

Correspondence

Comment on: Surgical and oncological outcome after laparoscopic versus open nephroureterectomy for non-metastatic, upper-tract urothelial carcinoma. *A single-centre experience*

To the Editor

Alothman et al¹ presented their center's experience with UTUC in a well-written interesting article. The authors compared the outcomes of the open and laparoscopic nephroureterectomy techniques in management of UTUC. Among many recently published articles,^{2,3} the article addressed debatable issues of UTUC including the surgical and oncological outcomes and metachronous bladder cancer recurrence. In spite of the relatively small size sample, the authors went thoroughly in analysis of the related variables. Vigilantly, they included this issue in the limitations section. However, there are a few unclear notions that may warrant further explanation.

Upper tract urothelial carcinoma (UTUC) is a rare urological malignancy. However, volume of the literature of this tumor has rapidly been grown up during the last decades. On the other hand, retrospective studying is the most convenient methodology for building up the evidence-based guidelines of UTUC.²

Although the authors confidently reported in the sections of Results and Discussion that the intra- and perioperative variables including blood loss, operative time, and hospital stay were significantly in favor of laparoscopic nephroureterectomy, the values in Table 2 referred to the opposite for the 2 latter variables. It is not clear whether this confusion resulted from just incorrect orientation of the values in the corresponding columns of each technique in this table.

In spite of exclusion of the patients who had positive lymph nodes and metastasis at diagnosis according to the exclusion criteria, tumor stage T4 and nodal stages $\geq N1$ were included in the statistical analysis.² According to the tumor, node, and metastasis (TNM) system, stage T4 means invasion of the tumor into the adjacent organs or structures. In the case of the pelvicalyceal carcinoma, extension beyond the renal parenchyma into the perinephric fascia and fats is also classified as T4. Tumor stage and grade, lymph nodes involvement ($\geq N1$), and muscular invasion are powerful predictors

of prognosis and survival rates.⁴ It is unclear whether this issue was a result of re-staging according to the postoperative findings. However, in case of preoperative inclusion of these cases, further reasoning is warranted.

The following sentence was mentioned in the section of Discussion: "3 of 4 patients developed recurrence in the ureterectomy stump, which was managed with bladder cuff excision later."² However, the number of "4 patients" in this sentence is confusing and it is not clear whether the authors referred to the 5 patients with remaining ureteral stumps. Also, occurrence of tumors in these stumps should not be reasoned by non-excision of a bladder cuff like what it was reported in the results. Excision of a bladder cuff is mainly a prophylaxis against the intra-vesical or metachronous recurrence of the carcinoma (in the peri-ureteral orifice area of the urinary bladder) rather than against missed or metachronous ureteral stump carcinoma. In other words, non-excision of the whole ureteral stump and the excision of the ureteral stump without a bladder cuff during nephroureterectomy are 2 different technical points and should be differentiated in relation to the expected sequels of their negligence. The reasons should be justified to avoid the life-threatening risks.

Rabea A. Gadelkareem

Assiut Urology and Nephrology Hospital

Faculty of Medicine

Assiut University

Assiut, Egypt

ORCID ID: <https://orcid.org/0000-0003-4403-2859>

Reply from the Author

Thank you very much Dr. Gadelkareem for your review. Although there are many studies publishing in various journals now a day but upper tract TCC is not so common all over the world like bladder cancer. Similarly, our center is main oncology referral center all over the kingdom, we have only 50 cases in 16 years.

We admit that there are some clerical mistakes which highlighted by our respected reviewer in result and discussion section which were overlooked. In Table 2, value of blood loss is normal but values of operative time and hospital stay are not correct. Regarding lymph nodes, positive lymph nodes were found on postoperative histopathology. We did not include patients who had preoperative positive lymph nodes or metastatic disease on imaging. Similarly, 3 of 5 not 4 patients developed recurrences in the ureterectomy

stumps, which was managed with bladder cuff excision later as mentioned in discussion section.

In comments regarding bladder cuff excision, we have 5 cases in which simple nephroureterectomies were carried out and bladder cuffs were not taken due to small volume upper tract TCC and uncertain diagnosis on imaging. Three of these cases developed recurrence in those small stumps which were seen on surveillance cystoscopies. Therefore, stumps were removed and bladder cuffs were excised on follow up. These were early cases before 2010 when it was not routine and mandatory to excise bladder cuff.

Khalid I. Alothman

Department of Urology

King Faisal Specialist Hospital & Research Centre,

Riyadh, Kingdom of Saudi Arabia

ORCID ID: <https://orcid.org/0000-0002-7448-770X>

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