一、本共識依下列參考資料修改版本：

NCCN Clinical Practice Guidelines in Oncology- Bladder cancer V.1.2014

二、制訂人員：

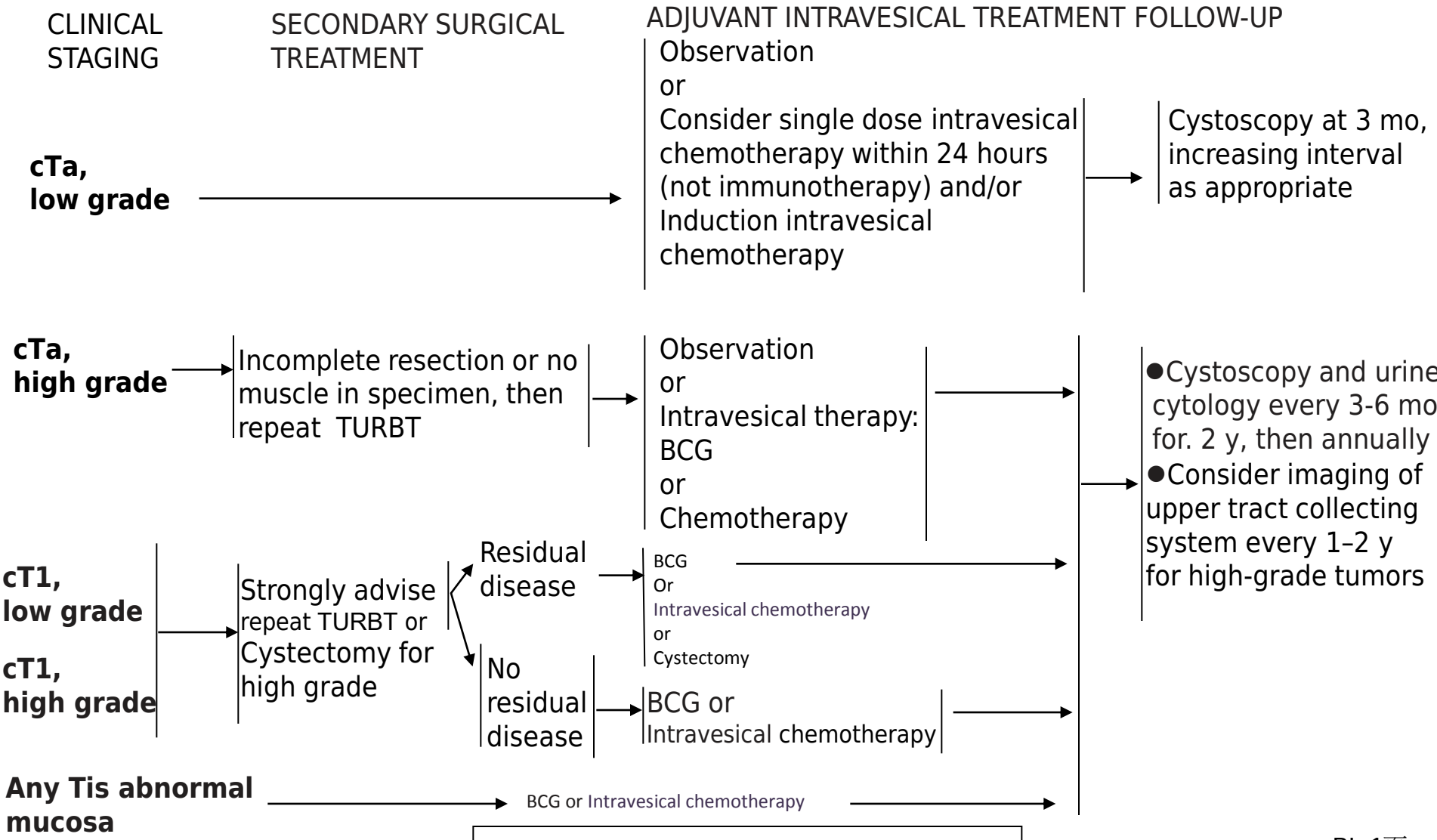
- 泌尿外科：鍾旭東醫師、蔡宗佑醫師、洪順發醫師
- 腫瘤內科：蕭吉晃醫師
- 放射腫瘤：熊佩韋醫師
- 組織病理：蔡建誠醫師
- 影像醫學：曾旭明醫師、黃俊傑醫師
- 個 管 師：詹令合

三、guidelines內容:

亞東紀念醫院
亞東紀念醫院

膀胱癌臨床指引
(cancer of the Bladder)

Bladder Cancer Clinical Guidelines in Oncology FEMH-V.1.2014

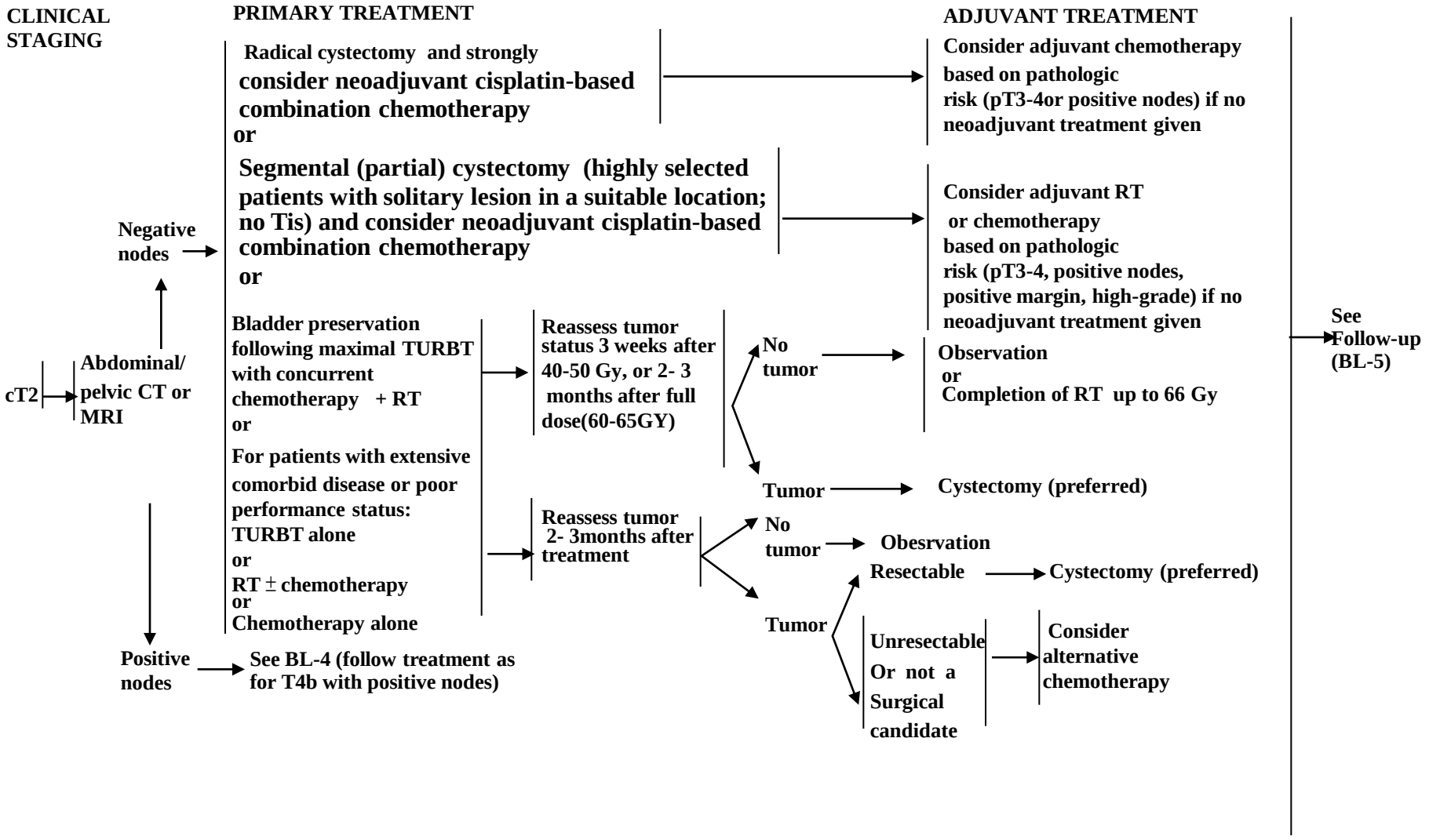


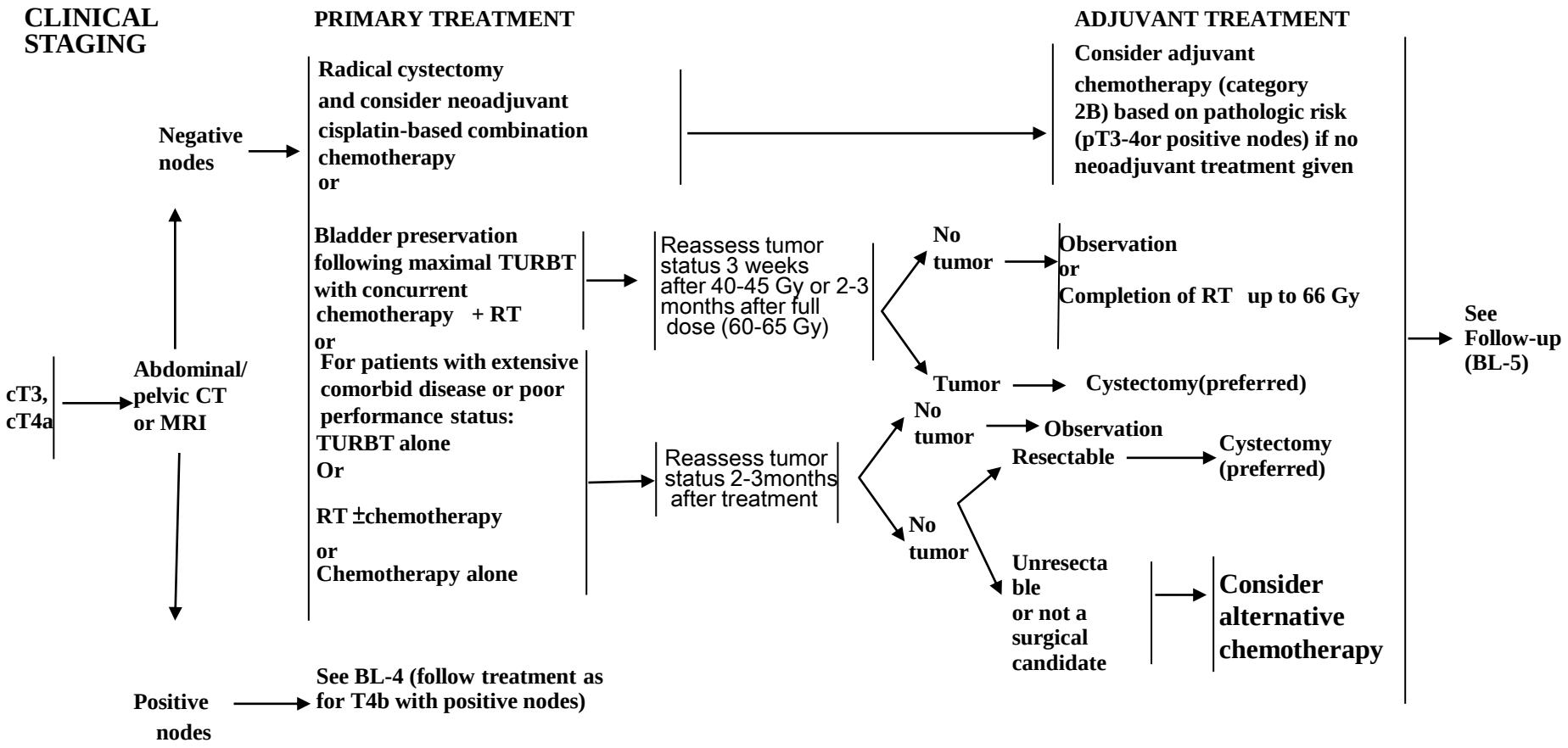
P.S.:BCG according to performance status

亞東紀念醫院

膀胱癌臨床指引 (cancer of the Bladder)

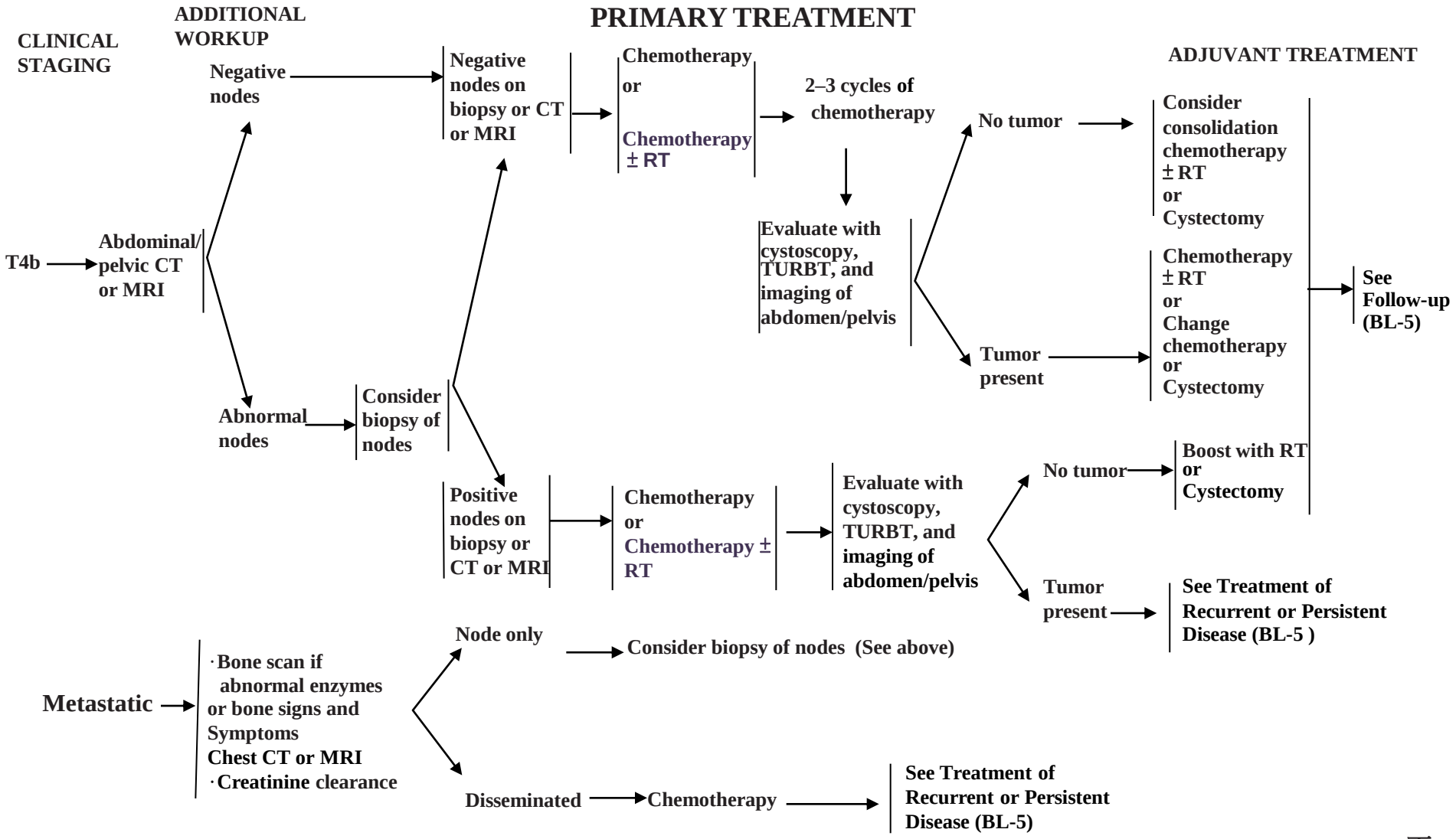
Bladder Cancer Clinical Guidelines in Oncology FEMH-V.1.2014




CLINICAL STAGING
PRIMARY TREATMENT
ADJUVANT TREATMENT
cT3, cT4a
Abdominal/ pelvic CT or MRI
Negative nodes
Positive nodes
Radical cystectomy and consider neoadjuvant cisplatin-based combination chemotherapy or
Bladder preservation following maximal TURBT with concurrent chemotherapy + RT or
For patients with extensive comorbid disease or poor performance status: TURBT alone Or RT ±chemotherapy or Chemotherapy alone
See BL-4 (follow treatment as for T4b with positive nodes)
Reassess tumor status 3 weeks after 40-45 Gy or 2-3 months after full dose (60-65 Gy)
Reassess tumor status 2-3months after treatment
No tumor
Observation or Completion of RT up to 66 Gy
Tumor
Cystectomy(preferred)
No tumor
Observation
Resectable
Cystectomy (preferred)
No tumor
Unresectable or not a surgical candidate
Consider alternative chemotherapy
Consider adjuvant chemotherapy (category 2B) based on pathologic risk (pT3-4or positive nodes) if no neoadjuvant treatment given
See Follow-up (BL-5)

亞東紀念醫院 膀胱癌臨床指引 (cancer of the Bladder)

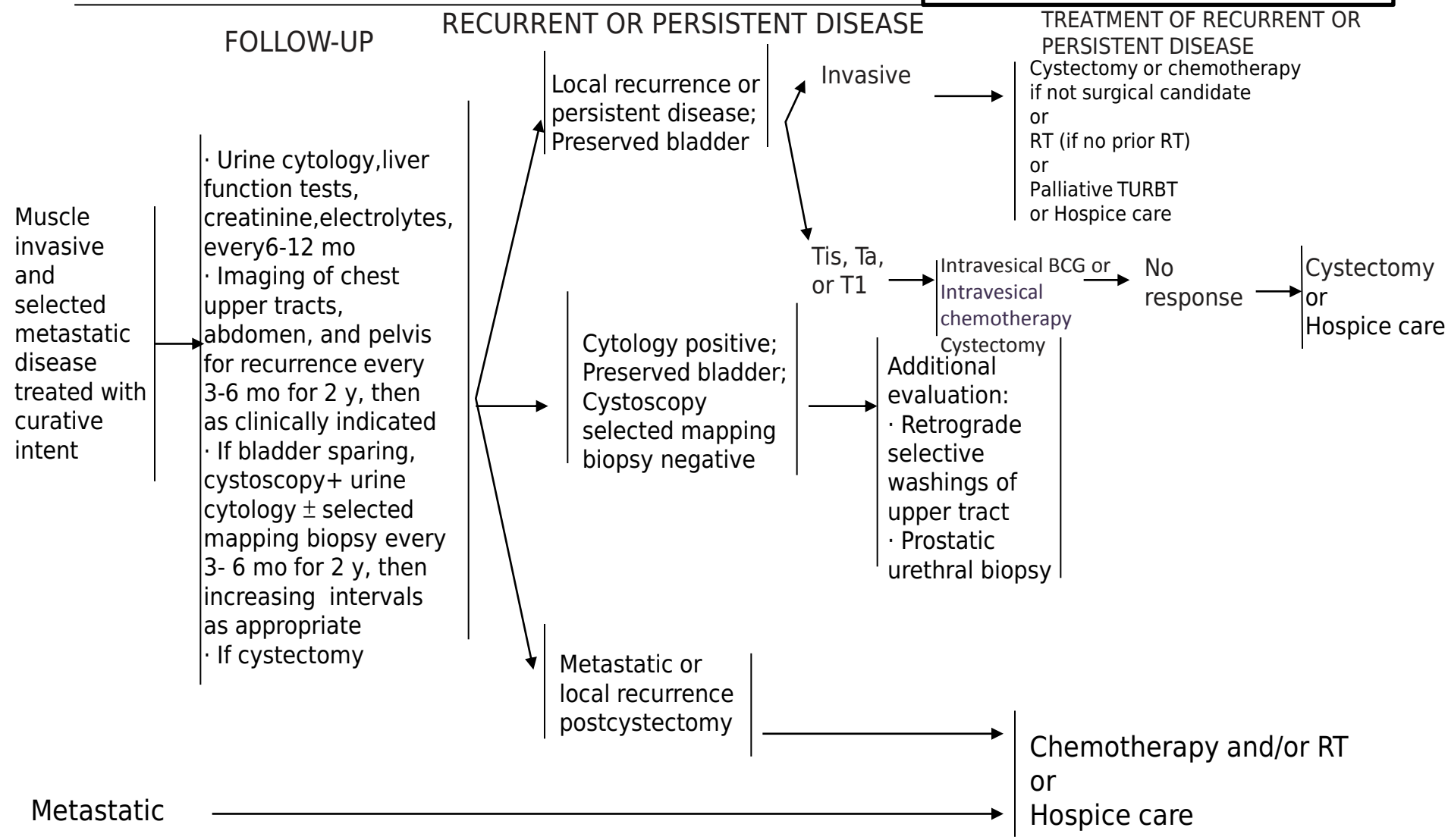
Bladder Cancer Clinical Guidelines in Oncology FEMH-V.1.2014



亞東紀念醫院

膀胱癌臨床指引 (cancer of the Bladder)

Bladder Cancer Clinical Guidelines in Oncology FEMH-V.1.2014



四、Staging:

Table 1

American Joint Committee on Cancer (AJCC)

TNM Staging System for Bladder Cancer (7th ed., 2010)

Primary Tumor (T)

TX	Primary tumor cannot be assessed
T0	No evidence of primary tumor
Ta	Noninvasive papillary carcinoma
Tis	Carcinoma in situ: "flat tumor"
T1	Tumor invades subepithelial connective tissue
T2	Tumor invades muscularis propria
pT2a	Tumor invades superficial muscularis propria (inner half)
pT2b	Tumor invades deep muscularis propria (outer half)
T3	Tumor invades perivesical tissue
pT3a	Microscopically
pT3b	Macroscopically (extravesical mass)
T4	Tumor invades any of the following: prostatic stroma, seminal vesicles, uterus, vagina, pelvic wall, abdominal wall
T4a	Tumor invades prostatic stroma, uterus, vagina
T4b	Tumor invades pelvic wall, abdominal wall

Regional Lymph Nodes (N)

Regional lymph nodes include both primary and secondary drainage regions. All other nodes above the aortic bifurcation are considered distant lymph nodes.

NX	Lymph nodes cannot be assessed
N0	No lymph node metastasis
N1	Single regional lymph node metastasis in the true pelvis (hypogastric, obturator, external iliac, or presacral lymph node)
N2	Multiple regional lymph node metastasis in the true pelvis (hypogastric, obturator, external iliac, or presacral lymph node metastasis)
N3	Lymph node metastasis to the common iliac lymph nodes

Distant Metastasis (M)

M0	No distant metastasis
M1	Distant metastasis

ANATOMIC STAGE/PROGNOSTIC GROUPS

Stage 0a	Ta	N0	M0
Stage 0is	Tis	N0	M0
Stage I	T1	N0	M0
Stage II	T2a	N0	M0
	T2b	N0	M0
Stage III	T3a	N0	M0
	T3b	N0	M0
	T4a	N0	M0
Stage IV	T4b	N0	M0
	Any T	N1-3	M0
	Any T	Any N	M1

Continued on next page

Table 1 (Continued)

American Joint Committee on Cancer (AJCC)

TNM Staging System for Bladder Cancer (7th ed., 2010)

Clinical Staging

Primary tumor assessment includes bimanual examination under anesthesia before and after endoscopic surgery (biopsy or transurethral resection) and histologic verification of the presence or absence of tumor when indicated. Bimanual examination following endoscopic surgery is an indicator of clinical stage. The finding of bladder wall thickening, a mobile mass, or a fixed mass suggests the presence of T3 and/or T4 disease, respectively. Appropriate imaging techniques for extravesical extension of the primary tumor and lymph node evaluation should be incorporated into clinical staging. When indicated, evaluation for distant metastases includes imaging of the chest, biochemical studies, and isotopic studies to detect common metastatic sites.

Pathologic Staging

Microscopic examination and confirmation of extent are required. Total cystectomy and lymph node dissection generally are required for this staging; however, a pathologic staging classification should be given for partial cystectomy specimens. Laterality does not affect the N classification.

Histologic Grade (G)

For urothelial histologies, a low- and high-grade designation is used to match the current World Health Organization/International Society of Urological Pathology (WHO/ISUP) recommended grading system:

LG Low grade
HG High grade

If a grading system is not specified, generally the following system is used:

GX Grade cannot be assessed
G1 Well differentiated
G2 Moderately differentiated
G3 Poorly differentiated
G4 Undifferentiated

Histopathologic Type

The histologic types are as follows:

Urothelial (transitional cell) carcinoma
In situ
Papillary
Flat
With squamous differentiation
With glandular differentiation
With squamous and glandular differentiation
Squamous cell carcinoma
Adenocarcinoma
Undifferentiated carcinoma

The predominant cancer is urothelial (transitional cell) carcinoma. Histologic variants include micropapillary and nested subtypes.

五、Updated

- **Reference from NCCN V.2.2011 , Updated on100/2/17 difference as following:**
- Page7, EUA 此檢查因院內無故刪除及在RECURRENT OR PERSISTENT DISEASE的地方加入hospice care。
- **Updated on 101/6/14**
- **Reference from NCCN V.1.2013 , Updated on102/3/7 difference as following:**
- Page5-7,Primary Treatment for cT2-cT4b disease part ,修改與NCCN一致。
- Page5-7,Primary Treatment for cT2-cT4b,PRIMARY TREATMENT→Chemotherapy ± RT,爲符合本院治療狀況故暫不與NCCN同步。
- Page4and8,因國內BCG貨源短缺,故Any Tis abnormal mucosa, cT1 -> ADJUVANT INTRAVESICAL TREATMENT 增列option Intravesical chemotherapy。 Tis, Ta, or T1 ->TREATMENT OF RECURRENT OR PERSISTENT DISEASE增列option Intravesical chemotherapy 。
- **Reference from NCCN V.1.2014 , Updated on103/5/15 difference as following:**
- 依照NCCN,BL4~5 and BL-7修改。