



Universiteit
Leiden
The Netherlands

EAU-ESMO consensus statements on the management of advanced and variant bladder cancer: an international collaborative multistakeholder effort under the auspices of the EAU-ESMO guidelines committees

Witjes, J.A.; Babjuk, M.; Bellmunt, J.; Bruins, H.M.; Reijke, T.M. de; Santis, M. de; ... ; Horwich, A.

Citation

Witjes, J. A., Babjuk, M., Bellmunt, J., Bruins, H. M., Reijke, T. M. de, Santis, M. de, ... Horwich, A. (2020). EAU-ESMO consensus statements on the management of advanced and variant bladder cancer: an international collaborative multistakeholder effort under the auspices of the EAU-ESMO guidelines committees. *European Urology*, 77(2), 223-250. doi:10.1016/j.eururo.2019.09.035

Version: Publisher's Version
License: [Creative Commons CC BY 4.0 license](#)
Downloaded from: <https://hdl.handle.net/1887/3181572>

Note: To cite this publication please use the final published version (if applicable).

Bladder Cancer – Editor's Choice

EAU-ESMO Consensus Statements on the Management of Advanced and Variant Bladder Cancer—An International Collaborative Multistakeholder Effort[†]

Under the Auspices of the EAU-ESMO Guidelines Committees

J. Alfred Witjes^{a,*}, Marek Babjuk^{b,c}, Joaquim Bellmunt^{d,e}, H. Maxim Bruins^a, Theo M. De Reijke^f, Maria De Santis^{c,g}, Silke Gillessen^{h,i,j,k}, Nicholas James^{l,m}, Steven Maclennanⁿ, Juan Palou^o, Tom Powles^{p,q}, Maria J. Ribal^r, Shahrokh F. Shariat^{b,c,s,t,u}, Theo Van Der Kwast^v, Evangelos Xylinas^{w,x}, Neeraj Agarwal^y, Tom Arends^z, Aristotle Bamias^{aa}, Alison Birtle^{h,bb}, Peter C. Black^{cc}, Bernard H. Bochner^{s,dd}, Michel Bolla^{ee}, Joost L. Boormans^{ff}, Alberto Bossi^{gg}, Alberto Briganti^{hh,ii}, Iris Brummelhuis^a, Max Burger^{jj}, Daniel Castellano^{kk}, Richard Cathomas^{ll}, Arturo Chiti^{mmm,nn}, Ananya Choudhury^{h,i}, Eva Comp erat^{oo,pp}, Simon Crabb^{qq}, Stephane Culine^{rr}, Berardino De Bari^{ss,tt}, Willem De Blok^{uu}, Pieter J.L. De Visschere^{vv}, Karel Decaestecker^{ww}, Konstantinos Dimitropoulos^{xx}, Jose L. Dominguez-Escrig^{yy}, Stefano Fanti^{zz}, Valerie Fonteyne^{aaa}, Mark Frydenberg^{bbb}, Jurgen J. Futterer^{ccc}, Georgios Gakis^{ddd}, Bogdan Geavlete^{eee}, Paolo Gontero^{fff}, Bernhard Grubm uller^c, Shaista Hafeez^{ggg,hhh}, Donna E. Hanselⁱⁱⁱ, Arndt Hartmann^{jjj}, Dickon Hayne^{kkk}, Ann M. Henry^{lll}, Virginia Hernandez^{mmm}, Harry Herr^{dd}, Ken Herrmannⁿⁿⁿ, Peter Hoskin^{h,i,ooo}, Jorge Huguet^o, Barbara A. Jerezek-Fossa^{ppp,qqq}, Rob Jones^{rrr}, Ashish M. Kamat^{sss}, Vincent Khoo^{ggg,hhh,ttt,uuu}, Anne E. Kiltie^{vvv}, Susanne Krege^{www}, Sylvain Ladoire^{xxx}, Pedro C. Lara^{yyy,zzz}, Annemarie Leliveld^{aaaa}, Estefania Linares-Espin os^{bbbb}, Vibeke L ogager^{cccc}, Anja Lorch^{ddd}, Johann Loriot^{eeee}, Richard Meijer^{fff}, M. Carmen Mir^{yy}, Marco Moschini^{gggg}, Hugh Mostafid^{hhhh}, Arndt-Christian M ullerⁱⁱⁱⁱ, Christoph R. M uller^{jjj}, James N'Dow^{n,xx}, Andrea Necchi^{kkkk}, Yann Neuzillet^{lll}, Jorg R. Oddens^f, Jan Oldenburg^{mmmm,nnnn}, Susanne Osanto^{oooo}, Wim J.G. Oyen^{mm,nn,ccc,pppp}, Lu s Pacheco-Figueiredo^{qqqq,rrrr}, Helle Pappot^{ssss}, Manish I. Patel^{tttt}, Bradley R. Pieters^{uuuu}, Karin Plass^{vvvv}, Mesut Remzi^c, Margitta Retz^{wwww}, Jonathan Richenberg^{xxxx,yyyy}, Michael Rink^{zzzz}, Florian Roghmann^{aaaaa}, Jonathan E. Rosenberg^{bbbbb,cccc}, Morgan Roupr et^{ddddd}, Olivier Rouvi ere^{eeeee,ffff}, Carl Salembier^{ggggg}, Antti Salminen^{hhhhh}, Paul Sargosⁱⁱⁱⁱ, Shomik Sengupta^{jjjjj,kkkkk}, Amir Sherif^{lllll}, Robert J. Smeenk^{mmmmm}, Anita Smits^a, Arnulf Stenzlⁿⁿⁿⁿⁿ

[†] These consensus statements were developed by EAU and ESMO and are published simultaneously in *European Urology* (DOI: 10.1016/j.eururo.2019.09.035) and *Annals of Oncology* (DOI: 10.1093/annonc/mdz296).

* Corresponding author. Professor Johannes Alfred Witjes, Department of Urology, internal mail 659, Radboud University Nijmegen Medical Centre, PO Box 9101, 6500 HB Nijmegen, The Netherlands. Tel. +31 024 36 13 735.

E-mail address: Fred.Witjes@radboudumc.nl (J.A. Witjes).

George N. Thalmann^{ooooo}, **Bertrand Tombal**^{ppppp}, **Baris Turkbey**^{qqqqq},
Susanne Vahr Lauridsen^{rrrrr}, **Riccardo Valdagni**^{sssss}, **Antoine G. Van Der Heijden**^a,
Hein Van Poppel^{ttttt}, **Mihai D. Vartolomei**^{c,uuuuu}, **Erik Veskimäe**^{vvvvv}, **Antoni Vilaseca**^r,
Franklin A. Vives Rivera^{wwwwww}, **Thomas Wiegel**^{xxxxx}, **Peter Wiklund**^{yyyy,zzzzz},
Andrew Williams^{aaaaa}, **Richard Zigeuner**^{bbbbbb}, **Alan Horwich**^{ccccc}

^a Department of Urology, Radboud University Medical Center, Nijmegen, The Netherlands; ^b Department of Urology, 2nd Faculty of Medicine, Hospital Motol, Charles University, Prague, Czech Republic; ^c Department of Urology, Medical University of Vienna, Vienna, Austria; ^d IMIM-Hospital del Mar Medical Research Institute, Barcelona, Spain; ^e Harvard Medical School, Boston, Massachusetts, USA; ^f Department of Urology, Amsterdam University Medical Centers, University of Amsterdam, The Netherlands; ^g Department of Urology, Charité University Hospital, Berlin, Germany; ^h Division of Cancer Sciences, University of Manchester, Manchester, UK; ⁱ The Christie NHS Foundation Trust, Manchester, UK; ^j Division of Oncology and Haematology, Kantonsspital St Gallen, St Gallen, Switzerland; ^k University of Bern, Bern, Switzerland; ^l University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK; ^m Institute of Cancer and Genomic Sciences, University of Birmingham, Birmingham, UK; ⁿ Academic Urology Unit, University of Aberdeen, Aberdeen, UK; ^o Department of Urology, Fundació Puigvert, Universitat Autònoma de Barcelona, Barcelona, Spain; ^p The Royal Free NHS Trust, London, UK; ^q Barts Cancer Institute, Queen Mary University of London, London, UK; ^r Uro-Oncology Unit, Hospital Clinic, University of Barcelona, Spain; ^s Department of Urology, Weill Cornell Medical College, New York, New York, USA; ^t Department of Urology, University of Texas Southwestern Medical Center, Dallas, Texas, USA; ^u Institute for Urology and Reproductive Health, I.M. Sechenov First Moscow State Medical University, Moscow, Russia; ^v Department of Pathology, Erasmus Medical Center, Rotterdam, The Netherlands; ^w Department of Urology, Bichat-Claude Bernard Hospital, Assistance Publique Hôpitaux de Paris, Paris, France; ^x Paris Descartes University, Paris, France; ^y Huntsman Cancer Institute, University of Utah (NCI-CCC), Salt Lake City, Utah, USA; ^z Urology Department, Canisius-Wilhelmina Ziekenhuis Nijmegen, The Netherlands; ^{aa} 2nd Propaedeutic Dept of Internal Medicine, Medical School, National & Kapodistrian University of Athens, Athens, Greece; ^{bb} Rosemere Cancer Centre, Lancashire Teaching Hospitals, Preston, UK; ^{cc} Department of Urologic Sciences, Vancouver Prostate Centre, University of British Columbia, Vancouver, British Columbia, Canada; ^{dd} Urology Service, Department of Urology, Memorial Sloan Kettering Cancer Center, New York, New York, USA; ^{ee} Emeritus Professor of Radiation Oncology, Grenoble - Alpes University, Grenoble, France; ^{ff} Department of Urology, Erasmus University Medical Center, Rotterdam, The Netherlands; ^{gg} Department of Radiation Oncology, Gustave Roussy Institute, Villejuif, France; ^{hh} Department of Urology, Urological Research Institute, Milan; ⁱⁱ Vita-Salute University, San Raffaele Scientific Institute, Milan, Italy; ^{jj} Department of Urology, Caritas-St. Josef Medical Center, University of Regensburg, Regensburg, Germany; ^{kk} Medical Oncology Department, 12 de Octubre University Hospital (CIBERONC), Madrid, Spain; ^{ll} Departement Innere Medizin, Abteilung Onkologie und Hämatologie, Kantonsspital Graubünden, Chur, Switzerland; ^{mm} Department of Biomedical Sciences, Humanitas University, Milan, Italy; ⁿⁿ Humanitas Research Hospital, Milan, Italy; ^{oo} Department of Pathology, Tenon hospital, HUEP, Paris, France; ^{pp} Sorbonne University, Paris, France; ^{qq} Cancer Sciences Unit, University of Southampton, Southampton, UK; ^{rr} Department of Cancer Medicine, Hôpital Saint Louis, Paris, France; ^{ss} Radiation Oncology Department, Centre Hospitalier Régional Universitaire "Jean Minjot" of Besançon, INSERM UMR 1098, Besançon, France; ^{tt} Radiation Oncology Department, Centre Hospitalier Universitaire Vaudois, Université de Lausanne, Lausanne, Switzerland; ^{uu} Department of Urology, University Medical Center Utrecht, Utrecht, The Netherlands; ^{vv} Department of Radiology and Nuclear Medicine, Division of Genitourinary Radiology and Mammography, Ghent University Hospital, Ghent, Belgium; ^{ww} Department of Urology, Ghent University Hospital, Ghent, Belgium; ^{xx} Department of Urology, Aberdeen Royal Infirmary, Aberdeen, UK; ^{yy} Servicio de Urología, Fundación Instituto Valenciano de Oncología, Valencia, Spain; ^{zz} Department of Nuclear Medicine, Policlinico S Orsola, University of Bologna, Italy; ^{aaa} Department of Radiotherapy Oncology, Ghent University Hospital, Ghent, Belgium; ^{bbb} Department of Surgery, Faculty of Medicine, Nursing and Health Sciences, Monash University, Clayton, Australia; ^{ccc} Department of Radiology and Nuclear Medicine, Radboud University Medical Center, Nijmegen, The Netherlands; ^{ddd} Department of Urology and Paediatric Urology, University Hospital of Würzburg, Julius-Maximilians University, Würzburg, Germany; ^{eee} Department of Urology, Saint John Emergency Clinical Hospital, Bucharest, Romania; ^{fff} Division of Urology, Molinette Hospital, University of Studies of Torino, Torino, Italy; ^{ggg} Division of Radiotherapy and Imaging, The Institute of Cancer Research, London, UK; ^{hhh} Department of Clinical Oncology, The Royal Marsden NHS Foundation Trust, London, UK; ⁱⁱⁱ Department of Urology, University of California, San Diego Pathology, La Jolla, California, USA; ^{jjj} Institute of Pathology, Friedrich-Alexander University (FAU) Erlangen-Nürnberg, Erlangen, Germany; ^{kkk} Department of Urology, UWA Medical School, University of Western Australia, Perth, Australia; ^{lll} Leeds Institute of Medical Research, University of Leeds, Leeds, UK; ^{mmm} Department of Urology, Hospital Universitario Fundación de Alcorcón, Madrid, Spain; ⁿⁿⁿ Department of Nuclear Medicine, Universitätsklinikum Essen, Essen, Germany; ^{ooo} Mount Vernon Centre for Cancer Treatment, London, UK; ^{ppp} Department of Oncology and Hemato-oncology, University of Milan, Milan; ^{qqq} Division of Radiotherapy, IEO European Institute of Oncology, IRCCS, Milan, Italy; ^{rrr} Institute of Cancer Sciences, College of Medicine, Veterinary and Life Sciences, University of Glasgow, Glasgow, UK; ^{sss} Department of Urology - Division of Surgery, The University of Texas, MD Anderson Cancer Center, Houston, Texas, USA; ^{ttt} Department of Medicine, University of Melbourne; ^{uuu} Monash University, Melbourne, Australia; ^{vvv} CRUK/MRC Oxford Institute for Radiation Oncology, University of Oxford, Oxford, UK; ^{www} Department of Urology, Pediatric Urology and Urologic Oncology, Kliniken Essen-Mitte, Essen, Germany; ^{xxx} Department of Medical Oncology, Centre Georges François Leclerc, Dijon, France; ^{yyy} Department of Oncology, Hospital Universitario San Roque; ^{zzz} Universidad Fernando Pessoa, Canarias, Spain; ^{aaaa} Department of Urology, University Medical Center Groningen, University of Groningen, Groningen, The Netherlands; ^{bbbb} Department of Urology, University Hospital La Paz, Madrid, Spain; ^{cccc} Department of Radiology, Copenhagen University Hospital Herlev and Gentofte, Herlev, Denmark; ^{dddd} Department of Medical Oncology and Hematology, University Hospital Zürich, Zürich, Switzerland; ^{eeee} Département de Médecine Oncologique, Gustave Roussy, INSERM U981, Université Paris-Sud, Université Paris-Saclay, Villejuif, France; ^{fff} UMC Utrecht Cancer Center, MS Oncologic Urology, Utrecht, The Netherlands; ^{ggg} Department of Urology, Luzerner Kantonsspital, Luzern, Switzerland; ^{hhh} Department of Urology, Royal Surrey County Hospital, Guildford, UK; ⁱⁱⁱ Department of Radiation Oncology, Eberhard Karls University, Tübingen, Germany; ^{jjj} Cancer Treatment Centre, Sorlandet Hospital, Kristiansand, Norway; ^{kkk} Department of Medical Oncology, Istituto Nazionale Tumori of Milan, Milan, Italy; ^{lll} Department of Urology, Hospital Foch, University of Versailles-Saint-Quentin-en-Yvelines, Suresnes, France; ^{mmm} Department of Oncology, Akershus University Hospital, Lørenskog, Norway; ⁿⁿⁿ Faculty of Medicine, University of Oslo, Oslo, Norway; ^{ooo} Department of Clinical Oncology, Leiden University Medical Center, Leiden, The Netherlands; ^{ppp} Department of Radiology and Nuclear Medicine, Rijnstate Hospital, Arnhem, The Netherlands; ^{qqq} Department of Urology, Centro Hospitalar São João, Porto, Portugal; ^{rrr} Life and Health Sciences Research Institute (ICVS), School of Medicine, University of Minho, Braga, Portugal; ^{sss} Department of Oncology, Rigshospitalet, University Hospital of Copenhagen, Copenhagen, Denmark; ^{ttt} Department of Urology, Westmead Hospital, University of Sydney, Sydney, Australia; ^{uuu} Department Radiation Oncology, Amsterdam University Medical

Centers, University of Amsterdam, Amsterdam, The Netherlands; ^{vvvv} EAU Guidelines Office, Arnhem, The Netherlands; ^{wwwww} Department of Urology, Rechts der Isar Medical Center, Technical University of Munich, Munich, Germany; ^{xxxx} Department of Imaging and Nuclear Medicine, Royal Sussex County Hospital, Brighton, UK; ^{yyyy} Brighton and Sussex Medical School, Brighton, UK; ^{zzzz} Department of Urology, University Medical Center Hamburg-Eppendorf, Hamburg, Germany; ^{aaaaa} Department of Urology, Ruhr-University Bochum, Marien Hospital, Herne, Germany; ^{bbbbb} Department of Medicine, Memorial Sloan Kettering Cancer Center, New York, New York, USA; ^{ccccc} Weill Cornell Medical College, New York, New York, USA; ^{ddddd} Department of Urology, Sorbonne Université, GRC n°5, ONCOTYPE-URO, AP-HP, Hôpital Pitié-Salpêtrière, Paris, France; ^{eeeee} Hospices Civils de Lyon, Service d'Imagerie Urinaire et Vasculaire, Hôpital Edouard Herriot, Lyon, France; ^{ffff} Université de Lyon, Université Lyon 1, faculté de médecine Lyon Est, Lyon, France; ^{ggggg} Department of Radiation Oncology, Europe Hospitals Brussels, Belgium; ^{hhhhh} Department of Urology, University Hospital of Turku, Finland; ⁱⁱⁱⁱ Department of Radiotherapy, Institut Bergonié, Bordeaux, France; ^{jjjj} Department of Surgery, Austin Health, University of Melbourne, Melbourne, Australia; ^{kkkkk} Eastern Health Clinical School, Monash University, Melbourne, Australia; ^{llll} Department of Surgical and Perioperative Sciences, Urology and Andrology, Umeå university, Umeå, Sweden; ^{mmmmm} Department of Radiation Oncology, Radboud University Medical Center, Nijmegen, The Netherlands; ⁿⁿⁿⁿⁿ Department of Urology, Eberhard Karls University Tübingen, Tübingen, Germany; ^{oooo} Department of Urology, Inselspital, Bern University Hospital, Bern, Switzerland; ^{ppppp} Division of Urology, IREC, Cliniques Universitaires Saint Luc, UCL, Brussels, Belgium; ^{qqqqq} Molecular Imaging Program, National Cancer Institute, Bethesda, Maryland, USA; ^{rrrrr} Department of Urology, Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark; ^{sssss} Department of Oncology and Hemato-oncology, Università degli Studi di Milano, Fondazione IRCCS Istituto Nazionale dei Tumori, Milan, Italy; ^{ttttt} Department of Urology, University Hospitals Leuven, Belgium; ^{uuuuu} Department of Cell and Molecular Biology, George Emil Palade University of Medicine, Pharmacy, Science, and Technology of Targu Mures, Romania; ^{vvvvv} Department of Urology, Tampere University Hospital, Tampere, Finland; ^{wwwww} Clinica HematoOncologica Bonadona Prevenir, Universidad Metropolitana, Clinica Club de Leones, Barranquilla, Colombia; ^{xxxxx} Department of Radiation Oncology, University Hospital Ulm, Ulm, Germany; ^{yyyyy} Icahn School of Medicine, Mount Sinai Health System New York City, New York, USA; ^{zzzzz} Department of Urology, Karolinska Institutet, Stockholm, Sweden; ^{aaaaa} Department of Urology, Auckland City Hospital, Auckland, New Zealand; ^{bbbbb} Department of Urology, Medizinische Universität Graz, Graz, Austria; ^{ccccc} Emeritus Professor, The Institute of Cancer Research, London, UK

Article info

Article history:

Accepted September 26, 2019

Associate Editor: James Catto

Keywords:

Bladder cancer
Consensus
Delphi
Diagnosis
Treatment
Follow-up



[www.eu-acme.org/
europeanurology](http://www.eu-acme.org/europeanurology)

Please visit

www.eu-acme.org/europeanurology
to answer questions on-line. The EU-ACME credits will then be attributed automatically.

Abstract

Background: Although guidelines exist for advanced and variant bladder cancer management, evidence is limited/conflicting in some areas and the optimal approach remains controversial.

Objective: To bring together a large multidisciplinary group of experts to develop consensus statements on controversial topics in bladder cancer management.

Design: A steering committee compiled proposed statements regarding advanced and variant bladder cancer management which were assessed by 113 experts in a Delphi survey. Statements not reaching consensus were reviewed; those prioritised were revised by a panel of 45 experts prior to voting during a consensus conference.

Setting: Online Delphi survey and consensus conference.

Participants: The European Association of Urology (EAU), the European Society for Medical Oncology (ESMO), experts in bladder cancer management.

Outcome measurements and statistical analysis: Statements were ranked by experts according to their level of agreement: 1–3 (disagree), 4–6 (equivocal), and 7–9 (agree). A priori (level 1) consensus was defined as $\geq 70\%$ agreement and $\leq 15\%$ disagreement, or vice versa. In the Delphi survey, a second analysis was restricted to stakeholder group(s) considered to have adequate expertise relating to each statement (to achieve level 2 consensus).

Results and limitations: Overall, 116 statements were included in the Delphi survey. Of these statements, 33 (28%) achieved level 1 consensus and 49 (42%) achieved level 1 or 2 consensus. At the consensus conference, 22 of 27 (81%) statements achieved consensus. These consensus statements provide further guidance across a broad range of topics, including the management of variant histologies, the role/limitations of prognostic biomarkers in clinical decision making, bladder preservation strategies, modern radiotherapy techniques, the management of oligometastatic disease, and the evolving role of checkpoint inhibitor therapy in metastatic disease.

Conclusions: These consensus statements provide further guidance on controversial topics in advanced and variant bladder cancer management until a time when further evidence is available to guide our approach.

Patient summary: This report summarises findings from an international, multistakeholder project organised by the EAU and ESMO. In this project, a steering committee identified areas of bladder cancer management where there is currently no good-quality evidence to guide treatment decisions. From this, they developed a series of proposed statements, 71 of which achieved consensus by a large group of experts in the field of bladder cancer. It is anticipated that these statements will provide further guidance to health care professionals and could help improve patient outcomes until a time when good-quality evidence is available.

© 2019 European Society of Medical Oncology and European Association of Urology.

Published by Elsevier B.V. All rights reserved.

1. Introduction

Bladder cancer is the 10th most common form of cancer globally, with 549 393 new cases and 199 922 bladder cancer-related deaths estimated in 2018 [1]. It is around four times more common in men, where it is the sixth most common cancer and the ninth leading cause of cancer death. The incidence of bladder cancer varies globally, with the highest rates in men and women reported in Southern and Western Europe and North America, which appears to reflect the prevalence of tobacco smoking, the main risk factor for bladder cancer [1,2].

Various oncology and urology societies, including the European Society for Medical Oncology (ESMO) [3] and the European Association of Urology (EAU) [4,5], all produce clinical practice guidelines (CPGs) that provide guidance to health care professionals (HCPs) regarding the optimal strategies for diagnosis, treatment, and follow-up of patients with bladder cancer based on the latest evidence and expert opinion. However, evidence is limited and/or conflicting in some areas of advanced and variant bladder cancer management, and the optimal approach remains controversial, warranting further discussion and clarification. For example, the pathological features and prognosis of bladder cancer with variant histologies differ from pure urothelial bladder cancer, and evidence regarding response to systemic therapy in these variant histologies is scarce and divergent [6]. In addition, although efforts have been made to identify molecular subtypes of bladder cancer and to link these with clinical-pathological features and treatment response [7–10], there is no consensus regarding the number of subtypes that can be defined and available evidence to link subtypes with response to specific therapies is conflicting [11].

In terms of disease management, although transurethral resection of bladder tumour (TURBT) is the initial treatment of choice for non-muscle-invasive bladder cancer (NMIBC), with subsequent treatment tailored according to risk stratification [3,4], TURBT followed by concurrent chemoradiation (i.e., trimodality bladder preservation treatment) is also an option for muscle-invasive bladder cancer (MIBC) in patients considered medically unfit for surgery and in those wishing to avoid radical surgery [3,4]. However, patient selection for bladder-sparing strategies varies globally, and there are no uniform criteria on which to base these decisions. The optimal chemotherapy regimen to be used as part of trimodality bladder preservation treatment has also not been defined [12].

Radical cystectomy with extended lymphadenectomy is considered the standard treatment of MIBC, and although neoadjuvant therapy has been used in this setting for several decades, the role of adjuvant therapy remains controversial [3,5,12]. The benefit of adding (neo)adjuvant chemotherapy to radical cystectomy and node dissection in oligometastatic disease (OMD) is also unknown. In the metastatic setting, cisplatin-based chemotherapy remains the first-line treatment of choice for patients considered fit enough to receive this regimen, but the preferred approach

for cisplatin-ineligible patients is less clear [5,12]. Options include various carboplatin-based regimens or immune checkpoint inhibitors (ICIs), pembrolizumab or atezolizumab, although approvals of these ICIs are based on data from single-arm phase 2 trials [13,14], and their use in Europe is currently restricted to programmed death-ligand 1 (PD-L1)-positive patients with different companion diagnostics and cut-offs used for each ICI. In terms of second-line treatment, various chemotherapy options have been evaluated, but results are highly variable [5]. Three ICIs (pembrolizumab, atezolizumab and nivolumab) are approved in this setting in Europe (durvalumab and avelumab are also approved in the USA but not in Europe), although only pembrolizumab has demonstrated an overall survival (OS) benefit versus chemotherapy in a phase 3 randomised controlled trial [15]. There are no data to provide guidance regarding the optimal treatment sequencing approach for ICIs and chemotherapy.

Finally, although there is no evidence to suggest that regular follow-up after definitive treatment is associated with any survival benefit in patients with bladder cancer, most guidelines recommend regular follow-up, but no high-level, evidence-based follow-up protocol exists.

Collectively, these and other topics represent points in the bladder cancer care pathway where evidence is limited/conflicting and thus where a variation in practice may exist. Given this, the aim of this consensus-finding project was to gain insights from a multidisciplinary group of experts in order to produce consensus statements that would further guide HCPs on selected clinically relevant topics. It was anticipated that these consensus statements would underpin CPG recommendations produced by existing society guidelines and facilitate an optimal approach to the diagnosis, treatment and follow-up of patients with advanced and variant bladder cancer.

2. Methods

In 2018, the EAU and the ESMO formed a collaboration to produce consensus statements for the management of bladder cancer. A project steering committee was established, which comprised a multidisciplinary panel of 13 experts from the EAU and the ESMO, including two chairpersons (J.A. Witjes and A. Horwich). This steering committee worked together to develop a series of statements, based on their knowledge of the field, relating to potential management strategies for patients with advanced and variant bladder cancer. They were asked to focus on specific situations where good-quality evidence is lacking or where available evidence is conflicting. A systematic literature review was not conducted. Statements were divided into six discrete topic areas, with the members of the steering committee appointed to chair each of these working groups as follows:

- 1 Strategies for variant histologies (chairs: S.F. Shariat and M. De Santis).

- 2 The role of prognostic molecular markers in MIBC (chairs: M.J. Ribal and J. Bellmunt).
- 3 Bladder preservation strategies (chairs: N. James and J.A. Witjes).
- 4 Treatment of curative intent for patients with OMD (chairs: A. Horwich and M. Babjuk).
- 5 ICIs in urothelial bladder cancer (chairs: T. Powles and H. M. Bruins).
- 6 Follow-up strategies and survivorship (chairs: S. Gillissen and J. Palou).

All final statements were entered into DelphiManager (a bespoke online Delphi tool, written in C# using WebForms and a MySQL backend) [16]. The resulting Delphi survey was distributed to key stakeholder groups, including (1) urologists, (2) oncologists (including medical and radiation oncologists) and (3) “others” (consisting of radiologists, pathologists, specialist nurses, clinical oncologists and specialists in nuclear medicine). The participants were purposefully sampled by contacting professional societies, including the EAU, ESMO, the American Society of Clinical Oncology (ASCO), American Urological Association (AUA), European Society for Radiotherapy and Oncology (ESTRO), European Forum for Primary Care (EFPC), European Association of Urology Nurses (EAUN), Canadian Urological Association (CUA), International Society of Urological Pathology (ISUP), Urological Society of Australia and New Zealand (USANZ), European Society of Urogenital Radiology (ESUR), Urological Association of Asia (UAA), American Society for Radiation Oncology (ASTRO), EAU bladder cancer guideline panels (both MIBC & NMIBC panels) and the EAU Section of Oncological Urology (ESOU). Consent to participate was implied by registering and completing the questionnaire. All HCPs were asked to rate their strength of agreement with each statement on a scale of 1 (strongly disagree) to 9 (strongly agree). An additional option of ‘unable to score’ was included to allow participants to refrain from rating any statements where they felt that they had insufficient expertise to do so. Two iterative rounds of the Delphi survey were conducted. In the first round, participants were also encouraged to propose additional statements, which were reviewed for relevance by the chairpersons. In the second round, participants were reminded of their own scores from round 1 and were also provided with a summary score from each of the three stakeholder groups. From this, participants had the opportunity to revise or retain their original scores. None of the statements were amended between rounds.

Descriptive statistics were used to summarise the results of each survey round, which included calculating the percentage of participants who scored each statement as 1–3 (disagree), 4–6 (equivocal), 7–9 (agree) and ‘unable to score’. Results were summarised according to the three stakeholder groups described above. After the final survey round, the level of agreement for each statement was assessed for all three stakeholder groups separately, with consensus defined *a priori* as follows:

- 1 Item scored as agree (7–9) by $\geq 70\%$ of participants and disagree (1–3) by $\leq 15\%$, OR
- 2 Item scored as disagree (1–3) by $\geq 70\%$ of participants and agree (7–9) by $\leq 15\%$.

Results of this analysis showed that consensus was reached for a relatively small (28%) number of statements. On further review, the steering committee felt that these results might have been affected by some participants who provided a score of 4–6 (ie, equivocal) instead of selecting ‘unable to score’ in cases where they had insufficient expertise to adequately assess the statement. To address this, a second analysis was conducted using the same consensus rules as described above, but where the analysis was restricted to specific stakeholder group(s) considered to have adequate relevant expertise relating to the specific statement. Stakeholder group(s) considered as having adequate relevant expertise for each statement were defined by the chairmen prior to this second analysis.

Final results were tabulated according to the three stakeholder groups with a consensus level defined for each statement, which considered both the analyses conducted as follows:

- Level 1: *a priori* consensus threshold met across all three stakeholder groups (ie, original consensus analysis).
- Level 2: *a priori* consensus threshold not met across all three stakeholder groups but is met when analysis restricted to most relevant stakeholder group(s).
- Level 3: *a priori* consensus threshold not met.

A subsequent review of the results was performed by the steering committee in order to identify statements where a consensus was almost reached. These statements were prioritised for further review and discussion as part of a consensus conference meeting held on 8 November 2018 in Amsterdam, The Netherlands.

All HCPs who completed the survey were invited to attend the consensus conference. However, based on their limited availability for a face-to-face meeting, additional HCPs also considered important stakeholders in the management of bladder cancer were invited, with all attending experts allocated to one of the six working groups defined earlier. During the conference, statements prioritised for further review were discussed by each of the working groups during parallel breakout sessions. This included a review of related supporting and/or conflicting evidence informing each statement and revision of these statements, where necessary. The final statements from each working group were then presented to the entire expert panel for further deliberation and amendment. Finally, the expert panel was asked to rate its strength of agreement with each of the revised statements on the same scale applied during the Delphi survey using online voting software (<https://www.poll Everywhere.com/>). All voting was conducted using individual smartphone devices and was anonymous. Panel members could abstain from voting

in cases where they had insufficient expertise to adequately assess the statement (which negated the requirement for an 'unable to score' option).

Results from the Delphi survey and consensus conference are described in this article. For statements revised and reassessed during the consensus conference, the updated results as well as a summary of evidence and/or the rationale for statement revisions are also included. The authors of this article include all Delphi survey participants, consensus conference attendees, and other individuals who contributed significantly to this project, all of whom have reviewed and approved the final manuscript.

3. Results

The steering committee generated 115 statements relating to the management of advanced and variant bladder cancer for assessment as part of the Delphi survey; after round 1, an additional statement was added for assessment during round 2.

Overall, 221 HCPs were invited to participate in the Delphi survey, and of these, 113 registered and completed at least some of the survey (scores for completed questions were retained); 106 completed round 1 and 97 completed round 2 of the survey. A summary of participants who completed the Delphi survey according to specialty is shown in Table 1. A total of 45 experts attended the consensus conference, 24 of whom also participated in the Delphi survey. As such, this project included the participation of 134 experts with representation from 23 different countries (The Netherlands: 19, UK: 18, France: 12, Germany: 12, Spain: 11, USA: 10, Italy: 8, Austria: 7, Switzerland: 6, Belgium: 6, Australia: 5, Denmark: 3, Czech Republic: 2, Romania: 2, Norway: 2, Finland: 2, Sweden: 2, Russia: 1, Greece: 1, Canada: 1, Portugal: 1, Colombia: 1, New Zealand: 1).

In the Delphi survey, the initial (*a priori*) analysis resulted in a level 1 consensus for 18 (16%) statements in round 1 and 33 (28%) in round 2, with the inclusion of statements reaching level 2 consensus increasing this to 49 (42%) statements after round 2. At the consensus conference meeting, 27 statements were amended/presented for voting and 22 (81%) achieved consensus among the group, giving a

total of 71 statements that achieved consensus throughout the whole process.

The following section provides detailed results according to each of the six topic areas, including:

- 1 All Delphi survey statements developed by the steering committee for each topic area.
- 2 Delphi survey results for each of these statements highlighted according to the consensus level reached for each statement, as shown in Table 2.
- 3 All statements generated by the consensus conference working groups for each topic area.
- 4 Consensus conference voting results for each of these statements.
- 5 A summary of expert panel discussions from the consensus conference to support these statements.

3.1. Strategies for variant histologies

The Delphi survey included 14 proposed statements regarding the management of bladder cancer with variant histologies, including the role of different treatment approaches such as radical cystectomy, lymphadenectomy, radiotherapy, chemotherapy and checkpoint inhibitor therapy, in this setting (Table 3).

According to the Delphi survey results, five of the 14 statements reached consensus among all stakeholder groups (Table 3). For the remaining statements, seven were prioritised and four new/modified statements were presented at the consensus conference for further discussion and voting. Results from the consensus panel voting are shown in Table 4 and supporting text is provided below.

3.1.1. Treatment of high-grade bladder urothelial carcinoma (established after complete TURBT and/or re-TURBT) with micropapillary variant

Variant histology of bladder cancer includes urothelial carcinoma with divergent differentiation, such as urothelial carcinoma with micropapillary features (World Health Organization 2016 classification) [17]. The proportion of carcinoma with micropapillary features can vary significantly, with a larger component being associated with a worse prognosis [18]. Micropapillary variant is strongly associated with lymphovascular invasion and metastasis to the lymph nodes, and pT1 bladder cancer with micropapillary variant is often upstaged to more advanced stages [18]. Its pathological diagnosis on a transurethral resection (TUR) specimen is subject to both under-reporting by pathologists and understaging due to intrinsic biological properties of the variant histology in addition to the normal risk of understaging with TURBT. In one study, after adjustment for the effects of pathological stage, only the presence of micropapillary variant, but not that of squamous or sarcomatoid differentiation, was associated with worse survival [19].

Given the poor response rate (RR) to intravesical bacillus Calmette-Guérin (BCG) administration, the current standard of care treatment for most cT1 urothelial carcinomas of the

Table 1 – Delphi survey participants according to specialty.

Specialty	Round 1, N	Round 2, N
Urology	52	45
Oncology		
Medical oncology	18	18
Radiation oncology	18	14
Other		
Nuclear medicine	3	3
Pathology	8	5
Radiology	9	7
Specialist nurse	3	3
Clinical oncology	2	2
Total	113	97

Table 2 – Consensus levels applied for original Delphi survey.

Consensus level	Definition
1	<i>A priori</i> consensus ^a threshold met across all three stakeholder groups
2	<i>A priori</i> consensus ^a threshold not met across all three stakeholder groups, but is met when analysis restricted to relevant ^b stakeholder group(s)
3	Consensus threshold not met

^a*A priori* consensus: item scored as agree (7–9) by $\geq 70\%$ of participants and disagree (1–3) by $\leq 15\%$, or item scored as disagree (1–3) by $\geq 70\%$ of participants and by agree (7–9) $\leq 15\%$.

^bRelevant stakeholder groups: Urologists, others (includes specialties in Nuclear Medicine, Pathology, Radiology, Specialist Nurse, Clinical Oncology); Oncologists.

bladder, a recent study evaluated the potential benefits of early (immediate) radical cystectomy for cT1 micropapillary variant urothelial carcinoma [20]. In this retrospective, comparative design study, which included 72 patients with cT1 micropapillary bladder cancer, 40 patients received primary intravesical BCG and 26 underwent upfront radical cystectomy. Of those who received intravesical BCG, 75%, 45% and 35% experienced disease recurrence, progression and lymph node metastasis, respectively, during a median follow-up of 67.5 mos. However, patients treated with upfront radical cystectomy had improved survival compared with those treated with BCG (5-yr disease-specific survival [DSS] of 100% vs 60%, $p = 0.006$) and those who underwent delayed radical cystectomy after disease recurrence (5-yr DSS of 62%, $p = 0.015$). Patients in the delayed radical cystectomy group also had higher rates of pT3 disease (25% vs 0%, $p = 0.04$) and overall pathological disease progression (pT2 or greater, or nodal disease: 40% vs 27% in the upfront radical cystectomy group) [20].

Given the above, the panel decided to add the recommendation for concomitant pelvic lymph node dissection (PLND) to the original statement regarding the treatment of T1 high-grade bladder urothelial carcinoma with micropapillary variant to read as follows:

Statement 1: T1 high-grade bladder urothelial carcinoma with micropapillary histology (established after complete TURBT and/or re-TURBT) should be treated with immediate radical cystectomy and lymphadenectomy.

Level of consensus: 86% Agree, 14% disagree (29 voters).

3.1.2. Treatment of high-grade bladder urothelial carcinoma with plasmacytoid, sarcomatoid, squamous, glandular or nested variant histologies

Understaging at the time of TUR is more frequent in urothelial carcinomas with variant histology compared with pure urothelial carcinomas and has been shown to be closely associated with lower median OS (1.4 vs 10.6 yrs, $p < 0.001$) [21]. Therefore, immediate radical cystectomy for

better staging and definitive treatment purposes seems to be an appropriate option. However, the resulting statement shown below failed to reach consensus among the panel, and this is likely due to the low level of evidence currently available to support this approach in urothelial carcinomas with variant histology.

Statement 2: T1 high-grade bladder urothelial carcinoma (established after complete TURBT and/or re-TURBT) with plasmacytoid, sarcomatoid, squamous, glandular or nested variant should be treated with immediate radical cystectomy and concomitant lymph node dissection.

Level of consensus: 48% Agree, 39% disagree, 13% equivocal (31 voters).

3.1.3. Treatment of MIBC with micropapillary or plasmacytoid variant, or with squamous or glandular differentiation

Only limited evidence is available regarding the added benefit of neoadjuvant chemotherapy for bladder cancers with variant histology due to a lack of prospective studies [22]. In one retrospective population-based study, Vetterlein et al [6] evaluated the added benefit of neoadjuvant chemotherapy administration in patients with muscle-invasive urothelial carcinoma harbouring variant histologies (369 patients underwent neoadjuvant chemotherapy followed by radical cystectomy, whereas 1649 patients underwent upfront radical cystectomy). Patients with neuroendocrine tumours benefited most from neoadjuvant chemotherapy administration, as evidenced by better OS (hazard ratio 0.49; 95% confidence interval 0.33–0.74; $p = 0.01$) and lower rates of non-organ-confined disease at the time of radical cystectomy (41.6% vs 76.4%). For tumours with micropapillary differentiation, sarcomatoid differentiation, or adenocarcinoma, neoadjuvant chemotherapy decreased the rates of non-organ-confined disease but did not impact OS [6].

The revised statement proposed was as follows:

Statement 3: Muscle-invasive bladder urothelial carcinoma with micropapillary or plasmacytoid variant, or with

Table 3 – Delphi results regarding proposed statement for the management of bladder cancer with variant histologies.

Proposed statements ^a	Level of agreement												Relevant stakeholder groups	Consensus level (see Table 2)
	Urologists (n = 45)				Oncologists (n = 32)				Others (n = 20)					
	D (%)	E (%)	A (%)	U (n)	D (%)	E (%)	A (%)	U (n)	D (%)	E (%)	A (%)	U (n)		
1. T1 high-grade bladder urothelial carcinoma (established after complete TURBT and/or re-TURBT) with micropapillary variant should be treated with immediate radical cystectomy	7	11	82	0	44	22	33	5	36	27	36	9	Ur + O	3
2. T1 high-grade bladder urothelial carcinoma (established after complete TURBT and/or re-TURBT) with plasmacytoid or sarcomatoid or nested variant should be treated with immediate radical cystectomy	2	7	91	0	22	7	70	5	27	18	55	9	Ur + O	3
3. T1 high-grade bladder urothelial carcinoma (established after complete TURBT and/or re-TURBT) with squamous or glandular variant or nested variant should be treated with immediate radical cystectomy	16	20	64	0	41	7	52	5	64	18	18	9	Ur + O	3
4. Muscle-invasive bladder urothelial carcinoma with micropapillary variant should be treated with primary radical cystectomy and lymphadenectomy	11	11	78	0	30	17	53	2	8	8	83	8	Ur + On + O	3
5. Muscle-invasive bladder urothelial carcinoma with plasmacytoid variant should be treated with primary radical cystectomy and lymphadenectomy	9	9	82	0	29	19	52	1	17	17	67	8	Ur + On + O	3
6. Muscle-invasive bladder urothelial carcinoma with squamous or glandular variant should be treated with primary radical cystectomy and lymphadenectomy	16	4	80	0	20	23	57	2	17	25	58	8	Ur + On + O	3
7. Bladder urothelial carcinoma with small cell neuroendocrine variant should be treated with neoadjuvant chemotherapy followed by consolidating local therapy	2	2	96	0	0	0	100	1	0	0	100	8	Ur + On + O	1
8. Muscle-invasive pure squamous cell carcinoma of the bladder should be treated with primary radical cystectomy and lymphadenectomy	2	0	98	0	0	16	84	0	8	17	75	8	Ur + On + O	1
9. Muscle-invasive pure adenocarcinoma of the bladder should be treated with primary radical cystectomy and lymphadenectomy	4	2	93	0	3	9	88	0	8	8	83	8	Ur + On + O	1
10. Radiotherapy (with or without radiosensitising chemotherapy) is an effective therapy for patients with muscle-invasive urothelial carcinoma with variant histologies	58	40	2	0	13	28	59	0	40	30	30	10	Ur + On	3
11. Muscle-invasive small cell neuroendocrine variant of bladder urothelial carcinoma should receive preventive brain irradiation to avoid brain recurrence	76	20	4	0	74	19	6	1	86	14	0	13	On	1
12. Differentiating between urachal and nonurachal subtypes of adenocarcinoma is essential when making treatment decisions	7	14	80	1	6	19	74	1	0	8	92	8	Ur + On + O	1
13. Patients with pT3/4 pure adenocarcinoma or squamous carcinoma of the bladder should receive perioperative radiotherapy	75	23	2	1	58	13	29	1	14	29	57	13	Ur + On	3
14. Checkpoint inhibitor therapy is effective in metastatic urothelial carcinoma with variant histology	5	56	40	2	7	37	56	5	0	75	25	12	On	3

A = agree; D = disagree; E = equivocal; O = others (includes specialties in Nuclear Medicine, Pathology, Radiology, Specialist Nurse, Clinical Oncology); On = Oncologists; TURBT = transurethral resection of bladder tumour; U = unable to respond; Ur = Urologists.
^aStatements highlighted in green achieved level 1 consensus and those in yellow failed to reach consensus (level 3) as part of the Delphi survey; numbers highlighted in red indicate where the level of agreement among individual stakeholder groups reached $\geq 70\%$ (see Table 2 for details of consensus level criteria). Statements indicated in bold were subsequently reviewed at the consensus conference with revised statements and voting shown in Table 4.

Table 4 – Consensus meeting statements regarding the management of bladder cancer with variant histologies.

Proposed statements ^a	Level of agreement (%)			N	Consensus achieved
	Disagree	Equivocal	Agree		
1. T1 high-grade bladder urothelial cancer with micropapillary histology (established after complete TURBT and/or re-TURBT) should be treated with immediate radical cystectomy and lymphadenectomy	14	0	86	29	Yes
2. T1 high-grade bladder urothelial carcinoma (established after complete TURBT and/or re-TURBT) with plasmacytoid, sarcomatoid, squamous, glandular or nested variant should be treated with immediate radical cystectomy and concomitant LND	39	13	48	31	No
3. Muscle-invasive bladder urothelial carcinoma with micropapillary or plasmacytoid variant, or with squamous or glandular differentiation, should be treated with neoadjuvant chemotherapy followed by radical cystectomy and concomitant lymphadenectomy	12	24	63	33	No
4. Adjuvant radiotherapy (with or without radiosensitising chemotherapy) is a standard treatment for patients with muscle-invasive urothelial carcinoma with variant histologies	37	21	41	29	No

LND = lymph node dissection; N = number of voters; TURBT = transurethral resection of bladder tumour.

^aStatements highlighted in green achieved consensus.

squamous or glandular differentiation, should be treated with neoadjuvant chemotherapy followed by radical cystectomy and concomitant lymphadenectomy.

Level of consensus: 63% Agree, 12% disagree, 24% equivocal (33 voters).

3.1.4. The role of adjuvant radiotherapy for the treatment of MIBC with variant histologies

Patients with urothelial carcinoma with squamous and/or glandular differentiation are more likely to have pT3-T4 tumours (70% vs 38%, $p < 0.0001$) and pN+ disease (20% vs 15%, $p = 0.05$) than those with pure urothelial carcinoma, confirming the observation that they are more likely to die of local than of distant metastatic disease [23]. This would provide a strong argument to consider improving local control by adjuvant radiotherapy, especially in cases of positive margins at areas amenable for radiotherapy [24,25].

Statement 4: Adjuvant radiotherapy (with or without radiosensitising chemotherapy) is a standard treatment for patients with muscle-invasive urothelial carcinoma with variant histologies.

Level of consensus: 41% Agree, 37% disagree, 21% equivocal (29 voters).

3.2. The role of prognostic molecular markers in MIBC

The Delphi survey included 21 statements relating to the role of prognostic molecular markers in MIBC, which included 11 statements on the value of genetic profiling and specific mutation patterns or RNA subtypes when

making therapeutic decisions, and ten statements covering the value of tumour mutation burden, microsatellite instability, neutrophil to lymphocyte ratio (NLR), albumin and lactate dehydrogenase (LDH) when making treatment decisions regarding cystectomy, chemotherapy or immunotherapy (Table 5).

According to the Delphi survey results, ten out of these 21 statements achieved consensus—four among all stakeholder groups and six among relevant stakeholder groups only (Table 5). For the remaining statements, three controversial topics were identified and prioritised, and related statements were discussed and reassessed at the consensus conference. Results from the consensus panel scoring of the relevant statements are shown in Table 6 and supporting text is provided below.

3.2.1. Before prescribing checkpoint inhibitor therapy, do we need to identify molecular subtypes based on RNA analysis?

Molecular classification of bladder cancer has gained momentum in recent years and is still under development. Several attempts have been made and there is still no agreement regarding how many subgroups can be established and defined. All these molecular classifications have been updated in the past 4 yrs, with The Cancer Genome Atlas (TCGA) and the Lund classifications being the most recently updated [7,26]. Clearly, different subtypes exist, and among them, two main subtypes can be distinguished: luminal and basal. According to their molecular appearance, urothelial carcinomas react differently to different therapies. However, it is important to consider that TCGA data provide no information regarding

the response to subsequent treatment after cystectomy for MIBC. There is only one report based on retrospective data from patients receiving different types of neoadjuvant chemotherapies where RNA subtypes have been linked to outcome [27]. For immunotherapy, conflicting findings have been reported regarding response enrichment in luminal II and basal subtypes [28]. A lack of consensus on the description of the different RNA subtypes is also a problem. Data linking responses of atezolizumab with the

‘genomically unstable’ subgroup of the Lund classification are discordant with previously reported findings for the luminal II subtype [29].

Given the currently available evidence, the panel agreed that RNA subtypes are not needed when ICIs are prescribed, since it is too early and requires further validation. The original statement from the Delphi survey was therefore retained and a consensus regarding this statement was reached by the expert panel, as shown below.

Table 5 – Delphi results regarding proposed statements for the role of prognostic molecular markers in MIBC.

Proposed statements ^a	Level of agreement												Relevant stakeholder groups	Consensus level (see Table 2)
	Urologists (n = 45)				Oncologists (n = 32)				Others (n = 20)					
	D (%)	E (%)	A (%)	U (n)	D (%)	E (%)	A (%)	U (n)	D (%)	E (%)	A (%)	U (n)		
1. In patients with metastatic disease, genetic profiling should never be done	87	13	0	0	87	10	3	2	83	8	8	8	On	1
2. In patients with metastatic disease, genetic profiling should be done before any type of therapy	34	55	11	1	43	43	13	2	9	64	27	9	On	3
3. In patients with metastatic disease, genetic profiling should be done only after failing standard therapy	5	34	61	1	50	27	23	2	45	18	36	9	On	3
4. Before prescribing neoadjuvant chemotherapy, RNA subtypes always need to be identified	63	37	0	4	87	13	0	2	78	11	11	11	On	2
5. Before prescribing neoadjuvant chemotherapy, RNA subtypes only need to be identified in patients with anticipated limited benefit from neoadjuvant chemotherapy	40	38	23	5	76	21	3	3	29	43	29	13	On	2
6. Before prescribing checkpoint inhibitor therapy, RNA subtypes always need to be identified	44	46	10	4	69	7	24	3	50	25	25	12	On	3
7. Before prescribing checkpoint inhibitor therapy, RNA subtypes only need to be identified in selected patients	21	40	38	3	69	17	14	3	14	29	57	13	On	3
8. Before prescribing neoadjuvant chemotherapy, DDR or ERCC mutations always need to be identified	53	40	8	5	79	21	0	3	38	13	50	12	On	2
9. Before prescribing neoadjuvant chemotherapy, DDR or ERCC mutations only need to be identified in selected patients with anticipated limited benefit from neoadjuvant chemotherapy	28	40	33	5	59	24	17	3	13	63	25	12	On	3
10. Before offering subsequent treatment to patients failing first-line (platinum based) treatment and immunotherapy, selected targeted mutations (TSC1, HER2, FGFR3 mutations/translocations) always need to be identified	43	33	25	5	39	32	29	4	44	22	33	11	On	3
11. Before offering subsequent treatment to patients failing first-line (platinum based) treatment and immunotherapy, selected targeted mutations (TSC1, HER2, FGFR3 mut/translocations) only need to be identified in selected patients	18	25	58	5	41	24	34	3	22	22	56	11	On	3
12. Before prescribing a checkpoint inhibitor, TMB always needs to be assessed	70	20	10	5	85	11	4	5	78	0	22	11	On	1
13. Before prescribing a checkpoint inhibitor, TMB only needs to be assessed in selected patients	17	51	32	4	44	26	30	5	40	30	30	10	On	3

14. Before selecting patients for checkpoint inhibitor therapy, MSI and DDR mutations always need to be assessed	67	30	2	2	74	26	0	5	71	0	29	13	On	2
15. Before radical cystectomy or chemotherapy, the NLR always needs to be assessed	78	20	2	0	86	14	0	4	67	11	22	11	Ur + On	2
16. Before radical cystectomy or chemotherapy, the NLR does NOT need to be assessed	13	36	51	0	7	14	79	4	25	13	63	12	Ur + On	3
17. Before radical cystectomy or chemotherapy, the NLR only needs to be assessed in selected patients	40	42	18	0	57	36	7	4	86	14	0	13	Ur + On	3
18. In patients with metastatic disease, always measure the LDH and/or serum albumin	16	24	60	0	24	10	66	3	0	0	100	14	On	3
19. In patients with metastatic disease, LDH and/or serum albumin only need to be assessed in selected patients	50	23	27	1	82	14	4	4	100	0	0	14	On	2
20. In all fit metastatic patients receiving chemotherapy, established prognostic factors for first-line and second-line therapy must be considered when making treatment decisions (Bajorin for first-line and Bellmunt for second-line therapy)	0	11	89	1	4	11	85	5	0	0	100	13	U + On	1
21. In all fit metastatic patients receiving chemotherapy, established prognostic factors for first-line and second-line therapy need NOT be considered when making treatment decisions (Bajorin for first-line and Bellmunt for second-line therapy)	84	11	5	1	81	11	7	5	86	14	0	13	U + On	1

A = agree; D = disagree; DDR = DNA damage response; E = equivocal; ERCC = DNA excision repair protein; FGFR3 = fibroblast growth factor receptor 3; HER2 = human epidermal growth factor receptor 2; LDH = lactate dehydrogenase; MIBC = muscle-invasive bladder cancer; MSI = microsatellite instability; NLR = neutrophil to lymphocyte ratio; Oncologists; RNA, ribonucleic acid; TMB = tumour mutation burden; TSC1 = tuberous sclerosis complex 1; U = unable to respond; Ur = Urologists.

^aStatements highlighted in green achieved level 1 consensus, those in blue achieved level 2 consensus, and those in yellow failed to reach consensus (level 3) as part of the Delphi survey; numbers highlighted in red indicate where the level of agreement among individual stakeholder groups reached ≥70% (see Table 2 for details of consensus level criteria). Statements indicated in bold were subsequently reviewed at the consensus conference with revised statements and voting shown in Table 6.

Table 6 – Consensus meeting statements regarding the role of prognostic molecular markers in MIBC.

Proposed statements ^a	Level of agreement (%)			N	Consensus achieved
	Disagree	Equivocal	Agree		
1. Before prescribing checkpoint inhibitor therapy, RNA subtypes always need to be identified	91	6	3	31	Yes
2. Before radical cystectomy or chemotherapy, the NLR does NOT need to be assessed	3	0	97	31	Yes
3. In patients with metastatic disease, always measure the LDH and/or serum albumin as general prognostic markers of patient outcome	16	19	65	31	No

LDH = lactate dehydrogenase; MIBC = muscle-invasive bladder cancer; N = number of voters; NLR = neutrophil to lymphocyte ratio; RNA, ribonucleic acid.

^aStatements highlighted in green achieved consensus.

Statement 1: Before prescribing checkpoint inhibitor therapy, RNA subtypes always need to be identified.

Level of consensus: 3% Agree, 91% disagree, 6% equivocal (31 voters).

3.2.2. *Before radical cystectomy or chemotherapy, do we need to assess the NLR?*

Several studies have already demonstrated that systemic inflammation correlates with worse prognosis in several malignancies. In this setting, biomarkers such as C-reactive protein (CRP), lymphocyte-monocyte ratio and platelet-lymphocyte ratio have been investigated. Recently, NLR has emerged as a prognostic factor in upper urinary tract tumours [30] and other non-urological malignancies. The use of NLR as a predictive tool is derived from studies using chemotherapy in oesophageal, gastric and colorectal cancers. Data have also emerged for NLR as a potentially predictive biomarker in patients receiving immunotherapy for melanoma, lung cancer, and renal cell carcinoma. In a recent pooled analysis of 21 studies analysing the prognostic role of NLR in bladder cancer, the authors correlated elevated pretreatment NLR with OS, recurrence-free survival, and DSS in patients with localised disease and in those with metastatic disease [31]. In contrast, in a recent secondary analysis from the Southwest Oncology Group (SWOG) 8710 trial, which assessed the role of neoadjuvant chemotherapy in MIBC, the authors could not demonstrate any correlation between NLR and OS (prognostic) or the OS benefit from neoadjuvant chemotherapy (predictive) [32].

After considering the available data, the panel agreed that before radical cystectomy or chemotherapy, NLR does not need to be assessed. Although it is easy to do, we require prospective data before this can be used to drive or change treatment decisions.

Statement 2: Before radical cystectomy or chemotherapy, the NLR does NOT need to be assessed.

Level of consensus: 97% Agree, 3% disagree (31 voters).

3.2.3. *In patients with metastatic disease, do we need to assess LDH and/or serum albumin?*

No strong data exist regarding the value of albumin or LDH as prognostic factors in metastatic bladder cancer. In Bajorin et al's [33] risk factor analysis in patients with previously untreated metastatic bladder cancer, neither LDH nor albumin was identified as a significant risk factor in a multivariate analysis despite being significant in the univariate analysis. However, as albumin and LDH are easy to measure in peripheral blood and are already validated in other cancers, these parameters are being used in daily clinical practice. For patients treated with second-line chemotherapy, haemoglobin, performance status (PS), and liver metastasis are recognised prognostic factors [34]. However, in a pooled analysis of data from ten phase 2 trials evaluating various different therapies, the addition of albumin to these already-established prognostic factors emerged as significant [35]. A recent meta-analysis has also confirmed the prognostic role of LDH in urological cancer [36].

After considering the available data, working group 2 proposed that LDH and/or serum albumin should always

be measured in patients with metastatic disease as a general prognostic marker of outcome, not relating to bladder cancer specifically but rather as a prognostic cancer marker. Although there was some agreement by the expert panel for this statement, it failed to reach the consensus threshold.

Statement 3: In patients with metastatic disease, always measure the LDH and/or serum albumin as general prognostic markers of patient outcome.

Level of consensus: 65% Agree, 16% disagree, 19% equivocal (31 voters).

3.3. *Bladder preservation strategies*

The Delphi survey included 19 statements relating to bladder preservation strategies, including patient selection, chemoradiation and radiosensitisers, adjuvant therapy and PLND (Table 7). An additional statement was added to this category following the results of round 1 of the survey.

According to the Delphi survey results, nine of the 20 statements reached consensus—six among all stakeholder groups and three among relevant stakeholder groups only (Table 7). For the remaining statements, nine were prioritised for further discussion and revision. Results from the consensus panel scoring of the new/revised statements are shown in Table 8 and supporting text is provided below.

3.3.1. *Patient selection for bladder preservation strategies*

Patient selection depends on the organisation of the health care system per country in general and per department in particular. Specialist bias and available therapeutic options can and will influence the treatment of cancer patients. For example, despite the known benefits of neoadjuvant chemotherapy, its use is strongly associated with communication with and referral to a medical oncologist. In colorectal cancer, collaboration between surgeons and oncologists has been shown to improve both all-cause and cancer-specific survival [37]. The role of the specialist nurse, which also differs according to the country and department, has also been shown to improve patient quality of life, be cost effective, and lower the workload of the physician [38].

Statement 1: Candidates for curative treatment, such as cystectomy or bladder preservation, should be clinically assessed by at least an oncologist, a urologist and a neutral HCP such as a specialist nurse.

Level of consensus: 83% Agree, 6% disagree, 12% equivocal (34 voters).

3.3.2. *Chemoradiation for inoperable, locally advanced MIBC*

For MIBC, multiple studies have shown that the addition of chemotherapy to radiotherapy improves local control and survival rates compared with radiotherapy alone, and also results in good long-term bladder function and low rates of salvage cystectomy [39–42]. The addition of gemcitabine, cisplatin, carbogen/nicotinamide (BCON), or 5-fluorouracil (5FU)/mitomycin C (MMC) (BC2001) to radiotherapy have all either been compared with radiotherapy alone or have single-arm data and extensive use in clinical practice [39–42].

Table 7 – Delphi results regarding proposed statements for bladder preservation strategies.

Proposed statements ^a	Level of agreement												Relevant stakeholder groups	Consensus level (see Table 2)
	Urologists (n = 45)				Oncologists (n = 32)				Others (n = 20)					
	D (%)	E (%)	A (%)	U (n)	D (%)	E (%)	A (%)	U (n)	D (%)	E (%)	A (%)	U (n)		
1. Patients should be counselled on all treatment options by a neutral healthcare professional (e.g. a nurse specialist)	42	24	33	0	19	19	63	0	6	13	81	4	Ur + On + O	3
2. All patients diagnosed with MIBC should be seen by an Oncologist as well as by a Urologist	23	18	59	1	0	3	97	0	0	0	100	1	Ur + On + O	3
3. All patients over 75 yrs of age should be evaluated preoperatively by a geriatrician	13	24	62	0	16	16	69	0	11	11	78	2	Ur + On + O	3
4. An important determinant for patient eligibility in case of bladder preserving treatment is absence of carcinoma <i>in situ</i>	4	7	89	0	3	13	84	1	7	7	86	6	Ur + On	1
5. An important determinant for patient eligibility in case of bladder preserving treatment is absence or presence of hydronephrosis	0	7	93	0	10	6	84	1	7	7	87	5	Ur + On	1
6. When assessing patient eligibility for bladder preservation, the likelihood of successful debulking surgery should be taken into consideration (optimal debulking)	0	7	93	0	9	6	84	0	6	6	88	4	Ur + On	1
7. In patients with clinical T4 or clinical N+ disease (regional), radical chemoradiation can be offered accepting that this may be palliative rather than curative in outcome	9	20	71	0	3	3	94	0	0	6	94	4	Ur + On	1
8. The preferred radiotherapeutic schedule is radiotherapy alone (single block)	100	0	0	3	93	0	7	2	90	0	10	10	On	1
9. The preferred radiotherapeutic schedule is radiotherapy given concurrently with BCON	87	11	3	7	60	23	17	2	71	29	0	13	On	3
10. The preferred radiotherapeutic schedule is radiotherapy alone, split course with interval cystoscopy and immediate cystectomy for non-responders	58	19	23	2	74	13	13	1	50	38	13	12	On	2
11. The preferred radiosensitiser is 5-fluorouracil + mitomycin C	26	39	34	7	19	13	69	0	17	17	67	14	On	3
12. The preferred radiosensitiser is cisplatin	5	13	82	6	10	13	77	1	33	17	50	14	On	2
13. The preferred radiosensitiser is gemcitabine	42	37	21	7	42	26	32	1	0	50	50	14	On	3
14. The preferred radiosensitiser is BCON	67	31	3	9	58	26	16	1	50	50	0	14	On	3
15. Brachytherapy has a role in the treatment of MIBC	87	4	9	0	59	24	17	3	44	22	33	11	Ur + On	3
16. PLND should be an integral part of bladder preservation strategies in patients with MIBC	38	16	47	0	69	6	25	0	0	17	83	8	Ur + On	3
17. When adjuvant chemotherapy is offered, patients should be selected based on the result of PLND (if done)	11	4	84	0	13	16	71	1	0	17	83	8	Ur + On	1
18. When adjuvant chemotherapy is offered, patients should be selected based on response to trimodality therapy	35	26	40	2	33	37	30	2	33	44	22	11	Ur + On	3
19. When adjuvant chemotherapy is offered, patients should be selected based on pT3 or pT4 at cystectomy	7	4	89	0	3	10	87	1	17	17	67	8	Ur + On	2
20. Irradiation of the lymph nodes should be standard during trimodality treatment	7	24	68	4	33	10	57	2	25	13	63	12	Ur + On + O	3

A = agree; BCON = carbogen and nicotinamide; D = disagree; E = equivocal; MIBC = muscle-invasive bladder cancer; N = node; O = others (includes specialties in Nuclear Medicine, Pathology, Radiology, Specialist Nurse, Clinical Oncology); On = Oncologists; PLND = pelvic lymph node dissection; pT = pathological tumour stage; T = tumour; U = unable to respond; Ur = Urologists.

^aStatements highlighted in green achieved level 1 consensus, those in blue achieved level 2 consensus, and those in yellow failed to reach consensus (level 3) as part of the Delphi survey; numbers highlighted in red indicate where the level of agreement among individual stakeholder groups reached ≥70% (see Table 2 for details of consensus level criteria). Statements indicated in bold were subsequently reviewed at the consensus conference with revised statements and voting shown in Table 8.

Table 8 – Consensus meeting statements regarding bladder preservation strategies.

Proposed statements ^a	Level of agreement (%)			N	Consensus achieved
	Disagree	Equivocal	Agree		
1. Candidates for curative treatment, such as cystectomy or bladder preservation, should be clinically assessed by at least an oncologist, a urologist and a neutral healthcare professional such as a specialist nurse	6	12	83	34	Yes
2. Chemoradiation should be given to improve local control in case of inoperable locally advanced tumours	3	12	85	32	Yes
3. In case of bladder preservation with radiotherapy, combination with a radiosensitiser is always recommended to improve clinical outcomes, such as cisplatin, 5FU/MMC, carbogen/nicotinamide or gemcitabine	0	0	100	29	Yes
4. In patients with cN0 disease, PLND in case of bladder preservation is not recommended	14	22	64	31	No
5. Radiotherapy for bladder preservation should be performed with IMRT and IGRT to reduce side effects	0	16	84	25	Yes
6. Dose escalation above standard radical doses to the primary site in case of bladder preservation, either by IMRT or by brachytherapy, is not recommended	7	7	86	28	Yes

5FU = 5-fluorouracil; IGRT = image-guided radiotherapy; IMRT = intensity-modulated radiotherapy; MMC = mitomycin C; N = number of voters; PLND = pelvic lymph node dissection.

^aStatements highlighted in green achieved consensus.

Statement 2: Chemoradiation should be given to improve local control in cases of inoperable locally advanced tumours.

Level of consensus: 85% Agree, 3% disagree, 12% equivocal (32 voters).

3.3.3. Radiosensitisers

As no comparative data are available for the use of radiosensitisers in MIBC, there was consensus among the expert panel not to recommend any specific radiosensitiser in case of chemoradiation therapy. Obviously, the patient needs to be fit enough to undergo chemotherapy. If not, radiotherapy alone is an option to be discussed with the patient as a palliative treatment strategy.

Statement 3: In case of bladder preservation with radiotherapy, combination with a radiosensitiser is always recommended to improve clinical outcomes, such as cisplatin, 5FU/MMC, carbogen/nicotinamide or gemcitabine.

Level of consensus: 100% Agree, 0% disagree (29 voters).

3.3.4. Pelvic lymph nodes

According to several large cystectomy series, micrometastases in the pelvic lymph nodes are found in 25–44% of patients with MIBC. For patients receiving chemoradiation, a group that often has a worse prognosis, this might be even higher. In order to minimise bowel toxicity for patients with cN0 disease, many centres do not target pelvic lymph nodes. However, with modern intensity-modulated radiotherapy (IMRT) and image-guided radiotherapy (IGRT) techniques,

this is now much more feasible. Surprisingly, findings from the large BC2001 and BCON trials, which included radiotherapy confined to the bladder only, did not report high rates of lymph node relapse (typically <10%) as might have been expected from surgical pathological staging on cystectomy, suggesting that chemoradiation partially eradicates pelvic lymph node micrometastases [43]. However, this was not confirmed in a chemoradiation trial comparing radiotherapy of the whole pelvis versus that of the bladder (tumour site) alone. Among complete responders, the incidence of pelvic lymph node recurrence was 15.8% and 17.6%, respectively [44]. Consequently, given the current literature, no consensus could be reached regarding whether or not to perform a PLND in bladder preservation strategies.

Statement 4: In patients with cN0 disease, PLND in case of bladder preservation is not recommended.

Level of consensus: 64% Agree, 14% disagree, 22% equivocal (31 voters).

3.3.5. Radiotherapy techniques

IMRT is a modern type of external beam radiotherapy (EBRT) that delivers precise dose distribution to the target area, whilst minimising dose to the surrounding at-risk organs. Possible challenges for IMRT are organ motion, and inaccuracy in delineation of tumour and other adjacent organs. However, these limitations can be overcome by IGRT. Therefore, the combination of IMRT and image guidance is essential. Lower toxicities can also be achieved with the combination of IGRT and IMRT in bladder cancer [45].

Statement 5: Radiotherapy for bladder preservation should be performed with IMRT and IGRT to reduce side effects.

Level of consensus: 84% Agree, 16% equivocal (25 voters).

3.3.6. Radiotherapy dosing

Brachytherapy for MIBC is not widely performed and data are therefore limited to highly selected patients in centres with a particular interest in this field. So far, only retrospective studies have been carried out, which have included a wide variation in patient and tumour characteristics. In the majority of patients who received brachytherapy, this was preceded by EBRT [46]. Moreover, it is an invasive procedure that requires surgical catheter placement. Since prospective or randomised controlled trials on brachytherapy are lacking, there was consensus among the expert panel not to recommend brachytherapy for MIBC. There was also a consensus not to recommend dose escalation by IMRT based on limited early results [47]. A UK-based randomised trial (RAIDER) addressing the potential value of dose escalation has just completed accrual and will provide further insights on this topic.

Statement 6: Dose escalation above standard radical doses to the primary site in case of bladder preservation, either by IMRT or brachytherapy, is not recommended.

Level of consensus: 86% Agree, 7% disagree, 7% equivocal (28 voters).

3.4. The role of treatment of curative intent in OMD

OMD is generally defined as occurrence of ≤ 5 metastases, and may be found synchronous with the primary tumour or as a metachronous recurrence. There has been much biological research regarding how OMD may arise as an early phase in the metastatic cascade, and on how this might be distinguished from polymetastatic disease [48]. Although the finding of OMD may offer hope of cure, for the responsible clinician, an important consideration is the avoidance of toxicities associated with radical therapies in a palliative setting.

There are few published series about the radical treatment of OMD in urothelial cancers; hence, no guidelines have addressed its management [49]. Thus, questions need to be addressed, at least in part, by reference to other cancers or other disease stages. For example, a multicentre review of radical surgery for 5206 cases of lung metastases reported a 5-year survival rate of 36%, encouraging the belief that an early stage of metastasis exists which may be very limited in extent and thus curable by radical treatment [50]. Important prognostic factors in this series included whether the OMD was solitary and whether the recurrent OMD occurred a long time (>36 months) after treatment of the primary tumour. Similarly, in non-small cell lung cancer, findings from a systematic review and pooled analysis showed that among 110 patients who had an adrenalectomy for an isolated adrenal metastasis, OS was shorter for those with synchronous versus metachronous metastasis (12 vs 31 mos, respectively; $p=0.02$) [51]. Simi-

larly encouraging series based on the radical treatment of metastases with stereotactic radiotherapy have also been reported.

This Delphi survey included 21 statements relating to the role of treatment of curative intent in OMD, including the number of metastatic sites consistent with possible cure, curability of different OMD organ locations, synchronous versus metachronous OMD, the question of delayed restaging and staging technology, use of adjuvant chemotherapy, choice of radical OMD therapy, extent of primary surgery, and the sequence of treating synchronous presentations (Table 9).

According to the Delphi survey results, four of the 21 statements reached consensus across all stakeholder groups (Table 9). For the remaining statements, three controversial topics were identified and prioritised and related statements were discussed and reassessed at the consensus conference. Results from the consensus panel scoring of the relevant statements are shown in Table 10 and supporting text is provided below.

3.4.1. Number of metastatic sites consistent with possible cure

Results from the Delphi survey showed that there was a consensus among participants that the presence of more than two metastatic sites should discourage attempted cure, that the liver or bone is an adverse prognostic site and that longer time to metachronous OMD recurrence is associated with a more favourable outcome. However, there was no consensus regarding whether cure should be attempted for patients with one or two metastatic sites.

Based on the results from prospective phase 3 trials, approximately 10% of patients with urothelial cancer and visceral metastases survive 5 yrs after chemotherapy [52]. Prognostic factors include PS, laboratory parameters (albumin, haemoglobin, leukocyte count, or CRP), visceral metastasis, and the number of metastatic sites. The number of metastatic sites was identified as an independent predictive factor for survival with the best prognosis seen in those with a single metastatic site only [53].

Although there is only low-level evidence, encouragingly long survival time has been reported for patients with favourable prognostic factors after the combination of systemic chemotherapy and local treatment (radical cystectomy, metastasectomy). A retrospective study of 44 patients treated across 15 German centres reported a 5-yr survival rate of 28% [54], and in a series of 42 patients from Japan treated by metastasectomy, in patients with solitary nodal or lung metastasis (15 patients), the median OS reached 81 months [55]. A small series from Korea [49] also supported these conclusions. As summarised in a recent collaborative systematic review in metastatic bladder cancer [56], the beneficial role of metastasis surgery remains unproven by a prospective trial, but may be considered in those with low-volume disease (especially pelvic node disease) and ideally in those with chemosensitive disease.

Statement 1: In a minority of patients with one metastatic lesion, cure is possible after radical treatment.

Level of consensus: 91% Agree, 6% disagree, 3% equivocal (31 voters).

Table 9 – Delphi results regarding proposed statements for the role of treatment of curative intent in OMD.

Proposed statements ^a	Level of agreement												Relevant stakeholder groups	Consensus level (see Table 2)
	Urologists (n = 45)				Oncologists (n = 32)				Others (n = 20)					
	D (%)	E (%)	A (%)	U (n)	D (%)	E (%)	A (%)	U (n)	D (%)	E (%)	A (%)	U (n)		
1. In patients with one metastatic site, cure is still possible	18	13	69	0	13	19	69	0	21	0	79	6	Ur + On	3
2. In patients with two metastatic sites, cure is still possible	40	18	42	0	47	22	31	0	46	8	46	7	Ur + On	3
3. In patients with more than two metastatic sites, cure is still possible	91	4	4	0	88	6	6	0	86	7	7	6	Ur + On	1
4. Liver is a favourable OMD site for curative therapy	95	2	2	1	81	16	3	1	93	7	0	6	Ur + On	1
5. Bone is a favourable OMD site for curative therapy	93	2	5	1	77	16	6	1	87	0	13	5	Ur + On	1
6. Lung is a favourable OMD site for curative therapy	36	9	56	0	55	6	39	1	43	21	36	6	Ur + On	3
7. Extrapelvic lymph node is a favourable OMD site for curative therapy	22	13	64	0	19	13	68	1	29	14	57	6	Ur + On	3
8. OMD is more favourable prognostically as a relapse syndrome (metachronous disease) than as a presentation syndrome (synchronous disease)	16	36	48	1	6	31	63	0	18	45	36	9	Ur + On	3
9. After staging reveals OMD, curative therapy should be deferred pending confirmation restaging 6 weeks later using the same staging method as the initial staging	36	44	20	0	44	31	25	0	40	60	0	10	Ur + On	3
10. It is important to include PET-CT scanning in OMD staging	16	13	71	0	22	16	63	0	6	6	88	3	Ur + On + O	3
11. Radiotherapy to the whole bone should follow resection of a bone metastasis	33	40	26	3	16	23	61	1	60	40	0	10	On	3
12. Radiotherapy to the whole brain should follow resection of a brain metastasis	44	34	22	4	53	13	34	0	56	11	33	11	On	3
13. Radical treatment of oligometastases should be accompanied by neoadjuvant chemotherapy only	33	28	40	2	26	42	32	1	43	14	43	13	Ur + On	3
14. Radical treatment of oligometastases should be accompanied by adjuvant chemotherapy only	57	38	5	3	58	35	6	1	43	29	29	13	Ur + On	3
15. Radical treatment of oligometastases should be accompanied by no chemotherapy at all	100	0	0	2	65	26	10	1	63	13	25	12	Ur + On	3
16. Curative treatment of OMD is especially indicated for pure squamous cell cancers	30	58	13	5	37	47	17	2	0	50	50	12	Ur + On	3
17. In case of OMD at first presentation, the primary site must be treated first before treating distant metastatic sites	35	28	37	2	27	50	23	2	17	42	42	8	Ur + On	3
18. In metachronous OMD, time to relapse is an important prognostic indicator	2	4	93	0	0	3	97	0	0	8	92	7	Ur + On	1
19. Initial local treatment for OMD should be radical surgery rather than radiotherapy, when possible	24	38	38	0	42	42	16	1	30	40	30	10	Ur + On	3
20. In case patients with visceral OMD are offered a radical cystectomy, a standard LND should be offered (pelvic lymph nodes up to crossing of ureter with common iliac vessels)	7	20	73	0	39	32	29	4	10	30	60	10	Ur + On	3
21. In case patients with visceral OMD are offered a radical cystectomy, an extended LND should be offered (up to inferior mesenteric artery)	38	27	36	0	57	36	7	4	30	40	30	10	Ur	3

A = agree; CT = computed tomography; D = disagree; E = equivocal; LND = lymph node dissection; O = others (includes specialties in Nuclear Medicine, Pathology, Radiology, Specialist Nurse, Clinical Oncology); On = Oncologists; OMD = oligometastatic disease; PET = positron emission tomography; U = unable to respond; Ur = Urologists.

^aStatements highlighted in green achieved level 1 consensus and those in yellow failed to reach consensus (level 3) as part of the Delphi survey; numbers highlighted in red indicate where the level of agreement among individual stakeholder groups reached $\geq 70\%$ (see Table 2 for details of consensus level criteria). Statements indicated in bold were subsequently reviewed at the consensus conference with revised statements and voting shown in Table 10.

Table 10 – Consensus meeting statements regarding the role of treatment of curative intent in OMD.

Proposed statements ^a	Level of agreement (%)			N	Consensus achieved
	Disagree	Equivocal	Agree		
1. In a minority of patients with one metastatic lesion, cure is possible after radical treatment	6	3	91	31	Yes
2. PET-CT scanning should be included in OMD staging when considering radical treatment	3	9	88	32	Yes
3. Radical treatment of OMD should be accompanied by adjuvant or neoadjuvant systemic therapy	6	22	72	32	Yes

CT = computed tomography; N = number of voters; OMD = oligometastatic disease; PET = positron emission tomography.

^aStatements highlighted in green achieved consensus.

3.4.2. The role of positron emission tomography-computed tomography in staging of OMD

To minimise the risk of overtreatment, patients with OMD should be restaged using the most sensitive imaging technique available. F-18-fluorodeoxyglucose (FDG)-positron emission tomography (PET)-computed tomography (CT) scanning is generally more sensitive than CT in urothelial cancer, although its use around the bladder is compromised by the urinary excretion of the isotope and its use in staging of the primary tumour currently lacks sufficient evidence to support its recommendation. However, in a staging study of 42 patients prior to cystectomy, FDG-PET-CT detected metastases in seven patients who showed no evidence of disease on CT and bone scans [57]. A published review of six series also found a high diagnostic accuracy for metastatic lesions using FDG-PET-CT [58], and a recent review from the National Institutes of Health (Bethesda, MD, USA) concluded that FDG-PET-CT was the optimal technology in this setting [59].

Statement 2: PET-CT scanning should be included in OMD staging when considering radical treatment.

Level of consensus: 88% Agree, 3% disagree, 9% equivocal (32 voters).

3.4.3. The role of downstaging chemotherapy in OMD

There are no direct comparative studies regarding whether or not to combine systemic therapy with local therapy for urothelial OMD. However, outcomes research on OMD in other tumours emphasises the high risk of recurrence after local treatment alone. There is evidence to support the use of systemic chemotherapy as a component of treatment for high-risk (muscle-invasive) primary bladder cancer. Neoadjuvant chemotherapy with cisplatin/methotrexate/vinblastine was associated with a 16% reduction in mortality risk. An overview of adjuvant chemotherapy trials has also suggested a reduction in mortality risk by over 20%, with a particular benefit seen in higher-risk (ie, node-positive) cases [60].

Statement 3: Radical treatment of OMD should be accompanied by adjuvant or neoadjuvant systemic therapy.

Level of consensus: 72% Agree, 6% disagree, 22% equivocal (32 voters).

3.5. ICIs in urothelial bladder cancer

The Delphi survey included 20 statements relating to ICIs in urothelial bladder cancer, including patient selection, timing and duration of ICI therapy (Table 11).

According to the Delphi survey results, nine of the 20 statements reached consensus—five among all stakeholder groups and four among relevant stakeholder groups only (Table 11). For the remaining statements, four key topics were prioritised, and related statements were discussed and reassessed at the consensus conference. Results from the consensus panel scoring of the corresponding new/revised statements are shown in Table 12 and supporting text is provided below.

3.5.1. Pseudo-progression with ICIs

Pseudo-progression, defined as tumour growth followed by tumour response after initiation of ICI therapy, has been described in melanoma [61]. It is thought that the initial immune infiltration may make the tumour appear radiologically larger without defining treatment failure. It tends to occur at the start of therapy and can confuse clinical assessment.

Progression of disease is the commonest radiological outcome with single-agent ICI therapy in urothelial cancer [13,15,62]. However, there is a lack of data to support the hypothesis that a proportion of these tumours can recede after initial progression, and the consensus panel agreed that pseudo-progression has not been demonstrated in urothelial cancer. The biology of urothelial cancer and that of melanoma are distinct, as are responses to ICI therapy. Treatment with ICIs beyond progression in the hope of pseudo-progression may therefore be counterproductive in urothelial cancer.

Statement 1: Pseudo-progression has not been demonstrated in urothelial cancer.

Table 11 – Delphi results regarding proposed statements for ICIs in urothelial bladder cancer.

Proposed statements ^a	Level of agreement												Relevant stakeholder groups	Consensus level (see Table 2)
	Urologists (n = 45)				Oncologists (n = 32)				Others (n = 20)					
	D (%)	E (%)	A (%)	U (n)	D (%)	E (%)	A (%)	U (n)	D (%)	E (%)	A (%)	U (n)		
1. In patients with advanced/metastatic urothelial cancer who are ineligible for cisplatin-based therapy but with high PD-L1 expression (as per approved drug specific methodology), both treatment with an ICI and chemotherapy can be offered	7	4	89	0	4	0	96	4	0	20	80	10	On	1
2. Since no data exist for cisplatin-ineligible PD-L1-positive patients in order to differentiate between different ICIs (atezolizumab and pembrolizumab), either agent can be administered	2	7	91	0	0	0	100	5	0	0	100	11	On	1
3. Sequencing of ICIs and chemotherapy maximises outcomes for patients with cisplatin-ineligible advanced/metastatic urothelial cancer	2	50	48	3	7	36	57	4	0	45	55	9	Ur + On	3
4. Sequencing of different ICIs is indicated in cisplatin-ineligible advanced/metastatic urothelial cancer	34	51	15	4	81	19	0	5	0	71	29	13	On	2
5. Treatment with ICIs past radiological progression in patients with cisplatin-ineligible advanced/metastatic urothelial cancer is associated with potentially disease-related harmful risk. This approach should usually be avoided	58	26	16	7	59	19	22	5	40	20	40	15	On	3
6. Enrolment in a clinical trial remains the preferred option for patients with cisplatin-ineligible advanced/metastatic urothelial cancer until ongoing randomised trials report in this population	0	2	98	0	0	0	100	1	0	0	100	8	Ur + On	1
7. Hyper-progression occurs frequently and is a clinical problem in patients with cisplatin-ineligible advanced/metastatic urothelial cancer	33	40	28	5	50	32	18	4	40	20	40	15	On	3
8. Treatment with an ICI should be offered to patients with advanced/metastatic urothelial cancer with progression after platinum-based chemotherapy. This includes tumours which have progressed within a year or following perioperative (cystectomy) chemotherapy	0	2	98	0	3	0	97	3	0	0	100	10	Ur + On	1
9. In patients with advanced/metastatic urothelial cancer with progression after platinum-based chemotherapy, there are no data to differentiate between the five different ICIs. All are well tolerated with long-term durable remissions and can be used interchangeably	27	7	67	0	36	0	64	4	0	17	83	14	On	3
10. PD-L1 biomarkers should be used to select patients eligible for ICIs in patients with advanced/metastatic urothelial cancer with progression after platinum-based chemotherapy	30	23	48	1	52	10	38	3	0	11	89	11	Ur + On	3
11. Sequencing of different ICIs is indicated when one fails in patients with advanced/metastatic urothelial cancer with progression after platinum-based chemotherapy	24	29	48	3	68	7	25	4	13	13	75	12	On	3

12. Pembrolizumab is the preferred agent in patients with advanced/metastatic urothelial cancer with progression after platinum-based chemotherapy, and should be offered where possible	0	29	71	0	3	21	76	3	17	33	50	14	On	2
13. ICIs should not be recommended as neoadjuvant or adjuvant treatment in patients with non-metastatic MIBC	16	16	69	0	3	7	90	2	14	0	86	13	Ur + On	3
14. ICIs can be considered in patients with locally advanced (T4b), but potentially operable, bladder cancer who are ineligible for cisplatin-based neoadjuvant therapy	14	23	64	1	33	30	37	2	29	0	71	13	Ur + On	3
15. ICI therapy should not be recommended in patients with NMIBC	16	18	67	0	10	10	80	2	20	0	80	15	Ur + On	3
16. Each ICI has a different PD-L1 biomarker to define positivity. The biomarkers define distinct populations and therefore are not interchangeable in clinical practice	28	23	49	2	18	32	50	4	57	29	14	13	On	3
17. In patients with advanced/metastatic urothelial cancer, it is not recommended to use combinations of ICIs, or a combination of ICIs and other anticancer treatments prior to the reporting of randomised trials	2	7	91	1	3	7	90	2	17	17	67	14	On	2
18. Once initiated, ICI therapy should be continued until progression of disease in patients with advanced/metastatic urothelial cancer	2	4	93	0	7	3	90	3	0	25	75	12	On	1
19. Pseudo-progression with ICIs is rare in patients with advanced/metastatic urothelial cancer. Treatment past radiological progression is of unproven benefit in advanced/metastatic urothelial cancer, but should be considered especially in platinum-refractory disease where other treatment options are lacking	5	21	74	2	0	21	79	3	0	33	67	14	On	2
20. ICIs are cost effective in licenced indications in advanced/metastatic urothelial cancer	28	44	28	6	8	32	60	7	40	40	20	15	On	3

A = agree; D = disagree; E = equivocal; ICI = immune checkpoint inhibitor; MIBC = muscle-invasive bladder cancer; NMIBC = non-muscle-invasive bladder cancer; On = Oncologists; PD-L1 = programmed death-ligand 1; U = unable to respond; Ur = Urologists.

^aStatements highlighted in green achieved level 1 consensus, those in blue achieved level 2 consensus, and those in yellow failed to reach consensus (level 3) as part of the Delphi survey; numbers highlighted in red indicate where the level of agreement among individual stakeholder groups reached $\geq 70\%$ (see Table 2 for details of consensus level criteria). Statements indicated in bold were subsequently reviewed at the consensus conference with revised statements and voting shown in Table 12.

Level of consensus: 89% Agree, 11% equivocal (28 voters).

3.5.2. *The role of PD-L1 biomarkers to guide the use of ICI therapy*
 Five different ICI cancer drugs are currently available, all of which have a different companion diagnostic to measure PD-L1 (142-atezolizumab, 288-nivolumab, 263-durvalumab, 7310-avelumab, 223-pembrolizumab) [63]. Each has a different antibody and method of measurement (immune cell vs tumour cell expression, different percentage cut points, Dako vs Ventana technology). For these reasons, positivity varies between 20% and 60% in the platinum-refractory setting for the five different methods. The biomarkers are also inconsistent in the platinum-refractory metastatic setting and appear more prognostic than predictive [15,62]. None can be reliably used to select treatment due to their lack of sensitivity and specificity [63].

In the front-line, cisplatin-ineligible setting, only data from single-arm trials of atezolizumab and pembrolizumab are in the public domain [13,14], and again, the data appear inconsistent. However, the European Medicines Agency (EMA) has changed their scope of use to restrict them to only PD-L1-positive patients in this setting. This must be related to publicly unavailable data suggesting that the biomarker is predictive. It suggests that the biomarker is effective for selecting patients in the front-line, cisplatin-ineligible setting, unlike the platinum-refractory setting. The reasons for this are unclear.

Statement 2: In contrast to the first-line setting, the PD-L1 biomarker is not useful for selecting patients for immunotherapy in platinum-refractory metastatic urothelial cancer.

Level of consensus: 81% Agree, 4% disagree, 15% equivocal (28 voters).

Table 12 – Consensus meeting statements regarding ICIs in urothelial bladder cancer.

Proposed statements ^a	Level of agreement (%)			N	Consensus achieved
	Disagree	Equivocal	Agree		
1. Pseudo-progression has not been demonstrated in urothelial cancer	0	11	89	28	Yes
2. In contrast to the first-line setting, the PD-L1 biomarker is not useful for selecting patients for immunotherapy in platinum-refractory metastatic urothelial cancer	4	15	81	28	Yes
3. Carboplatin-based chemotherapy remains a viable first-line treatment option in cisplatin-ineligible, PD-L1-positive patients with metastatic urothelial carcinoma until data from randomised phase 3 trials of ICIs are available	3	10	87	29	Yes
4. Cisplatin-ineligible, immunotherapy-refractory patients with metastatic urothelial carcinoma should be considered for chemotherapy instead of sequencing of immunotherapy	7	12	81	27	Yes

ICI = immune checkpoint inhibitor; N = number of voters; PD-L1 = programmed death-ligand 1.

^aStatements highlighted in green achieved consensus.

3.5.3. The role of chemotherapy in cisplatin-ineligible, PD-L1-positive patients with metastatic urothelial carcinoma

Although ICIs are associated with long-term durable remissions as a first-line treatment of cisplatin-ineligible, PD-L1-positive patients with metastatic urothelial carcinoma, RRs, progression-free survival and OS have not been proven to be superior to carboplatin-based chemotherapy [13,14]. Chemotherapy is associated with significant RRs in this setting. Data from randomised phase 3 trials of ICIs in this setting will be available soon, and as results are unpredictable, it seems prudent to wait until these data are available before definitive decisions are made.

Statement 3: Carboplatin-based chemotherapy remains a viable first-line treatment option in cisplatin-ineligible, PD-L1-positive patients with metastatic urothelial carcinoma until data from randomised phase 3 trials of ICIs are available.

Level of consensus: 87% Agree, 3% disagree, 10% equivocal (29 voters).

3.5.4. The role of chemotherapy in cisplatin-ineligible, immunotherapy-refractory patients with metastatic urothelial carcinoma

To the best of our knowledge, there is no evidence that sequencing ICIs in the face of disease progression is of clinical benefit in urothelial carcinoma. The drugs have, at least in part, an overlapping mechanism of action, and therefore sequencing of these drugs is counterintuitive [63]. Retrospective data suggest that patients who progress on first-line immunotherapy appear to maintain a reasonable objective RR to a subsequent line of chemotherapy [64]. Thus, sequencing chemotherapy after first-line immunotherapy is attractive whilst we await data from prospective clinical trials.

Statement 4: Cisplatin-ineligible, immunotherapy-refractory patients with metastatic urothelial carcinoma should be considered for chemotherapy instead of sequencing of immunotherapy.

Level of consensus: 81% Agree, 7% disagree, 12% equivocal (27 voters).

3.6. Follow-up strategies and survivorship

The Delphi survey included 20 statements relating to follow-up strategies and survivorship after radical cystectomy, trimodality bladder preservation treatment, or chemotherapy for urothelial carcinoma (Table 13).

According to the Delphi survey results, 12 of the 20 statements reached consensus—nine among all stakeholder groups and three among relevant stakeholder groups only (Table 13). Of the eight remaining statements, seven were prioritised for further discussion and revision at the consensus conference. Results from the consensus panel scoring of the new/revised statements are shown in Table 14 and supporting text is provided below.

3.6.1. Follow-up after radical cystectomy

After cystectomy, depending on the stage (pT and pN), up to 70% of patients will have tumour recurrence, which may be local or systemic. There is also a risk of second cancers in the remaining urothelial tract (in the upper urinary tract and in the urethra). There are no prospective data evaluating the benefit of regular follow-up in patients with urothelial cancer of the bladder after treatment with curative intent versus staging when symptoms occur.

In general, chemotherapy is better tolerated and is associated with more favourable outcomes in patients with a good PS, suggesting that earlier detection of metastases may be beneficial for patients compared with waiting for

Table 13 – Delphi results regarding proposed statements for follow-up strategies and survivorship.

Proposed statements ^a	Level of agreement												Relevant stakeholder groups	Consensus level (see Table 2)
	Urologists (n = 45)				Oncologists (n = 32)				Others (n = 20)					
	D (%)	E (%)	A (%)	U (n)	D (%)	E (%)	A (%)	U (n)	D (%)	E (%)	A (%)	U (n)		
1. After radical cystectomy with curative intent, no regular follow-up is needed	100	0	0	0	100	0	0	0	100	0	0	4	Ur	1
2. To detect relapse after radical cystectomy with curative intent, patients should be followed up every 3–4 mos for 2 yrs, every 6 mos up to 5 yrs and then annually	16	4	80	0	3	9	88	0	0	0	100	5	Ur	3
3. To detect relapse after radical cystectomy with curative intent, patients should be followed up every 6 mos for 5 yrs and then annually	33	24	42	0	53	31	16	0	53	33	13	5	Ur	3
4. After radical cystectomy with curative intent, regular follow-up in the majority of patients should stop after 5 yrs	80	16	4	0	42	16	42	1	60	7	33	5	Ur	2
5. After radical cystectomy, patients should be followed up with a CT scan of the thorax/abdomen alone	67	7	27	0	55	0	45	1	75	0	25	4	Ur + O	3
6. After radical cystectomy with curative intent, follow-up for the detection of second cancers in the urothelium is recommended	0	4	96	0	0	13	87	1	0	7	93	5	Ur	1
7. After radical cystectomy with curative intent, follow-up of the urethra with cytology and/or cystoscopy is recommended in all patients	29	11	60	0	0	11	89	4	7	27	67	5	Ur	3
8. After trimodality treatment with curative intent, follow-up for the detection of relapse is recommended every 3–4 mos initially; then after 3 yrs, every 6 mos in the majority of patients	0	4	96	0	0	0	100	0	0	0	100	4	Ur + On	1
9. After trimodality treatment with curative intent, NO regular follow-up for the detection of relapse is needed in the majority of patients	100	0	0	0	100	0	0	0	100	0	0	4	Ur + On	1
10. After trimodality treatment with curative intent, follow-up should stop after 5 yrs in the majority of patients	91	7	2	0	56	9	34	0	57	7	36	6	Ur + On	3
11. After trimodality treatment with curative intent, follow-up imaging to assess distant recurrence or recurrence outside the bladder should be done by CT scan of the thorax/abdomen alone	40	4	56	0	31	0	69	0	33	0	67	2	Ur + On + O	3
12. After trimodality treatment with curative intent, NO follow-up imaging to assess distant recurrence or recurrence outside the bladder is needed	100	0	0	0	100	0	0	0	94	0	6	3	Ur + On + O	1
13. After trimodality treatment with curative intent, assessment of the urothelium to detect recurrence is recommended every 6 mos in the majority of patients	2	5	93	1	9	6	84	0	0	6	94	2	Ur	1
14. After trimodality treatment with curative intent, in addition to a CT scan, NO other investigations of the bladder are recommended	100	0	0	0	100	0	0	0	100	0	0	2	Ur	1
15. In patients with a partial or complete response after chemotherapy for metastatic urothelial cancer, NO regular follow-up is needed. Imaging studies may be done according to signs/symptoms	91	7	2	0	97	0	3	2	88	13	0	4	Ur + On	1

16. In the majority of patients with a long complete response after chemotherapy for metastatic urothelial cancer, regular follow-up should be stopped after 3 yrs	91	7	2	0	100	0	0	2	81	0	19	4	Ur + On	2
17. No routine assessment of the urothelium is required in patients with a partial or complete response after chemotherapy for metastatic urothelial cancer	80	9	11	0	77	10	13	2	81	0	19	4	Ur + On	2
18. When following up patients with urothelial cancer, LDH and CEA do NOT need to be assessed	11	31	58	0	19	13	68	1	33	33	33	11	Ur + On	3
19. In patients treated with radical cystectomy with curative intent and who have a neobladder, management of acid bases household includes regular measurements of pH and sodium bicarbonate substitution according to the measured value	4	4	91	0	4	13	83	9	0	25	75	12	Ur	1
20. In patients treated with radical cystectomy with curative intent and those who have a neobladder, management of vitamin B12 levels does not require any measurements	77	2	20	1	59	27	14	10	63	38	0	12	Ur	3

A = agree; CEA = carcinoembryonic antigen; CT = computed tomography; D = disagree; E = equivocal; LDH = lactate dehydrogenase; O = others (includes specialties in Nuclear Medicine, Pathology, Radiology, Specialist Nurse, Clinical Oncology); On = Oncologist; U = unable to respond; Ur = Urologists. *Statements highlighted in green achieved level 1 consensus, those in blue achieved level 2 consensus, and those in yellow failed to reach consensus (level 3) as part of the Delphi survey; numbers highlighted in red indicate where the level of agreement among individual stakeholder groups reached $\geq 70\%$ (see Table 2 for details of consensus level criteria). Statements indicated in bold were subsequently reviewed at the consensus conference with revised statements and voting shown in Table 14.

symptomatic progression. Regular follow-up is recommended in most guidelines despite the lack of high-level evidence. As such, follow-up protocols after cystectomy are mainly based on the natural history of the disease.

Incidence rates and timing of recurrence after cystectomy vary according to the type of recurrence observed. Systemic recurrence occurs in 22–30% of patients, mostly in the first 3 yrs, whereas local recurrence occurs in 5–15% of patients, mostly in the first 2 yrs and typically between 6 and 18 mos [65–67]. The lifetime incidence of a second cancer in the urethra is 4–6%, with most diagnosed during the first 3 yrs, although such cancers have been reported beyond 5–10 yrs. The lifetime incidence of upper urinary tract tumours is 2–6%. Here, the median time to diagnosis exceeds 3 yrs in 70% of cases, indicating that they are typically a late event [65–67].

The probability of a systemic or local recurrence is largely related to the final pathological stage of the cystectomy specimen. The highest likelihood of onset of extravesical recurrence is related to the presence of multifocal disease (a common risk factor), tumour in the distal ureter in the case of upper urinary tract tumours, and tumour in the prostatic urethra in men in the case of urethral tumours [67]. In women, where urethrectomy is becoming less common during radical cystectomy, the main risk factors for urethral recurrence are bladder neck and anterior vaginal wall involvement [68].

According to these recurrence rates, it seems reasonable to apply a more intense follow-up protocol during the first 2–3 yrs in order to detect systemic relapse after cystectomy, with the recommendation to stop follow-up after 5 yrs for the majority of patients. Those with risk factors of urethral

and/or upper urinary tract tumours should, however, be followed up for a longer duration by specific examinations based on their higher risk of a late recurrence. Supplementary Table S1 shows the follow-up strategies after cystectomy and trimodality bladder preservation treatment according to the guidelines issued by ESMO and EAU [3,5].

Statement 1: To detect relapse after radical cystectomy with curative intent, routine imaging with CT of the thorax and abdomen should be stopped after 5 yrs in the majority of patients.

Level of consensus: 88% Agree, 3% disagree, 9% equivocal (32 voters).

Statement 2: To detect relapse after radical cystectomy with curative intent, a CT of the thorax and abdomen is recommended as the imaging method for follow-up in the majority of patients.

Level of consensus: 94% Agree, 0% disagree, 6% equivocal (34 voters).

Statement 3: After radical cystectomy with curative intent, follow-up of the urethra with cytology and/or cystoscopy is recommended in selected patients (e.g. multifocality, carcinoma *in situ* and tumour in the prostatic urethra).

Level of consensus: 88% Agree, 6% disagree, 6% equivocal (33 voters).

3.6.2. Follow-up after trimodality bladder preservation treatment
Between 26% and 43% of patients treated with trimodality bladder preservation treatment will present with recurrences, which mostly occur within the first 2 yrs [69]. Follow-up after trimodality bladder preservation treatment must detect not only systemic recurrences but also local and

Table 14 – Consensus meeting statements regarding follow-up strategies and survivorship.

Proposed statements ^a	Level of agreement (%)			N	Consensus achieved
	Disagree	Equivocal	Agree		
1. To detect relapse after radical cystectomy with curative intent, routine imaging with CT of the thorax and abdomen should be stopped after 5 yrs in the majority of patients	3	9	88	32	Yes
2. To detect relapse after radical cystectomy with curative intent, a CT of the thorax and abdomen is recommended as the imaging method for follow-up in the majority of patients	0	6	94	34	Yes
3. After radical cystectomy with curative intent, follow-up of the urethra with cytology and/or cystoscopy is recommended in selected patients (e.g. multifocality, CIS and tumour in the prostatic urethra)	6	6	88	33	Yes
4. To detect relapse (outside the bladder) after trimodality treatment with curative intent, CT of the thorax and abdomen is recommended as the imaging method for follow-up in the majority of patients	0	0	100	34	Yes
5. To detect relapse (outside the bladder) after trimodality treatment with curative intent, routine imaging with CT of the thorax and abdomen should be stopped after 5 yrs in the majority of patients	3	13	84	30	Yes
6. Levels of LDH and CEA are NOT essential in the follow-up of patients with urothelial cancer to detect recurrence	0	0	100	34	Yes

CEA = carcinoembryonic antigen; CIS = carcinoma in situ; CT = computed tomography; LDH = lactate dehydrogenase; N = number of voters.

^aStatements highlighted in green achieved consensus.

non-muscle-invasive bladder recurrences. Indeed, studies with a longer follow-up protocol mainly use cystoscopy in order to follow patients after the trimodality bladder preservation treatment [70].

There are no data to show whether regular follow-up after systemic therapy for patients with a partial or a complete response is associated with any benefit.

Statement 4: To detect relapse (outside the bladder) after trimodality treatment with curative intent, CT of the thorax and abdomen is recommended as the imaging method for follow-up in the majority of patients.

Level of consensus: 100% Agree (34 voters).

Statement 5: To detect relapse (outside the bladder) after trimodality treatment with curative intent, routine imaging with CT of the thorax and abdomen should be stopped after 5 yrs in the majority of patients.

Level of consensus: 84% Agree, 3% disagree, 13% equivocal (30 voters).

3.6.3. Follow-up monitoring of carcinoembryonic antigen, LDH and vitamin B12

There is no evidence that any tumour markers are helpful in monitoring recurrence in patients with bladder cancer. LDH is non-specific and can be elevated in a multitude of clinical scenarios independent of a recurrence. Carcinoembryonic antigen (CEA) is also not specific for bladder cancer and can

be positive in follow-up since it can be elevated in smokers. Low vitamin B12 levels have been reported in 17% of patients with bowel diversion [71]. Thus, in case of cystectomy and bowel diversion, vitamin B12 levels should be measured.

Statement 6: Levels of LDH and CEA are not essential in the follow-up of patients with urothelial cancer to detect recurrence.

Level of consensus: 100% Agree (34 voters).

Statement 7: Vitamin B12 levels have to be measured annually in the follow-up of patients treated with radical cystectomy and bowel diversion with curative intent.

Level of consensus: 75% Agree, 17% disagree, 7% equivocal (29 voters).

4. Discussion

This international, multistakeholder, consensus-finding collaborative project was the first of its kind to bring together a large multidisciplinary group of professional medical societies and world-leading experts in the management of advanced and variant bladder cancer with a view to identifying specific situations where guidance is lacking and defining the optimal approach as far as possible based on the available evidence and collective experience and expert opinions.

This project resulted in the development of 71 consensus statements that will help address controversial topics in the management of advanced and variant bladder cancer and can be used to underpin future guideline recommendations. Although too many to discuss here in detail, some key conclusions are worth highlighting. For example, since variant histologies are increasingly recognised and diagnosed, our consensus statements in this area are important and provide additional guidance for the management of this group of patients, although not for all variant histologies. In spite of advice from the Food and Drug Administration and EMA, markers are not yet adequate for clinical decision making, including PD-(L)1 status, (epi)genetic markers and several simple serum measurements. Trimodality bladder preservation treatment with chemoradiation is gaining consensus. It is a multidisciplinary decision where several sensitisers can be used. Modern radiotherapy techniques are preferred, whereas dose escalation and brachytherapy are not. The role of PLND in case of chemoradiation remains unresolved. OMD can still be cured in selected cases, depending on the site and number of metastases and the interval between diagnosis of the primary tumour and metastases. Treatment is a multimodal approach. ICIs are an option in the treatment of metastatic urothelial cancer in unfit, PD-L1-positive patients or after platinum-based chemotherapy. When ICIs are used, pseudo-progression has not been demonstrated in urothelial cancer. When progression occurs on ICI therapy, chemotherapy should be considered rather than sequencing another ICI. Oncological follow-up after cystectomy or bladder preservation should last 5 yrs, with the highest intensity in the first 2 yrs since most recurrences occur within 18–24 mos. Follow-up should consist of CT of the thorax and abdomen, and cystoscopy/cytology in case of bladder preservation.

Taken together, these findings serve to complement existing guidelines and promote a consistent approach to the management of patients with advanced and variant bladder cancer, especially across smaller hospitals where a high level of expert guidance may be lacking.

Whilst we believe that the methodology applied here is novel and represents an effective approach to obtain a consensus of expert opinion, it is not without its limitations. For example, no systematic literature review was conducted ahead of the Delphi survey and proposed statements were compiled based on the collective expert opinion of the steering committee members. However, as this comprised a group of 13 leading experts, it is unlikely to have resulted in any significant omissions or bias. Another potential limitation was the difference in the participants of the Delphi survey versus those who attended the consensus conference. Ideally, this would have comprised the same group of experts; however, based on limited availability of survey participants for a face-to-face meeting, it was felt that additional HCPs should also be invited in order to ensure sufficient collective expertise at the consensus conference.

Regarding the Delphi survey methodology, a potential limitation was the inclusion of an 'equivocal' score in addition to 'unable to score'. On reflection, it is likely that some participants could have scored statements as

'equivocal' when they did not have sufficient expertise to assess the statement rather than selecting 'unable to score', which could have increased the proportion of statements that failed to reach consensus as part of the Delphi survey. We attempted to address this limitation by conducting a second, *ad hoc* analysis, restricting results to specific stakeholder groups considered to have adequate relevant expertise relating to the specific statement. Indeed, this increased the number of statements achieving consensus from 33 (28%) to 49 (42%). This point was also rectified during the consensus conference with participants advised to refrain from voting in cases of uncertainty or insufficient expertise, and this likely influenced the high level (81%) of consensus achieved.

As with all guidelines, the development of specific statements and recommendations poses a challenge since treatment decisions are typically based on a multitude of parameters unique to the individual patient being treated, with specific parameters rarely considered in isolation. Voting on the level of agreement for each statement is therefore also challenging without a broader clinical context. However, providing such additional information would make statements unwieldy and may also restrict their applicability and use. It is also assumed that the treating physician is able to consider the consensus statements provided and adapt his/her approach in light of the individual clinical context faced.

5. Conclusions

The results reported here represent a significant achievement by providing collective international expert opinion and guidance on the optimal management strategies to employ in controversial situations until a time when further evidence is available to guide our approach. Together with existing CPGs, it is anticipated that the consensus statements provided here will help optimise and standardise the diagnosis, treatment and follow-up of patients with advanced and variant bladder cancer.

Author contributions: J.A. Witjes had full access to all data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Babjuk, Bellmunt, Bruins, De Reijke, De Santis, Gillessen, Horwich, James, Maclennan, Palou, Powles, Ribal, Shariat, Witjes.

Acquisition of data: Babjuk, Bellmunt, Bruins, De Reijke, De Santis, Gillessen, Horwich, James, Maclennan, Palou, Powles, Ribal, Shariat, Witjes.

Analysis and interpretation of data: Babjuk, Bellmunt, Bruins, De Reijke, De Santis, Gillessen, Horwich, James, Maclennan, Palou, Powles, Ribal, Shariat, Witjes.

Drafting of the manuscript: Babjuk, Bellmunt, Bruins, De Reijke, De Santis, Gillessen, Horwich, James, Maclennan, Palou, Powles, Ribal, Shariat, Van Der Kwast, Witjes, Xylinas.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Maclennan.

Obtaining funding: None.

Administrative, technical, or material support: Maclennan.

Supervision: Horwich, James, Maclennan, Witjes.

Other: None.

Financial disclosures: J.A. Witjes certifies that all conflicts of interest, including specific financial interests and relationships and affiliations relevant to the subject matter or materials discussed in the manuscript (e.g., employment/affiliation, grants or funding, consultancies, honoraria, stock ownership or options, expert testimony, royalties, or patents filed, received, or pending), are the following: Neeraj Agarwal: consultancy to Astellas, AstraZeneca, Argos, BMS, Bayer, Clovis, Eisai, Exelixis, EMD Serono, Ely Lilly, Foundation One, Genentech, Janssen, Merck, Medivation, Novartis, Nektar, Pfizer and Pharmacyclics; research funding (to institution) from AstraZeneca, Bavarian Nordic, BMS, Calithera, Celldex, Eisai, Exelixis, Genentech, GSK, Immunomedics, Janssen, Medivation, Merck, New link Genetics, Novartis, Pfizer, Prometheus, Rexahn, Sanofi, Takeda, Tracon, Bayer, Clovis, EMD Serono, Ely Lilly, Janssen and Nektar. Marek Babjuk: consultant activities for Roche, MSD, Olympus, Ipsen and Ferring. Aristotelis Bamias: steering committee member and advisor for Roche; research support, honoraria and advisor for BMS and MSD; research support from AstraZeneca and BMS. Joaquim Bellmunt: lecture fees, advisory boards and institutional research funding/support from Pfizer; lecture fees and advisory boards for Merck, AstraZeneca, BMS and Pierre Fabre; institutional research funding/support from Merck GmbH and Takeda. Alison Birtle: advisory boards for Roche and MSD. Peter C. Black: research support from GenomeDx Biosciences; clinical trial support, advisory board and speaker for Roche/Genentech; advisory boards for Merck, BMS, AstraZeneca, Urogen, Abbvie, Bayer, Lilly, Spectrum, Allergan, Biocancell and Asieris; advisory boards and speaker for Janssen, Sanofi and Ferring; speaker for BioSynt; grants from iProgen and New B Innovation. Michel Bolla: lecture fees and travel support from AstraZeneca, Ipsen and Janssen. Joost L. Boormans: personal fees for consultancy work from BMS, Merck and Roche; advisory board fees from Janssen; research grant from GenomeDx Biosciences. Alberto Briganti: personal fees from Astellas, Janssen, Opko Health, MDx Health, Bayer and Ferring; grant/research support from Sandoz. Max Burger: consultant for Medac GmbH; speaker honorarium from Medac GmbH. Daniel Castellano: personal fees, speaker and advisory boards for Roche, Pfizer, Janssen, Astellas, MSD, Bayer, AstraZeneca, Lilly, Novartis, BMS and Ipsen. Richard Cathomas: personal fees from Roche, Pfizer, MSD, BMS, AstraZeneca, Janssen, Astellas, Bayer, Sanofi Aventis, Debiopharm, Novartis and Ipsen. Arturo Chiti: personal fees from General Electric, Blue Earth Diagnostics, Sirtex Medical System and Advanced Accelerator Applications; grant from Sanofi Genzyme. Ananya Choudhury: nonfinancial support from EAU; grants from Cancer Research UK, Prostate Cancer Research UK and Medical Research Council; research support from the Manchester Biomedical Research Centre. Simon Crabb: grant/research funding and personal fees for advisory work from Clovis Oncology; grant/research funding from Astex Pharmaceuticals; personal fees for advisory work from MSD, Janssen and Roche. Stephane Culine: grant and personal fees from Roche; personal fees from Merck and Janssen; grant from Astellas. Willem de Blok: grant for development of patient information from Roche, Astellas, Combat Hivec, Hollister, Hoogland Medical and Pfizer. Maria de Santis: consultant for Amgen, Astellas, AstraZeneca, Bayer, BMS, Celgene, Dendreon, Eisai Inc., ESSA, Ferring, GSK, Incyte, Ipsen, Janssen, Cilag, Merck, MSD, Novartis, Pfizer, Pierre Fabre Oncology, Roche, Sanofi Aventis, Seagen, Shionogi, Synthon, Takeda, Teva, OncoGenex and Sandoz; speaker honoraria from Amgen, Astellas, AstraZeneca, Bayer, BMS, Ferring, GSK, Ipsen, Janssen Cilag, Merck, MSD, Novartis, Pfizer, Pierre Fabre Oncology, Roche, Sanofi Aventis, Synthon and Takeda; trial participation for Amgen, Astellas, AstraZeneca, Bayer, BMS, Celgene, Dendreon, Eisai Inc., Ferring, GSK, Ipsen, Incyte, Janssen, Cilag, Merck, MSD, Novartis, Pfizer, Pierre Fabre Oncology, Roche, Sanofi Aventis,

SOTIO, EORTC GU Group member, IIT (Technische Universität München), Exelixis/Ipsen, Incyte and AstraZeneca; grant, fellowship and travel grants from Amgen, Astellas, AstraZeneca, Bayer, BMS, Celgene, Dendreon, Ferring, GSK, Ipsen, Incyte, Janssen Cilag, Merck, MSD, Novartis, Pfizer, Roche, Pierre Fabre Oncology, Sanofi Aventis, SeaGen, Shionogi, Synthon, Takeda and Teva/OncoGenex; grants/research support from Pierre Fabre Oncology; reviewing protocols for EORTC GUCA group; reviewing grants and protocols for Cancer Research UK; reviewer for *Annals of Oncology*, *Journal of Clinical Oncology*, *European Urology*, *European Urology Focus*, *Prostate*, *European Journal of Cancer*, *Cancer and New England Journal of Medicine*. Jose L. Dominguez-Escrig: trial participation for COMBAT BRS, BTS, Presurgy, Ipsen, STORZ, Arguer and Angiodynamics. Stefano Fanti: advisory boards for Bayer and Astellas. Silke Gillissen: pending patent application for a method for biomarker WO 2009138392 A1; advisory boards fees from Astellas Pharma, CureVac, Janssen Cilag, Pfizer, Sanofi Aventis Group, Bayer, Dendreon Corporation, Millenium Pharmaceuticals, Orion, Sanofi and Roche; advisory boards fees paid to institution from Bayer, Novartis, Astellas Pharma, Janssen Cilag, Roche, AAA International, BMS, CureVac, Ferring, Sanofi, Orion, Innocrin Pharmaceuticals, Clovis, CellSearch and Menarini; uncompensated advisory boards for Menarini, Astellas Pharma, Bayer, ESSA Pharmaceuticals Corporation, Nectar, ProteoMediX and Sanofi; speaker bureau fees paid to institution from Janssen and Novartis; uncompensated speaker bureau for Amgen, Astellas Pharma, Bayer, Janssen and Sanofi Aventis Group; independent data monitoring committee (IDMC) fees from MaxiVAX SA; independent data monitoring committee fees paid to institution from Active Biotech AB and Janssen Cilag. Paolo Gontero: grant from Ipsen; advisory board fees from Arkuer, Cepheid and Ferring. Shaista Hafeez: grant from the National Institute for Health Research (NIHR) Biomedical Research Centre at the Royal Marsden NHS Foundation Trust and the Institute of Cancer Research; nonfinancial support from Elekta (Elekta AB, Stockholm, Sweden), MSD. Donna E. Hansel: advisory boards for AstraZeneca and Genentech; consultant for Taris. Arndt Hartmann: grants and personal fees from Roche, Janssen and Cepheid; grants from Qiagen and Biontech; personal fees from AstraZeneca, Diaceutics, BMS, MSD, Abbvie and Boehringer Ingelheim. Ken Herrmann: personal fees for speaker bureau and consultancy from Bayer; personal fees for speaker bureau from Sirtex; board member of Sofie Biosciences; research material support from ABX; advisory board fees from Adacap, Curium, Endocyte and Ipsen; grant and personal fees from BTG; advisory board fees and collaboration with Siemens Healthineers; nonfinancial support from and collaboration with GE Healthcare. Peter Hoskin: research support from the Manchester Biomedical Research Centre. Nicholas James: trial funding as an investigator and the chief investigator from Cancer Research UK and the UK National Cancer Research Network. Barbara A. Jereczek-Fossa: research funding from Accuray (institutional grant) and AIRC Italian Association for Cancer Research (institutional grants); travel expenses or speaker fees from Janssen, Ferring, Bayer, Roche, Astellas, Elekta, Carl Zeiss and Ipsen. Rob Jones: research grant, honoraria for advisory board, speaker honoraria and trial funding for institution from Roche; travel support, honoraria for advisory board, speaker honoraria and trial funding for institution from MSD; speaker honoraria and trial funding for institution from Merck Serono; honoraria for speaker and advisory board and trial funding for institution from BMS. Ashish Kamat: personal fees for advisory board and consulting and research funding from Merck; personal fees for advisory boards and consulting from BMS, Photocure, Eisai, Arquer, MDx Health, AstraZeneca, Abbott Molecular, US Biotest, Ferring and BioClin; research funding from FGD Industries. Vincent Khoo: personal fees for lecture from Astellas; personal fees and nonfinancial support for lecture, meeting and educational attendance from Bayer; nonfinancial support for meeting and educational attendance from Janssen. Anja Lorch: principal investigator for phase II and III trials with Roche, MSD, AstraZeneca, Ipsen, Janssen, Bayer, Novartis and BMS;

advisory boards for Roche, Novartis, Ipsen, MSD, BMS, and Janssen; honoraria for lectures and travel fees from Roche, AstraZeneca, Novartis and Ipsen; travel fees from MSD. Yohann Lorient: grant, personal fees and nonfinancial support from Janssen and MSD; personal fees and nonfinancial support from Astellas, Roche, AstraZeneca, BMS and Seattle Genetics; grant and personal fees from Sanofi; personal fees from Clovis, Incyte and Pfizer. Richard Meijer: advisory board fees from Janssen; speaker fees from Roche and Bayer; research funding from Roche and Janssen. Arndt-Christian Müller: financial and technical support to institution under a research agreement from Elekta, Philips and Siemens; sponsorship for travel and scientific symposia from Opaska. Andrea Necchi: grant and personal fees from Merck, BMS, AstraZeneca and Incyte; personal fees from Roche, Bayer, Janssen, BioClin Therapeutics and Clovis Oncology. Yann Neuzillet: consultant for Astellas, AstraZeneca, Bouchara-Recordati, BMS, Ipsen, Janssen, Medac, MSD, Roche, Sanofi Pasteur and Sanofi Aventis. Jorg Oddens: speaker fees from Janssen and Astellas; advisory board fees from Amgen. Susanne Osanto: advisory boards fees paid to institution from Bayer, Eisai, Novartis, Janssen Cilag, Roche, BMS and Pfizer; institutional research funding/support from Ipsen; travel support from Bayer. Luis Pacheco-Figueiredo: personal fees from Lilly Farma, Ld^a; nonfinancial support from Laboratórios Pfizer Portugal, Ld^a, Jaba Recordati, S.A. and Menarini Portugal. Joan Palou: honoraria or consultation fees from Combat BRS, Olympus, Sanofi Pasteur and Cepheid; trial participation for Ipsen, COMBAT BRS, Presurgy, STORZ and Archer. Helle Pappot: research grants from MSD and Roche; lecture fees from BMS. Bradley R. Pieters: grant/research funding from Elekta. Thomas Powles: consultant, speaker honoraria and research support/grants from Novartis, Pfizer, Pierre Fabre Oncology, Roche, Sanofi Aventis and Seattle Genetics; consultant, speaker honoraria, trial participation and research support/grants from Pfizer and GlaxoSmithKline; speaker honoraria and trial participation for Genentech; grant and personal fees for trial participation from BMS, MSD, Merck, Ipsen, Exelixis, Seattle Genetics and AstraZeneca. Mesut Remzi: advisory board and/or speaker for Astellas, Bayer, Ipsen, Janssen, Pfizer, Baxter and Novartis. Margitta Retz: presentations and advisory boards for Astellas, AstraZeneca, BMS, Ipsen, Janssen-Cilag, MSD, Pfizer and Roche; scientific support from BMS. Maria J. Ribal: speaker honoraria from Astellas, Janssen, Ipsen and Olympus. Michael Rink: advisory board and/or speaker for BMS, Ipsen, MSD, Pfizer and Roche. Florian Roghmann: personal fees from Ipsen, Roche, Novartis and Janssen. Jonathan E. Rosenberg: clinical trial funding and personal fees from Astellas, Seattle Genetics, AstraZeneca, Mirati and Bayer; clinical trial funding, personal fees and non-financial support from Roche; personal fees and non-financial support from BMS; personal fees and stock from Merck; personal fees from Lilly, EMD Serono, Adicet Bio, Inovio, QED Therapeutics, Ranier (Bioclin) Therapeutics, Sensei Biotherapeutics, Chugai Pharma, Western Oncolytics, Pharmacyclics, GSK and Janssen. Morgan Rouprêt: grants/research support from GSK, Pfizer and Roche; honoraria or consultation fees from Lilly, GSK, Ipsen, Astellas, Takeda, Sanofi Pasteur and Medac. Olivier Rouvière: travel expenses from Philips. Antti Salminen: lecture fee from Roche. Paul Sargos: grants/research support from Ipsen and AstraZeneca; honoraria or consultancy fees from Astellas, Janssen, Bayer, Ipsen, Ferring, Recordati, Roche, Sanofi, Nanobiotix and Takeda. Shomik Sengupta: speaker honorarium (donated to institutional research fund) from Mundipharma Australia, Ipsen Australia, MSD Australia and Eastern Melbourne Primary Health Network; consulting honorarium for advisory board (donated to institutional research fund) from Janssen Australia. Shahrokh Shariat: honoraria, consulting or advisory role and speaker bureau for Astellas, AstraZeneca, Bayer, BMS, Cepheid, Ferring, Ipsen, Janssen, Lilly, MSD, Olympus, Pfizer, Pierre Fabre, Richard Wolf Roche, Sanochemia, Sanofi and Urogen; patents: method to determine prognosis after therapy for prostate cancer granted 2002-09-06, methods to determine prognosis after therapy for bladder cancer granted 2003-06-19, prognostic methods for patients with prostatic disease granted 2004-08-05 and

soluble Fas urinary marker for the detection of bladder transitional cell carcinoma granted 2010-07-20. Arnulf Stenzl: advisory boards for BMS, Stebiotech and Synergo; advisory board/consultant for Ipsen Pharma, Roche, Janssen and Alere; speaker for Janssen, Ipsen Pharma, Sanofi Aventis, CureVac and Astellas; clinical studies for Johnson & Johnson, Roche, Cepheid, Roche, Bayer AG, CureVac, Immatics Biotechnologies GmbH and GemeDx Biosciences; research grants from Amgen Inc, Immatics biotechnologies GmbH Novartis AG and Karl Storz AG. Bertrand Tombal: personal fees from Amgen, Astellas, Bayer, Ferring, Janssen and Sanofi. Theo Van Der Kwast: consultant activities for Janssen. Thomas Wiegel: advisory board for Ipsen; speaker honorarium from Ipsen and Hexal; trial participation for Atlas trial; member of steering committee for Janssen. J. Alfred Witjes: personal fees as advisor for Roche, Merck and BMS. Richard Zigeuner: fellowships, travel grants, company grants, research support and speaker honoraria from Bayer Healthcare; fellowships, travel grants and consultant and speaker honoraria from Pfizer; speaker honoraria, fellowships and travel grants from Novartis, Astellas and Takeda; fellowships, travel grants and speaker honoraria from Amgen and GSK; speaker honoraria from Roche, BMS and Eisai. **All the remaining authors declared no conflict of interest.**

Funding/support and role of the sponsor: All costs relating to the consensus conference were covered jointly by the European Association of Urology and the European Society for Medical Oncology. No grant numbers are applicable. There was no external funding of the event or manuscript production.

Acknowledgements: The authors would like to thank Peter E. Clark from Atrium Health, Levine Cancer Institute, Charlotte, NC, USA, for his contribution to the Delphi survey. Angela Corstorphine of Kstorfin Medical Communications Ltd provided medical writing support with the preparation of this manuscript; this support was funded jointly by EAU and ESMO.

Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:<https://doi.org/10.1016/j.eururo.2019.09.035>.

References

- [1] Bray F, Ferlay J, Soerjomataram I, Siegel RL, Torre LA, Jemal A. Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA Cancer J Clin* 2018;68:394–424.
- [2] Antoni S, Ferlay J, Soerjomataram I, Znaor A, Jemal A, Bray F. Bladder cancer incidence and mortality: a global overview and recent trends. *Eur Urol* 2017;71:96–108.
- [3] Bellmunt J, Orsola A, Leow JJ, Wiegel T, De Santis M, Horwich A. Bladder cancer: ESMO practice guidelines for diagnosis, treatment and follow-up. *Ann Oncol* 2014;25(Suppl 3), iii40–8.
- [4] Babjuk M, Burger M, Compérat E, et al. EAU guidelines on non-muscle-invasive bladder cancer. Presented at the EAU Annual Congress Barcelona Arnhem The Netherlands; EAU Guidelines Office 2019 <https://uroweb.org/guideline/non-muscle-invasive-bladder-cancer/>
- [5] Witjes JA, Bruins M, Compérat E, et al. EAU guidelines on muscle-invasive and metastatic bladder cancer. Presented at the EAU Annual Congress Barcelona Arnhem The Netherlands; EAU Guidelines Office 2019 <https://uroweb.org/guideline/bladder-cancer-muscle-invasive-and-metastatic/>
- [6] Vetterlein MW, Wankowicz SAM, Seisen T, et al. Neoadjuvant chemotherapy prior to radical cystectomy for muscle-invasive bladder cancer with variant histology. *Cancer* 2017;123:4346–55.

- [7] Robertson AG, Kim J, Al-Ahmadie H, et al. Comprehensive molecular characterization of muscle-invasive bladder cancer. *Cell* 2017;171:540–56, e25.
- [8] Choi W, Porten S, Kim S, et al. Identification of distinct basal and luminal subtypes of muscle-invasive bladder cancer with different sensitivities to frontline chemotherapy. *Cancer Cell* 2014;25:152–65.
- [9] Lindgren D, Frigyesi A, Gudjonsson S, et al. Combined gene expression and genomic profiling define two intrinsic molecular subtypes of urothelial carcinoma and gene signatures for molecular grading and outcome. *Cancer Res* 2010;70:3463–72.
- [10] Damrauer JS, Hoadley KA, Chism DD, et al. Intrinsic subtypes of high-grade bladder cancer reflect the hallmarks of breast cancer biology. *Proc Natl Acad Sci U S A* 2014;111:3110–5.
- [11] Ingersoll MA, Li X, Inman BA, Greiner JW, Black PC, Adam RM. Immunology, Immunotherapy and Translating Basic Science into the Clinic for Bladder Cancer. *Bladder Cancer* 2018;4:429–40.
- [12] González Del Alba A, De Velasco G, Lainez N, et al. SEOM clinical guideline for treatment of muscle-invasive and metastatic urothelial bladder cancer (2018). *Clin Transl Oncol* 2019;21:64–74.
- [13] Balar AV, Castellano D, O'Donnell PH, et al. First-line pembrolizumab in cisplatin-ineligible patients with locally advanced and unresectable or metastatic urothelial cancer (KEYNOTE-052): a multicentre, single-arm, phase 2 study. *Lancet Oncol* 2017;18:1483–92.
- [14] Balar AV, Galsky MD, Rosenberg JE, et al. Atezolizumab as first-line treatment in cisplatin-ineligible patients with locally advanced and metastatic urothelial carcinoma: a single-arm, multicentre, phase 2 trial. *Lancet* 2017;389:67–76.
- [15] Bellmunt J, de Wit R, Vaughn DJ, et al. Pembrolizumab as second-line therapy for advanced urothelial carcinoma. *N Engl J Med* 2017;376:1015–26.
- [16] Comet Initiative DelphiManager, 2011–2015. <http://www.comet-initiative.org/delphimanager/>.
- [17] Humphrey PA, Moch H, Cubilla AL, Ulbright TM, Reuter VE. The 2016 WHO classification of tumours of the urinary system and male genital organs—part B: prostate and bladder tumours. *Eur Urol* 2016;70:106–19.
- [18] Compérat E, Roupert M, Yaxley J, et al. Micropapillary urothelial carcinoma of the urinary bladder: a clinicopathological analysis of 72 cases. *Pathology* 2010;42:650–4.
- [19] Monn MF, Kaimakliotis HZ, Pedrosa JA, et al. Contemporary bladder cancer: variant histology may be a significant driver of disease. *Urol Oncol* 2015;33:18, e15–20.
- [20] Willis DL, Fernandez MI, Dickstein RJ, Daignault S, Lee CT, Shah RB. Clinical outcomes of cT1 micropapillary bladder cancer. *J Urol* 2015;193:1129–34.
- [21] Weizer AZ, Wasco MJ, Wang R, et al. Multiple adverse histological features increase the odds of under staging T1 bladder cancer. *J Urol* 2009;182:59–65, discussion 65.
- [22] Black PC, Brown GA, Dinney CP. The impact of variant histology on the outcome of bladder cancer treated with curative intent. *Urol Oncol* 2009;27:3–7.
- [23] Honma I, Masumori N, Sato E, et al. Local recurrence after radical cystectomy for invasive bladder cancer: an analysis of predictive factors. *Urology* 2004;64:744–8.
- [24] Zaghoul MS, Awwad HK, Akoush HH, Omar S, Soliman O, el Attar I. Postoperative radiotherapy of carcinoma in bilharzial bladder: improved disease free survival through improving local control. *Int J Radiat Oncol Biol Phys* 1992;23:511–7.
- [25] Lewis GD, Haque W, Verma V, Butler EB, Teh BS. The role of adjuvant radiation therapy in locally advanced bladder cancer. *Bladder Cancer* 2018;4:205–13.
- [26] Marzouka NA, Eriksson P, Rovira C, Liedberg F, Sjö Dahl G, Höglund M. A validation and extended description of the Lund taxonomy for urothelial carcinoma using the TCGA cohort. *Sci Rep* 2018;8:3737.
- [27] Seiler R, Ashab HAD, Erho N, et al. Impact of molecular subtypes in muscle-invasive bladder cancer on predicting response and survival after neoadjuvant chemotherapy. *Eur Urol* 2017;72:544–54.
- [28] Rosenberg JE, Hoffman-Censits J, Powles T, et al. Atezolizumab in patients with locally advanced and metastatic urothelial carcinoma who have progressed following treatment with platinum-based chemotherapy: a single-arm, multicentre, phase 2 trial. *Lancet* 2016;387:1909–20.
- [29] Mariathasan S, Turley SJ, Nickles D, et al. TGFbeta attenuates tumour response to PD-L1 blockade by contributing to exclusion of T cells. *Nature* 2018;554:544–8.
- [30] Rouprêt M, Babjuk M, Burger M, et al. European Association of Urology guidelines on upper urinary tract urothelial carcinoma. Presented at the EAU Annual Congress Barcelona Arnhem The Netherlands: EAU Guidelines Office 2019 In: <https://uroweb.org/guideline/upper-urinary-tract-urothelial-cell-carcinoma/>
- [31] Wu S, Zhao X, Wang Y, et al. Pretreatment neutrophil-lymphocyte ratio as a predictor in bladder cancer and metastatic or unresectable urothelial carcinoma patients: a pooled analysis of comparative studies. *Cell Physiol Biochem* 2018;46:1352–64.
- [32] Ojeholm E, Smith A, Hwang WT, et al. Neutrophil-to-lymphocyte ratio as a bladder cancer biomarker: assessing prognostic and predictive value in SWOG 8710. *Cancer* 2017;123:794–801.
- [33] Bajorin DF, Dodd PM, Mazumdar M, et al. Long-term survival in metastatic transitional-cell carcinoma and prognostic factors predicting outcome of therapy. *J Clin Oncol* 1999;17:3173–81.
- [34] Bellmunt J, Choueiri TK, Fougeray R, et al. Prognostic factors in patients with advanced transitional cell carcinoma of the urothelial tract experiencing treatment failure with platinum-containing regimens. *J Clin Oncol* 2010;28:1850–5.
- [35] Sonpavde G, Pond GR, Rosenberg JE, et al. Improved 5-factor prognostic classification of patients receiving salvage systemic therapy for advanced urothelial carcinoma. *J Urol* 2016;195:277–82.
- [36] Zhang Y, Xu T, Wang Y, et al. Prognostic role of lactate dehydrogenase expression in urologic cancers: a systematic review and meta-analysis. *Oncol Res Treat* 2016;39:592–604.
- [37] Hussain T, Chang HY, Veenstra CM, Pollack CE. Collaboration between surgeons and medical oncologists and outcomes for patients with stage III colon cancer. *J Oncol Pract* 2015;11:e388–97.
- [38] Cook O, McIntyre M, Recoche K. Exploration of the role of specialist nurses in the care of women with gynaecological cancer: a systematic review. *J Clin Nurs* 2015;24:683–95.
- [39] Choudhury A, Swindell R, Logue JP, et al. Phase II study of conformal hypofractionated radiotherapy with concurrent gemcitabine in muscle-invasive bladder cancer. *J Clin Oncol* 2011;29:733–8.
- [40] Coppin CM, Gospodarowicz MK, James K, et al. Improved local control of invasive bladder cancer by concurrent cisplatin and preoperative or definitive radiation. The National Cancer Institute of Canada Clinical Trials Group. *J Clin Oncol* 1996;14:2901–7.
- [41] Hoskin PJ, Rojas AM, Bentzen SM, Saunders MI. Radiotherapy with concurrent carbogen and nicotinamide in bladder carcinoma. *J Clin Oncol* 2010;28:4912–8.
- [42] James ND, Hussain SA, Hall E, et al. Radiotherapy with or without chemotherapy in muscle-invasive bladder cancer. *N Engl J Med* 2012;366:1477–88.
- [43] Koga F, Kihara K, Fujii Y, et al. Favourable outcomes of patients with clinical stage T3N0M0 bladder cancer treated with induction low-dose chemo-radiotherapy plus partial or radical cystectomy vs immediate radical cystectomy: a single-institutional retrospective comparative study. *BJU Int* 2009;104:189–94.
- [44] Tunio MA, Hashmi A, Qayyum A, Mohsin R, Zaeem A. Whole-pelvis or bladder-only chemoradiation for lymph node-negative invasive bladder cancer: single-institution experience. *Int J Radiat Oncol Biol Phys* 2012;82:e457–62.

- [45] Collins SD, Leech MM. A review of plan library approaches in adaptive radiotherapy of bladder cancer. *Acta Oncol* 2018;57:566–73.
- [46] Bos MK, Marmolejo RO, Rasch CR, Pieters BR. Bladder preservation with brachytherapy compared to cystectomy for T1-T3 muscle-invasive bladder cancer: a systematic review. *J Contemp Brachytherapy* 2014;6:191–9.
- [47] Whalley D, Caine H, McCloud P, Guo L, Kneebone A, Eade T. Promising results with image guided intensity modulated radiotherapy for muscle invasive bladder cancer. *Radiat Oncol* 2015;10:205.
- [48] Weichselbaum RR. The 46th David A. Karnofsky Memorial Award lecture: oligometastasis—from conception to treatment. *J Clin Oncol* 2018;36:3240–50.
- [49] Kim T, Ahn JH, You D, et al. Pulmonary metastasectomy could prolong overall survival in select cases of metastatic urinary tract cancer. *Clin Genitourin Cancer* 2015;13:e297–304.
- [50] Pastorino U, Buyse M, Friedel G, et al. Long-term results of lung metastasectomy: prognostic analyses based on 5206 cases. *J Thorac Cardiovasc Surg* 1997;113:37–49.
- [51] Tanvetyanon T, Robinson LA, Schell MJ, et al. Outcomes of adrenalectomy for isolated synchronous versus metachronous adrenal metastases in non-small-cell lung cancer: a systematic review and pooled analysis. *J Clin Oncol* 2008;26:1142–7.
- [52] von der Maase H, Sengelov L, Roberts JT, et al. Long-term survival results of a randomized trial comparing gemcitabine plus cisplatin, with methotrexate, vinblastine, doxorubicin, plus cisplatin in patients with bladder cancer. *J Clin Oncol* 2005;23:4602–8.
- [53] Galsky MD, Moshier E, Krega S, et al. Nomogram for predicting survival in patients with unresectable and/or metastatic urothelial cancer who are treated with cisplatin-based chemotherapy. *Cancer* 2013;119:3012–9.
- [54] Lehmann J, Suttman H, Albers P, et al. Surgery for metastatic urothelial carcinoma with curative intent: the German experience (AUO AB 30/05). *Eur Urol* 2009;55:1293–9.
- [55] Abe T, Shinohara N, Harabayashi T, et al. Impact of multimodal treatment on survival in patients with metastatic urothelial cancer. *Eur Urol* 2007;52:1106–13.
- [56] Abufaraj M, Dalbagni G, Daneshmand S, et al. The role of surgery in metastatic bladder cancer: a systematic review. *Eur Urol* 2018;73:543–57.
- [57] Kibel AS, Dehdashti F, Katz MD, et al. Prospective study of [18F] fluorodeoxyglucose positron emission tomography/computed tomography for staging of muscle-invasive bladder carcinoma. *J Clin Oncol* 2009;27:4314–20.
- [58] Lu YY, Chen JH, Liang JA, et al. Clinical value of FDG PET or PET/CT in urinary bladder cancer: a systemic review and meta-analysis. *Eur J Radiol* 2012;81:2411–6.
- [59] Bagheri MH, Ahlman MA, Lindenberg L, et al. Advances in medical imaging for the diagnosis and management of common genitourinary cancers. *Urol Oncol* 2017;35:473–91.
- [60] Leow JJ, Martin-Doyle W, Rajagopal PS, et al. Adjuvant chemotherapy for invasive bladder cancer: a 2013 updated systematic review and meta-analysis of randomized trials. *Eur Urol* 2014;66:42–54.
- [61] Nishino M, Giobbie-Hurder A, Manos MP, et al. Immune-related tumor response dynamics in melanoma patients treated with pembrolizumab: identifying markers for clinical outcome and treatment decisions. *Clin Cancer Res* 2017;23:4671–9.
- [62] Powles T, Durán I, van der Heijden MS, et al. Atezolizumab versus chemotherapy in patients with platinum-treated locally advanced or metastatic urothelial carcinoma (IMvigor211): a multicentre, open-label, phase 3 randomised controlled trial. *Lancet* 2018;391:748–57.
- [63] Powles T, Smith K, Stenzl A, Bedke J. Immune Checkpoint inhibition in metastatic urothelial cancer. *Eur Urol* 2017;72:477–81.
- [64] Szabados B, van Dijk N, Tang YZ, et al. Response rate to chemotherapy after immune checkpoint inhibition in metastatic urothelial cancer. *Eur Urol* 2018;73:149–52.
- [65] Giannarini G, Kessler TM, Thoeny HC, Nguyen DP, Meissner C, Studer UE. Do patients benefit from routine follow-up to detect recurrences after radical cystectomy and ileal orthotopic bladder substitution? *Eur Urol* 2010;58:486–94.
- [66] Volkmer BG, Kuefer R, Bartsch Jr GC, Gust K, Hautmann RE. Oncological followup after radical cystectomy for bladder cancer—is there any benefit? *J Urol* 2009;181(1587), discussion 1593.
- [67] Huguet J. Follow-up after radical cystectomy based on patterns of tumour recurrence and its risk factors. *Acta Urol Esp* 2013;37:376–82.
- [68] Chan Y, Fisher P, Tilki D, Evans CP. Urethral recurrence after cystectomy: current preventative measures, diagnosis and management. *BJU Int* 2016;117:563–9.
- [69] Pieras E, Palou J, Salvador J, Rosales A, Marcuello E, Villavicencio H. Management and prognosis of transitional cell carcinoma superficial recurrence in muscle-invasive bladder cancer after bladder preservation. *Eur Urol* 2003;44:222–5, discussion 225.
- [70] Giacalone NJ, Shipley WU, Clayman RH, et al. Long-term outcomes after bladder-preserving tri-modality therapy for patients with muscle-invasive bladder cancer: an updated analysis of the Massachusetts General Hospital experience. *Eur Urol* 2017;71:952–60.
- [71] Nieuwenhuijzen JA, de Vries RR, Bex A, et al. Urinary diversions after cystectomy: the association of clinical factors, complications and functional results of four different diversions. *Eur Urol* 2008;53:834–42, discussion 842–4.