SIUJ Société Internationale d'Urologie Journal

Comment

Revisiting Prognostic Nomograms in Upper Tract Urothelial Carcinoma. Comment on Wei et al. External Validation of Postoperative Nomograms in Upper Tract Urothelial Carcinoma Following Radical Nephroureterectomy. *Soc. Int. Urol. J.* 2026, *7*, 40

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Xinyi Wei and colleagues report on outcomes after radical nephroureterectomy for upper tract urothelial carcinoma (UTUC) in 103 patients from a single institution [1]. Although the sample size is modest, the cohort is well annotated and the follow-up is relatively long, allowing the investigators to make the most of the cohort by using it to validate four previously published postoperative nomograms. External validation in contemporary cohorts is an important and necessary step in translating prognostic tools into clinical practice, and the authors should be commended for addressing this gap.

Three of the four nomograms were constructed with data from very large cohorts. The Seisen nomogram included 2233 patients, the Cha nomogram included 2244 patients and the Roupret nomogram included 3487 patients. The Abdul-Muhsin nomogram included only 237 patients and appears to be included more as a convenience because the variables available from the current cohort match those in this nomogram. The patients in these nomograms spanned the entire spectrum of disease from low-grade non-invasive disease to high-grade infiltrative tumors, although almost all patients in the Seisen nomogram had high-grade pT1–T3 tumors. This heterogeneity is difficult to capture in a single nomogram, yet the current study suggests that the nomograms are quite effective in stratifying risk in a mixed cohort from a different continent.

Conceptually clinical decision-making is quite different for low-grade non-invasive tumors versus high-grade invasive tumors. The greatest need for risk stratification lies in the context of renal preservation versus nephroureterectomy for low-grade tumors, and neoadjuvant therapy versus immediate surgery in high-grade tumors. These post-nephroureterectomy nomograms stratify risk after nephroureterectomy, where the clinical decisions address the need for adjuvant therapy in the highest risk patients and the schedule for surveillance in all patients. One quarter of patients in the current series received adjuvant chemotherapy, which reflects a more recent shift in practice and is not considered in any of the nomograms.

The observation that the identified prognostic factors largely align with established risk determinants is reassuring and supports the internal validity of the dataset. Notably, tumor grade did not emerge as an independent predictor, which may reflect collinearity with other pathological variables such as stage or architecture. The modeling strategy omits several clinically relevant variables, including hydronephrosis and method for management of the distal ureter.

In an era of increased use of neoadjuvant chemotherapy, none of these nomograms account for it as a variable. Since the nomograms are based on nephroureterectomy

Check for updates

Received: 17 June 2026
Accepted: 18 June 2026
Published: 20 June 2026

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specimens, they cannot be used to guide neoadjuvant therapy, but extent of residual disease after nephroureterectomy likely has significant prognostic value. Excluding neoadjuvant therapy from the nomogram risks excluding the highest risk patients.

The systematic review by Pallauf et al. identified 26 prognostic nomograms for patients who have undergone nephroureterectomy for UTUC [2]. This begs the question of why the field needs 26 nomograms, and how we can move forward with a small number of prognostic tools that are well validated and have demonstrated clinical utility. This study reinforces the relative robustness of established UTUC nomograms within a contemporary Australian cohort. While the findings are largely confirmatory, they highlight the ongoing need for larger, multi-institutional validation efforts with standardized data collection to meaningfully refine prognostic modeling in this heterogeneous disease.

Conflicts of Interest: The author declares no conflict of interest.

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