

Guideline Amendment Summary

DIAGNOSIS AND TREATMENT OF NON-MUSCLE INVASIVE BLADDER CANCER: AUA/SUO GUIDELINE

Published 2016; Amended 2020, 2024, 2026

The changes below constitute updates made in the 2026 Amendment:

Section	Document Update
Introduction	Section has been restructured to align with current AUA Guideline format Note: table numbering has changed throughout
Methodology	Updated to include 2026 amendment process
Background	Updated the following sections: “Epidemiology” “Presentation and Diagnosis” “Risk Stratification”
Table 3 (previously Table 5)	Intermediate- and high-risk categories have been modified
Peer Review and Document Approval	Updated to include 2026 peer review information

Section	Document Update
General Terminology Modifications	“Variant histology” has been modified to “subtype histology” throughout “BCG-failure” has been modified to “BCG-unresponsive” throughout
Statement #4	- Statement updated to: “In patients with a history of NMIBC who have normal cystoscopy and positive cytology for high-grade urothelial carcinoma, clinicians should perform upper urinary tract evaluation, random bladder biopsies, and prostatic urethral biopsies. Enhanced cystoscopy techniques like blue light cystoscopy (BLC) should be used when available. (<i>Expert Opinion</i>)” - Supporting text updated
Statement #5	- Statement remains unchanged - Minor supporting text update to remove “poor response to BCG”
Statement #6	- Statement updated to: “An experienced genitourinary pathologist should review the pathology of a patient with any doubt in regards to subtype or suspected subtype histology (e.g., micropapillary, plasmacytoid, small cell/neuroendocrine, sarcomatoid) and/or extensive divergent differentiation (e.g., squamous or glandular), and/or the presence/absence of LVI. (<i>Moderate Recommendation; Evidence Level: Grade C</i>)” - Supporting text updated
Statement #7	- Statement remains unchanged - Supporting text updated
Statement #8	- Statement updated to: “Due to the high rate of upstaging associated with subtype histology, clinicians should discuss the option of early radical cystectomy with the patient. (<i>Expert Opinion</i>)” - Supporting text updated

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Statement #9	• Statement remains unchanged • Supporting text updated
Statement #11	• Statement updated to: “In patients with NMIBC, clinicians may use biomarkers to assess and predict response to intravesical therapy and adjudicate equivocal cytology. (<i>Expert Opinion</i>)” • Supporting text updated
Statement #13	• New statement: “In patients with recurrent low-grade NMIBC, clinicians may perform a transurethral resection/fulguration, use an intravesical chemoablative agent, or manage with active surveillance. (<i>Conditional Recommendation; Evidence Level: Grade C</i>)” • New supporting text
Statement #14	• Statement has been updated (previously Statement #13): “In patients with high-grade Ta tumors, clinicians may perform repeat TUR of the primary tumor site within six weeks of the initial TURBT. (<i>Conditional Recommendation; Evidence Level: Grade C</i>)”
Statement #15	• New statement: “In patients with high-risk NMIBC in the prostatic urethra who decline radical cystectomy and elect for intravesical therapy, clinicians should perform a repeat TUR of the prostatic urethra to improve staging accuracy and optimize the efficacy of subsequent intravesical therapy. (<i>Expert Opinion</i>)” • New supporting text
Statement #16	• Statement remains unchanged (previously Statement #14) • Supporting text updated
Statement #17	• Statement has been updated (previously Statement #15): “In patients with suspected or known low- or intermediate-risk bladder cancer, clinicians should administer a single postoperative

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	instillation of intravesical chemotherapy (e.g., gemcitabine, mitomycin C) within 24 hours of TURBT. In patients with suspected perforation or extensive resection, clinicians should not use immediate postoperative intravesical chemotherapy. (<i>Moderate Recommendation; Evidence Level: Grade B</i>)”
Statement #19	- Statement has been updated (previously Statement #17): “In intermediate-risk patients, clinicians may administer a six-week course of induction intravesical therapy. (<i>Conditional Recommendation; Evidence Level: Grade B</i>)” - Supporting text updated
Statement #20	- Statement has been updated (previously Statement #18): “In newly diagnosed high-risk patients, clinicians should administer a six-week induction course of BCG. (<i>Strong Recommendation; Evidence Level: Grade B</i>)” - Supporting text updated
Statement #21	- Statement remains unchanged (previously Statement #19) - Supporting text updated
Statement #22	Statement has been updated (previously Statement #20): “In intermediate-risk patients who completely respond to induction BCG, clinicians may offer maintenance BCG for 12 months, as tolerated. (<i>Conditional Recommendation; Evidence Level: Grade C</i>)”
Statement #23	Supporting text updated (previously Statement #21)
Statement #24	Statement has a minor update to change “should consider performing” to “may perform” (previously Statement #22)

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	Supporting text updated: parts of the text have been relocated to Statement #4
Statement #25	Statement has been updated (previously Statement #23): removed intermediate-risk from the recommendation
Statement #26	- Statement grading has been updated from Grade C to Grade B (previously Statement #24) - Supporting text updated
Statement #27	- Statement remains unchanged (previously Statement #25) - Supporting text updated
Statement #28	- Statement remains unchanged but was relocated (previously Statement #29) - Supporting text updated
Statement #29	- Statement has been updated to (previously Statement #26): “In patients with persistent or recurrent high-grade NMIBC within 12 months of completion of adequate BCG therapy (adequate defined as two induction courses or one induction course plus two treatments of a maintenance cycle) who are unwilling or unfit for cystectomy, clinicians should recommend an alternative intravesical immunotherapy or alternative intravesical chemotherapy, systemic immunotherapy, or clinical trial enrollment. (<i>Moderate Recommendation; Evidence Level: Grade C</i>)” - Supporting text updated
Statement #30	- Statement remains unchanged (previously Statement #27) - Added “intravesical chemoablation” to the supporting text

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Statement #31	- Statement has been updated (previously Statement #28) to modify “should consider offering” to “should offer” - Supporting text updated
Statement #33	Statement has been updated (previously Statement #31) to modify “may consider” to “may use”
Statement #37	- Statement has been updated to (previously Statement #35): “In patients with a history of low-grade Ta disease who experience a small papillary recurrence, clinicians may offer surveillance and/or in-office fulguration or chemoablation as an alternative to TUR under anesthesia. (<i>Expert Opinion</i>)” - Supporting text updated
Statement #40	Statement has been updated (previously Statement #38) to modify “should consider performing” to “should perform”
Future Directions	Text has been updated
References	The reference list was updated to reflect document additions and deletions
Algorithms	Algorithms have been split into 1) low- and intermediate-risk 2) high-risk. Both algorithms have been updated

Note: Additional editorial changes were made throughout the Guideline to align with current AUA Guideline criteria and for consistency purposes. These additional changes were not substantial and were not content-related.