Dr. Sindu Kanjeekal



Dr. Sindu Kanjeekal is a medical oncologist and hematologist practicing at the Windsor Regional Cancer Centre for the past 20 years.

She is Assistant Professor at the Schulich School of Medicine and Clinical Lecturer at the University of Windsor. She is passionate about the care of GU malignancies and her academic research has focused on molecular insights into bladder and prostate cancer.

As Chief of the Department of Oncology at Windsor Regional Hospital, she believes in the importance of trusting relationships among colleagues and is committed to the goal of providing world class cancer care close to home.

Bladder Cancer

Sindu Kanjeekal MD FRCPC
Medical Oncology/Hematology
Assistant Professor Schulich School of Medicine
Clinical Lecturer University of Windsor
Chief Department of Oncology

Presenter Disclosure

Relationships with financial sponsors:

- Grants/Research Support: N/A
- Speakers Bureau/Honoraria: Bristol Myers Squibb, Pfizer Novartis
- Consulting Fees: N/A
- Patents: N/A
- Advisory Boards: N/A

AI Disclosure:

- AI was used to create slides 25, 26 and 32

Objectives

- Current treatment paradigm for advanced bladder cancer
- Describe potential side effects of immunotherapy
- Evolving role of multidisciplinary care
- Highlight the Importance of early involvement of palliative care

Progression of non-invasive urothelial carcinoma to invasive cancer

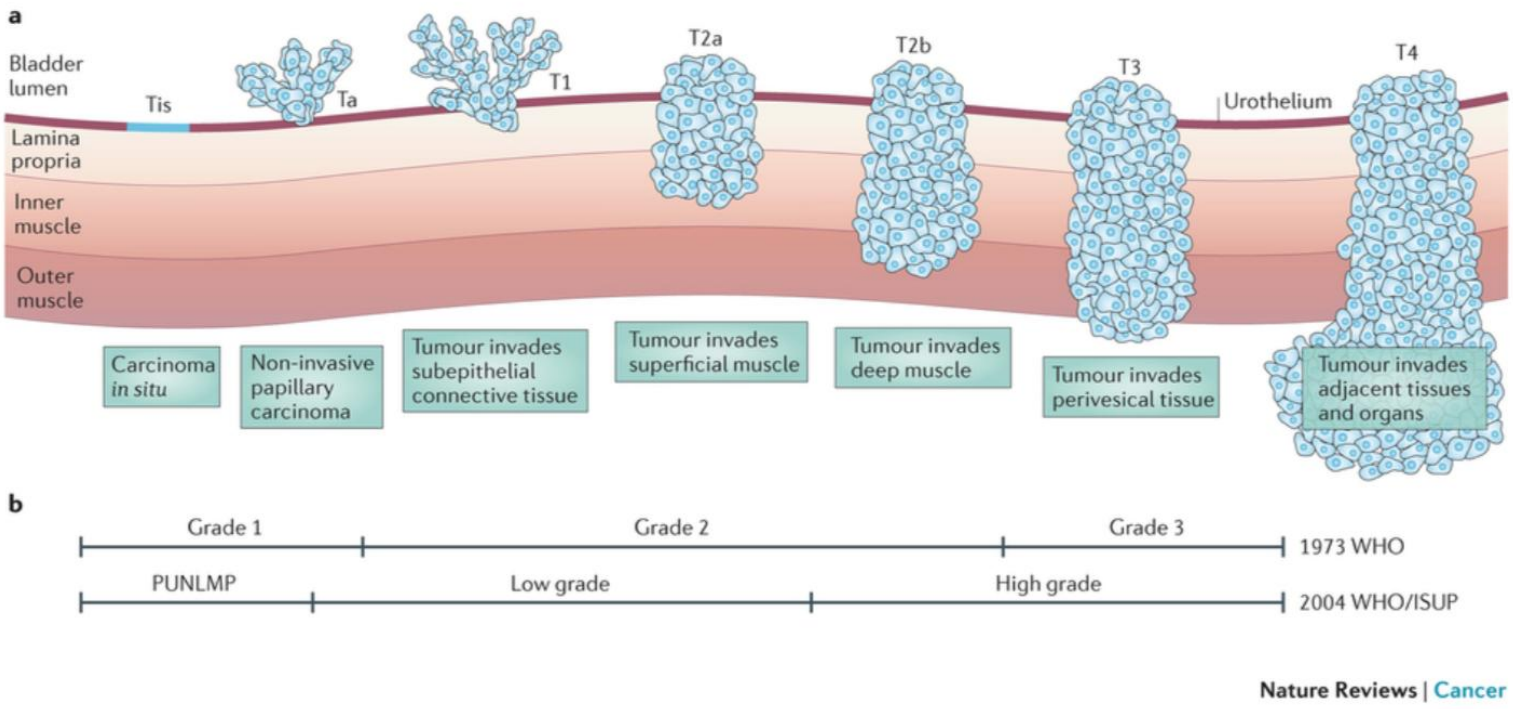
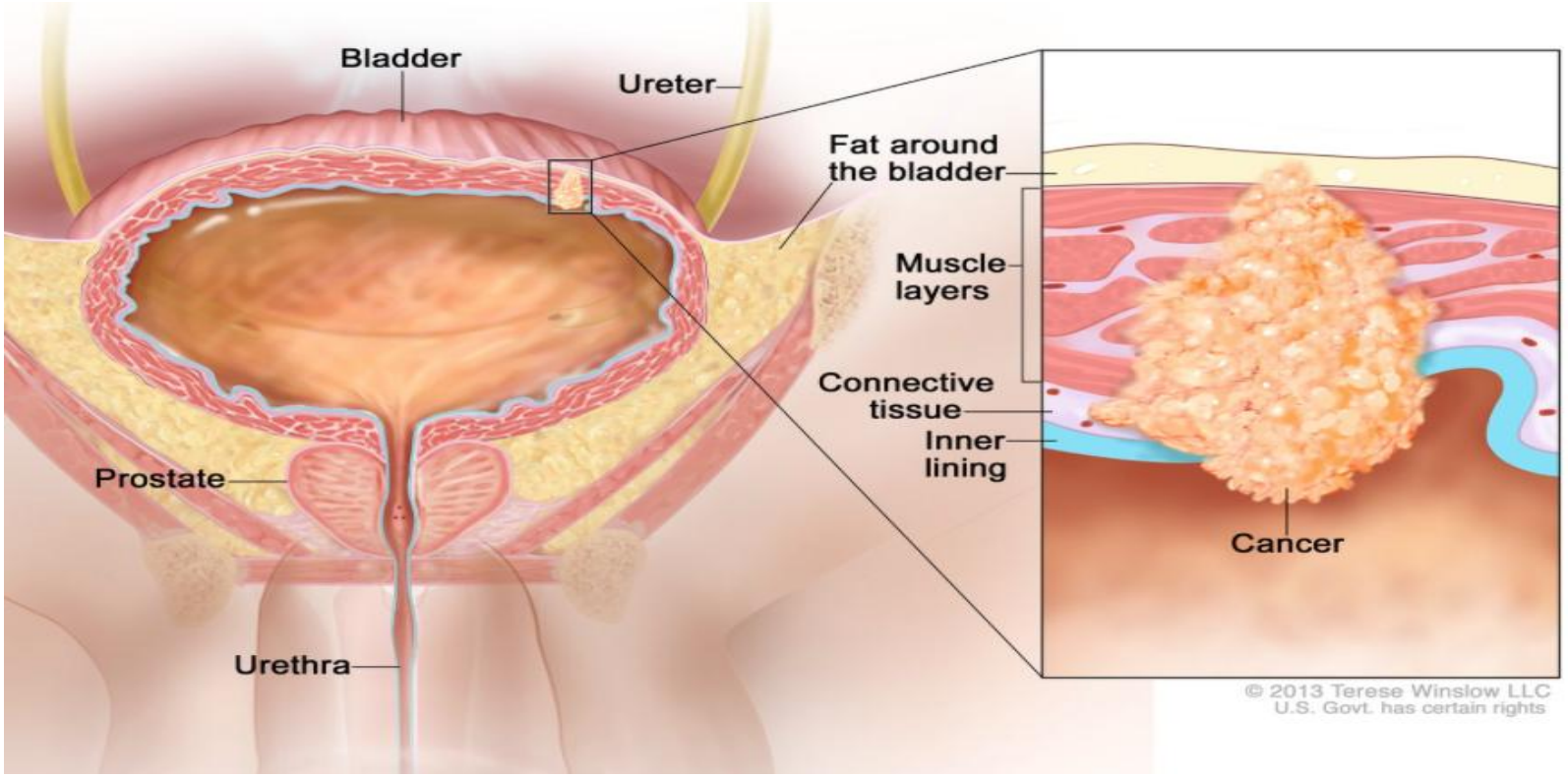
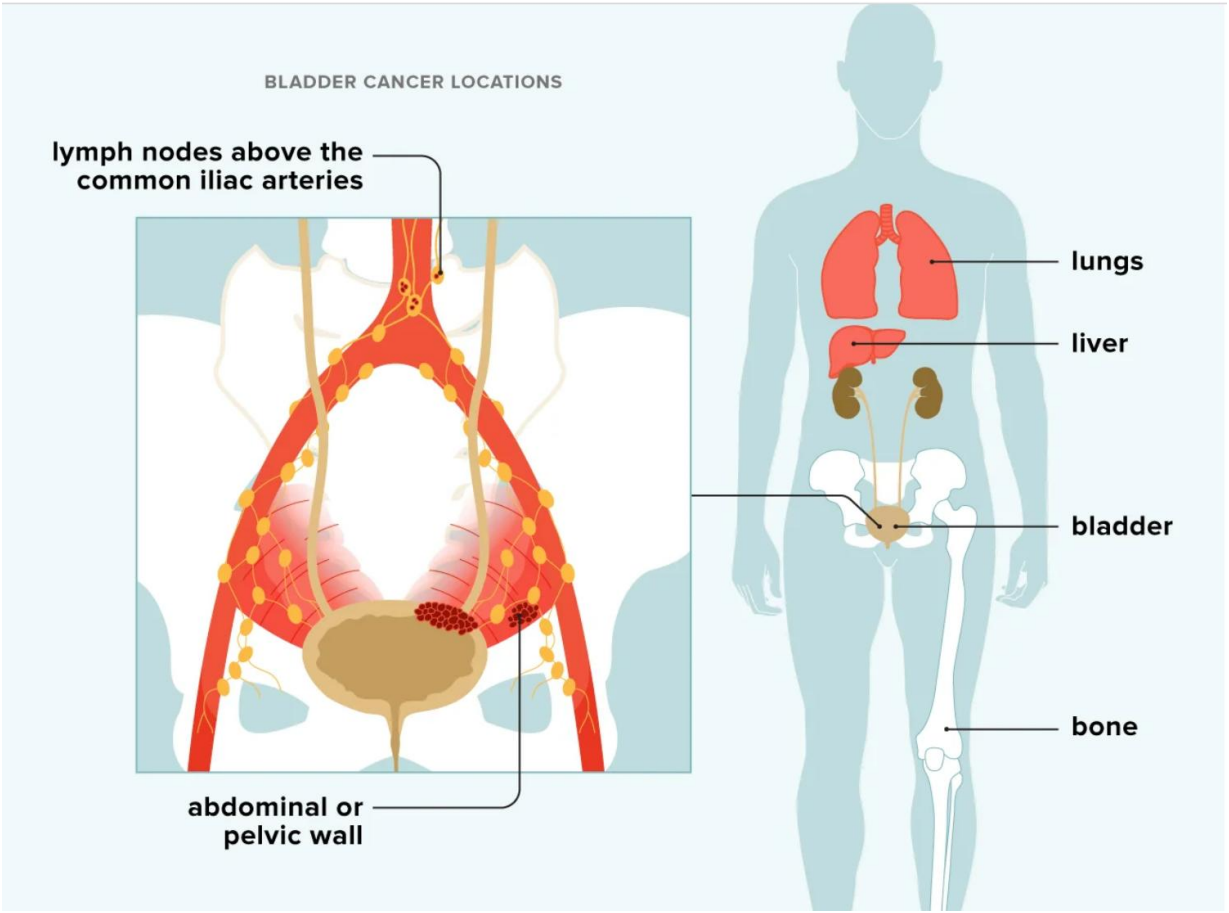


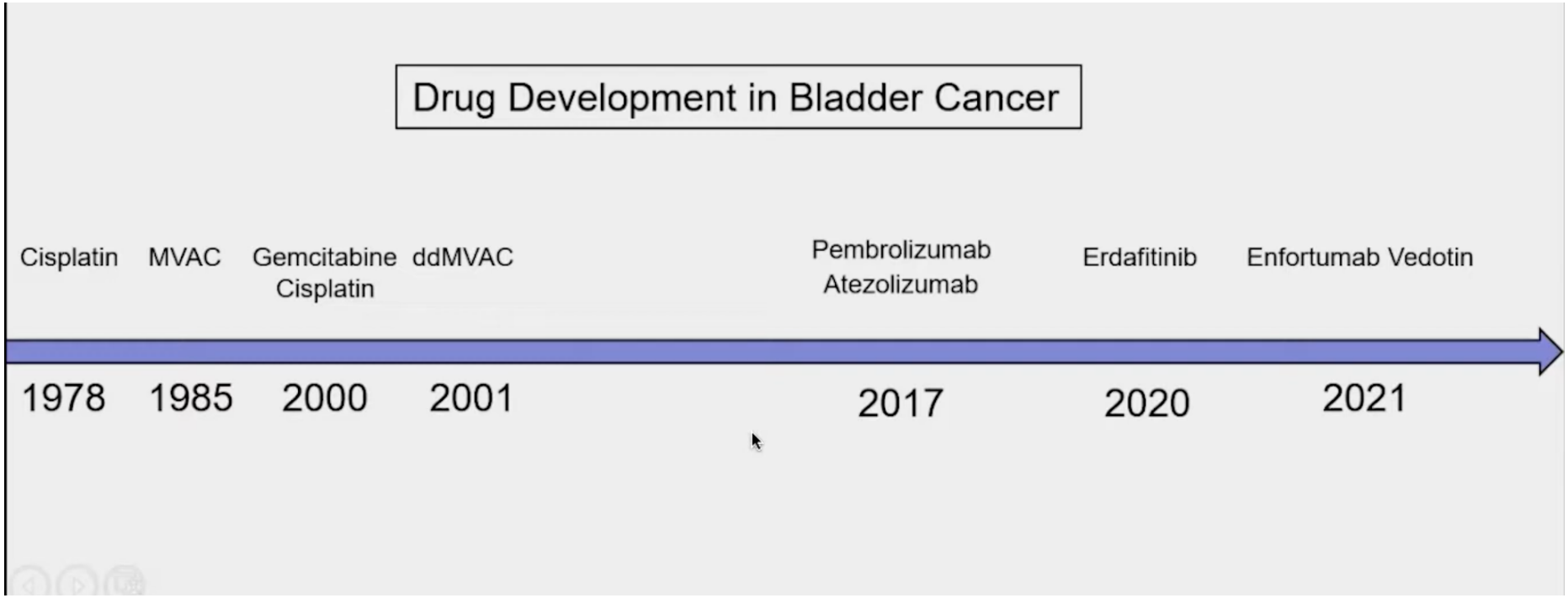
Figure 2. Schematic diagram illustrating bladder cancer progression (Knowles and Hurst (2015) *Nature Reviews Cancer* **15**, 25-41

Bladder cancer-Muscle Invasive





https://www.healthline.com/health/bladder-cancer/does-bladder-cancer-spread-quickly

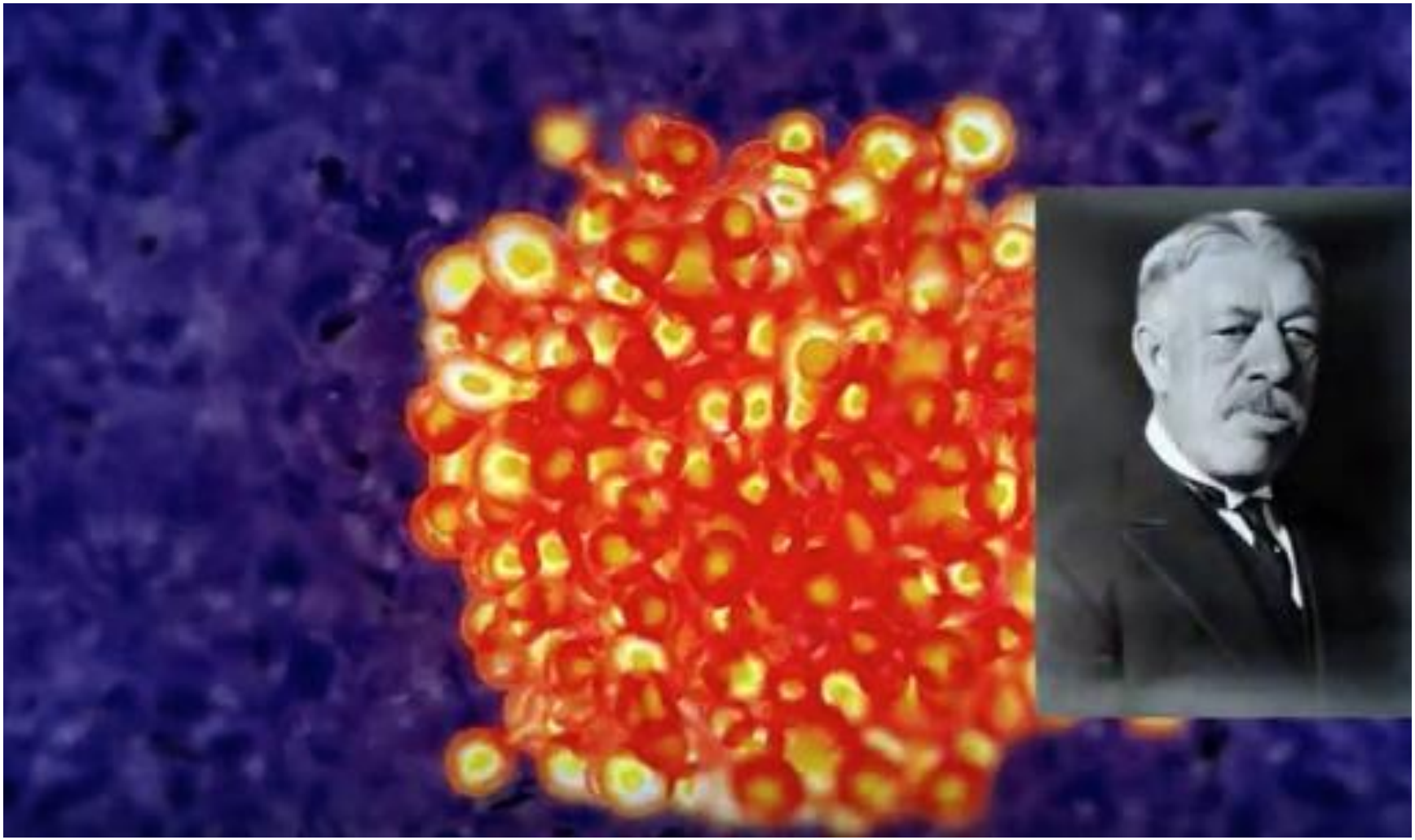


Bladder Cancer Canada Webinar Dr Shridhar

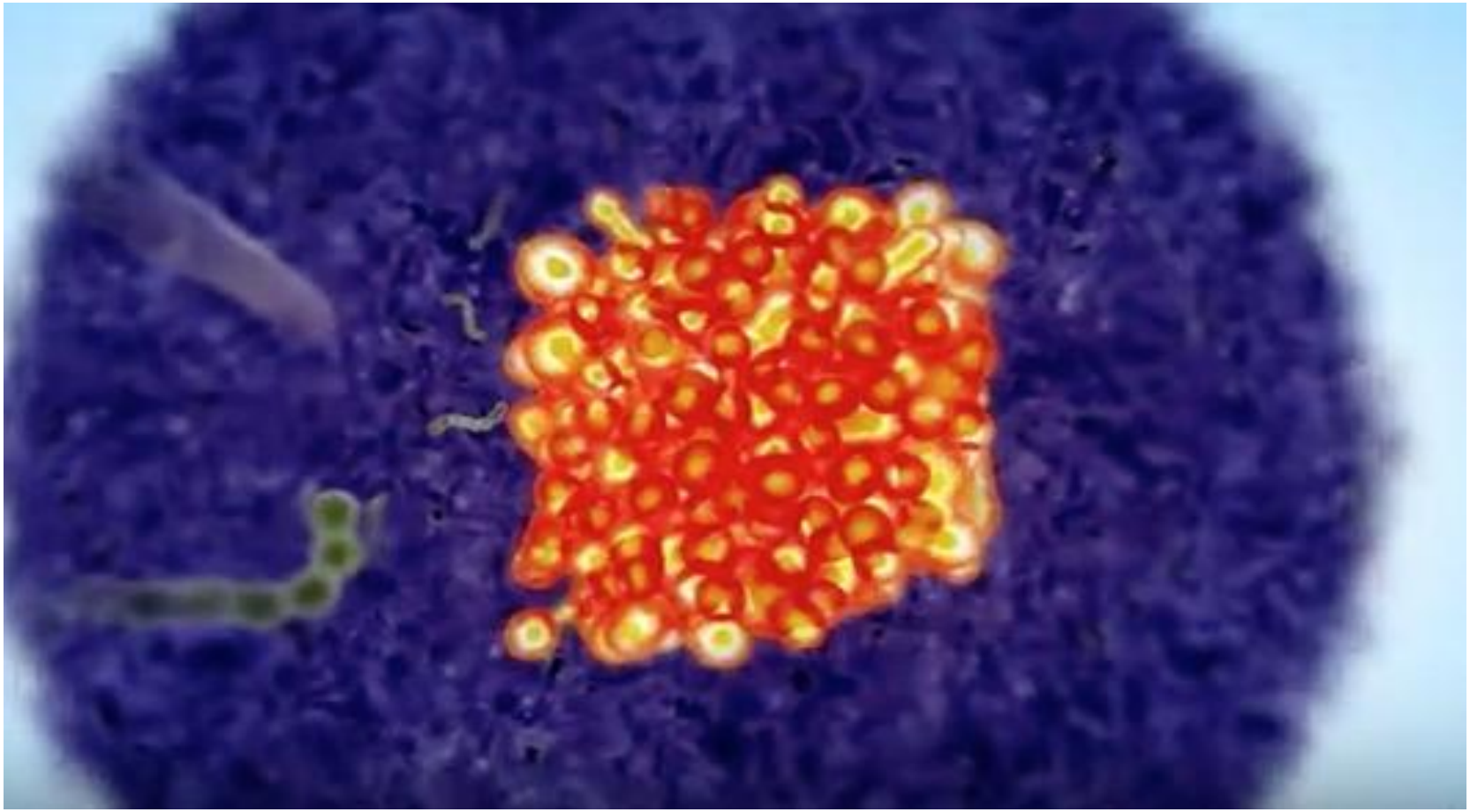


March 24, 2016

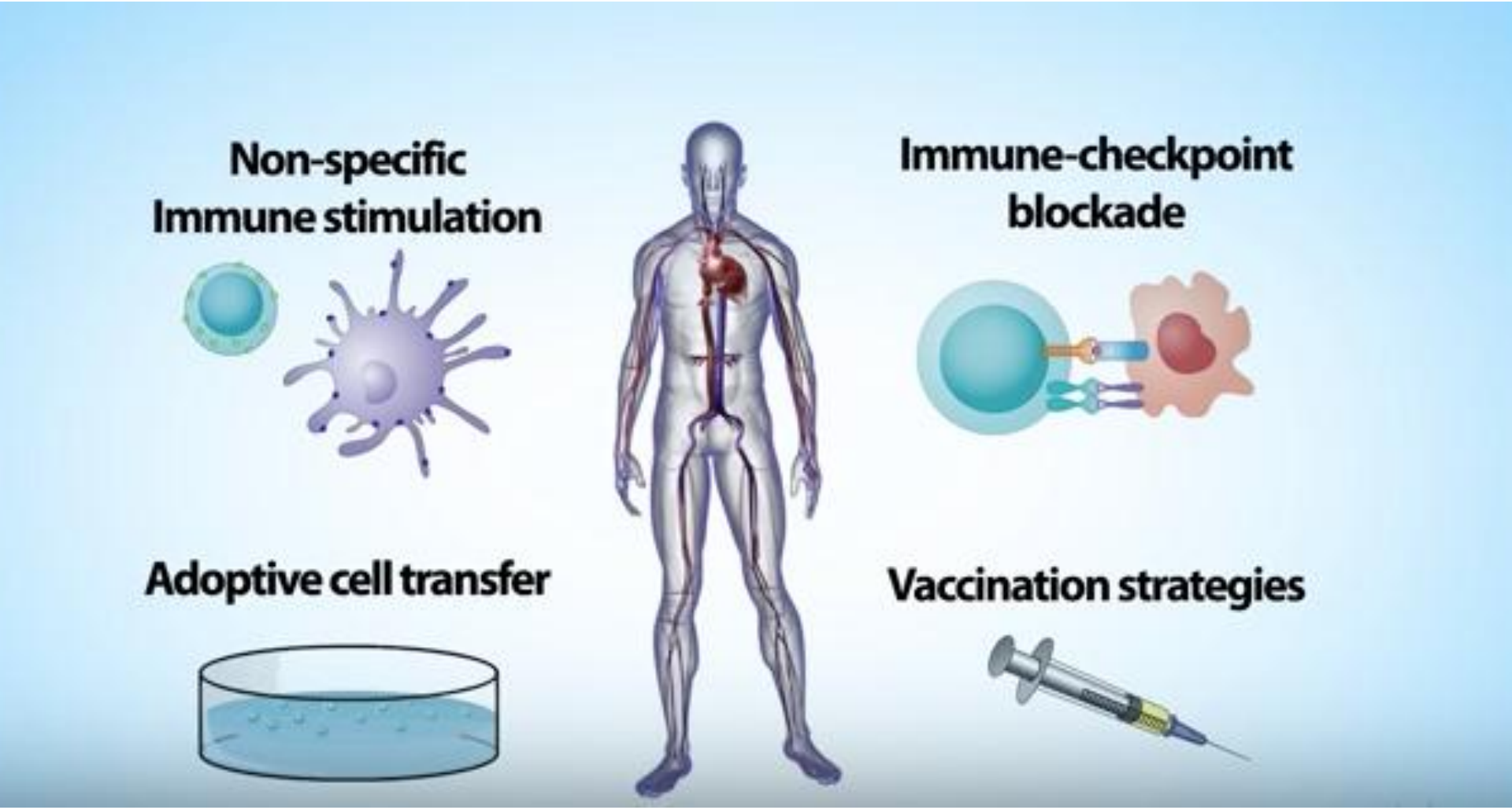
1891
Toxins of William B Coley



Introduced bacteria to initiate an immune response against the tumour



Cancer Immunotherapy



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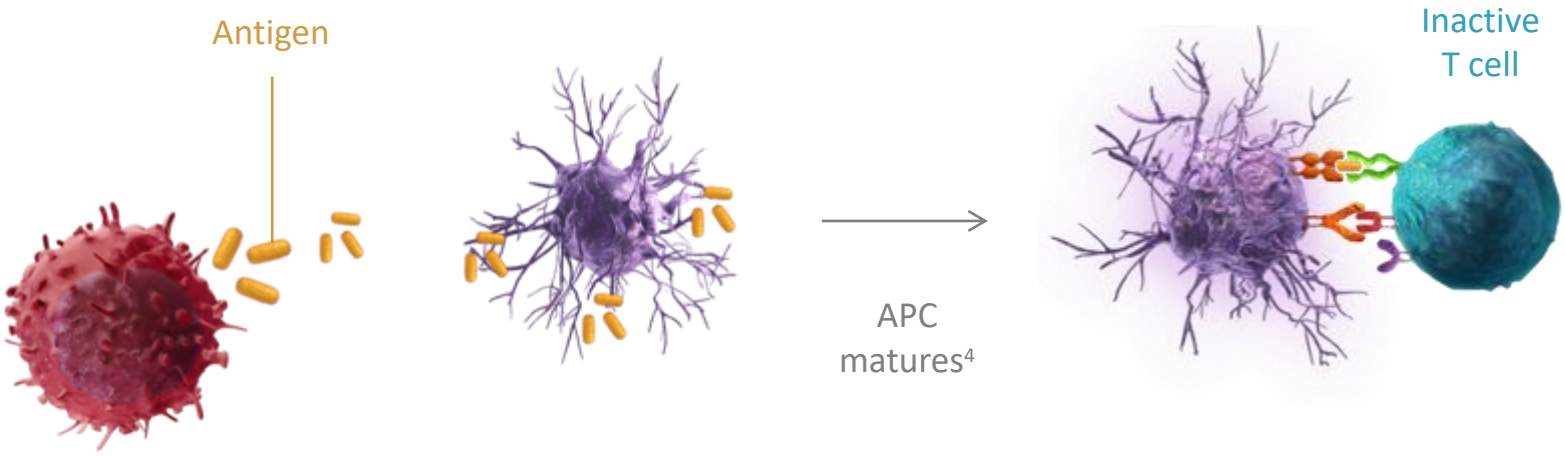
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New Drugs Free the Immune System to Fight Cancer

By releasing the brakes that tumor cells place on the immune system, researchers are developing a new generation of more powerful treatments against malignancy

T-cell Activation: Tumor-associated antigens

Tumor-associated antigens can trigger a tumor-specific immune cellular response:



1
Tumors express a multitude of proteins, known as tumor-associated antigens[1,2,3,4]

2
Antigen presenting cell (APC) captures tumor-associated antigens[2]

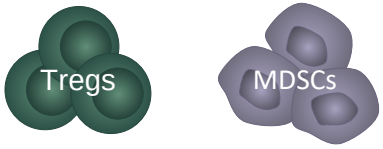
3
Activated APC can interact with T cells[4]

Pardoll DM. The blockade of immune checkpoints in cancer immunotherapy. *Nat Rev Cancer*. 2012;11:252-264 2. Mellman I, Coukos G, Dranoff G. Cancer immunotherapy comes of age. *Nature*. 2011;480:480-489 3. Heemskerk B, Kvistborg P, Schumacher TNM. The cancer antigenome. *EMBO J*. 2013;32(2):194-203 4. Boudreau JE, Bonehill A, Thielemans K, Wan Y. Engineering dendritic cells to enhance cancer immunotherapy. *Mol Ther*. 2011;19(5):841-853

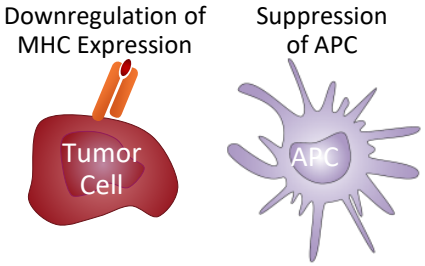
Immune Escape in Cancer

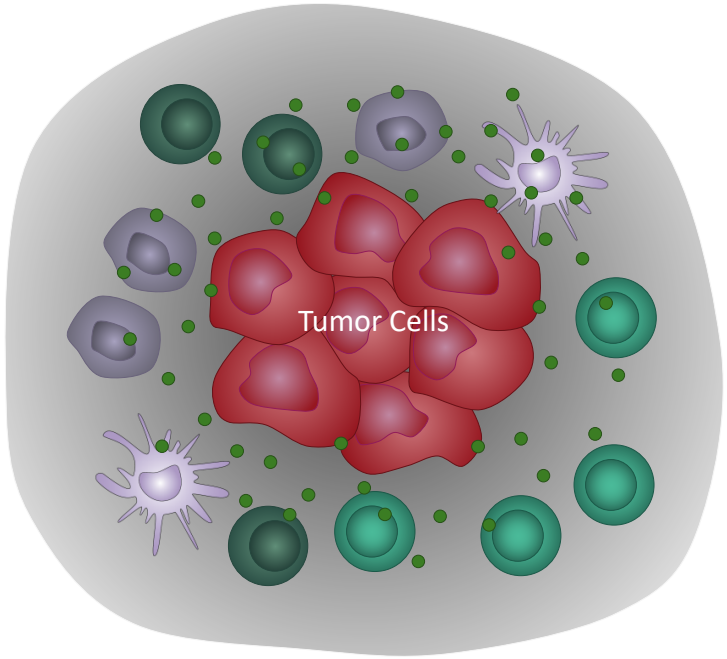
Many tumors escape the immune response by creating an immunosuppressive microenvironment that prevents an effective antitumor response[1,2]

B. Recruitment of immunosuppressive cells



A. Ineffective presentation of tumor antigens to the immune system



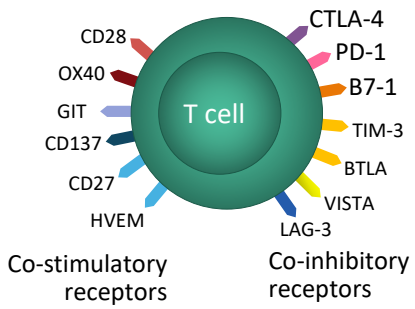


C. Release of immunosuppressive factors



Factors/enzymes directly or indirectly suppress immune response

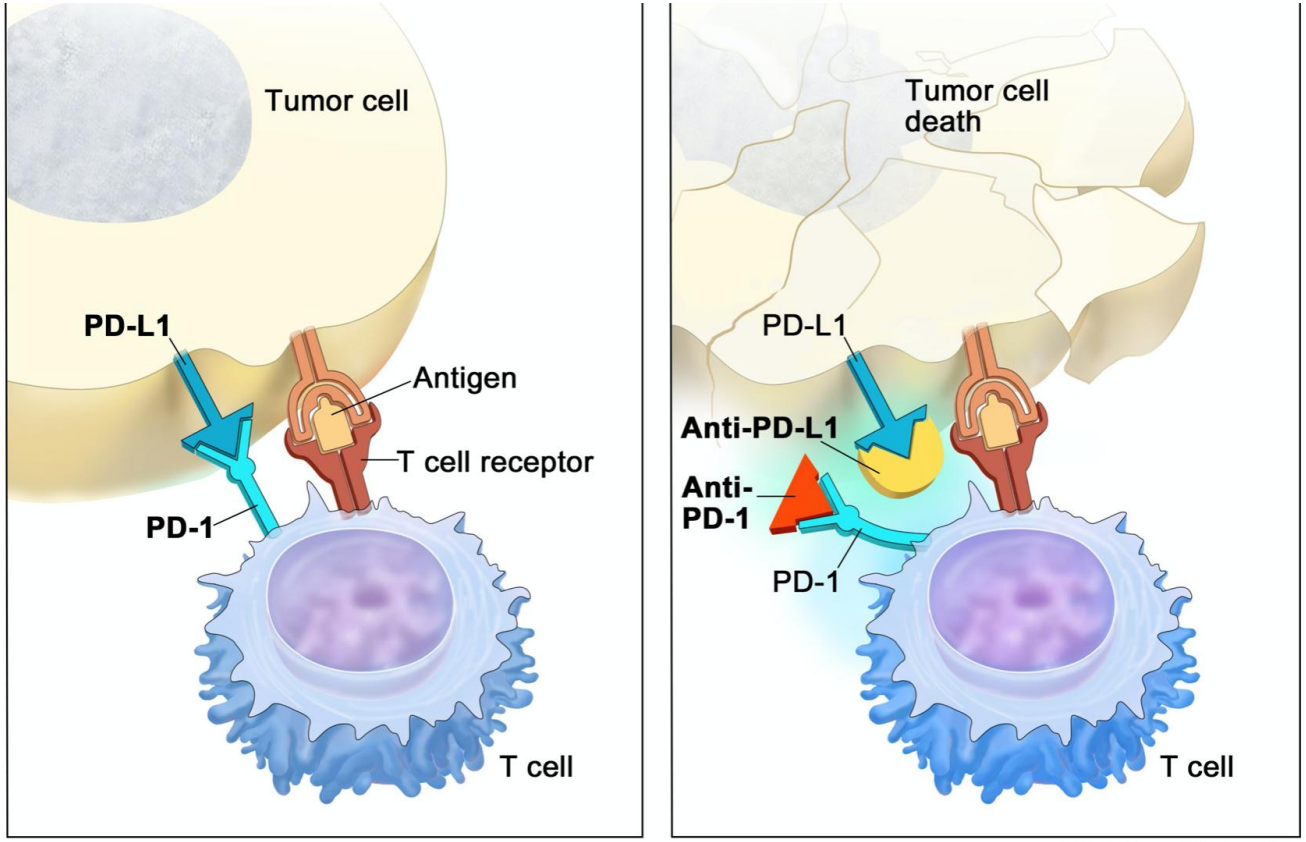
T-cell checkpoint dysregulation



- **The mechanisms tumors use to escape the immune system provide a range of potential therapeutic targets for cancer**

C=antigen-presenting cell; MDSC=myeloid-derived suppressor cell; MHC=major histocompatibility complex; Treg=regulatory T cell.

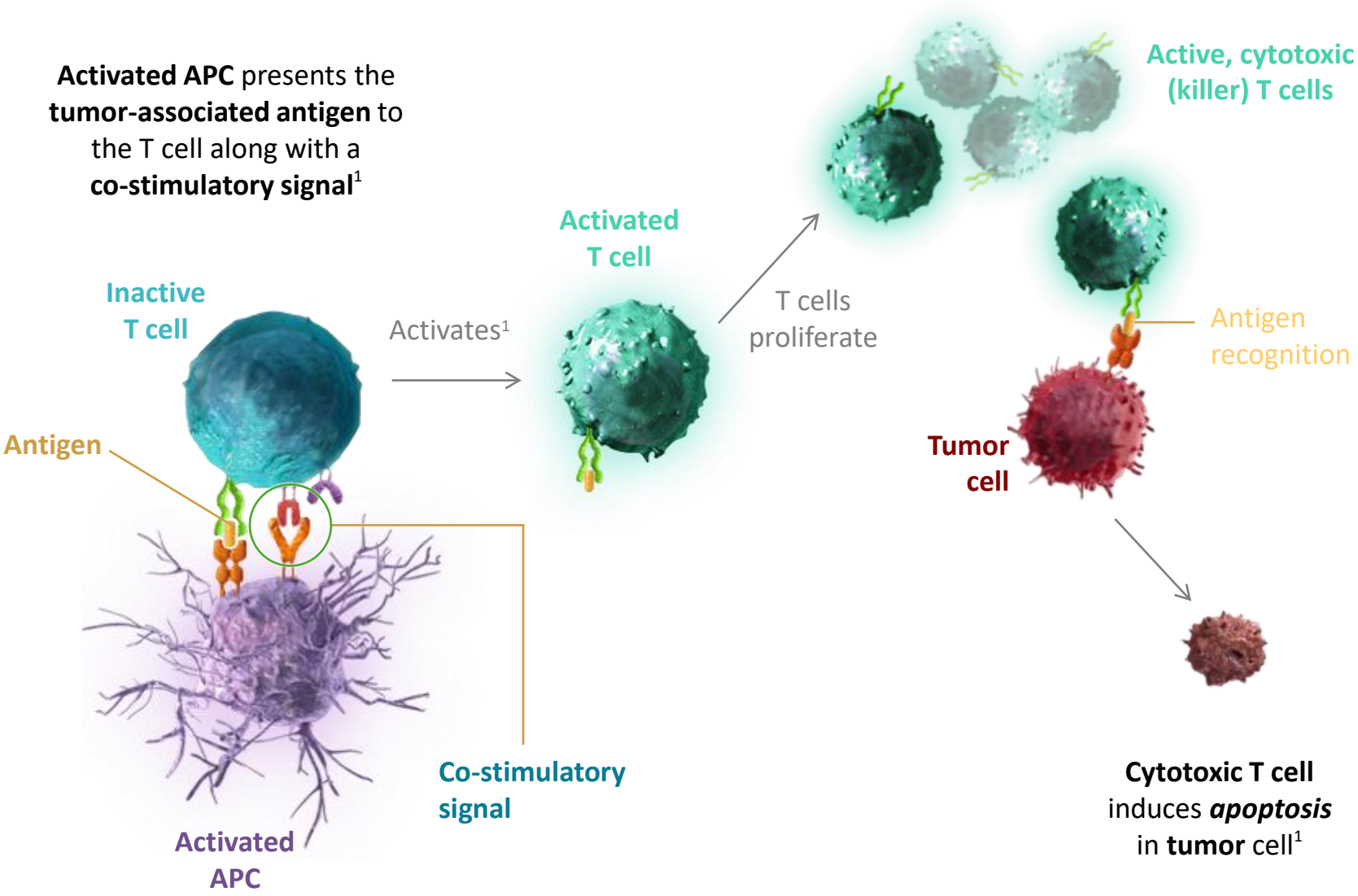
1. Bremnes RM et al. *J Thorac Oncol*. 2011;6:824-833. 2. Jadus MR et al. *Clin Dev Immunol*. 2012:160724.



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T-cell Activation: Cytotoxic T cells

Activated APC presents the **tumor-associated antigen** to the T cell along with a **co-stimulatory signal**[1]



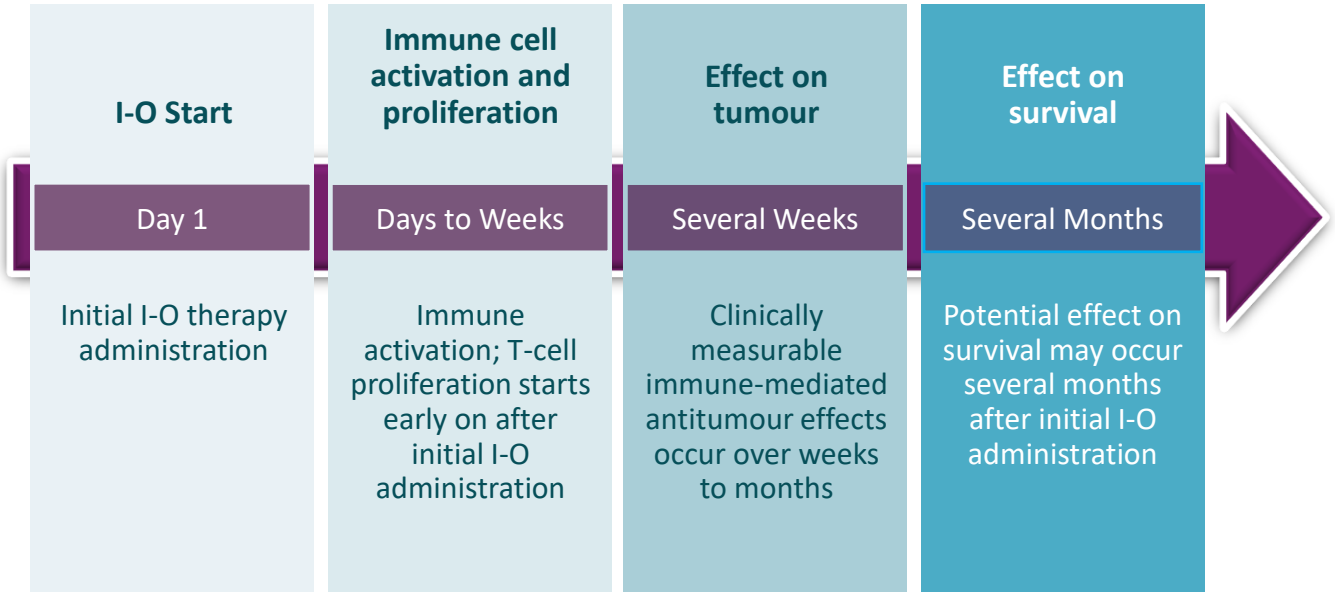
1. Janeway CA, et al. Immunobiology: The Immune System in Health and Disease. 6th ed. New York, NY: Garland Science; 2004

Differences you Can You Expect

Chemotherapy	Immuno-Oncology
Attacks tumours or cancer cells directly	Activates the immune response
Tumours may shrink immediately	Tumours shrink but this may take longer, and may grow before they get smaller (pseudo-progression)
Attacks all rapidly dividing cells, both healthy and cancerous cells	Overactive immune system results in immune-related side effects
Works as long as the drug is in the system	May help the immune system long after treatment ends; durable response

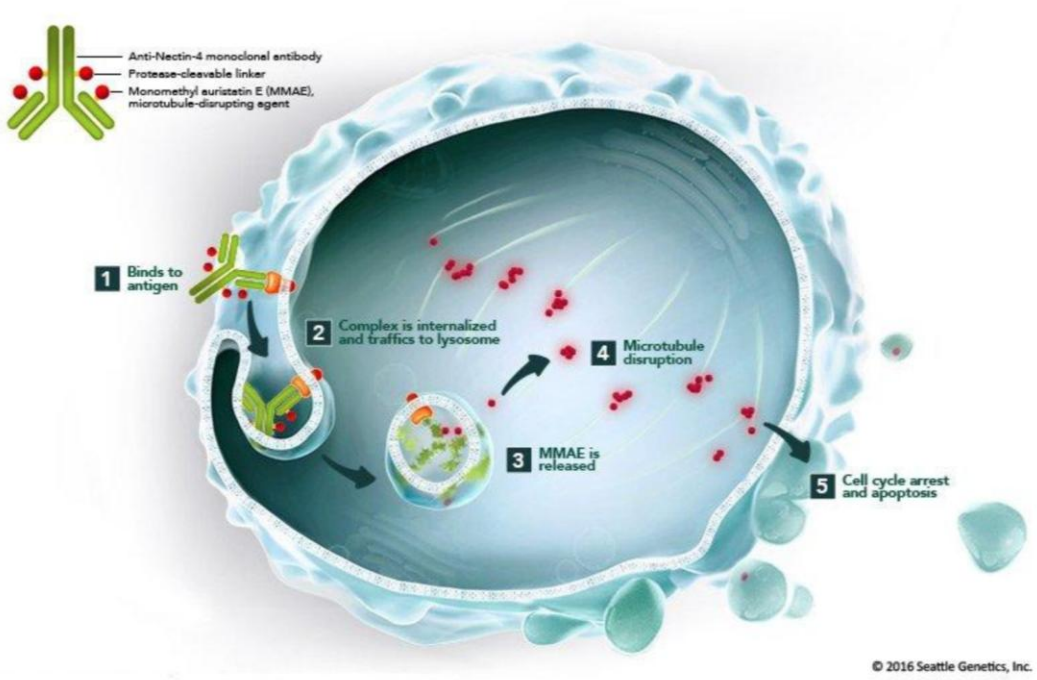
I-O Therapy Takes Time

Multi-Step Process



Hoos A, Britten CM. *OncoImmunology*. 2012;1:334-339; Hoos A, et al. *J Natl Cancer Inst*. 2010;102:1388-1397.

Enfortumab-Antibody Drug Conjugate (ADC)



Dose Modification (1/2)

Next page

EV Dose Modifications Based on AEs[1]

Adverse Reaction	Severity[a]	Dose Modification
Skin reactions	Suspected SJS or TEN; worsening or Grade 3 (severe)	Withhold until Grade ≤1, then resume treatment at the same dose level or dose reduce by one dose level
	Confirmed SJS or TEN; Grade 4 or recurrent Grade 3 skin reactions	Permanently discontinue
Hyperglycemia	Blood glucose 13.9 mmol/L; >250 mg/dL	Withhold until elevated blood glucose has improved to 13.9 mmol/L; ≤250 mg/dL, then resume treatment at the same dose level
Pneumonitis/ILD	Grade 2	Withhold until Grade ≤1, then resume treatment at the same dose level or consider dose reduction by one dose level
	Grade ≥3	Permanently discontinue
Peripheral neuropathy	Grade 2	Withhold until Grade ≤1, then resume treatment at the same dose level (if first occurrence). For a recurrence, withhold until Grade ≤1, then resume treatment reduced by one dose level
	Grade ≥3	Permanently discontinue
Other nonhematologic toxicity	Grade 3	Withhold until Grade ≤1, then resume treatment at the same dose level or consider dose reduction by one dose level
	Grade 4	Permanently discontinue
Hematologic toxicity	Grade 3, or Grade 2 thrombocytopenia	Withhold until Grade ≤1, then resume treatment at the same dose level or consider dose reduction by one dose level
	Grade 4	Withhold until Grade ≤1, then reduce dose by one dose level or discontinue treatment

[a]Grade 1 is mild, Grade 2 is moderate, Grade 3 is severe, and Grade 4 is life-threatening.[1]

1. PADCEV® [product monograph]. Health Canada. Date of Revision: Aug 20, 2024.

Prepared by Pfizer for non-promotional purposes – Not for further distribution

Management of Muscle Invasive Bladder Cancer

Multidisciplinary Care necessary

BLADDER CANCER | STAGE-DIRECTED TREATMENT

Urothelial carcinoma • Multidisciplinary treatment algorithm • 2026

NON–MUSCLE-INVASIVE
Ta / T1 / CIS

TURBT ± repeat TURBT
Risk-adapted intravesical therapy (BCG / chemotherapy)

High-risk BCG-unresponsive disease: consider cystectomy or other approved options.

MUSCLE-INVASIVE | cT2–T4a, N0 M0

Two curative-intent approaches (patient selection / preference)

RADICAL CYSTECTOMY PATH

Neoadjuvant systemic therapy
Cisplatin-based chemo ± perioperative durvalumab[1]

Radical cystectomy + LND

Adjuvant therapy
Durvalumab[1] / nivolumab

BLADDER PRESERVATION

Maximal TURBT
Concurrent chemoradiation

Response assessment + surveillance

Salvage cystectomy for invasive local recurrence or nonresponse.

Adjuvant therapy
Durvalumab[1]

UNRESECTABLE / METASTATIC

First-line EV + pembrolizumab[3]
Preferred for most eligible patients

At progression: Platinum chemo biomarkerdirected -

Clinical trials and supportive / palliative care throughout advanced disease.

Directed Tx:
SBRT
surgery

[1] NIAGARA (perioperative GC + durvalumab) [2] Javelin Bladder 100 [3] EV-302 / KEYNOTE-A39

NIAGARA | Perioperative durvalumab in resectable MIBC

Phase III • n=1,063 • Cisplatin-eligible • Curative-intent radical cystectomy

GC + durvalumab × 4 → Cystectomy → Durvalumab × 8	GC × 4 → Cystectomy → Observation
24-month EFS	**67.8% vs 59.8% | HR 0.68**
24-month OS	**82.2% vs 75.2% | HR 0.75**

Sources: Powles et al. NEJM 2024; ESMO Insights 23 Oct 2026; NIAGARA reimbursement review.

Early stage/locally advanced bladder cancer
Cystectomy

1. Neoadjuvant chemo+immunotherapy
2. Radical Cystectomy
3. Adjuvant immunotherapy for ~8 months

Early stage/locally advanced bladder cancer
Bladder Preservation

Careful selection criteria

- fully resectable
- no hydronephrosis
- Good kidney function for chemotherapy
- No extensive Cis

1. Maximal transurethral resection of the bladder tumour (TURBT)
2. Concurrent chemotherapy + radiation
3. Reassess with TURBT
4. Careful, frequent surveillance

**New strategy:

Add upfront chemo+immunotherapy and adjuvant immunotherapy

(similar to surgical sequencing)

Advanced muscle invasive bladder cancer

Case #1: Mr. C

Aug. 2024 53 yo man presented to family physician with severe pelvic pain and hematuria

- Primary Care and ED

Ct and PET showed bladder wall thickening, invasion into prostate, hydronephrosis, adenopathy and liver mets and renal failure

- radiology, nuclear medicine, nephrology, palliative care

TURBT

- Urology

Pathology confirmed high grade transitional cell cancer

- pathology

Mr C: What happened…

Nephrostomy tubes

- interventional radiology

- Palliative Care Consultation
  - Palliative care team

Palliative EBRT to pelvis and retroperitoneal nodes

- Radiation Oncology

September 12, 2024 first patient in the region to receive compassionate access to Enfortumab Vedotin+Pembrolizomab

- Medical Oncology, Pharmacy, Oncology Nursing

Platinum based chemotherapy

Bladder cancer does respond to chemotherapy

- ORR=40-50%
- DOR ~9m
- Median OS cisplatinum=15m
- Median OS carboplatinum=10m


Enfortumab
Vedotin
+
Pembro-
lizumab
Locally Advanced
or Metastatic
Urothelial Carcinoma

EV-302 / KEYNOTE-A39 | First-line advanced urothelial cancer

Phase III • n=886 • Previously untreated unresectable locally advanced / metastatic UC

Enfortumab vedotin + pembrolizumab	Gemcitabine + cisplatin / carboplatin

ASCO 2026 | Median follow-up 42.8 months

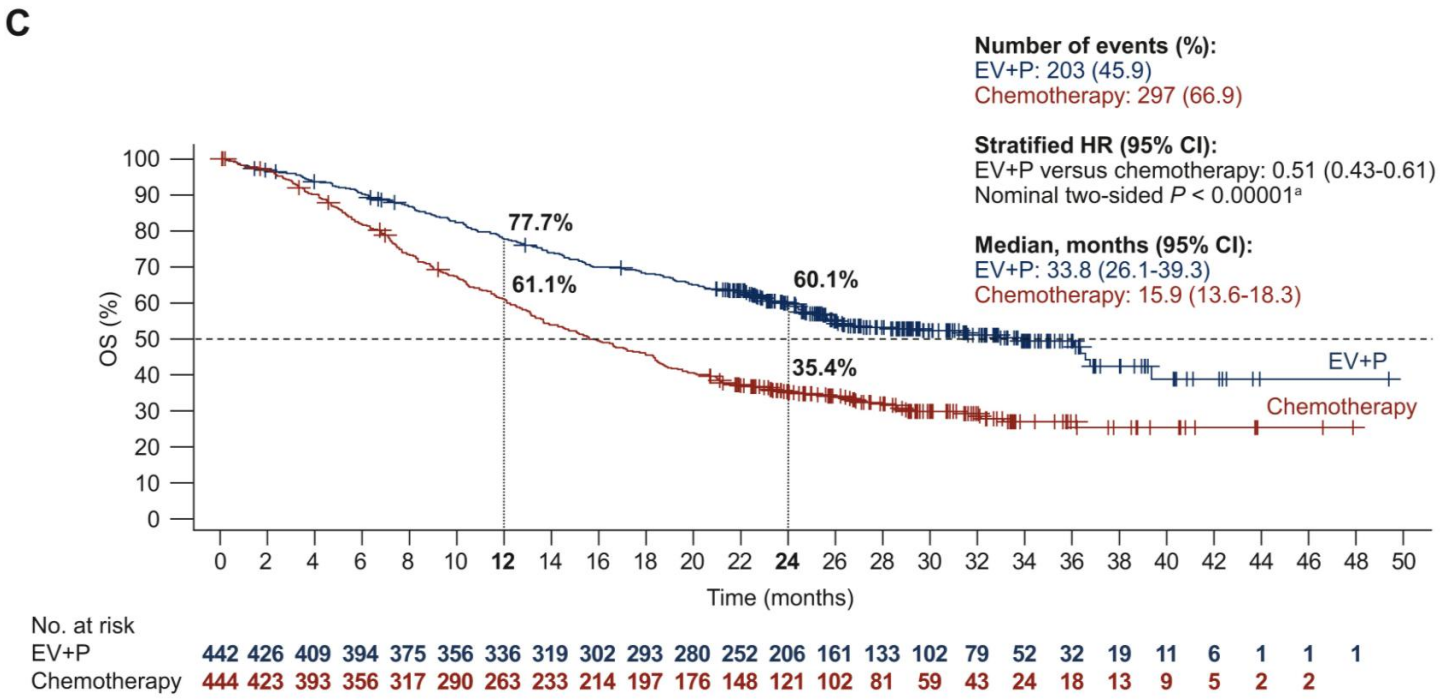
Median overall survival	**33.6 vs 15.9 months**
Overall survival HR	**0.53 (95% CI 0.45–0.63)**
42-month OS	**44.0% vs 24.6%**

Response update: 42-month OS among EV+P complete responders 83.6%; exploratory, responder-selected analysis.

Clinical message: durable survival advantage supports EV + pembrolizumab as preferred first-line treatment; cumulative neuropathy remains important.

Sources: Powles et al. JCO ASCO 2026 abstract 4507; Ann Oncol 2025 EV-302 follow-up.

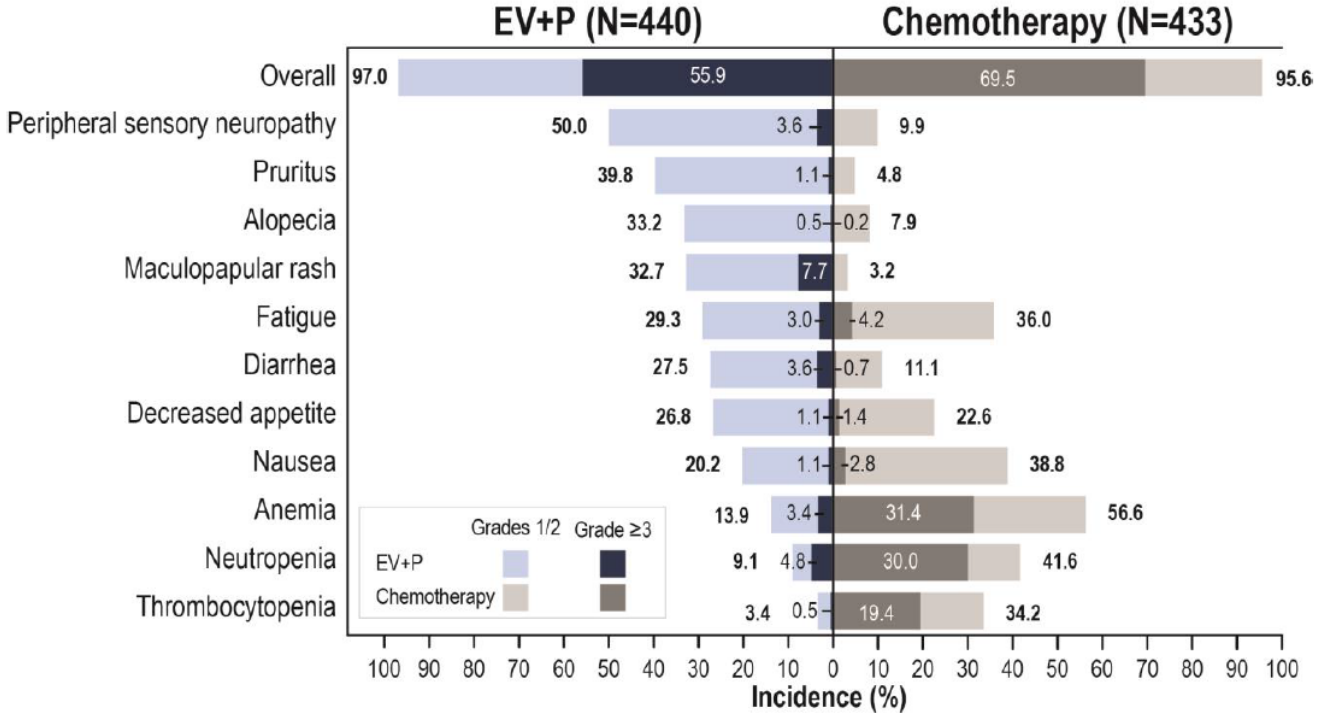
Overall Survival:
Risk of death reduced by 49%



Powles at al Annals of Oncology 2025

Treatment-Related Adverse Events

Grade ≥3 events were 56% in EV+P and 70% in chemotherapy



Serious TRAEs:
- 122 (27.7%) EV+P
- 85 (19.6%) chemotherapy

TRAEs leading to death (per investigator):
EV+P: 4 (0.9%)
- Asthenia
- Diarrhea
- Immune-mediated lung disease
- Multiple organ dysfunction syndrome

Chemotherapy: 4 (0.9%)
- Febrile neutropenia
- Myocardial infarction
- Neutropenic sepsis
- Sepsis

Median number of cycles (range): 12.0 (1,46) for EV+P; 6.0 (1,6) for chemotherapy

Data cutoff: 08 Aug 2023

MADRID 2023 ESMO congress

Powles et al.

TRAEs shown in figure are any grade by preferred term in ≥20% of patients for any grade in either arm
TRAEs, treatment-related adverse events

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Summary

1. OS doubled with immunotherapy+ADC

2. Response Rates:

   Objective Response Rate (ORR): 68% for EV+P vs. ~44% for chemotherapy.

   Complete Response (CR) Rate: 30% for EV+P, with over 70%–80% of patients achieving a complete response remaining alive at 3.5 years. [1, 2, 3]

Mr C: What happened…

September 2024: Started treatment with EV+Pembro September 2024

December 2024: resolution of adenopathy on CT and decreased size of bladder mass

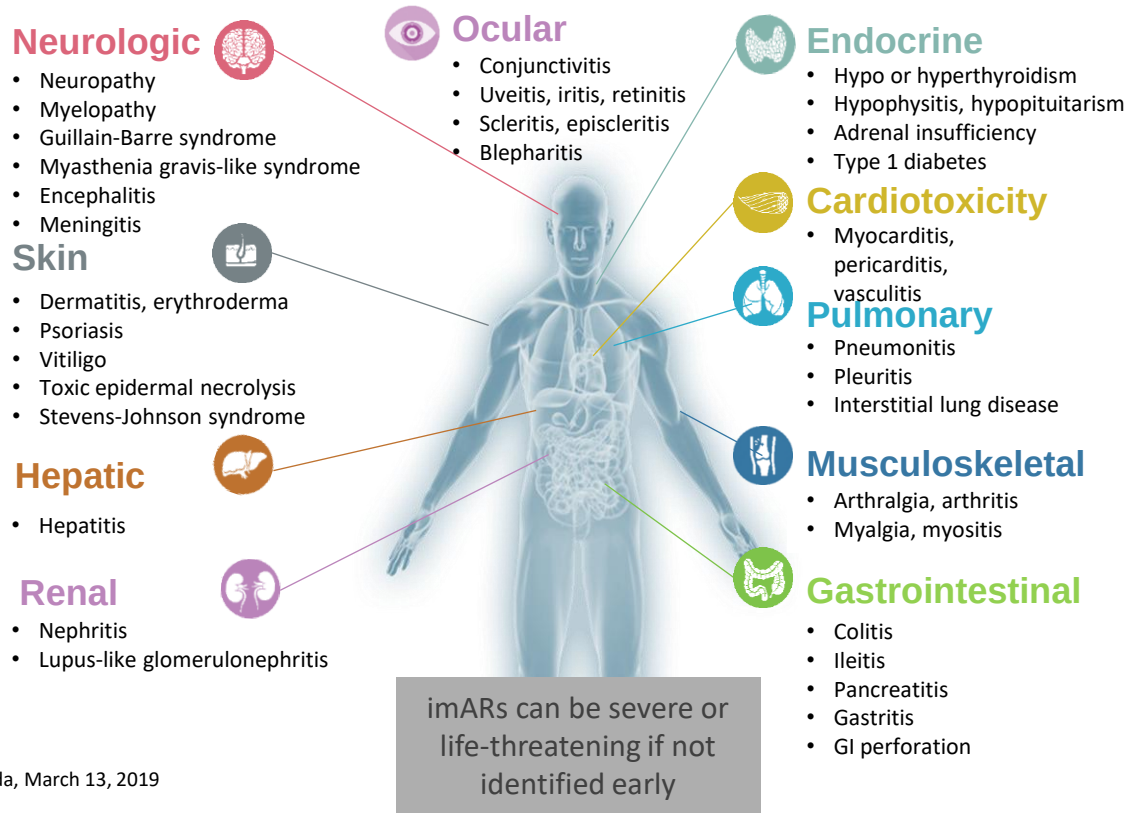
Feb-March 2024:

Sepsis related to nephrostomy tube changes

Developed grade 1 and 2 immune related side effects

- Nephritis
- hypothyroidism
- Rash
- hyperglycemia.
  - RN, NP, pharmacy, dietician, endocrinology, nephrology

Any Organ System can be Affected, Leading to Inflammation ("itis" or "opathy")

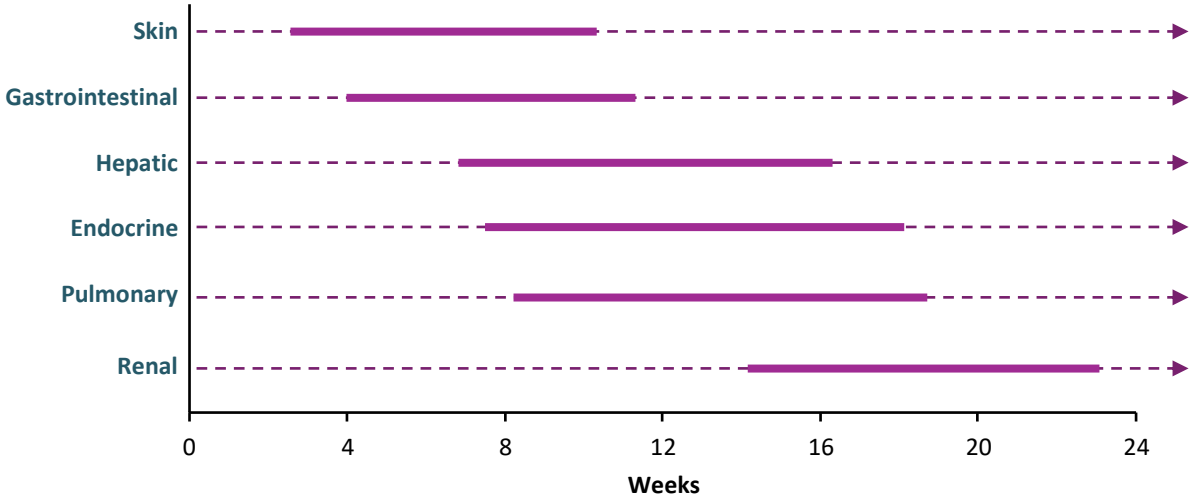


OPDIVO Product Monograph, Health Canada, March 13, 2019

Overall Appearance of Immune-Related Adverse Effects

- irAEs usually take several weeks to months to occur (typically peak between 4–12 weeks)
- irAEs associated with combination therapy may occur earlier, even a few days after treatment administration
- The majority of irAEs occur in the first few months of treatment

However, irAEs can develop at any time (at the beginning, under treatment, and even after treatment discontinuation)



Weber JS, et al. *J Clin Oncol.* 2012; 30:2691-2697; Fay AP, et al. *Expert Rev Qual Life Cancer Care.* 2016;1:89-97.
Villadolid, J, Amin A. *Translational Lung Cancer Research.* 2015;4:560-575.

Most Common Adverse Events with Immune Checkpoint Inhibitors

The most frequent side effects associated with immune checkpoint inhibitors involve the skin (pruritus and rash), gastrointestinal tract (diarrhea), as well as fatigue and nausea.

Anti-CTLA-4:
ipilimumab

AE, average	Any Grade	Grade ≥3
Pruritus	24%	<1%
Rash	19%	1%
Diarrhea	28%	5%
Colitis	8%	5%
Endocrine	6%	2%
Hepatic	4%	2%
Pneumonitis	<1%	<1%

All Any Grade: 65–85%
All Grade ≥3 AEs: 10–20%

Anti-PD-1/PD-L1:
nivolumab, pembrolizumab, atezolimumab

AE, average	Any Grade	Grade ≥3
Pruritus	23%	<1%
Rash	21%	1%
Diarrhea	20%	<1%
Colitis	1%	1%
Endocrine	12%	1%
Hepatic	6%	1%
Pneumonitis	7%	<1%

All Any Grade: 70–80%
All Grade ≥3 AEs: 5–10%

Anti-CTLA-4 + Anti-PD-1:
ipilimumab + nivolumab

AE, average	Any Grade	Grade ≥3
Pruritus	33%	2%
Rash	28%	3%
Diarrhea	44%	9%
Colitis	12%	8%
Endocrine	30%	5%
Hepatic	30%	19%
Pneumonitis	6%	1%

All Any Grade: 90–95%
All Grade ≥3 AEs: 45–55%

Data reported in selected systematic reviews and trials. Values may slightly vary across various tumour types and the specific regimen used.

Suarez-Almazor ME, et al. *Arthritis Rheumatol.* 2017;69:687-699; Emens LA, et al. *Eur J Cancer.* 2017;81:116-129.
Fay AP, et al. *Expert Rev Qual Life Cancer Care*. 2016;1:89-97; Kumar V, et al. *Front Pharmacol.* 2017;8:49.
Medina PJ, Adams VR. *Pharmacotherapy.* 2016;36:317-34; Michot JM, et al. *Eur J Cancer*. 2016;54:139-48.

Unusual and rare immune related toxicities

- Hypophysitis
- Triple M syndrome-Myositis, Myocarditis, Myesthenia Gravis
- HLH syndrome (Macrophage activation)
- Stevens Johnson Syndrome
- Guillaine Barre Syndrome
- Autoimmune encephalitis

And more….

Determining Degree of irAE Toxicity is The Key to Management



Grade 1: Mild, asymptomatic, no intervention required





Grade 2: Moderate, local or non-invasive intervention required



Grade 3: Severe or medically significant, but not life-threatening



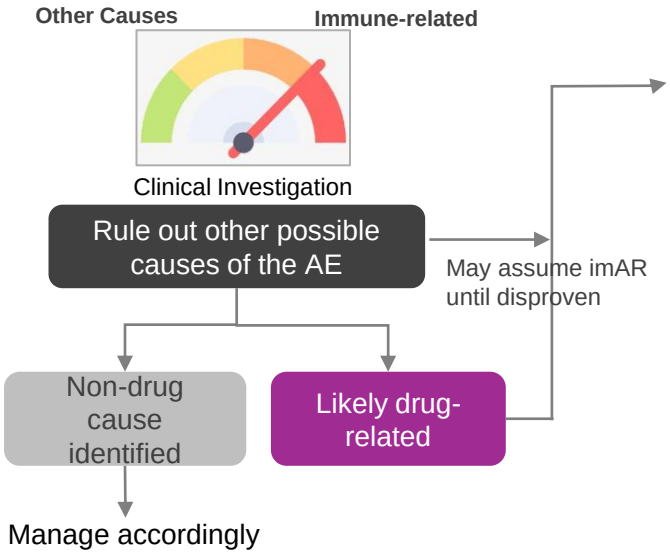
Grade 4: Life-threatening consequences; urgent intervention required

Grade 1-3 example images: courtesy of Krista M. Rubin, MS, RN, FNP-BC, at Massachusetts General Hospital Cancer Center, Boston, Massachusetts.

Mundi. Int J Case Rep Imag. 2016;7:300.

Slide credit: clinicaloptions.com

General Approach to Safety Management for Patients on Immunotherapy

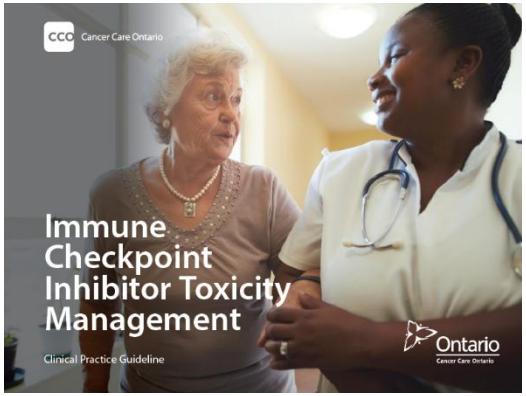


The majority of imARs are manageable and reversible with drug interruption ± corticosteroids

Grade (CTCAE v4)	Patient Care	Corticosteroids/ Immunosuppressants	I-O therapy
Mild (grade 1)	• Monitor closely		• **Continue** (except consider delay for pneumonitis)
Moderate (grade 2)	• Symptomatic management • Monitor closely	• If persistent toxicity, oral steroids	• **Hold** the dose (except if skin or endocrine toxicity, can be maintained) • **Resume** when AEs resolve to grade ≤1 or baseline
Severe (grade 3–4)	• Consult specialist • Symptomatic management • Hospitalization • Monitor closely	• High dose IV steroids • If not improving, add immunosuppressive therapy (e.g., infliximab)	• **Discontinue** permanently (except for skin or some endocrine toxicities)

OPDIVO Product Monograph, Health Canada, March 13, 2019
Management algorithm from BMS Investigational Brochure-936558/MDX1106/ONO-4538 v18.0.

Management Guidelines for irAEs – Cancer Care Ontario Toolkit



DIARRHEA/ COLITIS

	Description	Referral	Corticosteroids	Supportive Therapy	Immune Therapy
GRADE 1	<4 stools/day above baseline.	Not required.	Not required.	Initiate loperamide[4] therapy; maintain oral hydration; consider electrolyte supplementation and dietary modifications.[†]	Monitor closely and continue immune therapy.
GRADE 2	4-6 stools/day above baseline; abdominal pain, mucus or blood in stool.	Refer to a gastroenterologist for flexible sigmoidoscopy or colonoscopy for persistent grade 2 diarrhea (especially if diagnosis is in question) or any grade 3-4 diarrhea. If any chance of perforation avoid colonoscopy and suggest surgical consult.	Consider starting steroids right away (do not need to wait for consult) or if no improvement after 24 hours of loperamide. Start 0.5-1 mg/kg/day PO prednisone[†] until resolution to grade 0-1. Then taper over 2-4 weeks if 0.5 mg/kg and over 4 weeks if 1 mg/kg. If no improvement in 72 hours, treat as grade 3-4.	Start loperamide[4] and monitor after 24 hours; continue if symptoms improved. Consider prednisone if symptoms worsen or no resolution; give oral/IV hydration; consider electrolyte supplementation and dietary modifications.[†]	Withhold therapy until grade 0-1 and on prednisone <7.5 mg/day (CTLA-4) or <10 mg/day (PD-1). Consider discontinuation if no improvement within 12 weeks or inability to reduce steroids.
GRADE 3	≥7 stools/day above baseline; incontinence, need for hospitalization for IV fluids ≥24hrs.		Start 1-2 mg/kg/day IV methylprednisolone until improvement, then slow taper over ≥4 weeks. If no response after 3 days, give infliximab 5 mg/kg IV once every 2 weeks* (use with caution in grade 4 due to risk of perforation and avoid if contraindicated).	Admit to hospital and initiate IV hydration. Consider empiric antibiotics as per institutional guidelines for patients who present with fever/leukocytosis. Use opioid analgesics with caution due to risk of narcotic bowel.	Permanently discontinue therapy.
GRADE 4	Grade 3 plus fever, or peritoneal signs consistent with bowel perforation, or ileus; life-threatening.	Suggest surgical consult.			

4 loperamide 4 mg followed by 2 mg q4h or after every loose BM until diarrhea-free for 12hrs (max 16 mg/day)
† or equivalent
‡ Refer to CCO Diarrhea Guidelines: https://www.cancercareontario.ca/en/symptom-management/41151
* If infliximab is contraindicated (possibility of perforation, sepsis, TB, NYHA 3/4 CHF), consider mycophenolate mofetil or other immunosuppressive agents

Managing imARs is a Team Effort
Everyone has a PART to Play



Patient education

- Patients must report new, persistent or worsening symptoms[1-3]

Education is key!



Assess signs & symptoms

- Most imARs occur during treatment but imARs can also occur weeks to months later. Monitor at least 5 months after last dose.[4]



Recognize potential imARs early

- imARs can be severe or life-threatening if not identified early

Communication is key!



Treat and intervene quickly

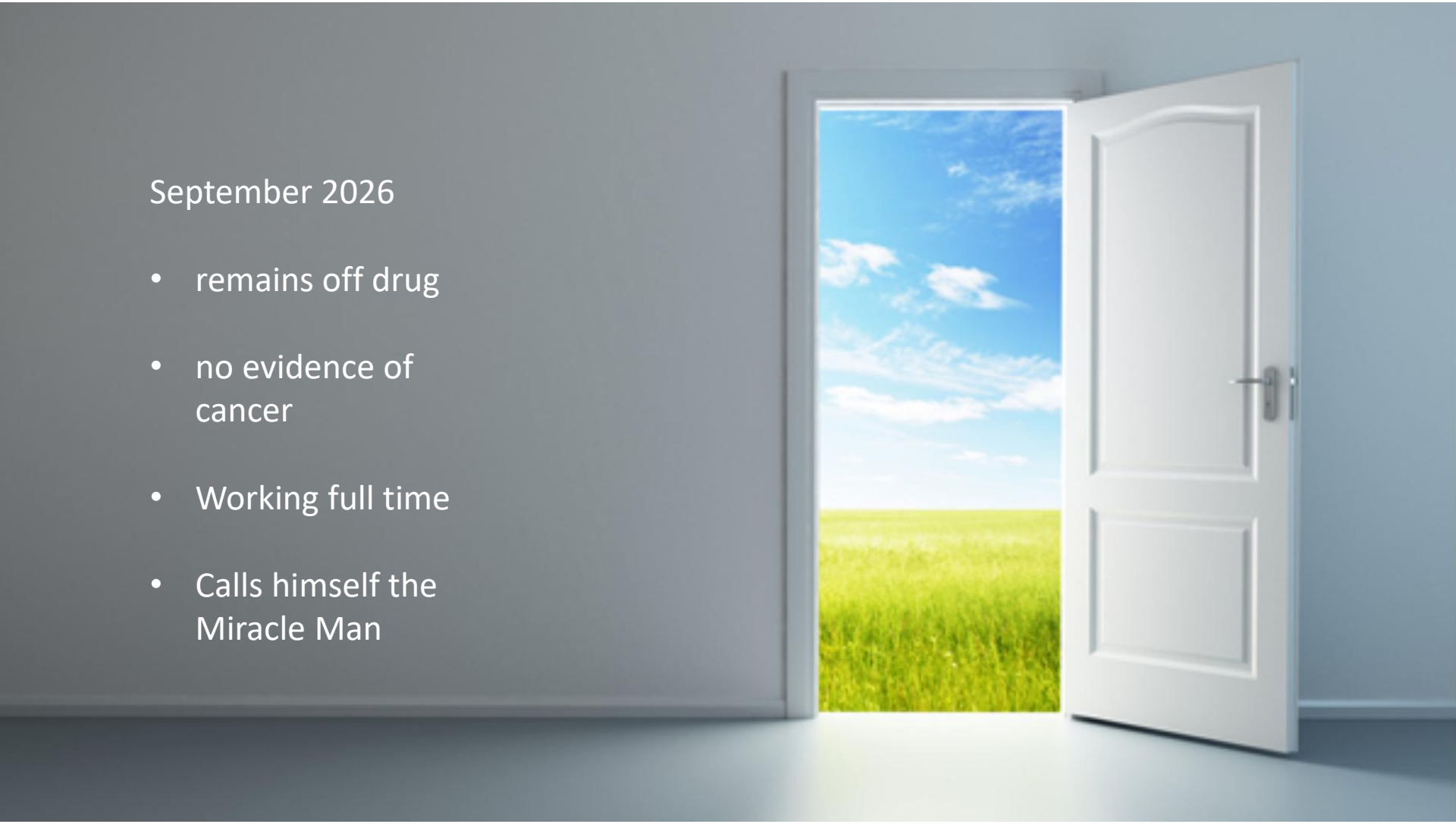
- Correlation of toxicity with clinical response has not yet been established
- Evaluate differential diagnoses per standard practice (consider non-inflammatory etiologies)[1,2]
- Where appropriate, use corticosteroids and other therapies, combined with either delaying or discontinuing treatment[4]

1. Yervoy Risk Evaluation and Mitigation Strategy. http://www.accessdata.fda.gov/drugsatfda_docs/rems/Yervoy_2012-02-16_IMMUNE%20MEDIATED%20ADVERSE%20REACTION%20MANAGEMENT%20GUIDE.pdf. Accessed January 2016.
2. http://www.opdivohcp.bmscustomerconnect.com accessed March 2016
3. Ledezma B, et al. *Cancer Manag Res*. 2014;6:5-14.
4. OPDIVO Product Monograph, Health Canada, March 13, 2019

Mr C: What happened…

April 2025: Normal CT and cystoscopy

Drug stopped April 2025


September 2026
• remains off drug
• no evidence of cancer
• Working full time
• Calls himself the Miracle Man

2024 CUA-GUMOC Expert Report: Management of unresectable locally advanced and metastatic urothelial carcinoma

Monday, January 13, 2025

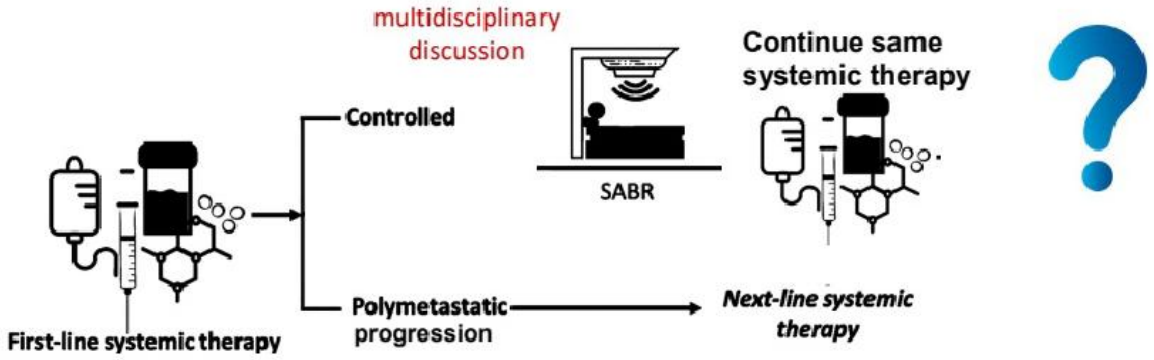
Dr. Scott North MD MSC FRCPC
Medical Oncologist, Professor
Cross Cancer Institute
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Medical oncologist, Assistant Professor
Princess Margaret Cancer Center
University of Toronto

Consolidation MDT for Low Volume Residual Disease

- Statement 11

  For patients who have significant tumor regression and/or low-volume residual metastatic disease after starting systemic palliative 1L treatment, we encourage multidisciplinary discussion to determine whether definitive local management or treatment of oligometastatic disease is warranted.



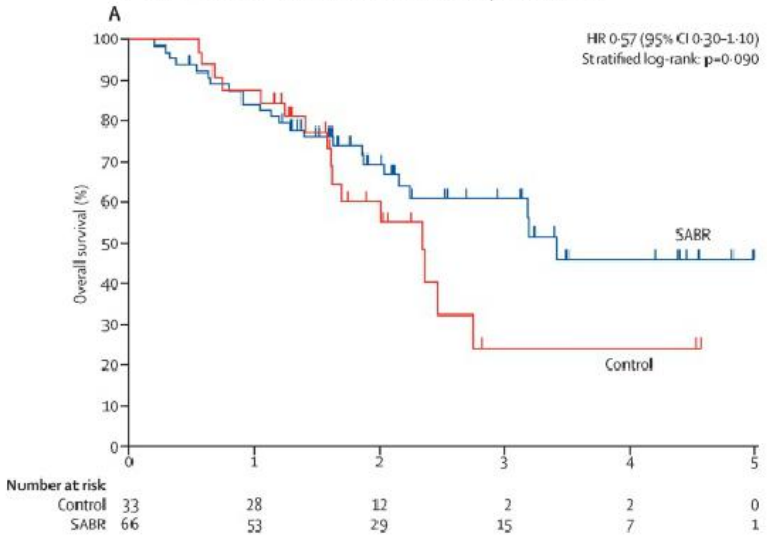
Modified from Ho et al. Diagnostics 2023

Oligoprogressive Bladder Cancer

- Prospective data of using SBRT to treat oligoprogressive metastases in other cancers

SABR-COMET phase II trial: 1-5 metastatic lesions

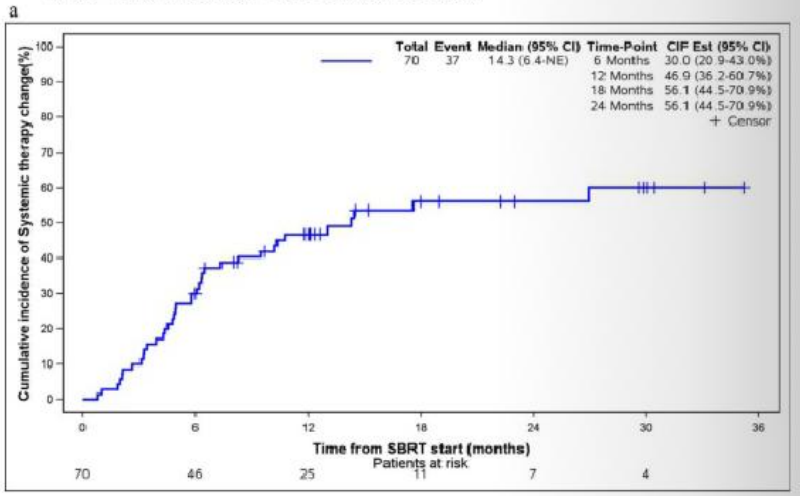
- Median OS 41 vs 28 months, HR 0.57



Palma et al. Lancet 2019

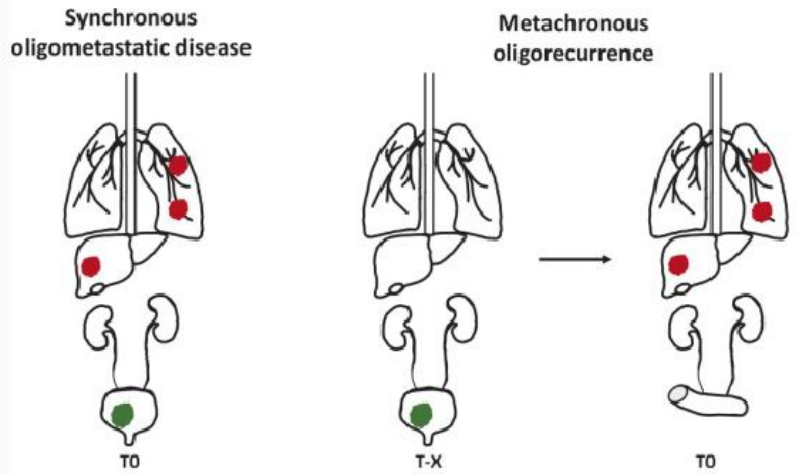
RADIANT phase II trial: 1-5 metastatic lesions

- The cumulative incidence of change of ST at 1 year was 46.9% (95% CI. 36.2%-60.7%)



Glicksman et al. Int J Radiation Oncol Biol Phys

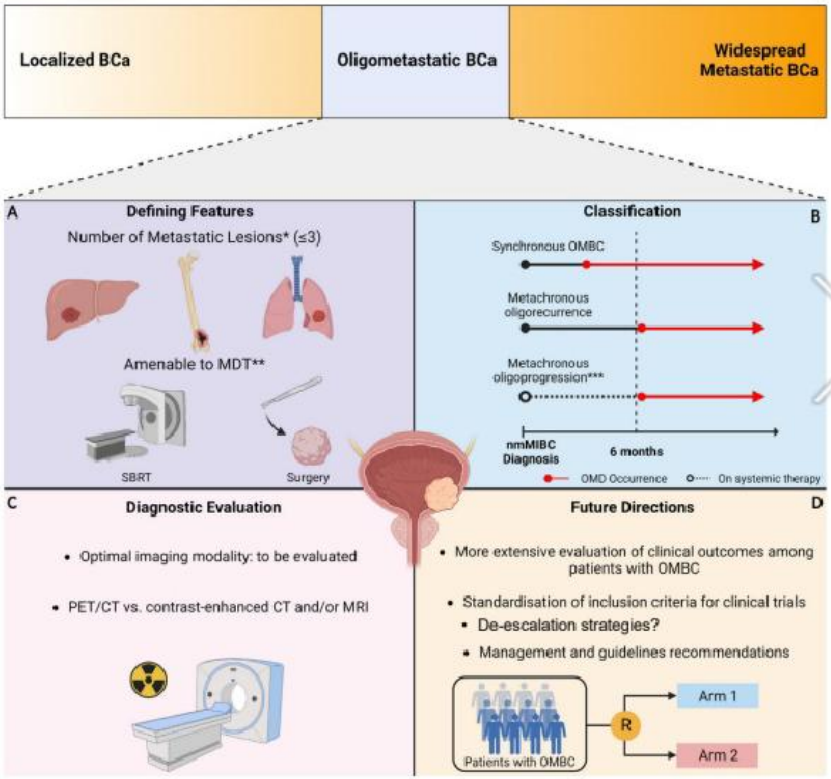
Oligometastatic Bladder Cancer



- **T0:** first-time diagnosis of primary bladder cancer (green) and oligometastases in liver and lung (red) within 6 mo

- **T-X:** diagnosis and treatment of primary bladder cancer (green) in a nonmetastatic state
- Systemic therapy–free interval
- **T0:** first-time diagnosis of new oligometastases in liver and lung (red) >6 mo after diagnosis of cancer

Bamias et al. Eur Urol 2023



Labaki et al. Eur Urol 2023

Integration of Early Palliative Care with cancer treatment from the time of diagnosis or soon after

focuses on :

1. Improving quality of life
2. Managing symptoms
3. Addressing psychosocial and spiritual needs ***alongside active cancer treatment***.

Studies have shown that early palliative care can lead to improved quality of life, reduced symptom burden, and even increased survival in some cases.

Recommended in JCO and NCCN clinical guidelines


Palliative Care for Patients With Cancer: ASCO Guideline Update

Authors: Justin J. Sanders, MD, MSc, Sarah Temin, MSPH, Arun Ghoshal, MBBS, MD, MRes, Erin R. Alesi, MD, Zipporah Vunoro Ali, MD, Cynthia Chauhan, MSW, James F. Cleary, MD, ... SHOW ALL ..., and Betty R. Ferrell, PhD | AUTHORS INFO & AFFILIATIONS

Publication: Journal of Clinical Oncology • Volume 42, Number 19 • https://doi.org/10.1200/JCO.24.00542

Key messages

1. For resectable bladder cancer the new standard of care is neoadjuvant chemo+immunotherapy followed by surgery then adjuvant immunotherapy

2. For bladder preserving strategies:
    1. we can sometimes offer concurrent chemo+radiation.
    2. In some cases ***neoadjuvant chemo+immunotherapy followed by adjuvant immunotherapy

3. Median OS for metastatic bladder cancer has increased from 16 months with chemotherapy to 33 months with combination immunotherapy and antibody drug conjugates (ADC)

4. And there are some long-term survivors

5. Immunotherapy can have significant toxicities. Patient education and clinician awareness is paramount.

6. With better disease control and survival there is the opportunity to push boundaries including targeting oligometastatic disease and oligoprogressive disease with local therapies

7. Think of early palliative involvement