

Harnblasenkarzinom

Muskelinvasives und metastasiertes Harnblasenkarzinom
(MIBC)

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EAU Guidelines on Muscle-invasive & Metastatic Bladder Cancer – 2026

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Zusammenfassung der Handlungsempfehlungen mit Empfehlungsstärke (Strength rating).

Grundlage: 26 Empfehlungsboxen der Vollversion (98 Seiten), inkl. Original-Abbildungen und Kerntabellen.

Legende: Strong = starke Empfehlung Weak = schwache Empfehlung

TNM-Klassifikation (2025, 9. Auflage) – Table 4.1

T - Primary tumour	
Tx	Primary tumour cannot be assessed
T0	No evidence of primary tumour
Ta	Non-invasive papillary carcinoma
Tis	Carcinoma <i>in situ</i> : "flat tumour"
T1	Tumour invades subepithelial connective tissue
T2	Tumour invades muscle
T2a	Tumour invades superficial muscle (inner half)
T2b	Tumour invades deep muscle (outer half)
T3	Tumour invades perivesical tissue:
T3a	microscopically
T3b	macroscopically (extravesical mass)
T4	Tumour invades any of the following: prostate stroma, seminal vesicles, uterus, vagina, pelvic wall, abdominal wall
T4a	Tumour invades prostate stroma, seminal vesicles, uterus or vagina
T4b	Tumour invades pelvic wall or abdominal wall
N - Regional lymph nodes	
Nx	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	Metastasis in a single lymph node in the true pelvis (hypogastric, obturator, external iliac or presacral)
N2	Metastasis in multiple regional lymph nodes in the true pelvis (hypogastric, obturator, external iliac or presacral)
N3	Metastasis in a common iliac lymph node(s)
M - Distant metastasis	
M0	No distant metastasis
M1a	Nonregional lymph nodes
M1b	Other distant metastasis

1. Epidemiologie & Risikofaktoren

Recommendations	Strength rating
Counsel patients to stop active and avoid passive smoking.	Strong
Inform workers in potentially hazardous workplaces of the potential carcinogenic effects of a number of recognised substances, including duration of exposure and latency periods. Protective measures are recommended.	Strong

2. Beurteilung des Tumormaterials (Pathologie)

Recommendations	Strength rating
Record the depth of invasion for the entire specimen (categories pT2a and pT2b, pT3a and pT3b, or pT4a and pT4b).	Strong
Record margins with special attention paid to the radial margin, prostate, ureter, urethra, peritoneal fat, uterus and vaginal vault.	Strong
Record the total number of lymph nodes (LNs), the number of positive LNs and extranodal spread.	Strong
Record lymphovascular invasion.	Strong
Record the presence of carcinoma <i>in situ</i> .	Strong
Record the sampling sites, as well as information on tumour size, when providing specimens to the pathologist.	Strong

3. Urotheliale Marker

Recommendations	Strength rating
Use susceptible fibroblast growth factor receptor 3 alterations to select patients with unresectable or metastatic urothelial carcinoma for treatment with erdafitinib.	Strong
Determine immunohistochemical human epidermal growth factor receptor (HER) 2 expression to select patients for HER2-directed antibody-drug conjugate therapy.	Weak

4. Primärdiagnostik bei V.a. invasiven Tumor

Recommendations	Strength rating
Describe all macroscopic features of the tumour (site, size, number and appearance) and mucosal abnormalities during cystoscopy. Use a bladder diagram.	Strong
Take a biopsy of the prostatic urethra in the following cases: bladder neck tumour; when bladder carcinoma <i>in situ</i> is present or suspected; when there is positive cytology without evidence of tumour in the bladder; or when abnormalities of the prostatic urethra are visible.	Strong
In males with a negative prostatic urethral biopsy undergoing subsequent orthotopic neobladder construction, an intraoperative frozen section can be omitted.	Strong
In males with a prior positive transurethral prostatic biopsy, subsequent orthotopic neobladder construction should not be denied <i>a priori</i> , unless an intraoperative frozen section of the distal urethral stump reveals malignancy at the level of urethral dissection.	Strong
In females undergoing subsequent orthotopic neobladder construction, obtain procedural information (including histological evaluation) of the bladder neck and urethral margin, either prior to, or at the time of cystectomy.	Strong

5. Staging beim MIBC

Recommendations	Strength rating
If magnetic resonance imaging (MRI) is performed for local staging of bladder cancer (BC), it should be carried out before transurethral resection of the bladder tumour.	Strong
In patients with confirmed muscle-invasive BC, use computed tomography (CT) of the chest, abdomen and pelvis for staging, including some form of CT urography with designated phases for optimal urothelial evaluation.	Strong
Offer MRI to assess the local response to systemic therapy.	Weak

Rolle der Bildgebung in der Therapieplanung (Table 5.1)

Goal	Imaging modality
Detect bladder tumours	US, CT and MRI
Differentiate T1 from T2 tumours, as treatment will differ	MRI with the VI-RADS score
Assess upper urinary tract	CT or MRI urography
Evaluate locally advanced disease or LN staging	CT or MRI for abdominal- and pelvic LNs or PET/CT scan
Distant staging	CT, MRI or PET/CT to detect distant organ metasta-sis

6. Multidisziplinäres Team

Recommendations	Strength rating
Manage all patients who are candidates for trimodality therapy in a multidisciplinary team setting. The choice of treatment modality should be made through a shared decision-making process.	Strong
Fully inform the patient about the benefits and potential risks of all possible alternatives before radical cystectomy. The final decision should be based on a balanced discussion between the patient and the surgeon.	Strong

7. Komorbiditäts-Scores & Gesundheitsstatus

Recommendations	Strength rating
Base the decision on bladder-sparing treatment or radical cystectomy in older/frail patients with invasive bladder cancer on tumour stage and frailty.	Strong
Assess comorbidity by a validated score, such as the Charlson Comorbidity Index. The American Society of Anesthesiologists score should not be used in this setting (see Section 6.4).	Strong

Clinical Frailty Scale v2.0 (Figure 6.1)

CLINICAL FRAILITY SCALE			
	1	VERY FIT	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
	2	FIT	People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally , e.g., seasonally.
	3	MANAGING WELL	People whose medical problems are well controlled , even if occasionally symptomatic, but often are not regularly active beyond routine walking.
	4	LIVING WITH VERY MILD FRAILITY	Previously "vulnerable," this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities . A common complaint is being "slowed up" and/or being tired during the day.
	5	LIVING WITH MILD FRAILITY	People who often have more evident slowing , and need help with high order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
	6	LIVING WITH MODERATE FRAILITY	People who need help with all outside activities and with keeping house . Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
	7	LIVING WITH SEVERE FRAILITY	Completely dependent for personal care , from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).
	8	LIVING WITH VERY SEVERE FRAILITY	Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
	9	TERMINALLY ILL	Approaching the end of life. This category applies to people with a life expectancy <6 months , who are not otherwise living with severe frailty . (Many terminally ill people can still exercise until very close to death.)
SCORING FRAILITY IN PEOPLE WITH DEMENTIA The degree of frailty generally corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal. In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting. In severe dementia, they cannot do personal care without help. In very severe dementia they are often bedfast. Many are virtually mute. Clinical Frailty Scale ©2005–2020 Rockwood, Version 2.0 (EN). All rights reserved. For permission: www.geriatricmedicineresearch.ca Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.			
 DALHOUSIE UNIVERSITY www.geriatricmedicineresearch.ca			
 UNIVERSITÄT FREIBURG KLINIKUM			

G8-Screening-Tool (Table 6.1)

	Items	Possible responses (score)
A	Has food intake declined over the past three months due to loss of appetite, digestive problems, chewing or swallowing difficulties?	0 = severe decrease in food intake
		1 = moderate decrease in food intake
		2 = no decrease in food intake
B	Weight loss during the last three months?	0 = weight loss > 3kg
		1 = does not know
		2 = weight loss between 1 and 3kg
		3 = no weight loss
C	Mobility?	0 = bed or chair bound
		1 = able to get out of bed/chair but does not go out
		2 = goes out
D	Neuropsychological problems?	0 = severe dementia or depression
		1 = mild dementia
		2 = no psychological problems
E	BMI? (weight in kg)/(height in m ²)	0 = BMI < 19
		1 = BMI 19 to < 21
		2 = BMI 21 to < 23
		3 = BMI ≥ 23
F	Takes more than three prescription drugs per day?	0 = yes
		1 = no
G	In comparison with other people of the same age, how does the patient consider their health status?	0.0 = not as good
		0.5 = does not know
		1.0 = as good
		2.0 = better
H	Age	0 = ≥ 85
		1 = 80-85
		2 = < 80
	Total score	0-17

Charlson-Komorbiditätsindex (Table 6.2)

Number of points	Conditions
1	50-60 years
	Myocardial infarction
	Heart failure
	Peripheral vascular insufficiency
	Cerebrovascular disease
	Dementia
	Chronic lung disease
	Connective tissue disease
	Ulcer disease
	Mild liver disease
	Diabetes
2	61-70 years
	Hemiplegia
	Moderate to severe kidney disease
	Diabetes with organ damage
	Tumours of all origins
3	71-80 years
	Moderate to severe liver disease
4	81-90 years
5	> 90 years
6	Metastatic solid tumours
	AIDS

8. Neoadjuvante Therapie

Recommendations	Strength rating
Offer perioperative chemoimmunotherapy with cisplatin/gemcitabine and durvalumab to patients with muscle-invasive bladder cancer (MIBC) (T2-T4a, cN0-1 M0) who are eligible for cisplatin-based chemotherapy (glomerular filtration rate ≥ 40 mL/min. allowed) and immunotherapy.	Strong
Offer perioperative enfortumab vedotin plus pembrolizumab to patients with MIBC who are ineligible for cisplatin-based chemotherapy.	Strong
Offer neoadjuvant cisplatin-based combination chemotherapy to patients with MIBC (T2-T4a, cN0-1 M0) who are eligible for cisplatin-based chemotherapy.	Strong
Do not offer neoadjuvant carboplatin-containing combination chemotherapy to patients who are ineligible for cisplatin-based combination chemotherapy.	Strong

9. Adjuvante Therapie

Recommendations	Strength rating
Offer adjuvant cisplatin-based combination chemotherapy to patients with pT3/4 and/or pN+ disease if no neoadjuvant systemic therapy has been given.	Strong
Offer adjuvant nivolumab to patients with high-risk muscle-invasive urothelial carcinoma ($\geq$ ypT2N0 after NAC or pT3/4 and/or pN+) who are not eligible for, or who declined, adjuvant cisplatin-based chemotherapy. Of note: FDA approval irrespective of PD-L1 status, EMA approval only for PD-L1 tumour cell expression $\geq$ 1%.	Strong

10. Prä-/postoperative Radiotherapie

Recommendations	Strength rating
Do not offer preoperative radiotherapy (RT) for operable muscle-invasive bladder cancer since it will not improve survival.	Strong
Adjuvant RT to the cystectomy bed and local pelvic nodes can be offered following radical cystectomy (pT3b-4 or positive nodes or positive margins) to improve locoregional relapse free survival, but not overall survival.	Weak

11. Radikale Zystektomie

Recommendation	Strength rating
Offer radical cystectomy to patients with T2-T4a N0M0 disease.	Strong

12. Funktionserhalt (Mann)

Recommendations	Strength rating
Only offer sexual-preserving techniques to eligible male patients who are highly motivated to preserve their sexual function.	Strong

13. Funktionserhalt (Frau)

Recommendation	Strength rating
Perform sexual organ-preserving techniques in eligible female patients. Select patients based on absence of tumour in the area to be preserved to avoid positive soft tissue margins.	Strong

14. Lymphadenektomie

Recommendations	Strength rating
Perform a lymph node dissection (LND) as an integral part of radical cystectomy.	Strong
Perform a standard LND, because an extended LND does not improve survival and increases the risk of morbidity.	Strong

15. Roboterassistierte Zystektomie

Recommendations	Strength rating
Inform the patient of the advantages and disadvantages of open radical cystectomy (RC) and robotic assisted radical cystectomy (RARC) to allow selection of the proper procedure.	Strong
Select centres for both RARC and open RC based on experience, rather than the technique used.	Strong
Do not delay RC for more than three months, as this increases the risk of progression and cancer-specific mortality, unless the patient receives neoadjuvant chemotherapy.	Strong

16. Harnableitung nach Zystektomie

Recommendations	Strength rating
Do not offer an orthotopic bladder substitute diversion to patients who have an invasive tumour in the urethra or at the level of urethral dissection.	Strong
Do not offer preoperative bowel preparation.	Strong
Employ 'fast track' measurements to reduce the time to bowel recovery.	Strong

Management der Neoblasen-Morbidität (Table 6.3, Teil 1)

CLAVIEN System		Morbidity	Management
Grade I	Any deviation from the normal postoperative course without the need for pharmacological treatment or surgical, endoscopic and radiological interventions. Allowed therapeutic regimens are: drugs such as antiemetics, antipyretics, analgesics, diuretics and electrolytes, and physiotherapy. This grade also includes wound infections opened at the bedside.	Immediate complications:	
		Postoperative ileus	Nasogastric intubation (usually removed at day one) Chewing gum Avoid fluid excess and hypovolemia (provoke splanchnic hypoperfusion)
		Postoperative nausea and vomiting	Antiemetic agent (decrease opioids) Nasogastric intubation
		Urinary infection	Antibiotics, no ureteral catheter removal Check the three drainages (ureters and neobladder)
		Ureteral catheter obstruction	Inject 5cc saline in the ureteral catheter to resolve the obstruction Increase volume infusion to increase diuresis
		Intra-abdominal urine leakage (anastomosis leakage)	Check and reposition drainages, if required
		Anaemia well tolerated	Martial treatment (give iron supplement)
		Late complications:	
		Non-compressive lymphocele	Watchful waiting
		Mucus cork	Catheterise and rinse the bladder
		Incontinence	Urine analysis (infection) Echography (post-void residual) Physiotherapy
		Retention	Drainage and self-catheterisation education
		Ureteral reflux	No treatment if asymptomatic
Grade II	Requiring pharmacological treatment with drugs other than those allowed for grade I complications. Blood transfusions and total parenteral nutrition are also included.	Anaemia badly tolerated or if myocardial cardiopathy history	Transfusion ¹
		Pulmonary embolism	Heparinotherapy ²
		Pyelonephritis	Antibiotics and check kidney drainage (nephrostomy if necessary)
		Confusion or neurological disorder	Neuroleptics and avoid opioids
Grade III	Requiring surgical, endoscopic or radiological intervention	Ureteral catheter accidentally dislodged	Reposition the ureteral catheter
		Anastomosis stenosis (7%)	Renal drainage (ureteral catheter or nephrostomy)

Management der Neoblasen-Morbidität (Table 6.3, Teil 2)

III-a	Intervention not under general anaesthesia	Compressive lymphocele	Transcutaneous drainage
III-b	Intervention under general anaesthesia	Ileal anastomosis leakage	Ileostomy, as soon as possible
		Evisceration	Surgery in emergency
		Compressive lymphocele	Surgery (marsupialisation)
Grade IV	Life-threatening complication (including central nervous system complications: brain haemorrhage, ischaemic stroke, subarachnoid bleeding, but excluding transient ischaemic attacks) requiring intensive care/ intensive care unit management.	Neobladder rupture	Nephrostomy and indwelling catheter/surgery for draining the neobladder
		Severe sepsis	Antibiotics and check all the urinary drainages and CT scan in emergency
IV-a	Single organ dysfunction	Non-obstructive renal failure	Bicarbonate/aetiology treatment (including dialysis)
IV-b	Multi-organ dysfunction	Obstructive pyelonephritis and septicaemia	Treatment at intensive care unit, including urinary drainage and antibiotics
Grade V	Death of a patient		
<i>Suffix 'd'</i>	<i>If the patient suffers from a complication at the time of discharge, the suffix 'd' (for 'disability') is added to the respective grade of complication. This label indicates the need for a follow-up to fully evaluate the complication.</i>		

17. Qualitätsindikatoren der Zystektomie

Recommendations	Strength rating
Perform at least 20 radical cystectomies (RCs) per hospital/per year.	Strong
Offer pharmacological venous thromboembolism prophylaxis, such as low-molecular-weight heparin, to RC patients, starting the first day post-surgery for a period of at least four weeks.	Strong

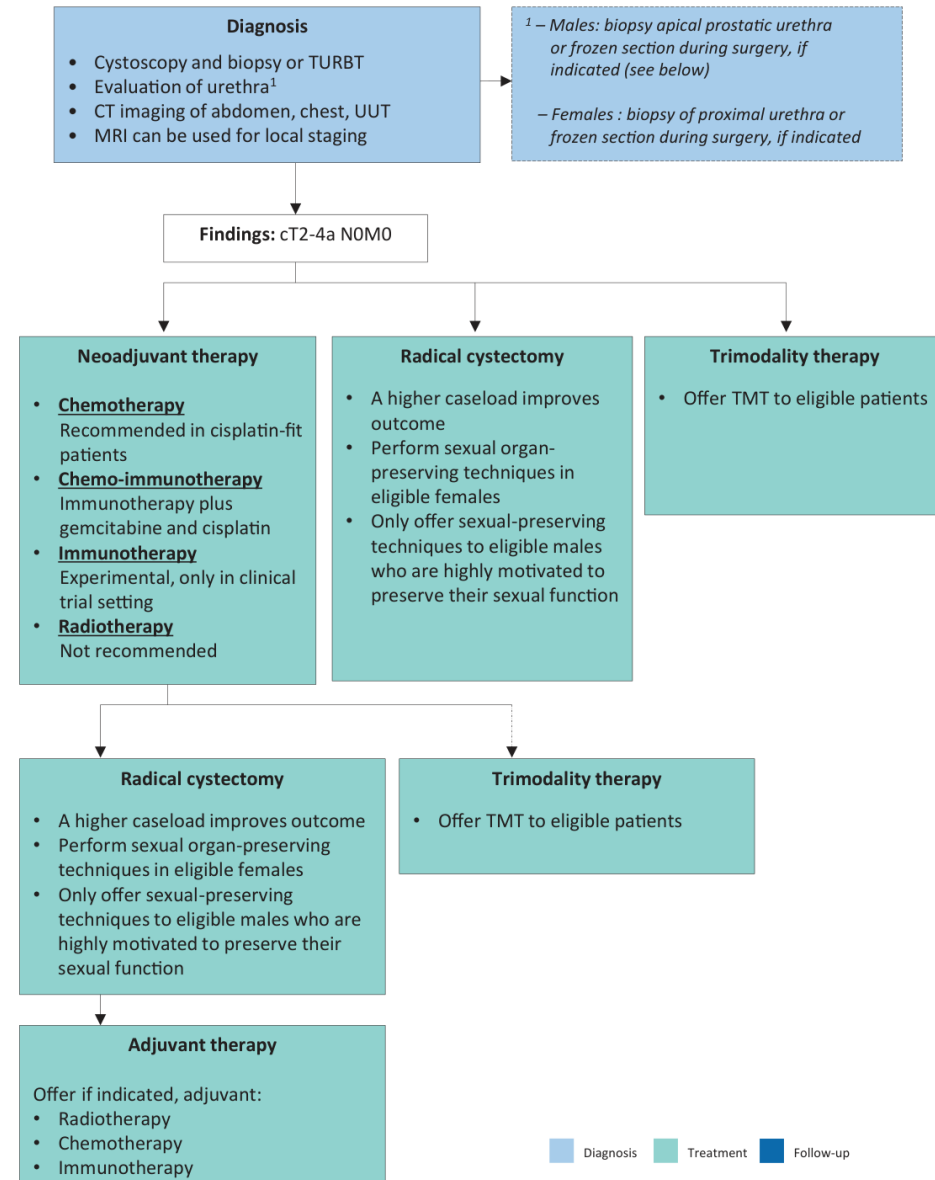
18. Palliative Zystektomie

Recommendations	Strength rating
Offer cystectomy as a palliative treatment to patients with locally advanced tumours.	Weak
Offer palliative cystectomy to patients with symptoms, if control is not possible by less invasive methods.	Weak

19. Trimodale blasenerhaltende Therapie (TMT)

Recommendations	Strength rating
Offer radical cystectomy or bladder-preserving trimodality treatment (TMT) as primary curative option for eligible patients since they are more effective than radiotherapy alone.	Strong
Advise patients who are candidates for TMT that bladder monitoring post-treatment is essential.	Strong

Abb. 6.2: Management-Algorithmus T2–T4a N0M0



20. Externe Strahlentherapie

Recommendation	Strength rating
Do not offer radiotherapy alone as primary therapy for localised bladder cancer.	Strong

21. TURB (bei blasenerhaltender Therapie)

Recommendation	Strength rating
Do not offer transurethral resection of bladder tumour alone as a curative treatment option as most patients will not benefit.	Strong

22. Chemotherapie (blasenerhaltend)

Recommendation	Strength rating
Do not offer chemotherapy alone as primary therapy for localised bladder cancer.	Strong

23. Ansprechen auf neoadjuvante Therapie

Recommendation	Strength rating
Perform restaging computed tomography after neoadjuvant therapy to rule out local progression and the presence of metastatic disease.	Strong

24. Salvage-Zystektomie & Rezidive

Recommendation	Strength rating
Offer salvage cystectomy to patients with muscle-invasive bladder cancer recurrence after trimodality therapy.	Strong

Rahmen für die Nachsorge (Table 7.1)

	Day 0-90	Frequency in year 1					Frequency in year 2					Frequency in year 3					Frequency in year 4-5					Frequency in year 5-10			Frequency after year 10				
		0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	0	1	2	0	1	2		
Patient assessment	According to individual patient's needs, depending on postoperative course and adjuvant therapies																												
Stoma care					x				x					x				x					x			No cons.			
Pain					x				x					x				x					No cons.			No cons.			
Sexuality					x				x					x				No cons.			No cons.			No cons.					
Mental health			x					No cons.						x				No cons.			No cons.			No cons.					
Urinary tract infections			x						x					x				No cons.			No cons.			No cons.					
Physical examination																													
General health						x				x				x				x					No cons.			x			
Abdomen						x				x				x				No cons.			No cons.			No cons.			x		
Stoma (if applicable)						x				x				x				x					No cons.			x			
Genital region			No cons.					No cons.					No cons.					No cons.					x			x			
Laboratory tests - blood																													
Creatinine and GFR						x				x				x					x					x			No cons.		
Hemoglobine						x				x								No cons.			No cons.			No cons.					
Sodium and potassium						x				x				x					x								No cons.		
Vit B12, chloride, bicarb, leuko			No cons.					No cons.					No cons.					No cons.					No cons.			x			
Laboratory tests - urine																													
Cytology			No cons.					No cons.					No cons.					No cons.					No cons.			No cons.			
Imaging																													
CT chest-abdomen-pelvis/IVU					x				x				x					x				No cons.			No cons.				
Ultrasound of abdomen		No cons.					x					No cons.					x					x			x				

25. Metastasierte Erkrankung (Teil 1/2)

Recommendations	Strength rating
<i>First-line treatment if eligible for combination therapy</i>	
Use antibody-drug conjugate enfortumab vedotin (EV) in combination with checkpoint inhibitor (CPI) pembrolizumab.	Strong
If contraindications for EV or EV not available: Offer platinum-containing combination chemotherapy (cisplatin or carboplatin plus gemcitabine) followed by maintenance treatment with CPI avelumab in patients with at least stable disease on chemotherapy.	Strong
If contraindications for EV (or EV not available) and cisplatin-eligible: Offer cisplatin/gemcitabine in combination with CPI nivolumab.	Strong
If contraindications for EV and CPI therapy: Use platinum-containing combination chemotherapy (cisplatin or carboplatin plus gemcitabine).	Strong
<i>First-line treatment if not eligible for combination therapy</i>	
Offer single agent CPI pembrolizumab or atezolizumab in case of high programmed death-ligand 1 (PDL-1) expression (for definitions see text).	Weak
<i>Later-line treatment</i>	
<i>After prior EV + CPI</i>	
Offer platinum-containing combination chemotherapy (cisplatin or carboplatin plus gemcitabine).	Weak
If actionable fibroblast growth factor receptor (FGFR) alterations: offer erdafitinib	Strong
Offer single agent chemotherapy (docetaxel, paclitaxel, vinflunine).	Weak
<i>After prior platinum-based chemotherapy +/- CPI</i>	
Offer antibody-drug conjugate enfortumab vedotin.	Strong
If actionable FGFR alterations and prior CPI: offer erdafitinib.	Strong
If no prior CPI: offer pembrolizumab.	Strong
Consider single agent chemotherapy (docetaxel, paclitaxel, vinflunine).	Weak
<i>Further treatment after EV, CPI, platinum-based therapy</i>	
Offer antibody-drug conjugate Trastuzumab deruxtecan in case of human epidermal growth factor receptor (HER) 2 over expression (IHC 3+) and consider in case of HER2 (IHC 2+).	Weak

25. Metastasierte Erkrankung (Teil 2/2)

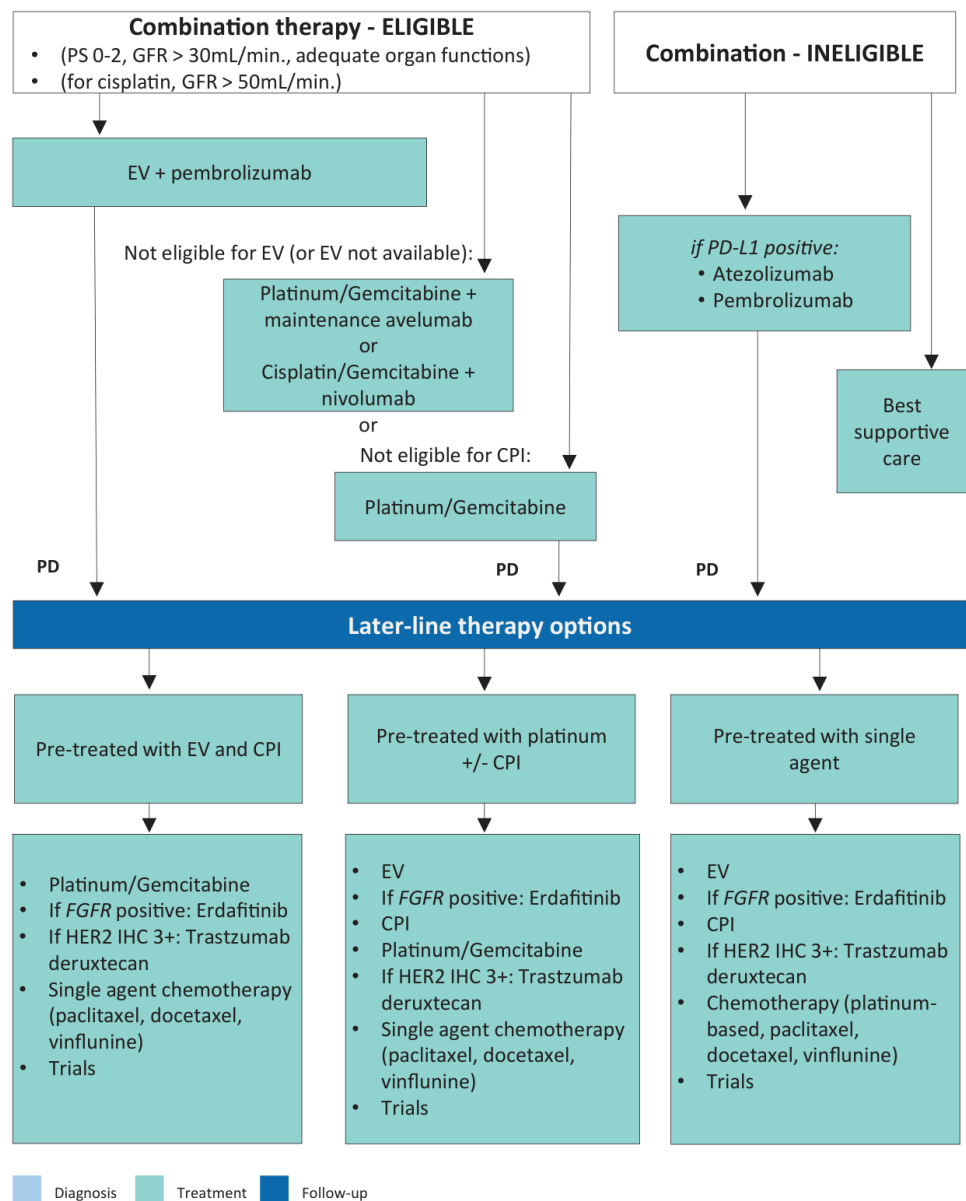
Recommendations	Strength rating
Offer treatment in clinical trials. Consider best supportive care alone if patient is not a candidate for further cancer-specific systemic therapy.	Strong
If actionable <i>FGFR</i> alterations: offer erdafitinib.	Strong

Definition der Platin-Eignung (Table 9.1)

Platinum-eligible		Platinum-ineligible
Cisplatin-eligible	Carboplatin-eligible	
ECOG PS 0-1 <i>and</i>	ECOG PS 2 <i>or</i> GFR 30-60mL/min.	Any of the following:
GFR > 50-60mL/min. <i>and</i>	<i>or</i> not fulfilling other cisplatin-eligibility criteria	GFR < 30mL/min.
Audiometric hearing loss grade < 2 <i>and</i>		ECOG PS > 2
Peripheral neuropathy grade < 2 <i>and</i>		ECOG PS 2 <i>and</i> GFR < 60mL/min.
Cardiac insufficiency NYHA class < III		Comorbidites > Grade 2

ECOG PS = Eastern Cooperative Oncology Group performance status; GFR = glomerular filtration rate; NYHA = New York Heart Association

Abb. 9.2: Management-Algorithmus metastasierte Erkrankung



26. Gesundheitsbezogene Lebensqualität

Recommendations	Strength rating
Use validated questionnaires to assess health-related quality of life in patients with muscle-invasive bladder cancer, both at baseline and post-treatment.	Strong
Discuss the type of urinary diversion considering patient preference, existing comorbidities, tumour variables and coping abilities.	Strong

Gültigkeit	Datum der Aktualisierung	Version	Änderung	Verantwortliche
März 2017 – März 2019	15.08.2017	1.1	Anpassung des Pathways	Prof. Dr. Schultze-Seemann
Juni 2019 – März 2021	26.08.2019	1.2	Anpassung des Pathways	Prof. Dr. Schultze-Seemann
September 2021 – September 2022	05.10.2021	2	Inhaltliche Aktualisierung des Pathways	Prof. Dr. Schultze-Seemann
November 2022 – November 2023	15.11.2022	2	Verlängerung der Gültigkeit	Prof. Dr. Schultze-Seemann
August 2024 - August 2025	26.08.2024	3.0	Anpassung des Pathways	Prof. Dr. C. Jilg
August 2025 - August 2026	05.08.2025	3.1	Anpassung des Pathways	Prof. Dr. C. Jilg
Juli 2026 – Juli 2027	09.08.2026	3.2	Inhaltliche Aktualisierung des Pathways	Prof. Dr. C. Jilg