

Editorial comment to: Grzególkowski P, Kaczmarek K, Lemiński A, Soczawa M, Gołąb A, Słojewski M. Assessment of the infiltrative character of bladder cancer at the time of transurethral resection: a single center study. *Cent European J Urol.* 2017; 70: 22-26.

Endoscopic appearance of a tumor can predict the stage of bladder cancer

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Timing of radical cystectomy influences patients' survival, however, the surgery in Central Europe is very often unnecessarily delayed in every fourth case [1]. Moreover, five-year postoperative survival in this region does not exceed 32% and definitively needs improvement [2]. Prediction of the stage of bladder cancer at the time of primary transurethral resection of the tumor (TUR) can potentially accelerate radical treatment in patients with muscle-invasive bladder cancer (MIBC). This allows early qualification for neoadjuvant chemotherapy and proper preparation for cystectomy, especially lifestyle changes, and nutritional and educational interventions.

Grzególkowski et al. presented results of clinical staging of bladder cancer in a series of 272 patients. Based on ultrasonography, endoscopy and physical examination they noticed accurate clinical staging in as many as 88% of cases [3]. We congratulate the authors on their fantastic work and excellent results. Simultaneously, we believe that there are two important issues that deserve discussion at this point.

First, it should be highlighted that the authors presented clinical data from an experienced, high volume bladder cancer center. Even taking into account that residents were included in the study, it should be debated whether these results can be representative and are feasible to obtain in an average urological department. To the best of our knowledge, the impact of urologist experience on the accuracy of bladder cancer stage prediction has never been

tested. However, keeping in mind differences in oncological results of TUR between urologists, we can assume that surgical experience plays an important role also in the proper interpretation of the cystoscopic image [4].

Second, as the study proved high accuracy in clinical staging of non-muscle-invasive bladder cancer, conclusions regarding diagnosis of MIBC based only on 25 cases are rather debatable. The problem of a low number of patients with MIBC can potentially lead to underpowered results, especially when the rate of both positive bimanual examination and presence of hydronephrosis was marginal, suggesting negative selection of patients. Nevertheless, Skrzypczyk et al., based on endoscopic appearance of the tumour, noticed an 18% rate of clinical upstaging to MIBC. Moreover, in the same paper they pointed out that in 73% of cases, the urologist can properly distinguish between Ta and T1 lesions [5]. It is also worthwhile to mention that there is a growing number of endoscopic tools for staging of bladder cancer at the time of TUR, such as optical coherence tomography or confocal laser endomicroscopy [6].

Despite the points mentioned above, we are impressed by the study Grzególkowski et al. have published. We fully agree with the authors that clinical evaluation of the tumor at the time of TUR is mandatory and can be useful in advanced planning of further treatment.

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