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Reply from Authors to the Editorial Comment

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We read with interest the editorial comment by S. Daneshmand [1] regarding our recent article. The fact that lymph node metastases are found unexpectedly in the pathological specimens of up to 27% of patients with preoperatively staged cN0 muscle-invasive bladder cancer makes an extended pelvic lymph node dissection (ePLND) mandatory [2]. A significant number of these lymph node-positive patients have contralateral lymph node metastases. We therefore fully agree with the editorial comment that this argues for a bilateral ePLND, as demonstrated and clearly stated in our article [3]. Indeed, even in lymph node-positive bladder cancer patients in whom the tumor was strictly localized on the lateral bladder wall of a single bladder hemisphere, 27% of patients had contralateral lymph node metastases [3]. No positive lymph node, however, was found in the internal iliac (called by some the presacral) region contralateral to the tumor.

Although we greatly appreciate the opinion of S. Daneshmand and understand his concern, we respectfully disagree with his viewpoint that another study has already found positive nodes in the contralateral internal iliac region in unilateral bladder cancer strictly localized on the lateral bladder wall [4]. Indeed, in that study the authors examined tumors located in a single bladder hemisphere including tumors involving the bladder neck, trigone, and/or posterior bladder wall, regions well known to drain everywhere within the pelvis [5, 6]. This points out a major drawback of every retrospective analysis, namely that the exact tumor site is difficult to evaluate retrospectively. It must be borne in mind that tumors located unilaterally (located within a single bladder hemisphere) are not equal to tumors located strictly laterally within a single bladder hemisphere as in the cohort of bladder cancer patients in our recent article [2]. We perform a cystoscopy (including exam under anesthesia and urethral biopsies) as a standard procedure in every bladder cancer patient scheduled for radical cystectomy in order to facilitate an individualized approach (e.g. nerve sparing, seminal vesical sparing). During this examination we also determine the localization of the tumor. This is why we can select the patients who might be candidates for a limited lymphadenectomy on the contralateral site, namely those with tumors located strictly unilaterally on the lateral bladder wall.

As confirmed by several studies and in agreement with the editorial comment, any kind of PLND is better than none, and an extended PLND is better than a limited PLND [7, 8]. In future, however, further individualization of PLND templates depending on the localization of the bladder tumor might be an option in some patients. It must always be borne in mind, however, that these patients have to be carefully selected and that this approach is certainly not suitable for all patients or all institutions. In any case, the best functional and oncological results can be achieved if ePLND, radical cystectomy, and urinary diversion are performed in a high-volume hospital (at least 40–50 cases annually) by high-volume surgeons working with an experienced team [9]. Only then is there a guarantee of adequate patient selection leading to the best available therapeutic practices and results.

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