

Editorial Comment on: Defining Early Morbidity of Radical Cystectomy for Patients with Bladder Cancer Using a Standardized Reporting Methodology

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Neoadjuvant and adjuvant chemotherapy settings are referred with consistently different rates of administration from different institutions in different countries [1–3]; however, there is a general agreement that perioperative chemotherapy remains infrequently used to date. Suboptimal design of trials based on the insufficient number of patients has limited the clinical application of chemotherapy as an adjuvant approach. In addition, although similar results (5–6% net benefit in overall survival) are presumed for adjuvant chemotherapy when compared with neoadjuvant chemotherapy, this finding is still definitively unproved [4]. Apart from the overall limited clinical outcomes, age, medical morbidity, severity of renal failure, and patient reluctance affect the extant confined role of adjuvant chemotherapy.

Donat et al [5] investigated the potential impact of surgical complications related to radical cystectomy on the timing of adjuvant chemotherapy for stage III bladder cancer. This monoinstitutional experience, including numerous series of patients submitted to radical cystectomy over a period of 10 yr, certainly has many merits. The study specifically focused on the potential for surgical complications to affect the patient’s ability to use an adjuvant chemotherapy approach. Few publications [6,7] have treated in detail the limiting effect of cystectomy-related morbidity on adjuvant therapy. To reach their target, the authors adopted a detailed and reproducible methodology based on a grade system (modified Clavien 5-grade system) that allowed for rigorous assessment of both category type and severity of surgical complications. Because adjuvant chemotherapy should be given within 90 d postoperatively, the authors adequately decided to extend the overall period of time for the postoperative evaluation of surgical complications up to 90 d. This represents an additional value when compared with the majority of previous studies in which surgical complications were generally described within 30–60 d.

According to the results of Donat et al’s study [5], 30% of patients could have been excluded from a timing-adjuvant chemotherapy due only to grade

2–5 surgical complications; however, as clearly admitted, since the authors were not able to identify how many patients actually received chemotherapy, this study appears to be more speculative than of practical relevance. The key point is to know how many patients, mainly those with grade 2 complications (about 60%), may have recuperated in time to start chemotherapy or may have been able to complete treatment even though the start of therapy may have been delayed. We cannot, however, definitively assume that a delay of the prescribed timing can minimize or cancel the benefit of the adjuvant approach.

Although not the final point of the study, an assessment of the reasons why so many patients did not receive adjuvant chemotherapy would have been of interest and provided useful information on the relative burden of surgical complications. In addition, when looking at such a high rate of high-risk patients, the results from this study at a high-volume, tertiary American center could be difficult to translate directly to the majority of urologic centers, particularly in Europe.

Although the results of this study cannot definitively suggest preference for neoadjuvant therapy, they represent a practical example of what can be deduced when a standardized methodology for surgical complication reporting is adopted. This methodology, including five grades and 11 specific categories and used for the definition of type, incidence, and severity of morbidities following radical cystectomy, was extensively presented by the authors in a contemporary paper [8]. According to their experience, when using such a rigorous method of collection and evaluation, the overall rate (64%) of postoperative complications is consistently higher than is generally shown in the literature, and the majority of complications (51%) are of moderate severity (grades 1–2). Gastrointestinal complications are unquestionably the most frequent (29%) early on, and the highest grades of complications (grades 3–5) occur mainly within the first 30 d postoperatively. Multivariate analysis shows that American Society of Anesthesiologists (ASA) score and type of urinary diversion are significant predictors for any grade of postoperative complication.

The need for a uniformly accepted definition of some surgical morbidity (ie, small bowel obstruction, ileus, constipation) and a standard classification of severity of complications has been universally advocated for many years. Although this risk stratification methodology comes from a tertiary referral institution managing a special

patient population (>90% of patients are overweight or very obese, about 50% have had previous abdominal surgery, >40% have ASA 3 or 4), it appears to be widely reproducible. It could be used as a point of reference for prospective studies designed to define correlations among postoperative complications and different surgical techniques, institution type and surgical volume, patient populations, and, of course, surgeon ability. The first step in making the results of different experiences actually readable and comparable is to speak the same language.

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