

Bladder cancer session: Peri-operative systemic treatments

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Holiday Inn Brussels Airport

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

Conflicts of interest

- I have the following potential conflict(s) of interest to report

Type of affiliation / financial interest	Name of commercial company
Research funding and medical writing support	Merck Sharp & Dohme LLC, a subsidiary of Merck & Co., Inc., Rahway, NJ, USA (MSD)
Advisory board (personal)	MSD, Janssens-Cilag, GSK, Astellas Pharma, BMS, Leo Pharma, Bayer, AstraZeneca, Pfizer, Merck, Atheneum Partners
Research grant (to institution)	MSD



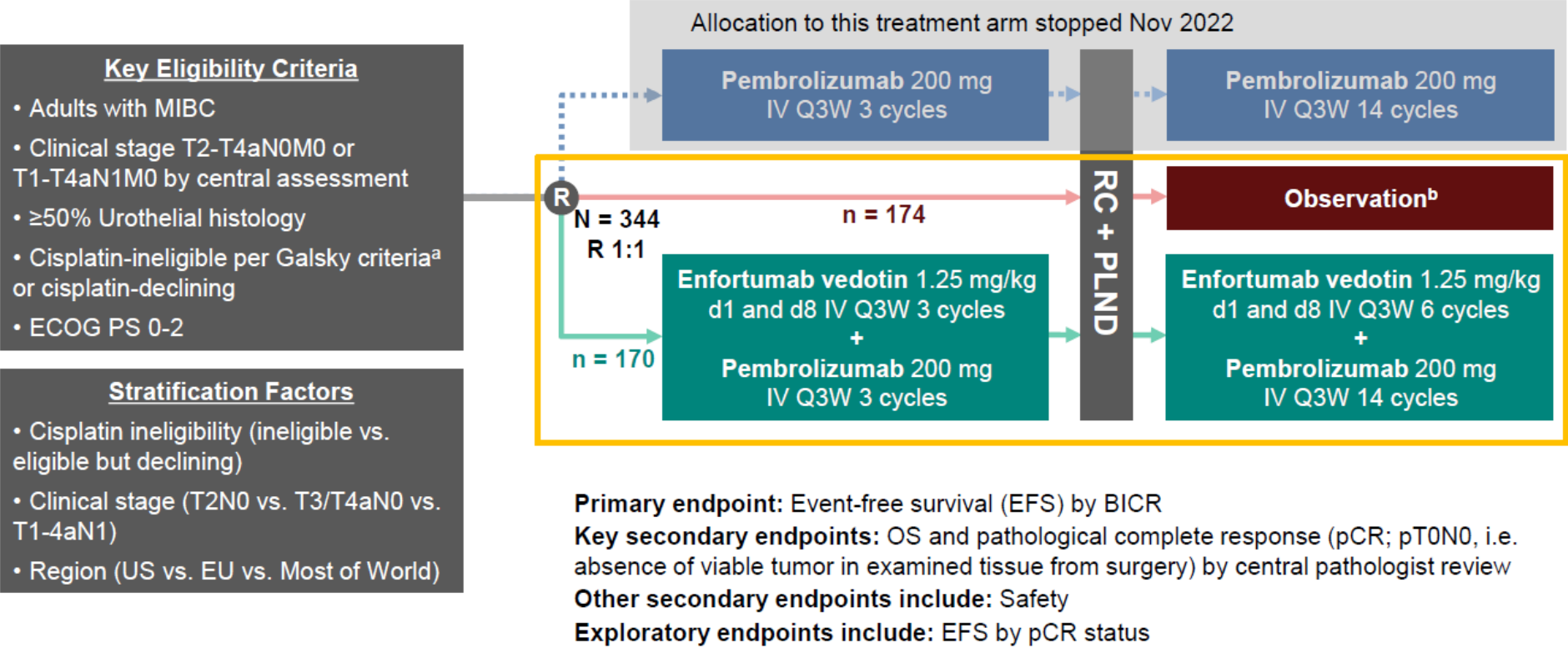
BACKGROUND

- Patients with MIBC are at significant risk of disease recurrence after surgery (RC + PLND), with a median overall survival of < 5 years^{1,2}
- Neoadjuvant cisplatin-based chemotherapy (with/without perioperative durvalumab, or adjuvant nivolumab for high-risk disease) and RC + PLND is standard of care for patients with MIBC^{3,4}
- Nearly 50% of patients with MIBC are ineligible for cisplatin (per Galsky criteria)⁵⁻⁸
 - These patients have no neoadjuvant options and tend to be older, frailer, and have more comorbidities
- Limited literature in this cisplatin-ineligible population with MIBC suggests poor outcomes with RC + PLND alone, highlighting a significant unmet medical need⁵⁻⁷
 - No prior phase 3 trial has shown benefit from perioperative therapy in this population
- Enfortumab vedotin (EV) + pembrolizumab (pembro) has strong rationale for investigation in the perioperative setting in this population

MIBC, muscle-invasive bladder cancer; RC + PLND, radical cystectomy with standard pelvic lymph node dissection

1. Barton Grossman et al. *N Engl J Med* 2003; 2. International Collaboration of Trialists et al. *J Clin Oncol* 2011; 3. Powles T, et al. *Ann Oncol* 2022; 4. NCCN Bladder Cancer (v1.2025); 5. Fazili AN, et al. *J Urol* 2025; 6. Jiang DM, et al. *Nat Rev Urol* 2021; 7. Galsky MD, et al. *Lancet Oncol* 2011; 8. Dash A, et al. *Cancer* 2006.

STUDY DESIGN (NCT03924895)



BICR, blinded independent central review; IV, intravenous; Q3W, every 3 weeks. ^aProtocol-defined as having ≥1 of the following: impaired renal function (creatinine clearance 30–59 ml/min), ECOG PS 2, gr ≥2 audiometric hearing loss, or NYHA class III heart failure; ^bAs of Nov 2022, adjuvant nivolumab was permitted when clinically indicated and regionally available.



Perioperative Enfortumab Vedotin Plus Pembrolizumab in Participants With Muscle-invasive Bladder Cancer Who Are Cisplatin-ineligible: Phase 3 KEYNOTE-905 Study

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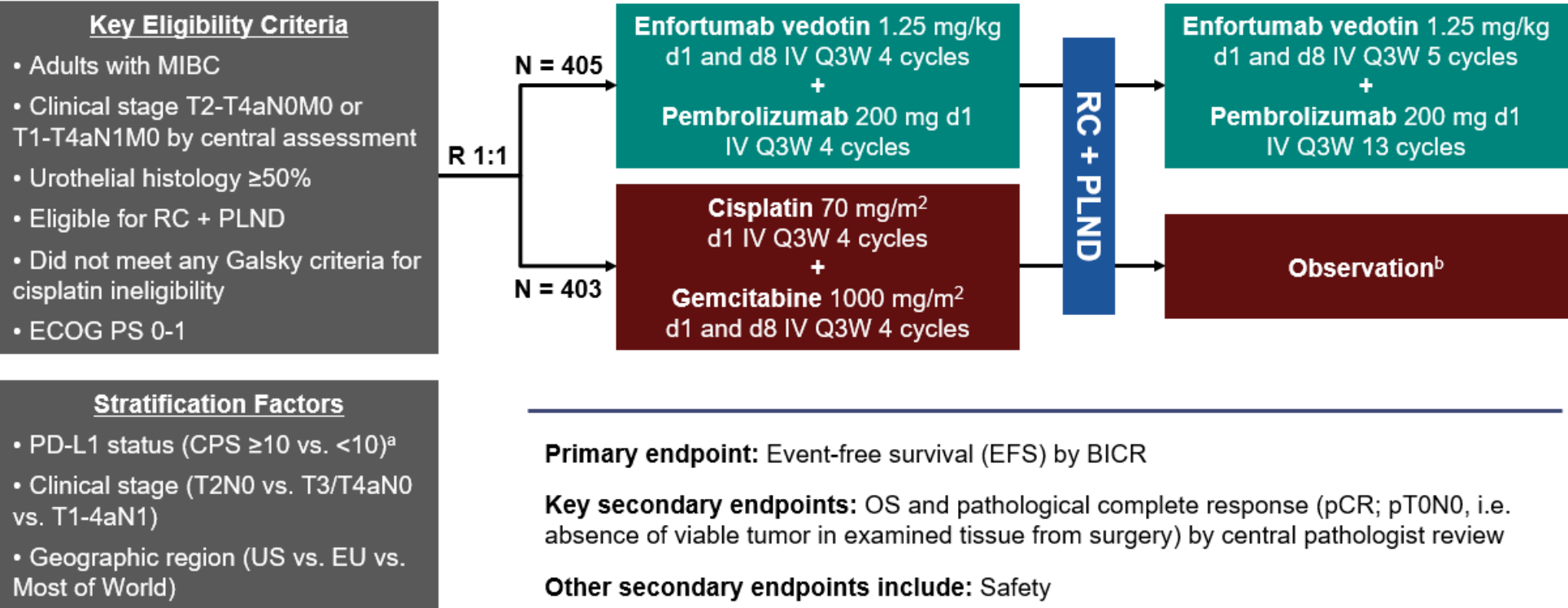
The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Perioperative Enfortumab Vedotin and Pembrolizumab in Bladder Cancer

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STUDY DESIGN (NCT04700124)



BICR, blinded independent central review; CPS, combined positive score; IV, intravenous; Q3W, every 3 weeks.

^aAssessed by PD-L1 IHC 22C3 pharmDx (Agilent, Carpinteria, CA); CPS = # PD-L1–staining cells (tumor cells, lymphocytes, and macrophages) ÷ total # viable tumor cells × 100.

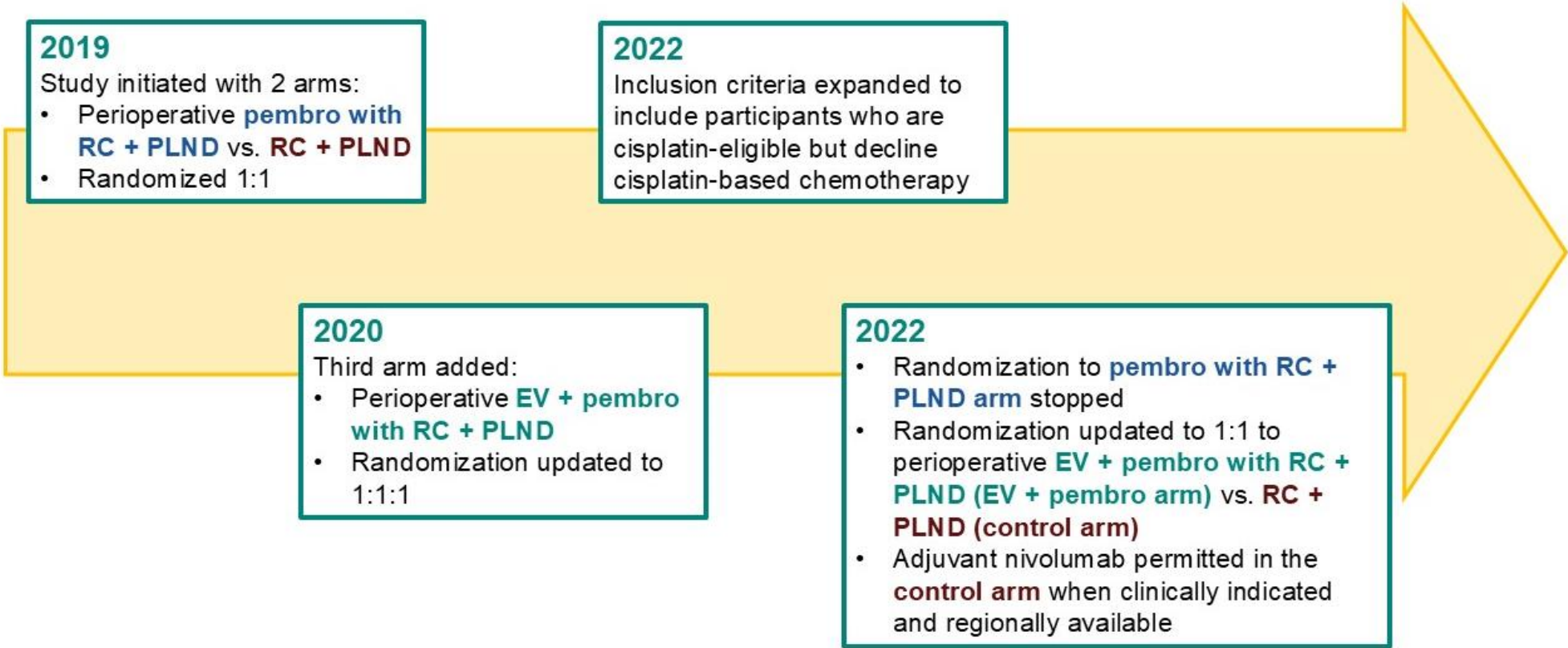
^bAs of Feb 2023, adjuvant nivolumab was permitted when clinically indicated and regionally available.

Data cutoff date: 27 October 2025

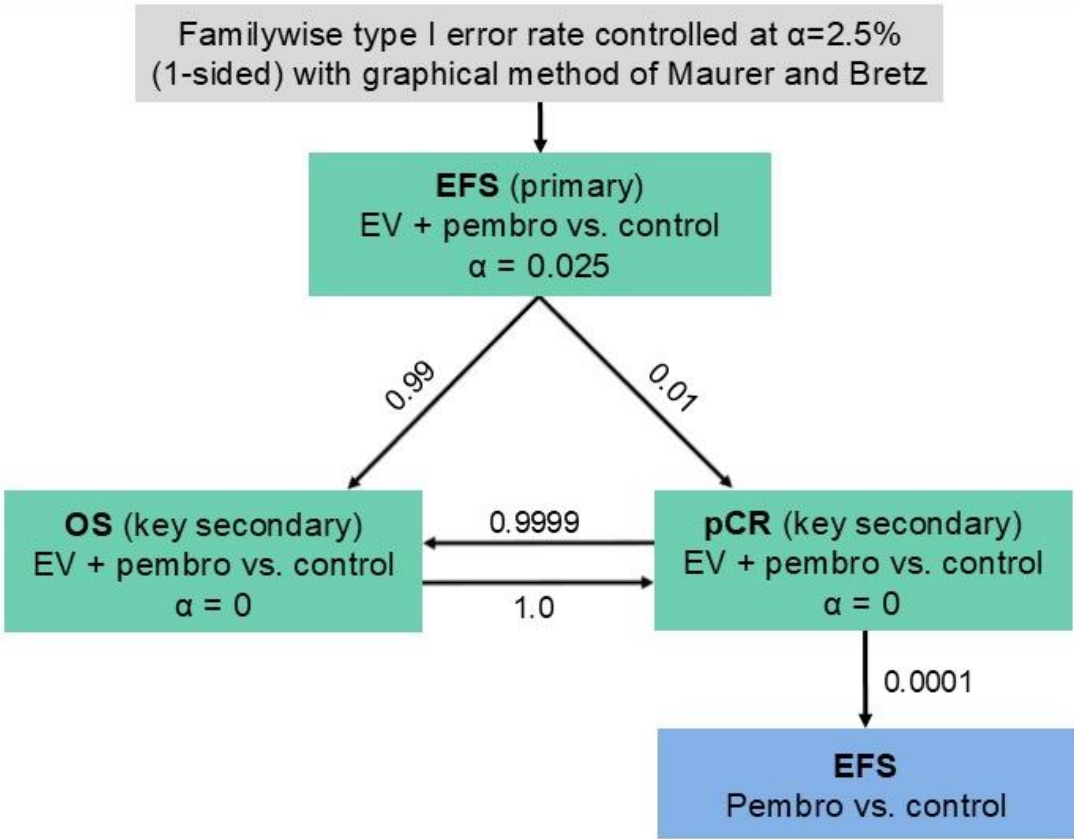
KEYNOTE-905 / EV-303: Topline results



TIMELINE OF STUDY DESIGN DEVELOPMENT



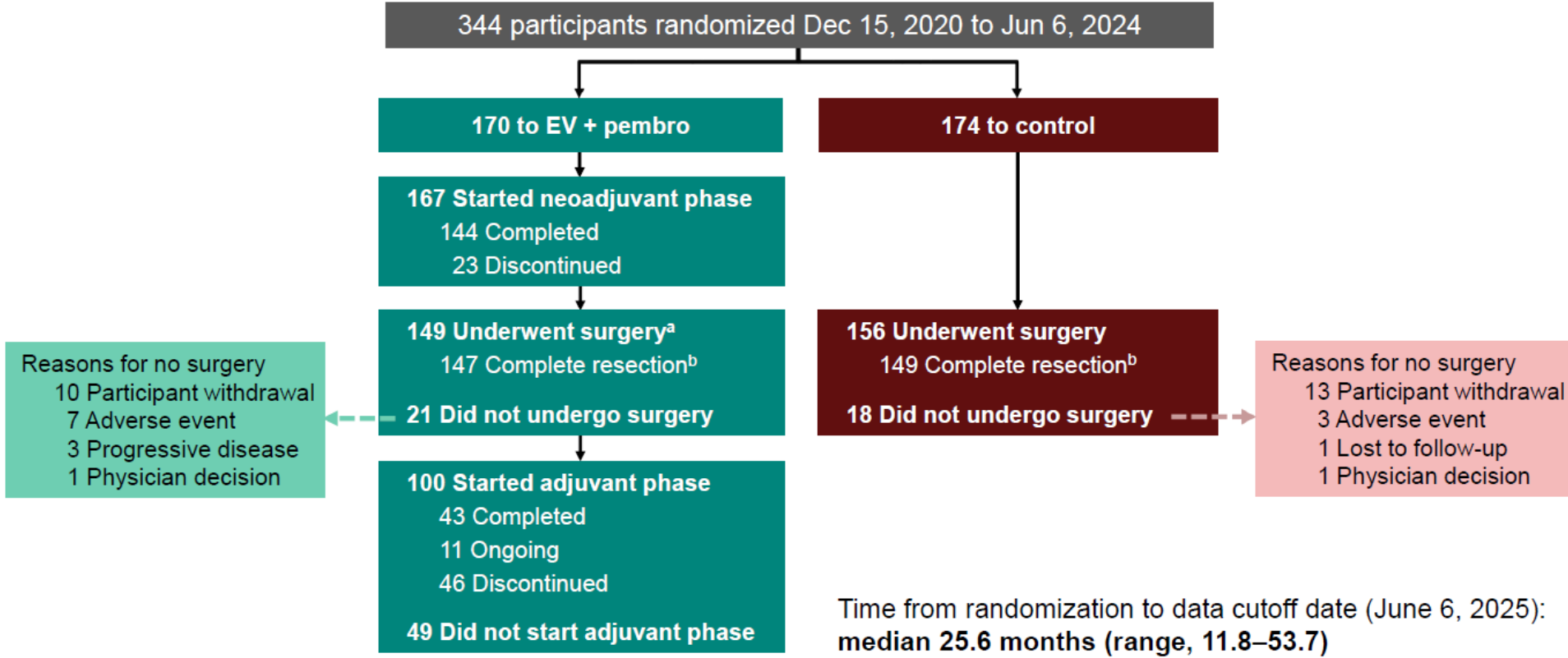
STATISTICAL CONSIDERATIONS



ITT, intention-to-treat; TEAE, treatment-emergent adverse event.

- **Efficacy** for EV + pembro vs control was assessed in all concurrently randomized participants (ITT population) to the EV + pembro and control arms
- **TEAEs** were assessed in all participants with ≥ 1 dose of study treatment, including surgery
- Study continues to evaluate additional hypotheses for perioperative pembro arm

PARTICIPANT DISPOSITION



^aIncluded 3 pts who received surgery without on-study neoadjuvant therapy. ^bIncomplete resection included: unresectable tumor, newly discovered metastatic disease, or other.

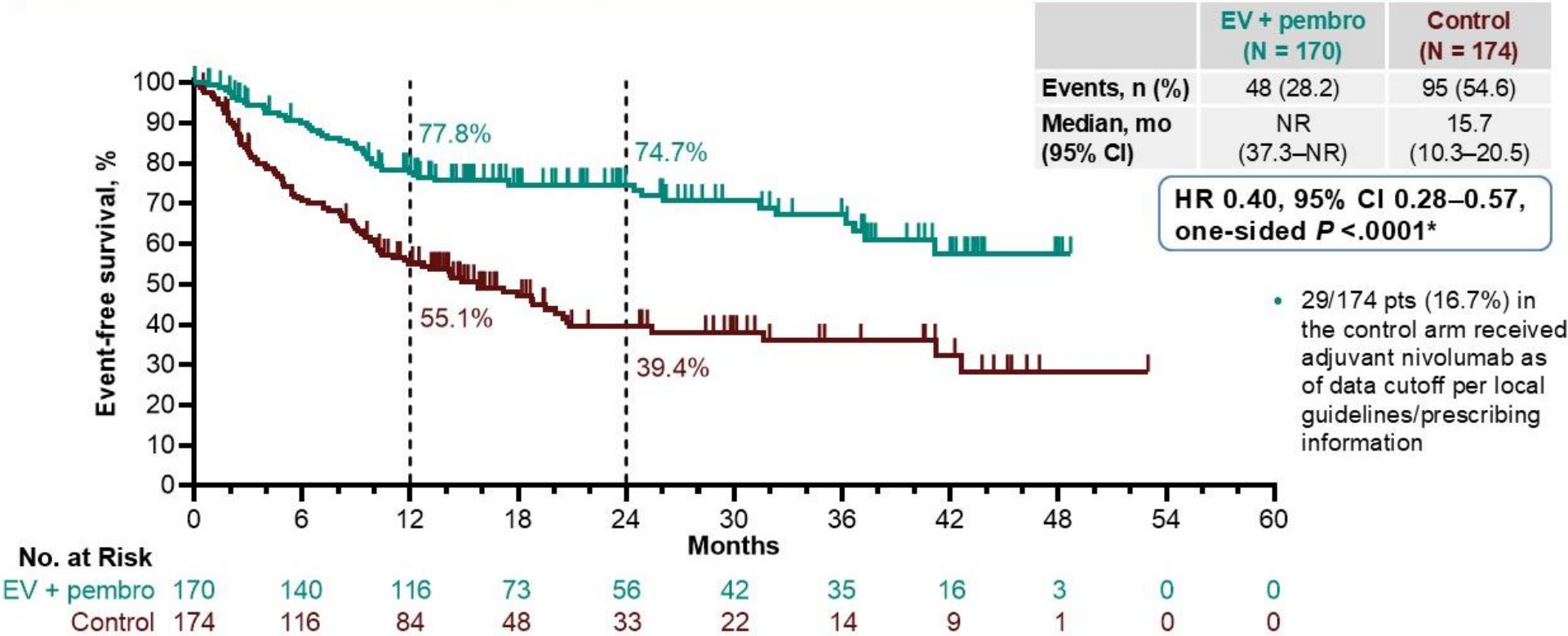
BASELINE CHARACTERISTICS

Characteristic, n (%)	EV + pembro (N = 170)	Control (N = 174)
Median age (range), years	74.0 (47–87)	72.5 (46–87)
≥65 to <75 years	63 (37.1)	77 (44.3)
≥75 years	78 (45.9)	68 (39.1)
Male	137 (80.6)	131 (75.3)
ECOG PS		
0	102 (60.0)	95 (54.6)
1	47 (27.6)	53 (30.5)
2	21 (12.4)	26 (14.9)
Region		
United States	21 (12.4)	23 (13.2)
European Union	78 (45.9)	77 (44.3)
Most of World	71 (41.8)	74 (42.5)
Cisplatin eligibility status (per Galsky criteria)		
Ineligible	142 (83.5)	139 (79.9)
Eligible but declining	28 (16.5)	35 (20.1)
PD-L1 combined positive score (CPS) ≥10^a	80 (47.1)	83 (47.7)
Tumor stage at baseline (centrally assessed using both pathology of TURBT specimen and imaging)^b		
T2N0	30 (17.6)	32 (18.4)
T3/T4aN0	133 (78.2)	132 (75.9)
T1-4aN1	7 (4.1)	10 (5.7)
Creatinine clearance		
≥60 mL/min	68 (40.0)	72 (41.4)
≥30 and <60 mL/min	102 (60.0)	101 (58.0)
<30 mL/min	0	1 (0.6)
Pure urothelial carcinoma histology	152 (89.4)	161 (92.5)

TURBT, transurethral resection of bladder tumor. ^aBy PD-L1 IHC 22C3 pharmDx (Agilent, Carpinteria, CA); CPS = # PD-L1–staining cells (tumor cells, lymphocytes, and macrophages) ÷ total # viable tumor cells × 100. ^bBy investigator assessment, 124 pts (72.9%) in the EV + pembro arm and 119 pts (68.4%) in the control had T2N0 stage MIBC at baseline. Data cutoff date: 6 June 2025



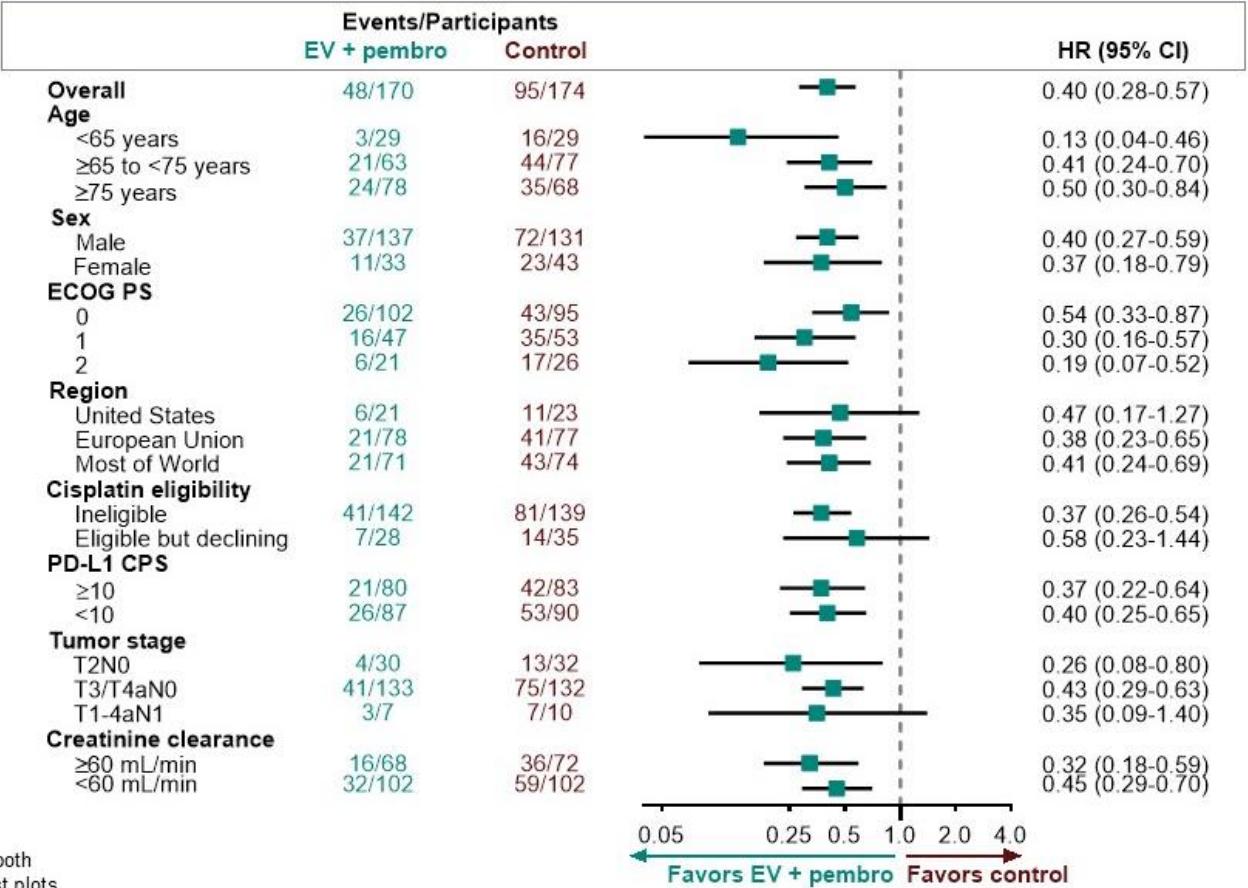
Primary Endpoint: EFS^a by BICR ITT Population



NR, not reached. * denotes statistical significance (one-sided boundary 0.0097). ^aTime from randomization to first occurrence of: radiographic PD precluding surgery; biopsy-proven residual MIBC (pts who did not undergo surgery); gross residual disease post-surgery or newly detected metastatic disease at surgery; local/distant recurrence post-surgery (imaging or biopsy); or death (any cause). Any new high-risk NMIUC was also considered an event. Pts who did not undergo surgery were considered as having an EFS event if they met criteria for EFS events at any point in time or were censored within ≤16 wks from last dose of neoadjuvant therapy or surgery.

Data cutoff date: 6 June 2025

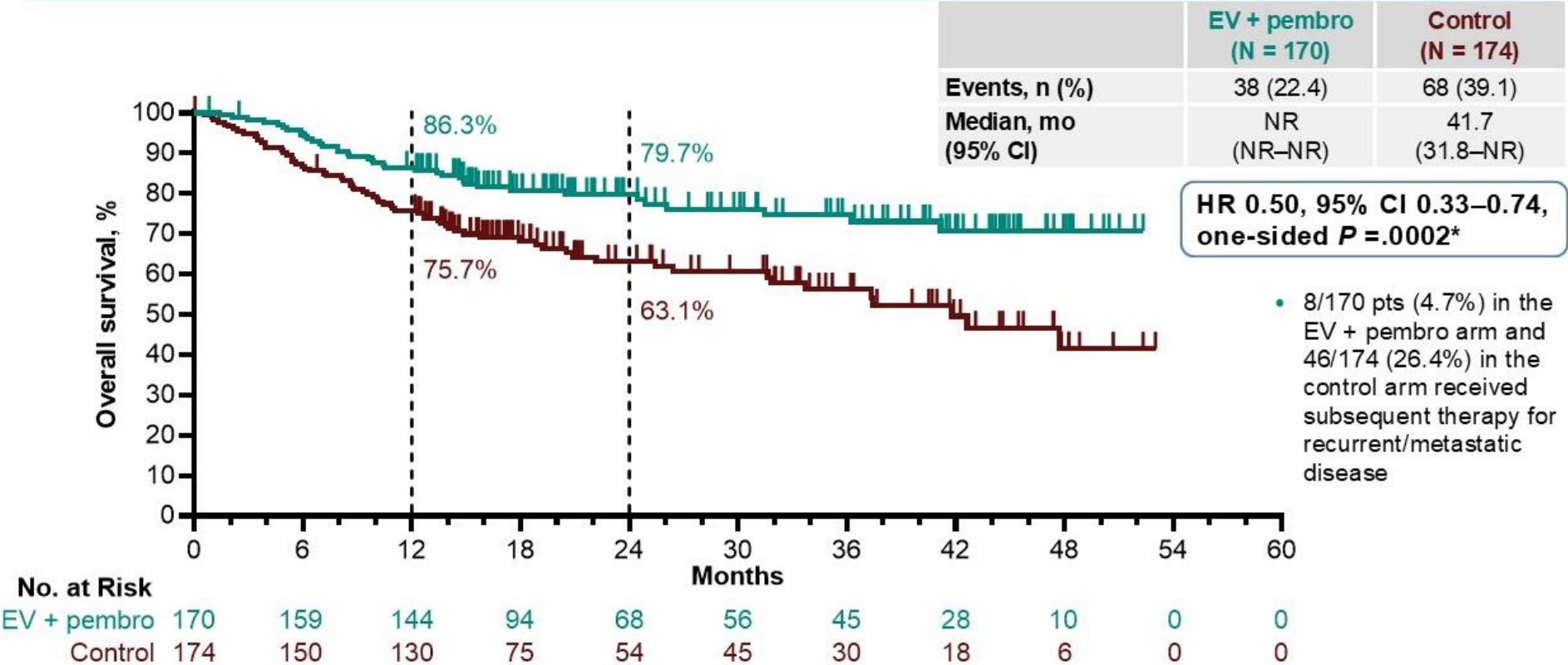
EFS by BICR in Key Subgroups ITT Population



Subgroup levels with <10 events across both treatment arms were not included in forest plots.

Data cutoff date: 6 June 2025

Key Secondary Endpoint: OS ITT Population

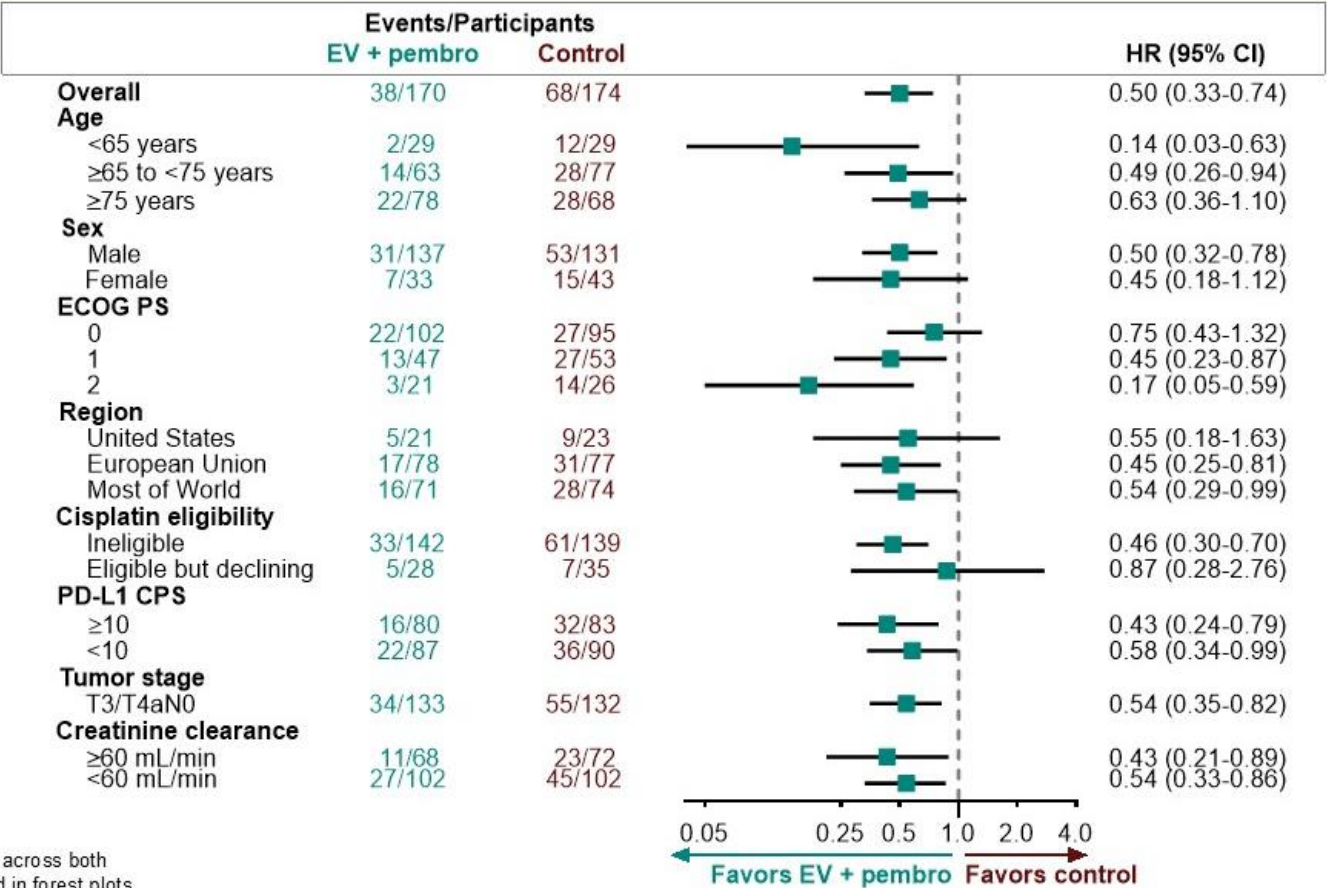


NR, not reached. * denotes statistical significance (one-sided boundary 0.00488).

Data cutoff date: 6 June 2025

OS by Key Subgroups

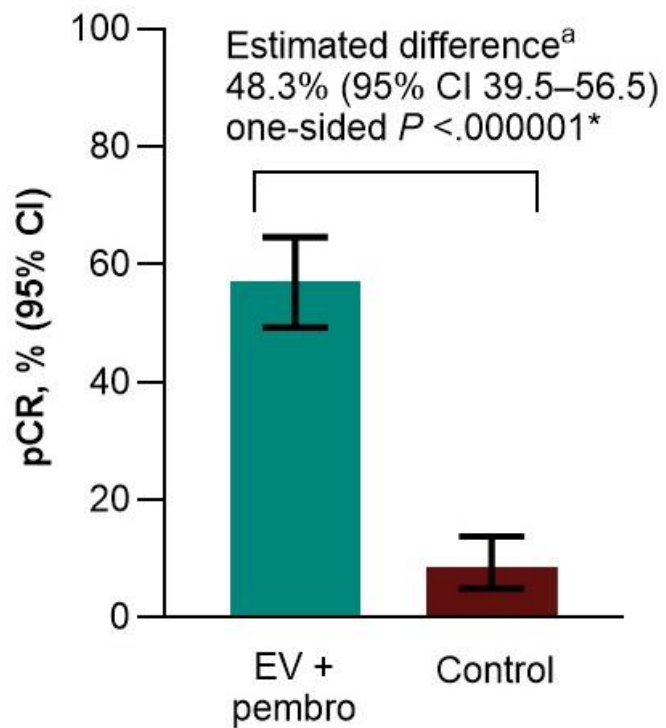
ITT Population



Subgroup levels with <10 events across both treatment arms were not included in forest plots.

Data cutoff date: 6 June 2025

Key Secondary Endpoint: pCR by Central Pathology Review ITT Population

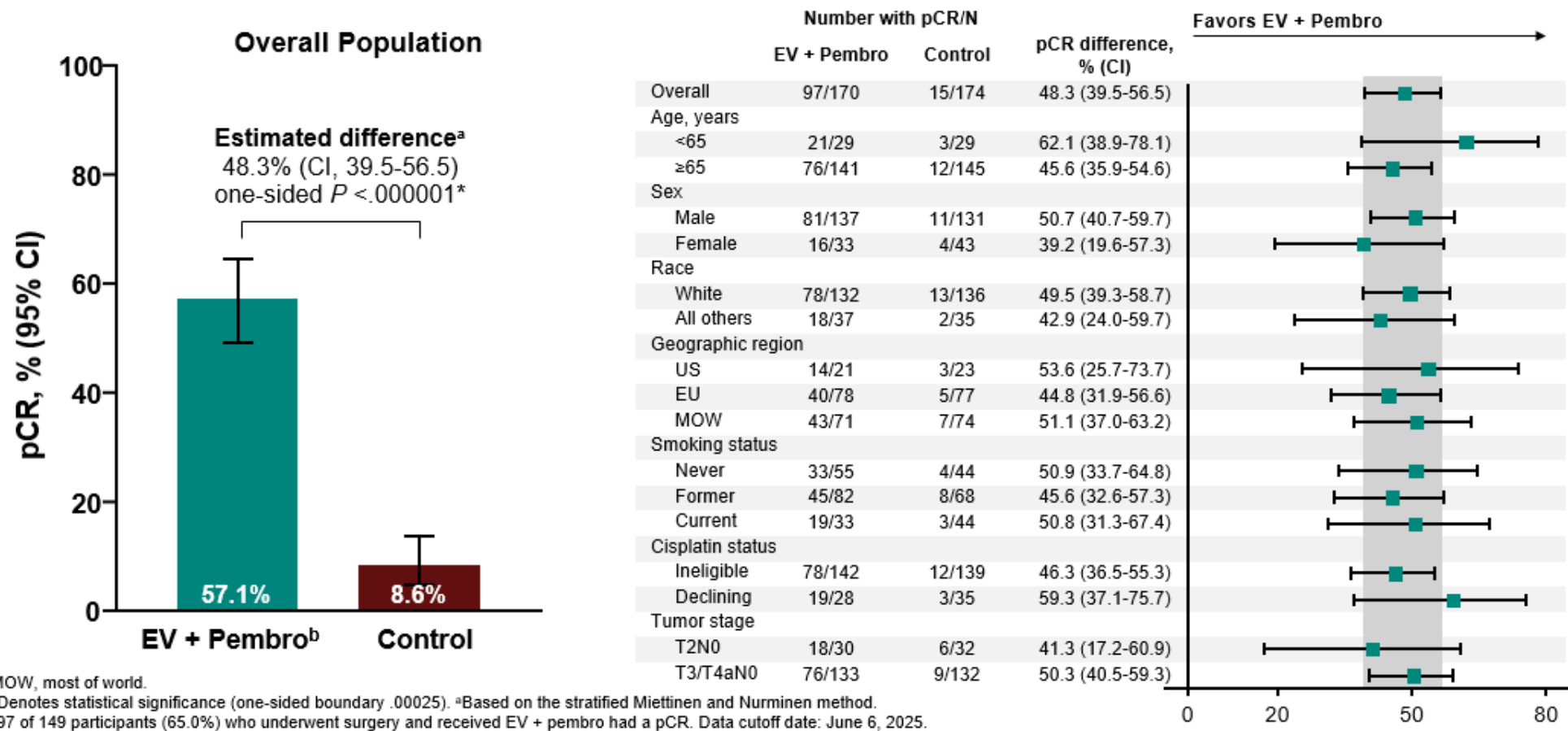


	EV + pembro (N = 170)	Control (N = 174)
pCR, n	97	15
pCR rate, % (95% CI)	57.1 (49.3–64.6)	8.6 (4.9–13.8)

- **pCR:** absence of viable tumor (pT0N0) in examined tissue from RC + PLND
- Pts who did not undergo surgery, including those with clinical complete response after neoadjuvant therapy, were considered non-responders

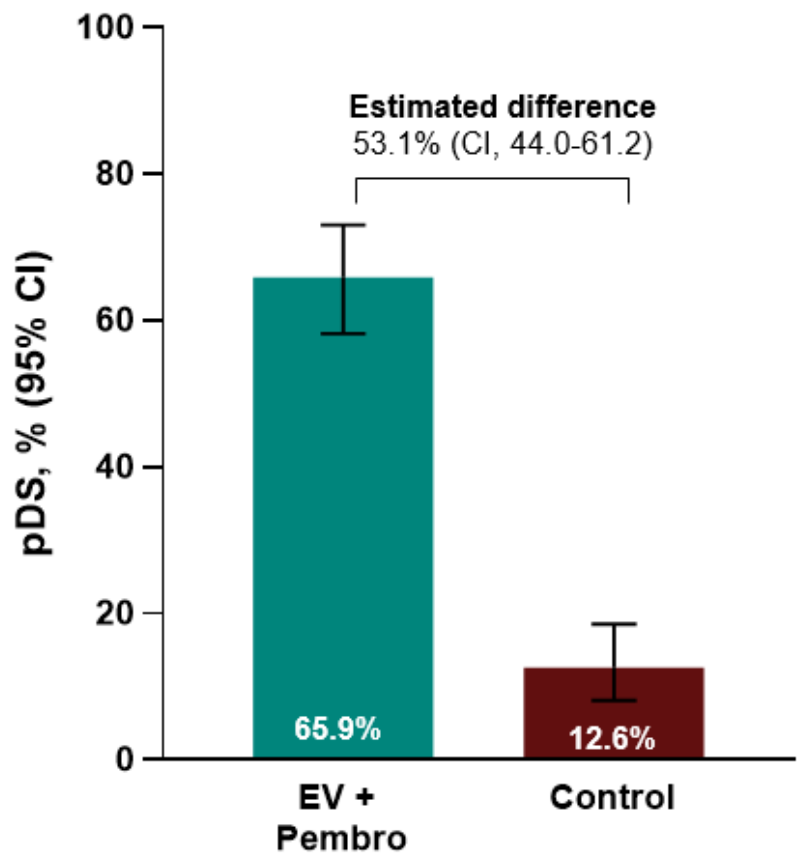
* denotes statistical significance (one-sided boundary 0.00025).
^aBased on stratified Miettinen and Nurminen method.

pCR by BICR in the ITT Population



MOW, most of world.
*Denotes statistical significance (one-sided boundary .00025). ^aBased on the stratified Miettinen and Nurminen method.
^b97 of 149 participants (65.0%) who underwent surgery and received EV + pembro had a pCR. Data cutoff date: June 6, 2025.

pDS by BICR in the ITT Population

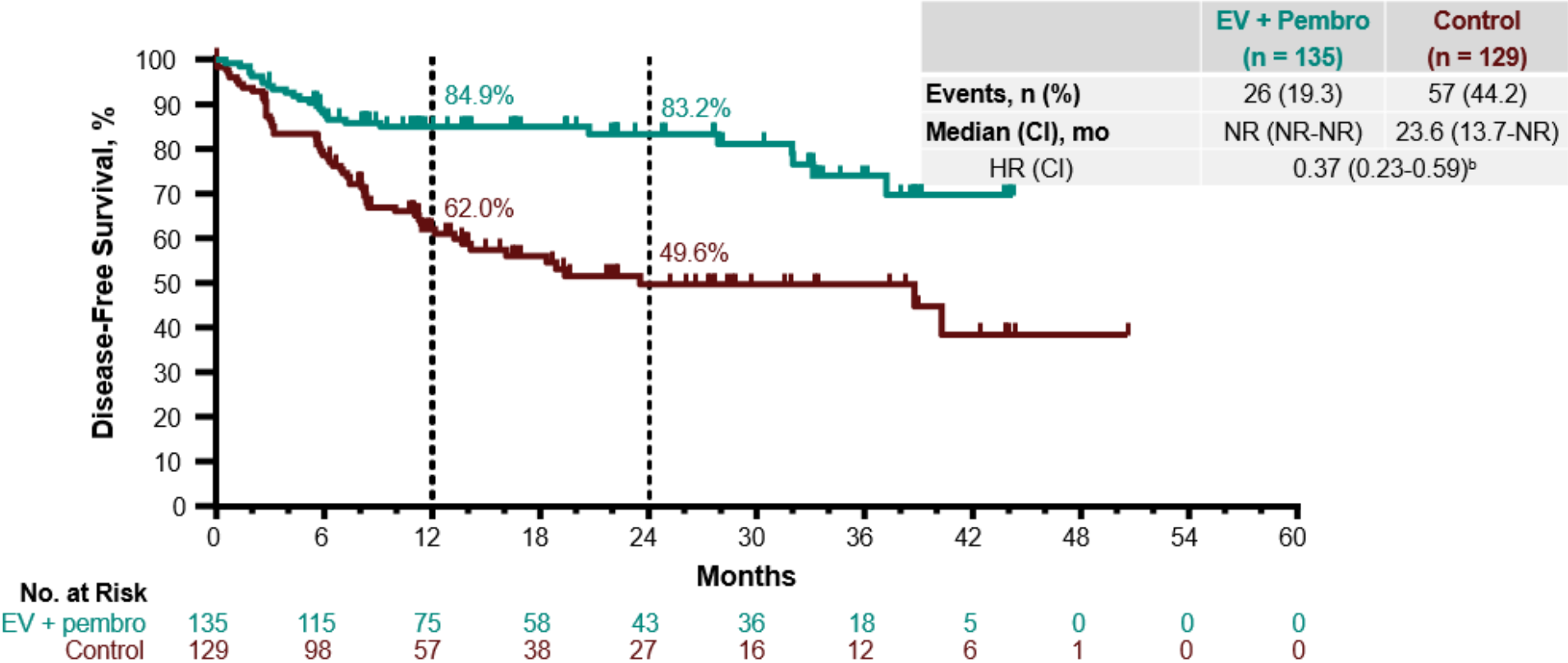


n (CI), %	EV + Pembro (n = 170)		Control (n = 174)	
pDS (<pT2N0)	112	65.9 (58.2-73.0)	22	12.6 (8.1-18.5)
pT0N0	97	57.1 (49.3-64.6)	15	8.6 (4.9-13.8)
pTisN0	7	4.1 (1.7-8.3)	2	1.1 (0.1-4.1)
pTaN0	1	0.6 (0.0-3.2)	0	0.0 (0.0-2.1)
pT1N0	7	4.1 (1.7-8.3)	5	2.9 (0.9-6.6)
Non-pDS (≥pT2N0)	33	19.4 (13.8-26.2)	112	64.4 (56.8-71.5)
Incomplete resection	2	1.2 (0.1-4.2)	7	4.0 (1.6-8.1)
No surgery	21	12.4 (7.8-18.3)	18	10.3 (6.2-15.9)
Other ^a	2	1.2 (0.1-4.2)	15	8.6 (4.9-13.8)

^aNot evaluated centrally for pDS due to no available evaluable surgical sample, nonprotocol systemic therapy prior to RC + PLND, or operational issues; considered non-pDS in analysis.
Data cutoff date: June 6, 2025.

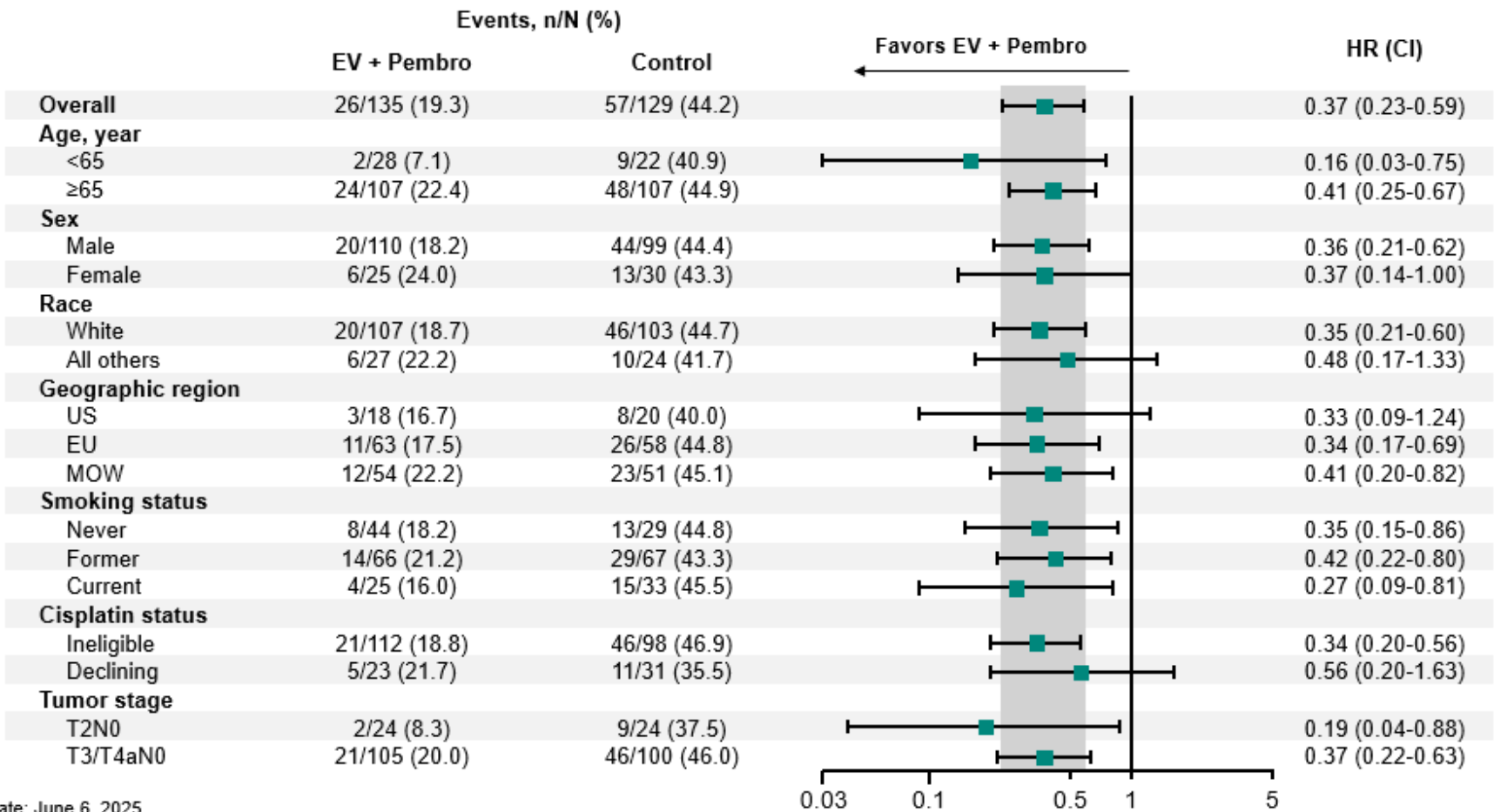


Disease-Free Survival by BICR^a



HR, hazard ratio; NR, not reached.
^aParticipants were considered disease-free after RC + PLND for DFS analysis if they had complete resection (no gross residual disease) and no evidence of disease on a post-surgery scan. ^bBased on Cox regression model with the Efron method of tie handling with treatment as a covariate. Data cutoff date: June 6, 2025.

Disease-Free Survival: Subgroups



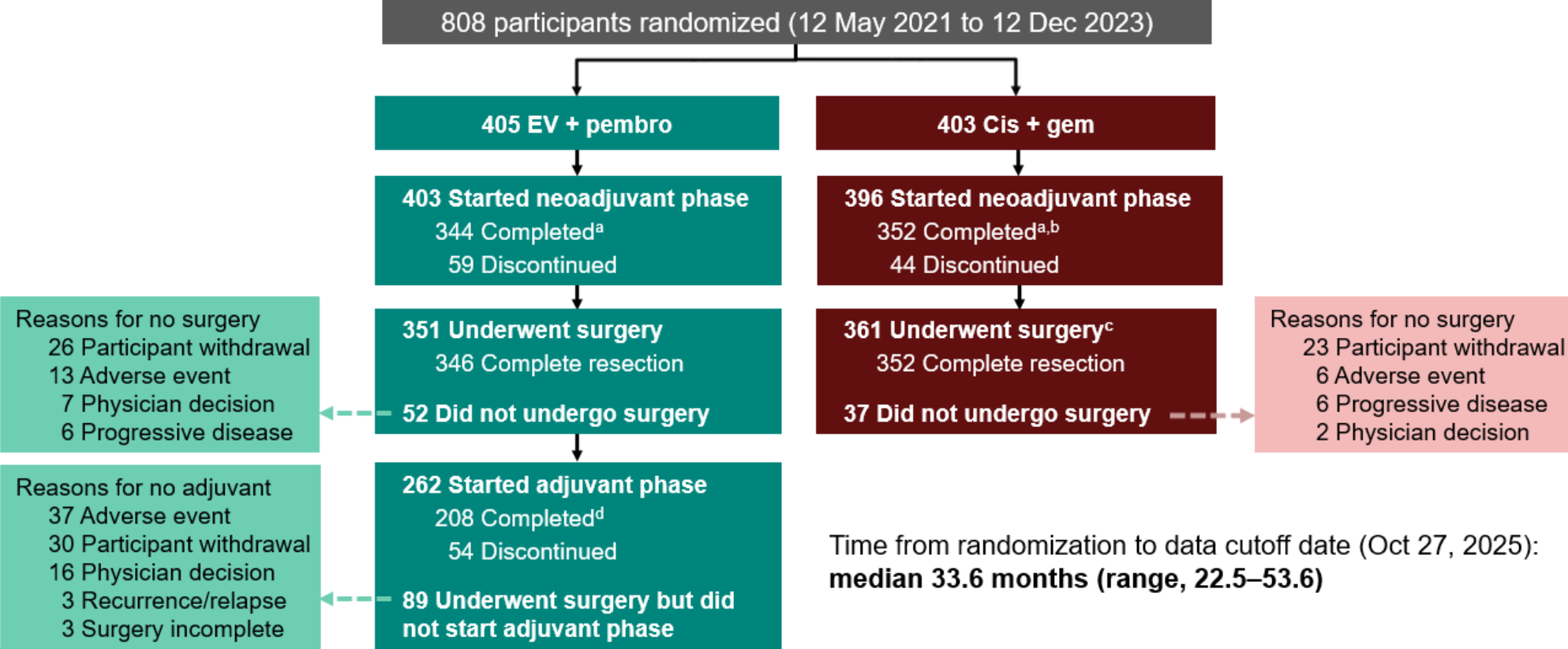
Data cutoff date: June 6, 2025.



KEYNOTE-B15 / EV-304: Topline results



PARTICIPANT DISPOSITION



^aIndicates pt received 4 cycles of at least 1 of the 2 study drugs (EV or pembro or cis or gem). ^b29/396 pts (7.3%) received all cis + gem cycles with split-dose cisplatin. ^cTwo participants underwent surgery but did not start neoadjuvant cis + gem. ^dCompleted indicates a pt received 5 adjuvant cycles of EV or 13 adjuvant cycles of pembro.

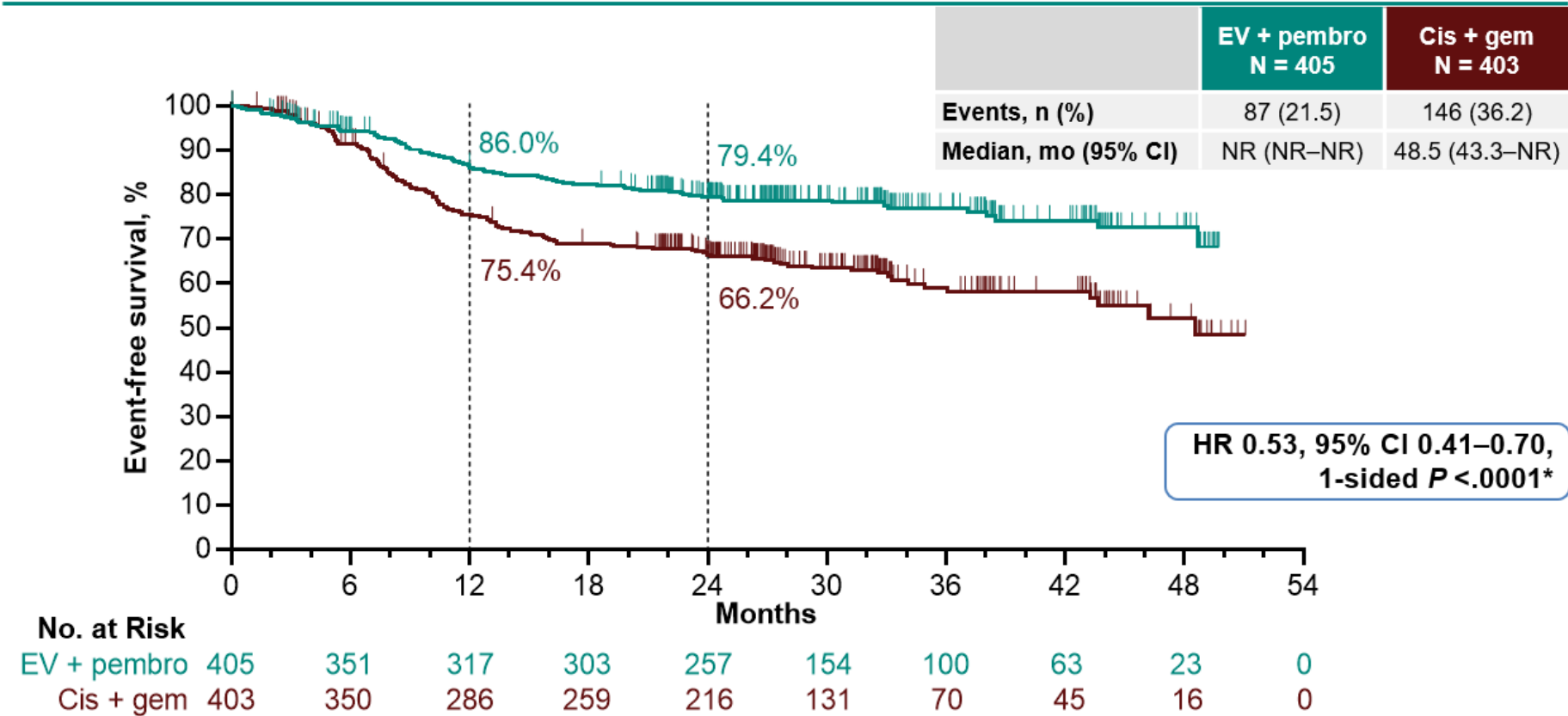
BASELINE CHARACTERISTICS

Characteristic, n (%)	EV + pembro N = 405	Cis + gem N = 403
Median age (range), years	66.0 (35–83)	66.0 (37–85)
≥65 years	247 (61.0)	247 (61.3)
Male	327 (80.7)	327 (81.1)
ECOG PS		
0	317 (78.3)	310 (76.9)
1	88 (21.7)	93 (23.1)
Region		
United States	59 (14.6)	59 (14.6)
European Union	206 (50.9)	205 (50.9)
Most of world	140 (34.6)	139 (34.5)
PD-L1 CPS		
≥10	233 (57.5)	230 (57.1)
<10	171 (42.2)	173 (42.9)
Missing	1 (0.2)	0
Tumor stage at baseline (central assessment) ^a		
T2N0	79 (19.5)	77 (19.1)
T3/T4aN0	293 (72.3)	293 (72.7)
T1-4aN1	33 (8.1)	33 (8.2)
Pure urothelial carcinoma histology	370 (91.4)	353 (87.6)
Creatinine clearance		
≥90 mL/min	149 (36.8)	156 (38.7)
≥60 and <90 mL/min	252 (62.2)	245 (60.8)
≥30 and <60 mL/min ^b	4 (1.0)	2 (0.5)

^aUsing both pathology of transurethral resection of bladder tumor specimen and imaging. **By investigator assessment, 287 pts (70.9%) in the EV + pembro arm and 296 pts (73.4%) in the cis + gem arm had T2N0 stage MIBC at baseline.** ^bProtocol deviation.



Primary Endpoint: EFS by BICR ITT Population

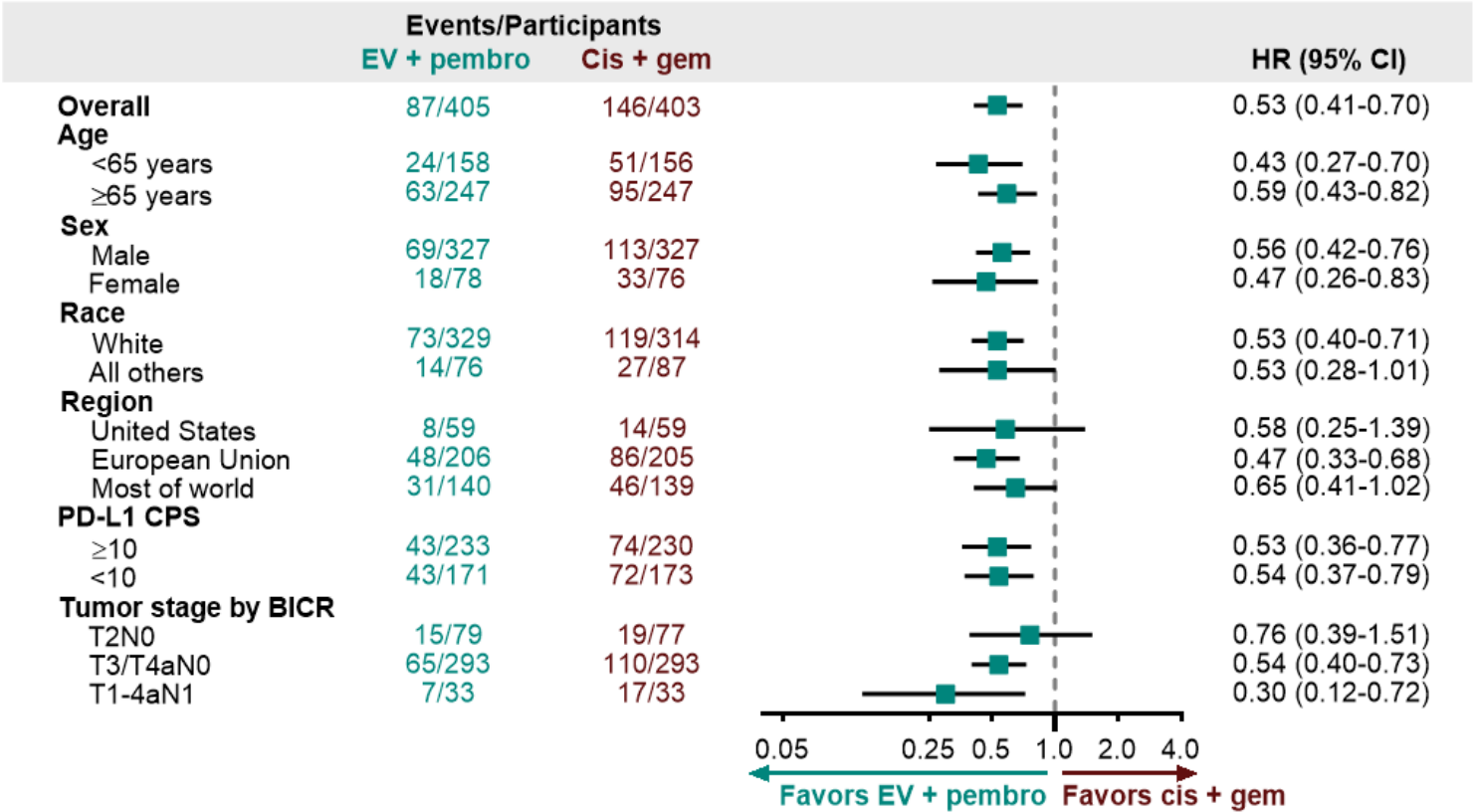


NR, not reached. * denotes statistical significance (one-sided boundary 0.0082).

Data cutoff date: 27 October 2025

EFS by BICR in Key Subgroups

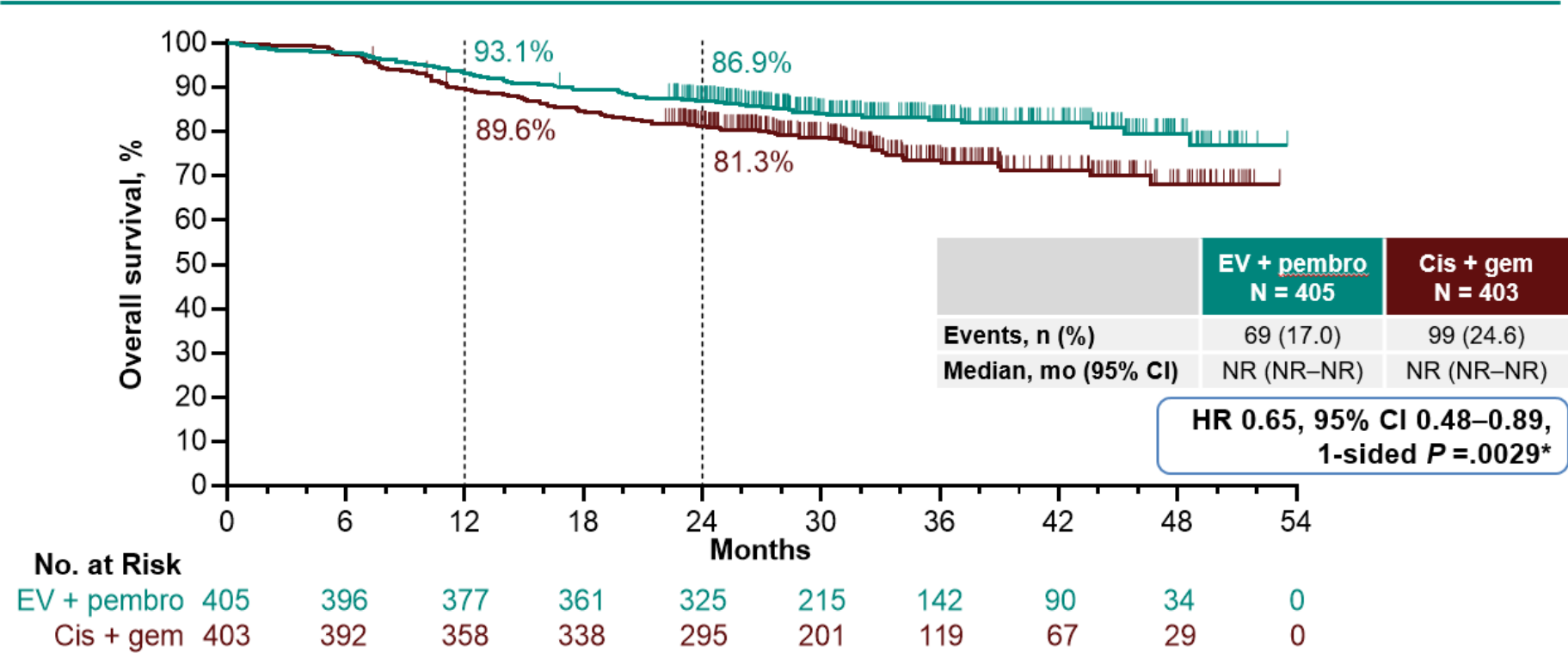
ITT Population



Subgroup levels with <10 events across both treatment arms were not included in forest plots.

Data cutoff date: 27 October 2025

Key Secondary Endpoint: OS ITT Population



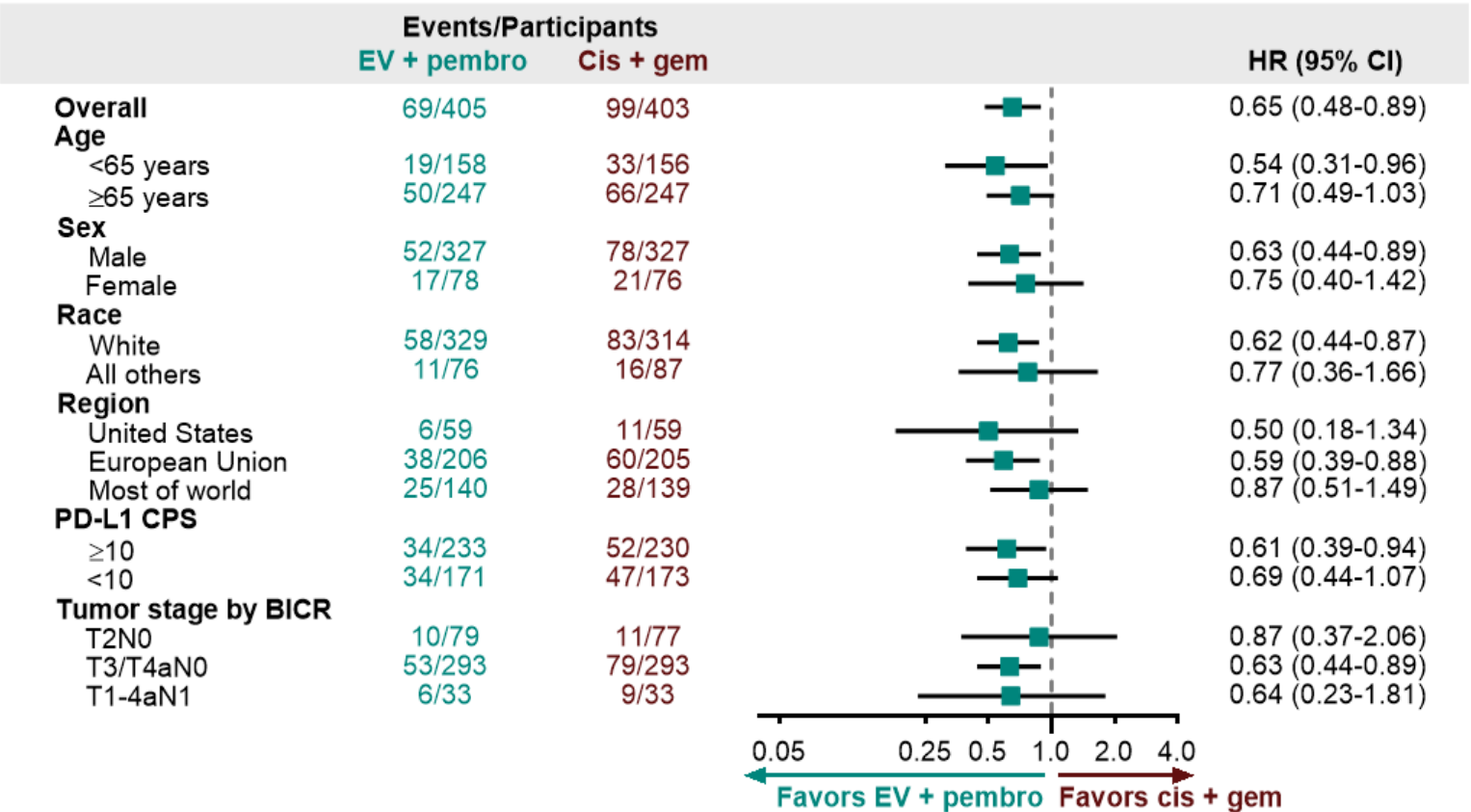
- In total, 44/87 (50.6%) of pts with an EFS event in the EV + pembro arm and 86/146 (58.9%) of pts with an EFS event in the cis + gem arm received any subsequent systemic therapy

NR, not reached. * denotes statistical significance (one-sided boundary 0.0038).

Data cutoff date: 27 October 2025

OS by Key Subgroups

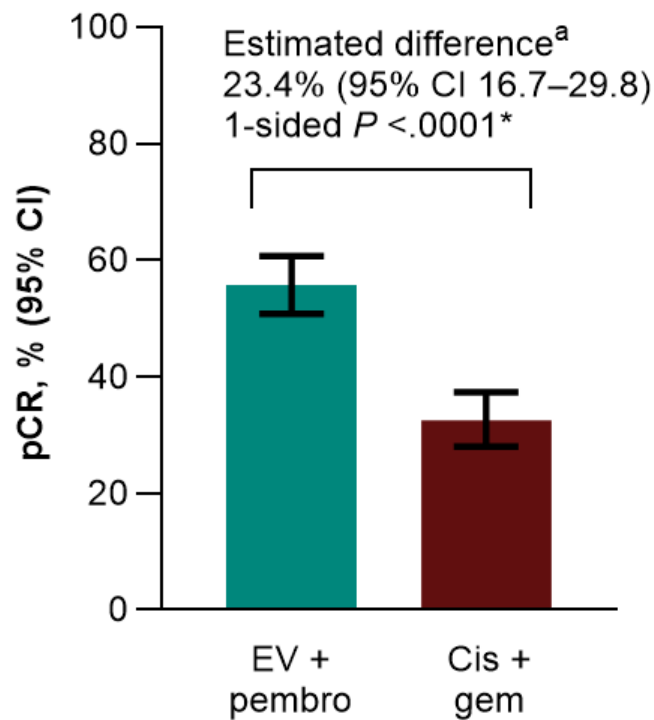
ITT Population



Subgroup levels with <10 events across both treatment arms were not included in forest plots.

Data cutoff date: 27 October 2025

Key Secondary Endpoint: pCR by Central Pathology Review ITT Population



	EV + pembro N = 405	Cis + gem N = 403
pCR, n	226	131
pCR rate, % (95% CI)	55.8 (50.8–60.7)	32.5 (28.0–37.3)

- **pCR:** defined as absence of viable tumor in examined tissue from RC + PLND (pT0N0)
- Pts who discontinued study therapy prior to definitive surgery were classified as non-responders
- Out of pts who underwent surgery, 226/351 (64.4%) in the EV + pembro arm and 131/361 (36.3%) in the cis + gem arm had pCR

* denotes statistical significance (one-sided boundary 0.001).
ªBased on stratified Miettinen and Nurminen method.



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

Toxicities



Summary of AEs, All Phases of Treatment Safety Analysis Population

- Median (range) duration of **neoadjuvant therapy** in the EV + pembro arm (N = 167): 1.6 months (0.03–2.8)
 - Median cycles of neoadjuvant EV + pembro: 3.0 (range, 1.0–3.0)
- Median (range) duration of **adjuvant therapy** in the EV + pembro arm (N = 100): 8.0 months (0.03–12.9)
 - Median (range) number adjuvant cycles of EV was 6.0 (1.0–6.0) and of pembro was 12.0 (1.0–14.0)

	EV + pembro (N = 167)	Control (N = 159)
Any grade TEAE ^a	167 (100)	103 (64.8)
Surgery phase only ^b	99/146 (67.8)	103 (64.8)
Grade ≥3 TEAE	119 (71.3)	73 (45.9)
Surgery phase only	52/146 (35.6)	73 (45.9)
Serious TEAE	97 (58.1)	65 (40.9)
Surgery phase only	42/146 (28.8)	65 (40.9)
AE leading to surgery delay ^c	6/149 (4.0)	1/156 (0.6)
TEAE leading to dose reduction of EV	28 (16.8)	NA
TEAE leading to discontinuation of EV	69 (41.3)	NA
TEAE leading to discontinuation of pembro	57 (34.1)	NA
TEAE leading to death	13 (7.8)*	9 (5.7)
Surgery phase only	4/146 (2.7)	9 (5.7)

TEAE, treatment-emergent adverse event. Data are n (%) when denominator matches header, and n/N (%) when denominator is different.

*Included 2 drug-related deaths (both during neoadjuvant phase: n = 1 myasthenia gravis and n = 1 toxic epidermal necrolysis).

^aCollected up to 30 days after cessation of study treatment (serious AEs collected up to 90 days, or 30 days after if pt started a new anticancer therapy). ^bDefined as time from date of surgery to 30 days post-surgery for nonserious events (90 days for serious events) and prior to date of first postoperative study drug (if applicable). ^cSurgery delay defined as >8 weeks from last preoperative drug dose (or randomization if no preoperative drug received) to surgery for the EV + pembro arm (18/149 pts; 12.1%); and >8 weeks from randomization to surgery for the control arm (25/156 pts; 16.0%). Data cutoff date: 6 June 2025

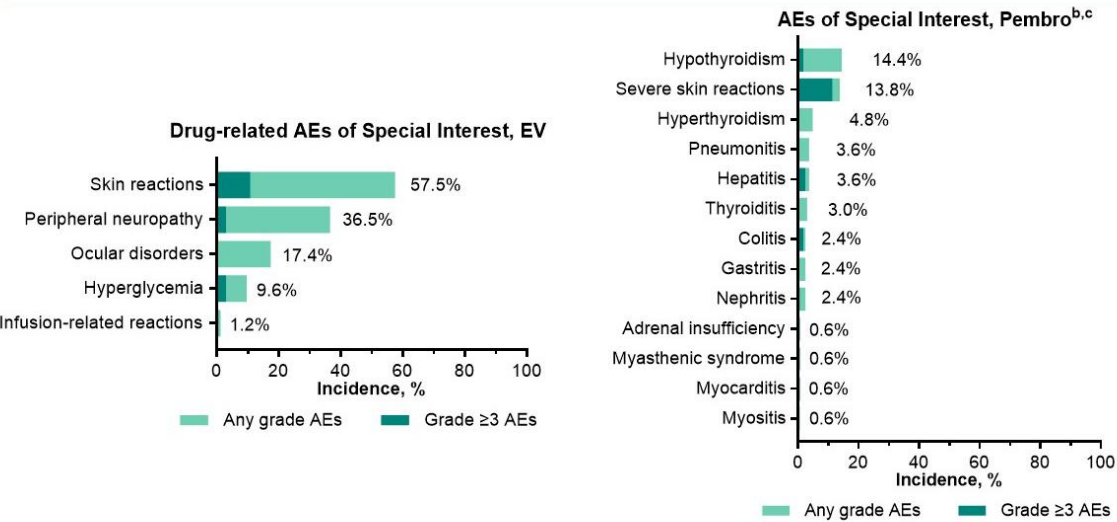
Summary of Treatment Exposure and Safety Safety Analysis Population

	EV + pembro	Cis + gem
Median (range) total duration of therapy, months	N = 403 10.2 (0.03–25.5)	N = 396 3.5 (0.03–16.8)
Median (range) cycles, neoadjuvant phase	N = 403	N = 396
Enfortumab vedotin	4.0 (1.0–4.0)	NA
Pembrolizumab	4.0 (1.0–4.0)	NA
Gemcitabine	NA	4.0 (1.0–4.0)
Cisplatin	NA	4.0 (1.0–4.0)
Median (range) cycles, adjuvant phase	N = 262	NA
Enfortumab vedotin	5.0 (1.0–5.0)	NA
Pembrolizumab	13.0 (1.0–13.0)	NA
Pts with AE,^a n (%)	EV + pembro, N = 403	Cis + gem, N = 396
Any-grade TEAE	395 (98.0)	389 (98.2)
Grade ≥3 TEAE	305 (75.7)	266 (67.2)
Serious TEAE	255 (63.3)	190 (48.0)
TEAE leading to death	17 (4.2)	11 (2.8)
Treatment-related AEs leading to death ^b	2 (0.5)	1 (0.3)
Neoadjuvant phase TEAE leading to drug discontinuation	101 (25.1)	61 (15.4)
Adjuvant phase TEAE leading to drug discontinuation, n/N (%)	75/262 (28.6)	NA

^aCollected up to 30 days after cessation of study treatment (90 days for serious AEs); EV + pembro reporting window included neoadjuvant, surgery, and adjuvant phases, cis + gem reporting window included neoadjuvant and surgery phases. ^bEV + pembro arm: multiple organ dysfunction syndrome (n = 2); cis + gem arm: pneumonia (n = 1).

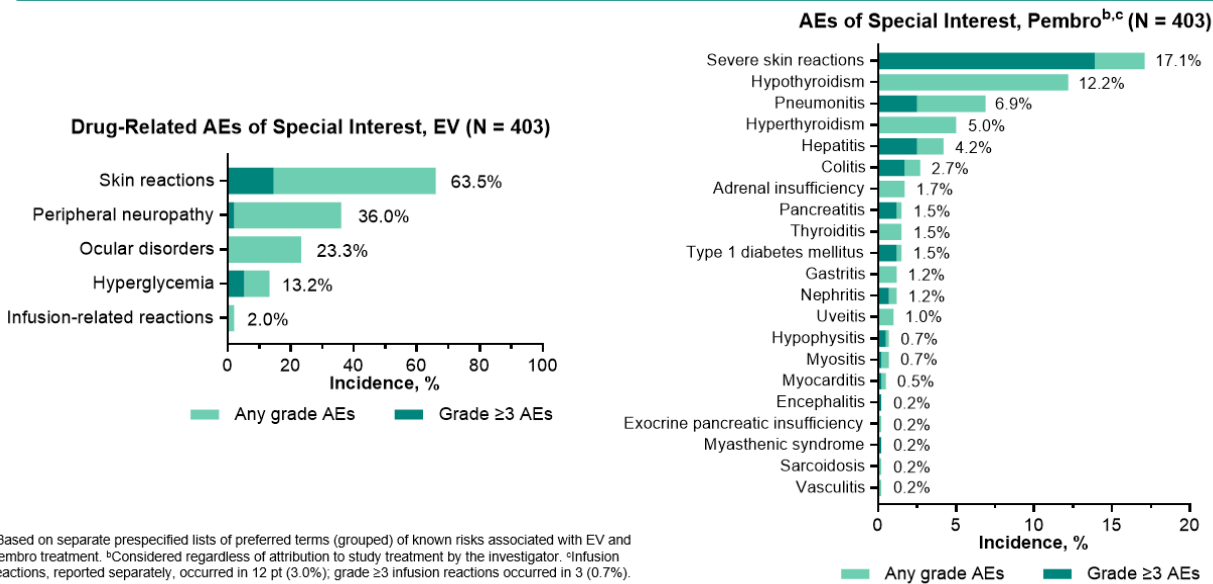


AEs of Special Interest^a Safety Analysis Population, EV + Pembro Arm



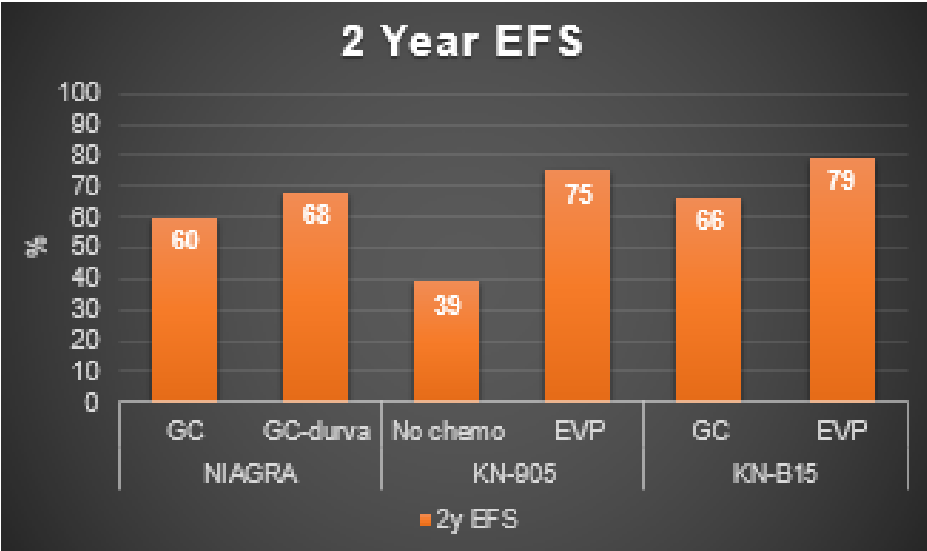
^aBased on separate prespecified lists of preferred terms (grouped) of known risks associated with EV and pembro treatment. ^bConsidered regardless of attribution to study treatment by the investigator. ^cInfusion reactions, reported separately, occurred in 1 pt (0.6%); no grade ≥3 infusion reactions occurred. Data cutoff date: 6 June 2025

AEs of Special Interest^a Safety Analysis Population, EV + Pembro Arm



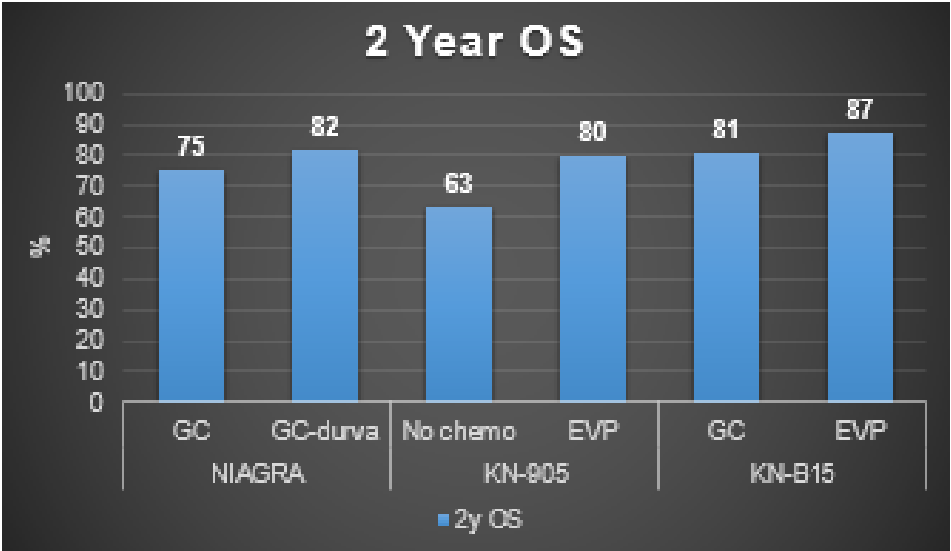
^aBased on separate prespecified lists of preferred terms (grouped) of known risks associated with EV and pembro treatment. ^bConsidered regardless of attribution to study treatment by the investigator. ^cInfusion reactions, reported separately, occurred in 12 pt (3.0%); grade ≥3 infusion reactions occurred in 3 (0.7%). Data cutoff date: 27 October 2025

EFS and OS across MIBC Trials



HR 0.68
@ median 42 months

HR 0.53
@ median 33 months

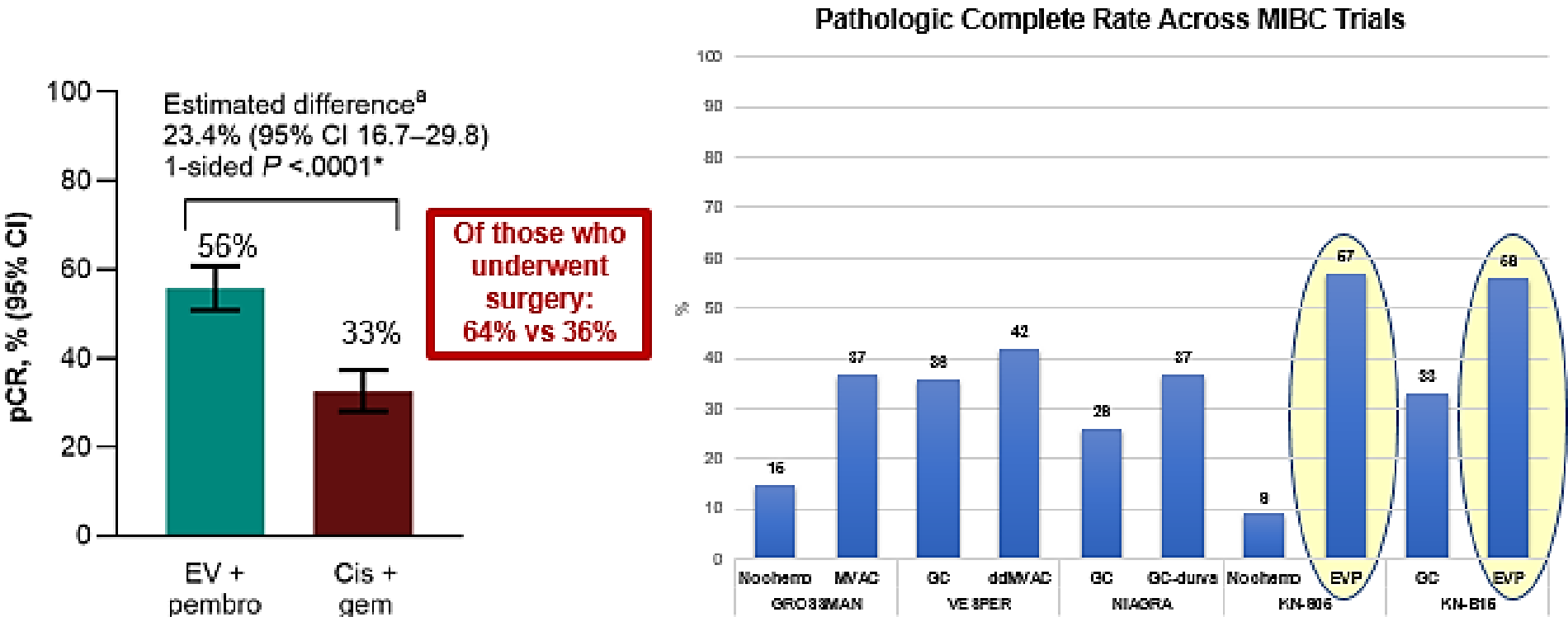


HR 0.75
@ median 46 months

HR 0.65
@ median 33 months

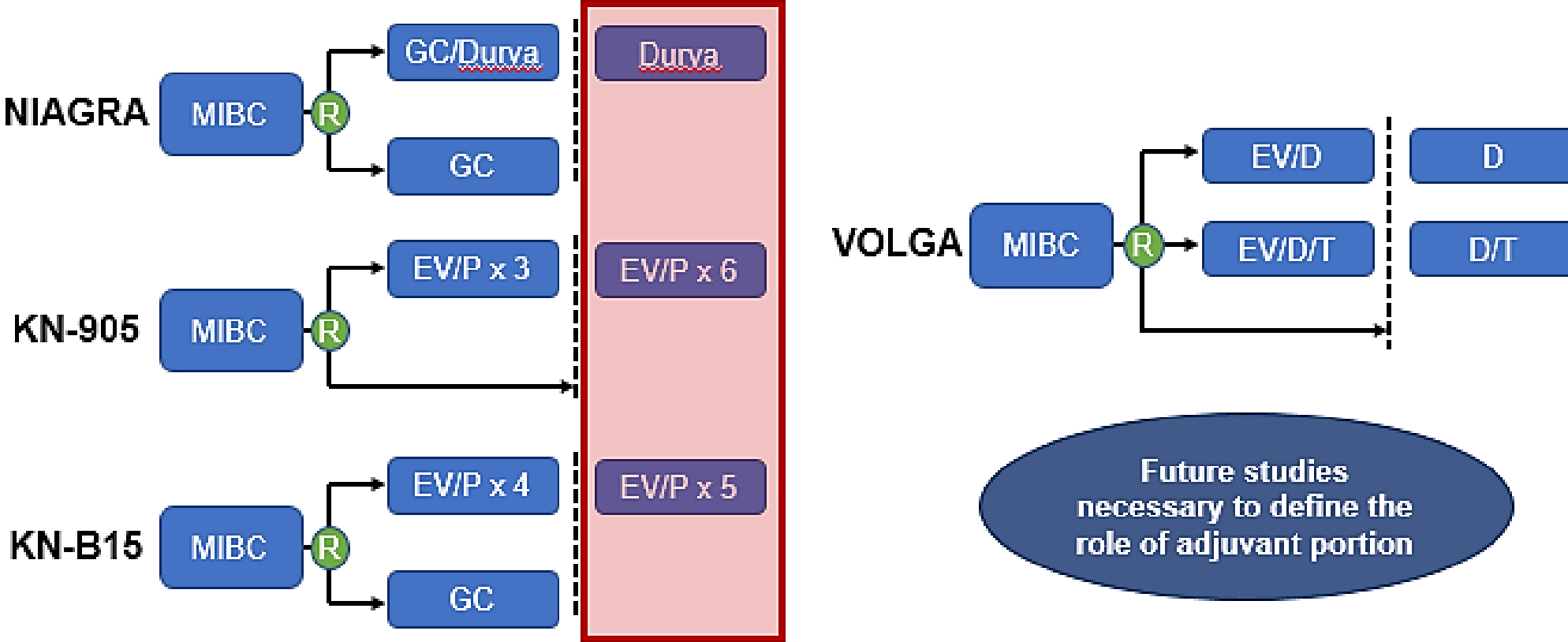
Rowlinson et al. *N Engl J Med*. 2024 Nov 14;391(19):1773-1785; *Galsky J. *Clin Oncol* 43, 15-21(2025); *N Engl J Med. 2025 Dec 18;393(24):2386-2408.; *Vallejos ESMO 2025; *Galsky GU ASCO 2026

Complete Pathologic Response Across Trials

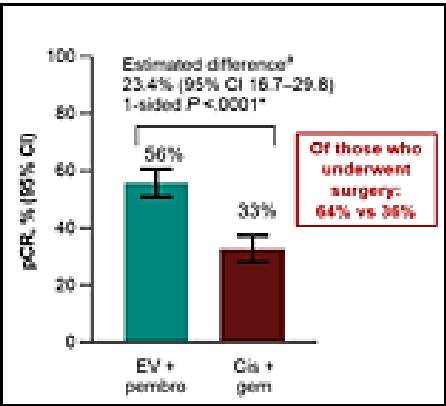


Powles et al N Engl J Med. 2024 Nov 14;391(19):1773-1786; Valsheva ESMO 2025; Galsky GU ASCO 2025; Grossman N Engl J Med. 2023 Aug 28;369(9):850-861; Pflor J Clin Oncol. 2022 Jun 20;40(15):2013-2022.

How many cycles of EV/P? Is the Adjuvant Portion Necessary?

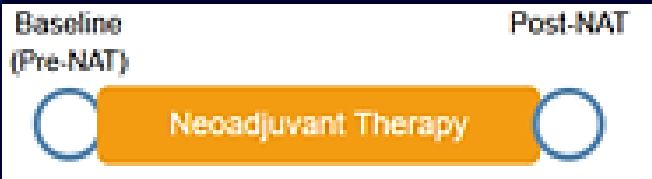


13th Belgian Multidisciplinary Meeting on Urological Cancers



PRESENTED BY: **Tyler F. Stewart, MD**
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ctDNA detection and clearance with neoadjuvant therapy

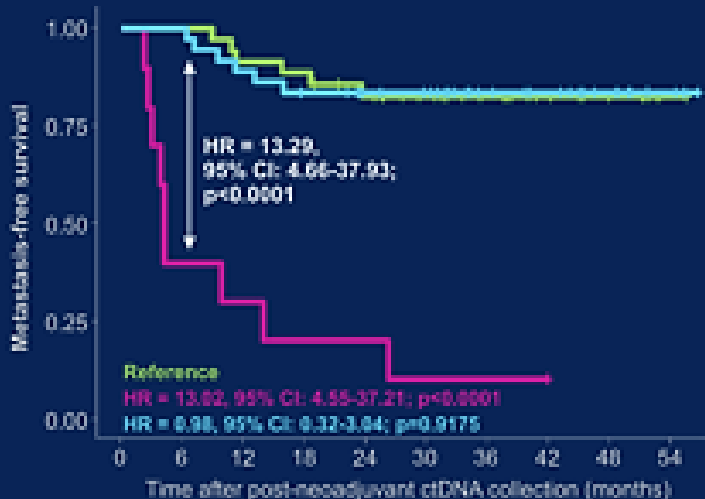


	RETAIN1/2	HCRN GU16-257
N with ctDNA available	45	62
% ctDNA positive at baseline	42%	64%
% ctDNA clearance at restaging	73%	69%
Among <u>cCR</u> , % ctDNA negative at restaging	83%	100%

Gaglio et al. PNAS 2026 Vol. 123 No. 8 e2533449123

RETAIN-1/2

ctDNA after neoadjuvant therapy identifies metastatic risk



	No.	at risk	0	6	12	18	24	30	36	42	48	54
AS, ctDNA-negative	35	35	32	31	27	22	17	11	7	1		
Cx, ctDNA-positive	10	4	3	2	2	1	1	0	0	0		
Cx, ctDNA-negative	37	37	33	30	26	24	16	13	8	3		

- **ctDNA negative at restaging**
 - excellent 2-year MFS – 85% in active surveillance patients
 - Similar to ctDNA negative cystectomy patients
- **ctDNA positive at restaging**
 - **High metastatic risk**
 - 70% develop metastasis within 1 year despite cystectomy

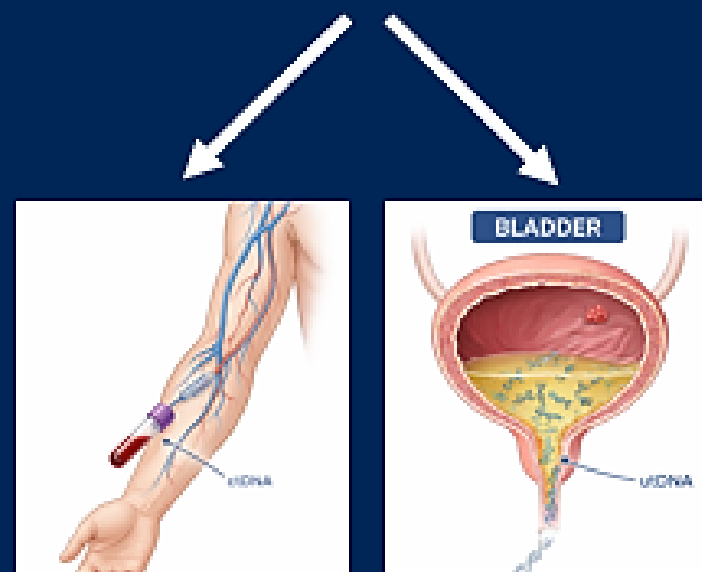
ctDNA positive after NAT may require systemic intensification rather than local consolidation

ctDNA does not reliably monitor the bladder compartment

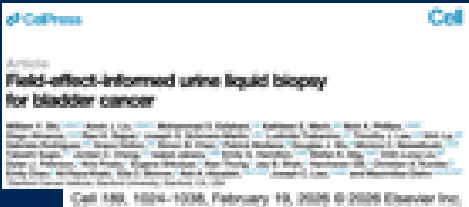
- RETAIN-1/2 surveillance cohort
 - 52% developed local recurrence
 - <10% were ctDNA positive
 - All metastatic events preceded by local recurrence

Cystoscopy and imaging required for bladder surveillance

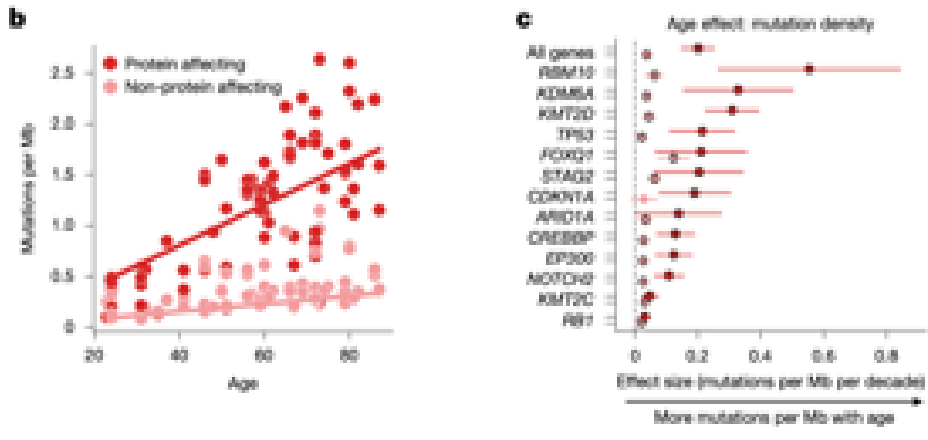
2 Compartment Approach



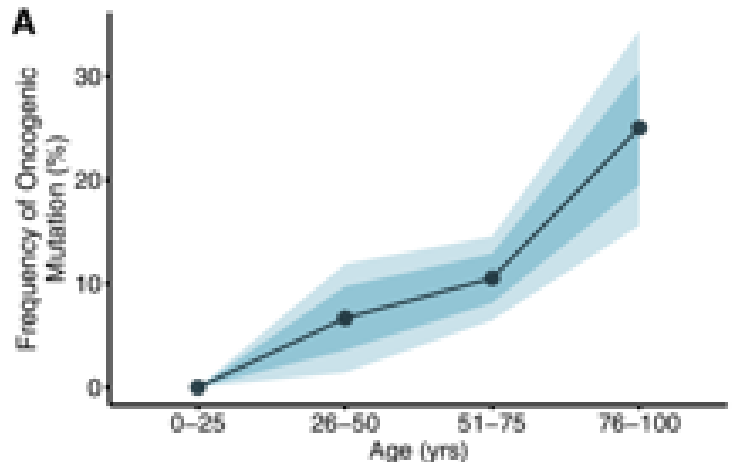
Urine tumor DNA: Clonal mutations in normal bladders



Clonal mutations in normal urothelium increase with age



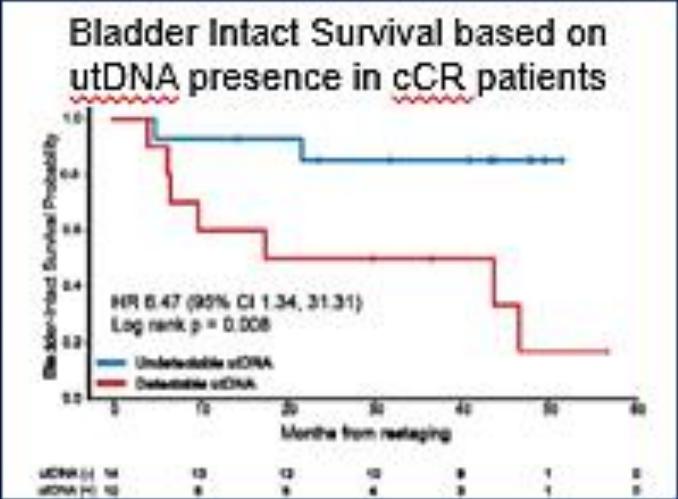
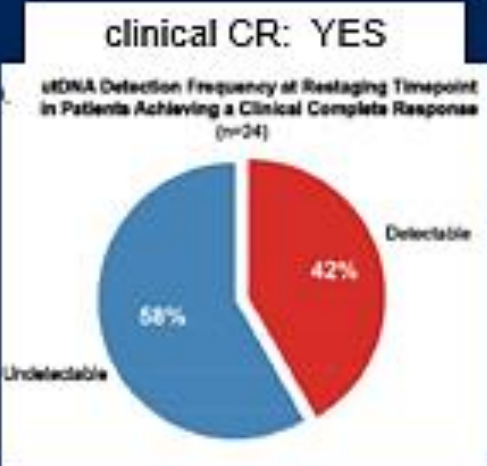
Oncogenic mutations in urine from HEALTHY controls



"clonal cystopoesis"

HCRN GU16–257: urine tumor DNA at Restaging

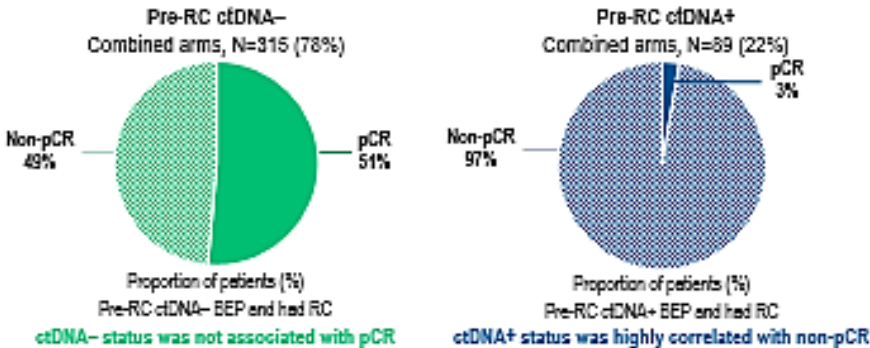
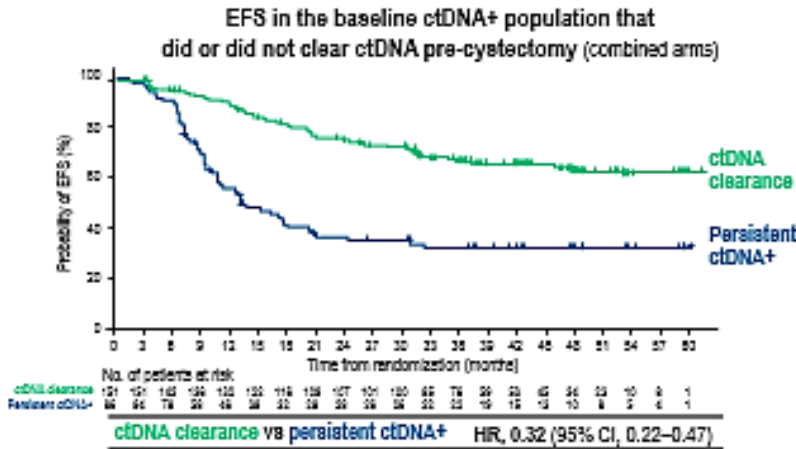
utDNA collected after neoadjuvant therapy



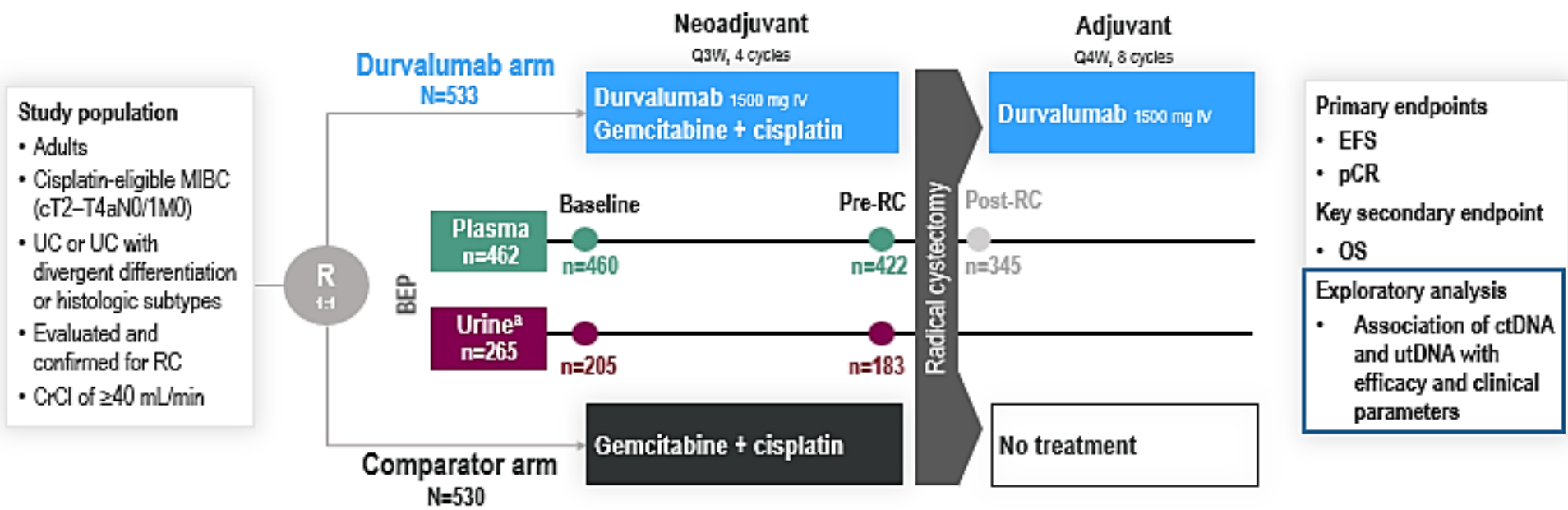
Gashy, et al. PNAS 2026 Vol. 123 No. 8 e2533449123

NIAGARA: Background

- In NIAGARA, the addition of perioperative durvalumab to NAC demonstrated:
 - Statistically significant improvement in
 - EFS: HR, 0.68 (95% CI, 0.56–0.82), $P<0.0001$
 - OS: HR, 0.75 (95% CI, 0.59–0.93), $P=0.0106$
 - 10% improvement in pCR rate¹
- In prior exploratory analysis, plasma ctDNA– status after neoadjuvant treatment was not associated with pCR but was prognostic for EFS²
- Here, we expanded the analysis to assess potential utility of utDNA testing in MIBC management

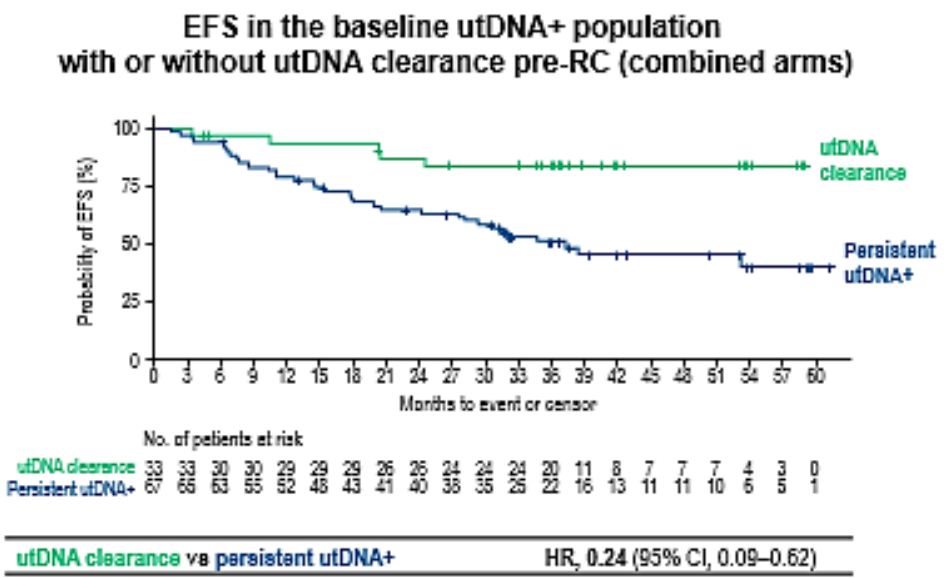
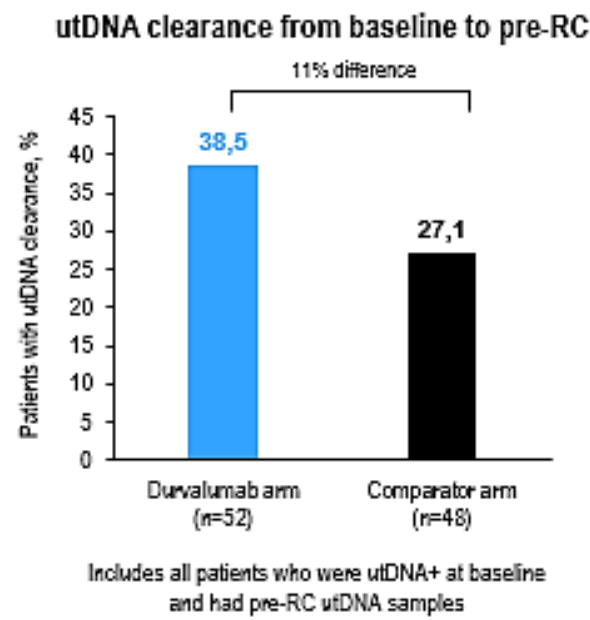


NIAGARA: Study Design and ctDNA/utDNA Analysis



- Baseline characteristics were generally similar between the BEP and ITT populations
- ctDNA/utDNA assessed using Signatera™ assay (Natera, Inc, Austin, TX, USA)

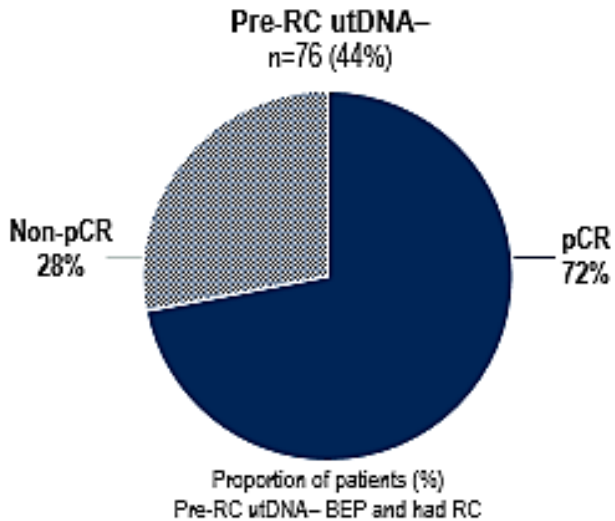
NIAGARA Neoadjuvant: utDNA Clearance Was 11% Higher in the Durvalumab Arm and Appears to Be Prognostic for EFS



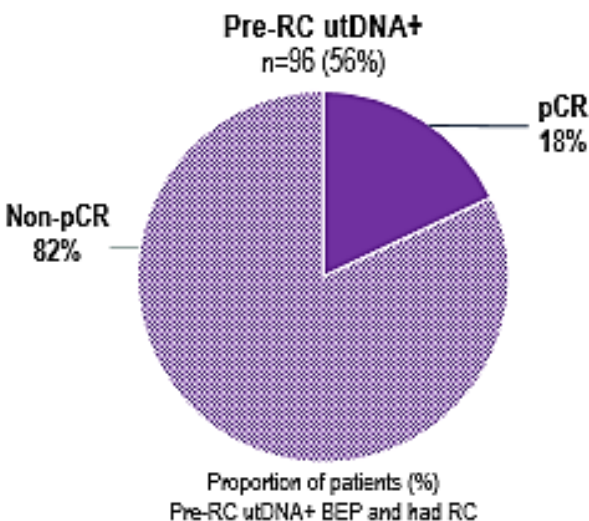
- Similar results were also observed with plasma ctDNA clearance¹
- 85% of patients were utDNA positive at baseline, which reduced to 55% following neoadjuvant treatment (combined arms)

1. Powles T, et al. J Clin Oncol. 2025;43:14_suppl:4503. Pre-RC denotes sample collection after neoadjuvant treatment but before RC. CI, confidence interval; ctDNA, circulating tumor DNA; EFS, event-free survival; HR, hazard ratio; RC, radical cystectomy; utDNA, urinary tumor DNA.

NIAGARA Pre-cystectomy: utDNA– Status Is Associated With pCR



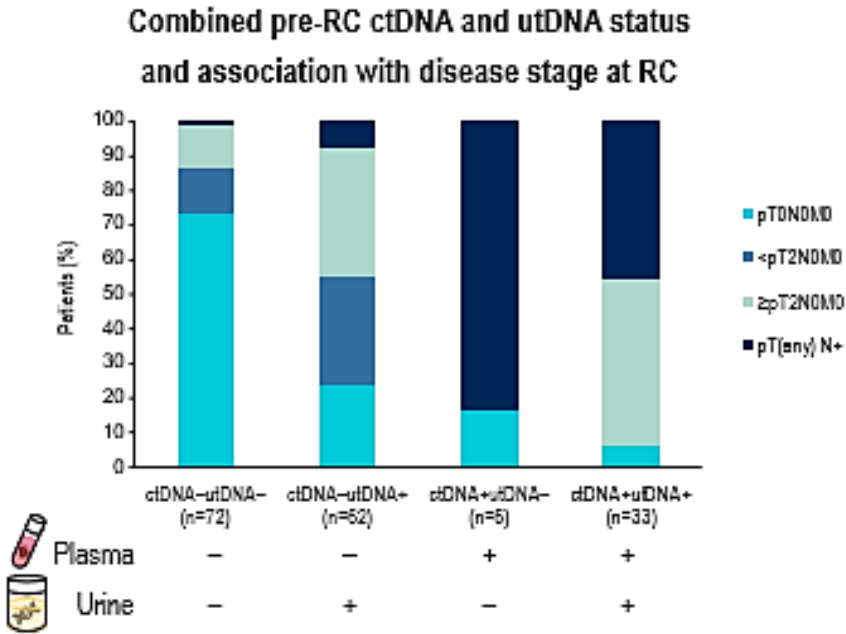
utDNA– status at pre-RC is associated with higher likelihood of pCR



utDNA+ status at pre-RC is associated with higher likelihood of non-pCR

- In contrast, 51% of patients with plasma ctDNA– status after neoadjuvant treatment had pCR¹
- Pre-RC BEP with recorded pCR/non-pCR result, n=172 patients

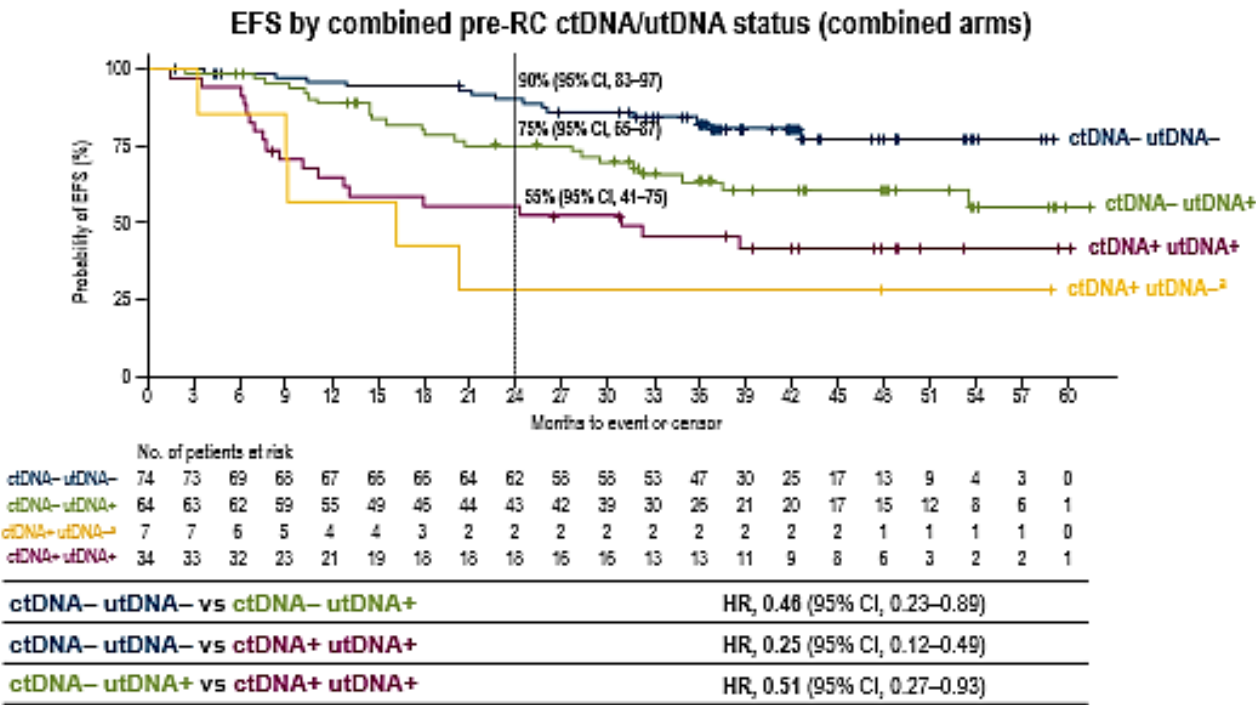
NIAGARA Pre-cystectomy: utDNA and ctDNA Status Is Differentially Associated With Disease Stage at Cystectomy



- utDNA+ status is associated with a higher frequency of non-invasive disease (<pT2N0M0), consistent with detection of local residual disease
- ctDNA+ status is associated with a higher frequency of invasive disease (≥pT2N0M0) and nodal involvement (N+), reflecting systemic spread

Pre-RC BEP with ctDNA and utDNA results, n=179^a

NIAGARA: 24-Month EFS Was Highest for Patients With Dual-Negative Status at Pre-cystectomy



Pre-RC BEP with ctDNA and utDNA results, n=179

MUSCLE INVASIVE BLADDER CANCER (POLL)

- The number of cystectomy's will increase: agree / disagree
- Radiochemotherapy of the bladder will increase: agree / disagree
- Active surveillance will increase: agree / disagree



Looking forward in MIBC...

Systemic therapy should come first, with the locoregional approach to be discussed later.

- Vulsteke C

