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Standard Operating Procedure (SOP) for Triage of Bladder Cancer Patients to Fast-Tracked TURBT

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Title of paper	Standard Operating Procedure (SOP) for Triage of Bladder Cancer Patients to Fast Tracked TURBT
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Purpose of the paper	To support the process of identifying, triaging and prioritising patients with newly diagnosed suspected bladder cancer for urgent Transurethral Resection of Bladder Tumour (TURBT).
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Triage of Bladder Cancer Patients to Fast-Tracked TURBT

1. Purpose

This SOP outlines the process for identifying and triaging patients with newly diagnosed suspected bladder cancer for urgent Transurethral Resection of Bladder Tumour (TURBT) within a 10-day target.

2. Scope
This SOP applies to all urology healthcare professionals, including urologists, urology nurse specialists, and administrative staff responsible for scheduling procedures.

3. **Criteria for Fast-Tracked TURBT**
Patients should be referred for urgent TURBT if they meet any of the following criteria identified during flexible cystoscopy:

- **Large tumours**: Tumours estimated to be ≥5 cm in diameter.
- **Invasive-looking tumours**: Tumours with suspicious features such as irregular borders, sessile morphology, or deep muscle invasion appearance.

Patients who do not meet this criteria (but have a bladder tumour) should be referred for TURBT in the usual fashion, aiming to be performed within 31 days of flexible cystoscopy and the 62 days of referral as per existing cancer waiting time targets.

Patients who have been referred for normal priority TURBT should have a CT urogram (if not performed prior to diagnostic flexible cystoscopy) and this imaging reviewed before finalising the prioritisation. If the following criteria are present then the priority should be adjusted and fast tracked:

- **Invasive features identified on CT:** Radiology reports suggesting invasive bladder cancer
- **Tumours documented to be >5cm:** Radiology reports documenting tumours as >5cm in size
- **Hydronephrosis**: Presence of hydronephrosis on imaging, suggesting potential upper tract obstruction due to bladder tumour involvement.
- **Metastatic disease:** in patients who would be eligible systemic treatment

4. **4. Process for Fast-Tracking TURBT**

1. **Identification During Flexible Cystoscopy**

- If a patient meets any of the above criteria during flexible cystoscopy, the finding should be immediately documented in the patient record.
- The clinician performing the cystoscopy should inform the patient of the need for fast tracked TURBT and the diagnosis of bladder cancer.

2. **Urgent Referral Entry**
    - A referral should be placed in the urology fast-track TURBT pathway, clearly indicating the reason for expedited surgery. Although the mechanism may vary between trusts, this could include specific TURBT listing forms, clinician access to live theatre listings scheduling software or regular clinican input into the weekly cancer patient tracking list (PTL) meetings.
    - Radiological staging (CT Urogram or MRI if needed) should be requested urgently if not already performed. MRI should be considered in patients where the TURBT is likely to understage the bladder cancer, this may include very large tumours where complete resection in one TURBT is unlikely, patients with a higher bleeding risk (where TURBT may be limited) or patients with a higher risk of perforation during TURBT. However, this should not delay performing TURBT.
3. **Coordination with Scheduling Team**
    - The urology scheduling team should be notified immediately, and efforts made to book TURBT within 10 days.
    - If operating theatre capacity is limited, priority should be given based on clinical urgency, with alternative arrangements considered if necessary. This will usually be to move normal priority TURBT later to allow fast tracked TURBT to take place.
    - Each trust should have a nominated consultant with an interest in bladder cancer who can act as a point of contact for scheduling teams to clarify the clinical appropriateness of rescheduling patients waiting for TURBT.
4. **Preoperative Preparation**
    - The patient should be assessed for fitness for anesthesia and surgery as per standard preoperative protocols.
    - Necessary preoperative tests (FBC, U&Es, clotting profile, MSU) should be expedited and performed at the same time as flexible cystoscopy where possible.
    - Informed consent should be obtained with a discussion of risks, benefits, and potential need for further treatment (e.g., re-resection, intravesical therapy, or radical treatment in case of muscle-invasive disease).
5. Monitoring

- Data will be reporting alongside cancer waiting time data at the urology pathway board. This will include raw counts of days on pathway for patients with newly diagnosed TURBT at 0-10, 11-20, 21-30, 31-40, 41-50, 51-62 and 63 + stratified by treating trust.

Appendix

? Standardised Listing Form

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