

Late Presentation of Bladder Cancer—A Disturbing Trend

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Abstract

Background: Bladder cancer is a highly recurrent urological malignancy. In developing regions like sub-Saharan Africa, late clinical presentation and post-treatment patient default pose critical challenges to effective urological and oncological management. **Case Report:** A 47-year-old man who was presented to our facility with one-year history of recurrent painless, total visible hematuria, associated with clots. He also had lower urinary tract symptoms. The patient initially defaulted for seven months after symptom onset. Clinical examination after re-presentation revealed a middle-aged male who was relatively stable with bilateral pitting pedal edema and palpable immobile suprapubic mass. He was evaluated and underwent transurethral resection of bladder tumour. Histology revealed infiltrating urothelial carcinoma (high grade). **Conclusion:** Advanced stage at presentation and high post-operative loss-to-follow-up highlight deep-seated socioeconomic barriers and poor health-seeking behavior in urological cancer care within our environment. Urgent public awareness campaigns are necessary to curb this disturbing clinical trend.

Keywords

Late Presentation, Bladder Cancer, Disturbing Trend

1. Introduction

Bladder cancer is a highly prevalent urological malignancy arising from the transitional epithelial cells (urothelium) lining the urinary bladder, characterized by one of the highest recurrence rates among all malignancies [1]. Globally, the annual incidence of urinary bladder malignancies is estimated at over 613,000 cases, causing approximately 220,000 deaths worldwide and posing a persistent chal-

lenge to global public health [2]. While high-income regions reflect a high incidence linked heavily to advanced industrial carcinogens and aging populations, Africa contributes a growing share of approximately 37,064 new diagnoses annually [3] [4].

In African settings, bladder cancer dynamics are traditionally split between *Schistosoma haematobium*-associated squamous cell carcinoma (SCC) and industrial/smoking-related urothelial carcinoma (UC) [5]. However, recent multi-center data from Nigeria demonstrated a shifting epidemiological trend, with infiltrating UC becoming increasingly prevalent due to rapid urbanization, industrialization, and changing lifestyle habits [6]. Despite diagnostic advances worldwide, a major systemic challenge in Nigerian urological practice remains the late presentation of patients, frequently complicated by financial limitations, alternative traditional healthcare utilization, and poor compliance with clinical follow-up [7].

2. Case Report

A 47-year-old married Yoruba male administrative officer who was referred to our tertiary health facility with one-year history of recurrent, painless, total visible hematuria, associated with clots. He also had lower urinary tract symptoms. There was no history of childhood hematuria, cigarette smoking, pelvic irradiation or chronic urinary bladder catheterization. Following his initial diagnostic workup recommendation, the patient defaulted for approximately seven months before returning to the clinic. Clinical examination at re-presentation revealed a middle-aged male who was relatively stable with elevated blood pressure of 132/100 mmHg, bilateral pitting pedal edema and palpable immobile suprapubic mass. A working diagnosis of hematuria secondary to advanced bladder tumour was made.

Urinalysis demonstrated red blood cells in the urine. Hemoglobin was 12.7 g/dL and kidney function was normal. Urine microscopy, culture and sensitivity yielded *Enterococcus faecalis* sensitive to Gentamycin, Ceftriazone, Penicillin and Azithromycin. Computed Tomography urogram showed enhancing lobulated masses in the right posterior ($4.4 \times 4.2 \times 4.5$ cm), left posterior ($4.5 \times 3.3 \times 3.0$ cm) and midline posterior ($1.2 \times 1.1 \times 0.8$ cm).

He was optimized and underwent transurethral resection of bladder tumour under spinal anaesthesia after an informed consent. Intra-operative findings matched the imaging, indicating highly aggressive, deeply rooted exophytic tissue (**Figure 1**, **Figure 2**). Histology revealed infiltrating urothelial carcinoma (high grade).

The post-operative packed cell volume was 23.4%, for which he had two pints of blood transfused. The multidisciplinary oncology team was formally co-opted to design an adjuvant chemo-radiation therapy regimen. However, on the third post-operative day, the patient became highly agitated to leave the hospital and was discharged against medical advice. Despite aggressive tracking efforts via telephone to remind him of his critical oncology and urology appointments, the patient has completely defaulted and has not returned to the outpatient clinic.

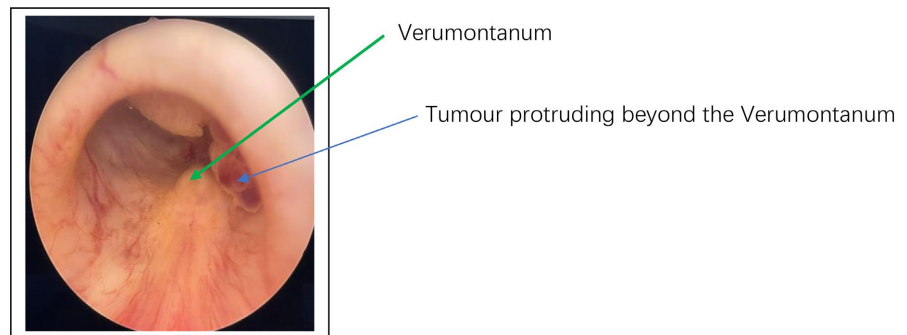


Figure 1. Preliminary urethro-cystoscopy showing the tumour extending beyond the verumontanum.

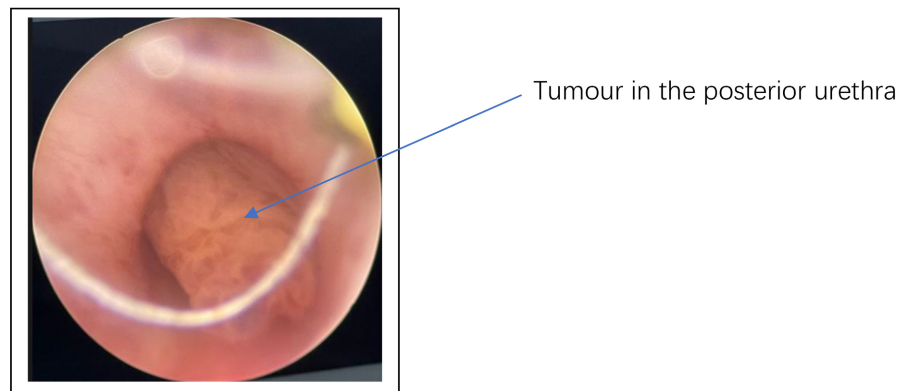


Figure 2. Endoscopic view of the prostatic urethra during TURBT.

The index case highlights a highly problematic, yet common scenario in West African urology: a middle-aged male presenting with advanced, high-grade urothelial carcinoma who defaults from care at multiple stages of management.

Painless visible hematuria is the classic hallmark symptom of urological malignancies globally. Literature across Nigerian tertiary centers corroborates that over 80% - 90% of bladder cancer patients present primarily with hematuria [8] [9]. Unfortunately, this symptom is frequently ignored by patients or misdiagnosed as simple urinary tract infections by primary healthcare providers, creating an extensive diagnostic lag [7].

This diagnostic delay severely worsens survival rates; global oncological data indicate that a diagnostic or treatment lag exceeding several months from the initial onset of hematuria correlates with significantly higher tumor grades, non-organ-confined disease (pT3 - pT4 stages), and significantly elevated cancer-specific mortality [10] [11]. A multi-center Nigerian study noted that over 54% of late-presentation bladder cancer cases require urgent blood transfusions due to chronic, severe hematuria, directly mirroring the post-operative transfusion needs seen in our patient [6].

The presentation of an immobile suprapubic mass and bilateral pedal edema in this 47-year-old indicates advanced pelvic disease extension causing lymphatic or venous obstruction. While squamous cell carcinoma historically dominated sub-

Saharan Africa due to *S. haematobium* endemics, contemporary global and local urological trends show that infiltrating urothelial carcinoma is rising rapidly in urban centers, increasingly affecting younger cohorts under 50 years of age [5] [12].

The most disturbing element of this case is the compounded clinical default. The patient presented a year after the onset of symptoms, then delayed intervention by seven months post-presentation, allowing a highly aggressive, high-grade tumor to advance unchecked. He then self-discharged prematurely on day three and ignored follow-up clinic invites. In developing regions, these default behaviors are heavily driven by economic strain (out-of-pocket medical expenditure), deep-rooted fear of radical surgical procedures (such as cystectomy or urinary diversion), and a false sense of temporary relief following palliative TURBT [7] [12]. The 2026 EAU Guidelines indicate that histological analysis showing high-grade infiltrating urothelial carcinoma meets standard criteria for muscle-invasive bladder cancer [13]. Furthermore, these guidelines confirm that delays exceeding 3 months between initial presentation and definitive treatment reduce overall survival rates [13].

International data highlight that structured tracking systems and reducing socio-economic barriers are key to preventing post-resection default and lowering the global burden of advanced urological malignancies [2] [10].

3. Conclusion

Late presentation of bladder cancer is a major urological challenge in Nigeria. This case underscores that even when timely surgical palliation (TURBT) is achieved, patient retention within standard oncological surveillance remains poorly optimized due to complex psychosocial behaviors and religious beliefs. Combating this trend requires a coordinated effort, including widespread community education regarding the importance of treating painless hematuria as a potential malignancy, alongside structural healthcare financing reforms to alleviate burdens of paying out-of-pocket.

Ethical Approval

Ethical approval for this study was obtained from the Institutional Health Research Ethics Committee (Approval Number: HREC 26-60).

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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