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EDITORIAL COMMENT

The cancer stigma – the importance of nomenclature

Cancer registries, in particular the Nordic cancer registries are valuable when assessing the epidemiology of cancer. These registries have been in existence for a long time, hence we can learn about the evolution of the biology and the trend in management through the years.

In the 1960s almost 20% of bladder tumor were called papillomas but within the framework of WHO recommendations, this category was reclassified as low-grade carcinomas [1]. Especially, countries dominated by private caregivers have a tendency to expand the cancer definition justifying more intensive control programs.

It was therefore a logical step when the category 'papillary urothelial neoplasm of low malignant Potential' (PUNLMP) grade was introduced in 1998. This term was particularly useful when we found such small papillomas in young people. Many including myself welcomed this change since a cancer diagnosis creates anxiety and it is not always that the information is understood that not all cancers are life-threatening.

From the pioneering work of Swedish pathologists we learned that PUNLMP constituted almost a third of the Ta bladder tumors [2]. Later it was obvious that the pathologists in general hesitated to categorize bladder tumors as of low malignant potential, a fact not surprising in eras of defensive medicine. In the report from Bobjer et al. in this issue, the proportion of PUNLMP in the study population of low-grade Ta was around 6% during the years 2004–2008 [3]. In the most recent report from the Swedish Cancer Registry this category was not separately reported due to their scarcity. The same trend has been reported from other countries.

To prognosticate the future risk of recurrence or progression at the date of diagnosis is important to recommend an optimal management. This could be in the form of prophylactic therapy and a risk adapted follow-up schedule. For the majority of patients with non – muscle-invasive bladder cancer recurrence is the dominating risk even if this has been reduced during more recent years [4]. The EORTC risk calculator, based on several clinical studies, show that the most important prognosticators are number of tumors at diagnosis and tumor diameter as well as the presence or absence of a recurrence at the first follow-up cystoscopy.

Histological grade is less useful and thus a lot of hope has been set on molecular grading of cancers as a valuable prognostic tools. Unfortunately, this has not proven useful yet. It is mind blowing that other simple tools as tumor weight does not have the attention in the era of molecular medicine [5].

It can be concluded that the good intention of avoiding a cancer diagnosis for this category of aberrations did not succeed. A lesson for the future is the importance of nomenclature, perhaps the original term 'papilloma' would be more appropriate and less prone to misinterpretation.

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