

Difficulties encountered in the implementation of international guidelines

« Managing NMIBC by Algerian urologist »

Oncofurm juin 2022
Pr ATOUI MM
Clinique Al farabi Annaba

How are we dealing with international guidelines ?

How are we dealing with international guidelines ?

No disclosures

Introduction

Hard mission : (sujet qui interpelle)

Topic of paramount importance

- 1st cancer urology, letality
- Heavy handling and health care, morbidity
- Most expensive /patient

Hard mission

- Limited data
 - Limited communications (local)
 - Limited publications (guidelines statement)
- (4 or 5 studies , Belasla, Sayoud, Yousfi(kerroumi), Taleb Ben Diab, Saighi)

Introduction



...main reference

Introduction



...main reference

- Sometimes notice discrepancy

Introduction



...main reference

- Sometimes notice discrepancy
- Major concern for **URO & ONCO**
- Ideal trt :difficult to achieve!

Introduction



...main reference

- Sometimes notice discrepancy
- Major concern for **URO & ONCO**
- Ideal trt :difficult to achieve!
- NMIBC: **CASE IN POINT**

Introduction

- Adapt treatment :
 - **To patient**
 - **Field reality**
- Ethical dimension :
 - Medical service provided (SMR)?
 - Chance loss ?

AIM of the Work

Pinpointing:

- The extent of these discrepancies
- The potential reasons for such discrepancies

Methodology

- **CHU study:**

Descriptive, analytical, 2008 to 2014, 302 patients

NMIBC: Diagnosis, TRT follow up

- **Survey:**

Methodology

- **CHU study:**

Descriptive, analytical, 2008 to 2014, 302 patients

NMIBC: Diagnosis, TRT follow up

- **Survey:**

Confirmed **Urologists**

Trainees

About: guidelines

Managing **NMIBC**

Achieving bladder instillations

Outcomes

Our study

first

Outcomes

NMIBC management

Outcomes

NMIBC management

Who performs TURP ?

Outcomes

NMIBC management

Who performs TURP ?

Almost everyone

Outcomes

NMIBC management

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Mainly private physicians

Outcomes

NMIBC management

Who performs TURP ?

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Poor data

Outcomes

- No national Cancer Register (no details)

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- Average age 60 y (comorbidities)
- Average time to TURBT: 76 d

Outcomes

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- Chronophagic activity > 66%
- Average age 60 y (comorbidities)
- **Average time to TURBT: 76 d**
- NMIBC diagnosed at advanced stages
- **Average tumor size > 3 cm (EORTC)** (70 % Belasla)
- 30% multifocal (78% taleb diab)(35% belasla)

Then...

The survey

Outcomes

273 Urologists

71 feed back

Outcomes

273 Urologists

71 feed back

Activity sector:

Private: 47,9%

Academic : 33,8%

**We asked them
Questions**

What is your usual standpoint in the use of guidelines?

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94% support the implementation

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Wich guidelines do you use for monitoring your patients?

What is your usual standpoint in the use of guidelines?

94% support the implementation

Which guidelines do you use for monitoring your patients?



**Do you take "deep" samples (looking for muscle layer)
during your TURBT?**

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- YES: 100 %

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Do you take "deep" samples (looking for muscle layer) during your TURBT?

- YES: 100 %

Do you achieve a second TUR if pathologist tells “NO MUSCLE” on the samples?

- NO: 58 %

Do you always perform required instillations?

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•NO: 53,5%

Do you always perform required instillations?

- NO: 53,5%

- Public : 1/3

- Private : 2/3

Why not?

Why not?

Dearness

Why not?

Dearness

Unavailable Products

Both sectors

Private +++

Back to

Our study

Results

T1: 43%

High risk : 49%

T1 G3 : 40%

Results

T1: 43%

High risk : 49%

T1 G3 : 40%

Cis : 6% (No PDD)

Micropapillary invasion?

Results

T1: 43%

High risk : 49%

Single immediate instillation MMC : 91%

T1 G3 : 40%

Results

T1: 43%

High risk : 49%

Single immediate instillation MMC : 91%

BCG: 30,8%

T1 G3 : 40%

Results

T1: 43%

High risk : 49%

T1 G3 : 40%

Single immediate instillation MMC : 91%

BCG: 30,8%

Maintenance trt: 37%

Results

Recurrence rate: 54 %
(56% EHU)(52 CHU O)

59%: **If HIGH RISK**

65%: **If No BCG**

Results

Recurrence rate: 54 %

Progression rate: 24,5 %
(15% EHU)(23% CHU O)

59%: If HIGH RISK

29% if HIGH RISK

65%: If No BCG

57% if no instillation

Results

Recurrence rate: 54 %

Progression rate: 24,5 %
(15% EHU)(23% CHU O)

59%: If HIGH RISK

29% if HIGH RISK

65%: If No BCG

57% if no instillation

main risk factors (univariate analysis)

STAGE, GRADE, TUMOR SIZE

PTIC Grp, DELAYED TRT

(p 0.03 RR: 0,62) Confirmé par CHU Oran

Discussion

Discussion

- Algerian urologists dealing with guidelines
- NMIBC case in point
- Hesitation of practitioners to “auto assessment”
- Situation affecting optimal treatment
- Impact on healthcare Quality
- Loss of luck

Discussion

About diagnosis

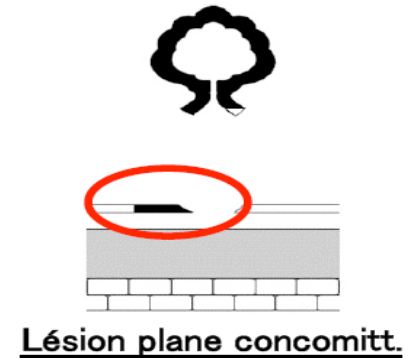
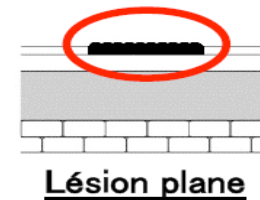
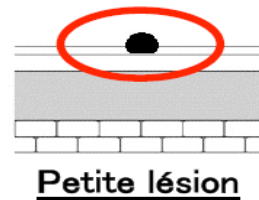
Discussion

- **Fortunate CIS diagnosis**
- No clear picture about muscle invasion
- No normalized histopathology report
- No accurate prognosis
- Difficult treatment guidance
Drugs, protocol schedule...

Discussion

No PDD

- Ignoring small size tumors «invisible»
- (<5mm)
- plane tumors
- CIS



33 % incompleated TURBT
RF Survival!

*Holzbeierlein JM, Urol Clin North Am 2000
Vogeli TA, Urologe A 2002*

Courtesy Roupret

Discussion

- Fortunate CIS diagnosis
- **No clear picture about muscle invasion**
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Discussion

«no Re RTUBT »

- 2 à 28% staging error BABJUK European urology supp 2011
- 49% of T1 upstaged to T2 BICHART, IRANI progrès FMC 2010
- 38 à 63% residual tumors (day 8 to day15) M BRAUSI Urology 2002



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ARTICLE ORIGINAL

Traitement par instillations vésicales de BCG et mitomycine C dans les tumeurs de vessie n'infiltrant pas le muscle : enquête de pratique de l'Afu auprès des urologues français[☆]

A. Descazeaud^{a,*}, J.-P. Mignard^b,
J.-L. Davin^c, J. Irani^d

Conclusion. – Les réponses des 156 urologues ayant répondu à cette enquête ont permis d'évaluer les pratiques des urologues français concernant les instillations intravésicales dans le traitement des TVNIM. Sans s'éloigner de façon majeure des recommandations de l'Afu, les pratiques des urologues étaient souvent hétérogènes. Les points nécessitant une clarification ont été mis en lumière.

Traitement par instillations vésicales de BCG et mitomycine C dans les tumeurs de vessie n'infiltrant pas le muscle : enquête de pratique de l'Afu auprès des urologues français[☆]

Treatment of non-muscle invasive bladder tumours by instillations of mitomycin C and BCG: A survey on French urologists by the French Urological Association

A. Descazeaud^{a,*}, J.-P. Mignard^b,
J.-L. Davin^c, J. Irani^d

Concernant le traitement

« **souvent** » 62 %

« **systématiquement** » 36 %

autres réponses : 3 %

Abstract

Cancer. 2011 Dec 1;117(23):5392-401. doi: 10.1002/cncr.26198. Epub 2011 Jul 11.

Compliance with guidelines for patients with bladder cancer: variation in the delivery of care.

Chamie K¹, Saiqal CS, Lai J, Hanley JM, Setodji CM, Konety BR, Litwin MS; Urologic Diseases in America Project.

RESULTS: Of the 4545 subjects analyzed, only 1 received all the recommended measures. Approximately 42% of physicians have not performed at least 1 cystoscopy, 1 cytology, and 1 instillation of immunotherapy for a single patient nested within their practice during the initial 2-year period after diagnosis. After 1997, only use of radiographic imaging (odds ratio [OR], 1.19; 95% confidence interval [95% CI], 1.03-1.37) and instillation of immunotherapy (OR, 1.67; 95% CI, 1.39-2.01) were found to be significantly increased. Surgeon-attributable variation for individual guideline measures (cystoscopy, 25%; cytology, 59%; radiographic imaging, 10%; intravesical chemotherapy, 45%; and intravesical immunotherapy, 26%) contributes to this low compliance rate.

Discussion

About treatment

Discussion

- TURBT + instillations: High cost
- Cystectomy: not enough performers, often delayed
- Still no data

Instillations:

- Erratic availability of MMC (Public hospitals)
- Unavailable (BCG) through the official market

Discussion

- Additional costs during health care
- Non-refundable expenses
- Dearness with medico-economic issues
- Bladder Cancer = most expensive cancer budgétivore
\$ 96,000 to \$ 187,000 / patient

Botteman, Pharmacoeconomics 2003
Avritscher, Urology 2006

- Compromised treatment and follow up schedule

To summerize....

Discussion

**Difficulty (impossibility) to deal with the
guidelines**



Discrepancies in medical practice
(monitoring NMIBC)



GAP

**Discrepancy with
Guidelines**



Different levels



Health care access



Diagnosis



Treatment

Optimizing health care



Interventions Different levels



Practitioners

Multidisciplinary
Collaboration



Official institutions

Health care
policy and access



Academic

Medical training

Conclusion

Bias

(sampling, weakness of the questionnaire...)

Need more results coming from other centers

Show difficulties encountered NMIBC trt

GAP: what is supposed **Vs what is actually done**

Need set down own guidelines.

**Merci pour votre
attention**

