# INTRODUCTION

Carcinoma of urinary bladder, after prostate cancer, is the most common malignant tumour in the urinary tract. It accounts for 2% of all malignancies ***(Kiemeney et al., 1993).***

In Egypt, the situation is worse as a result of Bilharizasis. It is not only endemic in our country, but also considered to be a historical disease. The uncommon aggressive squamous cell carcinoma is frequently associated with Bilharzial bladder ***(El-Bolkainy et al., 1981).***

As *Jewett* has said "the single most important characteristic of the tumour which influences its curability is the depth of infiltration". The treatment and prognosis of carcinoma of the urinary bladder are largely determined by the depth of tumour infiltration and the extent of metastases ***(Putman et al., 1994).***

Furthermore, the correct evaluation and staging of mural infiltration of bladder carcinoma is fundamentally important for the planning of optimal surgical or chemoradiotherapeutic treatment, establishing prognosis and assessing the results of therapy ***(Caterino et al, 2001).***

The traditional staging methods include clinical examination, intravenous urography, cystoscopy and biopsy. Cystography, lymphangiography and arteriography may play a role. The recent modalities are (transabdominal, transrectal, transvaginal) ultrasound; computed tomography and magnetic resonance imaging have the accurate answer for staging of urinary bladder carcinoma ***(Outwater et al., 1994).***

CT is often routinely obtained for bladder cancer staging at most academic urological centers. CT has been used to help assess key factors in the staging of invasive bladder carcinoma, including depth of tumour invasion into the bladder wall, extent of extravasical tumour spread, pelvic lymphadenopathy indicating nodal metastases and distant organ metastases ***(Michael et al, 2000).***