Peterborough and Stamford Hospitals NHS
NHS Foundation Trust

Bladder Cancer Risk Stratification

Patient details here

Treatment Recommendations (2009 ACN Guidelines)

pTaT1 or pTa G2 tumours

Initial resection		**3 month cystoscopy**	**Recurrence risk group**	**Tick Appropriate Column**
Solitary tumour	and	negative	**Low risk of recurrence**	
Solitary tumour	and	positive	**Medium risk of recurrence**	
	or			
Multifocal tumour	and	negative	**Medium risk of recurrence**	
Multifocal tumour	and	positive	**High risk of recurrence**	

Subsequent management as follows:

Recurrence risk group	**Plan**
Low	flexible cystoscopy at 1 year, then annually for 7 years, then if no recurrence, annual GP symptom review and urinalysis.
Medium	intravesical chemo after 3 month flexible cystoscopy if recurrence, then 3 monthly flexible cystoscopy until 1 year, then six monthly flexible cystoscopy until 3 years, then annual flexible cystoscopy for 7 years, then if no recurrence, annual GP symptom review and urinalysis.
High	six doses of intravesical chemo, then 3 monthly flexible cystoscopy until 1 year, then six monthly flexible cystoscopy until 3 years, then annual flexi. for 7 years, then if no recurrence, annual GP symptom review and urinalysis.

pT1G2

- • 2nd look TURBT & LMDT review
- • If not upstaged or upgraded, recommend BCG, as below

pTaG3

Recommend BCG, as below

pT1G3

- • 2nd look TURBT & LMDT review
- • discuss BCG and cystectomy with the patient, recommend BCG, as below
- • If 2nd look worse than pT1G3, refer to SMDT

pTis (CIS, carcinoma in situ)

discuss BCG and cystectomy with the patient, recommend BCG, as below

Intravesical BCG

- • An induction course of six weekly doses of BCG, with GA cystoscopy and biopsy 6 weeks after 1st course
- • then Lamm's maintenance schedule (three instillations at 3 months, 6 months, then six monthly for a further 3 years), with 3 monthly flexible cystoscopy for two years, then six monthly for two years, then annually for life

Recurrent non-muscle invasive Tumours Initial pTaG1 or pTaG2 disease

- • for single recurrence, resect/biopsy & diathermy, single post operative dose of intravesical chemotherapy if larger than 3 mm max diameter
- • for multiple recurrences, resect/biopsy & diathermy, single post operative dose of intravesical chemotherapy
- • LMDT review
- • Flexible cystoscopy at three months
- • for large recurrences (>1cm), multiple (>5) or if worsening recurrence history,
  consider a 6 weeks course of intravesical chemotherapy, then flexible cystoscopy at two months
- • Consider BCG if failed chemotherapy.
- • if failed BCG consider radical therapy

For other patients treated with BCG (pTaG3, pT1G2/3 or Cis)

- o • if recurrence, resect/biopsy & diathermy
- o • LMDT review and refer to SMDT, to discuss radical treatment

Muscle-invasive Tumours

- • If a new tumour looks solid at initial flexible cystoscopy, arrange MRI or CT before TURBT
- • At TURBT, resect/debulk tumour and consider sending separate bladder tumour base for analysis
- • TUR biopsy of prostatic urethra to assess indication for urethrectomy
- • Document bimanual examination of clinical stage
- • LMDT discussion of histology

- • Consider 2nd look TURBT:
  - Debulking, if RT likely
  - Biopsy prostatic urethra if not done beforehand
- • MRI or CT pelvis & abdomen, if not done already
- • Chest X-ray, alkaline phosphatase (bone scan, if elevated alkaline phosphatase
  or otherwise indicated)
  For proven pT2 (or worse) disease

• Refer to SMDT

Discussion of cases at SMDT

• Assess suitability for neo-adjuvant chemotherapy.

If not a suitable candidate for neo-adjuvant chemotherapy, arrange to see in Addenbrooke's or N & N Uro-Oncology Clinic if a surgical candidate, or with an Oncologist either locally, or at Addenbrooke's or the Norfolk and Norwich University Hospital.