available at www.sciencedirect.com
journal homepage: www.europeanurology.com

European Association of Urology

CME Questions for European Urology Supplements Volume 8 (2009) pp. 535–562

CME questions

Please visit www.eu-acme.org/europeanurology to answer these CME questions online. The CME credits will then be attributed automatically.

1. **The gold standard to evaluate the performance of urine markers is:**
   A. Cytology.
   B. Cystoscopy.
   C. Ultrasound of the bladder.
   D. CT-scan of the pelvis.
2. **Which are the best tools to compare the performance of urine markers between studies?**
   A. Sensitivity and specificity.
   B. Sensitivity and negative predictive value.
   C. Specificity and negative predictive value.
   D. Specificity and positive predictive value.
3. **In which clinical setting would a urine marker other than cytology be the most useful?**
   A. Screening of individuals without symptoms.
   B. Primary detection in a patient with hematuria.
   C. Follow-up of a high-risk non–muscle-invasive bladder cancer patient.
   D. Follow-up of a low-risk non–muscle-invasive bladder cancer patient.
4. **The sensitivity of a urine-test for patients under surveillance for non–muscle-invasive bladder cancer . . . the sensitivity reported in review articles on these tests.**
   A. is higher than.
   B. is lower than.
   C. is equal to.
   D. has not been investigated versus.
5. **Which of the following statements is correct?**
   A. Point-of-Care tests are more expensive than genetic tests in urine like FISH(UroVysion).
   B. A positive urinary Microsatellite analysis accompanied by a negative cystoscopy has no anticipatory positive predictive value for patients under surveillance for non–muscle-invasive bladder cancer.
   C. Probably as a result of different thresholds, the specificity of the NMP22 point-of-care test (BladderCheck) is higher than the NMP22 Elisa test in urine.
   D. A blue-light cystoscopy has no additional value in patients with a negative white-light cystoscopy and a positive cytology.
6. **In a recent randomized study which investigated the possibility to lower the frequency of cystoscopy for surveillance,**
   A. high-risk non–muscle-invasive patients were included and these patients had the highest recurrence rates.
   B. both Microsatellite analysis and cytology were used as urine tests.
   C. knowledge of the urine-test outcome had a profound influence on tumor-detection.
   D. less than 15% of the samples could not be analyzed.
7. **The most important factor determining the risk of tumor understaging by the initial TURB is:**
   A. Absence of the muscle in the specimen from the initial resection.
   B. Tumor location on the bladder neck.
   C. Tumor size over three centimeters.
   D. Associated CIS.
8. **A re-TUR after the initial TURB of TaT1 lesions is indicated:**
   A. In all patients.
   B. In patients where immediate intravesical instillation of chemotherapy was not administered.
   C. When T1 or high-grade non–muscle-invasive tumour was detected, when the pathologist has reported that the specimen contained no muscle tissue or when the urologist is not sure that the initial resection was complete.
   D. Only in patients with associated CIS at the initial TURB.
9. **Biopsies from normal-looking mucosa (R-biopsies) in patients with exophytic non–muscle-invasive tumor are indicated:**
   A. Only in multiple tumors.

1569-9056/$ – see front matter doi:10.1016/j.eursup.2009.06.015

B. In patients with positive urinary cytology or non-papillary tumors.
C. Only if cystectomy is planned.
D. In all patients.

10. Larger tumors, over one centimeter in diameter:
A. Can be only coagulated.
B. Should be resected separately in fractions.
C. Should be always referred to cystectomy.
D. Cannot be resected completely. The re-TUR is necessary in all cases.

11. The rate of residual tumor detected by re-TUR varies in published series between:
A. 4–10%.
B. 5–27%.
C. 33–76%.
D. 80–90%.

12. Compared to standard white light investigation fluorescence cystoscopy:
A. Does not bring any meaningful clinical benefit.
B. Improves detection of both exophytic and flat tumors.
C. Reduces the risk of bladder perforation during TURB.
D. Improves detection of CIS, but nor exophytic tumors.

13. Which of the following statements regarding the 2008 EAU and 2007 AUA guidelines on non–muscle-invasive urothelial carcinoma of the bladder is correct?
A. Induction therapy with BCG is considered standard, but maintenance BCG or chemotherapy are not firmly advocated for high-risk disease.
B. Neither the EAU or AUA recommends any adjuvant intravesical therapy for low-risk disease.
C. BCG induction, but not maintenance, is advocated in cases of low-risk disease.
D. In intermediate-risk disease, induction therapy with BCG or chemotherapy is considered standard, but the EAU more definitively recommends maintenance therapy whereas the AUA considers this optional.

14. Which of the following types of BCG failure is incorrectly defined below?
A. BCG refractory: failure to achieve disease-free status by 6 months after induction or progression in grade or stage by 3 months after the first induction cycle.
B. BCG resistant: upstaging or upgrading of disease after initial induction, but then a complete response at 12 months after TURBT (after two or more induction cycles).
C. BCG relapsing: disease-free status at 6 months, but then early (within 12 months), intermediate (12–24 months), or late (>24 months) recurrence.
D. BCG intolerance: recurrence after an inadequate treatment course, halted early because of serious adverse events or symptomatic intolerance.

15. What is the most commonly reported side effect of BCG therapy?
A. Hematuria.
B. Fevers and chills.
C. Lower urinary tract symptoms.
D. Skin rash.

16. All of the following factors have been identified as high risk for disease recurrence or progression in BCG treated patients with urothelial carcinoma of the bladder except:
A. Grade 3 tumor.
B. Presence of carcinoma in situ.
C. Age >50 years.
D. Presence of multiple tumors.

17. Which of the histologic patterns or variants of non–muscle-invasive bladder cancer can most appropriately be treated with BCG induction plus long-term maintenance after thorough transurethral resection (+/- re-resection)?
A. High grade urothelial carcinoma with concurrent carcinoma in situ.
B. Squamous cell carcinoma.
C. Micropapillary variant urothelial carcinoma.
D. Adenocarcinoma.

18. Which of the following statements regarding intravesical treatment for BCG failure patients is not true?
A. Approximately 35% of patients who recur with the same, or lower, T stage and grade at 3 months after induction BCG will respond to a second 6-week BCG induction.
B. Late recurrence patients (>2 years after complete response) fare nearly as well with BCG re-induction as with initial BCG.
C. Combination BCG-IFN-α may have some promise in the treatment of BCG failure patients but has not been proven superior to BCG monotherapy in BCG-naïve patients.
D. The intravesical chemotherapy agents shown to be most effective in BCG failure patients include valrubicin and mitomycin C monotherapy.

19. What is the most important risk factor for the development of non–muscle-invasive bladder cancer?
A. Smoking.
B. Occupational exposure with aromatic amines.
C. Occupational exposure with polycyclic aromatic hydrocarbons.
D. Genetic predisposition.

20. What is the most important clinical prognostic factor for bladder tumour recurrence?
A. Tumour multiplicity.
B. Tumour stage.
C. Tumour grade.
D. First follow up cystoscopy results after transurethral resection.

21. What are the long term (more than 5 years follow-up) results of intravesical chemotherapy in non–muscle-invasive bladder cancer?
A. It lowers both the recurrence and progression rate by less than 10%.
B. It lowers the recurrence rate by 50%, but progression rate is not influenced.

C. It lowers the recurrence rate by 50% and the progression rate by less than 10%.
D. It lowers the recurrence rate by less than 10%, but the progression rate is not influenced.

22. Which of the following statement about urine markers and cytology is true?

A. Urine markers have a high sensitivity and specificity.
B. Urine markers have a lower sensitivity and higher specificity compared to urine cytology.
C. Urine markers have a higher sensitivity and lower specificity compared to urine cytology.
D. Urine cytology is superior to urine markers in all aspects.

23. What is the best method to decrease the progression rate in non–muscle-invasive bladder cancer?

A. Six weekly intravesical BCG instillations.
B. Early cystectomy.
C. Intravesical chemotherapy instillations in a maintenance scheme.
D. Intravesical BCG instillations in a maintenance scheme.

24. With what type of non–muscle-invasive bladder tumour is the fibroblast growth factor receptor 3 (FGFR3) gene mutation associated?

A. Genetically stable high grade and high stage non–muscle-invasive bladder tumours.
B. Genetically unstable high grade and high stage non–muscle-invasive bladder tumours.
C. Genetically stable low grade and low stage non–muscle-invasive bladder tumours.
D. Genetically unstable low grade and low stage non–muscle-invasive bladder tumours.