EDITORIAL Highlights from the Canadian Bladder Cancer Network

D. Robert Siemens, Associate Editor

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It is an honour and privilege to introduce this issue of the *CUAJ* as the recently appointed Associate Editor for our journal.

One of the important contributions in this issue includes that of Dr. Pouliot and colleagues from Université Laval further defining the risk factors associated with renal deterioration after laparoscopic partial nephrectomy.[1] The authors suggest that our surgical planning should focus more on limiting resection of normal tissue, careful closure of the collecting system and hemostasis, while paying less heed to early unclamping of vessels as long as warm ischemic time can be limited to 30 minutes. Also, Dr. Abdullah and Dr. Kapoor present a well-timed review of what is a mounting paradigm-shift around the management of castration-resistant prostate cancer (CRPC).[2] This article should be required reading for all those who manage patients with prostate cancer.

Finally, we are delighted to be able to highlight the recent work from the research team of the Canadian Bladder Cancer Network (CBCN).[3] This consortium of Canadian investigators has evolved out of an unmet need due to traditionally underfunded urothelial cancer research. The network has so far compiled the clinical and pathologic data of 2287 contemporary patients who underwent cystectomy, implementing multiple strict quality control procedures to ensure accuracy and concordance of their data. This article focuses on patients who underwent cystectomy for high-grade T1 bladder cancer and confirms the ominous results recently demonstrated in other series.[4,5] In this cohort of patients, local tumour upstaging to muscle invasive disease was evident in 48% of cases, with an alarming lymph node involvement of 19.9%.

Although the treatment options for non-muscle invasive transitional cell carcinoma are well-described in many guidelines,[6] including the recent CUA offering,[7] there is little debate that the optimal management of high-grade T1 disease remains a common and vexing dilemma. Most recommendations for high-grade T1 disease include an initial attempt at bladder preservation (grade A) with the option of "early" cystectomy in those with high risk of progression (grade C). The extraordinarily high rates of pathologic upstaging and only modest disease-free survival demonstrated in this and other reports however would suggest the inadequacy of our clinical decision-making based on available tools for risk stratification and current treatment algorithms. Although the present study is limited by selection bias and the lack of certain clinical parameters, the results underscore the need to more effectively identify patients at high risk of progression. Given the propensity towards bladder sparing in Canada and the fact that randomized trials are unrealistic, it is apparent that the time has come to rally support and resources for future collaborative work embodied by the CBCN. Facilitating prospective, multi-institutional registry studies to further identify clinical, pathologic and molecular factors predicting progression is needed to inform us when we should "cut bait" and move on to definitive therapy for this invasive stage of disease.

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