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Management of Advanced Prostate Cancer in the Asia-Pacific Region: Summary of the Asia-Pacific Advanced Prostate Cancer Symposium 2025

Edmund Chiong[1,2] | Renu Eapen[3] | Nicholas Buchan[4] | Kenneth Chen[5] | Lukman Hakim[6,7] | Agus Rizal Hamid[8] | Jae-Young Joung[9] | Ravindran Kanesvaran[10] | Makarand Khochikar[11] | Jason Letran[12] | Bannakij Lojanapiwat[13] | Indranil Mallick[14] | Chi Fai Ng[15] | Pei Ing Ngam[16] | Teng Aik Ong[17] | Jacob Pang[18] | Darren M. C. Poon[19] | Natasha Roberts[20] | Marniza Saad[21] | Shinichi Sakamoto[22] | Jeremy Tey[23] | Sue Ping Thang[24] | Poh Choo Toh[25] | Levent Türkeri[26] | Nguyễn Tuấn Vinh[27] | Alvin Wong[28] | Yao Zhu[29] | ANZUP Cancer Trials Group[30] | Ian D. Davis[31,32]

[1]Department of Urology, National University Hospital, Singapore, Singapore | [2]Department of Surgery, Yong Loo Lin School of Medicine, National University of Singapore, Singapore, Singapore | [3]Division of Cancer Surgery, Department of Genitourinary Oncology, Peter MacCallum Cancer Centre, Melbourne, Victoria, Australia | [4]Department of Urology, Christchurch Public Hospital, Christchurch, New Zealand | [5]Department of Urology, Singapore General Hospital, Singapore, Singapore | [6]Department of Urology, Faculty of Medicine, Universitas Airlangga, Surabaya, Indonesia | [7]Department of Medicine, Faculty of Medicine and Health, Institut Teknologi Sepuluh Nopember, Surabaya, Indonesia | [8]Department of Urology, Faculty of Medicine Universitas Indonesia – Cipto Mangunkusumo Hospital, Jakarta, Indonesia | [9]Department of Urology, Center for Urological Cancer, National Cancer Center, Goyang, South Korea | [10]Division of Medical Oncology, National Cancer Centre Singapore, Singapore, Singapore | [11]Department of Urology/Uro-oncology, Ushakal Abhinav Institute of Medical Sciences, Sangli, India | [12]Department of Urology, Chinese General Hospital and Medical Center, Manila, Philippines | [13]Department of Surgery, Chiang Mai University, Chiang Mai, Thailand | [14]Department of Radiation Oncology, Tata Medical Center, Kolkata, India | [15]SH Ho Urology Centre, The Chinese University of Hong Kong, Ma Liu Shu, Hong Kong | [16]Department of Diagnostic Imaging, National University Hospital, Singapore, Singapore | [17]Department of Surgery, Faculty of Medicine, Universiti Malaya, Kuala Lumpur, Malaysia | [18]Department of Urology, Chang Gung Memorial Hospital Linkou, Taoyuan, Taiwan | [19]Department of Clinical Oncology, The Chinese University of Hong Kong, Ma Liu Shu, Hong Kong | [20]STARS Education and Research Alliance, Metro North Health and The University of Queensland, Herston, Queensland, Australia | [21]Department of Clinical Oncology, Faculty of Medicine, Universiti Malaya, Kuala Lumpur, Malaysia | [22]Department of Urology, Chiba University Graduate School of Medicine, Chiba, Japan | [23]Department of Radiation Oncology, National University Cancer Institute Singapore, Singapore, Singapore | [24]Department of Nuclear Medicine and Molecular Imaging, Singapore General Hospital, Singapore, Singapore | [25]Department of Urology, National University Hospital, and Department of Surgery, National University of Singapore, Singapore, Singapore | [26]Department of Urology, Altunizade Hospital, Acibadem M.A. Aydinlar University, Istanbul, Türkiye | [27]Department of Urology, Binh Dan Hospital, Ho Chi Minh City, Vietnam | [28]Department of Haematology Oncology, National University Hospital, Singapore, Singapore | [29]Department of Urology, Fudan University Shanghai Cancer Center, Shanghai, China | [30]Level 8, Health Translation Hub, Randwick, New South Wales, Australia | [31]Monash University, Melbourne, Victoria, Australia | [32]Eastern Health, Melbourne, Victoria, Australia

Correspondence: Ian D. Davis (ian.davis@monash.edu)

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ABSTRACT

Aim: The aim of the fourth Asia-Pacific Advanced Prostate Cancer Symposium (APAC APCS 2025) was to discuss the application in the Asia-Pacific (APAC) region of outcomes from the fifth Advanced Prostate Cancer Consensus Conference (APCCC 2024).

Methods: The one-day symposium in September 2025 brought together 28 experts from 15 APAC countries or regions. The symposium covered five topics: (1) high-risk localized/locally advanced prostate cancer; (2) prostate-specific antigen persistence and recurrence; (3) radioligand therapy; (4) genetics and genomics; (5) bone protection and other aspects of supportive care.

Presymposium polling and expert presentations prefaced in-depth discussions to gather insights on current practice and challenges in the region.

Results: APAC APCS 2025 highlighted the increasing complexities in diagnosis and management of advanced prostate cancer and the impact on practice of variations in access and cost. Panelists described variations in access and reimbursement for PSMA-PET/CT, abiraterone, androgen receptor pathway inhibitors, ^{177}Lu-PSMA, and bone-protecting agents. While most panelists reported access to nuclear medicine expertise, access to genetic counsellors continues to be limited in many parts of the region. Discussions highlighted creative approaches used to minimize costs while maximizing options for patients.

Conclusion: APAC Advanced Prostate Cancer Symposia are important forums for discussing APAC-specific considerations in areas where clinical evidence is evolving. In an era of increasingly sophisticated technologies, discussions highlight the importance of not losing sight of patient and clinical factors in decision-making. Multidisciplinary and personalized management is critical, along with the need for locally relevant data to inform APAC-specific guidelines.

1 | Introduction

The biennial Advanced Prostate Cancer Consensus Conference (APCCC) brings global expert focus to clinical issues in advanced prostate cancer, where high-level evidence may be lacking. Consensus recommendations assume an "ideal world" without resource limitations or treatment contraindications. At APCCC 2024, 120 physician experts voted on 183 questions, with a consensus threshold of 75% [1].

Since 2018, Asia-Pacific (APAC) Advanced Prostate Cancer Symposia have explored the application of APCCC consensus statements in the APAC region. These symposia apply a "real-world" view to understand regional practice variations and their drivers. Previous symposia have highlighted variations in access to treatments and technologies and cultural differences against an evolving diagnostic and treatment landscape [2–4].

2 | Methods

APAC Advanced Prostate Cancer Symposium (APCS) 2025 was held in Singapore on September 3, 2025. The one-day multidisciplinary symposium involved 28 prostate cancer experts from 15 APAC countries or regions (Table 1).

Panelists discussed APCCC topics relevant to the APAC region:

1. High-risk localized/locally advanced prostate cancer
2. Prostate-specific antigen (PSA) persistence and PSA recurrence
3. Radioligand therapy (RLT)
4. Genetics and genomics
5. Bone protection and other aspects of supportive care.

Before the symposium, panelists collated evidence, reviewed APCCC 2024 consensus statements, and identified APAC-specific questions. A presymposium poll gathered panelist insights. During the symposium, panelists presented evidence and polling insights and discussed local practice and challenges.

3 | Results

The Supplementary Appendix presents all presymposium polling results. Key insights are presented and discussed below.

3.1 | Regional Availability of Drugs and Technologies

Access to and reimbursement of diagnostic technologies (Figure 1A) and treatments (Figure 1B) continue to vary across the APAC region. While next-generation imaging is widely available (13 of 15 countries/regions), reimbursement is limited to five countries/regions. ^{177}Lu-PSMA is available in 10 countries/regions, including four providing locally compounded radioligands. However, reimbursement is limited to four countries/regions. Reimbursement is also limited for genetic testing and genetic counselling.

3.2 | Management of High-Risk Localized/Locally Advanced Prostate Cancer

APAC APCS 2025 panelists discussed management of high-risk localized or locally advanced prostate cancer in the context of the risk-stratified approach discussed at APCCC 2024 (Table 2) [1].

3.2.1 | Treatment

Treatment for high-risk clinically localized or locally advanced prostate cancer depends on symptoms and time since diagnosis [5, 6]. A majority of panelists voted for the use of radiation therapy (RT) and long-term androgen deprivation therapy (ADT) plus abiraterone. Practice is influenced by the availability of PSMA-PET/CT and abiraterone, although some panelists queried the benefit of abiraterone for high-risk localized/locally advanced disease. Panelists preferring surgery (as part of a multimodality approach) noted its utility in highly symptomatic patients, highlighting the importance of clinical assessment to determine suitability and resectability.

TABLE 1 | APAC APCS 2025 panelists and survey respondents: disciplines and countries/regions ($n = 28$).

	Urology	Medical oncology	Radiation oncology	Clinical oncology	Uro-oncology	Nuclear medicine	Nursing	Total
Australia	1	1					1	3
China					1			1
Hong Kong	1			1				2
India			1		1			2
Indonesia					2			2
Japan	1							1
Korea	1							1
Malaysia	1			1				2
New Zealand	1							1
Philippines	1							1
Singapore	2	2	1			2	1	8
Taiwan					1			1
Thailand	1							1
Turkey					1			1
Vietnam					1			1
Total	**10**	**3**	**2**	**2**	**7**	**2**	**2**	**28**

3.2.2 | Neoadjuvant ADT and RT

No clear evidence exists on the use of neoadjuvant ADT before RT in locally advanced prostate cancer based on PSMA PET/CT imaging [7, 8]. The majority of panelists would consider neoadjuvant ADT (with or without an androgen receptor pathway inhibitor [ARPI]) before RT for high-risk localized/locally advanced prostate cancer. Shorter treatment duration was preferred; longer duration for tumor downstaging would only be considered to minimize RT toxicity, noting that rectal spacers can also be used for this purpose.

3.2.3 | Management of Pelvic Lymph Nodes

Clinical trials demonstrate no clear evidence of survival benefit for pelvic RT in locally advanced disease with risks of gastrointestinal and urinary toxicity [9–11]. Benefit in biochemical control has been demonstrated in a randomized controlled trial in very high-risk patients staged with PSMA-PET CT [12]. EAU guidelines do not recommend extended pelvic lymph node dissection (ePLND) with radical prostatectomy (RP) in patients with intermediate risk disease. For patients with high-risk disease undergoing pelvic lymph node dissection, ePLND is recommended [13]. However, ePLND risks a higher rate of complications than limited PLND [14, 15]. Omitting ePLND where PSMA PET/CT is negative remains contentious [16].

Discussion highlighted the importance of individualized management of pelvic lymph nodes, considering staging and oncological benefits and morbidity. It was noted that the need for and use of ePLND is likely to decrease with more accurate staging modalities like PSMA PET/CT and increasing use of newer systemic treatments.

3.2.4 | Adjuvant Versus Salvage Therapy

Randomized controlled trials comparing adjuvant and salvage RT in patients with positive margins after RP reported no significant difference in outcomes for the two treatment arms [17–19]. Patients with positive pelvic lymph nodes were underreported in these trials. A survival benefit has been reported for immediate versus delayed ADT with adjuvant RT in node-positive patients [20]. However, no large randomized controlled trials have compared adjuvant RT and adjuvant ADT in these patients.

Panelists discussed preferences for adjuvant and salvage therapy. The majority of panelists would consider monitoring and salvage therapy with RT or ADT or a combination (21 of 27 panelists) in patients with pT3b pN0 disease and undetectable PSA following RP and ePLND. However, responses were divided regarding monitoring and salvage therapy (12 of 27 panelists) or adjuvant therapy (13 of 27 panelists) in patients with LNI and undetectable PSA. Discussion highlighted the importance of PSA kinetics and degree of lymph node involvement (LNI) (e.g., extranodal extension vs. microscopic disease) to inform treatment.

3.2.5 | Management of Younger Patients

Panelists discussed multimodal therapy, including surgery, for younger patients with high-risk localized/locally advanced disease. Aggressive treatment was preferred. Panelists emphasized the importance of informed decision-making, noting patients may select nonsurgical options because of concerns regarding functional outcomes. Long-term risks of RT-related secondary malignancies were discussed. Multidisciplinary treatment planning was viewed as essential for informed decision-making.

TABLE 2 | Management of high-risk localized/locally advanced prostate cancer.

Management strategy	APCCC	APAC APCS
Treatment for high-risk localized disease	No consensus Combined total of 84% voted for RT plus long-term ADT ± abiraterone	• RT + long-term ADT + abiraterone (14 of 27 panelists) • RT + ADT (6 of 27 panelists) • Surgery (6 of 27 panelists)
Treatment for positive pelvic nodes (PSMA-PET imaging) but no signs of metastasis and otherwise not meeting the STAMPEDE definition of high-risk locally advanced disease	Consensus (90%) in favor of RT (prostate and pelvis) plus long-term ADT and abiraterone for 2 years	• RT to the prostate and pelvis plus long-term ADT (9 of 27 panelists) • RT to the prostate and pelvis plus long-term ADT plus abiraterone (14 of 27 panelists) • Surgery (3 of 27 panelists)
Use of neoadjuvant ADT in patients with high-risk localized or locally advanced disease planned to have RT	Combined total of 79% in favor of neoadjuvant systemic therapy (3–9 months of ADT ± ARPI) before the start of RT, at least in selected patients	• Consider neoadjuvant therapy with 3–9 months ADT ± an ARPI (24 of 27 panelists) • Of these, six indicated would consider neoadjuvant therapy in selected patients only (e.g., because of a long waiting time) • Preference for maximum ADT treatment duration of 6 months, with most panelists preferring of 3–4 months
Use of pelvic node RT in locally advanced disease	Combined total of 77% voted in favor of recommending RT to the pelvic nodes, at least in selected patients	• Consider pelvic RT in at least selected patients based on risk factors (20 of 26 panelists)
Use of ePLND in locally advanced disease	No consensus Preferences for use distributed across a range of risk thresholds for LNI	• Preferences for use distributed across a range of risk thresholds for LNI • Do not recommend (7 of 27 panelists) • Abstain (7 of 27 panelists)
Use of salvage therapy in patients with pT3b pN0 disease following RP with ePLND and ISUP grade group 4–5 and R1 and with undetectable postoperative PSA	73% voted for monitoring and salvage	• Consider monitoring and salvage therapy (with RT or ADT or both) (21 of 27 panelists)
Use of salvage therapy in patients with pT3b and 1–2 pathologically involved pelvic lymph nodes (pN1) following RP with extended PLND and ISUP grade group 4–5 and with undetectable postoperative PSA	61% voted for monitoring and salvage	• Consider monitoring and salvage therapy (12 of 27 panelists) • Consider adjuvant therapy (13 of 27 panelists)

Abbreviations: ADT, androgen deprivation therapy; ARPI, androgen receptor pathway inhibitor; ePLND, extended pelvic lymph node dissection; LNI, lymph node involvement; PLND, pelvic lymph node dissection; PSA, prostate-specific antigen.

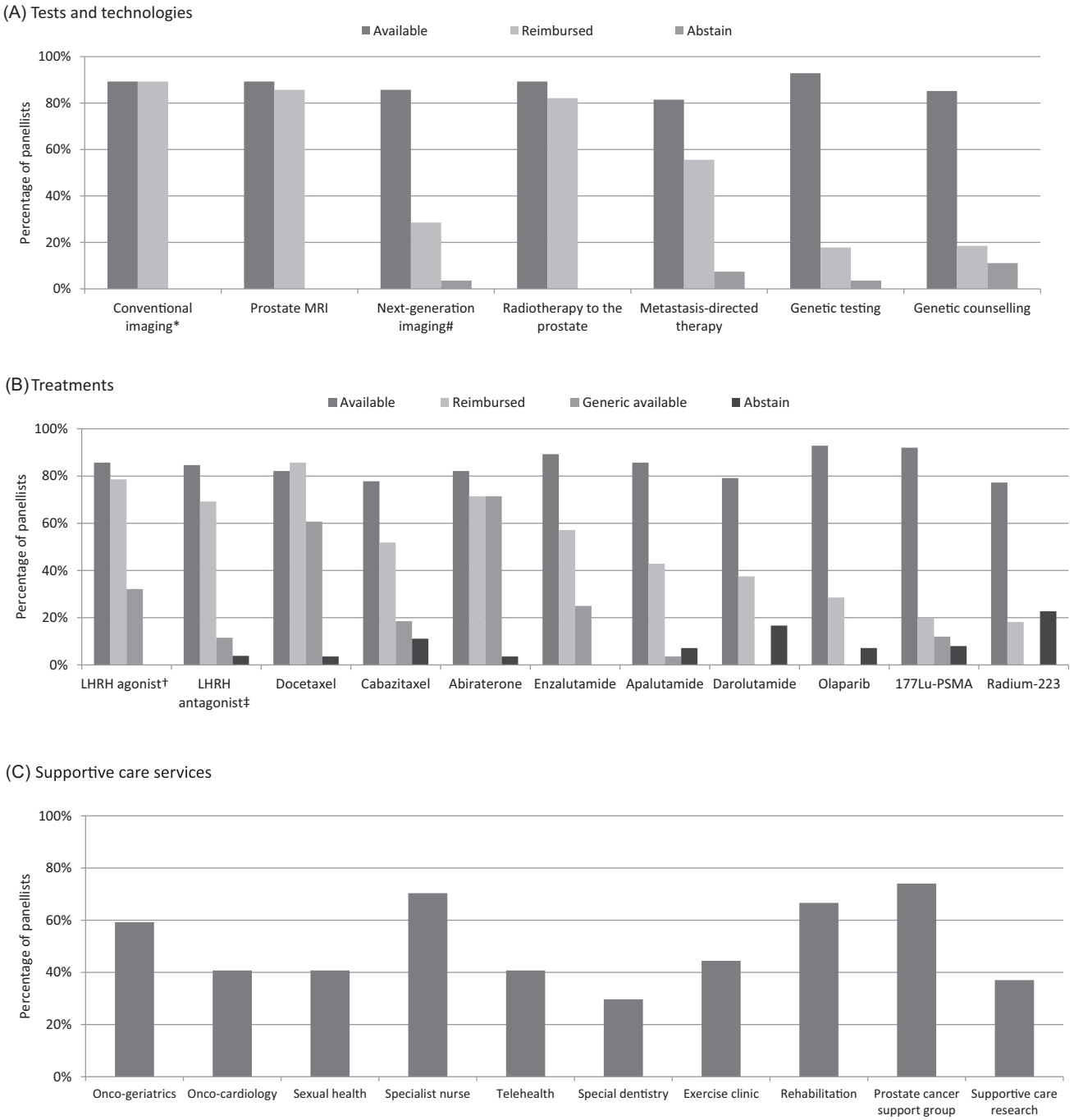

FIGURE 1 | Access, approval, and reimbursement of technologies and treatments in the APAC region ($n = 28$). Figures show individual panelist responses not country-specific responses, and include multiple responses from the same country; (A) tests and technologies; (B) treatments; (C) supportive care services.

3.3 | PSA Persistence and PSA Recurrence

PSA persistence after RP is defined as PSA >0.1 ng/mL 4–8 weeks post-RP [13]. While panelists had differing views on the timing of salvage therapy after RP, there was broad agreement that waiting at least 6–8 weeks is appropriate. Definitions of PSA recurrence after RP vary, but in general describe detectable and rising PSA. Guidelines differ in the lower level of PSA [13, 21, 22].

PSA persistence after RP is a negative prognostic factor [23]. PSA recurrence, while associated with worse outcomes, is not necessarily predictive of poorer overall survival because salvage ADT with or without RT is an option [24].

3.3.1 | Ideal Timing of PSMA-PET/CT

PSMA-PET/CT is changing the categorization and management of PSA recurrence [25, 26]. Given access differences, this topic was pertinent for the APAC APCS discussion. Polling indicated a range of approaches to management of persistent PSA, ranging from immediate PSMA-PET/CT ($n = 8$), imaging when PSA

>0.5 ng/mL (n = 3), immediate adjuvant therapy (n = 6), and monitoring plus salvage therapy (n = 5). Panelists noted that practice will evolve as systemic therapy options increase.

Panelists were divided about whether they would (n = 12) or would not (n = 12) use magnetic resonance imaging (MRI) to evaluate the prostate bed with rising PSA after RP. Reasons for using MRI included PSA ≥0.2 ng/mL, equivocal PSMA-PET/CT findings, lack of PSMA-PET/CT access, and use to guide salvage RT.

In discussing the influence of PSMA-PET/CT, panelists noted the importance of PSA doubling time, primary pathology, and resection margins in informing decision-making. The challenge of interpreting PSA doubling time for very low/ultrasensitive PSA levels was noted. Panelists also discussed the potential for harm if the optimal window for salvage therapy (commonly PSA 0.2–0.5 ng/mL) is missed, where PSMA-PET/CT is negative.

3.4 | Radioligand Therapy

Use of RLT in advanced prostate cancer is evolving. ^{177}Lu-PSMA-617 has US Food and Drug Administration approval for metastatic castration-resistant prostate cancer (mCRPC) following an ARPI and taxane-based chemotherapy [27]. In 2025, this was expanded to include taxane-naïve patients [28, 29]. Trials are investigating earlier use of ^{177}Lu-PSMA, combination treatments, and different radioligands. A 2025 consensus statement [30] synthesizes perspectives of Hong Kong specialists regarding clinical application of RLT in advanced prostate cancer.

3.4.1 | Access to RLT and Nuclear Medicine Expertise

APAC APCS 2023 highlighted the increasing use of RLT in the region [4]. Polling in 2025 highlighted that most respondents now have access to nuclear medicine expertise (Figure 1). Responsibility for prescribing varies. Discussion highlighted that, even where ^{177}Lu-PSMA is available, cost is prohibitive for many patients. Panelists from Hong Kong, Singapore, Malaysia, and China described the capacity to produce locally compounded radioligands, and 18 of 27 respondents would consider a locally compounded radioligand if available. Locally compounded ^{177}Lu-PSMA is no longer available in Australia at the time of writing.

3.4.2 | Role of RLT in Pretaxane mCRPC

^{177}Lu-PSMA-617 can prolong radiographic progression-free survival compared with ARPI switch in mCRPC [28]. However, polling indicated a preference for docetaxel in chemotherapy-fit patients with mCRPC following one line of ARPI and no chemotherapy (17 of 27 panelists), even if patients meet criteria for ^{177}Lu-PSMA treatment. This mirrors the Hong Kong consensus statement, where 86% of respondents preferred docetaxel [30]. The Hong Kong consensus statement achieved 93% consensus for the use of ^{177}Lu-PSMA for chemotherapy-unfit patients. However, APAC APCS 2025 panelists noted that some Asian patients would prefer another ARPI to avoid chemotherapy, noting this is not an evidence-based approach but instead reflecting cultural bias.

3.4.3 | Imaging for Patient Selection and Response Monitoring

Trials have used different imaging modalities and frequencies to select patients for ^{177}Lu-PSMA and response monitoring [27, 31]. Without restrictions on imaging, more panelists preferred PSMA-PET/CT plus FDG-PET (14 of 27 panelists) to determine ^{177}Lu-PSMA use. Nine panelists indicated use only in equivocal cases. However, the discussion highlighted the impact of access to PSMA PET/CT on real-world practice. Panelists also discussed acting on discordant findings using dual imaging with PSMA-PET/CT and FDG PET. They noted evidence is evolving and cautioned against incurring out-of-pocket expenses where ^{177}Lu-PSMA may not be effective.

Polling reflected differing approaches to response assessment using ^{177}Lu-PSMA-SPECT/CT, PSMA-PET/CT or contrast-enhanced CT, and bone scintigraphy. Discussion highlighted the need to consider CT and PET components of imaging, reflecting trial use of conventional CT for response assessment. Some panelists described using lower-cost ^{177}Lu-PSMA SPECT/CT as an alternative for treatment response assessment, and to assess ongoing expression of the target.

3.4.4 | Retreatment After Six Cycles of RLT

Data are limited about the efficacy of retreatment with ^{177}Lu-PSMA-617 in mCRPC. The mainly retrospective data involve small patient cohorts [32]. The majority of panelists (18 of 27 respondents) would recommend ^{177}Lu-PSMA retreatment for patients responding to six cycles of ^{177}Lu-PSMA who meet relevant PET criteria; 17 of these would only consider retreatment for an initial response longer than 6 months. Panelists noted evolving evidence about rechallenge and discussed the need to consider long-term benefit and toxicities and available resources.

3.4.5 | Combining ^{177}Lu-PSMA With an ARPI

Panelists discussed combination therapy using ^{177}Lu-PSMA and an ARPI. The ENZA-p trial (ANZUP 1901; NCT04419402) demonstrated the benefit of adding ^{177}Lu-PSMA to enzalutamide in patients with mCRPC who had factors predicting poorer outcomes from enzalutamide alone [33].

The majority of panelists (15 of 27 respondents) would not consider using an alternative ARPI in the wider population of patients with mCRPC who had been treated with ^{177}Lu-PSMA following ARPI treatment. However, 12 would consider an alternative ARPI at least in selected patients.

3.4.6 | Impaired Bone Marrow and Renal Function

Recent trials required patients to have adequate bone marrow function and good renal function [27, 28]. Treatment-related hematologic adverse events were higher with ^{177}LuPSMA617, although complications and the need to manage hematologic treatment-emergent adverse events were low and similar between

treatment arms. Data on long-term nephrotoxicity of ^{177}Lu-PSMA are unclear, although guidelines do not recommend treatment where the glomerular filtration rate is less than 30 mL/min [34].

Polling highlighted a range of treatment approaches for patients with mCRPC who progress on an ARPI and have impaired bone marrow or renal function. Approaches included reduced ^{177}Lu-PSMA dose, docetaxel, switching ARPI, or best supportive care. Panelists emphasized the role of best supportive care and the importance of not giving false hope, particularly given that financial toxicity is a real concern in the region.

3.4.7 | Alternate Radioligands

Trials are investigating alternate PSMA ligands, including ^{177}Lu-PNT-2002 [35, 36] and ^{177}Lu-PSMA-I&T in mCRPC [37]. Preliminary data suggest a favorable dosimetry and safety profile [38]. Panelists had differing views on whether data from trials using ^{177}Lu-PSMA can be extrapolated to all PSMA ligands (yes: $n = 11$; no: $n = 4$; only extrapolate to PSMA-I&T: $n = 7$).

3.5 | Genetics and Genomics

Genetic testing provides prognostic and risk information to guide treatment in advanced prostate cancer, in particular PARP inhibitor (PARPi) treatment. *BRCA* mutations are the most common mutations, about half of which are germline-derived. *ATM* mutations are also relatively common but are less predictive of PARPi response [39].

3.5.1 | APAC Experience and Access to Genetic Testing and Genetic Counselling

APAC APCS 2023 reported increasing confidence in genetic testing in the region, with issues flagged around variability of testing platforms and challenges in tissue source and quality [4]. APAC APCS 2025 participants indicated widespread access to germline genetic testing (see Figure 1). However, reimbursement and access to genetic counselling are variable.

3.5.2 | Whom to Test

Panelists reflected on the value of genetic testing to inform treatment decisions and enable early detection in family members, noting the need to balance risks of over- and undertesting. Some panelists reported a lower frequency of mutations than international reports of 23% [40], highlighting a need for APAC-specific data on mutation frequency among Asian populations.

Factors influencing panelist decisions to undertake genetic testing in advanced prostate cancer included: metastatic disease ($n = 22$); family history of prostate, breast, ovarian or pancreatic cancer ($n = 22$); early onset prostate cancer ($\leq$55 years) ($n = 21$); Gleason score 8–10 or intraductal histology ($n = 8$); and localized high-risk/locally advanced disease ($n = 4$).

An Asian Prostate Cancer Germline Risk Calculator was presented that considers factors associated with increased likelihood of germline mutation in East Asian patients [41]. While the calculator has not yet been robustly validated, early results indicate a better performance than other international guidelines in predicting the risk of DNA damage response (DDR) mutations in Asian patients.

3.5.3 | When to Test

Studies exploring prognostic outcomes of somatic and germline homologous recombination repair (HRR) alterations in people with mCRPC and metastatic hormone-sensitive prostate cancer (mHSPC) report poorer prognosis for people with BRCA mutations in people diagnosed with metastatic disease [42, 43]; however, evidence is still evolving.

Most panelists (17 of 27 respondents) would consider genetic testing at CRPC progression. Others would also consider testing at initial diagnosis ($n = 11$), after failure of ARPI therapy ($n = 8$), after failure of an ARPI and docetaxel ($n = 8$), and at PSA recurrence ($n = 3$). Other factors discussed included PARPi access, cost, and patient preference. Limited panel testing and industry-funded testing were identified as ways to reduce out-of-pocket expenses.

3.5.4 | What Panel to Use

Gene mutation profiles and frequencies of specific mutations vary by prostate cancer stage and between population groups [44]. A multicenter study of 1836 patients defined the optimal genetic testing panel for Chinese patients as *BRCA2*, *MSH2*, *PALB2*, and *ATM* [45].

Polling highlighted different genetic panels used in the APAC region, including: HRR genes, comprehensive gene panels, MMR genes and TMB, *BRCA1* and BRCA2, and tumor suppressor genes such as *PTEN*, *TP53*, *RB1*, and *CDK12*.

3.5.5 | Treatment Implications of Genomic Testing in Asian People

A number of trials of PARPis have reported data for Asian participants with mCRPC and mHSPC and show safety, tolerability, and efficacy data comparable to global results [46, 47].

Panelists discussed the benefits and tolerability of PARPi-based treatment in Asian patients with BRCA or HRR mutations, noting that the timing of treatment is an evolving research area. Panelists flagged that APAC regulatory approvals can be expedited if international trials include Asian subgroups. An opportunity was identified for APAC collaboration on phase III trials to understand differences in genetic profiles and treatment responses among Asian populations.

3.6 | Bone Protection and Other Aspects of Supportive Care

Questions about bone protection did not achieve consensus at APCCC 2024. International guidelines recommend the use of

bone protection agents (BPAs) to prevent skeletal-related events (SREs) secondary to bone metastases in patients with mCRPC [5, 48, 49]. Guidelines also describe the use of BPAs to mitigate against ADT-related bone loss. Recent clinical trials [50, 51] provide evidence about the role of BPAs in patients receiving newer treatments such as radium-223 and ARPIs (abiraterone and enzalutamide). BPA use was made mandatory in PEACE-3 following positive benefits for the use of BPAs in the ERA-223 trial [51]. Questions remain about the optimal dose and duration of BPAs in mCRPC.

In discussions about bone protection, panelists noted the distinction between SREs secondary to bone metastases and those secondary to treatment, noting that metastasis-related SREs remain relevant even with newer treatments that do not affect bone loss.

3.6.1 | Use of BPAs

Panelists reflected on the importance of discussing bone health and bone symptoms with patients [52]. Almost all (26 or 27 respondents) consider therapy for prevention of cancer treatment-induced bone loss (other than calcium, vitamin D3, and exercise) in all or selected patients with mHSPC on long-term continuous ADT-based therapy. Denosumab cost influences management, with some panelists instead using bisphosphonates or recommending exercise and vitamin D only.

Views differed on BPA scheduling in patients with bone metastases, from monthly to 3- and 6-monthly. Preferences were influenced by pragmatism (aligning with treatment protocols), cost of denosumab and bisphosphonates, and toxicity concerns. A preference for bisphosphonates in frail and/or elderly patients was noted.

Panelists also discussed the risk of rebound bone resorption on denosumab discontinuation in the osteoporosis setting, noting that guidelines recommend consolidating therapy with a bisphosphonate on cessation of denosumab [53].

3.6.2 | Strategies to Optimize Wellbeing

People with prostate cancer experience impaired quality of life across psychological, physical, social, and spiritual domains [54, 55]. Validated tools [55] can identify distress and its causes.

Panelists discussed the importance of shared and informed decision-making, noting the influence of cultural perspectives among Asian populations. It was noted that some Asian people may be willing to risk more side effects for longer survival, while misconceptions that chemotherapy results in shorter survival can also influence decisions. However, views vary across the region and are often agent-specific.

Polling highlighted a range of strategies used by panelists to optimize wellbeing and bone health supportive care (Figure 1C). Less common strategies included survivorship care plans (n = 13) and patient-reported screening interventions (n = 11). Panelists noted the importance of resistance exercise in building bone strength, noting the importance of personalized and staged guidance.

3.7 | Other Aspects of Treatment for Advanced Prostate Cancer

3.7.1 | Docetaxel

Docetaxel use is more common in the APAC region than in other parts of the world because of the cost of other systemic therapies. However, in some APAC countries, there is a bias against using it because of cultural preferences against chemotherapy.

Panelists discussed management of docetaxel-associated myelosuppression. Practice varied in use of granulocyte colony-stimulating factor (G-CSF) to manage myelosuppression in patients with metastatic disease, noting that dose reduction or stopping docetaxel may be more appropriate than treating myelosuppression in the context of noncurable disease.

3.7.2 | Use of New Technologies

Discussions highlighted evolving APAC practice in RT techniques, including external beam technology using fewer fractions and stereotactic radiation protocols. Use of brachytherapy is decreasing, although it may still be useful when external beam radiation risks significant toxicity to surrounding organs.

Panelists reflected on decreasing use and skills in open RP in the context of robotic surgery. Advances in robotic surgery, including single-port robots and extraperitoneal techniques, are reducing limitations on suitability. However, where services do not have access to robotic surgery, it is important that open RP skills are maintained.

4 | Discussion

APAC APCS 2025 highlights how evolving evidence in the management of advanced prostate cancer is influencing practice in the region. The increasing complexity and cost of diagnosis was noted, with current practice often involving multiparametric MRI, image-guided biopsy, PSMA PET/CT, and genetic testing. Access to and reimbursement of PSMA PET/CT, ARPIs, RLT, and BPAs continue to drive variation in imaging, treatments, and models of care.

Panelists discussed strategies to mitigate cost, such as minimizing futile investigations for older or frail patients and those with aggressive disease, preserving resources for later-line therapy. Some panelists also use lower-cost alternatives, including low-dose abiraterone [56, 57] and alternative RLT ligands.

Personalized treatment remains central, with management guided by clinical, imaging, and genetic factors, alongside age-related factors, comorbidities, and economic considerations. With newer therapies extending survival, panelists emphasized the importance of early and ongoing discussions about goals of

care to understand the relative value patients place on survival, quality of life, simplicity of treatment, delayed progression, and cost. Preferences may shift as the disease progresses, reinforcing the need for continuous communication.

Next-generation imaging and newer systemic treatments are increasingly used, yet inequities persist. A recurring theme was the need to balance technological advancement with clinical judgment, and to avoid losing expertise in older techniques where access to newer modalities is inconsistent. Caution was also raised about overdiagnosis and missing windows for salvage therapy with increasing imaging sensitivity.

Multidisciplinary care continues to expand across the APAC region. Medical oncologists are now more involved in settings once led predominantly by urologists, whose roles have also broadened to include surgical and nonsurgical management. Nuclear medicine specialists are more commonly involved, but access to genetic counsellors remains limited.

Emerging evidence areas include the role of PSMA PET/CT in PSA recurrence, the evolving role of ePLND and pelvic nodal RT as systemic treatments improve, optimal BPA dosing with newer agents, and opportunities for treatment deintensification.

The need for APAC-specific data to inform local guidelines was strongly emphasized, highlighting the need for increased participation of Asian patients in global and biomarker-driven trials, alongside Asian-led research. Real-world data on RLT, particularly locally compounded radioligands, was identified as a priority. With ongoing cultural differences in attitudes to chemotherapy, further exploration of how cultural preferences influence treatment decisions in the era of new systemic options was also encouraged.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.

Supporting File: ajco70092-sup-0001-Appendix.docx