Prevalence

In the Western world urinary bladder cancer is the fourth most common form of cancer in men, with an estimated 47,010 new cases diagnosed in 2005 in the US and 7,250 new cases diagnosed in 2002 in the UK. While it is often regarded as a “men’s condition” - affecting 3-4 times more men - its prevalence in women must not be underestimated. In women, it is the eighth most common malignancy, ranking on a par with cervical and ovarian cancer, with an estimated 16,200 new cases in 2005 in the US.

Causes

The most likely cause of bladder cancer is smoking. This epidemiological association was first noted in 1950. It is estimated that 20 years of smoking is needed for the development of bladder cancer. Furthermore, tobacco smoking intensity is directly correlated with the likelihood of its occurrence. However, its origins are still not fully understood. While occupational and lifestyle exposures to carcinogens play an important role, a connection with hereditary factors remains controversial.

Classification

The type and degree of bladder cancer is established following the classification of bladder tumours according to the 2002 TNM Classification of Malignant Tumours. This UICC body assesses malignancy according to tumour invasiveness, extent of spread to lymph nodes and distant metastases. Ta (noninvasive papillary carcinoma), CIS (carcinoma in situ) and T1 (tumour invades subepithelial connective tissue) represent superficial tumours, while T2, T3 and T4 are progressively more muscle-invasive tumours. In addition, cancer is graded as being either low-grade or high-grade (which assesses microscopically how abnormal the cancer cells are).

Diagnosis - Treatment

The most common initial sign is macroscopic haematuria, which calls for radiological examination of the upper urinary tract and cystoscopy. If confirmed, two distinct forms of bladder cancer can be identified. The first form are nonmuscle- invasive - “superficial” carcinomas. These account for 70 percent of all newly diagnosed bladder cancer cases. While most of these cases show a high potential to recur, they are generally unlikely to progress. Essentially, the treatment will consist of transurethral resection (TUR; also: TURB, TURBT) of affected bladder areas followed by intra-vesical immunotherapy. The second form of bladder cancer, making up the remaining 30 percent, is characterised by muscle-invasive tumours with an associated 5-year mortality rate of 50 percent. In these cases radical cystectomy (bladder removal), lymphadenectomy and/or chemotherapy are the recommended treatments.

After initial TUR, further treatment will depend on how far the tumour has invaded the surrounding tissue and if it has spread to other parts of the body. If a cancer is superficial, a single instillation of a chemotherapy agent immediately after TUR is advocated. An additional course of chemotherapy or Bacillus Calmette-Guerin (BCG) instillations for 4 to 8 weeks is advocated in intermediate and high-risk groups. Chemotherapy instillations are repeated monthly thereafter while BCG instillations are repeated at 3 and 6 months.

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Bleeding and lymphatic system disorders, Uncommon, Anaemia

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Pharmacological Properties

Photodynamic properties Photodynamic therapy Photodynamic therapy is a technology that involves the administration of a “photoactive” drug to the patient, followed by exposure to the affected area of light. Through its wavelength selective properties, this breakthrough technology allows for early diagnosis and precise treatment

First Authorisation/Renewal of the Authorisation

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