

Reply to Trey Durdin, Alvin Goh, and Eugene Pietzak. Can an imaging-guided pathway replace the current paradigm for muscle-invasive bladder cancer?

BladderPath Trial Management Group

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EDITORIAL REPLY

Re: Durdin T et al. Can an Imaging-guided Pathway Replace the Current Paradigm for Muscle-invasive Bladder Cancer? Eur Urol 2021; in press.

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Conflicts of interest: JWFC has received reimbursement for consultancy from Astra Zeneca and Janssen, speaker fees from BMS, MSD, Nucleix and Roche, and honoraria for membership of advisory boards for Ferring and Janssen. RTB has contributed to advisory boards for

Olympus Medical Systems, Janssen, UroGen Pharma and QED Therapeutics. NDJ has no relevant conflicts of interest for this work.

We thank Durdin and colleagues for their comments on our study (1). As with all challenges to normal practice, we expect debate and interest; a detailed inspection of our study protocol (that accompanied the publication) will demonstrate the safeguards that are in place to abrogate the risk of overtreatment, as illustrated by the number of patients who did undergo transurethral resection (TURBT) following a diagnosis of muscle-invasive bladder cancer (MIBC) by multiparametric magnetic resonance imaging (mpMRI) in Pathway 2 (2). Most importantly, we have the support of our patients and advocacy groups - who are keen to improve the diagnostic paradigm.

We would like to reply to Durdin et al's statement that *"the impetus for this trial is the authors' recognition that in their health care system, the waiting time for diagnostic TURBT can result in significant delays to definitive management and potential harm for patients with MIBC"*. It is crucial to highlight that delays to correct treatment for MIBC patients are commonplace internationally and not just the UK (3).

Firstly, the UK's healthcare system is sufficiently connected such that we can measure the total time from initial community (GP) consultation to radical treatment. Our concern was raised by seeing these total delays, and that many women were misdiagnosed with infective cystitis prior to urological referral (4). Similar findings are seen in: Canada, where women with bladder cancer spend twice as long in the community (40-56 days before urological referral) as male patients (5); the USA, where mean delays are around 85 days for women, and 17% of women wait 6 months for inward referral (6); Denmark, where the interval from onset of symptoms to treatment averages 28 weeks (7); Australia, where the median time to urology consultation is 65 days for women and 33.5 days for men (8); and Germany (9).

Secondly, delays after initial urological consultation are also widespread. In the USA, delays of over 12 weeks from BC diagnosis to radical cystectomy (RC) are not uncommon, and Chu et al. found the median time from TURBT to surgery was over two months (69 days) (10, 11). Additional delays of over 7 weeks from completion of neoadjuvant chemotherapy (NAC) to RC have been reported (12), resulting in potential delays from BC diagnosis to RC of over 22 weeks (13). In Europe, data from The Netherlands show a median delay

from BC diagnosis to RC (in the absence of NAC) of 7 weeks, with over 93% of patients undergoing RC in ≤ 12 weeks; for NAC patients these figures are 19 weeks and 16%, respectively (14).

Therefore, attempts to improve and refine the diagnostic and treatment pathways for BC patients are of international importance and a priority for patients and healthcare professionals alike (15).

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