Indication	For the treatment of metastatic hormone-relapsed prostate cancer before chemotherapy is indicated. NB No previous treatment with enzalutamide or darolutamide or apalutamide or abiraterone should have been received OR if the patient has previously received enzalutamide it was stopped within 3 months of starting due to dose limiting toxicity and there is clear absence of disease progression. OR For the treatment of hormone-relapsed (castrate-resistant) metastatic prostate cancer which has progressed during or following treatment with docetaxel-containing chemotherapy. NB No previous treatment with any 2nd generation receptor inhibitors (such as enzalutamide, darolutamide or apalutamide) or CYP17 enzyme inhibitors (such as abiraterone) should have been received, unless the patient previously received enzalutamide for this same post-chemotherapy indication but it was stopped within 3 months of starting due to dose-limiting toxicity and there is clear absence of disease progression.
Treatment Intent	Palliative
Frequency and number of cycles	Repeat every 28 days Continue until disease progression, unacceptable toxicity or patient choice.

Monitoring Parameters pre-treatment	• **Virology screening:** All new patients referred for systemic anti-cancer treatment should be screened for hepatitis B and C and the result reviewed prior to the start of treatment. Patients not previously tested who are starting a new line of treatment, should also be screened for hepatitis B and C. Further virology screening will be performed following individual risk assessment and clinician discretion.
	• Monitor U&Es and FBC with each cycle for 6 months and then every 3 months thereafter if clinically indicated.
	• Monitor LFTs every 2 weeks for first 3 months then monthly for 3 months and then every 3 months thereafter if clinically indicated.
	• Blood pressure, serum potassium and fluid retention should be monitored before treatment and at least monthly thereafter. In patients at high risk of congestive heart failure monitoring should be 2 weekly for the first 3 months of treatment, then if clinically stable monthly thereafter.
	• Use with caution if history of cardiovascular disease (before treatment hypertension must be controlled and hypokalaemia corrected, consider maintaining potassium levels at >/=4mmol/L during treatment). New patients with cardiac failure should have an ECHO (transthoracic echocardiogram to measure Left Ventricular Ejection Fraction) before starting treatment.
	• **Hepatic impairment:** no dose adjustment in pre-existing mild (Child-Pugh A) impairment. Limited data available in moderate (Child-Pugh B) impairment, to be prescribed at clinician's decision. Not to be used in severe hepatic impairment.
	• **Renal Impairment:** Use with caution in severe renal impairment.
	• **Management of adverse reactions and dose adjustments:**
	  ○ Hepatotoxicity and hepatic impairment:
	  ○ If increase in ALT>5x ULN, discontinue treatment and all other concomitant medications that are potentially hepatotoxic. Re-treatment may take place only after return of liver function tests to the patient's baseline, and at the reduced dose level of 500mg once a day with serum transaminases monitored at least every two weeks for three months and monthly thereafter. No further dose

	reduction is permitted; if hepatotoxicity recurs at the reduced dose treatment should be discontinued. o If patients develop severe hepatotoxicity (ALT 20 x ULN) discontinue treatment and do not re-treat. o For patients who develop Grade >/= 3 toxicities including hypertension, hypokalaemia, oedema and other non-mineralocorticoid toxicities, treatment should be withheld and appropriate medical management should be instituted. Treatment should not be reinitiated until symptoms of the toxicity have resolved to Grade 1 or baseline. o Prednisolone dose may be reduced to 5 mg od at clinicians' discretion. • **<u>Common drug interactions (for comprehensive list refer to BNF/SPC):</u>** • Caution is recommended in patients concomitantly treated with drugs known to be associated with myopathy/rhabdomyolysis (e.g glucocorticoids, cholesterol lowering drugs, zidovudine, amiodarone, colchicine) • Strong inducers (e.g. phenytoin, carbamazepine, rifampicin) of CYP3A should be avoided or used with caution. • Dose reduction of medicines with a narrow therapeutic index metabolized by CYP2D6 (e.g. metoprolol, propranolol, venlafaxine, haloperidol, risperidone) should be considered. • Use with caution when given concomitantly with other medications known to prolong QT interval. • Avoid spironolactone, co administration with abiraterone is not recommended. • **Hyperglycaemia/Hypoglycaemia:** The risk of hypoglycaemia has been linked to co-administration with pioglitazone or repaglinide. Patients with diabetes should be advised to closely monitor their blood sugars and liaise with their diabetic team. Close monitoring for toxicity is recommended for patients taking CYP2C8 substrate with a narrow therapeutic index (e.g. pioglitazone and repaglinide). • **Missed dose**: in the event a dose of abiraterone or prednisolone is missed, the patient should not take the dose and wait until the next scheduled dose to continue. • For oral self-administration: refer to local Trust policy on oral anti-cancer medicines and supply Patient Information Leaflet.
References	KMCC protocol URO-021 V5 SPC accessed online 29.01.2025 CDF list v1.344 accessed online 28.01.2025

NB For funding information, refer to CDF and NICE Drugs Funding List

<u>Repeat every 28 days</u>

TTO	Drug	Dose	Route	Directions
Day 1	**ABIRATERONE**	**1000mg**	PO	Each day continuously for 28 days. Tablets should be taken at least 1 hour before food or at least 2 hours after eating. Swallow whole with water. Available as 250mg and 500mg tablets.
	PREDNISOLONE	**5mg**	PO	BD for 28 days When abiraterone is discontinued, the patient should commence a reducing dose of prednisolone.