NHS
Wessex
Cancer Alliance

Primary Care Conference – Bladder Cancer

26.2.26










Introductions

- Ms Naomi Neal – Consultant Urological Surgeon
- Dr Jenny Rattray – GP at Meon Health Practice, Fareham, and Wessex Cancer Alliance GP Advisor

Why bladder cancer?

Cases

around 10,500

new bladder cancer cases every year, UK (2017-2019)

Survival

More than 4 in 10 (42.3%)

people diagnosed with bladder cancer survive their disease for 10 years or more, UK (2018)

Common Cancers Mortality

9th most common cause of cancer death

accounting for 3% of all cancer deaths, UK (2021-2023)

Common Cancers Incidence

11th most common cancer

accounting for 3% of all new cancer cases, UK (2017-2019)

Incidence Rates

decreased by 42%

since the early 1990s, UK

Survival Rates

increased by 6.9 percentage points

since the early 1970s, UK

Presenting symptoms are commonly seen in primary care for lots of reasons – how do we ensure the right patients are referred in a timely way?

CRUK Cancer Statistics Data Hub - Bladder cancer accessed 10.2.26

Local context

- Deep dive into bladder cancer pathways as part of national ask for cancer alliances including:
  - Audit of referral practice
  - Consensus development in managing non-visible haematuria
- Discrepancies in primary care around different treatment pathways, eg pharmacy first for urinary tract infections
- Challenges in early diagnosis of urological cancers has informed Dorset Cancer LIS – audit newly diagnosed bladder/kidney and prostate cancer

Referral Audit – current practice in HIOW

- What we are doing well:
  - 78.5% of referrals had the reason for referral and/or free text description of symptoms included
  - Urinalysis was complete for 74.7% of referrals of which 8.7% had recurrent UTIs (66.7% male and 33.3% female) prior to referral. Of those with recurrent UTIs, 50% were diagnosed with muscle-invasive bladder cancer (Staging data available for 33.3% of those with recurrent UTIs.
- Areas to improve:
  - 40% did not have performance status (frailty score) completed
  - 64.6% referrals sent on wrong form
  - Cytology/ filter tests were missing for the majority of referrals. 77.2% had WCC missing, 82.3% had U&Es and eGFR missing. (a further 7.6% did have tests requested at time of referral, and 11.4% had results within 3 months)

Reminder of USC Fast track referral criteria

Bladder/ Renal

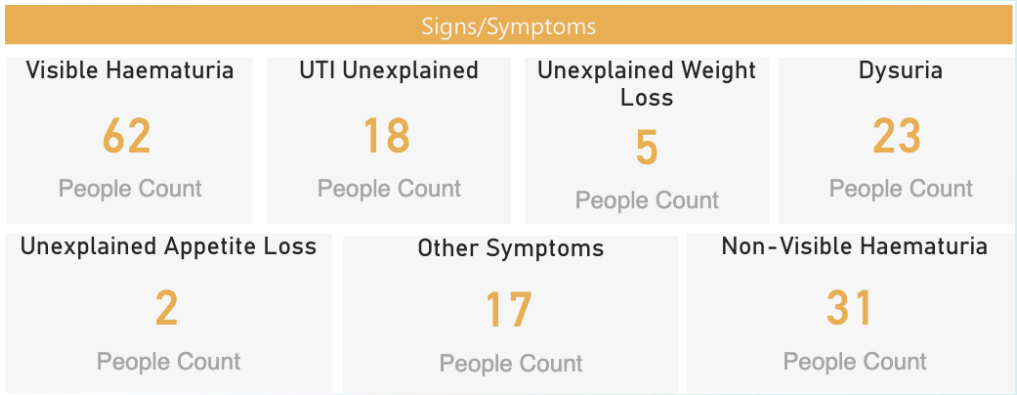
- ☐ ≥ 45y with unexplained visible haematuria without UTI
- ☐ ≥ 45y with visible haematuria that persists or recurs after successful treatment of UTI
- ☐ ≥60y with unexplained non-visible haematuria on urine dip and either dysuria or raised white cell count

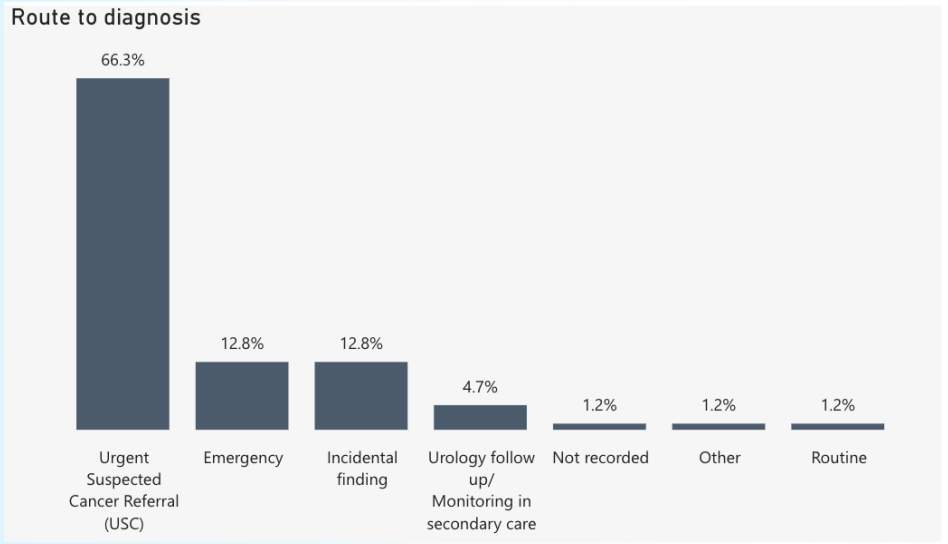
https://wessexcanceralliance.nhs.uk/referral-forms/

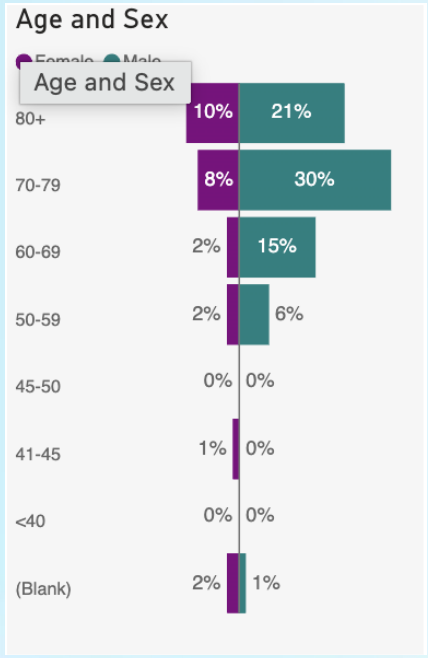
Remember to use the most up to date referral form (on ardens) and include:
Urine dip and MSU results
Bloods including Hb, WCC, UEs (currently form indicates these must be within 4 weeks due to scanning with contrast but this will be changing)

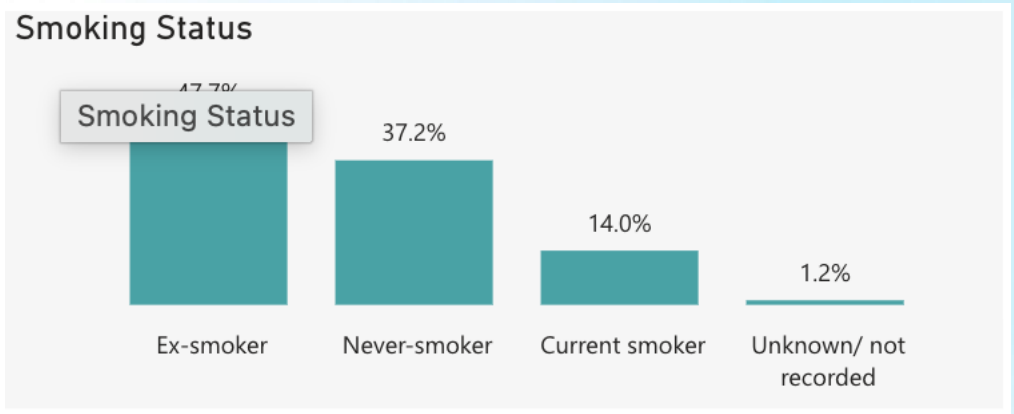
Dorset Local Incentive Scheme audit

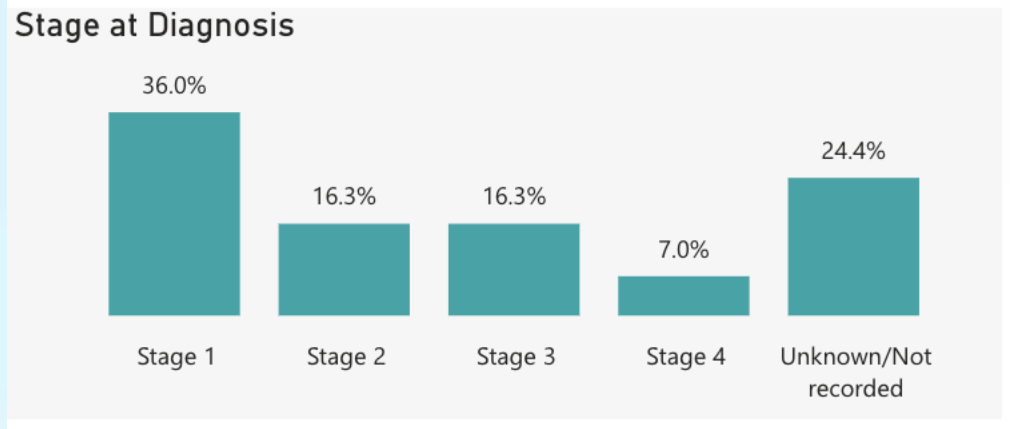
86 patients with a new diagnosis of bladder cancer across 17/18 PCNs in Dorset











Dorset LIS – reasons for diagnostic delay in primary care

- 15/86 patients experienced primary care delay – 17.4%
- UTI symptoms managed without testing urine
- MSU results confirming absence of UTI in presence of haematuria not followed up
- Recurrent UTI not referred
- Anaemia referred on GI pathway as urine not dipped
- Non-visible haematuria with anaemia, repeat testing awaited
- Overlay of GI or prostate issues presumed cause of symptoms

Non-Visible Haematuria Consensus Statement

Who and how to refer when USC criteria for non-visible haematuria are not met

- There was consensus amongst Wessex clinicians that patients aged over 45 years with non-visible haematuria AND one or more of the following risk factors should be **referred to Urology via Advice and Guidance** to be considered by secondary care for a flexible cystoscopy and upper tract imaging:
  - Lynch syndrome
  - Occupational exposure
  - Previous pelvic radiotherapy
  - Previous bladder cancer
  - Current or ex smoker
  - Sudden onset of urinary urgency
  - Clinician discretion on any other risks that may be relevant.

Recurrent UTIs: when to refer

- ≥ 45 years with visible haematuria that persists or recurs after successful treatment of UTI
- ≥ 60 years with non-visible haematuria and dysuria or raised white cell count after treatment of UTI
- Recurrent upper UTI
- Recurrent lower UTI (2 or more infections in 6 months, or 3 or more infections in 12 months – refer via Advice and guidance)

Risk factors

- **Deprivation:** Incidence rates in England in females are 47% higher in the most deprived quintile compared with the least, and in males are 23% higher in the most deprived quintile compared with the least (2013-2017).
- **Ethnicity:** Incidence rates for bladder cancer are lower in the Asian and Black ethnic groups, compared with the White ethnic group, in England (2013-2017).
- **Smoking History:** risk is up to 4 times that of someone who has never smoked. 45% of bladder cancer cases in the UK are caused by smoking and risk increases with the amount and duration of smoking.
- **Family History:** Bladder cancer is 1.8 times higher in people with an affected first degree relative, though shared smoking habits are thought to explain some of this association.
- **Ionising radiation:** 2% of bladder cancer cases are caused by ionising radiation, for example previous pelvic radiotherapy.
- **Occupational exposure:** There is an association with occupational exposure and bladder cancer and there can be a latency period of 30-40 years from exposure to cancerous change:
    - **Dye and rubber industries:** These are significant sources of exposure to aromatic amines.
    - **Textile and leather industries:** Workers in these sectors may encounter various hazardous chemicals, including aromatic amines.
    - **Metalworking:** Machinists, turners, and drill press operatives have shown high risks due to exposure to metalworking fluids.
    - **Printing:** Workers involved in printing processes may be exposed to chemicals that increase their risk of bladder cancer.
    - **Chemical and petrochemical industries:** Exposure to organic solvents and other chemicals used in these sectors presents a risk.
    - **Construction and transportation:** These occupation may involve exposure to diesel exhaust and other fumes or solvents.

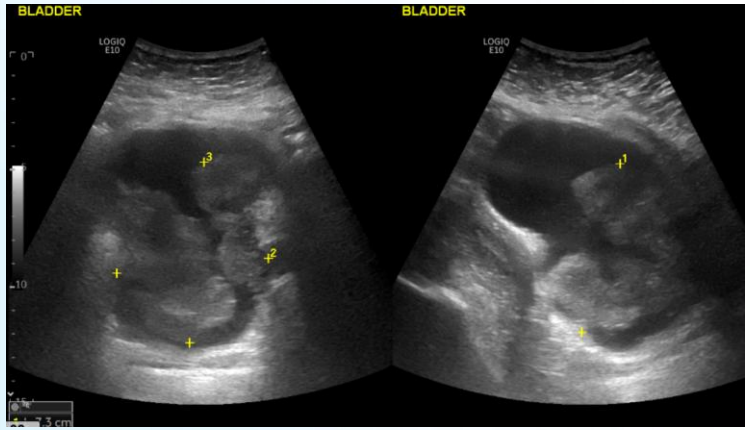
Who not to refer with non-visible haematuria

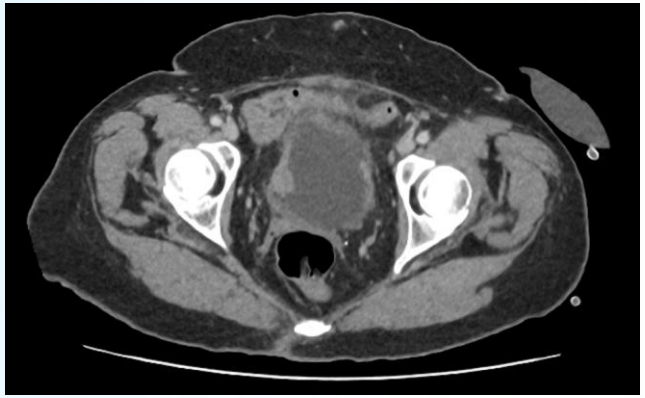
Who not to refer (as no further investigations are required)

- Patients with a WHO performance status of 2 or worse, or a frailty score of 5 or worse.
- Patients who were previously investigated on a bladder pathway for non-visible haematuria with upper tract imaging and cystoscopy, unless there has been a change in symptoms or risk factors (as outlined above).
- Patients who are <45, or 45 and over with no risk factors

Patient 1 Example

- 71 year old female
- Referred by Gynaecology (seen with incontinence) to Urology after ultrasound bladder showed 7 cm bladder mass
- 2 year history of UTIs and visible haematuria
- Multiple courses of antibiotics
- PS 0
- CT confirmed extensive bladder cancer, T3b N2 M1a, bilateral hydronephrosis
- Transurethral resection of bladder tumour – incomplete, Grade 3 high grade pT2, sarcomatoid and squamous cell differentiation
- Radical cystectomy and ileal conduit





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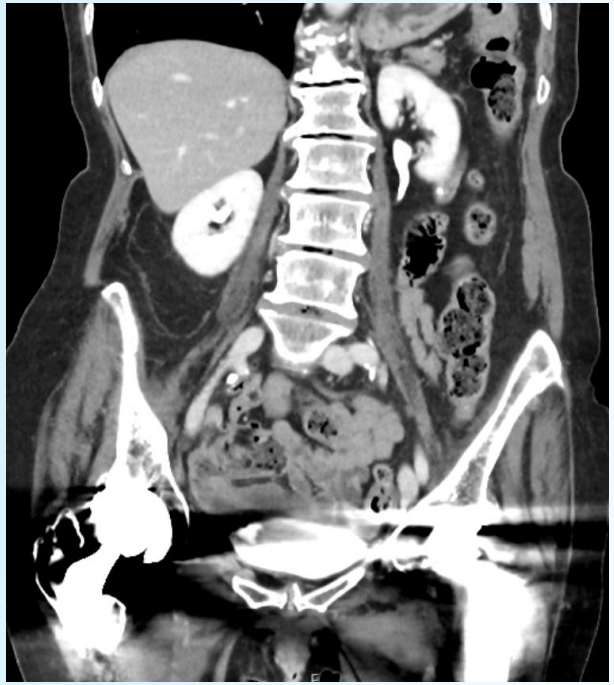
Patient 2 Example

- 81 year old female
- Referred with recurrent UTIs over 1 year, ex-smoker
- Never had visible haematuria
- Flexible cystoscopy showed bladder tumour
- Transurethral resection of bladder tumour – squamous cell muscle-invasive bladder cancer involving diverticulum
- High dose palliative radiotherapy
- Disease progression
- Nephrostomy insertion
- Palliative care



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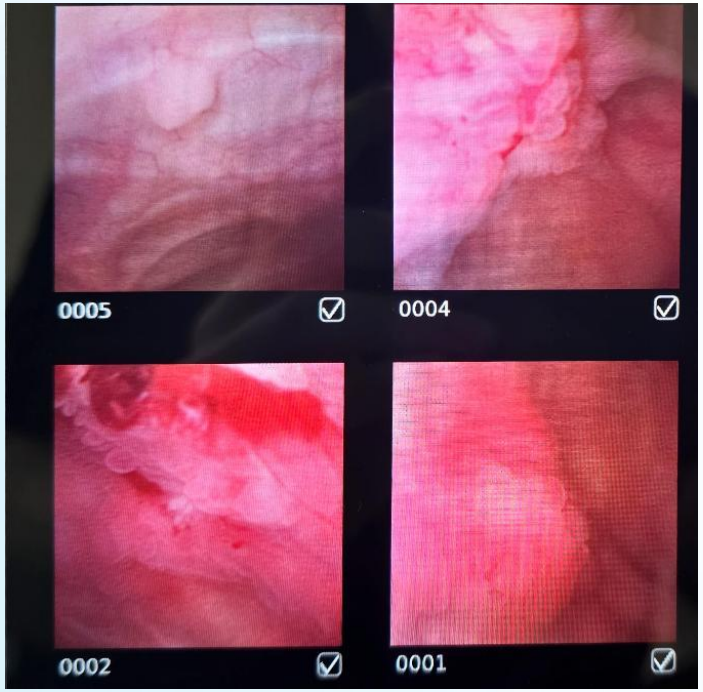
Patient 3 Example

- 83 year old female
- FDS referral with visible haematuria
- Background of recurrent UTIs over 12 months, 7 courses of antibiotics
- Previous CVA, hypertension
  PS 0
- Multifocal tumours at flexible cystoscopy
- Transurethral resection of bladder tumour – muscle invasive urothelial cancer
- Awaiting radical radiotherapy



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Patient 4 Example

- 62 year old female
- Persistent non-visible haematuria and sterile pyuria
- PS 0, non-smoker
- Flexible cystoscopy showed small raised red area in bladder
- Transurethral resection of bladder tumour showed high grade Grade 3 pTa urothelial cancer and carcinoma in situ, left ureteric stent placed
- Elective re-resection showed high grade Grade 3 pT2 invasive cancer
- Radical cystectomy and conduit – nodal involvement, left ureteric margin CIS, adjuvant Cisplatin and Gemcitabine

Q&A

- Any questions?

Thank you

If you have any queries about any content in this presentation, please contact Naomi.Neal@hhft.nhs.uk or Jennifer.Rattray@nhs.net

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