

# Comparative Efficacy of First-line Therapies for Patients with Asymptomatic/Mildly Symptomatic Metastatic Castration-resistant Prostate Cancer: An Updated Systematic Literature Review and Bayesian Network Meta-analyses

Imtiaz A. Samjoo<sup>1</sup>, Stefanie Paganelli<sup>1</sup>, Jenna Ellis<sup>1</sup>, Anja Haltner<sup>2</sup>, Melissa Kirker<sup>3</sup>, Neo Su<sup>3</sup>, Jane Chang<sup>3</sup>, Elena Castro<sup>4</sup>

<sup>1</sup>EVERSANA®, Burlington, Ontario, Canada; <sup>2</sup>EVERSANA®, New York, New York, USA; <sup>3</sup>Pfizer, Inc., New York, New York, USA; <sup>4</sup>Hospital Universitario 12 de Octubre, Madrid, Spain



## Objective

To compare the efficacy of 1L treatments in an unselected mCRPC population, irrespective of gene status, using the latest available evidence in a network meta-analysis (NMA).



## Conclusions

This NMA, incorporating the latest evidence, suggests that talazoparib + enzalutamide offers the greatest survival benefit among 1L treatments for mCRPC in the unselected population.



Presenting author:  
Neo Su, PharmD, MPH, MS



Email for more information:  
neo.su@pfizer.com

## Background

- Several therapies are available for first-line (1L) treatment of patients with metastatic castration-resistant prostate cancer (mCRPC). This disease is an area of active investigation, with new treatments and trials emerging to help fulfill an unmet need and with more mature survival data becoming available for earlier trials.

- Given a lack of head-to-head studies comparing 1L mCRPC treatments, a network meta-analysis (NMA) informed by a systematic literature review (SLR) was conducted to understand the relative efficacy of available treatments in an unselected mCRPC population, irrespective of gene status.

## Materials and Methods

### SYSTEMATIC LITERATURE REVIEW

- An SLR was conducted to identify evidence from inception through August 2024.
  - Methods aligned to latest guidance from Cochrane Handbook and PRISMA statement.<sup>1,2,3</sup>
  - Protocol was registered with PROSPERO (CRD42021283512).
- Sources included MEDLINE®, Embase, Cochrane via Ovid®, and key grey literature sources.
- Phase 2 or 3 randomized controlled trials (RCTs) of available therapies for 1L mCRPC were included.
- A feasibility assessment was conducted to confirm that RCTs were sufficiently similar to be included in a valid NMA.

### NETWORK META-ANALYSIS

- Bayesian random-effects NMAs were conducted for radiographic progression-free survival (rPFS) and overall survival (OS), using vague priors for treatment effects.
  - Methods aligned to guidance from Dias et al.<sup>4</sup>
  - Continuous survival model (log hazard scale) was utilized.
  - For rPFS, we used the latest data cutoff available. In the event where rPFS by blinded independent central review (BICR) was not available, or was not the most recent data cutoff available, rPFS inputs assessed by investigator were used. For trials which did not specify the approach, BICR was assumed.
  - Placebo and steroid-based treatments were considered “best supportive care”. Prednisone and prednisolone were considered similar, as were regimens that were equal in their administration over 24 hours.
- Base case analyses excluded trials with clinical heterogeneity or violating proportional hazards assumptions.
  - Sensitivity analyses assessed the impact of including/excluding these trials from the base case.
- Hazard ratios (HR) and 95% credible intervals (CrI) were calculated for each outcome.
- Treatments were ranked using surface under the cumulative ranking curves (SUCRAs), with higher values indicating greater likelihood of being effective.
- Network diagrams were developed to reflect the evidence base for each NMA, and results were summarized using league tables and forest plots.



An electronic version of this poster may be obtained by scanning this QR code. Copies of this poster obtained through the QR code are for personal use only and may not be reproduced without permission. To request permission or to ask questions about the poster, please contact neo.su@pfizer.com.

**References:** 1. Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *bmj*. 2021;372:2. Page MJ, McKenzie JE, Bossuyt PM, et al. Updating guidance for reporting systematic reviews: development of the PRISMA 2020 statement. *Journal of clinical epidemiology*. 2021;134:103-112. 3. Higgins J, Thomas J, Chandler J, Cumpston M, Li T, Page M. *Cochrane Handbook for Systematic Reviews of Interventions*. Version 6.4 (Updated August 2023). Cochrane, 2023. 2024. 4. Dias S, Sutton AJ, Ades A, Welton NJ. Evidence synthesis for decision making 2: a generalized linear modeling framework for pairwise and network meta-analysis of randomized controlled trials. *Medical Decision Making*. 2013;33(5):607-617.

**Abbreviations:** AAP = Abiraterone acetate PO QD 1000mg + Prednisone/Prednisolone 5mg PO BID/10mg PO QD; AAP2.5BID = Abiraterone acetate PO QD 1000mg + Prednisone 2.5mg BID; AAP5QD = Abiraterone acetate 1000mg PO QD + Prednisone 5mg PO QD; AAPnLHRH = Abiraterone acetate 1000 mg PO QD + Prednisone 5 mg PO BID with no LHRH therapy; AAPnENZA = Abiraterone acetate 1000mg PO QD + Prednisone 5mg PO BID or Enzalutamide 160mg PO QD; AA+DEX = Abiraterone acetate 1000mg PO QD + Dexamethasone 0.5mg PO QD; APA+AAP = Apalutamide 240mg PO QD + Abiraterone acetate 1000mg PO QD; BIC = Bicalutamide 50mg PO QD; BSC = Best supportive care (Placebo, Prednisone 5mg PO BID, Hydrocortisone 40mg PO QD, and Prednisolone 5mg PO BID); CABA20 = Cabazitaxel 20mg/m<sup>2</sup> IV Q3W + Prednisone 10mg PO QD; CABA25+AAP = Cabazitaxel 25mg/m<sup>2</sup> IV Q3W + Abiraterone Acetate 1000mg PO QD + Prednisone 5mg PO BID; CABA25+PS = Cabazitaxel 25mg/m<sup>2</sup> IV Q3W + Prednisone 5mg PO BID/10mg PO QD; DOC30+PS = Docetaxel 30mg/m<sup>2</sup> IV Q1W + Prednisone/Prednisolone 5mg PO BID; DOC75+PS = Docetaxel 75mg/m<sup>2</sup> IV Q3W + Prednisone/Prednisolone 5mg PO BID/10mg PO QD; ENZA = Enzalutamide 160mg PO QD; ENZA+AAP = Enzalutamide 160mg PO QD + Abiraterone acetate PO QD 1000mg + Prednisone 5mg BID; HR = hazard ratio; IPA+AAP = Ipilimumab 400mg PO QD + Abiraterone acetate 1000mg PO QD + Prednisone/Prednisolone 5mg PO BID; MIT12+PS = Mitoxantone 12mg/m<sup>2</sup> IV Q3W + Prednisone/Prednisolone 5mg PO BID/10mg PO QD; MIT14+HC = Mitoxantone 14mg/m<sup>2</sup> IV Q3W + Hydrocortisone 40mg PO QD; OLAP+AAP = Olaparib 300mg PO BID + Abiraterone acetate 1000mg PO QD + Prednisone/Prednisolone 5 mg PO BID; OS = overall survival; PEM+ENZA = Pembrolizumab 200mg IV Q3W + Enzalutamide 160mg PO QD; Ra55+AAP = Radium-223 55 kBq/kg Q4W + Abiraterone acetate 1000mg PO QD + Prednisone/Prednisolone 5mg PO BID; Ra55+ENZA = Radium-223 55 kBq/kg Q4W + Enzalutamide 160mg PO QD; rPFS = radiographic progression-free survival; SIP-T = Sipuleucel-T (1 infusion every 2 weeks for 6 weeks); TALA+ENZA = Talazoparib 0.5mg QD + Enzalutamide 160mg PO QD.

**Acknowledgments:** This study was sponsored by Pfizer Inc. The authors would like to acknowledge Joanna Bielecki who developed the database searches and Teresa Kangappaden, Krista Tantakoun, Christopher Olsen, and Amrita Debnath for assisting with the literature review. Joanna, Christopher, and Amrita are currently employed by EVERSANA™, Canada. Teresa and Krista were previous employees of EVERSANA™, Canada. Medical writing support was provided by Stefanie Paganelli, Di Wang, Anja Haltner, and Imtiaz Samjoo from EVERSANA™ and funded by Pfizer Inc.

Copyright ©2025. All rights reserved.

## Results

### RADIOGRAPHIC PROGRESSION-FREE SURVIVAL

- In the base case, the rPFS network included 16 RCTs and 17 treatments (**Figure 1A**), while the sensitivity analysis included 15 RCTs and 16 treatments.
- In the base case, talazoparib + enzalutamide is the top-ranked treatment for rPFS (SUCRA = 89.6%).
- Talazoparib + enzalutamide is numerically superior to all 16 other treatments in the network (**Figure 1B and Figure 3A**).
- Talazoparib + enzalutamide is statistically superior to five treatments in the network (**Figure 1B and Figure 3A**).
- In the sensitivity analysis, the results remained consistent with the base case (SUCRA = 92.0% for talazoparib + enzalutamide).

### OVERALL SURVIVAL

- In the base case, the OS network included 20 RCTs and 18 treatments (**Figure 2A**), while the sensitivity analysis included 22 RCTs and 20 treatments.
- In the base case, talazoparib + enzalutamide is the top-ranked treatment for OS (SUCRA = 84.4%).
- Talazoparib + enzalutamide is numerically superior to all 17 other treatments in the network (**Figure 2B and Figure 3B**).
- Talazoparib + enzalutamide is statistically superior to MIT14+HC and BSC in the network (**Figure 2B and Figure 3B**).
- In the sensitivity analysis, the results remained largely consistent with the base case (SUCRA = 78.7% for talazoparib + enzalutamide).

Figure 1. Base Case NMA Evidence Network (A) and League Table (B) for rPFS

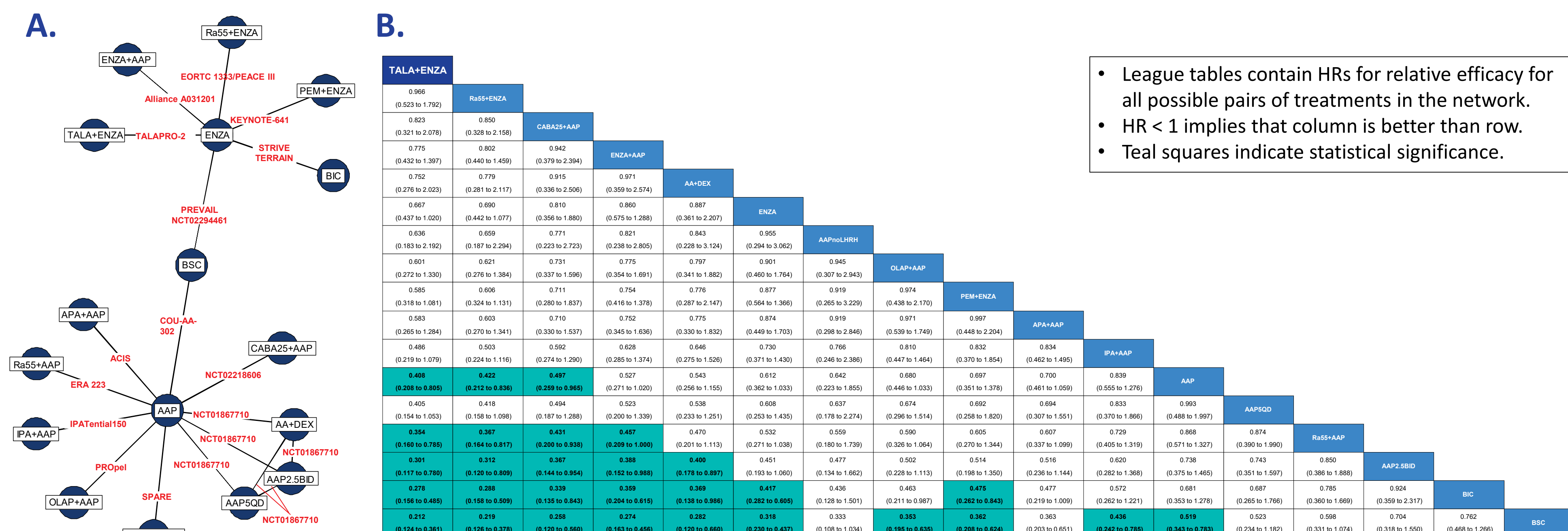


Figure 2. Base Case NMA Evidence Network (A) and League Table (B) for OS

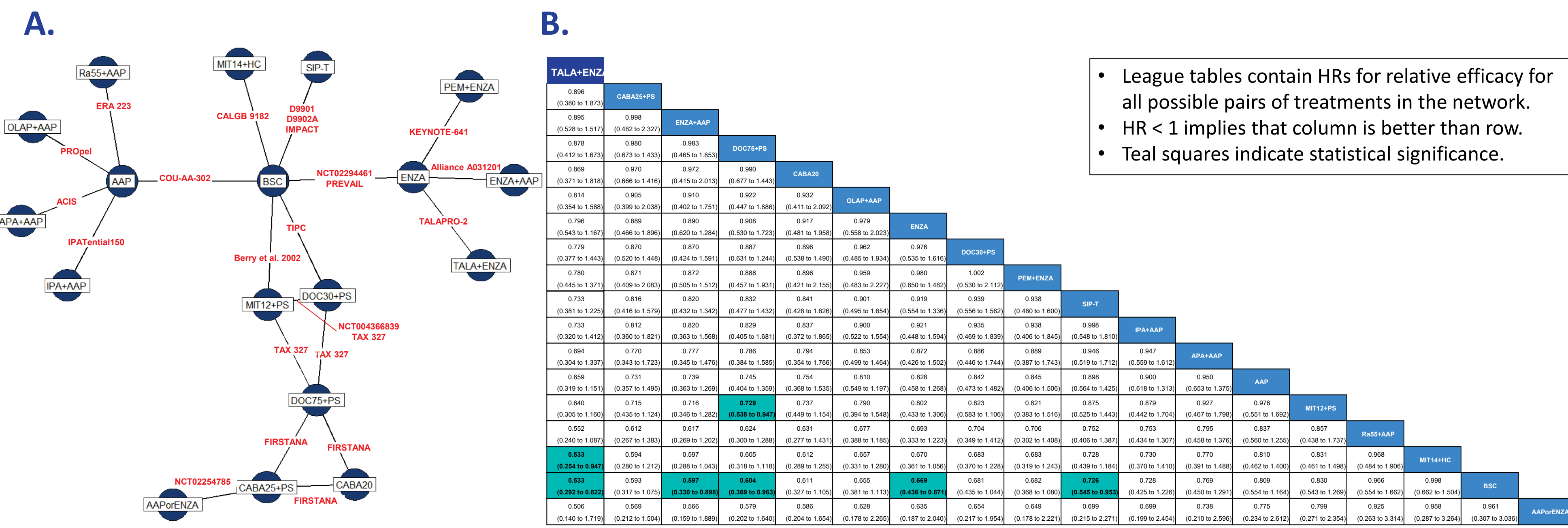


Figure 3. Base Case Forest Plots of Talazoparib plus Enzalutamide vs Comparators for (A) rPFS and (B) OS

