

Late breaking session on uro-oncology

A Urologist's point of view

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bmuc.be/bmuc-2026



**13th Belgian Multidisciplinary
Meeting on Urological Cancers**

Conflicts of interest

- I have no potential conflict of interest to report



Late breaking abstracts EAU 2026

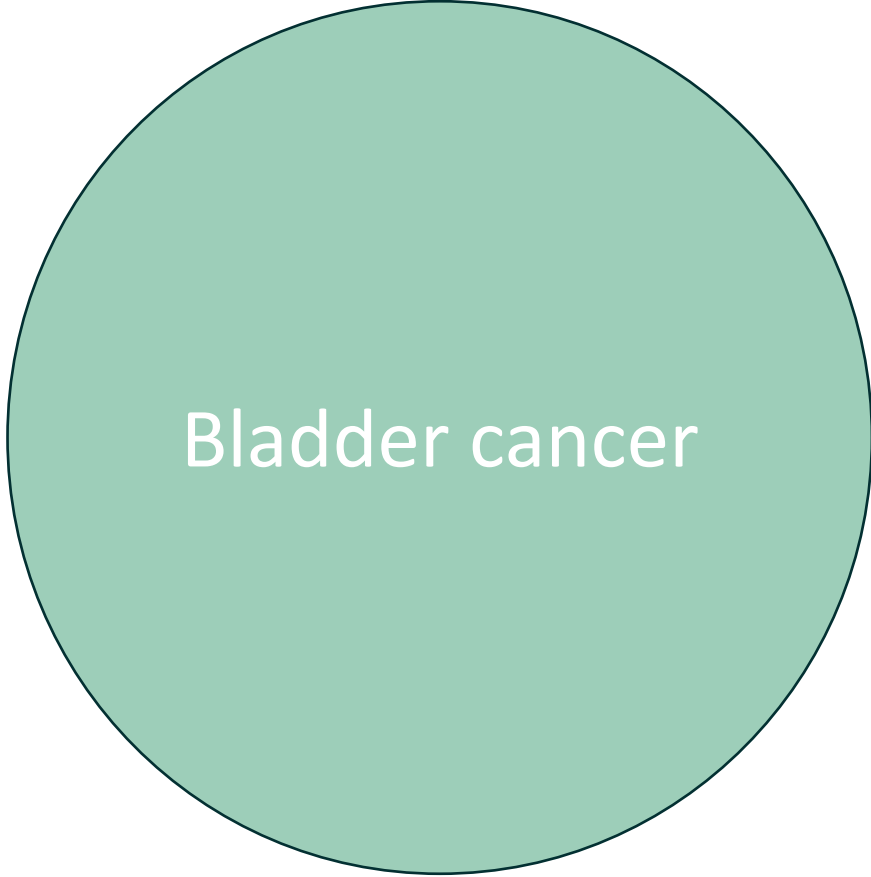
I will focus on 2 EAU abstracts and give context



Late breaking abstracts EAU 2026



Prostate Cancer



Bladder cancer

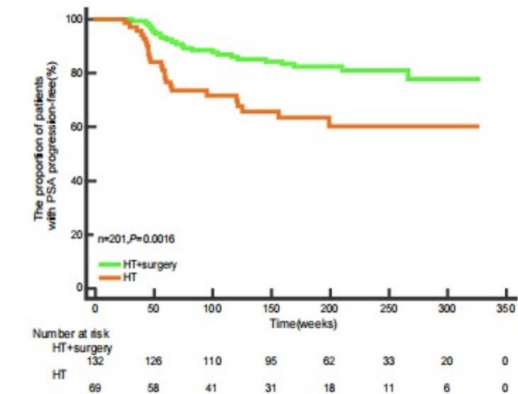
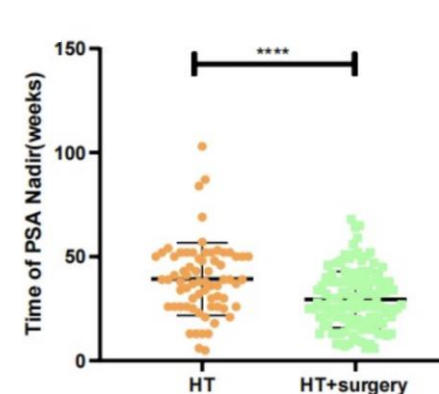


Prostate cancer – Role of local therapy in M+ disease

EAU P0156: “Effect of cytoreductive radical prostatectomy combined with hormonal therapy in patients with oligometastatic prostate cancer: A multicentered prospective non-randomized control study”

Chen X et al.

- Multi-center prospective non-randomized study
- N=201 with omPCa (≤ 3 bone metastases)
- Staging = CT/bone scan
- N=69 (HT only), 132 (HT + RALP within one year)



Prostate cancer – Role of local therapy in M+ disease

Question: Is there a role for surgery in metastatic prostate cancer?

- A) Yes, of course
- B) No, definitely not
- C) I believe it does, but I'm not sure
- D) I really do not know



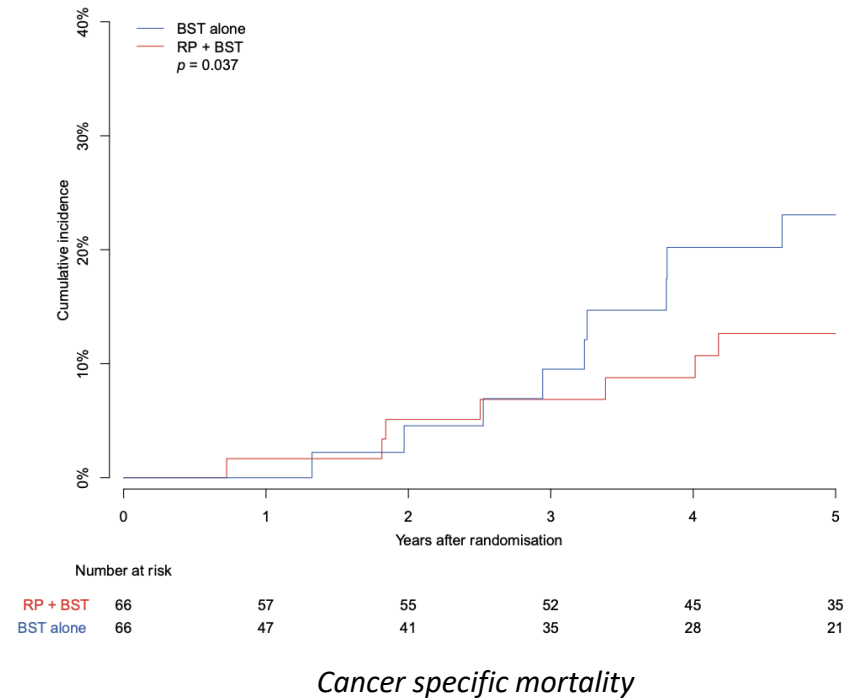
Prostate cancer – Role of local therapy in M+ disease

*Remember... **RAMPP trial***

RCT BST vs BST + RALP

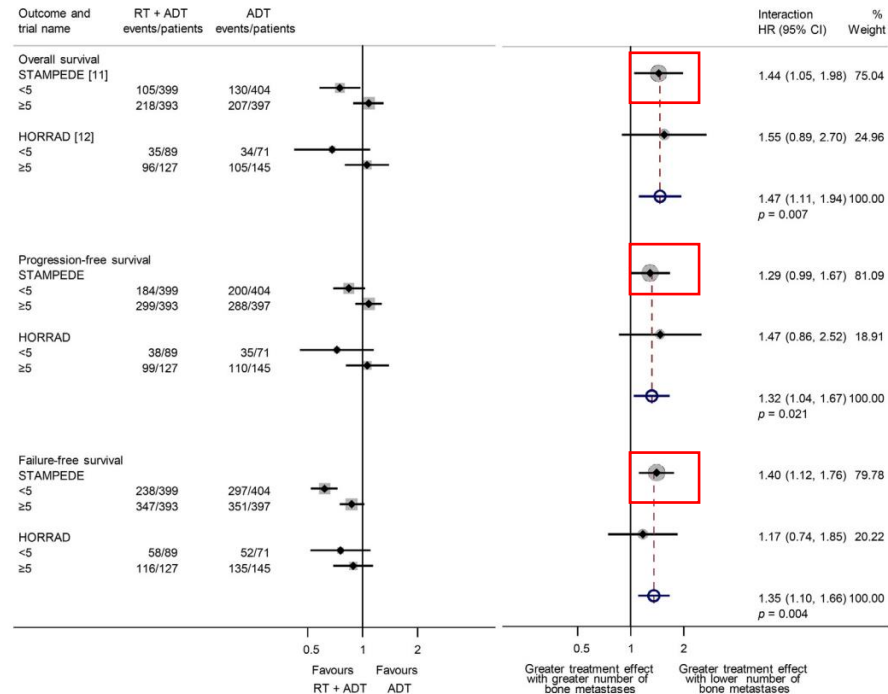
Recruitment issues & data of on RT

*Despite underpowered, positive effect on
CSM*



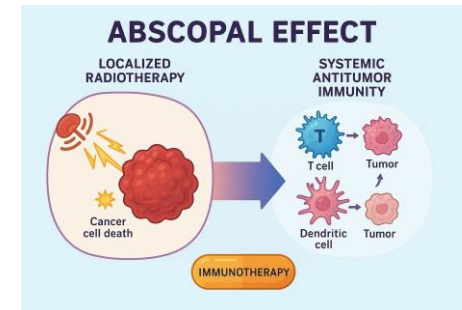
Prostate cancer – Role of local therapy in M+ disease

STOPCAP

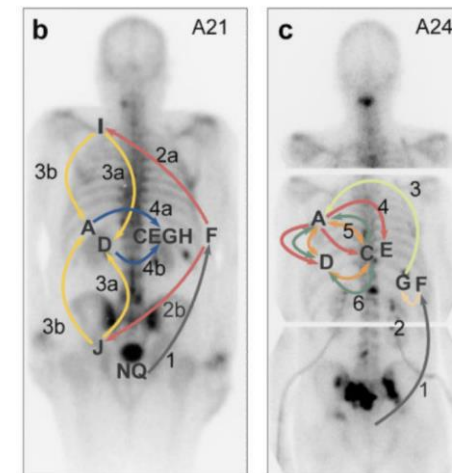


*Driven by STAMPEDE data
Data questionable, but SoC*

Why would local RT work better than surgery?



? Prostate cancer = immune-cold



Clones of the primary tumor can lead to metastatic lesions, which by itself can cause more metastases.

Target the primary tumor = preventing multiple metastatic clones

Prostate cancer – Role of local therapy in M+ disease

Conclusion: Is there a role for radical prostatectomy in metastatic prostate cancer?

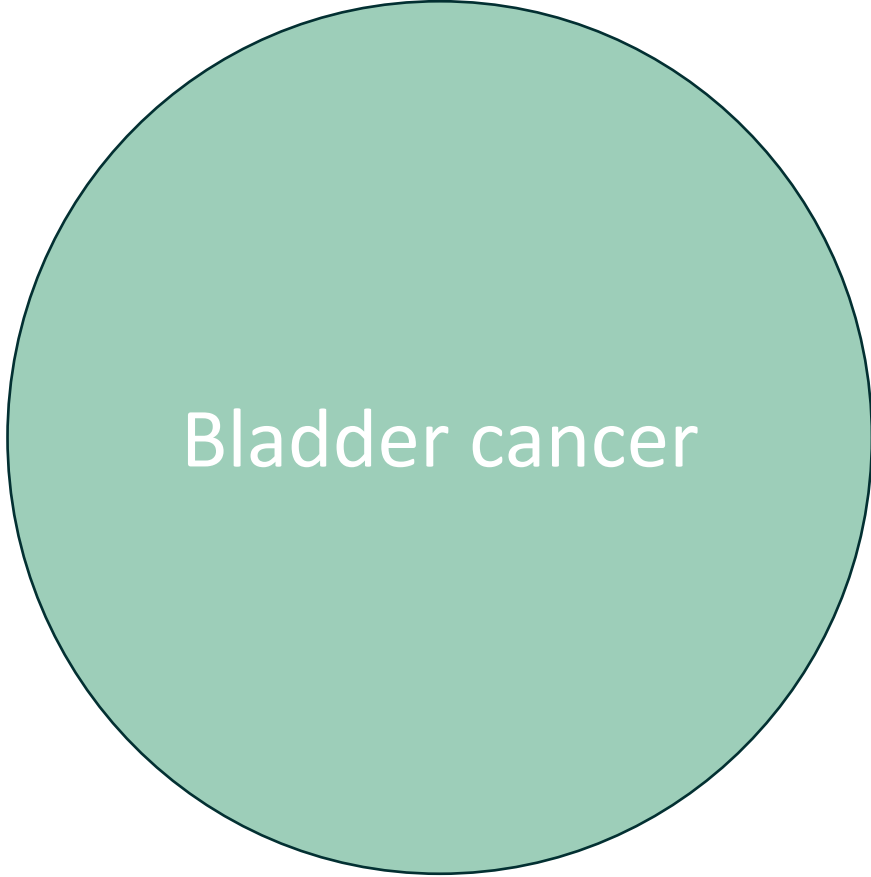
- Evidence of local RT = stronger (RCTs, but HORRAD remains negative)
- Increasing evidence of radical prostatectomy for local control and metastatic progression in oligometastatic prostate cancer
- especially in patients with severe LUTS and recurrent acute urinary retentions
 - But: include in prospective observational study to follow-up outcomes.



Late breaking abstracts EAU 2026



Prostate Cancer



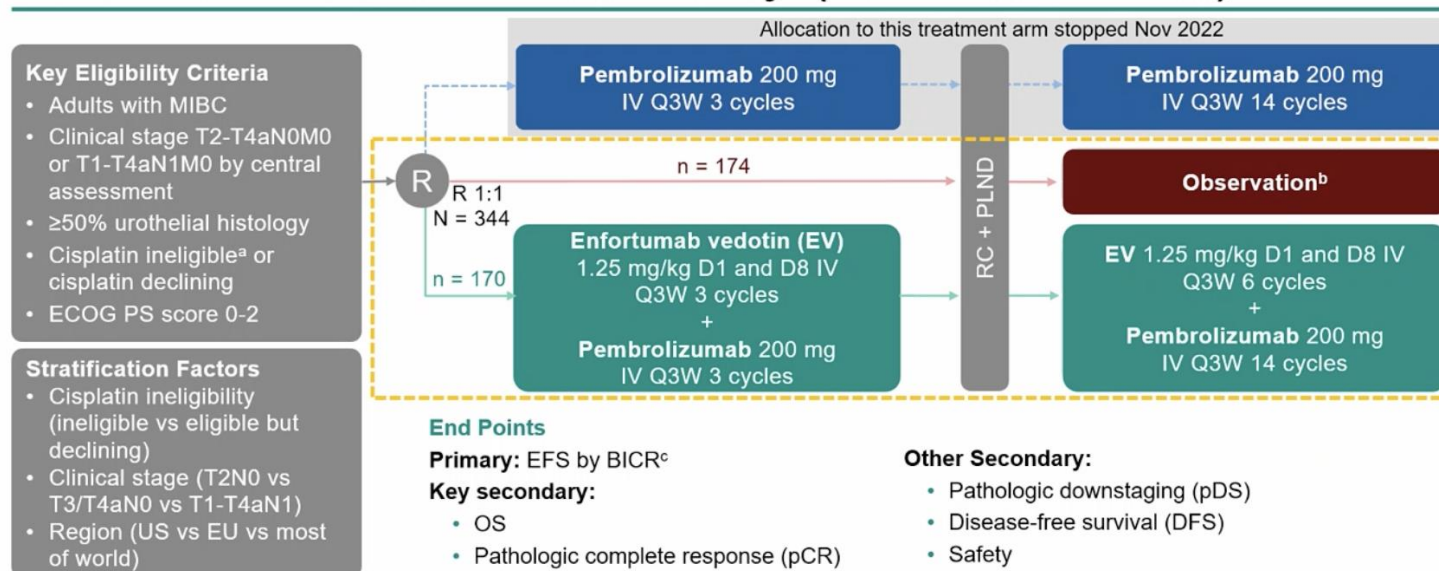
Bladder cancer



Bladder cancer – Role of surgery in MIBC

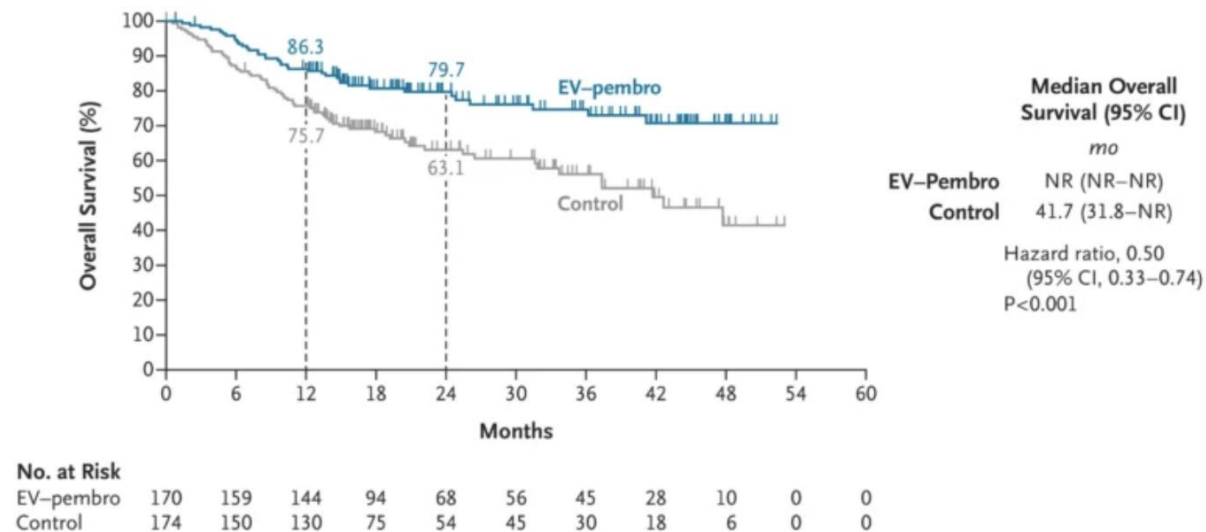
A0875: KEYNOTE-905 study of neoadjuvant and adjuvant (neoadj-adj) Enfortumab Vedotin (EV) plus pembrolizumab (pembro) in participants with muscle-invasive bladder cancer (MIBC) who are cisplatin-ineligible: Assessment of surgical outcomes
Shore N et al.

KEYNOTE-905/EV-303 Study (NCT03924895)



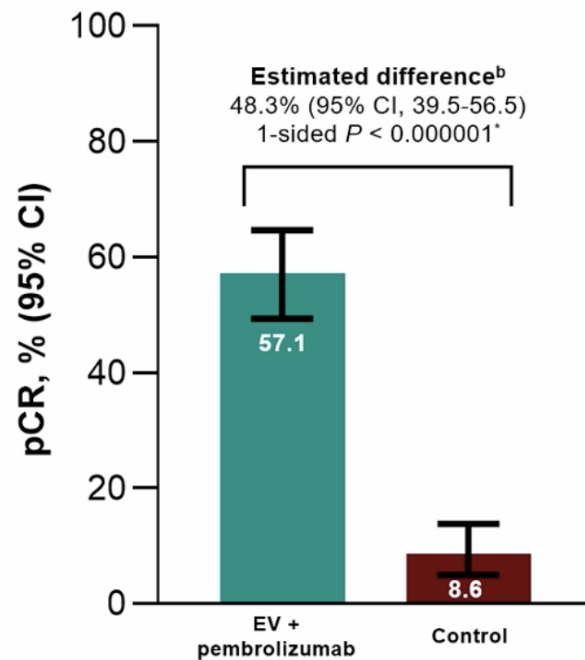
Bladder cancer – Role of surgery in MIBC

A0875: KEYNOTE-905 study of neoadjuvant and adjuvant (neoadj-adj) Enfortumab Vedotin (EV) plus pembrolizumab (pembro) in participants with muscle-invasive bladder cancer (MIBC) who are cisplatin-ineligible: Assessment of surgical outcomes
Shore N et al.



- Deaths:
 - 22.4% in the combination group
 - 39.1% in the control group
- Unseen survival data!

Bladder cancer – Role of surgery in MIBC



- High rates of pCR (60% vs 9% for radical cystectomy)
 - Compared to neo-adjuvant chemotherapy trials: pCR +- 30%
- Role of surgery for such high pCR rates?
 - Bladder sparing treatment: EBRT?
 - Bladder sparing treatment: Active surveillance?

Bladder cancer – Role of surgery in MIBC

Question: What would be the role of surgery in MIBC when (Neo-)adjuvant EV-Pembro is reimbursed?

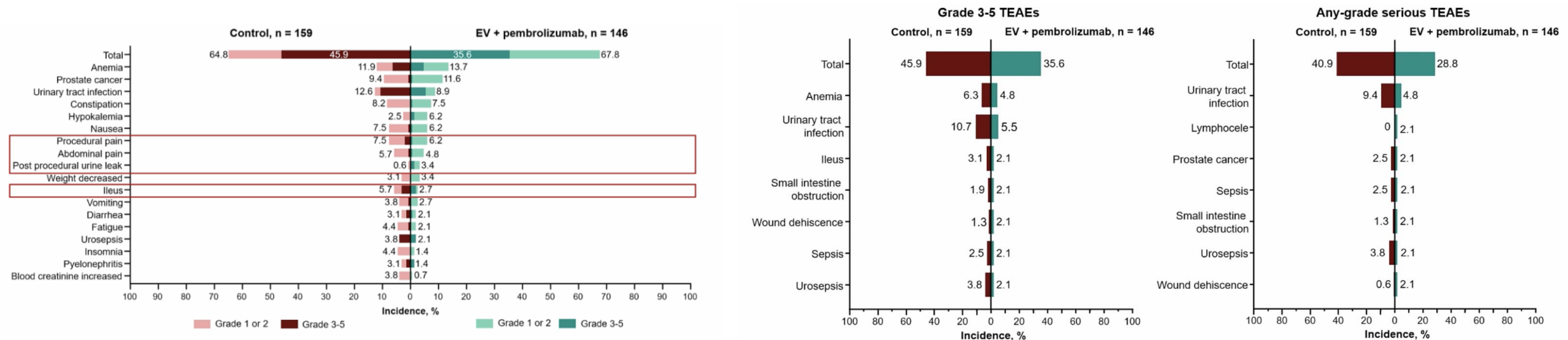
- A) Surgery remains the SoC
- B) Patients should be carefully followed up
- C) Patients should receive consolidating radiotherapy
- D) I really do not know



Bladder cancer – Role of surgery in MIBC

Surgery as SoC

A0875: KEYNOTE-905 study of neoadjuvant and adjuvant (neoadj-adj) Enfortumab Vedotin (EV) plus pembrolizumab (pembro) in participants with muscle-invasive bladder cancer (MIBC) who are cisplatin-ineligible: Assessment of surgical outcomes
Shore N et al.



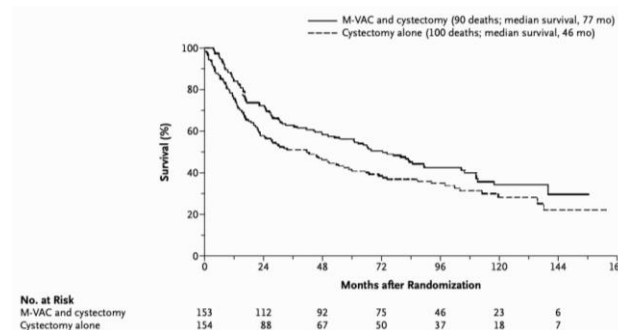
Adverse events very comparable between control arm and EV-Pembro

Surgery = safe during treatment with EV-Pembro

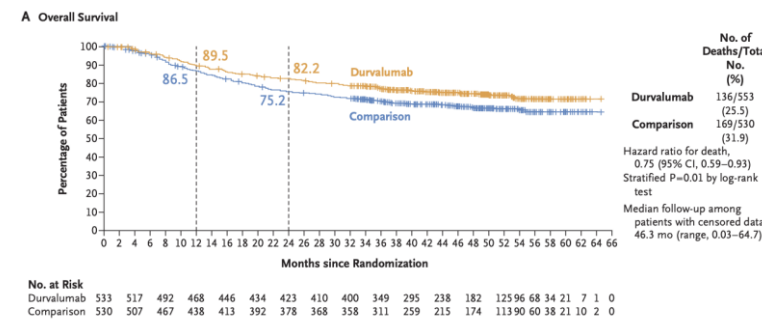
Bladder cancer – Role of surgery in MIBC

Data on radical cystectomy

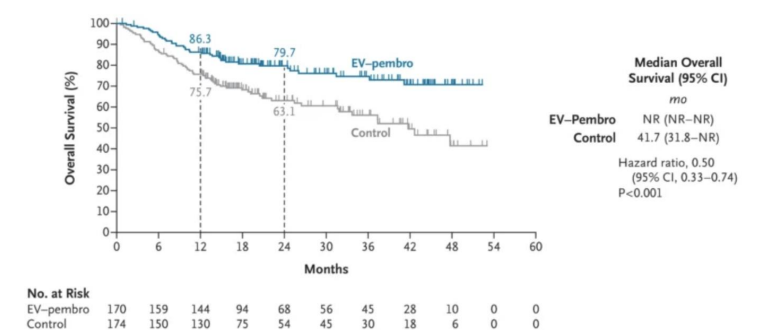
NAC



NAC + Durvalumab



EV-Pembro

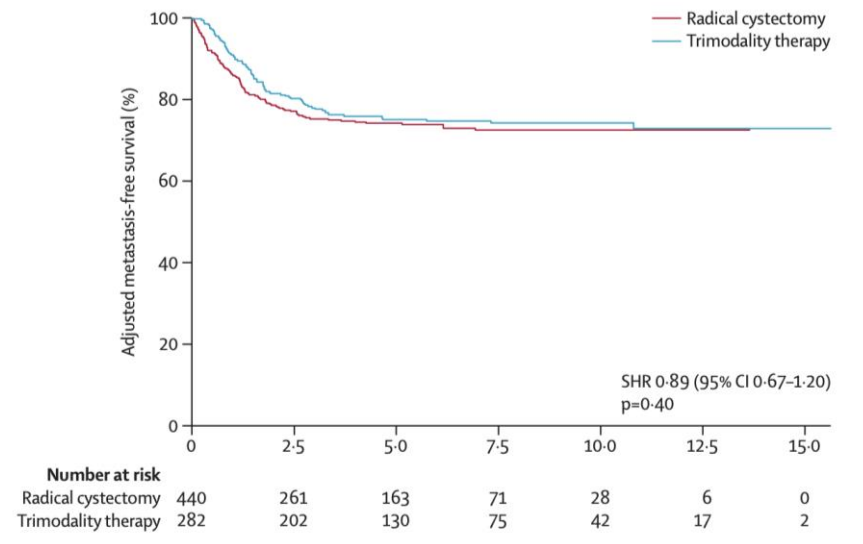


3 RCTs on (neo-)adjuvant therapy followed by surgery
Best available data

Bladder cancer – Role of surgery in MIBC

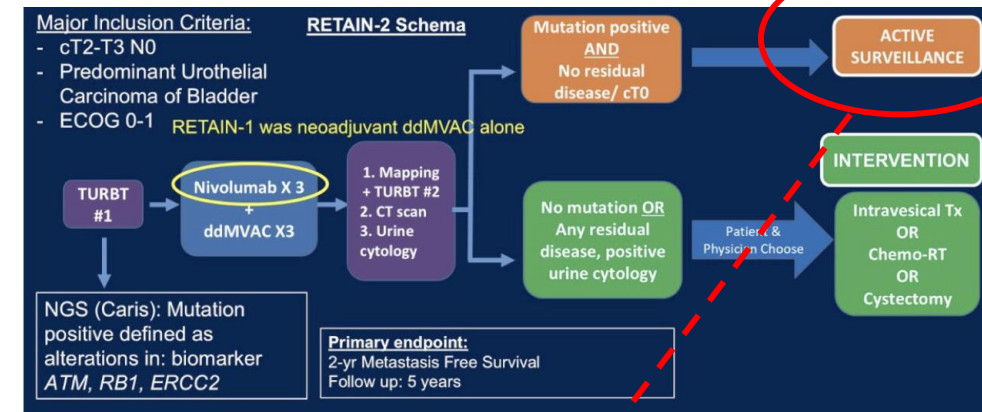
What about bladder preservation options?

Trimodal therapy



- Retrospective data
- Pre-immunotherapy era

Active surveillance

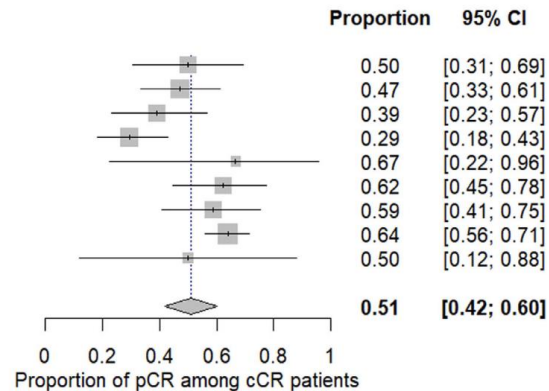


- 2-year MFS 82%
- 2-year MFS with intact unradiated bladder: 60%

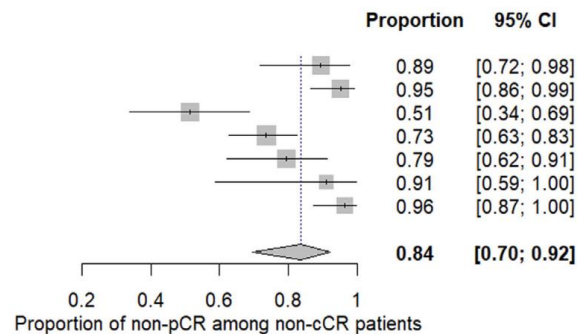
No certainty on the safety/efficacy of TMT or AS with current (neo-)adjuvant systemic treatment

Bladder cancer – Role of surgery in MIBC

cCR = not pCR – pre EV-Pembro era



51% with cCR = pCR



84% with no cCR = no pCR

- Clinical complete response = a poor prognostic factor for pathological complete response!
- After cCR + surveillance: **45–70%** develop intravesical recurrence (mostly NMIBC), with 10–20% progressing to MIBC/metastatic disease over ~3–5 years.
- After surgery, ypT0N0 disease after NAC has a recurrence-free survival of **93.5%** after 5-year recurrence-free survival

Bladder cancer – Role of surgery in MIBC

RIZIV criteria

TERUGBETALING IMFINZI INF. OPLOSS. (CONC.) I.V. [FLAC.] 1 X 120 MG / 2,4 ML (BRON: RIZIV)

SKP + bijsluiter	
CTI-ext	538853-01
CNK	3687-514
in ziekenhuisforfait	neen
eenheidstarificatie	neen
grote verpakking	neen

categorie a

remgeld reguliere tegemoetkoming:

remgeld verhoogde tegemoetkoming:

regelgeving

🗨️ hoofdstuk IV § 9670000 (controle: a priori)

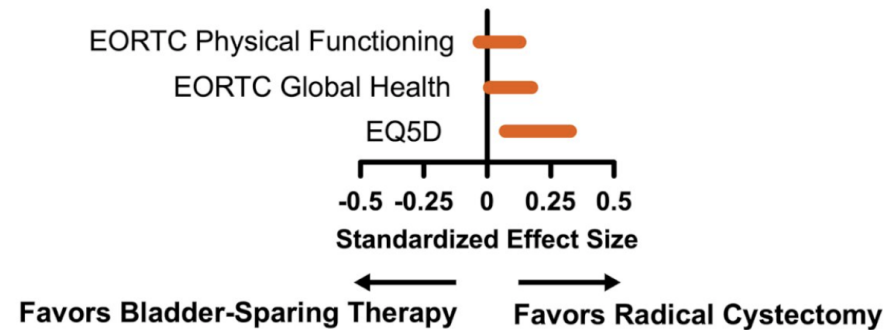
- a) De farmaceutische specialiteit op basis van het werkzaam bestanddeel durvalumab, ingeschreven in de huidige paragraaf, komt in aanmerking voor vergoeding indien ze gebruikt wordt.
- De behandeling van volwassen rechthebbenden met resectabele, spierinvasieve blaaskanker (Muscle Invasive Bladder Cancer – MIBC) in combinatie met gemcitabine en cisplatine als neoadjuvante behandeling, gevolgd door monotherapie als adjuvante behandeling na radicale cystectomie.

No cystectomy = no reimbursement of adjuvant Durvalumab = 7% reduction in OS

Bladder cancer – Role of surgery in MIBC

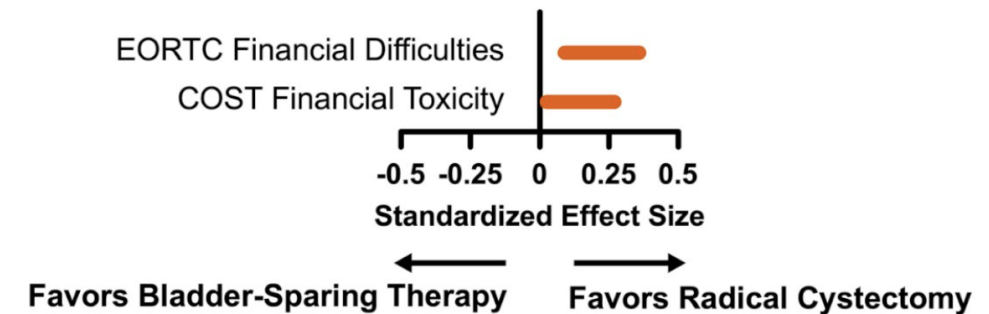
QoL cystectomy vs bladder sparing therapy – CISTO trial

Results: General Quality of Life



QoL: favors radical cystectomy

Results: Financial Well-Being Outcomes

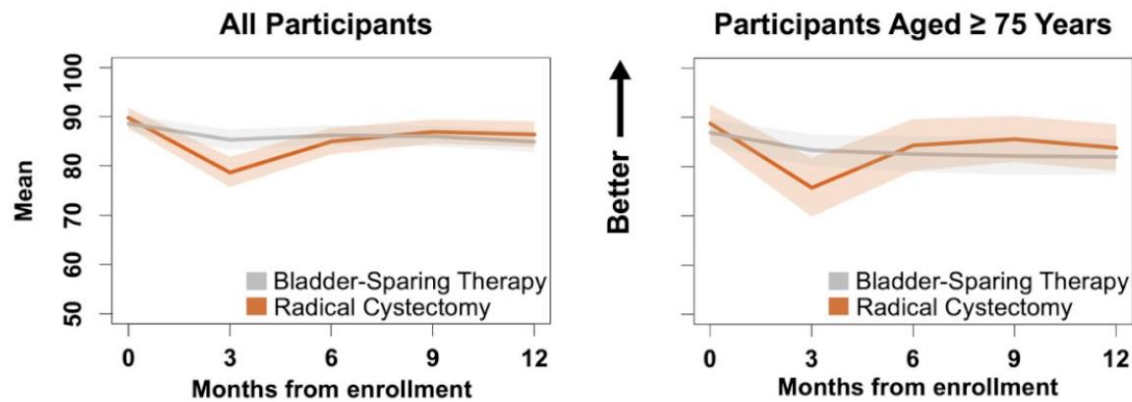


Financial well being: favors cystectomy

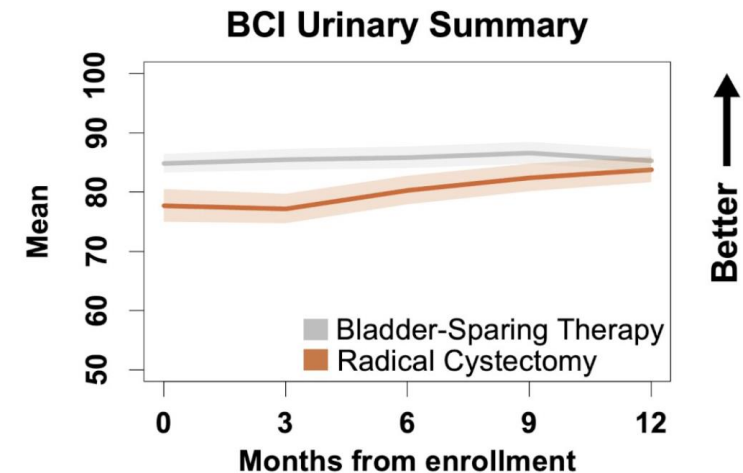
Bladder cancer – Role of surgery in MIBC

QoL cystectomy vs bladder sparing therapy – CISTO trial

Results: Longitudinal Physical Functioning



Physical functioning: Declined at 3m, normalised at 6 mo, even slightly better for elderly.



Urinary health: worse during the first year, then normalizes

Bladder cancer – Role of surgery in MIBC

QoL cystectomy vs bladder sparing therapy – CISTO trial

Summary of 12-Month Outcomes

Favors BST	No Difference	Favors RC
Bowel health Sexual health	Physical functioning • Overall • By age Role functioning Social functioning Urinary health	Physical functioning • Patients w/ CIS • Unpartnered Cognitive functioning Mental health Financial health

Patients who undergo cystectomy have clearly more benefits than harms compared to bladder sparing treatments (anxiety for cystoscopies, urine cytologies, biopsies, etc)

Conclusion

Prostate cancer

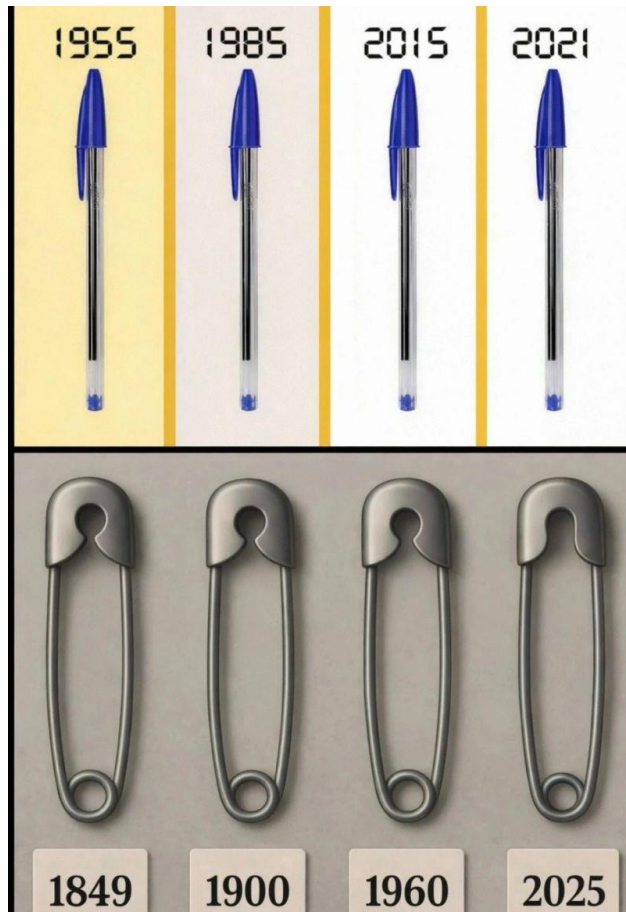
- There is **increasing evidence** that radical prostatectomy in oligometastatic prostate cancer has an impact on survival.
- In patients with oligometastatic disease with serious LUTS or recurring urinary retentions, radical prostatectomy can be **considered** as an **alternative** to EBRT, but follow-up data should be collected in a prospective registry.

Bladder cancer

- The **side effects/complications** of radical cystectomy **do not increase** with neo-adjuvant EV-Pembro and are **low**, hence the procedure is safe.
- Based on the EV-905 and NIAGARA trial, we can conclude that:
 - **Active surveillance and TMT** have **insufficient data** to be SoC with current systemic treatments
 - In patients who have **resectable MIBC (neo-) adjuvant therapy + radical cystectomy is the current SoC** (cfr reimbursement) with **excellent QoL**



Final Conclusion



**Faris
Abushamma MD,
MSc(Urol), FPBU,
FRCS(Urol)**

Dean of Medicine | Hospital B...

[Mijn website bezoeken](#)

1 d • 

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 [Connectie maken](#) ...

In urology, not every new trend deserves adoption.

If a procedure delivers safe, consistent, and proven outcomes, it still holds its place. 🏆

Innovation matters — but it must be evidence-based, not trend-driven. 🧐

We don't follow trends. We follow outcomes.

If your procedure works for you and for your patient, stick to it until you adopt the new one successfully, + the new one should stand the test of time 😊