Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/project-oncology/advanced-urothelial-carcinoma-optimizing-second-line-care/67081/

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Advanced Urothelial Carcinoma: Optimizing Second-Line Care

Announcer:
This is *Project Oncology* on ReachMD. On this episode, Dr. Guru Sonpavde will be discussing second-line treatment options for advanced urothethial carcinoma. Dr. Sonpavde serves as the Medical Director of Genitourinary Oncology, Director of the Phase One Clinical Trial program and the GU Oncology Program, and the Christopher K. Glanz Chair for Bladder Cancer Research at AdventHealth Cancer Institute in Orlando. Let's hear from him now.

Dr. Sonpavde:
When the patient progresses on EV plus pembrolizumab, the de facto community standard has become platinum-based chemotherapy, gemcitabine platinum. Many of these patients might have neuropathy lingering from the EV, so usually gemcitabine carboplatin might be more frequently used in the clinic.

Obviously, performance status, the FGFR3 mutation status, and HER2 IHC status all might impact what you end up using in the second-line setting. In this context, if you have an FGFR3 mutation, erdafitinib would not have neuropathy. So that is something to consider as opposed to a cisplatin in that setting if someone has neuropathy lingering after the previous EV. For HER2 IHC3+, trastuzumab deruxtecan has a pan-tumor approval. This deruxtecan payload is not neurotoxic, so that might be advantageous in someone with neuropathy after EV pembrolizumab who has HER2 3+ disease.

Now, with organ function, if you have poor renal function after EV pembrolizumab, if you are cisplatin ineligible, that would preclude cisplatin. Carboplatin might still be feasible. Now, if you have retinal disease in the posterior eye, then erdafitinib could be a challenge because erdafitinib can have retinal toxicities.

And one of the other issues, of course, the key issue, is patient preference. Would the patient prefer an oral regimen like erdafitinib if there is an FGFR3 mutation as opposed to an intravenous regimen like gemcitabine platinum? So that's something the patients decide.

And one of the things to remember is that oligometastatic disease progression is something to also consider for metastasis-directed therapy with stereotactic body radiotherapy, which could be weaved into the strategy in addition to a change in systemic therapy.

Announcer:
You just heard Dr. Guru Sonpavde talking about second-line care for patients with advanced urothelial carcinoma. To access this and other episodes in our series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!