FOLLOW-UP

No single follow-up plan is appropriate for all patients. The follow-up tables are to provide guidance, and should be modified for the individual patient based on sites of disease, biology of disease, and length of time on treatment. Reassessment of disease activity should be performed in patients with new or worsening signs or symptoms of disease, regardless of the time interval from previous studies. Further study is required to define optimal follow-up duration.

Table 1: AUA Risk Stratification for Non-Muscle Invasive Bladder Cancer*

Low Risk	Intermediate Risk	High Risk
• Low grade (LG) solitary Ta ≤3 cm • Papillary urothelial neoplasm of low malignant potential	• Recurrence within 1 year, LG Ta • Solitary LG Ta >3 cm • LG Ta, multifocal • High grade (HG) Ta, ≤3 cm • LG T1	• HG T1 • Any recurrent, HG Ta • HG Ta, >3 cm (or multifocal) • Any carcinoma in situ (CIS) • Any BCG failure in HG patient • Any variant histology • Any lymphovascular invasion • Any HG prostatic urethral involvement

*Reproduced with permission from Chang SS, Boorjian SA, Chou R, et al. Diagnosis and treatment of non-muscle invasive bladder cancer: AUA/SUO guideline. J Urol 2016;196:1021.

Table 2: Low-Risk,[1] Non-Muscle-Invasive Bladder Cancer

Test	Year						
	1	2	3	4	5	5–10	>10
Cystoscopy	3, 12	Annually				As clinically indicated	
Upper tract[2] and abdominal/ pelvic[3] imaging[4]	Baseline imaging	As clinically indicated					
Blood tests	N/A						
Urine tests	N/A						

[1] See Table 1: AUA Risk Stratification for Non-Muscle Invasive Bladder Cancer definitions on BL-E (1 of 5) above.
[2] Upper tract imaging includes CTU, MRU, intravenous pyelogram (IVP), retrograde pyelography, or ureteroscopy.
[3] Abdominal/pelvic imaging includes CT or MRI.
[4] See Principles of Imaging for Bladder/Urothelial Cancer (BL-A).
[5] Urine cytology should be done at time of cytoscopy if bladder in situ.

FOLLOW-UP

No single follow-up plan is appropriate for all patients. The follow-up tables are to provide guidance, and should be modified for the individual patient based on sites of disease, biology of disease, and length of time on treatment. Reassessment of disease activity should be performed in patients with new or worsening signs or symptoms of disease, regardless of the time interval from previous studies. Further study is required to define optimal follow-up duration.

Table 3: Intermediate Risk,[1] Non-Muscle-Invasive Bladder Cancer

Test	Year						
	1	2	3	4	5	5–10	>10
Cystoscopy	3, 6, 12	Every 6 mo	Annually			As clinically indicated	
Upper tract[2] and abdominal/ pelvic[3] imaging[4]	Baseline imaging	As clinically indicated					
Blood tests	N/A						
Urine tests	Urine cytology[5] 3, 6, 12	Urine cytology every 6 mo	Annually			As clinically indicated	

Table 4: High-Risk,[1] Non-Muscle-Invasive Bladder Cancer

Test	Year						
	1	2	3	4	5	5–10	>10
Cystoscopy	Every 3 mo		Every 6 mo			Annually	As clinically indicated
Upper tract[2] imaging[4]	Baseline imaging, and at 12 mo	Every 1–2 y					As clinically indicated
Abdominal/ pelvic[3] imaging[4]	Baseline imaging	As clinically indicated					
Blood tests	N/A						
Urine tests	• Urine cytology[5] every 3 mo • Consider urinary urothelial tumor markers (category 2B)		Urine cytology every 6 mo			Annually	As clinically indicated

[1] See Table 1: AUA Risk Stratification for Non-Muscle Invasive Bladder Cancer definitions on BL-E (1 of 5).
[2] Upper tract imaging includes CTU, MRU, intravenous pyelogram (IVP), retrograde pyelography, or ureteroscopy.
[3] Abdominal/pelvic imaging includes CT, MRI, or FDG PET/CT (category 2B) (PET/CT not recommended for NMIBC).
[4] See Principles of Imaging for Bladder/Urothelial Cancer (BL-A).
[5] Urine cytology should be done at time of cystoscopy if bladder in situ.