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Challenging Cases in Urothelial Cancer

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INTRODUCTION

Urothelial cancer of the urinary tract is common and affects a large number of men and women, resulting in a reasonably large part of the work effort of urologists who take care of adults. Most of the urothelial tumors arise in the bladder but the same causative factors can lead to similar tumors in the kidneys, ureters, prostate, and urethra. Due to the heterogeneous nature of these tumors as well as their propensity for "recurring" in time and location over the patient's life the clinician is often in the position of deciding among often challenging treatment choices for his/her patient. Although there are published guidelines many cases do not readily fit into a typical scenario, thus leaving ample room for decision making for the individual patient. We invite our readers to review and comment on the case and management by email to: mssoloway@yahoo.com.

Case 2. T2 muscle invasive urothelial bladder cancer

A 61 year old previously healthy man had gross hematuria and was found to have a muscle invasive urothelial cancer of the bladder. The clinical stage was T2 and there was lymphovascular invasion.

A metastatic work up consisting of lab work and imaging with a CT scan of the chest, abdomen, and pelvis was negative. He did have left upper tract obstruction with resultant hydronephrosis. A stent was placed to preserve as much renal function as possible. His creatinine was 1.6 after the stent.

After a thorough discussion, the patient agreed to neoadjuvant chemotherapy to be followed by a radical cystoprostatectomy and an orthotopic neobladder.

He received 4 cycles of cisplatin and gemcitabine which he tolerated quite well. An office flexible cystoscopy after two cycles indicated an excellent response with no obvious tumor in the bladder. The patient received two additional cycles of chemotherapy.

Three months after the diagnosis he underwent a radical cystoprostatectomy with bilateral standard PLND, and an orthotopic neobladder was constructed. The postoperative course was benign.

The pathology revealed a small area of residual urothelial carcinoma of the bladder. One of 14 removed lymph nodes contained metastatic urothelial carcinoma.

It is now 6 weeks from surgery. The patient looks and feels well. He is continent during the day and usually continent at night.

A CT scan shows one enlarged paraaortic lymph node, 1.5 cm.

A rectal exam indicates an empty fossa with no apparent local recurrence.

In light of the pathology after four cycles of systemic induction chemotherapy and the current imaging results what is the optimal approach?

1) PET/CT to further characterize para-aortic node and identify other potential metastatic sites.
2) CT guided biopsy of para-aortic node.
3) Salvage systemic chemotherapy.
4) Adjuvant/Salvage immunotherapy with checkpoint inhibitor.
5) Retroperitoneal lymphadenectomy.
6) Other _____.

Please indicate recommendation and provide a short description of justification.

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