



ONCOLOGY/RECONSTRUCTION
ORIGINAL ARTICLE

The value of extended good quality transurethral resection of bladder tumour in the treatment of the newly diagnosed bladder cancer



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Received 21 July 2016, Received in revised form 28 August 2016, Accepted 10 October 2016
Available online 26 November 2016

KEYWORDS

Bladder cancer;
TURBT;
T1G3

ABBREVIATIONS

CIS, carcinoma *in situ*;
MIBC, muscle-invasive bladder cancer;
NMIBC, non-muscle-invasive bladder cancer;
RC, radical cystectomy;
TURBT, transurethral resection of bladder tumour

Abstract Objective: To report our experience for the initial management of patients with newly diagnosed bladder tumours using our team approach for each case and using an aggressive extended transurethral resection of bladder tumour (TURBT) in order to investigate the real need for a routine 'second-look' cystoscopy in the current era.

Patients and methods: The study included 50 consecutive patients admitted to the urology department, of our tertiary care centre, for management of newly diagnosed bladder cancer. Exclusion criteria included past history of bladder tumour, palpable mass on bimanual examination under anaesthesia, presence of residual tumour at the end of resection, and patients with tumours of the bladder dome as thorough resection is difficult to achieve in this area without an attendant risk. Patients that had pathologically confirmed carcinoma *in situ* were also excluded. White-light cystoscopy was used in all of the cases. Extended TURBT was defined as resection of the whole tumour, resection of the tumour base and 1 cm of apparently normal bladder wall around the circumference of the tumour.

Results: The median (range) age of the patients was 52 (39–60) years. After initial TURBT, 10 patients (20%) were identified as having muscle-invasive bladder cancer. Of the remaining 40 patients, three had low-grade Ta disease, and so second biopsies

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Peer review under responsibility of Arab Association of Urology.



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were not taken. The remaining 37 patients had T1, grade 2–3 disease and none of them had evident residual disease at the site of tumour resection.

Conclusion: Re-staging TURBT could be safely omitted for select groups of patients. An experienced surgeon and teamwork, together with an extended TURBT can accurately achieve complete tumour resection, with accurate tumour staging, on initial resection.

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Introduction

Transurethral resection of bladder tumour (TURBT) under spinal or general anaesthesia is the initial treatment for all macroscopic bladder lesions to clear all visible disease and establish tumour type, grade, and pathological stage [1]. Although TURBT is a procedure familiar to all urologists, it is not easy to perform and may not always achieve the desired goals. Moreover, its potential complications have negative impacts on patient outcomes [2].

Complete tumour removal is not always possible during a first TURBT, whether due to poor cystoscopic views, large tumour size and multifocality, a critical location, an inexperienced surgeon, medical instability requiring abandoning of the procedure, or complications such as bleeding or significant extravasation [3]. To achieve optimal results and overcome all drawbacks, efforts have been made to standardise all steps performed during the procedure and introduce potential technological improvements [4].

The aim of our present study was to report our experience for the initial management of patients with newly diagnosed bladder tumours using our team approach for each case and an aggressive extended TURBT in order to investigate the real need for a routine 'second-look' cystoscopy in the current era.

Patients and methods

The study included 50 consecutive patients admitted to the urology department, of our tertiary care centre, for management of newly diagnosed bladder tumour.

Cystoscopy and TURBT was done by one of two experienced urologists, using a monitor during the whole procedure, and in the presence of a senior registrar and a resident, to get a group opinion confirming complete bladder mapping and identification of all visible tumours. Only patients in whom there was team approval of adequate resection of all visible tumours were included in the study. An indwelling catheter was left *in situ* for 5 days, as a routine manoeuvre, following the extended TURBT.

Exclusion criteria included: past history of bladder tumour, palpable mass on bimanual examination under

anaesthesia, presence of residual tumour at the end of resection, and cases with tumours in the bladder dome, as vigorous resection is difficult to achieve in this area without an attendant risk. Patients with pathologically confirmed carcinoma *in situ* (CIS) were also excluded. White-light cystoscopy was used in all of the cases.

Extended TURBT was defined as resection of the whole tumour, resection of tumour base and 1 cm of apparently normal bladder wall around the circumference of the tumour. Fig. 1 shows the bladder wall after the extended TURBT.

All patients underwent urine cytology and ultrasonography of the abdomen and pelvis before endoscopic management. CT urography was done before cystoscopy for patients with multiple bladder tumours identified by ultrasonography. All patients underwent a 'second-look' cystoscopy and a biopsy of the tumour bed at 1 month after the extended TURBT.

A urethral indwelling catheter was left *in situ* for 5 days after TURBT. Before catheter removal, in the first five patients urine leakage was excluded by cystography; however, this was not done routinely for the subsequent patients.

Data were analysed using the IBM Statistical Package for the Social Sciences (SPSS®) software package version 20.0. Qualitative data were described by the number and percentage and quantitative data were described using the mean, standard deviation (SD), and range.

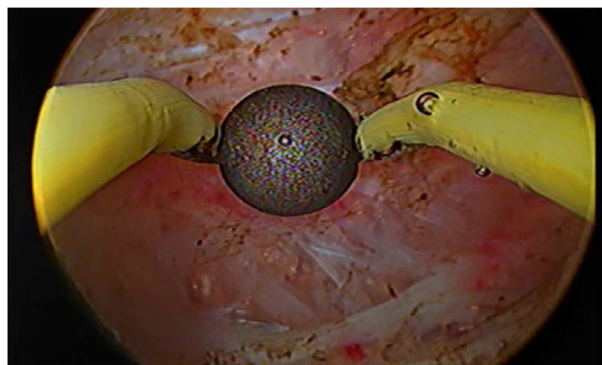


Fig. 1 Bladder wall following extended TURBT.

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