

Conclusions: Explanation of the etiology of the upper caliceal stone by the anatomic features is very difficult, and these caliceal anatomic variables (IPA, IL, IW) seem not to be a significant risk factor for stone formation in the upper calyx.

Editorial Comment

The study is interesting and demonstrated that there is any statistically significant difference between the stone-bearing and the normal kidneys of patients with upper caliceal stones and healthy individuals in terms of infundibulopelvic angle (IPA), infundibular length (IL) and width (IW) of upper caliceal system. Previous anatomical findings on pelvicaliceal features are well presented and discussed.

The mean pelvicaliceal volume of 42 stone-bearing was $2455,2 \pm 1380,2$ mm³ and contralateral kidneys was $2114 \pm 2081,5$, with no statistical difference between stone-bearing and contralateral normal kidneys ($p=0,34$). When comparing to bilateral kidneys of healthy individuals not bearing stones the difference was significant. Nevertheless, as the authors stated, these finding must be viewed with caution.

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UROLOGICAL ONCOLOGY

Is A Second Transurethral Resection Necessary For Newly Diagnosed Pt1 Bladder Cancer?

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Purpose: We evaluated the potential benefit of a second transurethral resection in patients with newly diagnosed pT1 transitional cell carcinoma of the bladder.

Materials and Methods: Between January 2001 and May 2003, 80 patients with stage T1 bladder cancer were included in this protocol in which all patients prospectively received second TUR within 2 to 6 weeks following the initial resection. Patients with incomplete resections were excluded from study. The pathological findings of the second TUR were reviewed.

Results: Of the 80 patients who underwent second resection, 18 (22.5%) had macroscopic tumors before resection. However, with the addition of microscopic tumors, overall residual disease was determined in 27 (33.8%) patients. Of the 27 patients 7 had pTa, 14 had pT1, 3 had pT1+pTis and 3 had pT2 disease. Residual cancers were detected in 5.8%, 38.2% and 62.5% in G1, G2 and G3 tumors, respectively. The risk of residual tumor directly correlated with the grade of the initial tumor ($p = 0.009$).

Conclusions: Although second TUR dramatically changed the treatment strategy in a small percentage of cases, we strongly recommend performing second TUR in all cases of primary pT1 disease, especially in high-grade cases.

Editorial Comment

This paper highlights the usefulness of a second transurethral resection in superficial bladder cancer by providing own data and a review of the meanwhile large body of literature evidence.

In their own data the authors found at least 18.8% residual tumor at second TUR with an increasing rate up to 33.8% in large and/or multifocal tumors. In the literature, up to 74% of T1G1-3 tumors had residual disease. A second TUR is highly recommended at least in large tumors and all T1 tumors.

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Guidelines on TaT1 (Non-muscle Invasive) Bladder Cancer

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European Association of Urology
http://www.uroweb.org/files/uploaded_files/guidelines/05%20TaT1%20Bladder%20Cancer.pdf

No abstract available

Editorial Comment

These guideline represent and evolutional development from the “old” EAU bladder cancer guidelines, which were well received worldwide. They incorporate recommendations for such major steps in superficial bladder cancer treatment as postoperative single shot instillation with chemotherapy and maintenance therapy with BCG.

The most important information, which led to these steps forward, came from recently published metaanalyses, which were prepared in close cooperation predominantly from members of the guidelines group.

Specifically, the following changes appear as of highest importance and are commented below. Guidelines for superficial and invasive bladder cancer are generated from different groups and are distinct.

Use of histological classification - However, until the 2004 WHO classification has been validated by more clinical trials, tumors should be graded according to both the 1973 and the 2003 WHO classification.

Fluorescence cystoscopy - This investigational method has not yet been implemented on a regular basis in daily practice.

Second resection is recommended in most intermediate and all high-risk tumors.

Single-shot postoperative instillation of chemotherapy is strongly recommended.

Intravesical BCG is superior to intravesical chemotherapy in reducing recurrences and is the only drug to interfere with progression of SBC. BCG immunotherapy is indicated in intermediate risk and high-risk bladder cancer. The use of maintenance therapy of at least 1 year is strongly recommended.

An algorithm for predicting tumor recurrence and progression is extensively provided in these guidelines.

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