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LETTER TO THE EDITOR

To cystoscope or not to cystoscope patients with traumatic spinal cord injuries managed with indwelling urethral or suprapubic catheters? That is the question!

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We would like to thank Colgate *et al.*[1] for their interest in our manuscript, their 'speedy response' and their humorous redrafting of the title.

We would like, however, to respectfully point out to the correspondent the following that we had hoped was clear in both the abstract and the body of the report.

The cystoscopic surveillance is only carried out on patients with permanent suprapubic (SPC) or urethral catheter (IUC) drainage.

The cystoscopic surveillance was not primarily carried out to look for neoplastic changes in the bladder but to mitigate distressing symptoms from complications and/or morbidity related to permanent catheters. While Hamid and Yang carried out their surveillance on 36 and 56 patients, they only reported on bladder cancer that most people will agree is not a good enough reason to subject patients to such surveillance considering the small incidence, even though cord injury increased the risk of dying of bladder cancer in this group of patients by a factor of about 20.[2]

Our practice of surveillance was commenced following many years of observation that within a period of 18 months to 2 years since insertion of SPC/IUC, the majority of these patients presented during the outpatient clinic reviews with recurrent urinary tract infections many with systemic manifestation, recurrent blockage of the catheters, distressing symptoms of autonomic dysreflexia and/or excess spasticity, all related to permanent catheter following exclusion of other causes. The incidence of these complaints was negligible in the non-permanently catheterized population.

During the cystoscopic surveillance, there was a significant incidence of vesical calculi and proteinaceous material thick enough to be washed out through the catheter. A significant number of patients were also found to have metaplastic changes that by themselves did not cause undue concern if they were not keratinizing.

It is possible that we may not have made it as clear as the correspondent wished it to be—that all our patients with SPC/IUC undergo cystoscopic surveillance, hence our inability to compare those who do not undergo cystoscopic surveillance with those who do. In our article, we have indeed suggested that such a study to compare findings in the group who underwent cystoscopy with those who did not undergo cystoscopy should be done and this suggestion may have been missed in the heat of the discussion. With the development of the National Institute for Health and Care Excellence (NICE) guidelines, and considering that the guidelines relied on publications that only dealt with the incidence of bladder cancer, we decided to audit our findings to make a decision either to support the implementation of the guidelines and abandon the cystoscopic surveillance or to continue the surveillance dependent upon our findings in this small group of patients.

With the available material, we looked into the presence and absence of distressing symptomatology and comorbidities that patients with SPC/IUC presented with and these were documented in Tables 4 and 5 in the article.

We did not feel that the two publications the correspondents refer to added anything to our message considering the relatively small number of patients included in each, their limitation to cancer of the bladder and the fact that we had already made reference to the NICE guidelines.

The purpose of our article was to focus attention a little away from bladder cancer that seems to date to be the main concern to clinicians and to focus some attention to what can cause distress to patients. We did, however, have to discuss bladder cancer considering that the two patients with keratinizing metaplasia were in the asymptomatic group and we had to highlight the evidence that NICE did not acknowledge while drafting the guidelines.

We believe that the answer to the question or indeed if the question should be asked at all will depend to a great extent on how much importance is given to the human cost in comfort, good health, well-being and quality of life of the patient with SPC/IUC, and to the currently unknown monetary cost of preventing these complications. It is possible that if adequately calculated, prevention may be found to be cheaper than treatment.

We hope we have demonstrated that if the rationale of management of this small group of patients is to prevent morbidity that causes distress, can harm and/or negatively affect the well-being and quality of life of the patient then cystoscopic surveillance is essential. If, on the other hand, it is only bladder cancer that the clinician should be concerned about, irrespective of other effects, and if the development of bladder cancer can be prevented and/or diagnosed early by some better and cheaper method, then cystoscopic surveillance for this small group of patients is obviously unlikely to be essential.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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1 Colgate C, Derry F, Allison HC, van Middendorp JJ. 'To cystoscope or not to cystoscope' Was that really the question? *Spinal Cord* 2014; **52**: 499.
2 Miller A, Mitchell JP, Brown NJ. The Bristol Bladder Tumour Registry. *Br J Urol* 1969; **41** (Suppl), 1–64.