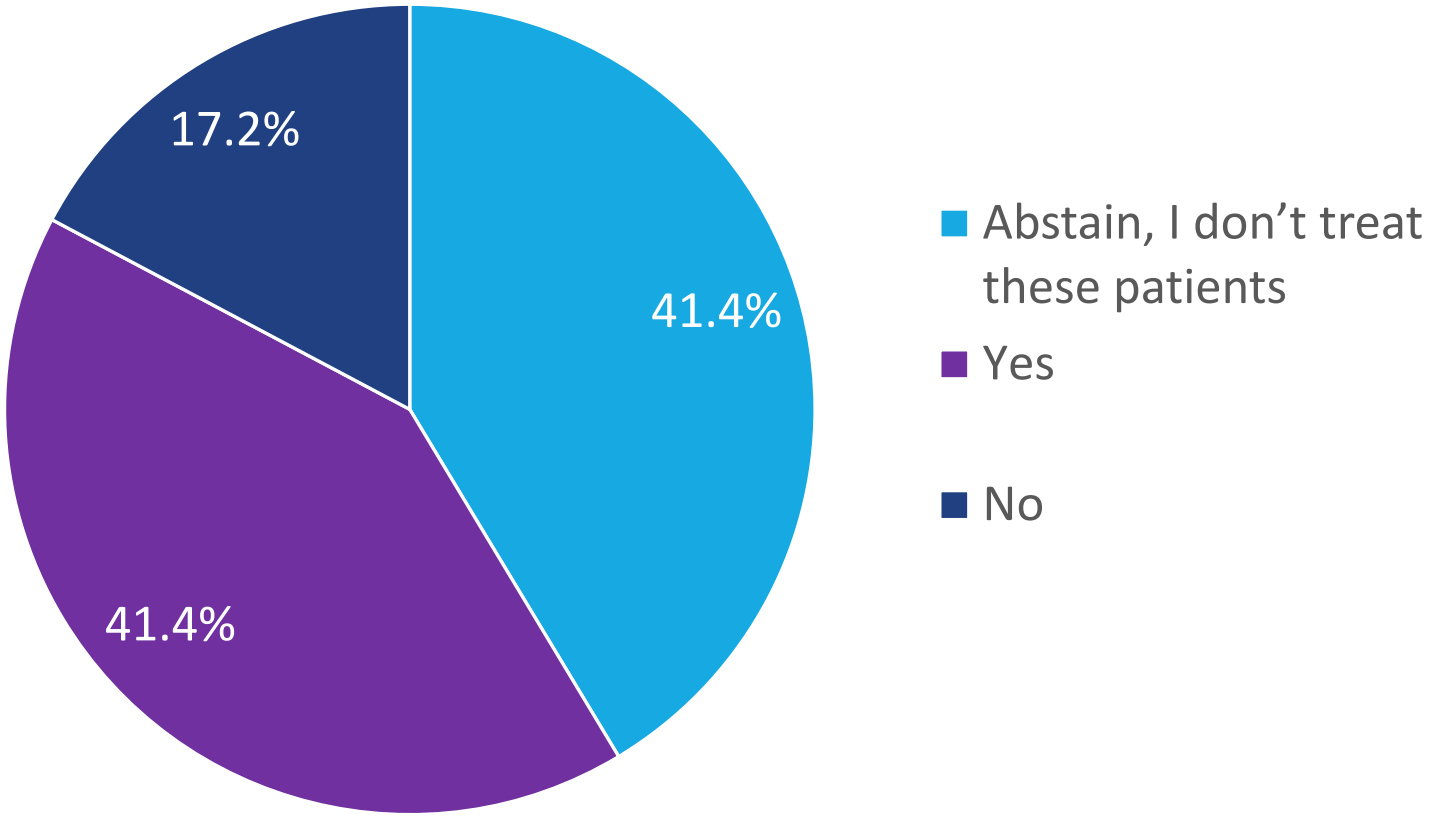
S4: For the majority of your patients, at what PSA level would you recommend salvage radiation?

Opt	Votes
	8
	9
	11
	1



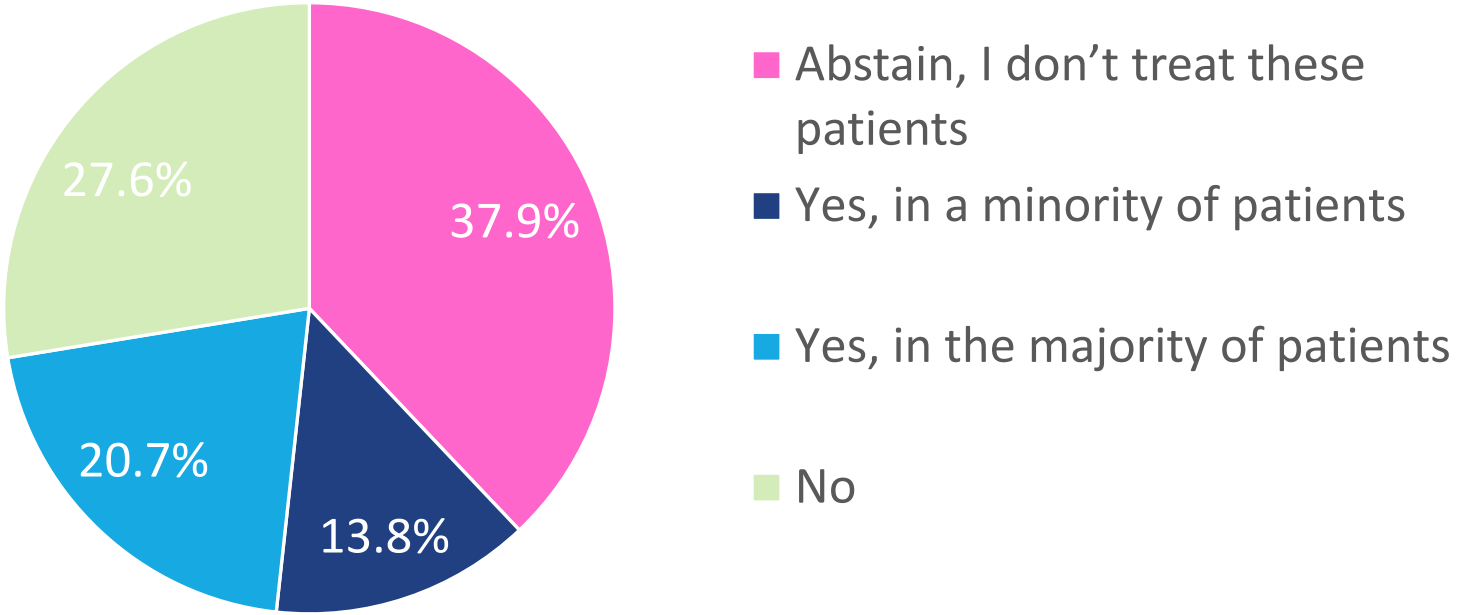
S5: For patients receiving salvage radiation following surgery, do you recommend ADT in the majority of your patients?

Opt	Votes
	5
	12
	12



S6: For patients with undetectable postoperative PSA who have recovered urinary continence, do you recommend adjuvant radiation therapy (whole pelvis and prostate bed) in cases of: pN1 disease of <=2 lymph nodes?

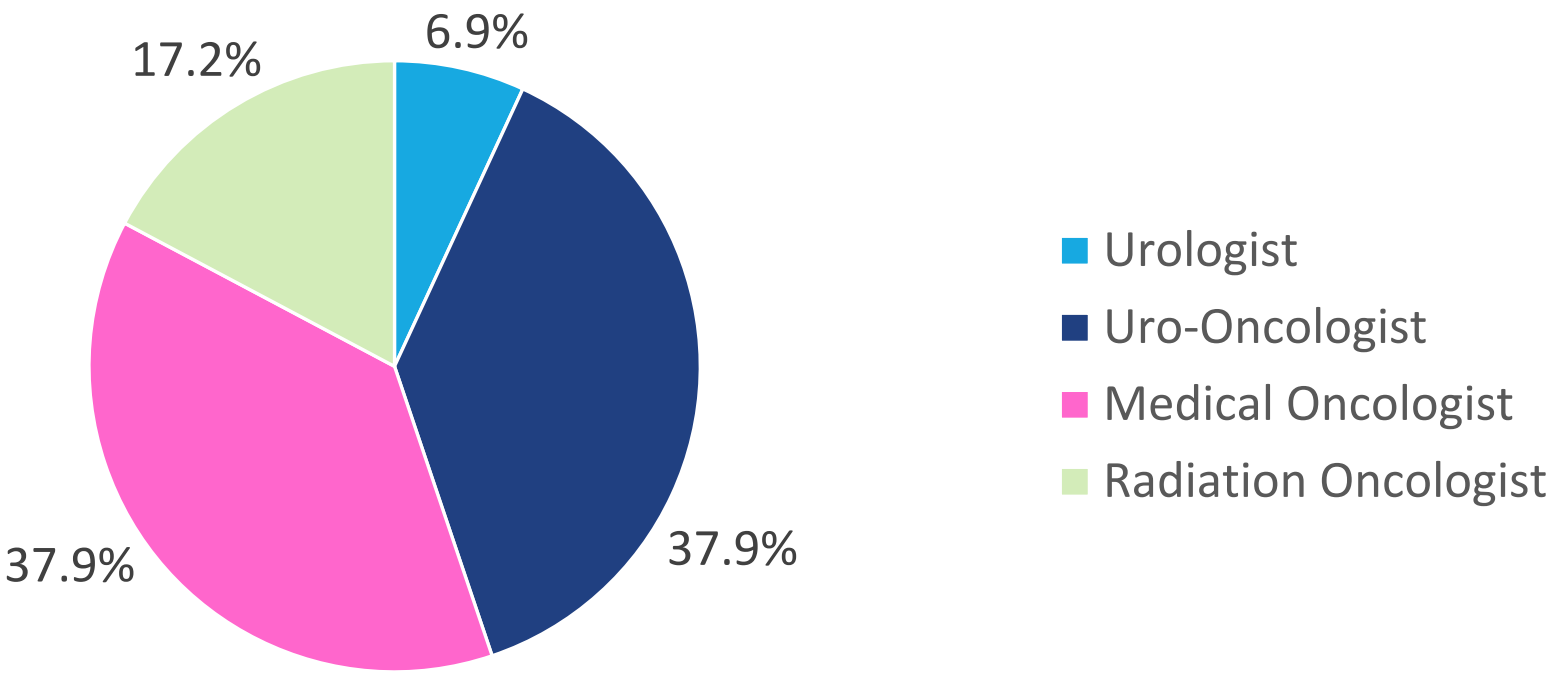
Opt	Votes
	6
	4
	11
	8



Supplemental Online Questionnaire

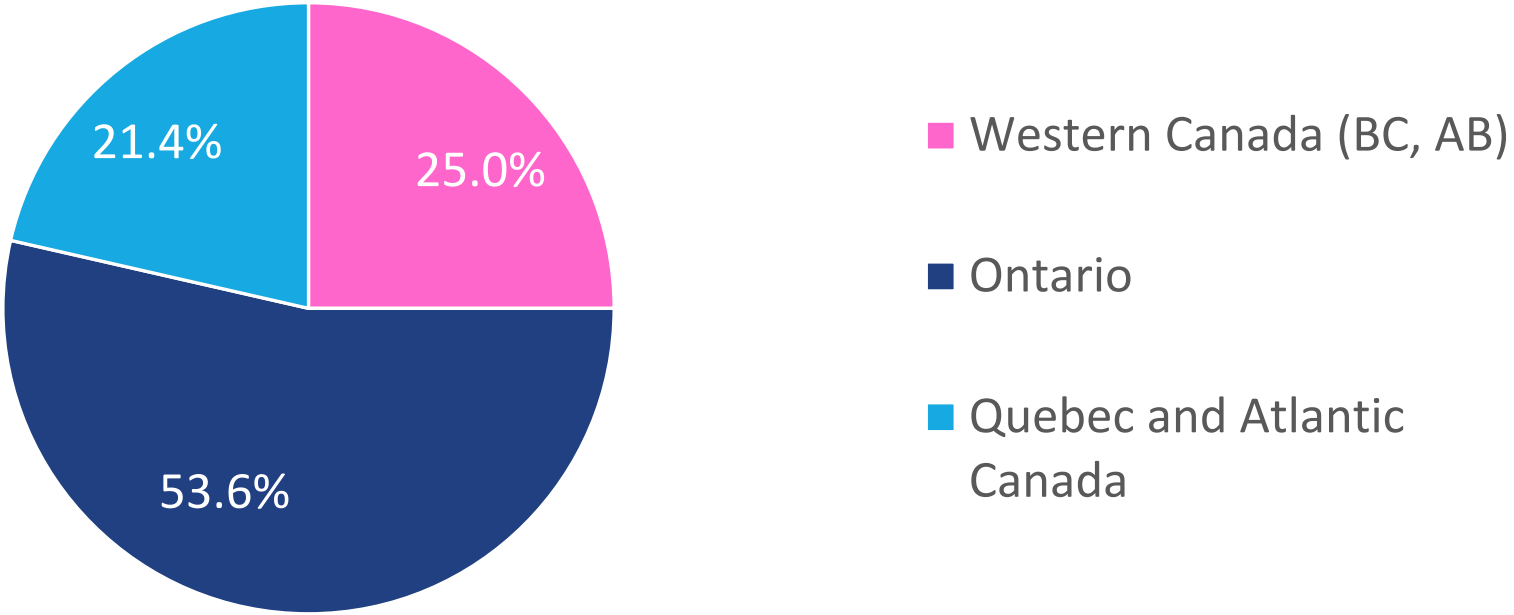
A1. Please indicate your area of specialty

Opt	Votes
	2
	11
	11
	5



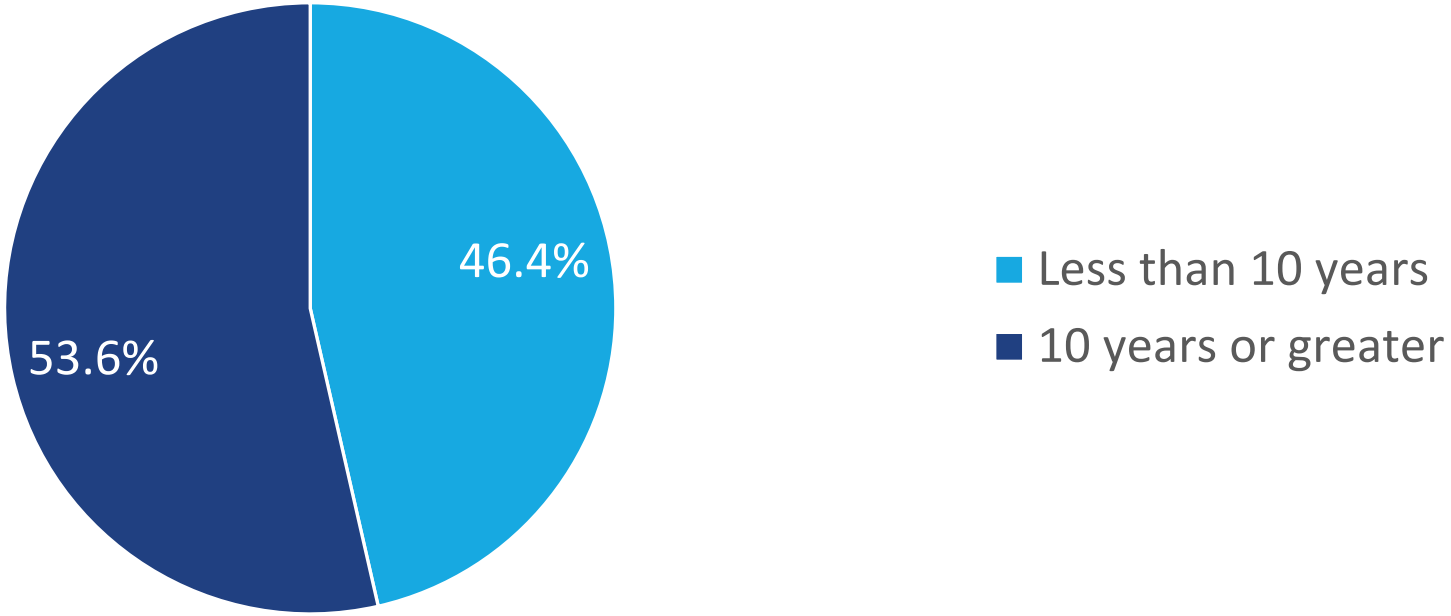
A2. Please indicate your region of practice

Opt	Votes
	6
	15
	7

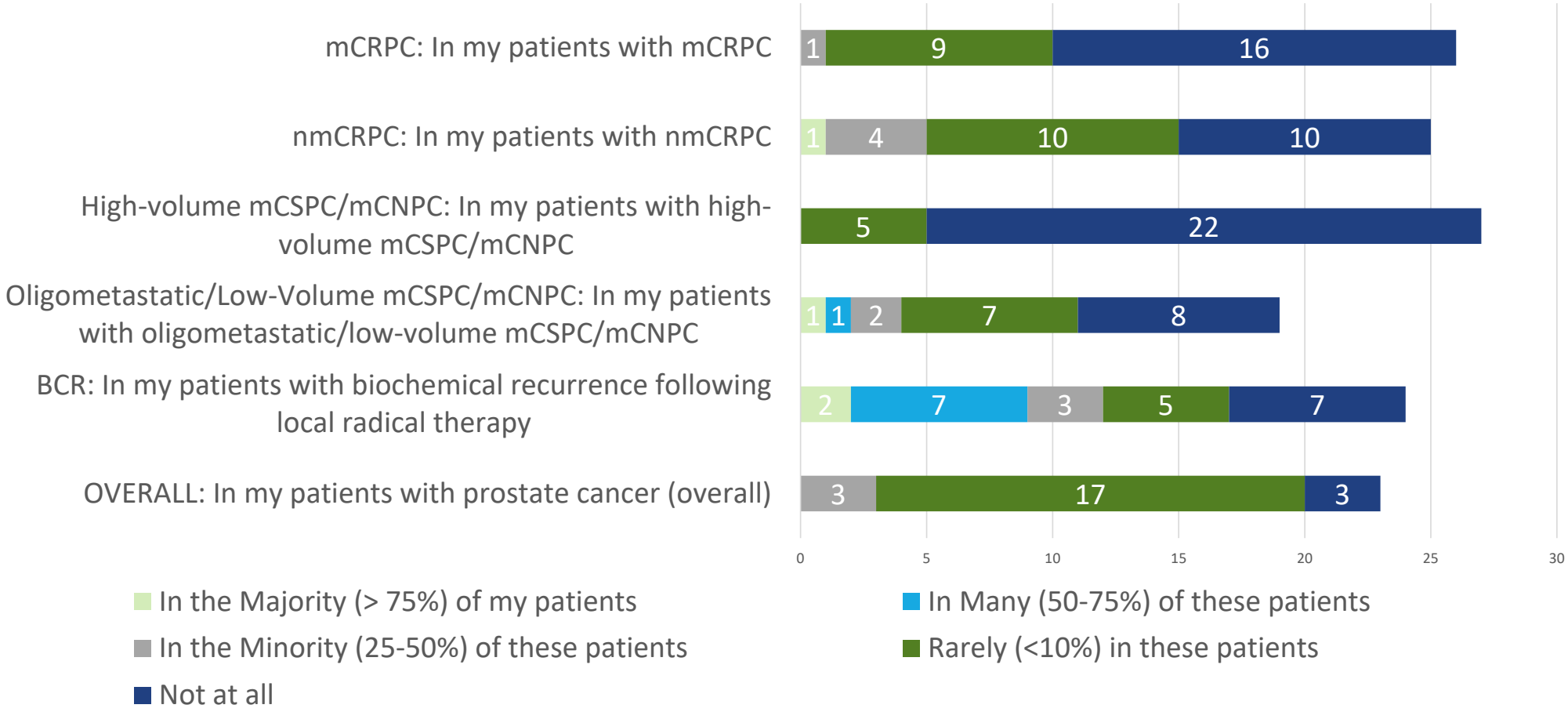


A3. Please indicate the number of years you have been in practice

Opt	Votes
	13
	15

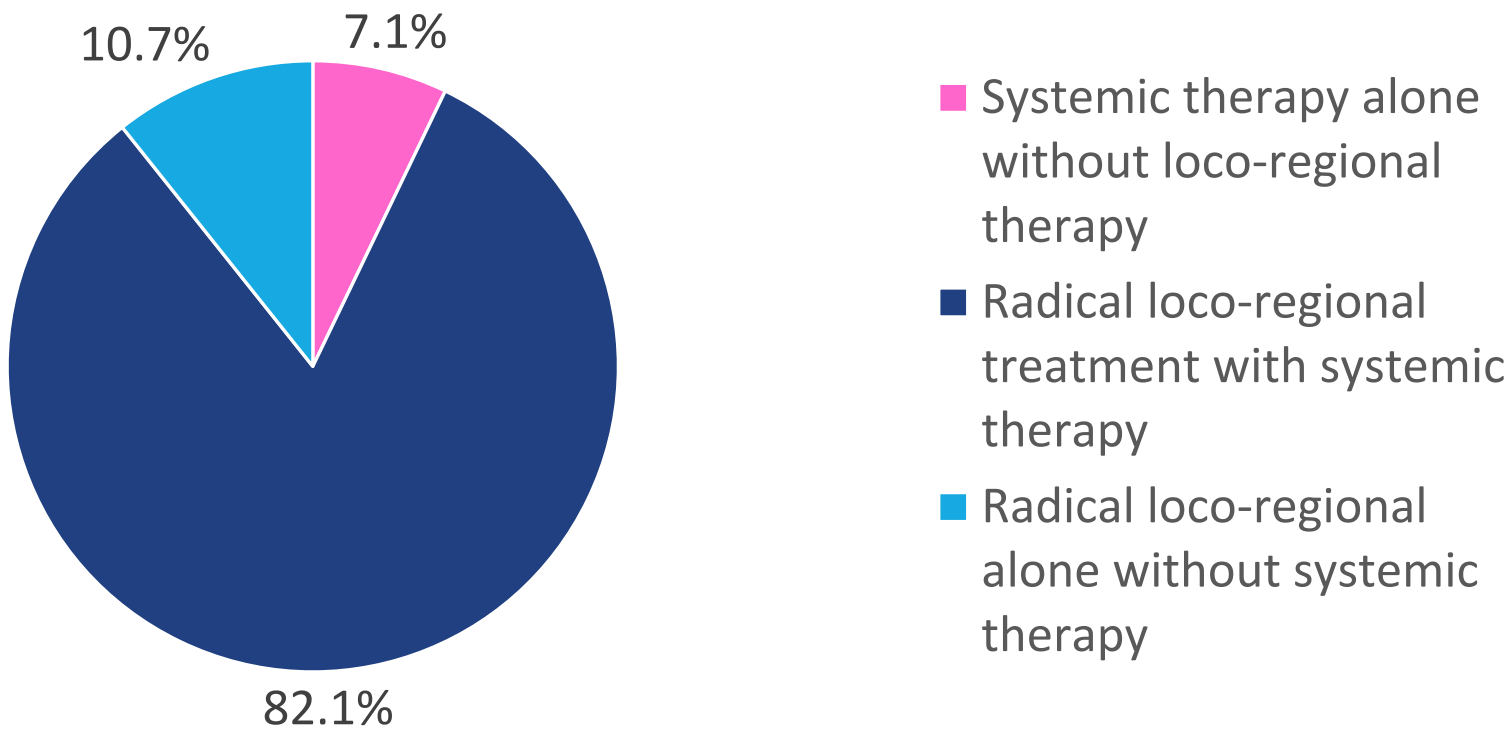


B1. Please indicate the extent to which you currently use PSMA-PET in the following patient clinical states



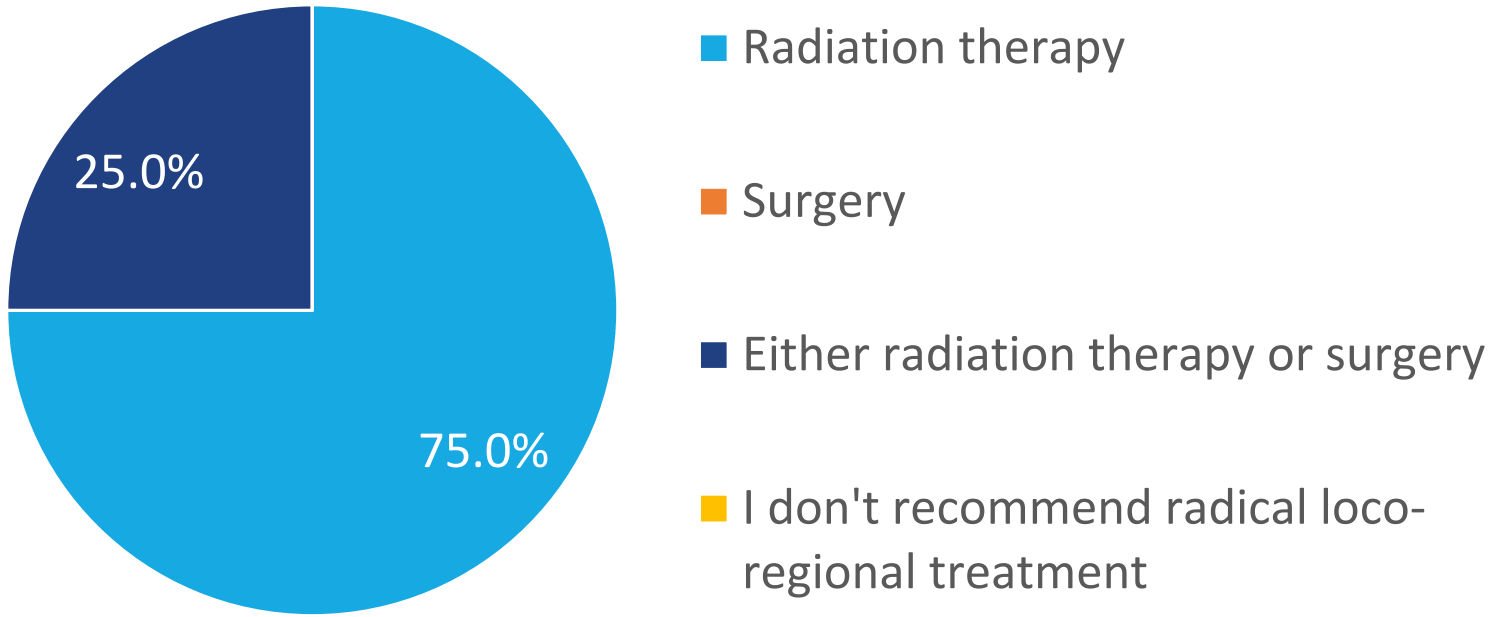
1. What is your preferred treatment recommendation for the majority of patients with newly diagnosed cN1 (pelvic lymph nodes), M0 prostate cancer?

Opt	Votes
	3
	23
	2



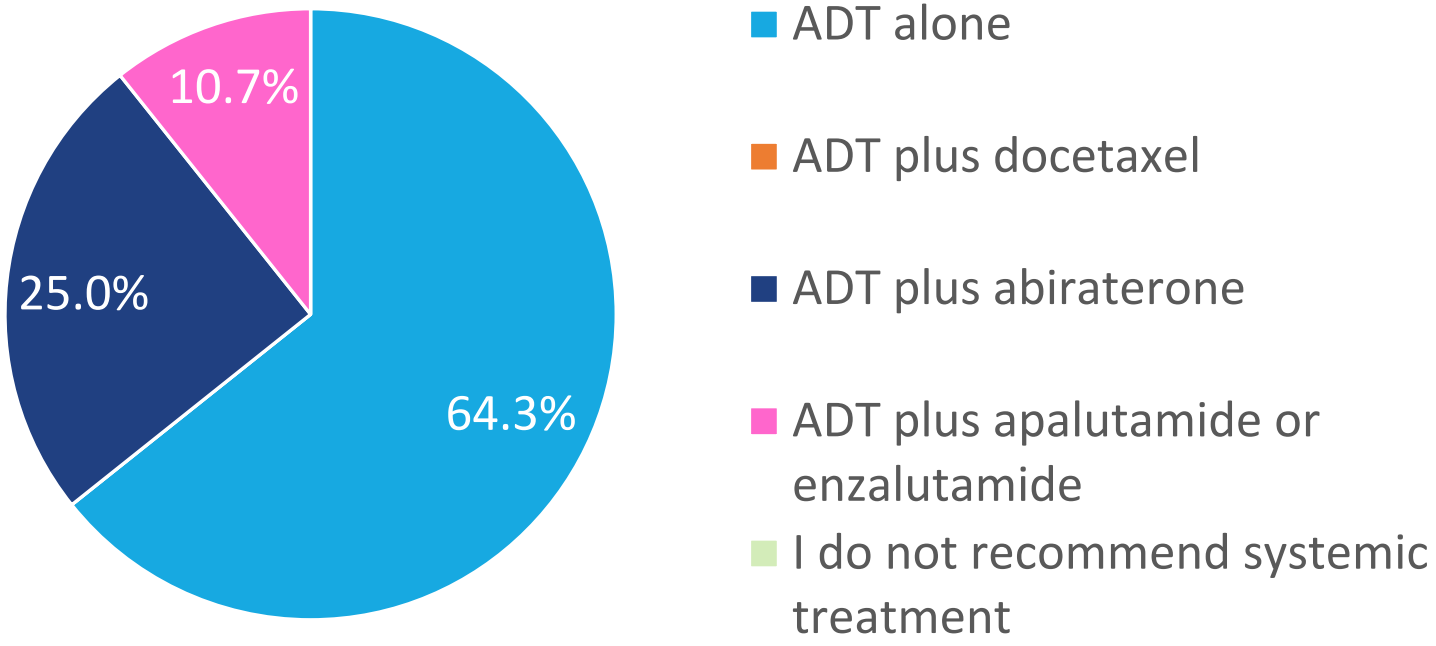
2. What is your preferred primary loco-regional treatment in cN1 (pelvic lymph nodes), M0 prostate cancer?

Opt	Votes
	21
	7



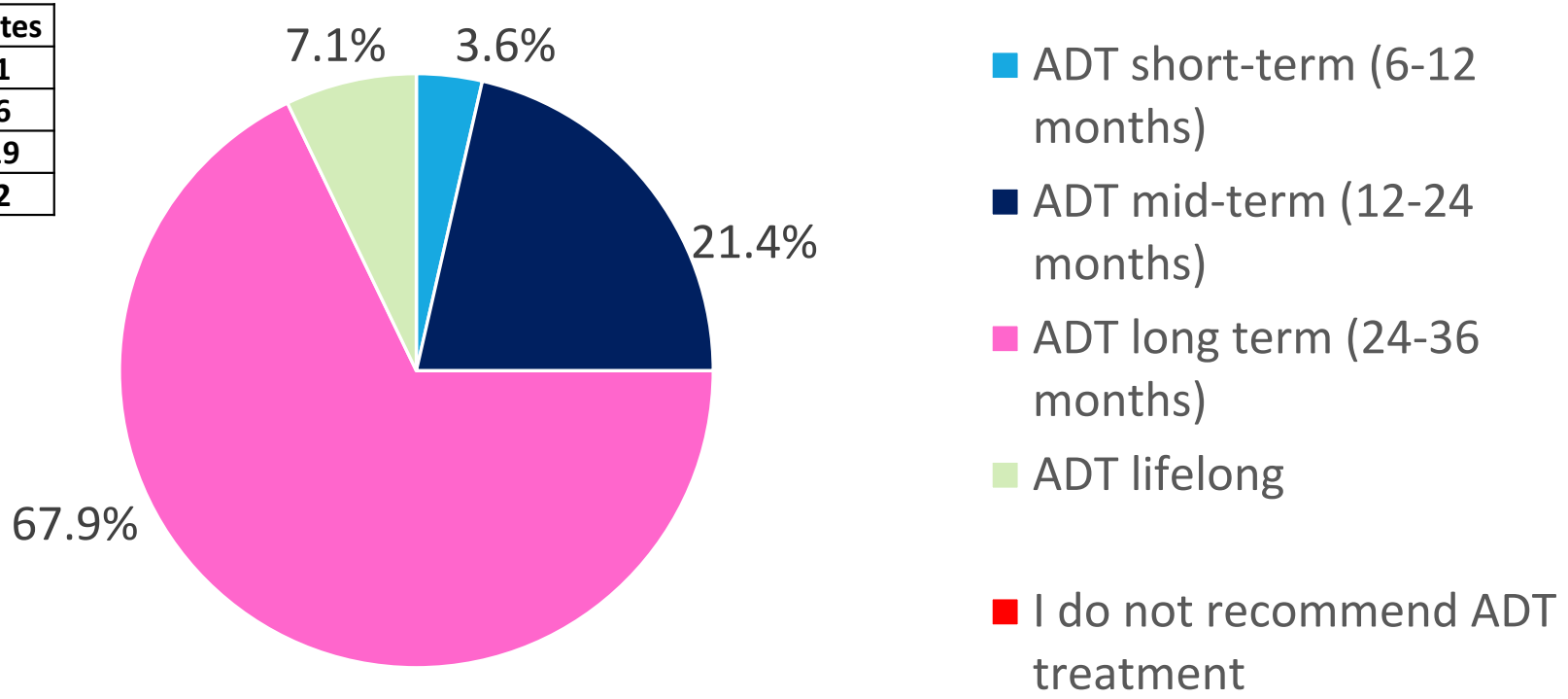
3. For patients with M0 prostate cancer with cN1 disease who are receiving radical loco-regional radiation therapy, which systemic therapy do you most often recommend?

Opt	Votes
	18
	7
	3



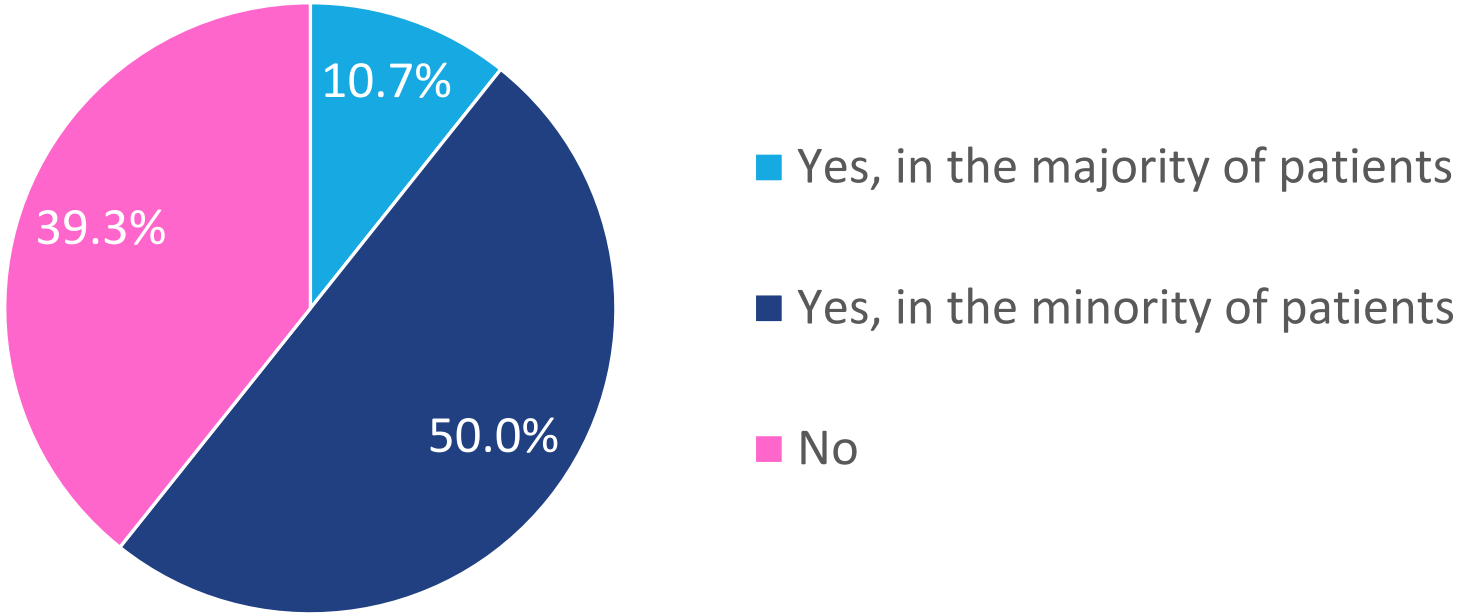
4. For patients with cN1, cM0 prostate cancer who are receiving radiation therapy as radical loco-regional treatment, which duration of ADT do you most often recommend?

Opt	Votes
	1
	6
	19
	2



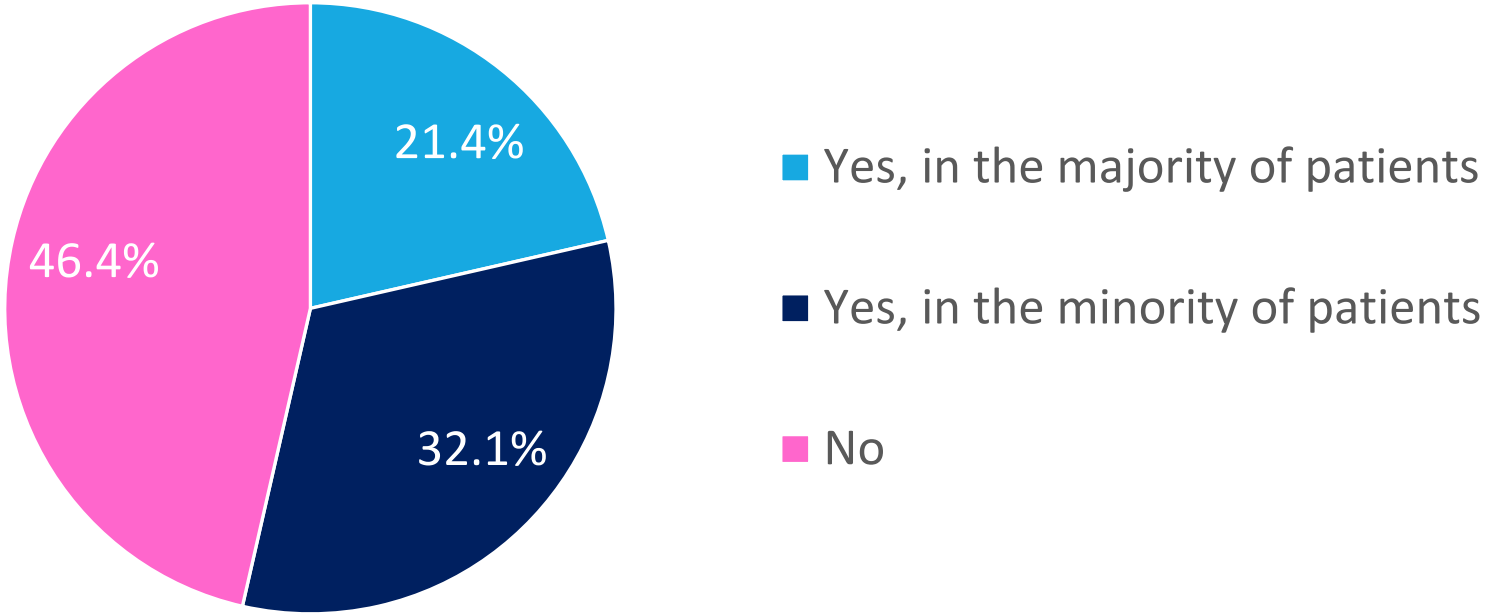
5. For patients with undetectable postoperative PSA who have recovered urinary continence, do you recommend adjuvant radiation therapy (whole pelvis and prostate bed) in cases of: pN1 disease of <=2 lymph nodes?

Opt	Votes
	3
	14
	11

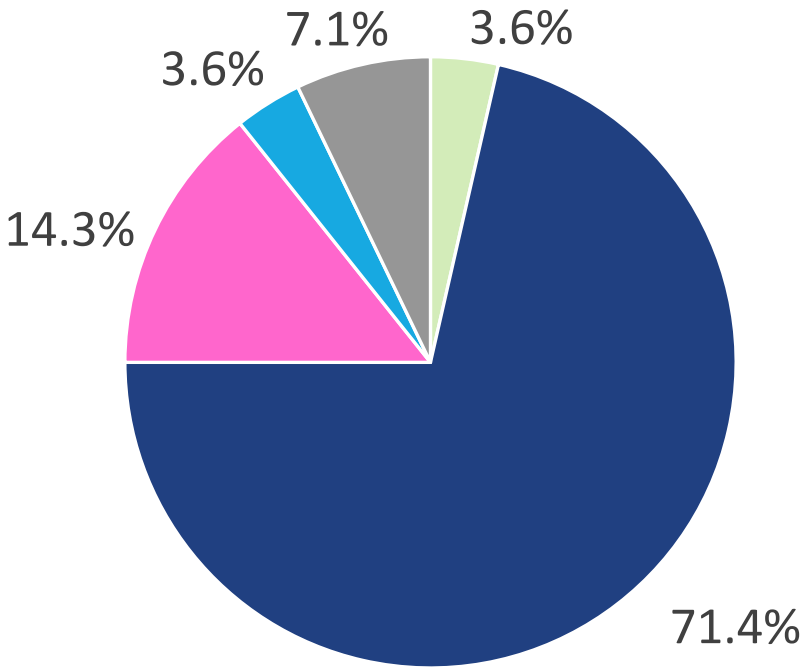


6. For patients with undetectable postoperative PSA who have recovered urinary continence, do you recommend adjuvant radiation therapy (whole pelvis and prostate bed) in cases of: pN1 disease of 3 or more lymph nodes?

Opt	Votes
	6
	9
	13



7. Which systemic therapy do you most often recommend with adjuvant radiation therapy in patients with pN1 disease?

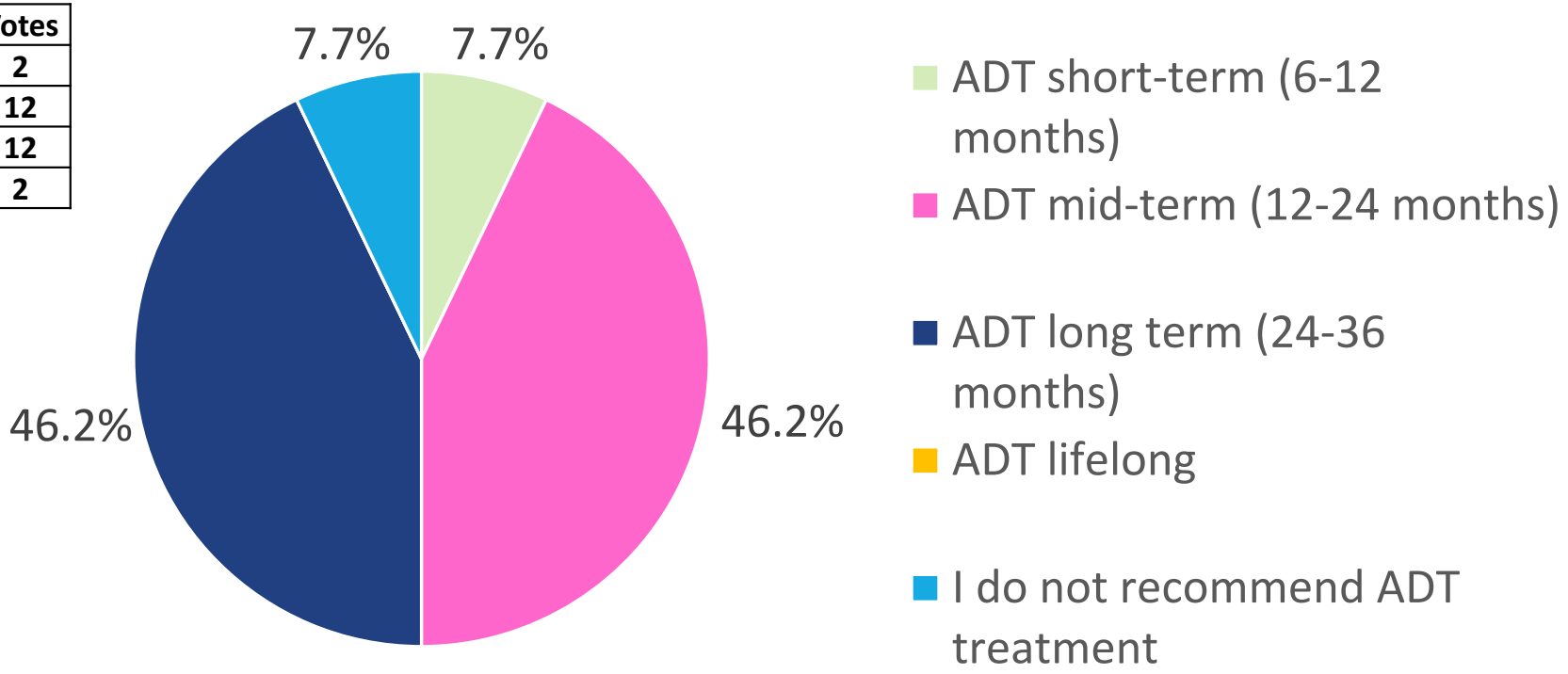


Opt	Votes
	1
	20
	4
	1
	2

- No systemic treatment
- ADT alone
- ADT plus docetaxel
- ADT plus abiraterone
- ADT plus apalutamide or enzalutamide
- I do not recommend systemic treatment

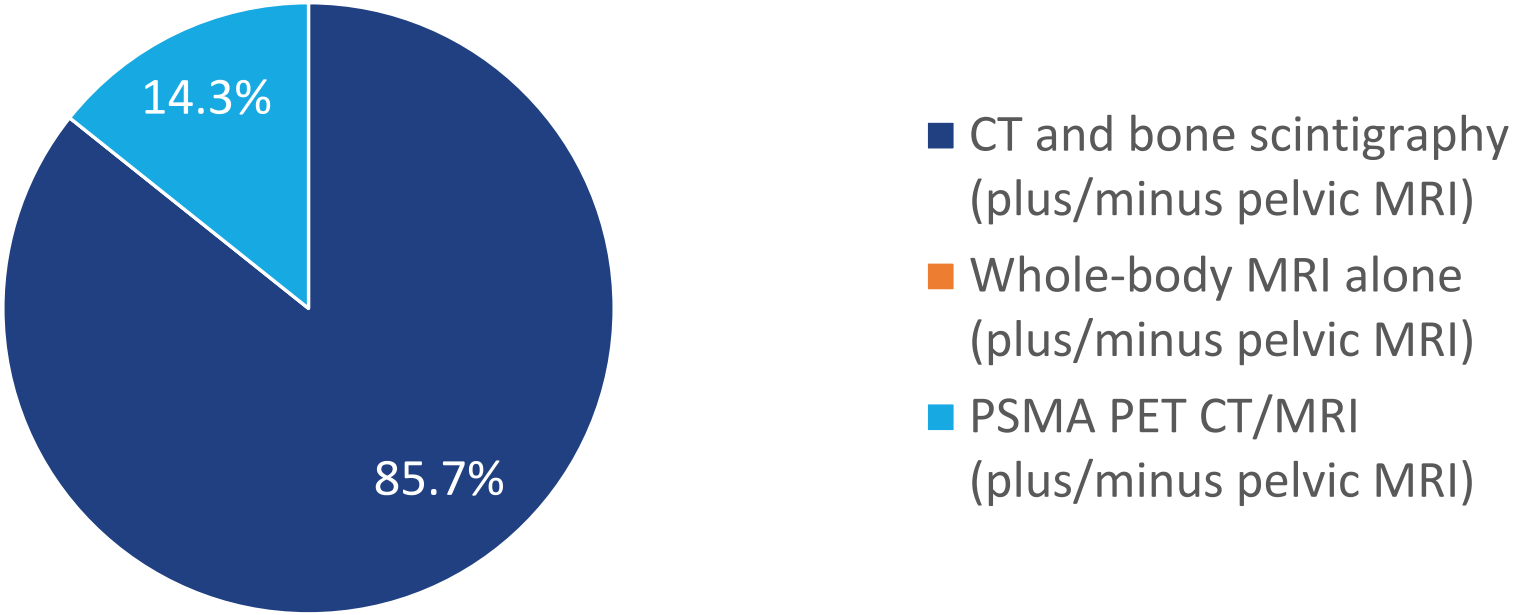
8. Which duration of ADT do you most often recommend with adjuvant radiation therapy in the majority of patients with pN1 disease?

Opt	Votes
	2
	12
	12
	2

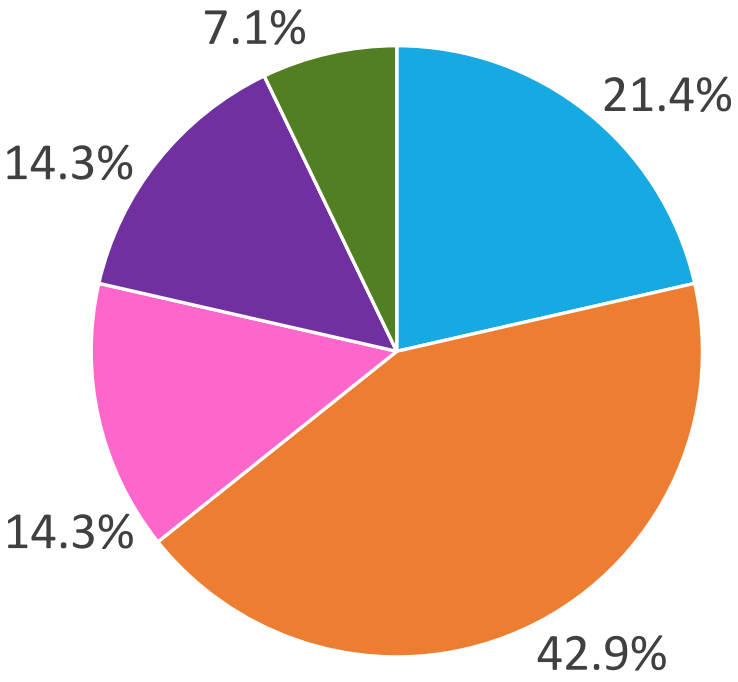


9. Which imaging modality(ies) do you most often use for patients with rising PSA after radical radiation therapy of the prostate?

Opt	Votes
	4
	24



10. For the majority of post-prostatectomy patients with isolated rising PSA only, if salvage RT is planned, at what confirmed upper PSA level do you recommend starting salvage radiation therapy?

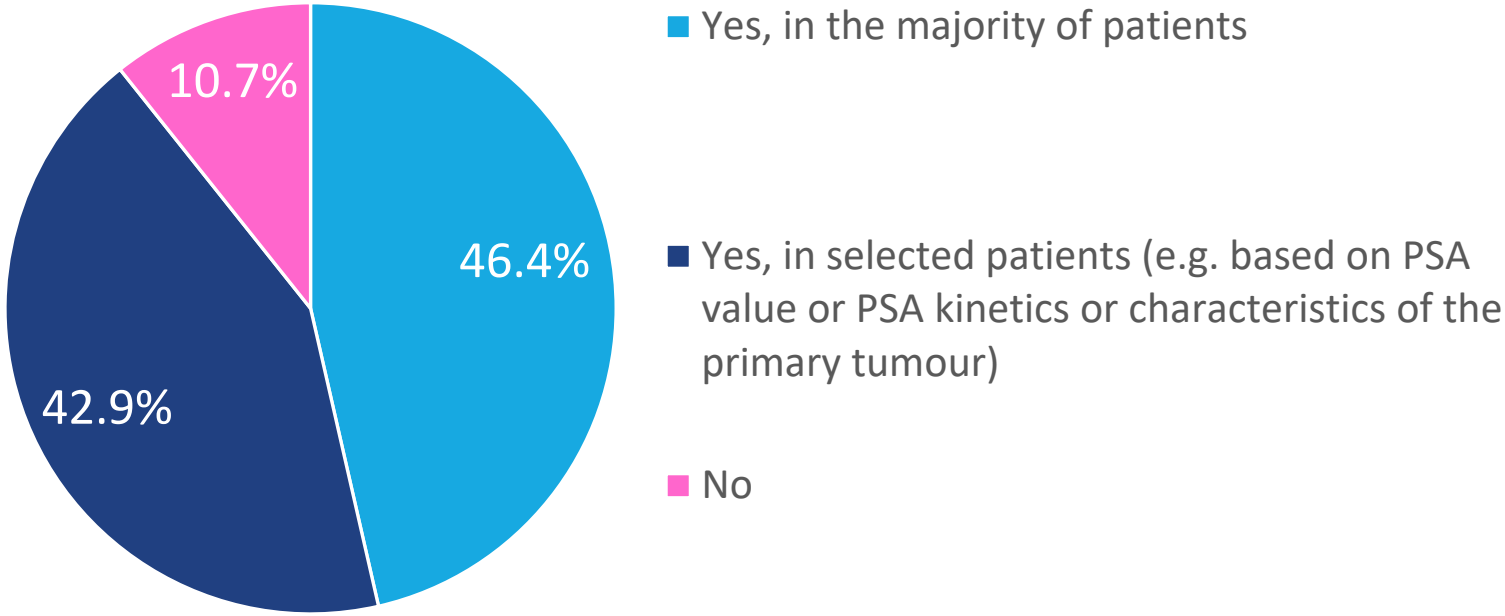


- PSA up to 0.1 ng/mL
- PSA up to 0.2 ng/mL
- PSA up to 0.5 ng/mL
- PSA up to 1.0 ng/mL
- Only after PSA reaches >=1.0 ng/mL
- I do not recommend salvage RT based only on PSA value alone but e.g. based on PSA doubling- time and ISUP grade

Opt	Votes
	6
	12
	4
	4
	2

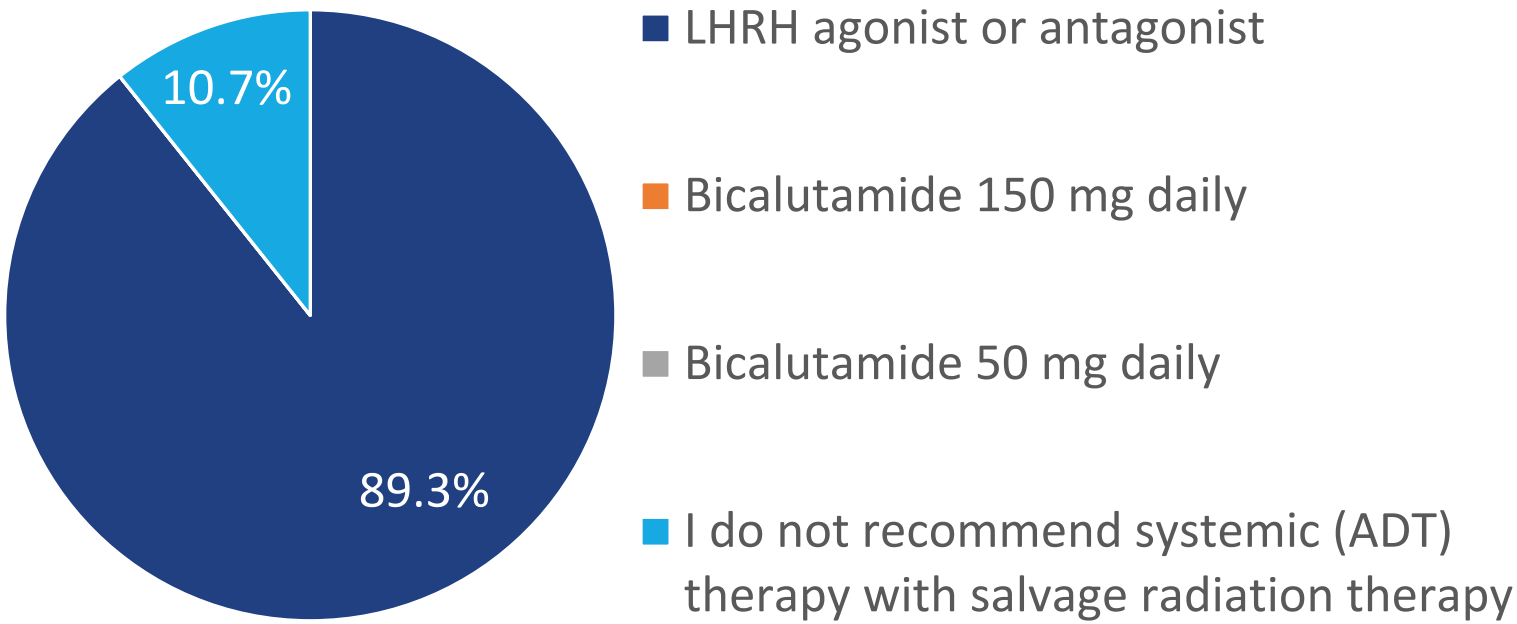
11. Do you recommend systemic (ADT) hormonal treatment in combination with salvage radiation therapy for patients with PSA recurrence after radical prostatectomy?

Opt	Votes
	13
	12
	3

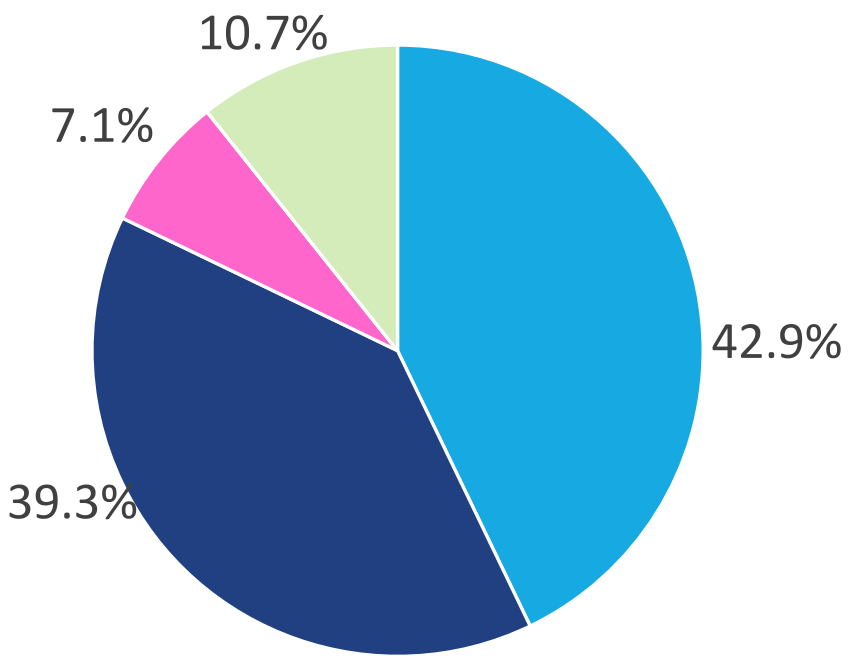


12. What systemic (ADT) hormonal therapy do you most often recommend in combination with salvage radiation therapy?

Opt	Votes
	3
	25



13. What duration of systemic (ADT) hormonal treatment do you most often recommend in combination with salvage radiation therapy?

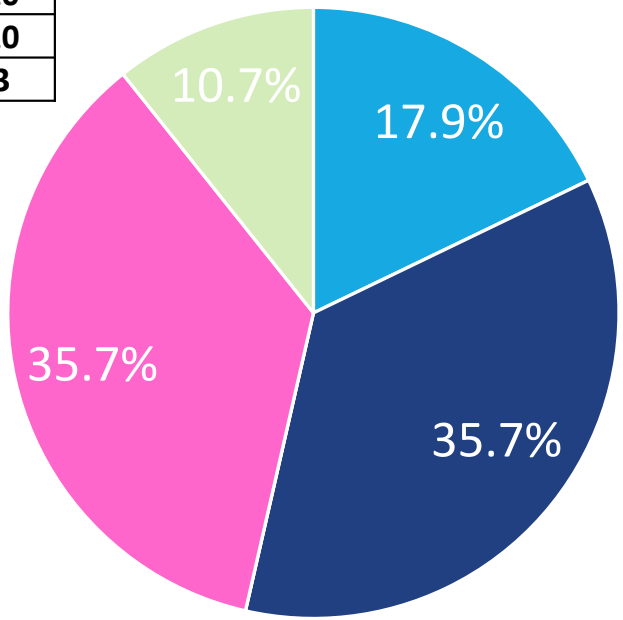


- Short-term (6-12 months)
- Mid-term (12-24 months)
- Long term (24-36 months)
- Lifelong
- I do not recommend systemic (ADT) treatment with salvage radiation therapy

Opt	Votes
	12
	11
	2
	3

14. When repeat imaging is conducted four to eight weeks after radical prostatectomy and shows no evidence of macroscopic disease, which treatment do you most often recommend for an asymptomatic pN0 patient with PSA persistence (=0.1 ng/mL and confirmed not to be falling)?

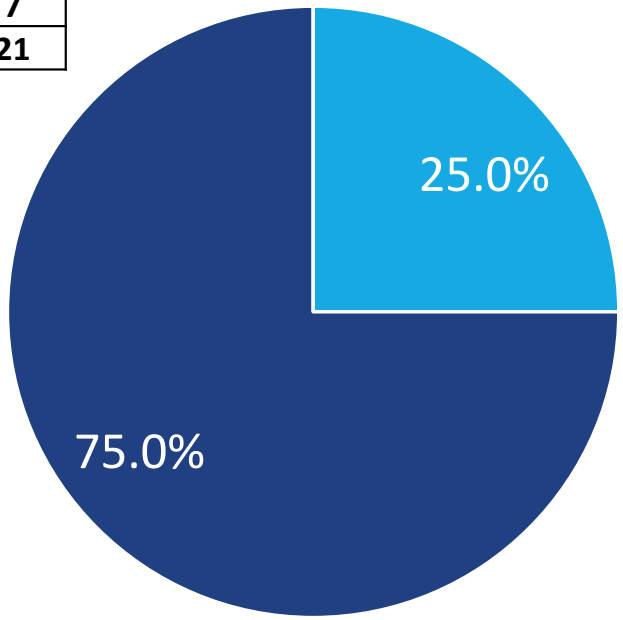
Opt	Votes
	5
	10
	10
	3



- Salvage radiation therapy without systemic hormonal treatment
- Salvage radiation therapy with systemic hormonal treatment
- Systemic hormonal treatment alone
- No immediate active treatment, PSA surveillance
- I do not recommend repeat imaging

15. In men with non-metastatic disease on conventional imaging and confirmed rising PSA following salvage radiation therapy (or ineligible for salvage radiation therapy), what would be your recommended treatment strategy?

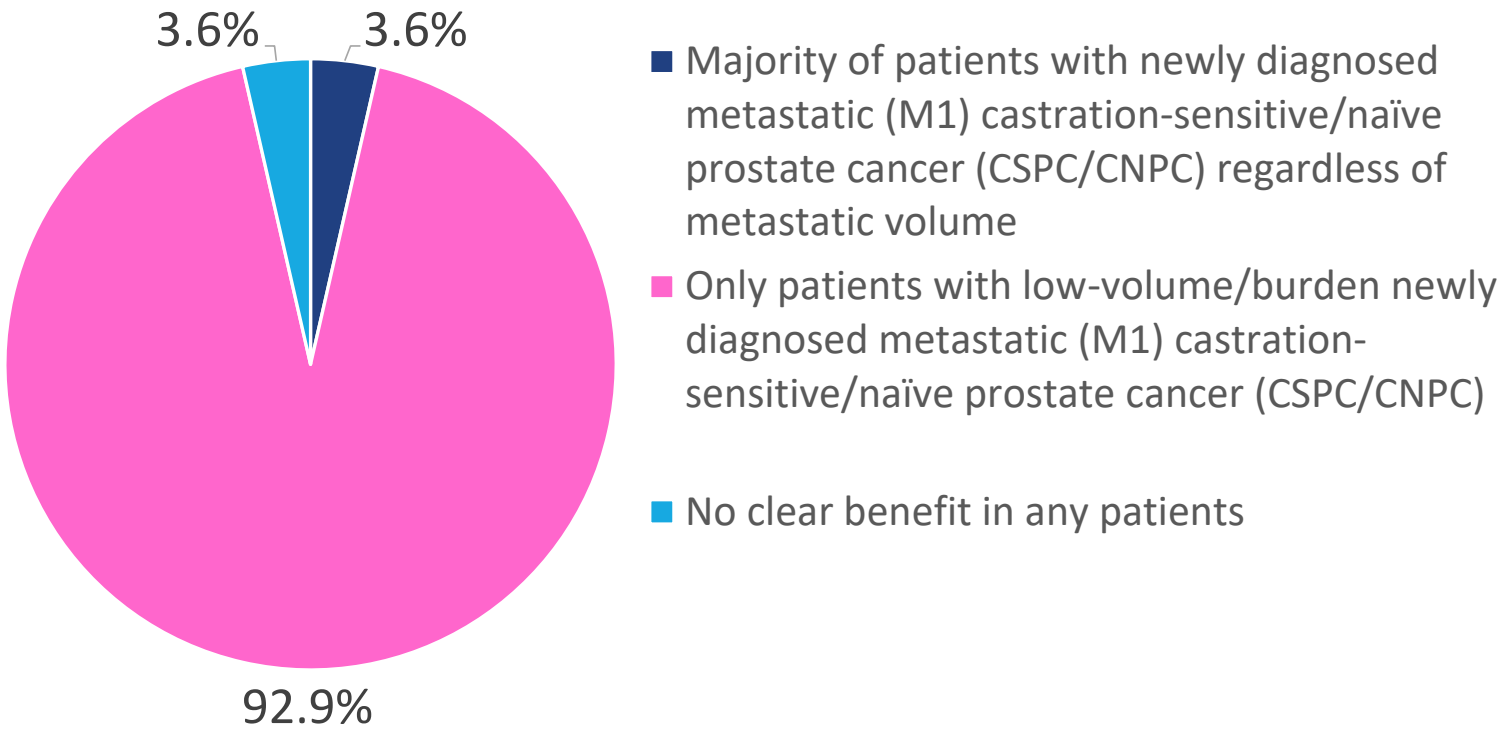
Opt	Votes
	7
	21



- Long-term ADT (continuous or intermittent), in the majority of patients
- Long-term ADT (continuous or intermittent), in selected patients e.g. PSA >10ng/ml post RT, or PSA > 5 ng/mL post RP, or PSADT < 10 months
- No long-term ADT, I only recommend ADT after detection of metastatic disease

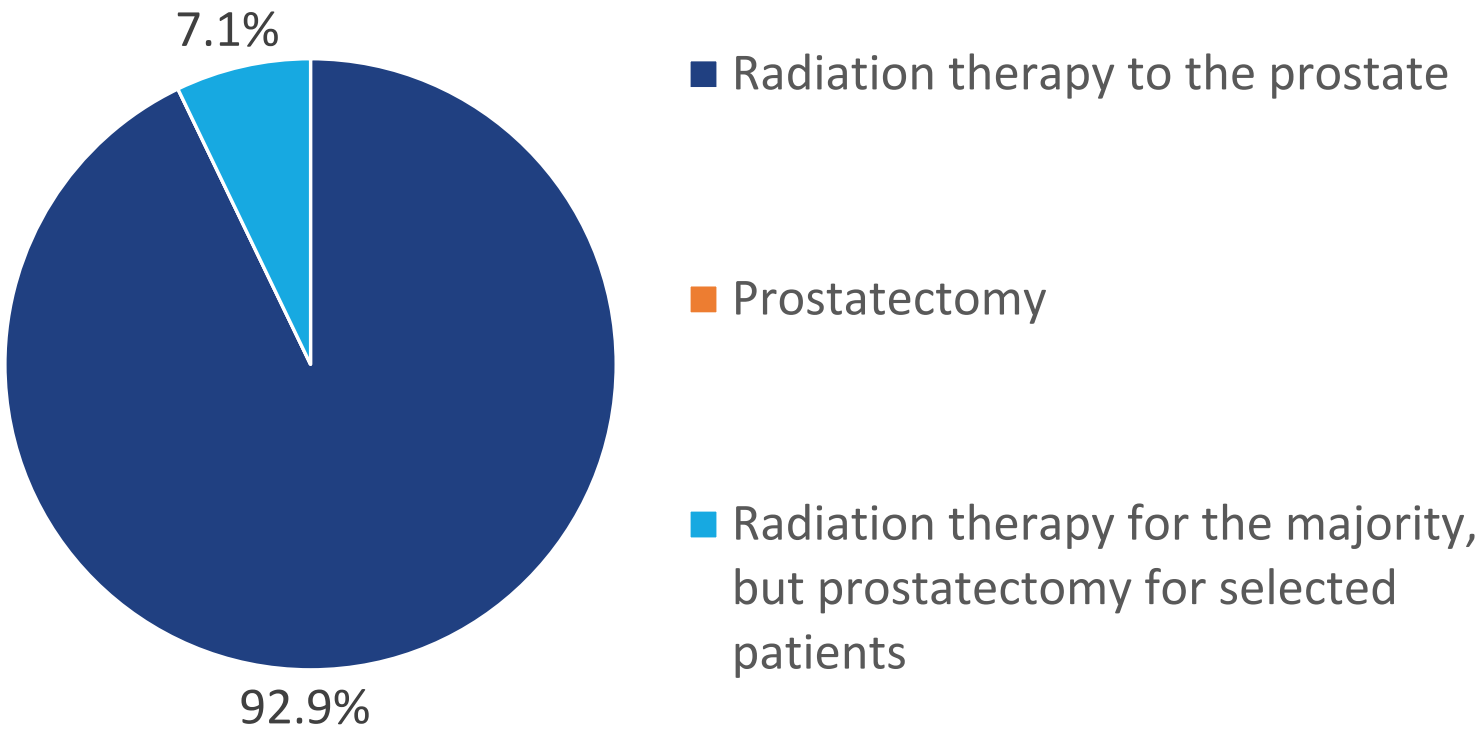
16. Based on the current literature, do you think that local treatment of the primary tumour has an overall survival benefit in:

Opt	Votes
	1
	26
	1



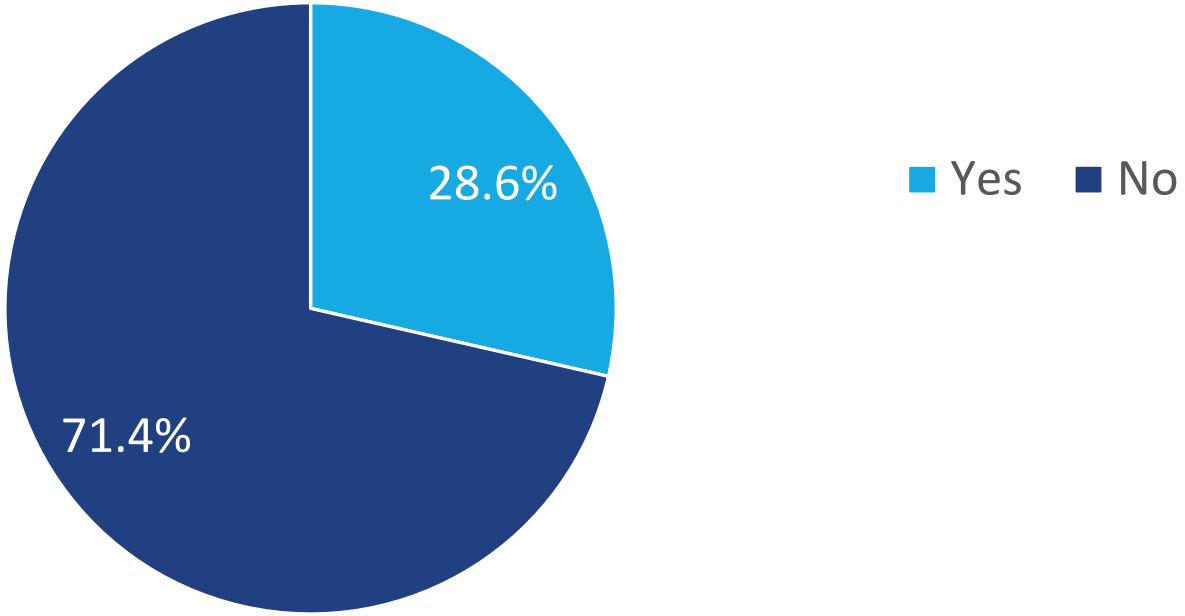
17. What is your preferred local treatment of the prostate in the majority of patients with newly diagnosed low-volume/burden metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC)?

Opt	Votes
	2
	26



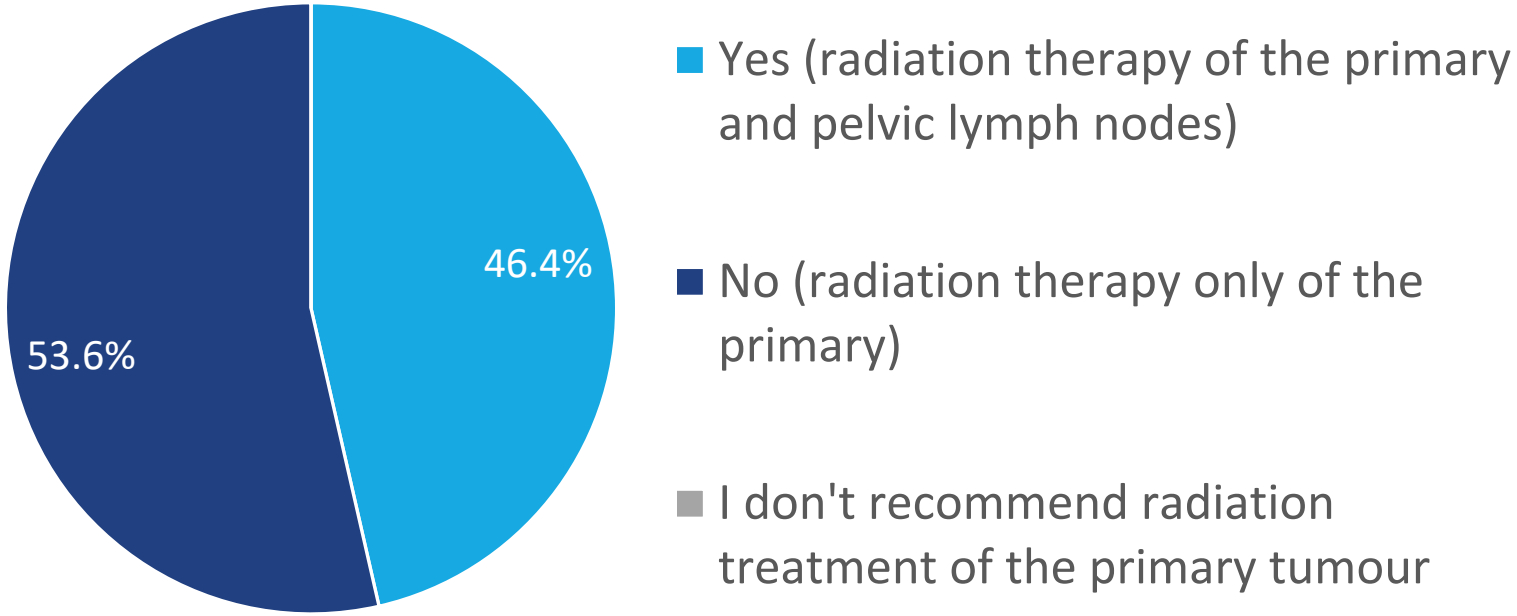
18. For patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC), is it appropriate to extrapolate data from STAMPEDE (radiation therapy of the prostate) to radical surgery of the prostate?

Opt	Votes
	8
	20



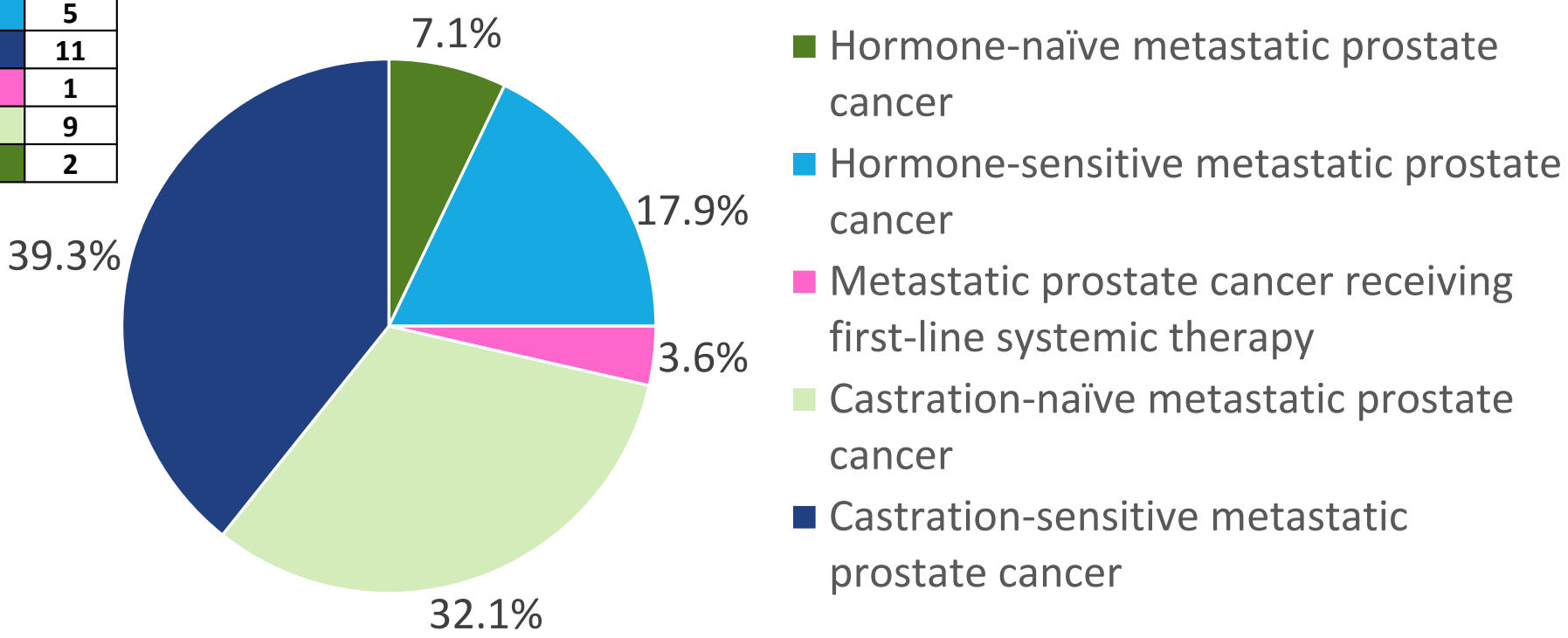
19. Do you recommend that the radiation treatment volume encompass the pelvic lymph nodes with radiation therapy of the primary tumour in patients with newly diagnosed low-volume/burden metastatic (M1) castration-sensitive/ naïve prostate cancer (CNPC) who also have clinical pelvic N1 disease?

Opt	Votes
	13
	15



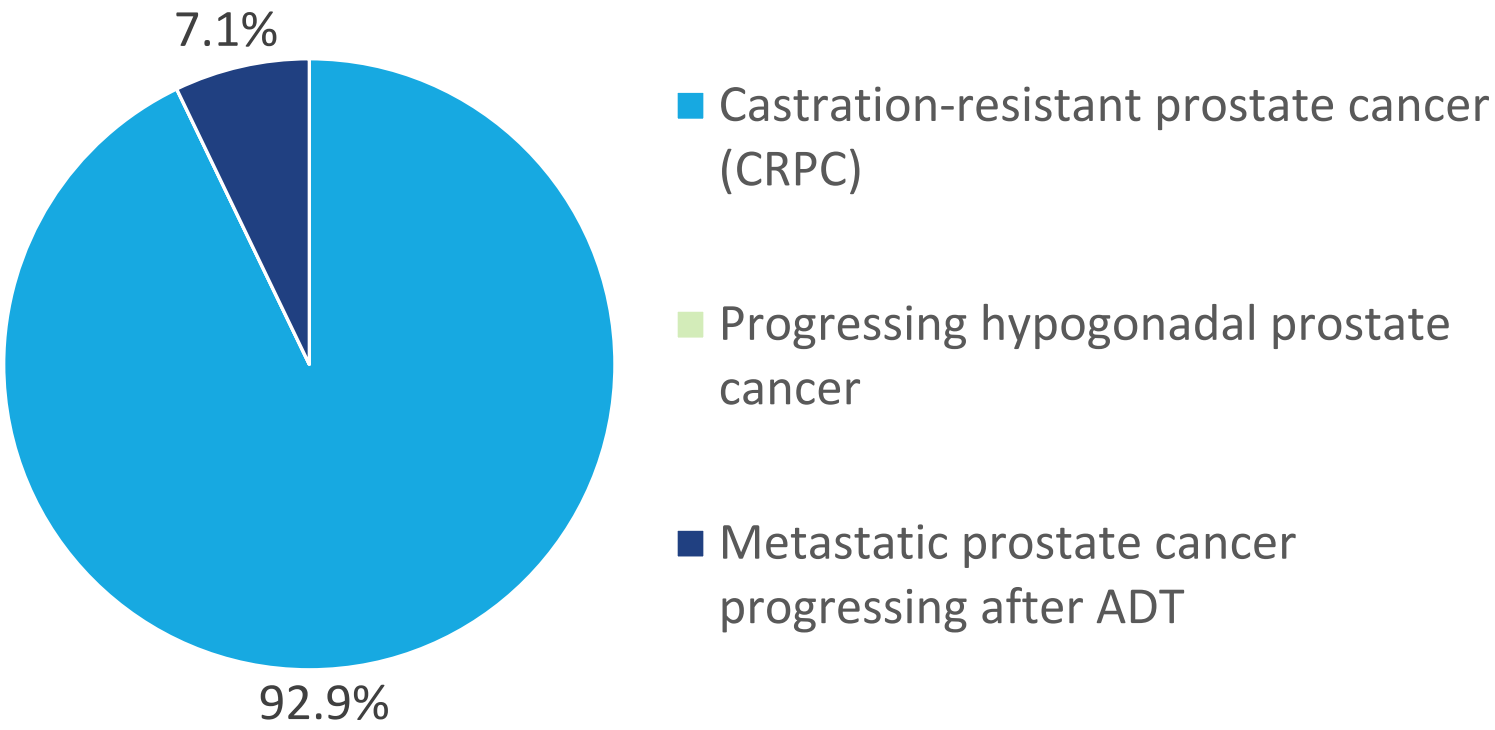
20. In your opinion, which terminology best describes metastatic prostate cancer in patients who are about to start ADT?

Opt	Votes
	5
	11
	1
	9
	2



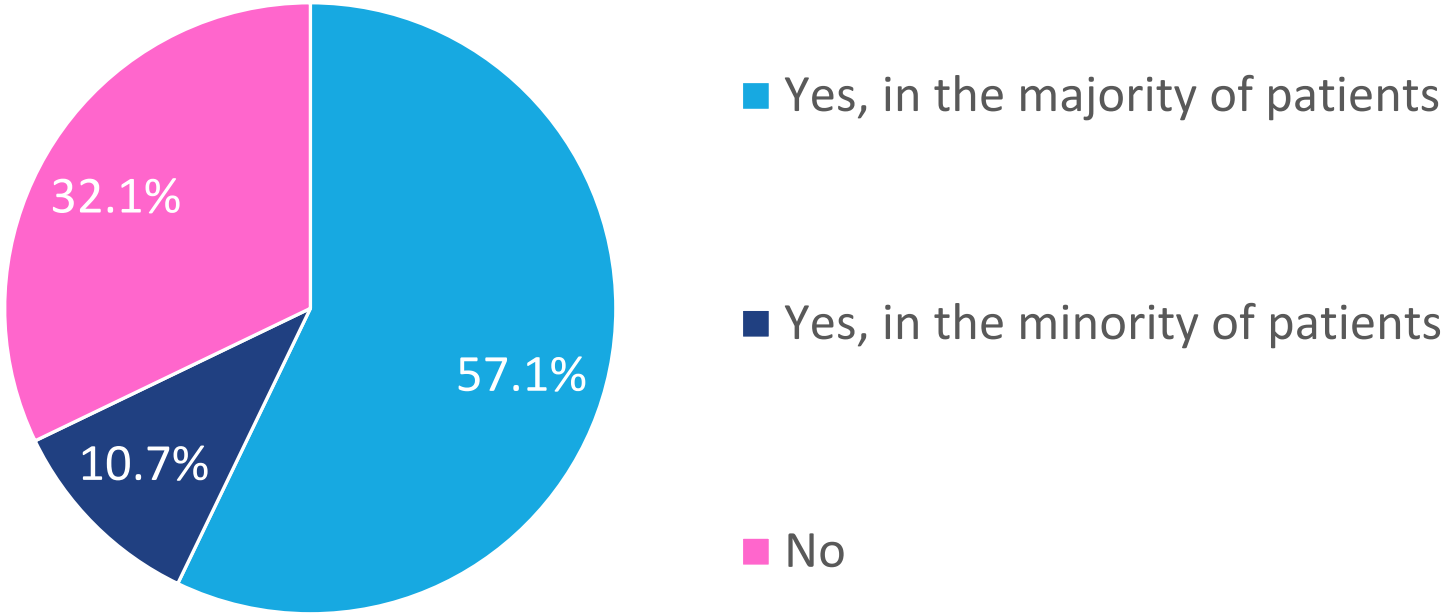
21. In your opinion, which terminology best describes patients with metastatic prostate cancer who are progressing (testosterone level <50ng/mL)

Opt	Votes
	26
	2



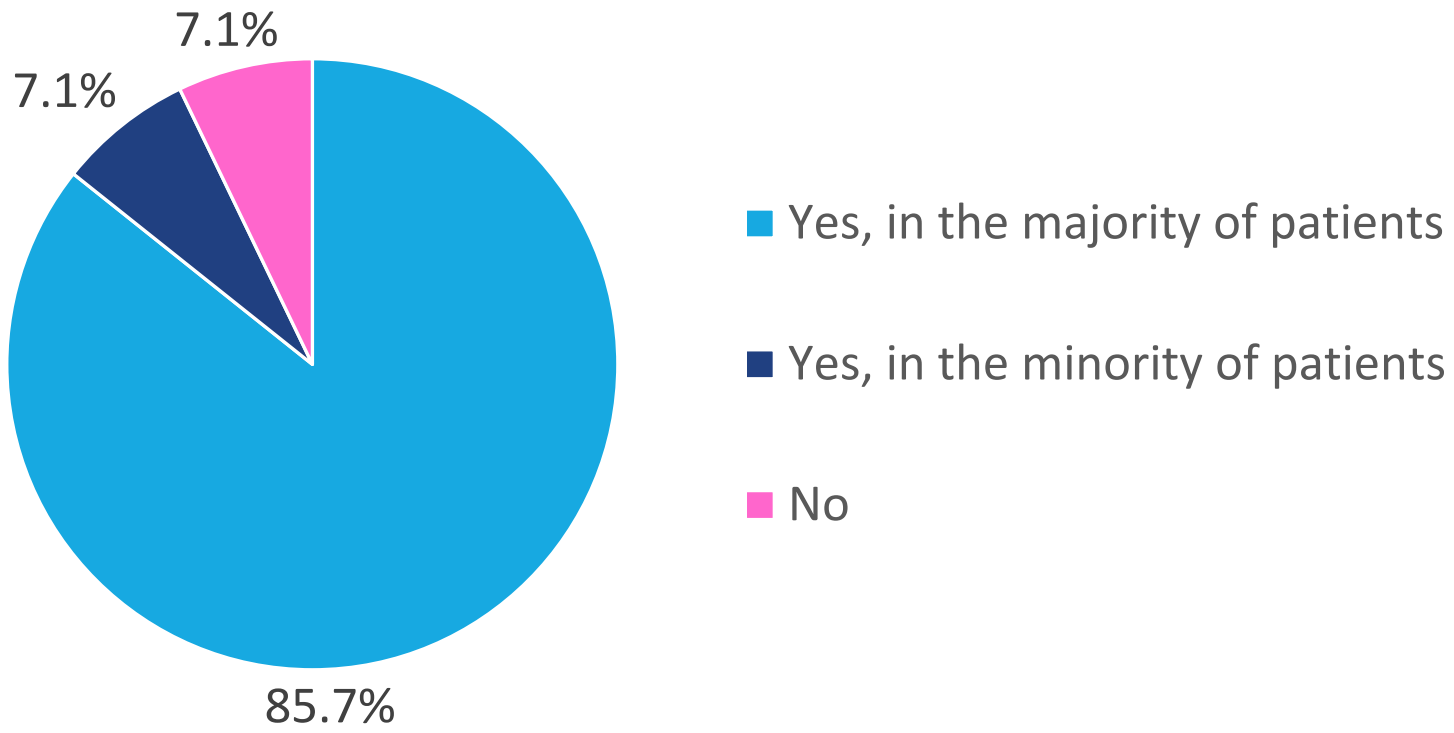
22. Do you recommend measuring total testosterone level before starting first-line treatment with ADT?

Opt	Votes
	16
	3
	9



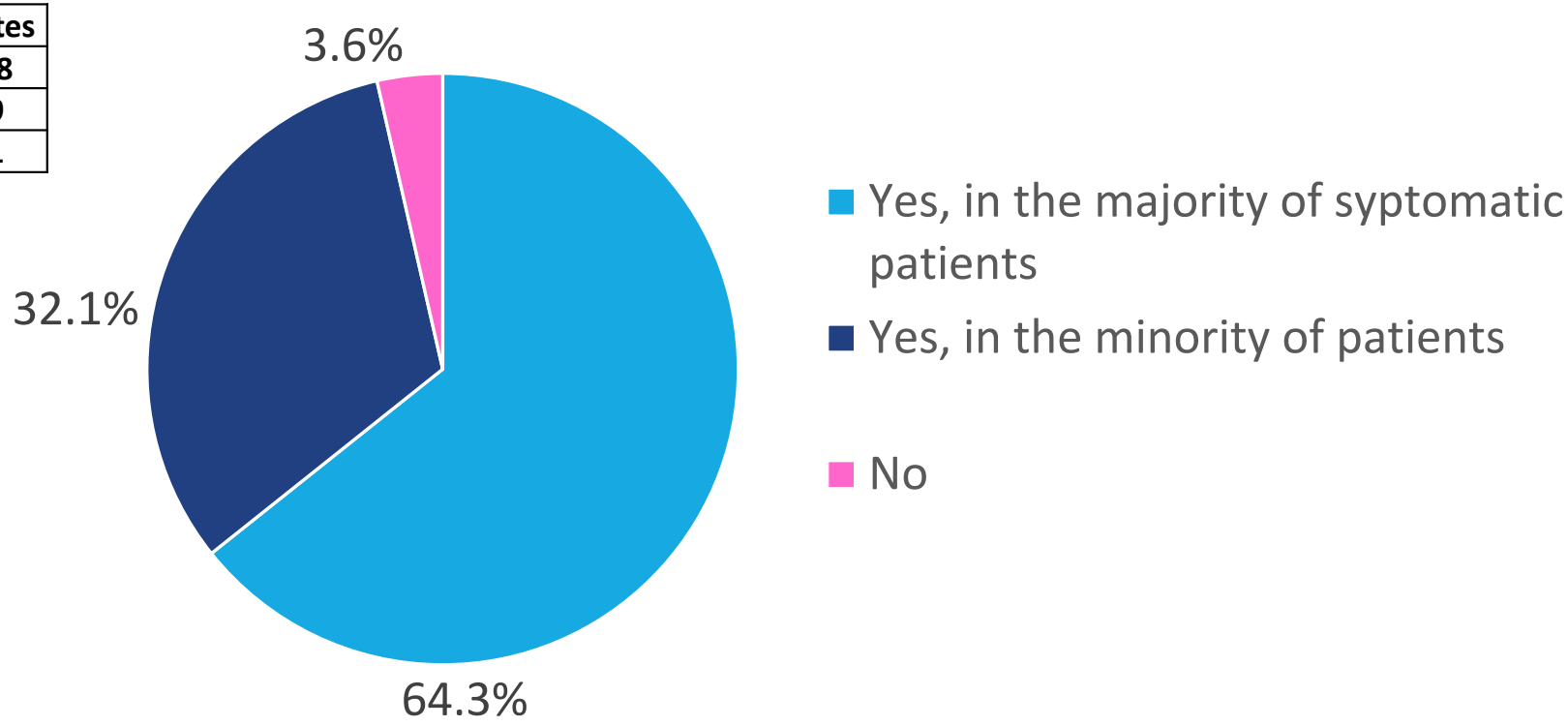
23. In patients with high suspicion of metastatic prostate cancer (based on PSA, imaging) do you recommend histopathological confirmation of prostate cancer (either before or after initiation of ADT)?

Opt	Votes
	24
	2
	2



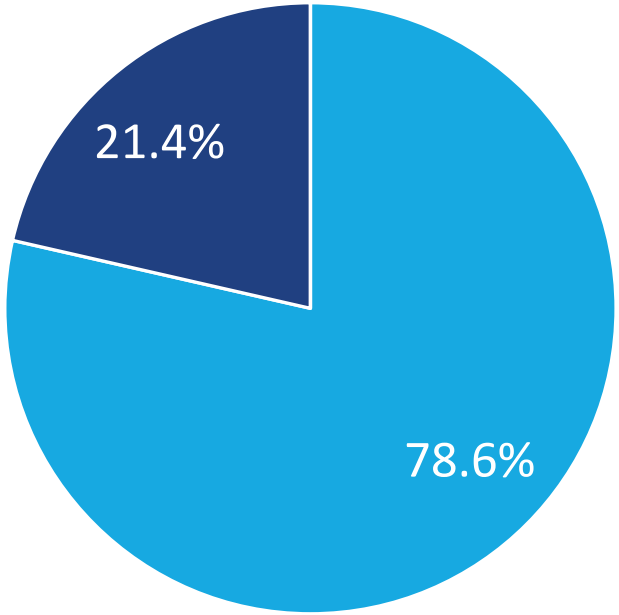
24. In symptomatic patients with high suspicion of metastatic prostate cancer (PSA, imaging) do you initiate ADT before histopathological confirmation of prostate cancer?

Opt	Votes
	28
	9
	1



25. Do you recommend a short course of a first-generation non-steroidal AR antagonist (NSAA) as flare protection when you initiate GnRH agonist therapy and AR targeted therapy in patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC)?

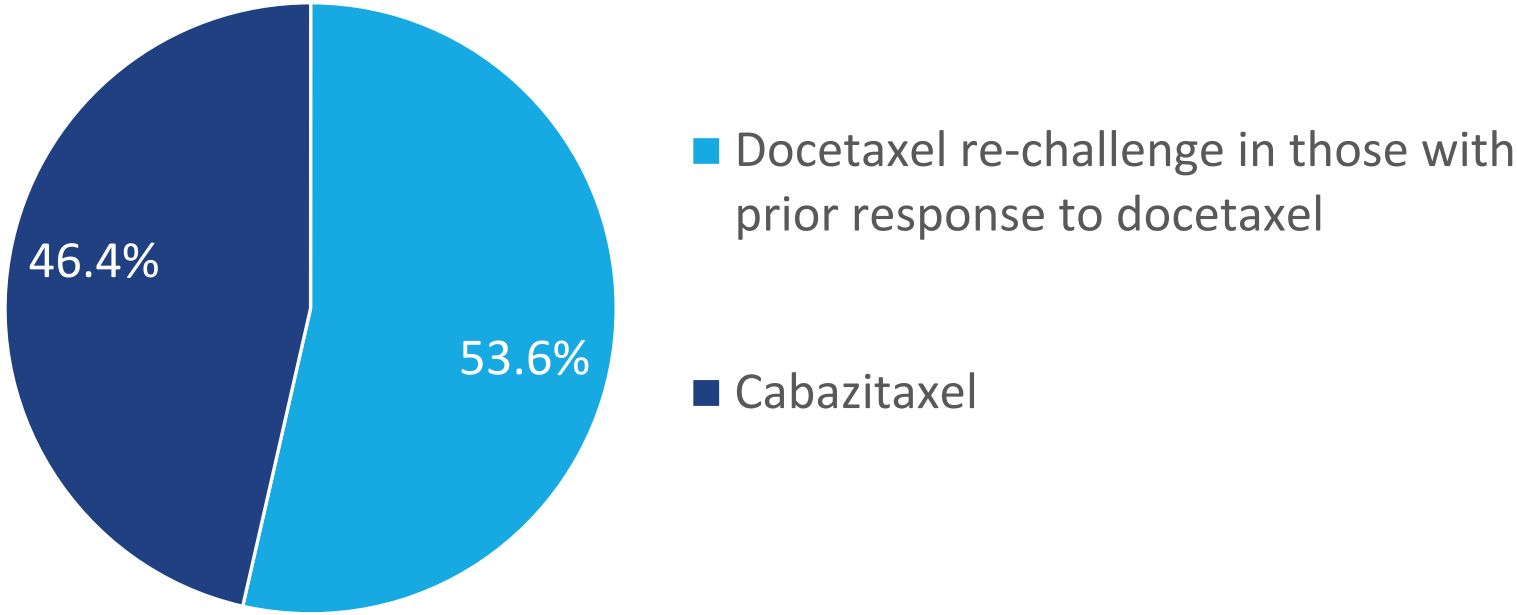
Opt	Votes
	22
	6



- Yes, in the majority of patients
- Yes, but only if AR targeted therapy is not started at the same time
- No

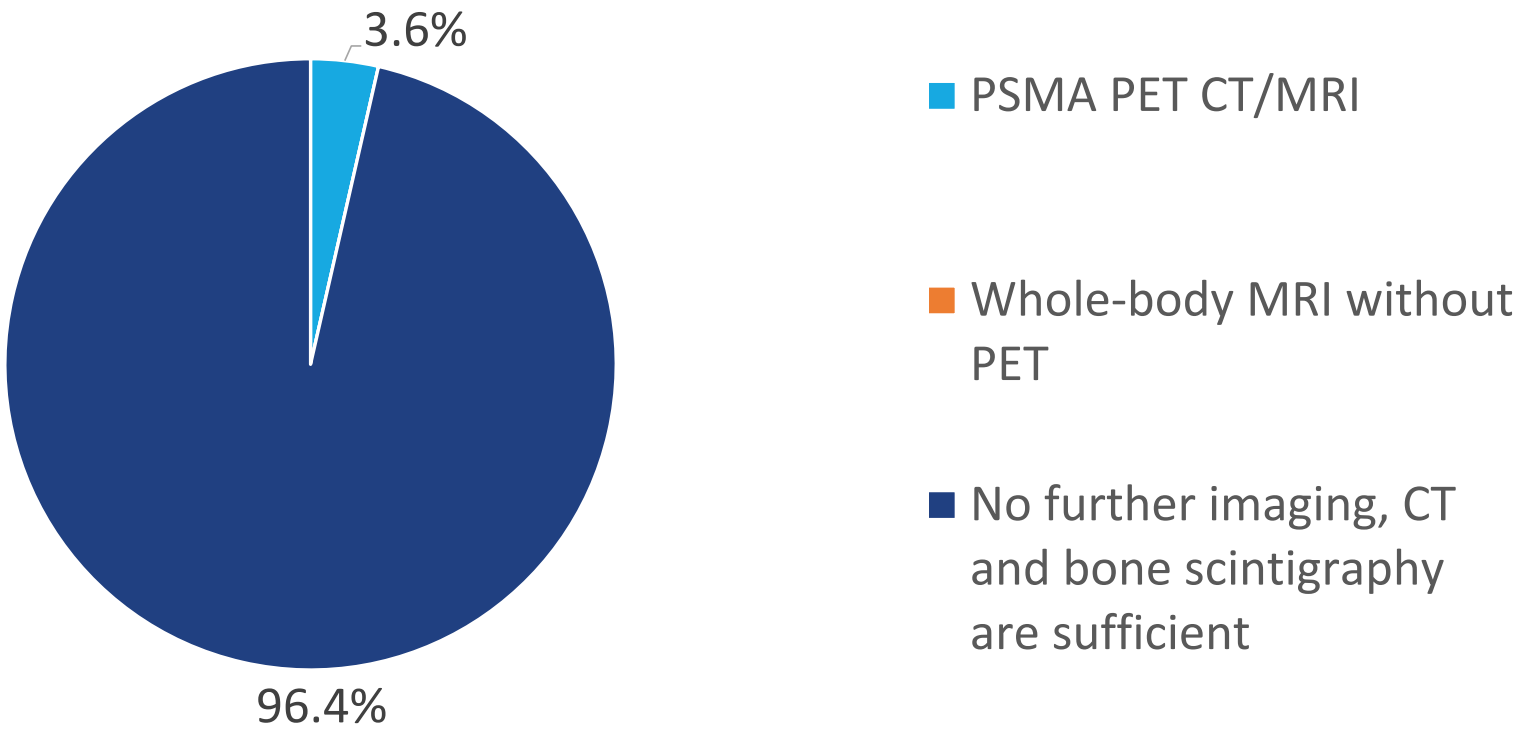
26. In patients who received docetaxel in castration-sensitive, castration-naïve setting, what is your treatment approach for the majority of patients for whom you like to treat with a second chemotherapy course in the mCRPC setting?

Opt	Votes
	15
	13



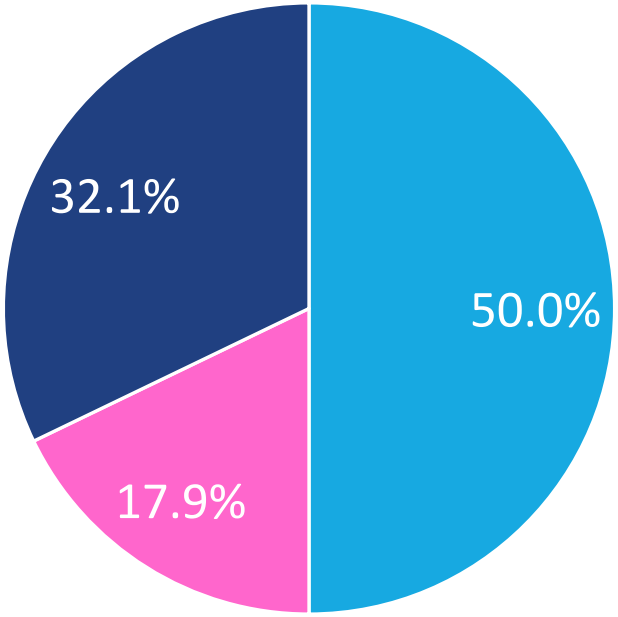
27. For the majority of patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC) based on conventional imaging, what additional imaging modalities do you use to guide selection of systemic treatment?

Opt	Votes
	1
	27



28. Is there a subset of patients with mCSPC for whom you would consider drug-holidays, intermittent, or fixed duration treatment approach?

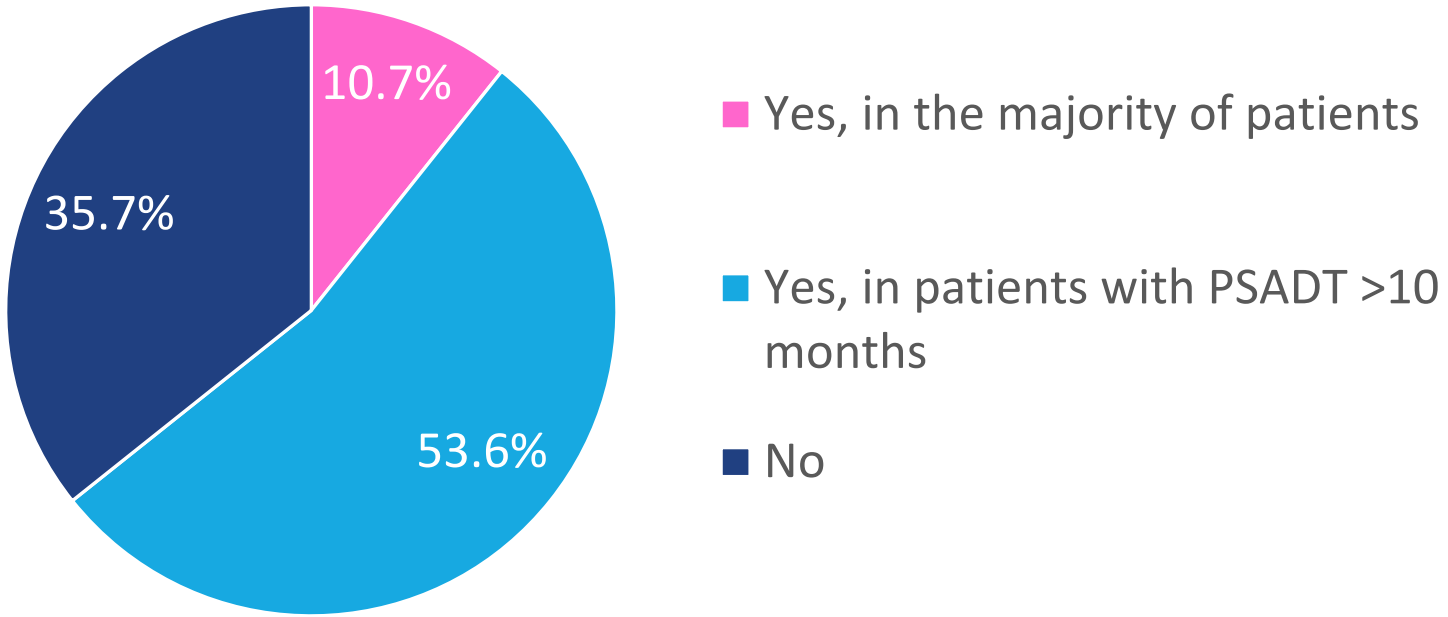
Opt	Votes
	14
	9
	5



- In a majority of patients with mCSPC or mCNPC
- In selected patients (ie patients with oligometastatic disease who has received treatment to primary, metastases directed treatment of all lesions, and 2 years of intensification to ADT)
- In selected patients (ie patients with only node positive disease who have received 2 years of intensification to ADT)
- I would not recommend in patients until more evidence becomes available

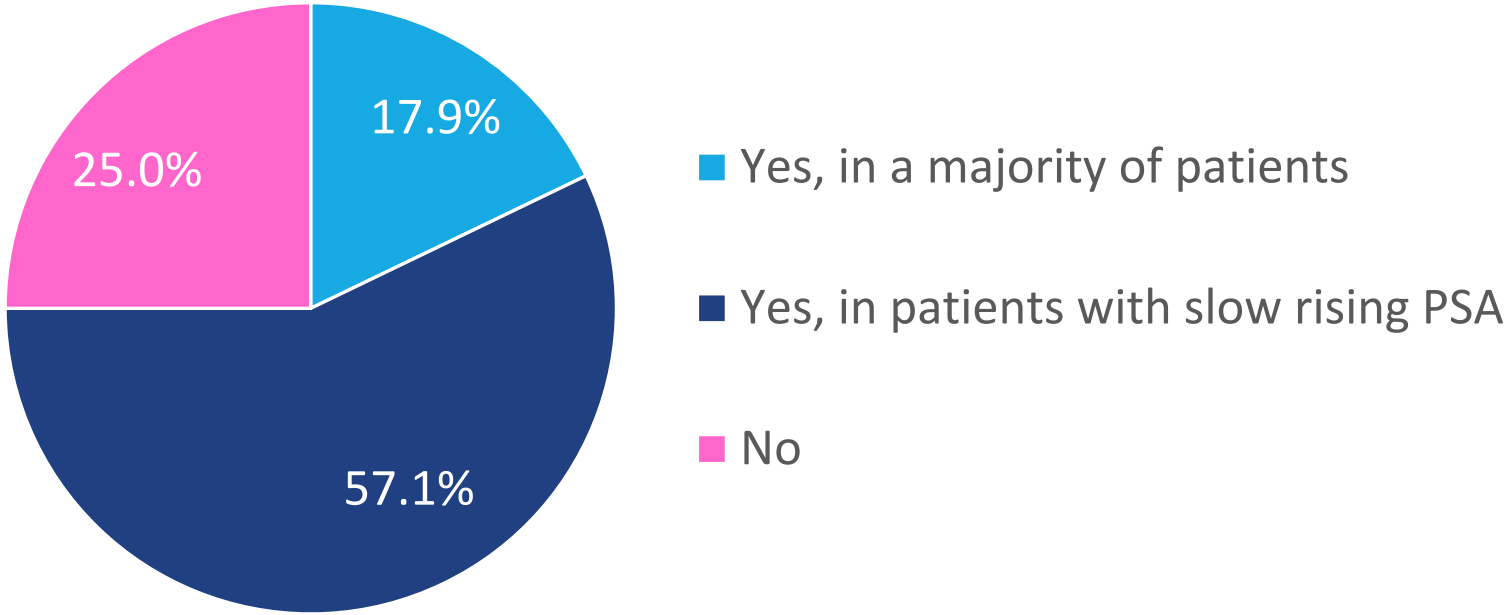
29. Do you recommend adding a first-generation non-steroidal AR antagonist (NSAA) to ADT for patients with nmCRPC (M0 CRPC)?

Opt	Votes
	14
	9
	5



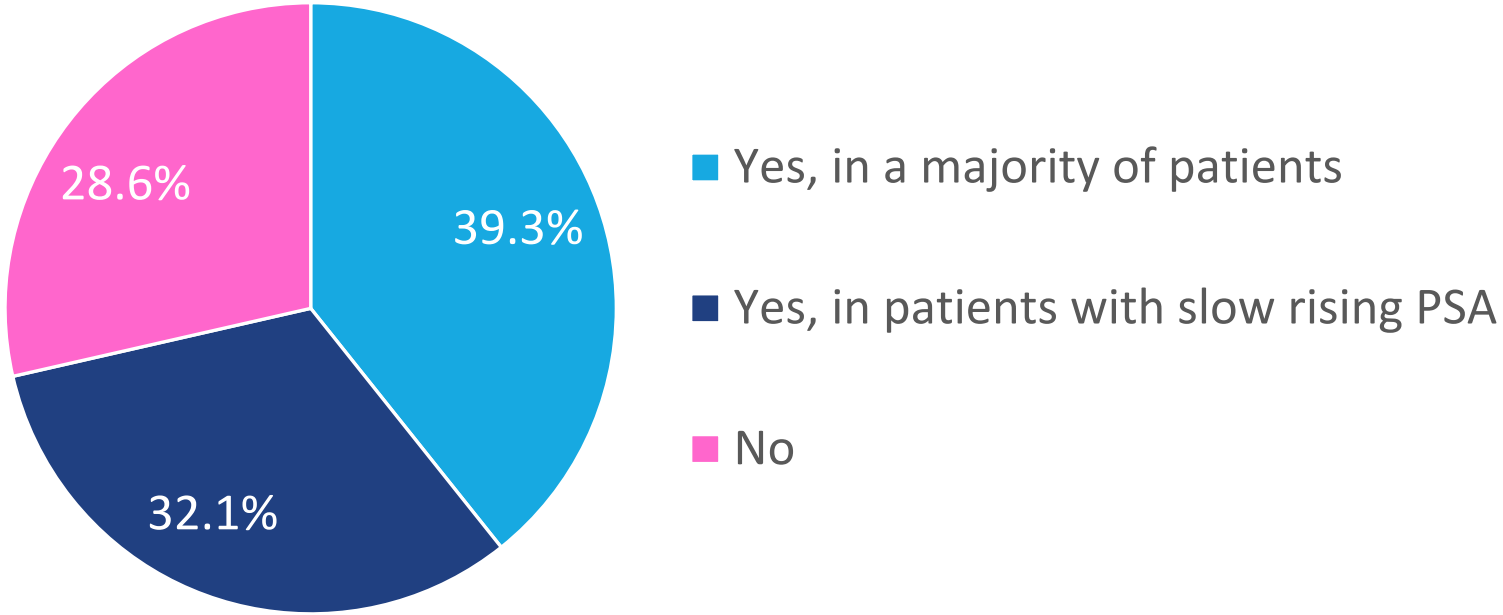
30. For patients with nmCRPC (M0 CRPC), with an untreated primary, showing PSA progression only during treatment with AR pathway inhibitor do you recommend radiation to the primary as an approach to stretch the time to next subsequent treatment?

Opt	Votes
	5
	16
	7



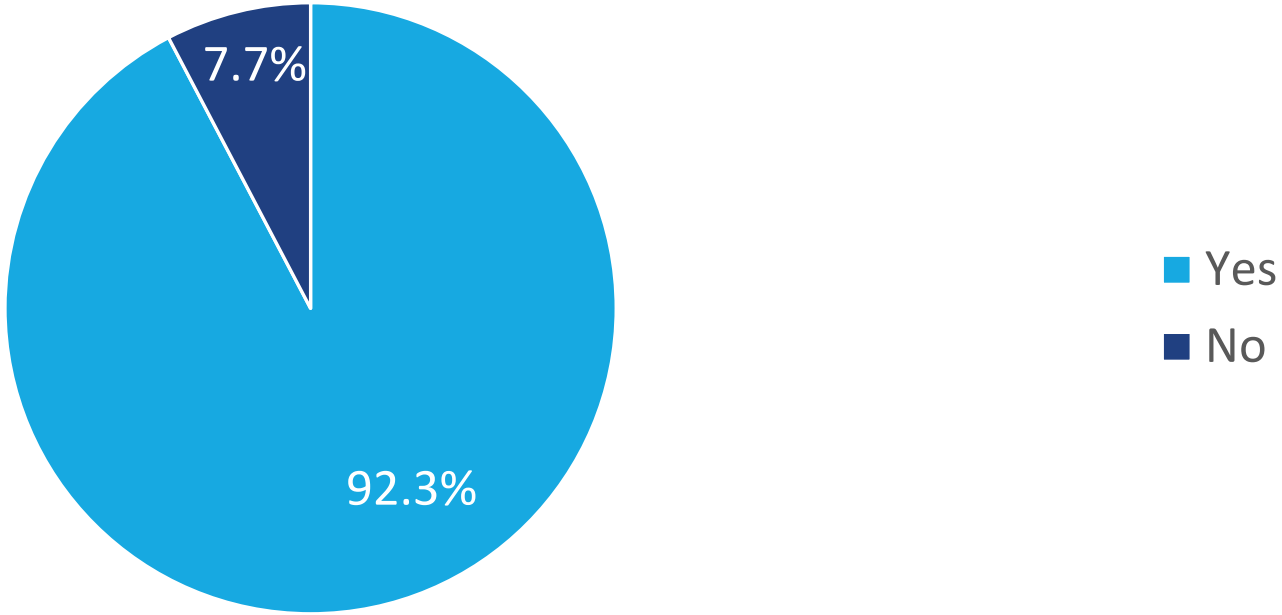
31. For patients with nmCRPC (M0 CRPC) and no evidence of disease outside the prostate bed who have received previous radical prostatectomy but no prior local radiation therapy, do you recommend salvage radiation therapy to delay intensifying systemic therapy if recurrence in the prostate bed is confirmed?

Opt	Votes
	11
	9
	8



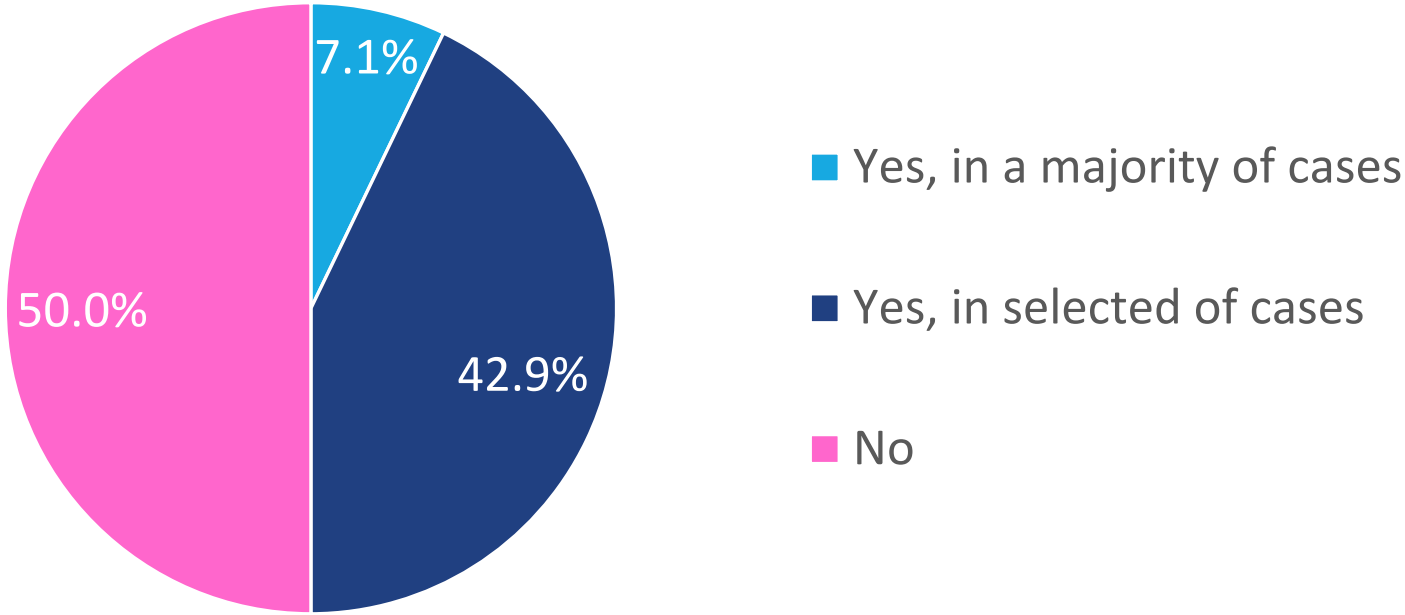
32. At the time of PSA progression (alone) for asymptomatic mCRPC pts treated with abiraterone plus prednisone, do you switch the steroid from prednisone to dexamethasone?

Opt	Votes
	24
	2



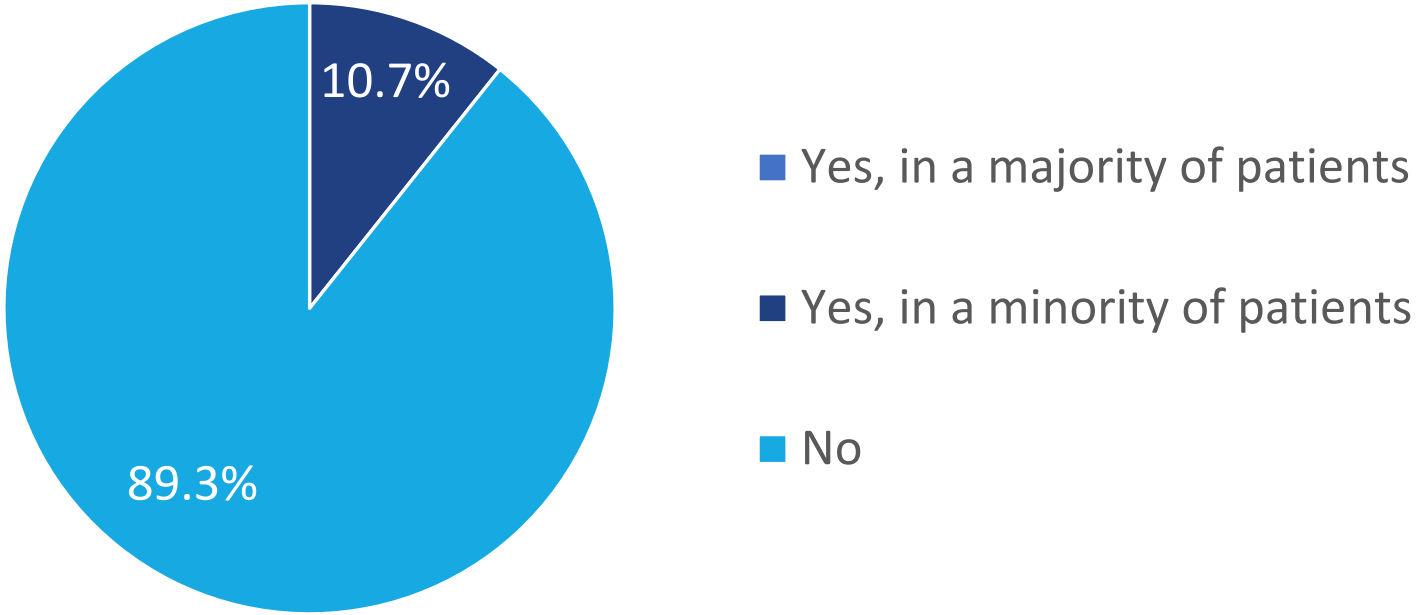
33. Is there a role for biomarker testing (ie AR-V7 or other, assume access is available) as an approach to select candidates who may potentially respond to a second AR pathway inhibitor at some point later in the treatment continuum?

Opt	Votes
	2
	12
	14



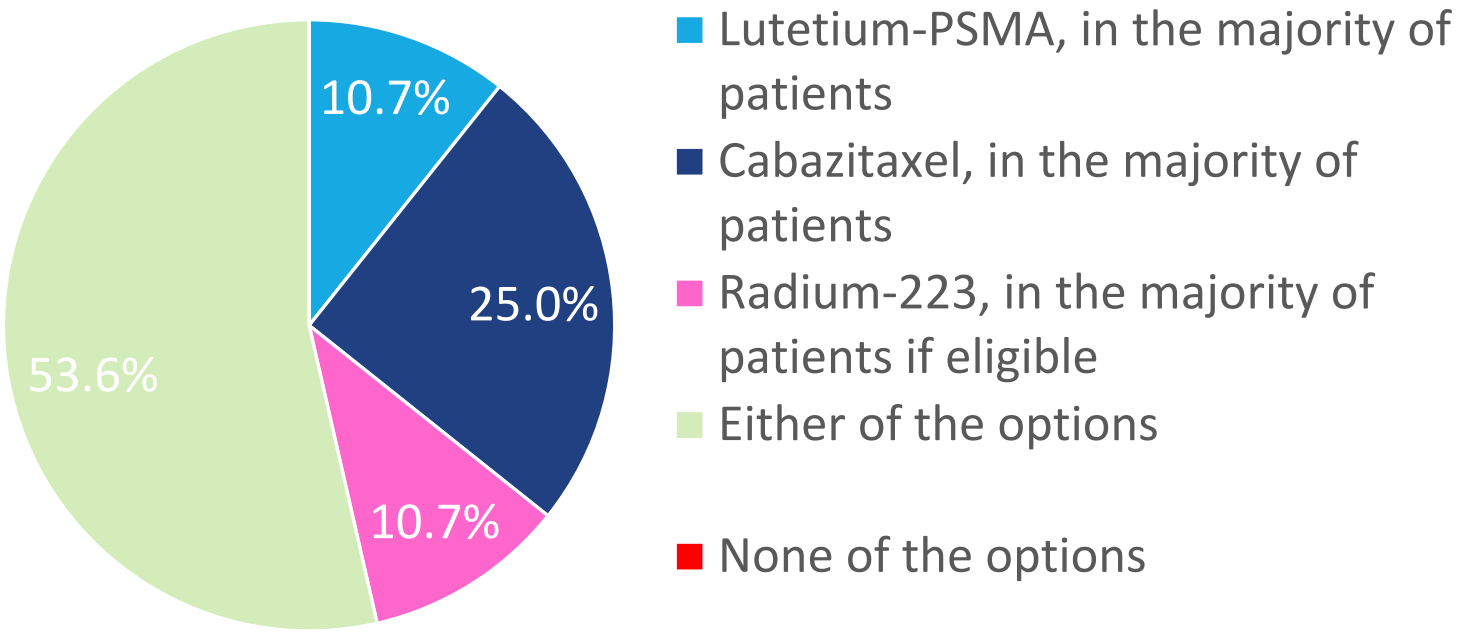
34. Do you recommend bicalutamide as sole additional therapy to ADT in patients with mCRPC?

Opt	Votes
	25
	3



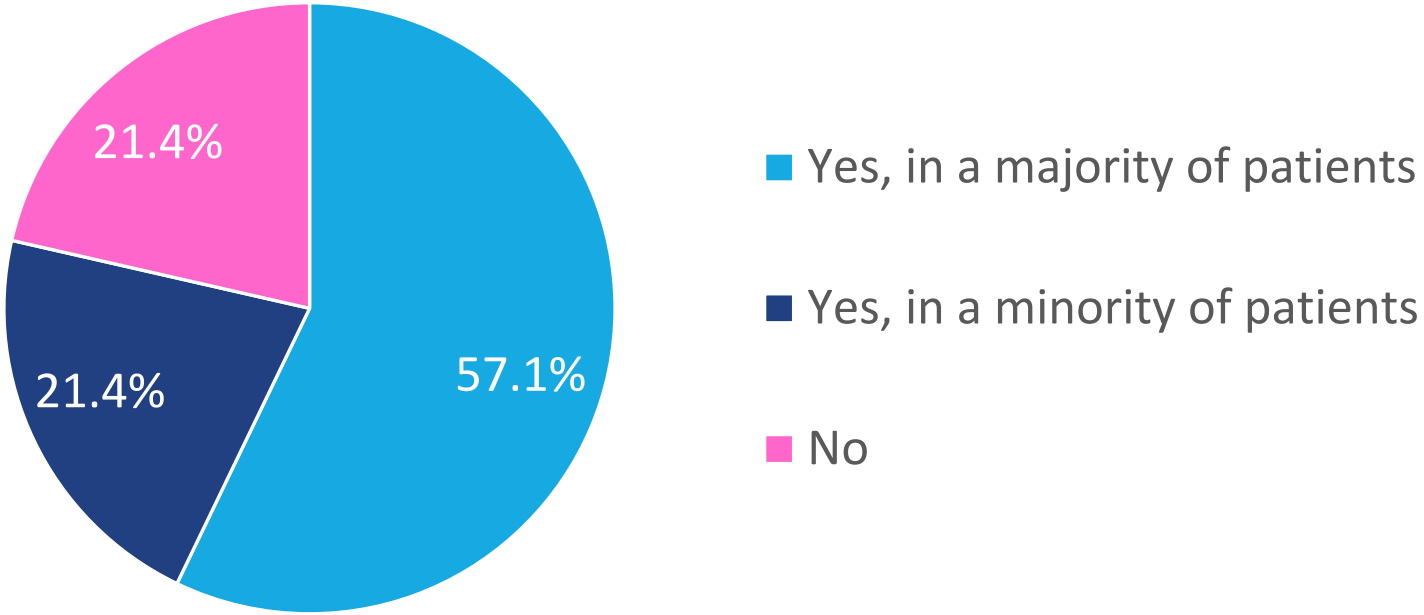
35. Which treatment would you recommend for patients with mCRPC who have failed docetaxel and prior AR pathway inhibitors? Assume there are no regulatory or access limitations.

Opt	Votes
	3
	7
	3
	15



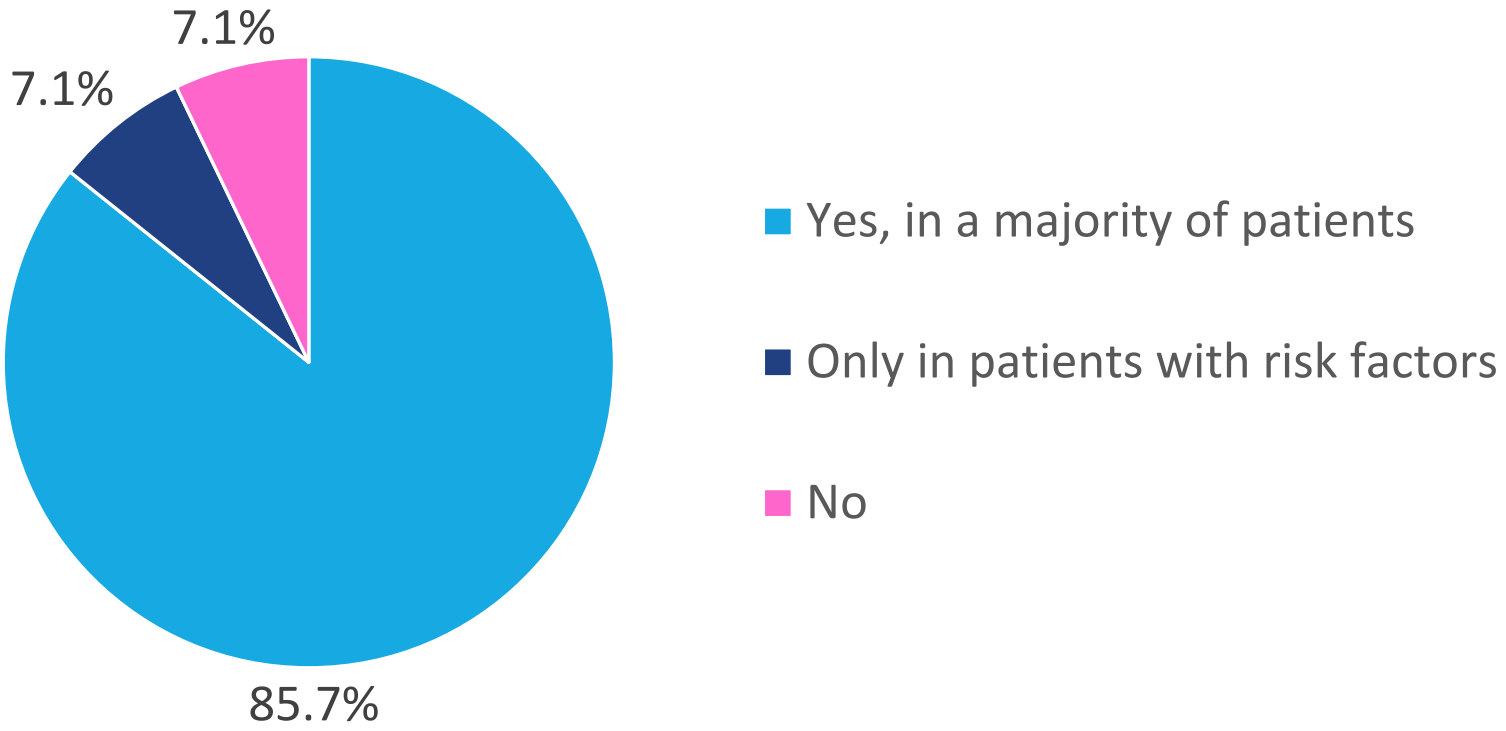
36. Do you routinely screen for osteoporosis risk factors (e.g. current/history of smoking, corticosteroids, family history of hip fracture, personal history of fractures, rheumatoid arthritis, >3 alcohol units/day, BMI) in patients with prostate cancer starting on long-term ADT?

Opt	Votes
	16
	6
	6



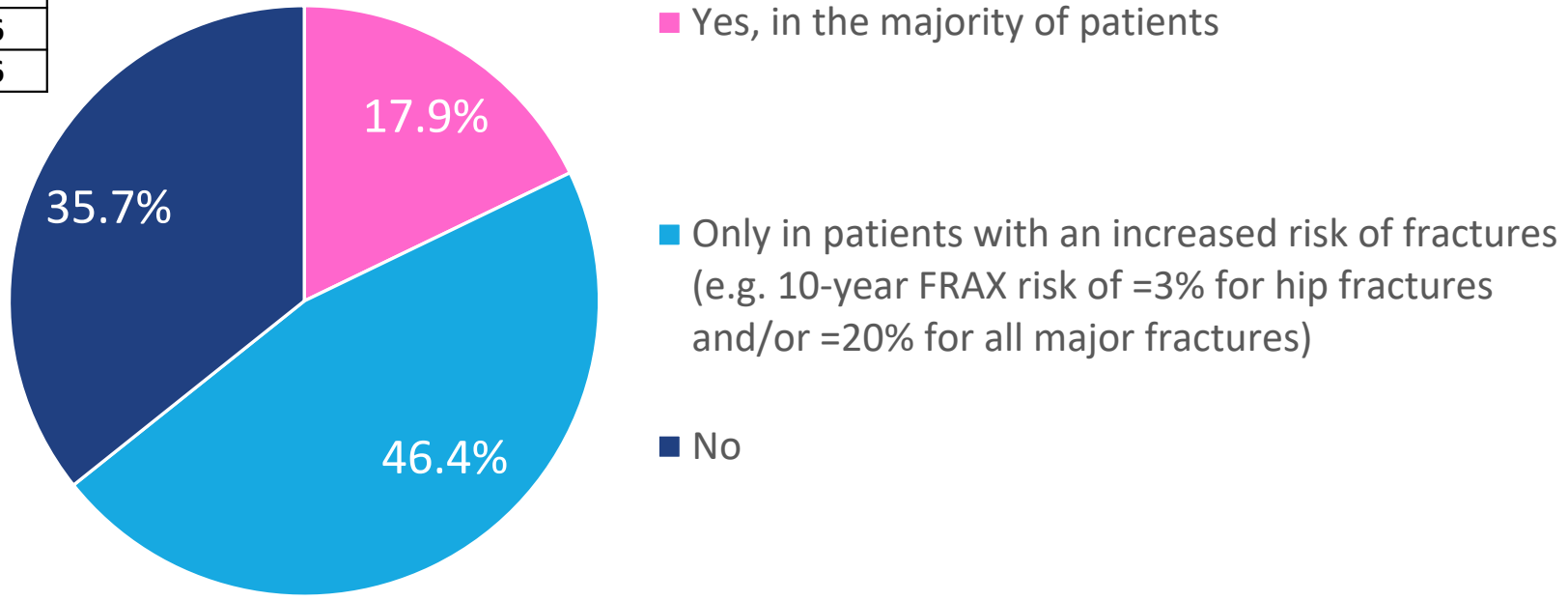
37. Do you routinely recommend measurement of bone mineral density in patients with prostate cancer starting on long-term ADT?

Opt	Votes
	16
	6
	6



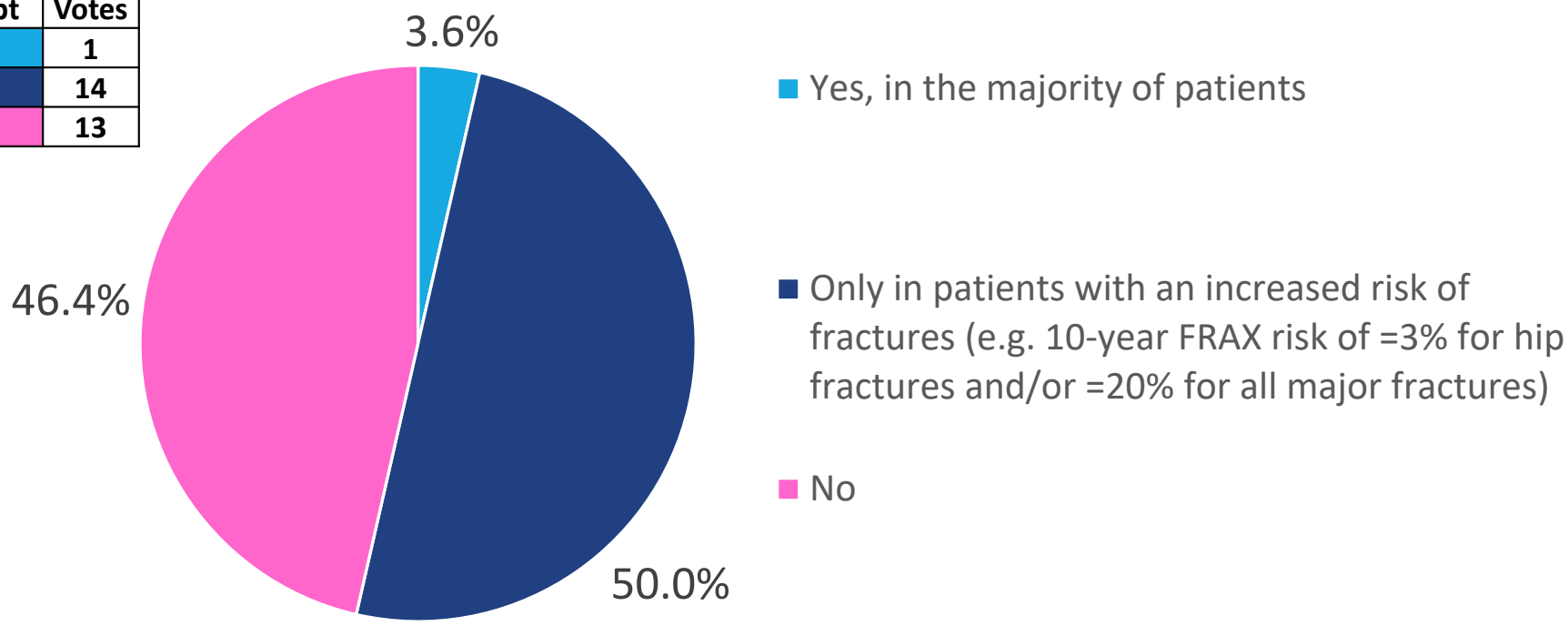
38. Is it appropriate to start an osteoclast-targeted therapy at the dose and schedule used for osteoporosis in order to prevent cancer treatment-induced bone loss (CTIBL)/fractures in patients with prostate cancer starting on long-term ADT without a bone mineral density measurement?

Opt	Votes
	16
	6
	6



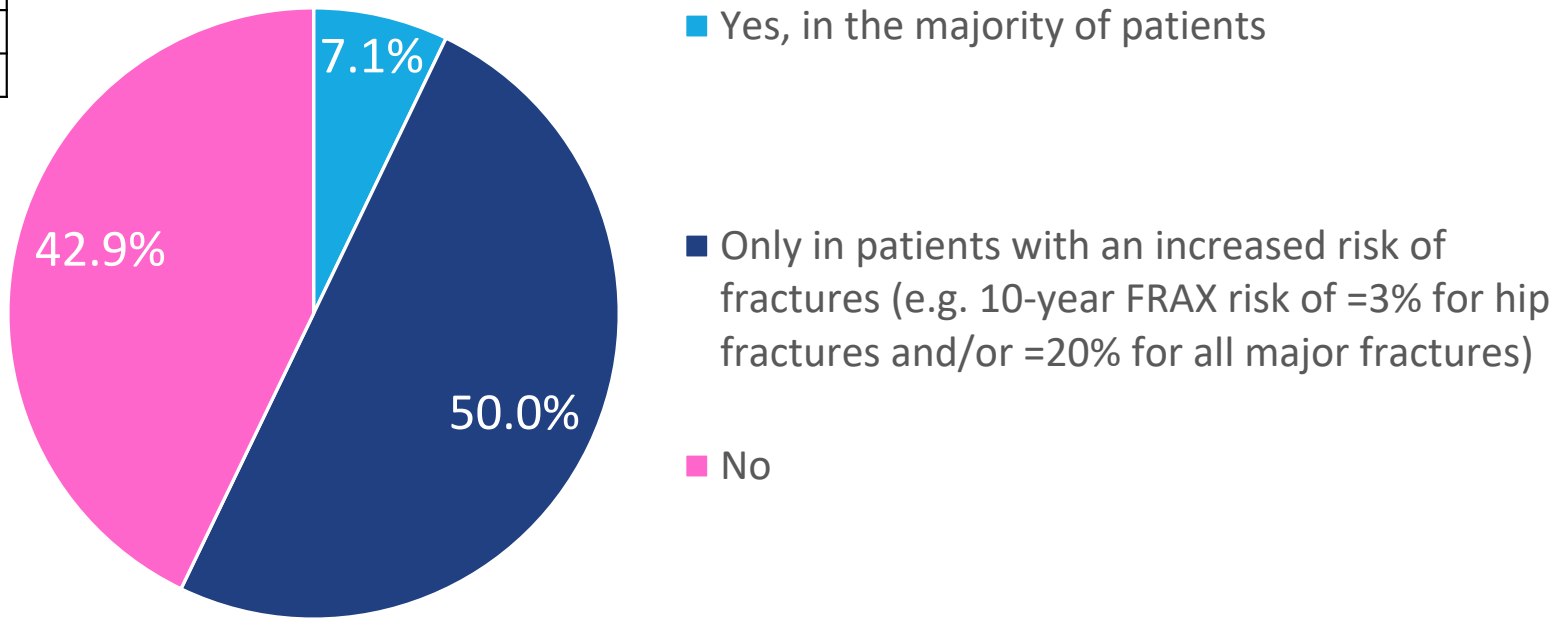
39. For prostate cancer patients starting on long-term ADT who have NO documented osteoporosis on bone mineral density measurement, do you routinely recommend initiating denosumab or a bisphosphonate at the dose and schedule used for osteoporosis, in order to prevent cancer treatment-induced bone loss (CTIBL)/ fractures?

Opt	Votes
	1
	14
	13



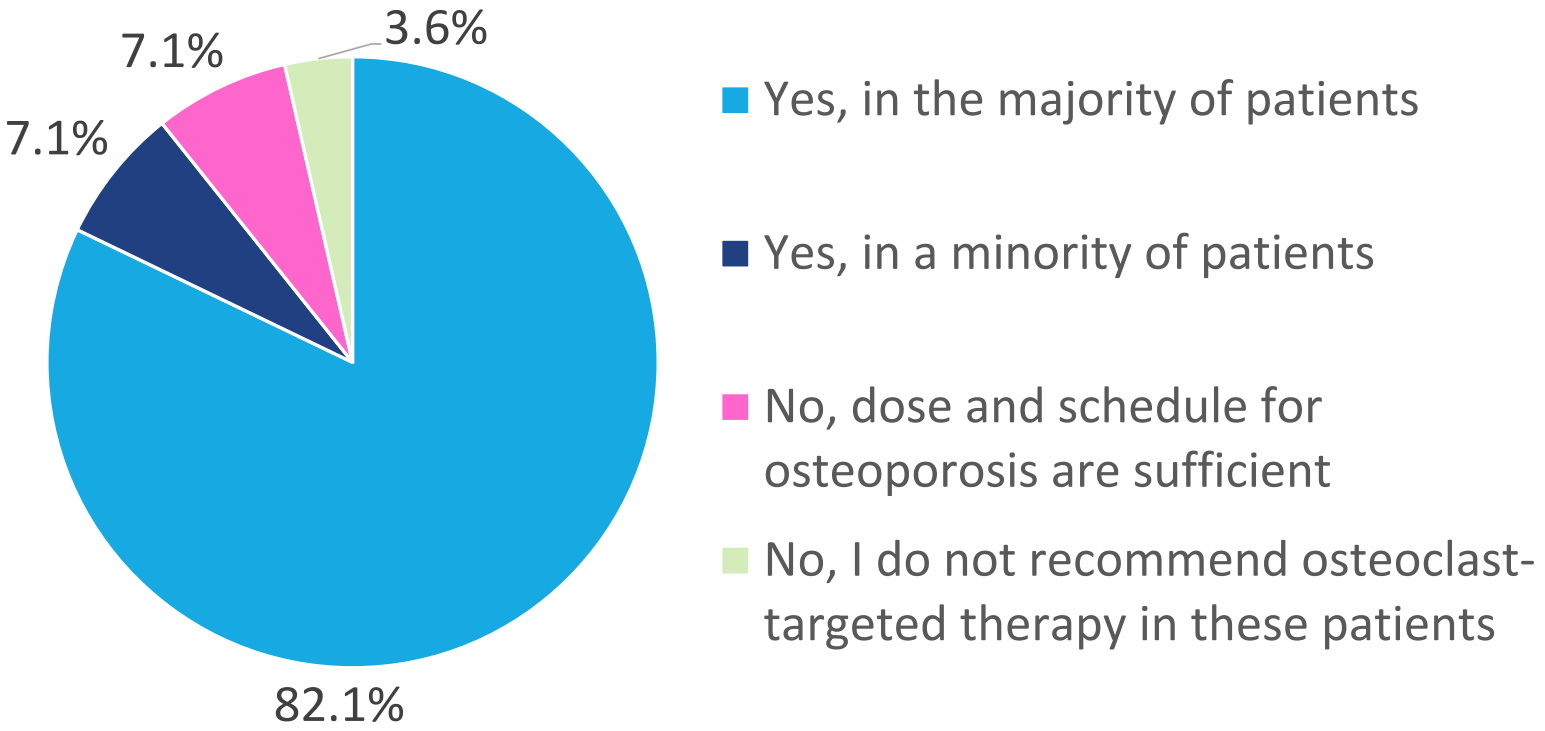
40. For patients starting on long-term ADT plus abiraterone/prednisone who have NO documented osteoporosis, do you routinely recommend initiating denosumab or a bisphosphonate at the dose and schedule used for osteoporosis, in order to prevent cancer treatment-induced bone loss (CTIBL)/ fractures?

Opt	Votes
	2
	14
	12



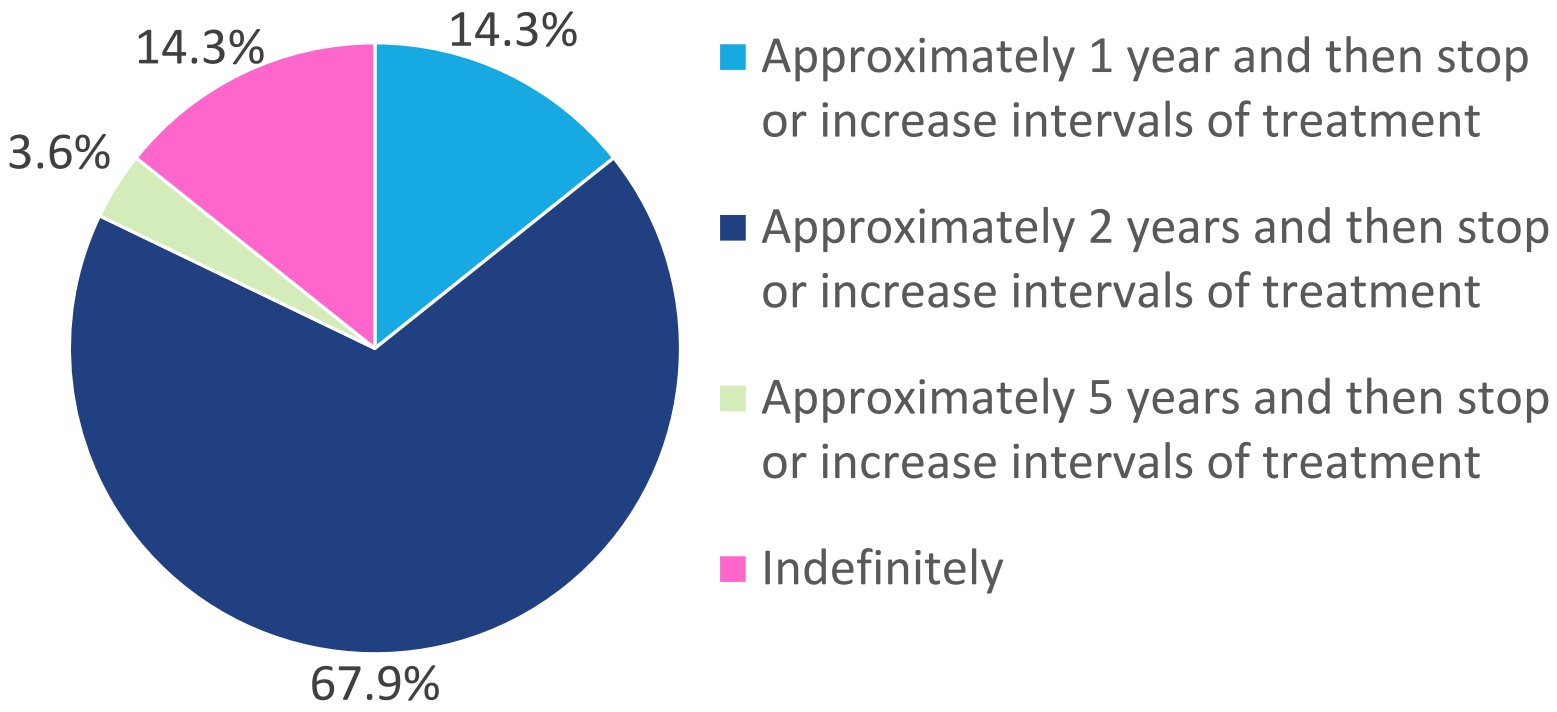
41. In patients with CRPC and bone metastasis or mCRPC patients treated with radium-223, do you recommend osteoclast-targeted therapy (zoledronic acid or denosumab) at the higher dose and more frequent schedule used for reducing the risk of SRE (skeletal-related events) in patients with CRPC and bone metastases?

Opt	Votes
	23
	2
	2
	1



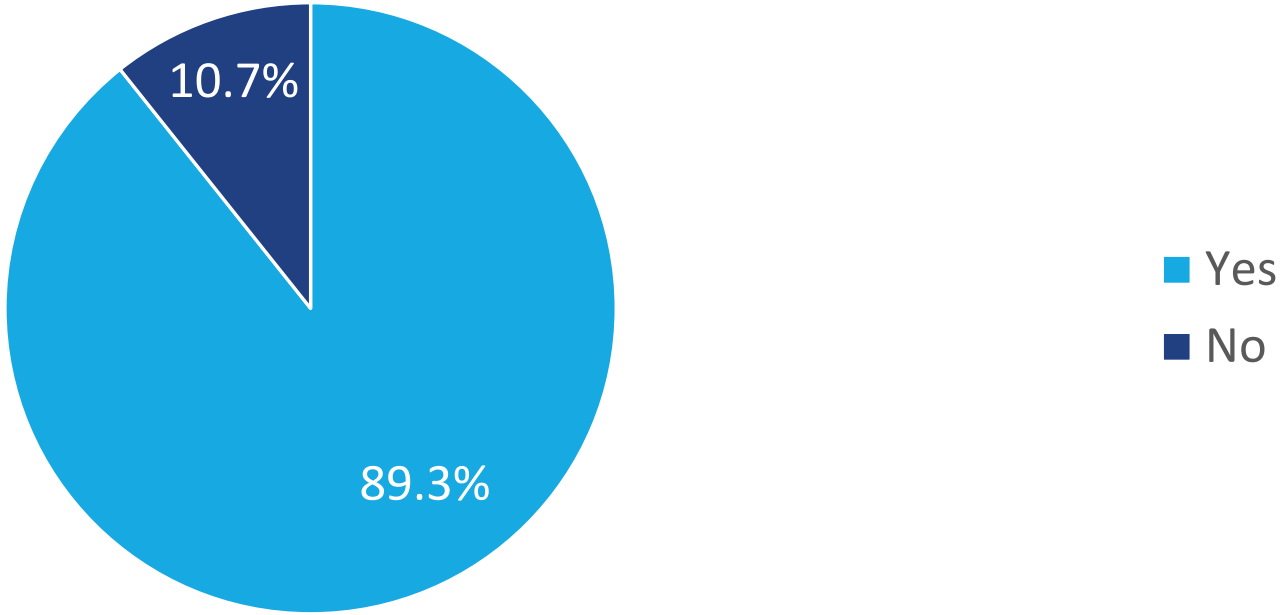
42. What treatment duration and frequency do you recommend when you use osteoclast-targeted therapy for reducing the risk of SRE in patients with mCRPC and bone metastases?

Opt	Votes
	4
	19
	4
	1



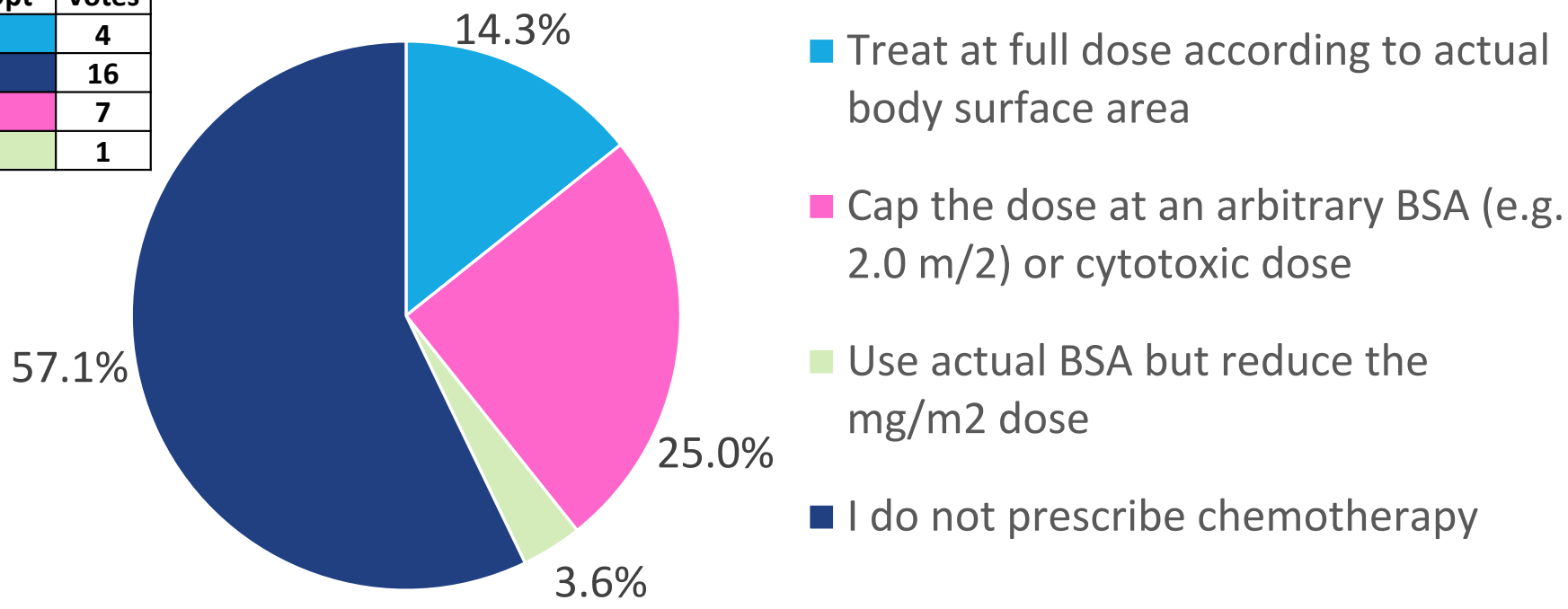
43. Do you recommend collecting a detailed family history of cancer for all patients with newly diagnosed metastatic (M1) castration-sensitive/naïve prostate cancer (CSPC/CNPC)?

Opt	Votes
	25
	3



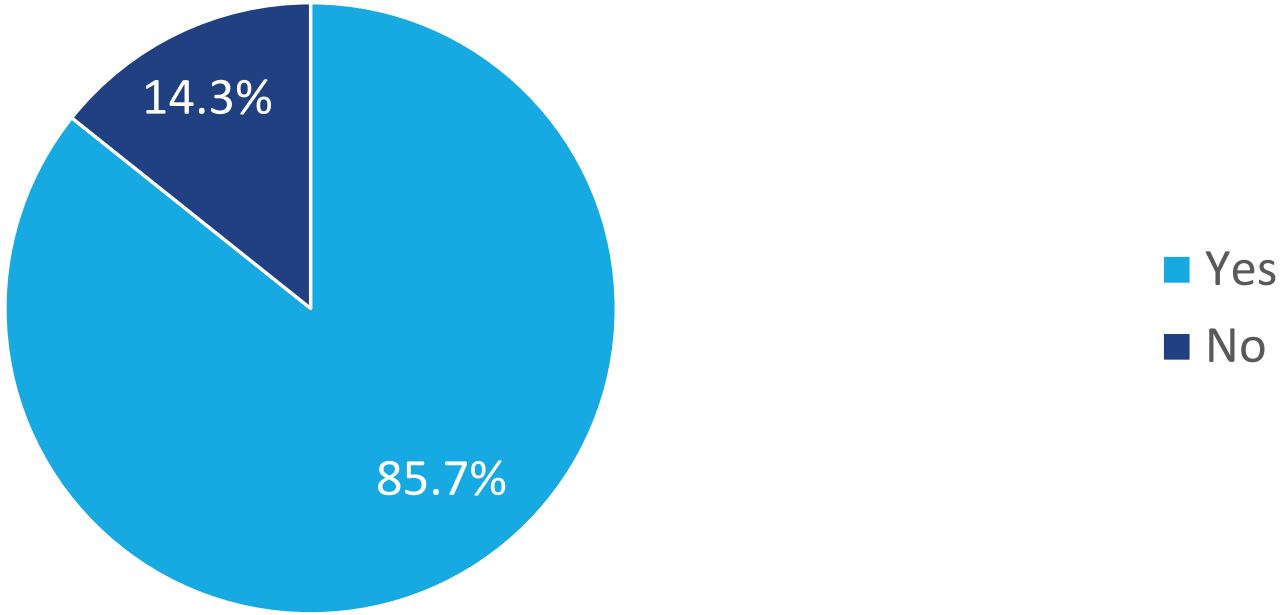
44. What is your preferred strategy for dose calculation of chemotherapy to treat patients who are highly obese?

Opt	Votes
	4
	16
	7
	1



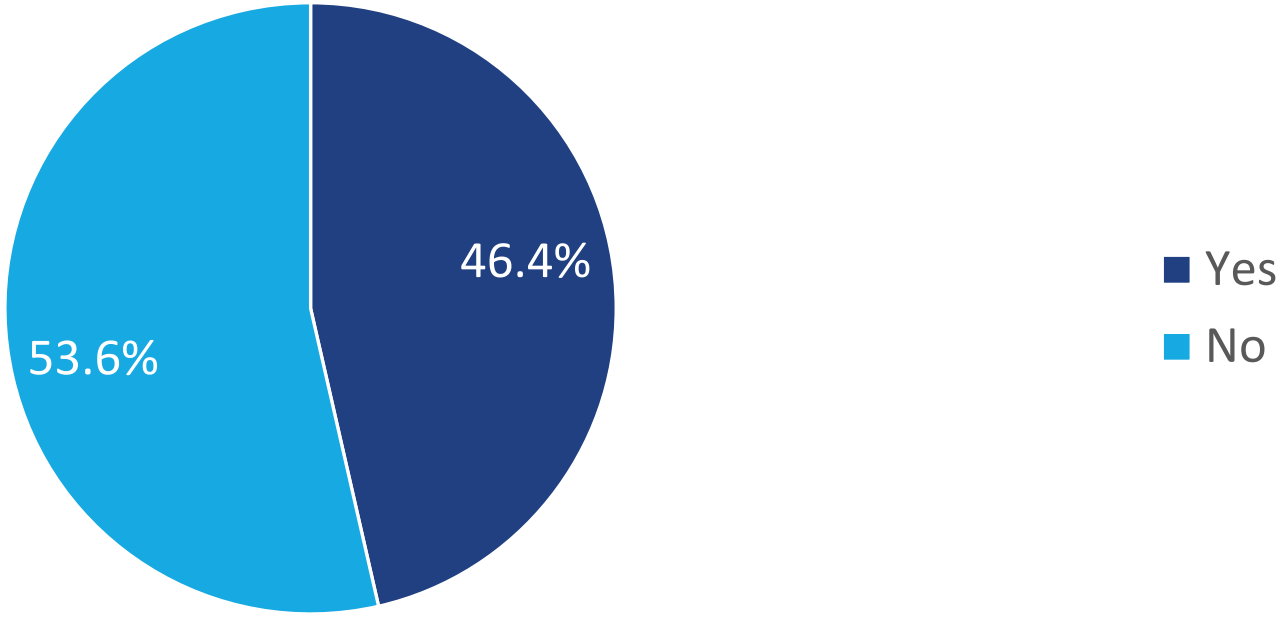
45. Can we extrapolate mCRPC clinical trial data regarding efficacy to the treatment of patients who are older than the majority of patients enrolled in these trials?

Opt	Votes
	24
	4



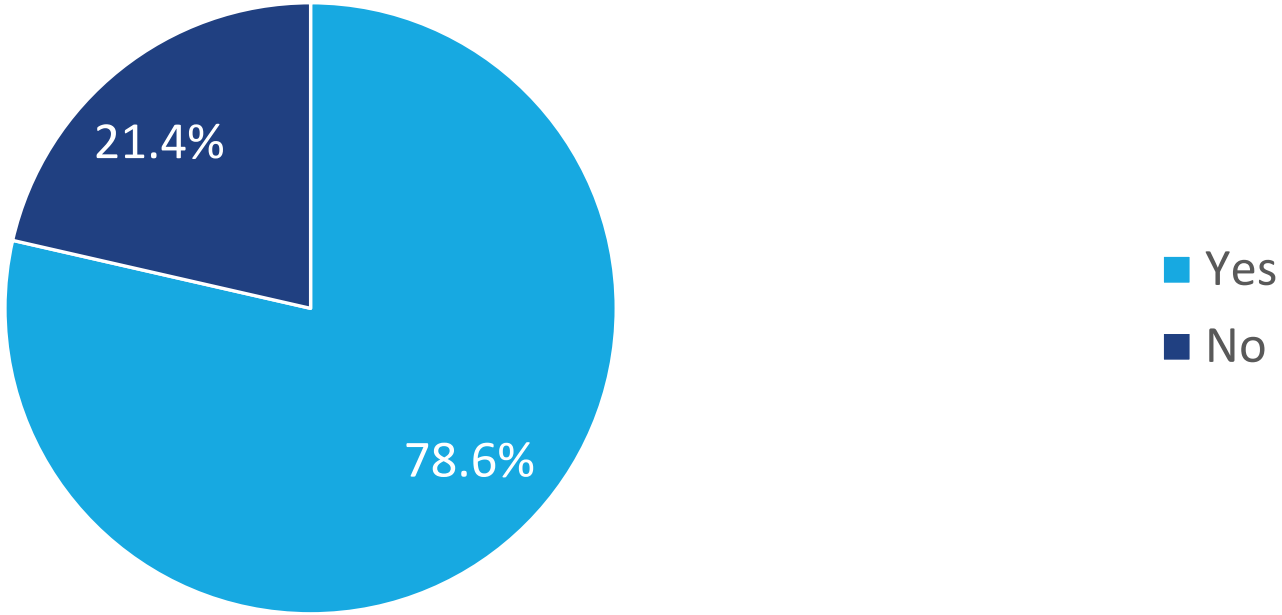
46. Can we extrapolate mCRPC clinical trial data regarding toxicity to the treatment of patients who are older than the majority of patients enrolled in these trials?

Opt	Votes
	15
	13



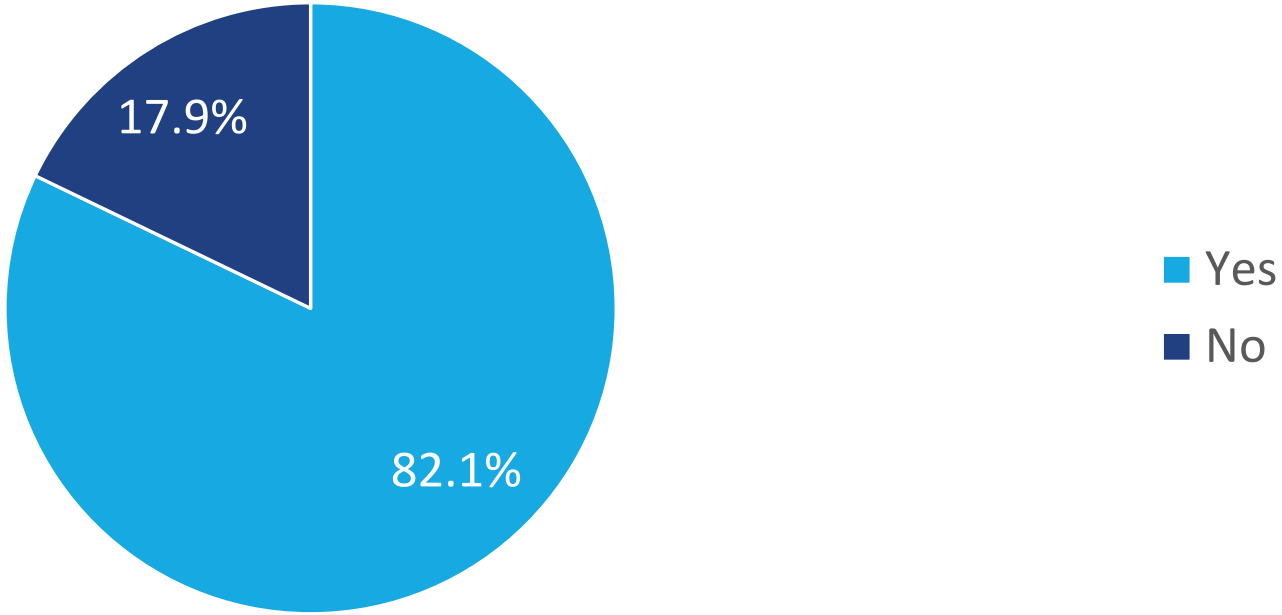
47. Can we extrapolate mCRPC clinical trial data regarding efficacy to the treatment of patients of other ethnicities than the majority of patients enrolled in these trials?

Opt	Votes
	22
	6



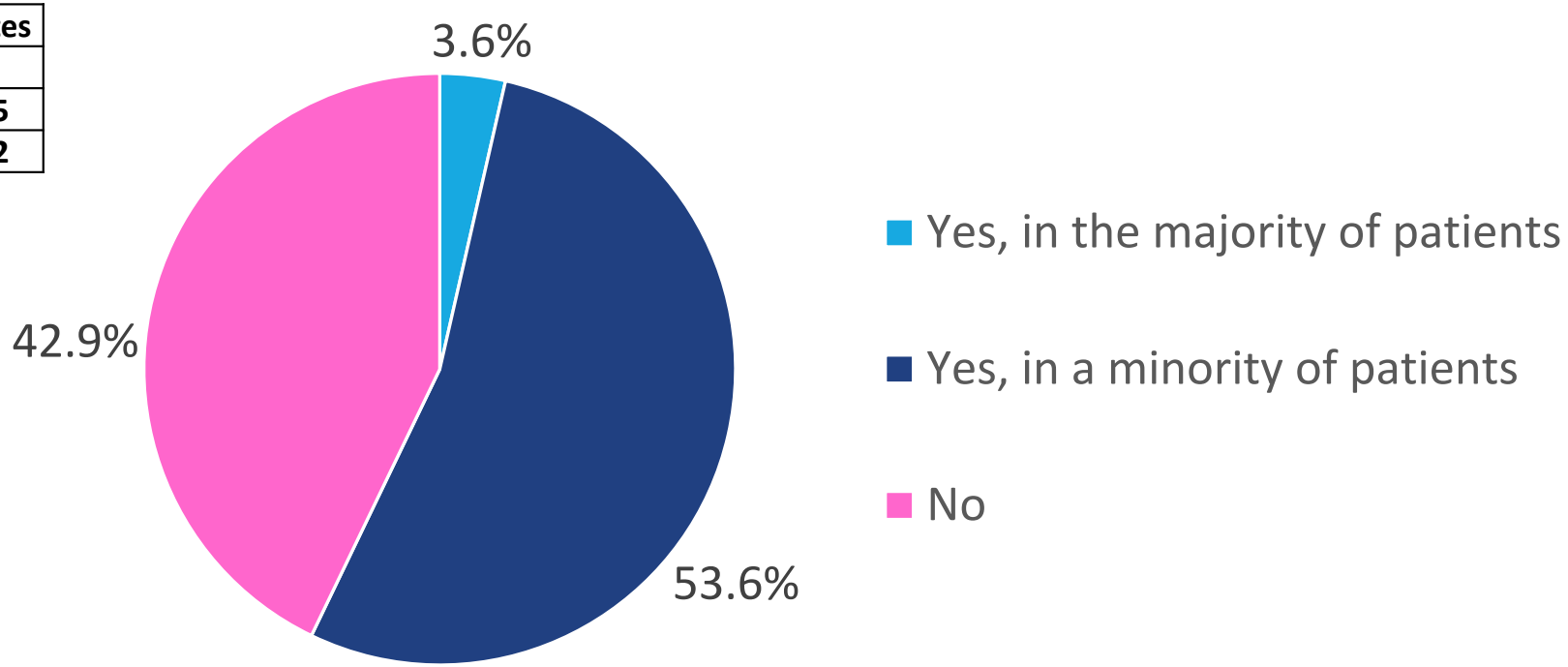
48. Can we extrapolate mCRPC clinical trial data regarding toxicity to the treatment of patients of other ethnicities than the majority of patients enrolled in these trials?

Opt	Votes
	23
	5



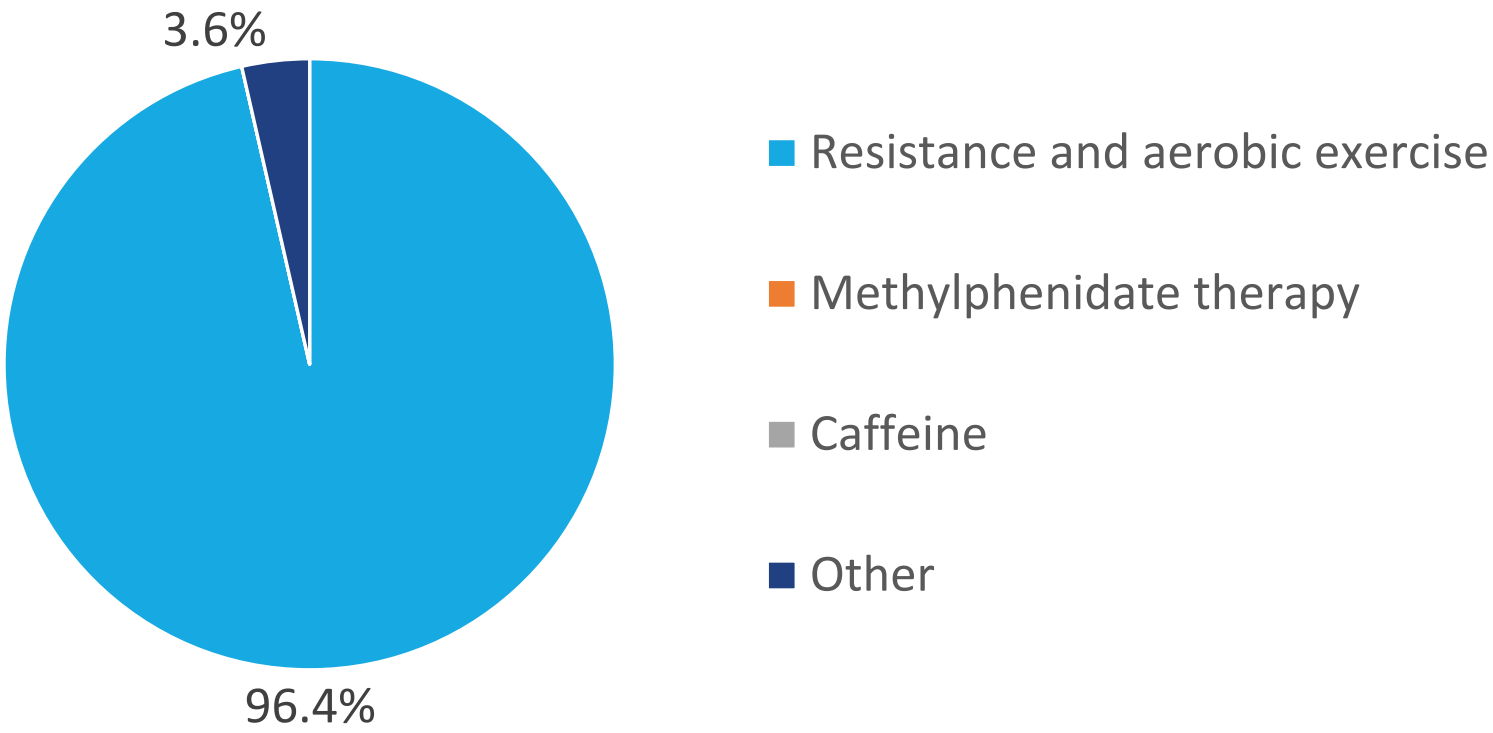
49. Do you recommend a geriatric assessment prior to treatment selection in patients with advanced prostate cancer who are =70 years old?

Opt	Votes
	1
	15
	12



50. What is your preferred first management option to reduce fatigue in patients receiving systemic therapy for prostate cancer (apart from therapy dose reduction if possible)?

Opt	Votes
	27
	1



51. What is your preferred first management option for patients who develop clinically significant cognitive impairment on enzalutamide or apalutamide?

Opt	Votes
	10
	18