NICE National Institute for Health and Care Excellence

2019 surveillance of bladder cancer: diagnosis and management (NICE guideline NG2)

Surveillance report

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Surveillance decision

We will not update the guideline on bladder cancer: diagnosis and management.

Reasons for the decision

The majority of evidence was found to be consistent with the current guideline recommendations. Improvements were seen in the area of robotic cystectomy for some patient outcomes, however as the guideline does not currently state which method of radical cystectomy should be used, there is unlikely to be an impact at this time. New evidence was found for urinary biomarkers but was found to support the current recommendations in this area.

For further details and a summary of all evidence identified in surveillance, see appendix A.

Overview of 2019 surveillance methods

NICE's surveillance team checked whether recommendations in bladder cancer: diagnosis and management (NICE guideline NG2) remain up to date.

The surveillance process consisted of:

- Feedback from topic experts via a questionnaire.
- A search for new or updated Cochrane reviews.
- Examining related NICE guidance and quality standards and NIHR signals.
- A search for ongoing research.
- Examining the NICE event tracker for relevant ongoing and published events.
- Literature searches to identify relevant evidence.
- Assessing the new evidence against current recommendations to determine whether or not to update sections of the guideline, or the whole guideline.
- Consulting on the decision with stakeholders.
- Considering comments received during consultation and making any necessary changes to the proposal.

For further details about the process and the possible update decisions that are available, see ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual.

Evidence considered in surveillance

Search and selection strategy

We searched for new evidence related to specific parts of the guideline. Focused searches were undertaken for the areas of robotic assisted radical cystectomy and urinary biomarkers. A search for Cochrane reviews was also undertaken as part of the initial intelligence gathering. These searches were selected following input from topic experts

and evidence found in the initial intelligence gathering.

We found 30 studies in a search for systematic reviews, randomised controlled trials and diagnostic accuracy studies published between 1 April 2014 and 20 November 2018.

We also included 1 relevant study from a total of 9 identified by topic experts (this study was also identified through our search).

From all sources, we considered 30 studies to be relevant to the guideline.

See appendix A: summary of evidence from surveillance for details of all evidence considered, and references.

Selecting relevant studies

For the search on urinary biomarkers, studies were included for adults aged over 18 with suspected, newly diagnosed or recurrent bladder cancer. Studies were only included if they compared a biomarker to the current recommended method, cystoscopy and if sensitivity and specificity results were stated.

For the search on robotic cystectomy, only studies in adults aged over 18 with newly diagnosed or recurrent bladder cancer or newly diagnosed cancer of the urethra were included. Studies were required to have standard open cystectomy as a comparator.

Ongoing research

We checked for relevant ongoing research; of the ongoing studies identified, 15 studies were assessed as having the potential to change recommendations; therefore, we plan to regularly check whether these studies have published results and evaluate the impact of the results on current recommendations as quickly as possible. These studies covered robotic cystectomy, intravesical therapy, tumour imaging, quality of life, and chemotherapy.

Intelligence gathered during surveillance

Views of topic experts

We considered the views of topic experts, including those who helped to develop the guideline. For this surveillance review, topic experts completed a questionnaire about developments in evidence, policy and services related to the NICE guideline.

We sent questionnaires to 10 topic experts and received 6 responses. The topic experts were recruited to the NICE Centre for Guidelines Expert Advisers Panel to represent their specialty.

Topic experts highlighted the new evidence available for immunotherapy such as pembrolizumab. However this area is covered by the NICE technology appraisal guidance on pembrolizumab for treating locally advanced or metastatic urothelial carcinoma after platinum-containing chemotherapy and pembrolizumab for untreated PD-L1-positive locally advanced or metastatic urothelial cancer when cisplatin is unsuitable, and is currently limited to use within the cancer drugs fund. As these technology appraisals are linked within the NICE Pathway on bladder cancer, we will not be covering immunotherapy in this surveillance review. Time to definitive treatment for muscle-invasive bladder cancer was also raised as an issue, as treatment is classed in trusts (according to NHS cancer waiting times guidance) as commenced when the initial transurethral resection of bladder tumour (TURBT) has been performed. Feedback from stakeholders suggests that patients are having to wait longer for their definitive treatment than the 62-day target. However, the bladder cancer guideline describes TURBT in section 1.2 on diagnosing and staging bladder cancer. Therefore, it appears that this issue is related to how the waiting times directives are being implemented locally for bladder cancer as opposed to an issue with the guideline recommendations specifically.

Other sources of information

We considered all other correspondence received since the guideline was published. A study was highlighted at the 2014 consultation on the draft guideline regarding photodynamic versus white-light guided treatment of non-muscle-invasive bladder cancer. The study aims to compare time to recurrence for each of the 2 methods and evaluate the cost-effectiveness. We included this study in our summary of evidence.

Views of stakeholders

Stakeholders are consulted on all surveillance reviews except if the whole guideline will be updated and replaced. Because this surveillance proposal was to not update the guideline, we consulted with stakeholders.

Overall, 7 stakeholders commented. One stakeholder agreed with the proposal not to update the guideline, and 6 disagreed. Stakeholders included a university, industry, professional bodies and charities.

Immunotherapies

Stakeholders highlighted the new immunotherapies available, such as atezolizumab and pembrolizumab. Immunotherapies were considered during the surveillance review; however, they are covered by NICE technology appraisals and are largely recommended for use only within the cancer drugs fund. In order to highlight the available technology appraisals in this area we will make editorial amendments to recommendations 1.7.7 and 1.7.8, adding a hyperlink to the NICE Pathway on bladder cancer where all relevant technology appraisals are linked.

Transurethral resection of bladder tumour

Stakeholders highlighted that TURBT was being interpreted as a definitive treatment, and as such the '62 days to treatment' clock was stopped when the initial TURBT was performed. Stakeholders reported that people with high risk bladder cancer that requires further treatment such as radiotherapy or cystectomy were having to wait a lot longer than the 62-day NHS target. The recommendations in the NICE guideline do not define TURBT as a definitive treatment, and the recommendations relating to TURBT are largely in section 1.2 on diagnosing and staging of bladder cancer. We sought advice from topic experts following consultation who advised that for non-muscle-invasive bladder cancer (NMIBC), TURBT could generally be considered definitive treatment but not for muscle-invasive bladder cancer (MIBC). For high risk NMIBC, a second TURBT could be considered, from which a number of cases will have their diagnosis change to MIBC. For those who remain as high risk NMIBC, the second TURBT could be considered as definitive treatment, as could the commencement of adjuvant therapy. No new evidence was highlighted at this surveillance review regarding the classification of TURBT as diagnostic or definitive treatment, and no evidence was submitted during consultation. We will monitor this issue and consider it again at the next surveillance review. We are also

tracking several ongoing trials that relate to TURBT and imaging and photodynamic guided treatment for NMIBC, which will be evaluated for impact once results are available.

Urinary biomarkers

A stakeholder highlighted that there have been advances in urinary biomarkers since the guideline was published. This was also highlighted by topic experts and as such formed a focused search. The evidence found at this surveillance review was for a broad selection of different tests, none of which were found to be more accurate than the current recommended test, cystoscopy.

Robotic cystectomy

Stakeholders highlighted that robotic cystectomy is becoming more common in surgical practice. We found evidence that for a number of patient outcomes, robotic cystectomy was advantageous, however it did have a longer operative time. The recommendations in the NICE guideline currently do not describe which method of cystectomy should be used and as such allow the option of robotic cystectomy. We are also tracking ongoing studies in this area that will be evaluated for impact once results are available.

Haematuria

Hospital investigation of haematuria was raised by a stakeholder, highlighting that most guidance focuses on primary care diagnosis rather than secondary care diagnosis. The evidence found at this review related to urinary biomarkers and found the results were not as accurate as cystoscopy. No evidence was found specifically for secondary care diagnosis, as such this will be considered again at the next surveillance review.

See appendix B for full details of stakeholders' comments and our responses.

See ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual for more details on our consultation processes.

Equalities

Stakeholders raised the issue of gender differences in bladder cancer. This related to presentation, mis-diagnosis, late referral, overall survival and higher odds of advanced disease in women. Section 1.6 of NICE's guideline on suspected cancer: recognition and

referral details advice on bladder cancer referral from primary care. This includes recommendations relating to urinary tract infection, which stakeholders noted may result in mis-diagnosis. This guideline is linked to in the NICE Pathway on bladder cancer. No evidence was found at this review relating to gender inequality, as such this issue will be considered at the next surveillance review.

Editorial amendments

During surveillance of the guideline, we identified the following points in the guideline that should be amended.

Recommendation 1.1.6 links to NICE's guidelines on stop smoking services and smoking: brief interventions and referrals, which have both been replaced with NICE's guideline on stop smoking interventions and services. This recommendation will be refreshed to state: Offer smoking cessation support to all people with bladder cancer who smoke, in line with the NICE guideline on stop smoking interventions and services.

Recommendation 1.4.3 has a cross referral to low-risk. This should hyperlink to recommendation 1.3, however this link goes to recommendation 1.2. The low-risk hyperlink will be updated to link to recommendation 1.3.

We will add a cross referral to the NICE Pathway on bladder cancer from recommendations 1.7.7 and 1.7.8 to highlight the new technology appraisals that are available. The following text will be added: Following the development of this guideline, new technology appraisals are available that are relevant to this recommendation. Please see the NICE Pathway on bladder cancer for further information.

Improving outcomes in urological cancers (NICE guideline CSG2)

There are inconsistencies between the related NICE guideline on improving outcomes in urological cancers and the NICE guideline on bladder cancer in relation to grading/staging, neo-adjuvant chemotherapy, superficial tumours and terminology used. The guideline on improving outcomes in urological cancers will be amended to remove the inconsistencies.

Overall decision

After considering all evidence and other intelligence and the impact on current recommendations, we decided that no update is necessary.

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