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Durvalumab (D) in combination with BCG induction and maintenance (I+M) for BCG-naïve, high-risk non-muscle-invasive bladder cancer (NMIBC): Early recurrence and cystectomy-free survival in patients (pts) with papillary only tumours from POTOMAC

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Background

In POTOMAC (NCT03528694), D+BCG (I+M) demonstrated a statistically significant and clinically meaningful disease-free survival benefit vs BCG (I+M) in pts with BCG-naïve, high-risk NMIBC. 64% of pts had high-risk papillary only tumours, many high-grade T1, with an acute unmet medical need: after BCG failure, pts with papillary only tumours have few options beyond radical cystectomy. We report efficacy and safety analyses in this population.

Methods

Eligible pts were randomised 1:1:1 to D+BCG (I+M), D+BCG (I) or BCG (I+M). For D+BCG (I+M) vs BCG (I+M), we report post hoc exploratory analyses in pts with papillary only tumours: incidence of high-risk disease events (high-risk NMIBC recurrence [high-grade Ta/T1/CIS]; persistent CIS at 6 mo; or MIBC/metastasis); BCG-unresponsive disease; time to cystectomy; cystectomy-free survival (time from randomisation to cystectomy/death), and safety.

Results

In pts with papillary only tumours, fewer high-risk events occurred with D+BCG (I+M) (28/217) vs BCG (I+M) (44/220), with 16/28 (57%) vs 29/44 (66%) pts experiencing early high-risk events (≤ 1 yr from randomisation). At recurrence, 11/18 (61%) pts in the D+BCG (I+M) arm and 30/34 (88%) in the BCG (I+M) arm had BCG-unresponsive disease. Time to cystectomy and cystectomy-free survival showed numerically greater benefit for D+BCG (I+M) vs BCG (I+M) (HR 0.51 [95% CI, 0.18–1.32] and 0.59 [95% CI, 0.38–0.92], respectively). Max. grade 3/4 treatment-related adverse events (AEs) occurred in 49/215 (23%) and 6/219 (3%) pts, respectively. With D+BCG (I+M), immune-mediated AEs occurred in 58/215 (27%) pts (max. grade 3/4, 20/215 [9%]); imAEs were resolved/resolving for 35/58 (60%) pts.

Conclusions

Fewer early high-risk events, BCG-unresponsive recurrences and cystectomies, with favourable trends for time to cystectomy and cystectomy-free survival, occurred with D+BCG (I+M) vs BCG (I+M) in pts with papillary only tumours. Safety was consistent with the overall population. These data further support D+BCG (I+M) as a potential new treatment for pts with BCG-naïve, high-risk NMIBC.

Clinical trial identification

NCT03528694; EudraCT: 2017-002979-26.

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Legal entity responsible for the study

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Disclosure

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