Enhancing Bladder Cancer Surgery Recovery: **Strategies for Better Patient Outcomes**

Guest Presenter:
Dr. Saum Ghodoussipour

Stephanie Chisolm:
Thank you so much. That was an amazing presentation. I think all the people that were on the call will agree with me that bladder cancer treatment, whether it's a TURBT, or a radical cystectomy, has really evolved in a good way over the last 70 years. So again, I think that your reference of putting it in a historical perspective has been really helpful. I want to encourage people to submit any questions that they may have for you into the Q&A box. But I wanted to start out, what would you think, if you were just going to give a best guesstimate, what percentage of practitioners that might not be at a large academic center like what Rutgers University are implementing all of these procedures? Are people more likely to receive ERAS protocols if they go to a large academic center? Or is this something that has trickled down to community practice at say a small community cancer center?

Dr. Ghodoussipour:
I think that's an excellent question, and the truth is, that there's a lot of evidence to support the fact that patients do better at centers that are experienced and have a high volume in taking of patients with bladder cancer. And that's a fact, and I think it comes from the experience, and the discussions, and understanding of all these measures, but I know that not everyone has access to an institution like that. And you can still get good outcomes in the community so long as best practice is adhered to, and you're avoiding dogmatic practices that may be harmful. A lot of the interventions that I said on their own are now considered standard of care. Getting up and out of bed after surgery, I think everyone would agree it is a good thing, but having a standardized pathway to take care of this complex operation, it's a little bit harder to do, if you don't have support. It's not just up to one person, it really is a team effort and you want to make sure you have that team in place.

Stephanie Chisolm:
Sure. So if you're looking at maybe somebody is not asking, or somebody's not giving information about what they should do prior to their surgical procedure, how would you suggest somebody bring it up? If

they're on this call and they're facing a cystectomy, or even a TURBT, and they're thinking, "Wow, my doctor never does this or hasn't told me about it." How should they bring it up?

Dr. Ghodoussipour:
I think that your clinic visit, obviously it's overwhelming to hear that you have bladder cancer, or to hear that you may need a cystectomy, or honestly even a transurethral resection of bladder tumor. So it's hard to think of these questions on the fly, but patients, you always want to try to be an advocate for yourself, and if you ask questions of your care team, no one's ever going to be offended. You should feel comfortable asking questions. But there are a lot of resources out there if for whatever reason, you may not feel comfortable bringing things up in the clinic. And I think that the BCAN website is an amazing resource for patients. I direct a lot of my patients that way.
There's a lot of easily digestible material and videos like this that you can watch. But one of my favorite recommendations, because I give a lot of stats and numbers in clinic, and I talk about things from my perspective as the physician, but you're never going to get a true understanding of what your experience is going to be like when you hear it from another patient. Survivor to survivor programs are really important. There's a great phone number for that through BCAN that you can call. And if you're at your home institution where you're receiving treatment, you can ask most of the time to speak with someone who's been through this before. And I honestly think that might be the most important way to get information.

Stephanie Chisolm:
Great. And thank you for the infomercial about the survivor to survivor program. Visit bcan.org and look on the top tab for caregivers or finding some support, and you'll find the link to ask for a patient to call you and speak with you about treatment. We do have a few questions that have come in. First, Annie said, thank you for a great talk, and asked, “Does the implementation of ERAS have any impact on the recurrence rate following a TURBT? Or is that completely separate?”

Dr. Ghodoussipour:
Well, I think it might be a little bit too early to say. There's no evidence in that regard, and there isn't a lot of evidence that ERAS improves cancer outcomes after radical cystectomy. But much of the focus has been on physical, emotional and recovery as we talked about. But in other surgical fields, like in colorectal surgery, there is data that ERAS protocols after colorectal surgery for colorectal cancers improve outcomes, specifically recurrence rates and survival rates after colorectal surgery. And that's not because necessarily pain medicine influences your cancer recovery, but it's the little nitty-gritty details that you alluded to with where you receive care matters. But if you have a standardized pathway, nothing is missed, everything is done to the highest level. And if you are able to recover quickly after surgery, you might be able to get on more life-saving therapies afterwards. I just talked about neoadjuvant chemotherapy as an example in here, but adjuvant therapies, immunotherapy, biomarker testing that we have nowadays, that's sort of in the future for bladder cancer. And if you're able to recover quicker and get to subsequent therapies, you're going to do better. And I think that that's probably the same for TURBT and going on to intravesical and bladder sparing therapies afterwards.
Stephanie Chisolm:

Right. Yeah. So one of our participants said they've never heard of ERAS in the TURBT setting. “The issue I had was an extremely sore throat due to the intubating in my first one, sending me to the emergency department. The second one was done without in-tubing, and both have had equal results, and both were done in academic centers. Why is this not being addressed? Why is it inconsistent?”

Dr. Ghodoussipour:
Yeah, and again, a lot of credit to my colleague Max Kates for starting ERAS and TURBT, but it's not something that has been talked about. I think that we have really overlooked TURBT, saying, "Oh, it's just a quick outpatient procedure. There's no incisions. We just got to do it and you'll be fine. And when we come back, we'll talk about the pathology." But as time goes on, and we become a little bit more reflective as Leadbetter encouraged back in 1950, we understand that all these little things matter. I can't speak to everyone, but for example, when I do transurethral resections, I really try to avoid intubations. In the past, everyone was intubated for TURBT so that they could have muscle paralysis so that there was no leg kicks, which can happen during a bladder tumor resection. But there's a lot of different techniques and whatnot that you can do to avoid that. And if you avoid the need for muscle relaxation, you don't need intubation. You can just use a mask airway. But that's a little bit controversial, and I think that as we study this more and more, we can try to avoid things like that.

Stephanie Chisolm:
Great. Question, are your Rutgers checklists that you showed briefly, available online?

Dr. Ghodoussipour:
We do not have it available online quite yet because we're making some modifications. If you go back and look at this video, some of the measures on there, we no longer do. We've evolved in a lot of things, but ERAS is continually evolving. For example, thromboprophylaxis medications to prevent blood clots after surgery. We used to send everyone home after a cystectomy on blood thinning injections, we've switched to pills. Those checklists that I showed you say that we use injections, but we avoid that. So hopefully in the near future they will be.

Stephanie Chisolm:
One of the projects that BCAN has been doing a lot of work on is really developing survivorship resources. And perhaps this is something that can be added specifically about bladder cancer procedures, something similar that we can work on together to help really develop a whole checklist that could be really used either for the TURBT, or for a radical cystectomy that patients might be able to download to bring to their doctors and ask questions about. I think that would be really helpful.

Dr. Ghodoussipour:
I think that's a great idea, and I do look forward to having the specialty specific guidelines updated. And once that happens, I think we can put forward a little bit more clear consensus checklists. I don't want to just highlight what I do. I want to highlight what's best practice, that varies from state to state within the US, but also from country to country. The guidelines that we're trying to put forth are international, so

patients in Europe have a very different experience and desire to get out of the hospital, for example, after surgery.

Stephanie Chisolm:
I will definitely introduce you. Speaking of having you talk again, you're going to be coming to our fall summit in November in Philadelphia, and everyone on this call will be getting an invitation to attend. And there'll also be a session where we're going to have Mary Dunn, nurse practitioner who is down at UNC, and is focused on our survivorship task force. I will introduce you if you don't already know Mary, and perhaps we can think about how we can collaborate to work together on that. A couple more quick questions. I just want to try to get to them while we still have some time. You mentioned the removal of ureteral stents. Is that something that occurs after all radical cystectomies? If yes, what is the typical timing post-surgery?

Dr. Ghodoussipour:
Yeah, good question. And that's something that we're trying to have in the guidelines. Ureteral stents are used when we sew the ureters to the bowel that is used for the urinary diversion, whether it be an ileal conduit, neobladder or Indiana pouch. The majority of surgeons do use ureteral stents. But there is emerging evidence now that you can avoid the use of ureteral stents, so long as you do a meticulous repair. Traditionally, we've used these stents to prevent scarring or stricture formation, which can happen in the long run in up to 10% of patients, and it can prevent things like urine leakage from where we sew everything together.
But as of now, I would say that most people use ureteral stents. There might be a few high volume places that don't use ureteral stents. We try to remove them as early as possible. There have been studies where they're removed immediately after the sewing is done, where they're removed a day after surgery, where they're removed three weeks after surgery. For ileal conduits, I try to remove them before patients leave the hospital, which with our ERAS protocols is about four days now. So we try to remove those on post-op day four. But when we make neobladders, that's a little bit more complex and there's more time required for the neobladder to heal. I have the urethral stents attached to a urethral catheter, which comes out three weeks after surgery. But there's a lot of variation, I'll admit to you, in how people do that. That's just my practice, but the earlier, the better.

Stephanie Chisolm:
Sure. Okay. Well, one of the things you talked a lot about was this issue of rehabilitation, almost getting yourself ready for the very significant procedures that are involved in a radical cystectomy. The question came in asking, are there guidelines for pre-habilitation that are available?

Dr. Ghodoussipour:
No, there are not guidelines. So the American Society of Clinical Oncology does recommend preoperative exercise before surgery, but the specific details of that exercise are not clear. So it could be small things like hand strength exercises, just push/pull exercises that you can do at home, versus going on a 20-minute walk every day before surgery, versus getting your heart rate up to a certain level. There aren't specific guideline recommendations because I think it's such a new and emerging topic, but there

are ongoing clinical trials. I think Sarah Psutka from the University of Washington has a really exciting trial coming up that is tailored to specific patients based off of their heart rate monitors. I forget the name of it, you may remember that. It's the Get Up and Move trial?

Stephanie Chisolm:
Yes.

Dr. Ghodoussipour:
But I think once all this data comes out, then maybe we'll have guidelines on specifically what there should be. But until then, at this point, I think it's just important to stay active before surgery, and try to implement as we all should be doing every day, I'll admit that I don't do it myself. We should have some amount of exercise and every day, or at least the majority of days of the week. And if you think about it, surgery is a physical battle that you're going through almost like a marathon. So the fitter you are going into it, the better you'll do, and exercise before can get you to that point.

Stephanie Chisolm:
Absolutely. And I am very proud to say that BCAN supported Dr. Sarah Psutka research. We gave her a $1.5 million grant to do the Get Up and Move protocol, and really do a clinical trial looking at whether patients can really build their stamina and do all of these other things. And so there is information about that on our website, including some webinars by Dr. Psutka. So again, visit bcan.org and look at all of our previously recorded videos. Dr. Psutka is a favorite for BCAN. She's done a lot of amazing work on the issue of pre-habilitation. So that and many other topics, including Dr. Bernie Bochner did a wonderful program, both as a webinar and a podcast, looking at some of the quality of life measures that they took after doing radical cystectomies in a number of patients.
So there's a lot of good resources available, and I think it's something that you'll all agree with me on that when you've got a surgeon like Dr. Ghodoussipour, who's also a talented researcher who's documenting all of these things, the future is really bright and a comprehensive overview of ERAS was incredibly helpful. I know that it's inspired, I hope, many of you to talk to your doctors about that. I'd like to just end with one more question. First of all, I'd like to thank you, because I think this is a wonderful program. But the last question I'm going to ask is, what would be the single most important message you want our listeners to leave with today?

Dr. Ghodoussipour:
I think the single most important message is probably to look at the whole picture of what I presented today. Almost a century's worth of work. We're really in a much better place than we used to be in the management of patients with bladder cancer, but there's a lot of physicians, not just like me, but better than me, who are doing this work, and I think that we're going to be in a really great place. But the most important voice that we need to hear more from, and incorporate more into these studies in this research, is you the patients. So I look forward to face-to-face meetings in the future at the summit through our work, and to see how we can really move the needle even further.

Stephanie Chisolm:

Well, again, this has been a phenomenal program. That's all we have time for today. I want to just again, thank our sponsors, Merck and UroGen for making this webinar possible. Thank you so much, Dr. Ghodoussipour, and thank you to all of the listeners for joining us.

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