



European Association of Urology



## Letter to the Editor

### Reply to Sigurdur Gudjónsson, Wiking Månsson, Sten Holmäng and Fredrik Liedberg's Letter to the Editor re: Richard J. Sylvester, Willem Oosterlinck. An Immediate Instillation after Transurethral Resection of Bladder Tumor in Non-Muscle-Invasive Bladder Cancer: Has the Evidence Changed? *Eur Urol* 2009;56:43–5

We thank Dr. Gudjónsson and colleagues for their comments on our editorial [1].

We agree that there is an insufficient level of evidence for the efficacy and economics of an early instillation after the transurethral resection (TUR) of recurrent and high-grade non-muscle-invasive bladder cancer (NMIBC) as well as of multiple NMIBCs. We reached this conclusion in our editorial, where we indicated that further studies are required before any definitive conclusions can be drawn in this setting. For Gudjónsson et al, this insufficient level of evidence is a reason to abandon this treatment; for us, sufficient arguments still recommend its use.

The data on which our recommendations are based are carefully explained in our editorial, and the letter by Gudjónsson et al does not contradict them. In the study by Hendricksen et al [2], which was not cited in our editorial, the instillation was not given on the same day as TUR, as advocated in the European Association of Urology guidelines. This difference may be a reason for the inefficacy of the treatment.

We also agree that the number needed to treat is higher than 8.5 patients because the instillation will be given to some patients for whom the diagnosis will not be NMIBC. In the study by Gudjónsson et al, this amounted to 28% of the patients randomized [3], which is remarkably high; in the study by Oosterlinck et al [4], this was only 16%. Other authors have noticed a very good correlation between the visual judgment of the urologist and the pathology of the tumour. Herr and colleagues, for example, found an excellent correlation of cystoscopic appearance with histologic findings in recurrent patients [5]. We did not mention in our editorial that it is unlikely that most multiple and most low-grade recurrent tumours will have biology that is different from single, primary tumours. Biology may be completely different in high-grade tumours, which, largely, are insufficiently studied.

We agree that office fulguration is a good option for many recurrences of low-grade tumours.

Instead of attacking each other in journals and at congresses, it would be better to spend our time putting together all of the available data from both old and new studies of intermediate- and high-risk NMIBC. There might be enough data now to draw valid conclusions in some subgroups of patients. The recurrence rate during the first 2 yr should be studied as an end point, since one cannot expect an influence on the behaviour of the tumour after this time.

**Conflicts of interest:** The authors have nothing to disclose.

## References

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