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## Research Article

### PAPILLARY BLADDER TUMOR

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#### ABSTRACT

**Introduction:** Bladder cancer represents 4.9% of total neoplastic deaths in males and 1.8% in females (3). And the 3rd tumor by prevalence in Italy In the Italian Association of Tumor Registries (AIRT), every year, 70.7 cases of bladder cancer per 100,000 men and 16.3 per 100,000 women were diagnosed on average. In Eastern Sicily On 1646 (75-80) cases in 84% the disease affects the male and the remaining 16% the female also has a net chance of casualty between urbanization and industrialization with the increase in the incidence of bladder neoplasms. **Material and Methods:** In the Department of Specialist Surgery II of the Clinical Hospital of Catania from January 2010 to December 2016, there were n 152 patients with bladder n 127 males in 25 females and mean age 65. of these n 90 (60%) affected From ca infiltrating in 60 (40%) with non-infiltrating ca). Screening carried out with non-invasive investigations due to hematuria and urinary cytology included the following examinations: Ultrasonography, urinary cytology Uretrocistoscopia Fluorescence cystoscopy URO-TC RMN PET molecular urinary test **Results:** Surgical treatment in 29 cases (48.9%) With non-infiltrating bladder tumor was to undergo TUR-B. The patients. In 51% of cases there was a tumor of less than 1 cm, while in the remaining 49% the tumor was more than 1 cm with the presence of an associated cis in 10% of the cases (n 3 paz). The objectives of -TUR-B were: complete eradication of the tumor; The correct staging; The optimization of the therapeutic and follow up program. The presence of residual tumor at TUR involved n 9 cases (15%) was a prognostic negative prognosis of recurrence and progression (12.13) of the disease present in high-risk tumor (high grade T1) **Discussion:** in tumor Non-infiltrating bladder is based on the definition of 6 predictive factors that can be deduced at TUR: 1-Number of tumor , 2-Size of the tumor 1-Previous recurrence rate2 -Stadio of the tumor (T) 3-Presence of concomitant CIS4 -Grade of tumor (G) The identified parameter codes encode a risk score that is predictive of reduced survival: -Base Risk: single lesion, Ta, G1, diameter <3 cm -Internal Interference: Ta-T1, G1-2, multifocality, diameter > 3 cm-High risk: multifocality, high relapse rate, T1 stage, G3 grade, CIS, these parameters were adopted in the study and treatment of patients with satisfactory clinical picture Ermade to point to the treatment that has resulted in T2 survival beyond 120 months). Another important factor in TUR-B remains the decline in the risk of residual tumor after TUR for Ta-T1 tumors, with accurate staging. **Conclusion:** Radical cystectomy confirms the choice of treatment for bladder infiltrating cancer that determines the best results in all age groups, feasible and well-tolerated by the elderly population with morbidity and mortality rates that can be overlapped by the global population. Neo-Adjuvant chemotherapy has many advantages: 1 It permits an in vivo drug sensitivity test 2 It is better tolerated 3The response can have a prognostic value 4 It can make a tumor initially inoperable.

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#### INTRODUCTION

Bladder cancer represents 4.9% of total neoplastic deaths in males and 1.8% in females (1). And the 3rd tumor by

prevalence in Italy In the Italian Association of Tumor Registers (AIRT), every year, 70.7 cases of bladder cancer per 100,000 men and 16.3 per 100,000 women were diagnosed on average (2). In Eastern Sicily on 1646 (75-80) cases in 84% the

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disease affects the male and the remaining 16% the female also has a net chance of casualty between urbanization and industrialization with the increase in incidence of bladder neoplasms. It is estimated that due to population aging, 24,472 cases of bladder cancer in 2011 and 30,311 in 2020 will be diagnosed in Italy. Cigarette smoking is surely the most recognized risk factor for bladder cancer. Occupational chemical agents represent the most important risk factor for cancer associated with the presence of chronic urinary tract infections (3.4), and finally drugs such as cyclophosphamide and most recently the identification of genetic predisposition. Survival relative to 5 years has gone from 72% in men and 74% in women between 1990 and 1992, respectively at 80% in both sexes in the period from 2005 to 2007. (5.6) Research refers to cancer cellular cancer that accounted for 90% of bladder cancer, placing Attention to the correct therapeutic approach, onset and evolution, early diagnosis with recognition Accumulation of precancerous lesions

## MATERIAL AND METHODS

At the Department of Specialist Surgery II of the Clinical Hospital of Catania from January 2010 to December 2016, there were n 152 patients with bladder cancer n 127 males and 25 females and mean age 65. of these n 90 (60%) affected by infiltrating ca In 60 (40%) patients with non-infiltrating ca. Symptomatology was characterized by total which was the Bulky hematuria brain and often single sign observed in patients with bladder cancer. In the Ta-T1 forms it manifested with dysuric disorders (mental urgency, pollachiuria, stranguria). Tumor occurring close to the bladder neck or involving the urethra were urine retention. In the muscular-invasive vesicular tumor, besides the disorient associated with pelvic algae, and in some cases the hydro-ureteronephrosis typical of locally advanced disease. Screening carried out with noninvasive investigations for the presence of hematuria and urinary cytology included the following examinations:

**Ultrasonography:** Ultrasound is the initial investigation into the urinary tract; Has been able to identify hydronephrosis or defect of pelvic and bladder fillings with the same diagnostic accuracy as the neurograph (v.fig 1)

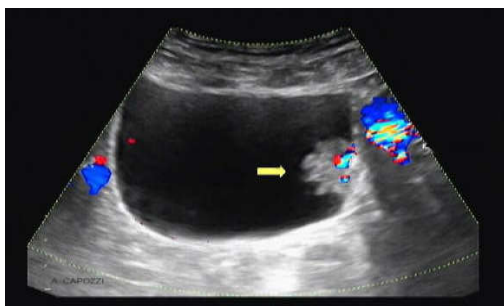


Fig 1 echo bladder lateral neoformation ds

### Urinary cytology

Cytological examination of spontaneous urine offers high sensitivity for high-grade but low-grade nephrosis (7.8). The outcome of a cytological examination is strictly dependent By the operator (9) and may be affected by the presence of some concomitant situations: poor chemotherapy sample. However, in expert hands the specificity of a cytological examination exceeds 90% (10). The histological examination included a

description of the histological type or histological types present, if more than one in tissue samples obtained from a TUR followed the following criteria: 1. Neoplasm 2. Degree 3. Extension of infiltration level 4. Quantity of muscle tissue present in the sample 5. Presence of CIS 6-. Eventual presence of vascular or lymphatic invasion. For specimens from radical cystectomy, the following characteristics were outlined: (Figure 2-3) 1. Number and size of neoplastic lesions 2. Architecture of lesions (papillary, sessile, flat) 3. Characteristics of the infiltrating part 4. Presence and extension Of pericytic fat infiltration or adjacent structures 5. Presence of CIS 6. Vascular or lymphatic invasion 7. Number of metastatic lymph nodes and number of lymph nodes removed. Radial margins

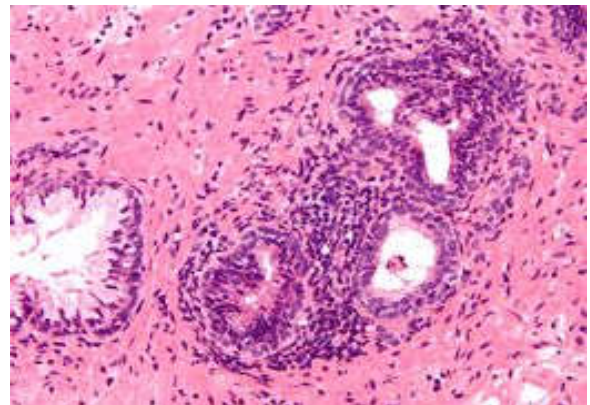
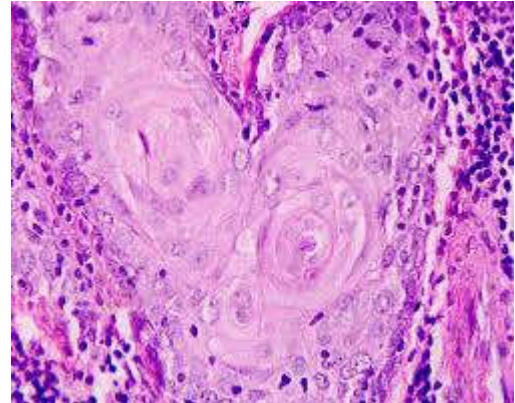


Fig. 2-3 Histologic samples from radical cystectomy

### Urethroscopy

Diagnostic or follow-up cystoscopy has been performed in the outpatient mode with the flexible instrument, and with a detailed description of the location, size, number, appearance (papillary or solid) of the bladder tumor as well as any abnormalities of Appearance of bladder mucosa.

### Cystoscopy fluorescence

Fluorescence cystoscopy performed using cystoscopes in blue light, after intravesical instillation of a photosensitizer, generally the 5-aminolevulinic acid (5-ALA) or hexaminolevulinato (HAL). Cold biopsy or light blue cystoscopic resonator showed greater sensitivity in identifying the CIS. False positives were caused by cystitis, or endoscopic resection Molecular urinary tests show the role of molecular urinary markers in the diagnosis and follow up of bladder cancer, already available in the market. They are divided into soluble markers (BTA STAT, BTATRAK, NMP22, NMP52,

BLCA-4, BLCA1, survivin, hyaluronic acid, cytokeratine) or cellular (telomerase, FISH, microsatellite DNA analysis, DD23, fibrinogen degradation products). Most of these tests have a higher sensitivity to urinary cytology in identifying low-intermediate but rather low-specific forms that can be considered a valid alternative to urinary cytology (11,12), for which they were performed in 10% Of cases with the cytology comparison yielding results only in 5% of cases. Have been studied with genetic investigations the role of oncogenes. Cytogenetic analysis has clearly shown that the loss of a suppressor gene, or more suppressor genes on chromosome 9 is frequently involved in the genesis of bladder cancer. Mutations of the p53 oncosoppress gene were found in 50% of high grade bladder cancer and in advanced stages; such mutations play an important role in determining survival after neo-adjuvant chemotherapy

**URO-TC and TC**

The thin-layer and contrast medium URO-TC has been used as an alternative to intravenous urography in the diagnosis of urinary tract malignancies and, with respect to the latter, provides a better definition of the bladder walls and possible defects in filling. The TC's accuracy in defining the extravascular extension of the neoplasia varies from 55% to 92% and increases proportionally for advanced disease stages (13). TC also has a lower sensitivity (89%) and a higher specificity (95%) than the RMN in identifying possible involvement of pericytic fat (14.15).

**MRI**

Magnetic resonance imaging (RM) provided a better definition of soft tissue than TC. The accuracy of staging obtained by RMN in the diagnosis of primitive tumor varies from 73% to 96%. These values are about 10-33% higher than those obtained with TC (16). RM with contrast medium manages to accurately differentiate between the neoplasm and the surrounding tissues because, with respect to the latter, the increase in neoangiogenesis processes, typical of the neoplasia, results in faster accumulation of the contrast medium (17). In addition, the dynamic RM, in which 1 image / second is captured, can differentiate between the neoplasm and a possible flogistic reaction of the secondary wall to a recent bladder resection (18). TC and RM have the same sensitivity (range: 48-87%) and specificity in the evaluation of lymph node disease (19,20). The definition limit for both procedures is 8 mm for pelvic lymph nodes and 10 mm for abdominal lymph nodes (21.). In addition to identifying and defining liver and lung metastases

**PET**

There is currently no evidence to support PET or PET / TC use in staging urothelial bladder cancer because of the limited number of studies and patients treated. (22) In our case, PET was used in doubtful cases without yet obtaining precise indications for its use.

**Endoscopic Bladder Resurfacing (TUR)**

Endoscopic resection with stage, diagnostic and therapeutic intent, is a surgical maneuver usually conducted in loco-regional anesthesia that aims to remove the esophytic portion of the tumor, its implant base and the surrounding margins of

the plant base. In order for the resective intent of resection to be guaranteed, it is necessary that the tissue reseeded at the plant base is contained histologically analyzable muscle tissue. For Tumor <1 cm were removed "en bloc" including in the sample also part of the muscle tonka at the implant base. For tumor > 1 cm, the esophytic portion and the plant base were collected separately and collected separately for perilous margins, avoiding, as much as possible, excessive electrocautery damage to the tissues removed. The samples were subsequently sent separately to the anatomy pathologist (23,24). Bladder tumor are often multifocal and may be associated with in situ carcinoma (CIS). Generally, patients with a history of bladder cancer have not been randomized (v.fig 4-5) biopsy specimens for CIS or areas of dysplasia in the absence of a real suspect (25,26,27). The likelihood of finding an associated CIS, especially in low risk cancers, is less than 2% (28,29,30). The random, random, biopsies on apparently normal bladder mucosa were performed when spontaneous cytology or bladder washings are positive or suspected for malignant tumor cells in the presence of a tumor whose papillary aspect is not papillary and in the presence of Suspected areas in blue light urethroscopy after instillation of photosensitizing substances. In the presence of tumor on the trigonum and bladder neck, biopsy specimens were also performed in prostate urethra because in such situations the probability of urothelial involvement of urethra or prostate ducts is greater,

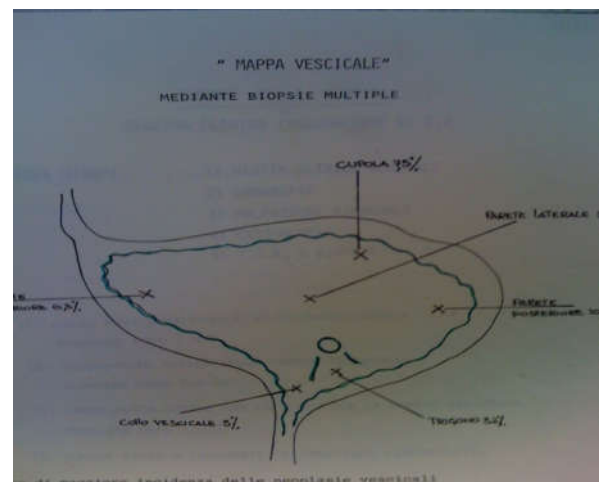


Figure 4 illustrates the site of bladder biopsies



Fig 5 bladder papilloma

## RESULTS

Surgical treatment in the 29 cases (48.9%) with non-infiltrating bladder tumor was to undergo TUR-B. the patients. In 51% of cases there was a tumor of less than 1 cm, while in the remaining 49% the tumor was more than 1 cm with the presence of an associated cis in 10% of the cases (n 3 paz). The objectives of -TUR-B were: complete eradication of the tumor; the correct staging; the optimization of the therapeutic and follow up program. The presence of residual tumor to TUR involved n 9 cases (15%) was a negative prognostic factor of recurrence and progression (12.13) of the disease present in high risk tumor (high grade T1), the median survival Free from relapse was 57 months. In patients with non-invasive muscle disease, the surgical treatment of the 31 cases also underwent Tur-B had a staging and therapeutic intent. The endoscopic method, in addition to providing information on the extent of the disease, gave guarantees on the resection radicality. The retrospective study has shown how the surgeon's capabilities had a positive impact on the rate of recurrence. All the resections performed were the muscle tone of the implant base and the biopsy samples were performed according to the diagram (see Fig. Fig. 4) the biopsy specimens were also performed on the trigonum and bladder neck in the prostate urethra. In all patients treated, mean median duration was 4 days, median survival free from recurrence even in this group was 57 months Adjuvant endovascular therapy was performed to complete the eradication of neoplasia carried out with early chemotherapy and instillation Endovascular mitomycin C following the therapeutic pattern; 1 time per week for 8 weeks followed by a monthly instinct for 12 months. For about 2 years the treatment pattern has changed with mono administration. Substitution after surgery. The other protocol included the use of BCG endovascular immunotherapy only in unifocal localization with negative bladder mapping, and in blistered multifocal (3-5 loc.) With localized mucous membrane and bladder dome. There was also a reduction in the risk of relapse with the free interval of the disease on average after 40mg The treatment of infiltrating disease was Radical cystectomy representing the standard treatment for muscular-invasive bladder tumors (T2-T4, N0, M0) In most Western countries . Of the ninety-nine cases observed in 46 cases (51%), the neoadjuvant chemotherapy (M-VAC) and later radical cystectomy were performed first, and in the other 44 cases (49%) partial cystectomy was indicated by the unifocal localization with dome Bladder or near the urethral outlet, associated with chemotherapy neoadjuvant. The disease-free interval was on average 72 months at stage T3-T4. At T2 stage, the mean interval was 120 months. The pathological anatomical examination depended on the absence of neoplastic outbreaks in both the bladder and peripheral and lymphoid fat. Radical cystectomy in the elderly patient was performed as a treatment for choice for bladder infiltrating carcinoma, well tolerated by the elderly population with morbidity and mortality rates overlapping by improved anesthesia. Of the N 40 cases observed, only 25% had the criteria for Operation after a careful assessment of operator risks, co-morbidity, quality of life, life expectancy and expected benefit from treatment.

## DISCUSSION

In non-infiltrating bladder tumor , the indication of treatment was based on the definition of 6 predictive factors deductible at TUR: 1-number of neoplasms, 2-size of the neoplasia 1-previous recurrence rate2 -this tumor (T) 3- Presence of concomitant CIS4 -Grade of the neoplasm (G) The identified parameter codes encode a risk score that is predictive of a reduced survival: -Base Risk: single lesion, Ta, G1, diameter <3 cm -Internal Interference: Ta-T1, G1-2, multifocality, diameter> 3 cm-High risk: multifocality, high recurrence rate, T1 stage, G3 grade, CIS, these parameters were adopted in the study and in treatment with a satisfactory clinical picture that allowed us to bring a Survival at T2 stage over 120 months. In Non-Muscle Invasive Treatment Treatment an extended transurethral endoscopic resection (TUR) provided more detailed information on the horizontal and vertical extent of the disease. A systematic review of the treated patients highlighted the importance of TUR quality as it determines the prognostic factors for the risk of recurrence, such as the number of tumor and subsequent endovascular therapy, in addition to the risk of prostatic urethral involvement in case of Urothelial bladder of non-infiltrating bladder which is about 10% . (31.32) which appears to be greater when the disease is in the trigemens, CIS or multiple tumors (33.34). Another important factor in TUR-B remains the risk of decreasing residual tumor after TUR for Ta-T1 tumors, an accurate staging. The implementation of the second endoscopic resection performed within 6 weeks of the original resection with the objectives of: 1-Complete tumor eradication; 2-Correct staging; 3-Therapeutic and follow-up optimization program. And with indications such as: - First ineffective resection for size, number or location; 2-Absence of muscle tonka in samples of the first resection; Reduction of recurrences was achieved, confirming the literature data. The aim of the endovascular treatment was to: 1-Lengthening the free interval between TUR and recurrences 2-Progression progression by stage and grade of disease after TUR Single. With immediate endovascular instillation of postoperative chemotherapy, recurrence reduction was achieved and the major benefit was expected when instillation was performed within the first 6 hours of TUR (33-34) finally in endovascular immune therapy with BCG There is a 22% reduction in recurrence risk for the untreated group with BCG. In Infiltrating Disease Treatment, survival in Radical Cystectomy free from disease progression ranges from 66 to 68% and survival at 5 years ranges from 50% to 60%. () The 5 and 10 year survival results to be correlated with the degree of infiltration Of the bladder wall, in the presence of extra-bladder extension and in the presence or absence of metastasis in loco-regional lymph nodes. After cystectomy the problem of urinary derivations is currently being performed in our case can be divided into: *ureterocutaneostomy*. Urethral abdominal wall is the simplest form of skin diversion (35,36); It can be considered a derivative of choice in patients with significant comorbidity and / or contraindications in the performance of an intestinal resection. Performed in 10% of cases of metastatic disease in our group of patients examined. *The ileumic duct* is a derivative of common use and well-known results in the literature. However, even today, up to 48% of patients develop early complications such as pielonephritis, dehydration of urethro-loose anastomosis and late ones such as skin stenosis and urolithiasis to the reservoir. (37)Stomach complications

(24% of patients) and functional and / or morphological alterations of the upper urinary tract (30%) are the most commonly reported complications in long-term end follow-up studies. The low pressure intestinal reservoir used as a derivation Urinary skin continent to be emptied with autocateterization is considered a valid alternative to urinary orthopedic derivation in highly selected cases. Derivatives with gastric, iliac, ileocolic and sigma segments have been described, *Ureterosigmoidostomy* The high incidence of high urinary tract infections, high risk of developing colon cancer and a poor quality of secondary life Altered sleep frequency and urgency incontinence (38) make this derivation decoupling *The New bladder orthotopic* Orthotopic bladder replacement is now commonly used in both men and women. Recent studies document the long-term safety and reliability of this procedure. The most commonly used intestinal segment for bladder replacement is terminal ileum while less used are ascending colon, blind and sigma. The orthotopic urinary derivations described are numerous. Early and long-term morbidity is reported in almost 22% of patients. Long-term complications include daytime and night-time incontinence in 25% of cases, stenosis of urethro-intestinal anastomosis (15%), incomplete urinary drainage (6%), metabolic disorders and vitamin B12 deficiency. There are various types of ureter-intestinal anastomoses: direct or anti-inflammatory. In accordance with long-term results, the high urinary tract is safeguarded by all these techniques. An intact sphincter mechanism, adequate capacity, no peristaltic contractions, and good compliance are the main factors that determine the function of neovascular and the quality of life of the patient. Finally Radical Cystectomy in the Elderly Patient Up to the 80s, radical cystectomy was burdened by a 12% mortality rate in patients > 65 years of age, 7% in patients with lower age. However, over the last 20 years, due to improvements in the surgical and anesthesiological field, an important decrease in the mortality rate has been observed. Cancer-related survival shows a better rate in all age groups undergoing cystectomy, with a decreasing trend for older patients

## CONCLUSIONS

Radical cystectomy confirms the choice of treatment for bladder infiltrating carcinoma and determines the best results in all age groups, is feasible and well tolerated by the elderly population with morbidity and mortality rates that can be overlapped by the global population. Neo-Adjuvant chemotherapy has many advantages: 1 It allows for a susceptibility test to in vivo drugs 2 It is better tolerated 3 The response can have a prognostic value 4 Can make a tumor initially unusable In non-infiltrating bladder tumor observation of predictive parameters allowed To obtain results. In non-invasive muscle disease, the TUR-B with stage and therapeutic intent provided more detailed information on the vertical and horizontal extent of the disease by adopting the schema we designed for bladder mapping. The repetition of TUR-B in the presence of incomplete resection with the healing of therapeutic chemistry or BCG within 6 hours. Has allowed us in our experience to obtain a longer period of free disease and a reduction in recurrences. In our opinion, the problem of reconstruction after removal of the bladder remains open as although the orthotopic novel is reliable as a future procedure with the use of stem cells (regenerative surgery) opens up the

possibility of new frontiers in the reconstruction of a new-bladder

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