BRITISH ASSOCIATION OF UROLOGICAL SURGEONS

COVID-19 strategy for the interim management of bladder cancer

Prepared by the BAUS Section of Oncology

This document has been produced to outline two contingency plans for how bladder cancer service provision may need to deviate from the internationally accepted standard of care, during the current COVID-19 pandemic. Step one reflects response to reduced service provision whereas step two reflects response to severely reduced service provision. It is recognised that individual hospital circumstances will differ and not all measures will be required in every unit.

DIAGNOSTICS

2WW Referrals

Existing NICE NG 12 2WW criteria	Current provision	Step 1 (reduced service provision)	Step 2 (severely reduced provision)
Visible haematuria over 45 years	Haematuria clinic	Haematuria clinic	Community based USS or emergency care if severe
Non-visible haematuria over 60 years	Haematuria clinic	Community based USS or defer	Defer investigations

TURBT

	Current provision	Step 1 (reduced service provision)	Step 2 (severely reduced provision)
New bladder tumour	TURBT	Restrict to solid tumours and actively bleeding tumours	Stop TURBT
Re-resection bladder tumour	TURBT	Restrict to very high risk NMIBC (very strong suspicion of understaging)	Stop TURBT

MDT

Clear documentation of NICE risk stratification of all bladder tumours

- low/intermediate/high risk NMIBC
- MIBC
- Metastatic bladder cancer

Document if MDT treatment plan has been modified in response to COVID 19

TREATMENT

Non-muscle invasive bladder cancer

Risk stratification	Current provision	Step 1 (reduced provision)	Step 2 (severely reduced provision)
Low risk	Flexible cystoscopy at 3/12	Flexible cystoscopy at 12/12	Stop surveillance
Intermediate risk	Intravesical chemotherapy then flexible cystoscopic surveillance	Flexible cystoscopy at 6/12	Flexible cystoscopy at 12/12
High risk	Intravesical BCG and flexible cystoscopic surveillance/cystectomy	Flexible cystoscopy at 3/12	Flexible cystoscopy at 6/12

No role for intravesical instillation (BCG or chemotherapy) for non-muscle invasive bladder cancer due to potential immunosuppressive effects.

Muscle invasive disease

Perform CT chest, abdo, pelvis for those being treated with curative intent

	Current provision	Step 1 (reduced service provision)	Step 2 (severely reduced provision)
T2-4N0M0 disease	Neoadjuvant chemotherapy + radical radiotherapy or cystectomy and urinary diversion	Radiotherapy	Radiotherapy if available
T2-4N0M0 where EBRT contra-indicated (previous EBRT, IBD, significant adhesions)	Neoadjuvant chemotherapy + radical (salvage) cystectomy and urinary diversion	Radical cystectomy and urinary diversion	Defer surgery for maximum 3/12

Use of neoadjuvant chemotherapy: Advise against neoadjuvant chemotherapy, some consideration could be given to patients with more locally advanced disease (T3/4) to a more downstaging approach if definitive curative treatment is thought to be appropriate thereafter.

Radiotherapy: All patients who have started radical radiotherapy to the bladder should continue. Consider offering radical radiotherapy treatment to muscle invasive disease if facilities continue. Chemotherapy combined with radiotherapy likely to have additional risks from COVID-19 in immunocompromised patients.
Metastatic disease: Chemotherapy should be considered, but with the use of growth factors to minimise risk of infection. In more indolent metastatic disease, a surveillance approach, if at all possible, should be advised.

PATIENTS CURRENTLY ON TREATMENT

Intravesical chemotherapy/BCG: complete induction if possible, then defer further treatment

Neoadjuvant chemotherapy: Stopping should be discussed with patients and if there have been any complications with treatment to date cessation of treatment should be recommended

Awaiting cystectomy: proceed ASAP – need to prioritise over other less urgent cases

Awaiting radiotherapy: Radical radiotherapy should continue if possible. Consideration given to circumstances where patients live in geographically remote areas and have to leave their homes to relocate locally for treatment to stay in hostels etc – as here risk of COVID 19 are going to be greater.

Palliative treatment should only proceed if patients are symptomatic e.g. with significant bleeding, and ideally plan and treat same day, and keep doses and fractionations to a minimum

FOLLOW-UP

Telephone follow-up: bloods/scans as dictated by symptoms, otherwise defer.

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