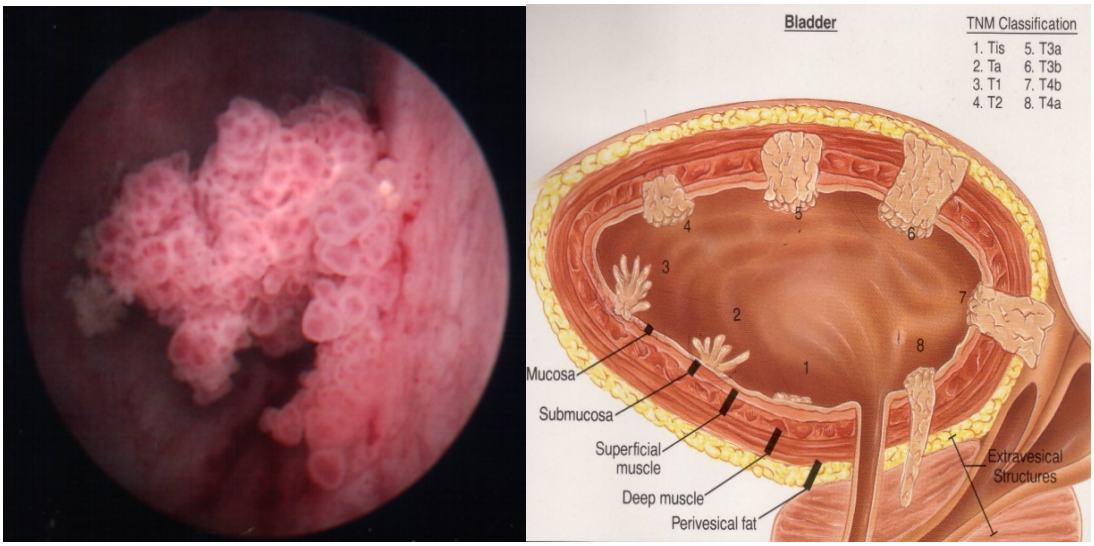
Bladder tumours

The majority of bladder tumours are transitional cell carcinomas or urothelial carcinomas and patients typically present with painless haematuria (blood in the urine). The incidence of bladder tumours is four times higher in smokers. Investigation of haematuria requires kidney imaging, usually a CT scan and a cystoscopy (telescopic bladder inspection). 75% of these bladder tumours are superficial at diagnosis and can be removed by endoscopic resection (burnt off through the telescope). Patients require regular surveillance because of the chance of recurrence but most superficial bladder tumours stay superficial and require no more invasive treatment. Sometimes intravesical chemotherapy or immunotherapy is advised where drugs are instilled in the bladder usually once a week for six weeks to reduce the risk of recurrence and progression. The most commonly used treatment is BCG, immunotherapy and this causes transient dysuria (burning when voiding) and urinary frequency but is usually very well tolerated and effective.

Unfortunately some bladder tumours are high grade or invasive at diagnosis and require more aggressive treatment such as a cystectomy (surgical removal of the bladder). If the bladder is removed, the ureters are joined to an isolated segment of small bowel and a stoma created to collect urine in a bag on the abdominal wall or a new bladder is fashioned out of small bowel so urine drains through the urethra in the normal way. Radiotherapy and chemotherapy can sometimes be used as well as or instead of surgery.



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