

Survival after radical surgery for huge sarcomatoid bladder tumor

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Introduction

A 58-year-old male with BMI 36,8 was seen due to his allegedly three months lasting dysuria and traces of blood in his urine. His renal function was normal, CRP 18,7 and urinary sediment was flooded with red blood cells, but w/o bacterial infection. There was no dilatation on U/S, but hyperechoic exophytic mass was seen in the bladder. The CT scan showed mass, as on Fig 1. Biopsy from the mass was taken to disclose sarcomatoid tumor of the bladder, Fig 2. Since there was no secondaries observable in time



Figure 1:

of CT scan and on scintigraphy, the radical cystectomy with ileal conduit was suggested. The patient agreed immediately, but there was the cardiac status in the way, since he had hardly survived severe cardiac attack with successive cardiac failure only two years ago, which did not resolved completely. The cardiac output, e.g. ejection fraction (EF), had improved only on permanent pacemaker to reach utmost 42%. Patient was made aware of possible serious complications after the surgery, cardiac arrest and possibility of re-operation due to his obesity and unfavorable medical status due to general ischaemia and atherosclerosis.

Despite that, he opted for surgical approach, since the malignancy was undisputable, he was incontinent due to lack of bladder

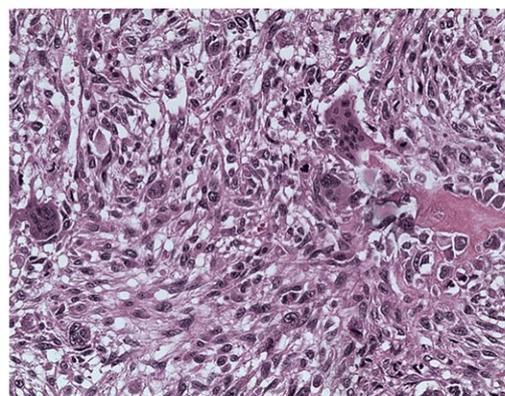


Figure 2:

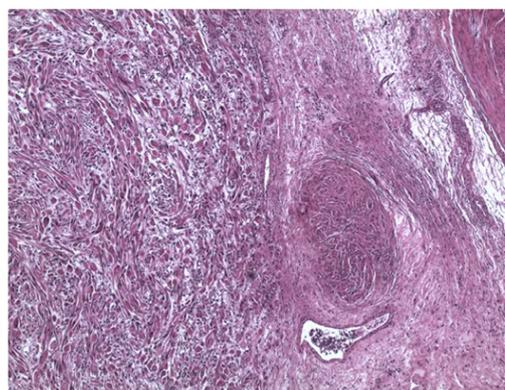


Figure 3:

capacity and there was intermittent urinary bleeding. Radical cystoprostatectomy with incontinent Bricker's diversion was carried out showing deep bladder smooth muscle involvement Fig 3, but without pelvic nodal infiltration. Moreover, early stage prostate cancer pT1a was found despite unsuspected PSA 1.48 ug/L, preoperatively.

Regarding the surgical approach, the common lower abdominal mid-line incision was carried out with routine pelvic internal and common iliac nodes dissection (both negative). The internal iliac veins were tied, but not transected, which according to my observations, reasonably reduces collateral bleeding when the bladder is made free using harmonic scalpel. Proximal urethra was closed with a resorbable figure of 8 stitch, when bladder/urethra specimen was separated below the prostatic apex. The left-sided ureter was delivered on the right side beneath the mesenteric radix through the „3-finger-opening“ to prevent its later kinking, e.g. obstruction. The Wallace I modification for side-to-side ureteric confluence was used to create single ureteral opening for uretero-ileal loop anastomosis. Stenting with ureteric catheters FG 7 „whistle“ is inevitable to prevent anastomotic oedema and post-operative urinary leakage, at least for 12 consecutive days. A single Jackson-Pratt drain to pelvic cavity and nasogastric tube for 4 days makes the intestinal paralysis post-op considerably shorter



Figure 4:



Figure 5:

The patient was discharged on the day 16 and despite trained in stoma care together with his wife, it became very soon clear, that this procedure was out of the capabilities of the couple. The patient did not comply with ambulatory care at all, he was not able to keep the stoma clean and hence the cutaneous plate for collecting urinary bag was difficult to seal on the fatty abdominal

wall resulting in urinary leakage around it. Patient had to be re-admitted to the hospital and local therapy for subcuticular abscess around the stoma had to be carried out. He was discharged cured, Fig 4 and IVU showed normal collecting system on both sides and ileal conduit with no urinary leakage, Fig 5.

One month later, the man was admitted to the hospital again, due to urosepsis. As it was disclosed later on, he attempted to stop the urine coming out of the stoma with plugging it with the swab (!). He lost on weight substantially and surgical repair of the ileal conduit was suggested to cut it short a little bit, since there was no need to have it so long as it was done originally, when the patient suffered from several obesity. He refused it and bilateral nephrostomy was done successively due to urinary leakage from the abscessed conduit. Patient was left on supra-conduit urinary diversion as the permanent urinary diversion and one year after the radical surgery, he was still without detectable metastases. No adjuvant radio- or chemotherapy was done to prevent possible later malignant spread. The patient succumbed to the widespread metastatic disease after another year, accomplishing two full years after diagnosis and 22 months after radical surgery.

Discussion

Sarcomatoid bladder tumors have very bad reputation regarding the patients' survival and possible treatment. If diagnosed, the afflicted patient has his days usually numbered, as generally observed [1]. Despite radical approach and adjuvant chemo and possible radiotherapy, the course of the disease remains straightforward and leads to deaths, almost inevitably. The course of the disease is generally considered to be quick, and the patients experience frequent complications, as recurrent bleeding, dysuria, infection, urosepsis, sometimes also post-renal anuria. In this case, patient was clinically unfit for chemotherapy from the very beginning, but an adjuvant possible radiotherapy on the pelvis minor (to kill the possible micrometastases in the time of surgery) might have proved to be beneficial. However, the major problem after successful surgery was patient's uncompliance with post-operative treatment and stoma care, as well as huge obesity. Despite that, the highly demanding surgery was met with quite unusual long patient's survival, but quality of life was rather dodgy regarding post-operative infections and subsequent urinary drainage through nephrostomic catheters.

The patient was quite young, 58, had clinical difficulties with bladder capacity and urinary bleeding. He did not show any mental disorders prior to surgery, but his mental status had probably been underestimated with miserable postoperative compliance with successive medical care and possible oncological adjuvant therapy.

It is hard to recommend any common guidelines for treatment such huge and malignant tumours. The prognosis is quite unfavorable, as Bostwick and al. already observed. The removal of the whole mass with extensive regional and iuxta-regional node dissection seems to be the bottomline of all attemptive procedures. The adjuvant chemo and radiotherapy should follow, whenever applicable and possible, which presumes the good patient's compliance. Any continent diversions depending

on pelvic intestinal pouch should be reconsidered and possibly avoided, regarding the likely complication with chemo and radiotherapy side effects.

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