

## NON-SURGICAL TREATMENT

### CONVENTIONAL RADIOTHERAPY

- A radical course of radiotherapy requires a minimum dose of 50Gy in 20 fractions over four weeks or 64Gy in 32 fractions if treating over 6.5 weeks.

### PALLIATIVE RADIOTHERAPY

- B** Radiotherapy using 21Gy in three fractions in one week should be considered for palliation of bladder cancer.

### NEOADJUVANT CHEMOTHERAPY

- A**
  - Neoadjuvant chemotherapy should be offered to suitable patients prior to definitive radical therapy for patients with T2-T4 transitional cell carcinoma of the bladder
  - A combination chemotherapy regimen containing cisplatin should be used.

### ADJUVANT CHEMOTHERAPY

- Adjuvant chemotherapy should be given within the context of a clinical trial.

## SUPPORT NEEDS

- C** Patients should be offered verbal and written information throughout their journey of care and should be made aware of the support mechanisms that are in place and how to access them.

## SOURCES OF FURTHER INFORMATION

**Milton Keynes Bladder Cancer Support Group**  
Milton Keynes General Hospital, Standing Way  
Milton Keynes MK6 5LD  
Tel: 01908 243 131

**CancerBACUP Scotland**  
Suite 2, Third Floor, Cranston House  
104/114 Argyle Street, Glasgow G2 8BH  
Tel: 0141 223 7676/0808 800 1234 • Fax: 0141 248 8422  
www.cancerbacup.org.uk

**Macmillan Cancer Relief (Scotland)**  
Osborne House, 1-5 Osborne Terrace, Edinburgh EH1 2DP  
Tel: 0131 346 5346 • Fax: 0131 346 5347  
www.macmillan.org.uk • Email: agow@macmillan.org.uk

**Maggie's Centres Scotland**

- The Stables, Western General Hospital, Edinburgh EH4 2XU  
Tel: 0131 537 3131 • Fax: 0131 537 3130
- The Gatehouse, Western Infirmary, Glasgow G11 6PA  
Tel: 0141 330 3311 • Fax: 0141 330 3363
- Maggie's Dundee, Ninewells Hospital, Dundee DD2 1ZV  
Tel: 01382 632 999 • Fax: 01382 632 998

www.maggiescentres.org • Email: maggies.centre@ed.ac.uk

**Marie Curie Cancer Care (Scotland)**  
29 Albany Street, Edinburgh, EH1 3QN  
Tel: 0131 456 3700 • Fax: 0131 456 3701  
www.mariecurie.org.uk

**Tak Tent Cancer Support Scotland**  
Flat 5, 30 Shelley Court, Gartnavel Complex  
Glasgow G12 0YN  
Tel: 0141 211 0122 • Fax: 0141 211 3988  
www.taktent.org.uk • Email: tak.tent@care4free.net

**Urostomy Association**  
Central Office, 18 Foxglove Avenue, Uttoxeter  
Staffs ST14 8UN  
Tel: 0870 770 7931 • Fax: 0870 770 7932  
www.uagbi.org • Email: secretary.ua@classmail.co.uk

This Quick Reference Guide provides a summary of the main recommendations in the SIGN guideline on **Management of transitional cell carcinoma of the bladder**.

Recommendations are graded **A B C D** to indicate the strength of the supporting evidence.

Good practice points  are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**



## LIFESTYLE ISSUES

**B** Smoking should be discouraged.

**B** People should be encouraged to:

- eat more fruit and vegetables
- reduce the amount of animal fat in their diet.

**B** Clinicians should be aware that previous treatments with radiotherapy and certain chemotherapy may predispose patients to transitional cell carcinoma of the bladder.

Clinicians using radiotherapy and chemotherapy treatments should do so utilising best practice to minimise any unnecessary exposure of patients.

## REFERRAL

Patients with frank haematuria should be referred and investigated so that primary treatment can be started within two months if bladder cancer is diagnosed.

**C** For optimum survival benefit, cystectomy for muscle invasive bladder cancer should be performed within three months of diagnosis.

Care of patients with bladder cancer should be managed within a cancer network.

**D** Healthcare professionals should involve patients in making decisions about their treatment, if the patient expresses a wish to do so.

All patients diagnosed with bladder cancer should have access to a clinical nurse specialist for support, advice and information.

## MANAGEMENT OF SUPERFICIAL BLADDER CANCER

### FOLLOW UP

**B** Only patients with high grade tumours (*including CIS*) at time of diagnosis should have regular upper tract surveillance.

**C** Patients with a single pTa G1/G2 tumour at the time of diagnosis and who are recurrence free at three months after the original resection should have annual cystoscopy.

### INTRAVESICAL THERAPY

**A** A single instillation of intravesical chemotherapy should be used to reduce the risk of recurrent disease following resection in all patients considered to be at high risk of recurrence.

### RANDOM BIOPSY OF NORMAL MUCOSA

**C** Normal looking areas of the bladder need not be routinely biopsied at the time of diagnosis or follow up.

### MANAGEMENT OF CARCINOMA IN SITU

**C** Patients with CIS of the bladder should be treated with BCG.

**B** Maintenance therapy with BCG should be considered in patients with CIS to improve local control and reduce the incidence of progression.

### MANAGEMENT OF G3pT1/G3pTA TUMOURS

If a G3pT1 tumour is diagnosed or suspected complete resection should be attempted

- If pathological depth of invasion cannot be assessed in patients with G3pT1/G3pTA tumours re-resection should be attempted
- For patients with persistent or recurrent disease cystectomy should be offered.

## SURGICAL TREATMENT

### IMAGING FOR STAGING OF INVASIVE DISEASE

**C** Patients with invasive bladder cancer should have cross-sectional imaging prior to treatment.

Cross-sectional imaging should take place prior to tumour resection.

### RADIOTHERAPY AND CYSTECTOMY

The choice of primary treatment for muscle invasive bladder cancer should be taken after the patient has been fully counselled on the short and long term risks and benefits of surgery and radiotherapy

- Salvage cystectomy should be offered to those patients who have local recurrence after radiotherapy if they are fit for surgery
- Patients should have access to a stoma therapist for advice and counselling prior to cystectomy.

### INDICATIONS FOR REMOVAL OF THE URETHRA

**C** Urethectomy should be performed in high risk patients having cystectomy and urinary diversion.

### INDICATIONS FOR REMOVAL OF THE LYMPH NODES

**C** All patients having curative radical cystectomy should have bilateral pelvic lymph node dissection.

**C** A meticulous node dissection should be performed for retrieval of the maximum number of nodes.

### BLADDER RECONSTRUCTION

**C** Where appropriate, patients should be given the option of bladder reconstruction after radical cystectomy.