Invasive bladder cancer: time is of the essence

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Several studies have investigated the relation between precystectomy delay and survival of patients with muscle-invasive bladder cancer. Most patients have shown a worse outcome when delays exceeded 12 weeks. In the study by Fahmy and colleagues¹ in this issue of *CUAJ*, a delay of 12 weeks or more resulted in a reduction of almost 20% of the 5- and 10-year survival. Obviously, delays that are slightly shorter would also likely be detrimental, and the first conclusion is that the window of opportunity is short for muscle-invasive bladder cancer. This study is particularly informative in dissecting out the various delays occurring from the family physician visit to the radical cystectomy. The first important observation, also found in other studies, is that referring physicians should be reminded of the need to rule out bladder cancer in women with hematuria and in patients with persistent irritative voiding symptoms, which were the most significant causes for initial delays.

The second important message is that rather than improving over time, delays between the first visit to the urologist and the radical cystectomy have increased by more than 1 month on average in the province of Quebec from 1990 to 2002. Urologists older than 59 years tended to have a shorter delay. However, radical cystectomies performed after 1995 were more frequently delayed longer than 12 weeks. This is clearly due to lack of access to radiological resources for staging and operating room availability. At our referral centre, despite a significant increase in uro-oncology cancer load, operating room priorities have not followed.

In very few other cancers is there strong evidence to support that delays in surgery will negatively impact cancer-specific survival. Despite the lack of evidence, organizations representing cancer surgeons for cancers of the ear, nose and throat, and gastrointestinal, gynecological and lung cancers, have recommendations of a maximum delay that rarely exceed 2 weeks for surgery. These recommendations are used to apply political pressure at the hospital level. Our specialty has played the evidence-based game and made recommendations that, for most urological cancers, suggested maximum delays of 1 month or more. It is no surprise then that operating room managers will not consider the urological cancers serious diseases. Strong recommendations, if used strategically, can help put in place care paths that are very efficient. As an example, although the few studies available in lung cancer never demonstrated a difference in outcome with delays in surgery, in Québec City, most lung cancer patients who are referred by

their family physicians for suspicion of cancer will have the diagnosis, complete staging and surgery within 2 weeks in a specialized centre. It is probably time for urologists to consider establishing a similar care path that takes no more than 2 weeks from transurethral resection of the bladder tumour to radical cystectomy.

It is important, however, not to let the government take the lead. The Ontario government, for example, proposed to post on the Internet the wait time for radical cystectomy of all urologists and suggested that patients could be informed of where to go to have it done faster. Patient survival may perhaps be improved by a few percent if the operation is performed only 1 month earlier by a urologist doing very few radical cystectomies a year. The same patient however may suffer a 10 to 20 times higher risk of dying within the first 3 months after surgery if the operation was performed in a nonacademic centre by a surgeon doing less than 6 radical cystectomies per year, as also shown by an analysis performed on the same Quebec database and presented in a previous meeting of the Quebec Urological Association.

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Reference

1. Fahmy N, Kassouf W, Jeyaganth S, et al. An analysis of preoperative delays prior to radical cystectomy for bladder cancer in Quebec. *CUAJ* 2008;2:102-8.

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