III JORNADA DE ACTUALIZACIÓN EN
URO-ONCOLOGÍA:
UPDATE 2026

Madrid, 17 de febrero de 2026

¿Podemos considerar la preservación vesical más allá del tumor T2 unifocal?

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TMT vs. cistectomía: Nuevo metaanálisis

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Review – Urothelial Cancer

Trimodality Therapy Versus Radical Cystectomy for Muscle-invasive Bladder Cancer: A Systematic Review and Meta-analysis of Matched Cohort Studies

Akihiro Matsukawa [a,b], Takafumi Yanagisawa [a,b], Marcin Miszczyk [a,c], Mehdi Kardoust Parizi [a,d], Tamás Fazekas [a,e], Ichiro Tsuboi [a,f], Stefano Mancon [a,g,h], Jakob Klemm [a,i], Robert Schulz [a,j], Anna Cudenar [a,j], Ekaterina Laukhtina [a,b], Paweł Rajwa [a,l], Keiichiro Mori [a,b], Jun Miki [b], Takahiro Kimura [b], Shahrokh F. Shariat [a,g,k,m,n,o,p,q,r,]*

No se observaron diferencias significativas para TMT en comparación con RC en

SG (HR: 1,05; intervalo de confianza [IC] del 95 %: 0,78-1,40)

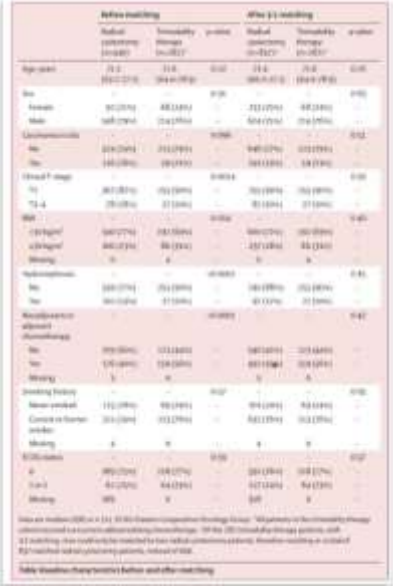
SCE (HR: 1,05; IC del 95 %: 0,69-1,58)

Matsukawa A. Eur Urol Focus. 2025

TMT=Cystectomy (87 studies)

TMT: resección transuretral máxima+ radioterapia con quimioterapia radiosensibilizante

Cistectomía radical versus terapia trimodal para el cáncer de vejiga con invasión muscular: un análisis multiinstitucional ponderado y emparejado por puntuación de propensión



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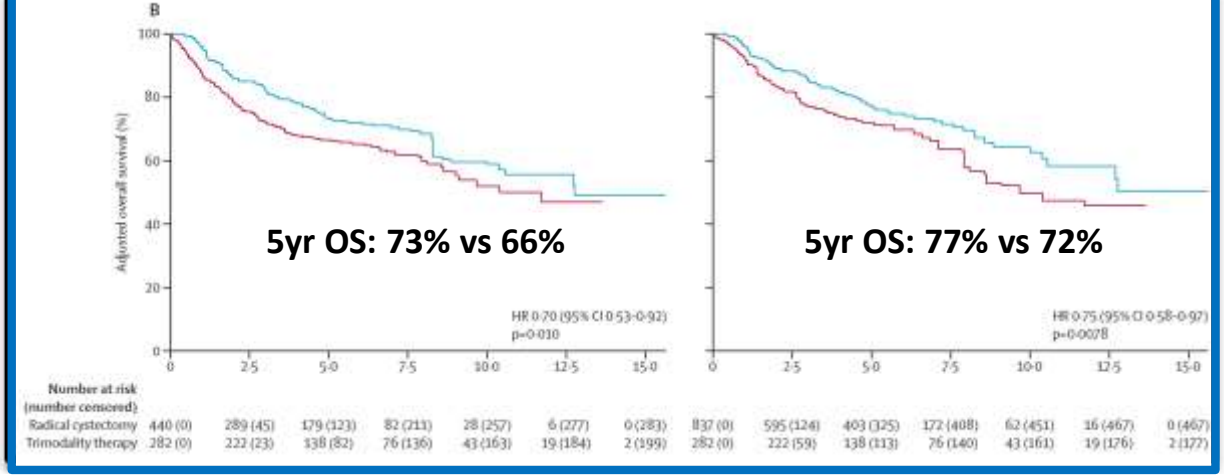
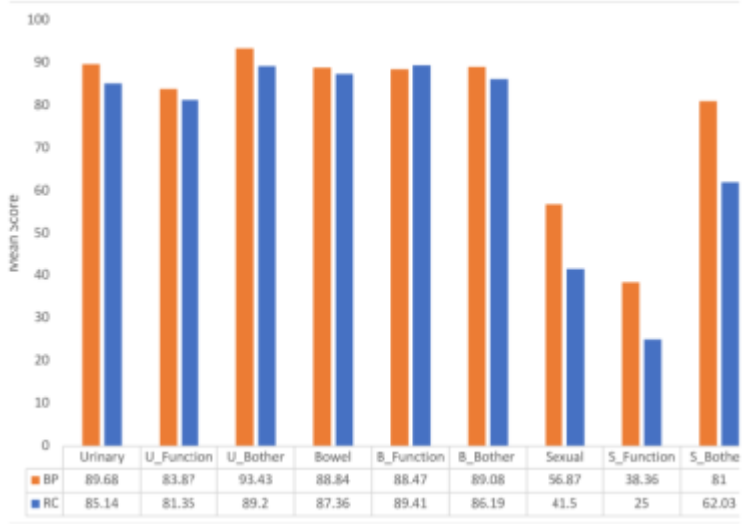


Este estudio multiicéntrico proporciona la mejor evidencia hasta la fecha que muestra resultados oncológicos similares entre la cistectomía radical y la terapia trimodal en pacientes seleccionados con cáncer de vejiga músculo-invasivo

Zlotta AR. Lancet Oncol. 2023

Estudio comparativo prospectivo de la calidad de vida en pacientes con cáncer de vejiga sometidos a cistectomía o preservación vesical



	Urinary	U_Function	U_Bother	Bowel	B_Function	B_Bother	Sexual	S_Function	S_Bothe
BP	89.68	83.87	93.43	88.84	88.47	89.08	56.87	38.36	81
RC	85.14	81.35	89.2	87.36	89.41	86.19	41.5	25	62.03

- En general, los sobrevivientes de cáncer de vejiga tienen una buena calidad de vida
- No hay diferencias en los dominios urinario e intestinal con radioterapia y cirugía
- La puntuación en la esfera sexual es mejor con radioterapia en comparación con cistectomía radical
- La calidad de vida debe ser fundamental en el proceso de toma de decisiones

Murthy V. BMJ Oncol. 2024

Calidad de vida tras el tratamiento radical para el cáncer de vejiga músculo-invasivo: Revisión sistemática y metaanálisis

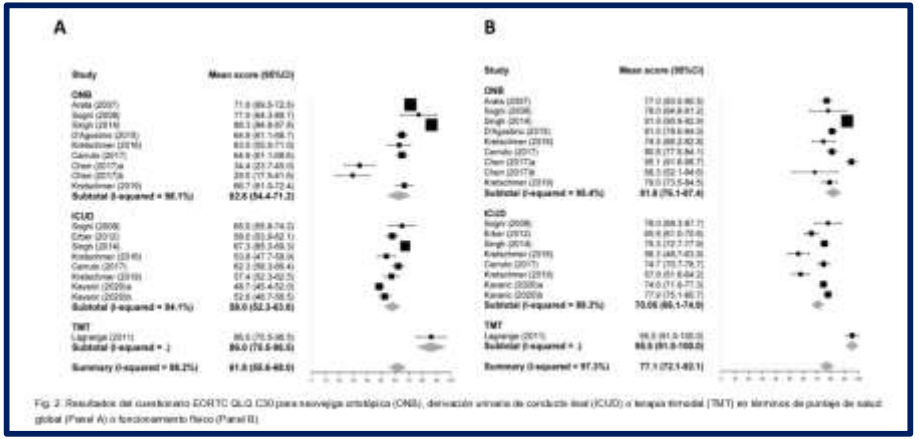


Fig. 2. Resultados del cuestionario EORTC QLQ C30 para neovejiga ortotópica (ONB), derivación urinaria de conducto ileal (ICUD) o terapia trimodal (TMT) en términos de puntaje de salud global (Panel A) o funcionamiento físico (Panel B).

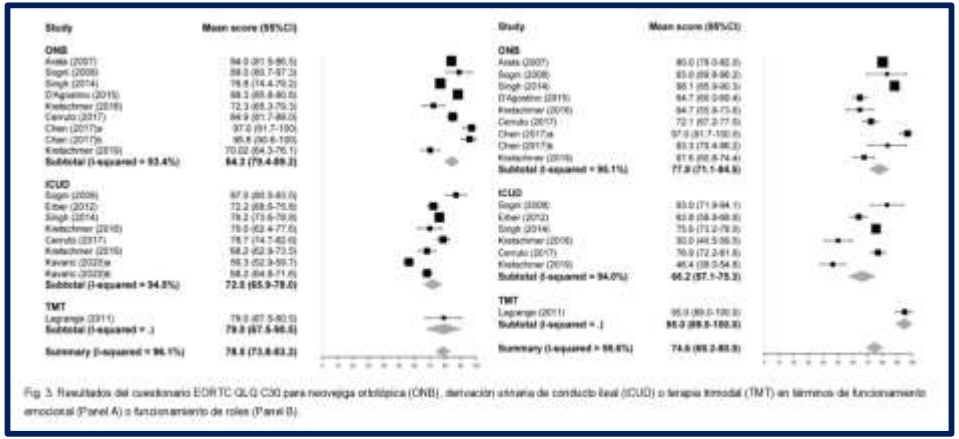


Fig. 3. Resultados del cuestionario EORTC QLQ C30 para neovejiga ortotópica (ONB), derivación urinaria de conducto ileal (ICUD) o terapia trimodal (TMT) en términos de funcionamiento emocional (Panel A) o funcionamiento de roles (Panel B).

No existe una comparación directa con TMT, pero los datos sugieren ventajas de este enfoque en comparación con ambos escenarios reconstructivos.

Francolini G. Radiother Oncol. 2024

Factores que pueden influir en la elección de TMT o CR en pacientes con cáncer de vejiga invasivo multisistémico (MIBC)

General recommendations:

1. Patients with newly diagnosed MIBC should be offered evaluation in a multidisciplinary setting that includes visits with urologic oncology, medical oncology, and radiation oncology providers (as appropriate) as well as input from experts in bladder cancer radiology and pathology.
2. When feasible, all MIBC cases, including those being considered for BPT, should be reviewed by a pathologist with experience and expertise in urothelial carcinoma.

Trimodal therapy:

Patient selection:

1. Ideal candidates for TMT include patients with unifocal cT2 stage without hydronephrosis or concomitant multifocal CIS, and who have good baseline bladder function.
2. While cT3-4a stage, hydronephrosis, and CIS are poor prognostic factors, their presence is not an absolute contraindication to TMT.

Technique:

3. When feasible, maximally safe TURBT should be performed prior to the initiation of TMT.
4. A radiosensitizing agent should be delivered concurrently with bladder RT. Reasonable options include 5FU + MMC, cisplatin, gemcitabine, or carbogen + nicotinamide.
5. Induction systemic chemotherapy (eg, cisplatin-based chemotherapy) prior to RT with a concurrent radiosensitizer can be offered, particularly for patients with high-risk features, including cT3–4 stage, hydronephrosis, and/or cN+ disease in the pelvis (strongly recommended for cN+).
6. The tumor bed, as well as any gross residual tumor remaining after TURBT, should receive the highest radiation dose. Uninvolved portions of the bladder may be treated with full or reduced radiation doses. The role of pelvic nodal radiation remains uncertain and should be discussed with patients (on a case-by-case basis) based on benefits versus risks.

Gupta S. Eur Urol. 2026

National Comprehensive Cancer Network®

NCCN Guidelines Version 3.2025
Muscle-Invasive Bladder Cancer

NCCN Guidelines Index
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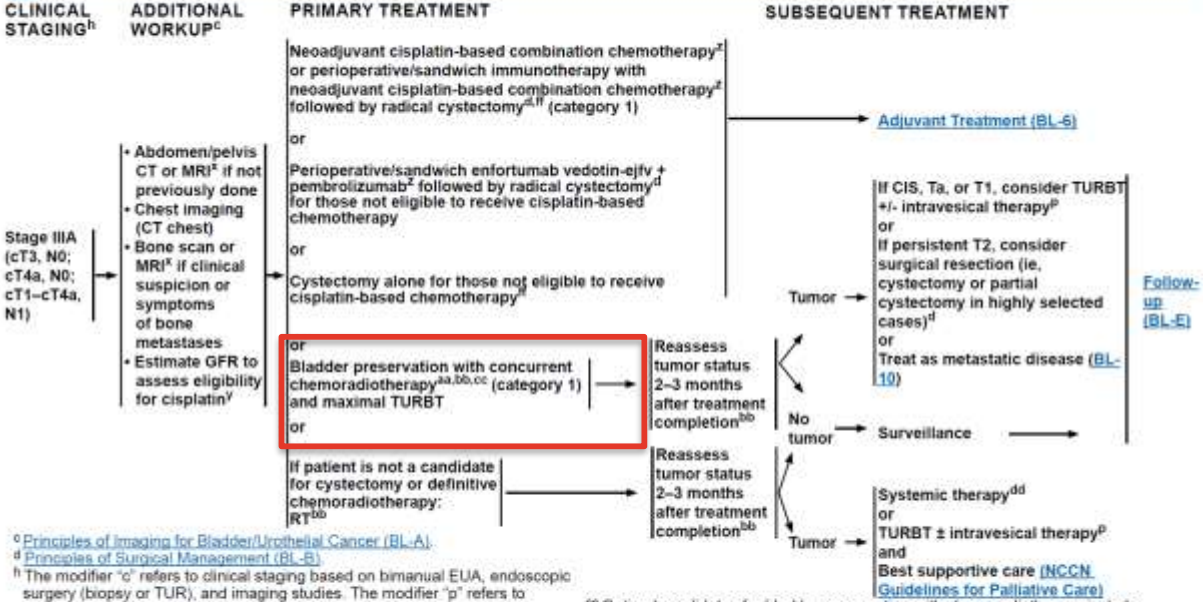

[c] Principles of Imaging for Bladder/Urothelial Cancer (BL-A).
[d] Principles of Surgical Management (BL-B).
[h] The modifier "c" refers to clinical staging based on bimanual EUA, endoscopic surgery (biopsy or TUR), and imaging studies. The modifier "p" refers to pathologic staging based on cystectomy and lymph node dissection.
[p] Principles of Instillation Therapy (BL-F).
[x] Consider FDG-PET/CT scan (skull base to mid-thigh) (category 2B).
[y] For patients with borderline GFR, consider timed urine collection, which may more accurately determine eligibility for cisplatin.
[z] Principles of Systemic Therapy (BL-G 1 of 7).
[aa] Principles of Systemic Therapy (BL-G 5 of 7).
[bb] Principles of Radiation Management of Invasive Disease (BL-H).

[cc] Optimal candidates for bladder preservation with chemoradiotherapy include patients with tumors that present without moderate/severe hydronephrosis, are without concurrent extensive or multifocal CIS, and are <6 cm. Ideally, tumors should allow a visually complete or maximally debulking TURBT. See Principles of Radiation Management of Invasive Disease (BL-H).
[dd] Principles of Systemic Therapy (BL-G 2 of 7).
[ff] Patients with cN1 disease have better outcomes if they are given neoadjuvant chemotherapy and have a response.

Note: All recommendations are category 2A unless otherwise indicated.

Recurrent or Persistent Disease (BL-11)

Actas Urológicas Españolas 48 (2024) 345–355

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Actas Urológicas Españolas

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REVIEW ARTICLE

Is trimodal therapy the current standard for muscle-invasive bladder cancer?

M. López Valcárcel[a,*], M. Barrado Los Arcos[b], M. Ferri Molina[c], I. Cienfuegos Belmonte[d], V. Duque Santana[e], P. Gajate Borau[f], J. Fernández Ibiza[g], M. Álvarez Maestro[h], P. Sargos[i], F. López Campos[j], F. Couñago[k]

Estos ensayos incluyen técnicas de radiación adaptativa, escalada de dosis, hipofraccionamiento y diferentes agentes sensibilizantes.

López Valcarcel M. Actas Urol Esp.2024

Table 1 Clinical studies of TMT in MIBC. An advanced search of ClinicalTrials.gov was performed in September 2023 for "TMT in MIBC". These were reviewed and selected based on the status of the study.

Study	Treatment scheme	1st END-POINT	Status
ARTIA-Vesica NCT05295992	Adaptive daily radiation therapy	Toxicity	Recruitment
HIRACOM NCT5453682	CT (cisplatin) + IMRT RT (64 Gy in 32 fx) CT (cisplatin) + hypo-IMRT RT (56-64 Gy in 20 fx high-risk volume) and 40–44 Gy in low-risk volume.	Bladder PFS at 2 years	Recruitment
HyBla_RCT NCT05397262	Hyperthermia 1–2/week in 10 sessions + RT (50.4 Gy in 28 fx + boost 5.4 Gy (R0) or 9 Gy (R1/2) + CT (Cisplatin + 5FU).	OS	Recruitment
ARTIA-Bladder NCT05700227	Adaptive daily radiation therapy + CT	Toxicity	Recruitment
RAIDER NCT02447549	WBRT; SART; DART	Toxicity	Active, not recruiting
NCT01104350	RT + Gemcitabine RT dose: 23.4 Gy/1.8 Gy x 13 fx (total dose 68.4 Gy) 27 Gy/1.8 Gy x 15 fx (total dose 72 Gy) 30.6 Gy/1.8 Gy x 17 fx (total dose 75.6 Gy)	Maximum tolerated dose	Active, not recruiting
GETUGV04 NCT01495676	RT (45 Gy pelvis and 63 Gy bladder at 1.8 Gy/fx) + Cisplatin Cisplatin + Gemcitabine	PFS	Active, not recruiting

DART: adaptive radiation therapy; fx: fraction; MIBC: muscle invasive bladder cancer; NA: not applicable; CT: chemotherapy; RT: radiotherapy; SART: standard dose adaptive tumour focussed radiotherapy; OS: overall survival; PFS: progression-free survival; WBRT: whole bladder radiotherapy.

Actas Urológicas Españolas 48 (2024) 345–351

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- Nivolumab + TMT: RCT Phase II (NCT03993249)

ESTRO2025

ESMO

Andromachi Kougioumtzopoulou. ESMO 2024; ESTRO 2025

Positive Trial: ⬆ PFS and OS

Table 2 Ongoing studies of TMT with immune checkpoint inhibitors.

Study	Treatment scheme	1st END-POINT	Status
CHEMORADIOTHERAPY + IMMUNOTHERAPY			
ANZUP 1502 NCT02662062	RT (64 Gy in 32 fx) + cisplatin(35 mg/m²) + Pembrolizumab (200 mg every 3 weeks)	Safety	Active, not recruiting
MK3475 NCT02621151	RT (52 Gy in 20 fx) + gemcitabine (27 mg/m²) + pembrolizumab (200 mg every 3 weeks x 3 courses)	BIDFS rate at 2 years	Active, not recruiting
KEYNOTE 992 NCT04241185	**Arm A:** RT (64 Gy or 55 Gy) + CT (cisplatin 35 mg/m² or 5FU 500 mg/m² + MMC 12 mg/m² **Arm B:** Gemcitabine 27 mg/m²) +/- Pembrolizumab (400 mg every 6 weeks)	BIDFS	Recruitment
SWOG/NRG 1806 NCT03775265	CTRT (cisplatin, 5FU, gemcitabine, or MMC) +/- atezolizumab (every 6 weeks for 6 months)	BIDFS	Recruitment
CRIMI NCT03844256	RT (42 Gy in 20 fx) + MMC 12 mg/m² + Capecitabine 750 mg/m² + Nivolumab/Ipilimumab + Nivolumab	Safety	Recruitment
ML-39576 NCT03620435	RT (50 Gy) + Atezolizumab (1200 mg every 3 weeks) + Gemcitabine (100 mg/m²)	Safety	Completed
BladderSpar	RT + CT + Atezolizumab 1200 mg/3 weeks for 12 months	DFS at 2 years	Recruitment
INSPIRE NCT04216290	RT + CT + Durvalumab (3 courses)	Complete clinical response	Recruitment
SunRiSe-2 NCT04658862	**Arm A:** Cetrelimab + intravesical TAR-200/3 weeks for 18 weeks, from week 24/12 weeks during 3 years) **Arm B:** CTRT (Cisplatin or Gemcitabine) + RT (64 Gy or 55 Gy only bladder)	BIDFS	Recruitment
RADIOTHERAPY + IMMUNOTHERAPY			
NUTRA NCT03421652	RT (64 Gy in 32 fx) + Nivolumab (240 mg every 2 weeks)	PFS at 12 months	Active, not recruiting
IMMUNOPRESERVE NCT03702179	RT (64–66 Gy) + Durvalumab (1500 mg every 4 weeks) + Tremelimumab (75 mg every 4 weeks)	Pathological complete response at 12 months	Active, not recruiting
ATEZOBLADDER PRESERVE NCT04186013	RT (60 Gy) + Atezoluzumab (1200 mg every 3 weeks 6 courses)	Pathological complete response	Active, not recruiting

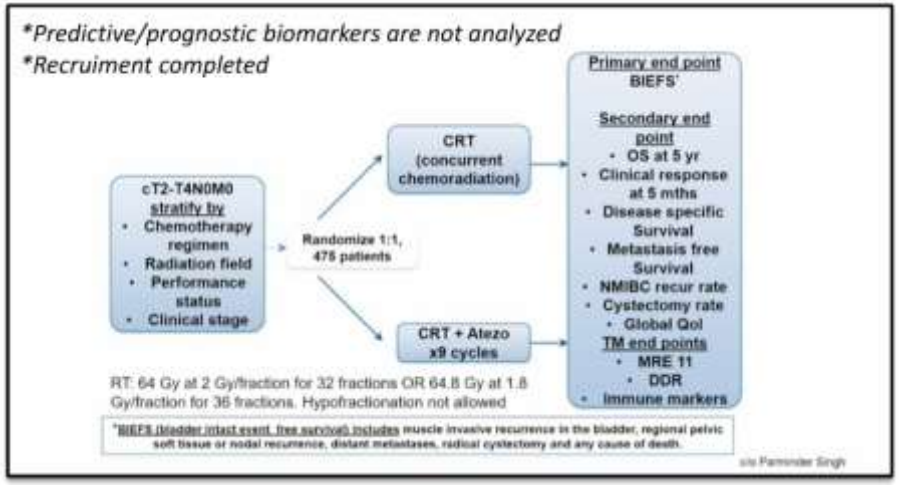
BIDFS: bladder intact disease-free survival; fx: fraction; RT: radiotherapy; PFS: progression-free survival.

Atezolizumab and Radiation Therapy (BPT-ART) for Invasive Bladder Cancer: A Multicentre, Prospective Phase 2 Trial

- La terapia de preservación vesical con atezolizumab y radioterapia mostró efectos terapéuticos favorables, con toxicidad manejable, en pacientes no aptos para la RC o rechazados

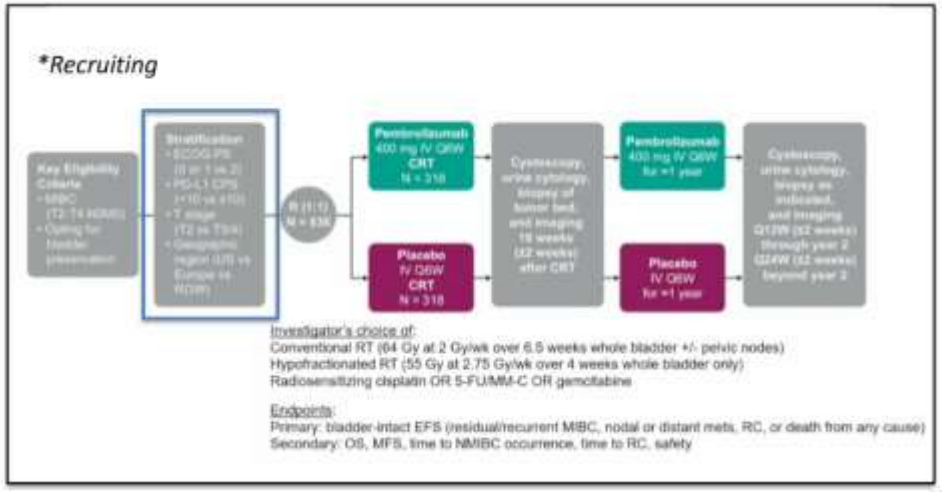
Nagumo Y. Eur Urol. 2026

SWOG/NRG S1806/INTACT: Atezolizumab + TMT:Ensayo de fase III



TMT: terapia trimodal
Estudio en investigación: Los datos presentados están en investigación, se basan en fuentes públicas y tienen únicamente finalidad ilustrativa

KEYNOTE-992: Pembrolizumab + TMT: Ensayo de fase III



TMT: terapia trimodal
Estudio en investigación: Los datos presentados están en investigación, se basan en fuentes públicas y tienen únicamente finalidad ilustrativa
Gupta, S., van der Heijden, M. S., James, N. D., Shariat, S. F., Weickhardt, A. J., et al. (2024). Phase III randomized trial of pembrolizumab plus chemoradiotherapy versus placebo plus chemoradiotherapy in muscle-invasive bladder cancer (KEYNOTE-992). Journal of Clinical Oncology, 42(4_suppl), TPS720. doi:10.1200/JCO.2024.42.4_suppl.TPS720

¿Podemos considerar la preservación vesical más allá del tumor T2 unifocal?

SI ¡Ni preservación vesical para todos, ni cistectomía para todos!

• Los casos deben ser evaluados por un **comité multidisciplinar de tumores**, y los pacientes deben tener la oportunidad de consultar con un **urólogo, un oncólogo médico y un oncólogo radioterápico** para analizar las diferentes opciones terapéuticas, lo que **permite al paciente participar activamente en la decisión final** sobre el tratamiento

• La llegada de la **inmunoterapia y los conjugados anticuerpo-fármaco** está cambiando rápidamente el tratamiento del cáncer de vejiga músculo-invasivo no metastásico

• Estamos a la espera de los resultados de los **ensayos de fase III** en curso que confirmarán el beneficio de la **inmunoterapia combinada con la terapia trimodal (TMT)**

Muchas gracias