Urothelial Carcinoma of Bladder and Upper Tract

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Note: Consider Clinical Trials as treatment options for eligible patients.

CLINICAL PRESENTATION

- Hematuria
- Recurrent unexplained urinary tract infection
- Other unexplained lower urinary tract symptoms

INITIAL EVALUATION

- History and physical
- Office cystoscopy
- Imaging: CT urogram or intravenous urogram (IVU)
- Lifestyle risk assessment

INITIAL DIAGNOSIS

- Negative for bladder cancer
  - Treat as indicated

- Positive for bladder cancer
  - Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Surrogate-Decision Maker (SDM)
  - Transurethral resection (TUR)
  - Consider single dose peri-operative chemotherapy instillation
  - Exam under anesthesia (EUA)

INITIAL STAGING

- Less than T2 (non-muscle invasive) → See Page 2-3
- T2-4 (muscle invasion) → See Page 4
- Any T, N+, M+ → See Page 5

See Page 6

1 May also consider urinary cytology or other MD Anderson approved genitourinary biomarkers
2 See Physical Activity, Nutrition, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
3 If persistent microhematuria, recommend repeat of history and physical, office cystoscopy, imaging (CT urogram or IVU) in 2-3 years
4 GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients or if clinically indicated the SDM should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to the GCC home page (for internal use only).
5 Refer to Principles of Intravesical Treatment on Page 8
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STAGE

Ta-Unifocal (low-grade solitary tumor)
- TUR and surveillance cystoscopy¹ at 3 months and if clear, then 9 months later (at 12 months after initial), and then annually
  - Recurrence?
    - Yes
      - Ta: Follow Ta - Multifocal path
      - Tis, T1-3: Follow appropriate path
    - No
      - Continue surveillance cystoscopy¹ (every 3 months for 2 years; every 6 months for 2 years; then annually)

Ta-Multifocal (low-grade)
- • BCG (weekly for 6 weeks) with or without maintenance or
  - • Intravesical chemotherapy with maintenance for 1 year or
  - • Observation (in selected cases) or
  - • Clinical trial
- Repeat cystoscopy to assess response (with or without biopsy if indicated) at 3 months
  - Residual disease?
    - Yes
      - • Radical cystectomy or
      - • Clinical trial or
      - • Salvage intravesical therapy or
      - • Pembrolizumab²
      - See Surveillance on Page 7
    - No
      - • Continue BCG as per SWOG protocol
      - • Continue surveillance cystoscopy¹ (every 3 months for 2 years; every 6 months for 2 years; then annually)

Carcinoma In-Situ (CIS)
- BCG (weekly for 6 weeks) plus maintenance for 3 years
- Cystoscopy¹ at 3 and 6 months
- Persistent carcinoma in-situ at 6 months?
  - Yes
    - • Radical cystectomy or
    - • Clinical trial or
    - • Salvage intravesical therapy or
    - • Pembrolizumab²
    - See Surveillance on Page 7
  - No
    - • Continue BCG as per SWOG protocol
    - • Continue surveillance cystoscopy¹ (every 3 months for 2 years; every 6 months for 2 years; then annually)

BCG = Bacillus Calmette-Guerin therapy
SWOG = Southwest Oncology Group

¹ Cystoscopy combined with either cytology or fluorescence in situ hybridization (FISH) cytology as indicated. In selected patients, fluorescent cystoscopy should be considered.
² Pembrolizumab is indicated for the treatment of patients with BCG-unresponsive, high-risk, non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors who are ineligible for or have elected not to undergo cystectomy.

Department of Clinical Effectiveness V10
Approved by The Executive Committee of the Medical Staff on 02/21/2023
Urothelial Carcinoma of Bladder and Upper Tract

TREATMENT AND FOLLOW-UP

STAGE

High-Grade (HG) Ta or T1-Unifocal

- Muscle in pathology specimen?
  - Yes
    - T1: re-biopsy to exclude T2
    - Ta, HG: consider re-biopsy
  - No
    - See Page 4

- cT1
  - Consider early cystectomy
  - Patient accepts surgery?
    - Yes
      - Cystectomy
    - No
      - Continue BCG as per SWOG protocol
      - Continue surveillance cystoscopy (every 3 months for 2 years; every 6 months for 2 years; then annually)

- cT2
  - See Page 4

- cTa
  - BCG (weekly for 6 weeks) plus maintenance for 3 years
  - Consider repeat biopsy to assess response at 3 months (if positive cystoscopy or no initial TUR)

- Residual disease?
  - Yes
    - Radical cystectomy or Clinical trial or Pembrolizumab
  - No
    - Cystoscopy

- pT3b
  - Observation

- N+, margins positive or prostatic stromal invasion pT4a
  - Observation

- pT3a
  - Observation

- Upstaged at surgery?
  - Yes
    - Consider adjuvant cisplatin or ifosfamide-based chemotherapy (see Page 9)
  - No

BCG = Bacillus Calmette-Guerin therapy
SWOG = Southwest Oncology Group

1 Pembrolizumab is indicated for the treatment of patients with BCG-unresponsive, high-risk, non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors who are ineligible for or have elected not to undergo cystectomy

2 Cystoscopy combined with either cytology or fluorescence in situ hybridization (FISH) cytology as indicated. In selected patients, fluorescent cystoscopy should be considered.

3 T1 multifocal, variant histology with concurrent carcinoma in situ (CIS), lymphovascular invasion (LVI) and/or resectable tumor 3 cm or greater with poor prognosticator or too large to resect completely

Note: Consider Clinical Trials as treatment options for eligible patients.

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**Note:** Consider Clinical Trials as treatment options for eligible patients.

**STAGE**

- **EUA**
- **CT chest, abdomen, and pelvis**
- **CT chest if positive chest x-ray or clinical suspicion for metastasis**
- **Bone scan if elevated alkaline phosphatase or bone pain**

**T2-4** (muscle invasion)

**T2/3a, N0, M0**

- **Patient accepts surgery?**
  - **Yes**
    - **Cystectomy**
    - **Upstaged at surgery?**
      - **Yes**
        - **Bladder sparing treatment**
          - Chemoradiation or Clinical trial
      - **No**
        - Observation
    - **No**
      - Consider metastatic chemotherapy clinical trial if available

**T3b/4a, N0, M0**

- **Neoadjuvant chemotherapy**
- **Clinical trial**

**T4b, N0, M0**

- **Consider metastatic chemotherapy clinical trial if available**

**Presence of poor risk factors?**

**Yes**

- **EUA**
- **CT thorax, abdomen, and pelvis**
- **CT chest if positive chest x-ray or clinical suspicion for metastasis**
- **Bone scan if elevated alkaline phosphatase or bone pain**

**T2/3a, N0, M0**

- **Patient accepts surgery?**
  - **Yes**
    - **Cystectomy**
    - **Upstaged at surgery?**
      - **Yes**
        - **Bladder sparing treatment**
          - Chemoradiation or Clinical trial
      - **No**
        - Observation
    - **No**
      - Consider metastatic chemotherapy clinical trial if available

**T3b/4a, N0, M0**

- **Neoadjuvant chemotherapy**
- **Clinical trial**

**T4b, N0, M0**

- **Consider metastatic chemotherapy clinical trial if available**

**Assess response by:**
- **Cystoscopy**
- **EUA**
- **Imaging**

**Resectable?**

- **Yes**
  - Radical cystectomy
  - See Surveillance on Page 7
- **No**
  - Salvage therapy
  - Consider cystectomy if surgically resectable

**pT3a**

- **Observation**

**pT3b**

- **N+**, margins positive or prostatic stromal invasion pT4a
- **Adjuvant cisplatin or ifosfamide-based chemotherapy (see Page 9) or Clinical trial**

**Resectable?**

- **Yes**
  - Radical cystectomy
  - See Surveillance on Page 7
- **No**
  - Additional chemotherapy

**Resectable?**

- **Yes**
  - Radical cystectomy
  - See Surveillance on Page 7
- **No**
  - Salvage therapy
  - Consider cystectomy if surgically resectable

**Consider metastatic chemotherapy if available**

1 Poor risk factors:
- Lymphovascular invasion
- Inability to assess depth of invasion
- Variant histology such as small cell
- Hydronephrosis
- Tumor involving bladder diverticulum
- Progression to MIBC from NMIBC after adequate BCG

2 Consider neoadjuvant/adjuvant cisplatin or ifosfamide-based systemic chemotherapy (i.e., DDMVAC, IAG, etc.). Refer to Principles of Systemic Therapy on Page 8

EUA = examination under anesthesia

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Note: Consider Clinical Trials as treatment options for eligible patients.

### CLINICAL PRESENTATION
- **Positive pelvic nodes or**
- **Nodes below aortic bifurcation**
- **Nodes above aortic bifurcation or**
- **Visceral metastasis**
- **CT chest, abdomen, and pelvis**
- **Bone scan**
- **Chemotherapy**
- **Consider metastatic clinical trial if available**

### METASTATIC DISEASE

#### Resectable?
- Yes → Surgical consolidation trials
- No → Clinical trial or systemic treatment

#### Non-nodal metastasis
- CT chest, abdomen, and pelvis
- Bone scan

#### Assess response by:
- Cystoscopy
- EUA
- Imaging

### Clinical trial or systemic treatment
- **Any T, N+, M+**
- **Nodes above aortic bifurcation or**
- **Visceral metastasis**

| DDMVAC = dose-dense methotrexate, vinblastine, doxorubicin, and cisplatin |
| GC = gemcitabine and cisplatin |
| GCa = gemcitabine and carboplatin |
| IAGem = ifosfamide, doxorubicin, and gemcitabine |
| ITP = ifosfamide, paclitaxel, and cisplatin |
| GT = gemcitabine, paclitaxel, and doxorubicin |
| TMP = paclitaxel, methotrexate, and cisplatin |
| CGI = cisplatin, gemcitabine, and ifosfamide |
| GTP = gemcitabine, paclitaxel, and cisplatin |
| GTA = gemcitabine, paclitaxel, and doxorubicin |
| GCtx = gemcitabine and cyclophosphamide |
| GVinorelbine = gemcitabine and vinorelbine |

1. Consider mutation testing
2. Patients are generally considered surgically resectable if no tumor present in the bladder and near complete response in lymph nodes. If tumor still present on cystoscopy or on biopsy of nodes, consider additional chemotherapy prior to considering surgical consolidation.
3. See Appendix A for standard systemic treatments
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Note: Consider Clinical Trials as treatment options for eligible patients.

CLINICAL PRESENTATION

Upper tract (renal pelvis or ureter) tumor

- Discuss GCC with patient or if clinically indicated, with SDM
- CT urogram
- Cystoscopy
- Ureteroscopy
- Biopsy (forcep or brush) strongly recommended
- Washing adequate only if positive for high grade
- MSI testing

TREATMENT AND FOLLOW-UP

Patient suitable for conservative management?

Yes

No

Low risk

Surgical removal
- Nephroureterectomy with bladder cuff
- Occasionally may consider segmental resection
- Regional node dissection (if high grade or stage)

High risk: High grade disease, sessile architecture, cT3 on imaging, or based upon clinical nomograms

Consider:
- Multidisciplinary discussion for neoadjuvant or adjuvant chemotherapy
- Clinical trial

Metastatic disease

See Box A on Page 5

Greater than or equal to pT3, LVI+, or N+, or based on expected recurrence risk per nomogram?

Yes

No

Observation

Consider adjuvant chemotherapy or clinical trials

- Consider instillation of mitomycin gel (Jelmyto™) or
- Laser ablation or
- Consider adjuvant instillation of BCG (2-3 weeks later) or intraluminal chemotherapy

MSI = microsatellite instability

1 GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients or if clinically indicated the SDM should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to the GCC home page (for internal use only).

2 See Appendix B, Appendix C and Appendix D for clinical risk nomograms

3 Conservative management is based on individual patient status and clinical findings; elective indications ideally meet low-risk European Association of Urology (EAU) criteria: unifocal disease, tumor size <2 cm, low-grade cytology, low-grade ureteroscopic (URS) biopsy, and no invasive aspect on computed tomography urography (CTU)

4 See Appendix E for postoperative nomogram for prediction of relapse-free survival

5 Consider neoadjuvant/adjuvant cisplatin or ifosfamide-based systemic chemotherapy (i.e., DDMVAC, IAG, etc.). Refer to Principles of Systemic Therapy on Page 8.
## SURVEILLANCE AFTER RADICAL CYSTECTOMY

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<th>12</th>
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<th>48</th>
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**PE** = physical examination

1. After 5 years, follow guidelines every 1-2 years at the discretion of the treating physician.
2. Patients with adverse pathologic features, e.g. micropapillary disease, presence of lymphovascular invasion (LVI), sacromatoid de-differentiation, or those who have been downstaged after neoadjuvant chemotherapy, may be followed as pT2 patients.
3. History should include urethral discharge/bloody mucus.
4. Laboratory tests include CBC, electrolytes, BUN, creatinine, and LFTs. Cytology is optional if imaging is routinely obtained.
5. As clinically indicated.

**Note:** For all patients with urinary diversion, imaging study 6-8 weeks after surgery to confirm patency of anastomosis is at treating surgeon’s discretion. Choices include: loopogram (or cystogram), IVU, or renal ultrasound.
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**PRINCIPLES OF RADIATION THERAPY MANAGEMENT OF INVASIVE DISEASE**
- External beam radiation is rarely appropriate for patients with superficial tumors or carcinoma in situ (CIS). Surgery remains the standard of care.
- Precede radiation by maximal transurethral resection (TUR) of the tumor when safely possible.
- Combining concurrent chemotherapy with radiation is encouraged for added tumor cytotoxicity.
- Simulate and treat patients with the bladder empty.
- Use multiple fields from high-energy linear accelerator beams.
- Treat the whole bladder with 40-55 Gy and then boost bladder tumor to a total dose of 64-66 Gy excluding, if possible, normal areas of bladder from the high-dose volume.

**PRINCIPLES OF SYSTEMIC THERAPY**
- Two-to-three drug combinations based on cisplatin, docetaxel, paclitaxel, ifosfamide, gemcitabine or MVAC (methotrexate, vinblastine, doxorubicin, cisplatin) are used for treatment of metastatic disease. Adjuvant or neoadjuvant therapy is also considered for patients at high risk of recurrence.
- Patients at increased risk for morbidity from more toxic regimens (e.g., MVAC) may be treated with combinations of lower toxicity profiles. These patients are characterized by more than one of the following:
  - Comorbid conditions
  - High alkaline phosphatase
  - Poor performance status
  - High LDH
  - Liver or bone metastases
  - Poor renal function
- Pembrolizumab is indicated for front-line platinum ineligible patients.
- Atezolizumab for any patient whose tumor expresses PD-L1 or for any patient ineligible for platinum-based chemotherapy.
- Immunotherapy (pembrolizumab, nivolumab, or avelumab) has been approved for patients failing front-line chemotherapy. PD-L1 testing is not required.
- Eradafitinib has been approved second-line for patients with FGFR3 mutations and fusions.
- Enfortumab vedotin has been approved for third-line setting. Nectin-4 testing is not required.
- Sacituzumab govitecan is indicated for the 4th line treatment of metastatic urothelial cancer. Trop-2 testing is not required.

**BLADDER CANCER TREATMENT PRINCIPLES**

**PRINCIPLES OF SURGICAL MANAGEMENT**

**TRANSURETHRAL RESECTION OF BLADDER TUMOR (TURBT)**
- The first step in surgical management of bladder tumors is a complete TUR of the tumor. Muscle must be present in the TUR specimen to appropriately stage the tumor; if no muscle is present in the specimen, re-resection/biopsy of tumor base should be discussed with patient.
- Repeat TUR at 4-6 weeks is to be strongly considered if incomplete initial resection, no muscle in specimen, or T1 stage. It must also be considered if first TURBT does not allow adequate staging or attribution of risk factor for treatment selection or when using bladder-preserving treatment by chemotherapy and/or radiation therapy.
- In cases of positive cytology with no evidence of tumor, patient should undergo multiple biopsies of the bladder mucosa (if visibly abnormal with or without use of fluorescent cystoscopy) as well as prostate urethral biopsies and evaluation of upper tracts.

**RADICAL CYSTECTOMY**
- Radical cystectomy should include bilateral pelvic node resection with goal of at least 10 nodes removed.
- Nerve sparing and type of diversion selected depends on many factors, several of which are patient specific.

**PRINCIPLES OF INTRAVESICAL TREATMENT**
- Immunoimmunotherapy
  - Bacillus Calmette-Guerin (BCG) immunotherapy is the most effective treatment for non muscle invasive bladder cancer.
  - It is ideal to wait 14-21 days after TURBT (no gross hematuria). BCG induction (6 weekly treatments) should be followed by maintenance therapy (weekly for 3 weeks at months 3 and 6, and then every 6 months for a total of 3 years).
  - Dose reduction of BCG is preferable to shorter duration of maintenance
  - If patient fails 2 courses of BCG, strongly consider radical cystectomy (or clinical trial).
- Chemotherapy
  - Peri-operative intravesical chemotherapy is most effective when given right after TUR (ideally within 6 hours).
  - Induction and maintenance chemotherapy in selected patients if indicated.
  - Agents include gemcitabine and mitomycin.
- Salvage therapy after BCG is preferably with combination chemotherapy (i.e., gemcitabine and docetaxel).
APPENDIX A: Standard Systemic Treatments

**Chemotherapy Regimens:**

- **Dose-dense MVAC (DDMVAC):**
  - Methotrexate 30 mg/m² IV and
  - Vinblastine 3 mg/m² IV and
  - Doxorubicin 30 mg/m² IV and
  - Cisplatin 70 mg/m² IV
  - Cisplatin followed with ½ NS IV plus mannitol 40 g/L typically for 3 liters
  - This regimen is repeated every 2 weeks with growth factor support

- **Gemcitabine, Cisplatin (GC):**
  - Gemcitabine 900 mg/m² IV over 90 minutes on Day 1 and Day 8 and
  - Cisplatin 70 mg/m² IV on Day 1
  - Cisplatin followed with ½ NS IV plus mannitol 40 g/L typically for 3 liters
  - This regimen is repeated every 3 weeks with growth factor support

- **Gemcitabine, Carboplatin (GCa):**
  - Gemcitabine 900 mg/m² IV over 90 minutes on Day 1 and Day 8 and
  - Carboplatin AUC 4.5 IV on Day 1
  - This regimen is repeated every 3 weeks with growth factor support

- **Gemcitabine, Paclitaxel, Doxorubicin (GTA):**
  - Doxorubicin 30 mg/m² IV and
  - Paclitaxel 135 mg/m² IV and
  - Gemcitabine 900 mg/m² IV over 90 minutes
  - This regimen is repeated every 2 weeks with growth factor support

- **Ifosfamide, Doxorubicin, Gemcitabine (IAGem):**
  - Ifosfamide 1500 mg/m² IV plus Mesna 300 mg/m² IV on Day 1 through Day 4 and
  - Mesna given at hours 0, 4, and 8 (with respect to ifosfamide’s start time)
  - Doxorubicin 45 mg/m² IV on Day 3 only and
  - Gemcitabine 150 mg/m² IV over 30 minutes on Day 2 and Day 4
  - This regimen is repeated every 3 weeks with growth factor support

- **Cisplatin, Gemcitabine, Ifosfamide (CGI):**
  - Gemcitabine 900 mg/m² IV over 90 minutes and
  - Ifosfamide 1000 mg/m² IV and
  - Cisplatin 50 mg/m² IV on Day 1
  - Cisplatin followed with ½ NS IV plus mannitol 40 g/L, typically for 3 liters
  - This regimen is repeated every 2 weeks with growth factor support

- **Paclitaxel, Methotrexate, Cisplatin (TMP):**
  - Methotrexate 30 mg/m² IV and
  - Paclitaxel 100 mg/m² IV and
  - Cisplatin 40 mg/m² IV
  - Cisplatin followed with ½ NS IV plus mannitol 40 g/L, typically for 3 liters
  - This regimen is repeated every 2 weeks with growth factor support

- **Gemcitabine, Vinorelbine (GemVinorelbine):**
  - Vinorelbine 25 mg/m² IV and
  - Gemcitabine 900 mg/m² IV over 90 minutes
  - This regimen is repeated every 2 weeks with growth factor support

Continued on next page
## APPENDIX A: Standard Systemic Treatments - continued

### Chemotherapy Regimens (continued):

- **Ifosfamide, Paclitaxel, Cisplatin (ITP):**
  - Paclitaxel 200 mg/m² IV and Ifosfamide 1500 mg/m² plus Mesna 300 mg/m² IV on Day 1 through Day 3 and Mesna given at hours 0, 4, and 8 (with respect to ifosfamide’s start time)
  - Cisplatin 70 mg/m² IV and Cisplatin followed with ½ NS IV plus mannitol 40 g/L, typically for 3 liters
  - This regimen is repeated every 3 weeks with growth factor support

- **Gemcitabine, Paclitaxel, Cisplatin (GTP):**
  - Paclitaxel 80 mg/m² IV on Day 1 and Day 8 and Gemcitabine 900 mg/m² IV over 90 minutes on Day 1 and Day 8 and Cisplatin 70 mg/m² IV on Day 1
  - Cisplatin followed with ½ NS IV plus mannitol 40 g/L, typically for 3 liters
  - This regimen is repeated every 3 weeks with growth factor support

### Immunotherapy:

- Atezolizumab 1,200 mg IV every 3 weeks
- Avelumab 800 mg IV every 2 weeks
- Nivolumab 240 mg IV every 2 weeks or 480 mg IV every 4 weeks
- Pembrolizumab 200 mg IV every 3 weeks or 400 mg IV every 6 weeks

### Antibody Drug Conjugate:

- Enfortumab vedotin 1.25 mg/kg (maximum dose 125 mg) IV on days 1, 8, and 15 of a 4-week cycle
- Sacituzumab govitecan 10 mg/kg IV on day 1 and day 8 of a 3-week cycle

### Targeted Therapy:

- Erdafitinib 8 mg PO daily
  - May titrate up to 9 mg PO daily if phosphorous level on Day 15 is ≤ 5.5 mg/dL
### Urothelial Carcinoma of Bladder and Upper Tract

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## APPENDIX B: Clinical Risk Nomograms

### Preoperative relapse-free probability following radical nephroureterectomy for high grade upper tract urothelial carcinoma

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</table>

### Total Points

| 0 | 50 | 100 | 150 | 200 | 250 | 300 | 350 | 400 |

### 2-year Relapse-Free Probability

0.95 0.9 0.8 0.7 0.6 0.5 0.4 0.3 0.2 0.1 0.03

### 5-year Relapse-Free Probability

0.93 0.9 0.8 0.7 0.6 0.5 0.4 0.3 0.2 0.1 0.05 0.01

* based on imaging studies

APPENDIX C: Clinical Risk Nomograms

Predicting the probability of ≥pT2/pN+ disease in patients undergoing radical nephroureterectomy

Instructions: Locate the patient’s age on the corresponding axis. Draw a line straight upward to the point axis to determine the points toward the probability of ≥pT2/pN+ disease the patient receives for his age value. Perform this process for each additional variable and sum the points for each predictor. Locate the final sum on the total point axis. Draw a line straight down to find the patient’s probability of having ≥pT2/pN+ disease. HN = hydronephrosis; RC = radical cystectomy.

APPENDIX D: Clinical Risk Nomograms

Preoperative probability of non-organ confined (pT3-4, N+) upper tract urothelial carcinoma, low or high grade

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* Peripelvic fat, parenchymal invasion (renal tumor) or periureteral fat invasion (ureteral tumor) or other infiltrative component on imaging

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Approved by The Executive Committee of the Medical Staff on 02/21/2023
APPENDIX E: Postoperative nomogram for prediction of relapse-free survival

Urothelial Carcinoma of Bladder and Upper Tract

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SUGGESTED READINGS

Non-muscle Invasive Bladder Cancer


Muscle Invasive Bladder Cancer


Continued on next page
Muscle Invasive Bladder Cancer – continued


Chemotherapy


SUGGESTED READINGS – continued

Disclaimers:

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SUGGESTED READINGS – continued

Chemotherapy- continued


Immunotherapy


Continued on next page
Antibody Drug Conjugate


Targeted Therapy

Rare Bladder Tumors


Small Cell


Plasmacytoid

Micropapillary

 Continued on next page
Micropapillary - continued


Suggested Readings – continued


Upper Tract


Urachal


Other Supportive Readings

MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy. Advance Care Planning (ACP) Conversation Workflow (ATT1925)
Urothelial Carcinoma of Bladder and Upper Tract

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This practice algorithm is based on majority expert opinion of the Genitourinary Center Faculty at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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