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Introduction

The Société Internationale d’Urologie (SIU) is committed to promoting medical education and sharing best practices toward improved urological care worldwide. With 10,000 members from 130 countries, the SIU continues to strengthen existing partnerships and form new relationships and collaborations with national societies and global organizations. SIU funds scholarships for young urologists, accredits training centres, equips and maintains centres in resource-constrained settings and holds an annual world congress. SIU’s many offerings include SIU Academy, an eLearning Portal that houses a rich library of educational urology content built around intuitive search-and-filter options.

SIU also offers Bench-to-Bedside (B2B) Programs as an engaging way for participants to learn about research breakthroughs and their translation to patient care. SIU conducts these programs in partnership with various organizations from various regions. The programs are available as one- or two-day meetings or as short course capsules on SIU Academy. These multidisciplinary programs bring together researchers, clinicians, and industry and foster understanding across specialties. Thus, B2B Programs offer not only educational opportunities, but also opportunities for participants to network with their colleagues.

SIU Uro-oncology: GU Cancers Triad Meeting

The SIU Uro-oncology: GU Cancers Triad Meeting offers an engaging way to review current clinical research advancements and their applications in uro-oncology. This meeting will comprise of an international high-profile faculty of experts in many fields. The multidisciplinary approach fosters an understanding across specialties. This series will focus on providing updates on the evolving trends in the early detection of disease, recent results of clinical trials, new therapies, biomarkers, and new technologies and strategies for the treatment of urological cancers, including new surgical techniques. The programme focuses on providing insights and sharing of knowledge and best practices aimed at guiding treatment decisions to improve patient outcomes. SIU partners with various organizations in various regions in organizing these meetings to provide updates on emerging clinical research advances in uro-oncology, and new approaches to patient care optimization. These meetings not only offer an educational opportunity, but also a way to network with colleagues, and acquire insights from the experts during the Q&A and panel sessions.
Scientific Programme Committee Bios

Peter Black, MD, FRCSC
Dr. Peter Black is a urologic oncologist at the Vancouver General Hospital, a research scientist at the Vancouver Prostate Centre, and Associate Professor in the Department of Urologic Sciences at the University of British Columbia (UBC). He received his undergraduate degree from the UBC and his medical degree from Johannes Gutenberg University in Mainz, Germany. He completed his urologic training at the University of Washington in Seattle and his fellowship in urologic oncology at M.D. Anderson Cancer Center in Houston, Texas.

Dr. Black has a clinical subspecialty interest in bladder cancer and also a translational research program in urothelial carcinoma with a focus on mechanisms of resistance to chemotherapy and immunotherapy, and novel targeted therapies for bladder cancer. He is Study Chair of a North American co-operative group trial (S1605) investigating the efficacy of immune checkpoint blockade in patients with BCG-unresponsive non-muscle invasive bladder cancer.

Dr. Black was a member of the Board of Directors of the Société Internationale d’Urologie and is General Secretary of the International Bladder Cancer Network. He was also Co-chair of the Joint SIU-ICUD Consultation on Bladder Cancer, which was held on October 19, 2017 and was co-editor of the publication for this consultation. Dr. Black has also been appointed as Editor-in-Chief of the upcoming SIU Journal (SIUJ), SIU’s own publication, which is set to launch in early 2021.

Christopher P. Evans, MD, FACS
Dr. Evans is professor and chairman of the Department of Urologic Surgery at the University of California, Davis School of Medicine and a member of the UC Davis Cancer Center. Dr. Evans attended Dartmouth Medical School on a Health Professional Services Program scholarship and he served on active duty in the United States Army, including two years as Chief of Experimental Surgery at the Walter Reed Army Institute of Research. He completed surgery and urology training at the University of California, San Francisco where he was also a National Kidney Foundation Scholar. Dr. Evans completed fellowship training in urologic oncology at the University of Texas, M.D. Anderson Cancer Center. He came to UC Davis in 1997 at which time he was also Director of Urology Research. In 2006, Dr. Evans became Department Chairman, and in 2010 he became Chairman of the UC Davis Medical Group Practice Management Board. Dr. Evans’ practice is dedicated to the management of patients with urologic malignancies. He works with medical oncologists and radiation oncologists to provide multimodal approaches to cancer therapy.

Dr. Evans’ research laboratory focuses on prostate cancer; specifically, mechanisms signaling the androgen receptor to activate prostate cancer growth and progression following castration and mechanisms of drug resistance. His laboratory has developed models to study this and has
identified novel mechanisms that activate the androgen receptor. His laboratory work has
tested new agents and brought them from bench studies to animal models to clinical trials.

Dr. Evans is the immediate Past-President of the Society of Urologic Oncology and is Past Chair
of the ASCO-GU Steering Committee. He is also an elected member of the American Association
of Genitourinary Surgeons. His research laboratory has received funding from the National
Institutes of Health, Department of Defense, New York Academy of Medicine, Prostate Cancer
Foundation, Stand-Up To Cancer and the American Cancer Society. He has published over 170
peer-reviewed articles. He is Co-chair of the Scientific Programme of the Société Internationale
d’Urologie.

**Peter Hammerer, MD**

Peter Hammerer is Professor and Chairman of the Department of Urology and Uro-Oncology at
the Academic Hospital Klinikum Braunschweig, Germany, which is one of the largest hospitals in
Germany. His clinical and research focus is on prostate, kidney and bladder cancer and he is
involved in many clinical Phase II and Phase III trials in uro-oncology.

After completing residency training at University of Hamburg and Berlin, he was research fellow
in the Department of Urology at Stanford University, California.

When he returned to the University of Hamburg, UKE, he joined the Faculty and became Vice-
Chairman in 2001. In 2003 he was elected as Chairman at the Academic Hospital Braunschweig.

Dr. Hammerer has been actively involved in the leadership of many organizations and societies.
He was a member of the Board of Directors of the Société Internationale d’Urologie (SIU). He
was President of the European Society of Oncological Urology (ESOU) and of the German
Nordkongress. He was board member of the European School of Urology (ESU) and is member
of the German Cancer Group (AUO).

As an internationally renowned expert in urological cancer diseases, Dr. Hammerer specialises
particularly in the diagnosis and treatment of prostatic tumours, bladder tumours, renal pelvis
tumours and renal cell carcinomas. In addition, Dr. Hammerer also treats benign diseases of the
genitourinary tract such as incontinence, benign enlargement of the prostate (BPH) and renal
calculi.

He was former Section Editor of the European Urology and is an *ad hoc* reviewer for many peer-
reviewed journals.
Simon Tanguay, MD, FRCSC

Dr. Tanguay completed his residency training at McGill University in 1992 and his fellowship in urologic oncology at the University of Texas M. D. Anderson Cancer Center in 1995. He is currently Professor and Chairman of the Division of Urology at McGill University and the M. Elhilali and D. Azrieli Chair in urologic sciences.

Dr. Tanguay was actively involved in the Quebec Urological Association where he served as president of the Continuing Medical Education committee from 2001 to 2004 and served as treasurer of this association. He was Co-Director of the clinical research unit within the Division of Urology at McGill University.

Dr. Tanguay served as member of the executive committee of the Genito-Urinary group at the National Cancer Institute of Canada and as the Chair of the Canadian Kidney Cancer Information System from 2009 to 2016. He was the General Secretary of the Société Internationale d’Urologie from 2011 to 2016 and now serves as Past-President of the SIU.

Programme Rationale

Background

The treatment of genitourinary (GU) malignancies has dramatically evolved over recent years. Urothelial carcinoma of the bladder, renal cell carcinoma and prostate adenocarcinoma are the most commonly encountered GU malignancies and represent a heterogeneous population of cancer, in both physiology and approach to treatment. All three of these cancers have undergone paradigm shifts in their respective treatment landscapes as a result of our enhanced understanding of their underlying mechanisms and oncogenic drivers.¹

Bladder Cancer

The paradigm for management of BCa, particularly advanced or metastatic BCa, has shifted substantially with the identification of immune checkpoint molecules whose overexpression help tumors escape immune response.²³ Since 2017, several landmark trials have led to the approval of novel agents, immune checkpoint inhibitors (CPIs), as first-line treatment for patients with metastases who are not candidates for platinum-based therapy or who have progression of disease after platinum therapy.⁴⁻⁶ Five CPIs (atezolizumab, pembrolizumab, nivolumab, durvalumab, and avelumab) have been approved by the U.S. Food and Drug Administration (FDA) for second-line treatment of platinum-refractory, advanced, or metastatic bladder cancer.¹²³ Two of these, atezolizumab and pembrolizumab, have been approved for cisplatin-ineligible patients,⁷ and they have been approved in Korea³ and in Europe. Other immune checkpoint inhibitors, such as tislelizumab and toripalimab, are under investigation in patients with metastatic BCa and have shown promising results.⁸⁻⁹ Recent studies have reported promising results for immune checkpoint inhibitor-based combinations as treatment for high-
risk non-muscle-invasive BCa (NMIBC),\textsuperscript{10,11} in the neoadjuvant setting,\textsuperscript{12-14} as switch maintenance therapy,\textsuperscript{15} and as salvage therapy.\textsuperscript{16}

Other targeted therapies are also making their way into the treatment landscape for advanced or metastatic bladder cancer. The fibroblast growth factor (FGF) pathway is yet another well-elucidated tyrosine kinase (TK) signaling pathway implicated in tumorigenesis and has a high mutational expression rate in urothelial cancer.\textsuperscript{17} A multitude of other trials investigating anti-FGF therapies in metastatic UC are currently in progress. These include infgratinib (BGI398), a potent and selective FGFR1-3 inhibitor with significant activity in patients with advanced or metastatic urothelial carcinoma (mUC),\textsuperscript{18} the BISCAY trial (NCT02546661) of durvalumab in combination with a potent and selective novel FGFR inhibitor, AZD4547, vofatamab (B-701), a novel FGFR3 inhibitor and is being studied in combination with pembrolizumab in the FIERCE-22 international phase I/II trial in mUC (NCT03123055), and rogaratinib, a novel pan-FGFR inhibitor being trialed in various solid tumours, including mUC in the FORT-2 trial as combination therapy with atezolizumab.\textsuperscript{19} The FDA has approved erdafitinib for patients with locally advanced or metastatic BCa that has FGFR2 or FGFR3 genetic alterations and has progressed during or after platinum-based chemotherapy.\textsuperscript{20,21}

The intravesical, gene-mediated therapy nadofaragene firadenovec and the nectin-4-targeting antibody drug conjugate enfortumab vedotin are under investigation in phase II trials for NMIBC and metastatic BCa, respectively.\textsuperscript{22,23}

Management of patients with cacillus Calmette-Guérin (BCG)-unresponsive, high-risk, non-muscle-invasive bladder cancer (NMIBC) presents a major challenge for urologists as they try to balance the risks of progression during further intravesical therapy, versus the morbidity of the current standard of care, radical cystectomy. Advances in this therapeutic space has been hampered due to inconsistencies in the definitions of BCG failure and difficulties in choosing the appropriate control treatments in clinical trials.\textsuperscript{24} Yet, despite these limitations, the spectrum of salvage therapy is now evolving to include improved intravesical chemo-, gene and immune-therapies.

Most recently, the FDA approved pembrolizumab for the treatment of patients with BCG-unresponsive, high-risk, non-muscle-invasive bladder cancer with carcinoma in situ with or without papillary tumors who are ineligible for or have elected not to undergo cystectomy. This was based on KEYNOTE-057,\textsuperscript{25} a single-arm study of 148 patients with high-risk non–muscle-invasive bladder cancer, 96 of whom had BCG-unresponsive carcinoma in situ with or without papillary tumors. In this study, the complete response rate was 41% and the median response duration was 16.2 months, with 24% of patients overall experiencing a complete response lasting at least 12 months.\textsuperscript{25}

Nadofaragene firadenovec (rAd-IFN/Syn3) is a replication-deficient recombinant adenovirus gene transfer vector. A multicenter, open-label Phase 3 study investigated nadofaragene firadenovac (rAd-IFN/Syn3) in the same patient population as the KEYNOTE-057 study: high-grade NMIBC (CIS $\pm$ Ta/T1, or Ta/T1 alone) unresponsive to BCG. The primary endpoint was
complete response (CR) at any time in patients with carcinoma in situ (CIS). Nadofaragene achieved CR in 53.4% of pts with BCG-unresponsive CIS and was well tolerated. Responses were noted early and remained durable to one year. These data represent a potentially significant management advancement for a historically difficult to treat disease state.22

Results from the EV-103 a phase Ib/II clinical trials of enfortumab vedotin in combination with pembrolizumab showed that the drug combination shrank tumours in the majority of bladder cancer patients.23 Enfortumab vedotin is a first-in-class antibody drug conjugate that is directed against Nectin-4, a protein located on the surface of cells and is highly expressed in bladder cancer.26 The drug was approved by the U.S. Food and Drug Administration (FDA) in December 2019 and is indicated for the treatment of adult patients with locally advanced metastatic urothelial cancer who have previously received a programmed death receptor (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and a platinum-containing chemotherapy before (neoadjuvant) or after (adjuvant) surgery or in a locally advanced or metastatic setting.27 Enfortumab vedotin was approved under the FDA’s Accelerated Approval Program based on the tumor response rate. Continued approval may be contingent upon verification and description of clinical benefit in confirmatory trials.27

Another antibody-drug conjugate, sacituzumab govitecan, has been found to be active in patients previously treated with chemotherapy or CPI therapy for mUC. The results came from a phase I/II basket study of this agent which were presented at the 2019 Genitourinary Cancers Symposium.28 In addition to these, a myriad of other promising emerging treatment options are underway. (Table 1).1
Table 1: Emerging targets with clinical significance in urothelial carcinoma

<table>
<thead>
<tr>
<th>Molecular target</th>
<th>Class</th>
<th>Trial</th>
<th>Disease setting</th>
<th>Agent</th>
<th>Experimental treatment</th>
<th>Study phase</th>
<th>Estimated completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD-1/PD-L1</td>
<td>CPI</td>
<td>NCT02807636 (IMvigor130)</td>
<td>Untreated mUC</td>
<td>Atezolizumab</td>
<td>Atezolizumab + (Carboplatin) (Gemcitabine) (Cisplatin)</td>
<td>Phase III</td>
<td>November 2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NCT02853305 (Keynote-361)</td>
<td>Untreated mUC</td>
<td>Pembrolizumab</td>
<td>Pembrolizumab + (Cisplatin) (Carboplatin) (Gemcitabine)</td>
<td>Phase III</td>
<td>May 2020</td>
</tr>
<tr>
<td>CTLA-4</td>
<td>Cytokine</td>
<td>NCT02516241 (DANUBE)</td>
<td>Untreated mUC</td>
<td>Tremelimumab</td>
<td>Durvalumab + tremelimumab or durvalumab monotherapy</td>
<td>Phase III</td>
<td>September 2019</td>
</tr>
<tr>
<td>CD122</td>
<td>Modulation</td>
<td>NCT02983045 (Pivot-2)</td>
<td>Advanced tumors (mUC)</td>
<td>NKTR-214</td>
<td>NKTR-214 + nivolumab or NKTR-214 + nivolumab + ipilimumab</td>
<td>Phase I/II</td>
<td>June 2021</td>
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<tr>
<td></td>
<td></td>
<td>NCT03785925 (Pivot-10)</td>
<td>Cisplatin-ineligible, mUC</td>
<td>NKTR-214</td>
<td>NKTR-214 + nivolumab</td>
<td>Phase III</td>
<td>May 2022</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NCT03138889 (PROPEL)</td>
<td>Advanced tumors (mUC)</td>
<td>NKTR-214</td>
<td>NKTR-214 + pembrolizum or NKTR-214 + atezolizumab</td>
<td>Phase I</td>
<td>May 2020</td>
</tr>
<tr>
<td>IL-7</td>
<td></td>
<td>NCT03513952</td>
<td>Advanced, inoperable or mUC</td>
<td>CYT107</td>
<td>CYT107 + atezolizumab</td>
<td>Phase I</td>
<td>December 2020</td>
</tr>
<tr>
<td>TGFβ + PD-1</td>
<td></td>
<td>NCT02517398</td>
<td>Advanced tumors (mUC)</td>
<td>MS00011359C (M7824)</td>
<td>MS00011359C (M7824)</td>
<td>Phase I</td>
<td>August 2020</td>
</tr>
<tr>
<td>CD137/4-1BB</td>
<td></td>
<td>NCT02845323</td>
<td>Cisplatin-ineligible MIBC</td>
<td>Urelumab</td>
<td>Urelumab + nivolumab or nivolumab monotherapy</td>
<td>Phase II</td>
<td>January 2020</td>
</tr>
<tr>
<td>OX40</td>
<td></td>
<td>NCT02554812 (JAVELIN Medley)</td>
<td>Advanced tumors (mUC)</td>
<td>PF-04518600</td>
<td>Avelumab UtomilumabPF-04518600 PD 0360324</td>
<td>Phase II</td>
<td>December 2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NCT03217747</td>
<td>Advanced tumors (UC)</td>
<td>PF-04518600</td>
<td>Avelumab UtomilumabPF-04518600 Radiation Cisplatin</td>
<td>Phase I/II</td>
<td>August 2023</td>
</tr>
<tr>
<td>IDO</td>
<td>T Cell</td>
<td>NCT03361865 (Keynote-672)</td>
<td>Cisplatin-ineligible UC</td>
<td>Epacadostat</td>
<td>Epacadostat + pembrolizum</td>
<td>Phase III</td>
<td>September 2020</td>
</tr>
<tr>
<td>Metabolism</td>
<td></td>
<td>(Keynote-698) (ECH0307)</td>
<td></td>
<td>Epacadostat</td>
<td>Epacadostat + pembrolizum</td>
<td>Phase III</td>
<td>August 2020</td>
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<tr>
<td>VEGF</td>
<td>TKI</td>
<td>NCT03133390</td>
<td>Cisplatin-ineligible mUC</td>
<td>Bevacizumab</td>
<td>Bevacizumab + atezolizum</td>
<td>Phase II</td>
<td>January 2020</td>
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<tr>
<td></td>
<td></td>
<td>NCT03272217</td>
<td>Cisplatin-ineligible mUC</td>
<td>Bevacizumab</td>
<td>Bevacizumab + atezolizum</td>
<td>Phase II</td>
<td>April 2021</td>
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<tr>
<td>cMET/VEGF</td>
<td></td>
<td>NCT02717156</td>
<td>Untreated mUC</td>
<td>EphB4-HSA</td>
<td>EphB4-HAS + pembrolizum</td>
<td>Phase II</td>
<td>November 2020</td>
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<tr>
<td></td>
<td></td>
<td>NCT03534804 (PemCab)</td>
<td>Cisplatin-ineligible mUC</td>
<td>Cabozantinib</td>
<td>Cabozantinib + pembrolizum</td>
<td>Phase II</td>
<td>September 2023</td>
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<tr>
<td>FGFR</td>
<td></td>
<td>NCT03170960</td>
<td>Advanced tumors (UC)</td>
<td>Cabozantinib</td>
<td>Cabozantinib + atezolizum</td>
<td>Phase I/II</td>
<td>December 2020</td>
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<tr>
<td></td>
<td></td>
<td>NCT02546661 (BISCAY)</td>
<td>Previously-treated MIBC</td>
<td>AZD4547</td>
<td>AZD4547 MEDI4736 Olaparib AZD1775 Vistusertib AZD9150 Selumetinib</td>
<td>Phase Ib</td>
<td>March 2020</td>
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<tr>
<td></td>
<td></td>
<td>NCT03123055 (FIERCE-22)</td>
<td>mUC</td>
<td>Vofatamab</td>
<td>Vofatamab + pembrolizum</td>
<td>Phase I/II</td>
<td>September 2022</td>
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<td></td>
<td></td>
<td>NCT03473756 (FORT-2)</td>
<td>FGFR-positive mUC</td>
<td>Rogaratinib</td>
<td>Rogaratinib + atezolizum</td>
<td>Phase Ib/II</td>
<td>July 2022</td>
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<tr>
<td>Nectin-4</td>
<td>ADC</td>
<td>NCT03288545 (EV-103)</td>
<td>mUC</td>
<td>Enfortumab Vedotin</td>
<td>Enfortumab vedotin + pembrolizum</td>
<td>Phase I</td>
<td>September 2024</td>
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<tr>
<td></td>
<td></td>
<td>NCT03219333 (EV-201)</td>
<td>mUC previously-treated with CPI</td>
<td>Enfortumab Vedotin</td>
<td>Enfortumab vedotin</td>
<td>Phase II</td>
<td>May 2025</td>
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<td></td>
<td></td>
<td>NCT02091999</td>
<td>Nectin-4-positive mUC</td>
<td>Enfortumab Vedotin</td>
<td>Enfortumab vedotin</td>
<td>Phase I</td>
<td>December 2020</td>
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<tr>
<td></td>
<td></td>
<td>NCT03474107 (EV-301)</td>
<td>Previously-treated mUC</td>
<td>Enfortumab Vedotin</td>
<td>Enfortumab vedotin</td>
<td>Phase III</td>
<td>September 2021</td>
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<td>HER-2</td>
<td></td>
<td>NCT03523572</td>
<td>mUC</td>
<td>Trastuzumab</td>
<td>Trastuzumab (DS-8201a)</td>
<td>Phase I/II</td>
<td>September 2020</td>
</tr>
</tbody>
</table>

ADC, antibody drug conjugate; CPI, checkpoint inhibitor; FGFR, fibroblast growth factor receptor; HER-2, human epidermal growth factor receptor; IDO, Indoleamine-2,3-dioxygenase; IL-7, interleukin 7; UC, urothelial carcinoma; TGF β, transforming growth factor beta; TKI, tyrosine kinase inhibitor; VEGF, Vascular endothelial growth factor

All trial information can be obtained through the publicly accessible ClinicalTrials.gov
Kidney Cancer

The management of metastatic renal cell cancer has evolved substantially over the last 20 years. The development of targeted therapies such as VEGF pathway inhibitors, mTOR inhibitors, and more recently, immune checkpoint inhibitors has led to a change in the treatment paradigm for RCC. EAU, ESMO, and the National Comprehensive Cancer Network (NCCN©) are consistent in recommending immunotherapy or anti-VEGF therapy as first-line therapy for metastatic RCC (mRCC), although there are some differences in recommended agents for good-risk mRCC. Current FDA-approved first-line agents are the TKI monotherapy with axitinib, cabozantinib, pazopanib, and sunitinib; combination CPI therapy with nivolumab and ipilimumab, pembrolizumab, and avelumab; combination TKI-CPI with axitinib and avelumab; mTOR inhibition with temsirolimus; and cytokine therapy with HDIL-2. The optimal sequencing of therapies has been heavily debated with few consensus guidelines in the literature. Updated NCCN guidelines recommend axitinib and pembrolizumab, pazopanib, or sunitinib as preferred first-line agents in favorable risk patients. The recommendation further includes ipilimumab and nivolumab, axitinib and pembrolizumab, or cabozantinib monotherapy for poor/intermediate risk patients. Second-line therapy may employ monotherapy with nivolumab, axitinib, pazopanib, sunitinib, cabozantinib, sorafenib, HDIL-2, everolimus, temsirolimus, or bevacizumab or combination therapy with ipilimumab and nivolumab, lenvatinib and everolimus, axitinib and pembrolizumab, or axitinib and avelumab.

Studies of systemic therapy in the adjuvant or neoadjuvant setting have focused primarily on the VEGF pathway, and sunitinib has been approved and is now recommended in the United States as adjuvant therapy for clear-cell RCC. However, ongoing studies are assessing immune checkpoint inhibitors, TKIs, and fusion proteins in both the adjuvant and neoadjuvant settings.

Combination therapies, which can aid in overcoming the limitations of monotherapy, represent the next wave of treatment for mRCC. Options for first-line treatment have expanded with recent FDA approvals of regimens combining anti-VEGF agents and immune checkpoint inhibitors, based on pivotal phase III trials that showed that these combinations significantly improve overall and/or progression-free survival. Studies of other immune checkpoint inhibitor/anti-VEGF agent combinations have recently reported longer progression-free survival compared with sunitinib. Options are also emerging for the second-line setting and beyond. Studies of immune checkpoint inhibitors or anti-VEGF agents combined with mTOR inhibitors have reported objective response rates of 23% to 27% in the second-line setting. Several other combinations are in clinical trials for advanced or metastatic RCC. A number of active clinical trials are examining agents for future use in mRCC which will likely further expand the list of FDA-approved drugs for this disease. (Table 2)

Although the prognosis for kidney cancer has significantly improved as a result of these rapid developments, treatment remains challenging. In most cases, RCC is primarily refractory or nonresponsive, or it becomes refractory after initially responding to therapy, and long-term survival is only achieved in about 20% of cases. With the expanded therapeutic options,
including immune checkpoint inhibitors, novel targeted agents, and combination strategies, that are available for RCC, optimal patient selection and treatment sequencing become increasingly important to optimize outcomes.\textsuperscript{40} Whereas in previous years, the clinicians were challenged with a lack of therapies and overwhelming toxicities, the current RCC landscape now offers an abundance of therapeutic options with complex data supporting them.\textsuperscript{1,41,42} It is therefore more important than ever to provide a platform for urologists who treat patients with GU malignancies to participate in continuing medical education to update their knowledge and apply this knowledge in their clinical practice.
## Table 2: Emerging Targets: Ongoing Clinical Trials in RCC

<table>
<thead>
<tr>
<th>Molecular target</th>
<th>Class</th>
<th>Trial ID</th>
<th>Disease setting</th>
<th>Agent</th>
<th>Experimental treatment</th>
<th>Study phase</th>
<th>Estimated completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEGF</td>
<td>TKI</td>
<td>NCT01253668</td>
<td>Previously-treated mRCC</td>
<td>Brivanib</td>
<td>Phase II</td>
<td>Completed*</td>
<td></td>
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<td>TGFβ</td>
<td></td>
<td>NCT01806064</td>
<td>Previously-treated mRCC</td>
<td>Endoglin</td>
<td>Phase I/II</td>
<td>June 2019</td>
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<tr>
<td>cMET</td>
<td></td>
<td>NCT02761057 (PAPMET)</td>
<td>Papillary mRCC</td>
<td>Cabozantinib</td>
<td>Phase II</td>
<td>January 2021</td>
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<td></td>
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<td>NCT03091192</td>
<td>MET-driven papillary mRCC</td>
<td>Savolitinib</td>
<td>Phase III</td>
<td>August 2019</td>
<td></td>
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<td>CCR4</td>
<td>Cytokine modulator</td>
<td>NCT022281809</td>
<td>Advanced tumors (mRCC)</td>
<td>Mogamulizumab</td>
<td>Phase I/II</td>
<td>October 2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NCT02946671</td>
<td>Pre-operative advanced tumors (mRCC)</td>
<td>Mogamulizumab</td>
<td>Phase III</td>
<td>March 2020</td>
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<td>HIF2-α</td>
<td>Small-molecule inhibitor</td>
<td>NCT02293980</td>
<td>Previously-treated mRCC</td>
<td>PT2385</td>
<td>Phase I</td>
<td>August 2020</td>
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<td>VHL disease-associated ccRCC</td>
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<td>September 2022</td>
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<td>PD-L1</td>
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<td>NCT02420821 (IMmotion-151)</td>
<td>Previously-untreated mRCC</td>
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<tr>
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<td></td>
<td>NCT02811861 (Keynote-S81/CLEAR)</td>
<td>Previously-untreated mRCC</td>
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<td></td>
<td>NCT03141177 (CheckMate 9ER)</td>
<td>Previously-untreated mRCC</td>
<td>Nivolumab</td>
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<td>April 2023</td>
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<td></td>
<td></td>
<td>NCT03149822</td>
<td>mRCC</td>
<td>Pembrolizumab</td>
<td>Phase I/II</td>
<td>June 2020</td>
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<td>CTLA-4</td>
<td></td>
<td>NCT02762006</td>
<td>Previously-untreated localized RCC</td>
<td>Neoadjuvant tremelimumab</td>
<td>Phase I</td>
<td>April 2019**</td>
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<td></td>
<td></td>
<td>NCT02626130</td>
<td>Previously-treated mRCC</td>
<td>Tremelimumab</td>
<td>Pilot study</td>
<td>March 2022</td>
<td></td>
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<tr>
<td>Autologous DCs</td>
<td>Tumor vaccine</td>
<td>NCT02432846 (MERECA)</td>
<td>mRCC</td>
<td>Intuvax</td>
<td>Phase II</td>
<td>August 2019</td>
<td></td>
</tr>
</tbody>
</table>

All trial information obtained through publicly accessible ClinicalTrials.gov

*Announcement of study results pending. **Remains active
Prostate Cancer
Androgen-deprivation therapy (ADT) remains the backbone of treatment for men with advanced or metastatic prostate cancer (PCa). However, as with BCa and RCC, the treatment landscape for advanced or metastatic PCas is evolving. Phase III studies have shown that second-generation antiandrogens improve overall survival, compared with nonsteroidal antiandrogens, among men with metastatic, castration-sensitive PCas. The paradigm for nonmetastatic, castration-resistant PCAs has changed with the FDA approvals of ADT combined with the second-generation antiandrogens apalutamide, enzalutamide, and darolutamide, based on a phase III pivotal trials showing improvements in a new clinical endpoint, metastasis-free survival. The combination of PSMA-targeted imaging and therapy has a promising future and will likely contribute to personalized medicine. Immune checkpoint inhibitors and PARP inhibitors are under investigation as monotherapy or in combination with other systemic agents for metastatic castration-resistant PCAs (mCRPC).

Most recently, pembrolizumab has joined many other treatment combinations to further test its efficacy. KEYNOTE-365 is an open-label phase Ib/II umbrella trial evaluating four different treatment combinations, cohort A: pembrolizumab plus olaparib, cohort B: pembrolizumab plus docetaxel plus prednisone, cohort C: pembrolizumab plus enzalutamide (NCT02861573). Preliminary results were recently presented only for cohort A, pembrolizumab plus olaparib. Olaparib belongs to a family of poly-ADP ribose polymerase (PARP) inhibitors. PARP is a family of enzymes, activated by DNA damage, facilitating DNA repair via single-stranded break and base excision repair pathways. More specifically, PARP binds to single-strand DNA damage via its zinc-finger DNA-binding domain and recruits proteins involved in DNA repair via auto-poly(ADP-ribosyl)ation. This becomes a critical component for cancer cell survival. PCas with DNA repair gene alterations have been found to be sensitive to PARP inhibitors. The PARP suppression in mCRPC first assessed in the TOPARP-A trial was significant for high response rates (88%) in patients with DNA repair gene deficits. In an ongoing phase II trial, patients previously treated with docetaxel demonstrated a prolonged radiologic progression-free survival of 13.8 months with olaparib plus abiraterone versus only 8.2 months in the abiraterone monotherapy group. An interesting result from this trial indicated that even patients without homologous recombination repair also benefited from the combination therapy. Of note, there were more reports of treatment-related AEs in the combination group compared to the control group. To build on the promising survival data, a phase III trial has commenced evaluating olaparib with abiraterone, but now as a first-line treatment for mCRPC (NCT03732820).

Yu and colleagues presented their results on the various treatment combinations with olaparib in 41 men in cohort A of the KEYNOTE-365 trial. These men were previously treated with second-generation hormonal therapy, chemotherapy, and docetaxel. Of the 28 patients with RECIST-measurable disease, 39% experienced a reduction in tumor burden. The ORR for the RECIST-measurable group was 7%. Overall, results showed a median OS of 13.5 months, PFS of 4.7 months, and PSA response of 12%. Yu and colleagues are expanding the current study
into a phase III trial, KEYLYNK-010, and will now be including patients who have also been previously treated with abiraterone and enzalutamide (NCT03834519).

In the second-line setting, Agarwal and colleagues evaluated the combination of cabozantinib and atezolizumab in patients with metastatic castration-resistant PCa (mCRPC) in the COSMIC-021 trial. Their results indicated that these two drugs had a tolerable safety profile and demonstrated a clinically meaningful activity with durable responses in men with mCRPC. This phase Ib study shows promise for cabozantinib combined with atezolizumab. Further evaluation of this combination in men with mCRPC is in progress.

Although recent advances in immunotherapy have revolutionized the management of various solid and liquid malignancies, there has been minimal benefits seen in prostate cancer. Sipuleucel-T is the first FDA-approved immunotherapy for prostate cancer, and none have been approved since. The two primary immune targeting approaches in ongoing PC research include antigen-targeted immunotherapy (i.e., vaccines) and CPI (CTLA, PD-1 inhibitors). A better understanding of the influence of the tumor microenvironment, protein alterations, and treatment resistance mechanisms may further advance the role of immunotherapy in PCa with improvements in tailored drug design. The presence of PD-L1 expression is continuing to be explored in advanced PCa. Trials combining immunotherapy with hormonal therapy and PARP inhibitors continue to grow and show great promise. Furthermore, identifying high-risk patients through gene sequencing can help delineate which subset of patients may most benefit from PARP inhibitors.

The identification of an oligometastatic state, a transitional state between localized and widespread metastatic disease, has shifted the paradigm in defining metastatic prostate cancer. Treatment for oligometastatic disease tends to be multimodal, although selecting patients who might benefit most from this treatment approach remains a challenge. Data from prospective clinical studies will aid in improving understanding of the underlying biology, which in turn might inform the optimal treatment pathway for oligometastatic disease.

Next-generation sequencing studies reveal that 25% of metastatic PCa patients harbor germline mutations in DNA damage repair (DDR) genes, which is higher than previously recognized. Therefore, determination of the mutated DDR genes is an emerging essential step to successfully personalize treatment and could guide clinical decisions at key milestones in the course of PCa treatment. However, widespread genetic testing remains a challenge due to the high prevalence of PCa in developed countries. That being said, future trial design incorporating DDR defect status will likely convey a survival advantage and further advance precision medicine outcomes.

Table 3 outlines the emerging targets with clinical significance in PCa.

The diagnostic and therapeutic pathway for PCa has seen many changes with these advances and with the development of prostate cancer biomarkers, multiparametric magnetic resonance imaging, active surveillance, partial prostatic gland ablative treatment, and other surgical and radiation approaches to reduce overdiagnosis and overtreatment. Awareness of emerging
systemic treatment paradigms that challenge current clinical practice must be increased to guide urologists in developing a more individualized approach that maximizes the efficacy of treatment.
Table 3: Emerging targets with clinical significance in PCa

<table>
<thead>
<tr>
<th>Molecular target</th>
<th>Class</th>
<th>Trial</th>
<th>Disease setting</th>
<th>Agent</th>
<th>Experimental treatment</th>
<th>Study phase</th>
<th>Estimated completion</th>
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<tbody>
<tr>
<td>Hormonal Therapy</td>
<td>Second-generation ADT</td>
<td>NCT03098836</td>
<td>mCRPC</td>
<td>Apalutamide</td>
<td>Apalutamide + abiraterone</td>
<td>Phase II</td>
<td>June 2021</td>
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<tr>
<td></td>
<td></td>
<td>NCT02106507</td>
<td>mCRPC</td>
<td>Apalutamide</td>
<td>Apalutamide + everolimus</td>
<td>Phase I</td>
<td>April 2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NCT02489318 (TITAN)</td>
<td>mCSPC</td>
<td>Apalutamide</td>
<td>Apalutamide + ADT</td>
<td>Phase III</td>
<td>July 2022</td>
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<tr>
<td>New-generation ADT</td>
<td></td>
<td>NCT02200614 (ARAMIS)</td>
<td>nmCRPC</td>
<td>Darolutamide</td>
<td>Darolutamide</td>
<td>Phase III</td>
<td>June 2020</td>
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<tr>
<td>AR inhibitor</td>
<td></td>
<td>NCT02445976</td>
<td>CRPC Progressing on Enzalutamide or Abiraterone</td>
<td>Seviteronel</td>
<td>Seviteronel</td>
<td>Phase II</td>
<td>January 2019*</td>
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<tr>
<td>Tumor Vaccine</td>
<td>Dendritic Cells</td>
<td>NCT02111577 (VIABLE)</td>
<td>mCRPC</td>
<td>DCVAC</td>
<td>DCVAC</td>
<td>Phase III</td>
<td>June 2020</td>
</tr>
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<td>PD-L1 and CTLA-4</td>
<td>CPI</td>
<td>NCT02861573 (KEYNOTE-365)</td>
<td>mCRPC</td>
<td>Pembrolizumab + olaparib (or Pembrolizumab + docetaxel + prednisone (or Pembrolizumab + enzalutamide)</td>
<td>Phase I</td>
<td>May 2022</td>
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<td>PD-L1</td>
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<td>NCT02985957 (CheckMate-650)</td>
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<td>Nivolumab + Ipilimumab</td>
<td></td>
<td>Phase II</td>
<td>March 2022</td>
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<tr>
<td>PARP Inhibitor</td>
<td>DNA Repair Inhibition</td>
<td>NCT03834519 (KEYLYNK-010)</td>
<td>mCRPC</td>
<td>Pembrolizumab</td>
<td>Pembrolizumab monotherapy (or Pembrolizumab + enzalutamide)</td>
<td>Phase II</td>
<td>December 2020</td>
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<td></td>
<td></td>
<td>NCT03732820</td>
<td>Previously-untreated mCRPC</td>
<td>Abiraterone + olaparib</td>
<td>Abiraterone</td>
<td>Phase III</td>
<td>August 2022</td>
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<td>Radioisotope</td>
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<td>NCT03737370</td>
<td>mCRPC</td>
<td>Radium-223</td>
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<td>ACTRN12615000912583*</td>
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<td>177Lutetium</td>
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<td>Phase I/II</td>
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</table>

*All trial information obtained through publicly accessible ClinicaTrials.gov
*Results pending
**Trial filed in Australia New Zealand Clinical trials registry, [http://www.anzctr.org.au](http://www.anzctr.org.au)
Needs Assessment

In 2019, SIU developed needs assessment surveys to help design accredited programs to increase awareness of new and novel treatment options and how best to use them for BCa and RCC, and to increase awareness of new assessment methods and therapies for PCa. Surveys were emailed to SIU members and SIU Academy subscribers, and they were closed to respondents after 2 weeks. Surveys were conducted from February 12 through February 25 for RCC and from June 16 through June 30 for BCa and PCa.

182 individuals from 65 countries responded to the survey on BCa. Most respondents felt comfortable in choosing when to offer chemotherapy for muscle-invasive BCa and in identifying patients who are ineligible for checkpoint inhibitor therapy or platinum-based treatment. However, only 45% of respondents felt comfortable with their knowledge about selecting patients for immunotherapy. Most respondents were not familiar with the implications of total mutational burden for response to systemic immunotherapy, nor were they familiar with the potential impact of the gut microbiome on systemic immunotherapy. In addition, less than a third, 29.1%, were familiar with novel therapies targeting FGFR. Use of immunotherapy, selecting the appropriate treatment for muscle-invasive bladder cancer, and treatment-related toxicities were cited by respondents as the most difficult topics.

There were 155 respondents from 62 countries for the RCC survey. Only 36% of respondents felt comfortable with identifying patients who are ineligible for immune checkpoint inhibitors, and almost a third, 32%, were uncomfortable. Less than half of respondents, 41%, were comfortable with identifying patients who are ineligible for VEGF- or mTOR-targeted therapy, and 30% were uncomfortable. Only 38% were confident in their knowledge of appropriate regimens combining immunotherapy with targeted therapies, and a little more than half, 56.8%, were aware of potential toxicities associated with these regimens. Only 38.5% were familiar with sequencing strategies for targeted therapies, and only 37.9% felt comfortable with selecting second-line therapies for patients with mRCC. Sequencing of agents, use of immunotherapy or immune-TKI combinations, and management of treatment-related toxicities were the top three difficulties cited by respondents.

144 individuals from 56 countries responded to the PCa survey. Only half were confident with their knowledge of genetic and molecular biomarkers, 60% were comfortable with selecting a biomarker to guide decisions about prostatic biopsies, and 52.1% were comfortable with selecting one to stratify PCa risk. A slight majority of respondents, just over 65%, were familiar with new hormonal treatments, including sequencing strategies and follow-up management, and approximately 70% were familiar with approaches to CRPC, including sequencing strategies and follow-up management. However, sequencing of agents, treatment-related toxicities, and selecting appropriate treatments were the top three difficulties cited by respondents.
2019 B2B Genitourinary Cancers Triad Conference

On December 13–14, 2019, SIU held its first B2B Uro-oncology conference on the genitourinary cancers triad in Berlin, Germany. The conference focused on management and treatment, with a session devoted to each cancer. Topics included immunotherapies for BCa and RCC, FGFR inhibitors for RCC, antibody-drug conjugates for BCa, and systemic therapies and PARP inhibitors for PCa. The feedback that SIU received from the attendees and the faculty following the conference was highly positive. The majority of participants felt that the conference had presented up-to-date findings and material applicable to practical clinical skills. Many also felt that their competency in program topics increased during the conference. Participants particularly enjoyed the level of discussion and interactions between attendees and speakers. At the same time, participants asked for more discussion of topics such as sequencing of RCC treatment, therapies for non-muscle-invasive bladder cancer, managing biochemical recurrence after definitive local therapy for prostate cancer, liquid biopsy, and tumor immunology.

SIU Uro-oncology GU Cancers Triad 2020 Meeting

Programme Description
Bladder cancer (BCa), renal cell carcinoma (RCC), and prostate cancer (PCa) are the most frequently encountered genitourinary malignancies and represent a heterogeneous population of cancers, in both histology and approach to treatment. A greater understanding of underlying molecular and oncogenic mechanisms has led to a revolution in treatment and major paradigm shifts in the treatment landscapes for these cancers. The increasingly complex treatment landscape for BCa, RCC, and PCa poses a challenge for urologists, medical oncologists, and radiation oncologists. In managing genitourinary cancers, these physicians will need to keep abreast of new data, select therapies on an individual case basis, and optimize sequences or combinations while effectively managing side effects.

Building on the success of the first GU Cancer Triad Meeting in 2019, SIU will convene a follow-up meeting in Montreal on October 7, 2020, in conjunction with the 40th Congress of the SIU. At this one-day meeting, world-renowned experts will discuss the latest research in BCa, RCC, and PCa, with an emphasis on clinical practice. We estimate that between 20 and 25 faculty members will participate.

The topics will enhance the target audience’s understanding of the latest trends in diagnostic modalities and treatment approaches. It will include a discussion of the challenges and opportunities that new therapeutic approaches in these fields offer. In addition, this programme includes interactive panel discussions to facilitate understanding of how advances in diagnosis and treatment can best be integrated into patient care.
Participant Feedback

Participants will be required to complete an evaluation/feedback survey after the meeting in order to receive a certificate of participation. SIU will provide participants with certificates of attendance.

Target Audience

This program is designed to meet the needs of urologists and other allied health specialists who have an interest in cancers of the bladder, kidney and prostate, as well as for those who manage patients with these diseases. A reduced registration rate is available for nurses, residents and fellows.

Preliminary Educational Objectives

The overarching goal of the program is to understand and increase participants’ ability to review and evaluate recent research findings in the field of GU oncology and apply these to clinical care, with the goal of improving clinical outcomes and patients’ quality of life. The B2B program will address three key components:

- Competence: ability to apply knowledge plus strategy in practice when necessary.
- Practice Performance: the application of new strategies or skills in the practice setting.
- Gap: the difference between what physicians are currently doing in practice and what is considered best or ideal practice.

At the end of this program, participants will be able to:

- Evaluate the benefits and risks of various treatment options across the treatment continuum in BCa, RCC, and PCa.
- Discuss strategies to identify and manage adverse events related to immunotherapy.
- Evaluate the role of immunotherapy vs VEGF-targeted therapies for RCC.
- Evaluate the role of imaging or biomarkers vs biopsy in active surveillance for localized prostate cancer.
- Discuss strategies for managing oligometastatic disease.
- Discuss the importance of personalized medicine, based on costs and patient preference, while minimizing toxicity and maximizing efficacy

Proposed Format

The one-day program will consist of three sessions, each devoted to one of the three genitourinary cancers. Two sessions, one focused on therapies for BCa and one focused on therapies for RCC, will take place in the morning. The third session, which will focus on
management and therapies for PCa, will be held over the entire afternoon. Each session will include a case-based panel, as well as a talk on five practice-changing advances on the horizon. Throughout the day, presentations will feature polling questions to assess participants’ gaps in knowledge, which will in turn serve as starting points for future programs. Each session will include a discussion to provide physicians and researchers with an opportunity to ask questions about the content.

A preliminary outline/agenda follows.

8:00–9:55  **Bladder Cancer**
- Evolving Therapies for Non-Muscle-Invasive Bladder Cancer
- Immunotherapy Combined with Radical Cystectomy and Trimodal Therapy
- Shifting Sands: Systemic Therapy for Advanced Disease in 2020
- Five Practice-Changing Advances on the Horizon
- Case-Based Panel on Immune-Related Adverse Events

10:15–11:50  **Kidney Cancer**
- Selecting VEGF-Targeted Therapy vs Immunotherapy
- Perioperative Immunotherapy
- Five Practice-Changing Advances on the Horizon
- Case-Based Panel on Managing Oligometastatic RCC

11:50–12:10  **State of the Art: The Microbiome in Oncology**

13:10–17:00  **Prostate Cancer**
- State of the Art: Who and When: Germline Testing
- Localized Prostate Cancer
  - High-Resolution Ultrasound
  - Case-Based Panel on Imaging and Biomarkers in Active Surveillance
- Locally Advanced Prostate Cancer
  - Neoadjuvant Therapy in High-Risk Prostate Cancer
  - Adjuvant vs Salvage Radiation for High-Risk Prostate Cancer
  - Case-Based Panel on Managing Biochemical Recurrence
- Metastatic Prostate Cancer
  - Downstream Implications of Adopting ARAT Therapy in Earlier Stages of Prostate Cancer
Case-Based Panel on the Adoption of Systemic Therapies by Urologists

Five Practice-Changing Advances on the Horizon

Communication and Publication Plan

SIU will promote the B2B Uro-oncology: The Genitourinary Cancer Triad conference through digital announcements, pre-course promotion, and social media (Twitter, Facebook, and LinkedIn) as well as in its SIU 2020 Congress Announcements. All lectures at the meeting will be transmitted live to reach a broader audience. The Berlin B2B last December, had an online audience of more than 3000 participants. Following the conference, the lectures will also be uploaded as webcasts onto SIU Academy, and they will be available to SIU members and SIU Academy users to watch on-demand at their own convenience. Summary highlights of the meeting will be posted on the SIU blog and on SIU Academy, and a more detailed scientific article will be published on SIU Academy. Non-members will simply be asked to register free of charge in order to view the content. This allows the SIU to collect metrics on those who viewed the programme on demand. Our objective is to structure a meeting with approximately 200-250 onsite participants. Medical oncologists and radiation oncologists from Canada will be contacted through advertisements via the Canadian Association of Medical Oncologist (CAMO) and the Canadian Association of Radiation Oncology (CARO), as well as the oncology centers of high-volume hospitals in Canada through our faculty. SIU will also promote the program to urologists within Canada (via the Canadian Urologists Association [CUA]), within the USA, and globally via our network and through its programme faculty and our various educational and research council members.

We estimate approximately 20 faculty members will contribute to the meeting. In addition, we will ask each faculty member to invite 2 to 3 residents or nurses from their institutions to attend the B2B on a complimentary basis in order to have strong presence of healthcare professionals from the urologic and medical oncologic communities.

Sponsor Invitation

Presenting Sponsor - $50,000 CAD – Partial subsides available

The Société Internationale d’Urologie would like to invite your organization to participate in this prestigious event with world-renowned opinion leaders in the fields of bladder, kidney and prostate cancers. Your support will include the opportunity to showcase late-breaking news on treatments, announce newly approved drugs and/or indications, and clinical trials in a multi-disciplinary forum.

Presenting sponsor benefits could include but are not limited to:

- *Meeting Highlights from Experts*: Priority selection of and sponsor of one expert’s spotlight in kidney, bladder or prostate cancer proceeding (including webcast on SIU Academy)
or

- Priority selection of, and sponsor of one expert’s B2B Meeting Capsules in kidney, bladder or prostate cancer proceeding including flipbook and pdf (please see sample below)
- Opportunity to provide up to 3 faculty recommendations to the chairs for their consideration, final decision rests with the SIU
- Upload of webcasts of the expert’s highlights’ proceedings and B2B sessions on SIU Academy, the SIU’s eLearning portal
- Opportunity to invite 4 company representatives (including registration, course materials, and one-night accommodation at the host hotel).
- Promotion as a Presenting Sponsor in all promotional material and on-site at the event, event microsite & social media sites
- Table-top display if required
- Facilitation of advisory board meeting is also possible

**Meeting Session B2B Capsules - $15,000 CAD**

The B2B **Meeting Capsule** is an educational tool developed by key experts in the field and summarizes the meeting session highlights. These capsules will be divided into three sections, with one expert selected for each of the bladder cancer, kidney cancer and prostate cancer sessions. The highlights will include the following:

- Key messages and clinical pearls of the session (maximum of two pages)
- Summary of the latest news in the field, including the most important key clinical trials that support new changes in guidelines
- Supporting references/websites for any studies or important facts mentioned in each of the respective sessions
- Creation of learning tools to meet the needs of attendees based on the post-polling and session evaluation results
- Meeting slide sets (add-on item*) – a summary slide set curated by our expert which supports the meeting session capsules

**Formats include:**

- PDF and flipbook for tablets
- *May include slide sets (where appropriate)
- A locked PDF copy will be uploaded on SIU Academy for our users
- Post-meeting: an email broadcast will be sent to meeting participants notifying them that resources on SIU Academy are available for viewing and downloading

For more information please contact Lillian Petrusa, Director, Corporate Development: Lillian.petrusa@siu-urology.org.

References
10. De Wit R, Kulkarni GS, Uchio EM, et al. Pembrolizumab (pembro) for patients (pts) with high-risk (HR) non-muscle invasive bladder cancer (NMIBC) unresponsive to Bacillus


21. BALVERSATM (erdafitinib) receives U.S. FDA approval for the treatment of patients with locally advanced or metastatic urothelial carcinoma with certain FGFR genetic


27. PADCEV (enfortumab vedotin-ejfv) [package insert]. Northbrook, IL: Astellas Inc.


