



FALCON Symposium and Studyathon

September 28 – October 1, 2026

OHDSI Community Meeting
6 October 2026

Disclosure



Asieh Golozar



Christian Reich



OHDSI Oncology WG



FALCON

Oncology Research Network

FALCON Symposium

Making real-world evidence count in oncology

28 September 2026 · Dunden, Antwerp, Belgium

Agenda and speakers

Speakers



Annelies Verbiest
UZA & OHDSI Belgium, Belgium



Leana Bellanca
AstraZeneca, United Kingdom



Miriam Koopman
UMC Utrecht & ESMO, Netherlands



Liesbet M. Peeters
Hasselt University & OHDSI Belgium



Peter De Jaeger
AZ Delta & FHIN, Belgium



Asieh Golozar
OHDSI & Nemesis Health, USA



Nick Marly
Cabinet of Frank Vandenbroucke, Belgium



Christian Reich
OHDSI & Nemesis Health, USA



Elad Sharon
Dana-Farber Cancer Institute, USA



Kimmo Porkka
University of Helsinki & HUS, Finland



Henar Hevia
Johnson & Johnson Innovative Medicine, Spain



Christof Vulsteke
AZ Maria Middelaers & University of Antwerp, Belgium

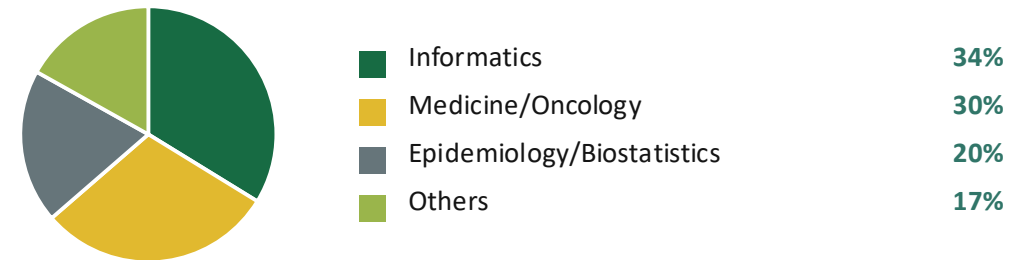
Time	Session	Speakers
12:15	Registration & welcome coffee	
13:00	Oncology today	Annelies Verbiest
13:20	ESMO roadmap 2030	Miriam Koopman
13:35	How are we using cancer data today — and where do they fall short?	Panel: P. De Jaeger, N. Marly, E. Sharon, H. Hevia, L. Bellanca, M. Koopman Moderators: L. M. Peeters, C. Reich
15:15	Coffee break	
15:45	Why real-world evidence does not work in cancer and what must change	Christian Reich
16:00	FALCON: a global high-quality cancer evidence network	Asieh Golozar
16:15	FALCON-Lung: lessons from the largest mNSCLC real-world study to date	Kimmo Porkka
16:30	Bladder cancer: revolution, hope and blind spots	Christof Vulsteke
16:45	FALCON-Bladder: pioneering a new way to generate guideline-relevant RWE	Asieh Golozar
17:05	Meet the FALCON data partners	
17:15	Closing remarks & network drink	

Who was in the room?

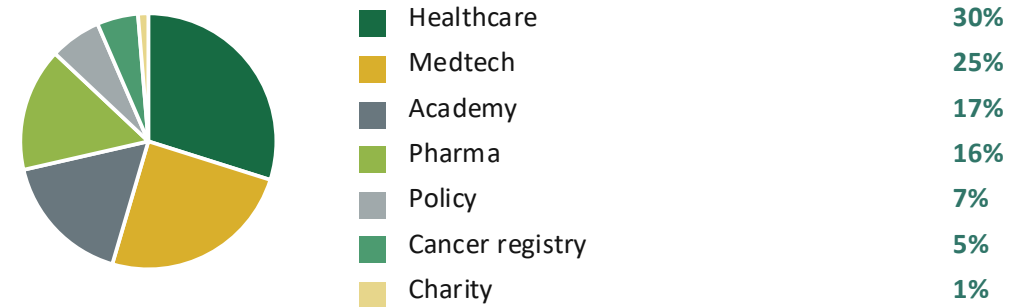


77 attendees

Fields of expertise



Affiliations



Panel Discussion Themes

- Speed of RWE generation: does it matter and why
- Minimal datasets: aren't we using full data
- Data Partners: what's in it for them and can they be incentivized to make data available
- AI: does it need quality data in OMOP, or can embedding do the semantics
- AI: will make it us obsolete if we are successful

FALCON Bladder Studyathon

Three hands-on days on the FALCON Bladder protocol

29 September – 1 October 2026
Dunden, Antwerp, Belgium

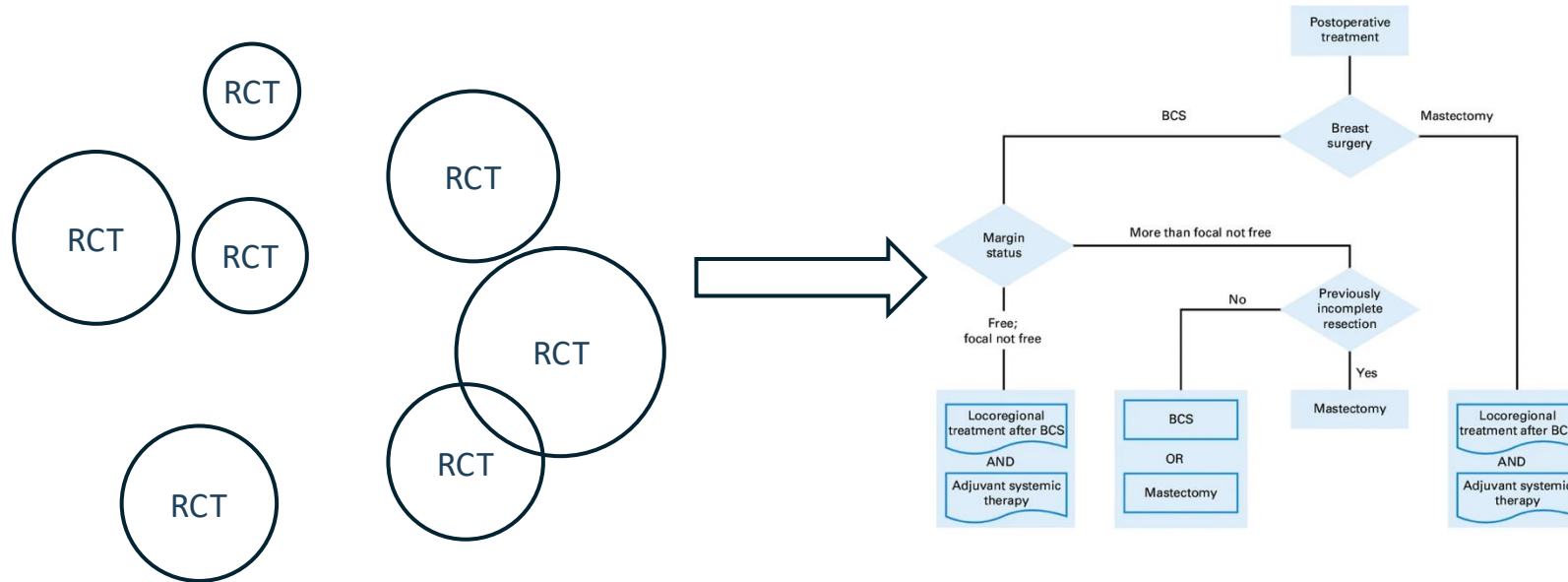
59 participants, in person and online



A patient has advanced bladder cancer.

How are treatment decisions made?

A Guideline is Constructed from RCTs

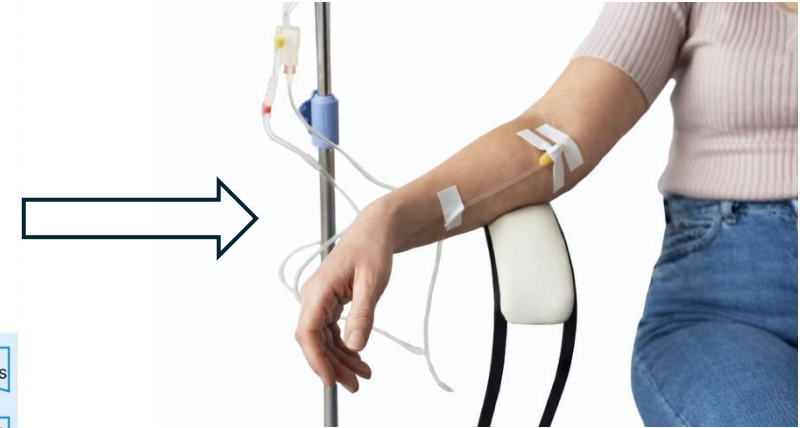
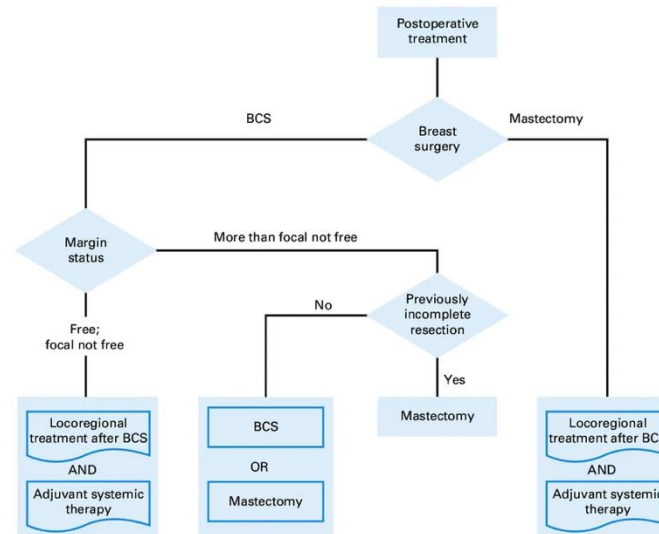


Abstraction

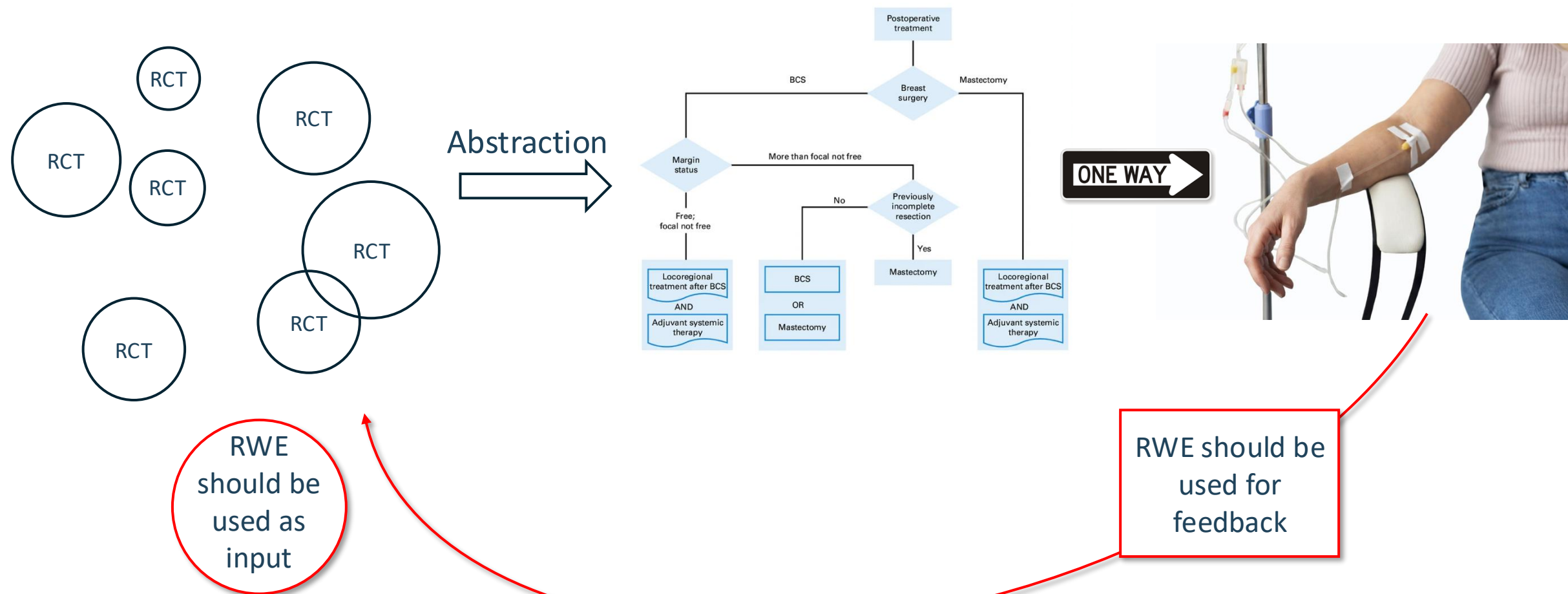
Why not from RW?

Providers know the Guideline and Treat Accordingly.

Are we sure?



What Value can RWE bring?



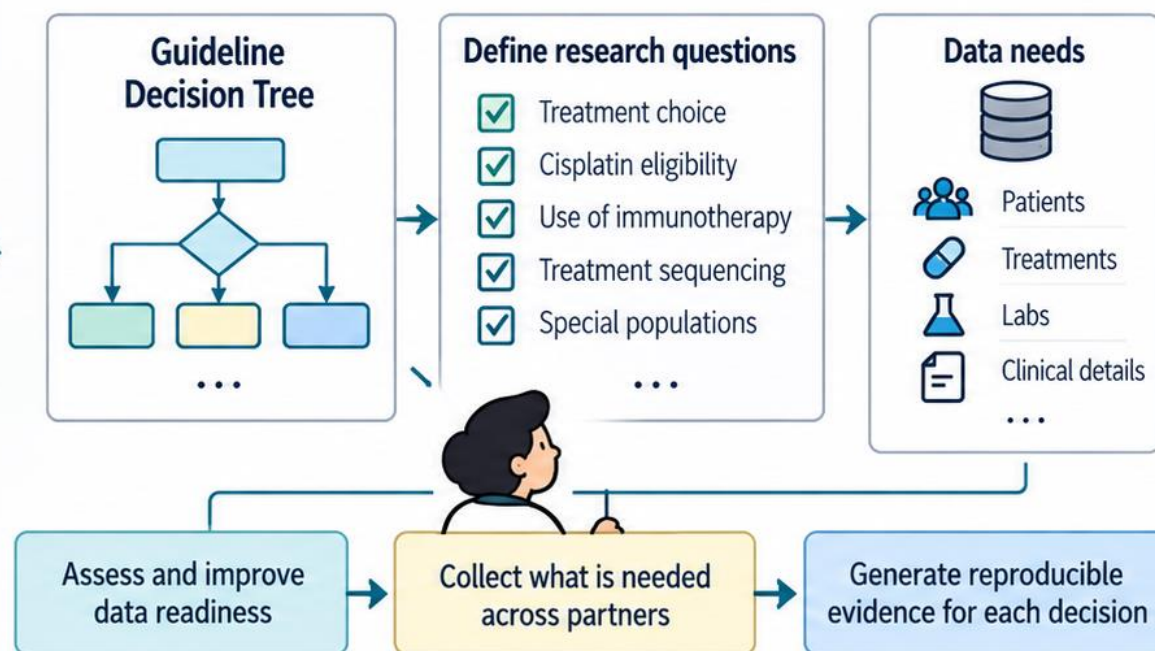
Traditional real-world evidence

Questions are driven by what the data can support.
Analyses are often adapted to fit the data.



Systematic real-world evidence

Start with the clinical questions, systematically assess and collect the data needed, and generate evidence for each decision.



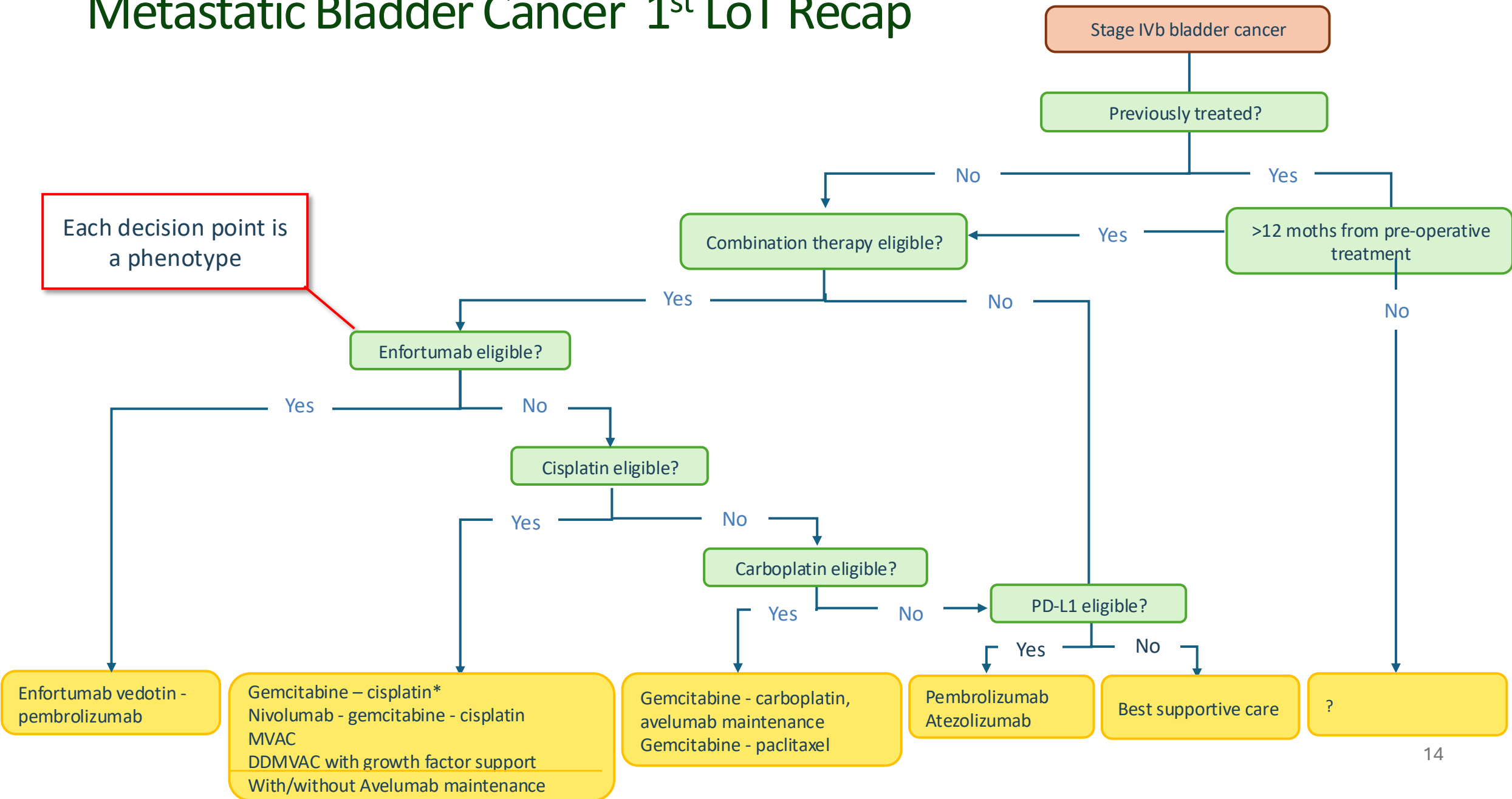


Guidelinathon Metastatic Bladder Cancer

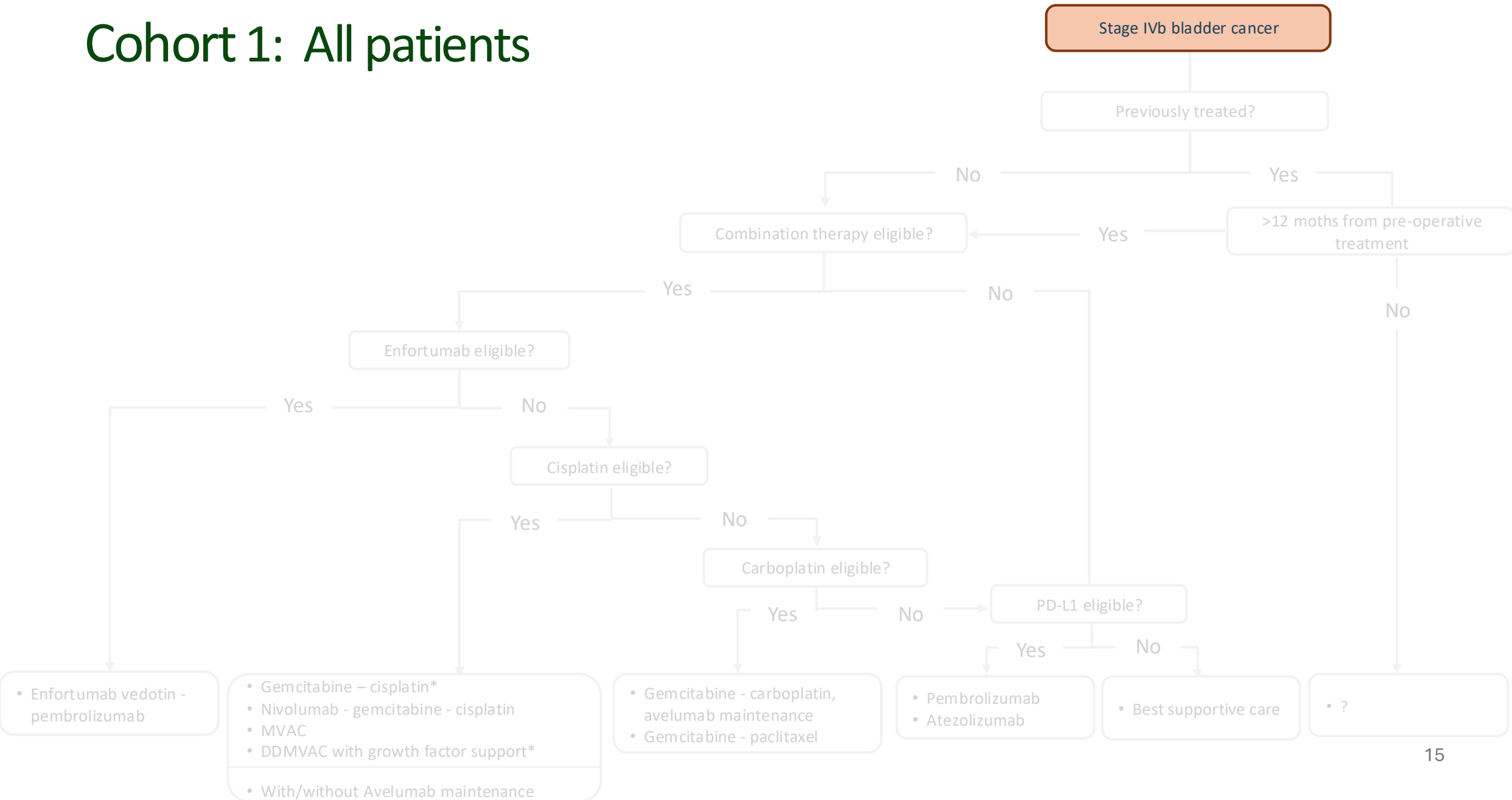


Metastatic Bladder Cancer 1st LoT Recap

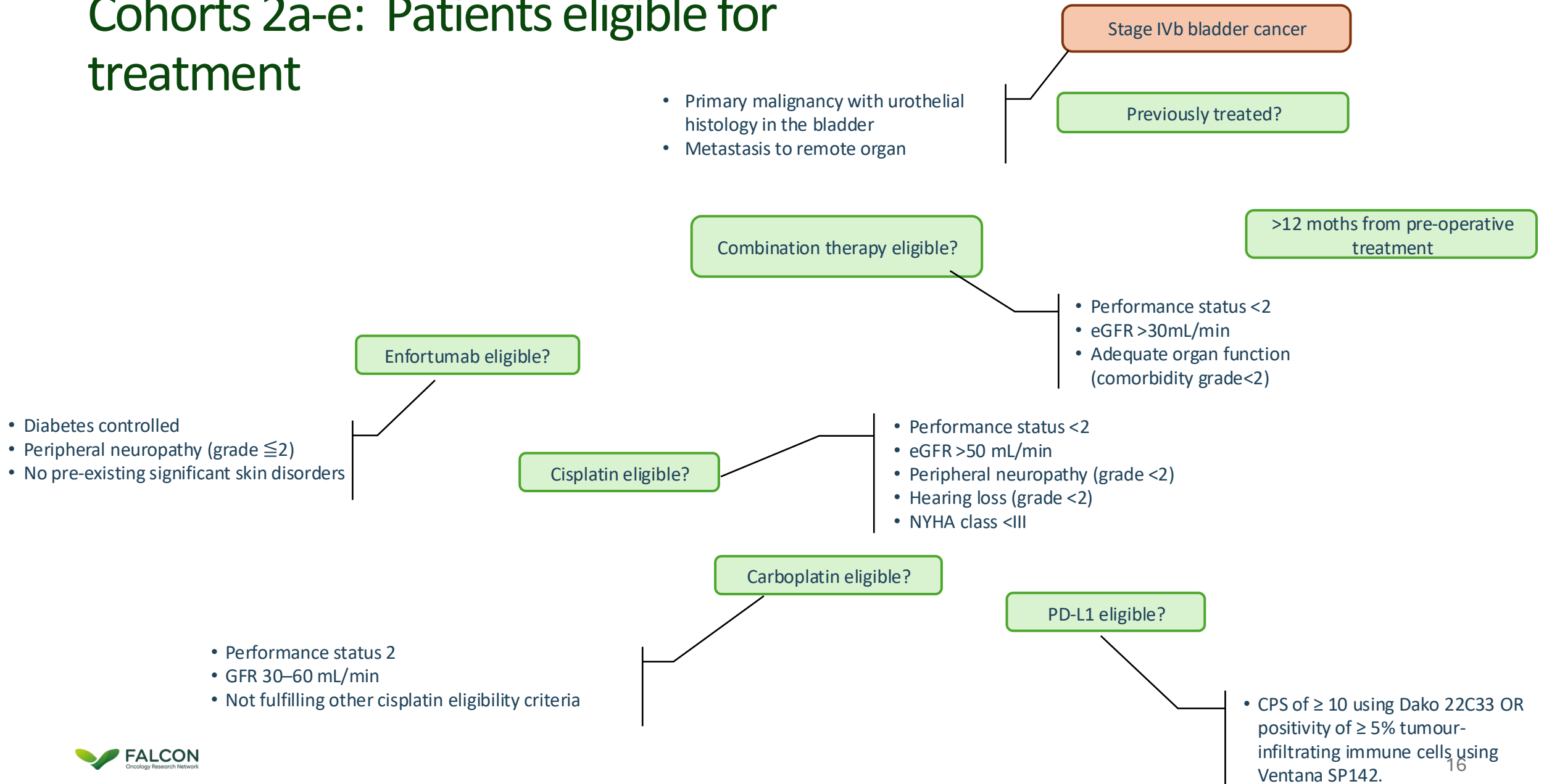
Each decision point is a phenotype



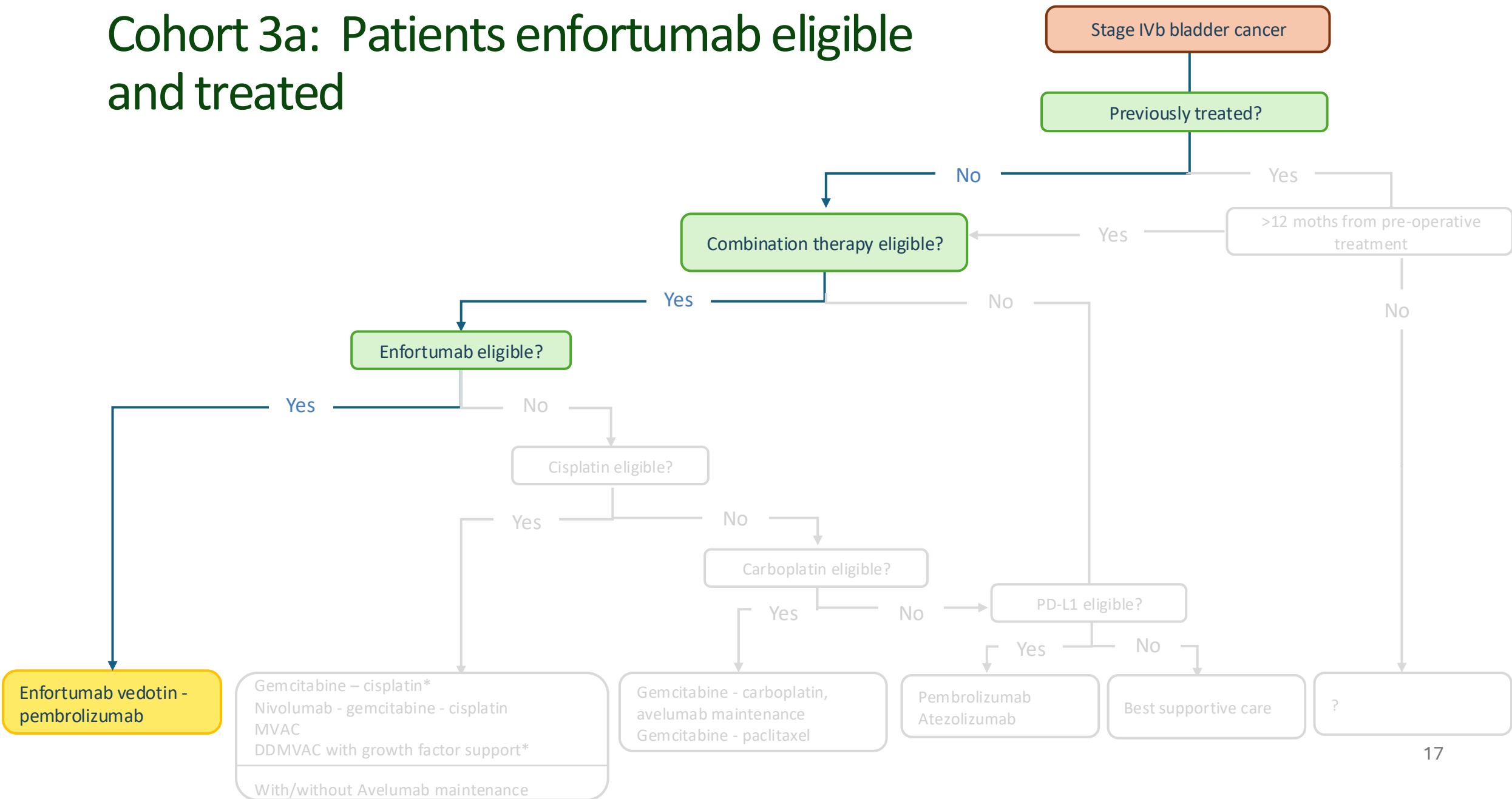
Cohort 1: All patients



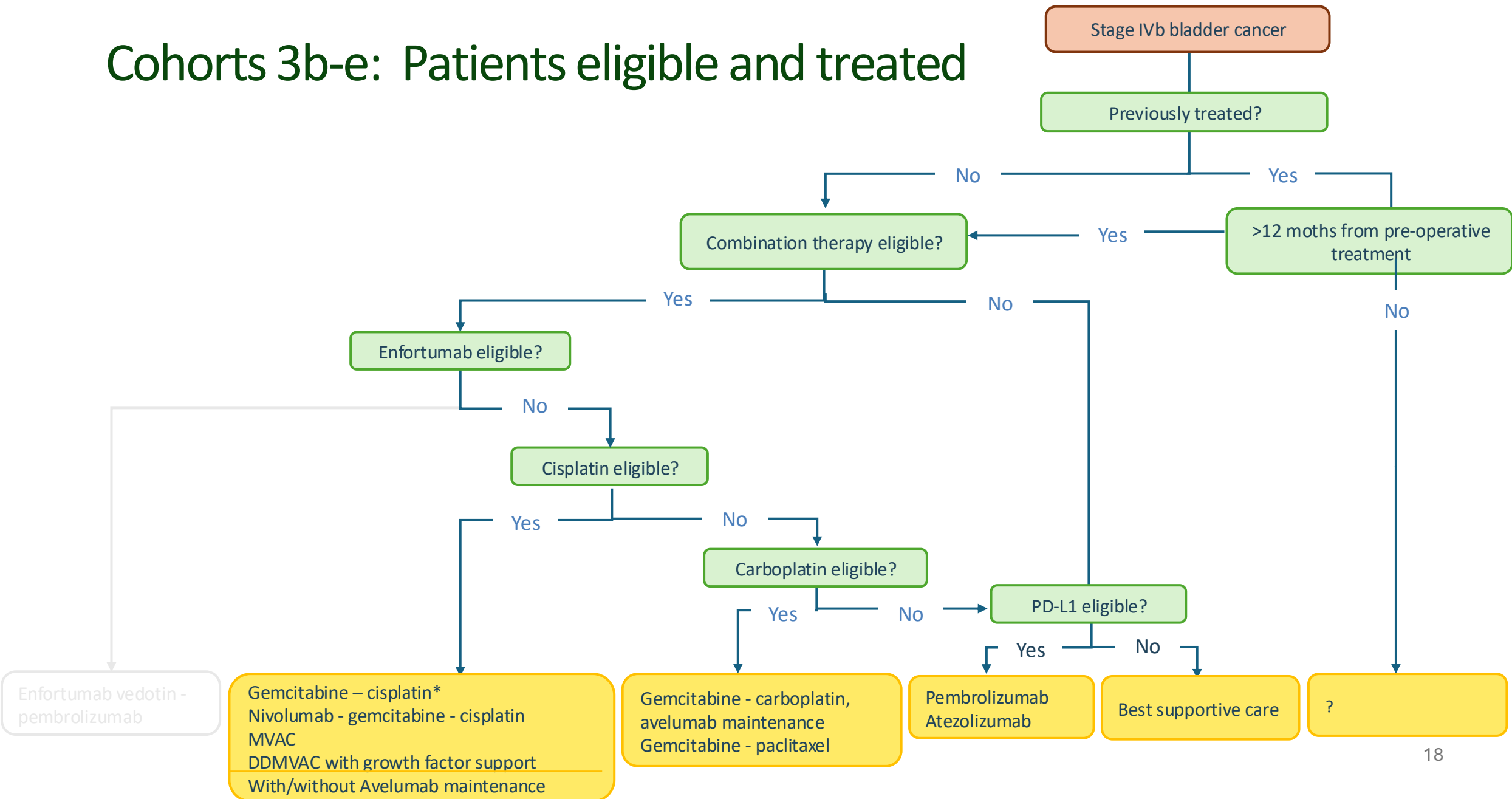
Cohorts 2a-e: Patients eligible for treatment



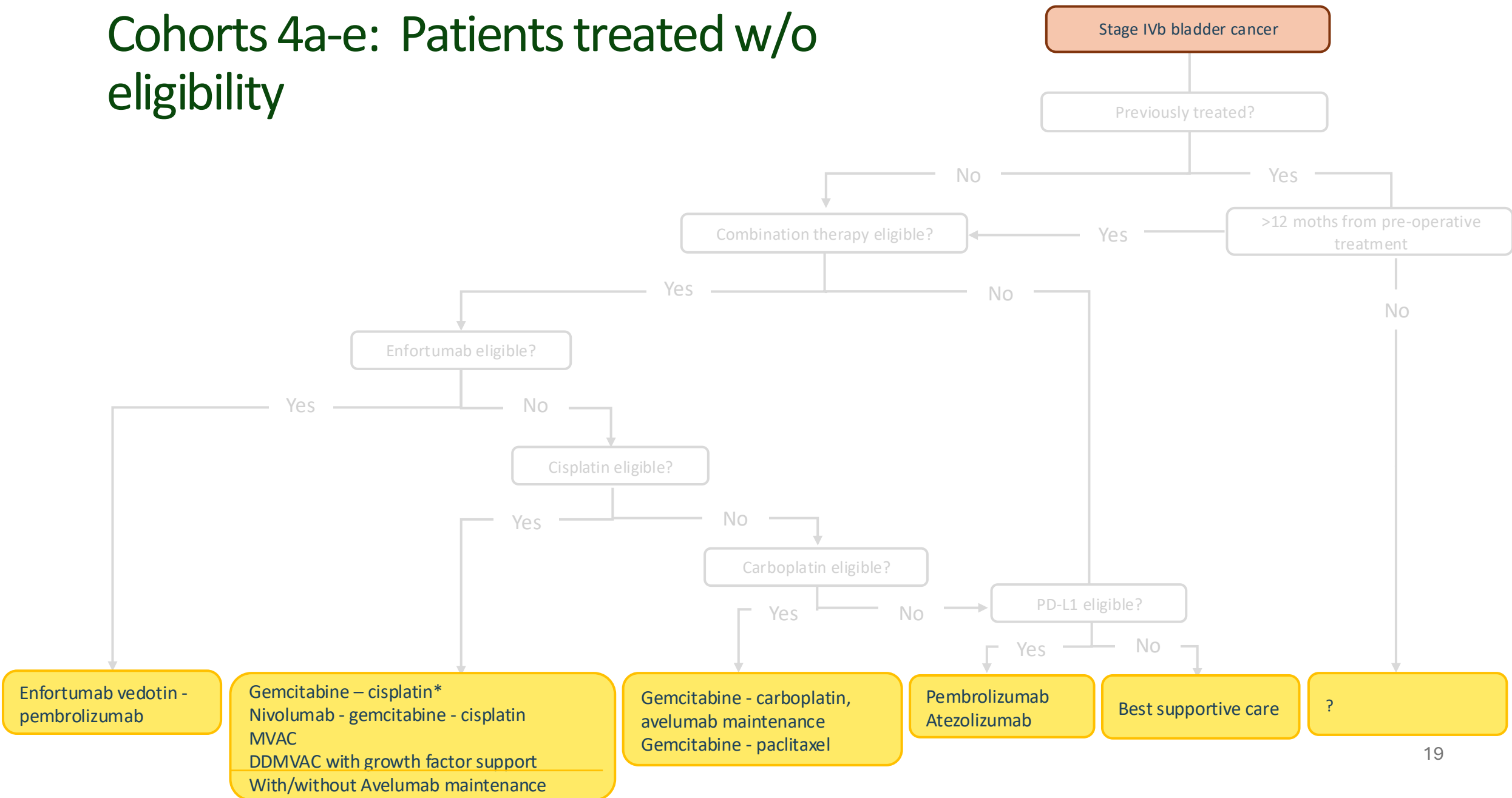
Cohort 3a: Patients enfortumab eligible and treated



Cohorts 3b-e: Patients eligible and treated



Cohorts 4a-e: Patients treated w/o eligibility

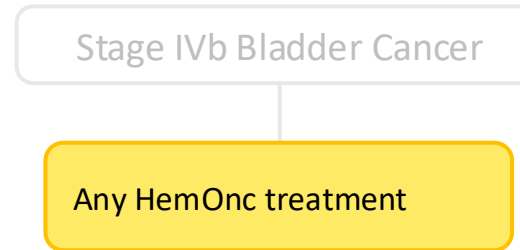


Cohorts 5: Patients with **indicated** HemOnc treatments

Stage IVb Bladder Cancer

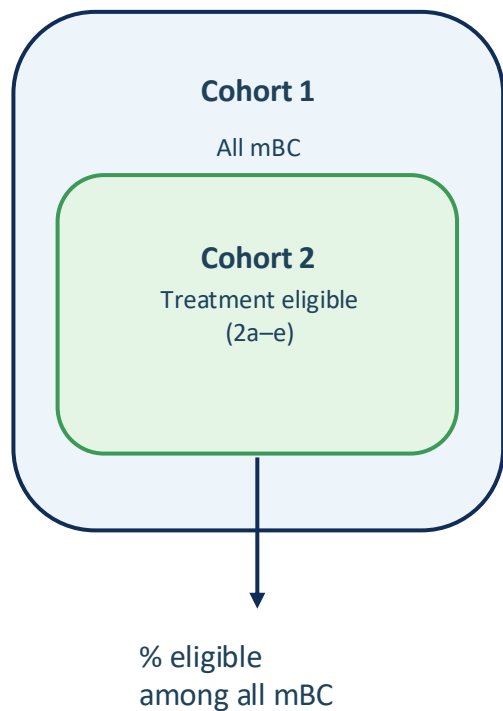
Any treatment not in
Guideline but in HemOnc

Cohorts 6: Patients with **any** HemOnc treatments



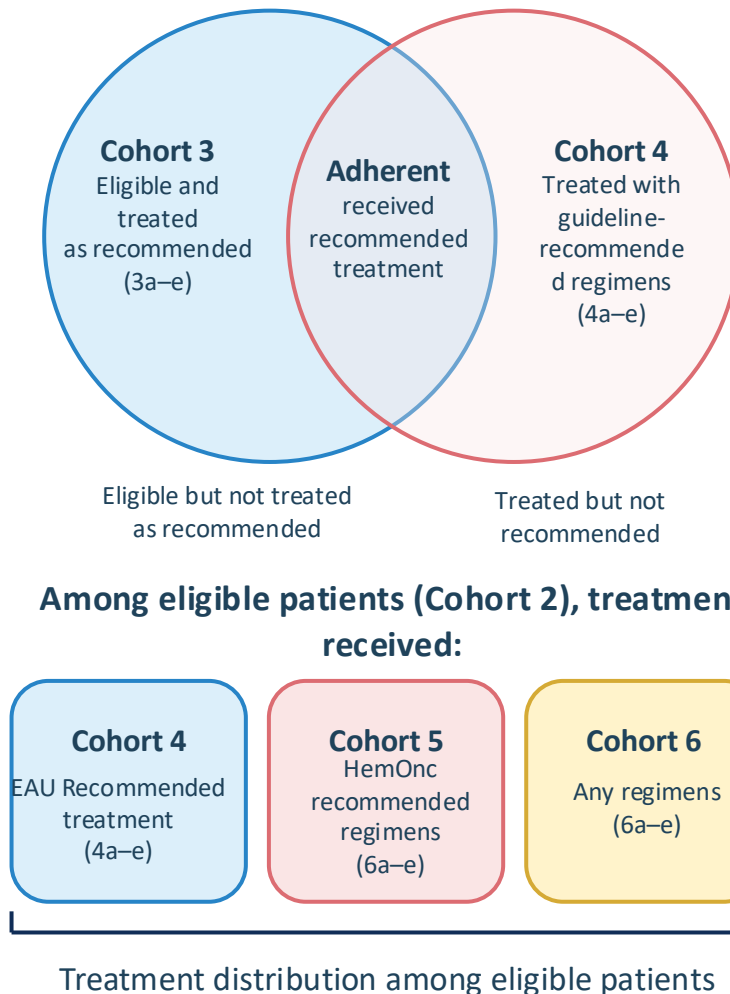
A. Relevance

What proportion of the mBC population is eligible at each decision point?



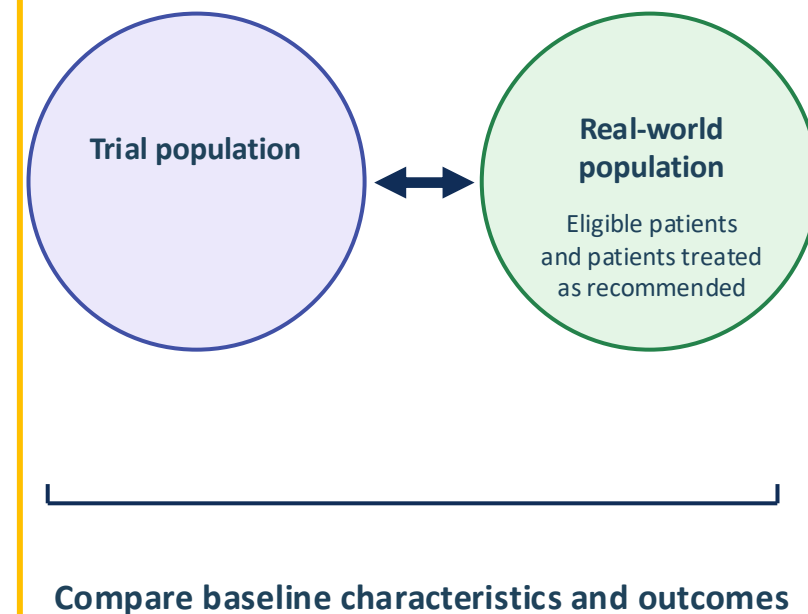
B. Adherence

Among eligible patients, did they receive the recommended treatment?



C. Generalizability

How do real-world eligible/treated patients compare with trial populations?





- The first large-scale federated oncology RWE network
- +50 data partners
- 19 countries
- 194,904,822 lives





Preconditions to Oncology Network Research

Dealing with Cancer Complexity

A Build the network

Move from fragmented single-center studies to federated, multi-site evidence generation at scale

B Build Research Questions from Guidelines

Identify and standardize oncology related details required for reliable evidence

Fixing the Data

C Connect the silos

Aggregate patient data from the silos inside an organization and take care of most of the fragmentation

D Fix the quality

Systematically assess, clean, and validate data through structured diagnostics



FALCON-Bladder Data Partner Status

Complete 19

FI	Helsinki University Hospital (HUS)
FI	Varsinais-Suomen hyvinvointialue (Varha)
FI	Pirkanmaan hyvinvointialue (Pirha)
EE	University of Tartu (Tartu)
DE	Universitätsklinikum Hamburg-Eppendorf (UKE)
GR	Papageorgiou General Hospital (PGH)
IT	Azienda Ospedaliero-Universitaria di Parma (Parma)
JP	Medical Data Vision Co., Ltd. (MDV)
NL	Integraal Kankercentrum Nederland (iKNL)
NO	Cancer Registry of Norway (CRN)
ES	Institut Hospital del Mar d'Investigacions Mèdiques (IMIM-IMASIS)
ES	Instituto de Investigación Sanitaria La Fe (IIS La Fe)
GB	Leeds Teaching Hospitals NHS Trust (Leeds)
BE	Universitair Ziekenhuis Antwerpen (UZA)
BE	Grand Hôpital de Charleroi (GHDC)
US	Dana-Farber Cancer Institute (DFCI)
US	HealthPartners Institute (HealthPartners)
US	University of Colorado (Colorado)
NS	Wayfind-R

Data preparation in progress 11

DE	Charité – Universitätsmedizin Berlin (Charité)
HU	Semmelweis University (Semmelweis)
NO	Oslo University Hospital (OUS)
PT	Unidade Local de Saúde de Matosinhos (ULMS)
KR	Yonsei University Hospital (Yonsei)
SE	Karolinska
TW	Taipei Medical University (TMU)
US	Mount Sinai Health System (Mt Sinai)
US	Johns Hopkins (JHMI)
US	University of Massachusetts (UMass)
US	Washington University in St. Louis (WashU)

Results will be expected after the studyathon 2

BE	Centre Hospitalier Chrétien (CHC)
BE	Centre Hospitalier Universitaire de Liège (CHU Liège)

Might join after the studyathon 7

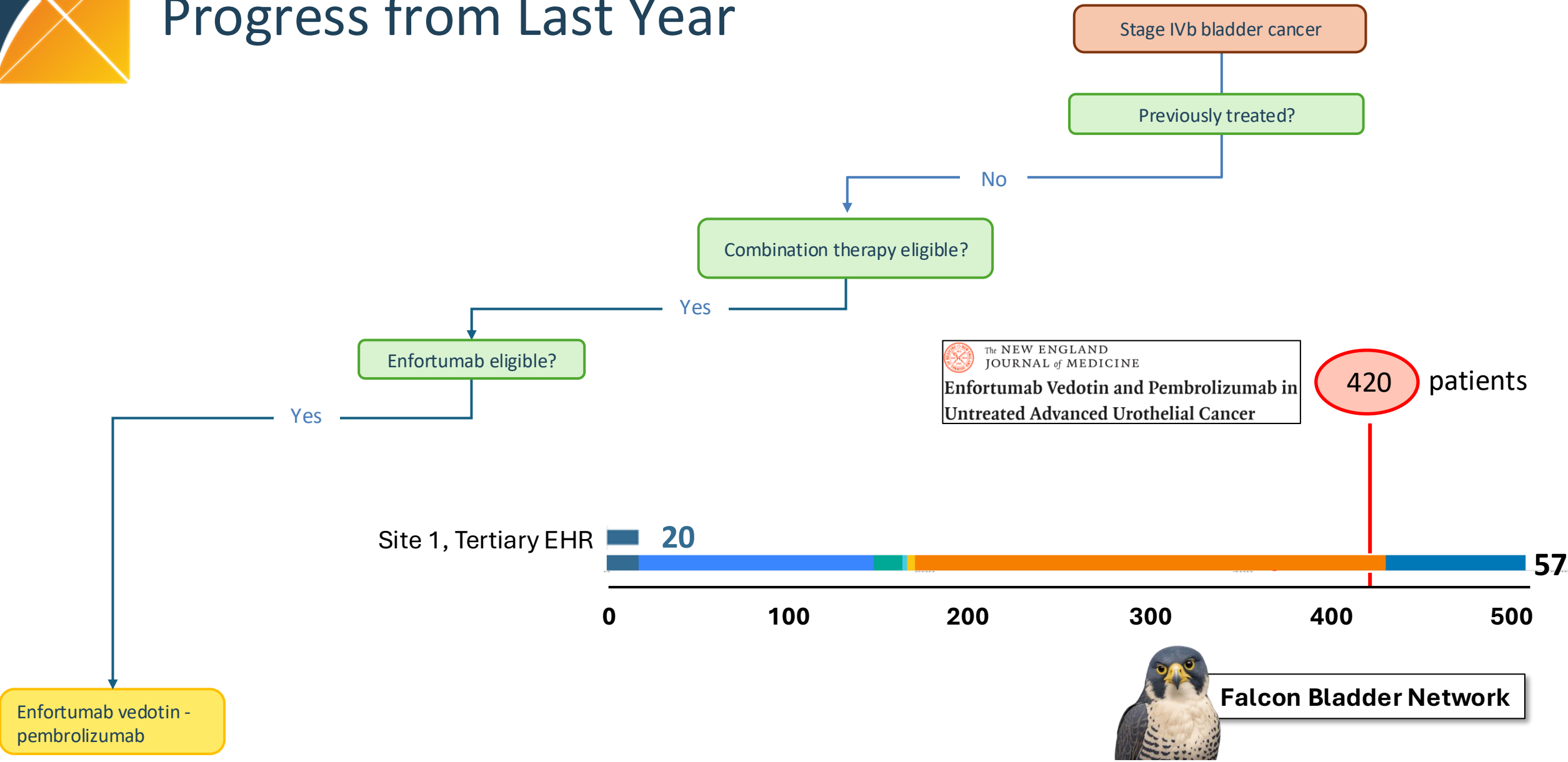
US	Mayo Clinic (Mayo)
US	University of California Health Systems (UC Health)
US	UT Southwestern Medical Center (UT Southwestern)
ES	Hospital Universitario Virgen Macarena
US	Tufts Medical Center (Tufts)
IQVIA	IQVIA Oncology EMR
IQVIA	IQVIA PharMetrics Plus / AmbEMR

Not participating 5

BE	Université catholique de Louvain (UC Louvain)
BE	AZ Groeninge
BE	AZ Maria Middelares
US	Columbia University Irving Medical Center (CUIMC)
US	Emory Winship Cancer Institute (Emory)



Progress from Last Year

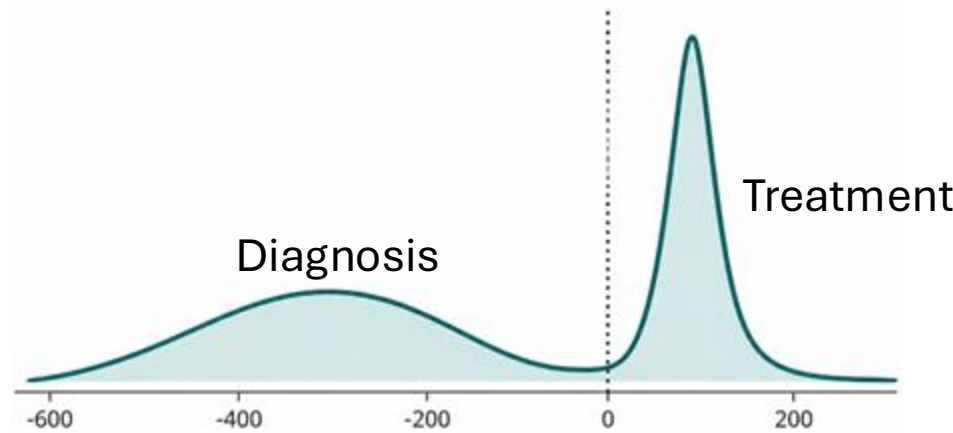


Results

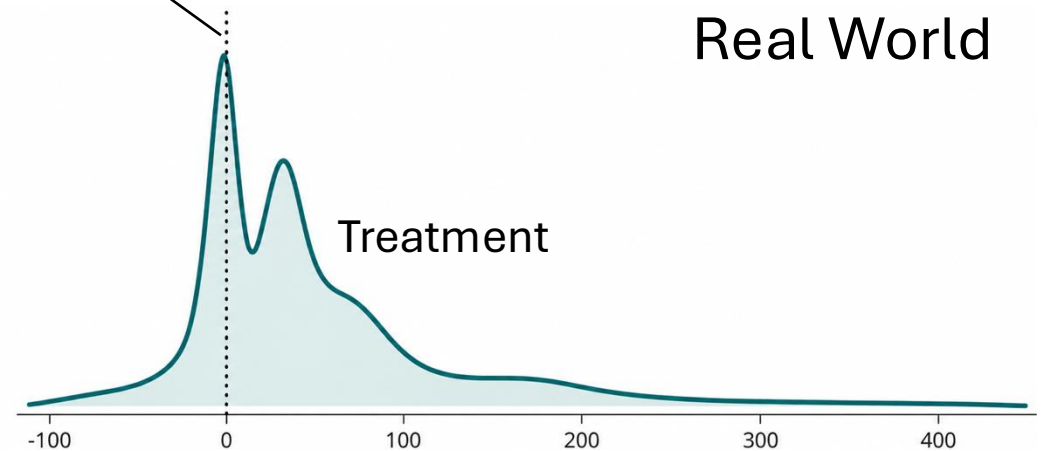
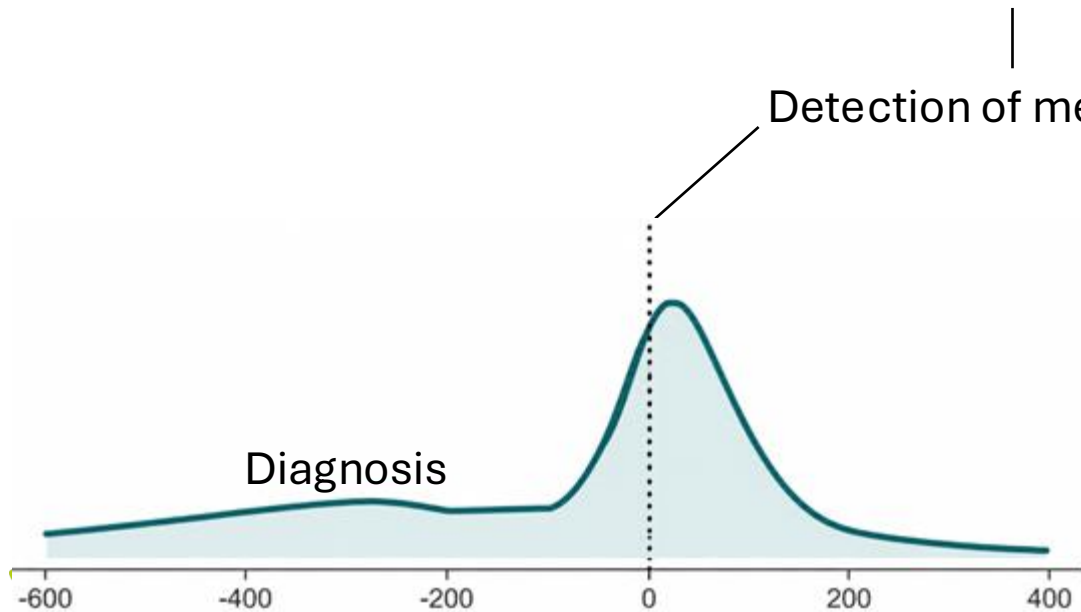


The clinical narratives and the real-world

Real-World Data may not be what You Expect

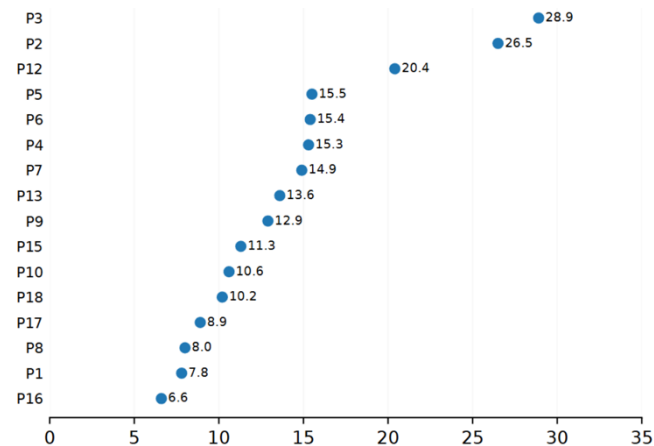


Expected narrative

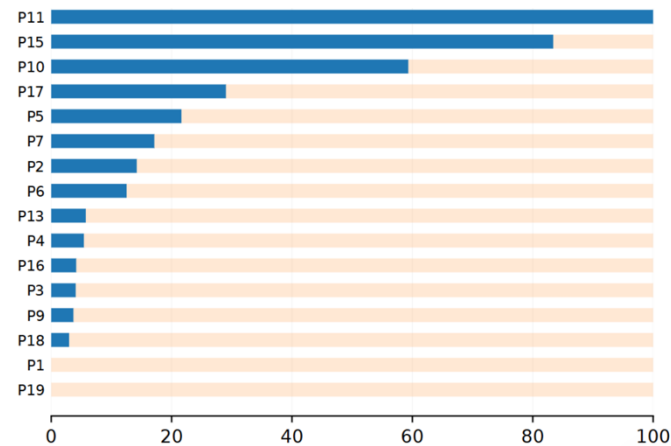


OncoDiagnostics checks for these

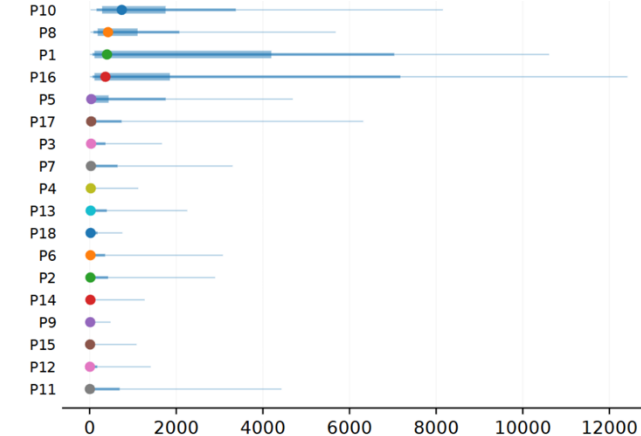
Metastasis before first diagnosis



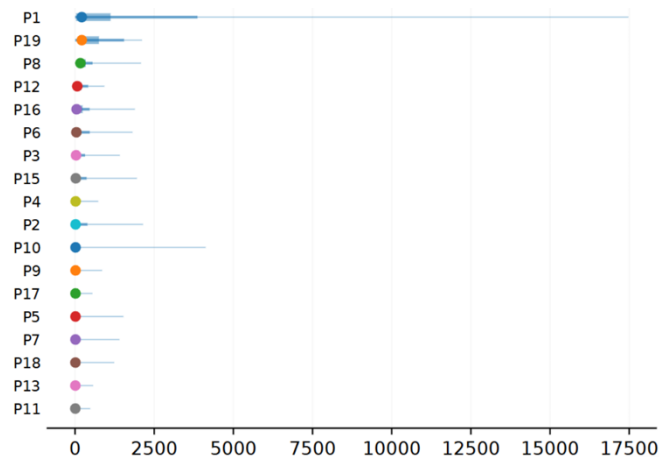
Procedure drug only



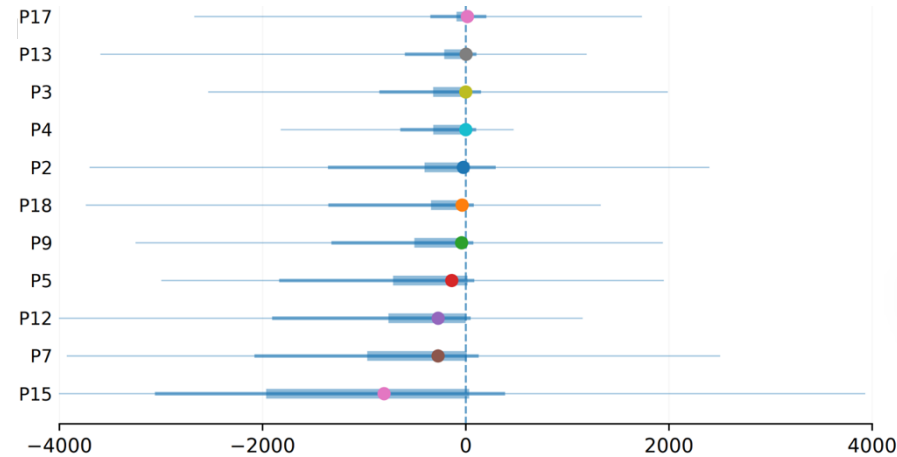
First to second diagnosis



First to second metastasis



Closest antineoplastic drug to first



OncoDiagnostics

Caution with excluding other primaries

Concept explorer

20 data partners · Sep 2026 results

Other cancer diagnosis · frequency across sites

Section 6. Other cancer diagnosis · Full cohort · 3,219 concepts · 10 sites

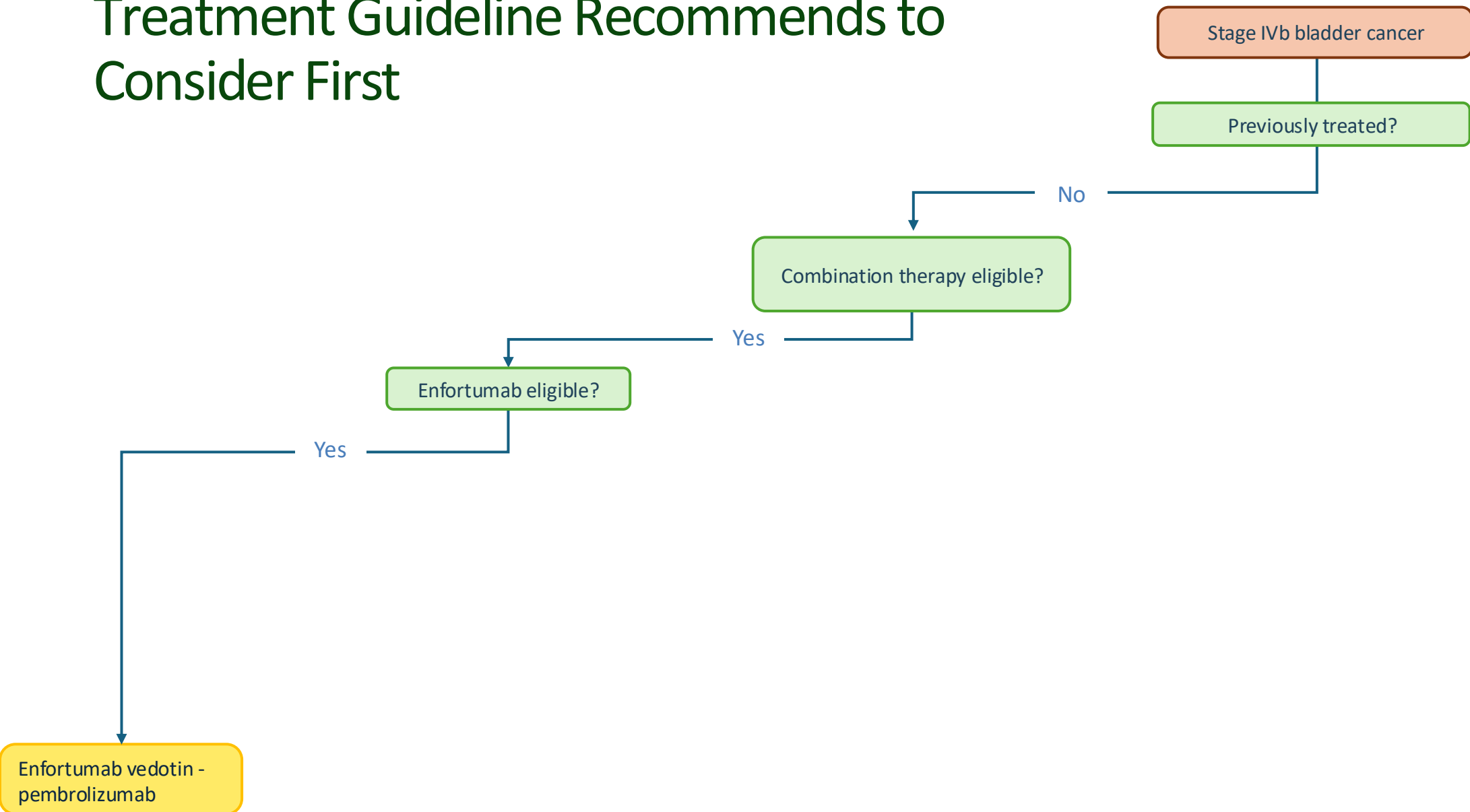
Patients with an other cancer diagnosis in the full cohort, against that site's own denominator. Cell shading is relative to the largest frequency shown, not an absolute scale.

CONCEPT	CU Anschutz	DFCI	HealthPartners	IMASIS	La Fe	MDV
200962 Primary malignant neoplasm of prostate	39.5	36.1	32.0	24.3	23.6	7.3
4311499 Primary malignant neoplasm of respiratory tract	7.4	10.9	8.5	21.2	15.6	2.0
198985 Primary malignant neoplasm of kidney	16.6	16.8	9.3	8.0	9.0	0.6
195480 Primary malignant neoplasm of renal pelvis	8.4	7.3	3.5	6.3	4.5	2.3
4157454 Primary malignant neoplasm of lower lobe, bronchus or lung	2.3	4.0	2.2	4.1	3.0	1.3
74582 Primary malignant neoplasm of rectum	2.6	2.4	1.3	3.6	5.5	1.4
436635 Primary malignant neoplasm of sigmoid colon	1.6	0.8	0.9	2.9	3.7	0.8
196044 Primary malignant neoplasm of stomach	0.7	0.9	0.5	2.0	1.9	2.4
197500 Primary malignant neoplasm of colon	5.2	4.3	3.4	6.0	9.6	1.2
196049 Primary malignant neoplasm of urethra	8.4	3.8	2.0	1.9	2.0	0.4
200051 Primary malignant neoplasm of ovary	1.5	1.5	0.6	0.3	0.3	0.1
4247719 Primary malignant neoplasm of ascending colon	0.9	1.0	0.9	2.4	2.6	0.4
133424 Primary malignant neoplasm of thyroid gland	1.9	2.2	1.1	0.6	0.5	0.1
441800 Primary malignant neoplasm of descending colon	0.4	0.2	0.4	0.4	0.8	0.1
433716 Primary malignant neoplasm of testis	0.8	0.8	0.6	0.5	0.3	0.1
199754 Primary malignant neoplasm of pancreas	1.6	1.8	1.5	1.8	1.7	0.3

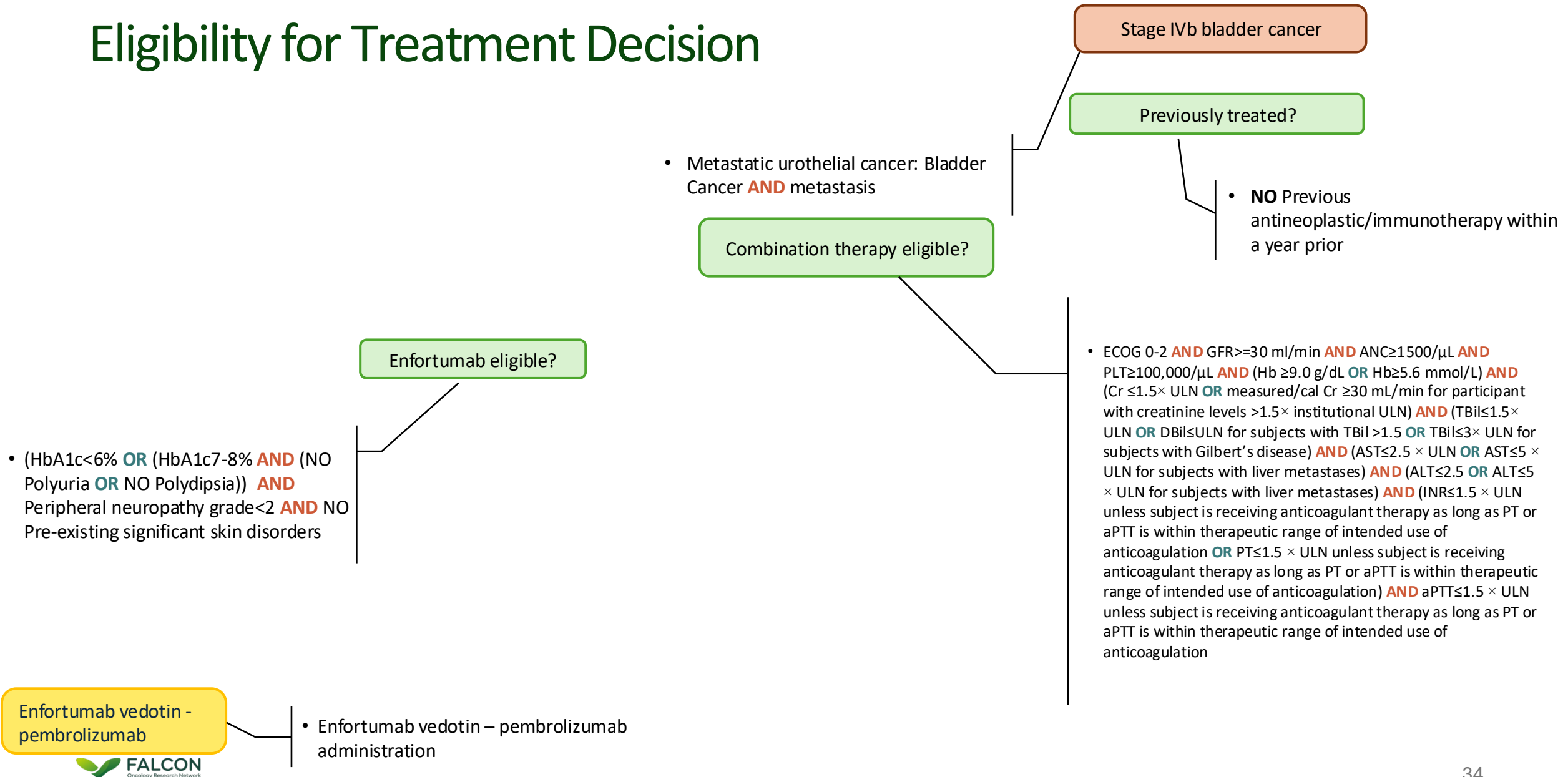


Theme 1. How does the difference between the clinical narrative and real-world practice impact phenotyping?

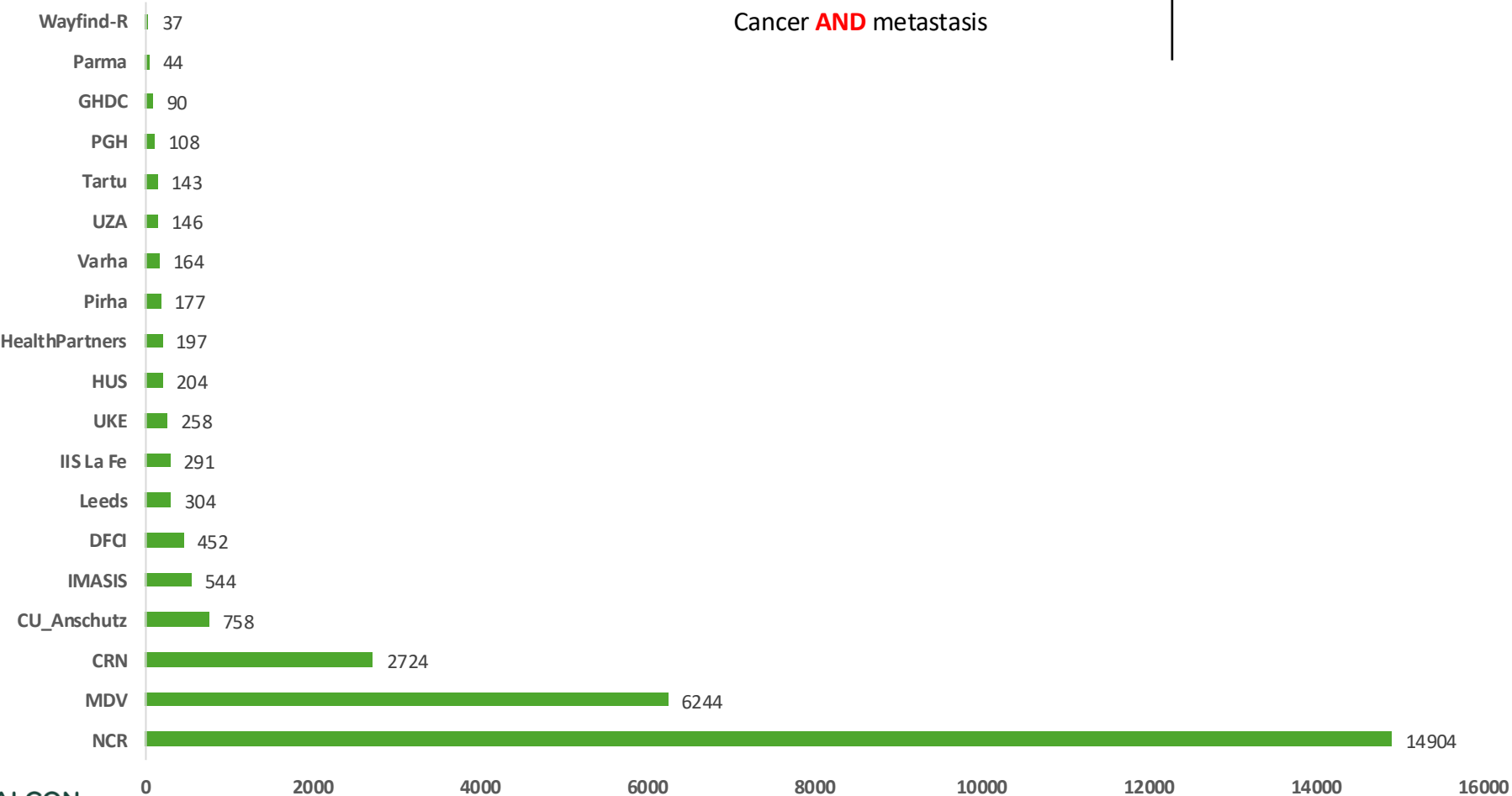
Treatment Guideline Recommends to Consider First



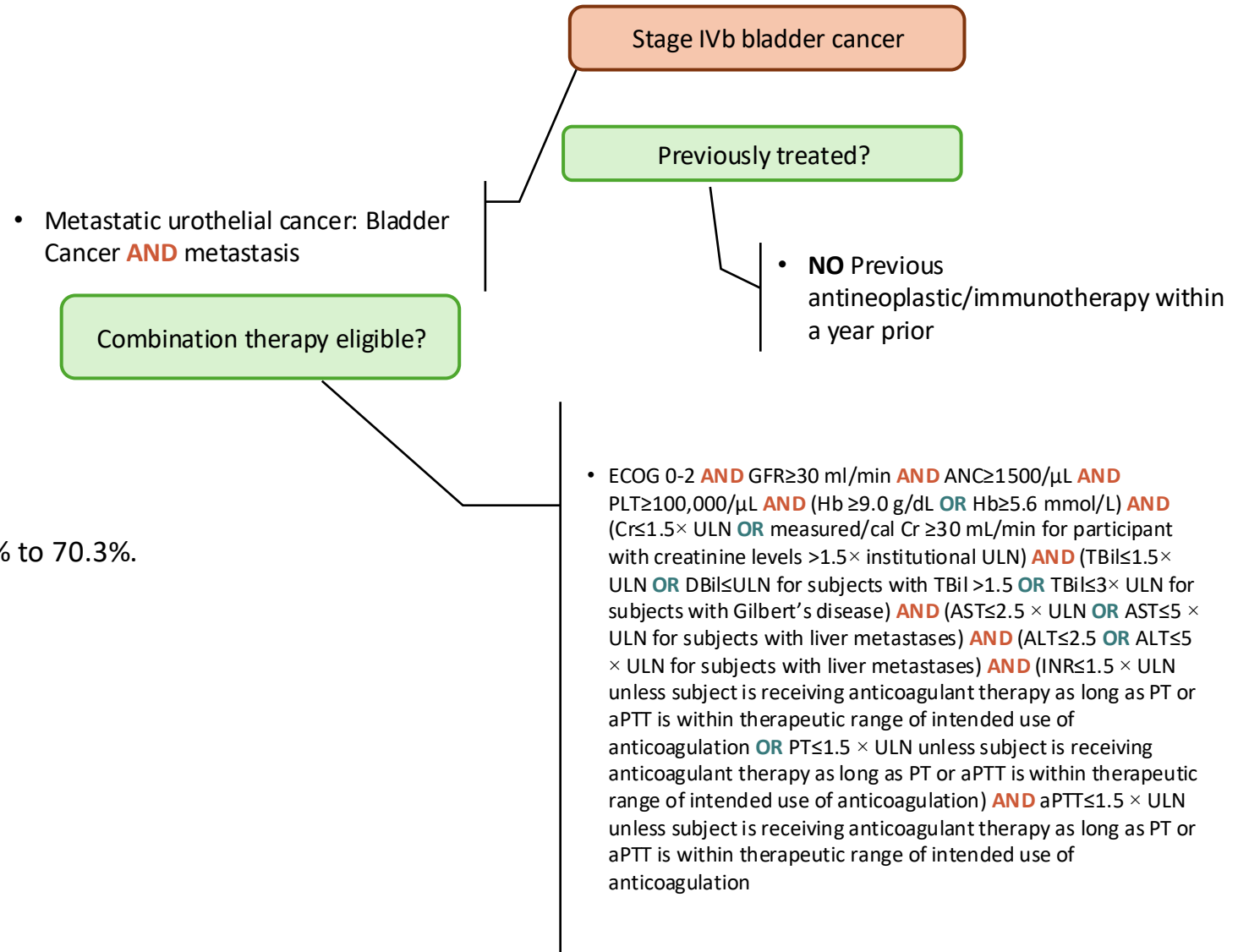
Eligibility for Treatment Decision



All Patients Cohort



Eligibility for any Chemo



ECOG: Only available in five sites, ECOG 0-2 ranges between 7.6% to 70.3%.

Most sites fail the first criterion.

Eligibility Lab Tests

- Metastatic urothelial cancer: Bladder Cancer **AND** metastasis

Combination therapy eligible?

Stage IVb bladder cancer

Previously treated?

- NO** Previous antineoplastic/immunotherapy within a year prior

- ECOG 0-2 **AND** GFR $\geq$ 30 ml/min **AND** ANC $\geq$ 1500/ μ L **AND** PLT $\geq$ 100,000/ μ L **AND** (Hb $\geq$ 9.0 g/dL **OR** Hb $\geq$ 5.6 mmol/L) **AND** (Cr $\leq$ 1.5 $\times$ ULN **OR** measured/cal Cr $\geq$ 30 mL/min for participant with creatinine levels $>$ 1.5 $\times$ institutional ULN) **AND** (TBil $\leq$ 1.5 $\times$ ULN **OR** DBil $\leq$ ULN for subjects with TBil $>$ 1.5 **OR** TBil $\leq$ 3 $\times$ ULN for subjects with Gilbert's disease) **AND** (AST $\leq$ 2.5 $\times$ ULN **OR** AST $\leq$ 5 $\times$ ULN for subjects with liver metastases) **AND** (ALT $\leq$ 2.5 **OR** ALT $\leq$ 5 $\times$ ULN for subjects with liver metastases) **AND** (INR $\leq$ 1.5 $\times$ ULN unless subject is receiving anticoagulant therapy as long as PT or aPTT is within therapeutic range of intended use of anticoagulation **OR** PT $\leq$ 1.5 $\times$ ULN unless subject is receiving anticoagulant therapy as long as PT or aPTT is within therapeutic range of intended use of anticoagulation) **AND** aPTT $\leq$ 1.5 $\times$ ULN unless subject is receiving anticoagulant therapy as long as PT or aPTT is within therapeutic range of intended use of anticoagulation

	GFR $\geq$ 30	ANC $\leq$ 1500	PLT $\geq$ 100k	Hb $\geq$ 9	Cr $\leq$ 1.5xULN	TBil $\leq$ 1.5xULN	DBil $\leq$ 1.5ULN	AST $\leq$ 2.5xULN	ALT $\leq$ 2.5xULN	INR $\leq$ 1.5xULN	aPTT $\leq$ 1.5xULN	PT $\leq$ 1.5xULN
DP1	--	--	--	--	--	--	--	--	--	--	--	--
DP2	18	60	60	71	45	74	46	78	47	60	73	17
DP3	26	71	72	69	55	73	--	75	39	--	72	8
DP4	--	--	--	--	--	--	--	--	--	--	--	--
DP5	14	63	67	76	78	77	37	67	33	65	68	37
DP6	15	74	14	90	53	94	--	93	--	--	67	--
DP7	35	42	40	36	35	43	--	44	35	37	45	--
DP8	80	75	75	84	47	83	54	85	28	66	86	8
DP9	37	51	--	59	50	61	--	--	--	--	61	--
DP10	--	--	11	10	9	10	--	10	--	--	--	--
DP11	--	--	--	18	--	23	--	--	--	--	--	--
DP12	--	95	--	--	--	--	--	--	--	--	--	--
DP13	--	96	--	87	--	94	--	--	65	--	97	82
DP14	9	75	8	84	42	94	--	94	--	59	51	--
DP15	9	16	16	--	--	21	--	18	--	--	6	--
DP16	16	60	58	59	57	72	37	73	--	51	60	--
DP17	25	--	19	20	22	25	--	26	--	--	--	--
DP18	7	89	6	92	68	97	47	98	--	83	73	--
DP19	--	--	--	--	--	--	--	--	--	--	--	--

Eligibility Lab Tests – example site

Lab Test	
GFR $\geq$ 30	18
ANC $\leq$ 1500	60
PLT $\geq$ 100k	60
Hb $\geq$ 9	71
Cr $\leq$ 1.5xULN	45
TBil $\leq$ 1.5xULN	74
DBil $\leq$ 1.5ULN	46
AST $\leq$ 2.5xULN	78
ALT $\leq$ 2.5xULN	47
INR $\leq$ 1.5xULN	60
aPTT $\leq$ 1.5xULN	73
PT $\leq$ 1.5xULN	17

- Metastatic urothelial cancer: Bladder Cancer **AND** metastasis

Combination therapy eligible?

Stage IVb bladder cancer

Previously treated?

- NO** Previous antineoplastic/immunotherapy within a year prior

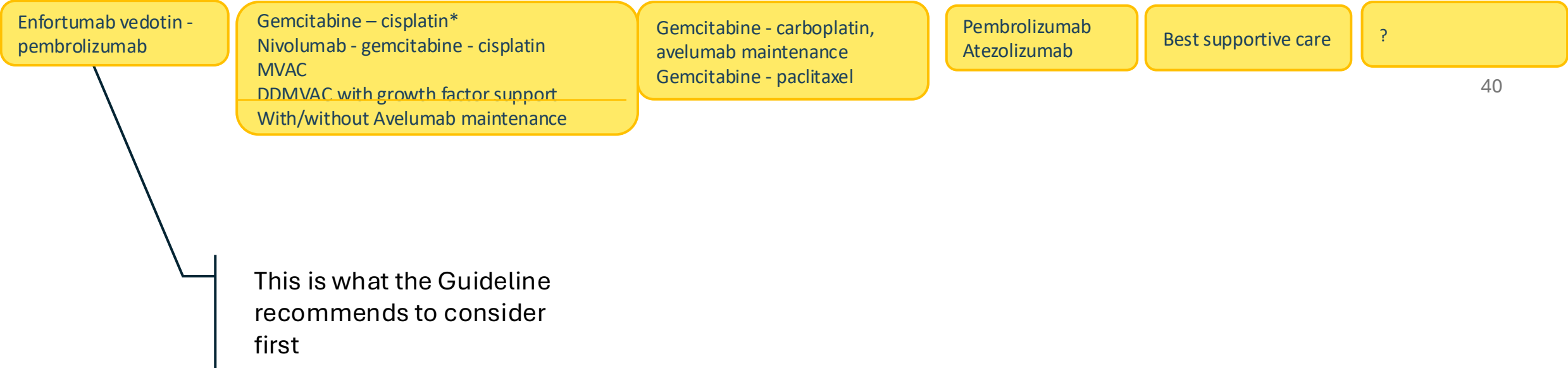
0.2% of mBC patients or ~0.15 patient eligible for combination therapy

- Not all laboratory tests are available at every site
- When available, fewer than 1% of patients are expected to meet all laboratory criteria for combination therapy eligibility.



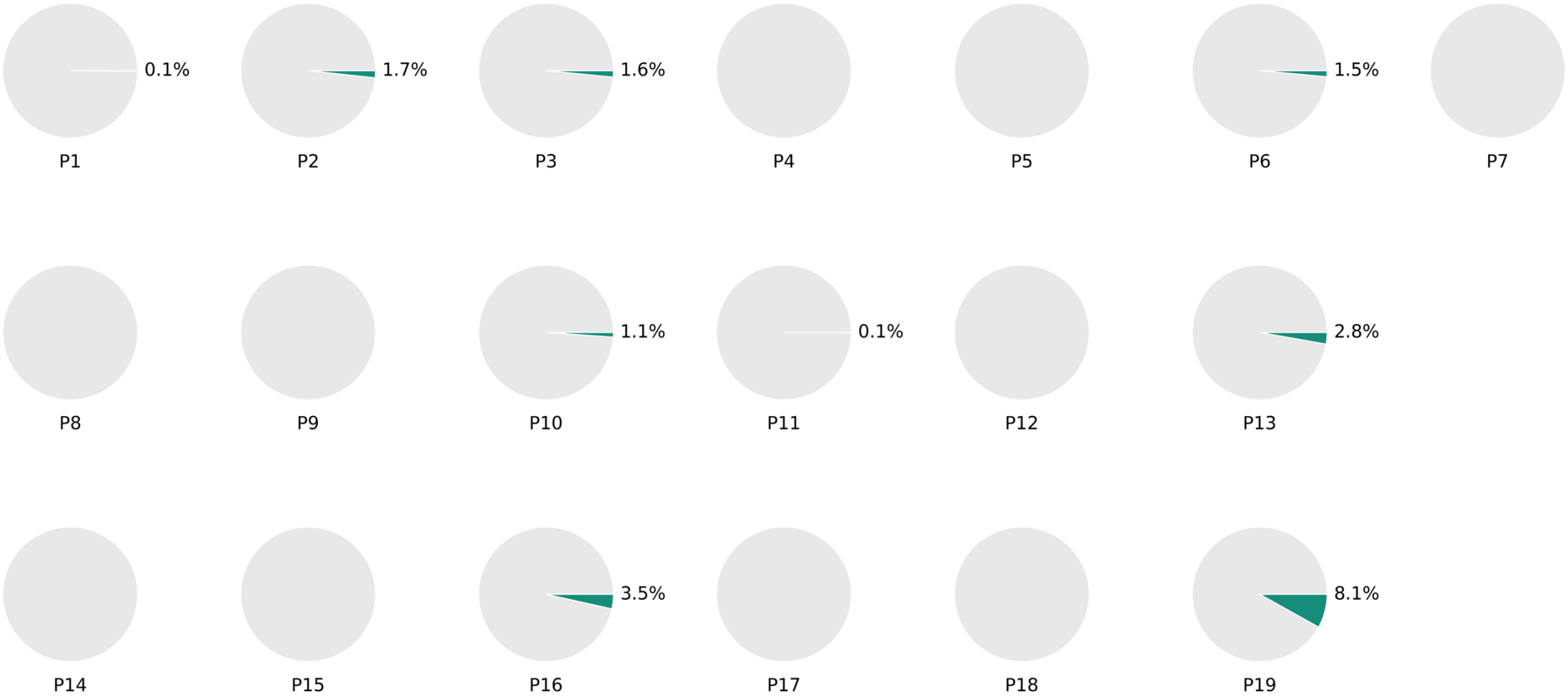
- Theme 2. Some criteria derived from clinical trials do not translate into routine practice or RWD. Can comorbidity information substitute for some of the eligibility criteria that cannot be measured?

Cohorts 4, 5 and 6: Treated Patients

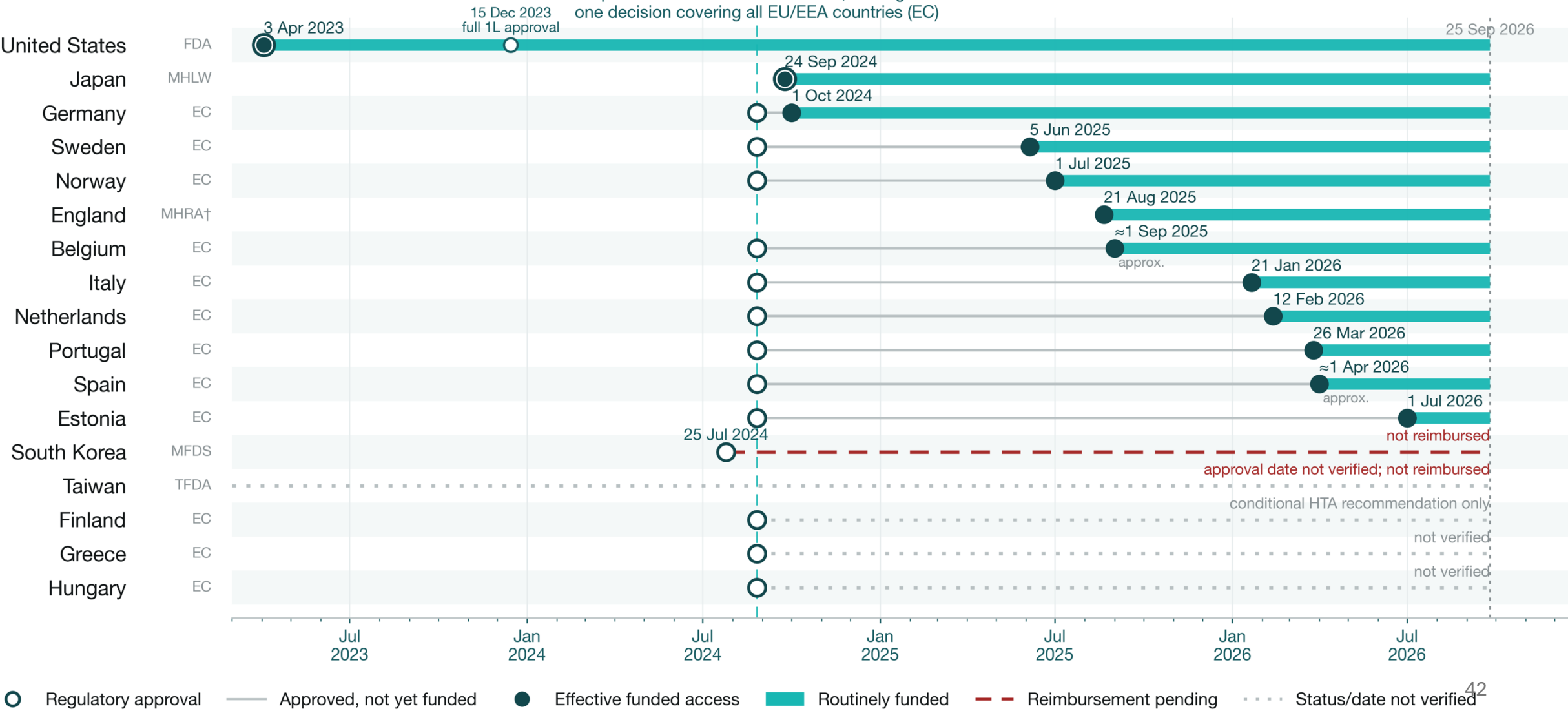


Cohorts 4a: Patients treated with Enfortumab vedotin + pembrolizumab

Enfortumab vedotin -
pembrolizumab



EV + P: approval and reimbursement timelines across FALCON-Bladder countries



Bars indicate routine funded availability, not treatment uptake or utilization.



Theme 3. Patients are not getting the treatment in contrast to what the guideline says.
Why?

Theme 4. What if no eligibility testing is in the data? Do we assume eligibility, particularly if they received treatment?

Lessons Learned to be a Coordinating Center

Central issues

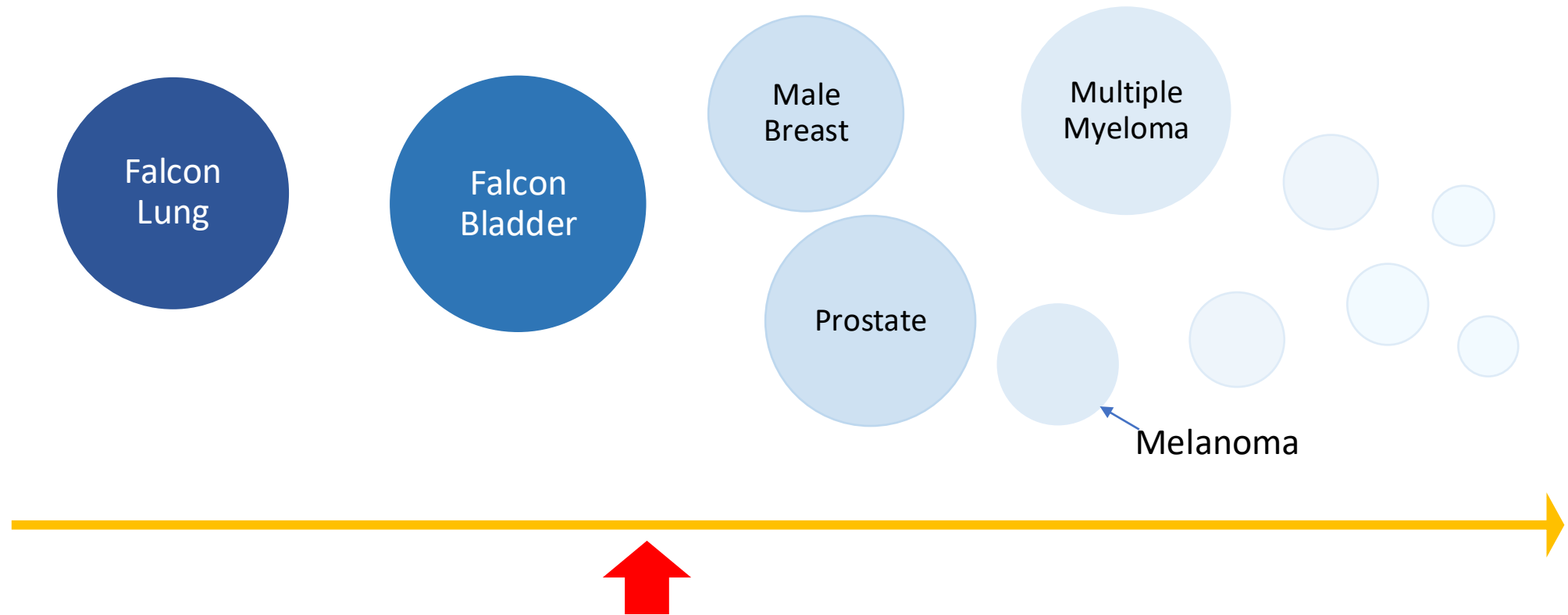
- Quality issues MUST be addressed, and data readiness needs to be achieved
- 1:1 meeting with Data Partners
- Protocol development as a hackathon
- Visualization of Data Partner outputs to facilitate result aggregation
- Maximal transparency and review cadence with issues

Data Partner issues

- It is possible to completely work out issues with Package Execution
- Code documentation highly useful for Data Partners
- C more robust and executable than Python for complex packages like ARTEMIS
- Execution of CohortDiagnostics NOT popular

Results Sneak Peek

What is Next?





FALCON
Oncology Research Network