Ask the Expert: Clinical Investigators Provide Perspectives on the Management of Renal Cell Carcinoma

In Partnership with Project Echo® and Florida Cancer Specialists

Wednesday, June 2, 2021
5:00 PM – 6:00 PM ET

Faculty

Walter Stadler, MD
Vikas Malhotra, MD

Moderator

Neil Love, MD

Faculty

Walter Stadler, MD
Fred C Buffett Professor of Medicine
Dean for Clinical Research
Deputy Director, Comprehensive Cancer Center
The University of Chicago
Chicago, Illinois

Vikas Malhotra, MD
Staff Medical Oncologist-Hematologist
Florida Cancer Specialists and Research Institute
Spring Hill, Florida

Steering Committee

Chung-Han Lee, MD, PhD
Assistant Attending Physician
Genitourinary Oncology Service
Memorial Sloan Kettering Cancer Center
New York, New York

David I Quinn, MBBS, PhD
Medical Director, USC Norris Cancer Hospital and Clinics
Head, Section of GU Cancer, Division of Oncology
Associate Professor of Medicine
USC Norris Comprehensive Cancer Center
Keck School of Medicine of USC
Los Angeles, California

Sumanta K Pal, MD
Clinical Professor, Department of Medical Oncology
City of Hope Comprehensive Cancer Center
Duarte, California

Walter Stadler, MD
Fred C Buffett Professor of Medicine
Dean for Clinical Research
Deputy Director, Comprehensive Cancer Center
The University of Chicago
Chicago, Illinois

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Commercial Support

This activity is supported by an educational grant from Pfizer Inc.

Dr Love — Disclosures

Dr Love is president and CEO of Research To Practice. Research To Practice receives funds in the form of educational grants to develop CME activities from the following companies: AbbVie Inc, Adaptive Biotechnologies Corporation, Agios Pharmaceuticals Inc, Alexion Pharmaceuticals, Amgen Inc, Array BioPharma Inc, a subsidiary of Pfizer Inc, Astellas, AstraZeneca Pharmaceuticals LP, Aveo Pharmaceuticals, Bayer HealthCare Pharmaceuticals, BeiGene Ltd, Blueprint Medicines, Boehringer Ingelheim Pharmaceuticals Inc, Bristol-Myers Squibb Company, Celgene Corporation, Clovis Oncology, Daiichi Sankyo Inc, Eisai Inc, Epizyme Inc, Exact Sciences Inc, Exelixis Inc, Five Prime Therapeutics Inc, Foundation Medicine, Genentech, a member of the Roche Group, Gilead Sciences Inc, GlaxoSmithKline, Grail Inc, Halozyme Inc, Helsinn Healthcare SA, ImmunoGen Inc, Incyte Corporation, Ipsen Biopharmaceuticals Inc, Janssen Biotech Inc, administered by Janssen Scientific Affairs LLC, Jazz Pharmaceuticals Inc, Karyopharm Therapeutics, Kite, A Gilead Company, Lilly, Loxo Oncology Inc, a wholly owned subsidiary of Eli Lilly & Company, Merck, Novartis, Novocure Inc, Oncopeptides, Pfizer Inc, Pharmacyclics LLC, an AbbVie Company, Puma Biotechnology Inc, Regeneron Pharmaceuticals Inc, Sanofi Genzyme, Seagen Inc, Sumitomo Dainippon Pharma Oncology Inc, Taiho Oncology Inc, Takeda Oncology, Tesaro, A GSK Company, TG Therapeutics Inc, Turning Point Therapeutics Inc and Verastem Inc.

Research To Practice CME Planning Committee Members, Staff and Reviewers

Planners, scientific staff and independent reviewers for Research To Practice have no relevant conflicts of interest to disclose.

Project ECHO® Disclosure

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Dr Stadler — Disclosures

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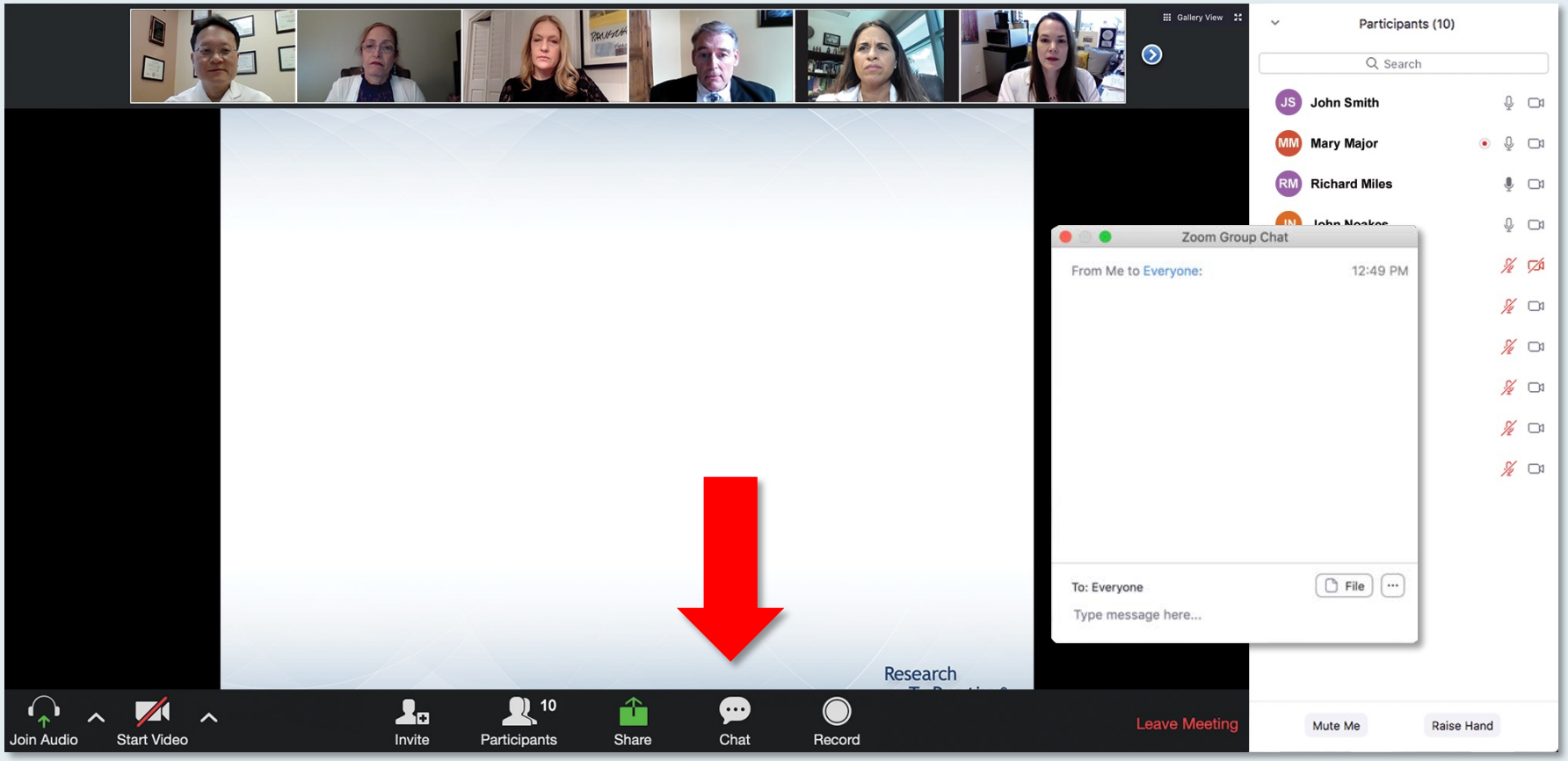
Dr Malhotra — Disclosures

No relevant conflicts of interest to disclose.

We Encourage Clinicians in Practice to Submit Questions



Feel free to submit questions now before the program begins and throughout the program.

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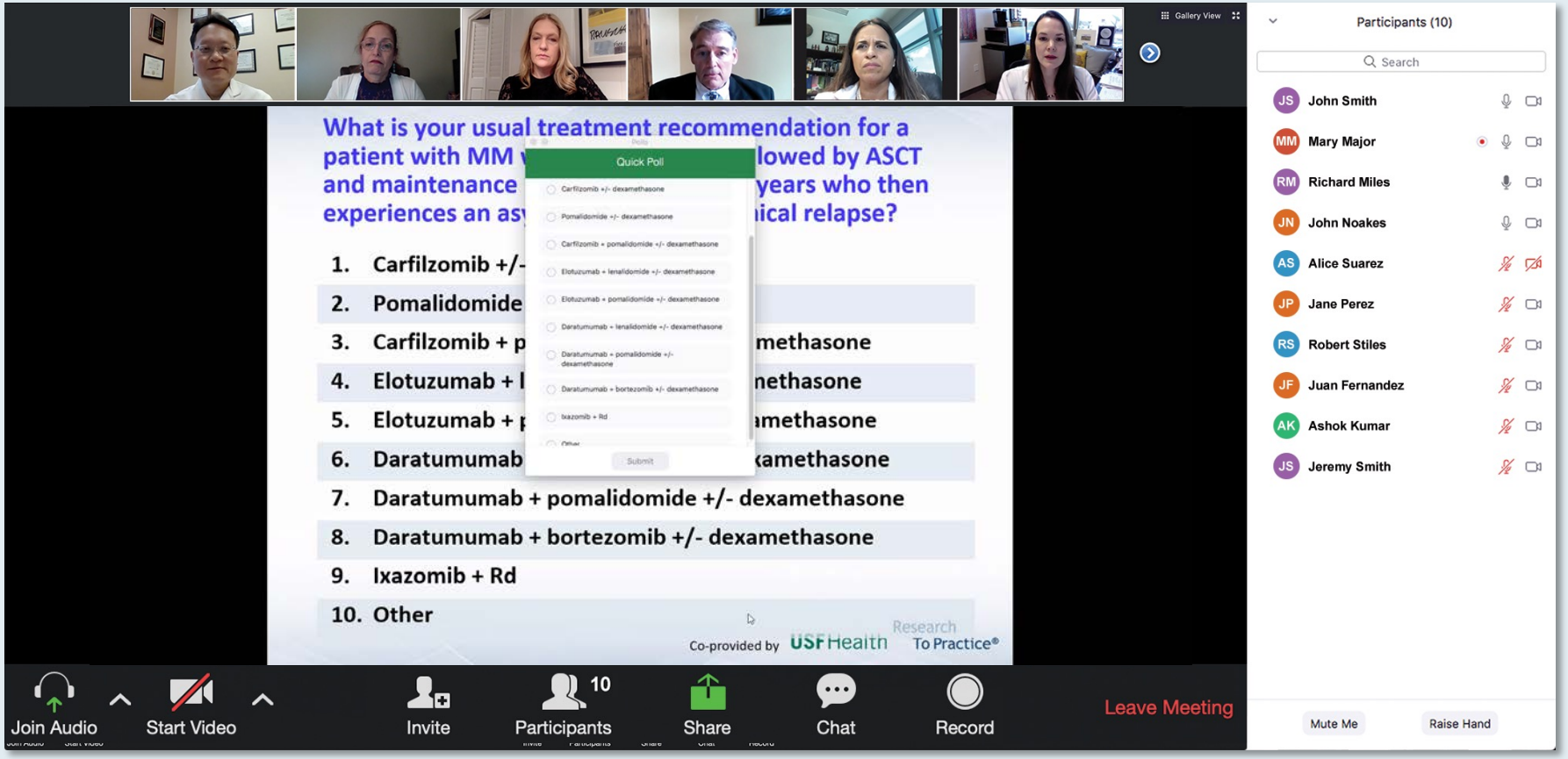
Familiarizing Yourself with the Zoom Interface

How to answer poll questions



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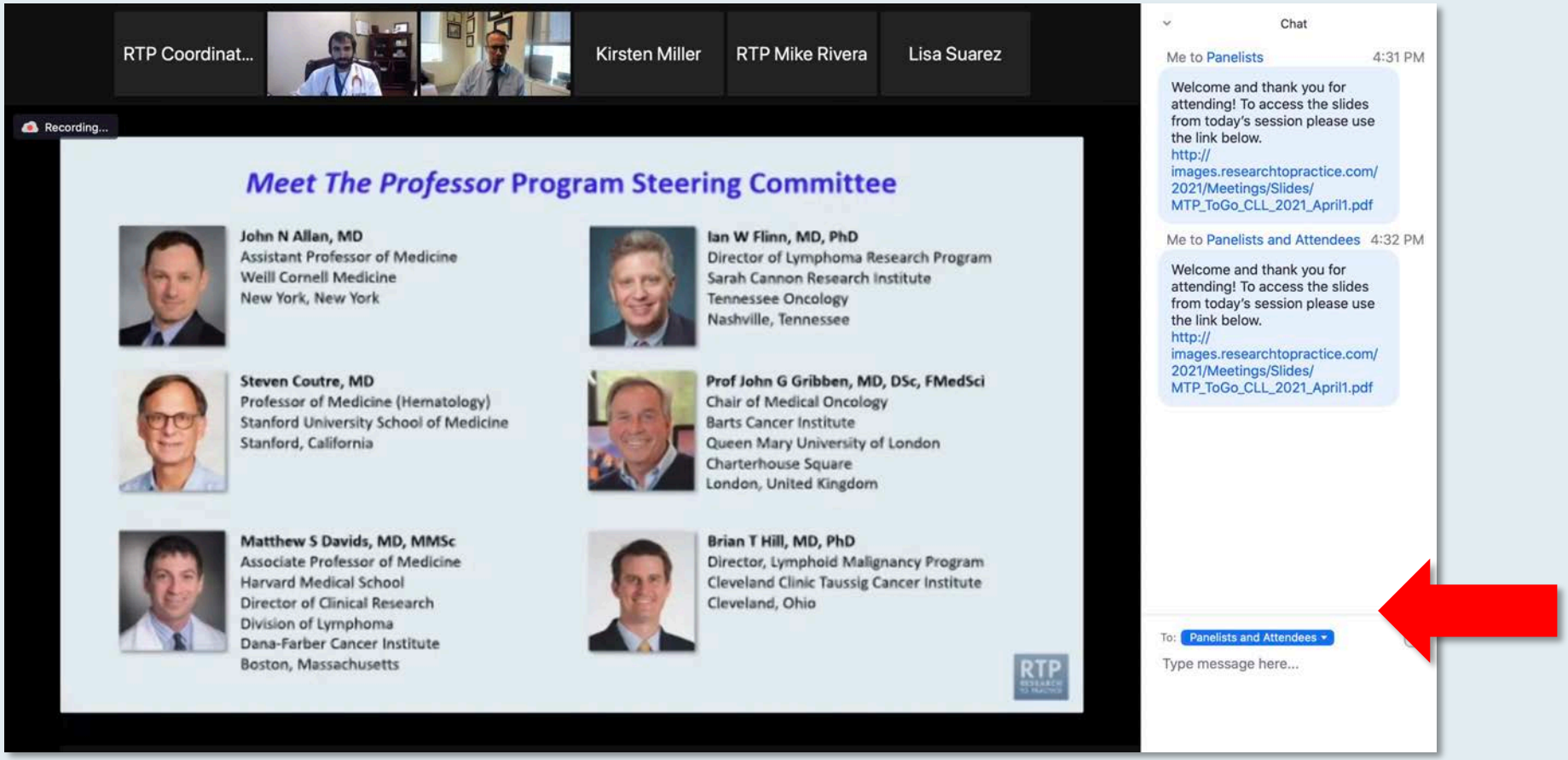
Familiarizing Yourself with the Zoom Interface

Expand chat submission box



Drag the white line above the submission box up to create more space for your message.

Familiarizing Yourself with the Zoom Interface

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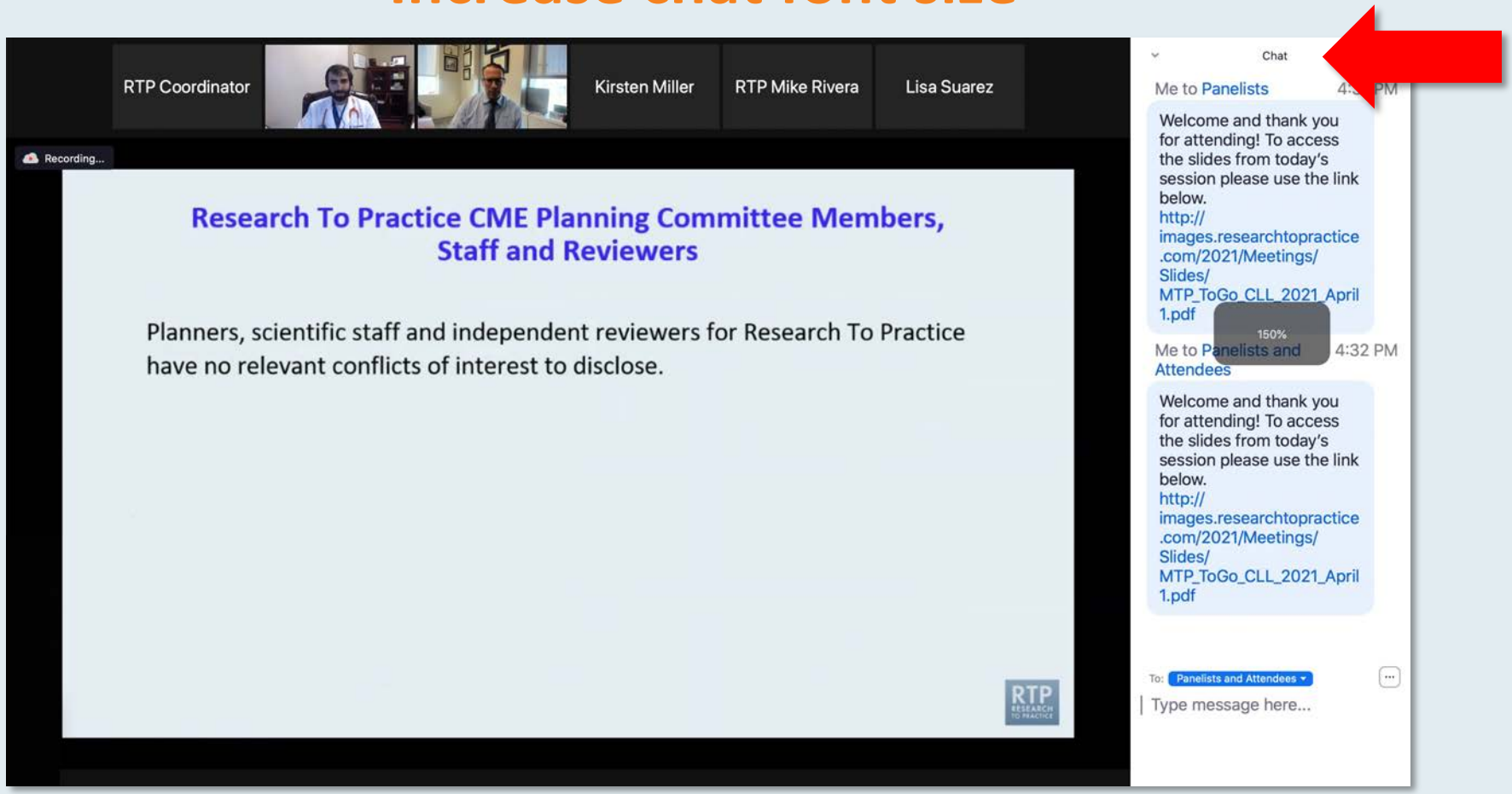

Press Command (for Mac) or Control (for PC) and the + symbol.
You may do this as many times as you need for readability.

ONCOLOGY TODAY

WITH DR NEIL LOVE

Renal Cell Carcinoma

DR CHUNG-HAN LEE

MEMORIAL SLOAN KETTERING CANCER CENTER

NEW YORK, NEW YORK

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Meet The Professor

Optimizing the Selection and Sequencing of Therapy for Patients with Advanced Gastrointestinal Cancers

Monday, June 7, 2021
5:00 PM – 6:00 PM ET

Faculty

Kristen K Ciombor, MD, MSCI

Moderator

Neil Love, MD

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Meet The Professor

Optimizing the Selection and Sequencing of Therapy for Patients with Renal Cell Carcinoma

Wednesday, June 16, 2021
5:00 PM – 6:00 PM ET

Faculty

Thomas E Hutson, DO, PharmD

Moderator

Neil Love, MD

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RESEARCH
TO PRACTICE

ASCO Highlights and More: Investigators Review Recent Data Sets and Provide Perspectives on Current Oncology Care

A Daylong Multitumor Educational Webinar in Partnership with the Texas Society of Clinical Oncology (TxSCO)

Saturday, June 26, 2021
8:00 AM – 3:00 PM Central Time
(9:00 AM – 4:00 PM Eastern Time)

RTP RESEARCH TO PRACTICE

17 Exciting CME/MOC Events You Do Not Want to Miss

A Live Webinar Series Held in Conjunction with the 2021 ASCO Annual Meeting

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Tuesday, June 22
5:00 PM – 6:00 PM ET

ER-Positive and Triple-Negative Breast Cancer
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Chronic Lymphocytic Leukemia and Follicular Lymphoma
Tuesday, June 29
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Ovarian Cancer
Wednesday, July 7
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Hormonal Therapy for Prostate Cancer
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RESEARCH TO PRACTICE

Ask the Expert: Clinical Investigators Provide Perspectives on the Management of Renal Cell Carcinoma

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Webinar 1 – Tuesday, April 6, 2021

Faculty
Sumanta K Pal, MD

Webinar 2 – Tuesday, May 4, 2021

Faculty
Chung-Han Lee, MD, PhD

Webinar 3 – Wednesday, June 2, 2021

Faculty
Walter Stadler, MD

Webinar 4 – Tuesday, July 6, 2021

Faculty
David I Quinn, MBBS, PhD

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Thank you for joining us!

CME and ABIM MOC credit information will be emailed to each participant within 5 business days.

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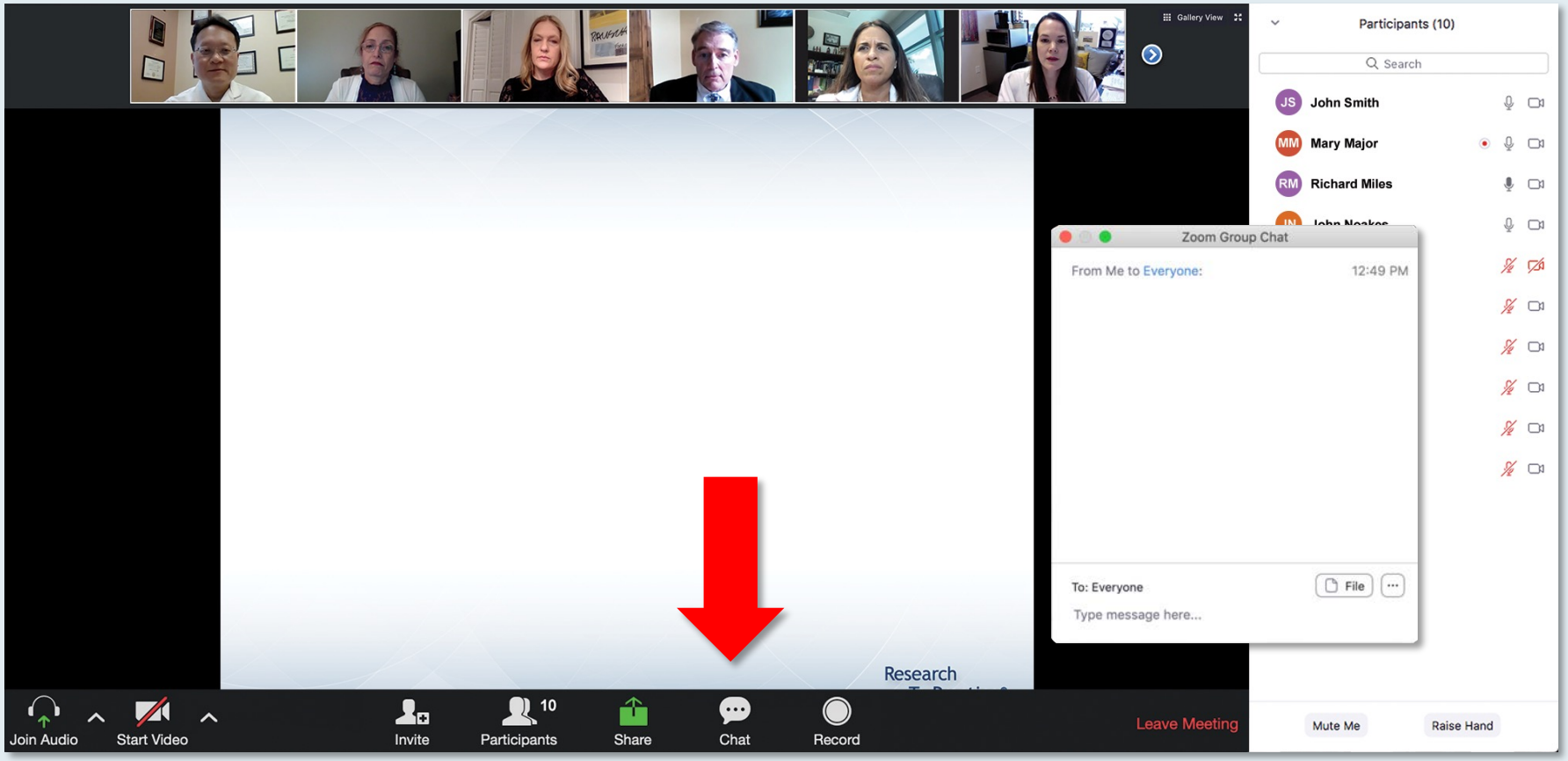

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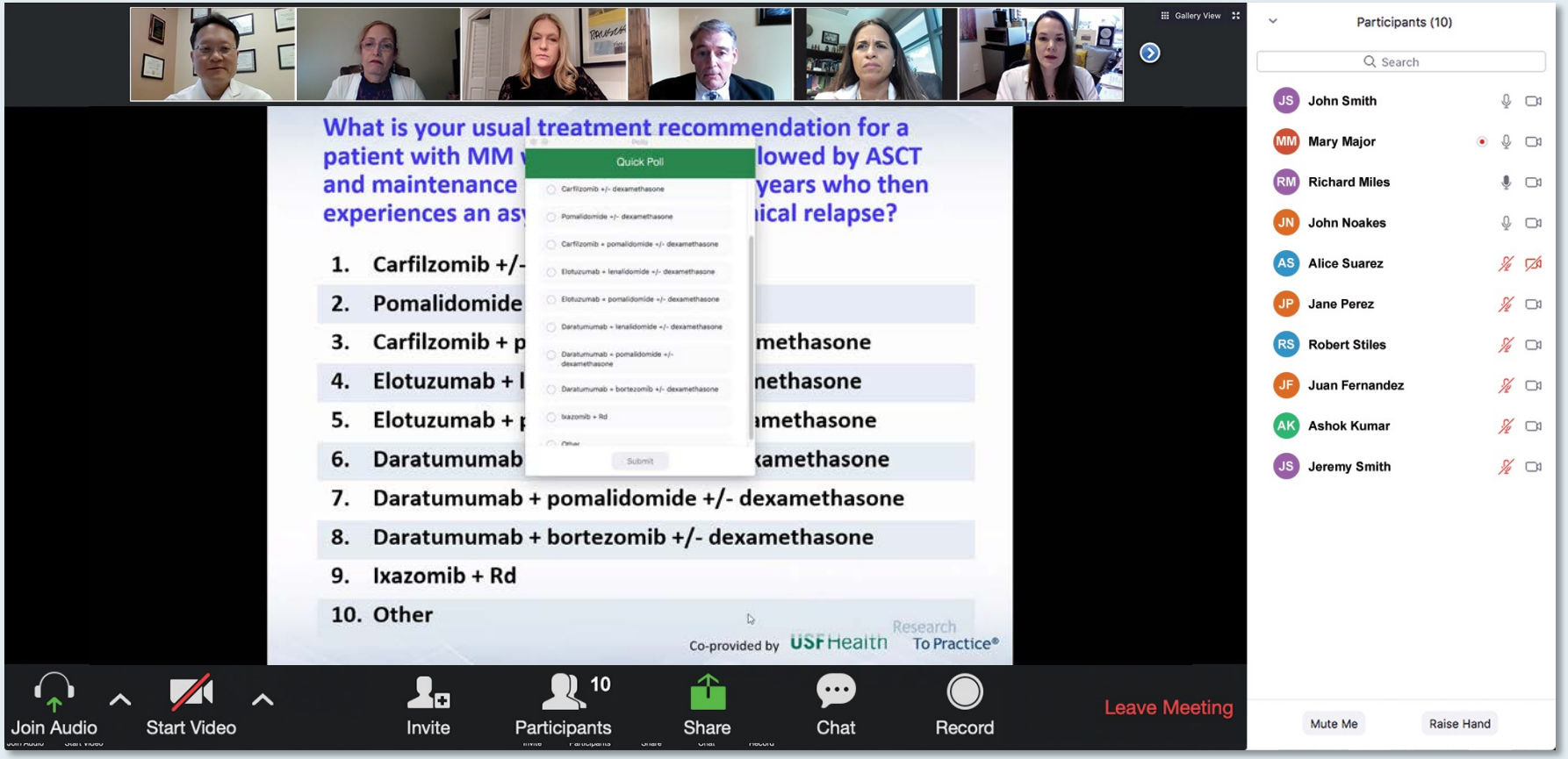

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MODULE 1: Cases from the Practice of Dr Malhotra

- A 75-year-old man with metastatic RCC treated with axitinib/nivolumab
- A 65-year-old man RCC with extensive bone and lung metastases
- A 70-year-old man with RCC with 3 small lung metastases

MODULE 2: Consensus or Controversy – Clinical Investigator Approaches to Clinical Scenarios

MODULE 3: Renal Cell Carcinoma Journal Club with Dr Stadler

MODULE 4: Key Data Sets

MODULE 5: Other Recent Data Sets

Pembrolizumab Demonstrated Superior Disease-Free Survival Compared with Placebo as Adjuvant Therapy for Patients with RCC Following Surgery

Press Release: April 8, 2021

"The pivotal Phase 3 KEYNOTE-564 trial evaluating pembrolizumab met its primary endpoint of disease-free survival (DFS) for the potential adjuvant treatment of patients with RCC following nephrectomy or following nephrectomy and resection of metastatic lesions.

Based on an interim analysis conducted by an independent Data Monitoring Committee, pembrolizumab monotherapy demonstrated a statistically significant and clinically meaningfully improvement in DFS compared with placebo. The trial will continue to evaluate overall survival (OS), a key secondary endpoint.

The safety profile of pembrolizumab in this trial was consistent with that observed in previously reported studies. Results will be presented at an upcoming medical meeting and will be submitted to regulatory authorities."

https://www.merck.com/news/mercks-keytruda-pembrolizumab-demonstrated-superior-disease-free-survival-dfs-compared-with-placebo-as-adjuvant-therapy-in-patients-with-renal-cell-carcinoma-rcc-following-surgery/

Pembrolizumab versus Placebo as Post-Nephrectomy Adjuvant Therapy for Patients with Renal Cell Carcinoma: Randomized, Double-Blind, Phase III KEYNOTE-564 Study

Choueiri TK et al.
ASCO 2021;Abstract LBA5.

Plenary Session: Sunday, June 6, 1:00 PM - 4:00 PM EDT

Agenda

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Case Presentation — Dr Malhotra: A 75-year-old man with metastatic RCC treated with axitinib/nivolumab

75-year-old male who presented with hematuria and CT scans showed 5 cm left kidney mass. He had left nephrectomy in January 2017. In May 2018 he presented with extensive lung mets, biopsy proven. Motzer score was low with anemia. He was started on axitinib and nivolumab with excellent ongoing response for 3 years. Dose of axitinib had to be reduced to 5 mg once daily due to hand-foot syndrome.

Question

- How do the faculty members handle dose of axitinib?

Case Presentation — Dr Malhotra: A 65-year-old man with RCC with extensive bone and lung metastases

65-year-old male presented with left flank pain and CT showed large 12 cm left kidney mass. Work up showed extensive bone and lung mets. He was started on axitinib and avelumab. He had very good partial response and continues with good response. His Motzer score was low with anemia and hypercalcemia.

Question

- How does the faculty decide between this regimen and ipi/nivo?

Case Presentation — Dr Malhotra: A 70-year-old man with RCC with 3 small lung metastases

70-year-old male with right kidney mass — biopsy proven RCC with three 1 cm lung mets — hypermetabolic on PET. Low risk. He had 4 cycles of ipi/nivo with excellent response.

Question

- Would the faculty consider nephrectomy?

Agenda

MODULE 1: Cases from the Practice of Dr Malhotra

- A 63-year-old man with metastatic renal cell carcinoma (RCC) treated with ipilimumab/nivolumab
- A 67-year-old man with metastatic RCC and high-risk oncocytic features who responded to ipilimumab/nivolumab
- A 65-year-old man with Stage III RCC

MODULE 2: Consensus or Controversy – Clinical Investigator Approaches to Clinical Scenarios

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Regulatory and reimbursement issues aside, which first-line therapy would you recommend for a 65-year-old patient with a history of nephrectomy for clear cell renal cell carcinoma (RCC) who on routine follow-up 3 years later is found to have asymptomatic bone metastases (PS 0)?

1. Nivolumab/ipilimumab
2. Avelumab/axitinib
3. Pembrolizumab/axitinib
4. Pembrolizumab/lenvatinib
5. Nivolumab/cabozantinib
6. Tyrosine kinase inhibitor (TKI) monotherapy
7. Anti-PD-1/PD-L1 monotherapy
8. Other

Regulatory and reimbursement issues aside, which first-line therapy would you recommend for a 65-year-old patient with a history of nephrectomy for clear cell renal cell carcinoma (RCC) who on routine follow-up 3 years later is found to have asymptomatic bone metastases (PS 0)?

 Dr Lee	Pembrolizumab/lenvatinib
 Dr Pal	Nivolumab/cabozantinib
 Dr Quinn	Nivolumab/cabozantinib
 Dr Stadler	Cabozantinib

Regulatory and reimbursement issues aside, which first-line therapy would you recommend for a 65-year-old patient who presents with clear cell RCC with multiple painful bone metastases and hemoglobin (Hb) of 11.4 g/dL (PS 1)?

1. Nivolumab/ipilimumab
2. Avelumab/axitinib
3. Pembrolizumab/axitinib
4. Pembrolizumab/lenvatinib
5. Nivolumab/cabozantinib
6. TKI monotherapy
7. Anti-PD-1/PD-L1 monotherapy
8. Other

Regulatory and reimbursement issues aside, which first-line therapy would you recommend for a 65-year-old patient who presents with clear cell RCC with multiple painful bone metastases and a hemoglobin (Hb) of 11.4 g/dL (PS = 1)?

 Dr Lee	Nivolumab/cabozantinib
 Dr Pal	Nivolumab/cabozantinib
 Dr Quinn	Cabozantinib
 Dr Stadler	Nivolumab/ipilimumab

In general, what would you recommend as second-line treatment for a 65-year-old patient (PS 0) with metastatic clear cell RCC who receives first-line ipilimumab/nivolumab and experiences disease progression after 12 months?

1. TKI monotherapy
2. Everolimus
3. Lenvatinib + everolimus
4. Avelumab/axitinib
5. Pembrolizumab/axitinib
6. Nivolumab/cabozantinib
7. Anti-PD-1/PD-L1 monotherapy
8. Other

In general, what would you recommend as second-line treatment for a 65-year-old patient (PS 0) with metastatic clear cell RCC who receives first-line ipilimumab/nivolumab and experiences disease progression after 12 months?

 Dr Lee	Cabozantinib
 Dr Pal	Cabozantinib
 Dr Quinn	Cabozantinib or axitinib
 Dr Stadler	Cabozantinib

In general, what would you recommend as second-line treatment for a 65-year-old patient (PS 0) with metastatic clear cell RCC who receives first-line nivolumab/cabozantinib and experiences disease progression after 12 months?

 Dr Lee	Lenvatinib + everolimus
 Dr Pal	Lenvatinib + everolimus
 Dr Quinn	Axitinib
 Dr Stadler	Axitinib

What would be your most likely third-line systemic therapy recommendation for a 65-year-old patient with metastatic RCC who experienced disease progression on first-line pembrolizumab/axitinib and second-line cabozantinib (PS 0)?

 Dr Lee	Lenvatinib + everolimus
 Dr Pal	Lenvatinib + everolimus
 Dr Quinn	Tivozanib
 Dr Stadler	Lenvatinib + everolimus

In general, how would you compare the efficacy of tivozanib to that of other commercially available tyrosine kinase inhibitors (TKIs) (eg, axitinib, cabozantinib, lenvatinib) in patients with relapsed metastatic RCC?

 Dr Lee	Other commercially available TKIs are more efficacious
 Dr Pal	Efficacy is about the same
 Dr Quinn	Efficacy is about the same
 Dr Stadler	Efficacy is about the same

In general, how would you compare the tolerability of tivozanib to that of other commercially available TKIs (eg, axitinib, cabozantinib, lenvatinib) in patients with relapsed metastatic RCC?

 Dr Lee	Tivozanib is more tolerable
 Dr Pal	Tivozanib is more tolerable
 Dr Quinn	Tivozanib is more tolerable
 Dr Stadler	Tolerability is about the same

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- Active surveillance of metastatic RCC: Results from a prospective observational study (MaRCC)
- Optimized management of nivolumab and ipilimumab in advanced RCC: A response-based Phase II study (OMNIVORE)

MODULE 4: Key Data Sets

MODULE 5: Other Recent Data Sets

Original Article

Cancer 2021;[Online ahead of print].

Active Surveillance of Metastatic Renal Cell Carcinoma: Results From a Prospective Observational Study (MaRCC)

Michael R. Harrison, MD [1]; Brian A. Costello, MD[2]; Nrupen A. Bhavsar, PhD[1]; Ulka Vaishampayan, MD[3]; Sumanta K. Pal, MD [4]; Yousef Zakharia, MD[5]; Heather S. L. Jim, PhD [6]; Mayer N. Fishman, MD[6]; Ana M. Molina, MD[7]; Christos E. Kyriakopoulos, MD[8]; Che-Kai Tsao, MD[9]; Leonard J. Appleman, MD[10]; Benjamin A. Gartrell, MD[11,12]; Arif Hussain, MD[13]; Walter M. Stadler, MD [14]; Neeraj Agarwal, MD[15]; Russell K. Pachynski, MD[16]; Thomas E. Hutson, DO[17]; Hans J. Hammers, MD[18]; Christopher W. Ryan, MD[19]; Brant A. Inman, MD [1]; Jack Mardekian, PhD[20]; Azah Borham, PharmD[20]; and Daniel J. George, MD[1]

Cancer 2021;127(11):1827-35.

original reports

Optimized Management of Nivolumab and Ipilimumab in Advanced Renal Cell Carcinoma: A Response-Based Phase II Study (OMNIVORE)

Rana R. McKay, MD[1]; Bradley A. McGregor, MD[2]; Wanling Xie, MS[2]; David A. Braun, MD, PhD[2]; Xiao Wei, MD[2]; Christos E. Kyriakopoulos, MD[3]; Yousef Zakharia, MD[4]; Benjamin L. Maughan, MD, PharmD[5]; Tracy L. Rose, MD[6]; Walter M. Stadler, MD[7]; David F. McDermott, MD[8]; Lauren C. Harshman, MD[2]; and Toni K. Choueiri, MD[2]

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Pembrolizumab (Pembro) plus Axitinib (Axi) versus Sunitinib as First-Line Therapy for Advanced Clear Cell Renal Cell Carcinoma (ccRCC): Results from 42-Month Follow-Up of KEYNOTE-426

Rini BI et al.

ASCO 2021;Abstract 4500.

Genitourinary Cancer – Kidney and Bladder: Monday, June 7, 8:00 AM - 11:00 AM

Phase 2 Study of Belzutifan (MK-6482), an Oral Hypoxia-Inducible Factor 2α (HIF-2α) Inhibitor, for Von Hippel-Lindau (VHL) Disease-Associated Clear Cell Renal Cell Carcinoma (ccRCC)

Srinivasan R et al.

ASCO 2021;Abstract 4555.

Genitourinary Cancer – Kidney and Bladder: Monday, June 7, 8:00 AM - 11:00 AM

A Phase 1b/2 Umbrella Study of Investigational Immune and Targeted Combination Therapies as First-Line Therapy for Patients with Advanced Renal Cell Carcinoma (RCC)

Plimack ER et al.

ASCO 2021;Abstract TPS4594.

Genitourinary Cancer – Kidney and Bladder: Monday, June 7, 8:00 AM - 11:00 AM

Indirect comparison of the 4 regimens available.

	CheckMate 214 (Ipi/Nivo) [1] (n=550 vs n=546)	KEYNOTE-426 (Axi/Pembro)[2] (n=432 vs n=429)	CheckMate 9ER (Cabo/Nivo)[3] (n=323 vs n=328)	CLEAR (Len/Pembro)[4] (N=355 vs n=357)
mOS, months HR (CI);	NR vs 38.4 **0.69** (0.59–0.81);	NR vs 35.7 **0.68** (0.55-0.85);	NR vs NR **0.60** (0.40–0.89);	NR vs NR **0.66** (0.49-0.88)
Landmark OS 12 mo Landmark OS 24 mo	**83%** vs. 78% **71%** vs. 61%	**90%** vs. 79% **74%** vs. 66%	**87%** vs. 78% (est) **74%** vs 60% (est)	**90%** vs 79% (est.) **79%** vs. 70%
mPFS, months HR (CI)	**12.2** vs 12.3 0.89 (0.76–1.05)	**15.4** vs 11.1 0.71 (0.60–0.84)	**16.6** vs 8.3 0.51 (0.41–0.64)	**23.9** vs 9.2 0.39 (0.32-0.49)
ORR, %	**39** vs 32	**60** vs 40	**56** vs 27	**71** vs 36
CR, %	**11** vs 3	**9** vs 3	**8** vs 5	**16** vs 4
Med f/u, months	**55**	**30.6**	**18.1**	**27**
Prognostic risk, % Favorable Intermediate Poor	 23 61 17	 32 55 13	 23 58 19	 31 59 9
Prior nephrectomy	82%	83%	69%	74%
Subsequent systemic therapies for sunitinib arm, %	Overall (69%) IO (42%)	Overall (69%) IO (48%)	Overall (40%) IO (29%)	NR

Please handle with care….

Courtesy of Thomas Powles, MBBS, MRCP, MD

Indirect comparison of the 4 regimens available.

	CheckMate 214 (Ipi/Nivo)[1] (n=550 vs n=546)	KEYNOTE-426 (Axi/Pembro)[2] (n=432 vs n=429)	CheckMate 9ER (Cabo/Nivo)[3] (n=323 vs n=328)	CLEAR (Len/Pembro)[4] (N=355 vs n=357)
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Landmark OS 12 mo Landmark OS 24 mo	**83%** vs. 78% **71%** vs. 61%			
mPFS, months HR (CI)	**12.2** vs 12.3 0.89 (0.76–1.05)			
ORR, %	**39** vs 32			
CR, %	**11** vs 3			
Med f/u, months	**55**			
Prognostic risk, % Favorable Intermediate Poor	 23 61 17			
Prior nephrectomy	82%			
Subsequent systemic therapies for sunitinib arm, %	Overall (69%) IO (42%)			

Please handle with care….

Courtesy of Thomas Powles, MBBS, MRCP, MD

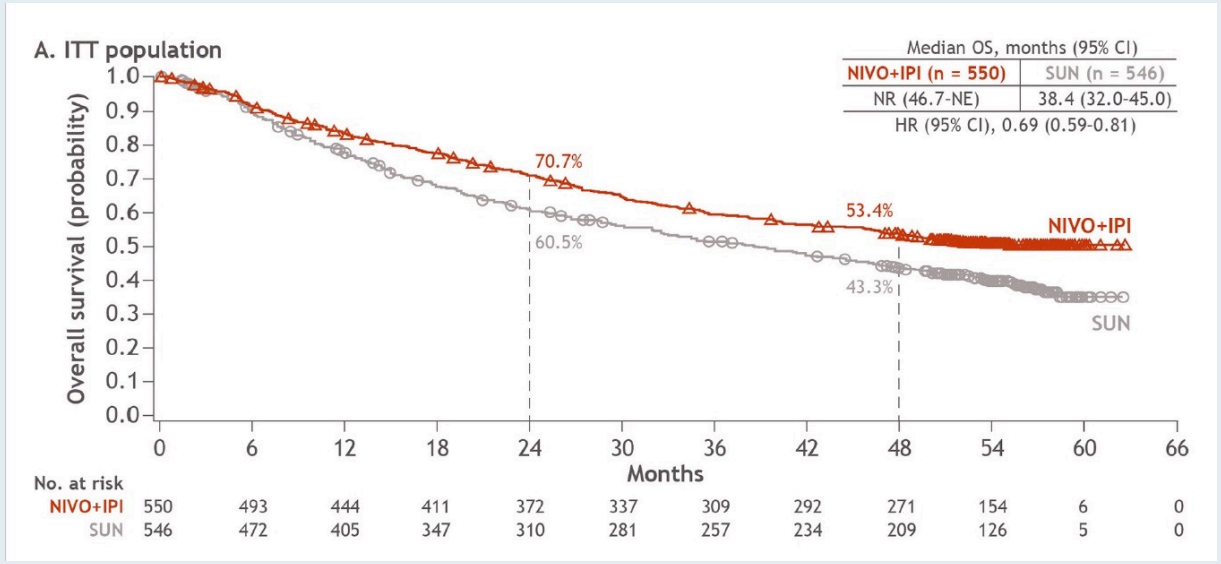
Open access Original research

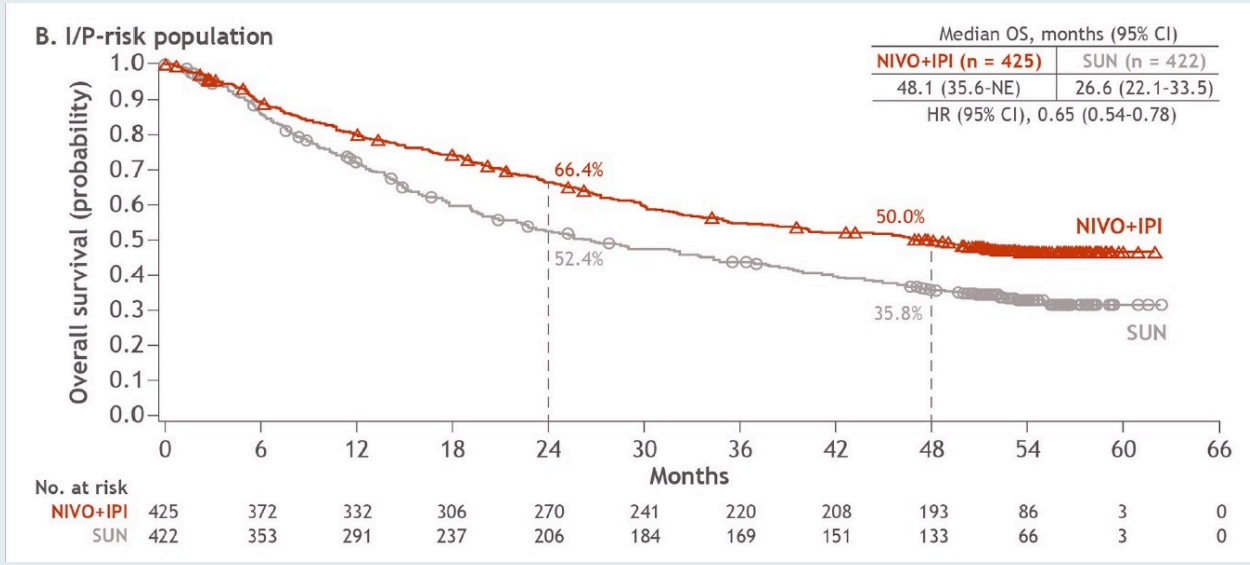
Nivolumab plus ipilimumab versus sunitinib for first-line treatment of advanced renal cell carcinoma: extended 4-year follow-up of the phase III CheckMate 214 trial

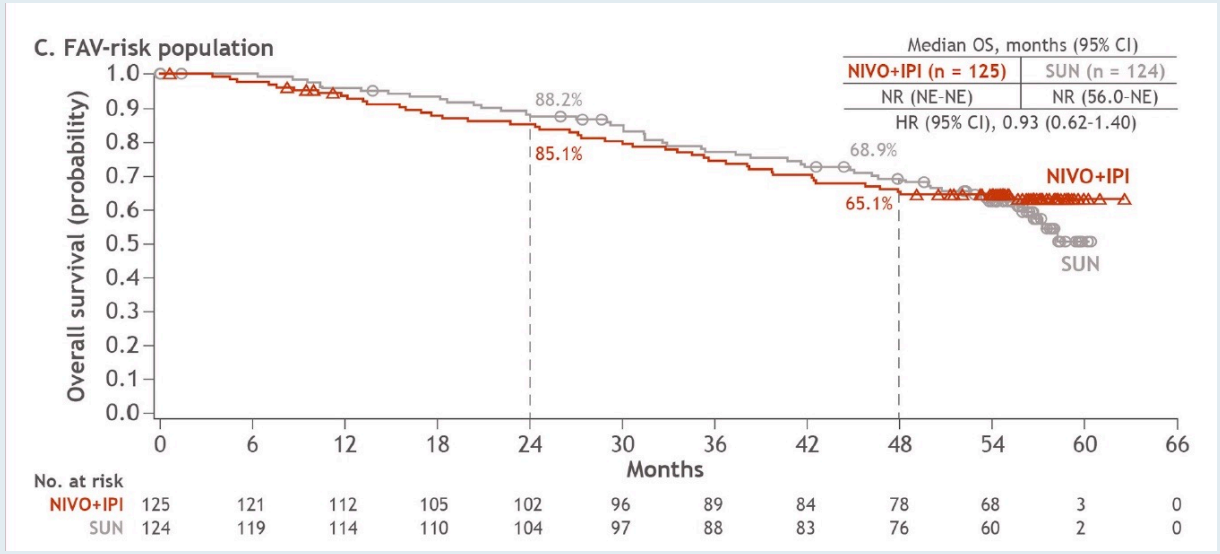
Laurence Albiges ,[1] Nizar M Tannir,[2] Mauricio Burotto,[3] David McDermott,[4,5] Elizabeth R Plimack,[6] Philippe Barthélémy,[7,8] Camillo Porta ,[9] Thomas Powles,[10,11] Frede Donskov,[12] Saby George,[13] Christian K Kollmannsberger,[14] Howard Gurney,[15,16] Marc-Oliver Grimm,[17] Yoshihiko Tomita,[18] Daniel Castellano,[19] Brian I Rini,[20] Toni K Choueiri,[21] Shruti Shally Saggi,[22] M Brent McHenry,[23] Robert J Motzer[24]

ESMO Open 2020;5(6):e001079

CheckMate 214: OS in ITT, Intermediate/Poor-Risk and Favorable-Risk Populations

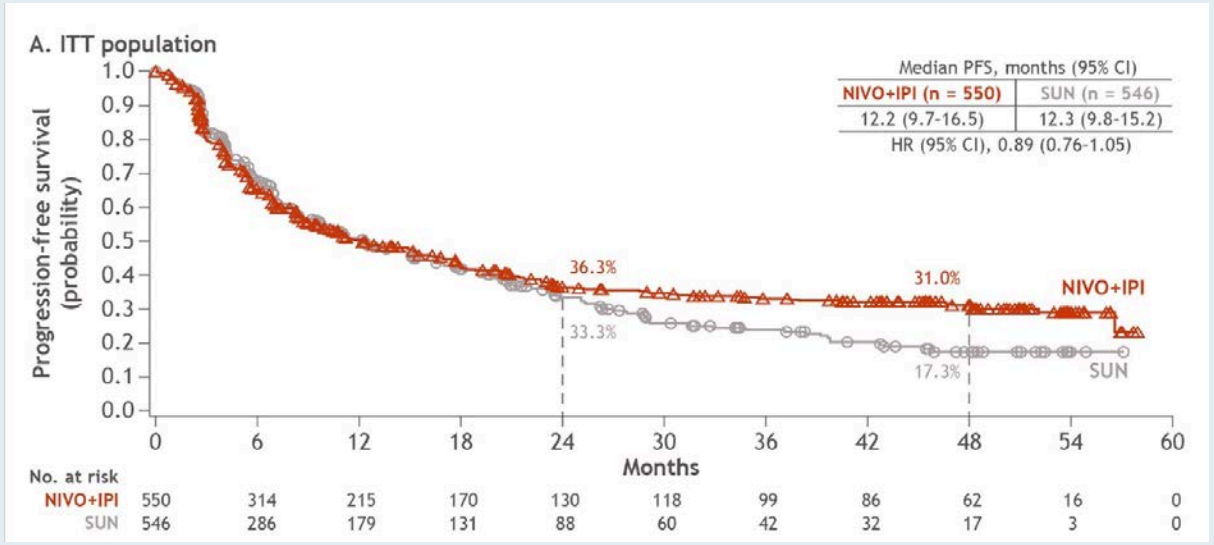


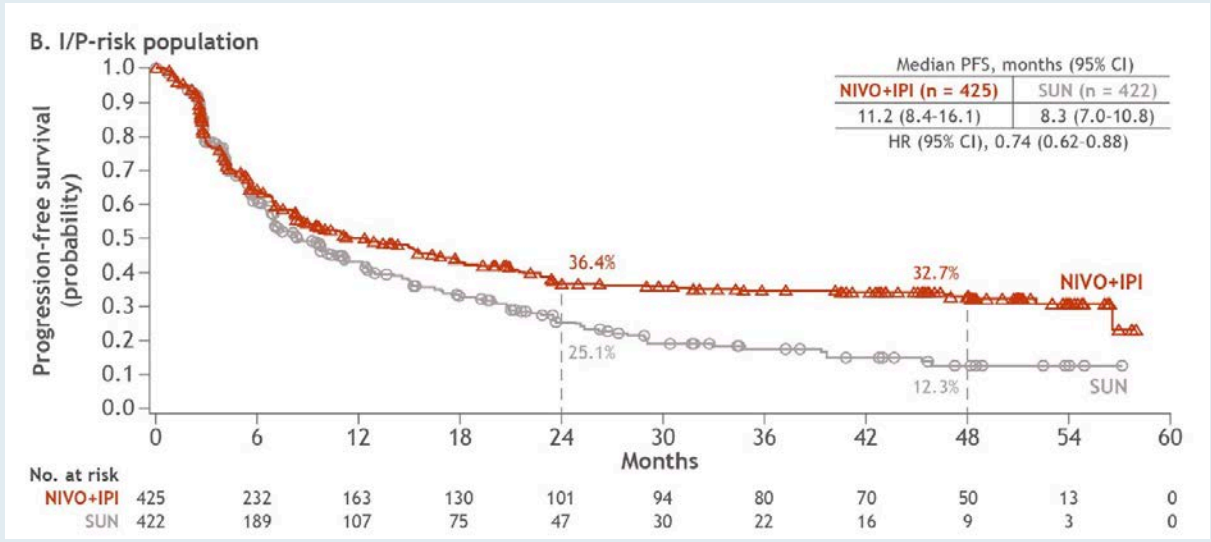


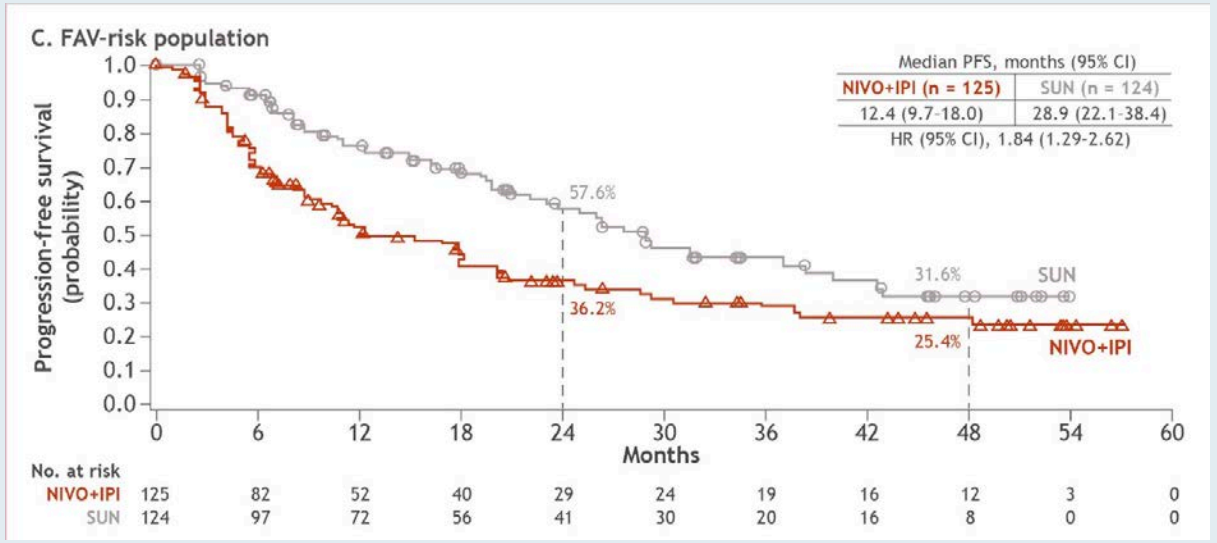


Albiges L et al. *ESMO Open* 2020;5(6):e001079.

CheckMate 214: PFS in ITT, Intermediate/Poor-Risk and Favorable-Risk Populations







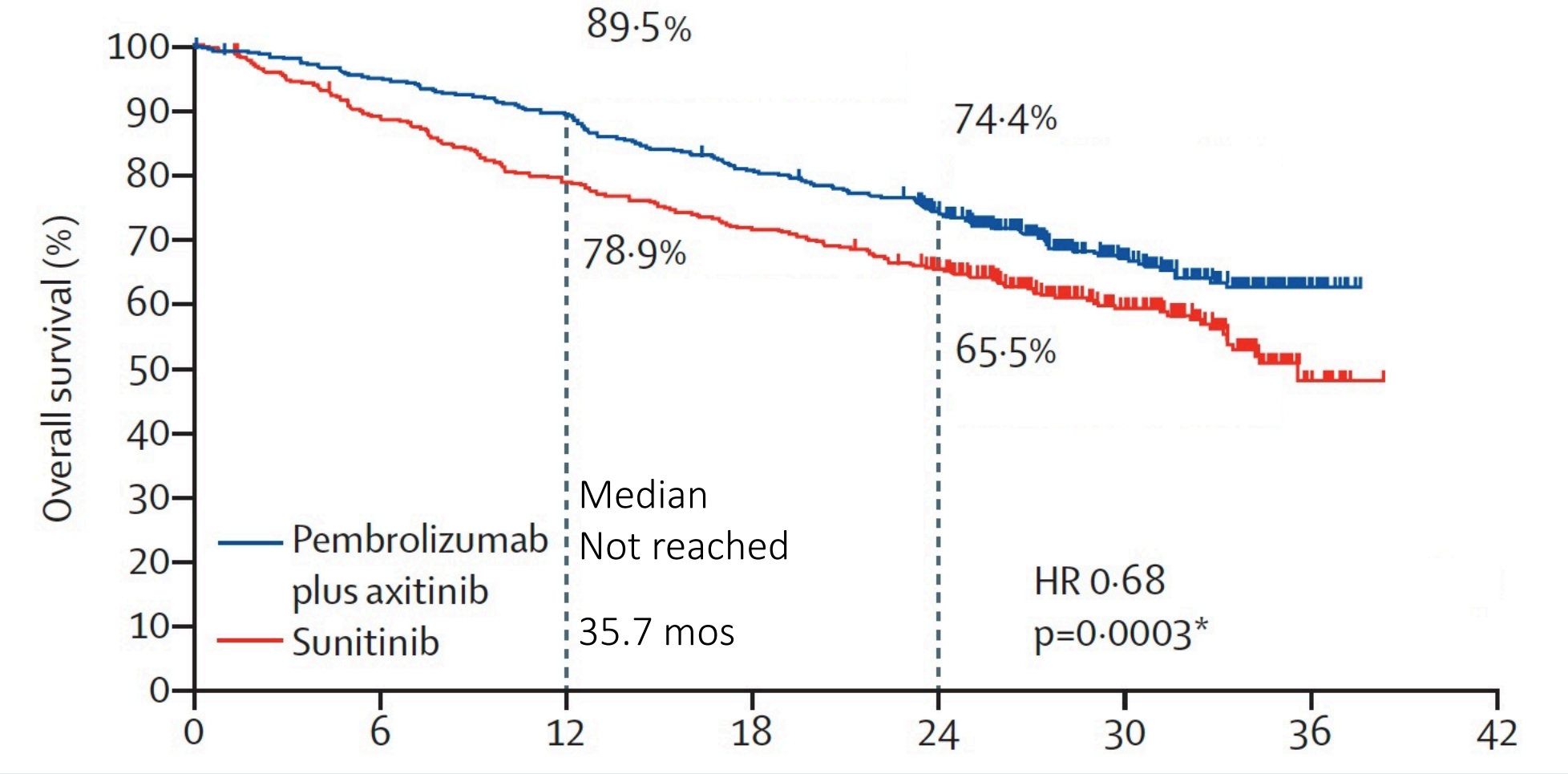
Albiges L et al. *ESMO Open* 2020;5(6):e001079.

Lancet Oncol 2020;21:1563-73

Pembrolizumab plus axitinib versus sunitinib monotherapy as first-line treatment of advanced renal cell carcinoma (KEYNOTE-426): extended follow-up from a randomised, open-label, phase 3 trial

Thomas Powles, Elizabeth R Plimack, Denis Soulières, Tom Waddell, Viktor Stus, Rustem Gafanov, Dmitry Nosov, Frédéric Pouliot, Bohuslav Melichar, Ihor Vynnychenko, Sergio J Azevedo, Delphine Borchiellini, Raymond S McDermott, Jens Bedke, Satoshi Tamada, Lina Yin, Mei Chen, L Rhoda Molife, Michael B Atkins, Brian I Rini

KEYNOTE-426: Overall Survival with Extended Follow-Up



Powles T et al. *Lancet Oncol* 2020;21:1563-73.

N Engl J Med 2021;384(9):829-41

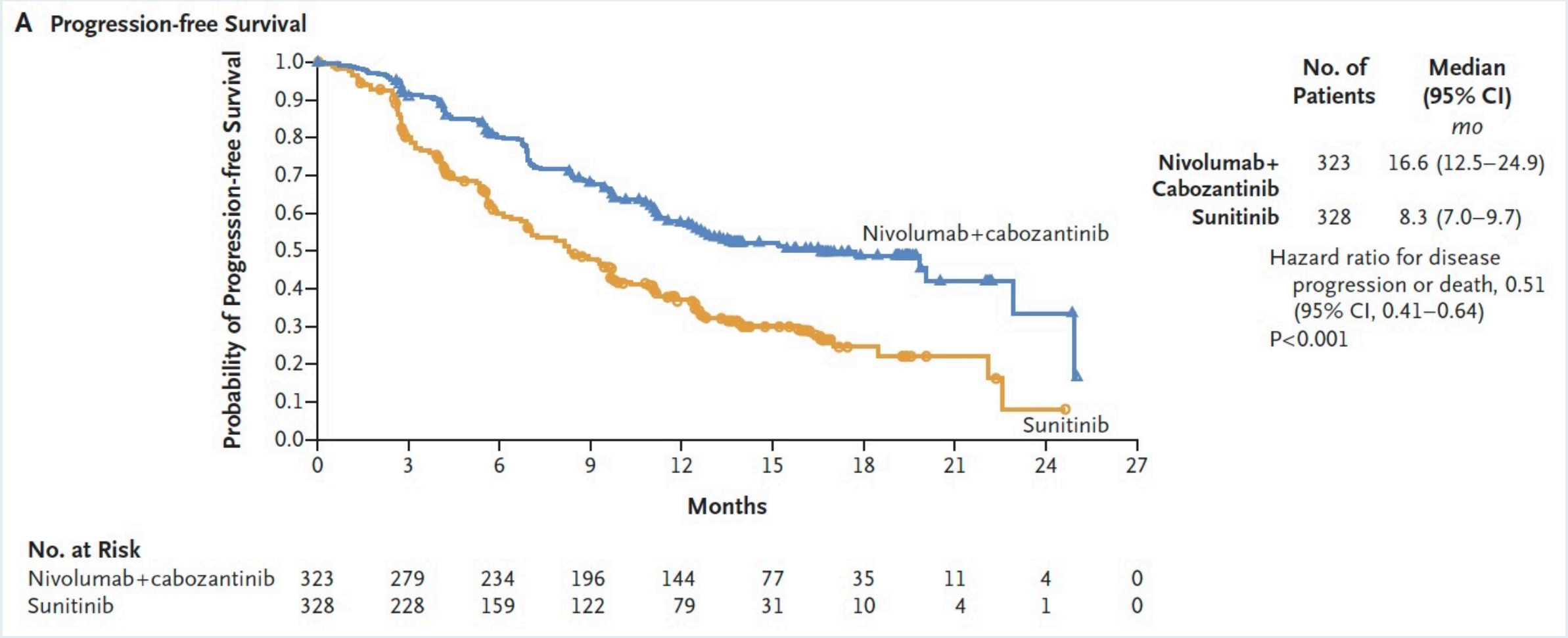
The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Nivolumab plus Cabozantinib versus Sunitinib for Advanced Renal-Cell Carcinoma

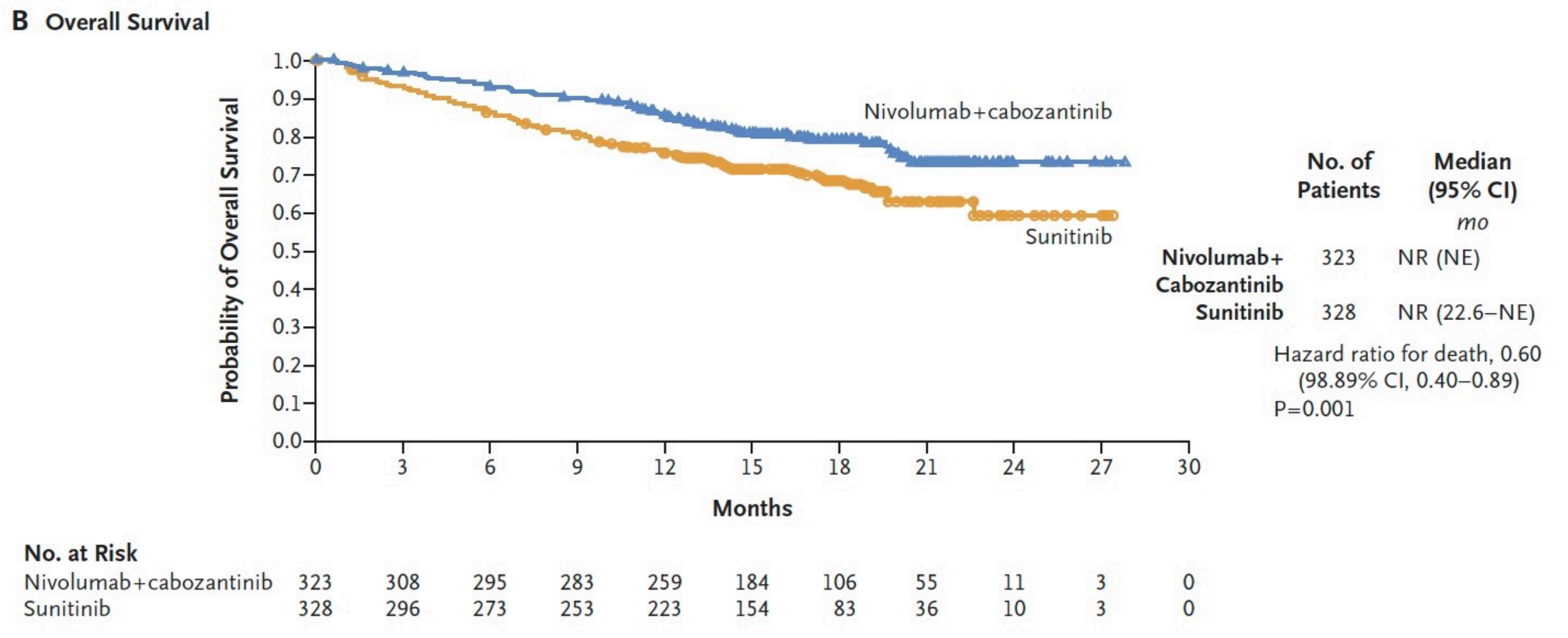
T.K. Choueiri, T. Powles, M. Burotto, B. Escudier, M.T. Bourlon, B. Zurawski, V.M. Oyervides Juárez, J.J. Hsieh, U. Basso, A.Y. Shah, C. Suárez, A. Hamzaj, J.C. Goh, C. Barrios, M. Richardet, C. Porta, R. Kowalyszyn, J.P. Feregrino, J. Żołnierek, D. Pook, E.R. Kessler, Y. Tomita, R. Mizuno, J. Bedke, J. Zhang, M.A. Maurer, B. Simsek, F. Ejzykowicz, G.M. Schwab, A.B. Apolo, and R.J. Motzer, for the CheckMate 9ER Investigators*

Progression-Free Survival in the Intention-to-Treat Population



Choueiri TK et al. *N Engl J Med* 2021;384(9):829-41.

Overall Survival in the Intention-to-Treat Population



	No. of Patients	Median (95% CI) *mo*
Nivolumab+ Cabozantinib	323	NR (NE)
Sunitinib	328	NR (22.6–NE)

Hazard ratio for death, 0.60 (98.89% CI, 0.40–0.89)
P=0.001

Choueiri TK et al. *N Engl J Med* 2021;384(9):829-41.

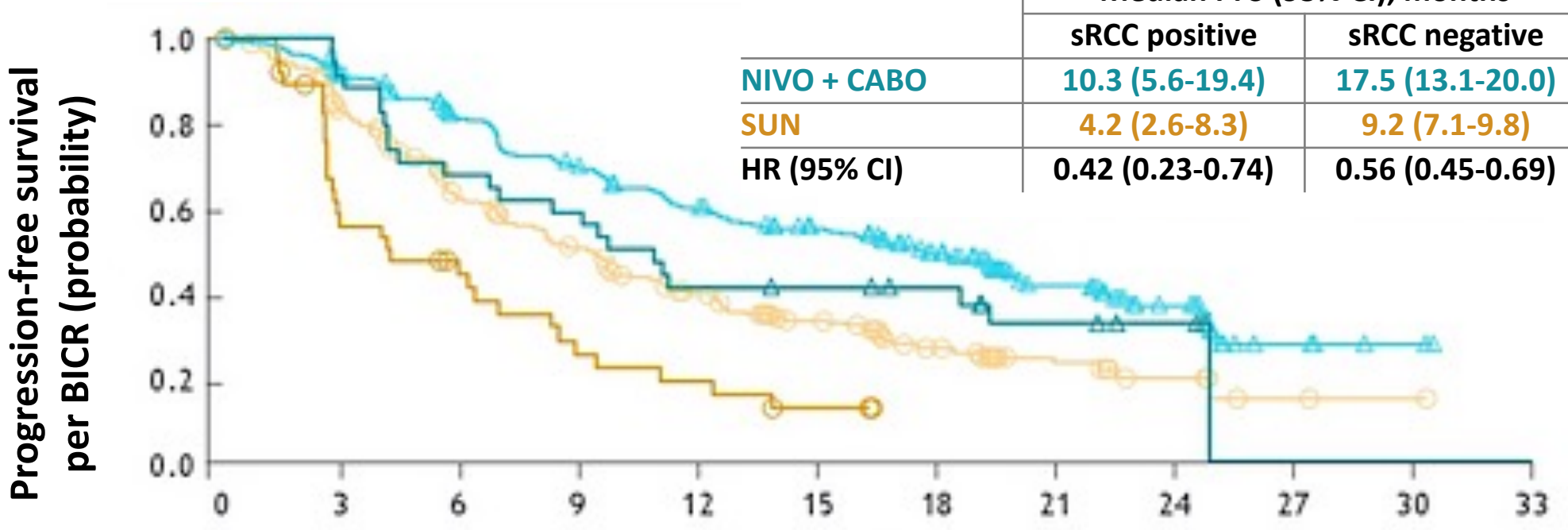
Nivolumab + Cabozantinib (NIVO + CABO) versus Sunitinib (SUN) for Advanced Renal Cell Carcinoma (aRCC): Outcomes by Sarcomatoid Histology and Updated Trial Results with Extended Follow-Up of CheckMate 9ER

Motzer RJ et al.

Genitourinary Cancers Symposium 2021;Abstract 308.

Progression-Free Survival per BICR by Sarcomatoid Histology

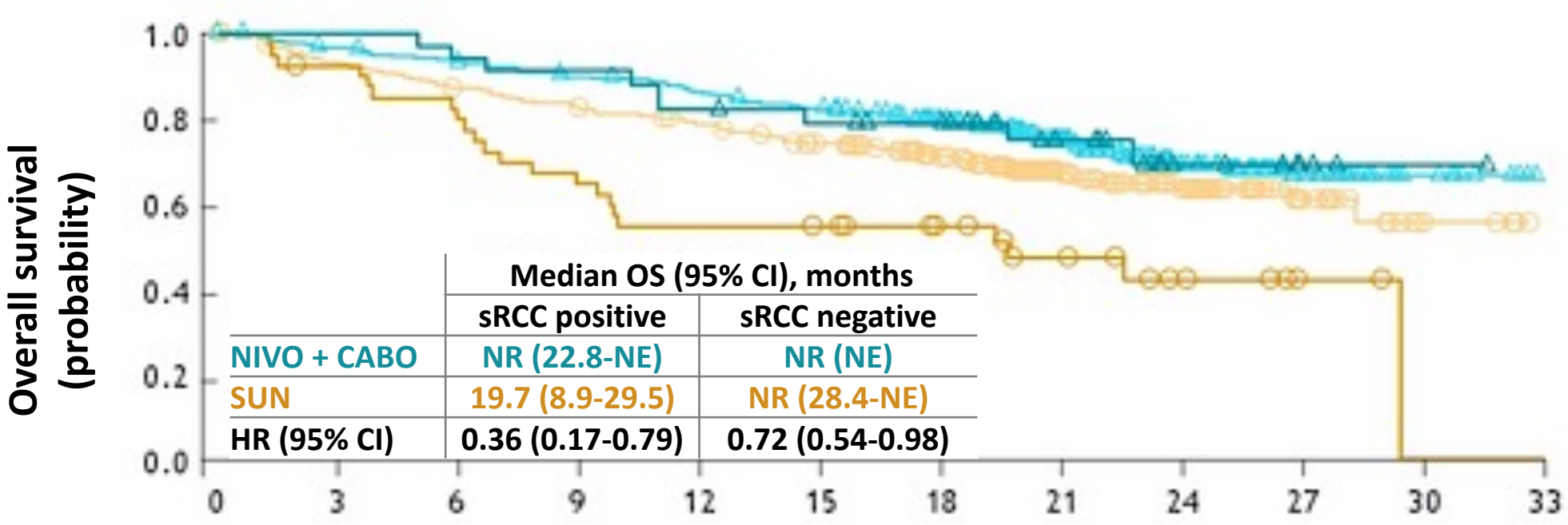
	Median PFS (95% CI), months	
	sRCC positive	sRCC negative
NIVO + CABO	10.3 (5.6-19.4)	17.5 (13.1-20.0)
SUN	4.2 (2.6-8.3)	9.2 (7.1-9.8)
HR (95% CI)	0.42 (0.23-0.74)	0.56 (0.45-0.69)



No. at risk												
NIVO + CABO sRCC positive	34	31	23	20	14	13	11	7	4	0	0	0
SUN sRCC positive	41	20	14	8	6	2	0	0	0	0	0	0
NIVO + CABO sRCC negative	289	249	213	181	152	132	91	49	22	5	2	0
SUN sRCC negative	287	210	146	114	81	59	37	17	7	2	1	0

Motzer RJ et al. Genitourinary Cancers Symposium 2021;Abstract 308.

Overall Survival by Sarcomatoid Histology



	Median OS (95% CI), months	
	sRCC positive	sRCC negative
NIVO + CABO	NR (22.8-NE)	NR (NE)
SUN	19.7 (8.9-29.5)	NR (28.4-NE)
HR (95% CI)	0.36 (0.17-0.79)	0.72 (0.54-0.98)

No. at risk												
NIVO + CABO sRCC positive	34	34	32	31	28	26	24	16	7	3	1	0
SUN sRCC positive	41	37	32	26	22	21	17	12	6	2	0	0
NIVO + CABO sRCC negative	289	274	263	252	241	229	196	131	77	37	9	0
SUN sRCC negative	287	258	240	228	214	196	172	106	56	20	4	0

Motzer RJ et al. Genitourinary Cancers Symposium 2021;Abstract 308.

N Engl J Med 2021;[Online ahead of print].

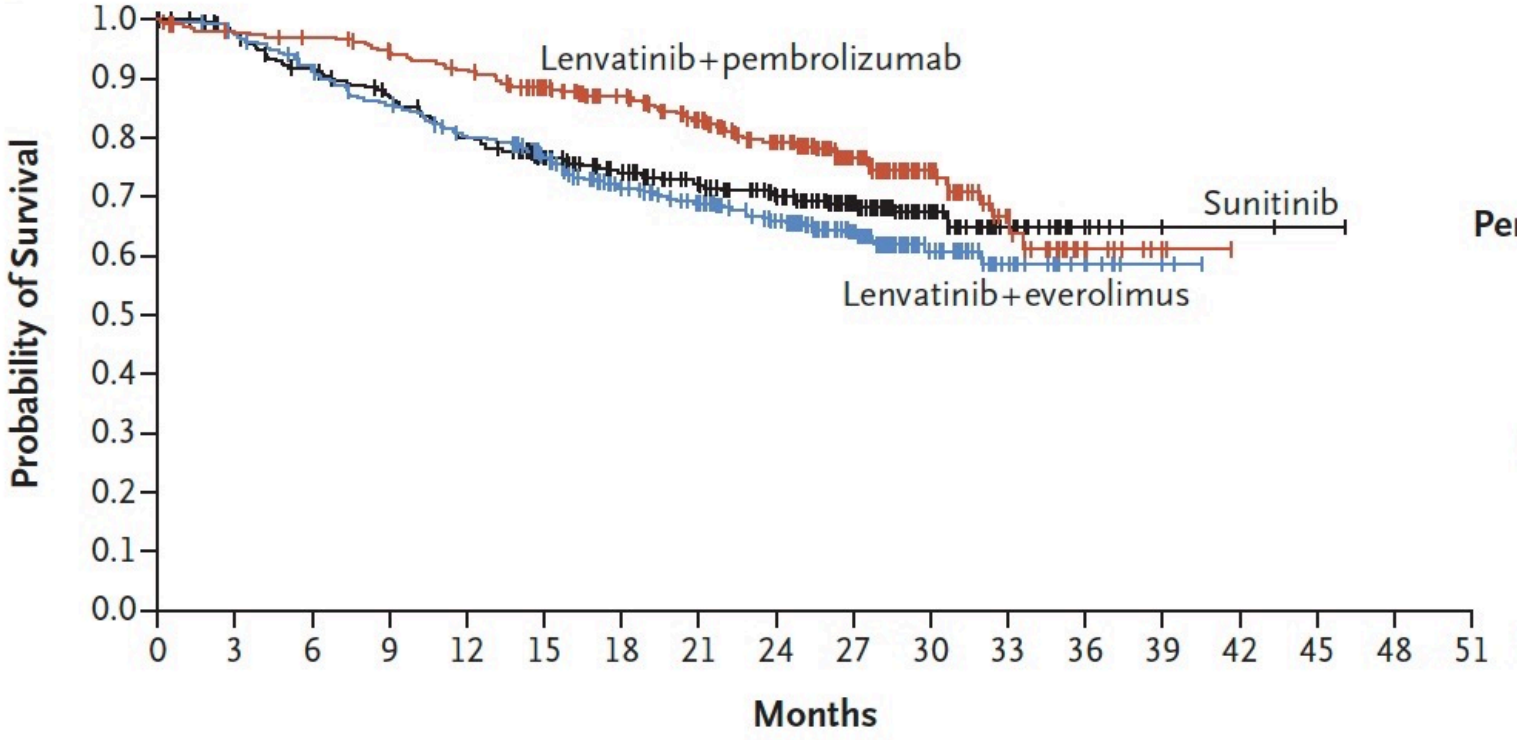
The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Lenvatinib plus Pembrolizumab or Everolimus for Advanced Renal Cell Carcinoma

R. Motzer, B. Alekseev, S.-Y. Rha, C. Porta, M. Eto, T. Powles, V. Grünwald, T.E. Hutson, E. Kopyltsov, M.J. Méndez-Vidal, V. Kozlov, A. Alyasova, S.-H. Hong, A. Kapoor, T. Alonso Gordoa, J.R. Merchan, E. Winquist, P. Maroto, J.C. Goh, M. Kim, H. Gurney, V. Patel, A. Peer, G. Procopio, T. Takagi, B. Melichar, F. Rolland, U. De Giorgi, S. Wong, J. Bedke, M. Schmidinger, C.E. Dutcus, A.D. Smith, L. Dutta, K. Mody, R.F. Perini, D. Xing, and T.K. Choueiri, for the CLEAR Trial Investigators*

Kaplan-Meier Analysis of Overall Survival



	Median Overall Survival (95% CI)
	mo
Lenvatinib+ Pembrolizumab	NR (33.6–NE)
Lenvatinib+ Everolimus	NR (NE–NE)
Sunitinib	NR (NE–NE)

Hazard ratio for death (lenvatinib+ pembrolizumab vs. sunitinib), 0.66 (95% CI, 0.49–0.88); P=0.005

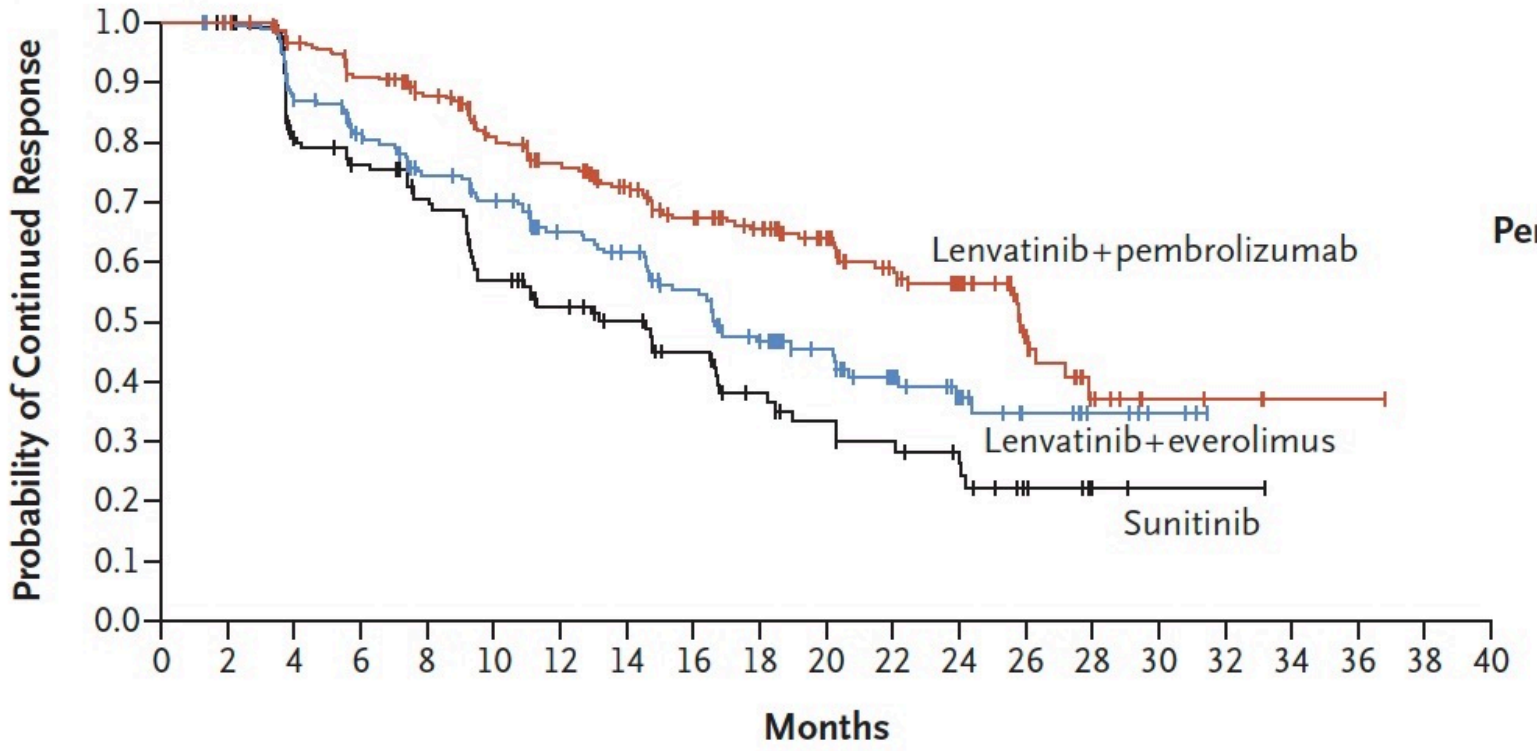
Hazard ratio for death (lenvatinib+ everolimus vs. sunitinib), 1.15 (95% CI, 0.88–1.50); P=0.30

No. at Risk

Lenvatinib+pembrolizumab	355	342	338	327	313	280	253	222	188	129	66	26	10	2	0		
Lenvatinib+everolimus	357	346	321	299	277	246	205	183	154	109	46	22	8	2	0		
Sunitinib	357	332	307	289	264	236	207	186	160	112	60	25	7	2	2	1	0

Motzer R et al. *N Engl J Med* 2021;[Online ahead of print].

Kaplan-Meier Analysis of Response Duration



Median Duration of Response (95% CI)	*mo*
Lenvatinib+ Pembrolizumab	25.8 (22.1–27.9)
Lenvatinib+ Everolimus	16.6 (14.6–20.6)
Sunitinib	14.6 (9.4–16.7)

No. at Risk

Lenvatinib+pembrolizumab	252	250	234	215	197	172	153	131	112	101	83	63	45	23	9	4	3	1	1	0
Lenvatinib+everolimus	191	186	159	142	125	113	93	83	65	50	39	27	18	11	6	3	0			
Sunitinib	129	125	91	82	73	57	47	40	33	25	20	17	13	7	2	1	1	0		

Motzer R et al. *N Engl J Med* 2021;[Online ahead of print].

Confirmed Tumor Responses

Measure	Lenvatinib plus Pembrolizumab (N = 355)	Lenvatinib plus Everolimus (N = 357)	Sunitinib (N = 357)
Objective response (95% CI) — %†	71.0 (66.3–75.7)	53.5 (48.3–58.7)	36.1 (31.2–41.1)
Relative risk vs. sunitinib (95% CI)	1.97 (1.69–2.29)	1.48 (1.26–1.74)	Reference
Best overall response — no. (%)			
Complete response	57 (16.1)	35 (9.8)	15 (4.2)
Partial response	195 (54.9)	156 (43.7)	114 (31.9)
Stable disease	68 (19.2)	120 (33.6)	136 (38.1)
Progressive disease	19 (5.4)	26 (7.3)	50 (14.0)
Unknown or could not be evaluated‡	16 (4.5)	20 (5.6)	42 (11.8)
Median time to response (range) — mo	1.94 (1.41–18.50)	1.91 (1.41–14.36)	1.94 (1.61–16.62)
Median duration of response (95% CI) — mo	25.8 (22.1–27.9)	16.6 (14.6–20.6)	14.6 (9.4–16.7)

Motzer R et al. *N Engl J Med* 2021;[Online ahead of print].

Selected Adverse Events of Any Cause That Emerged or Worsened During Treatment in at Least 25% of the Patients in Any Treatment Group

Event	Lenvatinib plus Pembrolizumab (N=352)		Lenvatinib plus Everolimus (N=355)		Sunitinib (N=340)	
	Any Grade	Grade ≥3†	Any Grade	Grade ≥3†	Any Grade	Grade ≥3†
	number of patients (percent)					
Any event	351 (99.7)	290 (82.4)	354 (99.7)	295 (83.1)	335 (98.5)	244 (71.8)
Diarrhea	216 (61.4)	34 (9.7)	236 (66.5)	41 (11.5)	168 (49.4)	18 (5.3)
Hypertension	195 (55.4)	97 (27.6)	162 (45.6)	80 (22.5)	141 (41.5)	64 (18.8)
Hypothyroidism‡	166 (47.2)	5 (1.4)	95 (26.8)	2 (0.6)	90 (26.5)	0
Decreased appetite	142 (40.3)	14 (4.0)	144 (40.6)	22 (6.2)	105 (30.9)	5 (1.5)
Fatigue	141 (40.1)	15 (4.3)	149 (42.0)	27 (7.6)	125 (36.8)	15 (4.4)

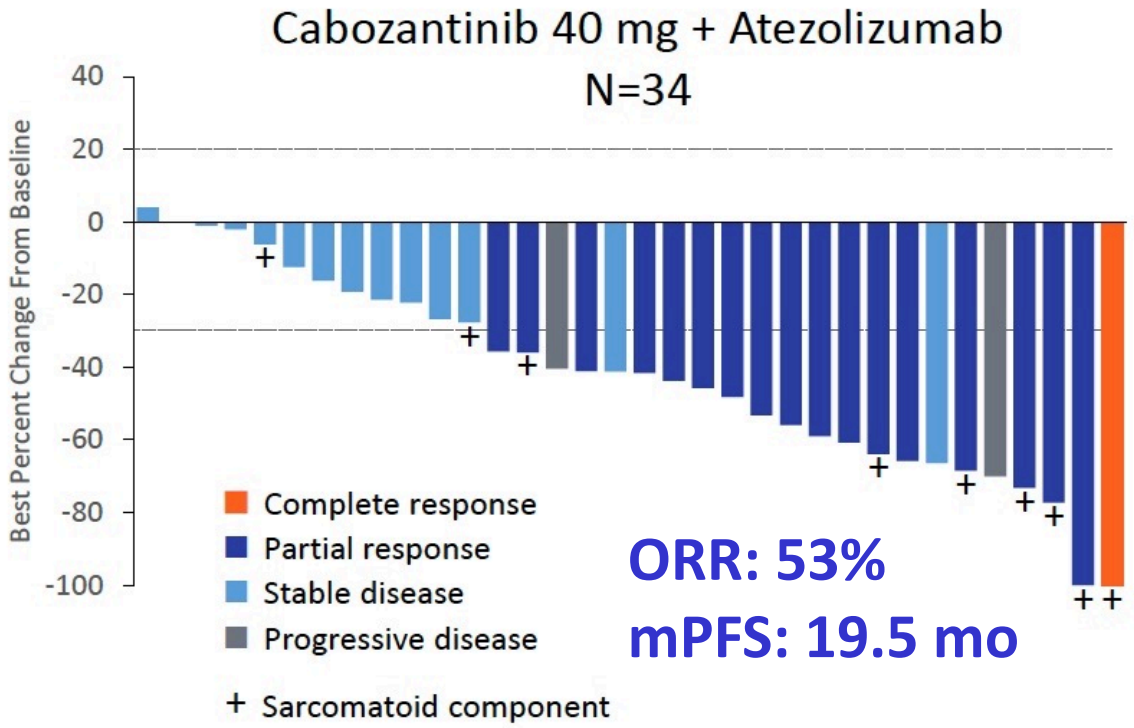
Motzer R et al. *N Engl J Med* 2021;[Online ahead of print].

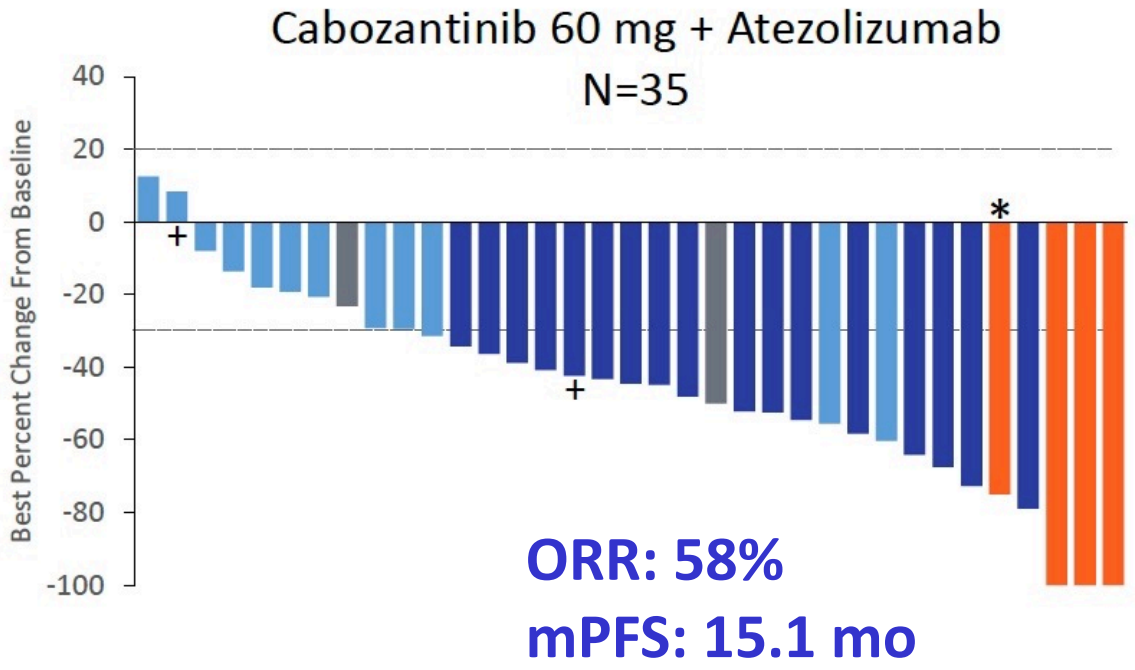
Cabozantinib (C) in Combination with Atezolizumab (A) as First-Line Therapy for Advanced Clear Cell Renal Cell Carcinoma (ccRCC): Results from the COSMIC-021 Study

Pal S et al.

ESMO 2020;Abstract 702O.

COSMIC-021: Cabozantinib/Atezolizumab for Previously Untreated Advanced ccRCC





Pal S et al. ESMO 2020;Abstract 702O.

Select, Ongoing Phase III Clinical Trials for Previously Untreated Metastatic Renal Cell Carcinoma

Study acronym	Target accrual	Randomization	Primary endpoint(s)	Estimated primary completion
COSMIC-313	840	• Cabozantinib + nivolumab + ipilimumab (4 doses) → cabozantinib + nivolumab • Placebo + nivolumab + ipilimumab (4 doses) → placebo + nivolumab	PFS	Nov 2021
PDIGREE	1,046	After Induction nivolumab/ipilimumab • Pts with CR → Nivolumab • Pts with non-CR or non-PD, *randomized* → Nivolumab → Nivolumab + Cabozantinib • Pts with PD → Cabozantinib	OS	Sept 2021

FDA Approves Tivozanib for Relapsed or Refractory Advanced RCC

Press Release: March 10, 2021

"On March 10, 2021, the Food and Drug Administration approved tivozanib, a kinase inhibitor, for adult patients with relapsed or refractory advanced renal cell carcinoma (RCC) following two or more prior systemic therapies.

Efficacy was evaluated in TIVO-3 (NCT02627963), a randomized (1:1), open-label, multicenter trial of tivozanib versus sorafenib in patients with relapsed or refractory advanced RCC who received two or three prior systemic treatments, including at least one VEGFR kinase inhibitor other than sorafenib or tivozanib.

The recommended tivozanib dose is 1.34 mg once daily (with or without food) for 21 consecutive days every 28 days until disease progression or unacceptable toxicity."

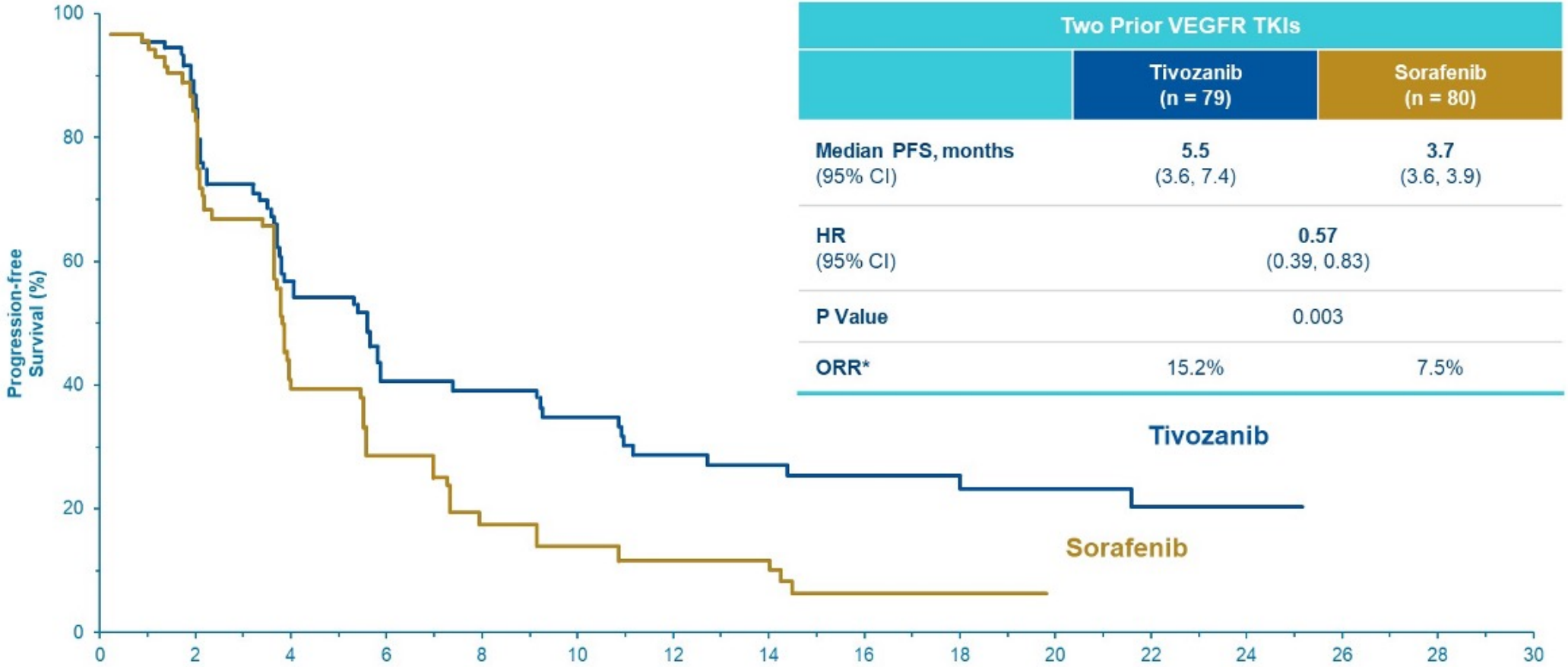
https://www.fda.gov/drugs/drug-approvals-and-databases/fda-approves-tivozanib-relapsed-or-refractory-advanced-renal-cell-carcinoma

Tivozanib in Patients with Advanced Renal Cell Carcinoma (aRCC) Who Have Progressed After Prior Treatment of Axitinib: Results from TIVO-3

Rini BI et al.

Genitourinary Cancers Symposium 2021;Abstract 278.

TIVO-3: Progression-Free Survival and ORR in Patient Subgroup with 2 Prior TKIs



Two Prior VEGFR TKIs		
	Tivozanib (n = 79)	Sorafenib (n = 80)
Median PFS, months (95% CI)	5.5 (3.6, 7.4)	3.7 (3.6, 3.9)
HR (95% CI)	0.57 (0.39, 0.83)	
P Value	0.003	
ORR*	15.2%	7.5%

Rini BI et al. Genitourinary Cancers Symposium 2021;Abstract 278.

TIVO-3: Tivozanib After Axitinib

RCC Population	N (subjects)		mPFS (months)		HR	ORR	
	Tivo	Sor	Tivo	Sor		Tivo	Sor
ITT	175	175	5.6	3.9	0.73	18%	8%
3rd Line Any Prior Axitinib	47	46	5.5	3.9	0.71	16%	6%
4th Line Any Prior Axitinib	36	43	5.5	3.6	0.64	11%	10%
3rd and 4th Line Any Prior Axitinib	83	89	5.5	3.7	0.68	13%	8%

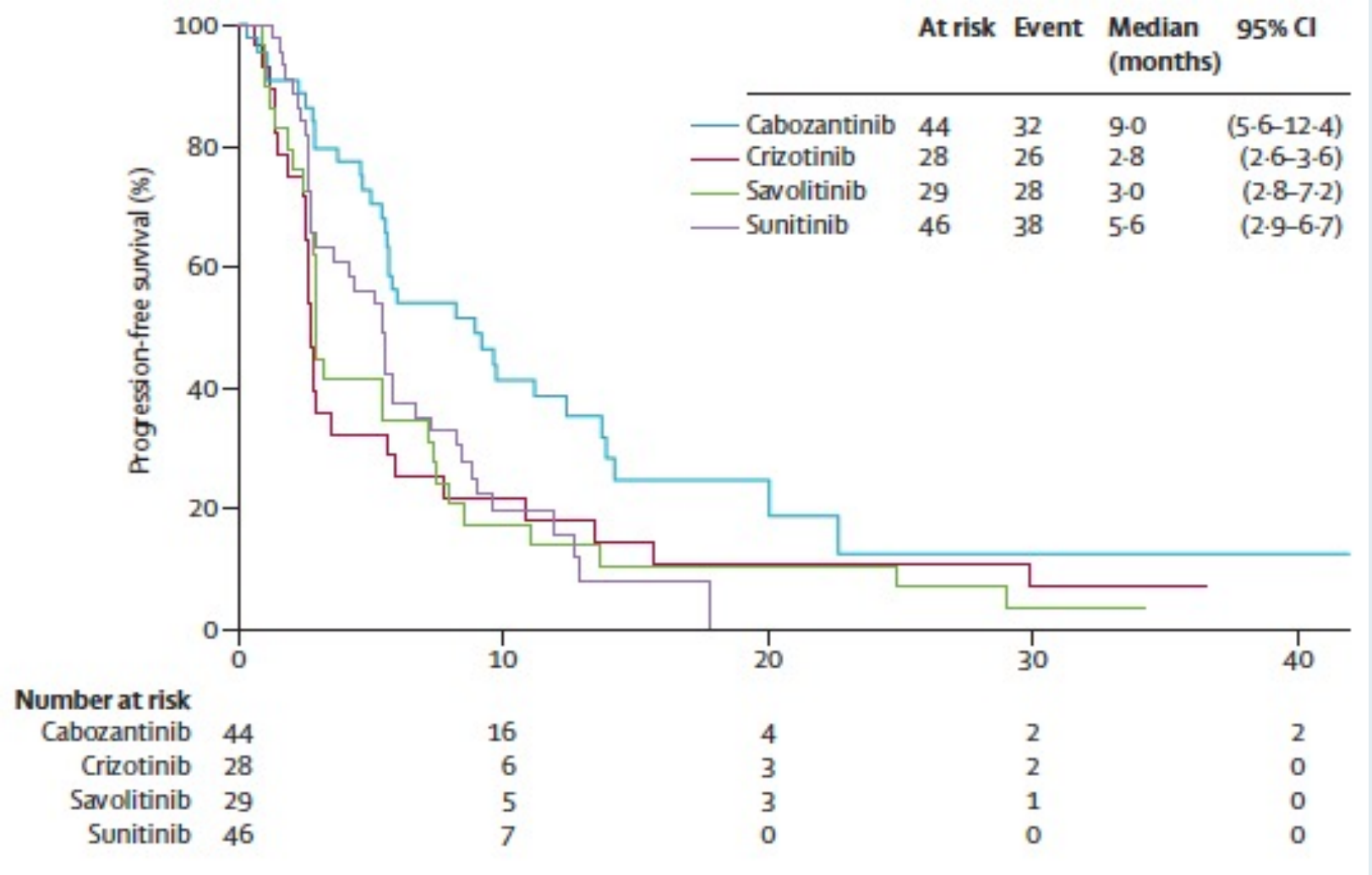
Rini BI et al. Genitourinary Cancers Symposium 2021;Abstract 278.

Lancet 2021;397:695-703

A comparison of sunitinib with cabozantinib, crizotinib, and savolitinib for treatment of advanced papillary renal cell carcinoma: a randomised, open-label, phase 2 trial

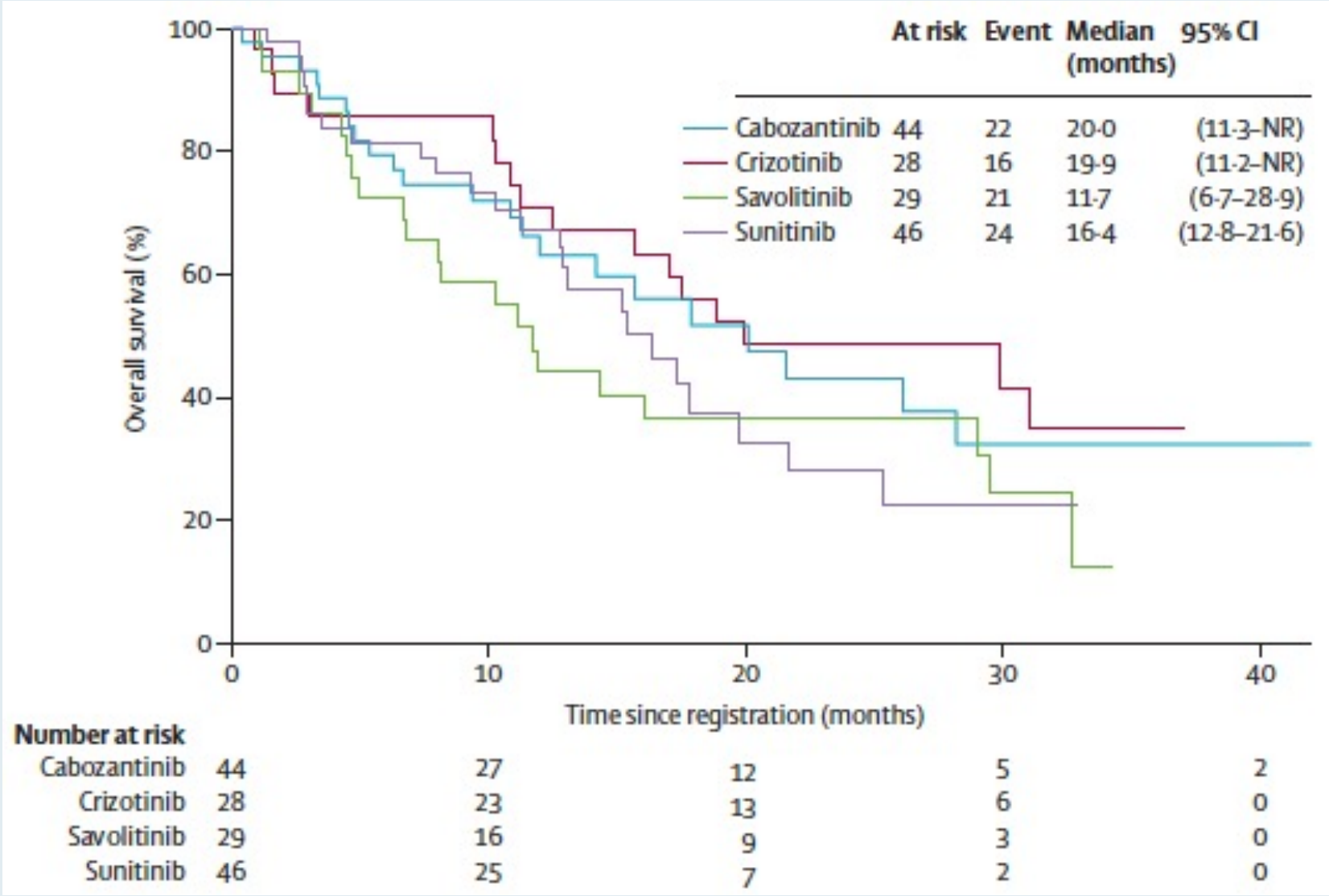
Sumanta K Pal, Catherine Tangen, Ian M Thompson Jr, Naomi Balzer-Haas, Daniel J George, Daniel Y C Heng, Brian Shuch, Mark Stein, Maria Tretiakova, Peter Humphrey, Adebowale Adeniran, Vivek Narayan, Georg A Bjarnason, Ulka Vaishampayan, Ajjai Alva, Tian Zhang, Scott Cole, Melissa Plets, John Wright, Primo N Lara Jr

Kaplan-Meier Analysis of Progression-Free Survival



Pal SK et al. *Lancet* 2021;397:695-703.

Kaplan-Meier Analysis of Overall Survival



Pal SK et al. *Lancet* 2021;397:695-703.

FDA Grants Priority Review to Belzutifan for von Hippel-Lindau Disease-Associated RCC

Press Release – March 16, 2021

"The FDA accepted a new drug application for belzutifan to treat von Hippel-Lindau disease-associated renal cell carcinoma and granted it priority review based on response rate results from a phase 2 trial.

A new drug application for belzutifan was accepted by the FDA and granted priority review for the treatment of patients with von Hippel-Lindau (VHL) disease-associated renal cell carcinoma (RCC), not requiring immediate surgery…

The application is based on results of a phase 2 trial, Study-004 (NCT03401788), of belzutifan in the treatment of VHL disease-associated RCC, with a primary end point of objective response rate and secondary measures of disease control rate, duration of response, time to response, progression-free survival, time to surgery, and safety. Patients treated on the trial must have had at least 1 measurable solid tumor localized to the kidneys and were not in need of immediate surgical intervention."

https://www.cancernetwork.com/view/fda-grants-priority-review-to-belzutifan-for-von-hippel-lindau-disease-associated-rcc

RTP RESEARCH TO PRACTICE

Project ECHO

Genitourinary Cancers Symposium 2021;Abstract 273.

The Oral HIF-2α Inhibitor Belzutifan (MK-6482) in Patients With Advanced Clear Cell Renal Cell Carcinoma: Updated Follow-up of a Phase 1/2 Study

Todd Michael Bauer,[1] Toni K. Choueiri,[2] Kyriakos P. Papadopoulos,[3] Elizabeth R. Plimack,[4] Jaime R. Merchan,[5] David F. McDermott,[6] M. Dror Michaelson,[7] Leonard Joseph Appleman,[8] Sanjay Thamake,[9] Rodolfo F. Perini,[9] Eric Kristopher Park,[9] Eric Jonasch[10]

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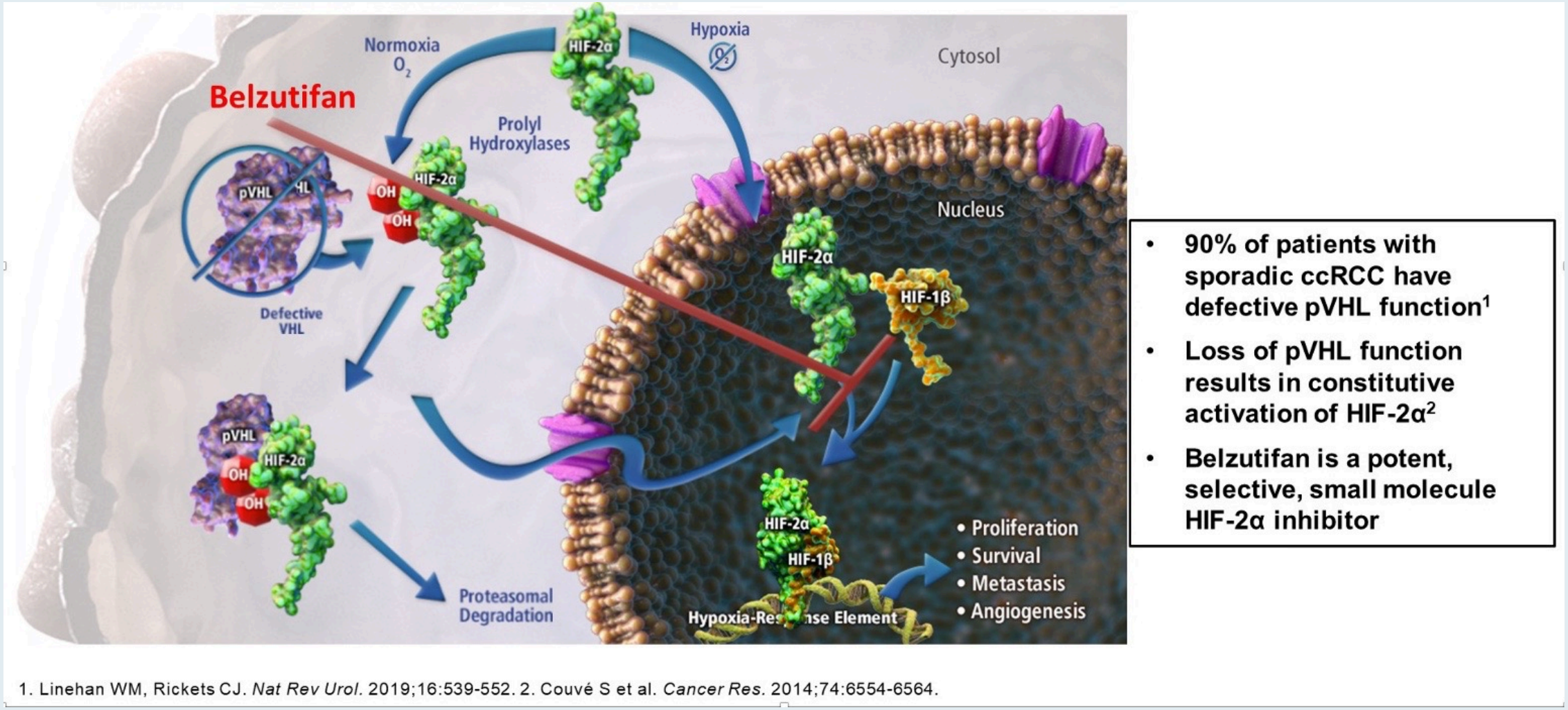
pVHL Deficiency Results in HIF-2-alpha Activation

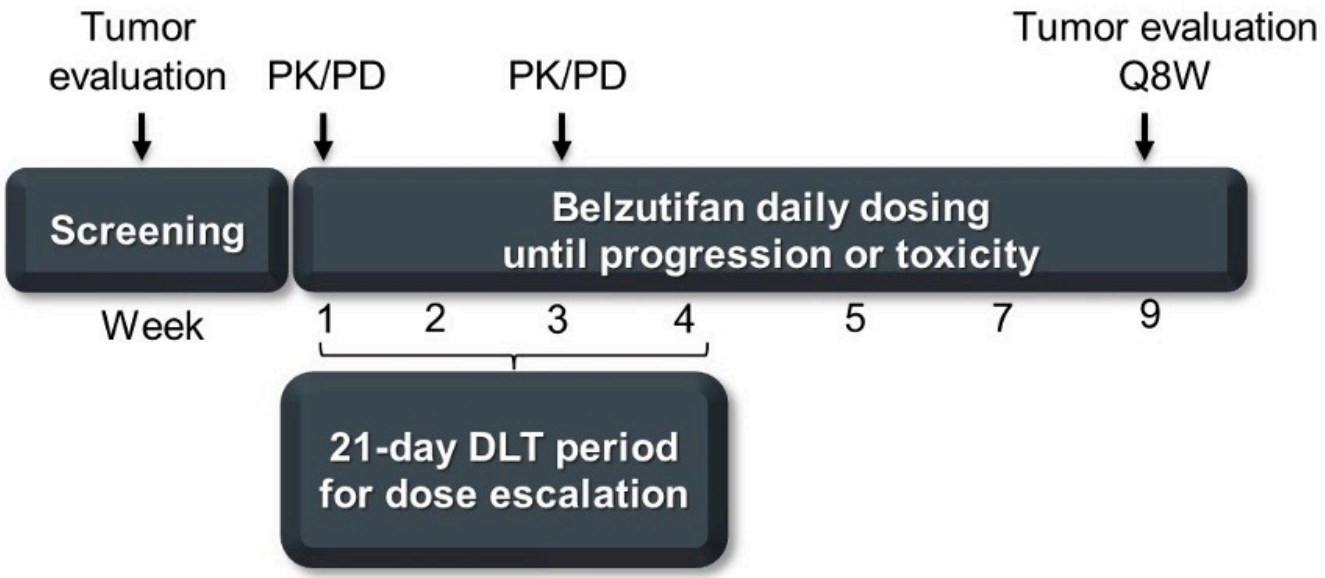


- 90% of patients with sporadic ccRCC have defective pVHL function[1]
- Loss of pVHL function results in constitutive activation of HIF-2α[2]
- Belzutifan is a potent, selective, small molecule HIF-2α inhibitor

1. Linehan WM, Rickets CJ. *Nat Rev Urol.* 2019;16:539-552. 2. Couvé S et al. *Cancer Res.* 2014;74:6554-6564.

Bauer TD et al. GU Cancers Symposium 2021;Abstract 273.

Study Design

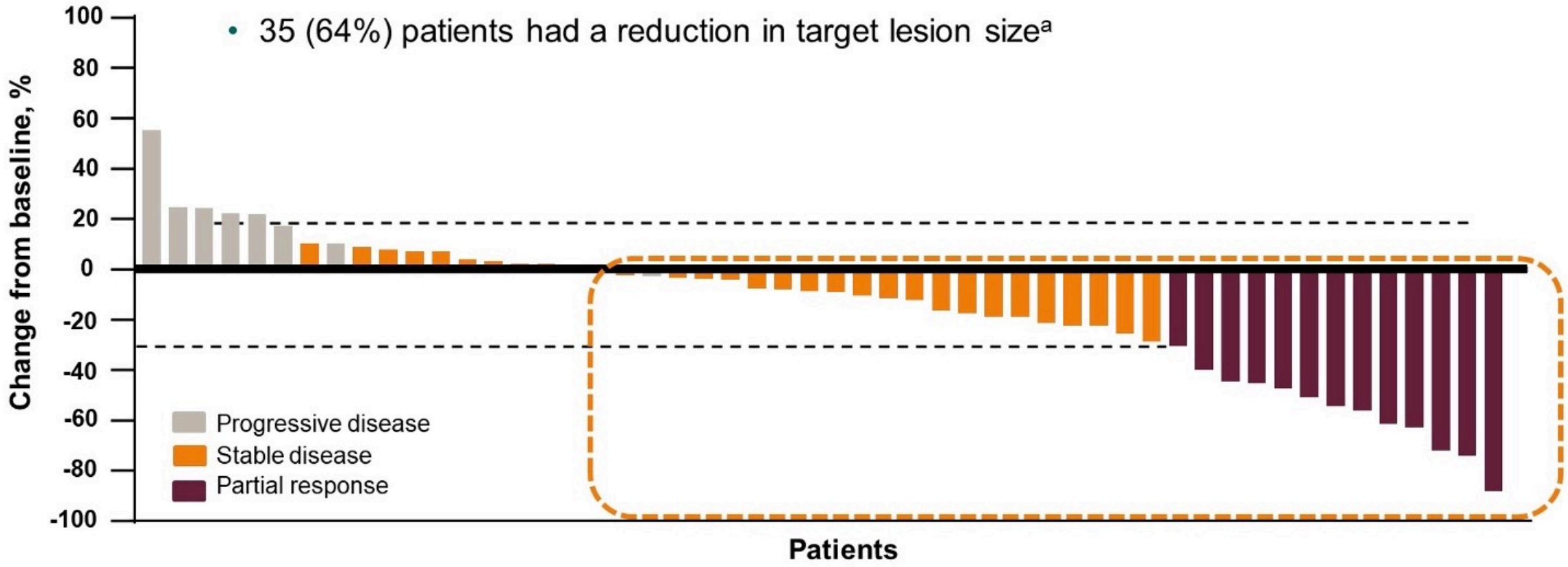


- Dose-escalation cohort for patients with advanced solid tumors
- Dose-expansion cohort for patients with advanced ccRCC who previously received ≥1 therapy
  - Key end points: Safety, objective response rate, duration of response

- Dose of 120 mg once daily selected for further clinical development from the dose-escalation cohort
- **55 patients with previously treated advanced ccRCC enrolled at 120 mg orally once daily in the dose-expansion cohort**
  - 44 (80%) discontinued
    - Most common reason was disease progression: 60%
  - 11 (20%) have treatment ongoing
- Median (range) follow-up:
  - 27.7 (24.8-34.3) months

Bauer TD et al. GU Cancers Symposium 2021;Abstract 273.

Best Tumor Change from Baseline (Investigator Assessment in the ccRCC Cohort)



[a]3 patients were nonevaluable. Data cutoff: June 1, 2020.

Bauer TD et al. GU Cancers Symposium 2021;Abstract 273.

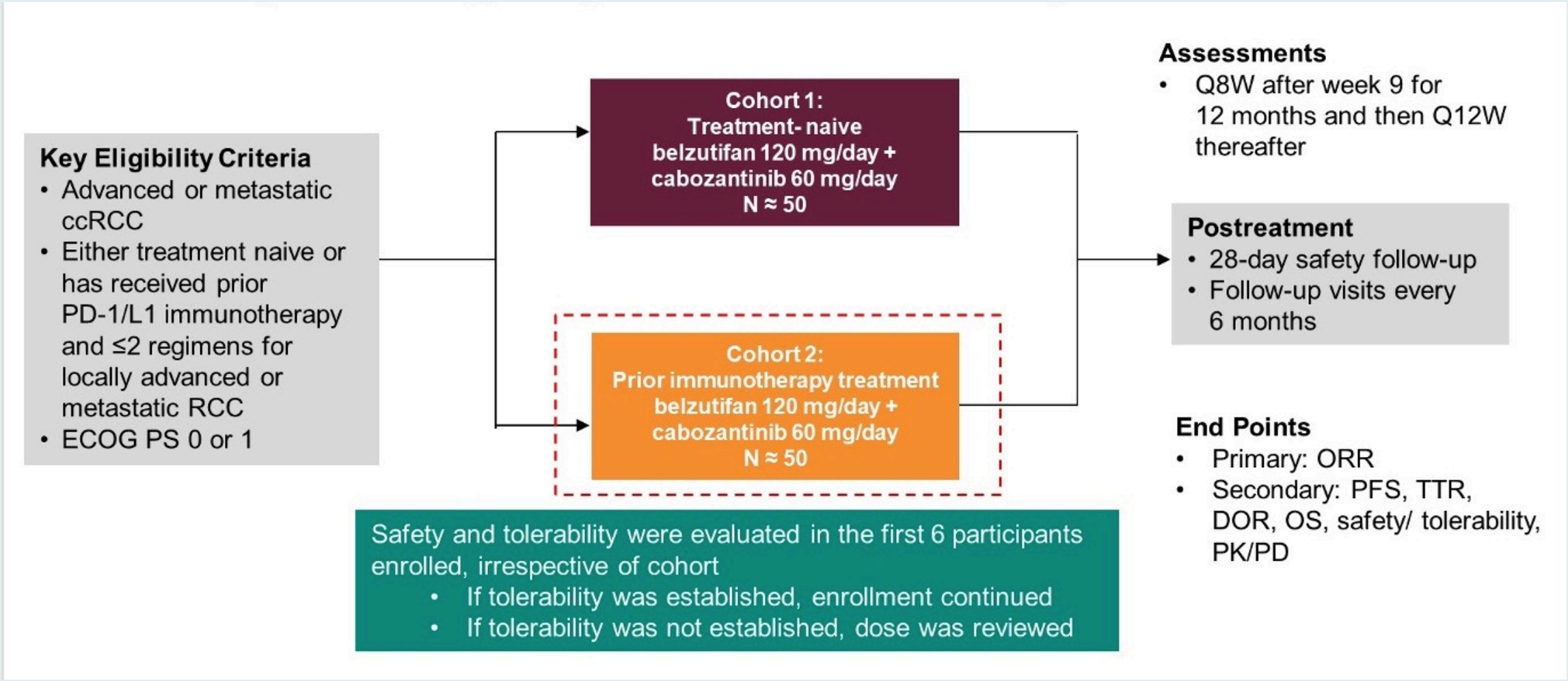
Genitourinary Cancers Symposium 2021;Abstract 272.

Phase 2 Study of the Oral Hypoxia-Inducible Factor 2α Inhibitor Belzutifan (MK-6482) in Combination With Cabozantinib in Patients With Advanced Clear Cell Renal Cell Carcinoma

Toni K. Choueiri[1]; Todd M. Bauer[2]; David F. McDermott[3]; Edward Arrowsmith[4]; Ananya Roy[5]; Rodolfo Perini[5]; Donna Vickery[5]; Scott S. Tykodi[6]

[1]Dana-Farber Cancer Institute, Boston, MA, USA; [2]Sarah Cannon Research Institute/Tennessee Oncology, Nashville, TN, USA; [3]Beth Israel Deaconess Medical Center, Boston, MA, USA; [4]Tennessee Oncology, Chattanooga, TN, USA; [5]Merck & Co., Inc., Kenilworth, NJ, USA; [6]University of Washington and Fred Hutchinson Cancer Research Center, Seattle, WA, USA

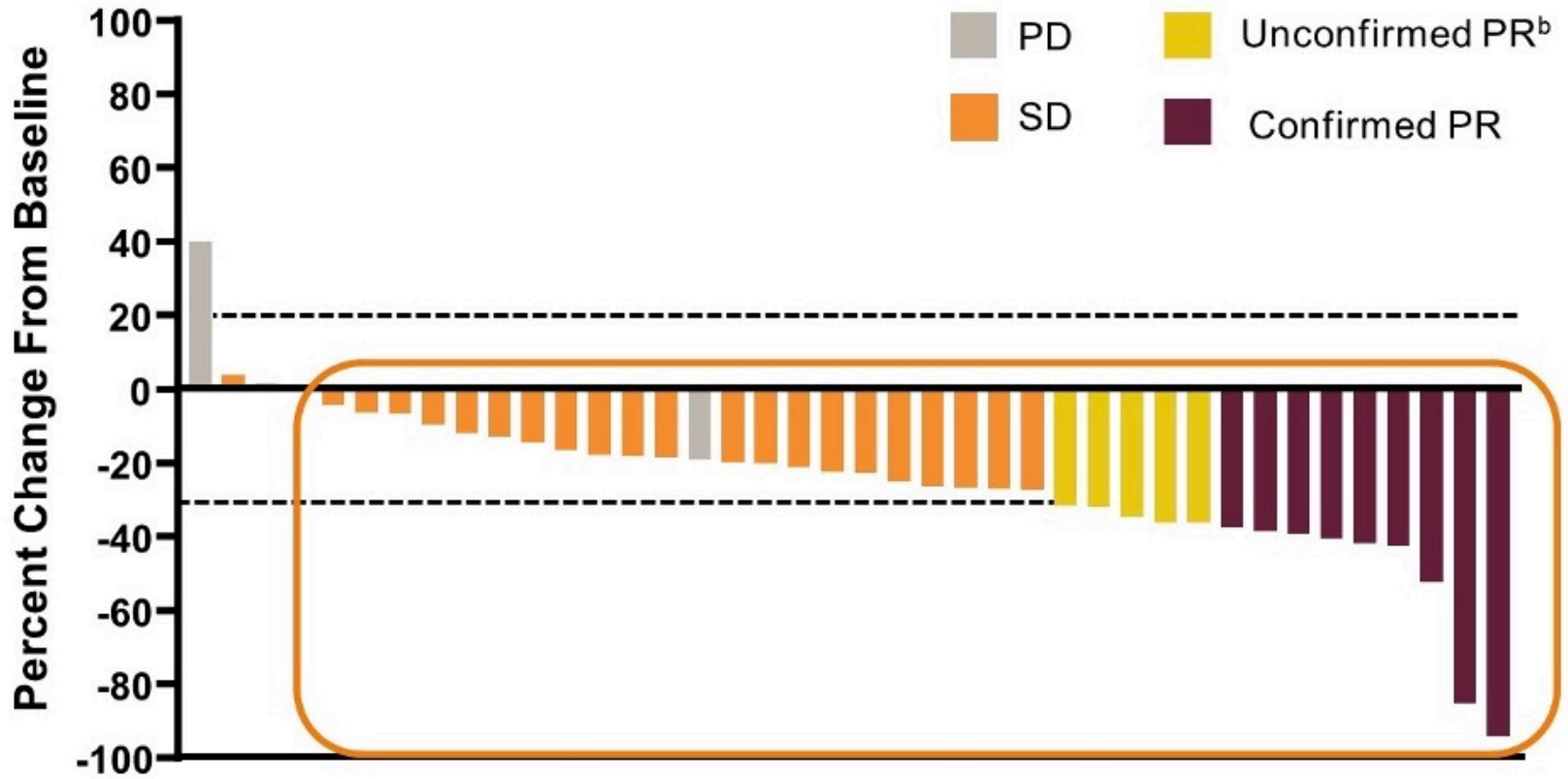
Study Design



Choueiri TK et al. Genitourinary Cancers Symposium 2021;Abstract 272.

Best Tumor Change from Baseline

- 36 of 41 patients (88%) experienced a reduction in target lesion size[a]



Choueiri TK et al. Genitourinary Cancers Symposium 2021;Abstract 272.

Treatment-Related Adverse Events

Treatment-Related AEs in ≥15% of Patients	Safety Analysis Set N = 52			
	Any Grade		Grade 3	
	Event, n	n (%)	Event, n	n (%)
Any	742	51 (98)	60	31 (60)
Anemia	92	40 (77)	8	6 (12)
Fatigue	67	35 (67)	10	6 (12)
Hand-foot syndrome	56	28 (54)	1	1 (2)
Diarrhea	49	23 (44)	2	2 (4)
Hypertension	52	23 (44)	15	12 (23)
Nausea	24	18 (35)	1	1 (2)
ALT increased	48	17 (33)	7	3 (6)
AST increased	34	17 (33)	2	2 (4)
Decreased appetite	22	15 (29)	1	1 (2)
Dysgeusia	19	12 (23)	1	1 (2)
Headache	12	10 (19)	0	0 (0)
Hypophosphatemia	18	9 (17)	2	2 (4)
Stomatitis	10	8 (15)	0	0 (0)

[a]All patients who received ≥1 dose of treatment. Data cutoff: October 15, 2020.

- There were no grade 4/5 treatment-related AEs
- Of all 742 AEs, 92% were grade 1 or 2 in severity
- Treatment-related hypoxia, considered an on-target AE for belzutifan, occurred in 2 patients (4%) (both were grade 3 AEs)

Choueiri TK et al. Genitourinary Cancers Symposium 2021;Abstract 272.

Agenda

MODULE 1: Cases from the Practice of Dr Malhotra

MODULE 2: Consensus or Controversy – Clinical Investigator Approaches to Clinical Scenarios

MODULE 3: Renal Cell Carcinoma Journal Club with Dr Stadler

- Active surveillance of metastatic RCC: Results from a prospective observational study (MaRCC)
- Optimized management of nivolumab and ipilimumab in advanced RCC: A response-based Phase II study (OMNIVORE)

MODULE 4: Key Data Sets

MODULE 5: Other Recent Data Sets

Ann Oncol 2020;31(8):1030-9

ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

ANNALS OF ONCOLOGY driving innovation in oncology

ORIGINAL ARTICLE

Updated efficacy results from the JAVELIN Renal 101 trial: first-line avelumab plus axitinib versus sunitinib in patients with advanced renal cell carcinoma

T. K. Choueiri[1*], R. J. Motzer[2], B. I. Rini[3†], J. Haanen[4], M. T. Campbell[5], B. Venugopal[6], C. Kollmannsberger[7], G. Gravis-Mescam[8], M. Uemura[9], J. L. Lee[10], M.-O. Grimm[11], H. Gurney[12], M. Schmidinger[13], J. Larkin[14], M. B. Atkins[15], S. K. Pal[16], J. Wang[17], M. Mariani[18], S. Krishnaswami[19], P. Cislo[20], A. Chudnovsky[21], C. Fowst[18], B. Huang[19], A. di Pietro[22] & L. Albiges[23]

JAVELIN Renal 101: Overall Response and Best Response Rate in the PD-L1-Positive and Overall Populations

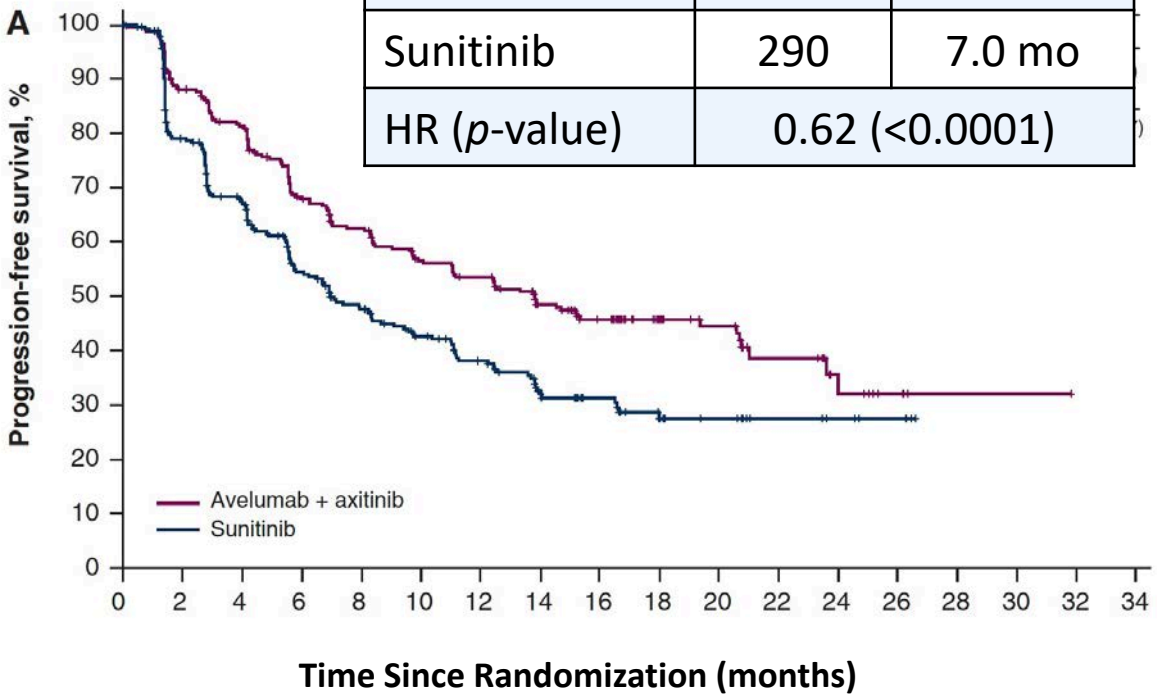
	PD-L1-positive		Overall	
	Avelumab + axitinib (n = 270)	Sunitinib (n = 290)	Avelumab + axitinib (n = 442)	Sunitinib (n = 444)
Confirmed ORR	55.9%	27.2%	52.5%	27.3%
CR	5.6%	2.4%	3.8%	2.0%
PR	50.4%	24.8%	48.6%	25.2%
Stable disease	27.0%	41.4%	28.3%	43.7%
Progressive disease	11.5%	22.4%	12.4%	19.4%
Ongoing response	55.6%	53.2%	54.3%	50.4%

Choueiri TK et al. *Ann Oncol* 2020;31(8):1030-9.

JAVELIN Renal 101: PFS in the PD-L1+ and Overall Populations

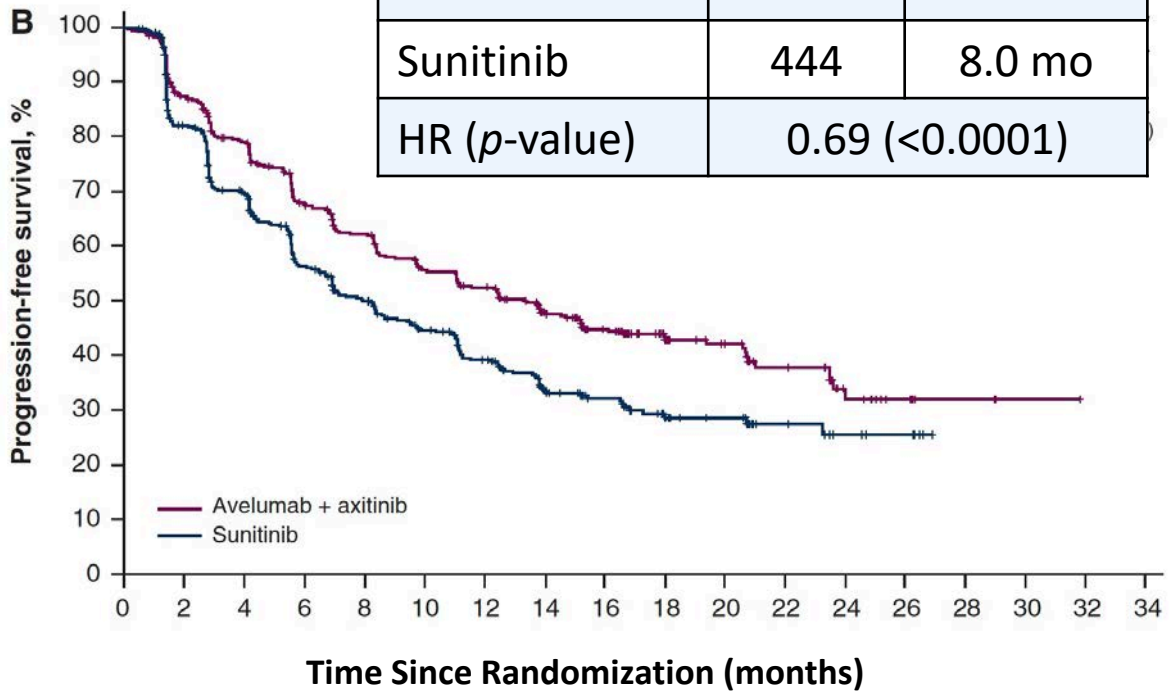
PD-L1 ≥ 1% Population

	N	mPFS
Avelumab + axitinib	270	13.8 mo
Sunitinib	290	7.0 mo
HR (*p*-value)	0.62 (<0.0001)	



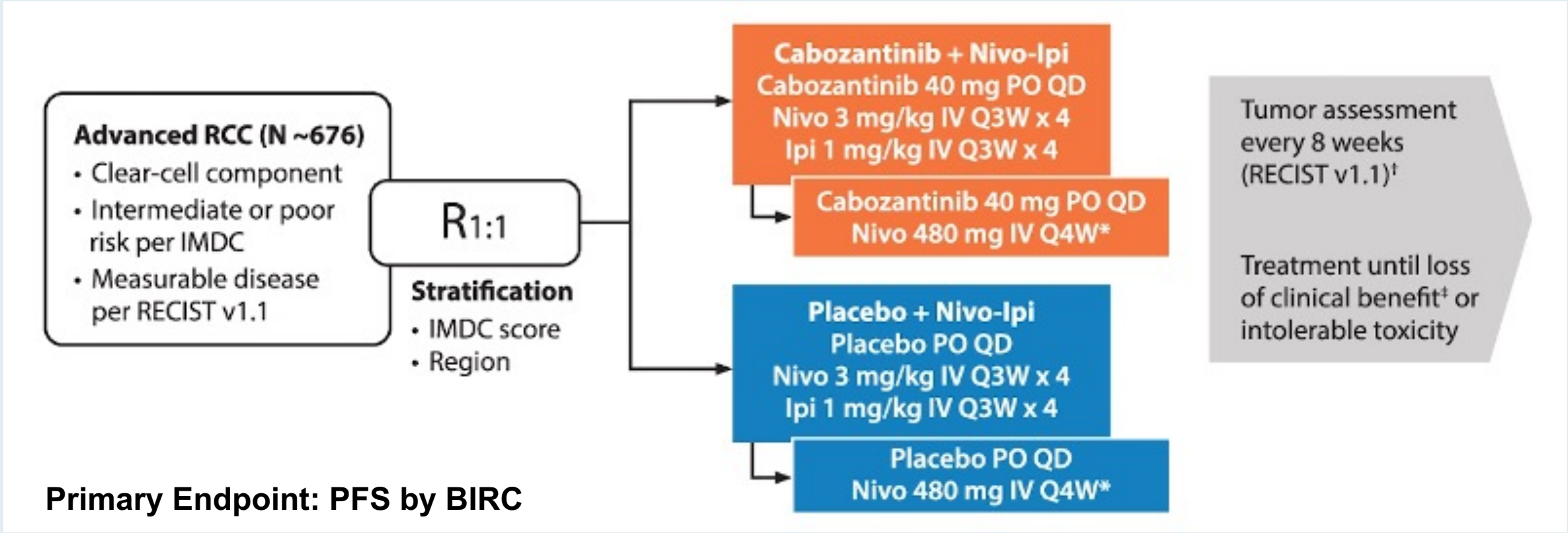
Overall Population

	N	mPFS
Avelumab + axitinib	442	13.3 mo
Sunitinib	444	8.0 mo
HR (*p*-value)	0.69 (<0.0001)	



Choueiri TK et al. *Ann Oncol* 2020;31(8):1030-9.

COSMIC-313 Phase III Schema



Primary Endpoint: PFS by BIRC

https://www.urotoday.com/conference-highlights/asco-2020/asco-2020-kidney-cancer/121877-asco-2020-cosmic-313-phase-iii-study-of-cabozantinib-in-combination-with-nivolumab-and-ipilimumab-in-patients-with-previously-untreated-advanced-renal-cell-carcinoma-of-intermediate-or-poor-risk.html

Sequencing of Therapy for Patients with Relapsed/Refractory (R/R) RCC; Novel Approaches Under Investigation

rapid communications

Salvage Ipilimumab and Nivolumab in Patients With Metastatic Renal Cell Carcinoma After Prior Immune Checkpoint Inhibitors

Anita Gul, MD[1]; Tyler F. Stewart, MD[2,3]; Charlene M. Mantia, MD[4]; Neil J. Shah, MD[5]; Emily Stern Gatof, MD[4]; Ying Long, PharmD[2]; Kimberly D. Allman, MSN, CNP[1]; Moshe C. Ornstein, MD, MA[1]; Hans J. Hammers, MD, PhD[6]; David F. McDermott, MD[4]; Michael B. Atkins, MD[5]; Michael Hurwitz, MD, PhD[2]; and Brian I. Rini, MD[1]

J Clin Oncol 2020;38:3088-94.

Salvage Ipilimumab/Nivolumab for mRCC After Prior ICI Therapy

Variable	No. (%)
No. of prior lines of systemic therapy	
1	9 (20)
2	12 (27)
3	8 (18)
4	6 (13)
> 4	10 (22)
Prior VEGF receptor inhibitor[a]	27 (60)
Prior immunotherapy	
Anti–PD-1[b]	34 (76)
Anti–PD-L1[b]	11 (24)
IL-2[c]	14 (31)
Best response to prior ICI	
PR	24 (53)
SD	12 (27)
PD	9 (20)

BOR to Prior ICI	No. (%)	BOR to Salvage Ipilimumab and Nivolumab	No. (%)
PR	24 (53)	PR	4 (17)
		SD	2 (8)
		PD	17 (71)
		NE	1 (4)
SD	12 (27)	PR	3 (25)
		SD	5 (42)
		PD	4 (33)
PD	9 (20)	PR	2 (22)
		PD	7 (78)

Abbreviations: BOR, best objective response; ICI, immune checkpoint inhibitor; NE, not evaluable; PD, progressive disease; PR, partial response; SD, stable disease.

Gul A et al. *J Clin Oncol* 2020;38:3088-94.

A Pooled Analysis of the Efficacy and Safety of Cabozantinib Post Immunotherapy in Patients with Advanced Renal Cell Carcinoma

Oya M et al.

ASCO 2020;Abstract 5089.

Efficacy of Cabozantinib with or without Prior Immunotherapy

	Prior IO (N = 33)	No Prior IO (N = 332)
Objective response rate	21.2%	17.2%
Clinical benefit rate	75.8%	83.7%
Median PFS	Not reached	7.4 mo
6-months PFS	65.5%	58.3%
Median PFS	19.5 mo	21.9 mo
6-months OS	90.8%	90.6%

Oya M et al. ASCO 2020;Abstract 5089.

Phase II Trial of Lenvatinib (LEN) plus Pembrolizumab (PEMBRO) for Disease Progression After PD-1/PD-L1 Immune Checkpoint Inhibitor (ICI) in Metastatic Clear Cell Renal Cell Carcinoma (mccRCC)

Lee C-H et al.

ASCO 2020;Abstract 5008.

Efficacy of Lenvatinib/Pembrolizumab in Patients Previously Treated with Immunotherapy

	Anti-PD-1/PD-L1 (N = 104)	Anti-PD-1/PD-L1 and anti-VEGF (n = 68)	Nivolumab + ipilimumab (n = 38)
ORR	55%	59%	47%
Median DOR	12 mo	9 mo	Not reached
Median PFS (irRECIST)	11.7 mo	Not reported	Not reported
OS at 12 months	77%	Not reported	Not reported

Lee C-H et al. ASCO 2020;Abstract 5008.

Meet The Professor

Optimizing the Selection and Sequencing of Therapy for Patients with Advanced Gastrointestinal Cancers

Monday, June 7, 2021
5:00 PM – 6:00 PM ET

Faculty

Kristen K Ciombor, MD, MSCI

Moderator

Neil Love, MD

RTP
RESEARCH TO PRACTICE

Thank you for joining us!

CME and ABIM MOC credit information will be emailed to each participant within 5 business days.