BCAN Patient WEBINAR SERIES

Understanding Systemic Chemotherapy Options in Bladder Cancer

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Part IV: Question & Answer Session

Presented by

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Question 1: Can you talk a little bit about what palliative care might be able to do for a patient who's going through chemo?

Sure. Thanks for that great question. To me, palliative care and I think to a lot us, palliative care is not a separate and sequential group of care, and you know what? Ever time I give a talk and someone asks me a question I learn something. So, what I learned from this question is that I need to include palliative care in those pillars of care. So, I clearly did not do that, so thank you for pointing that out, that palliative care is so important. So, we do have palliative care physicians that work with us, but honestly, people who give chemotherapy for a living tend to get pretty good at helping patients manage the side effects. For me, we have a little survival kit up front with instructions, and all the different medications that we send people home with, as well as really some expectations of what to expect and when to call. And we say we expect that you will call often and early.

And everyone's practice is different, but I like to see patients within a week of starting chemotherapy, just so we make sure everyone is on the same page in the family, that things are going well, and if at that point in time someone needs some additional hydration or some additional therapy for nausea that we might not give up front, like a drug called Ativan or something like that, we can add it in at that

point. But the expectation really is that the side effects of chemotherapy will be present and tolerable, and that someone will be in essentially the same physical condition prior to chemotherapy as following chemotherapy, because the role of that treatment is to successfully deliver a patient back to their surgeon or back to the radiation oncologist to get that definitive treatment. So, I hope that that was the answer that you were hoping for.

Question 2: For metastatic urothelial cancer with distant lymph nodes without a primary tumor, if there is a complete or partial response after first-line chemotherapy, what would you recommend as a second-line therapy? Immunotherapy, radiation, surgery? What option? If there was only a partial response, what would you recommend?

That's a great question, and I think that, again, we're learning more about how to treat patients. I think if someone has their bladder out and they have a recurrence of disease with lymph nodes only, that a lot of us would go probably towards immunotherapy in the second line, but that doesn't mean that other options, such as chemotherapy aren't on the table. And I think the other thing to think about is something called Next Generation Sequencing, and this is something that a lot of us are doing either perioperatively in the setting of a clinical trial, but also if someone comes to me and I'm starting chemotherapy for metastatic disease, I want to be able to think about what other options aside from what's on the list of standard therapy options that we have, so I want the tumor to tell me a little bit more information than just the subtype and where it is in the body.

And so, some centers do this in-house. Some sent it out to these different companies that do Next Generation Sequencing. There's Salvation, there's [Kerris 01:03:03], there's a whole bunch of other ones. But essentially what these do is somebody will take a piece of the tumor, and they really tell us what is driving, what are the mutations, what are the changes in the tissue that's driving that tumor, and we can find out whether or not someone may be a good candidate for a targeted therapy. So, a very common change in bladder cancer is something that's called the FGFR3 tumor mutation, or fibroblast growth factor receptor 3 mutation, and that's what we call a very druggable target. So, there's multiple clinical trials that are being done at different centers with drugs that are not yet unfortunately FDA-approved for this space, but that may be helpful.

And what clinical trials really do, Stephanie and everybody, is expand the tool box that we have to treat patients with bladder cancer and other diseases. So, that's a very long answer too. I would really individualize treatment to make a good decision.

Stephanie: Well, this is awesome. Thank you. And since you happened to mention clinical trials, I will mention that the Bladder Cancer Advocacy Network Clinical Trials dashboard is available to help you look for a clinical trial. If you visit us at **BCAN.org** on our website and you click on the clinical trials, find the trial. You can actually search for any type of trial that you're looking for by disease state, and you'll see a number of the different trials listed here so that you would be able to actually go in and learn about a trial, and see where the trial is offered, what's going to be covered in the trial, and ask your doctor about whether or not a trial is a good option for you.

Question 3: Is long-term BCG practical for high-grade non-invasive bladder or renal cell carcinoma? It's a little bit different than speaking specifically about the chemo, but when should somebody think about some other options when they have a high-grade non-muscle invasive disease?

Yeah. So, Stephanie, as a medical oncologist here at Jefferson and at many other cancer centers, non-muscle invasive disease and BCG is completely handled by urologists. But what I would say is that we have to be respectful of a tumor's biology, so if someone is getting BCG over and over again, and the tumor keeps recurring as high grade, then I would be concerned about that tumor's ability to change or to grow. So, that would be an individualized discussion with a physician about, are there other treatment options, different things that can go into the bladder? Are there things like clinical trials, which we definitely have, for BCG refractory disease, for high-grade T1 disease or non-muscle invasive disease there are definitely protocols that support thinking about something like chemoradiotherapy, or even taking out the bladder.

So, again, individualized discussions with a patient. If someone is very frail, Stephanie, and maybe just transurethral resection, and BCG every once in a while is really the best option for them given their medical problems, then that's the right answer. But we really have to individualize those discussions.

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