Re: Busby JE, Brown GA, Matin SF. Comparing Lymphadenectomy During Radical Nephroureterectomy: Open Versus Laparoscopic (Urology 71:413-416, 2008)

TO THE EDITOR:

We read with interest the elegant report by Busby et al.,[1] who addressed the feasibility of laparoscopic nephroureterectomy and lymphadenectomy for patients with urothelial carcinoma in their upper urinary tract. We totally agree with the oncologic efficacy of laparoscopic nephroureterectomy, as well as lymph node dissection. According to the results, it is not a good historical control to compare the number or density of the removed lymph nodes in open nephroureterectomy (ONU) with the corresponding values from the later period.

The median number of removed lymph nodes in the ONU group was only 3, much less than the 7 in a recently published Japanese study.[2]

Kondo et al.[2] reported their experience with 146 ONU with lymphadenectomy and concluded that extended lymphadenectomy is beneficial for patients with advanced urothelial carcinoma of the upper urinary tract. As the author mentioned, the incidence of urothelial carcinoma of the upper urinary tract in Western countries is lower than in Eastern countries; thus, I think the relatively small number removed in the ONU group could be attributed to the concept that only staging information is provided by lymphadenectomy and not a survival benefit. Increasing evidence has indicated that the extent of lymphadenectomy influences the oncologic outcome.[2-4]

The feasibility of laparoscopic lymphadenectomy has been confirmed by the study by Busby et al.[1] The efficacy of oncologic control of hand-assisted laparoscopic nephroureterectomy (HALNU) is also comparable to ONU.[5,6] However, whether laparoscopic nephroureterectomy with laparoscopic lymphadenectomy will provide comparable or better cancer control than treating patients with ONU plus lymphadenectomy remains to be determined.

Shiu-Dong Chung, M.D.
Division of Urology, Department of Surgery, Far-Eastern Memorial Hospital, Ban Ciao, Taipei, Taiwan; and Department of Urology, National Taiwan University Hospital, National Taiwan University College of Medicine Taipei, Taiwan

Chun-Hou Liao, M.D.
Division of Urology, Department of Surgery, Cardinal Tien Hospital, Fu-Jen Catholic University College of Medicine Hsin-Chuang, Taipei, Taiwan

Shih-Chieh Chueh, M.D.
Department of Urology, National Taiwan University Hospital, National Taiwan University College of Medicine Taipei, Taiwan

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Reply by the Authors

TO THE EDITOR:

We enthusiastically concur with the necessity of lymphadenectomy during nephroureterectomy for the prognostic value and oncologic efficacy, as demonstrated in several recent excellent reports.[1-3] Despite the variations in anatomy, the biologic similarity of upper tract urothelial carcinoma to its bladder counterpart emphasizes the need to include lymphadenectomy in such cases. Although our study may contain limitations, as suggested by the author of the Letter to the Editor, we do believe that lymphadenectomy will not be compromised when nephroureterectomy is performed using a laparoscopic approach. Furthermore, our results are very similar to the results from Kondo et al.,[2] whereby the median node count from complete lymphadenectomy was 7. Although our retrospective data might thus reflect more complete lymphadenectomy having been performed during laparoscopic cases in the contemporary period, these results nevertheless add validity to our assertion. Because a randomized study is unlikely to ever be performed for this disease outside of a major international effort, it is doubtful that we will be able to definitively answer whether a difference exists between the surgical arms and corresponding

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subgroups. Instead, what needs to be elucidated further is the extent of the boundaries in which the lymph nodes should be removed. This could reasonably be achieved with studies from groups such as Kondo et al.[2] that consistently perform lymphatic mapping during nephroureterectomy. Identifying the patient at high risk of metastasis before surgery is an even more important issue from our perspective. This has become more relevant as our focus has shifted to the use of neoadjuvant chemotherapy, instead of adjuvant therapy, such that the high-risk patient receiving neoadjuvant chemotherapy undergoes complete lymphadenectomy, regardless of the surgical approach, open or laparoscopic.[4] We look forward to data continuing to evolve in this disease, since no progress in survival has been demonstrated for these patients.[4]

J. Erik Busby, M.D.
Division of Urology
University of Alabama-Birmingham
Birmingham, Alabama

Surena F. Matin, M.D.
Department of Urology
University of Texas M.D. Anderson Cancer Center
Houston, Texas

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Re: Thompson RH, Krambeck AE, Lohse CM, et al. Endoscopic Management of Upper Tract Transitional Cell Carcinoma in Patients With Normal Contralateral Kidneys (Urology 71:713-717, 2008)

TO THE EDITOR:

We read with interest the elegant report by Thompson et al.,[1] who treated 83 patients with upper tract urothelial carcinoma in an elective setting by endoscopic treatment in a 20-year period and demonstrated a better oncologic outcome than their previous study in the imperative setting.[2] We agree with the authors' recommendation not to treat patients if the biopsy could not obtain adequate tissue for pathologic examination and address the importance of strict postoperative follow-up. They also found that a history of bladder urothelial carcinoma did not predict for a lower intravesical recurrence-free rate. Considering that most (78.3%) of the evaluated patients in the series had a history of tobacco use, which might have increased the recurrence rate of bladder urothelial carcinoma if the patients did not stop smoking,[3] the relapsed bladder lesions could be recurrence of previous bladder urothelial carcinoma. Thus, not all of the subsequent intravesical tumors will be recurrences from the upper tract disease; therefore, the cancer control rate specifically for upper tract urothelial carcinoma might have been underestimated. In addition, we recently found that renal function at the diagnosis of upper tract disease is a prognostic factor for bladder recurrence postoperatively.[4] The patients included in the study by Thompson et al. had normal contralateral kidneys and should have had better renal function than patients receiving endoscopic treatment because of an existing imperative indication. It could be expected that the outcome of bladder recurrence in these different groups will differ.

Shiu-Dong Chung, M.D.
Division of Urology, Department of Surgery
Far-Eastern Memorial Hospital
Ban Ciao, Taipei, Taiwan; and
Department of Urology
National Taiwan University Hospital
National Taiwan University College of Medicine
Taipei, Taiwan

Ming-Kuen Lai, M.D.
Department of Urology
National Taiwan University Hospital
National Taiwan University College of Medicine
Taipei, Taiwan

Shih-Chieh Chueh, M.D., Ph.D.
Department of Urology
National Taiwan University Hospital
National Taiwan University College of Medicine
Taipei, Taiwan

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