Clinical deliberation summary · Decision support, not a clinical decision · Research-drafted — not clinician-verified

Delibera · GU Tumor Board · Deliberation Summary

70-year-old Grade Group 2 prostate cancer

No PHI

De-identified — this document carries no name, date of birth, or MRN.

Every position in this record was generated by a model configured to a specialty's remit. “The board” and the specialty titles below name those configurations, not people; no clinician authored or reviewed them.

Run 2026-09-28 22:32 UTC

01 Patient case record

What the referring documents say about this patient, as we read them. Nothing here is the board's opinion.

Staging

Clinical T stage	Not provided
Clinical N stage	Not provided
Clinical M stage	Not provided
Disease state	indeterminate

Pathology

Gleason score	3+4=7 (Grade Group 2)
Cribriform pattern	present
IDC-P	absent
Histology	Acinar adenocarcinoma
Positive margin	present
EPE	present

SVI	present
Nodes positive	2/16

Imaging

study 1 of 5 [earliest] MRI	Transition zone: PI-RADS 5: 3.0 cm mass anterior left base to midgland. No pelvic adenopathy or suspicious osseous lesions.
study 2 of 5 [+3 mo] CT	No evidence of metastatic disease in the abdomen or pelvis.
study 3 of 5 [+4 mo] NM	No scintigraphic evidence of osseous metastasis.
study 4 of 5 [+5 mo] PET/CT	Radiotracer avid right internal iliac and left common iliac lymph nodes, most consistent with nodal metastases. No osseous uptake to suggest osseous metastases.
study 5 of 5 [latest] PET/CT	Posterior to the left posterior bladder wall at the resection site, there is a small area of markedly intense uptake separate from the bladder with SUV max 20.0 […] Enlarged left para-aortic lymph nodes with mild PSMA uptake measuring 1.6 x 1.1 cm with SUV max 2.8 and inferiorly 1.5 x 2.0 cm, previously nonenlarged without radiotracer uptake. […]

Labs

PSA	06/2025 38.6 (also reported 38.56) · 12/2025 40.67 · 03/2026 1.38 · 05/2026 2.56 · 08/2026 3.46

Performance status, history & goals of care

Patient age	70 years
ECOG performance status	0

He remains very active daily as a personal trainer, has been working as one for 40 years. […] PSA nadir to 1.38 after surgery, now with rising PSA

02 Board consensus — primary recommendation

What the board recommends, why, and what has to be true first. The treating clinician makes the final call.

Primary recommendation

No definitive call until serum testosterone, prior-therapy timeline, and formal cM adjudication return — then treat as conditional framework below.

This is a post-prostatectomy recurrence (pathology pT3b pN1, Grade Group 2, positive margins, extraprostatic extension, seminal-vesicle invasion, focal cribriform pattern) with PSMA-PET–confirmed macroscopic resection-site recurrence (SUV max 20.0, read by Nuclear Medicine) and progressive multi-station nodal disease including new left para-aortic uptake. The disease is under active progression; active surveillance is off the table on the imaging and rising-PSA findings alone. Beyond that, the plan forks on data that are not yet in the record, so no single confident plan is defensible here.

The most likely branch, if confirmed, is metastatic hormone-sensitive prostate cancer, metachronous and CHAARTED low-volume (no bone or visceral disease). In that branch the treating consensus (Medical Oncology, Radiation Oncology, Urology) is: start ADT plus an overall-survival–backed androgen-receptor pathway inhibitor as a doublet, coordinated with consolidative radiotherapy to the prostate bed and involved nodes. Do not add docetaxel routinely in this metachronous, low-volume, age-70 setting.

Two disease-state facts must be established before entering that branch. First, castrate status is undocumented — testosterone has not been measured, so hormone-sensitive versus castration-resistant cannot be assigned, and the whole systemic algorithm hinges on it.

Alternative if equipoise

If formal adjudication returns cM0 / regional-only disease, the emphasis shifts to postoperative prostate-bed plus pelvic-nodal radiotherapy with ADT; SPPORT is indirect (pN1 excluded, PSA capped at 2.0), so field and duration require radiation-oncology planning rather than direct extrapolation.

Patient Goal Alignment

This case record documents no explicit patient goal or care preference. The record notes he is 70, ECOG 0, and has worked as a personal trainer for 40 years — a functional context, not a stated goal.

Cited references:

ARCHES (NCT02677896, Armstrong et al.), final OS: enzalutamide+ADT HR 0.66 (95% CI 0.53–0.81). [OS] Moderate applicability (nodal-only metachronous subset less represented).

SPPORT / RTOG 0534 (PMID 35569466) — pelvic-nodal RT + prostate-bed RT + short-term ADT superior to prostate-bed RT alone in N0/Nx, pre-RT PSA 0.1–2.0. Does not apply directly (this patient is pN1, PSA 3.46). [OS/biochemical control in a different population].

NCCN Prostate Cancer Guidelines v5.2026 — germline-testing triggers (cribriform, node-positive disease); computed risk classifications INDETERMINATE pending cT/cM (verify against current NCCN document).

03 Next steps and prerequisites

6 prerequisites · 4 conditions

What to do next. Prerequisites always apply; conditional steps apply only if their "if" turns out to be true.

Prerequisites — recorded with no condition attached

Serum testosterone — assigns hormone-sensitive versus castration-resistant status; decisive for the entire systemic algorithm.

Complete prior ADT/ARPI/chemotherapy exposure timeline — the SATURN pooled analysis (PMID 40541485) signals worse outcomes in metachronous patients with prior ADT, so this changes both disease-state assignment and expected benefit.

Formal clinical M-stage adjudication of the para-aortic nodes (expert PSMA-PET re-read; biopsy if safe and genuinely decision-changing) — reclassification to M1a changes systemic duration and radiation intent. [...]

Germline testing and somatic/ctDNA HRR + MSI/MMR + TMB profiling — not yet ordered; both to be sent now (neither germline nor somatic is recorded as sent). NCCN germline-testing triggers are met on cribriform histology and node-positive disease.

Baseline cardiovascular, hepatic, renal, and metabolic status (blood pressure, LFTs, renal function, glucose/HbA1c, medication-interaction review) before ARPI selection.

Patient goals of care — the preference that would select between intensive multimodal therapy and a lower-intensity pathway is not documented and should be elicited.

Conditional steps — each applies only if its condition is met

IF testosterone is non-castrate AND para-aortic nodes are confirmed cM1

treat as metachronous, low-volume metastatic hormone-sensitive disease — ADT + an OS-backed ARPI (doublet, not triplet), coordinated with consolidative radiotherapy to the prostate bed and involved nodes.

IF testosterone is non-castrate AND disease is adjudicated cM0/regional-only

prioritize prostate-bed + pelvic-nodal radiotherapy with ADT; individualize systemic intensification.

IF testosterone is already below castrate level with progression

this is castration-resistant disease — reconstruct the full prior ADT/ARPI/chemotherapy timeline and select the next line accordingly; avoid an empiric ARPI-to-ARPI switch after prior ARPI progression.

IF germline/somatic testing returns a qualifying HRR alteration or MSI-H/dMMR

it opens a future targeted-therapy line at castration resistance — it does not displace the mature-OS ARPI doublet now.

04 Specialty opinions

`final where filed, otherwise last recorded`

Each specialist's final position and reasoning, in their own words.

Model-generated positions — see the authorship note at the head of this record.

Medical Oncologist

Final position

Position revised during the deliberation — the earlier wording is not retained in this record

Conditionally endorse ADT plus an OS-backed androgen receptor pathway inhibitor if non-castrate cM1 disease is formally established, generally without docetaxel, while Radiation Oncology evaluates prostate-bed and nodal treatment. First document serum testosterone, complete prior systemic-treatment exposure, cardiovascular and organ-function status, and formal clinical M stage; consider biopsy or expert imaging adjudication of the mildly PSMA-avid para-aortic nodes if their classification would materially change treatment intent.

Where this specialty disagreed

Partial agreement

with Radiologist: Agree that imaging shows progression and suspicious para-aortic disease, but disagree with describing this as CHAARTED high-volume disease.

Partial agreement

with Radiation Oncologist: Agree with multidisciplinary radiation review, but MDT or extended-field RT has no established OS benefit and must remain individualized.

Dissent

with Nuclear Medicine: The PSMA read is useful, but present-tense RLT eligibility is premature and wrong for the unresolved disease state.

Radiation Oncologist

Final position

Position revised during the deliberation

Conditional recommendation for consolidative radiotherapy coordinated with systemic therapy, pending confirmation of hormone-sensitive status. [...]

Important cautions: This extended-field treatment increases acute GI/GU toxicity and marrow exposure; discuss potential travel burden. Patient-specific factors: His active lifestyle and work as a personal trainer make ADT/RT side effects (fatigue, urinary/bowel changes) particularly consequential; involve supportive care early.

Where this specialty disagreed

Partial agreement

with Radiologist: Agree on imaging findings but refined 'polymetastatic' vs 'low-volume' terminology.

Partial agreement

with Medical Oncologist: Agree on systemic backbone (ADT+ARPI if HSPC) and need for testosterone confirmation. My role adds the radiation component.

Dissent

with Nuclear Medicine: Disagree on framing RLT eligibility as current-line actionable.

Urologist

Final position

Position revised during the deliberation

No urologic surgical re-intervention is indicated; management is systemic plus radiation, with handoffs to Medical Oncology and Radiation Oncology. New urologic constraint for RT planning: this patient's R1 resection (positive surgical margin), pT3b pathology, and macroscopic resection-site recurrence (SUVmax 20) place him in the prostate-bed-inclusive RT cohort — the Challis data supporting prostate-bed omission applied to R0/lower-stage patients and does not apply here.

Radiation Oncology should include the prostate bed in any field design. [...]

Where this specialty disagreed

Partial agreement

with Radiation Oncologist: MDT/extended-field RT framing is appropriate but did not explicitly anchor prostate-bed inclusion to R1/pT3b pathology; MDT OS benefit correctly limited to PFS claim

Dissent

with Nuclear Medicine: RLT-eligibility per VISION is a wrong-disease-state claim; patient is likely HSPC, ARPI/taxane-naive; RLT is not a current-line option

Radiologist

Final position

Position revised during the deliberation

The latest PSMA-PET/CT report states a small area of markedly intense uptake (SUV max 20.0) at the resection site, suspicious for residual or recurrent prostate cancer. [...] This constitutes progression by PCWG4 criteria due to new lesions, specifically new M1a nodal disease.

[...] This pattern of recurrence, with local recurrence and multi-station nodal involvement including new para-aortic nodes, indicates a significant disease burden that is low-volume by CHAARTED definition but extensive for MDT considerations.

Pathologist

Final position

Position revised during the deliberation

The post-prostatectomy pathology report describes acinar adenocarcinoma with a Gleason score of 3+4=7 (ISUP Grade Group 2), positive surgical margins, extraprostatic extension, seminal vesicle invasion, and involvement of 2 out of 16 regional lymph nodes (pN1). A focal cribriform pattern is present. [...] The presence of pN1 disease and cribriform histology are aggressive features.

Nuclear Medicine

Final position

Position revised during the deliberation

F-18-PSMA-PET demonstrates macroscopic local recurrence at the prostate bed (SUVmax 20.0, markedly intense) and progressive PSMA-avid nodal disease (right internal iliac, left obturator, left common iliac, and new left para-aortic nodes). [...]

This confirms PSMA-avidity adequate for RLT, but RLT is not an indicated current-line option—it is hypothetical for a future CRPC line only. [...]

Testosterone level and formal M1a adjudication remain critical gaps.

05 Supporting evidence

18 retrieved · 14 cited by a specialty

The papers and guidelines the board drew on, and which specialty used each one.

Source
The addition of androgen deprivation therapy and pelvic lymph node treatment to prostate bed salvage radiotherapy (NRG Oncology/RTOG 0534 SPPORT): an international, multicentre, randomised phase 3 trial. pubmed · PMID 35569466 · cited by a board statement
Salvage prostate bed plus elective pelvic node radiation without androgen deprivation therapy. pubmed · PMID 37480525 · retrieved, not cited by any specialty
Avoiding prostate bed radiation for the PSMA-PET detected nodal recurrence patient post prostatectomy. pubmed · PMID 39676999 · cited by a board statement

Pattern of recurrence after stereotactic body radiotherapy for para-aortic oligo-recurrent prostate cancer, a multicentric analysis.

pubmed · PMID 37597125 · cited by a board statement

Optimizing the therapeutic ratio of PSMA-PET-guided para-aortic radiotherapy for prostate cancer: A systematic review and structured quantitative synthesis.

pubmed · PMID 42691517 · cited by a board statement

Germline and somatic mutations in prostate cancer: Implications for treatment.

pubmed · PMID 38718711 · cited by a board statement

DNA repair deficiency as circulating biomarker in prostate cancer.

pubmed · PMID 36793600 · cited by a board statement

Recent and Future Developments in the Use of Poly (ADP-ribose) Polymerase Inhibitors for Prostate Cancer.

pubmed · PMID 39638687 · cited by a board statement

Clinical applications of PARP inhibitors in breast, ovarian, and prostate cancer: current insights and future directions.

pubmed · PMID 42283711 · retrieved, not cited by any specialty

Comparative Survival in Metastatic Hormone-sensitive Prostate Cancer by Volume of Disease and Timing of Metastasis: A Living Network Meta-analysis.

pubmed · PMID 41193370 · cited by a board statement

First-Line Systemic Treatments of Metastatic Hormone-Sensitive Prostate Cancer: Updated Systematic Review and Network Meta-Analysis.

pubmed · PMID 42171515 · retrieved, not cited by any specialty

Age and Treatment Intensification in Metastatic Hormone-Sensitive Prostate Cancer.

pubmed · PMID 41147826 · cited by a board statement

Development and Validation of a Computational Histology Artificial Intelligence-Powered Biomarker in Metastatic Hormone-Sensitive Prostate Cancer on Randomized Phase III Trials.

pubmed · PMID 42418739 · retrieved, not cited by any specialty

Impact of comedonecrosis on prostate cancer outcome: a systematic review.

pubmed · PMID 37195595 · cited by a board statement

Oncological outcomes of cribriform histology pattern in prostate cancer patients: a systematic review and meta-analysis.

pubmed · PMID 36216967 · cited by a board statement

SPARKLE: a new spark in treating oligorecurrent prostate cancer: adding systemic treatment to stereotactic body radiotherapy or metastasectomy: key to long-lasting event-free survival?

pubmed · PMID 36503429 · cited by a board statement

Pooled Analysis of the SOLAR and SATURN Clinical Trials Comparing Progression of Synchronous Versus Metachronous Prostate-specific Membrane Antigen-defined Oligometastatic Prostate Cancer Following Systemic and Tumor-directed Therapy.

pubmed · PMID 40541485 · cited by a board statement

Best therapeutic approach in metastatic hormone-sensitive prostate cancer based on disease volume: a systematic review and network meta-analysis.

pubmed · PMID 41247101 · cited during the deliberation, not in a final statement

06 Missing & unconfirmed data

structured data fields: insufficient

Facts the board wanted and did not have. Anything above that depends on one of these is an assumption until it is confirmed.

The board never established

Unestablished — not retrieved, not confirmed

The completeness assessment flagged the following as missing, and no structured input in the record supplies them. Any board argument resting on one of these rests on assumption.

- disease state (clinical M stage (cM0/cM1))
- clinical T stage
- NCCN risk group (prostate): INDETERMINATE (deterministic gate could not classify -- missing cT stage)

Retrospective: case facts this record has not established or did not use. The forward-looking actions the plan depends on are listed under “Next steps and prerequisites”, earlier in this document.

07 Clinical trials

10 found · as of 2026-09-28 22:42 UTC

Trials in the public registry for this diagnosis. Listing one here says nothing about eligibility — enrollment criteria were not evaluated.

This section lists registry entries matching the diagnosis and reproduces each entry's enrollment criteria exactly as the registry publishes them; it does not assess eligibility, and no criterion has been checked against this patient's record.

Searched “prostate cancer” (recruiting or not yet recruiting). Not narrowed by M stage: this case’s M stage is not recorded or not assessable.

PSMA PET/CT-Guided SBRT Plus Darolutamide in mHSPC NCT07649421

Status	Not yet recruiting
Phase	Phase 2
Study type	Interventional

Using Rectal Hydrogel Spacer for Salvage SABR in Prostate Cancer NCT05597852

Status	Recruiting
Phase	Not applicable
Study type	Interventional

Predictive and Prognostic Markers for Treatment Outcomes in Prostate Cancer Patients NCT03237026

Status	Recruiting
Phase	Not applicable (observational)
Study type	Observational

Human in the loop

This is decision support. The treating clinician makes the final call. Research-drafted board output; not yet clinician-verified.

Report ID
report_ee1359cb-aac0-4ba7-a9ca-f6c6738dd313

Run timestamp
2026-09-28 22:32 UTC

Board
GU Tumor Board

Synthetic patient. Seven sections of the document produced on 28 September 2026, shortened where marked [...]. The words are the product's; the type and colour are this site's.