West of Scotland Cancer Network

Urological Cancers
Managed Clinical Network

Bladder Cancer

Regional Follow-up Guidelines

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Approved by	Urological Cancers MCN Steering Group / Regional Cancer Clinical Leads Group / Regional Cancer Advisory Group
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Bladder Cancer Regional Follow-up Guidelines Review

The purpose of the bladder cancer regional follow-up guidelines is to ensure consistency of practice across the West of Scotland and the principles of any revision to the follow-up guideline will continue to ensure that management of patients after initial treatment for bladder cancer are:

- Patient-centred;
- Aligned to recognised current best practice;
- Equitable across the region;
- Clinically safe and effective; and
- Efficiently delivered.

The guidelines continue to be developed on the basis that the key aims underpinning the purpose of follow-up are to:

- Manage and treat symptoms and complications;
- Provide psychological and supportive care; and
- Detect and treat recurrent disease.

Follow-up practice has to be patient centred and, ideally, supported by empirical evidence of improved outcomes and survival. In the absence of good quality evidence, care should be tailored to the needs and preference of patients. The construction of appropriate follow-up guidance requires balancing perceived patient needs with effective utilisation of resources.

A review of the existing regional bladder cancer guidelines commenced in May 2015, led by Alastair McKay, Clinical Fellow, Urology, NHS Greater Glasgow and Clyde and Gren Oades, Consultant Urologist, NHS Greater Glasgow and Clyde.

A review of evidence and guidance on the management of follow-up was undertaken and the West of Scotland Urological Cancer MCN guidelines updated to reflect contemporary practice. The recently published NICE Bladder Cancer: diagnosis and management of bladder cancer and European Association of Urology Bladder Cancer Guidelines were utilised to inform changes.

This updated guideline indicates the need to have a change of emphasis to the follow-up of patients with bladder cancer. It will mean less intense follow-up for low and intermediate risk bladder cancers and a greater level of intensity for high risk patients. Overall, these changes will mean a modest decrease in the frequency of cystectomy in low and intermediate disease. Cystoscopy follow-up of high risk disease has been clarified to reflect current practice.

These regional guidelines are recommended by the Urological Cancers MCN whose members also recognise that specific needs of individual patients may require to be met by an alternative approach and that this will be provided where necessary and documented in the patient notes.

Bladder Cancer Follow Up Guidelines

Non-Muscle Invasive Bladder Cancer (NMIBC)

Patients with NMIBC should have the following features recorded to guide future discussions and follow-up:

- Date of diagnosis and recurrence history
- Size and number of cancers
- Histological type, grade, stage and presence (or absence) of flat urothelium, detrusor muscle (muscularis propria), and carcinoma in situ (CIS)
- Risk category of the patient's cancer (see below)

Risk Categories

Low Risk	Intermediate Risk	High Risk
Urothelial cancer with any of: • Solitary pTaG1 < 3cm • Solitary pTaG2 (LG) < 3cm • Any papillary urothelial neoplasm of low malignant potential	Urothelial cancer that is not low risk or high risk, including: • Solitary pTaG1 > 3cm • Multifocal pTaG1 • Solitary pTaG2 (LG) > 3cm • Multifocal pTaG2 (LG) • pTaG2 (HG) • Any low-risk NMIBC recurring within 12 months of last occurrence	Urothelial cancer with any of: • pTaG3 • pT1G2 • pT1G3 • pTis (CIS) • Aggressive variants of urothelial carcinoma (e.g. micropapillary)

NMIBC Follow-Up

All smokers with confirmed NMIBC should be offered smoking cessation advice and/or referral.

Low Risk

- First check LA cystoscopy at 3 months
- If recurrence free, check LA cystoscopy at 12 months
- Consider discharging after 12 months of disease-free follow-up (NICE)
- No indication for routine upper tract imaging

Intermediate Risk

- Offer 6 week course intravesical Mitomycin C ; check LA cystoscopy at 3 months, 9 months and 18 months
- Annual check LA cystoscopy thereafter
- Consider discharging after 5 years of disease-free follow-up (NICE)
- No indication for routine upper tract imaging

High Risk

- Stage with CTIVU
- Re-resect within 6 weeks
- Offer Immediate cystectomy or intravesical BCG induction and maintenance (see appendix 1)
- GA cystoscopy at 3 months and then GA/LA cystoscopy every 3 months for the first 2 years
- If no recurrence, check GA/LA cystoscopy every 6 months for the next 2 years
- Annual check cystoscopy from year 5 onwards

- Annual upper tract imaging by CT IVU or retrograde for 5 years
- Consider discharge after 10 years of disease free follow up

Muscle Invasive Bladder Cancer (MIBC)

Routine oncologic follow-up after radical cystectomy or radical chemoradiotherapy for MIBC is controversial and may be influenced by the feasibility and/or acceptability of further treatment options such as palliative chemotherapy or salvage cystectomy.

If routine follow up is considered, the following protocols may be useful:

Post-Radical Cystectomy

- CT TAP to assess for local or distal recurrence at 6, 12 and 24 months, then annual CTIVU and CT Chest to 5 years.
- Annual bloods assessing renal function and for the presence of metabolic acidosis and B12 and folate deficiency
- In males with defunctioned urethras, annual urethroscopy for 5 years (Add to MDT Outcome)
- After 5 years, all groups ultrasound scan to 10 years.

Post-Radical Radiotherapy

- In patients where salvage cystectomy would be considered, GA cystoscopy 3 months after radiotherapy is completed
- If residual disease resected at 3 months to go back to MDT for discussion
- If no recurrence, then check GA/Flexible cystoscopy every 3 months for the first 2 years and 6 months for the next 2 years
- Annually, thereafter, according to clinical judgement and patient preference
- CT TAP to assess for local or distal recurrence at 6, 12 and 24 months, then annual CTIVU and CT Chest to 5 years.

Metastatic or Locally Advanced MIBC

Those patients receiving first or second-line chemotherapy should have regular clinical and radiological assessment individualised to patient need.

Imaging of asymptomatic patients only recommended if patients would benefit from palliative chemotherapy.

Appendix 1 - BCG Maintenance Regime (Lamm)

Recommended treatment regime starts with an induction cycle and then follows with a full series of 6 maintenance treatments at 6-month intervals (36 months in total).

Absolute contraindications of intravesical BCG are:

- During the first 2 weeks after TURBT
- In patients with macroscopic haematuria
- After traumatic catheterisation
- In patients with symptomatic UTI

Induction '6+3' schedule

1. Should begin at least 10-14 days after biopsy or TUR.
2. One instillation of BCG per week for 6 weeks. GA cystoscopy.
3. Followed by a 6 week break.
4. Then a further 3 weekly installations of BCG. GA/LA cystoscopy.

Maintenance

One instillation each week for 3 weeks at 6, 12, 18, 24, 30 and 36 months following the start of treatment.
GA/LA cystoscopy after each maintenance cycle

Summary of Cystoscopic frequency by year

Year 1 = 3 cystoscopies

Year 2 = 3 cystoscopies

Year 3 = 2 cystoscopies

Year 3-5 = 6 monthly GA/LA cystoscopies

Year 5-10 annual GA/LA cystoscopies

If no recurrence discharge from follow up at 10 years

References:

National Institute for Health and Clinical Excellence: Bladder Cancer: diagnosis and management of bladder cancer: 25 February 2015

European Association of Urology (EAU) Guidelines on Muscle-invasive and Metastatic Bladder Cancer: Summary of the 2013 Guidelines

EAU Non–Muscle-invasive Urothelial Carcinoma of the Bladder: Update 2013