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THE TREATMENT **REPORTER**SM UROLOGY

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FAQs on Intravesical Immunotherapy for Superficial Bladder Cancer

Personal insights from Dr. Michael A. O'Donnell, principal investigator of BCG/interferon trials

Dear Colleague:

More than half of all patients with superficial bladder cancer will experience a recurrence following primary treatment. In such cases, physicians must make what is often a difficult decision regarding whether the risk of progression is too great—or whether the efficacy of remaining conservative treatment options is too small—to allow the patient to keep his or her bladder. In this *Tx Reporter*, the fourth in this series on intravesical immunotherapy, I help physicians work through this decision process, taking into account prognostic factors (eg, stage and grade of disease), prior treatment history, and timing of recurrence. Some of the excellent questions I have received from colleagues like yourselves addressed issues such as how many courses of induction therapy to offer if disease is still present after the first course, the optimal timing between a failed course of bacillus Calmette-Guérin (BCG) monotherapy and retreatment with BCG/interferon, how to recognize and treat a recurrence following BCG/interferon, and how to use immunotherapy regimens in the upper urinary tract. I am happy to share my answers to these and other related questions with you in this final part of the *Tx Reporter* series, *FAQs on Intravesical Immunotherapy for Superficial Bladder Cancer*. I hope that this series has helped you to better understand the use of immunotherapy and to improve your patient care.

Sincerely,

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Now available at www.projectsinknowledge.com:

- Part 1:** Current data on BCG/interferon combination therapy and their implications, including its relative benefits over BCG alone, its placement in current treatment algorithms, and the selection of appropriate treatment candidates
- Part 2:** The recommended protocol for dosing and administration for BCG-naïve patients and those with a prior history of BCG/interferon therapy. Includes protocols for induction, reinduction, and maintenance therapy, as well as dose reductions for side effects
- Part 3:** Safety issues and side effects management, including management of BCG cystitis, rash, hematuria, BCG sepsis, and other side effects

VOLUME II • PART 4

Inside This **REPORTER**SM

- Treatment of recurrence following BCG/interferon induction therapy
- Recognition of invasive "stealth recurrence" in patients without superficial disease
- BCG/interferon following recurrence of carcinoma in situ (CIS) in BCG-treated patient
- Treating recurrences following BCG/interferon as initial therapy
- Recurrence in a patient with partial cystectomy
- Positive cytology with negative or only "suspicious" cystoscopy and negative biopsy
- BCG/interferon for recurrence in the upper urinary tract
- Determining when to offer cystectomy

Did You Know?

- Vigorous activity in men decreases the risk of total cancers, prostate cancer, and upper digestive and stomach cancer, but *increases* the risk of bladder cancer.
- Use of permanent hair dye is a significant, independent risk factor for bladder cancer in women, which may be mediated by genetic susceptibility: In women with the phenotypes associated with slow metabolism of arylamines (NAT2 slow, NAT1 slow, and CYP1A2 slow), exclusive permanent hair dye use was associated with a greatly increased (2.5- to 6.8-fold) risk of bladder cancer.
- Spinal cord injury and indwelling catheter use are associated with increased risk of bladder cancer and bladder cancer-related mortality.
- An association with bladder cancer (as well as kidney failure) has been found among people who took the Chinese herb *Aristolochia fangchi* as part of a weight loss program.
- Men can reduce their risk of bladder cancer by drinking more water (at least 6 cups a day) and eating more cruciferous vegetables (specifically, broccoli and cabbage).

Sources: Wannamethee SG, et al. *Br J Cancer*. 2001;85:1311. Gago-Dominguez M, et al. American Association for Cancer Research's 93rd Annual Meeting, April 6-10, 2002; poster session. Groah SL, et al. *Arch Phys Med Rehabil*. 2002;83:346. www.cancer.org. Michaud DS, et al. *N Engl J Med*. 1999;340:1390. Michaud DS, et al. *J Natl Cancer Inst*. 1999;91:605.



Learning Objectives

This educational activity is designed to update urologists on the latest developments in the use of intravesical immunotherapy for treatment of superficial bladder cancer.

After participating in this activity, physicians will be better able to:

- Consider the latest data regarding BCG/interferon combination therapy when formulating treatment plans for patients with superficial bladder cancer
- Select appropriate candidates for BCG/interferon combination therapy and BCG monotherapy
- Formulate a treatment plan using immunotherapy that includes appropriate doses and treatment intervals
- Prevent and manage toxicities associated with BCG and interferon
- Diagnose and treat recurrences of superficial bladder cancer following an initial course of immunotherapy

CME Information

Projects In Knowledge is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Estimated time for completion of this four-part activity: 1 hour. Projects In Knowledge designates this four-part educational activity for up to 1 hour in Category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours that he/she actually spent in the educational activity.

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This activity may include a discussion of therapies that are unapproved for use or investigational, ongoing research, or preliminary data.

The opinions expressed during this activity are those of the faculty and do not necessarily reflect those of the sponsor or the commercial supporter.

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Introduction

Following standard treatment for superficial bladder cancer, recurrence rates are generally about 50% to 75%.

Although recurrences are usually the same grade and stage, progression to invasive disease occurs in 16% to 25% of recurrences among patients who initially had low-grade tumors. The prognosis for any patient with progressive or recurrent invasive bladder cancer is generally poor.

Risk factors for recurrence and progression include a history of multiple, frequent recurrences; papillary lesions with a thick stalk or sessile appearance; large (>5 cm) or multiple (>3) tumors; incomplete transurethral resection (TUR); stage T1 or Tis disease; and grade III disease. In addition, adverse prognostic features associated with a great risk of disease progression include the presence of multiple aneuploid cell lines, nuclear p53 overexpression, and expression of the Lewis-x blood group antigen.

Prevention of recurrence and progression are primary goals of initial treatment. Compared with TUR alone, TUR plus adjuvant intravesical immunotherapy with BCG has been shown to delay progression to muscle-invasive and/or metastatic disease, improve bladder preservation, and possibly even decrease the risk of death from bladder cancer. BCG maintenance therapy appears to further lower the risk of recurrence and disease worsening. Efficacy of BCG/interferon versus BCG monotherapy as first-line adjuvant therapy is currently being investigated.

Any recurrent bladder cancer in a patient who has been treated with BCG at any time in the past is considered a BCG failure. Upon detection of recurrence, physicians and patients must decide between additional bladder-sparing conservative therapies and cystectomy. Treatment choices are based on prognostic factors (particularly grade and stage), timing of recurrence, and patient preference. In patients who have already failed a course of BCG monotherapy, Dr. O'Donnell's research shows that BCG/interferon is associated with a

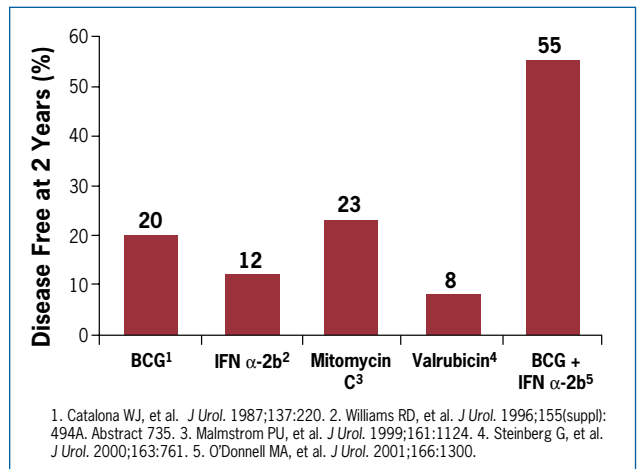


Figure 1. BCG/Interferon in BCG Failures: Efficacy Comparison with Historical Series. Source: O'Donnell M, et al. *J Urol*. 2001;166:1303.

55% recurrence-free survival rate at 2.5 years, which compares favorably with the efficacy of other available treatment options in historical series (Figure 1).

In this *Tx Reporter*, Dr. O'Donnell answers questions about some of the difficult decisions physicians commonly have to make in diagnosing and treating recurrences among patients initially treated with intravesical immunotherapy.

Q. If you see a recurrence by cystoscopy following induction therapy with BCG/interferon, do you still proceed with maintenance therapy, repeat induction therapy, or stop treatment?

Dr. O'Donnell: If a recurrence is observed, the tumor should be removed if it is physically visible and accessible. If it arises at the first evaluation cystoscopy, and there has been no progression in tumor stage, and it is not stage T1, grade III, then the patient should be considered for reinduction. Otherwise, treatment should be stopped and other options, including cystectomy, considered. Classically, reinduction has involved repeating a 6-week regimen of BCG/interferon (see protocol described in Part 2 of this series), although there is a move to compress this to 3 weeks so that it resembles a typical maintenance cycle. Perhaps two 3-week cycles separated by a 4-week rest will be even more rational, based on early immune response data. However, studies comparing various reinduction schedules—6-week versus 3-week, versus two cycles of 3-week dosing—have not yet been performed. If a recurrence develops

during active maintenance therapy, then a further attempt at reinduction is not generally recommended.

Q. Do BCG/interferon treatment failures present any differently than BCG monotherapy failures?

Dr. O'Donnell: The cystoscopic and biopsy results are generally the same for recurrences following BCG/interferon as for BCG monotherapy—with one possible exception. In two cases out of about 100 patients treated, we observed a complete surface urothelial response to BCG/interferon after a deep or extensive resection with normal cytology and normal surface urothelium, but with submucosal “mounding” of tumor. This “stealth recurrence,” as I call it, probably represents growth of a submucosal/intramural nest of tumor after complete healing of the surface. This is not unique to BCG/interferon—I have also seen this with standard BCG treatment alone, albeit more rarely.

Both of my patients with stealth recurrence had the aggressive micro-papillary type of high-grade cancer in their initial superficial presentations. CT scans in these patients were equivocal. In one case, a deep TUR biopsy showed disease in the muscle but not in the mucosa. In the other case, I explored and found cancer wrapped around the ureters. A cystectomy was performed, and it was confirmed that there was no mucosal involvement. (The mucosa had apparently been sterilized by the intravesical BCG/interferon where topical contact had been made.) In both cases, these hidden tumors were revealed by the later development of bilateral ureterovesicle junction obstruction and hydronephrosis. Unfortunately, both patients ultimately died of their disease, which had moved extensively and rapidly up the ureters.

Q. The pathology report from a biopsy done on first follow-up cystoscopy after BCG/interferon reads “nephrogenic adenoma, focal irritation, and squamous metaplasia. No evidence of urothelial neoplasia.” Should I do reinduction or maintenance therapy?

Dr. O'Donnell: Continue with maintenance therapy. This is a benign lesion caused by chronic inflammation. I had a similar patient who has had a complete response that has been durable for over

4 years now. Others have reported similar findings with BCG alone.

Q. About 2.5 months following a 6-week course of BCG, a patient's bladder exhibited some “fuzziness” on follow-up cystoscopy, and cytology was positive. How long should I wait before re-treating with BCG/interferon?

Dr. O'Donnell: This sounds like CIS. I would biopsy the suspicious areas and the prostatic urethra, and perform random biopsies as well for reassurance that the positive cytology is resulting from recurrence in the bladder and not elsewhere. An upper tract evaluation should be done if one was not performed within the last 12 months. Three weeks later, I would initiate retreatment with 1/3-dose BCG plus 50 mIU interferon weekly for 6 weeks. After another 6 weeks, the patient should be reassessed by cystoscopy with repeat biopsies and with a repeat cytology a few days before the procedure to help guide the rigorosity of subsequent biopsies.

Q. I treated a 52-year-old patient who had high-grade, multifocal bladder cancer with full-dose BCG plus 50 mIU interferon for 6 weeks (he was BCG naive). Follow-up cystoscopy shows that disease is still present. Cystectomy is not an option at this time. What should I do next?

Dr. O'Donnell: I would resect all visible disease, apply one dose of immediate perioperative mitomycin C (40 mg in 40 cc saline) for 1 hour, then re-treat this patient with 1/10-dose BCG and 100 mIU interferon beginning about 3 weeks later. (Even 1/3-dose BCG is hard to tolerate and shows early immune suppression after the first 3 treatments.) I also recommend rofecoxib 25 mg/d throughout the treatment period for up to 1 week prior to the follow-up cystoscopy with biopsies. I have some early evidence that rofecoxib or other COX-2 inhibitors may further enhance the effects of both BCG and interferon by decreasing production of the immune-suppressing prostaglandin PGE2. The 12-month disease-free response rate in such cases is about 40%.

Q. A patient who had a partial cystectomy (dome of the bladder) now has a recurrence of CIS. How should I treat this?

Dr. O'Donnell: First, I would recommend a CT scan and a chest x-ray to make sure there has been no recurrence outside the bladder, local extension, affected lymph nodes, or metastases. The bladder should be sampled with biopsies that include muscle around the margins of the partial cystectomy to make sure there is no disease lurking deeper in the muscle margin. If it looks like there is only superficial disease in the bladder, then it should be treated with appropriate intravesical therapy. My choice for CIS would be BCG/interferon combination therapy, particularly if the patient had failed prior BCG. I would treat according to our study protocol, including the maintenance plan (see Part 2 of this series). Although I do not generally recommend having the patient rotate positions during treatment, I do have patients with dome lesions lie on their bellies for 15 to 30 minutes while retaining the drug so it achieves good contact with the dome. The remainder of the 2-hour dwell time can be spent moving around in normal activity. The bladder should be reassessed with cystoscopy, bladder wash cytology, and random biopsies at about 6 weeks after completion of the 6-week course of treatment. If this assessment is negative, then maintenance therapy should be initiated. If the assessment is positive but there are some signs of improvement, then repeat another 6-week cycle, reducing the BCG dose to 1/10 in combination with 100 mIU interferon. Following that, if the patient is the same or worse, then a cystectomy may be the only safe option left.

Q. Following induction therapy, a patient had a “suspicious area” observed on follow-up cystoscopy, but biopsy of the area was negative. Does this still constitute a recurrence that requires reinduction, or can I proceed with maintenance therapy?

Dr. O'Donnell: Visually “false positive,” red, raised areas often turn out to be BCG granulomas. With practice, most of these can be recognized, but if there is doubt, a biopsy will reveal the correct diagnosis. Results from the actual pathology take precedence over any suspicious findings, visually or cytologically. The only exception is when the cytology is *positive* for cancer. In that case, even if the biopsy

were negative, I would consider the case a recurrence and repeat the biopsy or look elsewhere for sources of the positive cytology (eg, the upper urinary tract and prostate).

If the positive cytology is localized to the upper tract, then treatment of the upper tract is recommended (see next question below). If the prostatic urethra is positive, then circumferential TUR (superficial mucosa, then deep layer) should be done, keeping the specimens separate. If cancer is present in the ducts or surface epithelium, then the patient should be re-treated with 1/10-dose BCG plus 100 mIU interferon 4 weeks post-TUR. If cancer has invaded the prostatic stroma, then radical cytoprostatectomy is required.

Q. Do you use BCG/interferon to treat a recurrence that involves upper tract disease, and if so, how is it administered?

Dr. O'Donnell: I have a very specific protocol for upper tract instillation via temporary 4-Fr external ureteral stents, placed weekly. The stent is tied onto a Foley catheter with simple silk sutures. Treatment consists of 1/10-dose BCG plus 100 mIU interferon for 6 weeks followed by at least one set of three weekly maintenance administrations. The BCG/interferon is mixed in a 50-cc bag and administered as a slow gravity microdrip (1 drop/2 sec, or ~25–30 cc/h, at a height of ~20–25 cm above the renal pelvis; do not use a pump, which may cause high pressure) with the patient lying on a stretcher. Once the medication is all in, deflate the Foley balloon, and remove the Foley and attached external stent/catheter. The patient may then be discharged home. Our success rate with this regimen in 19 renal units (most with CIS) is 79%. I use a 4-Fr catheter to instill the BCG/interferon because it splints open the ureter, allowing the fluid medication to flow upward like a fountain, yet trickle down alongside the stent, ensuring both low pressures and bathing of the entire upper tract system, including the ureter.

A 6-Fr catheter should not be used because it occludes the ureter, forcing the kidney to develop high-pressure peristaltic waves to push the fluid around the stent. This greatly increases the chance of pyelovenous backflow and the likelihood that the BCG will be pushed into the circulation, causing potentially fatal BCG sepsis.

I use formal anesthesia for the first session to fully evaluate the anatomy and estimate the degree of difficulty in getting the stents in place. During this first session, I use fluoroscopy and contrast injection to determine the proper stent insertion length to nearly reach the midrenal pelvis. Thereafter, I do not routinely use fluoroscopy but simply advance the stents to the predetermined length up the ureters. Most women need no anesthesia or only lidocaine jelly, since passing the 4-Fr stent over the 0.018-inch slippery Glidewire™ (Boston Scientific Corporation) can be done atraumatically through a standard rigid cystoscope in about 5 minutes. Many older men can also tolerate the procedure under local anesthesia, but light to moderate intravenous sedation can be given if needed. Alternatively, men can be premedicated with two oxycodone/acetaminophen tablets and 30 mg of a short-acting benzodiazepine such as oxazepam 1 hour prior to the procedure, which takes about 10 minutes in men.

You might also consider adding oral rofecoxib (or another COX-2 inhibitor) and Oncovite™ Antioxidant Multi-vitamin tablets, given daily beginning 1 day before the first treatment and continued up to 1 week prior to the reevaluation cystoscopy with retrograde and ureteral washings. Oncovite can be continued as long as clinical response is occurring. The COX-2 inhibitor can be reinitiated if/when the maintenance course resumes.

Q. When and how do you decide to stop intravesical therapy and recommend cystectomy?

Dr. O'Donnell: Although bladder preservation is clearly preferable to cystectomy, this should not override patient survival and curative potential. In light of this, there are several guidelines for when to recommend cystectomy:

- I usually give stage T1, grade III only one course of BCG/interferon induction therapy, particularly if the patient has failed prior BCG therapy. In other words, if similar aggressive disease is present at first follow-up cystoscopy, I would advocate cystectomy at that point rather than reinduction.
- For CIS; stage T1, grade II; and Ta, grade III, I do offer reinduction if there is early treatment failure without disease progression after one course of induction therapy. I recommend cystectomy if there is a second failure after reinduction, or a failure with similar disease during active maintenance therapy. Such patients should be considered BCG/interferon resistant.
- For less aggressive tumors (eg, Ta, grade I–II), I rarely advocate cystectomy even after two failures on BCG/interferon. Rather, I would suggest a trial of another agent (eg, mitomycin C or an investigational regimen).
- Intravesical immunotherapy is usually discontinued if a recurrence develops during maintenance therapy. However, occasionally, I continue a “maintenance” type of treatment even if disease has not been completely eliminated but shows clear improvement with each cycle, leading one to expect that improvements might increase if therapy continues.

If one follows these guidelines, it has been my own experience and has been reported by others that the risk of metastasis at the time of “delayed” cystectomy is still negligible. TX

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FAQs on Intravesical Immunotherapy for Superficial Bladder Cancer

CME Instructions

This activity comprises four parts to be sent to you throughout the year. To earn credit, you must read and complete all four parts. To receive documentation of your participation in this four-part CME activity for a total of 1 hour of CME credit, please complete the following steps:

1. Read each newsletter.
2. Complete the CME posttest included in each of the four parts.
3. Mail or fax each of the completed posttests to Projects In Knowledge, One Harmon Plaza, Secaucus, NJ 07094; fax: 1-201-617-7333.
4. After reading the final part, complete the CME evaluation survey contained therein.
5. Mail or fax your final posttest and the CME evaluation survey to Projects In Knowledge at the address and fax number above.

CME Certificate

At the end of the series, Projects In Knowledge will mail you a certificate of completion for this activity if your combined score for all four posttests is 70% or higher. If your combined score is lower than 70%, you will be notified by mail and given an opportunity to take a single test covering information from all four parts.

Name _____ Degrees/Credentials _____

Mailing Address _____

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Please indicate your answers below (circle one):

1. In historical series of patients with a history of BCG failures, which of the following options for retreatment offers the highest recurrence-free survival rate at 2 years?
 - a. Mitomycin C
 - b. Valrubicin
 - c. Repeat BCG therapy
 - d. BCG/interferon
2. For a patient with high-grade, multifocal disease who fails first-line induction therapy with full-dose BCG and 50 mIU interferon, Dr. O'Donnell recommends resection of visible disease and one dose of mitomycin C, then:
 - a. 1/3-dose BCG + 50 mIU interferon
 - b. 1/10-dose BCG + 100 mIU interferon + rofecoxib 25 mg/d
 - c. A second course of full-dose BCG and 50 mIU interferon
 - d. Stopping immunotherapy and re-treating with interferon and mitomycin C
3. When administering BCG/interferon into the upper urinary tract, what size catheter should be used as a ureteral stent?
 - a. 4-Fr
 - b. 6-Fr
4. Dr. O'Donnell generally recommends cystectomy for all of the following patients *except*:
 - a. Patient with stage T1, grade III who has failed a single course of BCG/interferon induction therapy
 - b. Patient with CIS who has failed BCG/interferon induction and reinduction therapy
 - c. Patient with Ta, grade II disease who has failed BCG/interferon induction and reinduction therapy
 - d. Patient with T1, grade II disease who develops recurrence with similar disease during the maintenance cycle of BCG/interferon



FAQs on Intravesical Immunotherapy for Superficial Bladder Cancer

Name

CME Evaluation Survey

Instructions

Please complete this survey, along with the CME Posttest, and mail or fax (both sides) to Projects In Knowledge, One Harmon Plaza, Secaucus, NJ 07094; fax: 1-201-617-7333.

1. Please rate the extent to which you achieved the learning objectives:
- | | <i>Excellent</i> | <i>Very Good</i> | <i>Good</i> | <i>Satisfactory</i> | <i>Poor</i> |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| • Consider the latest data regarding BCG/interferon combination therapy when formulating treatment plans for patients with superficial bladder cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Select appropriate candidates for BCG/interferon combination therapy and BCG monotherapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Formulate a treatment plan using immunotherapy that includes appropriate doses and treatment intervals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Prevent and manage toxicities associated with BCG and interferon | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Diagnose and treat recurrences of superficial bladder cancer following an initial course of immunotherapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. Please rate the overall value of this enduring material:
- | | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. Course was free from commercial bias:
- | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| If you "Disagree" or "Strongly Disagree," why? | | | | |
| | | | | |

4. Please rate the level of the material presented:
- | | <i>Just Right</i> | <i>Too Advanced</i> | <i>Too Basic</i> |
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| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

5. Please list any changes in your practice that you would consider making as a result of participating in this activity:
-
-
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6. Please rate your interest in self-directed or distance learning in the following formats:
- | | <i>Very Interested</i> | <i>Moderately Interested</i> | <i>Not Interested</i> |
|--|--------------------------|------------------------------|--------------------------|
| a. Audioconference | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Videoconference | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Enduring materials (audiocassettes, videotapes, monographs) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Internet (on-line discussions with experts, educational activities) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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Education Initiative in Urology

THE TREATMENT REPORTERSM UROLOGY

CME Evaluation
(continued)

FAQs on Intravesical Immunotherapy for Superficial Bladder Cancer

Name

7. Please tell us how long it took you to complete this course:

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8. Please list topics and/or experts you would find interesting and professionally relevant for future CME activities:

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9. Follow-up:

As part of our ongoing continuous quality-improvement effort, we conduct postactivity follow-up surveys to assess the impact of our CME courses on professional practice. Please indicate your willingness to participate in such a survey:

Yes, I would be interested in participating in a follow-up survey.

No, I'm not interested in participating in a follow-up survey.

Additional comments about this activity:

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Thank you for your participation.