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
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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 February 2025, led by Siobhan Duffy, Urology specialty trainee, NHS Greater Glasgow and Clyde and Seamus Teahan, 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 European Association of Urology (EAU) Bladder Cancer Guidelines are updated annually and were utilised to inform changes. The NICE guidelines haven't been updated since 2015 and therefore where recent evidence has superseded the NICE guidelines this has been highlighted in document.

As per previous guidelines the follow-up of non-muscle invasive bladder cancer (NMIBC) is dependent on risk categorisation to try to limit the burden of follow up on patients and NHS resources to the minimum required. This updated guideline includes a change in risk stratification of patients with NMIBC with addition of specific patient and disease risk factors and the further sub-division of some high risk patients into a "very high risk" category. Risk stratification has become more complex and on line calculator can be used to aid categorisation (EAU NMIBC Risk Calculator)

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 Stratification (calculator: EAU NMIBC Risk Calculator)

Additional Risk factors (RF): Age >70, Multiple papillary tumours, Size > 3cm

Low Risk	A primary, single, Ta/T1 LG/G1 tumour < 3 cm in diameter without CIS in a patient ≤ 70 years A primary Ta/T1 LG/G1 tumour without CIS with at most ONE of the additional clinical risk factors
Intermediate Risk	Patients without CIS who are not included in either the low-, high-, or very high-risk groups Any Low-Risk Non-Muscle-Invasive Bladder Cancer recurring within 12 months of last tumour occurrence
High Risk	All T1 HG/G3 without CIS, EXCEPT those included in the very high-risk group All CIS patients, EXCEPT those included in the very high-risk group
	Stage, grade with additional clinical risk factors: Ta LG/G2 or T1G1, no CIS with all 3 risk factors Ta HG/G3 or T1 LG, no CIS with at least 2 risk factors T1G2 no CIS with at least 1 risk factor
Very High Risk	**Stage, grade with additional clinical risk factors:** Ta HG/G3 and CIS with all 3 risk factors T1G2 and CIS with at least 2 risk factors T1 HG/G3 and CIS with at least 1 risk factor T1 HG/G3 no CIS with all 3 risk factors

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 further follow up for up to 5 years at 12-24 month intervals
- 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 and Very Risk

- Stage with CT chest and CT IVU
- Re-resect within 6 weeks
- Offer treatment as follows:

    - **High risk:** Offer intravesical BCG induction and maintenance (see appendix 1) or early cystectomy if BCG is contra-indicated/patient preference
    - **Very high risk:** Offer cystectomy. If unsuitable/patient preference then discuss BCG.
- Endoscopic surveillance can be considered if patient preference/unsuitable for other options:
    - Cystoscopy every 3 months for the first 2 years
    - If no recurrence, check 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
- In patients who have under gone **radical cystectomy for NMIBC** (by definition these will be high risk/very high patients) and these patients should be followed up according to the MIBC protocol.

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. There are no prospective trials demonstrating a benefit in early detection of recurrent disease and the impact, if any on overall survival. Literature suggest most recurrence occurs in within the first 2 years and hence protocols with more intensive monitoring initially have been proposed.

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 annually to 5 years. If patients develop haematuria in this time should have dedicated IVU study.
- 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 annual 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 Induction and Maintenance Regime for High risk NMIBC

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.

3. Followed by a 6 week break. GA/LA cystoscopy during this time i.e. at 3 months.

4. Then a further 3 weekly installations of BCG.

Maintenance (1 to 3 years)

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

Years 1 and 2 = 4 cystoscopies (3 monthly)

Year 3 -5 = 2 cystoscopies (6 monthly)

Year 6-10 = 1 cystoscopy (annually)

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

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