



Platinum Priority – Editorial

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A Plea to Young Surgeons Dealing With Radical Prostatectomy Patients: Invest Your Time and Intellectual Energy in Optimizing Your Research Methodology and Keep Your Feet on the Ground

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1. Introduction

In this issue of *European Urology*, Menon et al. [1] report on the longest oncologic follow-up of patients with prostate cancer (PCa) who underwent robot-assisted radical prostatectomy (RARP). The authors should be commended for identifying an area of key interest for urologists and contributing to clarify the excellent impact of RARP on cancer control. I personally expected nothing different from what the authors reported, as I have been convinced for awhile now that RARP will progressively become the most common treatment modality for PCa worldwide. Having said this, it is very clear that the article by Menon et al represents a landmark contribution in the area of PCa management. The authors show in a methodologically sound fashion that the robotic approach is efficacious in controlling the disease at a long-term follow-up [1]. The paper by Menon et al becomes a reference study—full stop.

Perhaps even more important from an editor's perspective, I think that this article provides food for thought about several methodological and clinical issues that should be very clear in the minds of young surgeons dealing in their everyday practice with PCa patients.

2. The critical importance of collecting data

To be an excellent surgeon for patients with PCa, it is not enough to have talented hands that are capable of completing a well-done operation in a couple of hours. It is imperative that young surgeons understand that their future success is strongly linked with their capacity to

collect data and to know everything about the preoperative, intraoperative, perioperative, and postoperative conditions of the patients on whom they are operating. Many will think that the Editor in Chief of the Platinum Journal is stating the obvious. This is because nobody wants to admit that there is a lack of awareness of postprostatectomy patients' early and long-term results in terms of cancer control, urinary continence, and erectile function.

All surgeons managing patients who have an actual chance of being cured of the disease by surgery and thus surviving many years after the operation must be organized with an adequate number of well-trained data managers to collect patient data. The science of data management is now taught in the vast majority of universities, and finding a good data manager is no longer difficult. Many issues must be faced and resolved when starting the clinical research program on radical prostatectomy: approval of the research project by the ethics committee, finding adequate funding for salaries, and training the data manager on how to approach patients to deliver the questionnaires and collect data are three of the many fundamental steps that must be addressed.

3. The critical importance of long-term follow-up data

There is a unanimous agreement that radical prostatectomy should be considered only for patients with a life expectancy of ≥ 10 yr. This being the case, how come the number of studies reporting on postprostatectomy long-term follow-up is so small? We all know the reason:

Remaining in contact with patients following surgery may be difficult due to practical issues. In addition, all surgeons are happy to see the patients who spontaneously come into the office after the procedure but tend not to think about those who do not show up—our days are already busy enough. It is imperative to think about modern ways to remain in touch with patients for many years following the operation.

As Internet use has increased, it has become quite easy to use software to contact operated patients with a prewritten e-mail requesting information about their medical conditions. Via e-mail message, one can use simple questionnaires to request information about prostate-specific antigen value, continence, and erectile function. The software is clearly able to contact every patient at predefined time intervals. I personally believe that every modern surgeon who wants to manage his or her patients in a state-of-the-art fashion must be organized in this way.

4. Should urologists become good statisticians?

I am convinced that the modern urologist should be concentrating on one or maybe two areas of clinical interest at most if he or she wants to be at the very top of the field. If one deals with PCa, it is probably best to do PCa only, as the topic is so large. Having said this, the top expert in PCa must know the basics of medical statistics, which are needed, for example, to understand the real meaning of a scientific article. The growing field of outcomes research demonstrates the importance of statistics. A large academic urologic unit should have one professional statistician working full time with the surgeons to identify and run the most appropriate analyses. Urologists who are active in research will have the chance to learn a lot from this daily interaction with the expert statistician and will become able to find answers to the most intriguing questions.

5. Complications exist in robot-assisted radical prostatectomy

Although the paper by Menon et al. [1] does not address the topic of intra- and postoperative complications, I would like to emphasize that this area is of critical importance with RARP. I believe that the majority of those who developed a robust experience with open radical prostatectomy and then switched to the robotic approach remained quite surprised by the brisk reduction in complications and sequelae such as blood loss, fistulas, or strictures of the urethrovesical anastomosis and symptomatic lymphoceles. Having said this, RARP remains a demanding operation that

deserves full respect by all surgeons. A tear in the rectum or in an iliac vessel, for example, may be made inadvertently during RARP, although the surgeon sees every single anatomic detail much more precisely. We must recognize that these accidents may happen.

6. Robot-assisted radical prostatectomy and pelvic lymphadenectomy

In my opinion, the area of pelvic lymphadenectomy (PLND) during RARP has not been completely elucidated yet. I believe that the majority of surgeons in the initial part of the learning phase with RARP would tend to select patients who do not need PLND to cut down the operating time. Although well-accepted preoperative tools allow the urologist to determine the risk of positive lymph nodes [2], thus dictating the need to perform or avoid PLND, these tools are not commonly used. On the whole, this leads to the limited number of PLNDs done compared with the numbers reported in the open surgery literature. I think that every young surgeon embarking on RARP should identify a predictive tool for lymph node involvement and then perform a well-done PLND every time it is needed. A quality check is clearly warranted: At final pathology, the number of lymph nodes removed must be clearly checked by the surgeon to ensure efficacy during the operation.

7. Intraoperative surgical margins

The best intrafascial dissection performed during open surgery will inevitably keep the surgeon more distant from the prostatic capsule than intrafascial dissection during RARP. This has been my personal experience, and I am becoming increasingly convinced that the intraoperative analysis of surgical margins of the prostatic specimen may play a key role in the near future. We all agree that our patients want to be cured while remaining continent and potent: The perfect “trifecta” depends on perfect surgery. Future research will tell whether this idea holds true.

Conflicts of interest: The author has nothing to disclose.

References

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