

Results: Thanks to progress in anaesthesia, intensive care and surgery, cystectomy now forms part of the classical treatments for bladder cancer in elderly patients, with acceptable mortality and morbidity rates. The recent series of cystectomies performed in patients over 75 years old report a mortality rate associated with the procedure of less than 4.5%. The global mortality rate in the same population ranges from 10 to 50%. These rates are now similar to those reported in the general population. The mean survival after cystectomy in patients over 75 years old is more than 2 years. Global survival at 5 years is between 37 and 68%. It is acknowledged by most authors that resection alone is associated with higher relapse and progression rates than cystectomy.

Conclusions: Cystectomy appears to be reasonable in elderly people who have a life expectancy of more than 2 years, provided that a rigorous pre-operative assessment and anaesthetic management are performed. Transurethral resection alone should be proposed only to patients with poor health status and/or very advanced age.

Editorial Comment

The subject of this paper-whether radical cystectomy for muscle-invasive bladder cancer is justified in older patients-has been addressed by several authors in recent years. When dealing with this question, first of all the term “elderly” or “old” has to be defined. In this paper, elderly patients were those beyond 75 years, other authors included only patients older than 80 years. However, even if a clear definition is made we still have to question if every 75 or 80 year old can be compared based on his year of birth. In the clinical setting, the biological age is of much greater importance. Consciously or unconsciously, we tend to select patients who we assume are fit for such a procedure. If we make the wrong assumption and some surgeons are probably better than others, patients will have a larger chance of complications. This makes it difficult to compare different studies as long as we do not have better ways to define the biological age and not the actual age.

Another important aspect in this patient group is not only whether the patient survives the surgical procedure but also whether he lives long enough to benefit from an oncological aspect, that is to say “would he have lived long enough to die really from bladder cancer”. And how does an increase of live expectancy of a few years weigh against an incontinent urinary diversion. We should consider cystectomy for localized bladder cancer in patients of advanced age, but the oncological benefit and quality of life in these patients must be put into strong consideration.

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UROLOGICAL ONCOLOGY

Simultaneous transurethral resection of bladder tumor and benign prostatic hyperplasia: hazardous or a safe timesaver?

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Purpose: We evaluated the effect of simultaneous transurethral resection of bladder tumor (TURBT) and benign prostatic hyperplasia (TURP) on recurrences at the bladder neck and prostatic urethra.

Materials and Methods: During the 10-year study period 51 patients fulfilled the entry criteria of past simultaneous TURBT and TURP, histologically confirmed transitional cell carcinoma of the bladder and benign prostatic hyperplasia, a preserved bladder and a minimal followup of 12 months. Their records were analyzed retrospectively. Patients were divided into 28 with single (group 1) and 23 with multiple (group 2) bladder tumors.

Results: During the 12 to 120 months of followup (mean 37.3) the average tumor recurrence rate was 68.6%, that is 53.6% in group 1 and 86.9% in group 2. Recurrences appeared within an average of 14.9 months, that is within 18 (range 4 to 36) in group 1 and 13.5 (range 3 to 36) in group 2. Tumor recurrence was at the bladder neck and/or prostatic urethra in 11 of the 51 cases (21.5%). Average time to recurrence at the prostatic fossa was 23.8 months, that is 27 (range 13 to 46) in group 1 and 21.6 (range 4 to 60) in group 2. Only 1 patient had a single recurrence in the prostatic fossa, while the others also had synchronous and metachronous recurrences at other bladder sites. Tumor progression to invasiveness was diagnosed in 3 of the 51 patients (5.9%).

Conclusions: Our data indicate that simultaneous TURBT and TURP do not negatively affect tumor recurrence at the bladder neck and prostatic urethra.

Editorial Comment

Implantation of bladder tumor cells is an interesting topic and base of renewed interest of the scientific community. Here, the authors tried to answer clinically if implantation occurs predominant at resection sites, such as the prostatic urethra after TUR of the prostate. Their data do not support the hypothesis of predominant implantation in the previously resected area. On the other hands, the biological facts of implantation are by far more complex than the clinical situation analyzed. Implantation occurs on areas coated e.g. with fibronectin, an intermediate matrix protein. Simplified, this protein is shed by bleeding and attaches on the bladder surface, not only on traumatized surfaces. Therefore, during and after resection of the prostate, large areas of the bladder are covered with this protein, representing an ideal surface for bladder tumor implantation. The recurrence rate in their analysis is very high. Given the fact that intermediate risk tumors are resected, the authors have an average recurrence rate of around 70% within a follow up of slightly more than 3 years, and even 87% in group 2. This recurrence rate seems very impressive and rather supports the notion that simultaneous transurethral resection of the prostate should not be performed because of the higher probability of an overall tumor cell implantation. This statement, however, needs to be scientifically proven.

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FEMALE UROLOGY

Stress incontinence surgery for patients presenting with mixed incontinence and a normal cystometrogram

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