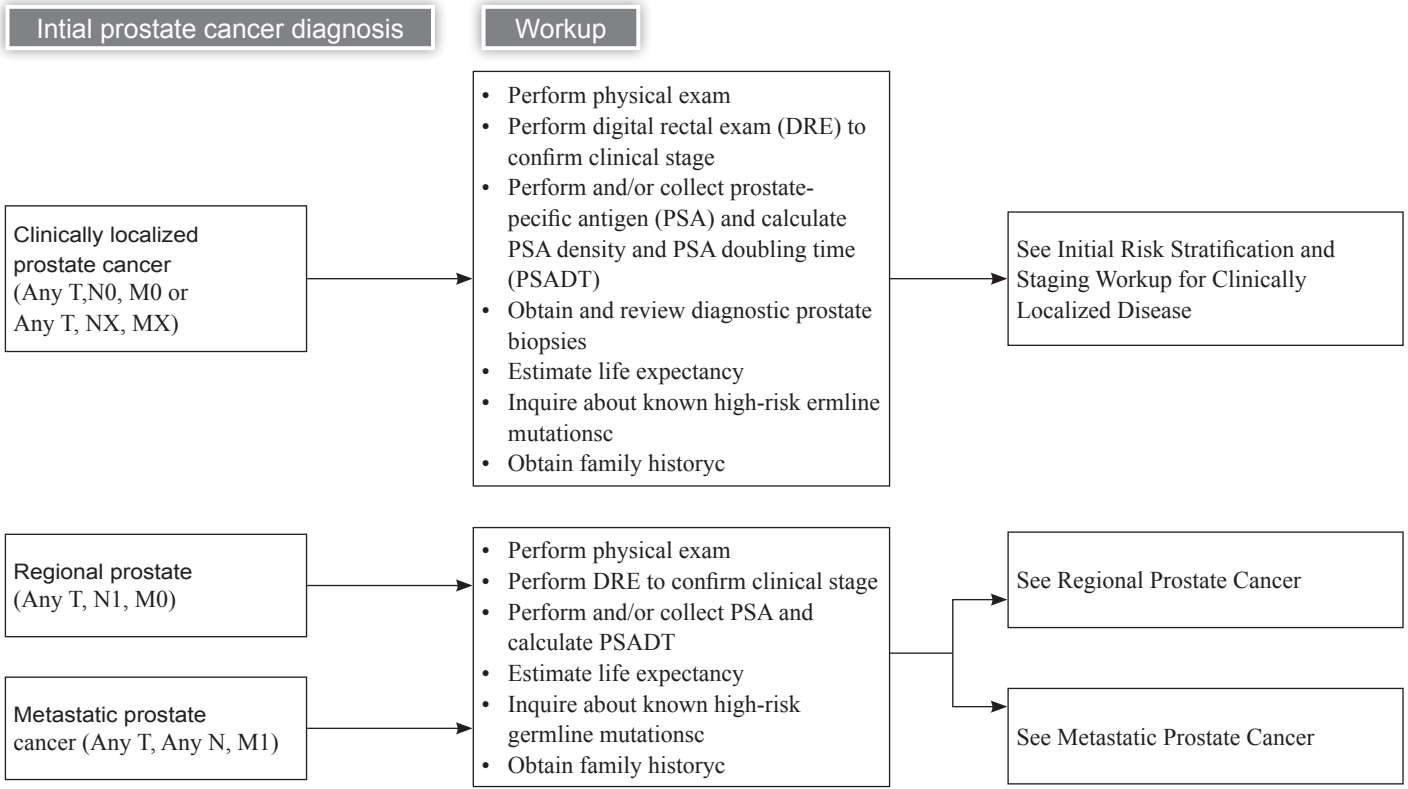
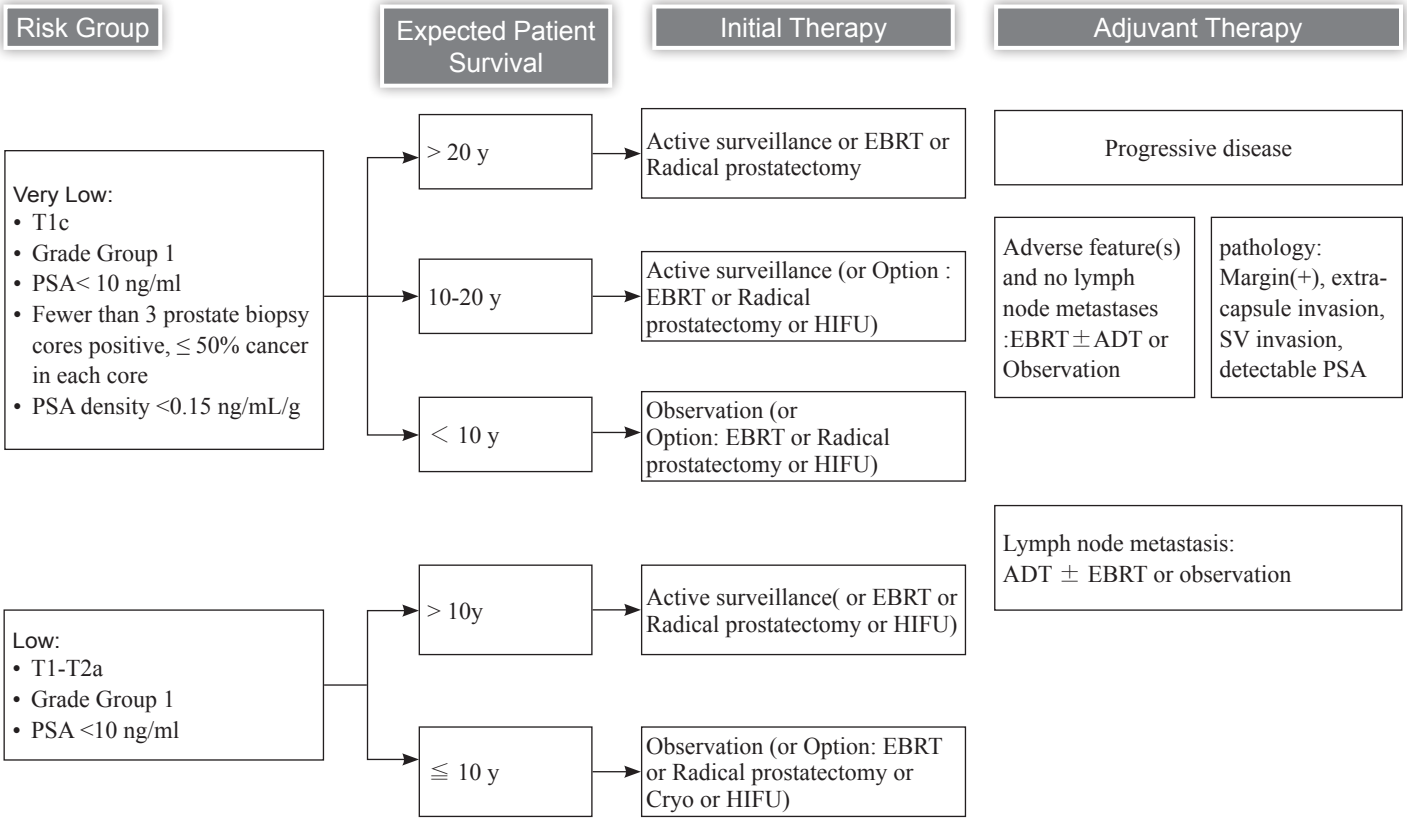
Urinary Tract Tumors


Intial prostate cancer diagnosis
Workup
Clinically localized prostate cancer (Any T,N0, M0 or Any T, NX, MX)
• Perform physical exam
• Perform digital rectal exam (DRE) to confirm clinical stage
• Perform and/or collect prostate-pecific antigen (PSA) and calculate PSA density and PSA doubling time (PSADT)
• Obtain and review diagnostic prostate biopsies
• Estimate life expectancy
• Inquire about known high-risk ermline mutationsc
• Obtain family historyc
See Initial Risk Stratification and Staging Workup for Clinically Localized Disease
Regional prostate (Any T, N1, M0)
Metastatic prostate cancer (Any T, Any N, M1)
• Perform physical exam
• Perform DRE to confirm clinical stage
• Perform and/or collect PSA and calculate PSADT
• Estimate life expectancy
• Inquire about known high-risk germline mutationsc
• Obtain family historyc
See Regional Prostate Cancer
See Metastatic Prostate Cancer

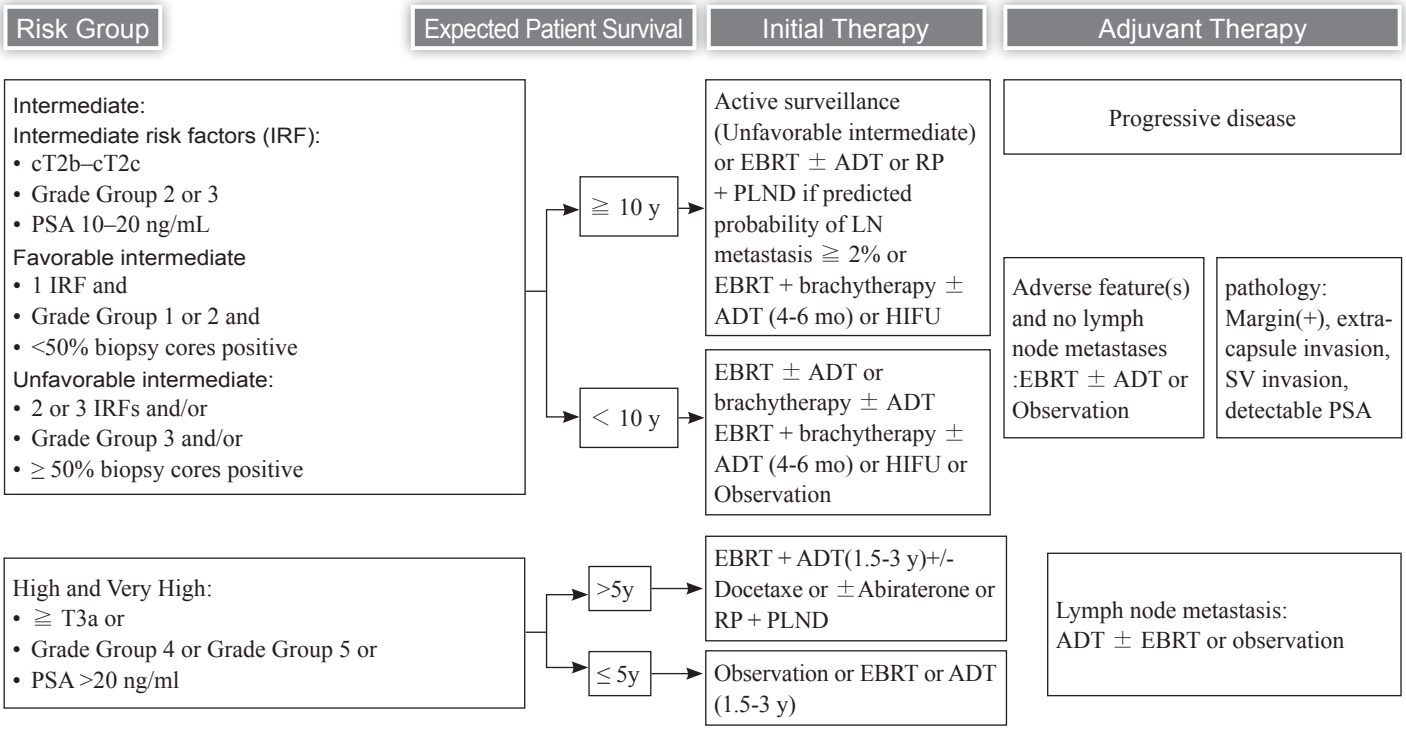
INITIAL RISK STRATIFICATION AND STAGING WORKUP FOR CLINICALLY LOCALIZED DISEASE

Risk Group	Clinical/Pathologic Features			Additional Evaluationg,h	Initial Therapy
Very low	Has all of the following: • cT1c • Grade Group 1 • PSA <10 ng/mL • Fewer than 3 prostate biopsy ffragments/cores positive, ≤ 50% cancer in each fragment/core • PSA density <0.15 ng/mL/g			• Consider confirmatory prostate biopsy ± mpMRI if not performed prior to biopsy to establish candidacy for active surveillance	See PROS-3
Lowe	Has all of the following but does not qualify for very low risk: • cT1–cT2a • Grade Group 1 • PSA <10 ng/mL			• Consider confirmatory prostate biopsy ± mpMRI if not performed prior to biopsy to establish candidacy for active surveillance	See PROS-4
Intermediate	Has all of the following: •No high-risk group features •No very-high-risk group features •Has one or more factors (IRFs): ◗ cT2b–cT2c ◗ Grade Group 2 or 3 ◗ PSA 10–20 ng/mL	Favorable intermediate	Has all of the following: • 1 IRF • Grade Group 1 or 2 • <50% biopsy cores positive (eg, <6 of 12 cores)	• Consider confirmatory prostate biopsy ± mpMRI if not performed prior to biopsy for those considering active surveillance	See PROS-5
		Unfavorable intermediate	Has one or more of the following: • 2 or 3 IRFs • Grade Group 3 • ≥ 50% biopsy cores positive (eg, ≥ 6 of 12 cores)	Bone and soft tissue imaging • If regional or distant metastases are found, see PROS-8 or PROS-12	See PROS-6
High	Has no very-high-risk features and has exactly one high-risk feature: • cT3a OR • Grade Group 4 or Grade Group 5 OR • PSA >20 ng/mL			Bone and soft tissue imagingi,j • If regional or distant metastases are found, see PROS-8 or PROS-12	See PROS-7
Very high	Has at least one of the following: • cT3b–cT4 • Primary Gleason pattern 5 • 2 or 3 high-risk features • >4 cores with Grade Group 4 or 5			Bone and soft tissue imagingi,j • If regional or distant metastases are found, see PROS-8 or PROS-12	See PROS-7

《 Urology tumor-Prostate cancer treatment consensus-3 》

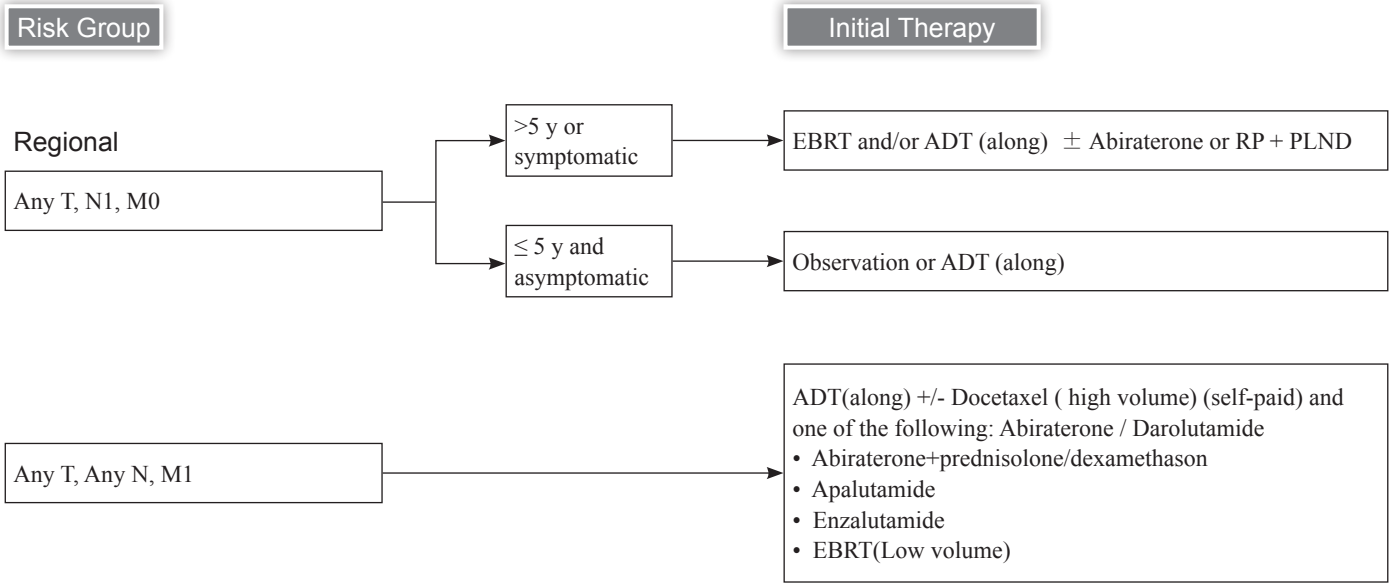


《 Urology tumor-Prostate cancer treatment consensus-4 》



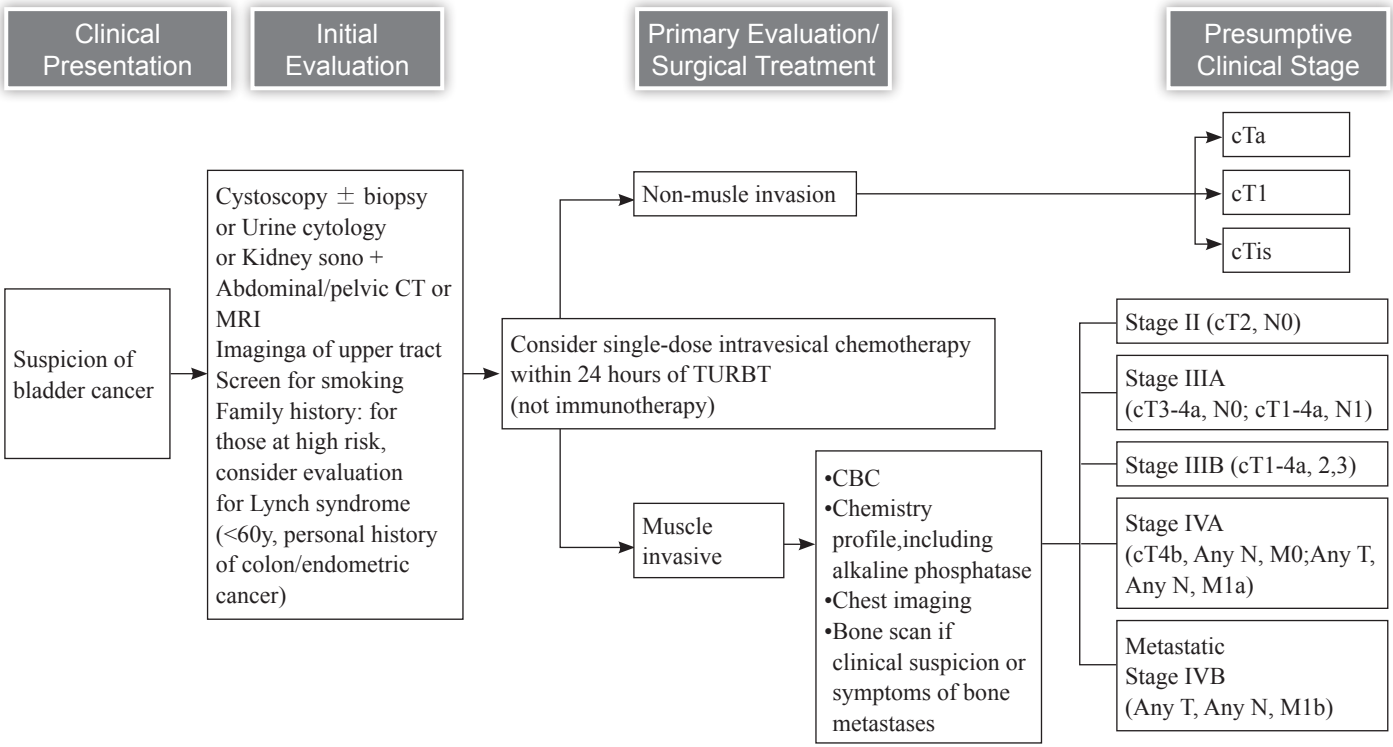
- low risk ≧ 10y, Intermediate ≧ 10y, if predicted probability of LN metastasis ≧ 2% : RP + PLND
- high risk, very high risk : RP + PLND

《 Urology tumor-Prostate cancer treatment consensus -5 》

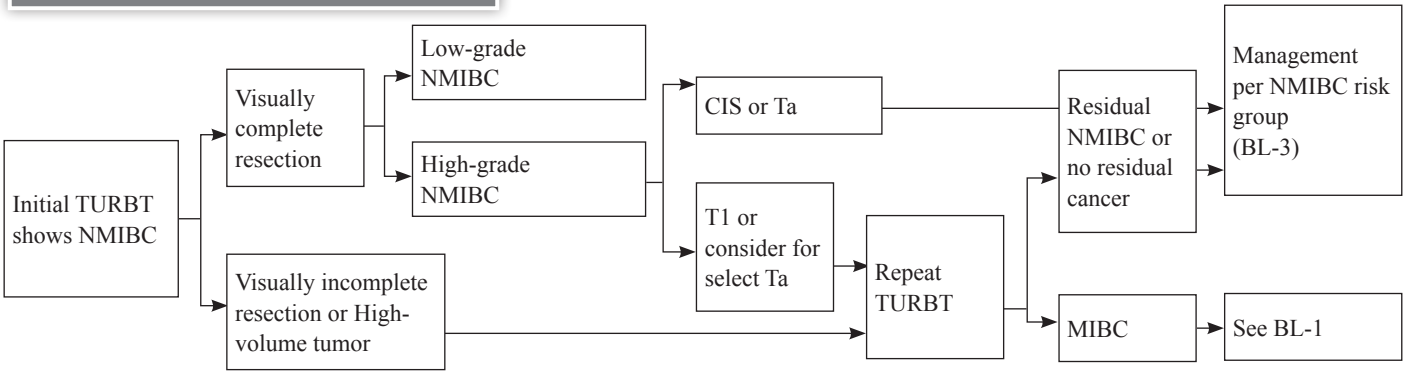


Bone Metastatic treatment: denosumab or zoledronic acid or Radium-223 (mCRPC)
CRPC treatment : abiraterone+prednisolone/dexamethason

《 Urology tumor-Bladder cancer treatment consensus-1 》



RISK STRATIFICATION OF NMIBC

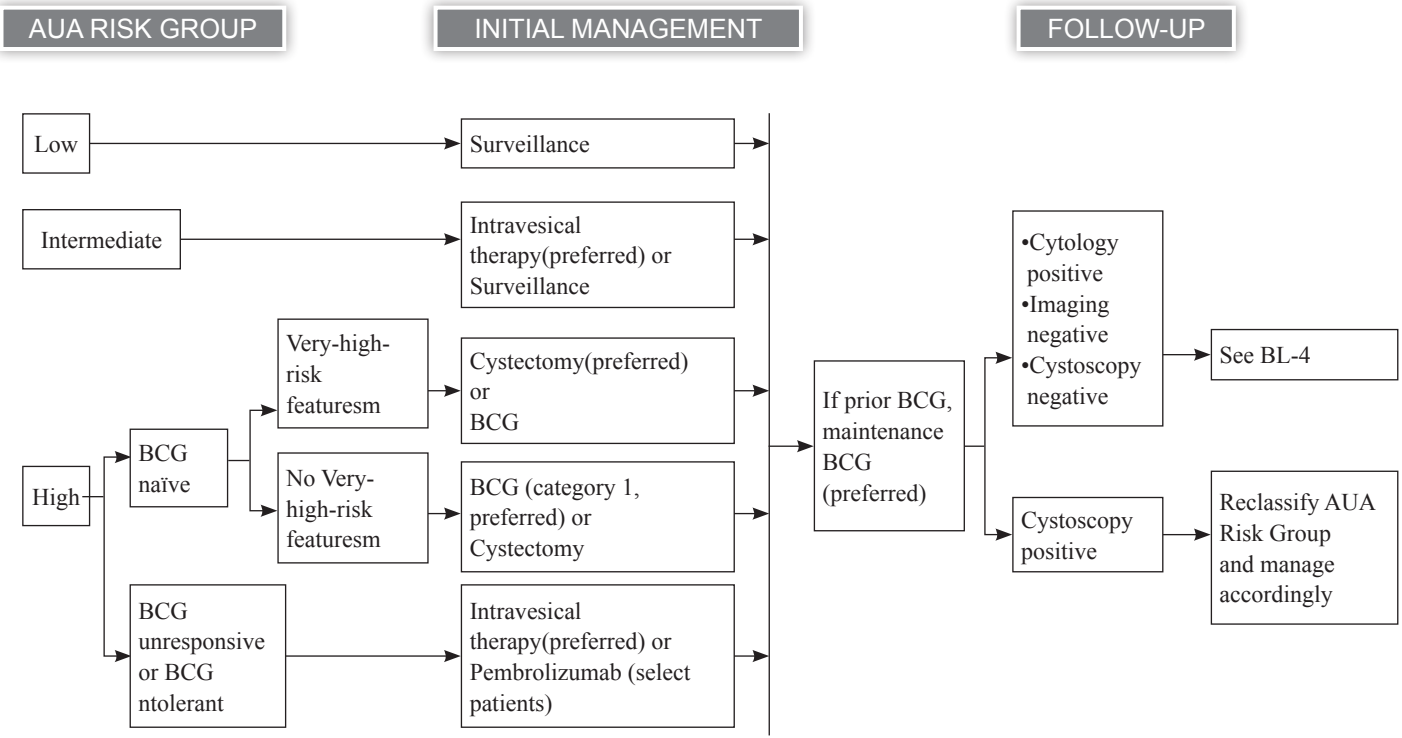


AUA Risk Stratification for Non-Muscle Invasive Bladder Cancer*

Low Risk	Intermediate Risk	High Risk
● Papillary urothelial neoplasm of low malignant potential ● Low grade urothelial Carcinoma ▸ Ta and ▸ ≤ 3 cm and ▸ Solitary	● Low grade urothelial carcinoma ▸ T1 or ▸ >3 cm or ▸ Multifocal or ▸ Recurrence within 1 year ● High grade urothelial carcinoma ▸ Ta and ▸ ≤ 3 cm and ▸ Solitary	● High grade urothelial carcinoma ▸ CIS or ▸ T1 or ▸ >3 cm or ▸ Multifocal ● Very high risk features (any): ▸ BCG unresponsive ▸ Variant histologies ▸ Lymphovascular invasion ▸ Prostatic urethral invasion

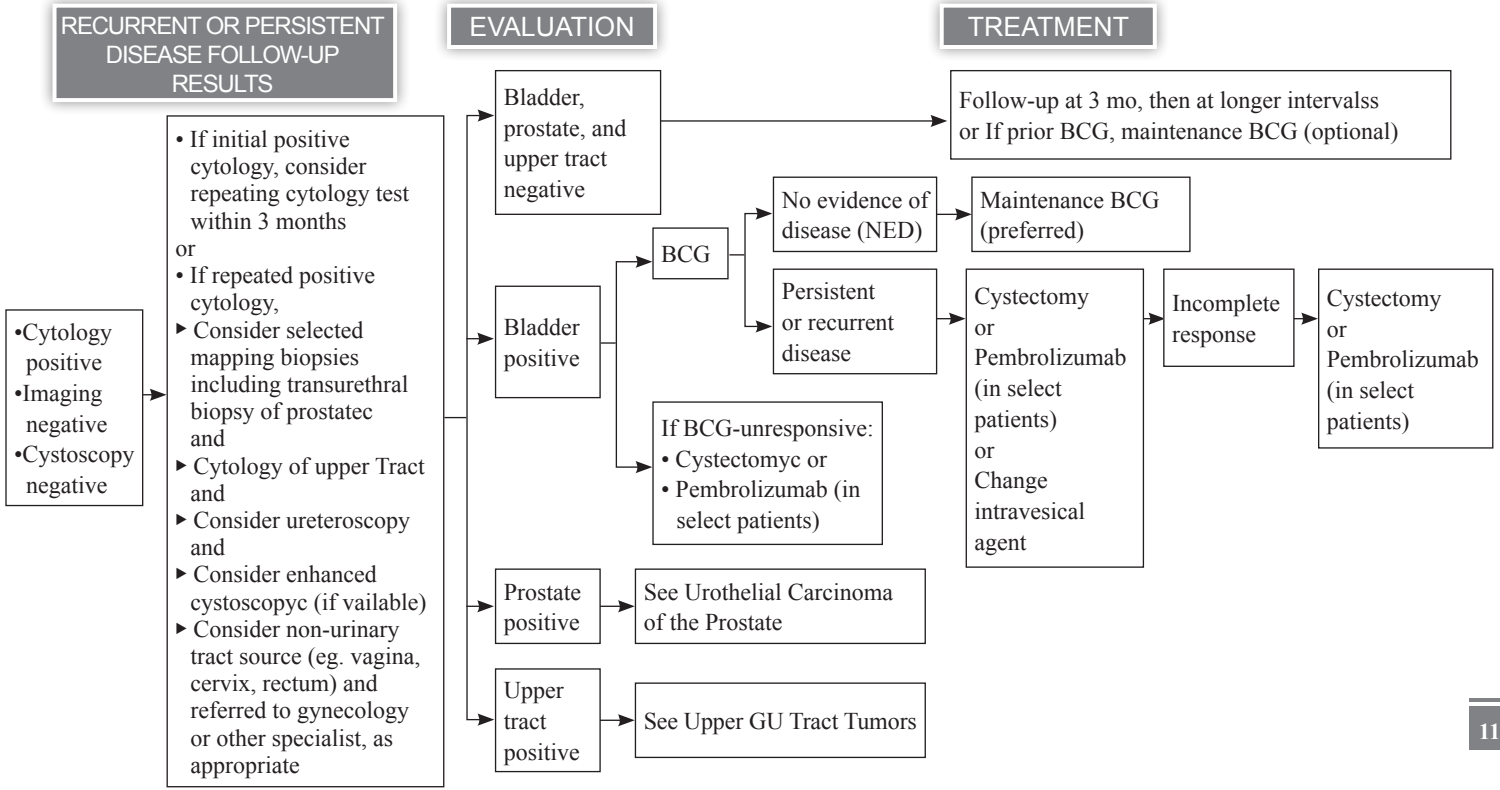
Observ
Intrave

MANAGEMENT PER NMIBC RISK GROUP

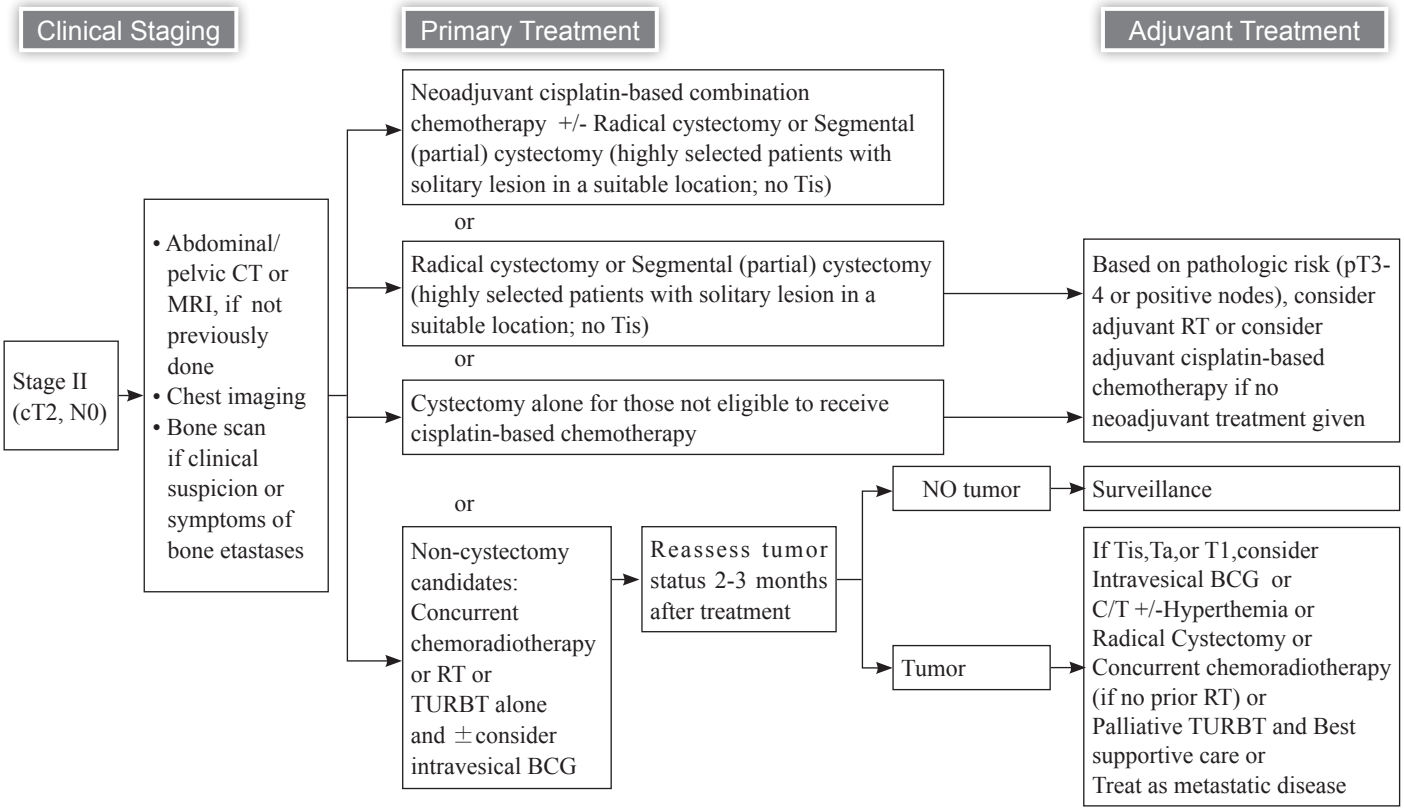


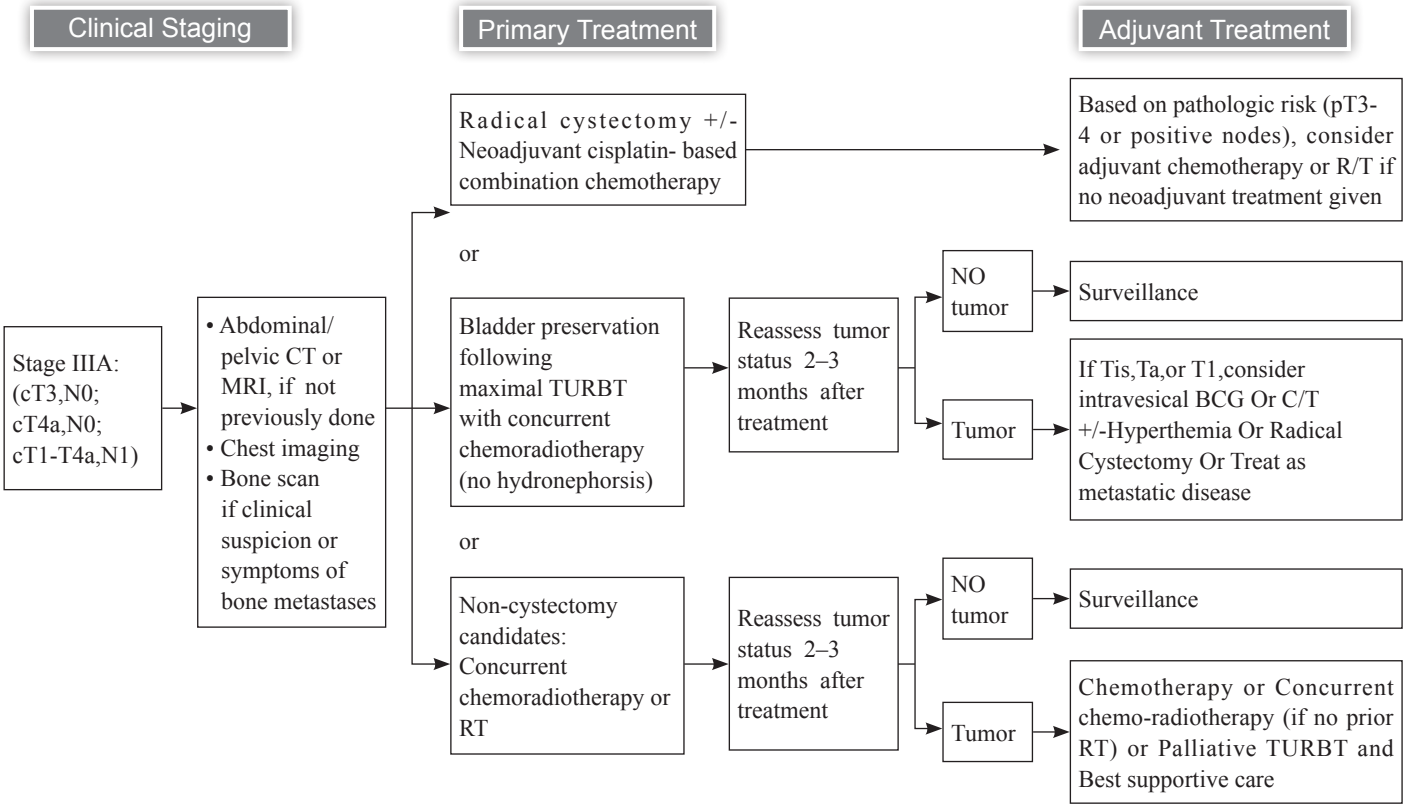
《 Urology tumor-Bladder cancer treatment consensus-4 》

Management of Positive Urine Cytology

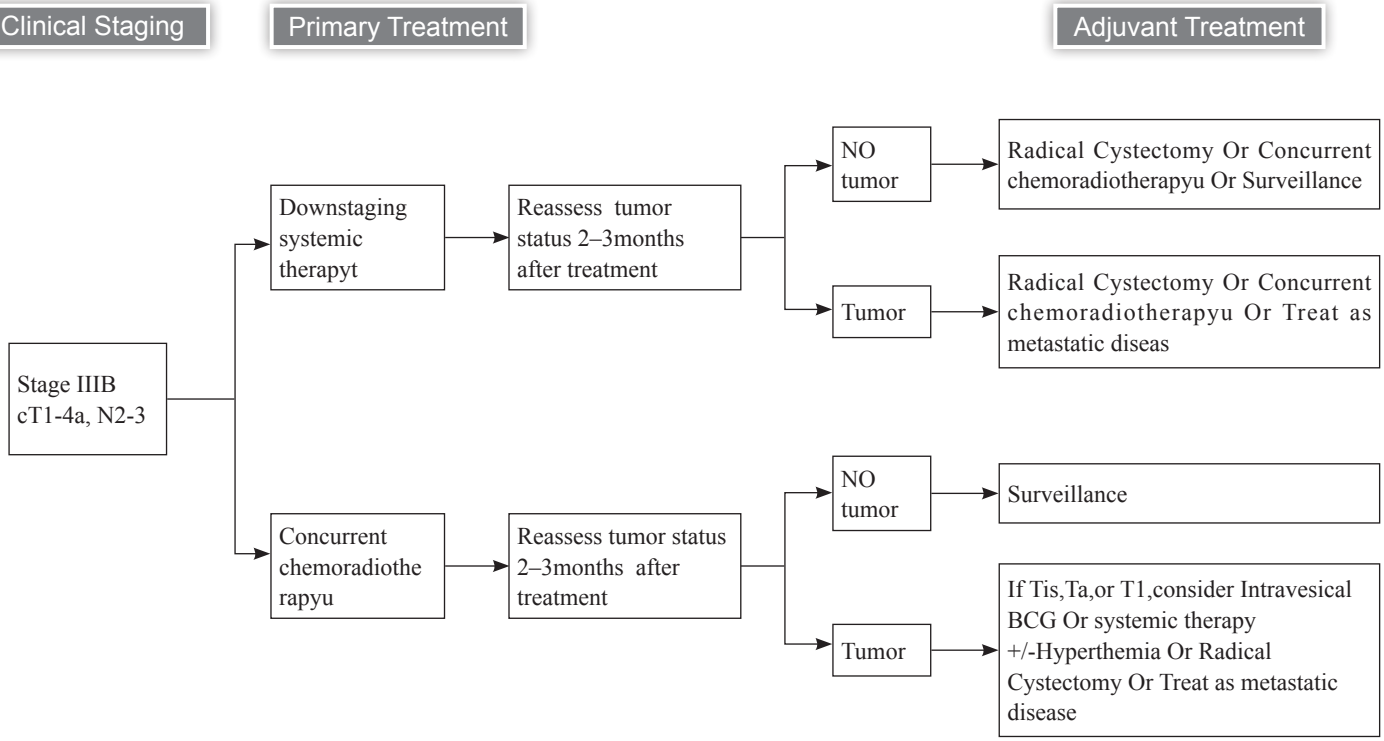


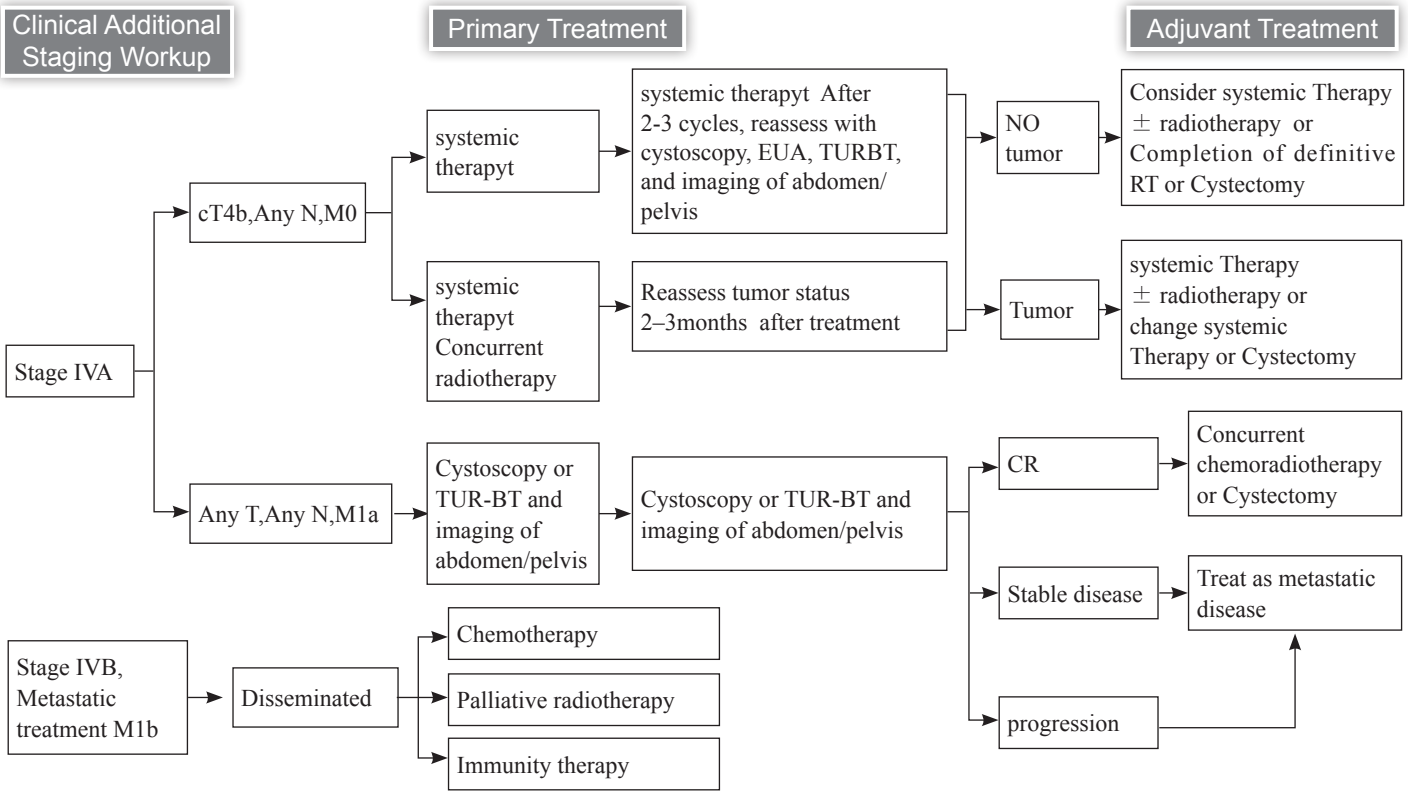
《 Urology tumor-Bladder cancer treatment consensus-5 》




Clinical Staging
Primary Treatment
Adjuvant Treatment
Stage IIIA: (cT3,N0; cT4a,N0; cT1-T4a,N1)
• Abdominal/ pelvic CT or MRI, if not previously done
• Chest imaging
• Bone scan if clinical suspicion or symptoms of bone metastases
Radical cystectomy +/- Neoadjuvant cisplatin- based combination chemotherapy
Based on pathologic risk (pT3-4 or positive nodes), consider adjuvant chemotherapy or R/T if no neoadjuvant treatment given
or
Bladder preservation following maximal TURBT with concurrent chemoradiotherapy (no hydronephorsis)
Reassess tumor status 2–3 months after treatment
NO tumor
Surveillance
Tumor
If Tis,Ta,or T1,consider intravesical BCG Or C/T +/-Hyperthemia Or Radical Cystectomy Or Treat as metastatic disease
or
Non-cystectomy candidates: Concurrent chemoradiotherapy or RT
Reassess tumor status 2–3 months after treatment
NO tumor
Surveillance
Tumor
Chemotherapy or Concurrent chemo-radiotherapy (if no prior RT) or Palliative TURBT and Best supportive care

《 Urology tumor-Bladder cancer treatment consensus-7 》




Clinical Additional Staging Workup
Primary Treatment
Adjuvant Treatment
Stage IVA
cT4b,Any N,M0
systemic therapyt
systemic therapyt After 2-3 cycles, reassess with cystoscopy, EUA, TURBT, and imaging of abdomen/ pelvis
NO tumor
Consider systemic Therapy ± radiotherapy or Completion of definitive RT or Cystectomy
systemic therapyt Concurrent radiotherapy
Reassess tumor status 2–3months after treatment
Tumor
systemic Therapy ± radiotherapy or change systemic Therapy or Cystectomy
Any T,Any N,M1a
Cystoscopy or TUR-BT and imaging of abdomen/pelvis
Cystoscopy or TUR-BT and imaging of abdomen/pelvis
CR
Concurrent chemoradiotherapy or Cystectomy
Stable disease
Treat as metastatic disease
progression
Stage IVB, Metastatic treatment M1b
Disseminated
Chemotherapy
Palliative radiotherapy
Immunity therapy

* The use of proton beam therapy is evolving in the treatment of primary proatate cancer and should be performed within the context of prospective registries or clinical trials.

《 Reference 》

1. N. Mottet (Chair), J. Bellmunt, E. Briers (Patient Representative), R.C.N. van den Bergh (Guidelines Associate), M. Bolla, N.J. van Casteren (Guidelines Associate), et al. Guidelines on prostate cancer. European Association of Urology (2015)
2. STEFAN THÜROFF, M.D., CHRISTIAN CHAUSSY, M.D., GUY VALLANCIEN, M.D., WOLFGANG WIELAND, M.D., HANS J. KIEL, M.D., ALAIN LE DUC, M.D., High-Intensity Focused Ultrasound and Localized Prostate Cancer: Efficacy Results from the European Multicentric Study. JOURNAL OF ENDOUROLOGY (2003);Volume 17, Number 8
3. NCCN clinical practice guidelines in oncology for prostate cancer. Version 1. 2022.
4. NCCN clinical practice guidelines in oncology-Bladder cancer. version 5. 2021.
5. Proton Beam Therapy for Prostate Cancer Position Statement. American Society for Radiation Oncology Web site. https://www.astro.org/ Practice-Management/Reimbursement/Proton-Beam-Therapy.aspx. Published November 15, 2013. Accessed April 9, 2014