# REPORT FROM PROSTATE CANCER WORKSHOP

15/02/2019

ESMO AFRICA Prostate cancer workshop 15/2/2019

| | Speaker | Time |
|---|---|---|
| 1. Welcome and introductions 10 min (send paper round to list names etc ) | | |
| 2. ESMO guidelines review for locally advanced / metastatic cancer. | R de Wit | 25 mins |
| 3. Perspective of MIC in Africa implementing guidelines and challenges | B Rapoport | 25 mins |
| 4. Perspective of LMIC in Africa implementing guidelines. | V Vanderpuye | 25mins |
| 5. Q&A. For all speakers. | Participants | 45 mins |
| 6. Country rep perspective of challenges, opportunities | Participants | 45 mins |
| 7. Summary and report of discussion | V Vanderpuye | 10 minutes |

# PARTICIPANTS

- SOUTH AFRICA – NUMEROUS PROVINCES (PUBLIC AND PRIVATE)
- GHANA
- KENYA
- NAMIBIA

Questions for each regional /country rep to discuss

1.Is Radical prostatectomy and extended lymphadenectomy available in country and performed by ?

2. What imaging is available and affordable., CT MRI , MRI DWI, BONE SCAN , PET/ PET Choline ?

3. What is reported on biopsy specimen?

4. Do you routinely stage group and prognosticate ?

5. Do you have a multidisciplinary meeting or team ?

6. What kind of hormone ablation do you have and culturally acceptable ?

7. Who pays for treatment?

6. Do you have radiation facilities available?

7. What mode of RT equipment ? 2D,Conformal, IMRT!VMAT! IGRT

8. Dose of curative RT With or without HT , adjuvant HT for how long?

9. What systemic drugs are readily available for metastatic disease?anti androgens, chemo, bispho,immunotherapy , radionuclide tx

# Summary of workshop findings

- Staging – many had CT scan , MRI DWI, BONE SCAN, FEW HAD PET SCAN AND PSMA, NO CHOLINE PET
- MDT - many had MDT but agreed urologist were the decision makers
- Surgery – no cancer specialist mostly, very few did e-lymphadenectomy

  no discussion with oncologist for surgery for very high risk patients
- RT - 74Gy average, 3D conformal minimum for most, IGRT, VMAT,
- HT - every one had chemical castration drugs, orchidectomy

  ( acceptable in SA, KENYA)
- Systemic tx - carbitaxel most countries, docetaxel, PSMA target in SA, ABI in most , few enzulatamide . RAD233 rare . Bisphosphonates
- Brachy boost - SA , GH, Kenya
- Finances - Kenya , Nam, SA coverage but limited , Ghana mostly out of pocket

# Consensus

Most have basic infrastructure

Will promote MDT

Will consider increasing RT dose

Things getter better with RT TECHNOLOGY IN AFRICA

A lot of inequity even in SA, private vrs public

To lobby for carbitaxel where unavailable

Ist line systemic therapy should be taxane

Sequencing of systemic therapy vital to improved survival

Consider patterns of care study in SSA