Upper urinary tract urothelial carcinoma is a disease that often is associated with a high propensity for recurrence and progression. Surgical treatment consists of complete removal of the kidney, the ureter in toto, and the ipsilateral bladder cuff including the ureteral orifice. When performed with an open approach, this operation requires either two incisions or an extended flank incision. The integration of the laparoscopic approach has been successful at reducing postoperative convalescence and improving recovery while maintaining the oncologic outcome[1].

The featured study by Kamihira et al represents a large experience with laparoscopic nephroureterectomy for upper urinary tract urothelial carcinoma from 51 centers in Japan[2]. Such a study, commissioned by the Japanese Society of Endourology and ESWL, is bound to provide a wealth of information and to raise a number of questions.

This study establishes that laparoscopic nephroureterectomy can be performed safely with low morbidity and a low complication profile. Most important, it reflects the heterogeneity of surgical practice patterns and brings forth the debate about the following technical issues: (1) the role of lymphadenectomy in the treatment of upper urinary tract urothelial carcinoma and (2) the inability to dissociate total removal of the distal ureter including the ipsilateral ureteral orifice from radical nephroureterectomy.

First, the present study [2] and another equally large multicenter study using mainly an open approach [3] report concomitant lymphadenectomy at the time of nephroureterectomy in 43–45% of cases. The indications and the anatomic template explored were at the discretion of the surgeon and, given the retrospective nature of the methodology, will be difficult to analyze. For a disease that shares so much background with urothelial carcinoma of the bladder, one wonders whether it is sound to extrapolate from the evidence supporting the role of a thorough lymphadenectomy in improving survival in bladder cancer until the evidence for upper urinary tract urothelial cancer materializes [4].

Second, total removal of the distal ureter including the ipsilateral ureteral orifice is undissociable from the radical nephroureterectomy. The fact that the present study by Kamihira et al [2] did not find an association between the different modalities of managing the distal ureter does not, by itself, validate an incomplete ureteral resection.

Finally, the higher rate of postoperative de novo bladder tumors after hand-assisted laparoscopic nephroureterectomy is an interesting point, bringing to the debate the hypothesis of tumor manipulation.

References


DOI: 10.1016/j.eururo.2009.03.006
DOI of original article: 10.1016/j.eururo.2009.03.003