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Bristol Urological Institute

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Urine cytology guidance at flexible cystoscopy for bladder cancer surveillance

Urine cytology should be sent in specific urine cytology urine specimen pot, and should be sent to the laboratory as soon as possible. The urine should not be the first urination of the morning, and should be a mid stream sample (25mls).

For any urine cytology sample sent, it is the responsibility of the clinician who has sent it to chase the result, inform patient of the result and act on this appropriately.

Urine cytology should not routinely be discussed at MDT, but if there is clinical doubt – speak to one of the Bladder Cancer Urology Consultants, and it may require discussion at MDT following this.

Indications for sending urine cytology:

1. If requested by MDT.
2. For high risk NMIBC patients with an existing red patch which has previously been biopsied and is previously benign. Urine cytology should be sent and the patient put forward for a repeat biopsy if it is positive. If negative they can continue surveillance.
3. For patients at high anaesthetic risk with a new red patch, in whom a general/spinal anaesthetic is risky. These patients need discussion with a Consultant Urologist after the cytology result is available.

Situations where not to send urine cytology routinely:

1. Haematuria clinic.
2. Routine bladder cancer follow-up surveillance protocol.

Interpretation of results:

If cytology shows atypia or is paucicellular (low cell number), then it needs repeating.

If concern or unsure about results please discuss with Bladder Cancer Urology Consultant.