

Response to: “Small-cell carcinoma of the genitourinary tract: a point of view”

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I thank Dr. Nabil Ismaili for reading our article¹ and giving his valuable comments with regard to the management of genitourinary small-cell carcinoma (scc). Dr. Ismaili agrees with us about the essential role of chemotherapy in the management of genitourinary scc. However, he does not agree with our suggestion of treatment being analogous to that in small-cell lung cancer.

We suggested a platinum-containing chemotherapy regimen for scc of the urinary bladder because the chemotherapy used in either scc or transitional-cell carcinoma of the bladder is platinum-based. Also, pure scc behavior is thought to be similar in its various anatomic sites, and no randomized trial has established a specific chemotherapy regimen in this malignancy. We mentioned in our article that scc of the urinary bladder can be managed by various combinations of chemotherapy, surgery, and radiotherapy. Our study demonstrated that approximately 37% of the cases of scc of the urinary bladder were associated with transitional-cell carcinoma of the bladder¹. In my opinion, those cases can be treated with neoadjuvant chemotherapy followed by surgery, if feasible. On the other hand, neoadjuvant chemotherapy followed by concurrent chemoradiation can be used when organ preservation is preferred, especially in cases with pure scc histology.

In our cohort, only 1 patient was treated with prophylactic cranial irradiation, and 1 who was untreated with prophylactic cranial irradiation developed brain metastasis

at a later stage¹. We therefore did not recommend routine use of prophylactic cranial irradiation in genitourinary scc. Any related decisions should be made on an individual case basis. I noted a 50% rate of brain metastasis reported by the MD Anderson group² in stage III and IV patients. That rate of brain metastasis is higher than the rate observed in our report and in other published retrospective studies^{1,3}.

I concur with Dr. Ismaili that the optimal management of small-cell carcinoma of the prostate is not well defined. However, we suggest limiting the use of androgen deprivation therapy in a mixed histology of scc and adenocarcinoma.

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CONFLICT OF INTEREST DISCLOSURES

I have read and understood *Current Oncology's* policy on disclosing conflicts of interest, and I declare that I have none.

REFERENCES

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