The need to better quantify EPE has been considered an important issue from the prognostic viewpoint by several authors. At a recent World Health Organization-sponsored meeting, several modifications were proposed to the 6th edition of the TNM Staging for Prostate Cancer [3]. It was suggested that pT3a should be subdivided into pT3a1 and pT3a2 to accommodate the degree of EPE, even though the exact criteria were not specifically indicated. In addition, involvement of the bladder neck was subdivided into microscopic and macroscopic, that is, pT3b (as for the seminal vesicle involvement) and pT4, respectively.

However, an important issue has not been considered in the definition of the accurate degree of EPE [4,5]. It is represented by that fact that the fascias around the prostate glands are identified by urologists. Pathologists have not yet conducted studies in which the relationship between the level of EPE and the various fascias are investigated. It is not excluded a priori that there might be close relationship between the level of EPE, measured by the radial distance, and the fascias enveloping the prostate.

In several organs the extent of invasion is correlated to prognosis. To remain in the field of urologic cancers, prognosis in bladder urothelial carcinoma includes the diameter of the tumor as well as the depth of invasion. The latter can be measured when dealing with early invasion or can be simply defined according to the wall components, such as muscularis mucosae, detrusor, etc. In the prostate, the situation might be quite similar when the EPE is subdivided as focal versus nonfocal involvement and the radial distance is evaluated. In non-urologic tumors, such as malignant melanoma of the skin, the depth of invasion, measured on the slide, is considered of paramount importance.

In conclusion, it is recommended that this parameter be routinely reported in radical prostatectomy pathology records. The added independent predictive knowledge regarding risk of PSA recurrence makes radial distance a potentially useful incorporation for future TNM staging systems to substage pT3a.

References


Rodolfo Montironi
Polytechnic University of the Marche Region, Ancona, Italy

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Re: Prognostic Risk Stratification and Clinical Outcomes in Patients Undergoing Surgical Treatment for Renal Cell Carcinoma with Vascular Tumor Thrombus

Lambert EH, Pierorazio PM, Shabsigh A, Olsson CA, Benson MC, McKiernan JM


Expert’s summary:
The purpose of the study was to examine the clinical outcomes of patients undergoing surgical treatment for renal cell carcinoma with vascular tumor thrombus. In this retrospective study the authors evaluated the outcome of 118 patients from 1989 until 2006 with a median follow-up of 18 mo (range: 1 mo to 13.55 yr). In about 57% of the patients the tumor thrombus extended into the renal vein; the infradiaphragmatic vena cava was infiltrated in 33% and the supradiaphragmatic vena cava in about 10% of the cases. At initial presentation, almost 36% presented with metastatic disease. The 5-yr disease-specific survival rate was 60.3% and 10% in patients without and with metastatic disease at presentation, respectively. The overall survival rate was 40.7% at 5 yr. Interestingly, in the multivariate model, level of tumor thrombus did not significantly alter survival in the cohort. In a subgroup analysis of patients without metastatic disease, positive lymph node status and greater tumor diameter (>7 cm) were significant predictors of disease-specific survival.

Expert’s comments:
Renal cell carcinoma invades the infradiaphragmatic vena cava in about 4–10% of newly diagnosed
patients. Historically, treatment of nonmetastatic renal cell carcinoma and concurrent vena caval thrombus resulted in a 5-yr survival rate of about 15%. Primary surgical resection of the kidney with the attached tumor thrombus remains the primary treatment option. Various surgical modifications have lowered the operative complications associated with extensive thrombus involvement of the infradiaphragmatic vena cava. Within the last three decades some prognostic factors for these patients have been introduced into clinical practice. Multiple studies have shown that the level of tumor thrombus extension is not associated with survival benefit. Interestingly, Haferkamp et al investigated 111 patients undergoing radical nephrectomy and tumor thrombus excision and found that the level of tumor thrombus (levels 1 and 2 vs. 3 and 4) is an independent prognostic factor [1]. This is contrary to most recent reports, but warrants further discussion [2,3]. Since other series have shown that local tumor extent or the presence of metastatic disease are important predictors for survival, the large series by Haferkamp et al underlines the importance of the tumor thrombus level [1–5]. There is no doubt that with a higher tumor thrombus level the surgical resection will be more difficult and may even require the assistance of cardiac surgeons to introduce cardiac arrest with cardiopulmonary bypass and deep hypothermia. Nevertheless, because the tumor thrombus level may not have been of prognostic importance, the surgical risk was taken.

However, in the present series only one patient died secondary to a tumor thrombus and only 19% of the patients experienced perioperative complications. In a subgroup analysis, no statistically significant difference in the rate of complications among the level of thrombi or the presence of metastatic disease was found. This underlines the relative safety of this major surgical intervention at specialized treatment centers.

It seems obvious that radical surgical intervention for renal cell carcinoma with vascular tumor thrombus extension is associated with poor prognosis. However, due to recent advancements in surgical techniques and perioperative care the complication rate has been lowered. Additionally, a multimodal treatment regimen with the introduction of novel chemotherapeutic agents has led to a more aggressive surgical approach. Nevertheless, radical nephrectomy and tumor thrombus excision are still considered major surgical interventions. On the other hand, surgical resection must be part of multimodal treatment to ensure improved disease-specific survival rates in carefully selected patients.

References


Patrick J. Bastian
Urologische Klinik und Poliklinik,
Klinikum der Universität München,
Ludwig Maximilians Universität, Marchioninistr. 15,
81377 München, Germany

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Re: Video Endoscopic Lymphadenectomy: A New Minimally Invasive Procedure for Radical Management of Inguinal Nodes in Patients with Penile Squamous Cell Carcinoma

Tobias-Machado M, Tavares A, Ornellas AA, Molina Jr WR, Juliano RV, Wroclawski ER


Expert’s summary:
The authors have envisaged and applied in a limited number of cases an original technique of video endoscopic inguinal lymphadenectomy (VEIL). The paper describes the operative technique in detail and reports a comparative study of the respective morbidity of VEIL and standard open inguinal lymphadenectomy on the same patient. In one limb VEIL was performed and in the other the traditional procedure; various intraoperative and postoperative parameters were examined and cancer control after at least 1 yr of follow-up was assessed. The number of cases treated is small (10), but preliminary results are encouraging and it is possible to foresee that this technique will be introduced into the urologic armamentarium.

Expert’s comments:
Minimal invasive surgery is rapidly expanding in almost all fields of urologic surgery. Inguinal lymphadenectomy in breast cancer [2]). The paper describes the operative technique in detail and reports a comparative study of the respective morbidity of VEIL and standard open inguinal lymphadenectomy on the same patient. In one limb VEIL was performed and in the other the traditional procedure; various intraoperative and postoperative parameters were examined and cancer control after at least 1 yr of follow-up was assessed. The number of cases treated is small (10), but preliminary results are encouraging and it is possible to foresee that this technique will be introduced into the urologic armamentarium.