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Urothelial primary bladder tumours include transitional cell carcinoma (TCC), squamous cell carcinoma (SCC) and adenocarcinomas. Nonurothelial primary bladder tumours are extremely rare and include small cell carcinoma, carcinosarcoma, primary lymphoma and sarcoma.  Today, cancer management demands increasing specialization and a multidisciplinary team (MDT) approach where a variety of healthcare professionals who possess expertise in their respective fields, work closely together.  The multidisciplinary team is comprised of urological surgeons, radiologists, pathologists, medical oncologists, urology and oncology nurse specialists and palliative care specialists, all with expertise and interest in urological cancers.  Together, they ensure that all patients receive timely, continuous, integrated and improved quality of cancer care.  MDT approach has a patient-centred approach and improves coordination of care and outcomes including quality of life and survival.  CONTENTS  BLADDER CANCER   * An overview of bladder cancer is presented. Epidemiology, aetiopathology, clinical presentation, investigations, diagnosis and staging are discussed. * Treatment of bladder cancer is discussed in detail * Management of superficial bladder cancer * Treatment of low risk superficial disease * Treatment of intermediate risk superficial disease * Treatment of high risk superficial disease * Treatment of muscle invasive disease (non metastatic) * Treatment of muscle invasive disease (metastatic) * Transurethral resection of bladder tumour (TURBT) is indicated in any suspected urothelial carcinoma; it can be the sole treatment but only in non muscle invasive urothelial tumour. Complete eradication of all visible tumours is accomplished by either resection or fulguration. * Intravesical chemotherapy and immunotherapy is administered perioperatively or postoperatively in an adjuvant fashion to prevent recurrence following TURBT and as an adjunctive therapy in carcinoma in situ where diffuse tumour prevents complete resection. * Laser ablation therapy is indicated in treatment of select lower and upper tract cancer and treatment of low-grade papillary tumours. It is not indicated in new lesions prior to tumour staging/grading * Conservative management (office fulguration or cystoscopic surveillance is indicated in low risk and recurrent non-muscle invasive papillary bladder tumours and in well-documented history of low-grade Ta tumours * Depending on patient and tumour characteristics, a number of patients may benefit from some form of intravesical therapy - bacillus Calmette-Guérin (BCG) , mitomycin C, interferon , ThioTEPA, doxorubicin, epirubicin , valrubicin and gemcitabine   *AUA guidelines*   * *A patient who presents with an abnormal growth on the urothelium but who has not yet been diagnosed with bladder cancer* * *If* the patient does not have an established histologic diagnosis, a biopsy should be obtained for pathologic analysis * Under most circumstances, complete eradication of all visible tumours should be performed * If bladder cancer is confirmed, periodic surveillance cystoscopy should be performed. An initial single dose of intravesical chemotherapy may be administered immediately postoperatively * *Patient with small volume, low-grade Ta bladder cancer* * An initial single dose of intravesical chemotherapy may be administered immediately postoperatively. * *Patient with multifocal and/or large volume, histologically confirmed, low-grade Ta or a patient with recurrent low-grade Ta bladder cancer* * An induction course of intravesical therapy with bacillus Calmette-Guérin or mitomycin C is recommended for the treatment of these patients with the goal of preventing or delaying recurrence * Maintenance bacillus Calmette-Guérin or mitomycin C may be considered * *A patient with initial histologically confirmed high-grade Ta, T1, and/or carcinoma in situ bladder cancer* * For patients with lamina propria invasion (T1) but without muscularis propria in the specimen, repeat resection should be performed prior to additional intravesical therapy * An induction course of bacillus Calmette-Guérin followed by maintenance therapy is recommended for treatment of these patients * Cystectomy should be considered for initial therapy in select patients * *A patient with high- grade Ta, T1, and/or carcinoma in situ bladder cancer which has recurred after prior intravesical therapy* * For patients with lamina propria invasion (T1) but without muscularis propria in the specimen, repeat resection should be performed prior to additional intravesical therapy * Cystectomy should be considered as a therapeutic alternative for these patients * Further intravesical therapy may be considered for these patients   ROLE OF THE MULTIDISCIPLINARY TEAM IN MANAGEMENT OF BLADDER CANCER   * A multidisciplinary team of physicians is essential for the successful treatment of patients with bladder cancer. The benefits of multidisciplinary disease management of patients include reducing recurrent disease, optimizing timing of surgery, prolonging survival for the patient and enhancing response to therapies   Bladder cancer – A candidate for the MDT approach   * As there are a variety oftherapeutic options available for patients with bladder cancer, a multidisciplinary team is essential for management * Multidisciplinary teams are involved in the diagnosis and staging of bladder cancer, treatment plans and delivery and they ensure that patient is involved in the decision making process.   Multidisciplinary teams take into account, the   * Grade of tumour * Tumour size * Stage of disease * New/recurrent tumour * Single/multiple tumour * Previous tumours * Previous response to intravesical therapy * Bladder symptoms/function * Bladder diverticula diagnosis * Bowel function * Bilateral hip prosthesis * Hydronephrosis * Renal function/GFR * Age, comorbidity, life expectancy * Patient preference * Patient expectations * The MDT team has regular meetings where specialists present patient cases for discussion of all available treatment options as well as clarification of diagnosis and management pathways * They exchange clinical evidence with the patient and then formulate an individualized management plan   The Core MDT in bladder cancer, individual roles and communication  The core MDT in bladder cancer includes urological surgeons, radiologists, pathologists, medical oncologists, urology and oncology nurse specialists and palliative care specialists.   * Urological surgeon is involved in the early diagnosis of bladder cancer. He performs * Cystoscopy, biopsy * TUR bladder tumour * Intravesical therapy * Radical and partial cystectomy * Urostomy * Continent urinary diversion   He is also involved in the follow up of patients with bladder cancer   * Pathologist is involved in the generation of histology from biopsy specimen and cytology reports * Radiologist is involved in the diagnosis - Ultrasound , IVU, Computerised tomography (CT) * Medical oncologist contributes to the treatment with chemotherapy * Oncology nurses are involved in the long-term care of patients with bladder cancer * Consultations between the urological surgeon, radiologist, pathologist are essential to ensure optimal care of patients with bladder cancer * Multidisciplinary teams ensure an integrated care and improved quality of cancer care. It has a patient-centred approach * The process of reviewing patient management issues through multidisciplinary meetings benefits both patients and team members * Delivery of multidisciplinary cancer care is usually by one stop multidisciplinary clinics where patients can see all relevant specialists in one visit   Patient communication   * Communication between multidisciplinary team and patients is most important. In cancer management, communication skills are a key to achieving the important goals   Benefits of the MDT approach in bladder cancer   * MDT approach in patients with bladder cancer ensures that patients receive timely treatment and care from appropriately skilled professionals resulting in improved outcomes including quality of life and survival | | | | | | |