Editorial Comment

This is a large series of a rare condition in the testis. Testicular vasculitis can cause localized infarction that clinically may mimic cancer (1). Testicular vasculitis may be an isolated finding, however, in most patients is associated with systemic vasculitis. All patients should be clinically investigated for systemic disease. In this series of 19 cases the mean age was 38 years and most cases (n = 14) showed polyarteritis nodosa-like features with transmural necrotizing inflammation of small-medium arteries (2). The pathologist must be aware of this condition and look for vasculitis whenever a patient with an infarcted testis has no history of torsion or trauma.

References

1. Atis G, Memis OF, Güngör HS, Arikan O, Saglican Y, Caskurlu T: Testicular polyarteritis nodosa mimicking testicular neoplasm. ScientificWorldJournal. 2010; 10: 1915-8.
2. Meeuwissen J, Maertens J, Verbeken E, Blockmans D: Case reports: testicular pain as a manifestation of polyarteritis nodosa. Clin Rheumatol. 2008; 27: 1463-6.

Dr. Athanase Billis
Full-Professor of Pathology
State University of Campinas, Unicamp
Campinas, São Paulo, Brazil
E-mail: athanase@fcm.unicamp.br

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Lymph node dissection at the time of radical nephrectomy for high-risk clear cell renal cell carcinoma: indications and recommendations for surgical templates

Crispen PL, Breau RH, Allmer C, Lohse CM, Cheville JC, Leibovich BC, Blute ML
Department of Urology, Mayo Clinic, Rochester, MN, USA
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Background: Observational studies suggest a proportion of patients with lymph node metastases will benefit from lymph node dissection (LND) at the time of nephrectomy for clear cell renal cell carcinoma (RCC).
Objective: Our aim was to report the performance of five previously identified high-risk pathologic features assessed by intraoperative examination on prediction of lymph node metastases and propose a template for LND based on locations of lymph node involvement.
Design, Setting, and Participants: The study included a historical cohort of consecutive patients from a single institution who received LND in conjunction with nephrectomy for high-risk clear cell RCC between 2002 and 2006.
Interventions: All patients underwent nephrectomy and LND.
Measurements: Patients were considered high risk for nodal metastasis if two or more of the following features were identified during intraoperative pathologic assessment of the primary tumor: nuclear grade 3 or 4, sarcomatoid component, tumor size ≥10cm, tumor stage pT3 or pT4, or coagulative tumor necrosis. Based on these

features, LND was performed at the time of nephrectomy, and the numbers and sites of regional lymph node metastasis were recorded for each patient.
Results and Limitations: Of the 169 high-risk patients, 64 (38%) had lymph node metastases. All patients with nodal metastases had nodal involvement within the primary lymphatic sites of each kidney prior to involvement of the nodes overlying the contralateral great vessel. A limitation of the study is the lack of a standardized LND performed throughout the study period.
Conclusions: Pathologic features of renal tumors are associated with the risk of regional lymph node metastases and lymph node metastases that appear to progress though the primary lymphatic drainage of each kidney. Based on these findings we recommend that when performing LND the lymph nodes from the ipsilateral great vessel and the interaortocaval region be removed from the crus of the diaphragm to the common iliac artery.

Editorial Comment

The landing zone of lymph node metastasis and hence the extent of lymph node dissection in renal cancer is not very well defined. The authors report on a historical cohort of patients with high-risk renal cancer and demonstrate the extent of lymph node metastases. Several clinically important conclusions can be drawn from these data. First, in 66% of patients with metastases these were suspected meaning that roughly one third of lymph node metastases were unsuspected. So clearly, lymphadenectomy (LND) should be performed in all high-risk patients. But to which extent? Interestingly, 45% of metastatic patients had no peri-hilar lymph node involvement. Furthermore, no patient with a right-sided tumor had para-aortic metastases without other retroperitoneal involvement, and no patient with a left-sided tumor had paracaval involvement without involvement of para-aortic or inter-aortocaval lymph nodes.

Thus, the surgical recommendation in high-risk tumors is that in patients with right-sided tumors LND should involve all para-caval and inter-aortocaval nodes, whereas in left-sided tumors para-aortic and inter-aortocaval lymph nodes should be removed.

Dr. Andreas Bohle
Professor of Urology
HELIOS Agnes Karll Hospital
Bad Schwartau, Germany
E-mail: boehle@urologie-bad-schwartau.de

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Sequential intravesical chemoimmunotherapy with mitomycin C and bacillus Calmette-Guérin and with bacillus Calmette-Guérin alone in patients with carcinoma in situ of the urinary bladder: results of an EORTC genito-urinary group randomized phase 2 trial (30993)

Oosterlinck W, Kirkali Z, Sylvester R, Silva FC, Busch C, Algaba F, Collette S, Bono A
Department of Urology, Ghent University Hospital, Ghent, Belgium
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Background: Bacillus Calmette-Guérin (BCG) is the intravesical treatment of choice for carcinoma in situ (CIS).
Objective: Our aim was to assess if sequential mitomycin C (MMC) plus BCG after transurethral resection (TUR) is worthy of further study in non-muscle-invasive bladder cancer patients with CIS.
Design, Setting, and Participants: In a noncomparative phase 2 study, 96 patients with primary/secondary/concurrent CIS of the urinary bladder were randomized to sequential MMC plus BCG or to BCG alone after TUR.