

# EAU16: Highlights in Oncology

## Studies tackle diagnostic tools, treatment and follow-ups



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In recent years, a clear trend towards ageing, in society, vis-à-vis care for the elderly, is evident. This is due to many factors, inter alia, ever more efficient, oncological treatment. The above also impacts on that cross-section of our patients who are simply getting older.

This situation requires a special approach at each stage of the treatment process. Adequate diagnostic tools, a proper assessment of risk factors, the choice of appropriate treatment methods, suitable care, both during and after surgery and appropriate follow-ups – all these topics were discussed in papers presented during EAU16 in Munich. As the space available in this edition is limited, I would like to present just a few selected papers.

A research group from Japan (Shiota et al. #60) analysed the medical history of patients with prostate cancer who had been treated with radiotherapy, surgical therapy and primary ADT. During the median follow-up period of between 45-51 months, secondary bladder cancer (BC) occurred in 14 (2.2%), 5 (1.1%), and 0 (0%), respectively, of those patients whose prostate cancer had been treated with radiotherapy, surgical therapy and ADT. Age and smoking history were significant risk factors in secondary bladder-

cancer, post radiotherapy. However, most interestingly, ADT, in combination with radiotherapy, did not affect the incidence of secondary BC. The authors concluded that there is some significance in the incidence rate of secondary BC, post-radiotherapy; in addition, a patient's smoking history may be helpful in navigating therapeutic selection for prostate cancer.

Data has been presented (Dell'Oglio et al. #509, Fröhner et al. #510) in which individual co-morbid conditions from the Charlson Comorbidity Index (CCI) are independently associated with the results of radical cystectomy or prostatectomy. One of the aforementioned researchers discovered that four of the 17 conditions in the CCI, such as chronic pulmonary disease, diabetes without complications, cerebro-vascular disease and congestive heart failure, are the most prevalent groupings of co-morbid conditions, post-radical cystectomy. The other group of researchers discovered that, based on their analysis, age, angina pectoris, chronic lung disease, peripheral vascular disease, cerebrovascular disease, diabetes mellitus, moderate or severe renal disease, current smoking and ASA class 3-4, are independent predictors of competing mortality, post-radical cystectomy or prostatectomy. Based on these results, they have created a combined mortality index, which could be used to predict competing mortality in candidates for radical cystectomy or radical prostatectomy.

Recently, sarcopenia has been discovered to be a novel, objective and pre-operative prognostic factor in various types of cancers. There were two abstracts (Hirasawa et al. #513, Fukushima et al. #809) in which the authors evaluated the prognostic significance of pre-operative parameters, including sarcopenia, in patients who had undergone radical cystectomy (RC) or nephron-ureterectomy. Based on the results of the

second group, sarcopenia, among other parameters, such as clinical T stage, neutrophil-to-lymphocyte ratio, was a significantly independent predictor of an adverse prognosis, post-RC.

An important issue regarding urinary diversion, especially orthotopic bladder substitutes (OBS), are long-term complications, particularly in the elderly. Researchers from Berne (Furrer et al. #622) reported their observations, which had taken place over two decades on OBS patients. Firstly, complications can occur; however, the majority of these are diversion-related; nevertheless, with close follow-up, most of these conditions are treatable endo-urologically. Secondly, with proper patient selection and correct surgical techniques, excellent urinary continence and renal function can be preserved for decades.

In spite of this, RC still remains the gold standard in the treatment of muscle-invasive bladder cancer (MIBC) and for that proportion of elderly patients who are unfit for RC because of its significant morbidity rates. Doctors in Japan (Fujii et al. #626) have evaluated the oncological and functional outcomes of MIBC treatment with bladder-sparing protocol. This protocol consists of debulking TURB followed by low-dose chemo-radiotherapy and, for those patients showing no massive residual disease, partial cystectomy. Patients achieved excellent, five-year, survival results (MIBC-RFS, CSS, OS) regardless of the age of the patient, some of whom were more than 75 years old while others were less than that age. Both elderly and younger patients maintained a high QoL with an intact and functioning bladder after their treatment.

Partial nephrectomy (PN) is the gold standard for small renal masses. A German team (Pop et al. #984) attempted to discover which groups of patients



profited most by undergoing PN and for whom radical nephrectomy (RN) is still a good option. The team came to the conclusion that there were several significant differences in OS between PN and RN patients. Elderly patients and those patients suffering from hypertension at diagnosis, benefit significantly from NSS. Thus, the presence of cardiovascular risk factors and comorbidities should be the main criteria in decision-making, ahead of surgery.

When RN is performed, one of the more important issues is long-term renal function. The Japanese research team (Kawamura et al. #529) presented their results, which were taken from over 700 patients who had undergone RN. Overall, the mean eGFR, which decreased at one-year, post RN, recovered to 51.3mL/min/1.73 m<sup>2</sup> at 10 years, post RN. Statistical analysis revealed that more advanced age (≥ 65 years) and diabetes mellitus were independent risk factors for severe renal impairment. They concluded that for those groups of patients, special attention is needed.

# EAU16: Highlights in Urethral reconstruction

## Challenges and prospects in urethral reconstruction



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There is an emerging effort among urethral surgeons to minimize the impact of urethral reconstruction. From a patient's perspective the hospital stay is important and the question arises whether urethroplasty can be done as a day-care procedure.

Zaid et al. (#322) assessed the safety of urethroplasty as day-care surgery (DCS) versus urethroplasty during hospital admission (HA). Emergency room visits (7.8% vs. 15.4%), readmission rates (4.5% vs. 7.7%) and complaints about the urinary catheter (7.8% vs. 15.3%) were lower in the group treated as DCS. A selection bias might be present as "simple" cases are likely to be treated in DCS whereas more complex cases, that are prone for a higher complication rate, are more likely to be treated during HA. At least this abstract shows that it is feasible to perform "simple" urethroplasty in DCS. The non-transsection anastomotic repair has been described for short bulbar strictures with the advantage of sparing the urethra's dual blood supply.

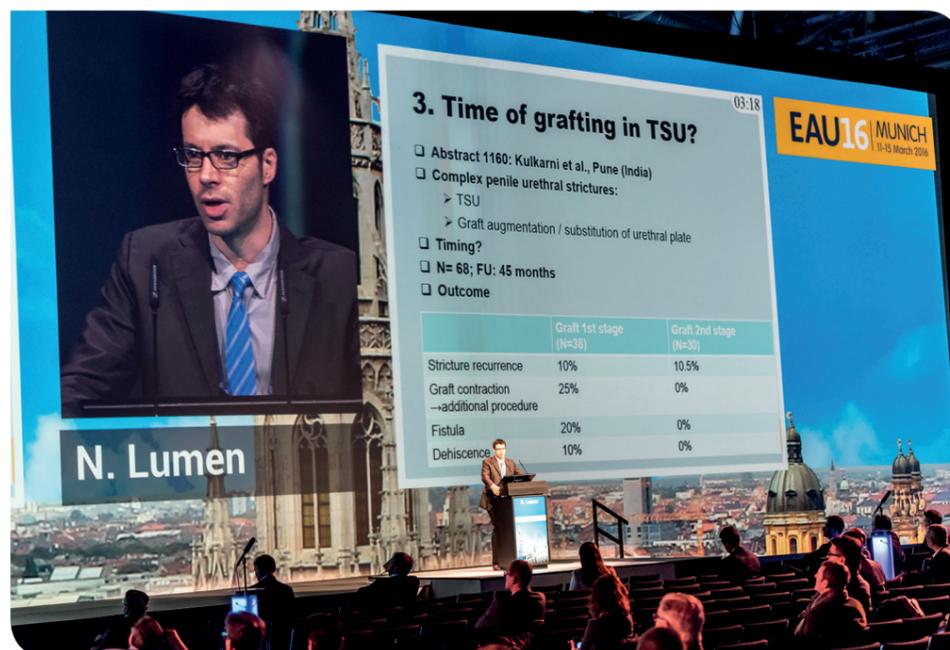
Bugeja et al. (#324) designed a modification of the graft augmented anastomotic repair for somewhat longer strictures in which the ventral spongiosus tissue is spared as well. All 26 patients were successfully treated after a median follow up of 19 months. Persistent erectile dysfunction was reported in 1 (3.8%) patient. This so-called ANTABU (Augmented non-transsecting anastomotic bulbar urethroplasty) is

a further effort to spare the surrounding tissues during urethroplasty whenever possible. Many, especially young patients, dislike scars at the penis after penile or penobulbar urethroplasty. Martins et al. (#1158) reported a perineal approach with penile inversion to access the penile urethra without scars at the penis itself ("Kulkarni"-technique). The ultimate goal is to preserve the penile appearance. Of 431 patients, 85.4% were treated successfully after a median follow-up of 51 months. Moreover, 92.1% were satisfied with the penile appearance after urethroplasty.

### Treatment of lower urinary tract morbidity after radical prostatectomy

Strictures at the vesico-urethral anastomosis after radical prostatectomy are a challenging problem. Historically, many patients were treated by intermittent dilation and if this was not possible by a suprapubic catheter or by another form of urinary diversion. Rosenbaum et al. (#1153) reported the outcome of endoscopic incision of vesico-urethral strictures (VUS) in 86 patients with a median follow-up of 27 months. Success rate was only 38.4%, but this is in line with more recent studies reporting on the outcome of endoscopic incision for urethral strictures. De novo incontinence was reported in 14%. Median time to recurrence was 3 months. In case of a highly recurrent stricture despite dilation or endoscopic incision, transperineal reanastomosis (TPRA) can be attempted. An advantage is the access to the stricture by tissues that have not been previously operated.

Furthermore, TPRA attempts a complete resection of the fibrosis which is not the case with endoscopic incision. Schüttfort et al. (#325) described the outcome of 21 patients with a median follow-up of 46 months treated by TPRA for highly recurrent (≥ 3 previous endoscopic attempts) VUS. Success rate was 85.7% and 18.8% reported worsening of the incontinence. However 80% of patients were already incontinent before TPRA and were later treated by an



artificial urinary sphincter (AUS). Improvement in quality of life and patient satisfaction was high (respectively 75 and 80%). As mentioned, there is a risk of urinary incontinence after treatment. This can be treated by implantation of AUS. Bugeja et al. (#321) reported on the outcome of AUS in patients previously treated for VUS after radical prostatectomy. AUS after endoscopic treatment (n = 50) and TPRA (n = 9) resulted in a favorable result ("dry and unobstructed) in, respectively, 80 and 89% of cases. It is important to leave a sufficient time interval (at least 3 months) between treatment of VUS and implantation of AUS in order to rule out an early recurrence of VUS.

**Timing of graft in two-stage urethroplasty**  
Complex penile strictures are usually treated by a two-stage urethroplasty in which the urethral plate is

augmented or resected and replaced by an oral graft. This graft is classically incorporated during the first stage. However, there is a major concern as an oral graft is not used to a dry environment which can lead to graft contraction and need for additional procedures. Therefore, it might be better to incorporate the graft during the second stage. This was the subject of a study by Kulkarni et al. (#1160), in which the graft was incorporated during the first stage (n = 38) or the second stage (n = 30). Stricture recurrence was equal in both groups (resp. 10 and 10.5%). No patient needed an additional procedure because of graft contraction, fistula or dehiscence when the graft was incorporated during the second stage. However, 25%, 20% and 10% of patients needed, respectively, an additional procedure for graft contraction, fistula or dehiscence when the graft was incorporated during the first stage.



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