

EAU Guidelines on Non-muscle-invasive Bladder Cancer (TaT1 and CIS)

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1. INTRODUCTION

1.1 Aim and scope

This overview represents the updated European Association of Urology (EAU) Guidelines for Non-muscle-invasive Bladder Cancer (NMIBC), TaT1 and carcinoma *in situ* (CIS). The information presented is limited to urothelial carcinoma, unless specified otherwise. The aim is to provide practical recommendations on the clinical management of NMIBC with a focus on clinical presentation and recommendations.

Separate EAU Guidelines documents are available addressing upper tract urothelial carcinoma (UTUC) [1], muscle-invasive and metastatic bladder cancer (MIBC) [2] and primary urethral carcinoma [3]. It must be emphasised that clinical guidelines present the best evidence available to the experts, but following guideline recommendations will not necessarily result in the best outcome. Guidelines can never replace clinical expertise when making treatment decisions for individual patients, but rather help to focus decisions - also taking personal values and references/individual circumstances of patients into account. Guidelines are not mandates and do not purport to be a legal standard of care.

1.2 Panel composition

The EAU Guidelines Panel on NMIBC consists of an international multidisciplinary group of clinicians, including urologists, uro-oncologists, a pathologist, and a statistician. Members of this Panel have been selected based on their expertise and to represent the professionals treating patients suspected of suffering from bladder cancer. In the course of 2021 two patient representatives have formally joined the NMIBC Panel. All experts involved in the production of this document have submitted potential conflict of interest statements which can be viewed on the EAU website Uroweb: <https://uroweb.org/guideline/non-muscle-invasive-bladder-cancer/>.

1.3 Available publications

A quick reference document (Pocket guidelines) is available, both in print and as an app for iOS and Android devices. These are abridged versions which may require consultation together with the full text version. Several scientific publications are available, the latest publication dating to 2022 [4], as are a number of translations of all versions of the EAU NMIBC Guidelines. All documents are accessible through the EAU website Uroweb: <https://uroweb.org/guideline/non-muscle-invasive-bladder-cancer/>.

1.4 Publication history and summary of changes

1.4.1 Publication history

The EAU Guidelines on Bladder Cancer were first published in 2000. This 2022 NMIBC Guidelines document presents a limited update of the 2021 publication.

1.4.2 Summary of changes

Additional data has been included throughout this document text. In particular in Chapters/Sections:

- 5.4 Imaging – with the introduction of Vesical Imaging-Reporting and Data System [VI-RADS]).
- 5.7.3 Surveillance of non-muscle-invasive bladder cancer – inclusion of urine biomarkers in a surveillance strategy of an individual patient.
- 5.8 Cystoscopy – inclusion of the procedural chance ('bag squeeze'). The recommendation was amended accordingly.

| Recommendations | Strength rating |
|---|-----------------|
| In men, use a flexible cystoscope, if available and apply irrigation 'bag squeeze' to decrease procedural pain when passing the proximal urethra. | Strong |

- 5.10.2.2 Evaluation of resection quality, resulting in a recommendation change.

| Recommendations | Strength rating |
|--|-----------------|
| Performance of individual steps | |
| Take biopsies from abnormal-looking urothelium. Biopsies from normal-looking mucosa (mapping biopsies from the trigone, bladder dome, right, left, anterior and posterior bladder wall) are recommended if cytology or urinary molecular marker test is positive. If the equipment is available, perform fluorescence-guided (PDD) biopsies. | Strong |

- 7.2.1.3.2 Device-assisted intravesical chemotherapy - *Microwave-induced hyperthermia effect (RITE)*
- New section 7.3 Chemoablation and neoadjuvant treatment was added.
- 7.6.3 Treatment of BCG unresponsive tumours, late BCG-relapsing tumours, low-grade (LG) recurrences after BCG treatment and patients with BCG intolerance, two recommendations were amended.

| General recommendations | Strength rating |
|---|-----------------|
| In patients with high-risk tumours, full-dose intravesical bacillus Calmette-Guérin (BCG) for one to three years (induction plus 3-weekly instillations at 3, 6, 12, 18, 24, 30 and 36 months), is indicated. The additional beneficial effect of the second and third years of maintenance should be weighed against its added costs, side effects and problems connected with BCG shortage. Immediate radical cystectomy (RC) may also be discussed with the patient. | Strong |
| In patients with very high-risk tumours offer immediate RC. Intravesical full-dose BCG instillations for one to three years to those who refuse or are unfit for RC. | Strong |

7.8 Guidelines for the treatment of TaT1 tumours and carcinoma *in situ* according to risk stratification

| Recommendations | Strength rating |
|---|-----------------|
| <i>EAU risk group: High</i> | |
| Offer intravesical full-dose BCG instillations for one to 3 years or discuss immediate radical cystectomy (RC). | Strong |

- Chapter 8 – Additional information on imaging modalities and urinary markers.

2. METHODS

2.1 Data Identification

For the 2022 NMIBC Guidelines, new and relevant evidence has been identified, collated, and appraised through a structured assessment of the literature.

A broad and comprehensive scoping exercise covering all areas of the NMIBC Guidelines was performed. Excluded from the search were basic research studies, case series, reports, and editorial comments. Only articles published in the English language, addressing adults, were included. The search was restricted to articles published between May 29th 2020 and June 3rd 2021. Databases covered by the search included Pubmed, Ovid, EMBASE and the Cochrane Central Register of Controlled Trials and the Cochrane Database of Systematic Reviews. After deduplication, a total of 1,463 unique records were identified, retrieved, and screened for relevance.

A total of 40 new references were added to the 2022 NMIBC Guidelines. A detailed search strategy is available online: <https://uroweb.org/guideline/non-muscle-invasive-bladder-cancer/?type=appendices-publications>.

For Chapters 3 through 6 (Epidemiology, Aetiology and Pathology, Staging and Classification systems, Diagnosis, Predicting disease recurrence and progression) the references used in this text were assessed according to their level of evidence (LE) based on the 2009 Oxford Centre for Evidence-Based Medicine (CEBM) Levels of Evidence [5]. For the Disease Management and Follow-up chapters (Chapters 7 and 8) a system modified from the 2009 CEBM levels of evidence was used [5].

For each recommendation within the guidelines there is an accompanying online strength rating form based on a modified GRADE methodology [6, 7]. Each strength rating form addresses a number of key elements namely:

1. the overall quality of the evidence which exists for the recommendation [5];
2. the magnitude of the effect (individual or combined effects);
3. the certainty of the results (precision, consistency, heterogeneity and other statistical or study related factors);
4. the balance between desirable and undesirable outcomes;
5. the impact of patient values and preferences on the intervention;
6. the certainty of those patient values and preferences.

These key elements are the basis which panels use to define the strength rating of each recommendation. The strength of each recommendation is represented by the words 'strong' or 'weak' [8]. The strength of each recommendation is determined by the balance between desirable and undesirable consequences of alternative management strategies, the quality of the evidence (including certainty of estimates), and nature and variability of patient values and preferences.

Additional information can be found in the general Methodology section of this print, and online at the EAU website; <http://www.uroweb.org/guideline/>. A list of associations endorsing the EAU Guidelines can also be viewed online at the above address.

2.2 Review

The 2021 publication was peer reviewed prior to print.

2.3 Future goals

The findings of the ongoing 'Individual Patient Data Validation of the Definition of bacillus Calmette-Guérin (BCG) Failure/BCG Unresponsive in Patients with Non-muscle Invasive Urothelial Carcinoma of the Bladder: an international multicentre retrospective study' will be included in the future update of the NMIBC Guidelines.

3. EPIDEMIOLOGY, AETIOLOGY AND PATHOLOGY

3.1 Epidemiology

Bladder cancer (BC) is the seventh most commonly diagnosed cancer in the male population worldwide, while it drops to tenth when both genders are considered [9]. The worldwide age-standardised incidence rate (per 100,000 person/years) is 9.5 in men and 2.4 in women [9]. In the European Union the age-standardised incidence rate is 20 for men and 4.6 for women [9].

Worldwide, the BC age-standardised mortality rate (per 100,000 person/years) was 3.3 for men vs. 0.86 for women [9]. Bladder cancer incidence and mortality rates vary across countries due to differences in risk factors, detection and diagnostic practices, and availability of treatments. The variations are, however, partly caused by the different methodologies used and the quality of data collection [10]. The incidence and mortality of BC has decreased in some registries, possibly reflecting the decreased impact of causative agents [11].

Approximately 75% of patients with BC present with a disease confined to the mucosa (stage Ta, CIS) or submucosa (stage T1); in younger patients (< 40 years of age) this percentage is even higher [12]. Patients with TaT1 and CIS have a high prevalence due to long-term survival in many cases and lower risk of cancer-specific mortality compared to T2-4 tumours [9, 10].

3.2 Aetiology

Tobacco smoking is the most important risk factor for BC, accounting for approximately 50% of cases [10, 11, 13-15] (LE: 3). The risk of BC increases with smoking duration and smoking intensity [14]. Low-tar cigarettes are not associated with a lower risk of developing BC [14]. The risk associated with electronic cigarettes is not adequately assessed; however, carcinogens have been identified in urine [16]. Environmental exposure to tobacco smoke is also associated with an increased risk of BC [10]. Tobacco smoke contains aromatic amines and polycyclic aromatic hydrocarbons, which are renally excreted.

Occupational exposure to aromatic amines, polycyclic aromatic hydrocarbons and chlorinated hydrocarbons is the second most important risk factor for BC, accounting for about 10% of all cases. This type of occupational exposure occurs mainly in industrial plants which process paint, dye, metal, and petroleum products [10, 11, 17, 18]. In developed industrial settings these risks have been reduced by work-safety guidelines; therefore, chemical workers no longer have a higher incidence of BC compared to the general population [10, 17, 18]. Recently, greater occupational exposure to diesel exhaust has been suggested as a significant risk factor (odds ratio [OR]: 1.61; 95% confidence interval [CI]: 1.08–2.40) [19].

While family history seems to have little impact [20] and, to date, no overt significance of any genetic variation for BC has been shown; genetic predisposition has an influence on the incidence of BC via its impact on susceptibility to other risk factors [10, 21-25]. This has been suggested to lead to familial clustering of BC with an increased risk for first- and second-degree relatives (hazard ratio [HR]: 1.69; 95% CI: 1.47–1.95) [26].

Although the impact of drinking habits is uncertain, the chlorination of drinking water and subsequent levels of trihalomethanes are potentially carcinogenic, also exposure to arsenic in drinking water

increases risk [10, 27] (LE: 3). Arsenic intake and smoking have a combined effect [28]. The association between personal hair dye use and risk remains uncertain; an increased risk has been suggested in users of permanent hair dyes with a slow NAT2 acetylation phenotype [10] but a large prospective cohort study could not identify an association between hair dye and risk of most cancer and cancer-related mortality [29]. Dietary habits seem to have limited impact, recently protective impact of flavonoids has been suggested and a Mediterranean diet, characterised by a high consumption of vegetables and non-saturated fat (olive oil) and moderate consumption of protein, was linked to some reduction of BC risk (HR: 0.85, 95% CI: 0.77–0.93) [30–35]. The impact of an increased consumption of fruits has been suggested to reduce the risk of BC; to date, this effect has been demonstrated to be significant in women only (HR: 0.92; 95% CI: 0.85–0.99) [36].

Exposure to ionizing radiation is connected with increased risk; a weak association was also suggested for cyclophosphamide and pioglitazone [10, 27, 37] (LE: 3). The impact of metabolic factors (body mass index, blood pressure, plasma glucose, cholesterol, and triglycerides) is uncertain [38]. Schistosomiasis, a chronic endemic cystitis based on recurrent infection with a parasitic trematode, is also a cause of BC [10] (LE: 3).

3.3 Pathology

The information presented in this text is limited to urothelial carcinoma, unless otherwise specified.

3.4 Summary of evidence for epidemiology, aetiology, and pathology

| Summary of evidence | LE |
|--|----|
| Worldwide, bladder cancer (BC) is the tenth most commonly diagnosed cancer. | 2a |
| Several risk factors connected with the risk of BC diagnosis have been identified. | 3 |
| Tobacco smoking is the most important risk factor for BC. | 3 |

4. PATHOLOGICAL STAGING AND CLASSIFICATION SYSTEMS

4.1 Definition of non-muscle-invasive bladder cancer

Tumours confined to the mucosa and invading the lamina propria are classified as stage Ta and T1, respectively, according to the Tumour, Node, Metastasis (TNM) classification system [39]. Intra-epithelial, high-grade (HG) tumours confined to the mucosa are classified as CIS (Tis). All of these tumours can be treated by transurethral resection of the bladder (TURB), eventually in combination with intravesical instillations and are therefore grouped under the heading of NMIBC for therapeutic purposes. The term ‘Non-muscle-invasive BC’ represents a group definition and all tumours should be characterised according to their stage, grade, and further pathological characteristics (see Sections 4.5 and 4.7 and the International Collaboration on Cancer Reporting website: <http://www.iccr-cancer.org/datasets/published-datasets/urinary-male-genital/bladder>). The term ‘superficial BC’ should no longer be used as it is incorrect.

4.2 Tumour, Node, Metastasis Classification (TNM)

The latest TNM classification approved by the Union International Contre le Cancer (UICC) (8th Edn.) is referred to (Table 4.1) [39].

Table 4.1: 2017 TNM classification of urinary bladder cancer

| T - Primary tumour | |
|--------------------|--|
| TX | Primary tumour cannot be assessed |
| T0 | No evidence of primary tumour |
| Ta | Non-invasive papillary carcinoma |
| Tis | Carcinoma <i>in situ</i> : ‘flat tumour’ |
| T1 | Tumour invades subepithelial connective tissue |
| T2 | Tumour invades muscle |
| T2a | Tumour invades superficial muscle (inner half) |
| T2b | Tumour invades deep muscle (outer half) |

| | |
|---------------------------------|--|
| T3 | Tumour invades perivesical tissue T3a Microscopically T3b Macroscopically (extravesical mass) |
| T4 | Tumour invades any of the following: prostate stroma, seminal vesicles, uterus, vagina pelvic wall, abdominal wall T4a Tumour invades prostate stroma, seminal vesicles, uterus or vagina T4b Tumour invades pelvic wall or abdominal wall |
| N – Regional lymph nodes | |
| NX | Regional lymph nodes cannot be assessed |
| N0 | No regional lymph node metastasis |
| N1 | Metastasis in a single lymph node in the true pelvis (hypogastric, obturator, external iliac, or presacral) |
| N2 | Metastasis in multiple regional lymph nodes in the true pelvis (hypogastric, obturator, external iliac, or presacral) |
| N3 | Metastasis in common iliac lymph node(s) |
| M - Distant metastasis | |
| M0 | No distant metastasis |
| M1a | Non-regional lymph nodes |
| M1b | Other distant metastases |

4.3 T1 subclassification

The depth and extent of invasion into the lamina propria (T1 sub-staging) has been demonstrated to be of prognostic value in retrospective cohort studies [40, 41] (LE: 3). Its use is recommended by the most recent 2016 World Health Organization (WHO) classification [42]. T1 sub-staging methods are based either on micrometric (T1e and T1m) or histo-anatomic (T1a and T1b) principles; the optimal classification system, however, remains to be defined [42, 43].

4.4 Carcinoma *in situ* and its classification

Carcinoma *in situ* is a flat, HG, non-invasive urothelial carcinoma. It can be missed or misinterpreted as an inflammatory lesion during cystoscopy if not biopsied. Carcinoma *in situ* is often multifocal and can occur in the bladder, but also in the upper urinary tract (UUT), prostatic ducts, and prostatic urethra [44].

From a clinical point of view, CIS may be classified as [45]:

- Primary: isolated CIS with no previous or concurrent papillary tumours and no previous CIS;
- Secondary: CIS detected during follow-up of patients with a previous tumour that was not CIS;
- Concurrent: CIS in the presence of any other urothelial tumour in the bladder.

4.5 Histological grading of non-muscle-invasive bladder urothelial carcinomas

4.5.1 Types of histological grading systems

In 2004 the WHO published a histological classification system for urothelial carcinomas including papillary urothelial neoplasm of low malignant potential (PUNLMP), non-invasive papillary carcinoma low grade (LG) and HG. This system was also taken into the updated 2016 WHO classification and will be maintained in the upcoming WHO 2022. It provides a different patient stratification between individual categories compared to the older 1973 WHO classification, which distinguished between grade 1 (G1), grade 2 (G2) and grade 3 (G3) categories [42, 46].

There is a significant shift of patients between the categories of the WHO 1973 and the WHO 2004/2016 systems (see Figure 4.1), for example an increase in the number of HG patients (WHO 2004/2016) due to inclusion of a subset of G2 patients with a favourable prognosis compared to the G3 category (WHO 1973) [47]. According to a multi-institutional individual patient data (IPD) analysis, the proportion of tumours classified as PUNLMP (WHO 2004/2016) has decreased to very low levels in the last decade [48].

4.5.2 Prognostic value of histological grading

A systematic review and meta-analysis did not show that the 2004/2016 classification outperforms the 1973 classification in prediction of recurrence and progression [47] (LE: 2a).

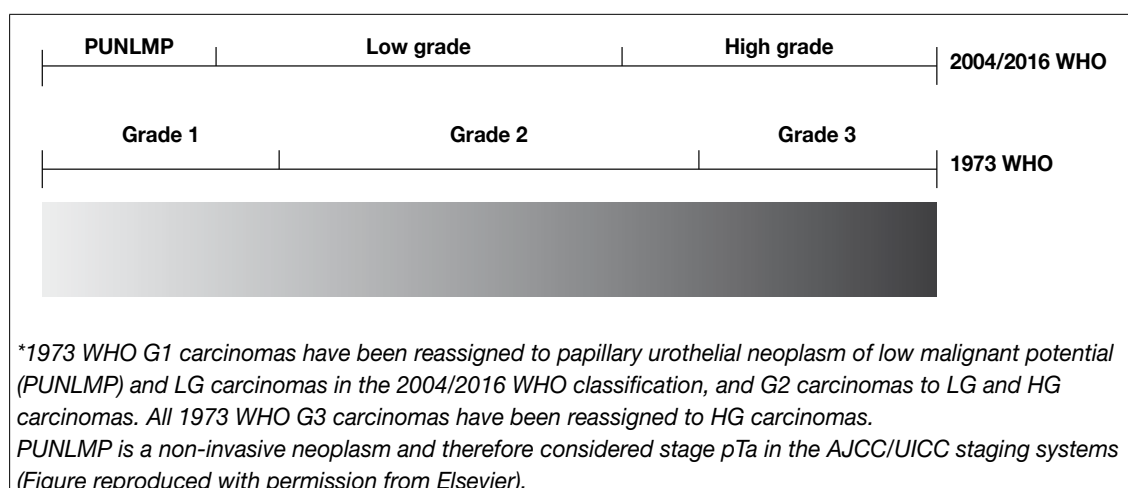
To compare the prognostic value of both WHO classifications, an IPD analysis of 5,145 primary TaT1 NMIBC patients from 17 centres throughout Europe and Canada was conducted. Patients had a transurethral resection of bladder tumour (TURBT) followed by intravesical instillations at the physician's discretion. In this large prognostic factor study, the WHO 1973 and the WHO 2004/2016 were both prognostic for progression but not for recurrence. When compared, the WHO 1973 was a stronger prognosticator of progression in TaT1 NMIBC than the WHO 2004/2016. However, a 4-tier combination LG/G1, LG/G2, HG/G2 and HG/G3 of both classification systems proved to be superior to either classification system alone, as it divides the large group of G2 patients into two subgroups (LG/HG) with different prognoses [49].

In a subgroup of 3,311 patients with primary Ta bladder tumours, a similar prognosis was found for PUNLMP and Ta LG carcinomas [50]. Hence, these results do not support the continued use of PUNLMP as a separate grade category in the WHO 2004/2016.

4.5.3 Clinical application of histological grading systems

- The WHO 2016 classification system is currently supported by the WHO for clinical application, nevertheless, the WHO 1973 is still being used by some pathologists.
- The most important parameters, which must be considered for clinical application of any grading system are its inter-observer reproducibility and prognostic value (see Sections 4.5.1 and 4.6).
- To facilitate the clinical utilisation in daily practice, these guidelines provide recommendations for tumours classified by both classification systems.

Figure 4.1: Stratification of tumours according to grade in the WHO 1973 and 2004/2016 classifications [51]*



4.6 Inter- and intra-observer variability in staging and grading

There is significant variability among pathologists for the diagnosis of CIS, for which agreement is achieved in only 70–78% of cases [52] (LE: 2a). There is also inter-observer variability in the classification of stage T1 vs. Ta tumours and tumour grading in both the 1973 and 2004/2016 classifications. The general conformity between pathologists in staging and grading is 50–60% [53–56] (LE: 2a). The WHO 2004/2016 classification provides slightly better reproducibility than the 1973 classification [47].

4.7 Subtypes of urothelial carcinoma and lymphovascular invasion

Currently the following differentiations of urothelial carcinoma are used [57, 58]:

1. urothelial carcinoma (more than 90% of all cases);
2. urothelial carcinomas with partial squamous and/or glandular or trophoblastic differentiation;
3. micropapillary urothelial carcinoma;
4. nested variant (including large nested variant) and microcystic urothelial carcinoma;
5. plasmacytoid, giant cell, signet ring, diffuse, undifferentiated;
6. lymphoepithelioma-like;
7. small-cell carcinomas;
8. sarcomatoid urothelial carcinoma;
9. neuroendocrine variant of urothelial carcinoma;
10. some urothelial carcinomas with other rare differentiations.

Most variants of urothelial carcinoma have a worse prognosis than pure HG urothelial carcinoma [2, 59–66] (LE: 3).

The presence of lymphovascular invasion (LVI) in TURB specimens is associated with an increased risk of pathological upstaging and worse prognosis [67–71] (LE: 3).

4.8 Tumour markers and molecular classification

Tumour markers and their prognostic role have been investigated [72–76]. These methods, in particular complex approaches such as the stratification of patients based on molecular classification, are promising but are not yet suitable for routine application [43, 77, 78].

4.9 Summary of evidence and guidelines for bladder cancer classification

| Summary of evidence | LE |
|--|----|
| The depth of invasion (staging) is classified according to the TNM classification. | 2a |
| Tumours confined to the mucosa and invading the lamina propria are classified as stage Ta and T1, respectively. Flat, high-grade tumours that are confined to the mucosa are classified as CIS (Tis). | 2a |
| Histological grading of urothelial NMIBC is classified according to the WHO 1973 (G1–G3) and/or the WHO 2004/2016 (PUNLMP, LG/HG) systems. | 2a |
| Both the WHO 1973 and the 2004/2016 classification systems are prognostic for progression, but not for recurrence. | 2a |
| The WHO 1973 is a stronger prognosticator of progression in TaT1 NMIBC than the WHO 2004/2016. However, a 4-tier combination (LG/G1, LG/G2, HG/G2 and HG/G3) of both classification systems proved to be superior to either classification system alone. | 2a |
| The WHO 2004/2016 classification provides better reproducibility than the 1973 classification. | 2a |
| PUNLMP lesions have the same prognosis as Ta LG carcinomas. | 2a |

| Recommendations | Strength rating |
|---|-----------------|
| Use the 2017 TNM system for classification of the depth of tumour invasion (staging). | Strong |
| Use both the 1973 and 2004/2016 WHO classification systems. | Weak |
| Do not use the term 'superficial' bladder cancer. | Strong |

5. DIAGNOSIS

5.1 Patient history

A focused patient history is mandatory.

5.2 Signs and symptoms

Haematuria is the most common finding in NMIBC. Visible haematuria was found to be associated with higher-stage disease compared to nonvisible haematuria [79]. Carcinoma *in situ* might be suspected in patients with lower urinary tract symptoms, especially irritative voiding symptoms.

5.3 Physical examination

A focused urological examination is mandatory although it does not reveal NMIBC.

5.4 Imaging

5.4.1 Computed tomography urography and intravenous urography

Computed tomography (CT) urography is used to detect papillary tumours in the urinary tract, indicated by filling defects and/or hydronephrosis [80].

Intravenous urography (IVU) is an alternative if CT is not available [81] (LE: 2b), but particularly in muscle-invasive tumours of the bladder and in UTUCs, CT urography provides more information (including status of lymph nodes and neighbouring organs).

The necessity to perform a baseline CT urography once a bladder tumour has been detected is questionable due to the low incidence of significant findings which can be obtained [82-84] (LE: 2b). The incidence of UTUCs is low (1.8%), but increases to 7.5% in tumours located in the trigone [83] (LE: 2b). The risk of UTUC during follow-up increases in patients with multiple and high-risk tumours [85] (LE: 2b).

5.4.2 Ultrasound

Ultrasound (US) may be performed as an adjunct to physical examination as it has moderate sensitivity to a wide range of abnormalities in the upper- and lower urinary tract. It permits characterisation of renal masses, detection of hydronephrosis, and visualisation of intraluminal masses in the bladder, but cannot rule out all potential causes of haematuria [86, 87] (LE: 3). It cannot reliably exclude the presence of UTUC and cannot replace CT urography.

5.4.3 **Multi-parametric magnetic resonance imaging**

The role of multi-parametric magnetic resonance imaging (mpMRI) has not yet been established in BC diagnosis and staging. A standardised methodology of MRI reporting (Vesical Imaging-Reporting and Data System [VI-RADS]) in patients with BC has recently been published and requires further validation [88]. A first systematic review of 8 studies showed that the VI-RADS scoring system can accurately differentiate NMIBC from MIBC with high inter-observer agreement rates [89].

A diagnosis of CIS cannot be made with imaging methods alone (CT urography, IVU, US or MRI) (LE: 4).

5.5 **Urinary cytology**

The examination of voided urine or bladder-washing specimens for exfoliated cancer cells has high sensitivity in HG and G3 tumours (84%), but low sensitivity in LG/G1 tumours (16%) [90]. The sensitivity in CIS detection is 28–100% [91] (LE: 1b). Cytology is useful, particularly as an adjunct to cystoscopy, in patients with HG/G3 tumours. Positive voided urinary cytology can indicate an urothelial carcinoma anywhere in the urinary tract; negative cytology, however, does not exclude its presence.

Cytological interpretation is user-dependent [92, 93]. Evaluation can be hampered by low cellular yield, urinary tract infections, stones, or intravesical instillations, however, in experienced hands specificity exceeds 90% [92] (LE: 2b).

A standardised reporting system known as The Paris System published in 2016 redefined urinary cytology diagnostic categories as follows [94]:

- No adequate diagnosis possible (No diagnosis);
- Negative for urothelial carcinoma (Negative);
- Atypical urothelial cells (Atypia);
- Suspicious for HG urothelial carcinoma (Suspicious);
- High-grade/G3 urothelial carcinoma (Malignant).

The principle of the system and its terminology underlines the role of urinary cytology in detection of G3 and HG tumours. The Paris system for reporting urinary cytology has been validated in several retrospective studies [95, 96].

Urine collection should respect the recommendation provided in Section 5.9. One cytospin slide from the sample is usually sufficient [97]. In patients with suspicious cytology repeat investigation is advised [98] (LE: 2b).

5.6 **Urinary molecular marker tests**

Driven by the low sensitivity of urine cytology, numerous urinary tests have been developed [99]. None of these markers have been accepted as routine practice by any clinical guidelines for diagnosis or follow-up.

The following conclusions can be drawn regarding the existing tests:

- Sensitivity is usually higher at the cost of lower specificity compared to urine cytology [100-105] (LE: 3).
- Benign conditions and previous BCG instillations may influence the results of many urinary marker tests [100-102] (LE: 1b).
- Requirements for sensitivity and specificity of a urinary marker test largely depend on the clinical context of the patient (screening, primary detection, follow-up [high-risk, low/intermediate-risk]) [101, 102] (LE: 3).
- The wide range in performance of the markers and low reproducibility may be explained by patient selection and complicated laboratory methods required [102, 103, 106-113].
- Positive results of cytology, UroVysion (FISH), Nuclear Matrix Protein (NMP)22®, *Fibroblast Growth Factor Receptor (FGFR)3/Telomerase Reverse Transcriptase (TERT)* and microsatellite analysis in patients with negative cystoscopy and upper tract work-up, may identify patients more likely to experience disease recurrence and possibly progression [107, 109, 112-117] (LE: 2b).
- Promising novel urinary biomarkers, assessing multiple targets, have been tested in prospective multicentre studies [106, 108, 112, 118-121].

5.7 **Potential application of urinary cytology and markers**

The following objectives of urinary cytology or molecular tests must be considered.

5.7.1 **Screening of the population at risk of bladder cancer**

The application of haematuria dipstick, followed by *FGFR3*, NMP22® or UroVysion tests if dipstick is positive has been reported in BC screening in high-risk populations [122, 123]. The low incidence of BC in the general population and the short lead-time impair feasibility and cost-effectiveness [115, 123]. Routine screening for BC is not recommended [115, 122, 123].

5.7.2 **Exploration of patients after haematuria or other symptoms suggestive of bladder cancer (primary detection)**

It is generally accepted that none of the currently available tests can replace cystoscopy. However, urinary cytology or biomarkers can be used as an adjunct to cystoscopy to detect missed tumours, particularly CIS. In this setting, specificity is particularly important.

5.7.3 **Surveillance of non-muscle-invasive bladder cancer**

Research has been carried out into the usefulness of urinary cytology vs. markers in the follow-up of NMIBC [106, 107, 119, 120, 124].

5.7.3.1 *Follow-up of high-risk non-muscle-invasive bladder cancer*

High-risk tumours should be detected early in follow-up and the percentage of tumours missed should be as low as possible. Therefore, the best surveillance strategy for these patients will continue to include cystoscopy and cytology (see Chapter 8).

5.7.3.2 *Follow-up of low/intermediate-risk non-muscle-invasive bladder cancer*

To reduce the number of cystoscopy procedures, urinary markers should be able to detect recurrence before the tumours are large, numerous and muscle invasive. The limitation of urinary cytology and current urinary markers is their low sensitivity for LG recurrences [101, 107] (LE: 1b).

According to current knowledge, no urinary marker can replace cystoscopy during follow-up or lower cystoscopy frequency in a routine fashion. One prospective randomised study (RCT) found that knowledge of positive test results (microsatellite analysis) can improve the quality of follow-up cystoscopy [125] (LE: 1b), supporting the adjunctive role of a non-invasive urine test performed prior to follow-up cystoscopy [125] (see Section 8.1).

Four of the promising and commercially available urine biomarkers, Cx-Bladder [106, 121], ADX-Bladder [118], Xpert Bladder [119] and EpiCheck [120], although not tested in RCTs, have such high sensitivities and negative predictive values in the referenced studies for HG disease that these biomarkers may approach the sensitivity of cystoscopy. These 4 tests might be used to replace and/or postpone cystoscopy as they may identify the rare HG recurrences occurring in low/intermediate NMIBC.

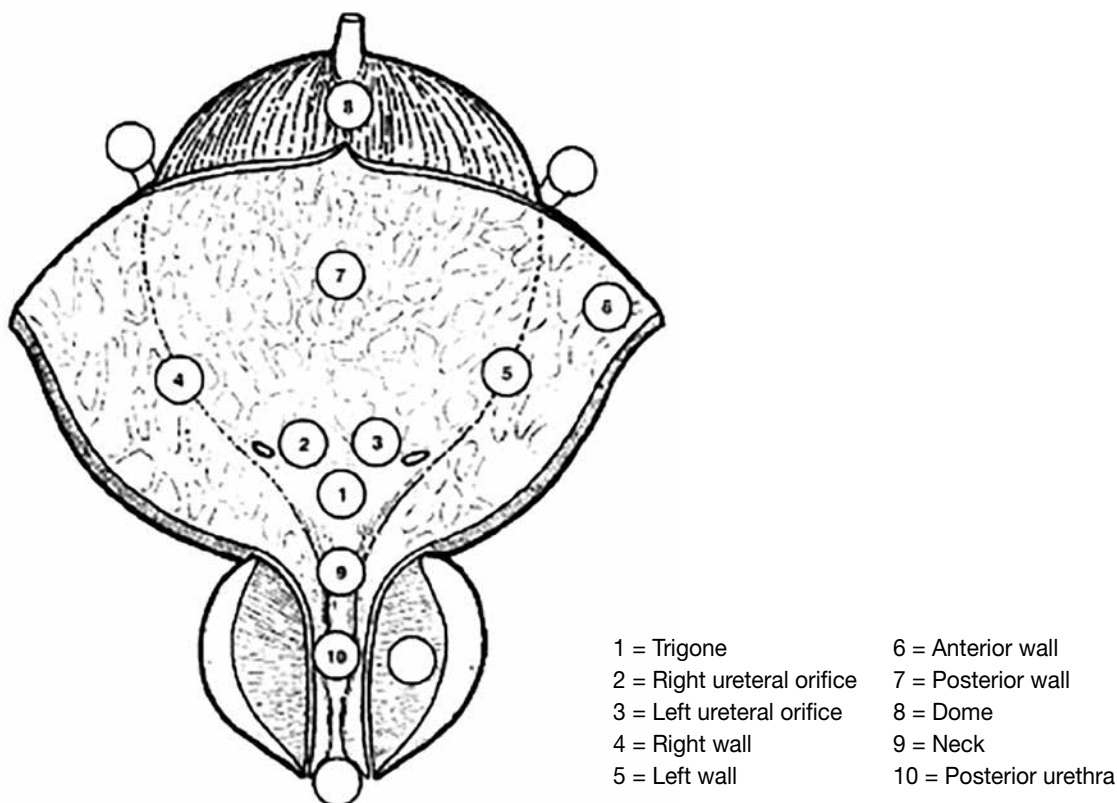
5.8 **Cystoscopy**

The diagnosis of papillary BC ultimately depends on cystoscopic examination of the bladder and histological evaluation of sampled tissue by either cold-cup biopsy or resection. Carcinoma *in situ* is diagnosed by a combination of cystoscopy, urine cytology, and histological evaluation of multiple bladder biopsies [126].

Cystoscopy is initially performed as an outpatient procedure. A flexible instrument with topical intraurethral anaesthetic lubricant instillation results in better compliance compared to a rigid instrument, especially in men [127, 128] (LE: 1b).

To temporarily increase the urethral pressure by irrigation 'bag squeeze' when passing membranous and prostatic urethra with a flexible cystoscope in males also decreases pain during the procedure [129, 130].

Figure 5.1: Bladder diagram



5.9 Summary of evidence and guidelines for the primary assessment of non-muscle-invasive bladder cancer

| Summary of evidence | LE |
|--|----|
| Cystoscopy is necessary for the diagnosis of BC. | 1 |
| Urinary cytology has high sensitivity in high-grade tumours including carcinoma <i>in situ</i> | 2b |

| Recommendations | Strength rating |
|--|-----------------|
| Take a patient history, focusing on urinary tract symptoms and haematuria. | Strong |
| Use renal and bladder ultrasound and/or computed tomography-intravenous urography (CT-IVU) during the initial work-up in patients with haematuria. | Strong |
| Once a bladder tumour has been detected, perform a CT urography in selected cases (e.g., tumours located in the trigone, multiple or high-risk tumours). | Strong |
| Perform cystoscopy in patients with symptoms suggestive of bladder cancer or during surveillance. It cannot be replaced by cytology or by any other non-invasive test. | Strong |
| In men, use a flexible cystoscope, if available and apply irrigation 'bag squeeze' to decrease procedural pain when passing the proximal urethra. | Strong |
| Describe all macroscopic features of the tumour (site, size, number, and appearance) and mucosal abnormalities during cystoscopy. Use a bladder diagram (Figure 5.1). | Strong |
| Use voided urine cytology as an adjunct to cystoscopy to detect high-grade tumour. | Strong |
| Perform cytology on at least 25 mL fresh urine or urine with adequate fixation. Morning urine is not suitable because of the frequent presence of cytolysis. | Strong |
| Use the Paris System for cytology reporting. | Strong |

5.10 Transurethral resection of TaT1 bladder tumours

5.10.1 Strategy of the procedure

The goal of TURB in TaT1 BC is to make the correct diagnosis and completely remove all visible lesions. It is a crucial procedure in the management of BC. Transurethral resection of the bladder should be performed systematically in individual steps [131, 132] (see Section 5.14).

The operative steps necessary to achieve a successful TURB include identifying the factors required to

assign disease risk (number of tumours, size, multifocality, characteristics, concern for the presence of CIS, recurrent vs. primary tumour), clinical stage (bimanual examination under anaesthesia, assignment of clinical tumour stage), adequacy of the resection (visually complete resection, visualisation of muscle at the resection base), and presence of complications (assessment for perforation) [132, 133]. To measure the size of the largest tumour, one can use the end of cutting loop, which is approximately 1 cm wide, as a reference. The characteristics of the tumour are described as sessile, nodular, papillary, or flat.

5.10.2 **Surgical and technical aspects of tumour resection**

5.10.2.1 *Surgical strategy of resection (piecemeal/separate resection, en-bloc resection)*

A complete resection, performed by either fractioned or *en-bloc* technique, is essential to achieve a good prognosis [131, 134].

- Piecemeal resection in fractions (separate resection of the exophytic part of the tumour, the underlying bladder wall and the edges of the resection area) provides good information about the vertical and horizontal extent of the tumour [135] (LE: 2b).
- *En-bloc* resection using monopolar or bipolar current, Thulium-YAG or Holmium-YAG laser is feasible in selected exophytic tumours. It provides high-quality resected specimens with the presence of detrusor muscle in 96–100% of cases [131, 136–139] (LE: 1b).

The technique selected is dependent on the size and location of the tumour and experience of the surgeon.

5.10.2.2 *Evaluation of resection quality*

The absence of detrusor muscle in the specimen is associated with a significantly higher risk of residual disease, early recurrence, and tumour under-staging [140] (LE: 1b). The presence of detrusor muscle in the specimen is considered as a surrogate criterion of the resection quality and is required (except in Ta LG/G1 tumours). Surgical checklists and a quality performance indicator programmes have shown to increase surgical quality (detrusor muscle presence) and decrease recurrence rates [132, 133, 141, 142].

It has been shown that surgical experience can improve TURB results, which supports the role of teaching programmes [143]. Virtual training on simulators is an emerging approach [144]. Its role in the teaching process still needs to be established [132]. Surgical experience and/or volume has been associated both with risk of complications [145], recurrence [146] and survival [147] in retrospective studies (LE: 3).

5.10.2.3 *Monopolar and bipolar resection*

Compared to monopolar resection, bipolar resection has been introduced to reduce the risk of complications (e.g., bladder perforation due to obturator nerve stimulation) and to produce better specimens. Currently, the results remain controversial [148–151] as a systematic review of 13 RCTs (2,379 patients) showed no benefit of bipolar vs. monopolar TURB for efficacy and safety [151].

5.10.2.4 *Office-based fulguration and laser vaporisation*

In patients with a history of small, Ta LG/G1 tumours, fulguration, or laser vaporisation of small papillary recurrences on an outpatient basis can reduce the therapeutic burden [152, 153] (LE: 3). There are no prospective comparative studies assessing the oncological outcomes.

5.10.2.5 *Resection of small papillary bladder tumours at the time of transurethral resection of the prostate*

It is not uncommon to detect bladder tumours in men with benign prostatic hyperplasia. Provided these tumours are papillary by aspect, rather small and not extensively multifocal, it seems feasible to resect these tumours and continue with the resection of the prostate [154, 155]. Although high-quality evidence is limited, simultaneous TURB and TUR of the prostate does not appear to lead to any increased risk of tumour recurrence or progression [156].

5.10.3 **Bladder biopsies**

Carcinoma *in situ* can present as a velvet-like, reddish area, indistinguishable from inflammation, or it may not be visible at all. For this reason, biopsies from suspicious urothelium should be taken. In patients with positive urine cytology (see Section 5.5), and normal-looking mucosa at cystoscopy, mapping biopsies are recommended [157, 158]. To obtain representative mapping of the bladder mucosa, biopsies should be taken from the trigone, bladder dome, right, left, anterior and posterior bladder wall [157, 158]. If the equipment is available, photodynamic diagnosis (PDD) is a useful tool to target the biopsy.

5.10.4 **Prostatic urethral biopsies**

Involvement of the prostatic urethra and ducts in men with NMIBC has been reported. Palou *et al.* showed that in 128 men with T1G3 BC, the incidence of CIS in the prostatic urethra was 11.7% [159] (LE: 2b). The risk

of prostatic urethra or duct involvement is higher if the tumour is located at the trigone or bladder neck, in the presence of bladder CIS and multiple tumours [160] (LE: 3b). Based on this observation, a biopsy from the prostatic urethra is necessary in some cases (see recommendation in Section 5.14) [159, 161, 162].

5.11 New methods of tumour visualisation

As a standard procedure, cystoscopy and TURB are performed using white light. However, the use of white light can lead to missing lesions that are present but not visible, which is why new technologies are being developed.

5.11.1 *Photodynamic diagnosis (fluorescence cystoscopy)*

Photodynamic diagnosis is performed using violet light after intravesical instillation of 5-aminolaevulinic acid (ALA) or hexaminolaevulinic acid (HAL). It has been confirmed that fluorescence-guided biopsy and resection are more sensitive than conventional procedures for the detection of malignant tumours, particularly CIS [163, 164] (LE: 1a). In a systematic review and meta-analysis, PDD had higher sensitivity than white light endoscopy in the pooled estimates for analyses at both the patient-level (92% vs. 71%) and biopsy-level (93% vs. 65%) [164]. A prospective RCT did not confirm a higher detection rate in patients with known positive cytology before TURB [165].

Photodynamic diagnosis had lower specificity than white-light endoscopy (63% vs. 81%) [164]. False-positivity can be induced by inflammation or recent TURB and during the first 3 months after BCG instillation [166, 167] (LE: 1a).

The beneficial effect of ALA or HAL fluorescence cystoscopy on recurrence rate in patients with TURB was evaluated. A systematic review and analysis of 14 RCTs including 2,906 patients, 6 using 5-ALA and 9 HAL, demonstrated a decreased risk of BC recurrence in the short and long term. There were, however, no differences in progression and mortality rates. The analysis demonstrated inconsistency between trials and potential susceptibility to performance and publication bias [168] (LE: 1a).

One RCT has shown a reduction in recurrence and progression with fluorescence-guided TURB as compared to white light TURB [169]. In another RCT flexible HAL-cystoscopy proved beneficial in the outpatient setting showing subsequent lower recurrence rates [170]. These results need to be validated by further studies.

5.11.2 *Narrow-band imaging*

In narrow-band imaging (NBI), the contrast between normal urothelium and hyper-vascular cancer tissue is enhanced. Improved cancer detection has been demonstrated by NBI flexible cystoscopy and NBI-guided biopsies and resection [171-174] (LE: 3b). A RCT assessed the reduction of recurrence rates if NBI is used during TURB. Although the overall results of the study were negative, a benefit after 3 and 12 months was observed for low-risk tumours (pTa LG, < 30 mm, no CIS) [175] (LE: 1b).

5.11.3 *Additional technologies*

Confocal laser micro-endoscopy is a high resolution imaging probe designed to provide endoscopic histological grading in real time but requires further validation [176]. The Storz professional image enhancement system (IMAGE1 S, formally called SPIES) is an image enhancement system using 4 different light spectra but prospective data using this system are still limited [177].

5.12 Second resection

5.12.1 *Detection of residual disease and tumour upstaging*

The significant risk of residual tumour after initial TURB of TaT1 lesions has been demonstrated [134] (LE: 1b).

A systematic review analysing data of 8,409 patients with Ta or T1 HG BC demonstrated a 51% risk of persistence and an 8% risk of under-staging in T1 tumours. The analysis also showed a high risk of residual disease in Ta tumours, but this observation was based only on a limited number of cases. Most of the residual lesions were detected at the original tumour location [178] (LE: 1a).

Another meta-analysis of 3,556 patients with T1 tumours showed that the prevalence rate of residual tumours and upstaging to invasive disease after TURB remained high in a subgroup with detrusor muscle in the resection specimen. In the subgroup of 1,565 T1 tumours with detrusor muscle present, persistent tumour was found in 58% and under-staging occurred in 11% of cases [179].

Prospective trials suggest that post-operative positive urine cytology [180] and Xpert-test (urine mRNA test) [181] independently are associated with residual disease at second resection and risk of future recurrences, respectively (LE: 2b). These data, however, need to be confirmed in further studies.

5.12.2 **The impact of second resection on treatment outcomes**

A second TURB can increase recurrence-free survival (RFS) [182, 183] (LE: 2a), improve outcomes after BCG treatment [184] (LE: 3) and provide prognostic information [185-188] (LE: 3).

In a retrospective evaluation of a large multi-institutional cohort of 2,451 patients with BCG-treated T1 G3/HG tumours (a second resection was performed in 935 patients), the second resection improved RFS, progression-free survival (PFS) and overall survival (OS) only in patients without detrusor muscle in the specimen of the initial resection [189] (LE: 3).

5.12.3 **Timing of second resection**

Retrospective evaluation showed that a second resection performed 14–42 days after initial resection provides longer RFS and PFS compared to second resection performed after 43–90 days [190] (LE: 3). Based on these arguments, a second TURB is recommended in selected cases 2 to 6 weeks after initial resection (for recommendations on patient selection, see Section 5.14).

5.12.4 **Recording of results**

The results of the second resection (residual tumours and under-staging) reflect the quality of the initial TURB. As the goal is to improve the quality of the initial TURB, the results of the second resection should be recorded.

5.13 **Pathology report**

Pathological investigation of the specimen(s) obtained by TURB and biopsies is an essential step in the decision-making process for BC [191]. Close co-operation between urologists and pathologists is required. A high quality of resected and submitted tissue and clinical information is essential for correct pathological assessment. To obtain all relevant information, the specimen collection, handling and evaluation, should respect the recommendations provided below (see Section 5.14) [192, 193]. In difficult cases, an additional review by an experienced genitourinary pathologist can be considered.

5.14 **Summary of evidence and guidelines for transurethral resection of the bladder, biopsies and pathology report**

| Summary of evidence | LE |
|--|----|
| Transurethral resection of the bladder tumour (TURB) followed by pathology investigation of the obtained specimen(s) is an essential step in the management of NMIBC. | 1 |
| The absence of detrusor muscle in the specimen is associated with a significantly higher risk of residual disease and tumour under-staging (with the exception of Ta LG/G1 tumours). | 2b |
| In patients with a history of small Ta LG/G1 tumours, fulguration of small papillary recurrences on an outpatient basis is feasible and safe. | 3 |
| A second TURB can detect residual tumours and tumour under-staging, increase recurrence-free survival, improve outcomes after BCG treatment and provide prognostic information. | 2 |

| Recommendations | Strength rating |
|---|-----------------|
| In patients suspected of having bladder cancer, perform a transurethral resection of the bladder tumour (TURB) followed by pathology investigation of the obtained specimen(s) as a diagnostic procedure and initial treatment step. | Strong |
| Outpatient fulguration or laser vaporisation of small papillary recurrences can be used in patients with a history of Ta LG/G1 tumours. | Weak |
| Perform TURB systematically in individual steps: <ul style="list-style-type: none"> • bimanual palpation under anaesthesia. • insertion of the resectoscope, under visual control with inspection of the whole urethra; • inspection of the whole urothelial lining of the bladder; • biopsy from the prostatic urethra (if indicated); • cold-cup bladder biopsies (if indicated); • resection of the tumour; • recording of findings in the surgery report/record; • precise description of the specimen(s) for pathology evaluation. | Strong |
| Performance of individual steps | |
| Perform <i>en-bloc</i> resection or resection in fractions (exophytic part of the tumour, the underlying bladder wall and the edges of the resection area). | Strong |
| Avoid cauterisation as much as possible during TURB to avoid tissue deterioration. | Strong |

| | |
|---|--------|
| Take biopsies from abnormal-looking urothelium. Biopsies from normal-looking mucosa (mapping biopsies from the trigone, bladder dome, right, left, anterior and posterior bladder wall) are recommended if cytology or urinary molecular marker test is positive. If the equipment is available, perform fluorescence-guided (PDD) biopsies. | Strong |
| Take a biopsy of the prostatic urethra in cases of bladder neck tumour, if bladder carcinoma <i>in situ</i> is present or suspected, if there is positive cytology or urinary molecular marker test without evidence of tumour in the bladder, or if abnormalities of the prostatic urethra are visible. If biopsy is not performed during the initial procedure, it should be completed at the time of the second resection. | Strong |
| Take a prostatic urethral biopsy from the pre-collicular area (between the 5 and 7 o'clock position) using a resection loop. In case any abnormal-looking areas in the prostatic urethra are present at this time, these need to be biopsied as well. | Weak |
| Use methods to improve tumour visualisation (fluorescence cystoscopy, narrow-band imaging) during TURB, if available. | Weak |
| Refer the specimens from different biopsies and resection fractions to the pathologist in separately labelled containers. | Weak |
| The TURB record must describe tumour location, appearance, size and multifocality, all steps of the procedure, as well as extent and completeness of resection. | Strong |
| In patients with positive cytology, but negative cystoscopy, exclude an upper tract urothelial carcinoma, CIS in the bladder (by mapping biopsies or PDD-guided biopsies) and tumour in the prostatic urethra (by prostatic urethra biopsy). | Strong |
| Perform a second TURB in the following situations: <ul style="list-style-type: none"> • after incomplete initial TURB, or in case of doubt about completeness of a TURB; • if there is no detrusor muscle in the specimen after initial resection, with the exception of Ta LG/G1 tumours and primary CIS; • in T1 tumours. | Strong |
| If indicated, perform a second TURB within 2–6 weeks after the initial resection. This second TURB should include resection of the primary tumour site. | Weak |
| Register the pathology results of a second TURB as it reflects the quality of the initial resection. | Weak |
| Inform the pathologist of prior treatments (intravesical therapy, radiotherapy, etc.). | Strong |
| The pathological report should specify tumour location, tumour grade and stage, lymphovascular invasion, subtypes of urothelial carcinoma (variant histologies), presence of CIS and detrusor muscle. | Strong |

6. PREDICTING DISEASE RECURRENCE AND PROGRESSION

6.1 TaT1 tumours

Treatment should take into account a patient's prognosis. In order to predict the risk of disease recurrence and/or progression, several prognostic models for specified patient populations have been introduced.

6.1.1 Scoring models using the WHO 1973 classification system

6.1.1.1 The 2006 European Organisation for Research and Treatment of Cancer (EORTC) scoring model

To be able to predict both the short- and long-term risks of disease recurrence and progression in individual patients, the EORTC Genito-Urinary Cancer Group (GUCG) published a scoring system and risk tables based on the WHO 1973 classification in 2006 [194]. The scoring system is based on the 6 most significant clinical and pathological factors in patients mainly treated by intravesical chemotherapy:

- Number of tumours;
- Tumour diameter;
- Prior recurrence rate;
- T category;
- Concurrent CIS;
- WHO 1973 tumour grade.

Using the 2006 EORTC scoring model, individual probabilities of recurrence and progression at 1 and 5 years may be calculated (<https://www.omnicalculator.com/health/eortc-bladder-cancer>).

6.1.1.2 *The model for patients with Ta G1/G2 (WHO 1973) tumours treated with chemotherapy*

Patients with Ta G1/G2 tumours receiving chemotherapy were stratified into 3 risk groups for recurrence, taking into account the history of recurrences, history of intravesical treatment, tumour grade (WHO 1973), number of tumours and adjuvant chemotherapy [195].

6.1.1.3 *Club Urologico Español de Tratamiento Oncológico (CUETO) scoring model for BCG-treated patients*

A model that predicts the risk of recurrence and progression, based on 12 doses of intravesical BCG over a 5 to 6 months period following TURB, has been published by the CUETO (Spanish Urological Oncology Group). It is based on an analysis of 1,062 patients from 4 CUETO trials that compared different intravesical BCG treatments. No immediate post-operative instillation or second TURB was performed in these patients. The scoring system is based on the evaluation of seven prognostic factors:

- gender;
- age;
- prior recurrence status;
- number of tumours;
- T category;
- associated CIS;
- WHO 1973 tumour grade.

Using this model, the calculated risk of recurrence is lower than that obtained by the EORTC tables. For progression, probability is lower only in high-risk patients [196] (LE: 2a). The lower risks in the CUETO tables may be attributed to the use of BCG in this study. The prognostic value of the EORTC scoring system has been confirmed by data from the CUETO patients treated with BCG and by long-term follow-up in an independent patient population [197, 198] (LE: 2a).

6.1.1.4 *The 2016 EORTC scoring model for patients treated with maintenance BCG*

In 1,812 intermediate- and high-risk patients without CIS treated with 1 to 3 years of maintenance BCG, the EORTC found that the prior disease-recurrence rate and number of tumours were the most important prognostic factors for disease recurrence, stage and WHO 1973 grade for disease progression and disease-specific survival, while age and WHO 1973 grade were the most important prognostic factors for OS. T1 G3 patients did poorly, with 1- and 5-year disease-progression rates of 11.4% and 19.8%, respectively. Using these data, EORTC risk groups and nomograms for BCG-treated patients were developed [199] (LE: 2a).

6.1.2 **Scoring model using the WHO 2004/2016 and WHO 1973 classification systems**

6.1.2.1 *EAU NMIBC 2021 scoring model*

To update the risk of disease progression and create new prognostic factor risk groups using both the WHO 1973 and WHO 2004/2016 classification systems (without central pathology review), individual patient data from 3,401 primary patients treated from 1990 to 2018 were used [50] (see Section 4.5). Only patients treated with TURB ± intravesical chemotherapy were included, those treated with adjuvant intravesical BCG were excluded because BCG may reduce the risk of disease progression. From the multivariate analysis, tumour stage, WHO 1973 grade, WHO 2004/2016 grade, concomitant CIS, number of tumours, tumour size and age were independent predictors of disease progression [50].

This is the only available model where the WHO 2004/2016 classification system is included as one of the parameters to calculate an individual patient's risk group and probability of progression. As the WHO 2004/2016 classification system is the main grading classification system used by pathologists, the Guidelines Panel recommends to use the 2021 EAU NMIBC scoring model for risk groups definition (see Section 6.3).

As the 2021 EAU NMIBC scoring model determines the risk of tumour progression, but not recurrence, any of models mentioned in Section 6.1.1 may be used for calculation of an individual's risk of disease recurrence.

6.1.3 **Further prognostic factors**

Further prognostic factors have been described in selected patient populations:

- In T1G3 tumours, important prognostic factors were female sex, CIS in the prostatic urethra in men treated with an induction course of BCG, and age, tumour size and concurrent CIS in BCG-treated patients (62% with an induction course only) [159, 200] (LE: 2b).
- Attention must be given to patients with T1G3 tumours in bladder (pseudo) diverticulum because of the absence of muscle layer in the diverticular wall [201] (LE: 3).
- In patients with T1 tumours, the finding of residual T1 disease at second TURB is an unfavourable prognostic factor [186-188] (LE: 3).

- In patients with T1G2 tumours treated with TURB, recurrence at 3 months was the most important predictor of progression [202] (LE: 2b).
- The prognostic value of pathological factors has been discussed elsewhere (see Section 4.6). More research is needed to determine the role of molecular markers in improving the predictive accuracy of currently available risk tables [197, 203].
- Pre-operative neutrophil-to-lymphocyte ratio may have prognostic value in NMIBC. This data, however, needs further validation [204].

6.2 Carcinoma *in situ*

Without any treatment, approximately 54% of patients with CIS progress to muscle-invasive disease [205] (LE: 3). There are no reliable prognostic factors, but some studies, however, have reported a worse prognosis in concurrent CIS and T1 tumours compared to primary CIS [206, 207], in extended CIS [208] and in CIS in the prostatic urethra [159] (LE: 3).

The response to intravesical treatment with BCG or chemotherapy is an important prognostic factor for subsequent progression and death caused by BC [196-198, 202]. Approximately 10 to 20% of complete responders eventually progress to muscle-invasive disease, compared with 66% of non-responders [209, 210] (LE: 2a).

6.3 Patient stratification into risk groups

To be able to facilitate treatment recommendations, the Guidelines Panel recommends the stratification of patients into risk groups based on their probability of progression to muscle-invasive disease. The new risk group definitions provided in these EAU Guidelines are based on an IPD analysis in primary patients and the calculation of their progression scores (2021 EAU NMIBC scoring model) as presented in Sections 4.5 and 6.1.2) [50].

For calculation of the risk group in individual patients, either one, or both, of the WHO 1973 and WHO 2004/2016 classification systems may be used. The probability of progression at 5 years varies from less than 1% to more than 40% between the risk groups.

For factors where IPD were not collected such as subtypes of urothelial carcinoma (variant histologies), LVI, primary CIS and CIS in the prostatic urethra; literature data have been used to classify patients into risk groups.

The clinical compositions of the new EAU NMIBC prognostic factor risk groups based on the WHO 2004/2016 or WHO 1973 classification systems are provided in Table 6.1. Apps for the web (www.nmibc.net), iOS and Android (iOS / <https://apps.apple.com/us/app/eau-nmibc-risk-calculator/id1578482687> and Android / <https://play.google.com/store/apps/details?id=net.ydeal.nmibc>) have been developed to facilitate determining a patient's risk group in daily clinical practice. The individual probability of disease progression at 1, 5 and 10 years for the new EAU NMIBC risk groups is presented in Table 6.2.

Table 6.1: Clinical composition of the new EAU NMIBC prognostic factor risk groups based on the WHO 2004/2016 or the WHO 1973 grading classification systems [50]

- Only one of the two classification systems (WHO 1973 or WHO 2004/2016) is required to use this table.
- If both classification systems are available in an individual patient, the Panel recommends using the risk group calculation based on the WHO 1973 as it has better prognostic value.
- The category of LG tumours (WHO 2004/2016) also includes patients with tumours classified as PUNLMP.
- Additional clinical risk factors are*:
 - o age > 70;
 - o multiple papillary tumours;
 - o tumour diameter \geq 3 cm.

| Risk group | |
|--------------------------|--|
| Low Risk | <ul style="list-style-type: none"> • A primary, single, TaT1 LG/G1 tumour < 3 cm in diameter without CIS in a patient \leq 70 years • A primary Ta LG/G1 tumour without CIS with at most ONE of the additional clinical risk factors (see above*) |
| Intermediate Risk | Patients without CIS who are not included in either the low-, high-, or very high-risk groups |
| High Risk | <ul style="list-style-type: none"> • All T1 HG/G3 without CIS, EXCEPT those included in the very high-risk group • All CIS patients, EXCEPT those included in the very high-risk group <p>Stage, grade with additional clinical risk factors:</p> <ul style="list-style-type: none"> • Ta LG/G2 or T1G1, no CIS with all 3 risk factors • Ta HG/G3 or T1 LG, no CIS with at least 2 risk factors • T1G2 no CIS with at least 1 risk factor |

| | |
|-----------------------|---|
| Very High Risk | Stage, grade with additional clinical risk factors: <ul style="list-style-type: none"> • Ta HG/G3 and CIS with all 3 risk factors • T1G2 and CIS with at least 2 risk factors • T1 HG/G3 and CIS with at least 1 risk factor • T1 HG/G3 no CIS with all 3 risk factors |
|-----------------------|---|

The scoring model is based on IPD, but does not consider patients with primary CIS (high risk) or with recurrent tumours, as well as some pathologic parameters like subtypes of urothelial carcinoma (variant histologies, see Section 4.7) and LVI. Nevertheless:

- Based on data from the literature, all patients with CIS in the prostatic urethra, with subtypes of urothelial carcinoma (see Section 4.7) or with LVI should be included in the very high-risk group.
- Patients with recurrent tumours should be included in the intermediate-, high-, or very high-risk groups according to their other prognostic factors.

Table 6.2: Probabilities of disease progression in 1, 5 and 10 year(s) for the new EAU NMIBC risk groups [50]*

| Risk group | Probability of Progression and 95% Confidence Interval (CI) | | |
|---|---|------------------------|----------------------|
| | 1 Year | 5 Years | 10 Years |
| New Risk Groups with WHO 2004/2016 | | | |
| Low | 0.06% (CI: 0.01%–0.43%) | 0.93% (CI: 0.49%–1.7%) | 3.7% (CI: 2.3%–5.9%) |
| Intermediate | 1.0% (CI: 0.50%–2.0%) | 4.9% (CI: 3.4%–7.0%) | 8.5% (CI: 5.6%–13%) |
| High | 3.5% (CI: 2.4%–5.2%) | 9.6% (CI: 7.4%–12%) | 14% (CI: 11%–18%) |
| Very High | 16% (CI: 10%–26%) | 40% (CI: 29%–54%) | 53% (CI: 36%–73%) |
| New Risk Groups with WHO 1973 | | | |
| Low | 0.12% (CI: 0.02%–0.82%) | 0.57% (CI: 0.21%–1.5%) | 3.0% (CI: 1.5%–6.3%) |
| Intermediate | 0.65% (CI: 0.36%–1.2%) | 3.6% (CI: 2.7%–4.9%) | 7.4% (CI: 5.5%–10%) |
| High | 3.8% (CI: 2.6%–5.7%) | 11% (CI: 8.1%–14%) | 14% (CI: 10%–19%) |
| Very High | 20% (CI: 12%–32%) | 44% (CI: 30%–61%) | 59% (CI: 39%–79%) |

WHO = World Health Organization.

*Table 6.2 does not include patients with subtypes of urothelial carcinoma (variant histologies), LVI, CIS in the prostatic urethra, primary CIS or recurrent patients.

6.4 Summary of evidence and guidelines for stratification of non-muscle-invasive bladder cancer

| Summary of evidence | LE |
|---|----|
| The EAU NMIBC 2021 scoring model and risk tables predict the short- and long-term risks of disease progression in individual patients with primary NMIBC using either the WHO 1973 or the WHO 2004/2016 classification system (see Section 6.1.2.1). | 2b |
| The 2006 EORTC scoring model and risk tables predict the short- and long-term risks of disease recurrence and progression in individual patients with NMIBC using the WHO 1973 classification system (see Section 6.1.1.1). | 1b |
| Patients with Ta G1/G2 tumours receiving chemotherapy have been further stratified into 3 risk groups for recurrence, taking into account the history of recurrences, history of intravesical treatment, tumour grade (WHO 1973), number of tumours and adjuvant chemotherapy (see Section 6.1.1.2). | 2b |
| In patients treated with 5 to 6 months of BCG, the CUETO scoring model predicts the short- and long-term risks of disease recurrence and progression using the WHO 1973 classification system (see Section 6.1.1.3). | 1b |
| In patients receiving at least 1 year of BCG maintenance; prior recurrence rate and number of tumours are the most important prognostic factors for disease recurrence. Stage and grade are the most important prognostic factors for disease progression and disease-specific survival; patient age and grade (WHO 1973) are the most important prognostic factors for OS (see Section 6.1.1.4). | 1b |

| Recommendations | Strength rating |
|---|-----------------|
| Stratify patients into 4 risk groups according to Table 6.1. A patient's risk group can be determined using the EAU risk group calculator available at www.nmibc.net . | Strong |
| For information about the risk of disease progression in a patient with primary TaT1 tumours not treated with BCG, use the data from Table 6.2. | Strong |

| | |
|--|--------|
| Use the 2006 EORTC scoring model to predict the risk of tumour recurrence in individual patients not treated with bacillus Calmette-Guérin (BCG). | Strong |
| Use the 2016 EORTC scoring model or the CUETO risk scoring model to predict the risk of tumour recurrence in individual patients treated with BCG intravesical immunotherapy (the 2016 EORTC model is calculated for 1 to 3 years of maintenance, the CUETO model for 5 to 6 months of BCG). | Strong |

7. DISEASE MANAGEMENT

7.1 Counselling of smoking cessation

It has been confirmed that smoking increases the risk of tumour recurrence and progression [211, 212] (LE: 3). While it is still controversial whether smoking cessation in BC will favourably influence the outcome of BC treatment, patients should be counselled to stop smoking due to the general risks connected with tobacco smoking [201, 213-215] (LE: 3).

7.2 Adjuvant treatment

Although TURB by itself can eradicate a TaT1 tumour completely, these tumours commonly recur and can progress to MIBC. The high variability in the 3-month recurrence rate indicates that the TURB was incomplete or provokes recurrences in a high percentage of patients [134]. It is therefore necessary to consider adjuvant therapy in all patients.

7.2.1 Intravesical chemotherapy

7.2.1.1 A single, immediate, post-operative intravesical instillation of chemotherapy

Immediate single instillation (SI) has been shown to act by destroying circulating tumour cells after TURB, and by an ablative effect on residual tumour cells at the resection site and on small overlooked tumours [216-219] (LE: 3).

Four large meta-analyses comprising 1,476 to 3,103 patients have consistently shown that after TURB, SI significantly reduces the recurrence rate compared to TURB alone [220-223] (LE: 1a). In a systematic review and IPD meta-analysis of 2,278 eligible patients [220], SI reduced the 5-year recurrence rate by 14%, from 59% to 45%. Only patients with primary tumours or intermediate-risk recurrent tumours with a prior recurrence rate of ≤ 1 recurrence/year and those with a 2006 EORTC recurrence score < 5 benefited from SI. In patients with a 2006 EORTC recurrence score ≥ 5 and/or patients with a prior recurrence rate of > 1 recurrence per year, SI was not effective as a single adjuvant treatment. No randomised comparisons of individual drugs have been conducted [220-223].

Single instillation with mitomycin C (MMC), epirubicin or pirarubicin, have all shown a beneficial effect [220]. Single instillation with gemcitabine was superior to placebo control (saline) in a RCT with approximately 200 patients per arm with remarkably low toxicity rates [224]. These findings are in contrast with a previous study, which, however, used a shorter instillation time [225]. In the Böhle *et al.* study, continuous saline irrigation was used for 24 hours post-operatively in both arms, which could explain the low recurrence rate in the control arm [225]. Two meta-analyses suggest efficacy of continuous saline irrigation in the prevention of early recurrences [226, 227].

Prevention of tumour cell implantation should be initiated within the first few hours after TURB. After that, tumour cells are firmly implanted and are covered by the extracellular matrix [216, 228-230] (LE: 3). In all SI studies, the instillation was administered within 24 hours. Two RCTs found no overall impact of SI with apaziquone; in contrast, a post-hoc analysis did find a reduction of recurrence risk in patients receiving apaziquone within 90 minutes following TURB [231]. To maximise the efficacy of SI, one should devise flexible practices that allow the instillation to be given as soon as possible after TURB, preferably within the first two hours in the recovery room or even in the operating theatre. As severe complications have been reported in patients with drug extravasation [232, 233] safety measures should be maintained (see Section 7.7).

7.2.1.2 Additional adjuvant intravesical chemotherapy instillations

The need for further adjuvant intravesical therapy depends on prognosis. In low-risk patients (Tables 6.1 and 6.2), a SI reduces the risk of recurrence and is considered to be the standard and complete treatment [220, 221] (LE: 1a). For other patients, however, a SI remains an incomplete treatment because of the considerable likelihood of recurrence and/or progression (Tables 6.1 and 6.2). Efficacy data for the following comparisons of application schemes were published:

Single instillation only vs. SI and further repeat instillations

In one study, further chemotherapy instillations after SI improved RFS in intermediate-risk patients [234] (LE: 2a).

Repeat chemotherapy instillations vs. no adjuvant treatment

A large meta-analysis of 3,703 patients from 11 RCTs showed a highly significant (44%) reduction in the odds of recurrence at one year in favour of chemotherapy over TURB alone [235]. This corresponds to an absolute difference of 13–14% in the number of patients with recurrence. Contrary to these findings, two meta-analyses have demonstrated that BCG therapy may reduce the risk of tumour progression [236, 237] (see Section 7.2.2.1) (LE: 1a). Moreover, BCG maintenance therapy appears to be significantly better in preventing recurrences than chemotherapy [238-240] (see Section 7.2.2.1) (LE: 1a). However, BCG causes significantly more side effects than chemotherapy [240] (LE: 1a).

Single instillation + further repeat instillations vs. later repeat instillations only

There is evidence from several studies in intermediate-risk patients that SI might have an impact on recurrence even when further adjuvant instillations are given [241-244]. A RCT including 2,243 NMIBC patients, which compared SI of MMC with an instillation of MMC delayed two weeks after TURB (followed by further repeat instillations in both treatment arms), showed a significant reduction of 9% in the risk of recurrence at 3 years in favour of SI, from 36% to 27%. The effect was significant in the intermediate- and high-risk groups of patients receiving additional adjuvant MMC instillations [241] (LE: 2a). Since the author's definition of the risk groups differed significantly in the initial publication, they adapted their patient stratification in the second analysis and consistently showed improved efficacy of SI followed by repeat MMC instillations [245]. The results of this study should be considered with caution since some patients did not receive adequate therapy. Another RCT found no impact of SI with epirubicin followed by further chemotherapy or BCG instillations in a cohort of predominant HR BC [246].

The optimal schedule of intravesical chemotherapy instillations

The length and frequency of repeat chemotherapy instillations is still controversial; however, it should not exceed one year [244] (LE: 3).

7.2.1.3 Options for improving efficacy of intravesical chemotherapy

7.2.1.3.1 Adjustment of pH, duration of instillation, and drug concentration

A prospective randomised, multi-institutional RCT showed that intravesical solution reduced the recurrence rate [247] (LE: 1b). Another trial reported that duration of a one hour instillation of MMC was more effective compared to a 30-minute instillation, but no efficacy comparisons are available for one- vs. two-hour durations of instillation [248] (LE: 3). Another RCT using epirubicin has documented that concentration is more important than treatment duration [249] (LE: 1b). In view of these data, instructions are provided (see Section 7.7).

It has been suggested that the efficacy of MMC may be improved by optimising application through the adjustment of urine pH, in addition to the use of alternative maintenance schedules. Neither aspect is reflected in the literature quoted above since most published studies do not support this approach.

7.2.1.3.2 Device-assisted intravesical chemotherapy

Microwave-induced hyperthermia effect (RITE)

Promising data have been presented on enhancing the efficacy of MMC using microwave-induced hyperthermia in patients with high-risk tumours [250]. In one RCT comparing one year of BCG with one year MMC and microwave-induced hyperthermia in patients with intermediate- and high-risk BC, increased RFS at 24 months in the MMC group was demonstrated [251] (LE: 1b).

Hyperthermic intravesical chemotherapy

Different technologies which increase the temperature of instilled MMC are available, however, data about their efficacy are still lacking.

Electromotive drug administration

The efficacy of MMC using electromotive drug administration (EMDA) sequentially combined with BCG in patients with high-risk tumours has been demonstrated in one small RCT [252]. The definitive conclusion, however, needs further confirmation.

For application of device-assisted instillations in patients recurring after BCG treatment, see Section 7.6.3.

7.2.1.4 Summary of evidence - intravesical chemotherapy

| Summary of evidence | LE |
|---|----|
| In patients with low-risk NMIBC and in those with a small Ta LG/G1 recurrence detected more than one year after previous TURB, a SI significantly reduces the recurrence rate compared to TURB alone. | 1a |
| Single instillation might have an impact on recurrence even when further adjuvant chemotherapy instillations are given. | 3 |
| Repeat chemotherapy instillations (with or without previous SI) improve RFS in intermediate-risk patients. | 2a |

7.2.2 Intravesical bacillus Calmette-Guérin (BCG) immunotherapy

7.2.2.1 Efficacy of BCG

7.2.2.1.1 Recurrence rate

Five meta-analyses have confirmed that BCG after TURB is superior to TURB alone or TURB plus chemotherapy for preventing the recurrence of NMIBC [238, 253-256] (LE: 1a). Three RCTs of intermediate- and high-risk tumours have compared BCG with epirubicin and interferon (INF) [257], MMC [258], or epirubicin alone [239] and have confirmed the superiority of BCG for prevention of tumour recurrence (LE: 1a). The effect is long lasting [239, 258] and was also observed in a separate analysis of patients with intermediate-risk tumours [239]. One meta-analysis [238] has evaluated the individual data from 2,820 patients enrolled in 9 RCTs that have compared MMC vs. BCG. In the trials with BCG maintenance, there was a 32% reduction in the risk of recurrence for BCG compared to MMC, but a 28% increase in the risk of recurrence for patients treated with BCG in the trials without BCG maintenance. A Cochrane systematic review confirmed that BCG is more effective in reducing the recurrence rate over MMC [259].

7.2.2.1.2 Progression rate

Two meta-analyses have demonstrated that BCG therapy delays and potentially lowers the risk of tumour progression [236, 237, 256] (LE: 1a). A meta-analysis carried out by the EORTC Genito-Urinary Cancers Group (GUCCG) has evaluated data from 4,863 patients enrolled in 24 RCTs. In 20 of the trials, some form of BCG maintenance was used. Based on a median follow-up of 2.5 years, tumours progressed in 9.8% of the patients treated with BCG compared to 13.8% in the control groups (TURB alone, TURB and intravesical chemotherapy, or TURB with the addition of other immunotherapy). This shows a reduction of 27% in the odds of progression with BCG maintenance treatment. The size of the reduction was similar in patients with TaT1 papillary tumours and in those with CIS [237]. A RCT with long-term follow-up has demonstrated significantly fewer distant metastases and better overall- and disease-specific survival in patients treated with BCG compared to epirubicin [239] (LE: 1b). In contrast, an IPD meta-analysis and Cochrane review were not able to confirm any statistically significant difference between MMC and BCG for progression, survival, and cause of death [238, 259].

The conflicting results in the outcomes of these studies can be explained by different patient characteristics, duration of follow-up, methodology and statistical power. However, most studies showed a reduction in the risk of progression in high- and intermediate-risk tumours if a BCG maintenance schedule was applied.

7.2.2.1.3 Influence of further factors

Two other meta-analyses have suggested a possible bias in favour of BCG arising from the inclusion of patients previously treated with intravesical chemotherapy [260]. In the IPD meta-analysis, however, BCG maintenance was more effective than MMC in reduction of recurrence rate, both in patients previously treated and not previously treated with chemotherapy [238] (LE: 1a). It was demonstrated that BCG was less effective in patients > 70 years of age, but still more effective than epirubicin in a cohort of elderly patients [261] (LE: 1a). According to a cohort analysis, the risk of tumour recurrence after BCG was shown to be higher in patients with a previous history of UTUC [262].

7.2.2.2 BCG strain

Although smaller studies without maintenance demonstrated some differences between strains [262-264], a network meta-analysis identified ten different BCG strains used for intravesical treatment in the published literature but was not able to confirm superiority of any BCG strain over another [265].

Similarly, a published meta-analysis of prospective RCTs [237], published data from a prospective registry [266] as well as from a *post-hoc* analysis of a large phase II prospective trial assessing BCG and INF- α in both BCG-naïve and BCG-failure patients did not suggest any clear difference in efficacy between the different BCG strains [267] (LE: 2a). The quality of data, however, does not allow definitive conclusions.

7.2.2.3 BCG toxicity

Bacillus Calmette-Guérin intravesical treatment is associated with more side effects compared to intravesical chemotherapy [237, 259] (LE: 1a). However, serious side effects are encountered in < 5% of patients and can be treated effectively in almost all cases [268] (LE: 1b). The incidence of BCG infections after BCG instillations was 1% in a registry-based cohort analysis [269]. It has been shown that a maintenance schedule is not associated with an increased risk of side effects compared to an induction course [268]. Side effects requiring treatment stoppage were seen more often in the first year of therapy [270]. Elderly patients do not seem to experience more side effects leading to treatment discontinuation [271] (LE: 2a). No significant difference in toxicity between different BCG strains was demonstrated [266]. Symptoms may be the result of side effects of the BCG treatment or caused by bladder disease (widespread CIS) itself. Consequently, the burden of symptoms is reduced after completion of the treatment in a significant number of patients [272].

Major complications can appear after systemic absorption of the drug. Thus, contraindications of BCG intravesical instillation should be respected (see Section 7.7). The presence of leukocyturia, nonvisible haematuria or asymptomatic bacteriuria is not a contraindication for BCG application, and antibiotic prophylaxis is not necessary in these cases [109, 273, 274] (LE: 3).

Bacillus Calmette-Guérin should be used with caution in immunocompromised patients; e.g., immunosuppression, human immunodeficiency virus (HIV) infection poses relative contraindications [275], although some small studies have shown similar efficacy and no increase in complications compared to non-immunocompromised patients. The role of prophylactic anti-tuberculosis medication in these patients remains unclear [276-278] (LE: 3). The management of side effects after BCG should reflect their type and grade according to the recommendations provided by the International Bladder Cancer Group (IBCG) and by a Spanish group [279, 280] (Table 7.1).

Table 7.1: Management options for side effects associated with intravesical BCG [280-283]

| Management options for local side effects (modified from International Bladder Cancer Group) | |
|---|---|
| Symptoms of cystitis | Phenazopyridine, propantheline bromide, or non-steroidal anti-inflammatory drugs (NSAIDs). |
| | If symptoms improve within a few days: continue instillations. |
| | If symptoms persist or worsen: <ul style="list-style-type: none"> a. Postpone the instillation b. Perform a urine culture c. Start empirical antibiotic treatment |
| | If symptoms persist even with antibiotic treatment: <ul style="list-style-type: none"> a. With positive culture: adjust antibiotic treatment according to sensitivity b. With negative culture: quinolones and potentially analgesic anti-inflammatory instillations once daily for 5 days (repeat cycle if necessary) [281]. |
| | If symptoms persist: anti-tuberculosis drugs + corticosteroids. |
| | If no response to treatment and/or contracted bladder: radical cystectomy. |
| Haematuria | Perform urine culture to exclude haemorrhagic cystitis if other symptoms present. |
| | If haematuria persists, perform cystoscopy to evaluate presence of bladder tumour. |
| Symptomatic granulomatous prostatitis | Symptoms rarely present: perform urine culture. |
| | Quinolones. |
| | If quinolones are not effective: isoniazid (300 mg/day) and rifampicin (600 mg/day) for 3 months. |
| | Cessation of intravesical therapy. |
| Epididymo-orchitis [282] | Perform urine culture and administer quinolones. |
| | Cessation of intravesical therapy. |
| | Orchidectomy if abscess or no response to treatment. |
| Management options for systemic side effects | |
| General malaise, fever | Generally resolve within 48 hours, with or without antipyretics. |
| Arthralgia and/or arthritis | Rare complication and considered autoimmune reaction. |
| | Arthralgia: treatment with NSAIDs. |
| | Reactive arthritis: NSAIDs. |
| | If no/partial response, proceed to corticosteroids, high-dose quinolones or antituberculosis drugs [283]. |

| | |
|--|--|
| Persistent high-grade fever (> 38.5°C for > 48 h) | Permanent discontinuation of BCG instillations. |
| | Immediate evaluation: urine culture, blood tests, chest X-ray. |
| | Prompt treatment with more than two antimicrobial agents while diagnostic evaluation is conducted. |
| | Consultation with an infectious diseases specialist. |
| BCG sepsis | Prevention: initiate BCG at least 2 weeks post-transurethral resection of the bladder (if no signs and symptoms of haematuria). |
| | Cessation of BCG. |
| | For severe infection: <ul style="list-style-type: none"> • High-dose quinolones or isoniazid, rifampicin and ethambutol daily for 6 months. • Early, high-dose corticosteroids as long as symptoms persist. • Consider an empirical non-specific antibiotic to cover Gram-negative bacteria and/or <i>Enterococcus</i>. |
| Allergic reactions | Antihistamines and anti-inflammatory agents. |
| | Consider high-dose quinolones or isoniazid and rifampicin for persistent symptoms. |
| | Delay therapy until reactions resolve. |

7.2.2.4 Optimal BCG schedule

Induction BCG instillations are given according to the empirical 6-weekly schedule introduced by Morales *et al.* [284]. For optimal efficacy, BCG must be given in a maintenance schedule [236-238, 256] (LE: 1a). Many different maintenance schedules have been used, ranging from a total of 10 instillations given in 18 to 27 weeks over 3 years [285].

7.2.2.4.1 Optimal number of induction instillations and frequency of instillations during maintenance

The optimal number of induction instillations and frequency of maintenance instillations were evaluated by NIMBUS, a prospective phase III RCT. Safety analysis after 345 randomised patients demonstrated that a reduced number of instillations (3 instillations in induction and 2 instillations at 3, 6 and 12 months) proved inferior to the standard schedule (6 instillation in induction and 3 instillations at 3, 6 and 12 months) regarding the time to first recurrence [286] (LE: 1b). In a RCT including 397 patients CUETO showed that in high-risk tumours a maintenance schedule with only one instillation every 3 months for 3 years was not superior to induction therapy only, which suggested that one instillation may be suboptimal to 3 instillations in each maintenance cycle [287] (LE: 1b).

7.2.2.4.2 Optimal length of maintenance

In their meta-analysis, Böhle *et al.* concluded that at least one year of maintenance BCG is required to obtain superiority of BCG over MMC for prevention of recurrence or progression [236] (LE: 1a).

In a RCT of 1,355 patients, the EORTC has shown that when BCG is given at full dose, 3 years' maintenance (3-weekly instillations 3, 6, 12, 18, 24, 30 and 36 months) reduces the recurrence rate compared to one year in high- but not in intermediate-risk patients. There were no differences in progression or OS. In the 3-year arm, however, 36.1% of patients did not complete the 3-year schedule [288] (LE: 1b). The main reason why these patients stopped treatment was treatment inefficacy, not toxicity.

7.2.2.5 Optimal dose of BCG

To reduce BCG toxicity, instillation of a reduced dose was proposed. However, it has been suggested that a full dose of BCG is more effective in multifocal tumours [289, 290] (LE: 1b). The CUETO study compared one-third dose to full-dose BCG and found no overall difference in efficacy. One-third of the standard dose of BCG might be the minimum effective dose for intermediate-risk tumours. A further reduction to one-sixth dose resulted in a decrease in efficacy with no decrease in toxicity [291] (LE: 1b). The EORTC did not find any difference in toxicity between one-third and full-dose BCG, but one-third dose BCG was associated with a higher recurrence rate, especially when it was given only for one year [270, 288] (LE: 1b). The routine use of one-third dose BCG is complicated by potential technical difficulties in preparing the reduced dose reliably.

7.2.2.6 BCG shortage

A statement by the Panel on BCG shortage can be accessed online:

<https://uroweb.org/guideline/non-muscle-invasive-bladder-cancer/?type=appendices-publications>.

7.2.2.7 Summary of evidence - BCG treatment

| Summary of evidence | LE |
|--|----|
| In patients with intermediate- and high-risk tumours, intravesical BCG after TURB reduces the risk of tumour recurrence; it is more effective than TURB alone or TURB and intravesical chemotherapy. | 1a |
| For optimal efficacy, BCG must be given in a maintenance schedule. | 1a |
| Three-year maintenance is more effective than one year to prevent recurrence in patients with high-risk tumours, but not in patients with intermediate-risk tumours. | 1a |

7.2.3 Combination therapy

7.2.3.1 Intravesical BCG plus chemotherapy versus BCG alone

In one RCT, a combination of MMC and BCG was shown to be more effective in reducing recurrences but more toxic compared to BCG monotherapy (LE: 1b). Using similar BCG schedules in both groups, each BCG instillation in the combination group was preceded a day before by one MMC instillation [292]. In a RCT using MMC with EMDA, a combination of BCG and MMC with EMDA showed an improved recurrence-free interval and reduced progression rate compared to BCG monotherapy [252, 293] (LE: 2). Two meta-analyses demonstrated improved disease-free survival (DFS), but no difference in PFS in patients treated with combination treatment comparing to BCG alone [293, 294].

7.2.3.2 Combination treatment using interferon

In a Cochrane meta-analysis of 4 RCTs, a combination of BCG and IFN-2 α did not show a clear difference in recurrence and progression over BCG alone [295]. In one study, weekly MMC followed by monthly BCG alternating with IFN-2 α showed a higher probability of recurrence compared to MMC followed by BCG alone [296]. Additionally, a RCT in a similar population of NMIBC comparing BCG monotherapy with a combination of epirubicin and INF for up to two years showed the latter was significantly inferior to BCG monotherapy in preventing recurrence [297] (LE: 1b).

7.2.4 Specific aspects of treatment of carcinoma in situ

7.2.4.1 Treatment strategy

The detection of concurrent CIS increases the risk of recurrence and progression of TaT1 tumours [194, 196]. In this case further treatment according to the criteria summarised in Sections 7.2.1, 7.2.2, 7.5 and 7.6 is mandatory. Carcinoma *in situ* cannot be cured by an endoscopic procedure alone. Histological diagnosis of CIS must be followed by further treatment, either intravesical BCG instillations or RC (LE: 4). Tumour-specific survival rates after immediate RC for CIS are excellent, but a large proportion of patients might be over-treated [205] (LE: 3).

7.2.4.2 Cohort studies on intravesical BCG or chemotherapy

In retrospective evaluations of patients with CIS, a complete response rate of 48% was achieved with intravesical chemotherapy and 72-93% with BCG [205-208, 298] (LE: 2a). Up to 50% of complete responders might eventually show recurrence with a risk of invasion and/or extravesical recurrence [208, 230, 285, 298] (LE: 3).

7.2.4.3 Prospective randomised trials on intravesical BCG or chemotherapy

Unfortunately, there have been few RCTs in patients with CIS only. A meta-analysis of clinical trials comparing intravesical BCG to intravesical chemotherapy in patients with CIS has shown a significantly increased response rate after BCG and a reduction of 59% in the odds of treatment failure with BCG [299] (LE: 1a).

In an EORTC-GUCG meta-analysis of tumour progression, in a subgroup of 403 patients with CIS, BCG reduced the risk of progression by 35% as compared to intravesical chemotherapy or immunotherapy [237] (LE: 1b). The combination of BCG and MMC was not superior to BCG alone [300]. In summary, compared to chemotherapy, BCG treatment of CIS increases the complete response rate, the overall percentage of patients who remain disease free, and reduces the risk of tumour progression (LE: 1b).

7.2.4.4 Treatment of CIS in the prostatic urethra and upper urinary tract

Patients with CIS are at high risk of extravesical involvement in the UUT and in the prostatic urethra. Solsona *et al.* found that 63% of 138 patients with CIS developed extravesical involvement initially or during follow-up [301]. Patients with extravesical involvement had worse survival than those with bladder CIS alone [301] (LE: 3). In the prostate, CIS might be present only in the epithelial lining of the prostatic urethra or in the prostatic ducts [302]. These situations should be distinguished from tumour invasion into the prostatic stroma (stage T4a in bladder tumours) and for which immediate radical cystoprostatectomy is mandatory. Patients with CIS in the epithelial lining of the prostatic urethra can be treated by intravesical instillation of BCG. Transurethral resection

of the prostate can improve contact of BCG with the prostatic urethra [128, 303] (LE: 3). However, potential spread of CIS has to be considered; no suprapubic trocar-placed catheter should be used.

In patients with prostatic duct involvement there are promising results of BCG, but only from small series. The data are insufficient to provide clear treatment recommendations and radical surgery should be considered [303, 304] (LE: 3).

7.2.4.5 Summary of evidence - treatment of carcinoma in situ

| Summary of evidence | LE |
|---|----|
| Carcinoma <i>in situ</i> cannot be cured by an endoscopic procedure alone. | 4 |
| Compared to intravesical chemotherapy, intravesical BCG maintenance instillations increase the complete response rate, the overall percentage of patients who remain disease free, and reduce the risk of tumour progression. | 1b |

7.3 Intravesical chemoablation and neoadjuvant treatment

Older marker lesion studies have shown that chemoablation with a single intravesical chemotherapy instillation can achieve a complete response in a proportion of patients [305]. In addition, hypothesis-generating findings from an older RCT comparing immediate pre-operative device-assisted (EMDA) MMC with post-operative SI with MMC and TURB only, showed improved long-term RFS among patients treated prior to TURB [306], and thus even suggest a long-term effect after neoadjuvant instillations. While this has not been reproduced by other groups, additional neoadjuvant clinical trials were recently published. In recurrent low-risk [307] and recurrent Ta tumours [308], 4 and 6 intravesical MMC instillations achieved complete response in 37% and 57% of the patients, respectively. The former study prematurely stopped recruitment as the anticipated 45% complete response after chemoablation was not achieved. Compared to TURB, less dysuria and incontinence occurred in the intervention arm of the trial. Before routine clinical application, additional high-level evidence with RFS as an outcome measure is required.

7.4 Radical cystectomy for non-muscle-invasive bladder cancer

There are several reasons to consider immediate RC for selected patients with NMIBC:

- The staging accuracy for T1 tumours by TURB is low with 27–51% of patients being upstaged to muscle-invasive tumour at RC [162, 309-313] (LE: 3).
- Some patients with NMIBC experience disease progression to muscle-invasive disease (Table 6.2).
- Patients who experience disease progression to muscle-invasive stage have a worse prognosis than those who present with 'primary' muscle-invasive disease [314, 315].

The potential benefit of RC must be weighed against its risks, morbidity, and impact on quality of life (QoL) and discussed with patients, in a shared decision-making process. It is reasonable to propose immediate RC in those patients with NMIBC who are at very high risk of disease progression (see Section 6.3 and Tables 6.1 and 6.2) [66, 159, 194, 196, 316] (LE: 3).

Early RC is strongly recommended in patients with BCG-unresponsive tumours and should be considered in BCG relapsing HG tumours as mentioned in Section 7.7 and Table 7.3. A delay in RC may lead to decreased disease-specific survival [317] (LE: 3).

In patients in whom RC is performed before progression to MIBC, the 5-year DFS rate exceeds 80% [318-320] (LE: 3).

7.5 Individual treatment strategy in primary or recurrent tumours after TURB without previous BCG intravesical immunotherapy

The type of further therapy after TURB should be based on the risk groups shown in Section 6.3 and Table 6.1. The stratification and treatment recommendations are based on the risk of disease progression. In particular in intermediate-risk tumours, the 2006 EORTC scoring model may be used (Section 6.1.1.1) to determine a patient's individual risk of disease recurrence as the basis to decide further treatment on.

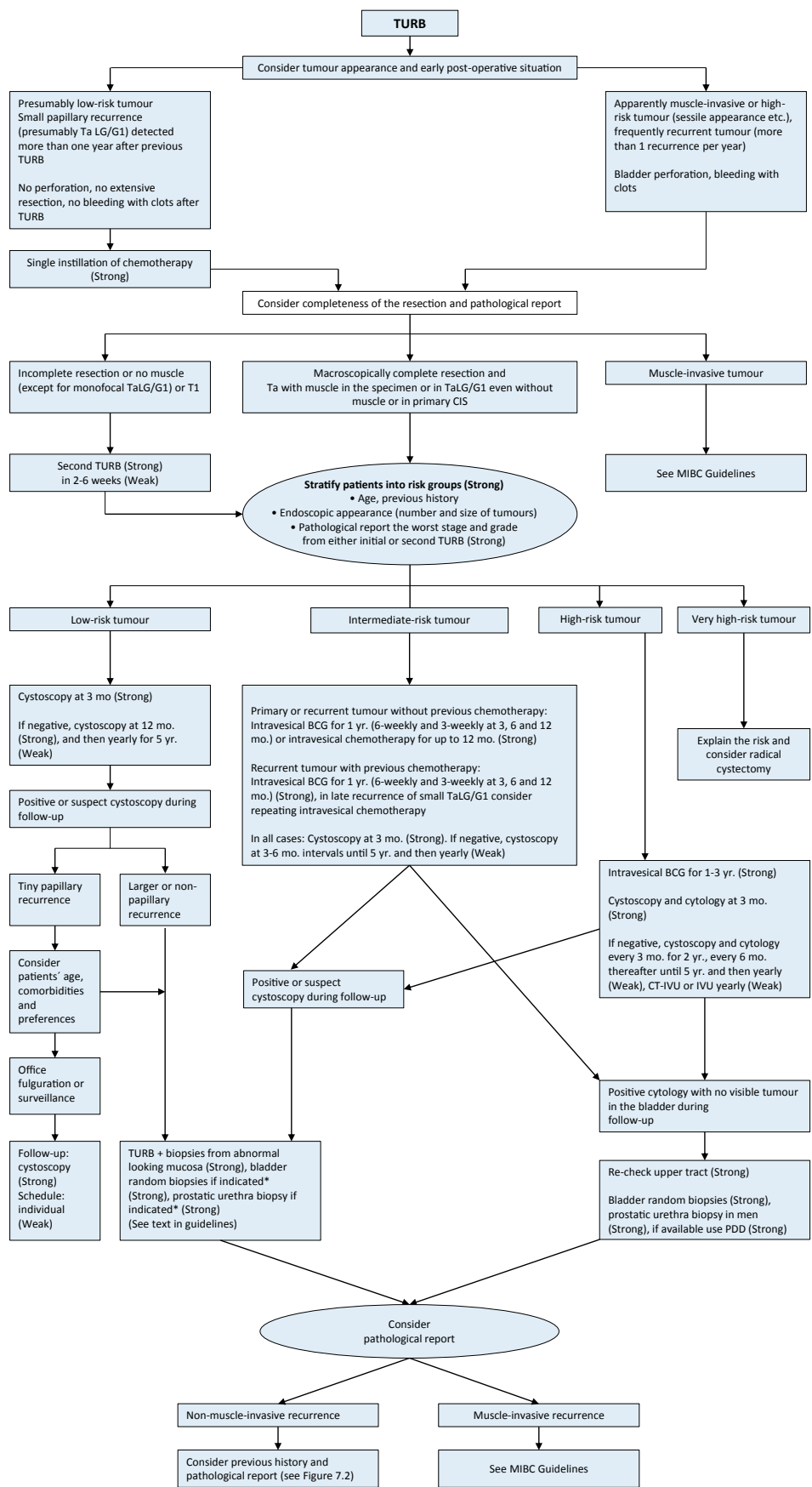
Any decisions should reflect the following principles:

- Patients in the low-risk group have a negligible risk of disease progression. The single post-operative instillation of chemotherapy reduces the risk of recurrence and is considered as sufficient treatment in these patients.

- Patients in the intermediate-risk group have a low risk of disease progression (7.4 and 8.5% after 10 years according to the 2021 EAU NMIBC scoring model). In these patients one-year full-dose BCG treatment (induction plus 3-weekly instillations at 3, 6 and 12 months), or instillations of chemotherapy (the optimal schedule is not known) for a maximum of one year, is recommended. The final choice should reflect the individual patient's risk of recurrence and progression as well as the efficacy and side effects of each treatment modality.
- Patients in the high-risk group have a high risk of disease progression (14.1 and 14.2% after 10 years according to the 2021 EAU NMIBC scoring model). In these patients full-dose intravesical BCG for one to 3 years (induction plus 3-weekly instillations at 3, 6, 12, 18, 24, 30 and 36 months), is indicated. The additional beneficial effect of the second and third years of maintenance should be weighed against its added costs, side effects and problems associated with BCG shortage. Because of the high risk of progression, immediate RC may also be discussed with the patient. Radical cystectomy is the safest approach from oncological point of view, it is, however, associated with the risk of complications and QoL impairment and represents overtreatment in some patients.
- Patients in the very high-risk group have an extremely high risk of tumour progression (53.1 and 58.6% after 10 years according to the 2021 EAU NMIBC scoring model). Immediate RC should be discussed with these patients. In case RC is not feasible or refused by the patient, full-dose intravesical BCG for one to 3 years should be offered.

Figure 7.1 presents a treatment flow chart based on risk category, which may guide management of an individual patient.

Figure 7.1: Treatment strategy in primary or recurrent tumour(s) without previous BCG*



* For details and explanations see the text of the guidelines.

BCG = bacillus Calmette-Guérin; CIS = carcinoma in situ; CT = computed tomography; IVU = intravenous urography; MIBC = muscle-invasive bladder cancer; PDD = photodynamic diagnosis; TURB = transurethral resection of the bladder.

7.6 Treatment of failure of intravesical therapy

7.6.1 Recurrence during or after intravesical chemotherapy

Patients with NMIBC recurrence during or after a chemotherapy regimen can benefit from BCG instillations. Prior intravesical chemotherapy has no impact on the effect of BCG instillations [238] (LE: 1a).

7.6.2 Treatment failure after intravesical BCG immunotherapy

Several categories of BCG failures, broadly defined as any HG disease occurring during or after BCG therapy, have been proposed (see Table 7.2). Non-muscle-invasive BC may not respond at all (BCG refractory) or may relapse after initial response (BCG relapsing). Some evidence suggests that patients with BCG relapse have better outcomes than BCG refractory patients [321].

To be able to specify the subgroup of patients where additional BCG is unlikely to provide benefit, the category of BCG-unresponsive tumour was defined. Further BCG instillations in these patients are associated with an increased risk of progression [209, 322]. The category of BCG-unresponsive tumours comprises BCG-refractory and some of BCG-relapsing tumours (see Table 7.2) [323]. The definition was developed in consultation with the U.S. Food and Drug Administration (FDA), in particular to promote single-arm trials to provide primary evidence of effectiveness in this setting [324].

Non-HG recurrence after BCG is not considered as BCG failure.

Table 7.2: Categories of high-grade recurrence during or after BCG

| |
|--|
| Whenever a MIBC is detected during follow-up. |
| BCG-refractory tumour |
| 1. If T1 HG/G3 tumour is present at 3 months [209, 322, 325] (LE: 3). |
| 2. If Ta HG/G3 tumour is present after 3 months and/or at 6 months, after either re-induction or first course of maintenance [302] (LE: 4). |
| 3. If CIS (without concomitant papillary tumour) is present at 3 months and persists at 6 months after either re-induction or first course of maintenance. If patients with CIS present at 3 months, an additional BCG course can achieve a complete response in > 50% of cases [45, 298, 302] (LE: 1b). |
| 4. If HG tumour appears during BCG maintenance therapy*. |
| BCG-relapsing tumour |
| Recurrence of HG/G3 (WHO 1973/2004) tumour after completion of BCG maintenance, despite an initial response [326] (LE: 3). |
| BCG-unresponsive tumour |
| BCG-unresponsive tumours include all BCG refractory tumours and those who develop T1/Ta HG recurrence within 6 months of completion of adequate BCG exposure** or develop CIS within 12 months of completion of adequate BCG exposure [323] (LE: 4). |
| BCG intolerance |
| Severe side effects that prevent further BCG instillation before completing treatment [280]. |

* Patients with LG recurrence during or after BCG treatment are not considered to be a BCG failure.

** Adequate BCG is defined as the completion of at least 5 of 6 doses of an initial induction course plus at least 2 out of 6 doses of a second induction course or 2 out of 3 doses of maintenance therapy.

7.6.3 Treatment of BCG-unresponsive tumours, late BCG-relapsing tumours, LG recurrences after BCG treatment and patients with BCG intolerance

Patients with BCG-unresponsive disease are unlikely to respond to further BCG therapy; RC is therefore the standard and preferred option. Currently, several bladder preservation strategies are being investigated such as cytotoxic intravesical therapies [327-330], device assisted instillations [331-333] intravesical immunotherapy [334, 335], systemic immunotherapy [336] or gene therapy [337-339].

A phase III RCT including predominantly high-risk NMIBC patients failing at least a previous induction course of BCG, MMC combined with microwave-induced hyperthermia provided 35% overall DFS at 2 years as compared to 41% in the control arm (treated with either BCG, MMC or MMC and electromotive drug administration at the discretion of the investigator). In the pre-planned sub-analysis, MMC and microwave-induced thermotherapy showed lower response rates in CIS recurrences but higher DFS in non-CIS papillary tumours (53% vs. 24%) [333].

Promising data on BCG-unresponsive cohorts of patients with CIS alone or concomitant to papillary tumours were recently reported following new immunotherapies. Systemic pembrolizumab achieved a 40% complete response rate in a prospective phase II study which was maintained in 48% of patients for up to 12 months (n = 101), resulting in FDA approval of the study drug for this patient population [340]. Promising data from a phase III multicentre RCT with intravesical nadofaragene firadenovec were published recently showing a complete response in 53.4% in patients with BCG-unresponsive CIS [341].

A systematic review and meta-analysis including 4 RCTs and 24 single-arm studies (all currently available prospective studies) assessed bladder-sparing treatments following BCG failure [342]. The significant heterogeneity of both trial designs and patient characteristics included in these studies, the different definitions of BCG failures used, and missing information on prior BCG courses may account for the variability in efficacy for the different compounds assessed across different trials. A higher number of previous BCG courses, BCG refractory/unresponsive or CIS predicted lower response rates. The pooled 12-month response rates were 24% for trials with ≥ 2 prior BCG courses and 36% for those with ≥ 1 BCG courses. Initial response rate did not predict durable responses highlighting the need for longer-term follow-up. More recently, a systematic review assessing 42 prospective trials on bladder preserving treatments after BCG showed that patients with papillary-only recurrences appeared more effectively treated (median recurrence free rates of 44% at 1 year, median progression-free rate 89% at a median follow-up of 19 months) than CIS-containing tumours (median complete response rate 17% at 1 year with a median progression-free rate of 95% at a median follow-up of 12 months), highlighting potential biological differences between these two tumour entities which should be analysed separately when reporting results of clinical trials [343].

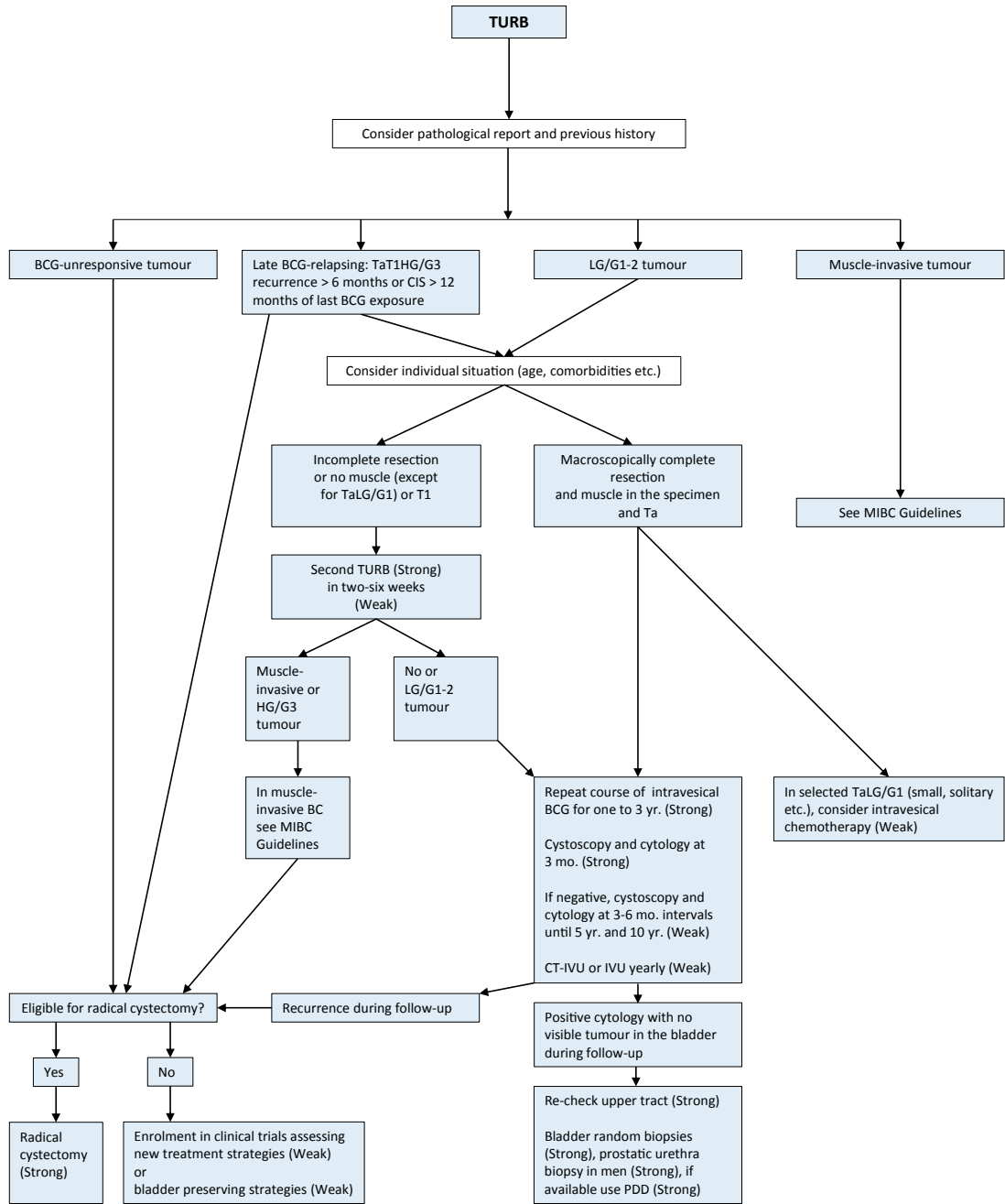
At the present time, treatments other than RC are considered oncologically inferior in patients with BCG-unresponsive disease [209, 322, 325] (LE: 3). Various studies suggest that repeat-BCG therapy is appropriate for non-HG and even for some HG recurrent tumours; namely those relapsing beyond one year after BCG exposure (cases which do not meet the criteria of BCG-unresponsive disease) [344, 345] (LE: 3).

Treatment decisions in LG recurrences after BCG (which are not considered as any category of BCG failure) should be individualised according to tumour characteristics. Little is known about the optimal treatment in patients with high-risk tumours who could not complete BCG instillations because of intolerance.

7.6.4 **Summary of evidence - treatment failure of intravesical therapy**

| Summary of evidence | LE |
|---|-----------|
| Prior intravesical chemotherapy has no impact on the effect of BCG instillation. | 1a |
| Treatments other than RC must be considered oncologically inferior in patients with BCG-unresponsive tumours. | 3 |

Figure 7.2: Treatment strategy in recurrence during or after intravesical BCG*



BCG = bacillus Calmette-Guérin; CIS = carcinoma in situ; HG = high-grade; IVU = intravenous urography; LG = low-grade; PDD = photodynamic diagnosis; TURB = transurethral resection of the bladder.

7.7 Guidelines for adjuvant therapy in TaT1 tumours and for therapy of carcinoma in situ

| General recommendations | Strength rating |
|---|-----------------|
| Counsel smokers with confirmed non-muscle-invasive bladder cancer (NMIBC) to stop smoking. | Strong |
| The type of further therapy after transurethral resection of the bladder (TURB) should be based on the risk groups shown in Section 6.3 and Table 6.1. For determination of a patient's risk group use the 2021 EAU risk group calculator available at www.nmibc.net . | Strong |
| In patients with tumours presumed to be at low risk and in those with small papillary recurrences (presumably Ta LG/G1) detected more than one year after previous TURB, offer one immediate chemotherapy instillation. | Strong |

| | |
|---|--------|
| In patients with intermediate-risk tumours (with or without immediate instillation), one-year full-dose Bacillus Calmette-Guérin (BCG) treatment (induction plus 3-weekly instillations at 3, 6 and 12 months), or instillations of chemotherapy (the optimal schedule is not known) for a maximum of one year is recommended. The final choice should reflect the individual patient's risk of recurrence and progression as well as the efficacy and side effects of each treatment modality. | Strong |
| In patients with high-risk tumours, full-dose intravesical BCG for one to 3 years (induction plus 3-weekly instillations at 3, 6, 12, 18, 24, 30 and 36 months), is indicated. The additional beneficial effect of the second and third years of maintenance should be weighed against its added costs, side effects and problems connected with BCG shortages. Immediate radical cystectomy (RC) may also be discussed with the patient. | Strong |
| In patients with very high-risk tumours discuss immediate RC. Offer intravesical full-dose BCG instillations for one to 3 years to those who refuse or are unfit for RC. | Strong |
| Offer transurethral resection of the prostate, followed by intravesical instillation of BCG to patients with CIS in the epithelial lining of the prostatic urethra. | Weak |
| The definition of 'BCG-unresponsive' should be respected as it most precisely defines the patients who are unlikely to respond to further BCG instillations. | Strong |
| Offer a RC to patients with BCG-unresponsive tumours. | Strong |
| Offer patients with BCG-unresponsive tumours, who are not candidates for RC due to comorbidities, preservation strategies (intravesical chemotherapy, chemotherapy and microwave-induced hyperthermia, electromotive administration of chemotherapy, intravesical- or systemic immunotherapy; preferably within clinical trials). | Weak |
| Recommendations - technical aspects for treatment | |
| Intravesical chemotherapy | |
| If given, administer a single immediate instillation of chemotherapy within 24 hours after TURB. | Weak |
| Omit a single immediate instillation of chemotherapy in any case of overt or suspected bladder perforation or bleeding requiring bladder irrigation. | Strong |
| Give clear instructions to the nursing staff to control the free flow of the bladder catheter at the end of the immediate instillation. | Strong |
| The optimal schedule and duration of further intravesical chemotherapy instillation is not defined; however, it should not exceed one year. | Weak |
| If intravesical chemotherapy is given, use the drug at its optimal pH and maintain the concentration of the drug by reducing fluid intake before and during instillation. | Strong |
| The length of individual instillation should be one to two hours. | Weak |
| BCG intravesical immunotherapy | |
| Absolute contraindications of BCG intravesical instillation are: <ul style="list-style-type: none"> • during the first two weeks after TURB; • in patients with visible haematuria; • after traumatic catheterisation; • in patients with symptomatic urinary tract infection. | Strong |

7.8 Guidelines for the treatment of TaT1 tumours and carcinoma *in situ* according to risk stratification

| Recommendations | Strength rating |
|---|-----------------|
| <i>EAU risk group: Low</i> | |
| Offer one immediate instillation of intravesical chemotherapy after transurethral resection of the bladder (TURB). | Strong |
| <i>EAU Risk Group: Intermediate</i> | |
| In all patients either one-year full-dose Bacillus Calmette-Guérin (BCG) treatment (induction plus 3-weekly instillations at 3, 6 and 12 months), or instillations of chemotherapy (the optimal schedule is not known) for a maximum of one year is recommended. The final choice should reflect the individual patient's risk of recurrence and progression as well as the efficacy and side effects of each treatment modality. Offer one immediate chemotherapy instillation to patients with small papillary recurrences (presumably Ta LG/G1) detected more than one year after previous TURB. | Strong |
| <i>EAU risk group: High</i> | |
| Offer intravesical full-dose BCG instillations for one to 3 years or discuss immediate radical cystectomy (RC). | Strong |

| | |
|--|--------|
| <i>EAU risk group: Very High</i> | |
| Offer RC or intravesical full-dose BCG instillations for one to 3 years to those who refuse or are unfit for RC. | Strong |

Table 7.3: Treatment options for the various categories of BCG failure

| Category | Treatment options |
|--|---|
| BCG-unresponsive | 1. Radical cystectomy (RC). 2. Enrolment in clinical trials assessing new treatment strategies. 3. Bladder-preserving strategies in patients unsuitable or refusing RC. |
| Late BCG relapsing: TaT1 HG recurrence > 6 months or CIS > 12 months of last BCG exposure | 1. Radical cystectomy or repeat BCG course according to a patient's individual situation. 2. Bladder-preserving strategies. |
| LG recurrence after BCG for primary intermediate-risk tumour | 1. Repeat BCG or intravesical chemotherapy. 2. Radical cystectomy. |

8. FOLLOW-UP OF PATIENTS WITH NMIBC

As a result of the risk of recurrence and progression, patients with NMIBC need surveillance following therapy. However, the frequency and duration of cystoscopy and imaging follow-up should reflect the individual patient's degree of risk. Using the EAU NMIBC prognostic factor risk groups (see Section 6.3, Tables 6.1 and 6.2) or further prognostic models for specific patient populations (see Chapter 6), the short- and long-term risks of recurrence and progression in individual patients may be predicted and the follow-up schedule adapted accordingly (see Section 8.1) [194, 196]. However, recommendations for follow-up are mainly based on retrospective data and there is a lack of RCTs investigating the possibility of safely reducing the frequency of follow-up cystoscopy.

When planning the follow-up schedule and methods, the following aspects should be considered:

- The prompt detection of muscle-invasive and HG/G3 non-muscle-invasive recurrence is crucial and the percentage of tumours missed should be as low as possible because a delay in diagnosis and therapy can be life-threatening. Therefore, the best surveillance strategy for these patients will continue to include frequent cystoscopy and cytology.
- Tumour recurrence in the low-risk group is nearly always low stage and LG/G1. Small, Ta LG/G1 papillary recurrence does not present an immediate danger to the patient and early detection is not essential for successful therapy [346, 347] (LE: 2b). Fulguration of small papillary recurrences on an outpatient basis could be safe [348] (LE: 3). Multiple authors have suggested active surveillance in selected cases [349-351] (LE: 3/2a).
- The first cystoscopy after TURB at 3 months is an important prognostic indicator for recurrence and progression [202, 208, 352-354] (LE: 1a). Therefore, the first cystoscopy should always be performed 3 months after TURB in all patients with TaT1 tumours and CIS.
- In tumours at low risk, the risk of recurrence after 5 recurrence-free years is low [353] (LE: 3). Therefore, in low-risk tumours, after 5 years of follow-up, discontinuation of cystoscopy or its replacement with less-invasive methods can be considered [354].
- In tumours originally intermediate-, high risk, or very high risk treated conservatively, recurrences after ten years tumour-free are not unusual [355] (LE: 3). Therefore, life-long follow-up is recommended [354].
- The follow-up strategy must reflect the risk of extravesical recurrence (prostatic urethra in men and UUT in both genders).
- The risk of UUT recurrence increases in patients with multiple- and high-risk tumours [85] (LE: 3).
- There may be a role for newer methods of tumour visualisation in follow-up cystoscopy. In a prospective study of blue light flexible cystoscopy (BLFC) for surveillance of NMIBC, BLFC alone showed an abnormality in 8% of which half had biopsy-confirmed BC [356]. On the other hand, a prospective study of narrow-band imaging (NBI) for NMIBC surveillance failed to show any benefit for NBI over white light cystoscopy alone [357].

- The current status of urine cytology and urinary molecular marker tests is discussed in detail in Sections 5.5, 5.6 and 5.7. Non-muscle-invasive BC follow-up strategies include urine cytology and urinary molecular marker tests as adjunct (or companion) tests to improve detection at the time of flexible cystoscopy or as replacement tests to reduce the number of flexible cystoscopies.
- The role of urinary cytology or urinary molecular markers as an adjunct to cystoscopy (companion test) in the follow-up of NMIBC has been investigated [106, 107, 119, 120, 124]. One prospective RCT found that knowledge of positive test results (microsatellite analysis) can improve the quality of follow-up cystoscopy [125] (LE: 1b), supporting the adjunctive role of a non-invasive urine test performed prior to follow-up cystoscopy [125] (see Section 5.7.3).
- In order for urinary markers to reduce or replace cystoscopy altogether, they should be able to detect recurrence across all risk groups. However, currently the limitation of urinary cytology and current urinary markers is their low sensitivity for LG recurrences [101, 107] (see Section 5.7.3) (LE: 1b).
- In patients initially diagnosed with Ta LG/G1–2 BC, US of the bladder or a urinary marker may be a mode of surveillance in case cystoscopy is not possible or refused by the patient [123, 124, 358].
- According to current knowledge, no urinary marker can replace cystoscopy during follow-up or lower cystoscopy frequency in a routine fashion.

8.1 Summary of evidence and guidelines for follow-up of patients after transurethral resection of the bladder for non-muscle-invasive bladder cancer

| Summary of evidence | LE |
|--|----|
| The first cystoscopy after transurethral resection of the bladder at 3 months is an important prognostic indicator for recurrence and progression. | 1a |
| The risk of upper urinary tract recurrence increases in patients with multiple- and high-risk tumours. | 3 |

| Recommendations | Strength rating |
|---|-----------------|
| Base follow-up of TaT1 tumours and carcinoma <i>in situ</i> (CIS) on regular cystoscopy. | Strong |
| Patients with low-risk Ta tumours should undergo cystoscopy at 3 months. If negative, subsequent cystoscopy is advised 9 months later, and then yearly for 5 years. | Weak |
| Patients with high-risk and those with very high-risk tumours treated conservatively should undergo cystoscopy and urinary cytology at 3 months. If negative, subsequent cystoscopy and cytology should be repeated every 3 months for a period of 2 years, and every 6 months thereafter until 5 years, and then yearly. | Weak |
| Patients with intermediate-risk Ta tumours should have an in-between (individualised) follow-up scheme using cystoscopy. | Weak |
| Regular (yearly) upper tract imaging (computed tomography-intravenous urography [CT-IVU] or IVU) is recommended for high-risk and very high-risk tumours. | Weak |
| Perform endoscopy under anaesthesia and bladder biopsies when office cystoscopy shows suspicious findings or if urinary cytology is positive. | Strong |
| During follow-up in patients with positive cytology and no visible tumour in the bladder, mapping biopsies or PDD-guided biopsies (if equipment is available) and investigation of extravesical locations (CT urography, prostatic urethra biopsy) are recommended. | Strong |
| In patients initially diagnosed with Ta LG/G1–2 bladder cancer, use ultrasound of the bladder, and/or a urinary marker during surveillance in case cystoscopy is not possible or refused by the patient. | Weak |

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10. CONFLICT OF INTEREST

All members of the Non-Muscle-Invasive Bladder Cancer guidelines working group have provided disclosure statements of all relationships that they have that might be perceived as a potential source of a conflict of interest. This information is open access available on the European Association of Urology website: <https://uroweb.org/guideline/non-muscle-invasive-bladder-cancer/?type=panel>.

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