

The Canadian Bladder Cancer Network: efforts to improve patient care

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The Canadian Bladder Cancer Network (CBCN) should be applauded for their reports on the experience at a national level with radical cystectomy for bladder cancer.¹ Such reports identify deficits for us, as urologists and allied physicians, to improve the care of our patients with bladder cancer.

In this paper, the CBCN has addressed the outcomes of one of the most challenging patient groups (clinical T1 bladder cancer); in so doing, the paper has identified a particularly glaring need for improvement.¹ The authors determined that 48% of patients were upstaged to pT2-4 and 26% were found to be node positive. Five- and 10-year overall survival was only 71% and 60%, respectively. The results are not markedly different from other published series.

While the authors recognize the poor outcomes and attribute these primarily to understaging, this is only one possible explanation. Nobody would argue the need for better staging tools or biomarkers to predict more aggressive disease. Unfortunately, the data set does not allow any conclusions to be made, but one can speculate on other contributing factors. The apparent understaging is likely a reflection of disease progression on a bladder-preserving regimen. These results add more fuel to the ongoing debate for immediate versus delayed cystectomy. Nonetheless, it would be relevant to ascertain the rate of administration of second-line intravesical treatment in Canada in this patient population to see if this is overused in patients who would be better managed with cystectomy. The rate of progression after failing intravesical Bacillus Calmette-Guerin (BCG) is high, so that further bladder preservation should only be offered to patients with a prohibitive surgical risk.²

Another particularly Canadian question relates to wait times and treatment delays. Bladder preservation in T1 bladder cancer involves many different steps from referral to diagnostic cystoscopy, to transurethral resection of a bladder tumour (TURBT) and re-TURBT, and to intravesical therapy and further diagnostic and therapeutic interventions – not

to mention the potential delay prior to cystectomy. In the Canadian system, there is ample room for multiple delays which may adversely affect the outcome of this difficult cohort.³

One must also consider that our poor adherence to treatment guidelines could contribute to the disappointing survival rates of these patients.⁴ We have seen how poorly we adhere to standards of care defined for bladder cancer.⁵ For T1 bladder cancer, are re-resections being performed, as advocated, after the initial diagnosis? Are we following induction BCG with maintenance BCG for these patients with T1 disease? Addressing these shortcomings is the low hanging fruit with which we can potentially make some immediate positive impact. Beyond this, this report underscores the need for more research on biomarkers and novel therapies for bladder cancer, as well as prospective randomized trials comparing existing treatment modalities.

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