



Bladder Cancer Video Series 2019

Muscle Invasive Bladder Cancer in the Elderly - Part 2

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Dr. Ramy Sedhom: Hi, my name is Ramy Sedhom and welcome to Cancer GRACE Bladder Cancer Series Webinar. The next question that we also wanted to highlight, Dr. Grievous had mentioned that one of the growing paradigms in the treatment of muscle invasive bladder cancer is the concept of neoadjuvant chemotherapy. And as a review for our patients, neoadjuvant therapy is one where someone gets chemotherapy before they get surgery. And so we had wanted to ask you in your clinic, what are some of the barriers to receiving neoadjuvant chemotherapy for an older adult population?

Dr. Elizabeth Kessler: Yeah, our clinic has a multidisciplinary approach to this. So we actually are really lucky to be able to meet with patients with all in one day, with providers from each of these specialties. So a radiation oncologist, a urologic surgical oncologist, and a medical oncologist like me, are able to meet somebody on the same day to kind of put together the care plan and the approach in that way. And it's nice because each of us have to consider these nuances about this person seems to be, you know, well enough to be able to get my chemotherapy, but radiation may be difficult because they don't have the ability to have transportation and independence on a daily basis. For example. So getting those multiple perspectives is important. From the neoadjuvant chemotherapy side, I would say generally we know that patients are oftentimes not offered or don't receive.

So, we're not sure about the offering part as much, but don't receive new adjuvant chemotherapy and one hypothesis or guess as to why that might occur is that they're not being referred to people to discuss the potential benefit or harms of having that treatment. Many times folks might say, well, I don't think this person would do well on that without necessarily going through that geriatric screen or assessment, where sometimes we identify that patients actually could get the same treatment as a 45 year old at the age of 75, you know. Or that we really don't have to adjust much in that way. So I'd say a lack of referral at times is a barrier and that the hope would be increasing the evidence to show the benefit of neoadjuvant therapy in older patients, as well as the safety would help the overall medical field potentially feel more comfortable with that.



And that data is starting to come out more and more where various expert centers are publishing on their own experience to say, look, of the patients that we've treated with neoadjuvant therapy that are in an older age group, they've still had a similar benefit in terms of cancer treatment outcomes, as well as good safety outcomes when the plan is put forth thoughtfully. The other aspect that I mentioned is this offer versus receive, and there may be parts of a patient's perspective that they choose not to undergo neoadjuvant chemotherapy. And that's a harder thing for us, I think to know right now from the data information we have, but another voice that we can consider and continue to learn from.

Dr. Ramy Sedhom: Wonderful. We think that's the value of these sorts of opportunities to share your expert opinion with patients so they can be better informed and knowledge is always power to share these conversations with their doctors. And I also just want to highlight, I think, one really important concept that you mentioned that both biases exist, both the under treatment and the overtreatment of older adults. So thank you for really highlighting that. The last thing that we really want to further explore with you have written extensively and you've worked a lot with leaders in the field of geriatric oncology, a space where we're truly understanding that the biology of cancer in older adults is unique. And in addition the considerations of how to treat and how to manage older adults is unique. Can you share with us what you're hopeful for, what you think the future an ideal future might look like when, considering how to push forward therapy for older adults?

Dr. Elizabeth Kessler: Yeah, yeah. We're hopeful for so many things. I think we can recognize that a ton of progress has been made in bladder cancer and bladder cancer treatment. And it's nice to also feel hopeful that we can continue to work on that. I think a few key areas would be looking to see how we can help the great number of people who cannot safely receive cisplatin chemotherapy, you know, to better understand, are there other medications, systemic therapies that could still offer a lot of control over the muscle invasive cancer, to still help enhance the effectiveness of surgical or radiology or radiation oncology treatments. But still, you know, not undergo the additional toxicity that's says platinum would include in those for the most part right now tend to be investigations into immunotherapies or immunotherapy combinations.

So, continuing to investigate the use of immunotherapy use around the operative setting, whether before or after, and then to also really understand what's happening in those tissues. So scientists, I think really need to take that opportunity to learn as much as possible from each individual patient and try to identify biomarkers or at least biologic assessments of what's happening in the tumor setting for patients that are on



this immunotherapy. You know, we have this opportunity to remove the area where the tumor used to sit and really be able to investigate that under the microscope because the surgery is already planned and should do our maximal efforts. You try to look at biomarkers there. The other aspect that I would say is just how we generally approach cancer research and clinical cancer research. We should continue to understand that the most patients, not just in bladder cancer, but in cancer in general fall into older age groups.

And making sure that our clinical trials and the data that we learn from those really applies to most of the patients that we see in clinic. You know, it's great to have very informative, well done, clinical research studies, where we can trust the rigor of that science. But if the science is not applicable to the people we're seeing in the clinic, it's sometimes harder to really understand how to adapt that. So making sure that the clinical trials have liberal criteria for who can participate, and the FDA has already recognized some of these barriers and just recently adjusted some of their guidance regarding eligibility criteria in cancer trials. So for one example would be this question of organ function or kidney function. There used to be very strict criteria on that. And it wasn't always due to a background of safety.

And so now the question would be, can we allow for the safety of the medication to really inform the kidney function criteria rather than just an arbitrary number, because we know that kidney function worsens as people get older, we know that if you've got a bladder tumor, that's blocking the drainage of urine, you might have already had some mild damage to the kidney, and yet would still be able to safely tolerate many of our substances and investigation. So liberalizing the eligibility criteria, as well as making these trials more pragmatic, meaning more real life, less burdensome on our, we definitely want to learn as much as we can, and we also want to make it so that not just folks that happen to live close to an academic center can participate. You know, we'd love to learn from people who are in more rural or underserved communities.

People who may not have as much medical literacy to understand complex protocol design, but maybe very willing to participate in a straightforward developed trial, and making these more adaptable to real life and more acceptable and accessible to patients. And then the other third kind of thing here would be to think through, are we measuring things that are certainly important in terms of slowing down the growth of cancer and improving our ability to cure and get rid of these tumors that invade into the muscle? But are we also measuring areas that are important to patients? So, you know, are the ways that we measure side effects or burden, really reflecting the experience of our patients, or are there other priorities that they'd like us to also measure and investigate?



Dr. Ramy Sedhom: Wonderful. And I think that last part is something dear to my heart as well. And I've learned from a lot of great oncologists like you to encourage patients, to make their voices heard and to go out and share with their doctors and their local leaders, how to better support their voice. So on that note are there any specific things you hear from patients or you recognize in your research circles that are important patient related metrics that are beginning to be considered in cancer clinical trials?

Dr. Elizabeth Kessler: Yeah. You know, I think that some of the metrics would be, for example, not just muscle invasive bladder cancer is a funny space, because the hope would be that we would do a really good job of being able to get rid of the cancer. Right. But in other times it's not always these measurements of longevity. It may be a measurement of, you know, how many times did I have to go into the hospital on this therapy? Or I might have not had a very serious side effect, but was it other, some to me over time, how long did it take for me to recover from the surgery or side effects? And then I'd say from an area that I'm very interested in is to make sure that the plan that was established at the outset, really lines up with the priorities and expectations of our patients. Right. So there's a lot of things that we can do or cannot do unfortunately in medicine.

But we really want to make sure that even though somebody could receive cisplatin, and could get new adjuvant chemotherapy and a cystectomy, that aligns with the other areas of importance to them and with the way that they've generally approached their life alignment. Yeah.

Dr. Ramy Sedhom: Yeah. So I think that is a wonderful way to really close this. And we'd really encourage patients to know that they have a voice and that doctors always want to know what your fears and your concerns are and what your values are. And we know from great researchers that oftentimes patients when they bring these things up, they're more likely to be discussed. So we do want to thank you so much for your time and your expertise, and most importantly, your dedication to improving the field.

Dr. Elizabeth Kessler: So, thank you so much. Thanks a bunch.