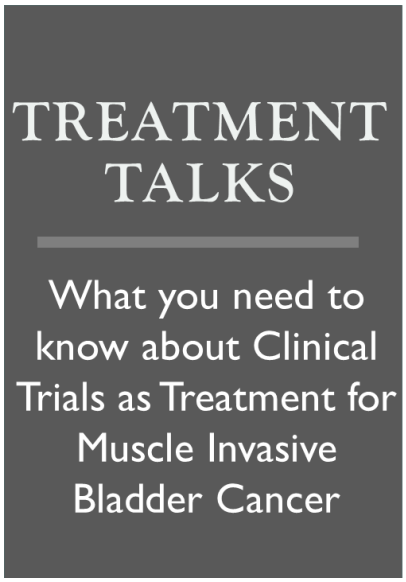

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Stephanie Chisolm:

Okay, great. So if you want to stop screen sharing right now, we'll open it up to questions. I would really like to bring in Alan and Karl who have been involved in clinical trials. Alan, you volunteered for a clinical trial. What motivated you to consider going into a clinical trial instead of just accepting the standard of care?

Patient Advocate Alan Soles:

Well, it was an easy decision because my standard of care, at that point in time, I wasn't getting any treatment. And so I approached my oncologist and said I'd be interested in any kind of studies that are available, because the only way that I got any treatment is from other people doing studies beforehand to see if they worked. So I was more than willing to be on board to be a participant.

Stephanie Chisolm:

Right. So tell me a little bit about your diagnosis, if you don't mind sharing.

Patient Advocate Alan Soles:

Yeah, I was diagnosed back in September of '19. And I had my scope and my cancer was at top of my bladder and was too large to be resected. And so I had my bladder removed in April of 2020. And I was diagnosed at that point in time with metastatic bladder cancer. It spread to lymph nodes and I had spots on my lungs. And so we were just monitoring at that time. And that's why when I approached my oncologist and said, "Hey, if there's a treatment, research, I'd be more than happy being on it." And he found the Keytruda one, and so I started with that one.

Stephanie Chisolm:

So obviously Dr. Tawagi, you see a lot of patients that would be good candidates for clinical trials. How do you bring it up to a patient, because it is taking a little bit of a risk to the, stepping off into the great unknown of science? But how do you suggest this to patients?

Dr. Karine Tawagi:

So the way that we approach trials, most trials in this setting will be at least the standard of care with the possibility of something better than the standard of care. So that's kind of how I approach it. Sometimes there are treatments for example, where you might get standard of care and you either get a placebo or an addition of a new treatment, but you're at the very least getting standard of care. So we're helping to advance what the current treatment regimens are. So I think really for any patient that's willing to do a clinical trials, they have the possibility of a new treatment that could be even better than what we already know works. And so if a patient is eligible and we have it at our center, I certainly encourage it. And again, it's always a choice never. It's never forced upon anyone.

And it's definitely a risk benefit discussion of all of the aspects that we talked about. What can be expected side effects, does it work for their schedule to come in more frequently? Perhaps some patients may need extra tests in order to enroll in the clinical trial, including additional CT scans or additional biopsies, depending on the trial. So definitely want to consider all of those aspects as well.

Stephanie Chisolm:

Sure. And you brought up a really good point when you said you're either going to get standard of care plus the new treatment or a placebo for that, but you're still going to get standard of care. You're going to get the regular care that you would get as treatment anyway. I think that's important because a lot of people might be a little bit gun shy about going in a clinical trial because they're afraid of being given a pink sugar pill, and they think they're not going to get treated initially because they're going into a clinical trial. But that's not the case, correct?

Dr. Karine Tawagi:

Correct. In this setting, we're giving at least what is considered the standard of care, because ethically, it wouldn't be right to give someone something that's below the standard of care. Sometimes there are trials where you're comparing the standard of care versus something that has the promise of being even better than the standard of care. So there are a lot of trials like that right now.

Stephanie Chisolm:

Yeah. Okay, good. And Karl, you got involved in a clinical trial, so let's get you to unmute your microphone. There we go. So tell us a little bit about your experience, your journey, and then why you got involved in a clinical trial.

Patient Advocate Karl Pritchard:

Well, I won't go into a lot of detail. It was early 2014 that I was diagnosed and I had my surgery. My tumor had already metastasized, spread throughout the body, so simple treatment wasn't going to work too well. My kidney, my left kidney was... Well, where the tumor was blocked off my left ureter, so my left kidney was severely compromised. So they said I could not have chemotherapy because of that. So they took me right into surgery and removed my bladder. And when I came out of surgery, the doctor told me that the gold standard of care is chemotherapy. He said, "But you can't have it because of your damaged kidney." And he said, "Go home and get your affairs in order. You have about three to six months." And now when I had first gotten my cancer diagnosis, I'd gone on the internet and gone right

to the BCAN site, found it very quickly, did tremendous research and learned an awful lot about immunotherapy.

And I asked the oncologist at the hospital about immunotherapy, and he said he'd never heard of it. Evidently, it was fairly new in 2014. I don't know. So I went home, I talked to the lawyer, I got everything all straightened out, but I had to see the local oncology center. They were going to track me and track the progression of my cancer. I asked the doctor there about immunotherapy and the doctor said, well, just by coincidence, we've just started participating in a trial for an immunotherapy drug, and I'll check and see if it's still open. And she came back and told me about it a day later, "Congratulations, you're in the trial. You're the last person worldwide that's been selected. They were closing it down. You're the last one to get in." This trial was for a drug called Atezolizumab, or the brand name was Tecentriq.

I got there... I was in... What do they call it? A stage one trial, I think, the one where there is no control group, no placebo. Everybody got the drug. For me, the drug was tremendously successful. As a matter of fact, the head of the oncology center in Virginia calls me his poster child for immunotherapy. He said he's never seen successful progression go that way. However, a problem with the Atezolizumab, if I'm saying that right, Tecentriq, was that it taught the immune system how to detect and attack cancer cells very well, but it unfortunately also taught the immune system how to attack some good cells, and it turned around and started attacking my kidneys. But the cancer, all trace of cancer was gone within six months.

So when they stopped the clinical trial, which was after six months, I was okay. I didn't have any more cancer. I did have a decreased kidney function, but I'm still fine. I attribute the fact that I'm still vertical today to that cancer trial, to that clinical trial. Because at the time, based on what I'd been told, I had no alternative. And it really worked for me. It really worked.

Stephanie Chisolm:

So what would you both suggest to a patient who's considering a clinical trial, but is like, I don't know if I want to do this or not. What would be your advice? What would be some questions? In addition to the wonderful questions that Dr. Tawagi had listed, what would be some other tips that you might give to them in terms of making sure that the clinical trial is the right choice for them? Do you have any ideas, Karl or Alan?

Patient Advocate Karl Pritchard:

Well, I do. I would say, first of all, because I've done this for people, if you're in a clinical trial, the sponsor of the trial is very, very concerned about how it's working in everybody. So if you're in a clinical trial, you're going to be heavily supervised. While I was getting my infusions and my immunology drug in a large infusion room at the drug oncology center, there were dozens of people getting chemotherapy. They came in once every three weeks and got chemotherapy. They saw the doctor once every several months. I saw the doctor every three weeks. Every three weeks, I had my immunology infusion and I saw a doctor for a comprehensive scan every three weeks. I think that's something to say to them. You're going to get more attention, I think, in a clinical trial. Plus, you might be opening the door to something that's really better than the alternative.

Stephanie Chisolm:

Alan, how is that for you as far as your care with the clinical trial? Just take it off from mute.

Patient Advocate Alan Soles:

Here we go now.

Stephanie Chisolm:

Now, we can hear you.

Patient Advocate Alan Soles:

Yeah. No, I had the same experience as Karl had, and the sense of the amount of care and things that I was followed with, it was fantastic. And in terms of questions to ask and stuff like that, I think Dr. Tawagi is right on board. Everything that she has listed is exactly what I asked when I went in. I would copy off that list and I would take it with me into another study, I would take that list with me and use that as a base plate.

Stephanie Chisolm:

Right. And we will make that list available when we put the transcript up on the website. So that whole list will be available. You can print out a copy and bring it with you if you're watching this as part of the recording, so absolutely. So Dr. Tawagi, when you're considering patients for a clinical trial, there are inclusion criteria, which means they have to have a certain aspect of the disease and there are exclusion criteria. When somebody doesn't qualify for a clinical trial because they have an exclusion criteria, how do you break that to them, especially when they were really excited about being in the clinical trial?

Dr. Karine Tawagi:

Yeah, that's difficult at times because it is the promise of a new better treatment. But of course, we want to be able to give these things safely. So for example, immunotherapy, which Alan and Karl were both on, if you have a significant history of an autoimmune disease, you might not be able to get immunotherapy because the risk of your autoimmune disease flaring up would be significant. So we really have to weigh kind of the risks and benefits, and we're always thinking of new trials that can help perhaps include patients that were traditionally excluded. So I think the needle is moving to have wider inclusion criteria. But yes, we certainly sometimes have to break the news that someone doesn't qualify for a clinical trial, or perhaps their disease is not the stage that we thought it was initially.

Let's say we thought it was stage three, and now it looks like it's stage four, then they might not qualify for a trial for those reasons as well. But it's not that they can never qualify for a trial in the future. Sometimes, let's say someone is stage four instead of three. Perhaps if the first treatment doesn't work, there might be a clinical trial after that. So it doesn't really necessarily close all the doors. There's always options for future clinical trials as well.

Stephanie Chisolm:

Right. So when they look at all these inclusion and exclusionary criteria, one of the things I think people don't understand is those exclusionary criteria are built into a trial to really make sure that they're able to assess the impact of this treatment that's not been confounded or confused by somebody's other, perhaps comorbidity or other health concern. So that's partly why it makes it so challenging. In general, bladder cancer tends to occur more frequently as people get older. Is there an age limit to being in a clinical trial?

Dr. Karine Tawagi:

No, there is not an age cutoff. One of the limiting things sometimes is something called performance status. So for most clinical trials, somebody needs to be able to do their daily living activities, like go to the bathroom on their own, be able to walk around. If they're more bedbound, for example, for either from their cancer or for other medical reasons, it's difficult for them to really benefit from the treatment. So often in those cases, we wouldn't necessarily be able to offer a clinical trial. And then other medical issues such as significant kidney issues may preclude you from certain types of clinical trials and things like that.

Stephanie Chisolm:

Right. And that would be because your body can't process sometimes some of the drug treatments that you might be given-

Dr. Karine Tawagi:

Right, right, right. It would be too risky and actually probably cause more harm than benefit.

Stephanie Chisolm:

Yeah. Well remember, if you're on this webinar and you have a question, drop it into the Q&A box at the bottom of your screen. So looking at the general picture, I think the future looks pretty bright because people do participate in clinical trials. But Dr. Tawagi, have you ever been involved as an investigator on a trial that had to close because there wasn't enough enrollment?

Dr. Karine Tawagi:

I have. I have. So some trials, if they're smaller trials, if they're not able to enroll enough patients or if there's... Sometimes, trials close because of safety signals. So if let's say there are side effects that were not expected, I haven't been involved in those specifically, but that does happen at times. As Karl mentioned... Earlier, I did mention that oftentimes, you get the standard of care or another treatment or the addition of a treatment. But in earlier phase trial, such as what Karl was on, he was on a phase one trial, there is no control arm as he mentioned. So sometimes it's an earlier phase because we don't have any treatments in this phase. And so really, you're either getting the treatment. There's not going to be a comparator arm. So it's also important to know, depending on the space that you're in, there might not always be a control arms, and there might just be kind of one treatment and they're trying to see what the best dose is, what the efficacy is or how well it will work, and what the toxicity or side effects are.

Stephanie Chisolm:

You brought up. A good point about the control arm, not the control arm, but the comparator arm. Do participants in a clinical trial get to pick, or do they always know whether they're getting the treatment or standard of care only?

Dr. Karine Tawagi:

No, not always. So in the case of an earlier phase trial, so like phase one or phase two, so there are different phases of clinical trials. You might only have one arm, so you would definitely know what you're getting. But in the case of, for example, a phase three trial, which are these big trials for which things get approved by the FDA, you might not necessarily know if you're getting the new treatment or

not. You might be getting the standard of care with either the placebo or the new drug, but you might be blinded, in which case you would not actually know if you're receiving it or not. And the reason that they do that is so that there's no bias in terms of whether it's working or not by people knowing what they're getting, both the doctors and the patients.

Stephanie Chisolm:

So sometimes not even the researchers know which one they're giving. So they basically go out of their way to make sure all the treatments look exactly the same. So if it's a pill, all the pills look the same and nobody really knows which one except on the backside for the data, so they can check and make sure that it's really measuring is there an impact or no impact.

Dr. Karine Tawagi:

Exactly.

Stephanie Chisolm:

That's important to know. So what if a patient decides, all right, I'm going to be in a clinical trial, and then they think, "You know what? This is way more monitoring. I don't want to go into town and get monitored every three weeks. It's really a hardship for me," can they back out, or they're stuck now?

Dr. Karine Tawagi:

Yeah, no, it's always a choice. Both at the beginning and throughout, it's not a forceful thing. It's something that we offer. Because if I had the option, I would want to be on a clinical trial knowing what I know. But it's always a choice.

Stephanie Chisolm:

If somebody were being seen in a community practice, not at a large institution that usually has an academic affiliation, like University of Illinois or something like that, and they wanted to go in a clinical trial, but there was no big medical hospital affiliated with the university near them, how do they get into a clinical trial?

Dr. Karine Tawagi:

So they can look for... On clinicaltrial.gov, you can search for clinical trials depending on the type of cancer that you have. So for bladder cancer, for example, you could search yourself on clinical trial.gov and see what the closest center is that might offer a clinical trial. I know that Karl mentioned he did his research through BCAN and kind of got familiarized with what was available. So patients can be their own advocates to try to get clinical trials. Even at community centers, it's possible sometimes to get clinical trials. And if not, kind of looking geographically what the closest place might be that might offer a clinical trial.

Stephanie Chisolm:

Right. I just dropped the link in the chat box. If you all open that up to our clinical trials dashboard, that's an important point. Clinicaltrials.gov is all the clinical trials that are open around the world, including some that are done recruiting, but they're still out there. BCAN keeps only the open recruiting trials because what's the point of telling you about a really exciting clinical trial if it's not even open yet? So

we have all the current open trials that are recruiting, and those are just the trials that are specific to bladder cancer. And you can sort by your disease diagnosis, so non-muscle invasive or muscle invasive, or advanced disease, and then you also can sort by your geographic location. So maybe you want to search for the closest trials to you, but maybe you have family or a vacation home in another state that would enable you to have another place to stay for six or so months if you had to, and you could look there. So that also kind of expands your footprint of potential clinical trials.

And especially if you've got family in Illinois, there are plenty of large academic hospitals that are doing clinical trials. But many times some of the routine screenings that need to be done, could they be done back in the community and just have those results shared with the large teaching hospital that might be sponsoring a trial?

Dr. Karine Tawagi:

Absolutely. So I did some of my training in New Orleans. And MD Anderson was about four hours away, so a lot of patients did clinical trials in Houston at MD Anderson, because it's one of the largest cancer centers in the US, and we would monitor them in New Orleans, do their testing, and communicate the results with the other institution. So definitely can happen.

Stephanie Chisolm:

And occasionally, clinical trials will help provide transportation.

Dr. Karine Tawagi:

Absolutely.

Stephanie Chisolm:

Sometimes if you may have to come in for an overnight and it's a little bit far, maybe they have a place that's affiliated with the institution that you can do overnights and be able to stay there. So I think many clinical trials go out of their way to try to be accessible to the patient community, but only if patients ask. So it's certainly something to think about. So if there are any other questions coming in from any of our participants, please feel free to drop them in. And while we're doing that, if Alan and Karl, you have any closing suggestions or thoughts? What would be things you would share with a new patient who's saying, "I don't know if I should go on a clinical trial?" What would you tell them, Alan?

Patient Advocate Alan Soles:

I would want- They're so hard because for me it was really easy because I don't have a wife and kids, all those kinds of things. So it's more of a matter, I think, of what's going to be comfortable for your family and things.

Stephanie Chisolm:

Okay. Yeah. Karl, anything to add?

Patient Advocate Karl Pritchard:

Well, the first thing that springs to mind, of course thinking about myself, clinical trial, in my mind, gives you a better chance to survive. If you don't go into clinical trial and you take, for example, the

chemotherapy, I don't know what the statistics are, and I'm sure the doctor does, but I know that when I started my immunotherapy, the prediction was, at that time, they had Keytruda, Opdivo, and a few others, and they said the predicted survival rates for people on immunology was higher than those that received chemotherapy, and of course, the quality of life was much higher. I would say to a person considering it, I don't see that they've got anything to lose and they have everything to gain. I don't know why anyone would turn it down, but I'm sure- I look at it as the chance to remain vertical. That's all.

Stephanie Chisolm:

Okay. That's a good way of looking at it. Any closing remarks, Dr. Tawagi?

Dr. Karine Tawagi:

Yeah, I think in this space of, you know, we're talking about muscle invasive bladder cancer, so a little bit different than what Alan and Karl had because there's had already spread. But in this muscle invasive space where the cancer really hasn't spread and we can give chemotherapy after or remove the bladder or give chemotherapy, sorry, before or after, we know that a significant portion of those patients, the cancer comes back. So we want to reduce the number of patients for which it comes back because the outcomes will be longer, you'll remain vertical for longer, as Karl mentioned.

And so we want to try to include more patients so those that have kidney issues that can get the standard of care cisplatin, we need more trials in order to determine if immunotherapy can be given in this setting. And really, we want to improve the treatments of bladder cancer. There has been tremendous advances in other types of cancer like melanoma, like I showed you, but bladder cancer still has a long way to go. We have made tremendous progresses in the last decade with all these new treatments, but there's definitely a lot more that can be done, and the only way that we're going to improve it is with clinical trials.

Stephanie Chisolm:

Excellent. Well, with that, I'm going to thank you all for a really informative webinar about clinical trials for the muscle invasive bladder cancer patient and their families, because this is a family affair in that everybody gets involved in the process. Ask questions, talk to your doctor, find out if you could do it even within your community setting. There are many community practitioners that are engaging in clinical trials as well, so don't be afraid to ask for that. Thank you all so much for a great program, and again, I'd like to thank our industry sponsors for making the Treatment Talk programs possible. Take care, bye.

Dr. Karine Tawagi:

Take care, everyone.

Stephanie Chisolm:

Bye.

Patient Advocate Karl Pritchard:

Thank you.

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