LETTER TO THE EDITOR

Comment on Umer Farooq et al. (JPMA 2018; 68 (7): 1129-31)

Short term surgical outcomes of Wilms tumour from a single institute

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Dear Madam, I read Farooq et al.[1] with interest. I congratulate the authors for their efforts in the management of these tumours, many of which were large. I have certain queries for the authors.

One, the authors have mentioned about clinical staging at presentation. I am not aware of any such clinical staging in the context of Wilms' tumour. The staging is always post-surgery after the resected specimen and the lymph nodes are reported by the histopathologists. Of course, one could say whether the disease is localized (non-metastatic) or metastatic (stage IV) at presentation, and if tumours are present bilaterally (stage V).

Two, the histopathological staging after NWTS/ COG is very different from that of SIOP/ UKCCLG.[2] When the authors had used the latter protocol, how could the histopathologists report the tumours as per NWTS staging? In fact, the tumours should have been risk-stratified as low, intermediate or high risk. Further, the terms' complete/partial and no histological response' have to be elaborated upon.

Three, concomitant ipsilateral adrenal excision is being given up globally,[3] as the incidence of its being involved is very low, similar to the authors' findings.

Four, there is no justification of administering metronidazole in these patients except the one who had colonic resection and anastomosis for enbloc tumour resection.

Five, there is no mention of postoperative flank radiation to stage III and IV patients.

Six, it is surprising that 3-drug regimen (VAD) was given to most of the patients postoperatively, thus overtreating the stage I 'intermediate-risk' patients. What was the cumulative dose of Doxorubicin administered to the patients?

Seven, though I understand some of the patients had only six-month follow-up, the authors should have mentioned 1-year event free and overall survival for the patients in their series.

Eight, two children had concomitant splenectomy, something that is unheard of in the developed world these days. Were these patients offered preoperative vaccination? What special efforts were done to avoid overwhelming post-splenectomy sepsis in such patients? These patients are as such immune-compromised due to malignancy and the neodjunct chemotherapy.

Nine, nephron-sparing surgery (NSS) was done for 3 patients who either had bilateral or syndromic patients. Why did the authors not try doing NSS in small unilateral non-syndromic Wilms' tumours. Instead, they chose to do laparoscopic or lap assisted procedures. SIOP categorially propagates that minimally invasive or laparoscopic surgery should not be done in patients in whom NSS can be safely performed.[4]

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