III JORNADA DE ACTUALIZACIÓN EN
URO-ONCOLOGÍA:
UPDATE 2026

Madrid, 17 de febrero de 2026

¿Tiene algún papel la QT basada en platino en el tratamiento de 1ª línea del carcinoma urotelial metastásico? **NO**

Dra Mª José Juan Fita. Instituto Valenciano de Oncología

Conflictos de interés

- He proporcionado asesoramiento científico a ***IPSEN, Novartis, Bristol-Meyers-Squibb, Johnson & Johnson, Sanofi, Bayer, Merck, MSD.***

- He recibido pagos por presentaciones por parte de ***Bristol-Meyers-Squibb,Atellas, Johnson and Johnson, IPSEN, Merck, Novartis, Pierre-Fabre, Astra-Zeneca.***

Repite conmigo …

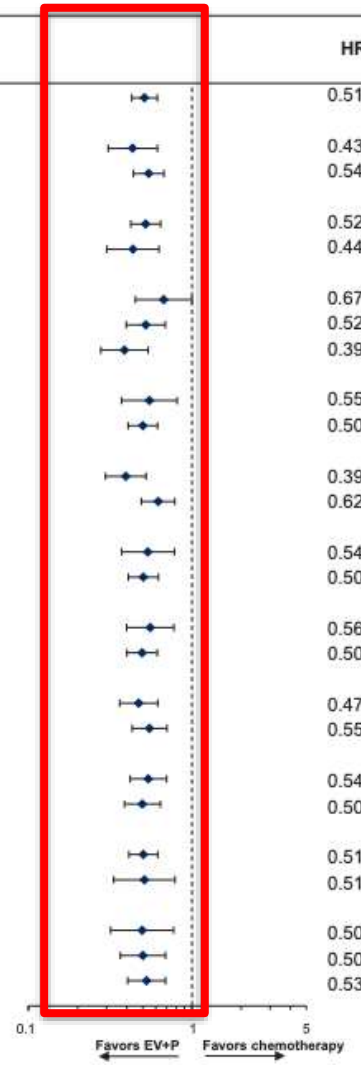
"Para todos"

Martín Mercado, 2002. Campaña Coca-Cola

Ya existe algo mejor

Para todos

	EV+P		Chemotherapy		HR (95% CI)
	Median OS, months	events/*N*	Median OS, months	events/*N*	
Overall	33.8	203/442	15.9	297/444	0.51 (0.43-0.61)
Age (years)					
<65	39.3	59/144	18.7	87/135	0.43 (0.31-0.61)
≥65	27.1	144/298	14.6	210/309	0.54 (0.44-0.67)
Race					
White	26.1	158/308	15.1	207/290	0.52 (0.42-0.64)
Other	36.3	45/134	19.1	90/154	0.44 (0.30-0.63)
Region					
North America	25.7	57/103	21.0	54/85	0.67 (0.45-1.00)
Europe	25.6	90/172	14.6	140/197	0.52 (0.40-0.69)
Rest of World	NR	56/167	15.5	103/162	0.39 (0.28-0.54)
Sex					
Female	25.4	46/98	14.6	70/108	0.55 (0.37-0.81)
Male	33.8	157/344	16.4	227/336	0.50 (0.41-0.62)
ECOG PS					
0	36.5	77/223	18.7	136/215	0.39 (0.30-0.52)
1-2	22.8	126/219	13.3	160/227	0.62 (0.49-0.79)
Primary disease site of origin					
Upper tract	36.5	60/135	18.3	63/104	0.54 (0.37-0.78)
Lower tract	32.9	142/305	15.6	233/339	0.50 (0.41-0.62)
Liver metastases					
Present	19.1	68/100	10.1	82/99	0.56 (0.40-0.78)
Absent	39.3	135/342	18.3	215/345	0.50 (0.40-0.62)
PD-L1 expression					
Low (CPS <10)	31.2	91/184	15.1	136/185	0.47 (0.36-0.62)
High (CPS ≥10)	36.5	111/254	17.1	158/254	0.55 (0.43-0.70)
Cisplatin eligibility					
Eligible	36.7	101/244	18.7	143/234	0.54 (0.42-0.70)
Ineligible	25.6	102/198	12.7	154/210	0.50 (0.39-0.64)
Metastatic disease site					
Visceral metastases	25.7	163/318	13.5	235/318	0.51 (0.41-0.62)
Lymph node only	NR	34/103	24.4	54/104	0.51 (0.33-0.79)
Renal function[b]					
Normal	39.3	33/84	18.6	61/95	0.50 (0.32-0.77)
Mild	36.5	69/165	18.4	101/162	0.50 (0.37-0.69)
Moderate/severe	25.6	101/193	13.3	135/187	0.53 (0.41-0.69)

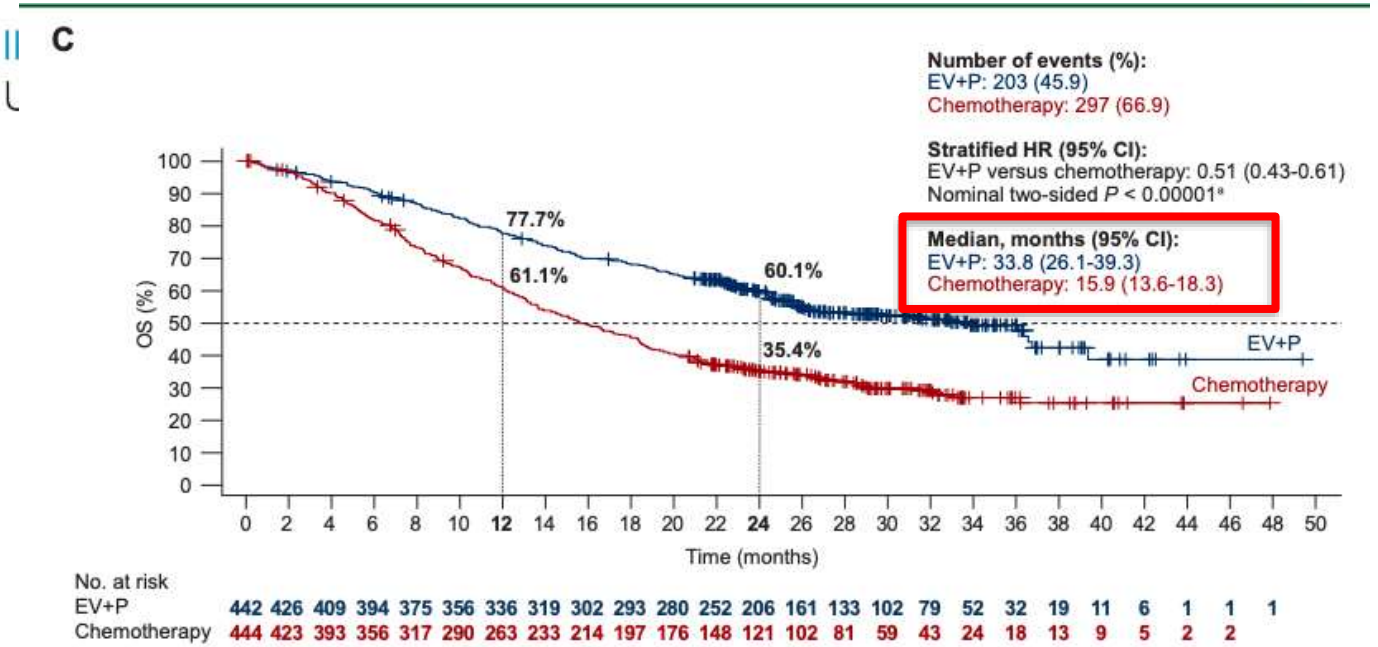


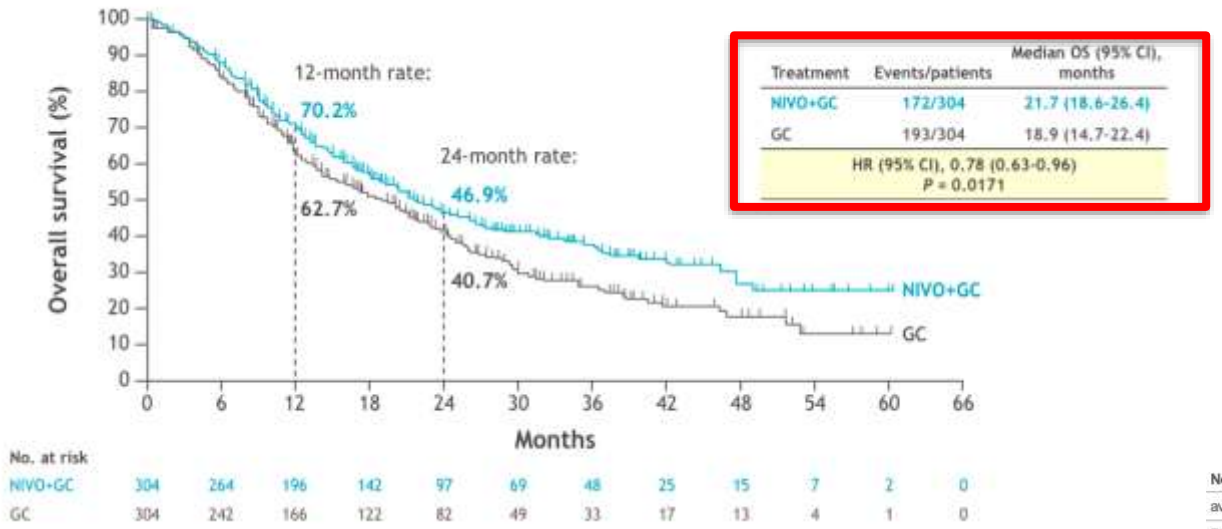
Powles T, et al. Ann Oncol 2025

Y cuando existe algo mejor, el estándar cambia

Ya existe algo mejor

Para todos



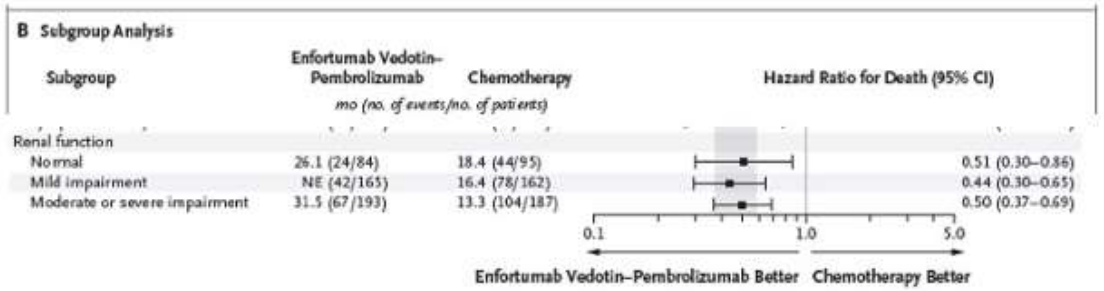


Treatment	Events/patients	Median OS (95% CI), months
NIVO+GC	172/304	21.7 (18.6-26.4)
GC	193/304	18.9 (14.7-22.4)
HR (95% CI), 0.78 (0.63-0.96) P = 0.0171		

Powles T, et al. Ann Oncol 2025;Van der Heijden MS, et al. N Engl J Med 2023; Powles T, et al. J Clin Oncol 2023

Ya existe algo mejor

Para Irenal



Powles T, et al. N Engl Med 2024

TABLE 3. Comparison of ORRs Among Relevant Subgroups of Patients Treated With EV Monotherapy and Evaluable for a Response

Subgroup	Patients, No.	ORR, % (95% CI)	*P*
Baseline neuropathy	71	62 (50-73)	.08
No neuropathy	139	48 (40-57)	
Baseline diabetes mellitus	29	59 (39-76)	.60
No diabetes mellitus	183	51 (44-59)	
eGFR < 30 mL/min	25	40 (22-61)	.27
eGFR ≥ 30 mL/min	187	54 (47-61)	
FGFR3 altered	28	57 (37-75)	.93
FGFR3 wild type	102	54 (44-64)	

Koshkin V, et al. Cancer 2022

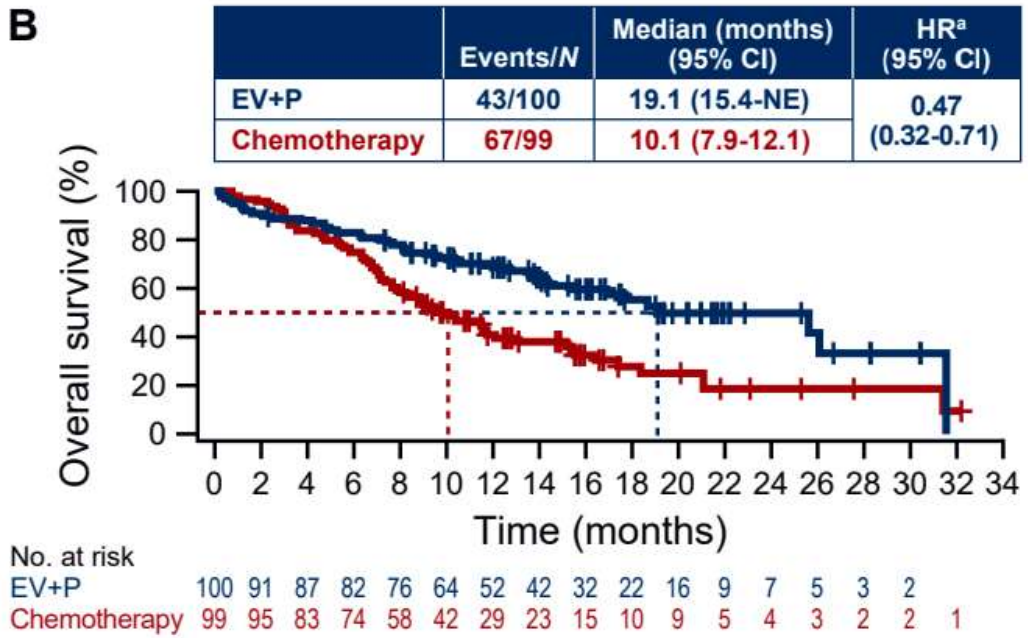
No dose adjustment is necessary in patients with mild [creatinine clearance (CrCL) >60–90 mL/min], moderate (CrCL 30–60 mL/min) or severe (CrCL 15–<30 mL/min) renal impairment. Enfortumab vedotin has not been evaluated in patients with end stage renal disease (CrCL <15 mL/min) (see section 5.2).

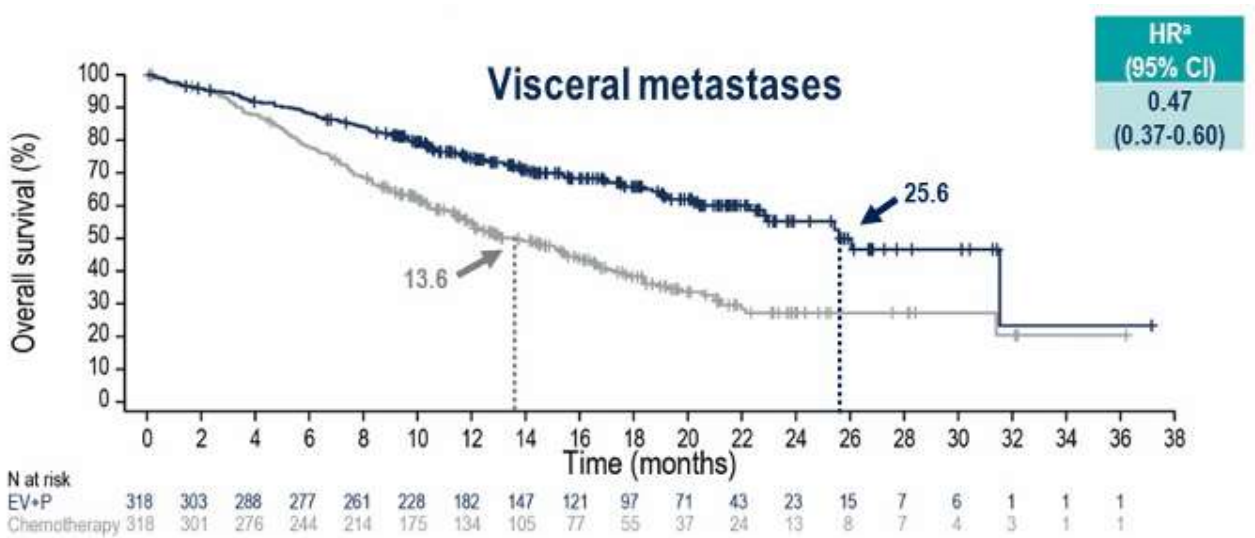
European Medicine Agency 2024; FDA Access data 2024; Ficha técnica

Ya existe algo mejor

Para aquellos con enfermedad AGRESIVA

With liver metastases





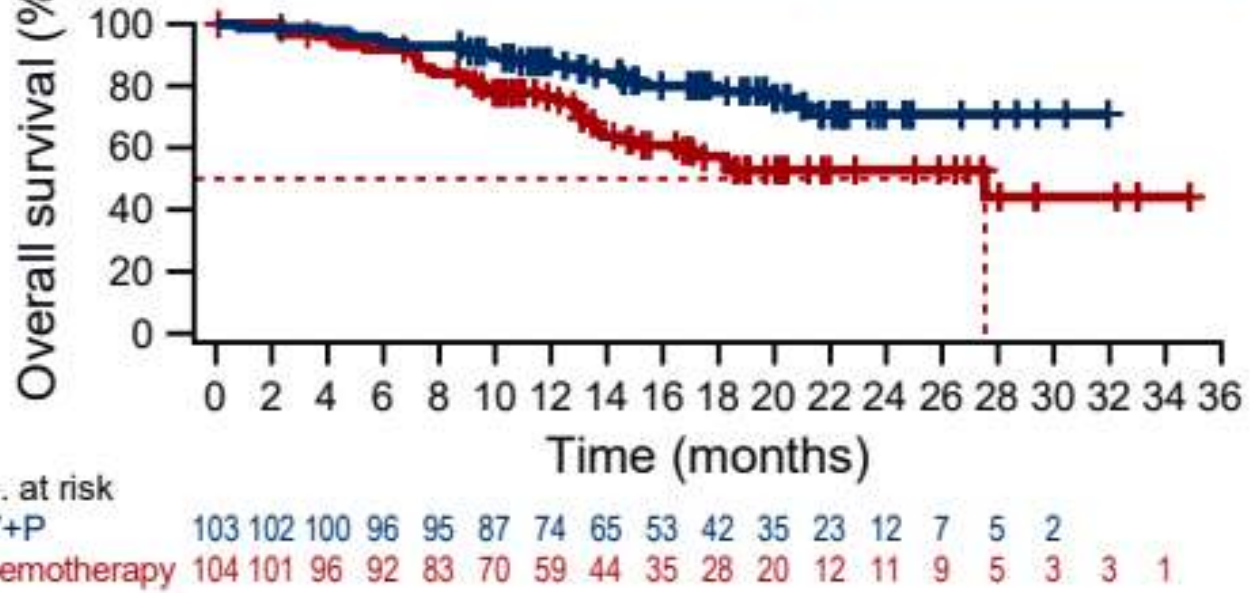
Van der Heijden M, et al. ASCOGU2024; ESMO Open 2025

Ya existe algo mejor

Para aquellos con solo enfermedad ganglionar

B

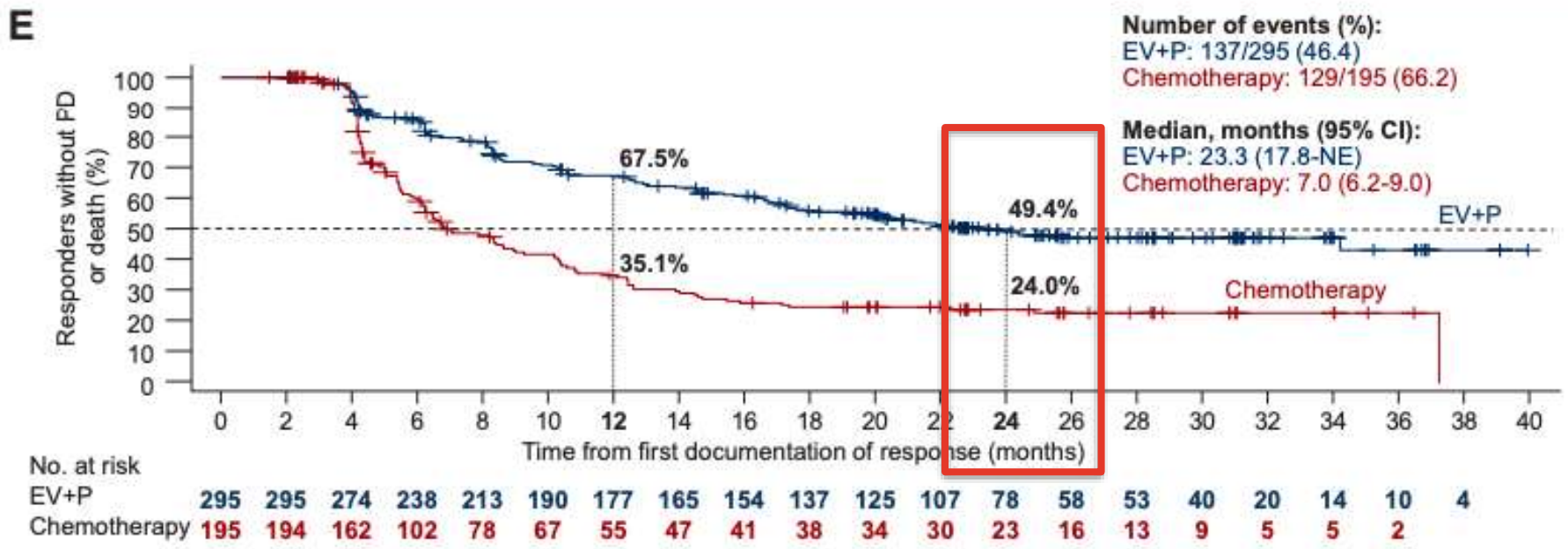
	Events/*N*	Median (months) (95% CI)	HR[a] (95% CI)
EV+P	22/103	NE (NE-NE)	0.46 (0.27-0.78)
Chemotherapy	39/104	27.5 (15.0-NE)	



Van der Heijden M, et al. ASCOGU2024; ESMO Open 2025

Ya existe algo mejor

Para alcanzar respuestas duraderas

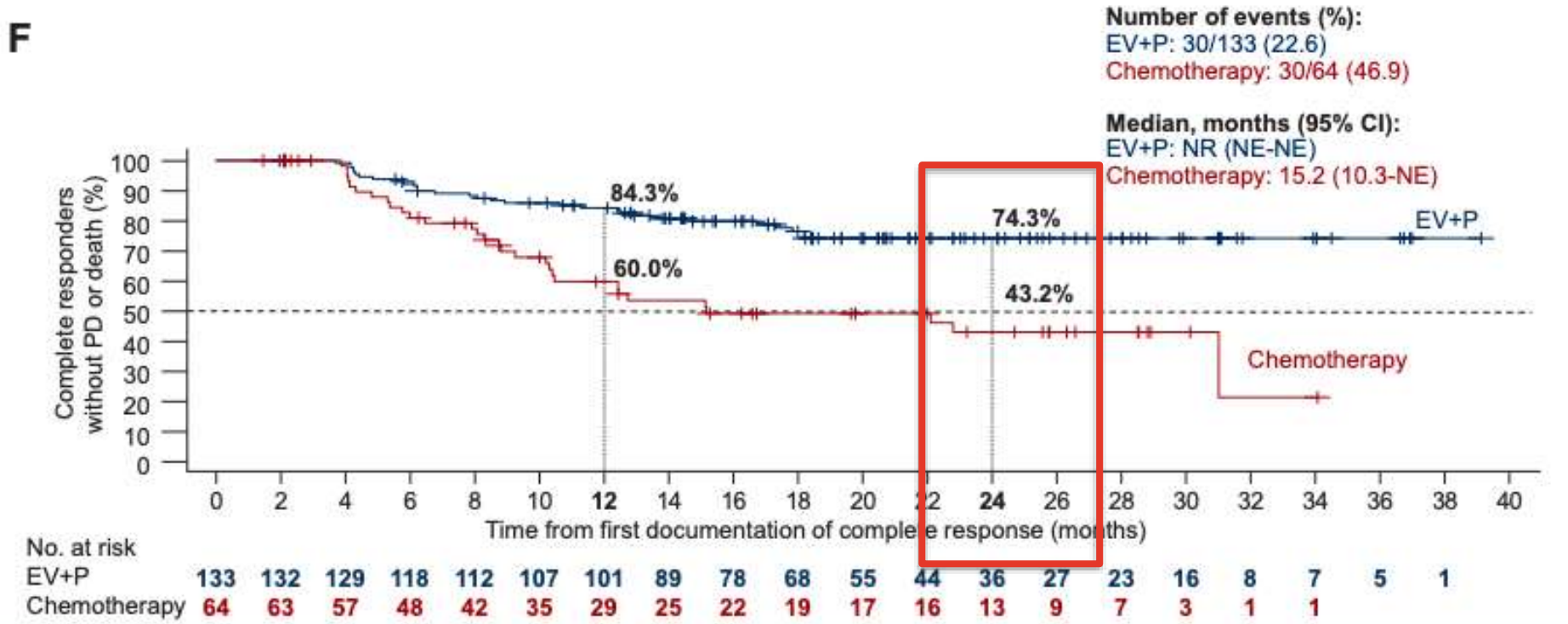


	EV+P (n=437)	Chemotherapy (n=441)	Nominal two-sided P-value
Confirmed ORR (CR or PR), n (%) [95% CI]	295 (67.5) [62.9, 71.9]	195 (44.2) [39.5, 49.0]	<0.00001[b]
Best overall response, n (%)			
CR	133 (30.4)	64 (14.5)	
PR	162 (37.1)	131 (29.7)	
SD	83 (19.0)	149 (33.8)	

Powles T, et al. Ann Oncol 2025

Ya existe algo mejor

Para buscar la máxima duración de la RC



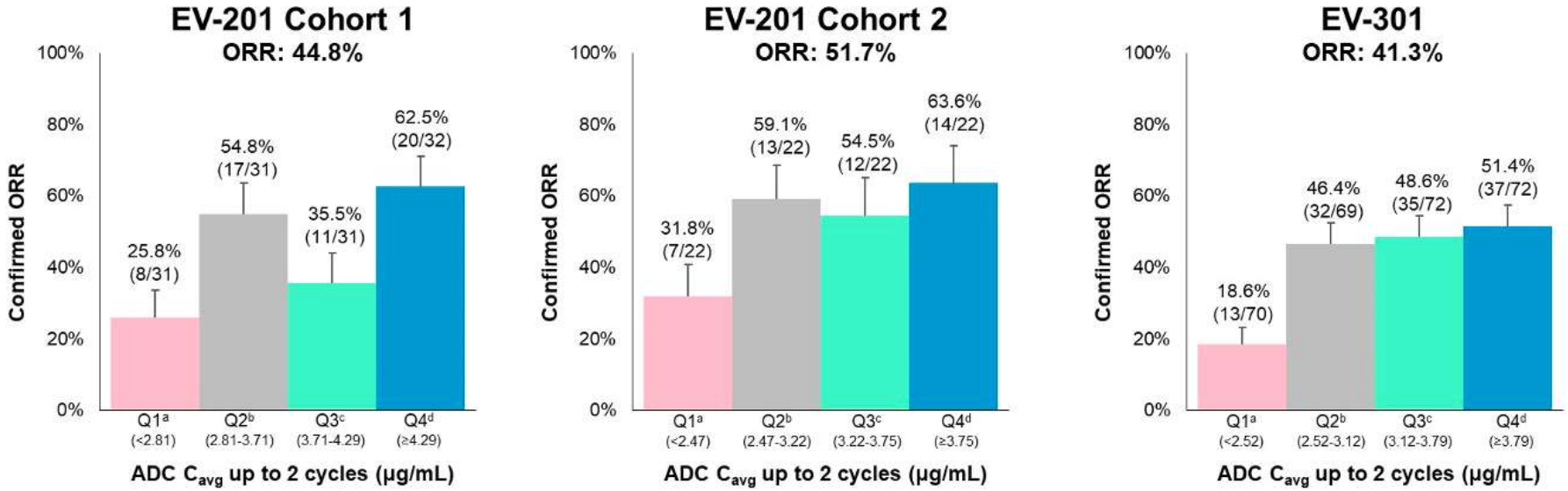
- For patients with cCR:
  - PFS HR=0.36; 95% CI: 0.21, 0.61; estimated 24-month PFS rate: 78.2% for EV+P vs 53.7% for chemotherapy
  - OS HR=0.37; 95% CI: 0.17, 0.80; estimated 24-month OS rate: 95.4% for EV+P vs 85.8% for chemotherapy

les T, et al. Ann Oncol 2025

Ya existe algo mejor

Para los que precisen ajuste de dosis

Higher early EV dose intensity was generally associated with a greater probability of response in pivotal trials



All data presented are from a post hoc, exploratory analysis.

Error bar = one standard deviation.

ADC, antibody–drug conjugate; C_{avg}, time-averaged exposure up to 2 cycles; EV, enfortumab vedotin; ORR, objective response rate; Q, quartile.

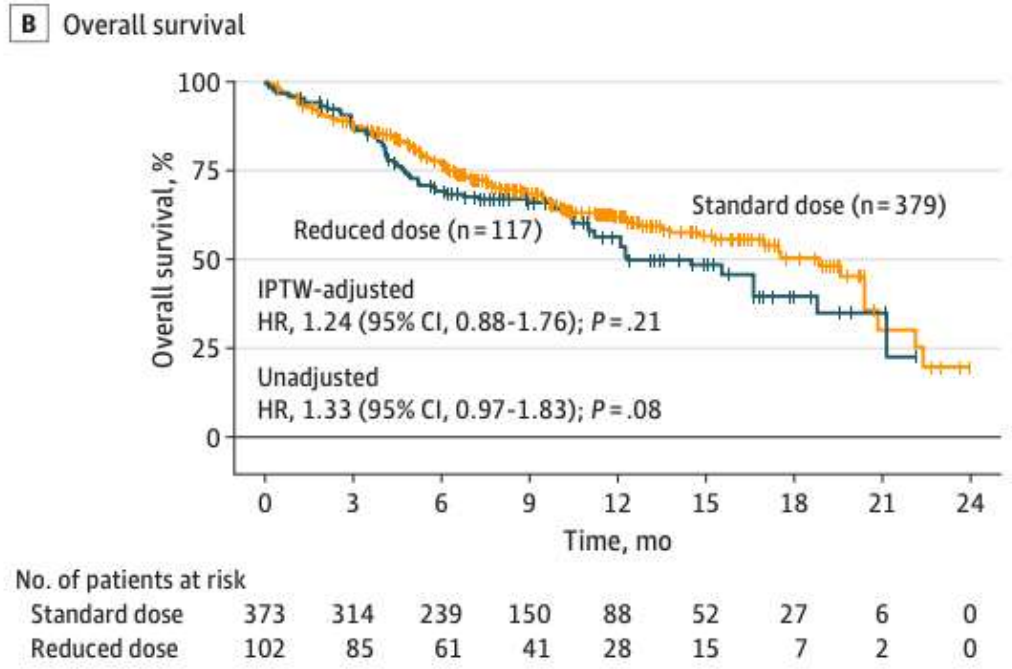
Average ADC exposures were divided into 4 quartiles: [a]Q1 represents the EV exposures between 0%-25%; [b]Q2: 25%-50%; [c]Q3: 50%-75%; [d]Q4: 75%-100% (the highest EV exposure quartile).

PRESENTED BY: Daniel Petrylak, MD

Ya existe algo mejor

Para los que precisen ajuste de dosis

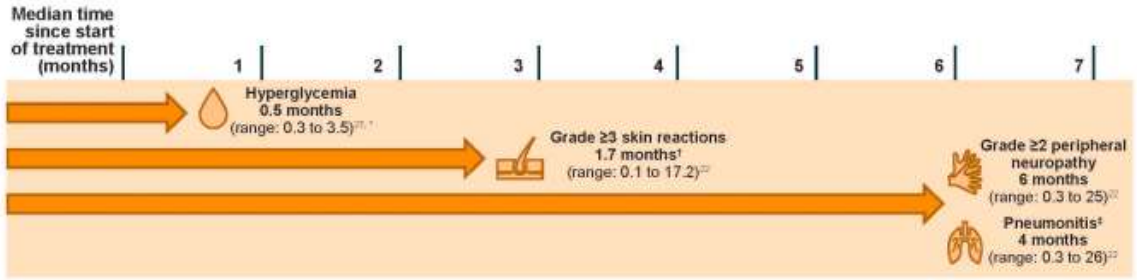
- N=496 pacientes
- 23.6% reducción dosis (se incrementó de 21.6% 1ª dosis a 38.8% 8ª dosis)



Chow R, et al. JAMA Oncol 2025

Ya existe algo mejor

Para aquellos cuyos médicos empiecen a manejarlo



Risk factors	Prevention
• Prior history of a dermatologic condition (including immune-related skin disorders such as psoriasis or lupus) • Rash/pruritus • Allergies • Dry skin • Immunosuppression • High sun exposure • Prior cutaneous reactions to previous lines of anticancer therapies • Skin damage due to therapeutic radiation	Recommendations for the prevention of skin reactions follow best practice prophylaxis protocols for general treatment-associated dermatologic events: • Barrier protectants (e.g., zinc-containing moisturizers) • Sunscreen • Emollients • Proper hydration • Avoid hot showers • Mild skin cleaners • Avoid OTC acne medications

MONITORING AND MANAGEMENT

- Routine skin assessments should begin with cycle 1
- Counsel patients and caregivers to immediately report new or worsening skin reactions

Grade 1	Closely monitor and continue at same dose level with supportive care as clinically indicated (topical emollients, topical corticosteroids, anti-infectives, and topical and oral antihistamines)
Grade 2	• Closely monitor and continue at same dose level with supportive care as clinically indicated (topical emollients, topical corticosteroids, anti-infectives, and topical and oral antihistamines) • For worsening rash or skin reactions with concomitant fever, hold both agents until grade ≤1 or has returned to baseline, then resume EV treatment at same dose level or reduced by one level, and resume Pembro. Consider specialist referral • For persistent or recurrent grade 2, hold both agents until grade ≤1, then consider reintroduction of EV at same or reduced dose, and resume Pembro. Consider specialist referral
Grade 3	• Hold both agents if rapid onset or worsening symptoms • Oral or systemic corticosteroids while holding both drugs until complete or partial resolution (grade ≤1) • May supplement with the supportive care recommendations described for Grades 1 and 2 above • Specialist referral • Consider skin biopsy to assist with diagnosis • After improvement to grade ≤1, and either on prednisone ≤10 mg (or equivalent) per day or off corticosteroids†: • Consider reintroduction of EV at same dose level or reduced by one level • Consider reintroduction of Pembro depending upon the severity and presentation of the skin reaction

Signs and symptoms of potential SJS/TEN include malaise, fever ≥100.4°F or ≥38°C, mucosal involvement (ocular, oral, genital), and dermatodynia
Biopsy of any desquamating or blistering rash recommended†

Suspected SJS/TEN	• Hold both agents. Perform skin biopsy. Discontinue permanently if confirmed SJS/TEN. Otherwise see grade 2–4 skin reactions • Consider inpatient and specialist management
Grade 4; recurrent grade 3	• Permanently discontinue both agents • Consider inpatient and specialist management • Skin biopsy may assist with diagnosis

Brower B, et al. Front Oncol 2024

Conclusiones