

is made more difficult by prior radiotherapy. Another difference between the two groups is that the post-radical prostatectomy patients were primarily managed by the authors whereas in post-radiation patients were referred for management after a failed period of conservative management.

In the radical prostatectomy series by Thomas et al., nearly half of the fistulas closed spontaneously, a few even without a colostomy. Importantly, the authors note that the absence of fecaluria was a good indicator of a fistula that would close spontaneously: 4 of 8 closed spontaneously in the absence of fecaluria (3 without a colostomy) but only 1 of 5 with fecaluria. Spontaneous closure occurred after 1-3 months of urethral catheterization. All fistula repairs were accomplished transperineally.

The radiation series is quite different. No fistulas closed spontaneously. Fistulas were much larger, ranging in size up to 7 cm. Patients presented with severe problems secondary to the fistula such as sepsis and Fournier's gangrene. Only 6/22 could be repaired with preserved orthotopic fecal and urinary function; the remainder had one or both streams diverted with an ostomy. Perioperative morbidity was likewise much higher in those undergoing fistula repair after radiation.

Rectourethral or rectovesical fistula is a rare but morbid complication of surgery or radiation for prostate cancer. These series highlight the fact that with appropriate expertise good outcomes can be achieved in those who have not been previously radiated however

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UROLOGICAL ONCOLOGY

doi: 10.1590/S1677-553820100002000026

Characteristics and outcomes of patients with clinical T1 grade 3 urothelial carcinoma treated with radical cystectomy: results from an international cohort

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Eur Urol. 2010; 57: 300-9

Background: Management of T1 grade 3 (T1G3) urothelial carcinoma of the bladder (UCB), with its variable behaviour, represents one of the most difficult challenges for urologists and patients alike.

Objective: To evaluate the characteristics and long-term outcome of patients with clinical T1G3 UCB treated with radical cystectomy (RC).

Design, Setting, and Participants: Data from 1136 patients treated with RC for clinical T1G3 UCB without neoadjuvant chemotherapy were collected at 12 centres located in Europe, the United States, and Canada. Median age was 67 yr (range: 29-94), with a male-to-female ratio of 4:1.

Measurements: Patients' characteristics and outcome are evaluated.

Results and Limitations: Of the 1136 patients, 33.4% had non-organ-confined stage at cystectomy, and 16.2% had lymph node (LN) metastasis; 49.7% were upstaged after RC to muscle-invasive disease, while 21.4% were

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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doi: 10.1590/S1677-553820100002000027

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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Eur Urol. 2009; 55: 773-80

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.