Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/project-oncology/patient-selection-perioperative-therapy-bladder-cancer/67087/

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Optimizing Patient Selection for Perioperative Therapy in Bladder Cancer

Announcer:
Welcome to *Project Oncology* on ReachMD. On this episode, Dr. Benjamin Garmezy will be talking about patient selection for perioperative enfortumab vedotin plus pembrolizumab in muscle-invasive bladder cancer. Dr. Garmezy is a board-certified medical oncologist and hematologist, and he serves as Associate Director of Genitourinary Research at the Sarah Cannon Research Institute in Nashville, Tennessee. Here he is now.

Dr. Garmezy:
I think, when we think about perioperative care in urothelial carcinoma, it's always complex who needs neoadjuvant therapy. And historically, when we were giving chemotherapy or chemotherapy and immunotherapy, it was a more complicated conversation, because of performance status, etc.

For me, now, anyone with stage III disease—which means a certain type of the way their tumor is poking through the bladder muscle wall—or with node-positive disease, or anyone with a large amount of T2 disease—which means the stage II disease where the tumor is actually invading into the muscle—should definitely get considered for perioperative therapy. So that's the neoadjuvant three to four cycles of enfortumab vedotin and pembrolizumab, followed by surgery, and then followed by—per the trial—an additional amount of cycles of enfortumab vedotin and pembrolizumab to complete nine cycles, then more pembrolizumab to complete out a year of therapy. That's the paradigm that we should all be using.

Now, who needs all of that enfortumab vedotin is complicated. If patients have a complete response to the systemic therapy at time of surgery, we use circulating tumor DNA in the blood to see how patients are responding there as well. If that's negative, can we spare some of the long-term side effects of enfortumab vedotin in some of our patients and hold it in the adjuvant setting, which means the time after surgery? I think the answer is probably yes, but we don't know.

The majority of my patients are going to try to get the whole cycle, but if we start to run into neuropathy or skin issues or anything like that, then we'll be quick to pull off enfortumab vedotin to continue the pembrolizumab alone after surgery if we think we've had a good enough response.

Now, from the pre-surgery standpoint—that neoadjuvant setting—I don't think there's a great biomarker out there to say who should get therapy and who shouldn't for anyone with muscle-invasive stage II disease or greater, so we're offering it to everyone. Now, patients at higher risk, like those with psoriasis—because this combination can cause a lot of immune-related events that can make psoriasis harder, as well as the skin toxicity or any kind of serious autoimmune disease—those patients with stage II disease probably are going to go straight to surgery or consider for neoadjuvant chemotherapy if their chemotherapy fits.

So I think that's the complex patient. Patients that are pre-diabetic have more weight on them. Those obese patients are actually more likely to flip into diabetes with enfortumab vedotin, because that drug can cause hyperglycemia. To me, that's not a reason to withhold the drug, but it is a careful conversation and shared decision-making with that patient prior to surgery.

Announcer:
You just heard Dr. Benjamin Garmezy discussing who should get enfortumab vedotin plus pembrolizumab before bladder cancer surgery. To access this and other episodes in our series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!