高 雄 榮 民 總 醫 院
膀胱癌診療原則

2017年03月07日 第一版

泌尿道癌醫療團隊擬訂

注意事項：這個診療原則主要作為醫師和其他保健專家診療癌症病人參考之用。假如你是一個癌症病人，直接引用這個診療原則並不恰當，只有你的醫師才能決定給你最恰當的治療。

會議討論

上次會議：2016/04/26

本共識與上一版的差異

上一版	新版
1.病理報告2-3期化療時機:.第二期需化療。	1.病理報告2-3期化療時機:病理報告第二期可視病人情形考慮是否執行，第二期以上則需輔助化療.

膀胱癌(圖一)

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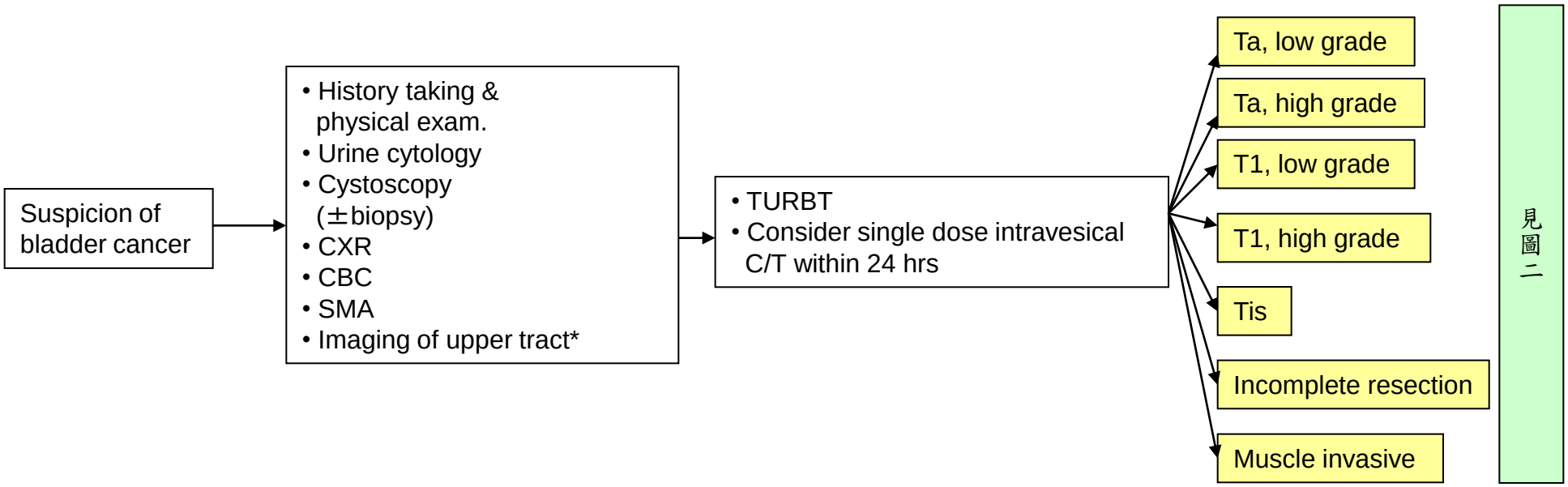
臨床診療指引　2017年第一版

臨床表徵	初期評估	診斷、治療	分期



* Imaging of upper tract may include IVP, ultrasonography, CT urography or MR urography.

膀胱癌(圖二)

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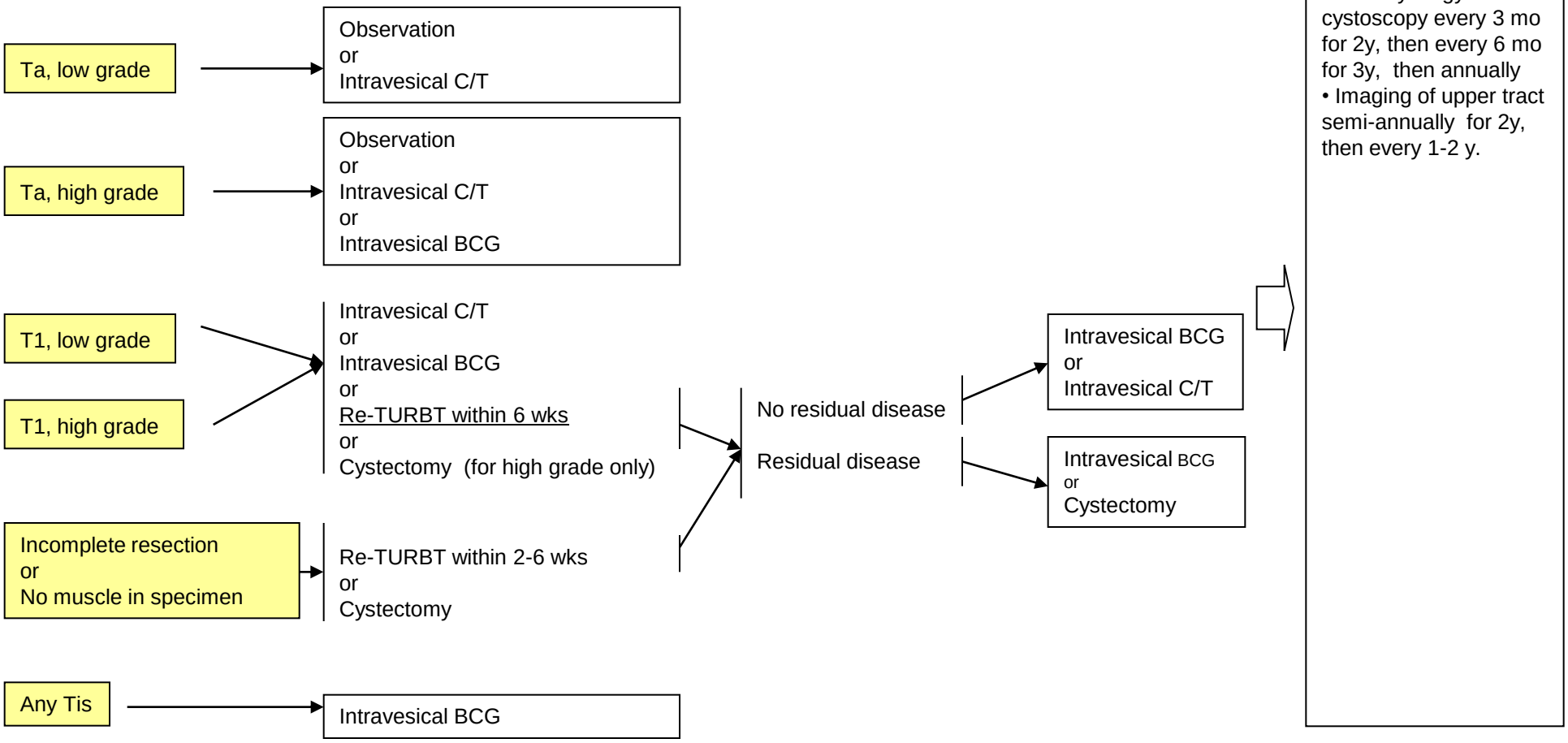
分期	輔助治療	追蹤



膀胱癌(圖三)

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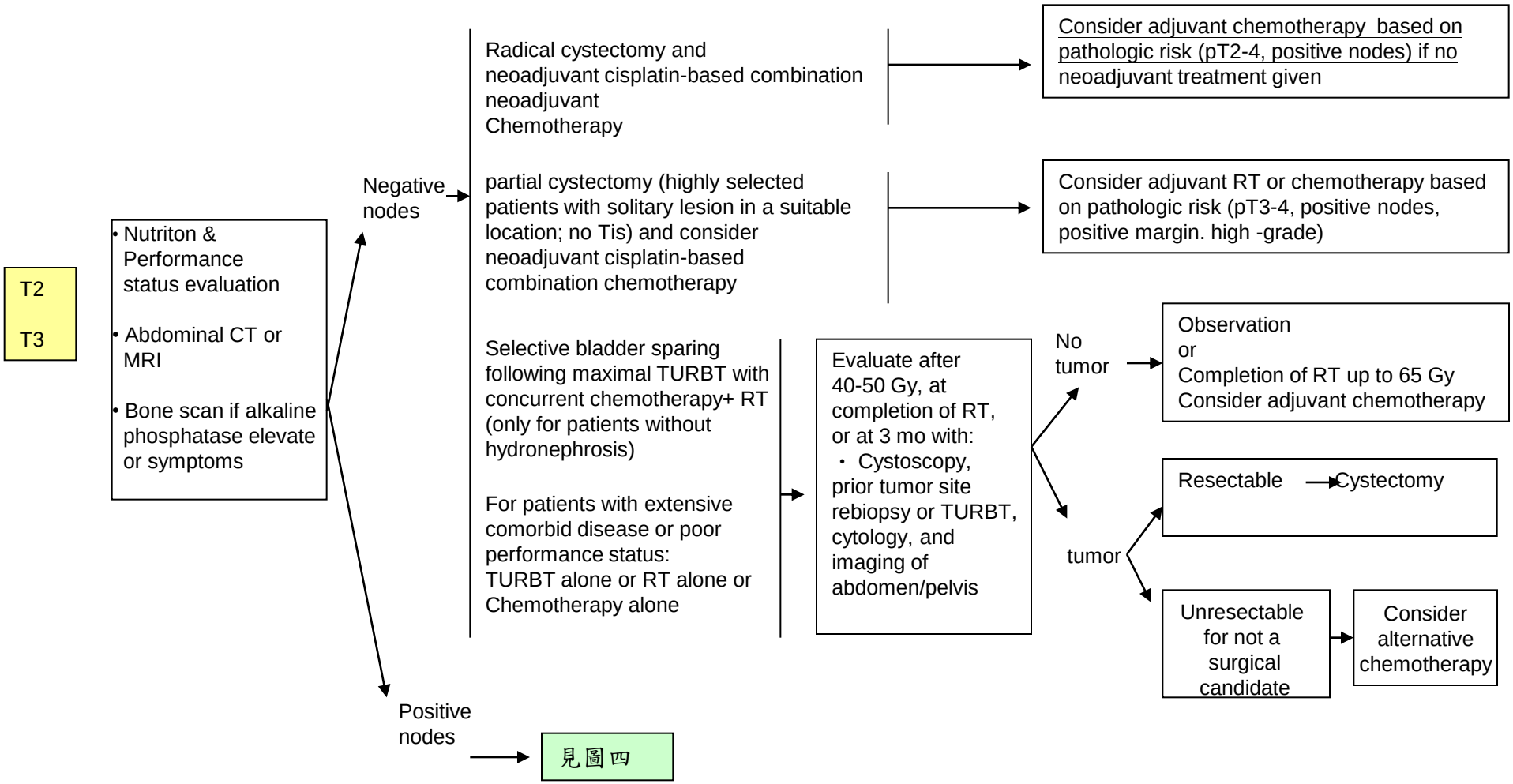
分期	深入評估	治療	輔助治療



膀胱癌(圖四)

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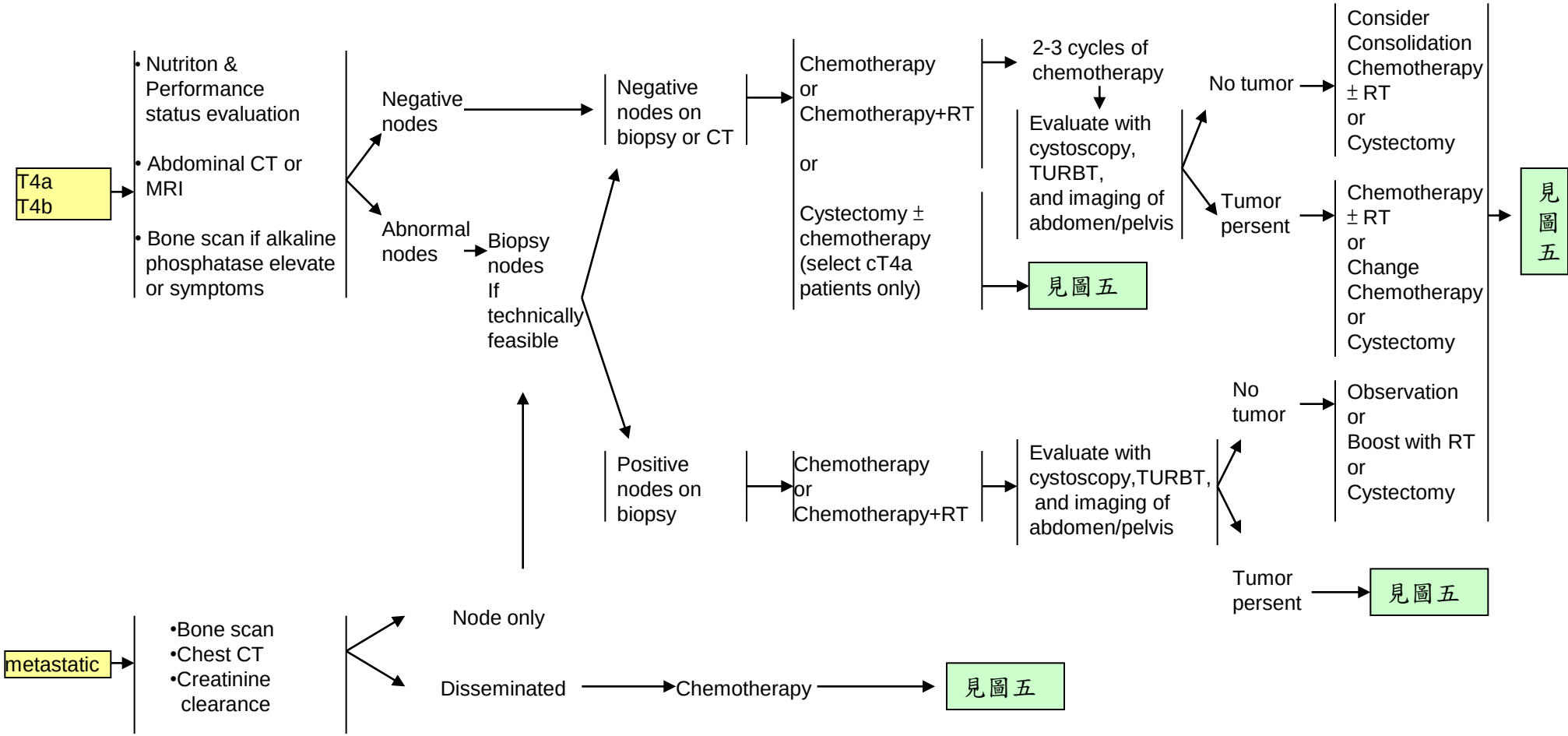
分期	深入評估	治療	輔助治療



膀胱癌(圖五)

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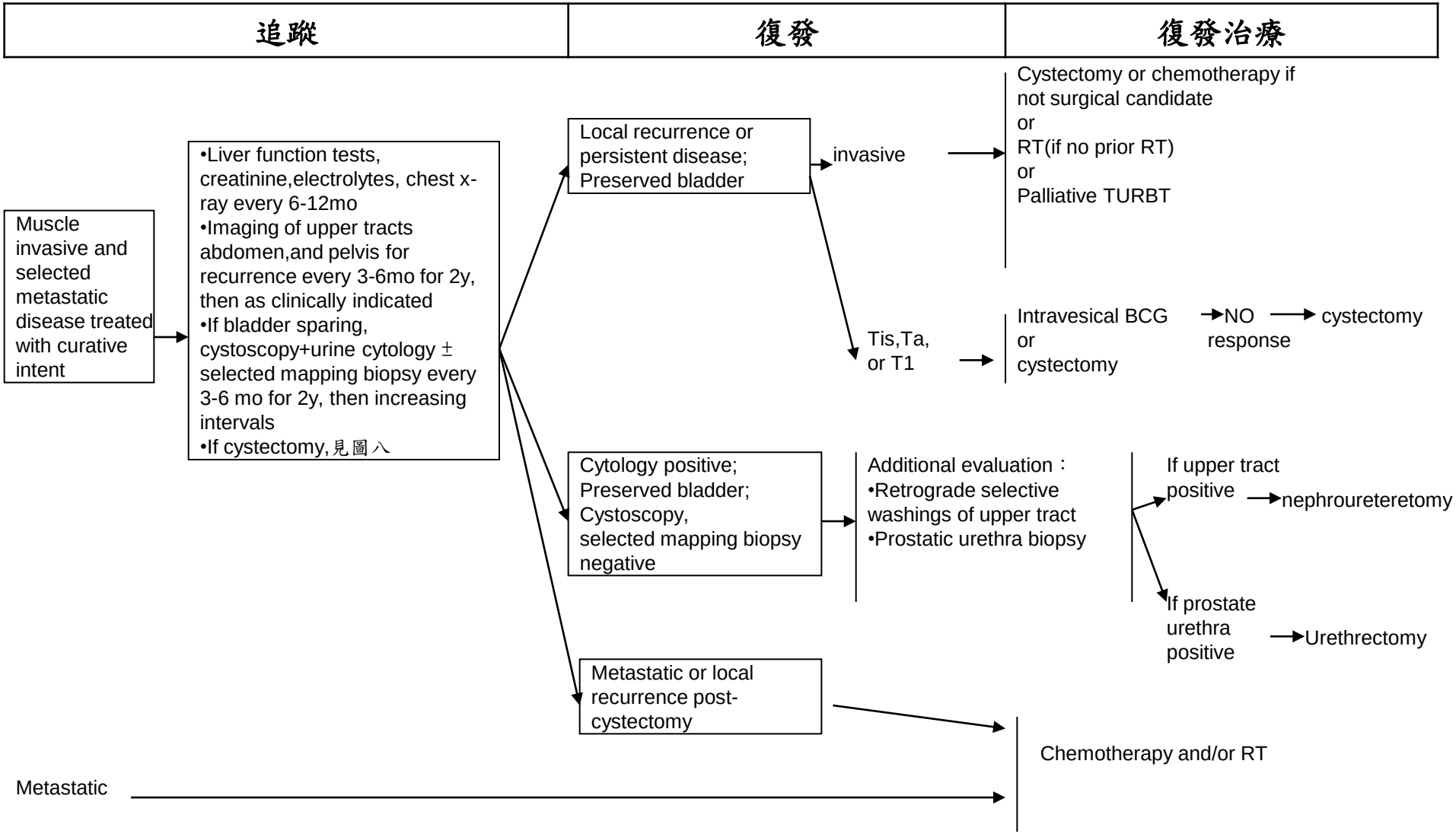

Principle of surgical management

TURBT: Papillarv

- Adequate resection with muscle If papillary high-grade lesion
- Re-resection If incomplete initial resection, no muscle in specimen or large lesion

TURBT: Tis

- Multiple random biopsies
- Biopsy adjacent to tumor
- Prostate urethral biopsies

TURBT: invasive

- Repeat re-resection:
  - If no muscle in biopsy
  - Small fragment of T2 insufficient to attribute risk
- Repeat TURBT should 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 RT

PARTIAL CYSTECTOMY

- Solitary lesion in location amenable to segmental resection with adequate margin, no Tis
- Pelvic lymphadenectomy should be performed in conjunction with the segmental cystectomy

RADICAL CYSTECTOMY

- Radical cystectomy should include bilateral node dissection at a minimum including common, internal and external iliac nodes, and obturator nodes

Non-Urothelial carcinoma of urinary bladder

Same as Urothelial cell carcinoma management with the following Issues:

Mixed Histology

•Urothelial carcinoma plus pure squamous, glandular adenocarcinoma, micropapillary, nested, plasmacytoid, sarcomatoid should be identified because of the potential to have a more aggressive natural history.

•Follow Urothelial Carcinoma of the Bladder guidelines with complete response less likely if bladder sparing considered

Pure Squamous:

•Cystectomy, RT,or other agents commonly used with squamous cell carcinoma of other sites such as 5-FU, taxanes, methotrexate, etc.

Adenocarcinoma

•Radical cystectomy or partial cystectomy

•Conventional chemotherapy (eg, MVAC) for urothelial carcinoma is not effective, however, the use of chemotherapy or RT should be individualized and maybe of potential benefit in select patients.

•Consider alternative therapy or clinical trial

Any Small-cell component:

•Neoadjuvant or adjuvant chemotherapy using small-cell regimens and local treatment (cystectomy or radiotherapy)

•Primary chemotherapy regimens similar to small cell lung cancer. see small cell lung cancer Guidelines

Urachal Carcinoma:

•Requires complete urachal resection

•Conventional chemotherapy for urothelial carcinoma Is not effective, however, the use of chemotherapy or RT should be individualized and maybe of potential benefit in select patients.

Primary Bladder Sarcoma

•See Soft Tissue Sarcoma Guidelines

Follow-up after cystectomy

After a radical cystectomy

•Urine cytology, creatinine, electrolytes, every 3 to 6 months for 2 years and then as clinically indicated
•Imaging of the chest, abdomen, and pelvis every 3 to 12 months for 2 years based on risk of recurrence and then as clinically indicated
•Urethral wash cytology, every 6 to 12 month； particularly if Tis was found within the bladder or prostatic urethra
•if a continent diversion was created, monitor for vitamin B12 deficiency annually

After a partial cystectomy

•Same follow-up as above, in addition to the following:
- Serial cytologic examinations and cystoscopies at 3-month intervals to monitor for relapse in the bladder

Principle of intravesical treatment

Intravesical chemotherapy:

Initiated within 24 hours after resection
Regimen: epirubicin 50mg or mitomycin-C 30mg in 50cc normal saline
Induction therapy: initiated 2 weeks after resection, weekly for 6 weeks
Maintenance therapy: role uncertain

Intravesical BCG therapy:

- Induction therapy:
  Initiated 2-4 weeks after resection
  Once weekly for 6 weeks
  Regimen: 81 mg BCG in 50cc normal saline

- Maintenance therapy
  81 mg BCG intravesical instillation once weekly for 1-3weeks at 3^{rd}, 6^{th} , 12^{th}, 18^{th}, 24^{th} month
  Regimen: 81 mg BCG in 50cc normal saline

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＊Perioperative chemotherapy（Neoadjuvant or Adiuvant）
Regimens ：

Regimen	Dosage	
Dose-Dense MVEC	Methotrexate	30MG/M2 on D1 or D2 of a 14 day cycle
	vinblastine	3MG/M2 on D1 or D2
	Epirubicin	45MG/M2 on D1 or D2
	Cisplatin	70MG/M2 on D1　References:NO2
MVEC	Methotrexate	30MG/M2 on D1,15,22
	vinblastine	3MG/M2 on D2,15.22
	Epirubicin	45MG/M2 on D2　References:NO3
	Cisplatin/Carbopatin	70MG/M2 on D2/AUCx4~6MG
Gemcitabine/Cisplatin	Gemcitabine	1000MG/M2 on D1,8,15 of a 28 day cycle
	Cisplatin/Carbopatin	70MG/M2 on D2/AUCx4~6MG　References:NO4

註：1.CCr ＜60使用Carbopatin　2.This dose should not combined with radiation

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＊First-line chemotherapy for metastativc disease
Regimens ：

Regimen	Dosage	
Dose-Dense MVEC	Methotrexate	30MG/M2 on D1 or D2 of a 14 day cycle
	vinblastine	3MG/M2 on D1 or D2
	Epirubicin	45MG/M2 on D1 or D2
	Cisplatin	70MG/M2 on D1　References:NO2
MVEC	Methotrexate	30MG/M2 on D1,15,22
	vinblastine	3MG/M2 on D2,15.22
	Epirubicin	45MG/M2 on D2　References:NO3
	Cisplatin/Carbopatin	70MG/M2 on D2/AUCx4~6MG
Gemcitabine/Cisplatin	Gemcitabine	1000MG/M2 on D1,8,15 of a 28 day cycle
	Cisplatin/Carbopatin	70MG/M2 on D2/AUCx4~6MG　References:NO4

註：1.CCr ＜60使用Carbopatin　2.This dose should not combined with radiation

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Principles of chemotherapy management

ΔDose-Dense MVEC regimen with growth factor support for 3 or 4 cycles

ΔMVEC regimen regimen for 6 cycles

Δ Gemcitabine/Cisplatin regimen for 6 cycles

＊CCRT　Regimens：

Regimen	Dosage	
Cisplatin alone	Cisplatin	35MG/M2 weekly　References:NO3

Reference

1. NCCN Clinical Practice Guideline in Oncology for Bladder Cancer ,Version 2,2013
2. Grossman HB, Natale RB, Tangen CM, et al Neoadjuvant chemotherapy plus cystectomy compared with cystectomy alone for locally advanced bladder cancer. N Engl J Med 2003;349:859-866.
3. Sternberg CN, de Mulder PH, Schornagel JH, et al. Randomized phase lll trial of high-dose-intensity methotrexate, vinblastine, doxorubicin, and cisplatin(MVAC) chemotherapy and recombinant human granulocyte colony-stimulating factor versus classic MVAC in advanced urothelial tract tumors: European Organization for Research and Treatment of Cancer Protocol no. 30924. J Ciln Oncil 2001;19:2638-2646.
4. Dash A, Pettus JA, Herr HW, et al. A role for neoadjuvant gemcitabine plus cisplatin in muscle-invasive urothelial carcinoma of the bladder: a retrospective experience. Cancer 2008;113:2471-2477.
5. Campbell-Walsh Urology, 9th edition, 2007
6. European Association of Urology Guideline, 2011