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Re: Repeat Transurethral Resection of Muscle-invasive Bladder Cancer Prior to Radical Cystectomy is Prognostic but Not Therapeutic

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Transurethral resection of bladder tumor (TURBT) serves both diagnostic and therapeutic purposes in the management of bladder cancer. These include providing tissue for diagnosis, debulking of tumor prior to neoadjuvant therapy, and fulguration in those with a bleeding tumor. The study by Bree et al offers a perspective on its therapeutic benefit.

The role of complete TURBT is established in non-muscle invasive disease and in bladder sparing therapy for muscle-invasive bladder cancer (MIBC) and is backed by practice guidelines.[1] The clinical benefit of repeat TURBT prior to radical cystectomy (RC) in patients with MIBC is less clear. The authors found that in patients with clinical stage T2 disease undergoing RC, repeat TURBT did not confer a survival benefit regardless of whether patients underwent neoadjuvant chemotherapy (NAC).

When contextualizing these data in clinical practice, a few factors should be considered. Although no survival benefit was shown in this large cohort at a quaternary center specializing in oncology, repeat resection may still be beneficial in general practice. It has been demonstrated that resection techniques vary by surgeon and institution, and the inclusion of muscle in the initial resection specimen correlates with experience.[2] Indeed, general urologists may be less likely to perform deep and extensive initial resections. For many urologists, repeat TURBT can provide a muscle-containing sample for more accurate staging. Secondly, there is evidence to suggest the value of debulking on improved response to NAC and a subsequent survival benefit.[3] We acknowledge that the data on this is varied. However, given the high rates of recurrence and progression after RC, the additional clinical benefit conferred by repeat TURBT is of particular importance. Finally, with an incomplete resection, the standard exam under anesthesia (EUA) can be less accurate. Evidence suggests that, even in the era of routine imaging, EUA remains an important part of staging.[4]

The authors make an important contribution to the discussion of whether to pursue repeat TURBT in these patients, as a second TURBT for debulking is not without risks. Perhaps in quaternary centers like MD Anderson Cancer Center repeat TURBTs are not needed in this instance, but in the vast majority of centers around the country a repeat TURBT should be entertained in this clinical scenario for the reasons described above.

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