

Exhibit 439

Supplemental Report – Mousser

It has come to my attention that Mr. Mousser has more recently been diagnosed with urothelial cancer of the bladder. See 00667_MOUSSER_VHA_0000001721-1857. More specifically, a routine follow up cystoscopy on 10/28/24 revealed a papillary tumor (abnormal growth) near the prostatic fossa that had grown slightly to approximately 2 cm. 00667_VHA_0000001642-1646. Follow up cystoscopic resection (transurethral resection of bladder tumor – TURBT) on 1/31/25 revealed a low grade papillary urothelial cancer. In a February 20, 2025 record, one of Mr. Mousser’s private providers recited Mr. Mousser’s reports that “he is doing well overall” after the diagnosis and surgery.

Approximately 30% of upper tract urothelial cancer (UTUC) patients will suffer such an event, which is best categorized as a recurrence of his earlier UTUC (Seisen et al. 2015). While some may categorize this as a “new” cancer, there is increasing molecular evidence that bladder recurrences of UTUC reflect “seeding” of the bladder epithelium by cells shed from the original tumor in the urine and then reimplanting and growing in the bladder. (Audenet et al. 2019; Petros et al. 2021). In other words, it is likely that the urothelial bladder cancer was most likely caused by the earlier UTUC. The urothelial bladder cancer does not affect my prior opinions that Mr. Mousser’s UTUC was unlikely to be related to Camp Lejeune exposures and is far more likely than not related to prior smoking and possibly an undiagnosed chronic inflammatory condition of the right kidney (see April 8, 2025 Report at 13).

Nevertheless, the clinical impact of this recurrence is low. Since the kidney has been removed, further seeding events are not possible. Furthermore, since bladder recurrences of UTUC almost always occur within 5 years of nephroureterectomy, new tumors from seeding events that occurred prior to surgical resection of the kidney are highly unlikely. It is possible to have a recurrence of the bladder cancer itself (i.e. regrowth from the resected bladder tumor), but this risk is low and has only minimal clinical implications. More specifically, for a low grade papillary urothelial cancer the recurrence risk is approximately 33%, but these can almost always be successfully treated with repeat resection and the risk of progression to more advanced disease that requires more aggressive therapy is only approximately 3% [PMID 28457661]. These resections can be performed in same manner as the resection that was performed on 1/31/25, i.e. as a repeat TURBT. The typical recovery and post-surgical follow-up would be the same as his unremarkable 1/31/25 recovery and follow the monitoring schedule as I describe below. If a repeat TURBT is needed, Mr. Mousser would likely be discharged from the hospital the same day, as the resection is performed without incision. Some patients experience minor discomfort or hematuria (blood in urine) following TURBT, but these symptoms usually subside. It is highly unlikely

that the resection on 1/31/25 will significantly impair Mr. Mousser's kidney or bladder function, and this remains true even if repeat resections (TURBT) are required. I agree with Dr. Smith that "[t]he development of low-grade bladder cancer does not independently impact or worsen Mr. Mousser's overall prognosis, which remains governed by his prior high-grade UTUC and the associated nephroureterectomy."

Standard monitoring would generally consist of cystoscopies at 3 months after initial resection and then every 6-12 months up until 3 years, and then annually until 5 years after resection assuming no further recurrences. The schedule is generally restarted if there is a recurrence. Additional CT scans beyond those that were necessary for monitoring his UTUC are not necessary.

Thus, Mr. Mousser may reasonably require a cystoscopy between April to June of this year (around the time of this report), then every 6-12 months until January 2028, and then annually until 2030, or no more than eight additional cystoscopies.

Walter
Stadler

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Stadler
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Walter Stadler, M.D., FACP

Facts and Data Considered:

All materials cited or referenced in my April 8, 2025 report in *Mousser v. United States*

Joseph J. Del Pizzo, Specific Causation Expert Supplemental Report for Frank W. Mousser (April 8, 2025)

Armine K. Smith, Specific Causation Expert Supplemental Report for Frank W. Mousser (April 9, 2025)

00667_MOUSSER_VHA_0000001721-1857

- Audenet, F., S. Isharwal, E. K. Cha, M. T. A. Donoghue, E. N. Drill, I. Ostrovnaya, E. J. Pietzak, J. P. Sfakianos, A. Bagrodia, P. Murugan, G. Dalbagni, T. F. Donahue, J. E. Rosenberg, D. F. Bajorin, M. E. Arcila, J. F. Hechtman, M. F. Berger, B. S. Taylor, H. Al-Ahmadie, G. Iyer, B. H. Bochner, J. A. Coleman, and D. B. Solit. 2019. 'Clonal Relatedness and Mutational Differences between Upper Tract and Bladder Urothelial Carcinoma', *Clin Cancer Res*, 25: 967-76.
- Petros, F. G., W. Choi, Y. Qi, T. Moss, R. Li, X. Su, C. C. Guo, B. Czerniak, C. Dinney, D. J. McConkey, and S. F. Matin. 2021. 'Expression Analysis of Same-Patient Metachronous and Synchronous Upper Tract and Bladder Urothelial Carcinoma', *J Urol*, 206: 548-57.
- Seisen, T., B. Granger, P. Colin, P. Leon, G. Utard, R. Renard-Penna, E. Comperat, P. Mozer, O. Cussenot, S. F. Shariat, and M. Roupret. 2015. 'A Systematic Review and Meta-analysis of Clinicopathologic Factors Linked to Intravesical Recurrence After Radical Nephroureterectomy to Treat Upper Tract Urothelial Carcinoma', *Eur Urol*, 67: 1122-33.