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LETTER TO THE EDITOR

Check for updates

Comment on: Cystoscopic surveillance of patients with non-muscle-invasive bladder cancer revisited

Dear Editor,

The present editorial comment from Professor Malmström addresses a very relevant issue: Current guidelines on follow-up cystoscopy are based on old traditions and 'gut feelings' rather than high level evidence. And maybe even more important: The only evidence behind the current guidelines are old patient series with a very high recurrence rates. Nowadays better diagnostic tools and more eager instillation therapy has apparently reduced the up-front recurrence rate per se and thus potentially should lead to less heavy follow-up regimens.

It is more or less clear that patients with a low grade and low-risk tumour should be followed for a shorter period and potentially less frequently than the patients with high grade and high-risk tumours. However, even though the risk of recurrence of a single low-grade tumour is low after a 1 year eventless follow-up, it is not zero. And conversely, the risk of recurrence in a patient with several years of eventless follow-up after BCG treatment for high grade tumours is more likely to be negligible the more time has passed. This calls for a more individualized follow-up. The problem with individualized follow-up is, however, given with the current intermediate risk patient group where EAU recommends a follow-up regimen in-between low risk and high risk. This is actually not a very precise recommendation and the variant interpretation of this will most likely never produce a uniform patient series that can be used for more structured guidelines. Thus, future guidelines can only be as good as the patient material they rely on. RCTs on follow-up regimens are therefore urgently needed and it is therefore interesting that two large RCTs are currently conducted where introduction of urinary biomarkers is utilized in the experimental arm in a direct randomization against the current standard cystoscopy follow-up. Hopefully these studies can enlighten us as to which patients with low grade tumours we can safely reduce the length of follow-up; and also help to safely reduce the cystoscopic burden in patients with high grade tumours.

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