25th Multidisciplinary Management of Cancers: A Case-based Approach

Genitourinary Cancers Tumor Board Cases

Sunday, March 9th, 11:00 am

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Panelists

- Chair: Mamta Parikh,MD,MS (UC Davis)
- Aman Arora, MD, Case Presenter (UC Davis Urology)

Medical Oncology

Thierry Friedlander, MD (UCSF)
Shuchi Gulati, MD,MS (UCD)
Andrea Harzstark, MD (TPMG)
Ali Khaki, MD (Stanford)
Lulu Zhang, MD (Pacific Cancer Care)

Urologic Oncology

Thenappan Chandrasekar, MD (UCD)
Benjamin Chung, MD (Stanford)
Sam Washington, MD,MAS (UCSF)

Radiation Oncology

Hilary Bagshaw, MD (Stanford)
Richard Valicenti, MD, MA (UCD)
Anthony Wong, MD, PhD (UCSF)

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Disclosures

Faculty Name	Role	Type of Financial Relationship	Company
Mamta Parikh	**Chair**	Advisory Board or Panel	Bicycle Therapeutics, Exelixis, Pfizer, Bristol Myers Squibb, Sanofi Aventis
		Consultant	Totus Medicines; Grants/Research Support: Gilead and Karyopharm
Aman Arora	**Fellow**	Disclosed no relevant financial relationships.	
Hilary Bagshaw	Panelist	Disclosed no relevant financial relationships.	
Thenappan Chandrasekar	Panelist	Disclosed no relevant financial relationships.	
Benjamin Chung	Panelist	Consultant	Intuitive Surgical, Johnson and Johnson, and Medtronic
		Salary/Contractual Services	VPIX Incorporated and DeepQure
Terence Friedlander	Panelist	Advisory Board or Panel	Aadi Biosciences, Abbvie, Adaptimmune, Astellas, Atkis Oncology, Bicycle Therapeutics, Bristol Meyers Squibb, Gilead, Merck Sharp & Dohme, McKesson, Pfizer/Seagen, and Samsung Bioepis
		Consultant	Samsung Bioepis
		Grants/Research Support	Roche Genentech, Pfizer, J&J Innovative Medicine, and Bicycle Therapeutics
Andrea Harzstar	Panelist	Disclosed no relevant financial relationships.	
Ali Raza Khaki	Panelist	Advisory Board or Panel	Pfizer (declined remuneration)
		Consultant	Janssen (declined remuneration); Grants/Research Support: 23andMe, Pfizer, Janssen, Acrivon Therapeutics.
Richard Valicenti	Panelist	Disclosed no relevant financial relationships.	
Sam Washington	Panelist	Disclosed no relevant financial relationships.	
Lulu Zhang	Panelist	Disclosed no relevant financial relationships.	

ANCO and i3 Health have mitigated all relevant financial relationships.

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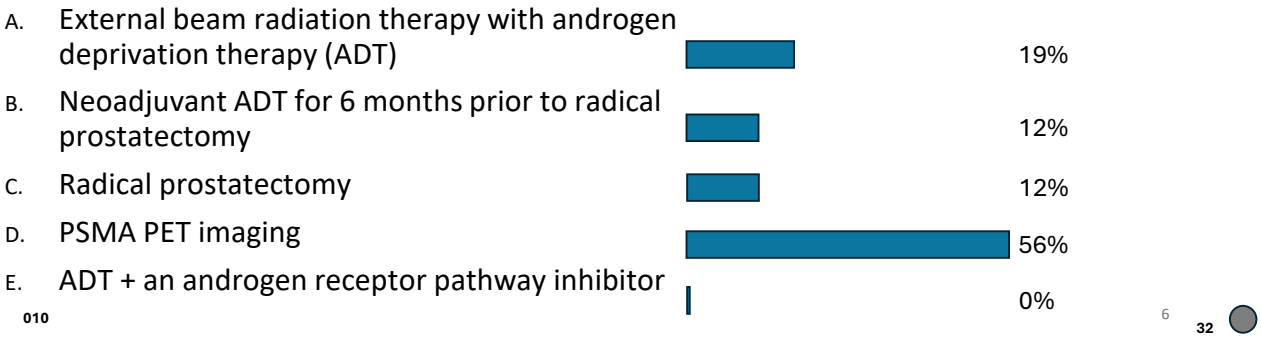
Case 1 – Prostate Cancer

A 60 year old man presents with significant increase in nocturia, and on DRE, prostate felt firm, irregular nodule palpated. PSA was 30 ng/mL. An MRI shows a PIRADS 5 transitional zone lesion of left anterior apical and mid prostate. He underwent a fusion-guided biopsy with findings of Gleason 4+4 prostate adenocarcinoma without clear evidence of extraprostatic extension. CT imaging and NM bone imaging do not show any evidence of metastatic disease. What do you recommend next for this patient?



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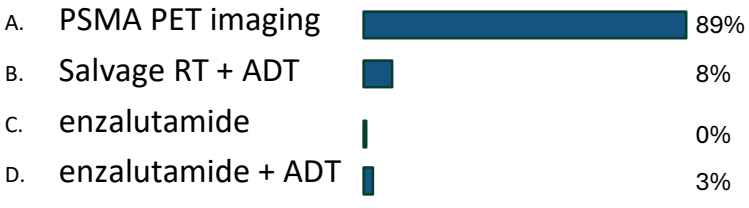
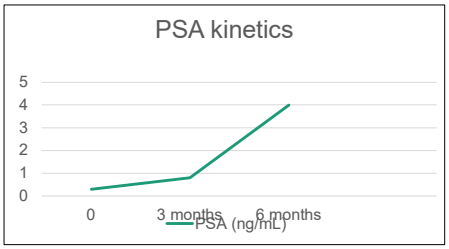
Case 1 –continued

A PSMA PET scan does not show any clear evidence of metastatic disease. After a thorough discussion with his radiation oncologist and urologist, he decides to undergo radical prostatectomy. Pathology reveals pT3b prostate adenocarcinoma, Gleason 4+5, with extraprostatic extension noted, but negative margins and no LN involvement. Ultrasensitive PSA at 6 months is undetectable.

Two years later, PSA becomes detectable. Aside from concern re: PSA increase, he feels otherwise well.

What do you recommend next?





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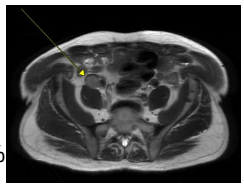
Case 2 – Prostate Cancer

A 73 year old with a history of DM2 presented with nocturia, urge incontinence, and was found initially to have a PSA of 11 ng/mL. An MRI of the prostate showed a 5cm PIRADS-5 lesion with frank EPE, as well as abnormal pelvic lymph nodes and osseous lesions. CT & NM bone imaging showed lesions in **T3, T12, right 4th rib, right femoral head, as well as enlarged pelvic nodes**. By then, PSA is 19 ng/mL. How would you treat the patient?



A. ADT with abiraterone + prednisone — 24%

B. ADT with 6 cycles of docetaxel as well as continuous abiraterone + prednisone — 47%

C. ADT with abiraterone + prednisone + EBRT to the prostate — 24%

D. ADT with darolutamide — 5%

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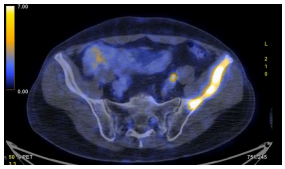
Case 3 – Prostate Cancer

A 70 year old man was diagnosed with high-volume metastatic prostate cancer with a PSA of 75 ng/mL, and was treated initially with ADT, docetaxel for 6 cycles, and abiraterone + prednisone. At 7 months, PSA was 3 ng/mL. At 12 months, PSA had increased to 15 ng/mL. He is feeling well except for mild pain in the left hip. What would you recommend next?

PSMA PET- only site of avid disease



NGS testing

CDK12
c.2419+2T>C Splice region variant - LOF

CHEK2
p.R148G Splice region variant - LOF

A. talazoparib + enzalutamide — 27%

B. Lutetium-177-PSMA-617 radioligand therapy — 32%

C. cabazitaxel — 14%

D. olaparib — 11%

E. Radium-223 radioligand therapy — 16%

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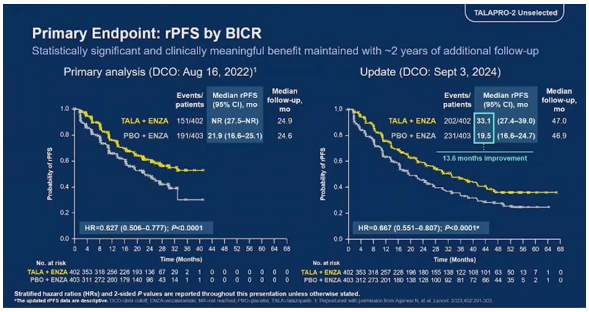
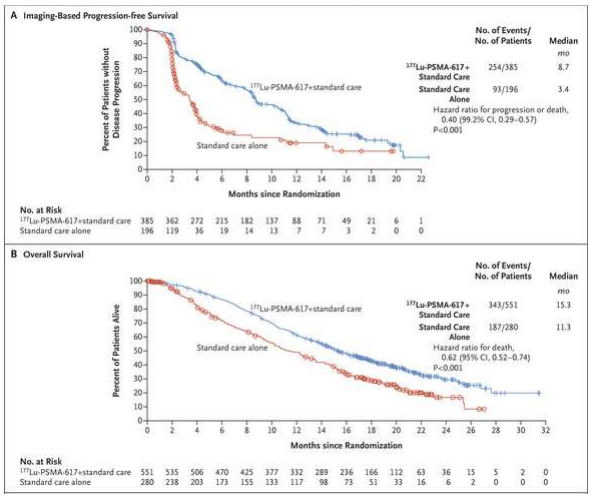
TALAPRO-2 Updated Efficacy regardless of HRR status



N Agarwal, ASCO GU 2025

VISION Efficacy



O Sartor et al, N Engl J Med 2021

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Case 4 – Bladder Cancer

A 66 year old man with a history of hypertension presented with gross hematuria and clot retention. CT imaging showed a tumor near the trigone of the bladder. TURBT showed a large tumor overlying the L trigone and sidewall, pathology demonstrating a high-grade papillary urothelial carcinoma with muscularis propria invasion. Imaging did not show any other lymphadenopathy or distant disease. Labs are all within normal limits. He is open to the best course forward. What do you recommend?

A. Neoadjuvant ddMVAC for 4 cycles followed by radical cystectomy — 25%
B. Neoadjuvant gemcitabine + cisplatin + durvalumab followed by radical cystectomy with 8 additional cycles of durvalumab — 72%
C. Concurrent cisplatin with radiation — 2%
D. Concurrent 5-FU/MMC with radiation — 0%

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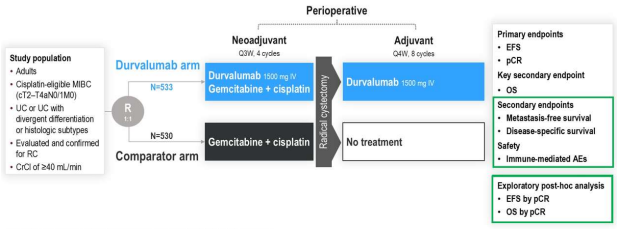
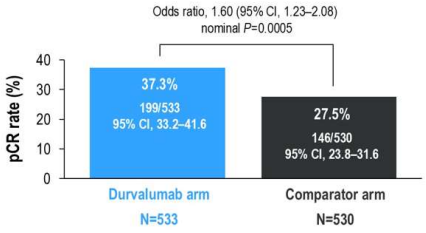
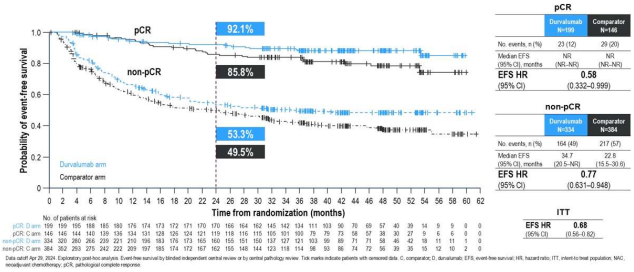
NIAGARA Updated Results



Full study design details are available in Powles T, et al. *N Engl J Med*. 2024;391:1773–1786.

ASCO Genitourinary Cancers Symposium #GU25 PRESENTED BY: Prof Matthew D. Galsky





pCR	Durvalumab N=199	Comparator N=146
No. events, n (%)	23 (12)	29 (20)
Median EFS (95% CI), months	NR (NR–NR)	NR (NR–NR)
EFS HR (95% CI)	0.58 (0.332–0.999)	

non-pCR	Durvalumab N=334	Comparator N=384
No. events, n (%)	164 (49)	217 (57)
Median EFS (95% CI), months	34.7 (20.5–NR)	22.8 (15.5–30.6)
EFS HR (95% CI)	0.77 (0.631–0.948)	

ITT	
EFS HR (95% CI)	0.68 (0.56–0.82)

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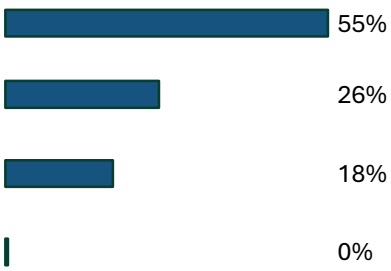
Case 4 – continued

The patient opted to receive neoadjuvant chemotherapy, and completed 3 cycles of ddMVAC, could not tolerate further due to tinnitus and nausea

Cystoscopy did not show any evidence of disease, and he had ctDNA testing that was undetectable. Original TURBT specimen NGS demonstrated mutations in ERBB3, ERCC2, TP53, TSC1

He wonders if he really has to move forward with radical cystectomy now. What do you recommend?

A. Emphasize the importance of radical cystectomy
B. Consolidative treatment with concurrent chemoRT
C. Surveillance with ctDNA, cystoscopies and imaging
D. Encourage additional 3 cycles of ddMVAC



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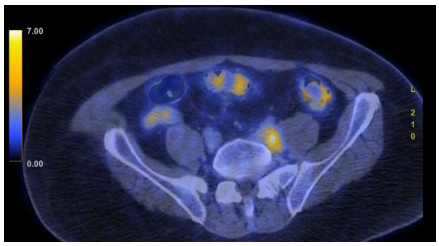
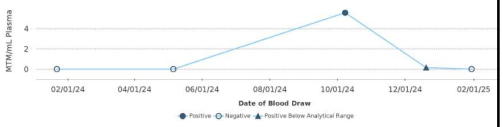
Case 4 – continued

The patient continued to decline radical cystectomy and opted for concurrent chemoRT with 5-FU/MMC. After 4 months, ctDNA became detectable, and he was found to have avid and enlarged L external iliac node on imaging. He received enfortumab vedotin + pembrolizumab with a complete response and clearance of ctDNA. Now considering radical cystectomy.





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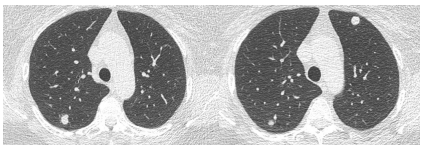
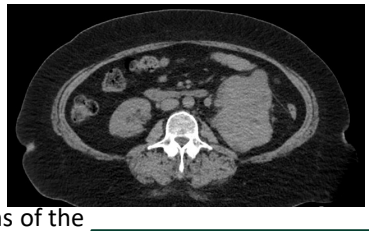
Case 5 – Renal cell carcinoma

A 65 year old woman with a history of hyperlipidemia and hypertension was vacationing in Kauai when she developed left lower quadrant abdominal pain, hematuria, nausea. CT imaging showed a L kidney mass that was 11.8 cm and multilobulated, and multiple subcentimeter pulmonary nodules. A biopsy revealed renal cell carcinoma with clear to eosinophilic cytoplasm. She had been referred to Urology, but there were delays in insurance. Restaging imaging showed two pulmonary nodules had increased to ~1.5 x 1.5 cm, one of which was biopsied and confirmed metastatic RCC. The only lab abnormality is elevated ANC of 9K. What would be the next step in management?





A.	L radical nephrectomy and SBRT or wedge resections of the pulmonary nodules	45%
B.	L cytoreductive nephrectomy	10%
C.	nivolumab + ipilimumab	20%
D.	pembrolizumab + lenvatinib	25%

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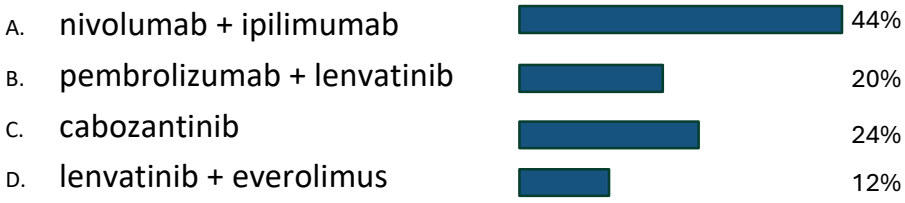
Case 5 – continued

The patient's case is discussed at tumor board after patient expresses hesitation to start systemic therapy. She undergoes L radical nephrectomy and when imaging is stable three months later, undergoes wedge resection of the LUL and SBRT to a right pulmonary nodule. She agrees to start treatment with pembrolizumab, but 6 months later, she has new increasing pulmonary lesions >2.5 cm bilaterally. What would you recommend next?



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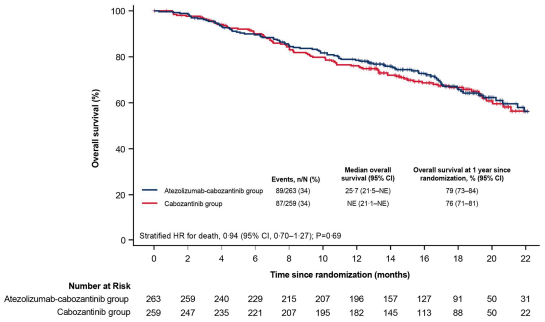
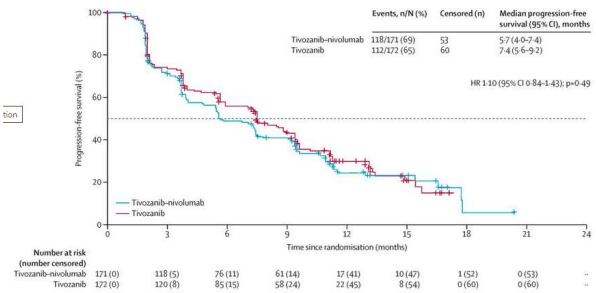
Data on continuation/rechallenge with IO

CONTACT-03: 1-2 prior lines of therapy (~90% treated with 2nd line nivolumab)



TiNivo-2: 1-2 prior lines of therapy (~70% received ICI in most recent line of therapy)



SK Pal et al Lancet 2023; 402 (10397):185-195.
TK Choueiri et al Lancet 2024; 404 (10460): 1309-1320.

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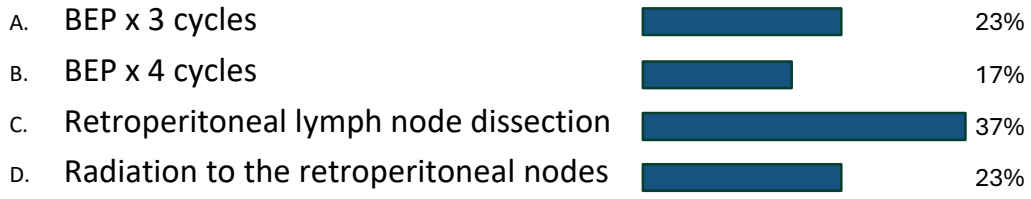
Case 6 – Testicular cancer

A 28 year old previously healthy man presents with right testicular swelling. An ultrasound confirmed multifocal calcification in the right testis. There were no elevations in LDH, β-hCG, AFP. He underwent a right radical orchiectomy with pathology consistent with pure seminoma. Post-operative imaging two months later showed a 1.2 x 1.8 lateral aortic lymph node, a 1.5 x 1.5 cm precaval node. Markers remain wnl. What would you next recommend?



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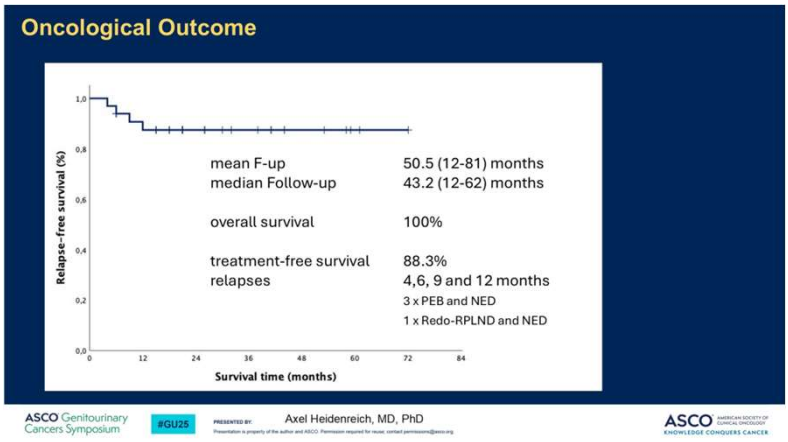
COTRIMS Trial Results

Guideline recommended therapy for clinical Stage IIA/B seminoma:
- RT
- BEP x 3, EP x 4

COTRIMS: to determine if RPLND is an alternative to possible long-term complications of chemotherapy or radiation

Single-arm study:
- pure testicular seminoma with negative markers
- clinical Stage IIA/IIB with no adjuvant carboplatin
- (used miR371)



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Case 7 – Penile cancer

A 49 year old man presents with a bump on the penis, and upon dermatology evaluation, a punch biopsy was consistent with squamous cell carcinoma. CT abdomen/pelvis showed a right inguinal lymph node enlarged to 1.8 cm. Seen by Urology and patient underwent a partial penectomy, pathology revealing an invasive, high-grade squamous cell carcinoma, 3.9 cm in size, involving foreskin, with surgical margins negative. Inguinal nodes were not palpable but right inguinal node remains enlarged on follow-up imaging. What is the next step in management in this otherwise healthy man?

A. TIP for 4 cycles — 21%
B. Bilateral inguinal lymph node dissection — 18%
C. Bilateral dynamic sentinel node biopsy — 39%
D. EBRT to the inguinal node — 21%

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Thank You!

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