Response to comments on: Laparoscopic distal ureterectomy for urothelial carcinoma is technically feasible... But is it oncologically safe?*

Réplica a «La ureterectomía distal laparoscópica por carcinoma urotelial es técnicamente posible, pero... ¿resulta oncologicamente segura?»

The authors question the lack of oncologic safety for the laparoscopic distal ureterectomy (LDU) taking as references the poor outcomes in two patients diagnosed of distal ureter tumor who underwent this technique,1 and a case referred in the literature in which urothelial carcinoma misdiagnosed as tuberculous atrophic kidney, showed port metastasis after laparoscopic nephrectomy. This fear reminds too much of the old dilemma about if laparoscopic nephroureterectomy should be considered a oncologically safe technique by itself.2,3 In contrast, good outcomes and no tumor relapse lasting more than two years have been obtained by us in 2 cases operated for DUT. Besides, we would like to show this dilemma similarly. For this reason, we describe in our article 40 cases of DUT, divided into several series, treated with LDU and with good outcomes.4 New publications are appearing, like McClain et al. manuscript describing favorable outcomes in 6 patients who underwent robotic technique.5 They conclude that robot-assisted LDU is an oncologically safe procedure for the treatment of low-grade urothelial carcinoma. In our series, both were low-grade cases, and therefore we must wonder: is it justified to perform nephroureterectomy in low-grade DUT?, or is it justified not to take advantage of the benefit of laparoscopy in low-grade tumors due to 'rather theoretical and not significant' risk of seeding?6 If distal or open segmental ureterectomy has been accepted as alternative for the treatment of DUT, let me ask you: Why LUD or robot-assisted ureterectomy cannot offer oncological safety? In laparoscopic nephroureterectomy series not showing an increased local relapse, the risk of tumor seeding has not been confirmed. By other side and reviewing the literature, the risk of tumor seeding by bladder rupture can also be considered minimum.7

As Gaya and Palou say, limited manipulation and en-bloc removal of the operative specimen are major oncological precepts for the treatment of DUT.1 Delicate and meticulous surgical execution, even higher in those cases of open surgery with magnified view and developed by experimented hands, are guaranteed by the improvement in laparoscopy and the acquisition of laparoscopic skills. Furthermore, the risk of seeding in laparoscopy can be considered equivalent to the risk of open surgery, since this is limited by the immediate sacking of the resected segment of the ureter performed in laparoscopy. Other basic precept in order to avoid the opening of renal collecting system is to clip the ureter distally and proximally. However, in those cases in which tumor reach to ureteral meatus it is not always possible to place a clip of Hem-o-lok, and furthermore, in these cases the clipping may propel tumor cells into the cavity. For this reason, in one of our cases distal clip could not be placed. This risk also is observed sometimes in open surgery. Finally and equal to conventional surgery, a bladder cuff was carried out in both cases.

It is totally logical and understandable that there are reticences in terms of the oncological safety of LDU, mainly in high-grade urothelial tumors. This is because there are still few publications in this regard given that there is not enough scientific evidence supporting it, but it is undeniable that with the advent of robotic surgery there is a rise of the LDU8 which might lead to questioning the fact that the lack of publications is due not only to the doubt on the oncological safety, but also to the complexity of the procedure laparoscopically that Gaya and Palou assume. Something similar is taking place with renal tumors higher than 4 cm. Some years ago, open partial nephrectomy was recommended versus laparoscopic procedure (because of technical difficulties, positive margins risk and the possible impairment in the renal function). The evolution of laparoscopic technique and the acquisition of laparoscopic skills are also changing this paradigm. We have exposed this reflection although it is not possible to compare the behavior of urothelial tumors with the renal tumors.

The most predictive prognostic factors in the treatment of DUT are histological grade and lesion stage. Thus, the success key in the laparoscopic or robotic DU must be the appropriate patient selection.9,10 More series and comparative studies are required in order to define true role of LDU in the DUT;10 however it is possible that paradigms could change with the evidence. For this reason we think that this kind of experiences (like the reported by Garcia-Segui et al.11) regarding the fundamental oncological principles, must be published in order to accumulate

References

3. J.M. Gaya*, J. Palou
Departamento de Urología, Fundació Puigvert, Universitat Autònoma de Barcelona, Barcelona, Spain
*Corresponding author.
E-mail address: jmgaya@fundacio-puigvert.es (J.M. Gaya).

Please cite this article as: Garcia-Segui A, Cáceres F, Angulo J. Réplica a «La ureterectomía distal laparoscópica por carcinoma urotelial es técnicamente posible, pero... ¿resulta oncologicamente segura?». Actas Urol Esp. 2014;38:206–207.
evidences supporting cutting-edge techniques. We acknowledge Gaya’s and Palou’s reflection and we expect to publish strong prospective experiences accurately assessing the risks and benefits of cutting-edge techniques, and criticized because of this, such as the LDU in the treatment of DU, favoring preservation of the renal parenchyma and the prompt recovery of our patients.

References


A. García-Seguí a,*, F. Cáceres b, J.C. Angulo b

a Servicio de Urología, Hospital del Vinalopó, Elche, Alicante, Spain
b Servicio de Urología, Hospital Universitario de Getafe, Universidad Europea de Madrid, Madrid, Spain

*Corresponding author.
E-mail address: agarciasegui@gmail.com (A. García-Seguí).