A Conversation with the Investigators: Bladder Cancer

Wednesday, July 21, 2021
5:00 PM – 6:00 PM ET

Faculty

Petros Grivas, MD, PhD
Daniel P Petrylak, MD
Arlene Siefker-Radtke, MD

Moderator

Neil Love, MD

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Faculty

Petros Grivas, MD, PhD
Associate Professor, Department of Medicine
Division of Oncology
Clinical Director, Genitourinary Cancers Program
University of Washington
Associate Member, Clinical Research Division
Fred Hutchinson Cancer Research Center
Seattle, Washington

Arlene Siefker-Radtke, MD
Professor
Department of Genitourinary Medical Oncology
Division of Cancer Medicine
The University of Texas
MD Anderson Cancer Center
Houston, Texas

Daniel P Petrylak, MD
Professor of Internal Medicine (Medical Oncology) and Urology
Yale School of Medicine
New Haven, Connecticut

Moderator

Neil Love, MD
Research To Practice
Miami, Florida

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Commercial Support

This activity is supported by educational grants from Astellas and Seagen Inc, AstraZeneca Pharmaceuticals LP, Gilead Sciences Inc, and Janssen Biotech Inc, administered by Janssen Scientific Affairs LLC.

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Dr Love — Disclosures

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Dr Grivas — Disclosures

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Dr Petrylak — Disclosures

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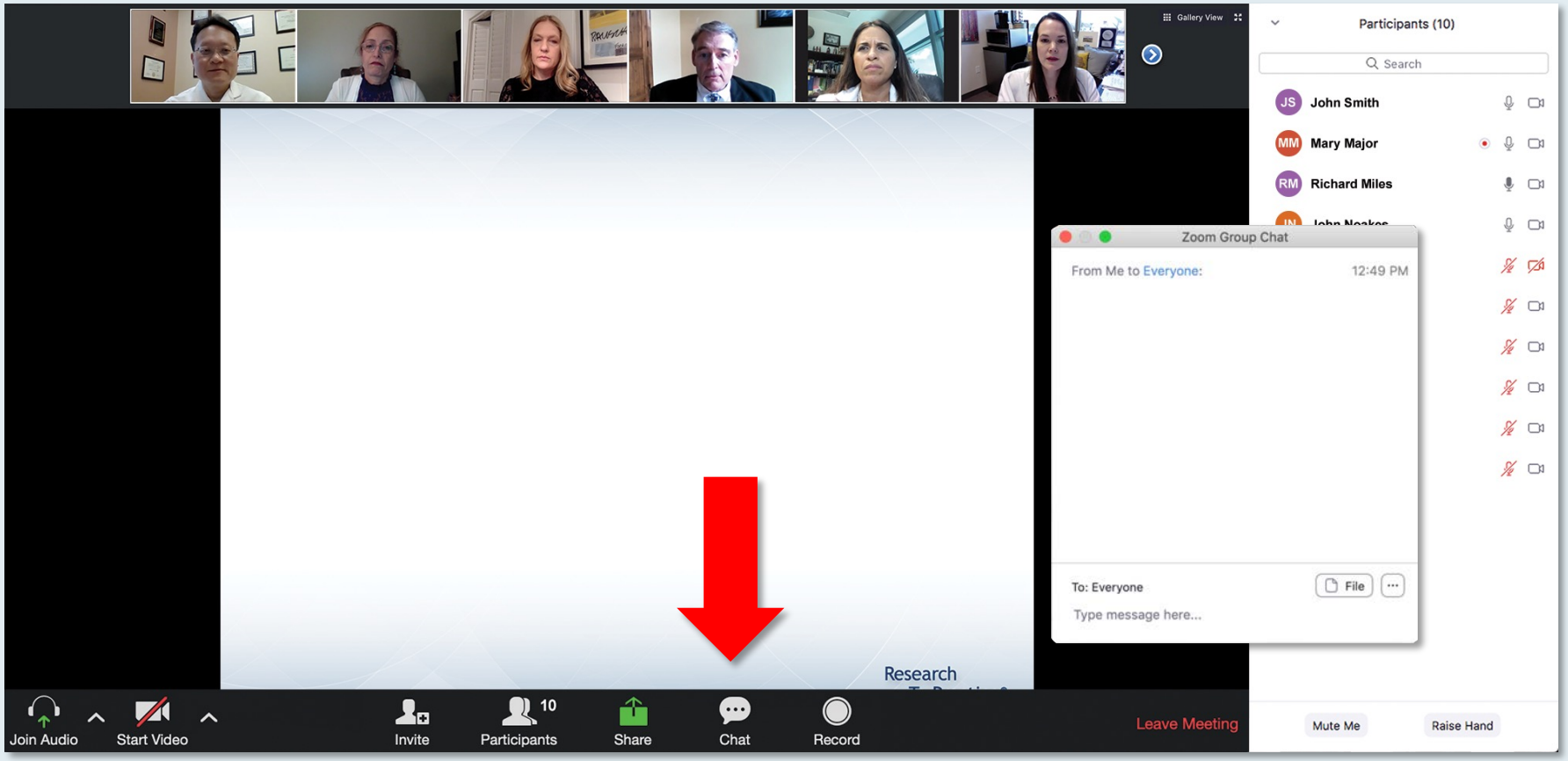

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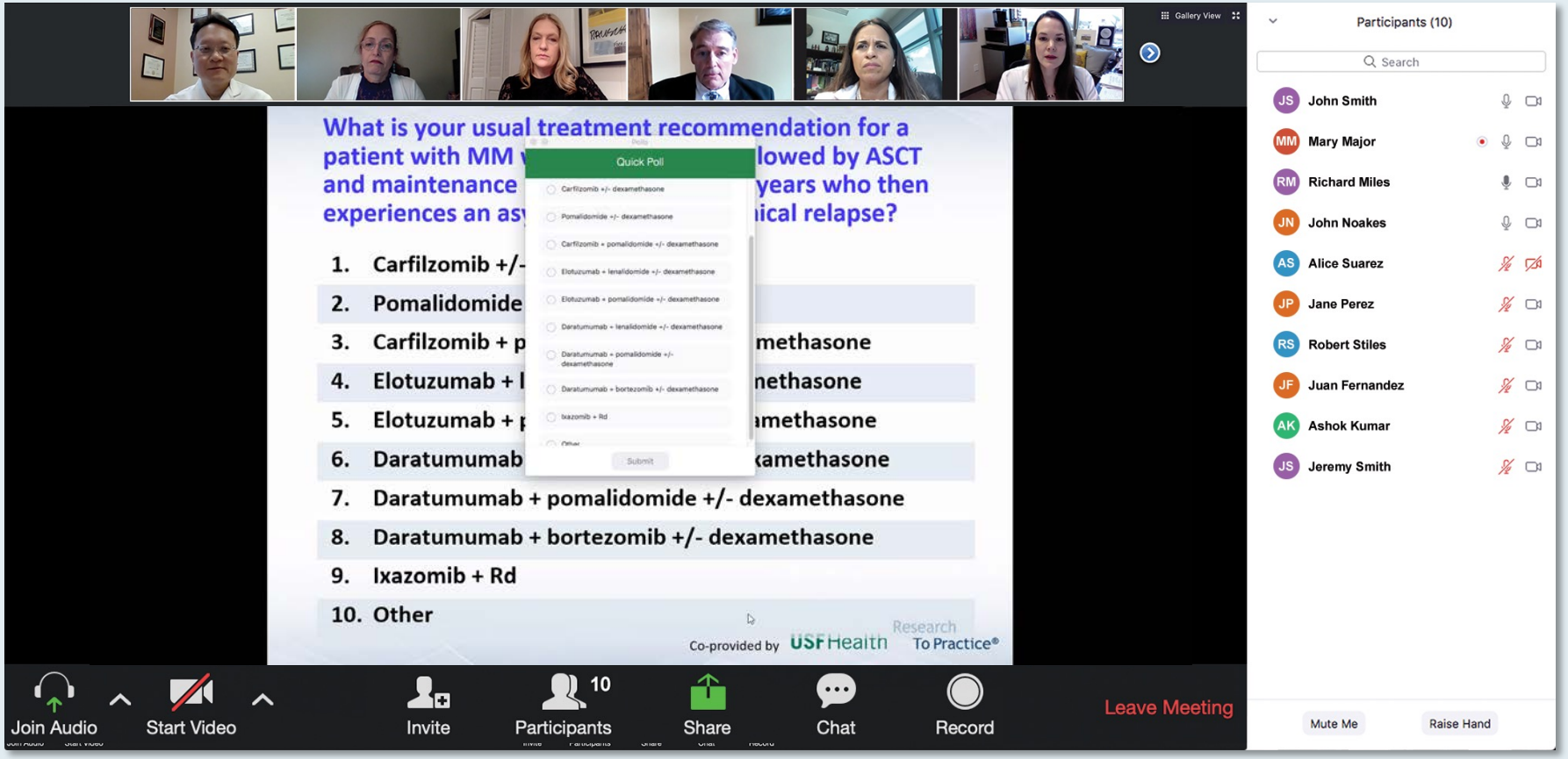
Familiarizing Yourself with the Zoom Interface

How to answer poll questions



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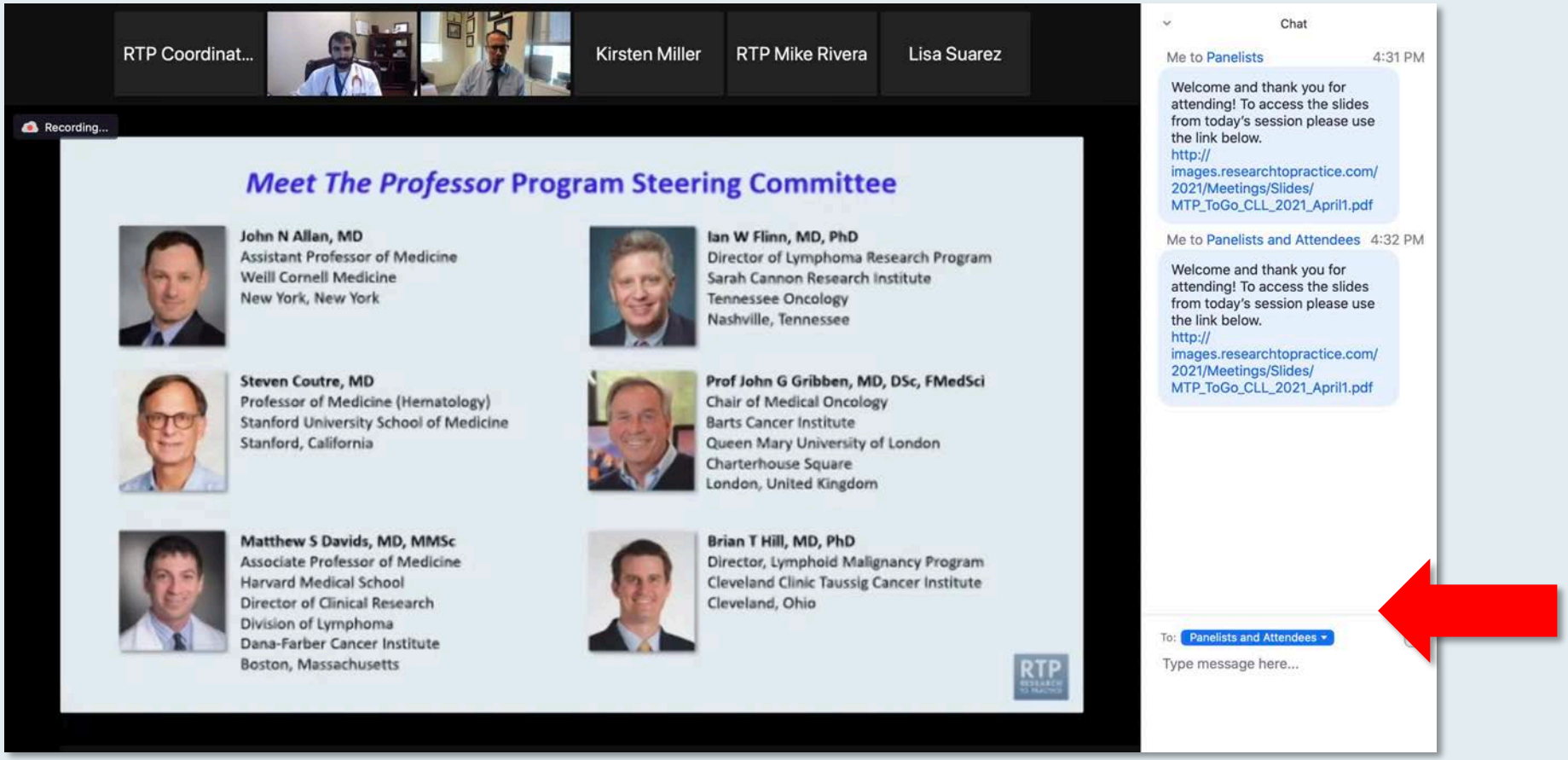
Familiarizing Yourself with the Zoom Interface

Expand chat submission box



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

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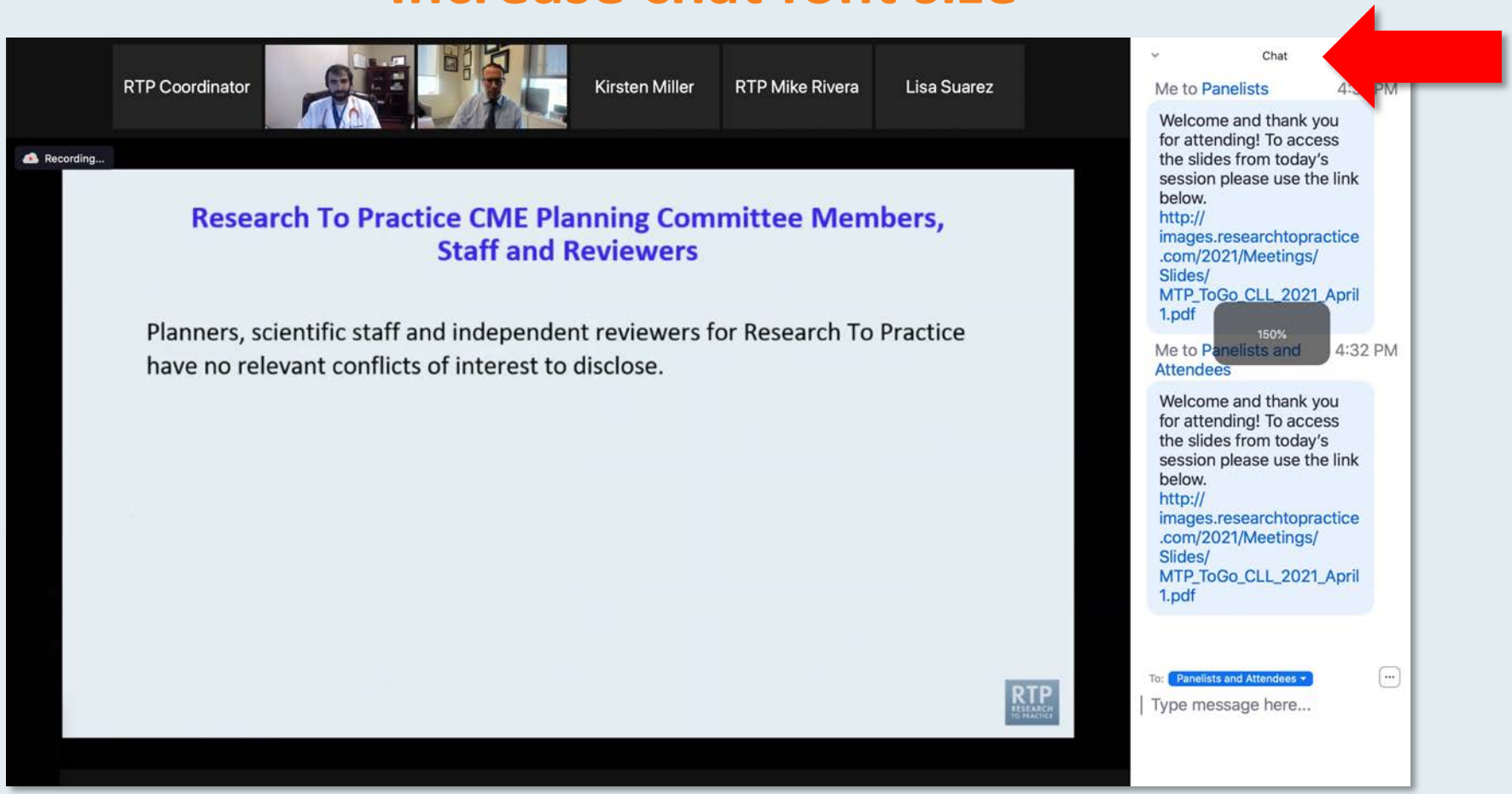
Familiarizing Yourself with the Zoom Interface

Increase chat font size



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

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Newly Approved Agents in the Management of Urothelial Bladder Carcinoma

DR MATTHEW GALSKY
ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI

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

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

Bladder Cancer
Wednesday, July 21
5:00 PM – 6:00 PM ET

Endometrial and Cervical Cancers
Monday, July 26
5:00 PM – 6:00 PM ET

Targeted Therapy for Non-Small Cell Lung Cancer
Tuesday, July 27
5:00 PM – 6:00 PM ET

Immunotherapy and Other Nontargeted Approaches for Lung Cancer
Wednesday, July 28
5:00 PM – 6:00 PM ET

Mantle Cell, Diffuse Large B-Cell and Hodgkin Lymphoma
Monday, August 2
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Tuesday, August 3
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Hepatocellular Carcinoma and Pancreatic Cancer
Wednesday, August 4
5:00 PM – 6:30 PM ET

Head and Neck Cancer
Wednesday, August 11
5:00 PM – 6:00 PM ET

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Meet The Professor

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

Thursday, July 22, 2021
5:00 PM – 6:00 PM ET

Faculty

David F McDermott, MD

Moderator

Neil Love, MD

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A Conversation with the Investigators: Endometrial and Cervical Cancers

Monday, July 26, 2021
5:00 PM – 6:00 PM ET

Faculty

Mansoor Raza Mirza, MD
David M O'Malley, MD
Angeles Alvarez Secord, MD, MHSc

Moderator

Neil Love, MD

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What General Medical Oncologists Want to Know About Targeted Therapy for Non-Small Cell Lung Cancer

Tuesday, July 27, 2021
5:00 PM – 6:00 PM ET

Faculty

Professor Solange Peters, MD, PhD
Zofia Piotrowska, MD, MHS
Gregory J Riely, MD, PhD

Moderator

Neil Love, MD

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What General Medical Oncologists Want to Know About Immunotherapy and Other Nontargeted Approaches for Lung Cancer

Wednesday, July 28, 2021
5:00 PM – 6:00 PM ET

Faculty

Mark Awad, MD, PhD
David R Spigel, MD
Heather Wakelee, MD

Moderator

Neil Love, MD

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RESEARCH
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Consensus or Controversy? Clinical Investigator Perspectives on the Current and Future Management of Mantle Cell, Diffuse Large B-Cell and Hodgkin Lymphoma

Monday, August 2, 2021
5:00 PM – 6:00 PM ET

Faculty

Stephen M Ansell, MD, PhD
Craig Moskowitz, MD
Laurie H Sehn, MD, MPH

Moderator

Neil Love, MD

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Consensus or Controversy? Clinical Investigator Perspectives on the Current and Future Management of Colorectal and Gastroesophageal Cancers

Tuesday, August 3, 2021
5:00 PM – 6:30 PM ET

Faculty

Chloe E Atreya, MD, PhD
Dustin Deming, MD
Eric Van Cutsem, MD, PhD
Zev Wainberg, MD, MSc

Moderator

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Consensus or Controversy? Clinical Investigator Perspectives on the Current and Future Management of Hepatocellular Carcinoma and Pancreatic Cancer

Wednesday, August 4, 2021
5:00 PM – 6:30 PM ET

Faculty

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Kim A Reiss Binder, MD
Eileen M O'Reilly, MD
Philip A Philip, MD, PhD, FRCP

Moderator

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Thank you for joining us!

CME and MOC credit information will be emailed to each participant within 2 to 3 business days.

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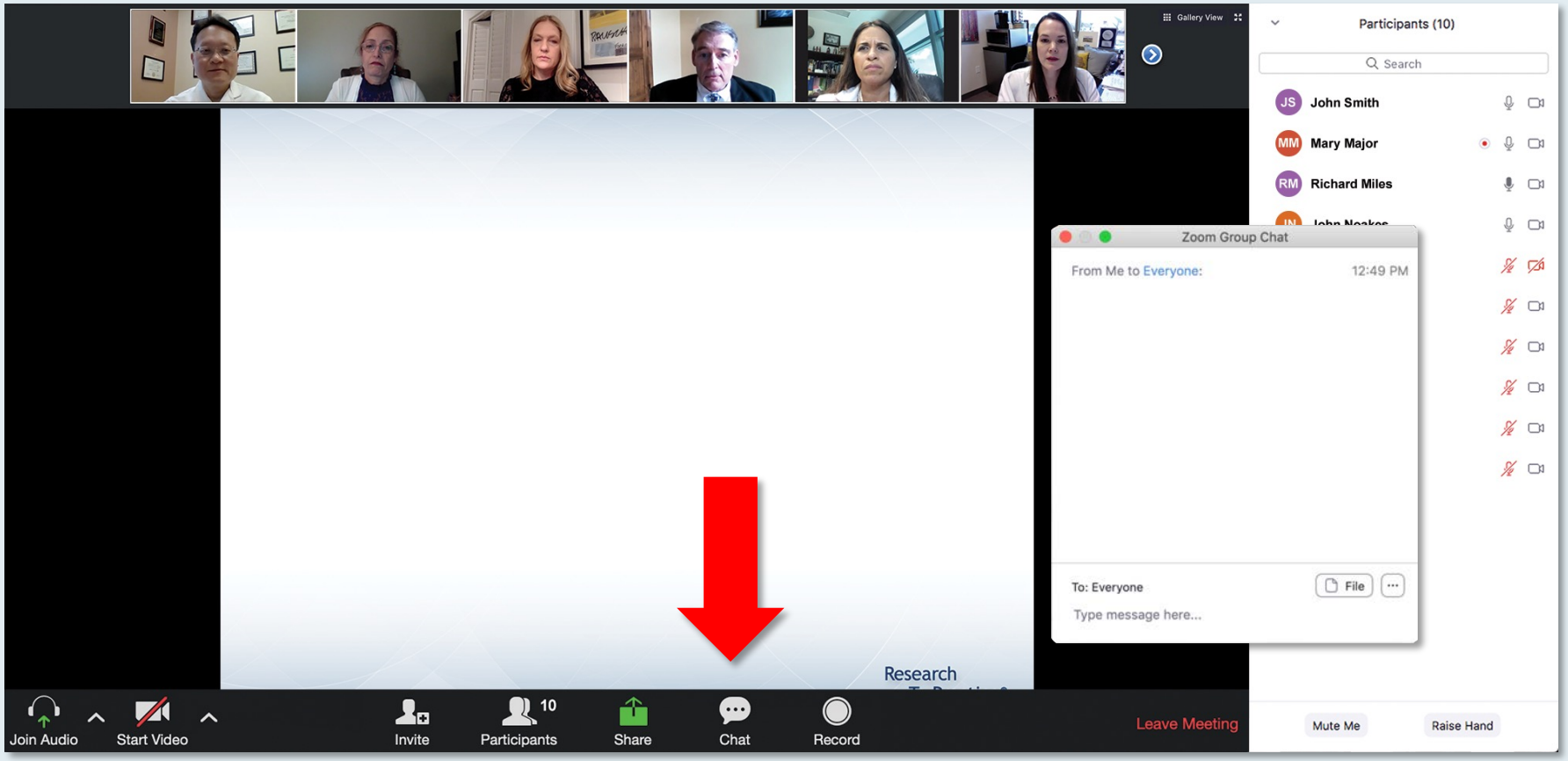

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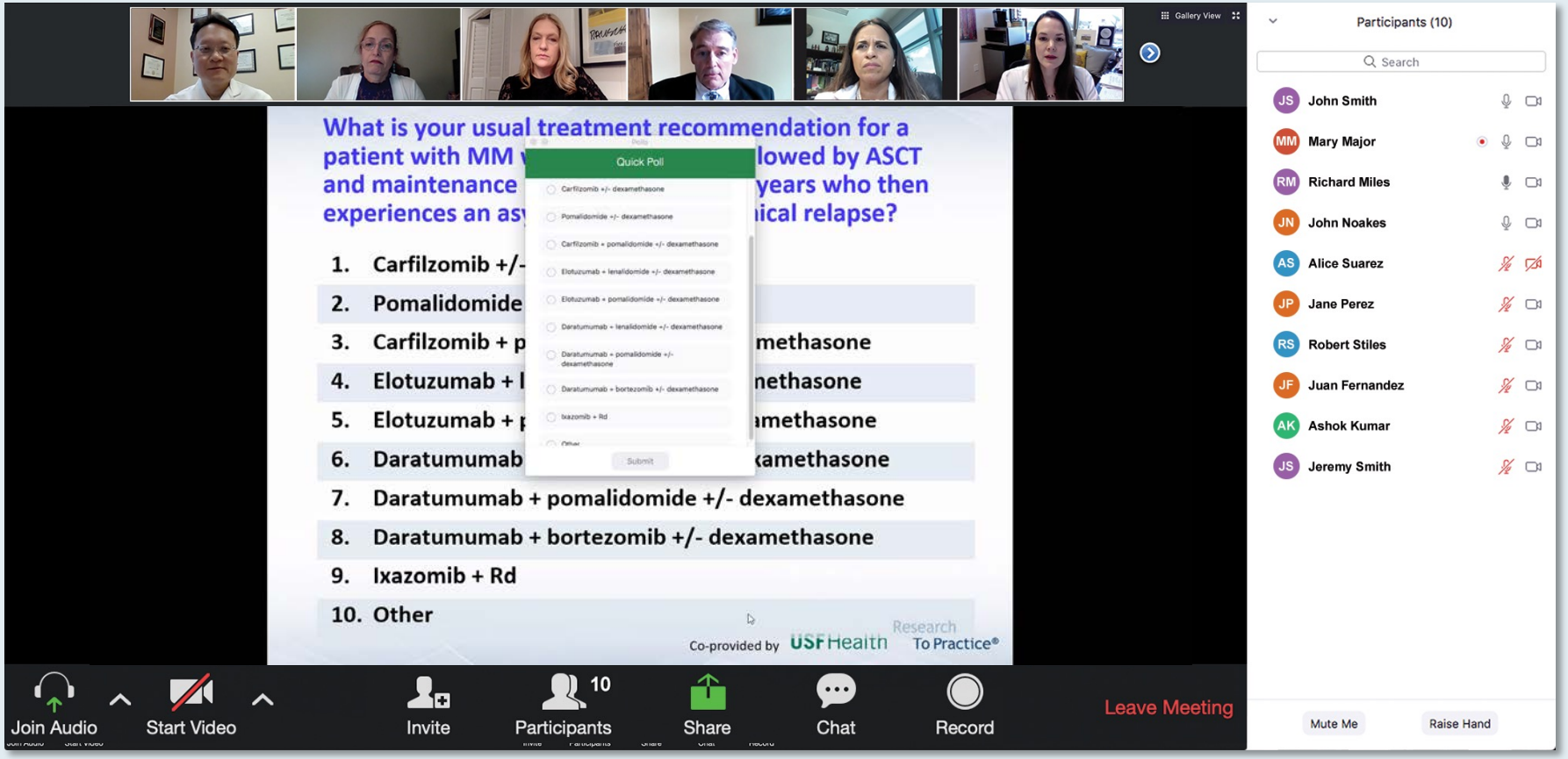

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ASCO 2021 Bladder Cancer Presentation Library

Current and Future Role of Immune Checkpoint Inhibitors in Urothelial Bladder Cancer (UBC)

Petros Grivas, MD, PhD

Download Slides

Key Data Supporting the Use of Antibody-Drug Conjugates in UBC

Daniel P Petrylak, MD

Download Slides

Approved and Investigational FGFR-Targeted Therapies in Advanced UBC

Arlene Siefker-Radtke, MD

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Agenda

Module 1: Treatment of Metastatic Urothelial Bladder Cancer (mUBC) – Third Line and Beyond

Part 1: Antibody-Drug Conjugates

- Enfortumab vedotin (EV) for progressive mUBC; potential clinical role in combination with pembrolizumab
- TROPHY U-01: Sacituzumab govitecan for progressive mUBC; recent FDA approval
- Incidence, severity and management of adverse events with EV and sacituzumab govitecan
- Faculty cases

Part 2: FGFR-Targeted Therapies in Advanced UBC

- BLC2001: Erdafitinib for patients with progressive mUBC with susceptible FGFR3 or FGFR2 alterations
- Incidence and severity of adverse events with erdafitinib; optimal monitoring and management strategies
- Ongoing studies evaluating erdafitinib alone or in combination with other systemic therapies in UBC
- Faculty cases

Module 2: Non-Muscle-Invasive Bladder Cancer; First- and Second-Line Therapy for mUBC

- Use of immunotherapy for BCG-refractory non-muscle-invasive bladder cancer
- Immunotherapy for mUBC: IMvigor130, DANUBE, JAVELIN Bladder 100
- Faculty cases

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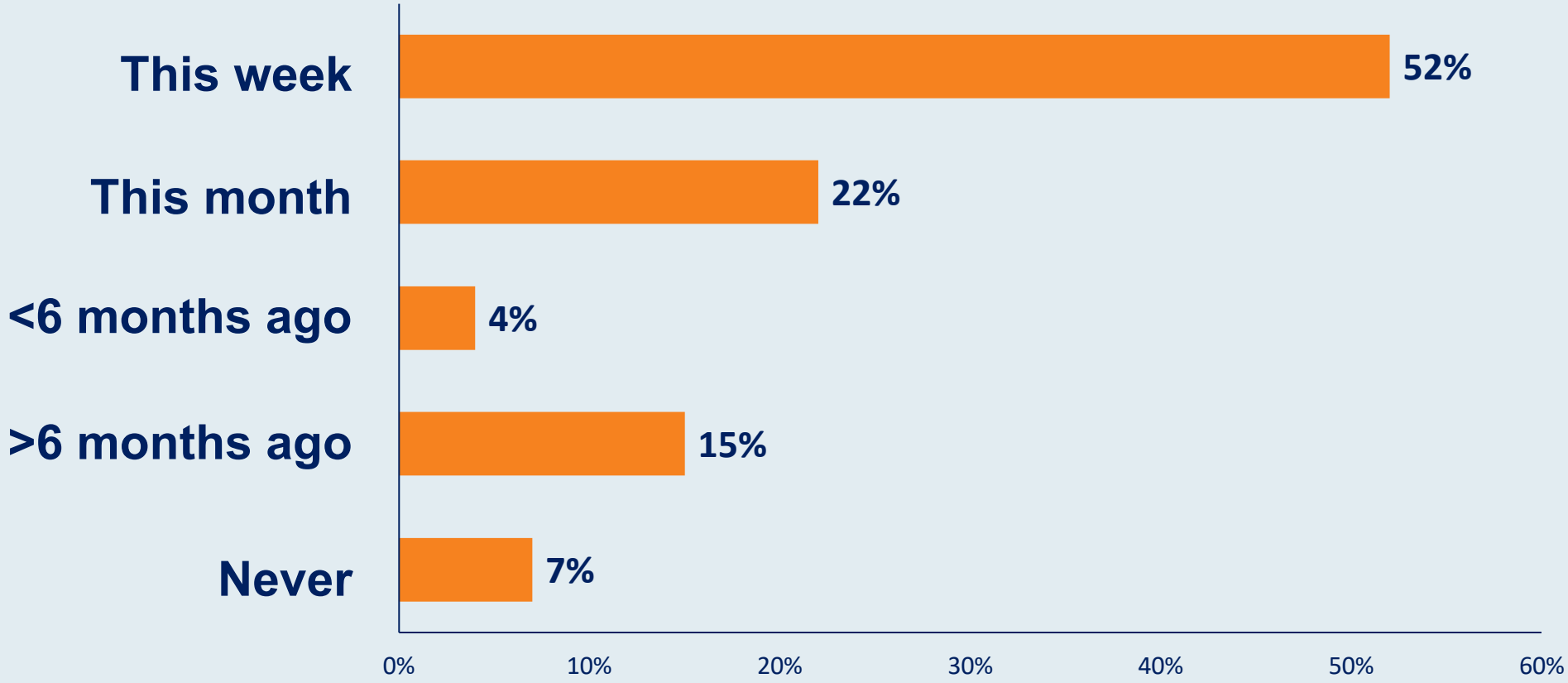
When was the last time that you presented, or had a case presented for you, at a local tumor board meeting?



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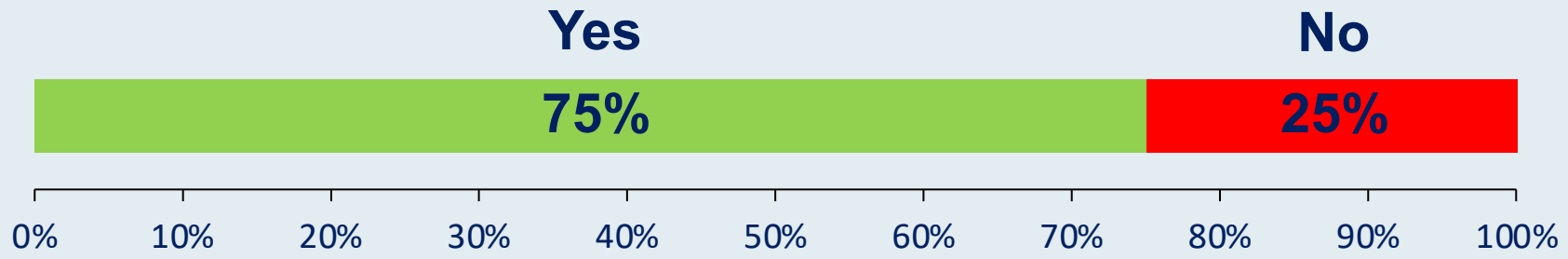
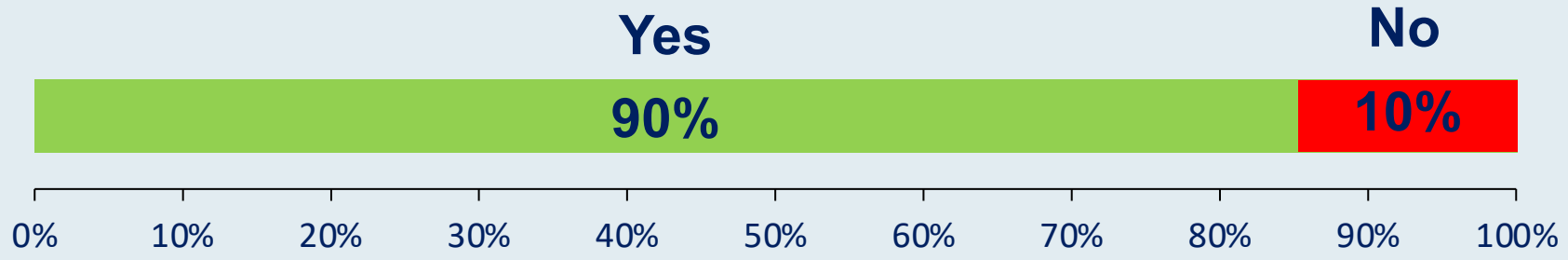
In the past month have you listened to audio podcasts not related to medicine?



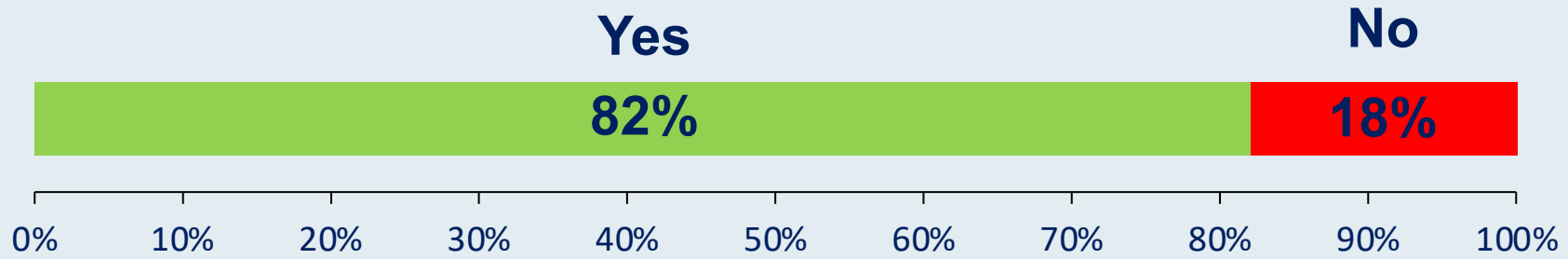
Median: 5 hours
Range: 1-60

In the past month have you listened to oncology-related audio podcasts?



Median: 5 hours
Range: 1-40

In the past month have you listened to RTP audio podcasts?



Median: 4 hours
Range: 1-66

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Questions for Genitourinary Clinical Investigators

- Use of immunotherapy for non-muscle-invasive bladder cancer
- Neoadjuvant treatment of muscle-invasive bladder cancer
- Bladder preservation
- Adjuvant treatment with immunotherapy
- Sequencing of therapies for mUBC
- Choice of chemotherapy for platinum-eligible patients
- Novel agents
- Role of immunotherapy in combination with enfortumab vedotin
- Other

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RTP RESEARCH TO PRACTICE

Questions for Genitourinary Clinical Investigators
"Oncology Family Feud"

- Use of immunotherapy for non-muscle-invasive bladder cancer
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Questions for Genitourinary Clinical Investigators
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• Sequencing of therapies for mUBC	**1**
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• Novel agents	
• Role of immunotherapy in combination with enfortumab vedotin	**2**
• Other	

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Questions for Genitourinary Clinical Investigators

Non-Muscle-Invasive Bladder Cancer:

“Use of check point inhibitors in non muscle invasive bladder cancer”

“How do you feel about treating non-muscle-invasive BC with an IO?”

“Would you give immunotherapy for non-invasive bladder cancer if the patient has not received BCG, but has gotten mitomycin?”

“Why does it seem that the general urologist is not that aware of data regarding IO agents for recurrent Ca in Situ of the bladder?”

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Questions for Genitourinary Clinical Investigators

Localized and Initial Treatment of Muscle-Invasive Bladder Cancer; Bladder Preservation:

“What is the best neoadjuvant systemic treatment?”

“Anything new on bladder preservation – particularly in the elderly?”

“Any more protocols in development for "cystectomy-sparing" strategies? To build on immunotherapy, or targeted combined?”

“What is your preferred chemo to pair with radiation if patient is not a candidate for cystectomy?”

“In what situations, if any, would you use dual checkpoint inhibitors to manage advanced bladder cancer?”

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Questions for Genitourinary Clinical Investigators

Sequencing of Agents for Metastatic UBC:

“What is your preferred algorithm in treatment of fit vs frail individuals with advanced MIUBC?”

“What is the best agent to treat post-chemo/post-immunotherapy recurrent urothelial bladder cancer?”

“What is the best treatment for third line mUTC?”

“AMONG PATIENTS WHO ARE ELIGIBLE FOR ALL THREE TARGETED AGENTS, (FORGET ABOUT FDA APPROVAL CONCERNING LINE OF THERAPY) WHICH AGENT WOULD THEY USE FIRST, EVEN BEFORE ANY CHEMO (IS CHEMO STILL THE NUMBER ONE PREFERRED REGIMEN FIRST LINE)?”

“Best sequence of enfortumab vedotin vs sacituzumab govitecan vs erdafitinib?”

“What is the appropriate sequencing of drugs in the metastatic setting?”

“Can these data be applicable to upper urinary tract transitional cell cancer? Any data for squamous cell UBC?”

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Questions for Genitourinary Clinical Investigators

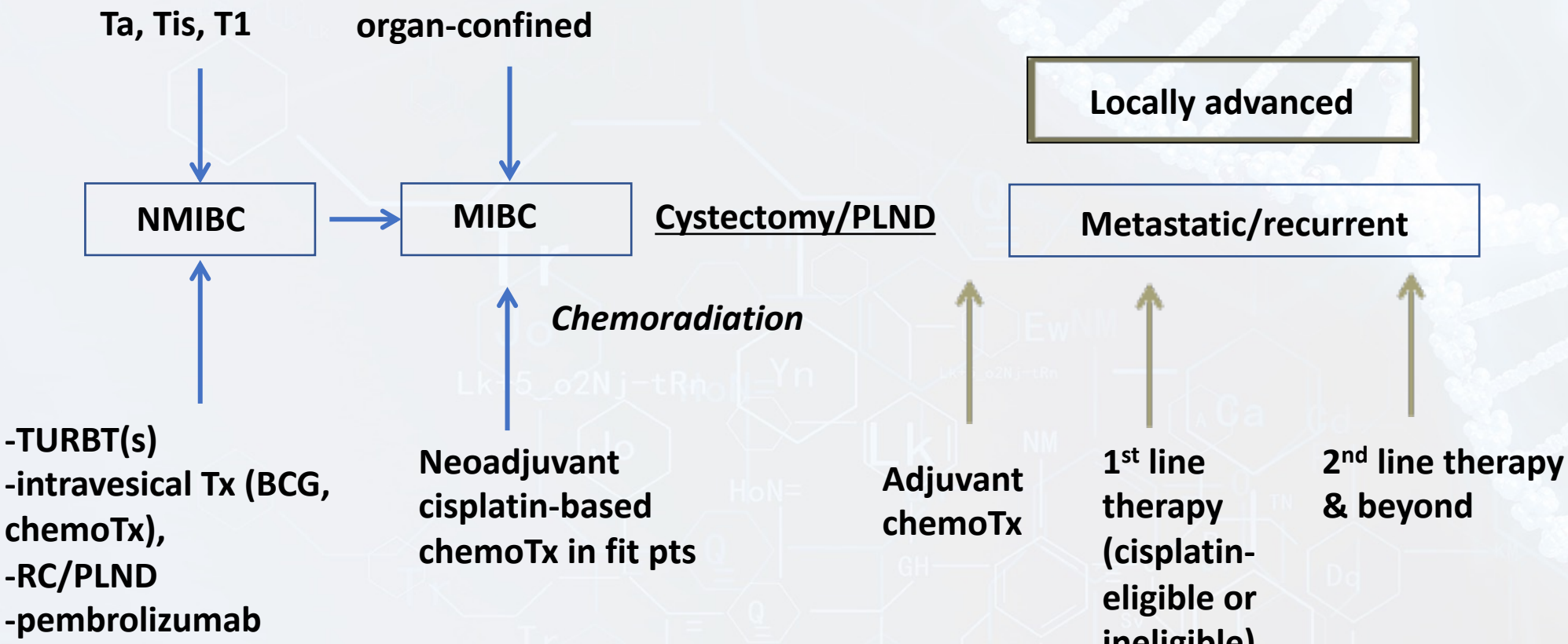
Checkpoint Inhibitors in Combination with Enfortumab Vedotin:

“Outside of clinical trial have you given a combo of IO plus enfortumab?”

“Will CPI + enfortumab become 1st line choice in metastatic urothelial cancer?”

“The data with enfortumab with pembrolizumab, even though it's a small study, is very impressive, do they anticipate that it will become standard of care in future considering traditional risk factors for bladder cancer are less common – smoking, chemicals, etc – why is incidence rising?”

Disease/treatment settings



Courtesy of Petros Grivas, MD, PhD

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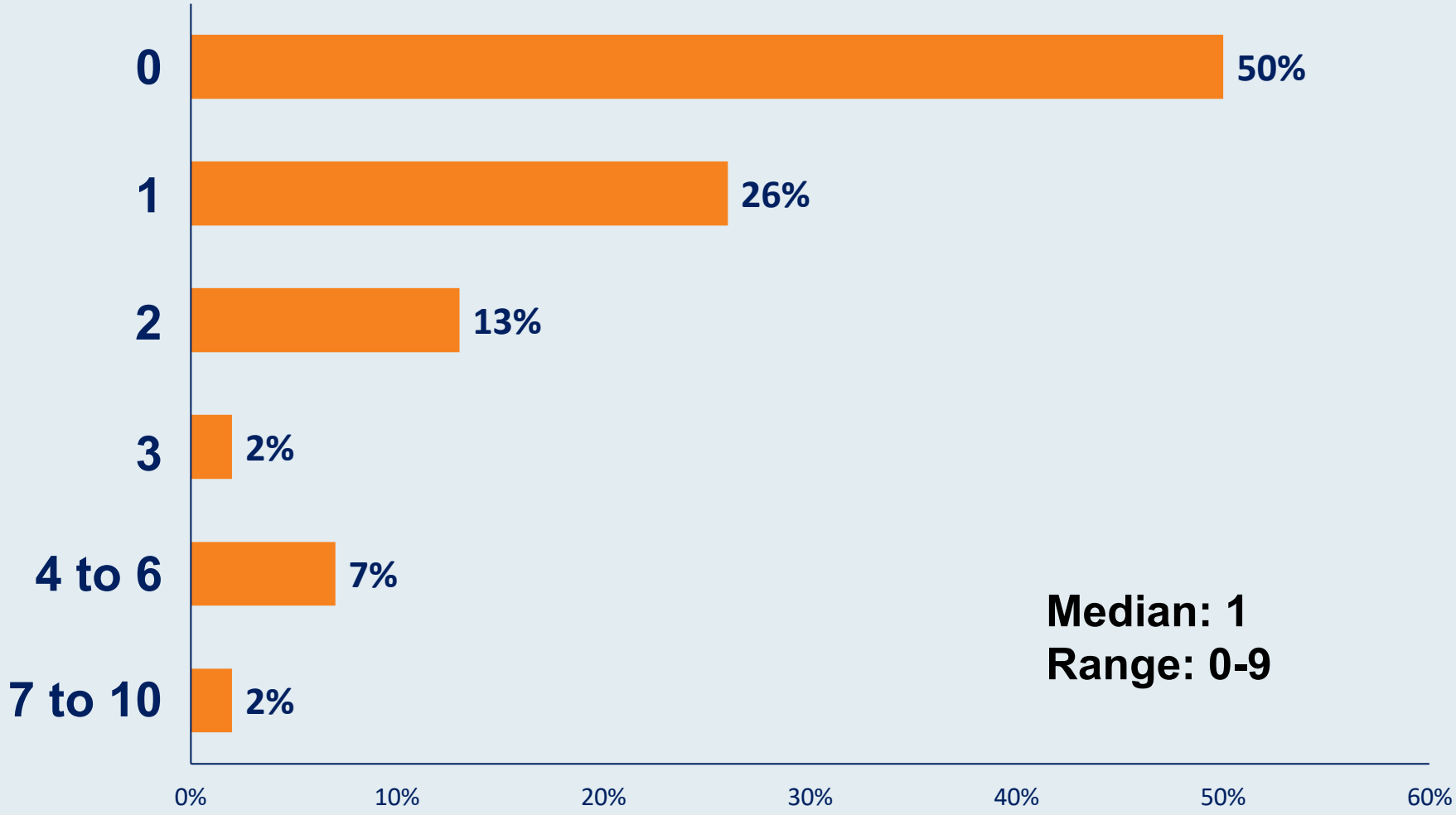
Module 2: Non-Muscle-Invasive Bladder Cancer; First- and Second-Line Therapy for mUBC

- Use of immunotherapy for BCG-refractory non-muscle-invasive bladder cancer
- Immunotherapy for mUBC: IMvigor130, DANUBE, JAVELIN Bladder 100
- Faculty cases

RTP RESEARCH TO PRACTICE

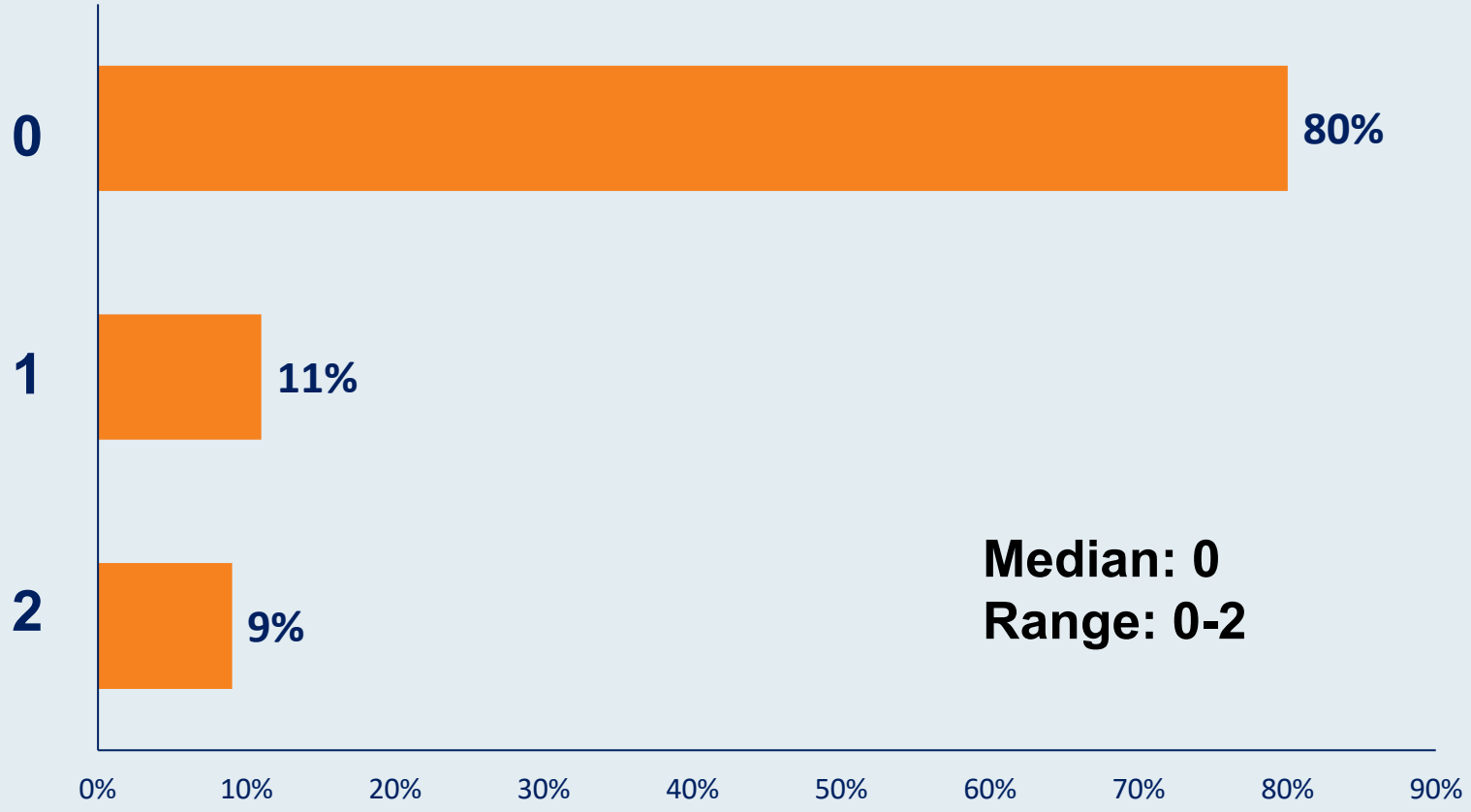
For approximately how many patients in your practice with mUBC have you utilized enfortumab vedotin?



Premeeting survey: July 2021

RTP RESEARCH TO PRACTICE

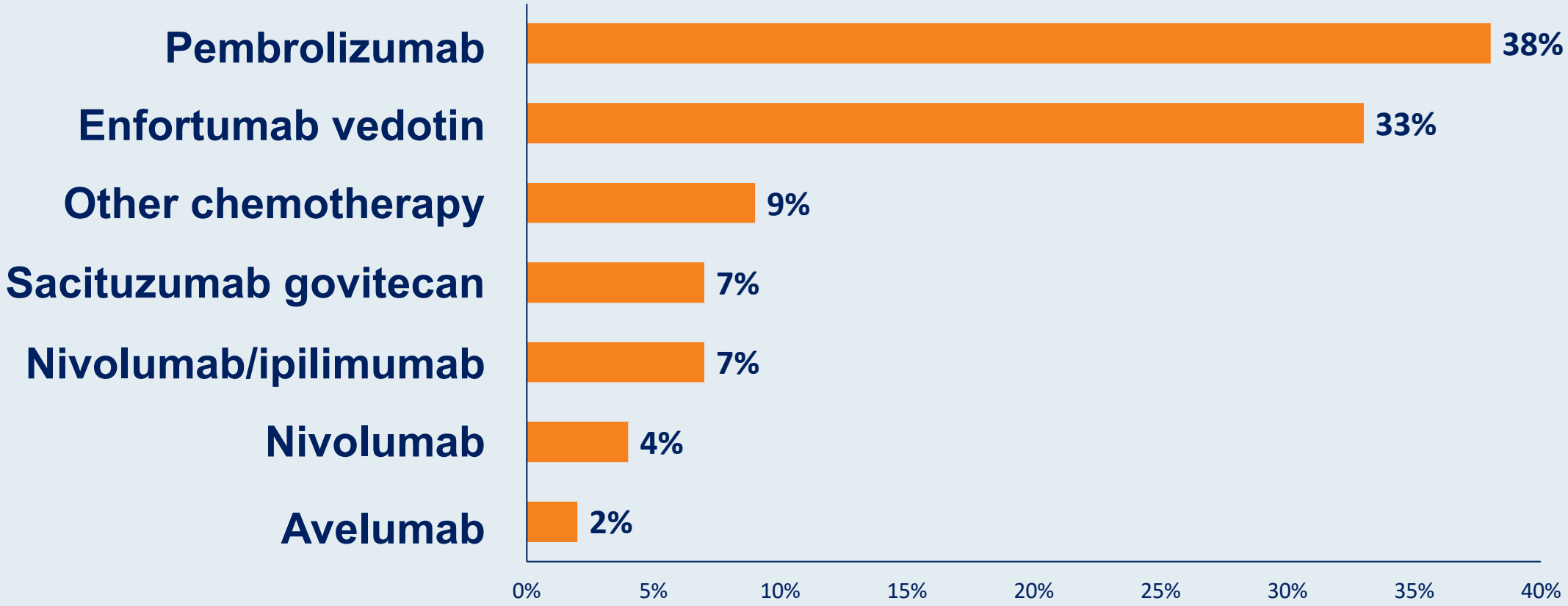
For approximately how many patients in your practice with mUBC have you utilized sacituzumab govitecan?



Premeeting survey: July 2021

RTP RESEARCH TO PRACTICE

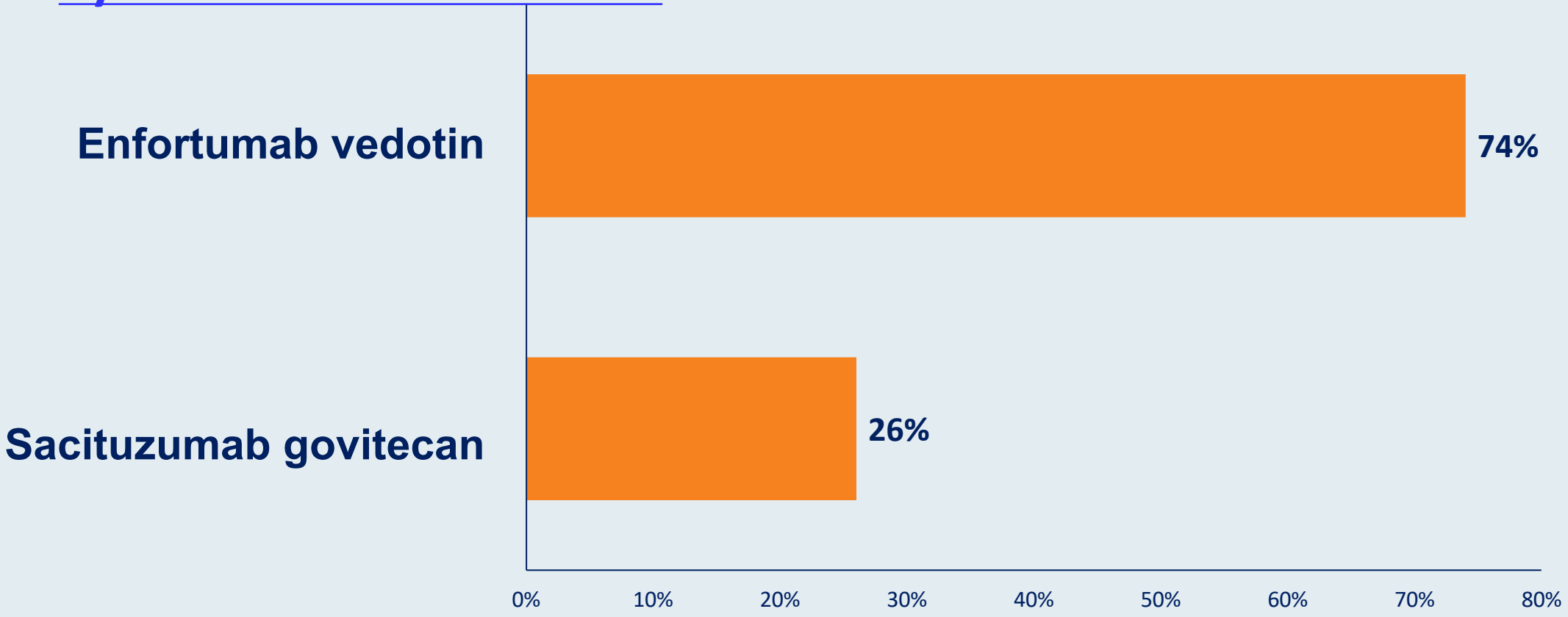
What would you generally recommend for a 65-year-old patient who experiences disease recurrence in the liver 9 months after cystectomy and adjuvant chemotherapy for muscle-invasive FGFR wild-type UBC?



Premeeting survey: July 2021

RTP RESEARCH TO PRACTICE

What would you generally recommend as second-line therapy for a 65-year-old patient with metastatic FGFR wild-type UBC to the liver whose disease progresses on first-line cisplatin/gemcitabine followed by avelumab maintenance?



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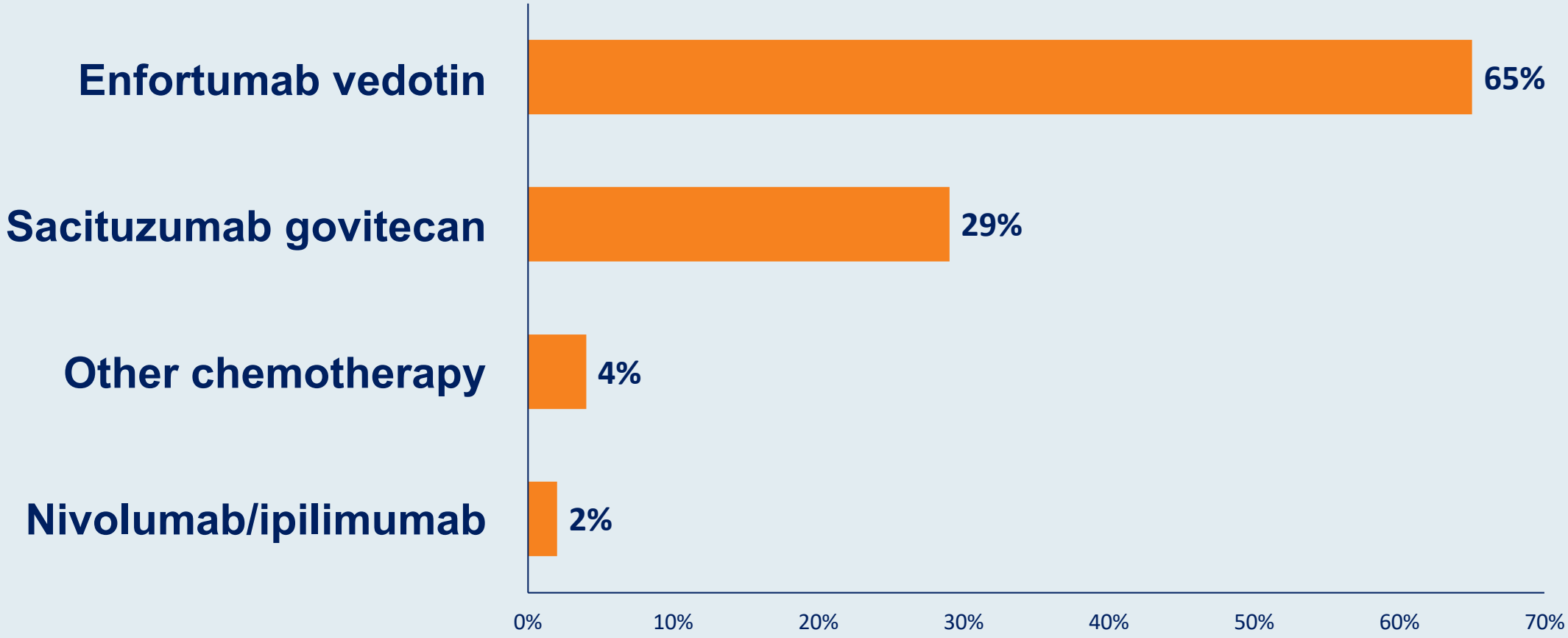
RTP RESEARCH TO PRACTICE

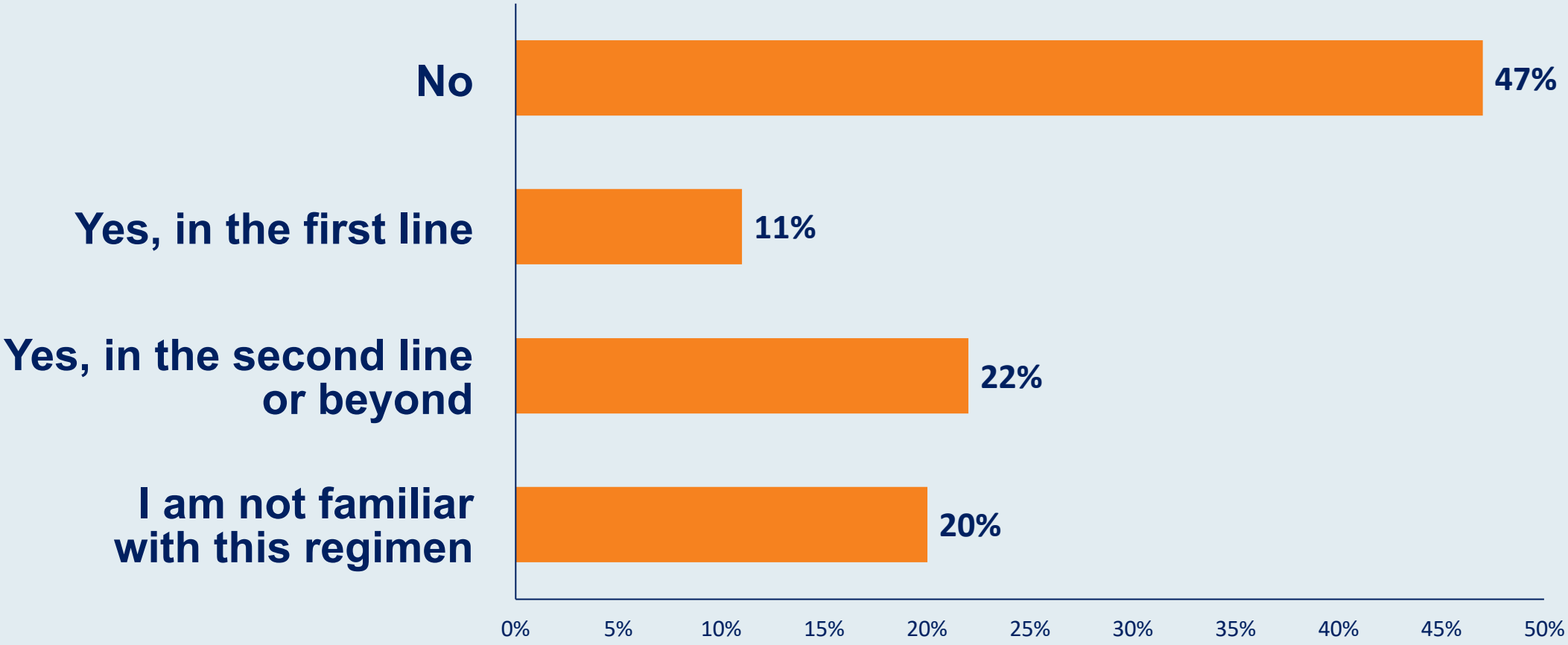
What would you generally recommend as second-line therapy for an 80-year-old patient with FGFR wild-type UBC metastatic to the liver whose disease progresses on first-line pembrolizumab?



Premeeting survey: July 2021

RTP RESEARCH TO PRACTICE

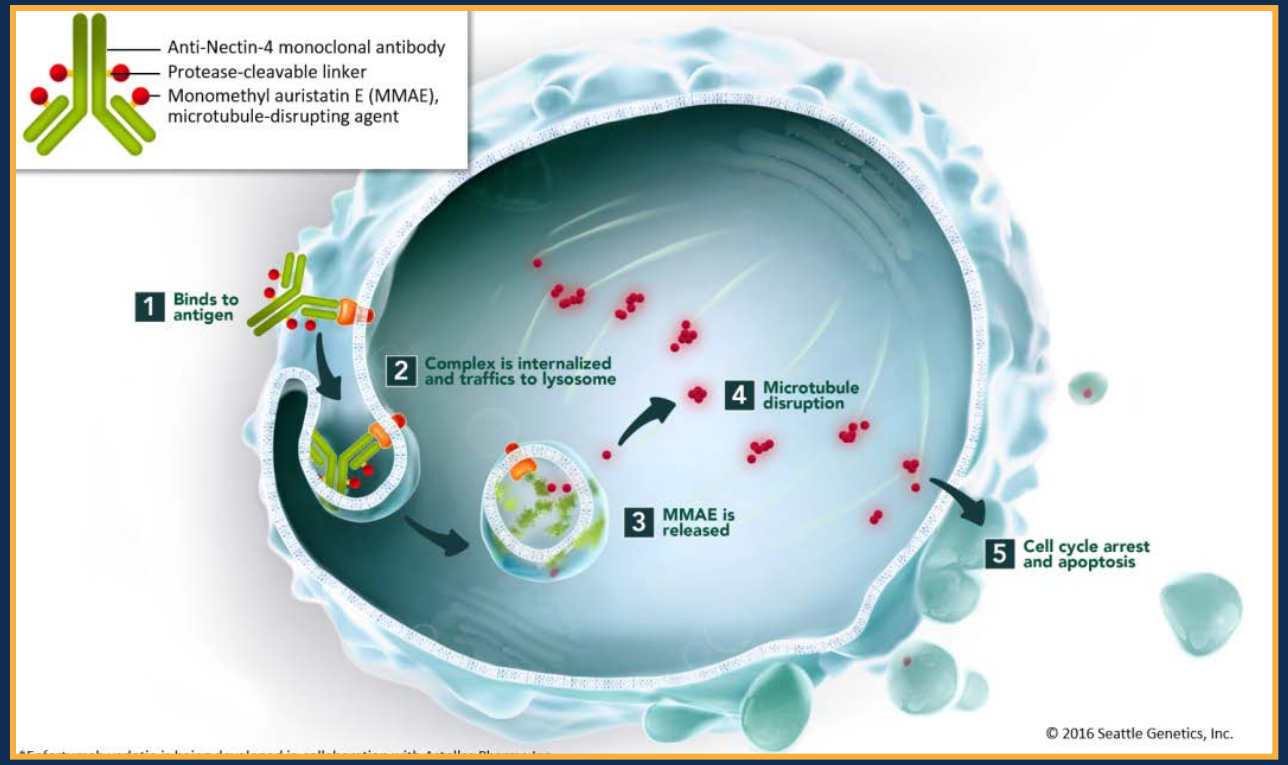
Regulatory and reimbursement issues aside, would you administer pembrolizumab in combination with enfortumab vedotin to a patient with mUBC outside of a protocol setting?



Premeeting survey: July 2021

RTP RESEARCH TO PRACTICE

Enfortumab Vedotin: Proposed Mechanism of Action



Enfortumab Vedotin is being co-developed by Seattle Genetics, Inc. and Astellas Pharma Inc.

Courtesy of Daniel P Petrylak, MD

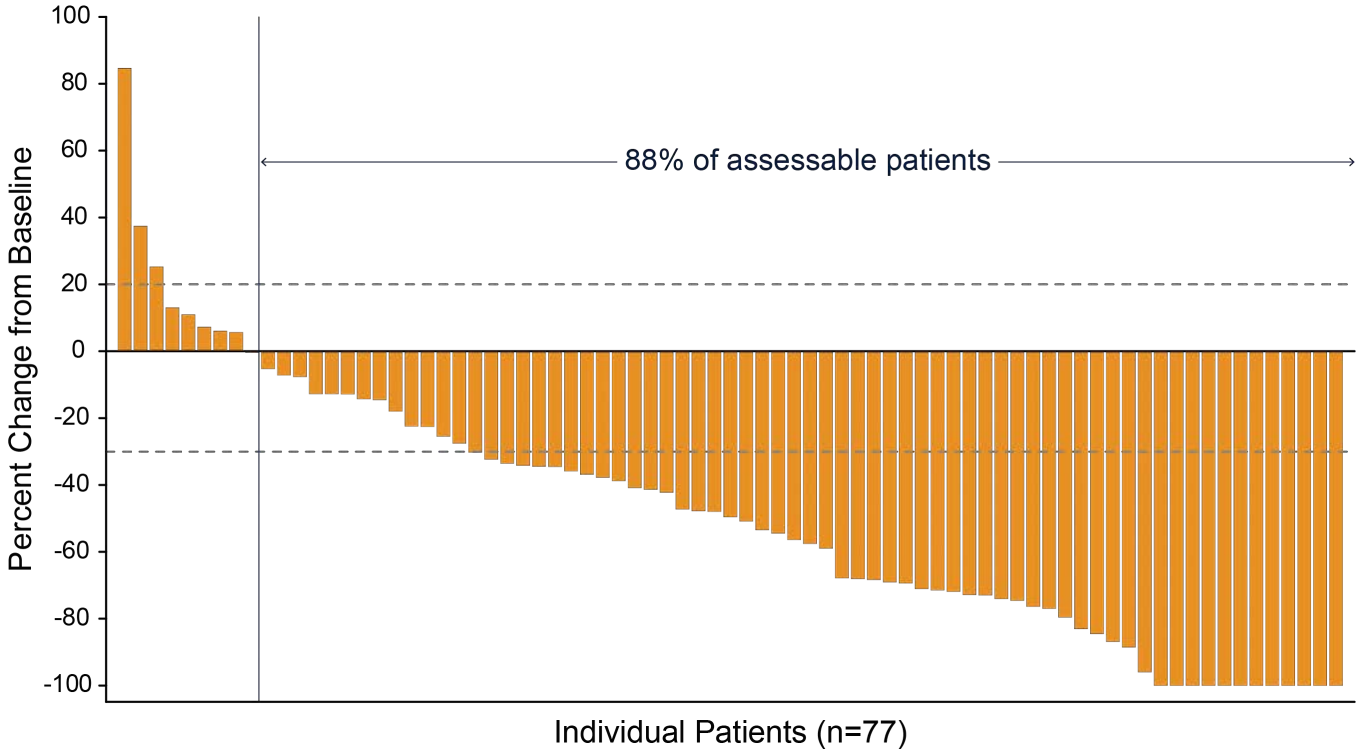
EV-201 Cohort 2: Best Overall Response with Enfortumab Vedotin per BICR

ORR per RECIST v 1.1 assessed by BICR	Patients (N=89) %
Confirmed ORR, 95% CI[1]	52 (40.8, 62.4)
Best overall response[2]	
Confirmed complete response	20
Confirmed partial response	31
Stable disease	30
Progressive disease	9
Not evaluable[3]	9

ORR = Objective Response Rate; RECIST = Response Evaluation Criteria in Solid Tumors; BICR = Blinded Independent Central Review
[1]CI = Confidence Interval, Computed using the Clopper-Pearson method
[2]Best overall response according to RECIST v1.1. Complete response and partial response were confirmed with repeat scans ≥28 days after initial response.
[3]Includes five subjects who did not have response assessment post-baseline, two subjects whose post-baseline assessment did not meet the minimum interval requirement for stable disease, and one subject whose response cannot be assessed due to incomplete anatomy.

Courtesy of Daniel P Petrylak, MD

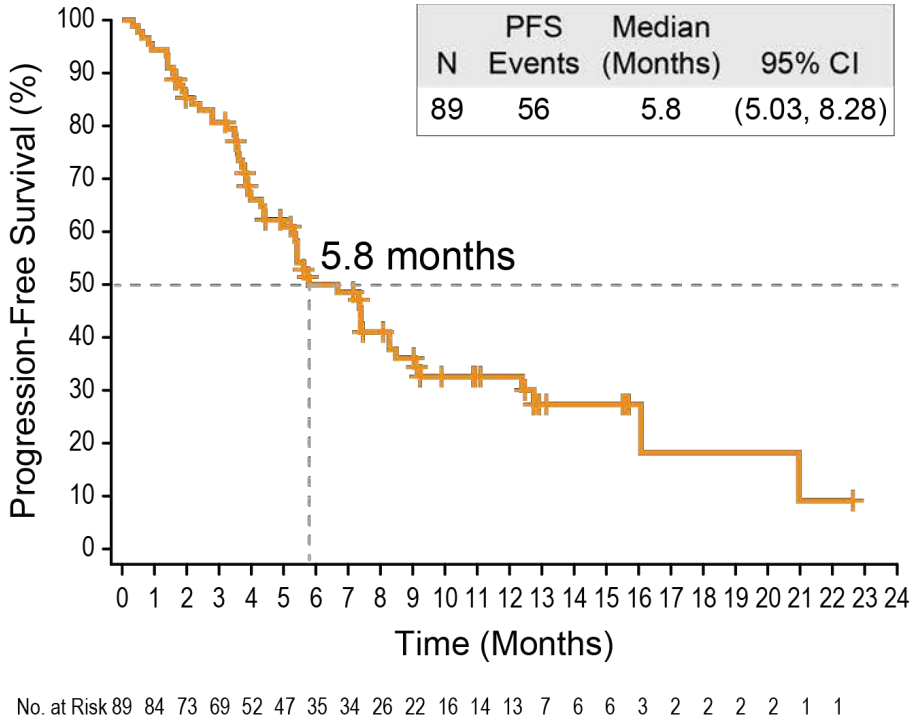
EV-201 Cohort 2: Change in Tumor Measurements per BICR

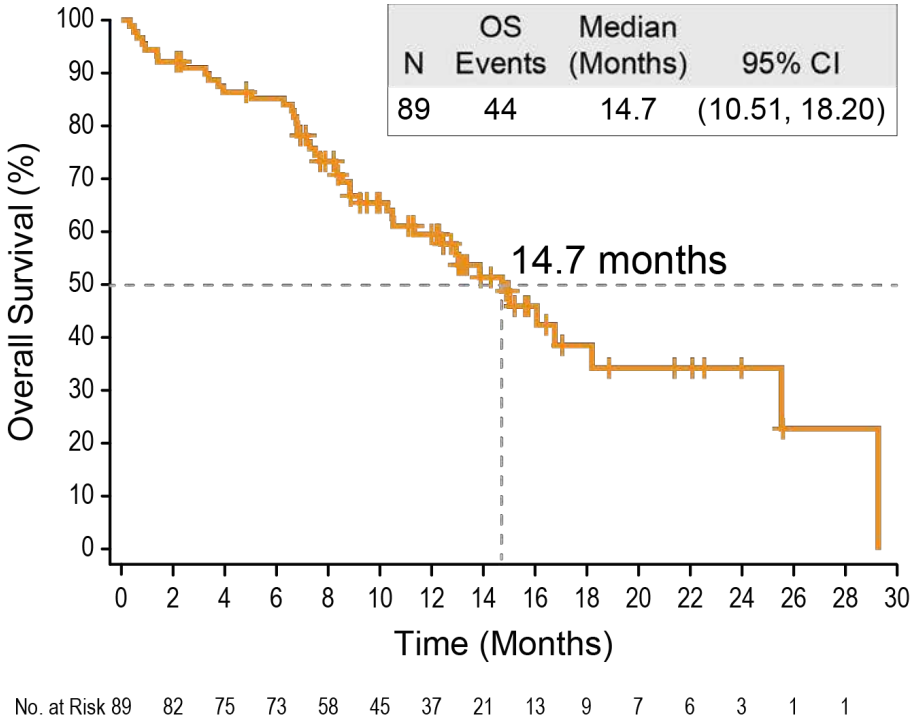


Data are not available for 12 subjects due to no response assessment post-baseline (n=5), incomplete assessment of target lesions post-baseline (n=1), or no measurable disease at baseline per BICR (n=6).

Courtesy of Daniel P Petrylak, MD

EV-201 Cohort 2: Progression-Free Survival and Overall Survival





Median follow-up: 13.4 months

Courtesy of Daniel P Petrylak, MD

EV-201 Cohort 2: Treatment-Related Adverse Events of Special Interest

Skin Reactions
61% any grade, 17% ≥Grade 3
Median Onset = 0.5 months[2]
% resolution/improvement[3] = 80%

- No Grade 5 events, 1 Grade 4 event
- 13 patients with severe cutaneous adverse reactions[4]
  - Most ≤Grade 2, no Grade 4 or 5 events
  - 4 patients with Grade 3 events: stomatitis, skin exfoliation, dermatitis bullous, dermatitis exfoliative generalised
  - 1 discontinuation due to severe cutaneous adverse reaction

Peripheral Neuropathy
54% any grade, 8% ≥Grade 3
Median Onset = 2.4 months
% resolution/improvement[3] = 56%

- PN rate was similar in patients with and without pre-existing PN (53% vs 54%)

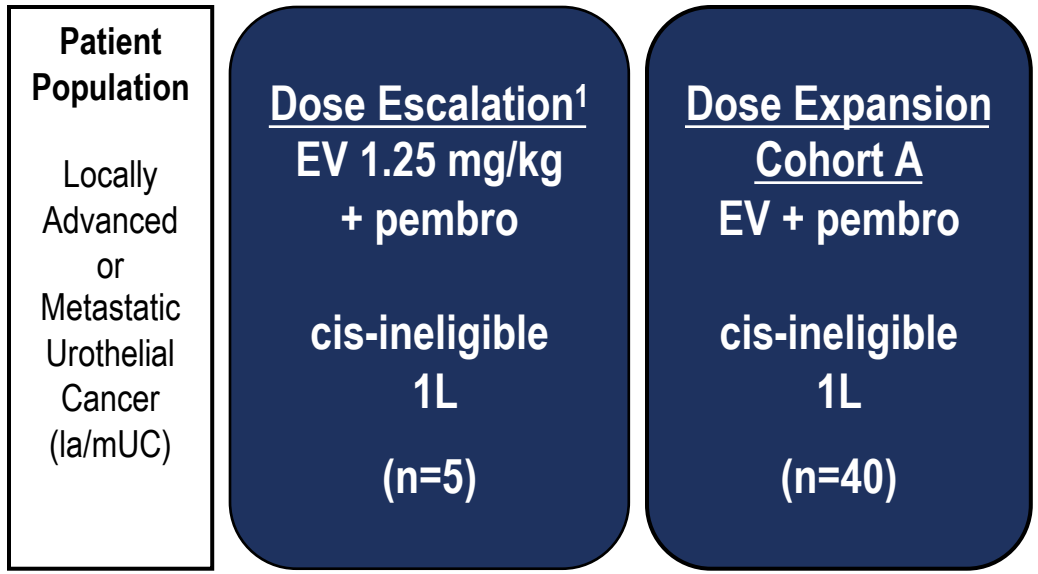
Hyperglycemia
10% any grade, 6% ≥Grade 3
Median Onset = 0.5 months[2]
% resolution/improvement[3] = 89%

- Higher rate of HG in patients with pre-existing HG than those without pre-existing HG (20% vs. 7%)
- Higher rate of HG in patients with BMI ≥30 kg/m^2 than those with BMI <30 kg/m^2 (23% vs. 8%)

Balar AV et al. Genitourinary Cancers Symposium 2021;Abstract 394.

EV-103: ENFORTUMAB VEDOTIN + PEMBROLIZUMAB COHORTS

EV 1.25 mg/kg + pembrolizumab (200 mg) in 1L la/mUC patients



Dosing: EV days 1 and 8 of 3-wk cycle to align with pembro (day 1 of 3-wk cycle)

EV exposure: Similar to EV monotherapy on 4-wk schedule (EV Days 1, 8, and 15)[2]

Primary endpoints: AEs, lab abnormalities

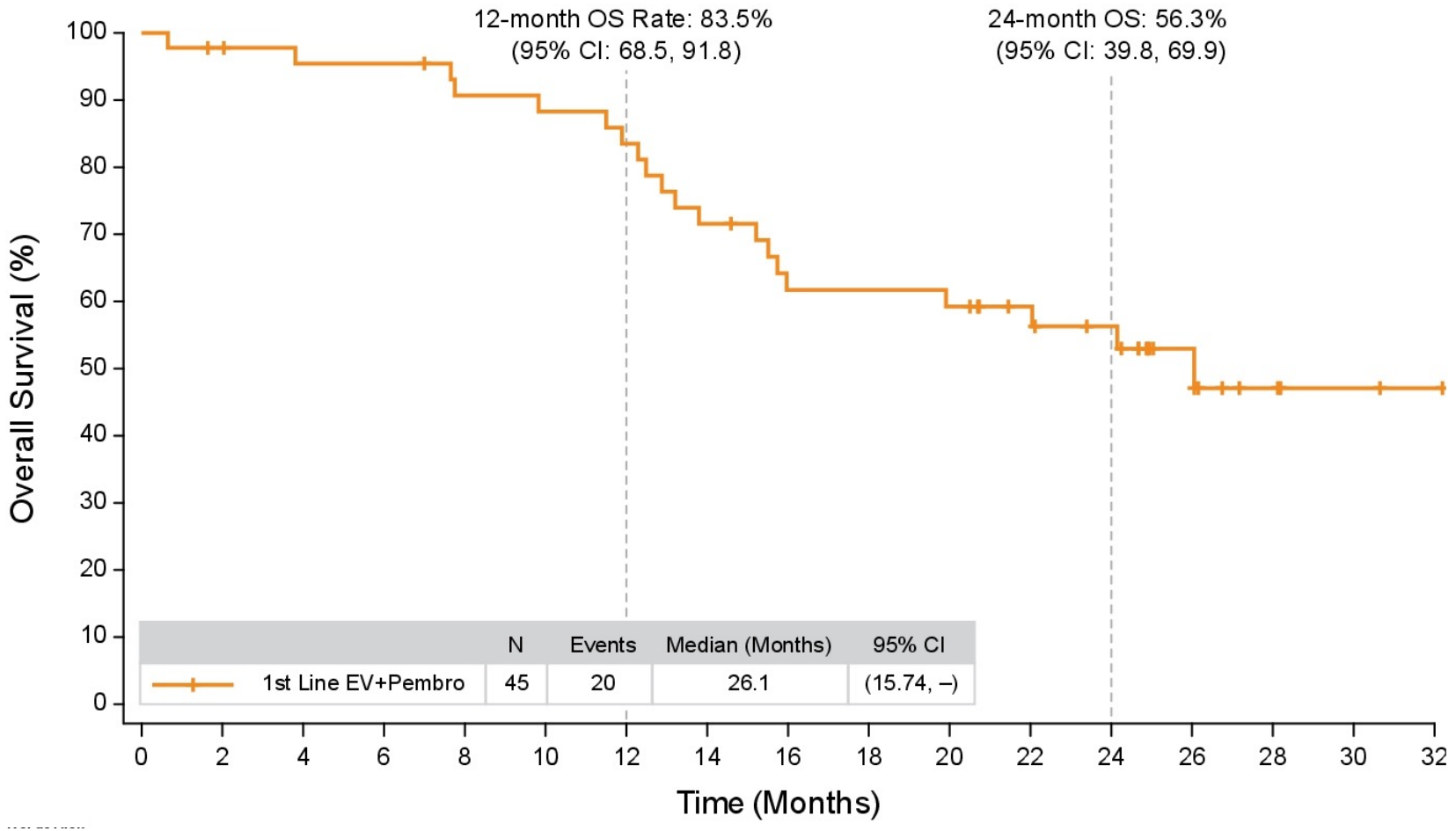
Key secondary endpoints: DLTs, ORR, DCR, DOR, OS

[1] Not included in the current analysis: three 1L patients treated with EV 1 mg/kg + pembro 200 mg and two 2L patients treated with EV 1.25 mg/kg + pembro 200 mg

[2] Rosenberg et al. *J Clin Oncol. Epub July* 2019

Courtesy of Daniel P Petrylak, MD

EV-103: Updated Survival Data



Median survival 26.1 months with a median follow-up of 24.9 months

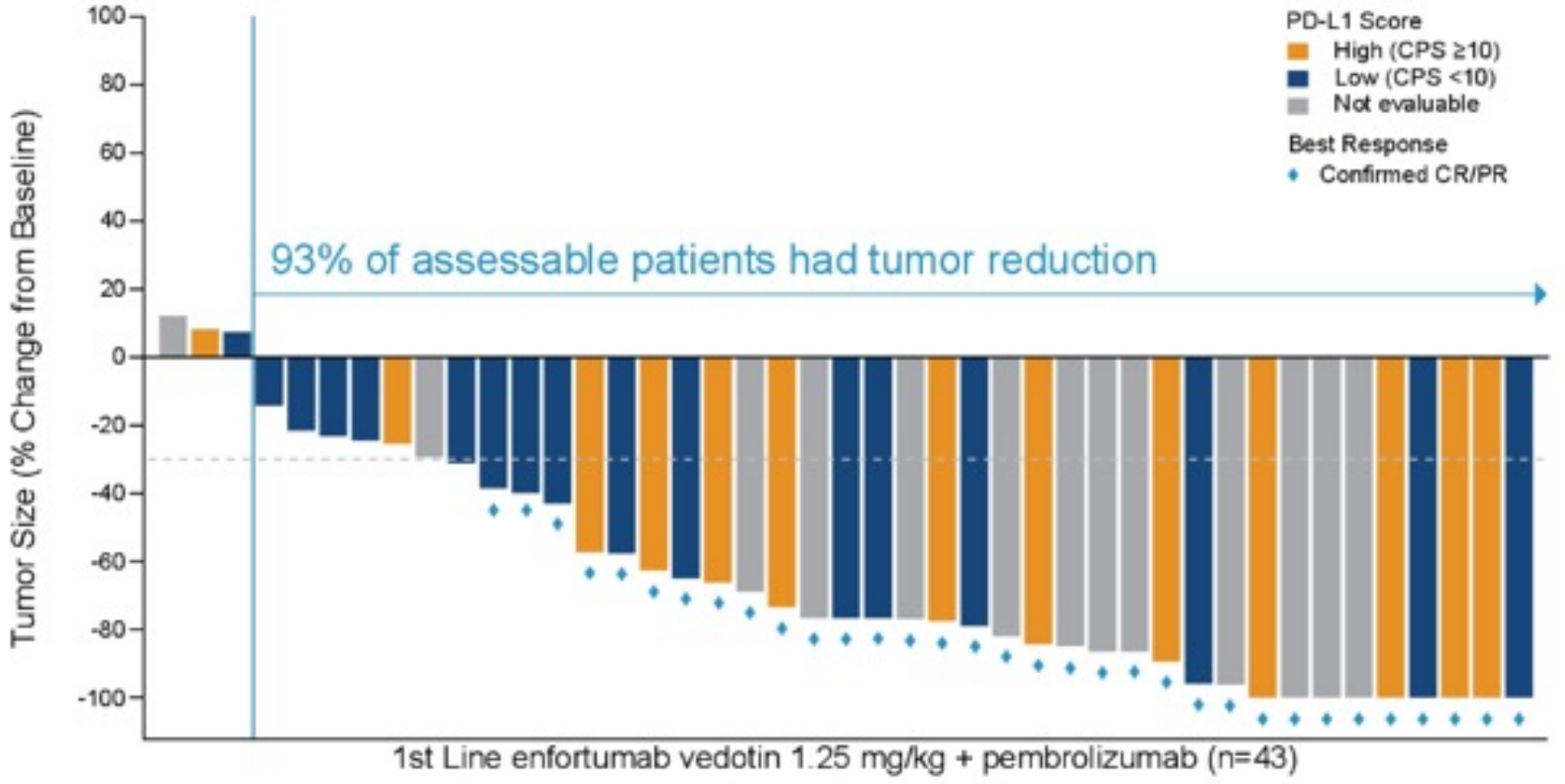
YaleNewHavenHealth
Smilow Cancer Hospital

Yale CANCER CENTER
A Comprehensive Cancer Center Designated by the National Cancer Institute

Friedlander TW et al. ASCO 2021;Abstract 4528.

Courtesy of Daniel P Petrylak, MD

EV-103: Response



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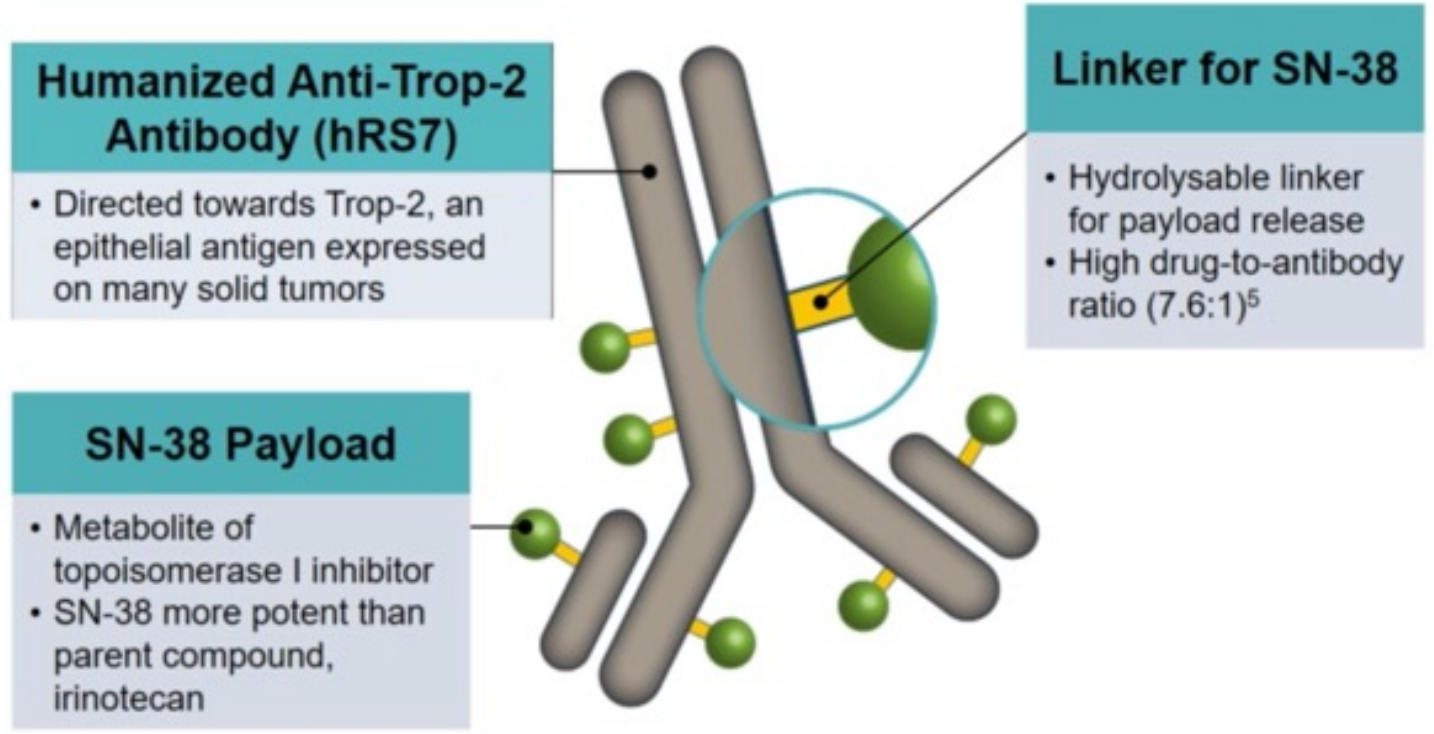
Smilow Cancer Hospital

Yale CANCER CENTER
A Comprehensive Cancer Center Designated by the National Cancer Institute

Friedlander TW et al. ASCO 2021;Abstract 4528. Courtesy of Daniel P Petrylak, MD

Sacituzumab Govitecan (SG) Is a Trop-2–Directed Antibody-Drug Conjugate (ADC)

- Trop-2 is an epithelial cell surface antigen highly expressed in UC[1]
- SG is distinct from other ADCs[2-6]:
  - High drug-to-antibody ratio[5]
  - Linker hydrolysis releases SN-38 intracellularly and in the tumor microenvironment[6a]
- SG has shown significant activity across tumor types[3,7-10]
  - Breakthrough therapy designation for mTNBC; accelerated approval submission pending
  - Phase 3 trials ongoing in breast cancer



[a]Sacituzumab govitecan–bound tumor cells are killed by intracellular uptake of SN-38, and adjacent tumor cells are killed by SN-38 released extracellularly.
mTNBC, metastatic triple-negative breast cancer; pts, patients; Trop-2, trophoblast cell surface antigen 2; UC, urothelial cancer. 1. Avellini et al. *Oncotarget* 2017; 2. Starodub et al. *Clin Cancer Res* 2015; 3. Cardillo et al. *Clin Cancer Res*. 2011; 4. Sharkey et al. *Clin Cancer Res*. 2015; 5. Cardillo et al. *Bioconjugate Chem*. 2015; 6.Govindan et al. *Mol Cancer Ther*. 2013; 7. Faltas et al. *Clin Genitourin Cancer*. 2016; 8. Bardia et al. *J Clin Oncol*. 2017; 9. Bardia et al. *N Engl J Med*. 2019; 10. Tagawa et al. *J Clin Oncol*. 2019.

Courtesy of Daniel P Petrylak, MD

TROPHY-U-01 Cohort 1: Responses with Sacituzumab Govitecan

	Sacituzumab Govitecan (n=113)
Overall Response Rate	
ORR, n (%) [95% CI]	31 (27.4) [19.5, 36.6]
CR, n (%) PR, n (%)	6 (5.3) 25 (22.1)
Response duration	
mDOR, months 95% CI Range	7.2 4.7-8.6 1.4-13.7

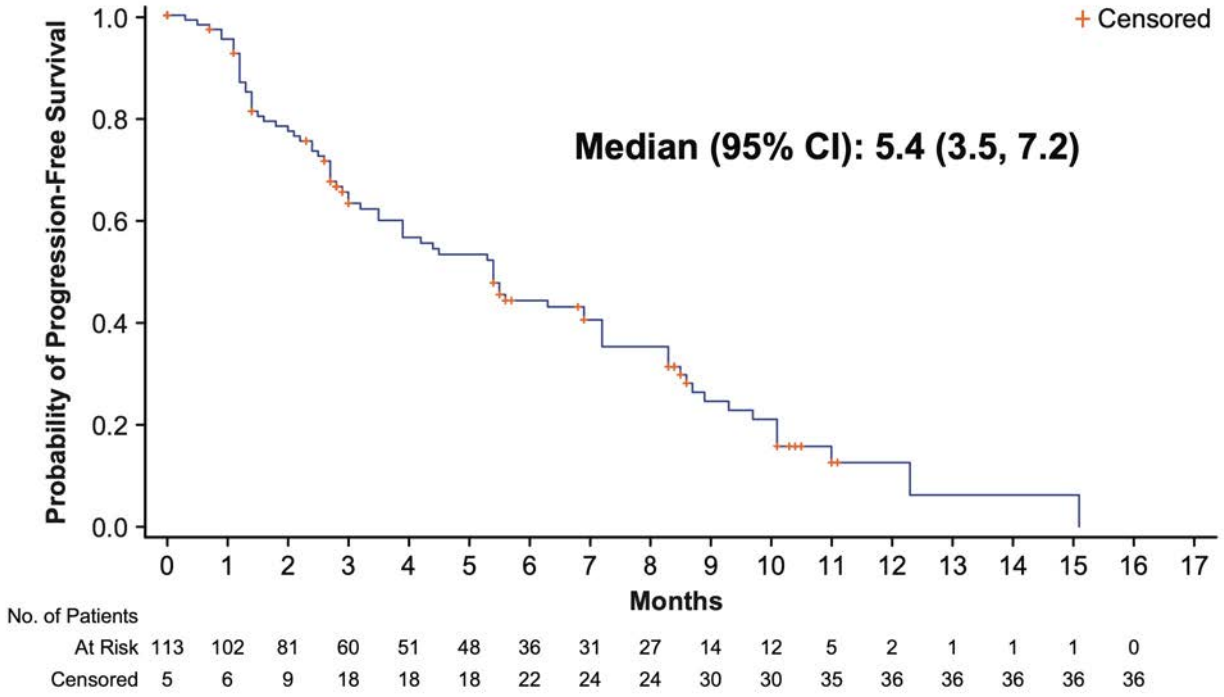
Subjects with visceral metastasis involving the liver had an ORR of 31.6% compared with 25.3% in those without liver involvement

[a] Assessments were per blinded independent review assessment, RECIST v1.1.
CR, complete response; mDOR, median duration of response; ORR, objective response rate; PR, partial response; RECIST v1.1, Response Evaluation Criteria in Solid Tumors version 1.1.
Tagawa ST, et al. TROPHY-U-01: A Phase 2 Open-label Study of Sacituzumab Govitecan in Patients With Metastatic Urothelial Carcinoma Progressing After Platinum-based Chemotherapy and Checkpoint Inhibitors. *J Clin Oncol*. 2021. In press.

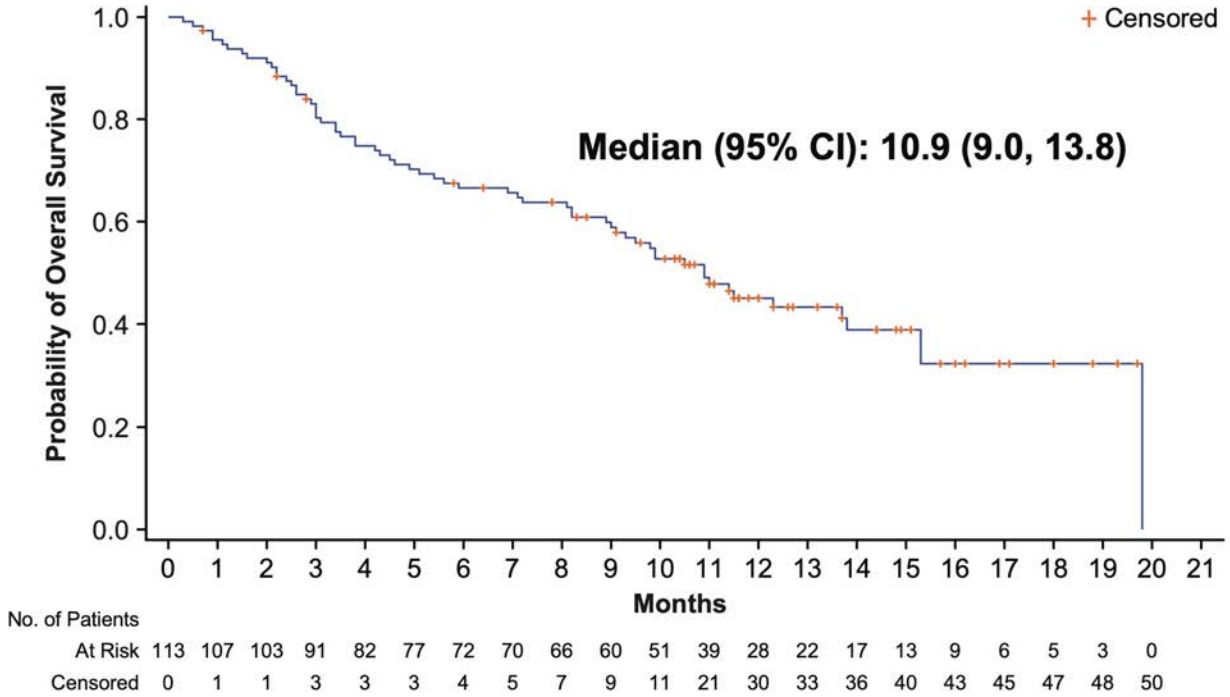
Courtesy of Daniel P Petrylak, MD

TROPHY-U-01 Cohort 1: Survival Outcomes

PFS



OS



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Courtesy of Daniel P Petrylak, MD

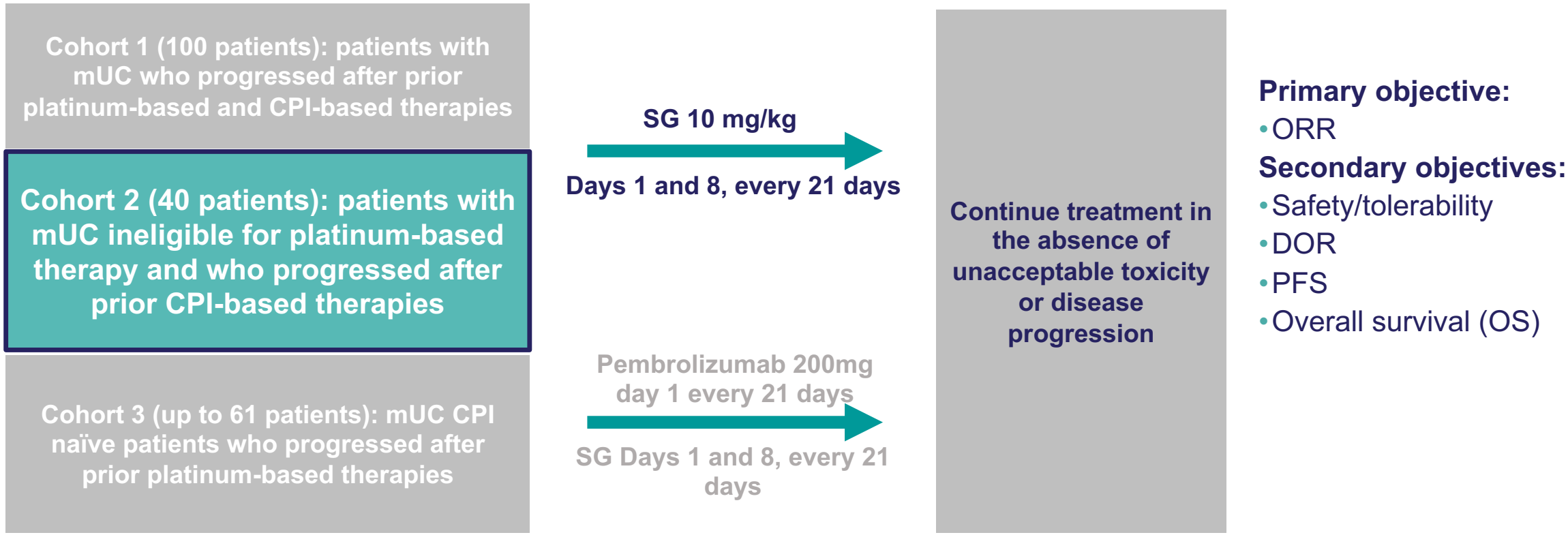
TROPHY-U-01 Cohort 1: Treatment-Related AEs
(≥20% Any Grade or ≥5% Grade ≥3 [n=113])

Category	Event	All Grades (%)	Grade 3 (%)	Grade 4 (%)
Hematologic[a]	Neutropenia	46	22	12
	Leukopenia	25	12	5
	Anemia	33	14	0
	Lymphopenia	11	5	2
	Febrile neutropenia	10	7	3
Gastrointestinal	Diarrhea[b]	65	9	1
	Nausea	60	4	0
	Vomiting	30	1	0
General disorders & administrative site conditions	Fatigue	52	4	0
Skin & subcutaneous tissue	Alopecia	47	0	0
Metabolism & nutrition	Decreased appetite	36	3	0
Infections & infestations	Urinary tract infection	8	6	0

- 6% (n=7) of patients discontinued Sacituzumab Govitecan due to adverse events
  - 4 patients discontinued due to neutropenia
- 30.1% G-CSF usage
- One treatment-related death (sepsis due to febrile neutropenia)

Courtesy of Daniel P Petrylak, MD

Figure 3. TROPHY-U-01: Phase II trial of SG in stage IV urothelial cancer after failure of a platinum-based regimen and/or anti-PD-1/PD-L1-based therapies



CPI therapy (includes anti-PD-1/anti-PD-L1–based therapies).
CPI, checkpoint inhibitor; DOR, duration of response; mUC, metastatic urothelial cancer; ORR, objective response rate; OS, overall survival; PD-1, programmed cell death-1; PD-L1, programmed death-ligand 1; PFS, progression-free survival.
EudraCT Number: 2018-001167-23; ClinicalTrials.gov Number: NCT03547973; IMMU-132-06 study.

Courtesy of Daniel P Petrylak, MD

TROPHY-U-01 (Cohort 2): Exposure and Response Outcomes

- Median treatment cycles (range): 5 (1-15)
- Median duration of treatment (range): 4.5 months (0.3 – 15.6)
- Median Dose intensity: 92%

- At a median follow-up of 6.8 months, ORR was 29% (6/21) with 6 confirmed PRs

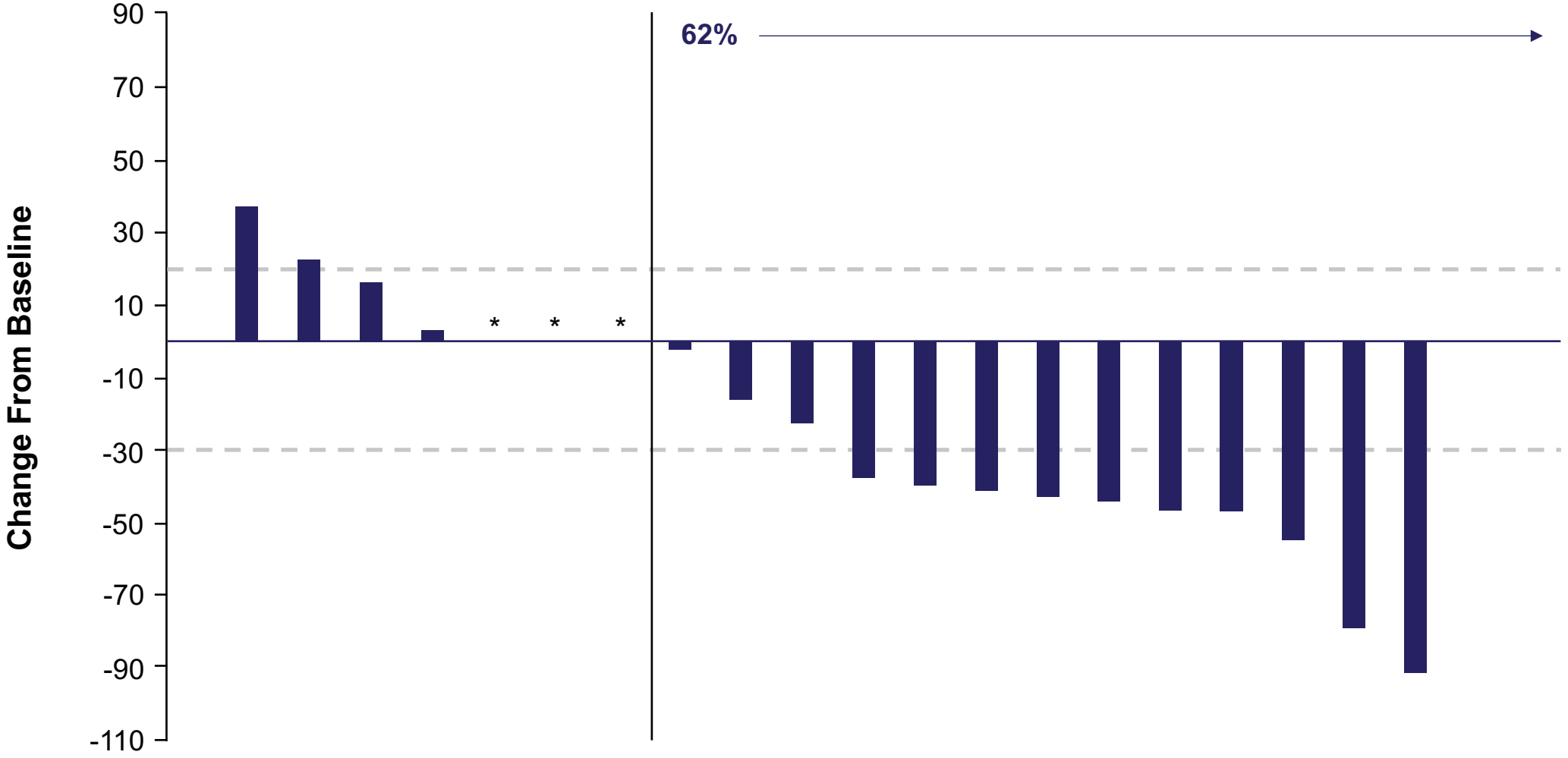
Response Outcomes

Endpoint	N=21
Median (range) follow-up, mon	6.8 (1.6–18.9)
Patients continuing treatment, n (%)	9 (43)
ORR, n (%) [95% CI]	6 (29) [12–54]
CR, n (%)	0 (0)
PR, n (%)	6 (29)
SD, n (%)	10 (48)
Median TTR, (range), mon	1.3 (1.1–1.5)
CBR, n (%) [95% CI]	7 (33) [15–59]
Median DOR (95% CI), mon	NR (4.3–NR)

CBR, clinical benefit rate defined as CR + uCR + PR + uPR or (SD >= 6 months); CI, confidence interval; DOR, duration of response; mon, month; NR, not reached; ORR, objective response; PR, partial response; SD, stable disease; TTR, time to response

Courtesy of Daniel P Petrylak, MD

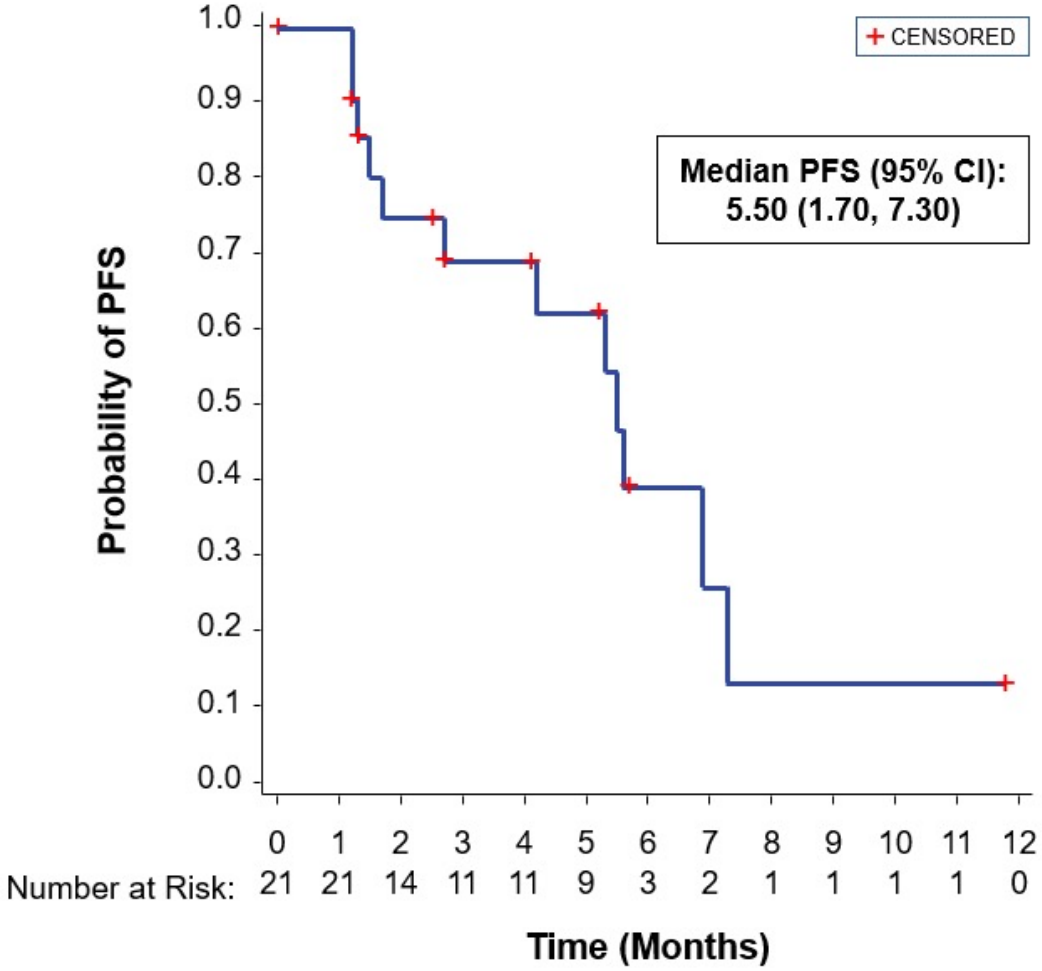
TROPHY-U-01 (Cohort 2): 62% (13/21) of Patients Demonstrated a Reduction in Tumor Size

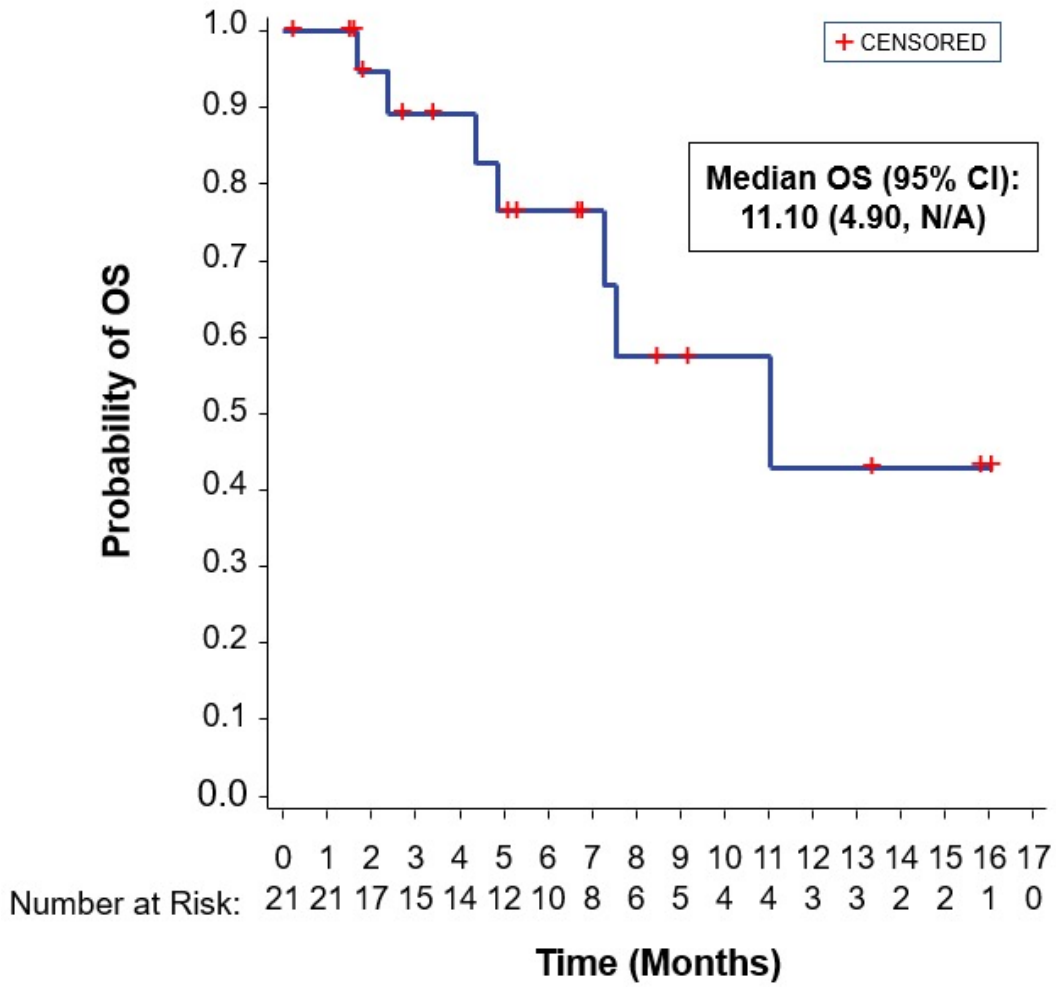


*Denotes patients who had a 0% change from baseline in tumor size.
One patient had only screening data and thus is not represented.

Courtesy of Daniel P Petrylak, MD

TROPHY-U-01 (Cohort 2): Survival Outcomes





- At this early follow-up, the median PFS and OS compare favorably to current standards of care for platinum-ineligible patients with mUC who have progressed after CPI therapy
- The OS rate (95% CI) at 6 months and 12 months was: 76.4% (48.4–90.5) and 43.0% (13.1–70.4), respectively

Courtesy of Daniel P Petrylak, MD

Case Presentation – Dr Petrylak: A 67-year-old woman with high-grade UBC

- 67-year-old female
- Gross hematuria 2014; CT scan abdomen/pelvis demonstrated paraaortic adenopathy, right renal pelvis mass; bx of right renal pelvis mass demonstrated high-grade urothelial cancer
- Underwent 4 cycles of gemcitabine/cisplatin, adenopathy resolved, right nephroureterectomy 12/14/2014 demonstrated invasive urothelial cancer with rhabdoid and micropapillary features into perinephric fat, 10/15 lymph nodes positive
- CT scan 1/2015 demonstrated hepatic metastases

Courtesy of Daniel P Petrylak, MD

Case Presentation – Dr Petrylak: A 67-year-old woman with high-grade UBC (continued)

- Entered a clinical trial of ipilimumab/nivolumab for 28 cycles, best response PR. Progressed in liver 5/2016. Treatment complicated by pneumonia, pneumonitis treated with steroids.
- Started phase I trial of Enfortumab Vedotin 7/2016. Has been on therapy since that time but doses have been held due to neuropathy, LFT abnormalities and pneumonitis. She has a CR to therapy and is intermittently treated with 1.0 mg/kg for 3 out of 4 weeks.

Courtesy of Daniel P Petrylak, MD

Case Presentation – Dr Petrylak: A 61-year-old man with low-grade papillary UBC

- 61-year-old male with low-grade papillary urothelial cancer diagnosed in 2003, subsequently developed muscle invasion 12/2017. CT scan at that time demonstrated pulmonary metastases
- Underwent treatment with gemcitibine/cisplatin, 6 cycles. Best response - stable disease.
- Started pembrolizumab 10/2018; progressed in lung 4/2018

Courtesy of Daniel P Petrylak, MD

Case Presentation – Dr Petrylak: A 61-year-old man with low-grade papillary UBC (continued)

- Underwent 28 cycles of Sacituzumab Govitecan from 5/2019 to 1/2021, best response SD, progressed in lung 1/2021. Side effects included diarrhea, which resulted in dose delays
- Started Enfortumab Vedotin 2/2021, best response - SD. Progressed in 6/2021.
- FGFR3 positive, now on Erdafitinib

Courtesy of Daniel P Petrylak, MD

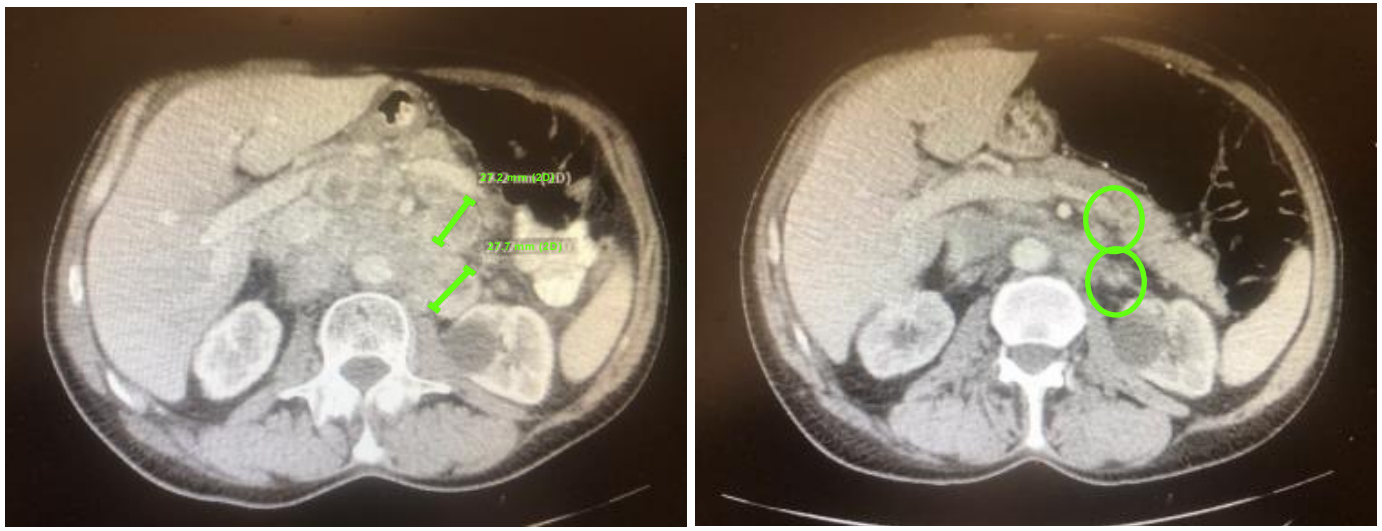
Case Presentation – Dr Petrylak: A 61-year-old man with previously treated metastatic bladder cancer

- 61-year-old male with past medical history of G1 neuropathy and RLE edema, with target lesions consisting of periportal, retroperitoneal, and mesenteric adenopathy

- Refractory to adjuvant tx: Cisplatin/gemcitabine
- Prior metastatic regimens:
  - Atezolizumab (24 mon)
  - Enfortumab vedotin (8 mon)
  - Pemetrexed (3 mon)

- **Confirmation of PR after cycle 4 with SG treatment[a]**
  - **No worsening of neuropathy reported**
  - **Significant reduction in lower extremity edema**
  - **On treatment for 7 mon and ongoing at time of data cut-off**

Images provided by Daniel P. Petrylak from the Yale School of Medicine, New Haven, CT



Baseline CT

Follow-up CT
(after 10 cycles of SG)

70% reduction of target lesions

[a]Assessed by investigator using RECISTv1.1.
CT, computed tomography; G1, grade 1; PR, partial response; RECIST, Response Evaluation Criteria In Solid Tumors; RLE, right leg extremity; SG, sacituzumab govitecan.

Courtesy of Daniel P Petrylak, MD

Agenda

Module 1: Treatment of Metastatic Urothelial Bladder Cancer (mUBC) – Third Line and Beyond

Part 1: Antibody-Drug Conjugates

- Enfortumab vedotin (EV) for progressive mUBC; potential clinical role in combination with pembrolizumab
- TROPHY U-01: Sacituzumab govitecan for progressive mUBC; recent FDA approval
- Incidence, severity and management of adverse events with EV and sacituzumab govitecan
- Faculty cases

Part 2: FGFR-Targeted Therapies in Advanced UBC

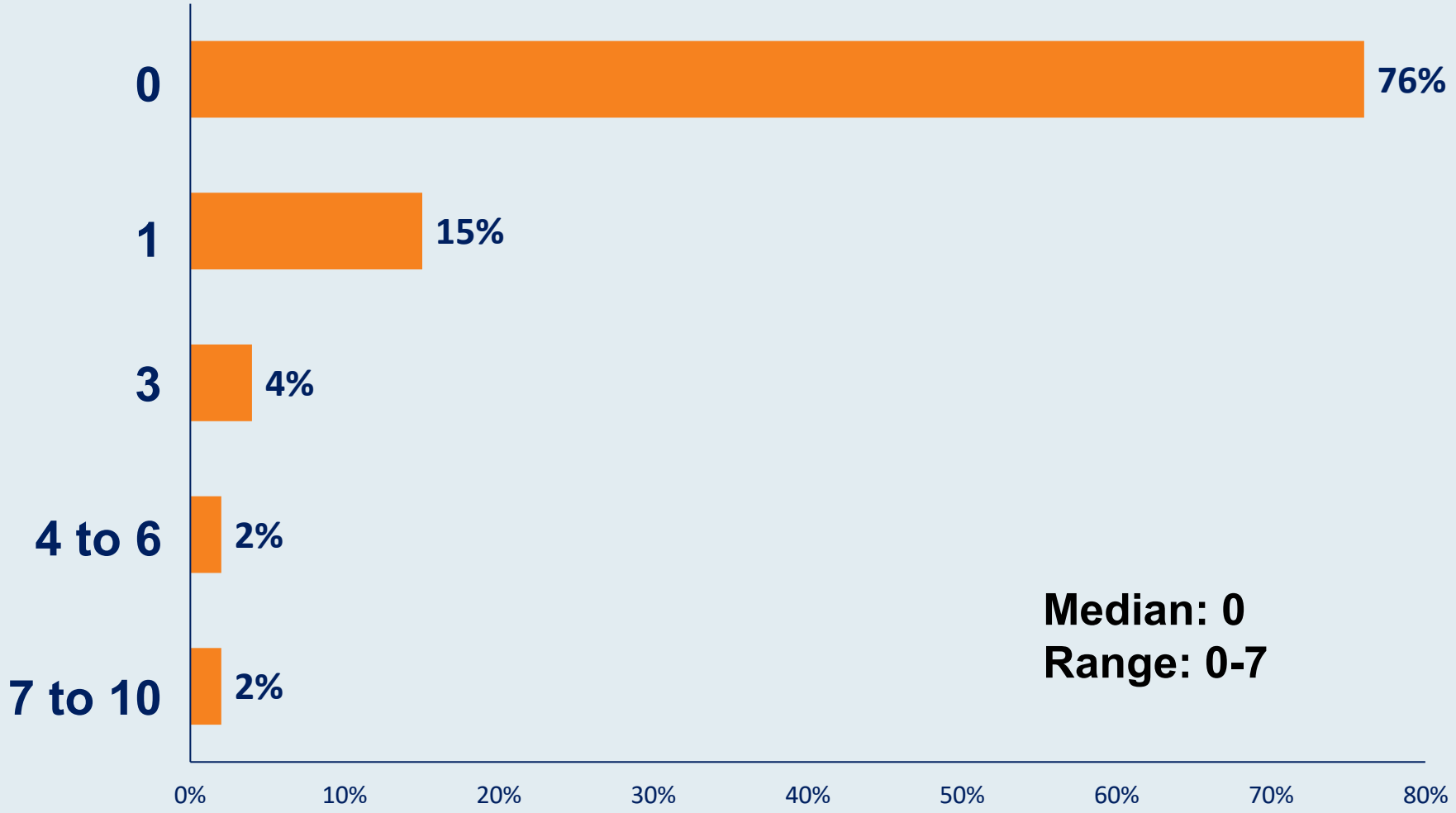
- BLC2001: Erdafitinib for patients with progressive mUBC with susceptible FGFR3 or FGFR2 alterations
- Incidence and severity of adverse events with erdafitinib; optimal monitoring and management strategies
- Ongoing studies evaluating erdafitinib alone or in combination with other systemic therapies in UBC
- Faculty cases

Module 2: Non-Muscle-Invasive Bladder Cancer; First- and Second-Line Therapy for mUBC

- Use of immunotherapy for BCG-refractory non-muscle-invasive bladder cancer
- Immunotherapy for mUBC: IMvigor130, DANUBE, JAVELIN Bladder 100
- Faculty cases

RTP
RESEARCH
TO PRACTICE

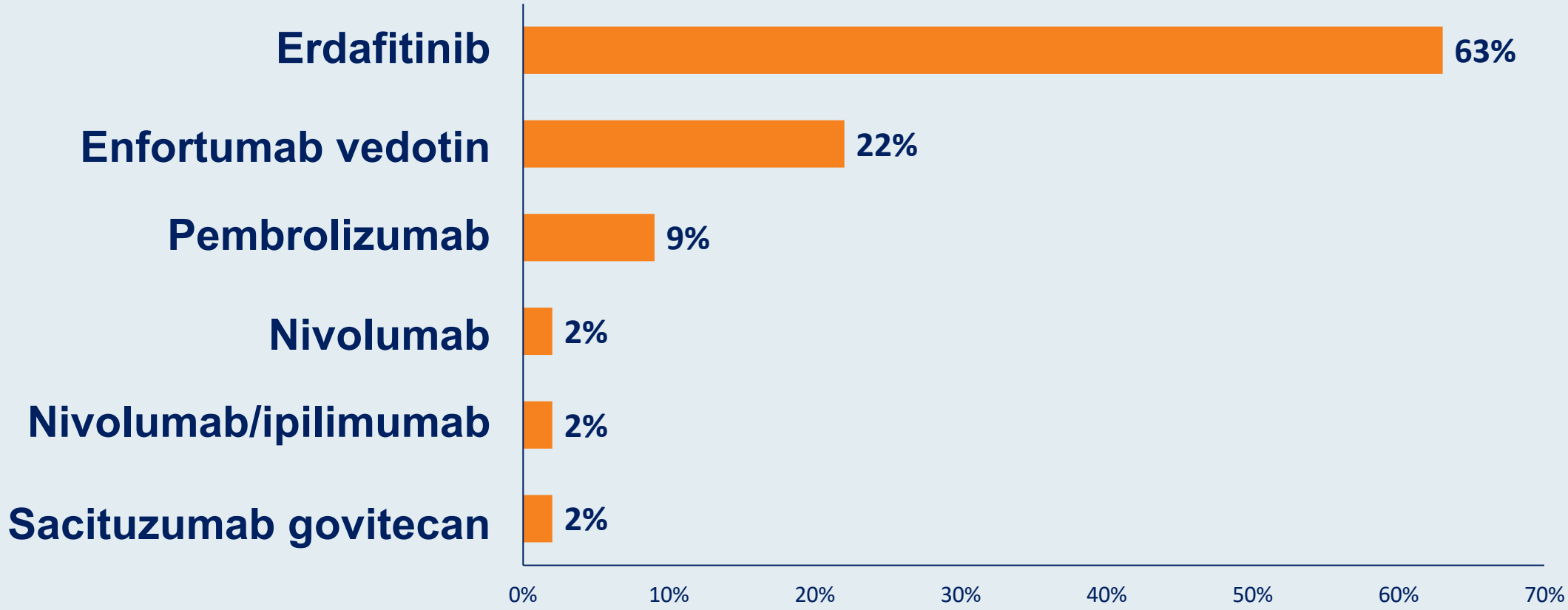
For approximately how many patients in your practice with mUBC have you utilized erdafitinib?



Premeeting survey: July 2021

RTP RESEARCH TO PRACTICE

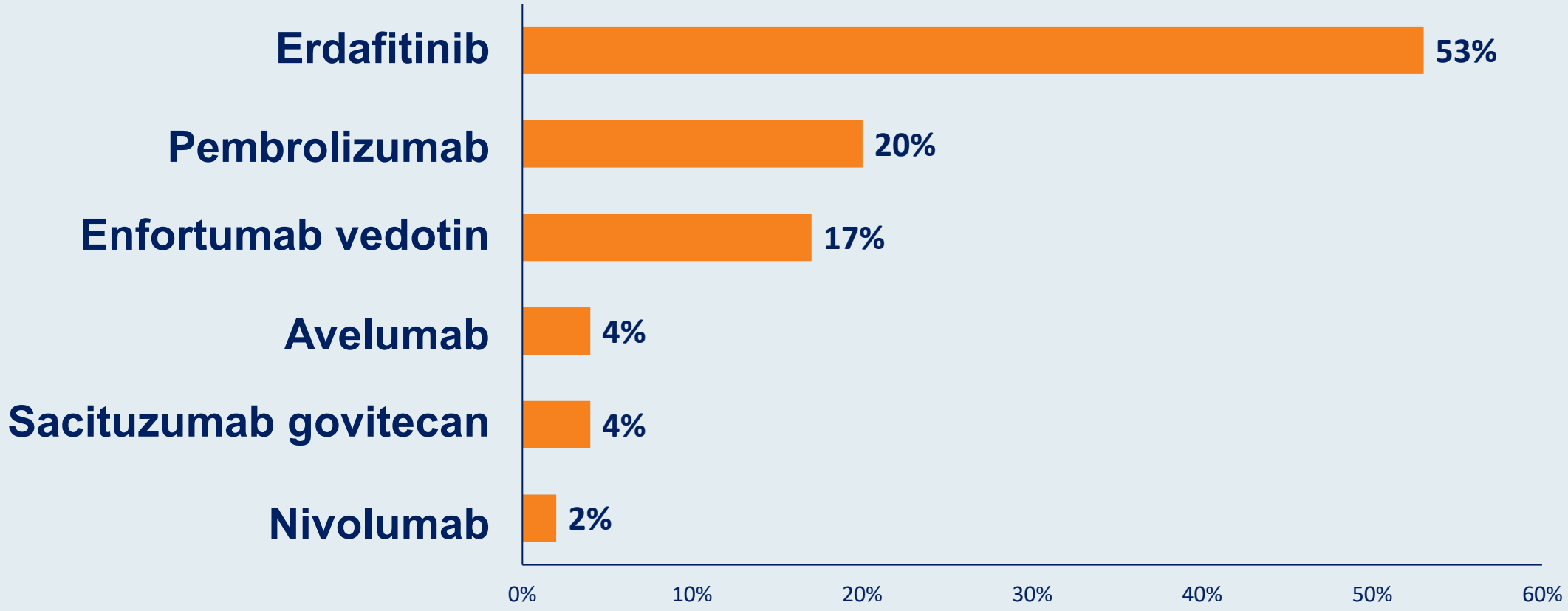
What would you generally recommend for a 65-year-old patient who experiences disease recurrence in the liver 9 months after cystectomy and adjuvant chemotherapy for muscle-invasive UBC who is found to have an FGFR3 mutation?



Premeeting survey: July 2021

RTP RESEARCH TO PRACTICE

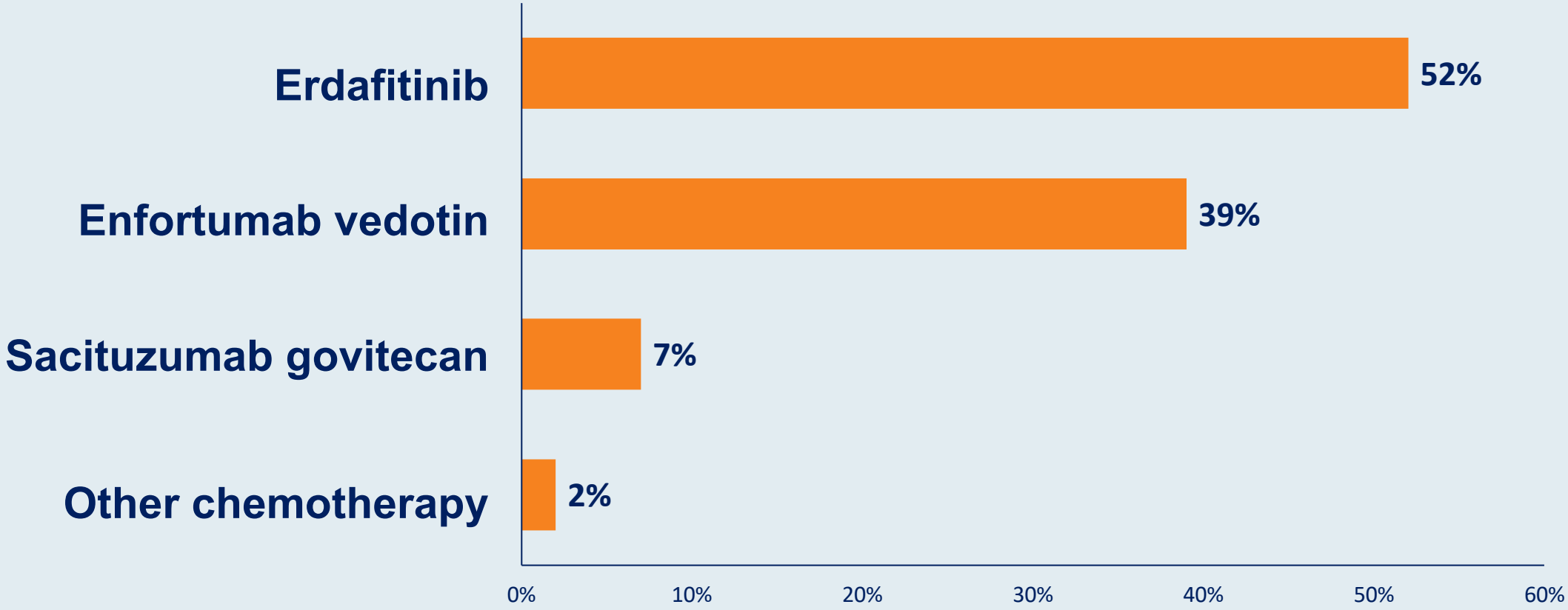
What would you generally recommend as second-line therapy for a 65-year-old patient with FGFR-mutated UBC metastatic to the liver whose disease progresses on first-line cisplatin/gemcitabine?



Premeeting survey: July 2021

RTP RESEARCH TO PRACTICE

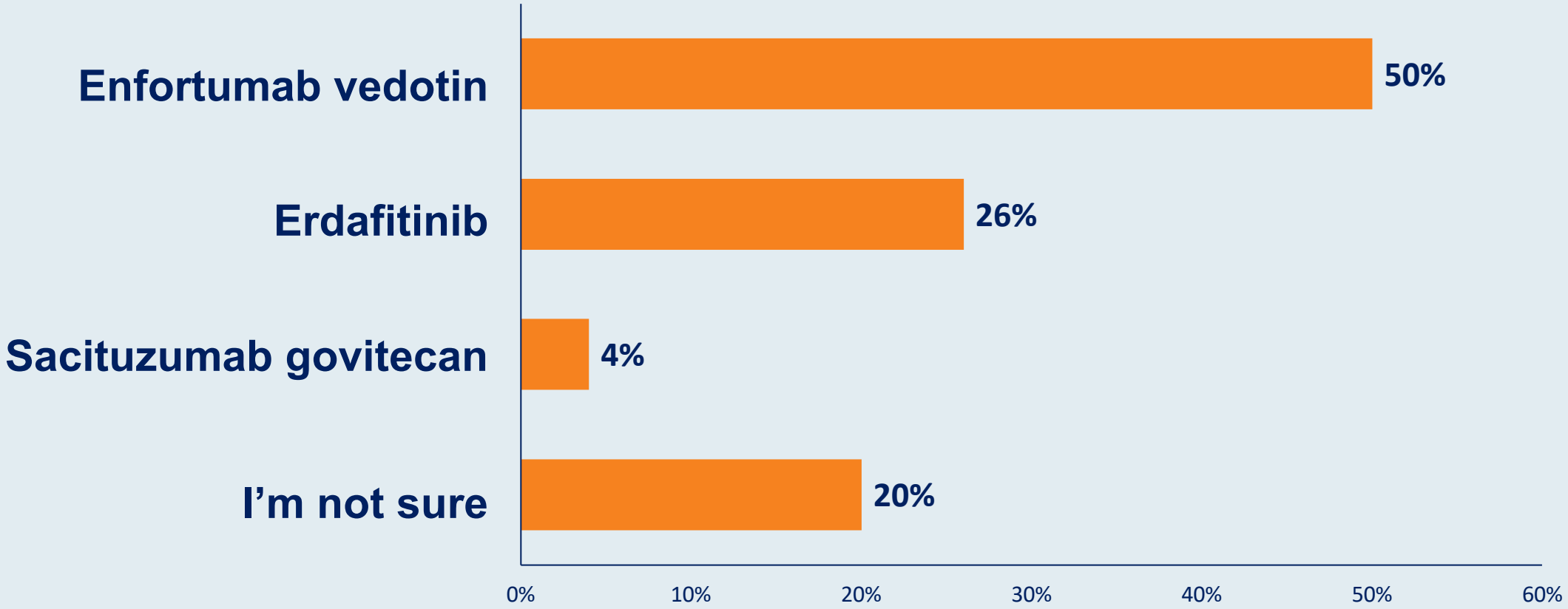
What would you generally recommend as second-line therapy for a 65-year-old patient with metastatic FGFR-mutated UBC to the liver whose disease progresses on first-line cisplatin/gemcitabine followed by avelumab maintenance?



Premeeting survey: July 2021

RTP RESEARCH TO PRACTICE

Which of the following would you generally recommend first for a patient with mUBC who is eligible to receive all 3 agents?

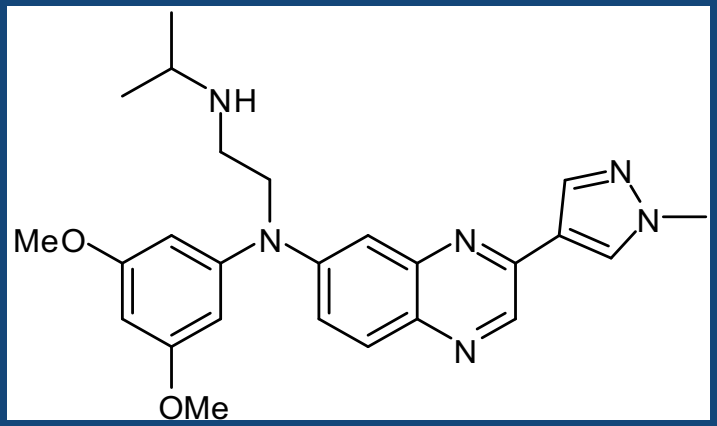


Premeeting survey: July 2021

RTP RESEARCH TO PRACTICE

Erdafitinib Is a Potent FGFR Inhibitor

- Erdafitinib is an oral pan-FGFR (1-4) inhibitor with IC_{50} in the single-digit nanomolar range[1]
- Erdafitinib is taken up by lysosomes, resulting in sustained intracellular release, which may contribute to its long-lasting activity[1]
- Erdafitinib has demonstrated promising activity in patients with metastatic or unresectable UC and other histologies (eg, cholangiocarcinoma) with *FGFR* alterations[2-5]



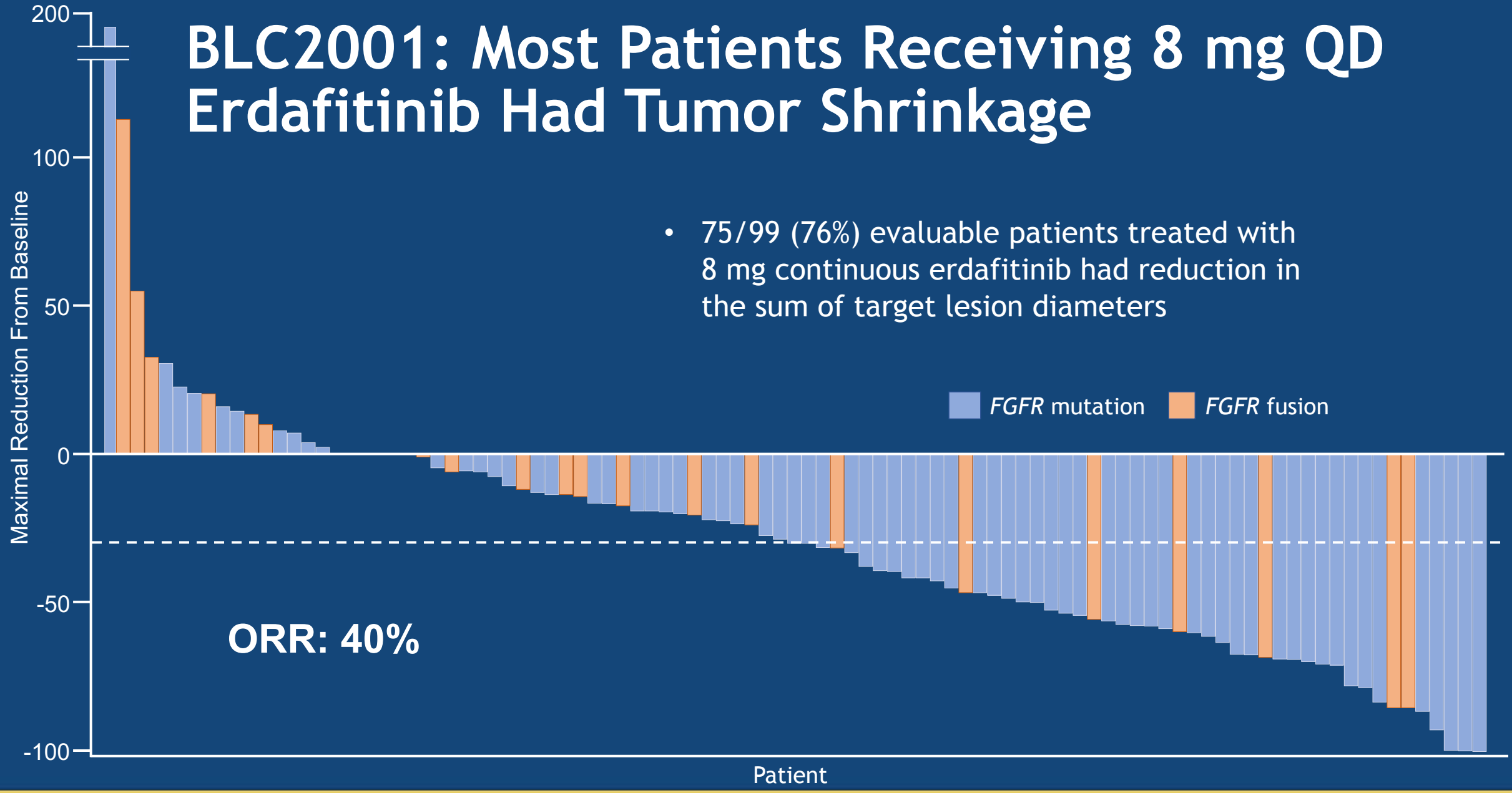
Abbreviation: IC_{50}, drug concentration at which 50% of target enzyme activity is inhibited.

1. Perera TPS, et al. *Mol Cancer Ther*. 2017;16:1010-1020.
2. Tabernero J, et al. *J Clin Oncol*. 2015;33:3401-3408.
3. Soria J-C, et al. ESMO 2016. Abstract 781PD.
4. Loriot Y, et al. ASCO GU 2018. Abstract 411.
5. Siefker-Radtke A, et al. ASCO GU 2018. Abstract 450.

Courtesy of Arlene Siefker-Radtke, MD

BLC2001: Most Patients Receiving 8 mg QD Erdafitinib Had Tumor Shrinkage

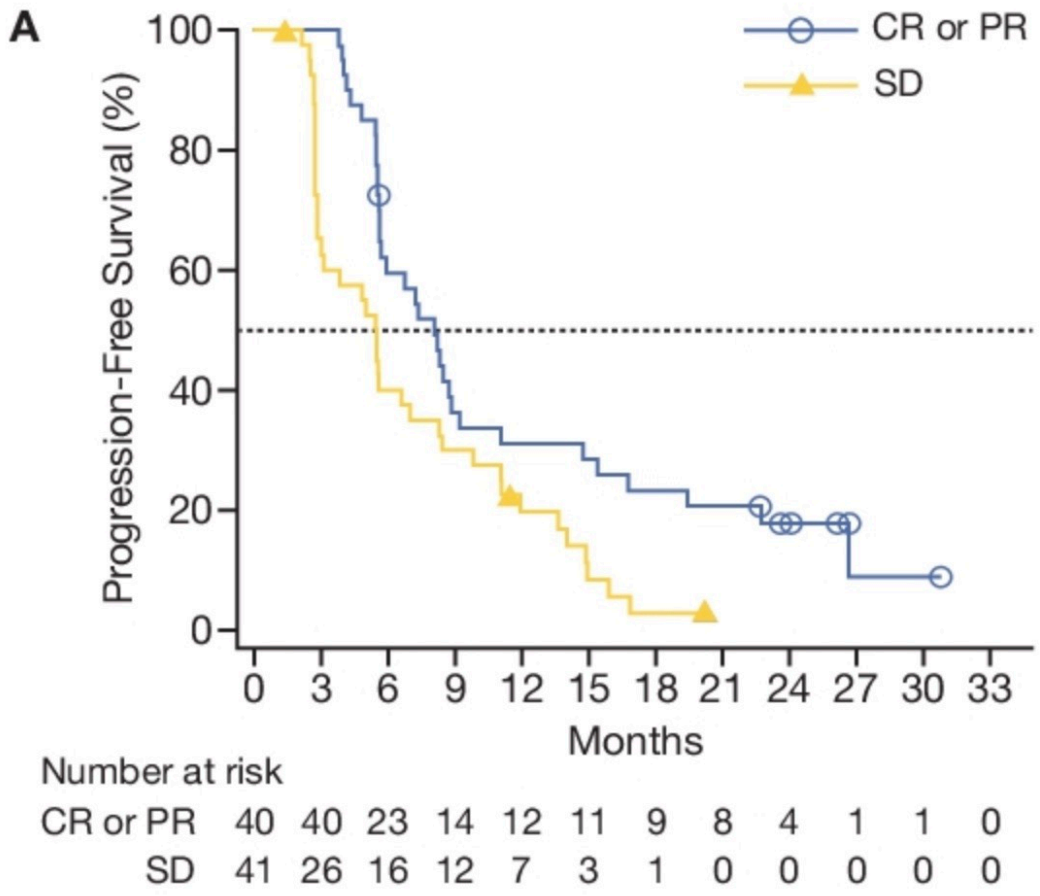
- 75/99 (76%) evaluable patients treated with 8 mg continuous erdafitinib had reduction in the sum of target lesion diameters



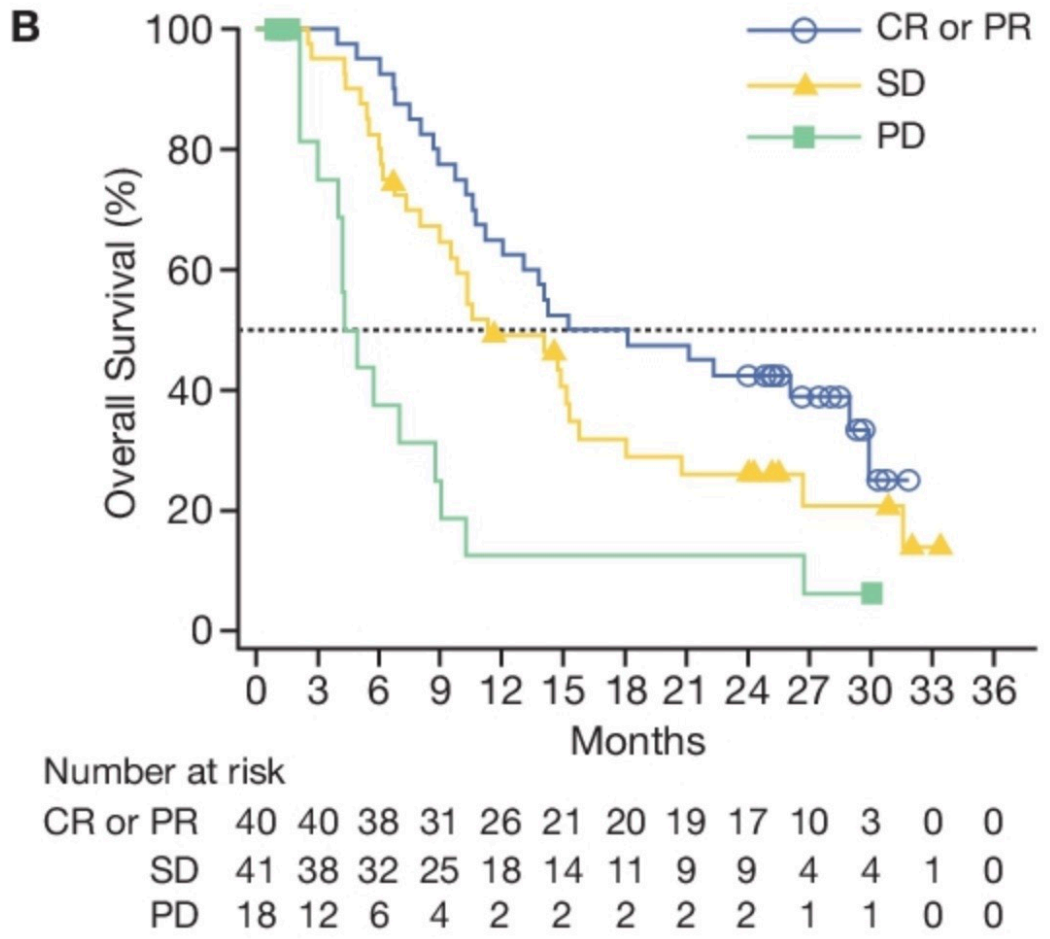
Courtesy of Arlene Siefker-Radtke, MD

BLC2001: Survival

Median PFS: 5.5 months



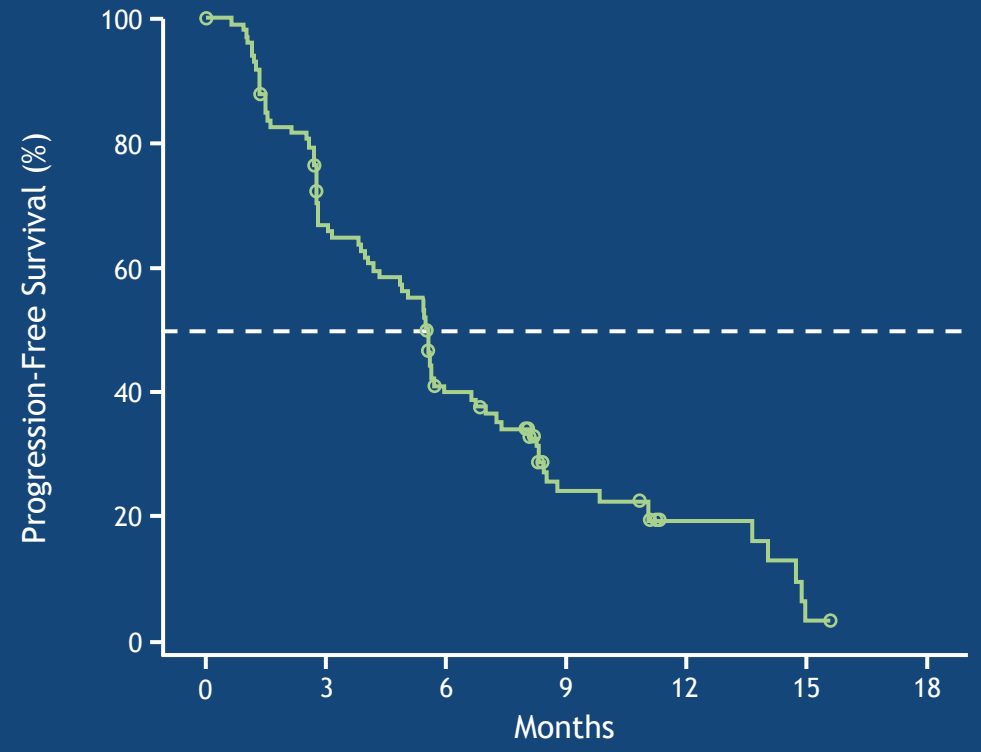
Median OS: 11.3 months



Siefker-Radtke AO et al. ASCO 2020;Abstract 5015.

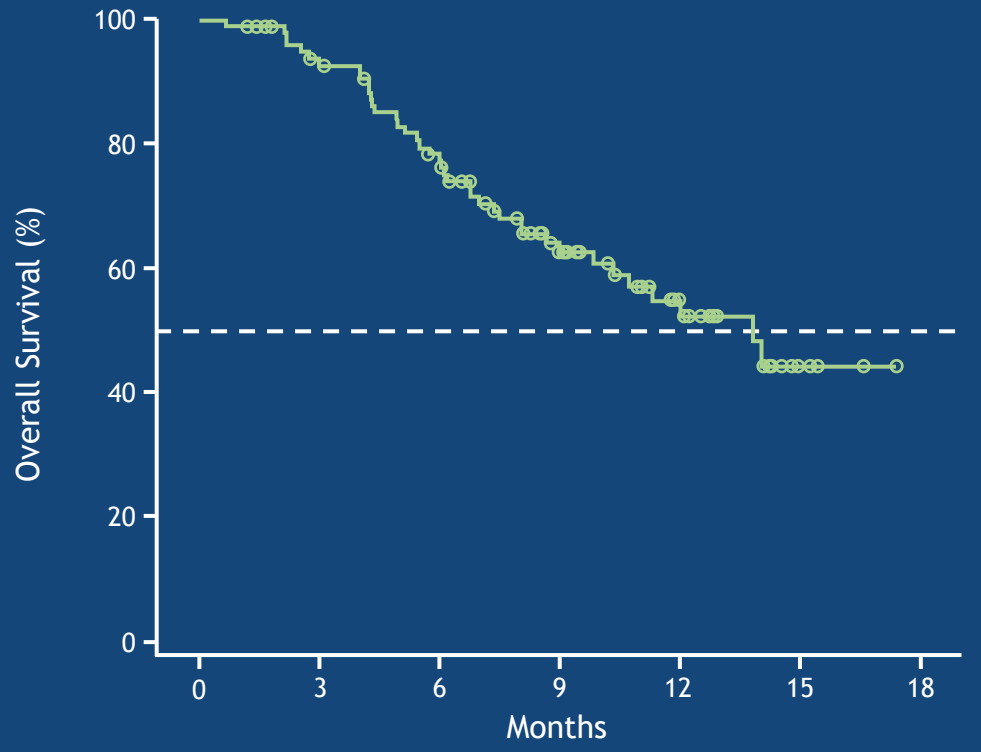
BLC2001: Progression-Free Survival ~6 Months Overall Survival > 1 Year

Median PFS = 5.5 months (95% CI, 4.2-6.0)
Progression/death events = 77



No. at risk	99	63	35	16	6	1	0

Median OS = 13.8 months (95% CI, 9.8-NE)
Survival events = 40



No. at risk	99	87	70	42	22	4	0

8 mg

Abbreviation: NE, not estimable.

Courtesy of Arlene Siefker-Radtke, MD

BLC2001: Most Common Treatment-Related AEs (TRAEs)

Reported in >20% of patients	8 mg continuous dose (n = 99)	
Patients with TRAEs, n (%)	**Any grade**	**Grade 3**
Hyperphosphatemia	72 (73)	2 (2)
Stomatitis	54 (55)	9 (9)
Dry mouth	43 (43)	0
Diarrhea	37 (37)	4 (4)
Dysgeusia	35 (35)	1 (1)
Dry skin	32 (32)	0
Alopecia	27 (27)	0
Decreased appetite	25 (25)	0
Hand-foot syndrome	22 (22)	5 (5)
Fatigue	21 (21)	2 (2)

Most were grade 1 or 2

There were no grade 4 or 5 TRAEs

Serious TRAEs were reported in 9 patients (9%); none was reported in more than 1 patient

Courtesy of Arlene Siefker-Radtke, MD

BLC2001: TRAEs of Clinical Importance or Special Interest

	8 mg continuous dose (n = 99)	
Patients with AEs, n (%)	**Any grade**	**Grade ≥ 3**
Hyperphosphatemia	72 (73)	2 (2)
Skin events	48 (49)	6 (6)
Dry skin	32 (32)	0 (0)
Hand-foot syndrome	22 (22)	5 (5)
Nail events	51 (52)	14 (14)
Onycholysis	16 (16)	2 (2)
Paronychia	14 (14)	3 (3)
Nail Dystrophy	16 (16)	6 (6)
Central serous retinopathy (CSR)	21 (21)	3 (3)
Non-CSR ocular events[a]	51 (52)	5 (5)

[a]Most common non-CSR ocular events included dry eye (19%), blurry vision (16%), increased lacrimation (11%), and conjunctivitis (9%).

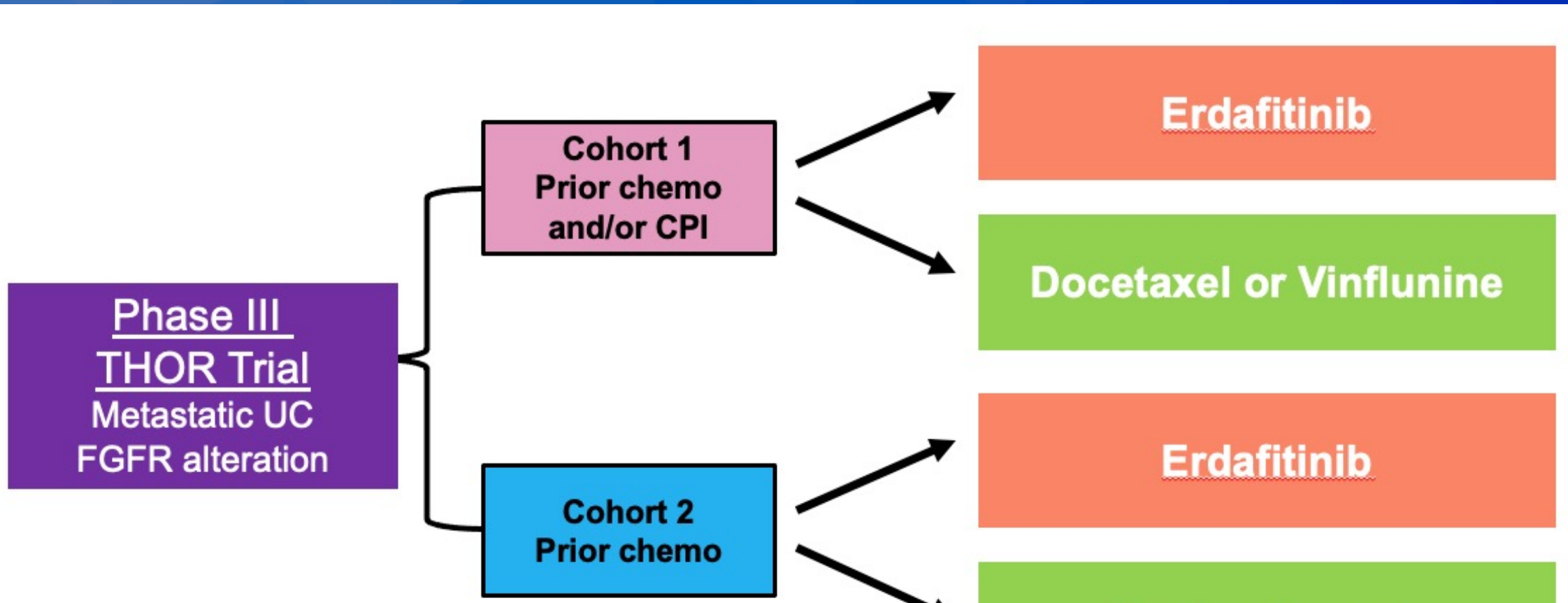
- Majority of events were grade 1/2
- Few patients (n = 7) discontinued because of AEs of special interest
- All AEs of special interest were managed with supportive therapies, dose interruption, and/or modification
- CSR is a known class effect of inhibitors of the MAPK pathway[1,2]
- Patients were routinely monitored
- CSR rarely led to discontinuation (n = 3), and no patient had retinal vein or artery occlusion

Abbreviation: MAPK, mitogen activated protein kinase.

1. Renouf DJ, et al. *J Clin Oncol*. 2012;30:3277-3286
2. Stjepanovic N, et al. *Ann Oncol*. 2016;27:998-1005.

Courtesy of Arlene Siefker-Radtke, MD

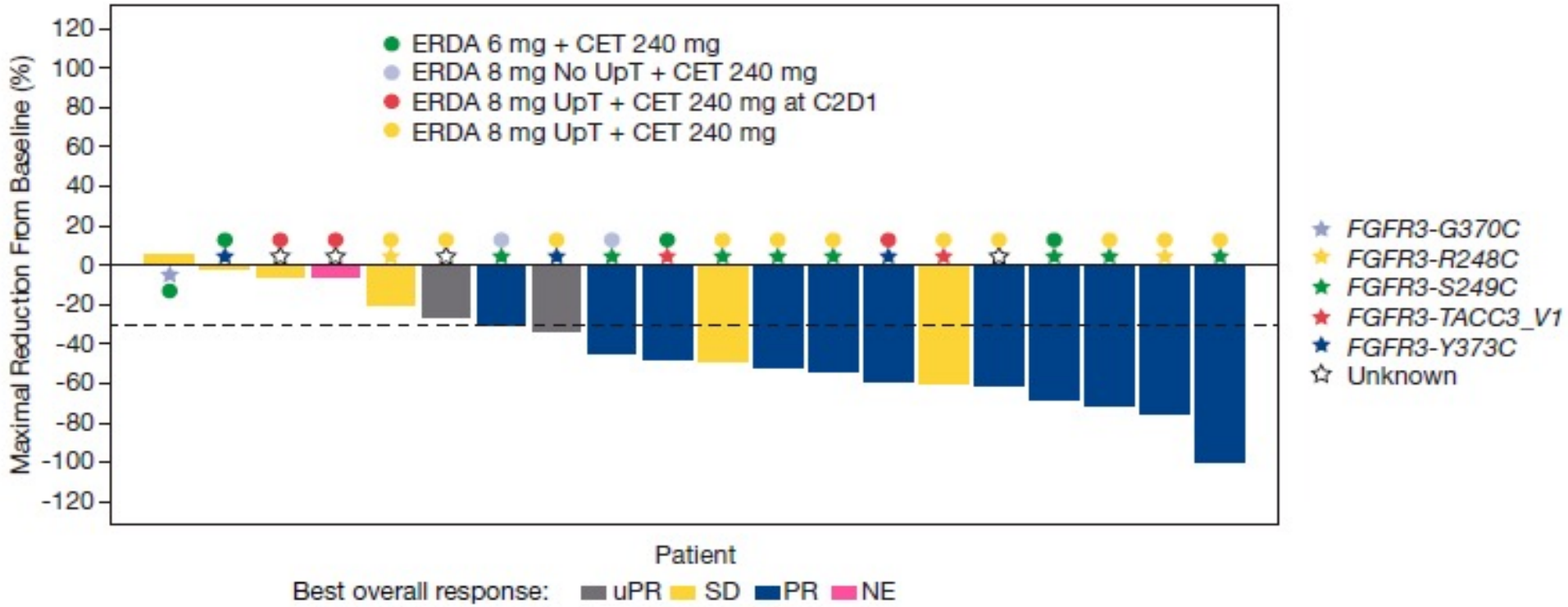
Ongoing Phase III THOR Trial Design



Primary endpoint: Overall survival
Secondary endpoints include progression-free survival, response, safety, change in disease severity and quality of life

Phase 1 Erdafitinib with Cetrelimab

Figure 2. Maximal Percentage Reduction of Sum of Target Lesion Diameters From Baseline[a]



[a]Safety analysis population; for a response to qualify as SD, follow-up measurements must have met the SD criteria at least once at a minimum interval not less than 6 weeks after the first dose of study drug. 1 patient was not response evaluable as they did not have measurable disease at baseline, and therefore this patient was excluded from the analysis for response. As of the time of data cutoff, 1 other patient did not have a subsequent on-study tumor assessment. To be counted as a PR, a second scan to confirm response was required.
NE, not evaluable.

Courtesy of Arlene Siefker-Radtke, MD

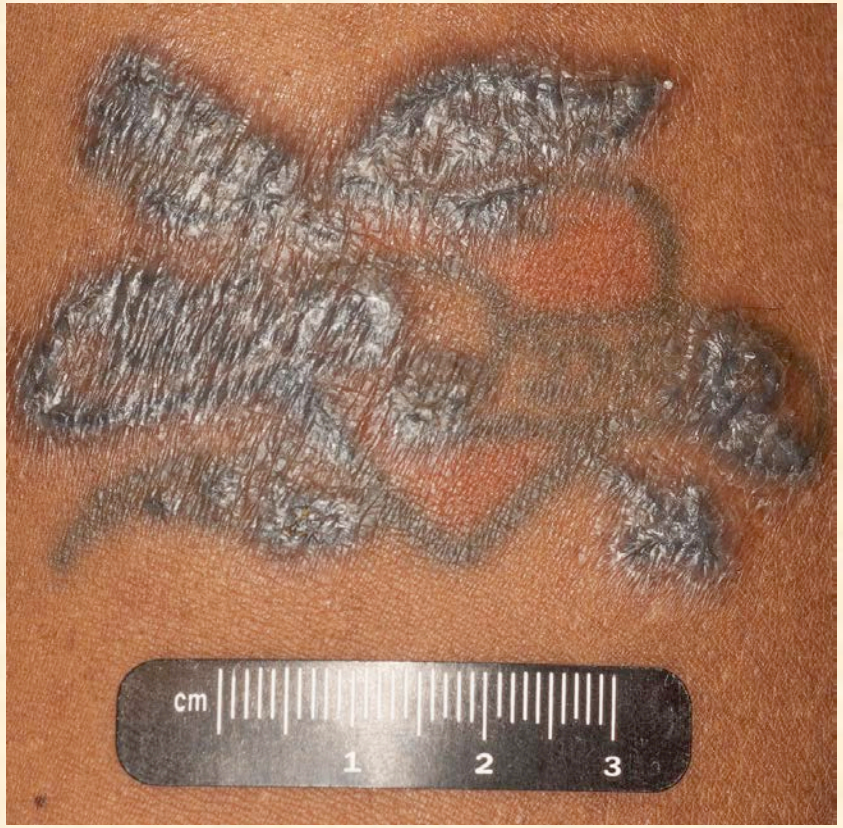
Siefker-Radtke et al. ESMO 2020

Case Presentation – Dr Siefker-Radtke: A 52-year-old man with metastatic urothelial carcinoma of the renal pelvis

- A 52 year old police officer presents with a metastatic urothelial carcinoma of the renal pelvis. He has failed prior therapy with DDMVAC, and gemcitabine with paclitaxel and doxorubicin. He enrolled on a clinical trial of ipilimumab (x4 doses), with concurrent nivolumab (continuous until progression). After 2 cycles of therapy, he develops some nodularity/flaking around his tattoo, and some papules on the skin.

Courtesy of Arlene Siefker-Radtke, MD

Case Presentation – Dr Siefker-Radtke: A 52-year-old man with metastatic urothelial carcinoma of the renal pelvis (continued)



A biopsy of his skin showed evidence of sarcoid. He was started on oral hydroxychloroquine. His immunotherapy was held with a return visit for restaging to evaluate further.

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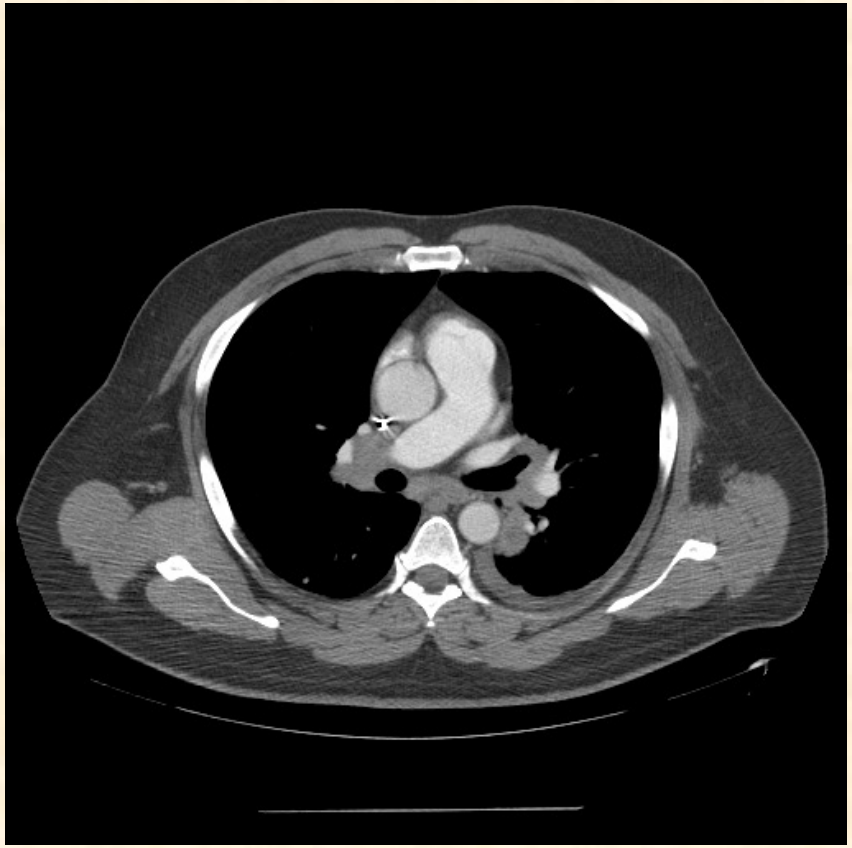
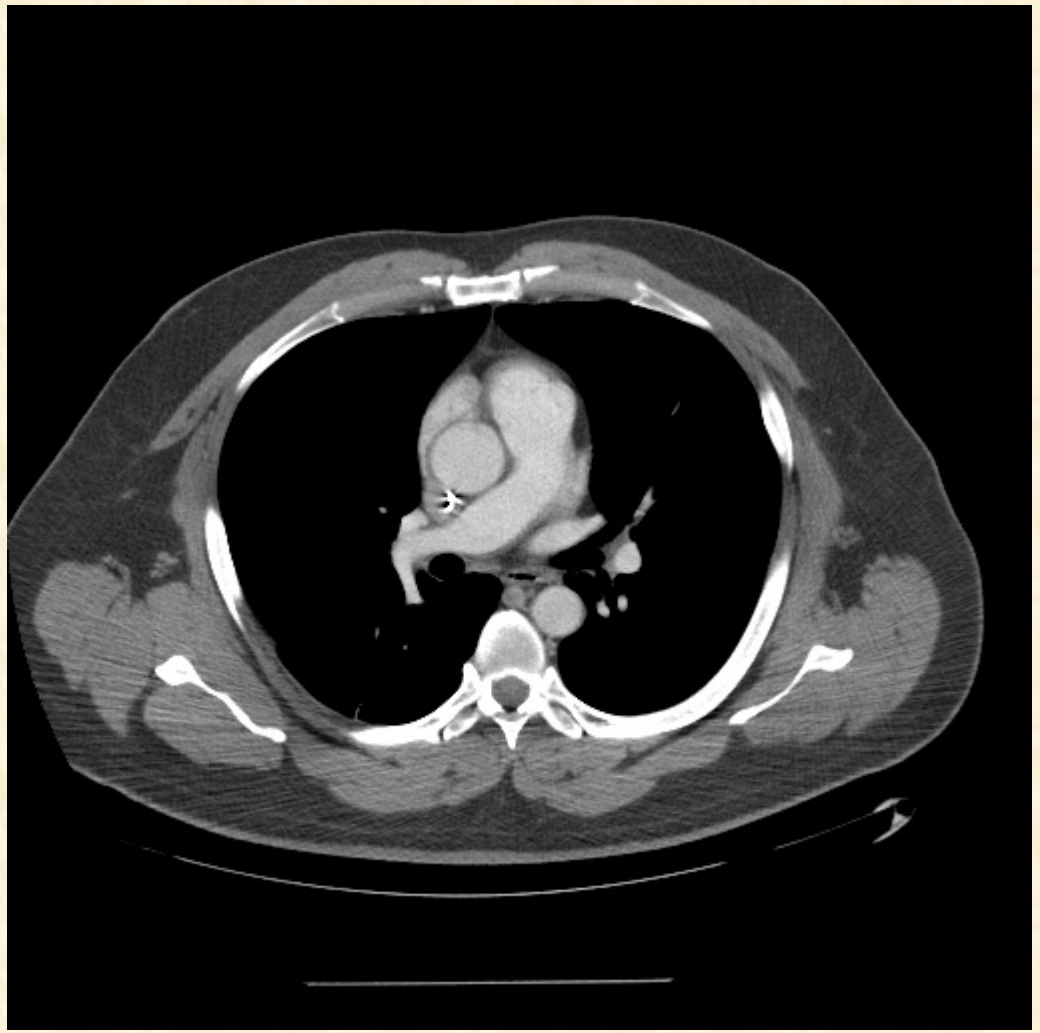


The patient returned reporting “bumps” on his legs, and achy joints (hands and knees). His restaging scans show progressive disease, including in the bed of resection.

Courtesy of Arlene Siefker-Radtke, MD

Case Presentation – Dr Siefker-Radtke: A 52-year-old man with metastatic urothelial carcinoma of the renal pelvis (continued)

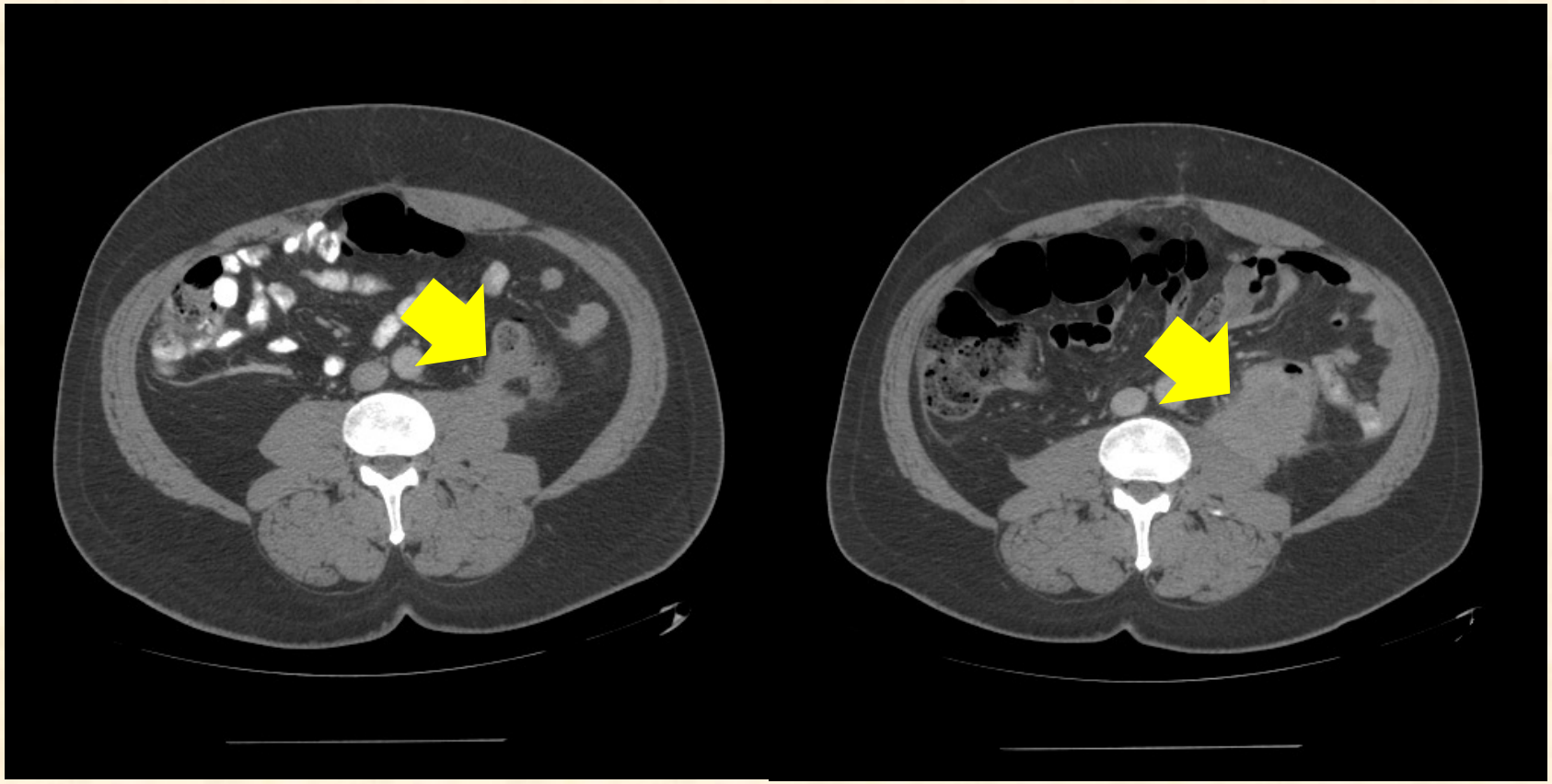
Loefgren's syndrome is a triad of perihilar nodes, erythema nodosum, and polyarthritis, seen with systemic sarcoidosis. A biopsy of a perihilar node confirmed sarcoid. He was started on IV methylprednisolone 1 mg/kg bid with resolution of his symptoms followed by a prednisone taper over 6 weeks. His perihilar nodes resolved.



Courtesy of Arlene Siefker-Radtke, MD

Kim, Siefker et al. BMJ 2016

Case Presentation – Dr Siefker-Radtke: A 52-year-old man with metastatic urothelial carcinoma of the renal pelvis (continued)



This patient also had an FGFR3 S249C mutation. He, along with 5 other patients with known FGFR3 mutations all progressed at the earliest time points on immunotherapy.

Courtesy of Arlene Siefker-Radtke, MD

Case Presentation – Dr Siefker-Radtke: A 65-year-old man with muscle-invasive bladder cancer

A 65 year old man was diagnosed with a cT2N0 bladder cancer, treated with neoadjuvant chemotherapy with DDMVAC in 12/2018, and had pT3bN+ disease at surgery. In 7/2019, his CT images show evidence of rapidly progressive disease with extensive liver metastases. His creatinine clearance is 45 ml/min. Mutation testing confirms an FGFR3 S249C mutation.

Courtesy of Arlene Siefker-Radtke, MD

Case Presentation – Dr Siefker-Radtke: A 65-year-old man with muscle-invasive bladder cancer (continued)

He starts treatment with erdafitinib at 8 mg po daily, and is uptitrated to 9 mg po daily based on a day 15 phosphorous level of 5.4 mg/dL. Prior to his 3rd cycle, he calls your office reporting intermittent blurry vision that comes and goes throughout the day in addition to dry eyes.

Courtesy of Arlene Siefker-Radtke, MD

Case Presentation – Dr Siefker-Radtke: A 65-year-old man with muscle-invasive bladder cancer (continued)

His blurry vision improves when he blinks. The artificial tears help with his dry eyes and the mucous. He continues on erdafitinib 9 mg po daily.

C4D8, he calls your office reporting blurred vision that does not improve with the artificial tears. He has noted wavy lines on the Amsler grid that he has kept on his refrigerator.

Courtesy of Arlene Siefker-Radtke, MD

Agenda

Module 1: Treatment of Metastatic Urothelial Bladder Cancer (mUBC) – Third Line and Beyond

Part 1: Antibody-Drug Conjugates

- Enfortumab vedotin (EV) for progressive mUBC; potential clinical role in combination with pembrolizumab
- TROPHY U-01: Sacituzumab govitecan for progressive mUBC; recent FDA approval
- Incidence, severity and management of adverse events with EV and sacituzumab govitecan
- Faculty cases

Part 2: FGFR-Targeted Therapies in Advanced UBC

- BLC2001: Erdafitinib for patients with progressive mUBC with susceptible FGFR3 or FGFR2 alterations
- Incidence and severity of adverse events with erdafitinib; optimal monitoring and management strategies
- Ongoing studies evaluating erdafitinib alone or in combination with other systemic therapies in UBC
- Faculty cases

Module 2: Non-Muscle-Invasive Bladder Cancer; First- and Second-Line Therapy for mUBC

- Use of immunotherapy for BCG-refractory non-muscle-invasive bladder cancer
- Immunotherapy for mUBC: IMvigor130, DANUBE, JAVELIN Bladder 100
- Faculty cases

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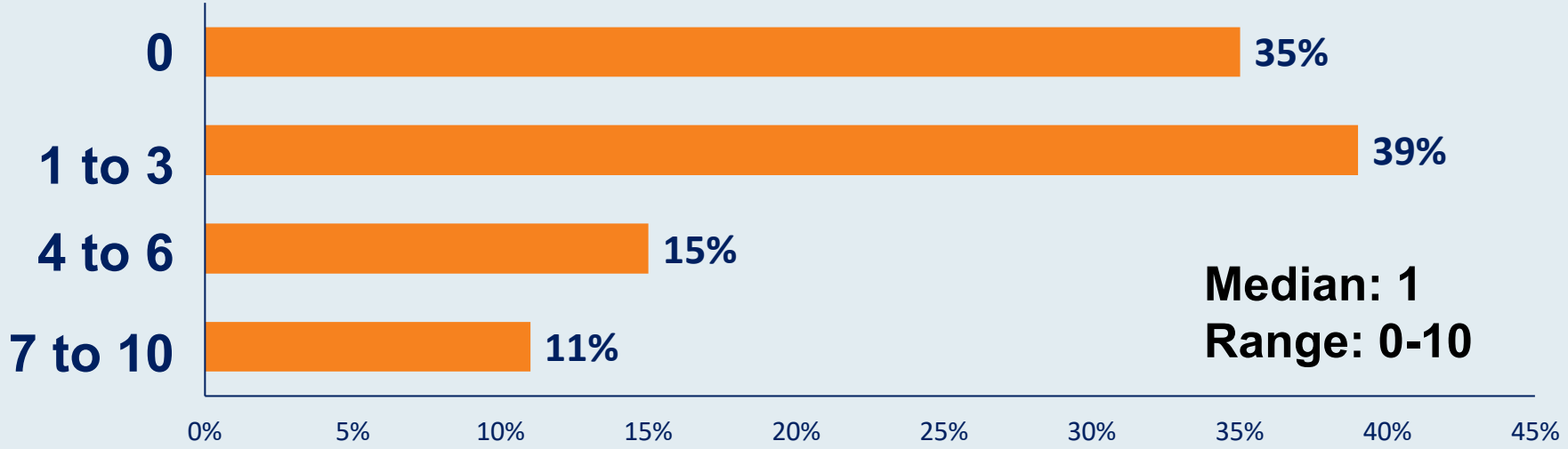
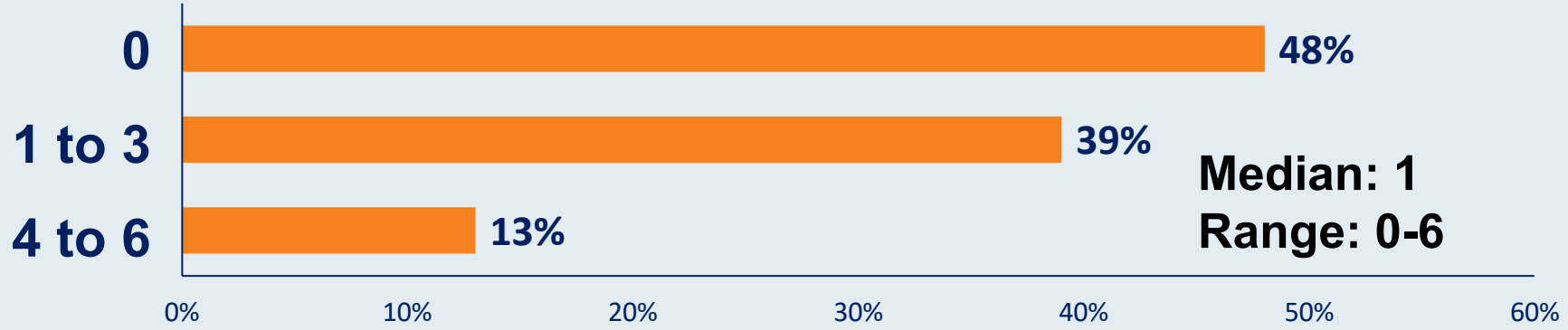
Approximately how many patients with BCG-unresponsive non-muscle-invasive UBC have you evaluated for treatment with pembrolizumab?



To approximately how many patients with BCG-unresponsive non-muscle-invasive UBC have you administered pembrolizumab?



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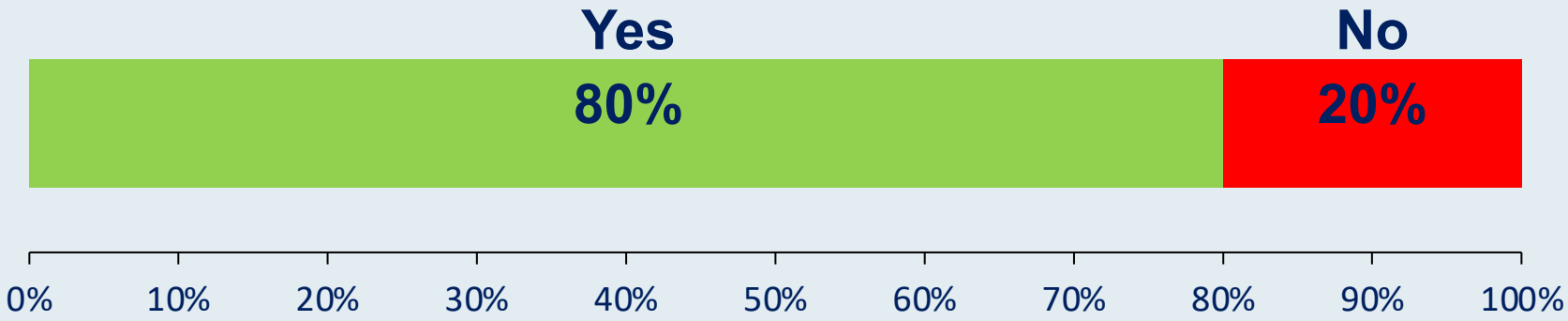
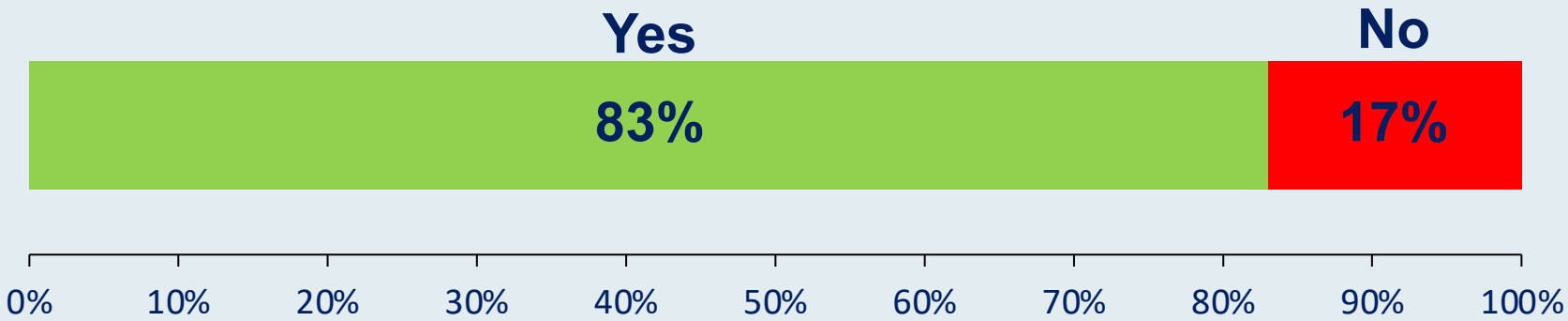
In general, would you recommend pembrolizumab to a patient with BCG-unresponsive non-muscle-invasive UBC in the following clinical situations?

A patient in their 70s who is otherwise healthy and prefers not to undergo cystectomy



A patient who is elderly or who has significant comorbidities who is not a candidate for cystectomy



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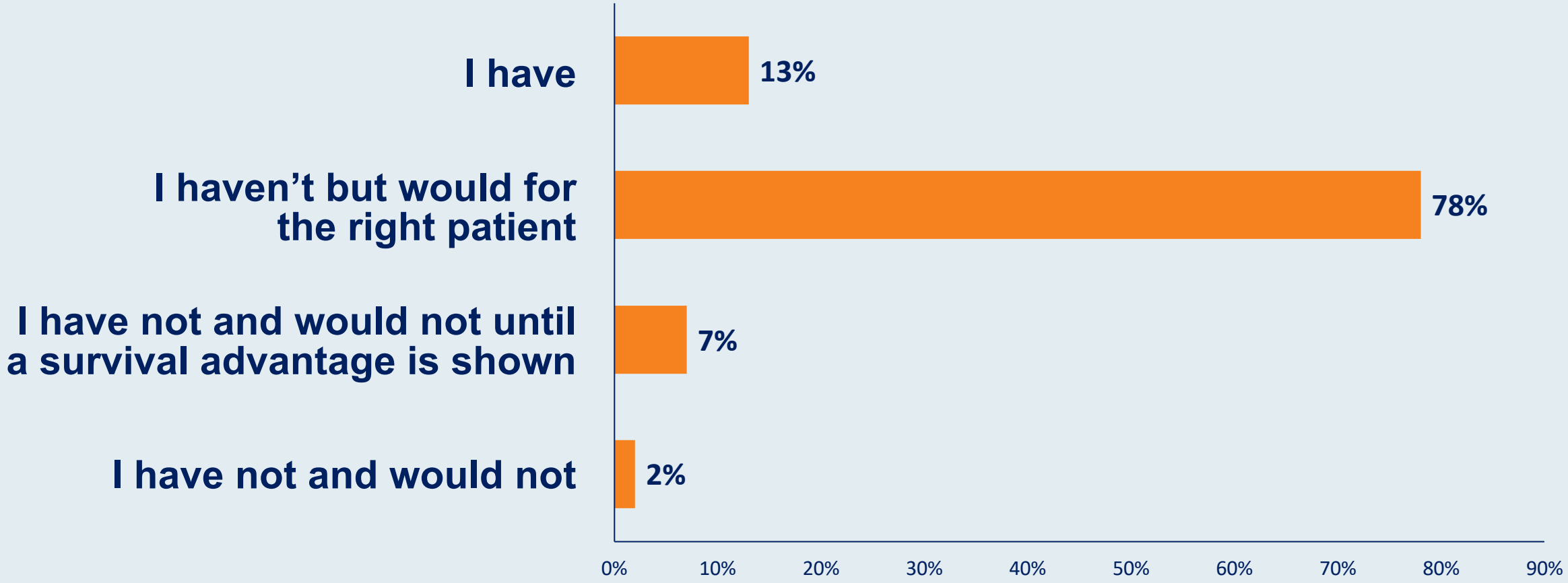
Have you or would you use adjuvant nivolumab after cystectomy for a patient with high-risk muscle-invasive bladder cancer?



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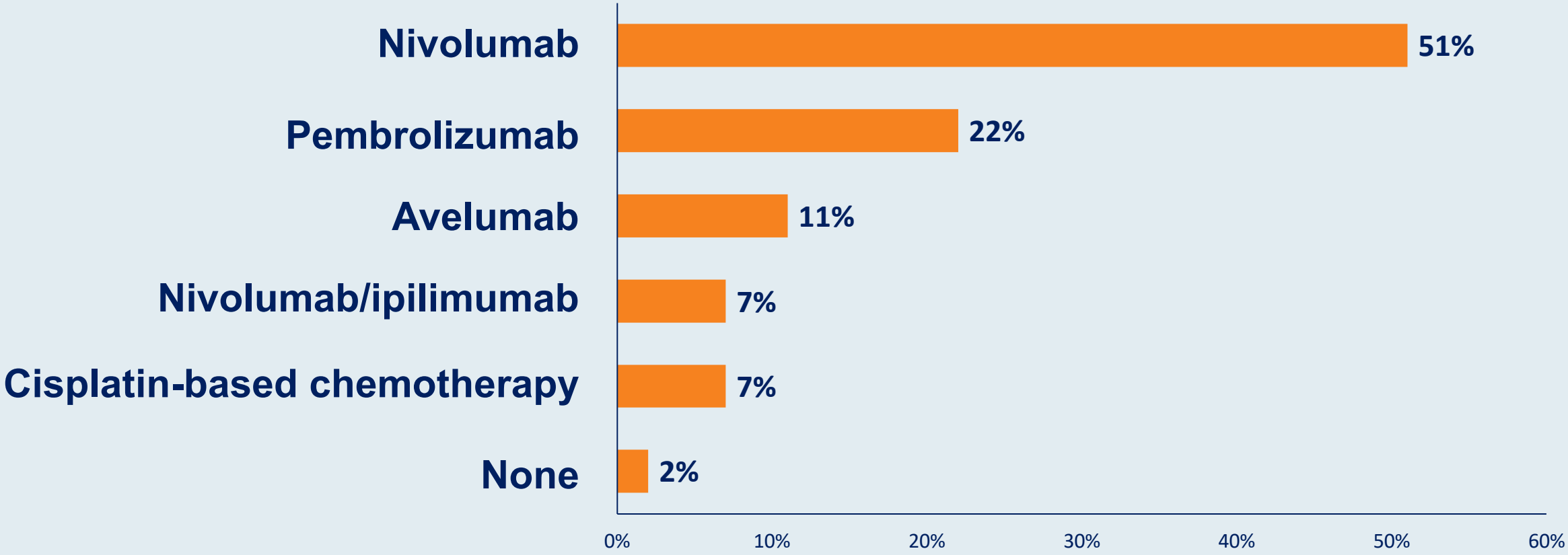
RTP RESEARCH TO PRACTICE

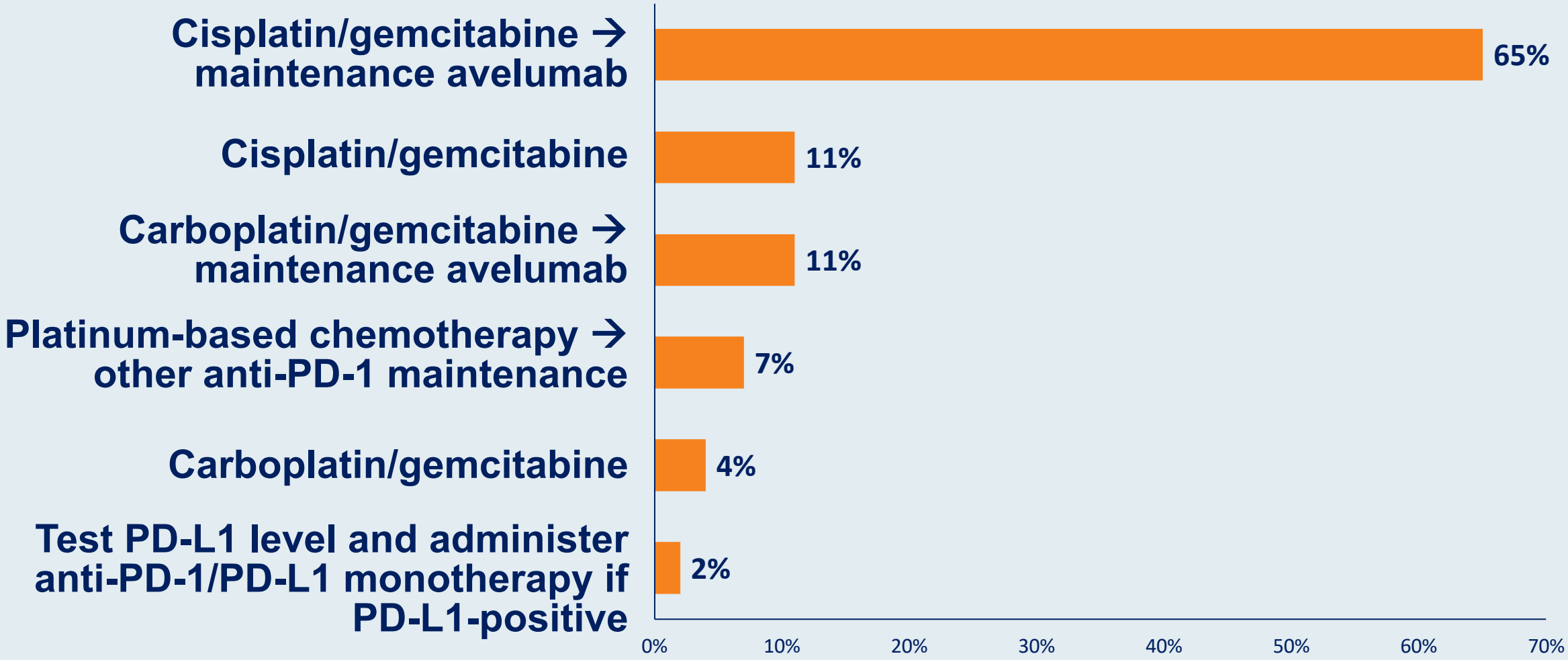
A 65-year-old man receives neoadjuvant dose-dense MVAC for muscle-invasive UBC and undergoes cystectomy, which reveals significant residual disease and a positive pelvic lymph node. PD-L1 = 80%. Regulatory and reimbursement issues aside, what adjuvant systemic therapy, if any, would you recommend?



Premeeting survey: July 2021

RTP RESEARCH TO PRACTICE

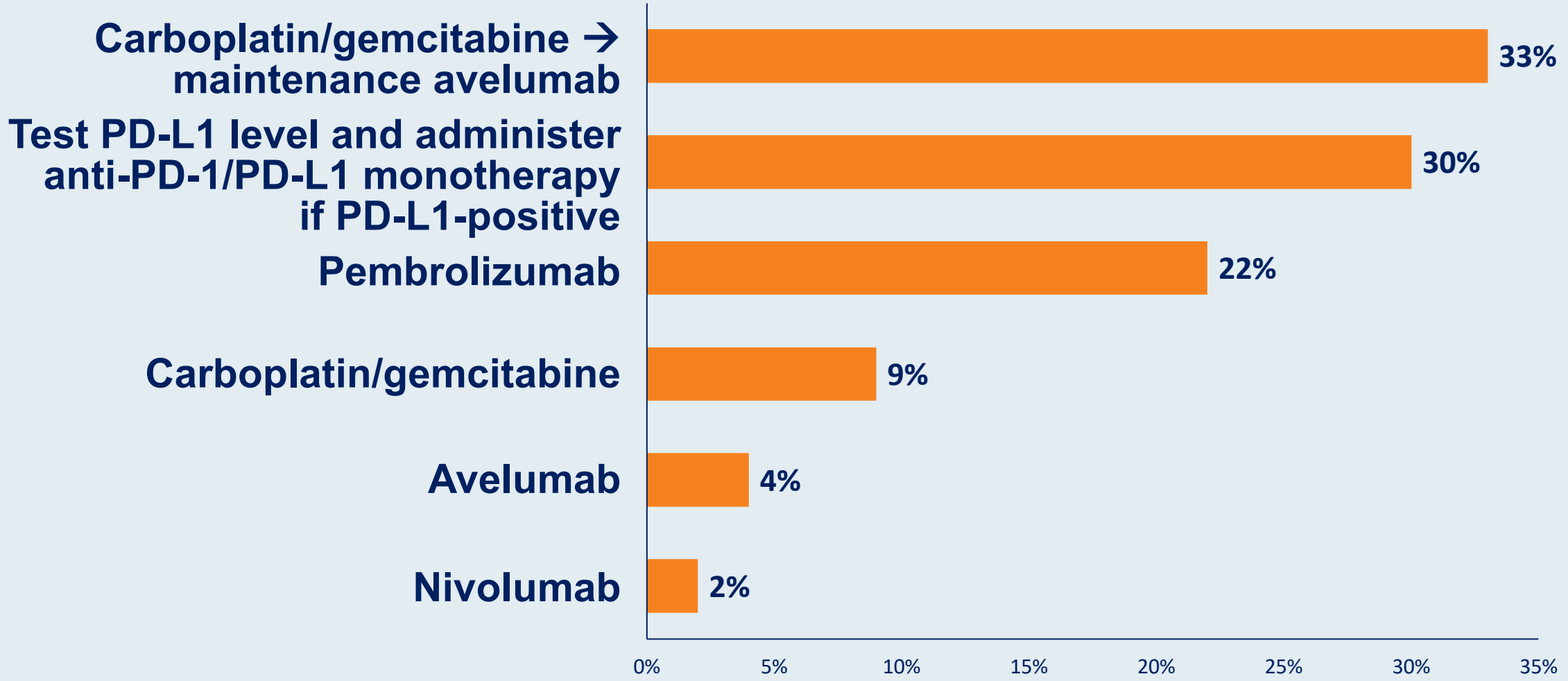
What would be your preferred first-line treatment regimen for a 65-year-old patient with metastatic UBC (mUBC)?



Premeeting survey: July 2021

RTP RESEARCH TO PRACTICE

What would be your preferred first-line treatment regimen for an 80-year-old patient with mUBC who is not a candidate for cisplatin-based chemotherapy?



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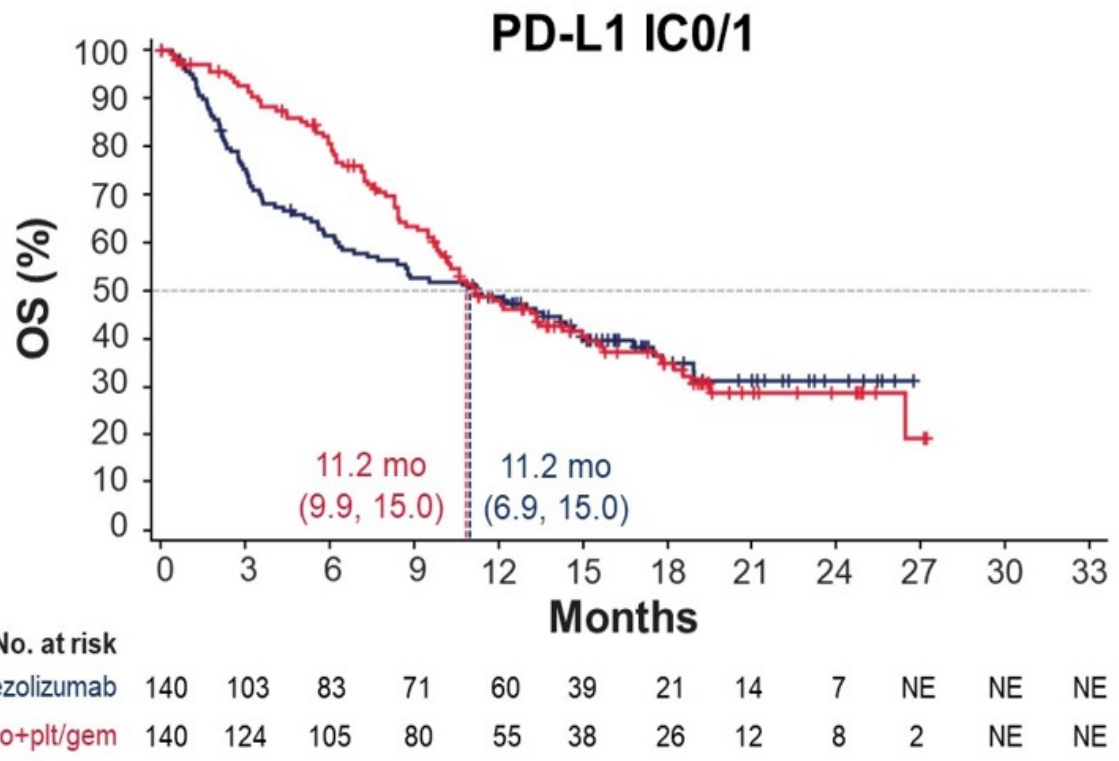
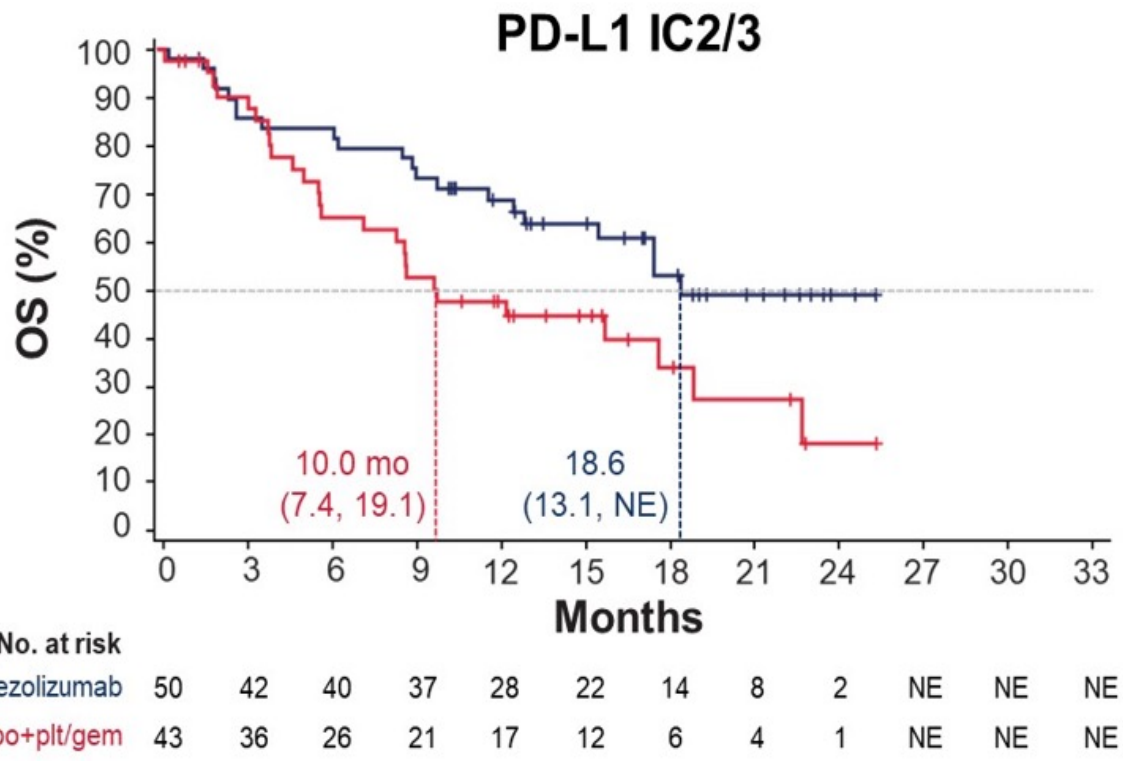
Interim OS by PD-L1 status (cisplatin-ineligible patients) IMvigor130



No. at risk												
Atezolizumab	140	103	83	71	60	39	21	14	7	NE	NE	NE
Placebo+plt/gem	140	124	105	80	55	38	26	12	8	2	NE	NE

	Atezolizumab (Arm B) (n=140)	Placebo + plt/gem (Arm C) (n=140)
OS events	85	85
OS HR (95% CI)	1.11 (0.82, 1.51)	
ORR (95% CI), %[a]	16 (10, 23)	42 (34, 51)



No. at risk												
Atezolizumab	50	42	40	37	28	22	14	8	2	NE	NE	NE
Placebo+plt/gem	43	36	26	21	17	12	6	4	1	NE	NE	NE

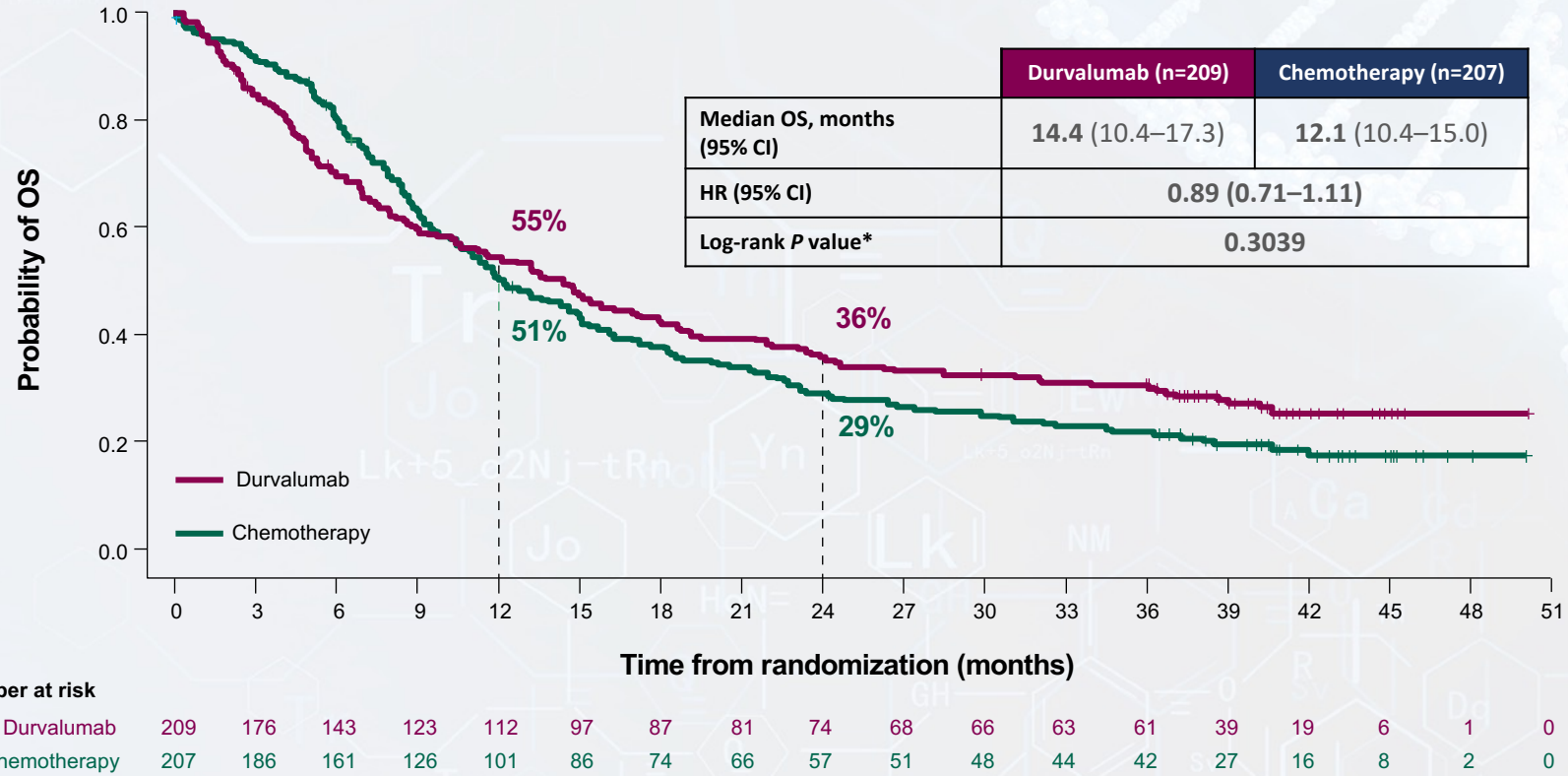
	Atezolizumab (Arm B) (n=50)	Placebo + plt/gem (Arm C) (n=43)
OS events	21	26
OS HR (95% CI)	0.53 (0.30, 0.94)	
ORR (95% CI), %	38 (25, 53)	33 (19, 49)

PD-L1–expressing immune cells covering ≥5% (IC2/3) or <5% (IC0/1) of the tumor area per VENTANA SP142 IHC assay. [a] For ORR, Arms B and C: n=139.

Courtesy of Petros Grivas, MD, PhD

Galsky MD, et al. Virtual poster presentation at ASCO GU 2021; abstract 434

DANUBE- Co-primary endpoint: OS with durvalumab vs chemotherapy in the PD-L1-high population[23]



	Durvalumab (n=209)	Chemotherapy (n=207)
Median OS, months (95% CI)	**14.4** (10.4–17.3)	**12.1** (10.4–15.0)
HR (95% CI)	0.89 (0.71–1.11)	
Log-rank *P* value*	0.3039	

Number at risk

Durvalumab	209	176	143	123	112	97	87	81	74	68	66	63	61	39	19	6	1	0
Chemotherapy	207	186	161	126	101	86	74	66	57	51	48	44	42	27	16	8	2	0

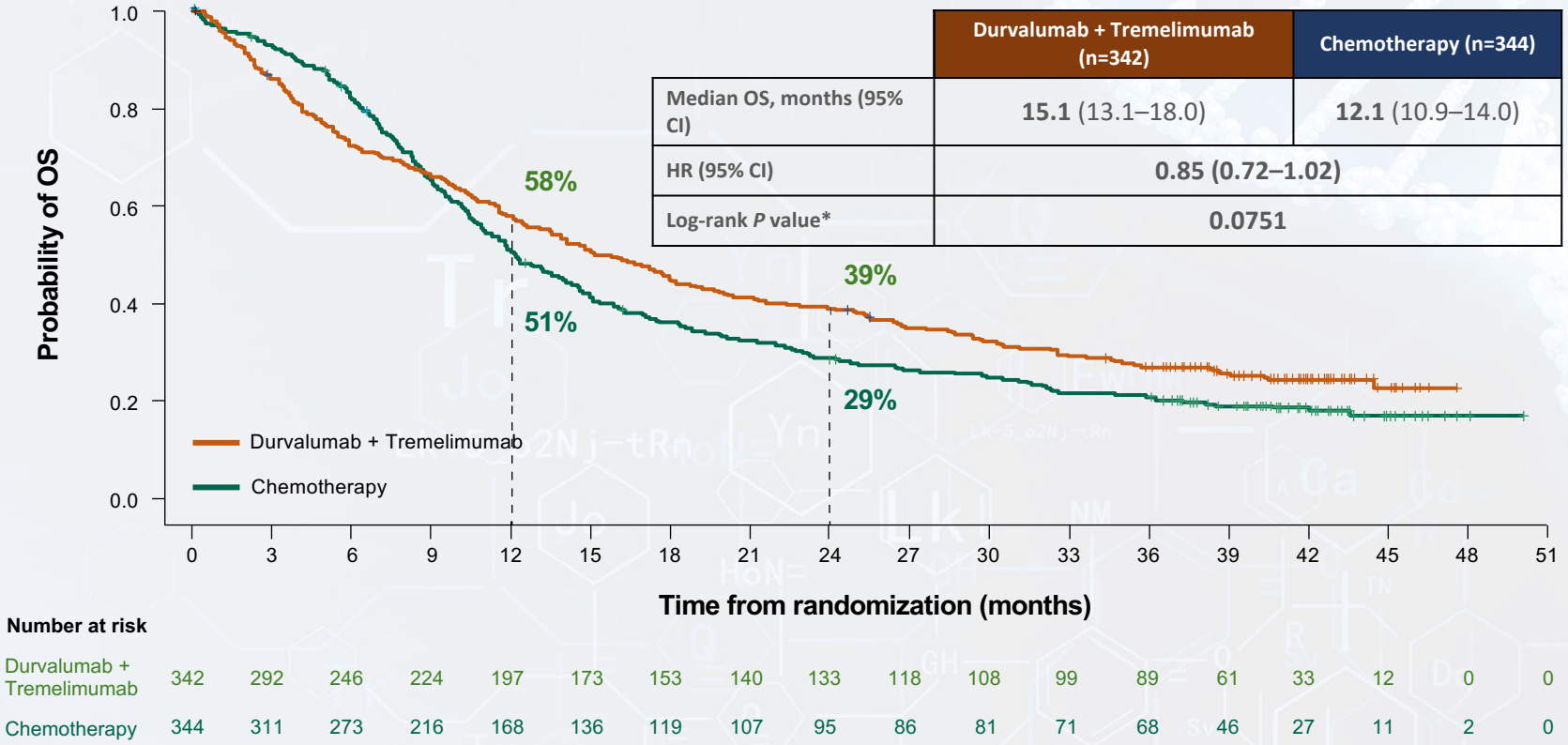
*Considered statistically significant if p<0.0301.

CI, confidence interval; HR, hazard ratio; OS, overall survival; PD-L1, programmed death-ligand 1.

23. Powles T, *et al.* Presented at ESMO 2020 697O.

Courtesy of Petros Grivas, MD, PhD

DANUBE- Co-primary endpoint: OS with durvalumab + tremelimumab vs chemotherapy in the ITT population[23]



	Durvalumab + Tremelimumab (n=342)	Chemotherapy (n=344)
Median OS, months (95% CI)	**15.1** (13.1–18.0)	**12.1** (10.9–14.0)
HR (95% CI)	**0.85 (0.72–1.02)**	
Log-rank *P* value*	**0.0751**	

Number at risk

Durvalumab + Tremelimumab	342	292	246	224	197	173	153	140	133	118	108	99	89	61	33	12	0	0
Chemotherapy	344	311	273	216	168	136	119	107	95	86	81	71	68	46	27	11	2	0

*Considered statistically significant if p<0.0301.

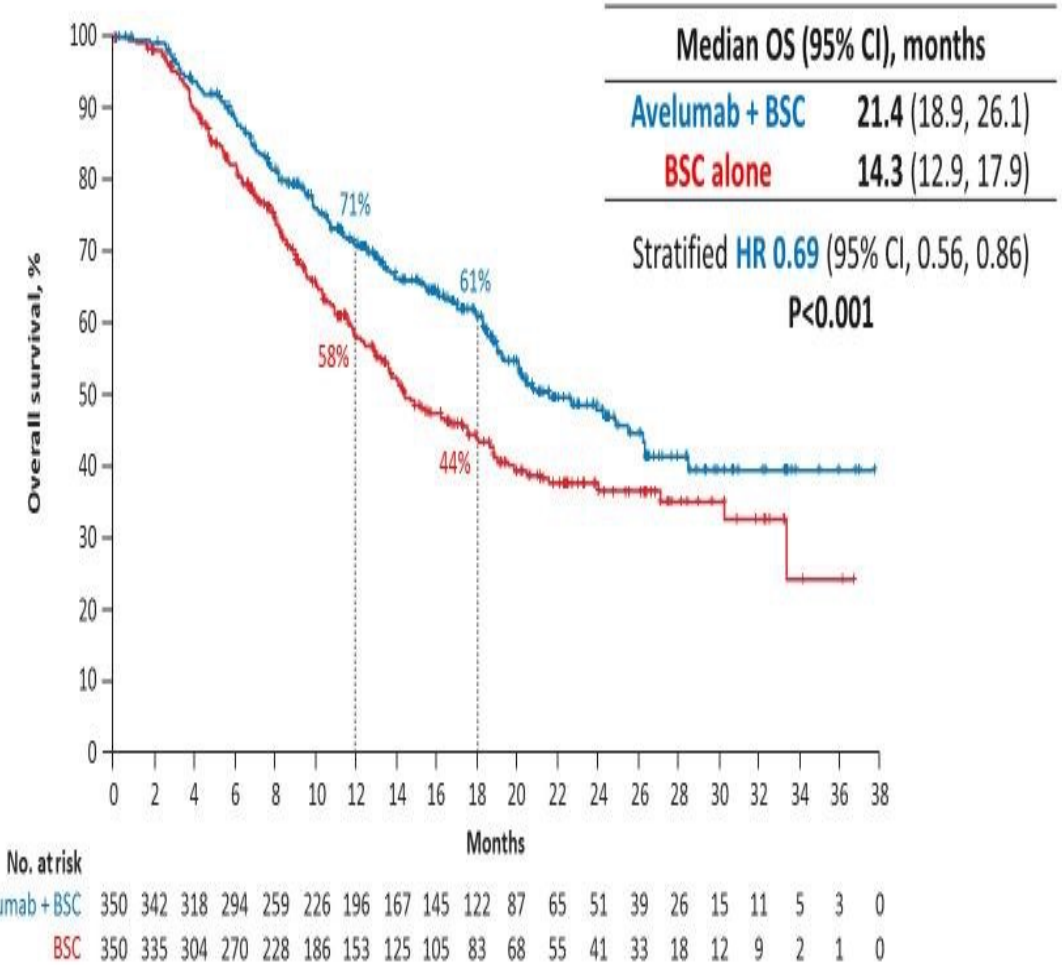
CI, confidence interval; HR, hazard ratio; ITT, intention-to-treat; OS, overall survival.

23. Powles T, *et al.* Presented at ESMO 2020 697O.

Courtesy of Petros Grivas, MD, PhD

JAVELIN Bladder 100

OS in the overall population



Median OS (95% CI), months	
Avelumab + BSC	**21.4** (18.9, 26.1)
BSC alone	**14.3** (12.9, 17.9)

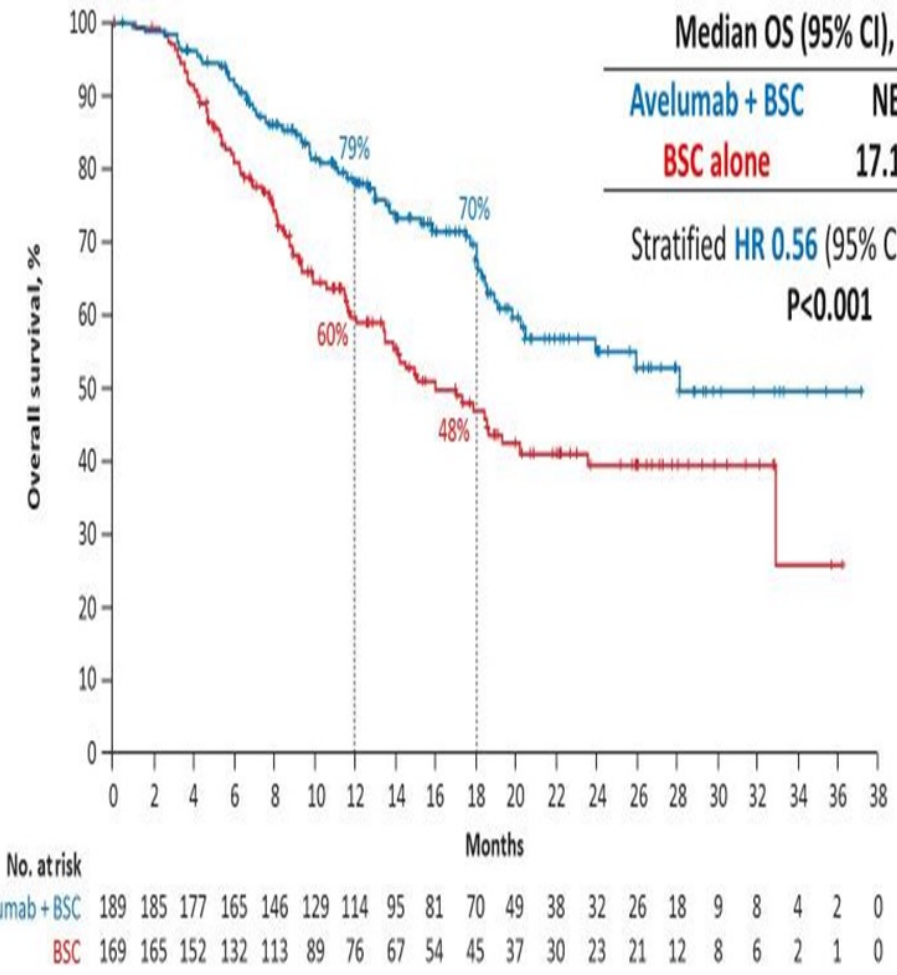
Stratified HR 0.69 (95% CI, 0.56, 0.86)

P<0.001

No. at risk																				
Avelumab + BSC	350	342	318	294	259	226	196	167	145	122	87	65	51	39	26	15	11	5	3	0
BSC	350	335	304	270	228	186	153	125	105	83	68	55	41	33	18	12	9	2	1	0

OS was measured post randomization (after chemotherapy); the OS analysis crossed the prespecified efficacy boundary based on the alpha-spending function (P<0.0053)

OS in the PD-L1+ population



Median OS (95% CI), months	
Avelumab + BSC	**NE** (20.3, NE)
BSC alone	**17.1** (13.5, 23.7)

Stratified HR 0.56 (95% CI, 0.40, 0.79)

P<0.001

No. at risk																				
Avelumab + BSC	189	185	177	165	146	129	114	95	81	70	49	38	32	26	18	9	8	4	2	0
BSC	169	165	152	132	113	89	76	67	54	45	37	30	23	21	12	8	6	2	1	0

OS was measured post randomization (after chemotherapy); the OS analysis crossed the prespecified efficacy boundary based on the alpha-spending function (P<0.0014). **NE**, not estimable

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Courtesy of Petros Grivas, MD, PhD

Treatment-emergent AEs (any causality)

	Avelumab + BSC (N=344)		BSC alone (N=345)	
	Any grade	Grade ≥3	Any grade	Grade ≥3
Any TEAE, %	**98.0**	**47.4**	**77.7**	**25.2**
Fatigue	17.7	1.7	7.0	0.6
Pruritus	17.2	0.3	1.7	0
UTI	17.2	4.4	10.4	2.6
Diarrhea	16.6	0.6	4.9	0.3
Arthralgia	16.3	0.6	5.5	0
Asthenia	16.3	0	5.5	1.2
Constipation	16.3	0.6	9.0	0
Back pain	16.0	1.2	9.9	2.3
Nausea	15.7	0.3	6.4	0.6
Pyrexia	14.8	0.3	3.5	0
Decreased appetite	13.7	0.3	6.7	0.6
Cough	12.8	0.3	4.6	0
Vomiting	12.5	1.2	3.5	0.6
Hypothyroidism	11.6	0.3	0.6	0
Rash	11.6	0.3	1.2	0
Anemia	11.3	3.8	6.7	2.9
Hematuria	10.5	1.7	10.7	1.4
IRR	10.2	0.9	0	0

- TEAEs led to discontinuation of avelumab in 11.9%
- Death was attributed by the investigator to study treatment toxicity in 2 patients (0.6%) in the avelumab + BSC arm
  - Due to sepsis (in Cycle 10) and ischemic stroke (100 days after a single dose of avelumab)

Table shows TEAEs of any grade occurring in ≥10% or grade ≥3 TEAEs occurring in ≥5% in either arm

AE, adverse event; **IRR**, infusion-related reaction; **TEAE**, treatment-emergent adverse event; **UTI**, urinary tract infection
Safety was assessed in all patients who received ≥1 dose of avelumab in the avelumab arm, or who completed the cycle 1 day 1 visit in the BSC arm (N=689)

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Courtesy of Petros Grivas, MD, PhD

	Atezolizumab[1]	Nivolumab[2]	Pembrolizumab[3]	Avelumab[4]	Durvalumab[5]
Phase	Phase III Randomized vs chemotherapy	Phase II Single Arm	Phase III Randomized vs Chemotherpay	Phase Ib	Phase I/II
Number of Patients	931	265	542	249 (161 pts ≥ 6 mos f/u)	191
Dosing	1200mg every 3 weeks	3mg/kg every 2 weeks	200mg every 3 weeks	10mg/kg every 2 weeks	10mg/kg every 2 weeks
ORR	13.4%	19.6%	21.1%	17%	17.8%
Duration of Response	63% of responses ongoing at median f/u of 21.7 mos	77% of responses ongoing at median f/u of 7 mos	72% of responses ongoing at median f/u of 14.1 mos	96% of responses ongoing at 6 mos f/u	50% of responses lasting ≥ 6 mos
Median OS	8.6 mos	8.7 mos	10.3 mos	6.5 mos	18.2 mos
Median PFS	2.1 mos	2.0 mos	2.1 mos	1.5 mos	1.5 mos
Rate of Grade 3/4 Treatment-related AEs	20%	18%	15%	8%	6.8%

1Powles T, et al. Lancet. 2018;391(10122):748-757.; 2Sharma P, et al. Lancet Oncol. 2017;18(3):312-322.; 3Bellmunt J, et al. N Engl J Med. 2017;376(11):1015-1026.; 4Patel MR, et al. Lancet Oncol. 2018;19(1):51-64.; 5Powles T, et al. JAMA Oncol. 2017;3(9):e172411

Courtesy of Petros Grivas, MD, PhD

Case Presentation – Dr Grivas: An 86-year-old man with BCG-unresponsive bladder cancer

- 86 yo man with PS ECOG 1, DM II, HTN, presented with hematuria; cystoscopy showed a small bladder tumor, TURBT showed Ta with adjacent CIS. CT CAP did not show extravesical disease or metastasis. He started intravesical BCG and received all 6 induction doses (CR on re-TURBT & urine cytology) with notable urinary urgency & frequency. Re-TURBT after 2 maintenance BCG doses showed recurrent CIS and 2 tumors both with Ta stage. He refused radical cystoprostatectomy despite counseling and wanted to consider other options:
- A. Clinical trial
- B. Intravesical docetaxel/gemcitabine
- C. Intravenous pembrolizumab

Courtesy of Petros Grivas, MD, PhD

Case Presentation – Dr Grivas: A 78-year-old man with localized muscle-invasive bladder cancer

- 78 yo man with CKD with GFR 35 ml/min, G3 hearing loss, ECOG PS 1 and localized muscle-invasive bladder cancer s/p radical cystoprostatectomy, pelvic lymph node dissection & urine diversion, path stage pT3N1.
- NGS testing from cystectomy tumor tissue revealed FGFR3 activating mutation. He recovered well after surgery and presents to discuss options:
- A. Clinical trial, e.g. AMBASSADOR or PROOF-302
- B. Observation

Courtesy of Petros Grivas, MD, PhD

Case Presentation – Dr Grivas: A 75-year-old woman with de novo metastatic UBC

- 75 yo woman with *de novo* metastatic urothelial cancer with enlarged pelvic & retroperitoneal lymph nodes & 2 small metastatic lesions in left lung.
- PS ECOG 1, HTN, hyperlipidemia, normal organ function, no hearing loss, neuropathy or autoimmune disease; GFR 60 ml/min;
- PD-L1 CPS 15 (22C3 Ab).
- She received 6 cycles of Gem/Cis with complete response on CT.
- What is the most appropriate next step? Switch maintenance avelumab?

Courtesy of Petros Grivas, MD, PhD

Meet The Professor

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

Thursday, July 22, 2021
5:00 PM – 6:00 PM ET

Faculty

David F McDermott, MD

Moderator

Neil Love, MD

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