AUTHOR'S REPLY

Reply to: Babjuk M. Optimized management in patients with bladder cancer. Cent European J Urol. 2015; 68: 15-16.

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Although bladder tumors can be considered as a common disease by any experienced urologist, their management remains a challenge for anyone trying to take into account every new study or additional data which continually brings significant changes.

Our study was focused on evaluating the delay between the last TURBT and radical cystectomy (RC) in several countries, even though some of the causes of this sometime long delay were not entirely analyzed [1]. It is, however, obvious that there is no standardized approach to the surgical treatment of bladder cancer, probably due to many conflicting data on different therapies. Our original paper was born from the idea that a shorter time between endoscopy and radical surgery is beneficial for the patient and so we decided to get real life data on how this aspect was managed in our countries. There seems to be a consensus that a 3 months interval remains safe for performing a cystectomy, but even this parameter is challenged by some authors [2].

There are many reasons leading to this delay, some of them being beyond the borders of medical science, and so we will not comment on those. But considering some medical reasons that might induce a delay, two major situations appear to be more frequent.

The first aspect is the neoadjuvant chemotherapy, recommended by the guidelines as an option, regardless of the stage or other features of the tumor. There are many ongoing studies trying to revolutionize the treatment of bladder cancer by imposing a neoadjuvant chemotherapy as a mandatory step before radical surgery [3], but such evidence needs a long period of time to mature and so we speculate that we are not going to see any significant changes in the guidelines for the near future. On the other hand, many patients are currently undergoing neoadjuvant treatment, either in clinical trials or as part of the standard of care in some centers [4]. Since the real benefit of this approach remains unknown, we might raise the question if the delay it induces has a clinical benefit or not. Prof. Babjuk is taking the step to personalized medicine by postulating that we need to get a deeper understanding of the tumor before deciding which patients are really going to benefit from one particular treatment compared to the other [2]. Until then, we can only witness the evolution of this treatment in the armamentarium of the modern urologist and make personal decisions based on our understanding of the disease.

Another potential factor for delaying the radical cystectomy is the noninvasive character of the initial tumor. This is another field where data is scarce and the decisions are most frequently based on expert opinion rather than clinical evidence [5]. There are centers which will not perform a radical cystectomy in a NMIBC patient regardless of his evolution, although there is some data suggesting that high grade T1 tumors are very prone to progression. Tumor understaging is also a potential factor for delays related to the noninvasive character [6].

Until more data becomes available on the several aspects of the treatment of patients with bladder cancer, we will have to rely on our experience for making the best decision in each particular case and to support the medical community by sharing this experience with our peers.

References

1. Poletajew S, Braticevici B, Brisuda A, Cauni V, Grygorenko V, Lesnyak M-Z, et al. Timing of radical cystectomy in Central Europe – multicenter study on factors influencing the time from diagnosis to radical treatment of bladder cancer patients. Cent European J Urol doi: 10.5173/ceju.2014.444 [Epub ahead of print]
2. Babjuk M. Optimized management in patients with bladder cancer. Cent European J Urol doi: 10.5173/ceju.2014.e93 [Epub ahead of print]
3. Vashistha V, Quinn DI, Dorff TB, Daneshmand S. Current and recent clinical trials for perioperative systemic therapy for muscle invasive bladder cancer: a systematic review. BMC Cancer. 2014; 14: 966.
4. Booth CM, Siemens DR, Peng Y, Tannock IF, Mackillop WJ. Delivery of perioperative chemotherapy for bladder cancer in routine clinical practice. Ann Oncol. 2014; 25: 1783-1788
5. Zehnder P, Thalmann GN. Timing and outcomes for radical cystectomy in nonmuscle in-vasive bladder cancer. Curr Opin Urol. 2013; 23: 423-428.
6. Poletajew S, Fus Ł, Walędziak M, Pomada P, Ciechańska J, Wasiutyński A, et al. Comparison of pathological staging and grading of urothelial bladder carcinoma in post-transurethral resection and post-radical cystectomy specimens. Pol J Pathol. 2014; 65: 305-312.

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