

NMP22 - Differential Diagnostic Algorithm - UROLOGIST

- The algorithm gives you good overview how to use and interpret NMP22 results in conjunction with a standard white light cystoscopy.
 - In any case NMP22 adds valuable information.
 - As cystoscopy is good but not perfect a marker is needed to improve the overall detection rate and to clarify the upper urinary tract. Newer comparison studies between white light (WL) and blue light (Hexvix) cystoscopy show an average detection rate for WL around 70%-80%.
 - Grossman clearly showed in his JAMA publications that NMP22 used together with cystoscopy increased the combined detection rate up to 96%-99% - picking also up initially missed life threatening cancers.
 - Risk group screening should be done first with a non invasive marker
- Seven years' experience with 5-aminolevulinic acid in detection of transitional cell carcinoma of the bladder. Urology. 2007 Feb;69(2):260-4. Hungerhuber E.
 - Surveillance for recurrent bladder cancer using a point-of-care proteomic assay. JAMA. 2006 Jan 18;295(3):299-305 Grossman HB,
 - Detection of bladder cancer using a point-of-care proteomic assay. JAMA. 2005 Feb 16;293(7):810-6. Grossman HB

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Alere™

Pathway
#1

NMP22 Test (NEG)
Cystoscopy (NEG)

Result: > 99% NPV
Action: Standard Surveillance

Pathway
#2

NMP22Test (POS)
Cystoscopy (NEG)

Result: Potential undetected cancer
Action: More intensive investigation
- upper tract tests
- follow-up shorter interval

Pathway
#3

NMP22Test (POS)
Cystoscopy (POS)

Result: Up to 99% cancers detected
Elevated risk muscle invasive
and/or high grade cancer
Action: Prioritize for biopsy

Pathway
#4

NMP22 Test (NEG)
Cystoscopy (POS)

Result: Greater chance non-muscle
invasive low grade cancer
Action: Standard biopsy