LETTER TO THE EDITORS

Walczak R, Bar K, Walczak J. The value of EORTC risk tables in evaluating recurrent non–muscle–invasive bladder cancer in everyday practice. Cent European J Urol. 2013; 66: 418–422

Letter to the Editor

EORTC tables are still the most commonly used tool for assessment of the risk of recurrence and progression of non–muscle invasive bladder cancer after endoscopic bladder–sparing management. Up until today, there is still no other tool as simple in use. Implementation of EORTC risk tables does not require any additional laboratory tests, clinical experience, or dedicated clinical approach to patient care [1]. Clinical limitations of the tables are well known and they result mainly from progress in adjuvant intravesical immuno–, and chemotherapy since the study by the EORTC group was conducted [2, 3]. Clinical limitations of EORTC risk tables may partially contribute to the results obtained by Walczak et al. [4].

Grade. The rate of intra–, as well as interobserver variability in pathological grading is still significant. Implementation of WHO/ISUP classification did not resolve this problem completely. Moreover, even in recently published papers, there are still cases of invasive G2 tumors, while these tumors by definition have no potential to invade basal membrane [5]. The issue of definition of progression should then be discussed. Should we treat upgrading as progression or rather consider inter– or intraobserver discrepancies in pathological assessment? This question is of vital clinical importance and the answer in most cases remains unknown. More and more experts outline the importance of a second pathologist's opinion in microscopic examinations of TURBT specimens.

Tumor size. This criterion is controversial. How should it be measured? In cystoscopic images by a urologist or during macroscopic assessment of a TURBT specimen by a pathologist? Authors of recently published papers declare the exact mean diameter of the tumor. If it is measured during cystoscopy, it should be taken as an approximate diameter, probably referring to the diameter of the resectoscope loop. On the other hand, pathological measurements would also be far from accurate. The specimens are often sent to the pathologist in fractions and can change their shape and diameters after fixation in formalin. Among the patients reported by Walczak et al. 48% had multiple tumors. How should the diameter be assessed in such cases? Should we measure the largest mass or rather estimate a mean value of all the tumors? These questions are rather an academic debate. However, clinical use of EORTC tables requires differentiation between a 29 mm and 31 mm tumor, whilst inappropriate measurements could influence the risk of recurrence or progression and hence could change the follow–up scheme [1].

EORTC risk tables are recommended for use in every day practice by European Association of Urology experts. Despite well known limitations, to date there is no better tool for assessment of the risk of disease recurrence and progression. However, we should continue searching for new solutions to improve urological care.

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