Reduce bladder cancer recurrence in patients treated for upper urinary tract urothelial carcinoma: The REBACARE-trial


a Erasmus University Medical Center, Rotterdam, The Netherlands
b Netherlands Comprehensive Cancer Organisation, The Netherlands
c Tergooi Medical Center, Hilversum, The Netherlands
d Franciscus Medical Center, Rotterdam, The Netherlands
e Ziekenhuis Groep Twente, Almelo and Hengelo, The Netherlands
f Radboud University Medical Center, Nijmegen, The Netherlands
g Netherlands Cancer Institute, Amsterdam, The Netherlands
h Isala Medical Center, Zwolle, The Netherlands
i Meander Medical Center, Amersfoort, The Netherlands
j Bijl-rustt Medical Center, Arnhem, The Netherlands
k University Medical Center Groeningen, Groningen, The Netherlands
l University Medical Center Utrecht, Utrecht, The Netherlands
m Sint Antonius Medical Center, Nieuwegein, The Netherlands
n Haaglanden Medical Center, Leiden, The Netherlands
o Academic Medical Center, Amsterdam, The Netherlands
p Martini Medical Center, Groningen, The Netherlands
q Elisabeth-TweeSteden Medical Center, Tilburg, The Netherlands

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ABSTRACT

Background: Following radical nephro-ureterectomy for urothelial carcinoma of the upper urinary tract (UUT), the reported bladder recurrence rate of urothelial carcinoma is 22–47%. A single intravesical instillation of chemotherapy within 10 days following nephro-ureterectomy has the potential to decrease the risk of a bladder recurrence significantly. Despite recommendation by the European Association of Urology guideline to administer a single instillation postoperatively, the compliance rate is low because of the risk of extravasation of chemotherapy.

Aim: To reduce the risk of bladder cancer recurrence by a single intravesical instillation of Mitomycin immediately (within 3 h) before radical nephro-ureterectomy or partial ureterectomy.

Methods: Adult patients (age ≥18 years) with a (suspicion of a) urothelial carcinoma of the UUT undergoing radical nephro-ureterectomy or partial ureterectomy will be eligible and will receive a single intravesical instillation of Mitomycin within 3 h before surgery. In total, 170 patients will be included in this prospective, observational study. Follow-up will be according to current guidelines.

Results: The primary endpoint is the bladder cancer recurrence rate up to two years after surgery. Secondary endpoints are: a) the compliance rate; b) oncological outcome; c) possible side-effects; d) the quality of life; e) the calculation of costs of a single neoadjuvant instillation with Mitomycin and f) molecular characterization of UUT tumors and intravesical recurrences.
Conclusions: A single intravesical instillation of Mitomycin before radical nephro-ureterectomy or partial ureterectomy may reduce the risk of a bladder recurrence in patients treated for UUT urothelial carcinoma and will circumvent the disadvantages of current therapy.
are too frail to undergo a RNU or have impaired renal function. Moreover, evidence is emerging that partial ureterectomy is feasible not only for an imperative indication, such as patients having a solitary kidney [17]. Given this increase in the number of partial ureterectomies performed, it is estimated that at least 90 patients per year can be included in the present study, whereby this number includes both patients undergoing RNU or partial ureterectomy.

See Appendix B for full inclusion and exclusion criteria of the study.

2.3. Study objectives

2.3.1. Primary objective

To demonstrate that a single intravesical instillation of chemotherapy immediately (within 3 h) before RNU or partial ureterectomy for urothelial carcinoma of the UUT reduces the risk of a subsequent urothelial bladder cancer recurrence up to two years after surgery with 40% (from 22-47% to 13.2-28.2%) compared to a matched historical cohort who received no perioperative intravesical instillation.

2.3.1.1. Index objective: risk reduction. A trial by O’Brien et al. randomized 144 patients to receive Mitomycin 40 mg at the time of urethral catheter removal following RNU (median time 7 days) and 140 patients to receive standard of care [9]. In the Mitomycin arm, 105 of 144 patients (73%) and 115 of 140 patients (82%) in the standard of care arm received their allocated treatment. Thirteen of 105 patients who received Mitomycin and 20 of 115 patients allocated to standard of care treatment did not complete follow-up. By modified intention-to-treat analysis, 21 of 120 patients (17%) in the Mitomycin arm developed a bladder recurrence in the first year versus 32 of 119 patients (27%) in the standard of care arm (p = 0.055). By treatment as per protocol analysis, 17 of 105 patients (16%) in the Mitomycin arm and 31 of 115 patients (27%) in the standard treatment arm developed a bladder recurrence (p = 0.03). This resulted in a relative risk reduction in the recurrence rate in the first year following RNU of almost 40%; the absolute risk reduction was 11%. Ito et al. evaluated the efficacy of a single early intravesical instillation of Pirarubicin within 48 h following RNU in the prevention of bladder recurrence [8]. In this smaller study, 36 patients were included in both the intervention and control arm. Significantly fewer patients in the Pirarubicin group compared to the control group had a bladder recurrence at 2 years following surgery (16.9% in the intervention vs. 42.2% in the control group). Consequently, this resulted in a considerable higher relative risk reduction as shown by O’Brien et al. (Ito et al. Odds ratio (OR) 0.280; 95% Confidence Interval (CI): 0.093–0.831, p = 0.023 vs. O’Brien et al. OR 0.577; 95% CI 0.310–1.073, p = 0.82) [10]. It’s possible that they achieved a higher reduction in recurrence due to the administration of chemotherapy within 48 h instead of within 10 days after surgery.

In addition a single instillation of chemotherapy following transurethral resection of bladder tumors (TURBT) for low- and intermediate-risk urothelial carcinoma of the bladder (UCB) induces a relative risk reduction of 40% to prevent a subsequent bladder tumor recurrence [18–20]. To prevent the implantation of tumor cells, the instillation should be given as soon as possible following TURB. In all studies which examined the effectiveness of a single, immediate, postoperative, intravesical instillation of chemotherapy following TURB, the instillation was given within 24 h following surgery [21]. This postoperative instillation following TURBT is most effective when administered within few hours of surgery [22].

2.3.2. Secondary objectives

2.3.2.1. Index objective: compliance rate. Despite level I evidence showing that a postoperative instillation with chemotherapy following RNU decreases the risk of a subsequent bladder recurrence, which is also recommended by the EAU guideline (Level B evidence) [2], the compliance rate is low in current clinical practice. A Dutch survey showed a compliance rate of less than 10% [10]. Therefore, by conducting this trial, we aim to show not only that a neoadjuvant instillation of chemotherapy is equally effective as a postoperative instillation in reducing the risk of a subsequent bladder cancer recurrence, but it must also lead to a much higher compliance rate of clinicians to this neoadjuvant strategy because it lacks the potential risk of extravesical extravasation of chemotherapy.

2.3.2.2. Index objective: survival rates. At the time of diagnosis, 60% of all urothelial carcinomas of the UUT are invasive resulting in overall poor survival rates for patients with urothelial carcinoma of the UUT. In a large retrospective study by Adibi et al., the 5-year survival rates among 1462 patients who underwent RNU were less than 50% for stage pT2 or pT3 disease and less than 10% for pT4 disease [23].

Several studies have assessed individual patient risk factors for oncologic outcomes [5,7,12,24,25]. Lughezzani et al. and Mathieu et al. identified tumor stage and grade to be the most significant factors in oncological outcome [5,26]. Moreover, with respect to surgery, cancer-free surgical margins and the method of bladder cuff resection (trans- or extravesically) had the most significant impact on cancer-specific survival and overall survival. The most significant risk factors for intravesical recurrence of a urothelial cell carcinoma post RNU were a previous history of a urothelial cell carcinoma of the bladder and multifocality of the UUT tumor [25].

In the present study, the 2-years survival rates post RNU and partial ureterectomy will be assessed and stratified by individual patient characteristics. The technique of bladder cuff resection is mandatory, including a trans- or extravesical approach, and uniformly performed in all study participants. A secondary aim of this study is to develop a novel predictive model for clinical outcome (bladder cancer recurrence and survival) following RNU for urothelial carcinoma of the UUT. Predictive nomograms are used widely in urology to help patients counseling and complex decision-making regarding treatment, but none of these to date have been developed based on prospective data and none have achieved widespread routine use, due to low level of evidence and lack of external validation. In a meta-analysis by Mboutcha et al. on predictive models for the treatment of urothelial carcinoma of the UUT [24], a positive predictive value of 89% was achieved when
combining hydronephrosis, ureteroscopic grade and urinary cytology for prediction of advanced-stage of UUT urothelial carcinoma [6]. If all three were negative, the negative predictive value was 100%. Xylinas et al. acquired an accuracy of 69% for postoperative prediction of intravesical recurrence risk at 2 years [11]. They combined age, gender, history of bladder cancer, tumor location, clinical stage, concomitant carcinoma in situ (CIS), lymph node metastasis, bladder-cuff excision and surgical approach.

2.3.2.3. Index objective: toxicity. Moriarity et al. reported on the safety of an intravesical instillation with MMC or Adriamycin that was administered during RNU in 51 patients. Through a two-way catheter, inserted at the beginning of the procedure, MMC (40 mg) or Adriamycin (40 mg) was instilled. The catheter was clamped for one to 2 h (median time 60 min, range 45–120 min). Just before the bladder was opened for the resection of the ureteric orifice, the chemotherapy was drained passively and the bladder was occasionally irrigated with saline. In total 31 of the 51 RNU’s were performed by an extravesical excision of the bladder cuff. The other techniques consisted of intravesical excision of the bladder cuff or intramural ureterectomy. Nine out of 51 patients underwent a distal ureterectomy only. The intra- and postoperative complications were monitored up to 90 days following surgery. No adverse events were reported that were attributable to MMC or Adriamycin instillation [27]. Furthermore, in the studies on the efficacy of a single instillation of post-operative intravesical chemotherapy by O’Brien et al. and Ito et al. only non-serious adverse events were reported [8,9].

Although the reported toxicity is acceptable it is important to recognize and monitor possible side-effects attributable to the MMC instillation. To manifest possible adverse events the toxicity will be assessed in the present study until 3 months following surgery by the National Cancer Institute Common Toxicity Criteria (CTCAE) version 4.0. These toxicity criteria consist of standardized definitions for adverse events that describe the severity of organ toxicity for patients receiving cancer therapy.

2.3.2.4. Index objective: quality of life. It is hypothesized that a neoadjuvant instillation with Mitomycin will not have a negative impact on the quality of life. To address this hypothesis, all patients will have to complete two questionnaires at inclusion (T0), before surgery (with neo-adjuvant treatment), and at two weeks (T2) and three months (T3) following surgery. The EQSD-5L, a standardized patient-reported instrument to measure general health, and the EORTC QLQ-C30, a questionnaire to assess the quality of life of cancer patients will be used. Both are validated questionnaires for measuring the quality of life within patients suffering from cancer. All time points (T0, T2 and T3) coincide with regular visits to the outpatient department in order to limit the extra burden for participating patients. To be able to adequately address the quality of life end point of the study, the dropout rate for completed questionnaires must be less than 10%.

2.3.2.5. Index objective: costs. The costs consist of direct costs (e.g., single gift of Mitomycin, personnel costs of health professionals involved, disorder related medication, disorder related innervations, time duration of hospital, informal care) and indirect costs (productivity loss) associated with each regimen. The economic evaluation will be a cost-utility analysis and a cost-effectiveness analysis performed from a societal perspective and will only be applicable to the Dutch healthcare system.

2.3.2.6. Index objective: molecular characterization (side-study). Due to the rarity of the disease, little is known about molecular aberrations related to urothelial carcinoma of the UUT and the prognostic profile of molecular alterations that correspond with or even might predict bladder recurrences. In a time that cancers are increasingly stratified by their molecular alterations and treatment decisions can be based upon these alterations, it is important to investigate the genetic profiles of urothelial carcinoma of the UUT. Sfakianos et al. compared the genetic profile of 59 high-grade urothelial carcinomas of the UUT with another cohort of 102 high-grade UCB by targeted sequencing [28]. The spectrum of genes mutated in tumors of the UUT and UCB was similar, but the frequency of mutations in FGFR3, HRAS, TP53 and RBL1 was not. In high-grade urothelial carcinoma of the UUT FGFR3 and HRAS were more frequently mutated, whereas mutations in TP53 and RBL1 were less prevalent compared to high-grade UCB. Most of the disparity in clinical manifestation between urothelial carcinoma of the UUT and UCB may result from anatomical differences because of the thinner smooth muscle covering the UUT, but Sfakianos et al. showed that there are also genomic differences that might contribute to this phenomenon [28]. These observations provide evidence that urothelial carcinoma of the UUT and the bladder have distinct biological behaviors despite their histopathological similarities and therefore might require individualized treatment recommendations.

In both retrospective and prospective studies, a high proliferation index as assessed by Ki-67 expression was associated with disease recurrence and cancer-specific survival in urothelial carcinoma of the UUT [29–33]. Furthermore, alterations in the mTOR-pathway, and the genes HER2, BCA1, CDS5 and p53 might play a role in the prognosis of high grade urothelial carcinoma of the UUT, but the impact of these biomarkers hasn’t been sufficiently validated because of the small portion of samples in single-institution cohorts [24].

Currently two hypotheses for the development of a bladder recurrence following RNU for urothelial carcinoma of the UUT are postulated: a) intraluminal seeding and implantation of cancer cells [14,15]; multifocal tumors are descendants of a single transformed cell, which proliferates and spreads by intraluminal seeding or intraepithelial spread or b) in field cancerization [24], where it is assumed that multiple cells become initiated or partially transformed as a result of carcinogenic hits. In order to address these hypotheses it is important to compare the genomic profile of the primary urothelial carcinoma of the UUT and the subsequent bladder recurrence within the same patients.

Therefore, at inclusion, patients will be asked to provide separate consent for the use of their tumor tissue for molecular analysis. DNA will be isolated from the primary urothelial carcinoma of the UUT, the bladder recurrence and a buccal swap or non-malignant kidney tissue. Genomic sequencing will be performed to investigate tumor-specific somatic mutations and copy number variations to compare the molecular profile of the primary urothelial carcinoma of the UUT and a subsequent carcinoma of the bladder.

2.4. Sample size calculation

The estimated recurrence of urothelial carcinoma of the bladder following RNU for a UUT urothelial carcinoma is based on the literature. It has been shown that in patients not treated with adjuvant intravesical therapy following RNU, the bladder recurrence rate at two years was between 10 and 50% (mean 33.2%, total number of patients reported 995, range 36–223) [10]. We hypothesize a reduction in the risk of a bladder recurrence of 40% after RNU or partial ureterectomy by the neoadjuvant regimen of a single instillation with chemotherapy within 3 h before surgery. Consequently, this translates into a 19.9% estimated bladder recurrence rate for this study. Therefore, it is calculated that a sample size of 170 patients is needed to show a 40% difference two years following surgery with a power of 80% using a two-sided p-value of 0.05.
2.5. Ethical approval

The study abides by the principles of the Declaration of Helsinki. Ethical approval for this study was obtained from the institutional review board of Erasmus University Medical Center Rotterdam (METC 2017–227, NL60919.078.17). Also the board of directors of all participating hospitals have given permission for execution of this particular trial.

3. Statistical analysis

All analyses are based on the intention-to-treat principle, i.e. all eligible patients will be included in the analysis independently of whether they received treatment or not. Data characterized by normal distribution will be expressed as mean ± standard deviation. Parameters not normally distributed will be expressed as median (range).

3.1. Primary study parameter

The bladder relapse rate at two years following surgery is the primary endpoint of the study. The relapse rate will be compared with the relapse rate of a matched historical cohort on a 1:2 basis (1 intervention cohort: 2 historical cohort). The historical cases will be selected by the following criteria: age ≥ 18 years, treated by RNU or partial ureterectomy for a histologically proven UUT urothelial carcinoma (cT1–T4 with or without CIS), no lymph node or distant metastasis at the moment of diagnosis as assessed by CT thorax-abdomen (cN0M0), a minimum of two years of follow-up following surgery, no perioperative systemic chemotherapy administered, and no history of urothelial carcinoma of the urinary tract before diagnosis of the UUT urothelial carcinoma. The difference in relapse rate between the intervention cohort and the matched historical cohort will be assessed using a multivariable Cox regression analysis and stratified by the following confounders: age, type of surgery (RNU versus partial ureterectomy), pathological stage, tumor grade, tumor size, tumor location, tumor multiplicity, concomitant CIS, medical center of treatment and surgical techniques (open versus laparoscopic).

3.2. Secondary study parameters

The difference in overall, cancer-specific and recurrence-free survival between the intervention cohort and matched historical cohort will be estimated using a multivariable Cox regression analysis. The toxicity of the treatment at different time points will be tested using a repeated measurements analysis. The quality of life at baseline, at 2 weeks and at 3 months following surgery will be compared using a repeated measurements analysis. Furthermore, potential risk factors will be identified using multivariable Cox proportional hazards. Covariates included in the analysis are: type of surgery (partial ureterectomy or RNU (laparoscopic or open)), result of pre-operative urine cytology, histological stage and grade of the tumor, tumor location, concomitant CIS and lymph node involvement.

The primary economic analysis will be a cost-utility analysis performed according to the Dutch guideline to determine whether neoadjuvant intravesical instillations with Mitomycin before RNU or organ sparing surgery are a cost-effective alternative to the standard of care (historical cohort) [35]. Additionally, a cost-effectiveness analysis will be conducted to determine the costs per prevented bladder recurrence. The time horizon will be from start of therapy (t = 0) till 24 months follow-up to take all relevant costs and effects regarding the MMC and standard of care strategy into account. The costs are defined as direct and indirect costs associated with procedures performed within each regimen. The costs will be estimated by multiplying resource utilization with the cost per unit of resource (market prices, guideline prices or self-determined prices based on costing methods, i.e. full costing) [35]. The incremental cost-effectiveness ratio (ICER) of MMC will be calculated (i.e., the difference in costs of MMC versus standard of care divided by the average change in QALYs and bladder recurrence rate, respectively). The sensitivity of various costs per unit of resource will be tested in sensitivity analyses.

All statistical analyses will be performed using statistics software (SPSS version 21.0 for Windows, Chicago, IL, USA). A two-tailed p-value of < 0.05 is considered significant.

4. Study procedures

A flow diagram of the REBACARE trial is presented in Appendix A. The following procedures are performed for research purposes at a different time point or in addition to the standardized care.

4.1. Treatment

After consent is obtained for both the primary study and the sub-study, patients will be asked to provide a buccal swab for the collection of germline DNA. On the day of surgery, MMC is administered intravesically in all patients within 3 h before surgery. The MMC is given directly into the bladder by an indwelling catheter. The indwelling catheter is inserted through the urethra and after instillation of the MMC the catheter is clamped, which allows the medication to remain in the bladder. The doses will be a suspension of 40 mg MMC in 50 ml sterile saline (NaCl 0.9%) and must remain in the bladder for a period of at least 1 h with a maximum of 2 h, if possible. The patient is then transported to the operating room. Once the bladder is emptied by the indwelling catheter, the bladder will be continuously rinsed with NaCl 0.9% to remove all remains of the MMC and possible floating tumor cells. The indwelling catheter will remain inside the bladder during surgery and the rinsing will be stopped at the moment the treating surgeon is about to incise the bladder wall for excision of the ureteric orifice. The indwelling catheter will remain for some days after surgery until the patient has recovered. The exact number of days the indwelling catheter will remain in the bladder following surgery is at the discretion of the treating physician. From a pilot experiment it is known that neoadjuvantly administered intravesical MMC can no longer be detected on the surgical equipment or inside the operating room once the bladder is appropriately rinsed with 2 × 50 mL of NaCl 0.9% (personal communication by Dr. A.G.M. van der Heijden, MD PhD, Radboud UMC). Therefore, medical personnel who will treat the study participants will not be exposed to MMC.

The surgical procedure is not performed for research purposes, however the participating physicians will be asked to carry out the procedures in a standardized matter; i.e. both the RNU or partial ureterectomy must start with clipping of the ureter distal of the tumor and, for the latter, the presence of a bladder cuff. The pathology report must describe the presence of the ureteral clip and, for the latter, the presence of a bladder cuff including the ureteric orifice. The administration of antibiotic prophylaxis is advocated and the antibiotic regimen (orally or intravenously) should be in accordance with the local guidelines of the participating hospitals or based on a urinary culture.

4.2. Follow up

The follow up will be in line with the standardized care and will not include additional investigations. Cystoscopy plus urine cytology will
be performed at 3, 6, 12, 18 and 24 months. The follow-up also includes CT-urography at 6, 12, 18, 24 months. In case of an invasive tumor, follow-up will include a CT-thorax at 6 and 12 months. All patients will complete two questionnaires at three moments during the study (Appendix A) to examine the quality of life following this treatment. To demonstrate side effects, patients will fill in a side-effects form 4 times. In case a bladder recurrence is suspected, it is warranted to take a diagnostic biopsy to histologically confirm and classify urothelial carcinoma of the bladder.

4.3. Side study: molecular analysis

Both a buccal swap and a biopsy of the tumor will be collected from participants who provide separate informed consent. DNA will be isolated from the primary UUT tumor, the subsequent intravesical recurrence and non-malignant kidney tissue or a buccal swab. Genomic sequencing will be performed to investigate tumor-specific somatic mutations and copy number variations to compare the molecular profile of the primary UUT tumor and subsequent bladder tumor.

5. Discussion

5.1. Exposition of protocol

Following RNU for urothelial carcinoma of the UUT, the reported recurrence rate of urothelial carcinoma in the bladder is 22–47% (4–7). Intraluminal seeding [1,14,15] or in field cancerization [34] are thought to be the two hypotheses of this high recurrence rate. Based on the assumption that intraluminal seeding has most of the impact on this recurrence rate, a single postoperative instillation of chemotherapy following RNU has been introduced, and has shown to decrease the risk of bladder recurrence by 52% (relative risk reduction) [10]. Given the fact that many treating physicians waive the addition of a postoperative instillation with chemotherapy following RNU or partial ureterectomy, despite recommendation by the EAU guideline [2], this could be an indication that another (neo)adjuvant treatment is desirable. To avoid the limitations in current treatment protocols of urothelial carcinoma of the UUT, the REBACARE trial will be the first prospective trial that could change current management. The fact that intravesical instillation will be administered before surgery makes this study unique and plausible positive for the compliance rate.

The REBACARE trial has additional aims besides the reduction of a subsequent bladder recurrence and a safer toxicity profile in comparison with a postoperative instillation, since the study also aims to explore the genetic profile of urothelial carcinoma of the UUT in more detail within a side-study performed during the REBACARE-trial. This is of specific interest, in a time in which the decision of certain treatment modalities of various tumors does not only rely on clinicopathological characteristics, but can possibly also rely on tumor-specific molecular alterations. Furthermore, molecular characterization may reveal tumor-specific alterations that are targets for new anticancer therapies. More important, by performing a molecular comparison of the primary UUT tumor and a subsequent bladder recurrence, the hypothesis that intraluminal seeding is responsible for developing bladder recurrences can be explored. If this is the case, tumors of both the UUT and the subsequent bladder tumor should have identical molecular alterations, i.e. tumor-specific mutations. On the other hand Skafianos et al. showed differences in the genetic profiles and mutational status between urothelial carcinoma of the UUT and UCB [28]. Although these alterations were not examined within the same patient, their findings support the hypothesis that subsequent bladder tumors are de novo primary tumors with specific molecular alterations. Lastly, a molecular comparison of the primary UUT of the patients who develop a recurrence versus those who do not might reveal important aberrations that could explain the risk of the development of a bladder recurrence or might even be predictive of a bladder cancer recurrence. The REBACARE trial is one of the first studies in which DNA from the primary tumor as well as DNA from the bladder recurrence of the same patient will be compared and this will result in unique information.

5.2. Study limitations

There are several limitations associated with the design of the study. Theoretically, the REBACARE trial could be designed as a prospective randomized controlled trial generating level 1 evidence. However, a randomized controlled trial would not be feasible due to the large number of study participants in relation to the relative low number of patients that will be diagnosed and treated for urothelial carcinoma of the UUT. In addition, due to the low compliance rate for a postoperative instillation with chemotherapy, inclusion of patients in the post-operative instillation arm (standard of care) will take very long. Furthermore, the recommendation in the EAU guideline for a postoperative instillation of chemotherapy following RNU makes it not ethical to conduct a study in which any form of intravesical instillation with chemotherapy is withheld in the control arm.

The exclusion criteria of a previous UCB will limit the inclusion rate of the REBACARE trial as the majority of patients with urothelial carcinoma of the UUT are known to have had one or more episodes of UCB in their history. However, this was necessary, because it is known that these patients are at much higher risk to develop a subsequent bladder recurrence following surgery for urothelial carcinoma of the UUT [11,24,36]. Including these patients will potentially jeopardize the outcome of this trial because it will have an impact on the primary endpoint of this trial.

6. Conclusion

Approximately 40% of patients will develop an intravesical recurrence following a RNU for urothelial carcinoma of the UUT. A single postoperative instillation with chemotherapy reduces the risk of a bladder cancer recurrence significantly. Nevertheless, the compliance rate of clinicians with a single postoperative instillation is low due to the potential risk of extravasation of chemotherapy. The REBACARE trial is the first prospective trial that aims to determine the effect of a single preoperative intravesical instillation with chemotherapy on the risk of a bladder cancer recurrence following RNU for urothelial carcinoma of the UUT. This change in order of treatment may prove to be equally effective as a postoperative instillation but with a safer profile and has the potential to change clinical practice in a definitive way.

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Appendix A. Flow-chart of the REBACARE trial.
Appendix B. In- and exclusion criteria of the REBACARE trial.

Inclusion criteria

1. Histologically proven urothelial carcinoma of the UUT with or without concurrent carcinoma in situ (CIS only is also allowed) or patients with a suspicion of a urothelial carcinoma of the UUT on CT-scan plus a urinary cytology sample showing high-grade urothelial carcinoma;
2. Patients planned to be treated either by partial ureterectomy or by a radical nephroureterectomy (open or laparoscopic) including a bladder cuff;
3. Age ≥ 18 years;
4. WHO performance status 0, 1 or 2;
5. Negative pregnancy test in woman with childbearing potential;
6. Written informed consent.

Exclusion criteria

1. If pre-operative histology by biopsy: aberrant histology of the UUT tumor of > 50% (adenocarcinoma, small cell carcinoma, squamous cell carcinoma).
2. History or presence of a malignant tumor or carcinoma in situ of the bladder.
3. History of UUT urothelial carcinoma on the contralateral side or presence of bilateral UUT urothelial carcinoma.
4. Known allergy against Mitomycin.
5. Anticipated adjuvant intravesical treatment with chemo- or immunotherapy.
6. Acute urinary tract infection at the time of inclusion as assessed by urinary culturing.
7. Lymphadenopathy or distant metastases as assessed by preoperative CT-scan of thorax and abdomen.
8. Any other concurrent severe or uncontrolled disease preventing the safe administration of intravesical Mitomycin.

References


