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Short Communication

Dear Sir,

Generally speaking, the bladder cancer is the 10th most common and 13th most deadly cancer worldwide, it was also known as the urological cancer or urinary bladder cancer, is the 10th most common cancer world, and its incidence is steadily rising worldwide, especially in developed nations (Bray *et al,* 2018). Schistosomiasis infection is the commonest cause of bladder cancer in the regions of Africa and the Middle East and is considered there the second most onerous tropical pathogen after malaria (CDC, 2018).

Schistosomiasis is an ancient disease, depicted in papyri from Pharaonic Egypt, with classic symptom of blood in the urine was described in the Ebers papyrus as the āāā disease and mentioned in various other medical papyri that contained prescriptions against hematuria (Ebeid, 1999). Ibrahim *et al.* (2014) in Egypt reported the incidence rates were calculated at a regional and a national level, and future projection up to 2050 was also calculated. They added that the age-standardized incidence rates/100,000 were 166.6 (both sexes), 175.9 (males), and 157.0 (females), with commonest sites were liver (23.8%), breast (15.4%), and bladder (6.9%) (both sexes): liver (33.6%) and bladder (10.7%) among men, but breast (32%) and liver (13.5%) among women. By 2050, a 3-fold increase in incident cancer relative to 2013 was estimated. They concluded that these data were the only available rates at national and regional levels of Egypt.

Re: Transurethral bladder biopsy after post intravesical therapy for superficial bladder cancer patients. J. Egypt. Soc. Parasitol. (JESP) 51, 2, 2021: 417-22: Presented original contributions with a lot of interesting information on the Bladder Cancer. This papers came from: Drs. Wael Morsy A. El-Said, Tarek Abdel Kader Sallam, and Ayman T.A. Morsy, Cairo-Egypt.

The authors reported on 32 patients with superficial transitional cell carcinoma (Non-muscle invasive bladder cancer (NMIBC) they were diagnosed, treated, and followed-up during the year 2018. The pathological diagnosis was (CIS) in 2 patients, Ta was in 4 patients, T1-2 was in 22 patients, all patients received transurethral resection of the bladder tumors (TURB) and received BCG course that was followed-up after 6 weeks with urine cytology and cystoscopy with biopsy of the primary site of the NMIBC, the authors reported that although the urine cytology was negative, four patients had positive pathological specimens that was in 4 patients, they were 2 patients having T1G1 tumors, and another 2 patients havingT1G2 tumors, these recurrences were similar to the primary tumors.

The authors recommended that taking biopsy from the previously resected site for diagnosis of recurrence in the patients with the negative urine cytology.

Undoubtedly, the study was well designed and pointed to the importance of biopsy of the site of previous tumors for diagnosis of recurrence or new occurrence. It would be of interest to know how the operator mapped the bladder wall to precisely locate the previous TURB and particularly in multiple tumors and in CIC. Table 1 showed that the primary tumors were 9 patients had T1G2 and 2 patients were T1 and 2 patients had T1G2 tumors. This category of patients was classified high risk tumors that mostly recur and upstage to muscle invasive bladder tumors particularly in cases of the multiple tumors (Sylveste *et al,* 2021).

Table 2 showed that there were changes in the bladder mucosa following BCG instillation, these changes were cystitis cystica, cystitis glandularis and polypoidal cystitis. Thechanges in the bladder mucosa would be due to the strain of BCG used in this series, these findings had been uncommonly reported and it is of interest to know if it would be reversible or not on long term follow-up (Wishahi *et al,* 1994).

The study had a small sample size and short follow-up, longer follow-up and more cases would legitimize this good procedure.

Yours sincerely

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