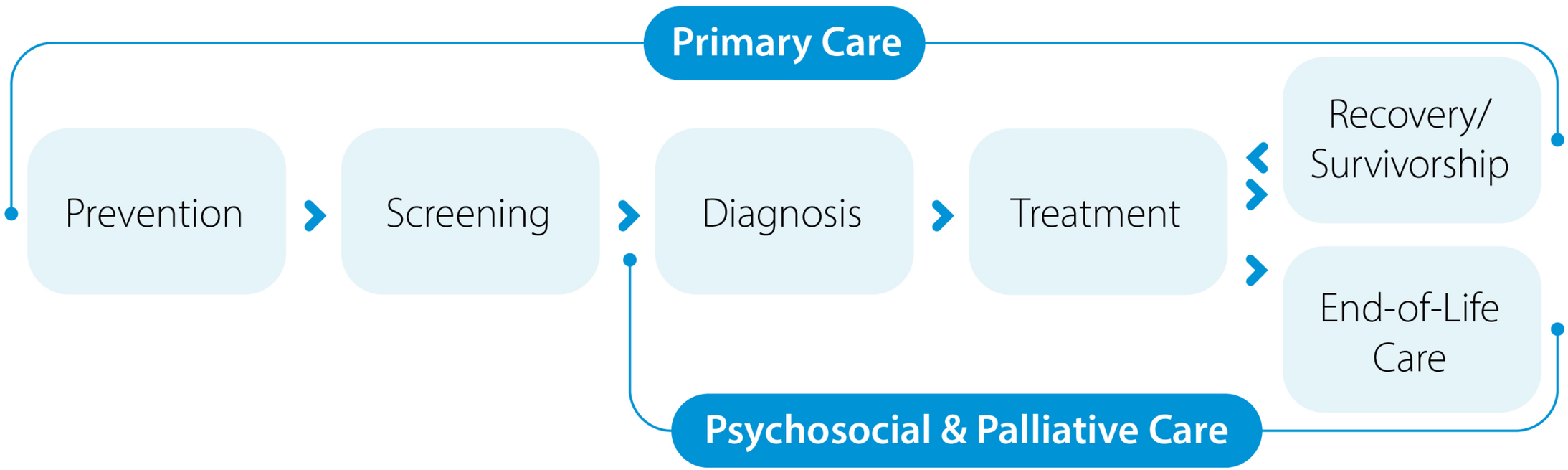
Bladder Cancer Diagnosis and Treatment Pathway

Version 2023.09



Ontario Health
Cancer Care Ontario

Target Population

- The Pathway Map is intended for the management of individuals who present with symptoms or incidental findings indicating a suspicion of bladder cancer, and describes the clinical management of patients with a confirmed diagnosis of urothelial carcinoma. Upper tract urothelial carcinoma is not in scope for this map.

Pathway Map Considerations

- Primary care providers play an important role in the cancer journey and should be informed of relevant tests and consultations. Ongoing care with a primary care provider is assumed to be part of the pathway map. For patients who do not have a primary care provider, Health811 is a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway map, a shared decision-making model should be implemented to enable and encourage patients to play an active role in the management of their care. For more information see Person-Centered Care Guideline and EBS #19-2 Provider-Patient Communication.*
- Hyperlinks are used throughout the pathway map to provide information about relevant Ontario Health (Cancer Care Ontario) tools, resources and guidance documents.
- The term 'health care provider', used throughout the pathway map, includes primary care providers and specialists, e.g. family doctors, nurse practitioners, and emergency physicians.
- Multidisciplinary Cancer Conferences (MCCs) may be considered for all phases of the pathway map. For more information on Multidisciplinary Cancer Conferences, visit MCC Tools
- For more information on wait time prioritization, visit Surgery
- Clinical trials should be considered for all phases of the pathway map.
- Sexual health should be considered throughout the care continuum. Healthcare providers should discuss sexual health with patients before, during and after treatment as part of informed decision-making and symptom management. See Psychosocial Oncology Guidelines Resources.
- Before initiating gonadotoxic therapy (e.g. surgery, systemic, radiation), healthcare providers should discuss potential effects on fertility with patients and arrange referral to a fertility specialist if appropriate. See Ontario Fertility Program
- Psychosocial oncology (PSO) is the interprofessional specialty concerned with understanding and treating the social, practical, psychological, emotional, spiritual and functional needs and quality-of-life impact that cancer has on patients and their families. Psychosocial care should be considered an integral and standardized part of cancer care for patients and their families at all stages of the illness trajectory. For more information, visit EBS #19-3.*

Pathway Map Legend

Colour Guide

- Primary Care
- Palliative Care
- Pathology
- Organized Diagnostic Assessment
- Surgery
- Radiation Oncology
- Medical Oncology
- Radiology
- Multidisciplinary Cancer Conference (MCC)
- Genetics
- Psychosocial Oncology (PSO)

Shape Guide

- Intervention
- Decision or assessment point
- Patient (disease) characteristics
- Consultation with specialist
- Exit pathway
- Off page reference (or)
- Referral (R)

Line Guide

- Required
- Possible

Pathway Map Disclaimer

This pathway map is a resource that provides an overview of the treatment that an individual in the Ontario cancer system may receive.

The pathway map is intended to be used for informational purposes only. The pathway map is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathway maps are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway map. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway map. The information in the pathway map does not create a physician-patient relationship between Ontario Health (Cancer Care Ontario) and the reader.

While care has been taken in the preparation of the information contained in the pathway map, such information is provided on an "as-is" basis, without any representation, warranty, or condition, whether express, or implied, statutory or otherwise, as to the information's quality, accuracy, currency, completeness, or reliability.

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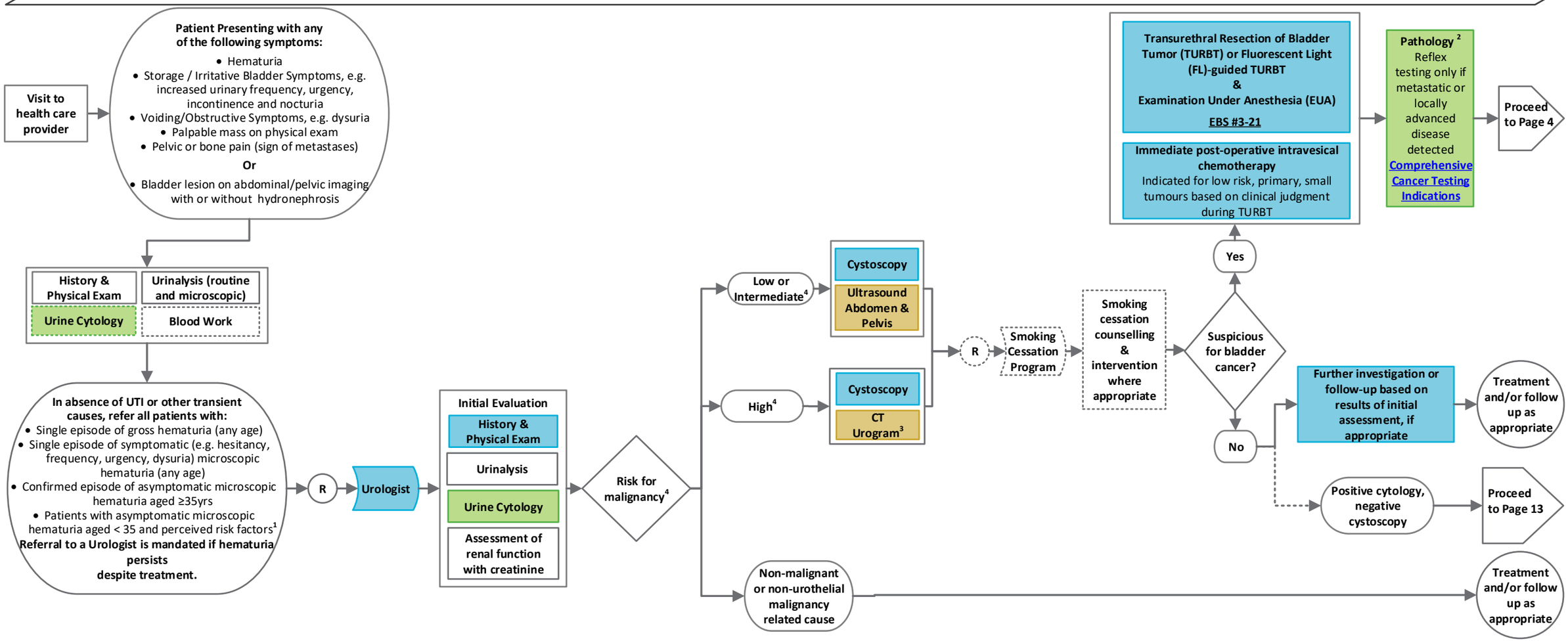
This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. Ontario Health (Cancer Care Ontario) and its content providers assume no responsibility for omissions or incomplete information in this pathway map. It is possible that other relevant scientific findings may have been reported since completion of this pathway map. This pathway map may be superseded by an updated pathway map on the same topic.

* **Note. EBS #19-2 and EBS #19-3** are older than 3 years and are currently listed as 'For Education and Information Purposes'. This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes.

Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Consider the introduction of palliative care, early and across the cancer journey. Click here for more information about palliative care

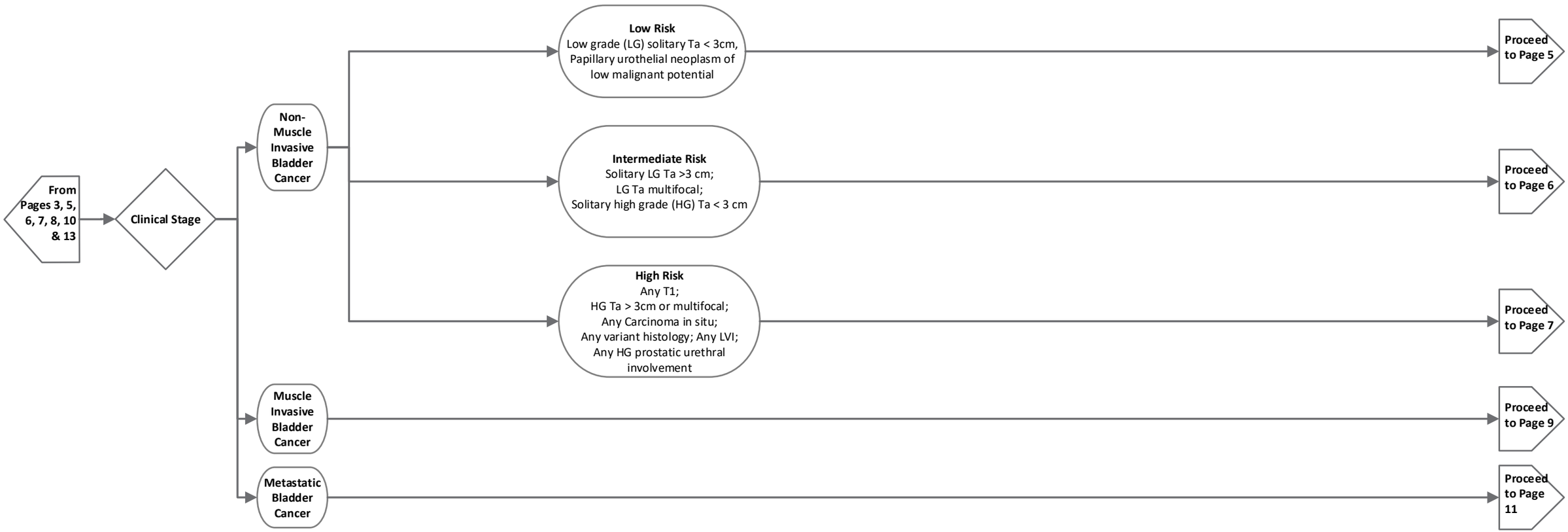


[1] Risk factors for urothelial cancer include age, male sex, past tobacco use, degree of microheaturia (> or <25RBC/HPF) and history of gross hematuria, irritative lower urinary tract voiding symptoms, cyclophosphamide or other carcinogenic alkylating agent exposure, history of pelvic irradiation, family history of bladder cancer or Lynch Syndrome, history of indwelling foreign body in the urinary tract, exposure to occupational hazards such as dyes, benzenes, and aromatic amines. Microhematuria: AUA/SUFU Guideline; Barocas DA, Boorjian SA, Alvarez RD et al: Microhematuria: AUA/SUFU guideline. J Urol 2020; 204: 778.

[2] Consider review by pathologist with genitourinary expertise when: variant histology, lamina propria/muscle invasive tumours with minimal invasion, or ambiguity as to whether muscularis propria is involved or a mismatch between clinical/cystoscopic findings is noted.

[3] Consider MR Urogram if patient is unable to receive IV contrast. If there are contraindications to CT and MR urography, consider retrograde pyelography in conjunction with non-contrast axial imaging or ultrasound.

[4] Low and intermediate risk: <60 years old, < 30 Pack-years smoking, < 25 RBC/HPF on one or repeat urinalysis, may have one or more risk factors (see footnote 1). High risk: >60 years old, > 30 Pack-years smoking, > 25 RBC/HPF on any urinalysis, History of gross hematuria. Microhematuria: AUA/SUFU Guideline; Barocas DA, Boorjian SA, Alvarez RD et al: Microhematuria: AUA/SUFU guideline. J Urol 2020; 204: 778.



Type of Cancer

Ta: Noninvasive papillary carcinoma
Tis: Carcinoma in situ
T1: Tumour invades subepithelial connective tissue
T2: Tumour invades muscularis propria
T3:Tumour invades perivesical tissue
T4: Tumour invades any of the following: prostate stroma, seminal vesicals, uterus, vagina, pelvic wall, abdominal wall
PUNLMP: Papillary urothelial neoplasms of low malignant potential
LG: Low-grade papillary urothelial carcinoma
HG: High-grade papillary urothelial carcinoma
WHO/ISUP 2004

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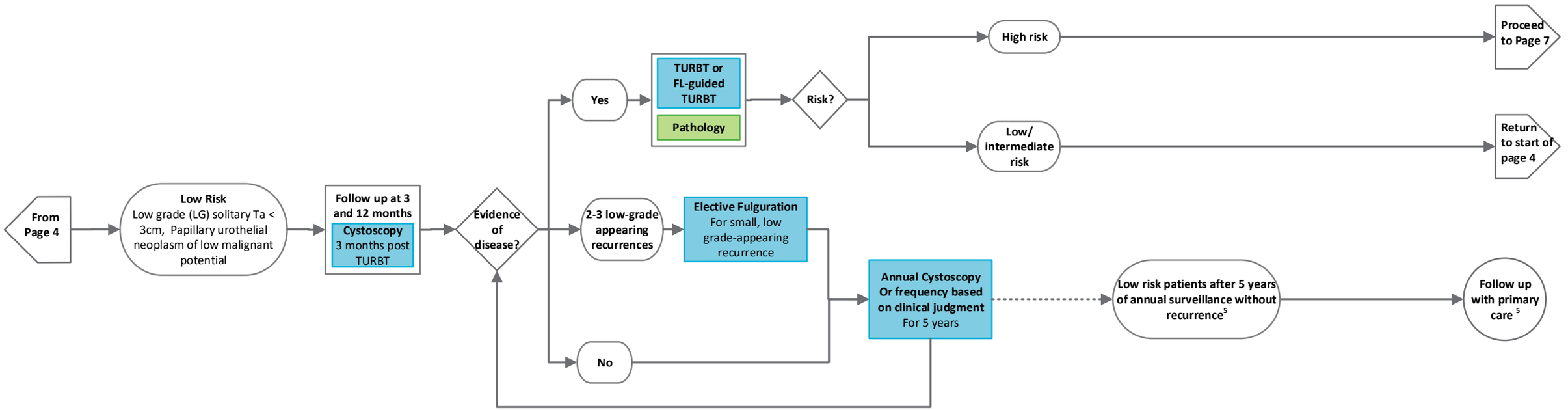

[5] Follow up after 5 years in absence of recurrence should be based on shared decision making between the specialist and patient. Annual urinalysis with a family physician can be considered in place of cystoscopy in some low risk patients after 5 years. In patients at intermediate risk lifelong follow up with cystoscopy may be warranted.

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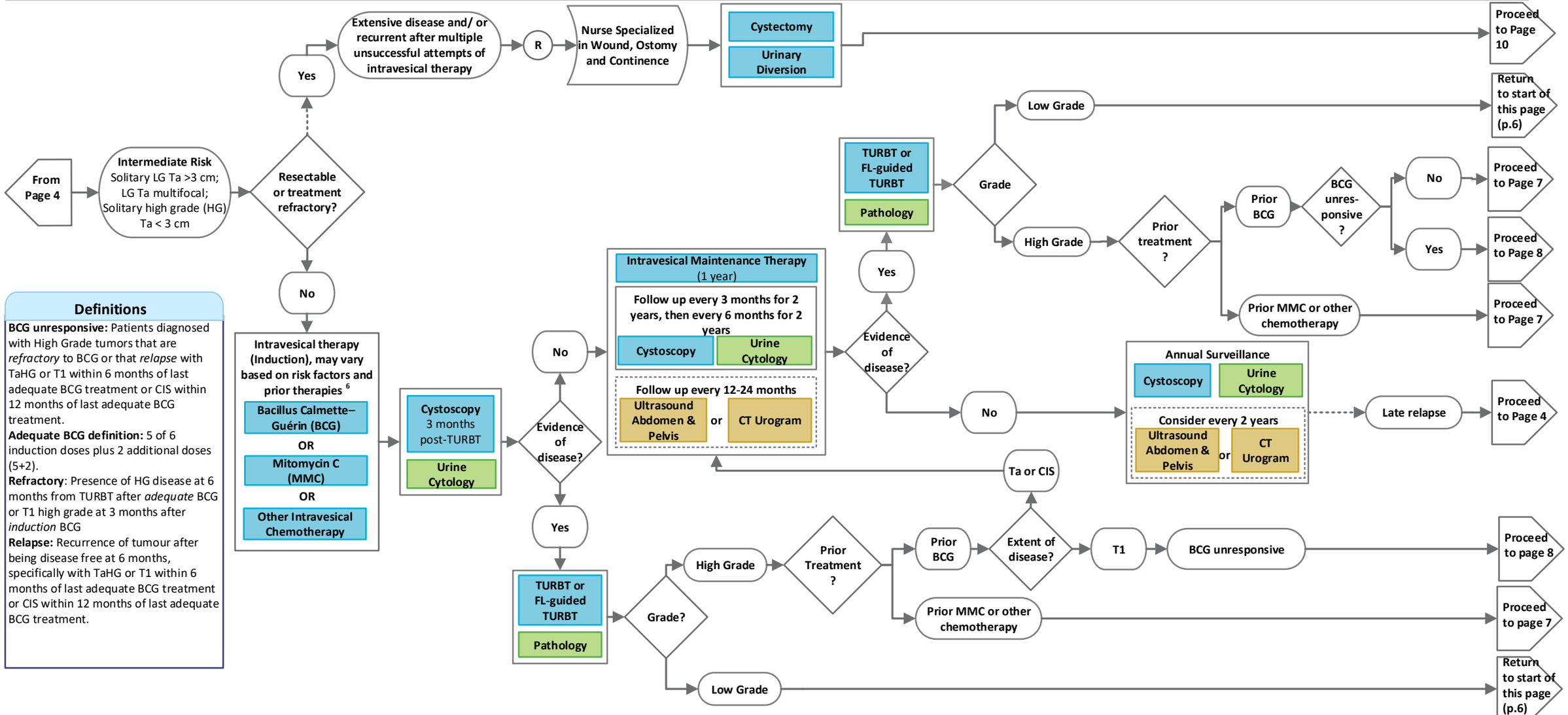

Definitions

BCG unresponsive: Patients diagnosed with High Grade tumors that are *refractory* to BCG or that *relapse* with TaHG or T1 within 6 months of last adequate BCG treatment or CIS within 12 months of last adequate BCG treatment.

Adequate BCG definition: 5 of 6 induction doses plus 2 additional doses (5+2).

Refractory: Presence of HG disease at 6 months from TURBT after *adequate* BCG or T1 high grade at 3 months after *induction* BCG

Relapse: Recurrence of tumour after being disease free at 6 months, specifically with TaHG or T1 within 6 months of last adequate BCG treatment or CIS within 12 months of last adequate BCG treatment.

[6] Choice depends on prior treatment (if any). Consider substratification: a) Low-intermediate risk: 0 factors* – consider treating as low risk patients; b) Intermediate risk: 1-2 factors*; c) High-intermediate risk: ≥3 factors* – consider treating as high risk patients.

*Factors include: Multiple tumours, >3cm, time to recurrence (<1year), and frequency of recurrence (>1 / year)

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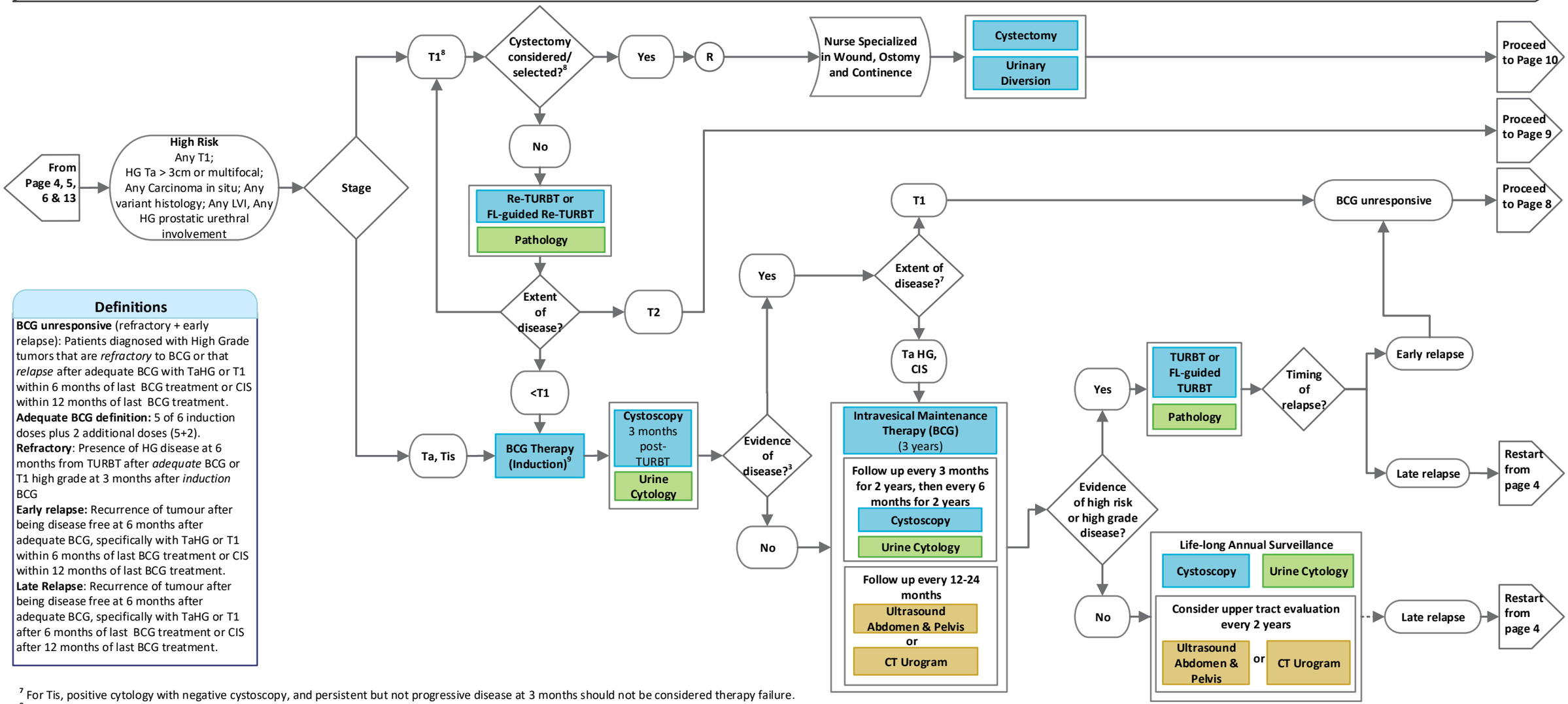

Definitions

BCG unresponsive (refractory + early relapse): Patients diagnosed with High Grade tumors that are *refractory* to BCG or that *relapse* after adequate BCG with TaHG or T1 within 6 months of last BCG treatment or CIS within 12 months of last BCG treatment.

Adequate BCG definition: 5 of 6 induction doses plus 2 additional doses (5+2).

Refractory: Presence of HG disease at 6 months from TURBT after *adequate* BCG or T1 high grade at 3 months after *induction* BCG

Early relapse: Recurrence of tumour after being disease free at 6 months after adequate BCG, specifically with TaHG or T1 within 6 months of last BCG treatment or CIS within 12 months of last BCG treatment.

Late Relapse: Recurrence of tumour after being disease free at 6 months after adequate BCG, specifically with TaHG or T1 after 6 months of last BCG treatment or CIS after 12 months of last BCG treatment.

[7] For Tis, positive cytology with negative cystoscopy, and persistent but not progressive disease at 3 months should not be considered therapy failure.

[8] Cystectomy should be strongly considered for highest risk pathology (T1HG+CIS, Multiple T1HG,T1HG > 3 cm, or micropapillary, nested/large cell, plasmacytoid, sarcomatoid, microcystic, small tubules or lymphoepithelioma-type urothelial carcinoma variants, LVI+). Review by a pathologist with genitourinary expertise should then be performed if not already done so.

[9] The maximum number of inductions that any patient should undergo in their lifetime is two. After completion of 2 inductions the risk of subsequent relapse is too high.

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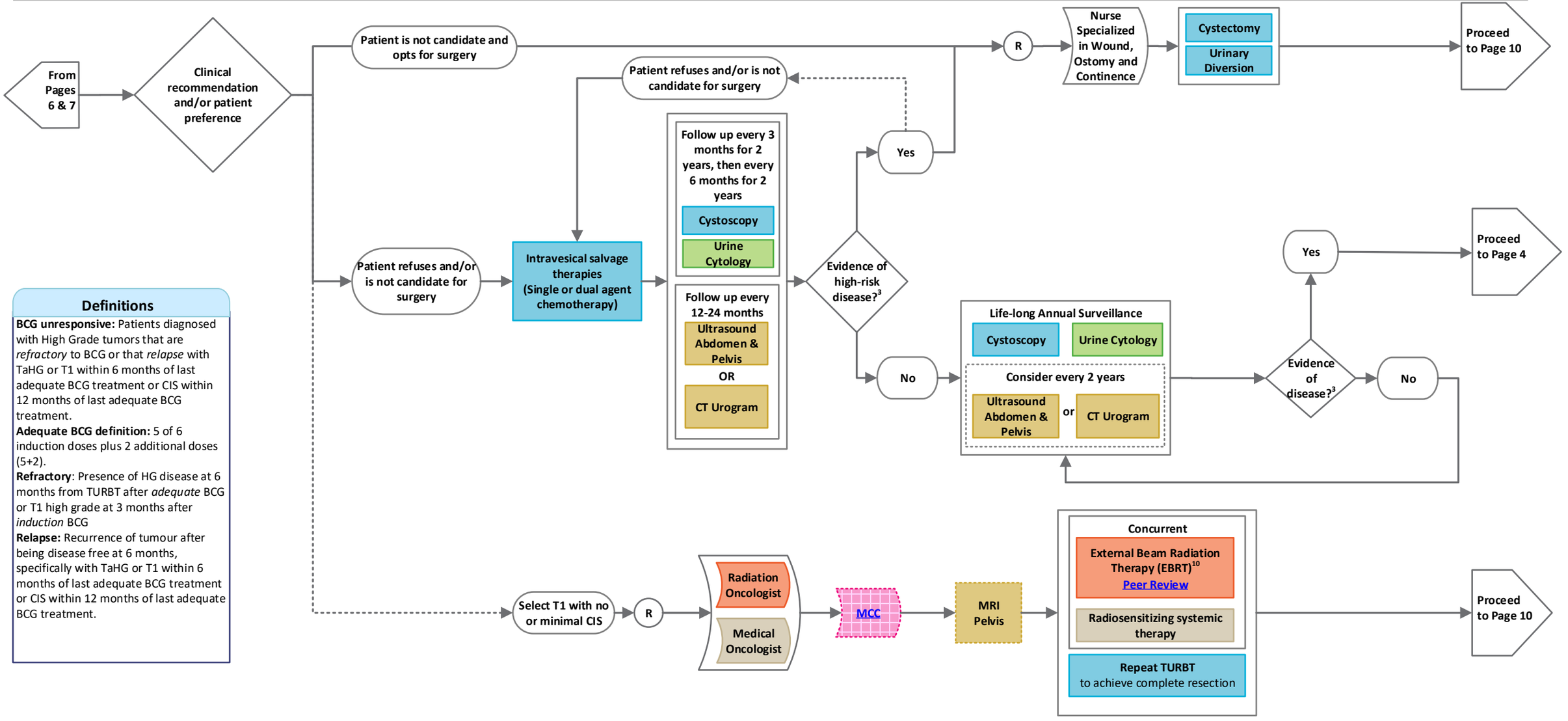

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Adequate BCG definition: 5 of 6 induction doses plus 2 additional doses (5+2).

Refractory: Presence of HG disease at 6 months from TURBT after *adequate* BCG or T1 high grade at 3 months after *induction* BCG

Relapse: Recurrence of tumour after being disease free at 6 months, specifically with TaHG or T1 within 6 months of last adequate BCG treatment or CIS within 12 months of last adequate BCG treatment.

[10] EBRT can be performed alone if not a candidate for Radiosensitizing systemic therapy.

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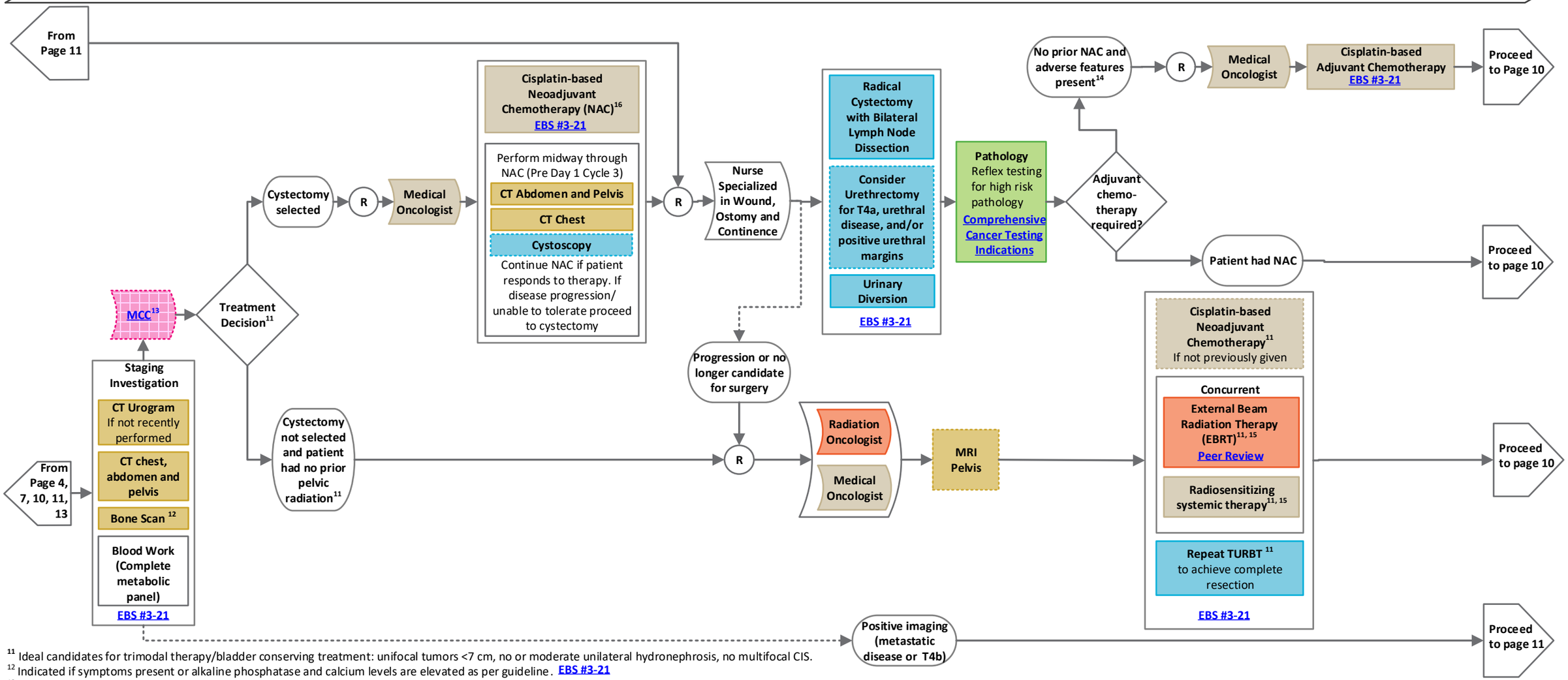

[11] Ideal candidates for trimodal therapy/bladder conserving treatment: unifocal tumors <7 cm, no or moderate unilateral hydronephrosis, no multifocal CIS.
[12] Indicated if symptoms present or alkaline phosphatase and calcium levels are elevated as per guideline. EBS #3-21
[13] Consider patient preference, performance status,co-morbidities, and if high risk factors present (micropapillary, nested, plasmacytoid variant).
[14] Adverse features: pT3-4 or N+, lymphovascular invasion and/or positive margins.
[15] EBRT can be performed alone if not a candidate for radiosensitizing systemic therapy.
[16] Per Galsky Criteria for eligibility, patients are unfit to receive cisplatin based therapy if: Performance status WHO or ECOG PS ≥2 or KPS of 60%-70%; Renal function CrCl <60 ml/min (calculated or measured); Neuropathy CTCAE v4 grade ≥2 peripheral neuropathy, Hearing CTCAE v4 grade ≥2 audiometric hearing loss; Cardiac function New York Heart Association class III heart failure.

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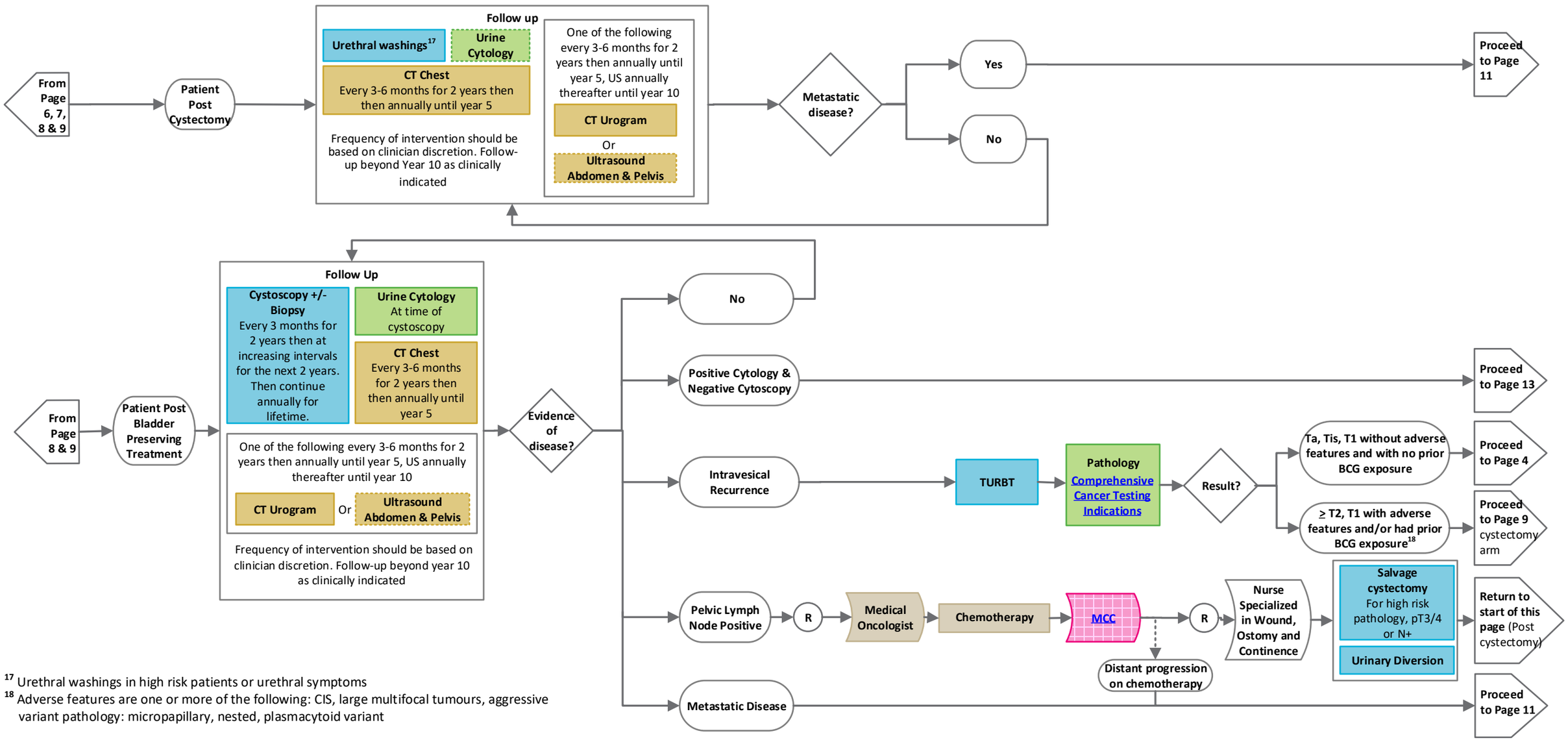

[17] Urethral washings in high risk patients or urethral symptoms

[18] Adverse features are one or more of the following: CIS, large multifocal tumours, aggressive variant pathology: micropapillary, nested, plasmacytoid variant

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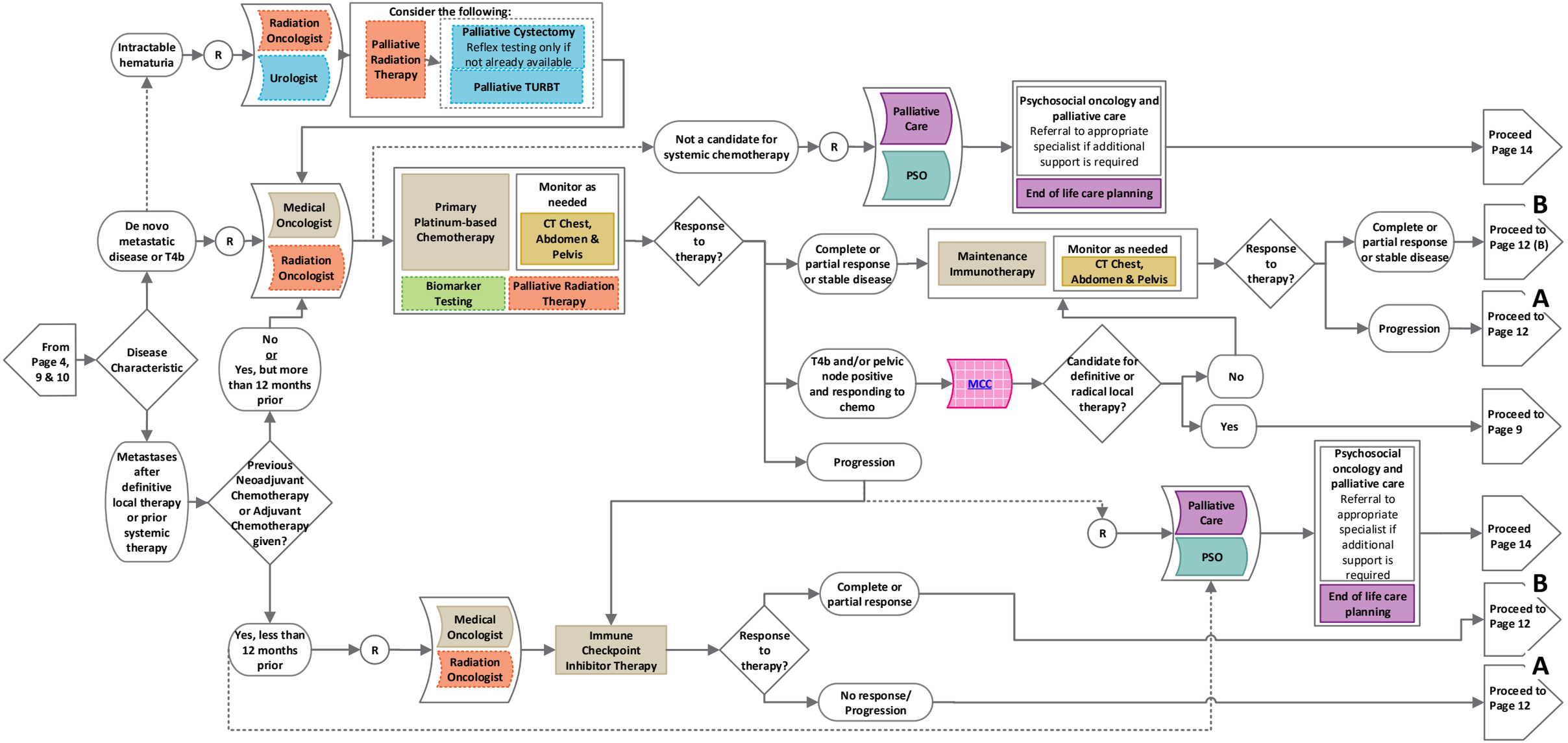

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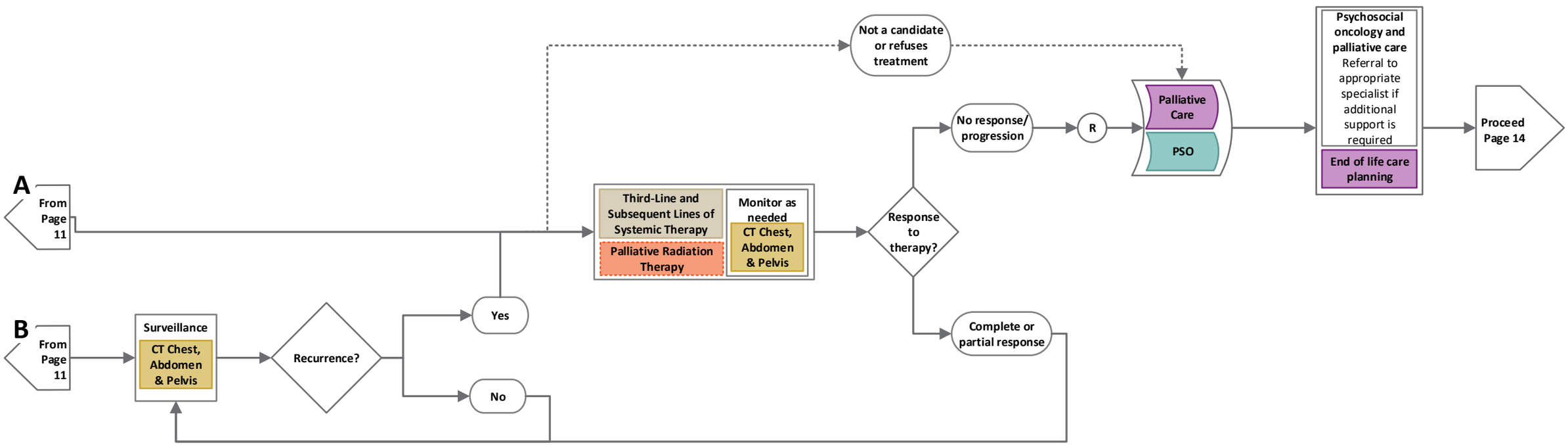

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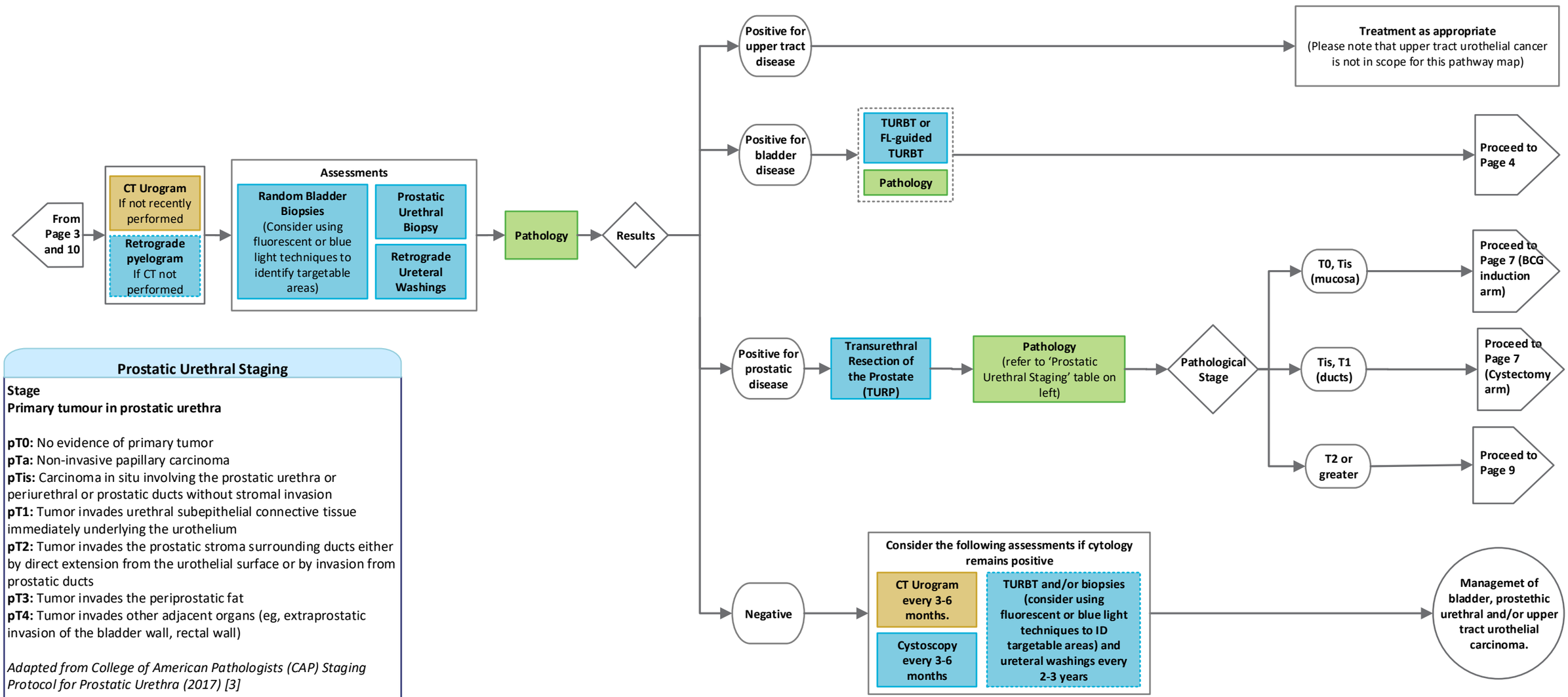

Prostatic Urethral Staging

Stage
Primary tumour in prostatic urethra

pT0: No evidence of primary tumor
pTa: Non-invasive papillary carcinoma
pTis: Carcinoma in situ involving the prostatic urethra or periurethral or prostatic ducts without stromal invasion
pT1: Tumor invades urethral subepithelial connective tissue immediately underlying the urothelium
pT2: Tumor invades the prostatic stroma surrounding ducts either by direct extension from the urothelial surface or by invasion from prostatic ducts
pT3: Tumor invades the periprostatic fat
pT4: Tumor invades other adjacent organs (eg, extraprostatic invasion of the bladder wall, rectal wall)

Adapted from College of American Pathologists (CAP) Staging Protocol for Prostatic Urethra (2017) [3]

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Pathway Map Target Population:

Individuals with cancer approaching the last 3 months of life and their families.

While this section of the pathway is focused on the care delivered at the end of life, palliative care should be initiated much earlier in the illness trajectory. In particular, providers can introduce a palliative approach to care as early as the time of diagnosis.

Triggers that suggest patients are nearing the last few months and weeks of life

- ECOG/Patient-ECOG/PRFS = 4
  OR
- PPS ≤ 50
- Declining performance status/functional ability

Screen, Assess, Plan, Manage and Follow Up

+

End of Life Care planning and implementation
Collaboration and consultation between specialist-level care teams and primary care teams

+

Conversations to determine where care should be provided and who will be responsible for providing the care

End of Life Care

☐ **Key conversations to revisit Goals of Care and to discuss and document key treatment decisions**

- Assess and address patient and family's information needs and understanding of the disease, address gaps between reality and expectation, foster realistic hope and provide opportunity to explore prognosis and life expectancy, and preparedness for death
- Explore the patient's views on medications, tests, resuscitation, intensive care and preferred location of death
- If a patient makes any treatment decisions relevant to their current condition (i.e., provides consent), these decisions can be incorporated into their Plan of Treatment
- Review Goals of Care and patient preferences regularly, particularly when there is a change in clinical status

☐ **Screen for specific end of life psychosocial issues**

- Assess and address patient and families' loss, grief and bereavement needs including anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
- Provide appropriate guidance, support and information to families, caregivers, and others, based on awareness of culture and needs, and make referrals to available resources and/or specialized services to address identified needs as required
- Identify family members at risk for abnormal/complicated grieving and connect them proactively with bereavement resources

☐ **Identify patients who could benefit from specialized palliative care services (consultation or transfer)**

- As patient and family/caregiver needs increase and/or change over time consult with palliative care specialists and/or other providers with additional expertise, as required. Transfer care only if/when needs become more extensive or complex than the current team can handle
- Discuss referral with the patient and their family/caregiver

☐ **Proactively develop and implement a plan for expected death**

- Explore place-of-death preferences and the resources required (e.g., home, hospice, palliative care unit, long term care or nursing home) to assess whether this is realistic
- Prepare and support the family to understand what to expect, and plan for when a loved one is actively dying, including understanding probable symptoms, as well as the processes with death certification and how to engage funeral services
- Discuss emergency plans with patient and family (including who to contact, and when to use or avoid Emergency Medical Services)

☐ **Home care planning (if this is where care will be delivered)**

- Contact the patient's primary care and home and community care providers and relevant specialist physicians to ensure an effective transfer of information related to their care. If the patient is transitioning from the hospital, this should include collaborating to develop a transition plan
- Introduce patient and family to resources in community (e.g., respite, day hospice programs, volunteer services, support groups, etc.)
- Connect with home and community care services early (not just in the last 2-4 weeks)
- Ensure resources and services are in place to support the patient and their family/caregiver, and address identified needs
- Anticipate/plan for pain and symptom management, including consideration for a Symptom Response Kit to facilitate access to pain, dyspnea, and delirium medication for emergency purposes
- If the patient consents to withholding cardiopulmonary resuscitation, A 'Do Not Resuscitate' order must be documented in their medical record, and a Do Not Resuscitate Confirmation (DNR-C) Form should be completed. This form should be readily accessible in the home, to ensure that the patient's wishes for a natural death are respected by Emergency Medical Services

Screen for psychosocial needs, and assessment and management of symptoms. [Click here for more information about symptom assessment and management tools]

Consider the introduction of palliative care, early and across the cancer journey. [Click here for more information about palliative care]

Patient Death

At the time of death:

- ☐ Pronouncement of death
- ☐ Completion of death certificate
- ☐ Allow family members to spend time with loved one upon death, in such a way that respects individual rituals, cultural diversity and meaning of life and death
- ☐ Implement the pre-determined plan for expected death
- ☐ Arrange time with the family for a follow-up call or visit
- ☐ Provide age-specific bereavement services and resources
- ☐ Inform family of grief and bereavement resources/ services
- ☐ Initiate grief care for family members at risk for complicated grief
- ☐ Encourage the bereaved to make an appointment with an appropriate health care provider as required

Bereavement Support and Follow-Up

- ☐ Offer psychoeducation and/or counseling to the bereaved
- ☐ Screen for complicated and abnormal grief (family members, including children)
- ☐ Consider referral of bereaved family member(s) and children to appropriate local resources, spiritual advisor, grief counselor, hospice and other volunteer programs depending on severity of grief

Provide opportunities for debriefing of care team, including volunteers