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Exploring High-Risk Non-muscle Invasive Bladder Cancer (NMIBC)

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Dr. Gary Steinberg:

Hello, I am Dr Gary Steinberg, Professor, Department of Urology, at NYU Grossman School of Medicine, Director, Urology Bladder Cancer Program. I am pleased to share with you today background information on high-risk non-muscle invasive bladder cancer, or NMIBC.

High-risk NMIBC is a type of bladder cancer. Nationally, bladder cancer is estimated to be the sixth most prevalent cancer in the United States in 2021.

Bladder cancer is a disease of advanced age, with median age at diagnosis being 73 years, and is about 4 times more likely to occur in men than in women. Additional risk factors include being White, a history of smoking, having a personal or family history of bladder cancer, pelvic radiation, certain environmental exposures, exposure to certain drugs, chronic infection or irritation of the urinary tract, and certain medical conditions, including obesity and diabetes.

For patients presenting with bladder cancer, the most common symptom is microscopic or gross hematuria, followed by a change in urinary frequency due to irritation or reduced bladder capacity.

In the United States, an estimated 83,730 people were diagnosed with bladder cancer in 2021.

Nationally, approximately 75% of newly detected cases are non-muscle invasive disease and 5% to 10% have carcinoma in situ at diagnosis. These rates may vary between regions and in your specific practice.

Bladder cancers are staged by the depth of penetration into the layers of the bladder wall. Non-muscle invasive lesions include flat Tis lesions (also called CIS or carcinoma in situ), as well as Ta and T1 lesions.

The TNM staging system by the AJCC refers to flat lesions on the mucosa as Tis. They are also referred to as CIS.

Broadly, the lesions that encompass NMIBC can be described as flat or papillary lesions. CIS is described as a high-grade flat lesion confined to the mucosa. CIS can appear isolated as a single lesion or as a multifocal lesion. Ta and T1 lesions are described as papillary in nature and can occur on their own or concomitantly with CIS lesions.

Central to prognosis is stratification of NMIBC lesions by the risk of recurrence and/or progression. The American Urological Association (AUA) recommends that at each occurrence or recurrence, a clinician should assign a clinical stage and stratify the patient. Risk stratification is determined by assessing the following: Recurrence rate, number of tumors present, size of the tumor, the T-stage, high or low grade, presence of CIS lesions, and the outcome of any prior instillations of BCG.

These factors lead to the designation of a patient as low, intermediate, or high risk. Of note for our discussion is that any CIS lesion and any BCG failure in a high-grade patient categorizes the risk of recurrence and progression as high according to the AUA. CIS is the only NMIBC lesion that requires no other associated risk factors for progression or recurrence to be classified high risk.

Approximately 5% to 10% of patients with NMIBC have CIS at diagnosis. CIS lesions present a unique treatment challenge because they can be difficult to visualize and diagnose with white light cystoscopy. Variable morphology, ranging from normal-looking mucosa to erythematous areas, can be hard to distinguish from inflammatory lesions. There are new optical technologies that significantly increase the detection rate of CIS, but their use has not been standardized in daily clinical practices.

In addition to being difficult to detect and diagnose with white light cystoscopy, CIS lesions confer a high risk of recurrence and progression and may not be cured by resection alone.

Currently, cystectomy remains the standard of care for patients with high-risk NMIBC whose condition has failed to respond to BCG treatment. Certain patients with NMIBC may not be eligible for this procedure because of advanced age and/or comorbidities. In addition, some patients refuse to undergo a radical cystectomy. I hope you have found this background information on high-risk NMIBC helpful to your clinical practice.

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