



Guidelines

EAU Guidelines on Muscle-invasive and Metastatic Bladder Cancer: Summary of the 2013 Guidelines

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Abstract

Context: The European Association of Urology (EAU) guidelines panel on Muscle-invasive and Metastatic bladder cancer (BCa) updates its guidelines yearly. This updated summary provides a synthesis of the 2013 guidelines document, with emphasis on the latest developments.

Objective: To provide graded recommendations on the diagnosis and treatment of patients with muscle-invasive BCa (MIBC), linked to a level of evidence.

Evidence acquisition: For each section of the guidelines, comprehensive literature searches covering the past 10 yr in several databases were conducted, scanned, reviewed, and discussed both within the panel and with external experts. The final results are reflected in the recommendations provided.

Evidence synthesis: Smoking and work-related carcinogens remain the most important risk factors for BCa. Computed tomography (CT) and magnetic resonance imaging can be used for staging, although CT is preferred for pulmonary evaluation. Open radical cystectomy with an extended lymph node dissection (LND) remains the treatment of choice for treatment failures in non-MIBC and T2–T4aN0M0 BCa. For well-informed, well-selected, and compliant patients, however, multimodality treatment could be offered as an alternative, especially if cystectomy is not an option. Comorbidity, not age, should be used when deciding on radical cystectomy. Patients should be encouraged to actively participate in the decision-making process, and a continent urinary diversion should be offered to all patients unless there are specific contraindications. For fit patients, cisplatin-based neoadjuvant chemotherapy should always be discussed, since it improves overall survival. For patients with metastatic disease, cisplatin-containing combination chemotherapy is recommended. For unfit patients, carboplatin combination chemotherapy or single agents can be used.

Conclusions: This 2013 EAU Muscle-invasive and Metastatic BCa guidelines updated summary aims to increase the quality of care and outcome for patients with muscle-invasive or metastatic BCa.

Patient summary: In this paper we update the EAU guidelines on Muscle-invasive and Metastatic bladder cancer. We recommend that chemotherapy be administered before radical treatment and that bladder removal be the standard of care for disease confined to the bladder.

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1. Introduction

The previous summary of the European Association of Urology (EAU) guidelines on Muscle-invasive and Metastatic bladder cancer (BCa) was published in 2011 [1]. Since 2011, the guidelines have been regularly updated, and the current summary presents a synthesis of the 2013 guidelines document of March 2013. New scientific publications published after March 2013 will be incorporated into the 2014 update. The guidelines panel comprises an international multidisciplinary group of experts from the fields of urology, pathology, radiology, and oncology.

For each section of the muscle-invasive BCa (MIBC) guidelines, comprehensive literature searches covering the last 10 yr in several databases were set up. Searches were discussed internally and with an expert external consultant. Extensive use of free text ensured the sensitivity of the searches. Search results were scanned by the panel members, reviewed, and finally used to provide levels of evidence (LEs) and grades of recommendation (GRs). Definitions of LEs and GRs follow the listings in the full text version [2]. The link between LE and GR is not directly linear. For example, randomised controlled trials are not necessarily given a grade A recommendation if there are methodological limitations or disparity in published results. Conversely, overwhelming clinical experience and consensus can translate into a grade A recommendation.

2. Epidemiology and risk factors

BCa is the ninth most common cancer worldwide, with >330 000 new cases each year, >30 000 deaths per year, and an estimated male-to-female ratio of 3.8 to 1.0 [3]. At presentation, approximately 30% of patients have MIBC.

Tobacco smoking is the most established risk factor for BCa, responsible for 50–65% of male cases and 20–30% of female cases [4]. A recent meta-analysis found a relative risk of 2.77 (95% confidence interval [CI], 2.17–3.54) for current smokers and 1.72 (95% CI, 1.46–2.04) for former smokers [5]. Since stopping smoking lowers the risk of BCa by 60% after 25 yr [6], encouraging people to stop smoking is worthwhile. The second most important risk factor is occupational exposure [7], accounting for 20–25% of all BCa cases in a number of series. The latency period following exposure may be as long as 30 yr [8]. In Western countries the incidence of BCa due to occupational exposure is decreasing [9]. Radiotherapy to pelvic organs (eg, external radiotherapy for prostate cancer [PCa]) has also been related to an increased risk of BCa [10]. Since longer follow-up data are not yet available and BCa requires a long period to develop, close surveillance of irradiated patients with a long life expectancy is appropriate [11].

Women are more likely to be diagnosed with primary muscle-invasive disease than men (85% vs 51%) [12], and female gender has a significant negative impact on cancer-specific survival (CSS) in specific patient groups, suggesting different clinical phenotypes [13]. Conclusions and recommendations for epidemiology and risk factors are listed in Tables 1 and 2.

3. Tumour classification

The seventh edition of the TNM classification of malignant tumours, effective as of 2010 [14], is recommended (Table 3). The last change in the grading system was in 2004 [15]. However, since all muscle-invasive bladder tumours are considered high grade, grading is not considered very important for MIBC [8].

After radical cystectomy, specimen handling should follow published rules [16] to study all parts of the specimen

Table 1 – Conclusions on epidemiology and risk factors

Conclusion	LE
The incidence of muscle-invasive disease has not changed for 5 yr.	
Active and passive tobacco smoking is the main risk factor. Exposure-related incidence is decreasing.	2a
Patients undergoing EBRT, brachytherapy, or a combination of EBRT and brachytherapy are at increased risk of developing bladder cancer.	3
Patients treated with radiotherapy at a young age are at high risk for bladder cancer and should be followed up closely.	
The estimated male-to-female ratio for bladder cancer is 3.8 to 1.0. Women are more likely to have primary muscle-invasive disease than men.	3
Currently, treatment decisions cannot be based on molecular markers.	3

EBRT = external-beam radiotherapy; LE = level of evidence.

Table 2 – Recommendations on epidemiology and risk factors

Recommendation	GR
The principal preventable risk factor for muscle-invasive bladder cancer is active and passive smoking.	B
Workers should be informed about the potential carcinogenic effects of a number of recognised substances, duration of exposure, and latency periods. Protective measures should be recommended.	A

GR = grade of recommendation.

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