

## EDITORIAL

# Local solutions to shorten treatment delays in bladder cancer. Results of a survey among CEJU authors

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Several months ago, I asked urologists who contribute to Central European Journal of Urology (CEJU) what methods are used in their centers to shorten the waiting time of patients suspected of having bladder cancer. The path a patient with painless hematuria takes to reach a urologist can be lengthy and challenging. The duration often depends on the patient themselves and the structure of the primary care system. However, the question that looms large is how much influence urologists can wield to improve the chances of survival for these patients by streamlining the process within their institutions.

The survey encompassed the following key inquiries:

1. Do you have and use procedures to facilitate quick urological consultation of a patient referred by a GP with a suspicion of a primary bladder tumor or with gross painless hematuria?
2. Does a patient with a primary bladder tumor confirmed by imaging or cystoscopy have an earlier hospitalization date compared to other patients awaiting surgery?
3. Do you use rapid pathology procedures? What kind if any?

4. Does neoadjuvant chemotherapy or cystectomy take place immediately after the histopathology result is available?

A total of 118 urologists from 31 countries responded to over 900 invitations. More than 3 responses came from the following countries: Egypt, Greece, India, Italy, Poland, Spain, Turkey, Ukraine. Notably, the majority of the responses (92%) came from urologists affiliated with academic hospitals, which is not surprising considering the group selected for the study. Scientific analysis of the responses was challenging due to the wide range of response types, from simple "yes/no" answers to short essays. Consequently, I will endeavor to provide a summary of my impressions and offer insights based on the 118 answers.

In most of the 31 countries, there appear to be no consistent systemic solutions to expedite the transition to subsequent stages of the procedure. Some fast-track systems for managing suspected neoplasms are implemented by national institutions in the UK, Norway, or Poland. These systems impose specific timeframes for waiting for a consultation, diagnosis, and treatment implementation. However, these timeframes are typically universal procedures

**Table 1.** Three responses chosen as examples of three types of approach of centers to patients with hematuria or suspected bladder tumor

Procedure	Waiting time		
	No priority scenario	High priority scenario	No waiting time scenario
First consultation (Imaging +/- cystoscopy)	No priority at waiting lists. Exact waiting time not specified – assumed 2 months.	Cystoscopy and US within 2 weeks of registration	Immediate initial diagnosis
TURBT	“Less than three months” – assumed 2 months	2 weeks	2 weeks
Pathology	2 weeks	7–10 days	2–7 days
Multidisciplinary team meeting Start of MIBC therapy (neo-CTX or RC)	6 weeks	6–8 weeks	maximum of 4 weeks
<b>Total time</b>	6 months	3 months	2 months

TURBT – transurethral resection of bladder tumor; MIBC – muscle-invasive bladder cancer; neo-CTX – neoadjuvant chemotherapy; RC – radical cystectomy; US – ultrasound

for all cancers and may not necessarily reduce wait times for aggressive urothelial cancer or be widely adopted.

The lack of systemic solutions does not imply their absence. Quite the opposite, 78% of urologists responded positively to the first question, and 85% claimed that they prioritize bladder cancer patients for surgery. Different centers have adopted various methods to facilitate access and expedite the diagnostic process. The most common methods described by respondents include:

- Hematuria clinic with same-day cystoscopy and ultrasound
- Immediate diagnostics at the emergency department
- Fast-track outpatient management within 1–2 weeks from registration
- All procedures and consultations conducted without delays
- High priority code for all consultations and diagnostics
- Multiple communication channels for patients with symptoms to register for consultations.

Various patient management scenarios shared by colleagues lead to significant differences in the overall time from presentation to cystectomy (Table 1).

While many centers prioritize expediency for oncology patients, there is often no specific preference for bladder cancer patients. Oncology hospitals have a unique dynamic as all patients there are treated with equal urgency, which may occasionally lead to longer waiting periods than in multi-specialty hospitals. However, some oncology hospitals still exhibit variations in waiting times based on the diagnosis.

The most significant disparities in time are typically associated with the initial patient registration and examination phase. Following the determination of the need for transurethral resection of bladder tu-

mor (TURBT) the waiting time for the procedure varies from several days to three months, although most responses indicated a wait of less than four weeks. The waiting time for pathology results varies from 2 days to 4 weeks, and the waiting time for cystectomy ranges from 2 weeks to 2 months. Some centers experience longer waiting times for robotic surgery.

Unfortunately, centers that do not prioritize bladder cancer patients at one stage typically exhibit delays at other stages as well, resulting in a large cumulative delay compared to better-organized hospitals.

The European Urological Association Guidelines (EAU) state that cystectomy should not be delayed by more than 3 months [1], based on a meta-analysis from 2020 [2]. Interestingly, the authors of that analysis found that delays were calculated in various ways in the studies, preventing a specific safe delay recommendation. Their pooled analysis of heterogeneous studies led them to conclude that a "delay in radical cystectomy after diagnosis was found to have a significantly detrimental effect on overall survival for bladder cancer patients." Looking at studies included in the analysis, it appears that a 3-month delay was taken from studies that were looking at the time period between TURBT and cystectomy. None of the survey respondents reported longer than a "3-month period" from TURBT to cystectomy, suggesting that we interpret the EAU recommendation on cystectomy delay in this way.

In conclusion, the diversity of responses, even within the same healthcare systems, underscores that there are no legal obstacles to expediting procedures. The responsibility for implementing effective procedures typically rests with the hospital and urology center. The implementation of fast-track processes for bladder cancer patients at each stage can potentially reduce the overall process duration by up to three months, compared to the extended times

seen in busy hospitals with lengthy waiting lists. Reducing delays in the initial stages of care may allow more time to properly prepare patients for major surgery. For some, risk factors are modifiable [3, 4].

The disparities revealed in this simple survey emphasize the significant impact that the organization

of the diagnostic and therapeutic process within a center can have on the outcomes of bladder cancer treatment.

#### CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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