



Audit

Disease-centred advice for patients with superficial transitional cell carcinoma of the bladder

Jonathan Dearing

Department of Orthopaedic Surgery, Ninewells Hospital, Dundee, UK

Introduction: Urologists tend to regard superficial tumours (e.g. pTa or pT1 transitional cell carcinoma of the bladder) as being of low pathogenicity. There is a clearly established link between cigarette smoking and bladder cancer, with incidence, recurrence and mortality being positively associated with duration of smoking and number of cigarettes smoked.

Patients and Methods: A questionnaire-based audit was undertaken to determine the amount of information being provided by urologists for patients who had been diagnosed with pTa or pT1 transitional cell carcinoma of the bladder about both their disease, its aetiology and appropriate advice regarding life-style change.

Results: A total of 78 patients adequately completed the questionnaire. Of these, 55 (71%) had been smokers at some time, and 24 (31%) continued to smoke at the time of follow-up. Only 26 of these 55 (47%) were aware of their underlying diagnosis. This level of knowledge was similar in non-smokers, of whom only 12 (52%) were aware of their disease. Of the ever-smokers, only 12 (22%) were aware that smoking was a risk factor for the development of bladder cancer, and 7 (13%) were aware that continued smoking could worsen the prognosis. Only 18 (33%) of the 55 smoking patients had been told to stop smoking, for any reason, by their general medical practitioner, and only 4 (7%) had been told to stop by a urologist.

Conclusion: In the urology department in which the audit was performed, patients with bladder cancer were not being provided with adequate information about their disease.

Key words: Advice – Superficial transitional cell carcinoma – Bladder

Transitional cell carcinoma of the bladder (TCC) is a common disease which, in the US in 1999, accounted for 6% of all new cases of malignant disease in males and 3% in females, with 12,100 deaths.¹ There is a clearly established link between cigarette smoking and bladder cancer, with incidence, recurrence and mortality being positively associated with duration of smoking and number of cigarettes smoked. Tumour stage is an important factor in determining treatment; superficial

tumours (pTa/pT1) being treated by transurethral resection or cystodiathermy, intravesical chemotherapy and regular surveillance, whilst more invasive bladder carcinomas are more likely to be treated by cystectomy or radiotherapy. Urologists tend to regard superficial tumours as being of low pathogenicity, and an audit was undertaken to determine the amount of information being provided by urologists for patients who had been diagnosed with pTa or pT1 transitional cell carcinoma of

Correspondence to: Jonathan Dearing, Department of Orthopaedic Surgery, Perth Royal Infirmary, Tullylumb Terrace, Perth PH1 1NX, UK Tel: +44 (0)1382 660111; E-mail: jonathan.dearing@tuht.scot.nhs.uk

Table 1 Summary of results

	Smokers	Non-smokers
Total	55	23
Current	24	
Ex-smokers	31	
Aware of diagnosis	26	12
Recurrence		
Total	29	12
Current	18	
Ex-smokers	11	
Aware of smoking as a risk factor	12	
Advised to stop smoking		
By urologist	4	
By GP	18	

the bladder about both their disease, its aetiology and appropriate advice regarding life-style change.

Patients and Methods

All patients attending for follow-up flexible cystoscopy after diagnosis of pTa or pT1 transitional cell carcinoma of the bladder at a district general hospital over a 3-month period were included. Patients were requested to complete a questionnaire documenting their awareness of the underlying diagnosis, their smoking status at the time of diagnosis and at follow-up, number of recurrences and awareness of smoking as a risk factor for development of their disease. A nurse explained the purpose of the study and was available to assist patients if necessary as well as to answer any queries. A notional gold standard level of information provision against which the audit was assessed was that all patients would have been told their exact diagnosis, the linkage between the disease and cigarette smoking, would have been advised to stop and would have done so.

Results

The results are summarised in Table 1. A total of 78 patients adequately completed the questionnaire. Of these, 55 (71%) had been smokers at some time, and 24 (31%) continued to smoke at the time of follow-up. Only 26 of these 55 (47%) were aware of their underlying diagnosis, with those ignorant of their condition having been informed only that they had 'warts' or 'bleeding areas' in the bladder. This level of knowledge was similar in non-smokers, of whom only 12 (52%) were aware of their disease.

Of the ever-smokers, only 12 (22%) were aware that smoking was a risk factor for the development of bladder

cancer, and 7(13%) were aware that continued smoking could worsen the prognosis. Only 18 (33%) of the 55 smoking patients had been told to stop smoking, for any reason, by their general medical practitioner, and only 4 (7%) had been told to stop by a urologist.

The overall number of recurrences in ever-smokers was 29 (53%), with 11 of these in ex-smokers and 18 in those patients who continued to smoke. This recurrence rate in smokers was similar to the rate for recurrence in never-smokers, in whom 12 (52%) recurrences were recorded.

Discussion

Despite a perception amongst specialists that superficial bladder cancer is a disease with a small impact on a patient's life, it has a 3-year recurrence rate of up to 70% and may progress to invasive bladder cancer, particularly in smokers.² There is a corresponding reduction in the rate of recurrence in patients who cease smoking,³ with non-stage specific 10-year mortality being 27% in non-smokers and 40% in smokers.⁴ Any intervention on the part of a clinician to influence a patient to stop smoking should be patient-centred and, in order to permit active patient participation in the process, they should be given adequate and accurate information.⁵ Between 80–96% of patients would want to be informed if they had a malignant disease,^{6,7} a stark contrast to the approximately 50% who were informed unequivocally in this study. This is, however, in keeping with the findings of another study, which showed only 23% of patients surveyed were aware that they had bladder cancer.⁸ It is the role of the urologist not only to diagnose and to treat the disease, but also to inform the patient about their disease so that they may be better able to make appropriate decisions regarding their care and their life-style. Integral to this is the provision of the patient with information with respect to the diagnosis; dealing in euphemisms leads only to confusion and a false sense of patient security. There must also be some concern regarding the legal standing of the clinician who withholds a diagnosis of malignant disease from a patient.

Bladder cancer is associated with duration and heaviness of the smoking habit, and with the gender of the smoker.⁹ For those smoking less than 20 pack years, the odds ratio for developing TCC is 1.9 (95% CI 1.4–2.5) for males and 1.7 (95% CI 1.1–2.6) for females. In those smoking over 40 pack years, the OR is 3.0 (95% CI 2.3–3.9) in males and 3.5 (95% CI 2.4–5.2) in females.¹⁰ Of all bladder cancer cases in both sexes, 66% is attributable to tobacco use, but smoking cessation results in an absolute risk reduction of 30% at 4 years and 60% at 25 years.^{11,12} Previous studies have reported that 69% of patients continue to smoke following the diagnosis of TCC, despite 78% being advised to quit by a urologist, and these

individuals are at a higher risk of recurrence.¹³ Of general medical practitioners, 65% reportedly advise against smoking routinely, with 90% offering similar advice to patients who have a smoking-related disease. The reported success rate for such routine in-consultation counselling against smoking is a 3% quit rate, with 60% of smokers not recalling that they have ever been counselled at all.¹⁴ The major reported barrier to smoking cessation advice provision is negative patient reaction, as less than 50% of smokers perceive their smoking status as being problematic, and also a desire on the part of the health care professional to allow the patient to make their own decision without pressure. In this study, only 7% of smokers were urged to stop smoking by a urologist, whilst 33% had been advised to do so by their general practitioner for reasons other than TCC. It is probable that tailoring advice to appropriate patients will result in a greater quit rate and, following the trigger of a TCC diagnosis, urologists and GPs are ideally placed to offer such advice. A dedicated counselling session by a doctor, coupled with assistance such as nicotine patches will result in a 16% quit rate;¹⁵ unfortunately, this study suggests that a great opportunity to reinforce the anti-smoking message is being missed. This study was performed in one district general hospital unit and, as such, the findings may not be applicable to all urology departments. However, the papers by Teschke⁸ and Ostroff *et al.*¹³ indicate that the smoking cessation message is not being reinforced internationally. Locally or nationally produced patient information sheets detailing all relevant facts may provide great benefits for future patient education.

Conclusions

In the urology department in which the audit was performed, patients with bladder cancer were not being provided with adequate information about their disease. They may have been misinformed about their diagnosis and left in the dark about life-style changes which may lessen the risk of disease recurrence or progression. Both

urologists and general practitioners should work in concert to put an end to this unsatisfactory situation.

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