

Round up

DELAY IN RADICAL PROSTATECTOMY IS NOT ASSOCIATED WITH ADVERSE ONCOLOGICAL OUTCOMES

This was a retrospective review of 128,062 men with intermediate- and high-risk prostate cancers from 2010 to 2016, in the National Cancer Database in the USA, wherein patients were divided into two groups; those who had immediate radical prostatectomy within 3 months of diagnosis and patients who had delayed radical prostatectomy defined as in 3-month intervals up to 12 months. Multivariable logistic regression comparison analysis was done for adverse pathology, upgrading on radical prostatectomy, node-positive disease, and postradical prostatectomy secondary treatments. There was no significant difference in adverse pathology, upgrading, node-positive disease, or postradical prostatectomy secondary treatments. Subgroup analysis of men with Grade Group 4 and 5 prostate cancer did not show any association between delayed radical prostatectomy and poorer oncologic outcomes.^[1]

Diamand *et al.* analyzed a European cohort of 926 men undergoing radical prostatectomy for intermediate- and high-risk prostate cancers between 2012 and 2019. The median time between diagnosis and surgery was 3 months. The final pathology, lymph node invasion, need for adjuvant therapy, and biochemical recurrence were analyzed. There was no association between surgical delay and any adverse oncological outcomes.^[2]

These conclusions are likely to be of interest in the current pandemic where prostate cancer surgery may be delayed.

MANAGEMENT OF MICROHEMATURIA

The recently published AUA/SIFU guidelines define microhematuria (MH) as ≥ 3 red blood cells per high-power field on microscopic evaluation of a single urine specimen. The prevalence of MH in healthy volunteers is 2.4%–31.1% with an incidence of genitourinary malignancy in approximately 3% of these cases. A positive urine dipstick test is not sufficient for diagnosis, and microscopic examination is recommended to confirm microscopic hematuria in all cases. In patients with MH, who are on anticoagulants or on antiplatelets, it is best to perform the same evaluation as is indicated in patients who are not on these drugs.

In most studies, the performance of both cystoscopy and imaging occurs in <20% of patients, and there is a reliance on imaging alone. The underuse of cystoscopy can be a matter of concern as the most common underlying malignant pathology is likely to be bladder cancer which is best diagnosed with cystoscopy.

The guidelines classify MH into three groups stratified as low-, intermediate-, or high-risk for genitourinary malignancy. The highest risk category includes age >60 years, smokers with over 30 pack-years, >25 RBC/HPF, and those with a history of gross hematuria. A computed tomography urogram with a cystoscopy is recommended in this group. For the low- and intermediate-risk groups, an USG with cystoscopy may be sufficient. In patients with hematuria attributed to a urinary tract infection, it is recommended to repeat urine analysis after treatment of infection to confirm the resolution of MH. Repeat evaluation is necessary in all those who have gross hematuria after an initial negative hematuria evaluation.^[3]

IS DIRECT VISUAL URETHROTOMY AS GOOD AS URETHROPLASTY IN RECURRENT BULBAR STRICTURES?

Direct visual urethrotomy (DVIU) is often offered by urologists for urethral strictures, even recurrent ones. The OPEN Trial (open urethroplasty versus endoscopic urethrotomy) is an open-label superiority randomized controlled trial (RCT) which was performed in patients with recurrent bulbar urethral strictures and aimed to assess whether DVIU or open urethroplasty was better in providing symptom control and greater duration of benefit before recurrence. It involved 222 men who were randomized to receive either urethroplasty or endoscopic urethrotomy. The success and primary outcome were assessed with a questionnaire with six questions which evaluated voiding symptoms over the next 2 years. It was patient-reported and evaluated symptomatic improvement. The secondary clinical outcomes were difference in reintervention, improvement in urinary of urinary flow rate, and recurrence (reintervention, voiding score regression to baseline, and flow at the preintervention level). At 24 months, the primary outcome (void score) and the patient-reported outcomes (symptoms and satisfaction with sexual function) were similar in both the groups. However, the secondary clinical outcomes of time to reintervention and change in maximal flow rate were better in urethroplasty. In this study, the recurrent strictures evaluated were short segment (1.7 cm for urethrotomy and 2 cm for urethroplasty). Recurrence was seen in 19/108 urethroplasties and in 39/112

urethrotomies, and the reintervention rate was almost twice in number for urethrotomy. The urethroplasty arm was heterogeneous with 16.6% patients undergoing anastomotic and 48.5% having augmentation urethroplasty, respectively. The study did not measure “hard” outcomes using cystoscopy or retrograde urethrogram to measure recurrence.^[4]

The OPEN trial is significant for two reasons (a) it is one of the rare studies where reconstructive surgical procedure was randomized (b) it shows that over the medium term, in a real-world scenario, the symptom improvement is no different between a complex reconstruction and endoscopic management of a short segment urethral stricture, regardless of etiology.

In previous studies involving DVIU, the recurrence rate at 12 months was approximately 40% for strictures shorter than 2 cm, 50% for strictures 2–4 cm, and 80% for those longer than 4 cm with the recurrence rate increasing with increased duration.^[5]

EN BLOC RESECTION OF BLADDER TUMORS: CAN IT BE THE NEW STANDARD?

En bloc resection of bladder tumor (ERBT) is not a new technique. With the advent of bipolar electrodes and lasers, it is acquiring a new-found popularity. The proponents of ERBT feel it improves the quality of histopathological specimen by allowing better assessment of margin status and depth of invasion. Furthermore, the absence of piecemeal resection will result in lesser dissemination of free-floating tumor cells and theoretically less tumor seeding.

A consensus statement on ERBT that incorporates two systematic reviews and two surveys with expert opinions has been published. Only randomized trials have been included 10 RCTs – 1155 patients – 586 ERBT vs. 569 TUR. The data itself are heterogeneous and of poor quality. All outcomes are not reported uniformly. The fact that a 2-round Delphi survey was needed reflects this uncertainty. The aim must be to include deep muscle in the specimen. It can only be recommended for non muscle invasive bladder cancer and is obviously unsuitable for muscle invasive cancer and carcinoma *in situ*. The consensus agreement was that ERBT is best performed in tumor <3 cm, fewer than 4 tumors, preferably not at the dome. No energy source is better (monopolar vs. bipolar vs. holmium laser vs. thulium laser vs. hybrid knife hydrodissection) than the other. The lack of high-quality data means the effectiveness (recurrence) has to be interpreted with caution.

^[6] The results of ongoing RCTs are eagerly awaited.

Standard transurethral resection of bladder tumor is not in accordance with standard oncologic resection i.e. – complete resection with a margin of normal tissue. Yet, it has stood the test of time, and there is no evidence that it leads to

increased recurrence or decreased cancer-specific survival. There is no evidence that EBRT reduces recurrences. It can be technically challenging to do *en bloc* resection in large tumors, multiple tumors, and tumors at difficult locations – posterolateral wall and dome. The jury will remain out on this technique till we get better quality data from multiple centers.

POSTPARTUM VOIDING DYSFUNCTION – RISK FACTORS AND MANAGEMENT

Postpartum urinary retention or postpartum voiding dysfunction (PPVD) is defined as the inability to void within 6 h of delivery or catheter removal or a postvoid residual urine of >150 ml. It has been hypothesized to be due to pregnancy affecting bladder capacity, underactive detrusor contractions with a lack of urethral relaxation, possibly due to elevated progesterone levels causing a reduced tone of the detrusor. Pudendal nerve neuropraxia during vaginal delivery has been also speculated to play a part.^[7] In a large retrospective study, Perú Biurrun *et al.* studied 1894 vaginal deliveries. The prevalence of PPVD was found to be around 10% (73/1894). Severe PPVD (postvoid residual urine of >150 ml, >48 h after birth) was found in 13.7% (10/73) of the cases. Epidural anesthesia, higher birth weight >4 kg, and previous LSCS were found to be independent risk factors. It was also more frequent in pregnancies that were postterm, in primiparous women, in those assisted by gynecologists versus midwives (possible selection bias), and after episiotomy.^[8] In contrast, in a previous Indian study, the prior mode of delivery was not found to be a risk factor.^[9]

PPVD is best managed with clean intermittent catheterization till recovery of bladder function. Counseling is warranted in high-risk groups about the possibility of this distressing condition.

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