Clinical Management of Intravesical Drug-Releasing Systems in the Treatment of Bladder Cancer: Considerations Based on Expert Panel Recommendations

Information provided below was developed based on expert clinical experience. There is no data to support the effectiveness of the recommendations below. Prescribing HCPs should use their clinical judgement when treating patients with intravesical drug releasing systems.

International Expert Panel[1]

An international (US, Europe, China, and Japan) expert panel was convened to develop consensus recommendations on the management of side effects associated with iDRS treatment

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Urologists and urologic oncologists with experience with iDRS in clinical trials	Functional urologists	Physicians and clinical scientist affiliates of the sponsor (Johnson & Johnson)

General Principles and Prophylactic Measures

General recommendations are **consistent** with other intravesical therapies:[1–3]

- **Counsel on potential LUTS** prior to initiation and throughout the treatment course, and **screen** for **pre-existing LUTS**
- Consume **≥1500 mL** of non-alcoholic, non-caffeinated **liquid** each day during the iDRS dosing period
- **Avoid bladder irritants** (spicy foods, citrus fruits) if they have ongoing LUTS or history of LUTS prior to treatment

LUTS[1]

Dysuria

1. Consider continuing iDRS treatment while initiating symptom management
2. If no clinical improvement, consider removing/delaying insertion
3. After complete resolution, iDRS treatment may be resumed

OAB*

Steps 1-3 may be followed as listed for dysuria

1. If OAB symptoms persist despite symptom management, consider cystoscopy to evaluate the degree of mucosal irritation†

Bladder pain with OAB

Steps 1-3 may be followed as listed for dysuria

1. Follow the WHO three-step analgesic ladder, with the potential addition of antispasmodics and/or phenazopyridine‡

UTI[1]

Most UTIs

1. Consider initiating appropriate antibiotics based on urinalysis and urine culture results
2. iDRS may remain in the bladder through antimicrobial treatment
3. If signs and symptoms worsen after treatment for 48-72 hours, clinical judgement should be used regarding whether the iDRS should be removed

Urosepsis

1. Consider removing iDRS as soon as patient is clinically stable following initiation of broad-spectrum antibiotics
2. After complete resolution, iDRS treatment may be resumed based on clinical judgement

Hematuria[1]

Macroscopic¶

1. Consider continuing iDRS, initiate therapy to target cause
2. If no clinical improvement, consider removal/delaying insertion
3. If persistent, consider cystoscopy to evaluate presence/recurrence of bladder tumor

Complicated§

1. Consider removing iDRS
2. Consider invasive intervention as clinically indicated
3. After complete resolution, iDRS treatment may be resumed based on clinical judgement

Please flip to view suggestions for **symptom management**

For more information, please read the full manuscript:
Pradere B, et al. *Curr Opin Urol.* 2025.

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*OAB symptoms include micturition urgency, pollakiuria, urge incontinence, and/or nocturia. †To treat mucosal irritation, HCPs could consider a short course of corticosteroids. ‡Step 1 initially and step 2 for persistent pain. ¶Defined as with no clots, no signs of retention, and negative urine culture. §Defined as with clots leading to retention, and/or dysuria or hematuria with anemia.

iDRS, intravesical drug-releasing systems; LUTS, lower urinary tract symptoms; OAB, overactive bladder; UTI, urinary tract infection; WHO, world health organization.

1. Pradere B, et al. *Curr Opin Urol.* 2025. 2. Koch GE, Smelser WW, Chang SS. *Urol.* 2021;149:11-20. 3. Mathes J, Todenhofer T. *Eur Urol Focus.* 2018;4(4):464-467.

Considerations for iDRS Toxicity Management Based on Expert Panel Recommendations

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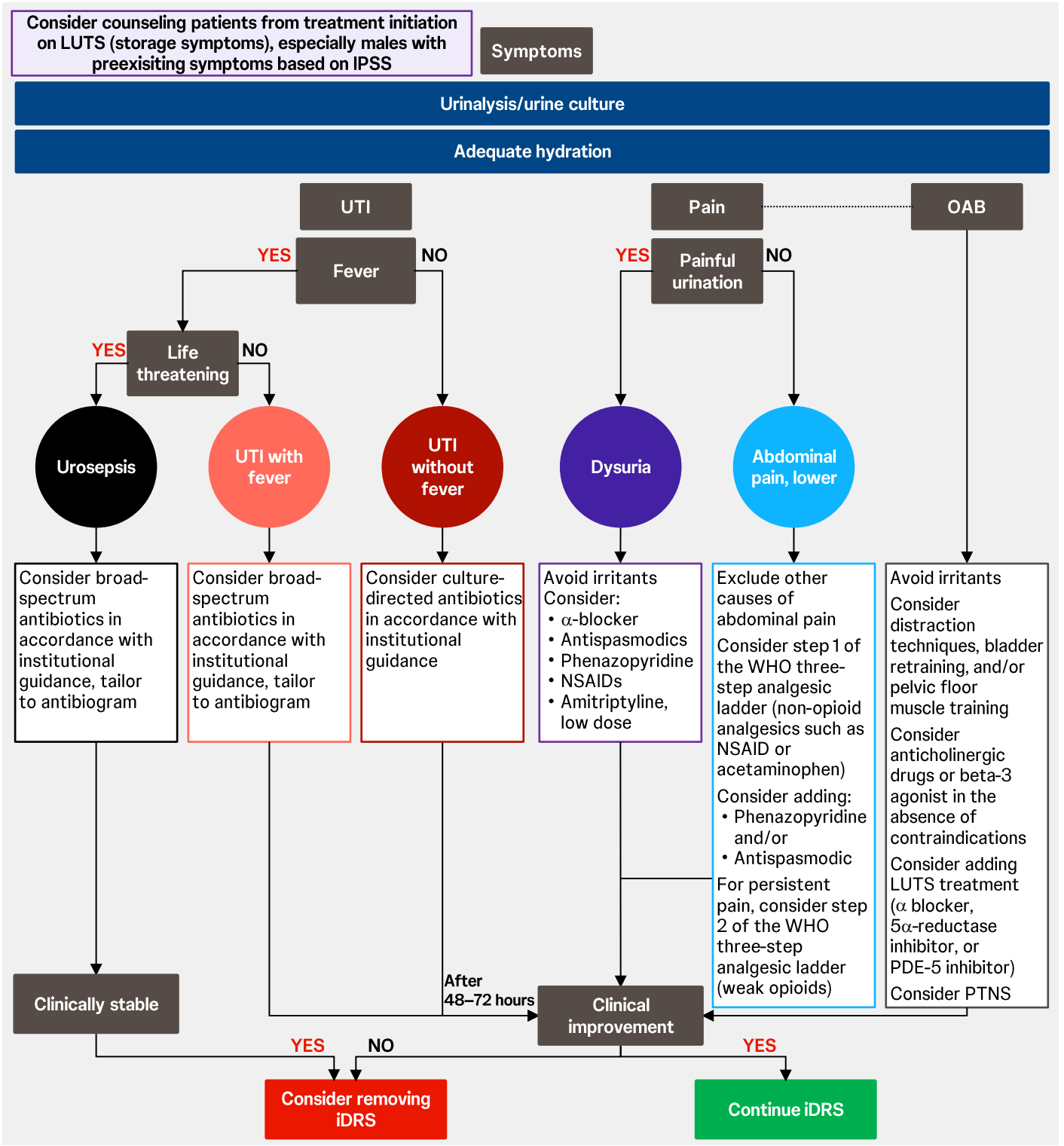

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iDRS, intravesical drug-releasing systems; IPSS, International Prostate System Score; LUTS, lower urinary tract symptoms; NSAIDs, nonsteroidal anti-inflammatory drugs; OAB, overactive bladder; PDE-5, phosphodiesterase-5; PTNS, percutaneous tibial nerve stimulation; UTI, urinary tract infection; WHO, World Health Organization.

Pradere B, et al. *Curr Opin Urol.* 2025.