

Commentary on Treatment of Large Non-Muscle Invasive Bladder Cancer: The Potential Role of Neo-Adjuvant Intravesical Chemotherapy

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Description

When first diagnosed, bladder tumors are non-muscle invasive (NMIBC) in approximately 75% of cases. However, while maintaining their non-invasive features, the tumors may grow unnoticed and without symptoms until they reach a large size. These large intraluminal masses on first presentation raise some diagnostic and therapeutic challenges. They may not have any invasive features on imaging, and histopathology is often inconclusive. Most of these large bladder cancers pose a significant risk for tumor recurrence and progression. In these cases of large, high risk and hardly resectable tumors, there are well supported reasons to offer immediate radical cystectomy. However, in some patients this invasive treatment may not be feasible because of advanced age, co-morbidities, and patients' refusal. It is not uncommon in daily practice to see patients who do not accept such mutilating surgery without sound evidence of infiltration, which, in turn, we cannot provide unless through examination of the cystectomy sample.

For that reason, we focused on finding an alternative way on how to deal with these bulky tumors. We started from questioning why these resections are so tricky. The big size is of course one good reason. A large tumor volume does mean a longer operating time, a higher risk of bleeding and of reabsorption syndrome unless one uses bipolar energy. The resection itself may be challenging because of the numerous papillary branches that make it difficult to identify the main trunk and the tumor base. We all have experienced severe bleeding with impaired view and the risk of getting lost during the resection, the risk of damage to the ureteral orifices and of bladder wall perforation. In a worst case but realistic scenario, conversion to an urgent open cystectomy may happen.

Therefore, similarly to other tumors, we considered applying neo-adjuvant chemo-resection to reduce the tumor size before surgical treatment. After comprehensive research in the literature, we found a few previous experiences on adjuvant chemoresection, and we decided to start our protocol after approval of our local ethical committee. We intended to use mitomycin's cytoreductive effect to resect all those bulky tumors completely in a single session. The short intensive schedule of intravesical instillations of mitomycin significantly reduced the tumor size before endoscopic resection. It allowed us to stage accurately and to spare most of the bladders, without delaying a possible radical cystectomy significantly where needed. In our experience in our admittedly small series of patients, we observed that invasive features are possible in those large NMIBC, but not as widely encountered as perhaps expected. It means that immediate radical cystectomy might be an overtreatment in many of these tumors. On the other hand, these large bladder masses are hardly resectable transurethrally. We like to point out that we do in no way suggest an alternative treatment to cystectomy in high-risk bladder cancer patients, which remains the primary option. However, even if radical cystectomy is a suitable and oncologically safe treatment for high-risk NMIBC, in high-risk patients with significant co-morbidities, and those refusing cystectomy, one can consider this bladder sparing strategy. This treatment approach must be well explained to the patient who must understand and consent to the risks and benefits, be aware of the rationale and objectives, and be aware about the possibility of still having an early or salvage cystectomy at a later point in time.