INTERNATIONAL BLADDER CANCER GROUP

IBCG

International Bladder Cancer Group

Newsletter



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INTERNATIONAL BLADDER CANCER GROUP

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IBCG Global Guidelines Initiative

MEXICAN BLADDER CANCER GUIDELINES



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As part of the IBCG's ongoing Global Guidelines Initiative—launched to support countries in developing evidence-based, resource-adapted national guidelines for bladder cancer— Mexico became the latest nation to collaborate under the IBCG framework. Following the success of the Chilean Guidelines led by Dr. Mario Fernández, the IBCG invited Mexican leaders to undertake a similar effort, extending the organization's mission to unify global standards while respecting local realities.

Under the joint leadership of **Dr. Ashish Kamat**, President of the **International Bladder Cancer Group (IBCG)**, and **Dr. Arturo Mendoza-Valdés**, member of the IBCG and Scientific Committee Chairman of the **Mexican Urologic Oncology Association (AMUO)**, and its former and current Presidents, Dr. Juan Carlos Huerta and Dr. Héctor Sanchez, respectively, a landmark initiative was launched to develop the Mexican Bladder Cancer Guidelines.

Following almost two years of dedicated work, the IBCG, together with the **AMUO**, the **Mexican Urologic Association (SMU)**, and the **Colegio Mexicano de Urología (CMUN)**, convened on **October 3–4, 2024** in Mexico City to create the first national, evidence-based guidelines for the diagnosis and management of bladder cancer in Mexico.

While numerous international guidelines exist—such as those of the AUA, EAU, NCCN, and IBCG—most are broadly concordant, differing mainly in nuance. The goal of this project was **not to reinvent new guidelines**, but rather to **integrate the best elements of existing ones**, updated with the latest evidence, into a **clear, practical, and resource-sensitive framework** reflecting Mexico's healthcare systems.

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MEXICAN BLADDER CANCER GUIDELINES

To ensure genuine national representation and broad consensus, the Presidents of the major Mexican urologic associations and leading urologists dedicated to bladder cancer were invited to participate, along with the heads of the most important academic and government institutions, including **ISSSTE (Hospital 20 de Noviembre, Hospital de Iztapaluca), IMSS (Centro Médico Nacional Siglo XXI, La Raza)**, the **Central Military Hospital**, and hospitals under the **Health Ministry**, such as **Hospital General de México, Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, Hospital Gea González**, and the **National Cancer Institute**, as well as leading centers in **Guadalajara, Monterrey**, and **Mérida**. These institutions also represent the country's major urology residency training programs.

In total, around **40 specialists** from across Mexico participated—predominantly urologists, joined by medical oncologists and radiation oncologists. From the IBCG, participants included **Drs. Ashish Kamat, Roger Buckley, Roger Li, Mario Fernández, and Andrea Apolo.**

The meeting opened with welcoming remarks from **Dr. Kamat** and Dr. **Mendoza-Valdés**, who outlined the rationale, objectives, and methodology for developing the guidelines. **Dr. Kamat** emphasized the spirit of collaboration, inclusiveness, and patient-centeredness that defines IBCG's global mission.

The scientific sessions covered the full spectrum of bladder cancer:

- **Dr. Roger Buckley** presented on NMIBC screening and diagnosis, including epidemiology, etiology, staging systems, CIS and variant histology, and biomarkers for early detection as presented at IBCG25.
- **Dr. Roger Li** addressed NMIBC risk stratification, treatment strategies, and recurrence after BCG, including practical recommendations for Mexico such as the adoption of enhanced imaging technologies for cystoscopy where feasible.
- **Dr. Mario Fernández** discussed MIBC management, focusing on neoadjuvant therapy, bladder preservation, and partial cystectomy.
- **Dr. Andrea Apolo** concluded the meeting with a comprehensive update on systemic therapies for metastatic urothelial carcinoma, including newly available and forthcoming options in Mexico.

Each presentation was followed by vigorous discussion and debate, with participants actively engaged in refining statements and recommendations. On the final day, all topics underwent structured review and voting in the **IBCG's modified Delphi consensus format**, similar to IBCG's annual international retreats.

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MEXICAN BLADDER CANCER GUIDELINES

The meeting was highly successful, achieving its academic and collaborative goals in a collegial, respectful, and energetic environment. On Friday evening, participants gathered for a traditional Mexican dinner that reinforced the camaraderie and unity of purpose shared by all.

The finalized Mexican Bladder Cancer Guidelines will be formally presented to the national urology community at upcoming major meetings, including the SMU Annual Meeting (November 2025), ANUER (January 2026), CMUN (June 2026), and AMUO (July 2026). They will be disseminated widely to ensure that urologists across the country have access to up-to-date, evidence-based recommendations, enabling the best possible care for patients with bladder cancer in Mexico.

The finalized **Mexican Bladder Cancer Guidelines** will be formally presented to the national urology community at upcoming major meetings, including the **SMU Annual Meeting (November 2025), ANUER (January 2026), CMUN (June 2026)**, and **AMUO (July 2026)**. They will be disseminated widely to ensure that urologists across the country have access to up-to-date, evidence-based recommendations, enabling the best possible care for patients with bladder cancer in Mexico.

In conclusion, this **IBCG initiative**, which this year focused on Mexico, was an outstanding success thanks to the dedication and enthusiasm of every participant —from both the Mexican and IBCG teams. The meeting demonstrated that Mexican specialists from diverse associations and institutions can unite under a shared vision to advance patient care, echoing IBCG's broader mission of global collaboration and scientific excellence in bladder cancer.

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Proceedings of the IBCG Bladder Cancer Symposium Centenary Congress of the Chilean Society of Urology, 2025



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Introduction

In October, the International Bladder Cancer Group (IBCG) Symposium was held in Santiago within the framework of the Centenary Annual Course of the Chilean Society of Urology. With an attendance of more than 250 participants, numerous experts presented and discussed relevant aspects of bladder cancer (BC) management. The IBCG faculty included:

- Ashish Kamat MD, Urologist, Endowed Professor, Wayne B. Duddlesten Professorship in Cancer Research, The University of Texas MD Anderson Cancer Center, Houston, USA; President of the IBCG

- Gustavo Villoldo MD, Urologist, Deputy Head of the Urologic Surgery Department, Alexander Fleming Institute (IAF), Buenos Aires, Argentina

- Sima Porten MD, Urologist, Chief of Urologic Oncology, University of California San Francisco (UCSF), USA

- Mario I. Fernández MD, Urologist, Faculty of Medicine, Clínica Alemana Universidad del Desarrollo, Santiago, Chile

How Should My Transurethral Resection of the Bladder (TURBT) Be Performed?

Dr. Villoldo reviewed the historical evolution of this procedure and emphasized how complete resection with adequate specimen quality impacts risk stratification and treatment success, highlighting the importance of experienced genitourinary pathologists. He subsequently demonstrated, through a series of videos, the potential complications associated with each TURBT technique and strategies for their prevention, such as the use of operating room checklists. He also highlighted the role of TURBT in selected cases according to current clinical guidelines and emphasized en bloc TURBT as a safe and effective technique with potential advantages over fragmented resection.

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Centenary Congress of the Chilean Society of Urology, 2025



Mario I. Fernández, MD

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Risk Stratification in Intermediate-Risk NMIBC

Dr. Kamat began his presentation by reviewing two cases of non–muscle-invasive bladder cancer (NMIBC), highlighting differences between the European Association of Urology (EAU) and American Urological Association (AUA) definitions of intermediate risk. He emphasized that intermediate-risk disease represents a broad spectrum, as proposed by the IBCG, with a wide range of management options, from active surveillance and fulguration to adjuvant BCG or chemotherapy, as well as novel intravesical devices such as TAR-200.
He presented a new IBCG-developed risk categorization system that predicts outcomes in intermediate-risk patients based on clinical factors (multiplicity, early recurrence within one-year, frequent recurrence >1/year, tumor size >3 cm, and prior intravesical therapy failure). This validated system enables patient selection for strategies such as active surveillance, allowing treatment de-escalation in selected individuals. Dr. Kamat concluded by emphasizing the need for standardized criteria to define intermediate-risk NMIBC and for personalized management guided by prognostic factors and patient-centered outcomes.

Intravesical Therapy in High-Risk NMIBC

Dr. Fernández defended BCG therapy as the standard of care for high-risk NMIBC. He reviewed BCG indications according to AUA and EAU guidelines and emphasized that available evidence shows satisfactory outcomes regarding recurrence and toxicity when the correct regimen and dose are used. He reinforced the ongoing role of BCG based on recent trials combining systemic immunotherapy with BCG (POTOMAC, ALBAN, and CREST), which nevertheless demonstrated excellent results in the BCG- only control arms. He concluded by underscoring the need for randomized clinical trials comparing different intravesical therapies and combinations to establish a new standard of care.

In contrast, Dr. Porten presented the rationale for implementing alternative intravesical therapies in BCG-naïve high-risk NMIBC, particularly in the context of BCG shortages over the past decade. She reviewed ongoing strategies, highlighting the BRIDGE study evaluating sequential intravesical gemcitabine and docetaxel, noting favorable results in retrospective series compared with BCG. She also discussed studies evaluating intravesical drug-delivery devices for gemcitabine and erdafitinib (TAR-200 and TAR-210), as well as an oncolytic immunotherapeutic agent (Cretostimogene Grenadenorepvec). She concluded that expanding therapeutic options underscores the importance of effective biomarkers for treatment selection.

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Centenary Congress of the Chilean Society of Urology, 2025

Magnetic Resonance Imaging in Bladder Cancer

Dr. Andrés Labra (Radiologist, Faculty of Medicine, Clínica Alemana–Universidad del Desarrollo) advocated for magnetic resonance imaging (MRI) as a new diagnostic standard in bladder cancer. He emphasized the importance of identifying muscularis propria invasion and discussed the limitations of traditional methods such as cystoscopy and TURB, which are invasive and have variable sensitivity and specificity, lack depth assessment, and may result in up to 30% understaging. He highlighted the advantages of multiparametric bladder MRI as a noninvasive, high-resolution technique allowing comprehensive anatomical evaluation, with emerging integration of artificial intelligence to optimize results.

Conversely, Dr. Porten argued against MRI as a new diagnostic standard at present, noting that despite its advantages, it is not flawless. Diagnostic accuracy depends on technical factors and operator expertise, and misclassification can occur; therefore, MRI should be interpreted alongside clinical and pathological data. Additional limitations include tumors at ureteral orifices or the bladder neck, variations related to bladder filling, and higher costs compared with other imaging modalities.

How Radical Should TURB Be in Muscle-Invasive Bladder Cancer?

Dr. Villoldo advocated for maximal TURB in muscle-invasive bladder cancer (MIBC), citing tumor heterogeneity and the need for sufficient tissue for genetic and molecular analyses. This is particularly relevant given the prognostic role of biomarkers in recent immunotherapy studies, such as circulating tumor DNA (ctDNA) in the NIAGARA trial, where 57% of patients remained ctDNA-positive despite TURB, suggesting residual microscopic disease.

In contrast, Dr. Kamat argued that maximal TURB is not necessary in MIBC. He outlined procedural risks, including bladder perforation (up to 5%), hematuria requiring transfusion (13%), urinary tract infection (39%), ureteral orifice injury (19%), obturator nerve stimulation (11%), and rare catastrophic complications. He cited evidence showing that favorable prognosis in pT0 patients is independent of whether pT0 is achieved through neoadjuvant chemotherapy or complete TURB prior to cystectomy. He concluded that non-maximal TURB provides sufficient tissue for histologic subtyping, avoids delays in neoadjuvant therapy, and preserves the ability to assess systemic treatment response.

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Centenary Congress of the Chilean Society of Urology, 2025

Management of Localized MIBC in 2025

Dr. Porten reviewed the aggressive natural history of MIBC, with metastasis developing within approximately 12 months and death occurring within 18–24 months. She presented data supporting neoadjuvant chemotherapy as the current standard, with meta-analyses demonstrating a 5–7% improvement in 5-year survival, particularly in locally advanced disease. However, toxicity and cisplatin ineligibility—affecting nearly half of patients—support the complementary role of cystectomy for accurate risk stratification and recurrence prevention.

Dr. Fernández defended trimodal therapy (TMT) as a standard approach, emphasizing that immediate cystectomy is not necessary for all patients and that bladder-preserving strategies may be appropriate. He described commonly used TMT algorithms with favorable outcomes, including 5-year cancer-specific survival of 56–85% and bladder preservation rates up to 85%. While acknowledging traditional prognostic factors, he noted increasing flexibility in patient selection. Comparative series and meta-analyses show no differences in overall or cancer-specific survival between TMT and cystectomy, but TMT is associated with improved quality of life. He also highlighted increasing TMT utilization in the United States, now reaching 32%, and its inclusion in all major clinical guidelines for localized MIBC.

Finally, Dr. Villoldo argued that neither cystectomy nor radiotherapy is necessary after complete response to systemic therapy in MIBC. He reviewed supporting evidence, including the HCRN GU16-127 trial combining chemotherapy with nivolumab, where 48% of patients achieved complete clinical response and opted to avoid cystectomy, demonstrating improved overall and metastasis-free survival. He emphasized high response rates achieved with novel combinations such as enfortumab vedotin plus pembrolizumab and concluded that bladder preservation will increasingly be preferred, potentially extending eligibility criteria to N+ patients.

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At the Bladder Cancer Advocacy Network (BCAN), we believe that today's medical research is the engine that drives better todays and more tomorrows for patients and those who love them.

Our goal is to identify the best and most promising medical research to advance our understanding of bladder cancer. BCAN awards grants to support early and seasoned investigators performing innovative research to develop lifesaving treatments and improve patient outcomes.

To learn more about BCAN's research program and grant funding, please visit **bcan.org/research**.

BCAN
Bladder Cancer Advocacy Network



Join us for our **Walks to End Bladder Cancer** in the Spring of 2025. Our in-person and virtual walks raise spirits and raise funds to defeat bladder cancer. Please visit **bcanwalk.org**.

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A year in review



Petros Grivas, MD PhD FASCO

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In 2025, we experienced rapid and unprecedented progress in the field of bladder cancer with higher cure rates, longer survival and better quality of life, esp. with the combination of antibody drug conjugate (ADC) with checkpoint inhibitor (ICI) in patients with localized and those with metastatic urothelial carcinoma. At the same time, major advances in the field of circulating tumor (ct)DNA (liquid biopsy) can help with prognostication and therapeutic decision making in certain scenarios after radical cystectomy in ICI-naive patients (adjuvant setting). Bladder preservation strategies are expected to occur more frequently corresponding to the consistent request from patients and advocacy groups.

In NMIBC, two large, randomized phase III trials (CREST and POTOMAC) showed significant benefit in event-free and disease-free survival, respectively, with the addition of a systemically administered ICI to intravesical BCG vs BCG alone in patients with BCG-naïve NMIBC. Both trials showed that maintenance BCG is critical and cannot be replaced by ICI. Toxicity remains a concern with a fraction of patients developing immune related adverse events, but treatment related deaths were extremely rare. The proportions of patients who developed MIBC or metastatic disease were very small, therefore those endpoints could not be used for adequate data interpretation. Regulatory decision is pending for those two trials, while a third similar trial (ALBAN) evaluating the addition of intravenous atezolizumab to intravesical BCG did not meet its primary endpoint, which could be potentially explained by several factors related to the patient population, cancer characteristics, trial design (BCG re-induction was not allowed), assessment of primary endpoint, etc. The performance of intravesical BCG in all those trials was better than historical data, “raising the bar” in trials in this setting. The BRIDGE (ECOG-ACRIN 8212) trial comparing intravesical BCG to intravesical gemcitabine/docetaxel completed accrual and results are eagerly awaited. Another trial in this BCG-naïve setting is Sunrise-3, evaluating TAR-200 alone or combined with cetrelimab (ICI) vs intravesical BCG. All the ongoing trials, including Keynote 676 (intravenous pembrolizumab with intravesical BCG) are very important also in the context of national BCG shortage in Unites States.

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A year in review

In MIBC, we saw very impressive data (with higher pathologic complete response rate, longer event-free and overall survival vs upfront radical cystectomy) with enfortumab-vedotin plus pembrolizumab given as peri-operative regimen (neoadjuvant and adjuvant) in patients who were not eligible for (or refused) cisplatin but underwent radical cystectomy. Results from the EV-303/Keynote905 trial were presented at ESMO'25 and resulted in the FDA approval of this combination in this therapy setting. In parallel, the NIAGARA phase III trial showed that the addition of peri-operative durvalumab to neoadjuvant gemcitabine/cisplatin significantly prolonged event-free and overall survival vs neoadjuvant gemcitabine/cisplatin with no planned adjuvant therapy. The pathologic response rate was higher with the addition of durvalumab, while this regimen received regulatory approval for cisplatin-eligible patients who plan to undergo radical cystectomy. Subset analysis, including ctDNA, was very interesting suggesting, among other findings, that the addition of neoadjuvant durvalumab increased ctDNA clearance. Toxicity, cost and therapy burden remain important and often discussed issues with these perioperative regimens; future analysis from those and other peri-operative phase III trials can help answer questions related to over- vs under-treatment, therefore, refining further optimal patient selection, esp. in the adjuvant therapy phase.

The IMVigor011 phase III trial showed that ctDNA can be a very useful biomarker that can help inform the decision and timing regarding adjuvant ICI in ICI-naive patients who underwent radical cystectomy (with or without neoadjuvant chemotherapy). Results from that trial were presented at ESMO'25 and externally validated the hypothesis-generating findings of the exploratory analysis from the IMvigor010 phase III trial. Moreover, subset analysis with ctDNA in available blood samples from the Checkmate274 phase III adjuvant trial (nivolumab vs placebo) suggested similar findings, further supporting the prognostic and predictive role of ctDNA in this adjuvant therapy setting.

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A year in review

In the frontline setting of metastatic urothelial carcinoma, disitamab-vedotin (anti-HER2 ADC) plus toripalimab (ICI) showed impressively longer progression-free and overall survival as well as higher overall response rate vs platinum/gemcitabine in a large phase III trial conducted in China. These results reminded us of the findings of the EV-302 phase III trial with enfortumab-vedotin plus pembrolizumab vs platinum/gemcitabine, while there are additional phase III trials testing combinations in the frontline and salvage therapy settings.

Ongoing clinical trials, testing various regimens and biomarkers, will keep "reshaping" the treatment landscape and help identify optimal combination and sequential therapy approaches in individual patients. Input from patient advocates remains critical in the design of clinical trials and pragmatic studies, while multi/inter-disciplinary tumor boards
with experts are becoming increasingly important in routine clinical practice. Global equitable and timely access to life-prolonging therapies and elimination of healthcare disparities are also essential expanding the need and scope of “implementation science”.

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