

# Incidence of Muscle Invasive Bladder Cancer in Men and its Classification

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## Commentary

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## DESCRIPTION

With an expected 76,960 new cases and 16,390 cancer-related deaths in 2016, bladder cancer is the sixth most frequent cancer in the United States. The incidence is higher in men and rises with advancing age, reaching its peak in the 1960s and 1970s. Around 90% of bladder cancers are Transitional Cell Carcinomas, which are urothelial in origin (TCC). According to the Tumour, Nodes, and Metastases (TNM) staging system, bladder TCC is frequently staged. While bladder TCC is primarily separated into Nonmuscle-Invasive Bladder Cancer (NMIBC) and Muscle-Invasive Bladder Cancer (MIBC), which account for roughly 80%-85% and 20%-25%, respectively, T stage is classed according to the degree of invasion of the bladder wall.

In patients with bladder cancer, determining the appropriate TNM staging category is crucial since it has a direct impact on therapy planning, treatment success prediction, and prognosis. For instance, MIBC will need a cystectomy or even adjuvant therapy, whereas NMIBC may only need Transurethral Resection (TUR). Preoperative clinical staging determined by a clinical examination, a cystoscopic biopsy, and imaging frequently differs with final pathologic staging.

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Preoperative imaging currently relies primarily on traditional anatomical imaging techniques like Computed Tomography (CT) and magnetic resonance imaging (MRI). They have largely taken the place of the older intravenous pyelography in this therapeutic environment. Regarding their capacity to recognise metastatic lymph nodes, precisely stage local invasion, and detect tiny tumours, there is still some cause for concern. Recent developments in MRI technology have shown encouraging results, and mounting evidence supports its use in the diagnosis of bladder cancer.

Transitional Cell Carcinoma (TCC) (90%), Squamous Cell Carcinoma (7%), and Adenocarcinoma (2%), are the three main histologic forms of bladder cancer. According to the TNM (Tumor, Nodes, and Metastases) classification, there are different prognosis phases for bladder cancer. The extent of local invasion determines the T stage, the size and number of swollen lymph nodes determines the N stage, and the presence or absence of metastases to distant sites determines the M stage.

Below is a definition of each stage; *In situ* carcinoma (CIS). Ta: Papillary tumour without invasion. T1: Invades connective tissue beneath the epithelium. T2a: Muscle surface invasion by tumour (inner half). T2b: Deep muscle invasion by tumour (outer half). T3a: The tumour microscopically invades the surrounding tissue. T3b: Tumor macroscopically infiltrates perivascular tissue (extravesical mass). T4a: Tumor that invades the vagina, uterus, or prostate. T4b: Tumor invades the abdominal or pelvic walls. NO: No lymph nodes are enlarging. N1: A 2 cm single node. N2: One node that is >2 but 5 cm, or many nodes that are all 5 cm. N3: Any node more than 5 cm. MO: No. Stage 0a: TaNOM0. M1. TisNOM0 is Stage 0. T1NOM0 is Stage 1. T2aNOM0 or T2bNOM0, stage 2. The third stage is T3aNOM0, T3bNOM0, or T4aNOM0. Stage IV: TanyN1-3M0 or TanyNanyM1 or T4bNOM0.

A history and physical examination, blood tests, and a careful evaluation of the extent of the local tumour should all be part of the staging inquiry. The latter may also involve a pelvic CT scan or a cystoscopy with anaesthesia. Random epithelial biopsies should be taken to rule out the presence of CIS. By doing an Intravenous Pyelogram (IVP) or expanding the CT to cover the abdomen, the upper urinary system should be evaluated. A chest x-ray should be performed if muscle-invasive illness is evident to rule out pulmonary metastases. If clinically necessary, imaging of the liver or a bone scan should be done to rule out metastases.