Urology CHEAT SHEETS

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EAU Guidelines on Muscle-invasive and Metastatic Bladder Cancer

Disease management II

Urinary diversion after radical cystectomy (RC)

Different types of segments of the intestinal tract can be used to reconstruct the urinary tract, including the ileum, colon and appendix, with ileum used in most cases. The ileal conduit is an established option with well-known/predictable results. An orthotopic bladder substitution to the urethra is used in approximately 10–20% of both male and female patients.

Several studies have compared advantages and disadvantages in terms of quality of life (QoL), sexual function, urinary continence and body image between different urinary diversions, but further research evaluating the impact of tumour stage, functional- and socio-economic status are needed.

Do not offer an orthotopic bladder substitute diversion to patients who have an invasive tumour in the urethra or at the level of urethral dissection.	Strong

Peri-operative care

Patients treated according to a 'Fast tract'/ERAS (Early Recovery After Surgery) protocol have shown to score better on the emotional and physical functioning scores and suffer less from wound healing disorders, fever and thrombosis

Do not offer pre-operative bowel preparation.	Strong
Employ 'Fast track' measurements to reduce the time to bowel recovery.	Strong
Offer pharmacological VTE prophylaxis, such as low-molecular-weight heparin to RC patients, starting the first day post-surgery, for a period of at least 4 weeks.	Strong

Flow chart for the management of T2–T4a N0M0 urothelial bladder cancer

Diagnosis
- Cystoscopy and tumour resection
- Evaluation of urethra[1]
- CT imaging of abdomen, chest, UUT
- MRI can be used for local staging

[1] – *Males: biopsy apical prostatic urethra or frozen section during surgery if indicated (see below)*

– *Females : biopsy of proximal urethra or frozen section during surgery if indicated*

Findings
- cT2-4 N0M0

cT2 N0M0 selected patients
– Trimodality bladder-sparing therapy can be offered to properly selected patients.

Neoadjuvant therapy
- **Chemotherapy**
  Recommended in cisplatin-fit patients (5–8% survival benefit)
- **Radiotherapy**
  Not recommended
- **Immunotherapy**
  Experimental, only in clinical trial setting

Radical cystectomy
- **Know general aspects of surgery**
  - Preparation
  - Surgical technique
  - Integrated node dissection
  - Urinary diversion
  - Timing of surgery
- **A higher case load improves outcome**

Adjuvant systemic therapy
- Consider adjuvant immunotherapy in selected patients
- Consider chemotherapy in selected patients only if no neoadjuvant chemotherapy was given

Management of locally-advanced disease

Unresectable locally-advanced tumours (T4b, invading the pelvic or abdominal wall) may be accompanied by debilitating symptoms, including bleeding, pain, dysuria and urinary obstruction.

These patients are candidates for palliative treatments, such as palliative radiotherapy (RT). If control of the symptoms is not possible by less invasive methods, patients may be offered a palliative cystectomy with urinary diversion or urinary diversion only.

Recommendations	Strength rating
Offer radical cystectomy as a palliative treatment to patients with locally-advanced tumours (T4b).	Weak
Offer palliative cystectomy to patients with symptoms if control is not possible by less invasive methods.	Weak

Consensus statement
In patients with clinical T4 or clinical N+ disease (regional), radical chemoradiation can be offered accepting that this may be palliative rather than curative in outcome.
Chemoradiation should be given to improve local control in cases of inoperable locally-advanced tumours.

Bladder-sparing treatments for localised disease

Transurethral resection of bladder tumour

Recommendation	Strength rating
Do not offer transurethral resection of bladder tumour alone as a curative treatment option as most patients will not benefit.	Strong

External beam radiotherapy

External beam RT alone should only be considered as a therapeutic option when the patient is unfit for cystectomy. Radiotherapy can also be used to stop bleeding from the tumour when local control cannot be achieved by transurethral manipulation.

Recommendation	Strength rating
Do not offer radiotherapy alone as primary therapy for localised bladder cancer.	Strong

Chemotherapy

Complete and partial local responses have been reported with cisplatin-based chemotherapy as primary therapy for locally-advanced tumours in highly selected patients.

Recommendation	Strength rating
Do not offer chemotherapy alone as primary therapy for localised bladder cancer.	Strong

Trimodality bladder-preserving treatment (TMT)

In a selected patient population, long-term survival rates of TMT bladder-preserving treatment are comparable to those of early cystectomy.

Recommendations	Strength rating
Offer surgical intervention or trimodality bladder-preserving treatments (TMT) to appropriate candidates as primary curative therapeutic approaches since they are more effective than radiotherapy alone.	Strong
Offer TMT as an alternative to selected, well-informed and compliant patients, especially for whom radical cystectomy is not an option or not acceptable.	Strong

EAU Guidelines Dissemination Committee