UNDERSTANDING CYSTOSCOPY AND TURBT

With Drs. Ken Nepple and Jeffrey Montgomery

Morgan Powell:

Thank you so much Dr. Montgomery and Dr. Nepple. We did have a couple of questions come in during the course of the program. I'm going to go ahead and ask them to you. Feel free to answer as you see fit. The first question is, how frequently is a bimanual palpitation done as part of the TURBT procedure?

Dr. Montgomery:

I'll go ahead and answer that. This is Jeff Montgomery. The bimanual exam should be done on each initial resection. If you're having repeat receptions or a recurrence, it's easy enough to do by manual exam. Now say you have a non-muscle invasive bladder cancer, you have another small tumor that you develop, you go to the operating room for a resection, it's unlikely that a bimanual exam is essential in that situation. What we want to know is, is their bulky tumor that is deforming the wall of the bladder that we're able to palpate? Another thing is for men who are having this procedure, it's rarer and rarer that primary care doctors do prostate exams, so the digital prostate exam.

That's an another benefit to doing a bimanual exam and particularly in men is that you also do a thorough prostate exam. As far as the frequency is concerned, there's no hard standard on that, but in my practice on all first resections, I do it and document it, but it may not be required for future resections, depending on the situation.

Dr. Nepple:

Yeah and from my perspective, I agree with all the points that Dr. Montgomery brought up and I would just maybe also highlight with initial diagnosis, CT scan gives us a pretty good idea about what a bladder tumor looks like and some concept about aggressiveness. There maybe still be value in doing that exam, but we're not oftentimes finding that a small tumor on this scope, CT scan looks okay and then finding something surprising on bimanual exam. They typically correlate together. I think the other important

thing to note from the patient's standpoint is we don't separately consent patients for a bimanual exam. Most of us will document it in our operative note, but maybe not universally.

I wouldn't take home that if your urologist has never mentioned a bimanual exam that's something about your care has been lacking, it's actually probably relatively frequent that that exam has been done, but it's just not something that in the course of a normal clinic conversation that I typically go into in any great detail. It's more for me a learning point with our residents as we're training them to point out that hey, you should do this so you know what normal feels like if you ever do have a bigger bulkier bladder tumor that you're trying to figure out if it's mobile or not.

The other practical side is if you're a man and you need to have a rectal exam, that well someone's asleep under anesthesia, that seems like a great time to have it done for everybody involved to avoid that discomfort that might come with that exam in the course of a clinic visit.

Morgan Powell:

Great. Thank you so much. We have time for just two more questions. Our next question is, under what circumstances is TURBT done under local anesthesia during an outpatient cystoscopy?

Dr. Montgomery:

TURBT technically implies that it's done with a larger scope that allows the resecting loop that I showed in order to get a deeper sample of tissue, so that is not a procedure that would be tolerated in an office procedure. Now situations where you have a small tumor that can be biopsied in the clinic or even fulgurated or burned in the clinic, we do that. It's not all that frequent, but if we do run into those situations, that's something that we're able to perform at that time in clinic, but a classic TURBT could not be done under local anesthetic. It's generally a general anesthetic or we can do them under spinal anesthetic.

Morgan Powell:

Thank you so much. To build on that, there was another question that was related to that. If they had a tumor fulgurated or burned off in the office and it couldn't be sent to pathology, is there a reason for concern for that?

Dr. Nepple:

Yeah. I can fill that one. I think most commonly, there wouldn't be a reason for concern if it was something that was quite small and specifically in patients where there's a history of low-grade type of bladder cancer. I think that I've actually seen research level data that that type of procedure is probably way more frequent than is perceived at the academic institutions. I think I specifically in my practice am quite conservative about not doing too many of those procedures in the office because every once in a while, if you actually remove the tumor and you do the biopsy, you find out that there's a high grade cell there that's not the low-grade type.

That's something that is specifically triggering us to consider a different management of liquid into the bladder and those types of patients. I think in general that it's probably a safe procedure if something was small enough that the urologist felt that that was a reasonable thing to do, but if it's something that is happening, if a patient's having a fulguration every three months, then there may be situations where it's better to try to go to the operating room and clean out everything, fulgurate everything and then look at what the pathology is and what the options are. I'm always very cautious about judging someone's specific example or experience.

There probably was good reasoning behind it, but I think it is just good to have an overall concept of. It's a relatively uncommon procedure in general for bladder cancer.

Dr. Montgomery:

I'll just quickly add that there are situations where people get more frequent recurrences where every time you sent the tumor that you've biopsied in clinic, it comes back as a low-grade TA, so non-invasive. You look in, it looks like the same exact tumor. There's really no benefit to sending that tumor for a pathologic analysis and just really adds to the cost of bladder cancer management. There are circumstances where you would remove the tumor or fulgurate it without sending it to pathology.

Dr. Nepple:

Yeah, I agree, that's a great point.

Morgan Powell:

Great. Thank you. Thank you so much Dr. Montgomery and Dr. Nepple for joining us this evening. That's all the time we have for questions today.