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The Uromigos Score in Asian Countries: A Regional Analysis of Expert Treatment Preferences in Genitourinary Oncology

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Abstract

Background

The Uromigos is a global genitourinary (GU) oncology initiative that developed the Uromigos Score, a 0–3 scale quantifying clinical expert support for treatment options across advanced GU cancer disease states. The perspectives of Asian clinicians have not been systematically analyzed as a distinct cohort. We characterized the Uromigos Score among Asian GU oncology experts and compared it with global expert opinion.

Methods

GU oncology experts from across Asia, predominantly Japan, scored treatment options across seven disease states in urothelial and prostate cancer using the same four-point scale as the global panel (3 = undisputed standard of care [SOC]; 2 = potentially inferior but reasonable; 1 = limited role; 0 = should be avoided). Mean scores were computed and compared descriptively with the global cohort.

Results

Broad consensus was observed across most disease states. Enfortumab vedotin plus pembrolizumab received the maximum score (3.0) from both cohorts in first-line advanced urothelial cancer, and androgen deprivation therapy (ADT) plus an androgen receptor pathway inhibitor was near-undisputed SOC for metastatic hormone-sensitive prostate cancer. Notable regional differences included higher scoring by Asian experts of ADT monotherapy (0.9–1.6 vs 0.1–0.9) and lutetium-177–PSMA therapy (2.4–2.8 vs 1.8–2.4), higher scoring of BCG plus durvalumab in papillary high-risk NMIBC without CIS (2.3 vs 1.5), and lower scoring of disitamab vedotin plus toripalimab (1.9 vs 2.5).

Conclusion

Asian and global expert opinion align across most GU cancer disease states. Several regional differences likely reflect differential drug availability, regulatory timelines, and practice patterns, and identify areas warranting Asia-specific evidence generation.

Introduction

The Uromigos is a GU oncology educational initiative founded in early 2017 by Brian Rini (Vanderbilt-Ingram Cancer Center, Nashville, USA) and Thomas Powles (Barts Cancer Institute, London, UK), with the mission of delivering balanced, evidence-based content on urologic malignancies and representing diverse viewpoints from the global GU oncology community [1]. Since the launch of its dedicated podcast in early 2020, the platform has grown rapidly, accumulating over 500 episodes and over 500,000

total listens. The first live Uromigos meeting was held in Nashville in late 2022, cementing the initiative as a respected forum for international GU oncology discussion.

Despite the availability of clinical practice guidelines from the European Association of Urology (EAU), the American Society of Clinical Oncology (ASCO), and the National Comprehensive Cancer Network (NCCN), treatment decisions in advanced GU malignancies remain complex and patient-centered [2–5]. In addition, several Asian countries and regions have developed their own clinical practice guidelines, which are widely used to inform treatment decision-making in local practice. Guideline recommendations do not always reflect the nuanced clinical conviction of practicing oncologists, particularly when multiple options carry similar levels of endorsement despite meaningful differences in real-world impact. The Uromigos Score was developed to quantify clinical expert support for specific treatment options in a manner that complements binary guideline endorsement.

The scoring exercise has been conducted among a global expert panel from 13 countries spanning the Americas, Europe, and Asia-Pacific [1]. However, the perspectives of Asian clinicians—particularly those practicing in Japan, where treatment paradigms, drug approval timelines, and clinical practice patterns may differ from Western settings [6, 7]—have not been systematically analyzed as a distinct cohort. The present study reports the Uromigos Score among Asian GU oncology experts, predominantly from Japan, and provides a comparative analysis against global expert opinion across key disease states in urothelial cancer and prostate cancer.

Materials and methods

Scoring framework

The Uromigos Score quantifies clinical expert support for individual treatment options across predefined advanced GU cancer disease states. All patients were assumed to be fit, eligible, and appropriate for the treatment options listed, without contraindications, personal preferences, or limitations related to drug availability or funding. Each expert scored each treatment on a four-point scale: 3, “undisputed standard of care (SOC)”; 2, “potentially inferior to SOC, but a reasonable option”; 1, “has a limited role”; and 0, “should be avoided.”

The mean score across all respondents in each cohort is presented. Score ranges were categorized as follows: ≥2.5, universally undisputed SOC; 1.5–2.4, potentially inferior but reasonable; 0.5–1.4, limited role; and <0.5, should not be used.

Expert panels

The global expert panel comprised GU oncologists and urologists from 13 countries. Americas: Rahul Aggarwal, Alan Bryce, Ana Aparicio, Arun Azad, Neeraj Aggarwal, Fernando Maluf, Denis Jardin, Maha Hussein, Michael Morris, Tanya Dorff, and Brian Rini. Europe: Nick James, Rob Jones, Bertrand Tombal,

Yuksel Urun, Elena Castro, Silke Gillessen, Axel Merseburger, Consuelo Buttigliero, and Maria De Santis. Asia-Pacific: Chris Sweeney, Ravi Kanesvaran, Ian Davis, and Hiroshi Kitamura.

The Asian expert cohort consisted predominantly of Japanese urologists and oncologists identified through the authors of the Pan-Asian ESMO Clinical Practice Guidelines [8], the Japan Clinical Oncology Group, and associated academic networks; for the prostate cancer disease states, the panel also included experts from several other Asian countries. Prostate cancer contributions included Ravindran Kanesvaran (Singapore), Alvin Wong (Singapore), Melvin M. L. Chua (Singapore), Yanju Zhu (China), Hemant Malhotra (India), Yuji Miura (Japan), Jae Lyun Lee (Korea), Flora Li Tze Chong (Malaysia), Yeong-Shiau Pu (Taiwan), Chueh-Chuan Yen (Taiwan), Marniza Saad (Malaysia), Hyo Jin Lee (Korea), Hiroshi Kitamura (Japan), Kumar Prabhash (India), Qin Zou (China), Eileen Poon (Singapore), Su Pin Choo (Singapore), and Elaine Lim (Singapore). Urothelial cancer contributors (all Japanese) included Makito Miyake, Rikiya Taoka, Shuichi Tatarano, Takeshi Sano, Yuki Kita, Ryoichi Saito, Syuichi Morizane, Yusuke Ito, Junichi Inokuchi, Takashi Yoshida, and colleagues. Prostate cancer contributors (all Japanese) included Masaki Shiota, Takayuki Sumiyoshi, Toyonori Tsuzuki, Hiromi Sato, Shinro Hata, Takuma Kato, Yoichiro Tohi, Shigehiro Tsukahara, and colleagues. All respondents participated independently using the same scoring instrument and assumptions as the global panel. The global panel scored in October 2025, whereas the Asian panel scored in March 2026.

Disease states evaluated

Seven disease states were evaluated: first-line locally advanced/metastatic urothelial cancer (1L la/mUC); perioperative treatment for cisplatin-eligible muscle-invasive bladder cancer (MIBC); perioperative treatment for cisplatin-ineligible MIBC; previously untreated high-risk non-muscle-invasive bladder cancer (NMIBC); metastatic hormone-sensitive prostate cancer (mHSPC; four clinical scenarios, metachronous/synchronous × low-volume/high-volume); metastatic castration-resistant prostate cancer (mCRPC) after ADT + ARPI without prior docetaxel (three genomic subgroups: no HRR/unknown; HRR non-BRCA; BRCA1/2); and mCRPC after ADT + ARPI + docetaxel (same three genomic subgroups).

Statistical analysis

Because individual-level score distributions were not collected, formal hypothesis testing of between-cohort differences (e.g., Mann–Whitney U or t-test) could not be performed, and global-versus-Asian comparisons are therefore descriptive rather than inferential. Differences were characterized using the pre-specified score-range categories described above, and a difference of ≥0.5 points between cohorts was used as a heuristic threshold for highlighting a notable regional difference. This approach is consistent with prior Uromigos Score publications [1] and reflects the nature of expert-opinion scoring exercises, but it means that apparent differences should be interpreted as descriptive trends rather than statistically confirmed effects.

Results

Prostate cancer—mHSPC

Across all four mHSPC scenarios, ADT plus an ARPI received scores of 2.6–3.0 from both cohorts, reflecting near-universal endorsement as standard of care (Table 1). In synchronous high-volume disease, ADT + ARPI + docetaxel was rated undisputed SOC by both groups (global 2.9; Asian 3.0), consistent with landmark trials including TITAN, ARCHES, ENZAMET, and ARASENS [9–12]. In metachronous low-volume disease, however, ADT + ARPI + docetaxel received markedly lower scores (global 0.6; Asian 1.9), reflecting the lack of evidence for triple therapy in this lower-risk scenario.

A notable divergence was observed for ADT monotherapy: global experts scored it 0.1–0.9 across scenarios, while Asian experts scored it 0.9–1.6, most notably in metachronous low-volume disease (global 0.9; Asian 1.6). This persistent gap likely reflects residual prescribing of ADT alone in parts of Asia attributable to historical practice patterns and drug access considerations. Radiotherapy to the prostate received meaningful endorsement only in the synchronous low-volume setting (global 2.5; Asian 2.7), consistent with STAMPEDE and HORRAD data [13, 14]. Scores were 0.0 in metachronous scenarios in both cohorts, and 1.1 (global)/1.4 (Asian) in synchronous high-volume disease.

Prostate cancer—mCRPC after ADT + ARPI (no prior docetaxel)

In patients progressing on ADT + ARPI without prior docetaxel, docetaxel was highly rated across all three genomic subgroups by both cohorts (Table 2). Notably, in BRCA1/2-mutated disease, docetaxel scored lower globally (2.1) than in other subgroups, likely reflecting the availability of PARPi as a preferred option in this genomically defined population; Asian experts scored docetaxel at 2.7 even in BRCA1/2-mutated patients.

Lutetium-177 (^{177}Lu)-PSMA therapy was scored notably higher by Asian experts (2.4–2.7) than by global experts (1.8–2.4) across all subgroups, with the greatest difference in the no-HRR/unknown subgroup (global 2.4; Asian 2.7), which likely reflects Japan's relatively early adoption of PSMA-based theranostics and growing institutional experience and reimbursement support for this modality. In BRCA1/2-mutated disease, PARPi monotherapy received near-unanimous scores of 2.8 from both cohorts [16, 17]. PARPi plus ARPI combinations were scored more modestly overall (0.7–1.9), reflecting selective rather than universal adoption. In the HRR non-BRCA subgroup, a clinically meaningful divergence was observed: PARPi plus ARPI was scored 1.5 (reasonable) globally versus 0.9 (limited) by Asian experts, and PARPi monotherapy was similarly scored 1.5 globally versus 0.9 in Asia, suggesting more conservative adoption of PARPi-based strategies in HRR non-BRCA disease among Asian clinicians.

Prostate cancer—mCRPC after ADT + ARPI + docetaxel

Global comparator data were not available for this disease setting; accordingly, only Asian cohort scores are reported (Table 3). In heavily pretreated patients with prior ADT + ARPI + docetaxel, ^{177}Lu-PSMA therapy and cabazitaxel emerged as the leading options across all three genomic subgroups among Asian experts. Asian experts scored ^{177}Lu-PSMA at 2.6–2.8 and cabazitaxel at 2.7–2.9. In BRCA1/2-

mutated disease, PARPi monotherapy received a score of 3.0 from Asian experts—reflecting undisputed SOC status in this genomically defined population [16, 17]—while PARPi scored 1.1 in HRR non-BRCA and 0.4 in the no-HRR/unknown subgroup. ARPI switch was uniformly scored 0.9 across all subgroups, confirming limited clinical utility.

Urothelial cancer—first-line la/mUC

EV plus pembrolizumab in unselected patients received a perfect mean score of 3.0 from both global and Asian experts, confirming universal consensus as undisputed SOC (Table 4), reflecting the landmark EV-302/KEYNOTE-A39 trial [18]. Pembrolizumab monotherapy for patients unfit for antibody-drug conjugate (ADC) or platinum therapy was scored 1.7 globally and 1.8 in Asia.

A notable regional divergence was observed for disitamab vedotin plus toripalimab in HER2-positive urothelial cancer: global 2.5 versus Asian 1.9. Recent ESMO 2025 data (Guo J, et al.) demonstrated improved progression-free and overall survival for this regimen versus chemotherapy in first-line HER2-positive metastatic urothelial carcinoma, with a markedly lower rate of grade ≥3 treatment-related adverse events (55.1% vs 86.1%). The lower Asian score likely reflects limited regulatory availability and clinical familiarity with this agent outside China at the time of scoring. Cisplatin-based chemotherapy with sequenced avelumab scored 1.2 globally and 1.6 in Asia, while platinum-based chemotherapy for cisplatin-ineligible/unfit patients scored 1.0 globally and 1.2 in Asia—both reflecting limited relevance in the era of EV + P.

Urothelial cancer—perioperative treatment for cisplatin-eligible MIBC

For cisplatin-eligible MIBC, perioperative EV + pembrolizumab scored 2.5 globally and 2.8 among Asian experts (Table 5). Neoadjuvant cisplatin-based chemotherapy with perioperative durvalumab received identical scores from both groups (2.7). Neoadjuvant cisplatin chemotherapy with adjuvant atezolizumab in ctDNA-positive patients scored 2.1 globally and 1.7 in Asia. Adjuvant nivolumab regardless of ctDNA or PD-L1 status was scored 1.6 globally and 1.8 in Asia. Cystectomy or trimodality therapy alone received the lowest scores of any regimen (global 0.6; Asian 1.1), reflecting broad consensus that local treatment without systemic intensification is no longer adequate.

Urothelial cancer—perioperative treatment for cisplatin-ineligible MIBC

For cisplatin-ineligible MIBC, perioperative EV + pembrolizumab achieved maximum endorsement: 2.9 globally and 3.0 among Asian experts (Table 6), making it the only regimen to reach undisputed SOC status in this setting. A ctDNA-guided modification of the perioperative EV + P approach scored 2.0 in both cohorts. Adjuvant nivolumab/pembrolizumab regardless of ctDNA/PD-L1 was scored 1.5 globally and 1.1 in Asia. A ctDNA/PD-L1-guided adjuvant immune checkpoint inhibitor (ICI) approach was scored 1.3 globally and 1.8 in Asia, suggesting Asian experts place somewhat greater value on biomarker-guided ICI escalation.

Urothelial cancer—high-risk NMIBC

In previously untreated high-risk NMIBC, BCG plus sasanlimab (2 years) scored 2.3 globally and 2.5 in Asia for the overall high-risk population, with identical scores in the CIS-positive/mixed papillary subgroup (Table 7). BCG plus durvalumab (1 year) was scored 2.2 globally and 2.3 in Asia for the overall high-risk NMIBC population. A clinically meaningful regional difference was observed for BCG plus durvalumab specifically in papillary high-risk NMIBC without CIS: global 1.5 versus Asian 2.3. BCG induction and maintenance alone received robust scores in both cohorts (global 2.2; Asian 2.4), affirming that traditional BCG therapy remains a relevant standard even in the era of ICI combinations.

Discussion

This analysis demonstrates a high degree of alignment between Asian and global GU oncology expert opinion on leading treatment options across advanced urothelial cancer and prostate cancer. The unanimous endorsement of EV plus pembrolizumab in 1L la/mUC and near-universal support in cisplatin-ineligible MIBC, irrespective of geography, reflects the strength of the evidence base supporting ADC-based regimens [18, 19]. Similarly, the strong consensus on ADT + ARPI as the cornerstone of mHSPC management aligns with multiple international guidelines and landmark trials [9–12].

The higher scoring of ADT monotherapy among Asian experts in mHSPC is a clinically relevant observation. The gap is most prominent in metachronous low-volume disease (global 0.9; Asian 1.6) and remains evident across all scenarios. This likely mirrors residual prescribing of ADT alone in parts of Asia due to reimbursement constraints, regulatory timelines, and historical prescribing habits [6, 7]. As ARPIs become more broadly accessible across Asian healthcare systems, this divergence is expected to narrow.

The consistently higher enthusiasm for ^{177}Lu-PSMA therapy among Asian experts in mCRPC is particularly striking. In the post-ADT + ARPI setting, ^{177}Lu-PSMA was scored 2.4–2.7 by Asian experts versus 1.8–2.4 globally; in the post-ADT + ARPI + docetaxel setting, Asian experts scored it 2.6–2.8. Japan has been among the early adopters of PSMA-based diagnostics, and the increasing institutional experience with theranostics and improving reimbursement may explain this regional enthusiasm [15].

The divergence in scoring of disitamab vedotin plus toripalimab in HER2-positive urothelial cancer (global 2.5 vs Asian 1.9) reflects a geographic and regulatory asymmetry. While the data [20] demonstrate compelling clinical activity, this agent has been approved primarily in China with a limited regulatory footprint across the broader Asia-Pacific region at the time of scoring. Conversely, the higher scoring of cisplatin-based chemotherapy plus sequenced avelumab by Asian experts (1.6 vs 1.2 globally) may reflect continued clinical familiarity with this approved regimen in settings where newer options remain less accessible.

The higher scoring of BCG plus durvalumab in papillary high-risk NMIBC without CIS among Asian experts (2.3 vs 1.5 globally) warrants investigation. CIS-negative papillary high-risk NMIBC is a distinct

entity, and regional differences in pathological classification, BCG availability, and ICI experience may contribute to divergent scoring in this subgroup.

Several limitations should be acknowledged. As noted above, formal statistical significance testing of global-versus-Asian differences was not feasible, and the regional differences highlighted throughout should be regarded as descriptive observations rather than statistically validated findings. The Asian cohort consisted predominantly of Japanese experts and may not fully represent the diversity of clinical practice across Asia. The scoring exercise captures expert opinion at a single time point; the rapidly evolving GU oncology landscape necessitates periodic reassessment. Global comparator data for the post-ADT + ARPI + docetaxel mCRPC setting were not available, limiting direct comparison. The Uromigos Score does not incorporate patient-reported outcomes, quality of life, treatment toxicity, cost-effectiveness, or reimbursement context. Finally, the Asian scoring was conducted later than the global scoring, introducing a potential temporal bias: the body of published evidence differed between the two time points, and because the global Uromigos Scores had already been published and were publicly available at the time of Asian scoring, some Asian experts may have been aware of the global scores, which may have been reflected in their own ratings.

Conclusion

The Uromigos Score reveals broad alignment between Asian and global GU oncology expert opinion on leading treatment options in advanced urothelial cancer and prostate cancer, affirming the universality of evidence-based treatment standards. While consensus was observed across most clinical scenarios, several notable regional differences were identified. The unanimous endorsement of EV + pembrolizumab in urothelial cancer and ADT + ARPI in mHSPC is consistent across geographies. Identified regional differences—including higher scoring of ADT monotherapy and ^{177}Lu-PSMA therapy in prostate cancer, greater enthusiasm for ICI–BCG combinations in NMIBC without CIS, and lower familiarity with HER2-targeted urothelial regimens—likely reflect differential drug availability, regulatory timelines, and regional clinical trial exposure. These findings highlight the value of inclusive, multi-regional consensus exercises and identify specific areas where dedicated evidence generation within Asian patient populations is most warranted.

Declarations

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Conflict of interest Hiroshi Kitamura reports lecturer fees from Astellas, AstraZeneca, Bristol-Myers Squibb, Daiichi-Sankyo, Johnson & Johnson/Janssen, Merck Biopharma, MSD, Nippon Shinyaku, and Takeda; and research expenses from Johnson & Johnson/Janssen. Yuji Miura reports honoraria from Astellas, MSD, and Takeda. Nobuaki Matsubara reports honoraria from Novartis and Pfizer; and research expenses from Amgen, Astellas, Bayer, Bicycle TX, Boehringer Ingelheim, Bristol-Myers Squibb, Chugai, Eisai, Eli Lilly, GlaxoSmithKline, Johnson & Johnson/Janssen, MSD, Novartis, Pfizer, Taiho, Takeda, and

Telix. Brian I. Rini reports employment/ leadership position/ advisory role from Arcus, AstraZeneca, AVEO, Bristol-Myers Squibb, Calico, Eisai, Exelixis, Formedics, Johnson & Johnson/Janssen, Merck, Pfizer, and Xencor; research funding from Adela, Arcus, AstraZeneca, AVEO, Bristol-Myers Squibb, Daiichi-Sankyo, Deciphera, Exelixis, Genentech, Gilead, HiberCell, Incyte, Johnson & Johnson/Janssen, Merck, Pfizer, POINT Biopharma, Regeneron, Surface Oncology, and Tempus; and legal fees in case of lawsuit from Merck. Thomas Powles reports honoraria: Astellas, AstraZeneca, BMS, Eisai, Elexis, Gilead, Incyte, Ipsen, Johnson & Johnson, Mashup, MSD, Merck Serono, Novartis, Pfizer, Roche, and Seagen; consulting or advisory role: Astellas, AstraZeneca, BMS, Eisai, Elexis, Gilead, Incyte, Ipsen, Johnson & Johnson, Mashup, MSD, Merck Serono, Novartis, Pfizer, Roche, and Seagen; research funding: Astellas, AstraZeneca, BMS, Eisai, Elexis, Incyte, Ipsen, Johnson & Johnson, MSD, Merck Serono, Novartis, Pfizer, Roche, and Seagen; and travel, accommodations, or expenses: Astellas, AstraZeneca, Gilead, Ipsen, MSD, Pfizer, and Roche.

Ethics approval This study was an anonymous expert-opinion scoring exercise that did not involve individual patient data, identifiable personal information, or human or animal subjects. Formal institutional review board approval was therefore not required. [Please confirm this statement is consistent with your institutional policy.]

Consent to participate All participating experts contributed voluntarily to the scoring exercise.

Consent for publication Not applicable.

Data availability The aggregated scoring data supporting the findings of this study are available from the corresponding author upon reasonable request.

Author contributions Hiroshi Kitamura: conceptualization, data collection (Asian cohort), analysis, and writing—original draft. Yuji Miura: data collection and writing—review and editing. Nobuaki Matsubara: data collection and writing—review and editing. Brian I. Rini: conceptualization of Uromigos Score methodology, data collection (global cohort), and writing—review and editing. Thomas Powles: conceptualization of Uromigos Score methodology, data collection (global cohort), and writing—review and editing. All authors approved the final version of the manuscript.

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Tables

Table 1 Uromigos Scores for metastatic hormone-sensitive prostate cancer (mHSPC)

Treatment	Clinical scenario	Global	Asian
ADT monotherapy	Metachronous, low volume	0.9	1.6
	Synchronous, low volume	0.5	1.3
	Metachronous, high volume	0.1	0.9
	Synchronous, high volume	0.1	0.9
ADT + ARPI	Metachronous, low volume	3.0	3.0
	Synchronous, low volume	2.9	3.0
	Metachronous, high volume	2.7	2.8
	Synchronous, high volume	2.6	2.8
ADT + ARPI + docetaxel	Metachronous, low volume	0.6	1.9
	Synchronous, low volume	1.4	1.5
	Metachronous, high volume	2.5	2.7
	Synchronous, high volume	2.9	3.0
XRT to prostate	Metachronous, low volume	0.0	0.0
	Synchronous, low volume	2.5	2.7
	Metachronous, high volume	0.0	0.0
	Synchronous, high volume	1.1	1.4

ADT androgen deprivation therapy, ARPI androgen receptor pathway inhibitor, XRT external beam radiotherapy.

Table 2 Uromigos Scores for mCRPC after progression on ADT + ARPI (without prior docetaxel), by genomic subgroup

Treatment	No HRR/unknown – Global	No HRR/unknown – Asian	HRR non-BRCA – Global	HRR non-BRCA – Asian	BRCA1/2 – Global	BRCA1/2 – Asian
Docetaxel	2.8	2.9	2.7	2.8	2.1	2.7
ARPI switch	0.5	1.0	0.5	0.9	0.5	0.9
Ra-223 + ARPI	1.5	1.9	1.3	1.6	1.4	1.6
Ra-223	1.8	1.9	1.8	1.7	1.5	1.7
^{177}Lu-PSMA therapy	2.4	2.7	2.3	2.5	1.8	2.4
PARPi + ARPI	0.8	0.7	1.5	0.9	1.8	1.9
PARPi monotherapy	0.5	0.4	1.5	0.9	2.8	2.8

^{177}Lu-PSMA lutetium-177 PSMA-617, PARPi PARP inhibitor, ARPI androgen receptor pathway inhibitor, HRR homologous recombination repair, Ra-223 radium-223.

Table 3 Uromigos Scores for mCRPC after progression on ADT + ARPI + docetaxel, by genomic subgroup—Asian cohort only

Treatment	No HRR/unknown (Asian)	HRR non-BRCA (Asian)	BRCA1/2 (Asian)
Cabazitaxel	2.9	2.9	2.7
ARPI switch	0.9	0.9	0.9
Ra-223 + ARPI	1.7	1.7	1.6
Ra-223	1.8	1.9	1.9
^{177}Lu-PSMA therapy	2.8	2.8	2.6
PARPi + ARPI	0.5	0.8	1.8
PARPi monotherapy	0.4	1.1	3.0

^{177}Lu-PSMA lutetium-177 PSMA-617, PARPi PARP inhibitor, ARPI androgen receptor pathway inhibitor. Global comparator data were not available for this setting.

Table 4 Uromigos Scores for first-line locally advanced/metastatic urothelial cancer (1L la/mUC)

Treatment	Patient population	Global	Asian
EV + pembrolizumab	Unselected	3.0	3.0
Disitamab vedotin + toripalimab	HER2-positive	2.5	1.9
Pembrolizumab monotherapy	Unfit for ADC or platinum	1.7	1.8
Cisplatin-based chemo + sequenced avelumab	Cisplatin-eligible	1.2	1.6
Platinum-based chemo	Cisplatin-ineligible/unfit for EV+P	1.0	1.2

EV enfortumab vedotin, ADC antibody-drug conjugate, EV+P enfortumab vedotin plus pembrolizumab.

Table 5 Uromigos Scores for perioperative treatment of cisplatin-eligible muscle-invasive bladder cancer (MIBC)

Treatment	Global	Asian
Perioperative EV + pembrolizumab (cT2–T4a N0–1 M0)	2.5	2.8
Neoadjuvant cisplatin chemo + perioperative durvalumab	2.7	2.7
Neoadjuvant cisplatin chemo + adjuvant atezolizumab (ctDNA+)	2.1	1.7
Adjuvant nivolumab (irrespective of ctDNA/PD-L1)	1.6	1.8
Adjuvant pembrolizumab or nivolumab (ctDNA/PD-L1 guided)	1.7	1.8
Cystectomy or trimodality therapy alone	0.6	1.1

EV enfortumab vedotin, ctDNA circulating tumor DNA, PD-L1 programmed death-ligand 1.

Table 6 Uromigos Scores for perioperative treatment of cisplatin-ineligible muscle-invasive bladder cancer (MIBC)

Treatment	Global	Asian
Perioperative EV + pembrolizumab	2.9	3.0
Perioperative EV + pembrolizumab (ctDNA-guided modification)	2.0	2.0
Adjuvant atezolizumab (ctDNA-positive)	1.9	1.5
Adjuvant nivolumab/pembrolizumab (irrespective of ctDNA/PD-L1)	1.5	1.1
Adjuvant nivolumab/pembrolizumab (ctDNA/PD-L1 guided)	1.3	1.8
Cystectomy + radiotherapy alone	1.6	1.5

EV enfortumab vedotin, ctDNA circulating tumor DNA, PD-L1 programmed death-ligand 1.

Table 7 Uromigos Scores for previously untreated high-risk non-muscle-invasive bladder cancer (NMIBC)

Treatment	Patient population	Global	Asian
BCG + sasanlimab (2 yr)	Previously untreated high-risk NMIBC	2.3	2.5
BCG + sasanlimab (2 yr)	CIS-positive or mixed papillary subgroup	2.3	2.5
BCG + durvalumab (1 yr)	Previously untreated high-risk NMIBC	2.2	2.3
BCG + durvalumab (1 yr)	High-risk papillary NMIBC without CIS	1.5	2.3
BCG induction + maintenance alone	Previously untreated high-risk NMIBC	2.2	2.4

BCG bacillus Calmette-Guérin, CIS carcinoma in situ, NMIBC non-muscle-invasive bladder cancer.