

MasterClass in Bladder Cancer 2026

Discussion with ~~one~~ two clinical cases

Organized by:
HENDERE HEALTHCARE

 #BladderMasterClass26

 Hospital Universitario
SaludMadrid 12 de Octubre



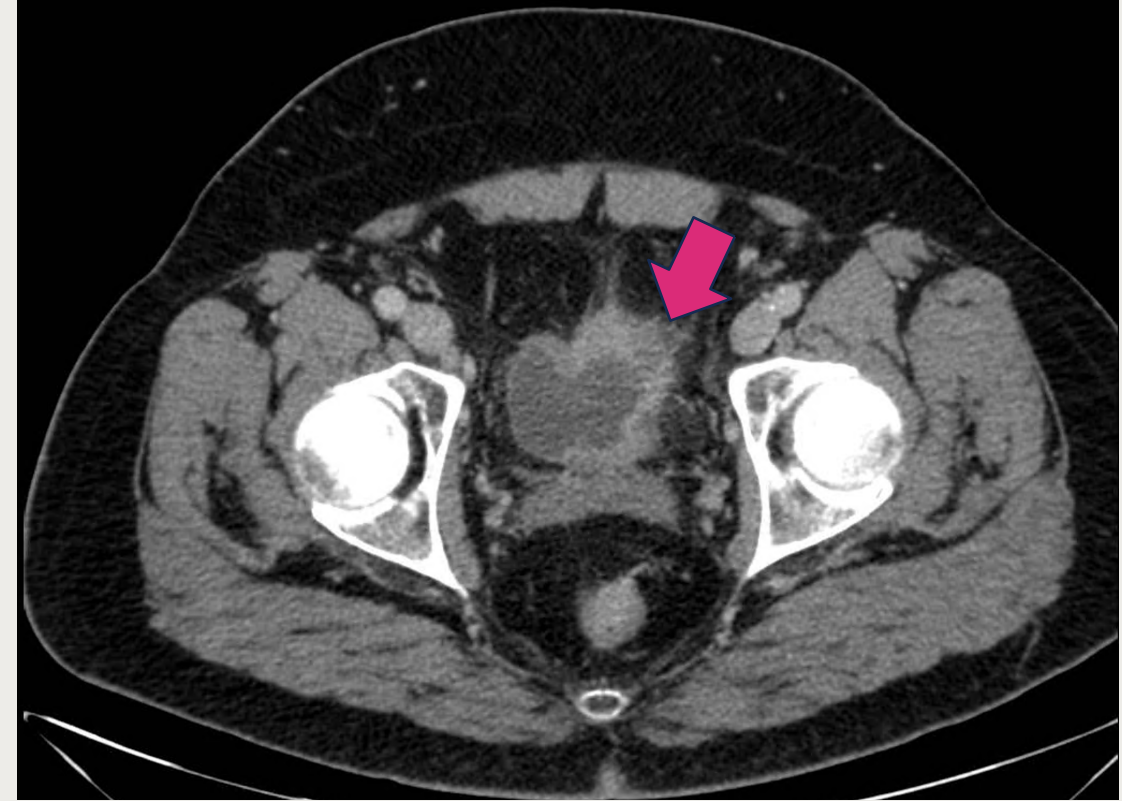
Case 1

Medical history

- 68 years old male.
- Hypertension.
- Prior smoking history: 30 packet-year.
- Initial presentation: Hematuria in June/2024. Intense pain.
- Cystoscopy: Solid mass occupying left anterior wall of the bladder. Patent ureteral orifices.
- TURBT in July/2024: Pure UC G3 pT2.



Clearly pathologic right iliac lymphadenopathy
2x Suspicious left iliac lymphadenopathy



Locally advanced neoplasm

MIBC: T2-3N2M0

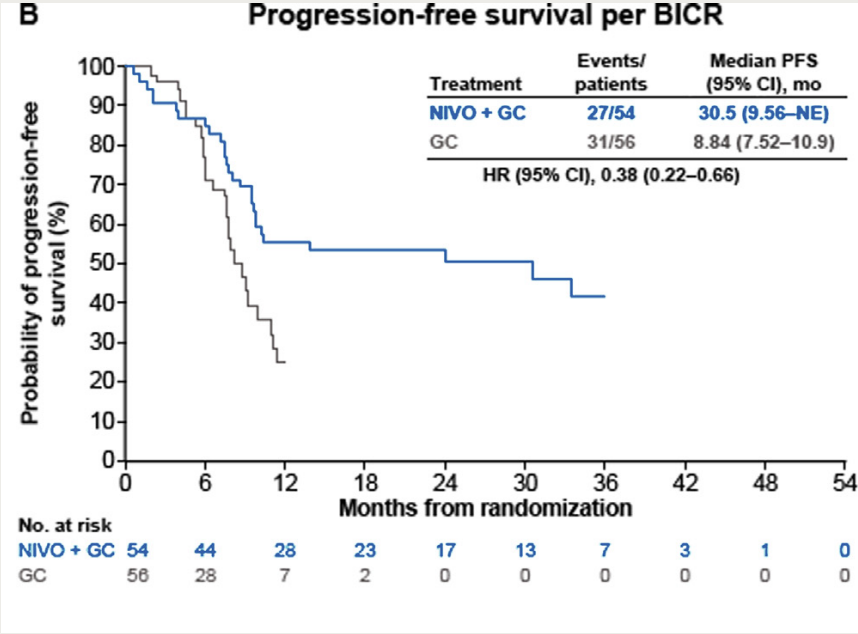
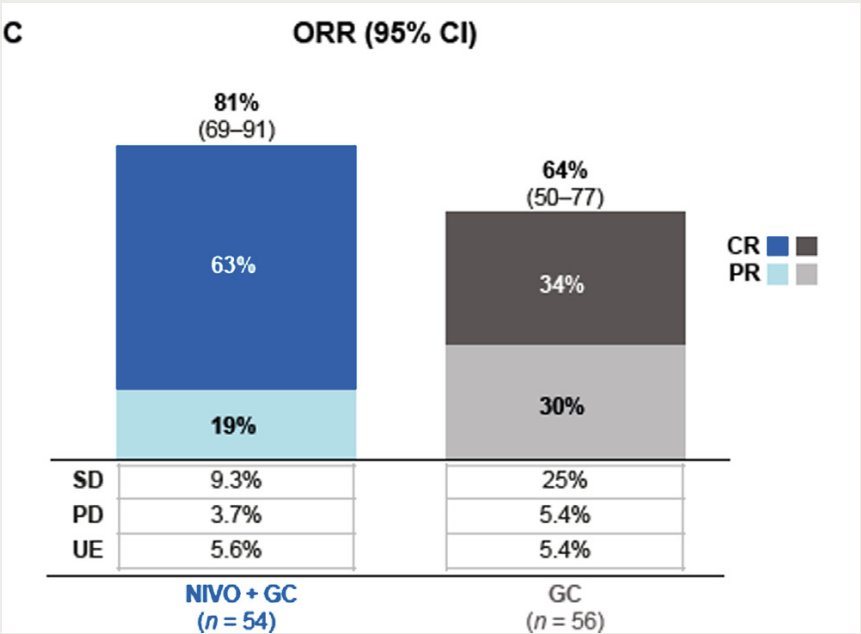
Questions for you

- Would you consider performing a PET-TC scan in this patient?
- EV-P was not available in Spain at that moment. What would have been your treatment of choice?

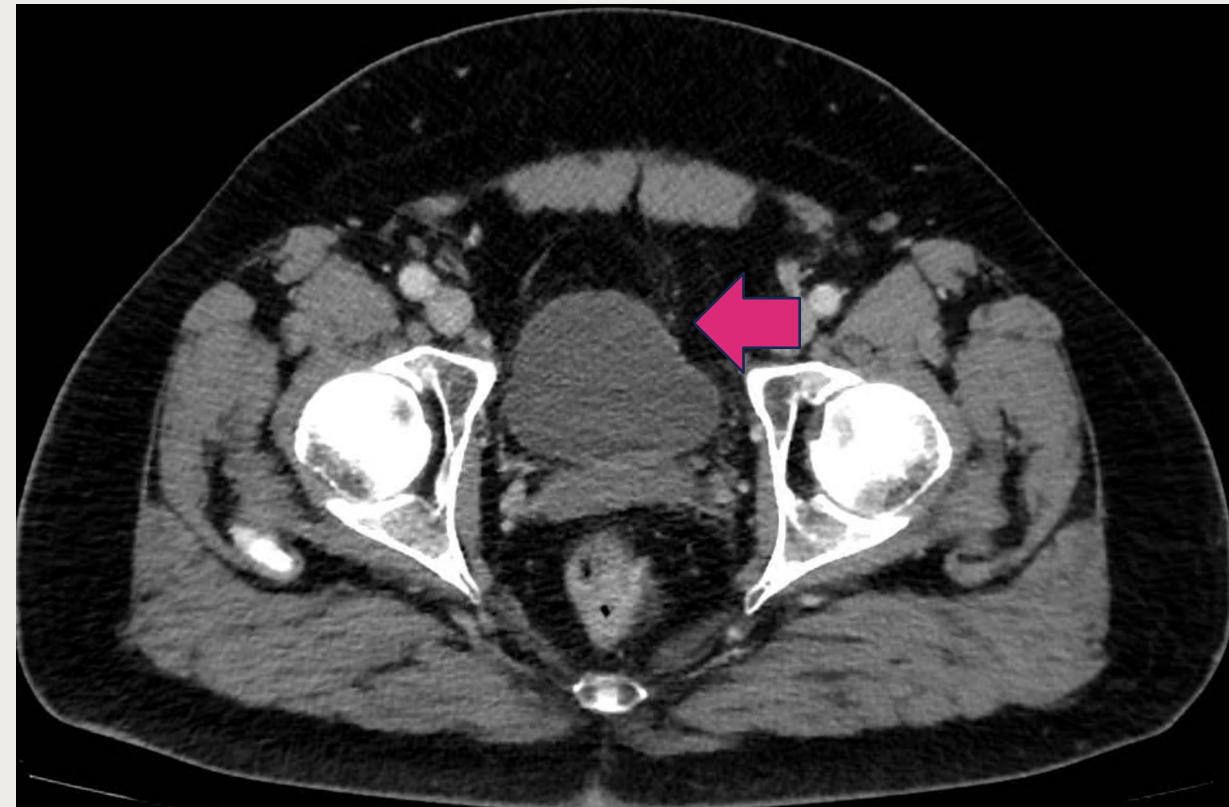
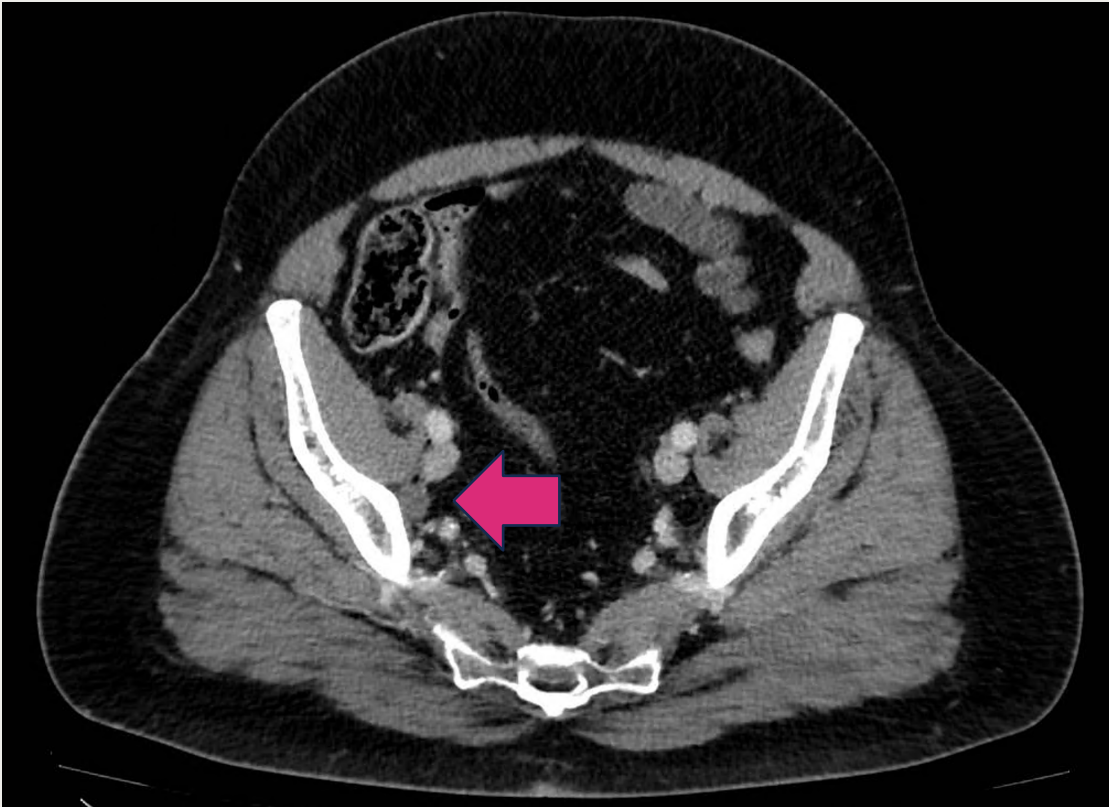
Our approach

- Cisplatin + Gemcitabine + Nivolumab was started on October/2024

CheckMate 901



After 4 cycles of CDDP + Gem + Nivo...



Questions for you

- What would be the next steps for this patient?
 - Continue with Nivolumab?
 - Treatment of the primary?
 - Would you need more information about this patient?
 - Imaging: PET-CT
 - Molecular
 - Cystectomy? Chemoradiation? TURBT only?

Our approach: Radical cystectomy

- No PET-CT scan performed
- ypT0N2.
- CT scan after cystectomy:
 - Small collection in the surgical bed
 - No evidence of disease
- Would you continue Nivolumab after surgery? And for how long?
 - CheckMate 901: 2 years
 - CheckMate 274: 1 year.

One year after surgery...

- G2 arthritis badly controlled despite corticosteroids.
- No evidence of disease
- Nivolumab interruption.

Case 2

Medical history

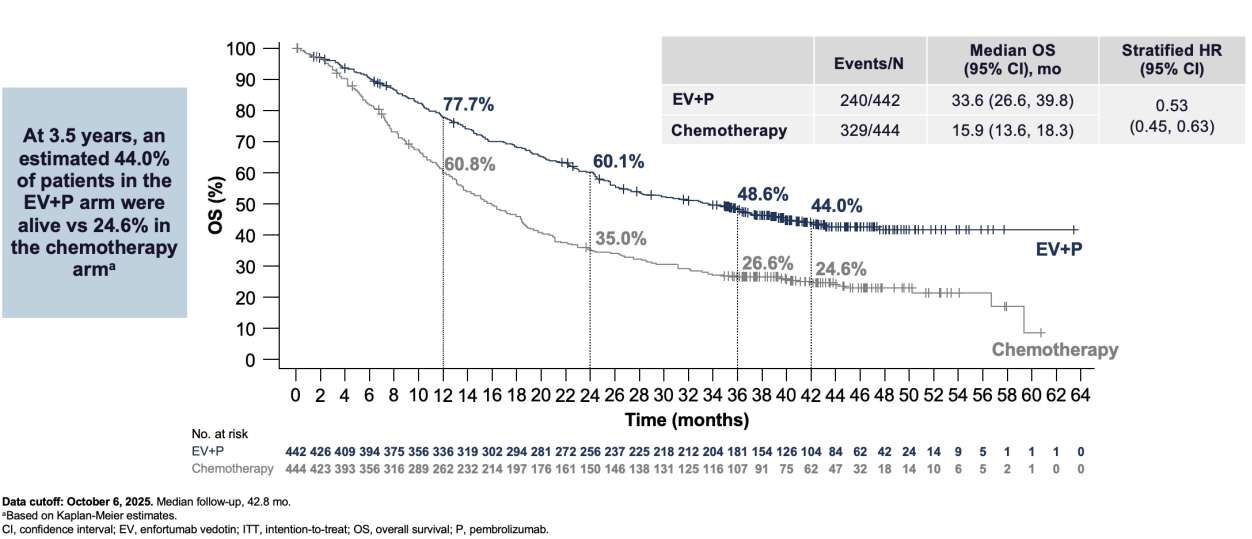
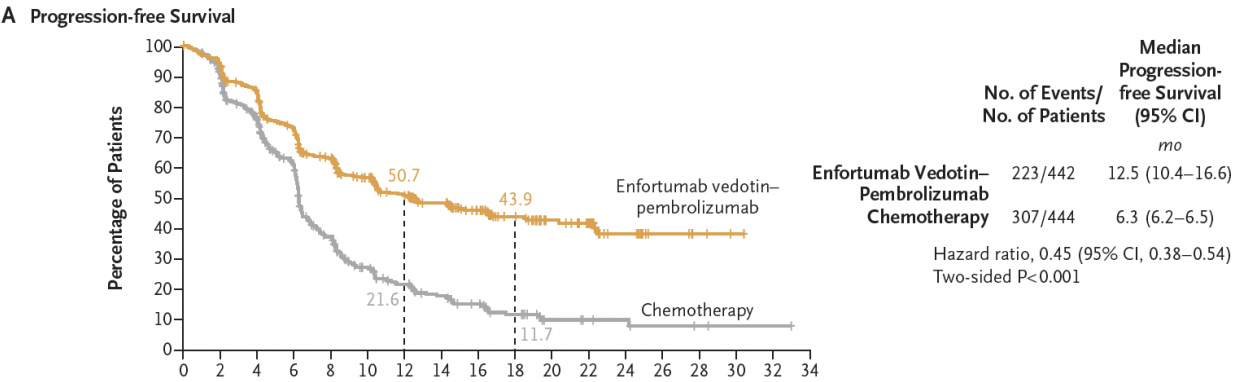
- 64 years old male.
- Prior smoking history: 20 packet-year.
- Initial presentation: Hematuria in January/2022.
- TURBT in April/2023: Pure UC G3 pT2.
- Neoadjuvant ddMVAC in June/2023. Radical cystectomy ypT2bN0M0 in October/2023.

September/2024

- Appearance of retroperitoneal lymph nodes + bone mets.
- Biopsy: UC.
- Started 1st line with EV-P in October/2024.

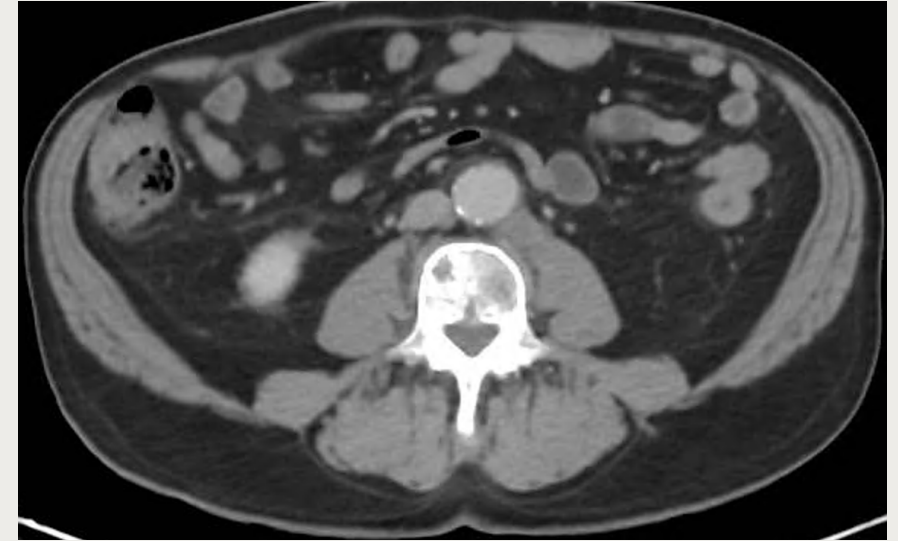
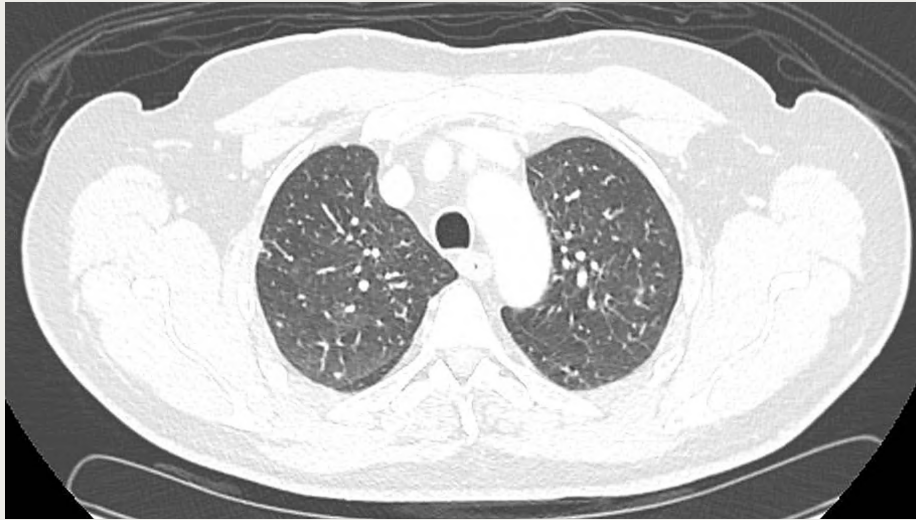
What we should expect with this treatment?

Variable	Enfortumab Vedotin– Pembrolizumab (N = 437)	Chemotherapy (N = 441)
Confirmed best overall response — no. (%)		
Complete response	127 (29.1)	55 (12.5)
Partial response	169 (38.7)	141 (32.0)
Stable disease	82 (18.8)	149 (33.8)
Progressive disease	38 (8.7)	60 (13.6)



We should be optimistic about the outcomes of this patient.

January/2025



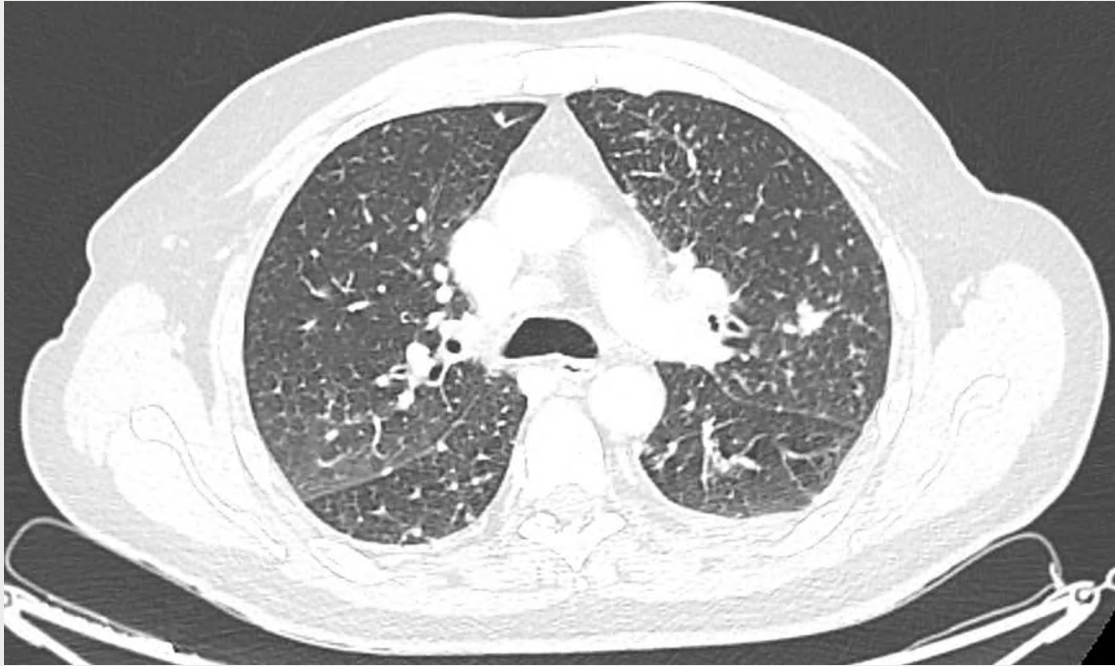
Questions for you

- What additional information would you need to choose next treatment?
- In case you might have said an NGS, would you perform it on the primary tumor or biopsy of the LN, or liquid biopsy?
- Without actionable mutations, what treatment would you choose?

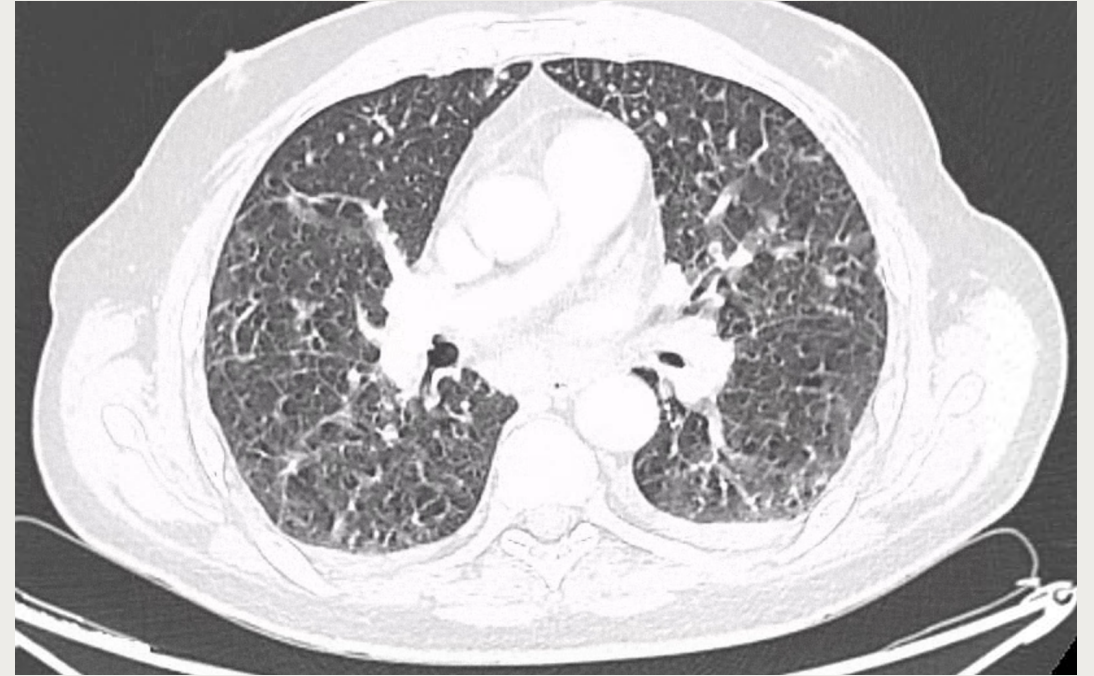
February/2025

- Patient was included in a trial with a HER3-Topo1 payload ADC.
- Treatment was administered for 6 cycles. Best response: SD.

June/2025



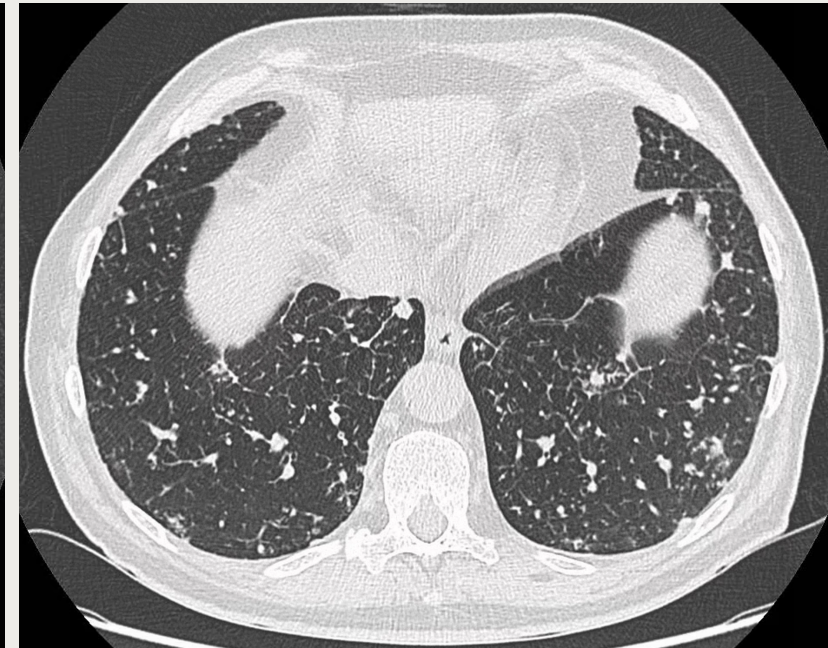
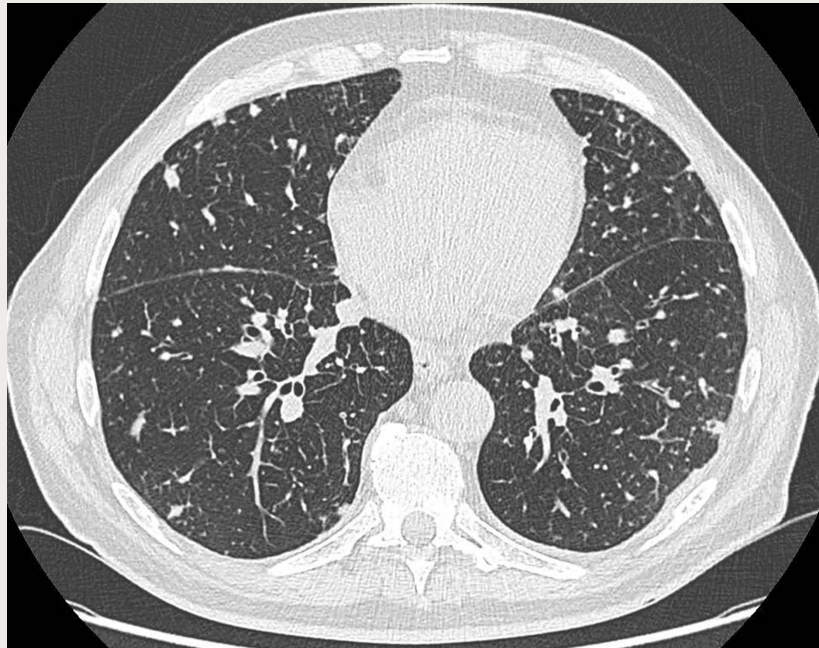
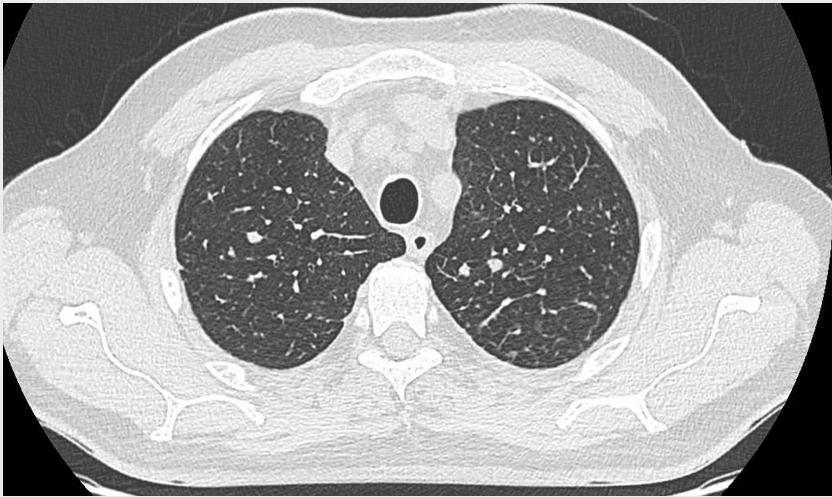
Main symptom: Cough
Prior ADC treatment.



Is this a pneumonitis??

June/2025

- Steroid treatment and diagnostic evaluations were promptly initiated.



Lymphangitic carcinomatosis

July/2025

Genomic Signatures

Tumor Mutational Burden - 14 Muts/Mb

HRD signature - HRDsig Negative

Microsatellite status - Cannot Be Determined ^a

Gene Alterations

For a complete list of the genes assayed, please refer to the Appendix.

BRCA1 E1053*

ERBB2 S310F

ARID1A S11fs*91

CCNE1 amplification

MCL1 amplification

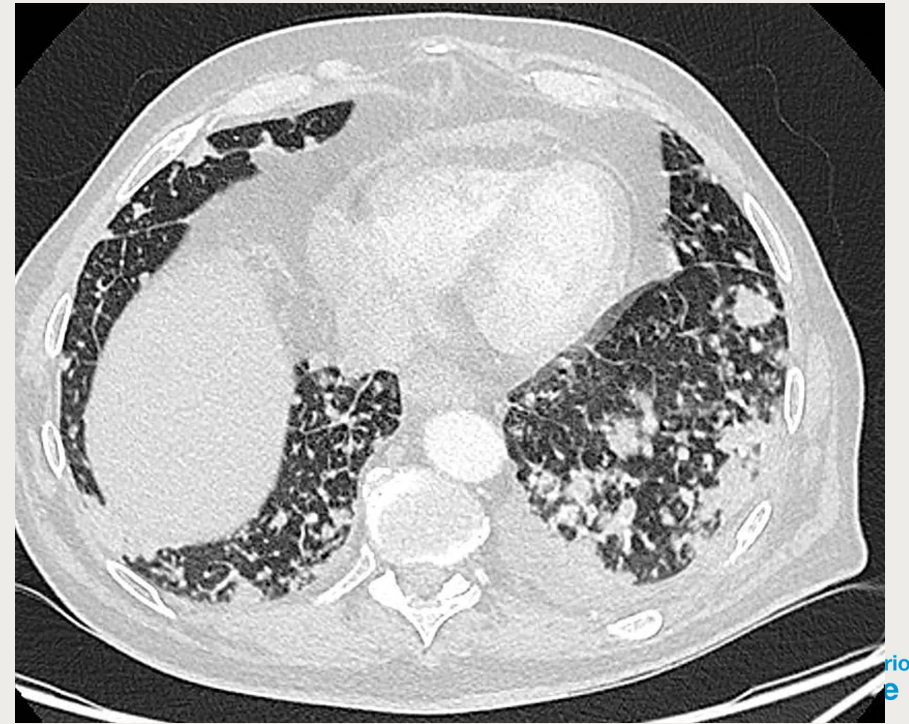
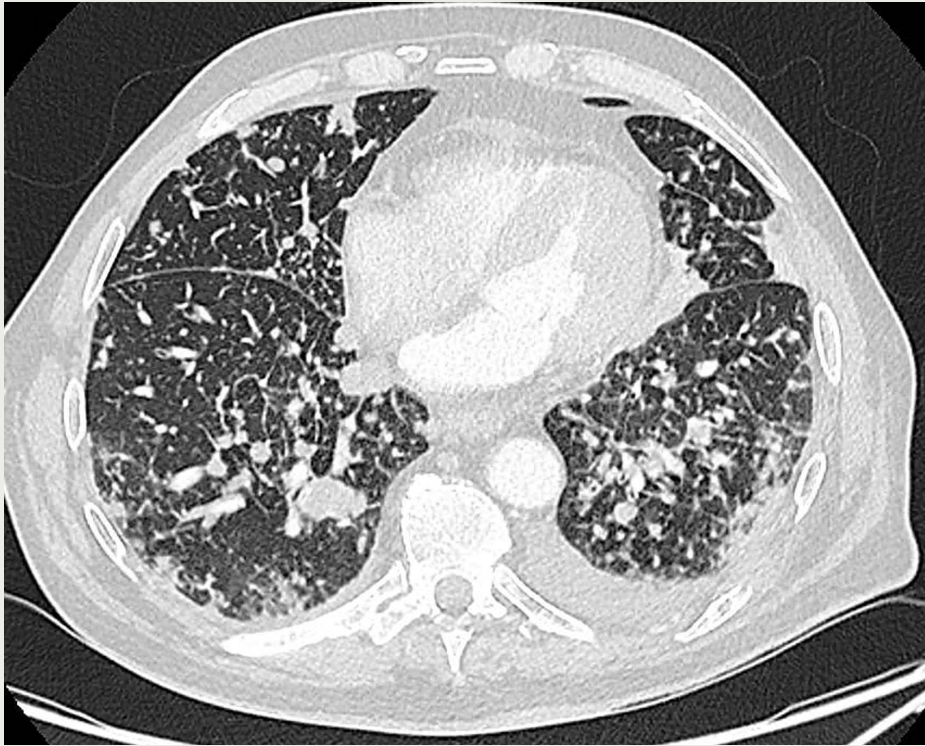
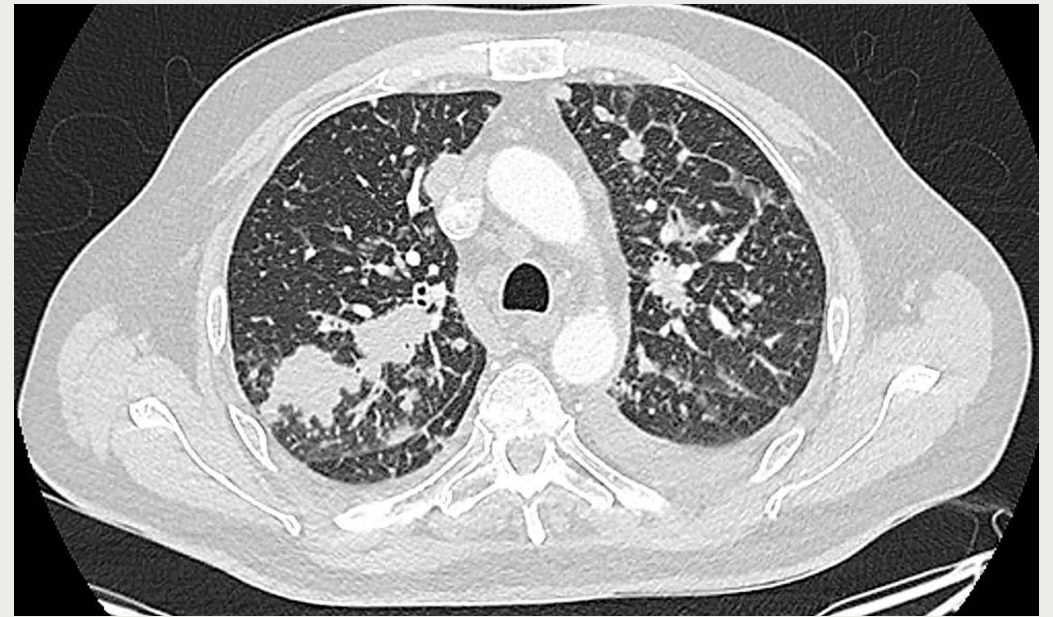
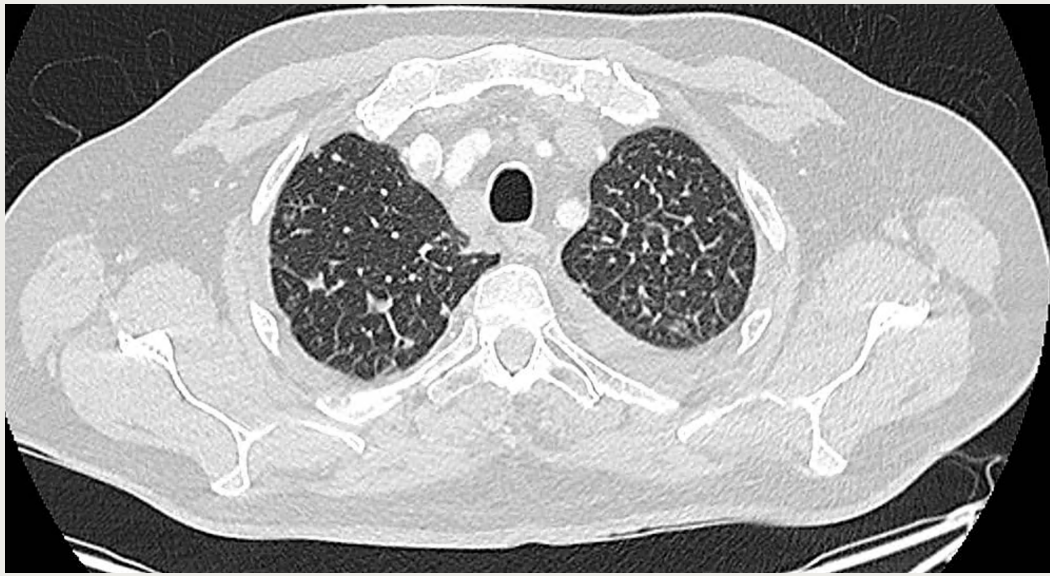
RB1 I246fs*18

RBM10 Q650*

TERT promoter -124C>T

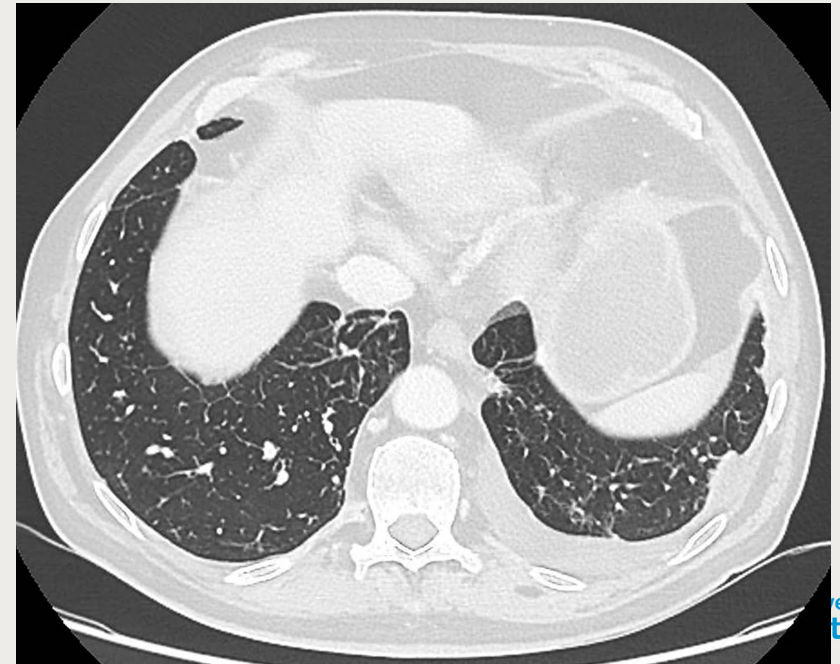
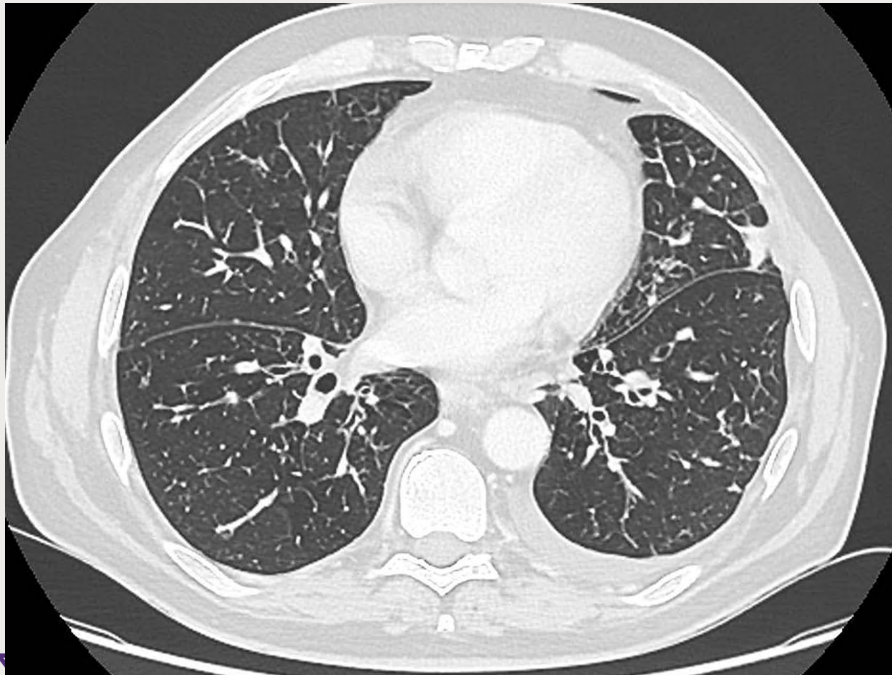
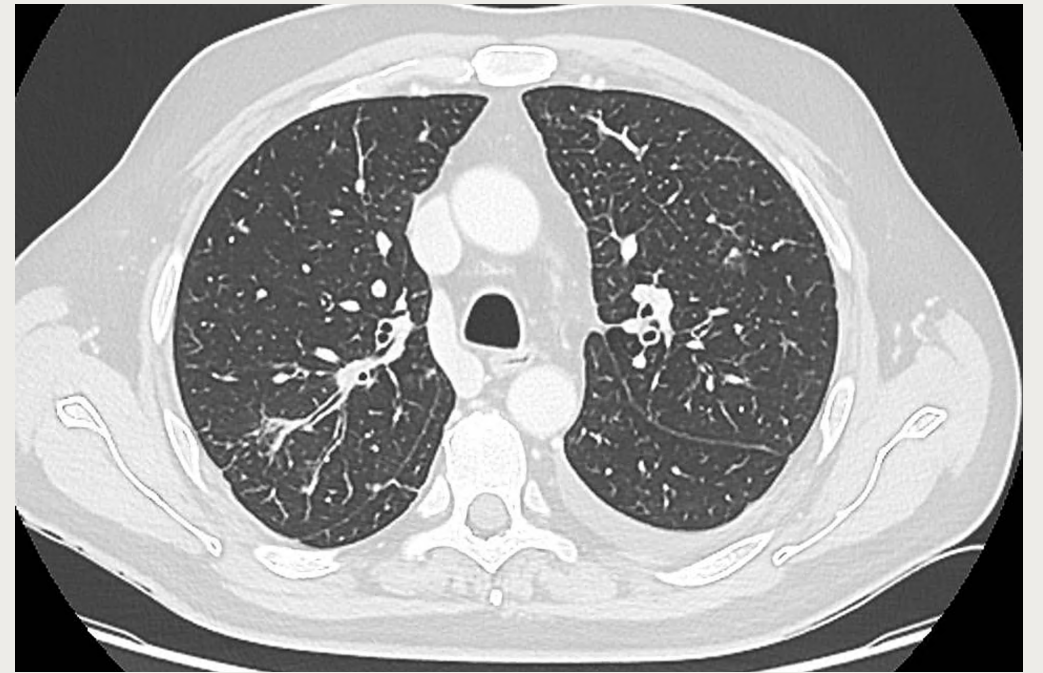
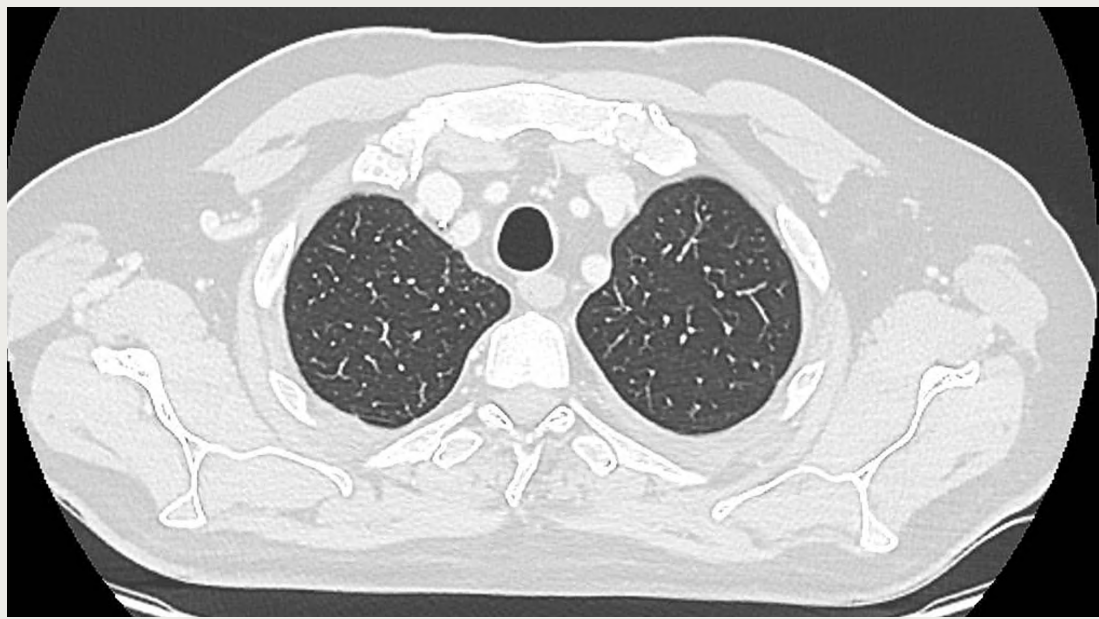
TP53 E336*

- Patient was evaluated in another institution to be included in a clinical trial.
- But... hell was about to break loose.



Questions for you

- Patient was admitted due to a hypoxemic respiratory failure with need of supplementary oxygen.
- Would you have initiated any treatment in this patient? In case you have started treatment, what would you have chosen?
- We decided to start Carboplatin + Gemcitabine.



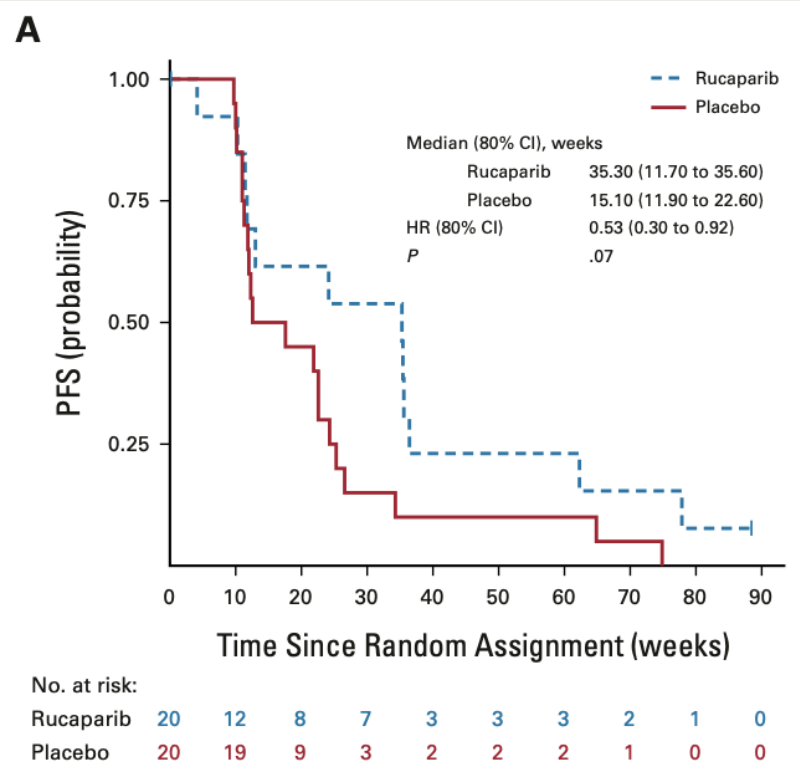
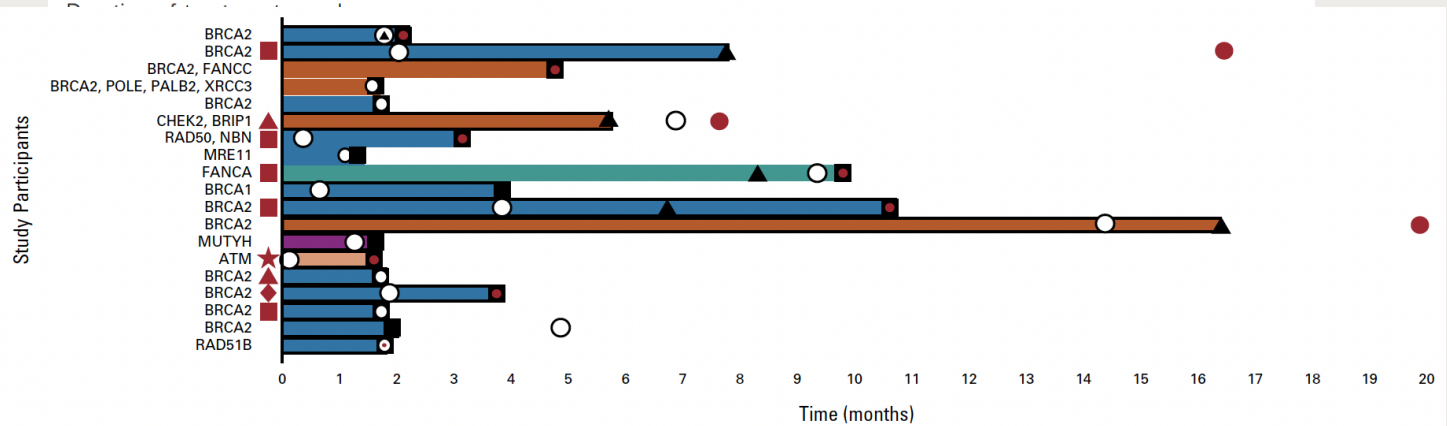
December/2025

- Patient has received treatment for six cycles, with significant hematologic toxicity.
- So... what can we do next?
 - Nothing.
 - Continue Carboplatin + Gemcitabine as we can.
 - Parp inhibitor.

Treatment can be maintained more than 6 cycles and iPARP activity seems limited

Table 2. Amount of Treatment Received and Toxicity

Amount of Treatment Received	GC (n = 118)		M-CAVI (n = 118)	
	No.	%	No.	%
No. of cycles of therapy				
1	12	10.2	23	19.5
2	17	14.4	23	19.5
3	10	8.5	11	9.3
4	18	15.3	18	15.3
5	10	8.5	11	9.3
6	38	32.2	22	18.6
> 6	13	11.0	10	8.5
Median	4.0		5.0	
Range	1.0-23.0		1.0-10.0	



January/2026

- We decided to give a treatment-break to allow for hematological recovery.
- Unfortunately, disease progression started to develop quickly.
- Treatment with Olaparib 300mg BID was started on January/2026.
- Patient condition worsened and died in March/2026.

Future directions

- The definition of oligometastatic urothelial carcinoma
- The role of treatment directed to the primary tumor or the metastasis in advanced patients
- Optimal duration of therapy in advanced patients is not established
- Correct therapeutic sequence after EV-P treatment

Conclusions

- Modern ADC (or chemo)-IO combinations (or in sequence) have revolutionized the care of aUC patients.
- This allows us to make questions we have not been able to make before.
- Although the bar has been set very high, we have to keep raising it.

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¡Gracias!

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 Hospital Universitario
SaludMedica 12 de Octubre

