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EDITORIAL

Long-term patient follow-up should be routinely implemented in radiotherapy units to detect late adverse effects after cancer treatment

Editorial comment to Urosymphyseal fistula after pelvic radiotherapy – an entity in patients with significant comorbidity requiring multidisciplinary management Scand J Urol. 2023

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It is well known that curatively intended cancer treatment may result in short- and long-term adverse effects with a negative impact on patients' quality of life. That sequelae after such treatment may result in need of major surgery and death is less recognized.

In the current issue of the Scandinavian Journal of Urology, Brändstedt et al. present a cohort of patients with urosymphyseal fistulas (USFs) after pelvic radiotherapy in a tertiary referral center in Sweden. The authors bring to attention a complex condition requiring multidisciplinary management (urological, orthopaedic, colorectal, infectious disease) and extensive surgical interventions in the majority of cases. Within few years of diagnosis, one in three men had died as a direct consequence of USF.

Radiotherapy is administered in highly specialized centers, and long-term patient follow-up is mainly organized within the primary health care services. Adverse effects related to the urinary tract (e.g. USFs, secondary bladder cancers, radiation cystitis, urethral or ureteral strictures, bladder contractures and dysfunction) may manifest long after pelvic radiotherapy and are generally managed within local or regional urology departments [1–9]. Unless long-term patient follow-up is routinely implemented by the cancer therapy units, late complications escape the attention of the radiation physicians. Local radiation toxicity often becomes evident during the first years after treatment, but the cumulative incidence of adverse post-radiotherapy events continues to increase with time [10, 11]. In the current literature, there is a paucity of population-based data on late complications and mortality after pelvic radiotherapy.

In our clinical experience, urology departments are frequently visited by patients with post-radiotherapy complications involving the urinary tract. Direct and indirect sequelae after pelvic radiotherapy may lack specific diagnostic codes (like USFs) and conditions may not be coded with the external cause of morbidity that is radiotherapy. Therefore, complete adverse event data cannot be easily retrieved retrospectively from electronic journals or public health registries. For USF after pelvic radiotherapy, only case reports and small case series are described in the literature. The case series from Skåne University Hospital is a prudent attempt to present population-data on USF, however, when post-treatment outcome data have not been prospectively collected, the real-world prevalence still remains unknown. Late adverse effect profiles of new radiation regimens cannot be compared with older methods when historical data are missing [12, 13].

The majority of the patients in the Skåne cohort were elderly with significant comorbidities and had undergone primary or salvage radiotherapy for prostate cancer median 5 years prior to the diagnosis of USF. It would be interesting to know the patient characteristics at the time of curatively intended radiotherapy, being aware that these men suffered severe treatment-related morbidity, and in some cases death, few years later. This could help in identification of specific groups with increased risk of USF. The potential late and severe side-effects following radiotherapy must be recognized by physicians and properly communicated to patients at increased risk so they can make informed decisions about their treatment, particularly when other options are available. Patients who are deemed unfit for or have previously undergone surgery, however, are often referred for radiotherapy as the only remaining curative treatment alternative. As with surgery, higher age and comorbidity increase the risk of adverse effects after radiotherapy [14, 15].

The authors importantly highlight an increased risk of secondary complications for patients who are managed with

invasive procedures for local sequelae of the urinary tract after radiotherapy. The cause–effect relationship of urological interventions and USFs in previously irradiated patients, however, cannot be concluded based on the current material. The findings implicate that patients with urinary complications after radiotherapy may benefit from management in more experienced centers, to avoid secondary unwanted effects of invasive investigations and treatments.

For patients with USFs, it is correctly emphasized that a multidisciplinary approach is likely to improve diagnostic workup and treatment. An early raised suspicion of USF should lead to referral to a highly specialized hospital in order to avoid suboptimal management in smaller centers lacking the experience of such entities. The early use of MRI seems reasonable and attainable in local centers. The authors present a wide range of therapeutic approaches, including extensive surgery as the only definitive treatment, in a widely heterogenic group of patients. It is clear that multidisciplinary treatment approaches need to be tailored individually. The lack of guidelines on USF management support the need to centralize care to obtain sufficient experience. This would also be beneficial in terms of population-based registration and research into this presumably rare condition.

With their study, Brändstedt et al. have successfully increased the awareness and knowledge about USFs after pelvic radiotherapy. In our opinion, long-term patient follow-up should be routinely implemented in radiotherapy units to document late adverse effects after cancer treatment, ultimately improving patient selection and counselling.

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