# P050 Effectiveness of abiraterone acetate in elderly chemotherapy-naïve patients with metastatic castration-resistant prostate cancer

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**Introduction & Objectives:** Therapeutic optimization remains challenging in elderly patients with metastatic castration-resistant prostate cancer (mCRPC) given their greater likelihood of having comorbidities and lower tolerance for toxicity. Abiraterone acetate (AA) improved overall survival in chemotherapy-naïve patients. The oral route of administration and the safety profile are other advantages of this therapy in the elderly. We aim to evaluate the effectiveness of AA treatment in the elderly population (aged ≥75 years) with mCRPC before docetaxel-based chemotherapy.

**Materials & Methods:** A single-centered, retrospective study was conducted, including patients with mCRPC who initiated treatment with 1000mg AA and 10mg prednisolone daily between October 2014 and April 2019 without previous chemotherapy exposure. Outcomes of interest were prostate-specific antigen (PSA) response rate, time to PSA progression (TTPP), radiographic progression-free survival (rPFS) and overall survival (OS). Toxicities of degree ≥3 were reported according to the National Cancer Institute scale, Common Terminology Criteria for Adverse Events, version 4.0. Median time to event and hazard ratio (HR) were estimated using Kaplan-Meier method and Cox model, respectively.

**Results:** Forty-five patients were included, with median age of 78 years [58-88], 68.9% (n=31) of whom were elderly, with median age of 81 years (75-88). At baseline, 38.7% in the elderly and 35.7% in the younger group had modified Charlson Comorbidity Index ≥5. In the elderly group, 32.3% took ≥5 medicines and 64.5% had Eastern Cooperative Oncology Group-Performance Status (ECOG-PS) of 1. In the younger group, 28.6% took ≥5 medicines and the majority (50%) had ECOG-PS of 0. Median time of follow-up was 10 (0-41) months and median time of treatment with AA was 7 (0-27) months. PSA response rate was 71% in the elderly and 64% in the younger. When comparing both groups, there was no statistic difference concerning OS (16 months in the elderly vs 30 months; HR 1,78; 95% CI 0.63-5.02; p=0.277), rPFS (7 months in the elderly vs 6 months; HR 1.15; 95% CI 0.44-2.95; p=0.778) or TTPP (8 months in the elderly vs 10 months; HR 1.36; 95% CI 0.52-3.53; p=0.529). Grade ≥3 adverse events occurred in 25% of elderly patients and in 36% of patients aged <75 years (p=0.49). In each group, 2 patients permanently discontinued AA due to severe toxicity.

**Conclusions:** Despite the non-negligible frequency of grade ≥3 adverse events, a minority of elderly patients discontinued AA due to toxicity and there were no statistically significant differences in the survival analysis when comparing these patients with the younger ones, suggesting that this is an important therapeutic option for elderly patients. However, longer follow-up and larger populations are needed to confirm the effectiveness of AA in this context.