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STRENGTHENING SHARED DECISION MAKING BETWEEN nmCRPC PATIENTS AND THE HEALTHCARE TEAM

GUIDE COMMUNICATION FRAMEWORK – PART 2

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nmCRPC, non-metastatic castration-resistant prostate cancer

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A REMINDER OF GUIDE

GUIDE'S five letters each represent a crucial step in your conversations with patients with prostate cancer

Gain insight into the goals of treatment and care G

Understand the gaps in the patient's knowledge U

Inform and educate I

Direct to additional support D

Empower the patient E

Steps 1-2 and 4-5 of the GUIDE framework for **'Strengthening shared decision making between nmCRPC patients and the healthcare team'** can be found on:
GU Nurses CONNECT

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PRINCIPLES AND USE OF THE GUIDE COMMUNICATION FRAMEWORK

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PRINCIPLES OF GUIDE

- ✓ GUIDE aims to support nurses in their role as a go-to figure for their patients
- ✓ The ultimate goal is to improve patient outcomes through enhanced patient engagement, understanding and outlook
- ✓ The framework may be delivered over several interactions and should be adapted to meet the patient's needs
- ✓ The role of the carer should also be considered, so they feel engaged appropriately

HOW COULD YOU USE GUIDE?

- ✓ Include each step into your conversations with patients with nmCRPC
- ✓ Consider the need to incorporate the framework over a series of consultations
- ✓ Apply the principles to communication with family or carers
- ✓ Use GUIDE in conversations with patients with other types of cancers
- ✓ Encourage your team to complete this training and follow the steps consistently

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nmCRPC, non-metastatic castration-resistant prostate cancer

STEP 3

THE GUIDE COMMUNICATION FRAMEWORK

INFORM AND EDUCATE

THE RIGHT KNOWLEDGE

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- As a nurse it is essential to have **up-to-date knowledge** on:

1. The **disease** and common symptoms
2. The **key studies** related to nmCRPC
3. The **treatment aims and options**
4. Potential **side effects and proactive management**

- Be aware of the type of information that is relevant for each individual patient, considering the patient's knowledge level and preferences

nmCRPC, non-metastatic castration-resistant prostate cancer

THE RIGHT KNOWLEDGE

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DISEASE, SYMPTOMS AND DIAGNOSTICS

Examples of resources for healthcare professionals

American Urological Association

National Comprehensive Cancer Network®

ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

ASCO® AMERICAN SOCIETY OF CLINICAL ONCOLOGY

eau European Association of Urology

Examples of resources for patients

Prostate Cancer Foundation
Curing Together.

UsTOO Prostate Cancer
SUPPORT - EDUCATION - ADVOCACY

Prostate Cancer Research

ZERO
THE END OF PROSTATE CANCER

Cancer.Net™
Doctor-Approved Patient Information from ASCO®

PROSTATE CANCER UK

- Its important to have a **detailed understanding of the pathophysiology, symptoms and key studies** related to nmCRPC
- There are many **high-quality information sources** available to help you gather this background knowledge, as well as to refer patients to

nmCRPC, non-metastatic castration-resistant prostate cancer

THE RIGHT KNOWLEDGE

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THE DISEASE: WHAT IS nmCRPC

- **Patients with rising PSA with castrate levels of testosterone** (≤50 ng/dL) despite ongoing ADT
- **No detectable metastases by conventional imaging** (bone scan and CT or MRI)
- **Generally asymptomatic** apart from symptoms from prior therapies
- nmCRPC patients with a PSADT <10 months are at significant risk for metastatic disease and prostate cancer-specific mortality
- The recent approvals of new-generation androgen-receptor pathway inhibitors address the gap in the management of nmCRPC

ADT, androgen deprivation therapy; CT, computed tomography; MRI, magnetic resonance imaging; nmCRPC, non-metastatic castration-resistant prostate cancer; PSA, prostate-specific antigen; PSADT, prostate-specific antigen doubling time

Saad F, et al. Prostate Cancer Prostatic Dis. 2021;24(2):323-34; Olivier KM, et al. Int J Urol Nurs. 2021;15:47-58; Smith MR, et al. J Clin Oncol. 2013;31:3800-3806

THE RIGHT KNOWLEDGE

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TREATMENT AIMS AND OPTIONS

Treatment goals for nmCRPC

- Delay metastases
- Prolongation of survival
- Maintaining quality of life (QoL)
  - Role functioning
  - Activities in daily life
- Balancing potential benefits against likely treatment toxicity
- Respecting patient preference in decision making

Be aware that the patient's goals and preferences may change over time, as symptoms increase, side effects mount or QoL declines

nmCRPC, non-metastatic castration resistant prostate cancer; QoL, quality of life

Lee VE, et al. J Cancer Sci Clin Ther. 2021;5:154-60

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WHAT DOES THE PATIENT WANT?

- Patients want to know that their treatment is intended to prolong their life. This means more time with family and friends
  - Meeting a new grandchild
  - Attending a wedding/graduation
  - Planning a vacation
- At this stage in their disease process, they should be educated that there is no cure for their disease and these treatments are meant to slow down the disease process to delay the development of metastases and prolong overall survival
- QoL means keeping their daily routine and being able to do the activities that they enjoy

QoL, quality of life

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HOW DOES THE PSA LEVEL AFFECT PATIENT'S PSYCHOLOGICAL OUTCOME?

- Patients are focused on their PSA level
  - Patients want to know their PSA levels and when they start treatment, they expect to see their PSA levels decrease
- Patients may have anxiety and/or depression while waiting for their PSA results
- How can Oncology Nurses help?
  - Educate patients that PSA is just one tool used to measure progression. Other tools include:
    - Imaging
    - Patient-reported symptoms
  - Reassure patients that one PSA result is not as important as the trend, which is why several PSA levels over time are used to calculate their PSADT
  - Encourage patients to focus on their well-being and maintaining their quality of life
  - The goal for patients is to feel confident with their treatment

PSA, prostate-specific antigen; PSADT, prostate-specific antigen doubling time

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EAU GUIDELINES: STRONG RECOMMENDATION

Recommendation	Strength rating
Offer apalutamide, darolutamide or enzalutamide to patients with M0 CRPC and a high risk of developing metastasis (PSADT <10 months) to prolong time metastases and overall survival.	Strong

Level 1 Evidence of Benefit:

Intensified Systemic Therapy

EAU, European Association of Urology; M0 CRPC, non-metastatic castration-resistant prostate cancer; PSADT, prostate-specific antigen doubling time

Mottet N, et al. EAU – ESTRO – ESUR – SIOG Guidelines on Prostate Cancer. Edn. presented at the EAU Annual Congress Milan 2021. ISBN 978-94-92671-13-4; https://uroweb.org/guideline/prostate-cancer/ Accessed 04-Nov-2021

THE RIGHT KNOWLEDGE

NCCN GUIDELINES: CATEGORY 1 RECOMMENDATION

National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2022
Prostate Cancer

NCCN Guidelines Index
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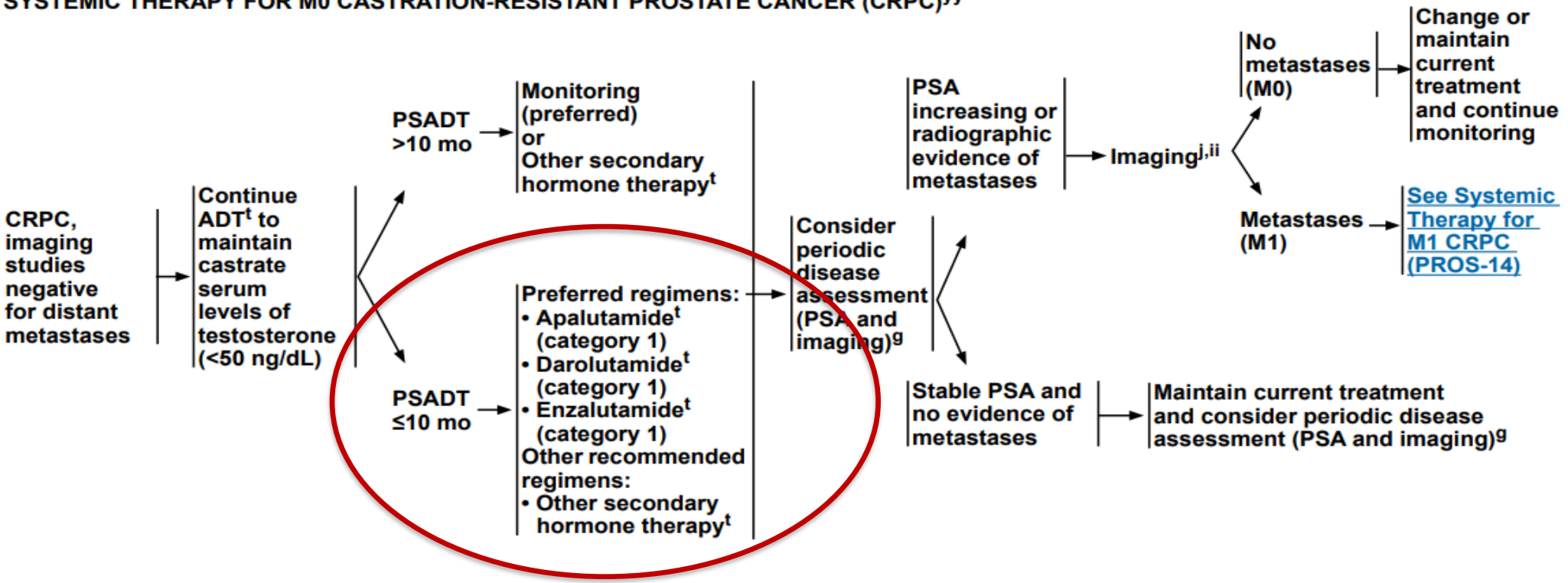
Discussion

SYSTEMIC THERAPY FOR M0 CASTRATION-RESISTANT PROSTATE CANCER (CRPC)[yy]



ADT, androgen deprivation therapy; CRPC, castration-resistant prostate cancer; M0, non-metastatic; NCCN, National Comprehensive Cancer Network; PSA, prostate-specific antigen; PSADT, prostate-specific antigen doubling time

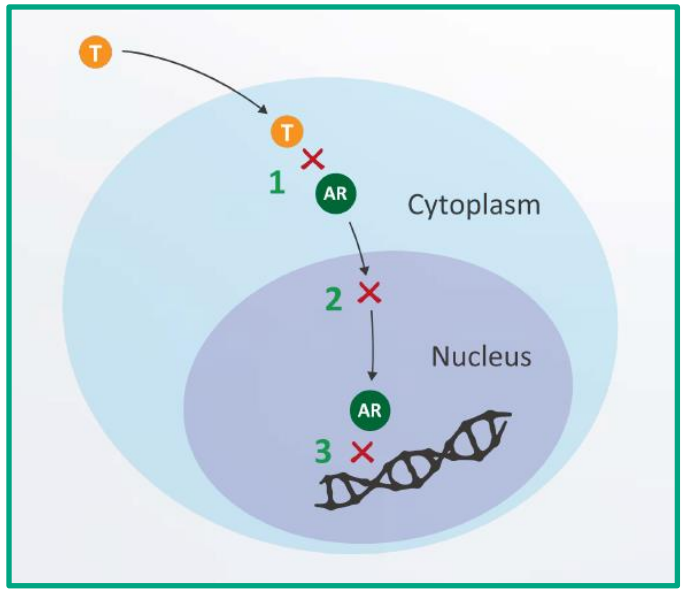
NCCN Clinical Practice Guidelines in Oncology – Prostate Cancer, Version 1.2022. Accessed 14-Oct-2021

THE RIGHT KNOWLEDGE

- APA, DARO, and ENZA are androgen receptor (AR)-signalling inhibitors

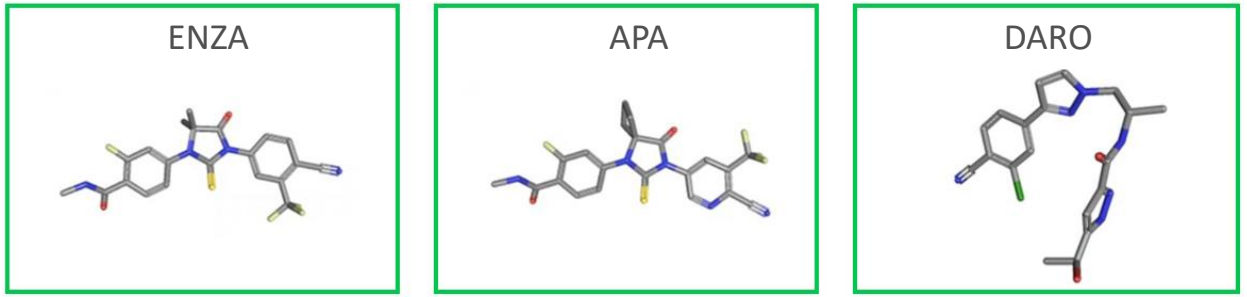
MECHANISM OF ACTION[1,2]

1. Inhibit androgen binding to AR
2. Inhibit nuclear translocation of AR
3. Inhibit AR binding to DNA



STRUCTURE

- DARO is structurally distinct from APA and ENZA, and is characterised by low blood–brain barrier penetration[2,3,4]
  - This could result in less central nervous system toxicity and improved tolerability



APA, apalutamide; AR, androgen receptor; DARO, darolutamide; ENZA, enzalutamide; T, testosterone

1. Tran C, et al. Science 2009;324:787-90; 2. Fizazi K, et al. Clin Genitourin Cancer. 2018;16(5):332-40; 3. Zurth C, et al. J Clin Oncol. 2018;36 suppl 6:345 (ASCO GU 2018 presentation); 4. Zurth C, et al. J Clin Oncol. 2019;37 suppl 7:156 (ASCO GU 2019 presentation); Images from PubChem database: https://pubchem.ncbi.nlm.nih.gov/

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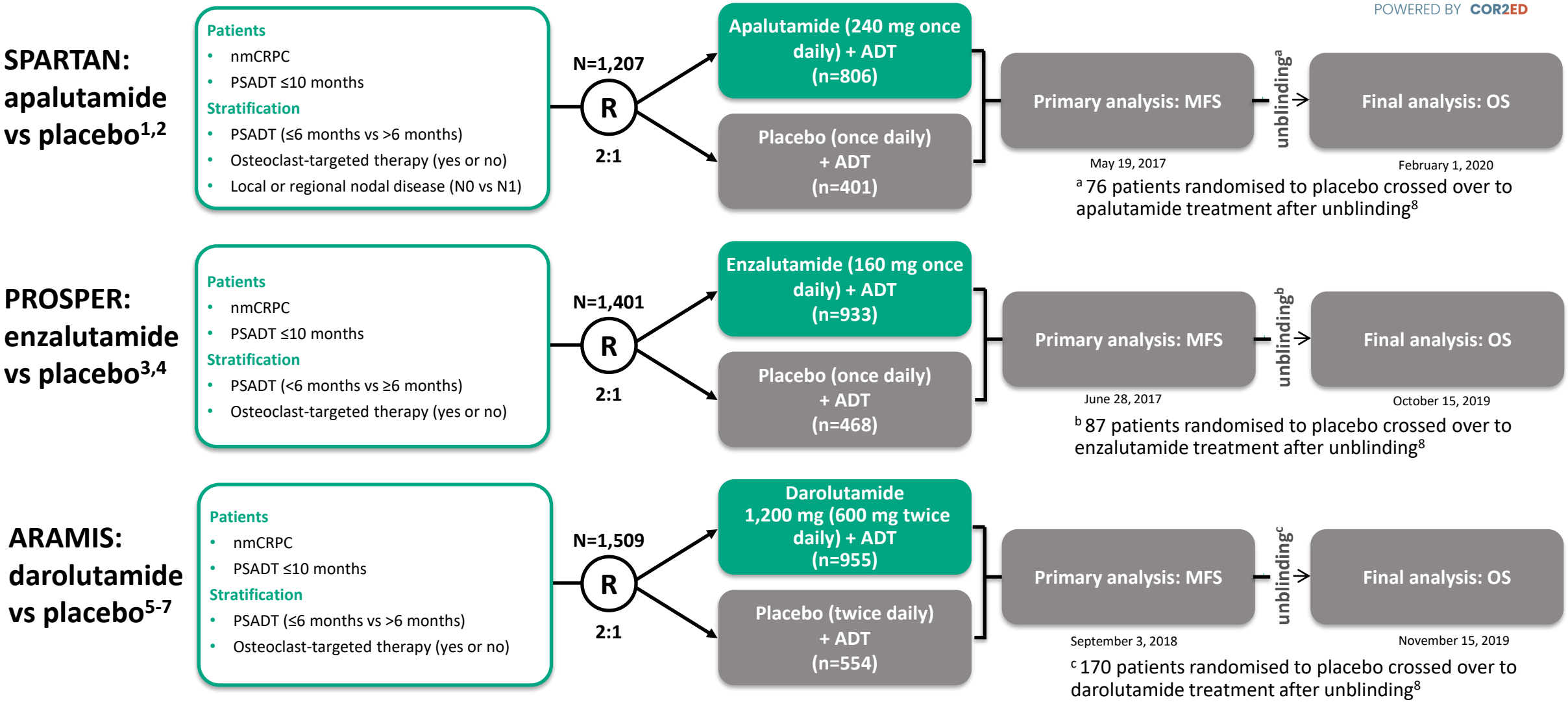
nmCRPC TREATMENT OPTIONS

- The nmCRPC treatment landscape has been transformed by the approval of three next-generation oral androgen receptor inhibitors[a]
- **Apalutamide**
  - FDA approved for nmCRPC in 2018 based on the Phase 3 SPARTAN trial
- **Enzalutamide**
  - FDA approved for nmCRPC in 2018 based on the Phase 3 PROSPER trial
- **Darolutamide**
  - FDA approved for nmCRPC in 2019 based on the Phase 3 ARAMIS trial

[a] Androgen deprivation therapy (ADT) should be given in conjunction with next-generation androgen receptor inhibitors
FDA, Food and Drug Administration; nmCRPC, non-metastatic castration resistant prostate cancer
Olivier KM, et al. Int J Urol Nurs. 2021;15:47-58

STUDY DESIGNS: SPARTAN, PROSPER, ARAMIS



ADT, androgen deprivation therapy; MFS, metastasis-free survival; nmCRPC, non-metastatic castration-resistant prostate cancer; N, node; OS, overall survival; PSADT, prostate-specific antigen doubling time; R, randomisation

1. Small EJ, et al. J Clin Oncol. 2018;36(6_suppl):161; 2. Smith MR, et al. N Engl J Med. 2018;378:1408-18; 3. Hussain M, et al. J Clin Oncol. 2018;36(6_suppl):3; 4. Hussain M, et al. N Engl J Med. 2018;378:2465-74; 5. Fizazi K, et al. J Clin Oncol. 2019;37(7_suppl):140; 6. Fizazi K, et al. N Engl J Med. 2019;380:1235-46; 7. Fizazi K, et al. N Engl J Med. 2020;383:1040-9; 8. Olivier KM, et al. Int J Urol Nurs. 2021;15:47-58

EFFICACY: PRIMARY ANALYSIS (METASTASIS-FREE SURVIVAL)

	SPARTAN (NCT01946204): Apalutamide (n=806) vs placebo (n=401)	PROSPER (NCT02003924): Enzalutamide (n=933) vs placebo (n=468)	ARAMIS (NCT02200614): Darolutamide (n=955) vs placebo (n=554)
Primary analysis			
Median follow-up	20.3 months	Enzalutamide: 18.5 months; placebo 15.1 months	17.9 months
Primary endpoint	Median MFS: 40.5 vs 16.2 months; HR 0.28; 95% CI 0.23-0.35; p<0.001	Median MFS: 36.6 vs 14.7 months; HR 0.29; 95% CI 0.24-0.35; p<0.001	Median MFS: 40.4 vs 18.4 months; HR 0.41; 95% CI 0.34-0.50; p<0.001
Secondary endpoints	Median PFS: 40.5 vs 14.7 months; HR 0.29; 95% CI 0.24-0.36; p<0.001 Median time to symptomatic progression: NR vs NR; HR 0.45; 95% CI 0.32-0.63; p<0.001 Median OS: NR vs 39.0 months; HR 0.70; 95% CI 0.47-1.04; p=0.07 Median time to first cytotoxic chemotherapy: NR vs NR; HR 0.44; 95% CI 0.29-0.66	Median time to PSA progression: 37.2 vs 3.9 months; HR 0.07; 95% CI 0.05-0.08; p<0.001 Median time to first use of new antineoplastic therapy: 39.6 vs 17.7 months; HR 0.21; 95% CI 0.17-0.26; p<0.001 Median OS: NR vs NR; HR 0.80; 95% CI 0.58-1.09; p=0.15	Median OS: NR vs NR; HR 0.71; 95% CI 0.50-0.99; p=0.045 Median time to pain progression: 40.3 vs 25.4 months; HR 0.65; 95% CI 0.53-0.79; p<0.001 Median time to first use of cytotoxic chemotherapy: NR vs 38.2 months; HR 0.43; 95% CI 0.31-0.60; p<0.001 Median time to first SSE: NR vs NR; HR 0.43; 95% CI 0.22-0.84; p<0.01
Exploratory endpoints	Second PFS: NR vs 39.0 months; HR 0.49; 95% CI 0.36-0.66 Median time to PSA progression: NR vs 3.7 months; HR 0.06; 95% CI 0.05-0.08		Median PFS: 36.8 vs 14.8 months; HR 0.38; 95% CI 0.32-0.45; p<0.001 Median time to PSA progression: 33.2 vs 7.3 months; HR 0.13; 95% CI 0.11-0.16; p<0.001 Median time to first prostate cancer-related invasive procedure: NR vs NR; HR 0.39; 95% CI 0.25-0.61; p<0.001 Median time to initiation of subsequent anti-neoplastic therapy: NR vs NR; HR 0.33; 95% CI 0.23-0.47; p<0.001

Note: these data do not represent a head-to-head comparison of SPARTAN, PROPSER and ARAMIS

CI, confidence interval; HR, hazard ratio, MFS, metastasis-free survival; NR, not reached; OS, overall survival; PFS, progression-free survival; PSA, prostate-specific antigen; SSE, symptomatic skeletal event

Olivier KM, et al. Int J Urol Nurs. 2021;15:47-58

EFFICACY: FINAL ANALYSIS (OVERALL SURVIVAL)

	SPARTAN (NCT01946204): Apalutamide (n=806) vs placebo (n=401)	PROSPER (NCT02003924): Enzalutamide (n=933) vs placebo (n=468)	ARAMIS (NCT02200614): Darolutamide (n=955) vs placebo (n=554)
Final analysis			
Median follow-up	52.0 months	48.0 months	29.1 months
Secondary endpoints	Median OS: 73.9 vs 59.9 months; HR 0.78; 95% CI 0.64-0.96; p=0.016 Median time to cytotoxic chemotherapy: NR vs NR; HR 0.63; 95% CI 0.49-0.81; p=0.0002 Median time to symptomatic progression: NR vs NR; HR 0.57; 95% CI 0.44-0.73; p<0.0001[a]	Median OS: 67.0 vs 56.3 months; HR 0.73; 95% CI 0.61-0.89; p=0.001 Median time to use of cytotoxic chemotherapy: NR vs NR; HR 0.54; 95% CI 0.44-0.67 Median time to first use of new subsequent antineoplastic therapy: 66.7 vs 19.1 months; HR 0.29; 95% CI 0.25-0.34 Chemotherapy-free survival: 58.3 vs 41.6 months; HR 0.62; 95% CI 0.52-0.72	Median OS: NR vs NR; HR 0.69; 95% CI 0.53-0.88; p=0.003 Median time to first cytotoxic chemotherapy: NR vs NR; HR 0.58; 95% CI 0.44-0.76; p<0.001 Median time to pain progression: 40.3 vs 25.4 months; HR 0.65; 95% CI 0.53-0.79; p<0.001 Median time to first SSE: NR vs NR; HR 0.48; 95% CI 0.29-0.82; P=0.005
Exploratory endpoints	Median time to PSA progression: 40.5 vs 3.7 months; HR 0.07; 95% CI 0.06-0.09; p<0.0001[a] Median time to second PFS2: 55.6 vs 41.2 months; HR 0.55; 95% CI 0.46-0.66; p<0.0001[a]		

Note: these data do not represent a head-to-head comparison of SPARTAN, PROPSER and ARAMIS

[a] Nominal P value

CI, confidence interval; HR, hazard ratio, MFS, metastasis-free survival; NR, not reached; OS, overall survival; PFS, progression-free survival; PSA, prostate-specific antigen; SSE, symptomatic skeletal event

Olivier KM, et al. Int J Urol Nurs. 2021;15:47-58

INCIDENCE OF ADVERSE EVENTS ASSOCIATED WITH ARIs

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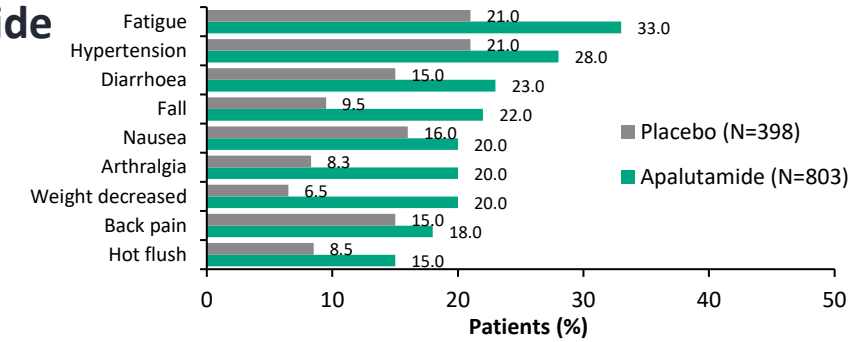
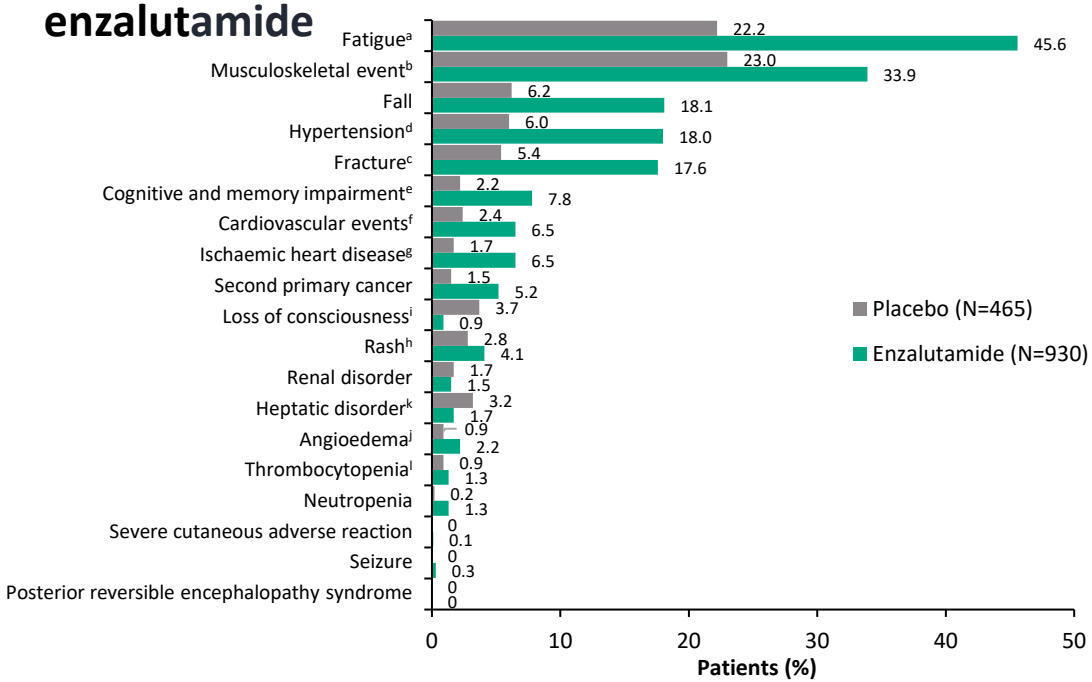
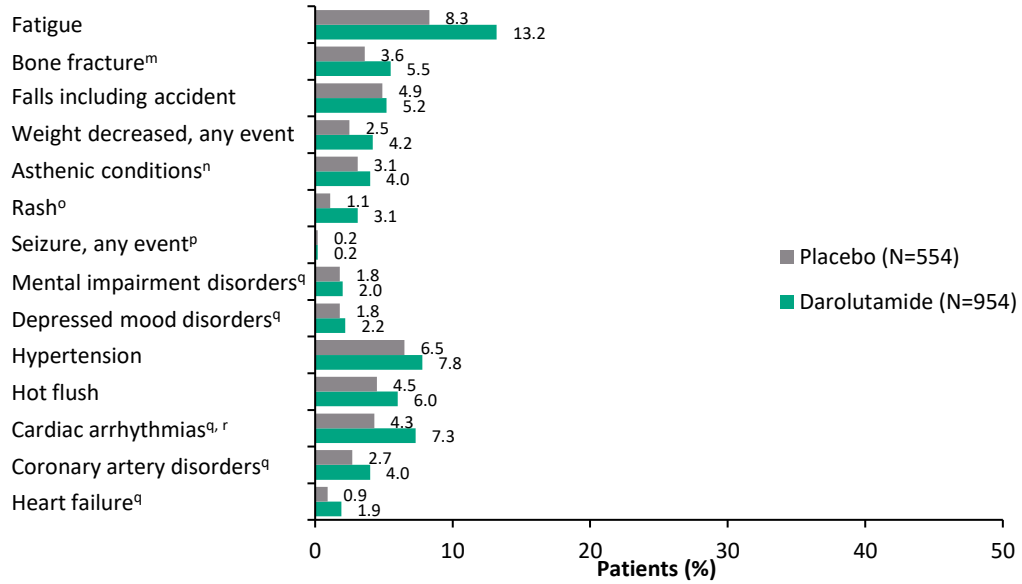
SPARTAN:[1,2] apalutamide



PROSPER:[3] enzalutamide



ARAMIS:[4] darolutamide



Incidence of adverse events associated with ARIs reported in the final analyses of the SPARTAN, PROSPER, and ARAMIS clinical trials.
SPARTAN: at final analysis, median follow-up was 52.0 months; median treatment duration in apalutamide arm was 32.9 months and in the placebo arm was 11.5 months.
PROSPER: at final analysis, median follow-up was 48.0 months; median treatment duration in enzalutamide arm was 33.9 months (95% CI 0.2–68.8) and in the placebo arm was 14.2 months (95% CI 0.1–51.3). [a]Fatigue events included asthenia. [b]Musculoskeletal events included back pain, arthralgia, myalgia, musculoskeletal pain, pain in extremity, musculoskeletal stiffness, muscular weakness, and muscle spasms. [c]Fracture events included bone and joint injuries. [d]Hypertension events included hypertensive retinopathy, increased blood pressure, systolic hypertension, and hypertensive crisis. [e]Events of cognitive and memory impairment included disturbance in attention, cognitive disorders, amnesia, Alzheimer's disease, dementia, senile dementia, mental impairment, and vascular dementia. [f]Cardiovascular events included haemorrhagic central nervous system vascular conditions, ischaemic central nervous system vascular conditions, and cardiac failure. [g]Events of ischaemic heart disease included myocardial infarction and other ischaemic heart disease. [h]Rash events included maculopapular rash, generalised rash, macular rash, papular rash, and pruritic rash. [i]Loss-of-consciousness events included syncope and presyncope. [j]Angio-oedema events included urticaria, eyelid oedema, periorbital oedema, swollen tongue, swollen lip, face oedema, laryngeal oedema, and pharyngeal oedema. [k]Hepatic disorders included hepatic failure, fibrosis, cirrhosis, and other liver damage-related conditions, and hepatitis and liver-related investigations, signs, and symptoms. [l]Thrombocytopenia events included decreases in platelet count.
ARAMIS: at final analysis, median follow-up was 29.0 months; median exposure in darolutamide arm was 18.5 months and in the placebo arm was 11.6 months. [m]Combined term comprising MedDRA terms of any fractures and dislocations, limb fractures and dislocations, skull fractures, facial bone fractures and dislocations, spinal fractures and dislocations, and thoracic cage fractures and dislocations. [n]Combined term comprising MedDRA terms of asthenic conditions, disturbances in consciousness, decreased strength and energy, malaise, lethargy, and asthenia. [o]Combined term comprising MedDRA terms of rash, macular rash, maculopapular rash, papular rash, and pustular rash. [p]One additional incidence of seizure occurred in the darolutamide group during the open-label period, in a patient with a history of epilepsy. [q]MedDRA High Level Group term. [r]Although the incidence of cardiac arrhythmia was higher with darolutamide than with placebo, both a history of cardiac arrhythmia and electrocardiogram abnormalities were present to a greater extent in the darolutamide group at baseline, as observed at primary analysis.

ARI, androgen receptor inhibitor; CI, confidence interval; MedDRA, Medical Dictionary for Regulatory Activities

1. Smith MR, et al. N Engl J Med. 2018;378:1408-18; 2. Smith MR, et al. Eur Urol. 2021;79:150-8; 3. Sternberg CN, et al. N Engl J Med. 2020;382:2197-206;
4. Fizazi K, et al. N Engl J Med. 2020;383:1040-9; Figure adapted from: Saad F, et al. Prostate Cancer Prostatic Dis. 2021;24(2):323-34

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MANAGING TREATMENT-EMERGENT ADVERSE EVENTS

Fatigue:

- Nurses should encourage regular exercise and eating a healthy diet
- If severe or unmanageable then nurses should encourage prescribers to modify treatment strategy, including dose interruptions or reductions

Bone health:

- Evaluate bone health and fracture risk prior to ADT and throughout treatment (DEXA, FRAX tool)
- Vitamin D and calcium supplementation and when applicable receive bisphosphonate or denosumab
- Nurses should encourage weight-bearing exercise and implement lifestyle changes to prevent falls

ADT, androgen deprivation therapy; DEXA, dual-energy X-ray absorptiometry; FRAX, Fracture Risk Assessment Tool

Olivier KM, et al. Int J Urol Nurs. 2021;15:47-58

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MANAGING TREATMENT-EMERGENT ADVERSE EVENTS

Cognitive impairment:

- Screen for cognitive function at baseline and periodically throughout treatment
- Nurses should elicit observations of cognitive changes from caregivers or responsible family members

Rash:

- Nurses should educate patients of the risk of developing a rash
- If rash is detected on physical exam nurses should encourage prescribers to consider management with oral antihistamines and/or systemic corticosteroids (for grade 3-4 rash) as well as topical corticosteroids or dose interruption
- Early intervention may lessen severity and recurrence of rash and may prevent dose interruptions

Olivier KM, et al. Int J Urol Nurs. 2021;15:47-58

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MANAGING TREATMENT-EMERGENT ADVERSE EVENTS

Metabolic changes:

- Monitor fasting glucose and LFTs at baseline and throughout treatment
- Nurses should educate on regular exercise and dietary modifications

Cardiovascular AEs:

- Monitor at baseline and throughout treatment
- Nurses should educate on heart-healthy diet
- Nurses should educate on how to recognise, control and prevent hypertension, DVT and PE

AEs, adverse events; DVT, deep vein thrombosis; LFT, liver function test; PE, pulmonary embolism

Olivier KM, et al. Int J Urol Nurs. 2021;15:47-58

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MANAGING TREATMENT-EMERGENT ADVERSE EVENTS

Hot Flashes:

- Consider venlafaxine, gabapentin, and medroxyprogesterone acetate

Sexual Health:

- Nurses can foster open communication between patients and their partners and provide counseling on pharmacologic and nonpharmacologic options to reduce the burden of erectile dysfunction

Olivier KM, et al. Int J Urol Nurs. 2021;15:47-58

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QUALITY OF LIFE

- The results of SPARTAN, PROSPER, and ARAMIS demonstrate that apalutamide, enzalutamide, and darolutamide have all been proven to delay disease progression and prolong overall survival
- In addition, in SPARTAN, PROSPER, and ARAMIS no treatment-induced deterioration in patient-reported quality of life occurred
  - Patients treated with enzalutamide or darolutamide also demonstrated delayed time to pain progression and delayed deterioration in urinary and bowel symptoms vs placebo

AR, androgen receptor; nmCRPC, non-metastatic castration-resistant prostate cancer

Olivier KM, et al. Int J Urol Nurs. 2021;15:47-58; Saad F, et al. Prostate Cancer Prostatic Dis. 2021;24(2):323-34; Saad F, et al. Lancet Oncol. 2018; 19:1404–16; Tombal B, et a.l Lancet Oncol. 2019; 20:556–69; Fizazi K, et al. J Clin Oncol. 2019;37 (15_Suppl):5000; Fizazi K, et al. N Engl J Med. 2019;380:1235-1246; Smith M, et al. European Journal of Cancer 2021; 154: 138-146

WHAT NEEDS TO BE EXPLAINED TO THE PATIENT

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TAILORING TREATMENT TO PATIENTS

- Oncology nurses can offer education to patients throughout the therapeutic course by providing reliable, factual information on what to expect from their prescribed treatment regimen
  - Dosing
  - Treatment-emergent adverse events
  - Life expectancy
- When considering the most appropriate treatment for a patient, the risks reported for different treatment should be considered

Olivier KM, et al. Int J Urol Nurs. 2021;15:47-58

WHAT NEEDS TO BE EXPLAINED TO THE PATIENT

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HOW TO FILL THE GAPS IN THE PATIENT'S KNOWLEDGE

- Knowing your audience is key when having treatment discussions
  - Patient's knowledge
  - Patient's support system

- Clinical trial data can be shared with patients and the emphasis should be that the studies have shown that these drugs prolong overall survival

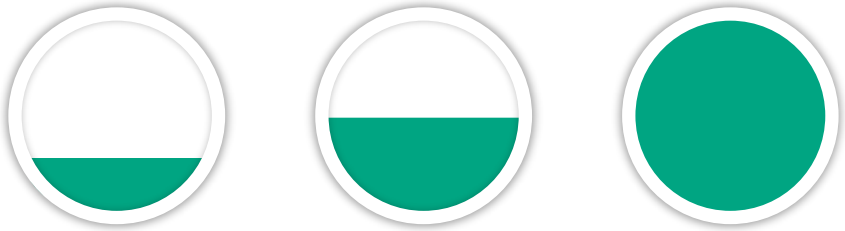
- Provide patients with educational materials about their disease state and treatments for them to take home and review

WHAT NEEDS TO BE EXPLAINED TO THE PATIENT

FILL THE GAPS IN THE PATIENT'S KNOWLEDGE

For more information on the Ask, Tell, Ask model, please refer to:

- The paper "If We Don't Ask, Our Patients Might Never Tell: The Impact of the Routine Use of a Patient Values Assessment" by J. Russell Hoverman et al.



G U I D E

Hoverman JR, et al. J Oncol Pract. 2017;13:e0831-7

THE RIGHT WAY TO DELIVER THE MESSAGES

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- Continue to use the **Ask, Tell, Ask model** to discover knowledge gaps and efficiently educate patients
  - Acknowledge the patient's **emotions**
  - Ask if they **wish and are ready to hear and understand** more information before you continue
  - **Repeat** information as often as needed
  - Listen actively
  - Continue to involve the carer
  - Use patient-friendly language
- Use **printed and/or written materials** to embed knowledge

Practical tips:

- When printed materials are not available, consider simply **writing** a brief summary or **drawing** a quick diagram supporting your explanation for patients to take with them
- Remember to educate the patient with **reassurance and confidence**

G U I D E

SUMMARY
THE GUIDE COMMUNICATION FRAMEWORK

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WHAT
THE GUIDE COMMUNICATION FRAMEWORK

- Is a 5-step communication framework to improve the benefit of nurse-patient interactions
- Supports nurses in their role as a knowledgeable go-to person for patients with nmCRPC strengthening shared decision making and delivering the best possible care
- Includes a memory aid – GUIDE
- May be delivered over several interactions and should be adapted depending on patient needs

WHY
IS THE COMMUNICATION FRAMEWORK NEEDED

- Nurses are to be regarded as a go-to person for their patients with nmCRPC and therefore must
  - empower patients through guidance and support throughout the treatment journey
  - be an active member of the MDT in delivering shared decision making

so they can provide patients with the greatest chance of success

GUIDE, a communication framework that will help you have even better conversations with your patients, to educate and guide them throughout their cancer treatment journey. GUIDE's five letters each represent a crucial step in your conversations with patients with nmCRPC.
nmCRPC, non-metastatic castration-resistant prostate cancer; MDT, multidisciplinary team

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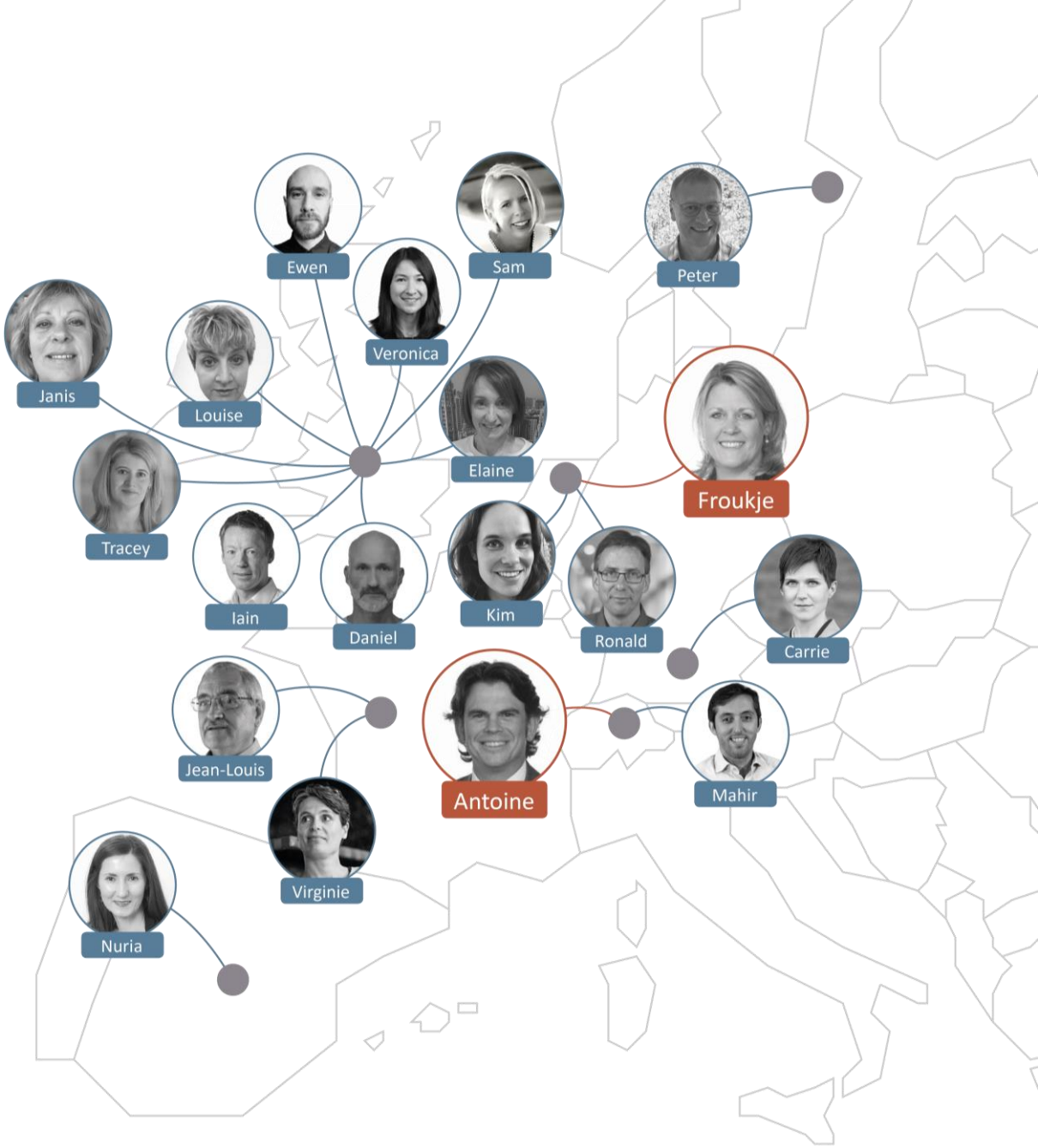

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