

International Braz J Urol

EDITOR'S COMMENT

Robotic Assisted Radical Prostatectomy

The November - December 2007 issue of the International Braz J Urol presents interesting contributions from different countries, and as usual, the editor's comment highlights some papers.

Doctor Colombo and co-workers, from Cleveland Clinic, Ohio, USA, presented on page 803 the surgical technique and outcomes of robotic assisted radical prostatectomy (RARP). They presented a prospective data collection at 250 RARP. The mean age of the patients was 60.5 ± 6.9 years, with BMI of 28.7 ± 3.7 , mean preoperative PSA of 6.2 ± 3.4 ng/mL, and median Gleason score on the preoperative prostate biopsy of 6 (IQR 6,7). Overall, 9% of the patients had a previous abdominal surgery, with a median ASA score was 2 (IQR 2,3). The mean operative time was 200 ± 61 min; of these, vesicourethral anastomosis took 24 ± 11 min to perform. The estimated blood loss was 250 mL (IQR 150,350), with blood transfusion rate of 1.9%, perioperative complication rate of 1.2%, and overall positive margin rate of 12%. Mean hospital stay was 1.8 ± 1.1 days since the admittance. No significant difference was noted between the transperitoneal and the extraperitoneal approaches as regards blood loss, blood transfusion rate, operative time, intraoperative urine output, urethrovesical anastomosis time, positive margins, and complications. Early oncologic and functional results are encouraging for both approaches.

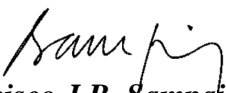
Doctor Iacono and colleagues, from the University of Naples, Italy, investigated on page 785 if as a consequence of a decrease in the corpus cavernosum radius, by excising a strip from each tunica albuginea, intracavernous pressure would increase during erection. After treating with this procedure four patients (mean age 41.5) with long-standing erectile dysfunction due to veno-occlusive dysfunction, non-responders to phosphodiesterase-5 inhibitors and intracavernous PGE1 injection, they found that 2 months post-surgery, intracavernous PGE1 (40 mcg) induced a satisfactory erection in 2 patients and a 45% and 58% tumescence in the other 2 patients. PGE1 responders also responded to 100 mg sildenafil. After 100 mg sildenafil or 20 mg tadalafil, the 2 non-responders had erections that enabled penetration but were short lasting. The authors concluded that the procedure described could be more effective than cavernous revascularization operations, and that the results seem to confirm the mathematical assumptions. Doctor Marco Grasso, from San Raffaele Hospital, Milan, Italy and Doctor Ali A. Shafik, from Cairo University, Egypt, provided exciting editorial comments on this polemic article.

Doctor May and associates, from the Carl-Thiem Hospital, Cottbus, Germany, investigated on page 764 if radical cystectomy can be performed in patients over 75 years-old at municipal hospitals with comparable intra and postoperative morbidity, and respective mortality, to major surgical centers. They analyzed 452 radical cystectomies and urinary diversions as ileum conduits or ileum neobladders due to transitional cell carcinoma were carried out at three municipal hospitals between 1992 and 2004. The authors found no

significant difference in the perioperative mortality with regard to the different case load of the evaluated hospital. There were no significant group differences regarding the 30 day reoperation rate, early and late complications. Progression-free and overall survival of all patients after 5 years was 56.1% and 53.6% respectively; here again the differences between the age groups was not significant ($p = 0.384$ and $p = 0.210$). The results for patients ≥ 75 do not differ from the published data of large clinics with a high cystectomy frequency. It was concluded that radical cystectomy on elderly patients can also be carried out in municipal hospitals with acceptable mortality and morbidity rates. Of prime importance is a careful patient selection based on comorbidity scores and possibly geriatric assessment. Doctor Massimo Maffezzini, from Ospedali Galliera, Genoa, Italy, Doctor Rainy Umbas, from University of Indonesia, Jakarta, Indonesia and Doctor Joerg Simon, from University of Ulm, Germany, provided excellent editorial comments on this paper.

Doctor Tokgoz and co-workers from Ankara University, Turkey, compare on page 777 the clinical outcomes of patients having urothelial tumors invading less than one half of the depth of bladder muscle with patients having tumor invading more than one half of bladder muscle, to determine various clinical variables as predictive factors for survival. After analyzing 35 patients (61.4 %) with pT2a (Group-1) and 22 patients (38.6%) with pT2b (Group-2) muscle invasive tumors at a mean follow up of 7.3 years for Group-1 and 6.1 years for Group-2, they found that age was noticed as an independent predictive factor for survival. Also, it was concluded that the depth of muscle invasion in bladder tumors has no prognostic significance. Being older than 60 years old during the time of radical surgery, is also a bad prognostic factor for overall and progression-free survival. Dr. Raj S. Pruthi, from The University of North Carolina at Chapel Hill, USA, provided an editorial comment on this paper.

Doctor Nakamura and colleagues, from University of Florida, USA, aimed to determine on page 746 if intraoperative frozen sections of the bladder neck during radical prostatectomy could decrease the incidence of final positive surgical margins at the bladder neck. After studying 51 patients, they found a final positive surgical margin rate of 20% (10 patients). An additional three patients had positive surgical margins at the bladder neck intraoperatively. These patients then had a wider resection of the affected bladder neck until the frozen sections were negative for cancer or prostatic tissue. Final pathologic evaluation of bladder neck margin was negative for tumor or persistent prostatic tissue in all 51 men. The authors concluded that with intra-operative frozen sections, they were able to obtain a negligible positive bladder neck margin rate. They suggested that surgeons who are still on the learning curve for radical prostatectomy should consider intraoperative frozen section of the bladder neck.


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