



Bladder Cancer and COVID-19 | Northeast Regional Update for Patients and Families.

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BCAN | Stephanie Chisolm:

Hello, and welcome to Bladder Cancer and COVID-19, a regional update for patients and their families. This is Stephanie Chisolm, and I'm the director of education and research with the Bladder Cancer Advocacy Network.

So, thank you so much for joining us. I'd like to welcome our speakers today, urologist [Dr. Gary Steinberg](#) who is the chair of BCAN's scientific advisory board. He is at the NYU Langone Cancer Center in New York City. I'd like to welcome you, Gary. And [Dr. Kent Mouw](#) is a radiation oncologist at Dana Farber Hospital in Boston, Massachusetts. [Dr. Arjun Balar](#) is a medical oncologist. He is there with Gary at NYU in New York City. [Dr. Louis Keeeler](#) is representing our community-based physicians. He's a urologist, and he is based out of Voorhees, New Jersey. Thank you all so much for coming and joining us today and helping us figure out how to do this program and be able to share what's going on in everybody's communities.

BCAN | Stephanie Chisolm:

What I'd like to do right now is ask you to weigh-in a little bit on what is going on in patient care in your areas. You have major hospitals, and then you also are dealing with a physician's office. So, Dr. Steinberg, if you want to kick it off and just let us know, from a urologic perspective, what's happening. You're in the center of things with Dr. Balar in the New York City area. What are you seeing in your practice?

Dr. Steinberg:

Well, first of all, I want to commend all of our hospital workers and, I must say, our hospital administration and leadership throughout the country because there's no question that the whole medical community has taken this extremely seriously. And I think that the whole medical community has mobilized very, very quickly, much more quickly than I could have imagined in my lifetime.

Dr. Steinberg:

I wish we would have had a little bit more lead time to have gotten even more prepared, but I think that all of the rules or guidelines that have been set out, the hospitals and the healthcare workers have been leading the way in terms of social distancing. We jumped on telemedicine very, very quickly. We're trying to think very hard about eliminating unnecessary visits, having patients be able to get tests and imaging and so forth, really, as safe as we possibly can.

Dr. Steinberg:

Having said that, this is a really once-in-a-lifetime life-threatening problem that we have to continue to evolve and improve our ways to keep people from becoming infected. As we know, our bladder cancer community, our bladder cancer patients, tend to be older, they have other medical problems. They can be in urban settings, rural settings, metropolitan areas. So it's a broad array of America. And we really

have to work in partnership with our patients so that we can keep them safe. But the healthcare system has really responded tremendously well, and we're doing great things, I think, and doing the best we can.

BCAN | Stephanie Chisolm:

As a medical oncologist, Arjun, what are you seeing in your practice in terms of everyday? There are a lot of different major cancer organizations that are trying to address some of the needs of cancer patients. What are you seeing for your bladder cancer patients? Because that's a really subpopulation that's very specific in their needs.

Dr. Balar:

So, to echo what Gary is saying, is that we are very much, in New York City, an all-hands-on-deck approach to taking care of patients. And this includes, obviously, patients with COVID, which is the primary concern, that our hospital is just literally full to the brim with patients with infection.

Dr. Balar:

And what's that forced us to do is to come up with kind of novel and creative ways to help still take care of our patients with bladder cancer, whether it's localized or advanced disease, and shepherd them through the process as safely as possible to treat disease as safely as possible, adhere to standards of care as best we can, and also so that we don't compromise outcomes. But also, at the same time, protect them from the toxicities of therapy so that we don't expose them to undue risks in terms of COVID.

Dr. Balar:

And, also, one of the biggest challenges that Dr. Steinberg may have mentioned is that our ability to bring patients into the hospital to perform necessary surgeries has also been challenged. And so, that's forced us to come up, again, with creative ways to treat patients, to safely treat their cancer while they can safely delay surgery. And so, that's what we have done.

Dr. Balar:

We have prioritized patients in terms of where they are in the course of their treatment, in terms of metastatic disease, earlier in the course versus later in the course, and we've developed algorithms for that, and also for patients with localized disease. We're finding ways to treat them systemically earlier on and safely with [chemotherapy](#) also as well in certain scenarios to help us delay surgery. But it's been an unprecedented challenge, but we benefit from having so many people who are such experts in the care of bladder cancer that we're doing the best we can.

BCAN | Stephanie Chisolm:

Thank you so much. I think we'll talk more about some of the specifics as we go through this program. Dr. Mouw, you're up there in Boston at Dana Farber. What's happening up there? You're a radiation oncologist. Are you seeing change?

Dr. Mouw:

Thanks, Stephanie, and thanks for having me. I think this is a really important topic, and so I'm happy to be a part of this. I would say that, at least to this point, we haven't been affected to the same extent as

our colleagues in New York. That said, the hospitals are full here, and we're all operating clearly under different circumstances than we're used to. Our beds in our ICUs are full of COVID patients.

Dr. Mouw:

As a radiation oncology department, we've also made some significant changes in the way we do business. We've, as many folks have already noted, moved largely to telemedicine visits for all patients who don't need to be in the department. But for people who are coming daily for radiation treatments, we've continued to stay open. We've continued to treat patients. I would say our overall volume is down a little bit, and that allows us to space patients out a little bit more. We've been really trying to minimize foot traffic in the department, so we ask patients to come in alone whenever possible. Everyone is wearing a mask at all times, and we've really tried to minimize the time in department for the patients.

Dr. Mouw:

I'm still treating many bladder cancer patients who were either getting their course, in the middle of their course of radiation when the COVID hit, or who had disease such that we didn't believe we could wait to start radiation. And so we are treating those patients, we're treating them safely. Whenever possible we're using abbreviated, shortened radiation courses, so fewer visits to the department in total.

Dr. Mouw:

But, again, as Dr. Balar stressed, we want to do things guided by data. Despite some of the regimes being somewhat shorter than we typically do, these are all things that are supported by data. We believe that they're just as good, that they can be safe, and that patients will still have similar outcomes while, obviously, trying to maximize everyone's safety and minimize exposure to COVID.

BCAN | Stephanie Chisolm:

Excellent. Thank you so much for joining us. We really appreciate that perspective. Dr. Keeler, if you could just give us a quick input as far as you are a community-based practitioner, yet, you do surgeries in your local hospital. What are you seeing? He just signed off, he'll be right back on. We'll get back to Dr. Keeler in just a few minutes, I guess, as soon as he gets back on. I apologize for that.

BCAN | Stephanie Chisolm:

Go ahead and move onto the next slide, and just looking at this perspective of when is it okay to have delays in treatment, and what should patients know? Because I know I hear all the time, I'm getting emails constantly from the doctors that are telling their patients, "No, you can't come in right now. We're not seeing patients for surveillance. We're not seeing patients for treatments. You're going to have to push it off for a few weeks." When is it okay to delay treatment or surveillance? Because patients have a hard time kind of sitting quietly with that.

Dr. Steinberg:

I think that it really does depend on the [stage and the grade](#) of the bladder cancer. And so I'm going to talk a little bit about the non-muscle invasive bladder cancer patient population. We do have a fair amount of data that can place patients in the low-risk, the intermediate-risk and the high-risk population. But we have to remember that with non-muscle invasive bladder cancer, while there certainly is a significant risk for bladder cancer recurrence, the risk for progression, at least within 12 months, is relatively low. Even in our high-risk, non-muscle invasive bladder cancer patients, the risk for

progression to muscle invasion within 12 months is really about 17%. Clearly, when we look at five years it's up to 45% risk of progression to more invasive disease and, potentially, muscle invasion. So we do have a good 12-to-24 month window, I believe, to really determine which direction a patient with high-risk non-muscle bladder cancer, which way they're going to go.

Dr. Steinberg:

And so, I think that a delay with non-muscle invasive bladder cancer, even a high-grade disease, of two months, three months, while it certainly is upsetting, it certainly is something that the patients are very unhappy and ill-at-ease with, I think that, overall, the risk for their cancer is not nearly as great as if they've got muscle-invasive disease or metastatic bladder cancer.

Dr. Steinberg:

I think that we truly have to weigh the risk of having patients come in for [TURBT](#), especially in, for example, New York City, at the time when their greatest risk of mortality is coming down with a COVID infection, rather than their TURBT. Even though all urologists think we're great surgeons, patients have complications. If they need to come back to that ER or get readmitted, or they have bleeding post-TURBT, our ability to take care of them is really quite, quite limited, and made much, much more complicated.

Dr. Steinberg:

In terms of trying to get [intravesical therapy](#), again, I think patients, our doctors' offices are using social distancing. The rooms are being cleaner than I've ever seen any hospital or any clinic. And I think that it is safe for a patient to come in, get some intra-vessel therapy and go home. One of the things I want to clear up is that BCG is an immune system stimulant. It's not an inhibitor, it's not going to make somebody immuno-compromised. If anything, it will stimulate a patient's immune system, and then, hopefully, it has some off-target stimulation that may be protective against infectious disease in general. Is it protective against COVID-19? Nobody knows, and that, I think, would be a pretty large leap to say that it can be or should be. Certainly, it needs more study.

BCAN | Stephanie Chisolm:

Thank you. Dr. Balar, what are you seeing as far as when can patients delay treatment? When should they think about coming in for their treatment? What's important in terms of chemotherapy or [immune therapies](#)?

Dr. Balar:

So, I'll kind of break down the answer to that question into two kind of disease categories, those patients who have metastatic disease, and then those who have localized. So, in the case of metastatic disease, we have tried to prioritize patients in terms of is really medically-necessary to come in, really, for patients who are early in the course of their treatment? So these are patients who are newly-diagnosed or recently diagnosed. They are, certainly, within the first three months of their treatment. And for us in the medical oncology world, this is the time period where we have our best opportunity to get disease control and, also, to really shape the prognosis of the patient. And so coming in for treatment is really critical in the first three-to-four months.

Dr. Balar:

And with chemotherapy, we generally give up to six cycles of treatment up front with platinum-based combination. And each cycle is three weeks long, so you're, roughly, looking at six times three, 18 weeks of therapy. And so that's really the meat of the treatment right there, so that's the first three to four months. And so we try our best to keep our patients who are on systemic chemotherapy they're on.

Dr. Balar:

The places where we have the opportunity to reduce the number of visits is, in particular, in patients who've received immunotherapy-based treatments. And we know that treatment can be given in definitely, safely, at least. The data supports as little as a year, possibly two-to-three years or longer, based on the current evidence from phase two and three trials.

Dr. Balar:

But I know from our experience and with those of others, is that after four-to-five months of treatment many patients who have achieved a response are likely in a confirmed response with multiple scans. And it's possible that after six months of treatment we could safely miss a treatment or two and keep people out of the healthcare system for six-to-nine weeks while we're trying to wait for the COVID outbreak to, hopefully, lessen over time.

Dr. Balar:

It's important to understand that this is not necessarily evidence-based. This is anecdotal. This is experiential. Patients who are in a response at that point are unlikely to progress after they've been off of treatment for a few cycles. But, again, we don't have hard evidence to support that approach, but, essentially, we're trying to do the best we can.

Dr. Balar:

In patients with localized disease, systemic chemotherapy is actually great because we know it improves survival, it improves their cure rates in the neoadjuvant setting. And for us, particularly in New York, it helps us schedule that surgery much later. So some patients who are cisplatin-ineligible, that's a different challenge, but for patients who are eligible for cisplatin-containing chemotherapy, we know that's up to 12 weeks of systemic platinum-based chemotherapy. And then an additional six-to-eight weeks or so of rest before their cystectomy can be safely done.

Dr. Balar:

That is a significant amount of time that allows us to, hopefully, get through this whole thing and allow us to safely schedule cystectomies again. And so they have [neoadjuvant](#) as platinum-based chemotherapy as such a strong component of a standard of care already really strengthens the argument in the era of COVID

Dr. Balar:

The really, really tough part is our patients who are cisplatin-ineligible. And for those people we know that the standard of care is definitive local therapy with either cystectomy as soon as we can schedule it. I still think [Trimodality](#) bladder preservation is a standard of care, we should be looking at it more closely, especially in this context if we cannot schedule surgeries. But, if let's say, our outpatient radiation facilities are working well, I would counsel patients about that also as an option. And I've certainly done that with a few patients who were unable to schedule a surgery. So these are some of the

examples of things that we are doing to treat, both patients with metastatic advanced bladder cancer, as well as those with localized disease as well.

BCAN | Stephanie Chisolm:

Great. Thank you. So Dr. Mouw, what are you seeing?

Dr. Steinberg:

The one question for Arjun, what about the concerns about immunosuppression with chemotherapy during this time period?

Dr. Balar:

That's a great question, Gary. I am not concerned about it, and that's not what I've observed in patients who are treated with platinum. Is that in all of our experience over decade, and this is obviously not just me, but we don't see a higher risk of viral infections during chemotherapy. Obviously, this is before the era of COVID, which is, obviously, a very unknown scenario. But we saw the same rates of viral infection in the common population as compared to those who were treated with, let's say, Gemcitabine and Cisplatin. It's primarily bacterial infections that we're worried about.

Dr. Balar:

Now that being said, though, patients who are, let's say, develop a bacterial infection, they're introduced into the healthcare system, and then they're exposed to COVID, that's another added layer of risk. But the primary risk of chemotherapy, in my opinion and in my experience, is not to increase the risk for COVID infections. In fact, their antiviral immunity is pretty much the same, without or without chemotherapy.

BCAN | Stephanie Chisolm:

Dr. Mouw, what's going on up there in Boston as far as when should patients have a delay? Is there some way that radiation can be used to help delay some of the other things that need to happen? What are you seeing?

Dr. Mouw:

Yes. So, I see bladder cancer patients primarily in two contexts. One is what Dr. Balar just sort of outlined, those with localized muscle-invasive disease. In that case, for many patients, or for a subset of patients, chemo-radio therapy is a reasonable treatment approach, independent of other factors. And so I would say that, despite that, I've seen a little bit of uptick in terms of referrals, just for the reasons that Dr. Steinberg outlined with the challenges of getting folks into the OR on time. And so these are patients who either have received some cisplatin-based chemotherapy, and had planned to do either surgery or radiation following that, or those who were ineligible for cisplatin-based chemotherapy and came directly to me. And, in most cases, we've been able to get those folks started with curative radiation programs with relatively little delay.

Dr. Mouw:

Again, I want to stress that we want to make sure that we treat patients based on the best evidence that we have with COVID as one of the, obviously, nowadays large considerations. But many patients may be eligible for radiation independent of COVID, and those I'm, obviously, continuing to treat. And then,

also, we are seeing some additional referrals for folks who had been planned for surgery, but due to scheduling and COVID considerations for the OR are now getting treated with curative radiation.

Dr. Mouw:

And then a much smaller subset of my patients are those patients who are having specific symptoms from bladder cancer, so bleeding or pain due to a bladder cancer lesion somewhere. In those cases where patients are symptomatic we're, obviously, not delaying treatment. And the advantage, if you will, in that scenario is that we can often use much, much shorter radiation courses to try to address the bleeding. So as few as one treatment, or maybe a couple of treatments over the course of a single week can often be enough to address specific problems for patients with more advanced disease.

BCAN | Stephanie Chisolm:

Great. That's really good to know. Thank you so much. Dr. Keeler, I apologize because you dropped off at the last point. So, maybe you want to just share a little bit about what's happening in your actual community-based practice and at the local hospital where you're doing your surgeries and things like that.

BCAN | Stephanie Chisolm:

But then also talk about what's your perspective on when is it okay to have a delay. Or in the case of surveillance, I know a lot of patients are concerned. They are supposed to come in for their regular cystoscopies, and they're being told it's non-essential. And then they feel like they're being forced to sort of sit and wait, and not know if their treatment is working or not working. So what are you seeing in your practice?

[Dr. Keeler: Experienced technical difficulties]

BCAN | Stephanie Chisolm:

So the three of you are still on. Do you want to talk a little bit about what each of you have said? Do you have any questions for each other that we can share with our community as far as what you talked about with the urologic perspective, the medical oncology, or the radiation oncology perspective of being when is it okay to delay treatments or surveillance?

Dr. Steinberg:

Again, I think that it's important to break things down by stage, non-muscle-invasive, localized and metastatic. And I think that in the non-muscle-invasive space there is going to be some delays from BCG anyway because of our [BCG shortage](#). So, actually, the BCG shortage has kind of helped us kind of prepare for this time, so we're thinking more about who needs maintenance therapy, how much maintenance therapy they should get, is it okay to miss? A lot of times we have a BCG of six plus three weeks of BCG at three months, six and then 12 months. And so, a lot of times we're having to skip one of those time periods because of BCG shortage, and then give it later.

Dr. Steinberg:

And I think that we're beginning to see that we can be equally as effective by using additional strategies. Sometimes we're giving intravesical chemotherapy instead of BCG. But all these things, I think, have taught us that we can allow less rigidity in terms of our scheduling to try to maintain the patient, keep following them up. I think that it's critically important that you do an outstanding TURBT, and so

sometimes if you do a better TURBT you can, of course, stall some of the intra-vessel, which is adjuvant therapy to prevent disease from coming back.

Dr. Steinberg:

But, as you know, right now in New York we're not doing any TURBT, and haven't since the later part of March, and we're not going to be doing any in the entire month of April. But I think that, again, when we look at the risk table analysis and the data we do have time. I don't think that a patient with high-risk non-muscle invasive bladder cancer is going to lose that opportunity to still be cured, and, potentially, even continue to preserve their bladder, even though there may be a couple of months of delay.

BCAN | Stephanie Chisolm:

Well, I certainly appreciate what had mentioned earlier about the progression rate is relatively low, even with non-muscle invasive disease, within 12 months. So I hope that that gives people a little bit of comfort in knowing that if they can't get in right away that you will be first on the list to be able to get back in once things are up and running back to normal again. So any other comments, Dr. Balar, Dr. Mouw?

BCAN | Stephanie Chisolm:

Well, I'd like to jump to the next question, then, if that's possible. What constitutes an urgent need for care, and what should patients and their families know about what to expect in the doctor's office or in the hospital when they do get in there? What do you see as, "You know what? You're going to have to come in for care. This is a big risk," what should people with bladder cancer be aware of that they know that they need to come in?

Dr. Mouw:

Well, I can just say the majority of folks that I'm seeing, or that I'm meeting virtually, even for the first time, who have a new diagnosis or those with the muscle-invasive cases, in that case I do think that getting a plan in place, even if it includes things like virtual visits to substitute for in-person visits upfront with urology, medical oncology and radiation oncology. I do, as much as possible, think that it's worth continuing to do that in a timely fashion for those folks, again, with newly-diagnosed muscle-invasive disease.

Dr. Mouw:

Dr. Steinberg touched on the non-muscle-invasive space. I think in the muscle-invasive space at least getting a plan in place and meeting, albeit virtually, with the providers in as timely a fashion as possible to get the plan in place, understanding that the plan may be not exactly the same as it would be in a non-COVID environment. But, in my view, having those discussions, again, in a timely manner makes sense. And those, thankfully, can often be done remotely at many centers.

BCAN | Stephanie Chisolm:

Dr. Keeler, I see that you're back on. I'm very glad that you're there. Give me two seconds. Dr. Balar, did you have anything else to add as far as chemo for immune therapy if people are experiencing any of the adverse effects or side effects from these treatments? When should they come in? When is this really imperative, or should be calling you and maybe do telehealth to try to find a solution before they get into the hospital? What have you seen?

Dr. Balar:

So I think one of the things that this COVID outbreak has really forced us to do is accelerate our timelines to moving toward a balance of telemedicine versus direct physician-to-patient visits. And that's been part of the imperative for many medical centers for a while, but they were slowly rolling it out because, obviously, not everybody is onboard, and there's a huge learning curve involved with it. Well, we don't have that luxury anymore. And so it's coming to us front and center.

Dr. Balar:

So I'll tell you within a week, maybe about seven or eight days, I quickly saw a little video icon show up on my Epic schedule. And that's, basically, the icon that tells me that the patient has checked into a virtual waiting room. And I click on that message and it activates the visit on my phone, and all of a sudden I'm seeing that patient live and in person across a secure messaging platform. And it allows us to see patients virtually. And we did this very quickly. We had no choice.

Dr. Balar:

And so I think what it's helped us do in a very short period of time is help us understand, really, in fact, how many patients do we really need to see face-to-face? It's really forced us to ask that question. And it turns out that we probably don't need to see that many people face-to-face and have patients come through traffic and parking and just the amount of burden. It does take them away from their jobs and so forth and their otherwise busy lives to come to their doctor's appointments.

Dr. Balar:

And it allows us to interact with them very freely but via video. So that's been incredible, especially for our patients on surveillance who may have, otherwise, five minute visits, 10 minute visits that don't last that long. They spend more time in transit than they spend actually with us, so that's been great. What it's allowed us to do is actually spend more time with patients who really need our attention, to be honest, patients who have a lot of symptoms, et cetera, and so that's been great. That part is actually one of the little silver linings in all of this.

Dr. Balar:

And then, as it relates to your question, which is how do we manage patients who are developing toxicity at home? Having these video visits is really critical and allows us to, at least, lay eyes on the patient. I told every one of my patients that, "One of the best things about them coming to see us is that I get to see you. And a lot happens because I can lay eyes on you." Now, obviously, video is no perfect replacement for this, but it has to be good enough.

Dr. Balar:

And so we've stayed in really close communication with our patients. They know exactly what symptoms to report. And if they do, they know to get into contact with myself or my nurse, and we come up with creative ways of treating these patients without actually having to physically. There will be some hiccups along the way. There naturally will be.

BCAN | Stephanie Chisolm:

Well, this is great. I think we're all going to be learning something that is going to get to my last question of the day where we see this going in the future. But, Dr. Keller, it's so nice to see you and to be able to hear you now. So, thank you so much for joining us as our community urologist.

BCAN | Stephanie Chisolm:

And can you just talk a little bit, just to kind of recap what we've already covered, in a sense, are you changing any protocols in your practice? And when do you think it's okay for patients not to come into your office or for a treatment and, or, surveillance? And then, also, when should they definitely come in to see you? What's important from the community perspective?

Dr. Keeler:

Thank you for having me back, Stephanie. Like I was starting to say, we have very few patients come in now, maybe 20%. Like everyone else said, we're evolving with telemedicine, which is great, but, obviously, not applicable to bladder cancer patients all the time. And we're still giving BCG. The patients who get BCG are high-risk patients because, as you know, Stephanie, we have had that national BCG shortage, so we've had to allot them carefully. So most of the people that are getting BCG are not yet to TA multifocal, but the carcinoma in situ to the T-1 patients, and they're coming in still.

Dr. Keeler:

Unfortunately, we have patients, a little easier than in New York City, patients, caregivers can wait outside. We have them literally come from their car through the waiting room to the actual office room. So we have very few people in the office at any one time, in addition to seeing less patients.

Dr. Keeler:

And I think, by and large, it's individual. If somebody had recent T-1 disease, and they have only gotten two doses of BCG and they're healthy patients, we're still seeing them. Somebody is 86, and scheduled for their doses seven-through-nine, and maybe they're on [inaudible 00:33:39] or something. Maybe they want to wait a little bit. So, it's an individual approach based on the seriousness and, of course, patient anxiety matters too. I think it's a little bit easier for us because we're not in a big university setting to take care of some of those patients.

Dr. Keeler:

In the hospital, a little different. Dr. Steinberg is in a worse situation than I am. I have done some bladder cancer surgery for people that I'm concerned that are younger and may have muscle-invasive disease, but they're very limited. They have to be symptomatic. We're certainly not taking anybody back with low-grade tumors. So it's a pretty similar approach.

BCAN | Stephanie Chisolm:

Excellent. Do any of you have any questions for Dr. Keller about what's happening in the community?

Dr. Steinberg:

Are patients reluctant to come into the office? Are you having to do a lot of rescheduling? Are they staying home and delaying because of their concerns?

Dr. Keeler:

I personally, me and my partners, are trying to have patients delay when they can, especially if they're non-cancer diagnosis. And there are some people that do want to come into the office. And there are some people you want to come in, and some people you're trying to keep out of the office. And so it's that judgment between you and the patient, I think, probably the same as you. It's a pickle sometimes.

Dr. Steinberg:

Yep, absolutely.

BCAN | Stephanie Chisolm:

You guys are learning on-the-fly. This is not anything that people have been prepared for. What do you think is going to happen when this all passes? Which, we hope is very soon. But do you think we're learning better ways to treat bladder cancer patients because of what we've had to do to accommodate the COVID-19 pandemic?

Dr. Mouw:

Well, I can echo what doctor Balar said in that it's been a catalyst for change to telehealth, which, I think, in many cases we're learning is, in many ways, as good or better for patients that don't need to be seen in person. And so I think that's going to be one effect of this that's going to persist, is that we're going to think hard about who needs to come in to actually physically be seen by a doctor. Often times many follow-up patients, it's more of a social visit, thankfully. And so are those things we could be doing virtually instead? So that's one aspect where I can see. We went quickly from sort of zero-to-60 miles an hour on the telehealth front. And I see that sticking around, and that, actually, being a benefit for patients, potentially, long after COVID is gone.

Dr. Steinberg:

One of the things that I worry about, Stephanie, is that we're all worried about from the time of muscle-invasive diagnosis to treatment and that we're adding delays, patients are getting neoadjuvant chemotherapy, and there may be some delays. And they're getting surgery or radiation, there may be some delays, especially for surgery. But the real delay for bladder cancer patients is not from the time of diagnosis to treatment, it's from the time of symptoms to that initial diagnosis. And all too often patients have blood in their urine or they have symptoms of their bladder cancer, and they're not coming to see the urologist.

Dr. Steinberg:

And I worry that they get into a habit, "Well, I'll just do everything over the phone," or, "I've got some symptoms," and that they're not going to, ultimately, be seen by the urologist in time, and that there will be significant delays in the initial diagnosis. And that is one of my greatest fears as we evolve to patients not being comfortable coming to see the doctor.

BCAN | Stephanie Chisolm:

It's a really good point in April because, remember, that May is bladder cancer awareness month, and BCAN is doing our part to really make sure people are aware of that. But, again, getting people to think about going in to see their doctor if they can't just get an appointment, or their doctors are saying, "We

can't see you if this is nonessential," then that also makes it a significant challenge. So, anybody else have anything to add before we move on to questions?

Dr. Balar:

Yeah, to Dr. Steinberg's point, that is one thing that does weigh on me is that there may be over the span of the next, well, actually, the preceding five, six weeks and the next several months, there may be patients that are at home right now with underlying symptoms of a malignancy that are subtle, they're sub-clinical, they're minimally symptomatic. And they're being counseled, "Well, listen, what you're having right now is not life-threatening. And so, therefore, we can safely delay you getting evaluated and diagnosed."

Dr. Balar:

And with that comes a risk that when we finally are able to kind of safely allow patients to reenter the healthcare system and social distancing rules get relaxed a little bit, and so when the patients are reentering the healthcare system again that we're going to have a lot of advanced malignancies, or that malignancies that you've been delayed in diagnosis because of it. And the healthcare system is going to feel that. And this is not just bladder cancer, obviously. This is a cross the spectrum of disease, and that is something that I think we all need to be aware of is likely to happen.

Dr. Keeler:

To Dr. Steinberg, you see somebody treated who had gross hematuria for urinary tract infection with no culture, maybe treated with antibiotics twice, and they're a smoker. And they come in six-to-eight weeks after the initial hematuria realizing it was never a urinary tract infection. We still see that from time-to-time, and during these times it's a little worrisome.

BCAN | Stephanie Chisolm:

Can you talk a little bit about what's going on now with [clinical trials](#)? Clearly, clinical trials that are dealing with COVID-19 are opening up very, very quickly. But the existing clinical trials, what are you seeing with clinical trials right now that have already been going on for bladder cancer, not specifically for COVID-19, but the trials that are already ongoing, what's the risk? What's the problem? What's happening with that if, in key institutions, and even some of the clinical trials that are happening in the community, if patients can't get in? What do you see going on with that?

Dr. Steinberg:

Well, you know, Stephanie, clinical trials really have to be a labor of love. And it really does require a tremendous amount of extra work and visits and a lot more patient interaction with the healthcare system. And I think that patients currently on trials, I think we need to do everything we can to continue them on trial. In newly-enrolling patients, I think it's problematic right now.

Dr. Keeler:

Problematic also too because a lot of our cancer trials, in general, not inappropriately, been shut down. The Keynote-57 is still open, but all other bladder cancer trials in the private practice, and prostate for that matter, have stopped accruing during the COVID crisis. So, like Dr. Steinberg said, it's a labor of love. But there is still one trial that I know of open. I'm sure there's other that other doctors know too.

Dr. Balar:

I will add just a few other comments to Dr. Steinberg and Dr. Keeler's, which I agree with. You need a lot of infrastructure and support and a number of visits. So it's not just the physician, and also the research nurses may be interacting with the patients, but it's all of the data coordinators, the specimen processing folks who collect tissue and blood. So there's a lot of machinery behind every trial, and if those people are not physically present, it's really tough to conduct this research because it's both for the benefit of the patient as well as benefit of future medicine. That's why we do these trials so we can learn a lot. And our opportunities to learn will be compromised in this era.

Dr. Balar:

But the other larger issue, and this is a mandate in our cancer center, which is to only focus on trials, at least right now, where the patient stands to benefit substantially above the standard of care, or it provides a treatment option to a patient for which the routine standard of care is simply not available.

Dr. Balar:

So, for instance, a bladder preservation trial in BCG-unresponsive disease, that may be their best option because we can't schedule a cystectomy, or a bladder preservation treatment in muscle-invasive disease when we cannot schedule a cystectomy. And so, I think that's kind of the larger message here, is that we should really focus on research where a trial really is a substantial benefit above the standard of care, and that's what we've done here.

Dr. Mouw:

I would say I'll echo that sentiment. In Boston we've, obviously, been less-affected to date by COVID than New York, but we've taken, again, a pretty pragmatic approach to clinical trial enrollment, really thinking hard about who stands to benefit the most from enrollment on a trial. We continue to enroll bladder cancer patients on trials. But certain aspects, so for one example that I know is no longer the case here in Boston, at least, is that we aren't routinely collecting biopsies strictly for research purposes. That's a thing that our patients are very generous. They agree to undergo these biopsies for research purposes, and that's a huge benefit for our research infrastructure. But right now in this environment, that's one thing that we can really tighten up ship. So we aren't doing those sorts of things, but we continue to enroll people with an eye towards those who stand to benefit most from enrollment on a trial.

BCAN | Stephanie Chisolm:

So, I'm going to open it up to see about the questions that have been submitted by the participants on this webinar. There was one. I think this question regarding TURBT delay while invasion is unlikely. What's the risk of its recurrence? I think, Dr. Steinberg, you mentioned the reduced risk of progression is relatively low, at least in the first 12 months. But what about the chance of recurrence if you haven't been able to get in for surveillance, what do you think? It's a little hard to predict that, but what do you tell patients?

Dr. Steinberg:

Well, one of the worst things in the world is to have to do unnecessary trips to the operating room for additional TURBTs if we can prevent those recurrences with intravesical therapy and so forth. I think that, again, a lot of our protocols are not necessarily evidence-based. A lot of them were kind of empiric

guidelines. I think that, in general, we probably survey too often, and that one of the things that we may learn from this is that we can survey less often.

Dr. Steinberg:

I know that as I've been doing this, it's now a generation that I've been seeing bladder cancer patients, that I am stretching out my surveillance for even high-risk non-muscle invasive bladder cancer patients. I think that the first 12-to-24 months, a lot of times, tells us what the natural history of that cancer is going to be. How well it's responded to intravesical therapy. And so that I've got a patient who's 15 months out, and they've been disease-free for 15 months, they may not necessarily need another cystoscopy in three months. We can do it in four or five or six months.

Dr. Steinberg:

So I think that we're going to learn a lot about, potentially, eliminating unnecessary cystoscopies and procedures. I think that the patients, they dread having all their cystoscopies in this rotation. But I think that, by and large, delaying some of the surveillance for a period of time is safe.

BCAN | Stephanie Chisolm:

Does that also apply for things like CT scans, chest x-rays, things that people will be routinely asked to go in and have these monitoring tests done? Should that also kind of apply to those things?

Dr. Steinberg:

I think so. Go ahead, Louis.

BCAN | Stephanie Chisolm:

Dr. Keeler.

Dr. Keeler:

A couple of things, one, I think, as Dr. Steinberg was alluding to, how far out, how long have you been no evidence of disease? The first six of BCG with carcinoma in situ to a T-1, you may really want your cysto, and it makes sense. On the other hand, you're on the hand you're 15 months out. And another thing I wanted to add was markers. You're 15 months out, maybe from something serious, CIS, T-1, you look back and the last fish test was negative, or if you use CX bladder or some other marker, or even cytology, all the markers, you can give patients data that you already have to say, "Hey, your fish testing website negative. Your CX cytology was negative. You're compromised. Let's wait till July." And give them some comfort based on some other data. So I think some of the urinary markers along with the natural history of the disease might help comfort patients who have justifiable anxiety about the disease.

BCAN | Stephanie Chisolm:

Kent, I know that the radiation in combination with chemotherapy and the selective surgery is used in the bladder preservation mode. As far as people coming in for the regular surveillance when they've chosen that option, you have any comments about that?

Dr. Mouw:

Yeah, that surveillance schedule after bladder-sparing trimodality therapy is somewhat similar to what folks do after cystectomy, obviously, with the addition that they would need a cystoscopy. Again, I think it's pretty case-dependent. That first couple of scans and cystoscopies after completion of chemo-radio therapy, I think, are important to understand, again, that what the response to treatment has been and get a sense of what the natural history is likely to be.

Dr. Mouw:

But, again, as patients, to echo the sentiment, as patients get further out from treatment and have not had any evidence of disease recurrence, I'm certainly pushing those patients back a month or two and not really thinking twice about it because I think that, on balance, avoiding that trip often from far away to come for a day of clinic visit and scans and labs probably makes sense to delay for a month or so in many cases without really any effect.

Dr. Balar:

I will just one additional comment to that. So for patients after definitive local therapy for muscle-invasive disease, whether it's a cystectomy or chemo-radiation, are scans are every three-to-four months, in general, for up to 18 months. And then every six months for the next 18 months, and then yearly thereafter, which is kind of the approach I've done, both on studies as well as standard of care. I don't think that's that frequent of imaging, or at least number of visits. So every three months, it's not the same as every three weeks visits for treatment and two weeks on, one week off for treatment and so forth.

Dr. Balar:

But one way to minimize number of trips and et cetera is that if a patient's scans are fine and they obtain their blood work locally, there's really no reason for the doctor's visit, which is to review the results and everything, to not be virtual. That makes perfect sense. But I don't think that we should suddenly not scan our patients at the intended frequency because, remember, those guidelines were developed on the basis of timing of recurrence, the frequency of recurrences and when they occur.

Dr. Balar:

And so the risk of, let's say, pushing scans out is that you miss a recurrence that could have been caught earlier, and how you've delayed two-to-three months, and you're in a tougher situation than you should have been. And the purpose of scans, let's say, every three months in patients who have had local definitive therapy is to capture metastatic disease before it is symptomatic, and so that you have time to think about treatment and start the patients on treatment. So I would argue that we need to stick to our schedule, but perhaps eliminate the number of doctor's visits that aren't necessary, especially in the context of negative imaging.

Dr. Balar:

Now the cystoscopies, I think, are really important early in the course of treatment. You don't know what you have in the bladder until you look. I think our two urologic oncologists would agree, you don't know until you've looked. And so, I think that those are really important in the first two years after bladder preservation. Maybe we can space those out after that, but in the first two years it's really critical.

BCAN | Stephanie Chisolm:

Well, this is all really important. I think there's a lot of concern from the patients, even those that might have had surgery a year ago or longer, and whether they have a radical cystectomy with a diversion or the TURBT and all the other treatments, they're just really concerned about should they go into the healthcare providers for these treatments.

BCAN | Stephanie Chisolm:

So you're, basically, saying there's a little bit of wiggle room. I know, obviously, this is all being driven by what the state and local health departments are saying people should be able to do. We're, obviously, all socially distancing, and this concept of medical distancing is really hard for patients, I think, with any kind of cancer, but particularly with bladder cancer because it has such high recurrence rate. Any advice that can share with them as we begin to wrap up this program today?

Dr. Keeler:

I think the patients are pretty cognizant. The ones that come in, by and large, have masks. Some of them are coming in with N95 masks that I don't have. They're pretty on the ball. I say, "Hey, can I borrow your N95 mask, or have one?" So they're pretty astute, especially the ones that show up.

Dr. Balar:

My advice is that this is a very important time in public health, but it is going to be temporary. And, eventually, we'll get back to a new normal, but it will be a new normal. I think at the end of the day the delivery of care to patients with bladder cancer, or all cancers, will be, I think, much more efficient. We will find things that are necessary, and we will eliminate the things that are unnecessary and, ultimately, patient care is going to benefit from all of this. But I do think that that's several months away, unfortunately.

Dr. Steinberg:

But one of the things that we've done throughout the history of our cancer management is that, especially in the pediatric population, we use less chemotherapy than we used to. We use less surgery than we used to. We use less imaging than we used to. And part of that is because children, by and large, with cancer are involved in clinical trials.

Dr. Steinberg:

And so the real tragedy would be that we lose our infrastructure for the clinical trials in bladder cancer because how often should you could get a CT after a neoadjuvant chemotherapy or after a cystectomy, after radiation? Both, actually, probably are more important questions now than were in the past. And so to tighten up those algorithms and tighten up those surveillance imaging requests by the healthcare providers are a much more important question today moving forward than they may have been three months ago.

BCAN | Stephanie Chisolm:

Dr. Mouw, do you have anything to add?

Dr. Mouw:

Just I agree with what everyone has sort of said. As much as unusual and as unprecedented as this landscape is, I think that the important part is that we continue to deliver sort of evidence-based care and be thoughtful about the way we manage patients because what we don't want, obviously, to happen is for these temporary changes induced by things like COVID to really impact the quality of care we're delivering on a patient-by-patient basis. And so I think we're all doing our best in this environment to be thoughtful about the ways we deliver care to maximize both the cancer outcomes as well as minimizing risk of our patients in this really unusual time.

BCAN | Stephanie Chisolm:

Well, I want to thank everybody for joining us. For those who dialed-in, to join us online, and especially Dr. Steinberg, Dr. Balar, Dr. Mouw and Dr. Keeler. And I'm so grateful that you got on live, finally we were able to hear you. So I'd like to thank everybody, and I'm going to go ahead and end this program.

BCAN | Stephanie Chisolm:

I'd love to invite everyone to please visit our www.BCAN.org/covid-19-FAQ because we're keeping that updated as we begin to learn more and the research evidence is being published. We're going to keep that updated so people can have a reliable, up-to-date resource to learn more about the impact of COVID-19 on bladder cancer and patients and their communities. I urge everybody to follow [the CDC guidelines](#) about social distancing and medical distancing, wear a mask is a good thing. And thank you all for joining us, and we wish you all good health.

BCAN | Stephanie Chisolm:

Thank you all so much.

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