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EDITORIAL

Cystoscopic surveillance for bladder cancer: Learning the lessons forced upon us by the Covid-19 pandemic*

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This is a timely editorial comment. Malmstrom highlights what is perhaps the least investigated and therefore least evidence-based aspect of the management of NMIBC -–the issue of follow-up cystoscopy surveillance schedules [1]. He points out that whilst recurrence rates for NMIBC have fallen steadily, the schedules have remained unchanged meaning that the number of negative cystoscopies has doubled. He asks whether low-risk Ta tumours need to be followed up for more than 1 year if they have had a clear flexible cystoscopy at 3 and 12 months. I would agree with these proposals for low-risk patients. This strategy has been carried out by most departments in the UK following a similar recommendation by NICE in 2015 [2]. The results of a National UK questionnaire survey was presented at the 2018 EAU Annual Meeting and showed that 3 years after adopting this strategy in the UK National Health Service, there were no reported adverse outcomes including progression to MIBC [3]. Anecdotally, such a strategy is popular with patients as long as they are told this from the beginning. Indeed, many patients welcome being discharged as there are often benefits such as reduced premiums for travel and life insurance.

The issue of an appropriate follow-up protocol for high-risk NMIBC is more difficult. Most of these patients will receive BCG including maintenance. It has always seemed to me somewhat odd that there is no clear co-ordination between the BCG instillations and flexible cystoscopy follow-ups. The two schedules can often run separately as nurses schedule the BCG and the flexible cystoscopies are booked by urologists. Often the timings become out of sync, especially if there is a delay to carry out flexible cystoscopy. I suspect we could come up with a clearer follow-up regime that logically incorporates the timing of BCG maintenance with a subsequent flexible cystoscopy to ensure an ongoing response (and one could include annual upper tract imaging as well) and that this would still safely result in fewer cystoscopies even in this group.

For the intermediate group, I suspect that the method proposed by IBCN to have two groups is too complex for most departments and I would support the proposal from the author of simply doubling the interval until 5 years. I have done this myself for many years and the patients find it simple and easy to remember. The option to safely incorporate 'active surveillance' of small bladder tumours, which has been shown to be safe [4] could easily be adopted into this schedule and would reduce the number of general anaesthetics and hospital admissions that such patients would be subjected to.

It is worth making two further comments. With the advent of urine-based biomarker testing, we might need to completely rethink our traditional follow-up schedules: first, the traditional 3, 6, 12 months, etc., follow-up schedule may not be the right way for urine biomarkers. Second, it is worth remembering that any process is only as good as the weakest link – increasingly flexible cystoscopy lists has been handed to junior trainees or nurses with minimal or no supervision. It is not surprising, therefore, that patients are often scheduled for repeat cystoscopy for many years when they could have been discharged. Hand-in-hand with this, therefore, is the need to keep the follow-up schedules as simple and easy to remember as possible so that during a busy list, a trainee will recall the correct timing of the next flexible cystoscopy or discharge the patient.

Despite the terrible human and economic cost of the Covid-19 pandemic, a few unexpected positives have emerged in medicine: Video- and telephone-based consultations have proved popular with both patients and doctors and look set to replace the traditional face-to-face consultation. During the pandemic, cystoscopic surveillance for most, if not all, of our bladder cancer patients was suspended with no obvious harm suffered by the vast majority of our patients. We should therefore 'Carpe Diem' – seize the day, and learn from being forced to suspend or delay cystoscopic surveillance to rethink our approach to bladder cancer surveillance. I am sure that our patients (and our teams who

have to carry out these flexible cystoscopies) will thank us for it.

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*Comment on 'cystoscopic surveillance of patients with non-muscle-invasive bladder cancer revisited' by Professor P U Malmstrom

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