SIUrO
Società Italiana di Urologia Oncologica

14.00 - 15.30 **SIMPOSIO AIRO-SIUrO**

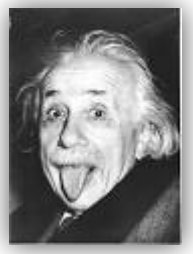
Approccio multidisciplinare nel Carcinoma della Vescica

Moderatori: C. Magno, L. Tomio

Il punto di vista del Chirurgo - **G. Conti**
Il punto di vista del Radio-Oncologo - **M. Orsatti**
Il punto di vista dell'Oncologo - **D. Amoroso**

Il punto di vista dell'urologo

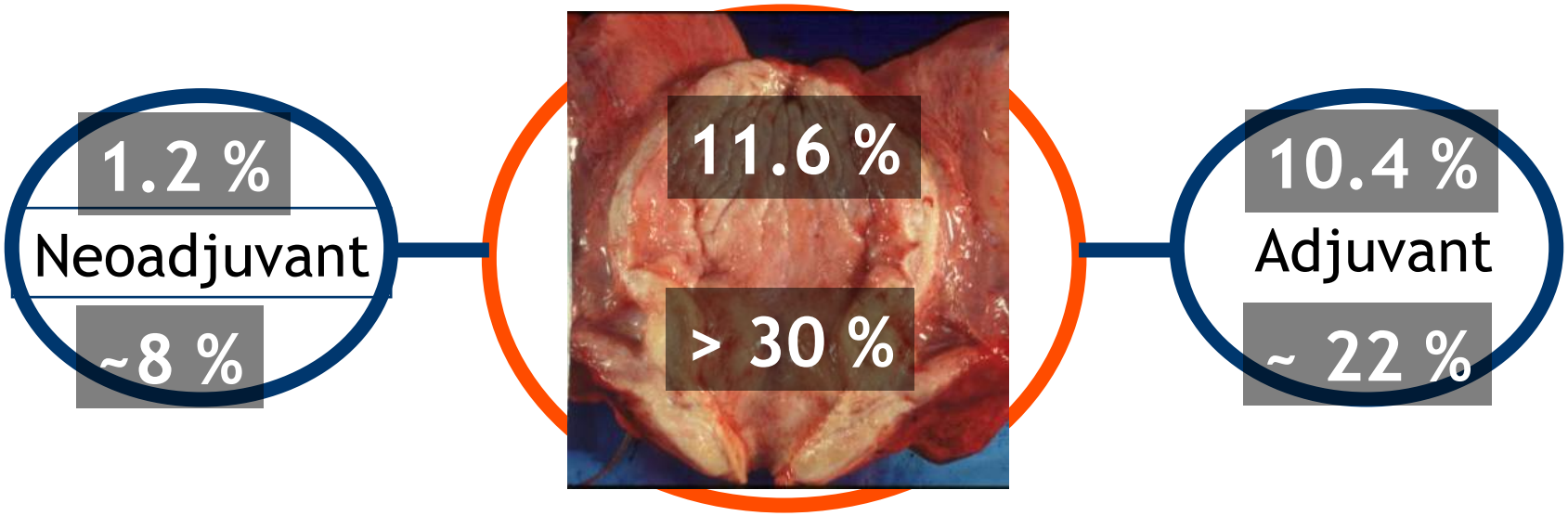
$E = mc^2$



MIBC = Cistectomia immediata

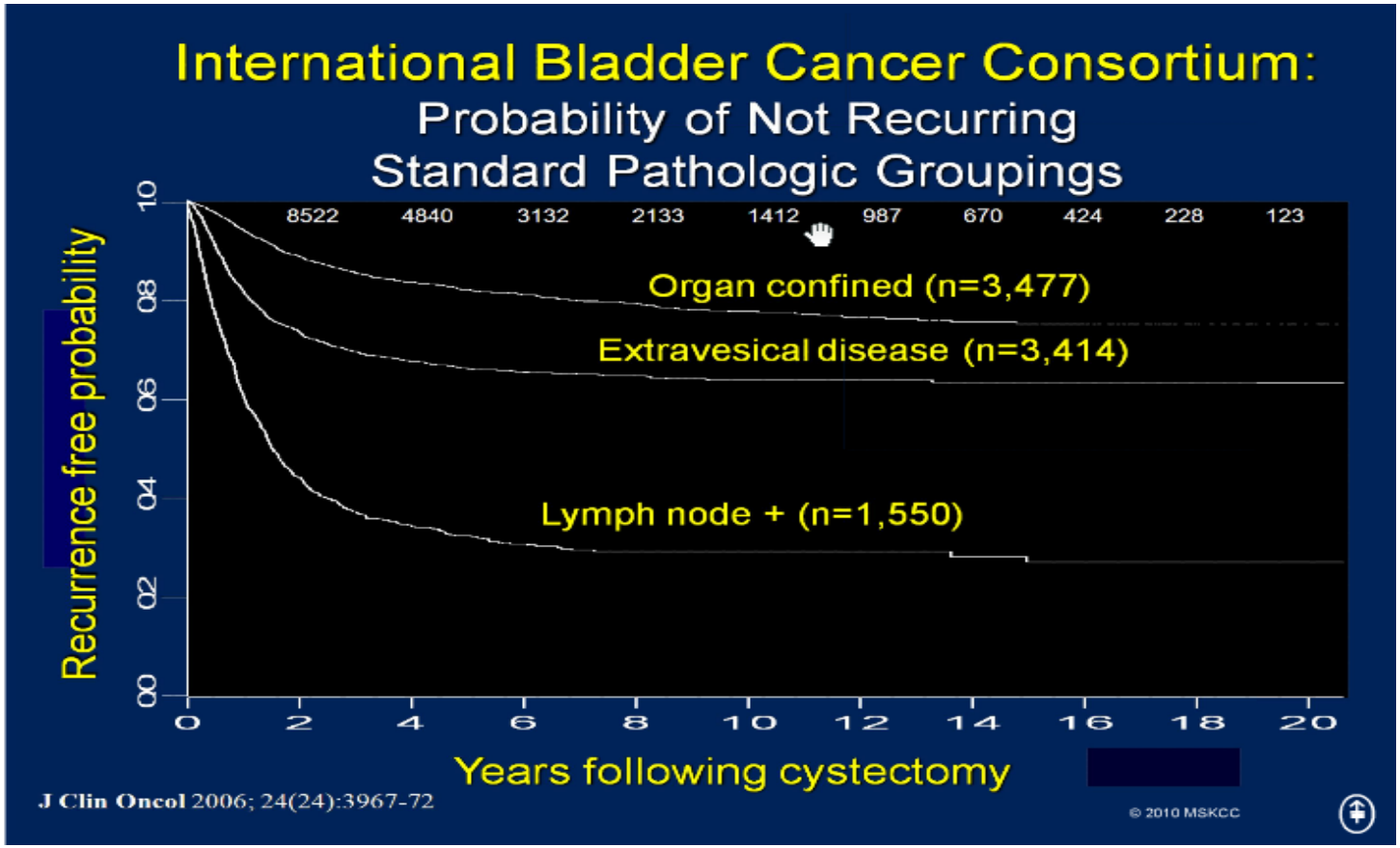
On average, roughly 12% of some 5000 MIBC patients undergoing cystectomy annually in Europe are considered for NCT.

Bladder Cancer:
Perioperative Chemotherapy



Neoadjuvant vs. Adjuvant 2003 - 2007

Courtesy by A. Stenzl-2012



Radical Cystectomy is still the best treatment for MIBC.
Long-term CSS and OS are low after RC single treatment for extravesical disease and N+ pathologic stages

JCO; 2006: 24: 3967-3972

Survival Outcomes Cystectomy Series

Series	Year	Treatment	Stage	n	Survival 5yr	Survival 10yr
Padua	1999	Cystectomy	P2-P4a	258	44%	-
USC	2001	Cystectomy +	P2-P4a	633	48%	32%
MSKCC	2001	Cystectomy +	P2-P4	184	36%	27%

Stein JCO 2001, Dalbagni J Urol 2001, Bassi J Urol 1999

Neo-Adjuvant Chemotherapy
Rationale

- Increasing T stage and extravesicular cancer
- Metastatic disease present at diagnosis

Chemotherapy in 2011

6.1 Conclusions for neoadjuvant chemotherapy

Conclusions	LE
Neoadjuvant cisplatin-containing combination chemotherapy improves overall survival by 5-7% at 5 years, irrespective of the type of definitive treatment used.	1a
Neoadjuvant chemotherapy has its limitations regarding patient selection, current development of surgical technique, and current chemotherapy combinations.	

6.2 Recommendations for neoadjuvant chemotherapy

Recommendations

	GR
Neoadjuvant cisplatin-containing combination chemotherapy should be considered in muscle-invasive bladder cancer, irrespective of further treatment.	A
Neoadjuvant chemotherapy is not recommended in patients with PS ≥ 2 and/or impaired renal function.	B

EAU Guidelines on Bladder Cancer
Muscle-invasive and Metastatic. **2011**

eau

Chemotherapy in 2013

6.4 Conclusions and recommendations for neoadjuvant chemotherapy

Conclusions	LE
Neoadjuvant cisplatin-containing combination chemotherapy improves overall survival.	1a
Neoadjuvant chemotherapy has its limitations regarding patient selection, current development of surgical technique, and current chemotherapy combinations.	
In current routine clinical practice, it is difficult to select patients who will respond to neoadjuvant chemotherapy due to the lack of a widely applicable test. In the future, genetic markers, in a 'personalised medicine' setting, will make it easier to select patients for treatment and to differentiate responders from non-responders.	

Recommendations	GR
Neoadjuvant chemotherapy is recommended for T2-T4a, cN0M0 bladder cancer and should always be cisplatinum-based combination therapy.	A
Neoadjuvant chemotherapy is not recommended in patients with PS ≥ 2 and/or impaired renal function.	B

EAU Guidelines on Bladder Cancer
Muscle-invasive and Metastatic. **2013**

eau

First-line treatment for “fit” patients: Cisplatin-containing combination chemotherapy

Gemcitabin/Cispaltin
CMV
MVAC
HD-MVAC

[Grade of raccomandation A]

EAU Guidelines, European Association of Urology 2013

Open Question

What is the current role of neoadjuvant chemotherapy for bladder cancer?

Is EBM data sufficient in order to recommend this kind of treatment?

Trial	Patients,n	Regimen	Survival benefits	FU Years
BA 06 30894	976	CMV x3	5%	8
SWOG/US intergroup	317	MVAC x3	5%	5
ABC meta-analysis	>3000	Cisplatinum based CT	5%	5

For what clinical stage do you recommend NCT as an elective treatment?

All patients undergoing radical cystectomy, only cT2 or only ≥cT3?

Carcinoma della vescica: chemioterapia neoadiuvante

European Urology

European Urology 45 (2004) 297–303

Neoadjuvant Cisplatinum Based Combination Chemotherapy in Patients with Invasive Bladder Cancer: A Combined Analysis of Two Nordic Studies

Amir Sherif[a,*], Lars Holmberg[b,c], Erkki Rintala[d], Oddvar Mestad[e], Jonas Nilsson[b], Sten Nilsson[f], Per-Uno Malmström[a]

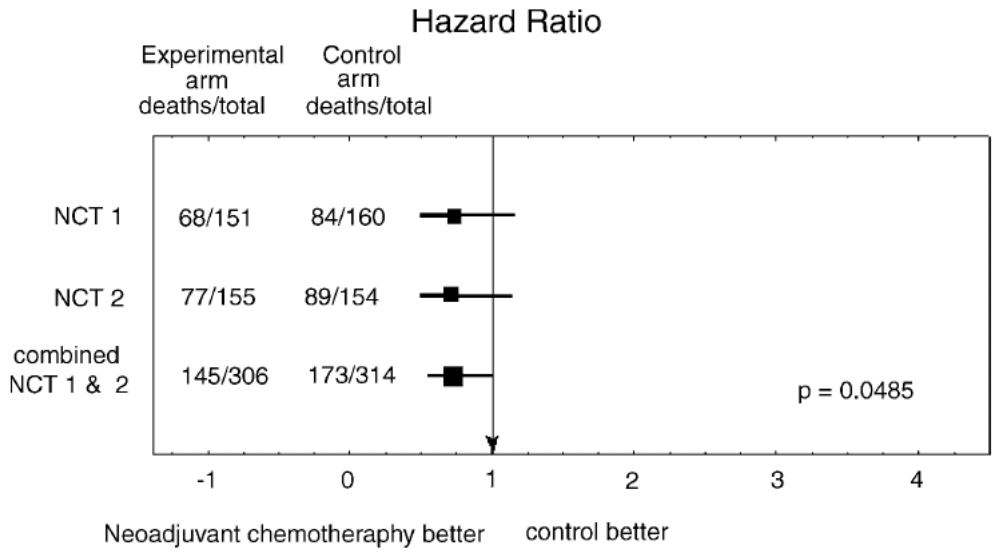
other co-workers in the Nordic Urothelial Cancer Group

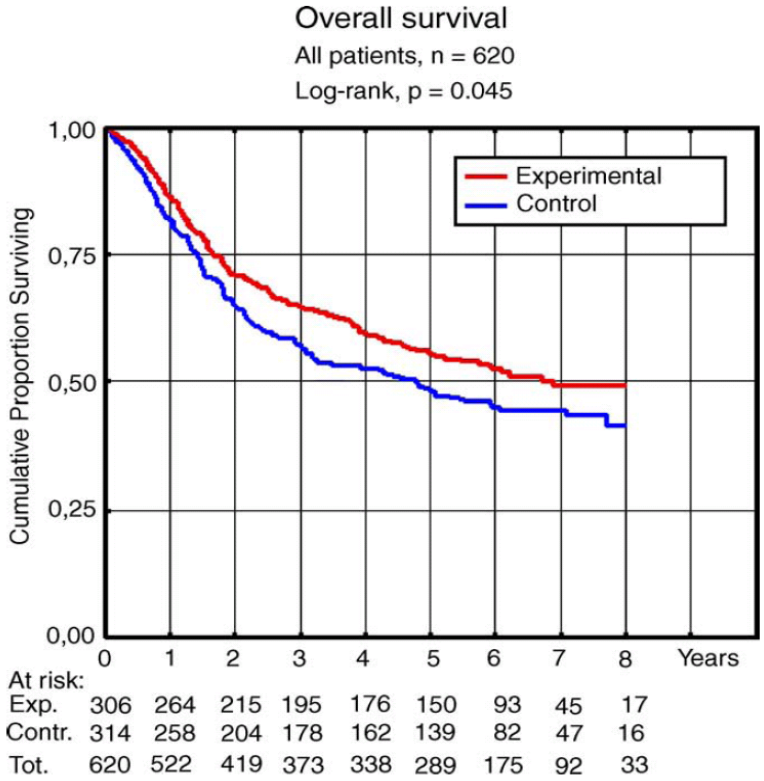
Courtesy Dr. C. Ortega

620 pazienti
T1G3, T2–T4aNXM0
arruolamento: **1985–1997**

CDDP + ADM (Nordic I)
CDDP + MTX (Nordic 2)

- riduzione del rischio di morte del 20% (HR: 0.80)
- sopravvivenza globale a 5 aa del 56% vs 48%
- riduzione del rischio assoluto di morte del 8%.



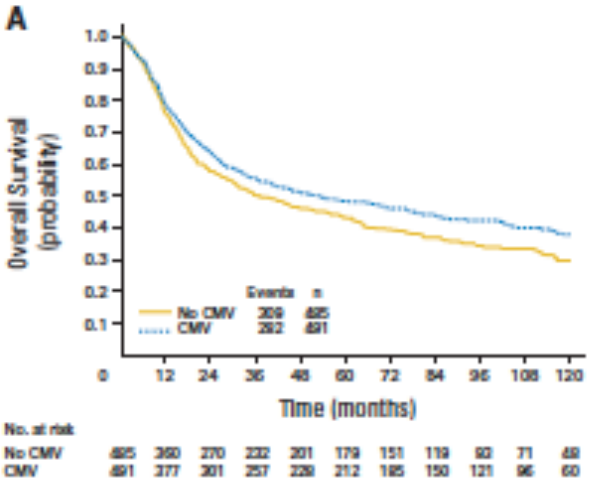


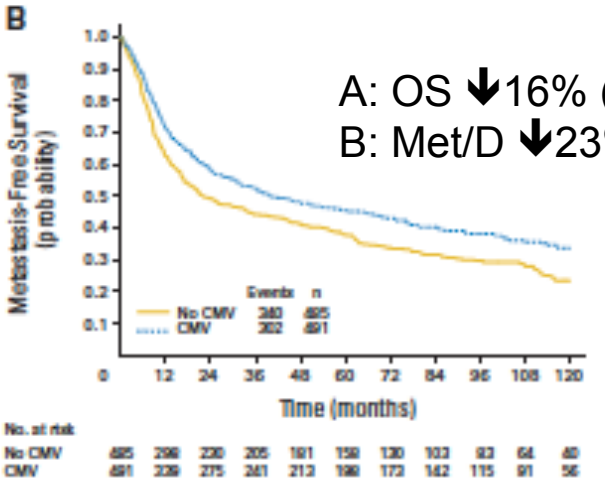
International Phase III Trial Assessing Neoadjuvant Cisplatin, Methotrexate, and Vinblastine Chemotherapy for Muscle-Invasive Bladder Cancer: Long-Term Results of the BA06 30894 Trial

VOLUME 29 · NUMBER 16 · JUNE 1 2011

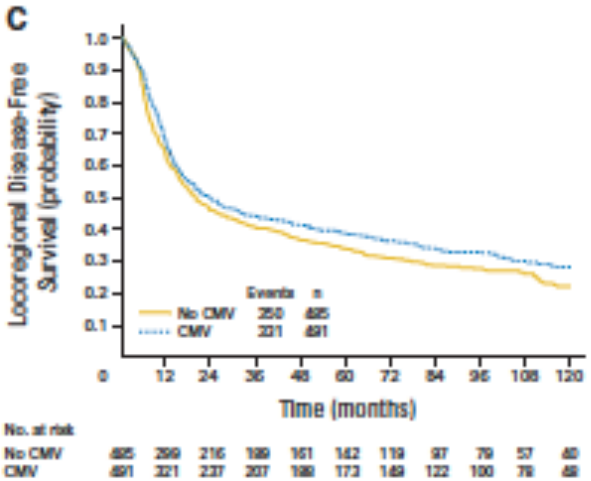
JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

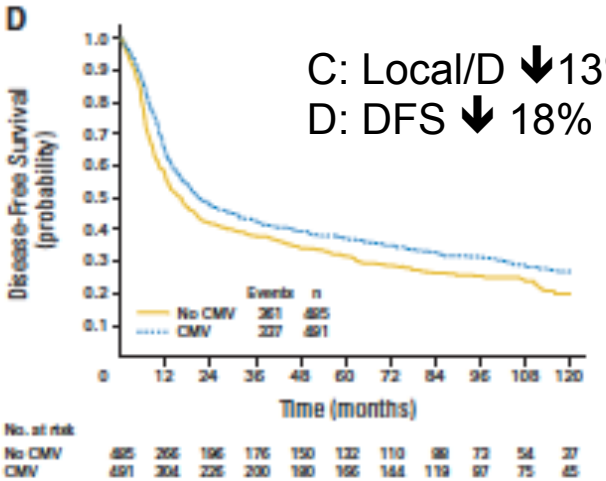
1989-95
976 pts
Data analysis 2005
FU for survivors > 8 yr





A: OS ↓16% (HR 0.84; 0.72-0.99) p 0.037
B: Met/D ↓23% (HR 0.77; 0.66-0.90) p 0.001



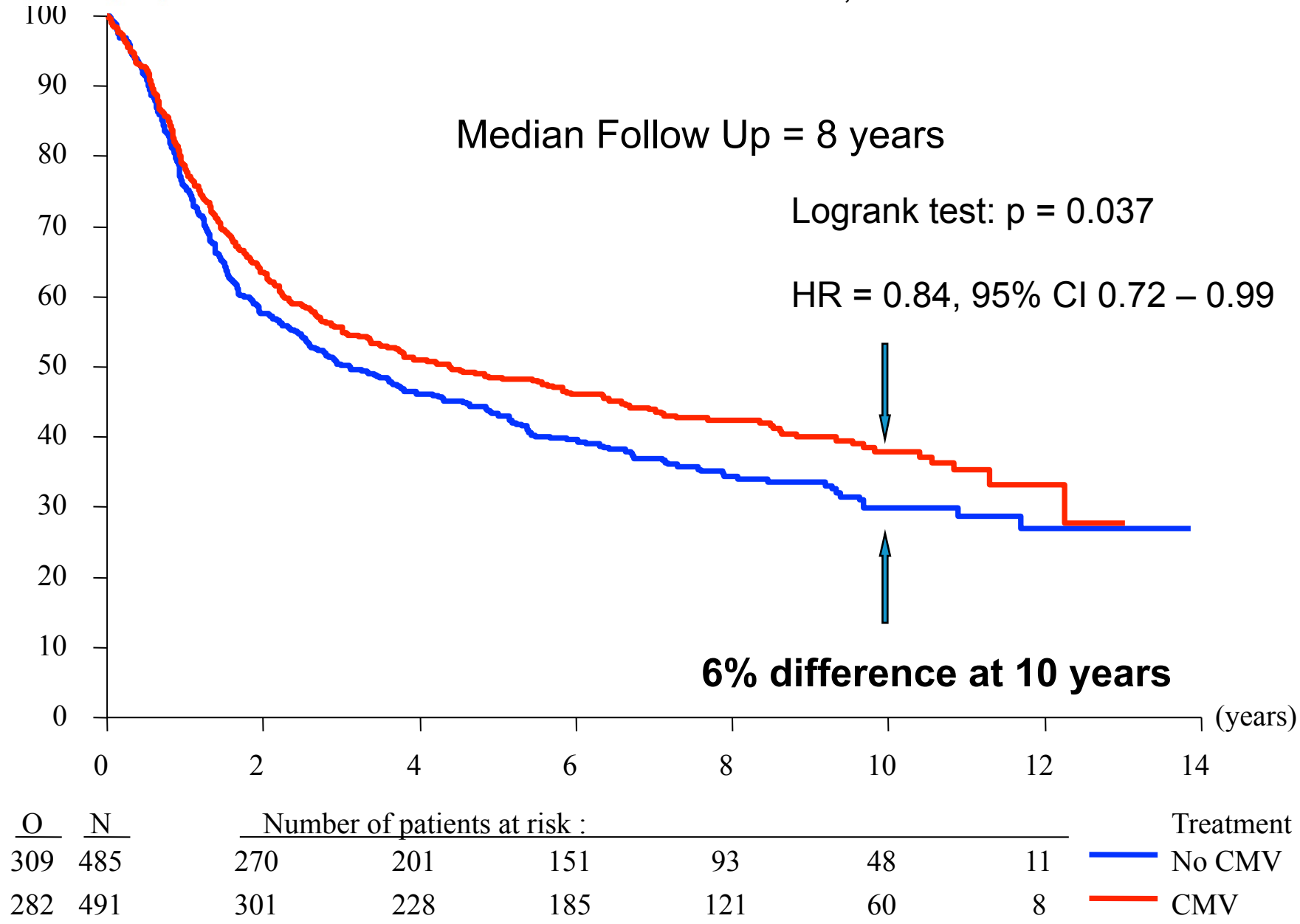


C: Local/D ↓13% (HR 0.87; 0.75-1.01) p 0.067
D: DFS ↓ 18% (HR 0.82; 0.70-0.95) p 0.008

Increase in survival (+ 7 mo.)
at 3 yrs from 50 to 56%
at 10 yrs from 30 to 36%

Duration of Survival

J Clin Oncol 29:2171-2177, 2011



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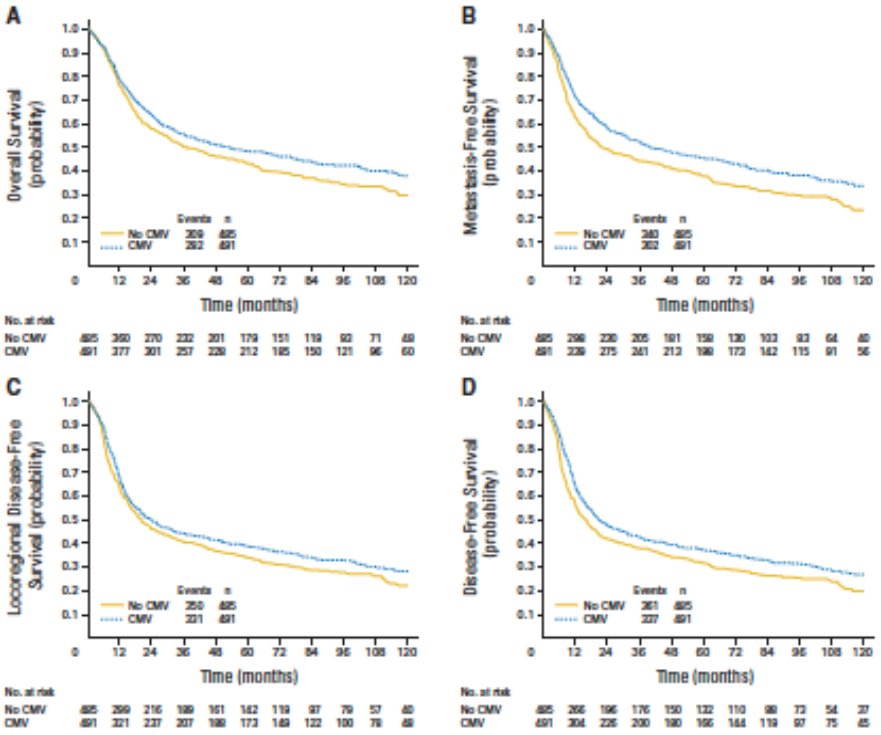
EORTC
European Organisation for Research and Treatment of Cancer
50 years of Progress Against Cancer



- NNT: 17
- No difference comparing RC and RT

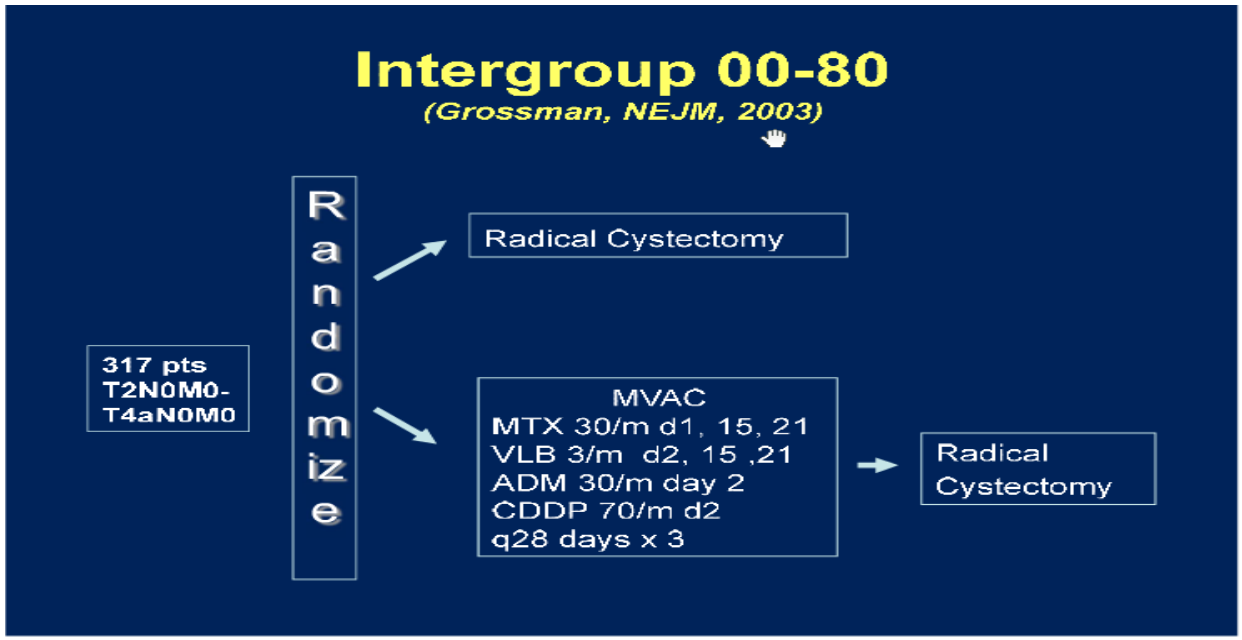
1999 Interim report: NB for MVC arm

2002 Update from ASCO (7.4 year F-U: significant improvement in survival in MVC arm (HR: 0.85; 95% CI 0.72-1.0)

1989-95
976 pts
Data analysis 2005
FU for survivors > 8 yr
Increase in survival (+ 7 mo.)
at 3 yrs from 50 to 56%
at 10 yrs from 30 to 36%

Predefined end point: 10% improvement in survival. Not reached

Neoadjuvant chemotherapy plus cystectomy compared with cystectomy alone for locally advanced bladder cancer. *Grossman HB, NEJM 349: 859-66, 2003*
Aug 28, 2003): 859-66.

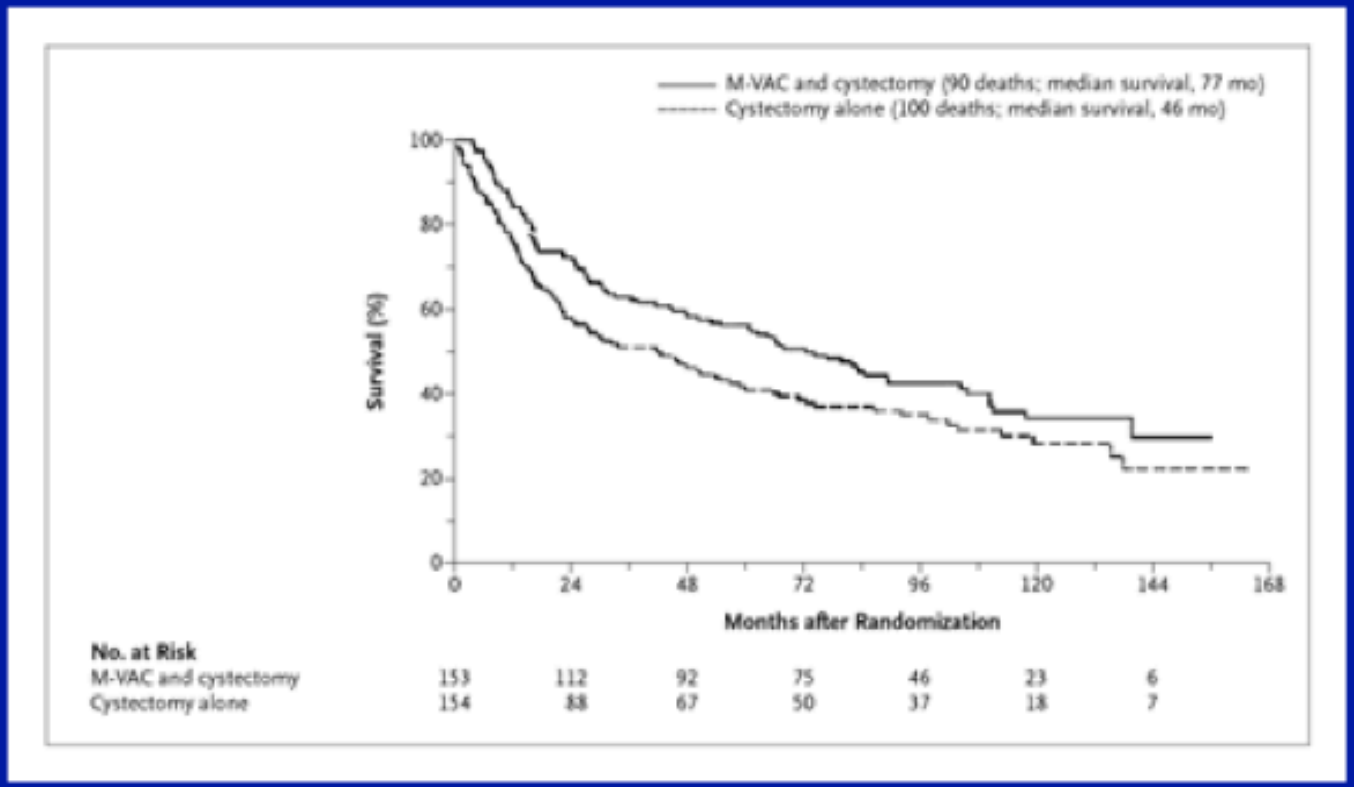


a)154 PtsT2-T4a treated by RC alone
b)153 Pts (3)M-VAC and RC

- Estimated reduction of risk of death: 25%
- NC did not adversely impact the ability to proceed with RC

Median FU: 8.7 years:
a)Median survival: 77 mo.
b)Median survival: 43 mo.
P=0.06

SWOG Intergroup Overall Survival (n=307)

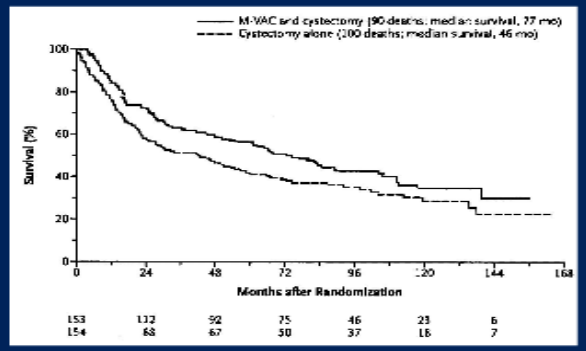


43% vs. 57% 5 yr survival p=0.06, 2-sided borderline significance) HR: 1.33 (95% CI 1.0- 1.76)

Grossman HB, NEJM 349: 859-66, 2003

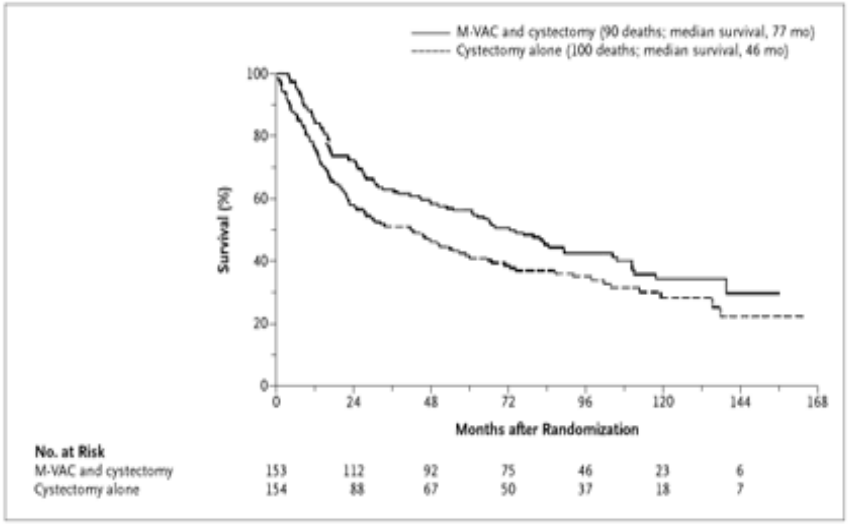
Intergroup 00-80: Survival

(Grossman, NEJM, 2003)



Arm	Median Survival (Years)	Alive at 5 years	P-value
Surgery	3.8	43%	
MVAC + Surgery	6.2	57%	0.06

- MVAC well tolerated.
- No increased complications after MVAC
- P0 after MVAC is 38%



43% vs. 57%
5 yr survival p=0.06, (2-sided borderline significance) HR: 1.33 (95% CI 1.0- 1.76)

Grossman HB, NEJM 349: 859-66, 2003

META-ANALYSIS STUDIES

Lancet 2003 **10 PRT**(but SWOG) 2688 Pts
absolute survival benefit at 5-y ***5%***
(13% decrease in the risk of death)

Eur Urol 2005 **11 PRT** 3005 Pts
absolute survival benefit at 5-y **5%**
(absolute disease-free survival at 5 y of 9%)

J Urol 2004 **16 PRT** 3315 Pts
absolute overall survival benefit **6.5%**

European Urology

European Urology 48 (2005) 202–206

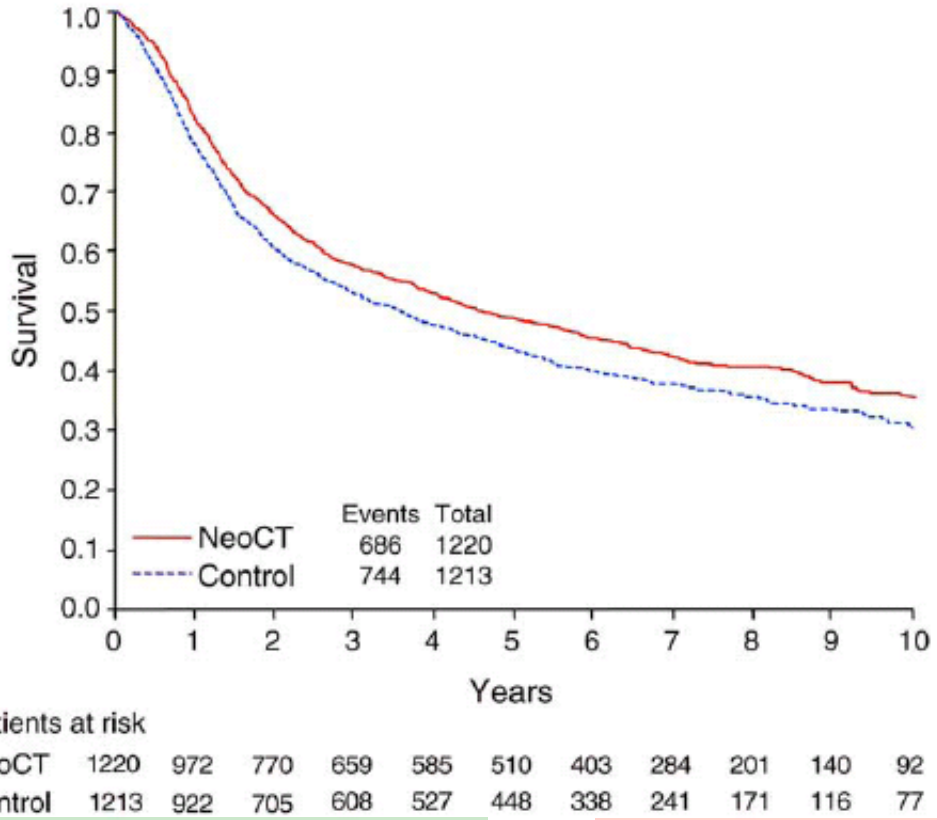
Review—Bladder Cancer

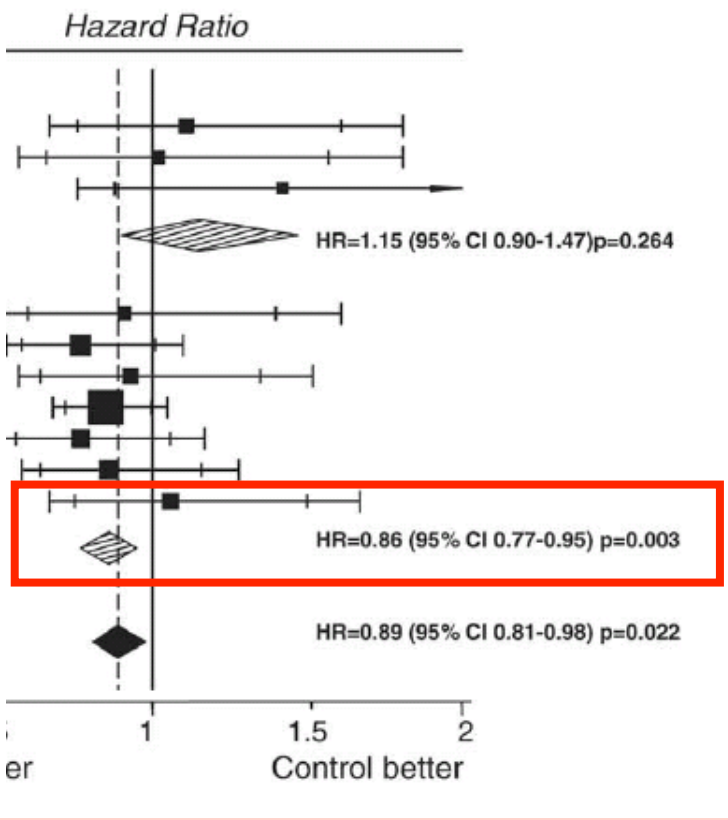
Neoadjuvant Chemotherapy in Invasive Bladder Cancer: Update of a Systematic Review and Meta-Analysis of Individual Patient Data

Advanced Bladder Cancer (ABC) Meta-analysis Collaboration

3005 pz
11 trials

chemioterapia neoadiuvante + trattamento locale (radioterapia o cistectomia) vs trattamento locale.





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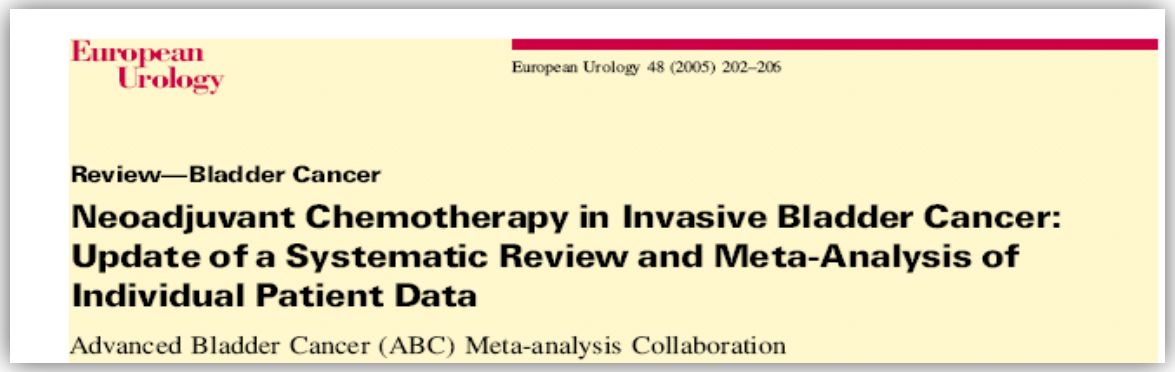
Courtesy Dr. C. Ortega

ABC meta-analysis Collaboration Eur Urol 2005:48;202



European Urology

European Urology 48 (2005) 202–206

Review—Bladder Cancer

Neoadjuvant Chemotherapy in Invasive Bladder Cancer: Update of a Systematic Review and Meta-Analysis of Individual Patient Data

Advanced Bladder Cancer (ABC) Meta-analysis Collaboration

2488 pz
9 trials

- Il beneficio clinico complessivo è del 5% a 5 anni e fornisce la miglior stima di effetto in tutte le categorie;
- Tuttavia l'interpretazione di questo beneficio ha impatti differenti in funzione della differente prognosi considerata per categoria:
- a 5 anni la terapia neoadiuvante migliora la sopravvivenza

(vantaggio relativo: VR):

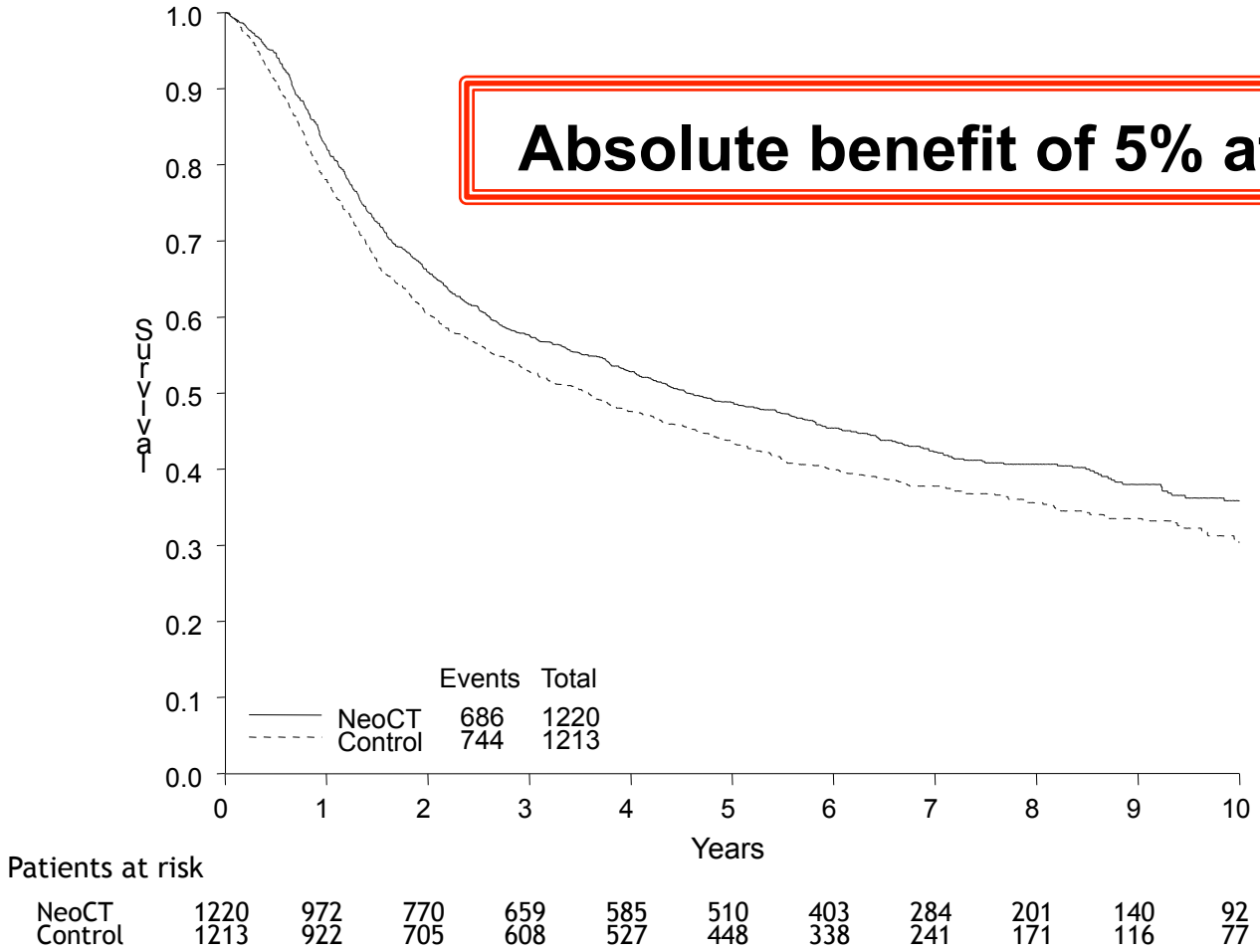
- dal 55% al 60% nei pazienti con malattia T1–2 → (VR 9%)
- dal 40% al 45% nei pazienti con malattia T3 → (VR 12,5%)
- dal 25% al 30% nei pazienti con malattia T4 → (VR 20%)

Adapted, Courtesy Dr. C. Ortega

ABC meta-analysis Collaboration Lancet 2003:361;1927

Advanced Bladder Cancer (ABC) Meta-analysis Collaboration

Platinum-based combination chemotherapy trials only
Overall survival



Eur Urol. 2005 Aug;48(2):202-5

Neo-Adjuvant Chemotherapy

- Neo-adjuvant Chemotherapy prior to cystectomy shows a real benefit
- There is consistent data to prove the benefit

Courtesy by Cora sternberg

Open Question

Are we able to state conclusively that patients who achieve pT0 after NC represent the best subgroup in terms of long term oncologic outcomes? Shell we consider the surrogate pT0 end point universally accepted?
What is the NC regimen that, at now, has proved to achieve the highest pT0 rate?

SWOG 8710: Survival by Pathologic Stage at Cystectomy

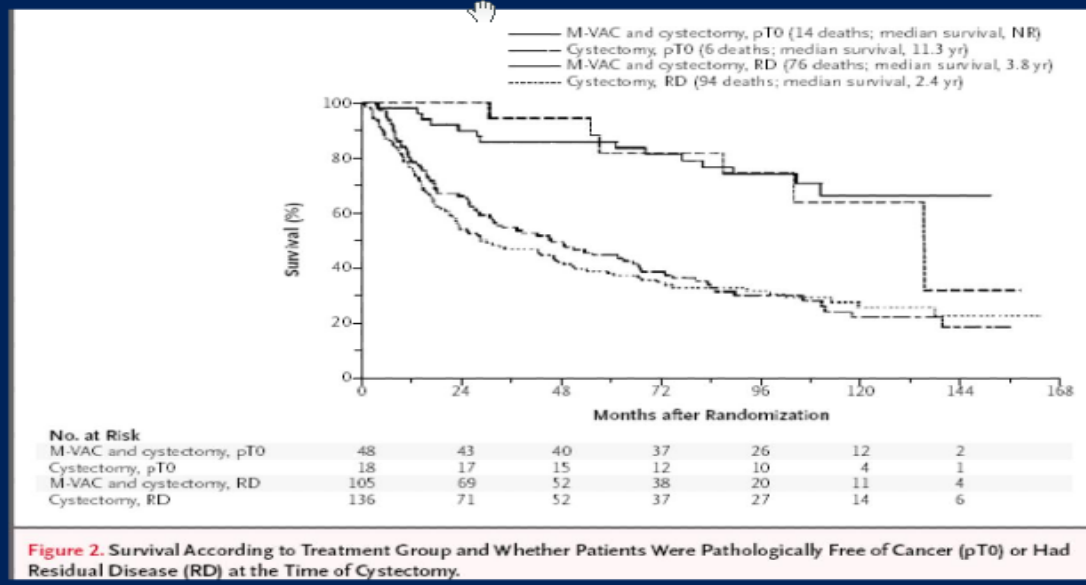


Figure 2. Survival According to Treatment Group and Whether Patients Were Pathologically Free of Cancer (pT0) or Had Residual Disease (RD) at the Time of Cystectomy.

The survival benefit of neoadjuvant M-VAC appears to be strongly related to downstaging of the tumor to **pT0**: 38 percent of the patients in this group had no evidence of cancer at cystectomy, as compared with 15 percent of the patients in the cystectomy group (P<0.001); the respective five-year survival rates were 85 and 82 percent.

Grossman HB, NEJM 349: 859-66, 2003

EURURO-5196; No. of Pages 8
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EUROPEAN UROLOGY XXX (2013) XXX–XXX
available at www.sciencedirect.com
journal homepage: www.europeanurology.com
European Association of Urology

Platinum Priority – Review – Bladder Cancer

Editorial by XXX on pp. x–y of this issue

Correlation of Pathologic Complete Response with Survival After Neoadjuvant Chemotherapy in Bladder Cancer Treated with Cystectomy: A Meta-analysis

Fausto Petrelli[a,], Andrea Coinu[a], Mary Cabiddu[a], Mara Ghilardi[a], Ivano Vavassori[b], Sandro Barni[a]*

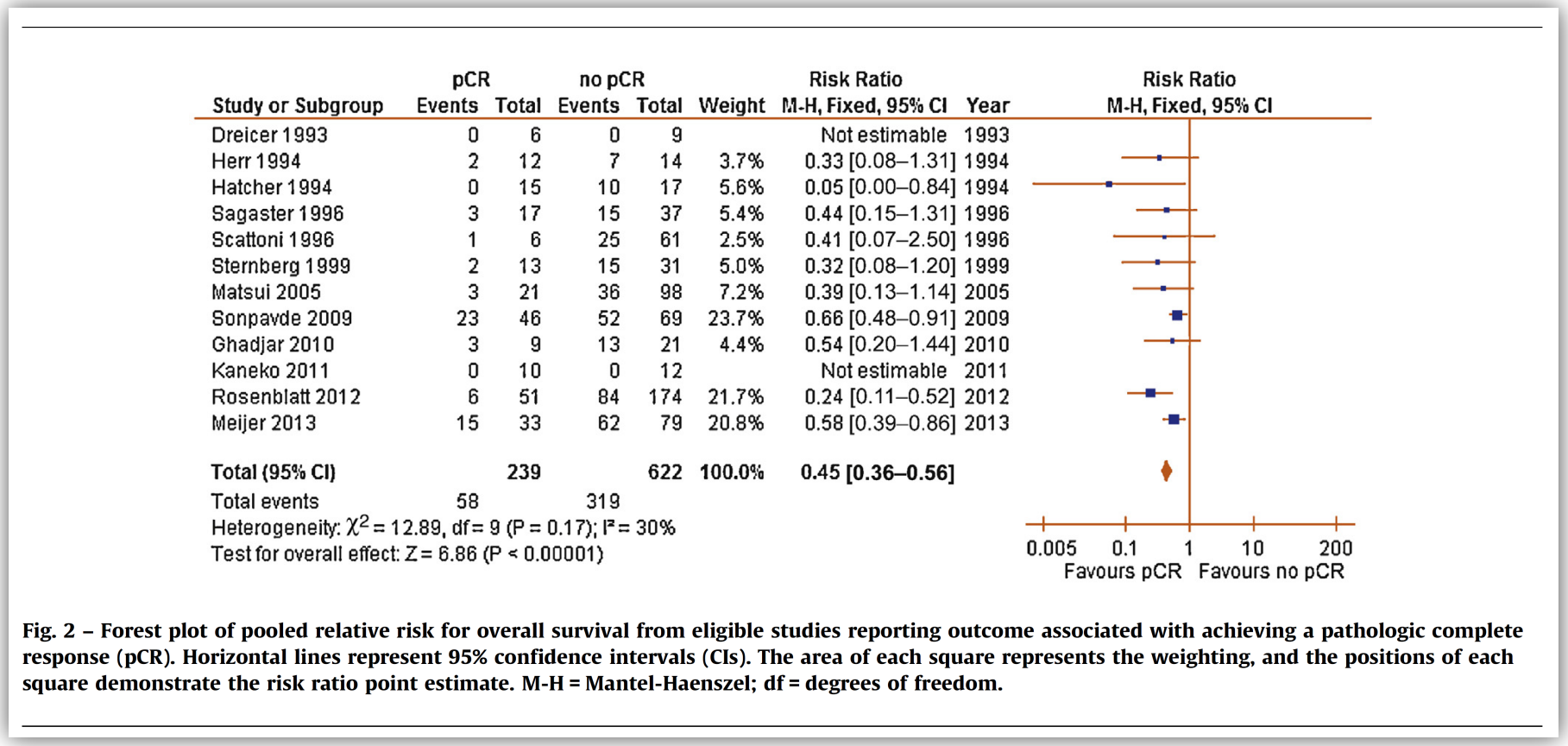

Fig. 2 – Forest plot of pooled relative risk for overall survival from eligible studies reporting outcome associated with achieving a pathologic complete response (pCR). Horizontal lines represent 95% confidence intervals (CIs). The area of each square represents the weighting, and the positions of each square demonstrate the risk ratio point estimate. M-H = Mantel-Haenszel; df = degrees of freedom.

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Study or Subgroup	pCR Events	pCR Total	no pCR Events	no pCR Total	Weight	Risk Ratio M-H, Fixed, 95% CI	Year
Dreicer 1993	0	6	3	9	6.4%	0.20 [0.01–3.36]	1993
Herr 1994	1	12	8	14	16.5%	0.15 [0.02–1.01]	1994
Donat 1996	1	8	15	16	22.4%	0.13 [0.02–0.84]	1996
Sternberg 1999	2	13	20	31	26.4%	0.24 [0.06–0.88]	1999
Ghadjar 2010	1	9	15	21	20.1%	0.16 [0.02–1.01]	2010
Kaneko 2011	1	10	4	12	8.1%	0.30 [0.04–2.27]	2011
Total (95% CI)		**58**		**103**	**100.0%**	**0.19 [0.09–0.39]**	
Total events	6		65				

Heterogeneity: $\chi^2 = 0.58$, df = 5 (P = 0.99); $I^2 = 0\%$
Test for overall effect: Z = 4.45 (P < 0.00001)

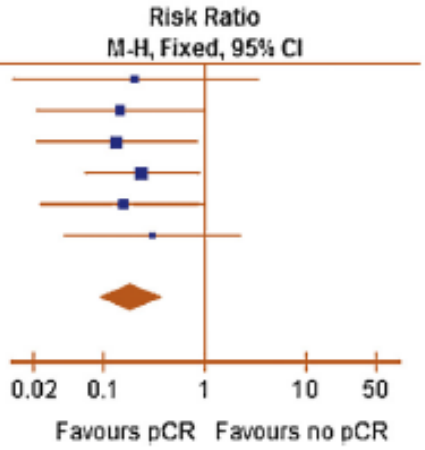

Fig. 3 – Forest plot of pooled relative risk for recurrence-free survival from eligible studies reporting outcome associated with achieving a pathologic complete response (pCR). Horizontal lines represent 95% confidence intervals (CIs). The area of each square represents the weighting, and the positions of each square demonstrate the risk ratio point estimate. M-H = Mantel-Haenszel; df = degrees of freedom.

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Fausto Petrelli[a,*], *Andrea Coinu*[a], *Mary Cabiddu*[a], *Mara Ghilardi*[a], *Ivano Vavassori*[b], *Sandro Barni*[a]

4. Conclusions

As we await further molecular prognostic factors and predictors of sensitivity to medical therapy for UC, achieving pCR in both the bladder and lymph nodes after neoadjuvant chemotherapy and RC for BCa is associated with an impressively better outcome.

Neo - Adjuvant Chemotherapy

- 12% at leading academic US institutions
- SEER national data - even less
- Consultation by MDT prior to surgery
- 5 yr survival rates 40-60% after cystectomy, no better than 80% pT2
- Transition to systemic disease paradigm - breast and colon cancers (26% colon cancer)

Open Question

Can we definitively state today that NC doesn't increase the rate of complications after radical cystectomy? This may be of crucial importance for the attitude of surgeons in favor of NC

SWOG 8710: Randomized Trial of Neo-Adjuvant Chemotherapy Followed by Cystectomy vs. Cystectomy Alone

Table 3. Postoperative Complications among Patients Who Underwent Cystectomy.*

Complication	Cystectomy Alone (N=124)			M-VAC and Cystectomy (N=126)		
	Grade 3	Grade 4	Grade 5	Grade 3	Grade 4	Grade 5
	number of patients					
Anemia	0	0	0	3	0	0
Hemorrhage	0	0	0	3	0	0
Infection	3	0	1	2	1	0
Neurologic effects	0	0	0	3	0	0
Pulmonary effects	1	0	0	3	0	0
Thrombosis or embolism	0	1	0	0	0	0
Delayed wound healing or wound infection	2	1	0	2	0	0
Other	2	0	0	1	1	0
Maximal grade of any adverse effect	15	10	1	15	11	1

Post-operative complications were the same whether or not neoadjuvant chemotherapy was given

Grossman, NEJM 2003

Surgical Factors Influence Bladder Cancer Outcomes:
A Cooperative Group Report

Harry W. Herr, James R. Faulkner, H. Barton Grossman, Ronald B. Natale, Ralph deVere White, Michael F. Sarosdy, and E. David Crawford

J Clin Oncol 22:2781-2789. © 2004 by American Society of Clinical Oncology

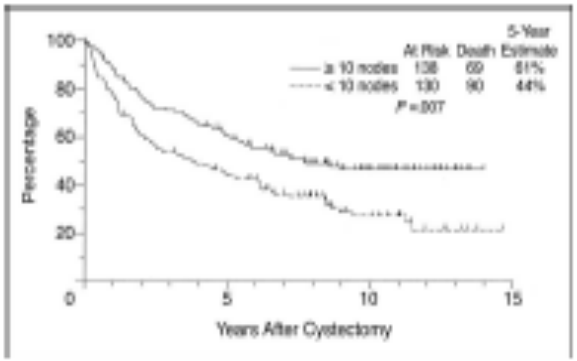


Fig 1. Postcystectomy survival by number of lymph nodes removed.

Table 3. Multivariate Proportional Hazards Regression Model for Postcystectomy Survival

Variable	HR*	95% CI	P†
Treatment RC v MVAC + RC	1.0	0.7 to 1.4	.97‡
Age ≥ 65 v < 65 years	1.5	1.0 to 3.6	.03
pT stage 3-4 v 0-2	2.3	1.5 to 3.6	.0002
Node status positive v negative	1.6	1.0 to 2.5	.04
Margins Positive v negative	2.7	1.5 to 4.9	.0007
Nodes removed < 10 v ≥ 10	2.0	1.4 to 2.8	.0001

Abbreviations: HR, hazard ratio; RC, radical cystectomy; MVAC, methotrexate, vinblastine, doxorubicin, and cisplatin.
*Each HR and P is adjusted for all other covariates in the model.
†P values are two sided and based on the Wald χ^2 test.
‡Treatment was insignificant because pT stage explains much of the treatment effect.

106 Surgeons
109 Institutions
5Y post RC survival and LR were 54% and 15%, respectively

Preictors of LR: positive margins and < 10 nodes removed

Surgical factors influence bladder cancer outcomes after cystectomy, after adjustment for pathologic factors and neoadjuvant chemotherapy usage. [LE 2]

Open Question

If we accept the surrogate pT0 status after NC as a reasonable end point, should we expect that the inclusion of new drugs [bevacizumab, sorafenib, avastin, sunitinib] in the NC regimen may increase this end point achievement**?**

At now, there is no prove that novel combination regimens provide increased pT0s rather than increased toxicity

Clinical trial setting: novel agents

- **Sunitinib as first line:**

  PS 0-1 Creat 30-60 ml/min median age 75 (range 70-80 yrs)

  Locally advance or metastatic UC

  Bellmunt J. et al Annals of Oncology 2011

- **Carboplatin / Gemcitabine / Bevacizumab:**

  KPS >60%, creat <2,0 or GFR>30ml/min [MSKCC; NCT00588666]

- **Neoadjuvant Dasatinib (oral multi-BCR/ABL and Src family TKI):**

  miUCB (T2-T4a,N0,M0), Creat <2 x ULN, PS 0/1: 19/6

  Unsuitable or unwilling to CDDP (relevant concomitant disease:tumors, cardiac failur, uncontrolled arythmia or hypertension) [Hoosier, NCT00706641**]**

  Hann N M et al ASCO 2012

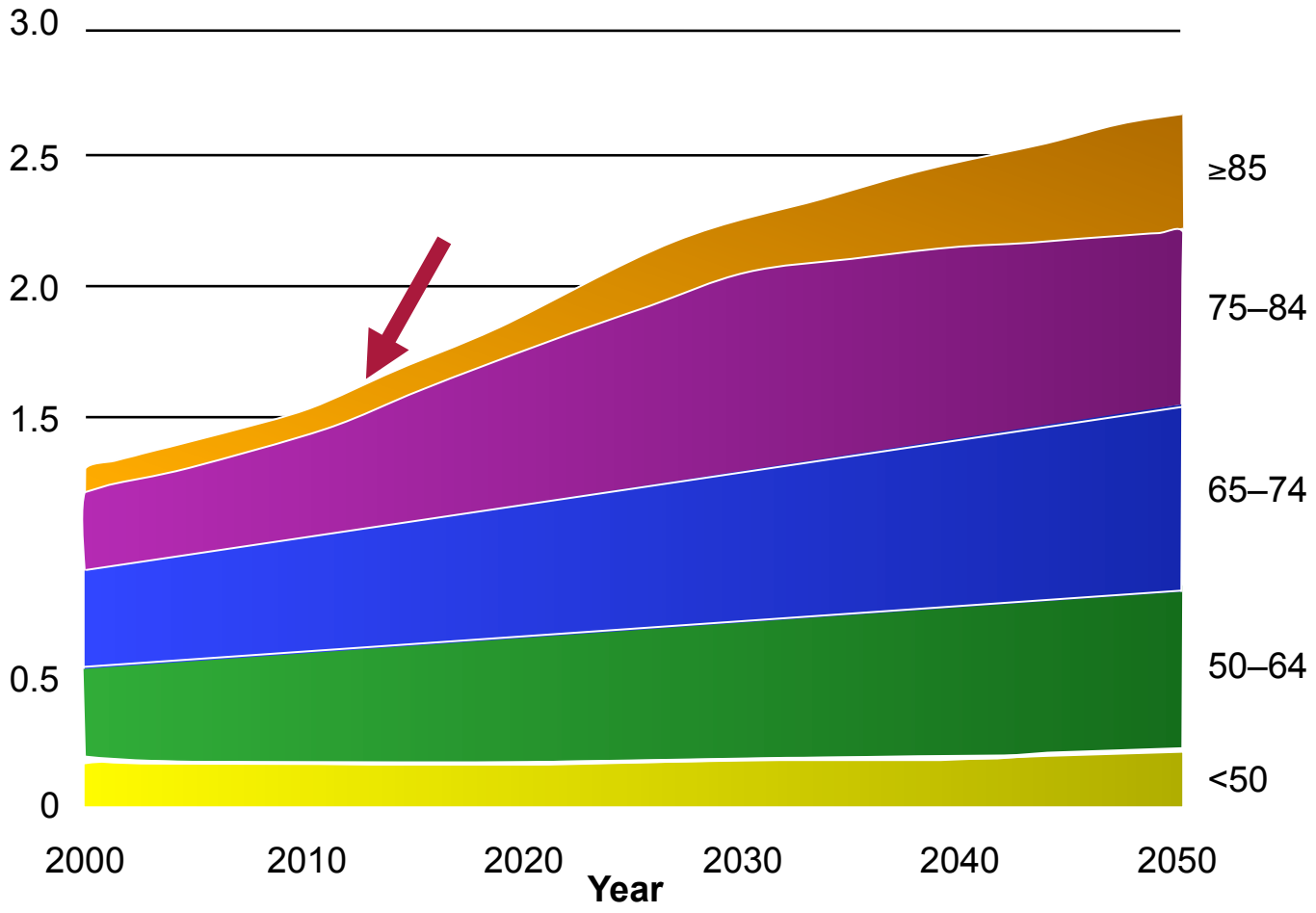
- **Neoadjuvant Ipilimumab:**

  T1-T3N0M0, CrCl < 40ml/min, ECOG 0-1 [MD Anderson, NCT00362713]

The burden of cancer is shifting to the elderly

Edwards BK et al. Cancer. 2002

Slide used with courtesy of T. Cerny



UNFIT DEFINITION

- At least on e of the following criteria

- ❑ WHO/ECOG PS 2; KPS: 60-70%
- ❑ Creatinine clearence (calculated or measured) less than 1 mL/s
- ❑ CTCAE version 4: grade 2 or above audiometric hearing loss
- ❑ CTCAE version 4: grade 2 or above peripheral neuropathy
- ❑ NYHA Class III

Galsky M et al J Clin Oncol 2011

EORTC Definition of "fit" and "unfit" for cisplatin (2011)

"Unfit"

GFR < 60 ml/min
and /or
PS ≥2
≥ grade 2 audiometric hearing loss
≥ 2 peripheral neuropathy
NYHA Class III heart failure

Patients selection, individualized treatment

Patients related factors:

- ✓ **Performace status/functional status**
- ✓ **Type of metastasis (visceral, bone, liver)**
- ✓ **Renal function**
- ✓ **Co-morbidity**

→ **Used in daily clinical practice**

Tumor related factors

- ✓ **Prediction of response to ciplatin, taxanes, gemcitabine…**
- ✓ **ERCC1 mRNA expression**
- ✓ **BRCA1**
- ✓ **RR M1,2**
- ✓ **P53 (conflicting reports)**
- ✓ **HER2/Neu**
- ✓ **Genomic profilemicroarrays**

Bellmunt, Ann Oncol, 2007

→ **<u>Not</u> (yet) ready for routine use**

Options for "unfit" patients with.....

PS 0-1 and organ function impairments

Performance status ≥ 2

Acquisitions

- Due to the discrepancy between clinical and pathologic complete response after NC, radical cystectomy cannot be obviated by response **[grade B]**

- Toxicity and mortality associated with NC is acceptable **[grade B]**

- The quality of radical cystectomy is a confounding factor in interpreting these studies **[grade B]**

Acquisitions

- Available data suggest that for average risk patient **<cT2** the benefit of adding NC to local therapy is at best modest

- Likewise, all available studies support much more substantial benefit for patients with high risk disease such as **cT2 -cT3b** or those with **N+** status **[grade B]**

Acquisitions

- All three major drugs regimens (M-VAC; GC; DD-MVAC), were proved to have a similar efficacy with a median survival of 15 mo with responses in 40-60%

- Presence of **squamous or glandular differentiation** in locally advanced UC doesn't confer resistance to NC and at contrary may be an indicator for the use of NC **[grade 3C]**

Acquisitions

- There are no data from PRT supporting the use of **new drugs** and novel drug combination in NC setting (just within phase II trials)

- At now is not possible to make a definitive statement about the role of **gene expression profiling** in the molecular prognostication on MIBC. (i.e.20-gene signature has been investigated as an independent predictor for N+ and p53 as well as Ki67)

- Baseline tumor genomics appear promising as **predictors of pCR** however, limited small studies have been reported

Why Neo-adjuvant Chemotherapy ?

- Neo-adjuvant chemotherapy should be the standard of care for eligible patients with muscle invasive bladder cancer !
- Challenge to incorporate a multidisciplinary approach!

MDT & adherence to guidelines

- MDT **adherence to guidelines in 71%** of cases
- Discordance mainly noted for:
  - older patients (70+)
  - borderline performance status
  - patients with co-morbidities

Vinod SK et al. Journal of Oncology Practice 2010; 6: 276-81

Multidisciplinary care and likelihood of undergoing AS in men with low risk PCa (1)

Aizer AA. Int J Radiat Oncol Biol Phys 2011:81(2 Suppl):S101-2(abs. 203)

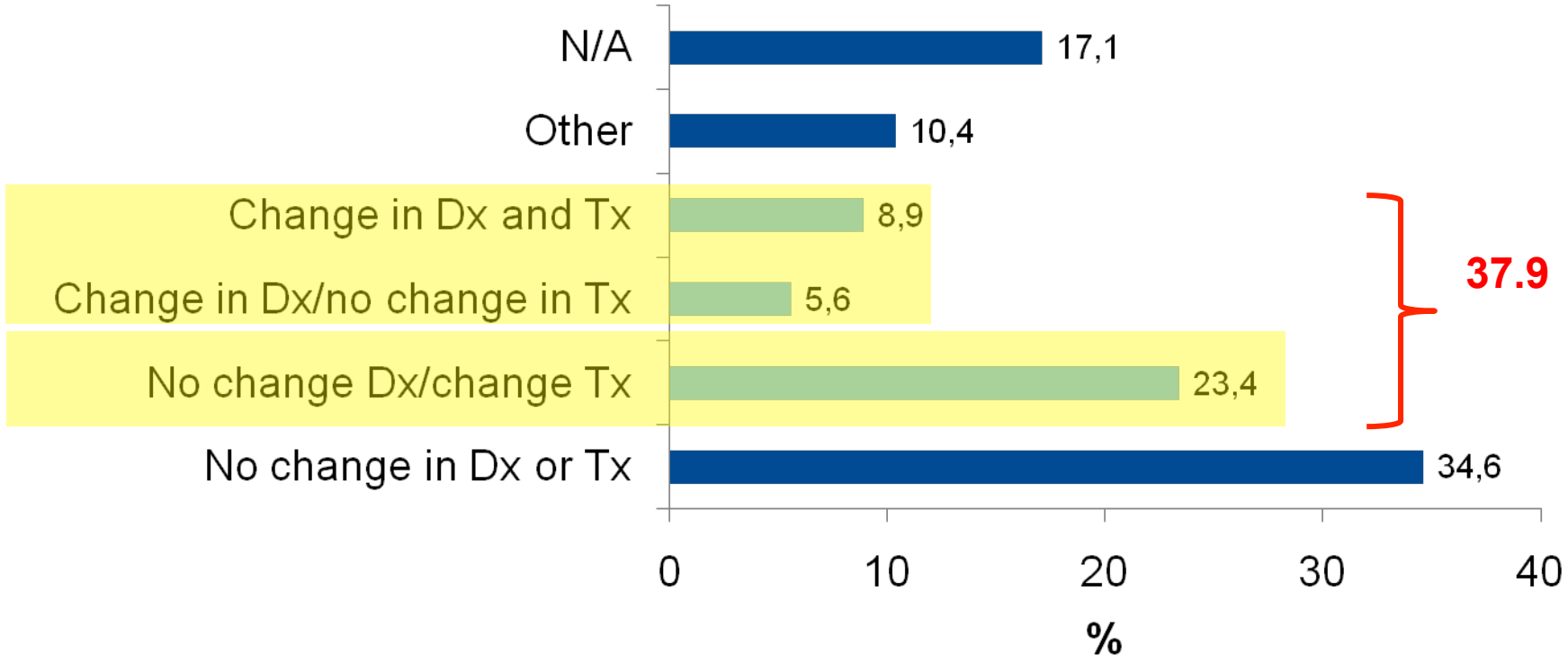
- Retrospective study; N=701 pts with <cT2b, GS<7, PSA<10 ng/ml PCa (2009)

	Multidisciplinary clinic (N=329)	Individual practitioners (N=462)	*P*-value
# physicians seen (N)	3.1	1.6	
# specialities seen (N)	2.8	1.4	
AS (%)	43	22	<0.001
RP (%)	43	56	
EBRT (%)	7	11	
BrachyT (%)	7	10	

Multidisciplinary clinic: concurrent consultation with ≥2 of following: urologic oncologist, radiation oncologist, medical oncologist

A MDT approach influences diagnostic and treatment decisions

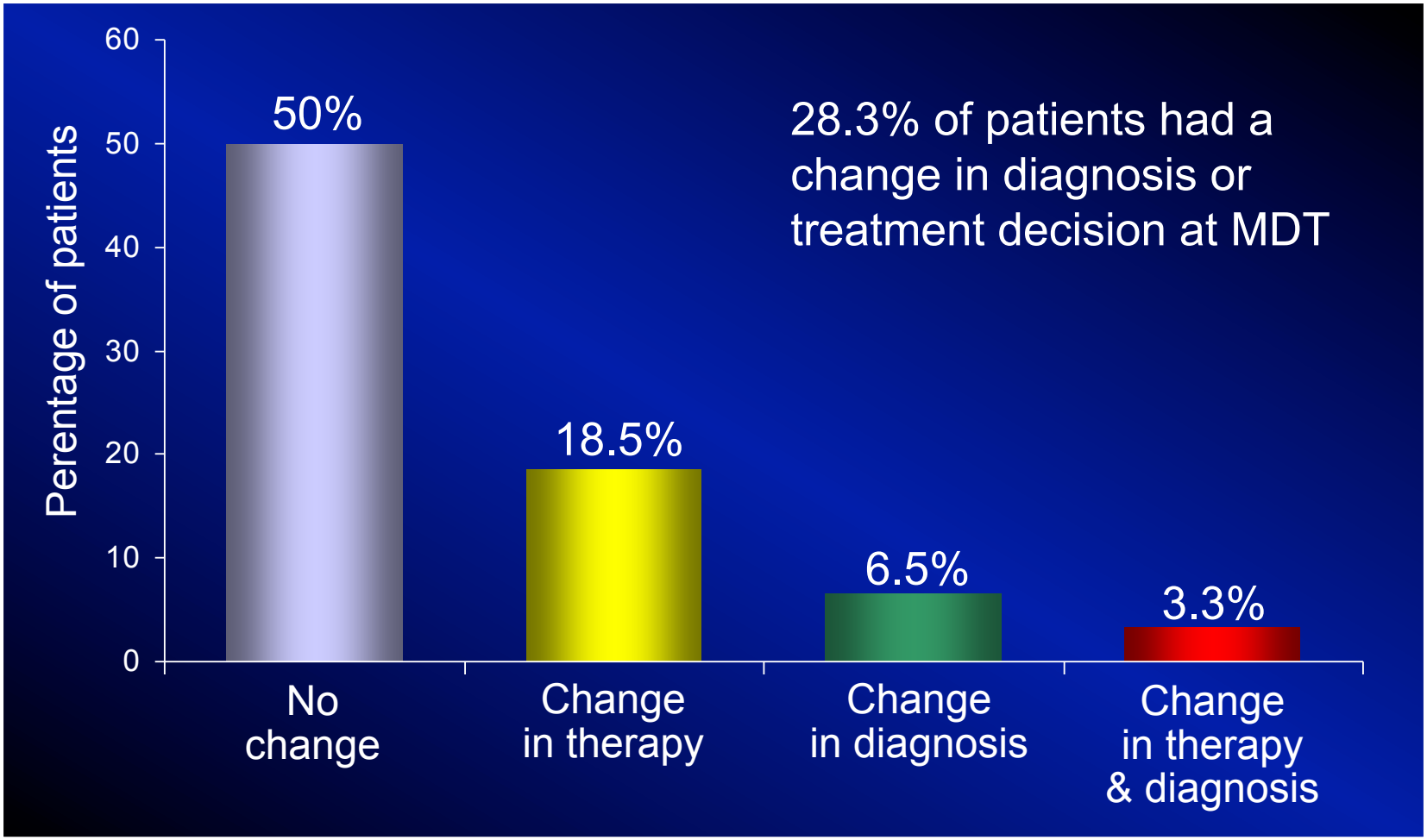
- 296 patients presented MDT with an outside diagnosis of a urologic malignancy



Dx: diagnostic decision; Tx: treatment decision

Kurpad R et al. Urol Oncol 2009 DOI: 10.1016/j.urolonc.2009.04.008 – B. Tombal **Cury 2011**

MDT in prostate cancer may change diagnosis and treatment decisions



92 consecutive patients with prostate cancer reviewed in MDT in a single institution

Kurpad R et al. Urol Oncol 2011, 29: 378-82

Enhancing Prostate Cancer Care Through the Multidisciplinary Clinic Approach: A 15-Year Experience

By Leonard G. Gomella, MD, Jianqing Lin, MD, Jean Hoffman-Censits, MD, Patricia Dugan, RN, Fran Guiles, RHIA, CTR, Costas D. Lallas, MD, Jaspreet Singh, DO, Peter McCue, MD, Timothy Showalter, MD, Richard K. Valicenti, MD, Adam Dicker, MD, and Edouard J. Trabulsi, MD

Kimmel Cancer Center, Thomas Jefferson University, Philadelphia, PA

VOL. 6, ISSUE 6 NOVEMBER 2010

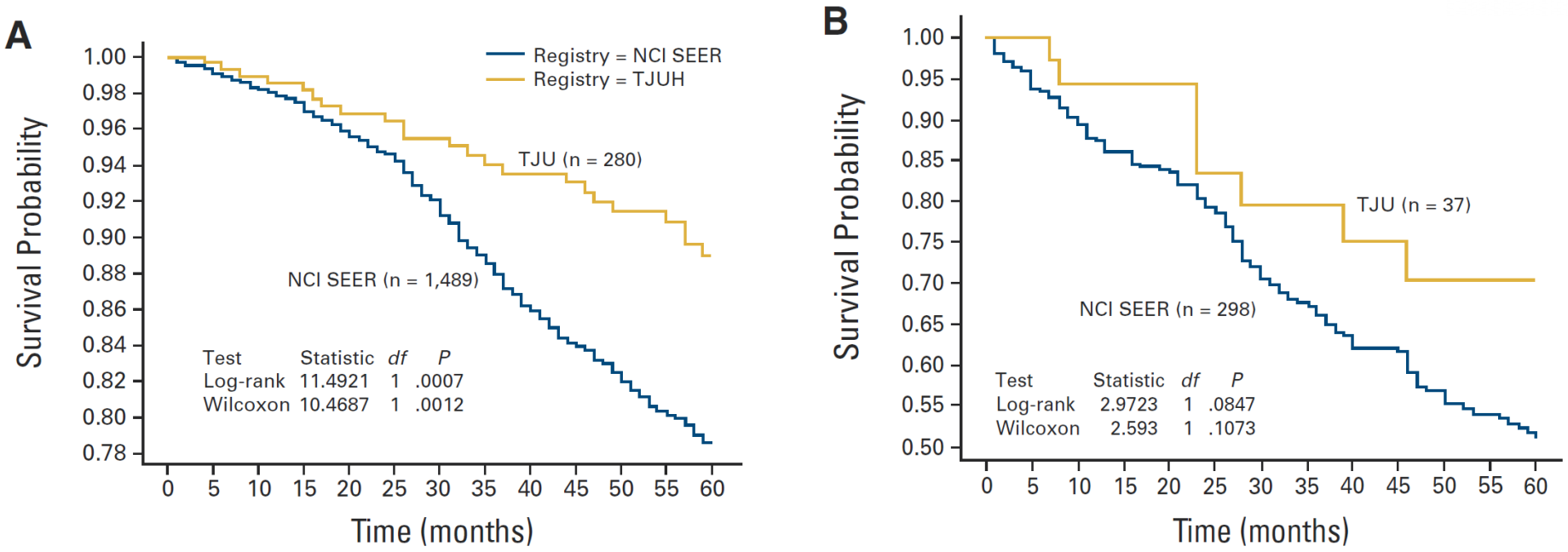
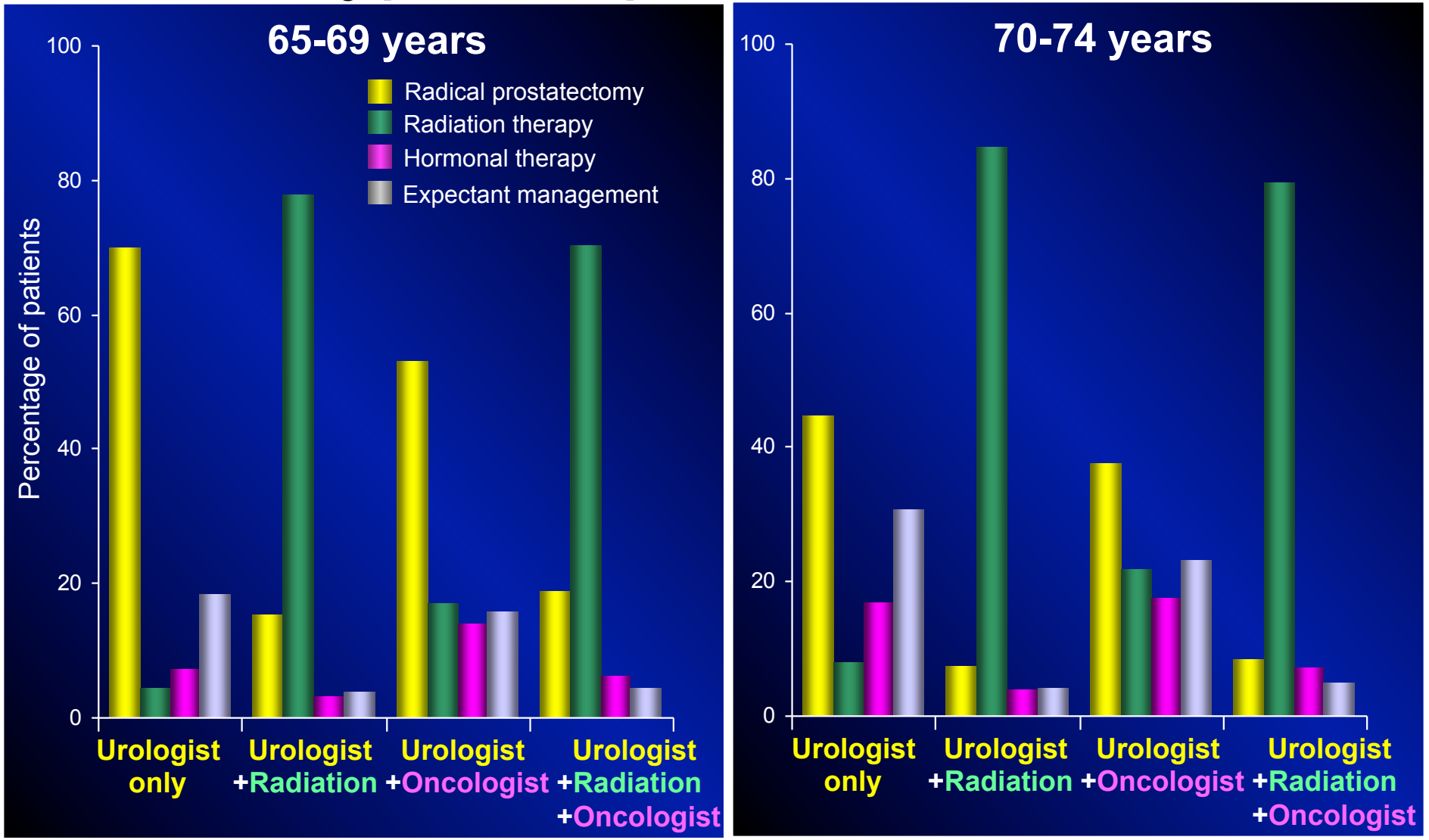


Figure 1. Kaplan-Meier survival of patients with newly diagnosed prostate cancer at the TJUH/KCC (1996-2008) and patients in NCI SEER (1997-2003). (A) Stage III (T3 N0 M0); (B) T4 N0 M0. TJUH, Thomas Jefferson University Hospital; KCC, Kimmel Cancer Center; NCI, National Cancer Institite; SEER, Surveillance, Epidemiology, and End Results.

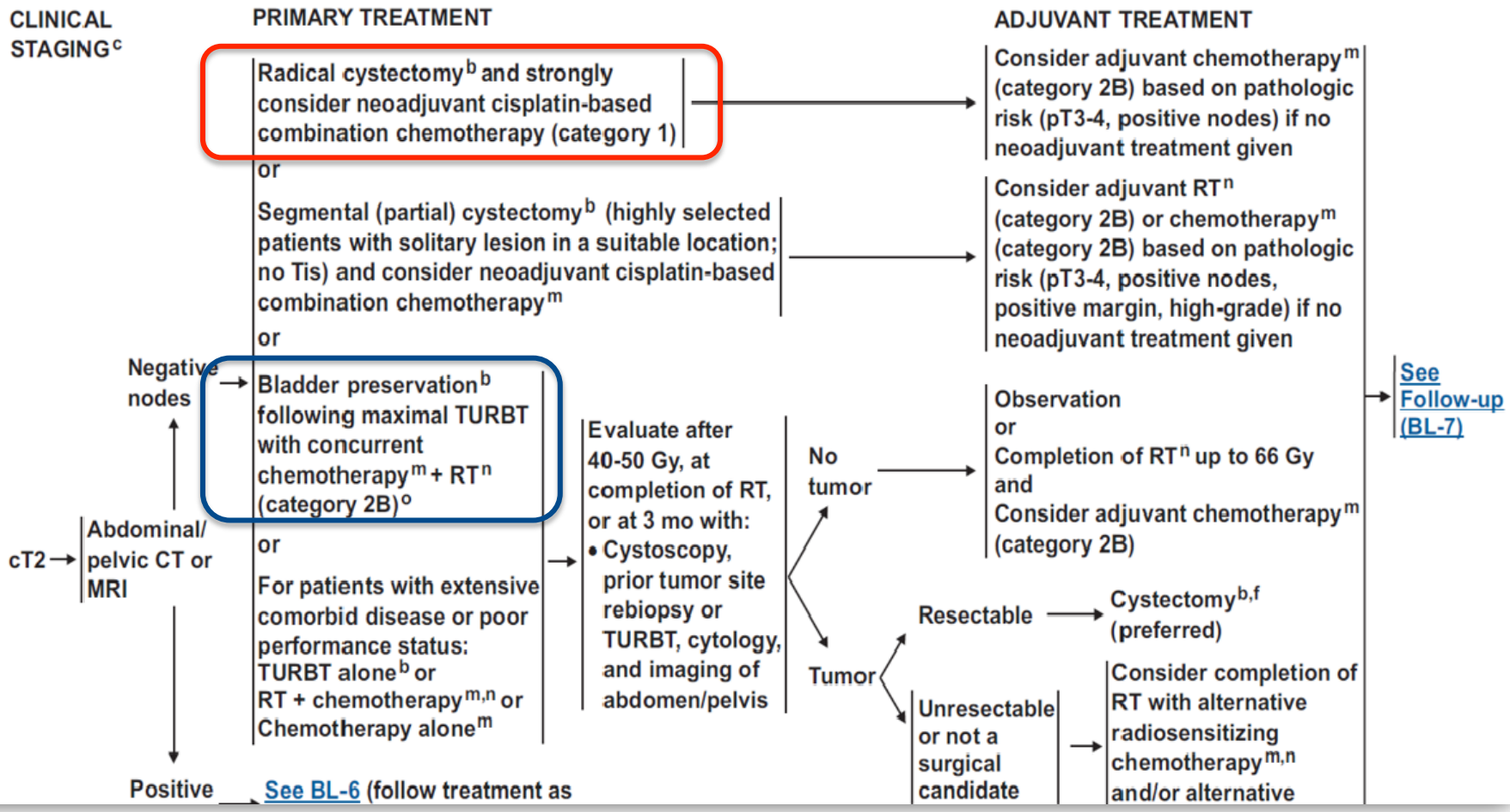
Strongest predictor of treatment is the type of specialist visited



Jang TL et al. Arch Int Med 2010, 170: 440-50

NCCN Guidelines Version 1.2013
Bladder Cancer

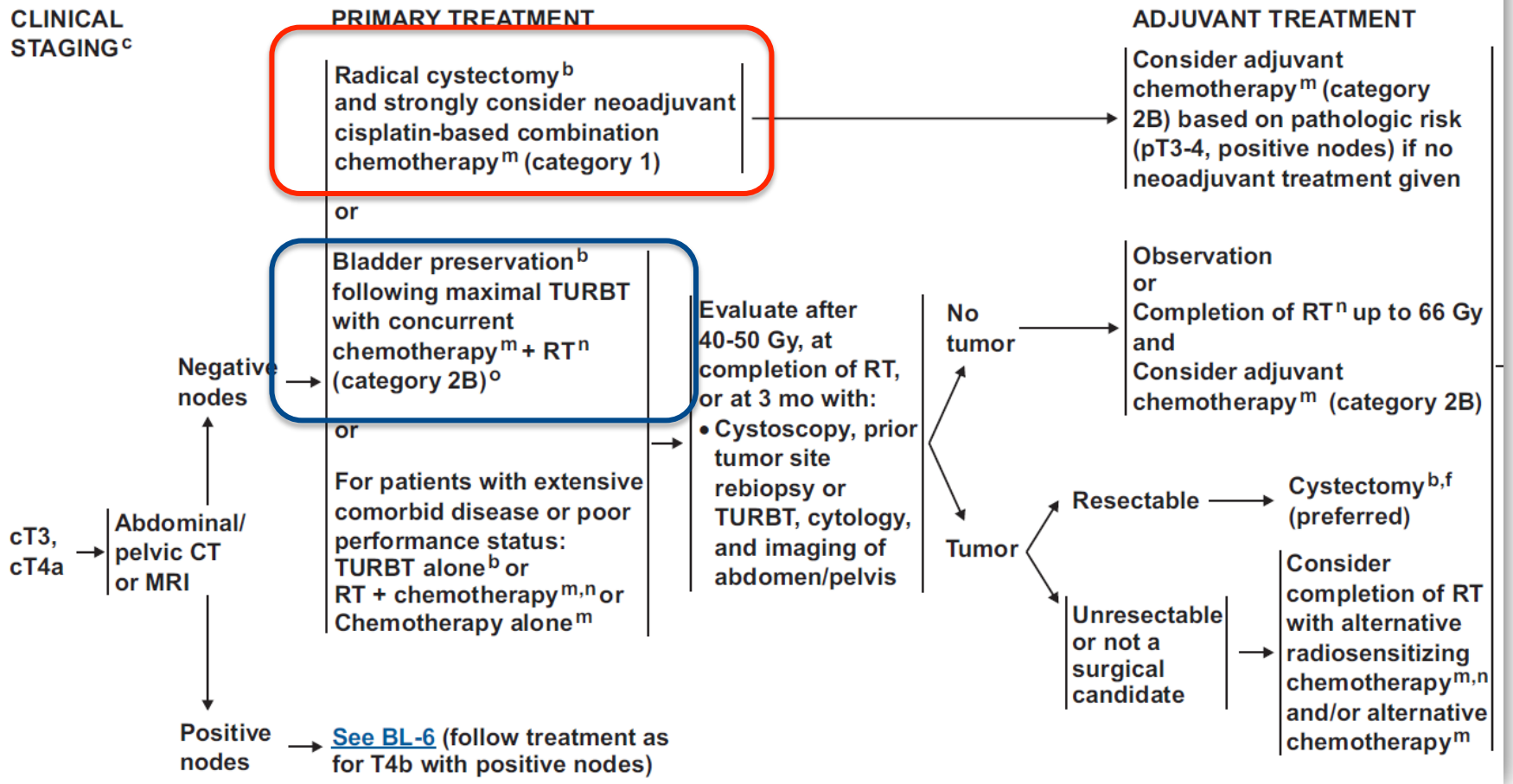
NCCN Guidelines Index
Bladder Cancer TOC
Discussion



National Comprehensive Cancer Network®

NCCN Guidelines Version 1.2013
Bladder Cancer

NCCN Gu
Bladde



SIUrO

Società Italiana di Urologia Oncologica
Italian Society of Uro-Oncology

CIPOMO

Collegio Italiano dei
Primari Oncologi
Medici Ospedalieri

perSTEP

con il contributo incondizionato di SANOFI

Azienda Ospedaliera
Ospedale Sant'Anna di Como
Piano di Organizzazione Aziendale (P.O.A.)

Approvato con deliberazione n. 669 del 13 novembre 2012

AZIENDA OSPEDALIERA OSPEDALE SANT'ANNA DI COMO

DIREZIONE GENERALE

Tel.: 031/585.9471
Telefax: 031/585.5739
e-mail: dir.gen@hsacomo.org

Deliberazione n. 762 del 18 ottobre 2013

OGGETTO: Istituzione del Gruppo Operativo Interdipartimentale Permanente "Prostat Cancer Unit".

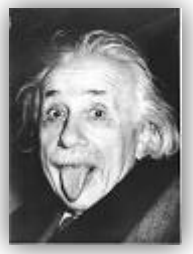
L'anno 2013, addì del mese di ottobre in Como, nella sede dell'Azienda Ospedaliera Ospedale Sant'Anna di Como, il Direttore Generale Dr. Marco Onofri prende in esame l'argomento in oggetto e delibera quanto segue con l'assistenza del Direttore Amministrativo Dott. Salvatore Gioia e del Direttore Sanitario Dr. Giuseppe Brazzoli.

IL DIRETTORE GENERALE

GOIP
Breast Unit
Cardiopatia ischemica
Epato - gastroenterologia
Fisiopatologia Neurorespiratoria
Medicina Nutrizionale, Dismetabolica ed Endocrinologica
Percorso Nascita
Prostate Unit
Attività di Pronto Soccorso Pediatrico Aziendale
Integrazione Soccorso Territoriale e Rete Emergenza Ospedaliera
Attività di Pediatria Chirurgica Aziendale
Radiologia Interventistica

Il punto di vista dell'urologo

$E = mc^2$



MIBC ≠ Cistectomia immediata