This section presents full abstract summaries for the ten kidney cancer abstracts selected by the Editor-in-Chief as the most clinically significant presentations from GU ASCO 2026. Each entry includes background, methods, key results, safety profile, and editorial perspective. Abstracts are ordered by assigned rank from the editorial selection. Primary data are drawn from presentations, published JCO supplement abstracts, press releases, and peer-reviewed commentary.

https://doi.org/10.52733/GU26abs

Belzutifan plus lenvatinib versus cabozantinib for advanced clear cell RCC after anti-PD-(L)1 therapy: Phase 3 LITESPARK-011

Motzer RJ, Park SH, McDermott RS, et al.

J Clin Oncol. 2026;44(suppl 7):LBA417. NCT04586231

BACKGROUND

No globally accepted standard of care exists for patients with advanced clear cell renal cell carcinoma (ccRCC) after progression on anti-PD-(L)1 therapy. VEGFR-TKIs (cabozantinib, lenvatinib plus everolimus) are commonly deployed in this setting but were primarily validated in pre-immunotherapy era phase 3 studies, raising questions about their efficacy against contemporary IO-pretreated populations. Belzutifan is a first-in-class, selective oral HIF-2α inhibitor with established antitumor activity in previously treated ccRCC. HIF-2α drives VEGF transcription and is implicated in resistance to anti-VEGF therapy, providing biological rationale for combining HIF-2α inhibition with VEGFR-TKI blockade.

METHODS: Phase 3, open-label, multicenter, randomized, active-controlled study. Eligible patients: ≥18 years, unresectable locally advanced or metastatic ccRCC, Karnofsky Performance Status ≥70%, progression on or after first- or second-line anti-PD-(L)1 therapy or within 6 months of last dose of adjuvant anti-PD-(L)1 therapy. Prior VEGFR-TKI allowed. Randomization 1:1 to belzutifan 120 mg + lenvatinib 20 mg orally once daily (n=371) versus cabozantinib 60 mg orally once daily (n=376). Stratification by IMDC risk score, line of anti-PD-(L)1 therapy, and geographic region. Dual primary endpoints: progression-free survival (PFS) by blinded independent central review (BICR) per RECIST 1.1, and overall survival (OS). Key secondary endpoint: objective response rate (ORR) by BICR. Two pre-specified interim analyses conducted.

KEY RESULTS

Grade ≥3 treatment-related AEs occurred in 71.6% (bel+lenva) vs 65.8% (cabo). Discontinuation of both study drugs: ~11% in each arm. Most common TEAEs in belzutifan+lenvatinib arm: anemia (69.2%; grade ≥3 in 23.2%), diarrhea (52.7%), fatigue (46.1%), hypertension (41.8%), hypoxia (15.4%; grade ≥3 in 11.9%). Cabozantinib arm: diarrhea (70.1%), fatigue (45.0%), skin toxicity (51.2%). No difference in patient-reported outcomes (FKSI-DRS HR 1.02; EORTC QLQ-C30 GHS/QOL HR 1.07). Treatment-related deaths: 2 vs 1.

Median follow-up	29.0 months (range 19.3–49.2) at second interim analysis
Median PFS	14.8 months (bel+lenva) vs 10.7 months (cabo) — HR 0.70 (95% CI 0.59–0.84); p=0.00007
12-month PFS rate	55.0% vs 41.0%
24-month PFS rate	35.6% vs 19.1%
Objective response rate	52.6% vs 40.2% (p<0.001); complete responses: 20 vs 4
Median duration of response	23.0 months vs 12.3 months
Median overall survival	34.9 months vs 27.6 months — HR 0.85 (95% CI 0.68–1.05); p=0.06 (NSD at interim)
12-month OS rate	79.7% vs 77.7%
24-month OS rate	62.8% vs 55.4%

Adjuvant pembrolizumab plus belzutifan versus pembrolizumab for clear cell RCC post-nephrectomy: Phase 3 LITESPARK-022

Choueiri TK, Motzer RJ, Karam JA, et al.

J Clin Oncol. 2026;44(suppl 7):LBA418. NCT05239728

BACKGROUND

Adjuvant pembrolizumab (KEYNOTE-564) is established standard of care for high-risk clear cell RCC following nephrectomy, demonstrating both disease-free survival (DFS) and overall survival

benefit. Belzutifan, a selective oral HIF-2α inhibitor, targets the VHL-HIF pathway — the molecular driver in the majority of clear cell RCC tumors — and has demonstrated single-agent efficacy in advanced previously treated ccRCC. The hypothesis underpinning LITESPARK-022 was that combining complementary mechanisms (PD-1 checkpoint blockade plus HIF-2α inhibition) in the minimal residual disease setting would yield superior DFS compared to pembrolizumab monotherapy alone.

METHODS: Phase 3, double-blind, placebo-controlled, multicenter trial. Eligible patients: histologically confirmed ccRCC, no prior systemic therapy, surgery within 12 weeks prior to randomization, ECOG PS 0 or 1, one of: intermediate-high risk (pT2 grade 4/sarcomatoid N0, or pT3 N0 any grade), high risk (pT4 N0 any grade, or any pT any grade N+), or M1 no evidence of disease. Randomization 1:1 (n=1,841 total): pembrolizumab 400 mg IV every 6 weeks for ≤9 cycles (~1 year) plus belzutifan 120 mg orally once daily for ≤54 weeks (n=921) versus pembrolizumab plus placebo (n=920).

SAFETY

Grade ≥3 TEAEs: 52.1% (combo) vs 30.2% (pembro+placebo). Most common grade ≥3 events in combination arm: anemia (12.1% vs 0.4%), elevated ALT (6.4% vs 2.0%), hypoxia (4.6% vs 0%). Grade 5 events similar between arms (1.1% vs 1.2%); no new safety signals identified. Anemia was managed with transfusions, dose modifications, and erythropoiesis-stimulating agents. Hypoxia managed with supplemental oxygen and dose interruption/reduction. Both toxicities are mechanistically expected from belzutifan and are reversible in the majority of cases.

Median follow-up	28.4 months (range 15.0–40.1)
DFS (primary endpoint)	HR 0.72 (95% CI 0.59–0.87); p=0.0003 — 28% reduction in recurrence or death
Median DFS	Not reached in either arm
12-month DFS rate	91.9% (combo) vs 85.2% (pembro alone)
24-month DFS rate	80.7% vs 73.7%
30-month DFS rate	75.8% vs 68.6%
Overall survival	HR 0.78 (95% CI 0.56–1.09); p=0.12 — immature (87 events of 300 needed)
Historical context	First adjuvant phase 3 RCC trial showing benefit for combination vs active immunotherapy comparator

Editorial note: This is the most consequential adjuvant RCC trial result since KEYNOTE-564. Enrolling 1,841 patients against an active immunotherapy comparator — not a placebo — is an ambitious design that makes the positive DFS result all the more clinically credible. The Nobel Prize-winning VHL-HIF biology now translates into a post-surgical combination standard. The key clinical nuance: patient selection for the toxicity burden is essential. Patients with significant pulmonary compromise or cardiovascular comorbidities require individual risk-benefit discussion before adding belzutifan to pembrolizumab.

Patient-reported outcomes in resected RCC: Active monitoring vs. durvalumab plus tremelimumab — RAMPART trial

Merrick S, Murphy L, Frangou E, et al.

J Clin Oncol. 2026;44(suppl 7):420. NCT03288532 (RAMPART)

BACKGROUND

RAMPART (NCT03288532) is an international, UK-led, multi-arm multi-stage (MAMS) phase 3 platform trial evaluating adjuvant immunotherapy after nephrectomy in patients with resected high- or intermediate-risk primary RCC. The primary efficacy results (presented at ESMO 2025) demonstrated that adjuvant durvalumab plus tremelimumab significantly improved DFS vs. active monitoring (3-year DFS: 81% vs 73%; HR 0.65; p<0.01), with the greatest benefit in patients at highest risk of relapse (HR 0.52 in high-risk subgroup). ASCO GU 2026 presented the pre-specified patient-reported outcomes (PRO) analysis for the durvalumab plus tremelimumab arm vs. active monitoring, providing critical quality-of-life data to contextualize the efficacy finding.

METHODS

790 patients enrolled from 80 international sites, randomized 3:2:2 to active monitoring (n=340), durvalumab monotherapy (n=225), or durvalumab plus tremelimumab (n=225). PRO analysis focused on Arm C (durvalumab plus tremelimumab) vs Arm A (active monitoring). Instruments: EORTC QLQ-C30 and EuroQoL EQ-5D. Primary PRO timepoint: Month 15. Secondary timepoints: Week 16 and other scheduled assessments. Clinically meaningful

differences defined as ≥10-point change on QLQ-C30 subscales.

CLINICAL IMPLICATIONS

The PRO data reveal an important trade-off: meaningful short-term quality-of-life decline at 16 weeks (fatigue, insomnia, role functioning) that largely resolves by month 15, followed by new declines in cognitive function and pain at the later timepoint. This pattern — consistent with immune-related adverse events and their downstream effects — must be integrated into patient counseling alongside the DFS benefit. The DFS benefit was most pronounced in the highest-risk subgroup, reinforcing the value of stratified patient selection.

KEY RESULTS

Week 16 PROs	Clinically meaningful declines in overall health/QoL, role functioning, fatigue, and insomnia in durvalumab+tremelimumab vs active monitoring
Month 15 PROs	Early week-16 differences largely resolved; new clinically meaningful declines in pain and cognitive function emerged at month 15 in the combination arm
3-year DFS	81% (combo) vs 73% (active monitoring); HR 0.65 (95% CI 0.45–0.93)
High-risk subgroup DFS	78% vs 61%; HR 0.52 — greatest benefit in highest-risk patients
Treatment completion	Only 23% of patients completed all 13 durvalumab infusions
Grade ≥3 AEs	40% in combination arm vs 8% in active monitoring; 32% discontinued due to toxicity; 36% required systemic corticosteroids

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CYTOSHRINK: Randomized phase II trial of cytoreductive stereotactic hypofractionated radiotherapy plus ipilimumab/nivolumab in metastatic kidney cancer. Lalani AK, Pond GR, Siva S, et al. *J Clin Oncol. 2026;44(suppl 7):416. NCT04090710*

BACKGROUND

The concept of using cytoreductive stereotactic body radiation therapy (SBRT) to debulk the primary tumor or dominant metastasis, combined with systemic immunotherapy, rests on the hypothesis that radiation-induced tumor antigen release (the 'abscopal effect') may prime the immune system and potentiate checkpoint inhibitor activity. CYTOSHRINK was designed as the first randomized trial to evaluate cytoreductive SBRT added to first-line ipilimumab plus nivolumab in patients with de novo advanced (poor- or intermediate-risk) metastatic RCC.

METHODS

Phase 2, randomized trial conducted at 7 sites in Canada and Australia. Eligible patients: biopsy-proven, untreated poor- or intermediate-risk de novo metastatic RCC. Randomization 2:1 to nivolumab plus ipilimumab with SBRT (30–40 Gy in 5 fractions; n=~32) versus nivolumab plus ipilimumab alone (n=24). SBRT delivered to the primary renal tumor or a dominant metastasis. Primary endpoint: 12-month progression-free survival rate in the intent-to-treat population.

KEY RESULTS

12-month PFS — ITT	34.9% (SBRT arm) vs 47.8% (IO alone arm) — HR 1.20 (95% CI 0.65–2.21); p=0.56 (not significant)
Median PFS — ITT	6.3 months (SBRT) vs 10.2 months (IO alone)
Per-protocol analysis	Median PFS 11.5 months vs 13.7 months — numerically favored addition of SBRT in compliant patients (underpowered)
Safety	No new safety signals attributable to SBRT addition; combination was safe and tolerable
Baseline imbalances	Noted by investigators; some prognostic imbalances may have influenced ITT outcome

LIMITATIONS

The trial was underpowered for definitive conclusions, with only ~56 total patients enrolled. Baseline imbalances between arms complicate direct comparison. The per-protocol subgroup showed numerically more favorable results for SBRT, but the difference was not significant. The hypothesis of radiation-immune synergy in RCC is mechanistically plausible but remains unconfirmed at this scale.

Editorial note: Negative trials matter. CYTOSHRINK closes the door on undifferentiated cytoreductive SBRT as a broad first-line add-on strategy in IO-treated metastatic RCC. It does not, however, disprove the biology — it raises the appropriate question of whether biomarker-selected populations (e.g., patients with high tumor mutational burden, specific immune microenvironment signatures, or single dominant lesions) might still benefit. The next iteration of this question should be hypothesis-driven and enriched.

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5. Adjuvant pembrolizumab in non-clear cell renal cell carcinoma: No clear benefit versus observation

ASCO GU 2026 · Abstract 473
J Clin Oncol. 2026;44(suppl 7):473

BACKGROUND

Non-clear cell RCC comprises approximately 20–25% of kidney cancer diagnoses, encompassing papillary, chromophobe, collecting duct, fumarate hydratase-deficient, and other rare histologies. Adjuvant pembrolizumab has demonstrated DFS and OS benefit in clear cell RCC following nephrectomy (KEYNOTE-564). Whether this benefit extends to non-clear cell histologies — which differ substantially in molecular biology, immune microenvironment, and natural history — has been unknown. This study evaluated adjuvant pembrolizumab vs. observation in a non-clear cell RCC cohort following nephrectomy.

METHODS

Single- or multi-cohort study evaluating adjuvant pembrolizumab in patients with non-clear cell RCC following curative-intent nephrectomy. Patients had histologically confirmed non-clear cell histology (subtypes including papillary, chromophobe, unclassified, and other variants). Comparator: observation/active monitoring. Primary endpoint: disease-free survival. A prospective, randomized cooperative group study for papillary RCC is being planned based on these findings.

KEY RESULTS

Primary outcome	No statistically significant or clinically meaningful DFS benefit for pembrolizumab vs observation in non-ccRCC
Clinical implication	KEYNOTE-564 adjuvant data should not be extrapolated to non-clear cell histologies
Next steps	Larger, molecularly stratified, prospective cooperative group trial planned for papillary RCC
Context	Papillary RCC accounts for ~15–20% of all RCC; is the most common non-ccRCC subtype

DISCUSSION

Non-clear cell RCC subtypes differ fundamentally from clear cell in their oncogenic drivers, immune infiltration patterns, and response to checkpoint inhibition. The negative result here is scientifically expected and clinically important — it disciplines the field against inappropriate extrapolation of clear cell data to biologically distinct histologies. The planned prospective study in papillary RCC represents the appropriate next step, with calls for molecular stratification (e.g., MET pathway activation in papillary type 1) to identify potential responders.

Editorial note: A principled negative result that protects patients from receiving ineffective therapy. In the non-ccRCC space, the most encouraging signal at GU26 came from FH-deficient RCC (lenvatinib plus tislelizumab, ~90% ORR) — suggesting subtype-specific trials, not blanket IO application, are the correct strategy. Abstract 473 reinforces that message emphatically.

Ivonescimab (PD-1 × VEGF bispecific antibody) in metastatic clear cell RCC after immune checkpoint inhibitor therapy — Phase II IVORY trial

ASCO GU 2026 · IVORY Trial.
J Clin Oncol. 2026;44(suppl 7).

BACKGROUND

Ivonescimab (AK112) is a novel bispecific antibody that simultaneously targets PD-1 (programmed death-1) and VEGF (vascular endothelial growth factor). Unlike combination regimens using separate agents, ivonescimab delivers dual blockade through a single molecule, potentially achieving spatial co-localization of immune checkpoint release and anti-angiogenic activity within the tumor microenvironment. The mechanism is conceptually distinct from sequential IO and TKI therapy, and may offer improved tumor penetration and a unique toxicity profile. The IVORY trial is the first dedicated evaluation of ivonescimab in RCC patients who have progressed on prior checkpoint inhibitor-based therapy — the same post-IO setting addressed by LITESPARK-011.

METHODS

Phase 2, single-arm trial evaluating ivonescimab monotherapy in patients with metastatic clear cell RCC who had received and progressed on prior immune checkpoint inhibitor therapy. Endpoints included objective response rate (ORR), duration of response

(DoR), progression-free survival, and safety. Patient population: post-IO ccRCC with measurable disease per RECIST 1.1.

KEY RESULTS & CONTEXT

The IVORY trial provided early efficacy and safety signals for ivonescimab in the post-IO RCC setting. In the broader ivonescimab clinical development program in oncology, ORRs of 20–35% have been reported in heterogeneous solid tumor populations treated post-IO. The bispecific mechanism generated particular interest for its potential to overcome resistance mechanisms operative after checkpoint inhibitor progression, including upregulation of VEGF-mediated immune suppression in the tumor microenvironment.

Mechanism	Bispecific antibody: dual PD-1 + VEGF blockade in a single molecule
Setting	Metastatic ccRCC after prior immune checkpoint inhibitor therapy
Trial design	Phase 2, single-arm
Differentiation	Single-molecule dual blockade vs. combination regimen; distinct from belzutifan (HIF-2α vs. VEGF)
Development status	Phase 2; phase 3 design pending efficacy/safety confirmation

Editorial note: Bispecifics represent the next frontier in RCC systemic therapy. With LITESPARK-011 now establishing the post-IO standard with a HIF-2a/VEGFR-TKI combination, ivonescimab must demonstrate clear differentiation — whether through distinct mechanism of action, improved tolerability, or superior efficacy in specific molecular subgroups. The IVORY data position ivonescimab as a credible pipeline asset, but definitive clinical validation requires randomized phase 3 data. Worth tracking closely as the post-IO landscape evolves.

Abstract 537 Circulating KIM-1 and ctDNA as prognostic markers in oligometastatic clear cell RCC: The K-COMPASS model.

Tang C et al. J Clin Oncol. 2026;44(suppl 7):537. NCT03575611

BACKGROUND

Patients with oligometastatic clear cell RCC (≤5 metastases) represent a clinically distinct population in whom metastasis-directed therapy (MDT) — including stereotactic radiotherapy, surgical resection, or thermal ablation — can achieve meaningful disease control without systemic therapy. However, no validated biomarkers exist to triage these patients for de-escalation strategies (MDT alone) versus escalation to systemic therapy. Two promising blood-based biomarkers are kidney injury molecule-1 (KIM-1) — a transmembrane glycoprotein overexpressed in RCC and detectable in peripheral blood — and circulating tumor DNA (ctDNA), which reflects tumor-derived genomic material. Both have demonstrated independent prognostic value in metastatic RCC; this is the first study to analyze them in tandem specifically in the oligometastatic setting.

METHODS

Prospective single-arm phase 2 trial (NCT03575611) of MDT without systemic therapy in patients with oligometastatic ccRCC (≤5 metastases). Blood samples collected at baseline and 3 months post-MDT for KIM-1 measurement (ELISA) and ctDNA detection (next-generation sequencing). Primary endpoint: systemic therapy-free survival. K-COMPASS model developed by integrating KIM-1, ctDNA, and clinical factors (IMDC risk, number of metastases, prior therapy) using penalized regression with calibration assessment. n=112 patients.

KEY RESULTS

Sample size	n=112 oligometastatic ccRCC patients receiving MDT without systemic therapy
KIM-1 prognostic value	Baseline and 3-month KIM-1 levels strongly and independently associated with systemic therapy-free survival
ctDNA prognostic value	Baseline and 3-month ctDNA independently associated with outcomes; both detectable despite RCC's low-shedding phenotype
K-COMPASS model	Integration of KIM-1 + ctDNA + clinical factors yielded high discrimination and excellent calibration for risk-adapted decision-making
First-of-kind	First evaluation of KIM-1 in oligometastatic ccRCC; first combined KIM-1+ctDNA analysis in any RCC setting
Validation	External validation cohort planned; not yet validated for routine clinical use

CLINICAL SIGNIFICANCE

The K-COMPASS model addresses one of the most difficult clinical decisions in kidney cancer management: which oligometastatic patients can be safely managed with MDT alone, and which require systemic therapy added to local treatment. A well-calibrated, externally validated model combining low-cost blood biomarkers with clinical factors would represent a major advance in individualized decision-making, potentially sparing lower-risk patients from systemic therapy toxicity while directing higher-risk patients toward earlier treatment intensification.

Editorial note: The most sophisticated translational science abstract from GU26. The combination of two orthogonal biomarkers (a protein and DNA-based marker) with clinical variables into a decision model represents the kind of multi-dimensional thinking that moves beyond single-biomarker approaches. The field now needs a prospective validation study — ideally within a randomized trial that uses K-COMPASS to guide systemic therapy decisions — to establish clinical utility beyond prognostic association.

Abstract 445 Serum IgG as a predictive biomarker for outcomes with first-line IO plus TKI combinations in advanced clear cell RCC. ASCO GU 2026 · Abstract 445.

J Clin Oncol. 2026;44(suppl 7):445

BACKGROUND

Despite the availability of multiple IO-TKI combinations for first-line advanced ccRCC, no validated predictive biomarker guides selection between regimens or identifies patients most or least likely to benefit. Traditional markers — PD-L1 expression, IMDC risk score, VHL mutation status — have demonstrated limited predictive utility in randomized trials. Immunoglobulin G (IgG) is a circulating antibody produced by B cells and plasma cells that reflects humoral immune activation. Pre-clinical and retrospective clinical data have suggested that B cell and humoral immune function may contribute to checkpoint inhibitor efficacy, particularly in IO-TKI combinations.

METHODS

Biomarker analysis evaluating the predictive and prognostic value of serum IgG levels in patients with advanced clear cell RCC receiving first-line IO plus TKI combination therapy. Serial serum samples collected at baseline and on-treatment timepoints. Correlative analyses performed against PFS, ORR, and OS. Statistical analysis included landmark analyses and landmark IgG change analyses to assess whether dynamic changes in IgG predict outcomes beyond baseline levels.

KEY RESULTS

Primary finding	Changes in serum IgG levels identified as an independent and significant predictor of outcomes with first-line IO+TKI combinations
Directionality	On-treatment IgG dynamics (changes from baseline) stood out as more informative than baseline IgG alone
Clinical accessibility	IgG is a standard, low-cost, widely available clinical laboratory test — potential for immediate clinical translation if validated
Context	No single biomarker currently guides first-line IO+TKI selection in clinical practice
Validation needed	Prospective validation in a randomized biomarker-selected cohort required

DISCUSSION

The appeal of serum IgG as a biomarker lies in its simplicity. Unlike ctDNA (technically demanding, limited by RCC's low-shedding phenotype) or complex transcriptomic signatures (requiring tumor biopsy and specialized assays), IgG can be measured from a routine blood draw in any clinical laboratory globally. This makes it particularly relevant for equity-focused implementation in resource-limited settings. If prospectively validated, IgG monitoring could provide an accessible early signal of treatment response or resistance that can inform clinical decision-making without sophisticated infrastructure.

Editorial note: The most equity-relevant biomarker abstract at GU26. In a world where KIM-1 assays and next-generation sequencing platforms are not universally available, a routine immunoglobulin panel that predicts IO-TKI response would be transformative for global kidney cancer care. The hypothesis is mechanistically grounded in the growing recognition of B cell roles in anti-tumor immunity. The key next step: a prospective biomarker-stratified trial that tests whether IgG-guided treatment selection improves outcomes over unselected allocation.

BOOST-RCC BOOST-RCC: Bolstering outcomes by optimizing immunotherapy with evolocumab plus nivolumab in metastatic renal cell carcinoma

Gong K et al. · Peking University First Hospital

J Clin Oncol. 2026;44(suppl 7). Phase II

BACKGROUND & SCIENTIFIC RATIONALE

BOOST-RCC investigates a conceptually novel combination: evolocumab (a PCSK9 inhibitor, approved for hypercholesterolemia) combined with nivolumab in metastatic RCC. The rationale connects cholesterol metabolism to immune function: PCSK9 inhibition reduces LDL cholesterol and has been shown in pre-clinical models to upregulate surface expression of MHC class I molecules on tumor cells, thereby enhancing tumor antigen presentation and T-cell-mediated cytotoxicity.

METHODS

Phase 2 study evaluating evolocumab (PCSK9 inhibitor, subcutaneous administration every 2 weeks or monthly) combined with nivolumab (PD-1 inhibitor, intravenous every 4 weeks) in patients with metastatic RCC. Presented early clinical data including safety, tolerability, and preliminary efficacy signals from the phase 2 cohort.

KEY RESULTS & CONTEXT

Mechanism	PCSK9 inhibition → MHC-I upregulation → enhanced T cell recognition of tumor cells
Drug class	Cardiovascular drug (evolocumab) repurposed as immune potentiator
Combination partner	Nivolumab (anti-PD-1)
Setting	Metastatic RCC
Phase	Phase 2 — early clinical data
Novelty	First clinical evaluation of PCSK9 inhibition as an immunotherapy adjunct in RCC

Editorial note: Scientifically, BOOST-RCC is the most intellectually provocative abstract at GU26. Repositioning an approved cardiovascular drug as

an immune potentiator — grounded in mechanistic pre-clinical work on cholesterol-MHC interactions — exemplifies the kind of cross-disciplinary thinking that precedes paradigm shifts. The practical appeal: evolocumab is widely available, has a well-characterized safety profile, and could be added to IO regimens with manageable incremental toxicity. Whether the clinical signal justifies expansion to phase 3 will depend on the size and durability of the efficacy signal — but the concept is compelling enough to demand rigorous follow-up.

Emotional concerns in kidney cancer and disparities in patient support across North America: Results from the IKCC Global Patient Survey. Brugarolas JM et al. UT Southwestern Medical Center / International Kidney Cancer Coalition

J Clin Oncol. 2026;44(suppl 7):490

METHODS

Cross-sectional survey of kidney cancer patients across North America (United States, Canada) via the IKCC Global Patient Survey platform. Participants self-reported: emotional concerns related to kidney cancer diagnosis and treatment, help-seeking behaviors for emotional support, access to psychosocial services, communication with clinical teams about emotional wellbeing, and sociodemographic characteristics. Analyses examined disparities across racial, socioeconomic, geographic, and disease-stage subgroups.

CLINICAL AND POLICY IMPLICATIONS

As kidney cancer treatment becomes more effective — and more complex, with multi-drug combinations requiring active management — the psychological infrastructure supporting patients must scale in parallel. The growing adjuvant treatment paradigm creates a population of patients receiving systemic therapy for 1+ years in the setting of no measurable disease, creating unique psychological challenges around treatment-related anxiety, fear of recurrence, and functional impairment. These patients are at particular risk for underrecognized emotional burden. The disparities documented across racial and socioeconomic lines have direct implications for health equity in oncology — access to psycho-oncology support should not be a premium service available only to well-resourced patients.

KEY RESULTS

Emotional burden	Majority of North American kidney cancer patients report significant emotional distress attributable to their diagnosis
Help-seeking	Few patients sought formal psychological support despite reporting meaningful emotional burden
Clinical team communication	Low rates of proactive discussion of emotional wellbeing by clinical teams; patients rarely directed to support resources
Disparities documented	Racial, socioeconomic, and geographic disparities in access to and utilization of psychosocial support identified across North America
Unmet need	Gap between reported emotional burden and formal support access is widest in underserved and rural populations
System gap	Psychological support infrastructure does not scale proportionally with treatment intensity or survivorship duration

Editorial note: The only abstract in this top 10 without a hazard ratio — and among the most important for everyday clinical practice. In a meeting focused on molecular precision, this survey serves as a reminder that patient-centered care requires attending to the whole person. The data are a mandate: not a suggestion that clinical teams 'consider' psychological support, but evidence that the field is systematically failing to provide it, particularly to the patients who face the greatest structural barriers to accessing it. This is not a soft finding. It is a call for systemic change in how oncology practices are resourced and evaluated.