Genitourinary Masterclass

Today's treatment landscape for 1L advanced UC

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EV as first-line therapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer. Combination therapy with pembrolizumab.

EV as monotherapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer who have previously received a programmed death receptor-1 or programmed death-ligand 1 inhibitor, and have received a platinum-containing chemotherapy

1L, first line; EV, enfortumab vedotin; UC, urothelial carcinoma.
PADCEV® (enfortumab vedotin). Prescribing Information

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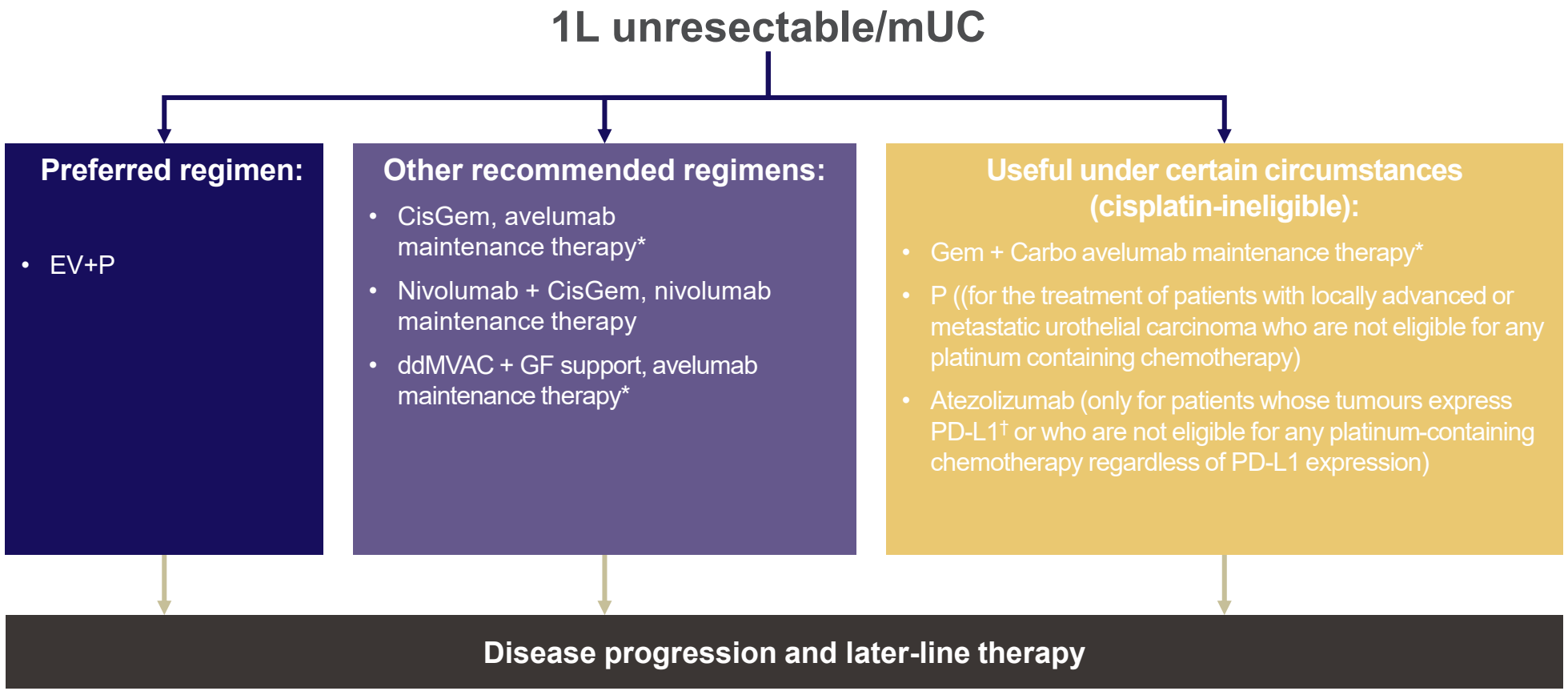
Recent data updates are reflected in clinical guideline updates – NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)



Disclaimer: EV+P is not approved for the 1L treatment of unresectable or metastatic UC in adults in some countries/regions. All HCPs should refer to their own country's specific Prescribing Information.

*Maintenance therapy with avelumab only if there is no progression on first-line platinum-containing chemotherapy; †Atezolizumab: SP142 assay, PD-L1–stained tumor-infiltrating immune cells covering ≥5% of the tumor area.

1L, first line; Carbo, carboplatin; Cis, cisplatin; DDMVAC, dose-dense methotrexate, vinblastine, doxorubicin, and cisplatin; EV, enfortumab vedotin-ejfv; Gem, gemcitabine; GF, growth factor; HCP, healthcare professional; LA/mUC, locally advanced/metastatic urothelial carcinoma; NCCN, National Comprehensive Cancer Network; P, pembrolizumab; PD-L1, programmed cell death ligand 1.

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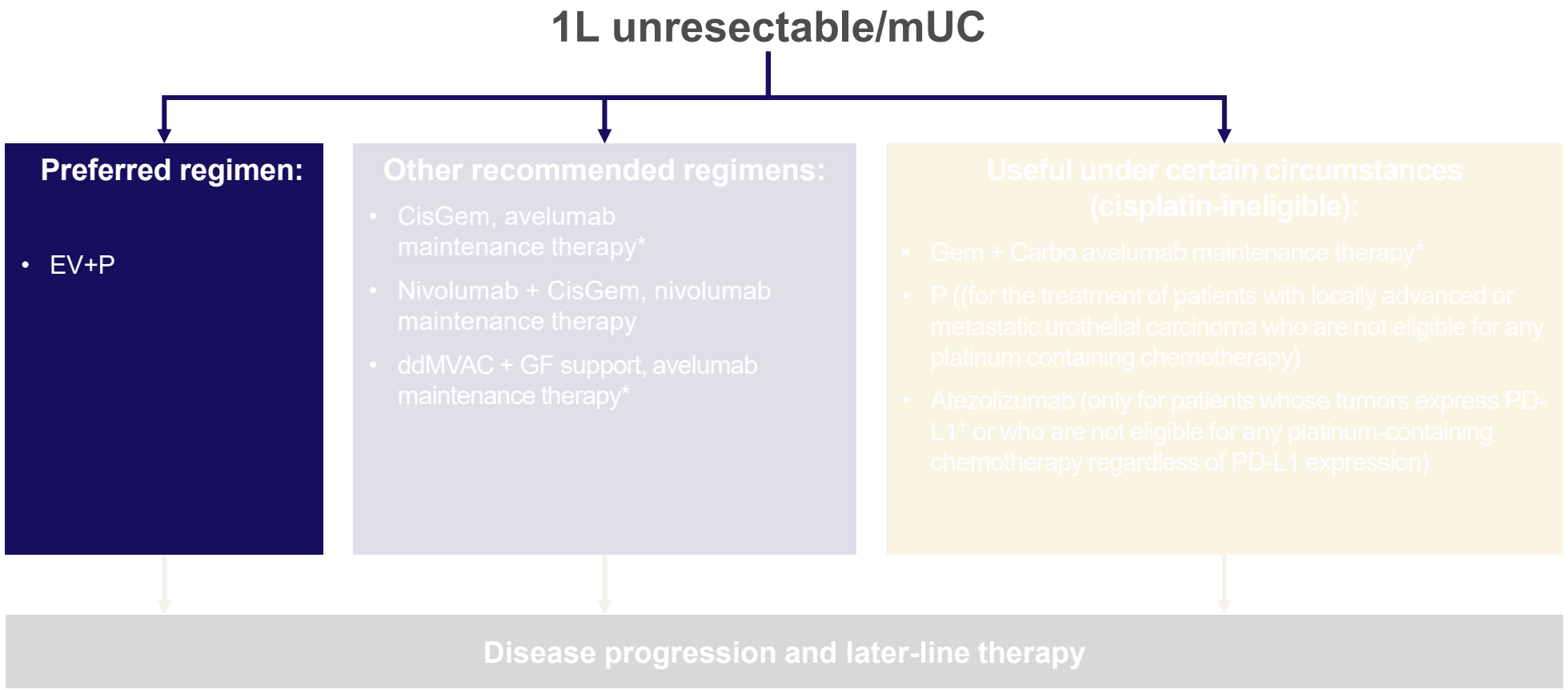

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EV-302: Enfortumab vedotin + pembrolizumab vs. PBCT

Study design[1,2]

Patient population
- Untreated, unresectable LA/mUC
- PD-1/L1 inhibitor-naïve
- Adequate renal function (≥30 ml/min)*
- ECOG PS ≤2†

N=866

R 1:1

Stratification factors
- Cis eligibility
- PD-L1 expression (high/low)
- Liver metastases (present/absent)

EV+P
No maximum treatment cycles for EV, maximum of 35 cycles for P (n=442)

CisGem or CarboGem
Maximum of 6 cycles (n=444)

Treatment until disease progression per BICR, clinical progression, unacceptable toxicity, or completion of maximum number of cycles

Maintenance therapy could be added following PBCT

Primary endpoints
- PFS (by BICR)
- OS

Select secondary endpoints
- ORR per RECIST 1.1 by BICR and investigator assessment
- Safety

EV-302/KEYNOTE-A39[1,2]	
Patient population	• ECOG PS **≤2** • GFR **≥30 ml/min**
Comparator	• CisGem or CarboGem (max. 6 cycles) • Avelumab maintenance (~30% of population)
Primary endpoint	PFS by BICR; OS

Select baseline characteristics (EV+P)[1]	
Cis eligible, %	54.3
Upper tract, %	30.5
Visceral metastases, %	71.9
Liver metastases, %	22.6
High PD-L1+ expression (CPS ≥10), %	58.0

*GFR ≥30 ml/min measured by the Cockcroft–Gault formula, modification of Diet in Renal Disease or 24-hour urine test;[2] †Patients with an ECOG PS of 2 were required to meet additional criteria: hemoglobin ≥10 g/dL, GFR ≥50 ml/min, may not have NYHA Class III heart failure.[2]

BICR, blinded independent central review; Carbo, carboplatin; Cis, cisplatin; CPS, combined positive score; ECOG, Eastern Cooperative Oncology Group; EV, enfortumab vedotin; Gem, gemcitabine; GFR, glomerular filtration rate; LA, locally advanced; m, metastatic; NYHA, New York Heart Association; ORR, objective response rate; OS, overall survival; P, pembrolizumab; PBCT, platinum-based chemotherapy; PD-1/L1, programmed cell death receptor/ligand 1; PFS, progression-free survival; PS, performance status; R, randomization; RECIST, Response Evaluation Criteria in Solid Tumours; UC, urothelial carcinoma.

1. Powles T et al. *N Engl J Med* 2024;390:875–888; 2. Powles T et al. *N Engl J Med* 2024;390:875–888 (supplementary appendix).

EV-302: Key demographics and baseline disease characteristics

Characteristics	EV+P (n=442)	Chemotherapy (n=444)
Male sex, n (%)	344 (77.8)	336 (75.7)
Age (years), median (range)	69.0 (37–87)	69.0 (22–91)
Race, n (%)		
White	308 (69.7)	290 (65.3)
Asian	99 (22.4)	92 (20.7)
Geographic location, n (%)		
North America	103 (23.3)	85 (19.1)
Europe	172 (38.9)	197 (44.4)
Rest of World	167 (37.8)	162 (36.5)
ECOG PS, n (%)		
0	223 (50.5)	215 (48.4)
1	204 (46.2)	216 (48.6)
2	15 (3.4)	11 (2.5)
Primary tumour location, n (%)		
Upper tract	135 (30.5)	104 (23.4)
Lower tract	305 (69.0)	339 (76.4)
H score of nectin-4 expression*		
Patients tested, n	394	406
Median score (range)	280 (0–300)	270 (0–300)

Characteristics	EV+P (n=442)	Chemotherapy (n=444)
Creatine clearance, n (%)		
≥60 ml/min	249 (56.3)	257 (57.9)
<60 ml/min	193 (43.7)	187 (42.1)
No. of Bajorin risk factors,† n (%)		
0	179 (40.5)	183 (41.2)
1	263 (59.5)	259 (58.3)
Cisplatin eligible,‡ n (%)	240 (54.3)	242 (54.5)
Metastatic category, n (%)		
Visceral metastases	318 (71.9)	318 (71.6)
Bone	81 (18.3)	102 (23.0)
Liver	100 (22.6)	99 (22.3)
Lung	170 (38.5)	157 (35.4)
Lymph node only disease	103 (23.3)	104 (23.4)
PD-L1 expression,¶ n/N (%)		
High (CPS ≥10)	254/438 (58.0)	254/439 (57.9)
Low (CPS <10)	184/438 (42.0)	185/439 (42.1)

Data cutoff: 8 August 2023.

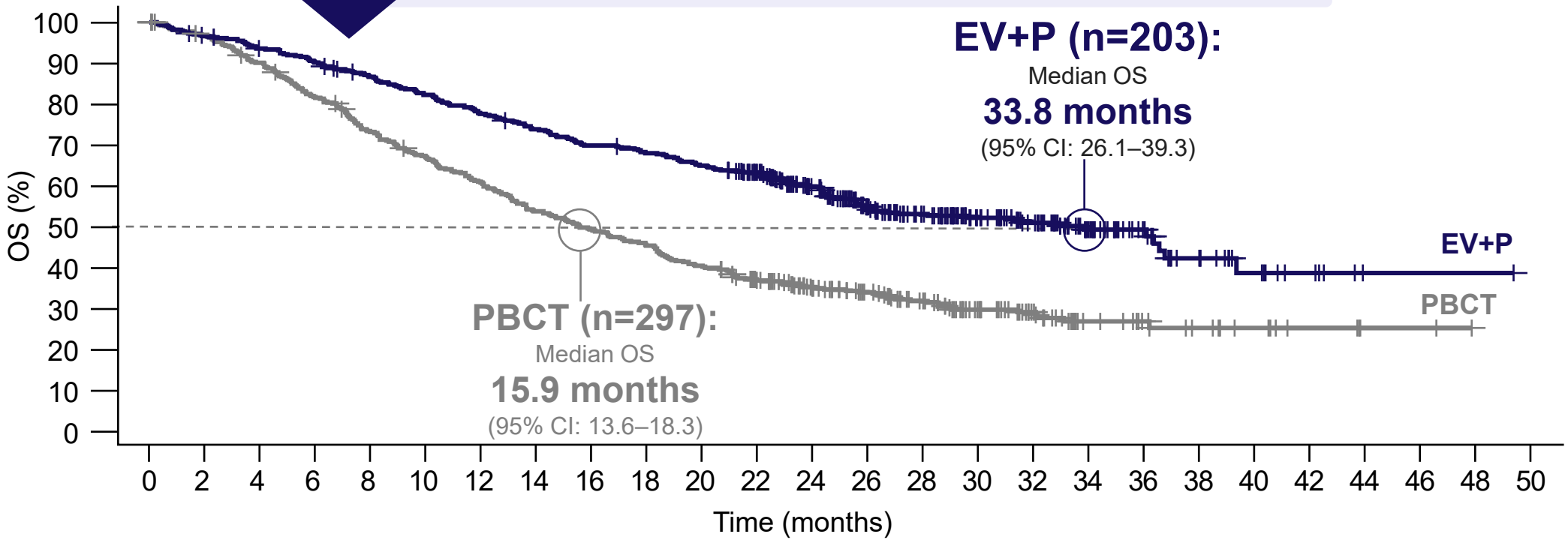
*Nectin-4 H scores were determined with the use of a validated Nectin-4 immunohistochemical assay performed at Q2 Solutions. H scores range from 0 to 300, with higher values indicating higher expression; †Bajorin risk factors include visceral metastases (metastases to the bone, lung, or liver) and an ECOG performance-status score of 3 or higher; ‡Represents eligibility at time of randomisation; ¶CPS status was determined using the validated PD-L1 IHC 22C3 pharmDx assay at NeoGenomics and Labcorp; four patients in the EV+P arm and five patients in the chemotherapy arm had samples that were of inadequate tissue quality for analysis. CPS, Combined Positive Score; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; IHC, immunohistochemistry; LA/mUC, locally advanced/metastatic urothelial carcinoma; P, pembrolizumab; PD-L1, programmed cell death ligand 1.

Powles T et al. *N Engl J Med* 2024;390:875–888.

EV-302: After an additional 1-year follow-up, EV+P more than doubled OS vs. PBCT

Almost 50%

Reduction in risk of death with EV+P* vs. PBCT*
(HR 0.51 [95% CI: 0.43–0.61; p<0.00001†])



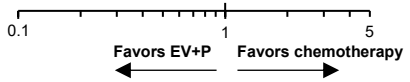
No. at risk

EV+P	442	426	409	394	375	356	336	319	302	293	280	252	206	161	133	102	79	52	32	19	11	6	1	1	1
PBCT	444	423	393	356	317	290	263	233	214	197	176	148	121	102	81	59	43	24	18	13	9	5	2	2	

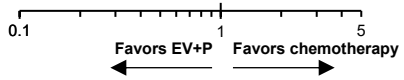
Median follow-up: 21.9 months. Data cut-off: August 8, 2024.
*Events/N were 203/442 for EV+P and 297/444 for PBCT. †P-value is nominal and descriptive.
CI, confidence interval; EV, enfortumab vedotin; HR, hazard ratio; OS, overall survival; P, pembrolizumab; PBCT, platinum-based chemotherapy.
Powles T, presented at ASCO GU 2025, Abstract 664.

EV-302: The OS benefit of EV+P was consistent with the overall population regardless of patient subgroup

	Median OS, months (event/N) EV+P	PBCT	HR (95% CI)
Overall	33.8 (203/442)	15.9 (297/444)	0.513 (0.428, 0.614)
Age			
<65 years	39.3 (59/144)	18.7 (87/135)	0.434 (0.307, 0.614)
≥65 years	27.1 (144/298)	14.6 (210/309)	0.544 (0.439, 0.674)
Race			
White	26.1 (158/308)	15.1 (207/290)	0.521 (0.422, 0.644)
Other	36.3 (45/134)	19.1 (90/154)	0.436 (0.302, 0.629)
Region			
North America	25.7 (57/103)	21.0 (54/85)	0.672 (0.451, 1.000)
Europe	25.6 (90/172)	14.6 (140/197)	0.522 (0.397, 0.687)
Rest of world	NR (56/167)	15.5 (103/162)	0.386 (0.277, 0.539)
Sex			
Female	25.4 (46/98)	14.6 (70/108)	0.549 (0.371, 0.811)
Male	33.8 (157/344)	16.4 (227/336)	0.501 (0.407, 0.617)
ECOG PS			
0	36.5 (77/223)	18.7 (136/215)	0.394 (0.296, 0.524)
1-2	22.8 (126/219)	13.3 (160/227)	0.621 (0.490, 0.787)
Primary disease site of origin			
Upper tract	36.5 (60/135)	18.3 (63/104)	0.538 (0.371, 0.781)
Lower tract	32.9 (142/305)	15.6 (233/339)	0.504 (0.408, 0.623)



	Median OS, months (event/N) EV+P	PBCT	HR (95% CI)
Overall	33.8 (203/442)	15.9 (297/444)	0.513 (0.428, 0.614)
Liver metastases			
Present	19.1 (68/100)	10.1 (82/99)	0.556 (0.399, 0.776)
Absent	39.3 (135/342)	18.3 (215/345)	0.496 (0.400, 0.615)
PD-L1 expression			
Low (CPS <10)	31.2 (91/184)	15.1 (136/185)	0.472 (0.361, 0.618)
High (CPS ≥10)	36.5 (111/254)	17.1 (158/254)	0.550 (0.431, 0.703)
Cisplatin eligibility			
Eligible	36.7 (101/244)	18.7 (143/234)	0.541 (0.419, 0.699)
Ineligible	25.6 (102/198)	12.7 (154/210)	0.498 (0.386, 0.642)
Metastatic disease site			
Visceral metastases	25.7 (163/318)	13.5 (235/318)	0.505 (0.412, 0.619)
Lymph node only	NR (34/103)	24.4 (54/104)	0.512 (0.332, 0.789)
Renal function			
Normal	39.3 (33/84)	18.6 (61/95)	0.496 (0.318, 0.773)
Mild	36.5 (69/165)	18.4 (101/162)	0.502 (0.365, 0.689)
Moderate/severe	25.6 (101/193)	13.3 (135/187)	0.528 (0.405, 0.689)

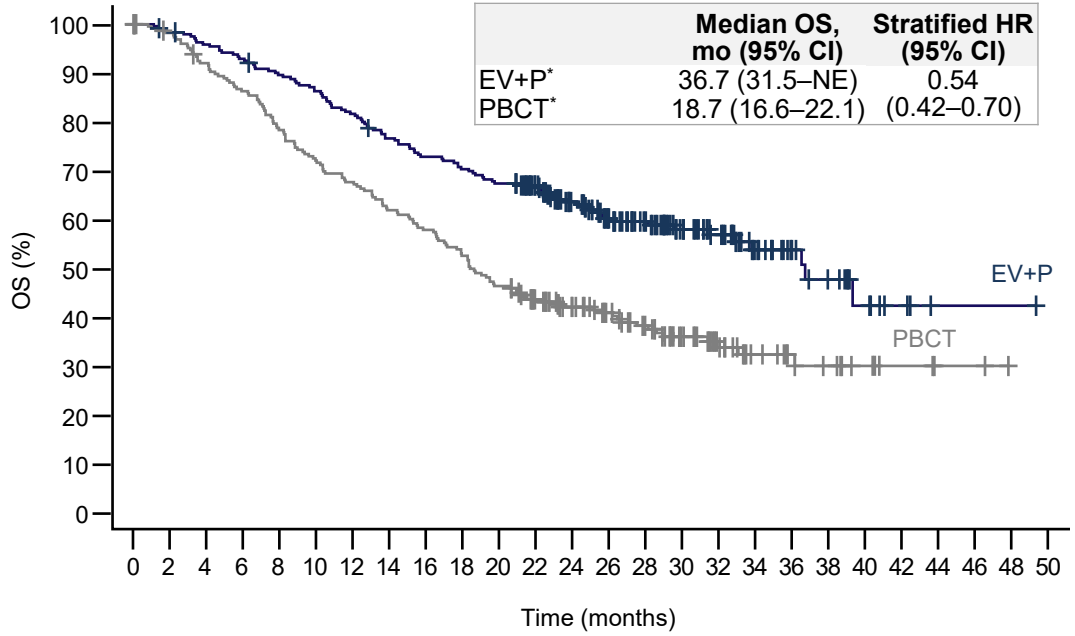


Median follow-up: 29.1 months. Data cut-off: August 8, 2024.
CI, confidence interval; CPS, combined positive score; ECOG PS, Eastern Cooperative Oncology Group Performance Status; EV, enfortumab vedotin; HR, hazard ratio; NE, not estimable; OS, overall survival; P, pembrolizumab; PBCT, platinum-based chemotherapy; PD-L1, programmed death-ligand 1.
Powles T, presented at ASCO GU 2025, Abstract 664.

EV-302: OS by cisplatin eligibility

- **OS benefit was consistent with the overall population regardless of cisplatin eligibility**

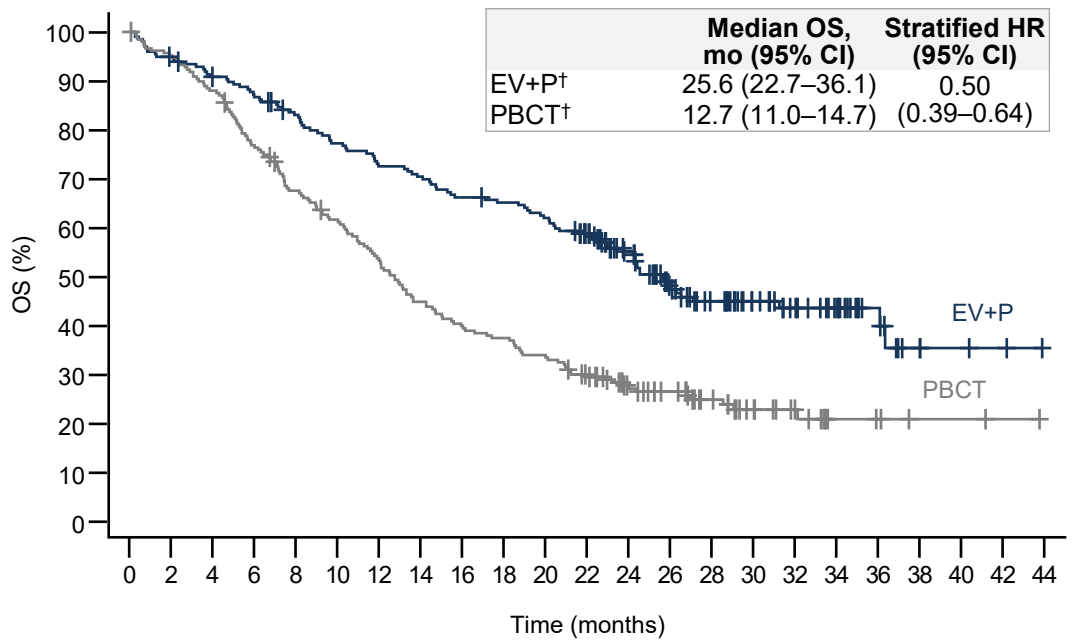
Cisplatin eligible



No. at risk

EV+P	244	239	232	225	216	208	197	184	175	169	162	147	121	98	83	64	50	30	20	14	8	4	1	1	1
PBCT	234	224	209	196	178	164	154	141	132	120	106	90	77	65	54	41	30	19	14	11	7	4	2	2	

Cisplatin ineligible



No. at risk

EV+P	198	187	177	169	159	148	139	135	127	124	118	105	85	63	50	38	29	22	12	5	3	2	
PBCT	210	199	184	160	139	126	109	92	82	77	70	58	44	37	27	18	13	5	4	2	2	1	

Data cutoff: August 8, 2024.

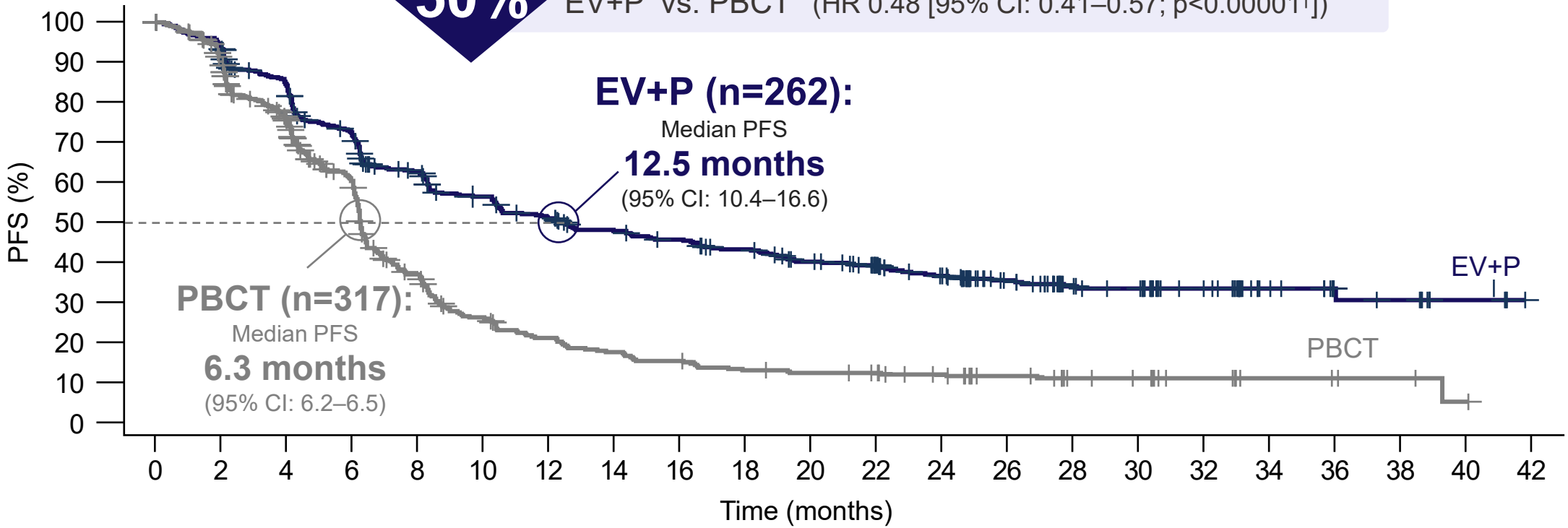
*Events/N in the cisplatin-eligible population were 101/244 for EV+P and 143/234 for PBCT. †Events/N in the cisplatin-ineligible population were 102/198 for EV+P and 154/210 for PBCT.

EV, enfortumab vedotin; HR, hazard ratio; mo, months; NE, not estimable; No., number; OS, overall survival; P, pembrolizumab; PBCT, platinum-based chemotherapy.

Powles T. Presented at ASCO GU 2025. Abstract 664.

EV-302: After an additional 1-year follow-up, EV+P almost doubled PFS vs. PBCT

More than **50%** **Reduction in risk of disease progression** with EV+P* vs. PBCT* (HR 0.48 [95% CI: 0.41–0.57; p<0.00001†])



No. at risk

EV+P	442	409	361	304	254	223	200	182	172	159	143	128	109	82	62	57	42	22	14	10	4
PBCT	444	379	296	213	125	86	68	57	50	42	39	37	31	23	16	14	9	5	4	3	1

Data cutoff: August 8, 2024.

*Events/N were 262/442 for EV+P and 317/444 for PBCT. †P-value is nominal and descriptive

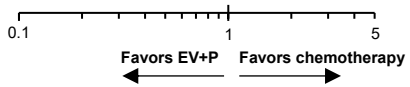
EV, enfortumab vedotin; P, pembrolizumab; PBCT, platinum-based chemotherapy; PFS, progression-free survival.

Powles T, presented at ASCO GU 2025, Abstract 664.

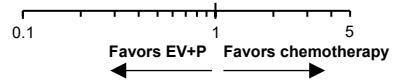
EV-302: After an additional 1 year, EV+P demonstrated superior PFS vs. PBCT, consistently across multiple prespecified subgroups

PFS by BICR in prespecified subgroups

	Median PFS, months (event/N) EV+P	PBCT	HR (95% CI)
Overall	12.5 (262/442)	6.3 (317/444)	0.481 (0.407, 0.570)
Age			
<65 years	14.6 (87/144)	6.4 (90/135)	0.490 (0.358, 0.670)
≥65 years	12.3 (175/298)	6.2 (227/309)	0.478 (0.390, 0.585)
Race			
White	10.5 (191/308)	6.2 (214/290)	0.492 (0.401, 0.604)
Other	19.2 (71/134)	6.5 (103/154)	0.461 (0.335, 0.633)
Region			
North America	10.3 (72/103)	6.3 (57/85)	0.605 (0.418, 0.876)
Europe	10.4 (102/172)	6.3 (149/197)	0.523 (0.403, 0.678)
Rest of world	19.3 (88/167)	6.2 (111/162)	0.376 (0.279, 0.508)
Sex			
Female	10.4 (59/98)	6.1 (75/108)	0.505 (0.351, 0.727)
Male	14.0 (203/344)	6.3 (242/336)	0.468 (0.385, 0.569)
ECOG PS			
0	17.3 (121/223)	6.7 (151/215)	0.404 (0.314, 0.520)
1-2	9.3 (141/219)	6.1 (166/227)	0.555 (0.440, 0.699)
Primary disease site of origin			
Upper tract	12.3 (81/135)	6.2 (70/104)	0.542 (0.384, 0.763)
Lower tract	12.8 (179/305)	6.3 (246/339)	0.462 (0.379, 0.564)



	Median PFS, months (event/N) EV+P	PBCT	HR (95% CI)
Overall	12.5 (262/442)	6.3 (317/444)	0.481 (0.407, 0.570)
Liver metastases			
Present	8.1 (74/100)	6.0 (80/99)	0.548 (0.392, 0.766)
Absent	16.4 (188/342)	6.4 (237/345)	0.458 (0.376, 0.557)
PD-L1 expression			
Low (CPS <10)	10.5 (122/184)	6.3 (131/185)	0.517 (0.400, 0.667)
High (CPS ≥10)	16.4 (138/254)	6.2 (182/254)	0.459 (0.365, 0.576)
Cisplatin eligibility			
Eligible	15.0 (140/244)	6.5 (155/234)	0.518 (0.409, 0.655)
Ineligible	10.6 (122/198)	6.1 (162/210)	0.455 (0.357, 0.580)
Metastatic disease site			
Visceral metastases	10.4 (203/318)	6.2 (242/318)	0.477 (0.393, 0.579)
Lymph node only	22.1 (50/103)	8.3 (60/104)	0.473 (0.317, 0.704)
Renal function			
Normal	18.7 (47/84)	6.7 (64/95)	0.520 (0.350, 0.774)
Mild	12.7 (91/165)	6.3 (118/162)	0.477 (0.358, 0.636)
Moderate/severe	10.5 (124/193)	6.2 (135/187)	0.493 (0.381, 0.637)



Data cutoff: August 8, 2024.

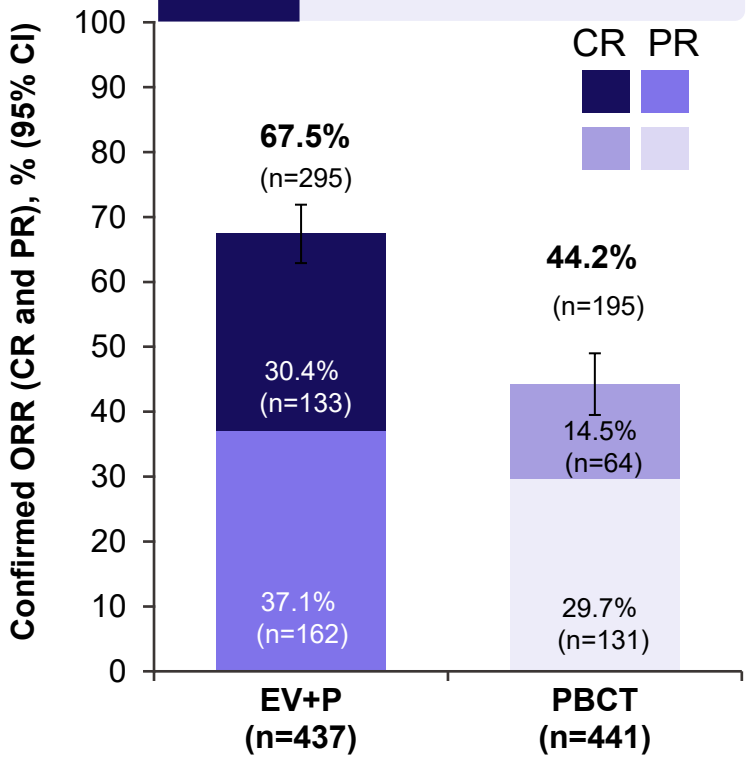
CPS, combined positive score; ECOG PS, Eastern Cooperative Oncology Group performance status; EV, enfortumab vedotin; P, pembrolizumab; PD-L1, programmed death ligand 1; PFS, progression-free survival

Powles T, presented at ASCO GU 2025, Abstract 664.

EV-302: Additional efficacy benefits were also significantly improved with EV+P vs. PBCT

Confirmed ORR: CR or PR*

~1.5X **higher ORR** with EV+P vs. PBCT (p<0.00001†)



DOR (CR or PR)*

~3.3X **increased DOR** with EV+P vs. PBCT

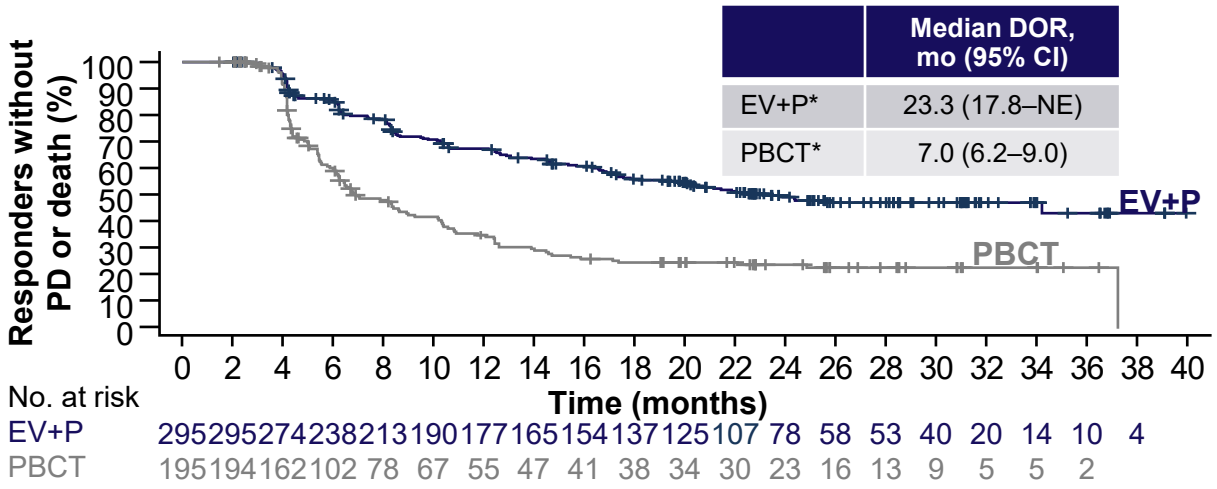
	EV+P (n=295)	PBCT (n=195)
mDOR,* mo (95% CI)	23.3 (17.8–NE)	7.0 (6.2–9.0)

Data cut-off: August 8, 2024.
*by BICR. †P-value is nominal and descriptive. ‡Upper CI not estimable
CI, confidence interval; CR, complete response; DOR, duration of response; EV, enfortumab vedotin; HR, hazard ratio; mo, months; NE, not evaluable; ORR, objective response rate; P, pembrolizumab; PBCT, platinum-based chemotherapy; PR, partial response.
Powles T, presented at ASCO GU 2025, Abstract 664.

EV-302 responders (CR+PR): Maintained response was ~50%, with over 75% of responders alive after 2 years in the EV+P arm

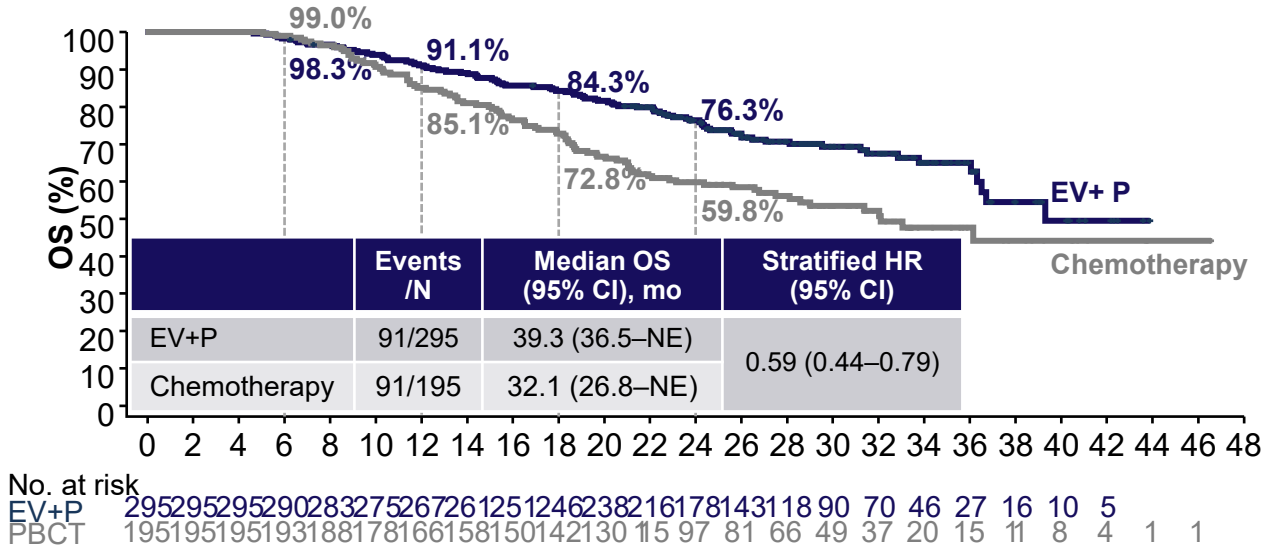
Among responders, the probability of maintained response at 24 months was ~50% with EV+P

- 58.3% of responders in the EV+P arm and 62.6% in the chemotherapy arm were cisplatin eligible



Survival rates of responders at 2 years was estimated to be 76.3% for patients treated with EV+P

- 58.3% of responders in the EV+P arm and 62.6% in the chemotherapy arm were cisplatin eligible



Data cutoff: August 8, 2024.

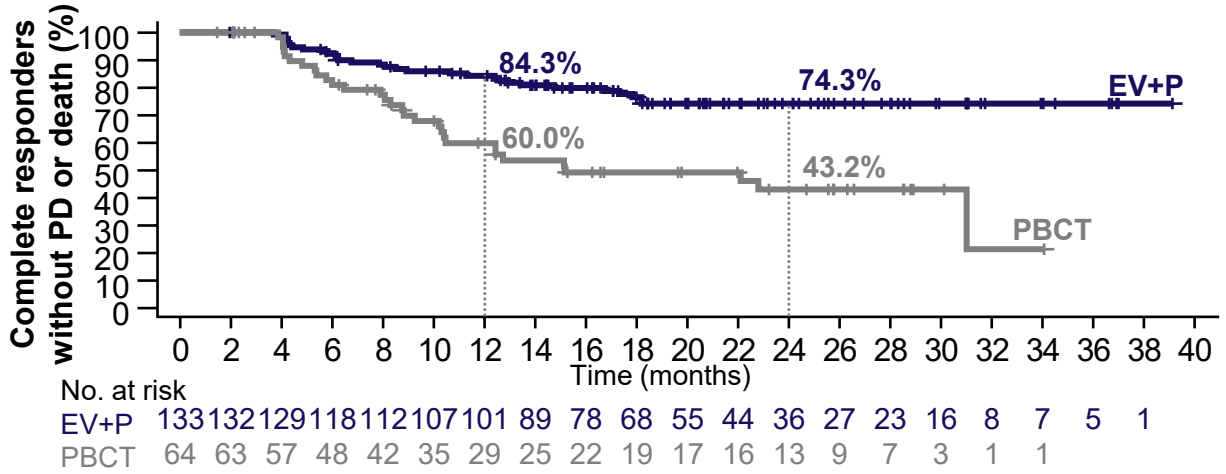
CI, confidence interval; CR, complete response; DOR, duration of response; EV, enfortumab vedotin; HR, hazard ratio; NE, not estimable; OS, overall survival; P, pembrolizumab; PBCT, platinum-based chemotherapy; PR, partial response.

Gupta S et al. Presented at ASCO 2025. #4502.

EV-302 responder (CR): Nearly 75% of responders maintained CR, with over 95% alive after 2 years in the EV+P arm

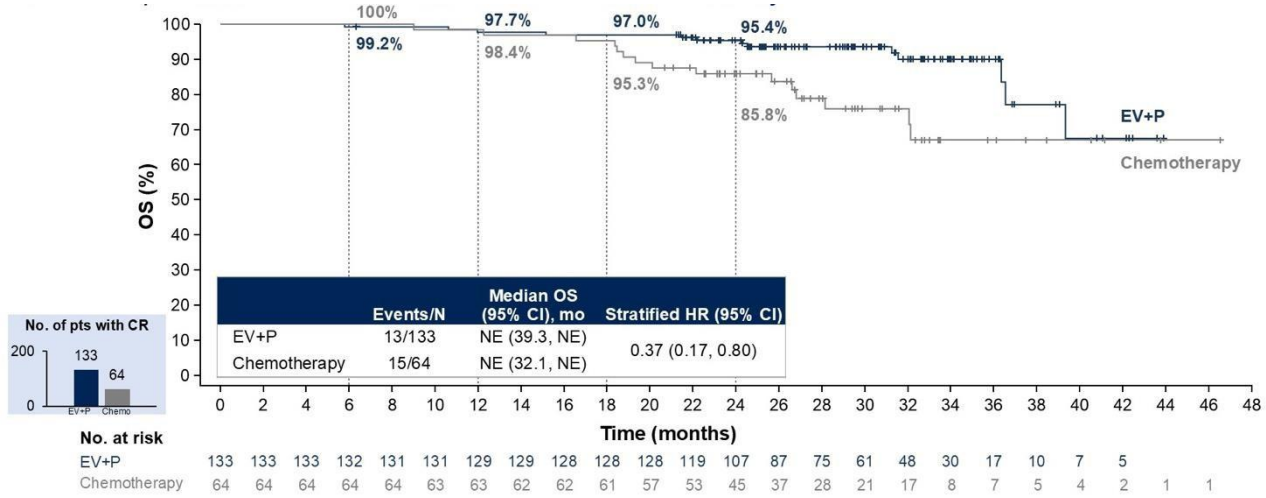
Probability of maintained CR at 24 months was 74.3% with EV+P

- 60.2% of patients with CR in the EV+P arm and 64.1% in the chemotherapy arm were cisplatin eligible



Survival rates of responders at 2 years was estimated to be 95.4% for patients treated with EV+P

- 60.2% of patients with CR in the EV+P arm and 64.1% in the chemotherapy arm were cisplatin eligible



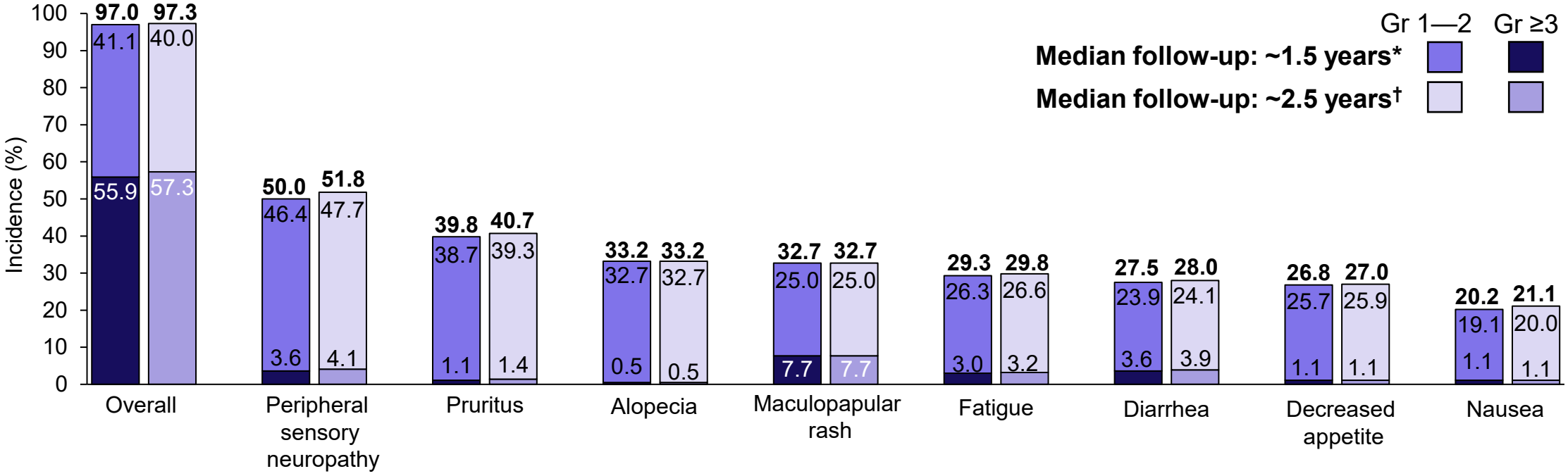
Data cutoff: August 8, 2024.

CI, confidence interval; CR, complete response; DOR, duration of response; EV, enfortumab vedotin; HR, hazard ratio; NE, not estimable; OS, overall survival; P, pembrolizumab; PBCT, platinum-based chemotherapy; PR, partial response.

Gupta S et al. Presented at ASCO 2025. #4502.

EV-302: After long-term follow up, the frequency and grade of EV+P related TRAEs remained consistent with the primary analysis

Most Frequent (≥ 20%) TRAEs with EV+P[1]



With an additional 1 year of follow-up, no new safety signals were identified with EV+P[1,2]

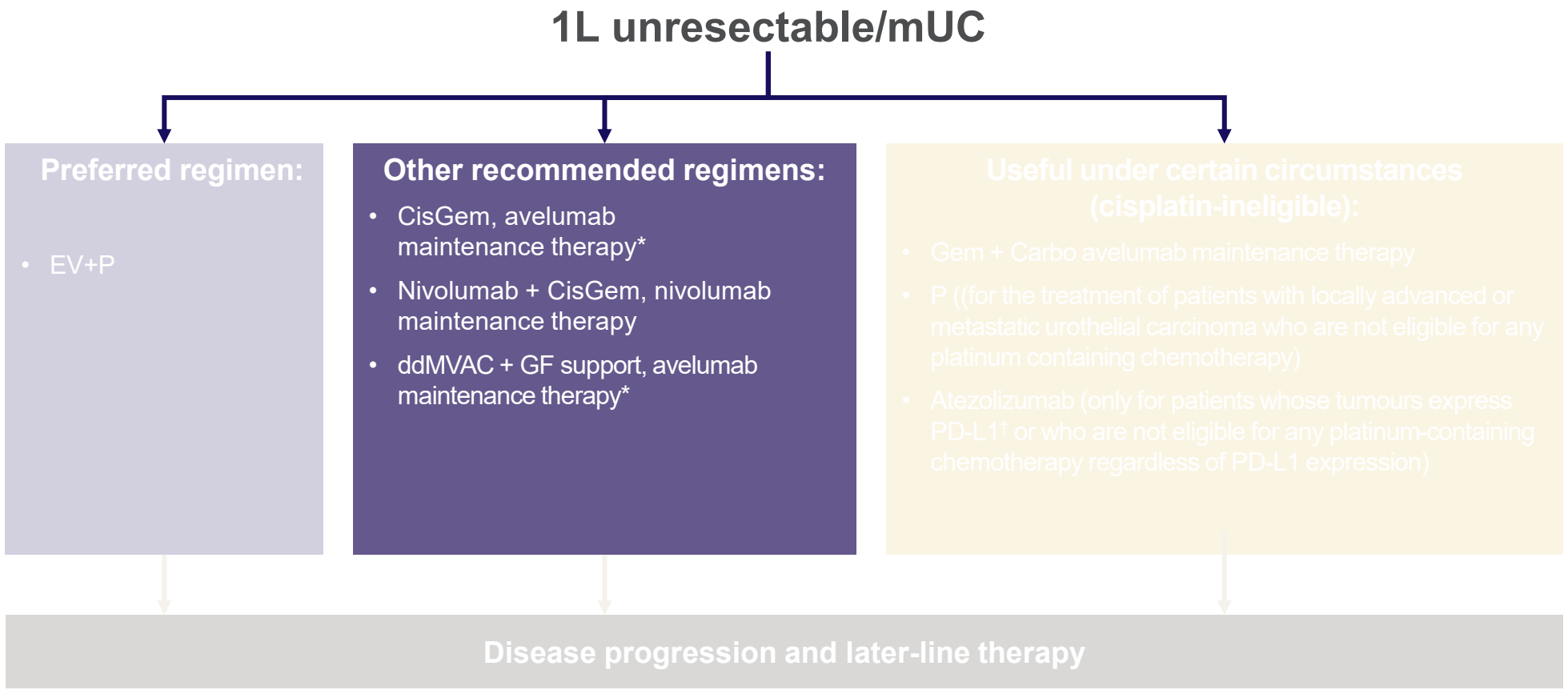
The combination of enfortumab vedotin plus pembrolizumab is pending of price and reimbursement in Spain.

Data cut-off: *August 8; 2023; †August 8, 2024.

EV, enfortumab vedotin; Gr, grade; P, pembrolizumab; TRAE, treatment-related adverse event.

1. Powles T, presented at ASCO GU 2025, Abstract 664; 2. Powles T, et al. *N Engl J Med*. 2024;390(10):875-88.

Recent data updates are reflected in clinical guideline updates – NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)



Disclaimer: EV+P is not approved for the 1L treatment of unresectable or metastatic UC in adults in some countries/regions. All HCPs should refer to their own country's specific Prescribing Information.

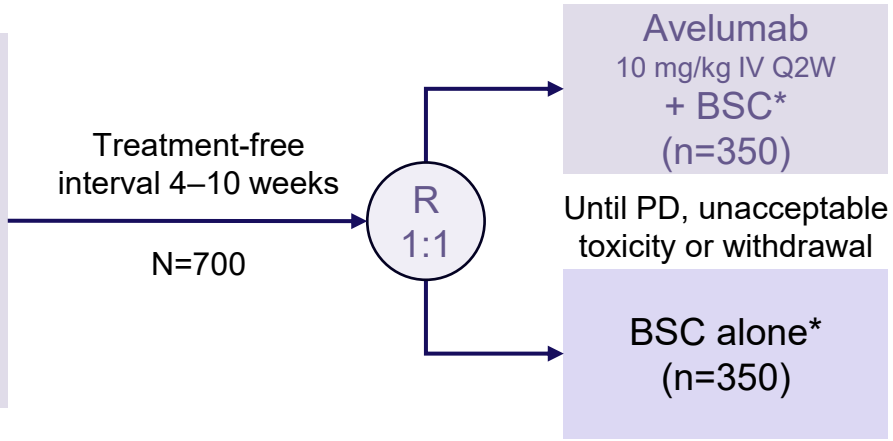
*Maintenance therapy with avelumab only if there is no progression on first-line platinum-containing chemotherapy; †Atezolizumab: SP142 assay, PD-L1–stained tumor-infiltrating immune cells covering ≥5% of the tumor area.

1L, first line; Carbo, carboplatin; Cis, cisplatin; DDMVAC, dose-dense methotrexate, vinblastine, doxorubicin, and cisplatin; EV, enfortumab vedotin-ejfv; Gem, gemcitabine; GF, growth factor; HCP, healthcare professional; LA/mUC, locally advanced/metastatic urothelial carcinoma; NCCN, National Comprehensive Cancer Network; P, pembrolizumab; PD-L1, programmed cell death ligand 1.

JAVELIN Bladder 100: Avelumab maintenance vs. BSC alone[1,2]

Study design[1]

Patient population:
- Unresectable LA/mUC
- CR,PR, and SD with standard 1L chemotherapy (4-6 cycles) - Gem/Cis or Gem/CarboAdequate renal function (CrCl ≥50 ml/min)
- ECOG PS 0 or 1



Primary endpoint
- OS

Primary analysis populations
- All randomized patients
- PD-L1+ population

Secondary endpoints
- PFS and objective response per RECIST 1.1
- Time to response, DOR, and disease control
- Safety and tolerability

Stratification factors
- Best response to 1L PBCT (CR or PR vs. SD)
- Metastatic site (visceral vs. non-visceral)

JAVELIN Bladder 100[1]	
Patient population	• ECOG PS 0/1 • Prior to initiating avelumab: received 4–6 cycles of PBCT and **did not have disease progression**
Comparator	BSC (unblinded)
Primary endpoint	OS

Select baseline characteristics† (avelumab arm)[2]	
Type of PBCT, %	**CisGem:** 52.3; **CarboGem:** 42
ECOG PS, %	**0:** 60.9; **≥1:** 39.1
Best response to 1L PBCT, %	**CR:** 25.7; **PR:** 46.6; **SD:** 27.7
Visceral metastases, %	54.6
PD-L1 positivity, %	54.0

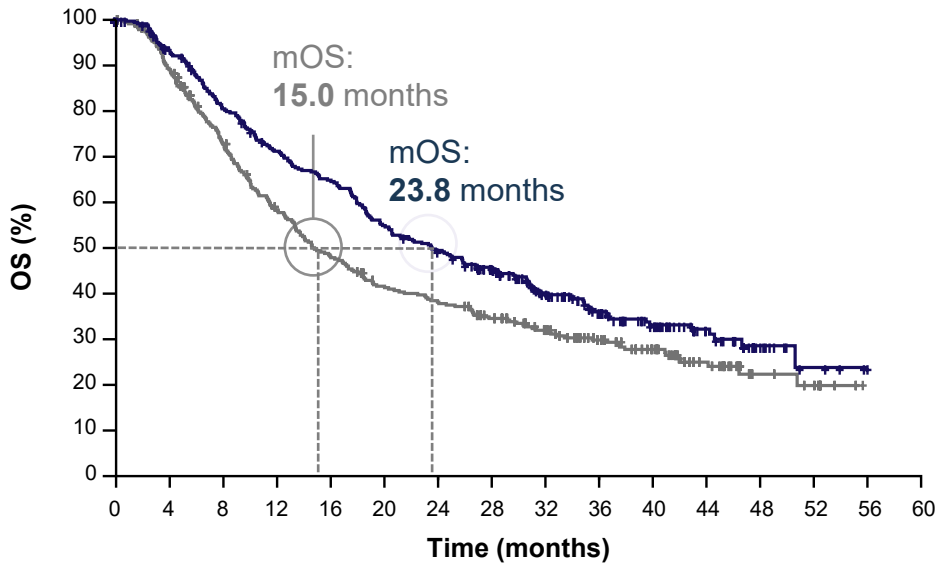
*Administered according to local practice based on clinical judgment and the patient's condition. BSC included antibiotic agents, nutritional support, hydration and pain management; other systemic anti-tumor therapy was not permitted, but palliative local radiotherapy for isolated lesions was permitted;[1] †From ≥2 years of follow-up.[3]

1L, first line; BSC, best supportive care; Carbo, carboplatin; Cis, cisplatin; CR, complete response; CrCl, creatinine clearance; DOR, duration of response; ECOG PS, Eastern Cooperative Oncology Group performance status; Gem, gemcitabine; IV, intravenous; LA, locally advanced; m, metastatic; OS, overall survival; PBCT, platinum-based chemotherapy; PD, progressive disease; PD-L1, programmed cell death ligand 1; PFS, progression-free survival; PR, partial response; Q2W, every 2 weeks; R, randomization; RECIST, Response Evaluation Criteria in Solid Tumours; SD, stable disease; UC, urothelial carcinoma.

1. Powles T et al. *N Engl J Med* 2020;383:1218–1230; 2. Powles T et al. *J Clin Oncol* 2023;41:3486–3492.

JAVELIN Bladder 100: A significant improvement in OS and PFS were seen with avelumab + BSC vs. BSC alone[1]

OS in the overall trial population[1]



No. at risk:

Avelumab + BSC	350	318	274	237	216	183	164	140	99	74	53	31	13	4	1	0
BSC alone	350	304	243	190	158	131	121	103	82	62	46	27	10	7	0	

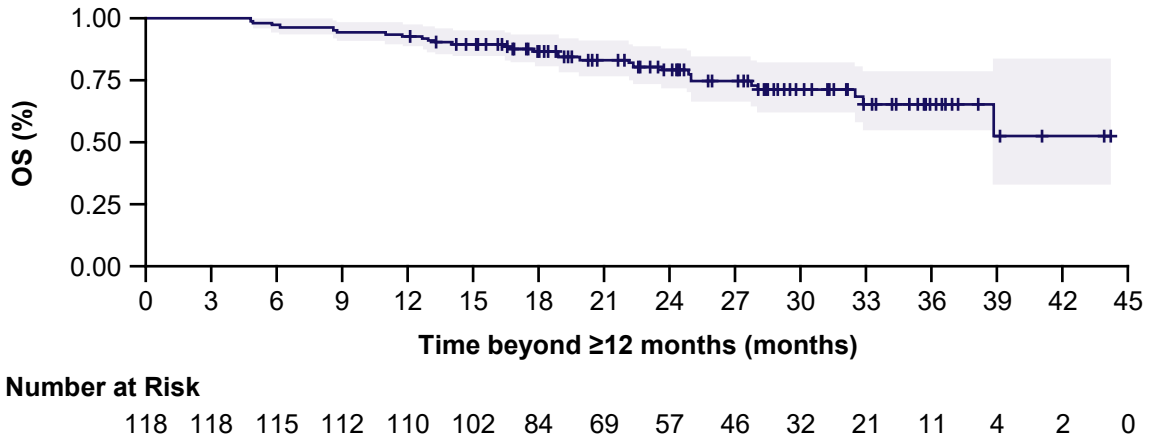
	Avelumab + BSC	BSC	HR (95% CI) *p-value*
mOS,[1] months	23.8	15	0.76 (0.63–0.91) *0.0036*
mPFS,[1] months	5.5	2.1	0.54 (0.46–0.64) *<0.0001*
ORR,[2] %	9.7	1.4	–
CR,[2] %	6.0	0.9	–
AE/TRAE[1]* Any grade, % Grade 3 or 4, %	98.3/78.2 53.8/19.5	NA†	–
TRAE leading to discontinuation,[4] %	11.6	NA‡	–
QOL[5] (FBISI-18, EQ-5D-5L, TTD)	Results were similar between both arms		

An improvement in OS was seen for PBCT + maintenance avelumab, in a highly selective patient population[1,2]

Because the trial met its objective in the initial analysis (data cut-off: October 21, 2019),[1] updated analysis are considered exploratory, and all p-values are descriptive.
*In patients with ≥12 months of avelumab treatment.[1] †Safety data from the primary analysis were 77.7% for any grade AE or 25.5% for ≥ Grade 3 AEs.[2] ‡TRAEs leading to discontinuation in the primary analysis were 0% in BSC arm.[3]
Avelumab + BSC median follow-up: 38.0 months; BSC median follow-up: 39.6 months.[1]
AE, adverse event; BSC, best supportive care; CI, confidence interval; CR, complete response; EQ-5D-5L, European Quality of Life 5-Dimension 5-Level Questionnaire; FBISI-18, National Comprehensive Cancer Network/Functional Assessment of Cancer Therapy Bladder Symptom Index-18; HR, hazard ratio; (m)OS, (median) overall survival; mPFS, median progression-free survival; NA, not available; ORR, overall response rate; QOL, quality of life; TRAE, treatment-related adverse event; TTD, time to deterioration.
1. Powles T et al. *J Clin Oncol* 2023;41:3486–3492; 2. Powles T et al. *N Engl J Med* 2020;383:1218–1230; 3. Powles T et al. *N Engl J Med* 2020;383:1218–1230 (supplementary appendix);
4. Powles T et al. *J Clin Oncol* 2023;41:3486–3492 (supplementary appendix); 5. Grivas P et al. *Eur Urol* 2023;83:320–328.

JAVELIN Bladder 100: Long-term conditional survival and AE probability

Patients with ≥1 year of avelumab treatment
n/N=118/350 (33.7%)

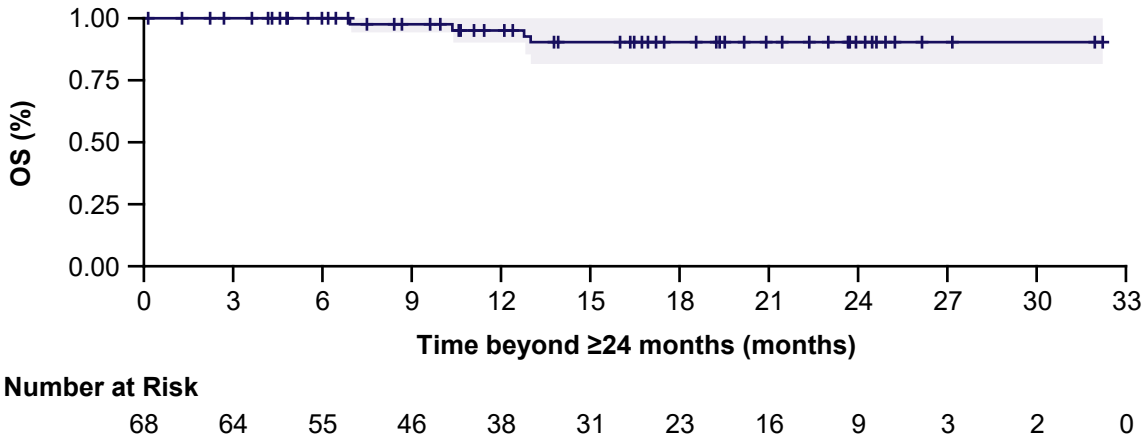


Number at Risk

118	118	115	112	110	102	84	69	57	46	32	21	11	4	2	0

	Patients who received ≥1 year of avelumab treatment (n=118)
Probability of additional OS ≥1 year, % (95% CI)	
6 months	97.5 (94.7–100)
1 year	93.2 (88.8–97.9)
1.5 years	86.8 (80.8–93.3)
2 years	79.6 (72.0–88.0)

Patients with ≥2 years of avelumab treatment
n/N=68/350 (19.4%)



Number at Risk

68	64	55	46	38	31	23	16	9	3	2	0

	Patients who received ≥2 years of avelumab treatment (n=68)
Probability of additional OS ≥2 years, % (95% CI)	
6 months	100 (100–100)
1 year	95.8 (90.2–100)
1.5 years	90.3 (81.6–99.9)

- **No new safety concerns were identified with long treatment duration**
- **Patients who experienced any TRAE for ≥1 year was 50% and for ≥2 years was 35.3%**

AE, adverse event; BSC, best supportive care; CI, confidence interval; OS, overall survival; TRAE, treatment-emergent adverse event.

UroToday. AUA 2025: Avelumab First-Line Maintenance in Advanced Urothelial Carcinoma: Conditional Survival and Long-Term Safety in Patients Treated for ≥1 or ≥2 Years in JAVELIN Bladder 100. Available at: AUA 2025: Avelumab First-Line Maintenance in Advanced Urothelial Carcinoma: Conditional Survival and Long-Term Safety in Patients Treated for ≥1 or ≥2 Years in JAVELIN Bladder 100. Last accessed: July 2025.

JAVELIN Bladder 100: Long-term safety data were consistent with observations from previous analyses[1]

AE occurrence,[2] n (%)	Avelumab maintenance (n=344)*†	
	Any grade	Grade ≥3
Overall	338 (98.3)	185 (53.8)
Arthralgia	68 (19.8)	2 (0.6)
Fatigue	65 (18.9)	6 (1.7)
Pruritus	64 (18.6)	1 (0.3)
Asthenia	62 (18.0)	0
Diarrhea	61 (17.7)	2 (0.6)
Urinary tract infection	61 (17.7)	15 (4.4)
Constipation	60 (17.4)	2 (0.6)
Back pain	59 (17.2)	4 (1.2)
Pyrexia	56 (16.3)	1 (0.3)

AE occurrence,[2] n (%)	Avelumab maintenance (n=344)*†	
	Any grade	Grade ≥3
Nausea	55 (16.0)	1 (0.3)
Decreased appetite	48 (14.0)	1 (0.3)
Cough	46 (13.4)	1 (0.3)
Vomiting	46 (13.4)	4 (1.2)
Anemia	44 (12.8)	14 (4.1)
Hypothyroidism	43 (12.5)	1 (0.3)
Rash	41 (11.9)	2 (0.6)
Hematuria	38 (11.0)	6 (1.7)
Abdominal pain	35 (10.2)	2 (0.6)

No new safety signals were identified during the additional ≥2-year follow-up[1]

*Long-term safety was not analysed in the BSC alone arm because the majority of patients had already discontinued by the time of the previously reported analysis, and data would be unlikely to change with additional follow-up;[2]
†The most common AEs of any grade and Grade ≥3 AEs with maintenance avelumab and BSC are shown (any grade in ≥10% or Grade ≥3 in ≥5% of patients).[2]
AE, adverse event; BSC, best supportive care.
1. Powles T et al. *J Clin Oncol* 2023;41:3486–3492; 2. Powles T et al. *J Clin Oncol* 2023;41:3486–3492 (supplementary appendix).

CheckMate 901: Nivolumab + CisGem vs. CisGem alone

Study design[1,2]

Patient population
- Untreated, unresectable LA/mUC
- PD-1/L1 inhibitor-naïve
- Adequate renal function (GFR ≥60 ml/min)
- ECOG PS 0 or 1
- Cisplatin eligible

N=608

R 1:1

Stratification factors
- PD-L1 expression*
- Presence of liver metastases

Combination phase

Nivolumab (360 mg on D1) + Gem (1000 mg/m² on D1/D8) + Cis (70 mg/m² on D1) Q3W up to 6 cycles†

Treatment until disease progression per BICR, clinical progression, unacceptable toxicity, or completion of maximum number of cycles

Gem (1000 mg/m² on D1/D8) + Cis (70 mg/m² on D1) Q3W†

Monotherapy phase

Nivolumab (480 mg) Q4W

Until disease progression, unacceptable toxicity, withdrawal, or up to 24 months‡

Up to 6 cycles or until disease progression, unacceptable toxicity, or withdrawal Q3W†

Primary endpoints
- OS
- PFS

Secondary endpoints
- OS and PFS by central review
- Change from baseline in EORTC QLQ-C30

Exploratory outcomes
- OR (CR and PR) per RECIST
- Safety and tolerability

CheckMate 901[1]	
Patient population	• ECOG PS **0, 1** • **Cis eligible**
Comparator	• CisGem (max. 6 cycles) • Subsequent therapy: Avelumab maintenance (9%)/atezolizumab (2%)[2]
Primary endpoints	OS; PFS by BICR

Select baseline characteristics (nivo/cis/gem), all values in %[1,2]	
Cis eligible, %	100
Renal pelvis/other tumor type at initial diagnosis, %	10.9/11.8
Liver metastasis at initial diagnosis, %	21.1
PD-L1-positive expression, %	36.5

*Per PD-L1 pharmDx IHC assay.[1]†Patients who discontinued cisplatin could be switched to CarboGem for the remainder of the platinum-doublet cycles (up to six in total); ‡A maximum of 24 months from first dose of nivolumab administered as part of the nivo + CisGem combination.[1]

BICR, blinded independent central review; Carbo, carboplatin; Cis, cisplatin; CR, complete response; D, day; ECOG, Eastern Cooperative Oncology Group; EORTC QLQ, European Organization of Research and Treatment of Cancer Quality of Life Questionnaire; Gem, gemcitabine; GFR, glomerular filtration rate; IHC, immunohistochemistry; LA, locally advanced; m, metastatic; Nivo, nivolumab; OR, objective response; OS, overall survival; PD-1/L1, programmed cell death ligand 1; PFS, progression-free survival; PR, partial response; PS, performance status; Q3W, every 3 weeks; Q4W, every 4 weeks; R, randomization; UC, urothelial carcinoma.

1. van der Heijden MS et al. *N Engl J Med* 2023;389:1778–1789; 2. van der Heijden MS et al. Presented at ESMO 2023. LBA7.

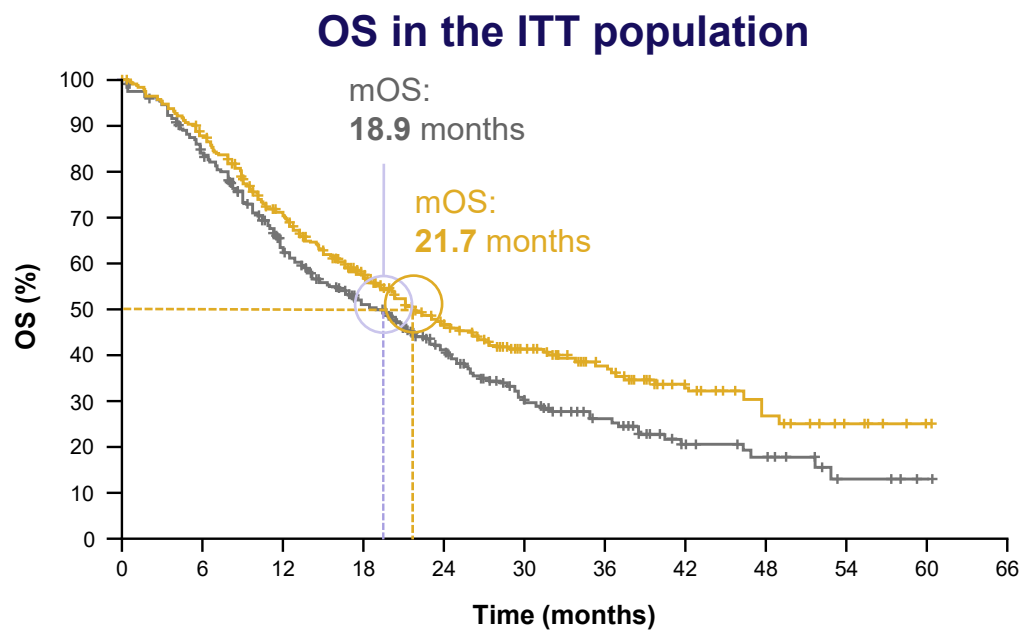
CheckMate 901: Select characteristics for all patients with CR

- Of the 608 total patients randomized, 102 (16.8%) reached a CR
- Approximately 50% of patients with CR had LN-only mUC vs. approximately 20% of all randomized patients

	All randomized patients		Patients with CR	
	Nivo + CisGem (N=304)	CisGem (N=304)	Nivo + CisGem (N=66)	CisGem
Median age (range), years	65.0 (32–86)	65.0 (35–85)	65.0 (33–81)	63.5 (36–80)
Male sex, n (%)	236 (78)	234 (77)	53 (80)	31 (86)
Race				
White	211 (69)	225 (74)	47 (71)	27 (75)
Black or African American	0	2 (<1)	0	0
American Indian or Alaska Native	1 (<1)	1 (<1)	0	1 (3)
Asian	75 (25)	63 (21)	16 (24)	6 (17)
Other	17 (6)	13 (4)	3 (5)	2 (6)
LN-only disease, n (%)	54 (18)	56 (18)	34 (52)	19 (53)
Disease stage at study entry, n (%)				
Stage III	37 (12)	28 (9)	9 (14)	5 (14)
Stage IV	265 (87)	274 (90)	56 (85)	31 (86)
Not reported	2 (<1)	2 (<1)	1 (2)	0
PD-L1 status, n (%)				
≥1%	112 (37)	109 (36)	28 (42)	11 (31)
<1%	192 (63)	195 (64)	38 (58)	25 (69)
Subsequent anticancer therapy received	108 (36)	156 (51)	23 (35)	15 (42)

CisGem, cisplatin + gemcitabine; CR, complete response; LN, lymph node; mUC, metastatic urothelial carcinoma; Nivo, nivolumab; PD-L1, programmed cell death ligand 1.
Galsky M et al. Presented at ASCO 2024. Abstract 4509.

CheckMate 901: Nivolumab + CisGem was associated with significant improvements in OS and PFS vs. CisGem alone



No. at risk:

Nivo + CisGem	304	264	196	142	97	69	48	25	15	7	2	0
CisGem	304	242	166	122	82	49	33	17	13	4	1	0

	Nivo + CisGem	CisGem	HR (95% CI) p-value
mOS, months	21.7	18.9	0.78 (0.63–0.96) 0.02
mPFS, months	7.9	7.6	0.72 (0.59–0.88) 0.001
ORR, %	57.6	43.1	–
CR, %	21.7	11.8	–
TRAE Any grade, % Grade ≥3, %	 97.4 61.8	 92.7 51.7	–
TRAE leading to discontinuation, %	21.1	17.4	–
QOL (EORTC QLQ-C30)	Stable, with no change of more than 10 points through Week 16 in both groups		

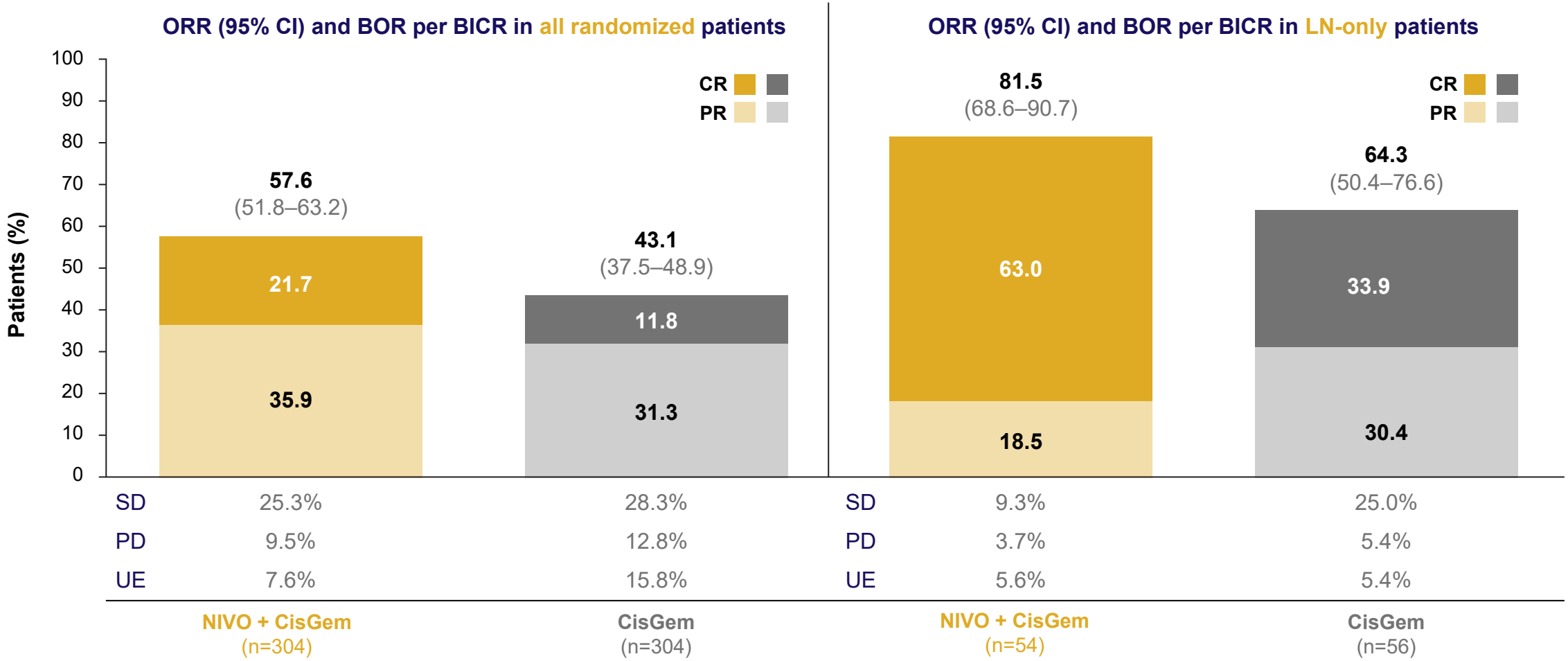
Median follow-up: 33.6 months.[1]

AE, adverse event; CI, confidence interval; Cis, cisplatin; CR, complete response; EORTC QLQ-C30, European Organisation for Research and Treatment of Cancer Core Quality of Life questionnaire; Gem, gemcitabine; HR, hazard ratio; ITT, intention to treat; (m)OS, (median) overall survival; mPFS, median progression-free survival; Nivo, nivolumab; ORR, objective response rate; QOL, quality of life; TRAE, treatment-related adverse event.

van der Heijden MS et al. *N Engl J Med* 2023;389:1778–1789.

CheckMate 901: Select characteristics for all patients with CR

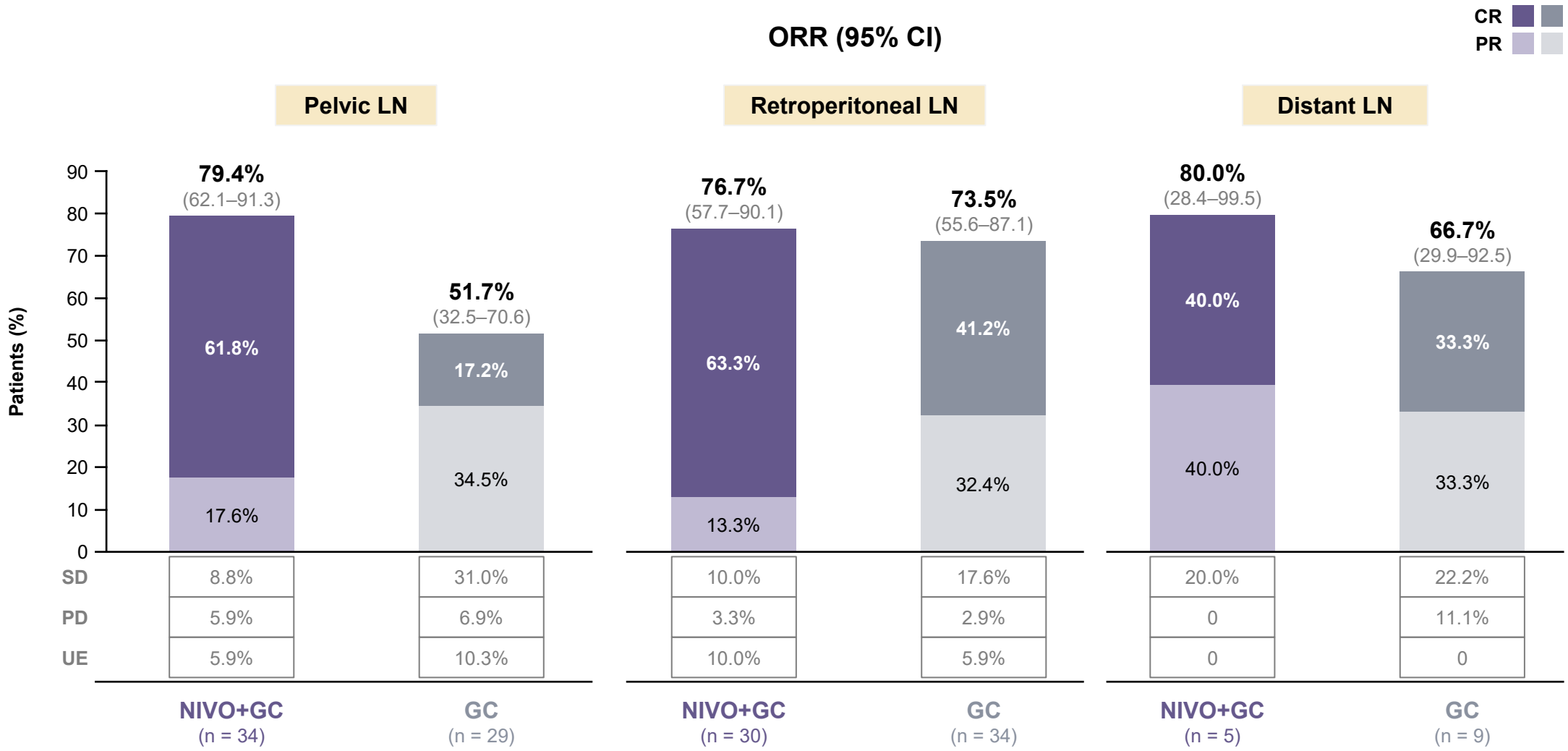
CR for Nivo + CisGem-treated patients with LN-only mUC were approximately twice that of CisGem-treated patients



BICR, blinded independent central review; BOR, best overall response; CI, confidence interval; CisGem, cisplatin + gemcitabine; CR, complete response; LN, lymph node; mUC, metastatic urothelial carcinoma; Nivo, nivolumab; ORR, overall response rate; PD, progressive disease; PR, partial response; SD, stable disease; UE, unevaluable.

Galsky M et al. Presented at ASCO 2024. Abstract 4509.

CheckMate 901: BOR for patients with LN-only mUC by LN involvement

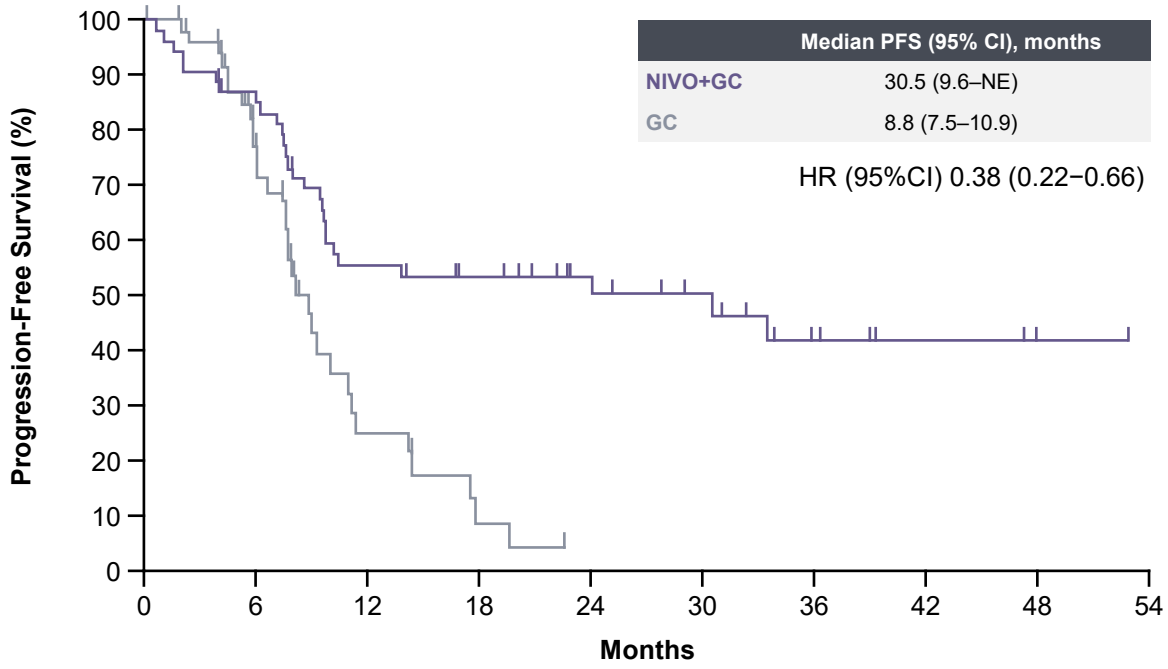


BOR, best overall response; CI, confidence interval; CR, complete response; GC, gemcitabine + cisplatin; LN, lymph node; mUC, metastatic urothelial carcinoma; NIVO, nivolumab; ORR, overall response rate; PR, partial response.

Galsky M et al. Presented at ASCO 2024. Abstract 4509.

CheckMate 901: PFS and OS in patients with LN-only mUC

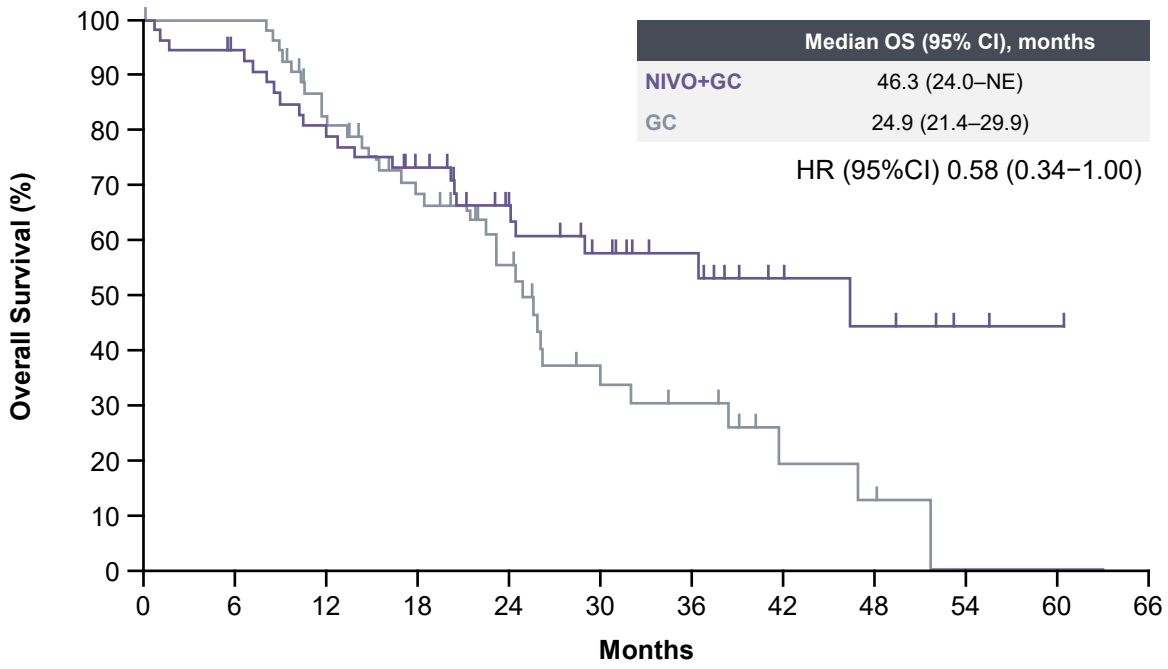
Progression-Free Survival



Number at Risk

NIVO+GC	54	44	28	23	17	13	7	3	1	0
GC	56	28	7	2	0	0	0	0	0	0

Overall Survival



Number at Risk

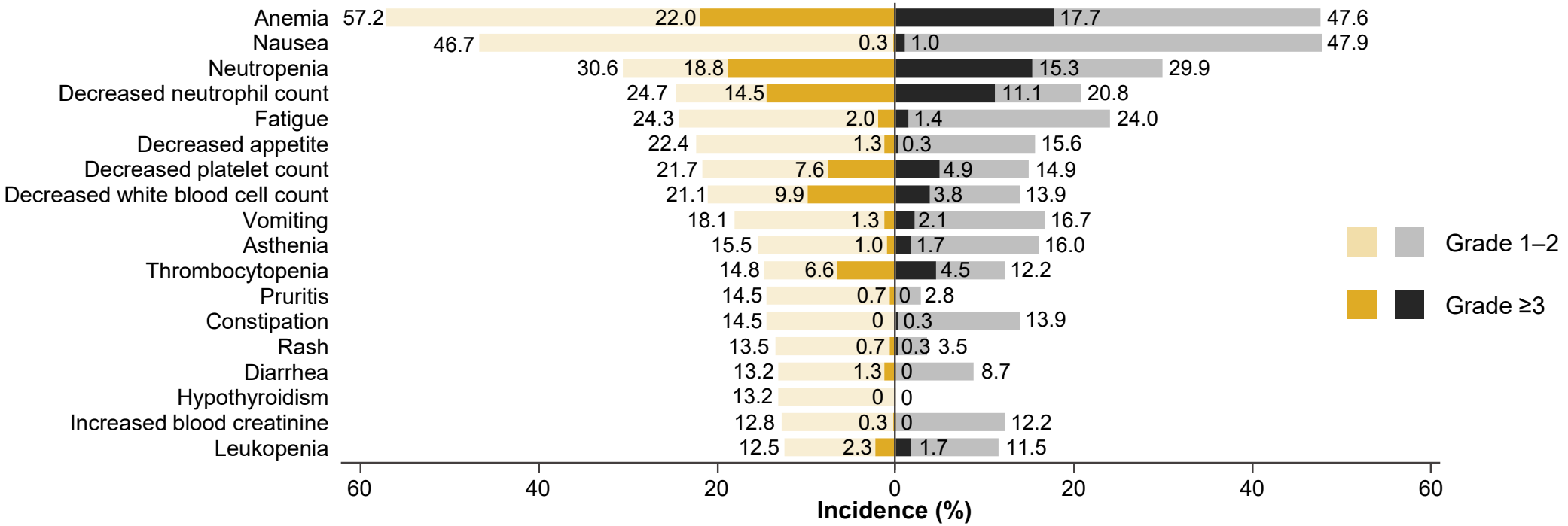
NIVO+GC	54	49	41	35	24	18	13	6	5	2	1	0
GC	56	54	41	32	20	10	8	3	2	0	0	0

CI, confidence interval; GC, gemcitabine + cisplatin; HR, hazard ratio; LN, lymph node; mUC, metastatic urothelial carcinoma; NE, not evaluable; NIVO, nivolumab; OS overall survival; PFS, progression-free survival.

Galsky M et al. Presented at ASCO 2024. Abstract 4509.

CheckMate 901: The safety profile of nivolumab + CisGem was consistent with the established safety profiles of these agents in previous trials

TRAE occurrence* (any grade in ≥10% of patients)	Nivo + CisGem (n=304)		CisGem (n=288)	
	Any grade	Grade ≥3†	Any grade	Grade ≥3†
Overall, %	97.4	61.8	92.7	51.7
Leading to discontinuation, %	21.1	11.2	17.4	7.6



*Includes events that occurred in treated patients between the first dose and 30 days after the last dose of study therapy. The tornado plot displays individual, TRAEs of any grade occurring in ≥10% of treated patients in either arm; †One Grade 5 event occurred in each arm (sepsis in the Nivo+ CisGem arm and acute kidney injury in the CisGem arm).

Cis, cisplatin; Gem, gemcitabine; Nivo, nivolumab; TRAE, treatment-related adverse event.

van der Heijden MS et al. *N Engl J Med* 2023;389:1778–1789.

Summary

- In the EV-302 trial, EV+P continued to demonstrate superior efficacy vs. PBCT in the long-term data analysis, and this was also maintained across pre-specified subgroups with no new safety signals identified after 1 year of additional follow-up[1]
- In the JAVELIN 100 trial, a significant improvement in OS and PFS were seen with avelumab + BSC vs. BSC in a population of patients with LA/mUC, who received 1L chemotherapy; without disease progression following 4−6 cycles of chemotherapy with gemcitabine plus cisplatin or carboplatin[2]
- In the CheckMate 901 trial, nivolumab + CisGem was associated with significant improvements in OS and PFS vs. CisGem alone, in a cisplatin-eligible population[3]
- EV+P provides a long-lasting, durable response for patients with unresectable/mUC[1]

BSC, best supportive care; Cis, cisplatin; EV, enfortumab vedotin; Gem, gemcitabine; LA, locally advanced; mUC, metastatic urothelial carcinoma; OS, overall survival; P, pembrolizumab; PBCT, platinum-based chemotherapy; PFS, progression-free survival.

1. Powles T. Presented at ASCO GU 2025. Abstract 664; 2. Powles T et al. *J Clin Oncol* 2023;41:3486–3492; 3. van der Heijden MS et al. *N Engl J Med* 2023;389:1778–1789.

Genitourinary Masterclass

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(7F Parnas tower, 521, Teheran-ro, Gangnam-gu, Seoul, Republic of Korea)

PI, Prescribing Information.

Genitourinary Masterclass

Subgroup analyses for EV+P

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EV as first-line therapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer. Combination therapy with pembrolizumab.

EV as monotherapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer who have previously received a programmed death receptor-1 or programmed death-ligand 1 inhibitor, and have received a platinum-containing chemotherapy

EV, enfortumab vedotin.
PADCEV® (enfortumab vedotin). Prescribing Information

Adverse events should be reported.
For Korea, healthcare professionals are asked to report any suspected adverse reactions to Astellas Pharma Korea. Inc
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PADCEV®
enfortumab vedotin
Injection for IV infusion 20 mg & 30 mg vials

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Disclosures

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Genitourinary Masterclass

Long-term subgroup analyses from EV-302

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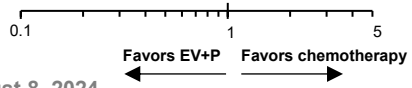
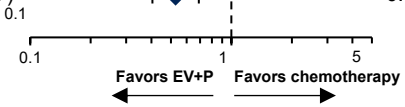
The OS benefit of EV+P was consistent with that of the overall population, across prespecified subgroups[1,2]

OS by BICR in prespecified subgroups

	Median OS, months (event/N)		Hazard ratio (95% CI)
	EV+P	PBCT	
Overall	33.8 (203/442)	15.9 (297/444)	0.513 (0.428–0.614)
Age			
<65 years	39.3 (59/144)	18.7 (87/135)	0.434 (0.307–0.614)
≥65 years	27.1 (144/298)	14.6 (210/309)	0.544 (0.439–0.674)
Race and ethnicity			
White	26.1 (158/308)	15.1 (207/290)	0.521 (0.422–0.644)
Other	36.3 (45/134)	19.1 (90/154)	0.436 (0.302–0.629)
Region			
North America	25.7 (57/103)	21.0 (54/85)	0.672 (0.451–1.000)
Europe	25.6 (90/172)	14.6 (140/197)	0.522 (0.397–0.687)
Rest of world	NR (56/167)	15.5 (103/162)	0.386 (0.277–0.539)
Sex			
Female	25.4 (46/98)	14.6 (70/108)	0.549 (0.371–0.811)
Male	33.8 (157/344)	16.4 (227/336)	0.501 (0.407–0.617)
ECOG PS			
0	36.5 (77/223)	18.7 (136/215)	0.394 (0.296–0.524)
1–2	22.8 (126/219)	13.3 (160/227)	0.621 (0.490–0.787)
Primary disease site of origin			
Upper tract	36.5 (60/135)	18.3 (63/104)	0.538 (0.371–0.781)
Lower tract	32.9 (142/305)	15.6 (233/339)	0.504 (0.408–0.623)



	Median OS, months (event/N)		Hazard ratio (95% CI)
	EV+P	PBCT	
Overall	33.8 (203/442)	15.9 (297/444)	0.513 (0.428–0.614)
Liver metastases			
Present	19.1 (68/100)	10.1 (82/99)	0.556 (0.399–0.776)
Absent	39.3 (135/342)	18.3 (215/345)	0.496 (0.400–0.615)
PD-L1 expression			
Low (CPS <10)	31.2 (91/184)	15.1 (136/185)	0.472 (0.361–0.618)
High (CPS ≥10)	36.5 (111/254)	17.1 (158/254)	0.550 (0.431–0.703)
Cisplatin eligibility			
Eligible	36.7 (101/244)	18.7 (143/234)	0.541 (0.419–0.699)
Ineligible	25.6 (102/198)	12.7 (154/210)	0.498 (0.386–0.642)
Metastatic disease site			
Visceral metastases	25.7 (163/318)	13.5 (235/318)	0.505 (0.412–0.619)
Lymph node only	NR (34/103)	24.4 (54/104)	0.512 (0.332–0.789)
Renal function			
Normal	39.3 (33/84)	18.6 (61/95)	0.496 (0.318–0.773)
Mild	36.5 (69/165)	18.4 (101/162)	0.502 (0.365–0.689)
Moderate/severe	25.6 (101/193)	13.3 (135/187)	0.528 (0.405–0.689)



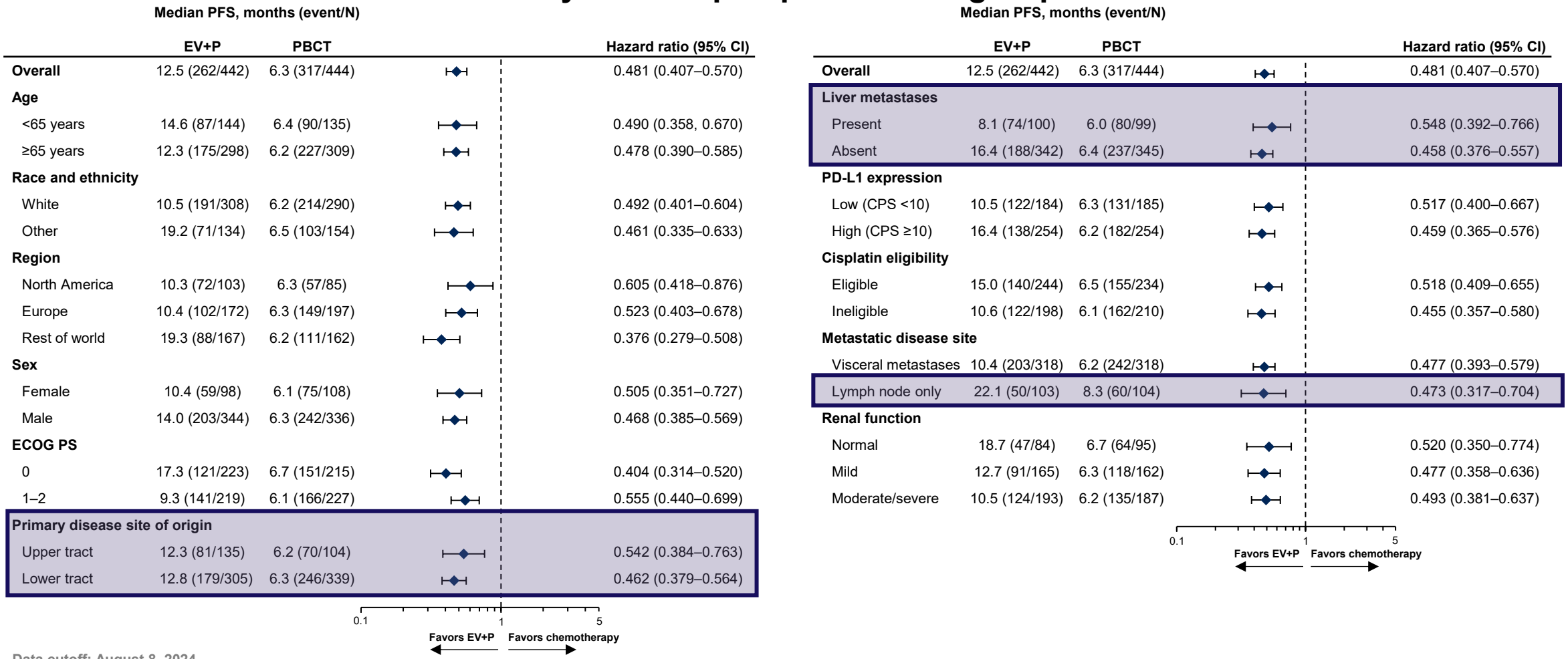
Median follow-up: 29.1 months. Data cutoff: August 8, 2024.

CI, confidence interval; CPS, combined positive score; ECOG PS, Eastern Cooperative Oncology Group performance status; EV+P, enfortumab vedotin plus pembrolizumab; NR, not reached; OS, overall survival; PBCT, platinum-based chemotherapy; PD-L1, programmed death-ligand 1.

1. Powles T. Presented at ASCO GU 2025. Abstract 664; 2. Bedke J et al. Presented at ASCO 2025. Abstract 4571.

After an additional year, EV+P continued to demonstrate superior PFS vs. PBCT across multiple prespecified subgroups[1,2]

PFS by BICR in prespecified subgroups

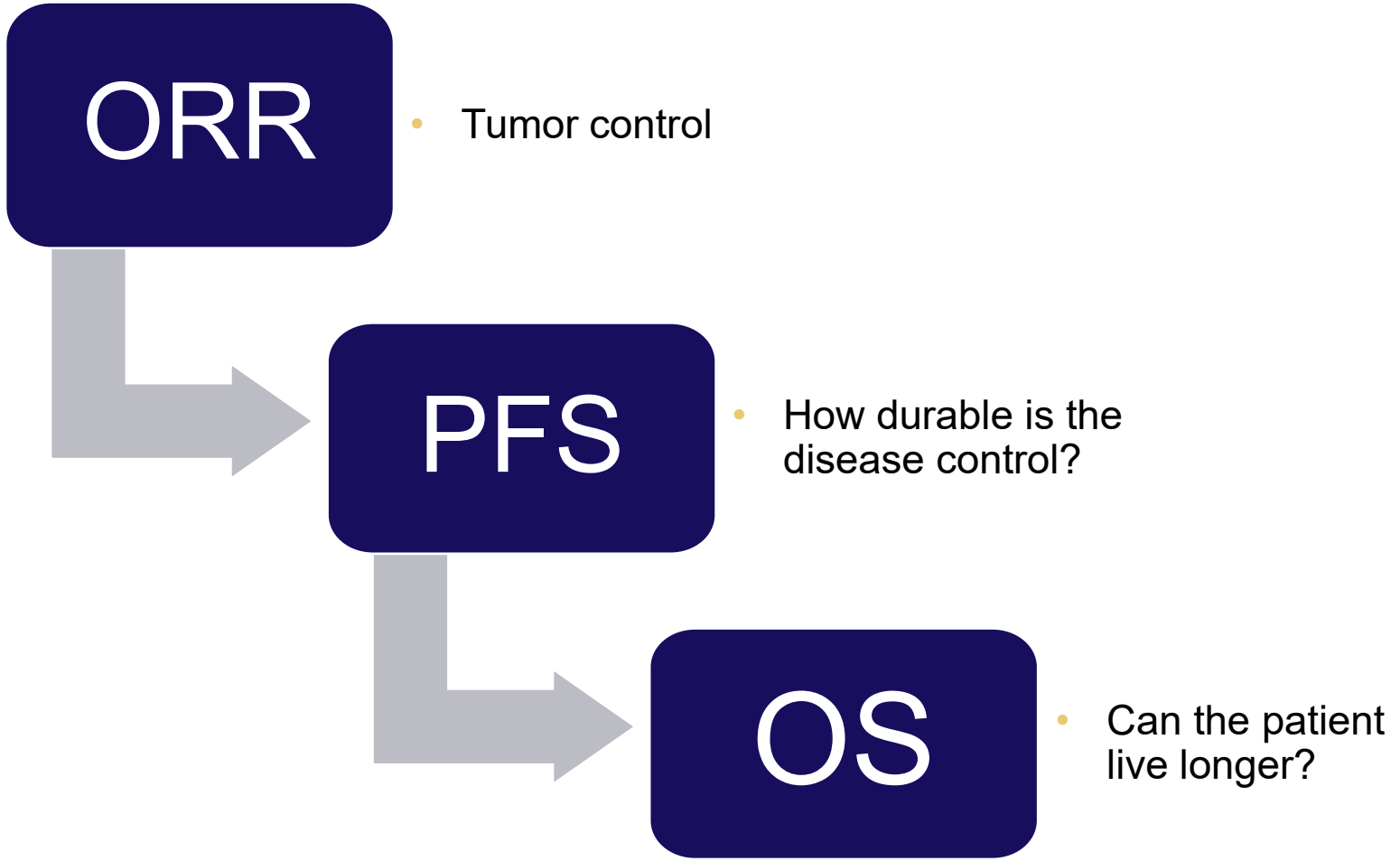


Data cutoff: August 8, 2024.

BICR, blinded independent central review; CI, confidence interval; CPS, combined positive score; ECOG PS, Eastern Cooperative Oncology Group performance status; EV+P, enfortumab vedotin plus pembrolizumab; PBCT, platinum-based chemotherapy; PD-L1, programmed death ligand 1; PFS, progression-free survival.

1. Powles T. Presented at ASCO GU 2025. Abstract 664; 2. Bedke J et al. Presented at ASCO 2025. Abstract 4571.

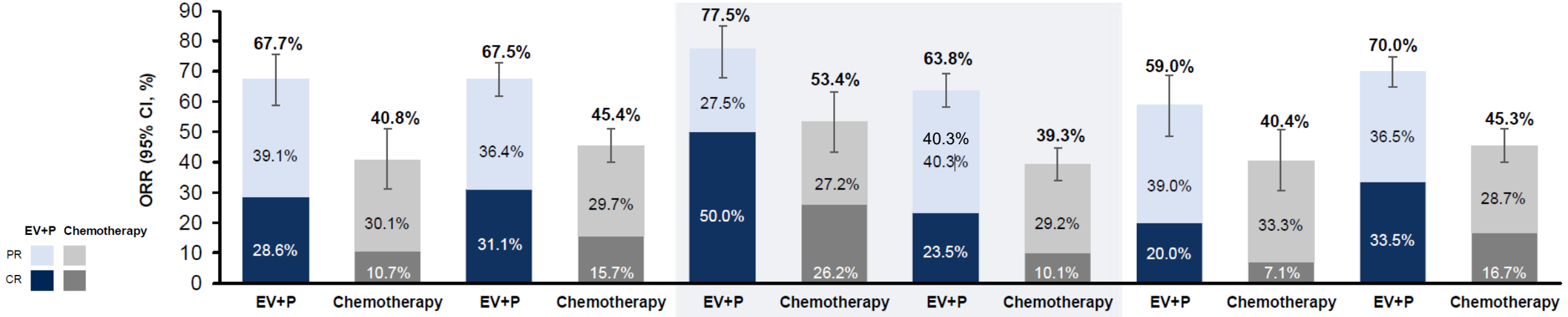
How durable is disease control across prespecified subgroups?



EV+P, enfortumab vedotin plus pembrolizumab; ORR, objective response rate; OS, overall survival; PFS, progression-free survival.

ORR continued to demonstrate the sustained benefit of EV+P vs. PBCT across prespecified subgroups after long-term follow-up

Results: ORR in prespecified subgroups



	Upper tract		Lower tract		LN-only mets		Visceral mets present		Liver mets present		Liver mets absent	
	EV+P n=133	Chemotherapy n=103	EV+P n=302	Chemotherapy n=337	EV+P n=102	Chemotherapy n=103	EV+P n=315	Chemotherapy n=318	EV+P n=100	Chemotherapy n=99	EV+P n=337	Chemotherapy n=342
ORR, n (%)	90 (67.7)	42 (40.8)	204 (67.5)	153 (45.4)	79 (77.5)	55 (53.4)	201 (63.8)	125 (39.3)	59 (59.0)	40 (40.4)	236 (70.0)	155 (45.3)
DOR, median (95% CI), month	23.3 (12.6–NE)	6.2 (4.9–12.5)	23.9 (17.3–NE)	7.0 (6.2–10.2)	NE (19.9–NE)	12.4 (8.6–24.9)	20.2 (14.7–25.6)	6.1 (5.4–6.9)	12.9 (8.4–20.2)	5.0 (4.3–6.2)	34.2 (21.5–NE)	8.4 (6.6–10.4)

Data cutoff: August 8, 2024.

CI, confidence interval; CR, complete response; DOR, duration of response; EV+P, enfortumab vedotin plus pembrolizumab; LN, lymph node; mets, metastases; NE, not estimable; ORR, objective response rate; PBCT, platinum-based chemotherapy; PR, partial response.

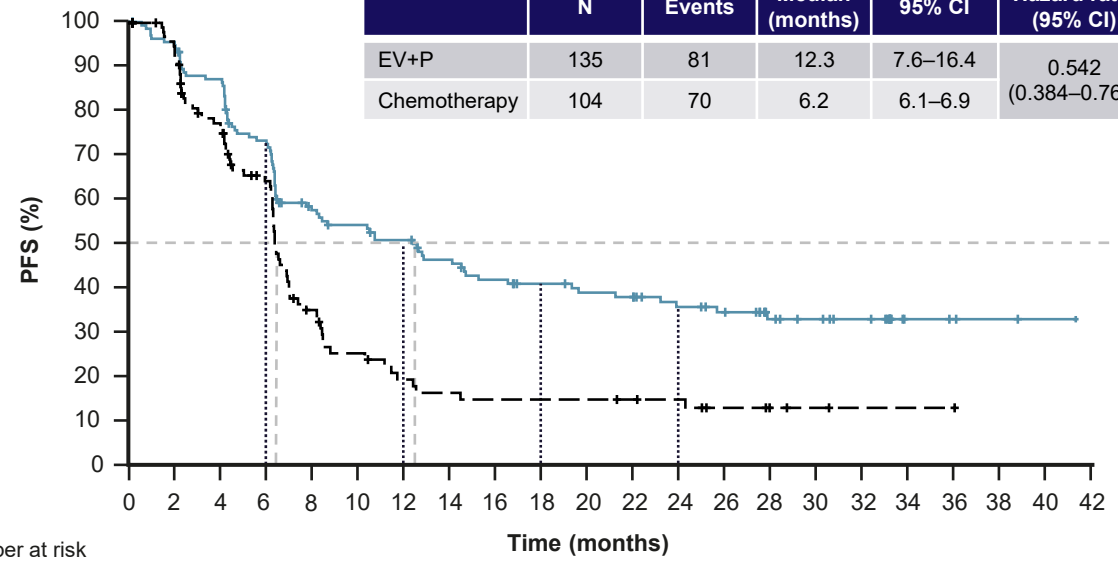
Bedke J, et al. Presented at ASCO 2025. Abstract 4571.

EV+P continues to demonstrate superior long-term PFS vs. PBCT in subgroups, regardless of disease site

PFS by BICR: Primary disease site of origin in the upper tract and lower tract

Primary disease site of origin in the upper tract

	N	Events	Median (months)	95% CI	Hazard ratio (95% CI)
EV+P	135	81	12.3	7.6–16.4	0.542 (0.384–0.763)
Chemotherapy	104	70	6.2	6.1–6.9	

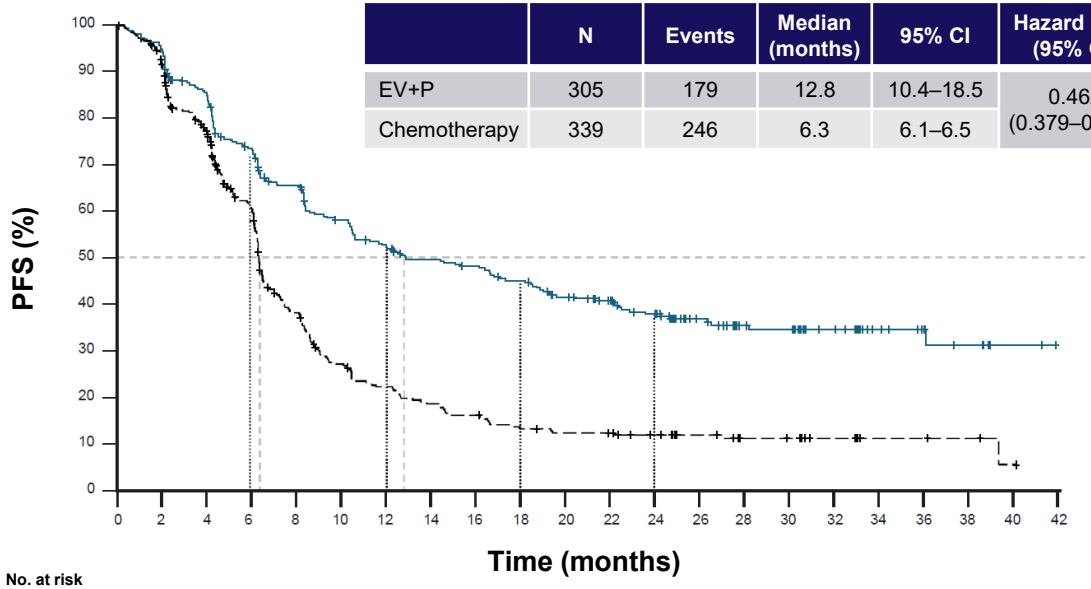


Number at risk

EV+P	135	124	112	92	69	64	59	51	46	42	39	36	32	28	21	18	15	4	3	2	1	0
Chemotherapy	104	86	65	51	26	18	13	11	10	10	10	9	8	5	3	2	1	1	0	0	0	0

Primary disease site of origin in the lower tract

	N	Events	Median (months)	95% CI	Hazard ratio (95% CI)
EV+P	305	179	12.8	10.4–18.5	0.462 (0.379–0.564)
Chemotherapy	339	246	6.3	6.1–6.5	



No. at risk

EV + P	305	283	248	211	184	159	141	131	126	117	104	92	77	54	41	39	27	18	11	8	3	0
Chemotherapy	339	293	231	162	99	68	55	46	40	32	29	28	23	18	13	12	8	4	4	3	1	0

- EV+P continued to demonstrate increased and sustained benefit vs PBCT across prespecified subgroups after long-term follow-up

Data cutoff: August 8, 2024. NCT04223856.

BICR, blinded independent central review; CI, confidence interval; EV+P, enfortumab vedotin plus pembrolizumab; PBCT, platinum-based chemotherapy; PFS, progression-free survival.

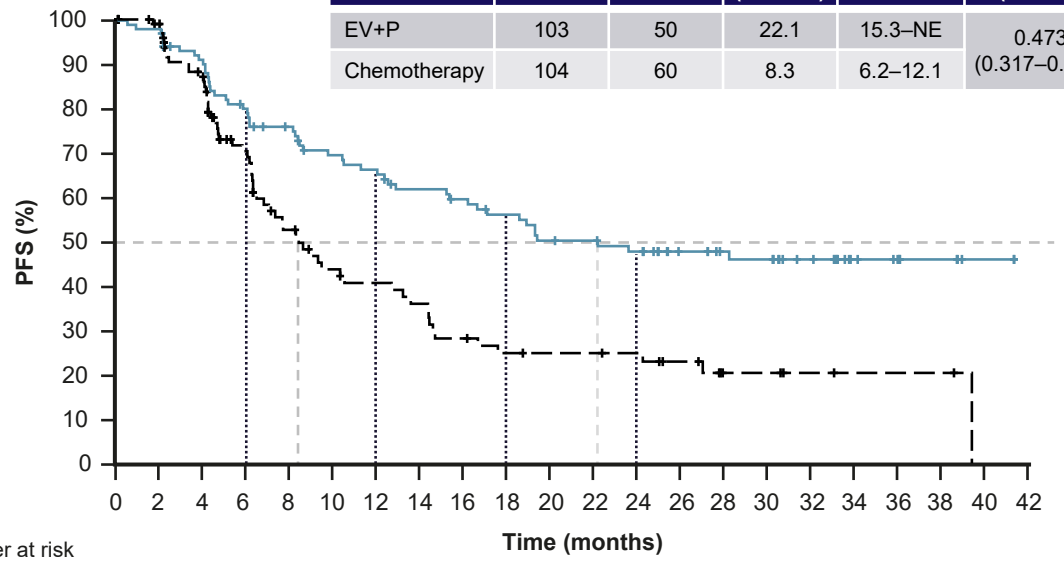
Bedke J, et al. Presented at ASCO 2025. Abstract 4571.

EV+P continues to demonstrate superior long-term PFS vs. PBCT in subgroups without visceral and liver metastases

PFS by BICR: Absence of visceral and liver metastases

LN-only metastases

	N	Events	Median (months)	95% CI	Hazard ratio (95% CI)
EV+P	103	50	22.1	15.3–NE	0.473 (0.317–0.704)
Chemotherapy	104	60	8.3	6.2–12.1	

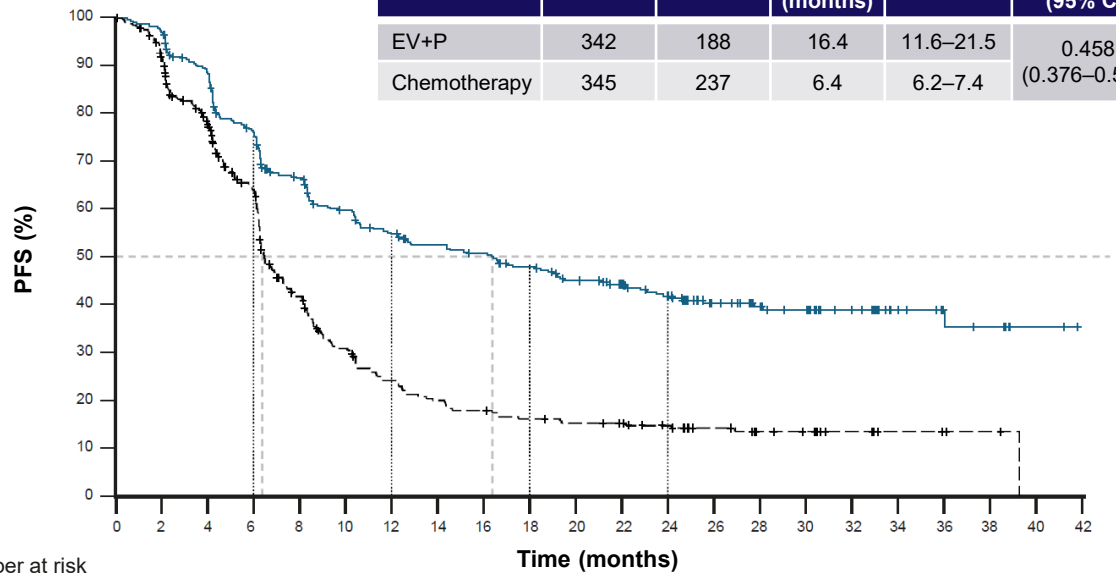


Number at risk

EV+P	103	101	90	78	72	64	60	55	52	48	43	42	39	31	27	26	20	11	7	5	2	0
Chemotherapy	104	95	76	52	37	29	26	23	18	15	14	14	13	10	5	5	3	2	2	2	0	0

Absence of liver metastases

	N	Events	Median (months)	95% CI	Hazard ratio (95% CI)
EV+P	342	188	16.4	11.6–21.5	0.458 (0.376–0.557)
Chemotherapy	345	237	6.4	6.2–7.4	



Number at risk

EV+P	342	328	292	247	209	182	165	153	147	136	124	112	95	70	57	52	39	21	13	9	3	0
Chemotherapy	345	297	234	172	106	75	57	47	42	37	34	32	27	20	14	12	7	4	3	2	0	0

- EV+P continued to demonstrate increased and sustained benefit vs PBCT across prespecified subgroups after long-term follow-up

Data cutoff: August 8, 2024. NCT04223856.

BICR, blinded independent central review; CI, confidence interval; EV+P, enfortumab vedotin plus pembrolizumab; LN, lymph node; NE, not estimable; PBCT, platinum-based chemotherapy; PFS, progression-free survival.

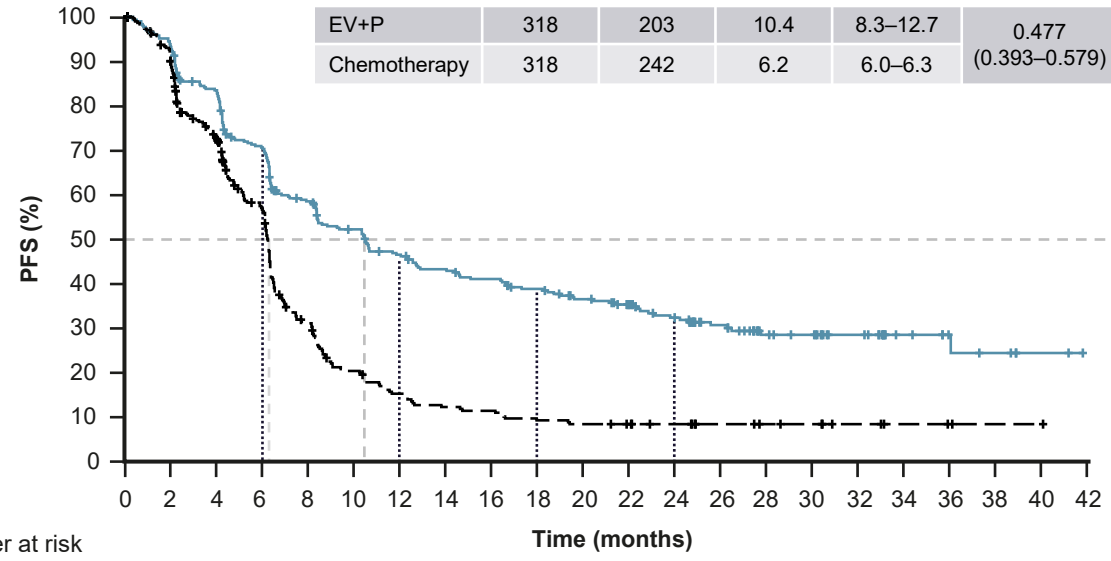
Bedke J, et al. Presented at ASCO 2025. Abstract 4571.

EV+P continues to demonstrate superior long-term PFS vs. PBCT in subgroups with both visceral and liver metastases

PFS by BICR: Presence of visceral and liver metastases

Visceral metastases

	N	Events	Median (months)	95% CI	Hazard ratio (95% CI)
EV+P	318	203	10.4	8.3–12.7	0.477 (0.393–0.579)
Chemotherapy	318	242	6.2	6.0–6.3	

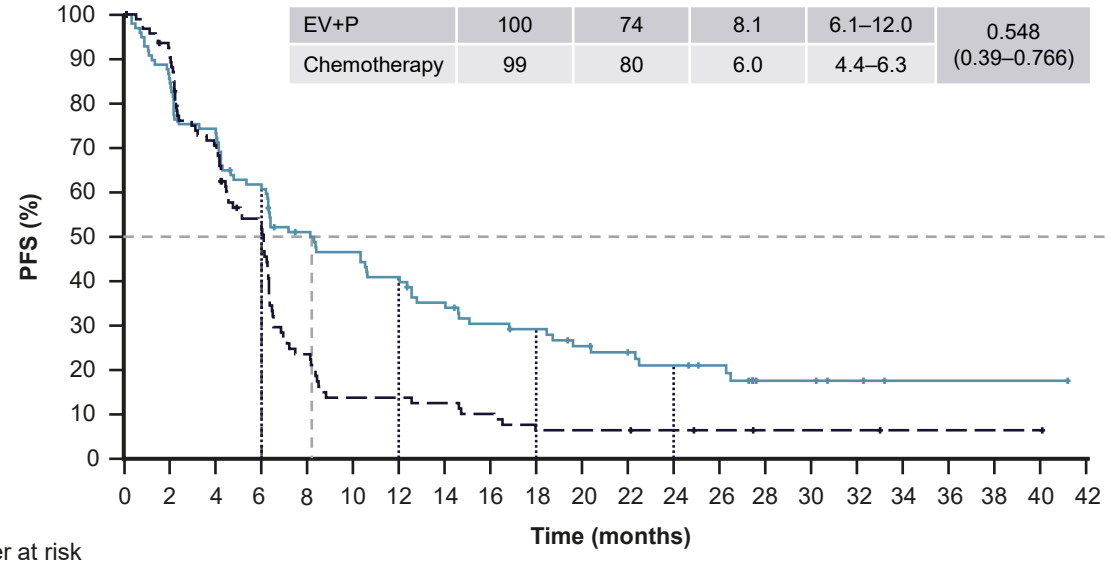


Number at risk

EV+P	318	287	251	211	170	148	129	118	112	103	93	80	64	48	33	30	22	11	7	5	2	0
Chemotherapy	318	263	201	144	77	49	36	29	27	22	20	18	15	11	9	8	5	3	2	1	1	0

Liver metastases

	N	Events	Median (months)	95% CI	Hazard ratio (95% CI)
EV+P	100	74	8.1	6.1–12.0	0.548 (0.39–0.766)
Chemotherapy	99	80	6.0	4.4–6.3	



Number at risk

EV+P	100	81	69	57	45	41	35	29	25	23	19	16	14	12	5	5	3	1	1	1	1	0
Chemotherapy	99	82	62	41	19	11	11	10	8	5	5	5	4	3	2	2	2	1	1	1	1	0

- EV+P continued to demonstrate increased and sustained benefit vs PBCT across prespecified subgroups after long-term follow-up

Data cutoff: August 8, 2024. NCT04223856.

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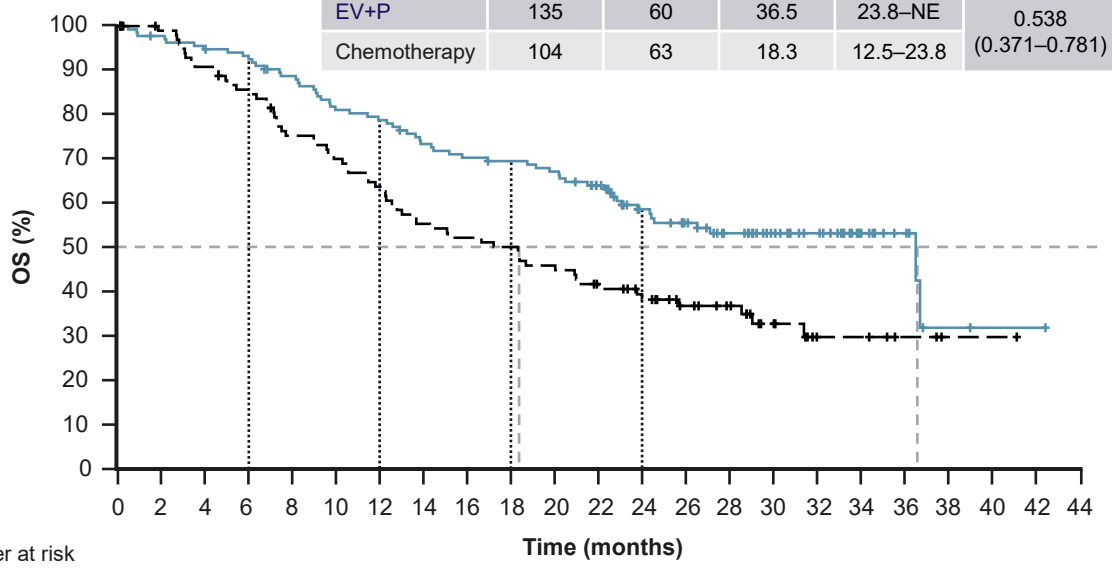
Bedke J, et al. Presented at ASCO 2025. Abstract 4571.

EV+P continues to demonstrate superior long-term OS vs. PBCT in subgroups, regardless of disease site

OS: Primary disease site of origin in the upper tract and lower tract

Primary disease site of origin in the upper tract

	N	Events	Median (months)	95% CI	Hazard ratio (95% CI)
EV+P	135	60	36.5	23.8–NE	0.538 (0.371–0.781)
Chemotherapy	104	63	18.3	12.5–23.8	

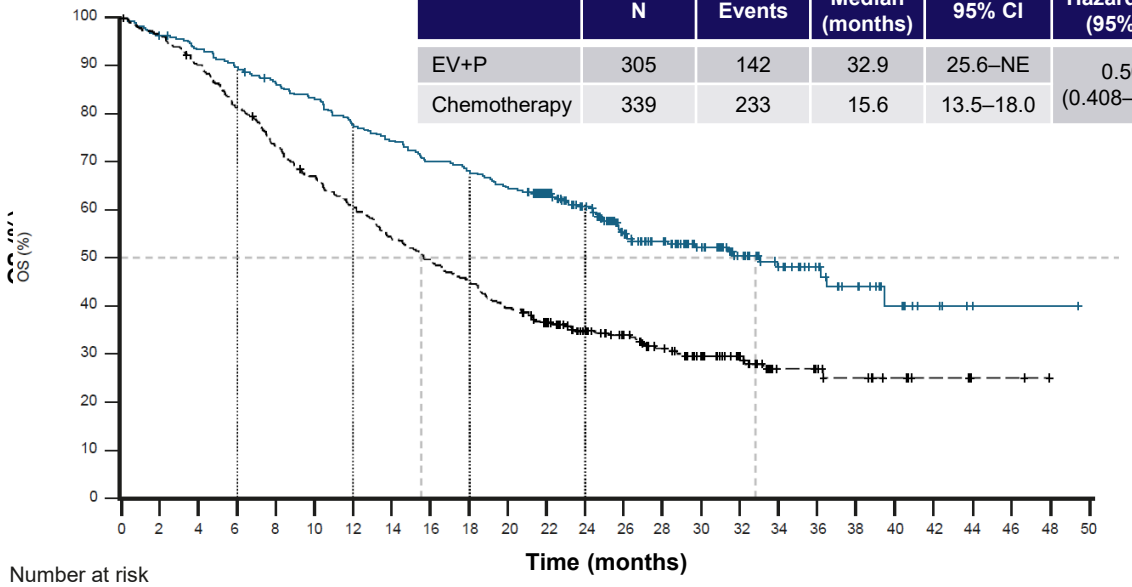


Number at risk

EV+P	135	131	126	123	116	106	103	95	91	89	86	77	57	50	41	32	25	13	7	2	1	1	0
Chemotherapy	104	97	89	83	72	67	61	53	50	48	44	37	32	25	21	13	7	6	3	1	1	0	0

Primary disease site of origin in the lower tract

	N	Events	Median (months)	95% CI	Hazard ratio (95% CI)
EV+P	305	142	32.9	25.6–NE	0.504 (0.408–0.623)
Chemotherapy	339	233	15.6	13.5–18.0	



Number at risk

EV+P	305	293	282	270	258	249	232	223	210	203	193	174	148	110	91	70	54	39	25	17	10	5	1	1	1	0
Chemotherapy	339	326	304	273	245	223	202	180	164	149	132	111	89	77	60	46	36	18	15	12	8	5	2	2	0	0

- EV+P continued to demonstrate increased and sustained benefit vs PBCT across prespecified subgroups after long-term follow-up

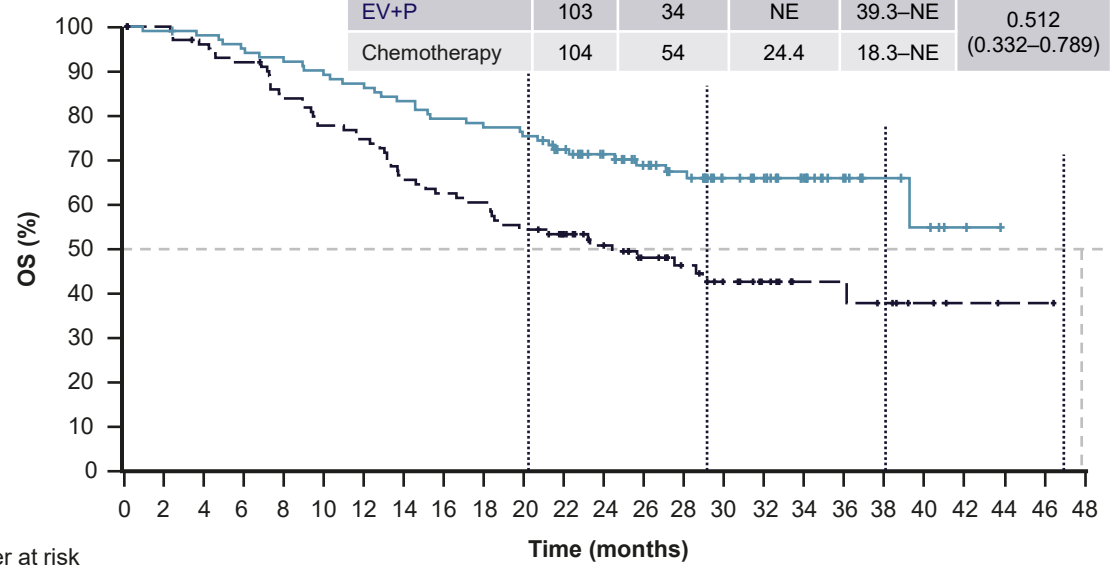
Data cutoff: August 8, 2024. NCT04223856.
CI, confidence interval; EV+P, enfortumab vedotin plus pembrolizumab; NE, not estimable; OS, overall survival; PBCT, platinum-based chemotherapy.
Bedke J, et al. Presented at ASCO 2025. Abstract 4571.

EV+P continues to demonstrate superior long-term OS vs. PBCT in subgroups without visceral and liver metastases

OS: Absence of visceral and liver metastases

LN-only metastases

	N	Events	Median (months)	95% CI	Hazard ratio (95% CI)
EV+P	103	34	NE	39.3–NE	0.512 (0.332–0.789)
Chemotherapy	104	54	24.4	18.3–NE	

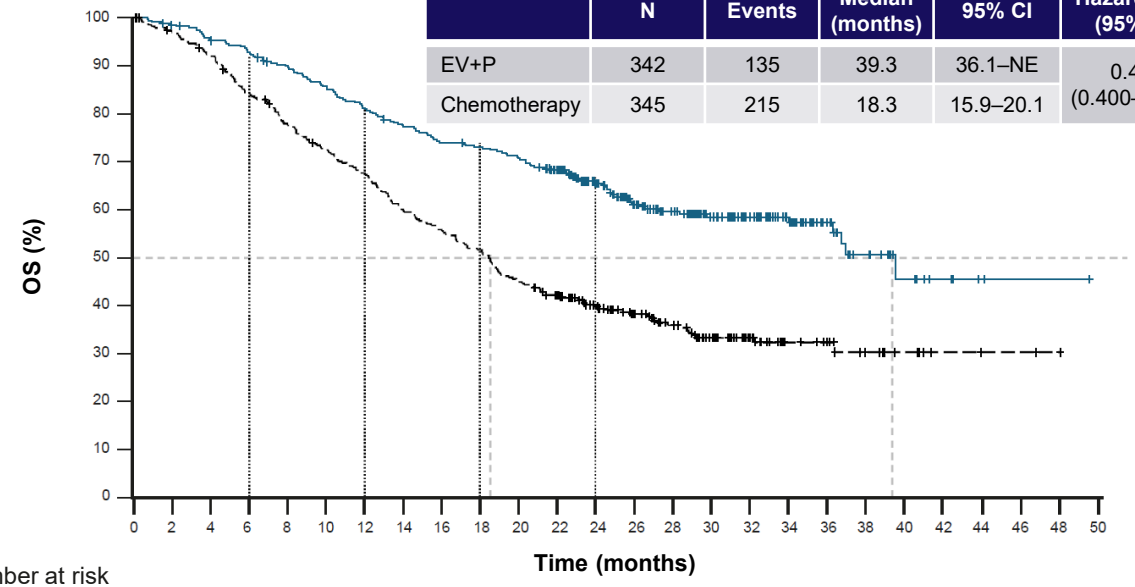


Number at risk

EV+P	103	102	100	96	94	91	88	85	81	79	77	70	61	52	46	34	30	21	13	7	5	2	0	0	0
Chemotherapy	104	101	96	92	83	77	74	65	62	60	54	47	39	32	26	20	15	9	9	7	4	2	1	1	0

Absence of liver metastases*

	N	Events	Median (months)	95% CI	Hazard ratio (95% CI)
EV+P	342	135	39.3	36.1–NE	0.496 (0.400–0.615)
Chemotherapy	345	215	18.3	15.9–20.1	



Number at risk

EV+P	342	335	322	312	299	285	270	258	247	242	234	210	172	135	116	89	70	48	29	17	9	5	1	1	1	0
Chemotherapy	345	328	310	282	259	240	223	198	184	169	150	129	108	90	72	52	37	22	17	12	8	4	2	2	0	0

- EV+P continued to demonstrate increased and sustained benefit vs PBCT across prespecified subgroups after long-term follow-up

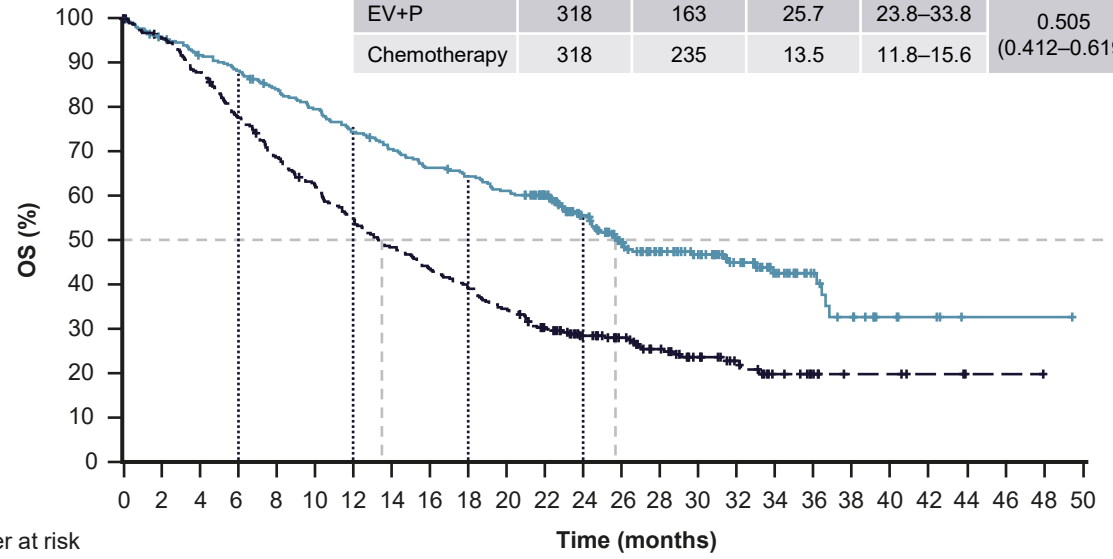
Data cutoff: August 8, 2024. NCT04223856.
*Censored observations are indicated by a "+" symbol.
CI, confidence interval; EV+P, enfortumab vedotin plus pembrolizumab; LN, lymph node; NE, not estimable; OS, overall survival; PBCT, platinum-based chemotherapy.
Bedke J, et al. Presented at ASCO 2025. Abstract 4571.

EV+P continues to demonstrate superior long-term OS vs. PBCT in subgroups with both visceral and liver metastases

OS: Presence of visceral and liver metastases

Visceral metastases

	N	Events	Median (months)	95% CI	Hazard ratio (95% CI)
EV+P	318	163	25.7	23.8–33.8	0.505 (0.412–0.619)
Chemotherapy	318	235	13.5	11.8–15.6	

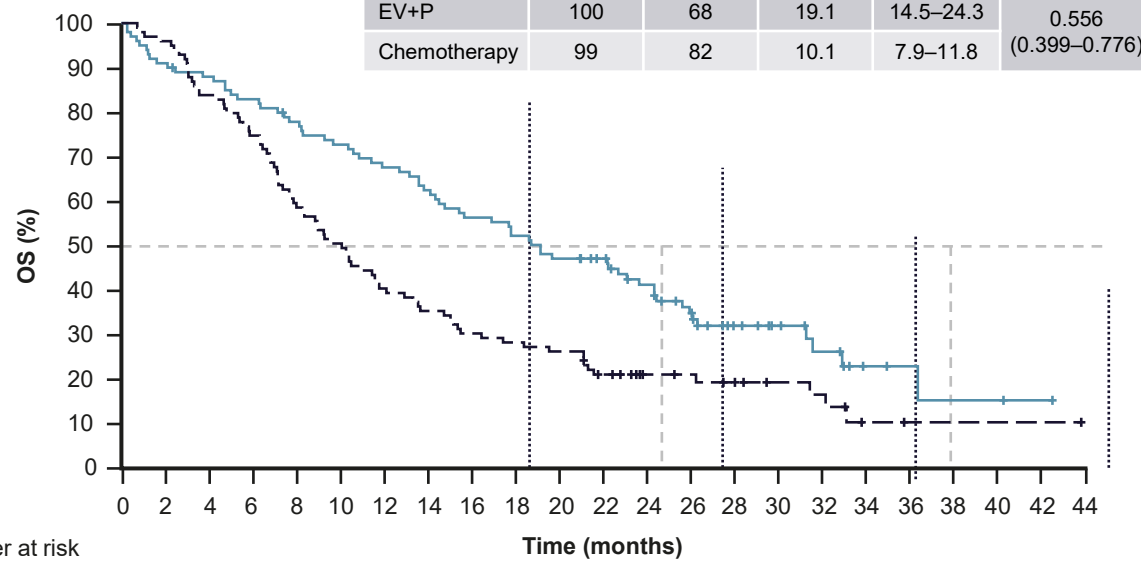


Number at risk

EV+P	318	303	288	277	261	247	231	218	205	198	188	169	133	100	80	66	47	30	18	11	6	4	1	1	1	0
Chemotherapy	318	301	276	244	214	194	170	150	135	121	107	86	68	58	44	33	24	14	8	5	5	3	1	1	0	0

Liver metastases*

	N	Events	Median (months)	95% CI	Hazard ratio (95% CI)
EV+P	100	68	19.1	14.5–24.3	0.556 (0.399–0.776)
Chemotherapy	99	82	10.1	7.9–11.8	



Number at risk

EV+P	100	91	87	82	76	71	66	61	55	51	46	42	34	26	17	13	9	4	3	2	2	1	0	
Chemotherapy	99	95	83	74	58	50	40	35	30	28	26	19	13	12	9	7	6	2	1	1	1	1	0	

- EV+P continued to demonstrate increased and sustained benefit vs PBCT across prespecified subgroups after long-term follow-up

Data cutoff: August 8, 2024. NCT04223856.
*Censored observations are indicated by a "+" symbol.
CI, confidence interval; EV+P, enfortumab vedotin plus pembrolizumab; OS, overall survival; PBCT, platinum-based chemotherapy.
Bedke J, et al. Presented at ASCO 2025. Abstract 4571.

TRAEs across prespecified subgroups were generally consistent with previous reports

- For EV+P, any grade TRAEs occurred in 96.0–98.5% and Grade ≥3 TRAEs in 53.4–60.7% of patients across prespecified subgroups, which is generally consistent with previous reports
- For chemo, any grade TRAEs occurred in 94.8–96.9% and Grade ≥3 TRAEs in 66.7–74.0% of patients across prespecified subgroups

	Upper tract		Lower tract		LN-only mets		Visceral mets present		Liver mets present		Liver mets absent	
	EV+P (n=135)	Chemo (n=97)	EV+P (n=303)	Chemo (n=335)	EV+P (n=103)	Chemo (n=102)	EV+P (n=316)	Chemo (n=309)	EV+P (n=99)	Chemo (n=96)	EV+P (n=341)	Chemo (n=337)
Any TRAE, n (%)	133 (98.5)	92 (94.8)	293 (96.7)	321 (95.8)	100 (97.1)	98 (96.1)	307 (97.2)	295 (95.5)	95 (96.0)	93 (96.9)	333 (97.7)	321 (95.3)
Any Grade ≥3 TRAE, n (%)	82 (60.7)	69 (71.1)	170 (56.1)	231 (69.0)	55 (53.4)	68 (66.7)	185 (58.5)	219 (70.9)	55 (55.6)	71 (74.0)	197 (57.8)	230 (68.2)
Any serious TRAE, n (%)	39 (28.9)	13 (13.4)	90 (29.7)	71 (21.2)	26 (25.2)	18 (17.6)	95 (30.1)	64 (20.7)	32 (32.3)	16 (16.7)	97 (28.4)	69 (20.5)

Chemo, chemotherapy; EV+P, enfortumab vedotin plus pembrolizumab; LN, lymph node; mets, metastases; TRAE, treatment-related adverse event.
Bedke J et al. Presented at ASCO 2025, Abstract 4571.

Genitourinary Masterclass

Post hoc analysis of EV-302 primary cohort in the Pan-Asian subgroup

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Baseline characteristics were balanced across treatment arms in this *post hoc* analysis

The pan-Asian subgroup is a subset of the overall ITT population in EV-302 and consists of all trial participants enrolled from China, Japan, Singapore, South Korea, Taiwan, and Thailand (N=176)

Characteristic	EV+P (n=94)	Chemotherapy (n=82)
Male sex, n (%)	62 (66.0)	59 (72.0)
Mean age (range), years	69.5 (37–86)	68.0 (48–91)
ECOG PS, n (%)		
0	57 (60.6)	40 (48.8)
1	36 (38.3)	40 (48.8)
2	1 (1.1)	2 (2.4)
Smoking status, n (%)		
Former or current smoker	49 (52.1)	39 (47.6)
Nonsmoker	45 (47.9)	42 (51.2)
Unknown	0	1 (1.2)
Primary tumor location, n (%)		
Upper tract	49 (52.1)	43 (52.4)
Lower tract	45 (47.9)	39 (47.6)

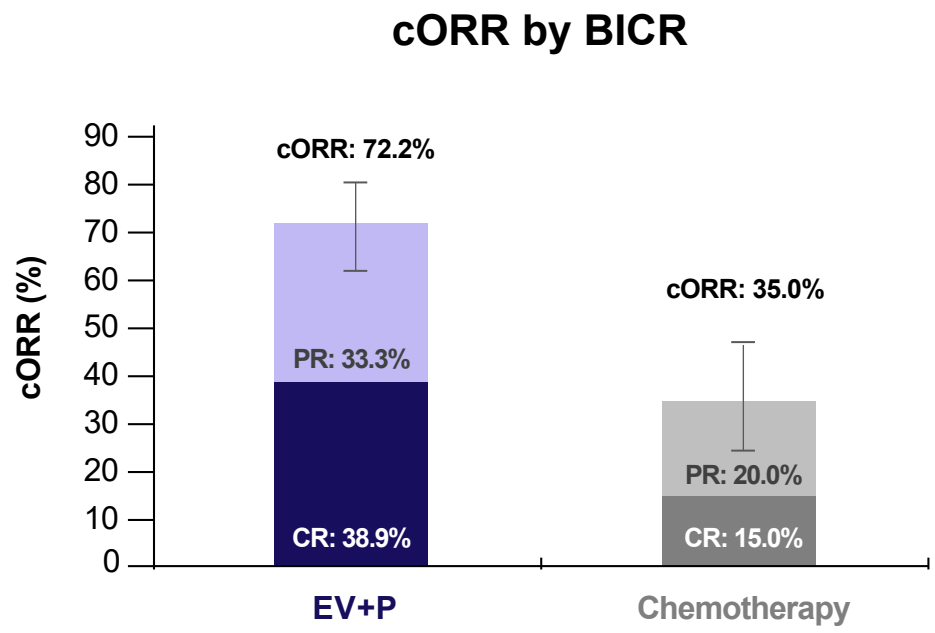
Characteristic	EV+P (n=94)	Chemotherapy (n=82)
Cisplatin eligibility,* n (%)	46 (48.9)	46 (56.1)
Disease status, n (%)		
Metastatic	89 (94.7)	76 (92.7)
Locally advanced	5 (5.3)	6 (7.3)
Metastatic category,† n (%)		
Visceral metastases	70 (74.5)	55 (67.1)
Bone	14 (14.9)	17 (20.7)
Liver	10 (10.6)	14 (17.1)
Lung	41 (43.6)	32 (39.0)
Lymph node-only disease	19 (20.2)	22 (26.8)
PD-L1 expression,‡ n/N (%)		
High (CPS ≥10)	52/93 (55.9)	45/82 (54.9)
Low (CPS <10)	41/93 (44.1)	37/82 (45.1)

*Cisplatin eligibility was based on post-randomization corrections of CRF; †A patient may have had metastatic disease in more than one location; ‡CPS status was determined using the validated PD-L1 IHC 22C3 pharmDx assay at NeoGenomics and Labcorp. One patient in the EV+P arm had a sample that was of inadequate tissue quality for analysis.

CPS, combined positive score; CRF, case report form; ECOG PS, Eastern Cooperative Oncology Group performance status; EV+P, enfortumab vedotin + pembrolizumab; IHC, immunohistochemistry; ITT, intention-to-treat; PD-L1, programmed cell death-ligand 1.

Kikuchi E et al. Presented at ESMO 2024. Abstract #269O.

A clinically meaningful improvement in ORR was observed with EV+P vs. PBCT



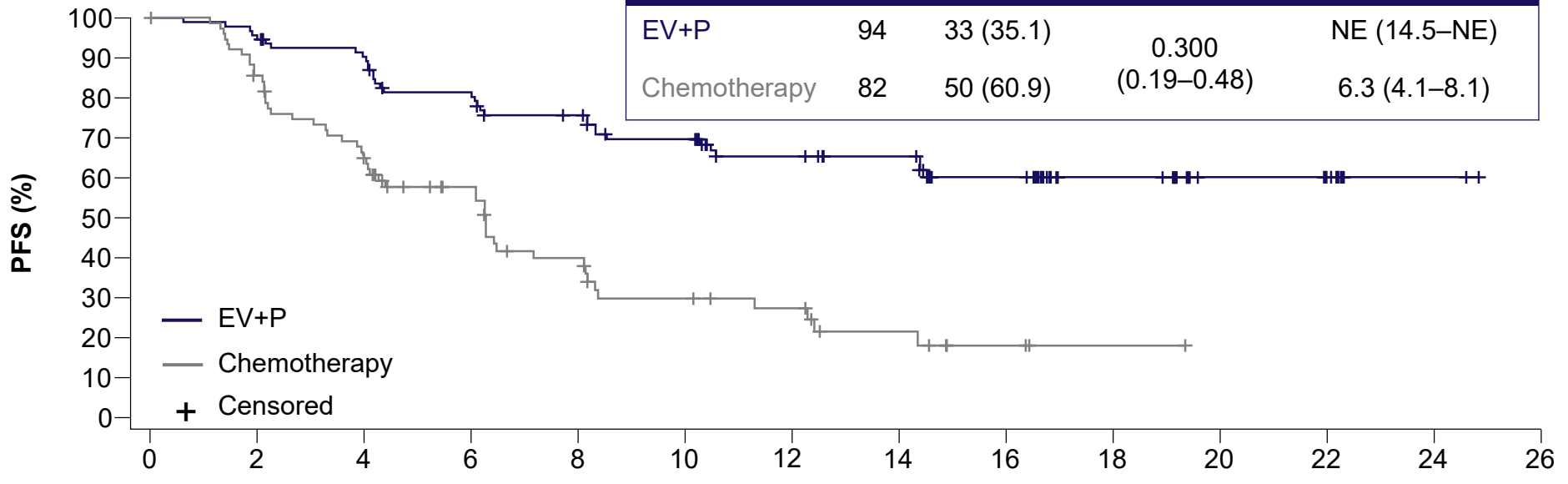
Median DOR (95% CI), months	NE (NE–NE)	12.5 (10.3–NE)

Parameter	EV+P* (n=90)	Chemotherapy* (n=80)
cORR, n (%) (95% CI)†	**65 (72.2)** (61.8–81.1)	**28 (35.0)** (24.7–46.5)
Best overall response,‡ n (%)		
CR	35 (38.9)	12 (15.0)
PR	30 (33.3)	16 (20.0)
Stable disease	18 (20.0)	27 (33.8)
Progressive disease	5 (5.6)	18 (22.5)
Not evaluable¶	0	2 (2.5)
No assessment§	2 (2.2)	5 (6.3)

Data cutoff: August 8, 2023.
*ORR was analyzed in the response evaluable set, which included all randomized patients with measurable disease per RECIST v1.1 at baseline; †Computed using the Clopper-Pearson method (Clopper 1934); ‡Best overall response according to RECIST v1.1 per BICR. CR or PR was confirmed with repeat scans ≥28 days after initial response; ¶Patients had post-baseline assessment, and the best overall response was determined not evaluable per RECIST v1; §Patients had no response assessment post-baseline.
BICR, blinded independent central review; CI, confidence interval; cORR, confirmed objective response rate; CR, complete response; DOR, duration of response; EV+P, enfortumab vedotin + pembrolizumab; NE, not estimable; ORR, objective response rate; PBCT, platinum-based chemotherapy; PR, partial response; RECIST v1.1, Response Evaluation Criteria in Solid Tumors version 1.1.
Kikuchi E et al. Presented at ESMO 2024, Abstract #269O.

Median PFS was improved with EV+P vs. PBCT in the pan-Asian subgroup

	N	Events, n (%)	Hazard ratio (95% CI)	Median PFS (95% CI), months
EV+P	94	33 (35.1)	0.300 (0.19–0.48)	NE (14.5–NE)
Chemotherapy	82	50 (60.9)		6.3 (4.1–8.1)

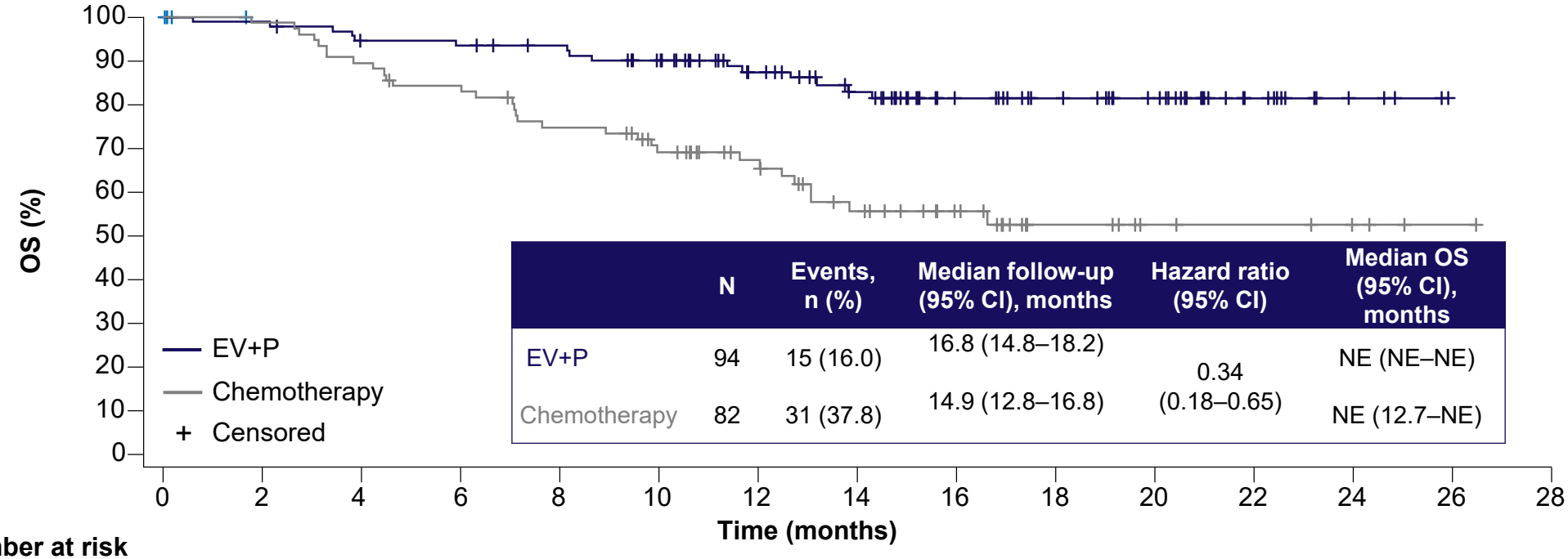


Number at risk

EV+P	94	89	82	72	64	55	44	39	28	18	9	7	2
Chemotherapy	82	64	47	33	21	14	11	6	3	1			

CI, confidence interval; EV+P, enfortumab vedotin + pembrolizumab; NE, not estimable; PBCT, platinum-based chemotherapy; PFS, progression-free survival.
Kikuchi E et al. Presented at ESMO 2024, Abstract #269O.

Median OS was improved with EV+P vs. PBCT in the pan-Asian subgroup



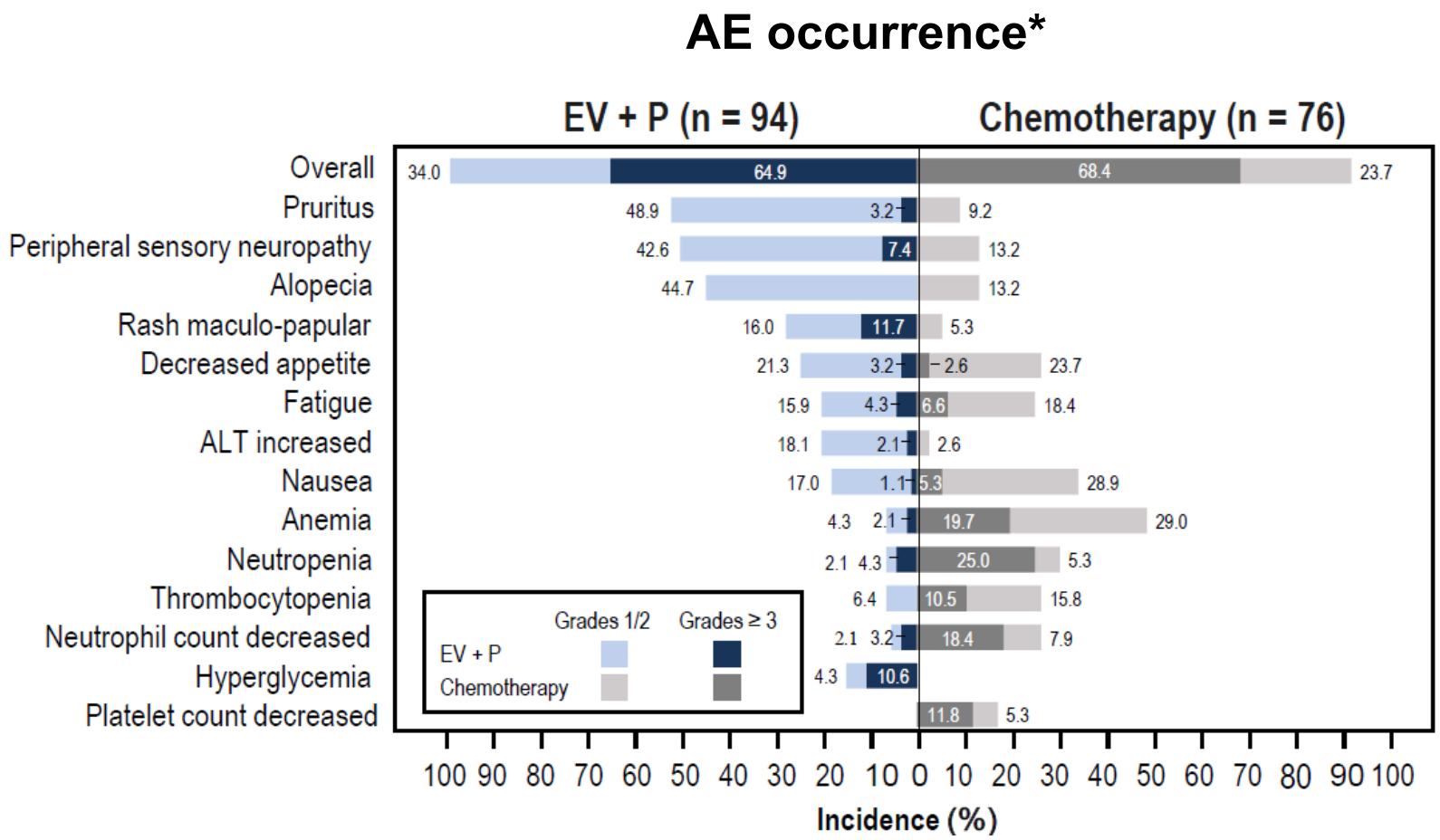
	N	Events, n (%)	Median follow-up (95% CI), months	Hazard ratio (95% CI)	Median OS (95% CI), months
EV+P	94	15 (16.0)	16.8 (14.8–18.2)	0.34 (0.18–0.65)	NE (NE–NE)
Chemotherapy	82	31 (37.8)	14.9 (12.8–16.8)		NE (12.7–NE)

Number at risk

EV+P	94	93	87	86	83	77	64	53	39	31	23	12	4	
Chemotherapy	82	75	68	63	55	47	38	26	19	10	6	5	3	1

CI, confidence interval; EV+P, enfortumab vedotin + pembrolizumab; NE, not estimable; OS, overall survival; PBCT, platinum-based chemotherapy.
Kikuchi E et al. Presented at ESMO 2024, Abstract #269O.

The safety profile was consistent between the pan-Asian subgroup and the overall safety population



Data cutoff: August 8, 2023.
*All grades, ≥20% of patients; Grade ≥3, ≥10% of patients. Patients were included from the safety analysis set, which consisted of all randomized patients who received at least one dose of investigational product (or any component of combination therapy); †Of the 82 patients in the chemotherapy group, six did not receive study treatment.
AE, adverse event; ALT, alanine aminotransferase; EV+P, enfortumab vedotin + pembrolizumab.
Kikuchi E et al. Presented at ESMO 2024, Abstract #269O.

No new AESI safety signals related to EV were identified in the pan-Asian subgroup*†

AESIs, n (%)	EV+P (n=94)		Chemotherapy (n=76)	
	Any grade	Grade ≥3	Any grade	Grade ≥3
Skin reactions	76 (80.9)	26 (27.7)	13 (17.1)	0
Peripheral neuropathy Sensory events Motor events	60 (63.8) 59 (62.8) 3 (3.2)	8 (8.5) 8 (8.5) 0	12 (15.8) 12 (15.8) 0	0 0 0
Ocular disorders Dry eye	8 (8.5) 5 (5.3)	0 0	0 0	0 0
Hyperglycemia	18 (19.1)	10 (10.6)	0	0
Infusion-related reactions	0	0	0	0

Data cutoff: August 8, 2023.

*There were differences in the rates of skin reactions reported for EV treatment-related AESIs and pembrolizumab TEAEs of special interest, because these AEs were reported via different methodologies developed for EV and pembrolizumab monotherapies, respectively; †Patients were included from the safety analysis set, which consisted of all randomized patients who received at least one dose of investigational product (or any component of combination therapy).

AE, adverse event; AESI, adverse event of special interest; EV, enfortumab vedotin; EV+P, enfortumab vedotin + pembrolizumab; TEAE, treatment-emergent adverse event.

Kikuchi E et al. Presented at ESMO 2024, Abstract #269O.

Summary

After a median follow-up of 2.5 years, EV+P **continued to demonstrate superior efficacy** vs. PBCT across pre-specified subgroups, with both favorable and poor prognoses[1]

There were no new safety signals observed, and the safety profile was consistent across prespecified subgroups, the *post hoc* pan-Asian subgroup, and the overall safety population[1,2]

Post hoc analysis of the EV-302 study showed that EV+P improved outcomes in patients from Asia*, consistent with outcomes observed in the overall study population[2]

EV+P provides a **long-lasting, durable response** for patients with unresectable/mUC across a broad patient population[1,2]

*Includes all trial participants enrolled from China, Japan, Singapore, South Korea, Taiwan, and Thailand.[2]
EV+P, enfortumab vedotin plus pembrolizumab; mUC, metastatic urothelial carcinoma; PBCT, platinum-based chemotherapy.
1. Bedke J et al. Presented at ASCO 2025, Abstract 4571; 2. Kikuchi E et al. Presented at ESMO 2024, Abstract #269O.

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PI, Prescribing Information

Genitourinary Masterclass

Changes in clinical practice since the approval of EV+P

Prof. Eun Hee Jung

Seoul National University Bundang Hospital
Korea

EV as first-line therapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer. Combination therapy with pembrolizumab.

EV as monotherapy is indicated for the treatment of adult patients with locally advanced or metastatic urothelial cancer who have previously received a programmed death receptor-1 or programmed death-ligand 1 inhibitor and have received a platinum-containing chemotherapy.

1L, first line; EV, enfortumab vedotin;
LA/mUC, locally advanced/metastatic urothelial carcinoma; P, pembrolizumab;
PD-1/L1, programmed cell death-1/ligand 1.
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July 2025 | MAT-KR-PAD-2025-00069

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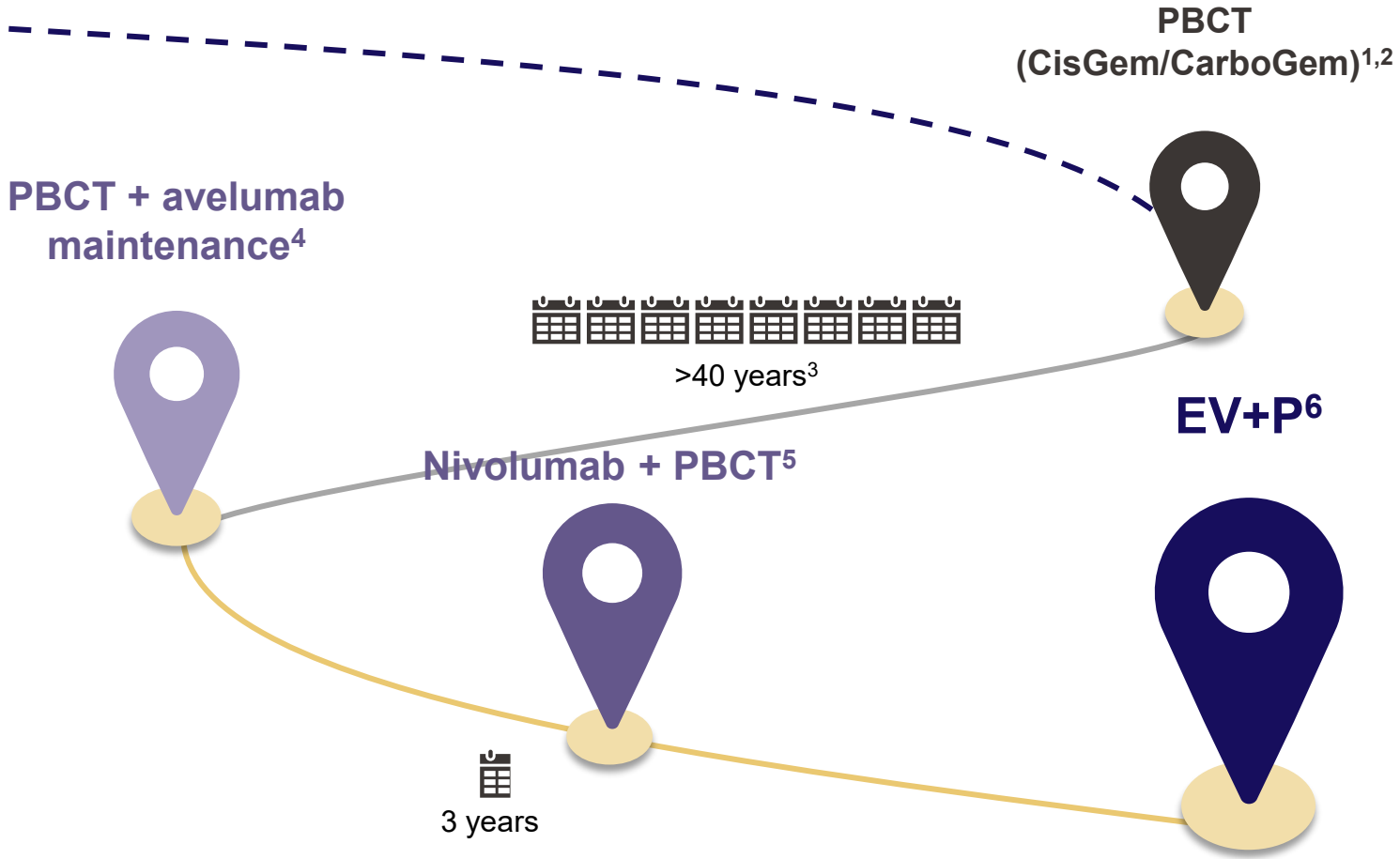
Speaker disclosures

- Nothing to declare

The approval of EV+P transformed the 1L treatment landscape for advanced UC, becoming the new SOC

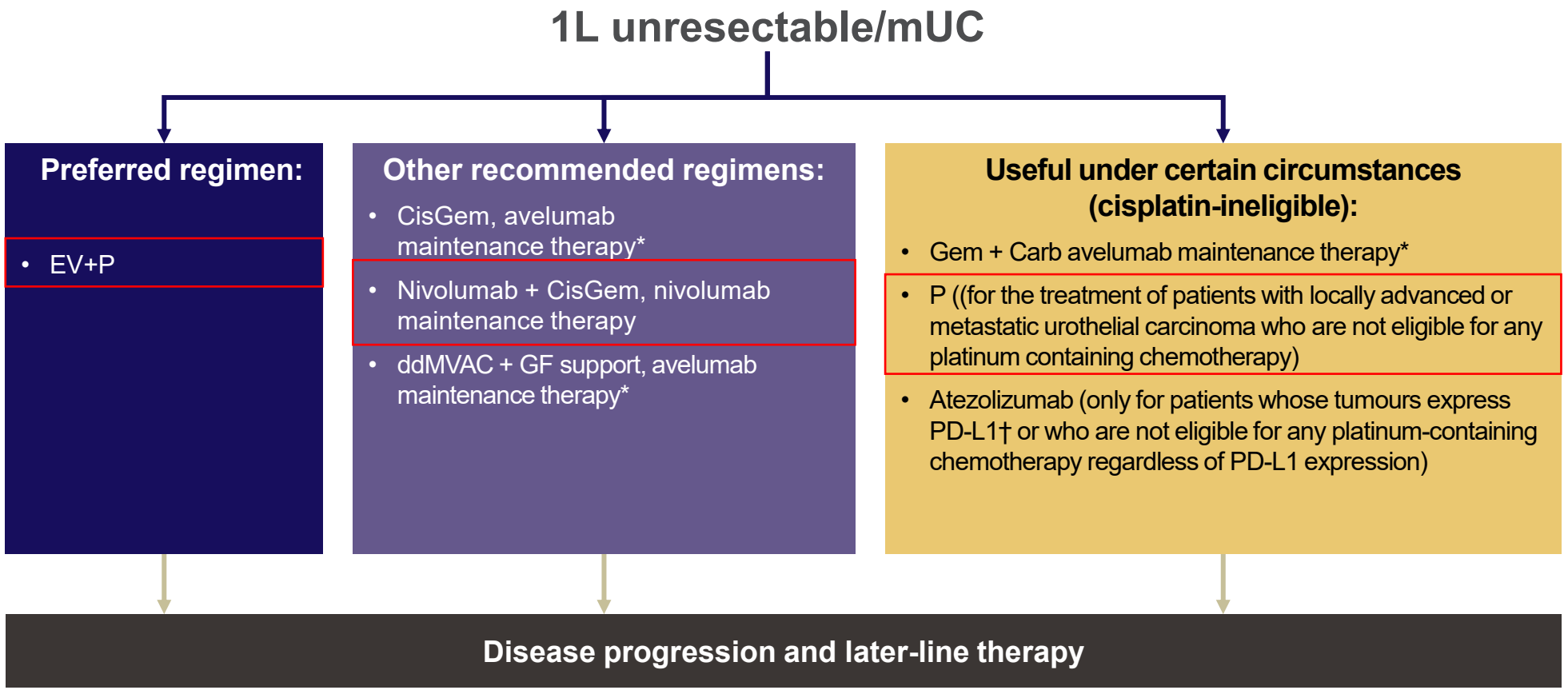
Evolution of the SOC for 1L treatment of advanced UC:



1L, first-line; Carbo, carboplatin; Cis, cisplatin; EV, enfortumab vedotin; P, pembrolizumab; PBCT, platinum-based chemotherapy; SOC, standard of care; UC, urothelial carcinoma.

1. von der Maase H et al. *J Clin Oncol* 2000;18:3068–3077; 2. De Santis M et al. *J Clin Oncol* 2012;30:191–199; 3. Giridhar KV et al. *Mayo Clin Proc* 2017;92:1564–15823; 4. Pfizer. Press release. January 2021. Available at: pfizer.com/news/press-release/press-release-detail/european-commission-approves-bavencior-avelumab-first-line. Last accessed: June 2025; 5. Bristol Myers Squibb. Press release. March 2024. Available at: news.bms.com/news/details/2024/U.S.-Food-and-Drug-Administration-Approves-Opdivo--nivolumab-in-Combination-with-Cisplatin-and-Gemcitabine-for-First-Line-Treatment-of-Adult-Patients-with-Unresectable-or-Metastatic-Urothelial-Carcinoma/default.aspx. Last accessed: June 2025; 6. EMA. Summary of opinion. July 2024. Available at: ema.europa.eu/en/documents/smop/chmp-post-authorisation-summary-positive-opinion-padcev-ii-13_en.pdf. Last accessed: June 2025.

NCCN Guidelines include EV+P for the 1L treatment of unresectable/mUC regardless of cisplatin eligibility

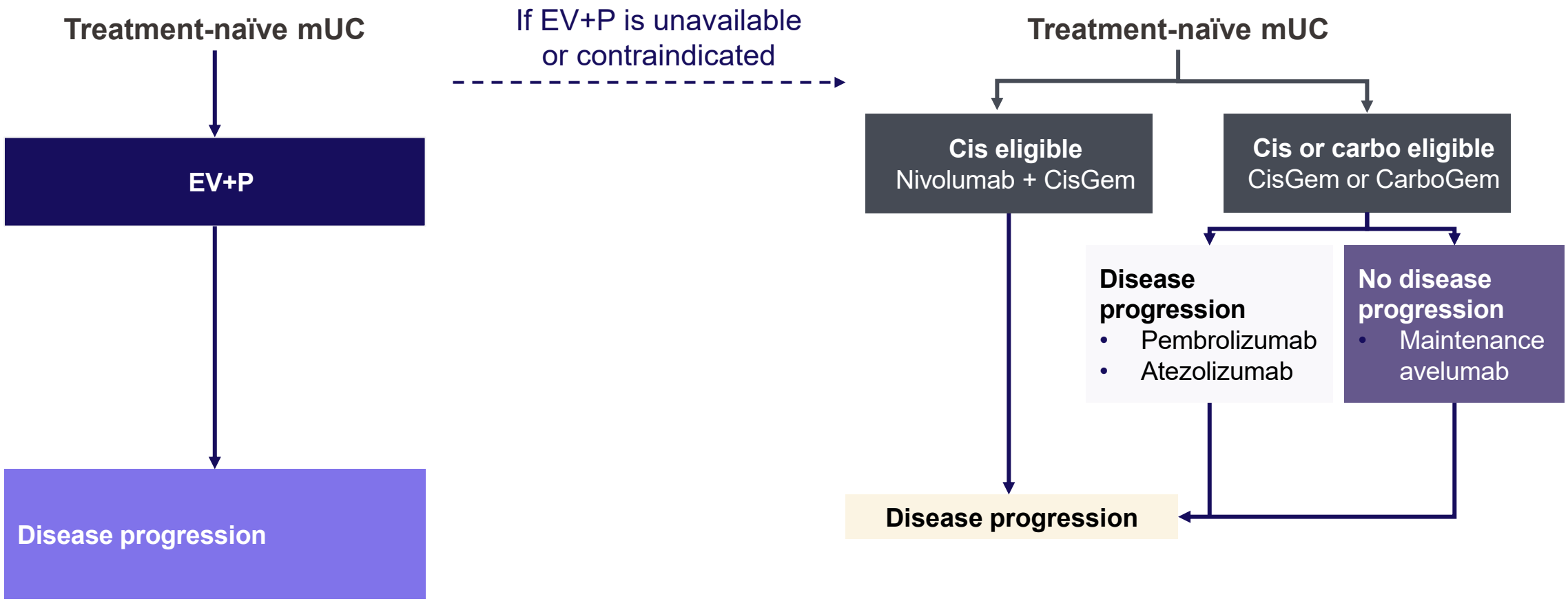


Disclaimer: EV+P is not approved for the 1L treatment of unresectable or metastatic UC in adults in some countries/regions. All HCPs should refer to their own country's specific Prescribing Information.

*Maintenance therapy with avelumab only if there is no progression on first-line platinum-containing chemotherapy; †Atezolizumab: SP142 assay, PD-L1–stained tumor-infiltrating immune cells covering ≥5% of the tumor area.

1L, first line; Carbo, carboplatin; Cis, cisplatin; DDMVAC, dose-dense methotrexate, vinblastine, doxorubicin, and cisplatin; EV, enfortumab vedotin-ejfv; Gem, gemcitabine; GF, growth factor; HCP, healthcare professional; LA/mUC, locally advanced/metastatic urothelial carcinoma; NCCN, National Comprehensive Cancer Network; P, pembrolizumab; PD-L1, programmed cell death ligand 1.

ESMO clinical guidelines recommend EV+P for the 1L treatment of unresectable/mUC



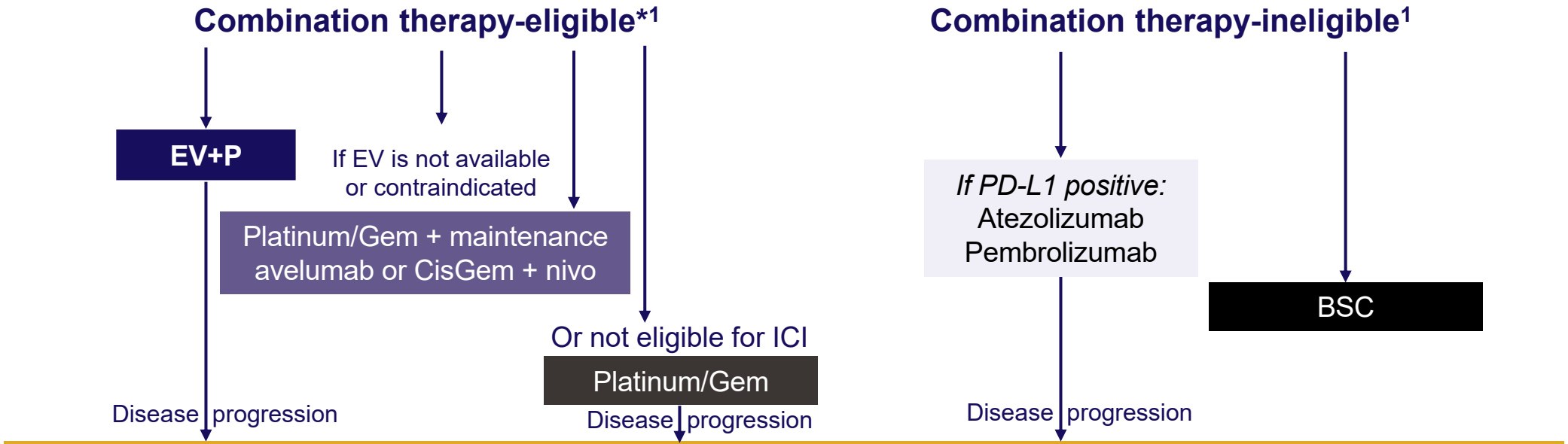
Disclaimer: The ESMO Clinical Practice Guideline aligns with the EU regulatory approval for pembrolizumab 'for the 1L treatment of unresectable or metastatic UC in adults. EV+P is not approved for the 1L treatment of unresectable or metastatic UC in adults in some countries/regions. All HCPs should refer to their own country's specific Prescribing Information.

Figure adapted from Powles T et al. 2024.

1L, first line; Carbo; carboplatin; Cis, cisplatin; ESMO, European Society for Medical Oncology; EV, enfortumab vedotin; Gem, gemcitabine; HCP, healthcare professional; m, metastatic; P, pembrolizumab; UC, urothelial carcinoma.

Powles T et al. *Ann Oncol* 2024;35:485–490.

EAU clinical guidelines recommend EV+P for the 1L treatment of unresectable/mUC



Later-line therapy options[1]

Pretreated with EV and ICI
- PBCT
- Erdafitinib if FGFR positive
- Sacituzumab govitecan
- Single agent chemotherapy
- Trials

Pretreated with platinum +/- ICI
- EV
- Erdafitinib if FGFR positive
- ICI
- Platinum/Gem
- Sacituzumab govitecan
- Single agent chemotherapy
- Trials

Pretreated with single agent
- EV†
- Erdafitinib if FGFR positive
- ICI
- Sacituzumab govitecan
- Chemotherapy
- Trials

Figure adapted from 2024 EAU Muscle-invasive and metastatic bladder cancer Guidelines.
*PS 0-2, GFR > 30 mL/min, adequate rogan functions, for cisplatin: GFR > 50 mL/min; †The indication for enfortumab vedotin monotherapy as per the SmPC requires patients to have previously received a platinum-containing chemotherapy and a PD-1/-L1 inhibitor.[2]
1L, first line; Carbo; carboplatin; Cis, cisplatin; EAU, European Association of Urology; EV, enfortumab vedotin; ICI, immune checkpoint inhibitor; Gem, gemcitabine; m, metastatic; BSC, best supportive care; P, pembrolizumab; PBCT, platinum-based chemotherapy; PD-L1, programmed death-ligand 1; UC, urothelial carcinoma.
1. EAU. Muscle-invasive and metastatic bladder cancer. Available at: https://www.uroweb.org/guidelines/muscle-invasive-and-metastatic-bladder-cancer. Last accessed: March 2025; 2. EMA. Padcev. Summary of Product Characteristics. Available at: ema.europa.eu/en/documents/product-information/padcev-epar-product-information_en.pdf. Last accessed: June 2025.

Reflections on guideline updates in 1L unresectable UC or mUC

Initial treatment decisions shift: cisplatin eligible → combination eligible

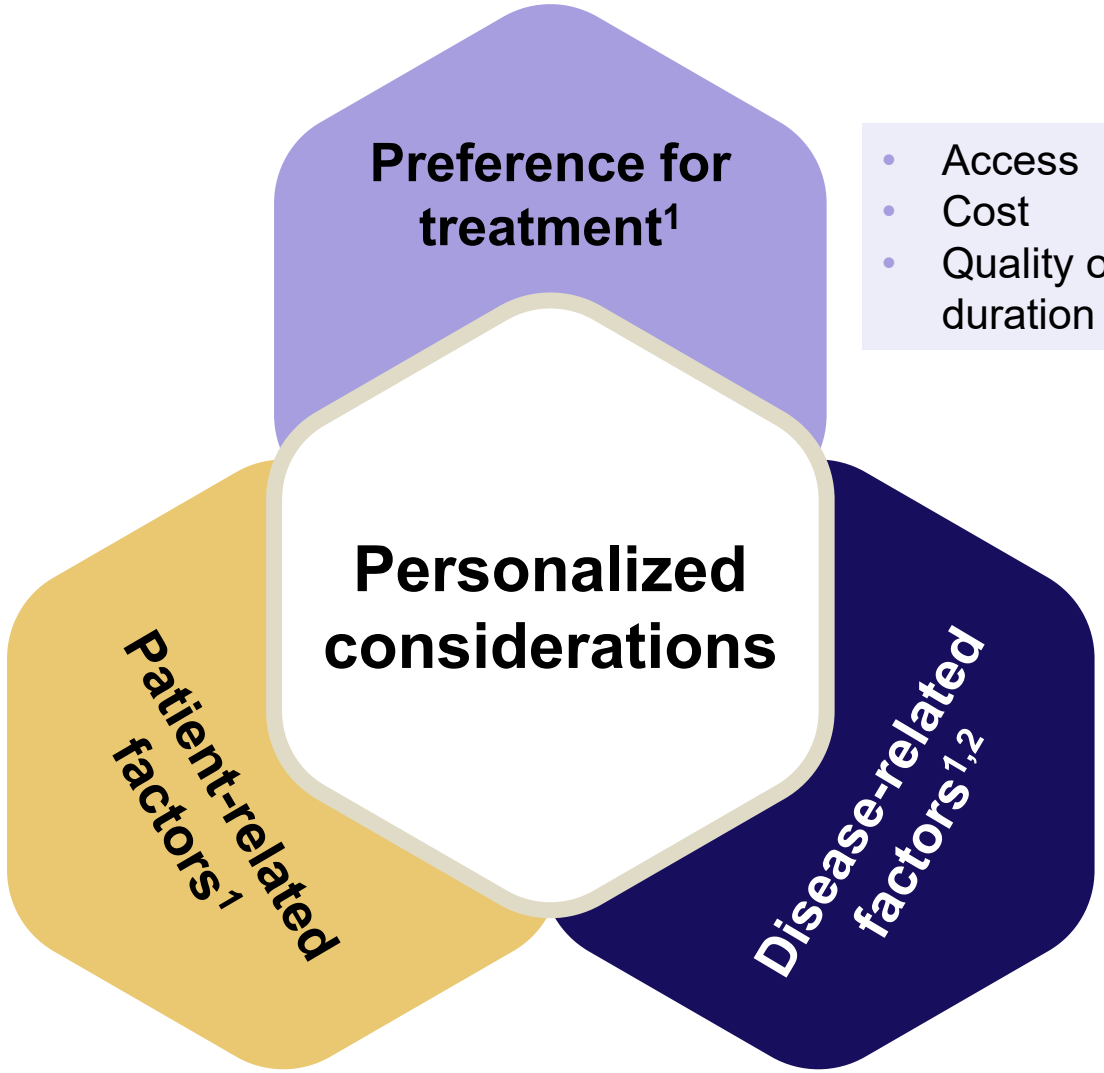
Broader range of eligible patients supported by consistent efficacy across subgroups

EV+P is now the standard of care for the 1L treatment of unresectable UC/mUC

How has this affected clinical practice?

1L, first line; EV, enfortumab vedotin; mUC, metastatic urothelial carcinoma; P, pembrolizumab; UC, urothelial carcinoma.
Speaker's expert opinion.

Personalized considerations for choosing treatment option: The need for shared decision-making



- Access
- Cost
- Quality of life: toxicity profile, duration of treatment, etc.

- Age
- ECOG PS
- Co-morbidities
  - Uncontrolled DM
  - HF
  - Peripheral neuropathy
  - Corneal/retinal abnormality
  - Hearing loss, etc.
- Kidney function (CrCl)
- Social economic status
- Polypharmacy

- Disease burden
  - LN-only metastases, lung, liver, brain, etc.
- Histology
- Primary site: UTUC vs. bladder
- Prior treatment

CrCl, creatinine clearance; DM, diabetes mellitus; ECOG PS, Eastern Cooperative Oncology Group performance status; HF, heart failure; LN, lymph node; UTUC, upper urinary tract urothelial cancer.

1. Tariman J et al. *Oncol Nurs Forum* 2012;39:E70–E83; 2. Speaker's expert opinion.

[CASE II 70/M]

- **Age: 70** years
- **ECOG PS: 2**
- **GFR: 46.2** mL/min
- **BMI: 24.55** kg/m^2
- **HbA1c: 6.4%**

Co-morbidities: HTN, DL, T2DM

Concomitant medications: Amlodipine, valsartan, rosuvastatin, MFM

Any other relevant medical history: None

Family history of cancer: None

- **No previous treatment history**

BMI, body mass index; DL, dyslipidemia; ECOG PS, Eastern Cooperative Oncology Group performance status; GFR, glomerular filtration rate; HbA1c, glycated hemoglobin; HTN, hypertension; T2DM, type 2 diabetes mellitus.

Treatment decision and initiation

[2024/11] → [2024/12]

Consider TURB + NUx
→ **Admission**

2MA

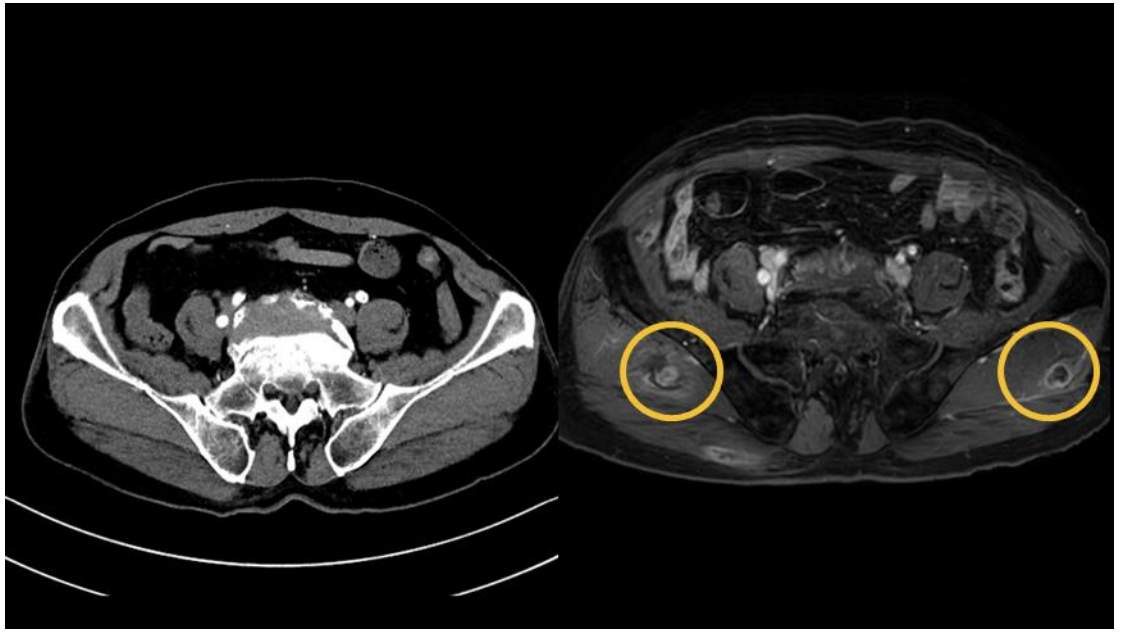
Back/thigh pain

Further work-up

Chest/abdomen CT: No evidence of metastasis

Bone scan: No evidence of metastasis

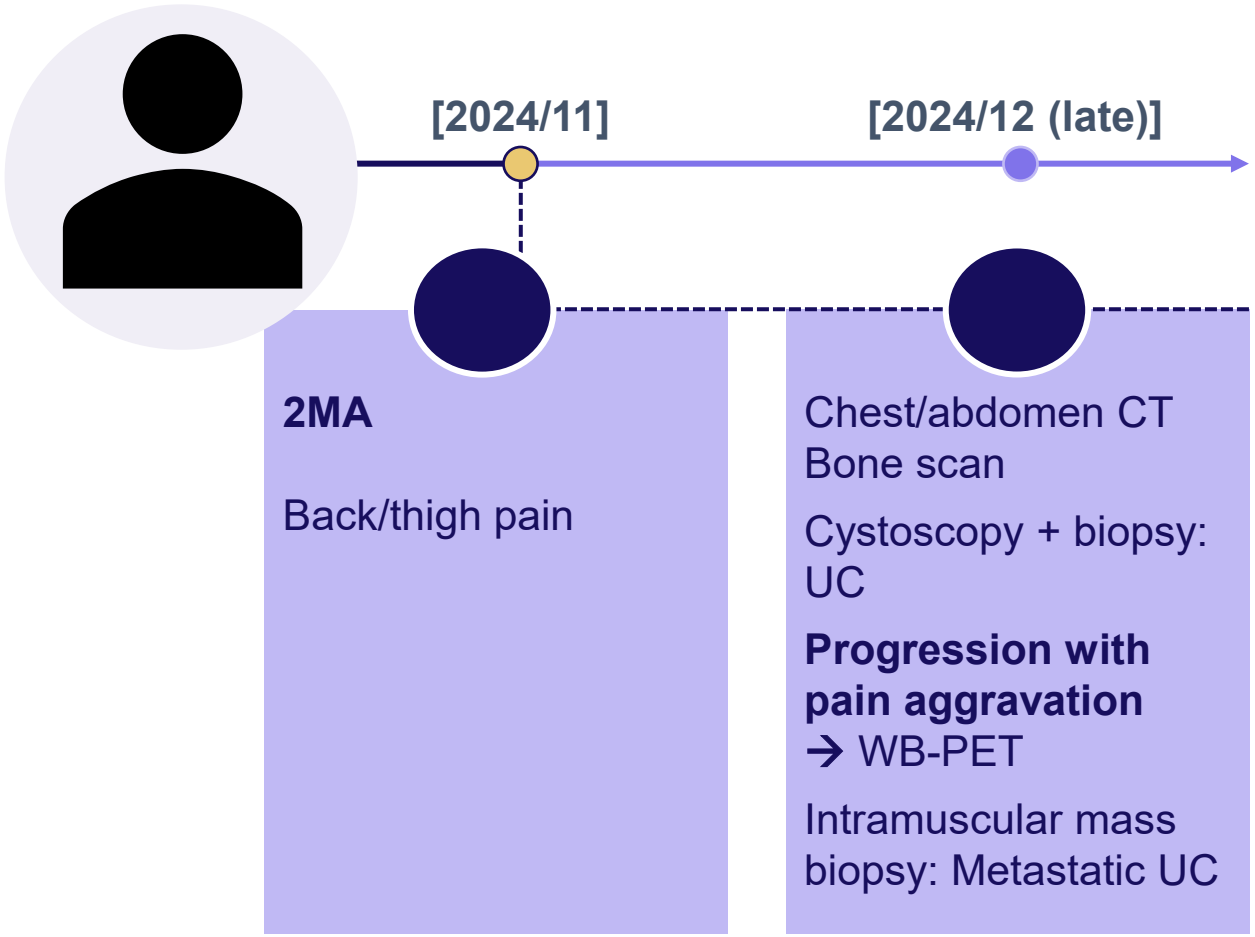
Cystoscopy + biopsy

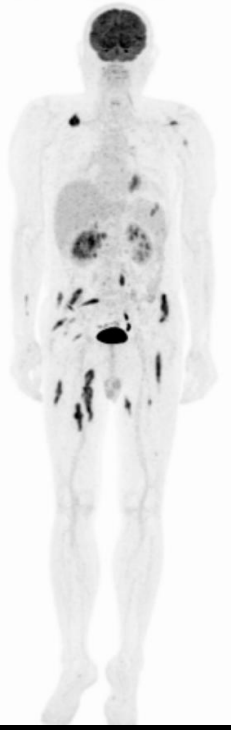


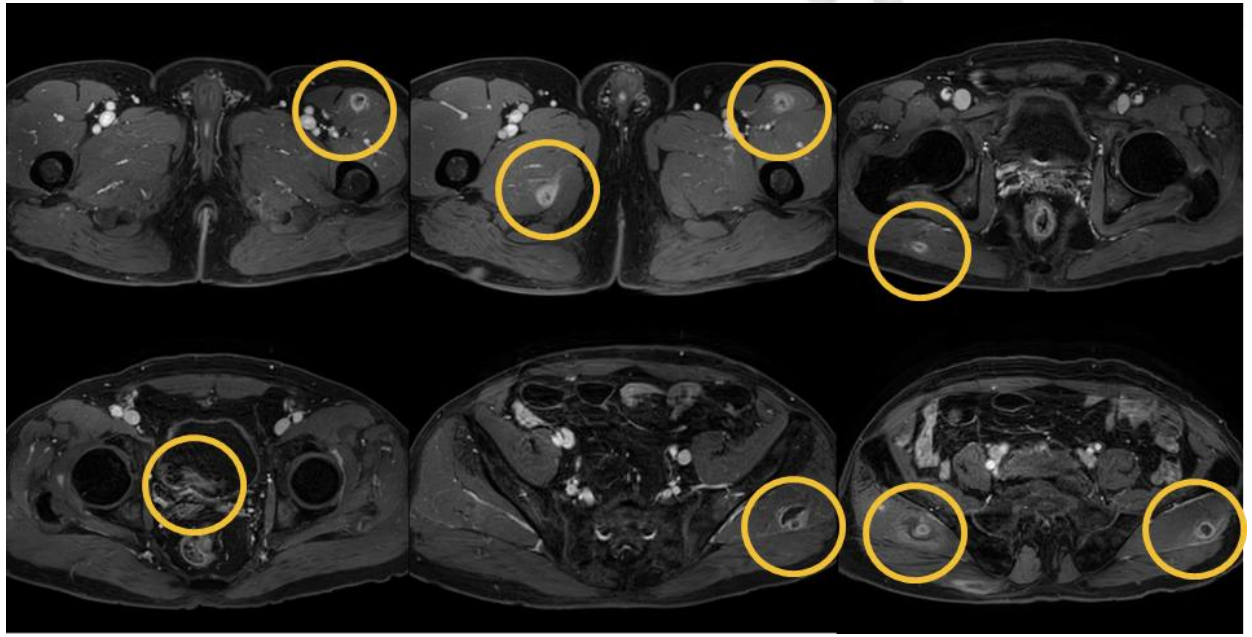
2024/12 (mid) **2024/12 (late)**
MRI follow-up at admission

Images courtesy of Prof. EunHee Jung, with permission of the patient.
CT, computed tomography; MRI, magnetic resonance imaging; NUx, nephroureterectomy; TURB, transurethral resection of a bladder tumor.

Treatment decision and initiation

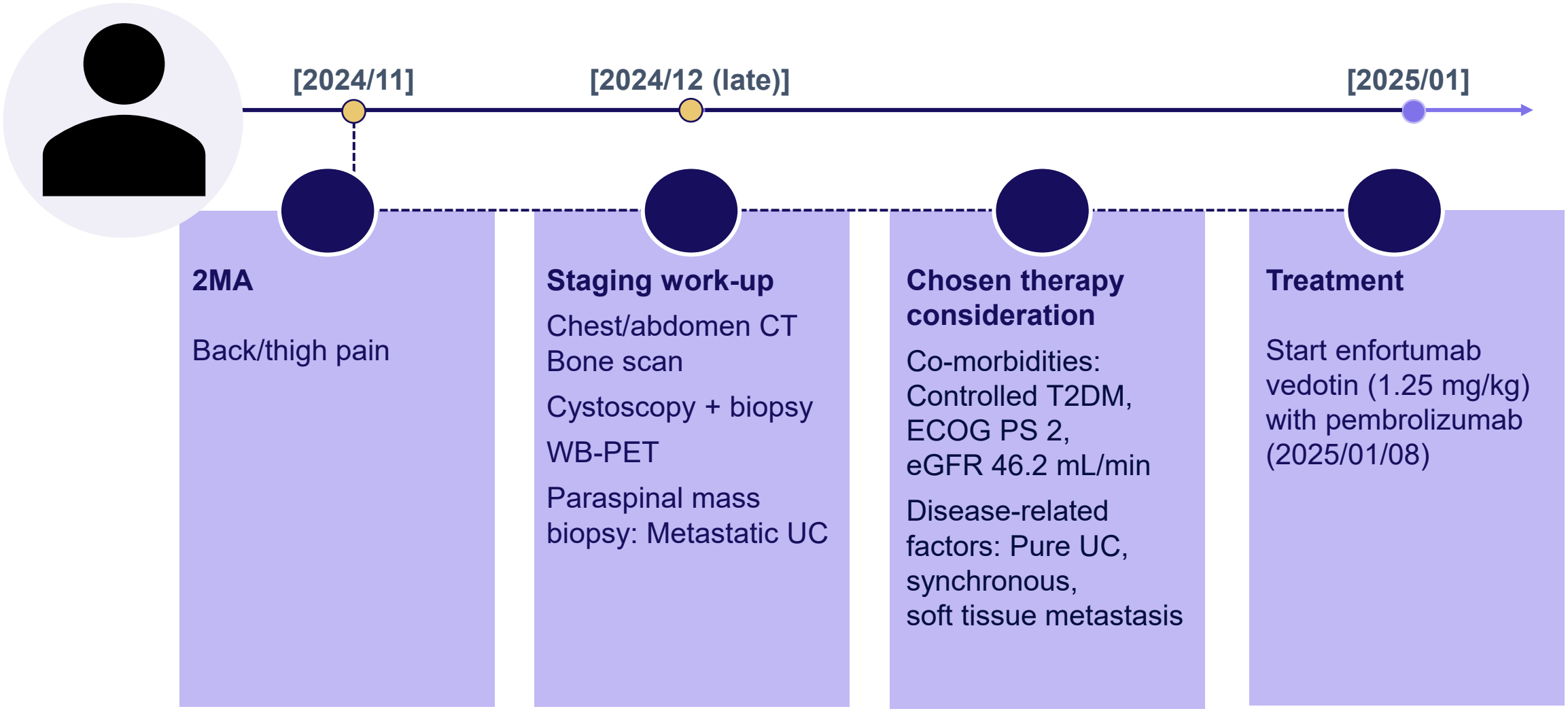






Images courtesy of Prof. EunHee Jung, with permission of the patient.
CT, computed tomography; UC, urothelial carcinoma; WB-PET, whole-body positron emission tomography.

Treatment decision and initiation



CT, computed tomography; ECOG PS, Eastern Cooperative Oncology Group performance status; eGFR, estimated glomerular filtration rate; T2DM, type 2 diabetes mellitus; UC, urothelial carcinoma; WB-PET, whole-body positron emission tomography.

AE presentation and management

EV+P

[25/01/08]

C1D1 — **C1D14** — **C2D1** — **C3D8** — **C5D1**

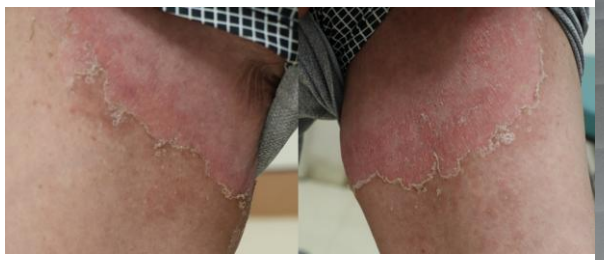
G2 (both inguinal/lower leg)
Topical steroid + PO steroid
Antihistamine

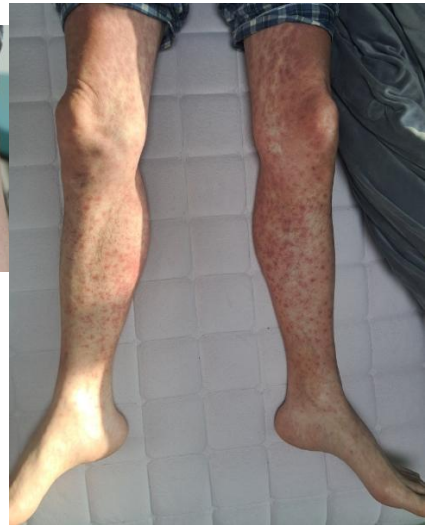
G1
Topical steroid
Antihistamine

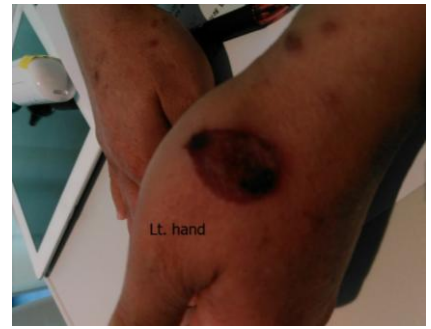
Wax and wane

G1
Topical steroid (prn)

Maculopapular rash and pruritus



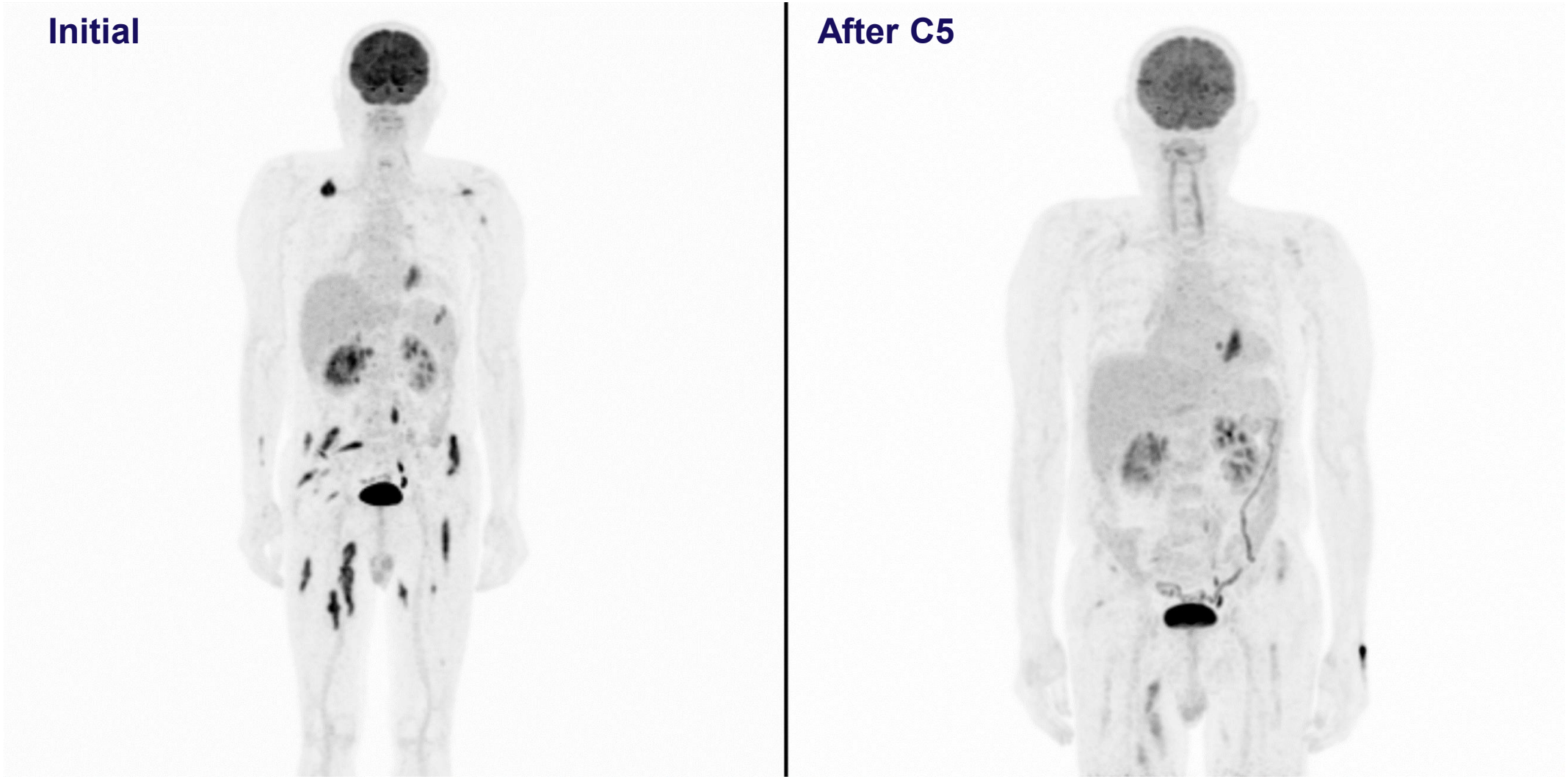




Images courtesy of Prof. EunHee Jung, with permission of the patient

AE, adverse event; C, cycle; D, day; EV, enfortumab vedotin; G, grade; P, pembrolizumab; PO, by mouth; prn, as needed.

Patient response to treatment



Images courtesy of Prof. EunHee Jung, with permission of the patient.
C, cycle.

[CASE 2 54/M]

- **Age: 54** years
- **ECOG PS: 2** d/t pain
- **GFR: 108.8** mL/min
- **BMI: 25.23** kg/m^2
- **HbA1c: 6.0%**

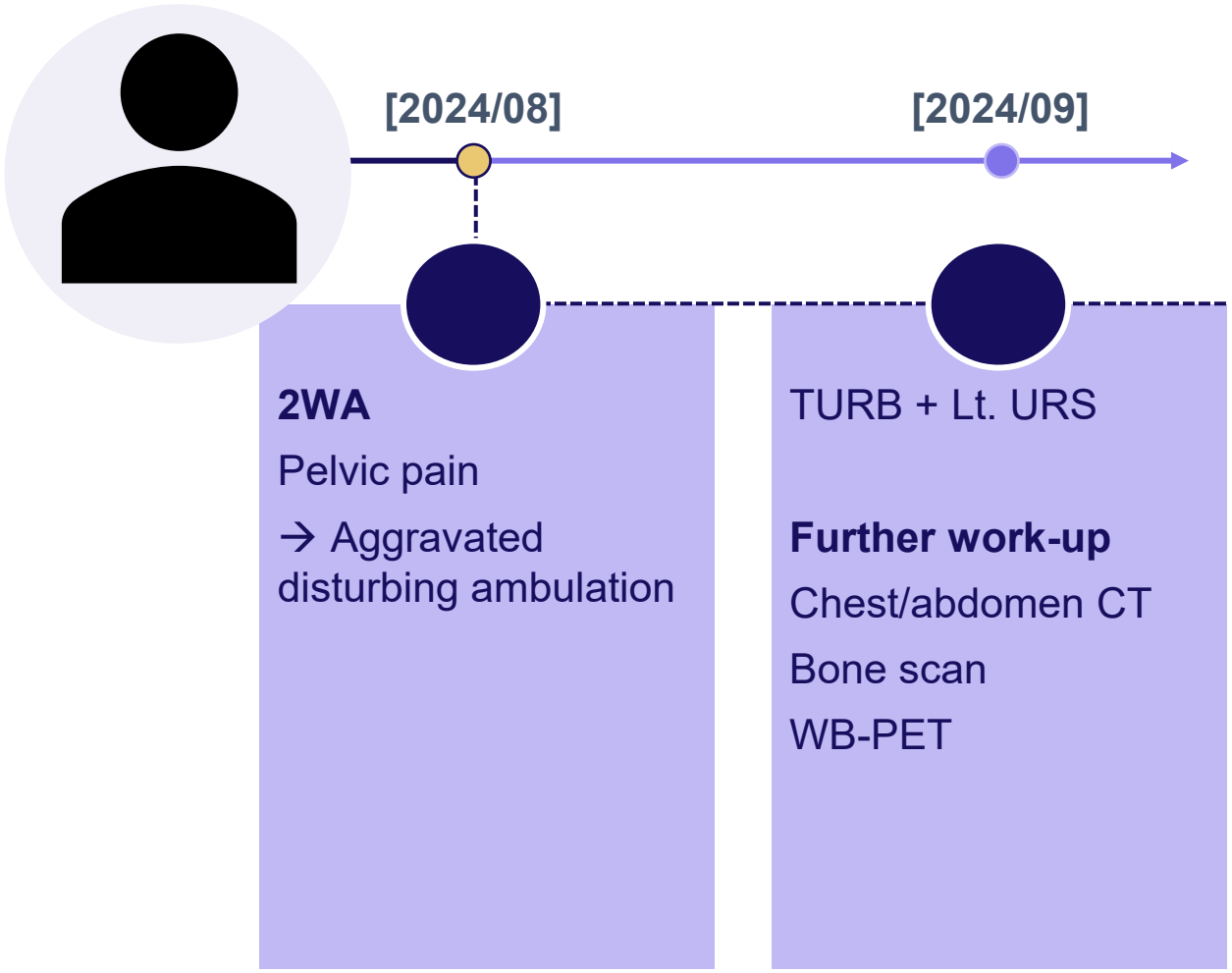
Co-morbidities: None
Concomitant medications: None
Any other relevant medical history: None
Family history of cancer: Prostate cancer (father)

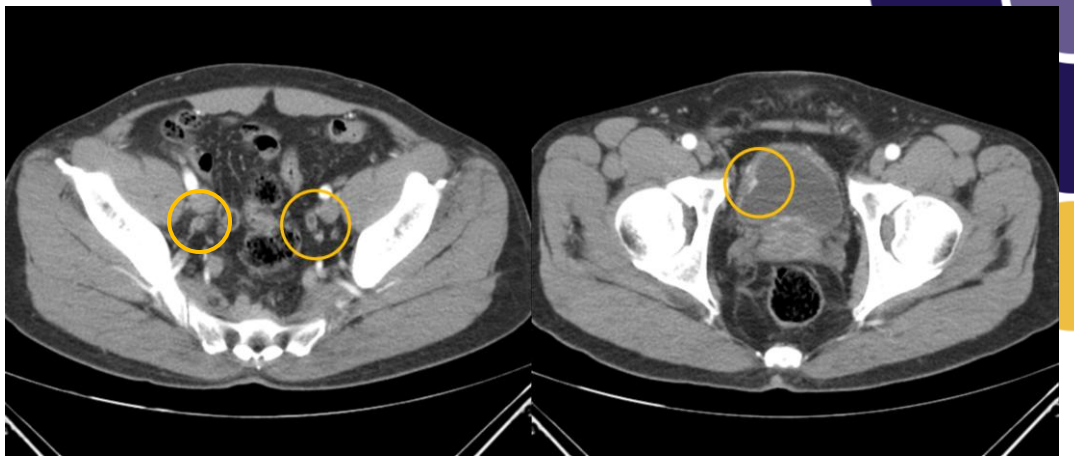
- **Previous treatment history:**

s/p cold cup bx + TURB (19/03/13); CIS
s/p intravesical BCG #1-1~6 (19/03/25–19/04/29)
s/p TURB (19/11/11); TCC, CIS
s/p intravesical gemcitabine #1-1~6 (19/11/19–19/12/24)
s/p intravesical gemcitabine 3mon #1-1~3 (20/03/24–20/04/07)
s/p intravesical gemcitabine 6mon #1-1~3 (20/10/06–20/10/20)
s/p intravesical gemcitabine 12mon #1-1~3 (21/04/20–21/05/04)
s/p TURB (23/04/20); papillary TCC, T1G3, high grade
s/p TURB (23/09/25); pTCC, T1G3, high, glandular +
s/p TUC (23/09/25)
s/p intravesical BCG #2-1~6 (23/11/03–23/12/08)

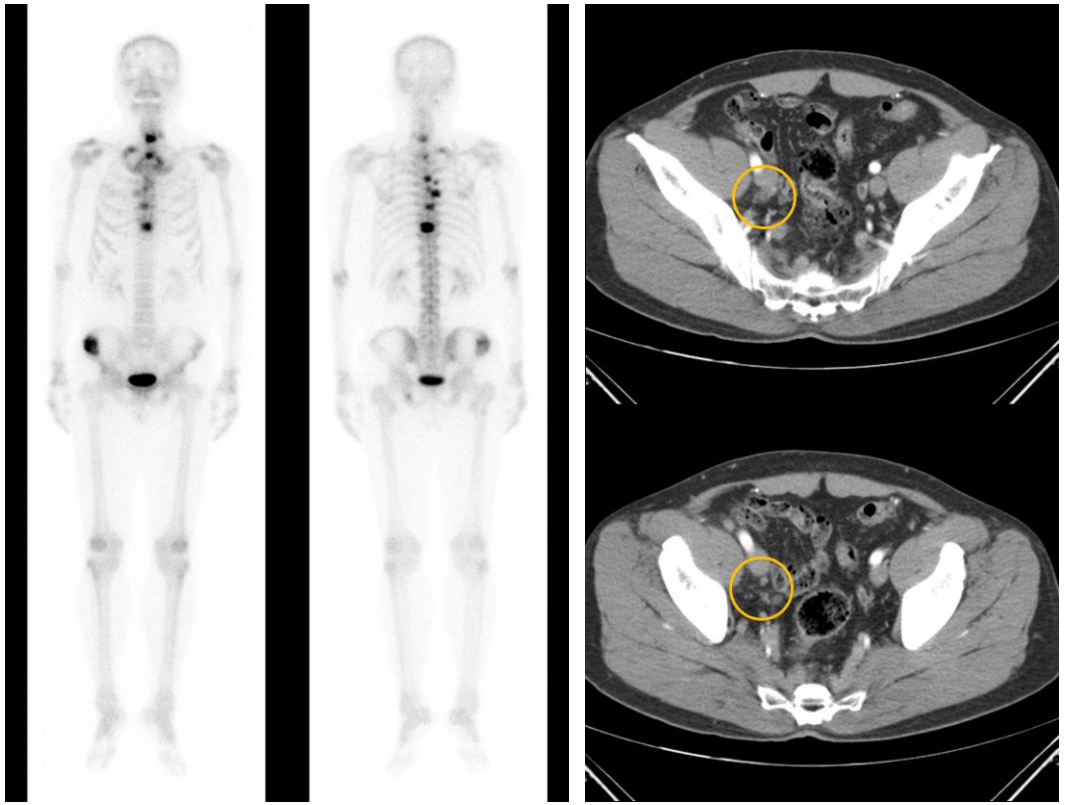
BCG, Bacillus Calmette-Guérin; BMI, body mass index; bx, biopsy; CIS, carcinoma in situ; ECOG PS, Eastern Cooperative Oncology Group performance status; GFR, glomerular filtration rate; HbA1c, glycated hemoglobin; pTCC, papillary transitional cell carcinoma; s/p, status post; T1G3, stage 1 grade 3; TCC, transitional cell carcinoma; TURB, transurethral resection of a bladder tumor.

Treatment decision and initiation





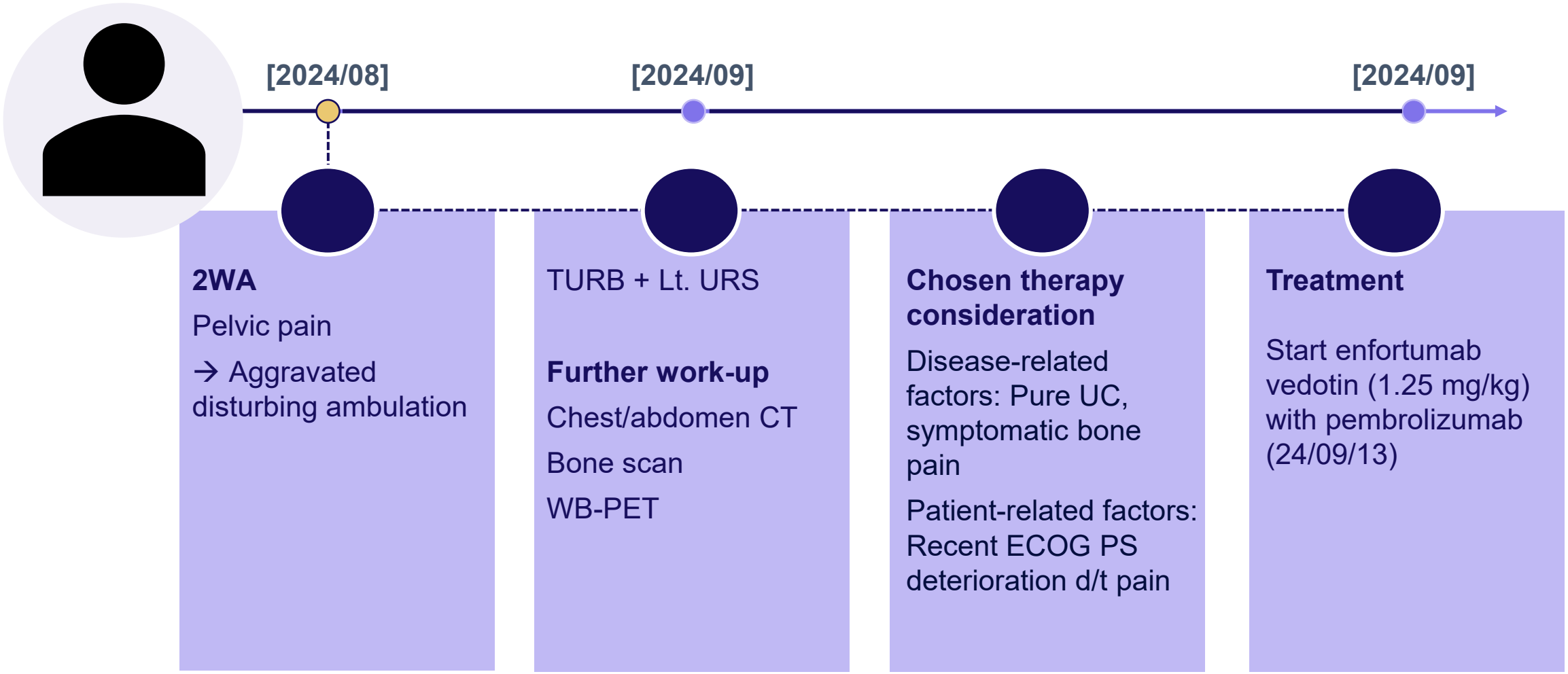
TCC, T2G3, high grade



Images courtesy of Prof. EunHee Jung, with permission of the patient.

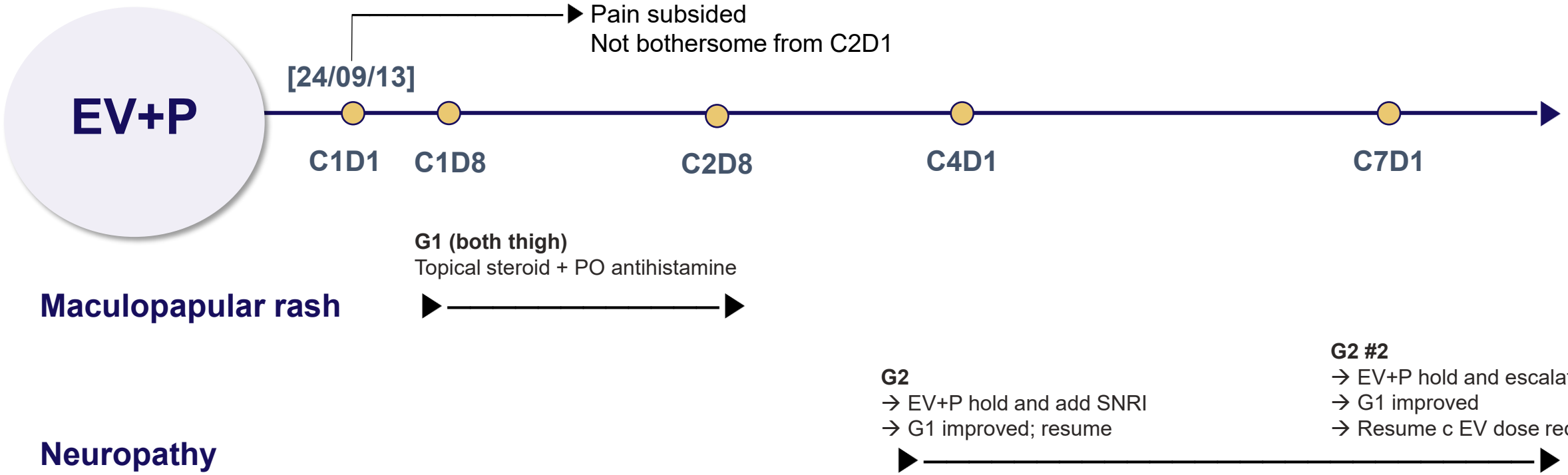
CT, computed tomography; Lt., left; T2G3, stage 2 grade 3; TCC, transitional cell carcinoma; TURB, transurethral resection of a bladder tumor; URS, ureteroscopy; WB-PET, whole-body positron emission tomography.

Treatment decision and initiation



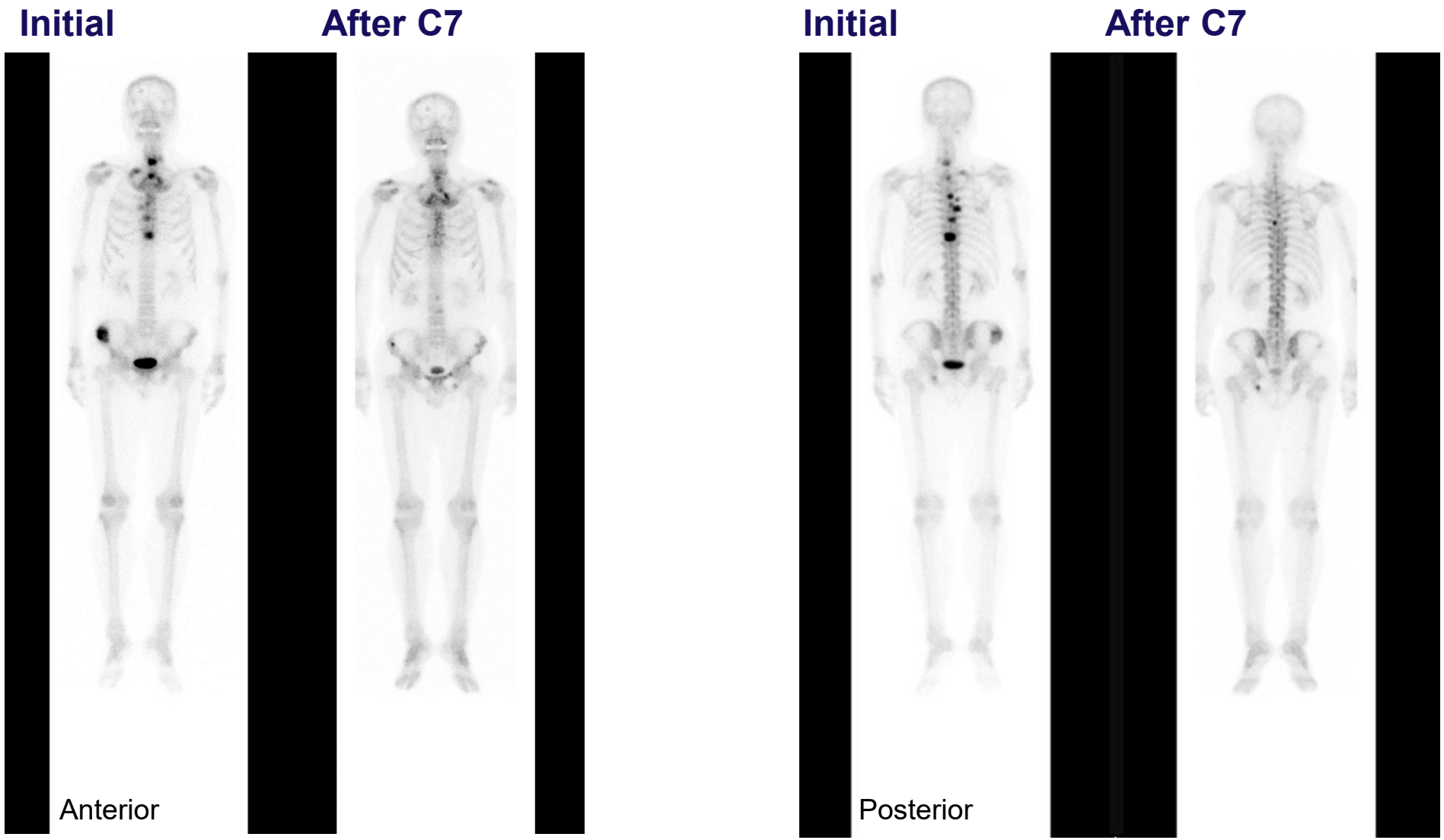
CT, computed tomography; ECOG PS, Eastern Cooperative Oncology Group performance status; Lt., left; T2G3, stage 2 grade 3; TURB, transurethral resection of a bladder tumor; UC, urothelial carcinoma; URS, ureteroscopy; WB-PET, whole-body positron emission tomography.

AE presentation and management



AE, adverse event; C, cycle; D, day; EV, enfortumab vedotin; G, grade; P, pembrolizumab; PO, by mouth; SNRI, serotonin-norepinephrine reuptake inhibitor.

Patient response to treatment



Images courtesy of Prof. EunHee Jung, with permission of the patient.
C, cycle.

Available for multi-agent combination

1

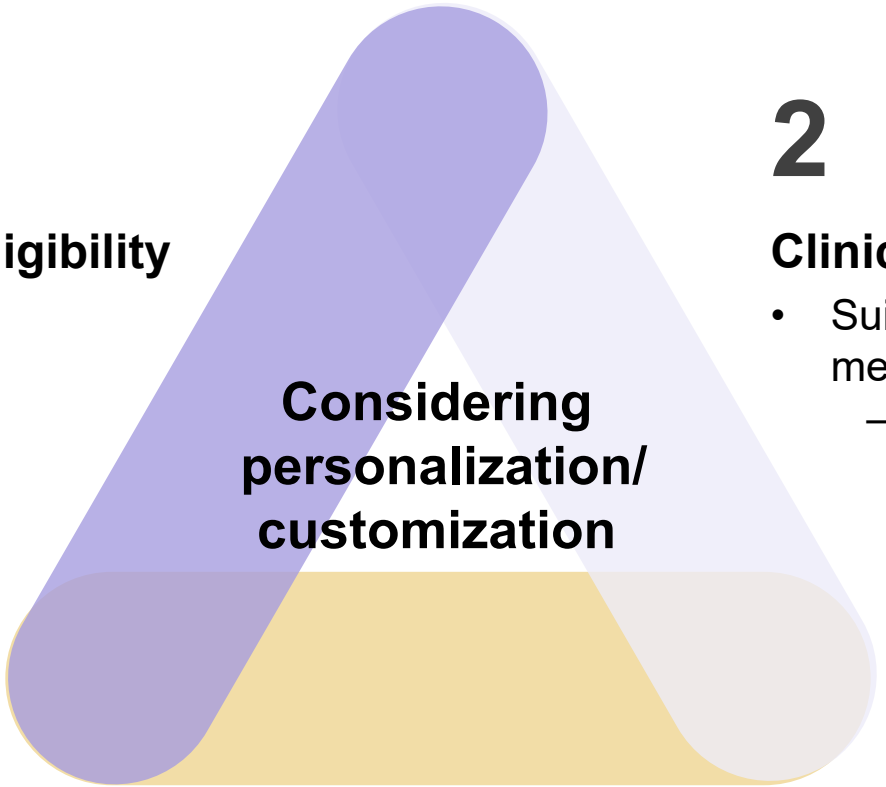
Broader eligibility

- Beyond cisplatin-eligible patients
  - Applicable regardless of platinum eligibility

2

Clinical versatility

- Suitable for patients with visceral metastases
  - Provides meaningful responses



3

A new default option

- Endorsed across guidelines as a preferred regimen

Speaker's expert opinion.

Summary

EV+P: Transition to a new standard of care and its associated challenges[1]

- Broader eligibility, clinical versatility
- Unique safety profile, importance of clinical judgement

Effective communication between patients, HCPs, and specialists should play an active role in the management of AEs to ensure timely identification and effective care,[2] allowing patients to continue to maximise the clinical benefits of EV+P

EV+P is the standard of care for the 1L treatment of patients with unresectable UC/mUC1

1L, first line; EV, enfortumab vedotin; mUC, metastatic urothelial carcinoma; P, pembrolizumab; UC, urothelial carcinoma.

1. Speaker's expert opinion; 2. Brower B et al. *Front Oncol* 2024;14:1326715.

Genitourinary Masterclass

astellas

Please refer to the Korean PI for PADCEV® (enfortumab vedotin) via the following link or QR Code:

<PADCEV 20mg>

<PADCEV 30mg>

Astellas Pharma Korea., Inc.
(7F Parnas tower, 521, Teheran-ro, Gangnam-gu, Seoul, Republic of Korea)

PI, Prescribing Information