



## DICHIARAZIONE

Relatore: MARCO ORSATTI

Come da nuova regolamentazione della Commissione Nazionale per la Formazione Continua del Ministero della Salute, è richiesta la trasparenza delle fonti di finanziamento e dei rapporti con soggetti portatori di interessi commerciali in campo sanitario.

- Posizione di dipendente in aziende con interessi commerciali in campo sanitario **(NIENTE DA DICHIARARE )**
- Consulenza ad aziende con interessi commerciali in campo sanitario **(NIENTE DA DICHIARARE )**
- Fondi per la ricerca da aziende con interessi commerciali in campo sanitario **(NIENTE DA DICHIARARE )**
- Partecipazione ad Advisory Board **(NIENTE DA DICHIARARE )**
- Titolarità di brevetti in compartecipazione ad aziende con interessi commerciali in campo sanitario **(NIENTE DA DICHIARARE )**
- Partecipazioni azionarie in aziende con interessi commerciali in campo sanitario **(NIENTE DA DICHIARARE )**

# **L'approccio Trimodale nella Preservazione d'organo e nella Qualità di Vita**

**M.Orsatti  
Sanremo**



## **MODERATORI:**

**R.SANTONI ( ROMA )**

**V.LORUSSO ( BARI )**

# TRIMODALE

- ✓ Turv radicale (massimale)
- ✓ RT
- ✓ CT

# La preservazione d'organo nel carcinoma vescicale infiltrante

## Obiettivi

- cura del paziente
- conservazione vescica funzionante  
(senza compromettere la sopravvivenza)

XXV CONGRESSO NAZIONALE

**AIRO2015**

PALACONGRESSI - Rimini, 7-10 novembre

# La preservazione d'organo nel carcinoma vescicale infiltrante

**TARGET**

**ABITUALE**

**Chirurgia ad alto rischio  
per comorbidità ( < OS )**

**OTTIMALE**

- pz. operabile
- malattia limitata
- cistectomia salvataggio

# SCHEMI DI ASSOCIAZIONE RT/CT

## RTOG/MGH

### Trifasica ( split course)

- ▣ induzione ( 40 Gy pelvi + CDDP)
- ▣ Rivalutazione( 4-6 settimane! )
- ▣ radicalizzazione ( chirurgica o 24.8 Gy + CDDP se CR)

## RT/CT DEFINITIVA

50- 60 Gy vescica + CT

Fase unica

## Studi RTOG: 468 pz.( 30 pz./anno)

Studio	Rif.	CT neo/ad	RT(Gy)	CT	N°.pz.	RC(%)	OS(%)	%OS vescica intatta
<b>85-12</b>	Tester IJROBP 1993	-	40+24	CDDP	<b>42</b>	<b>66</b>	<b>52</b>	<b>42</b>
<b>88-02</b>	Tester JCO 1996	Neo MCVx2	39.6+25. 2	CDDP	<b>91</b>	<b>75</b>	<b>51</b>	<b>44</b>
<b>89-03</b>	Shipley JCO 1998	Neo(R) MCVx2	39.6+25. 2	CDDP	<b>123</b>	<b>61</b> (CT) <b>55</b>	<b>49</b> <b>48</b> (CT)	<b>40</b> <b>36</b> (CT)
<b>95-06</b>	Kaufman JCO 2000	-	Iperfr. 24 + 20	CDDP+ FU	<b>34</b>	<b>67</b>	<b>83</b> (3 aa.)	<b>67</b> (3 aa.)
<b>97-06</b>	Hagan IJROBP 2003	Adiuv. MCVx3	Iperfr. 40.8+24	CDDP bisett.	<b>52</b>	<b>74</b>	<b>61</b> (3 aa.)	<b>48</b> (3 aa.)
<b>99-06</b>	Kaufman Urology 2009	Adiuv. GC x 4	Iperfr. 40.3+24	CDDP + Taxol	<b>80</b>	<b>81</b>	<b>56</b>	<b>47</b>
<b>02-33</b>	Mitin Lancet Onc 2013	Adiuv. GCP x 4	Iperfr. 40.3+24	CDDP+ Tax Vs CDDP+FU	<b>97</b>	<b>72</b> Vs <b>62</b>	<b>71</b> Vs <b>75</b>	<b>67</b> Vs <b>71</b>

# Studi RTOG

Studio	Rif.	CT neo/ad	RT(Gy)	CT	N <sup>o</sup> .p.z.	RC(%)	OS(%)	%OS vescica intatta
<b>05-24</b>	Michaelson JCO 2014		64.8/36 fx	Paclitax.50 +Trastuzuma b. in HER 2 +	21	<b>69 %</b>	-	-



## Pooled analysis RTOG

- **69% CR dopo induzione**
- **80% vescica conservata**
- **Tox.tardiva > 3: GU 5.7 %  
GI 1.9 %**

**F.UP MEDIANO 7,8 AA.**

## Pooled analysis RTOG (468 pz.)

Outcomes	5 year	10 year
OS	57 %	37 %
DFS	60 %	47 %
LF infiltranti	13 %	14 %
LF non inf.		36 %
DM	31 %	35 %

# Studi RTOG in corso

Studio	RT (Gy)	CT
07-12	Iperfrazionata	<b>CDDP + 5-FU</b> <b>Vs.</b> <b>Gemcitabina bassa dose</b>
RTOG/ NCI	Iperfrazionata	<b>5-FU + Mitomicina C</b>

# RT - CT DEFINITIVA

Autore	N° pz.	RT/CT	% RC	% S	% S vescica conservata
Orsatti(95)	76	50 Gy/ C+FU	81	62	45
Coppin(96)	99	60 Gy/ C	70	47	36
Housset(97)	120	64 Gy/ C+FU	77	63	41
Shipley(02)	190	64.8 Gy/ C	64	54	45
Hussain(04)	41	55Gy/ M+FU	71	36	40
Tirindelli(04)	77	69 Gy(1 Gy x 3)/ C + FU i.c.	90.3	58.5	46.6
Rodel(06)	415	54 Gy/ C+CP +FU	72	51	42
Weiss(07)	112	50-59 Gy/C+FU	88	63	50
Krause(11)	331	54 Gy/ C	78	54	45

	<b>RTOG/MGH (SPLIT COURSE)</b>	<b>RT/CT DEFINITIVA*</b>
<b>% RC</b>	<b>61-87 (70% dopo induzione)</b>	<b>71-91</b>
<b>% S (5 aa.)</b>	<b>49-57</b>	<b>36-74</b>
<b>% S con vescica conservata</b>	<b>38-46</b>	<b>40-67</b>
<b>% vesciche conservate</b>	<b>50-60</b>	<b>70-80</b>
<b>Cistectomie salvataggio</b>	<b>25</b>	<b>19</b>

**\*Ploussard, Eur Urol 2014**



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CRITICAL REVIEWS IN

*Oncology  
Hematology*

*Incorporating Geriatric Oncology*

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# A systematic review and meta-analysis of clinical trials of bladder-sparing trimodality treatment for muscle-invasive bladder cancer (MIBC)

Giorgio Arcangeli<sup>a</sup>, Stefano Arcangeli<sup>b</sup>, Lidia Strigari<sup>a,\*</sup>

<sup>a</sup> *Laboratory of Medical Physics and Expert Systems, Regina Elena National Cancer Institute, Rome, Italy*

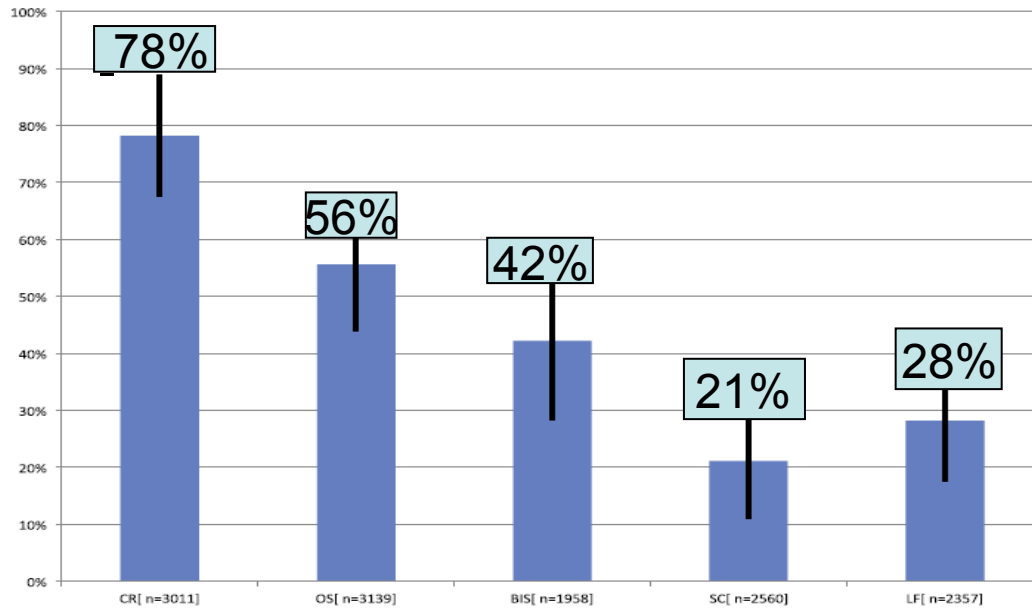
<sup>b</sup> *Department of Radiotherapy, Azienda Ospedaliera S. Camillo—Forlanini, Rome, Italy*

Accepted 27 November 2014

XXV CONGRESSO NAZIONALE

**AIRO2015**

PALACONGRESSI - Rimini, 7-10 novembre



3315 pts, 31 articoli

End point	Split	Cont.	HRs	95% CI	Abs. Benefit	HR
OS	737/1346	1009/1793	0.940	0.816-1.084		
CR	1009/1400	1344/1611	0.513	0.430-0.611	11.3%	
BIS	323/723	504/1235	1.171	0.973-1.410		
SC	287/1144	268/1416	1.435	1.188- 1.732	5.7%	
LF	222/825	443/1532	0.905	0.749 -1.094		

Univariate and multivariate analyses for different end-points.

Endpoints	Variables significant to univariate analysis	Variables significant to multivariate analysis
OS		
CR	Continuous course	Continuous course
BIS		
SC	Continuous course CP-based treatment	CP-based treatment
LF		

# Chirurgia Vs. RT- CT

<b>CISTECTOMIA</b>	<b>% S ( 5 aa.)</b>	<b>% S ( 10 aa.)</b>
Dalbagni(MSKCC) J Urol. 2001	36	27
Stein (USC) JCO 2001	48	32
Grossman NEJM 2003	50	34
Hautman(ULM) J urol 2006	57	45
<b>RT/CT</b>		
Erlangen 2002	45	39
MGH 2012	52	35
RTOG	57	36
Europei	63	42



# Cystectomy (CYS) or selective bladder preservation (SBP) in MIBC: the SPARE study

Huddart R. Int J Radiat Oncol Biol Phys 2012;84(Suppl 3):S119-20(abs.296)

- » Phase II, feasibility study; pts with T2-3 N0 M0 BCa receiving 3 cycles of neoadjuvant chemotherapy (NAC) and randomised to CYS or SBP (4<sup>th</sup> cycle NAC + RT)
- » Study was stopped for poor accrual after 30 mo (45 pts included, target 110) → primary endpoint not met
- » Secondary endpoint: adherence to treatment policy → high level of non-adherence: 32%!

79% response rate to NAC

Randomised to:	Response after 3 mo NAC (N=33)		No response after 3 mo NAC (N=9)		Response unknown (N=2)
	Adherence	Non-adherence	Adherence	Non-adherence	Non-adherence
SBP (N=20)	N=10 (SBP)	N=1 (CYS)	N=3 (CYS)	N=6 (SBP)	N=1 (SBP)
CYS (N=25)	N=17 (CYS)	N=5 (SBP)			N=1 (CYS)

(TREATMENT RECEIVED)



Critical Reviews in Oncology/Hematology xxx (2015) xxx–xxx

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*Oncology  
Hematology*

*Incorporating Geriatric Oncology*

[www.elsevier.com/locate/critrevonc](http://www.elsevier.com/locate/critrevonc)

# Radical cystectomy versus organ-sparing trimodality treatment in muscle-invasive bladder cancer: A systematic review of clinical trials

G. Arcangeli<sup>a</sup>, L. Strigari<sup>a,\*</sup>, S. Arcangeli<sup>b</sup>

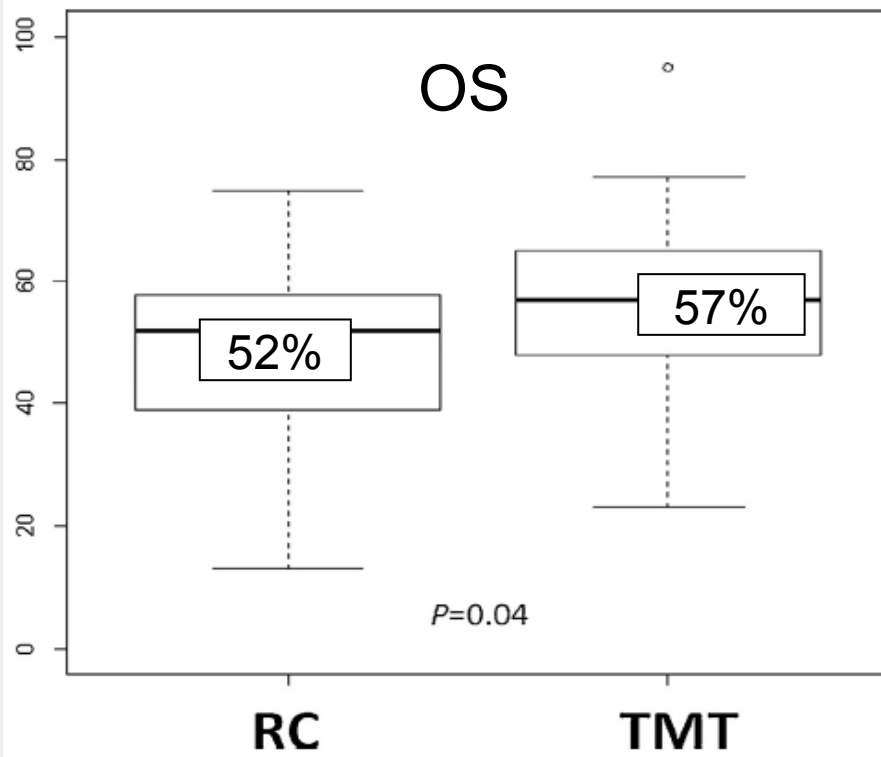
<sup>a</sup> *Medical Physics and Expert Systems Laboratory, Regina Elena National Cancer Institute, Via Elio Chianesi 53, 00144 Rome, Italy*

<sup>b</sup> *Radiotherapy Department, Azienda Ospedaliera S. Camillo-Forlanini, Rome, Italy*

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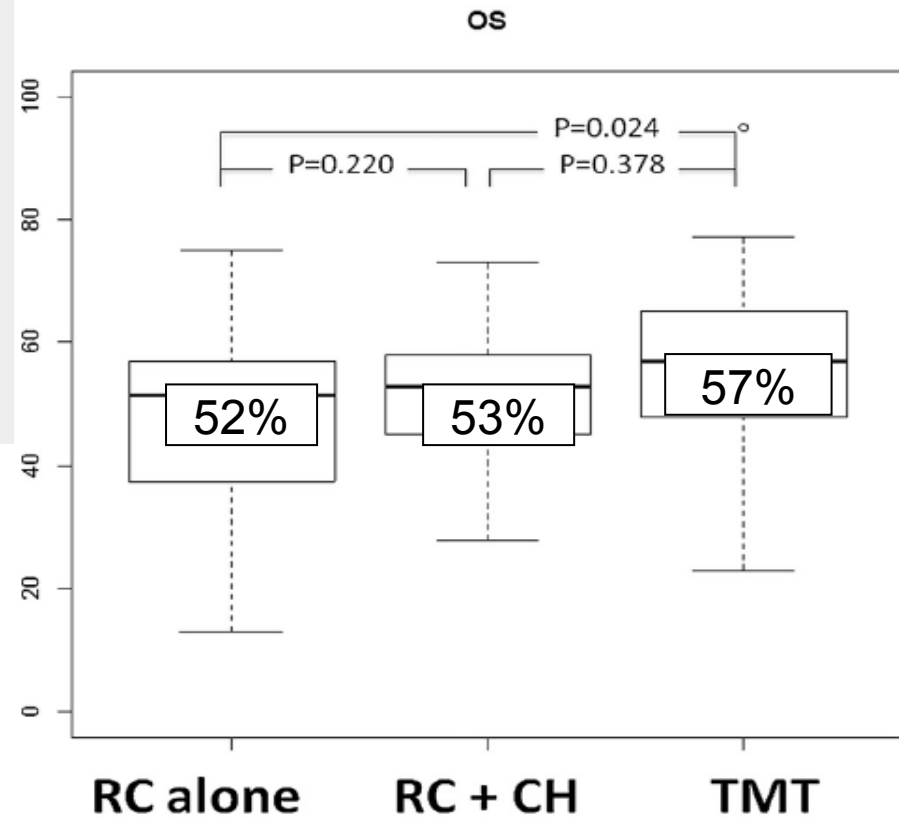
**AIRO2015**

PALACONGRESSI - Rimini, 7-10 novembre



10.265 pts

3131 pts



# Outcomes of Radical Cystectomy in Potential Candidates for Bladder Preservation Therapy

Eugene J. Pietzak, Matthew E. Sterling, Zachary L. Smith, S. Bruce Malkowicz, and Thomas J. Guzzo

**157 PZ. SOTTOPOSTI A CISTECTOMIA RADICALE , ELEGIBILI PER TRIMODALE(cT2N0M0)**

- 24% con mts linfonodali( 16% sopra la biforcazione iliaca)**
- 36% erano pT3 (19%) o pT4(17%)**
- 36% avevano CIS occulto**

# Preservazione vescica: controllo locale

<b>TURV esclusiva</b> (Herr 2001, Solsona 2010)	<b>30 %</b>
<b>TURV + CT</b> (Sternberg 2003, Herr 2008)	<b>33-56 %</b>
<b>RT esclusiva</b> (Pollack 1994, Rodel 2002)	<b>30-40 %</b>
<b>TURV + RT + CT</b>	<b>64-87 %</b>

# Recidive Trimodale

	LR	DM
T2	3-4 %	10-27 %
T3-T4	11-16 %	39-50 %

Hautmann, J Urol 2006  
James, NEJM 2012

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# CT Neoadiuvante

STUDIO	N° pz.	CT NEO	TERAPIA	RISULTATI
Nordic Trial Coppin JCO 1996	325	AC x 2	RT	T1-2 : N.S. <b>T3-4 : + 15% OS</b>
EORTC/MRC Lancet 1999 JCO 2011	976	MCV x 3	RT o CHIR.	36% Vs. 30 % OS 27 % Vs. 20 % DFS aa.) (10
Danish Trial Sengelov Acta Oncol. 2002	120	MC x 3	RT	<b>Negativo(- 5.6% OS)</b>
RTOG 89-03 Efsthathiou Eur.Urol.2012	151	MCV x 2	RT + CDDP	<b>N.S. ( 50% Vs. 49 %)</b>
Huddart BJC 2015	94	MVAC x3	RT+ CDDP/FU in CR(88%)	<b>&gt; OS in CR(69% vs 52%)</b>

**TRIMODALE**

**RADIOSENSIBILIZZANTI**



# RT + Gemcitabina

Autore	N.pz.	RT(Gy)	Gem. (mg/mq)	% RC	% OS	% S con vescica conservata
<b>Kent</b> JCO 2004	24	60	10-33 2/Sett. ( racc. 27)	91	78	65
<b>K.S.Oh</b> IJROBP 2009	24	60	10-33 2/sett. (MTD 27)	86	76	62
<b>Caffo</b> Cancer 2011	25	54	200-500 (racc. 400) 1/Sett. +CDDP 100	100	70	73.8
<b>Borut</b> R&O 2012	33	60	75 sett.	80	64	NR
<b>RTOG</b> 0712	IN COR SO					

# RT + Paclitaxel

<b>Autore</b>	<b>N.pz</b>	<b>RT(Gy)</b>	<b>Dose (mg/mq)</b>	<b>% RC</b>	<b>% S</b>	<b>% S con vescica conservata</b>
<b>Nichols Int.Journ. Canc. 2000</b>	<b>8</b>	<b>60</b>	<b>150 sett.+ Carboplatino</b>	<b>100</b>	<b>57 (2 anni )</b>	<b>-</b>
<b>Muller S&amp;O 2007</b>	<b>39</b>	<b>56</b>	<b>20-35 bisett.</b>	<b>65</b>	<b>40 (3 anni )</b>	<b>-</b>
<b>RTOG 99-06 Kaufman Urol.2009</b>	<b>80</b>	<b>64.3 lperfr.</b>	<b>50 sett + CDDP 20 + CT ad.</b>	<b>81</b>	<b>69 (2 anni )</b>	<b>-</b>
<b>Abdel- Wahab Asco 2013</b>	<b>30</b>	<b>64</b>	<b>60 sett. + CDDP 20</b>	<b>90</b>	<b>-</b>	<b>-</b>

# RT Vs RT + 5FU/MITOMICINA C

N° pz.	RT (Gy)	5 FU mg/mq	MIT.C mg/mq	% DFS	% OS
360	55/64	500	12	54 RT 65 CRT	35 RT 48 CRT

**- 50% REC.  
INFILTRANTI**

**BC 2001, James NEJM 2012**

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# Radiosensibilizzazione

Terapia	% RC	% OS	% OS con vescica conservata
RT	57	47	30
RT + CDDP	85	62	40
RT + CDDP +/- FU	87	65	45
RT + Paclitaxel	84	79 ( 2 anni )	69 ( 2 aani )
RT + Gemcitabina	86	76	43
RT + FU/Mit. C		48	

# Adult Urology

## Oncology: Adrenal/Renal/Upper Tract/Bladder

### Combining Mitomycin C and Regional 70 MHz Hyperthermia in Patients with Nonmuscle Invasive Bladder Cancer: A Pilot Study

Elisabeth D. Geijssen,\* Theo M. de Reijke, Caro C. Koning, Paul J. Zum Vörde Sive Vörding, Jean J. de la Rosette,† Coen R. Rasch, Rob M. van Os and Johannes Crezee

*From the Departments of Radiation Oncology and Urology (TMdR, JJdR), Academic Medical Center, Amsterdam, The Netherlands*

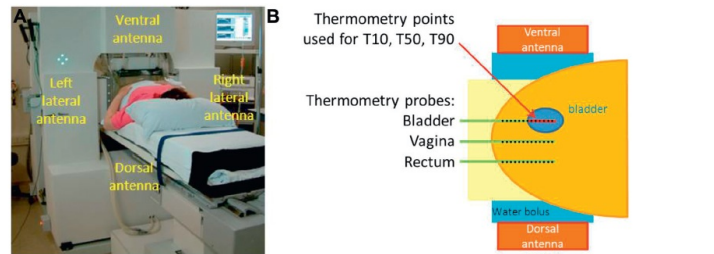


Figure 1. Locoregional 70 MHz hyperthermia using 4-phase array system. A, treatment setup during clinical use. B, schematic of thermometry.

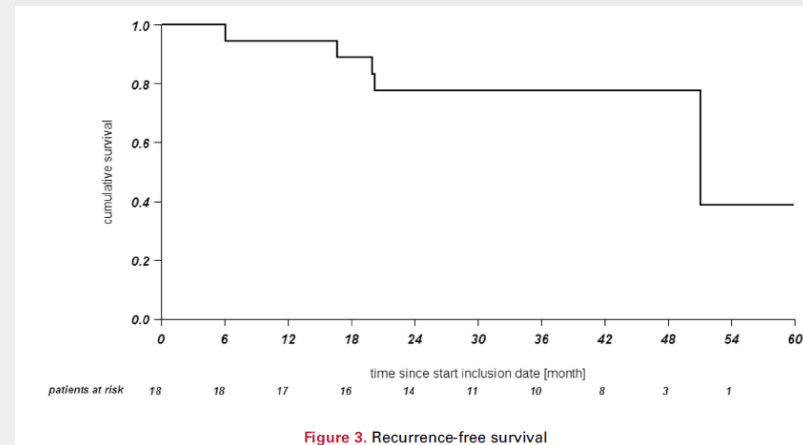


Figure 3. Recurrence-free survival

# FATTORI PROGNOSTICI TRIMODALE

Risposta Completa (dopo induzione o definitiva)

Tumore non visibile alla cistoscopia

Biopsie negative(pT0-pTis-pTa)

Citologico urine negativo

**70 % dei pz.**

# FATTORI PROGNOSTICI PER CR

**T**

	<u>T2</u>	<u>T3-T4</u>
CR	79%	62%
OS	61%	47%
Vescica intatta	57%	35%

R

Rodel JCO 2002

**IDRO  
NE  
FRO  
SI**

	<u>SI</u>	<u>NO</u>
OS	27%	53%
CR	38%	77%

Arcangeli G., Crit Rev Onc Hem 2015

# FATTORI PROGNOSTICI PER CR



	<u>R0</u>	<u>R1-2</u>
OS	64%	54%
RC	74%	63%

Rodel JCO 2002  
Efstathiou Eur Urol 2012  
Mak JCO 2014

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# TURV Radicale

<b>TURV</b>	<b>CISTECTOMIA SALVATAGGIO</b>
<b>RADICALE</b>	<b>22 %</b>
<b>INCOMPLETA</b>	<b>42 %</b>

Efstathiou Eur Urol 2012, Mitin, Curr Urol Rep 2013

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# Prognostic factors in MIBC pts who received RT ± chemotherapy: results from the BC2001 trial

Huddart R. Eur J Cancer 2015;51(S3):S475-6(abs.2507)

## » Multivariable analysis: factors associated with OS

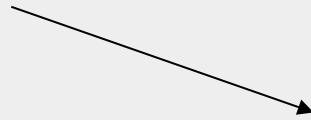
Factor	HR	95% CI	P
Residual mass after resection (yes vs no)	2.09	1.55-2.82	<0.0001
WHO performance status (1-2 vs 0)	1.79	1.32-2.41	<0.0001
Age	1.02	1.00-1.04	0.02

- » Presence of residual mass highly correlated with extent of resection (report urologist performing TURBT)
  - » 96% complete resections without residual mass
  - » 66% incomplete resections with residual mass

Residual mass after resection seems the main prognostic factor for local control and OS in MIBC pts who received RT ± chemotherapy

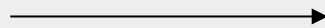
# FATTORI PROGNOSTICI PER CR

✓ Multifocalità



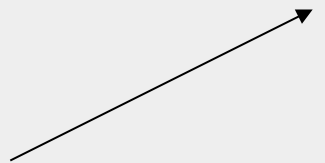
< CR

✓ CIS diffuso



> Recidive

✓ N +



Zietman Urol 2001  
Rodel JCO 2002

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# Fattori Prognostici

## *Erb-2 (Her-2) positivo (50%)*

- ✓ < risposta completa ( 50% Vs. 81% )
- ✓ Attivazione Her-2 = effetto anti-apoptosi =  
radioresistenza (Chakravarti, IJROBP 2005 )
- ✓ Associazione con anticorpi monoclonali  
anti-Her-2 ?( Trastuzumab )

# **Associazione RT/CT: considerazioni finali**

**“ Organ preservation is not for every patients, but for those who are most likely to benefit from this approach“**

# Associazione RT/CT: “ Miglior candidato “

- ✓ Stadio T1(G3)-T2 solitario, N0
- ✓ Turv iniziale completa
- ✓ Assenza di CIS e/o multifocalità
- ✓ Assenza di idronefrosi
- ✓ Erb2 negativi

**20 % dei  
pazienti**

# Trimodality Therapy in Bladder Cancer

## Who, What, and When?



Christopher Premo, MD<sup>a</sup>, Andrea B. Apolo, MD<sup>b</sup>,  
Piyush K. Agarwal, MD<sup>c</sup>, Deborah E. Citrin, MD<sup>a,\*</sup>

### Patient selection for bladder preservation

Preferred or Ideal	Less than Ideal	Relative Contraindications	Absolute Contraindications
T2 No hydronephrosis No CIS Visibly complete TURBT Unifocal tumor Good bladder function and capacity	T3a Incomplete TURBT Multifocal tumor Poor bladder function or capacity	T3b-T4a Diffuse CIS Lymph node positive disease	T4b Tumor-Related Hydronephrosis Prior pelvic radiation therapy Not a candidate for chemotherapy Prostatic stromal invasion

# Associazione RT/CT: “ Miglior risultato “

Turv radicale

```
graph TD; A[Turv radicale] --> B[RT + CT (CDDP+/- 5FU , 5FU/MIT.C, GEM Low dose)]; B --> C[RC]; B --> D[RP/Recidiva]; C --> E[Stretto F. UP]; D --> F[Cistectomia +/- CT adiuvante];
```

RT + CT (CDDP+/- 5FU , 5FU/MIT.C, GEM Low dose )

RC

**Stretto F. UP**

RP/Recidiva

Cistectomia +/- CT adiuvante



# Associazione RT/CT

## Cistectomia di salvataggio

**20-30 %**  
**Persistenza di**  
**malattia**

**20-30 %**  
**Recidive**  
**(7-45 mesi)**

**50 % Ca. superficiali** → **Turv +/- CT e.v.**  
**50% Ca. infiltranti** → **Cistectomia di**  
**salvataggio**

# Cistectomia di salvataggio

“ Potenzialmente curativa”

50% DFS a 5 anni ( 44% a 10 anni)

45 % OS a 5 anni

Rodel 2002, Shipley 2008, Sapre 2012

	<b>CISTECTOMIA IMMEDIATA</b>	<b>CISTECTOMIA SALVATAGGIO</b>
<b>OS</b>	<b>45 %</b>	<b>42 %</b>
<b>DFS</b>	<b>51 %</b>	<b>50 %</b>

**Addla, J Urol 2009; Sapre, J urol 2012**

# Morbidity Chirurgia

	<b>CISTECTOMIA</b>  Aghazadeh J Urol.2011	<b>CISTECTOMIA SALVATAGGIO</b>  Eswara Jr.J Urol 2012 Pietzak EJ Urol 2015
<b>DEGENZA</b>	<b>7-14 GIORNI</b>	
<b>COMPLICANZE NEI 90 GIORNI</b>	<b>27 %</b>	<b>31 %</b>
<b>MORTALITA'</b>	<b>2-6 %</b>	<b>2 %</b>

# Cistectomia di salvataggio

MA.....

**DIFFICILMENTE NEOVESCICA ORTOTOPICA**

**DIFFICILMENTE NERVE SPARING**



**INFORMARE IL PZ.....**

# Trimodale: Qualità di vita

Rif.	N.pz.	RT/CT	% Funz. vescicale buona	% Tox 3+	% Funz. Sessuale buona	FU mediano
Fokdal R&O 04	261	RT	86	-	75	29 mesi
Zietman J Urol 03	71	64.8 Gy/ C	78	8	50	6 anni
Rodel Astro 05	104	54 Gy/ C-CP-F	70	2	-	42 mesi
Efstathiou JCO 12	157	RTOG 8903-9506-970 6-9906	-	7	-	5.4 anni
BC2001 Astro 08	352	RT vs. RT/F-MIT.C	-	3 Vs. 9	-	6 mesi
James NEJM 12	360	64 Gy/ F-MIT.C	-	7	-	36 mesi

## ICUD-EAU International Consultation on Bladder Cancer 2012: Radical Cystectomy and Bladder Preservation for Muscle-Invasive Urothelial Carcinoma of the Bladder

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**Table 8 – Recommendations for radiation-based bladder-preserving strategies**

Treatment/comparison	Evidence	Level of evidence	Grade
Chemoradiotherapy vs RT alone	Two RCTs report significant improvement in bladder tumor eradication.	1b	A
Chemoradiotherapy preserves good bladder function	Three QOL studies and RTOG protocols report good tolerance.	2a	B
Complete TURBT with chemoradiotherapy	Three reports (one phase 3, two phase 2) show benefit.	2a	B
<u>Trimodality therapy vs immediate cystectomy</u>	Comparison of three contemporary series of each treatment report similar 5- and 10-yr survival.	3	C

RT = radiation therapy; RCT = randomized controlled trial; QOL = quality of life; RTOG = Radiation Therapy Oncology Group; TURBT = transurethral resection of bladder tumor.

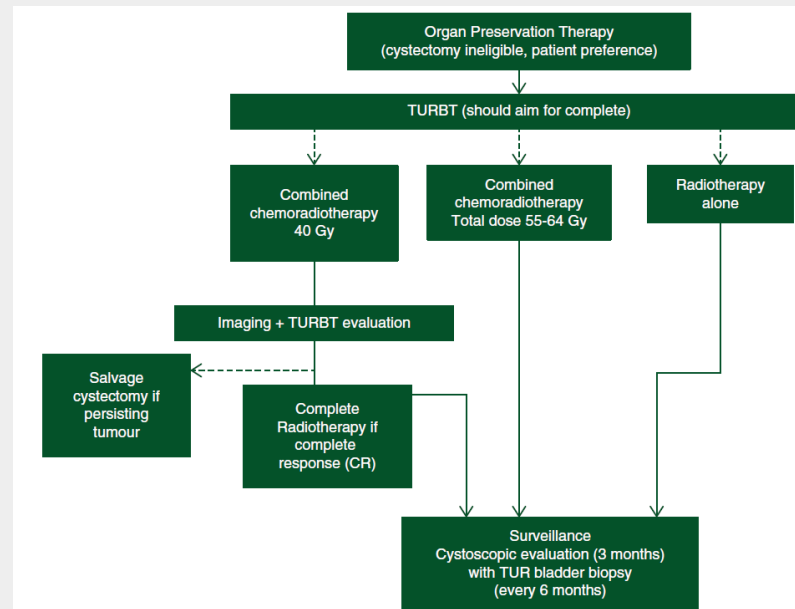
## Bladder cancer: ESMO Practice Guidelines for diagnosis, treatment and follow-up<sup>†</sup>

J. Bellmunt<sup>1,2</sup>, A. Orsola<sup>3</sup>, J. J. Leow<sup>1,2</sup>, T. Wiegel<sup>4</sup>, M. De Santis<sup>5</sup> & A. Horwich<sup>6</sup> on behalf of the ESMO Guidelines Working Group\*

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### organ preservation therapy

The approach of organ preservation therapy for MIBC is a reasonable option for patients seeking an alternative to cystectomy and a palliative option for those who are medically unfit for surgery [III, B]. Contemporary protocols utilise aggressive endoscopic TURBT alone, TURBT plus radiotherapy, TURBT plus chemotherapy or—as the preferred treatment—a tri-modality combination of TURBT plus radiotherapy and chemotherapy.





**NICE** National Institute for  
Health and Care Excellence



# Bladder cancer: diagnosis and management

NICE guideline

Published: 25 February 2015

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PALACONGRESSI - Rimini, 7-10 novembre

## Radical therapy for muscle-invasive urothelial bladder cancer

- Offer a choice of radical cystectomy or radiotherapy with a radiosensitiser to people with muscle-invasive urothelial bladder cancer for whom radical therapy is suitable. Ensure that the choice is based on a full discussion between the person and a urologist who performs radical cystectomy, a clinical oncologist and a clinical nurse specialist. Include in the discussion:
  - the prognosis with or without treatment
  - the limited evidence about whether surgery or radiotherapy with a radiosensitiser is the most effective cancer treatment
  - the benefits and risks of surgery and radiotherapy with a radiosensitiser, including the impact on sexual and bowel function and the risk of death as a result of the treatment.



## Linee guida

# CARCINOMA DELLA VESCICA

Edizione 2014

**Coordinatore:** Cora N. Sternberg

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**Referee AIRO** Marco Orsatti  
**Referee SIU** Vincenzo Serretta

Qualità dell'evidenza SIGN	Raccomandazione clinica	Forza della raccomandazione clinica
<b>D</b>	I pazienti non candidati a cistectomia radicale o che rifiutano il trattamento chirurgico, con neoplasia singola, assenza di idronefrosi e sottoposti TUR completa della neoplasia, possono essere trattati con radio-chemioterapia concomitante	<b>Positiva debole</b>
<b>A</b>	I pazienti non candidati a cistectomia radicale né a trattamento con cisplatino o che rifiutano il trattamento chirurgico, con neoplasia singola, assenza di idronefrosi e sottoposti TUR completa della neoplasia, possono essere trattati con radio-chemioterapia concomitante con schemi senza cisplatino	<b>Positiva debole</b>

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E D I T O R I A L

## Organ-Sparing Multimodality Treatment for Muscle-Invasive Bladder Cancer: Can We Continue to Ignore the Evidence?

Claus Rödel and Christian Weiss, *Goethe-University Frankfurt am Main, Frankfurt am Main, Germany*

See accompanying article on page 3801

available at [www.sciencedirect.com](http://www.sciencedirect.com)  
journal homepage: [www.europeanurology.com](http://www.europeanurology.com)



European Association of Urology



### Platinum Priority – Editorial

*Referring to the article published on pp. 823–829 of this issue*

## Radical Locoregional Therapy for Bladder Cancer: Underutilized, or Unsuitable in Many?

*Peter C. Black\**

*Department of Urologic Sciences, University of British Columbia, Vancouver, BC, Canada*

## Muscle-invasive bladder cancer: evaluating treatment and survival in the National Cancer Data Base

Angela B. Smith\*<sup>1</sup>, Allison M. Deal<sup>1†</sup>, Michael E. Woods\*<sup>†</sup>, Eric M. Wallen\*<sup>†</sup>, Raj S. Pruthi\*<sup>†</sup>, Ronald C. Chen<sup>†§</sup>, Matthew I. Milowsky<sup>†¶</sup> and Matthew E. Nielsen\*<sup>†¶\*\*</sup>

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months). When controlling for multiple covariates, the OS for cystectomy was similar to that for chemo-radiation (hazard ratio [HR] 1.05, 95% confidence interval [CI] 0.98, 1.12), but superior to other therapy (HR 1.42; 95% CI 1.35, 1.48), and no treatment (HR 2.40; 95% CI 2.12, 2.72). The OS time for chemo-radiation was superior to other therapy and no treatment.





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ORIGINAL ARTICLE

## Urinary bladder preservation for muscle-invasive bladder cancer: a survey among radiation oncologists of Lombardy, Italy

Barbara Alicja Jereczek-Fossa<sup>1,2</sup>, Renzo Colombo<sup>3</sup>, Tiziana Magnani<sup>4</sup>, Cristiana Fodor<sup>1</sup>, Marianna Alessandra Gerardi<sup>1,2</sup>, Paolo Antognoni<sup>5</sup>, Lucia Barsacchi<sup>6</sup>, Nice Bedini<sup>4</sup>, Stefano Bracelli<sup>7</sup>, Alberto Buffoli<sup>8</sup>, Emanuela Cagna<sup>6</sup>, Gianpiero Catalano<sup>9</sup>, Stefania Gottardo<sup>2,5</sup>, Corrado Italia<sup>10</sup>, Giovanni Battista Ivaldi<sup>11</sup>, Stefano Masciullo<sup>10</sup>, Anna Merlotti<sup>7</sup>, Enrico Sarti<sup>12</sup>, Marta Scorsetti<sup>13</sup>, Flavia Serafini<sup>6</sup>, Mariasole Toninelli<sup>8</sup>, Elisabetta Vitali<sup>12</sup>, Riccardo Valdagni<sup>4</sup>, Elisa Villa<sup>13</sup>, Dario Zerini<sup>1</sup>, Ottavio De Cobelli<sup>1,2</sup>, Roberto Orecchia<sup>1,2,14</sup>; on behalf of the Lombardy Oncological Network (Rete Oncologica Lombarda, ROL) and the Lombardy Section of the Italian Society of Oncological Radiotherapy (Associazione Italiana di Radioterapia Oncologica-Lombardia, AIRO-L)

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**Results:** Thirteen centers (41%) answered the survey; the presented data come from 11 active centers. In these centers, 11,748 patients were treated with external-beam radiotherapy in 2012, 100 of whom having bladder cancer (0.9%). 74/100 patients received radiotherapy as palliative treatment for T, N or M lesions. A further 9 and 5 patients received radiotherapy for oligometastatic disease (ablative doses to small volumes) and postoperatively, respectively. Bladder preservation was performed in 12 cases and included trimodality and other strategies (mainly TURBT followed by radiotherapy). A multidisciplinary urology tumor board met regularly in 5 of 11 centers. All responders declared their interest in the Lombardy multicenter collaboration on bladder preservation.

**Conclusions:** Our survey showed that bladder preservation is rarely used in Lombardy despite the availability of the latest radiotherapy technologies and the presence of an urology tumor board in half of the centers. The initiative of multicenter and multidisciplinary collaboration was undertaken to prepare the platform for bladder preservation as a treatment option in selected patients.

# Pazienti in Trimodale

UK	60 %
USA	10 %
ITALIA*	1 %

Munro, IJROBP 2010

\*Dati AIRO 2014

**Gruppo Multidisciplinare**

**Uro-Oncologico**

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