Resource-Stratified Practice
Prostate Cancer Management in Asia

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Disclosures

Research fundings

- Johnson & Johnson (J&J), MSD, Roche

Honoraria for lectures & adboard meetings

- J&J, Astellas, Sanofi, Amgen, Novartis, Bayer, Roche, MSD, Astra-Zeneca
“ACTION Study....29% patients were DEAD....48% experienced FINANCIAL CATASTROPHE within 1 year of being diagnosed with cancer....”

Cancer makes patients poor

PETALING JAYA: With over three-quarters of South-East Asian patients either dead or financially poorer one year after being diagnosed with cancer, getting the big C is debilitating in more ways than one.

The results of “The Asean Costs in Oncology Study (Action)” showed that 29% of patients were dead within one year of being diagnosed with cancer while 48% were experiencing financial catastrophe.
ASEAN Countries in ACTION Study
Middle Income: Indonesia, Laos, Malaysia, Philippines, Thailand, Vietnam
Low Income: Cambodia, Myanmar

Financial catastrophe:
Out-of-pocket cost at 12 months ≥30% of household income

>75% of new cancer patients in Southeast Asia experience financial catastrophe or die within 1 year of diagnosis

Significant risk factors for poor outcome
- Advanced stage at diagnosis
- Socioeconomic disadvantaged: primary education only, low income, no health insurance

There is an URGENT NEED for more RESOURCES to aid early detection and policies aimed to provide adequate financial protection from the COSTS OF CANCER

Financial Catastrophe & Death

- Twelve months after diagnosis,
  (i) 29% had died
  (ii) 48% experienced financial catastrophe
  (iii) 23% were alive with no financial catastrophe

Incidence of financial catastrophe and death at 1 year after cancer diagnosis

Economic Hardship

- Inability to make necessary household payments (housing energy, food and health care costs) following a cancer diagnosis

* 33% experienced economic hardship

**What kind of economic hardship?**

- Could not pay for school fees for children
- Could not pay for meals
- Could not pay for transport
- Could not pay for gas, electricity, phone bills
- Could not pay for health insurance
- Could not pay for rent or mortgage
- Could not pay for medical consultations
- Did not attend medical appointments
- Could not pay for medicines/drugs
- Did not buy medicines/drugs

**How do they cope with economic hardship?**

- Sold assets or other property
- Asked for financial assistance government/community
- Took out a personal loan
- Used savings set aside for other use
- Asked for financial assistance family/friends

Medical Impoverishment & Poverty

• A household with income above the poverty line at baseline incurred OOP health costs during 12 months which, when subtracted from baseline income, brought that household below the poverty line

  * 32% were medically impoverished and 4.9% were pushed into poverty
  * Direct medical costs account for 25% of 1-year risk of medical impoverishment

Incidence of poverty and medical impoverishment at 1 year following cancer diagnosis

Different PHASES of Prostate Cancer

First prostate cancer diagnosis
- Non-metastatic
- Metastatic hormone sensitive
- Metastatic castration resistant

Localised or locally advanced dx treated with local therapy

Biochemical recurrence

Newly diagnosed (de novo)
- mHSPC

Primary progressive mHSPC

mCRPC

Terminal disease (DEATH)

nmCRPC

ADT

mHSPC : metastatic hormone sensitive prostate cancer
mCRPC : metastatic castration-resistant prostate cancer
nmCRPC : non-metastatic castration-resistant prostate cancer

Androgen deprivation therapy (ADT)

Therapies after ADT

Chemotherapy

Non-Metastatic

- nmCSPC
  - Enzalutamide
  - Apalutamide
- nmCRPC
- mCSPC
  - ADT
  - Enzalutamide
  - Docetaxel
  - Abiraterone
- ADT + Abiraterone

Metastatic

- mCRPC asymptomatic
  - Abiraterone
  - Enzalutamide
- mCRPC mildly symptomatic
  - Docetaxel
- mCRPC symptomatic
  - Cabazitaxel
- mCRPC post-docetaxel
  - Radium-223
- Supportive care e.g. denosumab, bisphosphonates

Adapted from Edmund Chiong Sep 2017.
Management of patients with advanced prostate cancer: recommendations of the St Gallen Advanced Prostate Cancer Consensus Conference (APCCC) 2015

Resource-neutral (IDEAL-world setting)

Practical guide to clinicians to assist discussion with patients as part of shared & multi-disciplinary decision-making process
APCCC 2017

10 areas - 150 predefined questions

Consensus was declared if ≥75% of the panellists voted on the same option

1. Management of high-risk localised and locally advanced prostate cancer
2. “Oligometastatic” prostate cancer
3. Management of castration-sensitive/naive prostate cancer (CNCP)
4. Management of castration-resistant prostate cancer (CRPC)
5. Imaging in APC
6. Use of osteoclast-targeted therapy for skeletal related events (SRE)/symptomatic skeletal events (SSE) prevention for metastatic CRPC (mCRPC; not for osteoporosis/bone loss)
7. Molecular characterisation
8. Genetic counselling/testing
9. Side effects of systemic treatment: prevention, management, and supportive care
10. Global access to prostate cancer drugs and treatment in countries with limited resources
15 countries
Asia-Pacific region

21 participants
Discussed the APCCC 2017 relevance in APAC setting

Edmund Chiong USANZ Feb 2018.
Conclusions

In the APAC region:

- Cost and access issues are a major influence in prescribing practices
- Real-world application of best practice consensus recommendations is essential
- Principles of multidisciplinary care and shared decision making are the cornerstone of care regardless of access issues
- Collaboration across APAC region presents opportunities for addressing gaps and issues
The Asian Prostate Cancer (A-CaP) initiative
Launched in Dec 2015 in Tokyo, Japan
>20,000 patients on registry now

12 countries / regions in Asia
- Hong Kong, Indonesia, Japan, Korea, Malaysia, Philippines, Singapore, Taiwan, Thailand, Turkey, China

Collaborators
- University of California San Francisco (UCSF), Peter MacCallum Cancer Centre (Australia), University of Queensland (Australia), South Australia Prostate Cancer Clinical Outcomes Collaborative (SAPCCOC)
Prostate Cancer in Malaysia (M-CaP)

Localised disease - 80% high risk

New cases Jan 2016 – May 2018 from 9 centres

Total patients in A-CaP >20,000

M-CaP Data presented by Ong TA at 4th A-CaP Meeting, Korea Aug 2018.
Prostate Cancer Burden - Malaysia

- Incidence: 10.8 per 100,000.
- Mortality: 4.6 per 100,000.
23 panel members in Malaysia

Discuss prostate cancer treatment options based on APCCC 2017 in local setting

Include REAL-world resource limitations
Panellists

MyAPCCC 2018

- Private hospitals
- MOH hospitals
- MOE hospital
- Urologists (11)
- Oncologists (11)

Soo Hoo HF
Khairul Asri
Fuad Ismail
Adlinda Alip
Azad Razack
Marniza Saad
Ong Teng Aik
Jasmine Lim
Ibtisam Mohd Noor
Murali Sundram
Muthukkumaran T
Noor Ashani
Lim Chun Sen
HSI
HPP
UPM
UKMMC
UMMC
HKL
Sunway MC
GE KL
PCMC
SJMC

Noor Azam Nasuha
Rohan Malek
Chua Chong Beng
Loh Chit Sin
Rachael Khong
Matin Mellor
Tan Hui Meng
Voon Pei Jye
Teh Guan Chou

MyAPCCC 2018 SURF Meeting 2018
<table>
<thead>
<tr>
<th>Sections</th>
<th>Number of Qs with Consensus</th>
<th>% of Qs Achieving Consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. High risk &amp; locally advanced Mo prostate cancer</td>
<td>6/20</td>
<td>30%</td>
</tr>
<tr>
<td>2. Oligometastatic disease</td>
<td>0/10</td>
<td>0%</td>
</tr>
<tr>
<td>3. CSPC</td>
<td>14/24</td>
<td>58%</td>
</tr>
<tr>
<td>4. CRPC</td>
<td>23/53</td>
<td>43%</td>
</tr>
<tr>
<td>5. Osteoclast-targeted therapy</td>
<td>2/9</td>
<td>22%</td>
</tr>
<tr>
<td>6. Access to treatment</td>
<td>6/9</td>
<td>67%</td>
</tr>
</tbody>
</table>

Consensus was declared if ≥75% of the panellists voted on the same option.
Q34. For men who are suitable for chemotherapy:
Do you recommend Docetaxel in addition to ADT in men with de novo metastatic castration-sensitive/naive prostate cancer and high volume disease as defined by CHAARTED (visceral metastases and/or ≥4 bone lesions with ≥1 beyond vertebral bodies and pelvis)?

<table>
<thead>
<tr>
<th>Option</th>
<th>Option details</th>
<th>APCCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes, in the majority of patients</td>
<td>48</td>
</tr>
<tr>
<td>2</td>
<td>In a minority of selected patients</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

Total 50

≥75% = consensus achieved

MyAPCCC 2018

Modified APCCC 2017 Question

<table>
<thead>
<tr>
<th>Option</th>
<th>Option details</th>
<th>MyAPCCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>22</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

Total 22

Q41. Based on the current evidence, would you offer ADT + abiraterone (AAP) as upfront therapy in men with mCSPC?

<table>
<thead>
<tr>
<th>Original My APCCC 2018 Question</th>
<th>Option</th>
<th>1</th>
<th>2</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MyAPCCC</td>
<td>In the ideal world setting</td>
<td>19</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>In the real-world setting</td>
<td>6</td>
<td>16</td>
<td>22</td>
</tr>
</tbody>
</table>

≥75% = consensus achieved

Q42. What is your preferred treatment in men with de novo metastatic castration-sensitive/naive prostate cancer with high volume disease as defined by CHAARTED (visceral metastases and/or ≥4 bone lesions with ≥1 beyond vertebral bodies and pelvis) or high risk as defined by LATITUDE (2 out of 3 criteria: visceral metastases, ≥3 bone lesions, Gleason ≥8)?

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>ADT alone</td>
<td>1</td>
</tr>
<tr>
<td>ADT + docetaxel</td>
<td></td>
</tr>
<tr>
<td>ADT + abiraterone</td>
<td></td>
</tr>
<tr>
<td>No preference</td>
<td>0</td>
</tr>
</tbody>
</table>

≥75% = consensus achieved

MyAPCCC 2018

Q50. What is your preferred first-line mCRPC treatment option in the majority of asymptomatic or minimally symptomatic men who did NOT receive Docetaxel in the castration-sensitive/naïve setting?

a. In the IDEAL WORLD setting

b. In the REAL-WORLD setting

<table>
<thead>
<tr>
<th>Option</th>
<th>Modified APCCC 2017 Question</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Abiraterone or enzalutamide</td>
<td>19</td>
</tr>
<tr>
<td>Cabazitaxel</td>
<td></td>
</tr>
<tr>
<td>Docetaxel</td>
<td></td>
</tr>
<tr>
<td>Platinum-based chemotherapy</td>
<td></td>
</tr>
<tr>
<td>Radium-223</td>
<td></td>
</tr>
</tbody>
</table>

≥75% = consensus achieved

Q51. What is your preferred first-line mCRPC treatment option in the majority of symptomatic men who did NOT receive Docetaxel in the castration-sensitive/naïve setting?

<table>
<thead>
<tr>
<th>Modified APCCC 2017 Question</th>
<th>Option</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Abiraterone or enzalutamide</td>
<td>11</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Cabazitaxel</td>
<td>2</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Docetaxel</td>
<td>2</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Platinum-based chemotherapy</td>
<td>2</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Radium-223</td>
<td>2</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>22</td>
</tr>
</tbody>
</table>

≥75% = consensus achieved

Q100. Would you prescribe generic drugs if they were available in your practice?

MyAPCCC 2018

Option 1

Option 2

Option details

MyAPCCC

<table>
<thead>
<tr>
<th>Option</th>
<th>Option details</th>
<th>MyAPCCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>22</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>22</td>
</tr>
</tbody>
</table>

≥75% = consensus achieved

Q101. What would you consider as a reasonable cost for an average Malaysian household to have a life-prolonging treatment in metastatic prostate cancer?

Based on USD1 = RM4

81% voted for ≤USD 750 / mth

≥75% = consensus achieved
Incidence higher in Australia/New Zealand & Western countries

Lower incidence in Asia

Mortality seems low in Asian countries

BUT

High relative to their relative low incidence
LMICs invest a fraction of what high-income countries do for health expenditure
Ratio of Public & Private Expenditure 2011

Guidelines to Guide Practice

- Evidence-based recommendations for MDT management of prostate cancer
- International **GOLD standard to optimal care**
- Timely updates and review of evidence by experts
- Points of reference for clinicians globally
- **Do NOT take into account resource limitations & diversity** (‘resource-neutral’ / ‘resource-agnostic’)

- **What fraction of world’s cancer community can afford to deliver the GOLD standard care recommended by these guidelines?**
- **Can all health-care systems sustain it?**

- **Findings from online survey of oncologic practice in LMICs* by ASCO**
  - Treatments within these guidelines are not easily accessible
  - National health-care systems & insurance coverage not sufficiently funded for the recommendations
  - Predominantly used for private or self-paying patients

*LMICs = Low-middle income countries

Challenges in ASIA

- Projected \textit{in cancer burden} in the future
  - 60-70\% of world’s total new cancer, 70\% of deaths
- High \textit{diversity} (inter/intra-countries)
  - Cultural, geographical
  - Economic: many low-middle income countries (LMICs)
  - Health-care: medical systems, health insurance policy
- Paucity of data especially from prospective clinical trial
- Differing physiological effects to treatment might alter therapeutic ratio
- Existing global data derived from other populations of \textit{uncertain applicability}

- Resource-constrained setting is ubiquitous
  - A challenge to implement treatment according to clinical guidelines
- Increasing costs of cancer care
  - Competing priorities: prevention versus early detection versus therapy etc.

- How best to OPTIMISE use of limited resources to optimise outcome?

Treatment & investigation options have improved

Existing management guidelines do not account for diversity in health resources between different countries
  • Resource and economic variation across Asia, esp. in low-middle income countries

Recommendation on management stratified according to extent of resource availability
  • MDT panels from APAC countries – Australia, Singapore, Thailand, Indonesia, Japan

Asian countries with differing levels of health-care resources

Lack of high-level evidence pertaining to Asian population

Aspects of prostate cancer management after diagnosis from early to metastatic stages

Management guidelines sensitive to resources

MDT Approach
  • Therapeutic decision and clinical outcome can be optimised
  • Based on many specialists’ opinions
  • Substantial effect on patient management

Management framework based on 4-TIER of resource levels (based on guidelines by BHGI 2005)
  • Basic
  • Limited
  • Enhanced
  • Maximum

Health-Care 4-TIER System

<table>
<thead>
<tr>
<th>Tiers</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td><strong>Core resources or fundamental services</strong> that are <strong>absolutely necessary</strong> for any breast healthcare system to function; <strong>basic-level services</strong> typically are applied in a single clinical interaction.</td>
</tr>
<tr>
<td>Limited</td>
<td>Second-tier resources or <strong>services that are intended to produce major improvements in outcome</strong> such as increased survival, and are <strong>attainable with limited financial means and modest infrastructure</strong>; limited-level services may involve <strong>single or multiple clinical interactions</strong>.</td>
</tr>
<tr>
<td>Enhanced</td>
<td>Third-tier resources or <strong>services that are optional but important</strong>; enhanced-level resources should <strong>produce further improvements in outcome</strong> and <strong>increase the number and quality of therapeutic options</strong> and <strong>patient choice</strong>.</td>
</tr>
<tr>
<td>Maximum</td>
<td><strong>High-level resources or services</strong> that may be used in <strong>some high-resource countries</strong> and/or may be <strong>recommended by breast care guidelines</strong> that <strong>do not adapt to resource constraints</strong> but that nonetheless should be considered a lower priority than those resources or services listed in the basic, limited, or enhanced categories on the basis of <strong>extreme cost and/or impracticality for broad use</strong> in a resource-limited environment; to be useful, maximal-level resources typically depend on the existence and functionality of all lower level resources.</td>
</tr>
</tbody>
</table>

**Resource-stratified framework to guide management based on available resources**

### Resource-Stratified Practice

**Management of prostate cancer in Asia: resource-stratified guidelines from the Asian Oncology Summit 2013**

Scott Williams*, Edmund Chiong*, Bannakij Lojanapiwat, Raisy Umbas, Hideyuki Akaza

<table>
<thead>
<tr>
<th>Level</th>
<th>General</th>
<th>Treatment approaches</th>
<th>Imaging (where appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic level</strong></td>
<td>Health education about risk factors for prostate cancer</td>
<td>Open surgery if expertise and resources available:</td>
<td>Whole-body bone scans for staging in intermediate-risk or high-risk cases</td>
</tr>
<tr>
<td></td>
<td>Infrastructure to diagnose and treat the disease</td>
<td>Surgical castration (for primary androgen deprivation)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Radical prostatectomy</td>
<td></td>
</tr>
<tr>
<td><strong>Limited Level</strong></td>
<td>Health education about risk factors for prostate cancer</td>
<td>Curative-aim therapy (open radical prostatectomy)</td>
<td>Whole-body bone scans for staging in intermediate-risk or high-risk cases</td>
</tr>
<tr>
<td></td>
<td>Infrastructure to diagnose and treat the disease</td>
<td>Primary androgen-deprivation therapy</td>
<td>Cross-sectional CT or MRI (including functional MRI) of abdomen and pelvis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Doxorubicin-based chemotherapy as appropriate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multidisciplinary team management facilities</td>
<td>Active surveillance protocols</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary androgen-deprivation therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PSA monitoring</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Side-effect management (erectile dysfunction, continence, radiation proctitis)</td>
<td></td>
</tr>
<tr>
<td><strong>Enhanced Level</strong></td>
<td>Health education about risk factors for prostate cancer</td>
<td>Curative-aim therapy: radical prostatectomy (open or laparoscopic) with adjuvant radiotherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infrastructure to diagnose and treat the disease</td>
<td>or androgen-deprivation therapy as appropriate; radical radiotherapy, external (photon or charged-particle beam) approaches where available, and neoadjuvant or adjuvant androgen-deprivation therapy as appropriate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multidisciplinary team management facilities</td>
<td>Active surveillance protocols</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Surviorship programmes</td>
<td>Primary androgen-deprivation therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PSA monitoring</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Side-effect management (erectile dysfunction, continence, radiation proctitis)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access to clinical trials, where appropriate</td>
<td></td>
</tr>
</tbody>
</table>

**Table 1: Treatment of clinically localised prostate cancer according to level of health-care resources**

PSA = prostate-specific antigen.
### Table 2: Treatment of recurrent, locally progressive, or metastatic prostate cancer according to level of health-care resources

<table>
<thead>
<tr>
<th>Level</th>
<th>General</th>
<th>Biochemical or clinical recurrence</th>
<th>Castrate-resistant and metastatic disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic level</td>
<td>Palliation of symptoms</td>
<td>Surgical castration if expertise and resources available</td>
<td>..</td>
</tr>
<tr>
<td>Limited level</td>
<td>Palliation of symptoms</td>
<td>LHRH agonist or antagonist therapy (if available)</td>
<td>..</td>
</tr>
<tr>
<td>Enhanced level</td>
<td>Palliation of symptoms</td>
<td>LHRH agonist or antagonist therapy</td>
<td>Palliative chemotherapy with docetaxel and cabazitaxel Bone protection with zoledronic acid or denosumab</td>
</tr>
<tr>
<td></td>
<td>Multidisciplinary team management facilities</td>
<td>Surgical castration Additional non-steroidal or steroidal anti-androgens Salvage radiotherapy or prostatectomy (if expertise available)</td>
<td></td>
</tr>
<tr>
<td>Maximum level</td>
<td>Palliation of symptoms</td>
<td>LHRH agonist or antagonist therapy</td>
<td>Third-line hormone therapy—eg, abiraterone, enzalutamide, or ketoconazole</td>
</tr>
<tr>
<td></td>
<td>Multidisciplinary team management</td>
<td>Surgical castration Additional non-steroidal or steroidal anti-androgens Salvage surgery: radical prostatectomy, brachytherapy, or energy ablation (eg, cryotherapy) Post-prostatectomy salvage radiotherapy</td>
<td>Palliative chemotherapy with docetaxel and cabazitaxel Bone protection with zoledronic acid or denosumab Bone-seeking α-particle therapy or radioisotope therapy</td>
</tr>
</tbody>
</table>

LHRH = luteinising-hormone-releasing hormone.
Attempt by physicians in Asian countries to fuse the data & experience in Asia with the evidence from Westerns

**Statement 12: Androgen Deprivation Therapy in Asia**

ADT has been accepted as a major treatment in Asia, but its efficacy and safety profile in the Asian population seem different than in the Western population. In particular, primary ADT may be more effective than in the West. Nevertheless, care must be taken to avoid adverse effects when ADT is used, especially in patients with significant comorbidities.

1. The extensive ADT experience in Japan suggests that the effect of ADT on bone mineral density in Asians seems different from the effects reported in Caucasian patients.
2. There is a lack of data regarding the cardiovascular impact of ADT in the Asian population; current data on the relationship between ADT and cardiovascular risks are controversial.
3. There is a lack of data on the relationship between ADT and diabetes in the Asian population.
Prostate Cancer

- NCCN Guidelines with NCCN Evidence Blocks™ – About NCCN Evidence Blocks™
- NCCN Guidelines
  - Basic Resources
  - Core Resources
  - Enhanced Resources

The NCCN Framework™ resources are defined as:

- **Basic Resources**: Basic Resources include essential services needed to provide basic minimal standard of care.
- **Core Resources**: Core Resources include those provided in the Basic Resources Framework plus additional services that provide major improvements in disease outcomes (e.g. survival) and that are not cost prohibitive.
- **Enhanced Resources**: Enhanced Resources include those provided in the Core Resources Framework and additional services that provide major improvements in disease outcomes and/or services that provide major improvements in disease outcomes but are cost prohibitive in lower resource settings.
- **NCCN Guidelines**: The NCCN Guidelines are evidence-based, consensus-driven recommendations made by the NCCN Guidelines panels. They include services from the Enhanced Resources Framework and additional services that provide minor improvements in disease outcomes, interventions that are cost prohibitive in lower resource settings, and/or services that do not provide improvement in disease outcomes but are desirable services.

NCCN believes that the best available resources should be provided. If Basic Resources for cancer treatment are unavailable, palliative and best supportive care should be provided.
Prostate Cancer Management in ASIA

Current status
- Highly effective treatment improving outcomes
- Robust evidence
- Evidence-based guidelines for optimal care

Issues
- Diversity
- Lack of local data
- Resource-neutral guidelines
- Resource limitation
- (Sub)optimal care
- Cancer not seen as important public health issue
- Competing priorities

Steps
- Resource-stratified practice
- Best care possible with limited resources
- Prioritise
- Prospective studies in Asia
- Collaboration

Together Everyone Achieves More