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Insights Into Renal Cell Carcinoma (RCC)

March 27, 2026

Dallas, TX

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Report Snapshot

Report Snapshot: Session Overview

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Disease state and data presentations were led on **March 27, 2026,** by **Qian Qin, MD,** from UT Southwestern, and moderated by **Sushil Bhardwaj, MD, FACP,** from Good Samaritan Hospital, with content developed in conjunction with the Aptitude Health scientific team

The objectives of the meeting were to gain insights on the following

- **Factors that influence the adoption of first-line and subsequent therapies for advanced RCC and their impact on patient treatment in the community**
- **Current attitudes toward recently introduced and upcoming combination therapies**

Data collection was accomplished through use of **audience response system (ARS)** questioning and **moderated discussion**

Insights on the management of advanced RCC were obtained from **11 community oncologists** from Texas, United States

Report Snapshot: Session Agenda

Time (CT)	Topic
2.00 PM – 2.15 PM (5-min overview; 10-min ARS)	**Introduction** > Program overview > ARS questions
2.15 PM – 3.35 PM (35-min presentation; 45-min discussion)	**First-Line Therapy of Advanced RCC** > Overview of current data > Reaction and discussion
3.35 PM – 3.45 PM (10 min)	**BREAK**
3.45 PM – 4.45 PM (5-min ARS questions; 20-min presentation; 35-min discussion)	**Subsequent Management of Advanced RCC** > ARS questions > Overview of current data > Reaction and discussion
4.45 PM – 5.00 PM (15 min)	**Key Takeaways and Meeting Evaluation**

Report Snapshot: Attendee Overview

Scope of the Report

Objectives

1

Gain insight into how treatment decisions are made for RCC in the community oncology setting

2

Determine the factors that influence how approved combination therapies are used in the first-line RCC landscape

3

Evaluate how first-line treatment decision impacts the utilization of available therapies in the second line for the treatment of advanced RCC

Topline Takeaways

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Detailed Insights and Strategic Recommendations

Objective 1: Detailed Insights (1/2)

Objective 1: Detailed Insights (2/2)

Objective 1: Supportive Quotes From Discussion (1/2)

Topic	Physician Statements
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
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Objective 1: Supportive Quotes From Discussion (2/2)

Topic	Physician Statements
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Objective 1: Strategic Recommendations

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Objective 2: Detailed Insights (1/4)

Objective 2: Detailed Insights (2/4)

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[illegible] Understand the factors that influence how approved combinations therapies are used in the frontline RCC landscape

Topline Takeaway: Frontline RCC treatment is anchored by 3 main regimens: lenvatinib + pembrolizumab as the efficacy-driven standard; despite tolerability management needs, cabozantinib + nivolumab as a more tolerability-option for less fit patients; and ipilimumab + nivolumab for patients prioritizing durable responses. Physicians view a [illegible] as potentially practice changing but still limited by concerns around survival maturity and tolerability. Emerging subcutaneous IO formulations are seen primarily as a convenience and workflow improvement rather a driver of treatment selection.

Cabozantinib + nivolumab is preferred for patients with moderate frailty and high tumor burden requiring both efficacy and tolerability

- This regimen is frequently chosen as an alternative TKI + IO for patients who are less robust or unlikely to tolerate lenvatinib-based therapy. Physicians view it as a more manageable regimen, particularly for patients where toxicity avoidance is a key concern.
  - The 40mg cabozantinib dose (vs 60 mg) was recognized as providing better tolerability, with flexibility to decrease further to 20 mg if needed, offering a dosing advantage particularly for older patients and those unable to tolerate higher dose TKI therapy.

Ipilimumab + nivolumab is valued for its potential long-term disease control and durable responses

- This regimen is generally used in patients who do not require immediate tumor shrinkage, with clear avoidance in visceral crisis or highly symptomatic disease. Younger or fitter patients are often considered better candidates.
- The 5-year CheckMate 214 follow-up data strengthened physicians' confidence in IO + IO therapy as a durability-first strategy.
- Ipilimumab + nivolumab is most commonly aligned with intermediate- and poor-risk disease, but treatment selection is more strongly influenced by disease urgency and patient fitness than by formal IMDC risk stratification alone.
  - Some physicians do extend this regimen into favorable-risk patients but only in selected scenarios (eg, low tumor burden).

Treatment sequencing considerations influence first-line choices

- Several physicians noted that they deliberately preserve cabozantinib for second-line use, which influences avoidance of cabozantinib + nivolumab in the frontline setting.

Objective 2: Detailed Insights (3/4)

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Objective 2: Detailed Insights (4/4)

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Objective 2: Supportive Quotes From Discussion (1/7)

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Topic	Physician Statements
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Objective 2: Supportive Quotes From Discussion (2/7)

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Objective 2: Supportive Quotes From Discussion (3/7)

Topic	Physician Statements
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Objective 2: Supportive Quotes From Discussion (4/7)

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Objective 2: Supportive Quotes From Discussion (5/7)

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Objective 2: Supportive Quotes From Discussion (6/7)

Topic	Physician Statements
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Objective 2: Supportive Quotes From Discussion (7/7)

Topic	Physician Statements
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Objective 2: Strategic Recommendations

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Objective 3: Detailed Insights (1/2)

Objective 3: Detailed Insights (2/2)

Objective 3: Supportive Quotes From Discussion (1/7)

Topic	Physician Statements
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Objective 3: Supportive Quotes From Discussion (2/7)

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Objective 3: Supportive Quotes From Discussion (3/7)

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Objective 3: Supportive Quotes From Discussion (4/7)

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Objective 3: Supportive Quotes From Discussion (5/7)

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Objective 3: Supportive Quotes From Discussion (6/7)

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Objective 3: Supportive Quotes From Discussion (7/7)

Topic	Physician Statements
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Objective 3: Strategic Recommendations

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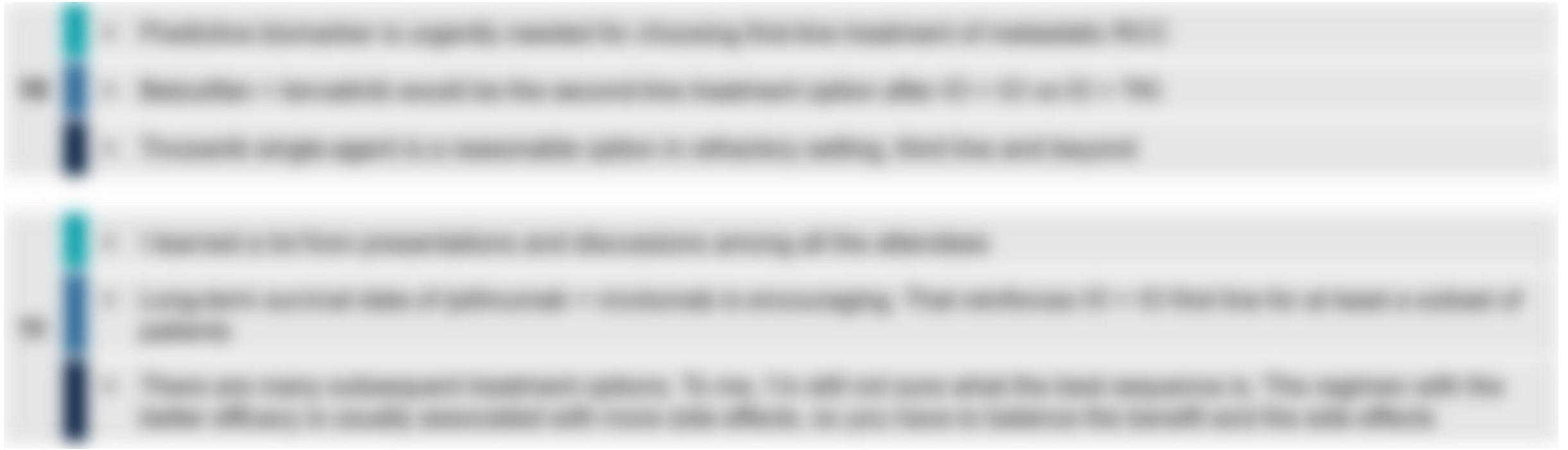
Attendee Key Takeaways

Attendee Key Takeaways (1/4)

Attendee Key Takeaways (2/4)

Attendee Key Takeaways (3/4)

Attendee Key Takeaways (4/4)



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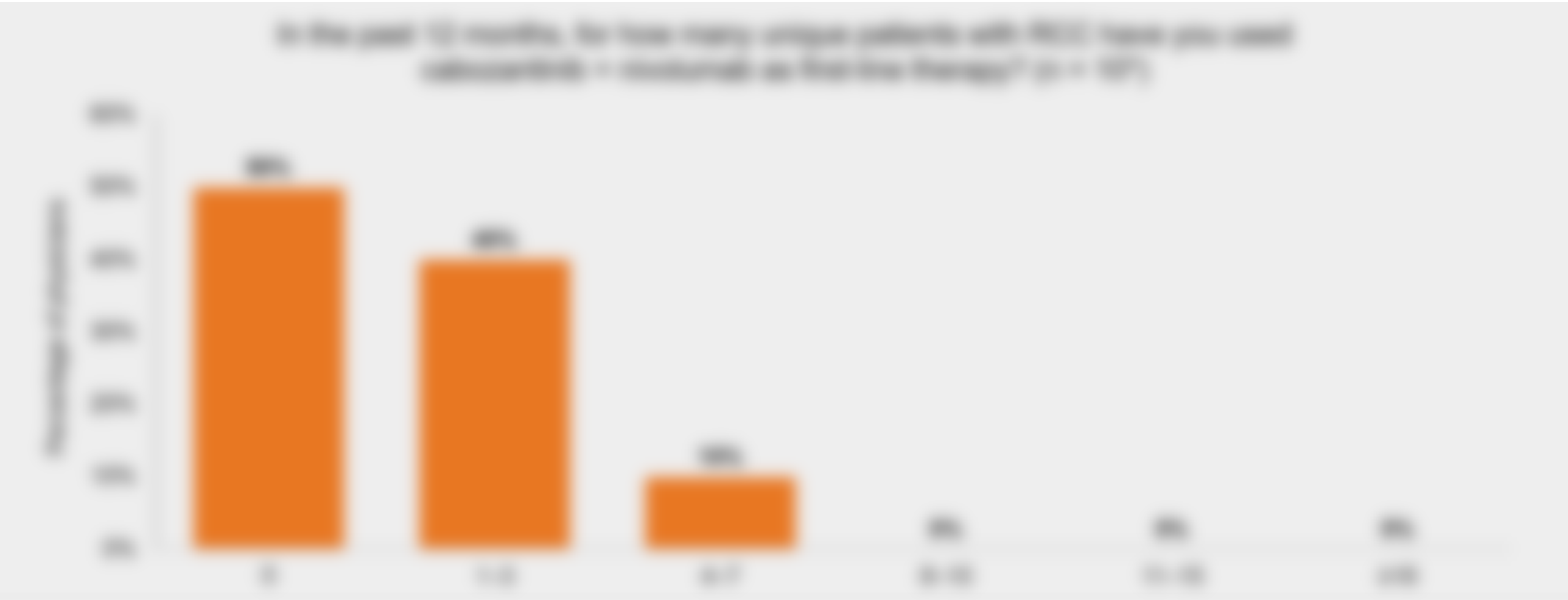
ARS Data

First-Line Therapy of Advanced RCC

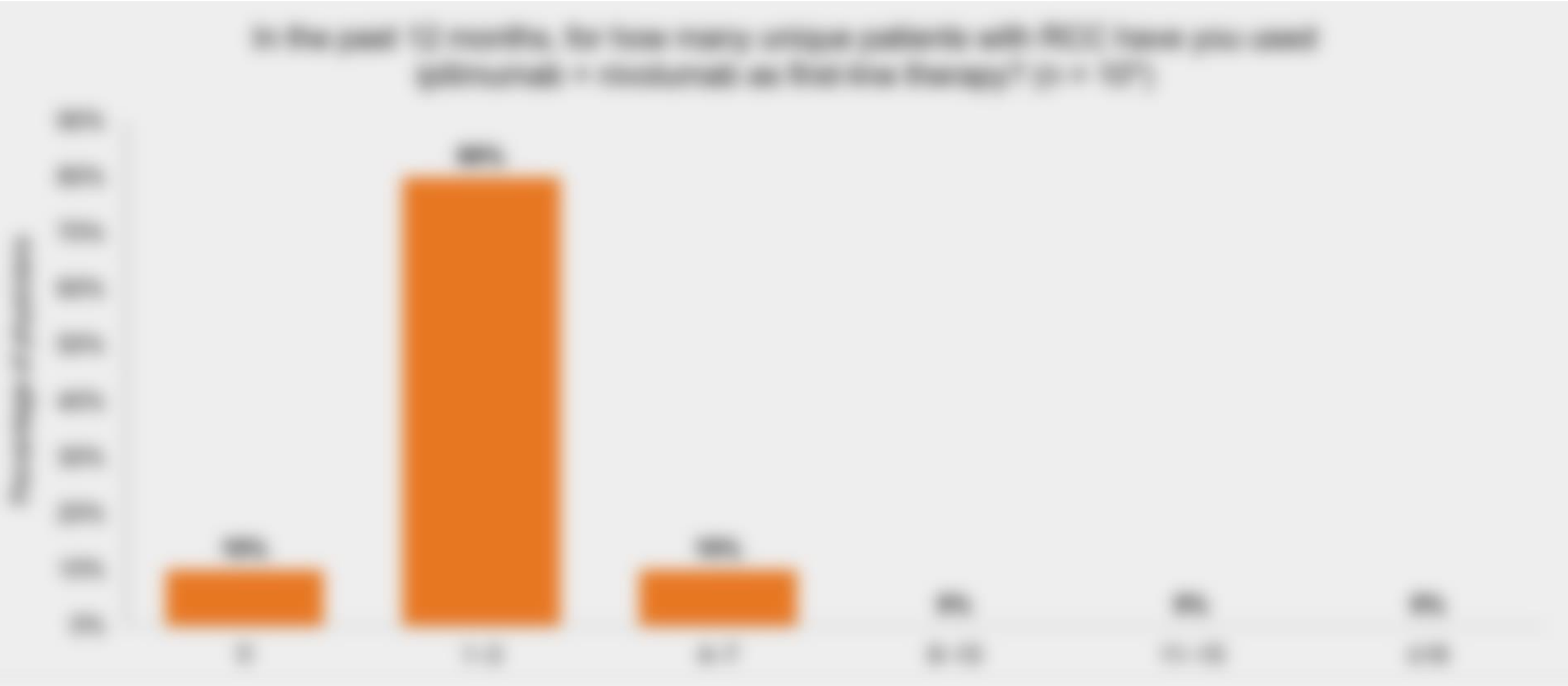
Over the Past Year, 60% of Physicians Did Not Treat Any Patients With First-Line Axitinib + Pembrolizumab; 40% Treated 1–3 Patients With This Regimen

Half of Physicians Did Not Use Cabozantinib + Nivolumab as First-Line Therapy in the Past Year; 40% Treated 1–3 Patients With This Regimen

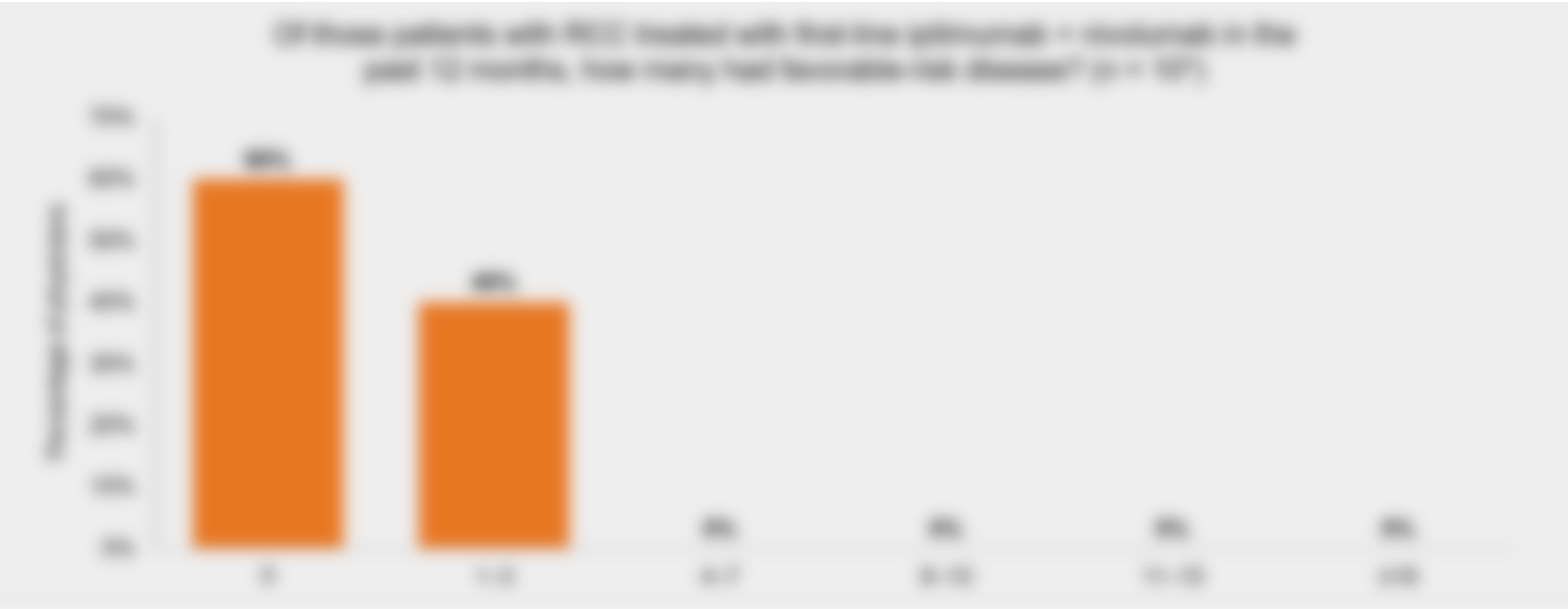


In the Past Year, 40% of Physicians Used First-Line Lenvatinib + Pembrolizumab in 1–3 Patients, 20% Used It in 4–7 Patients, and 30% Reported No Use

Most Physicians (80%) Treated 1–3 Patients With First-Line Ipilimumab + Nivolumab in the Past Year



Among Their Patients Treated With First-Line Ipilimumab + Nivolumab in the Past Year, 60% of Physicians Reported That No Patients Had Favorable-Risk Disease



Overall Survival Most Significantly Influences First-Line Therapy Selection for RCC

Patient Case 1

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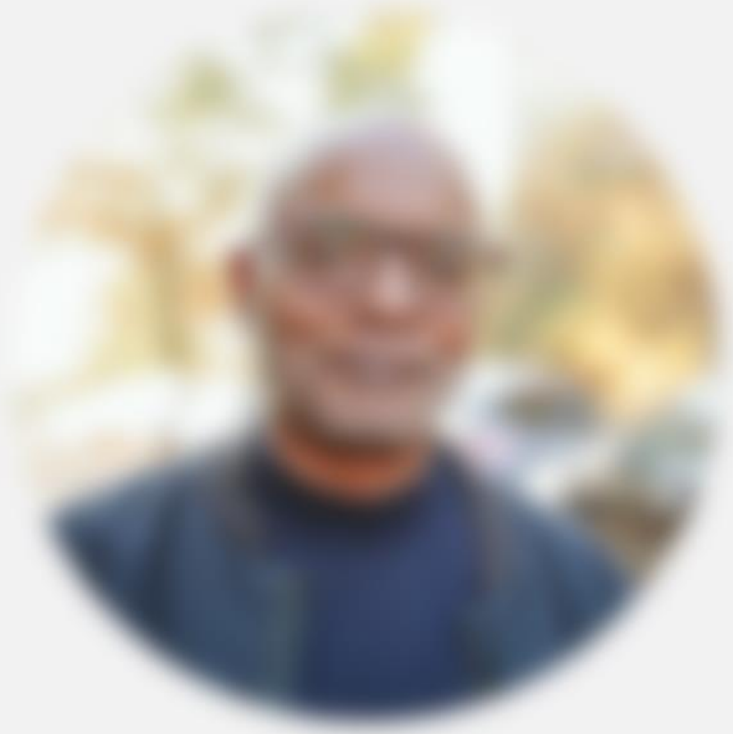

A 58-year-old man, diagnosed with RCC 4 years ago, underwent radical nephrectomy with no disease progression until now. He presents with multiple lung metastases found on CXR upon evaluation for a cough. He has PS 1, normal Hgb level, and normal calcium level.

An Equal Proportion of Physicians Selected Cabozantinib + Nivolumab, Ipilimumab + Nivolumab, and Lenvatinib + Pembrolizumab for This Favorable-Risk Patient (30% each)

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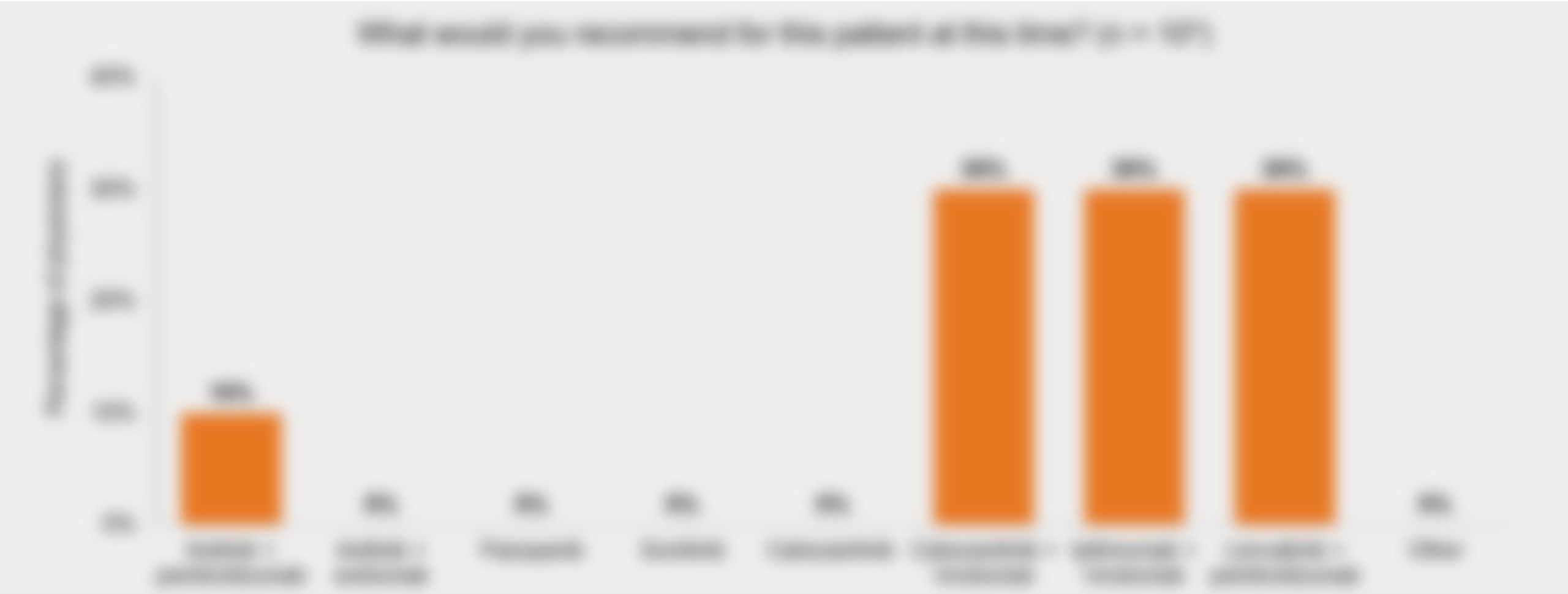

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Patient Case 2

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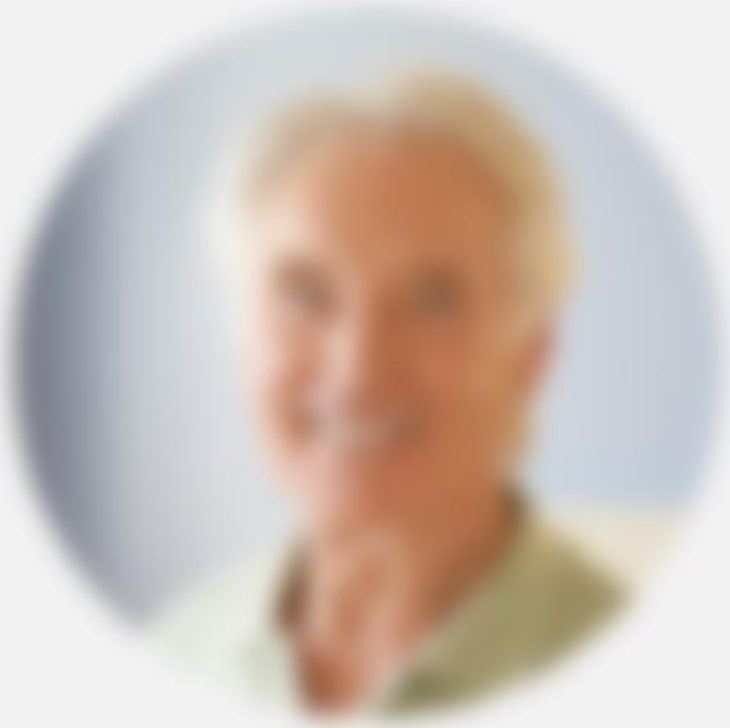

A 70-year-old man was initially found to have a 9-cm mass in his left kidney with extension into the left renal vein. He was diagnosed with RCC with clear cell histology (pT3aN0M0). He had a radical nephrectomy 6 months ago. He now presents with metastatic disease in his liver and lymph nodes and symptomatic bone involvement. High is 10.1, calcium 9.8, and LDH 247.

For This Patient With Multisite Metastases, Half of Physicians Would Recommend Lenvatinib + Pembrolizumab; 30% Prefer Cabozantinib + Nivolumab

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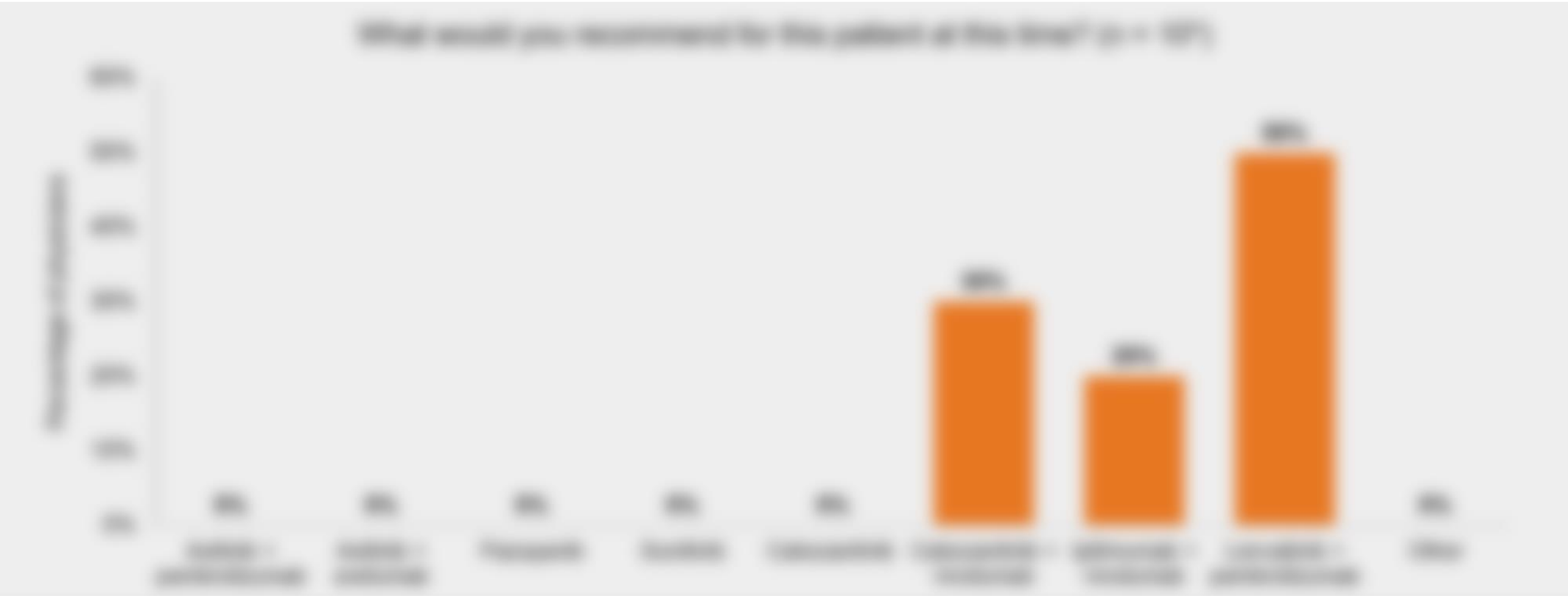

Patient Case 2 (cont.)

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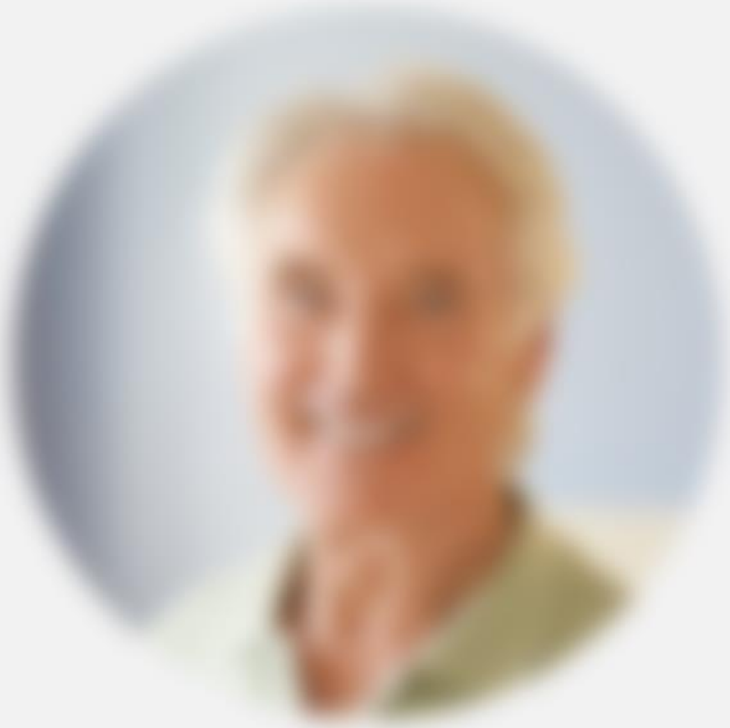
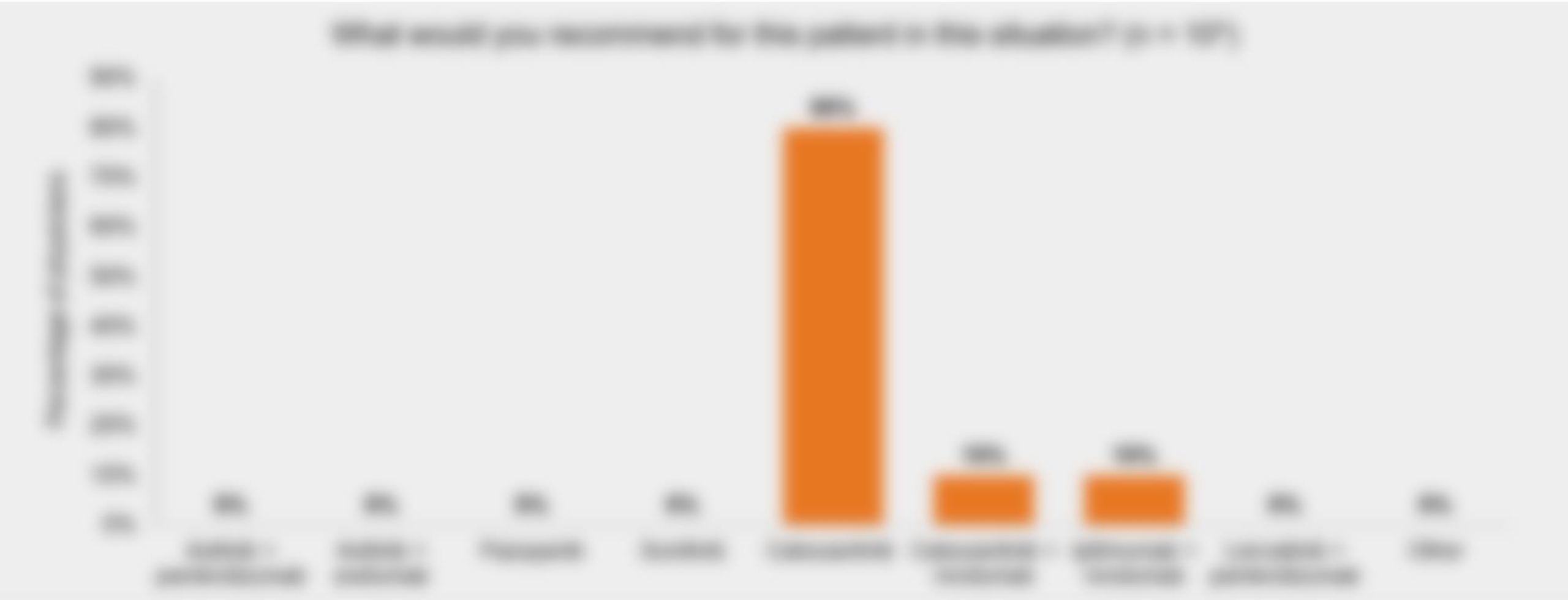


Assume the same 70-year-old man (5-cm mass in his left kidney, clear cell histology [pT3aN0M0]) was given adjuvant pembrolizumab following the radical nephrectomy and was on it for 8 months before experiencing progression with metastatic disease (liver, lymph nodes, and symptomatic bone involvement).

After Progression on Adjuvant Pembrolizumab, 80% of Physicians Would Recommend Cabozantinib Monotherapy for This Patient; 10% Would Choose Cabozantinib + Nivolumab



Patient Case 3

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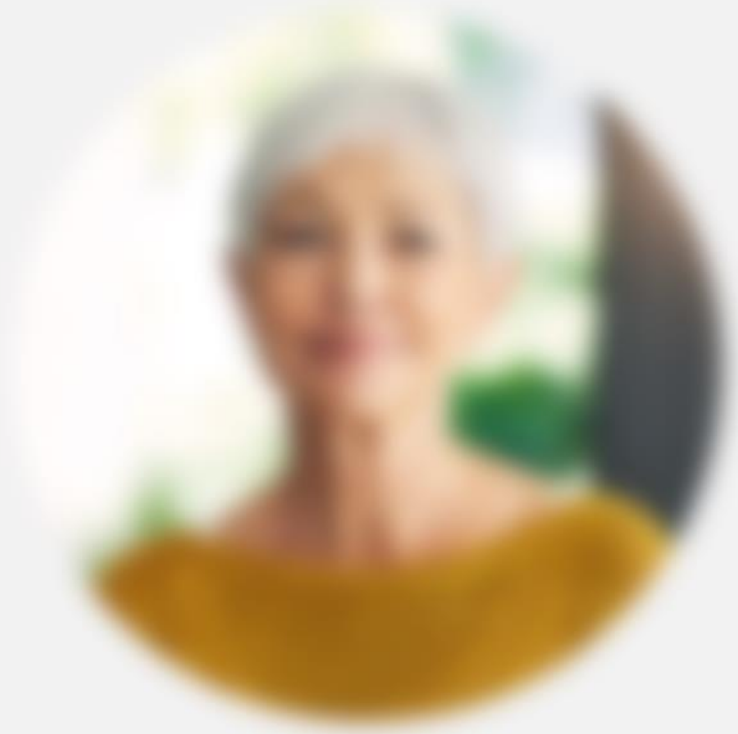

A 68-year-old woman presents with severe fatigue, blood in her urine, and pain in her lower right side. CT scan shows a lesion on her right kidney, metastases to both adrenal glands, and a thyroid nodule. She undergoes radical nephrectomy. Pathology indicates clear cell histology. Biopsy of the thyroid nodule confirms clear cell RCC. Hgb is 9.2, calcium 12.2, and LDH 285.

For This Patient With Multiorgan Metastases, 44% of Physicians Would Recommend Lenvatinib + Pembrolizumab; 22% Preferred Cabozantinib + Nivolumab, and 11% Opted for Cabozantinib Monotherapy

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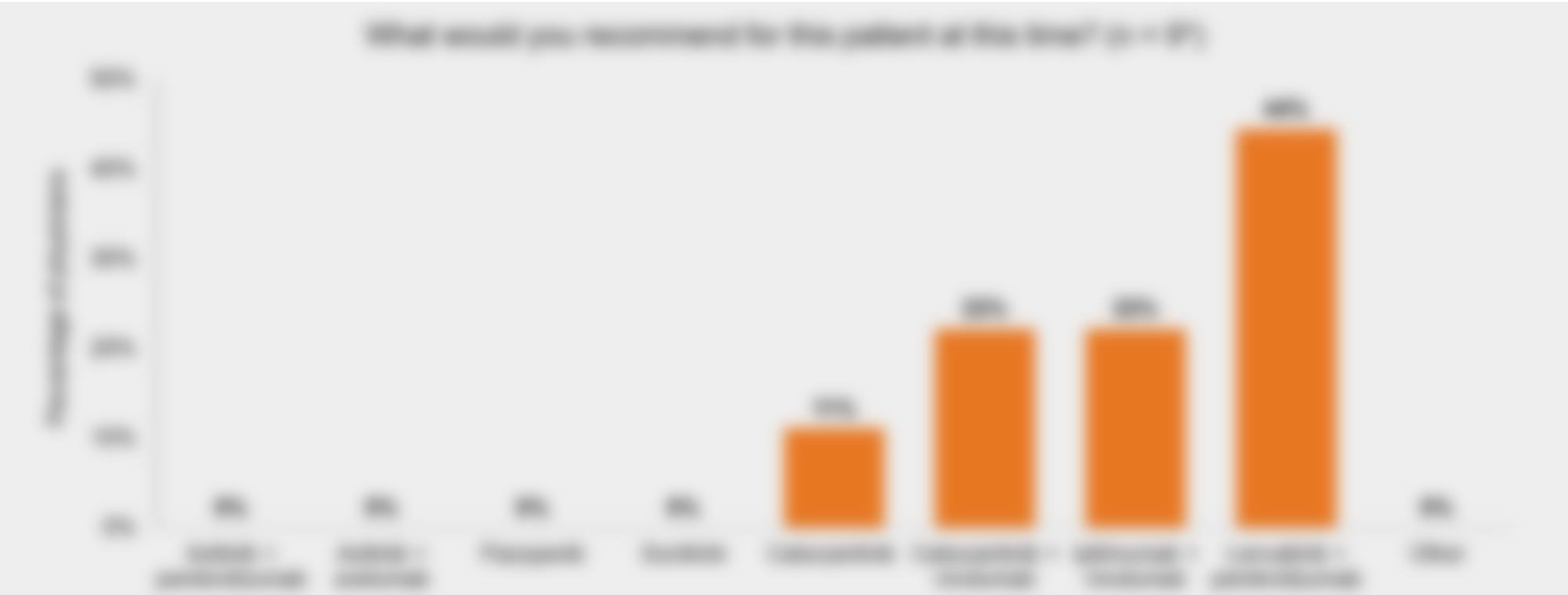

Patient Case 4

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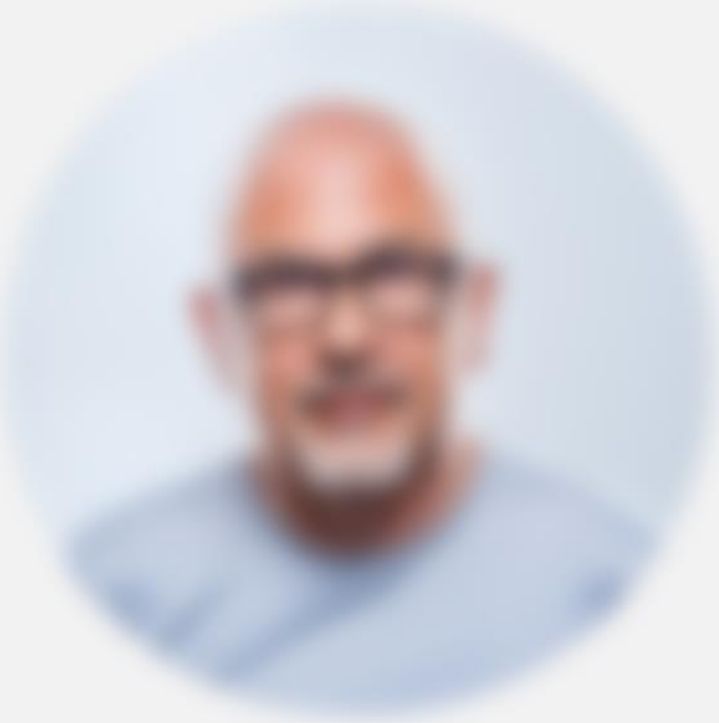

A 55-year-old man is found to have a 7-cm right renal lesion and no evidence of metastatic disease. He undergoes a right radical nephrectomy, and pathology reveals a 7-cm clear cell RCC with sarcomatoid features and renal vein invasion, consistent with pT3a grade 4. He receives adjuvant pembrolizumab for 12 months. Surveillance imaging shows disease recurrence with bilateral lung lesions 18 months after completion of adjuvant pembrolizumab.

Nearly Two-Thirds of Physicians (64%) Would Recommend Ipilimumab + Nivolumab for This Patient With Recurrent Disease After Adjuvant Pembrolizumab

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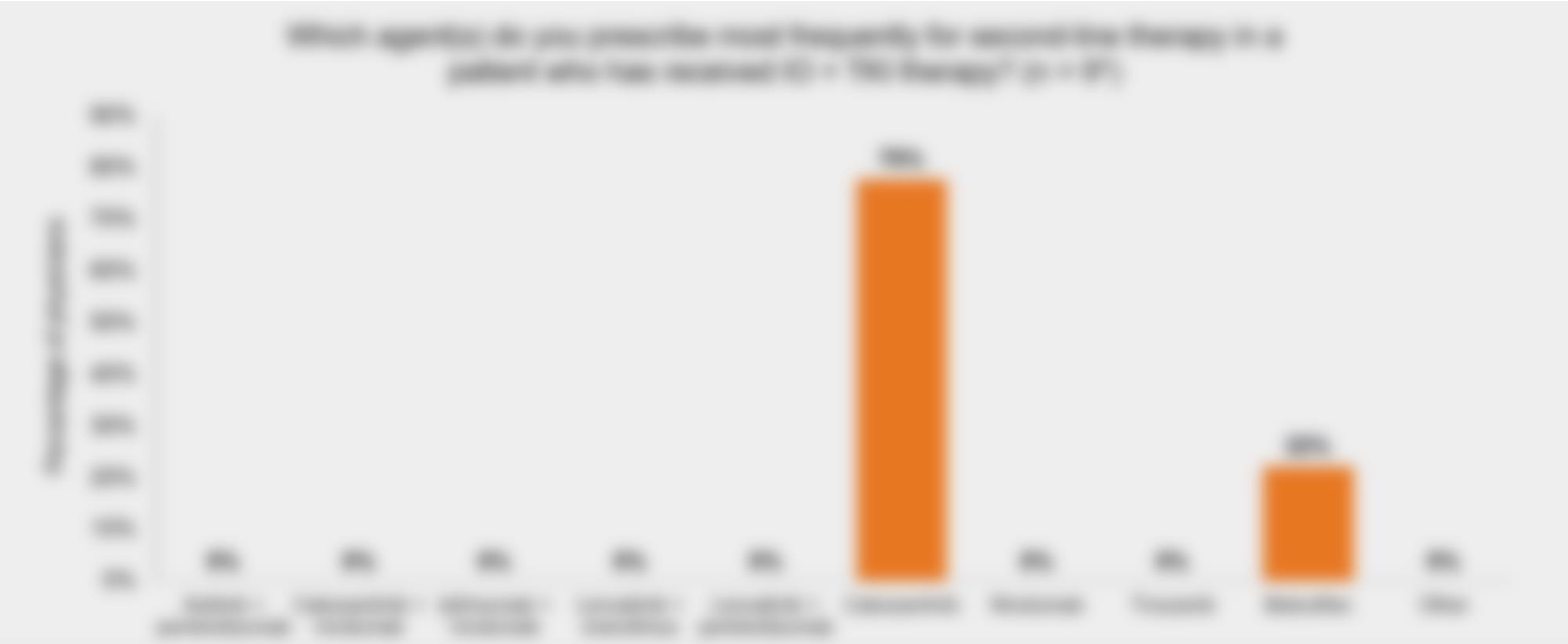
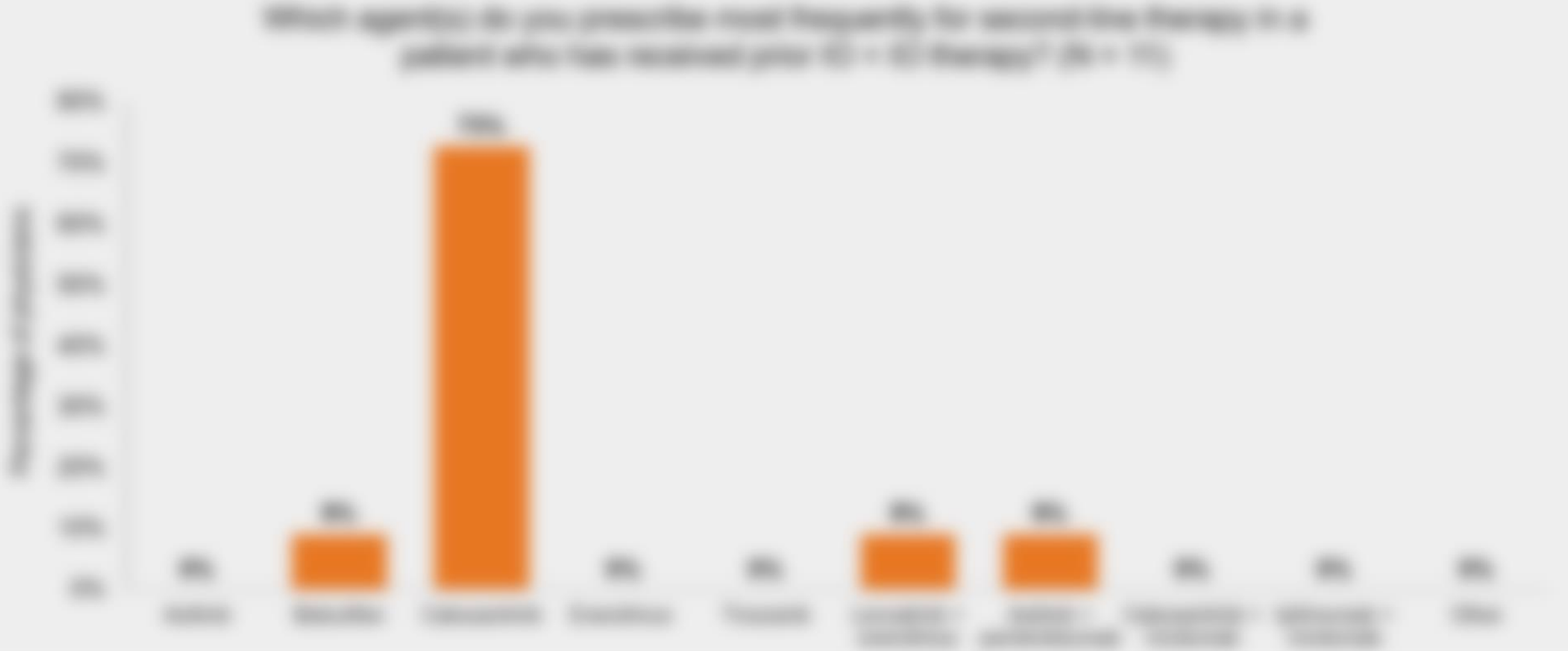
ARS Data

Subsequent Management of Advanced RCC

Most Physicians (78%) Use Cabozantinib Monotherapy in the Second Line After IO + TKI Therapy



Most Physicians (73%) Prescribe Cabozantinib Monotherapy in the Second Line After IO + IO Therapy



Patient Case 2 (cont.)

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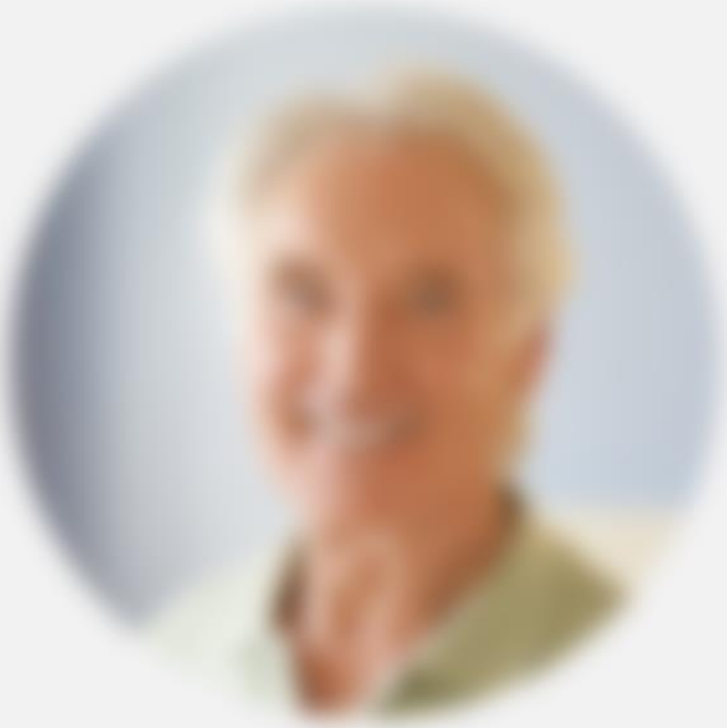
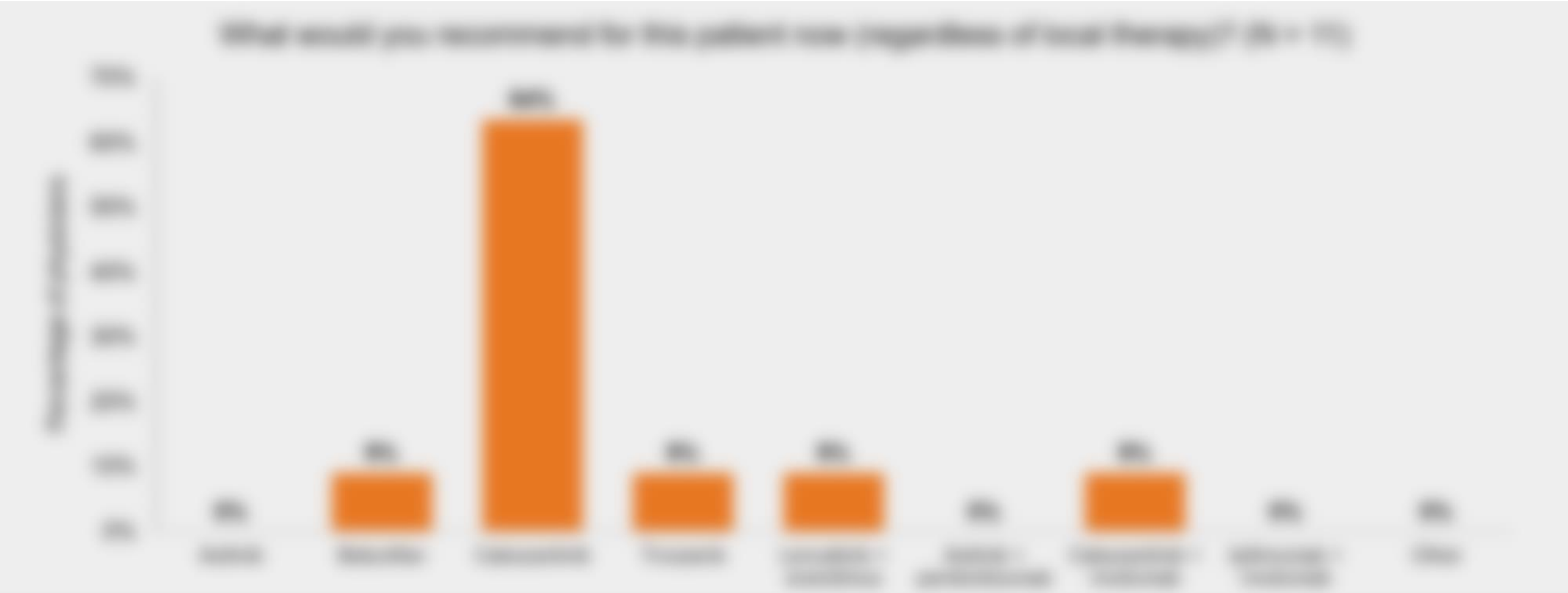


The 70-year-old man with past nephrectomy and metastatic RCC (liver, lymph nodes, and symptomatic bone involvement) was initially started on axitinib + pembrolizumab. Eleven months later, his disease has progressed. Brain MRI shows 2 focal frontal lobe lesions. Bone scan shows osseous metastases to his right femur, acetabulum, and spine.

Most Physicians (64%) Preferred Cabozantinib Monotherapy for This Patient With Brain and Osseous Metastases Following Axitinib + Pembrolizumab



Patient Case 5

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A 68-year-old man with past nephrectomy and metastatic RCC (lung, liver) initially started on ipilimumab + nivolumab and had evidence of disease progression after 11 months. He then received lenvatinib + everolimus as second-line therapy, which was poorly tolerated with hand-foot syndrome and GI toxicity. Restaging imaging scans show further disease progression. His ECOG performance status is 1, and he has no disease-related symptoms.

64% of Physicians Would Recommend Belzutifan for This Patient With Progression After Prior IO + IO and Lenvatinib + Everolimus Therapy, 18% Chose Tivozanib, and 9% Opted for Cabozantinib

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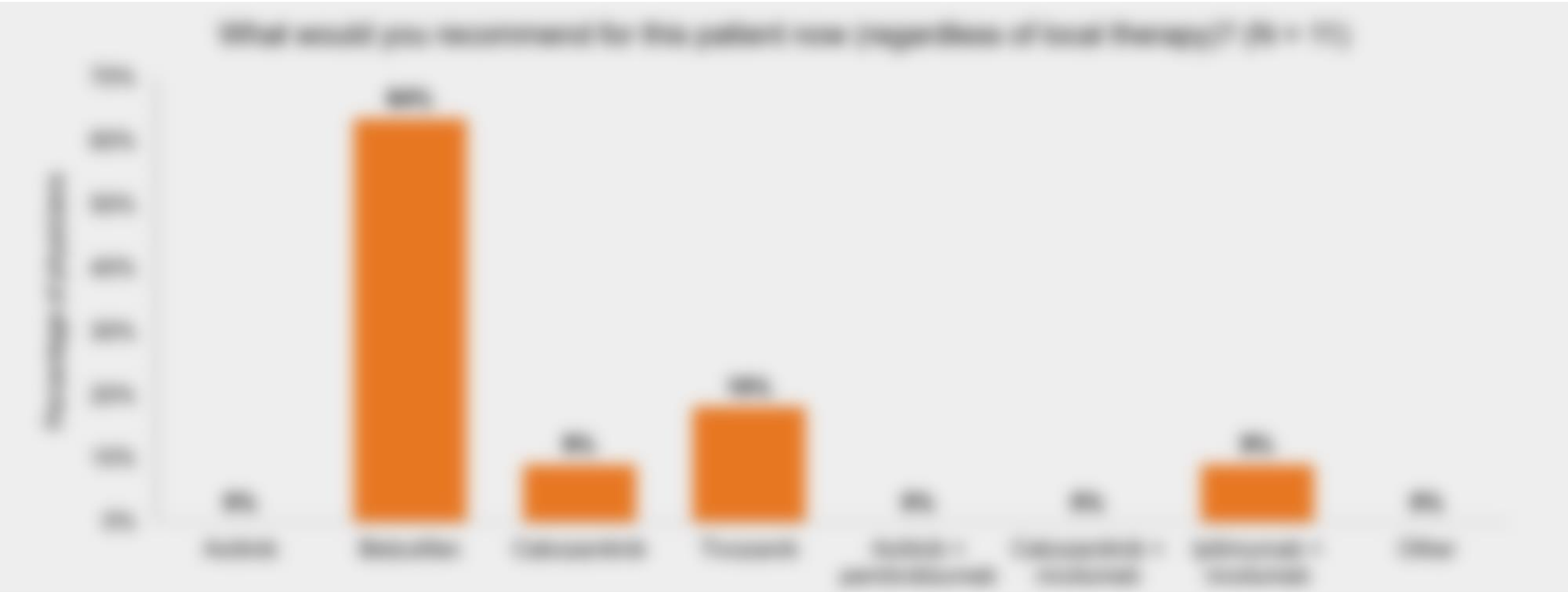

Patient Case 6

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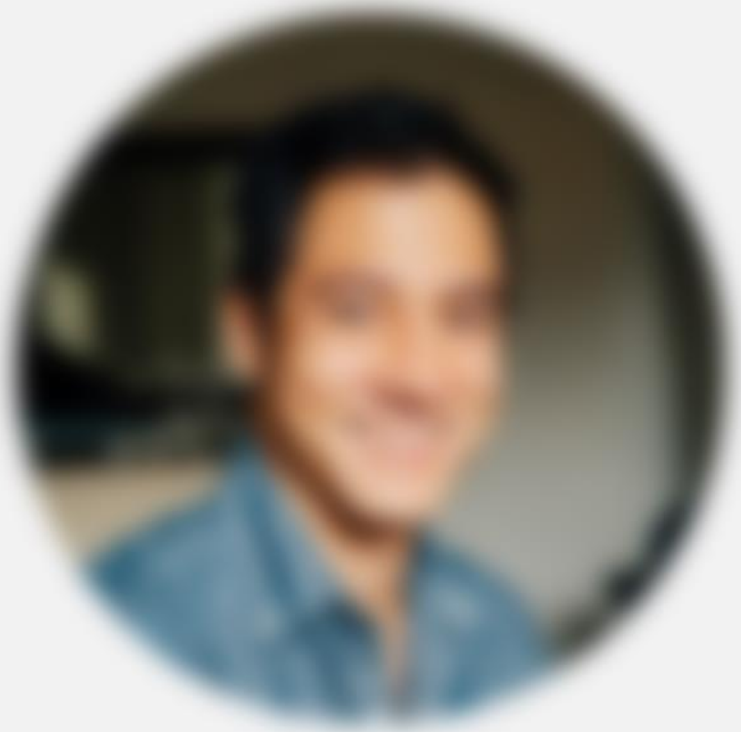

A 50-year-old man with history of metastatic clear cell RCC (bone, liver, and lymph nodes) received first-line pembrolizumab + axitinib with evidence of disease progression after 10 months of therapy. He then received cabozantinib as second-line therapy and had evidence of disease progression after 13 months, with new and progressive bone and liver lesions. His ECOG performance status is 1, and his disease is symptomatic.

Over Half of Physicians (55%) Would Recommend Belzutifan for This Symptomatic Patient With Progression on First-Line Axitinib + Pembrolizumab and Second-Line Cabozantinib; 27% Chose Tivozanib

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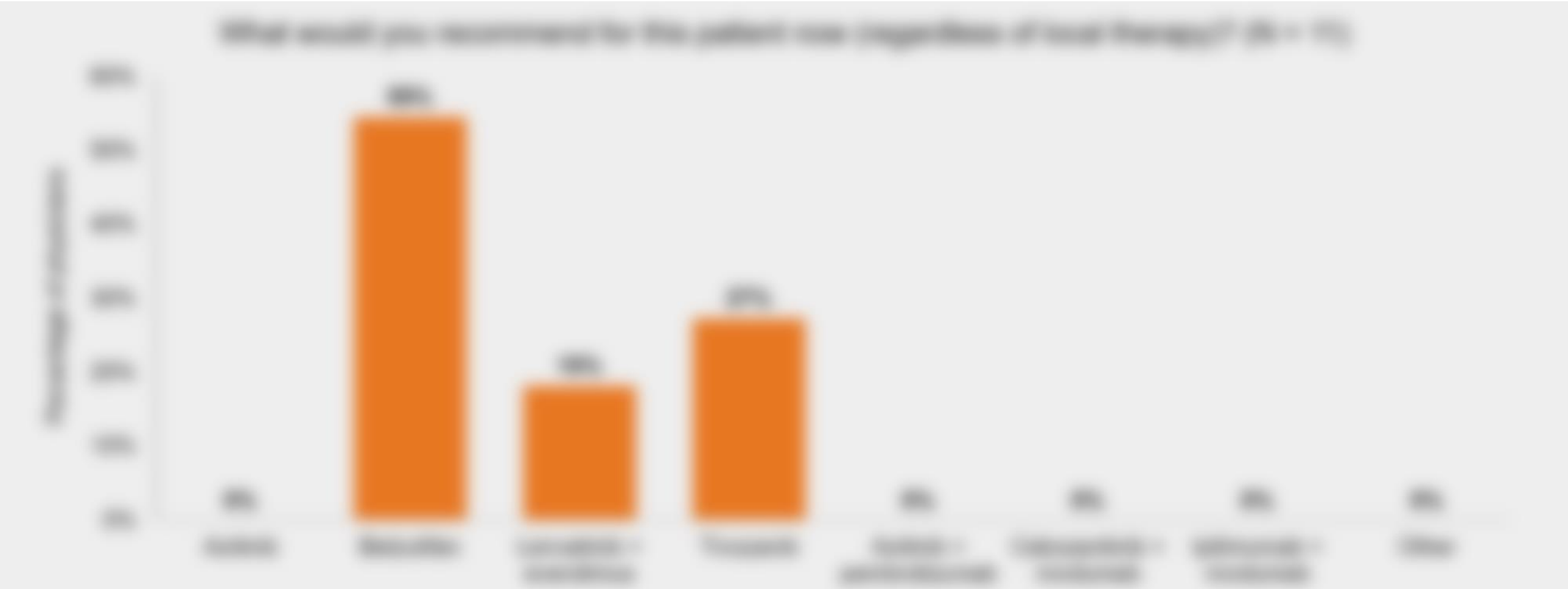

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