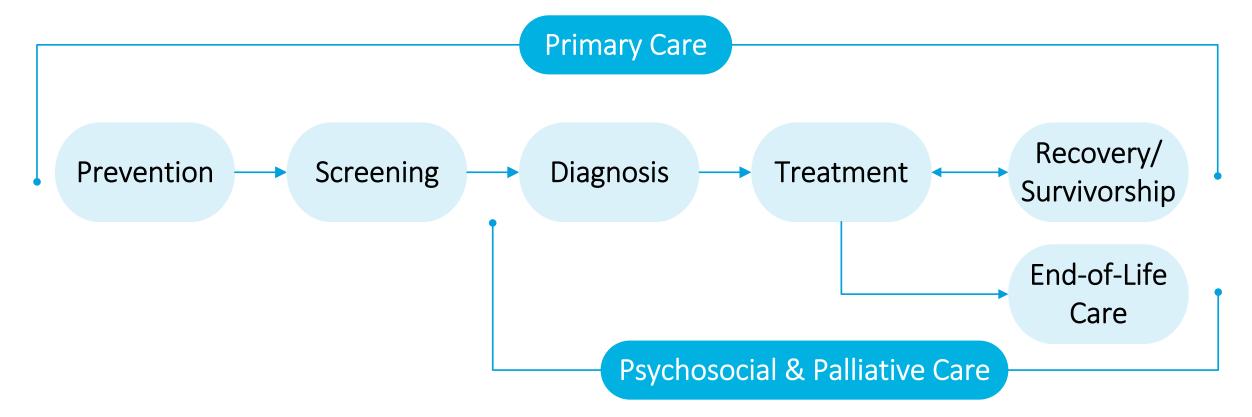
Bladder Cancer Diagnosis and Treatment Pathway Version 2025.06



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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 <u>MCC Tools</u>
- For more information on wait time prioritization, visit <u>Surgery</u>
- 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	Shape Guide		Line Guide	
Primary Care		Intervention		Required
Palliative Care	\Diamond	Decision or assessment point	•••••	Possible
Pathology		Patient (disease) characteristics		
Organized Diagnostic Assessment		Consultation with specialist		
Surgery		Exit pathway		
Radiation Oncology	\bigcirc or \bigcirc	Off page reference		
Medical Oncology	R	Referral		
Radiology				
Multidisciplinary Cancer Conference (MCC)				
Genetics				
Psychosocial Oncology (PSO)				

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.

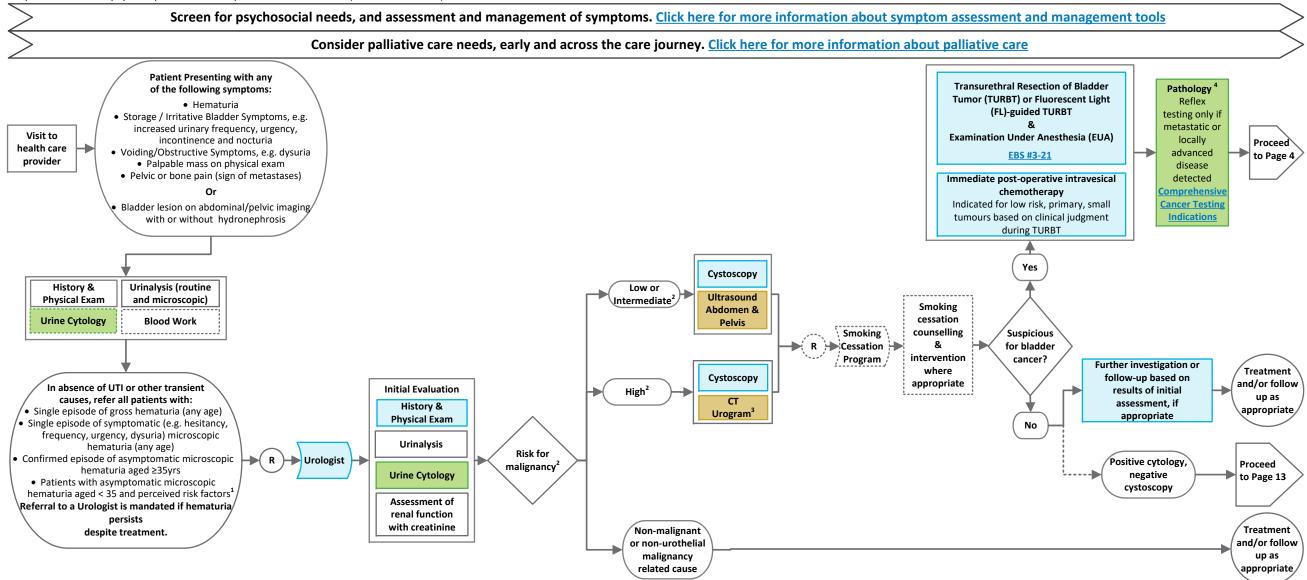
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This pathway map may not reflect all the available scientific research and is not intended as an exhaustive resource. Ontario Health (Cancer Care Ontario) and its content providers assume no responsibility for omissions or incomplete information in 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. <u>EBS #19-2</u> and <u>EBS #19-3</u> 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.

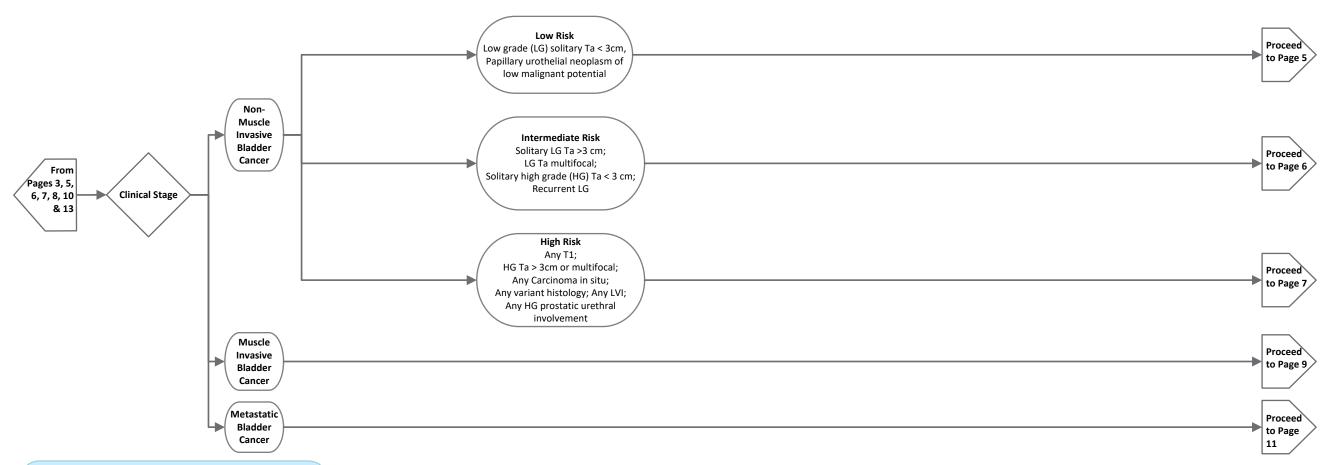


¹ Risk factors for urothelial cancer include age, male sex, past tobacco use, degree of microheaturia (> or <25RBC/HPF) and history of gross hematuria, irritative lower urinary tract voiding symptoms, cyclophosphamide or other carcinogenic alkylating agent exposure, history of pelvic irradiation, family 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 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: J Urol 2020; 204: 778.

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 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.



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

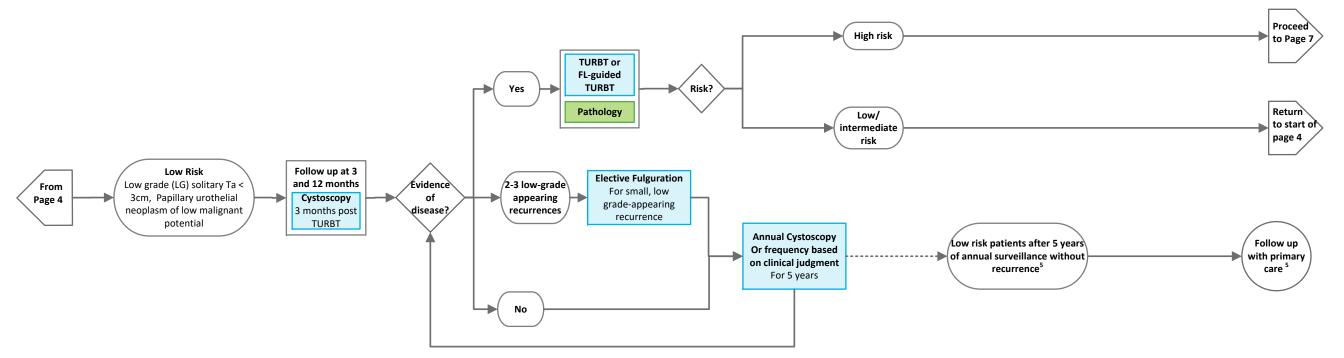
PUNLMP: Papillary urothelial neoplasms of low malignant potential

LG: Low-grade papillary urothelial carcinoma

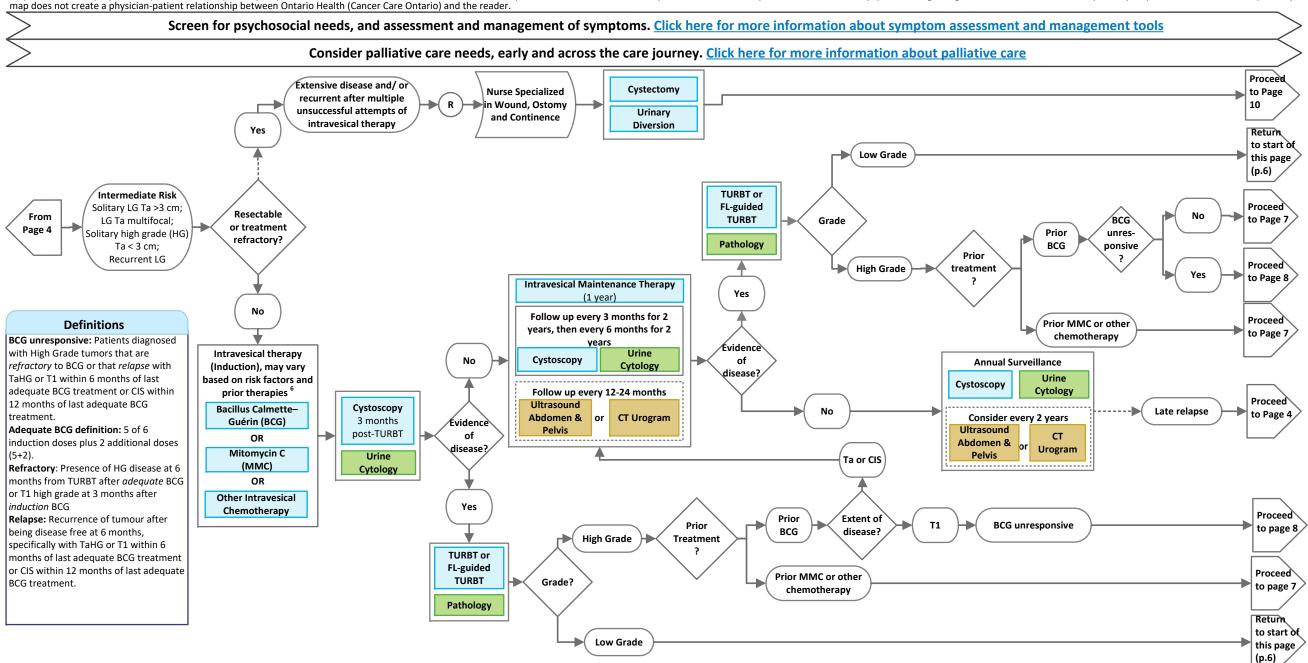
HG: High-grade papillary urothelial carcinoma

WHO/ISUP 2004

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

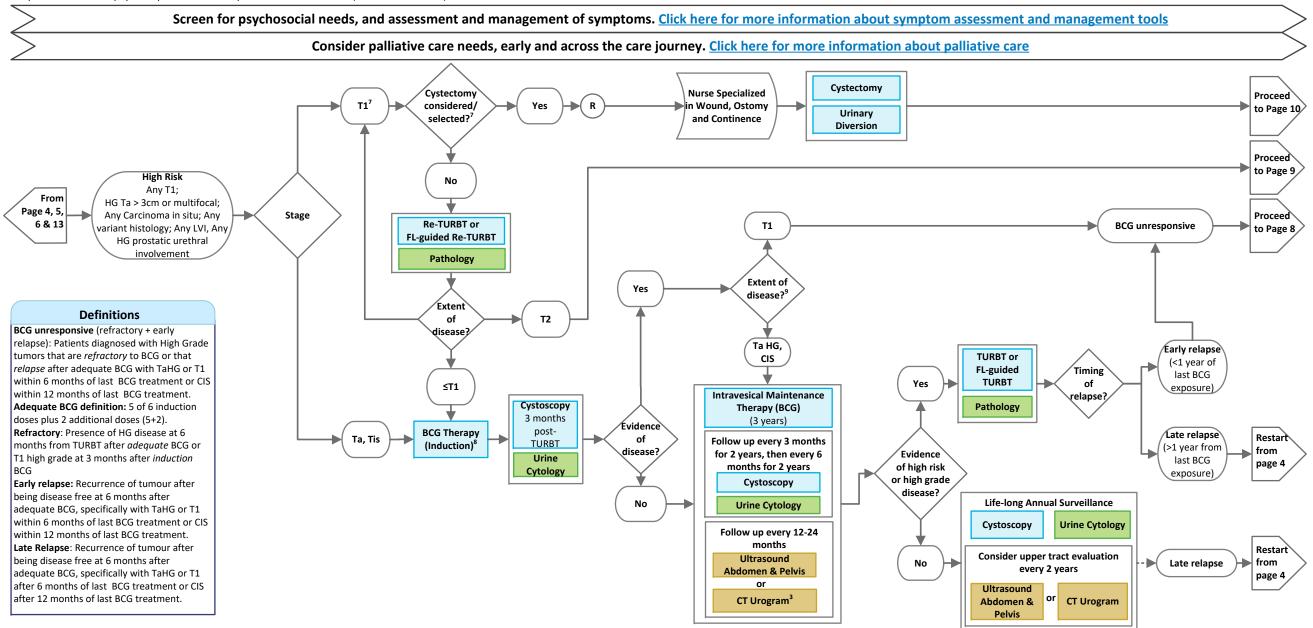


⁵ Follow up after 5 years in absence of recurrence should be based on shared decision making between the specialist and patient. Annual urinalysis with a family physician can be considered in place of cystoscopy in some low risk patients after 5 years. In patients at intermediate risk lifelong follow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



⁶Choice 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 (<1 year), and frequency of recurrence (>1 / year)

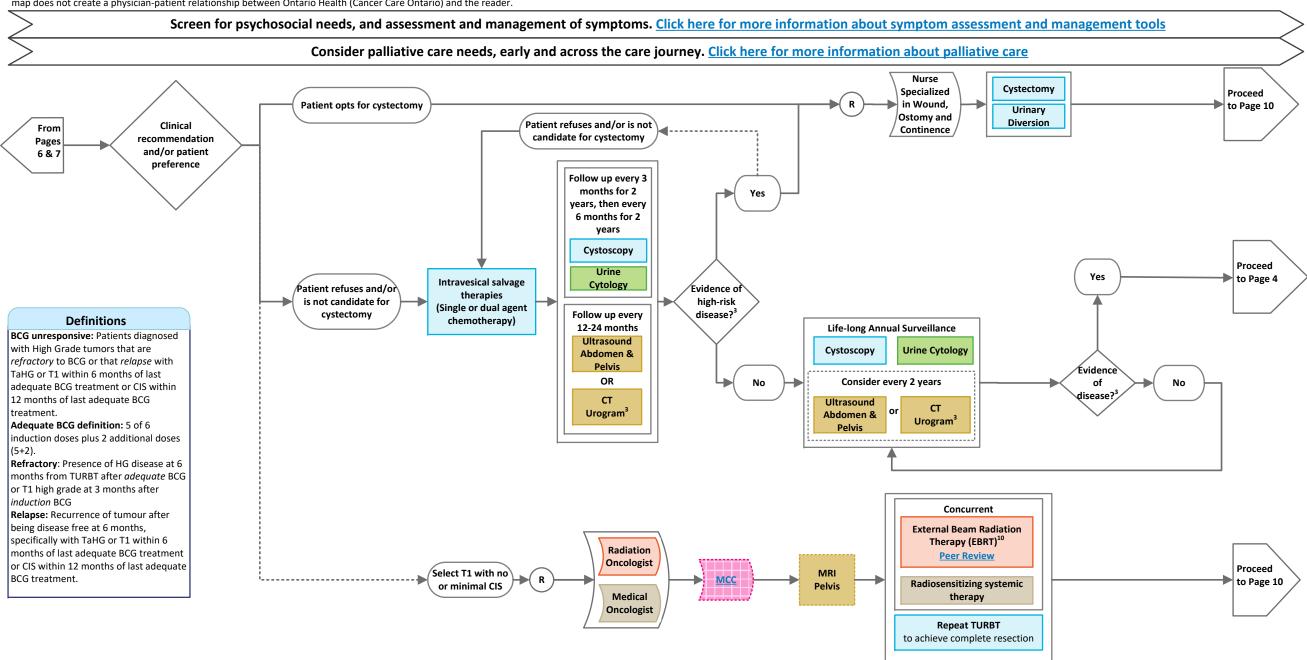


³ Consider MR Urogram if patient is unable to receive IV contrast. If there are contraindications to CT and MR urography, consider retrograde pyelography in conjunction with non-contrast axial imaging or ultrasound.

⁷ Cystectomy should be strongly considered for highest risk pathology (T1HG+CIS, Multiple T1HG,T1HG > 3 cm, or micropapillary, nested/large cell, plasmacytoid, sarcomatoid, LVI+). Review by a pathologist with genitourinary expertise should then be performed if not already done so.

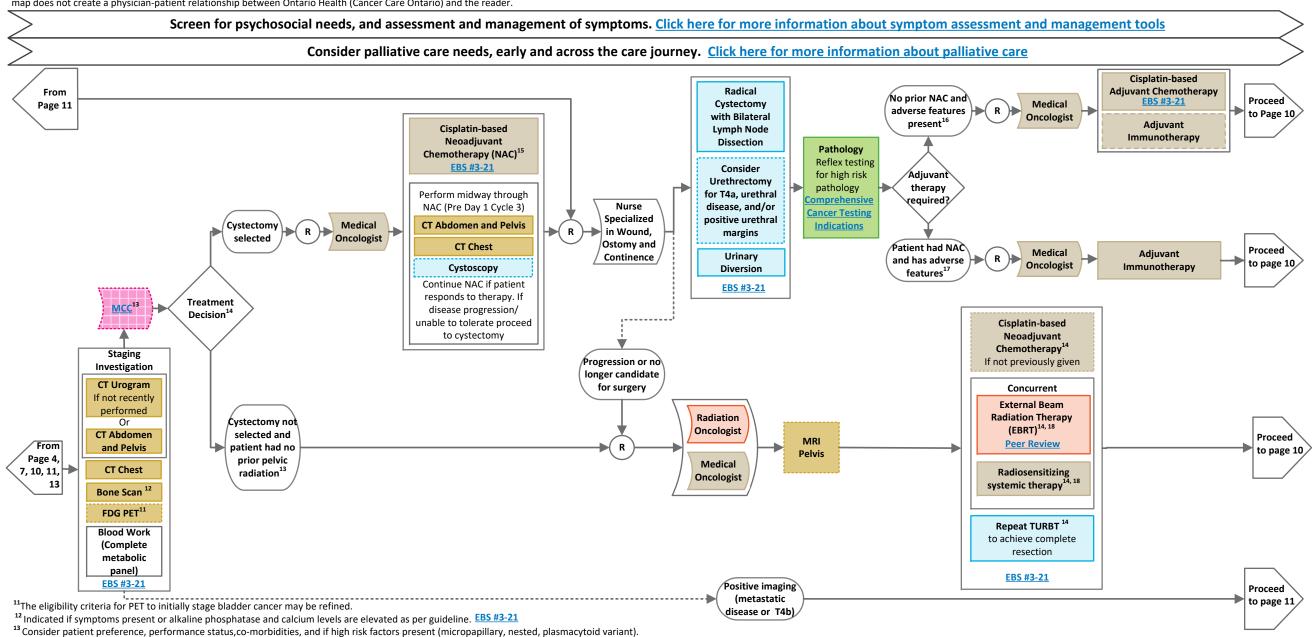
⁸The maximum number of inductions that any patient should undergo in their lifetime is two. After completion of 2 inductions the risk of subsequent relapse is too high.

⁹ For Tis, positive cytology with negative cystoscopy, and persistent but not progressive disease at 3 months should not be considered therapy failure.



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.

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



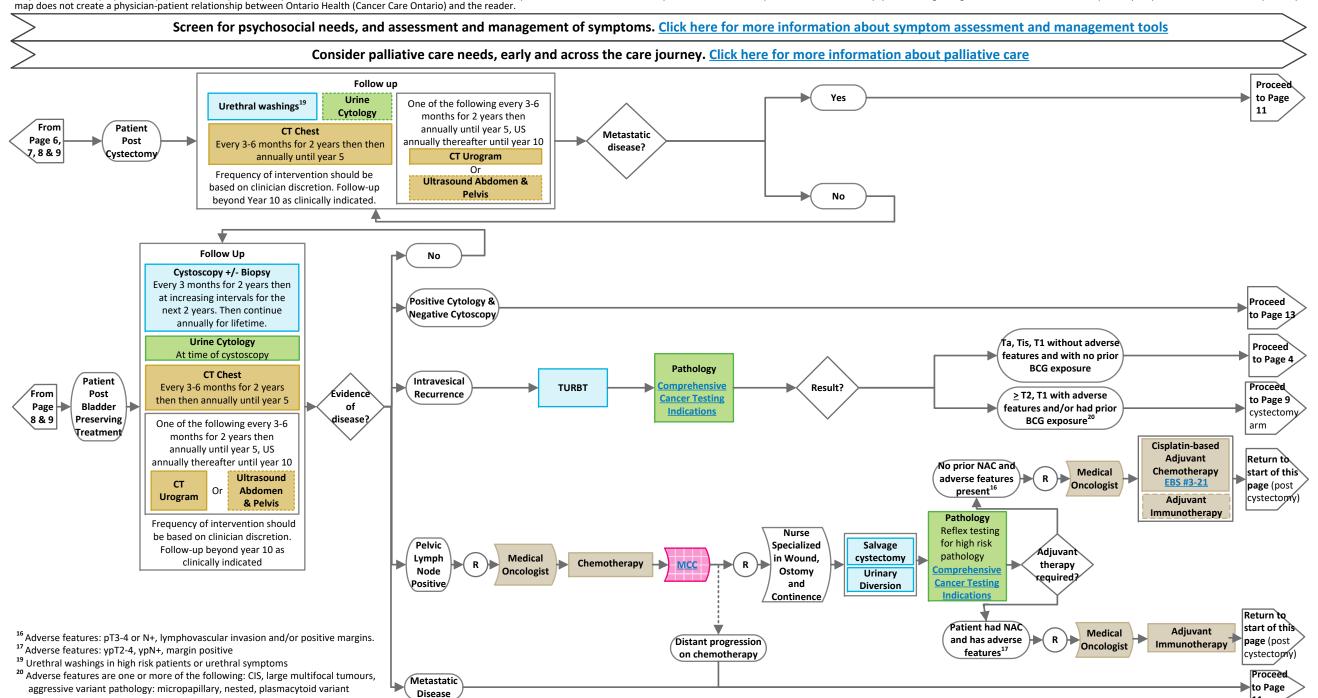
¹⁴ Ideal candidates for trimodal therapy/bladder conserving treatment: unifocal tumors <7 cm, no or moderate unilateral hydronephrosis, no multifocal CIS.

¹⁵ 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.

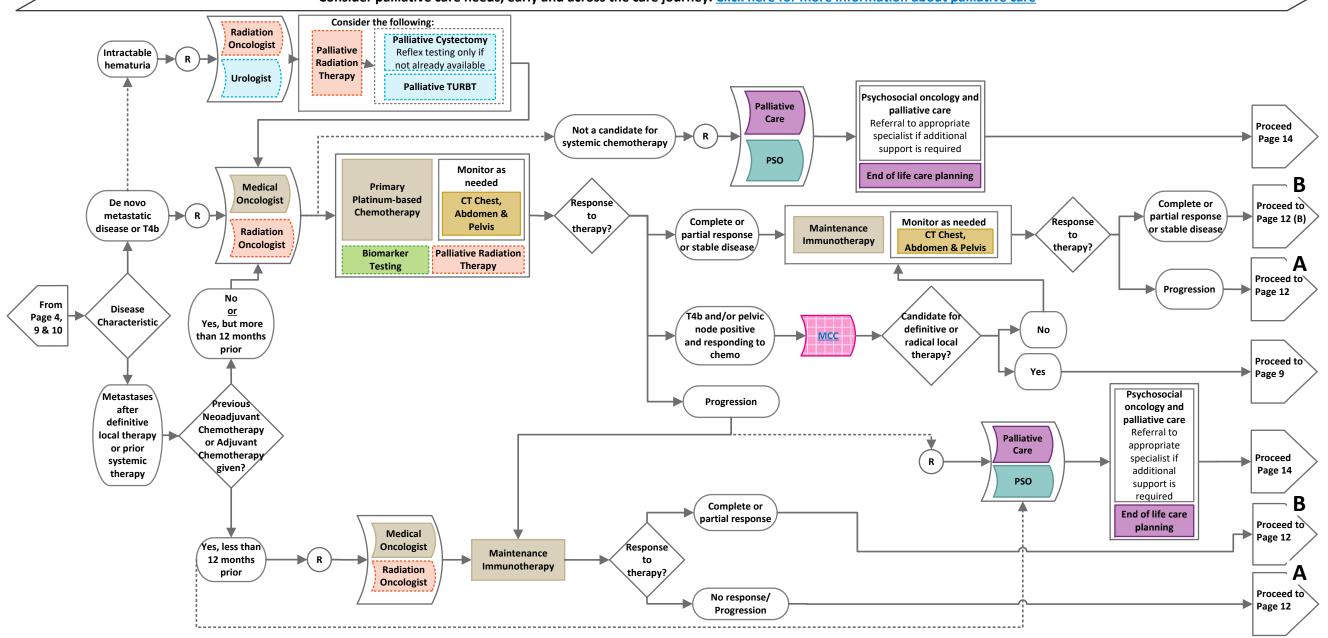
Adverse features: pT3-4 or N+, lymphovascular invasion and/or positive margins.

¹⁷ Adverse features: ypT2-4, ypN+, margin positive

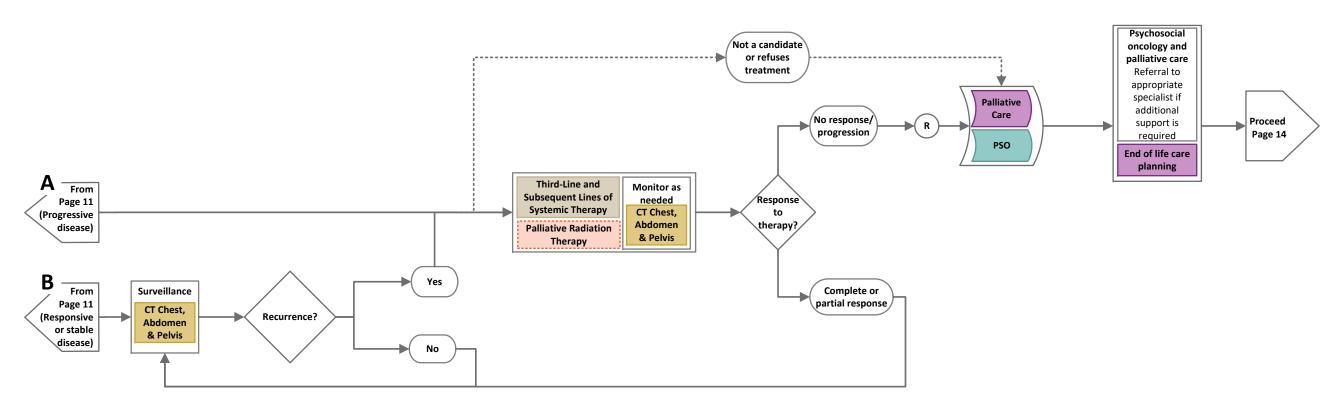
¹⁸ EBRT can be performed alone if not a candidate for radiosensitizing systemic therapy.



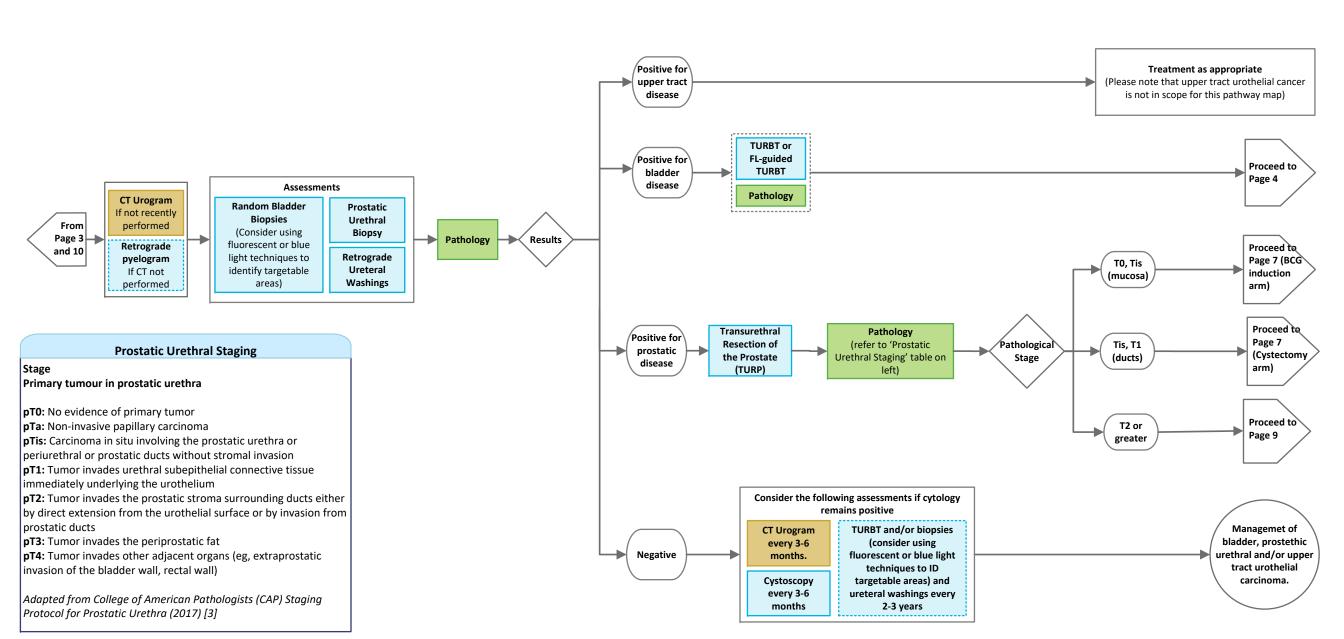
Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools



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

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

- Eastern
 Cooperative
 Oncology Group
 (ECOG)
 Performance
 Status/Patient ECOG/Patient
 Reported
 Functional Status
 (PRFS) = 4
- Palliative
 Performance
 Scale (PPS) ≤ 50

OR

 Declining performance status/functional ability Screen, Assess, Plan, Manage and Follow Up



End of Life Care
planning and
implementation
Collaboration and
consultation
between specialistlevel 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

Bladder Cancer Diagnosis and Treatment Pathway Map

End of Life Care cont

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Provide

opportunities for debriefing of care team, including volunteers

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——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	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
	an appropriate health care provider as required	

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