Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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European Association of Urology

Platinum Priority – Editorial

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Bladder Cancer Guidelines: Let Not the Cure Be Worse than the Disease

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The European Association of Urology (EAU) guidelines for the treatment of bladder cancer have over the years become the de facto standard consulted by more practitioners than any other guideline document. Why is this? My sense is that it is because, unhindered by the legalese that encumbers other guidelines committees, the EAU is able to list, in a succinct and definitive manner and based on an expert review of the latest data, what the expert panel believes is in the best interest of a wide group of patients. An immediate example that comes to mind is in the non–muscle-invasive bladder cancer (NMIBC) guidelines [1], in which the EAU clearly demarcates the risk categories into low and high, with all high-grade tumors falling into the high risk category, all low-grade tumors falling into the low risk category, and everything else in between. This prognostically relevant, yet relatively simple classification has led to the EAU risk stratification being adopted by most investigators in the design of clinical trials over other guidelines that are more complex, without obvious rationale [2].

The EUA guidelines on muscle-invasive and metastatic bladder cancer, as summarized by Witjes et al [3] in this issue of *European Urology*, continue in that tradition, with clear, well-defined recommendations.

However, as I write this editorial, we are in the throes of a global COVID-19 epidemic, with 1 853 297 total confirmed cases and 114 122 patients having succumbed to the disease by April 12, 2020 [4]. Several countries are in near total lockdown, and access to health care has been severely limited for our patients. To provide some guidance to our patients, the Bladder Cancer Advocacy Network has put together a frequently asked questions section on the website [5]. In addition, various groups have turned to social media to disseminate information about risk-stratified triaging of patients for appropriate care in the setting of limited access to surgical suites, chemotherapy units, and radiation oncology centers.

So with this in mind, what do I think about guidelines? First and foremost, we must remember this: we are partners with our patients in their journey towards cure, and cure entails not only treatment of their bladder cancer but also attention to their unique situations. Moreover, as always, treatments must be individualized to the unique personal situations that patients—and we—find ourselves faced with.

Towards this end, I would make the following modifications to the guidelines as stated in the manuscript, adopted in part from various collaborative efforts I have been part of to address these very questions.

First, as mentioned, accurate risk stratification of patients with advanced bladder cancer must be undertaken with well-performed transurethral resection/biopsy, a review of all aspects of the pathology including histologic variants, and the use of appropriate staging modalities.

The guidelines state that radical cystectomy with lymph node dissection remains the recommended treatment in highest-risk NMIBC and all MIBC, preceded by cisplatin-based neoadjuvant chemotherapy (NAC) for invasive tumors in “fit” patients. During these times, we must make it a point to remember that delays beyond 12 wk (from time of diagnosis or end of NAC) are generally not considered oncologically safe. At the same time, the risk of immunosuppression with NAC must be weighed against the average 5–9% benefit for most patients. In addition, in some centers, if the radiation units are separate and distinct from the main hospital, then radiation therapy—which is listed as an

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alternative—might actually be the preferred option to long delays to surgery.

For fit patients with metastatic disease, cisplatin-based chemotherapy remains the first choice and, even in times of COVID-19, should not be stopped without justification. In cisplatin-ineligible patients who are PD-L1–positive, immunotherapy is recommended and there is no evidence to suggest this should be modified in the current environment. For second-line treatment in metastatic disease, pembrolizumab is recommended by the guidelines, which is appropriate, since most clinical trials examining other strategies have been halted, with resources diverted towards dealing with the current pandemic.

In summary, the recommendations made in the guidelines remain valid not only during "normal times" but also during the current COVID-19 pandemic. Cutting corners is not an option for any disease but especially not for one as time-sensitive and potentially deadly as bladder cancer. Moreover, if not administered in a timely, appropriate manner, the therapy often fails (eg, surgery performed when the tumor has progressed to node-positive disease due to delays), yet still leads to toxicity in many. To paraphrase a world leader: Let not the cure be worse than the disease.

Conflicts of interest: The author is a scientific advisory board member for Merck, president of the International Bladder Cancer Group, and a scientific advisory board member for the Bladder Cancer Advocacy Network.

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