BRITISH ASSOCIATION OF UROLOGICAL SURGEONS

COVID-19 Bladder Cancer Contingency Plan
Prepared by the BAUS Section of Oncology

This document has been produced to outline two contingency plans for how bladder cancer service provision may need to deviate from the internationally accepted standard of care, during the current COVID-19 pandemic.

Step 1 reflects the response to reduced service provision whereas **Step 2** reflects the response to severely reduced service provision.

1. DIAGNOSTICS

a. Two-week wait referrals

CLINICAL SITUATION	CURRENT PROVISION	STEP 1 (REDUCED SERVICE PROVISION)	STEP 2 (SEVERELY REDUCED PROVISION)
Visible haematuria age > 45 yr	Haematuria clinic	Haematuria clinic	Community-based ultrasound or emergency care if severe
Non-visible haematuria age > 60 yr	Haematuria clinic	Community-based ultrasound or defer	Defer investigations

b. TURBT

CLINICAL SITUATION	CURRENT PROVISION	STEP 1 (REDUCED SERVICE PROVISION)	STEP 2 (SEVERELY REDUCED SERVICE PROVISION)
New bladder tumour	TURBT	Restrict to solid tumours & actively bleeding tumours. Consider pinch biopsy & MRI	Stop TURBT unless active bleeding
Re-resection of bladder tumour	TURBT	Restrict to very high-risk NMIBC (i.e. very strong suspicion of under-staging)	Stop TURBT

c. MDT

Clear documentation of NICE risk stratification of all bladder tumours

- low / intermediate / high-risk NMIBC
- MIBC
- metastatic bladder cancer

Document if the MDT treatment plan has been modified in response to COVID-19

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2. TREATMENT

a. Non-muscle invasive bladder cancer (NMIBC)

RISK	CURRENT PROVISION	STEP 1 (REDUCED PROVISION)	STEP 2 (SEVERELY REDUCED PROVISION)
Low	Flexible cystoscopy at 3 months	Flexible cystoscopy at 12 months	Stop surveillance

Intermediate	Intravesical chemotherapy then flexible cystocopy surveillance	Flexible cystoscopy at 6 months	Flexible cystoscopy at 12 months
High	Intravesical BCG and flexible cystoscopy surveillance / cystectomy	Flexible or rigid cystoscopy at 3 months. Consider the risk/benefit ratio of giving or continuing intravesical BCG/HIVEC therapy	Flexible or rigid cystoscopy at 6 months. Consider the risk/benefit ratio of giving or continuing intravesical BCG/HIVEC therapy

PLEASE NOTE: Consider the risk/benefit ratio of giving or continuing intravesical instillations (BCG or chemotherapy) for non-muscle invasive bladder cancer, due to their potential immunosuppressive effects.

b. Muscle-invasive disease

Perform CT chest, abdomen & pelvis for those patients being treated with curative intent.

CLINICAL SITUATION	CURRENT PROVISION	STEP 1 (REDUCED PROVISION)	STEP 2 (SEVERELY REDUCED PROVISION)
T2-4 N0 M0 disease	Neoadjuvant chemotherapy + radical radiotherapy or cystectomy & urinary diversion	Radiotherapy ± 5FU / Mitomycin	Radiotherapy if available ± 5FU / Mitomycin

T2-4 N0 M0 where EBRT is contra-indicated (previous EBRT, IBS, significant adhesions)	Neoadjuvant chemotherapy + radical (salvage) cystectomy & urinary diversion	Radical cystectomy & urinary diversion	Defer surgery for a maximum of 3 months

c. Upper tract transitional cell carcinoma

CLINICAL SITUATION	CURRENT PROVISION	STEP 1 (REDUCED PROVISION)	STEP 2 (SEVERELY REDUCED PROVISION)
Suspicion of upper tract TCC	CT-IVP, cytology & ureteroscopy if diagnosis is in doubt	CT-IVP only. Avoid ureteroscopy if possible	CT-IVP if significant haematuria
New ureteric or renal pelvis tumour	Nephro-ureterectomy or nephron-sparing surgery if appropriate	Nephro-ureterectomy if active haematuria or suspicion of high-grade/stage disease & good performance status. Consider embolisation.	Defer nephro-ureterectomy until facilities exist. Consider embolisation if significant haematuria.

d. Use of neoadjuvant chemotherapy

- Advise against neoadjuvant chemotherapy.
- Some consideration could be given, for patients with more locally advanced disease (T3/4), to a more downstaging approach if definitive, curative treatment is thought to be appropriate thereafter.

e. Radiotherapy

- All patients who have started radical radiotherapy to the bladder should continue.
- Consider offering radical radiotherapy treatment to muscle invasive disease if facilities continue.
- Chemotherapy combined with radiotherapy is likely to have additional risks from COVID-19 in immunocompromised patients.
- Consider 5FU/Mitomycin in the outpatient setting.

f. Metastatic disease

- Chemotherapy should be considered, but with the use of growth factors to minimise risk of infection.
- In more indolent metastatic disease, a surveillance approach, if at all possible, should be advised.
- Consider palliative radiotherapy is symptomatic.

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3. PATIENTS CURRENTLY ON TREATMENT

Intravesical chemotherapy/BCG: complete induction if possible, then defer further treatment.

Neoadjuvant chemotherapy: stopping should be discussed with patients and, if there have been any complications with treatment to date, cessation of treatment should be recommended.

Awaiting cystectomy & nephro-ureterectomy: proceed as soon as possible with need to prioritise over other less urgent cases. Consider change to radiotherapy/chemotherapy if feasible.

Awaiting radiotherapy: radical radiotherapy should continue if possible. Consideration given to circumstances where patients live in geographically remote areas and have to leave their homes to relocate locally for treatment; advised to stay in hostels etc. but the risk of COVID-19 is going to be greater.

***Radical radiotherapy*:** should continue if possible. Consideration may be given to circumstances where patients live in geographically remote areas and need to leave their homes to re-locate locally for treatment e.g. a stay in a hostel, where the risk of acquiring COVID-19 is going to be greater.

Palliative treatment: should only proceed if patients are symptomatic e.g. with significant bleeding and, ideally, plan & treat on the same day whilst keeping doses and fractionations to a minimum.

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4. FOLLOW-UP

Telephone follow-up with bloods & scans, as dictated by symptoms, otherwise defer.