American Urological Association

ASTRO
AMERICAN SOCIETY FOR RADIATION ONCOLOGY

SUO
Defining Excellence in Urologic Cancer
Society of Urologic Oncology, Inc.

ASCO GUIDELINES

TREATMENT OF NON-METASTATIC MUSCLE-INVASIVE BLADDER CANCER: AUA/ASCO/ASTRO/SUO GUIDELINE	
Recommendation	**Evidence Rating**
INITIAL PATIENT EVALUATION AND COUNSELING	
Before treatment consideration, a full history and physical exam should be performed, including an exam under anesthesia, at the time of transurethral resection of bladder tumor (TURBT) for a suspected invasive cancer.	Clinical Principle
Before muscle-invasive bladder cancer management, clinicians should perform a complete staging evaluation, including imaging of the chest and cross sectional imaging of the abdomen and pelvis with intravenous contrast if not contraindicated. Laboratory evaluation should include a comprehensive metabolic panel (complete blood count, liver function tests, alkaline phosphatase, and renal function).	Clinical Principle
An experienced genitourinary pathologist should review the pathology of a patient when variant histology is suspected or if muscle invasion is equivocal (e.g., micropapillary, nested, plasmacytoid, neuroendocrine, sarcomatoid, extensive squamous or glandular differentiation).	Clinical Principle
For patients with newly diagnosed muscle-invasive bladder cancer, curative treatment options should be discussed before determining a plan of therapy that is based on both patient comorbidity and tumor characteristics. Patient evaluation should be completed using a multidisciplinary approach.	Clinical Principle

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Recommendation	**Evidence Rating**
Before treatment, clinicians should counsel patients regarding complications and the implications of treatment on quality of life (e.g., impact on continence, sexual function, fertility, bowel dysfunction, metabolic problems).	Clinical Principle
TREATMENT	
NEOADJUVANT/ADJUVANT CHEMOTHERAPY	
Using a multidisciplinary approach, clinicians should offer cisplatin-based neoadjuvant chemotherapy to eligible radical cystectomy patients before cystectomy.	Type of recommendation: evidence based Evidence quality: grade B Strength of recommendation: strong
Clinicians should not prescribe carboplatin-based neoadjuvant chemotherapy for clinically resectable stage cT2-T4aN0 bladder cancer. Patients ineligible for cisplatin-based neoadjuvant chemotherapy should proceed to definitive locoregional therapy.	Expert Opinion
Clinicians should perform radical cystectomy as soon as possible after a patient's completion of and recovery from neoadjuvant chemotherapy.	Expert Opinion
Eligible patients who have not received cisplatin-based neoadjuvant chemotherapy and have non-organ confined (pT3/T4and/or N+) disease at cystectomy should be offered adjuvant cisplatin- based chemotherapy.	Type of recommendation: evidence based Evidence quality: grade C Strength of recommendation: moderate
RADICAL CYSTECTOMY	
Clinicians should offer radical cystectomy with bilateral pelvic lymphadenectomy for surgically eligible patients with resectable non-metastatic (M0) muscle-invasive bladder cancer.	Type of recommendation: evidence based Evidence quality: grade B Strength of recommendation: strong
When performing a standard radical cystectomy, clinicians should remove the bladder, prostate, and seminal vesicles in males and should remove the bladder, uterus, fallopian tubes, ovaries, and anterior vaginal wall in females.	Clinical Principle
Clinicians should discuss and consider sexual function preserving procedures for patients with organ-confined disease and absence of bladder neck, urethra, and prostate (male) involvement.	Type of recommendation: evidence based Evidence quality: grade C Strength of recommendation: moderate

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Recommendation	**Evidence Rating**
URINARY DIVERSION	
In patients undergoing radical cystectomy, ileal conduit, continent cutaneous, and orthotopic neobladder urinary diversions should all be discussed.	Clinical Principle
In patients receiving an orthotopic urinary diversion, clinicians must verify a negative urethral margin.	Clinical Principle
PERIOPERATIVE SURGICAL MANAGEMENT	
Clinicians should attempt to optimize patient performance status in the perioperative setting.	Expert Opinion
Perioperative pharmacologic thromboembolic prophylaxis should be given to patients undergoing radical cystectomy.	Type of recommendation: evidence based Evidence quality: grade B Strength of recommendation: strong
In patients undergoing radical cystectomy μ -opioid antagonist therapy should be used to accelerate gastrointestinal recovery, unless contraindicated.	Type of recommendation: evidence based Evidence quality: grade B Strength of recommendation: strong
Patients should receive detailed teaching regarding care of urinary diversion before discharge from the hospital.	Clinical Principle
PELVIC LYMPHADENECTOMY	
Clinicians must perform a bilateral pelvic lymphadenectomy at the time of any surgery with curative intent.	Type of recommendation: evidence based Evidence quality: grade B Strength of recommendation: strong
When performing bilateral pelvic lymphadenectomy, clinicians should remove, at a minimum, the external and internal iliac and obturator lymph nodes (standard lymphadenectomy).	Clinical Principle
BLADDER PRESERVING APPROACHES	
PATIENT SELECTION	
For patients with newly diagnosed non-metastatic muscle-invasive bladder cancer who desire to retain their bladder, and for those with significant comorbidities for whom radical cystectomy is not a treatment option, clinicians should offer bladder preserving therapy when clinically appropriate.	Clinical principle

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Recommendation	**Evidence Rating**
In patients under consideration for bladder preserving therapy, maximal debulking TURBT and assessment of multifocal disease/carcinoma in situ should be performed.	Type of recommendation: evidence based Evidence quality: grade C Strength of recommendation: strong
MAXIMAL TURBT AND PARTIAL CYSTECTOMY	
Patients with muscle-invasive bladder cancer who are medically fit and consent to radical cystectomy should not undergo partial cystectomy or TURBT as primary curative therapy.	Type of recommendation: evidence based Evidence quality: grade C Strength of recommendation: moderate
PRIMARY RADIATION THERAPY	
For patients with muscle-invasive bladder cancer, clinicians should not offer radiation therapy alone as a curative treatment.	Type of recommendation: evidence based Evidence quality: grade C Strength of recommendation: strong
MULTI-MODAL BLADDER PRESERVING THERAPY	
For patients with muscle-invasive bladder cancer who have elected multi-modal bladder preserving therapy, clinicians should offer TURBT, chemotherapy combined with external beam radiation therapy, and planned cystoscopic re-evaluation.	Type of recommendation: evidence based Evidence quality: grade B Strength of recommendation: strong
Radiation sensitizing chemotherapy regimens should include cisplatin or 5- fluorouracil and mitomycin C.	Type of recommendation: evidence based Evidence quality: grade B Strength of recommendation: strong
After completion of bladder preserving therapy, clinicians should perform regular surveillance with CT scans, cystoscopy, and urine cytology.	Type of recommendation: evidence based Evidence quality: grade C Strength of recommendation: strong
BLADDER PRESERVING TREATMENT FAILURE	
In patients who are medically fit and have residual or recurrent muscle-invasive disease after bladder preserving therapy, clinicians should offer radical cystectomy with bilateral pelvic lymphadenectomy	Type of recommendation: evidence based Evidence quality: grade C Strength of recommendation: strong

TREATMENT OF NON-METASTATIC MUSCLE-INVASIVE BLADDER CANCER: AUA/ASCO/ASTRO/SUO GUIDELINE	
Recommendation	**Evidence Rating**
In patients who have a non-muscle invasive recurrence after bladder preserving therapy, clinicians may offer either local measures, such as TURBT with intravesical therapy, or radical cystectomy with bilateral pelvic lymphadenectomy.	Type of recommendation: evidence based Evidence quality: grade C Strength of recommendation: moderate
PATIENT SURVEILLANCE AND FOLLOW UP	
IMAGING	
Clinicians should obtain chest imaging and cross sectional imaging of the abdomen and pelvis with CT or MRI at 6-12 month intervals for 2-3 years and then may continue annually.	Expert Opinion
LABORATORY VALUES AND URINE MARKERS	
After therapy for muscle-invasive bladder cancer, patients should undergo laboratory assessment at three to six month intervals for two to three years and then annually thereafter.	Expert Opinion
After radical cystectomy in patients with a retained urethra, clinicians should monitor the urethral remnant for recurrence.	Expert Opinion
PATIENT SURVIVORSHIP	
Clinicians should discuss with patients how they are coping with their bladder cancer diagnosis and treatment and should recommend that patients consider participating in a cancer support group or consider receiving individual counseling.	Expert Opinion
Clinicians should encourage bladder cancer patients to adopt healthy lifestyle habits, including smoking cessation, exercise, and a healthy diet, to improve long-term health and quality of life.	Expert Opinion
VARIANT HISTOLOGY	
In patients diagnosed with variant histology, clinicians should consider unique clinical characteristics that may require divergence from standard evaluation and management for urothelial carcinoma.	Expert Opinion

