SUMMARY AND CONCLUSION

Bladder cancer represents a major health problem not only in our community (where Bilharziasis is endemic) but also allover the world.

Preoperative tumor staging is still of prime importance for both treatment planning and prognostic assessment.

Still cystoscopy and biopsy are the first diagnostic and staging modality. However, it cannot assess valuable prognostic data namely perivesical tumor invasion, lymphatic (lymph vessels and lymph nodes) metastasis and distant metastases.

In this situation, computed tomography can play not only an additive role, but also a unique role. Although CT cannot probably differentiate stages T2 from T3a, CT can accurately diagnose stage T3b. using proper CT technique, CT can probably identify lymph node metastasis when it identifies lymph nodes larger than 1.5cm. By this, it can guide to select the mode of treatment of invasive bladder cancer (more than T2) from superficial bladder cancer where the later will be treated by cystoscopic resection, while the former will be treated by compound therapy using choices of surgery, radio-and chemotherapy.

It should be taken in consideration that in addition to the CT technique, the timing of CT examination will raise to diminish the diagnostic capability if the CT examination is done before cystoscopy as this will avoid lack of tissues definition by the oedema and superadded infection.

CT also plays an important role in the assessment of bladder cancer after treatment. A base line study (in addition to the pretreatment study) 4-8 weeks after treatment (whether by surgery, radio-or chemotherapy) should be obtained to avoid confusion made by postoperative scar, postoperative or post irradiation fibrosis.

CT in distant metastasis is not the first line of assessment, practically and economically. However, it will be the final line of assessment after positive bone scan, chest X-ray and ultrasound with additional role of CT guidance for obtaining a biopsy from metastatic lesions.

Comparing out study (25 patients) to other studies, we found out that both agree upon the finding that male, has much higher incidence than females (80% males, 20% females).

The pathological evidence in our study was 36% transitional cell carcinoma, 64% squamous cell carcinoma as the commanest pathology, as we had our studies bilharzial and nonbilharzial patients.

In our study, we tabulated cases of different stages as identified by CT findings and presented the cases that can demonstrate the capability of CT to identify the findings that can separate different stages of urinary bladder cancer. We also presented cases that demonstrate the important role of CT in demonstration of post-treatment (of bladder cancer) recurrence. In this respect we met an incidence different from other studies that found out that recurrence at pelvic lymph nodes alone was rare, while in our study it was as high as 24%.

In spite of its higher cost and lesser availability, MRI ha technical facilities and resolution ability that allows it to pl competitive role with CT role described before, with even much he capabilities when IV contrast is used.

CONCLUSION:

As a conclusion, with proper application as regard ti technique and requested data to be gained from, CT can play a helpful role in staging of bladder cancer and hence it can play a goo in treatment planning, prognostic evaluation and post-treatment f up.