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1 **Addition of docetaxel to androgen deprivation therapy for patients with hormone-**
2 **sensitive, metastatic prostate cancer: a systematic review and meta-analysis.**

3

4 Marcello Tucci¹, Valentina Bertaglia¹, Francesca Vignani¹, Consuelo Buttigliero¹, Cristian
5 Fiori², Francesco Porpiglia², Giorgio Vittorio Scagliotti¹ and Massimo Di Maio¹

6

7 ¹Division of Medical Oncology, Department of Oncology, University of Turin, San Luigi
8 Gonzaga Hospital, Orbassano, Turin, Italy.

9 ²Division of Urology, Department of Oncology, University of Turin, San Luigi Gonzaga
10 Hospital, Orbassano, Turin, Italy.

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21 **Corresponding author:**

22 Prof. Massimo Di Maio
23 Department of Oncology
24 University of Turin
25 San Luigi Gonzaga Hospital
26 Regione Gonzole 10, 10043 Orbassano (TO), Italy
27 Phone: +39 011 9026017
28 Fax: +39 011 9015184
29 Email: massimo.dimaio@unito.it

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31

32 **Abstract**

33 **Context:** Several randomized clinical trials (RCTs) have recently tested the early addition
34 of docetaxel to androgen deprivation therapy (ADT) in hormone-sensitive, metastatic
35 prostate cancer.

36 **Objective:** To perform a systematic review and meta-analysis of RCTs evaluating the
37 combination of docetaxel and ADT in hormone-sensitive, metastatic prostate cancer.
38 Primary endpoint was overall survival (OS). Secondary endpoint was progression-free
39 survival. Exploratory subgroup analysis according to high-volume vs. low-volume disease
40 was performed.

41 **Evidence acquisition:** A systematic review of PubMed/Medline, Embase, and
42 proceedings of main International meetings was performed in June 2015 and updated in
43 August 2015. Three trials were selected for inclusion.

44 **Evidence synthesis:** Overall, 2951 patients were included in the 3 trials. Two trials
45 enrolled only metastatic patients, while in the third trial 61% were metastatic: overall,
46 metastatic patients were 2262 (951 docetaxel+ADT, 1311 ADT alone). Most patients had a
47 good performance status. In metastatic patients, the addition of docetaxel was associated
48 with improved OS (hazard ratio [HR] 0.73, 95%CI 0.60–0.90, $p=0.002$), with non significant
49 heterogeneity among the 3 trials. Considering the whole study population (2951 patients),
50 addition of docetaxel was associated with a similar OS improvement (HR 0.74, 95%CI
51 0.61–0.91, $p=0.003$). Although with limited statistical power, no significant interaction was
52 demonstrated between the addition of docetaxel and the high or low volume of disease
53 ($p=0.5$). The addition of docetaxel was associated with improvement in progression-free
54 survival (metastatic patients: HR 0.63, 95%CI 0.57–0.70, $p<0.001$).

55 **Conclusions:** This meta-analysis shows a significant OS benefit from concomitant
56 administration of docetaxel and ADT in patients with metastatic, hormone-sensitive
57 prostate cancer.

58 **Patient summary:** We synthesized the evidence available about the early administration
59 of docetaxel in patients starting hormonal treatment for metastatic prostate cancer. Based
60 on results of this meta-analysis, we believe that the combination of chemotherapy and
61 hormonal treatment should be considered in fit patients.

62

63

64 Introduction

65 Prostate cancer is the second most frequently diagnosed cancer in men and is the
66 second leading cause of cancer death in male patients in United States and Europe [1].
67 Although localized prostate cancer may be successfully treated with radical prostatectomy
68 and external beam radiation, many patients will subsequently develop metastatic disease
69 [2]. In addition, in the United States, the proportion of patients presenting with advanced
70 stage at first diagnosis of prostate cancer is 4-5% for distant disease and 10-12% for
71 regional disease [3]. Androgen deprivation therapy (ADT) by medical or surgical castration
72 is the mainstay of treatment for locally advanced and metastatic prostate cancer, because
73 androgen receptor (AR) pathway plays a key role in the development and progression of
74 prostate cancer cells [4]. Although ADT is able to induce biochemical and clinical response
75 in more than 90% of patients, after a median of 24-36 months patients experience
76 progression to castration-resistant prostate cancer (CRPC), despite persisting low
77 testosterone levels [5].

78 Until very recently, chemotherapy with docetaxel has been the only effective
79 treatment for CRPC patients. In detail, the randomized clinical trial (RCT) TAX327
80 demonstrated that docetaxel plus prednisone prolonged overall survival (OS) compared to
81 mitoxantrone plus prednisone [6]. Another RCT, the SWOG-9916 study, also
82 demonstrated that the treatment with docetaxel, estramustine and dexamethasone
83 increased median OS by two months compared to mitoxantrone and prednisone [7].
84 Based on these results, docetaxel was the first cytotoxic drug to demonstrate an
85 improvement in OS in prostate cancer. More recently, several new agents, able to modify
86 the natural history of disease, have been introduced in clinical practice. Results from
87 phase III trials have demonstrated the efficacy of two new-generation hormonal therapies
88 (abiraterone [8] and enzalutamide [9]), an immunotherapy (sipuleucel-T [10]), a new

89 microtubule-targeting chemotherapy (cabazitaxel [11]) and an alpha-emitter (radium 223
90 [12]), all able to prolong OS.

91 Nowadays, progression of CRPC is known to be due to the onset of a number of
92 resistance mechanism induced by the selective pressure of endocrine therapy [13-18].
93 Castration is able to induce clonal selection and subsequent growth of androgen-
94 independent cellular clones [19]. Hormone-sensitive prostate cancer should be considered
95 a heterogeneous disease, characterized by the coexistence of both AR-positive and AR-
96 negative tumor cells.

97 In this biological context, patients with hormone-sensitive prostate cancer may
98 benefit of chemotherapy in association with endocrine therapy, targeting also AR-negative
99 cells and delaying the development of resistance mechanisms. In the “pre-docetaxel” era,
100 several RCTs investigated the combination of endocrine therapy with other cytotoxic drugs
101 in hormone-sensitive prostate cancer patients, but none of these studies showed a
102 significant and convincing advantage [20,21]. In the last two years, the results of three
103 different clinical trials (GETUG-AFU 15 [22], CHAARTED – E3805 [23] and STAMPEDE
104 [24]), that investigated the combination of docetaxel and ADT in hormone sensitive
105 disease, have been made available to scientific community.

106 The aim of this systematic review is to conduct a meta-analysis of RCTs that
107 evaluated the combination of docetaxel with ADT vs. ADT alone, in hormone-sensitive
108 metastatic prostate cancer, in order to assess the impact of this therapeutic option in terms
109 of overall survival.

110

111 Evidence acquisition**112 Identification of eligible trials**

113 Full protocol of the review is available on request from the corresponding author.

114 Search was performed in June 2015 and updated in August 2015, to identify all

115 randomized trials testing the addition of docetaxel to ADT in patients with hormone-naive

116 metastatic prostate cancer. Literature search was performed using PubMed, EMBASE,

117 Medline, Cochrane Library. The following key-words were used: (*prostate cancer*) AND

118 *docetaxel* AND (*random**). References of the selected articles were also checked to

119 identify further eligible trials. Furthermore, proceedings of the main International meetings

120 (American Society of Clinical Oncology [ASCO] annual meeting, ASCO Genitourinary

121 symposium, European Society of Medical Oncology, European Association of Urology),

122 were searched from 2010 onwards for relevant abstracts. Trials enrolling both patients with

123 metastatic disease and patients without metastases were eligible (details about subgroups

124 were collected as specified below). Trials enrolling only patients without metastases

125 [25,26] were excluded. When more than one report was available describing results of the

126 same trial, the most recent information (corresponding to a longer follow-up and a higher

127 number of events) was considered in the analysis.

128

129 Data collection and study quality

130 For each eligible trial, the following data were collected, if available:

131 • main inclusion criteria: age, performance status, stage, Gleason score, prostate-

132 specific antigen (PSA) at randomization, presence of visceral metastases,

133 volume (high vs. low) of metastatic disease, previous treatments;

134 • details of study treatment: type of ADT allowed, schedule and number of cycles of

135 docetaxel planned in experimental arm, timing of docetaxel start compared to ADT

- 136 initiation in experimental arm, number of docetaxel cycles actually administered
137 (median, range), proportion of patients completing planned docetaxel cycles,
138 proportion of patients needing dose reduction of docetaxel;
- 139 • study design: primary endpoint, study hypothesis;
 - 140 • patients' enrolment and follow-up: date of start and date of end of accrual; number
141 of patients assigned to experimental arm (docetaxel + ADT), number of patients
142 assigned to control arm (ADT alone), median follow-up;
 - 143 • Overall survival [OS]: number of deaths in each arm, median OS, hazard ratio with
144 95% confidence interval, p value, details of subgroup analysis of metastatic patients
145 (for trials enrolling both M0 and M1 patients), details of subgroup analysis in "high-
146 volume" patients and "low-volume" patients;
 - 147 • Progression-free survival [PFS]: number of events in each arm, median PFS,
148 hazard ratio with 95% confidence interval, p value, details of subgroup analysis of
149 metastatic patients (for trials enrolling both M0 and M1 patients).

150 For each study, the quality of the randomization process was evaluated based on the
151 information available in the publication [22, 23] or in the study protocol [24].

152

153 ***Statistical Methods***

154 After data were abstracted, analysis was performed the Review Manager (RevMan
155 5.3) software. In all the trials included, efficacy data were analysed from all randomly
156 assigned patients on an intention-to-treat basis. Primary endpoint of the meta-analysis was
157 overall survival. Secondary endpoint was biochemical progression-free survival (bPFS).
158 Definition of bPFS was different in the three trials and is reported in **Supplemental table**
159 **A1**.

160 For both overall survival and bPFS, summary measure was hazard ratio (with 95%
161 confidence interval). A random-effects model was applied. Statistical heterogeneity
162 between studies was examined using the χ^2 test and the I^2 statistic.

163 Main analysis was performed considering the 3 comparisons of docetaxel + ADT vs.
164 ADT alone. In one trial [24], a further experimental arm was reported, testing the addition
165 of docetaxel + zoledronic acid to ADT alone. Since the addition of zoledronic acid alone
166 did not show any significant efficacy compared to ADT, we decided to perform an
167 exploratory analysis adding also this comparison to the analysis of docetaxel. However,
168 since that trial used the same control arm for the two comparisons (docetaxel + ADT vs.
169 ADT alone, and docetaxel + zoledronic acid + ADT vs. ADT alone), the weight of each
170 comparison was reduced according to a correction factor equal to the number of events
171 actually observed in the trial, divided by the number of events taken into account in the
172 analysis (where the control arm was counted twice). This correction resulted in a
173 prudential increase in the width of the confidence interval for the estimated hazard ratio of
174 each comparison.

175 For overall survival, the subgroup analysis of patients according to disease volume
176 (“high-volume” vs “low-volume”) was available for two of the three trials [27,23]. In both
177 trials, “high-volume” disease was defined as the presence of at least 4 bone lesions and at
178 least 1 lesion in any bone beyond the spine / pelvis, or the presence of visceral
179 metastasis. Patients without these conditions were classified as “low-volume”. No
180 subgroup analysis of progression-free survival according to disease volume was available.

181

182 ***Role of funding source***

183 There was no funding source for this review. All authors had full access to all the
184 data and the corresponding author (MDM) had final responsibility for the decision to submit
185 for publication.

186

187 **Evidence synthesis**

188 ***Characteristics and quality of the trials***

189 The selection process of trials eligible for the meta-analysis is reported in **Supplemental**
190 **Figure 1**. In the search updated in August 2015, out of the 466 papers published *in*
191 *extenso*, 464 were excluded, while two (GETUG-AFU 15 and CHAARTED – E3805) were
192 found eligible for inclusion [22, 23]. One further eligible trial (STAMPEDE) was found
193 searching the proceedings of the main International meetings [24]. Furthermore, an
194 updated report of the already published GETUG-AFU 15 trial, with longer follow-up and a
195 higher number of events for analysis, was available [27].

196 Main characteristics of the three available trials are described in **Table 1**. In all the
197 trials, patients assigned to experimental arm received docetaxel 75 mg/m², for a maximum
198 of 6 [23,24] or 9 cycles [22]. The maximum interval since ADT start allowed to start
199 docetaxel ranged from 2 to 4 months: in the GETUG-AFU 15 trial about half of the patients
200 had started ADT within 15 days of enrolment [22]; in the CHAARTED – E3805 trial,
201 median time from ADT to randomization was slightly higher than 1 month in both arms
202 [23].

203 According to description available in the publication for 2 trials [22,23] and in the
204 study protocol for the third trial [24], quality of randomization process was judged adequate
205 in all the 3 trials.

206

207 ***Patients' characteristics***

208 Overall, 2951 patients were included in the 3 trials included in the meta-analysis,
209 1181 (40%) assigned to docetaxel + ADT, and 1770 (60%) assigned to ADT alone (**Table**
210 **2**). Main characteristics of the 2951 patients are described in **Table 2**. Patients were
211 enrolled between October 2004 and March 2013. Median age was 63-65 years, and most

212 of the patients had a good performance status. Two of the trials [22,23] enrolled only
213 metastatic patients, while in the STAMPEDE trial [24] metastatic patients were 61% of total
214 study population: overall, metastatic patients were 2262 (951 docetaxel+ADT, 1311 ADT
215 alone). Patients with metastatic disease at diagnosis were 71% in the GETUG-AFU 15 trial
216 and 73% in the CHAARTED – E3805 trial; 94% of patients enrolled in the STAMPEDE trial
217 had not received previous local therapy. Patients with high-volume disease were 48% in
218 the GETUG-AFU 15 trial, and 65% in the CHAARTED – E3805 trial; this information was
219 not available in the STAMPEDE trial.

220

221 ***Treatment compliance and toxicity***

222 Median number of docetaxel cycles actually administered was 8 in the GETUG-AFU
223 15 trial [22], 6 in the CHAARTED – E3805 [23] and 6 in the STAMPEDE trial [24].

224 Proportion of patients completing the planned number of cycles was 48% in the GETUG-
225 AFU 15 trial (9 planned cycles), 86% in the CHAARTED – E3805 trial (6 planned cycles)
226 and 76% in the STAMPEDE trial (6 planned cycles). Proportion of patients needing dose
227 reduction was 11% in the GETUG-AFU 15 trial and 26% in the CHAARTED –E3805 trial,
228 while this information was not available in the report of the STAMPEDE trial.

229 The most common adverse events reported with the addition of docetaxel were
230 haematologic toxicity (anemia, thrombocytopenia, neutropenia), fatigue, gastro-intestinal
231 toxicity (nausea, vomiting, constipation, diarrhea), alopecia, sensory neuropathy,
232 stomatitis/mucositis, nail changes and peripheral edema. In all the 3 trials, the addition of
233 docetaxel was associated to higher incidence of febrile neutropenia: 8%, 6% and 12% in
234 the GETUG-AFU 15, in the CHAARTED – E3805 and in the STAMPEDE trial, versus 0%,
235 not reported and 1% with ADT alone in the 3 trials respectively.

236

237 ***Overall survival***

238 Number of events and OS data reported in each trial are summarized in **Table 3**.
239 Overall, 916 deaths were recorded for the main comparison (docetaxel + ADT vs. ADT
240 alone) in metastatic patients. As shown in **Figure 1 (panel A)**, the addition of docetaxel to
241 ADT in metastatic patients was associated with a statistically significant benefit in overall
242 survival (hazard ratio [HR] 0.73, 95% confidence interval [CI] 0.60 – 0.90, $p = 0.002$).
243 There was no evidence of statistically significant heterogeneity among the three trials ($p =$
244 0.15 , $I^2 = 48\%$). In the whole study population, including also the minority of non-metastatic
245 patients (**Figure 1, panel B**), the addition of docetaxel to ADT was associated with a
246 similar, statistically significant benefit in overall survival (HR 0.74, 95% CI 0.61 – 0.91, $p =$
247 0.003). Very similar results were obtained in the exploratory analysis including also the
248 docetaxel + zoledronic acid arm of the STAMPEDE trial: HR 0.74 (95%CI 0.63 – 0.88,
249 $p < 0.001$) considering only metastatic patients (**Figure 1, panel C**), HR 0.76 (95%CI 0.64 –
250 0.89 , $p = 0.001$) in all patients (**Figure 1, panel D**).

251 Subgroup analysis was performed for metastatic patients with “high-volume” and
252 “low-volume” disease enrolled in the GETUG-AFU 15 and in the CHAARTED – E3805 trial
253 (**Figure 2**). The test for difference of efficacy among the two subgroups did not
254 demonstrate a statistically significant interaction ($p = 0.5$). Hazard ratio for the addition of
255 docetaxel to ADT was 0.67 (95% CI 0.51 – 0.88) in patients with “high-volume” disease
256 and 0.80 (95% CI 0.49 – 1.32) in patients with “low-volume” disease.

257

258 ***Progression-free survival***

259 As shown in **Figure 3 (panel A)**, the addition of docetaxel to ADT in metastatic
260 patients was associated with a statistically significant benefit in progression-free survival
261 (HR 0.63, 95% CI 0.57 – 0.70, $p < 0.001$), without significant heterogeneity among the
262 three trials ($p = 0.7$, $I^2 = 0\%$). The same benefit was shown considering the whole study
263 population, including the minority of patients without metastases (HR 0.63, 95% CI 0.57 –

264 0.70, $p < 0.001$) (**Figure 3, panel B**). Very similar results were obtained in the exploratory
265 analysis including also the docetaxel + zoledronic acid arm of the STAMPEDE trial: HR
266 0.63 (95%CI 0.56 – 0.70, $p < 0.001$) in metastatic patients (**Figure 3, panel C**), HR 0.63
267 (95%CI 0.57 – 0.70, $p < 0.001$) in all patients (**Figure 3, panel D**).

268

269 **Conclusions.**

270 This meta-analysis shows that the addition of docetaxel to ADT in patients with
271 metastatic, hormone-sensitive prostate cancer is associated with a significant
272 improvement in overall survival and progression-free survival.

273 A quantitative synthesis of the evidence currently available about this treatment
274 strategy can be really helpful for clinical decisions, because three recent, different phase III
275 trials (GETUG-AFU-15 [22,27], CHAARTED – E3805 [23], STAMPEDE [24]) tested the
276 activity of docetaxel in combination with endocrine therapy in the “early” setting of
277 hormone-sensitive prostate cancer. To the best of our knowledge, there are no other trials
278 conducted with docetaxel in the same setting, and this meta-analysis represents the
279 synthesis of all the evidence produced to date. Notably, in GETUG-AFU-15 trial, the first
280 trial to be published, the concomitant administration of docetaxel with ADT versus ADT
281 alone did not show a significant impact in terms of OS [22, 27]. On the contrary,
282 CHAARTED – E3805 trial showed a significant OS improvement for ADT plus docetaxel
283 [28], adding fuel to the scientific debate about the opportunity of this therapeutic option in
284 hormone-sensitive prostate cancer patients. In our meta-analysis, that also included the
285 recent results of the “third- comer”, the STAMPEDE trial [24], the addition of docetaxel to
286 ADT in metastatic patients was associated with a statistically significant increase in overall
287 survival, with a moderate, non significant heterogeneity among the three available RCTs.
288 Of note, the absence of statistical heterogeneity increases the validity of the result,
289 allowing a global, unambiguous interpretation of all the evidence available. Of course, a
290 meta-analysis based on individual patient data (IPD) would represent the best synthesis of
291 evidence, allowing for data checking, updated follow-up compared to publications,
292 calculation and comparison of times to events, and for investigation of treatment
293 heterogeneity in subgroups [29]. However, in the absence of IPD meta-analysis, a meta-

294 analysis based on abstracted data can be considered an acceptable surrogate, allowing a
295 timely synthesis of all the available trials.

296 The efficacy showed by docetaxel in combination with ADT in hormone-sensitive
297 patients is not surprising due to strong biological basis. Recent evidences show that one of
298 the mechanisms responsible for progression from hormone-sensitive to castration-
299 resistant phase of disease is the clonal selection and proliferation of pre-existing AR-
300 independent cells, able to survive in a low androgen levels environment [19]. Therefore it
301 is reasonable to assume that, since its onset, prostate cancer is a heterogeneous disease
302 where coexist AR-positive and AR-negative cells [19, 30]. Both these cellular clones are
303 likely involved in progression to castration-resistant disease [19]. Docetaxel administration
304 concurrent to ADT in hormone-sensitive prostate cancer patients allows to inhibit the
305 growth of the pre-existing AR-insensitive clones, killing these cells earlier when they are
306 still a small number and before the development of multiple escape mechanisms.
307 Moreover, preclinical data show that the adaptive response to ADT by prostate cancer
308 cells is mediated by both ligand-dependent AR activation and ligand-independent AR
309 activation and by mechanisms of progression bypassing AR signaling [19,31]. Taxanes are
310 able to interfere with several steps of these resistance mechanisms. Emerging preclinical
311 data demonstrated that taxanes could inhibit AR signaling pathway [32]. In fact, these
312 cytotoxic drugs interfere with polymerization of microtubules, blocking AR nuclear
313 translocation and AR-induced gene expression [32,33]. Therefore docetaxel could act
314 synergistically with endocrine therapy, because it impairs AR activity [32,33]. Additionally,
315 chemotherapy may also kill cells that escape ADT through activation of AR-independent
316 survival pathways [34].

317 From a clinical point of view, there are several potential advantages in administering
318 chemotherapy to metastatic prostate cancer patients in an early phase of disease. In the
319 hormone-sensitive setting, patients are, on average, in better clinical conditions compared

320 to castration-resistant setting, due to lower burden of disease. Consequently, they are able
321 to better tolerate chemotherapy and to maintain adequate drug dose intensity. Moreover, a
322 greater number of patients is eligible for chemotherapy; in the castration-resistant setting,
323 on the contrary, a relevant number of patients cannot receive chemotherapy, due to
324 worsening of performance status and clinical conditions.

325 Our meta-analysis shows an improvement in OS that is not only statistically
326 significant, but also clinically relevant. The addition of docetaxel to ADT is associated with
327 a 27% reduction in the risk of death of metastatic patients (Hazard Ratio 0.73), and the
328 reduction in the risk of death is as high as 33% in patients with high-volume disease
329 (Hazard Ratio 0.67). In absolute terms, such a benefit is rarely obtained in the setting of
330 advanced solid tumors: difference in median OS for metastatic patients was more than 13
331 months in the CHAARTED – E3805 trial [23], and 18 months in the STAMPEDE trial [24].
332 Much smaller benefits have been often judged sufficient to change clinical practice in
333 metastatic prostate cancer, as well as in other settings. However, we recognize that a
334 careful selection of patients to be treated with up-front docetaxel is essential for a
335 favorable benefit / risk ratio. Subgroup data of the CHAARTED trial had suggested that the
336 benefit associated with concomitant administration of docetaxel with ADT, at least in early
337 analysis, was more pronounced in patients with “high-volume” disease than in patients
338 with “low-volume” disease [28, 23]. Definition of “high-volume” disease follows previous
339 robust data showing that, in patients with hormone-sensitive disease, the presence of
340 extensive disease (visceral metastases or appendicular skeletal involvement) is related to
341 a worse prognosis [35-37]. In both the CHAARTED – E3805 (based on a prospective
342 definition) and the GETUG-AFU 15 (based on a retrospective assessment), “high-volume”
343 disease was defined as the presence of visceral metastases or the presence of at least 4
344 bone lesions, with 1 or more lesions in any bone beyond the spine / pelvis. However,
345 based on subgroup data available for those 2 trials [23, 27], we performed an exploratory

346 analysis of treatment efficacy according to disease volume: although the statistical test for
347 interaction is characterized by a limited statistical power, we did not demonstrate a
348 significant interaction between disease volume and treatment efficacy. Importantly, this
349 absence of significant interaction does not allow to state that the addition of docetaxel to
350 ADT is not effective in patients with low-volume metastatic disease. A longer follow-up with
351 a higher number of events in these latter patients, together with the availability of this
352 subgroup analysis also in the STAMPEDE trial, could increase the statistical power of the
353 analysis. With the currently available evidence, however, no definitive statement can be
354 made about the interaction between docetaxel efficacy and disease volume.

355 With the exception of a subgroup of patients eligible for the STAMPEDE trial, the
356 majority of patients included in the 3 trials had metastatic disease. Other trials have tested
357 the efficacy of the addition of docetaxel to androgen deprivation therapy in patients with
358 high-risk, localized prostate cancer [25,26]. However, the definition of the role of docetaxel
359 in patients with high-risk, localized prostate cancer is beyond the scope of this meta-
360 analysis.

361 Of course, particular attention should be given to toxicity associated with
362 combination treatment. In the experimental arm of GETUG-AFU 15 study, four treatment-
363 related deaths were reported (one due to febrile neutropenia, one neutropenia with
364 infection, one multiorgan failure, and one pulmonary embolism), compared to no
365 treatment-related deaths with ADT alone [22]. In CHAARTED – E3805 trial, only one
366 treatment-related death (sudden death) occurred in combination arm [23]. Although these
367 numbers, overall considered, are quite reassuring, it is well known that patients enrolled in
368 clinical trials are selected compared to all patients treated in daily clinical practice, in terms
369 of age, performance status, comorbidities. For instance, patients older than 70 years are a
370 relevant proportion of those treated in clinical practice, but were quite under-represented in

371 the 3 trials. In the CHAARTED trial, subgroup analysis according to age supports
372 docetaxel efficacy also in elderly patients, but they represented only 23% of total study
373 population [23]. Although a potential explanation is that the age of metastatic presentation
374 of patients eligible for these 3 trials could be younger than the whole population of patients
375 with new diagnosis of earlier stage prostate cancer, we believe that the main reason for
376 the under-representation of elderly patients in the trials included in this meta-analysis is
377 the selection bias, because patients had to be fit enough to receive chemotherapy with
378 docetaxel [38]. In any case, chemotherapy toxicity is often worse in the “real world”
379 population, compared with the toxicity reported in clinical trials. Therefore, clinicians must
380 properly take into account some relevant clinical factors (performance status, concomitant
381 diseases) before considering the addition of docetaxel to ADT, in order to reduce the risk
382 of severe toxicity, that could negatively affect quality of life and, in worst cases, survival.

383 In conclusion, our meta-analysis clearly shows a significant impact on overall
384 survival with the concomitant administration of docetaxel and androgen-deprivation
385 treatment in patients with metastatic, hormone-sensitive prostate cancer patients.
386 Considering the absence of heterogeneity among the available trials, and the balance
387 between magnitude of efficacy and risk of toxicity, combination of chemotherapy and
388 hormonal treatment should be reasonably offered to patients with metastatic disease, if
389 judged eligible for chemotherapy. Higher statistical power would be needed to better
390 understand the interaction, if any, between the efficacy of docetaxel and the volume of
391 disease.

392

393 **Figure legends.**

394

395 **Figure 1.** Forest plots of hazard ratios for overall survival from three randomized trials of
396 docetaxel added to androgen-deprivation therapy (ADT), compared with ADT alone, in
397 patients with advanced, hormone-sensitive prostate cancer. Pooled HRs were computed
398 using random-effect models. The bars indicate 95% confidence intervals (CI). Panel A
399 (only metastatic patients) and panel B (all randomized patients) consider only comparisons
400 between docetaxel + ADT vs. ADT alone. Panel C (only metastatic patients) and panel D
401 (all randomized patients) show a sensitivity analysis considering also the comparison of
402 docetaxel + zoledronic acid + ADT vs. ADT alone in the STAMPEDE trial.

403

404 **Figure 2.** Forest plots of hazard ratios for overall survival (subgroup analysis according to
405 disease volume: patients with “high-volume” disease and patients with “low-volume”
406 disease) in two randomized trials of docetaxel added to androgen-deprivation therapy
407 (ADT), compared with ADT alone, in patients with metastatic, hormone-sensitive prostate
408 cancer. Pooled HRs were computed using random-effect models. The bars indicate 95%
409 confidence intervals (CI). Definition of “high-volume” disease and “low-volume” disease is
410 detailed in the text.

411

412 **Figure 3.** Forest plots of hazard ratios for biochemical progression-free survival from three
413 randomized trials of docetaxel added to androgen-deprivation therapy (ADT), compared
414 with ADT alone, in patients with advanced, hormone-sensitive prostate cancer. Pooled
415 HRs were computed using random-effect models. The bars indicate 95% confidence
416 intervals (CI). Panel A (only metastatic patients) and panel B (all randomized patients)
417 consider only comparisons between docetaxel + ADT vs. ADT alone. Panel C (only

418 metastatic patients) and panel D (all randomized patients) show a sensitivity analysis
419 considering also the comparison of docetaxel + zoledronic acid + ADT vs. ADT alone in
420 the STAMPEDE trial.

421

422 **Supplemental Figure 1.** Selection process of randomized trials eligible for inclusion in
423 the meta-analysis.

424

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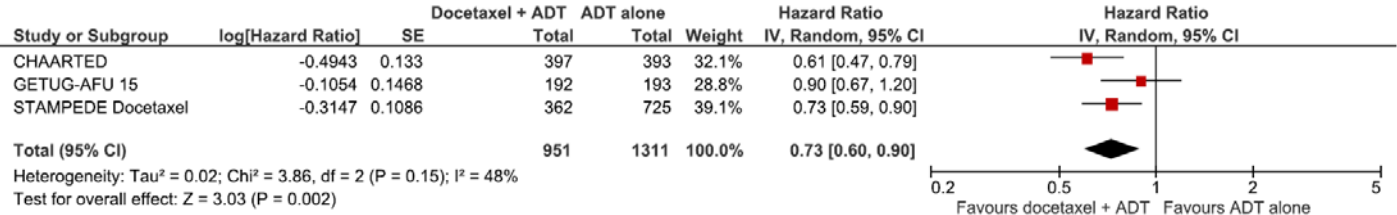
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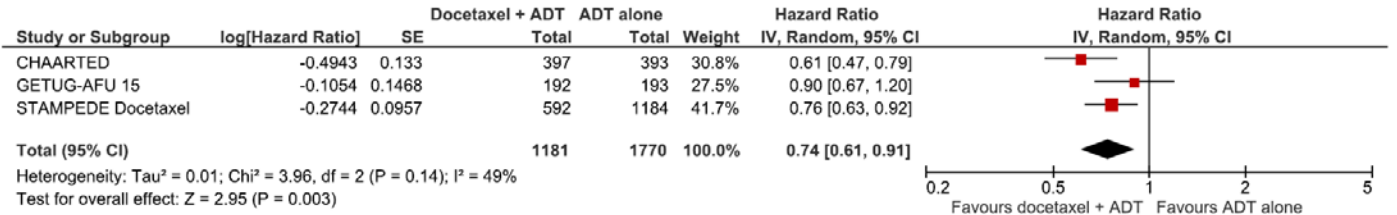
A

**Outcome: overall survival
(only metastatic patients)**



B

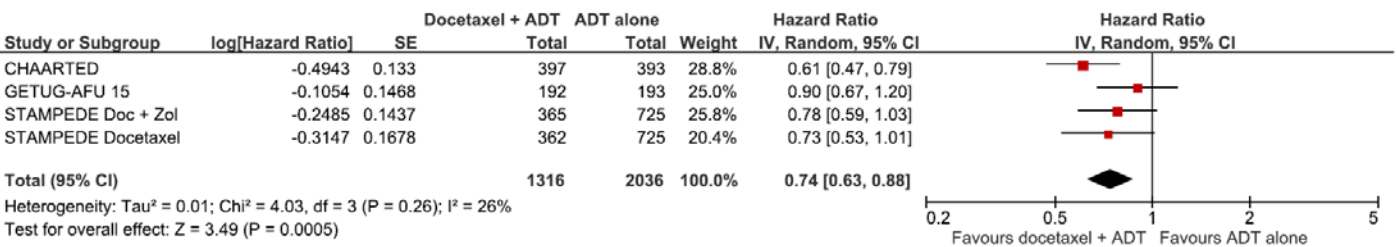
**Outcome: overall survival
(all randomized patients)**



C

**Outcome: overall survival
(only metastatic patients)**

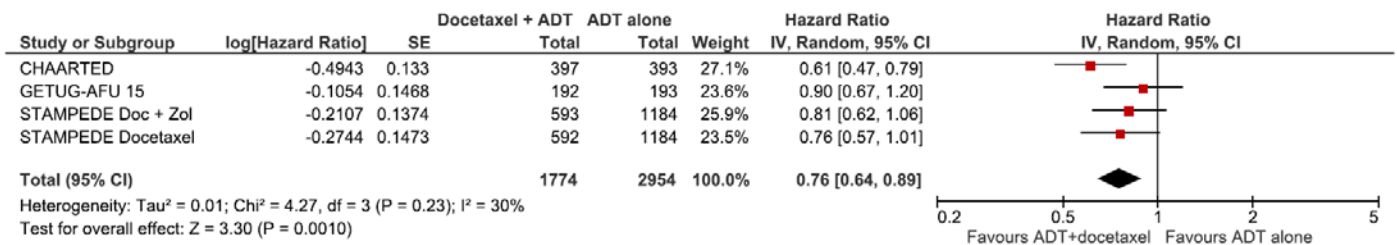
Sensitivity analysis including the docetaxel + zoledronic acid arm

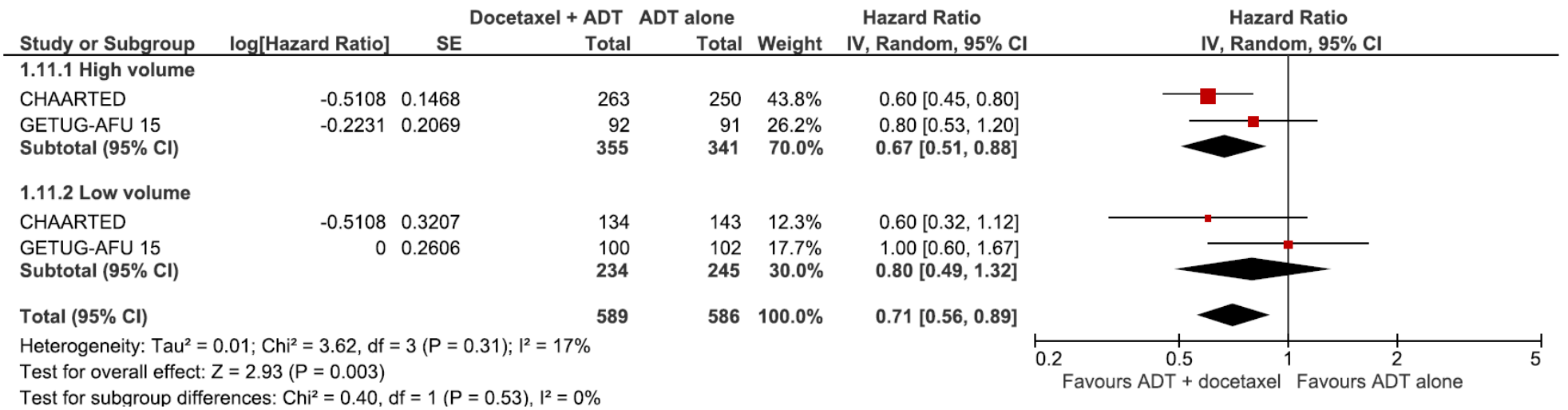


D

**Outcome: overall survival
(all randomized patients)**

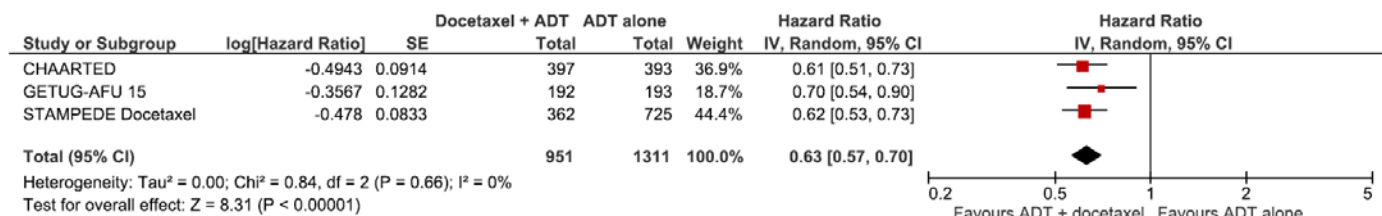
Sensitivity analysis including the docetaxel + zoledronic acid arm





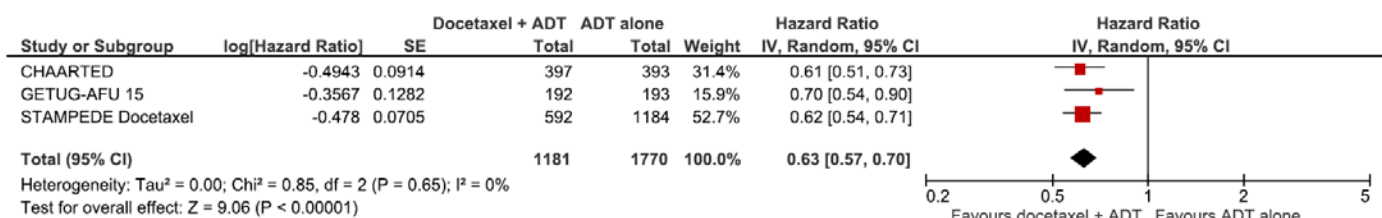
A

**Outcome: progression-free survival
(only metastatic patients)**



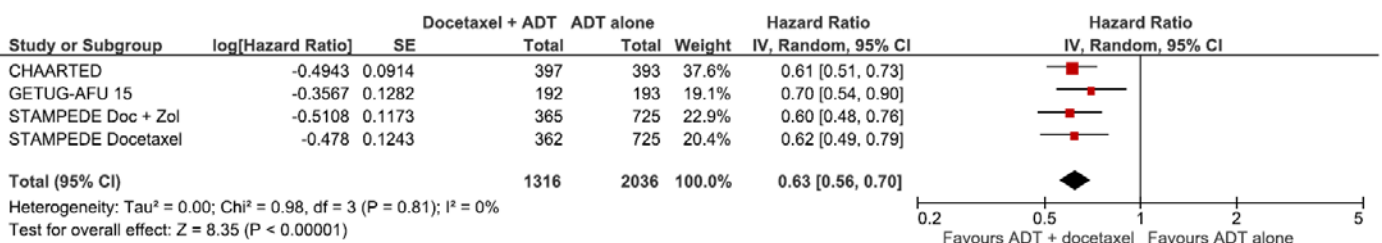
B

**Outcome: progression-free survival
(all randomized patients)**



C

**Outcome: progression-free survival
(only metastatic patients)
*Sensitivity analysis including the docetaxel + zoledronic acid arm***



D

**Outcome: progression-free survival
(all randomized patients)
*Sensitivity analysis including the docetaxel + zoledronic acid arm***

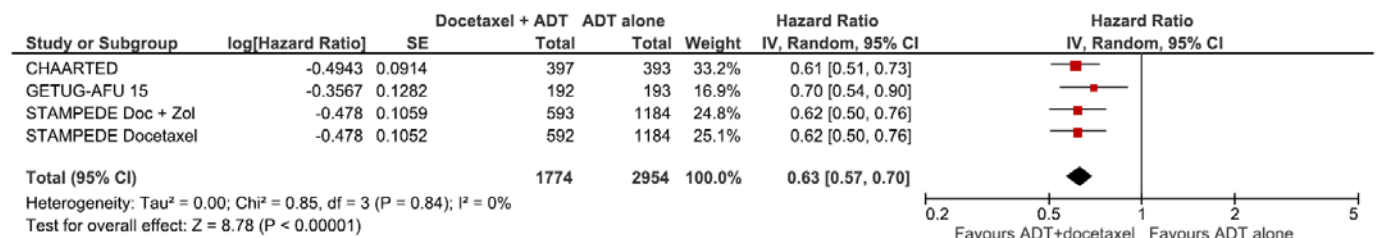


Table 1. Characteristics of the 3 trials included in the meta-analysis

	GETUG-AFU 15 [22,27]	CHAARTED – E3805 [23]	STAMPEDE [24]
Main inclusion criteria			
Age	Older than 18. No upper limit declared in the methods.	Both younger than 70 and older than 70 were eligible (stratification criteria).	Not specified.
Performance status	Karnofsky \geq 70	ECOG 0-2 (2 only if due to prostate cancer) (0-1 vs 2 stratification criteria)	WHO 0-2
Stage	Metastatic prostate cancer (High-volume vs low-volume assessed retrospectively)	Metastatic prostate cancer (High-volume vs low-volume stratification criteria)*	Prostate cancer if metastatic, node-positive or \geq 2 among: <ul style="list-style-type: none"> • Stage T3/T4 • PSA \geq40ng/ml • Gleason 8-10
Previous treatment	Previous chemotherapy for metastatic disease was not allowed. In the neoadjuvant and adjuvant settings or in the context of isolated PSA increase, previous chemotherapy or ADT, or both, were allowed, with the condition that the treatment had been discontinued at least 12 months before inclusion in the study.	No prior docetaxel was allowed. Adjuvant ADT was allowed, but $<$ 24 months (\leq 12 months vs $>$ 12 months stratification criteria) and interval between end of adjuvant treatment and progression $>$ 12 months.	Prior chemotherapy was not allowed. Long-term anti-androgen therapy was not allowed. Short periods of prior anti-androgens to cover tumour flare were allowed. Adjuvant or neo-adjuvant hormone therapy had to be completed at least 12 months before the trial, and duration of therapy had to be no longer than 12 months.

(table continues in next page)

Table 1. (continued)

	GETUG+AFU 15 [22,26]	CHAARTED – E3805 [23]	STAMPEDE [24]
Treatment			
ADT (both arms)	Orchiectomy or LHRH agonists, alone or combined with non-steroidal antiandrogens	Medical or surgical castration. Use of a nonsteroidal antiandrogen at the time of initiation of therapy was at the discretion of the investigator..	LHRH analogues or LHRH antagonists, or bilateral orchidectomy according to local practice
Docetaxel (experimental arm)	Docetaxel (75 mg/m ² i.v. day 1 q3w); up to 9 cycles. Standard corticosteroids premedication, no daily prednisone.	Docetaxel (75 mg/m ² i.v. day 1 q3w); up to 6 cycles. Standard dexamethasone premedication, no daily prednisone.	Docetaxel (75 mg/m ² i.v. day 1 q3w); up to 6 cycles. Standard dexamethasone premedication, daily prednisolone 10 mg.
Timing of treatment	Docetaxel within 2 months of ADT start.	Docetaxel within 4 months of ADT start.	Randomization within 12 weeks of ADT start.
Study design			
Primary endpoint	Overall survival	Overall survival	Overall survival
Hypothesis	Increase in 3-yr OS from 50% to 65%	33% increase in median OS (from 33 to 44 months in high-volume, from 67 to 89 months in low-volume)	25% increase in overall survival.
Patients' enrollment and follow-up			
Accrual start	October 2004	July 2006	October 2005
Accrual stop	December 2008	November 2012	March 2013
Number of patients			
ADT alone	193	393	1184

ADT + docetaxel	192	397	592
ADT + docetaxel + zoledronic acid			593
Median follow-up	82.9 months	28,9 months	n.a.

ADT: androgen-deprivation treatment; ECOG: Eastern Cooperative Oncology Group; WHO: World Health Organization; PSA: prostate-specific antigen; LHRH: luteinizing hormone – releasing hormone; OS: overall survival; n.a.: not available.

**after amendment. In the initial protocol version, only high-volume patients were eligible.*

Table 2. Main characteristics of enrolled patients

	GETUG-AFU 15 [22,27]	CHAARTED – E3805 [23]	STAMPEDE [24] (whole trial*)
Age	ADT alone: Median 64 years (IQR 58-70)	ADT alone: Median 63 years (range 39-91)	Median 65 years (range 40-84)
	ADT +docetaxel: Median 63 years (IQR 57-68)	ADT + docetaxel: Median 64 years (range 36-88)	
Performance status	ADT alone: Median Karnofsky 100% (IQR range 90%-100%)	ADT alone: ECOG 0: 69% ECOG 1: 29% ECOG 2: 1.5%	WHO PS0: 76% WHO PS1: 21% WHO PS2: 1%
	ADT+ docetaxel: Median Karnofsky 100% (IQR 90%-100%)	ADT + docetaxel: ECOG 0: 70% ECOG 1: 29% ECOG 2: 1.5%	
Gleason score	ADT alone (unknown 2/193): Gleason 2-6: 7% Gleason 7: 34% Gleason 8-10: 59%	ADT alone (unknown 46/393): Gleason 4-6: 6% Gleason 7: 24% Gleason 8-10: 70%	n.a.
	ADT+ docetaxel (unknown 5/192): Gleason 2-6: 10% Gleason 7: 35% Gleason 8-10: 55%	ADT + docetaxel (unknown 39/393): Gleason 4-6: 6% Gleason 7: 27% Gleason 8-10: 67%	
PSA at randomization	ADT alone: Median 26 (IQR 5 – 127)	ADT alone: Median 52.1 (range 0.1 – 8056.0)	n.a.
	ADT+ docetaxel: Median 27 (IQR 5 – 106)	ADT + docetaxel: Median 50.9 (range 0.2 – 8540.1)	
Stage	ADT alone: 100% metastatic	ADT alone: 100% metastatic	61% Metastatic 15% Node positive M0 24% NO M0
	ADT + docetaxel: 100% metastatic	ADT + docetaxel: 100% metastatic	

Metastatic at diagnosis	ADT alone: 67%	ADT alone: 73% had not received prior local therapy	94% of randomized patients had not received previous local therapy
	ADT + docetaxel: 76%	ADT + docetaxel: 73% had not received prior local therapy	
Presence of visceral metastases	ADT alone: 11% lung 2% liver	ADT alone: 17%	n.a.
	ADT + docetaxel: 11% lung 5% liver	ADT + docetaxel: 14%	
Volume of metastatic disease	ADT alone: 52% low-volume 48% high-volume	ADT alone: 36% low-volume 64% high-volume	n.a.
	ADT + docetaxel: 53% low-volume 47% high-volume	ADT + docetaxel: 34% low-volume 66% high-volume	

IQR: interquartile range; ADT: androgen- deprivation treatment; PS: performance status; PSA: prostate specific antigen; M0: absence of distant metastases; N0: absence of nodal metastases; n.a.: not applicable.

**details by arm are not provided*

Table 3. Overall survival data reported in each single trial.

	GETUG-AFU 15	CHAARTED – E3805	STAMPEDE [24]	
	[22,27]	[23]	All patients	Metastatic patients
Number of patients				
ADT alone	193	393	1184	725
ADT + docetaxel	192	397	592	362
ADT + docetaxel + zoledronic acid			593	365
Number of events				
ADT alone		136	405	343
ADT + docetaxel	212 (both arms)	101	165	134
ADT + docetaxel + zoledronic acid			181	152
Median OS				
ADT alone	46.5 months	44.0 months	67 months	43 months
ADT + docetaxel	60.9 months	57.6 months	77 months	65 months
ADT + docetaxel + zoledronic acid			72 months	n.a.
Hazard Ratio (95% confidence interval)				
ADT + docetaxel vs. ADT alone	0.9 (0.7 – 1.2), p=0.4	0.61 (0.47 – 0.80), P<0.001	0.76 (0.63 – 0.91), p=0.003	0.73 (0.59 – 0.89), p=0.002
ADT + docetaxel + zoledronic acid vs. ADT alone			0.81 (0.68 – 0.97), p=0.02	0.78 (0.65 – 0.95), p=n.a.

ADT: androgen-deprivation treatment; n.a.: not available.

Supplementary Table A1. Definition of biochemical progression-free survival

GETUG-AFU 15 [22]	CHAARTED – E3805 [23]	Stampede [24]
<p>Time to PSA progression, clinical progression or death. Biochemical progression was defined with the PSA Working Group definition: a previous confirmed PSA decrease of at least 50% and an increase of at least 50% above the nadir, with a minimum increase of 5 ng/mL. For patients without a previous PSA decrease of 50%, progression was defined as a PSA increase of at least 25% above the nadir and of at least 5 ng/mL.</p>	<p>Time to castration-resistant prostate cancer: time until documented clinical or serologic progression with a testosterone level of less than 50 ng per deciliter (or source documentation of medical castration or surgical castration). Disease progression on imaging was determined according to the Response Evaluation Criteria in Solid Tumors (RECIST), version 1.0. Serologic progression was defined as an increase in the PSA level of more than 50% above the nadir reached after the initiation of ADT, with two consecutive increases at least 2 weeks apart. The date of a first recorded increase of more than 50% above the nadir was deemed the date of progression. If the nadir level was less than 2 ng per milliliter, a minimum increase of more than 2 ng per milliliter was required.</p>	<p>Failure-free survival: First event among PSA failure, local failure, lymph node failure, distant metastases, prostate cancer death. PSA failure definition: If PSA fall \geq 50%:</p> <ul style="list-style-type: none"> • 24 week nadir + 50% and • >4 ng/ml <p>If PSA fall $<$ 50%:</p> <ul style="list-style-type: none"> • Failure at $t=0$

PSA: prostate-specific antigen; ADT: androgen deprivation therapy.