NHS England

Guidelines for the Management of Bladder Cancer

West Midlands Expert Advisory Group for Urological Cancer

West Midlands Clinical Networks and Clinical Senate

Coversheet for Network Expert Advisory Group Agreed Documentation

This sheet is to accompany all documentation agreed by the West Midlands Strategic Clinical Network Expert Advisory Groups. This will assist the Clinical Network to endorse the documentation and request implementation.

EAG name	Urological Cancer Expert Advisory Group	
Document Title	Guidelines for the management of bladder cancer	
Published date	December 2016	
Document Purpose	• The referral of patients presenting with symptoms suspicious of bladder cancer. • The management of patients with bladder cancer.	
Authors		
References		
Consultation Process	Guidelines drawn up as result of Urology workshop March 2016 with opportunity for comment via e-mail post workshop.	
Review Date (must be within three years)	December 2019	
Approval Signatures:	**EAG Chair**  Date: December 2019	**Network Clinical Director**  Date: December 2019

Guidelines for the Management of Bladder Cancer

This guideline has been produced to support the following:

a) Management of patients with suspected bladder cancer
b) Management of patients with bladder cancer

It is based on the NICE Guideline – Bladder cancer: diagnosis and management (2015) nice.org.uk/guidance/ng2 and Suspected cancer: recognition and referral (2015) nice.org.uk/guidance/ng12

1 Information and support for people with bladder cancer

1.1 Follow the recommendations on communication and patient-centred care in NICE's guideline on patient experience in adult NHS services and the advice in NICE's guidelines on improving outcomes in urological cancers and improving supportive and palliative care for adults with cancer throughout the person's care.

1.2 Offer clinical nurse specialist (CNS) support to people with bladder cancer and give them the CNS contact details.

1.3 Ensure that the CNS acts as the key worker to address the person's information and care needs

1.4 Offer a holistic needs assessment to identify an individualised package of information and support.

1.5 Discuss referral to smoking cessation support via the hospital if available or GP for all cancer patients who smoke

1.6 Offer people with bladder cancer and, if they wish, their partners, families or carers, opportunities to have discussions and care with a range of specialist healthcare professionals, including those who can provide psychological support other people with bladder cancer who have had similar treatments.

1.7 Clinicians caring for people with bladder cancer should ensure that there is close liaison between secondary and primary care with respect to ongoing and community-based support.

2 Diagnosing and staging bladder cancer

Diagnosis

2.1 Do not substitute urinary biomarkers for cystoscopy to investigate suspected bladder cancer or for follow-up after treatment for bladder cancer, except in the context of clinical research.

2.2 Consider CT or MRI before TURBT if muscle-invasive bladder cancer (MIBC) is suspected at cystoscopy.

2.3 Offer white-light-guided TURBT with photodynamic diagnosis, narrow-band imaging, cytology or a urinary biomarker test for suspected bladder cancer.

2.4 Obtain detrusor muscle during TURBT.

2.5 Do not take random biopsies of normal-looking urothelium during TURBT.

2.6 Record the size and number of tumours during TURBT.

2.7 Offer people with suspected bladder cancer single dose intravesical mitomycin C within 6 hours of first TURBT.

Staging

2.8 Consider further TURBT within 6 weeks if first specimen does not include detrusor.

2.9 Offer CT or MRI staging to people diagnosed with MIBC or high-risk non-muscle-invasive bladder cancer (NMIBC).

2.10 Consider CT urogram to detect upper tract involvement in people with new or recurrent high-risk NMIBC or MIBC.

2.11 Consider positron emission tomography (PET)-CT for people with MIBC or high-risk NMIBC before radical treatment if there are indeterminate findings on CT or MRI, or a high risk of metastatic disease.

3 Treating non-muscle-invasive bladder cancer

Low risk	Urothelial cancer with: • Solitary pTaG1/2 (low grade) with diameter < 3cm • any papillary urothelial neoplasm of low malignant potential
Intermediate risk	Urothelial cancer which is neither low or high-risk

High risk	Urothelial cancer with any of: • pTaG3 • pT1G2/3 • pTis (CIS) • aggressive variants (e.g. micropapillary or nested)

Prognostic markers and risk classification

3.1 For NMIBC record the following for discussion within MDT meetings and with the person, about prognosis and treatment options:

- recurrence history, size and number of cancers
- histological type, grade, stage and presence (or absence) of urothelium, detrusor muscle (muscularis propria), and carcinoma in situ
- the risk category of the person's cancer
- predicted risk of recurrence and progression

Low-risk NMIBC

3.2 See recommendations 2.3–2.7

Intermediate-risk NMIBC

3.3 People with newly diagnosed intermediate-risk NMIBC should consider a course of at least 6 doses of intravesical mitomycin C (MMC).

3.4 If intermediate-risk NMIBC recurs after a course of intravesical MMC, refer the person's care to a specialist urology MDT.

High-risk NMIBC

3.5 If first TURBT shows high-risk NMIBC, offer another TURBT within 6 weeks.

3.6 Offer the choice of intravesical BCG (Bacille Calmette-Guérin) or radical cystectomy for high-risk NMIBC, based on a full discussion with the patient, the CNS and an SMDT review including a urologist who performs radical cystectomy.

Intravesical BCG

3.7 Offer induction and maintenance intravesical BCG.

3.8 If induction BCG fails refer the patient to a specialist urology MDT.

3.9 When induction BCG has failed, the specialist urology MDT should assess the suitability of radical cystectomy or further intravesical therapy with hyperthermic MMC, if radical cystectomy is unsuitable, declined by the patient, or if the bladder cancer that recurs is intermediate- or low-risk.

Recurrent NMIBC

3.10 Consider fulguration without biopsy for people with recurrent NMIBC where:

- no previous intermediate- or high-risk bladder cancer
- disease-free interval of > 6 months
- solitary papillary recurrence
- tumour diameter < 3 mm.

Managing side effects of treatment

3.11 Do not offer primary prophylaxis to prevent BCG-related bladder toxicity.

3.12 Seek advice from a specialist urology MDT if symptoms of bladder toxicity after BCG cannot be controlled with antispasmodics or non-opiate analgesia and other causes have been excluded by cystoscopy.

4 Follow-up after treatment for NMIBC

4.1 GPs should re-refer urgently to the previous treating centre, if patients have haematuria or LUTS and history of NMIBC.

Low-risk non-muscle-invasive bladder cancer

4.2 Offer people with low-risk NMIBC cystoscopic follow-up 3 months and 12 months after diagnosis.

4.3 Do not use urinary biomarkers or cytology for follow-up after treatment.

4.5 Discharge to primary care people who have had low-risk NMIBC and who have no recurrence within 12 months, after discussion of the risks.

Intermediate-risk non-muscle-invasive bladder cancer

4.6 Offer people with intermediate-risk NMIBC cystoscopic follow-up at 3, 9 and 18 months, and yearly thereafter.

4.7 Consider discharging people who have had intermediate-risk NMIBC to primary care after 5 years disease-free.

High-risk non-muscle-invasive bladder cancer

4.8 Offer people with high-risk NMIBC cystoscopic follow-up: every 3 months for 2 years then every 6 months for 2 years then yearly.

4.9 Monitor the upper urinary tract with CT urogram every 18 months

4.10 For people who have had radical cystectomy for high-risk NMIBC, see recommendations 6.1 and 6.2.

5 Treating muscle-invasive bladder cancer

5.1 Ensure that a specialist urology MDT reviews all cases of MIBC, including adenocarcinoma, squamous cell carcinoma and neuroendocrine carcinoma, and that the review includes histopathology, imaging and treatment options.

Neoadjuvant chemotherapy for newly diagnosed MIBC

5.2 Offer neoadjuvant chemotherapy using a cisplatin combination regimen before radical cystectomy or radical radiotherapy to people with newly diagnosed MIBC for whom cisplatin-based chemotherapy is suitable.

Radical therapy for MIBC

5.3 Offer a choice of radical cystectomy or radiotherapy with a radiosensitiser to people with MIBC for whom radical therapy is suitable. Ensure that the choice is based on a full discussion with a urologist who performs radical cystectomy, a clinical oncologist and a CNS. Include in the discussion:

- prognosis with or without treatment
- limited evidence about whether surgery or radiotherapy with a radiosensitiser is the most effective cancer treatment
- benefits and risks of surgery and radiotherapy with a radiosensitiser, including the impact on sexual and bowel function and the risk of death.

Radical cystectomy

5.4 Offer people who have chosen radical cystectomy a urinary stoma, or a continent urinary diversion if there are no strong contraindications to continent urinary diversion.

5.5 Offer extended lymphadenectomy to patients undergoing radical cystectomy.

5.6 Members of the specialist urology MDT (including the bladder cancer specialist urological surgeon, stoma care nurse and clinical nurse specialist) should discuss with the person whether to have a urinary stoma or continent urinary diversion, and provide opportunities for the person to talk with people who have had these procedures.

5.7 Offer people with bladder cancer and, if they wish, their partners, families or carers, opportunities to have discussions with a stoma care nurse before and after radical cystectomy as needed.

Adjuvant chemotherapy after radical cystectomy for muscle-invasive or lymph-node- positive urothelial bladder cancer

5.8 Consider adjuvant cisplatin combination chemotherapy after radical cystectomy for people with a diagnosis of muscle-invasive or lymph-node-positive urothelial bladder cancer for whom neoadjuvant chemotherapy was not suitable (because muscle invasion was not shown on biopsies before cystectomy). Ensure that the person has an opportunity to discuss the risks and benefits with an oncologist who treats bladder cancer.

Radical radiotherapy

5.9 Consider the use of a radiosensitiser when giving radical radiotherapy for MIBC.

Managing side effects of treatment

5.10 Seek advice from a specialist urology MDT if bladder toxicity after radiotherapy cannot be controlled with antispasmodics or non-opiate analgesia and other causes have been excluded by cystoscopy.

6 Follow-up after treatment for MIBC

6.1 Offer follow-up after radical cystectomy or radical radiotherapy.

6.2 After radical cystectomy use a follow-up protocol that consists of:

- monitoring of the upper tracts for hydronephrosis, stones and cancer using imaging and glomerular filtration rate (GFR) estimation at least annually
- monitoring for recurrence using CT abdomen, pelvis and chest, carried out together with other planned CT imaging if possible, 6, 12 and 24 months after radical cystectomy
- monitoring for metabolic acidosis and B12 and folate deficiency at least annually
- for men with a defunctioned urethra urethroscopy annually for 5 years to detect urethral recurrence.

6.3 After radical radiotherapy consider using a follow-up protocol that includes all of the following:

- rigid cystoscopy 3 months after radiotherapy has been completed, followed by either rigid or flexible cystoscopy: every 3 months for 2 years then every 6 months for 2 years then yearly, according to clinical judgement and the person's preference
- upper-tract imaging every year for 5 years
- monitoring for recurrence using CT of the abdomen, pelvis and chest, carried out with other planned CT imaging if possible, 6, 12 and 24 months after radical radiotherapy.

7 Managing locally advanced or metastatic muscle-invasive bladder cancer

First-line chemotherapy

7.1 Discuss the role of first-line chemotherapy for locally advanced or metastatic bladder cancer. Include in your discussion:

- prognosis of their cancer
- advantages and disadvantages of the treatment options, including best supportive care.

7.2 Offer cisplatin-based chemotherapy to people with locally advanced or metastatic urothelial bladder cancer who are otherwise physically fit and have adequate renal function.

7.3 Offer carboplatin in combination with gemcitabine to people with locally advanced or metastatic urothelial bladder cancer if a cisplatin-based chemotherapy regimen is unsuitable.

7.4 For people having first-line chemotherapy for locally advanced or metastatic bladder cancer:

- carry out regular clinical and radiological monitoring
- actively manage symptoms of disease and treatment-related toxicity
- stop chemotherapy if excessive toxicity or disease progression.

Second-line chemotherapy

7.5 Discuss second-line chemotherapy with people who have locally advanced or metastatic bladder cancer. Include in your discussion:

- the prognosis of their cancer
- advantages and disadvantages of treatment options, including best supportive care.

7.6 Consider second-line chemotherapy with gemcitabine in combination with cisplatin, or accelerated (high-dose) MVAC in combination with G-CSF for people with incurable locally advanced or metastatic urothelial bladder cancer whose condition has progressed after first-line chemotherapy if:

- their renal function is adequate
- they are otherwise physically fit

7.7 Consider second-line chemotherapy with carboplatin in combination with paclitaxel or gemcitabine in combination with paclitaxel for people with incurable locally advanced or metastatic urothelial bladder cancer for whom cisplatin-based chemotherapy is not suitable, or who choose not to have it.

7.9 For people having second-line chemotherapy for locally advanced or metastatic bladder cancer:

- carry out regular clinical and radiological monitoring
- actively manage symptoms of disease and treatment-related toxicity
- stop chemotherapy if excessive toxicity or disease progression.

Managing symptoms of locally advanced or metastatic bladder cancer

Bladder symptoms

7.10 Offer palliative hypofractionated radiotherapy to people with symptoms of haematuria, dysuria, urinary frequency or nocturia caused by advanced bladder cancer that is unsuitable for potentially curative treatment.

Loin pain and symptoms of renal failure

7.11 Discuss treatment options with people who have locally advanced or metastatic bladder cancer with ureteric obstruction. Include in your discussion:

- prognosis of their cancer
- advantages and disadvantages of treatment options, including best supportive care.

7.12 Consider percutaneous nephrostomy or retrograde stenting (if technically feasible) for people with locally advanced or metastatic bladder cancer and ureteric obstruction who need treatment to relieve pain, treat acute kidney injury or improve renal function before further treatment.

7.13 If facilities for percutaneous nephrostomy or retrograde stenting are not available at the local hospital, or if these procedures are unsuccessful, discuss with a cancer centre.

Intractable bleeding

7.14 Evaluate the cause of intractable bleeding with the local urology team.

7.15 Consider hypofractionated radiotherapy or embolisation for people with intractable bleeding caused by incurable bladder cancer.

7.16 If a person has intractable bleeding caused by bladder cancer and radiotherapy or embolisation are not suitable treatments, discuss further management with a specialist urology MDT.

Pelvic pain

7.17 Evaluate the cause of pelvic pain with the local urology team.

7.18 Consider, in addition to best supportive care, 1 or more of the following to treat pelvic pain caused by incurable bladder cancer:

- hypofractionated radiotherapy if the person has not had pelvic radiotherapy
- nerve block
- palliative chemotherapy.

8 Specialist palliative care for people with incurable bladder cancer

8.1 A member of the treating team should offer people with incurable bladder cancer a sensitive explanation that their disease cannot be cured.

8.2 Tell the primary care team that the person has been given a diagnosis of incurable bladder cancer within 24 hours of telling the person.

8.3 A member of the urology MDT should discuss prognosis and management options with people with incurable bladder cancer.

8.4 Discuss palliative care services with people with incurable bladder cancer and, if needed and they agree, refer them to a specialist palliative care team

8.5 Offer people with symptomatic incurable bladder cancer access to a urological team with the full range of options for managing symptoms.