Editorial

A New Dawn for Bladder Cancer? Recommendations from the National Institute for Health and Care Excellence (NICE) on Managing Bladder Cancer

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Bladder cancer has been seen by many to be one of the Cinderella cancers, despite being one of the most expensive cancers to treat. Survival has not improved in the last 30 years, levels of patient satisfaction in national patient surveys are low and highly specialist services are few compared with other common cancers. Alongside this is evidence of poor outcomes for certain groups of patients, particularly women and those in lower socioeconomic classes.

It is on this background that the National Institute for Health and Care Excellence (NICE) commissioned a bladder cancer-specific management guideline with the aim to improve standards of care. The guideline, which has recently been published [1], emphasises the importance of patient-centred care, ensuring that the patient and their carers are involved in decision-making and that the full range of management options is available. An important part of this strategy will be to improve access to specialist multidisciplinary teams and clinical nurse specialists in particular. Evidence clearly shows that bladder cancer patients have a much lower level of access to clinical nurse specialists than patients with many other cancers. Improving this access should enable patients to navigate the often complex pathways and treatment choices better, and to improve the evaluation of a patient’s care needs through the application of holistic needs assessment. In addition, there is a specific recommendation to offer smoking cessation guidance where appropriate.

Focusing on muscle invasive bladder cancer (MIBC), what messages are there for the oncologist? The guideline proposes that, wherever possible, patients with suspected MIBC at initial diagnostic flexible cystoscopy should have pre-transurethral resection pelvic imaging with computed tomography or magnetic resonance imaging. There is a further recommendation that patients should be considered for a FDG-positron emission tomography-computed tomography scan if they have extravesical (T3B) or more advanced localised disease or suspicious/equivocal findings on standard cross-sectional imaging. The guideline strongly recommends the use of neoadjuvant chemotherapy before radical treatment of MIBC. Adjuvant chemotherapy is only recommended in exceptional circumstances where neoadjuvant chemotherapy could not have been delivered due to patient-specific factors. These patients should be given a fair choice between cystectomy and radiotherapy for definitive local treatment. If radiotherapy is used, radiosensitisation is recommended with chemotherapy or carbogen and nicotinamide as the main options. After the radical treatment of MIBC the guideline provides advice regarding surveillance for local (where the bladder is preserved), regional (upper tract) and distant relapse. This recommendation should help to harmonise services.

For patients with metastatic bladder cancer, cisplatin-based chemotherapy is recommended for those fit enough to receive it and carboplatin-based therapy for those who have contraindications to cisplatin but are still fit enough for chemotherapy. Recommendations for those who relapse after first-line treatment were more difficult to formulate, but the guideline suggests consideration of further treatment with the same chemotherapy (if there is a reasonable disease-free interval) or alternative chemotherapy in those who remain fit. For patients with intractable local symptoms, the guideline proposes the use of palliative hypofractionated radiotherapy and the need for specialist palliative care support within the multidisciplinary team.

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For those managing non-muscle invasive bladder cancer (NMIBC) there are important recommendations regarding assessment (including risk classification), initial and subsequent management, including the application of intravesical treatment. In particular, follow-up of patients with NMIBC places a heavy burden on National Health Service resources. The guideline attempts to standardise this follow-up in a cost-effective way with research recommendations to encourage the exploration of novel biomarkers.

The evidence base for the management of bladder cancer is poor relative to many other cancers of similar or lower incidence. This guideline focuses on the implementation of evidence-based medicine where possible, but using a consensus approach where good evidence is currently unavailable. Where the need for better evidence is particularly great, then a limited number of research recommendations have also been made. It is hoped that these recommendations will drive the National Health Service research agenda in bladder cancer in the coming years.

The guideline provides an excellent review of the current available evidence for the management of patients with bladder cancer. It is hoped that the implementation of these recommendations will improve the overall care for patients with bladder cancer and will go a long way in achieving the aims in improving patient care and outcomes. In addition to providing a uniform approach to the assessment and management of patients with this disease, these guidelines will probably drive the need for more specialised services designed specifically to meet the needs of people affected by bladder cancer.

Conflict of Interest

The authors were oncology members of the NICE bladder cancer guideline development group.

Reference