

D. Robert Siemens, MD,
FRCSC

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For most readers of *CUAJ*, the care of patients with bladder cancer represents one of the core features of our professional lives and is arguably a distinguishing hallmark of what it is to be a genitourinary surgeon. Bladder cancer management is complex, particularly so in the increasingly aged and comorbid North American patient population. It shares most properties of any chronic medical condition, including the need for multiple interventions, and the price tag to match. Given its prevalence, as well as its management intensity and complexity, the quality of bladder cancer care represents a relatively sensitive bellwether for our urological specialty, particularly in an ever-constricting Canadian healthcare environment.

So how are we doing? Despite attempts to address some of these concerns through publication of clinical guidelines, such as those offerings from advocacy networks and national associations, there is evidence of significant variability in the care of patients with both non-muscle-invasive bladder cancer (NMIBC) and those with muscle-invasive (MIBC) disease. In one review of 4545 patients in Surveillance, Epidemiology, and End Results-Medicare-linked data, Chamie et al found only one patient who received an optimal (albeit amalgamated) treatment care path for higher-risk NMIBC.¹ Multiple such reports exist, all highlighting the underuse of effective care across the disease spectrum of bladder cancer management — adherence to surveillance strategies, use of perioperative mitomycin, and use of neoadjuvant chemotherapy for MIBC.²

Although somewhat controversial, this variability in the care delivery in the general population likely results in marked variances in both early- and longer-term outcomes compared to possible outcomes in clinical trials or centers of excellence. The study described above demonstrated that lack of adherence to relatively commonplace recommendations of surveillance and adjuvant bacillus Calmette-Guérin immunotherapy was associated with increased mortality. Over a decade ago, Herr et al reported data from the randomized cooperative group trial (SWOG 8710, INT-0080) demonstrating wide variability in measures of surgical quality among the 109 participating institutions.³ Some of these factors, including both surgeon and institutional characteristics, were associated with cancer outcomes despite controlling for important patient and disease characteristics.

Given our unique geographic and funding realities in Canada, it should be no surprise that similar deviations in care are pervasive across our nation and are particularly obvious with respect to wait times and access to care.⁴ Several recent reports from institutional and regional databases suggest marked variations and in-coordination in bladder cancer care. Some of these have highlighted concerning gaps in adoption of standard of care, as well as incorporation of other processes of care delivery all leading to inferior early and late outcomes. Although all of these studies suffer from the serious limitation of lack of up-to-date information, the trends are worrisome.

In response to these perceived shortcomings, a national initiative co-sponsored by the Canadian Urological Association, Canadian Urological Oncology Group, and Bladder Cancer Canada was undertaken in late 2014. The initiative was an attempt to streamline and unify treatment approaches to bladder cancer care with a very keen eye on the realities and potential barriers of healthcare delivery in Canada. A multidisciplinary panel of expert clinicians was convened as a working group to provide consensus opinions and potential solutions. The 29 panelists included urologic oncologists, medical oncologists, radiation oncologists, patient representatives, a genitourinary pathologist, and an enterostomal therapy nurse. The discussion represented a “deep dive” into bladder cancer care in our universal healthcare system and ranged from optimized care of both NMIBC and MIBC, to defining process- and structure-level issues that need to be addressed by our community.

The proceedings of the consensus meeting were published as a white paper in the February 2016 issue of *CUAJ*; given its extensive discussion, the paper was published online only and not in the paper or digital version of the journal. We encourage all to access the document at <http://www.cuaj.ca/index.php/journal/article/view/3583/2541>. It should be required reading for all who manage patients with bladder cancer, as it presents both practical recommendations for complex issues, as well as a call to arms to improve our quality of care for bladder cancer in Canada.

This publication is just one recent example of several voices focused on improving the outcomes of those diagnosed with bladder cancer, including several provincial working groups and a recent national advocacy campaign, “See Red? See Your Doctor” from Bladder Cancer Canada (<https://bladdercancercanada.org/en/see-red-see-your-doctor/>).

We all want to witness the development of more effective and precise treatments for bladder cancer; however, the

immediate optimization of care delivery for existing therapies is required to maximize current outcomes and allow a narrowing of efficacy-effectiveness gaps.

References

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Correspondence: Dr. Robert Siemens, Department of Urology, Queen's University, Kingston, ON, Canada; siemensr@KGH.KARI.NET