AUTHOR'S REPLY

Reply to: Schewentner C. Sparing radical cystectomy – How much is enough? Cent European J Urol. 2015; 68: 146.

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We are thankful for the elaborate editorial comment. In the present study, we enrolled 13 young female patients with urothelial carcinoma (UC) of the bladder; 9 patients had muscle invasive cancer of T2-T3 and 5 women non-muscle invasive disease of T1 urothelial tumor that was recurrent, of high grade, and failed BCG therapy. These 13 patients did not have Bilharziasis-associated carcinoma of the bladder as the editorial comment had pointed to. In our study, we differentiate between bilharzial and non-bilharzial bladder cancer by examination of tissue biopsy and cystectomy specimens by standard histopathology for detection of bilharzial lesions and precise detection of schistosomal antigen expression in tissue by immunohisto-chemistry according to Wishahi et al. [1]. This cohort of patients did not have schistosomal associated bladder cancer as was proven by absent schistosomal lesions and negative schistosomal antigen expression in tissues. Early intervention with cystectomy in our series is in accordance with other studies, which stated that early intervention with cystectomy in T1 UC that failed BCG therapy provided better survival compared to delayed cystectomy [2]. Good oncological and functional results in our series are attributed to early intervention. Early cystectomy for T1-tumour with orthotopic urinary diversion offers the best possible functional results with high continence and maintains sexual function due to preservation of neurovascular bundles and vaginal walls [3].

In our series, the women were young, with an age range of 20-26 in four women, 32-37 in three women, and 42-54 in six women; they had a long survival rate, none got pregnant after the procedure, which could possibly be due to factors not related to genital sparing cystectomy.

There are reports of pregnancy following cystectomy with preservation of the uterus and appendages. Two women became pregnant following this surgical intervention and had a healthy child following an uncomplicated vaginal delivery. There is a risk for complications in such pregnancies and supervision should be carried out by both a gynecologist and an urologist [4].

Hypercontinence was recorded in three women in our series. These women had been trained in applying CIC and were satisfied with being continent which provided a satisfactory body image and social integration. The low incidence of hypercontinence in our series is due to preservation of neurovascular bundles, lateral and anterior walls of the vagina, avoidance of surgical trauma to the urethra-vaginal-junction, fixation of the uterus to the sacrum promontory, and anchoring the lateral horns of the neobladder to the psoas fascia to prevent anterior angulation of the neobladder-urethral segment. In another study, the incidence of hypercontinence was reported to be 31% of women, which was associated with age >65 years at the time of surgery ($p < 0.001$). Hypercontinence was not associated with any variable [5]. Our study provides long term follow-up data showing that, if patients are properly selected, genital sparing radical cystectomy with ileal neobladder reconstruction provides long-term survival, maintains health-related quality of life, preserves sexual life and, in young women, the possibility of getting pregnant.

## References

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