Bladder Masses and Bladder Cancer

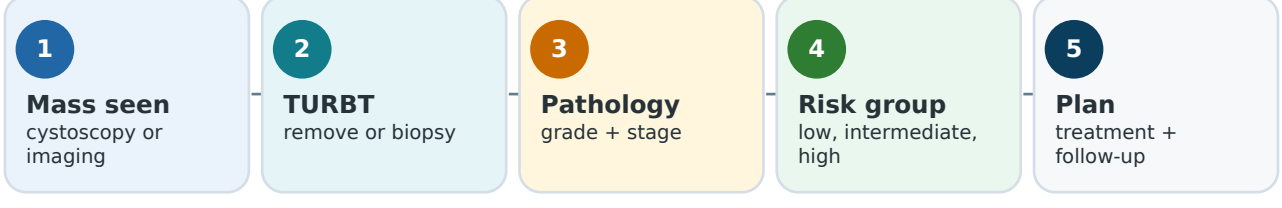
A step-by-step guide

Look
Confirm
Treat

The main idea

Hearing the words bladder mass or possible bladder cancer can be frightening. The good news is that bladder cancer evaluation is usually very stepwise. We do not decide the full treatment plan from a scan or cystoscopy alone. The first key step is usually to remove or biopsy the area and wait for the pathology report.

Many bladder tumors are found before they grow into the bladder muscle. These are called non-muscle-invasive bladder cancers. Many can be treated and followed with procedures through the urinary channel, without abdominal cuts or major surgery.



What is a bladder mass?

A bladder mass is an abnormal area seen inside the bladder. It may be seen during cystoscopy or on imaging such as CT scan or ultrasound. A mass is not fully diagnosed until tissue is removed and reviewed by a pathologist.

Common reasons include visible blood in the urine, microscopic blood in the urine, urinary symptoms that need evaluation, abnormal imaging, or bladder cancer surveillance.

Common ways a bladder mass is found

How it is found	Why the test was done
Cystoscopy	Blood in the urine, bladder symptoms, surveillance, or abnormal urine testing.
CT scan or ultrasound	Blood in the urine, pain, infection workup, kidney swelling, or another reason.
Urine cytology	Looks for abnormal cancer-type cells in the urine.

Step 1: confirm what we are seeing

Your evaluation is designed to answer two questions: Is there a tumor? and is there any sign that it extends beyond the bladder? The exact tests depend on your situation.

Test	Purpose
Office cystoscopy	Looks directly inside the bladder.
Urine cytology	Checks urine for abnormal cancer-type cells.
CT urogram or other imaging	Checks the kidneys, ureters, and bladder. It can also look for blockage or larger areas of disease.
Blood work	Checks kidney function, blood counts, and general readiness for a procedure.
Chest or bone imaging	Used selectively when staging is needed or symptoms suggest it.

NCCN-grounded principle

Initial evaluation for suspected bladder cancer commonly includes history and physical exam, office cystoscopy, consideration of urine cytology, imaging of the abdomen/pelvis and upper urinary tract before TURBT, basic labs, and smoking cessation support when relevant.

Step 2: TURBT - the main first procedure

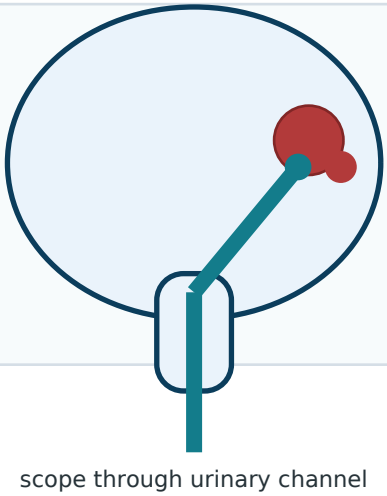
TURBT means transurethral resection of bladder tumor. A scope is passed through the urinary channel into the bladder. The visible tumor is removed or biopsied and sent to pathology. There are no abdominal cuts.

Goal of TURBT	Why it matters
Remove visible tumor	For many early bladder tumors, this is also the first treatment.
Get tissue for pathology	Confirms whether it is cancer and what type it is.
Include deep enough tissue when needed	Helps determine if cancer has reached the bladder muscle.
Control bleeding	Improves recovery and visibility.
Guide the next step	The pathology report determines surveillance, bladder medicine, repeat TURBT, or referral.

What to expect after TURBT

Many patients go home the same day. Some need a temporary catheter. Light bleeding, burning, and urinary frequency can happen. Pathology results usually drive the next visit and the next step.

TURBT is done through a scope



scope through urinary channel

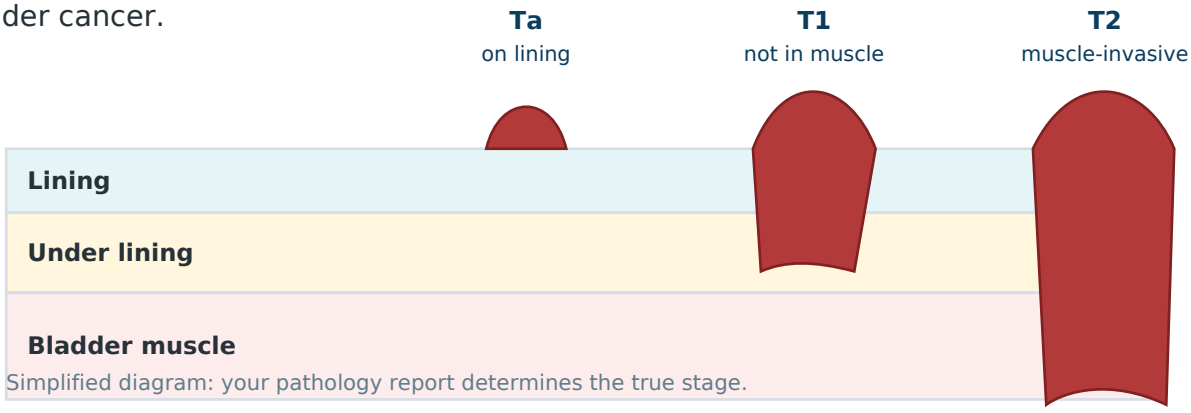
1. See the tumor
The camera looks inside the bladder.

2. Remove or biopsy
Small instruments remove visible tissue.

3. Send to pathology
The report tells grade and stage.

Step 3: understand the pathology report

The pathology report is the turning point. It tells us the type of tumor, how aggressive it looks, and how deep it goes. The most important split is non-muscle-invasive versus muscle-invasive bladder cancer.



Simplified diagram: your pathology report determines the true stage.

Term	Plain-language meaning
Low grade	Cells look less aggressive under the microscope.
High grade	Cells look more aggressive and need closer treatment and follow-up.
Ta	Tumor is on the inner bladder lining.
T1	Tumor has entered the layer under the lining but not the bladder muscle.
CIS	Flat, high-grade cancer cells on the bladder lining.
T2 / muscle-invasive	Cancer has entered the bladder muscle. This usually requires referral and a larger treatment team.
Muscle present	The TURBT sample included bladder muscle, which helps confirm staging.

Why a repeat TURBT may be recommended

Sometimes a second TURBT is needed soon after the first one. This can happen if the first resection was incomplete, if the tumor was high-grade and muscle was not present in the specimen, if the tumor was large or multifocal, or if the stage is T1. A repeat procedure helps confirm the stage and clear remaining tumor.

Step 4: risk group guides treatment

For non-muscle-invasive bladder cancer, treatment is based on risk features. These include tumor grade, stage, size, number of tumors, whether it came back, and how it responded to any prior bladder treatments.

Common treatment paths

Low-risk NMIBC

Often treated with TURBT and surveillance cystoscopy. A one-time bladder chemotherapy treatment after surgery may be considered when safe.

Intermediate-risk NMIBC

Usually treated with TURBT plus close follow-up. Some patients benefit from medicine placed directly into the bladder.

High-risk NMIBC

Requires closer surveillance and often bladder treatment such as BCG or other intravesical therapy. Some cases need tertiary-center support.

Muscle-invasive bladder cancer

A different category. Care usually involves a larger team and may include chemotherapy, immunotherapy, radiation, bladder removal, or bladder-preserving protocols.

What is intravesical therapy?

Intravesical therapy means medicine is placed directly into the bladder through a small catheter. It is not the same as IV chemotherapy. It is used to lower the chance of recurrence or treat cancer cells that remain on the bladder lining.

Treatment type	General purpose
Gemcitabine	Bladder chemotherapy. Sometimes used immediately after TURBT or as a treatment course.
Mitomycin	Bladder chemotherapy used in selected patients.
BCG	Bladder immunotherapy commonly used for higher-risk non-muscle-invasive disease.
Newer bladder options	Used in selected higher-risk, recurrent, or BCG-unresponsive situations.

Important

If bladder medicine is recommended but not available locally, referral is appropriate. Referral does not mean something was missed. It means the next step is best done where that therapy and support team are available.

What can usually start locally?

Often managed locally

- TURBT
- repeat TURBT when needed
- surveillance cystoscopy

Refer when needed

- BCG or advanced bladder instillations
- systemic therapy
- cystectomy / trials

Most non-muscle-invasive bladder cancer can begin with local urology care. This includes office cystoscopy, TURBT, repeat TURBT when needed, coordination of imaging and urine testing, and surveillance cystoscopy.

When do we refer to a tertiary center?

Reason for referral	Examples
Intravesical therapy not offered locally	BCG or advanced bladder instillation options.
BCG-unresponsive high-risk disease	Cancer persists or returns after BCG.
Muscle-invasive bladder cancer	Cancer has reached the bladder muscle.
Need for systemic therapy	Chemotherapy, immunotherapy, antibody-drug therapy, or combination treatment.
Need for cystectomy discussion	Bladder removal and urinary diversion counseling.
Clinical trials or complex pathology	Very-high-risk features, variant histology, or repeated recurrence.

Follow-up is part of treatment

Bladder cancer can recur, especially non-muscle-invasive bladder cancer. Surveillance cystoscopy is therefore routine. Follow-up schedules vary by risk group and are individualized.

Risk group	Typical cystoscopy pattern
Low risk	Often at about 3 and 12 months, then yearly if clear.
Intermediate risk	Often at about 3, 6, and 12 months, then spaced out if clear.
High risk	Often every 3 months early on, with urine cytology and imaging when appropriate.

Symptoms to report urgently

Call or seek care if you have	Why it matters
Cannot urinate	A clot or swelling may be blocking the bladder outlet.
Heavy bleeding with clots	You may need a catheter, irrigation, or urgent evaluation.
Fever or chills	Could be infection.
Severe worsening pain	Needs evaluation.
New flank pain	Could suggest kidney blockage or upper urinary tract involvement.

Some symptoms can be expected

After cystoscopy or TURBT, some burning, urinary frequency, urgency, and light blood in the urine can happen. Heavy bleeding, fever, inability to urinate, or worsening pain is not routine and should be reported.

Good questions to ask at your follow-up

- Was the tumor low grade or high grade?
- Was it Ta, T1, CIS, or muscle-invasive?
- Was bladder muscle present in the TURBT specimen?
- Do I need a repeat TURBT?
- Do I need bladder medicine, surveillance only, or referral?
- When is my next cystoscopy?

The main message

A bladder mass is scary to hear about, but the pathway is stepwise:

Look - remove/biopsy - pathology - stage/risk group - treatment plan - surveillance.

Many cases are non-muscle-invasive and can start with local urology care. Higher-risk or more advanced cases are referred so patients can access the full range of bladder cancer treatments.

Sources and guideline basis

Flaig TW, Spiess PE, Abern M, et al. Bladder Cancer, Version 1.2026, NCCN Clinical Practice Guidelines in Oncology. Journal of the National Comprehensive Cancer Network. 2026;24(5):186-203. doi:10.6004/jnccn.2026.0022.

National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Bladder Cancer. Version 2.2025. Updated October 10, 2025.

This handout is a patient-friendly summary. It does not replace individualized medical advice, pathology review, or shared decision-making with your urology and oncology teams.

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