

Bladder cancer: diagnosis and management of bladder cancer

NICE guideline

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If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

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Introduction

Bladder cancer is the seventh most common cancer in the UK. It is 3–4 times more common in men than in women. In the UK in 2011 it was the fourth most common cancer in men and the thirteenth most common in women. There were 10,399 people diagnosed with bladder cancer and 5,081 deaths from bladder cancer in 2011. The majority of cases occur in people aged over 60.

Bladder cancer is usually identified on the basis of visible blood in the urine or blood found on urine testing, but emergency admission is a common way for bladder cancer to present, and is often associated with a poor prognosis.

Most bladder cancers (75–80%) do not involve the muscle wall of the bladder and are usually treated by telescopic removal of the cancer (transurethral resection of bladder tumour [TURBT]), often followed by instillation of chemotherapy or vaccine-based therapy into the bladder, with prolonged telescopic checking of the bladder (cystoscopy) as follow-up. Some people in this group who are at higher risk are treated with major surgery to remove the bladder (cystectomy). People with cancer in or through the bladder muscle wall may be treated with intent to cure using chemotherapy, cystectomy or radiotherapy, and those who have cancer too advanced to cure may be treated with radiotherapy and chemotherapy.

The involvement of the urogenital tract and the nature of the treatments gives this cancer a strong psychological impact, in addition to the physical impact of the disease and its treatments, which is often profound. The prevalence of the condition and the nature of its management make bladder cancer one of the most expensive cancers for the NHS.

There is thought to be considerable variation across the NHS in the diagnosis and management of bladder cancer and the provision of care to people who have it. There is evidence that the patient experience for people with bladder cancer is worse than that for people with other cancers.

This guideline covers adults (18 years and older) referred from primary care with suspected bladder cancer and those with newly diagnosed or recurrent

bladder (urothelial carcinoma, adenocarcinoma, squamous-cell carcinoma or small-cell carcinoma) or urethral cancer.

It does not cover people aged under 18 or adults with bladder sarcoma, urothelial cancer of the upper urinary tract, or secondary bladder or urethral cancer (for example bowel or cervix cancer spreading into the bladder).

Drug recommendations

The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.

This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The patient (or those with authority to give consent on their behalf) should provide informed consent, which should be documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), these drugs are marked with a footnote in the recommendations.

Patient-centred care

This guideline offers best practice advice on the care of adults with bladder cancer.

Patients and healthcare professionals have rights and responsibilities as set out in the [NHS Constitution for England](#) – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. Healthcare professionals should follow the [Department of Health's advice on consent](#). If someone does not have capacity to make decisions, healthcare professionals should follow the [code of practice that accompanies the Mental Capacity Act](#) and the supplementary [code of practice on deprivation of liberty safeguards](#).

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in [Patient experience in adult NHS services](#).

Strength of recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Development Group is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision (see also 'Patient-centred care').

Interventions that must (or must not) be used

We usually use 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally we use 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions that should (or should not) be used – a 'strong' recommendation

We use 'offer' (and similar words such as 'refer' or 'advise') when we are confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, 'Do not offer...') when we are confident that an intervention will not be of benefit for most patients.

Interventions that could be used

We use 'consider' when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values

and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation. The full list of recommendations is in [section 1](#).

Information and support for people with bladder cancer

- Use a holistic needs assessment to identify an individualised package of information and support for people with bladder cancer and, if they wish, their partners, families or carers, at key points in their care such as:
 - when they are first diagnosed
 - after they have had their first treatment
 - if their bladder cancer recurs or progresses
 - if their treatment is changed
 - if palliative or end of life care is being discussed. **[1.1.4]**

Diagnosing and staging bladder cancer

Diagnosis

- Consider CT or MRI staging before transurethral resection of bladder tumour (TURBT) if muscle-invasive bladder cancer is suspected at cystoscopy. **[1.2.2]**
- Offer white-light-guided TURBT with photodynamic diagnosis, narrow-band imaging, cytology or a urinary biomarker (FISH, ImmunoCyt or NMP22) to people with suspected bladder cancer. This should be carried out or supervised by a urologist experienced in TURBT. **[1.2.3]**
- Offer people with suspected bladder cancer a single dose of intravesical mitomycin C given at the same time as TURBT. **[1.2.7]**

Managing non-muscle-invasive bladder cancer

Prognostic markers and risk classification

- Ensure that for people with non-muscle-invasive bladder cancer all of the following are recorded and used to guide discussions, both within the

multidisciplinary team and with the person, about prognosis and treatment options:

- recurrence history
- size and number of cancers
- histological type, grade, stage and presence (or absence) of flat urothelium, detrusor muscle (muscularis propria), and carcinoma in situ
- the [risk category](#) of the person's cancer
- predicted risk of recurrence and progression, estimated using a risk prediction tool. **[1.3.1]**

Managing high-risk non-muscle-invasive bladder cancer

- Offer the choice of intravesical BCG (Bacille Calmette-Guérin) or cystectomy to people with [high-risk](#) non-muscle-invasive bladder cancer, and base the choice on a full discussion with the person, the clinical nurse specialist and a urologist who performs both intravesical BCG and cystectomy. Include in your discussion:
 - the type, stage and grade of the cancer, the presence of carcinoma in situ, the presence of variant pathology, prostatic urethral or bladder neck status and the number of tumours
 - risk of progression to muscle invasion, metastases and death
 - risk of understaging
 - benefits of both treatments, including survival rates and the likelihood of further treatment
 - risks of both treatments
 - factors that affect outcomes (for example, comorbidities and life expectancy)
 - impact on quality of life, body image, and sexual and urinary function.**[1.3.6]**

Follow-up after treatment for non-muscle-invasive bladder cancer

Low-risk non-muscle-invasive bladder cancer

- Discharge to primary care people who have had [low-risk](#) non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months. **[1.3.20]**

Intermediate-risk non-muscle-invasive bladder cancer

- Offer people with [intermediate-risk](#) non-muscle-invasive bladder cancer cystoscopic follow-up at 3, 9 and 18 months, and once a year thereafter. **[1.3.22]**

Managing muscle-invasive bladder cancer

- Offer neoadjuvant chemotherapy using a cisplatin combination regimen before radical cystectomy or radical radiotherapy to people with newly diagnosed muscle-invasive urothelial cancer of the bladder for whom cisplatin-based chemotherapy is suitable. Ensure that they have an opportunity to discuss the risks and benefits with an oncologist who treats bladder cancer. **[1.4.2]**
- Offer a choice of cystectomy or chemoradiotherapy to people with muscle-invasive bladder cancer for whom radical therapy is suitable. Ensure that the choice is based on a full discussion between the person and a urologist who performs cystectomy, a clinical oncologist and a clinical nurse specialist. Include in the discussion:
 - the prognosis with or without treatment
 - the limited evidence about whether surgery or chemoradiotherapy is the most effective cancer treatment
 - the benefits and risks of surgery and chemoradiotherapy, including the impact on sexual and bowel function and the risk of death as a result of the treatment. **[1.4.3]**

Recommendations

The following guidance is based on the best available evidence. The [full guideline](#) [\[hyperlink to be added for final publication\]](#) gives details of the methods and the evidence used to develop the guidance.

Terms used in this guideline

World Health Organisation (WHO) performance status			
1	2	3	4
Asymptomatic, fully active and able to carry on all predisease activities without restriction	Symptomatic, up and about more than 50% of waking hours, ambulatory and able to carry out all self-care but unable to do any work activities	Symptomatic, confined to bed or chair for more than 50% of waking hours but not bedridden, able to carry out limited self-care	Completely disabled, totally confined to bed or chair, not able to carry out any self-care

1.1 Information and support for people with bladder cancer

1.1.1 Follow the recommendations on communication and patient-centred care in [Patient experience in adult NHS services](#) (NICE clinical guidance 138) and the advice in the NICE cancer service guidance [Improving outcomes in urological cancers](#) and [Improving supportive and palliative care for adults with cancer](#) throughout the person's care.

1.1.2 Offer clinical nurse specialist support to people with bladder cancer and give them the clinical nurse specialist's contact details.

1.1.3 Ensure that the clinical nurse specialist:

- acts as the key worker to address the person's information and care needs
- has experience and training in bladder cancer care.

1.1.4 Use a holistic needs assessment to identify an individualised package of information and support for people with bladder cancer and, if they wish, their partners, families or carers, at key points in their care such as:

- when they are first diagnosed
- after they have had their first treatment
- if their bladder cancer recurs or progresses
- if their treatment is changed
- if palliative or end of life care is being discussed.

1.1.5 When carrying out a holistic needs assessment recognise that many of the symptoms, investigations and treatments for bladder cancer affect the urogenital organs and may be distressing and intrusive. Discuss with the person:

- the type, stage and grade of their cancer and likely prognosis
- treatment and follow-up options
- the potential complications of intrusive procedures, including urinary retention, urinary infection, pain, bleeding or need for a catheter
- the impact of treatment on their sexual health and body image, including how to find support and information relevant to their gender
- diet and lifestyle
- smoking cessation for people who smoke
- how to find information about bladder cancer, for example through information prescriptions, sources of written information, websites or DVDs
- how to find support groups and survivorship programmes.
- how to find information about returning to work after treatment for cancer
- how to find information about financial support (such as free prescriptions and industrial compensation schemes).

- 1.1.6 Offer smoking cessation support to all people with bladder cancer who smoke, in line with [Smoking cessation services](#) (NICE public health guidance 10) and [Brief interventions and referral for smoking cessation](#) (NICE public health guidance 1)
- 1.1.7 Offer people with bladder cancer and, if they wish, their partners, families or carers, opportunities to have discussions at any stage during their care with:
- a range of specialist healthcare professionals, including those who can provide psychological support
 - other people with bladder cancer who have had similar treatments.
- 1.1.8 Clinicians caring for people with bladder cancer should ensure that there is close liaison between secondary and primary care with respect to ongoing and community-based support.
- 1.1.9 Trusts should consider conducting annual bladder cancer patient satisfaction surveys, the questions in which should be informed by the urology multidisciplinary team and people with bladder cancer, and use the results of these surveys to guide a programme of quality improvement.

1.2 *Diagnosing and staging bladder cancer*

Diagnosis

- 1.2.1 Do not substitute urinary biomarkers for cystoscopy to investigate suspected bladder cancer or for follow-up after treatment for bladder cancer, except in the context of a clinical research study.
- 1.2.2 Consider CT or MRI staging before transurethral resection of bladder tumour (TURBT) if muscle-invasive bladder cancer is suspected at cystoscopy.
- 1.2.3 Offer white-light-guided TURBT with photodynamic diagnosis, narrow-band imaging, cytology or a urinary biomarker (FISH,

ImmunoCyt or NMP22) to people with suspected bladder cancer. This should be carried out or supervised by a urologist experienced in TURBT.

- 1.2.4 Obtain detrusor muscle during TURBT.
- 1.2.5 Do not take random biopsies of normal-looking urothelium during TURBT unless there is a specific clinical indication (for example, investigation of positive cytology not otherwise explained).
- 1.2.6 Record the size and number of tumours during TURBT.
- 1.2.7 Offer people with suspected bladder cancer a single dose of intravesical mitomycin C given at the same time as TURBT.

Staging

- 1.2.8 Consider further TURBT within 6 weeks if the first specimen does not include detrusor muscle.
- 1.2.9 Offer CT or MRI staging to people diagnosed with muscle-invasive bladder cancer or [high-risk](#) non-muscle-invasive bladder cancer that is being assessed for radical treatment.
- 1.2.10 Consider CT urography, carried out with other planned CT imaging if possible, to detect upper tract involvement in people with new or recurrent high-risk non-muscle-invasive and muscle-invasive bladder cancer.
- 1.2.11 Consider CT of the thorax, carried out with other planned CT imaging if possible, to detect thoracic malignancy in people with muscle-invasive bladder cancer.
- 1.2.12 Consider fluorodeoxyglucose positron emission tomography (FDG PET)-CT for people with muscle-invasive bladder cancer or high-risk non-muscle-invasive bladder cancer before radical treatment if there are indeterminate findings on CT or MRI, or a high risk of metastatic disease (for example T3b disease).

1.3 *Managing non-muscle-invasive bladder cancer*

Risk categories for non-muscle-invasive bladder cancer¹

Low risk	Intermediate risk	High risk
Urothelial cancer with any of: <ul style="list-style-type: none"> solitary pTaG1 with a diameter less than 3 cm solitary pTaG2 low grade with a diameter less than 3 cm any papillary urothelial neoplasm of low malignant potential 	Urothelial cancer that is not low risk or high risk, including: <ul style="list-style-type: none"> solitary pTaG1 with a diameter more than 3 cm multifocal pTaG1 solitary pTaG2 low grade with a diameter more than 3 cm multifocal pTaG2 low grade pTaG2 high grade any pTaG2 grade not further specified any low-risk non-muscle-invasive bladder cancer recurring within 12 months of last tumour occurrence 	Urothelial cancer with any of: <ul style="list-style-type: none"> pTaG3 pT1G2 pT1G3 pTis (Cis) aggressive variants of urothelial carcinoma, for example micropapillary or nested variants
¹ There is no widely accepted classification of risk in non-muscle-invasive bladder cancer. To make clear recommendations for management, the Guideline Development Group developed this consensus classification based on the evidence reviewed and clinical opinion.		

Prognostic markers and risk classification

1.3.1 Ensure that for people with non-muscle-invasive bladder cancer all of the following are recorded and used to guide discussions, both within the multidisciplinary team and with the person, about prognosis and treatment options:

- recurrence history
- size and number of cancers
- histological type, grade, stage and presence (or absence) of flat urothelium, detrusor muscle (muscularis propria), and carcinoma in situ
- the [risk category](#) of the person's cancer
- predicted risk of recurrence and progression, estimated using a risk prediction tool.

Managing low-risk non-muscle-invasive bladder cancer

- 1.3.2 For management of low-risk non-muscle-invasive bladder cancer see recommendations [1.2.3-1.2.8](#).

Managing intermediate-risk non-muscle-invasive bladder cancer

- 1.3.3 Offer people with newly diagnosed [intermediate-risk](#) non-muscle-invasive bladder cancer a course of at least 6 doses of intravesical mitomycin C.
- 1.3.4 If intermediate-risk non-muscle-invasive bladder cancer recurs after a course of intravesical mitomycin C, refer the person's care to a bladder cancer specialist multidisciplinary team.

Managing high-risk non-muscle-invasive bladder cancer

- 1.3.5 If the first TURBT shows [high-risk](#) non-muscle-invasive bladder cancer, offer another TURBT as soon as possible and no later than 6 weeks after the first resection.
- 1.3.6 Offer the choice of intravesical BCG (Bacille Calmette-Guérin) or cystectomy to people with high-risk non-muscle-invasive bladder cancer, and base the choice on a full discussion with the person, the clinical nurse specialist and a urologist who performs both intravesical BCG and cystectomy. Include in your discussion:
- the type, stage and grade of the cancer, the presence of carcinoma in situ, the presence of variant pathology, prostatic urethral or bladder neck status and the number of tumours
 - risk of progression to muscle invasion, metastases and death
 - risk of understaging
 - benefits of both treatments, including survival rates and the likelihood of further treatment
 - risks of both treatments
 - factors that affect outcomes (for example, comorbidities and life expectancy)

- impact on quality of life, body image, and sexual and urinary function.

Intravesical BCG

- 1.3.7 Offer induction and maintenance intravesical BCG to people having treatment with intravesical BCG.
- 1.3.8 If induction BCG fails (because it is not tolerated, or bladder cancer persists or recurs after treatment with BCG), refer the person's care to a bladder cancer specialist multidisciplinary team.
- 1.3.9 For people in whom induction BCG has failed, the bladder cancer specialist multidisciplinary team should assess the suitability of radical cystectomy, or further intravesical therapy if radical cystectomy is unsuitable or declined by the person, or if the bladder cancer that recurs is [intermediate- or low-risk](#).

Cystectomy

- 1.3.10 Offer people who have chosen cystectomy a urinary stoma, or a continent urinary diversion (bladder substitution or a catheterisable reservoir) if there are no strong contraindications to continent urinary diversion such as cognitive impairment, impaired renal function or significant bowel disease.
- 1.3.11 Members of the multidisciplinary team (including the urological surgeon, stoma care nurse and clinical nurse specialist) should discuss with the person whether to have a urinary stoma or continent urinary diversion and provide opportunities for the person to talk to people who have had these procedures.
- 1.3.12 Offer people with bladder cancer and, if they wish, their partners, families or carers, opportunities to have discussions with a stoma care nurse before and after cystectomy as needed.

Recurrent non-muscle-invasive bladder cancer

- 1.3.13 Consider fulguration without biopsy for people with recurrent non-muscle-invasive bladder cancer if they have all of the following:
- no previous bladder cancer that was [intermediate- or high-risk](#)
 - a disease-free interval of at least 6 months
 - solitary papillary recurrence
 - a tumour diameter of 3 mm or less.

Managing side effects of treatment

- 1.3.14 Do not offer primary prophylaxis to prevent BCG- or radiation-related bladder toxicity except as part of a clinical trial.
- 1.3.15 Seek advice from a specialist team if symptoms of bladder toxicity after BCG or radiotherapy cannot be controlled with antispasmodics or non-opiate analgesia and other causes have been excluded by cystoscopy.

Follow-up after treatment for non-muscle-invasive bladder cancer

- 1.3.16 Refer people urgently to urological services if they have haematuria or other urinary symptoms and a history of non-muscle-invasive bladder cancer.
- 1.3.17 See recommendation [1.2.1](#) on the use of urinary biomarkers for follow-up after treatment for bladder cancer.

Low-risk non-muscle-invasive bladder cancer

- 1.3.18 Offer people with [low-risk](#) non-muscle-invasive bladder cancer cystoscopic follow-up 3 months and 12 months after diagnosis.
- 1.3.19 Do not use urinary biomarkers or cytology in addition to cystoscopy for follow-up after treatment for low-risk bladder cancer.
- 1.3.20 Discharge to primary care people who have had low-risk non-muscle-invasive bladder cancer and who have no recurrence of the bladder cancer within 12 months.
- 1.3.21 Do not offer routine urinary cytology or prolonged cystoscopic follow-up after 12 months for people with low-risk non-muscle-invasive bladder cancer.

Intermediate-risk non-muscle-invasive bladder cancer

- 1.3.22 Offer people with [intermediate-risk](#) non-muscle-invasive bladder cancer cystoscopic follow-up at 3, 9 and 18 months, and once a year thereafter.
- 1.3.23 Consider discharging people who have had intermediate-risk non-muscle-invasive bladder cancer to primary care after 5 years of disease-free follow-up.

High-risk non-muscle-invasive bladder cancer

- 1.3.24 Offer people with [high-risk](#) non-muscle-invasive bladder cancer cystoscopic follow-up:
- every 3 months for the first 2 years, then
 - every 6 months for the next 2 years, then

- once a year thereafter.

1.4 *Managing muscle-invasive bladder cancer*

- 1.4.1 Ensure that a specialist multidisciplinary bladder cancer team reviews all cases of muscle-invasive bladder cancer and that the review includes histopathology, imaging and discussion of treatment options.
- 1.4.2 Offer neoadjuvant chemotherapy using a cisplatin combination regimen before radical cystectomy or radical radiotherapy to people with newly diagnosed muscle-invasive urothelial cancer of the bladder for whom cisplatin-based chemotherapy is suitable. Ensure that they have an opportunity to discuss the risks and benefits with an oncologist who treats bladder cancer.
- 1.4.3 Offer a choice of cystectomy or chemoradiotherapy to people with muscle-invasive bladder cancer for whom radical therapy is suitable. Ensure that the choice is based on a full discussion between the person and a urologist who performs cystectomy, a clinical oncologist and a clinical nurse specialist. Include in the discussion:
- the prognosis with or without treatment
 - the limited evidence about whether surgery or chemoradiotherapy is the most effective cancer treatment
 - the benefits and risks of surgery and chemoradiotherapy, including the impact on sexual and bowel function and the risk of death as a result of the treatment.

Cystectomy

- 1.4.4 See recommendations [1.3.10–1.3.12](#) for people who have chosen cystectomy.

Adjuvant chemotherapy for muscle-invasive or lymph-node-positive bladder cancer

- 1.4.5 Consider adjuvant cisplatin combination chemotherapy after radical cystectomy for people with a diagnosis of muscle-invasive or lymph-node-positive bladder cancer who were not eligible for neoadjuvant chemotherapy. Ensure that the person has an opportunity to discuss the risks and benefits with an oncologist who treats bladder cancer.

Radical radiotherapy

- 1.4.6 Use a radiosensitiser (such as mitomycin¹ and fluorouracil² [5-FU] or carbogen³ and nicotinamide⁴) when giving radical radiotherapy (for example, 64 Gy in 32 fractions over 6.5 weeks or 55 Gy in 20 fractions over 4 weeks) for muscle-invasive bladder cancer.

Managing side effects of treatment

- 1.4.7 Manage side effects of treatment for muscle-invasive bladder cancer in line with recommendations [1.3.14](#) and [1.3.15](#).

Follow-up after treatment for muscle-invasive bladder cancer

- 1.4.8 Offer follow-up after radical cystectomy or radical radiotherapy for muscle-invasive bladder cancer.

¹ At the time of consultation (September 2014), mitomycin did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

² At the time of consultation (September 2014), fluorouracil did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

³ Although this use is common in UK clinical practice, at the time of consultation (September 2014), carbogen did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

⁴ Although this use is common in UK clinical practice, at the time of consultation (September 2014), nicotinamide did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

1.4.9 After radical cystectomy consider using a follow-up protocol that consists of:

- monitoring of the upper tracts for hydronephrosis, stones and cancer using imaging and glomerular filtration rate (GFR) estimation at least annually **and**
- monitoring for local and distant recurrence using CT of the abdomen, pelvis and chest, carried out together with other planned CT imaging if possible, 6, 12 and 24 months after radical cystectomy **and**
- monitoring for metabolic acidosis and B12 and folate deficiency at least annually **and**
- for men with a defunctioned urethra, urethral washing for cytology and/or urethroscopy annually for 5 years to detect urethral recurrence.

1.4.10 After radical radiotherapy consider using a follow-up protocol that consists of:

- rigid cystoscopy 3 months after radiotherapy has been completed **and**
- cystoscopy:
 - every 3 months for the first 2 years then
 - every 6 months for the next 2 years then
 - every year thereafter, according to clinical judgement and the person's preference **and**
- upper-tract imaging every year for 5 years **and**
- monitoring for local and distant recurrence using CT of the abdomen, pelvis and chest, carried out with other planned CT imaging if possible, 6, 12 and 24 months after radical radiotherapy has finished.

1.4.11 See recommendation [1.2.1](#) on the use of urinary biomarkers for follow-up after treatment for bladder cancer.

1.5 *Managing locally advanced or metastatic muscle-invasive bladder cancer*

First-line chemotherapy

1.5.1 Discuss the role of first-line chemotherapy with people who have locally advanced or metastatic bladder cancer. Include in your discussion:

- prognosis of their cancer **and**
- advantages and disadvantages of the treatment options, including best supportive care.

1.5.2 Offer one of the following cisplatin-based chemotherapy regimens to people with locally advanced or metastatic bladder cancer who are otherwise physically fit (have a [World Health Organisation \[WHO\] performance status](#) of 0 or 1) and have adequate renal function (GFR higher than 60 ml/min):

- cisplatin plus gemcitabine
- cisplatin plus gemcitabine with paclitaxel⁵
- accelerated (high-dose) methotrexate, vinblastine, doxorubicin and cisplatin (M-VAC) with granulocyte-colony stimulating factor (G-CSF).

1.5.3 Offer carboplatin⁶ plus gemcitabine⁷ to people with locally advanced or metastatic bladder cancer, after assessing and

⁵ Although this use is common in UK clinical practice, at the time of consultation (September 2014), the combination of cisplatin plus gemcitabine with paclitaxel does not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

⁶ Although this use is common in UK clinical practice, at the time of consultation (September 2014), carboplatin did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

⁷ Although this use is common in UK clinical practice, at the time of consultation (September 2014), gemcitabine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the

discussing the risks and benefits with the person, if they have any of the following:

- a WHO performance status of 2 or above
- inadequate renal function (GFR lower than 60 ml/min)
- another comorbidity.

1.5.4 For people having first-line chemotherapy for locally advanced or metastatic bladder cancer:

- carry out regular clinical and radiological monitoring **and**
- actively manage symptoms of disease and treatment-related toxicity **and**
- stop first-line chemotherapy if there is excessive toxicity or disease progression.

Second-line chemotherapy

1.5.5 Discuss second-line chemotherapy with people who have locally advanced or metastatic bladder cancer. Include in your discussion:

- the prognosis of their cancer
- advantages and disadvantages of treatment options, including best supportive care.

1.5.6 Consider second-line chemotherapy with gemcitabine plus cisplatin or accelerated (high-dose) methotrexate, vinblastine, doxorubicin and cisplatin (M-VAC) with G-CSF for people with incurable locally advanced or metastatic bladder cancer whose condition has progressed after first-line chemotherapy if:

- their renal function is adequate (GFR higher than 60 ml/min) **and**
- they are otherwise physically fit (have a [WHO performance status](#) of 0 or 1).

decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

- 1.5.7 Consider second-line chemotherapy with carboplatin⁸ plus paclitaxel⁹ or gemcitabine¹⁰ plus paclitaxel⁹ for people with incurable locally advanced or metastatic bladder cancer for whom cisplatin-based chemotherapy is not suitable, or who choose not to have it.
- 1.5.8 Do not offer people with incurable, locally advanced or metastatic bladder cancer second-line chemotherapy with a single agent except in a clinical study (including vinflunine, in line with [Vinflunine for the treatment of advanced or metastatic transitional cell carcinoma of the urothelial tract](#) [NICE technology appraisal guidance 272]).
- 1.5.9 For people having second-line chemotherapy for locally advanced or metastatic bladder cancer:
- carry out regular clinical and radiological monitoring **and**
 - actively manage symptoms of disease and treatment-related toxicity **and**
 - stop second-line chemotherapy if there is excessive toxicity or disease progression.

⁸ Although this use is common in UK clinical practice, at the time of consultation (September 2014), carboplatin did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

⁹ Although this use is common in UK clinical practice, at the time of consultation (September 2014), paclitaxel did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

¹⁰ Although this use is common in UK clinical practice, at the time of consultation (September 2014), gemcitabine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information.

Managing symptoms of locally advanced or metastatic bladder cancer

Bladder symptoms

- 1.5.10 Offer palliative hypofractionated radiotherapy to people with symptoms of haematuria, dysuria, urinary frequency or nocturia caused by advanced bladder cancer that is unsuitable for potentially curative treatment.

Loin pain and symptoms of renal failure

- 1.5.11 Discuss treatment options with people who have locally advanced or metastatic bladder cancer with ureteric obstruction. Include in your discussion:

- prognosis of their cancer **and**
- advantages and disadvantages of the treatment options, including best supportive care.

- 1.5.12 Consider percutaneous nephrostomy or retrograde stenting (if technically feasible) for people with locally advanced or metastatic bladder cancer and ureteric obstruction who need treatment to relieve pain, treat acute kidney injury or improve renal function before further treatment.

- 1.5.13 If percutaneous nephrostomy or retrograde stenting is not possible at the local hospital, discuss the options with a specialist urological multidisciplinary team for people with bladder cancer and ureteric obstruction.

Intractable bleeding

- 1.5.14 Evaluate the cause of intractable bleeding with the local urology team.
- 1.5.15 Consider hypofractionated radiotherapy or embolisation for people with intractable bleeding caused by incurable bladder cancer.

- 1.5.16 If a person has intractable bleeding caused by bladder cancer and radiotherapy or embolisation are not suitable treatments, discuss further management with a urology specialist multidisciplinary team.

Pelvic pain

- 1.5.17 Evaluate the cause of pelvic pain with the local urology team.
- 1.5.18 Consider, in addition to best supportive care, one or more of the following to treat pelvic pain caused by incurable bladder cancer:
- hypofractionated radiotherapy if the person has not had pelvic radiotherapy
 - nerve block
 - palliative chemotherapy.

1.6 *Specialist palliative care for people with incurable bladder cancer*

- 1.6.1 A member of the treating team should offer people with incurable bladder cancer a sensitive explanation that their disease cannot be cured and refer them to the urology multidisciplinary team.
- 1.6.2 Tell the primary care team that the person has been given a diagnosis of incurable bladder cancer within 24 hours of telling the person.
- 1.6.3 A member of the urology multidisciplinary team should discuss the prognosis and management options with people with incurable bladder cancer.
- 1.6.4 Discuss the role of specialist palliative care services with people with incurable bladder cancer and, if they agree, refer them to a specialist palliative care team (see NICE cancer service guidance on [Improving supportive and palliative care for adults with cancer](#) and [Improving outcomes in urological cancers](#)).

- 1.6.5 Offer people with symptomatic incurable bladder cancer access to a urological team with the full range of options for managing symptoms.

2 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline [\[hyperlink to be inserted at publication\]](#).

2.1 Patient satisfaction

What are the causative and contributory factors underlying the persistently very low levels of reported patient satisfaction for bladder cancer?

Why this is important

The urological cancers grouping (which includes bladder cancer but excludes prostate cancer) has consistently appeared near the bottom of the table of patient satisfaction comparisons of all cancer types in national patient experience surveys. Prostate cancer (which is also managed in urological services) is recorded separately and has continued to appear near the top of the tables.

It is uncertain why this is the case, except that there is now an accepted link between the level of clinical nurse specialist allocation, information and support provision and patient satisfaction. The urological cancers grouping has the lowest level of clinical nurse specialist allocation in comparison with all other cancer types or groupings (including prostate cancer). The prolonged pattern of intrusive procedures that dominate investigation, treatment and follow-up regimens for bladder cancer may also contribute to this position. Additionally, there is concern that people with bladder cancer at or near the end of life, who are by that stage often quite frail and elderly, may not always have access to the full range of palliative and urological support and may, at

times, be treated in general wards in hospital and experience significant symptoms of pain and bleeding (haematuria).

One avenue to start to explore this research question would be to separately identify bladder cancer patients from the generic group of urological cancer patients in nationally collected data sets.

2.2 *BCG or primary cystectomy in high-risk non-muscle-invasive bladder cancer*

Is primary radical cystectomy more effective than primary intravesical BCG in [high-risk](#) non-muscle-invasive bladder cancer in terms of quality of life and cancer-specific outcomes?

Why this is important

Options for people with high-risk non-muscle-invasive bladder cancer include cystoscopy surveillance, BCG immunotherapy or radical surgery. To date, these have not been directly compared across the same population to understand their relative benefits.

Bladder-sparing approaches avoid major surgery, but have a greater risk of cancer progression. However, the potential advantage of maintaining quality of life compared to cystectomy may be offset by continuing concern about cancer progression and morbidity of treatment. Primary cystectomy may improve survival, however it has high short-term risks and life-changing consequences. It will be overtreatment for those people whose cancer would not have progressed.

2.3 *Follow-up of high-risk non-muscle-invasive bladder cancer*

In people with [high-risk](#) non-muscle-invasive bladder cancer, are these 2 follow-up regimens equally effective in terms of identification of progression, cost effectiveness and health-related quality of life?

- Cystoscopic follow-up at 3, 6, 12, 18, 24, 36 and 48 months, and then annually, interspersed with non-invasive urinary tests.

- Cystoscopic follow-up at 3, 6, 9, 12, 15, 18, 21, 24, 30, 36, 42 and 48 months, and then annually thereafter.

Why this is important

Cystoscopy is currently the standard of care for follow-up of people with high risk non-muscle-invasive bladder cancer. Regular cystoscopy may be associated with anxiety, procedural discomfort to the person and significant costs to the NHS.

Urine tests based on a variety of technologies (including cytology, FISH and proteomic platforms) can detect high-grade recurrence, raising the possibility that one or more of these tests could be used to reduce the frequency of cystoscopy. This could improve acceptability to patients and reduce costs to the NHS without increasing the risk of disease progression.

There is a lack of evidence on the optimal frequency of follow-up and whether the frequency of cystoscopy follow-up can safely be reduced by substitution of urinary tests.

2.4 *Biomarkers for treatment selection*

In patients with muscle-invasive bladder cancer suitable for radical treatment, does the use of biomarkers to select treatment produce better outcomes than treatment selected without biomarkers?

Why this is important

Response to surgery or radiotherapy is difficult to predict for individuals. There is variation not only in the cure rates for patients with muscle-invasive bladder cancer treated with either surgery or radiotherapy, but also in the side effects experienced during and after treatment. The usefulness of current biomarkers in predicting treatment outcomes for individual patients has not been clearly established. Currently treatment decisions are based on patient-related factors and patient and clinician preference. Research into biomarkers that can predict the response of the patient's muscle-invasive bladder cancer to either radiotherapy or surgery could help individual patients and clinicians

decide which treatment is more suitable and is considered an important step toward individualised treatment.

2.5 *Follow-up after radical treatment for organ-confined muscle-invasive bladder cancer*

Is symptom-based review as effective as scheduled follow-up for people treated with radical cystectomy or radical radiotherapy for organ-confined muscle-invasive bladder cancer? Outcomes of interest are overall survival, health-related quality of life, resource use and cost.

Why this is important

Standard care after treatment for organ-confined muscle-invasive bladder cancer is scheduled follow-up at intervals set out by the treating team.

Although this can be reassuring for both the patient and the treating team, it is not known whether scheduled follow-up offers clinical benefit compared with symptom-based review, which is increasingly used for people with other cancers. Moreover, there are significant costs associated with follow-up. The current evidence about follow-up is confined to cystectomy. There is no evidence concerning follow-up after radiotherapy. In addition, the evidence on radiological follow-up uses mainly outdated imaging techniques.

3 Other information

3.1 *Scope and how this guideline was developed*

NICE guidelines are developed in accordance with a [scope](#) that defines what the guideline will and will not cover.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Cancer to develop this guideline. The Centre established a Guideline Development Group (see [section 4](#)), which reviewed the evidence and developed the recommendations.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#).

3.2 Related NICE guidance

Details are correct at the time of consultation on the guideline (September 2014). Further information is available on [the NICE website](#).

Published

General

- [Opioids in palliative care](#). NICE clinical guideline 140 (2012).
- Patient experience in adult NHS services. NICE clinical guidance 138 (2012).
- [Service user experience in adult mental health](#). NICE clinical guidance 136 (2011).
- [Medicines adherence](#). NICE clinical guidance 76 (2009).
- [Smoking cessation services](#). NICE public health guidance 10 (2008).
- [Brief interventions and referral for smoking cessation](#). NICE public health guidance 1 (2006).

Condition-specific

- [Vinflunine for the treatment of advanced or metastatic transitional cell carcinoma of the urothelial tract](#). NICE technology appraisal guidance 272 (2013).
- [Lower urinary tract symptoms](#). NICE clinical guideline 97 (2009).

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- [Laparoscopic cystectomy](#). NICE interventional procedure guidance 287 (2009).
- [Metastatic spinal cord compression](#). NICE clinical guideline 75 (2008).
- [Electrically-stimulated intravesical chemotherapy for superficial bladder cancer](#). NICE interventional procedure guidance 277 (2008).
- [Intraoperative red blood cell salvage during radical prostatectomy or radical cystectomy](#). NICE interventional procedure guidance 258 (2008).
- [Intravesical microwave hyperthermia with intravesical chemotherapy for superficial bladder cancer](#). NICE interventional procedure guidance 235 (2007).
- [Urinary incontinence](#). NICE clinical guideline 40 (2006).
- [Improving supportive and palliative care for adults with cancer](#). NICE cancer service guidance (2004).
- [Improving outcomes in urological cancers](#). NICE cancer service guidance (2002).

Under development

NICE is developing the following guidance (details available from [the NICE website](#)):

- Suspected cancer. NICE clinical guideline. Publication expected May 2015.

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