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Overall survival (OS) in patients (pts) with metastatic hormone-sensitive prostate cancer (mHSPC) who received prior androgen deprivation therapy (ADT) and reached low prostate-specific antigen (PSA) levels treated further with enzalutamide (ENZA): Post hoc analyses of ARCHES

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Background

In the phase 3 ARCHES trial, >90% of men with mHSPC received prior ADT and achieved a range of PSA values (\leq 0.2, >0.2-4, and >4 μ g/L) before randomization. This *post hoc* analysis examined the effect of treatment intensification with ENZA + ADT versus continuing ADT alone on OS and other efficacy outcomes by baseline PSA categories.

Methods

Pts with mHSPC were randomized 1:1 to ENZA (160 mg/day) + ADT or placebo (PBO) + ADT. Prior ADT (\leq 3 months [mo]/ \leq 6 mo + docetaxel) and up to 6 cycles of prior docetaxel were permitted before baseline assessment of PSA levels and study treatment initiation. After unblinding, 31.3% of PBO + ADT-treated pts crossed over to open-label ENZA + ADT (median time to crossover, 21.5 mo). *Post hoc* analyses of the primary endpoint radiographic progression-free survival (rPFS) and secondary endpoints such as OS were conducted to assess the efficacy of ENZA + ADT in pts achieving different baseline PSA categories after prior treatment with ADT.

Results

In the overall population (n=1150), >90% received prior ADT and 18% had prior docetaxel treatment. Median duration (range) of prior ADT was 1.6 mo (0.03–55.3) for ENZA + ADT pts versus 1.6 mo (0.03–198.8) for PBO + ADT pts. Of the overall population with available baseline PSA values who received prior ADT (n=1045), 133 pts had \leq 0.2 μ g/L, 372 had >0.2–4 μ g/L, and 540 had >4 μ g/L PSA at baseline (Table). A beneficial effect of ENZA + ADT was observed across all baseline PSA categories, including OS (adjusted for crossover) in pts with baseline PSA \leq 0.2 μ g/L, with no evidence of heterogeneity (Table).

Conclusions

These post hoc analyses in pts with mHSPC who received prior ADT and achieved baseline PSA values even to $\leq 0.2 \,\mu \text{g/L}$ support the additional durable clinical benefits of treatment intensification with ENZA + ADT for rPFS and OS and other secondary endpoints. Table: 1398P

	Baseline PSA, μg/L		
Endpoint, HR (95% CI) ^a	\leq 0.2 (n=62; ^b n=71 ^c)>0.2-4 (n=191; ^b n=181 ^c)>4 (n=278; ^b n=262 ^c)		
rPFS ^d	0.60 (0.27, 1.33)	0.32 (0.20, 0.50)	0.45 (0.32, 0.63)
OS	0.58 (0.27, 1.24)	0.56 (0.38, 0.82)	0.75 (0.56, 1.00)
Crossover-adjusted OS	0.48 (0.17, 0.96)	0.54 (0.33, 0.80)	0.65 (0.47, 0.88)
Time to PSA progression ^e	0.25 (0.09, 0.69)	0.28 (0.19, 0.42)	0.27 (0.21, 0.37)
Time to castration resistance	e 0.44 (0.24, 0.81)	0.40 (0.29, 0.55)	0.36 (0.28, 0.46)

^aHR<1 favors ENZA + ADT; ^bENZA + ADT; ^cPBO + ADT; ^dIndependent central review or death within 24 weeks of stopping treatment; ^e≥25%

increase and absolute increase ≥2 ng/mL above nadir.Cl=confidence interval; HR=hazard ratio.

Clinical trial identification

NCT02677896.

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Legal entity responsible for the study

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Disclosure

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