AUA2026 Washington, DC MAY 15-18

SATURDAY | MAY 16, 2026

DAILY NEWS

SEE THE DAILY SCHEDULE FOLLOWING PAGE 8

P2s Practice-Changing, Paradigm-Shifting Clinical Trials in Urology

Exceptional, groundbreaking studies expected to change the day-to-day practice of urology.

11-11:20 a.m.
2:35-3:05 p.m.
Plenary, Hall D

Learning Lab

Flip the Script: Case Submissions
1-3 p.m.
Hall B, The Square

AUA Robotics Theater

Don't miss today's live narration of robotic procedure videos and a panel discussion.

Prostate
9:30 a.m.-11:30 a.m.

Reconstruction
1-3 p.m.

S&T Hall, Booth #117

Patient Perspectives

11:30 a.m.-1:30 p.m.
Plenary Foyer

AUA2026 Washington, DC MAY 15-18
DAILY NEWS ONLINE

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The hidden cost of looking harder for cancer

Aggressive screening distorts survival statistics and fuels unnecessary treatment in asymptomatic patients.

Historically, cancer has been diagnosed in individuals showing symptoms. However, recent efforts to promote increased screening have resulted in more diagnoses among asymptomatic patients.

H. Gilbert Welch, MD, MPH, a general internist and cancer researcher at the Center for Surgery and Public Health at Brigham and Women's Hospital in Boston, used the annual Ramon Guiteras Lecture during Friday morning's Plenary to explore the concept of cancer "overdiagnosis."

"If you look harder for cancer, you find more," Dr. Welch said. "All medical students are taught that incidence is the true occurrence of disease, but it's not just that. It's influenced by how hard we're looking for cancer."

Dr. Welch also clarified that increased screening results in more diagnoses. For some, this might suggest a higher prevalence of the disease and the necessity for extra measures. However, some of these cancers will be detected in asymptomatic individuals and may never lead to problems, much less death. As a result, the average patient tends to appear healthier as the number of diagnoses increases. This perceived improvement can be quite influential; it can also be quite misleading.

Dr. Welch used five-year survival rates to illustrate his point. He suggested that many physicians and public health professionals link higher survival with lower mortality, but this isn't always correct.

> "If you look harder for cancer, you find more. All medical students are taught that incidence is the true occurrence of disease, but it's not just that. It's influenced by how hard we're looking for cancer."
>
> **–H. Gilbert Welch, MD, MPH**

To better understand this, it's important to remember that survival rates are calculated by dividing the number of diagnoses by the number of patients alive at the time being examined. As diagnoses rise, the survival rate can increase even if the death rate stays the same.

To put this in perspective, the 10-year survival rate for melanoma skin cancer increased from 50% to nearly 100% between 1971 and 2018, yet the death rate remained unchanged. Conversely, the 10-year survival rate for lung cancer improved only slightly, but the death rate has halved.

These misleading figures impact not just health care providers but also shape popular culture. As diagnosis rates rise, more survivors share their stories. Furthermore, more people believe they owe their lives to a screening

Lecture continued on page 4

INSIDE

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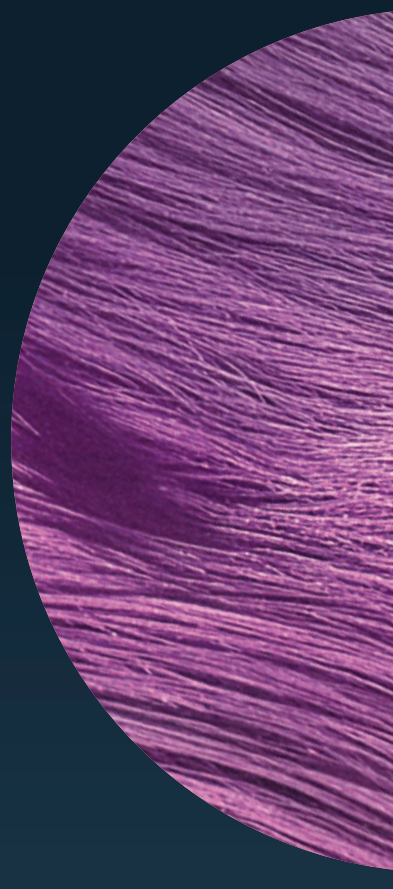

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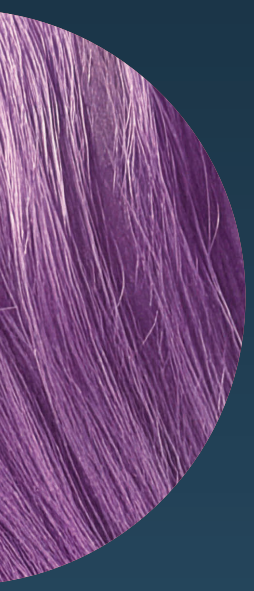

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Durvalumab + BCG continues to deliver in high-risk NMIBC

Longest-running NMIBC trial shows sustained disease-free survival benefit and delayed cystectomy at five years.

Updated results from the POTOMAC trial show continued improvement in disease-free survival, overall survival and time to cystectomy with durvalumab plus bacillus Calmette-Guérin (BCG) in patients with high-risk, non-muscle invasive bladder cancer (NMIBC). With five years of follow-up and counting, POTOMAC is already the longest-running clinical trial in NMIBC.

"These data clearly support one year of durvalumab with induction maintenance of BCG as a potential new treatment with high-risk NIMBC," said Neal Shore, MD, medical director of the START Carolinas/Carolina Urologic Research Center in Myrtle Beach, South Carolina. "The safety of durvalumab plus BCG in the overall safety population and across papillary subgroups was consistent with the known safety profiles of BCG and durvalumab."

Dr. Shore updated the efficacy and safety findings of POTOMAC in the first Practice-Changing, Paradigm-Shifting Clinical Trials presentation during Friday's Plenary Session. Initial data were presented in 2025 and published in The Lancet.

Early high-risk disease recurrence is associated with worse outcomes in NMIBC, and BCG unresponsiveness is an accepted indication for radical cystectomy. The initial results showed that adding one year of durvalumab to BCG was associated with a significant improvement in disease-free survival (DFS), with a hazard ratio (HR) of 0.68 and a nonsignificant trend toward improved overall survival (OS).

Five-year data presented on Friday showed the same 32% improvement in DFS, along with an overall decline in the number of early high-risk events and a delay in time to the first high-risk event. There was also a clinically significant delay in time to cystectomy: 14 months with BCG only versus 19 months with durvalumab + BCG, HR 0.63. The addition of durvalumab did not affect a patient's ability to receive adequate BCG therapy

Dr. Shore noted that while median cystectomy-free survival has not yet been reached, the durvalumab cohort already shows a statistically significant improvement, HR 0.69.

Most patients in the trial had papillary tumors, and there was a reduction in high-risk disease recurrence or death across papillary subtypes, HR 0.56. The median OS has not yet been reached, but the survival trend continues to favor durvalumab, HR 0.80.

Adverse events (AEs) were common, with 88% of patients showing some sort of AE that could be related to treatment. About a quarter of AEs (23%) were grade 3-4, and 13% were serious. Similar numbers of AEs leading to discontinuation were likely due to durvalumab (16%) and BCG (15%). Some 27% of AEs were immune-mediated events.

"Immune-mediated adverse events are important for our colleagues to become comfortable with," Dr. Shore said. "The most common things are thyroid events, followed by hepatic events and rash. The majority of these resolve with interruption, topical treatment and the potential use of steroids." ●

AUA 2026 Washington, DC | DAILY NEWS

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Lecture

continued from page 1

test, serving as evidence of screening's success.

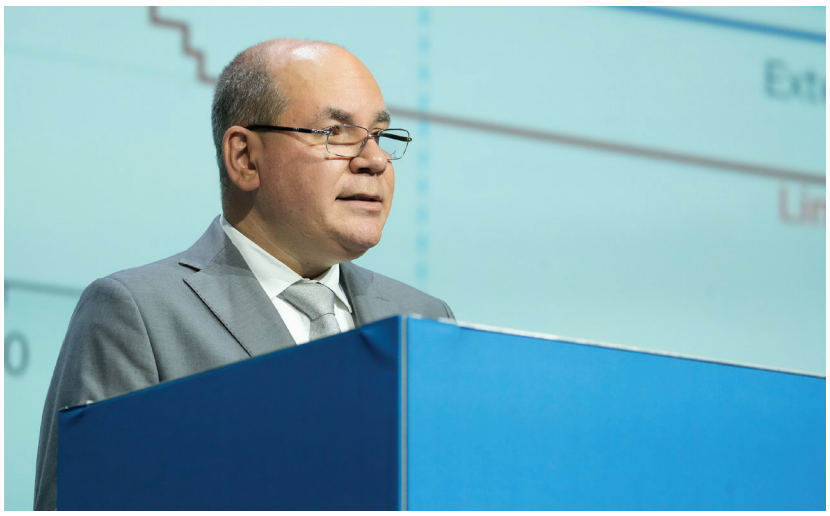
Of all specialties, Dr. Welch said he believes urologists understand the problem of overdiagnosis best and are taking steps to address it. For kidney cancer, they initiate active surveillance for small renal masses, and for prostate cancer, they make the case for active surveillance in low-risk disease.

"These approaches make use of what I call the diagnostic value of time. Not trying to decide something about phenotype at a single point in time, but instead, observing it over time and getting more data on growth. Time provides information," Dr. Welch said.

In terms of surveillance following treatment for curative intent, an analysis of 12 trials found no significant difference. Although recurrence markedly increases risk, knowing earlier doesn't extend patients' lives. ●

Updated trial refines role of extended lymph node dissection

More than 10 years of follow-up reveal improved outcomes with EPLND in patients with ISUP grade 3-5 prostate cancer.



Jean F.P. Lestingi, MD, PhD

The removal of pelvic lymph nodes is commonly performed during radical prostatectomy for prostate cancer. However, the use of extended pelvic lymph node dissection (EPLND) is controversial.

A phase 3 randomized trial evaluating EPLND versus limited pelvic lymph node dissection (LPLND) during radical prostatectomy for intermediate- and high-risk prostate cancer was published in 2021. During Friday's Practice-Changing, Paradigm-Shifting Clinical Trials in Urology session, Jean F.P. Lestingi, MD, PhD, assistant professor of urology at the Instituto de Cancer do Estado de Sao Paulo, presented updated data.

The trial enrolled 300 patients, randomized to EPLND (obturator, external iliac, internal iliac, common iliac and presacral nodes) or LPLND (obturator nodes). The primary endpoint was biochemical recurrence-free survival (BCRFS), and secondary endpoints included metastasis-free survival (MFS) and cancer-specific survival (CSS).

"As previously published, this randomized phase 3 trial did not demonstrate oncologic superiority of EPLND over LPLND among unselected intermediate- and high-risk prostate cancer patients," Dr. Lestingi said.

According to guidelines, clinicians should inform patients that pelvic lymph node dissection can provide staging information but does not have consistently documented improvement in MFS, CSS or overall survival. However, recent research has suggested otherwise: One study reported a better MFS among patients randomized to EPLND, although there was still no statistically significant difference in BCRFS.

Dr. Lestingi and team continued to follow the patients in this phase 3 trial. At a median of 130.6 months, patients with biopsy International Society of Urological Pathology (ISUP) group grade 3-5 demonstrated a significant and sustainable benefit in BCRFS.

The study also looked at secondary treatments needed. In the ISUP biopsy grade 3-5 subset, the median time to radiotherapy was 43.7 months in the LPLND group and was not reached in the EPLND group. The median time to androgen deprivation therapy was 66.5 months in the LPLND group and was not reached in the EPLND group. These results suggest that the benefits seen for the more aggressive cancer type came from the surgical approach.

Based on these findings, Dr. Lestingi suggests that EPLND could be considered the standard of care in ISUP grade 3-5 patients undergoing radical prostatectomy. He also emphasized the need for guideline recommendations to take these updated data into account. ●

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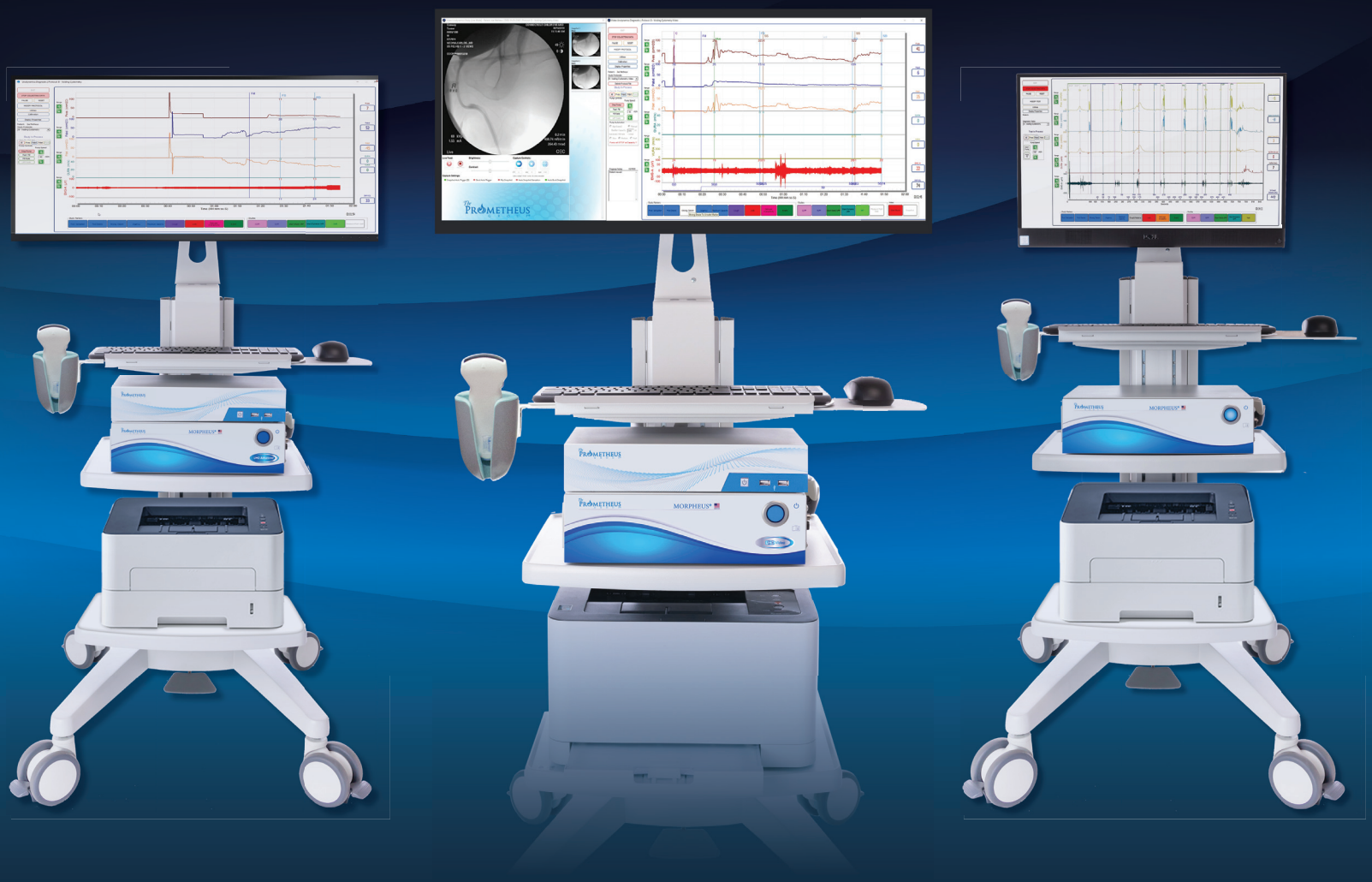

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QUESTION OF THE DAY

What is one thing you've seen at AUA2026 that made you stop and think, "This will reshape urology over the next five years"?

I thought the session on endoscopic urethroplasty for recurrent recalcitrant bladder neck stenosis was absolutely fabulous. I have already looked it up to see how I can get the instruments.

Melanie Aube-Peterkin, MD
Montreal, Quebec, Canada

I think the technology will be what reshapes urology, and how the surgeon uses that technology. The engineering and the robotics will help shape it, but the real difference will come in how the surgeon implements and decides to use it.

João Ernesto Aldred Pinto Filho, MD
Rio de Janeiro, Brazil

I think one thing I noticed that is going to shape urology down the road is that we are starting to extend the management of bladder conditions even into primary care, which is interesting. They are trying to identify misconceptions about the treatment of urinary urgency and complications that patients typically present to primary care, so maybe we can start intervening at the first place patients come with these concerns.

Vandanaa Jayaprakash, medical student
Richmond, Virginia

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9:30 – 10:15 a.m.
AUA Product Theater | Booth #2701

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How I do it: Robotic prostatectomy video case review

Presented by Dr. Ronney Abaza

Sunday, May 17
11:30 a.m. – 12:30 p.m.
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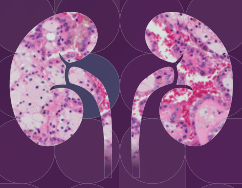
Select Square offerings have expanded to the **Plenary foyer, located on level 2:**

The Urology Care Foundation

Advocacy Booth

Patient Perspectives



WHICH OF YOUR PATIENTS WITH RCC ARE AT **HIGHER RISK OF RECURRENCE** AFTER SURGERY?

According to a retrospective, observational analysis of EMR data from 439 patients with RCC at higher risk for recurrence post nephrectomy from 2012 to 2021

More than half of patients in this analysis experienced recurrence[1]

51% experienced recurrence

34% experienced death

- Among patients with a recurrence, 85% had distant metastasis.[1]

Analysis Population[1]:

- Eligible patients were adults (aged ≥18 years) diagnosed with nonmetastatic RCC between January 1, 2012 and December 31, 2017 to allow for the potential of a 3-year follow-up period.
- Patients at higher risk for recurrence included: T2, N0, M0 with grade 4 cells or sarcomatoid histology; T3, N0, M0; T4, N0, M0, or any T stage with N ≥1, M0.
- **Median follow-up duration was 39 months.**

Analysis Limitations[1]:

- Data were sourced from principally community oncology practices, representing diverse practice locations in both rural and urban centers, within the US.
- Data from these practices were provided to the ConcertAI Oncology Dataset. Therefore, imaging assessments, procedures, or visits outside this network may not have been captured.

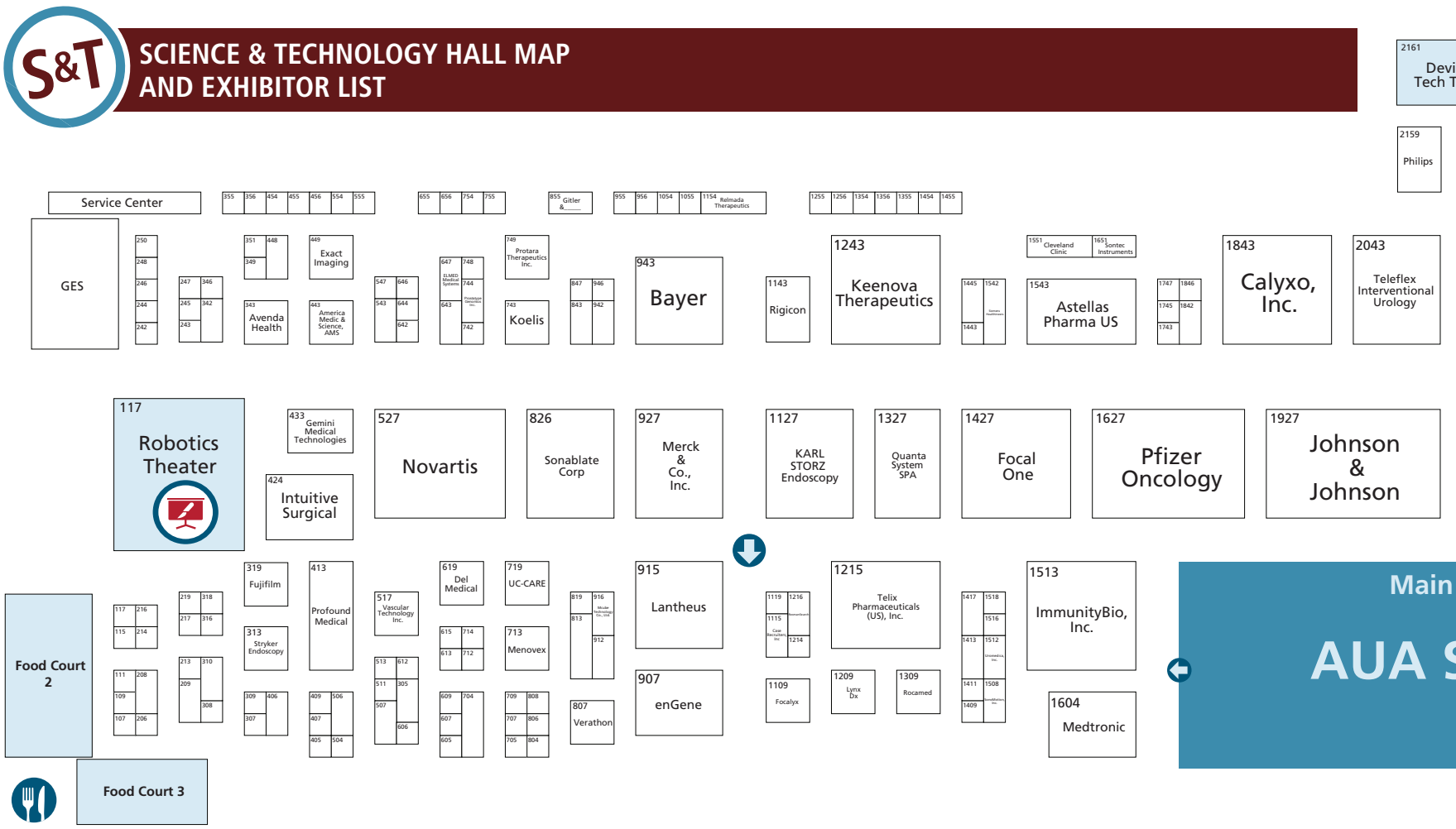
EMR = electronic medical record; M0 = no distant metastasis; N0 = no regional lymph node metastasis; RCC = renal cell carcinoma; T2 = tumor >7 cm in greatest dimension, limited to the kidney; T3 = tumor extends into major veins or perinephric tissues, but not into the ipsilateral adrenal gland and not beyond Gerota's fascia; T4 = tumor invades beyond Gerota's fascia (including contiguous extension into the ipsilateral adrenal gland).

References: 1. Karam JA, Bhattacharya R, Ogbomo A, et al. Real-world study on the characteristics, post-nephrectomy journey, and outcomes of patients with early-stage renal cell carcinoma based on risk groups. *Cancer Med*. 2024;13(11):e7247. doi:10.1002/cam4.7247 **2.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Kidney Cancer V.1.2026. © National Comprehensive Cancer Network, Inc. 2025. All rights reserved. Accessed July 28, 2025. To view the most recent and complete version of the guideline, go online to NCCN.org. **3.** Sundaram M, Song Y, Rogerio JW, et al. Clinical and economic burdens of recurrence following nephrectomy for intermediate high- or high-risk renal cell carcinoma: a retrospective analysis of Surveillance, Epidemiology, and End Results–Medicare data. *J Manag Care Spec Pharm*. 2022. doi:10.18553/jmcp.2022.22133 **4.** Sundaram M, Song Y, Rogerio JW, et al. Supplementary Materials for: Clinical and economic burdens of recurrence following nephrectomy for intermediate high- or high-risk renal cell carcinoma: a retrospective analysis of Surveillance, Epidemiology, and End Results–Medicare data. *J Manag Care Spec Pharm*. 2022. doi:10.18553/jmcp.2022.22133

Learn more about how patients who have T3 and T4 tumors may be at greater risk of their cancer returning after surgery.[2-4]

MERCK

SCIENCE & TECHNOLOGY HALL MAP AND EXHIBITOR LIST



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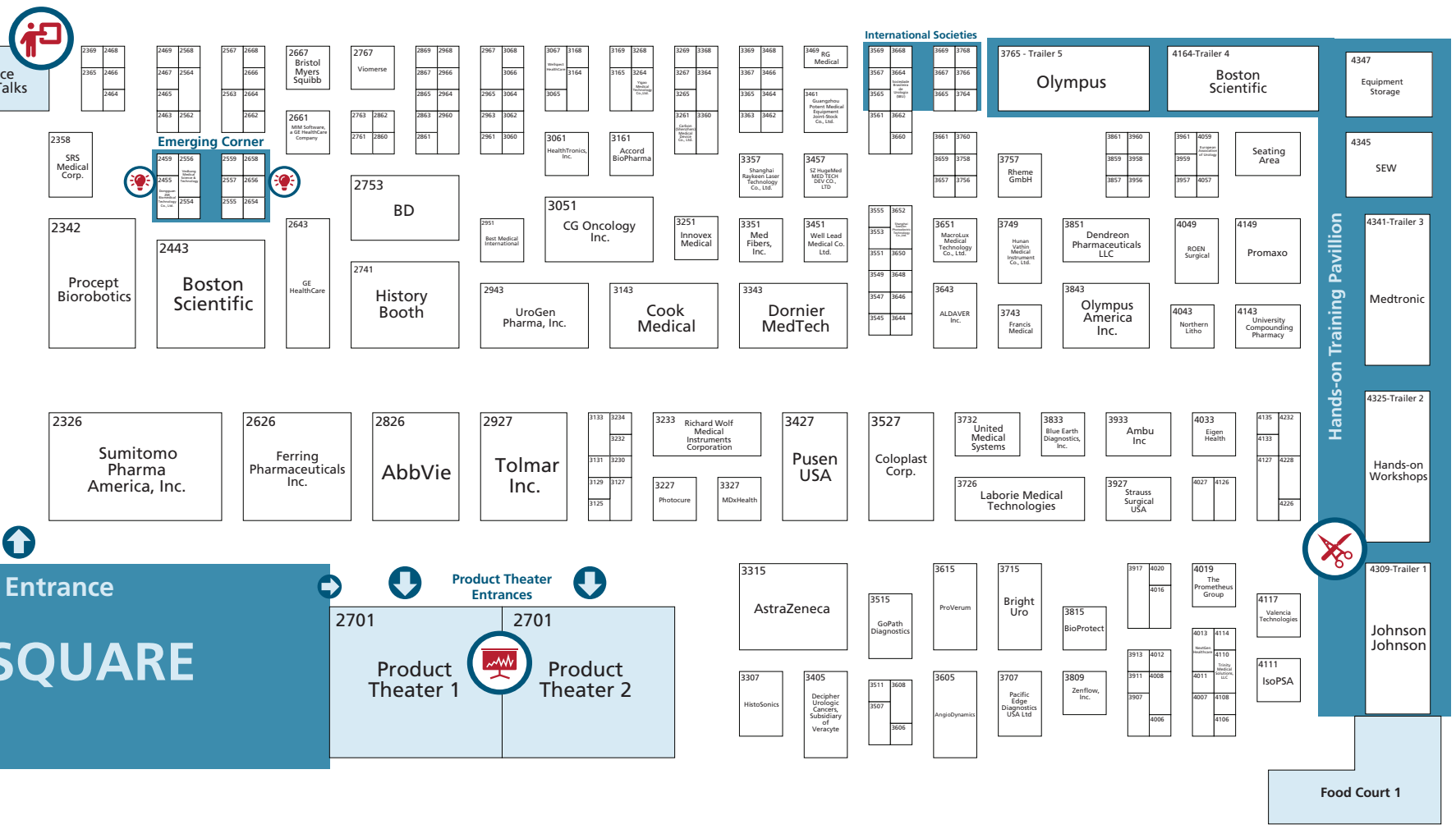

N-R

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U-Z

Current as of April 15, 2026

VOICES & VIEWS

Join the conversation on Instagram, Facebook and X. **#AUA2026**

Kyle A. Richards
@Uro_Rich
Just wrapped up our inaugural non-invasive bladder cancer course with faculty Betsy Koehne, Keli Syse (NP), and Peter O'Donnell (med onc).

Great cases and discussion from our very interactive audience and we all learned a lot!
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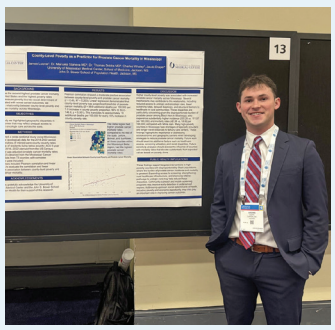
Jane K. Nguyen, MD, PhD
@JaneNguyen44
Full house at the PD03 podiums! ★ Super star ★ **@NicolasSoputro #SPARC #AUA2026 @drjkaouk @CleClinicUro @BradGillMD**



Jack Loome
@jackloome00
What a pleasure to present my research "County-Level Poverty as a Predictor for Prostate Cancer Mortality in Mississippi" at **#AUA2026**! Thank you to **@UMMCnews** and the John D. Bower School of Population Health!

Mack Roach III, MD

The expanding role of biomarkers in prostate cancer

Experts examine the rapid rise of PSMA PET, genetic testing and novel biomarkers.

PSA, the first biomarker in prostate cancer, has been part of patient care for decades. Use of PSMA PET for staging has skyrocketed from single digits in 2021 to over 50% currently. Trials for biomarkers, biomarker-based imaging, germline mutation testing and tumor somatic testing are on the rise. Prostate cancer guidelines increasingly incorporate novel biomarkers for potential clinical consideration.

"Biomarkers are something that everyone who is taking care of prostate cancer patients needs to be aware of," said Mohummad Minhaj Siddiqui, MD, professor of surgery and chief of urology at the University of Maryland School of Medicine and chief of urology at Maryland VA Healthcare System. He moderated a Focus On session Friday afternoon exploring the current state of biomarkers, MRI and PSMA PET imaging in prostate cancer.

Biomarkers are molecules in body fluids or tissues that can indicate a normal or abnormal biological process. They can be used alone or in combination with different imaging modalities and other clinical measures to help diagnose or guide management decisions.

"We have biomarkers that have been shown in multiple studies to improve the ability to detect high-grade cancer," said Simpa S. Salami, MD, MPH, associate professor of urology at the University of Michigan School of Medicine.

There are few direct comparisons between biomarkers, and many need further validation, he added, but diagnostic performance seems to be similar. Current biomarkers can confirm diagnosis with up to 30% fewer biopsies.

But not all widely used biomarkers have been well validated. Black patients, for example, are known to have lower electroretinogram (ERG) expression, which limits the utility of ERG-based tests.

MRI improves the detection of high-grade prostate cancer but should not eliminate surveillance biopsy. PSMA PET can facilitate staging before treatment.

"I use MRI and PET every day when I'm designing radiation-targeted areas," said Mack Roach III, MD, professor of radiation oncology and urology at the University of California, San Francisco. "It took us a long time to understand PSA, and it's going to take us a long time to figure out what to do with all these biomarkers and a lot of validation."

Multiple new agents have been approved for prostate cancer with multiple mechanisms and indications. Many are being moved into earlier, hormone-responsive settings without clear guidance. PSMA PET imaging is commonly used to diagnose, classify and track disease, also without clear guidelines.

Prostate Cancer Working Group 4 (PCWG4) is moving toward more evidence-based biomarker criteria and trial designs to optimize approaches for those who are most likely to benefit, said Michael A. Carducci, AEGON professor in prostate cancer research at the Hopkins Kimmel Cancer Center. PCWG4 is proposing a new indications model and new terminology, as well as specific approaches to the use of genetic testing and genomic evaluation to tailor treatment for PARP inhibitors and other agents. ●

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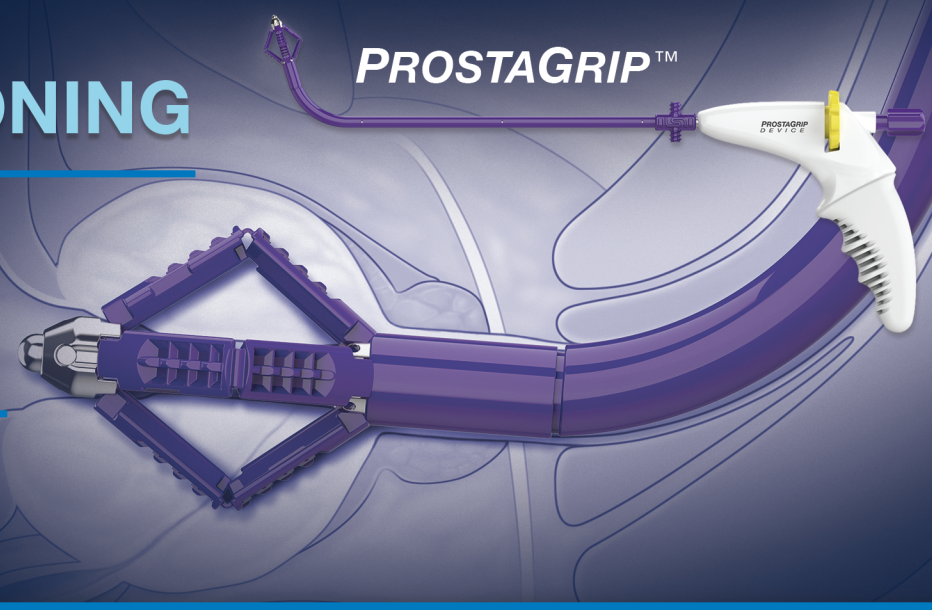

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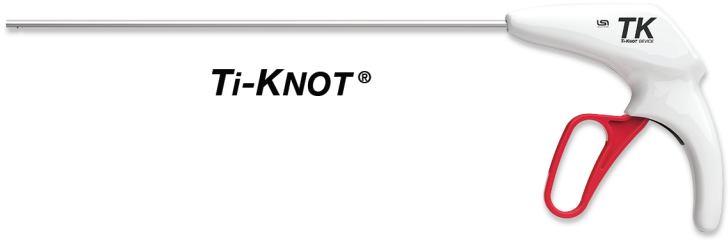

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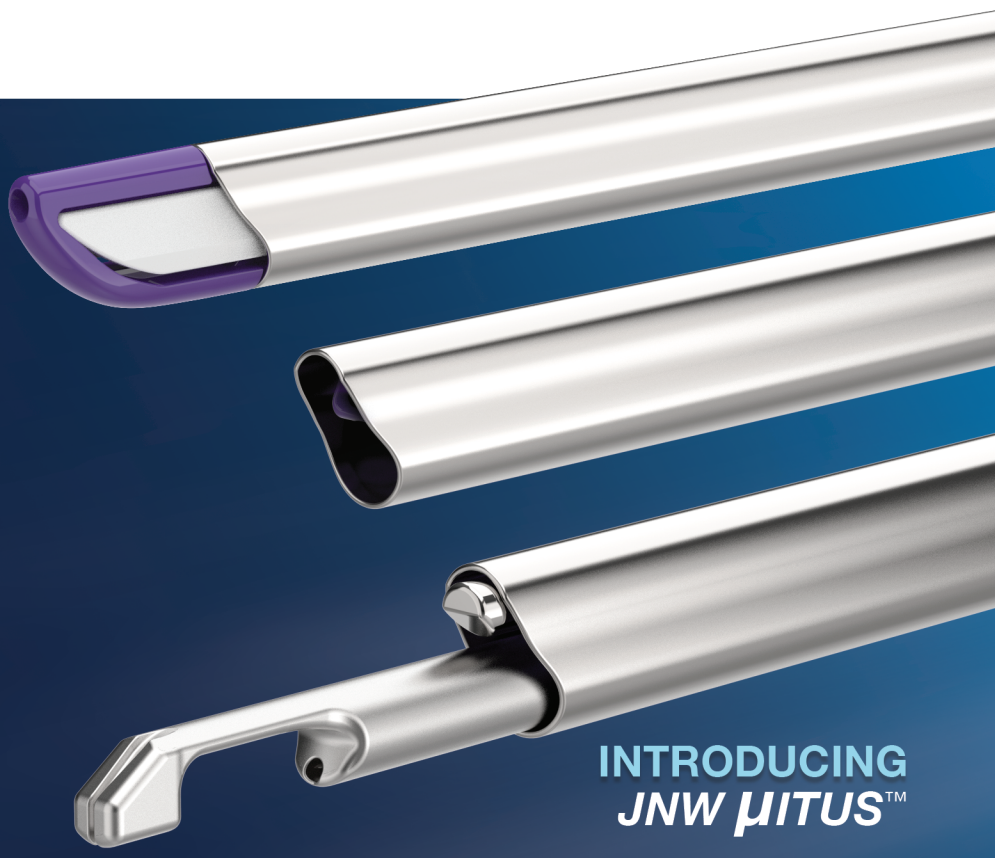

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