Consensus document: recommendations for optimal surgical wait times for patients with urological malignancies

On behalf of the Canadian Surgical Wait Times (SWAT) Initiative

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Background

Wait times for medical procedures in Canada continue to be a major issue in the delivery of timely health care. Patients scheduled to undergo surgery for urological malignancies, which include prostate, bladder, kidney and testes cancer, are among the many affected populations. To address these important issues, a Surgical Wait Time (SWAT) initiative was undertaken. The SWAT initiative, whose members consist of urological oncologists, surgeons and

Participants:

Address correspondence to Dr. Neil Fleshner, Department of Surgical Oncology, University Health Network, 610 University Avenue, Toronto, Ontario M5G 2M9 Canada Surgical Wait Time (SWAT) initiative was undertaken. The SWAT initiative, whose members consist of urological oncologists, surgeons and methodologists was mandated to assess current wait times in Canada, review the relevant literature on the surgical wait times for urological cancers and then develop a consensus document that can serve as a guide for patients, physicians and other key stakeholders in the Canadian health care system.

Key Words: urological cancer, surgery, wait time, guidelines, recommendations

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There is strong evidence to suggest that prolonged surgical wait times have a major impact on patient anxiety and overall quality of life.^{1,2} In addition, there are now reports that extending the wait time beyond a given threshold can have a negative impact on patient clinical outcomes.³⁻⁶ In this short consensus document, the recommendations by SWAT for optimal wait times in patients scheduled to undergo surgeries for prostate, bladder, kidney and testicular cancer are described in Tables 1-4. There are several wait time definitions such as the time from general practitioner referral to surgery, surgeon consultation date to hospital admission, referral to surgery, diagnosis to surgery, and diagnosis to hospital admission. For the purpose of this document, wait time was defined as the time period from decision to operate until the day of cancer surgery.

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Patient subtypes ¹	Recommended maximum wait time
Category 1: High risk • PSA > 20 ng/ml or Gleason score > 7 or $\ge T2$	≤ 28 days from decision to operate
Category 2: Intermediate risk •PSA between 10 ng/ml to 20 ng/ml	≤ 60 days from decision to operate
Category 3: Low risk • PSA < 10 ng/ml, Gleason < 7 and T1-T2a ¹ Accurate and timely tumor staging will also impact time to	< 90 days from decision to operate surgery

TABLE 1. Recommendations for optimal wait times in prostate cancer surgeries

TABLE 2.	Recommendations	for optimal	wait times in	testicular cance	er surgeries ¹
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Patient subtypes ¹	Recommended maximum wait time
Category 1: Orchiectomy	< 7 days from decision to operate
Category 1: RPLND stage 2	< 14 days from decision to operate
Category 2: RPLND stage 1	< 28 days from decision to operate
Category 2: RPLND – post chemotherapy	< 28 days from decision to operate
RPLND = Retroperitoneal lymph node dissection	

¹Spermatogenesis of the contralateral testis is sufficient for successful semen cryopreservation after orchidectomy. Urologists should be encouraged to increase the awareness among oncology teams and patients about the new developments in preserving fertility for patients with cancer.

TABLE 3. Recommendations for optimal wait times in bladder cancer surgeries

Patient subtypes	Recommended maximum wait time
Decision for TURBT to surgery	
Category 1 (aggressive/high risk tumors)	≤ 14 days from decision to operate
•Size, multifocal, early failure, CIS etc., any T1 or G3 tumor	
•Repeat TUR after T1G3 (re-staging)	
•Suspected invasive cancer	
•Symptomatic tumor	
Category 2 (possibility/suspected invasive)	\leq 42 days from decision to operate
•Low risk tumors	, I
•Superficial papillary tumor	
Decision for cystectomy to surgery ¹	
Category 1 (aggressive/high risk tumors)	\leq 14 days from decision to operate
•Invasive cancer (T2 and above)	
 Intractable symptoms with any stage disease 	
•Severe ongoing pain, bleeding or strangury	
•Salvage post-radiotherapy	
Category 2 (possibility/suspected invasive)	\leq 28 days from decision to operate
•Cystectomy for superficial TCC	у I
•T1G3	
 Uncontrollable superficial disease 	
• Persistent symptoms after treatment for superficial disease	
TURBT = Transurethral resection of the bladder tumor	
¹ In patients undergoing neoadjuvant chemotherapy, time after recovery fro	m last cycle.

Patient subtypes by stage	Recommended maximum wait time
Category 1	
Symptomatic	< 28 days from decision to operate
•T1a N0 M0	
•T1b N0 M0	
•T2 N0M0	
•T3a N0 M0	
•≥ T3b N0 M0	
•Any N+	
Any T $N+M+$ (highly selected group of patien	ts being considered for surgery)
Category 2	0 0 7
T1b, T2 or T3a, N0 M0	< 28 days from decision to operate
 Incidental detection (asymptomatic) 	
Category 3	
T1a N0 M0	< 90 days from decision to operate
 Incidental detection (asymptomatic) 	· ·

TABLE 4. Recommendations for optimal wait times in renal cancer surgeries¹

¹Recommendations on renal cancer recognize that the majority of renal masses are sporadic renal cell carcinomas (RCC). Included in this recommendation are complex cysts presumed to be cystic RCC. Treatment of hereditary renal cancers should be individualized. Treatment of renal masses includes nephrectomy, partial nephrectomy and non-ionizing physical therapies (RFA, cryotherapy etc.).

Discussion

The current document presents recommendations from the SWAT initiative on optimal surgical wait times for prostate, bladder, kidney and testicular cancer. The objective of this document is to provide recommendations based on a review of the medical literature and expert opinion that will facilitate health policy decision making for wait time benchmarks. However, it is important to point out that overall quality of care, during the surgical procedure and post-operatively also needs to be taken into consideration during the health care discussion. There is a growing body of evidence in the urological surgery literature that the hospital and an individual surgeon's volume have a direct impact on patient outcomes such as post operative complications, overall hospital length of stay and even mortality.⁷⁻¹⁰ A failure to consider overall quality of care when establishing wait time benchmarks may compromise care because patients may be shifted from high to low volume centres, which may not be able to offer the same level of attention, in order to reduce wait times. Through a partnership and collaborative discussion between the key stakeholders, it is the vision of SWAT to ultimately improve the care and quality of life of Canadian cancer patients. It is our hope that this document will contribute to the overall process.

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