

The Management of Bladder Cancer

Pathway of Care

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1.0 Purpose of this document

To describe the process for ensuring that all Bladder Cancer cases diagnosed within the Kent & Medway (K&M) region, are managed by the East and West Kent & Medway Urology Specialist Teams, achieving a coordinated seamless patient pathway in accordance with the best possible evidence based practice and to facilitate advancement in the specialty in the field of bladder cancer management.

This document is the product of the Kent & Cancer Collaborative (KMCC) Cancer Bladder Sub Group of the Urology Tumour Site Specific Group (TSSG) and been agreed by the full Urology TSSG.

The KMCC Urology TSSG has agreed that the European Association of Urology (EAU) Guidelines for the management of Bladder Cancer should underpin K&M guidance. The full EAU Guidelines can be found by following the links:

Non-muscle Invasive Bladder Cancer

- Full Guidance:

http://www.uroweb.org/gls/pdf/05_TaT1_Bladder_Cancer_LR%20March%2013th%202012.pdf

- Pocket Guidance:

http://www.uroweb.org/gls/pockets/english/04_Non-muscle_Invasive_BC.pdf

- European Urology Article:

[http://www.uroweb.org/gls/EU/2011%20Babjuk%20M%20et%20al%20Eur%20Urol%2059\(6\)997%20EAU%20Guidelines%20on%20Non-muscle-inv%20urothelial%20carcinoma%20of%20the%20bladder.pdf](http://www.uroweb.org/gls/EU/2011%20Babjuk%20M%20et%20al%20Eur%20Urol%2059(6)997%20EAU%20Guidelines%20on%20Non-muscle-inv%20urothelial%20carcinoma%20of%20the%20bladder.pdf)

Muscle Invasive and Metastatic

- Full Guidance:

http://www.uroweb.org/gls/pdf/07_Bladder%20Cancer_LR%20II.pdf

- Pocket Guidance:

http://www.uroweb.org/gls/pockets/english/06_Muscle-invasive%20BC.pdf

- European Urology Article:

[http://www.uroweb.org/gls/EU/2011%20Stenzl%20A%20et%20al%20Eur%20Urol%2059\(6\)1009%20Treatment%20of%20Muscle-inv.%20and%20metastatic%20bladder%20cancer.pdf](http://www.uroweb.org/gls/EU/2011%20Stenzl%20A%20et%20al%20Eur%20Urol%2059(6)1009%20Treatment%20of%20Muscle-inv.%20and%20metastatic%20bladder%20cancer.pdf)

A key feature of this document is to provide a quick reference guide to the management of patients with Bladder Cancer based on the EAU guidelines as well as to highlight any locally agreed interpretations of those guidelines for the purposes of clarification.

2.0 Scope

This Standard Operating Procedure (SOP) applies to all cases and suspected cases of bladder cancer within K&M. The K&M bladder cancer specification of delivery of care requires all Trusts within K&M to adopt an agreed policy for the delivery of care. The policy relates to the expected pathway of care / treatment regimes for patients diagnosed with bladder cancer.

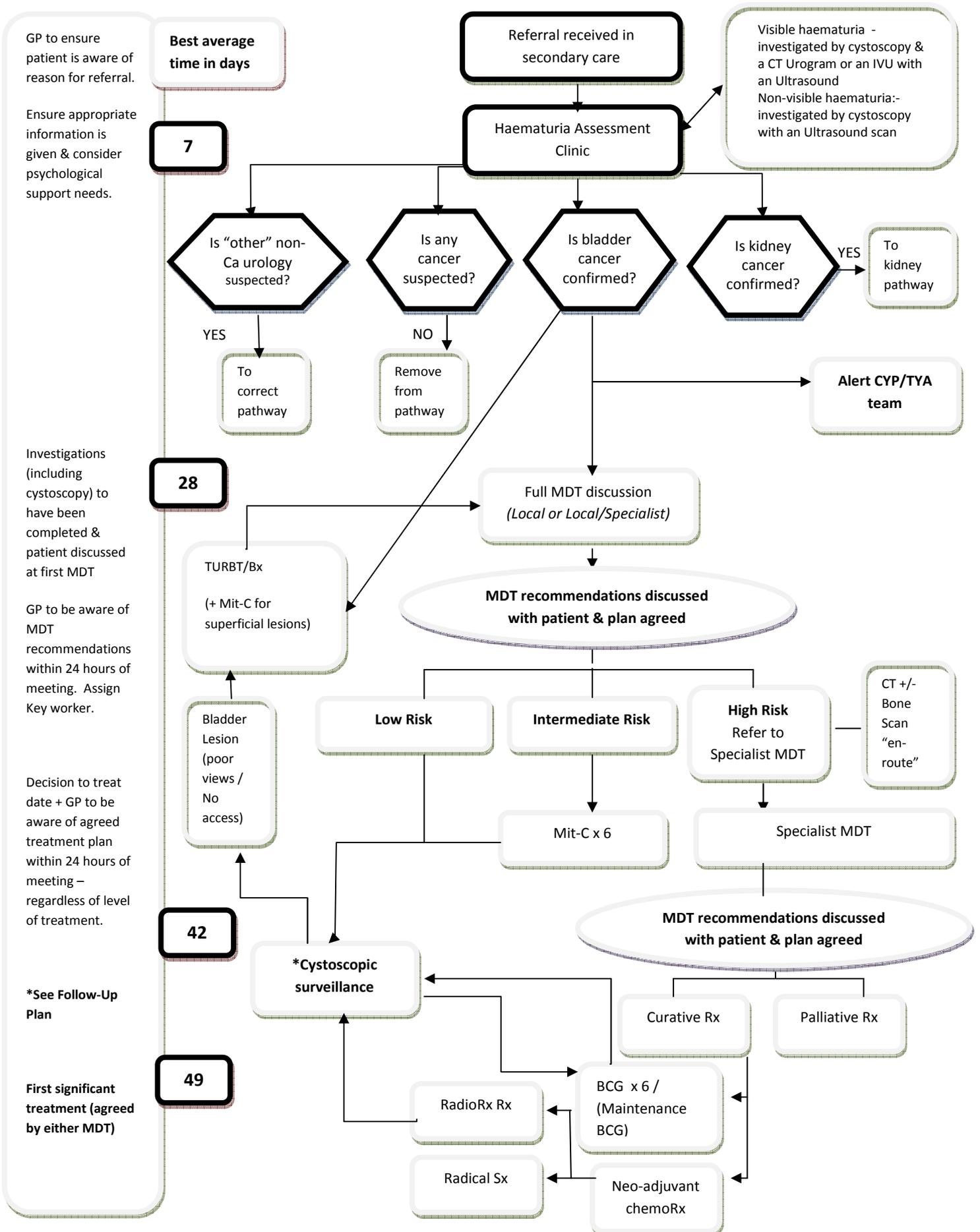
The policy covers the following:

- Access
- Initial Assessment
- Investigations
- Urological oncology multidisciplinary meeting (MDM)
- Surgical and non-surgical treatment.
- Recurrent disease
- Follow up

3.0 General Principles

- In East Kent, there will be a single Urology Team, which will function at both Local and Specialist Levels and will be hosted on the Canterbury site of the East Kent Hospitals University Foundation Trust.
- In West Kent:
 - All Specialist Urological Surgery will be undertaken at the Medway Foundation Trust
 - The Darent Valley Hospital and Medway Foundation Trust Urology Teams will cooperate as a single Urology Team functioning at both Local and Specialist Levels
 - The Maidstone and Tunbridge Wells Urology Team will provide Local Level Urological Services at Maidstone for Mid Kent, BUT will undertake any Specialist Urological Surgery for their patients at Medway Foundation Trust in accordance with K&M agreed clinical guidelines
- Patients with visible or non-visible haematuria should be considered at high suspicion of cancer and must be referred for urological assessment as outlined in the Improving Outcomes Guidelines.
- Any haematuria assessment service should be provided or led by a Consultant Urologist who is a K&M member, is a member of a K&M Urology MDT and is a member of the K&M Urology Tumour Site Specific Group.
- Any patient diagnosed with bladder cancer will be offered a Key Worker and should expect to receive clinical and supportive care of the highest standards at all stages along the Pathway of Care.
- All patients should be considered for entry into an approved clinical trial.
- Where patients fall into the Children's & Young Peoples age group (*Please see section 12.0*) an appropriate referral will be made.
- This pathway will be revised by the Kent & Medway Urology TSSG as and when appropriate.

4.0 Very High Level Overview of Bladder Cancer Pathway



5.0 Bladder Cancer Diagnostic and Staging Pathway

5.1 In Primary Care

- The GP should assess the WHO performance status and for patients with a score of 4, should discuss with them whether an urgent 2WW referral would benefit them and explore with them other and perhaps more appropriate options.
- No patient should be referred for an urgent 2WW appointment without first having been told that [1] the reason for urgent referral is that there is at least a suspicion of bladder cancer and that, [2] a suspicious result s *may* automatically trigger other investigations including a bladder examination and a scan of the urinary tract.
- The following indicate a significant risk of cancer:
 - *Male or female patient of any age with painless macroscopic haematuria*
 - *Macroscopic haematuria in the absence of infection*
 - *Persistent or recurrent UTI with haematuria in patients ≥ 40 years*
 - *Unexplained microscopic haematuria in patients ≥ 50 years*
- The primary care investigation should include:
 - History
 - Examination
 - Review of results
 - Perform flexible cystoscopy – not just arrange it, do it
 - Perform upper tract imaging urgently – CT Urogram on same day is possible. If CT Urogram not available then U/S and IVU is advised.
 - If an upper tract tumour is suspected then this should trigger a pre and post contrast CT Chest abdo pelvis which should be booked at once and performed as soon as possible.

Day 1

- **Refer to Rapid Haematuria 2WW clinic if (any):**
 - Presence of any of the alarm signals outlined in Box 1
 - MSU shows microscopic haematuria / no casts / no proteinuria / no UTI

5.2 In Secondary Care

In the urgent 2WW clinic for Non-Visible haematuria:

By Day 7

- History
- Examination
- Review of results
- Perform flexible cystoscopy – not just arrange it – do it
- Perform upper tract imaging urgently – U/S Upper Tracts on same day is possible – any suspected upper tract lesion should trigger and immediate booking for a pre and post contrast CT Chest, Abdo, Pelvis

Note: Clinicians may find the EORTC bladder cancer risk tool useful:

<http://www.eortc.be/tools/bladdercalculator>

6.0 Imaging for bladder cancers

6.1 Diagnosis

6.1.1 Diagnosis:

Diagnosis is made on history, examination and investigation. The investigations that MUST be performed are a bladder examination and imaging of the upper tracts. The bladder inspection is normally a fibre-optic cystoscopy but patients may prefer to have a general anaesthetic cystoscopy – this allows any biopsy or TURBT to be performed at the same sitting. The gold standard upper tract imaging is now a CT Urogram. A combination of U/S and an IVU may be used if CT Urography is not available.

Where no cause for visible haematuria is found and visible haematuria persist, flexible uretero-rensoscopy is advised. Cystoscopy may be helpful.

Note: Full KMCC imaging guidelines are located in the KMCC agreed document located on the K&M Cancer website on the following link:

<http://www.kentmedwaycancernetwork.nhs.uk/resource-library/diagnostics-ccag/>

6.2 Staging

- **CT chest, abdomen & pelvis**
For patients deemed fit for surgical or other radical Rx
- **MRI**
May be required for certain cases to improve assessment of local extent
- **Bone scan**
If clinically indicated

6.3 Surveillance

- **Selective imaging – follow EAU guidelines**
- **CT Chest, Abdomen & Pelvis for Invasive cancers**

7.0 Treatment

Patients must always be counselled on the full range of treatment options recommended as a result of an MDT discussion.

Treatment options will be based on cellular pathology findings, imaging investigations (where appropriate), the patients WHO performance status and always the patient's wishes.

7.1 Low Risk

Non Invasive Single Tumours: G1pTa, G1pT1, G2pTa and G2pT1

Consider that:

- For patients with TaT1 tumours at low risk of recurrence and progression should have a cystoscopy at 3 months. If negative, the following cystoscopy is advised 9 months later, and then yearly for 5 years.
- For patients with TaT1 tumours at high risk of progression and those with CIS should have a cystoscopy and urinary cytology at 3 months. If negative, the following cystoscopy and cytology should be repeated every 3 months for a period of 2 years, and every 6 months thereafter until 5 years, and then yearly. Yearly imaging of the upper tract is recommended.
- For patients with TaT1 tumours at intermediate risk of progression (about one-third of all patients) should have an in-between follow-up scheme using cystoscopy and cytology, which is adapted according to personal and subjective factors.
- During follow-up in patients with positive cytology and no visible tumour in the bladder, R-biopsies or biopsies with PDD (if equipment is available) and investigation of extravesical locations (CT urography, prostatic urethra biopsy) are recommended.

7.2 Intermediate Risk

Multifocal or high volume tumours: G1pTa, G1pT1, G2pTa, and G2pT1

Consider:

- Mitomycin-C (for regimen details please see NOG guidance). Then:
- Re-scope & re-biopsy (under GA) 3/12 weeks post diagnosis
 - If this is clear then repeat flexible cystoscopy at 6 monthly intervals
 - If this shows residual disease, consider biopsy and diathermy, followed by MDT review including advice about switching to a course of BCG (for regimen details please see NOG guidance)
 - Escalate to **High Risk** Pathway if there is any evidence of tumour upgrade/upstage

Note: Clinicians may find the EORTC bladder cancer risk tool useful:

<http://www.eortc.be/tools/bladdercalculator>

7.3 High Risk

Multifocal : CIS, G3pTa, G3pT1
Muscle Invasive: T2/T3/T4 /(including squamous, adenocarcinomas and others)

7.3.1 Multifocal

Consider:

- BCG
 - Re-biopsy 12 weeks post completion of BCG
 - Biopsy and resect
 - If there is no CIS on re-biopsy consider Maintenance BCG (please see EAU Treatment Guidelines)
 - BCG Failure
 - MDT discussion and consider:
 - Cystectomy
 - Endoscopic control
- Immediate cystectomy

7.3.2 Muscle Invasive

Consider:

(Patient counselling is always required when considering the full range of options)

- Curative Treatment:
 - Neo-adjuvant chemotherapy, (please see EAU Treatment Guidelines), followed by
 - Radical cystectomy (which may include urinary diversion/reconstruction)Or
 - Multimodality treatment
 - The **combination** of TURBT, Chemotherapy and Radiation is an alternative when radical surgery is not considered an option based on clinical reasons and/or informed patient choice
 - **Radiotherapy alone**
Usually only considered if the patient is considered unfit for surgery or multimodality treatment
 - Re-biopsy 12 weeks post completion of Radiotherapy
 - Re-biopsy
 - Re-resect recurrent TCC
 - A second TURBT should be considered when the initial resection is incomplete, for example, when multiple and/or large tumours are present, or when the pathologist has reported that the specimen contains no muscle tissue (TaG1 excluded). Furthermore, a second TURBT should be performed when a high-grade or T1 tumour has been detected at initial TURBT (103). It has been demonstrated that a second TURBT can increase the recurrence-free survival (98,99,104) (LE: 2a). There is no consensus about the strategy and timing of second TURBT. Most authors recommend resection at 2-6 weeks after initial TURBT. The procedure should include resection of the primary tumour site.
- Palliative Treatment:
 - Endoscopic control
 - Palliative radiotherapy
 - Cystectomy +/- urinary diversion
 - Chemotherapy

8.0 Follow Up After Treatment

8.1 Post Resection

- Review histology
- Discuss at MDM

8.1.1 High grade tumours

All high grade tumours are to be escalated to a specialist Bladder MDT.

8.1.2 G3 PT1

Patients with G3pT1 disease should have an appropriate early re-biopsy strategy 6 to 12 weeks after the 1st resection depending on the patient's performance status, co-morbidities and the specialist bladder MDT recommendation.

8.1.3 Superficial cancers (G1-G2)

Patients with Ta and T1 tumours should be stratified into low, intermediate or high risk groups for recurrence and progression. Cystoscopic surveillance as per EAU guidance should be arranged.

| Level of Risk of Recurrence / Progression | Cystoscopy | Other |
|---|--|---|
| Low risk of recurrence and progression | <ol style="list-style-type: none">1. At 3/12 <i>and negative then</i>2. At 9/12 <i>and then</i>3. Annually for 5 years | |
| High risk of progression | <ol style="list-style-type: none">1. At 3/12 <i>and if negative then</i>2. Every 3/12 for 2 years <i>then</i>3. Every 4/12 in year 3 <i>then</i>4. Every 6/12 in years 4 & 5 <i>then</i>5. Yearly thereafter | <ol style="list-style-type: none">1. Yearly imaging of the upper tracts |
| Intermediate risk of progression | Should have an intermediate FU scheme | |

- Multiple recurrences or mucosal abnormalities in either group should be biopsied and the Histology reviewed by the local MDT to advise on intravesical chemotherapy, ongoing surveillance strategy or escalation for specialist bladder MDT level advice.
- Single small superficial recurrences can be cauterised without biopsy but should re-enter the patient at the start of the cystoscopic surveillance follow-up pathway of their risk group at first biopsy.
- Patients who have regular small superficial recurrences should have a repeat biopsy and an MDT discussion to advise on intravesical chemotherapy.

Follow up surveillance cystoscopy may be delivered by an appropriately trained clinical nurse specialist provided that there is appropriate support from Urologists.

8.1.4 Invasive cancers (post radical resection)

1. 8.1.4.1 *Patients with ileal conduit:*

- Patient to be seen by Consultant at 6/52
- Chloride, B12 and creatinine clearance to be measured yearly
- Any further f/u may be nurse led by protocol
- Further episode of haematuria to be referred for CT Urogram
- Consider CT Chest Abdomen & Pelvis

2. 8.1.4.2 *Patients with neo-bladder:*

- Patient to be seen by Consultant at 6/52
- Any further f/u may be nurse led by protocol
- Annual neo-bladder cystoscopic surveillance should be offered from 5 years post surgery.
- Annual renal U/S
- Annual chloride, B12 and creatinine clearance measurements
- Acid-base balance if indicated
- Consider CT Chest Abdomen & Pelvis

3. 8.1.4.3 *Patients with continent diversion:*

- Patient to be seen by Consultant at 6/52
- Any further f/u may be nurse led by protocol
- Annual U/S or other upper tract imaging
- Annual chloride, B12 and creatinine clearance measurements
- Acid-base balance if indicated
- Consider CT Chest Abdomen & Pelvis

4. 8.1.4.4 *Post radiotherapy patients:*

- Patient to be seen by Consultant Oncologist at 6/52
- Cystoscopic follow up as per high risk protocol

5. 8.1.4.5 *Palliative care patients – patients unfit for cystectomy or known to have metastatic disease*

- Open access secondary care / palliative care nurse led f/u by protocol

9.0 Data

Collection of data at each stage of the pathway is the responsibility of the team looking after the patient at that time. The minimum dataset agreed by the TSSG will be a combination of those data items that meet national requirements, and additional items as agreed by the TSSG.

National data requirements will include:

- Cancer Waiting Times monitoring, including Going Further on Cancer Waits. The data items required will be as defined in ISB0147 at the time of referral and/or treatment.

Details of the Cancer Waiting Times dataset are available from:

<http://www.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation>

Cancer Waiting Times data will be submitted according to the timetable set out in the National Contract for Acute Services.

- The Cancer Outcomes and Services Dataset. The data items will be as defined in ISB1521, and any subsequent versions, at the time of diagnosis and/or treatment. The requirement will include those fields listed in the “Core” section of the dataset, and any additional tumour site specific sections, as applicable.

Details of the COSD are available from:

http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd.aspx

Cancer Registration and Cancer Outcomes and Services (COSD) data will be submitted according to the timetable set out by the National Cancer Registration Service (NCRS).

- Where applicable, teams will also collect additional data items as defined in any corresponding National Clinical Audit Support Programme (NCASP) audit dataset.

Details of these datasets are available from:

<http://www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/cancer>

Data for NCASP audits will be submitted, where applicable, according to timetables as agreed by the TSSG, and within the overall submission deadlines for each audit.

Submission of data to meet these national requirements will be the responsibility of each individual Trust.

Note that these standards are subject to variation from time to time, and where these requirements change, the data items required to be collected by the team will also change in line with national requirements.

Local data requirements will include any additional data items as agreed by the TSSG. These must be selected to avoid overlap with any existing data items, and where possible must use standard coding as defined in the NHS Data Dictionary.

Where possible and applicable, InfoFlex will be used for the collection and storage of data.

Additional areas of the COSD, relating to pathology, radiotherapy, SACT, diagnostic imaging and basic procedure details will feed into the dataset from other nationally mandated sources. It is the responsibility of each team to ensure that the whole of the relevant dataset is collected, and it is acknowledged that this may come from a variety of sources.

10.0 Audit

All K&M Urology MDTs should undertake the following audits and which should be presented and discussed at the Urology TSSG at least annually:

- Protocol compliance – the % patients deemed fit for cystectomy who undergo neo-adjuvant chemotherapy
- Other audit programmes may be undertaken at the discretion of the Urology TSSG

11.0 Supportive and Palliative Care

Patients with bladder cancer should have access to an appropriate Clinical Nurse Specialist support at all points of the pathway of clinical regardless of Primary, Local and Specialist team borders. Local and Specialist Team Clinical Nurse Specialists will actively co-operate to ensure that there is continuity of care, engaging with Primary Care and Palliative Care colleagues when appropriate. Patients may be referred to the Specialist and Palliative Care Team at any point along the pathway, whether by Primary, Local or Specialist Teams.

Open and frank discussions with patients should take place with patients at all stages of their journey so that patients are not confused about their prognosis or have unrealistic expectations of any of the forms of treatment offered to them. Relatives and carers will need to be appropriately supported and given appropriate information. However, in accordance with the recommendations set out in the various 'Improving Outcomes Guidance', relatives and carers should not be given information different to that given to the patient.

The prime aim of palliative treatment is to alleviate symptoms.

Palliative care provision should be made available for all patients:

- Hospital Teams, including Clinical Nurse Specialists for urology patients
- Primary Health Care Teams would provide for palliative care at home
- General Practitioners should be informed within 24 hours of the diagnosis, treatment plan and medication – including any MDM revisions to the treatment plan and medication.

The management of symptoms, psychological, social and spiritual issues, and the communication of the diagnosis and the any associated problems should be in the domain of all health care professionals.

Referral to specialist palliative care services should be considered when these issues have not been resolved and in particular for patients with:

- Complex symptom management issues, which are difficult to manage
- Difficulties in adjusting to the disease or progression
- Psychological and family issues – such as communication problems within the family
- Spiritual issues – such as the challenging of belief system/faith/cultural values as a result of the cancer.

Consideration of specialist palliative care support should be given throughout the patient pathway, particularly:

- At the MDM
- When no active treatment is considered
- After active treatment
- At relapse
- In the terminal stages

12.0 Children and Young Adults

Children and Young People with Urological Cancers will be treated in accordance with principles set out in the CYP IOG.

All Children and Young People up to the age of 18 must be referred to the CYP Principle Treatment Centre which for K&M is based at the Royal Marsden.

All Young People between 16 and 24 years of age must be offered a referral to the CYP Treatment Centre.

Referral to a CYP Principle Treatment Centre does not necessarily mean that treatment will be undertaken at that centre; shared care management protocols may allow some treatments to be undertaken locally.

13.0 Cellular Pathology

All KMCC reporting pathologists follow The Royal College of Pathologists Histopathology Reporting on Cancers guidelines – a copy of which is available through the KMCC Cancer website:-

<http://www.kentmedwaycancernetwork.nhs.uk/resource-library/pathology-ccag/>

This therefore supersedes the KMCC Urology Pathology Data Set and Guidelines.

KMCC have also agreed that reporting K&M pathologists should always stipulate which version of the TNM they are referring when issuing reports.

14.0 Appendix 4 – Mit-C & BCG Treatment Guidelines

EAU treatment recommendations in TaT1 tumours according to risk stratification Risk category Low Intermediate High

Recurrence:

- One immediate instillation of chemotherapy
- One immediate instillation of chemotherapy, followed by further instillations, either chemotherapy for a minimum 1 year of BCG (the final choice is determined by the risk of tumour progression)
- One immediate instillation of chemotherapy, followed by further instillations, either chemotherapy or a minimum of 1 year of BCG (the final choice is determined by the risk of tumour progression)

Progression:

- One immediate instillation of chemotherapy (it can be followed by further chemotherapy instillations if the patients have at the same time an intermediate risk of recurrence)
- One immediate instillation of chemotherapy, followed by a minimum of 1 year of BCG or further chemotherapy instillations Intravesical BCG for at least 1 year, or immediate cystectomy

EAU recommendations for adjuvant therapy in TaT1 tumours and for therapy of CIS

The type of intravesical therapy should be based on the risk groups shown below:

- In patients with TaT1 tumours at low risk of recurrence and progression, one immediate instillation of chemotherapy is recommended as the complete adjuvant treatment.
- In patients with TaT1 tumours at intermediate or high risk of recurrence and intermediate risk of progression, one immediate instillation of chemotherapy should be followed by a minimum 1 year of BCG treatment, or by further instillations of chemotherapy.
- If chemotherapy is given, it is advised to use the drug at its optimal pH and to maintain the concentration of the drug during instillation by reducing fluid intake. The optimal schedule and the duration of the chemotherapy instillations remain unclear, but it should be given no more than 12 months.
- In patients with TaT1 tumours at high risk of progression, intravesical BCG for at least 1 year is indicated.
- In patients with bladder CIS, intravesical BCG for at least 1 year is indicated.
- In patients with CIS in the epithelial lining of the prostatic urethra, TUR of the prostate followed by intravesical instillations of BCG could be an option.
- Immediate radical cystectomy may be offered to patients at highest risk of tumour progression.
- In patients with BCG failure, cystectomy is indicated.

15.0 Glossary

Acronyms in common usage throughout KMCC documentation:

| | |
|--------|--|
| CAT | Clinical Advisory Team |
| CCAG | Cross Cutting Advisory Group |
| CYP | Children & Young People (in relation to the IOG) |
| DCCG | Diagnostic Cross Cutting Group |
| DOG | Disease Orientated Group (NSSG/TSSG/TWG) |
| DVH | Darent Valley Hospital |
| EK | East Kent |
| EKHUFT | East Kent Hospitals University Foundation Trust |
| EAU | European Association of Urology |
| HOP | High Level Operational Policy |
| IOSC | Improving Outcomes: A Strategy for Cancer (Coalition Governments strategy for the delivery of cancer services) |
| K&C | Kent & Canterbury Hospital, Canterbury, (EKHUFT) |
| K&S | Kent and Sussex Hospital, Tunbridge Wells, (MTW) |
| KMCC | Kent & Medway Cancer Collaborative |
| KMCN | Kent & Medway Cancer Network |
| KMCRN | Kent & Medway Cancer Research Network |
| MFT | Medway Foundation Trust |
| MTW | Maidstone & Tunbridge Wells NHS Trust |
| NCIN | National Cancer Intelligence Network |
| NOG | Non Surgical Oncology Group (Permanent oncologist sub group of the TSSGs with a specific responsibility for chemo/rad pathways and advice to the TSSG, KMCC and geographical locations on new drugs) |
| OG | Operational & Quality Group (KMCC interface with Trust Cancer Lead Clinicians, Lead Nurses and Lead Managers to oversee the implementation of TSSG, CCAG agreed policies and which has delegated authority from the Trust CEO's to carry out this function) |
| QEQM | Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT) |
| QoL | Quality of life |
| RAT | Research and Trial Group (Permanent sub-group of the TSSGs with a specific responsibility for taking forward the clinical trials agenda) |
| QVH | Queen Victoria Foundation Trust Hospital East Grinstead |
| WHH | William Harvey Hospital, Ashford (EKHUFT) |
| WK | West Kent |

16.0 Personnel and Contact Information

A comprehensive, up to date list of MDM contact details can be found on the KMCC website via the following link: <http://www.kentmedwaycancernetwork.nhs.uk/resource-library/>

17.0 Document Administration

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|------------------------------------|--|
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| | |
|---------------------|---|
| Enquiries: | |
| [1] Hugh Evans | 01227 864241 iwh.evans@nhs.net |
| [2] Edward Streeter | 01227 864359 edward.streeter@nhs.net |

| Revision History | | | |
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| 15/09/2005 | 0.1 | Initial draft – all sections reviewed/ new flow chart | A.Jackson |
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| Sept 2012 | 4.4 | Draft – data collection section updated / general formatting | A.Brittle/C.Tsatsaklas |
| Oct 2012 | 4.5 | Draft – updates inserted | H.Evans |
| Jan 2013 | 4.6 | Draft – comments included from Urology DOG/TSSG 6/11/2012 – section 3, section 4 (visible haematuria), section 5.1/5.2. | H.Evans/Urology DOG/TSSG C.Tsatsaklas/I.Vousden |
| July 2013 | 5.0 | Published – final comments from 15/07/13 Urology TSSG inserted & admin text updated | H.Evans/Urology TSSG |
| July 2014 | 5.1 | Draft – update required to haematuria clinic box text page 5 & admin text updates – as agreed in Nov 2013 Urology TSSG | E.Streeter/C.Tsatsaklas |
| July 2014 | 5.2 | Final Draft – signed off as approved/final by the Urology TSSG via email 11 th July 2014 | Urology TSSG |
| July 2014 | 6.0 | Published - signed off as approved/final by the Operational & Quality Group via email 25/7/2014 | Operational & Quality Group |