To the Editors:

Characterisation of a bladder cancer cohort in a urological unit

Published data on urological malignancies in Sri Lanka are scarce and those in print are constrained by low patient numbers and short follow up periods. A large number of urological malignancies are never referred to the national oncological centre in the country. Hence, data from it suffers a serious selection bias (2).

A descriptive study was done on patients with newly diagnosed bladder tumour between 1 November 1999 and 31 December 2001 at one of the two units of a tretiary care urology centre.

A total of 139 patients were histopathologically diagnosed to have bladder cancer during the two year period. Baldder tumour is a predominantly disease of the aged. In our study only 16 out of 145 (11%) were below the age of 50 years. It was commonest in the seventh decade. The sex ratio (M: F, 9:1) was much higher than the figures quoted in the literature (M: F, 3:1) (1). The almost exclusive prevalence of tobacco smoking among Sri Lankan men, which is a major known cause of bladder tumour could be the explanation (1).

An overwhelming majority (96%) of tumours were transitional cell carcinomas (TCC), of which 88% (123/139) were early stage (Tis-T2) tumours (TNM classification). Of the early tumours 80% were of the low grades (Ash histological grading). Overall 75% of the TCC cases were at or below $pT2G_1$ Nx (Table 2). Only four (2.8%) had synchronous upper tract tumours and these data compare well with the reported figures (1) from other countries.

We have observed an inconsistency between the clinical and pathological staging. Only in 41% was the prediction accurate. More often the clinical assessment was an overestimate of the stage compared to histological confirmation (55%) due to absence of bladder muscle to assess the degree of invasiveness. When there is a mismatch it is reasonable to biopsy again or to consider adjunctive therapy giving the clinical stage appropriate consideration (5).

Mortality of TCC is directly related to the pathological stage and grade (4). Of the 10 cancer related deaths in our study, 3 had advanced stage tumours (pT3 and T4) and 5 of the deaths were of the 37 high grade (G III) group (Table 1).

Our study showed a significant dropout rate from the surveillance program for bladder tumour recurrence. Instead of the expected number of 172 patients moving in to the second year, only 150 did so (Table 2). This emphasises the need for an active surveillance and information system instead of the patient dependent passive request method currently practiced in our system.

Table 1. The stage and the histological grade of TCC

Number of patients (%)	*pStage (TNM)*	*Grade (Ash)*
1 (0.7)	Tis	-
14 (10)	Ta	I
1 (0.7)		II
1 (0.7)		III
22 (16)	T1	I
45 (32)		II
12 (8.6)		III
9 (6.4)	T2	I
7 (5)		II
11 (7.9)		III
0	T3	I
3 (2.1)		II
10 (7.1)		III
0	T4	I
0		II
3 (2.1)		III

Table 2. Relationship of endoscopic workload of bladder tumour in the context of the total cystocopy service

Description	*Year 2000*	*Year 2001*
Total cystoscopy sessions for the year	946	1118
Bladder tumour related cystoscopy sessions	538	617
Number of bladder tumour patients for cystoscopy	181	232
Newly diagnosed patients of bladder tumour	67*	82
Mortality	9**	5
Carried forward patients for next year	172	227
Brought forward from last year	114	150

* includes 4 patients with upper tract tumour alone.
** 4 patients were diagnosed before 1 November 1999.

References

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