Urologic Cancers: What Would You Do?

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Panelists

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CASE 1
Prostate cancer

- 62yo M with elevated PSA of 6
- Prostate biopsy GI 3+4, 5/12 cores
- Prostate 40g, T1c exam
- Potent with PDE5I therapy
- PMH: HTN, DM2
- No prior surgery
Poll: Would you use molecular testing (e.g. Decipher, Prolaris)?

A. Yes
B. No
Panel Discussion

• What are the pros/cons of molecular testing? What drives your decision to pursue testing?
What would you advise for treatment?

A. Radical Prostatectomy + PLND
B. Radical Prostatectomy
C. EBRT
D. Brachytherapy
E. EBRT + Brachy
F. EBRT + ADT
Panel Discussion

• In the setting of intermediate risk disease, what are the pros and cons of radiation therapy vs. prostatectomy w/ PLND?

• What impacts your decision to pursue PLND in patients with intermediate risk disease?

• If the patient elects RT, are there any benefits of concurrent ADT? Duration?
62yo M w/ Prostate Ca

• Patient chooses to undergo RP + PLND and has an uneventful postop recovery
• Path:
  – pT2c Gleason 4+3 disease, 40% of gland
  – Positive margin at L apex
  – No ECE or SV invasion
• PSA at 3 months undetectable
The patient is concerned about positive margins. What do you advise for management?

A. EBRT
B. Surveillance
C. Additional molecular testing
Panel Discussion

• What is the role of molecular testing in the setting of post-prostatectomy positive margins or ECE?

• What influences your decision to recommend radiation therapy in the setting of a positive margin?

• How long do you wait to initiate radiation therapy in the setting of positive margins or extracapsular extension?
62yo M w/ Prostate Ca

- The patient elects surveillance
- PSAs are checked every 6 months and remain undetectable
- At 2.5 years follow-up, PSA rises to 0.2
- Repeat PSA 3 months later is 0.4
- CT, bone scan negative for distant mets
What is your next step in treatment?

• Surveillance
• Prostate bed biopsy
• RT + ADT
• RT alone
Panel Discussion

• In which patients do you favor radiation therapy, ADT, or surveillance?
• Are there any clinical situations in which a prostate bed biopsy might be useful?
62yo M w/ Prostate Ca

- The patient undergoes EBRT and ADT but despite this, PSA continues to rise from 0.4 to 12 in 1 year.
- Bone scan now reveals two small foci in the femur and lumbar vertebrae.
- Patient asymptomatic, remains healthy.
What would you choose for additional therapy?

- Sipuleucel-T
- Addition of antiandrogen
- Abiraterone
- Enzalutamide
- Docetaxel
Panel Discussion

• In the setting of castrate-resistant prostate cancer, how do you decide between various chemotherapeutic regimens?
• What factors impact your decision for treatment?
CASE 2
65yo M presents with hematuria and local cystoscopy shows a solitary 3cm bladder mass at the left lateral wall

PMH: HTN, History of MI

PSH: None

Former smoker (30PY, quit 10yr ago)

TURBT: HGT1, muscle present
Next step in treatment?

A. Induction BCG
B. Re-resection
C. Radical cystectomy w/ diversion
D. Induction Gemcitabine
Panel Discussion

• What is the role of re-resection in the setting of HGT1 disease?
• How does the pathology from re-resection direct your subsequent management?
• If BCG is unavailable, what alternatives do you recommend? Does this change with CIS in specimen?
65yo M with HGT1

- TURBT re-resection show no residual disease
- Patient opts for BCG induction
- The patient does well and undergoes BCG maintenance at 3, 6, 12 months but surveillance cystoscopy at 15 months reveals a tumor
How would you proceed?

A. BCG induction
B. BCG + Interferon induction
C. Cystectomy
D. Chemo-radiation
E. Gemcitabine induction
F. Valstar
Panel Discussion

- How do you define BCG-refractory vs. BCG-relapsing disease?
- In the setting of BCG-relapsing disease, what is the role of a second course of BCG induction, BCG + Interferon, or induction gemcitabine?
- What is the role of radiation therapy in the setting of BCG refractory or relapsing disease?
- Are there any clinical trials that are appropriate in the setting of BCG-relapsing disease? BCG-refractory?
- What are factors involved in the decision to undergo early cystectomy in BCG-relapsing patients?
65yo M with HGT1

- Patient elects 2nd BCG induction course
- Follow-up cysto following induction reveals recurrent tumor
  - TURBT HGT1
Panel Discussion

• What factors lead you to recommend cystectomy vs. bladder-sparing treatment options?
• Is this patient a candidate for laparoscopic or robotic cystectomy? Does prior BCG affect tissue planes?
65yo M with HGT1

- Patient elects radical cystectomy - pathology reveals HGT3, negative nodes, negative margins
Next step?

A. Surveillance via NCCN guidelines
B. Gemcitabine/cisplatin chemotherapy
C. Radiation therapy
Panel Discussion

• What is the efficacy of adjuvant chemotherapy? How does this differ from neoadjuvant chemotherapy?
• Are there cases of HGT1 in which you would provide neoadjuvant chemo?
• In the setting of HGT3 disease, what is the role of RT?
CASE 3
Small renal mass

• 65yo F presents with an incidentally detected R small renal mass on MRI obtained for abdominal pain
• HTN, DM2
• No prior surgeries
• Negative family history
MRI

- 3cm anterior, interpolar mass
- Chest CT (not shown) negative
What would you do next?

A. Renal biopsy
B. Active surveillance
C. Lap/Robotic partial nephrectomy
D. Open partial nephrectomy
E. Radical nephrectomy
F. Ablation (e.g. cryotherapy)
Panel Discussion

- What is the role of renal biopsy in management of the small renal mass?
- What criteria do you use when selecting patients for active surveillance?
- How do you apply the AUA Guidelines for SRM management?
- Is this patient appropriate for a robotic partial?
65yo F with R renal mass

- Patient undergoes right robotic partial nephrectomy
- During procedure, tumor appeared connected to aberrant adrenal gland
- Intraoperative frozen section: benign adrenal
- Final pathology:
  - pT1a RCC, conventional clear cell
  - No sarcomatoid features
  - Negative margins
  - Frozen section confirmed → benign adrenal
What surveillance regimen would you recommend?

A. No further imaging
B. Chest imaging annually for 3 years
C. Chest and abdominal imaging annually for 3 years
D. Abdominal imaging in 3-6 months, chest and abdominal imaging annually for 3 years
AUA Guidelines for Surveillance of Localized RCC

• Risk stratified
  – Low Risk (T1, N0, Nx)
  – Moderate to High Risk (T2-4N0 Nx, N+)

• Low risk
  – Partial: baseline scan, then annual chest+abdomen 3 yrs
  – Radical: baseline scan, then annual chest 3 yrs (abdomen at MD discretion)

• Moderate to High risk
  – Baseline abdomen/chest scan 3-6 months postop then every 6 months x 3 years, annually to 5 years
  – Imaging beyond 5 years optional
Panel Discussion

• How do you follow patients after partial or radical nephrectomy?
  – Any pathologic features that push you toward more (or less) surveillance?

• If this patient had elected active surveillance, how would this change your regimen?

• If recurrence is detected early, does this change management or survival?
65yo F with R renal mass

- Surveillance CT in 4 months: negative
65yo F with R renal mass

- Patient remains asymptomatic but one year later CT reveals severe hydro, adjacent soft tissue nodule & interaortocaval LAD
65yo F with R renal mass

- Bone scan negative, chest CT negative
- R ureteroscopy attempted, unsuccessful
  - Stent placed
- VIR biopsy of RP mass
  - Confirmed RCC
What is the best treatment?

A. Systemic therapy
B. Open radical nephrectomy + RPLND
C. Open radical nephrectomy
D. Radical nephroureterectomy + RPLND
E. Radiation therapy
Panel Discussion

• What drives your decision to pursue excisional vs. systemic therapy in the setting of recurrence?
  – Location of recurrence
  – Site/number of recurrences
• Would you consider performing nephrectomy/RPLND robotically?
• What is the role of PET imaging in RCC? How does this guide your management?
• Is there any role for radiation in this setting?
65yo F with R renal mass

- Patient undergoes open R radical nephrectomy with partial ureterectomy and excision of retroperitoneal mass (RPLND)

- Path:
  - pT3a clear cell, Furhman grade 4
  - Capsular invasion, renal sinus
  - Involves ureter, obliterates lumen
  - Margins negative
  - LNs positive- c/w RCC
65yo F with R renal mass

- 2 months later, MR-PET negative
- Another 2 months later, MR-PET reveals:
  - 9mm soft tissue nodule in R chest wall with FDG avidity
  - 4mm R chest wall SQ fat nodule (no avidity)
  - New focus in pancreatic uncinate process
Options for Treatment?

A. Systemic therapy
B. Radiation
C. Cryotherapy
D. Surgical excision
Panel Discussion

• What is the role of various modalities (RT, cryo, excision, chemo) in the setting of localized recurrence?

• The patient ultimately underwent cryotherapy of these lesions. Any role for systemic therapy following treatment (or surveillance)?
CASE 4
L testis tumor

- 21yo M presents with pain in L testicle, US confirmed mass
- No medical problems, no surgery
- Smoker, occasional drinking
- Undergoes radical orchiectomy with pre-orch markers:
  - AFP = 1.6
  - Beta-HCG = 2
  - LDH = 173
21yo M with L testis tumor

- L radical orch: pT2Nx embryonal nonseminomatous GCT with LVI+
- CT– enlarged L paraaortic nodes (1.4cm), few subcm nodes in retroperitoneum
What would you advise for treatment?

A. Bilateral nerve-sparing RPLND
B. Left-sided modified template RPLND
C. Chemotherapy
D. Radiation
Panel Discussion

• What are the pros/cons of chemo vs. RPLND in the case of Stage IIA NSGCT?
• If markers are elevated, does this change your approach?
• What is the role of different templates for RPLND? Different approaches (open/lap/robotic)?
21yo M with L testis tumor

- Patient elects RPLND – full bilateral nerve-sparing template
- Pathology:
  - Metastatic NSGCT with embryonal carcinoma in 2/24 nodes (max size of mets 4cm, no ECE, + spermatic cord)
- Stage IIB with negative postoperative markers & no non-pulm visceral mets → Good risk
What is your next step?

A. Surveillance
B. Chemotherapy with EP 2 cycles
C. Chemotherapy with BEP 2 cycles
D. Radiation therapy
Panel Discussion

• NCCN guidelines reserve surveillance for “very select” cases of IIB NSGCT—how do you choose these patients?
• How do you choose between EP or BEP in patients? What is the survival difference between regimens (if any)?
21yo M with L testis tumor

- Patient undergoes 2 cycles of EP (due to smoking status)
- Repeat markers:
  - HCG <5
  - AFP 1.4
- Most recent CT shows NED
CASE 5
R upper tract mass

- 46yo M with recurrent R nephrolithiasis presents vague R flank discomfort and intermittent hematuria for 4-6 weeks
- PMH: Stones, GERD, DM2
- PSH: R shoulder, knee surgery
- Smoker 1ppd x 30 years
- FH: MGF lung cancer with brain mets
46yo M with R upper tract mass

- CT urogram & MRI: R upper tract renal mass (~3cm) with retrocaval LAD
46yo M with R upper tract mass

- Patient undergoes R ureteroscopy + stent
- Large high grade-appearing tumor noted with pathology consistent with high grade urothelial cancer
46yo M with R upper tract mass

- PET scan
  - FDG avid R renal mass, aortocaval node and R middle lobe pulmonary nodule
Next step in treatment?

A. Chemotherapy followed by nephroureterectomy + RPLND
B. Nephroureterectomy
C. Nephroureterectomy + RPLND
D. Percutaneous resection of upper tract tumor
Panel Discussion

• What is the role for chemotherapy in the setting of upper tract urothelial cancer (UTUC)?
  – How many cycles?
  – Interim imaging? Adjunctive imaging (PET)?

• Is there any role for RT in UTUC?
46yo M with R upper tract mass

- 6 cycles of neoadjuvant cisplatin-based chemotherapy recommended
46yo M with R upper tract mass

• Patient undergoes 3 cycles of chemo with repeat PET
  – No response noted in primary tumor
  – Minimal response (slight decrease in size) in lung
What would be your next step in treatment?

A. Additional 3 cycles of chemotherapy
B. Nephroureterectomy
C. Nephroureterectomy with RPLND
D. Clinical trial
Panel Discussion

• What factors are involved in the decision to complete 6 cycles of chemotherapy?
• If pursuing nephroureterectomy following chemotherapy, what approaches would you consider (e.g. robotic/open)?
• What is the role of RPLND in the setting of UTUC? How do templates differ for L and R sided tumors? Distal/proximal tumor?
46yo M with R upper tract mass

• Patient undergoes open nephroureterectomy with RPLND
• Path:
  – T4 UTUC with 10 of 26 nodes positive
  – Signet ring features prominent
Next steps in continued treatment?

A. Complete chemotherapy regimen
B. Surveillance only (3 month CT + cysto)
C. Radiation therapy
46yo M with R upper tract mass

- Patient underwent retroperitoneal XRT to address risk of local recurrence
- Small papillary bladder lesion (watched)
- Lung mets worsening (hemoptysis) - referred for MPDL3280A trial
- Mets to brain 4 months later
- Radiation treatment