downstaged to lower than T1G3. Within a median follow-up of 48 mo, 35.5% of patients died of metastatic UCB.
Conclusions: Approximately half of the patients treated with RC without neoadjuvant chemotherapy for clinical T1G3 UCB are upstaged to muscle-invasive UCB. These rates support the inadequacy of clinical decision making based on current treatment paradigms and staging tools. Therefore, identification of patients with clinical T1G3 disease at high risk of disease progression is of the utmost importance, as these patients are likely to benefit from early RC.

Editorial Comment

The optimal primary treatment of stage and grade T1G3 bladder cancer, radical or conservative, is a matter of debate since years. Here, 12 international centers with a large experience in radical cystectomies present their data on this aggressive "borderline" tumor. They found a high rate of nearly 50% of tumor upstaging to muscle invasive disease.

Alas, this study suffers from several drawbacks. No indication on previous intravesical therapy, or on the time between first diagnosis of bladder cancer and cystectomy are given. These data would have made it much easier to judge on the delay as reason for the high rate of upstaging and to get information on the proportion of "true aggressive" T1G3 tumors which would indeed need immediate cystectomy without an initial trial of TUR, re-TUR and BCG.

All in all, these data reflect the aggressive nature of T1G3 bladder cancer and the need for stringent management, be it conservative or radical.

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Should all patients with non-muscle-invasive bladder cancer receive early intravesical chemotherapy after transurethral resection? The results of a prospective randomised multicentre study

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Background: To decrease recurrences in non-muscle-invasive bladder cancer (NMIBC), the European Association of Urology (EAU) guidelines recommend immediate, intravesical chemotherapy after transurethral resection (TUR) for all patients with Ta/T1 tumours.
Objective: To study the benefits of a single, early, intravesical instillation of epirubicin after TUR in patients with low- to intermediate-risk NMIBC.
Design, Setting, and Participants: In this prospective randomised multicentre trial, 305 patients with primary as well as recurrent low- to intermediate-risk (Ta/T1, G1/G2) tumours were enrolled between 1997 and 2004. Patients were randomly allocated to receive 80 mg of epirubicin in 50 ml of saline intravesically within 24 h of TUR or no further treatment after TUR.
Measurements: The primary end point was time to first recurrence.

Results and Limitations: A total of 219 patients remained for analysis after exclusions. The median follow-up time was 3.9 yr. During the study period, 62% (63 of 102) of the patients in the epirubicin group and 77% (90 of 117) in the control group experienced recurrence (p=0.016). In a multivariate model, the hazard ratio (HR) for recurrence was 0.56 (p=0.002) for early instillation of epirubicin versus no treatment. In a subgroup analysis, the treatment had a profound recurrence-reducing effect on patients with primary, solitary tumours, whereas it provided no benefits in patients with recurrent or multiple tumours. Furthermore, patients with a modified European Organisation for Research and Treatment of Cancer (EORTC) risk score of 0-2 with and without single instillation had recurrence rates of 41% and 69%, respectively (p=0.003), whereas the corresponding rates for those with a risk score of > or = 3 were 81% and 85%, respectively (p=0.35).
Conclusions: A single, early instillation of epirubicin after TUR for NMIBC reduces the likelihood of tumour recurrence; however, the benefit seems to be minimal in patients at intermediate or high risk of recurrence. Future trials will determine the value of early instillation in addition to serial instillations in NMIBC.

Editorial Comment

Bladder cancer has a high rate of recurrence. Two pathways are considered responsible for this behavior, namely genetically instable urothelium resulting in truly new tumor formation, and re-implantation (seeding) of tumor cells resulting in new occurrences from the previous tumor. The best way to date to interfere with the second pathway, seeding of tumor cells, is immediate post-TUR single shot instillation of cytotoxic drugs. However, is this sufficient therapy for all tumors? The authors answer this important question in their randomized study. First, they show that single-shot instillation (in this study given within 24 hours, but best within 6 hours after TUR) indeed is highly effective, resulting in a significant overall reduction of recurrences. This effect was pronounced in the low risk group with single primary tumors, whereas barely evident in the intermediate risk group or that with multiple tumors. The numbers needed to treat (NNT) was 3.5, which supports similar figures from previous calculations.

The authors state correctly that single-shot treatment has little or no impact on genetically instable urothelium. Therefore, next to singe – shot instillation therapy, all intermediate to high-risk group patients with bladder cancer deserve more instillation therapy, be it regular courses of cytostatics or BCG.

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NEUROLOGY & FEMALE UROLOGY

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Regular moderate intake of red wine is linked to a better women's sexual health

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Introduction: While some evidence does exist for a positive correlation between moderate wine intake and men's sexual health, there is no study addressing the potential correlation between red wine intake and women's sexual function.