NCCN Guidelines Version 1.2013
Bladder Cancer

CLINICAL STAGING

Radical cystectomy and strongly consider neoadjuvant cisplatin-based combination chemotherapy (category 1)

or

Segmental (partial) cystectomy (highly selected patients with solitary lesion in a suitable location; no Tis) and consider neoadjuvant cisplatin-based combination chemotherapy

or

Bladder preservation following maximal TURBT with concurrent chemotherapy + RT (category 2B)

or

For patients with extensive comorbid disease or poor performance status: TURBT alone or RT + chemotherapy or Chemotherapy alone

PRIMARY TREATMENT

ADJUVANT TREATMENT

Consider adjuvant chemotherapy (category 2B) based on pathologic risk (pT3-4, positive nodes) if no neoadjuvant treatment given

Consider adjuvant RT (category 2B) or chemotherapy (category 2B) based on pathologic risk (pT3-4, positive nodes, positive margin, high-grade) if no neoadjuvant treatment given

Evaluate after 40-50 Gy, at completion of RT, or at 3 mo with:

- Cystoscopy, prior tumor site rebiopsy or TURBT, cytology, and imaging of abdomen/pelvis

No tumor

- Consider adjuvant chemotherapy

(cancer present)

Resectable

Cystectomy (preferred)

Unresectable or not a surgical candidate

Consider completion of RT with alternative radiosensitizing chemotherapy and/or alternative chemotherapy

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

See Principles of Surgical Management (BL-A).

See Principles of Chemotherapy Management (BL-G).

See Principles of Radiation Management of Invasive Disease (BL-H).

There are data to support equivalent survival rates, but not uniform consensus about the role of these approaches. Not all institutions have experience with these multidisciplinary treatment approaches, which require a dedicated team.

See Follow-up After Cystectomy (BL-E).