Stephanie Chisolm: Okay. Good tip, good tip. So make sure that you ask about that. I want to start with some of the questions that have come in. One of them is actually a little bit general, but is IV chemo ever indicated, Dr. Sonpavde, for non muscle-invasive disease?

Dr. Sonpavde: Yes. So the short answer is no. IV chemotherapy, intravenous chemotherapy, is only given for cancer invading the muscle or if it's metastatic. For cancer that's not invading the muscle, we give chemotherapy, but intravesically as we call it, but into the bladder. So no IV chemotherapy yet for cancer not invading the muscle.

Stephanie Chisolm: And is that because the endothelial lining there, the urothelial lining, does not get everything, because it's meant to keep the toxic chemicals inside the bladder? And so it's not getting what goes into your system. Is that why they don't give it for non muscle-invasive disease?

Dr. Sonpavde: Right. That's one reason. So the cancer is in the lining of the bladder and the non muscle-invasive cancer, that's one you give the chemotherapy to the bladder. That's a good logical reason. The second reason is that these cancers that are not invading the muscle are not dividing as rapidly as the muscle-invasive cancers, and they're not as aggressive. So cancer cells that are not dividing rapidly don't get killed by chemotherapy as well. Paradoxically, chemotherapy needs rapidly dividing cells for it to work. So since these cells are not dividing as rapidly, we think systemic chemotherapy given intravenously, that's probably one reason why it's not as effective.

Stephanie Chisolm: Okay. This is another question for you, Dr. Sonpavde. What about Taxol in combination with cisplatin? Are there treatments similar for patients with bladder cancer that's diagnosed as adenocarcinoma?

Dr. Sonpavde: Yeah, so Taxol has been used as a second-line chemotherapy or intravenous chemotherapy for patients where there was growth of cancer after they got the cisplatin-based combination chemotherapy. That's where it's been used. There was a big phase three, a randomized study done, where they tried to add Taxol on top of the GC, gemcitabine cisplatin chemotherapy, and there was a big study, around 630 patients. That did not show an improvement in survival. There was trends for improvement in outcomes, but so it did not make it. That's why we do not routinely add Taxol to the gemcitabine cisplatin when we give that regimen.

Stephanie Chisolm: Okay. Here's another question. How do you compare the immunotherapy, the immuno-oncology drugs like nivolumab or Keytruda, with chemotherapy? Is there a benefit of one over the other?

Dr. Sonpavde: Yeah. Good question, Stephanie. So immunotherapy, as you know, this is the era of immunotherapy. These drugs work differently, they're boosting your immune cells to fight the cancer, so they're not directly attacking the cancer cells, they're stimulating your immune cells, the lymphocytes, to attack it. So these drugs are unique because the way they work is unique.

And secondly, one of the traits of immunotherapy is when they work, they work for a long time. So with chemotherapy, when patients have a response, when the tumor shrinks, it tends to bounce right back in a few months, unfortunately. It does not stay controlled for a long time. But with immunotherapy, drugs like Keytruda, pembrolizumab, atezolizumab ... you may have heard some of these names ... these drugs are activating your immune cells. When patients respond, which is not everyone who responds, about a quarter of patients respond, unfortunately. We wish more patients respond, there is research going on, but the responders have a really long duration of response which can last even more than two years on average.

Stephanie Chisolm: Great. Okay, good. Donna, I have a question for you. You said you were in a clinical trial. What would you have thought as you were offered that as an option, in terms of thinking about a clinical trial? We know that clinical trials can be a viable treatment option for some folks. So what made you decide to be part of that trial?

Donna Calderbank: Well, two things. The first was listening to my options, I just realized that the immunotherapy was another layer of treatment that sounded like it had a viable benefit for me. And the other is I'm in the medical field, so I know the value of clinical trials. So why not? It might help somebody else in the future.

Stephanie Chisolm: Okay. Yeah. With a clinical trial, Dr. Sonpavde, maybe you can speak about that. You get more regular monitoring than you might in a regular physician's practice if you were just having, say chemo. So is that a benefit for patients to want to be on a clinical trial?

Dr. Sonpavde: You could say that. So it showed that patients getting on a clinical trial do get more rigorous monitoring than standard treatment. Now that's not to say that we don't monitor patients on a standard chemotherapy as well as something like that. It just means that when patients get on a trial, these are many times new drugs being tested, in this case in combination with the chemotherapy that you received. So we do have to pay extra attention than we would for standard chemotherapy, because these are new combinations and new drugs being tested. So yes, there is a little bit extra attention, for sure.

Stephanie Chisolm: Okay. Good. And again, the same thing. If there are side effects, they can certainly be managed with that extra attention, and patients can always come off of the trial, correct?

Dr. Sonpavde: Yes, you're right. So patients can certainly come off trials if they change their mind, don't want to continue with the trial, side effects may happen. Immunotherapy has a somewhat different list of side effects. We worry about diarrhea and inflammation in the lungs. Sometimes when the immune system gets boosted, it can attack some of these other organs. But most of these are not life-threatening. We can control them. Some people need steroid pills, prednisone pills. Sometimes admission for stronger drugs, but most of these can be controlled quite well with prompt attention to symptoms.

Stephanie Chisolm: Okay, great. So Donna and Sam, how much involvement did your family members have to be engaged in your treatment because of going to the chemo over a period of weeks? What was the experience from your family members? Can you talk about that?

Samuel Paolini: Okay. I'll go ahead. Actually my family was very involved and I tell them I was very blessed on it. I have three children, as I say, and each week I went in, each one of them took turns to take me in. Other than even the family, it was amazing how many people came to me, good friends, and said, "If you need a ride in, Sam, no problem, we're going to take you in. We'll take you in." So I had no problem whatsoever with the riding and going in. None whatsoever.

Donna Calderbank: So as I mentioned before, I was blessed in the fact that I always had somebody that was bringing me to and from chemo, and staying with me while I was receiving it, and distracting me. I think it was a great situation for them as well, because they feel as if they had something they could do positive to help, because you feel a little helpless with cancer. And so, again it was a blessing for me because I was never alone and felt quite spoiled. It was great. And then again, it allowed them to be a part of the treatment, really.

Stephanie Chisolm: Dr. Sonpavde, with chemo during the pandemic, how has that changed that family involvement? What are you seeing at Dana Farber?

Dr. Sonpavde: Yeah, we have had a policy where we have had to restrict visitors quite often, but there are situations when we do think a family member or a friend accompanying the patient is good for the patient and the benefits outweigh the risks in some specific situations like that. So we have made exceptions in many cases like that. But just the state of the epidemic is such that we do have to protect these patients from the pandemic. Of course, now we have the vaccines that are being administered, and that could help alleviate some of the situation. So basically it's balancing the risks and benefits. So we have on a case-by-case basis allowed visitors to come with patients.

Stephanie Chisolm: Okay. Good. Okay. You just mentioned the vaccine. So what about if somebody is facing chemotherapy as their treatment option? What are your recommendations about when should they get the vaccine? Before they start treatment? Should they take a break in the middle of treatment for their vaccination? Should they put it off? What should they do?

Dr. Sonpavde: You're exactly right, so we're still on a learning curve here. But logically, if you can wait safely, you can get the vaccine first and wait about three or four weeks before starting chemotherapy. Now that's not always possible. In someone with aggressive disease cancer growing, it's not possible usually to wait four or six weeks to start chemotherapy.

So the situation where this might be possible is postoperative chemotherapy. The bladder has come out for muscle-invasive cancer, easily we wait six to eight weeks to start chemotherapy. Studies have allowed waiting up to three or even four months to start chemotherapy. So there is some time there to get the vaccine in.

But in the other situation, the neoadjuvant situation, we really don't have six weeks to wait for the vaccine to kick in to start the chemotherapy, so in that case I would say the bladder cancer treatment is more important and more time sensitive. So that's different.

In patients with metastatic cancer, it depends on the aggressiveness of the cancer. Generally, with the metastatic cancer, you don't want to wait six weeks. So what I would suggest in that case is to get the chemotherapy going, get the cancer under control, and after four, five, six cycles, that's how long we like to go, we could take a little bit of a break and do the vaccine.

Stephanie Chisolm: Okay. Great. Here's a question about neuropathy. You mentioned that earlier, there's a patient on this call who is seven years out and they have neuropathy in both feet. Is there anything, like a vitamin or any other treatment, that might help bring that feeling back? Or reduce that pain from the neuropathy?

Dr. Sonpavde: Yeah, neuropathy is a tough problem, and this is one of the problems that can persist for many years. Now the best thing you can do is to prevent neuropathy by reduction of dose and interruptions of chemo when it's going in, when you start seeing the neuropathy appearing. But there are medications to treat patients with neuropathy: duloxetine, Cymbalta, neurontin. There are many other medications, Lyrica, which might help some patients. We have used topical creams, capsaicin, menthol-containing creams to help with the patients who have tingling and numbness in the hands and feet. Exercise, physical activity does help neuropathy. Some patients have gone with some alternative treatment and interventions such as acupuncture. So there are multiple ways of trying to alleviate it, but it can still be a difficult problem, and really, as they say, an ounce of prevention is better than a pound of cure. So this is a problem which is best prevented because the treatments can help, but they're not highly effective in my opinion.

Stephanie Chisolm: Sure. Absolutely. I agree, that's certainly an issue and a concern. So people should definitely, if they have signs and symptoms, they should bring them to the attention of their doctors. I think sometimes some patients don't want to bother their doctor, and they think they can handle it and it'll go away, but they should bring these things out so they can be remediated as they're happening, and you can change course a little bit and hopefully prevent some of that damage. So this is wonderful.

Anything else? Thank you all so much for sharing. This has been a very, very valuable session. As I said, we're going to have the recording available and online, but any closing remarks? Dr. Sonpavde, you want to start? Anything you want to say to our audience?

Dr. Sonpavde: Thank you, Stephanie. I think this was a highly informative, I think, session for patients and families facing this cancer. We've come a long way. Always ask your doctor about trials and other issues that you don't fully understand. I can tell you that sometimes a lot of oncologists may also not fully understand. We don't fully understand this disease, so there is a learning curve for everybody, so really we could learn from you as you learn from us, and I think that together we can really do a better job with chemotherapy and other forms of therapy.

Stephanie Chisolm: Sure. Absolutely. So as you heard from our two patient advocates, chemotherapy wasn't necessarily what you expected it to be, was it Sam? And so, maybe talk to your doctor. It's not your father's chemotherapy, if you want to think of it that way. If you think about patients that you knew 10 years ago, or even five years ago, there have been major advances and there's things that you can do to mediate any kind of side effects. I think that's important to understand. So the field is changing on a regular basis.

I see Sam is nodding, and I think Donna agrees too, it's not the same thing that you think about when you hear about chemotherapy, right?

Samuel Paolini: Absolutely.

BCAN-Stephanie Chisolm:

Yeah. So I want to thank everybody for joining us, and remember that there is a short survey that you will be getting right afterwards. We really appreciate, and we'll share with Donna and Sam and Dr. Sonpavde all of your feedback. It's very important, and we'd love to hear from you about that.