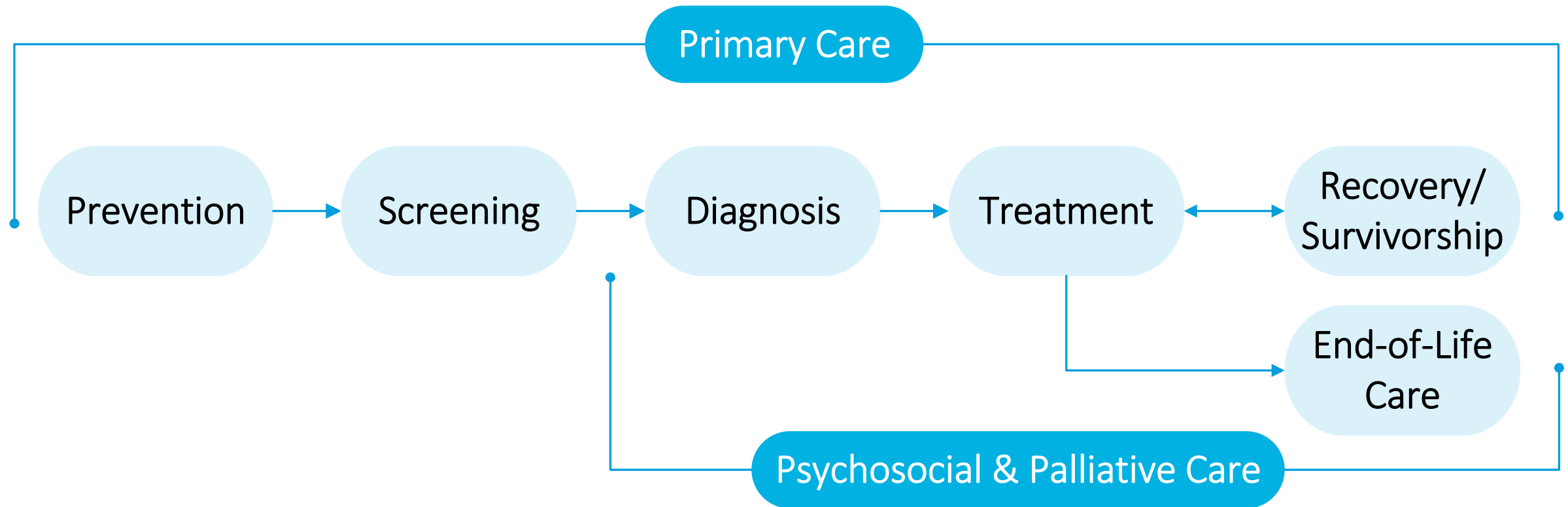


Bladder Cancer Diagnosis and Treatment Pathway

Version 2025.06



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Ontario Health
Cancer Care Ontario

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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 [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](#).*

* **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.

Pathway Map Legend

Colour Guide	Shape Guide	Line Guide
 Primary Care	 Intervention	 Required
 Palliative Care	 Decision or assessment point	 Possible
 Pathology	 Patient (disease) characteristics	
 Organized Diagnostic Assessment	 Consultation with specialist	
 Surgery	 Exit pathway	
 Radiation Oncology	 or  Off page reference	
 Medical Oncology	 Referral	
 Radiology		
 Multidisciplinary Cancer Conference (MCC)		
 Genetics		
 Psychosocial Oncology (PSO)		

Pathway Map Disclaimer

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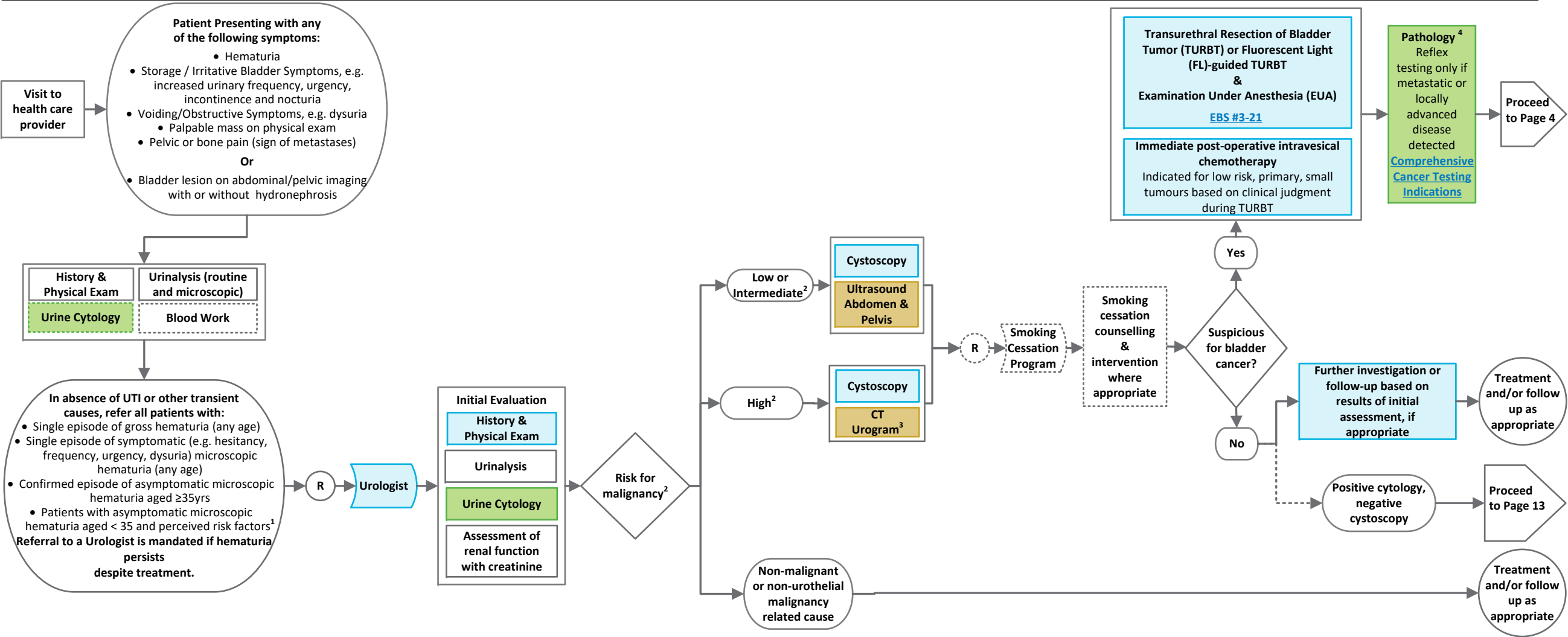
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¹ Risk factors for urothelial cancer include age, male sex, past tobacco use, degree of microhematuria (> or <25RBC/HPF) and history of gross hematuria, irritative lower urinary tract voiding symptoms, cyclophosphamide or other carcinogenic alkylating 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.

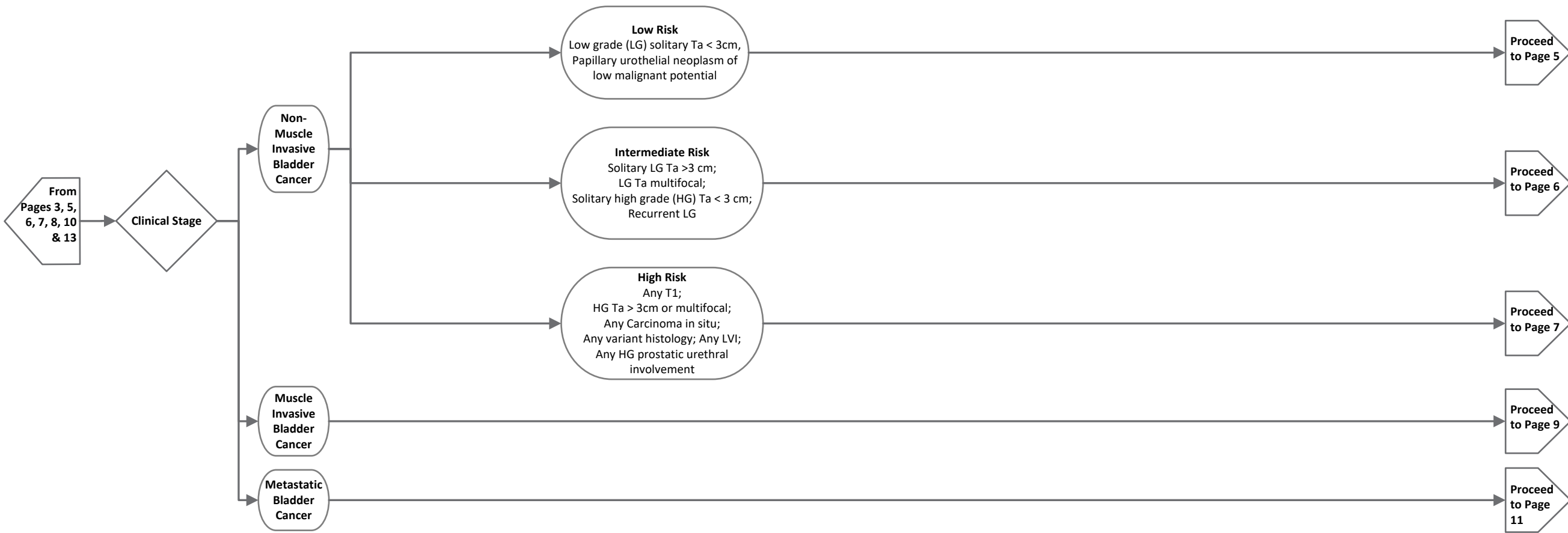
² Low and intermediate risk: <60 years old, < 30 Pack-years smoking, < 25 RBC/HPF on one or repeat urinalysis, may have one or more risk factors (see footnote 1). High risk: >60 years old, > 30 Pack-years smoking, > 25 RBC/HPF on any urinalysis, History of gross hematuria. Microhematuria: AUA/SUFU Guideline; Barocas DA, Boorjian SA, Alvarez RD et al: 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.

Bladder Cancer Diagnosis and Treatment Pathway Map

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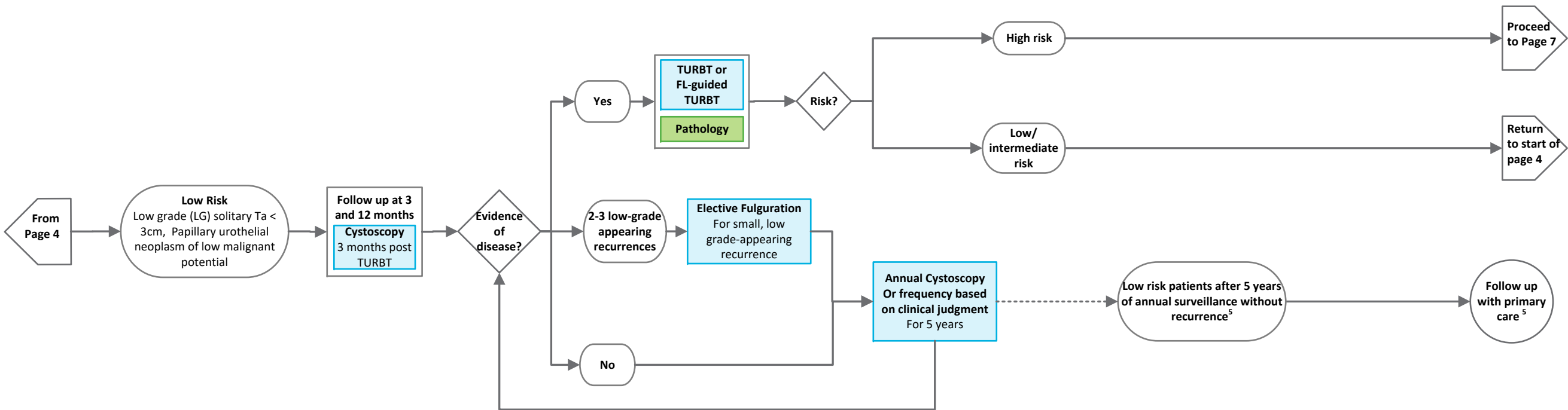
Type of Cancer

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

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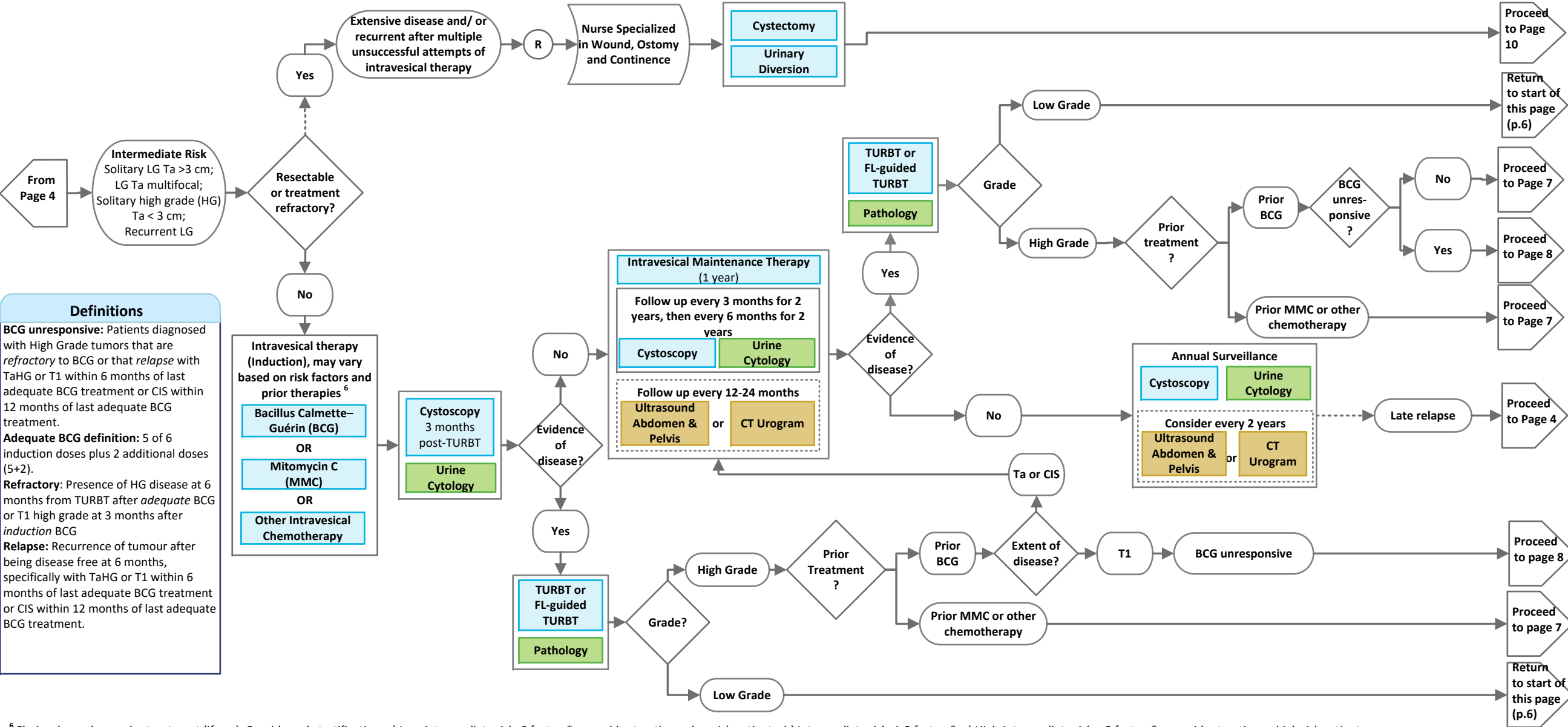


⁵ Follow up after 5 years in absence of recurrence should be based on shared decision making between the specialist and patient. Annual urinalysis with a family physician can be considered in place of cystoscopy in some low risk patients after 5 years. In patients at intermediate risk lifelong follow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

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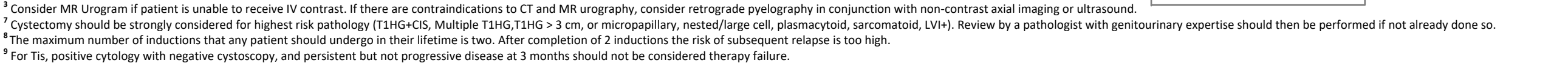
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⁶ Choice depends on prior treatment (if any). Consider substratification: a) Low-intermediate risk: 0 factors* – consider treating as low risk patients; b) Intermediate risk: 1-2 factors*; c) High-intermediate risk: ≥3 factors* – consider treating as high risk patients.
*Factors include: Multiple tumours, >3cm, time to recurrence (<1year), and frequency of recurrence (>1 / year)

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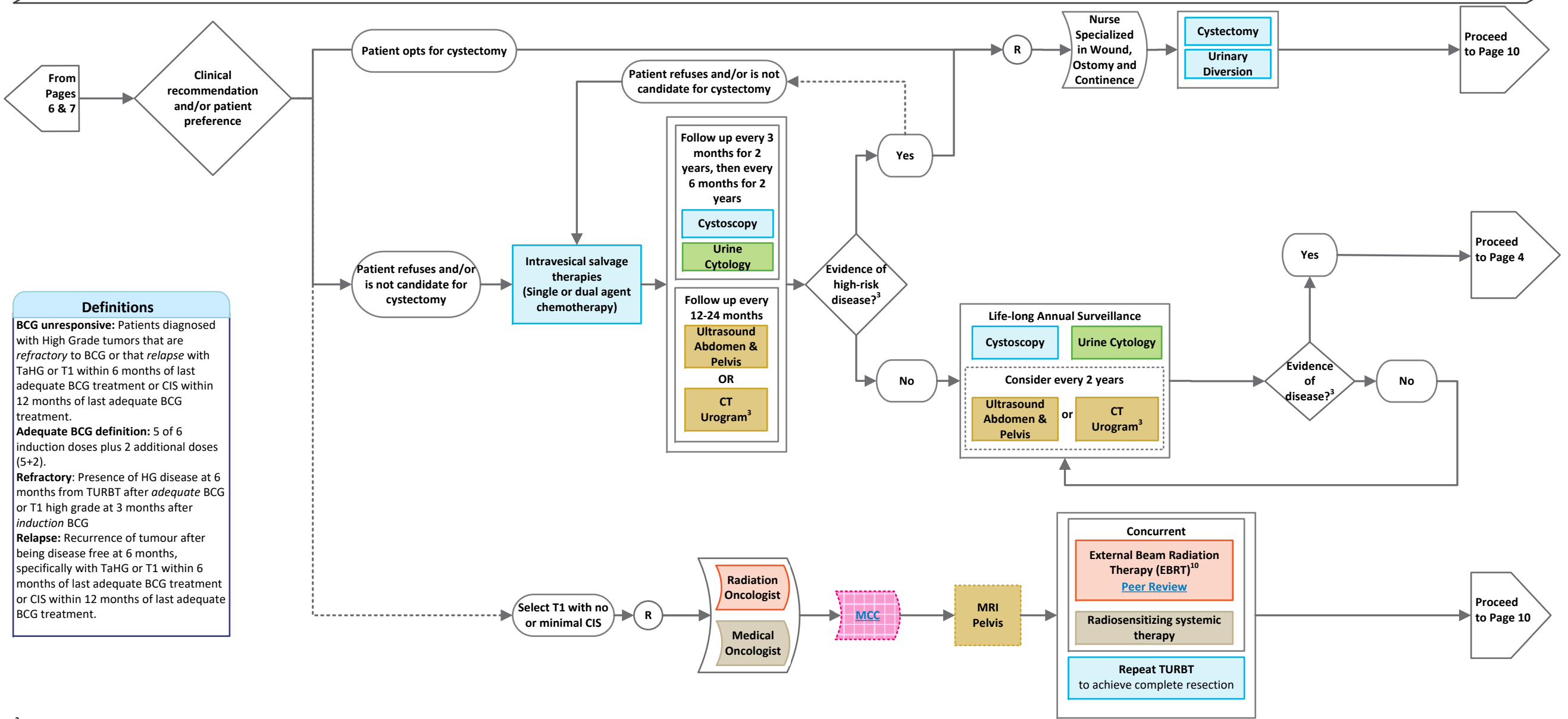
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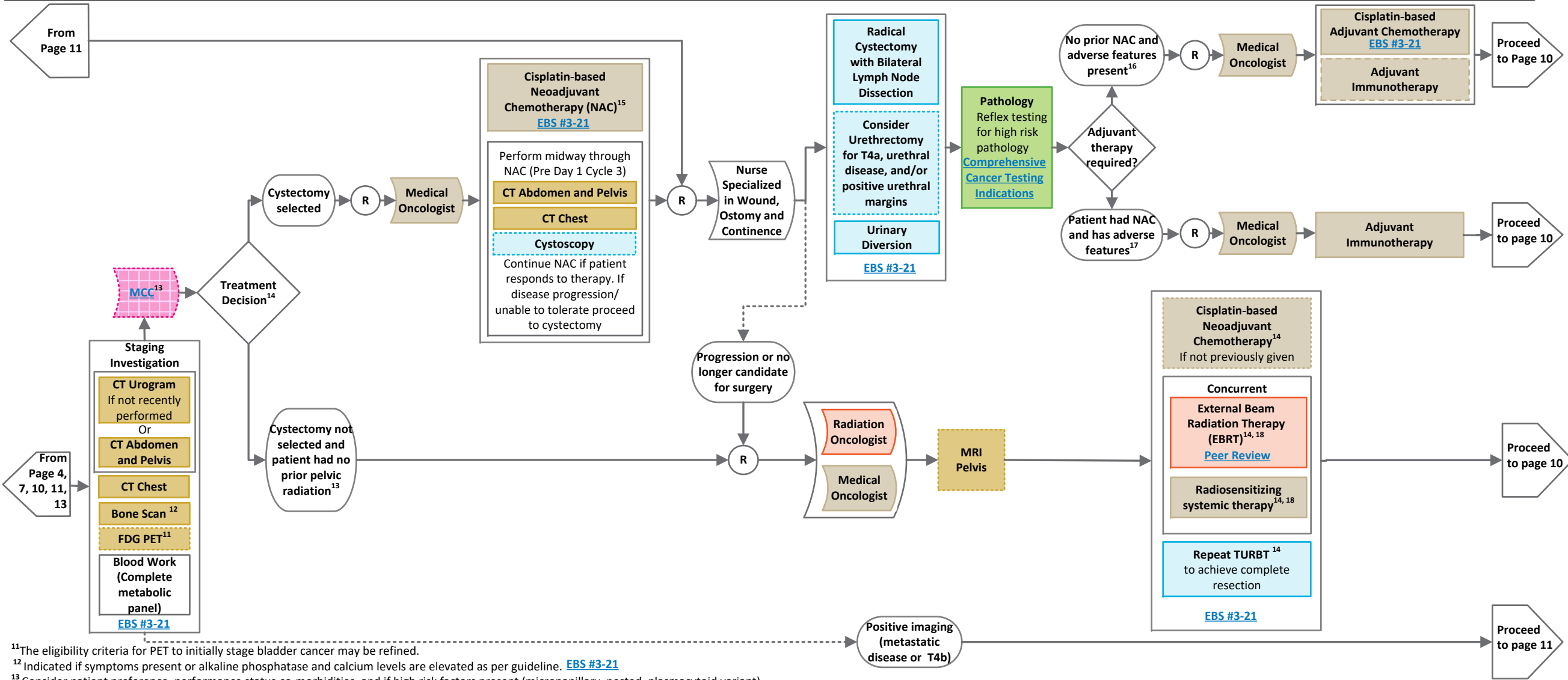
³ Consider MR Urogram if patient is unable to receive IV contrast. If there are contraindications to CT and MR urography, consider retrograde pyelography in conjunction with non-contrast axial imaging or ultrasound.

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

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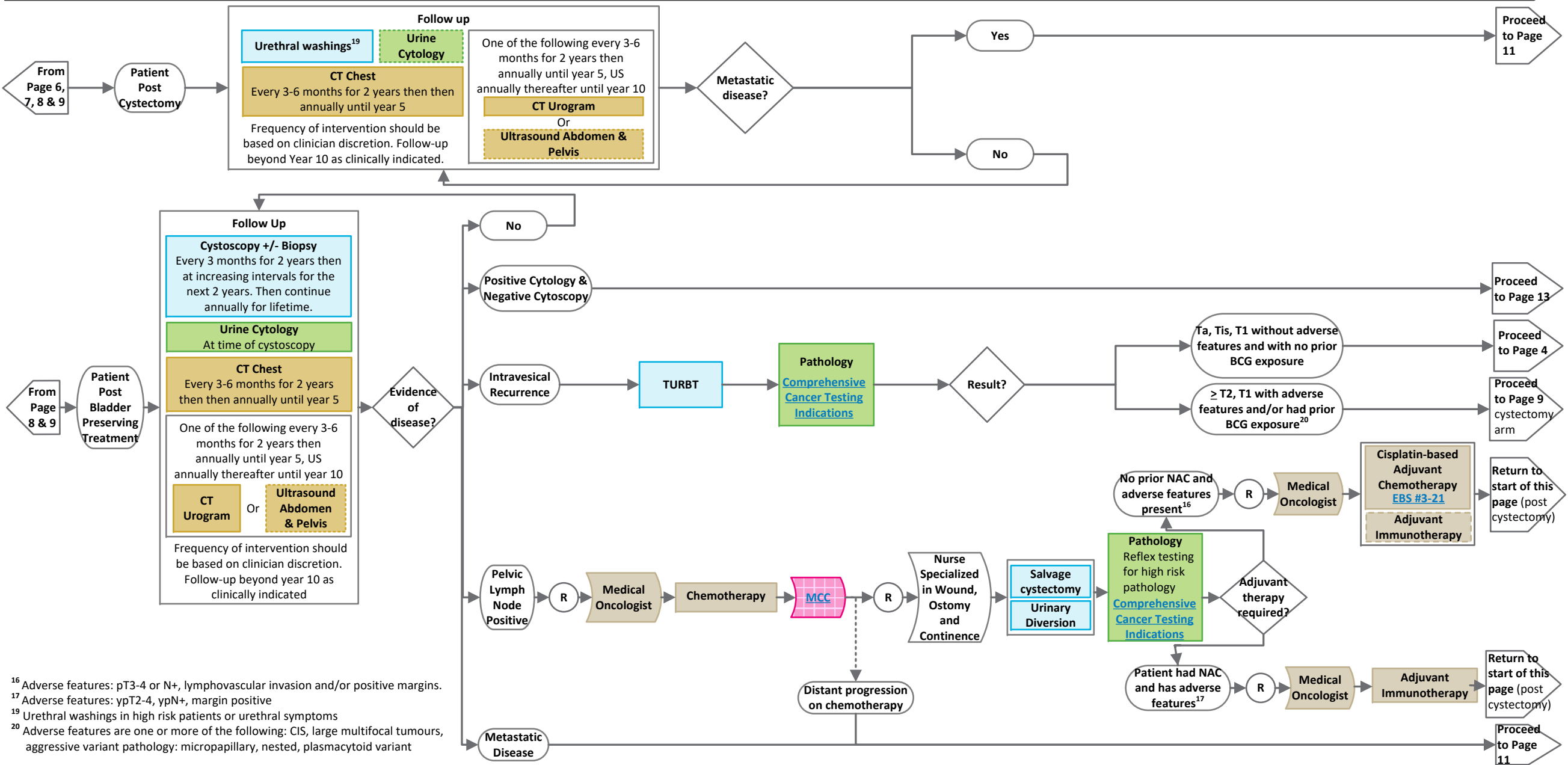


¹¹The eligibility criteria for PET to initially stage bladder cancer may be refined.
¹²Indicated if symptoms present or alkaline phosphatase and calcium levels are elevated as per guideline. [EBS #3-21](#)
¹³Consider patient preference, performance status, co-morbidities, and if high risk factors present (micropapillary, nested, plasmacytoid variant).
¹⁴Ideal candidates for trimodal therapy/bladder conserving treatment: unifocal tumors <7 cm, no or moderate unilateral hydronephrosis, no multifocal CIS.
¹⁵Per 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.
¹⁶Adverse features: pT3-4 or N+, lymphovascular invasion and/or positive margins.
¹⁷Adverse features: ypT2-4, ypN+, margin positive
¹⁸EBRT can be performed alone if not a candidate for radiosensitizing systemic therapy.

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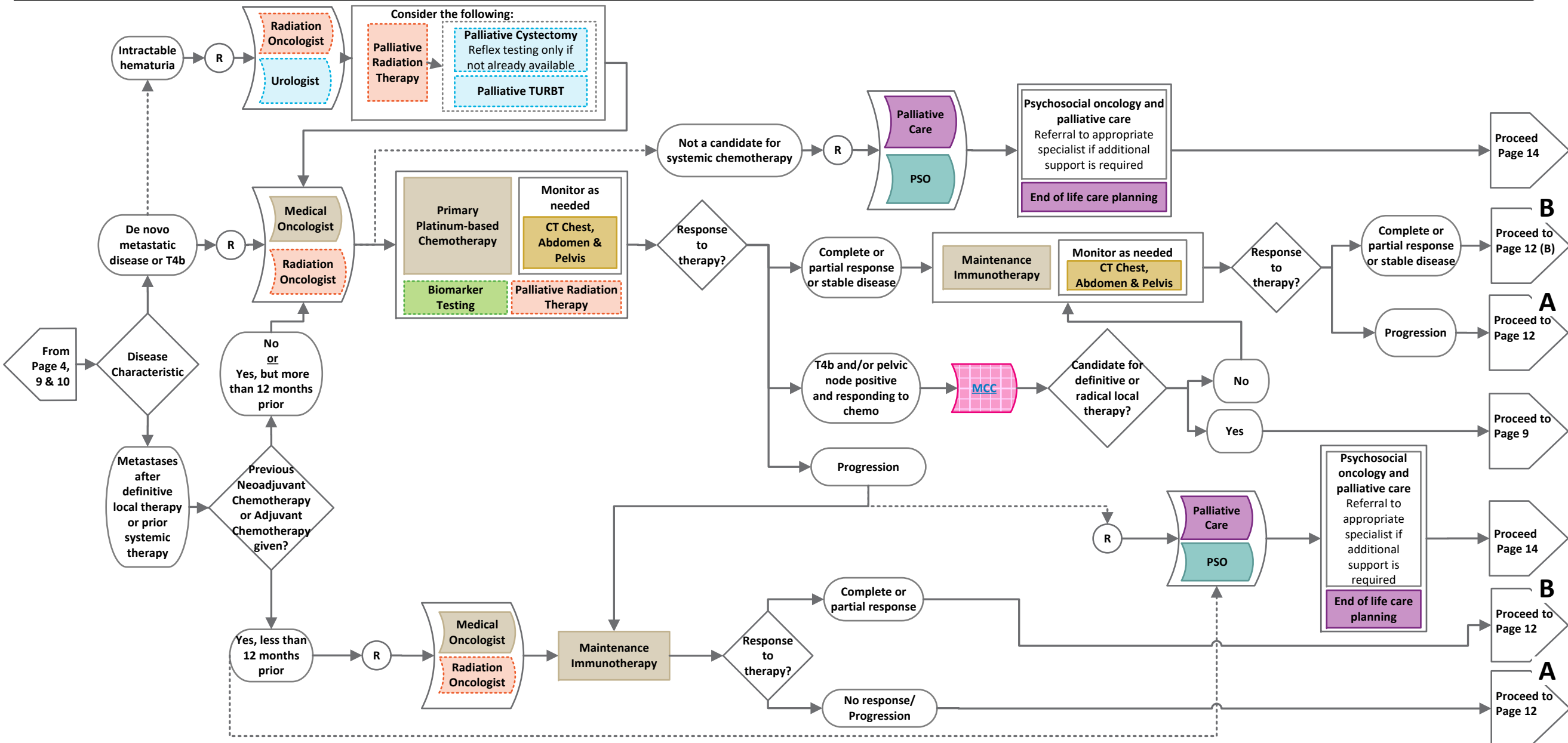
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¹⁶ Adverse features: pT3-4 or N+, lymphovascular invasion and/or positive margins.
¹⁷ Adverse features: ypT2-4, ypN+, margin positive
¹⁹ Urethral washings in high risk patients or urethral symptoms
²⁰ Adverse features are one or more of the following: CIS, large multifocal tumours, aggressive variant pathology: micropapillary, nested, plasmacytoid variant

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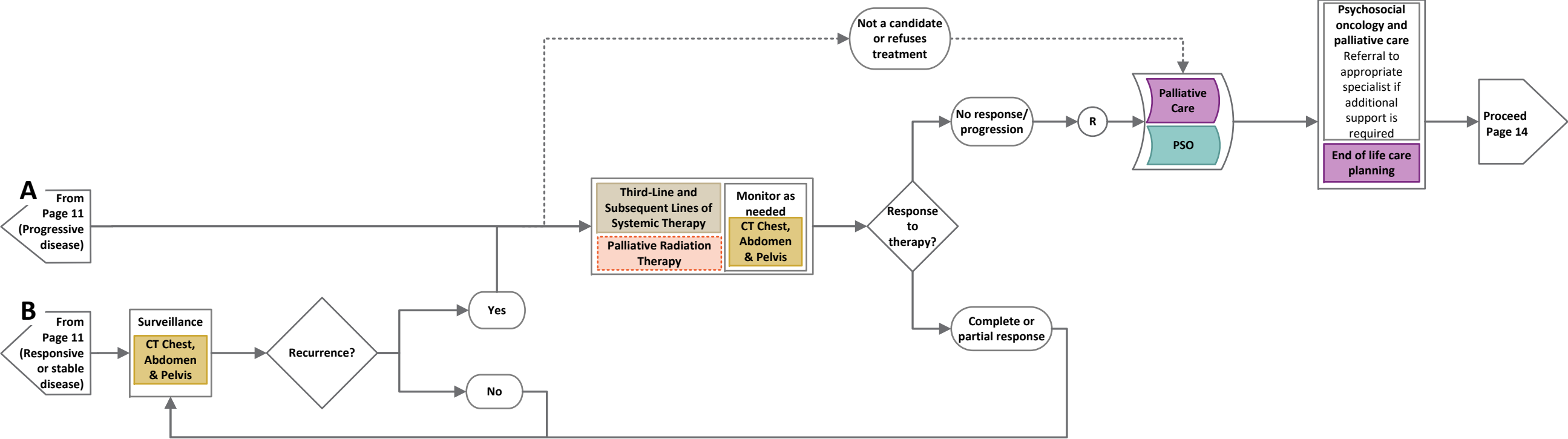
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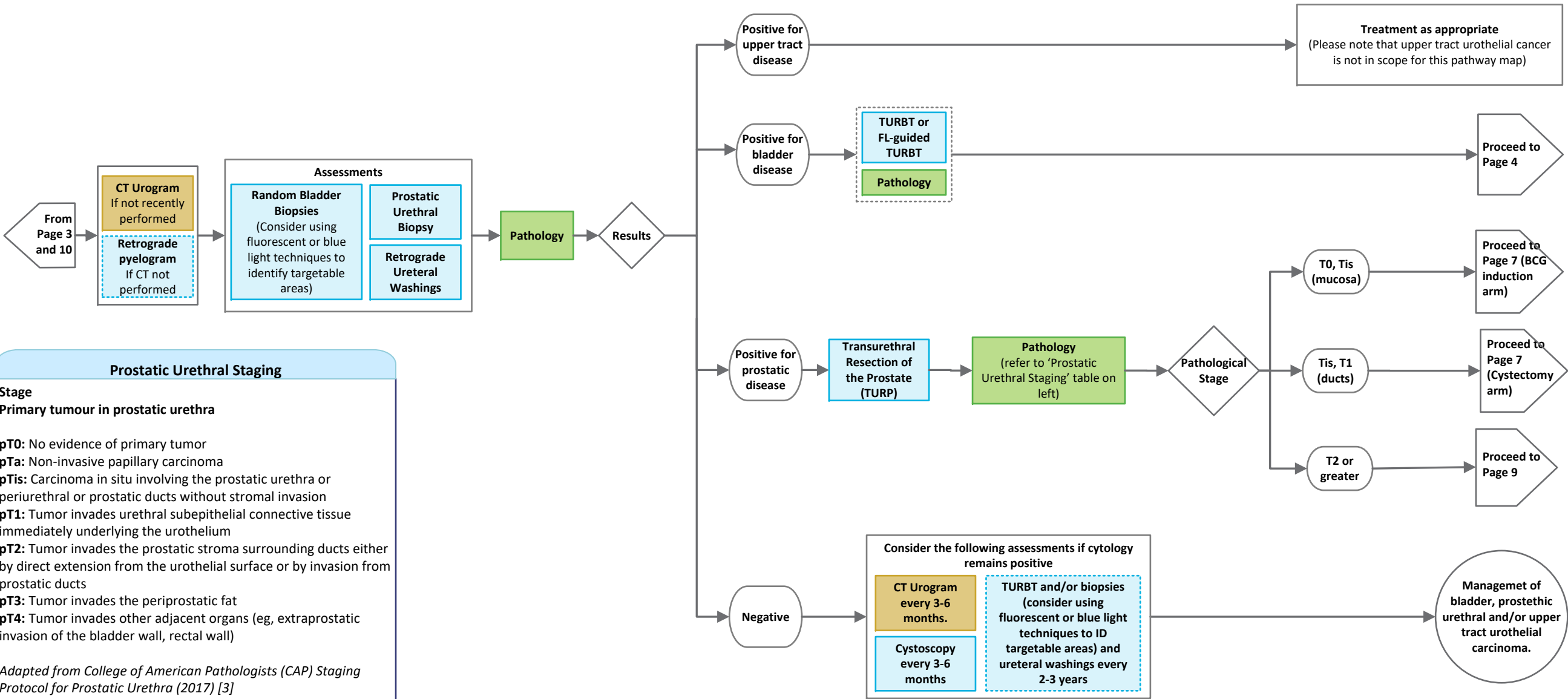
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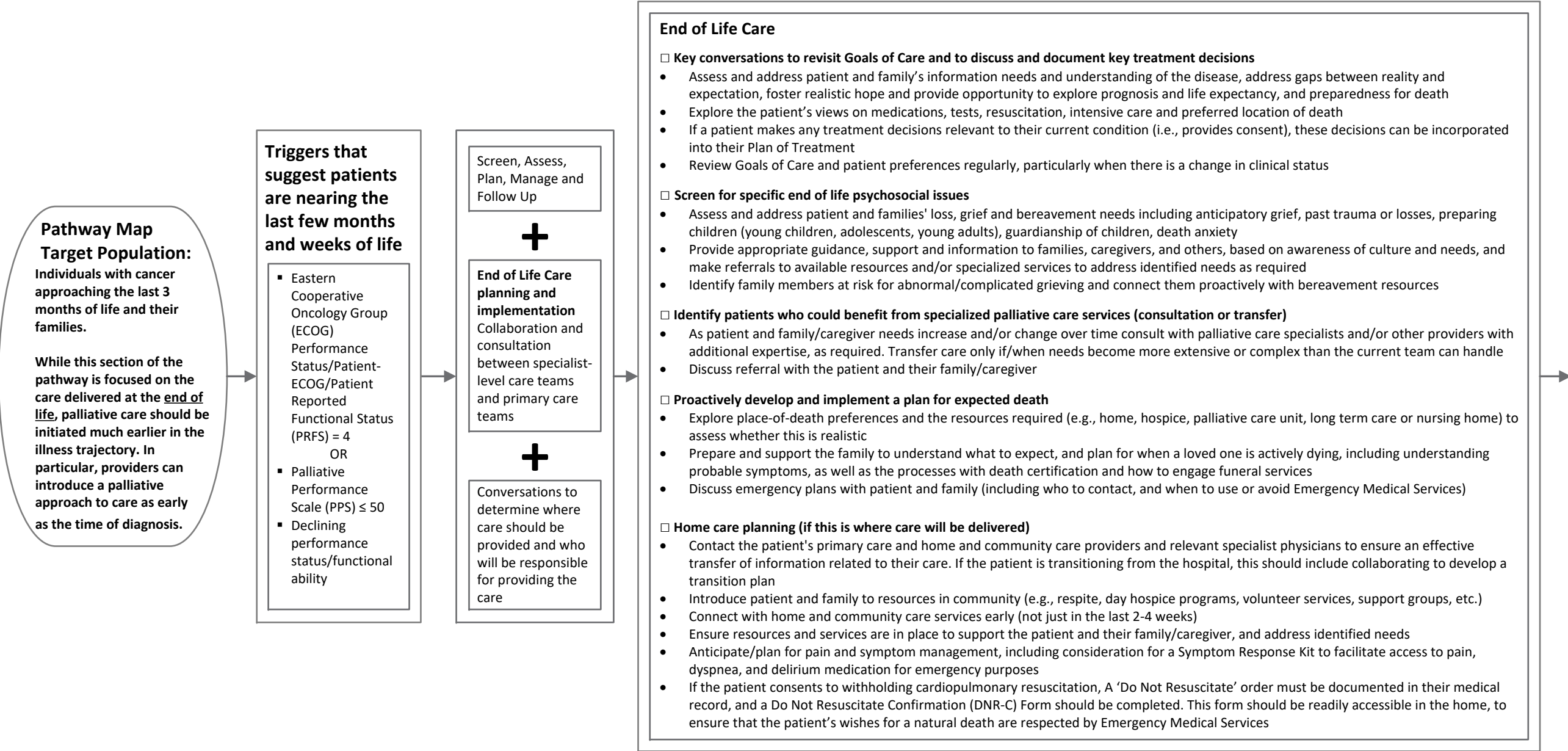
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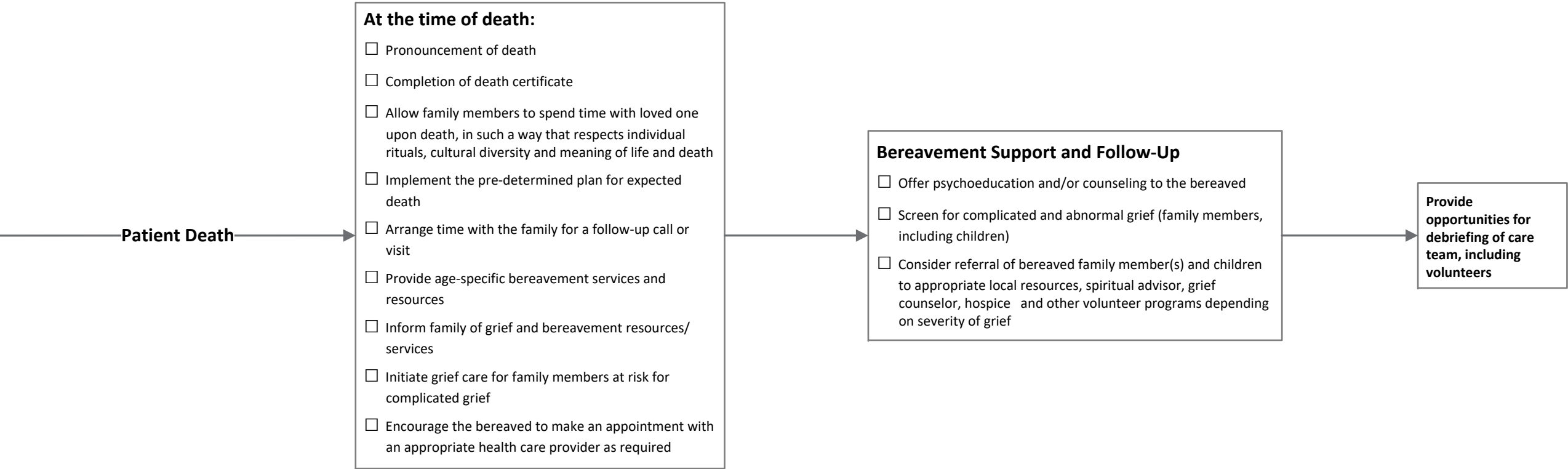
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