NHS
Wessex
Cancer Alliance

# Bladder & Kidney Cancer Education Webinar

22.9.26












# Introductions

- Ms Naomi Neal – Consultant Urological Surgeon & WCA Urology Pathway Improvement Clinical Lead

- Dr Jenny Rattray – GP at Meon Health Practice, Fareham, and Wessex Cancer Alliance GP Advisor

# Why bladder cancer?



**Bladder cancer incidence** →

10,876 new bladder cancer cases in the UK every year, 2019, 2021-2022, UK.



**Bladder cancer mortality** →

5,900 deaths from bladder cancer, 2022-2024, UK.



**Bladder cancer survival** →

42.3% survive bladder cancer for 10 or more years, 2018, UK.



**Bladder cancer risk** →

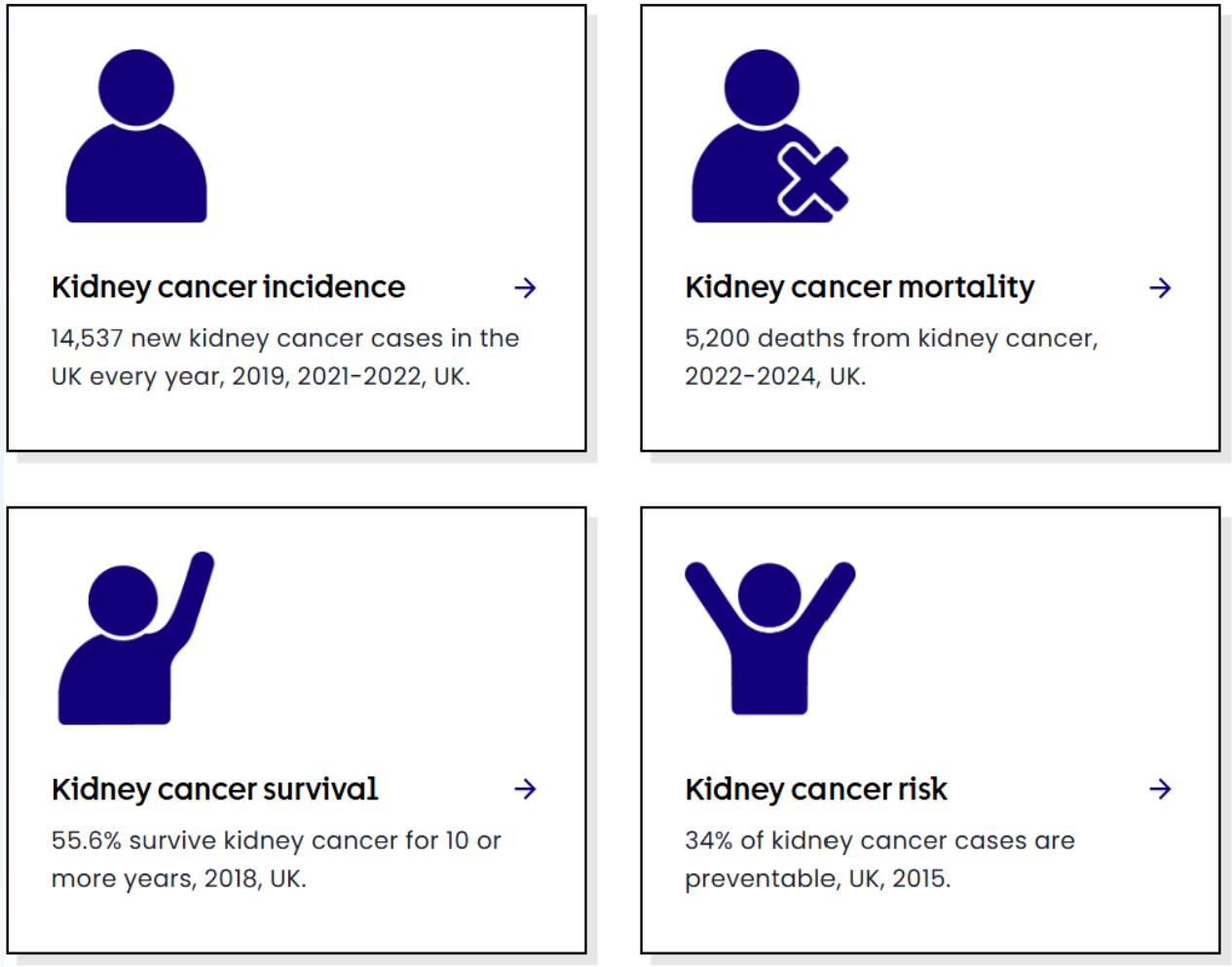
49% of bladder cancer cases are preventable, UK, 2015.

Presenting symptoms often coincide with common urological symptoms such as lower urinary tract symptoms – how do we ensure the right patients are referred in a timely way?

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Bladder cancer statistics | Cancer Research UK Accessed 15.9.26

# Why kidney cancer?




Most people with kidney cancer do not have any symptoms.

When someone does have symptoms, these might include blood in the urine or a mass in the kidney area.

How do we ensure the right patients are referred in a timely way?

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Kidney cancer incidence statistics | Cancer Research UK Accessed 15.9.26

# Red-Flag Symptoms

**What symptoms should raise suspicion of bladder/renal cancer?**

- Visible haematuria
- Non-visible haematuria
- Recurrent UTIs
- Urgency, frequency, unexplained dysuria
- Systemic or late signs – unexplained weight or appetite loss, fatigue, bone pain, lower-back pain
- Palpable abdominal mass

***Any of the above should be considered more suspicious in a person with risk factors for urothelial cancer, particularly smoking, occupational exposure, previous pelvic radiotherapy, family history***

# Dipstick Testing

## Why is dipstick testing important?

- NICE NG12 recommends dipstick testing for anyone with urinary symptoms or suspected infection
- Dipstick testing can detect microscopic (non-visible) haematuria
- Visible or non-visible blood in urine (haematuria) is a red flag symptom, and may meet criteria for a fast-track urgent suspected cancer (USC) and warrant secondary care investigation to rule out or diagnose cancer
- Dipstick testing is better at ruling out UTIs than MSU
- Can help to differentiate between benign causes e.g. UTI, and those needing urgent investigation
- Supports safety netting and follow up for recurrent UTIs

# Safety Netting in Primary Care

**Consider review of local practice for safety netting:**

- When sending MSU ensure symptoms/dipstick findings are on the ICE request – consider adding note with expectations e.g. 'if no infection needs follow up with repeat urine dip for haematuria'
- Booking of ‘pro-active’ follow up slot in clinical system to review patient
- SMS templates to support escalation e.g. haematuria
  - Scheduling of follow up text message to patient allowing response.
- Tracking urgent suspected cancer (USC) referrals e.g. safety netting searches
- C the Signs automatic reminders/alerts for overdue tests and referral tracking
- SystmOne/EMIS Ardens safety-netting toolkit

# 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, U&Es (Amended to 3-month timescale due to scanning with contrast to align with current recommendations and support primary care phlebotomy capacity)
- Clinical frailty score (CFS)

**INVESTIGATION RESULTS (ESSENTIAL)**

| *Please ensure the following recent blood results are available (U&E's must be within 3 months):* | | | | ☐ *Tests Requested* |
|---|---|---|---|---|
| Hb: | Na: | K: | eGFR: | WCC: |

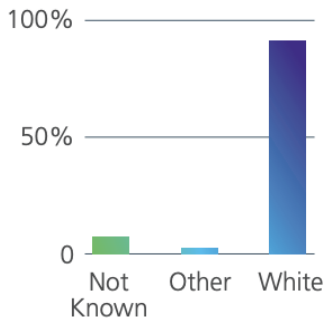
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# Dorset LIS Bladder audit

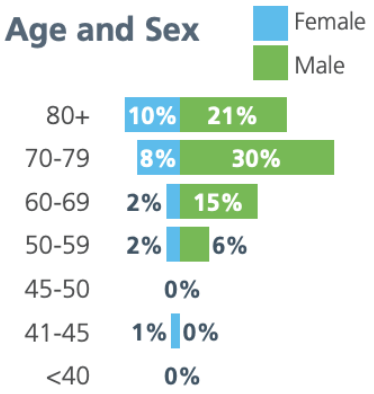
**86**
**Total Patients**

## Demographics

### Ethnicity



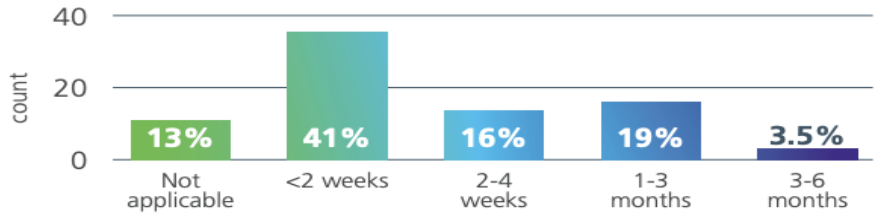

### Age and Sex



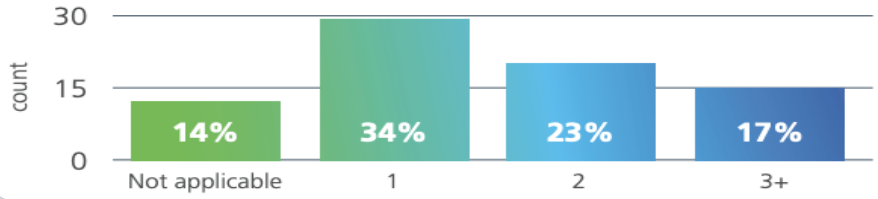

**40%**
referred on urgent suspected cancer pathway did not have frailty status recorded

## Primary Care Interval

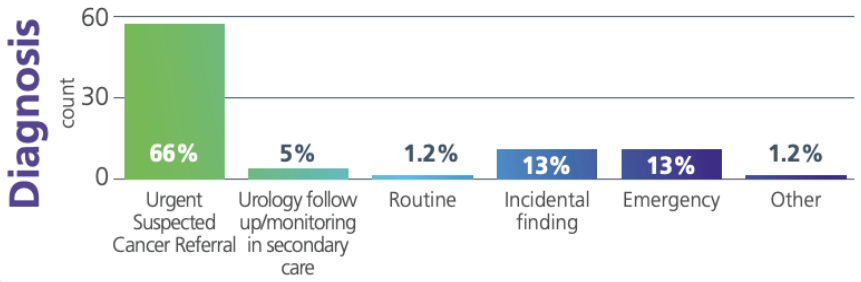
Time from first clinical contact to referral



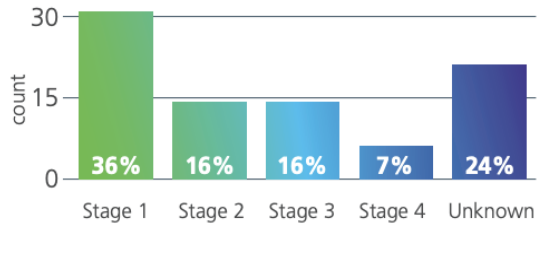

Number of relevant clinical contacts prior to referral




## Route to Diagnosis




## Stage at Diagnosis




## Investigations

(excludes those not seen in primary care before diagnosis)

**Full blood count (FBC)**

- **14%** no FBC
- **25%** anaemia
- **9%** no urine dipstick

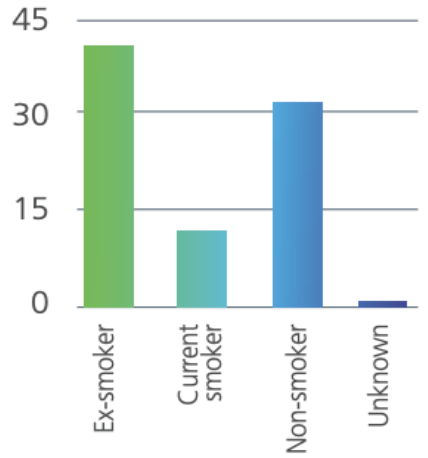
## Symptom Presentation

| % with visible haematuria | % with unexplained UTI | % unexplained weight loss | % with dysuria | % unexplained appetite loss | % non-visible haematuria | % with other symptoms |
|---|---|---|---|---|---|---|
| 72% | 21% | 6% | 27% | 2% | 36% | 20% |

## Risk Factors

- smoker/exsmoker **62%**
- occupational exposure **1%**
- catheterisation **6%**
- prior pelvic radiotherapy **6%**

### Smoking

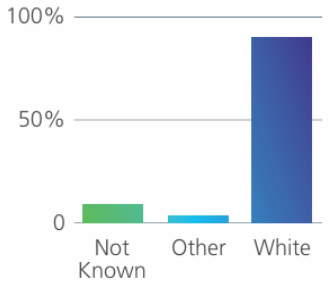


# Dorset LIS Kidney Audit

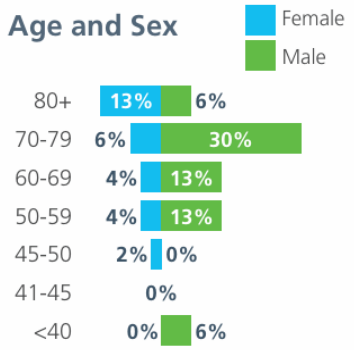
**47**
**Total Patients**

## Demographics

### Ethnicity

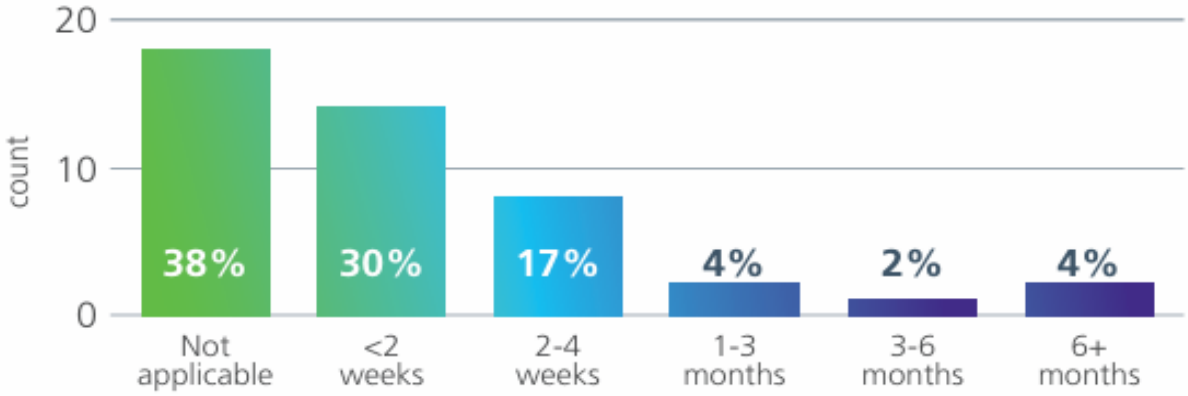



### Age and Sex

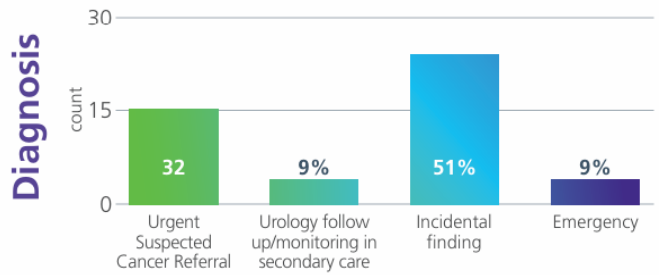



## Primary Care Interval

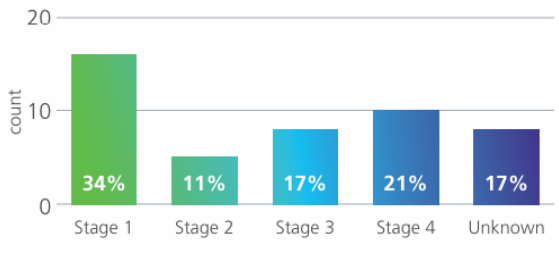
Time from first clinical contact to referral




### Route to Diagnosis




### Stage at Diagnosis




## Investigations

(excludes those not seen in primary care before diagnosis)

**Full blood count (FBC)**
13%
Not completed in primary care

**Urine dipstick**
40%
Not completed in primary care

## Symptom Presentation

| % with flank pain | % with visible haematuria | % with non-visible haematuria | % with no symptoms | % with mass in flank | % with unexplained appetite loss | % unexplained weight loss | % with other symptoms |
|---|---|---|---|---|---|---|---|
| 2% | 26% | 4% | 32% | 2% | 13% | 11% | 34% |

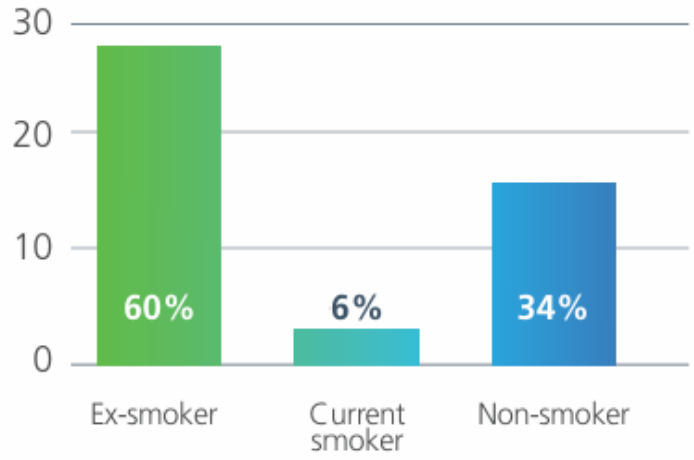
## Risk Factors

% CKD
**30%**

% with family history of kidney cancer
**2%**

% with family history of other cancer
**11%**

### Smoking



# Reasons for diagnostic delay in primary care



### 1. Haematuria management

Visible haematuria not referred at first presentation and non-visible haematuria not referred in context of negative urine culture



### 2. Recurrent UTI

Delays were identified in some cases where referral was not made at an earlier stage



### 3. Anaemia

Urological causes of anaemia were not always considered or investigated as part of the initial assessment



### 4. Symptom overlap

Overlay of prostate, gastrointestinal or gynaecological symptoms contributed to diagnostic delay



### 5. Administrative delay

Capacity for appointment availability in primary and secondary care



### 6. Patient factors

Variation in awareness of significance of haematuria as a symptom of cancer, delays handing in urine sample

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# Non-Visible Haematuria Consensus Statement (HIOW)

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

- Patients ≥ 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.

  - HIOW-consensus-statement-on-investigating-non-visible-haematuria-for-bladder-cancer-v7.0.pdf
  - This guidance is for HIOW only at this time and Dorset clinicians should refer to their local network guidance,

# 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

# Case Discussion 1

- Mrs A, 67 year old woman, well, PMH hypertension and OA.
- Ex-smoker, lives alone, no previous urological history.

- E-consultation – 3 day history of:
  - Dysuria
  - Frequency and urgency
  - Suprapubic discomfort
  - No fever/flank pain
- You are the triaging clinician – what would you do next?

# Case discussion 1

- Urine dipstick positive for leucocytes and blood
- Given antibiotics for presumed UTI and sample sent
- Mrs A symptoms resolve

- MSU confirms RBCs but no growth – filed by duty Dr as 'normal, no action required'

# Case discussion 1 – four months later

- Returns with recurrence of symptoms, and mentions on one occasion she noticed her urine looked "slightly pink".

- Again, treated for UTI and sample sent, this time grows E. coli.
- Her symptoms improve with this.

# Case discussion 1 – 6 months later

- Mrs A represents with visible blood in her urine and has ongoing dysuria.
- Review of notes:
  - 3 episodes of UTI symptoms in 6 months
  - Recurrent haematuria
  - Age 67
  - Previous smoking history
- Urgent suspected cancer fast track referral results in diagnosis of bladder cancer

# Case discussion 1 – learning points

- Recurrent UTI common presentation in GP
- Consider, when you can deal with this on triage, when patient needs a phone call and when they need F2F
- ICE requests and safety netting of patients
- Recurrent/persistent UTI – when do we need to think of urological cancer?

# 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)

# Case discussion 2

- Mr C, 74 year old retired car manufacturing worker, PMH of prostate cancer 11 years ago treated with radical pelvic radiotherapy and hormone therapy
- Worsening urinary symptoms with urgency, frequency, nocturia and weaker stream, been seen a few times and presumed by patient and clinicians to be consequence of previous treatment and age
- Now submits online consultation because over past few weeks he has noticed a few episodes of blood in his urine

- What would you do for this gentleman?

# Case discussion 2 - results

- Seen F2F
- Abdo exam normal, DRE – small firm prostate consistent with previous treatment
- Urine dip – 3+ blood, no nitrites or leucocytes
- Normal UEs, mild normocytic anaemia and stable PSA

- What now?

# Case discussion 2 - outcome

- ≥45 with unexplained visible haematuria – meets criteria for urgent suspected cancer fast track referral resulting in advanced bladder cancer diagnosis

- Several potential diagnostic traps here
  - Previous prostate cancer
  - Presuming LUTS/haematuria are consequences of radiotherapy
  - Recognition of risk factors – occupational history and radiotherapy

# Risk factors

- Deprivation
- Ethnicity
- Smoking History
- Family History
- Ionising radiation
- Occupational exposure
  - Dye and rubber industries
  - Textile and leather industries
  - Metalworking
  - Printing
  - Chemical and petrochemical industries
  - Construction and transportation

# Case discussion 3

- Mrs J, 64 year old woman
- Postmenopausal for 12 years. Ex-smoker with hypertension and BMI 29.
- No Hx of HRT, no previous urological or gynaecological problems

- Presents with 4-5 month history of:
  - Urinary frequency, urgency and occasional dysuria
  - Vaginal dryness and discomfort
  - Discomfort during intercourse
  - A feeling she needs to 'go again' shortly after passing urine
- 2 recent courses of antibiotic for presumed UTI, one from pharmacy first, one from OOO GP – temporary improvement in symptoms

What would you do next? What is your differential diagnosis?

# Case discussion 3

- You see her F2F
- You go through symptoms again and ask specifically about:
  - Vaginal dryness, been getting worse over past year, persistently uncomfortable past couple of months
  - Bloating – trousers feeling tighter
  - Reduced appetite but no weight loss
  - No post menopausal bleeding noted
- Abdo exam – normal, well looking patient, apyrexial
- Pelvic exam – vaginal dryness, pale thin mucosa consistent with oestrogen deficiency
- Urine dip –ve for nitrites and leucocytes but 1+ blood

- What do you think now? What investigations are needed?

# Case discussion 3 - results

- Ca125 normal
- MSU – no infection but RBCs
- Repeat urine sample handed in the following week also showed non-visible haematuria on dipstick testing

- USC fast track referral to urology resulted in bladder cancer diagnosis

# Case discussion 3 – learning points

- Wide differential diagnosis for presenting symptoms
  - Genitourinary syndrome of menopause
  - Ovarian cancer
  - Recurrent UTI
  - Bladder cancer
- Variation of management of UTI by different clinicians
- Diagnostic overshadowing in our middle aged/older women where common benign symptoms associated with menopause can coexist with or distract from significant underlying pathology

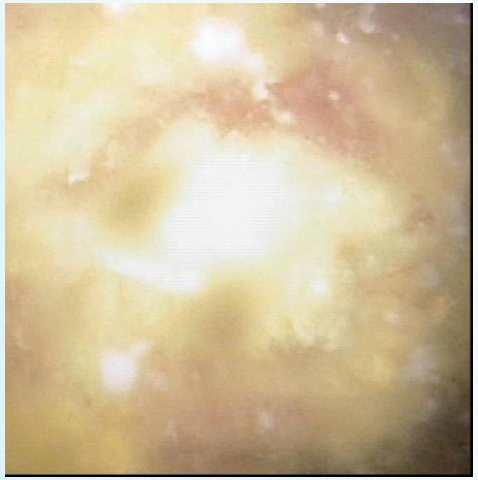
# Secondary Care Pathway

**What happens post-referral to secondary care?**

- Clinical triage
- USS and/or CT scan (CTU or CTKUB)
- Flexible cystoscopy
- MDT
- Cancer ruled out/diagnosis (aim to meet target of 80% within 28-days)
- Outpatient appointment – results
- Decision to treat
- Treatment (aim to meet target of 85% within 62-days):
  - Surgery – TURBT/radical cystectomy
  - Radiotherapy
  - Chemotherapy
  - Immunotherapy

# Case discussion 4

- 80 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





# Case discussion 5

- 64 year old male
- Intermittent visible haematuria with occasional dysuria, attributed to urine infections
- PS 0, non-smoker
- CT urogram showed large left renal cancer involving renal vein
- Normal bladder
- Radical nephrectomy



# Actions to Consider

**Local considerations at a Practice/PCN level:**

- Symptom and awareness through local clinical governance
- Audit use of dipstick testing
- Sharing of investigating non-visible haematuria guidance with colleagues (HIOW) and highlighting risk factors
- Ensuring referral forms are complete to prevent patient pathway delays
- Review safety netting processes and local tracking of fast-track USC referrals e.g. electronic safety netting tools, consistent with Network Contract DES

# 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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