Stephanie C: I think those patient cases were really an example of how this group discussion helps to really work together to explore the best options to recommend to the bladder cancer patients. So for the attendees on tonight's program, I think you've got a glimpse, a little bit about the behind the scenes discussion of how a multidisciplinary team works together. And as a Dr. Grivas and everyone pointed out a lot of times the best solution might be a clinical trial to explore many other options that may not be approved yet by the FDA. We do have time for just one question. I want to be conscious about everyone's time.

Could you briefly explain carcinoma in situ? And then for a patient with urothelial cancer that has metastasized to their lungs, can any treatment be continued to also treat the carcinoma in situ to bladder cancer if they've shown positive results after taking Keytruda for some of those lung nodules?

Jonathan Wright: Yeah, we've certainly focused in this session on those patients, that without metastatic disease, and certainly we could have a whole different webinar on the management of metastatic disease. CIS and I will put a plug in here, the BCAN website is wonderful and the patient handout for explaining the different stages within the bladder, that the urothelial cancer has. CIS is carcinoma in situ, it is a flat tumor on the surface of the bladder. It's often seen distinctly from the standard papillary tumors that look like little burn trees or cauliflowers. These look like red patches often, and they can be throughout the entire bladder. They require sometimes a different approach. As we mentioned in the case for bladder preservation, those patients with carcinoma in situ with CIS, who have extensive CIS tried to favor against more radiation in that setting. Yeah, I guess around sensitive to BCG therapies, in the upfront setting. It is considered and does fall into the high risk non-muscle invasive bladder cancer. It can be by itself, or I think more commonly eat alongside a high grade TA or T1 disease. So if a patient developed in the bladder after having metastatic disease, it certainly could be treated with additional Intravesical therapy. But the main driver for care in that patient is going to be the management of the metastatic disease. So I hope that answers the questions.

Petros Grivas: Just to do add here, a couple of points for both questions regarding the carcinoma in situ, sometimes it's very hard to see that as Dr. Wright mentioned the cystoscopy. So sometimes in the appropriate patient Dr. Wright may do random biopsies and sometimes there's technologies like blue

light and narrow band imaging, that actually can be used to enable the urologist to look more carefully in the bladder if these technologies are now available.

Stephanie C: Okay. I have one last quick question. How are the multidisciplinary services on the day of a clinic visit bill two patients single fee versus multiple separate consults? How does that usually happen? Do you have any clue about that? Can explain that?

Jay Liao: I do. It's a very important question. Since the patient is seeing three different doctor visits, they are billed for three separate doctor visits. The goal being for us is having that happen in real time with everyone together. It's not always feasible even in our setting and other places across the country. But our goal was to save three separate visits on three separate times to bring them all together. So yes, it is three separate billed visits, one by each physician. That's why each physician sees in two.

Stephanie C: Okay. Well I'd like to thank you all. I think this was very insightful, and I'm really, I'm really pleased with the way that this program turned out. Thank you so much. I'd like to, again, thank Bristol Myers Squibb, EMD Serono Pfizer, Ferring, Genentech Photocure, and Merck for making the patient insight webinar series possible.