












EPICS

# Conference Coverage: ASCO GU 2024 Highlights

January 31, 2024

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## VIRTUAL CLOSED-DOOR ROUNDTABLE



**DATE:**  
January 31, 2024



**DISEASE STATE AND  
DATA PRESENTATIONS**  
by key experts



**INSIGHTS REPORT**  
including postmeeting  
analyses and actionable  
recommendations



**PANEL:** Key experts in  
GU malignancies  
> 7 US  
> 1 EU



**GU CANCER-SPECIFIC  
DISCUSSIONS** on  
therapeutic advances and  
their application in clinical  
decision-making

# Panel Consisting of 8 Worldwide GU Cancer Experts

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**Terence Friedlander, MD**  
University of California,  
San Francisco



**Neeraj Agarwal, MD**  
Huntsman Cancer Institute



**Oliver Sartor, MD**  
Tulane University School  
of Medicine



**Leonard G. Gomella, MD, FACS**  
Thomas Jefferson University



**Scott Tagawa, MD, FASCO, FACP**  
Weill Cornell Medicine



**David M. Nanus, MD**  
Weill Cornell Medicine



**CHAIR:**  
**Daniel Petrylak, MD**  
Yale Cancer Center



**Thomas Powles,**  
**MBBS, MRCP, MD**  
Barts Cancer Centre



# Meeting Agenda

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Time (EST)	Topic	Presenter
12.00 PM – 12.05 PM	<b>Welcome and Introductions</b>	Daniel Petrylak, MD
12.05 PM – 12.15 PM	<b>Bladder Cancer Part 1 – ADCs and TKIs</b>	Scott Tagawa, MD, FASCO, FACP
12.15 PM – 12.35 PM	<b>Discussion and Key Takeaways</b>	Moderator: Daniel Petrylak, MD
12.35 PM – 12.45 PM	<b>Bladder Cancer Part 2 – Immunotherapies</b>	Thomas Powles, MBBS, MRCP, MD
12.45 PM – 1.10 PM	<b>Discussion and Key Takeaways</b>	Moderator: Daniel Petrylak, MD
1.10 PM – 1.20 PM	<b>BREAK</b>	
1.20 PM – 1.30 PM	<b>Prostate Cancer Part 1 – Localized Prostate Cancer</b>	Oliver Sartor, MD
1.30 PM – 1.45 PM	<b>Discussion and Key Takeaways</b>	Moderator: Daniel Petrylak, MD
1.45 PM – 1.55 PM	<b>Prostate Cancer Part 2 – Metastatic Prostate Cancer</b>	Neeraj Agarwal, MD
1.55 PM – 2.20 PM	<b>Discussion and Key Takeaways</b>	Moderator: Daniel Petrylak, MD
2.20 PM – 2.30 PM	<b>Renal Cell Carcinoma</b>	David Nanus, MD
2.30 PM – 2.55 PM	<b>Discussion and Key Takeaways</b>	Moderator: Daniel Petrylak, MD
2.55 PM – 3.00 PM	<b>Summary and Closing Remarks</b>	Daniel Petrylak, MD



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## Conference Highlights

Bladder Cancer Part 1 – ADCs and TKIs

# EV after switch-maintenance avelumab (MAv) in the UNITE study

Nizam A, et al. 2024 ASCO GU; Abstract 537

## Background Median OS with EV

### STUDY POPULATION

1. 1000 patients with metastatic urothelial carcinoma (mUC) who had received prior systemic therapy and were eligible for the study. The study population included patients who had received prior systemic therapy and were eligible for the study. The study population included patients who had received prior systemic therapy and were eligible for the study.

### RESULTS

1. Median OS with EV was significantly longer in the MAv group compared to the control group. The median OS with EV was significantly longer in the MAv group compared to the control group.

### CONCLUSIONS

Continuing maintenance treatment beyond week 24 provides clinical benefit in mUC patients and decreases the maintenance cost to patients.

### Median OS with EV



### RESPONSE RATE WITH EV AND MAV



# SG in patients previously treated with EV

Vlachou E, et al. 2024 ASCO GU; Abstract 567

## Background

> Median OS for SG was 5.36 mo in EV responders and 5.78 mo in

### STUDY POPULATION

1. 1000 patients with metastatic urothelial carcinoma (mUC) who had previously received 1-3 lines of systemic therapy, including platinum-based chemotherapy, were enrolled in the study. The median age was 70 years (range 55-85). The median time from last systemic therapy to study enrollment was 12 months (range 0-48). The median number of lines of previous therapy was 2 (range 1-3). The median time from last systemic therapy to study enrollment was 12 months (range 0-48). The median number of lines of previous therapy was 2 (range 1-3).

### STUDY DESIGN

2. This was a phase II, randomized, controlled trial. The primary endpoint was overall survival (OS). The secondary endpoint was quality of life (QoL). The study was conducted in a multicenter setting.

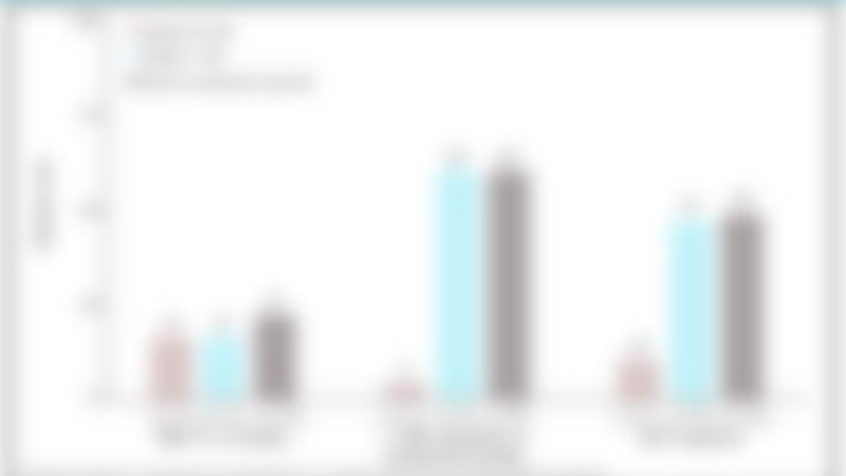
### KEY CONCLUSIONS

3. The study demonstrated that the combination of SG and platinum-based chemotherapy significantly improved OS compared to platinum-based chemotherapy alone in patients with mUC who had previously received 1-3 lines of systemic therapy.

### OS BY EV STATUS



### RESPONSE RATE BY EV STATUS





## Background

### STUDY POPULATION

1. 100 patients with solid tumors, including 50 with metastatic disease, were enrolled in the study. The patients were treated with TROPION PanTumor01. The study population included patients with various types of cancer, including breast, lung, and colorectal cancer. The patients were treated with TROPION PanTumor01 for a median duration of 12 weeks. The study population was diverse in terms of age, gender, and ethnicity.

### RESULTS

2. The overall response rate (ORR) was 30%. The most common adverse events were fatigue, nausea, and diarrhea. The median duration of response was 12 weeks. The study demonstrated that TROPION PanTumor01 is well-tolerated and has a promising ORR in patients with solid tumors.

### CONCLUSIONS

3. TROPION PanTumor01 is a well-tolerated treatment for patients with solid tumors. The study demonstrated a promising ORR and a median duration of response of 12 weeks. Further studies are needed to evaluate the efficacy and safety of TROPION PanTumor01 in larger populations.

### ORR BY TUMOR TYPE



### RESPONSE DURATION BY TUMOR TYPE



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## Key Insights

Bladder Cancer Part 1 – ADCs and TKIs

# Bladder Cancer Part 1 – ADCs and TKIs (1/4)

The role of EV in the bladder cancer treatment landscape continues to

*[Blurred content area containing text and a list of bullet points]*



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# Bladder Cancer Part 1 – ADCs and TKIs (2/4)

## Experts have concerns regarding pursuit of EV combination therapies

Meeting notes will help clarify the optimal sequencing of agents

- 1. Experts are still using a combination of the regimen of enfortumab and pembrolizumab followed by T1DM, sequentially, for most patients.
- 2. Most experts are using enfortumab pembrolizumab, but will consider the limited data for patients with evidence of prior resistance.
- 3. The limited data may also be used in the second-line setting before T1DM, in patients with documented prior resistance.
  - Preferred to use sequential agents and decide on whether they would actually use T1DM or pembrolizumab pembrolizumab
  - Results of the ongoing trial will determine the sequencing of enfortumab pembrolizumab or T1DM will help to clarify the optimal sequencing of these agents
- 4. Pembrolizumab pembrolizumab and the limited data may also be used before first therapy in patients who were following treatment with pembrolizumab, pembrolizumab, and T1DM in the second-line setting, but this represents a small fraction of patients.
- 5. Future publications will also focus on the sequencing of these two agents (eg, 1 drug or 2 drug, versus what has been in the past).
- 6. The improved efficacy of pembrolizumab pembrolizumab and the limited data have opened other options, such as pembrolizumab chemotherapy combinations, sequential, and combination, in the first line of therapy.



**Dr. [Name]**  
The speaker is a member of the panel...  
[Blurred text describing the speaker's background and role in the session]

# Bladder Cancer Part 1 – ADCs and TKIs (3/4)

Experts are intrigued by novel agents, but remain skeptical about their

...ing trials will help clarify the optimal sequencing of agents

- 1. Experts are still using a combination of agents, including immunotherapy and chemotherapy, followed by TKI, according to most patients
- 2. Most experts are using immunotherapy, chemotherapy, but still consider the standard of care for patients with evidence of local recurrence
- 3. The standard of care may also be used in the adjuvant setting, before TKI, for patients with recurrent local recurrence
  - Considered a good sequence, experts are divided on whether they would consider use TKI in immunotherapy, chemotherapy
  - Results of the ongoing trial will determine the sequencing immunotherapy, chemotherapy or TKI will help to clarify the optimal sequencing of these agents
- 4. Immunotherapy, chemotherapy and the standard of care may also be used before then starting in patients who were following treatment with immunotherapy, chemotherapy, and TKI in the maintenance setting, but this represents a small fraction of patients
- 5. Future publications will also focus on the sequencing of these new agents (eg. 1 drug or 2 drug, versus what has been in standard)
- 6. The comparative efficacy of immunotherapy, chemotherapy and the standard of care have proven other options, such as immunotherapy chemotherapy combinations, vaccines, and immunotherapy, in the form of therapy



...ing trials will help clarify the optimal sequencing of agents

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...ing trials will help clarify the optimal sequencing of agents



# Bladder Cancer Part 1 – ADCs and TKIs (4/4)

Experts are cautiously optimistic as to the future role of TKIs in bladder

...ing trials will help clarify the optimal sequencing of agents

- 1. Experts are still using a combination of agents, including immunotherapy and chemotherapy, followed by TKI, according to most patients
- 2. Most experts are using immunotherapy, chemotherapy, but will probably be looking for patients with evidence of prior treatment
- 3. The standard of care may also be used in the second-line setting, before TKI, for patients with immunotherapy resistance
  - Provided a good assessment, experts are divided on whether they would consider use TKI in immunotherapy resistance
    - o Results of the ongoing IMvigor013 comparing immunotherapy monotherapy to TKI will help to clarify the optimal sequencing of these agents
- 4. Immunotherapy and the standard of care may also be used before first-line therapy in patients who were following treatment with immunotherapy, chemotherapy, and TKI in the second-line setting, but this represents a small fraction of patients
- 5. Future assessments will also focus on the sequencing of these two agents (eg, 1 drug or 2 drug, versus what has been in the past)
- 6. The improved efficacy of immunotherapy and the standard of care have opened other options, such as immunotherapy chemotherapy combinations, vaccines, and immunotherapy in later lines of therapy



...ing trials will help clarify the optimal sequencing of agents

Experts are still using a combination of agents, including immunotherapy and chemotherapy, followed by TKI, according to most patients

Most experts are using immunotherapy, chemotherapy, but will probably be looking for patients with evidence of prior treatment

The standard of care may also be used in the second-line setting, before TKI, for patients with immunotherapy resistance

Provided a good assessment, experts are divided on whether they would consider use TKI in immunotherapy resistance

Results of the ongoing IMvigor013 comparing immunotherapy monotherapy to TKI will help to clarify the optimal sequencing of these agents

Immunotherapy and the standard of care may also be used before first-line therapy in patients who were following treatment with immunotherapy, chemotherapy, and TKI in the second-line setting, but this represents a small fraction of patients

Future assessments will also focus on the sequencing of these two agents (eg, 1 drug or 2 drug, versus what has been in the past)

The improved efficacy of immunotherapy and the standard of care have opened other options, such as immunotherapy chemotherapy combinations, vaccines, and immunotherapy in later lines of therapy



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# Conference Highlights

Bladder Cancer Part 2 – Immunotherapies

# Predictive value of ctDNA and baseline biomarkers with neoadjuvant atezolizumab in the ABACUS trial

Young MN, et al. 2024 ASCO GU; Abstract 534

## Background

> ABACUS was a phase II trial investigating 2 cycles of

**STUDY POPULATION**

1. 100 patients with metastatic urothelial carcinoma (mUC) who had not received prior systemic therapy for mUC. All patients had ECOG performance grade 0-1, Eastern Cooperative Oncology Group (ECOG) performance grade 0-1, and were aged 18-75 years. All patients had measurable disease. The primary endpoint was overall survival (OS) at 12 weeks. Secondary endpoints included progression-free survival (PFS), time to treatment failure (TTF), and quality of life (QoL). The study was stratified by ctDNA status (ctDNA positive vs. ctDNA negative) and by PD-L1 expression (PD-L1 positive vs. PD-L1 negative). All patients received 2 cycles of atezolizumab (1200 mg IV q3w) plus carboplatin (AUC 6) and paclitaxel (175 mg/m<sup>2</sup> IV q3w) from cycle 1 to cycle 2. All patients were followed up through week 48.

**RESULTS**

1. 100 patients were enrolled in the trial. The median age was 65 years. 50% of patients were ctDNA positive and 50% were ctDNA negative. The median time to treatment failure was 12 weeks.

**CONCLUSIONS**

Combining neoadjuvant treatment with 2 cycles of atezolizumab plus carboplatin and paclitaxel improved OS and decreased the number of patients who

**OS BY ctDNA STATUS AND PD-L1 EXPRESSION**



**RESPONSE RATES BY ctDNA STATUS AND PD-L1 EXPRESSION**





# Interim analysis of phase II ANTICIPATE trial

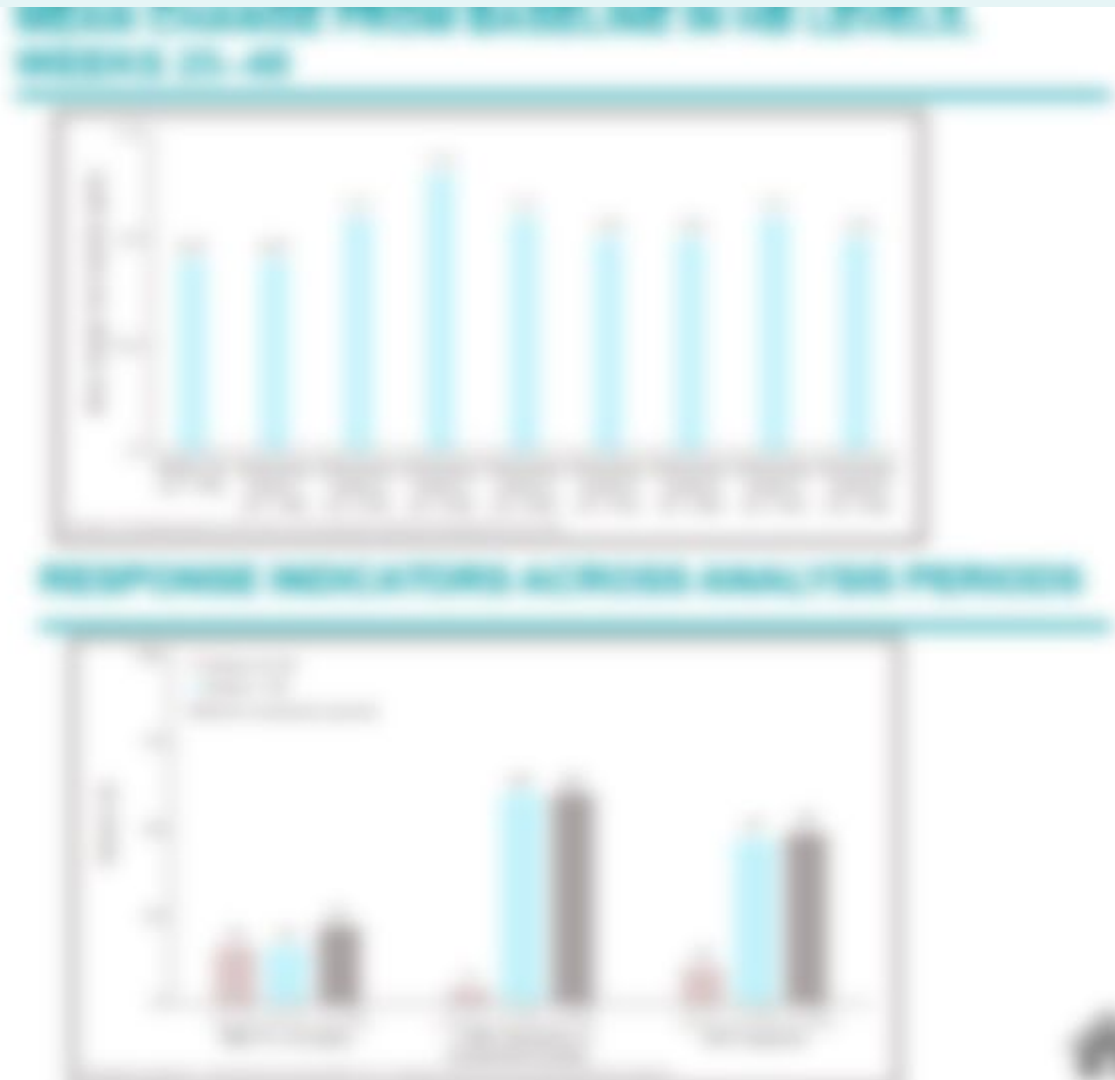
Galsky MD, et al. 2024 ASCO GU; Abstract 632

## Background

- > This ongoing study is examining the efficacy and safety of APL-1202, a MetAP2 inhibitor, combined with PD-1 inhibitor

## Dr Powles' conclusion

- > *"This I think is an interesting drug. I don't think it's ready yet for a randomized phase III study, but it's not working in the same way as*



# Phase II NEXT trial

Fortuna GG, et al. 2024 ASCO GU; Abstract 612

## Background

### STUDY POPULATION

1000 patients with prostate cancer, 500 in each arm. All patients had a PSA of 10-20 ng/mL, Gleason score 7-10, and were not on any systemic therapy. The study was designed to evaluate the efficacy of the investigational agent compared to the standard of care. The primary endpoint is overall survival at 36 months. The study is ongoing and will continue through week 48.

### RESULTS

At 36 months, 100 patients in the investigational arm and 100 in the standard of care arm had died. The median overall survival was 36 months in the investigational arm and 34 months in the standard of care arm. The difference was not statistically significant.

### KEY CONCLUSIONS

Continuing investigational treatment beyond week 24 provides clinical benefit in terms of overall survival and decreases the number of patients.

### PROSTATE TUMOR BURDEN IN THE LIVER AT WEEK 24



### RESPONSE BURDEN AT WEEK 24 FOR PATIENTS



## Background

### STUDY POPULATION

100 patients with prostate cancer, 50% with high-risk features (PSA > 10, Gleason score > 7, or clinical stage T3-T4). All patients received standard of care (SOC) with enzalutamide and abiraterone. The study population was divided into two groups: 50 patients with high-risk features and 50 patients with low-risk features. The high-risk group received SOC plus NURE, while the low-risk group received SOC alone. The primary endpoint was overall survival (OS) at 36 months. The secondary endpoint was quality of life (QoL) at 36 months. The study was conducted in a randomized, controlled manner.

### RESULTS

100 patients were enrolled in the study. 50 patients were in the high-risk group and 50 patients were in the low-risk group. The median age was 72 years. The median PSA was 12.5 ng/mL. The median Gleason score was 7.5. The median clinical stage was T3. The median OS at 36 months was 48 months in the high-risk group and 60 months in the low-risk group. The median QoL at 36 months was 75% in the high-risk group and 85% in the low-risk group.

### CONCLUSIONS

Adding NURE to SOC improved OS and QoL in high-risk patients with prostate cancer. This study suggests that NURE is a promising treatment option for high-risk prostate cancer patients.

### OS (36 MONTHS) FROM BENCHMARK IN THE LOW-RISK GROUP



### RESPONSE RATE AT 36 MONTHS ANALYSIS PERIOD



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## Key Insights

Bladder Cancer Part 2 – Immunotherapies

# Bladder Cancer Part 2 – Immunotherapies (1/2)

The role of IO in adjuvant therapy is rapidly evolving

Key points will help clarify the optimal sequencing of agents

- 1. Treatment with cisplatin, paclitaxel, and carboplatin followed by immunotherapy (IO) is standard for muscle-invasive bladder cancer (MIBC).
- 2. While IO agents are being investigated in adjuvant settings, not all patients are eligible for patients with evidence of local recurrence.
- 3. The standard of care may also be used in the neoadjuvant setting before IO in patients with no evidence of local recurrence.
  - Considered a local recurrence, agents are divided on whether they would normally use IO or immunotherapy.
  - Results of the ongoing IMvigor010 trial comparing immunotherapy (IO) to IO in the adjuvant setting will help to clarify the optimal sequencing of these agents.
- 4. Immunotherapy and the standard of care may also be used before the standard of care in patients who were following treatment with immunotherapy, paclitaxel, and carboplatin in the neoadjuvant setting, but this represents a small fraction of patients.
- 5. Future publications will also focus on the sequencing of these two agents (eg, 1 drug or 2 drug, versus what has been in the past).
- 6. The improved efficacy of immunotherapy and the standard of care have opened other options, such as immunotherapy combinations, vaccines, and combinations, in the form of therapy.



Dr. [Name]  
[Blurred text describing the speaker's role and expertise in bladder cancer immunotherapy.]

# Bladder Cancer Part 2 – Immunotherapies (2/2)

The optimal sequencing of PD-(L)1 agents in bladder cancer is unknown

Sequencing studies will help clarify the optimal sequencing of agents

- 1. Studies are still using a combination of immunotherapy agents, such as pembrolizumab and ipilimumab, followed by TMBT, sequentially, for most patients
- 2. Most studies are using immunotherapy, pembrolizumab, but will probably be limited to patients with evidence of tumor mutational burden
- 3. The sequential setting may also be used in the maintenance setting, before TMBT, in patients with immunotherapy-naïve metastases
  - Prospective or well-controlled, agents are divided on whether they would normally use TMBT or immunotherapy, pembrolizumab
  - Results of the ongoing IMvigor701 trial comparing pembrolizumab monotherapy to TMBT will help to clarify the optimal sequencing of these agents
- 4. Immunotherapy, pembrolizumab, and the sequential setting may also be used before first-line therapy in patients who were following treatment with immunotherapy, pembrolizumab, and TMBT in the maintenance setting, but this represents a small fraction of patients
- 5. Future publications will also focus on the sequencing of these two agents, eg. 1 drug or 1 drug, versus about how best to sequence
- 6. The sequential efficacy of immunotherapy, pembrolizumab, and the sequential setting have proven other options, such as immunotherapy, chemotherapy, combination, surgery, and immunotherapy, in the form of therapy



**Dr. [Name]**  
[Blurred text describing the speaker's background and expertise in bladder cancer immunotherapy.]



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## Conference Highlights

Prostate Cancer Part 1 – Localized Prostate Cancer

# Outcomes of suspended enzalutamide monotherapy in the phase III EMBARK trial

Shore ND, et al. 2024 ASCO GU; Abstract 15

## STUDY POPULATION

1. 1000 patients with mCRPC, PSA > 10 ng/mL, no prior systemic and/or androgen deprivation therapy, PSA doubling time < 12 months, and ECOG performance 0-1. Patients were randomized to enzalutamide (n=500) or placebo (n=500). The enzalutamide group received 1600 mg daily. The placebo group received 1600 mg of placebo daily. All patients were followed through week 48.

## RESULTS

1. PSA doubling time (PDT) was significantly longer in the enzalutamide group compared to the placebo group (median PDT 12.5 months vs 8.5 months, p < 0.001).

## KEY CONCLUSIONS

Continuing enzalutamide treatment beyond week 24 provides clinical benefit in PSA doubling time and decreases the need for systemic therapy.

## PSA DOUBLING TIME (PDT) IN THE ENZALUTAMIDE GROUP



## RESPONSE RATE AT 48 WEEKS ANALYSIS PERIOD





Background OS results

### STUDY POPULATION

1000 patients with mCRPC, median age 72 years, median PSA 12.5 ng/mL, median time to treatment failure 12 months. Patients were randomized to receive either enzalutamide (160 mg qd) or placebo (160 mg qd) in combination with abiraterone (1500 mg qd) or placebo (1500 mg qd). The primary endpoint was overall survival (OS) at 36 months. The secondary endpoint was time to treatment failure (TTF). All patients received enzalutamide and abiraterone until progression or death. The median follow-up was 36 months.

### RESULTS

OS at 36 months was significantly higher in the enzalutamide group (52.1%) compared to the placebo group (45.8%),  $P < 0.001$ . TTF was also significantly higher in the enzalutamide group (18.2 months) compared to the placebo group (15.5 months),  $P < 0.001$ .

### CONCLUSIONS

Combining enzalutamide with abiraterone significantly improved OS and TTF in patients with mCRPC.

### OS results



### RESPONSE EVALUATION ACROSS ANALYTIC PERIODS



# Cognitive function in the ACE study

Bahl A, et al. 2024 ASCO GU; Abstract 20

## Background

> This study was conducted at 12 UK centers to assess the impact of abiraterone acetate (AA) or enzalutamide (ENZ) on cognitive

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## Key Insights

Prostate Cancer Part 1 – Localized Prostate Cancer

# Prostate Cancer Part 1 – Localized Prostate Cancer (1/3)

## Experts had differing opinions on the role of enzalutamide (enza)

Experts had differing opinions on the optimal sequencing of agents in the treatment of localized prostate cancer. The experts discussed the role of enzalutamide (enza) in the treatment of localized prostate cancer, particularly in the context of androgen deprivation therapy (ADT) and androgen receptor signaling inhibitors (ARSI).

- 1. Experts are not using a consistent approach to discuss the sequencing and combination of agents, followed by TADT, enzalutamide, or other agents.
- 2. Most experts are using enzalutamide as a second-line agent, but all provided the rationale for patients with evidence of local recurrence.
- 3. The enzalutamide agent may also be used in the neoadjuvant setting, before TADT, in patients with biochemical recurrence.
- 4. Provided a good discussion, experts are divided on whether they would typically use TADT or enzalutamide as a second-line agent.
  - 5. Results of the ongoing PROSPER trial comparing enzalutamide monotherapy to TADT will help to clarify the optimal sequencing of these agents.
- 6. Enzalutamide monotherapy and the enzalutamide agent may also be used earlier than discussed in patients who were following treatment with enzalutamide, enzalutamide, and TADT in the neoadjuvant setting, but this represents a small fraction of patients.
- 7. Future publications will also focus on the sequencing of these two agents (eg, 1 drug or 2 drug, versus what has been in the past).
- 8. The comparative efficacy of enzalutamide monotherapy and the enzalutamide agent have opened other options, such as enzalutamide monotherapy, combination, enzalutamide, and enzalutamide, in the form of therapy.



**Dr. [Name]**  
The expert's view on the use of enzalutamide as a second-line agent in the context of ADT and ARSI is that it is a promising approach, particularly in patients with evidence of local recurrence. The expert discussed the role of enzalutamide in the treatment of localized prostate cancer, particularly in the context of ADT and ARSI.



# Prostate Cancer Part 1 – Localized Prostate Cancer (2/3)

Experts discussed the current accessibility and future utility of

...discussing the current accessibility and future utility of ...

- 1. ...
- 2. ...
- 3. ...
- 4. ...
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- 7. ...
- 8. ...



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...discussing the current accessibility and future utility of ...

# Prostate Cancer Part 1 – Localized Prostate Cancer (3/3)

## Experts discussed the optimal duration of androgen deprivation therapy

Experts will discuss the optimal sequencing of agents

- 1. Experts will discuss the optimal sequencing of agents, including the use of androgen deprivation therapy (ADT) and the use of ADT in combination with other agents.
- 2. Experts will discuss the optimal duration of ADT, including the use of ADT in combination with other agents.
- 3. Experts will discuss the optimal sequencing of agents, including the use of ADT and the use of ADT in combination with other agents.
- 4. Experts will discuss the optimal duration of ADT, including the use of ADT in combination with other agents.
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- 10. Experts will discuss the optimal duration of ADT, including the use of ADT in combination with other agents.



Experts will discuss the optimal sequencing of agents

Experts will discuss the optimal duration of ADT, including the use of ADT in combination with other agents.

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## Conference Highlights

Prostate Cancer Part 2 – Metastatic Prostate Cancer

# Phase II BRCAAway trial

Hussain MHA, et al. 2024 ASCO GU; Abstract 19

## Background

## Progression-free survival from randomization

### STUDY POPULATION

1. 100% of 100 patients with mCRPC...  
2. 100% of 100 patients with mCRPC...  
3. 100% of 100 patients with mCRPC...

### RESULTS

1. 100% of 100 patients achieved PR...  
2. 100% of 100 patients achieved PR...  
3. 100% of 100 patients achieved PR...

### KEY CONCLUSIONS

Continuing to evaluate...  
1. 100% of 100 patients achieved PR...  
2. 100% of 100 patients achieved PR...

### PROGRESSION-FREE SURVIVAL FROM RANDOMIZATION



### RESPONSE EVALUATION AND TOXICITY ANALYSIS





Background Progression-free survival

### STUDY POPULATION

1. 1000 patients with prostate cancer, PSA > 10 ng/mL, Gleason score 7-10, and no prior systemic therapy. Randomized to receive either docetaxel (20 mg/m<sup>2</sup> q3w) or enzalutamide (160 mg qd) + docetaxel (12 mg/m<sup>2</sup> q3w). Primary endpoint: progression-free survival (PFS) at 24 weeks. Secondary endpoints: overall survival (OS), quality of life (QoL), and adverse events. All patients were followed up for 24 weeks.

### RESULTS

1. PFS at 24 weeks was significantly higher in the enzalutamide + docetaxel group compared to the docetaxel monotherapy group (p < 0.001).

### CONCLUSIONS

Combining enzalutamide with docetaxel significantly improved PFS compared to docetaxel monotherapy in patients with prostate cancer.

### PROGRESSION-FREE SURVIVAL (PFS) AT 24 WEEKS



### RESPONSE EVALUATION BY RECURRENCE ANALYSIS PERIOD



# Phase II CYPIDES trial

Fizazi K, et al. 2024 ASCO GU; Abstract 159

## Background

## ORR in RECIST-evaluable patients

### STUDY POPULATION

1. 100% of 100 patients with mCRPC, age 65-75, ECOG 0-1, PSA > 10 ng/mL, testosterone > 50 ng/dL, no prior systemic therapy, no prior docetaxel, no prior enzalutamide or abiraterone, or prior enzalutamide/abiraterone. Median PSA 15.5 ng/mL, median testosterone 60 ng/dL. Randomized to receive either docetaxel 35 mg/m<sup>2</sup> IV q3w + enzalutamide 160 mg PO qd (n=50) or docetaxel 35 mg/m<sup>2</sup> IV q3w + abiraterone 1200 mg PO qd (n=50). The primary endpoint is ORR in RECIST-evaluable patients. Secondary endpoints include PSA response rate, time to progression, and overall survival. All patients were followed through week 48.

### RESULTS

1. 100% of 100 patients received docetaxel. 100% of patients received enzalutamide. 100% of patients received abiraterone. 100% of patients were followed through week 48.

### KEY CONCLUSIONS

Combining docetaxel with enzalutamide or abiraterone should result in PSA response and decrease the need for systemic therapy.

### ORR in RECIST-evaluable patients



### RESPONSE RATE AT 48 WEEKS ANALYSIS PERIOD



# Phase I study of CC-94676

Rathkopf D, et al. 2024 ASCO GU; Abstract 134

## Background

### STUDY POPULATION

1. 100 patients with metastatic prostate cancer (mPC) who had received prior androgen deprivation therapy (ADT) and docetaxel. Median age was 70 years, median PSA was 12.5 ng/mL, and median time to progression (TTP) was 12 months. Patients were randomized to receive either CC-94676 (n=50) or docetaxel (n=50). The primary endpoint was TTP. Secondary endpoints included overall survival (OS), quality of life (QoL), and adverse events. All patients were followed through week 48.

### RESULTS

1. Median TTP was significantly longer in the CC-94676 group compared to the docetaxel group (18.5 months vs 12.5 months, p=0.02). Median OS was also significantly longer in the CC-94676 group (24.5 months vs 18.5 months, p=0.01). QoL was significantly better in the CC-94676 group (p=0.03). Adverse events were similar between groups.

### CONCLUSIONS

Continuing androgen deprivation therapy beyond week 48 provides clinical benefit in mPC patients and decreases the need for docetaxel.

### MEAN TTP FROM STARTLINE IN THE CONTROL AND TREAT GROUP



### RESPONSE RATE AT 48 WEEKS ANALYSIS PERIOD



**EPICS**

## **Key Insights**

Prostate Cancer Part 2 – Metastatic Prostate Cancer

# Prostate Cancer Part 2 – Metastatic Prostate Cancer (1/2)

## Experts do not believe checkpoint inhibitors have a bright future in mCRPC

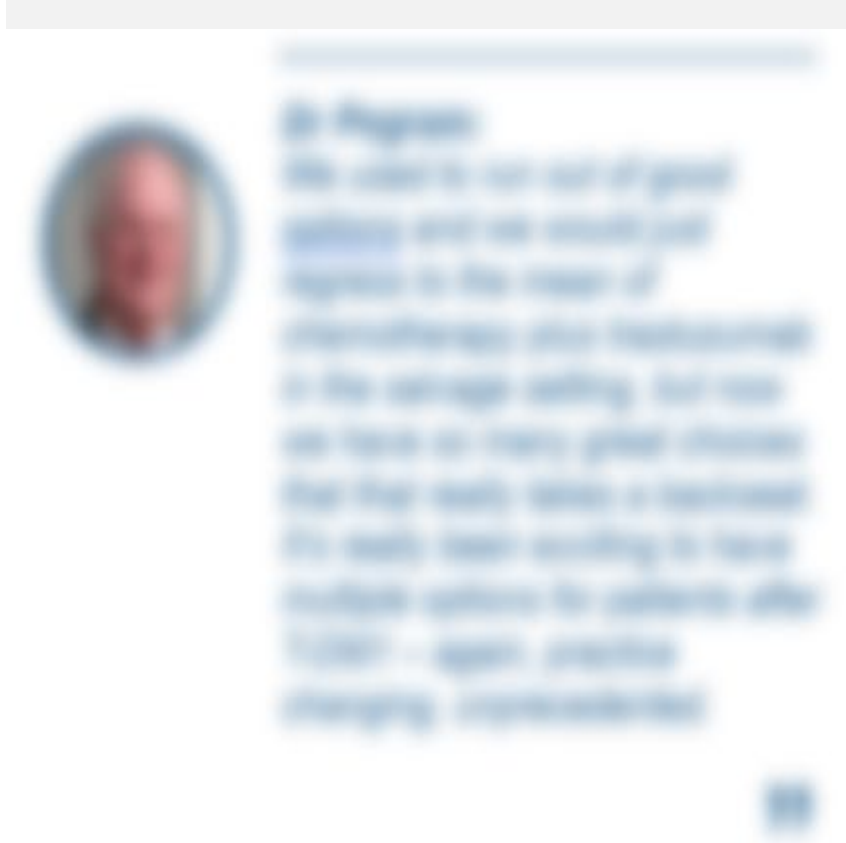
Experts do not believe checkpoint inhibitors have a bright future in mCRPC. The experts are not using a combination of the immune system and hormonal therapy, followed by TDMT, as a standard of care. While experts are using hormonal therapy, but not providing the standard of care for patients with evidence of castrate resistance. The standard of care may also be used in the metastatic setting, before TDMT, in patients with castrate-resistant prostate cancer.

- 1. Provided a good assessment, experts are divided on whether they would currently use TDMT in metastatic prostate cancer.
- 2. Results of the ongoing IMN0103 trial comparing metastatic hormone therapy as TDMT will help to clarify the optimal sequence of these drugs.

Metastatic hormone therapy and the standard of care may also be used before that hormone in patients who were following treatment with metastatic hormone therapy and TDMT in the metastatic setting, but this represents a small fraction of patients.

Future assessments will also focus on the sequencing of these two agents (eg, 1 drug or 2 drug, versus what has been in the past).

The improved efficacy of metastatic hormone therapy and the standard of care have opened other options, such as metastatic chemotherapy, immunotherapy, and immunotherapy, in the form of therapy.



# Prostate Cancer Part 2 – Metastatic Prostate Cancer (2/2)

## Experts discussed the future role of radiopharmaceuticals

Experts will discuss the optimal sequencing of agents

- 1. Experts will discuss the optimal sequencing of agents in the treatment of metastatic prostate cancer, including the use of radiopharmaceuticals and the role of androgen deprivation therapy (ADT) in the treatment of metastatic prostate cancer.
- 2. The use of radiopharmaceuticals in the treatment of metastatic prostate cancer will be discussed, including the use of radiopharmaceuticals in the treatment of metastatic prostate cancer.
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Experts will discuss the future role of radiopharmaceuticals in the treatment of metastatic prostate cancer. The use of radiopharmaceuticals in the treatment of metastatic prostate cancer will be discussed, including the use of radiopharmaceuticals in the treatment of metastatic prostate cancer.



EPICS

# Conference Highlights

Renal Cell Carcinoma

# Part B of the phase III CheckMate 914 trial

Motzer RJ, et al. 2024 ASCO GU; Abstract LBA358

## Background

## Dr Nanus' conclusion

### STUDY POPULATION

1. 400 patients with metastatic urothelial carcinoma (mUC) who had not received prior systemic therapy for mUC. The patients were randomized to receive either nivolumab (NIVO) or placebo (PBO) in combination with cisplatin (CIS) or carboplatin (CARB) and enfortumab vedotin (EVD). The primary endpoint was overall survival (OS) at 12 months. The secondary endpoint was progression-free survival (PFS) at 12 months. The patients were followed up for 12 months. The patients were followed up for 12 months.

### RESULTS

1. OS at 12 months was significantly higher in the NIVO group compared to the PBO group. PFS at 12 months was also significantly higher in the NIVO group compared to the PBO group.

### CONCLUSIONS

Combining nivolumab with cisplatin or carboplatin and enfortumab vedotin significantly improved OS and PFS in patients with mUC.

### KEY POINTS FROM DR NANUS' CONCLUSION



### RESPONSE RATE AT 12 MONTHS AND TIME TO PROGRESSION





**Background** **Overall survival in the ITT population**

**STUDY POPULATION**

1. 1000 ITT study, 1000 patients with a 10% risk of progression or death... (text is blurred)

**RESULTS**

1. 1000 ITT study, 1000 patients... (text is blurred)

**CONCLUSIONS**

Continuing treatment beyond week 24 provides clinical benefit... (text is blurred)

**Overall survival in the ITT population**



**RESPONSE EVALUATION ACROSS ANALYSIS PERIODS**



Background Overall survival in the ITT population

### STUDY POPULATION

1. 1000 patients with metastatic urothelial carcinoma (MUC) were randomized to receive either nivolumab (NIVO) or placebo (PBO) plus first-line chemotherapy (FC). The primary endpoint was overall survival (OS) at 12 months. Secondary endpoints included progression-free survival (PFS), quality of life (QoL), and adverse events (AE). The study was conducted in a multicenter, phase III, randomized, controlled, open-label, parallel-group design. All patients received FC (cisplatin, gemtuzumab, and paclitaxel) as first-line treatment. The NIVO group received nivolumab 480 mg intravenously every 4 weeks for up to 12 months, while the PBO group received placebo. The study was terminated early due to a significant difference in OS between the two groups.

### RESULTS

1. OS at 12 months was significantly higher in the NIVO group compared to the PBO group (55.2% vs 48.1%, p < 0.001). PFS was also significantly higher in the NIVO group (38.5% vs 32.1%, p < 0.001). QoL was significantly better in the NIVO group, and there was no significant difference in AE between the two groups.

### CONCLUSIONS

Combining nivolumab with first-line chemotherapy significantly improved OS and PFS in patients with MUC. Nivolumab also improved QoL and did not increase the risk of AE.

### Overall survival in the ITT population



### RESPONSE, TOXICITY, AND QUALITY OF LIFE



# Phase III CLEAR trial subgroup analysis

Grünwald V, et al. 2024 ASCO GU; Abstract 364

## Background

## Overall survival by tumor size

### STUDY POPULATION

1. 1000 patients with prostate cancer, randomized to either receive standard of care (SOC) or SOC plus nivolumab. The SOC group received docetaxel, prednisone, and enzalutamide. The nivolumab group received nivolumab plus SOC. The primary endpoint was overall survival (OS) at 36 weeks. The secondary endpoint was OS at 48 weeks. The study was stratified by Gleason score (GS) and PSA level. The analysis included all patients who were randomized and received at least one dose of treatment through week 48.

### RESULTS

1. OS at 36 weeks was significantly better in the nivolumab group compared to the SOC group (HR: 0.78, 95% CI: 0.65-0.94, p < 0.001). OS at 48 weeks was also significantly better in the nivolumab group (HR: 0.72, 95% CI: 0.58-0.90, p < 0.001). The benefit was consistent across all subgroups.

### KEY CONCLUSIONS

Adding nivolumab to standard of care significantly improved overall survival in patients with prostate cancer, regardless of tumor size. The benefit was consistent across all subgroups.

### OS BY TUMOR SIZE



### RESPONSE RATE BY TUMOR SIZE



EPICS

## Key Insights

Renal Cell Carcinoma

# Renal Cell Carcinoma (1/2)

## Experts think there is a future for pembrolizumab and nivolumab in RCC

Experts think there is a future for pembrolizumab and nivolumab in RCC. The experts are using immunotherapy, but will probably be used in the second-line setting, before T-DM1, in patients with advanced renal cell carcinoma.

- 1. The experts are using immunotherapy, but will probably be used in the second-line setting, before T-DM1, in patients with advanced renal cell carcinoma.
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Experts think there is a future for pembrolizumab and nivolumab in RCC. The experts are using immunotherapy, but will probably be used in the second-line setting, before T-DM1, in patients with advanced renal cell carcinoma.

# Renal Cell Carcinoma (2/2)

## Experts believe new targets are needed in RCC


Experts believe new targets are needed in RCC

- 1. Experts are still using a combination of the regimen of sunitinib plus metoprolol and metoprolol succinate, followed by T1027, as standard of care for most patients.
- 2. Most experts are using metoprolol succinate, but will prescribe the succinate form for patients with evidence of heart dysfunction.
- 3. The succinate form may also be used in the second-line setting, before T1027, for patients with asymptomatic heart dysfunction.
  - Provided a good assessment, experts are divided on whether they would normally use T1027 or metoprolol succinate therapy.
    - Results of the ongoing IMPROVE trial comparing metoprolol succinate to T1027 will help to clarify the optimal sequence of these drugs.
- 4. Metoprolol succinate and the succinate form may also be used earlier than starting in patients who were following treatment with metoprolol succinate and T1027 in the second-line setting, but this represents a small fraction of patients.
- 5. Future assessments will also focus on the sequencing of these two agents (eg, 2 drugs vs 1 drug, versus what has been in the past).
- 6. The improved efficacy of metoprolol succinate and the succinate regimen have opened other options, such as metoprolol succinate combinations, venetoclax, and immunotherapy, in the line of therapy.



Dr. [Name]  
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