

Bladder Cancer, Version 1.2026

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Abstract

The NCCN Guidelines for Bladder Cancer provide strategies for the diagnosis, treatment, and follow-up of patients with bladder cancer, which is the sixth most common cancer in the United States. Bladder cancer can be divided into 3 categories along a clinical spectrum: (1) non-muscle-invasive bladder cancer; (2) muscle-invasive bladder cancer; and (3) metastatic bladder cancer, with most patients falling into the category of non-muscle-invasive disease. Thus, the selected content featured in this issue specifically covers the clinical presentation and workup of and subsequent management recommendations for non-muscle-invasive bladder cancer.

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Overview

An estimated 84,530 new cases of urinary bladder cancer (64,730 in males and 19,800 in females) will be diagnosed in the United States in 2026, with approximately 17,870 deaths (12,640 males and 5,230 females) occurring during this period.¹ Bladder cancer, the sixth most common cancer in the United States, is rarely diagnosed in individuals aged <40 years. Given the median age at diagnosis of 73 years² and the associated risk factors, comorbid medical conditions are a frequent consideration in comprehensive care of patients with bladder cancer.

Risk factors for developing bladder cancer include smoking, personal or family history of bladder cancer, pelvic radiation, environmental/occupational exposures, exposure to certain medications, chronic infection or irritation of the urinary tract, male sex, white race, and certain medical conditions including obesity and diabetes.^{3–6} Certain genetic syndromes, most notably Lynch syndrome, may also predispose an individual to urothelial carcinoma.⁷

The clinical spectrum of bladder cancer can be divided into 3 categories that differ in prognosis, management, and therapeutic aims. The first category is non-muscle-invasive bladder cancer (NMIBC), for which treatment is directed at

reducing recurrences and preventing progression to a more advanced stage while minimizing adverse events (AEs) related to treatment. The second group encompasses muscle invasive, nonmetastatic disease. Unlike NMIBC, muscle invasive disease poses a much greater risk for progression and requires more definitive therapy, with patients often benefiting from a multidisciplinary approach including a combination of systemic therapy, surgery, and/or radiation. The current critical concern for the third group, consisting of metastatic lesions, is how to prolong survival and maintain quality of life. Numerous agents with different mechanisms of action have antitumor effects on this disease. The goal is to use these agents to increase survival and quality of life.

Clinical Presentation and Workup

The most common presenting symptom in patients with bladder cancer is microscopic or gross hematuria, although urinary frequency or urgency due to irritation or reduced bladder capacity can also be observed at presentation. Less commonly, the presenting symptom is a urinary tract infection. Upper tract obstruction or pain may occur in patients with a more advanced

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To view disclosures of external relationships for the NCCN Guidelines panel, go to <https://www.nccn.org/guidelines/guidelines-panels-and-disclosure/disclosure-panels>

The full NCCN Guidelines for Bladder Cancer are not printed in this issue of JNCCN. The complete and most recent version of these guidelines is available free of charge at NCCN.org.

NCCN CATEGORIES OF EVIDENCE AND CONSENSUS

Category 1: Based upon high-level evidence (≥1 randomized phase 3 trials or high-quality, robust meta-analyses), there is uniform NCCN consensus (≥85% support of the Panel) that the intervention is appropriate.

Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus (≥85% support of the Panel) that the intervention is appropriate.

Category 2B: Based upon lower-level evidence, there is NCCN consensus (≥50%, but <85% support of the Panel) that the intervention is appropriate.

Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise indicated.

NCCN recognizes the importance of clinical trials and encourages participation when applicable and available. Trials should be designed to maximize inclusiveness and broad representative enrollment.

PLEASE NOTE

The NCCN Guidelines® are a statement of evidence and consensus of the authors regarding their views of currently accepted approaches to treatment. Any clinician seeking to apply or consult the NCCN Guidelines® is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient's care or treatment. The National Comprehensive Cancer Network® (NCCN®) makes no representations or warranties of any kind regarding their content, use, or application and disclaims any responsibility for their application or use in any way.

NCCN CATEGORIES OF PREFERENCE

Preferred intervention: Interventions that are based on superior efficacy, safety, and evidence; and, when appropriate, affordability.

Other: Other interventions that may be somewhat less efficacious, more toxic, or based on less mature data; or significantly less affordable for similar outcomes.

Useful in certain: Other interventions that may be used for selected patient populations (defined with recommendation).

All recommendations are considered appropriate.

lesion. Patients presenting with these symptoms should be evaluated with office cystoscopy to determine if a lesion is present. Enhanced cystoscopy may be used if available. If a lesion is identified, the patient should be scheduled for a transurethral resection of the bladder tumor (TURBT) to confirm the diagnosis and determine the extent of disease within the bladder. Urine cytology may also be obtained around the time of cystoscopy. Because smoking is a major risk factor for bladder cancer,⁸ screening for smoking and initiation of treatment for smoking cessation, if appropriate, is recommended during the

initial evaluation (Figure 1); see also NCCN Guidelines for Smoking Cessation; available at NCCN.org).

Evidence has suggested that bladder cancer has a substantial hereditary component, including a high prevalence of urothelial carcinoma in patients with Lynch syndrome.^{7,9} Therefore, it is recommended to take a thorough family history for all patients with bladder cancer and consider germline multigene panel testing and referral to a genetic counselor for those who are at higher risk of Lynch syndrome based on younger age at presentation and/or a personal or family history of Lynch

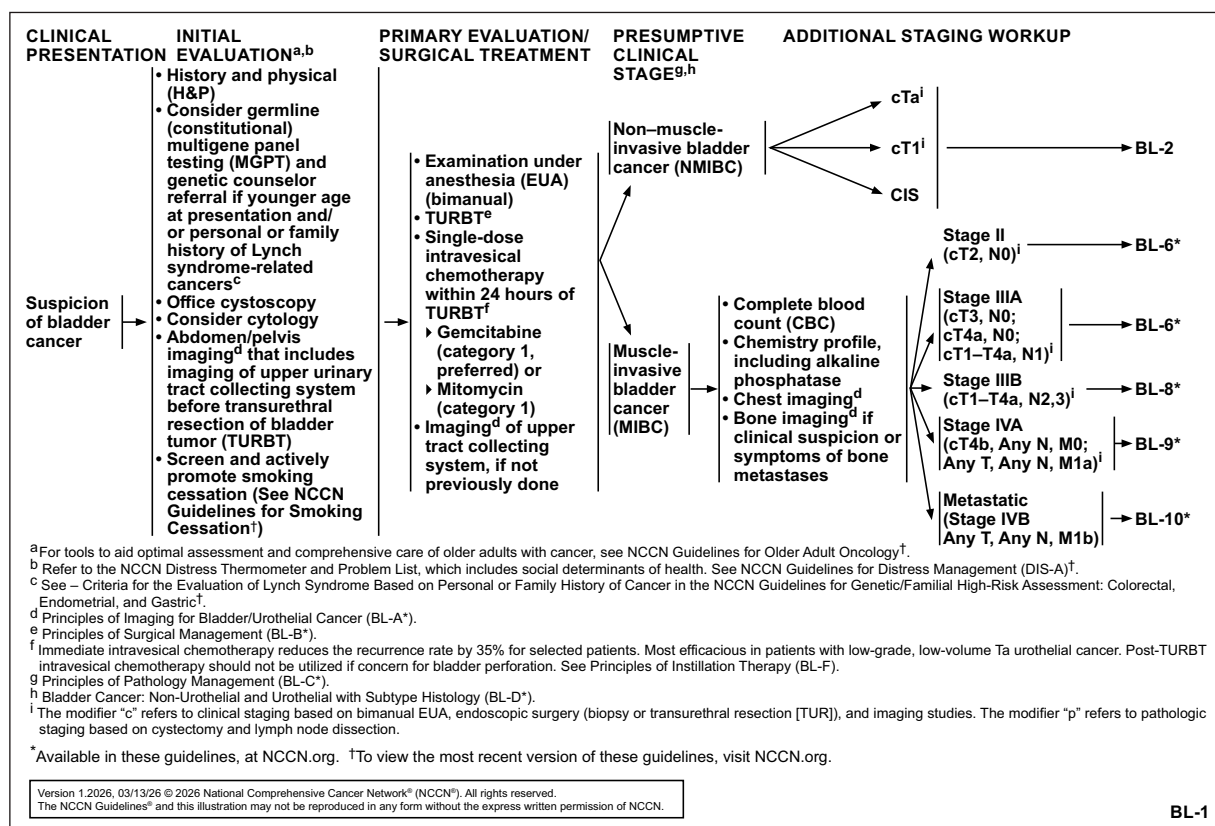


Figure 1. BL-1. NCCN Clinical Practice Guidelines in Oncology for Bladder Cancer, Version 1.2026.