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clinician's specialty, our patients are optimally served by whomever has the appropriate training, skills, and dedication to maintain competency in the management of patients with this complex disease.

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EDITORIAL COMMENT

The management of patients with prostate cancer, in contrast to that of most other neoplasms is somewhat unique in that care of patients is typically overseen to a variable degree by a variety of different clinicians including urologists, radiation, and medical oncologists over a disease course that may extend over many years.

Over the past 5-10 years, a number of important therapeutic developments in metastatic castration-resistant prostate cancer have led to a more complex clinical management landscape. Several recent clinical trials have provided evidence that earlier use of next-generation androgen receptor targeted agents such as abiraterone, enzalutamide, apalutamide, and likely darolutamide in the hormone sensitive and PSA only castration resistant setting improve overall survival and metastases free survival respectively.

In the current report which covers the period between 2013 and 2016 the investigators find that the number of urologists prescribing both enzalutamide and abiraterone increased over time and that the number of moderate-high prescribers (≥ 10 prescriptions/year) increased, with the bulk of these being members of single-specialty groups. They also note that the majority of urologists who prescribe these agents are low volume prescribers (at least 1 but ≤ 10 /year).

What are the implications of this observation? It is clear that more urologists, especially those members of single specialty groups are gaining experience in the management of these agents and with emerging data for their applications earlier in the disease course are well positioned to manage their patients. While seamless management of patients with advanced prostate cancer is an excellent goal, a note of caution is warranted. As our understanding of the disease biology increases, the complexity involved in making optimal management decisions is rapidly changing. The evolving role of genomics, management of drug toxicity especially in men on multiple medications, appreciation of drug crossresistance, and the changing therapeutic landscape requires more of clinicians than simply understanding how to administer one of these drugs.

Many of the patients appropriate for these agents are perhaps in the clinical state increasingly referred to as “oligometastatic.” While there is no defined standard of care, we will be increasingly challenged to determine optimal use and interpretation of next-generation imaging and making management decisions which will have significant impact on our patients.

All of the myriad of issues noted above require that clinicians managing these patients through this part of the disease continuum have the background, training, and skills commensurate with the task. As the authors note in their conclusions and as expressed by many leaders in uro-oncology, irrespective of the



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The treatment options for metastatic prostate cancer have increased dramatically over the past decade, including novel hormonal therapies, chemotherapies, and radiopharmaceuticals. The administration of myelosuppressive chemotherapies has generally been supervised by medical oncologists in the United States. The oversight of oral agents such as abiraterone + prednisone (abi) and enzalutamide (enza) has been less well defined. This issue of the *Gold Journal* describes the increasing role of urologists in prescribing these agents. By searching Medicare prescription databases, the authors describe the number of moderate to high urologist prescribers for either abi or enza or both have increased substantially between 2013 and 2016.

How should we react to the increasing role of urologists in prescribing systemic therapies for advanced prostate cancer? The authors present several positive aspects of this trend, most notably, the longitudinal involvement of urologists in their patient's care. However, we wish to raise several concerns from a medical oncology viewpoint.

First, are urologists trained to guide castration resistant patients through the myriad options, including systemic therapies that often require extensive training so common in medical oncology fellowships? Distinctions between “high-volume” vs “low-volume,” disease, appropriate use of both emerging, and novel diagnostic and molecular/genomic entities to help guide therapy, de novo vs recurrent disease are complex, and even the general medical oncologist may best understand them only after treating a large patient population with castration-resistant metastatic disease.

Second, do urologists adhere to best practices for prescribing and monitoring these medications? Abi requires concomitant prednisone, and typical monitoring includes frequent assessments of blood pressure, potassium, and liver function tests, with careful dose modifications or treatment holds as needed. In response to abi-induced hypertension, physicians might increase prednisone or prescribe a mineralocorticoid receptor antagonist. Baseline antihypertensive medications often require ongoing dose adjustments. Prednisone may require additional management of underlying diabetes mellitus and dose escalations when patients experience more stressful medical conditions.

Enzalutamide poses an additional set of adverse event monitoring not generally managed by urology. It is a significant inducer of CYP3A4 metabolism. Patients are frequently receiving direct oral anticoagulants or transdermal fentanyl, both substantially affected by the addition of enza. This requires decisions on usage of substitute drugs, which in turn requires a detailed knowledge of indications for anticoagulation and pain management.