

NMIBC TRAS FRACASO A BCG: CISTECTOMÍA PRECOZ VS NUEVAS TERAPIAS INTRAVESICIALES VS INMUNOTERAPIA SISTÉMICA

ENRIQUE CAPÓN SÁEZ

MIR 4 - ONCOLOGÍA RADIOTERÁPICA

HOSPITAL UNIVERSITARIO 12 DE OCTUBRE

ÍNDICE

- ▶ 1. INTRODUCCIÓN
- ▶ 2. MANEJO NMIBC
- ▶ 3. RT EN NMIBC
- ▶ 4. PERSPECTIVAS
- ▶ 5. CONCLUSIONES

1. INTRODUCCIÓN



EPIDEMIOLOGÍA Y ETIOLOGÍA

- ▶ El cáncer de vejiga es el **10º tumor más frecuente** considerando ambos sexos.
- ▶ Aproximadamente, el **75%** de los tumores vesicales se presenta como enfermedad confinada a la mucosa (**Ta o Tis**) o a la submucosa (**T1**).
- ▶ Los principales factores etiológicos son el **tabaco** y la exposición a **aminas aromáticas** o hidrocarburos policíclicos.

ESTADIAJE TNM

T - Primary tumour	
TX	Primary tumour cannot be assessed
T0	No evidence of primary tumour
Ta	Non-invasive papillary carcinoma
Tis	Carcinoma in situ: 'flat tumour'
T1	Tumour invades subepithelial connective tissue
T2	Tumour invades muscle
T2a	Tumour invades superficial muscle (inner half)
T2b	Tumour invades deep muscle (outer half)
T3	Tumour invades perivesical tissue
T3a	Microscopically
T3b	Macroscopically (extravesical mass)
T4	Tumour invades any of the following: prostate stroma, seminal vesicles, uterus, vagina pelvic wall, abdominal wall
T4a	Tumour invades prostate stroma, seminal vesicles, uterus or vagina
T4b	Tumour invades pelvic wall or abdominal wall
N - Regional lymph nodes	
NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	Metastasis in a single lymph node in the true pelvis (hypogastric, obturator, external iliac, or presacral)
N2	Metastasis in multiple regional lymph nodes in the true pelvis (hypogastric, obturator, external iliac, or presacral)
N3	Metastasis in common iliac lymph node(s)
M - Distant metastasis	
M0	No distant metastasis
M1a	Non-regional lymph nodes
M1b	Other distant metastases

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2. MANEJO NMIBC

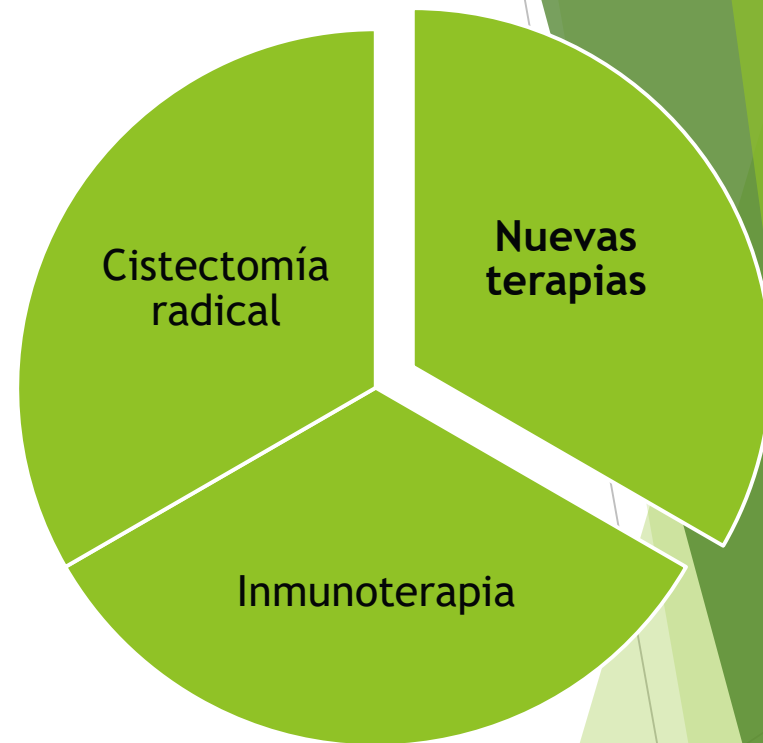


GRUPOS DE RIESGO

Risk group	
Low Risk	<ul style="list-style-type: none"> • A primary, single, TaT1 LG/G1 tumour < 3 cm in diameter without CIS in a patient ≤ 70 years • A primary Ta LG/G1 tumour without CIS with at most ONE of the additional clinical risk factors
Intermediate Risk	Patients without CIS who are not included in either the low-, high-, or very high-risk groups
High Risk	<ul style="list-style-type: none"> • All T1 HG/G3 without CIS, EXCEPT those included in the very high-risk group • All CIS patients, EXCEPT those included in the very high-risk group <p>Stage, grade with additional clinical risk factors:</p> <ul style="list-style-type: none"> • Ta LG/G2 or T1G1, no CIS with all 3 risk factors • Ta HG/G3 or T1 LG, no CIS with at least 2 risk factors • T1G2 no CIS with at least 1 risk factor
Very High Risk	<p>Stage, grade with additional clinical risk factors:</p> <ul style="list-style-type: none"> • Ta HG/G3 and CIS with all 3 risk factors • T1G2 and CIS with at least 2 risk factors • T1 HG/G3 and CIS with at least 1 risk factor • T1 HG/G3 no CIS with all 3 risk factors



Recurrencia



3. RT EN NMIBC

EVIDENCIA ACTUAL

A Randomized Trial of Radical Radiotherapy for the Management of pT1G3 NXM0 Transitional Cell Carcinoma of the Bladder

S. J. Harland,^{a,†,§} H. Kynaston,[†] K. Grigor, D. M. Wallace, C. Beacock, R. Kockelbergh, S. Clawson, T. Barlow, M. K. B. Parmar and G. O. Griffiths on behalf of the National Cancer Research Institute Bladder Clinical Studies Group

From the Institute of Urology and Department of Oncology, University College London (SJH) and Cancer Group, Medical Research Council Clinical Trials Unit (SC, TB, MKBP, GOG), London, Department of Urology, University Hospital of Wales, Heath Park, Cardiff (HK), Department of Pathology, Western General Hospital, Edinburgh (KG), Department of Urology, Queen Elizabeth Hospital, Birmingham (DMW), Department of Urology, Royal Shrewsbury Hospital, Shrewsbury (CB), and Department of Urology, Leicester General Hospital, Leicester (RK)

- ▶ Único estudio randomizado (2007) compara RT vs observación o BCG.
- ▶ 210 pacientes.
- ▶ Dosis 60 Gy a 2 Gy/sesión.
- ▶ No diferencias en SLP ni en SG.

EN PROCESO...

► 1. PREVERT

- * Fase 2
- * 67 pacientes
- * 60-66 Gy a 2 Gy/fx + Avelumab x 8 ciclos
- * Endpoint → SLP
- * Junio 2024

EN PROCESO...

▶ 2. ADAPT-BLADDER

* Fase 1

* 28 pacientes

➤ RT (18 Gy en 3 fx)+ Durvalumab vs

➤ BCG + Durvalumab vs

➤ Durvalumab en monoterapia

* Endpoint → Toxicidad y RC

RC:

T° seguimiento	D	D + BCG	D + RT
3 m	33%	85%	50%
6 m	0%	83%	33%
12 m	0%	73%	33%

Toxicidad:

Grado	D	D + BCG	D + RT
1-2	100%	100%	92%
3-4	33%	15%	42%

EN PROCESO...

▶ 3. CHICTR

- * Fase 2
- * 50 pacientes
- * RT + Tislelizumab
- * Endpoint → SLP

4. PERSPECTIVAS

The background features abstract, overlapping geometric shapes in various shades of green, ranging from light lime to dark forest green. These shapes are primarily located on the right side of the slide, creating a modern, layered effect. The rest of the slide is a plain white background.

[⁹⁰Y]- DBA

AVIDINA

- Glicoproteína que se une a las **lectinas** del urotelio vesical.

EVIDENCIA

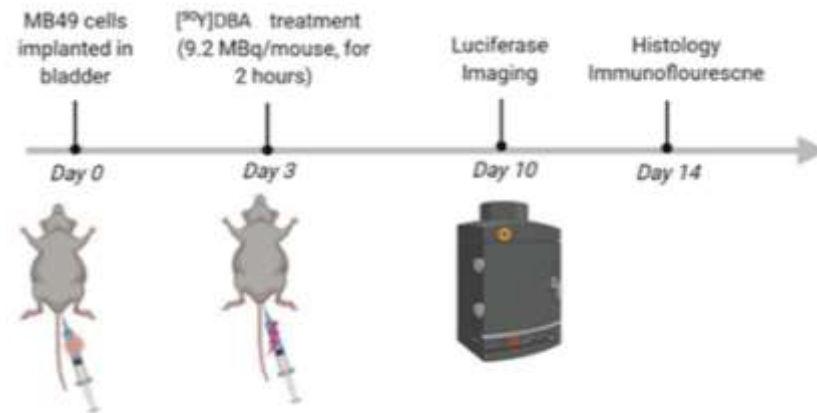
- Estudios en **animales** (ratones)

MÉTODO

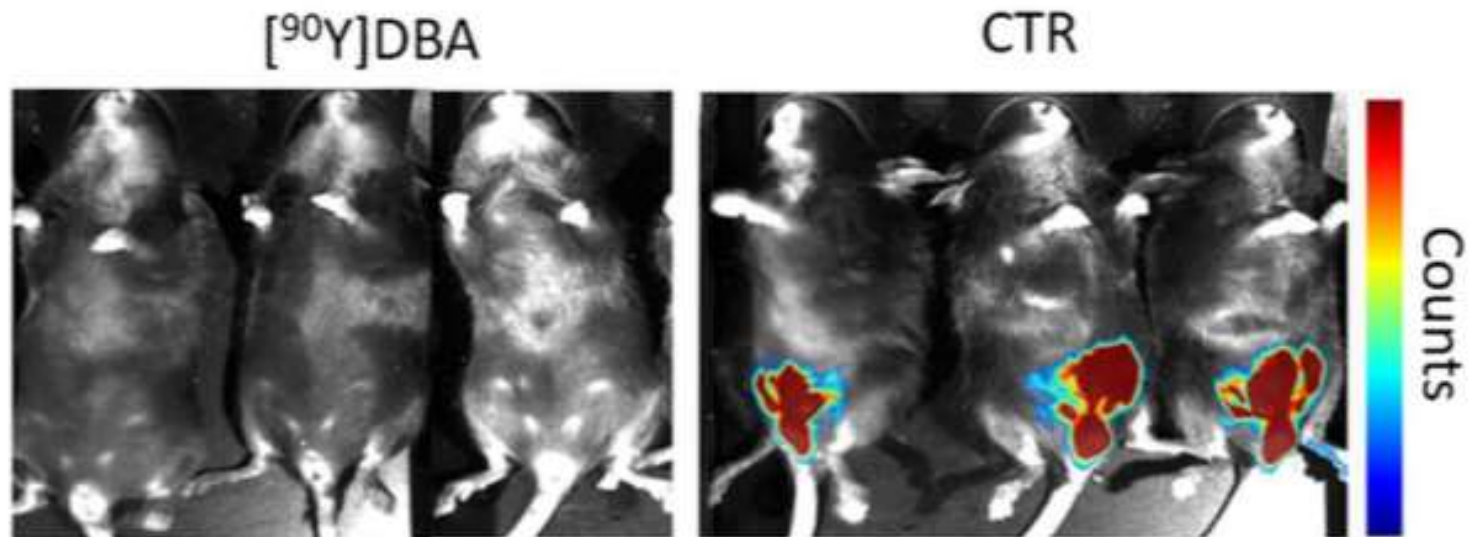
- Instilación intravesical de un radionúclido de avidina ([⁹⁰Y]-DBA)

DOSIS

- Exposición de 2 horas a **9,2 MBq \cong 12,6 Gy**



Ausencia de tumor en el 50% de los ratones tratados



5. CONCLUSIONES

- ▶ La evidencia actual respecto al tratamiento con RT tras fracaso a BCG es escasa.
- ▶ Los estudios más recientes al respecto han demostrado que la radioterapia es una alternativa segura y eficaz frente a la cistectomía radical.
- ▶ La utilización de RT + inmunoterapia resulta prometedora, si bien son precisos más estudios con mayor poder estadístico.
- ▶ La [⁹⁰Y]- DBA, aunque en fases experimentales, supone una alternativa terapéutica intravesical, a considerar en el futuro.

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MUCHAS GRACIAS

The background features abstract, overlapping geometric shapes in various shades of green, ranging from light lime to dark forest green. These shapes are primarily located on the right side of the frame, creating a modern, layered effect against the white background.