



Bladder Cancer Info and Questionnaire

In industrialized nations, 90% of urinary bladder cancer is transitional cell carcinoma. Other less common types include squamous cell carcinoma, adenocarcinoma, small cell carcinoma and sarcoma. Squamous cell carcinoma and adenocarcinomas have a poorer prognosis than transitional cell cancers. Men are affected more frequently than women, and it is rare in individuals who are younger than 40. Those demonstrating an increased risk are smokers and workers in the dye, chemical, and rubber industries. The tumors have a tendency to recur following removal and may become more invasive upon recurrence.

The major prognostic features are the depth of invasion into the bladder wall (stage) and the degree of cellular differentiation of the tumor (grade). A deeper level of invasion means a higher tumor stage and a poorer prognosis. If the tumor is confined to the epithelial layer (superficial lining of the bladder), it can be removed through a cystoscope. The prognosis of survival following superficial tumor removal is good. Treatment of invasive bladder cancer may include chemotherapy (placed in the bladder), or the surgical removal of the bladder (cystectomy). If the tumor has gone through the bladder wall, 5 year survival is 45% with treatment. With metastatic disease, patients have a less than 2 year survival.

Because the recurrence rate of bladder cancer is high, routine follow-up with cystoscopy and urine cytology is necessary. Patients with greatest risk for recurrence are those with large, high grade (II & III), or multiple tumors present on initial presentation.

Bacillus Calmette-Guerin (BCG), a protein, may be placed in the bladder as chemotherapy for bladder cancer. The first course is weekly for six weeks. BCG may be given as three-week maintenance therapy every three to six months as part of the surveillance follow up for a three-year period.

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Underwriting Specific Conditions

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Examples of Underwriting Guidelines for a history of bladder cancer absent other significant impairment with no further evidence of cancer and adequate routine follow-up care:

(Carriers will vary with underwriting decisions; this is only an example of one carrier)

Ratings:	
Transitional cell carcinoma:	
Very low risk tumors: Papillary urothelial neoplasm of low malignant potential, with or without recurrence (any number of lesions or recurrences)	No rating
Low risk tumors: Ta, grade 1-2, with or without recurrence, ≤3 tumors at one time and all tumors ≤3cm in size	Malignant Tumor Rating Schedule D, dating from latest occurrence
Moderate risk tumors • Low risk tumors with >3 tumors at one time or >3cm in size • Papillary urothelial carcinoma, low grade • T1, grade 1 • Ta, grade 3	Malignant Tumor Rating Schedule C. If recurrent, date from latest occurrence and add Class B. Decline if ≥ 5 occurrences
High risk tumors • Tis • High grade intraurothelial neoplasm • Papillary urothelial carcinoma, high grade • T1, grade 2-3	• One occurrence, with or without BCG, Cancer B plus rating required in Malignant Tumor Rating Schedule B. • Two occurrences, with BCG: Class B plus rating required in Malignant Tumor Rating Schedule B • More than two occurrences or two occurrences and no BCG: Decline
T2 – without total cystectomy	Decline
T2 or high risk tumors – with total cystectomy	Postpone 3yr, then Class B
Without high quality surveillance	Individual Consideration
T3, T4 or node positive	Decline
Other bladder cancer	
Squamous cell carcinoma Adenocarcinoma Small cell carcinoma Sarcoma	Malignant Tumor Rating Schedule A

Surveillance:

- All transitional cell bladder tumors must be postponed until there has been at least one follow-up visit (to include both cystoscopy and cytology that are not suspicious for recurrent tumor) after initial diagnosis. Then, ratings shown require high quality surveillance – which is defined as the following and dating from latest occurrence:

- For very low and low risk tumors proposed insured must follow urologist's recommended surveillance.
- For moderate and high risk tumors cystoscopy and cytology must be completed every 3 months for the first 2 years, then every 6 months for the next 3 years, then yearly.
- Without high quality surveillance, individual consideration is warranted.

Malignant Tumor Rating Schedule				
A	B		C	D
Within 1st year	Decline	Decline	Decline	\$5x3
2nd year	Decline	Decline	\$7.50x5	\$5x2
3rd year	Decline	\$10x6	\$7.50x4	\$5x1
4th year	\$15x6	\$10x5	\$7.50x3	0
5th year	\$15x5	\$10x4	\$7.50x2	0
6th year	\$15x4	\$10x3	\$7.50x1	0
7th year	\$15x3	\$10x2	0	0
8th year	\$15x2	\$10x1	0	0
9th year	\$15x1	0	0	0



Underwriting Specific Conditions

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Bladder Cancer Questionnaire

Producer _____ Phone _____

Client _____ Age/DOB _____ Sex _____

Height _____ Weight _____

If your client has a history of bladder cancer, please answer the following:

1. Please list date when first diagnosed: _____

2. How was the cancer treated? (check all that apply)

- Endoscopic resection only
- Endoscopic resection and chemotherapy placed in the bladder
- Radical cystectomy (removal of the bladder)
- Radiation therapy
- Systemic chemotherapy

3. What stage was the cancer?

- Tis T3a
- Ta T3b
- T1 T4
- T2

4. Has there been any evidence of recurrence?

- Yes, please give details _____
- No

5. Please give the date and result of the most recent cystoscopy and urine cytology

6. Is your client on any medications?

- Yes, please give details _____
- No

7. Has your client smoked cigarettes in the last 12 months?

- Yes, please give details _____
- No

8. Does your client have any other major health problems (ex: heart disease, etc.)?

- Yes (Please give details) _____
- No