

## AUTHOR'S REPLY

**Reply to:** Poletajew S, Radziszewski P. Endoscopic appearance of a tumor can predict the stage of bladder cancer. Cent European J Urol. 2017; 70: 27-28.

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In the beginning we would like to thank the authors for their valuable and meaningful editorial comment to our article. In our publication we have presented results of clinical staging of bladder cancer in a high-volume bladder cancer urological center [1]. This was the main reason for the authors to suggest that these outcomes may not be representative of the average urological department [2]. In our opinion it is of utmost importance for the more experienced centers to analyze valuable information from their expertise and share it with the community. This is especially true for bladder cancer, which remains one of the most burning problems of modern urology. High-volume centers with well-established clinical and pathological protocols must provide robust data regarding the management of bladder cancer. We would like to also emphasize that the quality of transurethral resection of the primary tumor is a vital factor influencing cancer recurrence [3]. In our study cohort, a small number of patients did not meet the inclusion criteria, due to substandard resection quality. This high quality of resection is usually achieved with years of training in high-volume centers. Nevertheless, transurethral resection of bladder tumor (TURBT) remains one of the most frequently performed surgeries in urology centers, and a decent case load may also be achieved in an average urology department. This, together with equipment improvements, and the training opportunities provided within the Polish and European Urological Associations, shall improve the quality of TURBT across Poland.

We are aware that a low number of patients with muscle-invasive bladder cancer (MIBC) are the limiting factor of our study (25 cases). However, we would like to emphasize that we included only cases in which radical TURBT was attempted. Patients with obvious muscle invasion and bulky tumors, in whom only a partial resection was performed, were excluded. Taking the above into consideration, the total accuracy of prediction of MIBC can be even higher. Inclusion and exclusion criteria allowed us to compare clinical staging with pathological reports and estimate the value of clinical staging in uncertain cases.

In the future we need to consider the utilization of newer bladder tumor resection techniques such as fluorescent cystoscopy and/or narrow band imaging to detect non-visible cancer foci and further improve the quality of TURBT [4]. Also there is definitely an urgent need for reliable genetic or molecular markers that can detect bladder cancer and predict the clinical characteristics of tumors [5].

There are no doubts that our study has several limitations. However, we strongly believe that clinical assessment of the tumor remains indispensable, as it is able to accurately predict the tumor stage in a majority of cases, and thus accelerate clinical decision making and treatment initiation. Clinicians should continuously refine their skills in endoscopic tumor assessment and TURBT in order to maximize and maintain the high quality and reproducibility of their work.

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