



Cystectomies and bladder preservation: What you need to know

Robin Morash RN, BNSc, MHS

Bladder Cancer Canada

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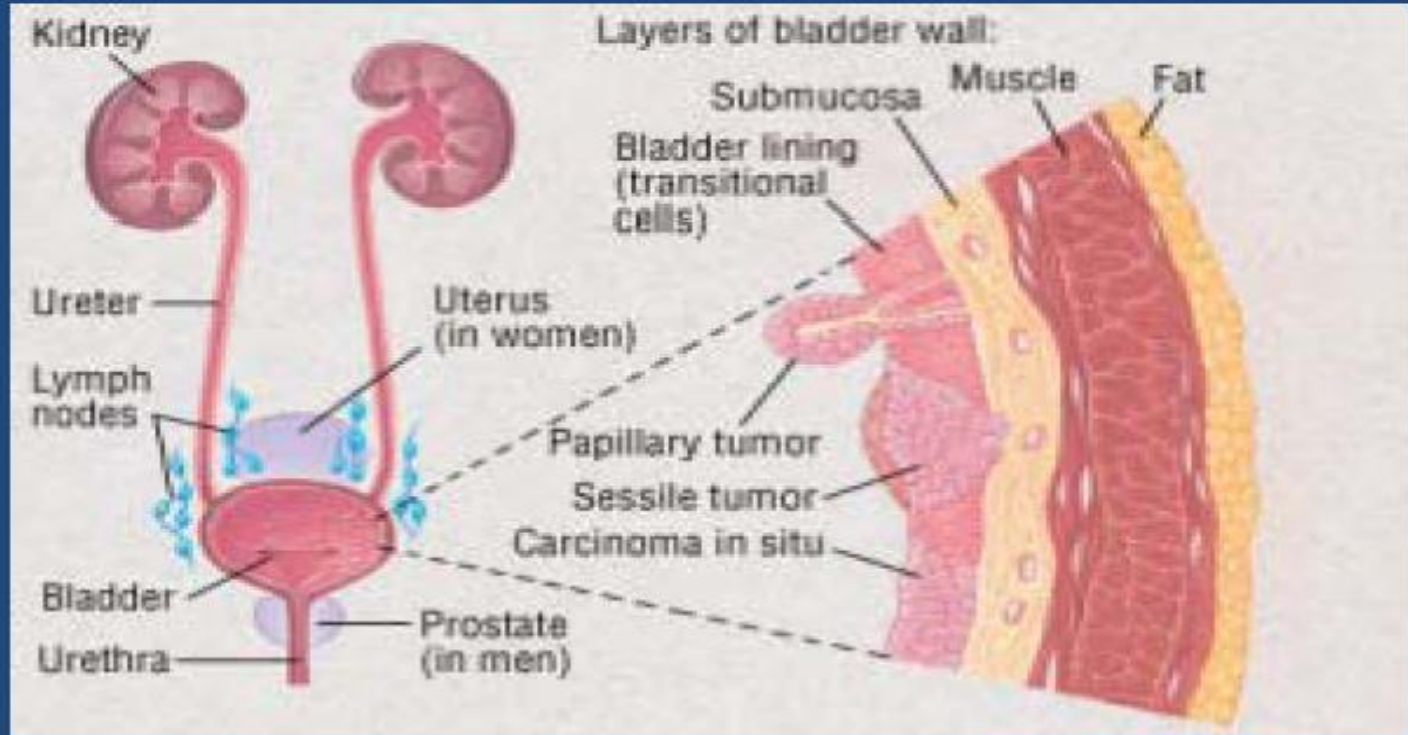




Presentation goals

- Review the options for treatment of muscle-invasive bladder cancer
- Describe the different types of urinary diversion after bladder removal
- Review what to expect after surgery
- Discuss sources of support

Bladder anatomy



Localized muscle invasive bladder cancer

Treatment Options

Surgery

+/- neoadjuvant chemotherapy
+/- adjuvant chemotherapy

Radiation (bladder sparing)

+/- chemotherapy

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-
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Icing on the cake

Without chemotherapy



With chemotherapy





What is the role of chemotherapy?

- Combined with surgery
 - Usually given neoadjuvantly but can be given adjuvantly
- Better outcomes when patients are given neoadjuvant chemotherapy.
 - Helps to eliminate undetectable cancer cells that are often found in other areas of the body.
 - Clinical trials have shown that neoadjuvant chemo reduces risk of death and improves 5 year survival.
- Recognized as standard of care.
- Reserved for patients who can tolerate aggressive treatment.



What is the role of radiation?

- Patients who have a strong preference to keep their bladder and have well defined, muscle invasive tumor inside the bladder without evidence of cancer on the lining (carcinoma in situ- often recurs)
- Patients who may not tolerate major surgery
- Up to six weeks treatment given 5 days per week
- Can be used in combination of chemotherapy
 - chemo acts as a radiosensitizer
 - Improves local pelvic control rates



Surgery: Radical cystectomy

All of the bladder is removed

- In men the prostate and seminal vesicles are also removed
- In women the uterus, ovaries, cervix and part of the vagina may be removed
- Nearby lymph nodes are also removed
- A new way is made for urine to be collected from the kidneys and stored = “Urinary Diversion”



Surgical urinary diversion options

During the cystectomy surgery, once the bladder is removed, the urologist will create a new way for urine to leave the body

Urinary Diversions:

1. Ileal Conduit (1950's)
2. Continent reservoir pouch (1980's)
3. Neobladder (1980's)

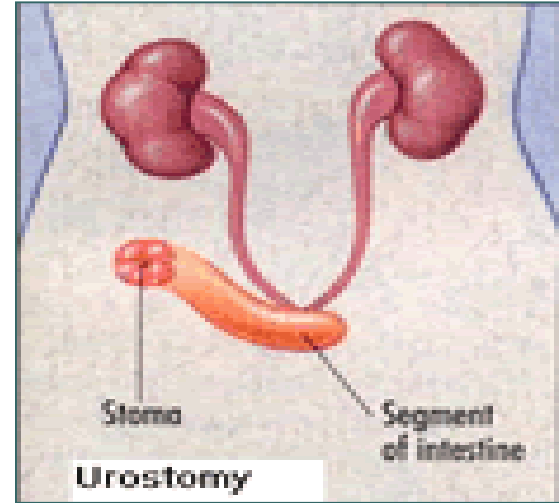
Choice depends on:

- Size, location of tumour
- Stage
- Age, fitness of patient, other health problems
- Patient preference

1. Ileal conduit

A short piece of the small intestine is removed and connected to the ureters creating a passageway known as an *ileal conduit*.

The conduit is connected to the skin on the front of the abdomen by an opening called a *stoma*.



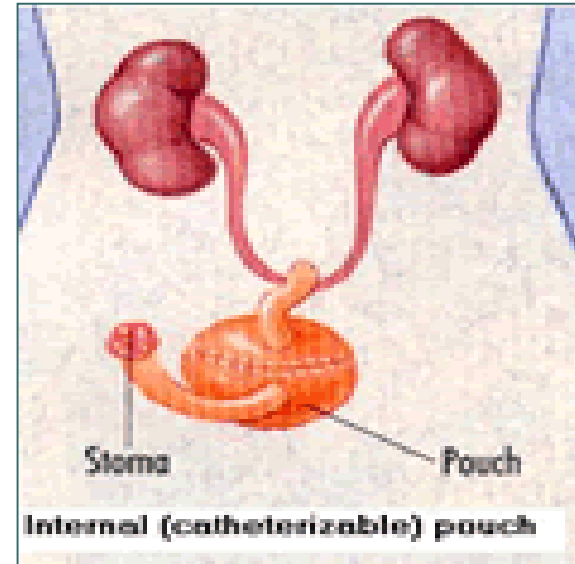
2. Catheterizable continent reservoir pouch

A valve is created in a pouch made from a piece of small intestine.

The valve allows urine to be stored in the pouch.

It is emptied several times each day by placing a drainage tube (catheter) into the stoma through the valve.

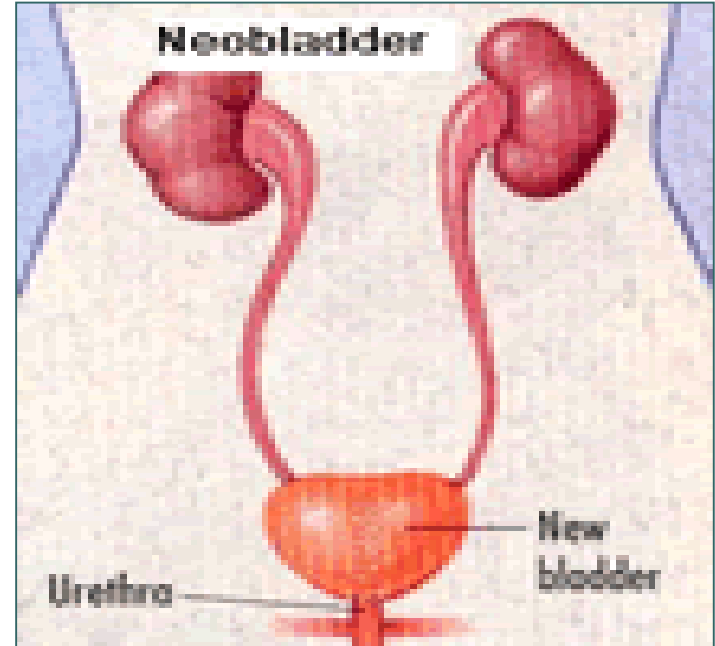
“Continent diversion to skin”



3. Neobladder

A urinary reservoir (neobladder) is made from a piece of small intestine.

The ureters are connected to the neobladder which is then connected to the urethra enabling the patient to urinate through the urethra.



What to expect after surgery

- Overnight in Recovery Room (PACU)
- 7-10 days in hospital
- Up walking 2nd day
- Progressive return to normal diet
- Pain control
- Home care services





Post-operative clinic visit

- Return appointment will be scheduled on discharge
- Discussion of surgery and pathology results
- Decision regarding next steps & plan of care:
 - This may include a possible referral to an oncologist
 - Future plans for blood work and imaging



After Surgery

- Activity
- Nutrition
- Care of the incision
- Care of the urinary diversion
 - Ileal conduit – ostomy, drainage bag
 - Neobladder – temporary catheter
- Follow up care with the urologist
 - every 3 months x 1 year; every 6 months x 3 years; then yearly



Ileal conduit – Ostomy care

- Enterostomal Therapy (ET) Nurse will be consulted before surgery to mark the spot on the abdomen & be available on TOH surgical units after surgery
- Patient must be able to empty, rinse and close the pouch before going home
- Patient will be provided with initial ostomy products on discharge
- Home care services will provide support in the care and changing of the pouches (appliances)



Instructions for Neobladder Patients

- Hydration - Fluid intake
- Urinary Catheter Care
- Flushing the urinary catheter (irrigating)
- Kegel (pelvic floor) exercises
- New urinating action



Going Forward

- Be kind to oneself, be patient!
- Accept help from others
- Keep a sense of humour
- Ask questions if unsure
- It may take 3-6 months to reach a new “normal” urinary pattern
- Support groups



Which is the best option for you?

Consider:

- Impacts on lifestyle
- An individual's personal preferences

In many cases the decision is up to the individual.



Education and support

- Decision making – connection with peer support, BCC members
- Preoperative prep
- Recovery after surgery
- Care at home: ostomy, neobladder
- Sexuality, erectile function
- What to expect: normal vs. abnormal



Pros and cons of an Ileal Conduit

Pros

- Simple to perform
- Least potential for post-treatment complications
- No need for catheterization
- Less absorption of urine
- For some people: simple to care for

Cons

- Need to wear an external collection bag
- Stoma complications
- Impaired body image
- Cost of supplies
- Perceived limits to leisure/social activities
- For some people: awkward to care for



Pros and cons of a neobladder

Pros

- No external bag or stoma to maintain
- Urinate through urethra
- May not need catheterization
- Body image

Cons

- Incontinence (10-30%)
- Urine retention (5-20%)
- Potential complications (e.g. infection)
- Need for specific exercise and pelvic floor muscle strengthening
- Need to “train” neobladder
- May need to catheterize