RETROPERITONEAL STAGING LYMPHADENECTOMY IN STAGE I NONSEMINOMATOUS GERM CELL TUMOURS OF THE TESTIS

Sinescu I., R. Constantiniu

Center of Urological Surgery, Dialysis and Renal Transplantation
"Fundeni" Clinical Institute, Bucharest, ROMANIA

Video

The treatment of testicular germ cell tumours has been a constant interest to our department, comprising 268 cases over the last two decades. Alongside the spectacular progresses of specific, highly effective combination chemotherapy and retroperitoneal lymphnode surgery which have dramatically improved life expectancy and cancer free rates even in advanced abdominal or metastatic disease, the treatment and follow-up protocols for stage I nonseminomatous germ cell testicular tumours (NSGCTT) are still a question of debate. The option of "wait and see" or primary specific chemotherapy require a rigorous and wealthy healthcare system, i.e. important social costs; moreover, chemotherapy associates well-known toxic effects. These comments should also take into account the risk of CAT retroperitoneal understaging in these patients.

Under this circumstances the authors propose the evaluation of the retroperitoneal lymphadenectomy (RPLA) in its modified fashion as the primary therapeutic approach in stage I NSGCTT, considering the accuracy of pathologic staging (chemotherapy becomes unnecessary) and the preservation of antegrade ejaculation (anejaculation being the major draw-back for the total bilateral RPLA). Another pro is its curative role in cases of occult abdominal disease. The main sequences of the modified RPLA are presented and commented, defining the rational ablation limits which assure a "nerve sparing" technique without oncologic rebate.

In a precarious healthcare system, the modified RPLA might well be considered the primary option in the management of stage I NSGCTT for its oncologic staging and therapeutic merits, with low social costs and practically no morpho-functional sequelae.

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The standard primary therapeutic approach recommended in stage II nonseminomatous germ cell testicular tumours (NSGCTT) in current practice is specific, aggressive chemotherapy. Retroperitoneal lymphadenectomy (RPLA) is a second line therapy, being currently restricted to those patients who present with residual abdominal mass after chemo regimens.

The authorsâ experience comprises 12 total RPLA for stage II NSGCTT in the last 4 years: 4 primary RPLA and 8 secondary RPLA (preceded by BEP cycles). The main sequence of the operative technique of primary total RPLA for stage II disease is presented.

Access was gained through a midline abdominal incision. Teratoma was present in the primary pathologic specimen in half of the cases. In such cases we consider the primary total RPLA as the first option, being aware of the inefficacy of combination chemotherapy on teratoma and the risk of hazardous, seriated, even incomplete surgical resections in advancing abdominal disease. In two of three cases the operative pathologic staging corrected the preoperative CAT staging! There were no intra or postoperative complications. Adjuvant specific chemotherapy (2 BEP cycles) was delivered as a routine, this strategy granting curability in all cases.

Conclusively, the authors propose a revaluation of the primary total RPLA in the therapeutic approach of NSGCTT stage II minimal or moderate abdominal disease, considering the operation as complete and easier to perform than in postchemo local conditions. This is especially valid in case of teratoma in the primary tumor, as teratomatous elements in the retroperitoneum will respond only to surgery. Moreover, the chemotherapeutic effort is reduced, more efficient, with lower toxic side effects. Under current conditions, this approach grants high cure rates with low medical and social costs.