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Bladder Cancer at the time of COVID-19 Outbreak

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ABSTRACT

The COVID-19 outbreak has led to the deferral of a great number of surgeries in an attempt to reduce transmission of infection, free up hospital beds, intensive care and anaesthetists, and limit aerosol-generating procedures. Guidelines and suggestions have been provided to categorize Urological diseases into risk groups and recommendations are available on procedures that can be or cannot be deferred. We aim to summarise updates on diagnosis, treatment and follow up of bladder cancer during the COVID-19 outbreaks.

Comment:

Recommendations from different associations and stakeholders in urology during the Covid-19 outbreak are based on deferring surgeries in order to save manpower, resources and ventilators, as well as to avoid unnecessary visits and reduce the risk of contagion. However, there is a risk of progression in urological tumors, such as bladder cancer, if patients are not diagnosed and treated in safe time intervals. Esperto and cols offer in their article, published in the special supplement dedicated to COVID in July 2020 in the International Braz J urology, a reflection on the bladder cancer recommendations based on the EAUguidelines before and during the Covid-19 outbreak.

Categorizing patients into priority groups is critical. In this sense, low priority cases, such as non-muscular invasive bladder cancers (NMIBC) <1cm, complete initial TURBT of

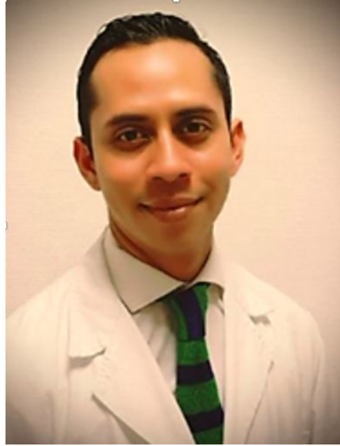
pT1 lesion, can be deferred by 6 months. Intermediate priority should be treated within 3 months, these include tumor >1cm, early recurrence, unresponsiveness or failure to BCG. High priority cases should be treated within <6 weeks and include: 1) TURBT for suspicious muscle invasive tumour 2) re-resection in patients with visibly residual tumor after TURB of large or multiple tumors.

Radical Cistectomy delays for MIBC of up to 12 weeks may be safe. A thorough discussion with the patient should be carried out concerning the type of urinary diversion. Orthotopic neobladder reconstruction has been systematically associated to increased hospital stay and posoperative complications. Multi- modal bladder-sparing therapy or Trimodal therapy (TMT), consisting of complete TURBT, chemotherapy and radiotherapy is an interesting alternative to surgery in selected patients during Covid-19 outbreak, but probably entails multiple accesses to a tertiary referral center.

Metastatic BC Asymptomatic patients with low disease burden can postpone treatment (8-12 weeks). High priority cases should be treated within <6 week. Emergency cases should be treated within <24 hours and include 1) patients with clot retention 2) intractable haematuria with anaemia; 3) nephrostomy for locally advanced BC with acute renal failure; 4) embolization or haemostatic radiotherapy for bleeding with haemodynamic repercussion.

Regard follow up during COVID-19, Low priority NMIBC cases are deferred by 6 months. Follow up include: 1) cystoscopy in patients low/intermediate-risk NMIBC before the end of 3 months without hematuria. High priority cases should be followed up within <6 weeks with cystoscopy in patients with NMIBC and intermittent haematuria. Apart from cytology, imaging, flexible-cystoscopy and TURBT, this may be the time to utilize molecular markers and next-generation sequencing to aid in the diagnosis and predicted outcome of NMIBC

The work presented by Esperto and cols, offers practical recommendations for safe time intervals for the diagnosis and treatment of bladder cancer during the COVID-19 outbreak. However, the exceptional nature of the current situation requires making decisions based on clinical evidence and the particular situations of the local environment.



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