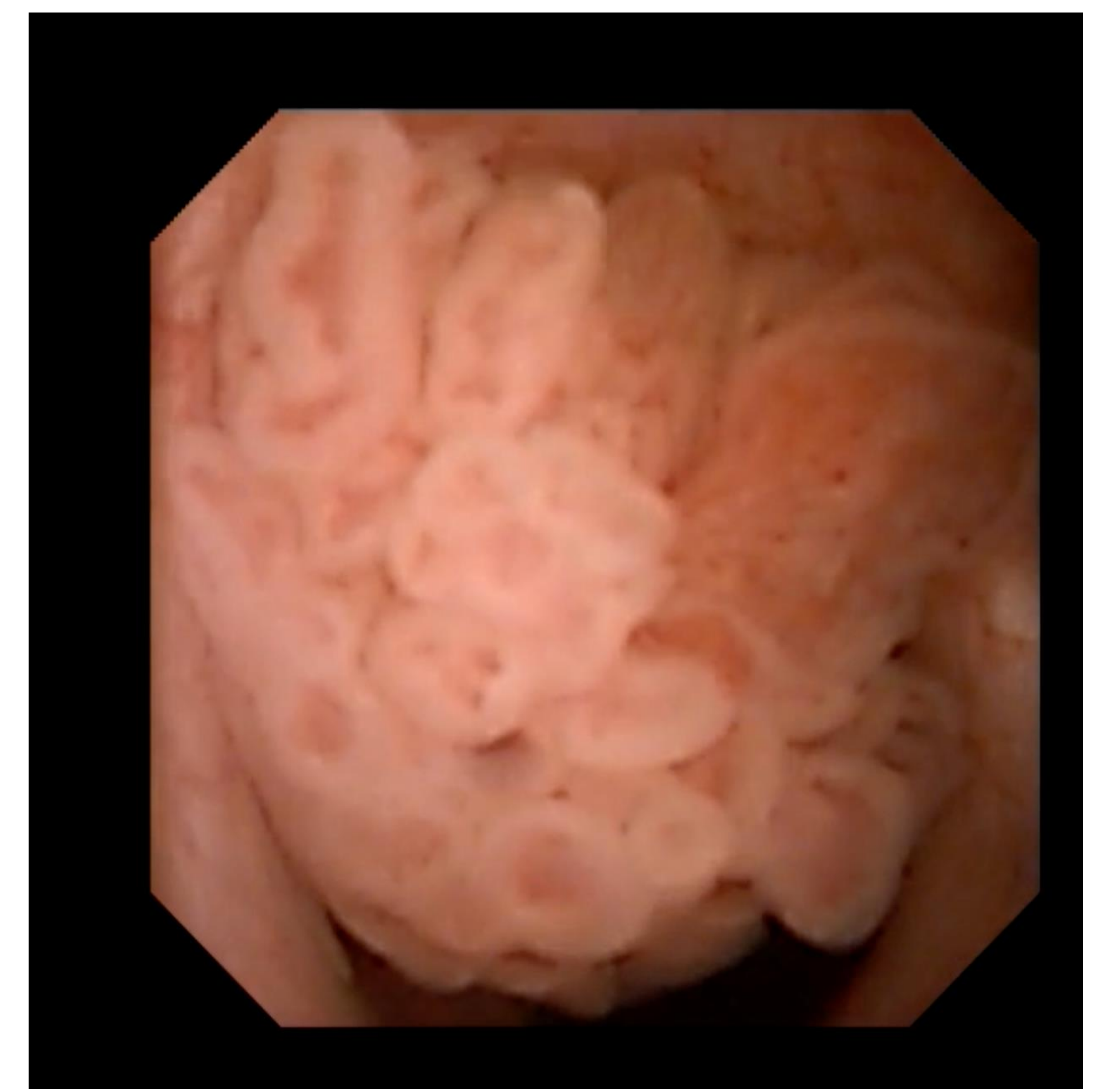
Tratamiento conservador de tumores de tracto superior ¿dónde estamos?

Alberto Rivero Cárdenes
H. U. San Roque M.
H. U. de Burgos



Introducción

El carcinoma urotelial del tracto superior (**UTUC**) es una enfermedad rara que cuenta con el **5%** de los cánceres uroteliales. (**2/100,000 habitantes**)

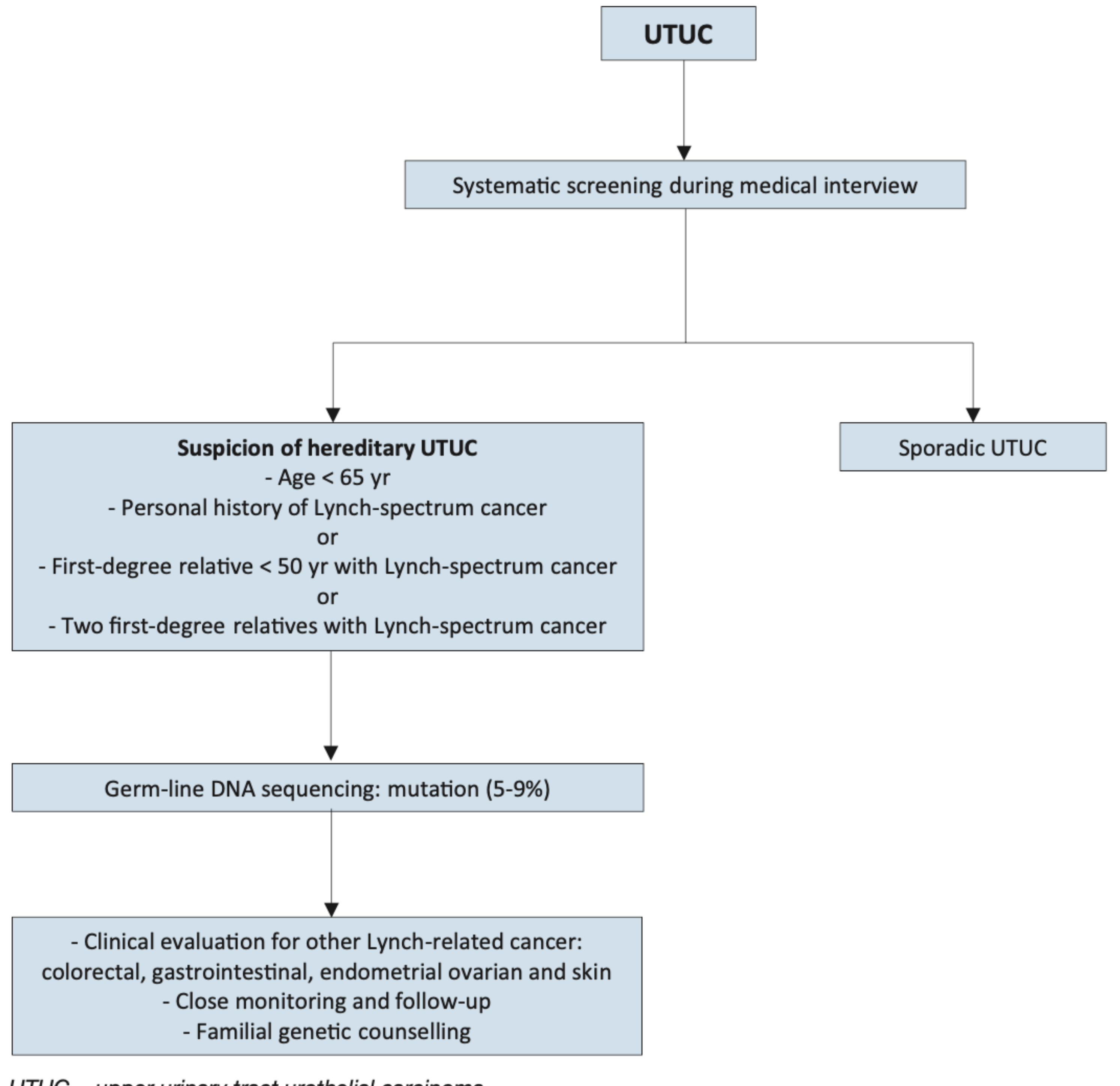
30% UTUC de bajo grado (LG-UTUC) con presentación papilar

17% de los casos se encuentra tumor vesical concurrente

The Amsterdam criteria (Lynch syndrome) - Germline mutations MMR in 9% of patients

Supervivencia específica del cáncer a 5 años <50% y <10% en los estadios pT2-3 y pT4 respectivamente.

Figure 3.1: Selection of patients with UTUC for Lynch syndrome screening during the first medical Interview



UTUC = upper urinary tract urothelial carcinoma.

¿Por donde empezar?

Diagnóstico

Citologías.

TAC- UIV

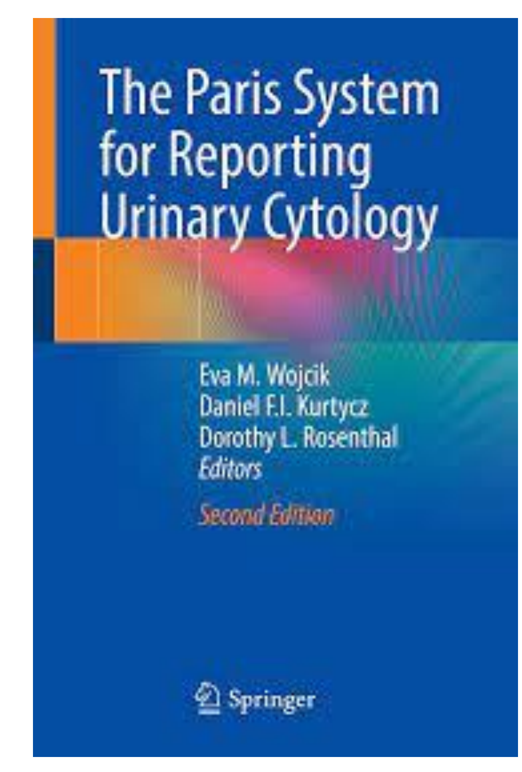
Ureteropielografía retrógrada

Ureteroscopia diagnóstica

Diagnostico: Citologia

Urinary cytology has a poor performance for predicting invasive or high-grade upper-tract urothelial carcinoma

Jamie Messer, Shahrokh F. Shariat*, James C. Brien, Michael P. Herman*, Casey K. Ng*, Douglas S. Scherr*, Benjamin Scoll†, Robert G. Uzzo†, Mark Wille‡, Scott E. Eggener‡, Gary Steinberg‡, John D. Terrell§, Steven M. Lucas§, Yair Lotan§, Stephen A. Boorjian† and Jay D. Raman



311 pacientes

- **Citologia vesical**

Sensibilidad 56% PPV 54%

- **Citologia selectiva**

Sensibilidad 71% PPV 53%

	Source of urine cytology	
	Bladder plus Ureteral (n= 199), % (95% CI)	Selective ureteral (n= 112), % (95% CI)
High-grade disease		
Sensitivity	56 (53–61)	71 (67–77)
Positive predictive value	54 (51–59)	53 (50–58)
Muscle-invasive disease		
Sensitivity	62 (56–69)	78 (70–86)
Positive predictive value	44 (39–49)	46 (41–51)

Diagnostico: TAC

Recommendations	Strength rating
Perform a urethrocystoscopy to rule out bladder tumour.	Strong
Perform a computed tomography (CT) urography for diagnosis and staging.	Strong
Use diagnostic ureteroscopy (preferably without biopsy) if imaging and/or voided urine cytology are not sufficient for the diagnosis and/or risk-stratification of patients suspected to have UTUC.	Strong
Magnetic resonance urography or ^{18}F-Fluorodeoxglucose positron emission tomography/CT (to assess [nodal] metastasis) may be used when CT is contra-indicated.	Weak

Diagnóstico

1._Proyecciones.

2. Reconstrucción 3-D

3. UTUC pelvis renal

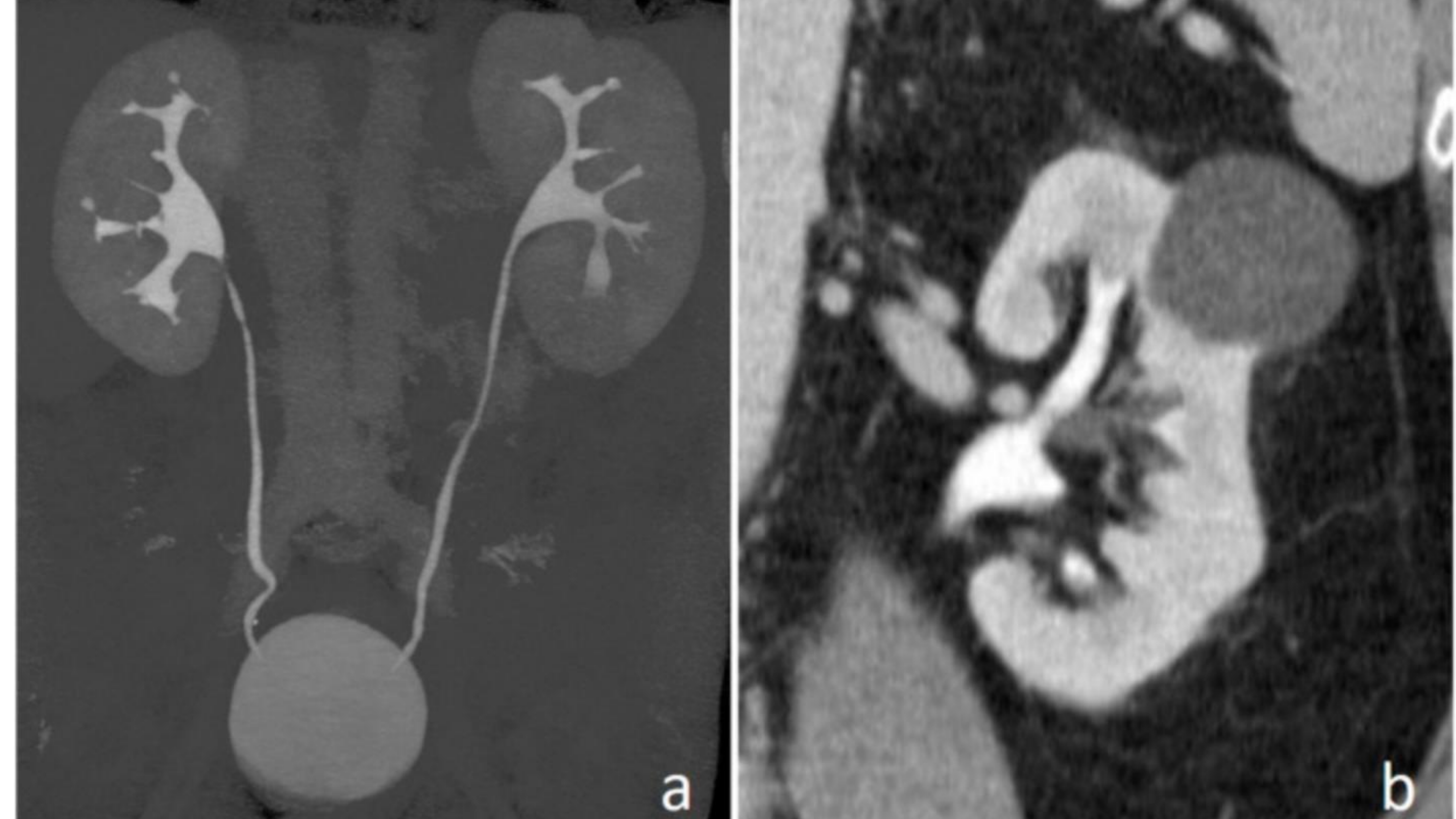
4. Procesos benignos

Pólipo fibroepitelial

Pielouretiritis quística

Papila hipertrofica

Coágulo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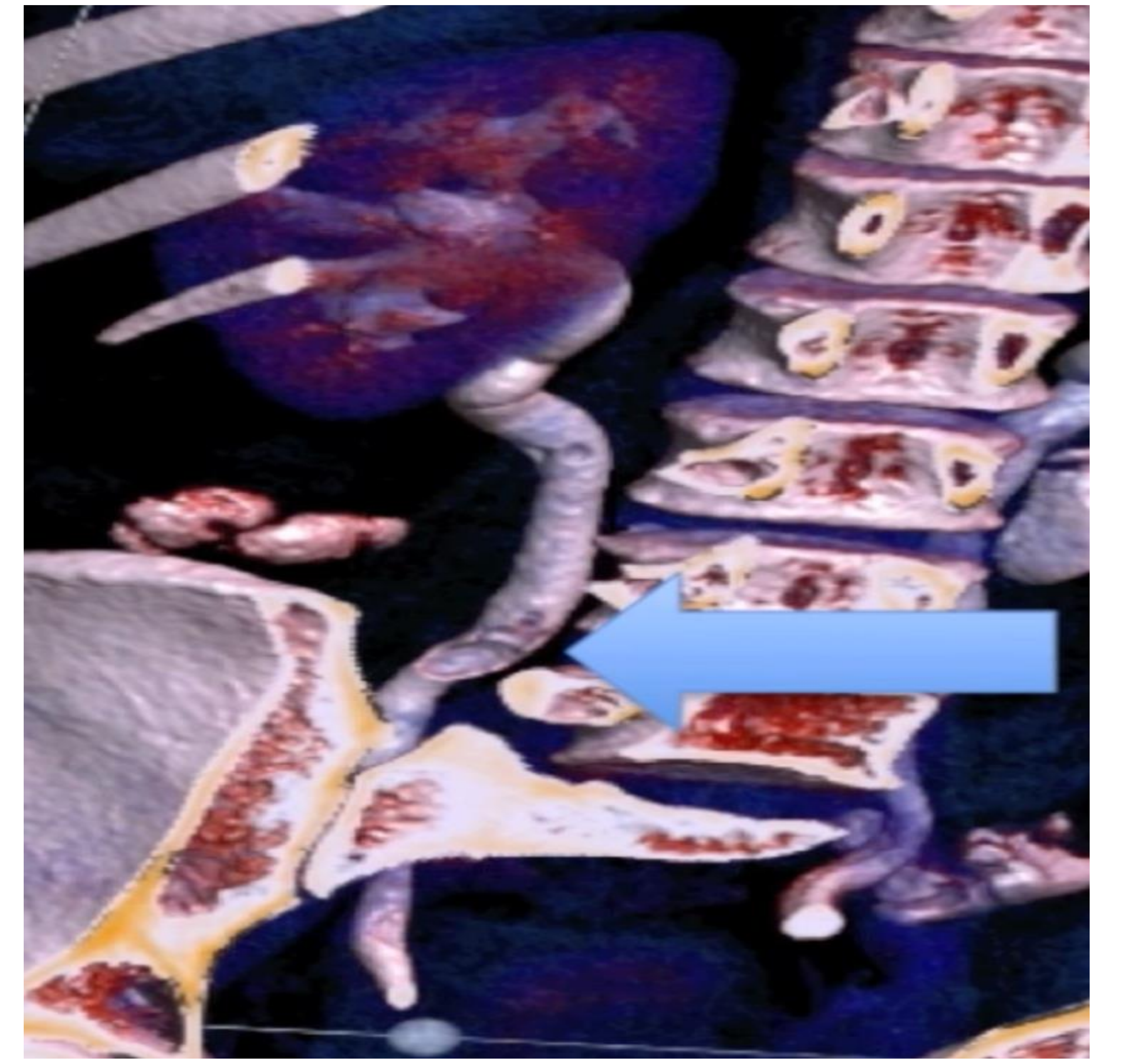

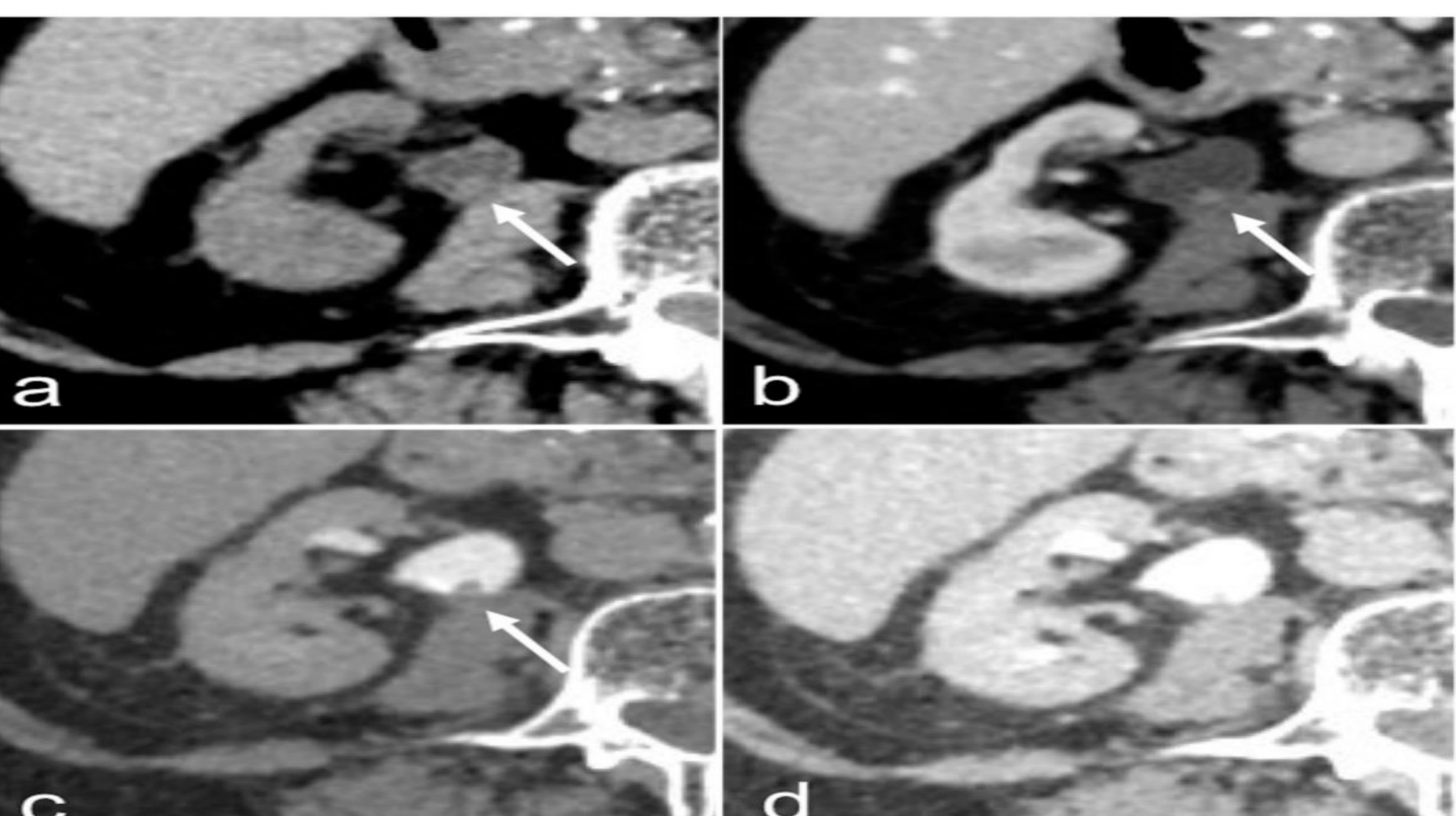
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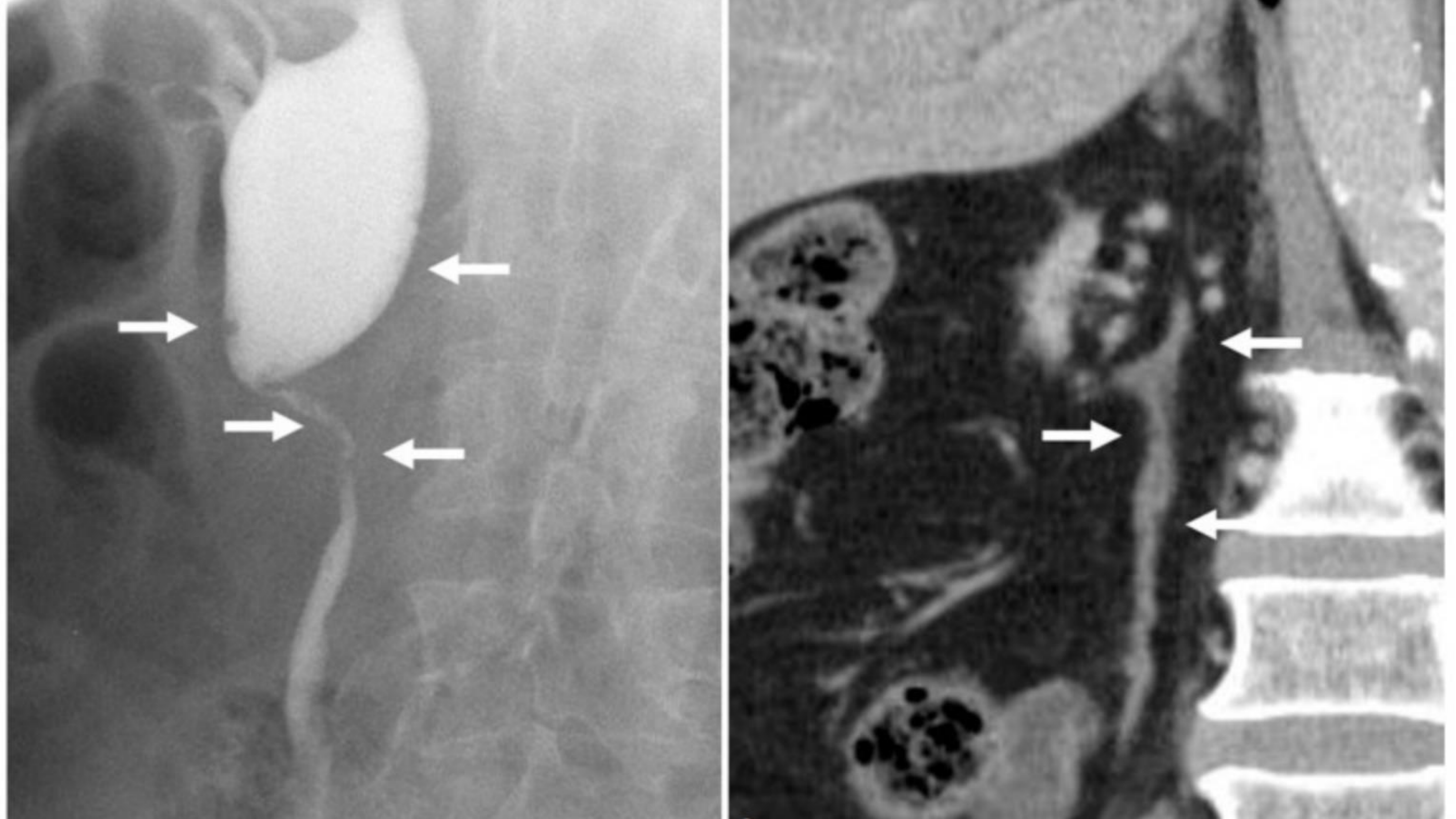

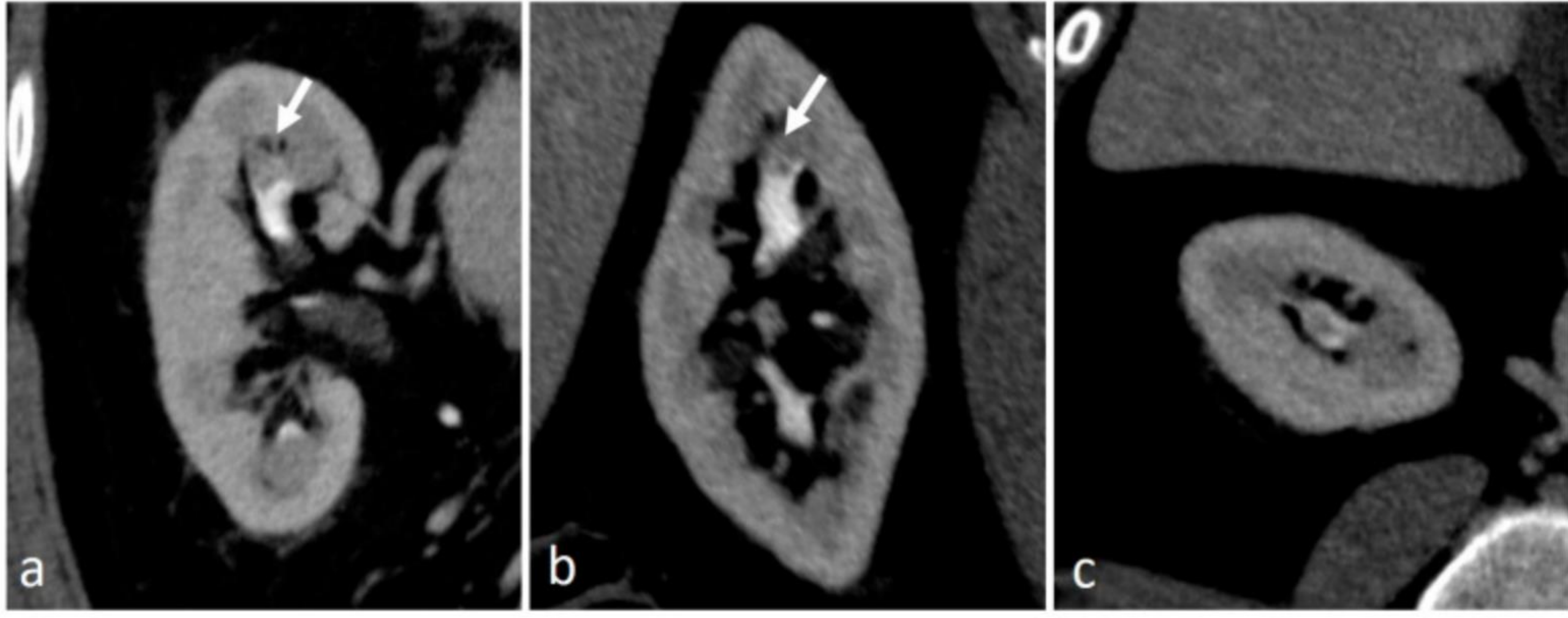
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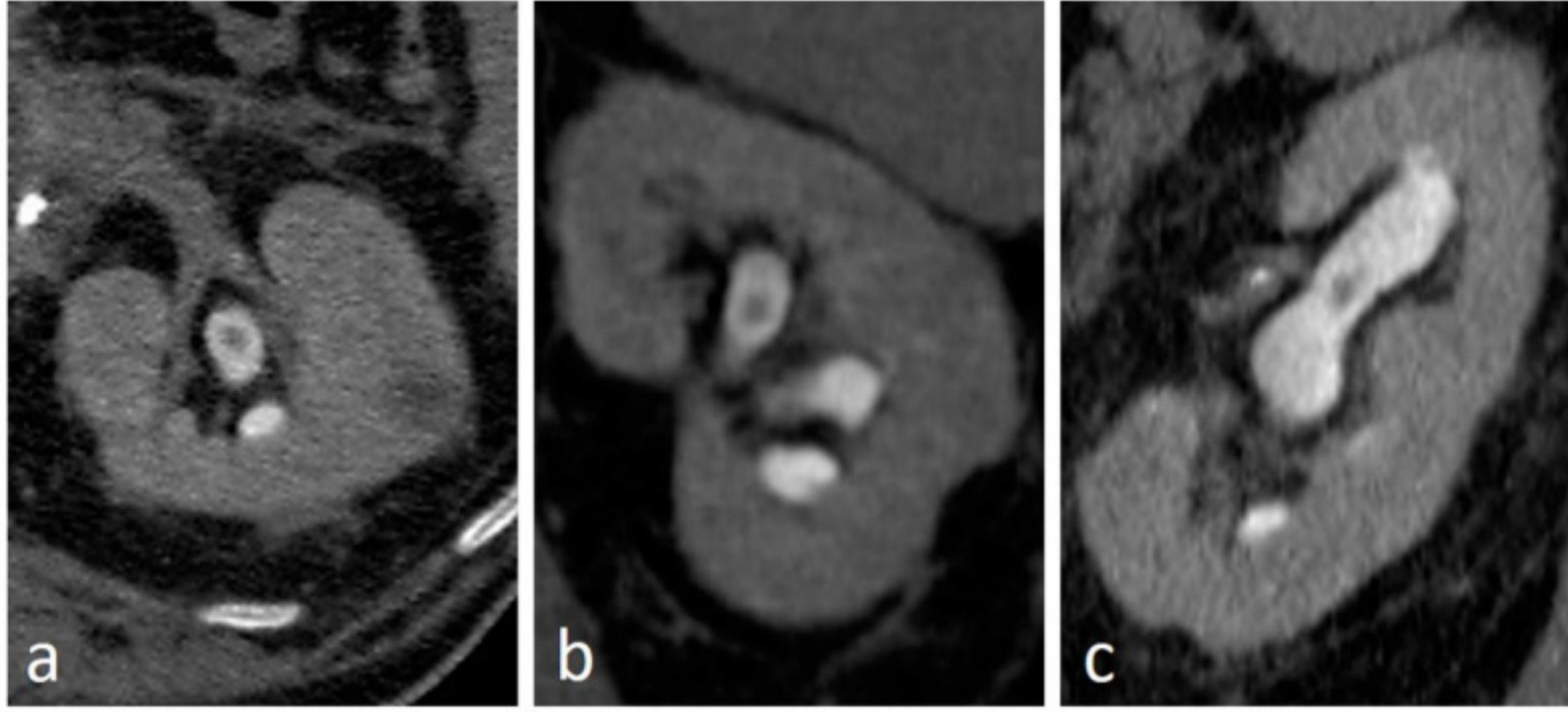
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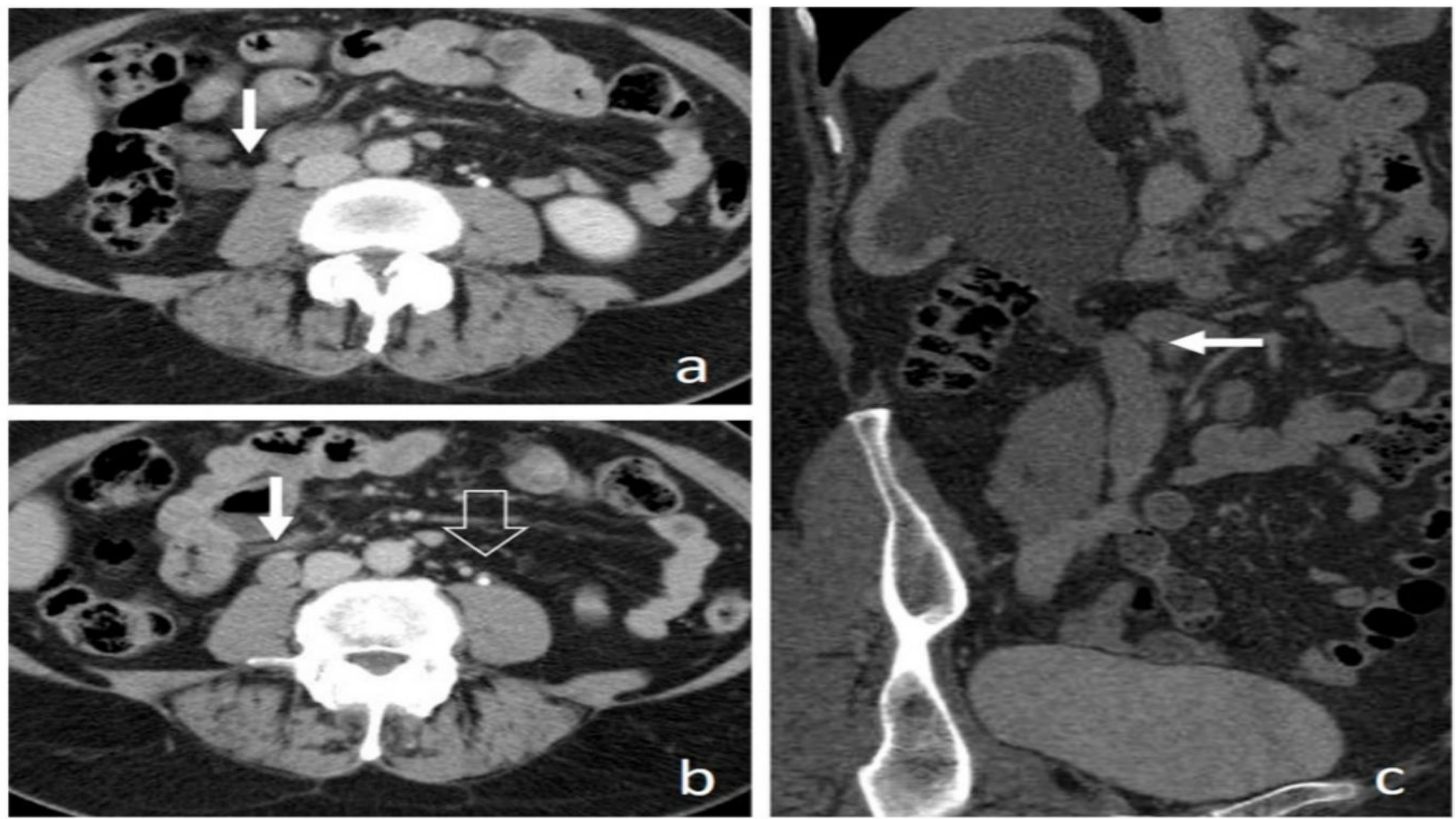
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Diagnostico: URS

Recommendations	Strength rating
Perform a urethrocystoscopy to rule out bladder tumour.	Strong
Perform a computed tomography (CT) urography for diagnosis and staging.	Strong
Use diagnostic ureteroscopy (preferably without biopsy) if imaging and/or voided urine cytology are not sufficient for the diagnosis and/or risk-stratification of patients suspected to have UTUC.	Strong
Magnetic resonance urography or ^{18}F-Fluorodeoxglucose positron emission tomography/CT (to assess [nodal] metastasis) may be used when CT is contra-indicated.	Weak

The Impact of Ureteroscopy following Computerized Tomography Urography in the Management of Upper Tract Urothelial Carcinoma

Diagnostico: URS

The Impact of Ureteroscopy following Computerized Tomography Urography in the Management of Upper Tract Urothelial Carcinoma

Andrea Gallioli, Angelo Territo, Asier Mercadé, Matteo Fontana, Romain Boissier, Josep Maria Gaya, Esteban Emiliani, Antoni Sánchez-Puy, Maria José Martínez, Joan Palou, and Alberto Breda

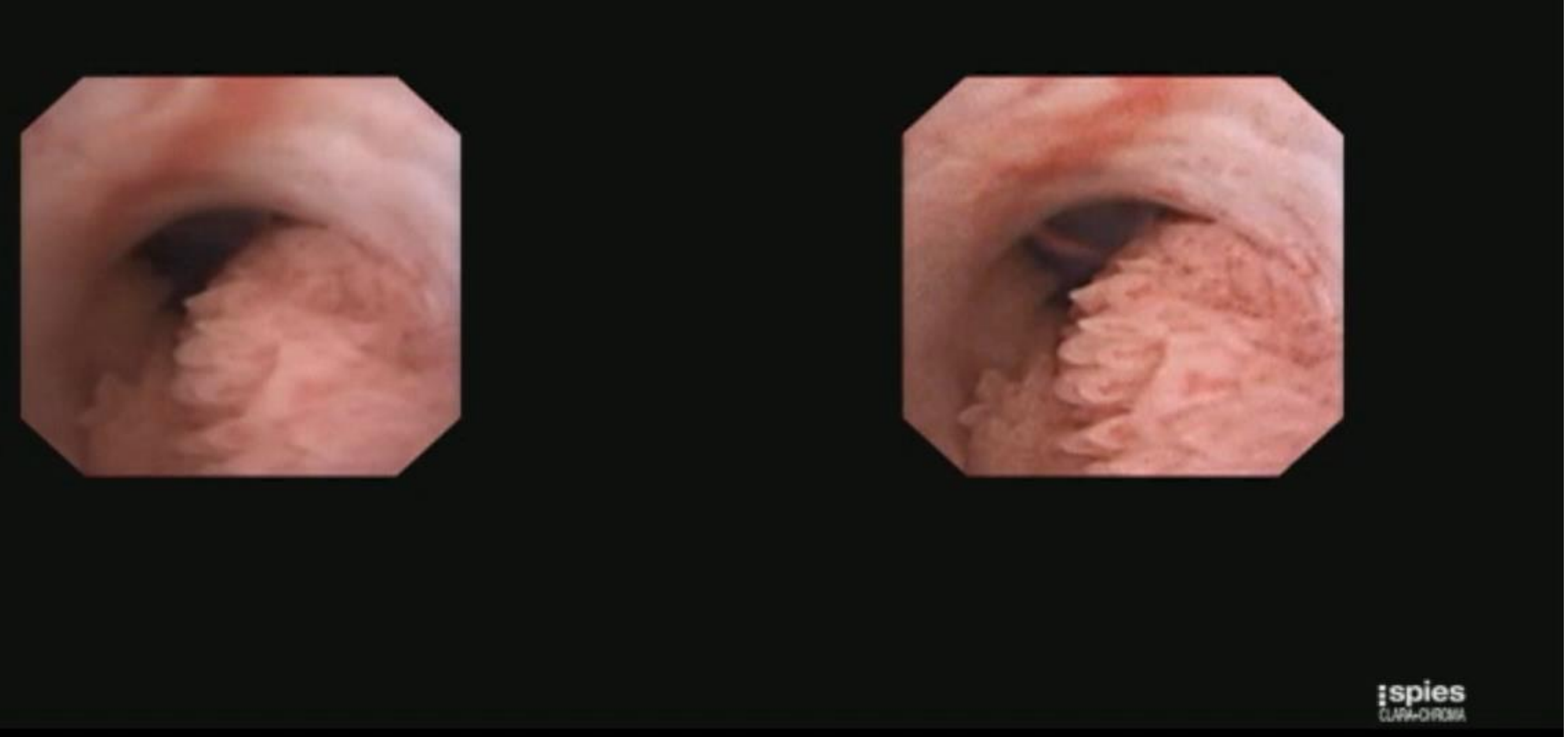
If an indication was given on the basis of positive/negative CT without performing a URS, it would have lead us to do:

- **28/76 (37%) unnecessary nephroureterectomy**
- **20/87 (23%) patients would have not be submitted to nephroureterectomy/ureterectomy**

NBI imaging by

Image1S by

STORZ
KARL STORZ—ENDOSKOPE



Courtesy of Dr. Breda

Microscopio Confocal

Urothelial Cancer

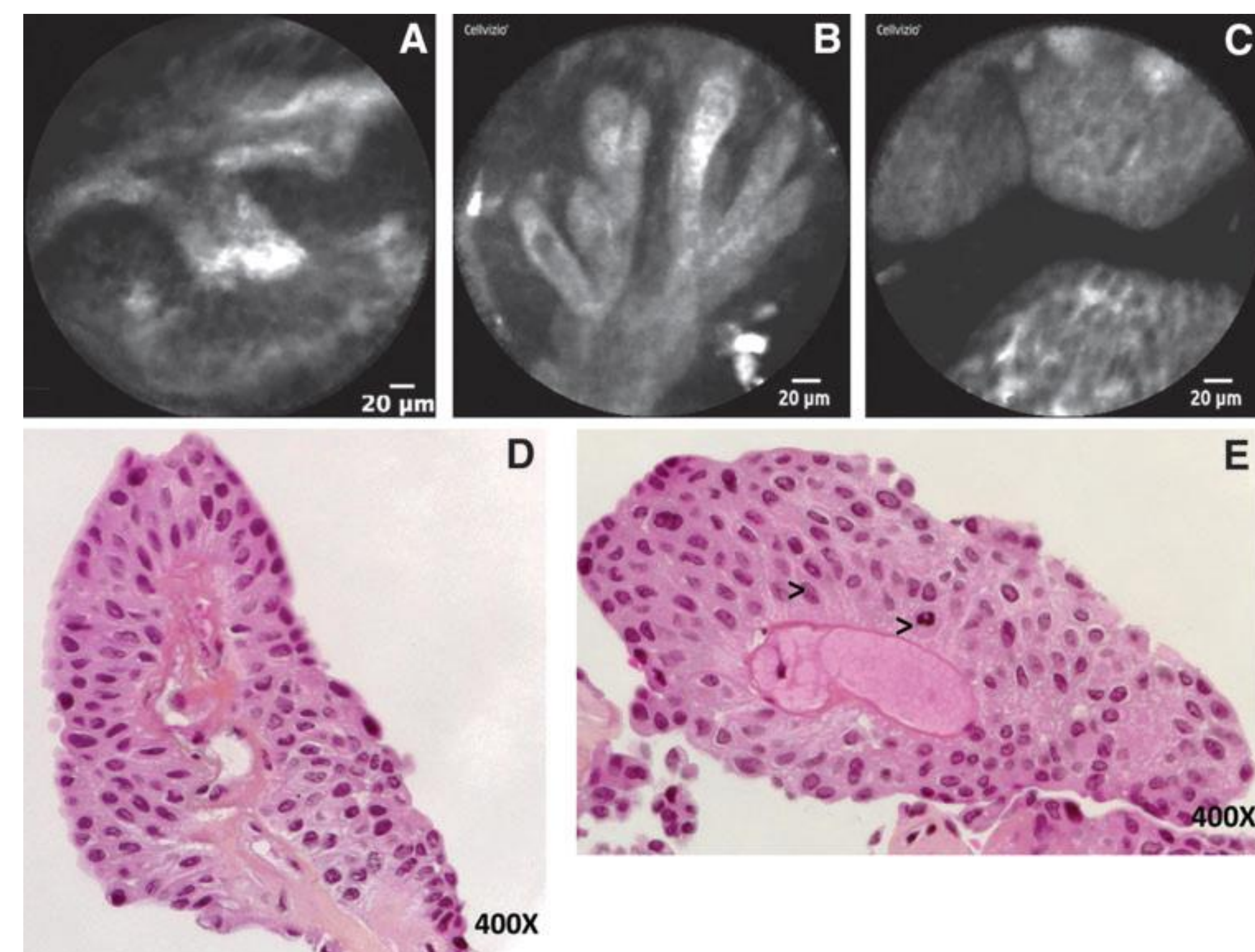
Correlation Between Confocal Laser Endomicroscopy (Cellvizio®) and Histological Grading of Upper Tract Urothelial Carcinoma: A Step Forward for a Better Selection of Patients Suitable for Conservative Management

Alberto Breda [a,], Angelo Territo [a], Andrea Guttilla [a,b], Francesco Sanguedolce [a], Martina Manfredi [a,c], Luigi Quaresima [a], Jose M. Gaya [a], Ferran Algaba [d], Joan Palou [a], Humberto Villavicencio [a]*

CLE aplicado en 14 pacientes
con diferente anatomía y localización de la lesión

85% concordancia con la patología final

Conclusiones: CLE puede seleccionar mejor a los pacientes para someterse a un tratamiento conservador frente a un tratamiento radical



Breda et al., Eur Urol Focus 2018

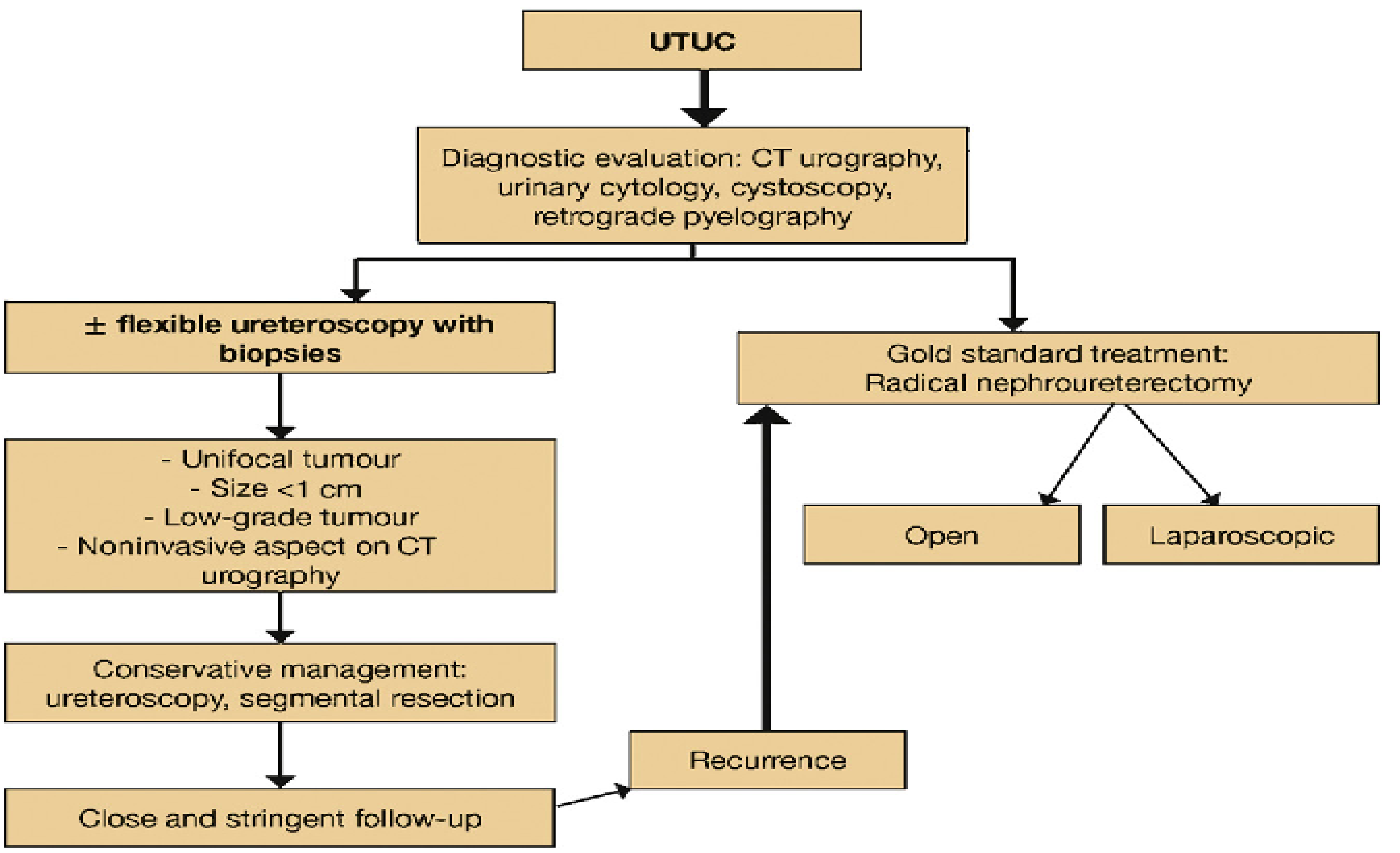
Tratamiento

Manejo Endoscopico (múltiples técnicas)

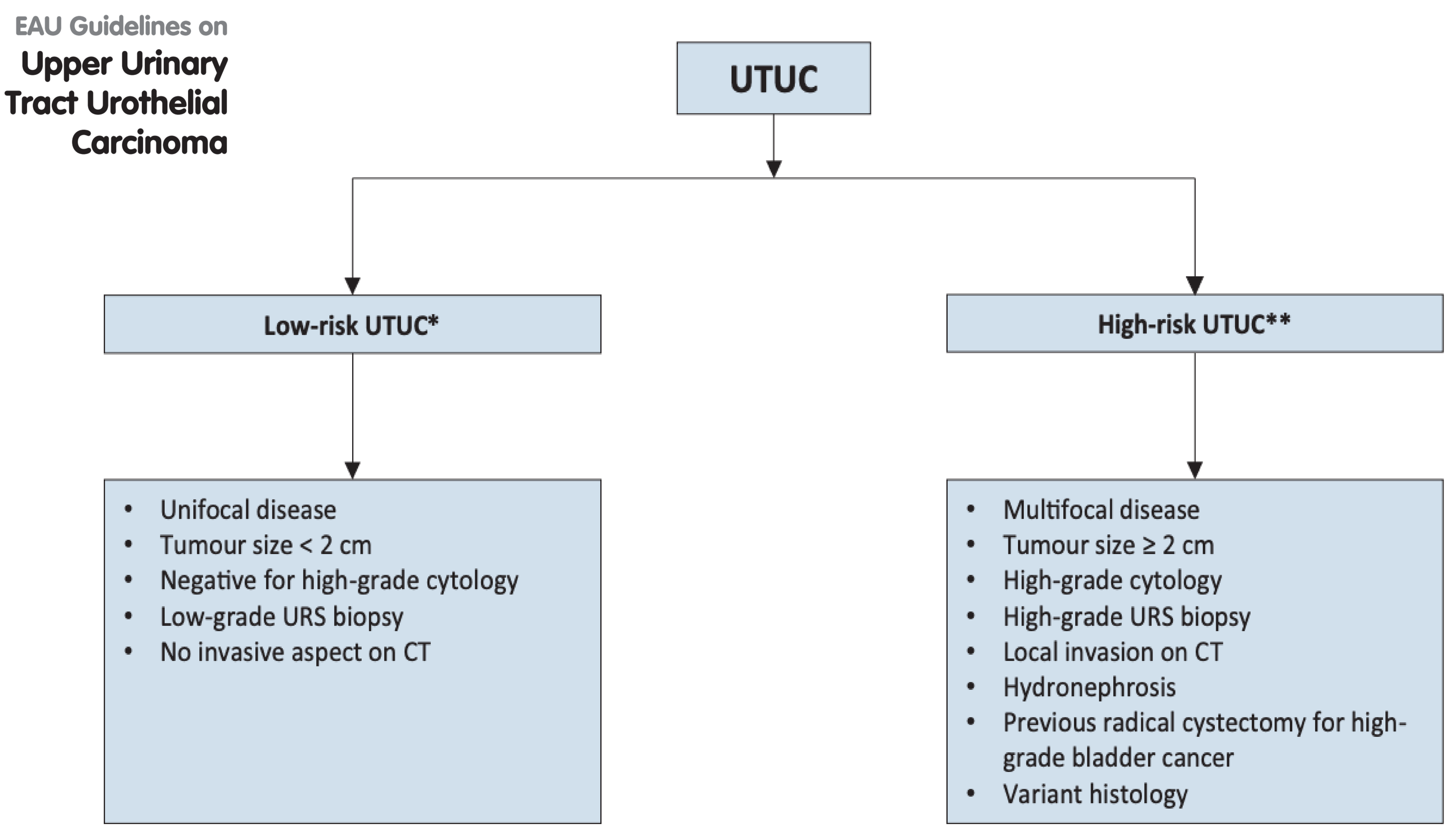
Nefroureterectomía Radical (NFU)

Tratamiento

Manejo conservador

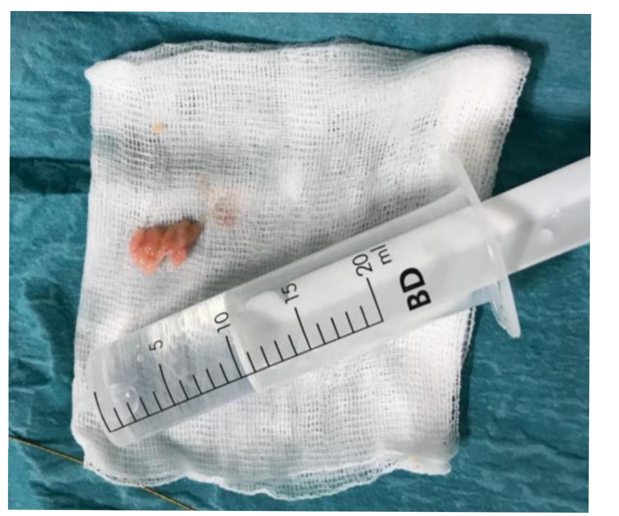


EAU Guidelines on
Upper Urinary Tract Urothelial Carcinoma



¿Podemos hacer algo más?

Estadiaje/biopsia



El TNM preoperatorio también es importante

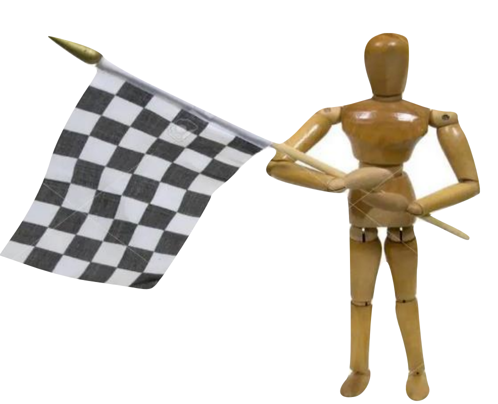
Grado histológico fuertemente asociado con el estadio patológico.

Obtener una biopsia que permita con ciertas garantías diferenciar la invasión o no de capas superficiales (Ta-T1)

Una **correcta biopsia** también permite descartar de formaciones benignas o inflamatorias.

~~Fulguracion de grandes tumoraciones.~~

Objetivos



- **Diagnostico adecuado** (citologías, pruebas de imagen, rentabilidad de las maniobras en quirófano)
- **Selección** casos para manejo conservador.
- **Técnica y formación adecuada** que no desvirtúe dicho manejo.
- Evitar y prevenir las **recidivas**.
- **Seguimiento** adecuado.

Alta tasa de recurrencia de UTUC manejado endoscópicamente.

Preservación renal alta (20 % de los pacientes pasan a RNU).

Para enfermedades de grado bajo, correctamente seleccionadas y manejadas, la supervivencia equivalente a RNU.

Se desaconseja manejo conservador en alto grado.

¿Que herramientas tenemos?

Conocer el instrumental y el abordaje

Ureter

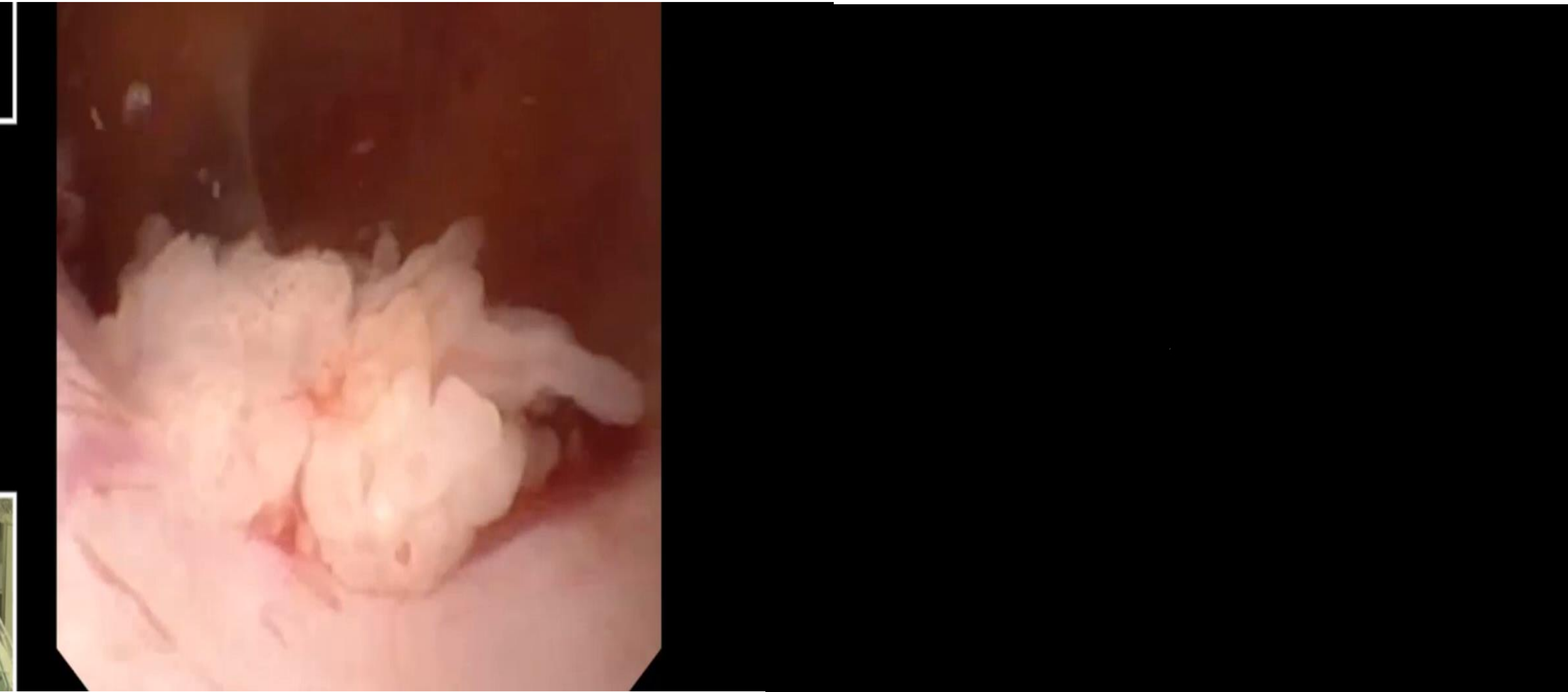
Ureteroscopia retrógrada o anterógrada: Láser, cestilla, pinza de biopsia.

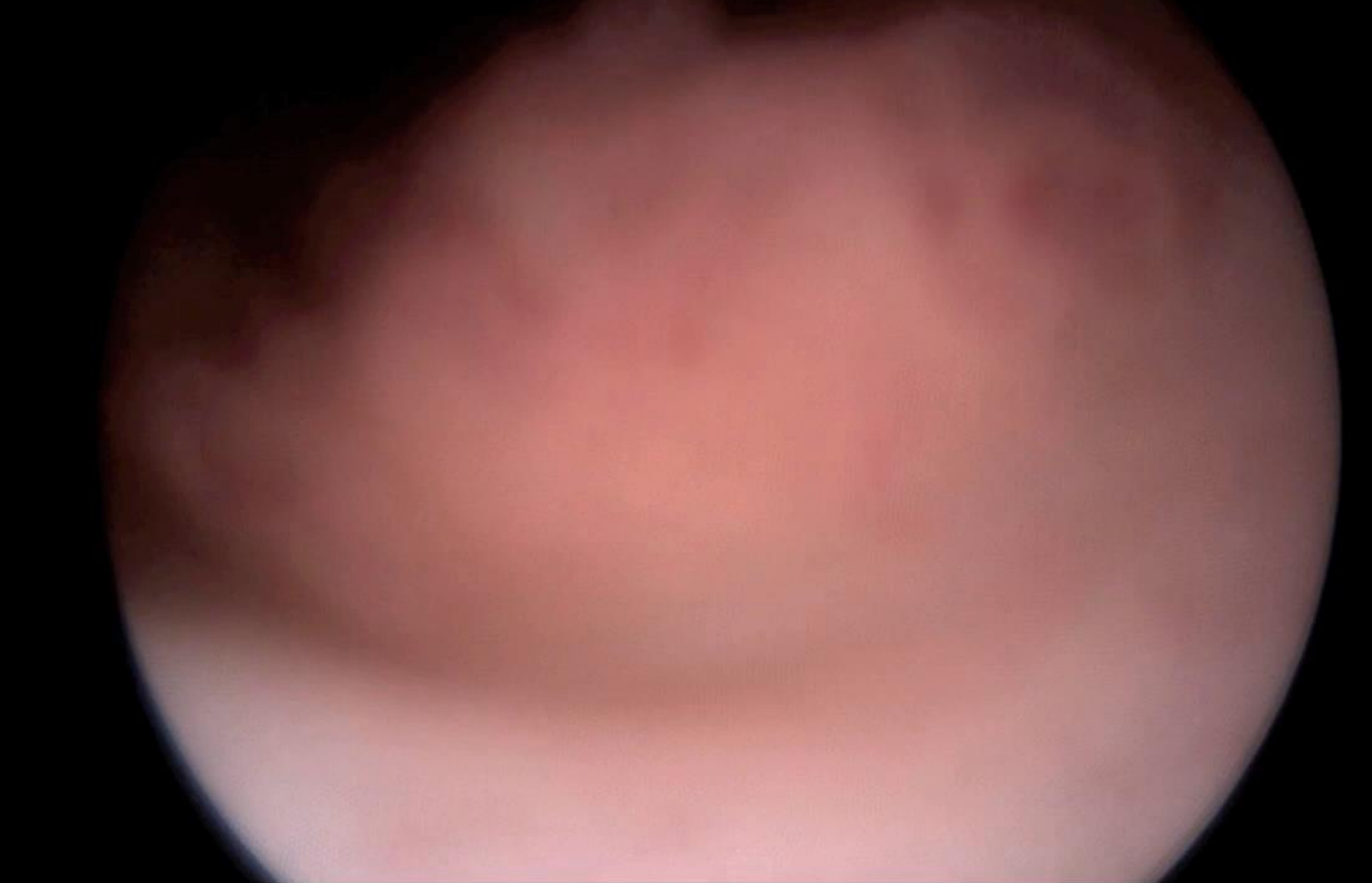
Resección segmentaria. Tumores circunferenciales, riesgo de desinserción, estenosis postoperatoria.

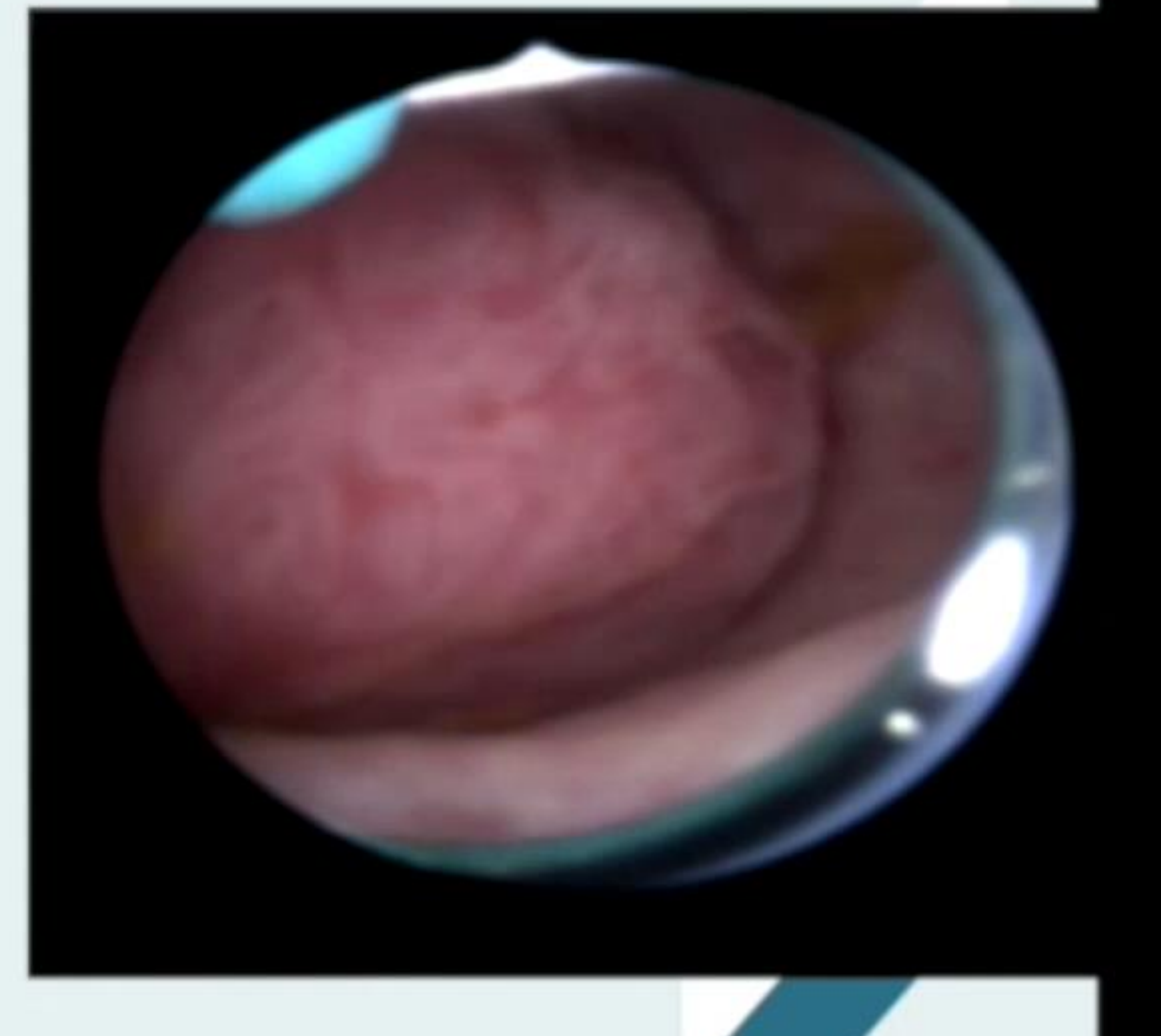
Riñón

Ureteroscopia flexible (láser, cestillas) tumores menor tamaño, papilares, múltiples.

Acceso percutaneo: Mayor tamaño, mayor pieza de biopsia, menor recidiva vesical?







¿Riesgo de diseminación percutanea?

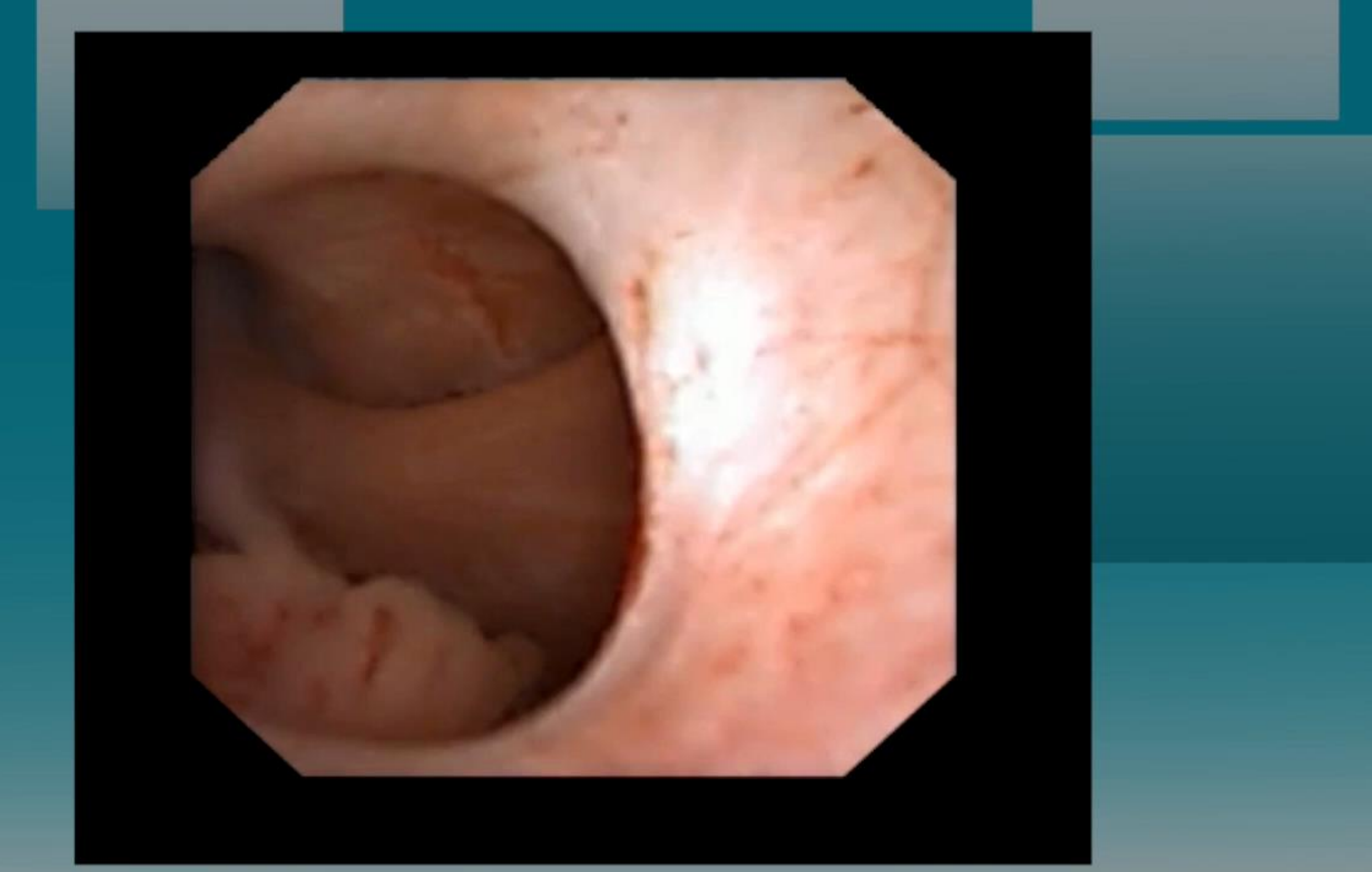
Abordaje percutaneo

La **diseminación** tumoral: circulación **sanguínea** o **linfática**, o del **implante** de células tumorales.

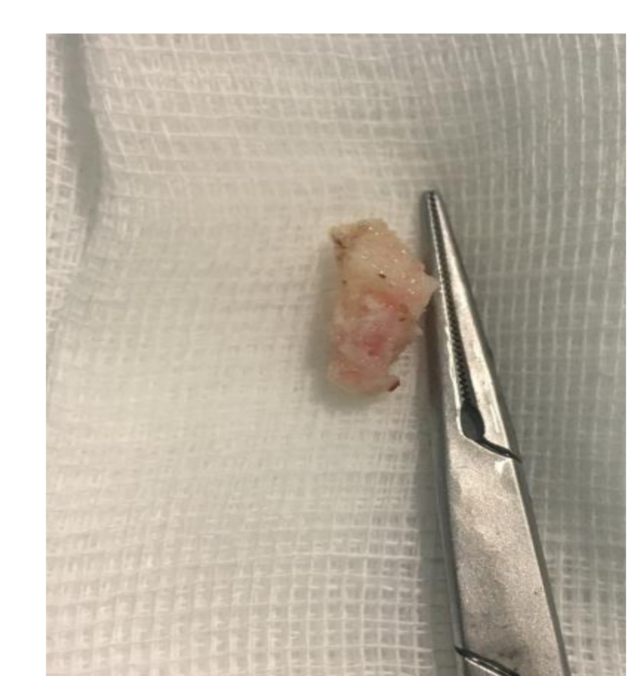
Muy baja incidencia de diseminación tumoral tras la resección endoscópica por vía percutánea.

Se recomienda la instilación anterógrada de BCG o MMC en el tracto superior después del tratamiento endoscópico

Ensayo OLYMPUS 4 (fase 3), eficacia, seguridad y tolerabilidad de UGN-101 (un gel térmico inverso que contiene mitomicina) en pacientes de bajo grado.



Resultados



- 10 años
- 54 casos → 23 Conservadora
- 4 Progresión/infraestadiaje/alta carga tumoral (NFU)
- Seguimiento 3 - 6 -12 meses
- Recidivas ↓ 30% tras mitomicin intraoperatorio

Controversias

Recurrencias

Secuelas

Seguimiento…

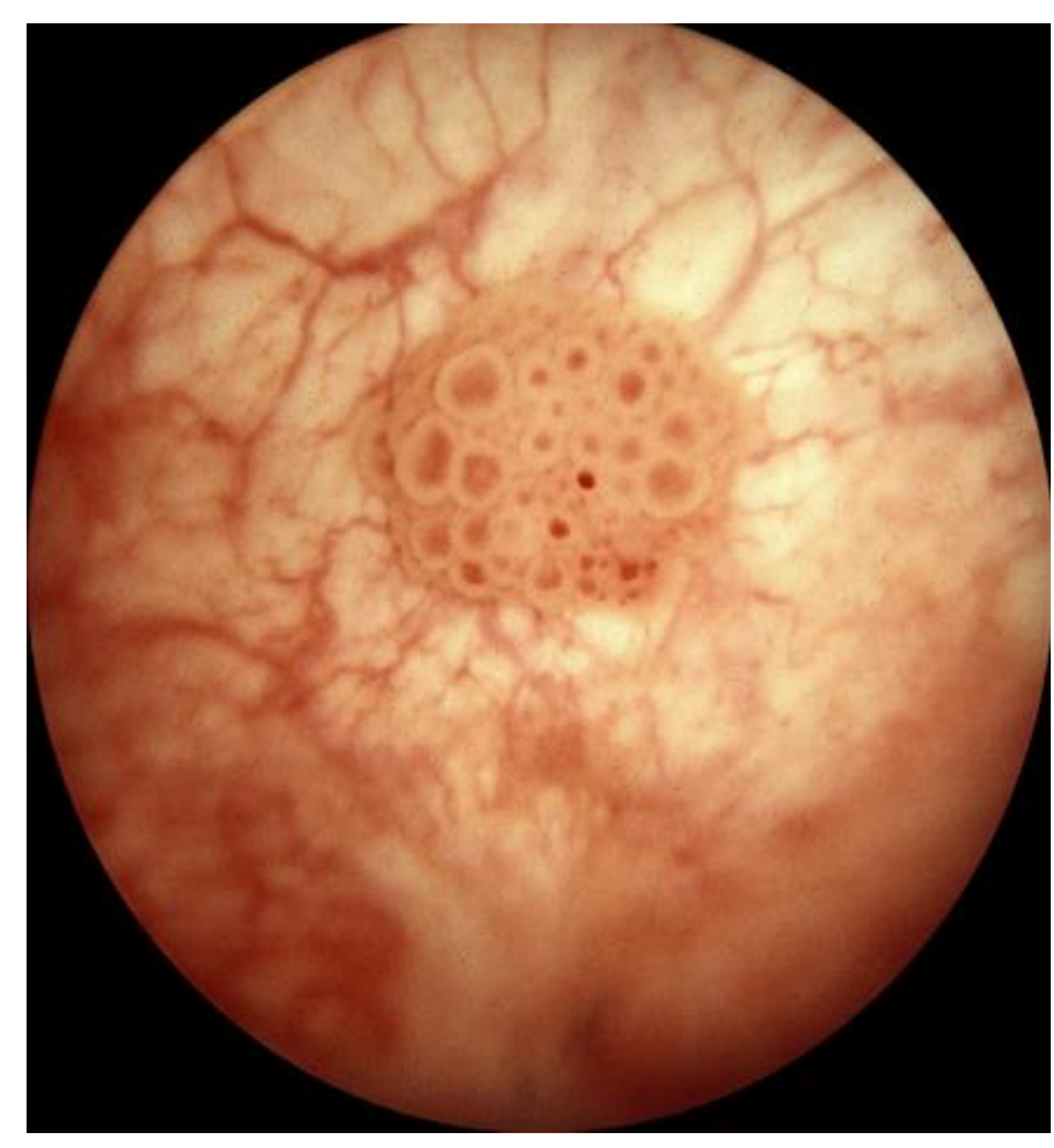
Recurencia post-URS

Impact of diagnostic ureteroscopy on intravesical recurrence in patients undergoing radical nephroureterectomy for upper tract urothelial cancer: a systematic review and meta-analysis[1]

Michele Marchioni*, Giulia Primiceri*, Luca Cindolo[†], Lance J. Hampton[‡§], Mayer B. Grob[‡§], Georgi Guruli[‡§], Luigi Schips[†], Shahrokh F. Shariat[¶] and Riccardo Autorino[‡§]

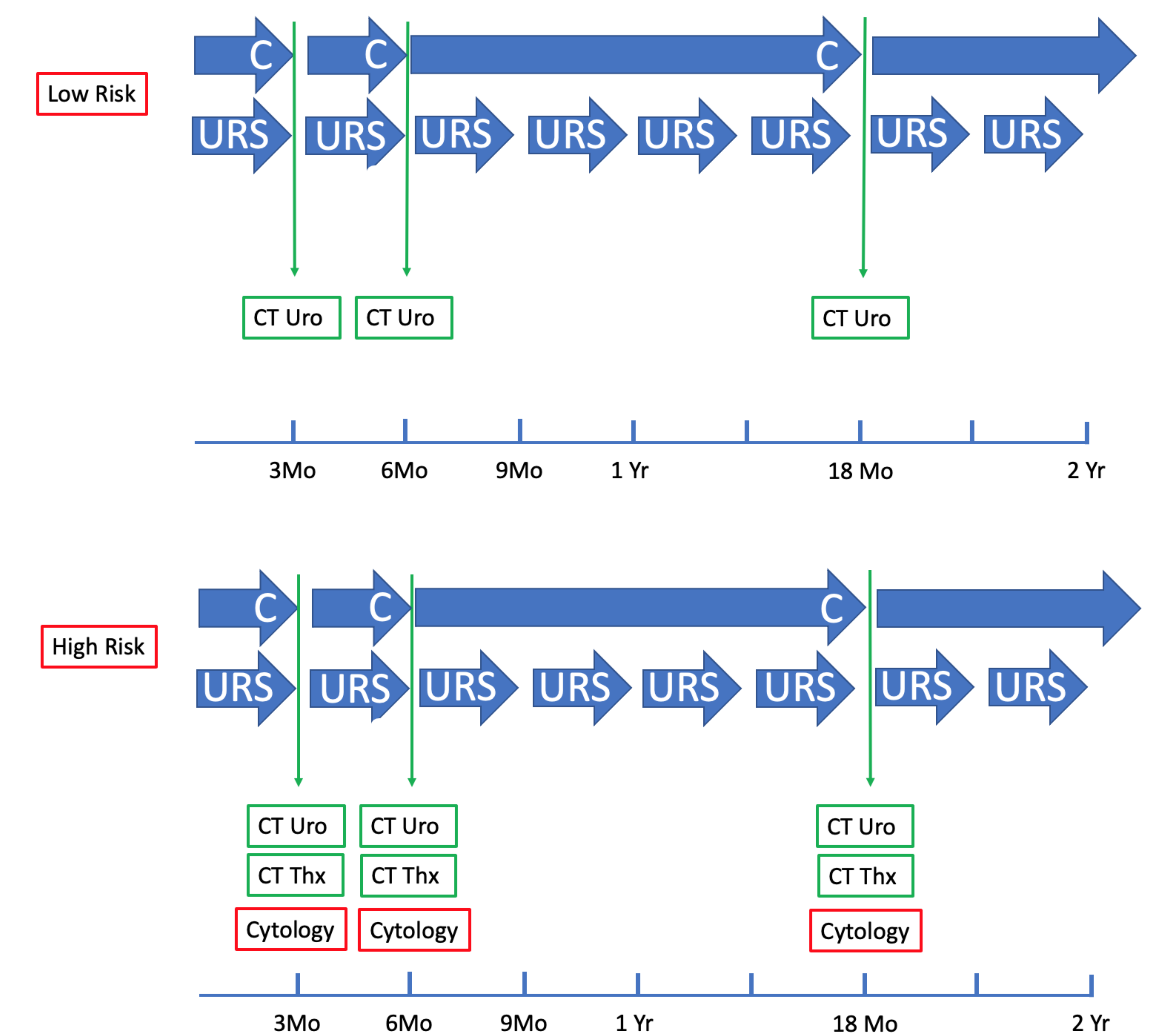
*Department of Urology, SS Annunziata Hospital, 'G. D'Annunzio' University of Chieti, Chieti, Italy, [†]Department of Urology, ASL Abruzzo 2, Chieti, Italy, [‡]Division of Urology, Virginia Commonwealth University, Richmond, VA, USA, [§]Division of Urology, McGuire Veterans Affairs Hospital, Richmond, VA, USA, and [¶]Department of Urology, Comprehensive Cancer Centre, Medical University of Vienna, Vienna, Austria

- Systematic review on 7 studies
- 765 patients who underwent diagnostic URS prior to RNFU
- Bladder recurrence rate:
  - With diagnostic URS: **39.2% - 60.7%**
  - Without diagnostic URS **16.7% - 46%**



Follow-Up

Compromiso del paciente, coste y morbilidad

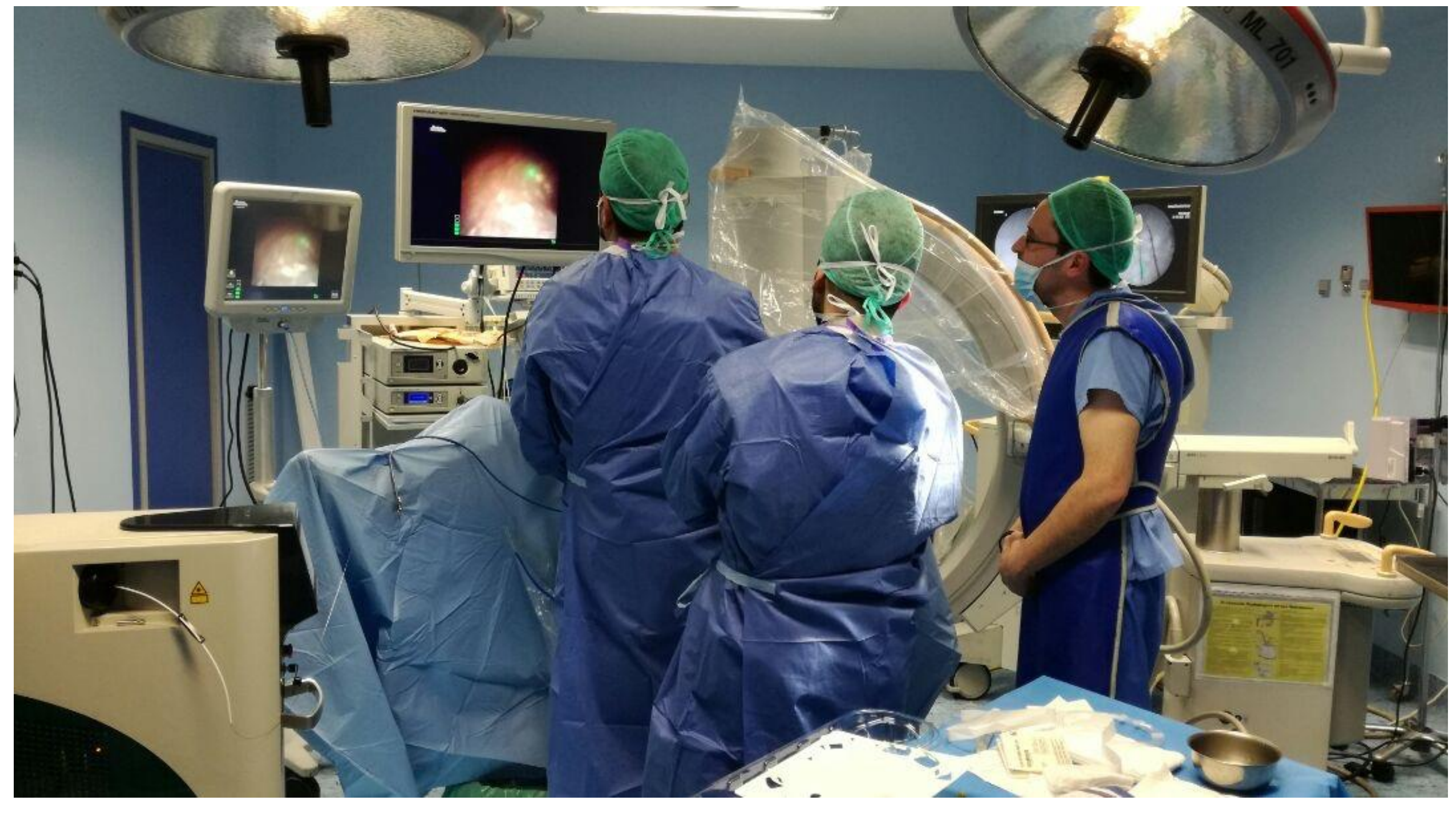


Courtesy of Dr. Breda

Mensajes para guardar

Tecnica precisa. Optimización de biopsia.
Estrecho seguimiento.
Centros de referencia.
Aumentar evidencia científica (Estudios multicéntricos).

- Long-term endoscopic management of upper tract urothelial carcinoma: 20-year single-centre experience. Mark L Cutress , Grant D Stewart, Paimaun Zakikhani, Simon Phipps, Ben G Thomas, David A Tolley
- Long-term endoscopic management of upper tract urothelial carcinoma: 20-year single-centre experience. Mark L Cutress 1 , Grant D Stewart, Paimaun Zakikhani, Simon Phipps, Ben G Thomas, David A Tolley
- Ureteroscopic and percutaneous management of upper tract urothelial carcinoma (UTUC): systematic review. Mark L Cutress 1 , Grant D Stewart, Paimaun Zakikhani, Simon Phipps, Ben G Thomas, David A Tolley
- https://uroweb.org/guidelines/upper-urinary-tract-urothelial-cell-carcinoma/chapter/staging-and-classification-systems
- CT Urography Findings of Upper Urinary Tract Carcinoma and Its Mimickers: A Pictorial Review. Paola Martingano 1 , Marco F M Cavallaro 2 , Alessandro M Bozzato 3 , Elisa Baratella 3 , Maria A Cova
- Upper urinary tract urothelial tumor. Antegrade percutaneous management] Pilar Pérez Sanz 1 , Ricardo García Navas, Enrique García Cuerpo, Francisco Lovaco Castellano
- A review of upper urinary tract cytology performance before and after the implementation of The Paris System. M. Lisa Zhang MD, Yurina Miki MBBS, Jen-Fan Hang MD, Manjiv Vohra MS, MBA, Stephen Peyton MBBS, Patrick J. McIntire MD, Christopher J. VandenBussche



Muchas Gracias