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Meeting abstract

Management of post-radiotherapy hemorrhagic cystitis refractory to conventional treatment

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Background

In the treatment of pelvis cancer such as rectum, bladder, prostate, cervix and others, the use of radiation therapy as primary or adjuvant cancer treatment is a common practice; however, complications and side effects could occur, the most common urological complication present in about 5.7 to 11.5% of the cases is the post radiation hemorrhagic cystitis (PRHC). We present the clinical evolution of all the patients with PRHC who did not respond to the standard management of the hemorrhagic cystitis.

Materials and methods

From January 2006 to August 2006, thirty seven patients with diagnosis of PRHC were evaluated including: sex, age, oncology diagnostic cystoscopic findings, clinical features, blood transfusion required, and failure to treatment, alternative treatment and clinical evolution.

Results

In a period of 8 months, 37 patients from the urology department of the Instituto Nacional de Cancerología, were evaluated, 36 female and 1 male, median age 62 years old (43 – 72 years), diagnosis of cervix cancer stage IIb and IIIb in the females and prostate cancer in the male, all of them treated with radiotherapy as primary therapeutic technique. The main symptoms were: pelvis pain in 34 cases, dysuria in 25 and gross hematuria in 37, all the patients underwent cystoscopic evaluation, which develop inflammatory changes and hemorrhagic lesions in bladder walls in 100% of the patients. All the cases were treated with 50 cc intravesical instillations of 50% solution of dimethylsulfoxide (DMSO) in saline solution weekly for 6 weeks.

Four cases presented therapeutic failure with gross hematuria and required prolonged hospitalization and blood transfusion of 3 units. The 4 cases were treated with urinary diversion only (ileal conduct) in 3 and urinary diversion and cystectomy in the other. One female treated only with urinary diversion due to intense desmoplasic reaction secondary to RT which makes cystectomy not possible, presented persistent hematuria and must be treated with instillation of 10% of formaldehyde solution under IV sedation. The evolution was satisfactory after the procedure and the hematuria stopped.

Conclusion

The PRHC must be treated according with the standard procedures however, the surgical management must be considered as the definitive procedure in patients with no response to the intra-vesical therapy.