EAU and IBCG guidelines overview: classification and management of patients with NMIBC

NMIBC risk stratification[a,1,2]

	EAU	IBCG consensus[2]
LR	• A primary, single, TaT1 LG/G1 tumour without CIS with 0 risk factors • A primary Ta LG/G1 tumour without CIS with ≤ 1 risk factor	• A solitary primary tumour, Ta LG/G1
IR	• Patients without CIS who are not included in the LR, HR, or VHR groups	• pTa LG/G1: newly diagnosed, multifocal or ≥ 3 cm, or recurrent[b] • Any pTa G2[b] • Any pT1 LG/G1-2[b]
HR	• CIS (except in VHR) • Without CIS – Ta LG/G2 or T1G1, with 3 risk factors – Ta HG/G3 or T1 LG, with 2 or 3 factors – T1 G2 with ≥ 1 risk factor – T1 HG/G3 (except in VHR)	• All HG tumours • All CIS • Variant histology
VHR	• LVI, subtypes of UC, prostatic urethra CIS • T1 HG/G3 without CIS with 3 risk factors • With CIS – Ta HG/G3 with 3 risk factors – T1 G2 with 2 or 3 risk factors – T1 HG/G3 with ≥ 1 risk factor	N/A
	Risk factors • Age > 70 years • Multiple papillary tumours • Tumour diameter > 3 cm	Multifocality • Recurrence – Early (< 1 per yr) – Frequent (> 1 per yr) • Size (≥ 3 cm) • Prior intravesical treatment failure

[a] In EAU guidelines, patients with recurrent tumours should be included in the intermediate-, high-, or very high-risk groups according to their other prognostic factors.

[b] IBCG recommends the exclusion of pT1 LG/G1-2 tumours from clinical trials or IR-NMIBC patients due to the high possibility of misclassification and variation among pathologists.

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Treatment guidelines

EAU recommendations based on risk stratification[1]

LR	IR	HR	VHR	
TURBT followed by immediate single intravesical CTx instillation	• First-line intravesical CTx in 1 yr • Alternative: Intravesical BCG 1 yr full dose	Offer intravesical BCG 1–3 yrs, but discuss immediate RC	RC or intravesical BCG 1–3 yrs, especially if decline or unfit for RC	**Second TURBT** in 2–6 weeks if: • Incomplete resection • No detrusor muscle in the specimen (except Ta LG/G1 tumours) • T1 tumour

IBCG consensus IR stratified by risk factors[2]

Risk factors
- Multifocality
- Recurrence
  - Early (< 1 per yr)
  - Frequent (> 1 per yr)
- Size (≥ 3 cm)
- Prior intravesical treatment failure

0 risk factors
- TURBT + single post-operative CTx instillation
- Consider office fulguration and follow-up

1 or 2 risk factors
- TURBT+ single post-operative CTx instillation
- Induction IVCT
- BCG with maintenance up to 1 yr if recurring after CTx

3 or more risk factors
- TURBT
- BCG induction with maintenance up to 1 yr or IVCT with maintenance
- Consider combination CTx or chemohyperthermia if recurrence after BCG, or CTx if BCG unavailable

Follow-up schedule based on risk category[1]

	LR	IR[a]	HR and VHR
Cytology[a]	No	No	Yes[b]
Cystoscopy	At 3 and 12 mos Then annually	At 3 mos, then every 6 mos for 2 yrs Then annually	Every 3 mos for 2 yrs, then every 6 mos up to 5 yrs Then annually
Imaging	Not systematic	Not systematic	CT annually up to 5 yrs, then CT every 2 yrs up to 10 yrs
FU duration	5 yrs	10 yrs	Lifelong

[a] IR HG/G3 subgroup should be followed up as HR.
[b] At the same intervals as cystoscopy.

EAU categories of HG recurrence during and after BCG, and treatment options for various BCG failures[1,3]

BCG-unresponsive

BCG-refractory

• T1 HG/G3 at 3 mos	T1/Ta HG recurrence within 6 mos of completion of adequate BCG exposure[b]
• Ta HG/G3 after 3 mos and/or at 6 mos after re-induction or first-course maintenance	
• CIS only, at 3 mos and persists at 6 mos after re-induction or first-course maintenance (without concomitant papillary tumour)	CIS within 12 mos of completion of adequate BCG exposure
• HG tumour appearance during BCG maintenance[a]	

Treatment options

● RC ● Clinical trial enrolment ● Other BST in patients ineligible for or refusing RC

[a] Patients with LG recurrence during or after BCG treatment are not considered to be BCG failures.
[b] Adequate BCG exposure is defined as the completion of ≥ 5 of 6 doses of an initial induction course plus ≥ 2 of 6 doses of a second induction course of 2 out of 3 doses of maintenance therapy.[1]

BCG-relapsing

- HG/G3 recurrence after BCG maintenance completion despite initial response

→ **Late relapsing** TaT1/HG recurrence
> 6 mos or CIS
> 12 mos since last BCG

Treatment options
- RC or repeat BCG
- BST
- Clinical trial enrolment

LG recurrence after BCG for primary IR tumour

Treatment options
- Repeat BCG or IVCT
- Clinical trial enrolment

BCG-exposed

- BCG-resistant: Ta HG/G3 or CIS at 3 mos after full induction
- Delayed relapse after adequate or inadequate BCG[a]

Treatment options
- Repeat BCG or RC
- Clinical trial enrolment

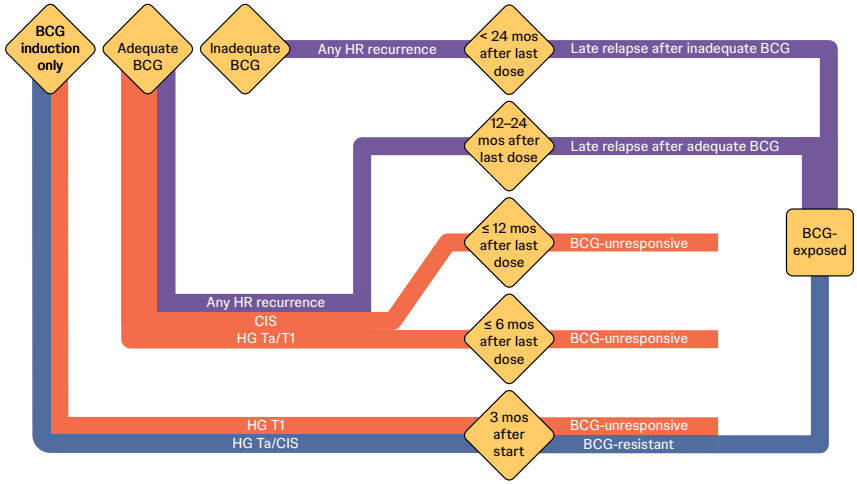
BCG-intolerant

- Severe side effects that prevent further instillations before treatment completion

[a] Ta/T1 HG or CIS patients found disease free at the 3 mo evaluation that recur in between 6 and 24 mos without receiving more than an induction course.

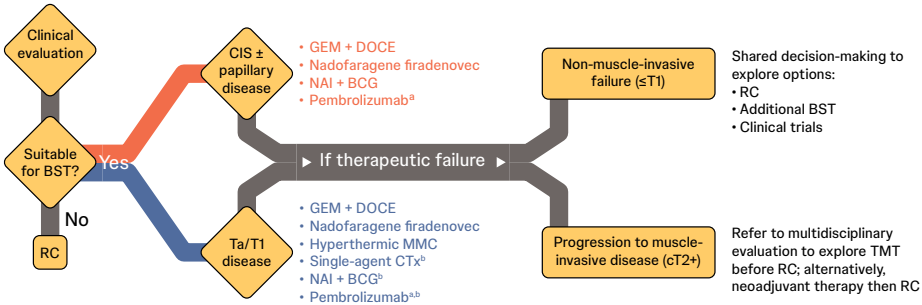
Summary of disease states related to prior BCG treatment[4]

NMIBC recurrence after BCG treatment[a]



[a]Patients with HR recurrence > 24 mos after last dose of BCG are generally treated in the same way as BCG naïve patients.

IBCG recommendation for BST in BCG-U patients who are ineligible for or refuse RC[5]



[a] Only consider in patients who have no safer alternative treatment option.
[b] Not specifically approved for this subgroup but considered based on available data.

Abbreviations: BCG, Bacillus Calmette–Guérin; BCG-U, BCG-unresponsive; BST, bladder-sparing treatment; CIS, carcinoma in situ; cT2+, clinical staging of T2 and beyond; CT, computed tomography; CTx, chemotherapy; DOCE, docetaxel; G, Grade; GEM, gemcitabine; EAU, European Association of Urology; FU, follow-up; HG, high grade; HR, high risk; IBCG, International Bladder Cancer Group; IR, intermediate risk; IVCT, intravesical chemotherapy; LG, low grade; LR, low risk; LVI, lymphovascular invasion; MMC, mitomycin C; mos, months; N/A, not applicable; NAI, nogapendekin alfa inbakicept-pmln; NMIBC, non-muscle invasive bladder cancer; RC, radical cystectomy; Ta, non-invasive papillary carcinoma; T1, tumour invades subepithelial connective tissue; T2, tumour invades muscle; TMT trimodal therapy; TURBT, transurethral resection of bladder tumour; VHR, very high risk; UC, urothelial carcinoma; yr(s), year(s).

References:

1. EAU Guidelines (full version). Edn. presented at the EAU Annual Congress Madrid 2025. ISBN 978-94-92671-29-5.
2. Tan W, et al. Eur Urol Oncol. 2022;5:505-16.
3. EAU Guidelines (pocket version). Edn. presented at the EAU Annual Congress Madrid 2025. ISBN 978-94-92671-29-5.
4. Roumiguie M, et al. Eur Urol. 2022;82:34-46.
5. Li R, et al. Eur Urol. 2024;86:516-27.

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