

Letter to the Editor

Transitional cell carcinoma of the ovary

To the editors:

We recently read the report prepared by Yu et al entitled “Primary ovarian transitional cell carcinoma after renal transplantation”¹ with great interest. Transitional cell carcinoma (TCC) of the ovary is a rare, recently recognized subtype of epithelial ovarian cancer and is a type of cell that is frequently found in the urinary tract¹; therefore, accurately diagnosing TCC in the ovaries as the primary or metastatic lesion is important because the appropriate treatment choice could differ depending on the initial diagnosis. In addition, a malignant Brenner tumor of the ovary is very similar to primary ovarian TCC, but these are different diseases with different treatment protocols. In order to make a clearer and more accurate differential diagnosis, in addition to identifying any basic histological differences, immunohistochemical staining may be helpful. We learned a lot from the authors’ effort because they addressed some important concepts. For example, the authors introduced four markers—CK7, CK20, thrombomodulin, and uroplakin III—to help differentiate the primary and metastatic lesions of ovarian TCC. The authors also emphasized two points: (1) the presence of CK7+/CK20+ always indicates a urinary tract origin; and (2) ovarian TCCs are negative for CK20, thrombomodulin, and uroplakin III.¹ However, in addition to the abovementioned immunohistochemical markers we would also like to introduce others, including vimentin, CA-125, Wilms’ tumor protein (WT1), and various estrogen receptors, because these markers are positive in primary ovarian TCC but negative in urinary tract TCC.² We hope this information will help the readers understand the characteristics of ovarian TCC.

We would, however, like to know which treatment regimen Yu et al¹ used to manage primary ovarian TCC, and we hope to see further discussions regarding this issue. We would also like to emphasize that this should not be considered an argument against the excellent and successful management of this patient’s condition that was provided by the authors. It is well known that primary ovarian TCC has a better prognosis than all other types of ovarian carcinomas following standardized chemotherapy.³ Higher survival rates can be achieved by using standard treatment options, such as surgical resection followed by cisplatin-based chemotherapy,³ which has been previously described by the authors.³ However, we

would like some clarification regarding Dr. Yu’s chemotherapy regimen: specifically, the combination use of carboplatin (300 mg/m²) and gemcitabine (1000 mg/m²). Based on our understanding of the guidelines provided by the National Health Insurance Bureau of Taiwan, we should prescribe a cisplatin-based regimen, which often includes the use of cyclophosphamide. In one literature review, this combination was popular and resulted in good therapeutic outcomes²; this regimen might also have been appropriate for the authors’ patient because this patient was diagnosed as surgicopathological stage IIa. Of course, other combinations could have been used to manage this patient’s condition. For example, carboplatin plus paclitaxel is also good therapeutic option—a recent report favored this combination for treating all forms of epithelial ovarian cancers. We assume that the authors’ use of gemcitabine and carboplatin might be based on the presence of bladder cancer since the Cochrane Database Systemic Review concluded that this combination is beneficial for unresectable, locally advanced or metastatic bladder cancer.⁴

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