Urothelial Cancer of Bladder

Cancer Centre of Southeastern Ontario
Standard Management Guidelines

Intended for use by Clinicians and Health Care Providers involved in the Management or Referral of adult patients with Urothelial Cancer of the Bladder

Section	Activity	Activity Description	Details	Reference(s)
AA	Cancer Centre Referrals		• All invasive (muscle-invasive) or metastatic cases referred to Cancer Centre	
A	Diagnosis	Biopsy Type	• Localized disease – transurethral resection (TURBT) • Metastatic disease – may include biopsy of met if unclear clinical picture	
B	Pathology of TURBT specimen	Pathology Guideline	• KGH Pathology review of all cases with outside pathology • Report to include grade, depth of invasion, histology	
C	History and Physical Exam		• Routine	
D	Investigations	As determined by results of TURBT and pathology	Staging Imaging: • CT abdomen/pelvis (MRI if contrast contra-indicated) • Chest X-ray (except CT chest to be done if high risk or clinical suspicion • Other imaging as clinically indicated (e.g. bone scan) Blood: • CBC, renal function, liver function, coagulation, other as indicated	
E	Post-investigation management	Curative Intent	All patients should have a discussion about bladder-sparing options and the role of neo-adjuvant chemotherapy with gemcitabine and cisplatin (CISGEMC). Unfit or complex cases should be discussed at Multidisciplinary Case Conference (MCC)	Cancer Care Ontario Adjuvant/ Curative/Neo-Adjuvant Intent

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			Three curative intent options: 1. Radical cystectomy/cystoprostatectomy o For most who are medically fit o Extended lymphadenectomy is indicated o Urinary diversion by surgeon and patient choice o Adjuvant radiation considered for incomplete resection 2. Concurrent chemoradiation (with CISGEMC) 3. Radiation alone if chemotherapy is contra-indicated	Systemic Therapy
F	Post-investigation management	Post-Operative Adjuvant Chemotherapy	• Consider adjuvant CISGEMC for patients with positive lymph nodes. Extravesical disease, lymphovascular invasion and suspicion of distant disease merit referral to medical oncology	
G	Post-investigation management	Metastatic Disease	• For palliative and symptomatic management, consider systemic therapy o Preferred chemotherapy regimen is CISGEMC o Substitution of carboplatin if necessary due to renal dysfunction o Other regimens, if CISGEMC unsuitable • Radiation therapy as indicated for hematuria, painful or function-compromising metastatic disease	Cancer Care Ontario Palliative Intent Systemic Therapy
H	Follow up with no evidence of disease		• Abdominal and chest imaging at q6m intervals for first 2 years and as clinically indicated • Clinic visit for history/physical exam q6m • Patients with cystectomy:	

Section	Activity	Activity Description	Details	Reference(s)
			○ Urethroscopy/urethral washing if indicated ○ Yearly urine cytology from diversion • Patients without cystectomy: ○ Cystoscopy and urine cytology at 3 months, then q6m intervals for patients undergoing bladder-sparing treatments	
I	Recurrent disease		• Referral to cancer center • Discussion at Multidisciplinary Case Conference (MCC) • Radiation and/or chemotherapy are options: Chemotherapy first line is CISGEMC unless previously given.	
J	Controversies		• No clear guidelines for use of adjuvant chemotherapy • Expansion of use of bladder sparing modalities • Imaging of Abdo/chest follow-up frequency	
K	Clinical Trials		• Patients should always be considered for available clinical trials	

References

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Revisions

- 2014/02/13: Draft created
- 2014/04/02: Revisions to text, addition of links and references
- 2014/04/09: Revisions to text
- 2014/06/09: Revisions to text
- 2014/06/25: Discussed at CCSEO Disease Site Group Chairs Council and conditionally approved pending minor revisions
- 2014/06/26: Revisions to text following discussion at CCSEO Disease Site Group Chairs Council (2014/06/25)