Bladder Cancer Diagnosis, Treatment & Follow-up Care Pathway Map
Version 2017.02

The cancer journey
Better cancer services every step of the way

Disclaimer
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**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
- Off-page reference
- Patient/Provider interaction
- Referral
- Wait time indicator time point

**Pathway Preamble**

**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 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 consultation. 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, Systemic Treatment, Radiation Treatment Wait Times prioritizations
- For more information on the systematic 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 potent disease:

- Hyperthermic perineal treatment
- Radiation therapy (external beam)
- Chemotherapy
- Palliative care

**Pathway Disclaimer**

This pathway map is a resource that provides an overview of the presentation and clinical work-up of a cancer diagnosis that an individual in the Ontario cancer system may receive.

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Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

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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.

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**Type of Cancer**
- Ta: Noninvasive papillary carcinoma
- Tis: Carcinoma in situ
- T1: Tumour invades subepithelial connective tissue
- T2: Tumour invades muscle
- T3: Tumour invades perivesical tissue
- T4: Tumour invades any of the following: prostate stroma, seminal vesicles, 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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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.
**Bladder Cancer Diagnosis, Treatment & Follow-up Pathway**

**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 Cia)
- **Relapse:** Recurrence of tumour after being disease free at 6 months
  - Early relapse 6-12 months
  - Late relapse >12 months

Adapted from CUA Guidelines [2]

**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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**Non Muscle Invasive: Ta, Tis**

**From Page 3, 7, 9, 11**

- **Intermediate Risk** Ta >3 cm, multiple, or multirecurrent low grade tumours
- **High Risk** TaHG or Tis

**Follow up with specialist**

**Proceed to Page 6**

**G**

**Follow up with specialist**

**Proceed to Page 7**

**H**

**Proceed to Page 6**

**J**

**Proceed to Page 7**

**Definitions**
- For Tis, positive cytology with negative cystoscopy, and persistent but not progressive disease at 3 months should not be considered therapy failure.
- Follow up after 5 years in absence of recurrence should be based on shared decision making between the specialist and patient. Annual urinalysis and urinary cytology 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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Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

Non Muscle Invasive: T1

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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]

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

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**Bladder Cancer Diagnosis, Treatment & Follow-up Pathway**

**Non Muscle Invasive - Therapy Failure/Early Relapse**

**Version** 2017.02

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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**

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

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Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

Non Muscle Invasive - Late relapse

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.

Consider other salvage intravesical agents, clinical trials or MCC if patient has repeatedly failed induction (>2 times).

Definitions

Failure: Presence of HG disease at 6 months from TURBT (or at 3 months if tumour is T1 HG) 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].
Invasive Bladder Cancer (T2, T3, T4a)

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]

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Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

\[ \text{CT Urogram if not recently performed} \]
\[ \text{Chest Imaging} \]
\[ \text{Bone Scan} \]
\[ \text{CT Abdomen and Pelvis} \]
\[ \text{MRI Pelvis} \]
\[ \text{Repeat TURBT to achieve complete resection} \]
\[ \text{Positive imaging (metastatic disease or T4b)} \]

\[ \text{Adjuvant Chemotherapy (if patient was not given NAC)} \]
\[ \text{Neoadjuvant Chemotherapy (NAC)} \]
\[ \text{Perform midway through NAC (Pre Day 1 Cycle 3)} \]
\[ \text{CT Abdomen and Pelvis} \]
\[ \text{Cystoscopy} \]
\[ \text{Continue NAC if patient responds to therapy. If disease progression/unable to tolerate proceed to referral to cystectomy} \]

\[ \text{Neoadjuvant Chemotherapy} \]
\[ \text{Concurrent Medical Oncologist} \]
\[ \text{Radiation Oncologist} \]
\[ \text{Medical Oncologist} \]

\[ \text{Radical Cystectomy with Bilateral Lymph Node Dissection} \]
\[ \text{Consider Urethrectomy for T4a} \]
\[ \text{Urinary Diversion} \]

\[ \text{Consider one of the following:} \]
\[ \text{Adjunctive Chemotherapy (if patient was not given NAC)} \]
\[ \text{or} \]
\[ \text{Observation} \]

\[ \text{Progression or no longer candidate for surgery} \]

\[ \text{From Page 10} \]
\[ \text{T4b and/or pelvic N+} \]

\[ \text{Cystectomy selected} \]
\[ \text{Medical Oncologist} \]

\[ \text{Screen for psychosocial needs, and assessment and management of symptoms.} \]
\[ \text{Consider the introduction of palliative care, early and across the cancer journey} \]

8 Indicated if symptoms present or alkaline phosphatase levels are elevated
9 Consider patient preference, performance status, co-morbidities, and if high risk factors present (micropapillary, nested, plasmacytoid variant)
10 Refer if pT3-4 or N+
11 EBRT can be performed alone if not a candidate for chemotherapy
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**Type of Cancer**

**Stage**
- Primary tumour in prostatic urethra
  - Tis pu Carcinoma in situ in the prostatic urethra
  - Tis pd Carcinoma in situ in the prostatic ducts
- T0 No evidence of primary tumour
- T1 Tumour invades subepithelial connective tissue (only in case of concomitant prostatic urethral involvement)
- T2 Tumour invades any of the following structures: corpus spongiosum, prostatic stroma, periurethral muscle
- T3 Tumour invades any of the following structures: corpus cavernosum, beyond prostatic capsule, bladder neck
- T4 Tumour invades other adjacent organs

Adapted from EAU Guidelines on Primary Urethral Carcinoma (2015) [3]
Bladder Cancer Diagnosis, Treatment & Follow-up Pathway

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 CCAC 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

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

For more information on the Gold Standards Framework, visit http://www.goldstandardsframework.org.uk/
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

Patient Death

Provide opportunities for debriefing of care team, including volunteers