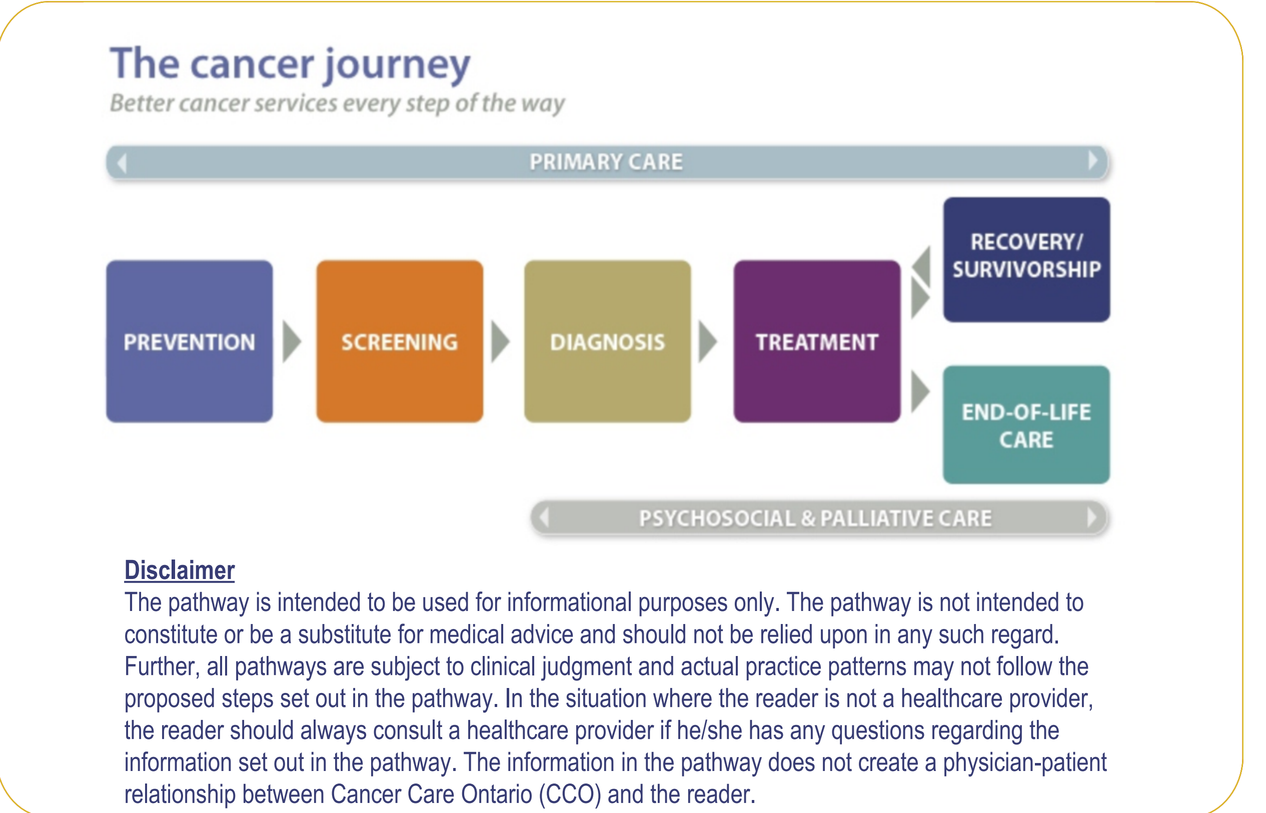
Bladder Cancer Diagnosis, Treatment & Follow-up Care Pathway Map

Version 2018.08



Disclaimer

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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.

Pathway Considerations

- Photodynamic Diagnosis (PDD) can be considered as an adjunct to Transurethral Resection of Bladder Tumor (TURBT), and Narrow Band Imaging (NBI) as an adjunct to cystoscopy if available.
- Clinical trials should be considered for all phases of the pathway.
- Counseling and treatment for smoking cessation should be initiated early on in the pathway and continued by care providers throughout the pathway as necessary. Program Training & Consultation Centre – Hospital Based Resources
- 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. For patients who do not have a primary care provider, Health Care Connect, is a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway, 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*
- Hyperlinks are used throughout the pathway to provide information about relevant CCO tools, resources and guidance documents.
- The term 'health care provider', used throughout the pathway, includes primary care providers and specialists, nurse practitioners, and emergency physicians.
- 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*
- For more information on Multidisciplinary Cancer Conferences visit MCC Tools
- For more information on wait time prioritization, visit: Surgery
- For more information on the systemic treatment QPB please refer to the Quality-Based Procedures Clinical Handbook for Systemic Treatment
- The following should be considered when weighing the treatment options described in this pathway map for patients with potentially life-limiting illness: (1) Palliative care may be of benefit at any stage of the cancer journey, and may enhance other types of care - including restorative or rehabilitative care - or may become the total focus of care, (2) Ongoing discussions regarding goals of care is central to palliative care, and is an important part of the decision-making process. Goals of care discussions include the type, extent and goal of a treatment or care plan, where care will be provided, which health care providers will provide the care, and the patient's overall approach to care

* **Note.** EBS #19-2 and #19-3 are older than 3 years and is 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.

References

[1] Kassouf, W., Aprikian, A., Black, P., Kulkarni, G., Izawa, J., Eapen, L., ... & Sridhar, S. S. (2016). Recommendations for the improvement of bladder cancer quality of care in Canada: A consensus document reviewed and endorsed by Bladder Cancer Canada (BCC), Canadian Urologic Oncology Group (CUOG), and Canadian Urological Association (CUA), December 2015. Canadian Urological Association Journal, 10(1-2), E46.
[2] Kassouf, W., Traboulsi, S. L., Kulkarni, G. S., Breau, R. H., Zlotta, A., Fairey, A., ... & Siemens, D. R. (2015). CUA guidelines on the management of non-muscle invasive bladder cancer. Canadian Urological Association Journal, 9(9-10), E690.
[3] McKenney, J. K., Zhou, M., Allan, R., Amin, M. B., Epstein J. I., Grignon, D. J., Humphrey, P. A., Oliva, E., Pettus, J., Reuter, V. E., & Srigley, J. R. (June 2017). Protocol for the Examination of Specimens From Patients with Carcinoma of the Urethra and Periurethral Glands (Version: Urethra 4.0.0.0). College of America Pathologists.

Pathway Map Legend

Colour Guide

- Primary Care
- Palliative Care
- Pathology
- Radiology
- Urology
- Radiation Oncology
- Medical Oncology
- Multidisciplinary Cancer Conference (MCC)
- Psychosocial Oncology (PSO)

Shape Guide

- Intervention
- Decision or assessment point
- Patient (disease) characteristics
- Consultation with specialist
- Exit pathway
- x or x Off-page reference
- Patient/Provider interaction
- R Referral
- W Wait time indicator time point

Line Guide

- Required
- Possible

Pathway Disclaimer

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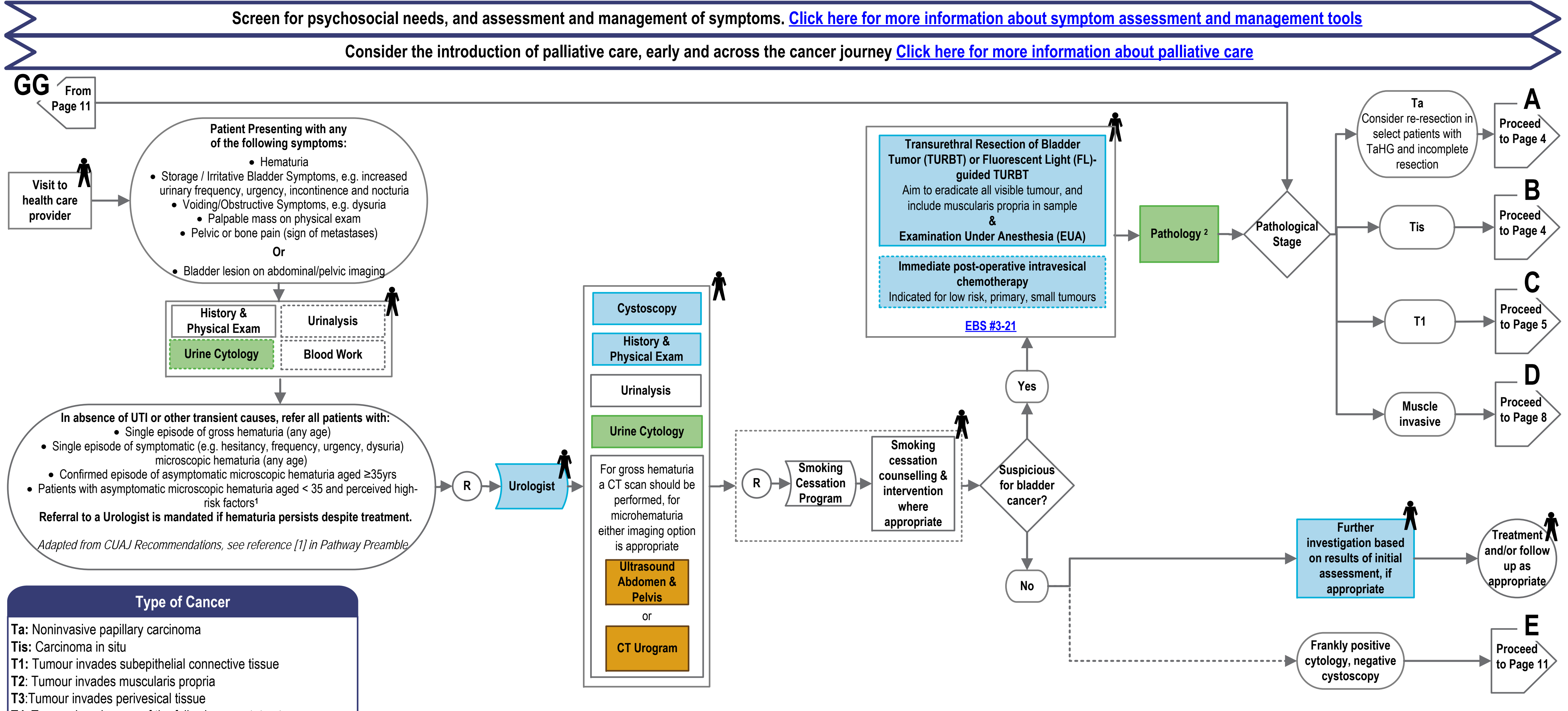

Type of Cancer

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

[1] High risk factors include past tobacco use, history of pelvic irradiation, cyclophosphamide or other carcinogenic alkylating agent exposure, and exposure to occupational hazards such as dyes, benzenes, and aromatic amines.
[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.

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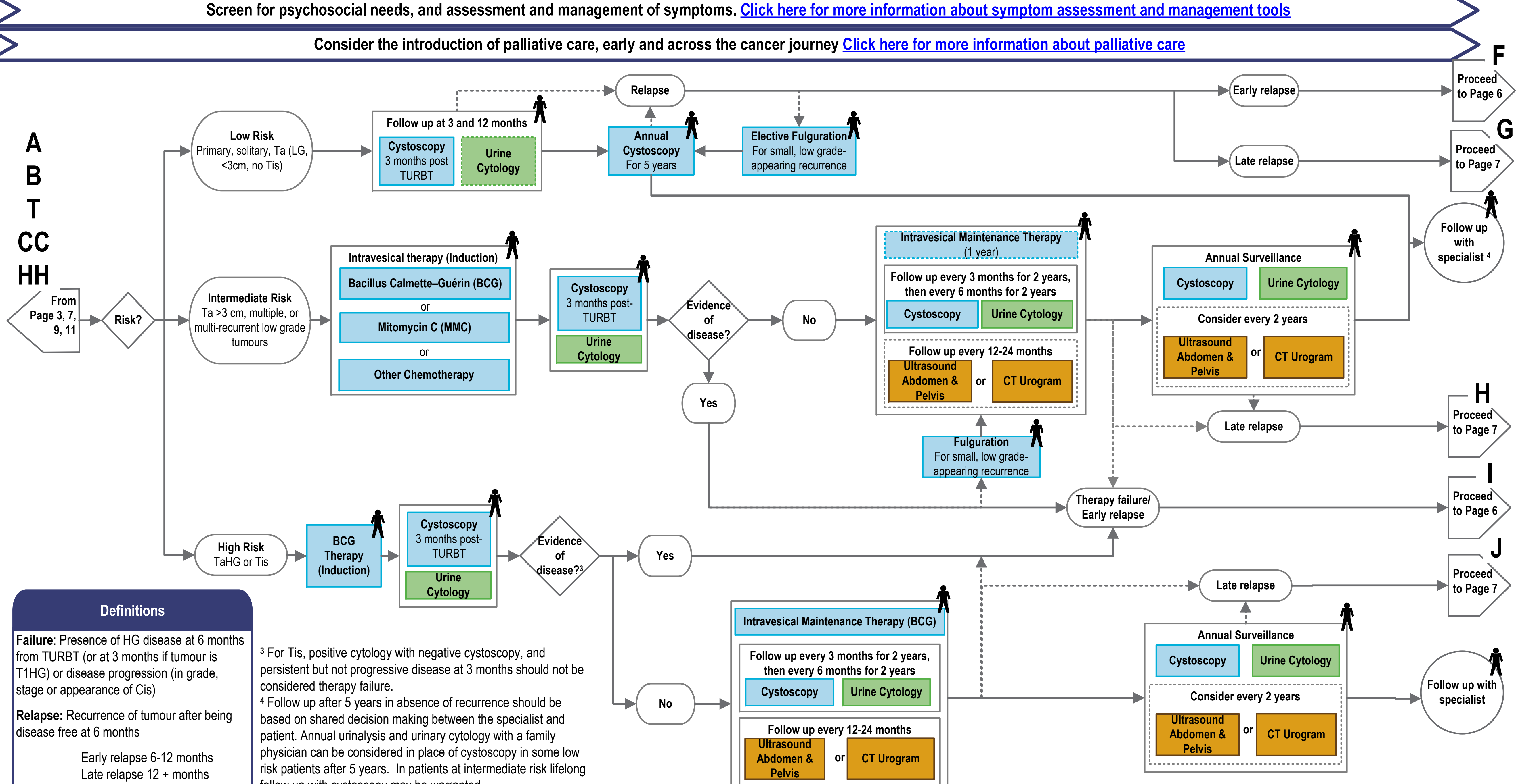

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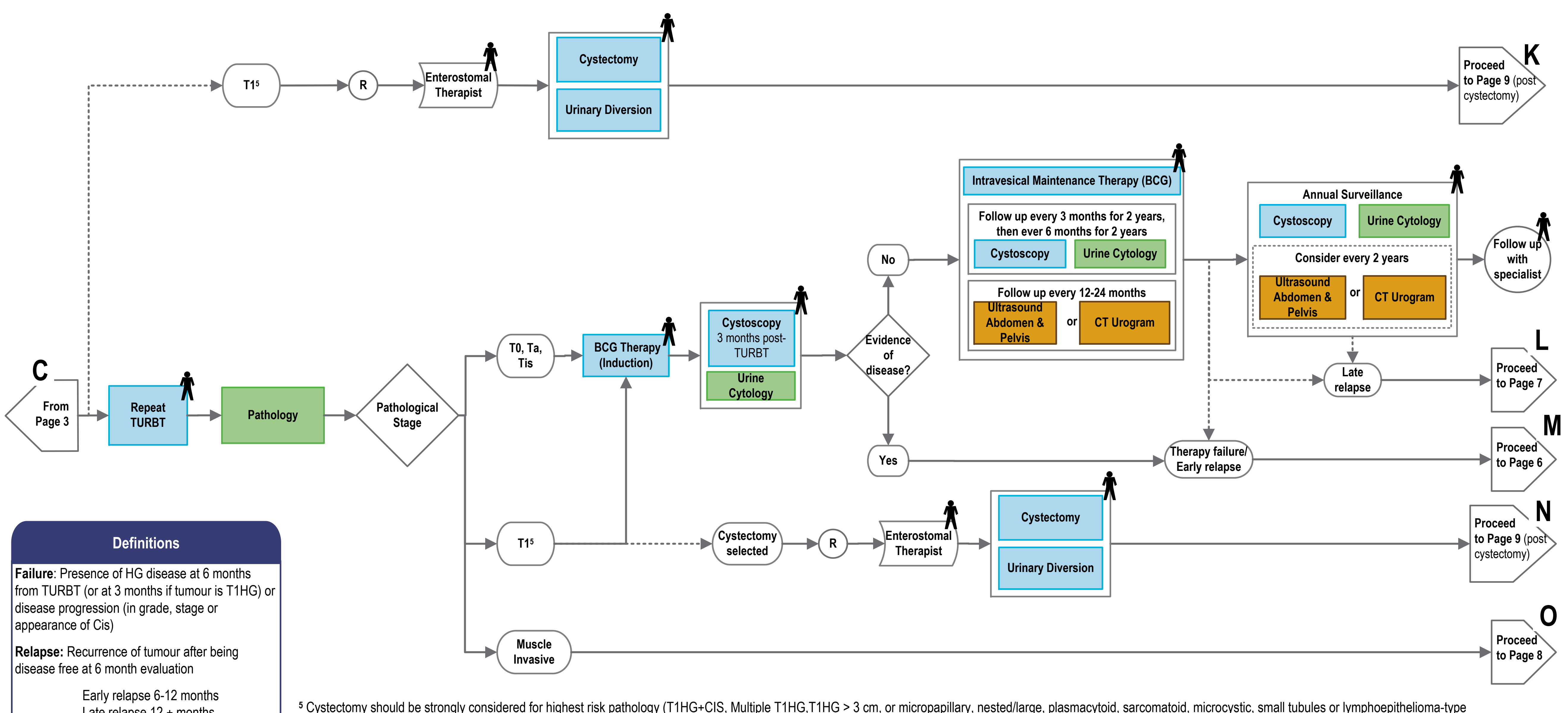
Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

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



Definitions

Failure: Presence of HG disease at 6 months from TURBT (or at 3 months if tumour is T1HG) or disease progression (in grade, stage or appearance of Cis)

Relapse: Recurrence of tumour after being disease free at 6 month evaluation

Early relapse 6-12 months
Late relapse 12 + months
Adapted from CUA Guidelines (2015) [2]

[5] Cystectomy should be strongly considered for highest risk pathology (T1HG+CIS, Multiple T1HG,T1HG > 3 cm, or micropapillary, nested/large, 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.

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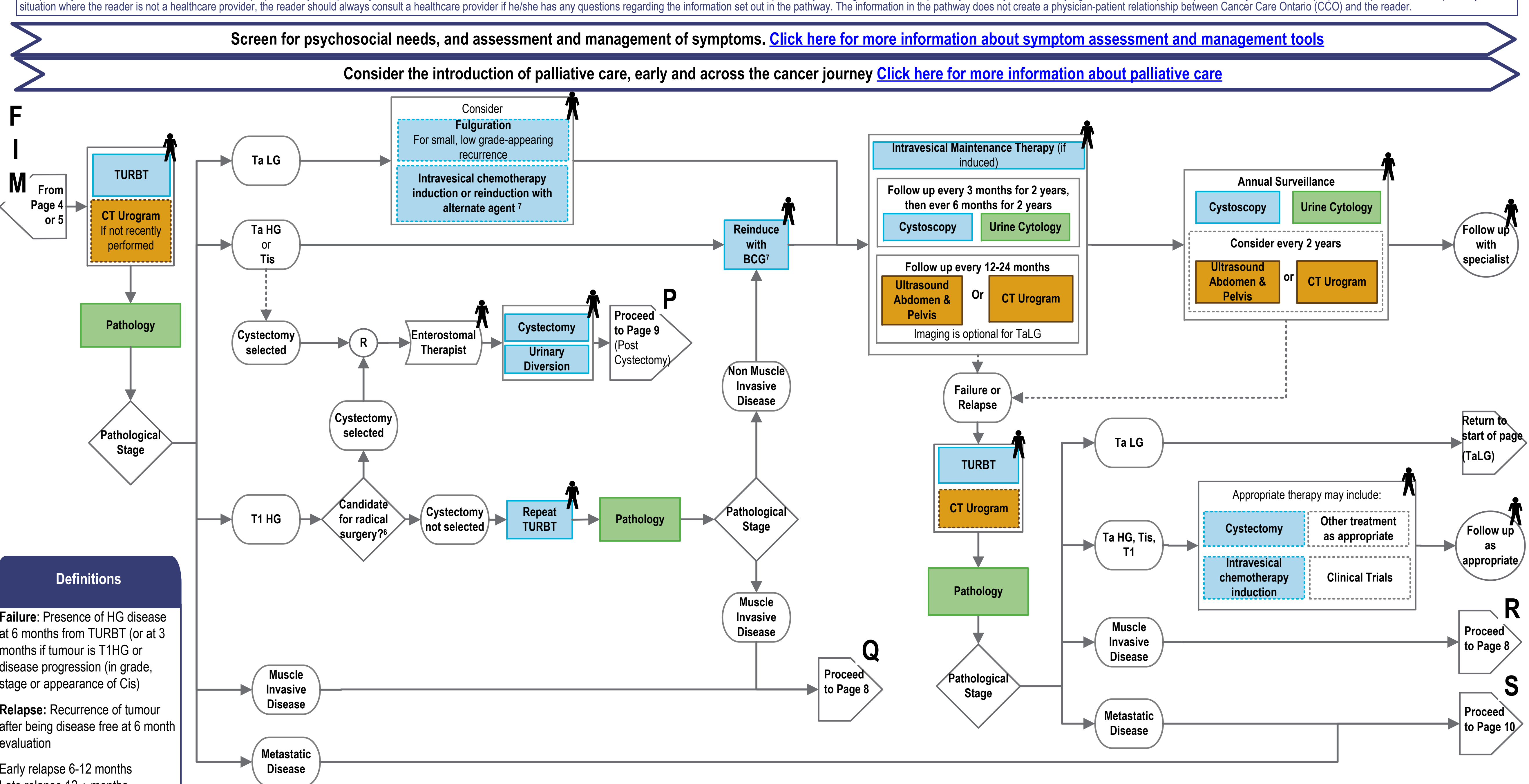

6 Consider patient preference, performance status, co-morbidities, and if high risk factors present (T1HG+CIS, Multiple T1HG,T1HG > 3 cm, or micropapillary, nested, plasmacytoid variant, LVI+)
7 Consider other salvage intravesical agents, clinical trials or MCC if patient has repeatedly failed induction (>2 times)

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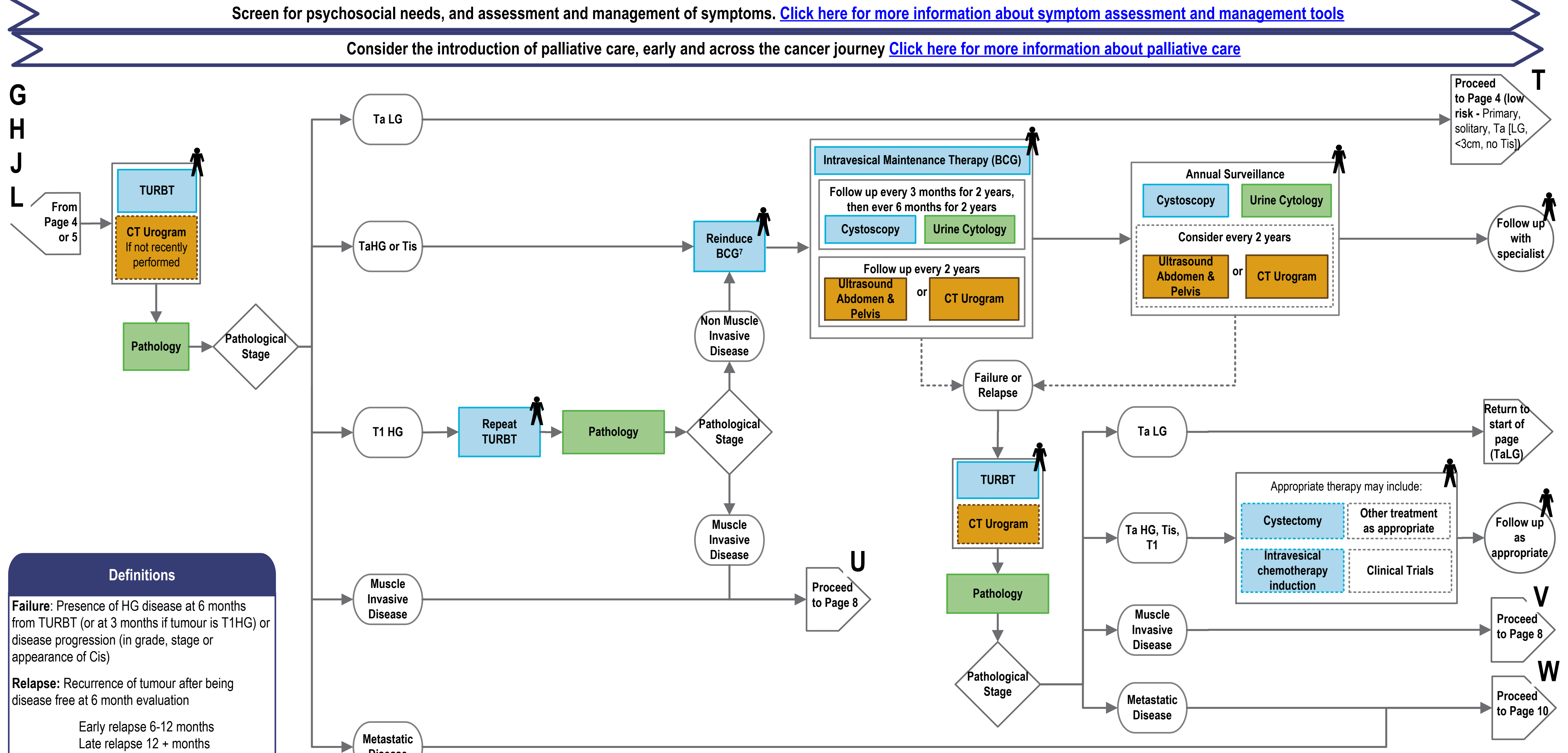

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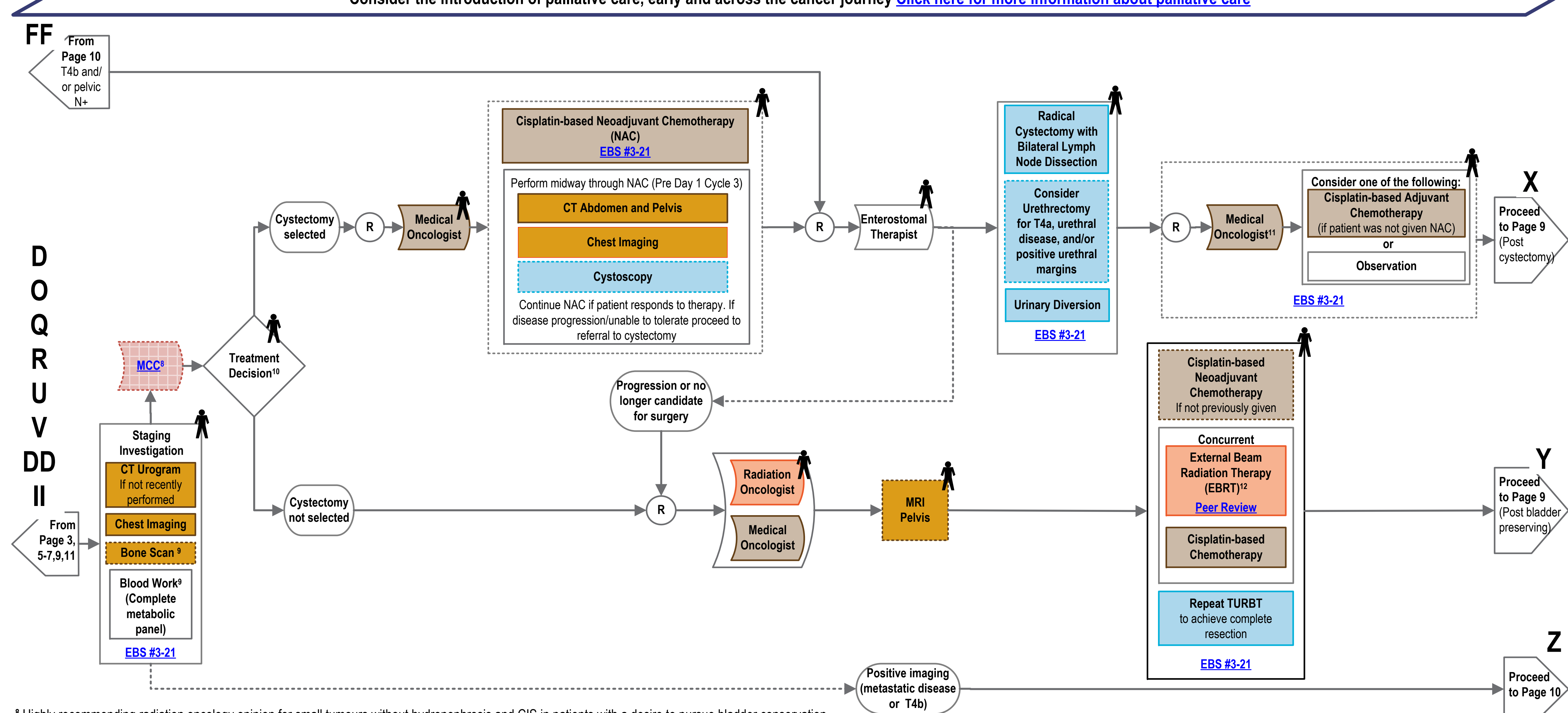

[8] Highly recommending radiation oncology opinion for small tumours without hydronephrosis and CIS in patients with a desire to pursue bladder conservation

[9] Indicated if symptoms present or alkaline phosphatase and calcium levels are elevated as per guideline EBS #3-21

[10] Consider patient preference, performance status,co-morbidities, and if high risk factors present (micropapillary, nested, plasmacytoid variant)

[11] Refer if pT3-4 or N+

[12] EBRT can be performed alone if not a candidate for chemotherapy

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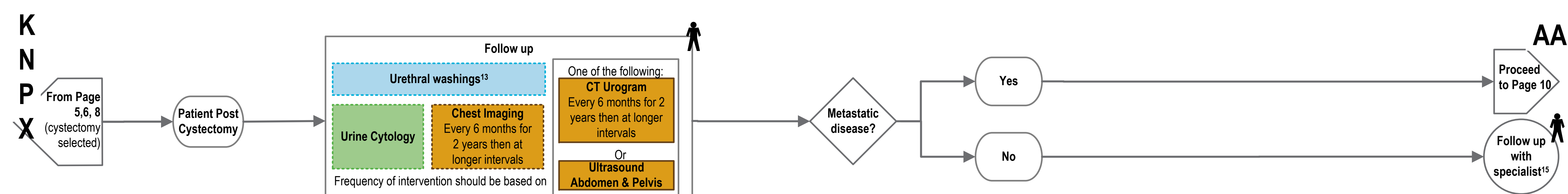

Y
From Page 8 (cystectomy not selected)
Patient Post Bladder Preserving Treatment

Follow Up
- Cystoscopy +/- Biopsy: Every 3 months for 2 years then at increasing intervals for the next 2 years. Then continue annually for lifetime.
- Urine Cytology: At time of cystoscopy
- Chest Imaging: Every 6 months for 2 years then at longer intervals
- One of the following: CT Urogram Every 6 months for 2 years then at longer intervals Or Ultrasound Abdomen & Pelvis

Frequency of intervention should be based on clinician discretion

Evidence of disease?
- No → Follow up with specialist
- Frankly Positive Cytology & Negative Cytoscopy → BB Proceed to Page 11
- Intravesical Recurrence → TURBT → Pathology → Result?
  - Ta, Tis → CC Proceed to Page 4
  - ≥ T1 or aggressive variant pathology[14] → DD Proceed to Page 8
- Pelvic Lymph Node Positive → R → Medical Oncologist → Chemotherapy → MCC → R → Enterostomal Therapist → Salvage cystectomy / Urinary Diversion → Return to start of page (Post cystectomy)
  - Distant progression on chemotherapy
- Metastatic Disease → EE Proceed to Page 10

[13] Urethral washings in high risk patients or urethral symptoms
[14] Aggressive variant pathology: micropapillary, nested, plasmacytoid variant
[15] Follow up with primary care provider may be considered after initial disease free period

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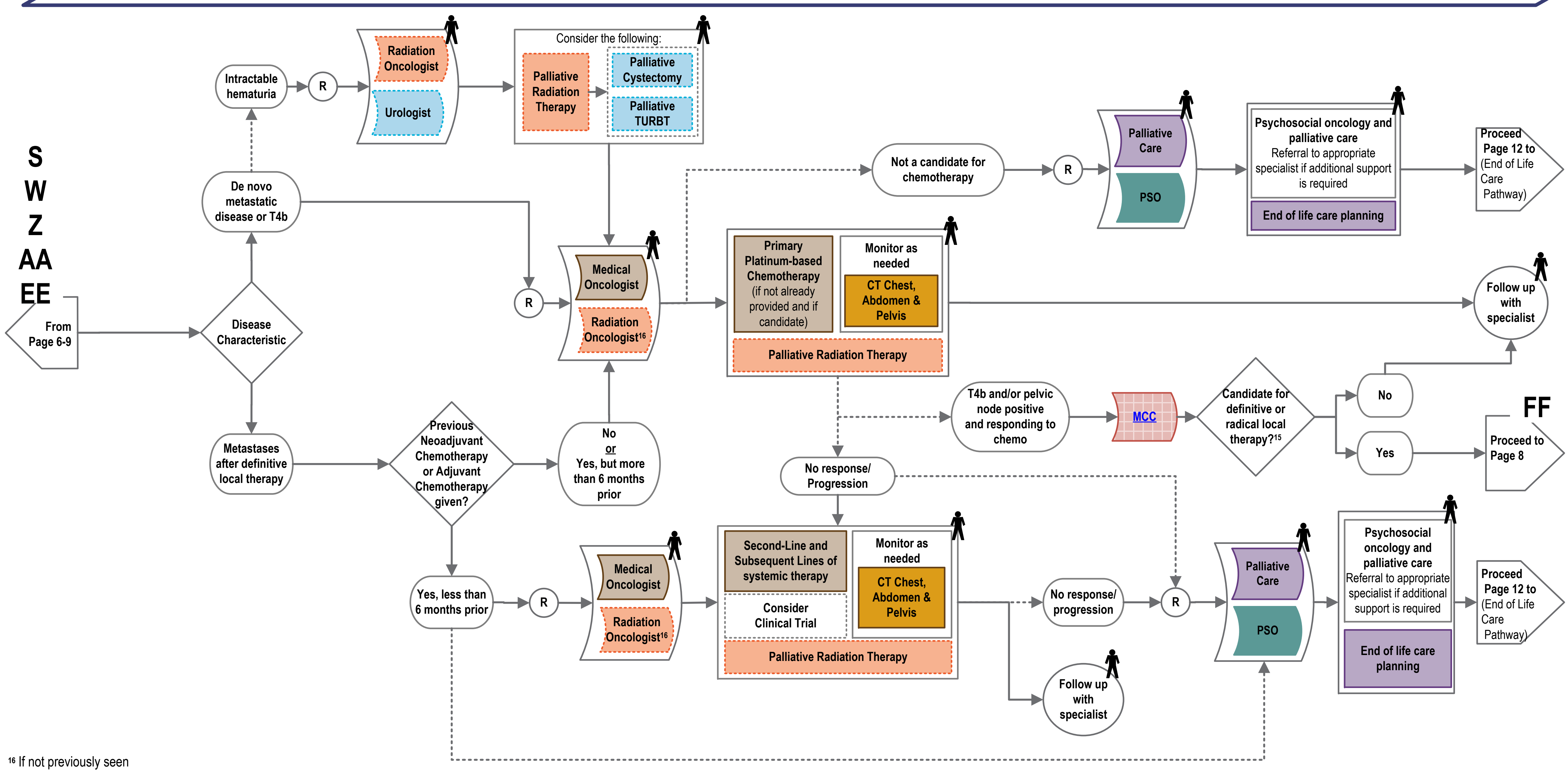

16 If not previously seen

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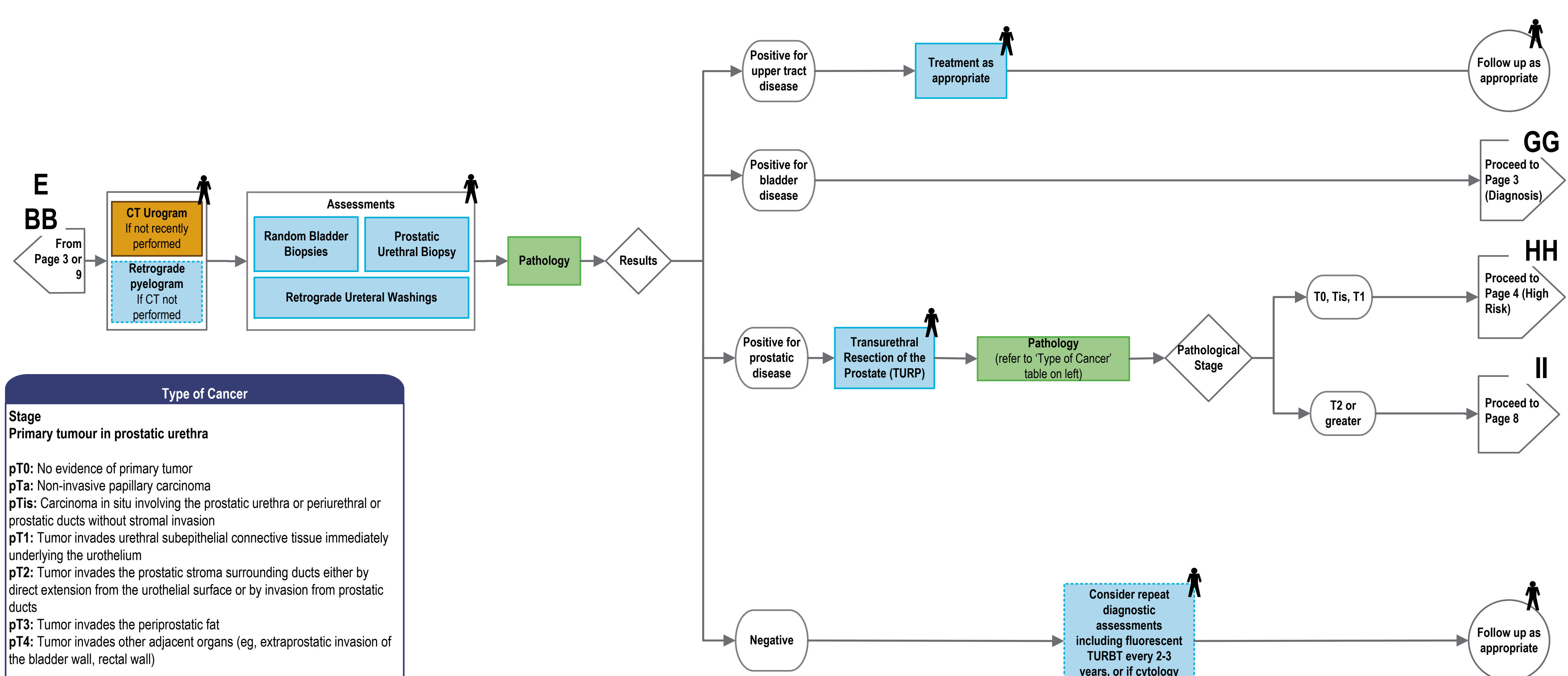

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Pathway Map Target Population:
Individuals with cancer approaching end of life, and their families.

While this section of the pathway map is focused on the care delivered at the end of life, the palliative care approach begins much earlier on in the illness trajectory.
Refer to Screen, Assess & Plan within the Psychosocial & Palliative Care Pathway Map

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

- **ECOG/Patient-ECOG/PRFS = 4**
  OR
- **PPS ≤ 30**
- **Declining performance status/functional ability**
- **Gold Standards Framework indicators of high mortality risk**

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

End of Life Care

☐ **Revisit Advance Care Planning**
- Ensure the patient has determined who will be their Substitute Decision Maker (SDM)
- Ensure the patient has communicated to the SDM his/her wishes, values and beliefs to help guide that SDM in future decision making

☐ **Discuss and document goals of care with patient and family**
- 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
- Introduce patient and family to resources in community (e.g., day hospice programs)

☐ **Develop a plan of treatment and obtain consent**
- Determine who the person wants to include in the decision making process (e.g., substitute decision maker if the person is incapable)
- Develop a plan of treatment related to disease management that takes into account the person's values and mutually determined goals of care
- Obtain consent from the capable person or the substitute decision maker if the person is incapable for an end-of-life plan of treatment that includes:
  - Setting for care
  - Resuscitation status
  - Having, withholding and or withdrawing treatments (e.g. lab tests, medications, etc.)

☐ **Screen for specific end of life psychosocial issues**
- Specific examples of psychological needs include: anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
- Consider referral to available resources and/or specialized services

☐ **Identify patients who could benefit from specialized palliative care services (consultation or transfer)**
- Discuss referral with patients and family

☐ **Proactively develop and implement a plan for expected death**
- Explore place-of-death preferences and assess whether this is realistic
- Explore the potential settings of dying and the resources required (e.g., home, residential hospice, palliative care unit, long term care or nursing home)
- Anticipate/Plan for pain & symptom management medications and consider a Symptom Response Kit (SRK) for unexpected pain & symptom management
- Preparation and support for family to manage
- Discuss emergency plans with patient and family (who to call if emergency in the home or long-term-care or retirement home)

☐ **Home care planning**
- Connect with Home & Community Care early (not just for last 2-4 weeks)
- Ensure resources and elements in place
- Consider a Symptom Response Kit (SRK) with access to pain, dyspnea and delirium medication
- Identify family members at risk for abnormal/complicated grieving and connect them proactively with bereavement resources

Eastern Cooperative Oncology Group Performance Status (ECOG); Palliative Performance Scale (PPS); Patient Reported Functional Status (PRFS)
For more information on the Gold Standards Framework, visit http://www.goldstandardsframework.org.uk/

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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 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