

Pathology

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The commonest type of bladder cancer is transitional cell (urothelial) carcinoma (Table 83.17). Squamous cell carcinoma occurs secondary to chronic inflammation (e.g. indwelling catheter, stone, schistosomiasis), and primary adenocarcinoma usually originates in the urachus (dome of the bladder) or in those with bowel in the urinary tract (augmentation enterocystoplasty, bladder exstrophy repair). Histological variants (e.g. micropapillary, sarcomatoid, plasmacytoid, nested variant) can coexist with urothelial carcinoma and generally signify aggressive tumours with poorer prognosis than pure urothelial carcinoma.

Smoking 2-5 times increased risk Occupational Tanner exposure Rubber (aromatic Paint and dyes hydrocarbons) Gas and tar Hairdressers Plumbers Painters Environmental Arsenic in drinking water carcinogens Chronic Indwelling catheter in inflammation of Stones bladder Schistosomiasis (predisposes to squamous cell carcinoma) Recurrent infections leading to keratinising squamous metaplasia Drugs Phenacetin Cyclophosphamide Pelvic radiotherapy Staging of urachal tumours There is no AJCC staging system for tumours arising in urachal remnants, but they may be staged according to several proposed systems Urothelium Lamina propria Muscularis propria Perivesical fat Tis Ta T1 Staging of diverticula Muscularis propria is T3 absent; thus, there is no T2 Figure 83.34 Staging of the primary tumour in bladder cancer. (Reprint. Staging of bladder cancer. Histopathology 2019; 74 (1): 112-34.) cancer. Type Frequency Transitional cell carcinoma

“ 90% Squamous cell carcinoma 1-7% Adenocarcinoma 2% Rare: Melanoma, lymphoma, sarcoma, small cell <1% carcinoma, pheochromocytoma Metastatic adenocarcinoma (colorectal, prostate, <1% kidney, ovary)

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