Nicholas Power
Division of Urology, Western University, London, ON, Canada

Cite as: Power N. Guideline adherence in treating non-muscle-invasive bladder cancer: Discipline can save lives. *Can Urol Assoc J* 2025;19(10):311. http://dx.doi.org/10.5489/cuaj.9439

See related article on page 302

Guideline adherence in treating non-muscle-invasive bladder cancer: Discipline can save lives

"Plentie is no deyntie, ye see not your owne ease. I see, ye can not see the wood for the trees."

- John Heywood, 1565

This month's study by Gotto et al provides a sobering yet invaluable snapshot of how high-risk non-muscle-invasive bladder cancer (HR NMIBC) is managed in the real world in Canada. Their findings, namely, that the majority of patients in Alberta failed to receive adequate bacillus Calmette-Guérin (BCG) after transurethral resection of bladder tumor (TURBT), highlight the perennial gap between evidence and practice.[1]

The SWOG 8507 trial demonstrated, nearly 25 years ago, that induction plus maintenance BCG reduced recurrence, progression, and cancer-specific mortality in HR NMIBC.[2] These results were reinforced by EORTC 30911, which confirmed the superiority of BCG, including improved time to distant metastasis, overall survival, and disease-specific survival.[3] Yet, despite endorsement in the CUA,[4] AUA/SUO, and EAU guidelines, only a minority of patients receive what could be considered "adequate" therapy.

In urologic oncology, we chase innovation, yet we fail to deliver the very regimen that has the strongest evidence base in bladder cancer. In prostate cancer, such neglect would be unthinkable. Consider this: patients with HR NMIBC who do not receive adequate BCG have five-year cancer-specific survival in the 60–70% range in most series. In prostate cancer, this is nearly identical to the five-year overall survival of 60–65% observed in low-volume metastatic hormone-sensitive prostate cancer (mHSPC) treated with ADT plus docetaxel or abiraterone, as reported in CHAARTED[5] and STAMPEDE.[6] Yet while failure to intensify therapy in mHSPC is met with professional censure, omission of adequate BCG in HR NMIBC too often passes without comment.

Ontario Cancer Statistics sharpen the point further: from 1984–2018, the five-year survival rate for bladder cancer declined from 76.1% to 65.4%, even as survival for most other major cancers improved.[7] The reasons are complex, but underuse of evidence-based therapies is a likely contributor.

What then is the solution? Human history suggests that behavioral inertia is not easily overcome by guidelines alone. Perhaps the promise lies in leveraging AI, not for dazzling discoveries, but for the menial and yet crucial tasks we routinely neglect. EMR-embedded nudges, automated scheduling of maintenance BCG, digital risk calculators, and AI-driven patient counseling tools could reduce the attrition of adherence.

This study should therefore be read less as a lament and more as a call to arms. Fidelity to guideline-based therapy is not mediocrity but mastery. If we continue to miss the forest for the trees, we will lose lives not for lack of innovation, but for lack of discipline. The most transformative act in HR NMIBC is not the discovery of the next drug, but the insistence that every patient receives the simple, proven therapy that already saves lives.

COMPETING INTERESTS: The author does not report any competing personal or financial interests related to this work.

REFERENCES

1. Gotto G, Alimohamed NS, Kulkarni GS, et al. A population-based analysis of patterns of care in patients with high-risk non-muscle-invasive bladder cancer from Alberta, Canada. *Can Urol Assoc J* 2025;19:302-10. http://dx.doi. org/10.5489/cuaj.9110
2. Lamm DL, Blumenstein BA, Crissman JD, et al. Maintenance bacillus Calmette-Guérin immunotherapy for recurrent Ta, T, and carcinoma in situ transitional cell carcinoma of the bladder: A randomized Southwest Oncology Group Study. *J Urol* 2000;163:1124-9. https://doi.org/10.1016/S0022-5347(05)67707-5
3. Sylvester RJ, et al. Long-term efficacy results of EORTC GU Group randomized phase 3 study 30911 comparing intravesical BCG and epirubicin. *Eur Urol* 2010;57:766-73. https://doi.org/10.1016/j.eururo.2009.12.024
4. Bhindi B, Kool R, Kulkarni GS, et al. Canadian Urological Association guideline on the management of non-muscle-invasive bladder cancer. *Can Urol Assoc J* 2021;15:E424-60. https://doi.org/10.5489/cuaj.7367
5. Sweeney CJ, Chen YH, Carducci M, et al. Chemohormonal therapy in metastatic hormone-sensitive prostate cancer. *N Engl J Med* 2015;373:737-46. https://doi.org/10.1056/NEJMoa1503747
6. James ND, de Bono JS, Spears MR, et al. Abiraterone for prostate cancer not previously treated with hormone therapy. *N Engl J Med* 2017;377:338-51. https://doi.org/10.1056/NEJMoa1702900
7. Cancer Care Ontario. *Ontario Cancer Statistics 2022*. Toronto, ON: Ontario Health (Cancer Care Ontario); 2022. Available at: https://www.cancercareontario.ca/en/statistical-reports/ontario-cancer-statistics-2022. Accessed August 21, 2025

CORRESPONDENCE: Dr. Nicholas Power, Division of Urology, Western University, London, ON, Canada; nicholas.power@lhsc.on.ca