13as JORNADAS DE UROLOGIA
DA ZONA CENTRO EM MEDICINA FAMILIAR

Diagnóstico e Seguimento em Oncologia Urológica

- Bexiga -

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Epidemiologia

- 11º Carcinoma mais comum
- 9,0 por 100,000 homens e 2,2 por 100.000 mulheres
- M:F = 4:1
- Mortalidade: Homens: 3,2 por 100,000

  Mulheres: 0,9 por 100,000
- Apresentação: Músculo-invasivos: 20%

  Não músculo-invasivos: 80%

Estimated New Cases

			Males	Females			
Prostate	180,890	21%			Breast	246,660	29%
Lung & bronchus	117,920	14%			Lung & bronchus	106,470	13%
Colon & rectum	70,820	8%			Colon & rectum	63,670	8%
Urinary bladder	58,950	7%			Uterine corpus	60,050	7%
Melanoma of the skin	46,870	6%			Thyroid	49,350	6%
Non-Hodgkin lymphoma	40,170	5%			Non-Hodgkin lymphoma	32,410	4%
Kidney & renal pelvis	39,650	5%			Melanoma of the skin	29,510	3%
Oral cavity & pharynx	34,780	4%			Leukemia	26,050	3%
Leukemia	34,090	4%			Pancreas	25,400	3%
Liver & intrahepatic bile duct	28,410	3%			Kidney & renal pelvis	23,050	3%
All Sites	**841,390**	**100%**			**All Sites**	**843,820**	**100%**

Estimated Deaths

			Males	Females			
Lung & bronchus	85,920	27%			Lung & bronchus	72,160	26%
Prostate	26,120	8%			Breast	40,450	14%
Colon & rectum	26,020	8%			Colon & rectum	23,170	8%
Pancreas	21,450	7%			Pancreas	20,330	7%
Liver & intrahepatic bile duct	18,280	6%			Ovary	14,240	5%
Leukemia	14,130	4%			Uterine corpus	10,470	4%
Esophagus	12,720	4%			Leukemia	10,270	4%
Urinary bladder	11,820	4%			Liver & intrahepatic bile duct	8,890	3%
Non-Hodgkin lymphoma	11,520	4%			Non-Hodgkin lymphoma	8,630	3%
Brain & other nervous system	9,440	3%			Brain & other nervous system	6,610	2%
All Sites	**314,290**	**100%**			**All Sites**	**281,400**	**100%**

FIGURE 1. Ten Leading Cancer Types for the Estimated New Cancer Cases and Deaths by Sex, United States, 2016.
Estimates are rounded to the nearest 10 and cases exclude basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder.

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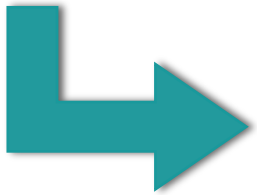
Como diagnosticar?

Não há rastreio para o carcinoma da bexiga.

Diagnóstico é feito na maior parte das vezes pelos sintomas



Importância dos cuidados primários

Como diagnosticar?

RESEARCH ARTICLE Open Access

Time intervals from first symptom to treatment of cancer: a cohort study of 2,212 newly diagnosed cancer patients

Rikke P Hansen[1,2*], Peter Vedsted[1,2], Ineta Sokolowski[3], Jens Søndergaard[4] and Frede Olesen[3]

Abstract

Background: Delay in diagnosis of cancer may worsen prognosis. The aim of this study is to explore patient-, general practitioner (GP)- and system-related delay in the interval from first cancer symptom to diagnosis and treatment, and to analyse the extent to which delays differ by cancer type.

Methods: Population-based cohort study conducted in 2004-05 in the County of Aarhus, Denmark (640,000 inhabitants). Data were collected from administrative registries and questionnaires completed by GPs on 2,212 cancer patients newly diagnosed during a 1-year period. Median delay (in days) with interquartile interval (IQI) was the main outcome measure.

Results: Median total delay was 98 days (IQI 57-168). Most of the total delay stemmed from patient (median 21 days (7-56)) and system delay (median 55 days (32-93)). Median GP delay was 0 (0-2) days. Total delay was shortest among patients with ovarian (median 60 days (45-112)) and breast cancer (median 65 days (39-106)) and longest among patients with prostate (median 130 days (89-254)) and bladder cancer (median 134 days (93-181)).

Conclusion: System delay accounted for a substantial part of the total delay experienced by cancer patients. This points to a need for shortening clinical pathways if possible. A long patient delay calls for research into patient awareness of cancer. For all delay components, special focus should be given to the 4th quartile of patients with the longest time intervals and we need research into the quality of the diagnostic work-up process. We found large variations in delay for different types of cancer. Improvements should therefore target both the population at large and the specific needs associated with individual cancer types and their symptoms.

Hansen et al. BMC Health Services Research 2011, 11:284

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Table 2 Delay (in days) for all and the 10 most frequent cancers in the study when the GP was involved in the diagnostic investigation process

	Total delay			Patient delay			GP delay			System delay																	
										Total system delay			System delay in primary health care			System delay in secondary health care									System delay in secondary health care (GP not involved)		
																System delay in secondary health care			Diagnostic delay in secondary health care			Treatment delay					
Cancer type (Cancer cases, GP involved/Cancer cases, GP not involved)	N	Median	IQI*	N	Median	IQI	N	Median	IQI	N	Median	IQI	N	Median	IQI	N	Median	IQI	N	Median	IQI	N	Median	IQI	N	Median	IQI
All cancers (1892/320)	936	98	57-168	1237	21	7-56	1877	0	0-2	1422	55	32-93	1874	0	0-12	1412	46	26-78	1823	29	14-57	1403	14	0-28	174	37	17-63
Breast cancer (291/20)	159	65	39-106	168	14	0-56	289	0	0-0	269	40	25-59	287	0	0-0	268	37	22-51	281	21	13-36	266	12	4-20	10	29	23-38
Colorectal cancer (254/37)	159	109	65-194	187	28	14-56	254	0	0-6	212	56	34-87	254	0	0-10	216	48	28-71	251	30	15-50	215	14	0-28	24	15	3-30
Lung cancer (253/75)	128	108	82-167	182	28	7-56	251	0	0-9	182	69	47-96	250	7	0-18	181	55	36-79	246	27	14-46	182	23	8-36	40	51	27-76
Prostate cancer (190/24)	73	130	89-254	110	28	0-112	186	0	0-6	117	102	55-151	187	6	0-18	115	75	44-135	183	80	44-110	114	9	0-29	16	83	48-139
Melanoma (122/9)	38	114	79-279	40	70	28-196	122	0	0-0	114	39	22-65	122	0	0-15	112	27	15-54	117	20	0-42	110	13	0-23	1	49	
Bladder cancer (73/7)	32	134	93-181	52	14	0-28	72	0	0-10	43	91	52-119	71	2	0-19	42	80	45-113	68	62	35-87	43	0	0-20	4	51	22-75
Non-Hodgkin's lymphoma (54/11)	29	78	58-118	43	21	7-42	53	0	0-3	34	60	44-86	54	2	0-14	34	55	39-73	51	36	14-68	34	12	5-29	4	38	33-51
Pancreas cancer (54/9)	21	87	49-153	40	14	7-42	53	0	0-6	28	63	27-117	54	0	0-15	28	59	25-91	51	27	11-68	27	14	0-41	5	15	10-50
Ovarian cancer (47/12)	32	60	45-112	38	21	0-35	47	0	0-2	40	30	21-49	47	0	0-8	40	26	20-43	45	21	12-31	39	1	0-21	9	40	20-62
Corpus uteri cancer (41/6)	35	99	51-22	35	21	0-140	41	0	0-0	41	64	41-106	41	0	0-1	41	60	32-101	39	38	23-79	39	7	0-14	3	59	28-77
Others (513/110)	233	96	56-178	342	21	7-56	509	0	0-6	338	63	35-110	507	0	0-11	335	52	29-93	491	27	12-55	334	17	0-34	58	32	13-62

N in each column is the number of answers with complete data. Last column shows system delay in secondary health care when the GP was not involved in the diagnostic investigation process

*IQI = interquartile interval

Como diagnosticar?

Research

Elizabeth A Shephard, Sally Stapley, Richard D Neal, Peter Rose, Fiona M Walter and William T Hamilton

Clinical features of bladder cancer in primary care

Table 2. Clinical features of bladder cancer (all ages)

Feature	Cases, *n* [%] *n* = 4915	Controls, *n* [%] *n* = 21 718	LR[a] [95% CI]	OR[b] [95% CI]
Symptoms				
Visible haematuria	2595 [53]	196 [1]	59 [51 to 67]	34 [29 to 41]
Dysuria	444 [9]	209 [1]	9.4 [8.0 to 11]	4.1 [3.4 to 5.0]
Abdominal pain	358 [7]	787 [4]	2.0 [1.8 to 2.3]	2.0 [1.6 to 2.4]
Constipation	286 [6]	708 [3]	1.8 [1.6 to 2.0]	1.5 [1.2 to 1.9]
Disease				
Urinary tract infection	835 [17]	705 [3]	5.2 [4.8 to 5.8]	2.2 [2.0 to 2.5]
Investigations				
Raised creatinine	660 [13]	1668 [8]	1.8 [1.6 to 1.9]	1.3 [1.2 to 1.4]
Raised inflammatory markers	293 [6]	717 [3]	1.8 [1.6 to 2.1]	1.5 [1.2 to 1.9]
Raised white blood cell count	250 [5]	401 [2]	2.8 [2.4 to 3.2]	2.1 [1.6 to 2.8]

[a]The univariate likelihood ratio, showing the likelihood of having a specific feature in a patient with bladder cancer, compared with the likelihood of having it in a patient without cancer. [b]In multivariate conditional logistic regression, containing all eight variables. LR = likelihood ratio. OR odds ratio.

British Journal of General Practice 2012

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Como diagnosticar?

Hematúria macroscópica

Nos adultos deve ser considerado sintoma de doença urológica maligna até prova em contrário.

Neoplasia vesical é a principal causa de hematúria em adultos com > 50 anos.

Avaliação urológica

Como diagnosticar?

Factores de risco:

(1) Tabaco

(2) Exposição ocupacional

(3) Radioterapia pélvica

(4) Fármacos (ciclofosfamida; pioglitazona)

(5) Infecção/inflamação crónica do aparelho urinário (Schistosomíase)

(6) Predisposição genética

Como diagnosticar?

Factores de risco:

Tabaco

(1) 50% dos casos

(2) Carga tabágica

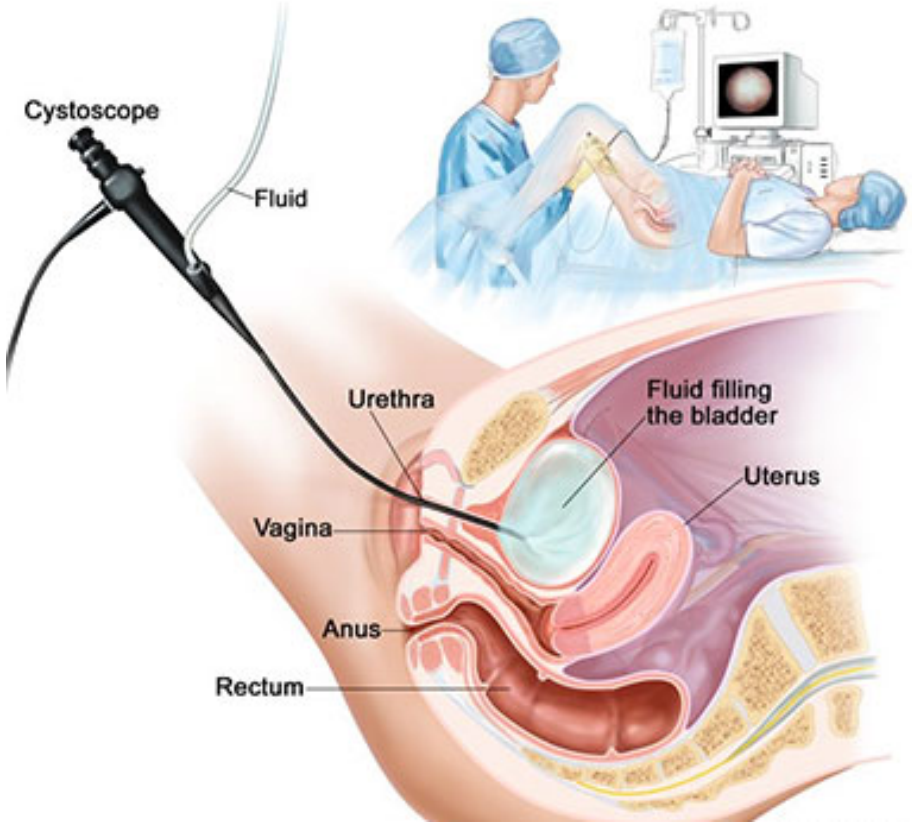
(3) Diminuição imediata do risco naqueles que deixam de fumar

(4) Aminas aromáticas (carcinogénio urotelial)

(5) Exposição passiva (principalmente in utero, amamentação e infância) aumenta o risco de tumor da bexiga em 40%

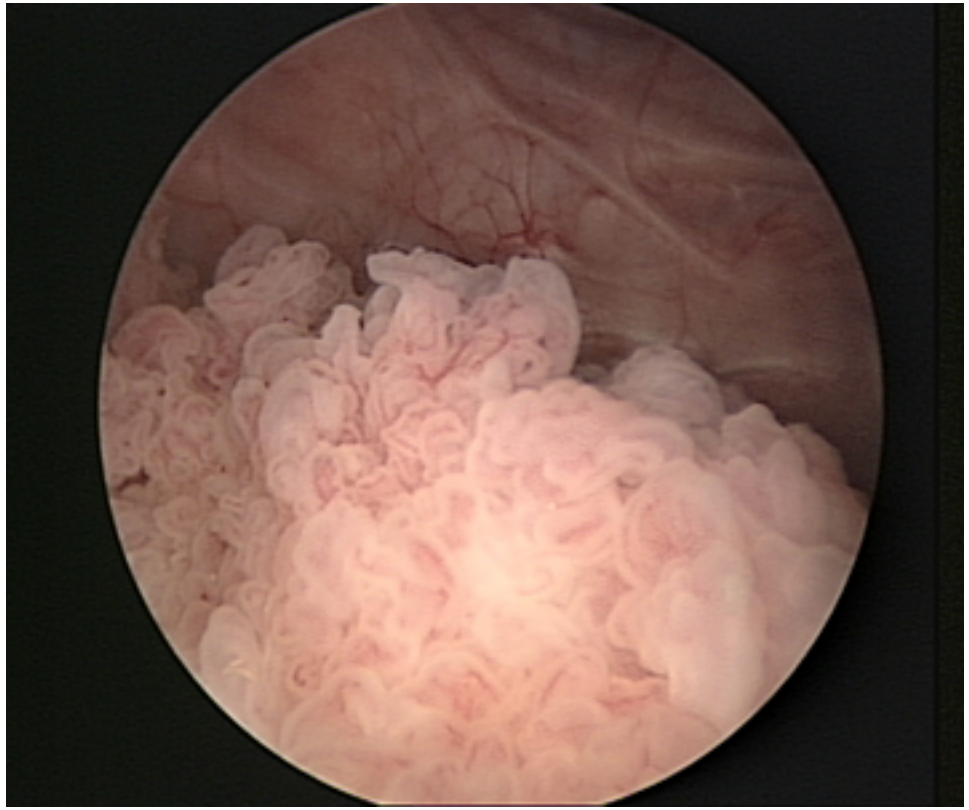
Como diagnosticar?

- Confirmação de neoplasia vesical por **<u>cistoscopia diagnóstica</u>**



Como diagnosticar?

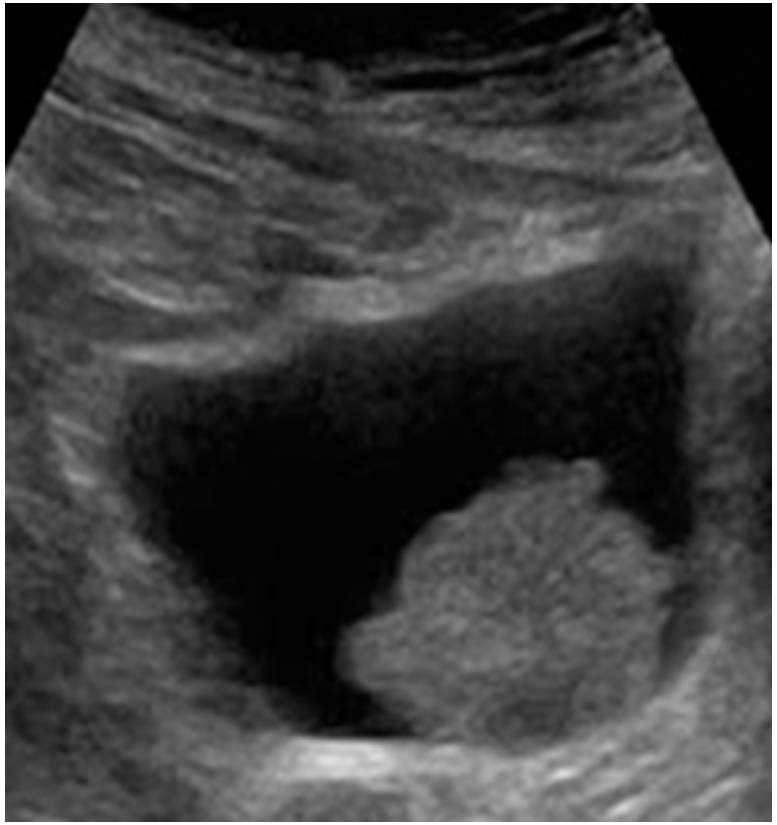
- Confirmação de neoplasia vesical por **cistoscopia diagnóstica**



Cirurgia

Como diagnosticar?

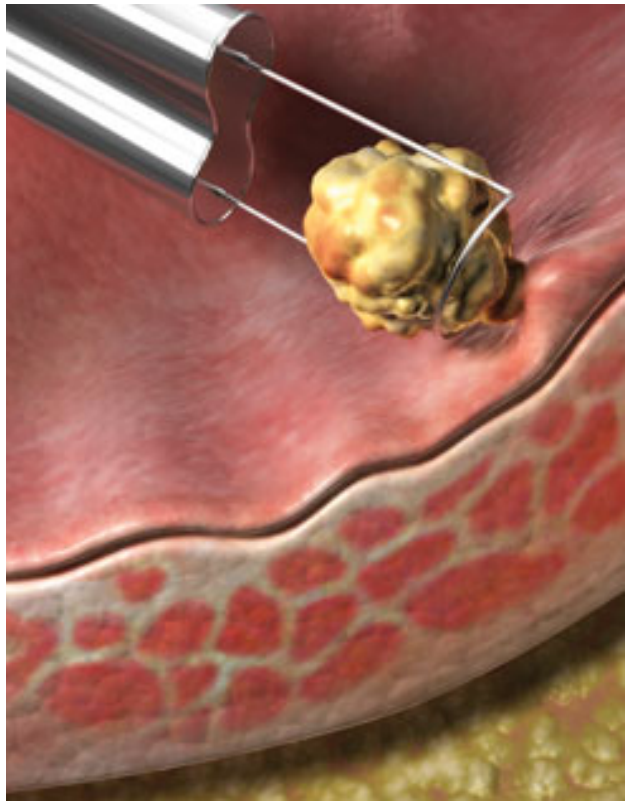
- Papel da ecografia vesical e citologia urinária

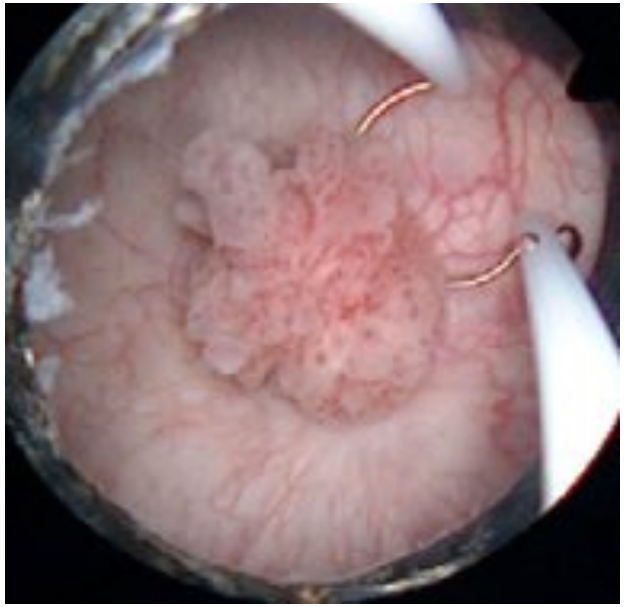


- Pouco sensíveis
- Exames negativos não excluem tumor
- Podem atrasar diagnóstico

Tratamento

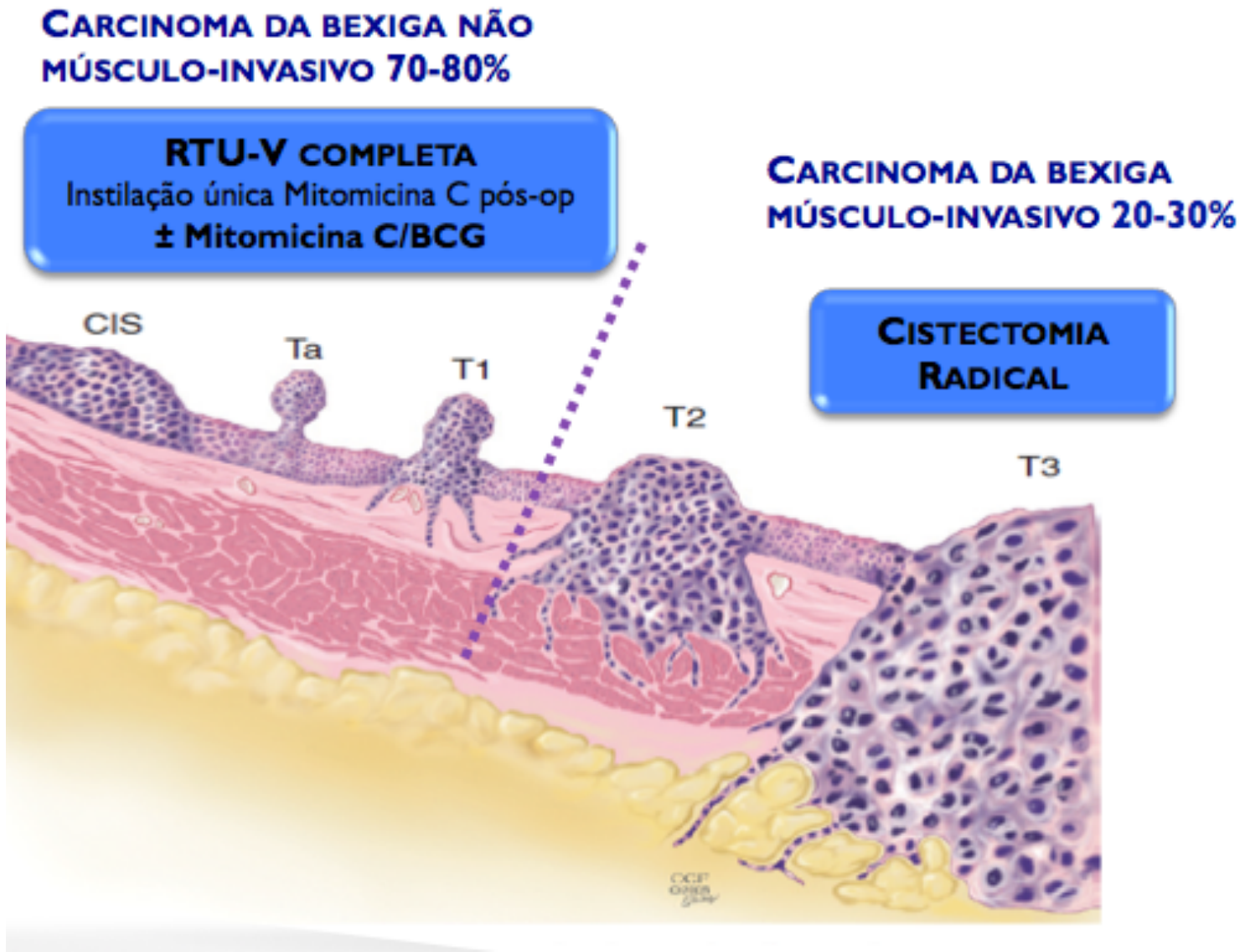
- Ressecção transuretral da bexiga – RTU-v





Tratamento

- Depende da histologia
- Vigilância vs nova cirurgia
- Terapia intravesical
- Controlo endoscópico



Tratamento

- Doença músculo-invasiva:
  - condição altamente letal
  - se não tratada → mortalidade de 85% aos 2 anos
  - várias opções terapêuticas:

1. Cistoprostatectomia radical / exenteração pélvica anterior

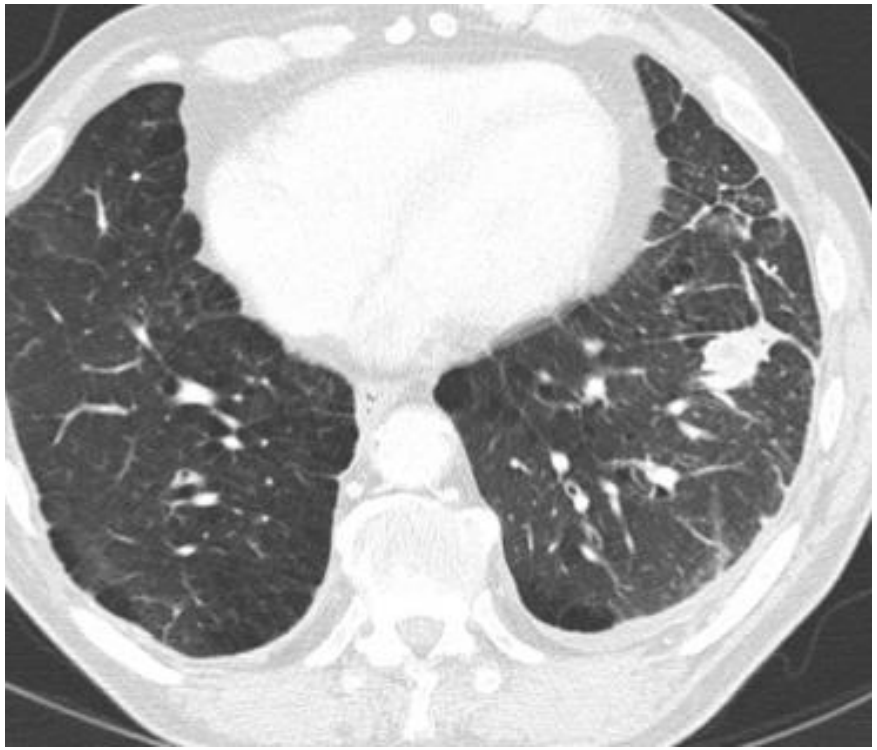
   +/-

   Quimioterapia neoadjuvante
2. Terapêutica trimodal
3. QT adjuvante
4. Cistectomia parcial

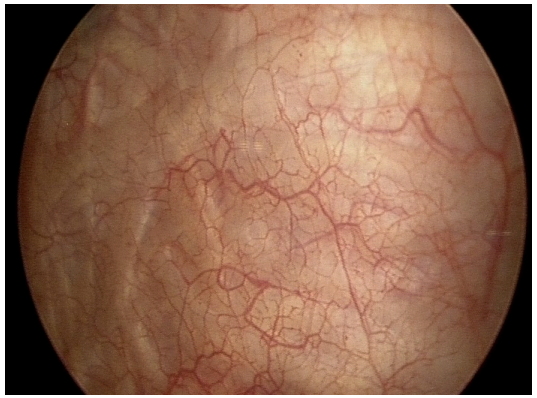
Tratamento

- Doença metastática:

  - QT sistémica
  - Esquemas com cisplatina
  - Gencitabina + Cisplatina
  - Mau prognóstico
  - Sobrevida global aos 5 anos – 5 a 20%



Seguimento

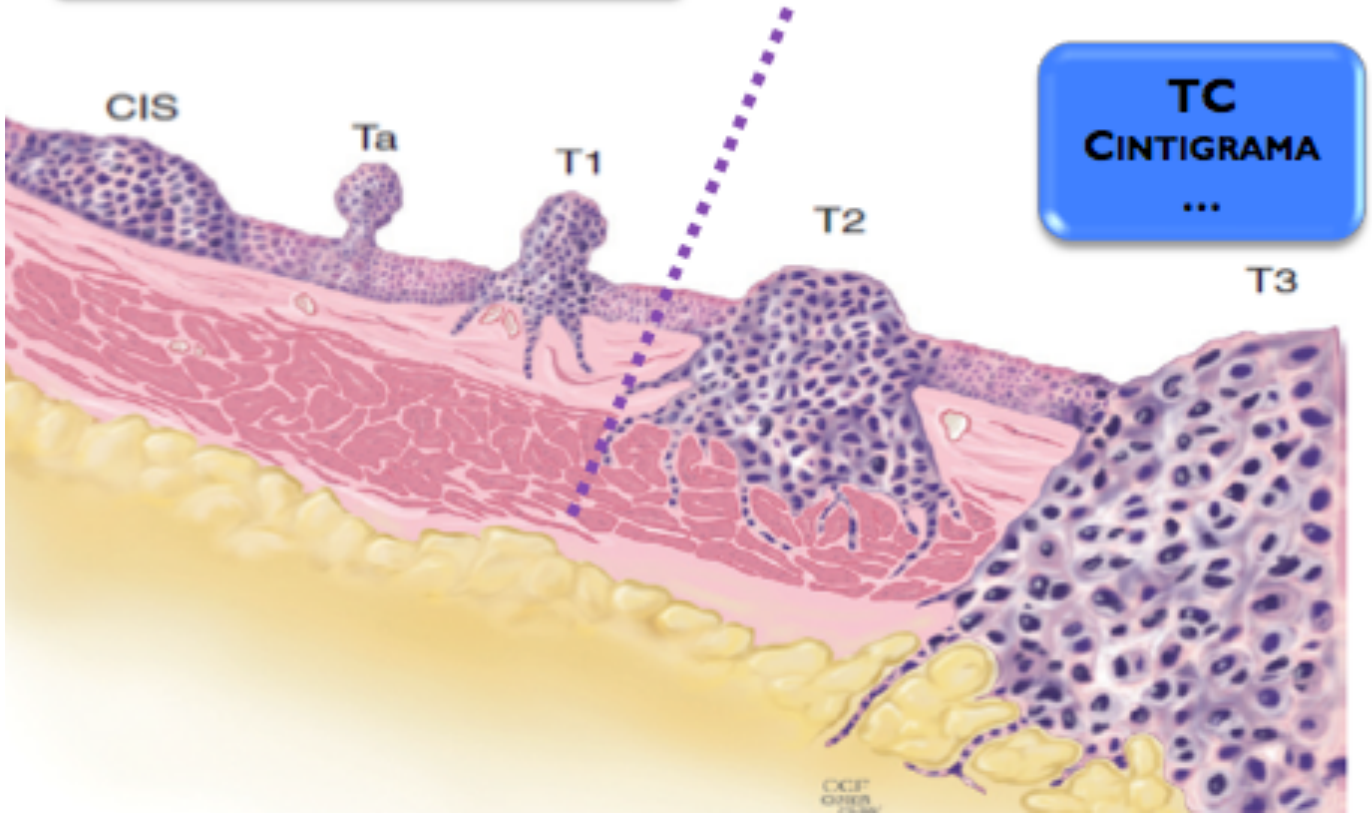


CARCINOMA DA BEXIGA NÃO MÚSCULO-INVASIVO 70-80%

CISTOSCOPIAS REGULARES

CARCINOMA DA BEXIGA MÚSCULO-INVASIVO 20-30%

TC
CINTIGRAMA
...



Seguimento

- Em doentes submetidos a RTU-v

  - controlo regular com cistoscopia e citologia uinária

	GR
The follow-up of Ta, T1 tumours and CIS is based on regular cystoscopy.	A
Patients with low-risk Ta tumours should undergo cystoscopy at 3 months. If negative, subsequent cystoscopy is advised 9 months later, and then yearly for 5 years.	C
Patients with high-risk tumours should undergo cystoscopy and urinary cytology at 3 months. If negative, subsequent cystoscopy and cytology should be repeated every 3 months for a period of 2 years, and every 6 months thereafter until 5 years, and then yearly.	C
Patients with intermediate-risk Ta tumours should have an in-between follow-up scheme using cystoscopy and cytology, which is adapted according to personal and subjective factors.	C
Regular (yearly) upper tract imaging (CT-IVU or IVU) is recommended for high-risk tumours.	C
Endoscopy under anaesthesia and bladder biopsies should be performed when office cystoscopy shows suspicious findings or if urinary cytology is positive.	B
During follow-up in patients with positive cytology and no visible tumour in the bladder, R-biopsies or biopsies with PDD (if equipment is available) and investigation of extravesical locations (CT urography, prostatic urethra biopsy) are recommended.	B

CIS = carcinoma in situ; CT-IVU = computed tomography intravenous urography; IVU = intravenous urography; PDD = photodynamic diagnosis.

European Urology Association, Guidelines 2016

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Seguimento

- Follow-up funcional vs oncológico:

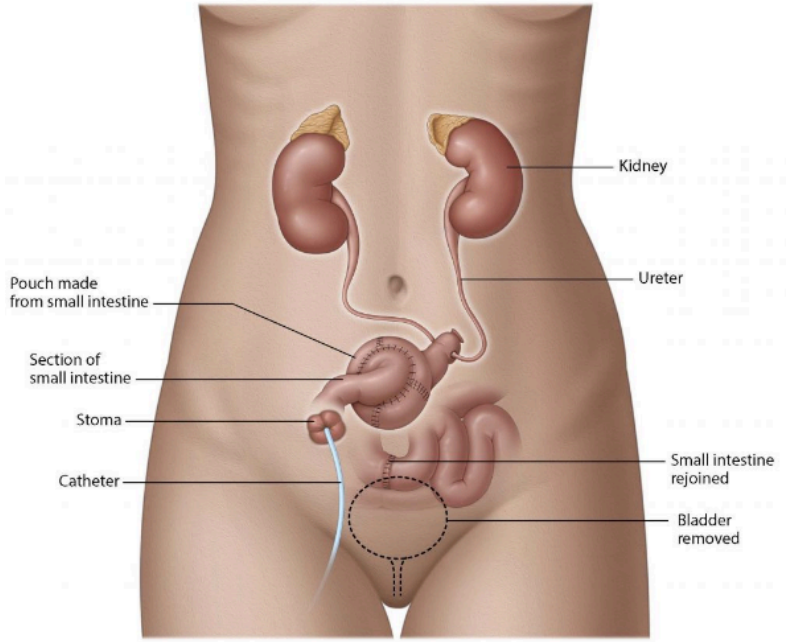
- 45% dos doentes apresentam complicações relacionadas com a derivação urinária aos 5 anos.

- aumentam com o tempo - >54% aos 15 anos

- importância do follow-up prolongado

- complicações funcionais:

1. défice de vit. B12
2. acidose metabólica
3. deterioração da função renal
4. infeções urinárias,
5. estenose da anastomose uretero-intestinal
6. complicações relacionados com o estoma



Seguimento

- Qual o papel do Médico de Família?

Seguimento

- Qual o papel do Médico de Família?

(1) Suspeita diagnóstica

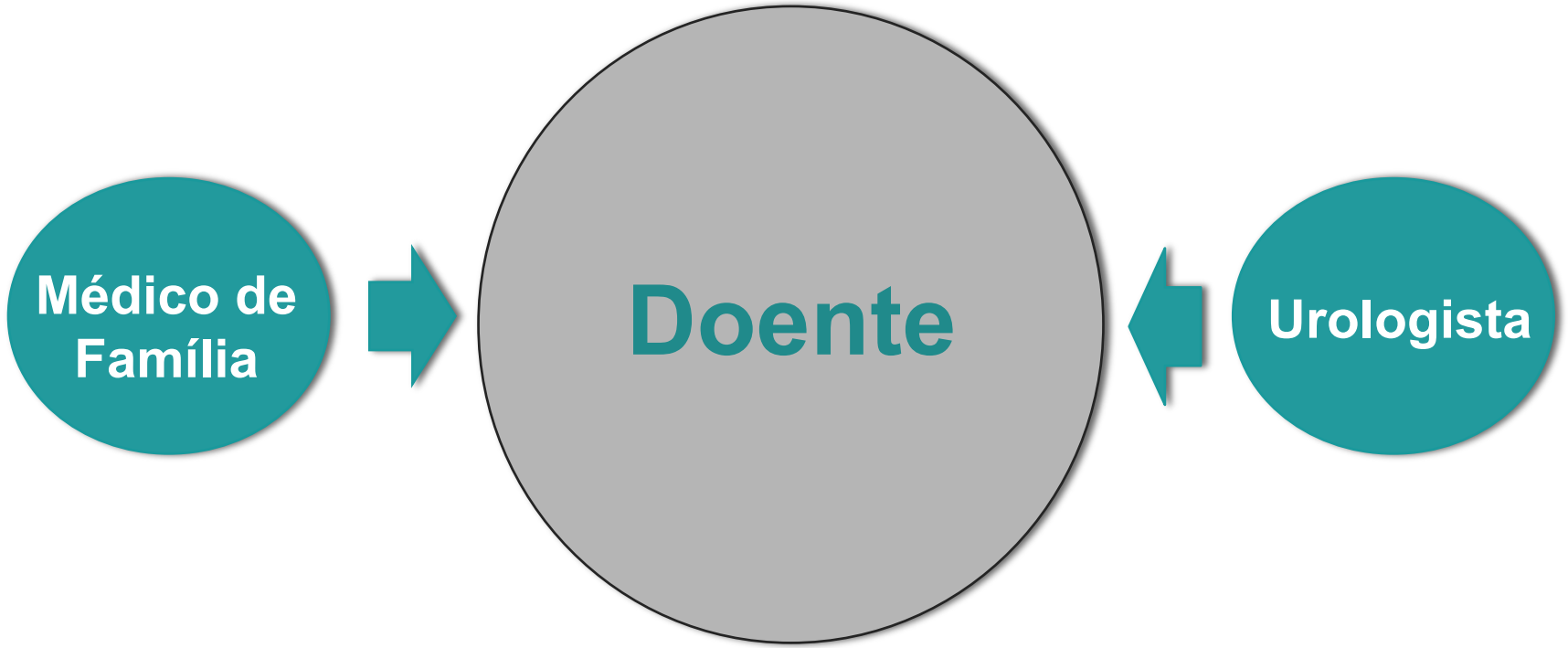
(2) Referenciação atempada

(3) Assegurar cumprimento de follow-up

(4) Cessação tabágica

(5) Acompanhamento psicológico/emocional

Seguimento



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Obrigado

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