




Shining a Light on Rare Forms of Bladder Cancer

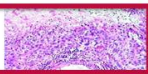
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Rare Forms of Bladder Cancer: Urothelial Carcinoma Variants

Dr. Apolo: So now I want to talk about urothelial carcinoma tumors that have a variant histology, and there's a lot of different types of variants. And I just listed the most common rare variants. These include squamous differentiation, adenocarcinoma/glandular differentiation, sarcomatoid, micropapillary, lymphoepithelioma-like carcinoma, and plasmacytoid. So, for urothelial carcinoma variants, similar to rare bladder tumors, it's difficult to diagnose. And the optimal treatment for these variants is unclear because we don't have randomized data. Most of the data that we have are from a single institution experience. And again, some of these are super rare.

Bladder cancer Histology

Urothelial Carcinoma	90%	
Variants (often mixed with urothelial carcinoma)		
Squamous differentiation (20-60%)		
Adenocarcinoma/glandular differentiation (10%)		
Sarcomatoid (7%)		
Micropapillary (3.7%)		
Lymphoepithelioma-like carcinoma		
Plasmacytoid		


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Urothelial Carcinoma with Squamous Differentiation

- 8-15% of bladder tumors invading lamina propria
- 20-60% of muscle-invasive bladder cancer
- High grade and advanced stage at presentation



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So I'll start off with urothelial carcinoma with squamous differentiation, and this is different than pure squamous cell carcinoma. Squamous differentiation within urothelial carcinoma is actually not too uncommon. We do see it in T1 tumors. These are non-muscle-invasive tumors occurring about 8 to 15% of the time. And we see it actually pretty commonly in muscle-invasive tumors, occurring about 20 to 60% of the time, depending on which surgical theories do you look at. These are high-grade and usually advanced stage at presentation. Next slide.

So, in terms of giving intravesical therapy for non-muscle-invasive disease, this is reasonable and this is okay to do as long as there's close surveillance with high vigilance for understaging and early cystectomy if the patient has recurrent. In terms of responding to chemotherapy, these tumors do respond. Remember, these are urothelial carcinoma with squamous differentiation. And they actually have a really good response to chemotherapy. Similar stage-matched to urothelial carcinoma in terms of their outcome, although some studies have suggested that these are potentially more aggressive, and there's more risk of understaging. Next slide.

Urothelial Carcinoma with Squamous Differentiation

- Intravesical immunotherapy can be considered in early non-muscle-invasive bladder cancer with close surveillance, high vigilance for understaging and early cystectomy if needed
- High rates of response to neoadjuvant chemotherapy with similar survival when controlled for stage
- Treated similar to stage-matched urothelial carcinoma and recognized that potentially more aggressive with risk for understaging



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So, moving onto urothelial carcinoma with glandular differentiation. These kind of look a little bit like the adenocarcinomas, but just a little spot of them have adenocarcinoma, and the rest of them are urothelial carcinoma. These occur in about 10% of urothelial carcinoma. You see small tubules or gland-like spaces in conventional urothelial carcinoma

Urothelial Carcinoma with Glandular Differentiation

- 10% of urothelial carcinoma
- Small tubules or gland-like spaces in conventional urothelial carcinoma, similar to enteric adenocarcinoma
- Thought to imply poorer prognosis but not clear
- Predictive of increased chemotherapy resistance in unresectable disease
- Same treatment considerations as squamous differentiation where treated similar to stage-matched urothelial carcinoma with recognition of potentially more aggressive with high-risk of understaging



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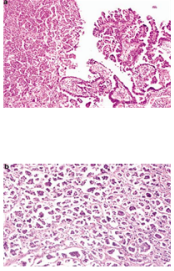
histology, similar to enteric adenocarcinoma. It's thought that these possibly have a poor prognosis, but it's not clear. In terms of the response to chemotherapy, there's a theory that these may be more resistant to chemotherapy, but this has not been shown consistently in trials. Some trials have actually shown that they're just as responsive to chemotherapy, and the treatment is the same. Similar to squamous cell differentiation, you treat it the same,

again, recognizing that these may be more aggressive, and again, a high risk of understaging.

So, micropapillary carcinoma. These are really rare. These are urothelial carcinoma with micropapillary in them. Initially they were about .6 to 1% of all urothelial carcinomas, but they're actually being found more now as pathologists learn how to find these. Histologically they look like a papillary serous ovarian carcinoma, but these are urothelial carcinoma. They just look like that under the microscope. They do have a worse disease-specific survival than urothelial carcinoma, with a poor prognosis. And actually, the higher the component of micropapillary within the specimen, then the more aggressive the tumor is. So, the more percentage of the tumor that has micropapillary features, the worse the outcome seems to be.

Micropapillary Carcinoma


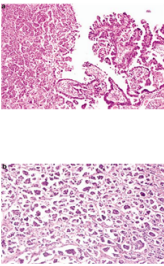
- 0.6-1% initially but up to 6% of bladder cancers due to increase awareness
- Histology reminiscent of papillary serous ovarian carcinoma
- Worse disease-specific survival than urothelial carcinoma with uniformly poor prognosis
- Higher percentage of micropapillary component associated with higher risk of recurrence



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Micropapillary Carcinoma

- Frequently high-grade and high stage with high rate of lymphovascular invasion (LVI)
- Lymph node metastases (47%)
- Distant metastases (35%)
- Limited response to BCG immunotherapy in early-stage disease and likely to progress while on intravesical therapy
- 67% progress and 22% develop metastases



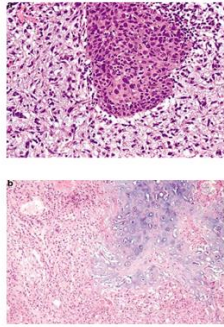
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So, frequently these are high-grade, higher stage with lymphovascular invasion. And what that means is that if you look under the microscope at the tissue and you see little vessels. Those little vessels often have tumor in them. You can see the tumor cells inside the vessels. Either these could be either vascular or lymphatic vessels. And that's how the tumor travels. So these do have a higher rate of lymphovascular invasion or LVI. And therefore, they present with lymph node metastases, a diagnosis more

commonly than urothelial carcinoma. And also, they present with distant metastases more commonly than regular urothelial carcinoma. So in terms of the treatment of non-muscle-invasive micropapillary tumors, the response to BCG is not very good. So, that needs to be taken into consideration. If this is a micropapillary non-muscle-invasive tumor, BCG will not work as well. They have a high rate of progression and also, a high rate of developing metastatic disease from non-muscle-invasive disease.

Sarcomatoid Carcinoma (Carcinosarcoma)

- Rare only about 0.6% of bladder cancer
- Biphasic malignant neoplasm
 - Epithelial (carcinomatous) component
 - Mesenchymal (sarcomatous) component
- Histologies in decreasing order of frequency:
 - Osteosarcoma
 - Chondrosarcoma
 - Rhabdomyosarcoma
 - Liposarcoma
 - Angiosarcoma
 - Mixture



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So, because of that, the treatment would be cystectomy instead of treating them with BCG. So, another rare variant is sarcomatoid carcinoma. These can be carcinoma and sarcoma, either and or. Really, really rare. They account for about .6% of bladder cancers. And there's different histologies. In order of frequency, there's osteosarcoma, there's chondrosarcoma, there's rhabdomyosarcoma, there's liposarcoma, angiosarcoma, and mix.

And the risk factors for developing

sarcomatoid carcinoma is radiation therapy, intravesical cyclophosphamide. The mean age is 66 years of age. These are high stage and grade tumors, frequently have lymph node and distant metastases. They're very aggressive. They're more aggressive than standard urothelial carcinoma, even when adjusted for stage. And there really isn't a good way of treating them. They don't respond well to chemotherapy. Radiation is often incorporated into the treatment. Surgery can often be incorporated into treatment. But in patients that have these tumors, it's important to have a multimodal approach. And what that means is that the medical oncologist, the urologist, and radiation oncologist should discuss the case to see what the best treatment option is for a particular case.

Plasmacytoid urothelial carcinoma is very rare. And it is associated with peritoneal involvement, that's the abdominal cavity, and local circumferential growth. So they can encase, for example, the rectum. These tumors do respond to chemotherapy, but they come back. So like in muscle-invasive tumors, you give them chemo, they downstage, but then within a year, the cancer comes back metastatic. These are aggressive tumors.

Sarcomatoid Carcinoma (Carcinosarcoma)

- Risk factors include:
 - Radiation therapy
 - Intravesical cyclophosphamide
- Mean age 66 years
- High stage and grade with frequent lymph node and distant metastases
- Very aggressive:
 - more aggressive than standard urothelial carcinoma even with adjustment for stage at presentation
- No recent large series to guide therapy with controversy regarding response to chemotherapy and radiation
 - Multimodal therapy may yield the best outcomes

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Plasmacytoid Urothelial Cancer

- Plasmacytoid tumors
 - Very rare
 - Associated with peritoneal involvement and local circumferential growth
 - Encasing rectum
 - Chemo-sensitive but poor prognosis
 - In muscle invasive disease these tumors respond to neoadjuvant chemotherapy with down-staging but usually recur within one year

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