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LETTER TO THE EDITOR
PRIMARY SMALL CELL BLADDER CARCINOMA

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We have read with interest the article by Zachos *et al.*[1] The paper reported a rare case of primary small cell bladder carcinoma (SCCB) along with a literature review. We appreciate the efforts of the authors to confirm the rarity of this disease and to describe in their review its clinical, diagnostic and therapeutic features. We recently observed a case of a primary SCCB and we consider it helpful to report our experience, which also describes the unusual coexistence of a primary non-small cell lung carcinoma (NSCLC).

In January 2006, a 73-year-old man underwent transurethral resection of a bladder cancer. Histological examination revealed SCCB. A total-body CT scan showed the bladder tumor with pelvic lymph node involvement, as well as a lesion in the right lung of about 4 cm with ipsilateral hilar lymph node involvement. SCCB was at stage IV. A CT-guided fine-needle biopsy of the pulmonary mass performed for diagnostic refinement showed the lesion to be a NSCLC at stage IIIa. Laboratory findings showed renal insufficiency with creatinine 1.2 mg/dL and spirometry revealed a condition of chronic bronchitis related to substantial tobacco use (60 cigarettes a day since the age of 19). Considering the patient's condition and his performance status, which precluded surgery or radiotherapy, palliative chemotherapy was started with a schedule including carboplatin AUC 4 on day 1 and gemcitabine 1000 mg/m^2 on days 1 and 8, every 28 days. Three courses of chemotherapy were administered, the last causing severe hematological toxicity with the onset of prolonged grade 3 thrombocytopenia, which made it necessary to stop the treatment. Restaging by total-body CT scan showed stabilization of the lung cancer and a remarkable partial remission of the bladder cancer and metastatic pelvic lymph nodes. Unfortunaltely, because of the persistence of thrombocytopenia, we were unable to resume chemotherapy, and the patient's condition declined due to pelvic progression of SCCB. Acute renal failure led to his death in June 2006.

As reviewed by Zachos *et al.*[1], most patients affected by SCCB have a history of smoking. In our case the concurrent development of the 2 cancers, which is very rare, was probably the result of this bad habit. Our experience confirms that SCCB has a poor prognosis. We agree with Zachos *et al.*[1] that platinum-based chemotherapy provides a chance to improve the survival of patients. Recently, Shirato *et al.*[2] reported the efficacy of the combination of cisplatin and gemcitabine as neoadjuvant chemotherapy in a case of SCCB. The carboplatin-gemcitabine combination may be active in both NSCLC[3] and SCCB[4]. We chose the carboplatin-gemcitabine regimen because of its presumed lower impact on the patient's renal function. Our experience suggests that this regimen can lead to objective responses in SCCB and may be considered a valid treatment option in the presence of synchronous NSCLC and SCCB. However, particular attention must be paid to the management of hematological toxicity. As Zachos *et al.*[1] remarked, we agree that the rareness of SCCB precludes prospective studies and the optimal therapeutic strategy is as yet undetermined.

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