

2. Heit M: Intraurethral ultrasonography: correlation of urethral anatomy with functional urodynamic parameters in stress incontinent women. *Int Urogynecol J Pelvic Floor Dysfunct.* 2000;11: 204-11.
3. Schaer GN, Schmid T, Peschers U, Delancey JO: Intraurethral ultrasound correlated with urethral histology. *Obstet Gynecol.* 1998 ; 91: 60-4.

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## UROLOGICAL ONCOLOGY

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### **Delay of Radical Prostatectomy and Risk of Biochemical Progression in Men with Low Risk Prostate Cancer**

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*J Urol.* 2006;175: 1298-302

**Purpose:** Men newly diagnosed with prostate cancer are faced with multiple treatment options. Understanding these options and their associated side effects, and making a decision often requires time, resulting in a delay before receiving treatment. This is particularly pertinent in men with low risk disease who may be considered candidates for watchful waiting and, thus, may not experience strong pressure to undergo treatment promptly. Whether delays and especially prolonged delays, eg greater than 180 days, before RP negatively impact the disease outcome is unclear.

**Materials and Methods:** We examined the association between time from diagnosis to surgery, and pathological features of the RP specimen and risk of biochemical progression in 895 men with low risk prostate cancer (prostate specific antigen less than 10 ng/ml and biopsy Gleason sum 6 or less) treated with RP between 1988 and 2004 in the Shared-Equal Access Regional Cancer Hospital Database using logistic regression and Cox proportional hazards, respectively.

**Results:** Time from biopsy to surgery was not significantly related to high grade disease in the RP specimen, positive surgical margins or extraprostatic extension (all p-trend >0.05). After adjustment for multiple clinical covariates a longer time from biopsy to surgery was significantly associated with an increased risk of biochemical progression (p-trend = 0.002). However, this increased risk of progression was only apparent in men with delays greater than 180 days (median 263, vs 90 or fewer days RR 2.73, 95% CI 1.51 to 4.94).

**Conclusions:** Our data suggest that patients with low risk prostate cancer can be reassured that immediate treatment is not necessary. Whether long delays (greater than 180 days) decrease the likelihood of curability in some patients requires further study.

### **Editorial Comment**

In contrast to the recent papers on surgery delay in bladder cancer a delay in radical prostatectomy for prostate cancer does not seem to be of equal consequences.

In accordance with the slower proliferation time in (most, but not all!) prostate cancers a negative impact of delay was seen in patients with more than 180 days in time to surgery.

Interestingly, in a subgroup analysis of 27 men there was no significant association between pre-prostatectomy PSA velocity and the risk of progression.

It is worthwhile to read the 2 editorial comments to this study, which give some comments on the impact these data may have on “wait-and-see” strategies.

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### **Cystectomy Delay More Than 3 Months from Initial Bladder Cancer Diagnosis Results in Decreased Disease Specific and Overall Survival**

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*J Urol. 2006; 175: 1262-7*

**Purpose:** Some groups hypothesize that a delay in cystectomy may result in higher pathological stage and possibly alter survival in patients with bladder cancer. The timing of this delay has been somewhat arbitrary. We evaluated the timing from T2 bladder cancer diagnosis to cystectomy, its impact on survival and potential causes of delay.

**Materials and Methods:** A contemporary cohort of 214 consecutive patients presented with clinical T2 bladder cancer and underwent radical cystectomy as primary therapy. Clinicopathological parameters were maintained in an institutional database. A review of time to cystectomy, pathological stage, disease specific survival and OS was performed. Variables were tested in univariate and multivariate analyses. The log rank test was used for exploratory analyses to determine meaningful delay cutoff points.

**Results:** Mean followup and time to cystectomy in the entire cohort was 40 months and 60 days, respectively. A significant disease specific survival and OS advantage was observed in patients undergoing cystectomy by 93 days or less (3.1 months) compared to greater than 93 days ( $p = 0.05$  and  $0.02$ , respectively). Pathological staging was similar between the groups ( $p = 0.15$ ). A multivariate benefit in OS was observed in patients treated with timely cystectomy. The most common factor contributing to cystectomy delay was scheduling delay, as seen in 46% of cases.

**Conclusions:** A cystectomy delay of 3.1 months undermines patient survival, likely through the development of micrometastases, since local stage progression is not apparent at this point. Most delays are avoidable and should be minimized. Despite the need for second opinions and the impact of busy surgical schedules clinicians must strive to schedule patients efficiently and complete surgical treatment within this time frame.

### **Editorial Comment**

A recent editorial comment in this journal on the effects of delay in radical bladder cancer surgery is supported by this brand new paper from Ann Arbor, Michigan.

The authors analyze their data on 214 consecutive pathological stage T2 cystectomies and performed uni- and multivariate analyses. The mean time to cystectomy was 53 days in the cohort with no delay (that is, 93 days or less), and 124 days in the cohort with delay (that is greater than 93 days delay).

Both, disease-specific and overall survival was impaired in the delay group.

Interestingly, scheduling delay was the reason most often indicated.

In conclusion, a delay of more than three months may be dangerous for the patients and cystectomy should be performed as soon as possible – a scheduling delay of more than 3 months should not be tolerable.

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## NEUROUROLOGY & FEMALE UROLOGY

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### **Long-term Results of Robotic Assisted Laparoscopic Sacrocolpopexy for the Treatment of High Grade Vaginal Vault Prolapse**

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**Purpose:** Transabdominal sacrocolpopexy is a definitive treatment option for vaginal vault prolapse with durable success rates. However, it is associated with increased morbidity compared with vaginal repairs. We describe a minimally invasive technique of vaginal vault prolapse repair and present our experience with a minimum of 1 year followup.

**Materials and Methods:** The surgical technique involves 5 laparoscopic ports: 3 for the da Vinci robot and 2 for the assistant. A polypropylene mesh is attached to the sacral promontory and vaginal apex using polytetrafluoroethylene sutures. The mesh material is then covered by peritoneum. Patient analysis focused on complications, urinary continence, patient satisfaction and morbidity with a minimum of 12 months followup.

**Results:** A total of 30 patients with post-hysterectomy vaginal vault prolapse underwent robotic assisted laparoscopic sacrocolpopexy at our institution and 21 have a minimum of 12 months followup. Mean followup was 24 months (range 12 to 36) and mean age was 67 years (range 47 to 83). Mean operative time was 3.1 hours (range 2.15 to 4.75). All but 1 patient were discharged home on postoperative day 1 and the 1 patient left on postoperative day 2. Recurrent grade 3 rectocele developed in 1 patient, 1 had recurrent vault prolapse and 2 had vaginal extrusion of mesh. All patients were satisfied with outcome.

**Conclusions:** The robotic assisted laparoscopic sacrocolpopexy is a minimally invasive technique for vaginal vault prolapse repair, combining the advantages of open sacrocolpopexy with the decreased morbidity of laparoscopy. We found a decreased hospital stay, low complication rates and high patient satisfaction with a minimum of 1 year followup.

### **Editorial Comment**

This article discusses the use of robotic assisted laparoscopic sacrocolpopexy for female vaginal vault prolapse. The authors review their findings in thirty patients treated with this technique with a minimum of 12 month follow-up and found excellent results at the end of the study period.

These surgeons should be congratulated for this and their previous report on the use of robotic technology in urologic and pelvic floor reconstruction (1). Currently, the vast majority of discussion of the use of the robot