Clinical Management Guideline for Muscle Invasive Non-metastatic Bladder Cancer

Initial Evaluation

- History
- Examination
- Performance Status
- FBC, U+Es
- LFTs, bone profile
- Cystoscopy + EUA + Urethral assessment
- Pathology
- CT urogram and CT chest
- Bone scan if bone pain or raised alk phos
- Consider MRI for local staging if available

Clinical Stage

- T2-4a
- N0-3
- M0

Pre-Treatment Evaluation

- TCC histology
  - Consider Trials — UK Clinical Trials Gateway
  - Medical Fitness
  - Assess eGFR and assess if correctable to >50ml/min
  - If cystectomy being considered in patients considered to be at very high risk of systemic disease, consideration may be given to a trial of neo-adjuvant Gemcitabine Carboplatin chemotherapy

- Non-TCC histology
  - Cisplatin + Gemcitabine
  - Suitable for cisplatin based chemotherapy

Treatment

- Best supportive care, if unfit for radical therapy
- Radical Cystectomy* or RT (+ concomitant MMC/5FU if fit).
  - Note: If CIS with muscle invasive disease – Radical cystectomy is preferred option
  - If cystectomy is being considered in patients considered to be at very high risk of systemic disease, consideration may be given to a trial of neo-adjuvant Gemcitabine Carboplatin chemotherapy

Follow up

- If responding, consider 4th cycle Cisplatin Gemcitabine
- If not responding, discuss with patient immediate Radical cystectomy or ChemoRT
- After Radical cystectomy: CT Adopelvis or CTU and CT chest at 6,12,24 month. Then annual US.
  - In men: urethroscopy annually for 5 years
- After RT: Rigid cystoscopy at 3 months then flexible cystoscopy every 3 months for 2 years, every 6 months for next 2 years and then yearly CT Adopelvis or CTU and CT chest at 6,12,24 month.

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* Patients who have not received neo-adjuvant chemotherapy (e.g. patients in whom immediate Radical cystectomy is necessary) should be offered adjuvant chemotherapy in the form of 4 cycles of 3-weekly cisplatin with gemcitabine if final pathology confirmed muscle invasive disease. It is expected that such circumstances will be rare and the majority of patients with muscle invasive disease should continue to be offered neo-adjuvant chemotherapy in line with current best evidence.