1. Do you **recommend** intermittent instead of continuous ADT in radiologically confirmed M1 patients that achieve an adequate PSA decline?

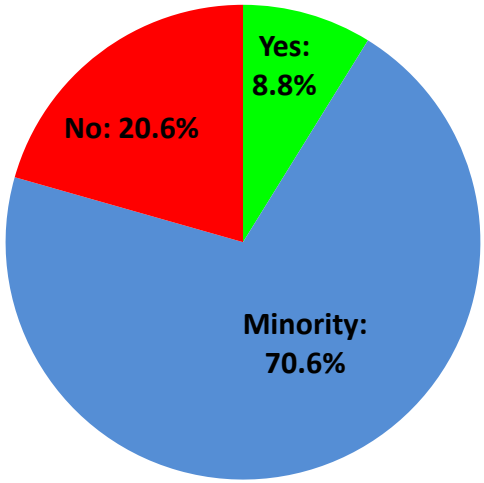
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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2. Do you **discuss the option of** intermittent instead of continuous ADT in radiologically confirmed M1 patients that achieved an adequate PSA decline?

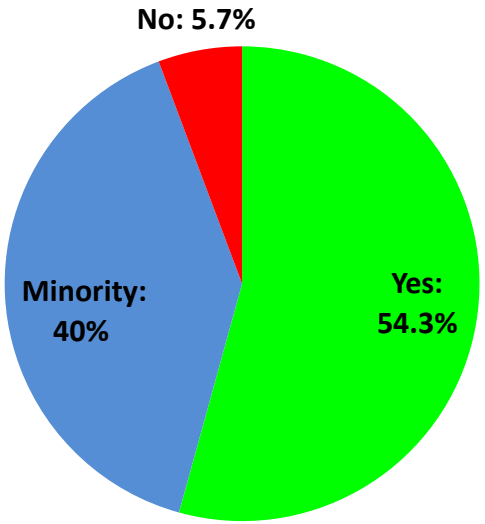
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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3. Do you **recommend** upfront combined ADT instead of ADT alone in patients with advanced metastatic prostate cancer?

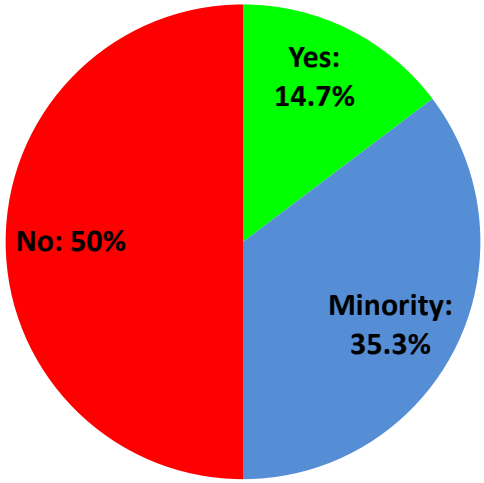
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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4. What is the **most meaningful** definition of high-volume disease in castration-sensitive prostate cancer?

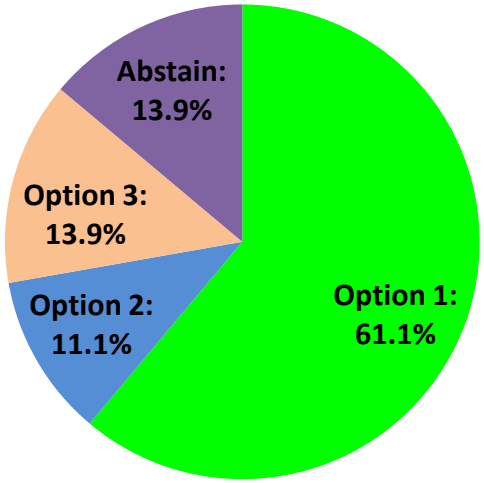
1 - Visceral and/or ≥4 bone metastases, at least 1 beyond pelvis and vertebral column (CHAARTED)

2 - Visceral (lung or liver) and/or any appendicular skeletal involvement (SWOG)

3 - Diffuse bone disease (chest, head and/or extremities)
and/or visceral organ (lung or liver) involvement
(extensive disease according to Glass et al. 2003)

4 - Abstain

5 - Unqualified to answer



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5. Do you **recommend** docetaxel in addition to ADT in M1 patients with castration-sensitive **"high-volume"** disease?

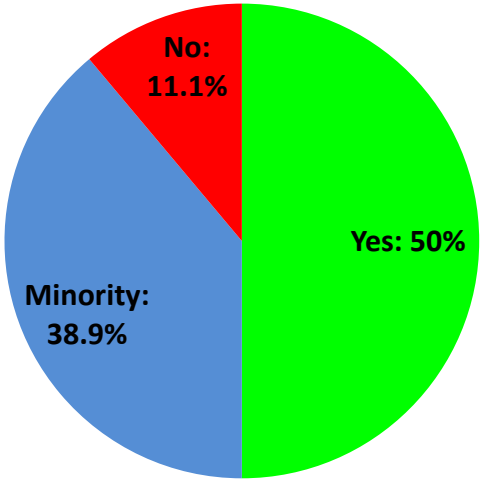
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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6. Do you **recommend** docetaxel in addition to ADT in M1 patients with castration-sensitive **“low-volume”** disease?

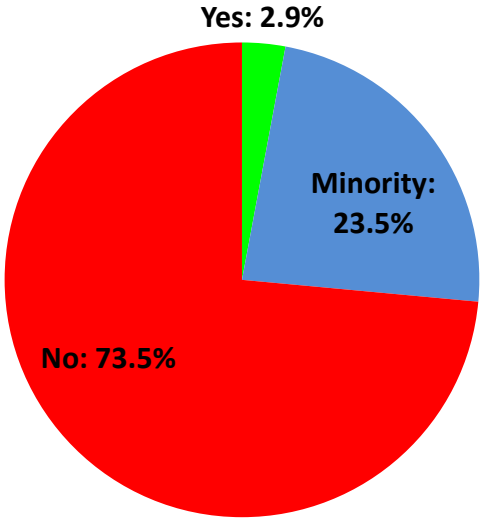
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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7. Do you **recommend** zoledronic acid (4mg every 3-4 weeks) in castration-sensitive M1 patients with bone metastases?

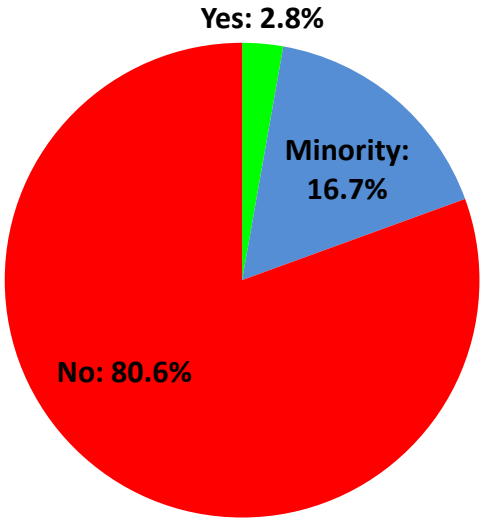
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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8. Do you **recommend** denosumab (120mg every 4 weeks) in castration-sensitive M1 patients with bone metastases?

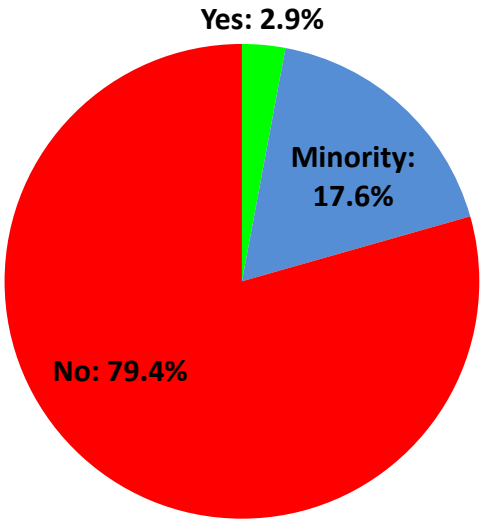
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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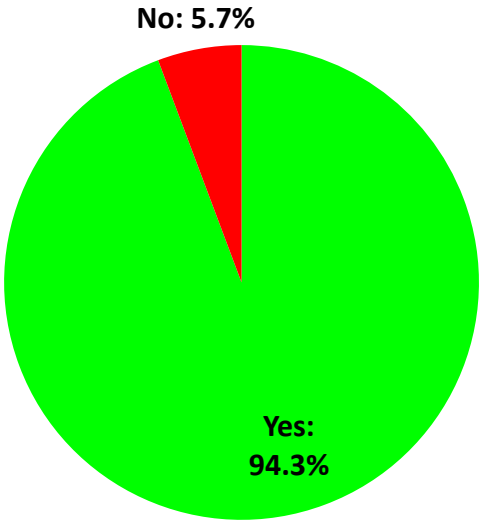
9. Is testosterone below a specific threshold **required** for the definition of CRPC?

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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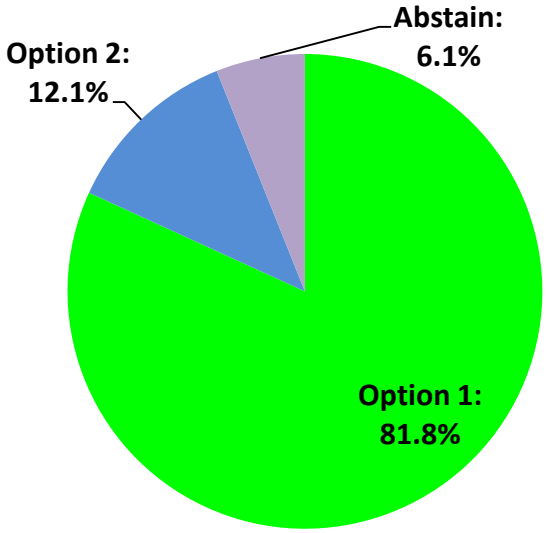
10. If you voted **yes to Q9**, which testosterone level is **appropriate**:

1 - Testosterone level <50 ng/dL (<1.7 nmol/L)

2 - Testosterone level <20 ng/dL (<0.69 nmol/L)

3 - Abstain

4 - Unqualified to answer



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11. In patients with castrate levels of testosterone, what is **required** for the definition of CRPC in daily practice?

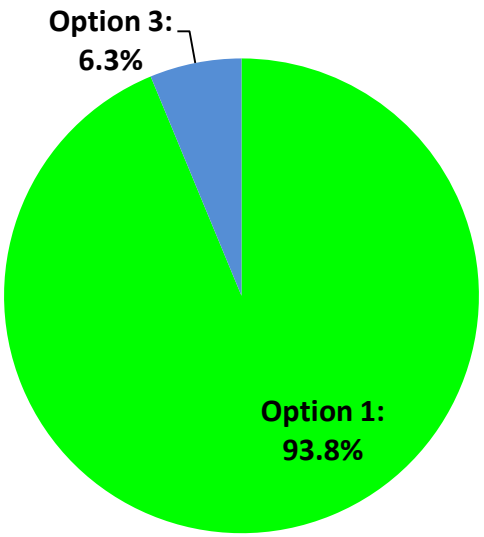
1 - Rising PSA (confirmed) on ADT is sufficient

2 - Rising PSA (confirmed) on combined androgen blockade (ADT pus AR antagonist) initiated upfront or initiated later

3 - PSA has to rise (confirmed) on ADT after stopping AR antagonist therapy and withdrawal period (4-6 weeks)

4 - Abstain

5 - Unqualified to answer



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12. What is your **preferred next management option** in a patient on a GnRH agonist with rising PSA in case a non-castrate testosterone level is confirmed and LH is suppressed?

1 - Change to Orchiectomy

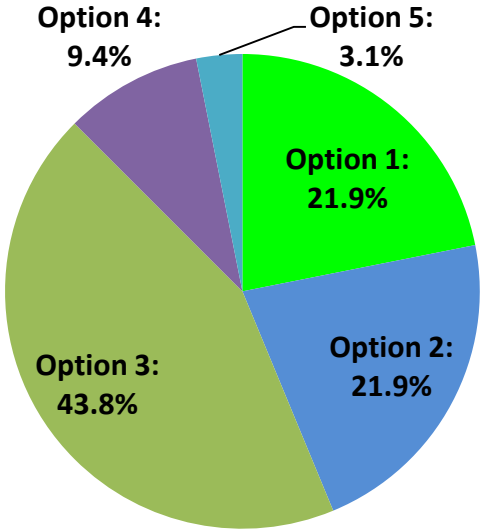
2 - Change to alternative GnRH agonist

3 - Change to GnRH antagonist

4 - Add AR antagonist

5 - Abstain

6 - Unqualified to answer



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13. Do you **recommend** a trigger for imaging in an asymptomatic patient with rising PSA on ADT and **no** known metastases (if you plan to initiate a therapy for M1 CRPC disease)?

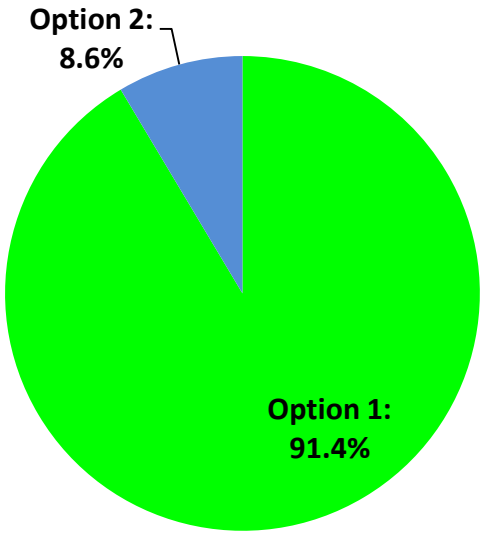
1 - Yes, PSA data (level and/or kinetics)

2 - Yes, calendar trigger (every X months)

3 - No, wait until symptomatic

4 - Abstain

5 - Unqualified to answer



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14. If you voted yes for **PSA level** to Q13, at which PSA (most recent, total) do you **recommend** imaging in an asymptomatic patient with rising PSA on ADT?

1 - PSA ≥ 2

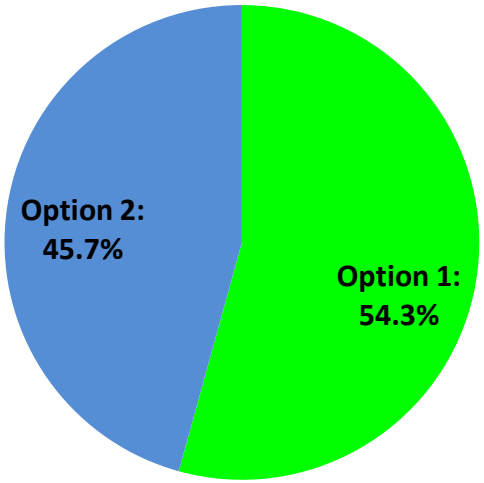
2 - PSA ≥ 10

3 - PSA ≥ 20

4 - PSA ≥ 50

5 - Abstain

6 - Unqualified to answer



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15. If you voted yes for **PSA kinetics** to Q13, at which PSA doubling-time do you **recommend** imaging in an asymptomatic patient with rising PSA on ADT?

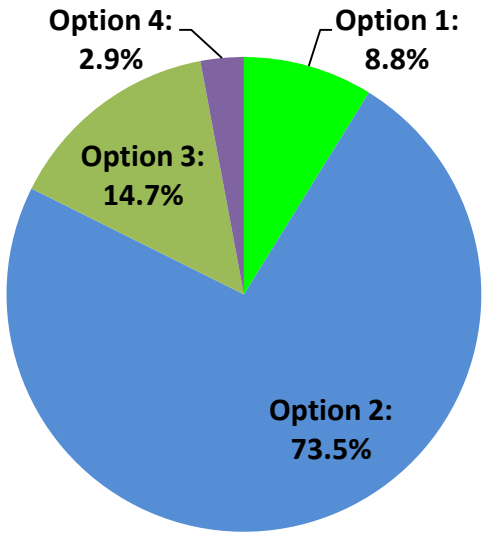
1 - PSA-DT ≤ 3 months

2 - PSA-DT ≤ 6 months

3 - PSA-DT ≤ 12 months

4 - Abstain

5 - Unqualified to answer



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16. If you voted yes for **calendar trigger** to Q13, at which time intervals do you **recommend** imaging in an asymptomatic patient with rising PSA on ADT?

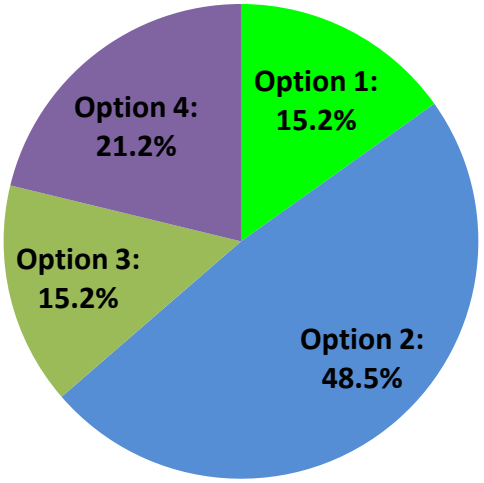
1 - Every 3 months

2 - Every 6 months

3 - Every 12 months

4 - Abstain

5 - Unqualified to answer



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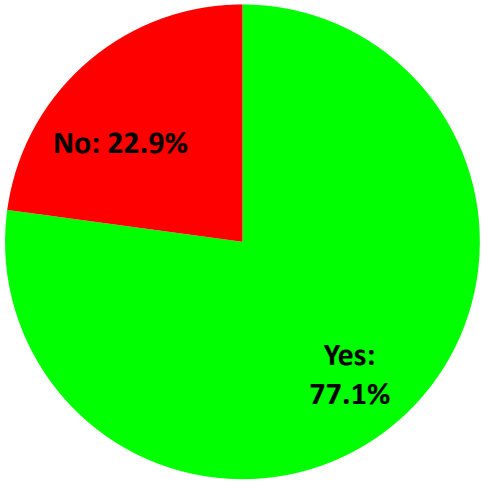
17. For the diagnosis /confirmation of **M0 CRPC** (rising PSA on ADT) in routine (non-trial) practice: Negative CT and bone scan is **sufficient** to diagnose **M0** CRPC.

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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18. When do you **recommend** initiating additional treatment for M0 CRPC patients (negative imaging, rising PSA, outside of clinical trials) apart from maintaining ADT?

1 - Not for M0

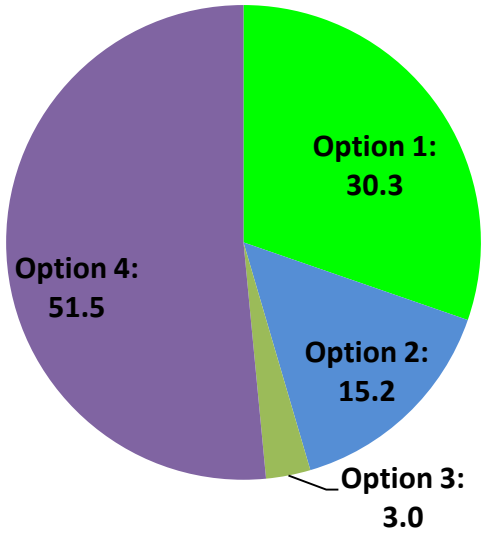
2 - Based on PSA doubling time

3 - Based on absolute PSA value

4 - Based on combination of PSA doubling time and absolute PSA

5 - Abstain

6 - Unqualified to answer



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19. If you **recommend** treatment for **M0 CRPC**, what is your preferred treatment option for M0 CRPC patients (negative imaging, rising PSA, outside of clinical trials) apart from maintaining ADT?

1 – Option omitted

2 - Abiraterone

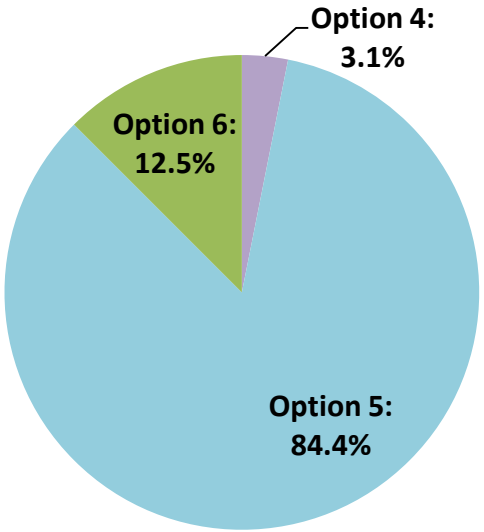
3 - Enzalutamide

4 - Sipuleucel-T

5 - One of the endocrine manipulations without proven survival benefit

6 - Abstain

7 - Unqualified to answer



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20. Are endocrine manipulations other than abiraterone or enzalutamide still **appropriate** treatments for asymptomatic metastatic CRPC patients with rising PSA on ADT when **abiraterone and/or enzalutamide are available**?

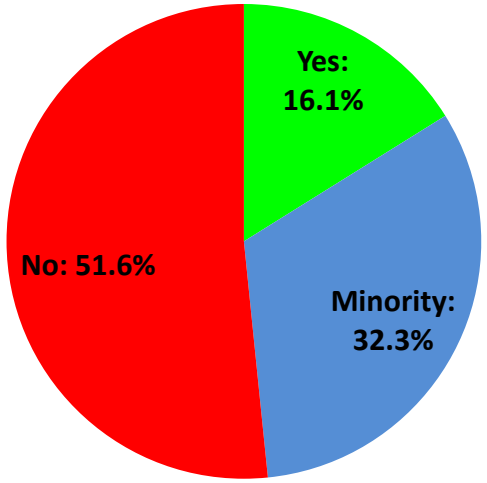
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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21. Are endocrine manipulations other than abiraterone or enzalutamide still **appropriate** treatments for asymptomatic metastatic CRPC patients with rising PSA on ADT when **abiraterone and/or enzalutamide are NOT available**?

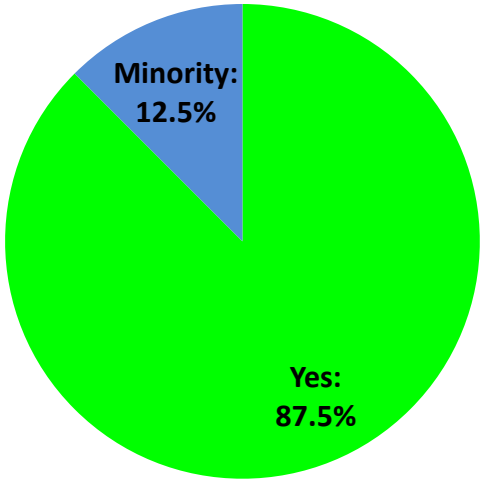
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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22. If you voted **yes** to Q20 and/or Q21, what is your **preferred treatment choice** in an asymptomatic patient with rising PSA on ADT?

1 - AR antagonist (bicalutamide, flutamide, nilutamide)

2 - Diethylstilboestrol

3 - Estramustine

4 - Ketoconazole

5 - Dexamethasone

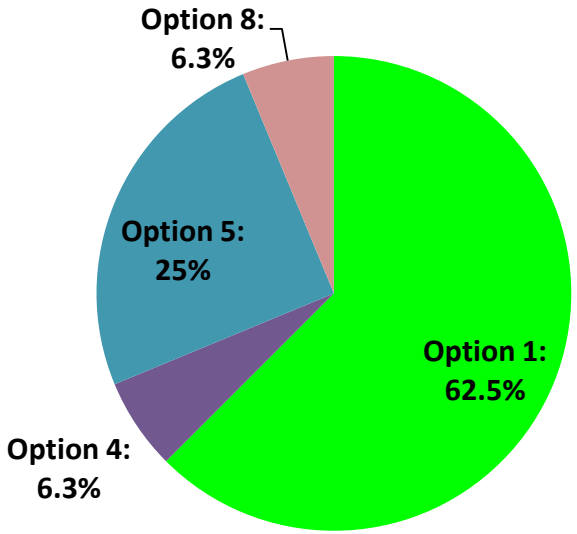
6 - Prednisone/prednisolone

7 - Cyproterone acetate

8 - No preferred option

9 - Abstain

10 - Unqualified to answer



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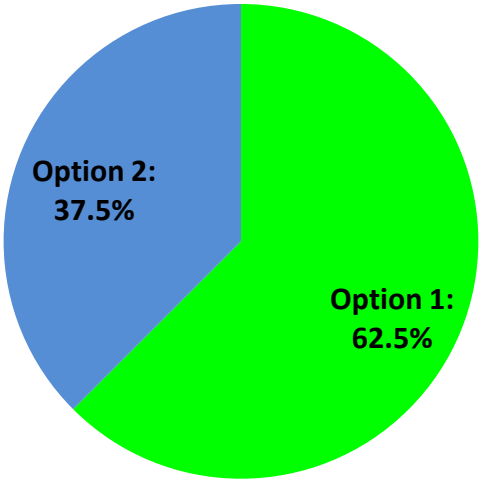
23. When do you **recommend** survival prolonging agents for patients progressing by PSA without radiographic progression in the absence of symptoms and imminent complications?

1 - Start within 4-8 weeks

2 - Can be postponed in the presence of adequate disease monitoring

3 - Abstain

4 - Unqualified to answer



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24. Do you **recommend** abiraterone or enzalutamide as first-line therapy for otherwise healthy, asymptomatic or minimally symptomatic CRPC patients in addition to ADT?

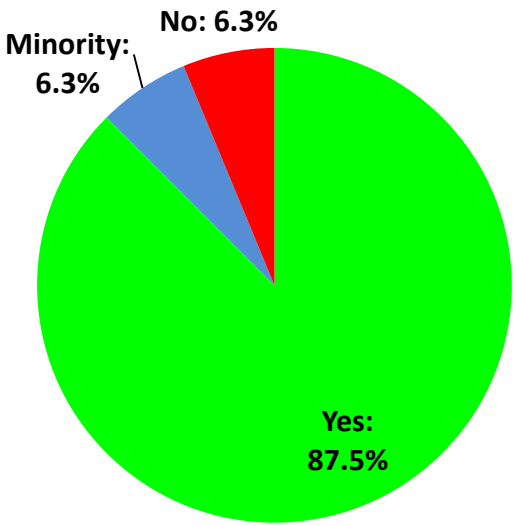
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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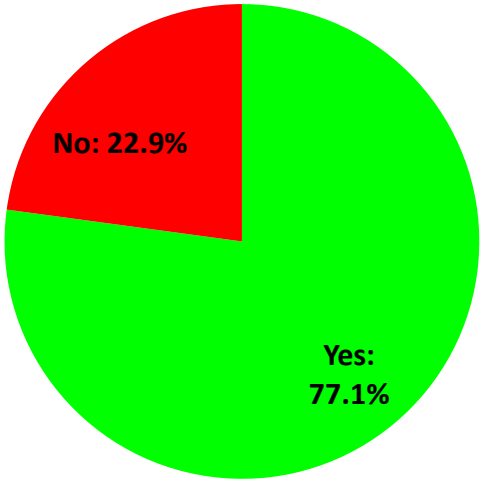
25. Is it **appropriate** to extrapolate the results of PREVAIL (enzalutamide vs placebo in chemotherapy naïve CRPC pts) and COU-302 (abiraterone + prednisone vs placebo + prednisone in chemotherapy naïve CRPC pts) to **symptomatic** chemotherapy naïve CRPC patients?

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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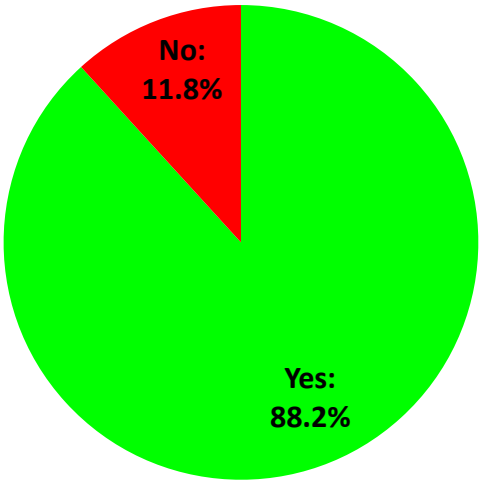
26. Is it **appropriate** to extrapolate the results of COU-302 (abiraterone + prednisone vs placebo + prednisone in chemotherapy naïve CRPC pts without visceral metastases) to chemotherapy naïve CRPC patients **with visceral metastases**?

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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27. What is your **preferred first-line choice for survival-prolonging endocrine agents** for otherwise healthy CRPC patients if all options are available?

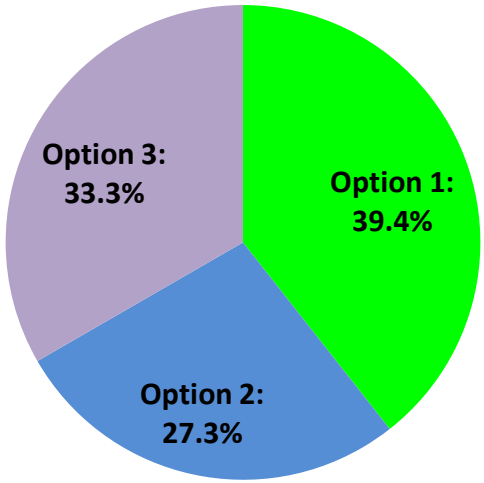
1 - Abiraterone

2 - Enzalutamide

3 - No preferred choice

4 - Abstain

5 - Unqualified to answer



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28. Do you **recommend** chemotherapy (usually taxane based) as first-line therapy for otherwise healthy **asymptomatic/minimally symptomatic** CRPC patients?

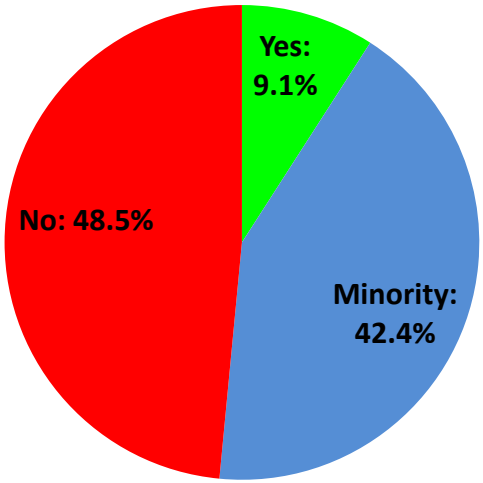
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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29. Do you **recommend** chemotherapy (usually taxane based) as first-line therapy for otherwise healthy **symptomatic** CRPC patients in addition to ADT?

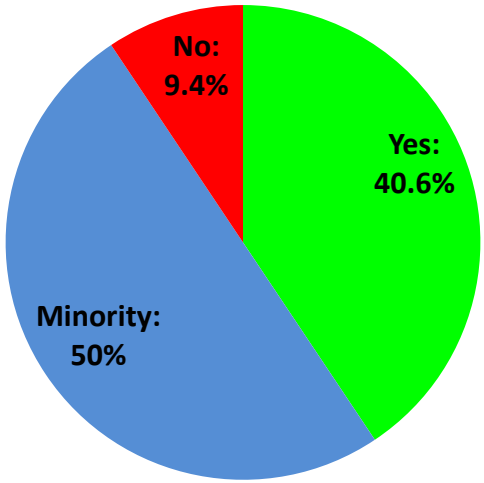
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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30. Do you **recommend** docetaxel chemotherapy as first-line CRPC treatment in an otherwise healthy **symptomatic** patient with short-response (≤12 months) to primary ADT?

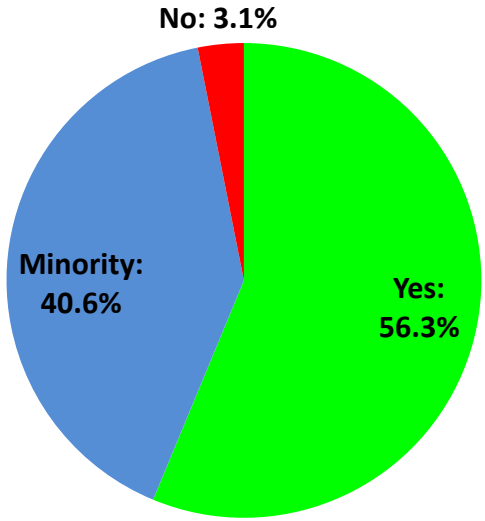
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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31. Do you **recommend** docetaxel chemotherapy as first-line CRPC treatment in an otherwise healthy **asymptomatic/minimally symptomatic** patient with short-response to primary ADT (≤12 months)?

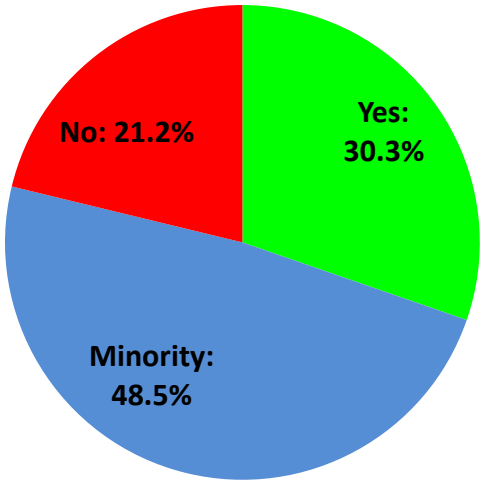
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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32. Do you **recommend** radium-223 as a first-line treatment for **symptomatic** CRPC patientswith bone but no visceral metastases?

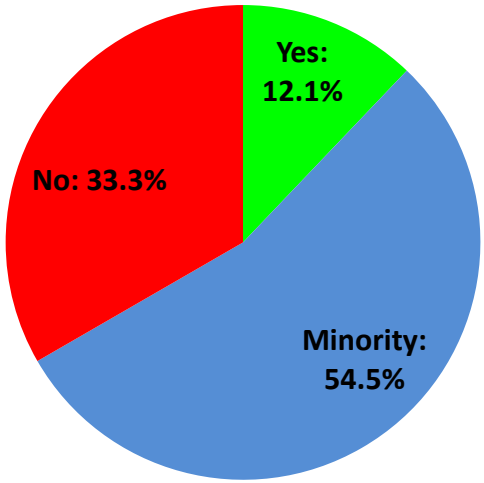
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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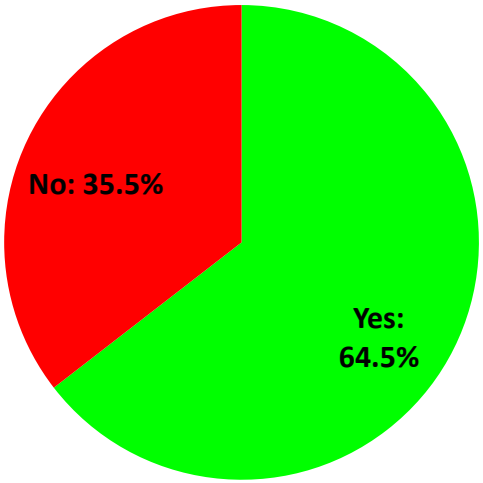
33. Is it **appropriate** to extrapolate the results of ALSYMPCA (Radium-223 vs placebo) to **symptomatic** CRPC patients with bone metastases that qualify as **fit for chemotherapy**?

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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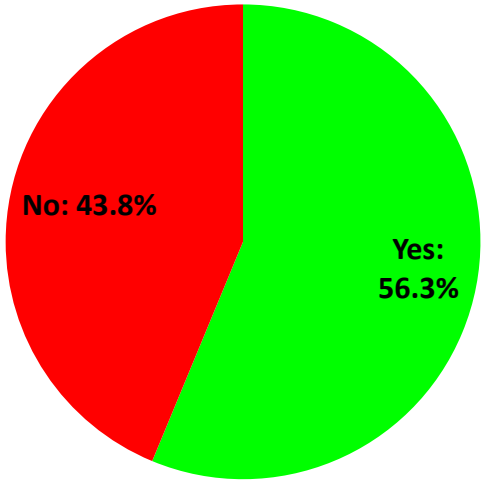
34. Is it **appropriate** to extrapolate the results of ALSYMPCA (Radium-223 vs placebo) to **asymptomatic** CRPC patients with bone but **no visceral metastases**?

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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35. Do you **recommend** Sipuleucel-T as first-line therapy for otherwise healthy, **asymptomatic** CRPC patients without visceral metastases?

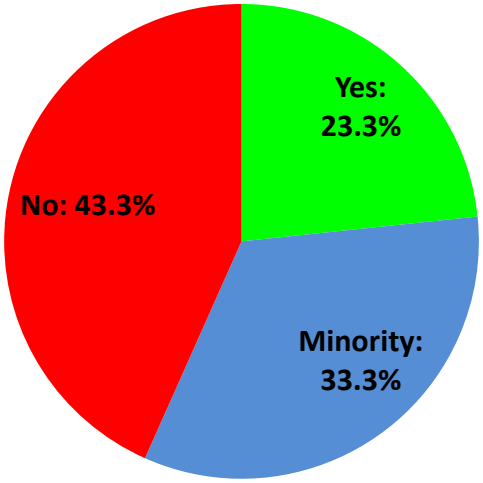
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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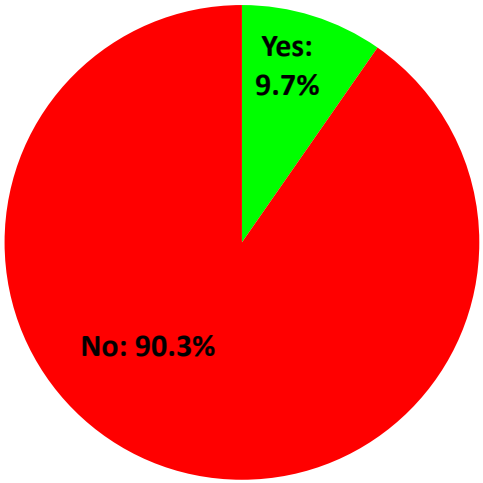
36. Is it **appropriate** to extrapolate the results of IMPACT (Sipuleucel-T vs Placebo) to patients that are **symptomatic** and/or have **visceral disease**?

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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Treatment selection abiraterone or enzalutamide in men with primary (innate) resistant and secondary (acquired) resistant prostate cancer

37. Do you **recommend** second-line treatment with abiraterone or enzalutamide in otherwise healthy patients judged to have **primary (innate) resistant** disease (no PSA decline, no radiological improvement, no clinical benefit) to first-line abiraterone or enzalutamide?

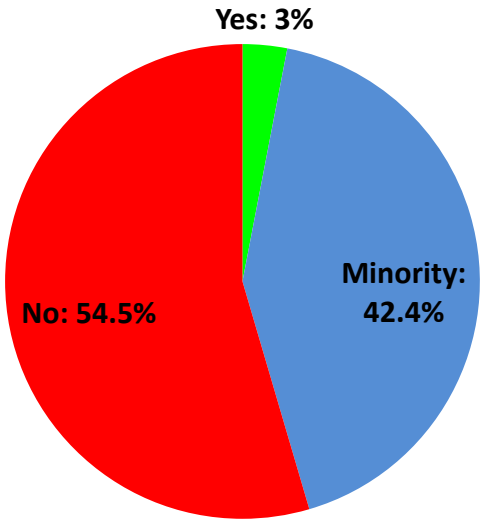
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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Treatment selection abiraterone or enzalutamide in men with primary (innate) resistant and secondary (acquired) resistant prostate cancer

38. Do you **recommend** second-line treatment with abiraterone or enzalutamide in otherwise healthy patients with **secondary (acquired) resistance** (initial response followed by progression) to first-line abiraterone or enzalutamide

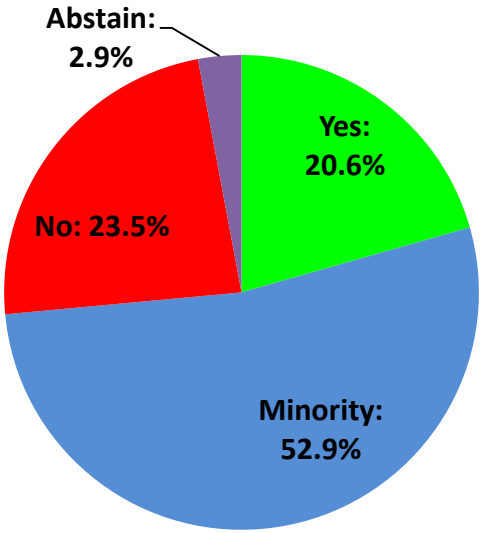
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to anser



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39. Do you **recommend** second-line treatment with cabazitaxel in otherwise healthy patients after first-line docetaxel (prior to abiraterone/enzalutamide/radium-223)?

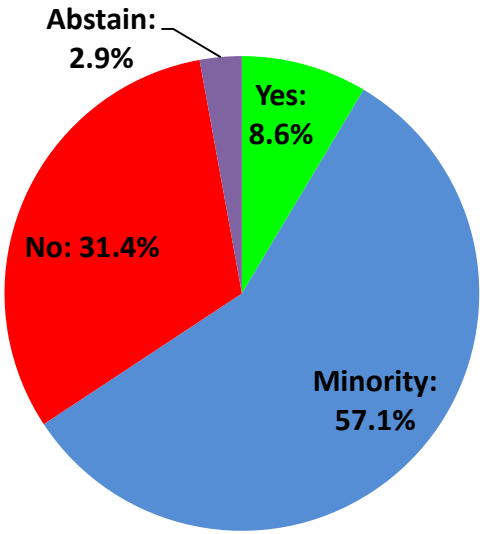
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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40. Do you **recommend** third-line treatment with cabazitaxel in otherwise healthy patients after second-line docetaxel (post first-line abiraterone or enzalutamide)?

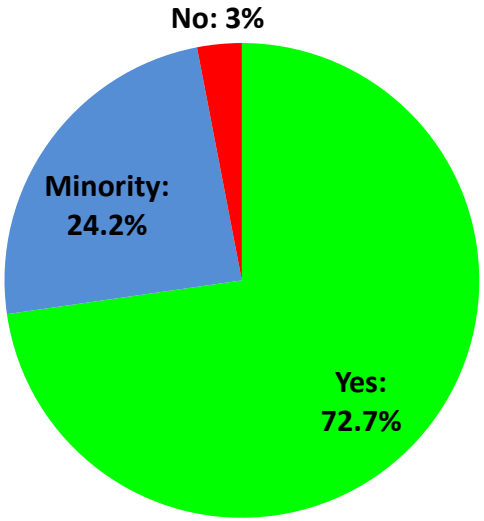
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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41. What is the **most meaningful** definition of asymptomatic/mildly symptomatic metastatic CRPC patients related to pain in the absence of other cancer related symptoms?

1 - No pain medication or only PRN pain medication

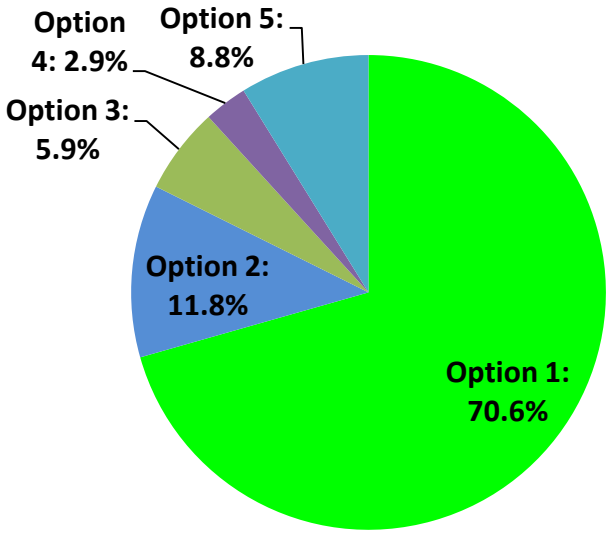
2 - A score of ≤ 4 on the brief-pain inventory short form question 3 (worst pain in the last 24 hours)

3 - Not on slow-release opioids (regular or intermittent)

4 - Other definition

5 - Abstain

6 - Unqualified to answer



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42. Do you **recommend** staging in metastatic CRPC patients before starting a new line of treatment?

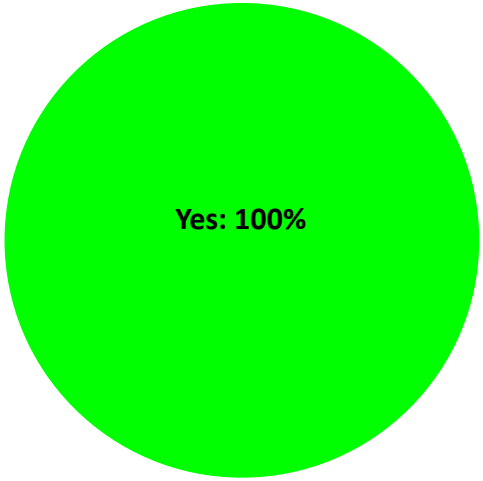
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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43. If you voted **yes** to Q42, **what** staging test(s) do you **recommend**, apart from history, clinical examination and baseline blood tests including PSA and alkaline phosphatase?

CT scan?

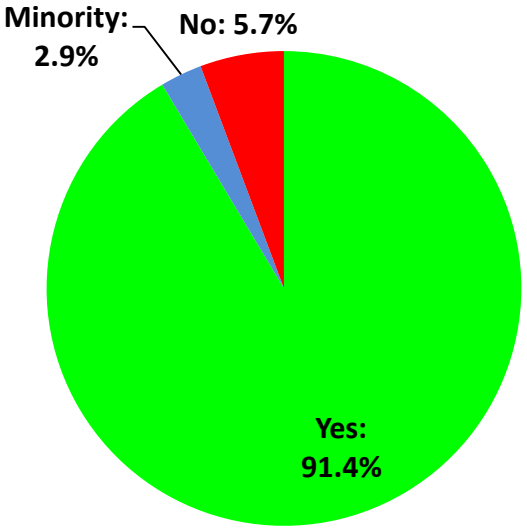
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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44. If you voted **yes** to Q42, **what** staging test(s) do you **recommend**, apart from history, clinical examination and baseline blood tests including PSA and alkaline phosphatase?

Bone scintigraphy?

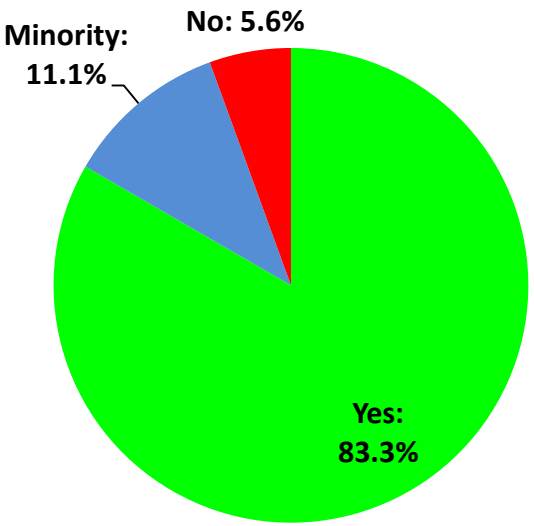
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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45. If you voted **yes** to Q42, **what** staging test(s) do you **recommend**, apart from history, clinical examination and baseline blood tests including PSA and alkaline phosphatase?

MRI of the whole spine?

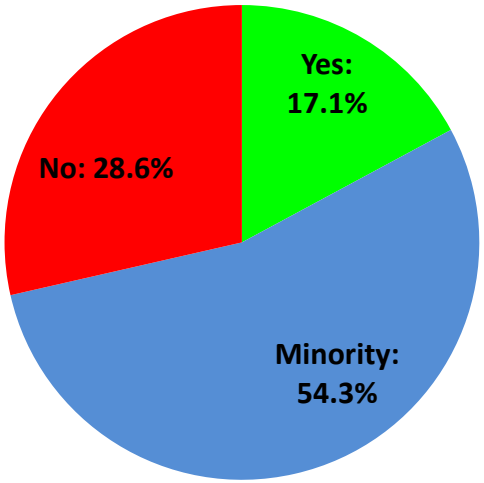
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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46. If you voted **yes** to Q42, **what** staging test(s) do you **recommend**, apart from history, clinical examination and baseline blood tests including PSA and alkaline phosphatase?

Whole body MRI and/or PET/CT (tracer of choice)?

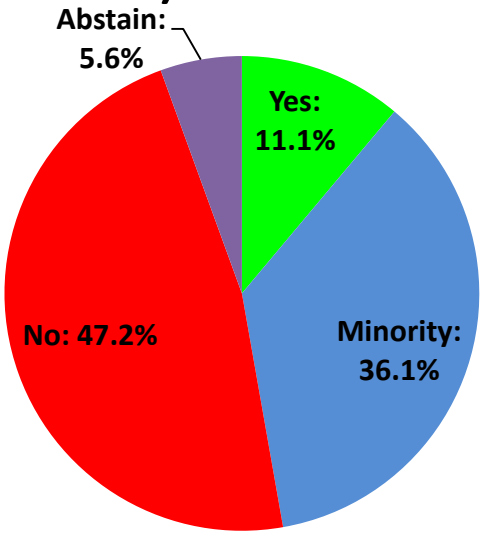
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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47. Do you **recommend regular** treatment monitoring (apart from clinical and laboratory assessment) for M1 CRPC patients on survival-prolonging therapies?

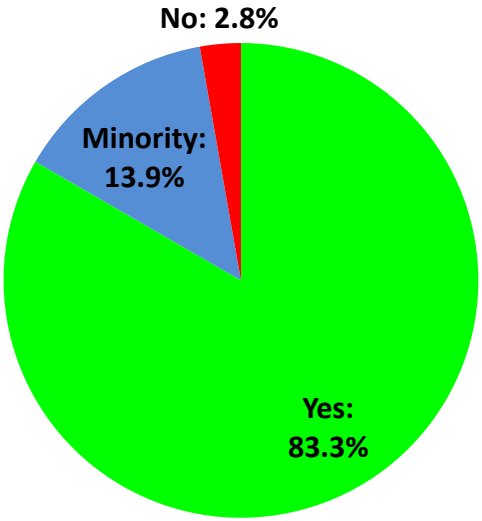
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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48. Do you **recommend regular** measurements of alkaline phosphatase for M1 CRPC patients on survival-prolonging therapies?

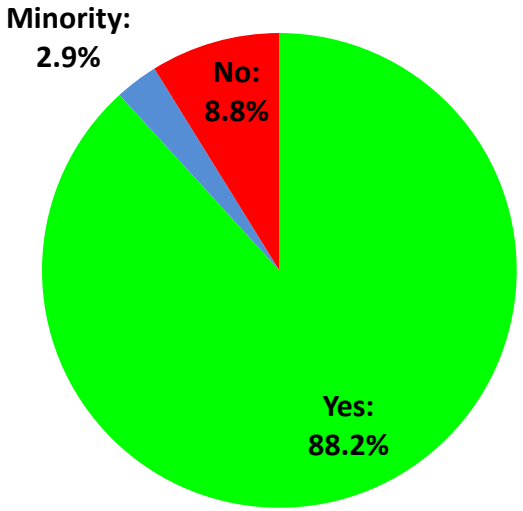
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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49. Do you **recommend regular** measurements of LDH for M1 CRPC patients on survival-prolonging therapies?

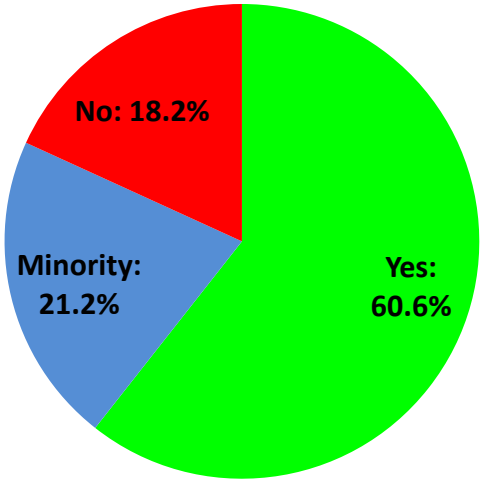
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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In M1 CRPC patients treated with **abiraterone or enzalutamide:**

50. How frequently do you recommend PSA testing?

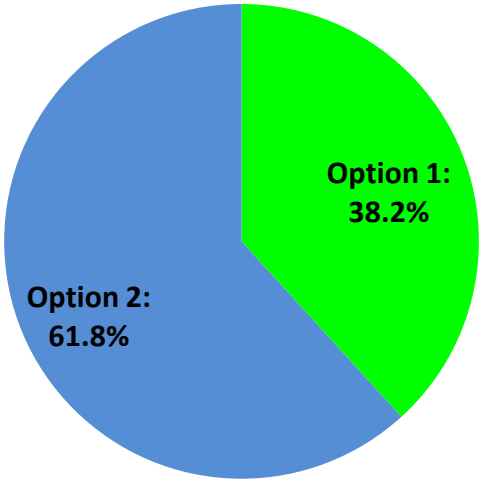
1 - Every 3-4 weeks

2 - Every 2-4 months

3 - Only if clinically indicated

4 - Abstain

5 - Unqualified to answer



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In M1 CRPC patients treated with **abiraterone or enzalutamide:**

51. If you perform CT scans for treatment monitoring, how frequently do you repeat them?

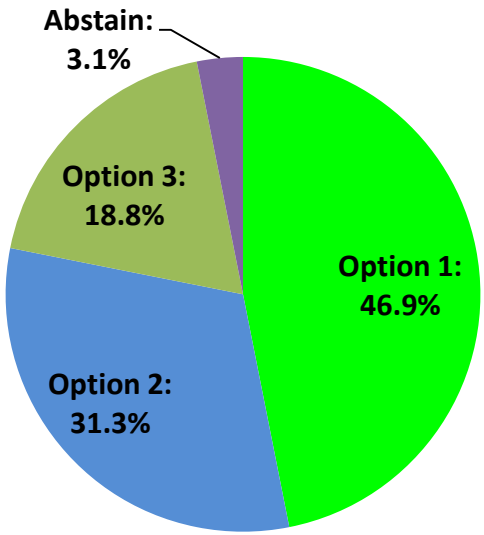
1 - Every 2-4 months

2 - Every 6 months

3 - Only if clinically indicated

4 - Abstain

5 - Unqualified to answer



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In M1 CRPC patients treated with **abiraterone or enzalutamide:**

52. If you perform bone scans for treatment monitoring, how frequently do you repeat them?

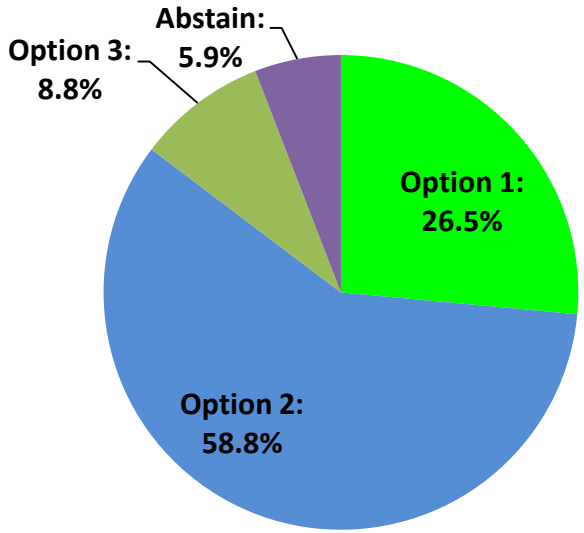
1 - Every 2-4 months

2 - Every 6 months

3 - Only if clinically indicated

4 - Abstain

5 - Unqualified to answer



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In M1 CRPC patients treated with **abiraterone or enzalutamide:**

53. If you perform whole body MRIs and/or PET/CTs (tracer of choice) for treatment monitoring, how frequently do you repeat them?

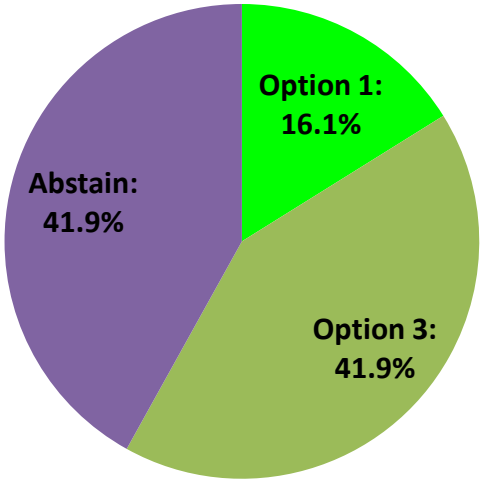
1 - Every 2-4 months

2 - Every 6 months

3 - Only if clinically indicated

4 - Abstain

5 - Unqualified to answer



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In M1 CRPC patients treated with **docetaxel or cabazitaxel:**

54. How frequently do you recommend PSA testing?

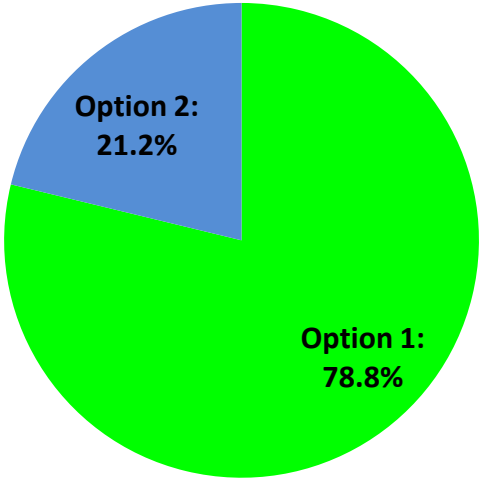
1 - Every 3-4 weeks (per treatment cycle)

2 - Every 2-4 months

3 - Only if clinically indicated

4 - Abstain

5 - Unqualified to answer



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In M1 CRPC patients treated with **docetaxel or cabazitaxel:**

55. If you perform CT scans for treatment monitoring, how frequently do you repeat them?

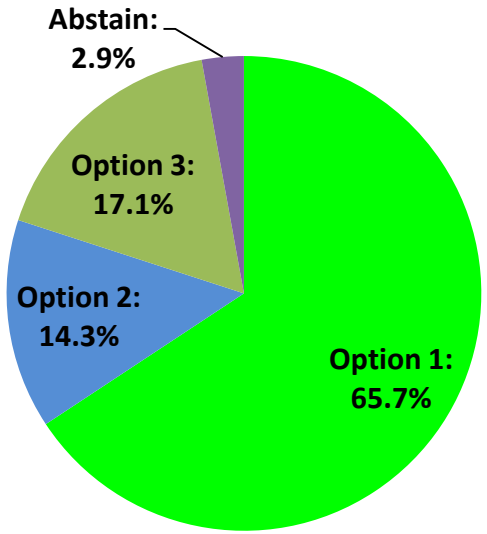
1 - Every 2-4 months

2 - Every 6 months

3 - Only if clinically indicated

4 - Abstain

5 - Unqualified to answer



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In M1 CRPC patients treated with **docetaxel or cabazitaxel:**

56. If you perform bone scans for treatment monitoring, how frequently do you repeat them?

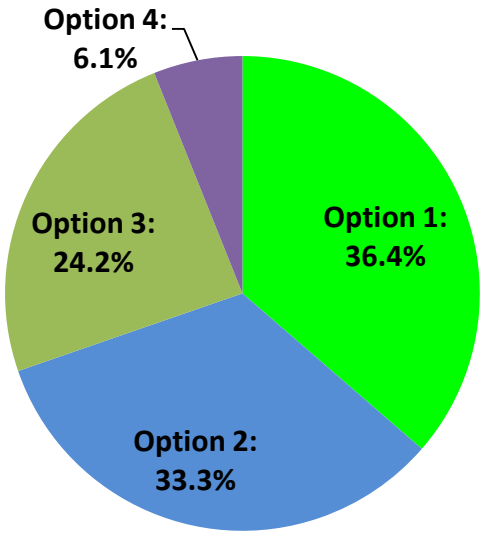
1 - Every 2-4 months

2 - Every 6 months

3 - Only if clinically indicated

4 - Abstain

5 - Unqualified to answer



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In M1 CRPC patients treated with **docetaxel or cabazitaxel:**

57. If you perform whole body MRIs and/or PET/CTs (tracer of choice) for treatment monitoring, how frequently do you repeat them?

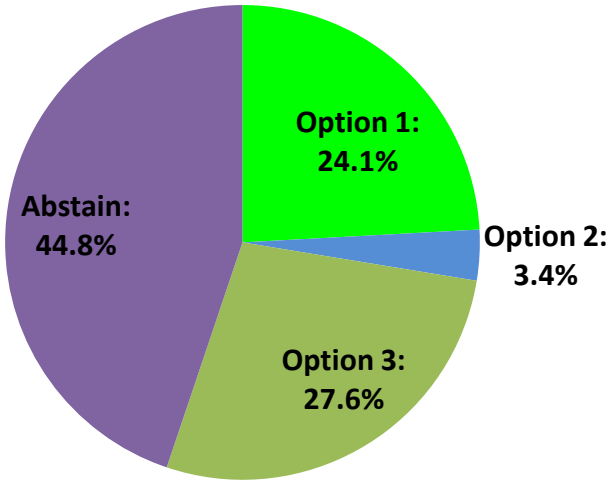
1 - Every 2-4 months

2 - Every 6 months

3 - Only if clinically indicated

4 - Abstain

5 - Unqualified to answer



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In M1 CRPC patients treated with **radium-223 or sipuleucel-T:**

58. How frequently do you recommend PSA testing?

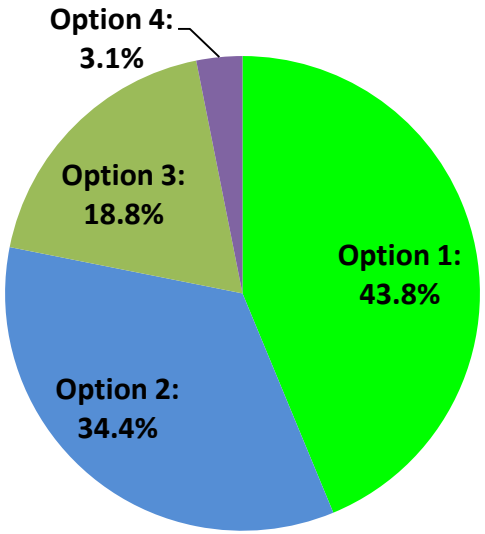
1 - Every 3-4 weeks

2 - Every 2-4 months

3 - Only if clinically indicated

4 - Abstain

5 - Unqualified to answer



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In M1 CRPC patients treated with **radium-223 or sipuleucel-T:**

59. If you perform CT scans for treatment monitoring, how frequently do you repeat them?

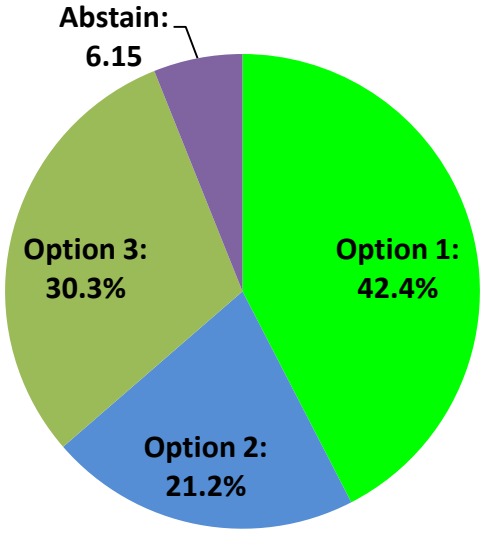
1 - Every 2-4 months

2 - Every 6 months

3 - Only if clinically indicated

4 - Abstain

5 - Unqualified to answer



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In M1 CRPC patients with **multiple spine lesions on a bone scan:**

60. How frequently do you recommend MRI of the whole spine?

1 - Every 3 months

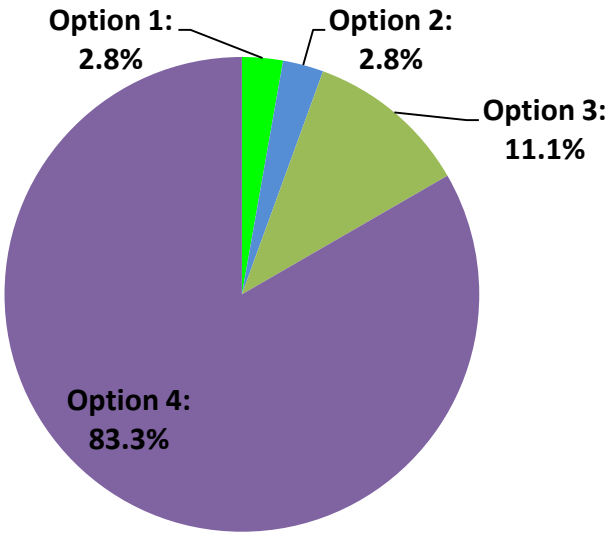
2 - Every 6 months

3 - At progression

4 - Only if clinically indicated

5 - Abstain

6 - Unqualified to answer



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61. When do you **recommend** stopping treatment for CRPC patients (excluding treatment change for toxicity):

1 - PSA rise (as per PCWG2 criteria) **only**

2 - Progression documented on imaging (as per PCWG2 criteria) **only**

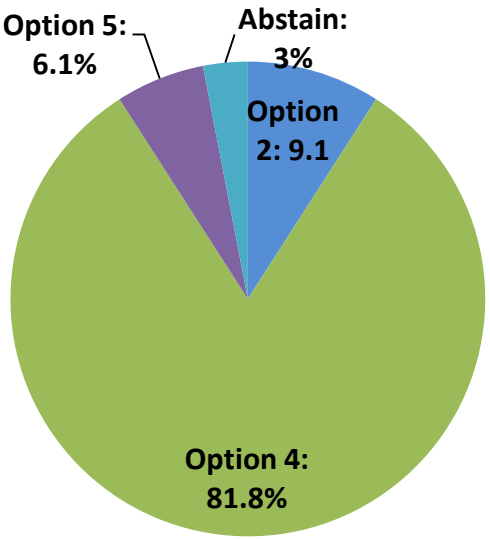
3 - Symptomatic progression **only**

4 - Two out of the three criteria above

5 - All three criteria

6 - Abstain

7 - Unqualified to answer



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62. Do you **recommend** an osteoclast-targeted therapy for SRE prevention in CRPC patients **with** bone metastases?

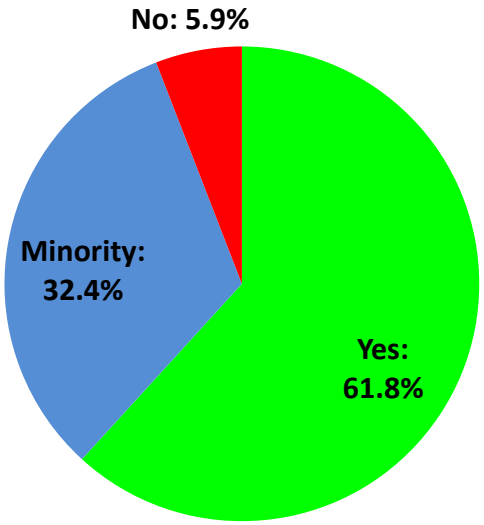
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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63. Do you **recommend** a dental check for CRPC patients with bone metastases prior to starting an osteoclast-targeted therapy?

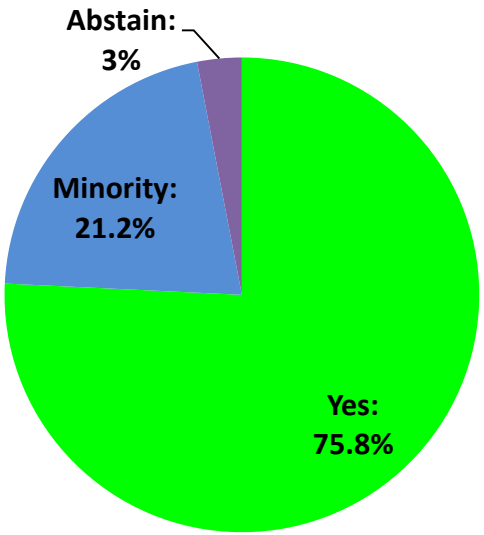
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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64. If you **recommend** an osteoclast-targeted therapy, which agent do you recommend?

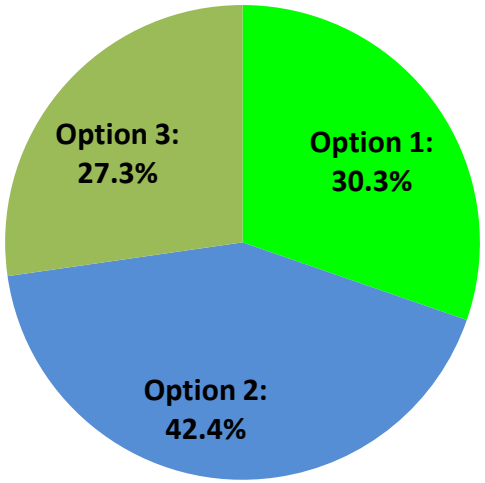
1 - Zoledronic acid

2 - Denosumab

3 - Either of them

4 - Abstain

5 - Unqualified to answer



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65. For patients with CRPC and bone metastases, what treatment schedule do you **recommend** for osteoclast-targeted therapy (zoledronic acid or denosumab)?

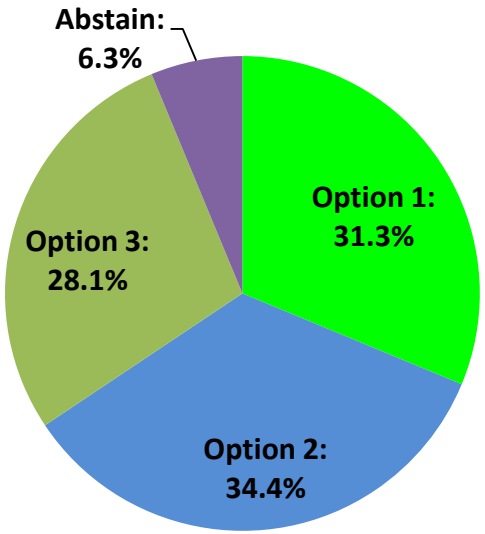
1 - Every 3-4 weeks

2 - Less frequently than every 3-4 weeks from start of therapy

3 - Every 3-4 weeks until approximately two years, after that less frequently

4 - Abstain

5 - Unqualified to answer



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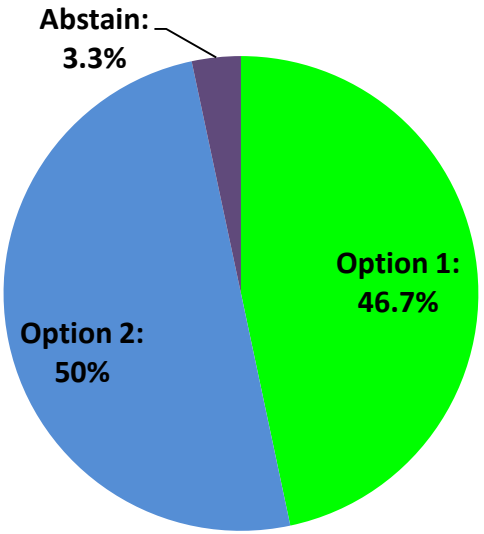
66. For patients with CRPC and bone metastases, what treatment duration do you **recommend** for osteoclast-targeted therapy (zoledronic acid or denosumab)?

1 - Approximately two years

2 - Indefinitely

3 - Abstain

4 - Unqualified to answer



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67. For patients with CRPC and bone metastases who are responding to current treatment with an approved agent, what do you **recommend** regarding concurrent osteoclast-targeted therapy (zoledronic acid or denosumab)?

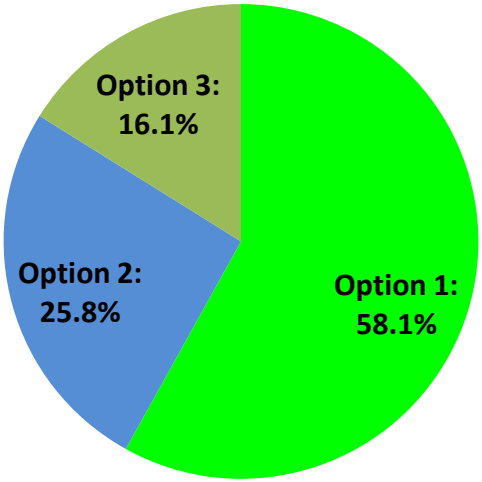
1 - Continue at the same schedule

2 - Decrease frequency of treatment

3 - Interrupt or discontinue treatment

4 - Abstain

5 - Unqualified to answer



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68. Do you **recommend** an osteoclast-targeted therapy for CRPC patients **without** bone metastases for delaying onset of metastases?

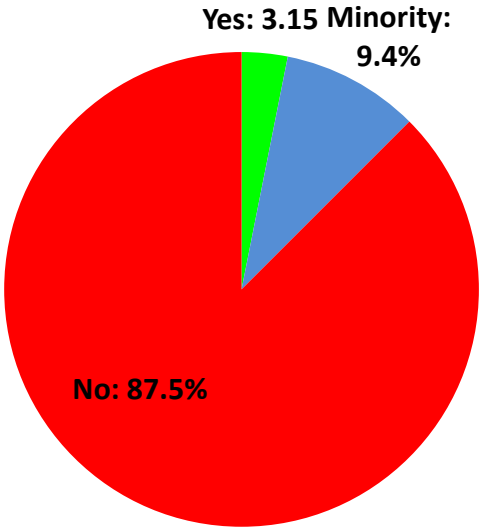
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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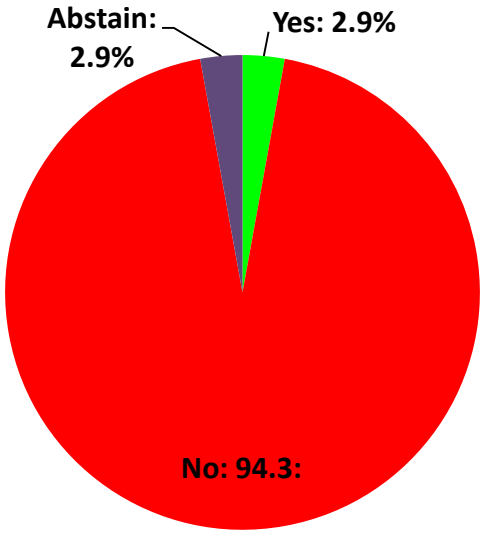
69. Is there currently a single factor to be used in daily clinical practice that is validated and established as **predictive factor** for treatment choice for CRPC patients?

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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Clinically important factors arguing **for chemotherapy** instead of survival prolonging endocrine agents are

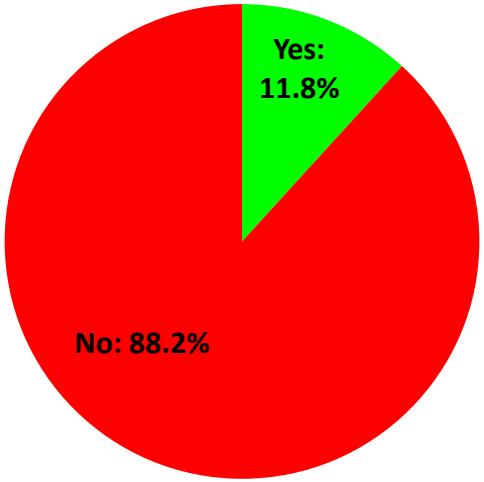
70. Gleason score ≥8

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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Clinically important factors arguing **for chemotherapy** instead of survival prolonging endocrine agents are

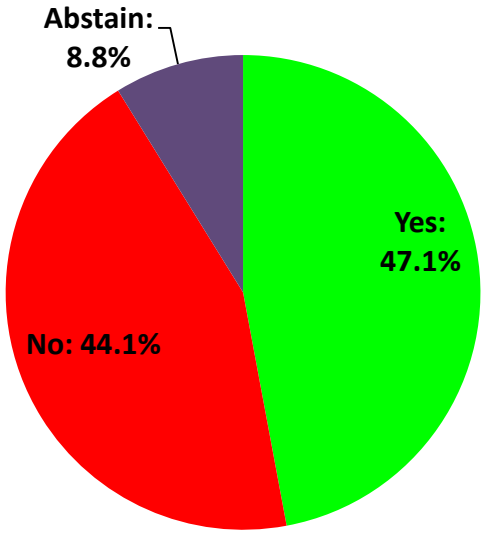
71. AR-splice variants

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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Clinically important factors arguing **for chemotherapy** instead of survival prolonging endocrine agents are

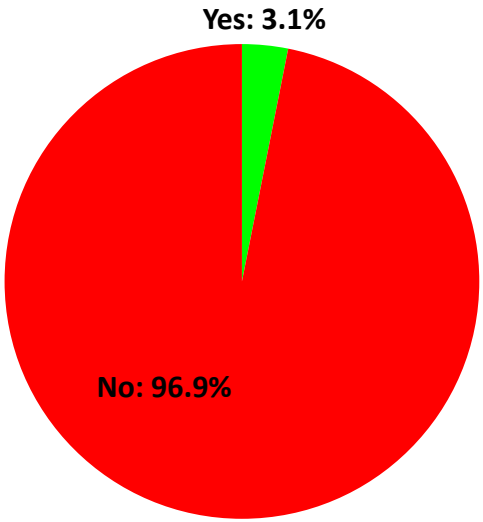
72. Baseline CTC count of ≥5/7.5ml

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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Clinically important factors arguing **for chemotherapy** instead of survival prolonging endocrine agents are

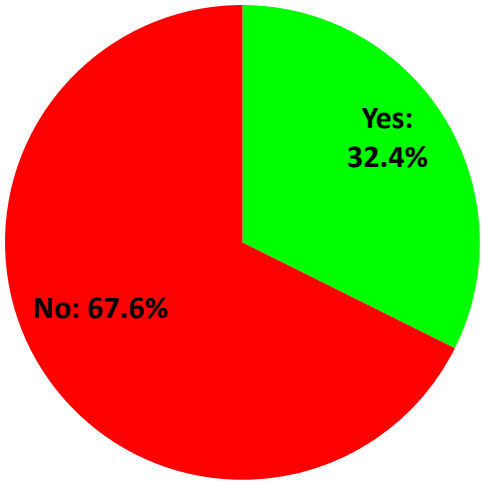
73. Extensive disease on imaging

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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Clinically important factors arguing **for chemotherapy** instead of survival prolonging endocrine agents are

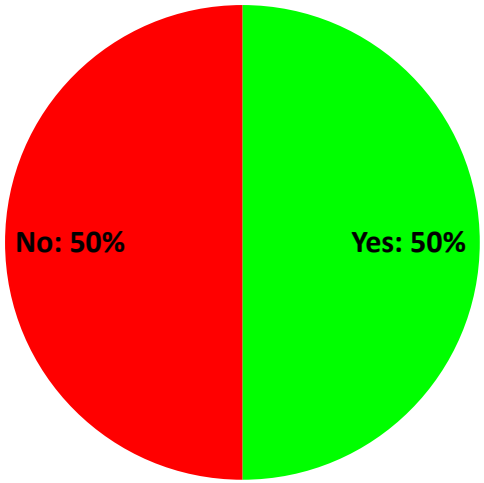
74. Visceral metastases

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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Clinically important factors arguing **for chemotherapy** instead of survival prolonging endocrine agents are

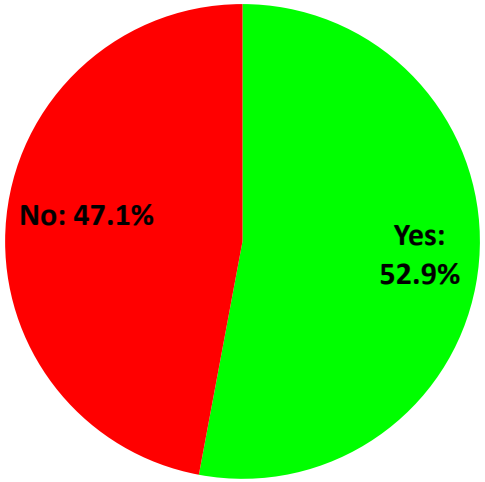
75. Short response to primary ADT (≤12 months)

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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Clinically important factors arguing **for chemotherapy** instead of survival prolonging endocrine agents are

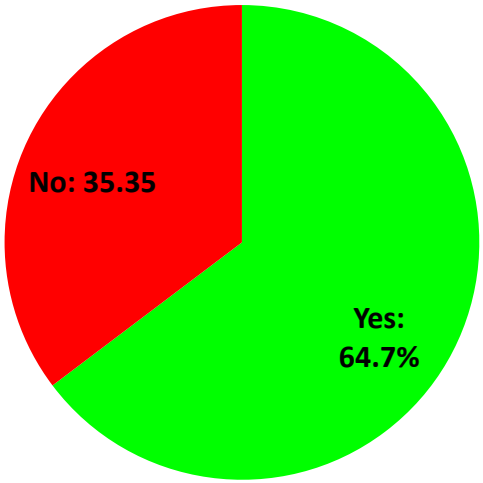
76. Low PSA (<20) and high tumour volume

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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When do you **recommend** a biopsy of a metastasis in a patient with a proven adenocarcinoma of the prostate in the initial biopsy?

77. In patients with low PSA (<20) and high tumour volume

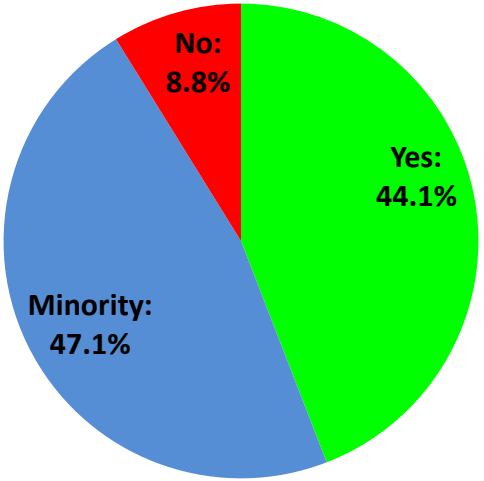
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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When do you **recommend** a biopsy of a metastasis in a patient with a proven adenocarcinoma of the prostate in the initial biopsy?

78. In patients with visceral metastases

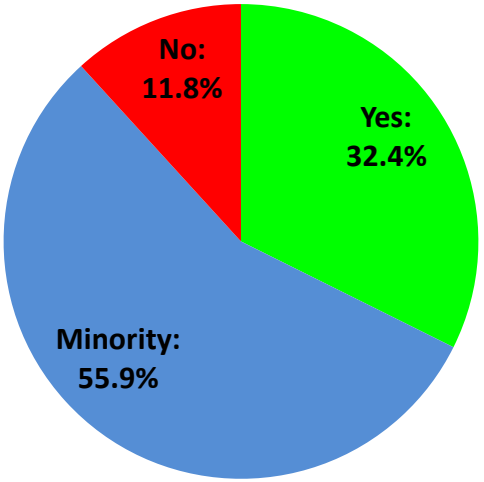
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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When do you **recommend** a biopsy of a metastasis in a patient with a proven adenocarcinoma of the prostate in the initial biopsy?

79. In case of discordant tumour response to treatment

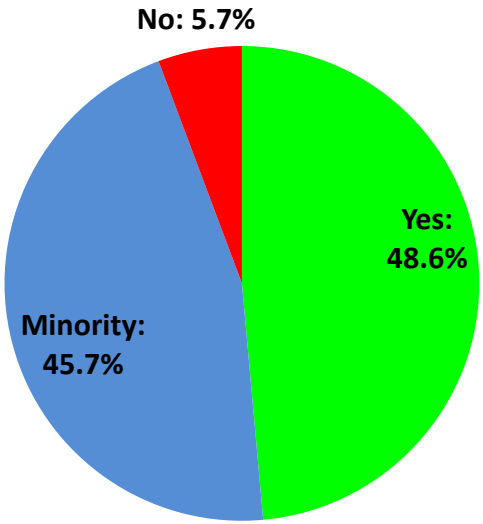
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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When do you **recommend** a biopsy of a metastasis in a patient with a proven adenocarcinoma of the prostate in the initial biopsy?

80. In case of predominantly lytic bone metastatic lesions

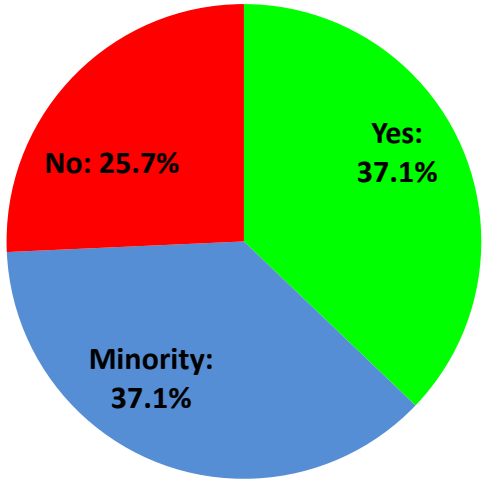
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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When do you **recommend** a biopsy of a metastasis in a patient with a proven adenocarcinoma of the prostate in the initial biopsy?

81. In a patient progressing on primary ADT within <6 months

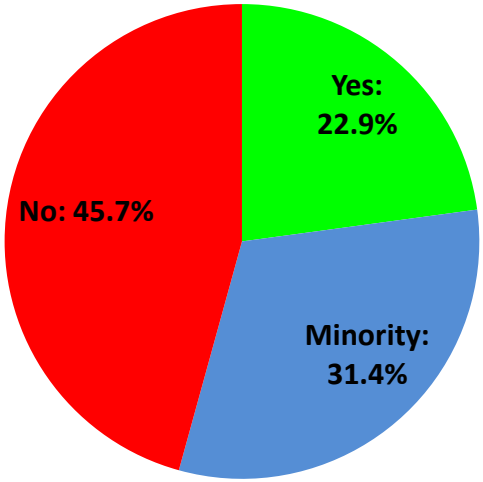
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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82. What is the most meaningful definition of oligometastatic prostate cancer

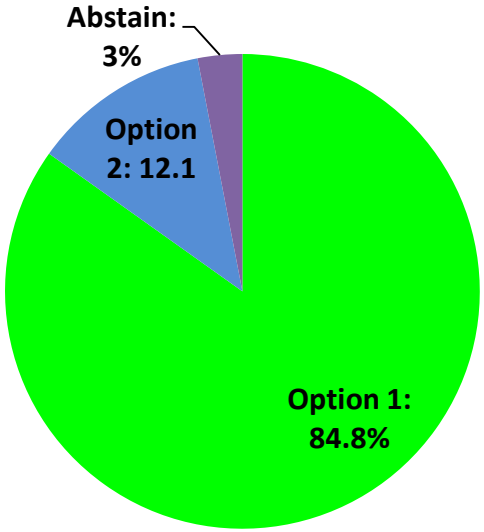
1 - ≤ 3 synchronous metastases (bone and/or lymph nodes)

2 - ≤ 5 synchronous metastases (bone and/or lymph nodes)

3 - Other definition

4 - Abstain

5 - Unqualified to answer



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83a. In a patient with newly diagnosed oligometastatic disease, do you **recommend** local treatment of the primary tumour and all metastases instead of systemic treatment?

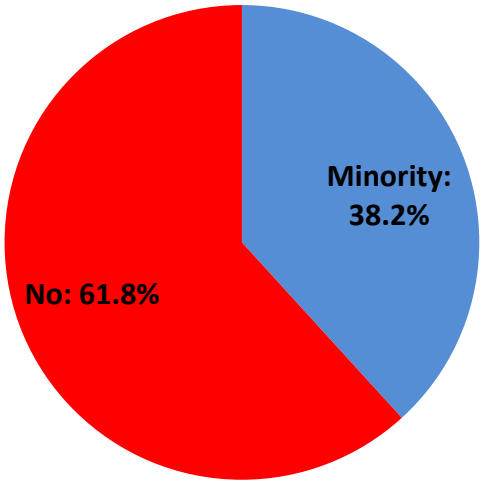
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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84a. Do you **recommend** treatment of all metastases in case of relapse with oligometastatic disease after radical local treatment instead of systemic treatment?

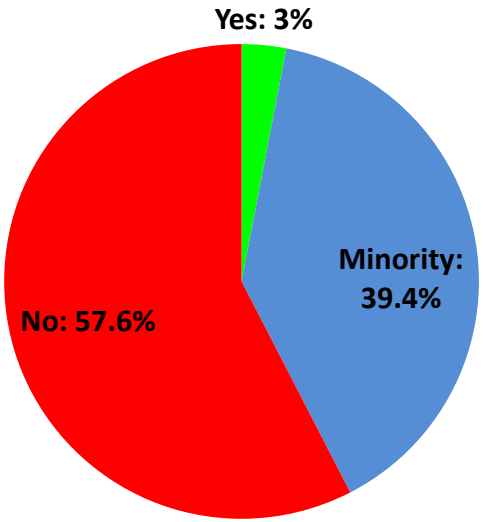
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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83b. In a patient with newly diagnosed oligometastatic disease, do you **recommend** local treatment of the primary tumour and all metastases in addition to temporary ADT?

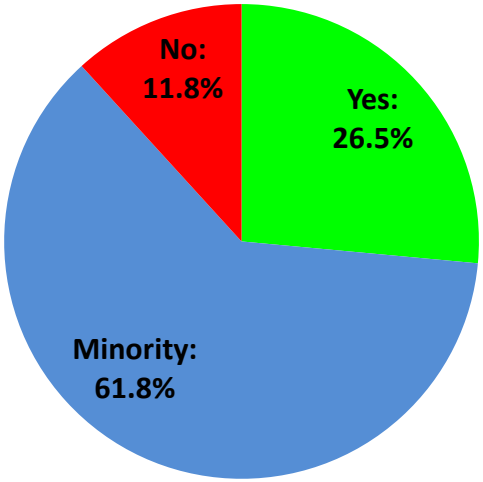
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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84b. Do you **recommend** treatment of all metastases in case of relapse with oligometastatic disease after radical local treatment in addition to temporary ADT?

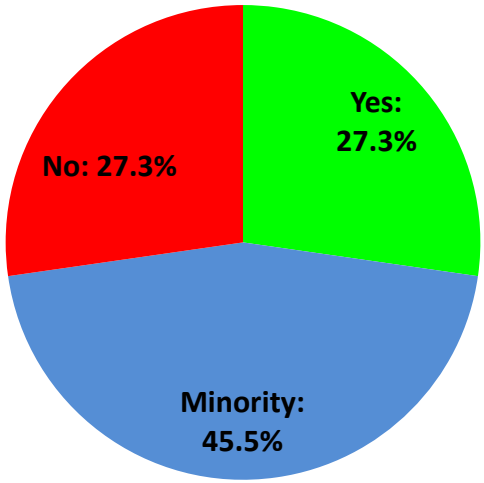
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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85. Do you **recommend** that patients should be discussed in an MDT before a new line of therapy is planned (multidisciplinary setting)?

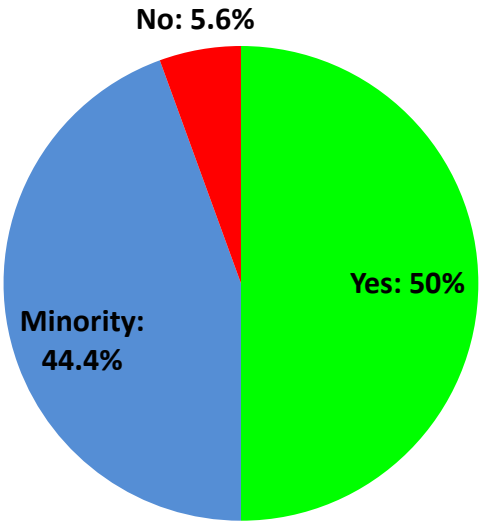
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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86. Do you **recommend** that before initiating standard treatment, otherwise healthy patients should be informed about the possibility of joining a clinical trial to improve the overall knowledge of the disease?

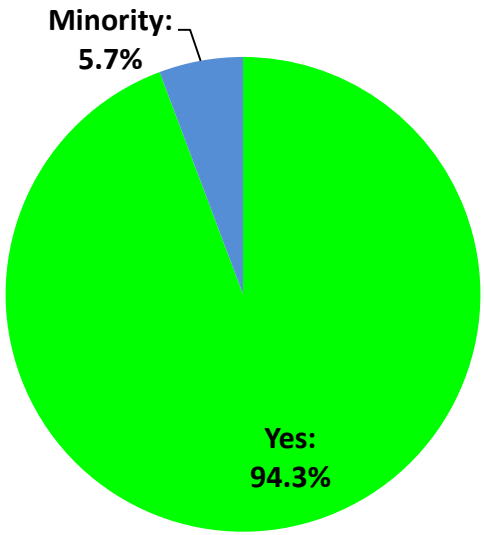
1 - Yes, in the majority of patients

2 - In a minority of selected patients

3 - No

4 - Abstain

5 - Unqualified to answer



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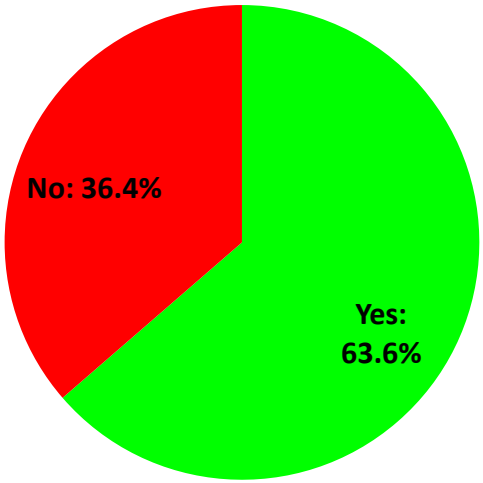
87. Do you **recommend** early access of CRPC patients to an expert in symptom palliation or a dedicated palliative care service?

1 - Yes

2 - No

3 - Abstain

4 - Unqualified to answer



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