VIEWPOINT

Integrating Oncology Lessons Across Tumor Types From Kidney to Prostate—A Good-Risk Shift

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In recent years, oncology has witnessed increasing complexity in the therapeutic management of metastatic prostate cancer. Notably, the paradigm of intensive systemic treatment—based on the early addition of agents such as chemotherapy or novel hormonal therapies to androgen deprivation therapy (ADT)—has been increasingly questioned in selected patient subgroups. Among these, patients with low-volume, metachronous metastatic disease stand out. According to classifications derived from the CHAARTED and LATITUDE studies,[1] these patients typically exhibit slower disease progression, a limited tumor burden, and a prolonged response to ADT alone, suggesting a more indolent clinical behavior.

Despite these favorable features, current international guidelines continue to recommend combination therapy with ADT and a novel androgen receptor pathway inhibitor (such as abiraterone, enzalutamide, apalutamide, or darolutamide) for these patients, based on overall survival data from pivotal trials including TITAN, ARCHES, ENZAMET, and ARASENS, which also enrolled individuals with low-volume disease.[2] The aim is to maximize disease control and delay progression to castration-resistant states.

Nevertheless, a relevant clinical question remains open: is intensive treatment always necessary from the outset in patients with metachronous, low-volume disease? In this population—characterized by lower biological aggressiveness and in which quality of life is of particular concern—there is growing support for a more personalized therapeutic approach. This involves critically assessing the balance between efficacy and toxicity while awaiting prospective trials designed specifically for this setting.

Several studies suggest that, despite their metastatic status, these patients display biological characteristics that are more indolent, in some respects resembling those of so-called "good-risk" metastatic renal cell carcinoma, as defined by the International Metastatic RCC Database Consortium (IMDC). In the latter group, systemic treatment is increasingly shifting toward less aggressive approaches, avoiding immediate dual-agent combinations. For patients with favorable risk (0 IMDC risk factors), international guidelines—including those from European Society For Medical Oncology and European Association of Urology—support initial monotherapy with a tyrosine kinase inhibitor, such as sunitinib or pazopanib, or the adoption of a sequential approach, initiating immunotherapy (eg, nivolumab) only upon disease progression.[3,4]

In the CheckMate 214 trial,[5] which compared nivolumab plus ipilimumab to sunitinib, patients with favorable risk experienced improved progression-free survival and higher objective response rates with tyrosine kinase inhibitor monotherapy, suggesting that treatment intensification may not be the optimal strategy for this subset. These findings have fostered a broader reflection within the scientific community: in patients with good risk, the risk of overtreatment is tangible, and quality of life may be compromised by avoidable toxicities without a clear oncological benefit.

The analogy with low-volume, metachronous metastatic prostate cancer is not only clinical but also strategic. Both groups present potentially indolent disease, prolonged time to progression, and sustained responses to hormonal or targeted therapies. This places the clinician before a similar challenge: to ensure the best balance between efficacy and tolerability while avoiding unnecessarily aggressive treatments in patients with favorable prognosis. In this context, personalization of therapy emerges as a clinical priority, guided not only by anatomical and temporal factors, but also by more refined biological, molecular, and functional profiling.

In this evolving scenario, ADT monotherapy is regaining relevance in the therapeutic discourse. Far from representing a suboptimal choice, ADT may constitute a rational, personalized, and sustainable option—especially for selected patients with low-volume metastatic disease and indolent biological behavior. However, for such an approach to be credibly proposed, more accurate selection criteria must be developed. These should incorporate molecular biomarkers, genomic profiling, radiomic analyses, and other clinico-biological parameters to better stratify individual risk and identify patients who may or may not benefit from treatment intensification.

In this context, the proposal to use ADT alone, rather than in combination with novel antiandrogens, finds rational clinical application in specific patient subgroups—such as older individuals with significant comorbidities, those with lymph node-only disease without bone involvement, and more broadly, those with metachronous and biologically indolent disease, in whom treatment tolerability is of paramount importance. In these cases, therapy intensification may not only fail to yield substantial survival benefits, but also expose patients to avoidable toxicities and impaired quality of life.

The comparison with favorable-risk renal cancer—though based on distinct biological grounds—illustrates a conceptual shift in the approach to metastatic disease: not all metastases necessitate aggressive treatment. In specific clinical contexts, a de-intensified approach can ensure effective disease control, reduced cumulative toxicity, and preservation of quality of life without compromising oncologic outcomes. Furthermore, rationalizing treatment intensity in patients with good prognosis contributes significantly to health care sustainability by limiting the early and widespread use of high-cost drugs in the absence of demonstrated clinical benefit.

An additional therapeutic dimension in low-volume metastatic prostate cancer is the role of radiotherapy. Evidence supports the use of prostate-directed radiotherapy in patients with synchronous low-volume disease.[6] Furthermore, metastasis-directed

therapy has shown promise in metachronous oligometastatic settings and in cases of oligoprogressive disease.[6] Notably, the potential for stereotactic body radiotherapy without concurrent systemic therapy is under investigation (eg, NRG Oncology GU011 trial [NCT05053152]). In renal cell carcinoma, while traditionally considered radioresistant, recent studies have highlighted a role for stereotactic body radiotherapy in selected metastatic lesions,[7] further supporting a personalized, multidisciplinary approach across tumor types.

Adopting a more selective and proportionate therapeutic model thus means not only offering a more tolerable and patient-centered treatment, but also avoiding potentially harmful overtreatment, both in terms of adverse effects and economic burden. In this light, the principle of less is more gains tangible legitimacy in prostate oncology, aligning with emerging paradigms in precision medicine and value-based care. Future prospective studies should consider this approach to better define which patients may safely benefit from treatment de-intensification.

ARTICLE INFORMATION

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Published Online: September 11, 2025. doi:10.1001/jamaoncol.2025.3168

Conflict of Interest Disclosures: None reported.

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Cancer Care Without a Safety Net—How Oncology Practices Confront the Gap

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Food insecurity remains a pressing issue in the US, affecting approximately 10% to 15% of the population. This crisis is even more pronounced in vulnerable populations, such as rural communities, racially and ethnically minoritized groups, and individuals with chronic illnesses, including cancer, where employment interruptions are common and food insecurity rates rise to 17% to 55%.[1] Despite growing recognition of the role that social determinants of health (SDOH) and health-related social needs (HRSN) play in patient outcomes, current policy trends suggest a troubling paradox: while federal funding for large-scale food assistance programs, such as the Supplemental Nutrition Assistance Program (SNAP), is being reduced, oncology practices and smaller health organizations are being tasked by payers to address these same issues—often without adequate support or financial backing.[2]

Food insecurity has significant implications for patients with cancer, who may also face more complex nutritional needs and treatment toxicity impairing nutrition, such as mucositis, dysphagia, and nausea. Lack of consistent access to nutritious food is associated with lower medication adherence, poorer quality of life, and increased rates of depression.[1,3] These factors contribute to increased medication waste, higher rates of acute care utilization, and, ultimately, faster cancer progression and higher mortality rates. Alarmingly, up to 20% of cancer-related deaths can be attributed to starvation and malnutrition rather than the disease itself.[4]

The Role of Oncology Practices in Addressing SDOH and HRSN

Recognizing the impact of food insecurity on cancer outcomes, the Center for Medicare and Medicaid Innovation and other stakeholders have expressed interest in investigating the role of oncology in addressing social needs—for example, the Enhancing Oncology Model (EOM) has explicit requirements that practices collect key pieces of information related to SDOH.[5] Many value-based care models in oncology now incorporate SDOH and HRSN considerations, but the requirements largely stop at data collection. Therefore, a key question arises: does collecting SDOH information alone lead to improved oncology outcomes in terms of quality and cost? Although oncology practices are being asked to explore this question, they are simultaneously being given minimal resources to implement meaningful interventions to address any identified SDOH needs. Practices are now being required to observe disparities, yet they are not mandated—nor funded—to address them. Neither the EOM nor commercial payers allocate additional budget to practices to fund programs that would meet the needs identified through systematic gap analysis.