Editorial comment referring to the paper: Kaynar M, Gul M, Kucur M, Çelik E, Bugday S, Goktas S. Necessity of routine histopathologic evaluation subsequent to bladder neck contracture resection. Cent European J Urol. 2016; 69: 353-357.

Histopathological evaluation is still useful after bladder neck resection

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The idea behind this paper [1] is novel and daring. Firstly, there are no previous papers looking into the actual necessity of pathological examination after removing a part of the urinary tract. And secondly, there are many possible implications after changing something that is widely considered as elementary and routine.

The conclusion that might be drawn from this paper is that if you are only looking for cancer, this might not be the best approach. But, since this type of surgery is done to relieve bladder outlet obstruction, you will most likely get a good clinical result regardless of the nature of the resected tissue. This would make a good argument for modern procedures like laser or plasma vaporization, when a biopsy would increase the total cost not only because of the pathological examination but also because of the extra time and the extra loop which is needed. But even in this field there are many voices saying that a preoperative biopsy might save a lot of trouble in the long run and, by that, be more than recommended. This will probably remain a hot topic for a while, with many good arguments from both sides [2].

The macroscopic aspect of the tissue in the area of interest might also provide a clue as to whether there is something suspect or just plain fibrosis. But the subjective opinion of the urologist might not be enough in the case of his decision being challenged at a later time and no hard evidence is available [3].

The most important argument of the authors for not doing a biopsy is the cost of the pathological examination. In their study, they had only two patients confirmed with prostate cancer out of a total of 340 patients. More than this, those two patients were known to have prostate cancer before the resection. For the rest of the group, the pathological examination diagnosed BPH or inflammation of the prostate or the bladder. The authors consider that the cost of diagnosing two cases of cancer is equivalent with the cost of 340 pathological examinations, and, if we are only looking for cancer, they are perfectly right. We consider that having an accurate diagnosis, whether it is cancer or not, is an important part of the systematic and professional approach towards every patient. Coming back to costs, this aspect is certainly very different from one county to another, and may be different from one clinic to another in the same country. But, generally, the cost of a pathological examination is not something that will dramatically increase the total cost of a procedure. Looking into the actual figures provided by the authors, we consider that a total price of 20 USD is not a significant burden for the healthcare system, considering not only the potential benefits of a clear diagnosis but also the consistency of the information offered to the patient [4].

Another argument discussed by the authors of this paper is that waiting for the pathology results represents a significant burden for the patient. While this is absolutely true and easy to understand, the solution to this problem might not be as simple. Just throwing away the tissue we removed will not remove the patient's anxiety as well. Even if the odds of diagnosing cancer after such a procedure are very remote, we must keep this possibility in mind in order to deal with the patient's anxiety. And having a result, whichever that might be, would help more in this direction than simply informing the patient that a pathological examination is not required because it will increase the cost while the chances of changing the treatment are very low. In the end, giving the patient a clear diagnosis will definitely be worth the wait. One solution to reduce this burden for the patient would be to improve the time from surgery to the biopsy results, which can take up to two months as data in the literature suggests [5].

The authors nuance their conclusion by stating that the option of not doing a biopsy or not sending

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the resected samples to the pathologist is ultimately a decision that should be made by the urologist who does the surgery. At the same time the paper fails to produce clear criteria, based on solid evidence, on the situations when a biopsy is mandatory and when it can be skipped. There is mention of T3 and T4 prostate cancer or bladder tumors, but, considering the progressive nature of prostate cancer, even a lower stage of a previously diagnosed cancer might require attention.

Last but not least, throwing away human tissue after a surgical procedure might have legal implications, because, as stated even by the authors, health care policies or laws impose a pathological evaluation. The paper suggests that taking informed consent from the patient will be enough to overcome this regulation, but, as a personal opinion, I consider such an approach as unethical. Since the patient does not have any medical education, passing the responsibility of your decisions to him seems unprofessional, if not illegal. The signed informed consent has no legal power, if the procedure is regulated otherwise by the authorities or a governing body. Even a written request from the patient should not sway the doctor to break the law [6].

What might be presented as a step forward in the optimization of healthcare is in fact a step backward, leaving the patient with a diagnosis obtained by statistical methods instead of a personalized one and the urologist with less arguments to support his decisions in front of the patient and even in the court of law, should it become necessary. And, since the patient is either insured or paying for healthcare out of his pocket, the price of the pathological examination should not lead to a suboptimal standard of care.

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