High risk nmCRPC patients with Xtandi® stay alive for over 5.5 years*

Xtandi® significantly prolonged overall survival by 10.7 months vs. placebo

*Median OS: 67.0 months (Xtandi® + ADT) vs. 56.3 months (Placebo + ADT)
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P. 02 An introduction to the HKSUO
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P. 09 Lecture 2: Understanding the role of PSMA-targeting agents in the management of advanced prostate cancer
P. 10 Lecture 3: Metastasis-directed therapy for oligometastasis
P. 11 Lecture 4: Evolving CRPC management with proven agents and emerging options
P. 12 Lecture 5: Managing the sequential therapeutic options in advanced urothelial carcinoma
P. 13 Lecture 6: Evolution of novel immunotherapy for the management of NMIBC - Update 2022
P. 14 Lecture 7: Liquid biopsy for guiding precision medicine in advanced prostate cancer
P. 15 Lecture 8: The evolving landscape of mHSPC: The latest perspective
P. 16 Lecture 9: Changing landscape in mHSPC
P. 17 Lecture 10: Optimizing ADT in PCa with CVD history: Real-world evidence & mitigation strategy
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P. 20 Acknowledgement of supporting organizations
P. 21 Acknowledgement of sponsors
Carcinoma: YERVOY 1 mg/kg in combination with 3 mg/kg nivolumab administered intravenously every 3 weeks for the first 4 months, followed by every 3 weeks thereafter as monotherapy for the treatment of adult patients with metastatic renal cell carcinoma low-risk according to ISUP criteria. 

For your 1L patients with intermediate or poor risk aRCC

**OPDIVO + YERVOY — 4 years of proven durability**

**Overall survival in patients with aRCC**

<table>
<thead>
<tr>
<th>Time (years)</th>
<th>OPDIVO + YERVOY</th>
<th>OPDIVO</th>
<th>Median OS (95% CI, mos)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>427</td>
<td>365</td>
<td>35 (35.6—NE)</td>
</tr>
<tr>
<td>1</td>
<td>373</td>
<td>291</td>
<td>(22.1—33.5)</td>
</tr>
<tr>
<td>2</td>
<td>306</td>
<td>270</td>
<td>0.65 (0.54—0.78)</td>
</tr>
<tr>
<td>3</td>
<td>270</td>
<td>241</td>
<td>56%</td>
</tr>
<tr>
<td>4</td>
<td>210</td>
<td>220</td>
<td>52%</td>
</tr>
<tr>
<td>5</td>
<td>208</td>
<td>208</td>
<td>66%</td>
</tr>
</tbody>
</table>

**PREGNANCY & LACTATION:**

- This refers to intermediate or poor risk aRCC.

**Indications:**

- Treatment of advanced (unresectable or metastatic) melanoma in adults, and adolescents 12 years of age and older.
- In combination with nivolumab

**YERVOY® 5 mg/ml concentrate for solution for infusion**

- Product code: N128M
- Lot release: Bristol-Myers Squibb
- Date of preparation: 18 June 2023
- Expiry date: 17 June 2024

**DOSAGE & ADMINISTRATION:**

- **YERVOY alone:**
  - As monotherapy: 1 mg/kg every 3 weeks by intravenous infusion for a total treatment duration of 1 year.
  - As combination therapy with nivolumab: 1 mg/kg every 3 weeks by intravenous infusion for the first 4 months, followed by every 3 weeks thereafter.

- **In combination with nivolumab:**
  - As combination therapy: YERVOY 1 mg/kg in combination with nivolumab 3 mg/kg administered intravenously every 3 weeks for the first 4 months, followed by every 3 weeks thereafter.

- **In combination with ipilimumab:**
  - As combination therapy: YERVOY 1 mg/kg in combination with ipilimumab 1 mg/kg administered intravenously over 30 minutes every 3 weeks for the first 4 months, followed by every 3 weeks thereafter.

**RECOMMENDATIONS:**

- The use of systemic corticosteroids before starting YERVOY should be avoided. 

**ADVERSE REACTIONS:**

- Immune-mediated adverse reactions, which may be severe or fatal, can occur in any organ system or tissue, including the skin, gastrointestinal tract, liver, and endocrine system.

**PRECAUTIONS:**

- Hypersensitivity to the active substance or to any of the excipients.

**PMSD:**

- Bristol-Myers Squibb Pharma (HK) Ltd.
- Tel: (852) 2510 6188 Fax: (852) 2510 6199

**OPDIVO + YERVOY, the only approved dual immunotherapy to provide the opportunity for longer life**
After what has been a challenging period, it is a pleasure to be able to welcome you to Uro-Oncology Asia 2022.

Uro-Oncology Asia is the Hong Kong Society of Uro-Oncology (HKSUO) Annual Scientific Meeting, and a leading regional platform for specialist disciplines to collaborate, and to facilitate a multi-disciplinary approach in the management and treatment of uro-oncology diseases.

It has been a real pleasure to see both this meeting and the HKSUO go from strength to strength since its founding in 2015. As our field has progressed, so have we, and we have continued to strive to keep Hong Kong at the forefront of science, international guidelines and patient care.

Despite the challenges of the pandemic, the last year has seen significant developments. More foundational scientific research has been done to advance our understanding of diseases, and further progress continues to be made towards ever more personalised treatments, many of which have already been successfully integrated into clinical use.

Liquid biopsies now allow a patient’s genetic status to be checked, providing both more time as well as more information on tumours so treatments may be better tailored for individual patients. Immunotherapy is playing an increasingly prominent role, including now in early-stage disease treatment. Personalised therapy integrating different media treatments has had stand-out successes, most notably the use of immune-checkpoint inhibitors in the treatment of kidney cancer, and the integration of radioactive isotopes in treating prostate cancer.

Uro-Oncology Asia 2022 is again delighted to be able to present a truly world-class line-up of expert guests to share with us their research and clinical experiences.

Finally, I wish to thank our guests for agreeing to be here with us today, the organizing committee for their efforts in making this event happen, and all of you for helping to make this event a success.

Dr. Philip Kwong
President
Hong Kong Society of Uro-Oncology
Evolving Therapy - Expanding Indication from Metastatic to Non-metastatic CRPC

Start Xtandi® early for non-metastatic CRPC,

Stay non-metastatic for over 3 years²

Stay without PSA progression for over 3 years²

Consistent with established safety profile of Xtandi®²

Full prescribing information is available upon request.

Start Xtandi® early for non-metastatic CRPC,

Stay non-metastatic for over 3 years²

Stay the way you are with a high health-related quality of life³¹

Consistent with established safety profile of Xtandi®²

Full prescribing information is available upon request.
The Hong Kong Society of Uro-Oncology (HKSUO) was founded in July 2015 by leading Hong Kong clinical oncologists with a special interest in urological cancers.

Urological cancers include cancers originating in the kidney, bladder and prostate. According to government statistics, prostate cancer is the 4th most common cancer and the 4th most common cause of cancer death in men; kidney cancer the 8th most common cancer in men; and there were 435 new cases of bladder cancer diagnosed in 2019.

The HKSUO provides a platform for specialist disciplines to work together, serving both clinical and practicing oncologists, as well as other professionals with a focus on urological cancers such as surgeons, pathologists and diagnostic radiologists. The Society promotes a multi-disciplinary approach to managing and treating urological cancers, which is both more up-to-date and potentially more effective than existing and less coordinated approaches.

The HKSUO has three aims:

Firstly, to provide patients with urological cancers the option to take a practical multidisciplinary approach to treatment, and to provide support for this option through Society events and activities;

Secondly, to raise public awareness of urological cancers and to increase public understanding and engagement via public education campaigns and programmes, including talks, community sharing sessions and exhibitions;

And thirdly, to promote more academic and clinical research on urological cancers via partnerships with local universities and research institutes and by conducting in-house clinical research in public hospitals.

From our beginnings in 2015, the HKSUO has grown in membership and influence to be Hong Kong’s leading society for professionals on uro-oncology, and a respected regional player. Our aims are ongoing, changing with the science and with advances in treatment. So too have our expectations.
Immune-mediated dermatologic adverse reactions, and immune-mediated nephritis and renal dysfunction. ADVERSE reactions: Discontinue OPDIVO for severe and life-threatening infusion reactions. Interrupt or slow the rate of infusion in patients with mild or moderate reactions. With ipilimumab, monitor for the first 12 weeks of treatment for the development of severe or life-threatening infusion-related reactions. OPDIVO is administered with ipilimumab for melanoma: OPDIVO can cause severe or fatal pneumonitis, colitis, hepatitis, endocrinopathies, autoimmunity, and serious infections. When administering OPDIVO to patients with intermediate or poor risk advanced renal cell carcinoma, melanoma, or urothelial carcinoma, the first dose of OPDIVO monotherapy should be administered after 3 weeks when using 3 mg/kg or 240 mg or 6 weeks when using 480 mg. For all patients, the first dose of OPDIVO monotherapy should be administered after 6 weeks when using 3 mg/kg or 240 mg or 12 weeks when using 480 mg. For patients with metastatic melanoma who require concomitant anticoagulant therapy should be monitored closely.

PREGNANCY & LACTATION: ipilimumab: fatigue, rash, diarrhea, nausea, pyrexia, musculoskeletal pain, pruritus, abdominal pain, vomiting, cough, arthralgia, decreased appetite, dyspnea, headache and upper respiratory tract infection. •

infusion) or 480 mg every 4 weeks (30-minute intravenous infusion). After completing 16 weeks of therapy, administer as single agent until disease progression or unacceptable toxicity. • With Ipilimumab: 3 mg/kg every 3 weeks (30-minute intravenous infusion) with ipilimumab 1 mg/kg every 3 weeks (42-minute intravenous infusion). Administer until disease progression, unacceptable toxicity, or up to 2 years. Administer Cabozantinib until disease progression or unacceptable toxicity. • With histology-based platinum-doublet chemotherapy: 360 mg every 3 weeks (30-minute intravenous infusion) with ipilimumab 1 mg/kg every 3 weeks (42-minute intravenous infusion). Administer until disease progression, unacceptable toxicity, or up to 2 years in patients with intermediate or poor risk advanced renal cell carcinoma.

Malignant Pleural Mesothelioma: • Single agent: 3 mg/kg every 2 weeks (30-minute intravenous infusion) or 240 mg every 2 weeks (30-minute intravenous infusion). Administer until disease progression or unacceptable toxicity. • With cabozantinib: 240 mg every 2 weeks

OPDIVO + YERVOY, the only approved dual immunotherapy to provide the opportunity for longer life* and all the moments in between.** BUILT TO LAST

OPDIVO® (nivolumab) + YERVOY® (ipilimumab)

OPDIVO® + YERVOY®, the only approved dual immunotherapy to provide the opportunity for longer life* and all the moments in between.**

OPDIVO® (nivolumab) + YERVOY® (ipilimumab)

OPDIVO® and YERVOY® are indicated for the treatment of patients with melanoma with involvement of lymph nodes or metastatic disease who have undergone complete resection. OPDIVO® and YERVOY® can cause serious or fatal immune-related adverse reactions in any organ system or tissue. In combination with ipilimumab, OPDIVO® + YERVOY® can cause immune-related pneumonitis, colitis, hepatitis, endocrinopathies, autoimmunity, and serious infections. OPDIVO® is indicated for the adjuvant treatment of patients with melanoma with metastatic disease who have undergone complete resection, OPDIVO® + YERVOY® for the treatment of patients with melanoma with metastatic disease who have undergone complete resection and are at high risk of disease recurrence despite complete resection of all gross disease, OPDIVO® for the treatment of patients with advanced renal cell carcinoma, and YERVOY® for the treatment of patients with unresectable or metastatic melanoma.

Please refer to Important Safety Information and Hong Kong Product Information for OPDIVO and YERVOY.

OPDIVO® (nivolumab) + YERVOY® (ipilimumab)
### AGENDA

#### 22nd January 2022 (Saturday)

<table>
<thead>
<tr>
<th>HK Time (GMT+8)</th>
<th>Topics</th>
<th>Speakers</th>
<th>Chairman</th>
</tr>
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<tbody>
<tr>
<td>13:25-13:30</td>
<td>Welcoming Speech</td>
<td>Dr. Philip Kwong</td>
<td>President of Hong Kong Society of Uro-Oncology, Hong Kong</td>
</tr>
</tbody>
</table>

#### SESSION 1 (PROSTATE SESSION)

| 13:30-14:00     | Lecture 1: Genomic testing in advanced prostate cancer | Associate Prof. Peter Chiu |
|                 | Associate Professor, Shiu Ho Urology Centre, Department of Surgery, The Chinese University of Hong Kong, Honorary Secretary, Hong Kong Urological Association | Dr. Martin Lam |
|                 |                                                    | Associate Consultant, Department of Oncology, United Christian Hospital, Hong Kong, Council Member, Hong Kong Society of Uro-Oncology |

| 14:00-14:30     | Lecture 2: Understanding the role of PSMA targeting agents in the management of advanced prostate cancer | Prof. Joe O’Sullivan |
|                 | Clinical Professor, School of Medicine, Dentistry and Biomedical Sciences, Fukuoka University Graduate School of Medicine, Fukuoka, Japan; Honorary Clinical Associate Professor, Research Institute of Molecular Imaging, Division of Cancer Research, Queen’s University Belfast, United Kingdom | Dr. Ma Wai Kit |
|                 |                                                    | Specialist in Urology, Honorary Clinical Associate Professor, The University of Hong Kong, Council Member, Hong Kong Urological Association |

| 14:30-15:00     | Lecture 3: Metastasis-directed therapy for oligometastasis | Prof. Piet Ott |
|                 | Associate Professor, Faculty of Medicine and Health Sciences, KU Leuven, Belgium | Dr. Law Ka Suet |
|                 |                                                    | Associate Consultant, Department of Oncology, Princess Margaret Hospital, Hong Kong, Council Member, Hong Kong Society of Uro-Oncology |

| 15:00-15:30     | Lecture 4: Evolving CRPC management with proven agents and emerging options | Prof. Bertrand Tombal |
|                 | Chair of Department of Surgery, Cliniques Universitaires Saint Luc, Université Catholique de Louvain, Belgium | Dr. Peter Chiu |
|                 |                                                    | Associate Professor, Department of Surgery, The Chinese University of Hong Kong, Honorary Secretary, Hong Kong Urological Association |

| 15:30-15:50     | Panel discussion and Q&A |  |
| 15:50-16:00     | BREAK |  |

#### SESSION 2 (UROTHELIAL CA SESSION)

| 16:00-16:30     | Lecture 5: Managing the sequential therapeutic options in advanced urothelial carcinoma | Prof. Andrea Necchi |
|                 | Associate Professor, MIA Salus San Raffaele University, Head of Urological Medical Oncology, IRCCS San Raffaele Hospital and Scientific Institute, Milan, Italy | Dr. Daisy Lam |
|                 |                                                    | Consultant, Department of Clinical Oncology, Prince of Wales Hospital, Hong Kong, Council Member, Hong Kong Society of Uro-Oncology |

| 16:30-17:00     | Lecture 6: Evolution of novel immunotherapy for the management of NMIBC - Update 2022 | Dr. Ashish M. Kamat |
|                 | Professor, Department of Urology, Division of Surgery, The University of Texas MD Anderson Cancer Center, Houston, Texas, United States | Dr. Samuel Yeo |
|                 |                                                    | Consultant, Division of Urology, Department of Surgery, Prince of Wales Hospital, Hong Kong, Council Member, Hong Kong Urological Association |

<p>| 17:00-17:20     | Panel discussion and Q&amp;A |  |
| 17:20-17:30     | Closing of day 1 |  |</p>
<table>
<thead>
<tr>
<th>Session</th>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
<th>Chairmen</th>
</tr>
</thead>
</table>
| Session 3 (Prostate Session) | 09:00-09:30 | Lecture 7: Liquid biopsy for guiding precision medicine in advanced prostate cancer | Dr. Joaquin Mateo  
Group Leader, Prostate Cancer Translational Research Group, Vall d’Hebron Institute of Oncology, Medical Oncology, BC Cancer, BC Cancer, Department of Medicine, University of British Columbia, Spain | Dr. Tim Chan  
Associate Consultant, Department of Clinical Oncology, Queen Elizabeth Hospital, Hong Kong, Council Member, Hong Kong Society of Uro-Oncology |
|         | 09:30-10:00 | Lecture 8: The evolving landscape of mHSPC: The latest perspective | Prof. Andrew Armstrong  
Professor of Medicine, Surgery, Pharmacology and Cancer Biology, Director of Research, the Duke Cancer Institute Center for Prostate and Urologic Cancers, Division of Medical Oncology and Urology, Duke University, United States | Dr. Clarence Leung  
Associate Consultant, Division of Urology, Department of Surgery, Kwong Wai Shiu Hospital, Hong Kong, Council Member, Hong Kong Urological Association |
|         | 10:00-10:30 | Lecture 9: Changing landscape in mHSPC                                | Prof. Kim Nguyen Chi  
Medical Oncologist, Vancouver Cancer Centre and Vancouver Prostate Centre, Chief Medical Officer, BC Cancer, Professor, Faculty of Medicine, University of British Columbia, Canada, Professor, Faculty of Health Sciences, Simon Fraser University, Canada | Dr. Angus Leung  
Clinical Oncologist, Clinical Associate Professor (Veneery), Department of Medicine and Therapeutics, The Chinese University of Hong Kong, Honorary Treasurer, Hong Kong Society of Uro-Oncology |
|         | 10:30-11:00 | Lecture 10: Optimizing ADT in PCa with CVD history: Real-world evidence & mitigation strategy | Prof. Ricardo Al Rendon  
Professor, Department of Urology, Faculty of Medicine, Dalhousie University, Canada | Dr. Raymond Kan  
Associate Consultant, Division of Urology, Department of Surgery, Queen Elizabeth Hospital, Hong Kong, Honorary Treasurer, Hong Kong Urological Association |
|         | 11:00-11:20 | Panel discussion and Q&A                                              |                                                                                               |                                                                                            |
| Session 4 (RCC Session) | 11:20-11:50 | Lecture 11: The evolving treatment landscape: Optimizing frontline strategy in advanced RCC | Prof. Sumanta Kumar Pal  
Professor, Department of Medical Oncology, City of Hope Comprehensive Cancer Center, United States | Dr. Darren Poon  
Honorary Consultant, Clinical Oncology, Hong Kong Sanatorium & Hospital, Hong Kong, Honorary Clinical Associate Professor, The Chinese University of Hong Kong, Vice-President, Hong Kong Society of Uro-Oncology |
|         | 11:50-12:20 | Lecture 12: Dual immune checkpoint blockade in the treatment of advanced RCC | Dr. Hans Hammers  
Associate Professor, Internal Medicine, Eugene F. fermel, M.D., Graduate School of Clinical Medicine, Division of Hematology-Oncology, The University of Texas Southwestern Medical Center, United States | Associate Prof. Ravi Pandian Rameswaran  
Deputy Head and Senior Consultant, Division of Medical Oncology, National Cancer Centre Singapore |
|         | 12:20-12:40 | Panel discussion and Q&A                                              |                                                                                               |                                                                                            |
|         | 12:40-12:45 | Closing Speech                                                        | Dr. Darren Poon  
Vice-President, Hong Kong Society of Uro-Oncology, Hong Kong |                                                                                           |
Changing tomorrow
Abbreviation: PCa, prostate cancer


DIPHERELINE® Hong Kong Abridged Package Insert (Refer to full prescribing information before prescribing)

Trade Name: DIPHERELINE® PR 3.75mg/11.25mg/22.5mg, INN: Triptorelin

Presentations: Powder and solvent for intramuscular injections, 28-day or 3-month or 6-month prolonged release form. This pack contains a glass vial of powder, an ampoule of 2 ml solvent, 1 syringe and 2 needles.

Posology & Administration:

- Prostate Cancer: one intramuscular injection every 4 weeks (PR 3.75) or every 3 months (PR 11.25) or every 6 months (PR 22.5).
- Endometriosis: one intramuscular injection every 4 weeks (PR 3.75) or every 3 months (PR 11.25).
- Treatment must be initiated in the first 5 days of the menstrual cycle and should not be administered for more than 6 months. Uterine fibromas prior to surgery (PR 3.75).
- Treatment must not exceed 3 months. Precocious puberty (PR 3.75): before 8 years in girls and 10 years in boys - children under 20kg half the dose of DIPHERELINE PR 3.75 every 28 days; children more than 20kg: one intramuscular injection of DIPHERELINE PR 3.75mg every 28 days.
- Female infertility (PR 3.75): supplementary treatment in combination with gonadotrophins. Injection of DIPHERELINE PR 3.75mg on the 2nd day of the cycle - gonadotrophins should be started generally 15 days after the injection.

Contraindications: Hypersensitivity to gonadotropin-releasing hormone (GnRH), its analogues or to any of the excipients; pregnancy.

Special Warnings & Precautions:

- Non-pregnancy should be confirmed before prescription. Treatments may cause reduction in bone mineral density; may reveal the presence of a previously unknown gonadotroph cell pituitary adenoma; mood changes, incl. depression, have been reported. Caution should be given to patients treated with anti-coagulants. In men: DIPHERELINE causes a transient increase in serum testosterone levels, which should be checked periodically. Caution should be given to patients with prostate cancer. Spinal metastases; urinary tract obstruction; additional risk factors of osteoporosis, diabetes and certain cardiovascular diseases. In women, every 4-week administration results in constant hypogonadotrophic amenorrhoea. If genital haemorrhage occurs after the first month, plasma oestradiol levels should be measured and if levels are below 50 pg/ml, possible organic lesions should be investigated. In female infertility, the follicular retrieval induced by the injection combined with gonadotrophins may increase markedly in some predisposed patients and particularly in cases of polycystic ovarian disease. The induced ovulation should be monitored closely.

Interactions: When triptorelin is used in combination with drugs that modify the secretion of pituitary gonadotropins, special precautions must be taken and it is recommended to closely monitor with hormone assays.

Undesirable Effects:

- In men: urinary symptoms, bone pain of metastatic origin and symptoms associated with medullary compression from spinal metastases, hot flushes, decreased libido, impotence, paresthesia in lower limbs, hyperhidrosis, asthenia, back pain. In women: exacerbation of endometriosis symptoms, menorrhagia, hot flushes, vaginal dryness, decreased libido and dyspareunia. In both: allergic reactions such as urticaria, rash, pruritus, nausea, vomiting, weight gain, hypotension, mood disorders, visual disturbances, pain at the injection site and fever.

Revision date: 07/09/2020

More Information available upon request

IPSEN Pharma (Hong Kong)
Unit 09-10, Level 28, Lee Garden Two, 28 Yun Ping Road, Causeway Bay, Hong Kong
Tel: 2637 8898  Fax: 2637 3987  http://www.ipsen.com

DIP-HK-000393 September 2021

The backbone in PCa treatment that:

Sustainably suppresses testosterone <20ng/dL

Is preferred by physicians and patients

Offers 6-month formulation
Meet our chairmen

Dr. Tim Chan
Associate Consultant,
Department of Clinical Oncology,
Queen Elizabeth Hospital, Hong Kong,
Council Member,
Hong Kong Society of Uro-Oncology

Dr. Raymond Kan
Associate Consultant, Division of Urology,
Department of Surgery,
Queen Elizabeth Hospital, Hong Kong,
Honorary Treasurer,
Hong Kong Urological Association

Dr. Daisy Lam
Consultant,
Department of Clinical Oncology,
Prince of Wales Hospital, Hong Kong,
Council Member,
Hong Kong Society of Uro-Oncology

Dr. Martin Lam
Associate Consultant,
Department of Oncology,
United Christian Hospital, Hong Kong,
Council Member,
Hong Kong Society of Uro-Oncology

Associate Prof. Ravindran Kanesvaran
Deputy Head and Senior Consultant,
Division of Medical Oncology,
National Cancer Centre Singapore

Associate Prof. Peter Chiu
Associate Professor,
SH Ho Urology Centre, Department of Surgery,
The Chinese University of Hong Kong,
Honorary Secretary,
Hong Kong Urological Association

*This sequence in alphabetical order.*
Meet our chairmen

Dr. Law Ka Suet
Associate Consultant, Department of Oncology, Princess Margaret Hospital, Hong Kong, Council Member, Hong Kong Society of Uro-Oncology

Dr. Angus Leung
Clinical Oncologist, Clinical Associate Professor (Honorary), Department of Medicine and Therapeutics, The Chinese University of Hong Kong, Honorary Treasurer, Hong Kong Society of Uro-Oncology

Dr. Clarence Leung
Associate Consultant, Division of Urology, Department of Surgery, Kwong Wah Hospital, Hong Kong, Council Member, Hong Kong Urological Association

Dr. Ma Wai Kit
Specialist in Urology, Honorary Clinical Associate Professor, The University of Hong Kong, Council Member, Hong Kong Urological Association

Dr. Darren Poon
Honorary Consultant, Clinical Oncology, Hong Kong Sanatorium & Hospital, Hong Kong, Honorary Clinical Associate Professor, The Chinese University of Hong Kong, Vice President, Hong Kong Society of Uro-Oncology

Dr. Samuel Yee
Consultant, Division of Urology, Department of Surgery, Prince of Wales Hospital, Hong Kong, Council Member, Hong Kong Urological Association

*This sequence in alphabetical order.
CABOMETYX®:

- The only TKI monotherapy recommended as “Preferred Regimen” for:
  - 1st line poor/intermediate aRCC
  - 2nd line aRCC
- The only single-agent TKI to demonstrate an overall survival benefit in 2nd line aRCC (Median OS: 21.4 vs 17.1 months everolimus [HR=0.70; 95%CI: 0.58-0.85; p=0.0002])
- Manageable tolerability profile proven across clinical trials

In a Phase 3, randomised, open-label study comparing CABOMETYX® (n=330) with everolimus (n=328) in adult patients with aRCC progressing after prior anti-VEGF therapy.

**References:**
1. NCCN. Evidence Blocks Kidney Cancer v1.2022.

**Indications:**
Treatment of advanced renal cell carcinoma (RCC) in treatment-naïve adults with intermediate or poor risk; or adults following prior vascular endothelial growth factor (VEGF)-targeted therapy; or treatment of hepatocellular carcinoma (HCC) in adults who have previously been treated with sorafenib.

**Posology & Administration:**
Treatment should be initiated by a physician experienced in the administration of anticancer medicinal product. CABOMETYX tablets and COMETRIQ capsules are not bioequivalent and should not be used interchangeably. For RCC and HCC, the recommended dose is 60 mg once daily. Treatment should continue until the patient is no longer clinically benefiting from therapy or until unacceptable toxicity occurs. Management of suspected adverse drug reactions may require temporary treatment interruption and/or dose reduction of CABOMETYX therapy. When dose reduction is necessary, it is recommended to reduce to 40 mg daily, and then to 20 mg daily. Dose modifications are recommended for management of CTCAE grade 3 or greater toxicities or intolerable grade 2 toxicities. Dose reductions are not recommended for events that, if persistent, could become serious or intolerable. If a patient misses a dose, the missed dose should not be taken if it is less than 12 hours before the next dose.

**Contraindications:** Hypersensitivity to the active substance or to any of the excipients.

**Special Warnings & Precautions:**
Physicians should evaluate the patient closely during the first 8 weeks of treatment to determine if dose modifications are warranted (in case of hypocalcaemia, hypokalaemia, hypertension, palmar-plantar erythrodyseaesthesia syndrome (PPES), proteinuria and gastrointestinal events). Warnings: hepatic effects, hepatic encephalopathy, perforations and fistulas, thromboembolic events, gastrointestinal disorders, haemorrhage, thrombocytopenia, wound complications, hypertension, PRES: proteinuria, reversible posterior leukoencephalopathy syndrome, prolongation of QT interval, biochemical laboratory test abnormalities, cytochrome P450 3A4 (CYP3A4) inducers and inhibitors, P-glycoprotein substrates, multidrug resistance-associated protein 2 (MRP2) inhibitors, excipient related warnings. Interactions: CYP3A4 inducers and inhibitors, P-glycoprotein substrates, multidrug resistance-associated protein 2 (MRP2) inhibitors, excipient related warnings. Interaction: Pregnanate & Lactation & Fertility: Pregnancy should be avoided while on cabozantinib, or while the partner is taking cabozantinib; an effective method of contraception should be used by both partners during treatment and for at least 4 months after completing therapy. Mothers should discontinue breast-feeding during the treatment. Male and female fertility may be compromised by treatment with cabozantinib. Ability to Drive & Use Machines: Caution should be recommended when driving or operating machinery while on cabozantinib. Undesirable Effects: RCC: diarrhoea, hypertension, dehydration, hypocalcaemia, nausea, decreased appetite, embolism, fatigue, hyponatraemia, PRES, HCC, hepatic encephalopathy, PRES, asthma, diabetes.

More information available upon request.

**IPSEN Pharma (Hong Kong)**
Unit 09-10, Level 28, Lee Garden Two, 28 Yun Ping Road, Causeway Bay, Hong Kong
Tel: 2637 8998 Fax: 2637 5987 http://www.ipsen.com
Genomic testing in advanced prostate cancer

Associate Prof. Peter Chiu
Associate Professor,
SH Ho Urology Centre, Department of Surgery,
The Chinese University of Hong Kong,
Honorary Secretary,
Hong Kong Urological Association

Dr. Peter Chiu graduated from the Faculty of Medicine of the Chinese University of Hong Kong and obtained the fellowship in Urology from the College of Surgeons of Edinburgh. He received post-graduate training on prostate cancer research and Andrology in the Erasmus Medical Centre in Rotterdam, The Netherlands, and obtained a PhD degree on prostate cancer diagnosis. The focus of his clinical practice and research is on prostate cancer, from prostate cancer screening, diagnosis with novel biomarkers (prostate health index, urine spermine) and MRI-guided transperineal prostate biopsy, to focal therapy and Robotic surgery. He is currently the Honorary Secretary of the Hong Kong Urological Association, a member of the prostate cancer working group of the EAU Young Academic Urologists, and a member of the SIU Academy Education council.

Abstract
A significant proportion of prostate cancer is diagnosed at an advanced stage, and more than 10-15% of these patients have one or more germline mutations associated with prostate cancer. There has been growing evidence supporting the use of genomic testing in germline and/or somatic (tumor) setting in various stages of prostate cancer. The most common inherited mutations include DNA repair genes like BRCA2, BRCA 1, ATM, etc., and they are mostly commonly found in patients with metastatic castration resistant prostate cancer (mCRPC). Poly (ADP-ribose) polymerase inhibitors (PARPi) like Olaparib is a novel treatment providing survival benefits in multi-drug resistant mCRPC patients with DNA repair mutations. It is applicable to both germline (blood testing) or somatic (tumor testing) mutations. More recently, circulating tumor DNA in blood provides a more convenient alternative than tumor tissue in somatic testing. In men with known DNA repair mutations like BRCA mutation, it is recommended to have earlier prostate cancer screening and more aggressive treatment even for early-stage prostate cancer. Therefore, genetic testing could guide management decisions in different stages of prostate cancer. It is important for both urologists and oncologists to be familiar with the indications and implications of genomic testing in prostate cancer.
CABOMETYX® efficacy in HCC is proven in:

- Majority of 2L patients (71%)²
- Patients tolerable/intolerable to prior sorafenib²
- Patients with any AFP levels³

AFP, alpha-fetoprotein; HCC, hepatocellular carcinoma; TKI, tyrosine kinase inhibitor

Lecture 2
Understanding the role of PSMA-targeting agents in the management of advanced prostate cancer

Prof. Joe O’Sullivan
Clinical Professor, School of Medicine, Dentistry and Biomedical Sciences, Patrick G Johnston Centre for Cancer Research, Queen’s University Belfast, United Kingdom

Joe O’Sullivan is Professor of Radiation Oncology at the Patrick G Johnston Centre for Cancer Research, Queen’s University Belfast and a Consultant Prostate Cancer Oncologist at the Northern Ireland Cancer Centre, Belfast. Joe is a world expert on advanced prostate cancer and in particular the use of ionising radiation and has worked at Queens University for almost 18 years.

Joe graduated from University College Dublin medical School in 1993 and trained in Radiation Oncology in St. Luke’s Hospital in Dublin. In 2000 he took up a Clinical research Fellowship at the Royal Marsden London, completing a Doctorate Thesis on the use of high doses of Rhenium-186HEDP with stem cell support in advanced prostate cancer. He was appointed as a senior lecturer and consultant clinical oncologist to Queen’s University Belfast in 2004 and was subsequently appointed as Professor of Radiation Oncology in 2011. He served as Clinical Director of Oncology at The Northern Ireland Cancer Centre, Belfast from 2014 to 2017.

His research interests include radionuclide therapy in metastatic prostate cancer, translational research in prostate cancer and radiotherapy, and clinical trials in advanced prostate cancer and he has published over 200 research papers. He is one the 4 Directors of the FASTMAN Prostate Cancer Centre of Excellence (Belfast and Manchester) which is a programme of research awarded in 2014 and funded by Movember and PCUK.

Joe is also a singer/songwriter and has released 3 albums of original songs, many of which were inspired by his patients.

Abstract
Bone-targeted Radionuclide therapy has played an important role in the management of advanced prostate cancer for many decades initially as a way to relief bone pain and subsequently as life prolonging therapy in the form of Radium-223. The cell surface protein, PSMA, which is highly expressed in advanced prostate cancers, offers a new target for radioligand therapy. In this talk I will discuss the mechanism of action of PSMA targeted Radioligand therapy, the role of PSMA PET imaging, as well as discussing the exciting, practice changing data from the VISION trial of Lutetium-177-PSMA-617. I will describe where Lu-177-PSMA will fit in the treatment sequence for mCRPC and speculate on future developments in the field.
CABOMETYX® is indicated in first-line treatment of advanced renal cell carcinoma (RCC) in adult patients with intermediate or poor risk (Alliance A031203 CABOSUN randomised trial): Progression-free survival by independent review and overall survival update. Eur J Cancer. 2018;94:115-25.

References:

Trade Name: CABOMETYX® 20 / 40 / 60 mg film-coated tablets. INN: Cabozantinib. Presentations: Film-coated tablets, HDPE bottle with a polypolyene child-resistant closure and three silica gel dessicant canisters. Each bottle contains 30 film-coated tablets. Indications: Treatment of advanced renal cell carcinoma (RCC) in treatment-naïve adults with intermediate or poor risk; or adults following prior vascular endothelial growth factor (VEGF)-targeted therapy; or treatment of hepatocellular carcinoma (HCC) in adults who have previously been treated with sorafenib. Posology & Administration: Treatment should be initiated by a physician experienced in the administration of anticancer medicinal product. CABOMETYX tablets and COMETRIQ capsules are not bioequivalent and should not be used interchangeably. For RCC and HCC, the recommended dose is 60 mg once daily. Treatment should continue until the patient is no longer clinically benefiting from therapy or until unacceptable toxicity occurs. Management of suspected adverse drug reactions may require temporary treatment interruption and/or dose reduction of CABOMETYX therapy. When dose reduction is necessary, it is recommended to reduce to 40 mg daily, and then to 20 mg daily. Dose interruptions are recommended for management of CTCAE grade 3 or greater toxicities or intolerable grade 2 toxicities. Dose reductions are recommended for events that, if persistent, could become serious or intolerable. If a patient misses a dose, the missed dose should not be taken if it is less than 12 hours before the next dose. Oral use: tablets should be swallowed whole and not crushed. Patients should be instructed to not eat anything for at least 2 hours before through 1 hour after taking the drug.

Contraindications: Hypersensitivity to the active substance or to any of the excipients. Special Warnings & Precautions: Physicians should evaluate the patient closely during the first 8 weeks of treatment to determine if dose modifications are warranted (in case of hypocalcaemia, hypokalaemia, thrombocytopenia, hypertension, palmar-plantar erythrodysesthesia syndrome (PPES), proteinuria and gastrointestinal events). Warnings: hepatic effects, hepatic encephalopathy, perforations and fistulas, thromboembolic events, gastrointestinal disorders, haemorrhage, thrombocytopenia, wound complications, hypertension, PPES, proteinuria, reversible posterior leukoencephalopathy syndrome, prolongation of QT interval, bioichemical laboratory test abnormalities, cytochrome P450 3A4 (CYP3A4) inducers and inhibitors, P-glycoprotein substrates, multidrug resistance-associated protein 2 (MRP2) inhibitors, excipient related warnings. Interactions: CYP3A4 inducers and inhibitors, P-glycoprotein substrates, MRPP inhibitors, gastric pH modifying agents, bile salt-sequestering agents. Pregnancy & Lactation & Fertility: Pregnancy should be avoided while on cabozantinib, or while the partner is taking cabozantinib; an effective method of contraception should be used by both partners during treatment and for at least 4 months after completing therapy. Mothers should discontinue breast-feeding during the treatment. Male and female fertility may be compromised by treatment with cabozantinib. Ability to Drive & Use Machines: Caution should be recommended when driving or operating machines while on cabozantinib.

HCC: hepatic encephalopathy, PPES, asthenia, diarrhoea.

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Patients experienced more months of progression-free disease with CABOMETYX®

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Piet Ost is an associate professor at Ghent University, Ghent, Belgium and radiation oncologist at the Iridium Network, Antwerp, Belgium. He is an expert in the treatment of genitourinary malignancies with a focus on prostate and bladder cancers. His research focuses on the implementation of stereotactic body radiotherapy (SBRT), oligometastases and drug-radiotherapy trials. Dr. Ost has led numerous clinical trials exploring the potential benefit of SBRT for oligometastases and radioimmunotherapy. He serves as a reviewer for several grant organizations and journals. He is a co-author of the ESMO clinical prostate cancer practice guidelines and the 2-yearly Advanced Prostate Cancer Consensus Conference. Dr. Ost is the chair of the Radiation Oncology Scientific Council of the EORTC. He received his M.D. degree at Ghent University in 2006, his PhD in 2011 and completed his radiation oncology training in 2012 at the same university.

Abstract
In 1995, the spectrum hypothesis was introduced, suggesting that some solid tumors develop metastases in a limited number and sites and have a slow progression. These metastases were coined oligometastases and might be ideally suited for treatment with a local ablative therapy. In prostate cancer the concept of oligometastases gained more interest following the introduction of more sensitive imaging with choline and more recently PSMA PET-CT. Especially in the recurrent setting, more and more patients were being diagnosed with a limited volume of metastases. During my lecture, I will discuss the different local therapy and systemic therapy approaches in the different settings.
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**BAVENCIO® (avelumab)** in combination with axitinib is an immunotherapy and a tyrosine kinase inhibitor in the first-line treatment of patients with advanced RCC.

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- **Indications**
  - Treatment of metastatic renal cell carcinoma (mRCC) and locally advanced or metastatic bladder cancer (mBC) with a programmed death-ligand 1 (PD-L1) positive tumor.

- **Dosage**
  - Avelumab: 10 mg/kg every 3 weeks.
  - Avelumab: 10 mg/kg every 2 weeks.
  - Avelumab: 10 mg/kg every 4 weeks.
  - Axitinib: 5 mg twice daily.

- **Contraindications**
  - Hypersensitivity to avelumab or axitinib.
  - Hypersensitivity to any component of the avelumab or axitinib formulation.

- **Warnings**
  - Developmental toxicity in animal reproduction studies.
  - Rare cases of hypersensitivity reactions.
  - Rare cases of serious infections.

- **Precautions**
  - Patients with renal impairment should be closely monitored.
  - Patients with liver impairment should be monitored for adverse hepatic effects.

- **Adverse Reactions**
  - Common adverse reactions include: nausea, decreased appetite, fatigue, cough, pyrexia, rash, diarrhea, and arthralgia.

- **Drug Interactions**
  - Patients should be advised to avoid concomitant use of drugs known to cause serious skin reactions.

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Lecture 4
Evolving CRPC management with proven agents and emerging options

Prof. Bertrand Tombal
Chairman, Department of Surgery, Cliniques Universitaires Saint Luc, Université catholique de Louvain, Belgium

Bertrand Tombal is the Chairman of the Department of Surgery and Full Professor of Urology at the Université catholique de Louvain (UCL), Cliniques universitaires Saint-Luc, Brussels, Belgium. He is the current President of the European Organization for Research and Treatment of Cancer (EORTC), the leading European academic research organization in the field of cancer. He has both a basic science and a clinical interest in urological oncology, particularly in the field of prostate and bladder cancer. Professor Tombal obtained his MD in 1990 and his PhD in 2003, both from the Université catholique de Louvain. During his PhD, he studied the mechanisms involved in apoptosis of prostate cancer cells and the modulation of apoptosis by growth factors. He completed part of his basic sciences training at Johns Hopkins University, Baltimore, MD, USA.

Professor Tombal’s primary clinical interest is the treatment of advanced stages of prostate cancer, and particularly hormonal treatment and development of new biological agents. He is heading the uro-oncology division at the Université catholique de Louvain where he is coordinating several trials in this research area. In addition, Professor Tombal has authored more than 300 published papers, books, and book chapters. He has presented at numerous national and international conferences and has been the recipient of various awards for his research in the field of urology, including the European Association of Urology thesis award, which he received in 2003.

Abstract
The treatment of advanced prostate cancer (PCa) has dramatically evolved in the last 10 years. The development of 4 AR pathway inhibitors (ARpI) has profoundly reshaped the PCa care pathway. ARpI that were initially developed to treat metastatic castration resistant prostate cancer (mCRPC) are now used much earlier, in patients presenting with hormone naïve metastatic PCa (mHNPC) and in high-risk non-metastatic CPRC (nmCPRC). Hence, modern PCa patients enter the mCRPC stage while already treated with androgen deprivation therapy and one ARpI. Real-world evidence surveys reveal that back-to-back ARpI are often prescribed although we have robust evidence of a very limited efficacy in that setting. Interestingly, docetaxel is often considered as the standard of care for these patients by treatment guidelines or consensus panel, although its use is only supported by rather poor results. Actually, docetaxel is compulsory for using cabazitaxel, the second line taxane chemotherapy and, in several countries, for Radium 223. The use of docetaxel in men progressing on ADT + ARpI will be more frequently challenged by new targeted therapies including PARP inhibitors olaparib and niraparib in patients harboring DNA repairs mutations and PSMA-targeted radionuclides such as PSMA-Lu. In that context, understanding the “3rd line” space and the characteristics of the emerging agent will become key to optimize the treatment of the patients.
In patients with mHSPC, ADT alone is not enough...

PUSH BACK EARLY. EXTEND LIFE.

By using ERLEADA™ + ADT early, you can improve survival and delay disease progression for longer than ADT alone.¹⁻³
Managing the sequential therapeutic options in advanced urothelial carcinoma

Professor Andrea Necchi is a medical oncologist specialized in the treatment of urological malignancies. He received his medical degree at the University of Milan, Italy, and subsequently he completed the post-doc specialization in medical oncology at the same University. Prof. Necchi's activity is fully dedicated to the treatment of genitourinary malignancies. Since his clinical training as a medical student, he worked at the Fondazione IRCCS Istituto Nazionale dei Tumori, Milan, Italy.

In November 2020 he was appointed associate professor of oncology at Vita-Salute San Raffaele University and Director of Genitourinary Medical Oncology at IRCCS San Raffaele Hospital and Scientific Institute in Milan, Italy. His research team is focused on the entire spectrum of urological malignancies, and is primarily devoted to the development of all-phases clinical trials with new experimental therapies. In particular, the most relevant interest in his recent work was focused on the development of perioperative strategies aimed at delivering new therapies combined with radical surgery in early-stage, operable disease.

He currently serves as a board member of the EAU Research Foundation, and he is associate member of the ASCO-EAU penile cancer guidelines panel.

He is principal investigator of several academic phase 1-2 trials of immuno-oncology combinations in urological malignancies.

Prof. Necchi has been the first recipient of the “Gianni Bonadonna prize for new drug development in Oncology”, and earned four Merit Awards from the Conquer Cancer Foundation of the American Society of Clinical Oncology (ASCO).
Synergistic mechanisms of dual I-O therapy with the potential for long-term anti-tumor immune response.\(^4,5\)

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**...AND HELPS FORM MEMORY T CELLS**

Some of the T cells stimulated by YERVOY can become memory T cells, which may allow for a long-term immune response.\(^3,4\)

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YERVOY does this by blocking CTLA-4 and also reduces Treg function.\(^3,9\) OPDIVO helps existing T cells discover the tumor by blocking PD-1.\(^8,10\)

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**PREGNANCY & LACTATION:**

- Women who require concomitant anticoagulant therapy should be monitored closely.
- Breastfeeding should be avoided.

** References:**

8. OPDIVO is indicated for the adjuvant treatment of completely resected melanoma in patients at high risk of recurrence.
9. OPDIVO is indicated for the adjuvant treatment of completely resected melanoma in patients at high risk of recurrence.
10. OPDIVO is indicated for the adjuvant treatment of completely resected melanoma in patients at high risk of recurrence.
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OPDIVO + YERVOY, the only approved dual immunotherapy to provide the opportunity for longer life* and all the moments in between.†

* Vs the comparator arm in CheckMate 214.

For your 1L patients with intermediate or poor risk aRCC

OPDIVO + YERVOY – 4 years of proven durability

Overall survival in patients with aRCC

<table>
<thead>
<tr>
<th>No. at risk</th>
<th>Time (years)</th>
<th>OPDIVO + YERVOY</th>
<th>Median OS (95% CI, mos)</th>
<th>HR (95% CI)</th>
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<tbody>
<tr>
<td>425</td>
<td>0</td>
<td>335</td>
<td>35.6 (6.9–22.5)</td>
<td>0.65 (0.54–0.78)</td>
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Please refer to important Safety Information and Hong Kong Product Information for OPDIVO and YERVOY.
MSD Oncology

Leading the transformation of cancer treatment
Evolution of novel immunotherapy for the management of NMIBC - Update 2022

Dr. Ashish M. Kamat
Professor, Department of Urology, Division of Surgery, The University of Texas MD Anderson Cancer Center, Houston, Texas, United States

Ashish M. Kamat is an Endowed Professor of Urologic Oncology (Surgery) and Cancer Research at University of Texas MD Anderson Cancer Center. He is also President of the International Bladder Cancer Group (IBCG) and International Bladder Cancer Network (IBCN). He is Associate Editor for European Urology Oncology, Editor for the UroToday Bladder Cancer Center of Excellence, directed the MDACC Urologic Oncology Fellowship from 2005-2016. Dr. Kamat is an expert recognized globally; emphasis on bladder cancer, immunotherapy, organ-sparing and minimally invasive techniques. He has an active research portfolio with a focus to develop novel therapies. He is an exceptional educator, as Program Director grew the Urologic Oncology Fellowship into the premier program today. In 2016, a scholarly endowment was created in honor of Dr Kamat, the "Wayne B. Duddlesten Professorship in Honor of Dr Ashish Kamat" for his work in Cancer Research and Education. He has over 390 publications and has won the 'Compassionate Doctor Award' from patient groups. He is on grant review panels of national and international study sections with advisory capacity to various organizations; National Cancer Institute’s (NCI) Bladder Cancer Task Force (BCTF), Society of Immunotherapy for Cancer (SITC); and as AUA International Faculty.

Abstract
The management of early-stage bladder cancer and specifically non-muscle invasive bladder cancer (NMIBC) is rapidly evolving. Novel immunotherapy agents beyond traditional Bacillus Calmette-Guerin (BCG), such as anti-PD-1 immune checkpoint inhibitors have recently demonstrated favourable efficacy and safety. More importantly, novel immunotherapies potentially provide a bladder-sparing option for eligible patients. This lecture is intended to provide an educational update delivered by Dr. Kamat on recent developments on the management of NMIBC patients with novel systemic therapy and practical considerations in clinical practice. Learn more about appropriate decision making on the possibility of avoiding cystectomy or providing eligible patients more time by deferring it for better patient outcomes.
Proposed Mechanism of Action

• Prostate-specific membrane antigen (PSMA) is highly expressed in prostate cancer (PC) but has limited expression in normal tissue.1,2

• In vivo, [177Lu]Lu-PSMA-617 binds to PSMA with high affinity.3

• Upon binding with PSMA, [177Lu]Lu-PSMA-617 is internalized into the cell by clathrin-mediated endocytosis.3,5

• Luetium 177 ([177Lu]) is a β- (electron) and γ-radiation-emitting radionuclide that has been shown to induce DNA single- and double-strand breaks through free radical formation in PSMA-positive cells and neighboring cells.1,2

Proposed Areas of Research

• PSMA-positive metastatic castration-resistant prostate cancer (mCRPC) and metastatic hormone-sensitive prostate cancer (mHSCP)8,9

Key Preclinical Data

- In vitro, [177Lu]Lu-PSMA-617 demonstrated a binding affinity of K<2.34 ± 2.94 nM (n=7) for PSMA on PC cells.2

- In vivo, [177Lu]Lu-PSMA-617 accumulation in PSMA-positive tumors was 45–49% IA/g at 2 hours post-injection, but uptake was <0.5% in PSMA-negative tumors.10

- In vivo, tumors with the highest uptake of [177Lu]Lu-PSMA-617 showed lower volumes at day 7 (323 ± 122 mm³) compared with tumors with intermediate or low uptake (590 ± 46 mm³) (P=0.039). Mean metabolic volume of tumors in each uptake group was 87 ± 23 mm³ (high), 91 ± 14 mm³ (intermediate), and 145 ± 19 mm³ (low). Consistent with this, mice with high and intermediate uptake showed prolonged survival, compared to mice with low uptake. One mouse in each of the high and intermediate groups survived and remained tumor-free for longer than 50 days.3

- In 224 patients with metastatic prostate cancer (mPC) who received [177Lu]Lu-PSMA-617, 54% demonstrated a >50% reduction of serum prostate-specific antigen (PSA). Median overall survival (OS) was 27 months and median progression-free survival (PFS) was 18 months. No severe bone marrow toxicity, nephrotoxicity, or other organ toxicity was observed.11

- In a retrospective, multicenter study of [177Lu]Lu-PSMA-617 in 145 heavily pretreated patients with mPC, 45% of evaluable patients demonstrated a ≥50% PSA decline. Grade 3–4 hematologic adverse events occurred in 12% of patients: 1 patient experienced severe leukopenia, 8% anemia, 2% thrombocytopenia, and 4 patients experienced a combination of these conditions. No nephrotoxicity grade 3 or 4 was observed.12

- In an open-label, nonrandomized, Phase II study, 50 patients with mCRPC were administered [177Lu]Lu-PSMA-617. Sixty-four percent of patients demonstrated ≥50% PSA decline. Median OS was 13.3 months, and patients with ≥50% PSA decline had a median OS of 18.4 months. Grade 3–4 adverse events were primarily hematologic: lymphopenia (32%), thrombocytopenia (10%), anemia (10%), and neutropenia (6%). No episodes of neutropenic sepsis were observed. One case of grade 4 thrombocytopenia was observed. No patients developed myelodyplasia during the extended follow-up period.13

Clinical Status

• A Phase III study showed that [177Lu]Lu-PSMA-617 plus standard care (SoC) improved radiographic PFS [hazard ratio 0.40, 99.2% CI 0.29-0.57, P<0.001] and OS [hazard ratio 0.62, 95% CI 0.52-0.74, P<0.001] compared to SoC alone in patients with progressive, PSMA-positive mCRPC (VISION: NCT03516644).14

• A Phase II randomized study of [177Lu]Lu-PSMA-617 theranostic versus cabazitaxel in mCRPC progressing after docetaxel is currently ongoing. Data presented at ASCO 2020 showed that at a median follow-up of 11.3 months, [177Lu]Lu-PSMA-617 improved PSA progression-free survival, compared to cabazitaxel [hazard ratio 0.63, 95% CI 0.45-0.88, P<0.007] (TherAvec: NCT03392428).15,16

[177Lu]Lu-PSMA-617 is an investigational compound. Efficacy and safety have not been established. There is no guarantee that [177Lu]Lu-PSMA-617 will become commercially available. MOA data are based on in vitro/vivo data. Clinical benefit is unknown.
Joaquin Mateo is a medical oncologist and physician scientist focused in the development of novel, more precise therapeutic strategies to treat advanced prostate cancer. After completing his training in Medical Oncology, he completed a fellowship in Phase I clinical trials at the Royal Marsden Hospital, followed by pursuing his PhD in prostate cancer genomics in the Johann de Bono’s lab in London. He has been involved in the development of PARP inhibitors and PI3K/AKT inhibitors in prostate cancer clinical trials, and in the clinical qualification of somatic and germline genomic testing for men with advanced prostate cancer. At present, he leads the Prostate Cancer Translational Research program at VHIO (Barcelona), and chairs the ESMO Precision Medicine Working Group.

Abstract
Metastatic prostate cancer is a lethal disease with significant genomic heterogeneity among patients. Genomic stratification of advanced prostate cancer for treatment selection is now recommended by international clinical guidelines for all men with metastatic prostate cancer; however, the difficulty for acquiring bone metastatic biopsies, the most common site of disease in mPC, as well as the degradation of FFPE-preserved primary diagnostic samples challenges the practical implementation of genomic testing in everyday’s practice. Liquid biopsy genomic profiling offers an alternative source of tumor material for genomic stratification. Moreover, quantification of circulating tumor cells and ctDNA in the plasma of mPC patients has prognostic value and also can be used longitudinally as response and resistance biomarker, assisting in therapeutic decisions.
Trustworthy Partner with 30 years of Clinical Experience\(^1\) in Prostate and Breast Cancer Treatment\(^2\)-\(^8\)

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Convenient and Reliable\(^7\)-\(^8\)
- Ready-to-use preloaded implant storing at ≤25°C with no refrigeration required to provide controlled, standard and effective treatment\(^7\)
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Faster Administration with Minimal Pain\(^10,\(^11\)
- Average of 1.7 minutes to prepare and deliver Zoladex® vs 3.34 minutes for leuprolide acetate\(^10,\(^11\)
- Minimal pain (VAS <10 mm) reported by majority of patients\(^10,\(^11\)

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References:

Dr. Andrew Armstrong is a tenured Professor of Medicine, Surgery, Pharmacology and Cancer Biology and Director of Research for the Duke Cancer Institute’s Center for Prostate and Urologic Cancer. He is a medical oncologist and internationally recognized expert in experimental therapeutics and biomarker development in genitourinary cancers, particularly in prostate cancer. He trained at Duke as a biomedical engineer, received his medical degree at the University of Virginia, medicine residency training at the University of Pennsylvania, fellowship and public health clinical investigation training at Johns Hopkins and the Bloomberg School of Public Health, and joined Duke’s faculty in 2006.

As a clinical and translational investigator, he is focused on experimental therapeutics for patients with advanced genitourinary malignancies, particularly with a focus on prostate and kidney cancer and the investigation of biomarkers of response and benefit both in the laboratory and in the clinic. He is funded by the US Department of Defense, PCF/Movember, the NIH, and the American Cancer Society for his work on circulating tumor cell biology and epithelial plasticity. He led the development of enzalutamide and FDA approval for men with metastatic prostate cancer and studies hormone resistance in the laboratory and ways to overcome this in the clinic. He was a Prostate Cancer Foundation, AACR, and ASCO Young Investigator Award recipient. He co-chaired Prostate Cancer Working Group 3 which established guidelines in 2016 for clinical research in advanced prostate cancer, and is a leading writing member of the NCCN Prostate Cancer panel since 2012 for national clinical guidelines on the treatment of men with prostate cancer.

Dr. Armstrong has developed a number of experimental agents in prostate and renal cell cancer, including completed or ongoing trials of AR inhibitors, immunotherapies, mTOR/PI3K inhibitors, and anti-angiogenic agents, and is heavily involved in the leadership of multiple ongoing phase 1-4 treatment and biomarker trials in men with advanced prostate cancer including serving as correlative science chair within the NCI ALLIANCE Cooperative Group in the GU Committee. He has authored over 200 peer reviewed publications as well as numerous chapters, reviews, and abstracts. He leads a team of over 50 research nurses, coordinators, data managers, regulatory specialists, scientists, and investigators dedicated to discovery science in GU cancers in the laboratory and treatment science in the clinic. As an R01 funded clinical-translational investigator, he has mentored over a dozen medical oncology fellows and junior faculty, and many residents and students both in the clinical, for clinical trials, and for laboratory training.

Abstract

Until recently, the standard of care for men with metastatic hormone sensitive prostate cancer (mHSPC) was testosterone suppression alone with androgen deprivation therapy (ADT) alone and the benefits of novel hormonal therapies (NHT) and docetaxel were limited to patients with metastatic castration resistant prostate cancer (mCRPC). However, major advances have been made from multiple phase 3 trials demonstrating the improved survival of men with mHSPC treated with ADT/docetaxel, and ADT plus several NHT including abiraterone, apalutamide and enzalutamide, as well as radiation to the prostate in men with low volume metastatic disease. When determining the most optimal treatment choices, a range of patient and disease specific factors are critical in these now increasingly complex treatment decisions including disease volume, patterns of spread, prior local therapy, patient comorbidities and concurrent medications, symptoms, and costs/availability. Docetaxel/ADT is effective in men with high-volume disease who are fit for chemotherapy, and docetaxel/ADT plus an AR inhibitor may extend survival even further. NHTs extend survival consistently regardless of disease volume/risk and prior therapy. Multiple international guidelines now recommend the use of ADT with another systemic therapy in men with mHSPC. Meanwhile, more advanced combination therapies are being investigated in men with mHSPC and in men with high risk localized nmHSPC. These treatments may be potential options in selected patients.
A LOT CAN HAPPEN IN EXTRA TIME

THANKS TO ITS DISTINCT MAO1, COMPARED WITH LHRR AGONISTS, FIRMAGON®:
- Provides significantly faster1,2 and lasting3 suppression of testosterone and PSA levels
- Delivers significantly improved overall survival during the 11 year of treatment4,5
- Significantly improves QoL and reduces prostate size compared with LHRR agonist + antiandrogen treatment6,7

PATIENTS ARE ASSOCIATED WITH 48% LESS RISKS OF CARDIOVASCULAR EVENTS WHEN RECEIVING FIRMAGON® COMPARED TO LHRR AGONISTS8,9

EUA RECOMMENDS LHRR ANTAGONISTS FOR PROSTATE CANCER PATIENTS WITH AN IMPENDING SPINAL CORD COMPRESSION OR BLADDER OUTLET OBSTRUCTION10

EUA European Association of Urology LHRR attenuating hormone-releasing hormone, MAO mechanism of action; PSA prostate-specific antigen; QoL quality of life
1 The primary endpoints were suppression of testosterone to ≤50 ng/dL and ≤30% measurements from the 28 to 54 month (treatment duration).
2 For the analysis of placebo vs. Firmagon and Gnr-Hc, comparisons post-maintenance were made in patients treated with Firmagon in urologist clinics, efficacy and safety outcomes were assessed.
3 Presence of hypertension; cardiovascular disease; diabetes mellitus; chronic obstructive pulmonary disease; and/or liver enzyme abnormalities.
4 Median reduction in testosterone suppression in patients maintaining FIRMAGON as anti-ERG and antihormone therapies in metastatic prostate cancer in patients receiving FIRMAGON as anti-ERG and antihormone therapies
5 Anti-ERG treatment including chemotherapy, second-line hormone therapy, prostatectomy, radiation therapy, and/or discontinuation of anti-ERG treatment.
6 Secondary endpoints included the effect on lower urinary tract symptoms (OAB), night urinary symptoms (OAB), and clinical symptom and body mass index (BMI) outcomes.

FOR PATIENTS WITH ADVANCED HORMONE-DEPENDENT PROSTATE CANCER12

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- For additional information, please consult the product package insert before prescribing.

REFERENCES:

START STRONG. STAY IN CONTROL.
Kim Chi is a medical oncologist and the Chief Medical Officer of BC Cancer, which provides a comprehensive cancer control program for the people of British Columbia (BC), in Canada. He is also Professor of Medicine at the University of British Columbia, in Vancouver, BC.

Prof. Chi’s research in the field of genitourinary cancers focuses on prostate cancer and investigational new drugs, where he has contributed to changing international standards of care practice for patients with advanced prostate cancer. Recently, he has been investigating circulating tumour DNA as a potential prognostic and predictive biomarker for patients with castration-resistant prostate cancer. Prof. Chi is the past-Chair of the Genitourinary Disease Site Committee for the Canadian Cancer Trials Group, and has held peer-reviewed grant funding from the Canada Institutes of Health Research (CIHR), National Cancer Institute of Canada (NCIC)/Canadian Cancer Society (CCS), the US Department of Defence, Movember, Prostate Cancer Foundation (USA), and Prostate Cancer Canada.

Prof. Chi has published widely in prestigious peer-reviewed journals including most recently the Journal of Clinical Oncology, Annals of Oncology, the New England Journal of Medicine, and Lancet Oncology.

Abstract
Castration therapy, also termed androgen deprivation therapy (ADT), has been the initial treatment of metastatic prostate cancer since its first description over 80 years ago. Since 2015, a series of phase 3 trials have reported out demonstrating improved clinical outcomes with ADT “intensification”. Compared to ADT alone, improved overall survival and other benefits were observed first with the addition of docetaxel to ADT in the CHAARTED and STAMPEDE (Arm C and E) studies. Subsequently, the LATITUDE and STAMPEDE (Arm G) studies demonstrated the benefits of the addition of abiraterone and prednisone to ADT, and more recently the addition of the next generation androgen receptor (AR) antagonists’ apalutamide (TITAN) and enzalutamide (ENZAMET, ARCHES) were also shown to improve survival. The clinical benefits of these additional therapies to ADT were observed across prognostic subgroups and collectively indicate that all patients with metastatic castration-naïve/sensitive prostate cancer (mCSPC) should be considered for intensified ADT therapy. Triplet therapy with the addition of an AR pathway inhibitor to ADT + docetaxel is also a treatment consideration based on consistent benefits on progression free survival observed in subgroup analysis of the TITAN, ENZAMET and ARCHES studies, and the recently reported PEACE-1 trial where improved overall survival with the addition of abiraterone to ADT + docetaxel was observed. The future is promising for additional treatment options, as clinical trials testing novel targeted agents are currently accruing patients with mCSPC that are biomarker selected including for PSMA-PET positive disease, alterations in homologous recombination repair associated genes, and PTEN deficiency.
OVERALL SURVIVAL AT ITS CORE

The FIRST and ONLY immunotherapy to demonstrate overall survival in the first-line setting for locally advanced or metastatic urothelial carcinoma (UC) as a maintenance treatment.

**Initial CT** may help decrease the tumor burden. **BAVENCIO** maintenance therapy may result in enhanced antitumor activity while avoiding cross-resistance and cumulative toxicity.

**JAVELIN Bladder 100 Trial:** 1L maintenance therapy with **BAVENCIO** + **BSC** vs **BSC** alone.

**mOS, Overall Population**

<table>
<thead>
<tr>
<th></th>
<th>mOS</th>
<th>Hazard ratio (HR)</th>
<th>95% CI</th>
<th>2-sided p</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAVENCIO + BSC</td>
<td>21.4 MONTHS</td>
<td>0.69</td>
<td>0.56, 0.86</td>
<td>0.001</td>
</tr>
<tr>
<td>BSC alone</td>
<td>14.3 MONTHS</td>
<td></td>
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</tr>
</tbody>
</table>

**OS rate at 12 months**

<table>
<thead>
<tr>
<th></th>
<th>OS rate at 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAVENCIO + BSC</td>
<td>79.1% (95% CI 0.72, 0.85)</td>
</tr>
<tr>
<td>BSC alone</td>
<td>60.1% (95% CI 0.52, 0.66)</td>
</tr>
</tbody>
</table>

**Benefit across subgroups** including type of 1L CT regimen, response to CT, PDL1 status and overall population.
Prostate Cancer Session

Lecture 10
Optimizing ADT in PCa with CVD history: Real-world evidence & mitigation strategy

Prof. Ricardo A Rendon
Professor, Department of Urology,
Faculty of Medicine,
Dalhousie University, Canada

Dr. Ricardo Rendon did his medical school and residency in Bogota, Colombia. He subsequently completed a clinical and research Uro-Oncology Fellowship at the University of Toronto, Canada and a Masters in Community Health Clinical Epidemiology. He joined Dalhousie University in Halifax, Canada in 2001 where he is a Professor in the Department of Urology and the Director of Research and Clinical Trials. He is the Chair of the Genito-Urinary Cancer Site Team, Nova Scotia Health Authority Cancer Program and a Senior Investigator at the Beatrice Hunter Cancer Research Institute. Dr. Rendon is currently the Vice-President of Education of the Canadian Urological Association and the secretary/treasurer of the Canadian Uro-Oncology Group. While his clinical practice focuses on all areas of urologic oncology, his research focuses on renal cell carcinoma, advanced prostate cancer and urothelial cell carcinoma. He has authored over 170 peer-reviewed manuscripts and has been particularly active in the development of clinical guidelines and national and international collaborations in kidney, bladder, upper tract urothelial cell carcinoma and prostate cancer.

Abstract
In his talk, Professor Rendon will elaborate the effect of androgen deprivation therapy on advanced prostate cancer patients with pre-existing cardiovascular disease, update the audience with the best evidence to illustrate the oncological outcomes and safety profiles of GnRH antagonist in metastatic disease, as well as CV risk mitigation strategy in the real-world setting.
It is Time for Balversa®

The First and Only FDA-approved Pan-FGFR Inhibitor for Metastatic UC

Limitations in Current Second-line Therapeutic Approaches

- Low response rates (10 to 20%)
- Poor overall survival (6 to 9 months)

Achieve Rapid and Durable Responses with Balversa®

- 40% Objective response rates
- Median duration of progression-free survival: 5.5 months
- Median duration of overall survival: 13.8 months

A Determining Clinical Trial which Studied Balversa® in Patients with FGFR+ Locally Advanced or Metastatic UC

- Primary endpoint: objective response rates (complete response + partial response)
- Secondary endpoints: overall survival, progression-free survival and duration of response

Efficacy and safety established in a phase 2, multicenter, open-label clinical trial of patients with locally advanced or metastatic UC who failed 2 or more prior chemotherapy regimens and whose tumor tissue had an FGFR3 gene mutation or an FGFR gene fusion.

References:

ACTIVE INGREDIENTS: Erdafitinib

INDICATIONS: Balversa® is indicated for the treatment of adult patients with locally advanced or metastatic urothelial carcinoma (UC) that has progressed on or following at least one line of prior platinum-containing chemotherapy, including at least 2 months of therapy with a platinum-containing chemotherapy regimen. DISEASE & MANAGEMENT: Recommended starting dose of BALVERSA® is 8 mg once daily. In patients with extensive metastatic disease, administer BALVERSA® for 8 mg once daily for 11 days after initiating treatment. In the patients with a dose of BALVERSA® at 8 mg once daily, the plasma half-life is approximately 27 hours, and there are no active metabolites or drug-like active metabolites. Therapeutic plasma levels are not reached for more than 12 hours. CONTRAINDICATIONS: Hepatic impairment, neoplastic transformation or complicating inflammatory conditions, renal impairment, hyperglycemia, severe allergic reactions, and severe infections, including tuberculosis. ADVERSE REACTIONS: The most common adverse reactions are fatigue, nausea, diarrhea, vomiting, pyrexia, anorexia, weight loss, anemia, leukopenia, lymphopenia, neutropenia, increased creatinine, hyperglycemia, and hypothyroidism. Other common adverse reactions are abdominal pain, rash, dehydration, and anorexia. laboratory abnormalities include increased alkaline phosphatase, increased aspartate aminotransferase, increased alanine aminotransferase, increased bilirubin, increased calcium, increased creatinine, increased lipase, increased sodium, and decreased potassium, decreased blood pressure. Report any suspected adverse reactions to the FDA or to the manufacturer.

Sumanta (Monty) Kumar Pal, M.D., is an internationally recognized leader in the area of genitourinary cancers, including kidney, bladder, and prostate cancer. He is co-director of City of Hope’s Kidney Cancer Program and is the head of the kidney and bladder cancer disease team at the institution. Dr. Pal entered college at the age of 13 and began medical school at University of California Los Angeles at the age of 17. After completing his residency training at UCLA, Dr. Pal completed a fellowship program in medical oncology at City of Hope’s comprehensive cancer center where he has remained on faculty since 2009. Over that span of time, he has published more than 400 PubMed cited articles that have been featured in prominent journals including Cancer Discovery, The Journal of Clinical Oncology, The Lancet, Cancer Cell and European Urology. Dr. Pal holds patents for new drugs currently under development in prostate cancer and also maintains one of the largest portfolios of clinical trials for kidney and bladder cancer research on the West Coast. He developed an integrated program that focuses heavily on collaborations with basic science researchers at the Beckman Research Institute of City of Hope and urologists in the Department of Surgery. Ultimately, Dr. Pal’s goal is to stimulate collaborative research across multiple departments in order to discover novel therapeutic approaches for currently incurable diseases. He has also worked to push the boundaries of personalized medicine in genitourinary cancers with several seminal publications in rare genitourinary cancers that describe unique therapeutic targets. He is the lead investigator on multiple trials, ranging from early phase 1 experiences to late stage phase 3 studies. Dr. Pal sits on the editorial board for Kidney Cancer and is a reviewer for multiple journals including The Lancet, The Journal of Clinical Oncology, The Journal of Urology, European Urology, New England Journal of Medicine and many others. Dr. Pal has received grants from the National Institute of Health, the Comprehensive Cancer Network, SWOG Cancer Research Network and multiple other leading entities in support of his formidable research.

Abstract
The landscape of front-line treatment for metastatic renal cell carcinoma has migrated substantially in recent years. Combinations of targeted therapy with immunotherapy or dual immunotherapy regimens now represent the standard. We will discuss strategies for selecting front-line regimens based on factors including efficacy, quality of life and toxicity.
KEYTRUDA® (PEMBROLIZUMAB) + AXITINIB: HELPING TO REDEFINE SURVIVAL EXPECTATIONS
FOR YOUR PATIENTS WITH aRCC

KEYTRUDA + axitinib achieved superiority across OS, PFS and ORR vs sunitinib

For KEYTRUDA + axitinib:

✓ MEDIAN OS NOT REACHED
  vs 36.7 months for sunitinib (95% CI: 33.3–NR)

✓ 32% REDUCED RISK OF DEATH
  (95% CI: 0.55–0.85) vs sunitinib; P=0.0003

✓ SUPERIOR MEDIAN PFS
  15.4 months vs 11.1 months for sunitinib;
  HR=0.71 (95% CI, 0.60–0.84); P<0.0001

✓ 60% ORR
  (95% CI: 54.4–64.8) vs 40% with sunitinib
  (95% CI: 35.2–44.7); P<0.0001

• 9% CR vs 3% with sunitinib

Median patient follow-up was 30.6 months
Kaplan-Meier Estimates of OS in KEYNOTE-426

Abbreviations: aRCC: advanced renal cell carcinoma; CI: confidence interval; CR: complete response; HR: hazard ratio; ITT: intention-to-treat; NR: not reached; PFS: progression-free survival; PR: partial response; ORR: objective response rate; OS: overall survival


Selected Safety Information for KEYTRUDA (pembrolizumab)

Contraindications: • Severe Precautions: immune-mediated pneumonitis • immune-mediated colitis • immune-mediated hepatitis (KEYTRUDA) and hepatocellular toxicity (KEYTRUDA in combination with axitinib) • immune-mediated nephritis and renal dysfunction • immune-mediated skin adverse reactions (including hypersensitivity and anaphylaxis) • Complications of allogeneic HSCT in patients after or prior to treatment with KEYTRUDA increase in mortality in patients with multiple myeloma when KEYTRUDA is added to a thalidomide analogue and lenalidomide • Embryo-fetal toxicity: Adverse Events: Most common adverse reactions reported (≥20% of patients) when KEYTRUDA was used as a single agent were fatigue, musculoskeletal pain, decreased appetite, pyrexia, nausea, dyspnea, constipation, diarrhea, cough, and conjunctivitis. When KEYTRUDA in combination with axitinib were diarhoea, fatigue/asthenia, hypertension, hypothyroidism, increased appetite, paronychial erythromelalgia, nausea, stomatitis/mucosal inflammation, dysphonia, rash, cough and constipation. • immune-mediated pneumonitis • immune-mediated colitis • immune-mediated hepatitis (KEYTRUDA) and hepatocellular toxicity (KEYTRUDA in combination with axitinib) • immune-mediated nephritis and renal dysfunction • immune-mediated skin adverse reactions (including hypersensitivity and anaphylaxis) • other immune-mediated adverse reactions • infusion-related reactions. As with all therapeutic proteins, there is the potential for immunogenicity. For detailed precautions and adverse events, please consult the full prescribing information.

Before prescribing KEYTRUDA®, please consult the full prescribing information.

MSD SHARP & DOHME (ASIA) LTD.
27/F, Lee Garden Two, 29 Yee Fung Road, Causeway Bay, Hong Kong.
TOLL: (852) 3971 2800 FAX: (852) 2864 0790
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Dual immune checkpoint blockade in the treatment of advanced RCC

Dr. Hans Hammers
Associate Professor, Internal Medicine, Eugene P. Frenkel, M.D. Scholar in Clinical Medicine, Division of Hematology-Oncology, The University of Texas Southwestern Medical Center, United States

Hans Hammers, M.D., Ph.D., is an Associate Professor of Internal Medicine in the Division of Hematology-Oncology at UT Southwestern Medical Center. He is the first Eugene P. Frenkel, M.D. Scholar in Clinical Medicine. Dr. Hammers received his M.D. and Ph.D. from the Medical University of Luebeck in Germany. He completed his residency in internal medicine at Johns Hopkins Bayview Medical Center and performed his fellowship in medical oncology at the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins. Also at Johns Hopkins, Dr. Hammers led the kidney cancer research efforts and played a major role in the development of immunotherapy with immune checkpoint inhibitors in kidney cancer. His work in immunotherapy has been nationally recognized, and he has been the principal investigator on several industry- and investigator-sponsored trials. Dr. Hammers joined the UT Southwestern faculty in 2016. He is co-leader of clinical research and immunotherapy for the kidney cancer research program and will be continuing his research efforts to develop novel immunotherapies for kidney cancer.

Abstract
Immune checkpoint inhibitors have revolutionized the treatment for many cancer types, including clear cell RCC. In the era of immune checkpoint combinations, dual immuno-oncology (IO) combination of nivolumab and ipilimumab has been approved as initial treatment for patients with IMDC intermediate and poor risk advanced RCC. With a minimum of 60-month follow-up in Checkmate 214 trial, dual IO combination continued to demonstrate consistent improvements in overall response rate (ORR), median progression-free survival (PFS) and median overall survival (OS) over sunitinib in patients with IMDC intermediate and poor risk disease. In addition, dual IO combination produced more CRs, of which >80% were still ongoing at 42 months. Responses produced by dual IO combination were also durable, with a median duration of response (DoR) remaining not reached at 60-month follow-up. Less patients in the dual IO combination arm developed treatment-related grade 3 or 4 adverse events, received subsequent therapies, and had better patient reported quality of life than sunitinib.
WE COULDN’T BELIEVE IT EITHER.

LUTATHERA® is indicated for the treatment of unresectable or metastatic, progressive, well differentiated (G1 and G2), somatostatin receptor positive gastroenteropancreatic neuroendocrine tumours (GEP-NETs) in adults.

PRIMARY ENDPOINT

79% REDUCTION IN THE RISK OF DISEASE PROGRESSION OR DEATH VS. CONTROL.

HOW OFTEN DO YOU SEE DATA LIKE THIS?

Significantly longer progression-free survival (PFS) in the LUTATHERA® arm (median PFS of 28.4 months vs. 8.5 months with octreotide LAR 60mg Q4W [not a licensed dose])

NETTER-1 is an international phase III study in patients with NENs. 231 patients with well-differentiated, metastatic midgut NETs received either LUTATHERA® 7.4GBq Q6W (a intravenous infusion) plus octreotide long-acting repeatable (LAR) 60mg (n=117) or octreotide LAR alone 60mg Q4W (n=114).

What LUTATHERA® achieves

In patients with somatostatin receptor positive GEP-NETs,

- **79%** Reduction of risk of progression or death*^
- **48** months Prolonged* median OS
- **28.8** months Improved* quality of life
- **Recommended** by ENETS guidelines after 1st line

*Not statistically significant (vs. 36.3 months in the control arm); HR, 0.84; 95% CI, 0.60–1.17; P=0.30, two-sided.

Median time to quality-of-life deterioration (global health status): 26.8 vs. 6.1 months in the control arm.*

Adverse drug reactions (very common [≥10%]): Hyperglycaemia, hypoglycaemia, anemia, pancytopenia, decreased appetite, nausea, vomiting, and fatigue.

CI, confidence interval; EMA, European Medicines Agency; ENETS, European Neuroendocrine Tumour Society; FDA, Food and Drug Administration; HR, hazard ratio; OS, overall survival; PRRT, peptide receptor radionuclide therapy.

References:
1. LUTATHERA® Hong Kong Prescribing Information. Revision date: 13 Mar 2020.
Choose Lynparza™ for your BRCA-mutated mCRPC patients who have progressed following prior NHA treatment1.

Lynparza™ is indicated as monotherapy for the treatment of adult patients with metastatic castration-resistant prostate cancer and BRCA1/2-mutations (germline and/or somatic) who have progressed following prior therapy that included a new hormonal agent.

Lynparza™ more than tripled median imaging-based PFS vs. physician’s choice2

<table>
<thead>
<tr>
<th>Lynparza™</th>
<th>Physician’s choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.8 months</td>
<td>3.0 months</td>
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</table>

Lynparza™ increased median OS by 5.7 months vs. physician’s choice3

<table>
<thead>
<tr>
<th>Lynparza™</th>
<th>Physician’s choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.1 months</td>
<td>14.4 months</td>
</tr>
</tbody>
</table>

Majority of patients stayed on Lynparza™4

80% of patients in the PROfound trial remained on Lynparza™ without discontinuing due to adverse events5.

Test your prostate cancer patients for BRCA mutations

References:
1. Lynparza™. Hong Kong Prescribing Information.
4. Presentation: Lynparza Tomorrolan talk. 300 mg or 150 mg, indication: Monotherapy for the maintenance treatment of adult patients with advanced (HRG) stages III and IV BRCA1/2-mutated advanced ovarian cancer, not previously treated.
5. Presentation: Lynparza Tomorrolan talk. 300 mg or 150 mg, indication: Monotherapy for the maintenance treatment of adult patients with advanced (HRG) stages III and IV BRCA1/2-mutated advanced ovarian cancer, not previously treated.
6. Presentation: Lynparza Tomorrolan talk. 300 mg or 150 mg, indication: Monotherapy for the maintenance treatment of adult patients with advanced (HRG) stages III and IV BRCA1/2-mutated advanced ovarian cancer, not previously treated.
Response that matters with the power of LENVIMA®

PROVEN EFFICACY IN 4 DIFFERENT CANCERS

MONOTHERAPY:

UNRESECTABLE HEPATOCELLULAR CARCINOMA

First-line treatment of patients with unresectable hepatocellular carcinoma (HCC) Now listed in Community Care Fund

IN COMBINATION:

ADVANCED RENAL CELL CARCINOMA

In combination with everolimus for the treatment of advanced renal cell carcinoma following one prior anti-angiogenic therapy

ADVANCED ENDOMETRIAL CARCINOMA

In combination with pembrolizumab for advanced endometrial carcinoma that is non-microsatellite instability-high or mismatch repair deficient, who have disease progression following prior systemic therapy and are not candidates for curative surgery or radiation therapy

Convenient oral—daily dosing

Manageable and consistent safety profile across all indications for both monotherapy and combination therapy

Abbreviations: HCC, Hepatocellular carcinoma
LENVIMA® (lenvatinib) Abbreviated Prescribing Information
Indications: Endometrial Carcinoma: LENVIMA, in combination with pembrolizumab, is indicated for the treatment of patients with advanced endometrial carcinoma (EC) that is non-microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), who have disease progression following prior systemic therapy and are not candidates for curative surgery or radiation. This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trial, Differentially Thrombogenic Cancer: LENVIMA is indicated for the treatment of patients with locally recurrent or metastatic, progressive, radioactive iodine refractory differentiated thyroid cancer (DTC). Hepatocellular Carcinoma: LENVIMA is indicated for the first-line treatment of patients with unresectable hepatocellular carcinoma (HCC). Renal Cell Carcinoma: LENVIMA is indicated in combination with everolimus for the treatment of patients with advanced renal cell carcinoma (RCC) following one prior anti-angiogenic therapy. Presentation: Hard capsules 4 mg and 10 mg. Dosage and administration: EC: The recommended daily dose is 20 mg orally once daily. In combination with pembrolizumab 100 mg administered as an intravenous infusion over 30 minutes every 3 weeks, until unacceptable toxicity or disease progression. Refer to the pembrolizumab prescribing information for other pembrolizumab dosing information. DTC: The recommended daily dose is 30 mg as lenvatinib administered orally once a day. RCC: The recommended daily dose is 15 mg as lenvatinib in combination with 5 mg everolimus administered orally once a day. HCC: LENVIMA capsules can be swallowed whole or dissolved in a small glass of liquid. To dissolve in liquid, put capsules into 1 tablespoon of water or apple juice without breaking or crushing the capsules. Leave the capsules in the water or apple juice for at least 10 minutes, stir for at least 3 minutes. After drinking the mixture, add 1 tablespoon of water or apple juice to the glass, swirl the contents a few times and swallow the water or apple juice. Warnings and precautions: Hypertension, Coagulopathy, Arterial thromboembolic events, Interstitial lung disease, Pulmonary embolism, Liver failure, Impairment of thyroid stimulating hormone suppression. Hypothyroidism. Impaired wound healing. Embryo-fetal toxicity. Pregnancy and lactation: For detailed precautions, please consult the full prescribing information. Contraindications: None. Adverse events: The most common adverse reactions (>20%) observed in LENVIMA with pembrolizumab in patients treated for EC include: fatigue, nausea, skin reactions, hypertension, hemolytic events, diarrhea, anemia, rash, dyspepsia, vomiting, abdominal pain. In patients treated for DTC include: hypertension, fatigue, diarrhea, arthralgia/myalgia, decreased appetite, weight decreased, nausea, stomatitis, headache, vomiting, pruritus, hypercholesterolemia, thyroid disease, dysphonia. The most common adverse reactions (≥30%) observed in LENVIMA in patients treated for RCC include: hypertension, fatigue, diarrhea, decreased appetite, arthralgia/myalgia, decreased weight, abdominal pain, pain, peripheral neuropathy, hypoglycemia, hyperglycemia, weight decreased. In patients treated for HCC include: hypertension, fatigue, diarrhea, decreased appetite, arthralgia/myalgia, decreased weight, abdominal pain, pain, peripheral neuropathy, hypoglycemia, hypothyroidism, and nausea. The most common adverse reactions (≥30%) observed in LENVIMA in patients treated for HCL include: hypertension, fatigue, diarrhea, decreased appetite, arthralgia/myalgia, decreased weight, abdominal pain, peripheral neuropathy, nausea, rash, decreased appetite, weight decreased, hypothyroidism, events and proteinuria. Storage: To be stored under 30°C. Store in the original blister in order to protect from moisture. Packaging: LENVIMA capsules are supplied in cartons of 2 blister cards. Each carton contains 20 capsules of LENVIMA 4 mg or 10 mg. Please refer to the Full Prescribing Information for details. Further information is available upon request.
Treatment for prostate cancer*

* Enantone 1M and 3M: Prostate Cancer, Enantone 4M is used in male adults for palliative treatment of the advanced hormone-dependent prostate carcinoma

**ADMINISTRATION STEPS**

**SIMPLICITY**

---

**EFFICIENCY**

---

Dual-chamber prefilled syringe DPs* with fine needle

Designed for Patient Comfort and Convenience

---

**Abbreviated Prescribing Information**

Enantone 1M: Delayed 3.75 mg (ENRMD003M171HP) Enantone 3M: Delayed 3.75 mg (ENRMD003M174HP) Enantone Doses: 30 mg (ENRMD003M179HP)

Active Ingredient: Leuprolide acetate Indications: Enantone 1M Delayed 3.75 mg Indemistone, decrease of myoma volume and/or amelioration of symptoms in uterine myoma with hypermenorrhea, hypertrophy, low back pain, menopause, etc. Premenopausal breast cancer (positive hormone receptor expression), Prostate cancer, Central precocious puberty, Enantone 3M: Delayed 3.75 mg in male Prostate cancer and its sequelae (advanced prostate cancer and radiation-advanced prostate cancer). Enantone 4M: Delayed 30 mg (ENRMD003M179HP) Indemistone, decrease of myoma volume and/or amelioration of symptoms in uterine myoma with hypermenorrhea, hypertrophy, low back pain, menopause, etc. Premenopausal breast cancer (positive hormone receptor expression), Prostate cancer, Central precocious puberty, Enantone 3M: Delayed 30 mg in male prostate cancer and its sequelae (advanced prostate cancer and radiation-advanced prostate cancer)

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**14**
Acknowledgement of Supporting Organizations

In Collaboration with:

- Hong Kong Urological Association

Major Supporting Organization:

- Hong Kong College of Radiologists

Supporting Organizations: (In alphabetical order)

- Hong Kong Association of Community Oncologists
- Hong Kong Association of Radiation Therapists
- Hong Kong Society of Clinical Oncology
- Hong Kong Society of Endourology
- Hong Kong Society of Practising Urologists
- Macau Oncology Association
- The Society of Hospital Pharmacists of Hong Kong
- Urological Nursing Chapter of Hong Kong Urological Association
Acknowlegement of Sponsors

Hong Kong Society of Uro-Oncology is deeply appreciative of the following companies’ contribution towards the success of our meeting.

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- Sanofi Hong Kong Ltd.

**Special Lecture Sponsor**
- Roche Hong Kong Ltd.

*In alphabetical order*
Xtandi® - EARLY-LINE treatment of mCRPC with proven benefit in PSA response to your patients

Durable PSA response in different mCRPC patient populations

POST-CHEMO  |  PRE-CHEMO

<table>
<thead>
<tr>
<th>STUDIES</th>
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<td>AFFIRM</td>
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<tr>
<td>TERRAIN</td>
<td>5.8 (19.4)</td>
</tr>
<tr>
<td>STRIVE</td>
<td>5.7 (24.9)</td>
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Bicalutamide
Placebo