OPTIMIZING MANAGEMENT OF ADVANCED PROSTATE CANCER: MULTIDISCIPLINARY APPROACHES

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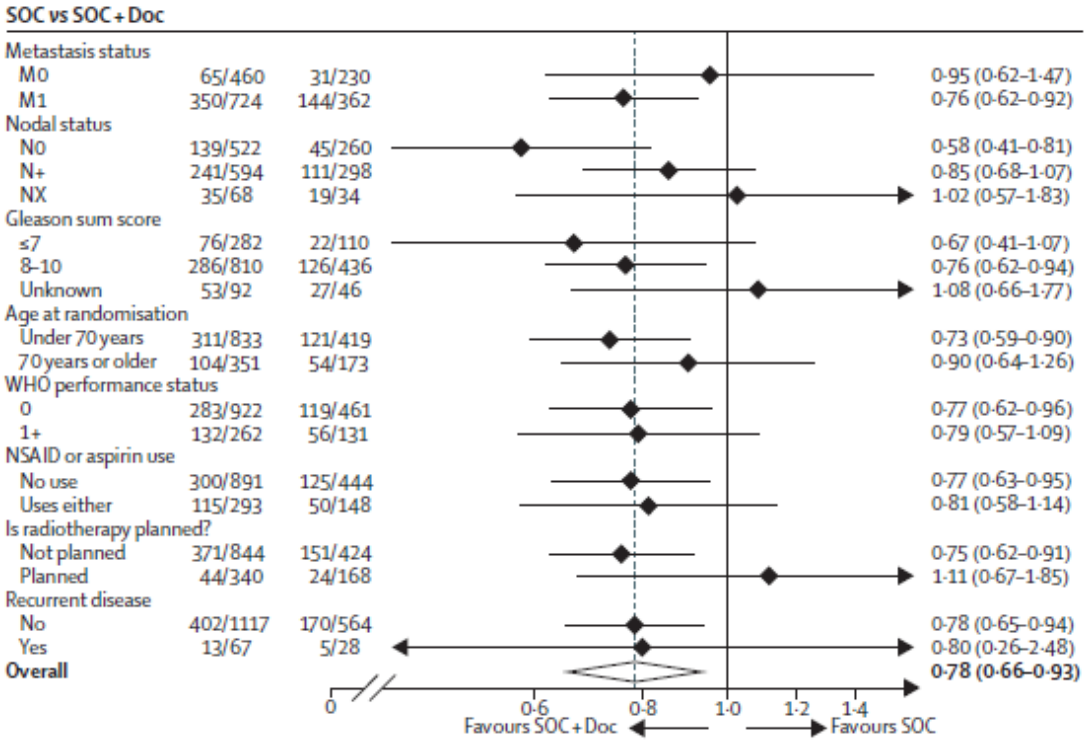
Disclosures

- Consultant for AbbVie, Advanced Accelerator Applications, Bayer, Exelixis, and Janssen.

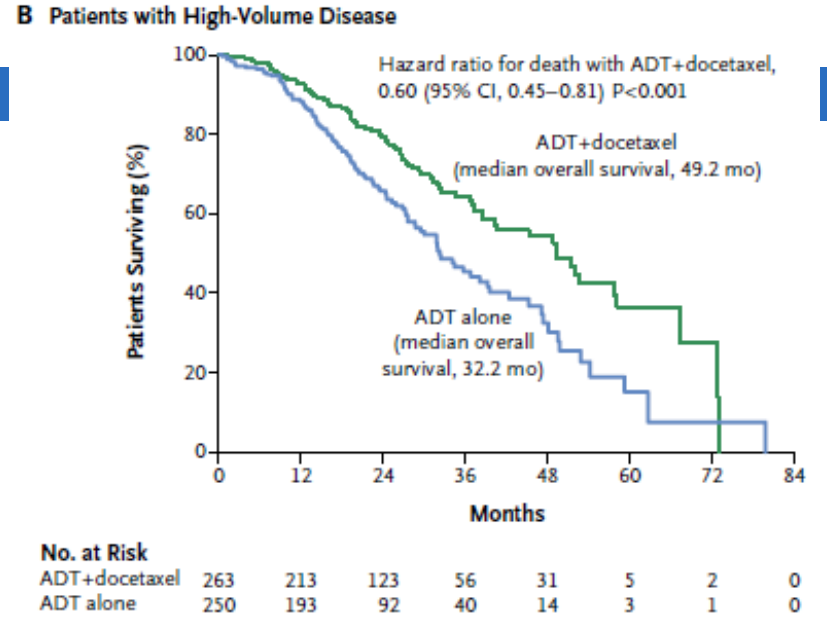
Prostate cancer: current and future/optimal management

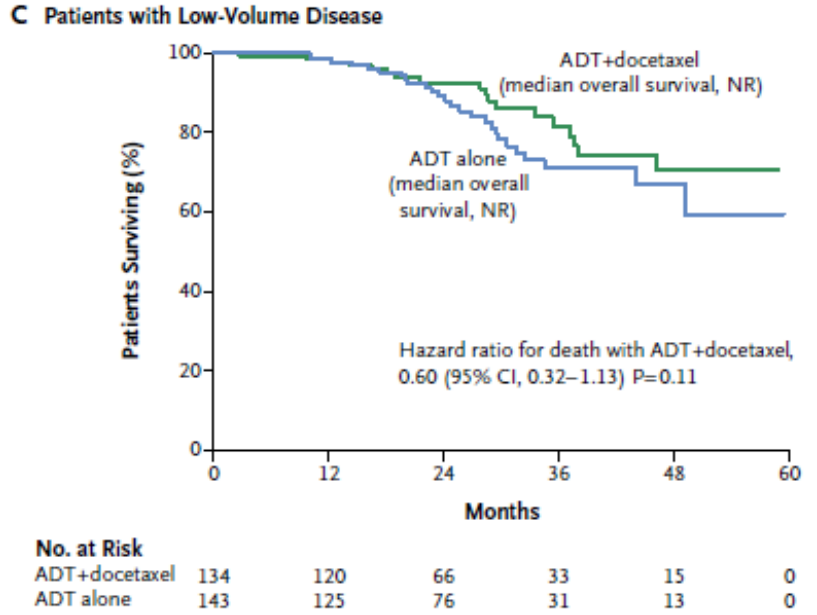
- mHSPC
  - Up-front intensification is appropriate for almost all
  - Choosing between chemo, ARTA, radiation to primary, or multiple
    - What does PEACE-1 add?
- Oligometastatic prostate cancer
  - Considerations for metastasis-directed therapy
- mCRPC
  - Implications of new mHSPC landscape on sequencing
  - New targets: Pi3K/AKT, PARP, ^{177}Lu-PSMA
- Advanced immunotherapy

Early chemotherapy improved survival in metastatic hormone sensitive prostate cancer (HSPC)



STAMPEDE (James et al, Lancet 2016; 387:1163-77)





CHAARTED (Sweeney CJ et al. NEJM 2015; 373:737-46)

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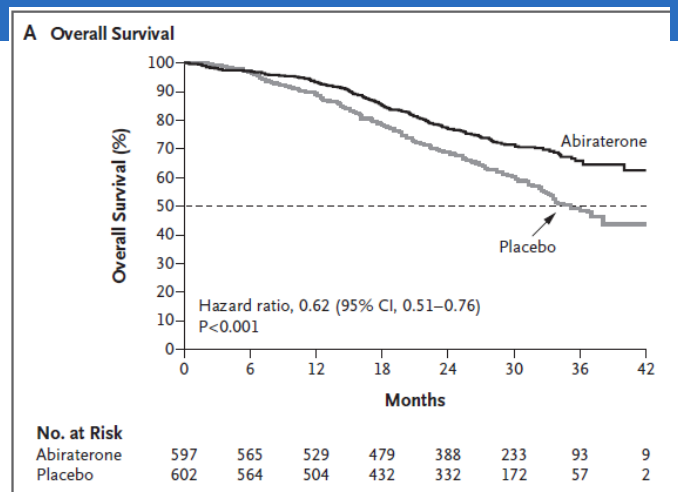
Early abiraterone improves survival in mHSPC



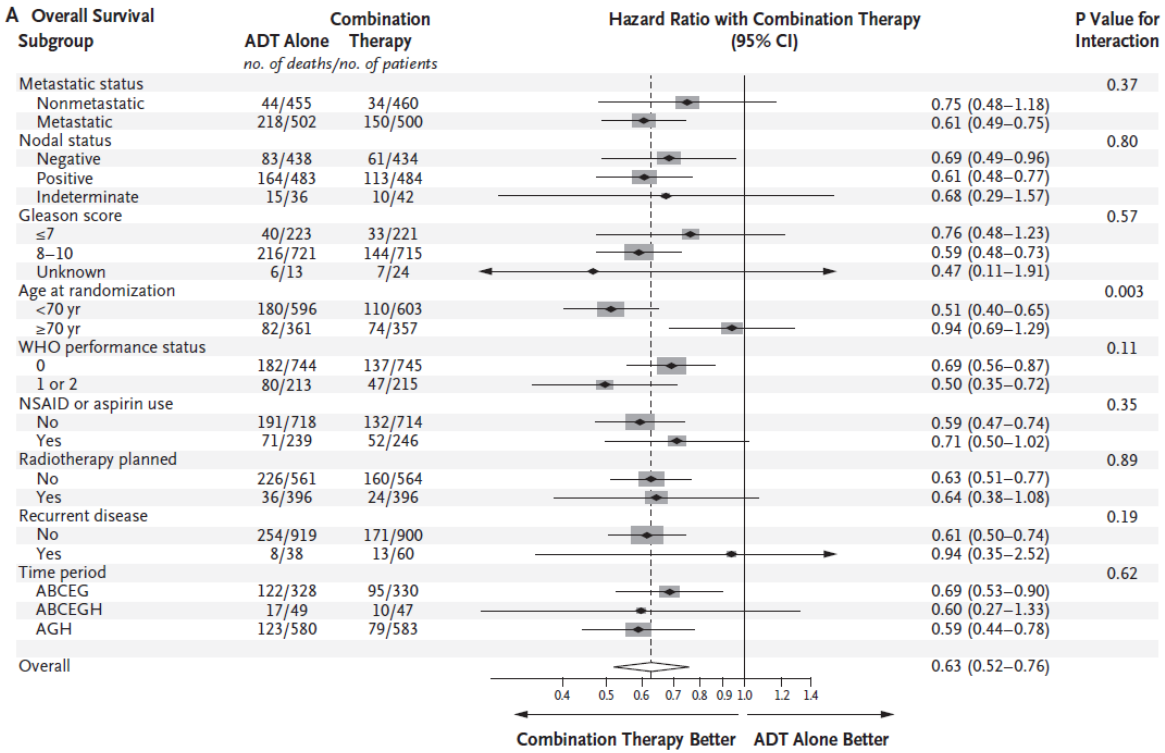
STAMPEDE:
Hi risk localized if 2/3:
Gleason 8-10 T3/T4 PSA >40

Biochemically recurrent if PSA >4 and PSA DT <6 mo

James ND et al. NEJM 2017;
DOI: 10.1056/NEJMoa1702900

LATITUDE 2 of 3 high risk features:
- **Gleason 8-10**
- **2+ bone metastases**
- **Visceral metastases**

Fizazi K et al. NEJM 2017
DOI:10.1056/NEJMoa1704174



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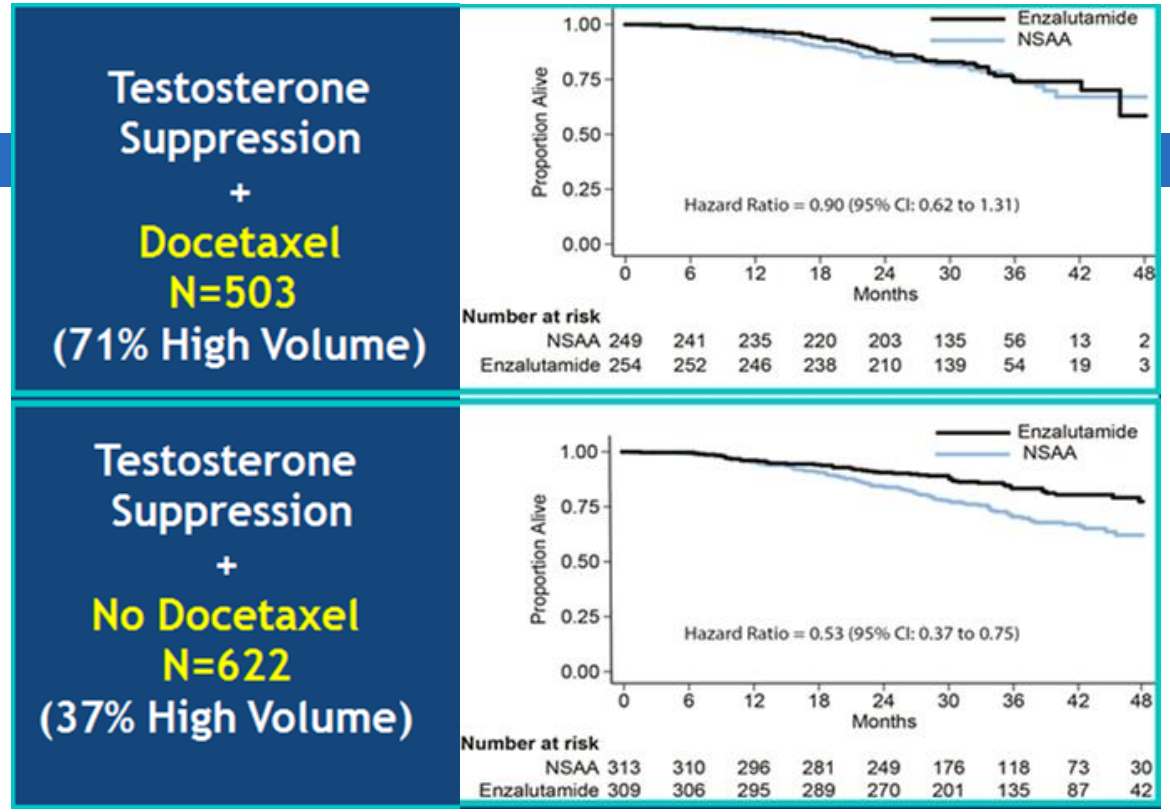
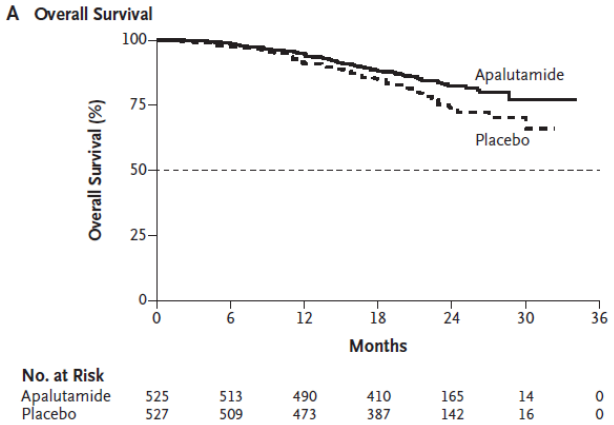
AR antagonists in mHSPC: ENZAMET, ARCHES and TITAN

- Up-front enzalutamide increased 3 year OS from 72% to 79% in ENZAMET[1], HR 0.67.
  - Bicalutamide allowed in control arm
  - No apparent advantage for enza after docetaxel; toxicity was noted

- TITAN[2] found improved OS at 24 months for apalutamide in mHSPC (82.4% vs 73.5%) compared to placebo





	No. of Patients	Median Overall Survival (95% CI)	Patients with Overall Survival at 24 Mo (95% CI)
		mo	%
Apalutamide	525	NE	82.4 (78.4–85.8)
Placebo	527	NE	73.5 (68.7–77.8)

Hazard ratio for death, 0.67 (95% CI, 0.51–0.89)
P=0.005

1. Davis ID et al. NEJM 2019; 381:121-31
2. Chi KN et al. NEJM 2019; 381:13-24

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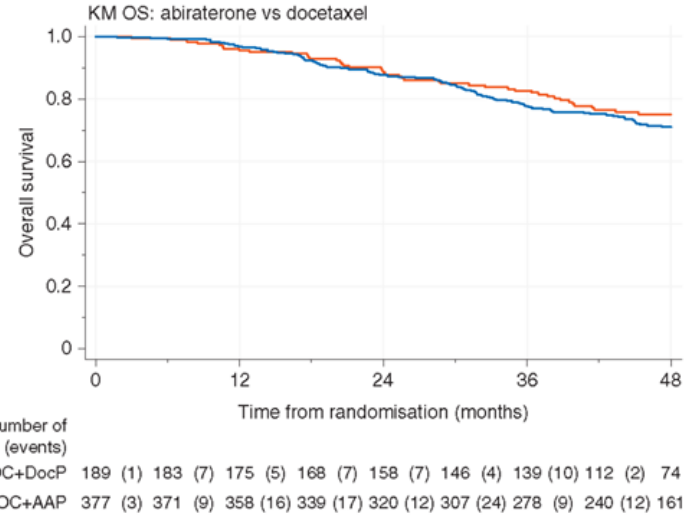
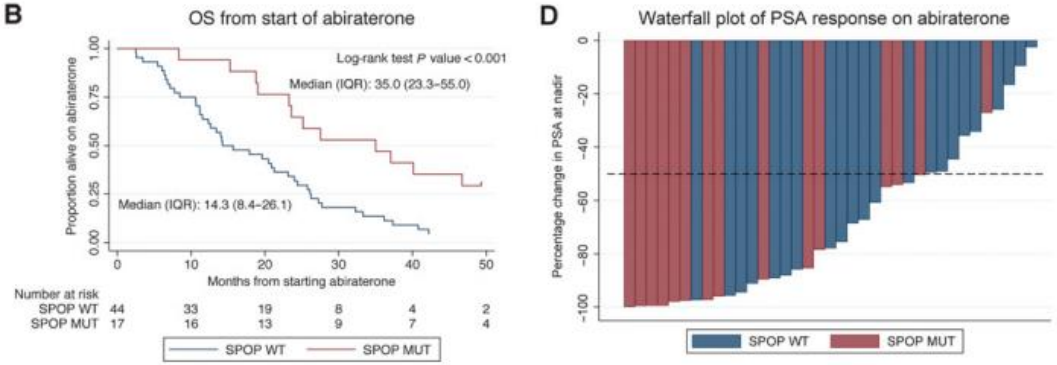
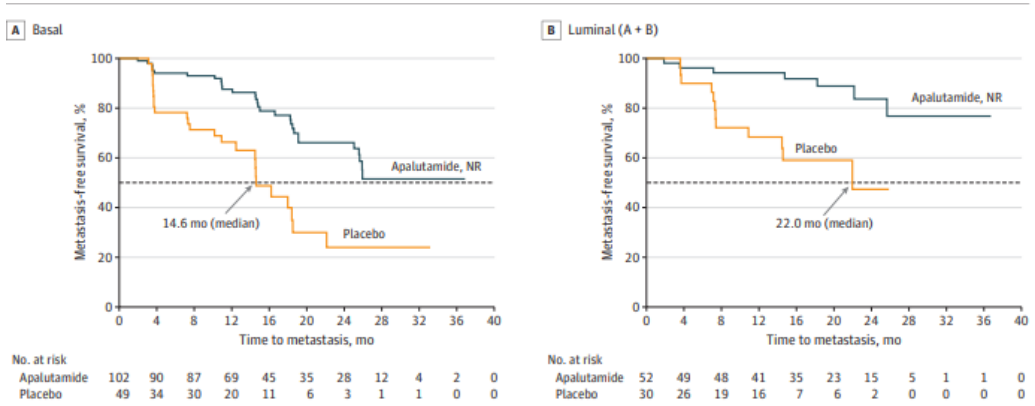
Next step: individualization of treatment selection?

- No difference between abiraterone and docetaxel for mHSPC during overlapping accrual on STAMPEDE[1]
  - If markers predict less response, could those patients be selected, or targeted with different intensification?
- SPOP mutation associated with enhanced response abiraterone in CRPC[2]
- Basal subtype progresses earlier with apalutamide i nmCRPC[3]
- KMD5D expression was associated with resistance docetaxel in CHAARTED[4]







1. Sydes MR et al. Ann Oncol 2018;29:1235
2. Boysen G et al. Clin Cancer Res 2018; 5585
3. Feng FY et al. JAMA Oncol 2021; 7:1005
4. Komura K et al. PNAS 2016; 113:6259

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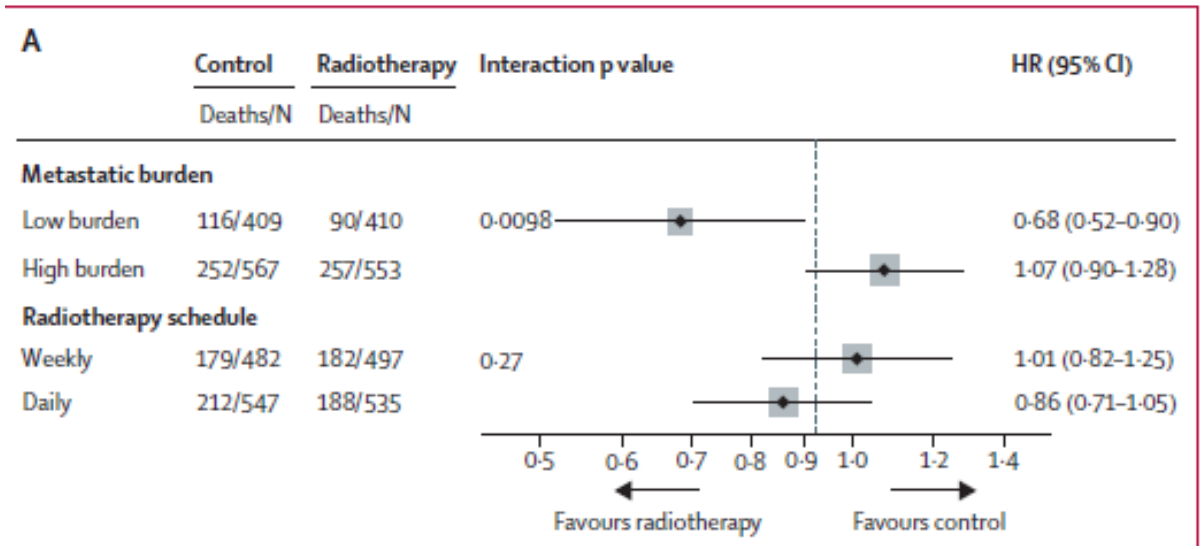
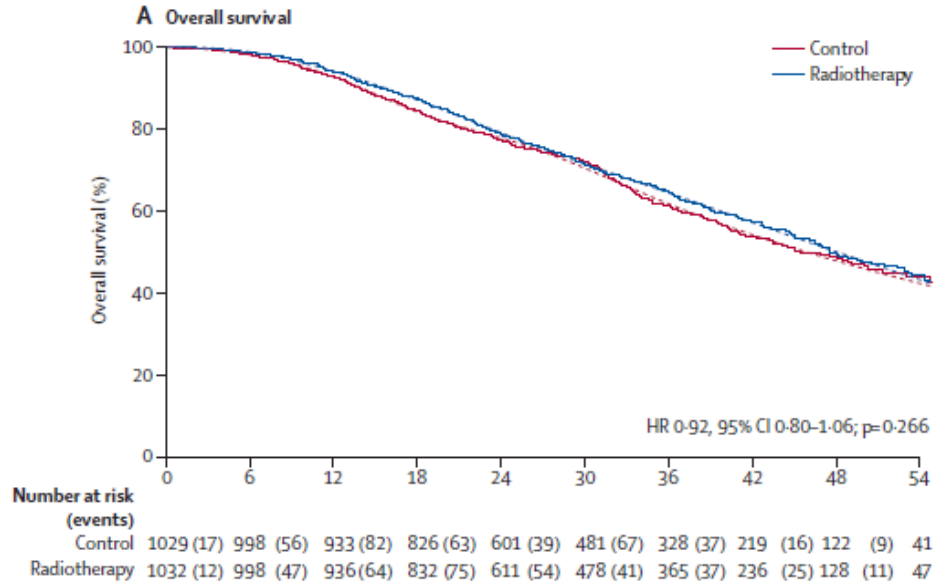
STAMPEDE: radiation to the prostate primary

Improved survival
- Only in low volume subset
- Patients did not receive intensified systemic therapy

Characteristic		SOC (n=1029)	SOC+RT (n=1032)
Age (years)	Median (IQR) Range	68 (63–73) 37–86	68 (63–73) 45–87
PSA (ng/ml)	Median (IQR) Range	98 (30–316) 1–20590	97 (33–313) 1–11156
Metastatic burden	Low High Not classified	409 (42%) 567 (58%) 53	410 (43%) 553 (57%) 69
Site of metastases	Bone Liver Lung Distant lymph nodes Other	919 (89%) 23 (2%) 42 (4%) 294 (29%) 35 (3%)	917 (89%) 19 (2%) 48 (5%) 304 (29%) 33 (3%)
Docetaxel use	No Yes	845 (82%) 184 (18%)	849 (82%) 183 (18%)





Parker CC et al. Lancet 2018
http://dx.doi.org/10.1016

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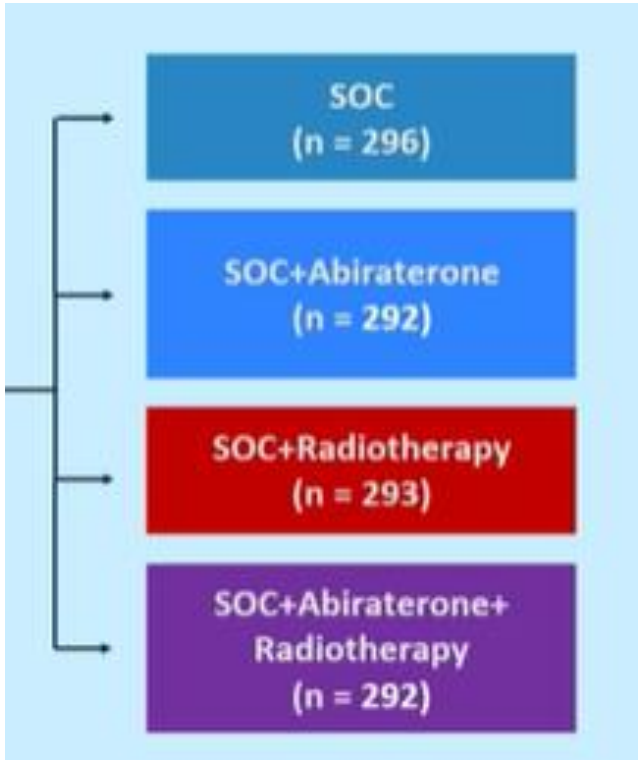
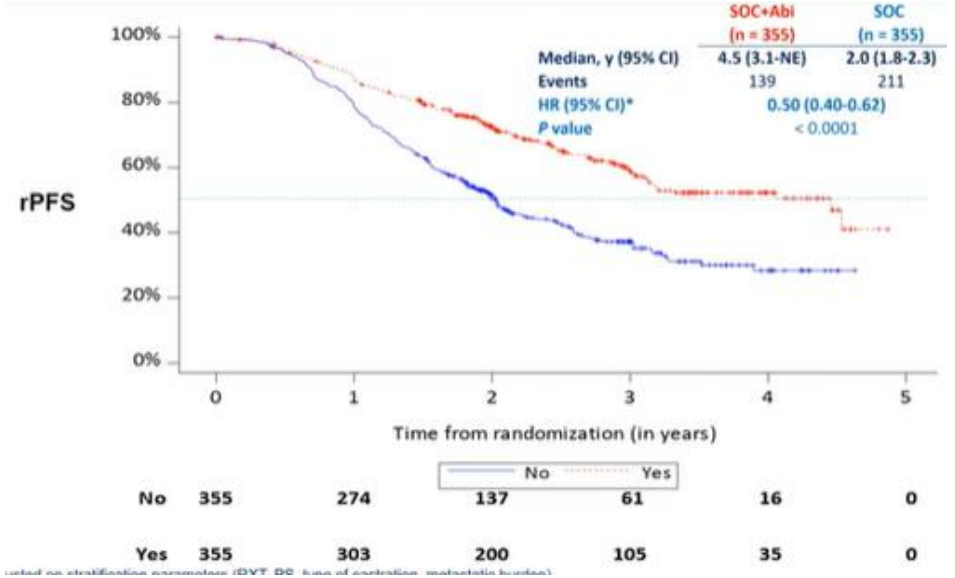
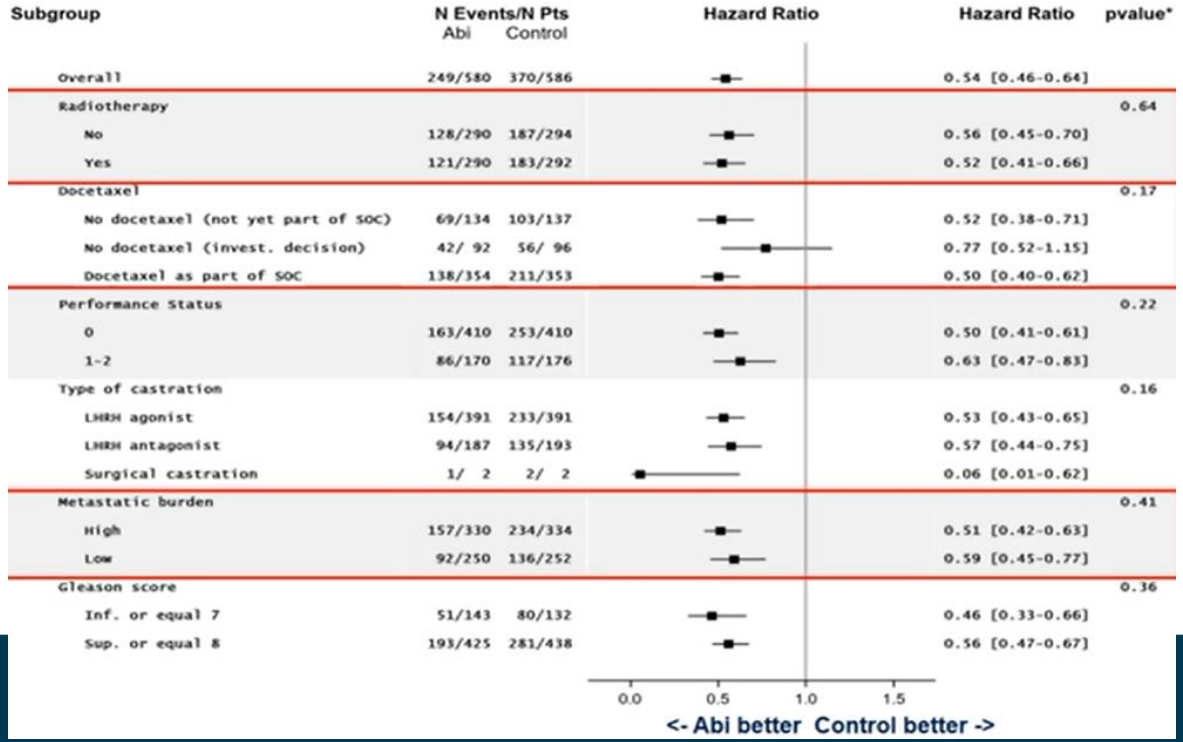
Abiraterone improves survival even after XRT to primary OR docetaxel up-front: PEACE-1



ENDPOINTS
rPFS
OS

Stratified by:
ECOG
Bone vs visceral mets
Type of castration
Docetaxel (yes/no)

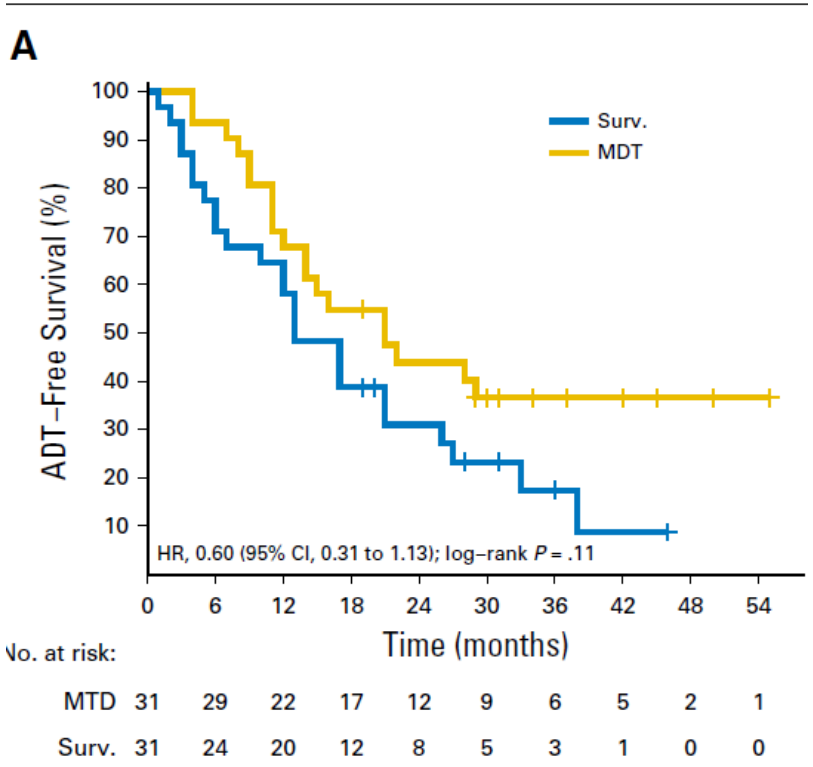




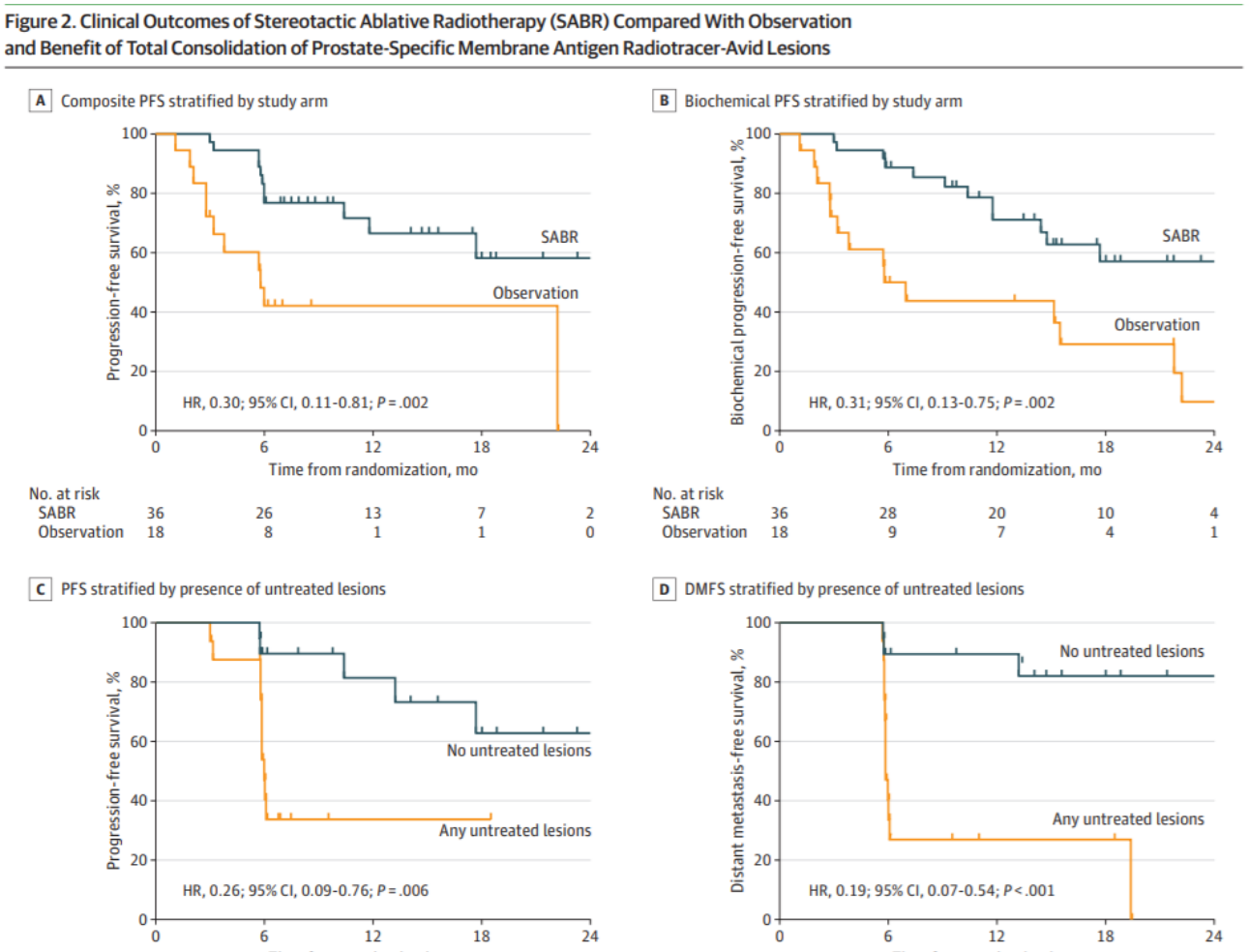
Fizazi K et al. 2021 ASCO annual meeting, abstr 5000

Metastasis directed therapy in oligomet prostate CA

Delayed time to ADT compared to observation[1] (STOMP)



ORIOLE[2] also showed benefit for MDT

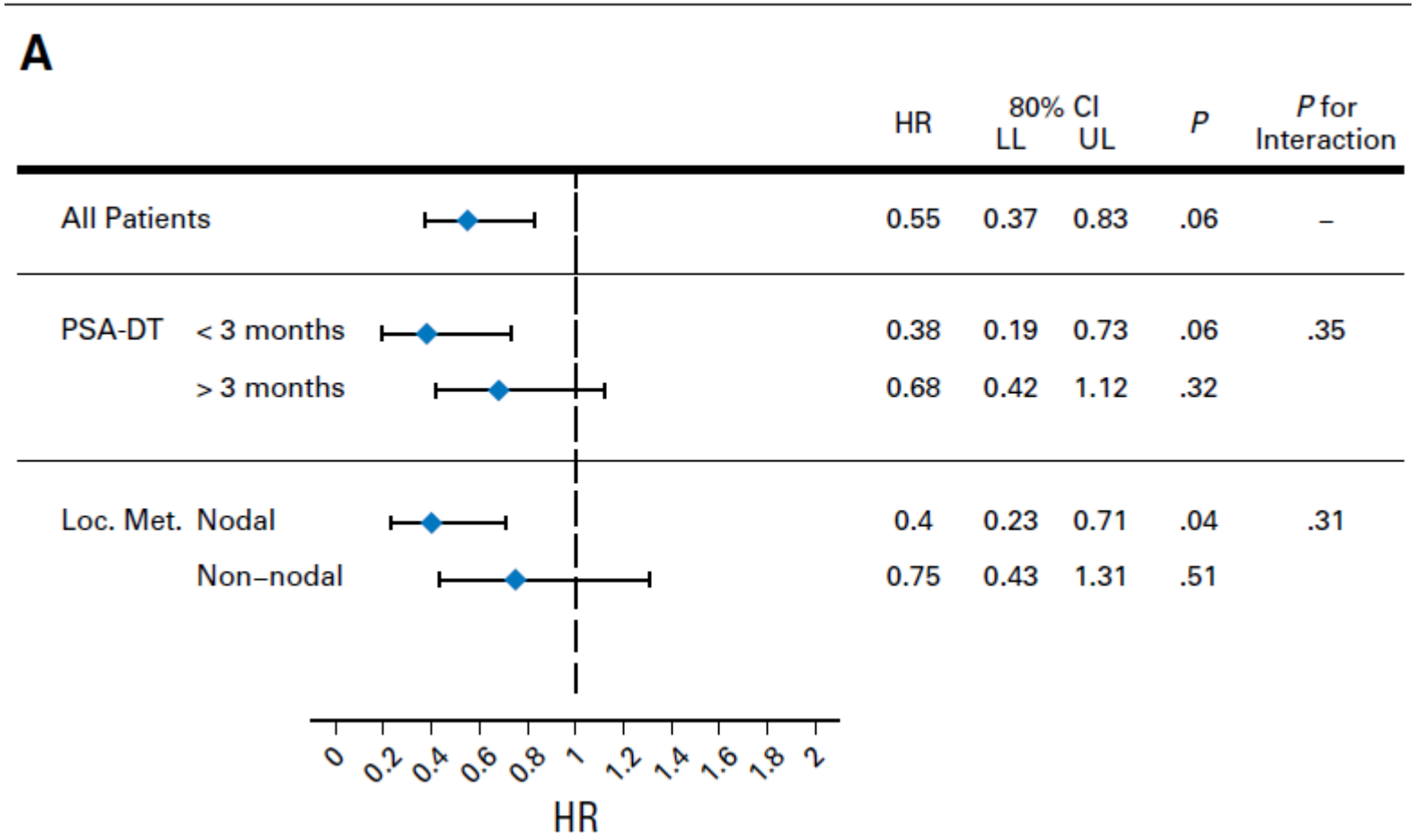


1. Ost P et al. J Clin Oncol 2018; 36:446-
2. Phillips R et al. JAMA Oncol 2020; 6:650-9.

Does metastasis-directed therapy impact overall survival?

SABR COMET
(all cancers)
Median OS improved for addition of SBRT to all metastatic sites on top of standard therapy

Palma DA et al. Lancet 2019; doi.org/10/1016/S0140-6736(18)32487-5



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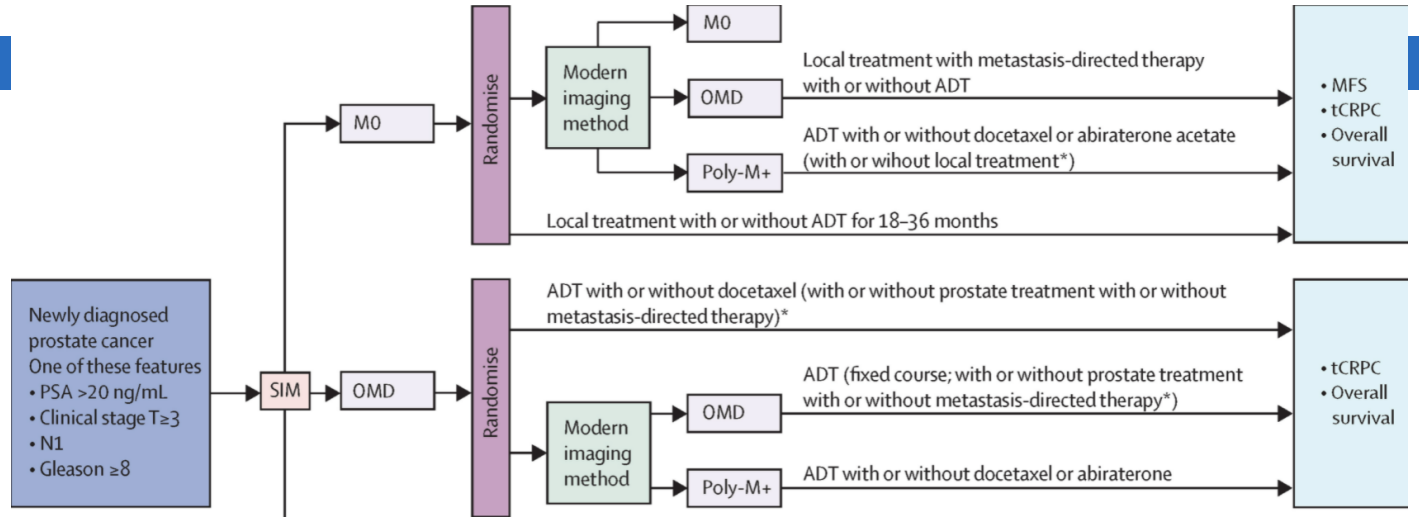
How to incorporate for Oligomet?

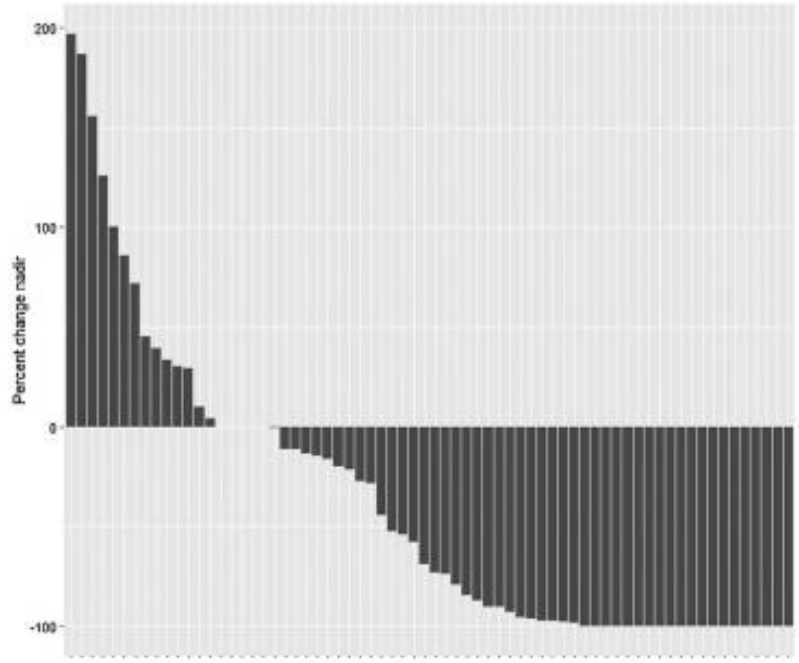
Oligomet

- Which imaging modality? [1]
- How many lesions?
- What form of radiation?



Up front or at Oligoprogression?

- Extend the utility of 1st line agent[2]
  - Med time to next treatment initiation 13.5 months



1. Lecouvet FE et al Lancet Oncol 2018; 19:e534-545
2. Deek MP et al. Eur Urol 2021; 4:447-455

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Prostate-specific membrane antigen PET-CT in patients with high-risk prostate cancer before curative-intent surgery or radiotherapy (proPSMA): a prospective, randomised, multicentre study

*Michael S Hofman, Nathan Lawrentschuk, Roslyn J Francis, Colin Tang, Ian Vela, Paul Thomas, Natalie Rutherford, Jarad M Martin, Mark Frydenberg, Ramdave Shakher, Lih-Ming Wong, Kim Taubman, Sze Ting Lee, Edward Hsiao, Paul Roach, Michelle Nottage, Ian Kirkwood, Dickon Hayne, Emma Link, Petra Marusic, Anetta Matera, Alan Herschtal, Amir Iravani, Rodney J Hicks, Scott Williams, Declan G Murphy, for the proPSMA Study Group Collaborators**

	N	Positive True/False	Negative True/False
Primary analysis			
Any metastatic disease	150	18/9	94/29
	145	34/2	103/6
Pelvic nodal	150	9/4	106/31
	145	29/1	109/6
Distant metasases	150	13/9	117/11
	145	22/1	120/2
Sensitivity analysis: equivocal lesions treated as positive			
Any metastatic disease	150	26/35	68/21
	145	35/11	94/5
Pelvic nodal	150	11/11	99/29
	145	29/2	108/6
Distant metasases	150	16/37	89/8
	145	22/11	110/2

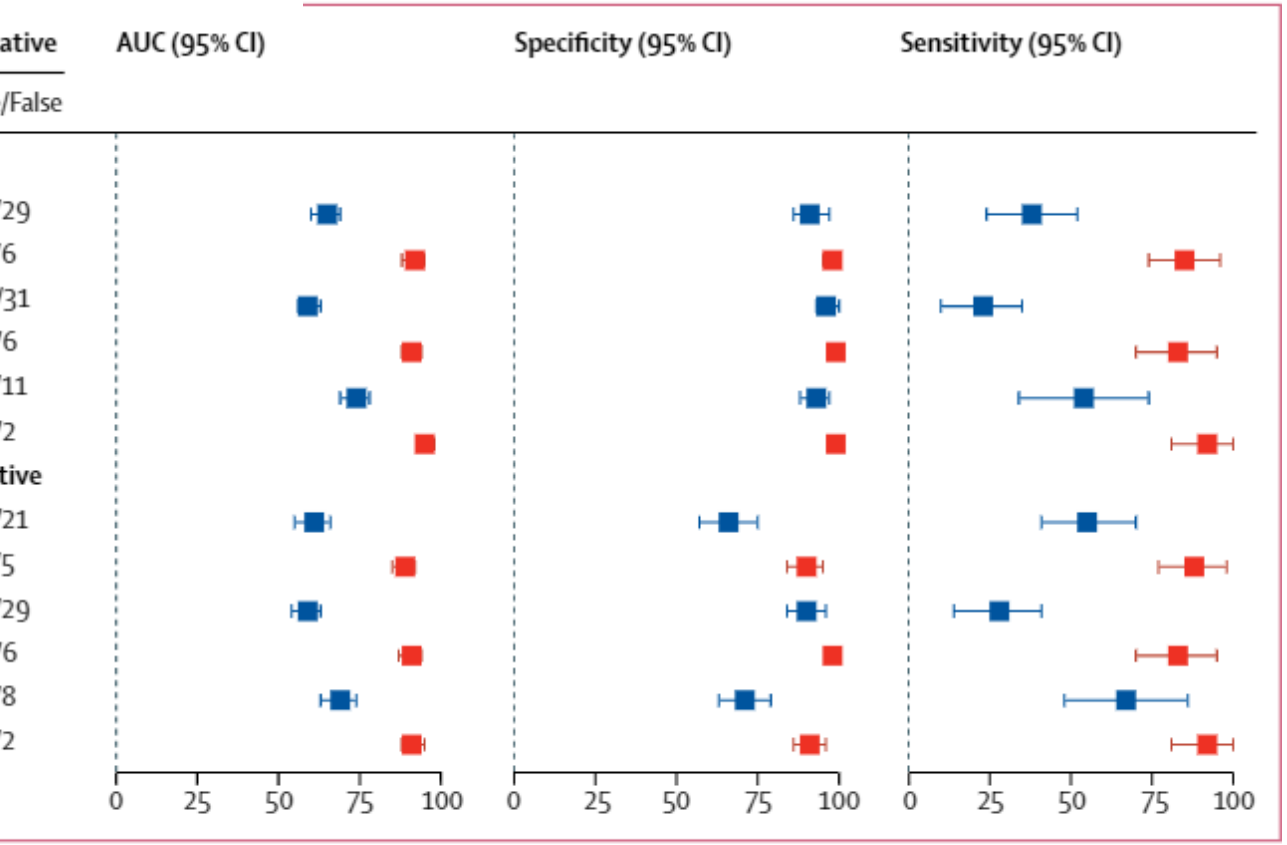

Figure 2: **Accuracy, sensitivity, and specificity of conventional imaging compared with PSMA PET-CT**
PSMA=prostate-specific membrane antigen. AUC=area under the curve.

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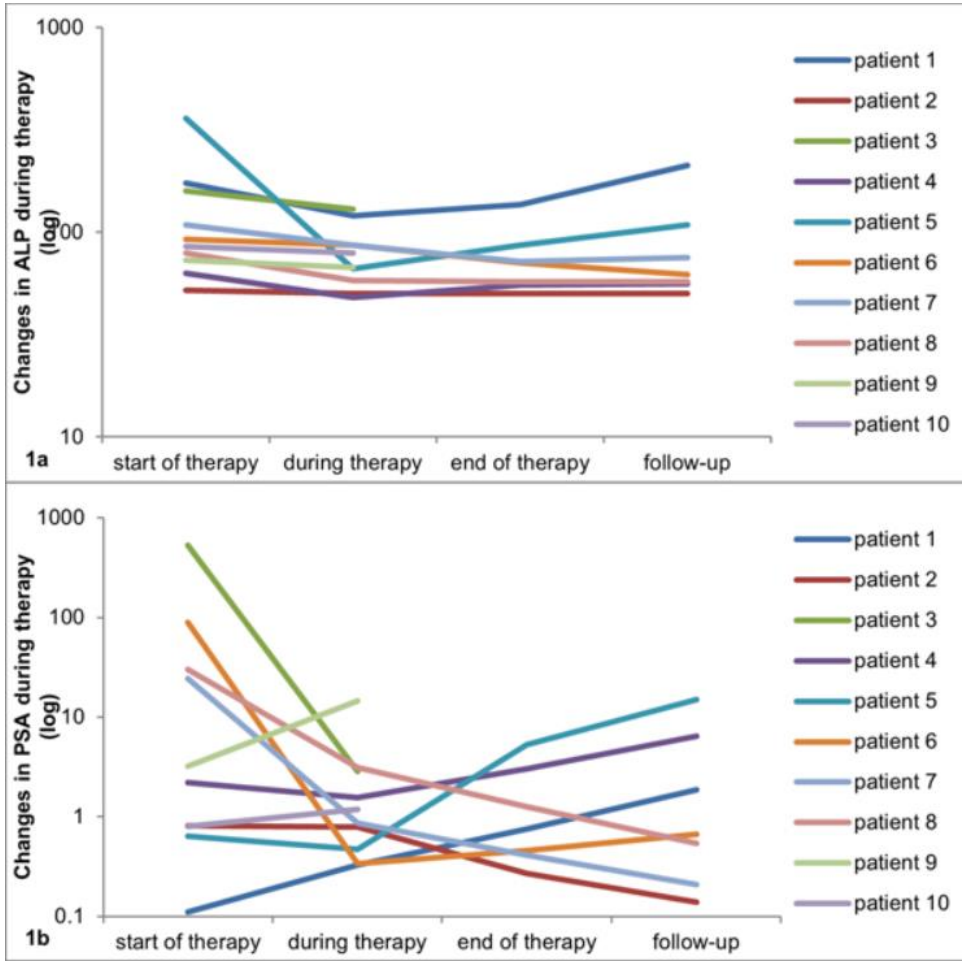
Could radiopharmaceuticals enhance eradication of micro-metastatic disease?

- Series of 10 men with mHSPC treated with radical prostatectomy followed by 6 doses of radium-223
  - No ADT
- Pain relief noted in all subjects
  - Median 44% decrease after cycle 3
- Radiographic improvement in bone scans was noted



Wenter V et al. Oncotgarget 2017; 8:44131-40

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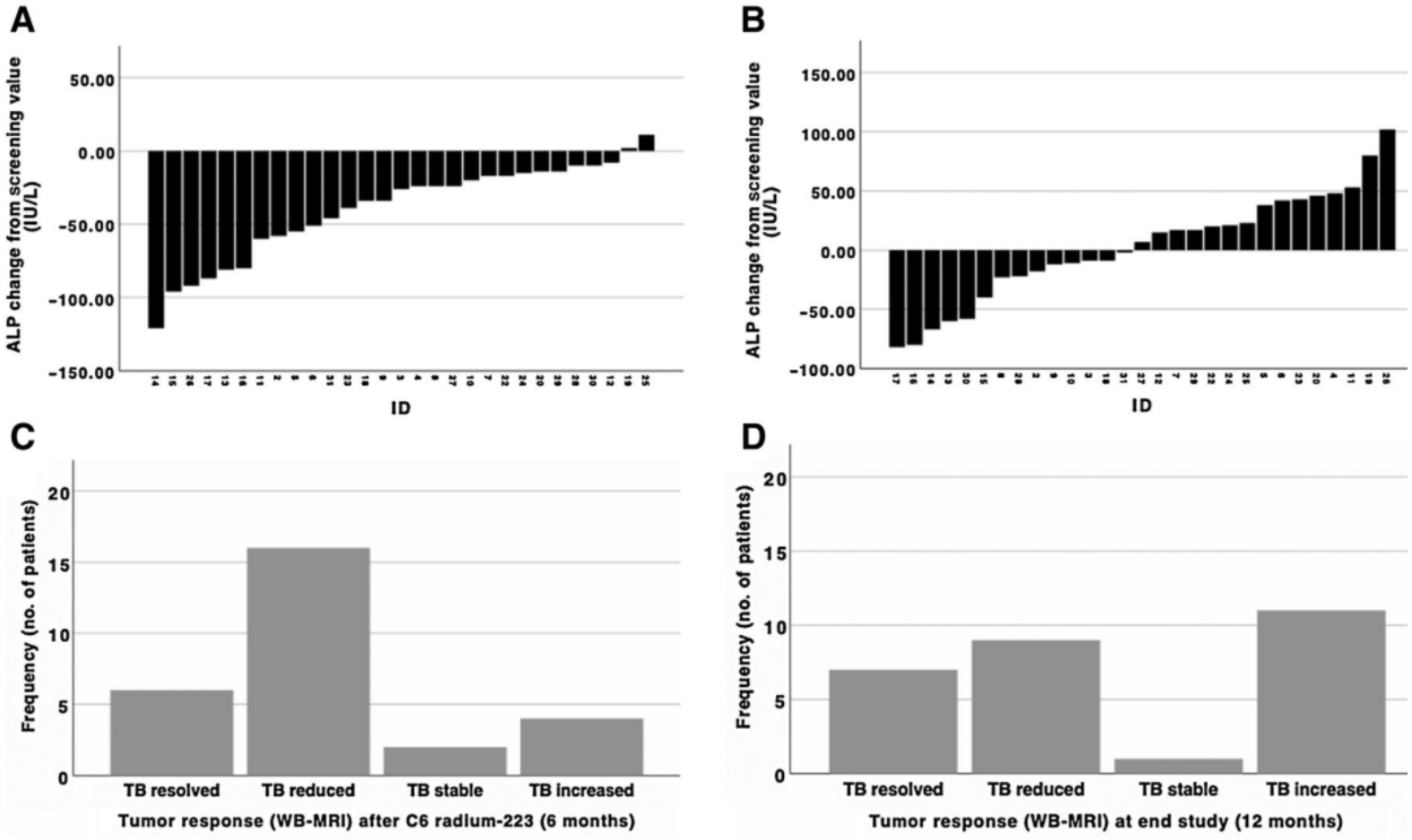
Could radiopharmaceuticals enhance eradication of micro-metastatic disease?

- ADRRAD: 30 men with mHSPC treated with ADT, up-front docetaxel, and pelvic radiation followed by 6 doses of radium-223
- Objective responses noted using whole body MRI
- No bone support; 10% had fragility fractures



Turner PG et al. Clin Cancer Res 2021;
DOI: 10.1158/1078-0432.CCR-21-0685

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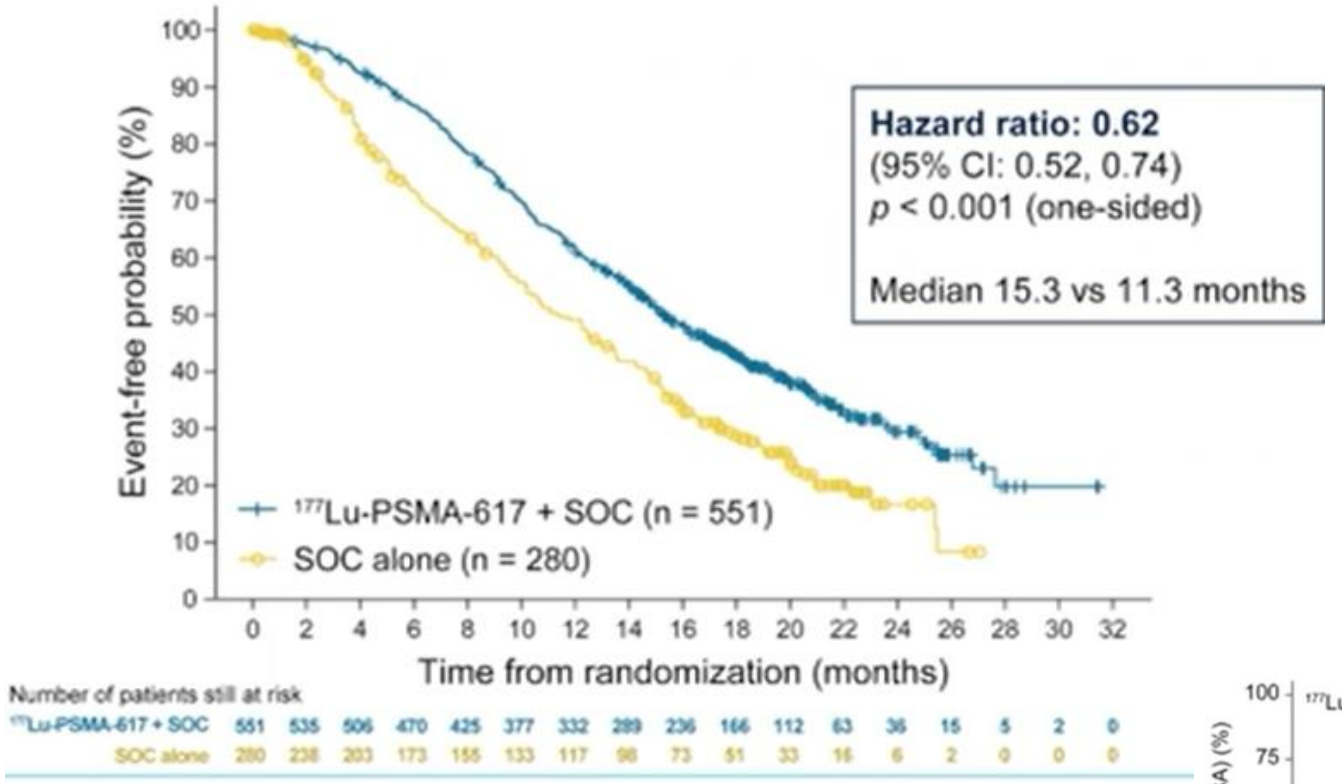
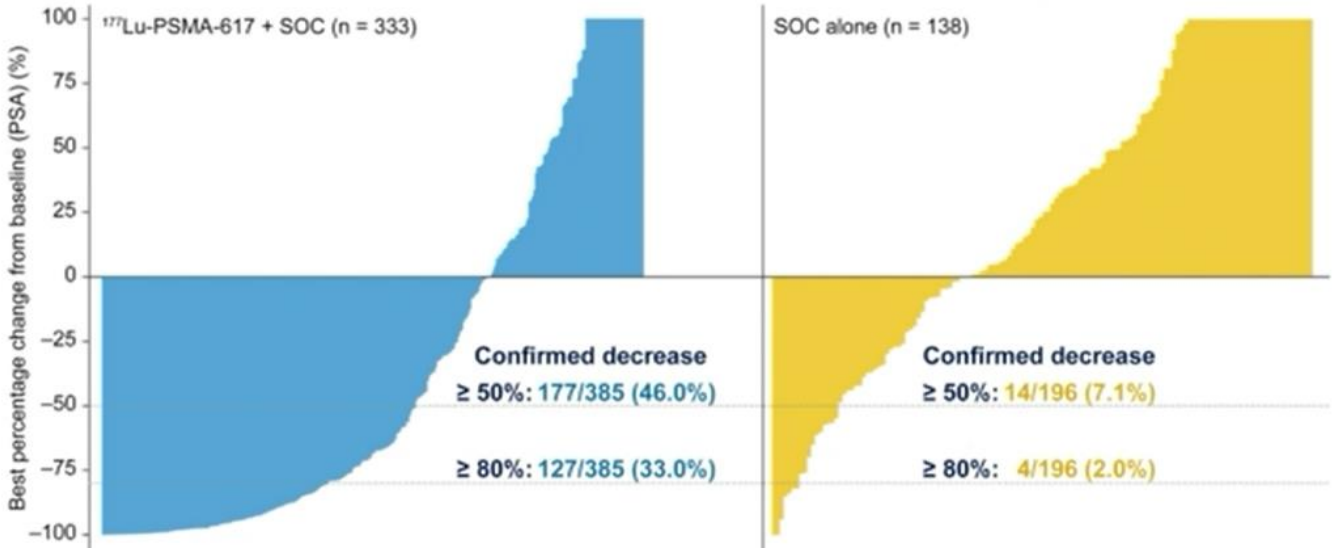


VISION trial: Lu177-PSMA compared to “standard care”

Morris et al, ASCO 2021

PSA responses



Nearly all tumors express PSMA

Phenotypic selection by PET scan used in VISION, Thera-P (in CRPC)

- 10-15% will not qualify

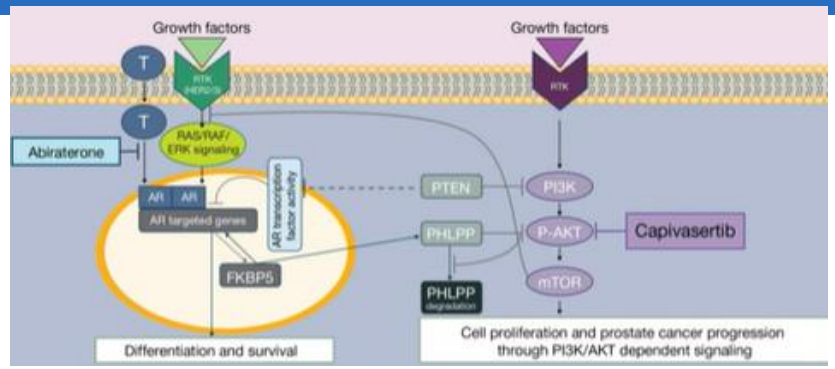
Lu-177-PSMA-617: moving into mHSPC

- Advantage of targeting both bone and soft tissue
  - ?will spare normal bone
- Phenotypic selection by PET scan
  - mHSPC has PSMA expression but less established rate
- **Moving into mHSPC:**
  - **PSMADDITION** (NCT 04720157) Randomized n=1126 (SST +/- Lu177-PSMA)
  - Bullseye (NCT04443062) Oligomet, randomized to Lu177-PSMA vs observation

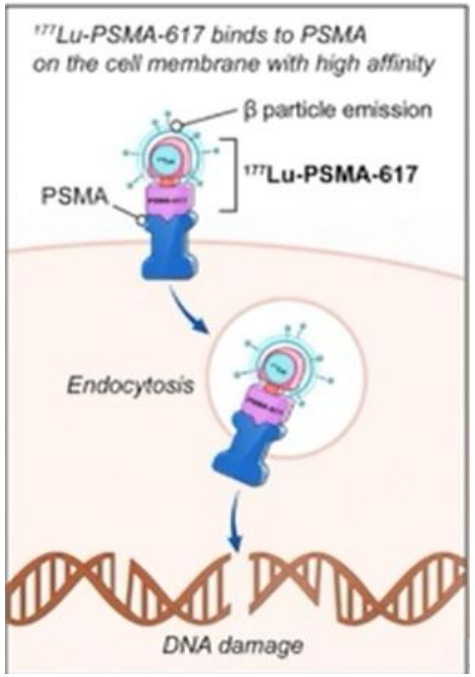
- ?Concern for late 2nd malignancy risk? (2% in VISION vs 1% placebo)

Next step: add novel agents in mHSPC

- Ipatasertib: Pi3K/AKT
  - Modest benefit added to abiraterone in mCRPC in iPATential
    - But suppression of AR upregulates Pi3K/AKT – so maybe need early application?
  - **Capivasertib being studied in mHSPC[1]**



- Olaparib, Rucaparib, Talazoparib: PARP
  - Molecularly selection identifies those who benefit in CRPC
    - ?different role in mHSPC due to cross-talk with AR
  - **Talazoparib trial in mHSPC** (City of Hope)



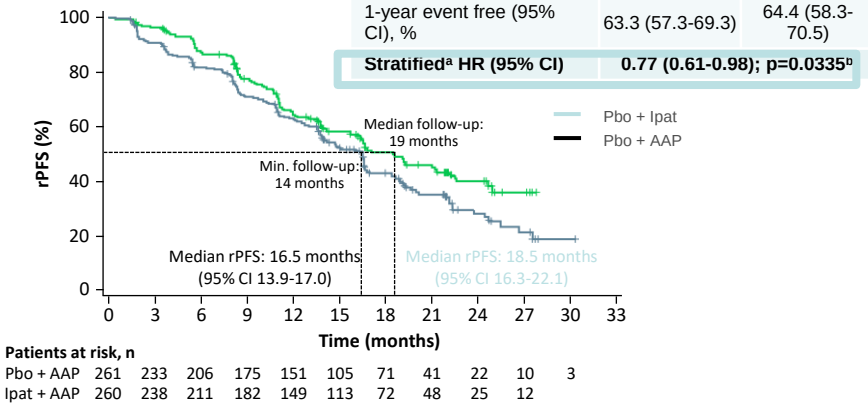
1. George D et al, GU ASCO 2021 abstr TPS178
2. Kasparian S et al. GU ASCO 2021 abstr TPS 5097

IPATential150: results in mCRPC

- Ipatasertib significantly improved radiographic progression-free survival (rPFS) in PTEN-loss mCRPC, but not in the intention-to-treat (ITT) population

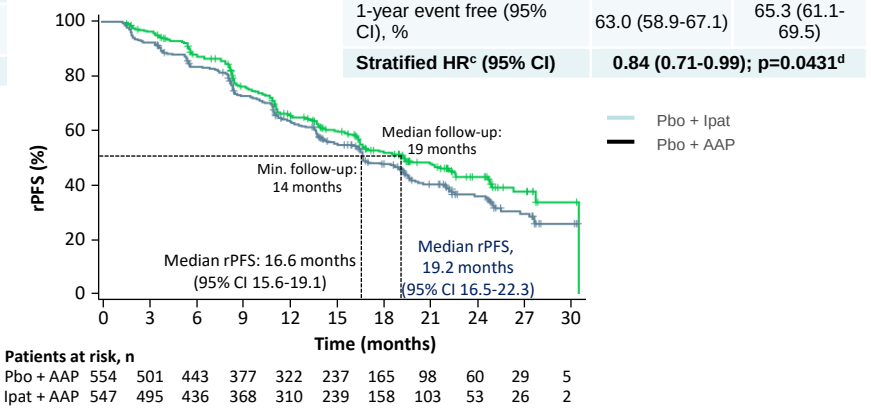
rPFS in the PTEN-loss (by IHC) population

	Pbo + AAP (N=261)	Ipat + AAP (N=260)
Patients with event, n (%)	154 (59)	124 (48)
1-year event free (95% CI), %	63.3 (57.3-69.3)	64.4 (58.3-70.5)
Stratified[a] HR (95% CI)	**0.77 (0.61-0.98); p=0.0335[b]**	



rPFS in the ITT population

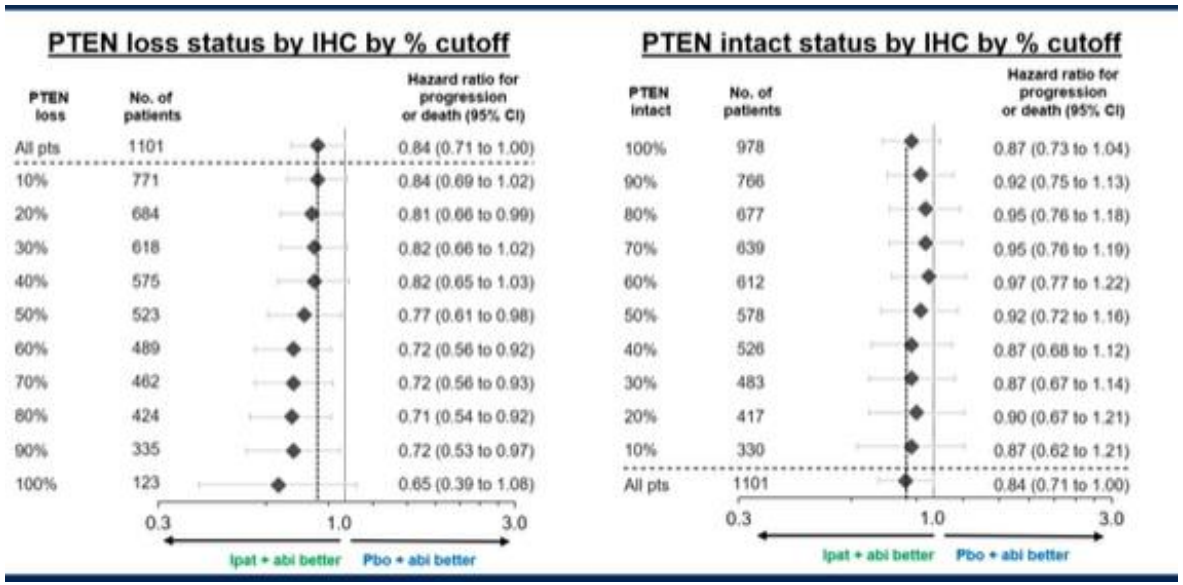
	Pbo + AAP (N=261)	Ipat + AA (N=260)
Patients with event, n (%)	306 (55)	252 (46)
1-year event free (95% CI), %	63.0 (58.9-67.1)	65.3 (61.1-69.5)
Stratified HR[c] (95% CI)	**0.84 (0.71-0.99); p=0.0431[d]**	



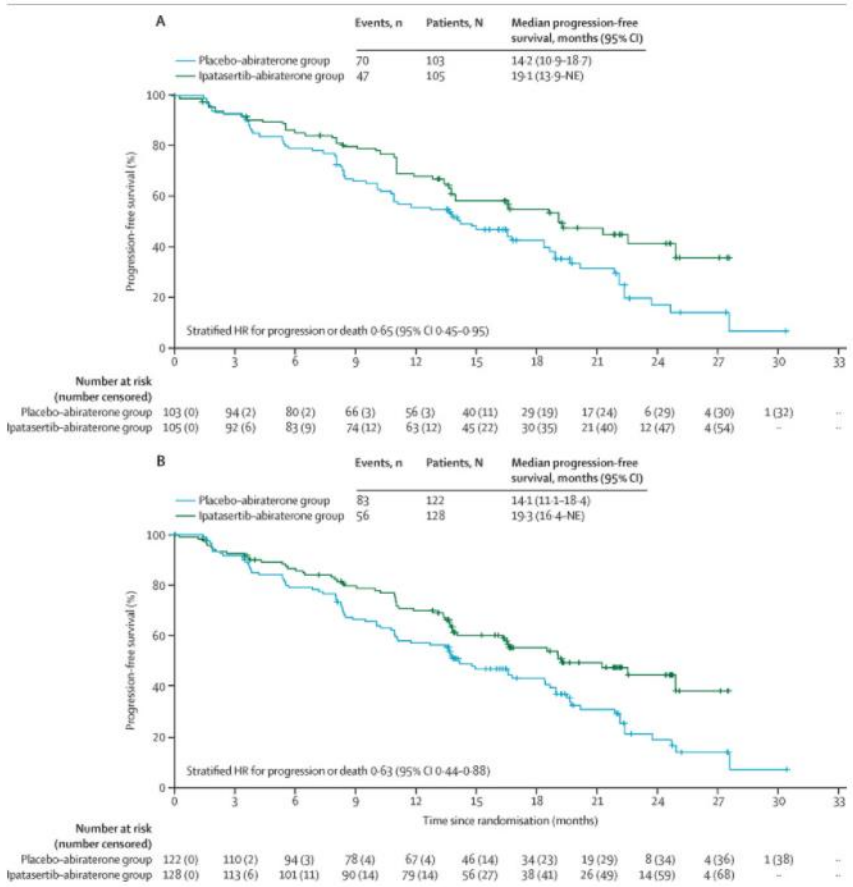
Data cut-off date: 16 March 2020; [a] Stratified for prior taxane-based therapy and PSA-only progression factor; [b] Statistically significant at α = 0.05 level; [c] Stratified for prior taxane-based therapy, PSA-only progression factor, and tumour PTEN loss status (by IHC); [d] Did not meet statistical significance α = 0.01 level
AAP, abiraterone acetate + prednisone; CI, confidence interval; HR, hazard ratio; IHC, immunohistochemistry; Ipat, ipatasertib;
mCRPC, metastatic castration-resistant prostate cancer; Pbo, placebo; PSA, prostate specific antigen; de Bono J, et al. ESMO 2020. Abstract #LBA4. Oral presentation

Pi3K/AKT pathway: the biomarker is key

- Ipatasertib in mCRPC added to abiraterone improved survival in PTEN loss group with stronger IHC loss[1]



- The effect was also more pronounced when there was more PTEN loss (A) or Pi3K/AKT pathway alteration (B) by NGS



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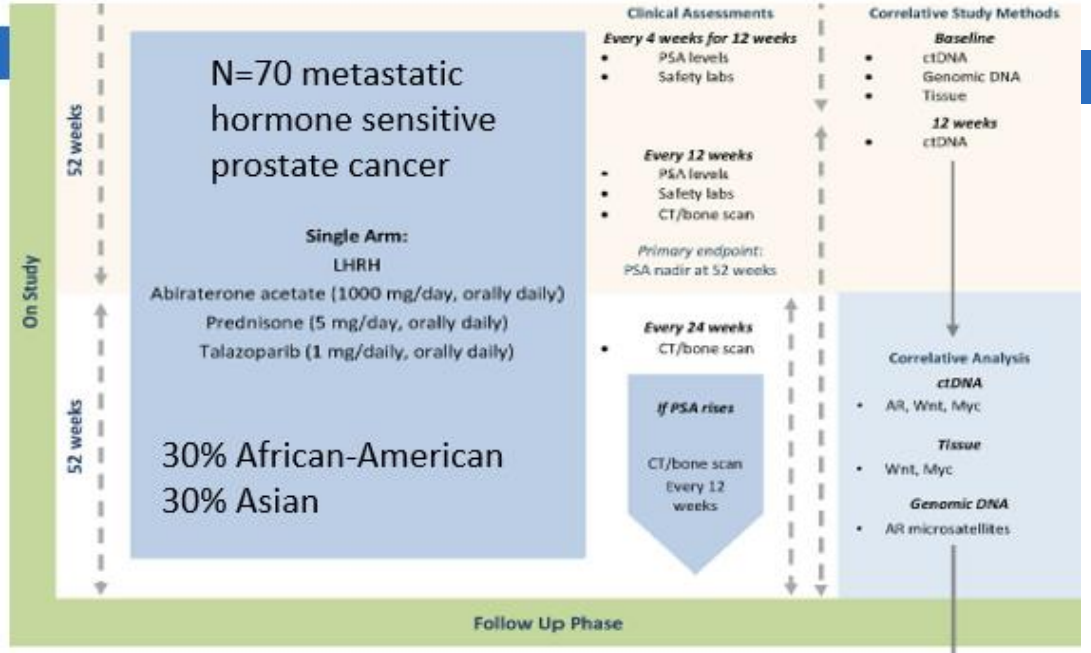
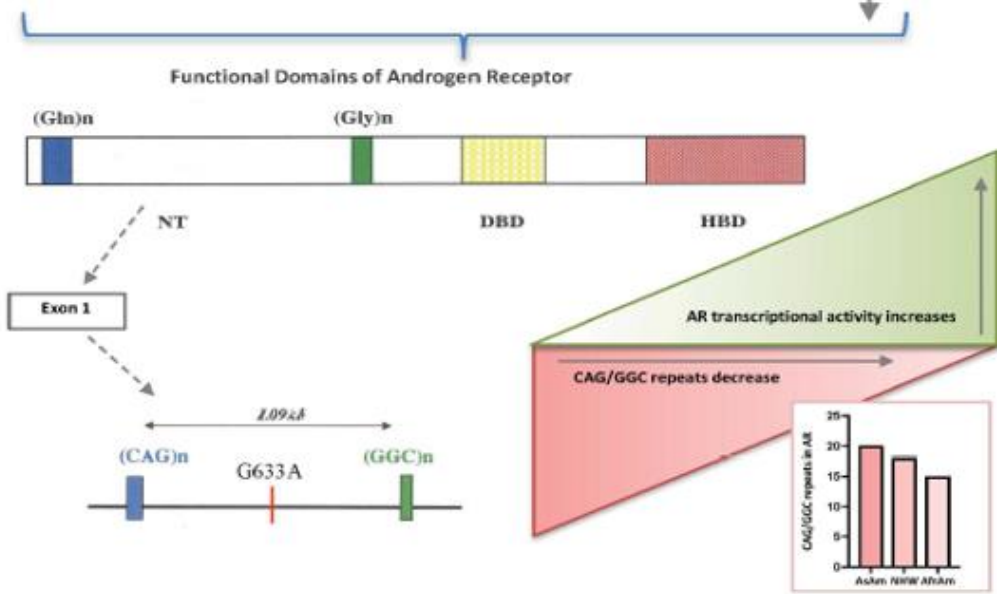
1. DeBono JS et al. GU ASCO 2021; abstr13
2. Sweeney C et al. Lancet 2021; 398:131

2020 PCF + Pfizer Award
Dorff /Kittles / Burnham / Sun





Identifying androgen receptor and genomic characteristics that define populations of patients with mHSPC who benefit from **early PARP inhibition therapy with talazoparib**

A phase II trial in mHSPC (NCT04734730)

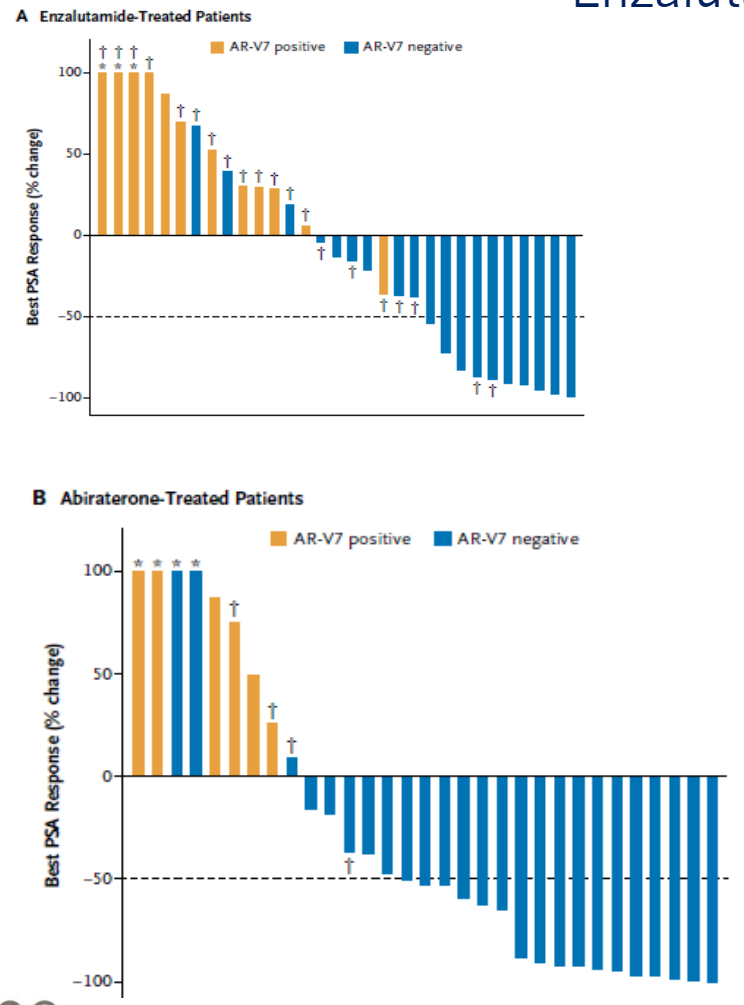
Sequencing in mCRPC

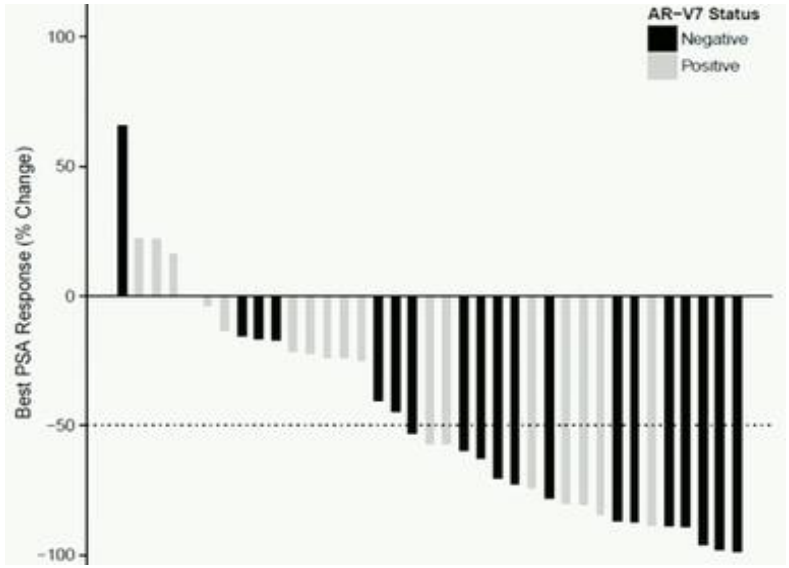
- Most patients are already post ARTA
- - switching to the other ARTA not very successful
- PROFOUND shows better survival for Olaparib compared to 2nd ARTA
  - For those with HRD
- Combinations also not very successful
  - ARTA + ARTA not successful up front or layered
  - Combinations with ARTA and targeted or radiopharmaceutical may work out

ARV7 explains some cross-resistance between ARTA

Antonarakis et al, NEJM 2014.

ARV7 Predicts Less Response to Enzalutamide and Abiraterone





But response to Docetaxel is not impacted by ARv7

Antonarakis et al, 2015.

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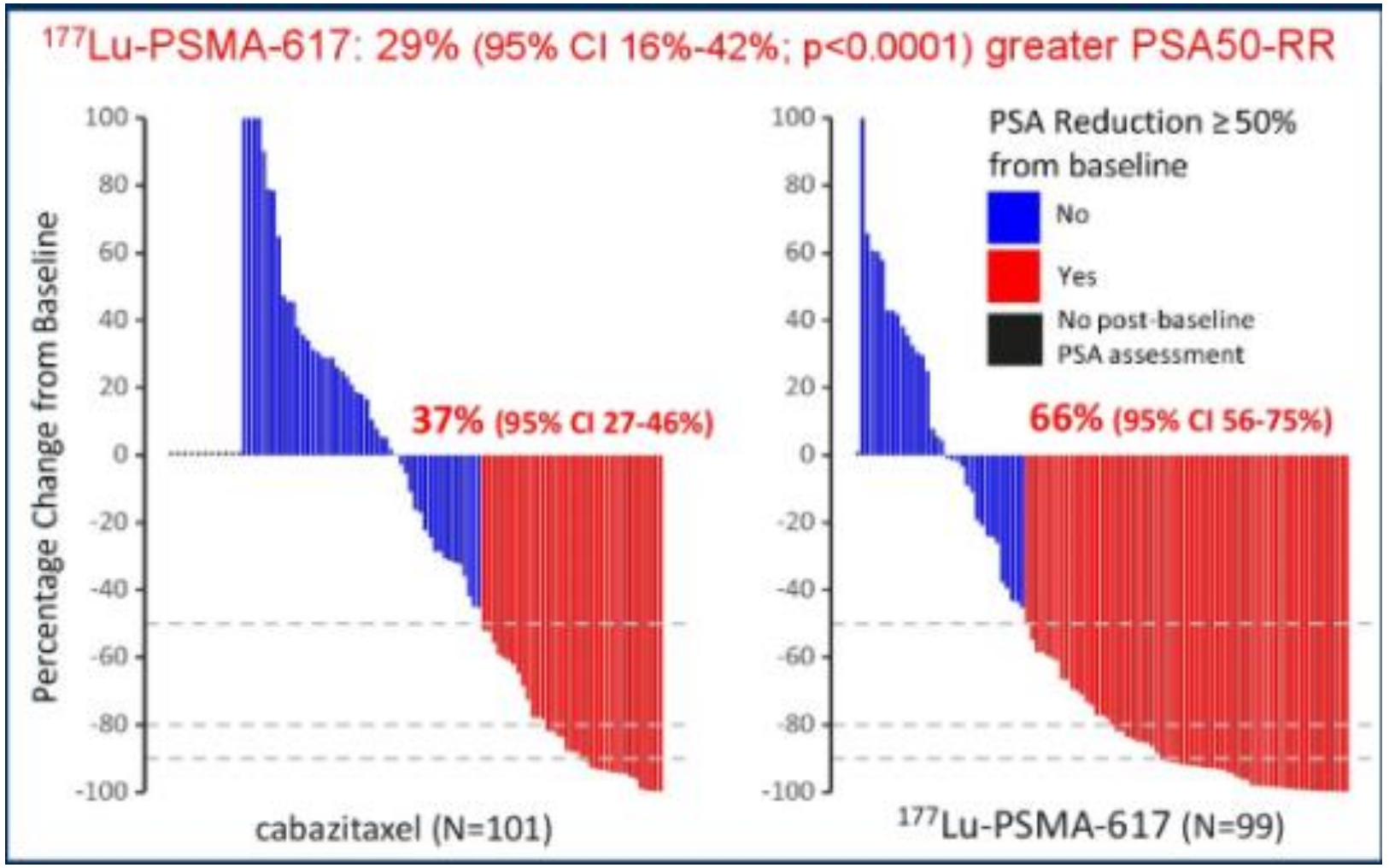
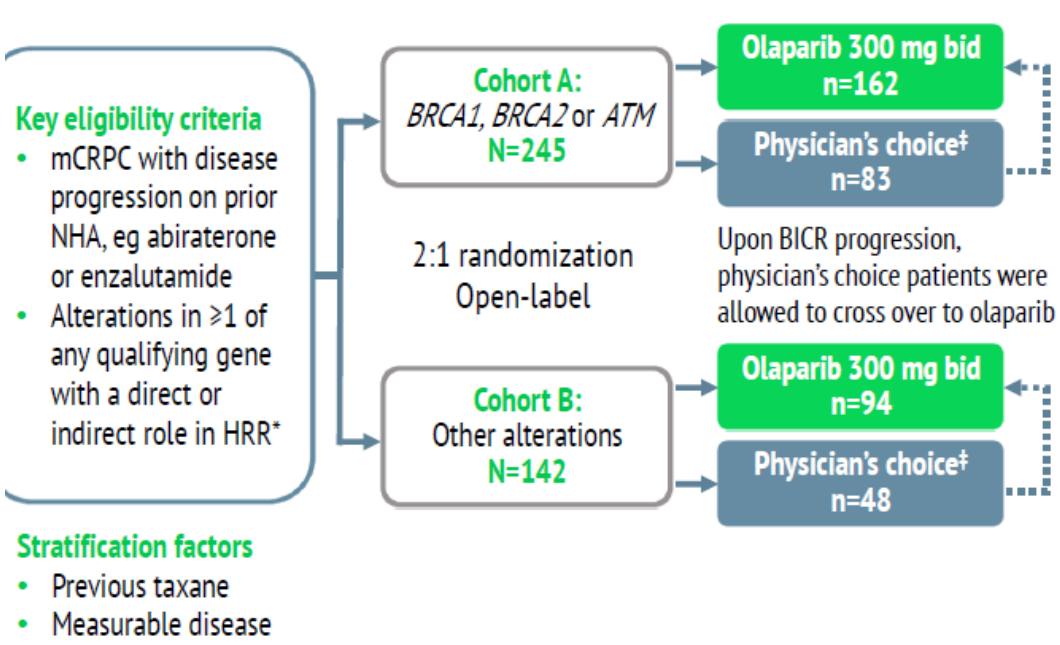
TheraP (ANZUP 1603)
Hofman MS et al
GU ASCO 2021

Median age 72 (67-77)
bPSA 110 (44-245)



PROFOUND: phase III data with PARP inhibitors

rPFS 7.39 months vs 3.55 mo in cohort A



Primary endpoint

Radiographic progression-free survival (rPFS) in Cohort A (RECIST 1.1 & PCWG3 by BICR)

Key secondary endpoints

- rPFS in Cohorts A+B
- Confirmed radiographic objective response rate (ORR) in Cohort A
- Time to pain progression (TTPP) in Cohort AS
- Overall survival (OS) in Cohort A

Hussain M, et al. Presented at ESMO 2019 Abstract #LBA12.

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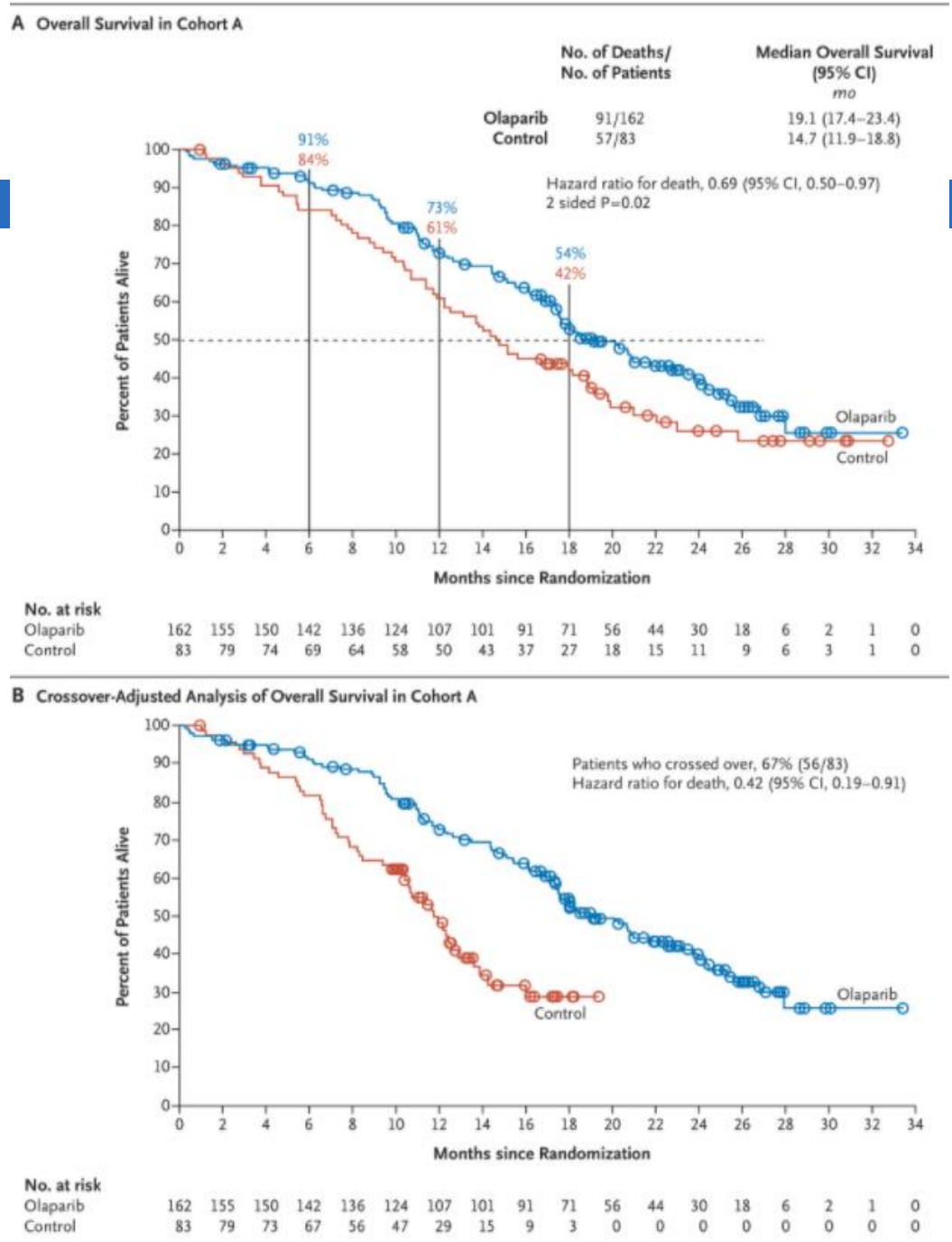
Overall survival in Cohort A (BRCA 1&2, ATM)



Hussain M, et al.
NEJM 2020; 383:2345

>80% crossover!

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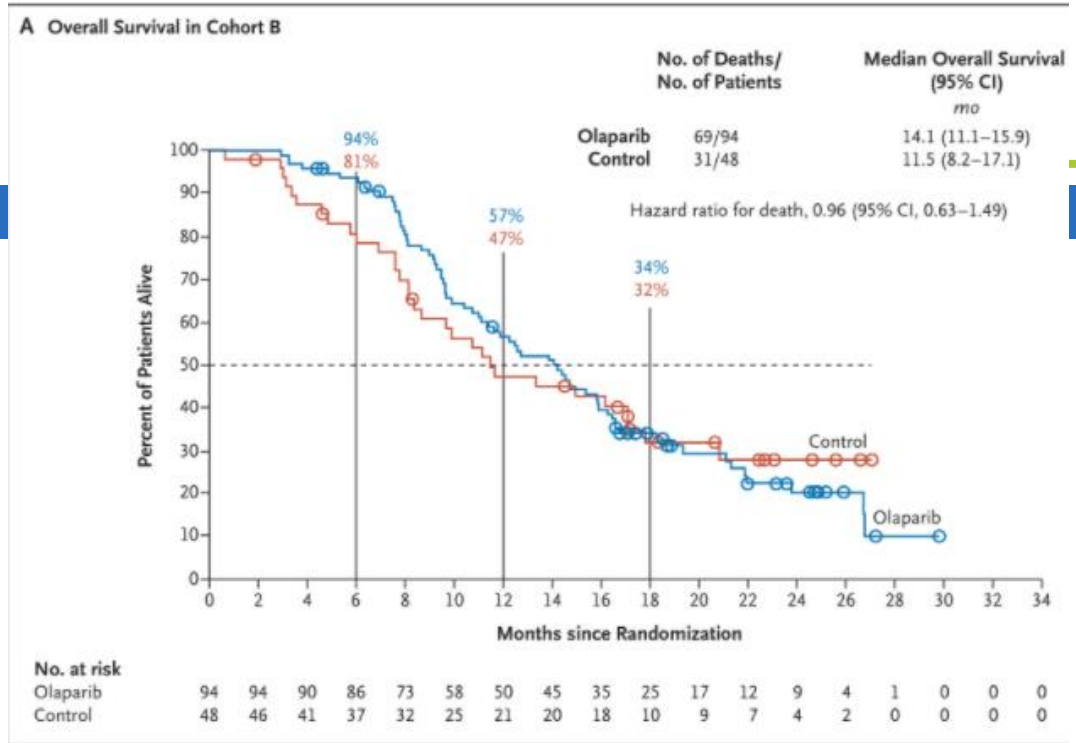
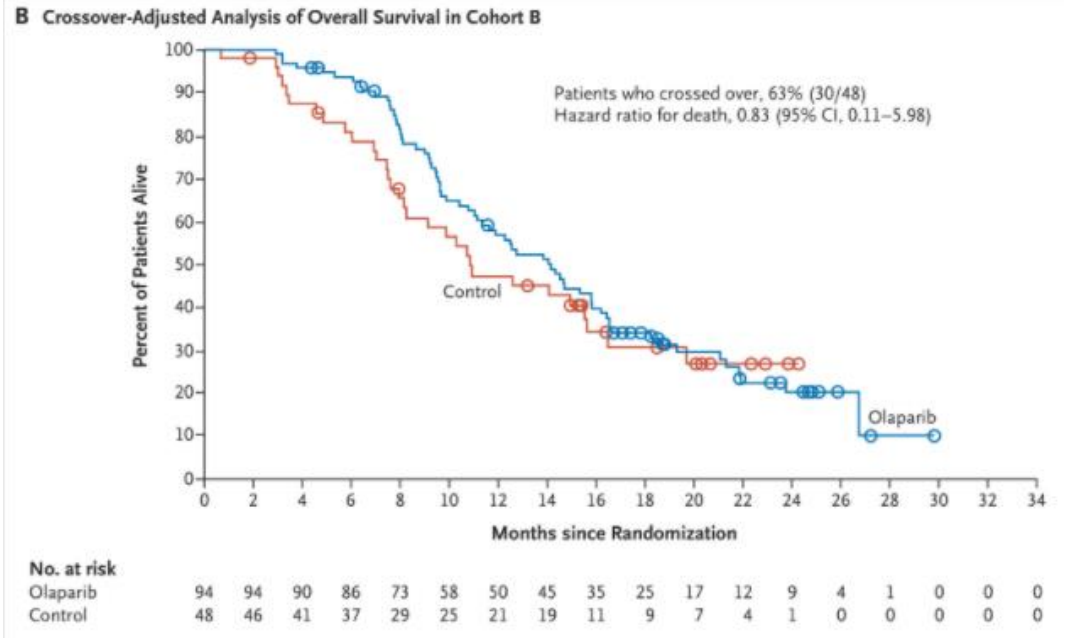


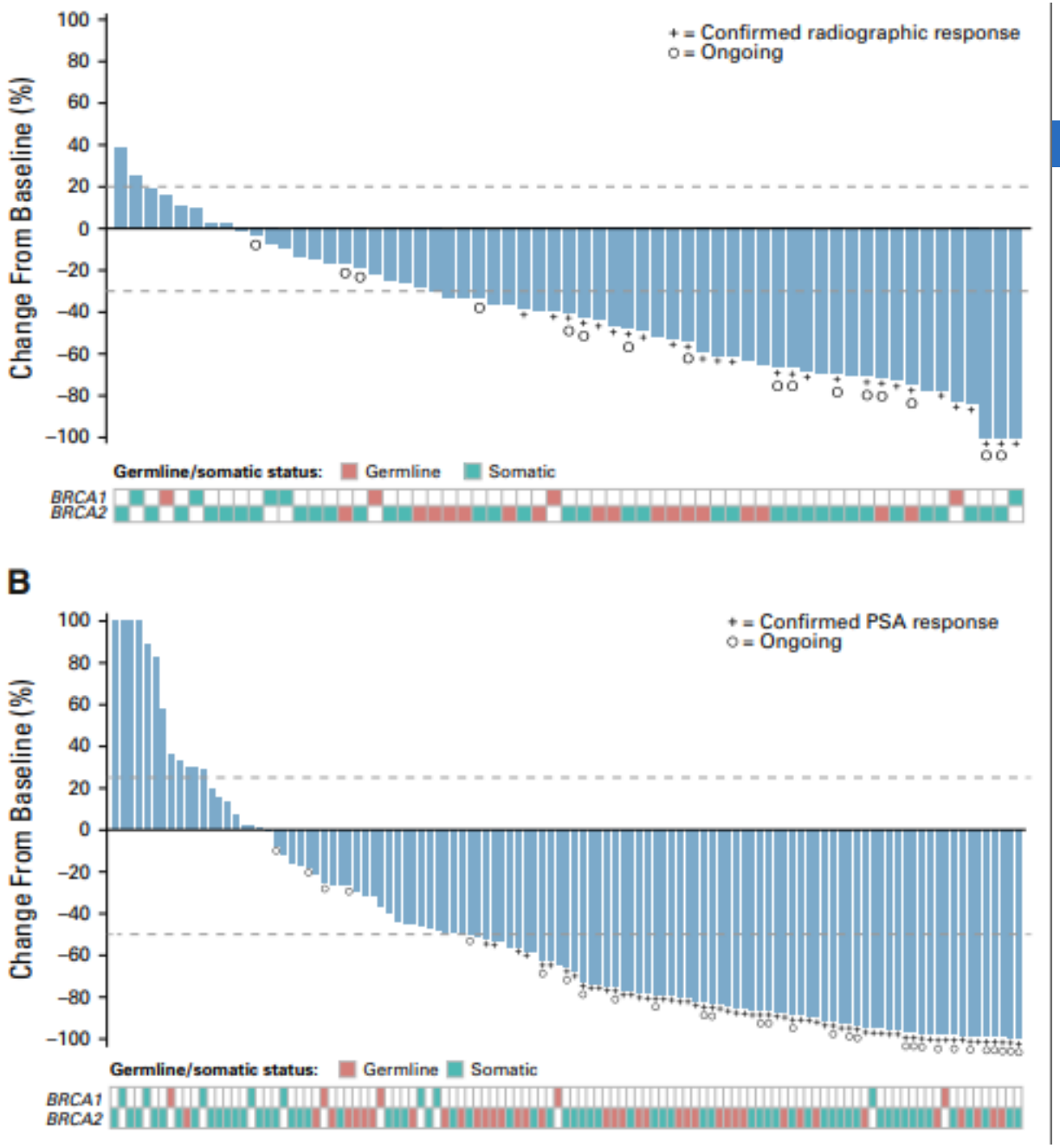


OS in cohort B (other mutations)

Hussain M, et al.
NEJM 2020; 383:2345

Rucaparib in mCRPC with BRCA alterations

Abida W, et al.
JCO 2020; 38:3763



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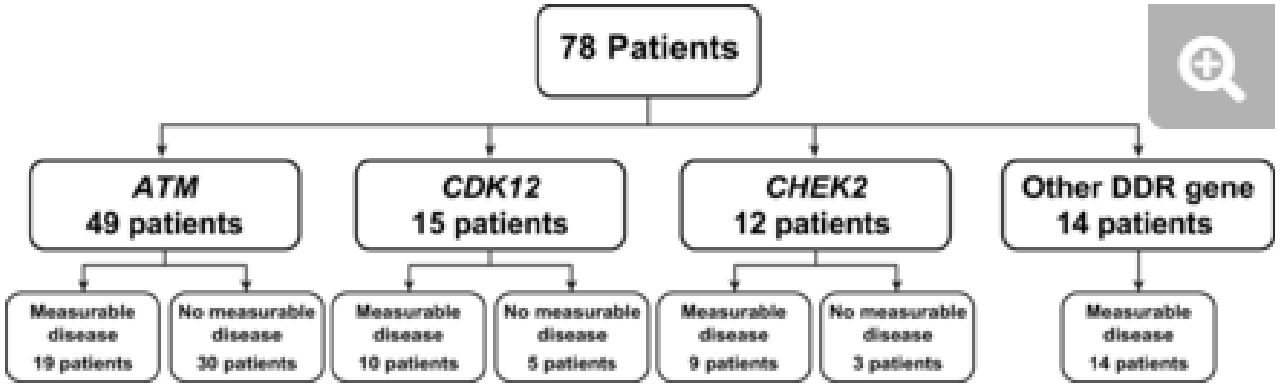
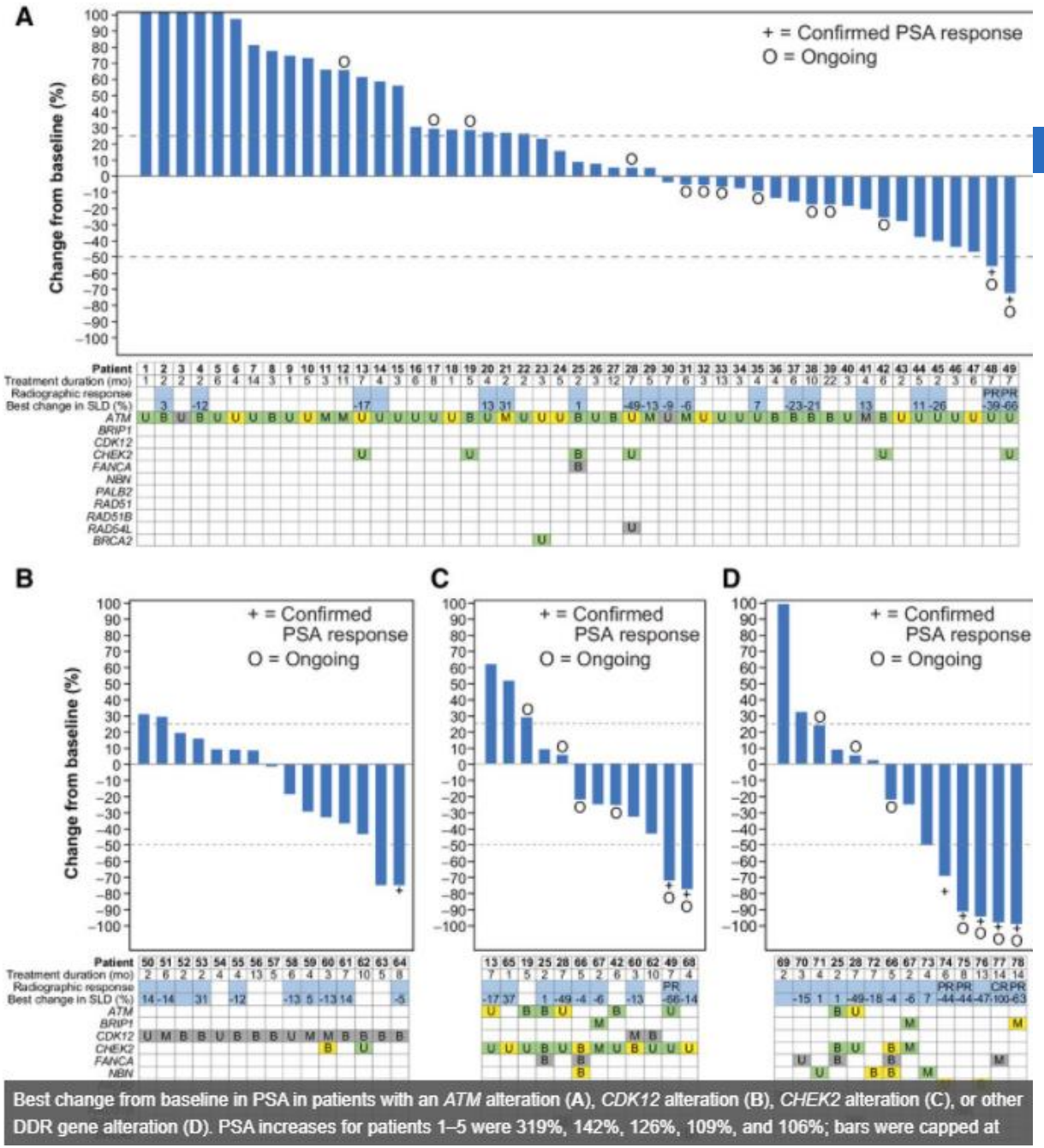
Rucaparib in men with non-BRCA DDR alterations



Abida W, et al. Clin Cancer Res 2020; 26:2487



Best change from baseline in PSA in patients with an *ATM* alteration (A), *CDK12* alteration (B), *CHEK2* alteration (C), or other DDR gene alteration (D). PSA increases for patients 1–5 were 319%, 142%, 126%, 109%, and 106%; bars were capped at

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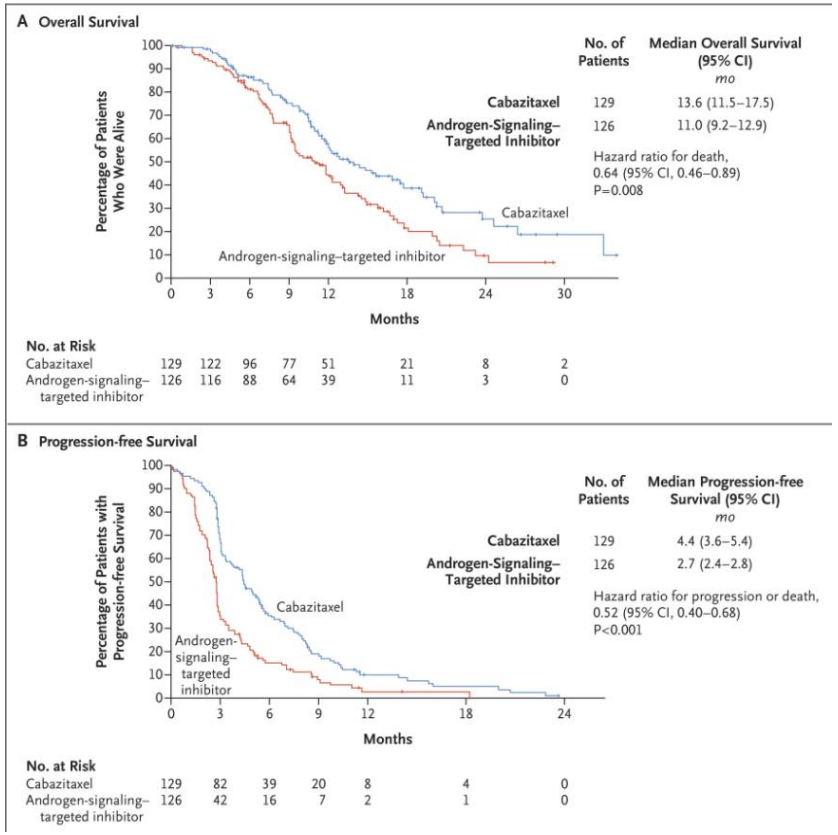
PARP inhibitors: moving into combinations and into localized disease

	Disease Stage	Agent	NCT
NRG-GU007	High risk localized	Niraparib (with definitive XRT + ADT)	NCT04037254
ASCLEPluS	High risk localized	Niraparib (with SBRT + ADT + abiraterone)	NCT04194554
PCCTC	Biochem recur	Olaparib + durvalumab	NCT03810105
ROAR	Biochem recur with “BRCAness”	Rucaparib	NCT03533946
COMRADE	mCRPC	Olaparib + radium223	NCT03317392
KEYLYNK-010	mCRPC	Olaparib + pembro	NCT03834519
PLATI-PARP	mCRPC, multi-pretreated	Rucaparib + Docetaxel + Carboplatin	NCT03442556
Bipolar UW	mCRPC	Olaparib + testosterone	NCT03516812
Javelin PARP medley	mCRPC	Talazoparib + avelumab	NCT03330405

CARD: cabazitaxel more effective than abi/enza (ASTI) post abi/enza

- Men previously treated with both docetaxel and abi or enza
  - Median age 70 (46-85)
  - 70% had pain progression
- ORR 37% cabazi, 12% ASTI
- Grade ≥ 3 Adverse events in 56.3% with Cabazi, 52.4% with ASTI
  - 44.7% grade 3+ neutropenia- 3.2% febrile
  - Grade 3+ Cardiac disorders 4.8% with ASTI



deWit R et al, NEJM 2019; 381:2506-18

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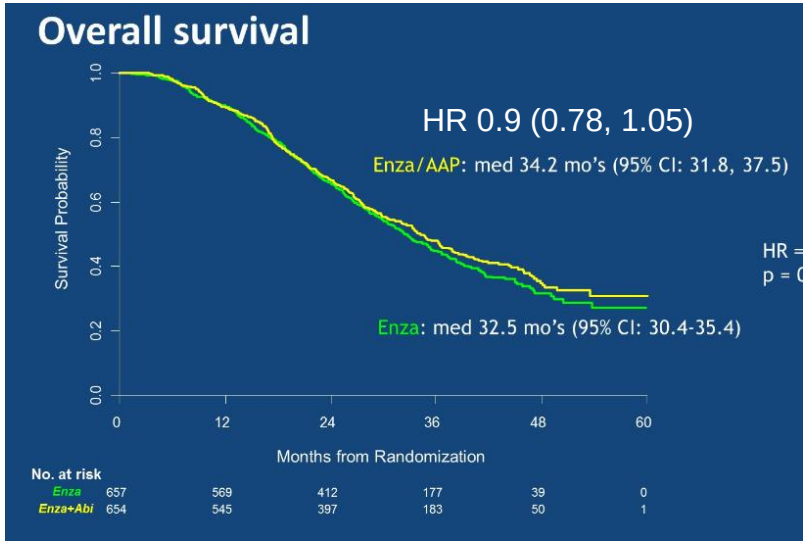
Combinations of ARTA have not been successful

- A031201 enza +/- abiraterone in mCRPC[1]
  - No diff in OS, higher rate grade 3-5 AEs on combination

- Neoadjuvant studies also confirm lack of added benefit from abiraterone + apalutamide[2,3]
  - 3% pCR rate with triple therapy, similar minimal residual disease rate[2]
  - 10% pCR with triplet vs 8% with doublet[3]



1. Morris MJ et al. ASCO 2019 abstr 5008 NCT01949337
2. Efstathiou E et al. J Clin Oncol 2020; abstr 5504
3. McKay R et al J Clin Oncol 2019; 37"923-31.

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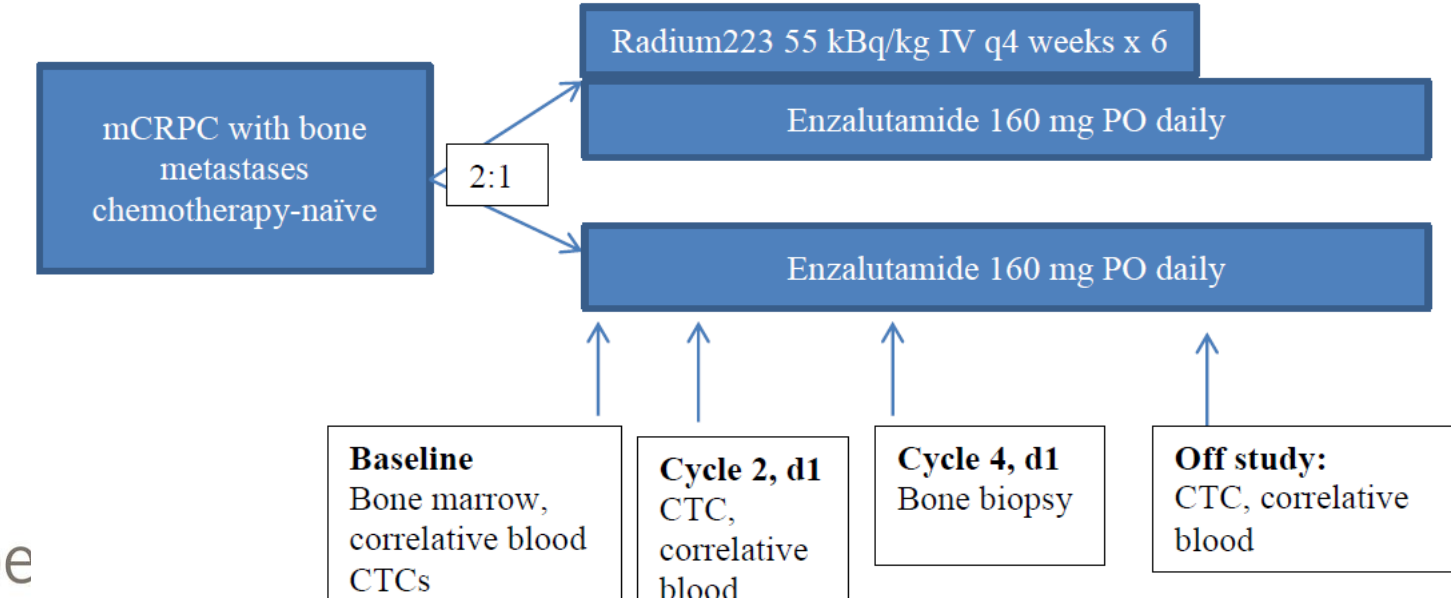
Combinations of ARTA with Radium223

- ERA223 identified increased fracture risk when abiraterone is used together with radium223[1]
  - No clinical benefit identified
- Shore et al (ASCO 2020) found this varied based on concurrent vs “layered” use[2]
  - Osteoporotic fractures; bone support mitigated the risk
- EORTC 1333/ PEACE III[3]
  - Excess fractures for combination of enza + rad223
  - bone support eliminated the increased risk
  - Unclear yet whether advantage for enza w/rad223

1. Smith M et al, Lancet Oncol 2019; 20:408-19.
2. Shore N et al, ASCO 2020 abstr
3. Tombal BF et al. ASCO 2019 abstr 5007 NCT02194842

Learning more about Radium223 in combination with enzalutamide: USC + CoH IIT

	Con	Pro	Plan
Does rad223 kill prostate cancer cells?	PSA doesn't always decline	Pain can improve, OS improved	Pathology: tumor infiltration, necrosis, ki67
Does rad223 activate immune system?	Via STAT3 could be pro-angiogenic immune suppress	Increased muc1, mhc etc due to tumor cell death	Flow cytometry, cytokines, immune infiltrates
Does rad223 impact bone health?	Reduced fractures in ALSYMPCA	Increased fractures ERA223, PEACE3	Pathology for osteoblast/ osteoclast activity



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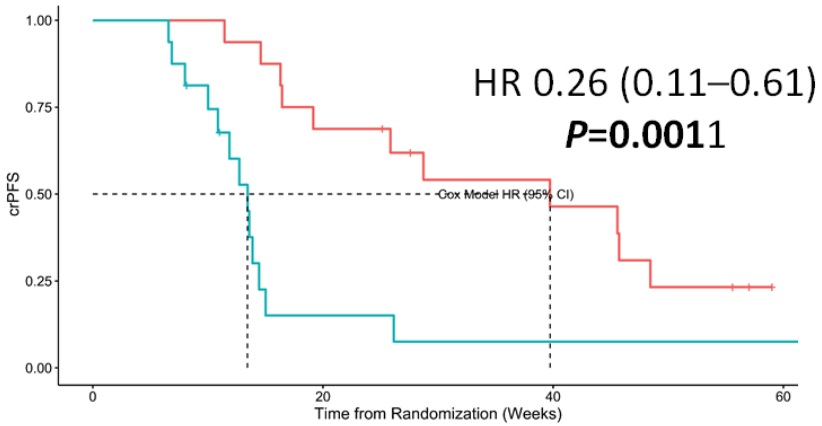
SipT + Radium223

Marshall CH et al. GU
ASCO abstr 2020

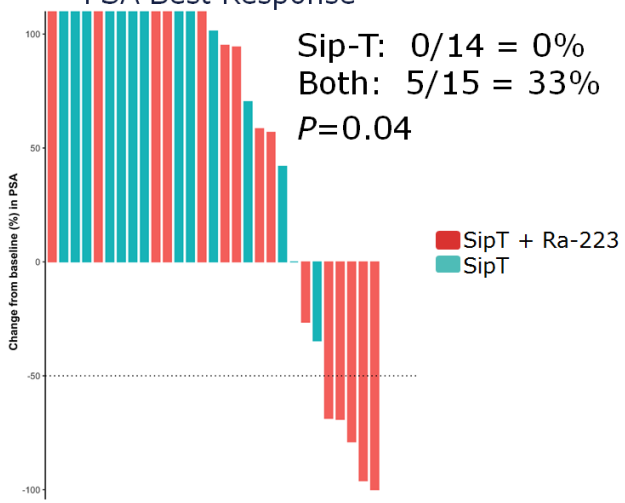
Time to radiographic/clinical progression



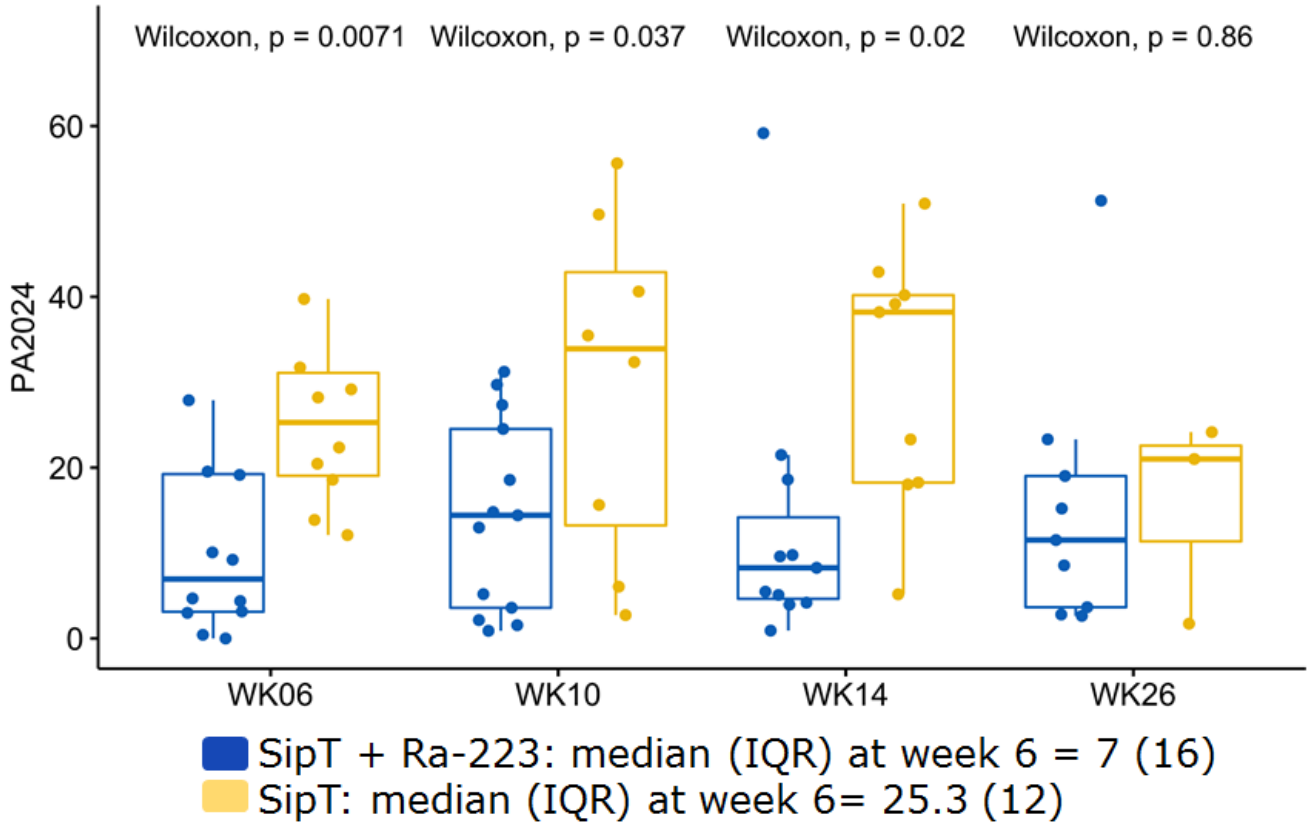
HR 0.26 (0.11–0.61)
***P*=0.0011**

SipT + Ra-223 (11 events): median 9.3 mo
SipT (14 events): median 3.1 mo

PSA Best Response



Sip-T: 0/14 = 0%
Both: 5/15 = 33%
P=0.04



SipT + Ra-223: median (IQR) at week 6 = 7 (16)
SipT: median (IQR) at week 6= 25.3 (12)

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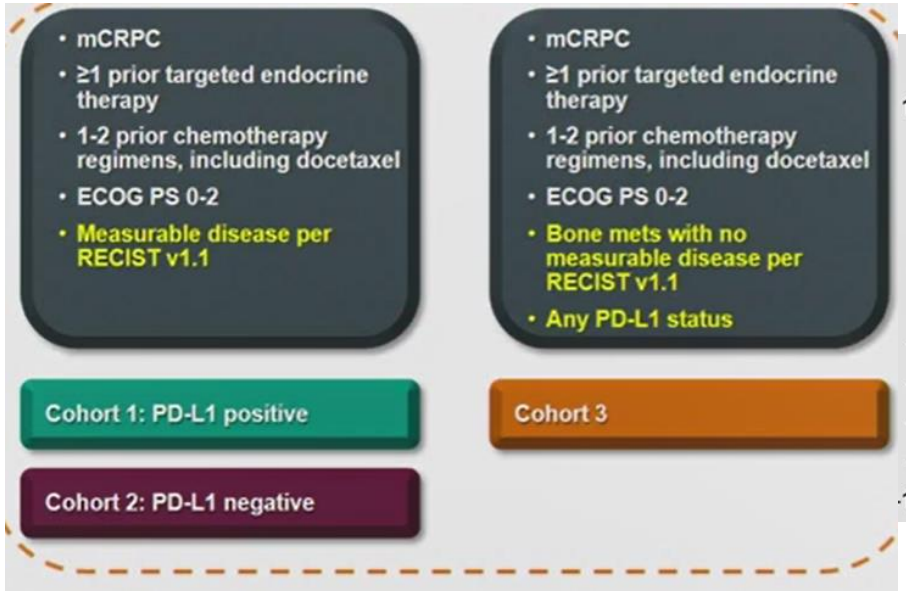
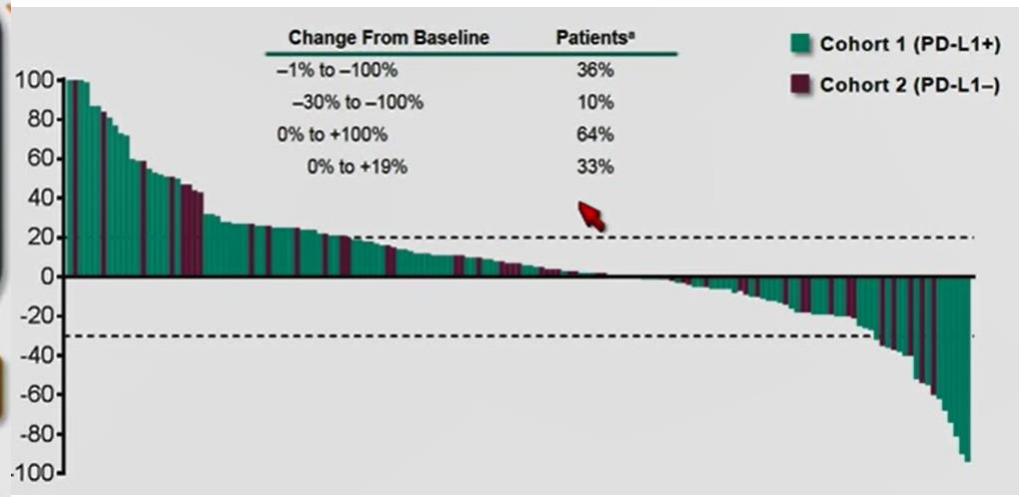
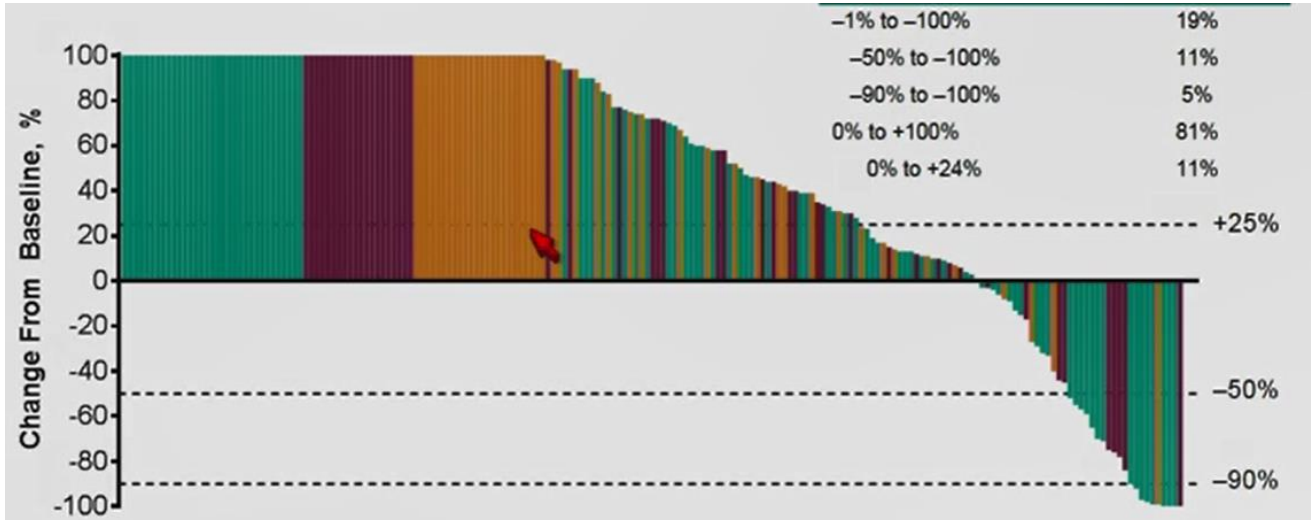
Immune checkpoint inhibitor therapy in mCRPC: Pembrolizumab (KEYNOTE-199)





Top right: objective response
Bottom right: PSA changes

DeBono JS. ASCO 2018; oral present



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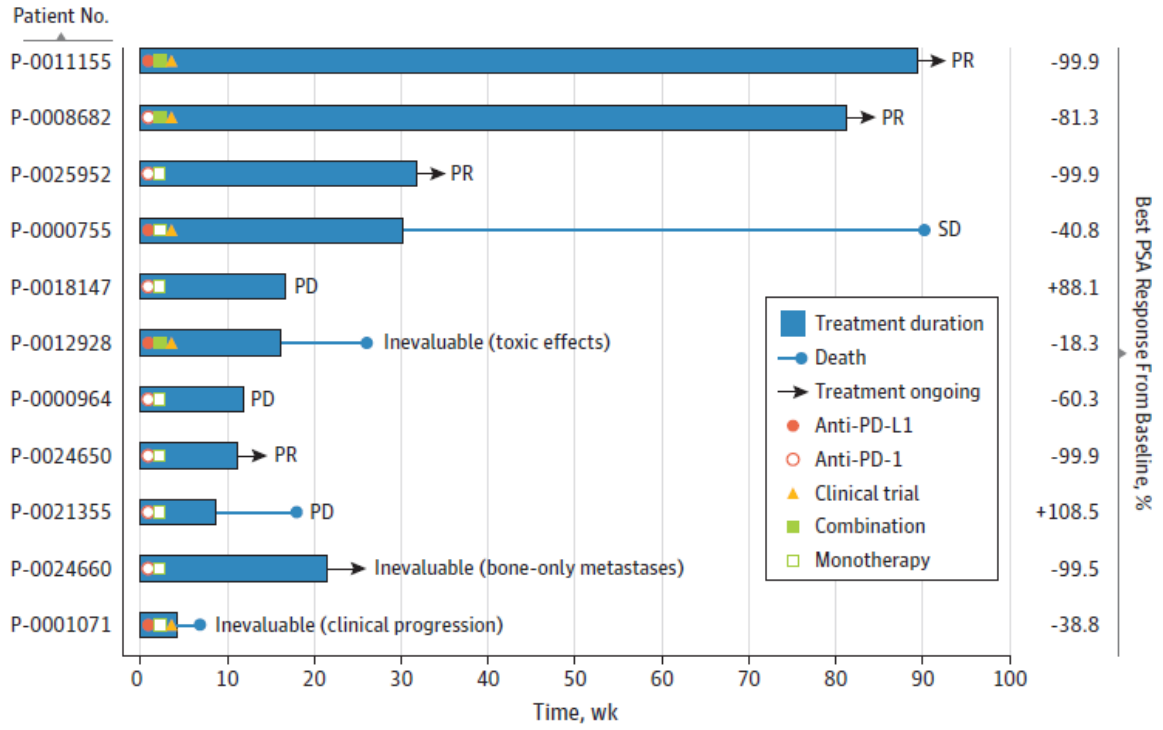
Immune checkpoint inhibitors in mCRPC: selcted by MSI

MSI is present in 3% of prostate cancers

Response to pembrolizumab about 50% (PSA, RECIST)



Abida W et al, JAMA Oncol 2019; 5:471-8

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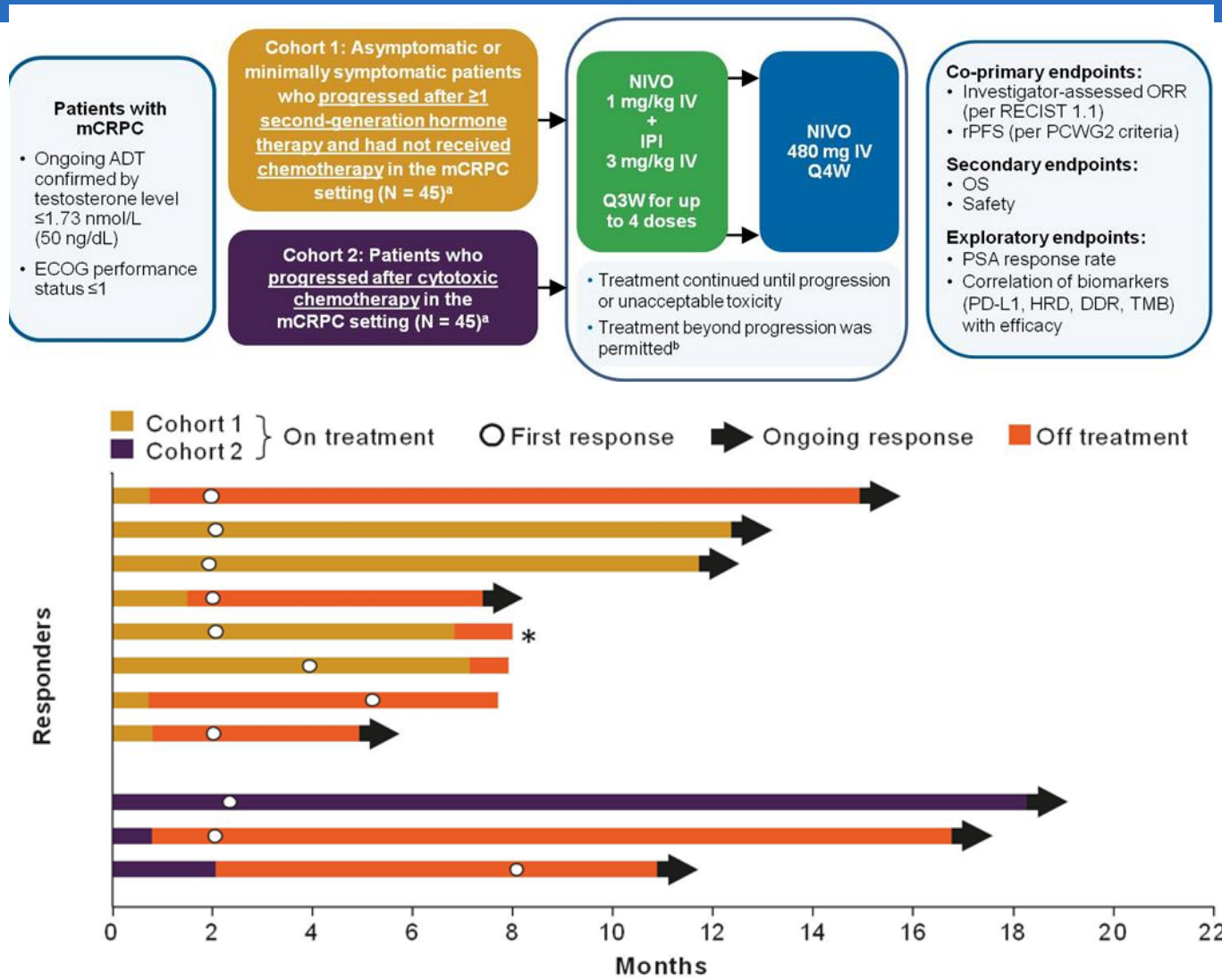
Combinations: checkpoint + checkpoint (Ipi + Nivo)

- <1/3 received all 4 induction doses
- Chemo naïve: 25% objective response with 2 (6%) CR
  - PSA response 17.6%
- Chemo pre-treated: 10% objective response, 2 (6.7%) CR
  - PSA response 10%
- **HRD+ had greater response**



Sharma P et al, Cancer Cell 2020; 38:489-99

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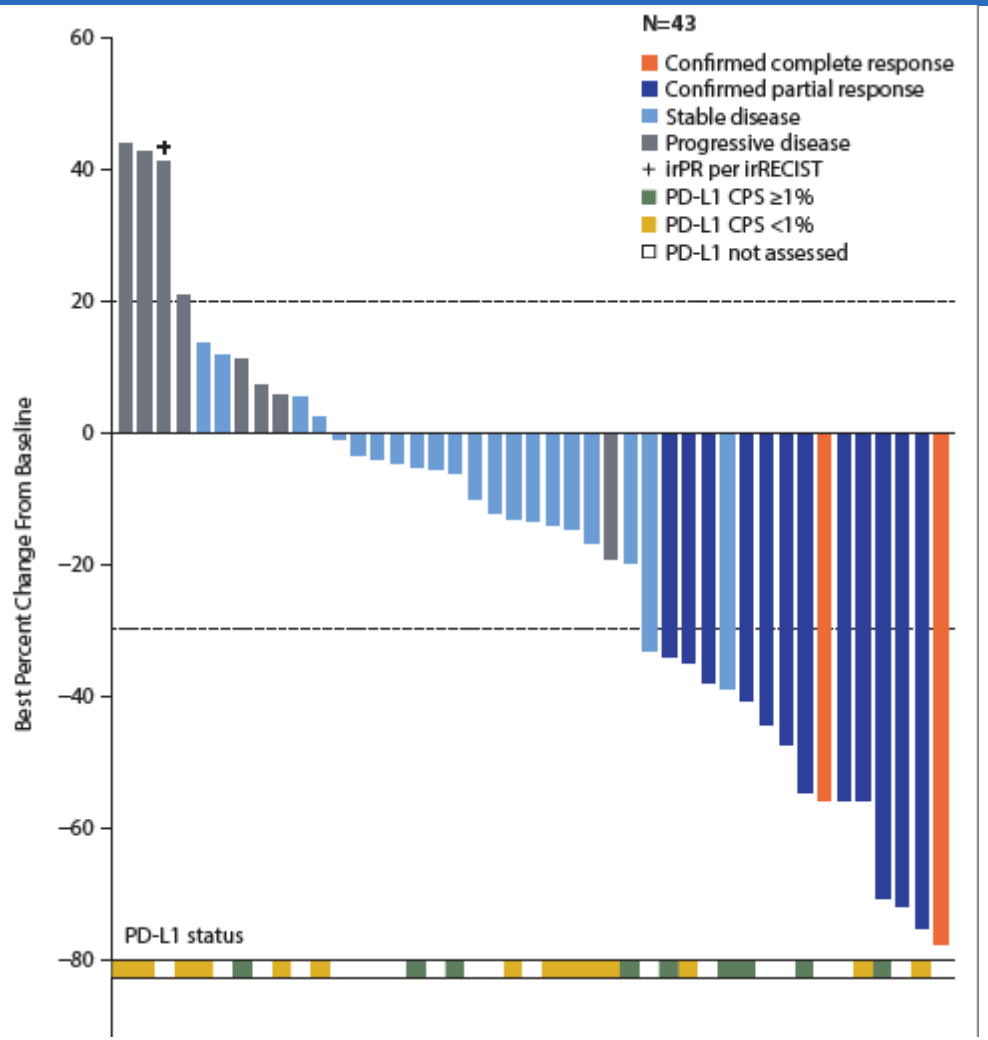
Cabozantinib + Atezolizumab



	CRPC Cohort (N=44)		
	Any Grade	Grade 3	Grade 4
Any AE, n (%)	42 (95)	25 (57)	1 (2.3)*
Fatigue	22 (50)	3 (6.8)	0
Nausea	19 (43)	0	0
Diarrhea	17 (39)	3 (6.8)	0
Decreased appetite	17 (39)	0	0
Dysgeusia	15 (34)	0	0
PPE	14 (32)	1 (2.3)	0
AST increased	11 (25)	2 (4.5)	0
Vomiting	11 (25)	1 (2.3)	0
ALT increased	8 (18)	2 (4.5)	0
Platelet count decreased	8 (18)	0	0
Weight decreased	8 (18)	0	0
White blood cell count decreased	7 (16)	2 (4.5)	0
Hypophosphatemia	7 (16)	1 (2.3)	0
Headache	7 (16)	0	0
Neutrophil count decreased	6 (14)	2 (4.5)	0
Hypertension	6 (14)	1 (2.3)	0
Stomatitis	6 (14)	1 (2.3)	0
Dysphonia	6 (14)	0	0
Hyponatremia	5 (11)	3 (6.8)	0
Arthralgia	5 (11)	1 (2.3)	0
Oral pain	5 (11)	0	0
Rash maculo-papular	5 (11)	0	0

Agarwal N et al. GU ASCO 2020 abstr 139

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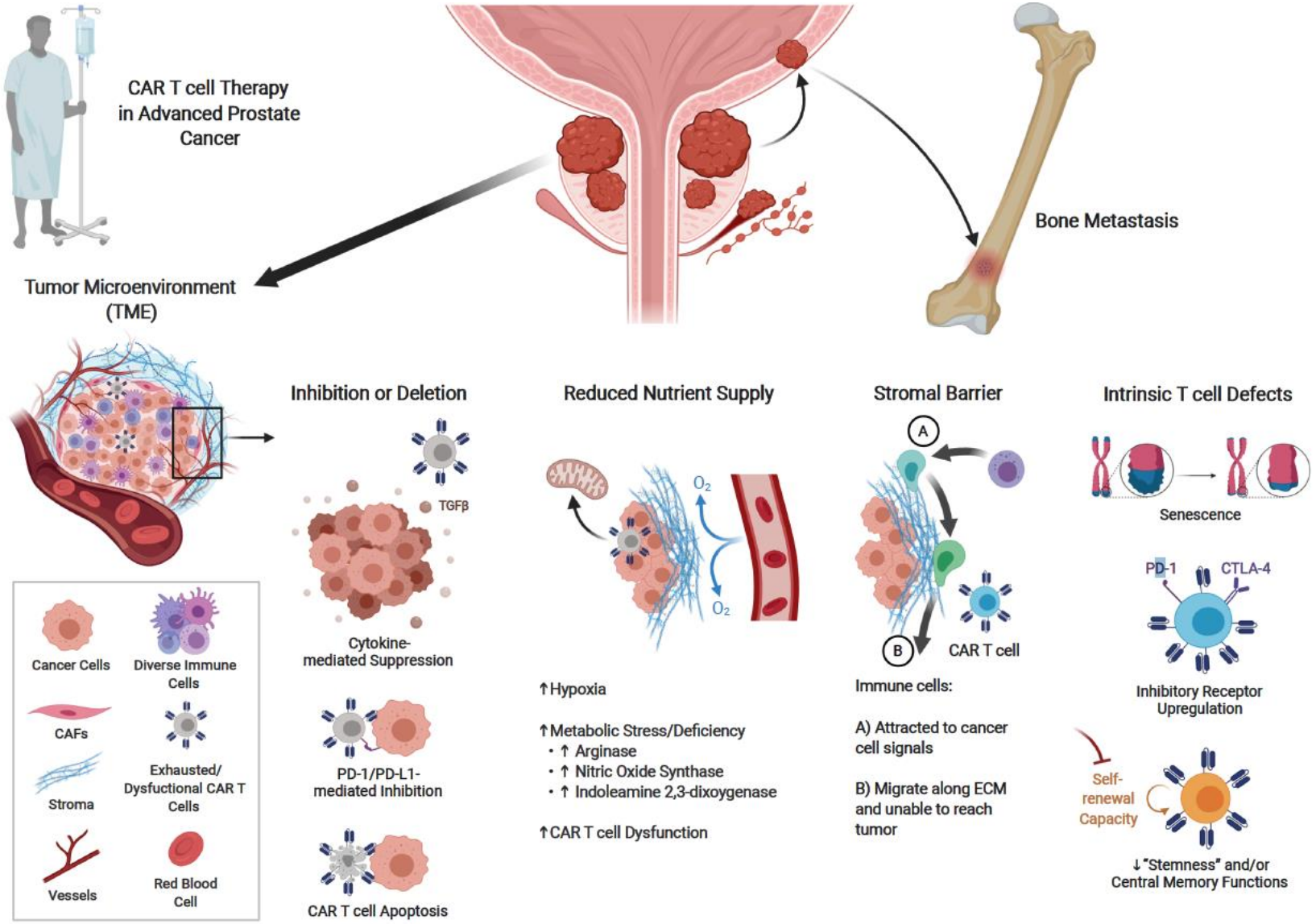
Prostate Cancer Challenges for Immunotherapy



TGFb negatively impacts T cell metabolism, differentiation and function (UPenn)

Persistence is problematic (?stem/memory selection)

Homing to tumor is critical (**COH future: add radiation?)**

MDSC: (**COH future – add STAT3 inhibitor**)

Dorff et al (in press, Clin Cancer Res)

Phase I Clinical Trial to Evaluate PSCA-BBζ CAR T Cells in mCRPC

- **PSCA+ metastatic castration resistant prostate cancer**
  (Clinical PI: Tanya Dorff, MD, Research PI: Saul Priceman, PhD) – enrolling

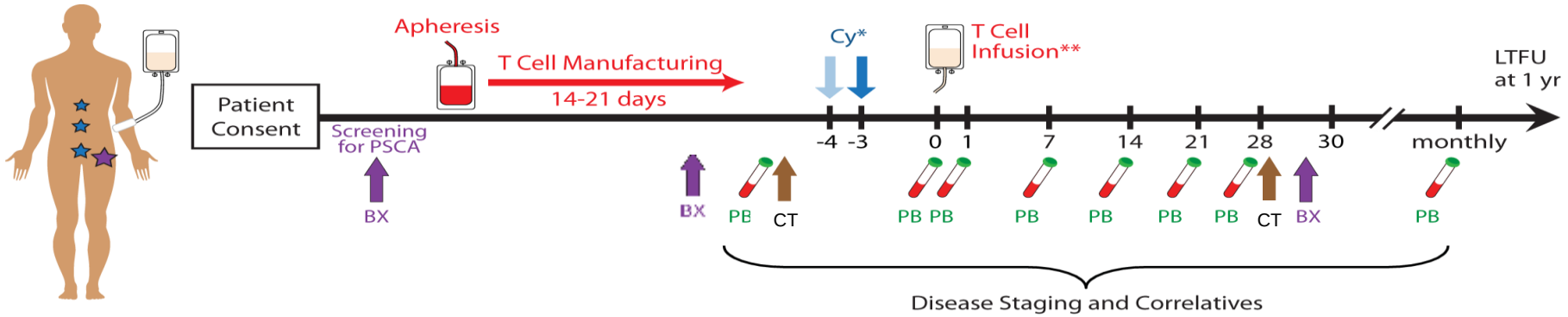


Table 1. CAR+ Cell Dose Schedule				
Dose -1	**Starting Dose 0a**	Dose 0b	Dose 1	Dose 2
50M	**100M**	100M +precond.	300M +precond.	600M + precond.

Cy* = cytoreductive chemotherapy
Bx = biopsy
PB = peripheral blood

Prostate Cancer Foundation Curing Together. Hope.

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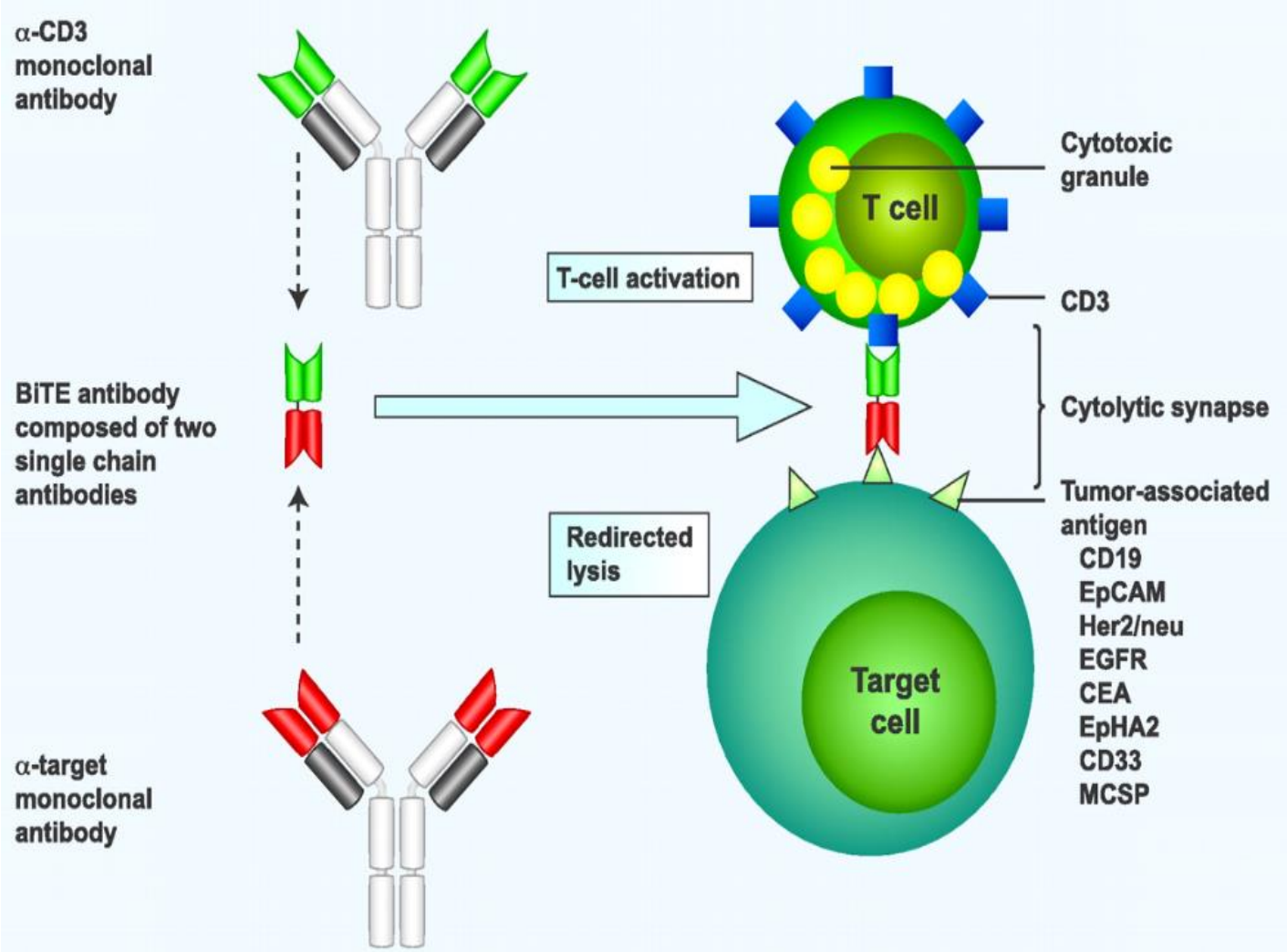
BiTE antibody therapy

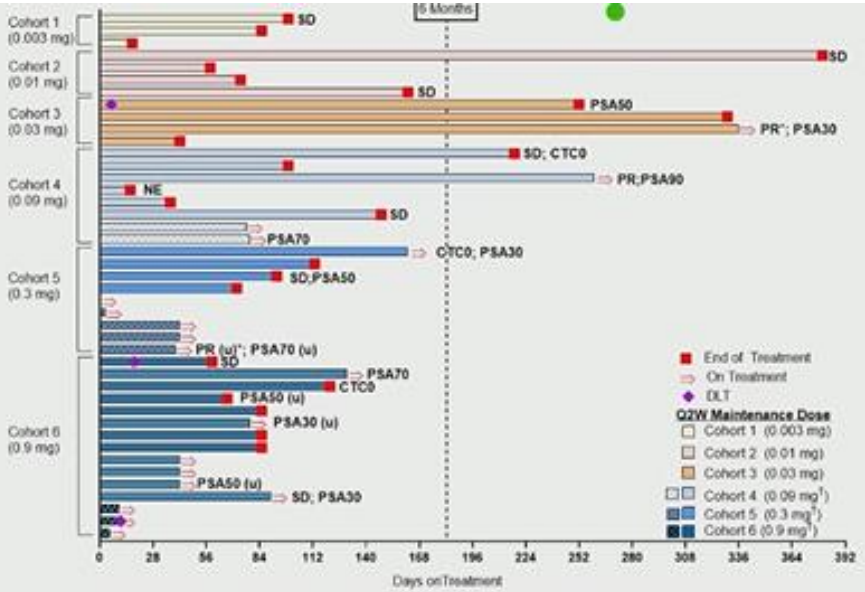
- Only approved BiTE is blinatumomab for ALL.
- AMG160 is half-life extended dual-targeted antibody to PSMA and CD3
  - Dosed every 2 weeks
- AMG509 is 3-headed (2 for target antigen
  - Dosed weekly



Efficacy Results AMG160 phase 1 (BiTE targeting PSMA)

PSA/CTC Responses (n = 13–35)	
Response	**All, n (%)**
PSA response, confirmed*	8 (27.6)
PSA response, unconfirmed†	4 (11.4)
CTC0 response‡	3 (23.1)

RECIST Responses (n = 15)	
Response	**All, n (%)**
Partial response, confirmed	2§ (13.3)
Partial response, unconfirmed	1§ (6.7)
Stable disease	8 (53.3)

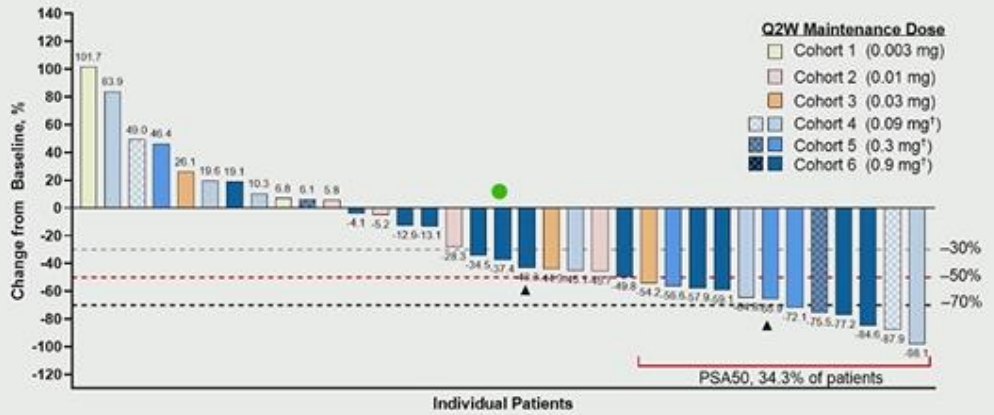


* ≥ 30% reduction based on 29 patients with 2 postbaseline PSA results
† ≥ 30% reduction based on 35 patients with measurable PSA at baseline
‡ Based on 13 patients with baseline CTC > 0 and postbaseline CTC assessment
§ 1 PR(u) and 1 PR confirmation occurred after 20 July 2020

CTC = circulating tumor cell; DLT = dose-limiting toxicities; NE = not evaluable; PSA = prostate-specific antigen; PR = partial response; Q2W = every 2 weeks; RECIST = Response Evaluation Criteria in Solid Tumors; SD = stable disease; (u) = unconfirmed
* PR occurred before but reported after 20 July 2020 data cutoff; PR (u) reported after 20 July 2020 data cutoff
† Checkered bars indicate cohorts with optimised cycle 1 priming strategies

10

- PSA reductions (best response) were dose dependent and occurred in 24/35 (68.6%) evaluable patients (20 July 2020)
- PSA reductions > 50% occurred in 12/35 (34.3%) evaluable patients



PSA = prostate-specific antigen; PSA50 = PSA decrease of ≥ 50%; Q2W = every 2 weeks
* Best PSA reductions at any time point in evaluable patients included those who had received ≥ 1 dose of AMG 160 and had measurable baseline PSA
† Checkered bars indicate cohorts with optimised cycle 1 priming strategies
▲ Indicates patient who had failed prior LuPSMA treatment

Tran B et al, ESMO 2020

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Conclusions

- mHSPC can be treated with much greater intensity to yield enhanced outcomes by adding abiraterone, enza/apa-lutamide, docetaxel +/- radiation to prostate primary
  - Additional agents in testing
- The future of CRPC will see further combinations and individualization, hopefully with molecular selection
  - Additional exciting new treatments coming: sabizabulin & PT-112
- Advanced immunotherapy (T cell centric) may overcome some of the immune resistance of prostate cancer
  - The hope is durable remissions