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.

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

Prior to Initiating ADT

EVALUATION AND REFERRAL

1 Confirm that the patient has a PCP

YES

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

NO

Refer to a PCP

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

YES

Document patient's approval to involve specified other people

NO

Continue to limit discussions and information-sharing to patient

3 Conduct a baseline cardiometabolic assessment

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)

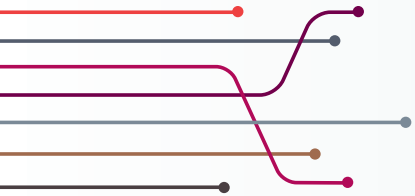
Additional Assessment for Consideration

- 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.

4 Take a stratified approach to CV risk mitigation

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

5 Determine statin-use status

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

6 Perform a baseline fracture risk and BMD assessment

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

7 Consider using a brief depression screen

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

8

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

9

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

EVALUATION AND REFERRAL

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

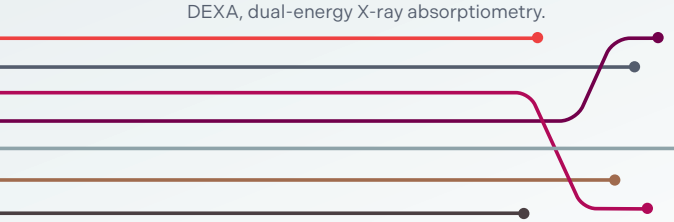
Annually

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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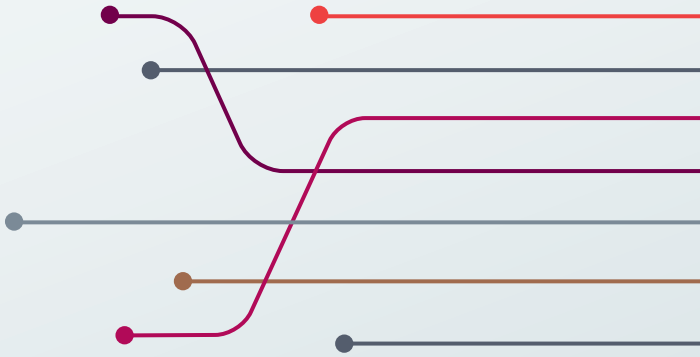

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