

Editorial

Editorial concerning “Pelvic lymph node dissection may be limited on the contralateral side in strictly unilateral bladder cancer without compromising oncological radicality”

The authors report a pathoanatomic study of lymph node involvement in relation to the laterality of the primary bladder tumor and find that if the tumor is strictly localized on one side, then patients do not have any contralateral internal iliac nodal involvement [1]. The authors demonstrate that there is indeed tumor spread to contralateral nodes in 27% of the patients including the external and common iliac nodes, with 10% of the node positive patients having only contralateral nodal involvement. On the other hand they are advocating for omitting the node dissection along the contralateral internal iliac chain in highly select group of patient with strictly unilateral tumors. In our own study of 1964 patients, 347 (17.6%) patients had unilateral bladder cancer of which 81 (23.3%) had lymph node metastases. Similar to this study, 22/81 (27.1%) patients had lymph node metastases to contralateral nodes, however we found 11/22 (50%) had nodal involvement in the internal iliac/perivesical region (unpublished data). Other studies have found positive nodes in the contralateral internal iliac region as well in unilateral bladder cancer [2]. As mentioned by the authors, it is possible that this study is limited due to sample size (51 pN+ patients with unilaterally localized bladder cancer). Part of the discrepancy may also be due to the variation in assignment of nodes to anatomic regions. In our center, pre-sacral nodes are those medial to the common iliac arteries, overlying the sacrum and the internal iliac nodes are sent together with the obturator nodal packet given the difficulty in anatomically demarcating these two packets.

The study is predicated on two notions:

- 1) Tumor laterality is known preoperatively with certainty
- 2) Preservation of the “autonomic nerves” medial to the internal iliac vessels on one side improves continence and potency outcomes.

The authors state that the functional benefits of preserving the autonomic nerves “are a logical conclusion based on anatomical and functional studies.” However, there is no direct evidence to suggest removal of the pre sacral nodes and damage to the post-ganglionic sympathetic fibers and the hypogastric nerve has any effect on continence or potency. We know from extensive experience with post-chemotherapy retroperitoneal lymph node dissection for testicular cancer that removal of all the tissue in the lower retroperitoneum leads to retrograde ejaculation and has no effect on continence or potency. It is generally well accepted that the external urethral sphincter is innervated by branches of the pudental nerve which runs deep in the pelvis and not at risk when performing a pelvic lymph node dissection. Nerve sparing techniques generally refer to sparing the well established neurovascular bundles along the prostate in men and the lateral vagina in women.

There is no debate regarding the diagnostic and therapeutic value of a meticulous lymph node dissection in patients undergoing radical cystectomy. Yet, it appears that lymph node dissection is excluded in almost one third of cases performed in the United States [2, 3]. A thorough pelvic lymph node dissection requires

skeletonization of the vessels and allows removal of potential cancer bearing lymphatic tissue, not just the lymph nodes. Extended lymph node dissections have proven to decrease pelvic recurrence rates and improve survival in multiple series [4]. As the authors point out, pelvic lymph node dissection is “an oncological cornerstone of surgery for bladder cancer. It seems that in an era where even experienced surgeons do not perform an adequate lymph node dissection [5], the message from this study should rather focus on the significant number of patients with contralateral spread of the tumor, rather than omitting any part of the lymph node dissection.

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