

# Neoadjuvant and Adjuvant Chemotherapy

Dr. Matt Galsky



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## Stephanie Chisolm:

Thank you so much Dr. Galsky, what a change from the program that you did for us like three or four years ago. There's just been so many new advances and I think that's really a testament to the people that are working so hard to find better ways to manage this disease.

So, I do have a couple of questions. And remember, if you have a question, please submit it in the Q&A box, and the question should be about the chemotherapy before or after your therapy. So, a question, you mentioned a number of different potential side effects from chemotherapy.

Is there ever a situation where a patient who should have surgery has to postpone that surgery because they have so many what we refer to as adverse events from their chemotherapy? Is that something that happens often?

## Dr. Matthew Galsky:

So, it happens. It thankfully doesn't happen often. And maybe a related question, the question comes up in terms of receiving chemotherapy prior to surgery, am I delaying the backbone of curative treatment? Am I delaying a surgery for chemotherapy which might not be effective in every individual and might not be needed in every individual as I pointed out.

Well, we know from the randomized studies that despite those theoretical concerns, there's still a benefit in terms of survival, getting chemotherapy prior to surgery versus going straight to surgery. So, if either of those issues were major concerns, then you wouldn't see that benefit. So, it happens in individual patients occasionally, but it doesn't happen the majority of the time.

## Stephanie Chisolm:

So, Dr. Galsky, you're a medical oncologist and you're working at a major academic institution in a big city. So, if somebody were, say, in a more suburban community, would they automatically be connected to a medical oncologist to do this immunotherapy or chemotherapy before or after surgery, or is this something they have to ask for?

## Dr. Matthew Galsky:

I think we see a lot of regional differences in practice patterns, and that's not limited to non-academic centers. We see that within individual academic centers as well. So, of course, I'm a medical oncologist, so my statement comes with that caveat, but I think all patients with muscle invasive bladder cancer should see a medical oncologist. It doesn't mean they have to get chemotherapy, but it's part of the discussion in terms of what the treatment options could be.

### **Stephanie Chisolm:**

Definitely part of that team approach and multidisciplinary team to really look at every facet of how you target this cancer and treat this cancer in the best interest of the patient.

Again, not everybody has that, especially if you're living in a more rural community where there might be one urologist and yes, they can do the surgery, but it makes it a little bit more of a challenge. Another question I have for you is are all doctors checking for biomarkers?

### **Dr. Matthew Galsky:**

So, there are some biomarkers that are now standard in individuals with bladder cancer in the timing of checking those biomarkers depends a little bit on what we refer to as the clinical disease state or commonly referred to as stage of cancer.

So, we do DNA sequencing in individuals with bladder cancer to determine if there's a specific mutation in a gene that might be associated with a specific treatment. But that treatment is currently FDA approved for individuals with bladder cancer that has spread.

So, that testing is often done later in the clinical disease states of bladder cancer compared to an individual who's initially diagnosed with muscle invasive bladder cancer where that information is somewhat less relevant. Checking for PDL1 protein expression, this protein that I mentioned associated with immunotherapy.

That's not done routinely anymore because many of the treatment decisions that we thought might be impacted by that information, the clinical trials haven't been as convincing as we thought they might be in terms of using that testing. So, you'll see that testing done once in a while still, but it's not done universally.

This testing for DNA in the blood that I mentioned toward the end of the talk, there is a commercially available test to do that right now that's Medicare covered. And so, that's being done more and more commonly.

As I mentioned, we don't necessarily have the prospective clinical trials to establish what we call clinical utility, which is not just can the test be done and not does the test correlate with a clinical outcome, but rather does knowledge of that test information impact a patient's course in a favorable and meaningful way?

And that's a little bit of a nuance of evidence development. And so, there are many trials designed to try and address that, but there are... is testing being done occasionally in clinical practice already?

### **Stephanie Chisolm:**

This is great. And so, again, everybody should ask, you should at least talk to your provider, find out what they recommend, see what's available in your community. And again, this program has really been quite an expansion of what we are covering just a few years ago, and thank you so much for all of your efforts.

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