- that early intervention prior to the development of ureteral edema and mucosal hyperplasia - may improve outcomes.

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Long-term results of a prospective, randomized trial comparing retroperitoneoscopic partial versus total adrenalectomy for aldosterone producing adenoma

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Purpose: The indication for laparoscopic total or partial adrenalectomy in patients with aldosterone producing adrenal adenoma remains controversial. We compared retroperitoneoscopic partial and total adrenalectomy for aldosterone producing adrenal adenoma in a prospective, randomized, multicenter trial.
Materials and Methods: Patients with aldosterone producing adrenal adenoma were randomized to retroperitoneoscopic partial or total adrenalectomy. Patient characteristics, surgical data, complications and postoperative clinical results were analyzed statistically.
Results: From July 2000 to March 2004, 212 patients were enrolled in this study, including 108 and 104 who underwent total and partial adrenalectomy, respectively. The 2 groups were comparable in patient age, gender, body mass index and tumor site. Mean follow-up was 96 months in each group. No conversion to open surgery was needed and no major complications developed. Partial adrenalectomy required a shorter operative time than total adrenalectomy but this did not attain statistical significance. Intraoperative blood loss in the partial adrenalectomy group was significant higher than in the total adrenalectomy group ($p < 0.05$) but no patient needed blood transfusion. All patients in each group showed improvement in hypertension, and in all plasma renin activity and aldosterone returned to normal after surgery. No patient required potassium supplements postoperatively. In the total and partial adrenalectomy groups 32 (29.6%) and 29 patients (27.9%), respectively, were prescribed a decreased dose of or fewer antihypertensive medicines at final follow-up.
Conclusions: Retroperitoneoscopic partial adrenalectomy is technically safe. It has therapeutic results similar to those of total adrenalectomy in patients with primary aldosteronism due to aldosteronoma.

Editorial Comment

The authors compared retroperitoneoscopic partial and total adrenalectomy for aldosterone producing adrenal adenoma in a prospective, randomized, multicenter trial. Primary aldosteronism often has a higher rate

of cardiovascular complications, target organ damage and metabolic syndrome than essential hypertension. The laparoscopic removal of the adenoma has shown preferable and more beneficial than medical treatment or open surgery to manage functioning adrenal tumors. The authors ask an important and controversial question of organ-sparing adrenalectomy in patients with primary aldosteronism due to aldosteronoma. Moreover, they questioned the role of adrenal vein sampling as the gold standard diagnostic test to identify the side of aldosterone secretion versus high-resolution computerized axial tomography. The data revealed a total of 212 patients enrolled in this study, including 108 that underwent total adrenalectomy and 104 patients in the partial adrenalectomy group. No open conversion or blood transfusions were needed. No major intraoperative complications occurred and no tumor recurrence was noted during the mean 96-month follow-up. All patients in each group showed improvement in hypertension and in all plasma renin activity and plasma aldosterone recovered to normal after surgery. However, 32 of 108 patients (29.6%) with total adrenalectomy remained hypertensive with normal plasma aldosterone after surgery. Blood pressure was managed with 20 or 40 mg nifedipine retard daily. Patients with partial adrenalectomy no longer required antihypertensive medication after surgery and 29 patients (27.9%) were prescribed a decreased dose or fewer antihypertensive medications. The authors concluded that partial adrenalectomy for unilateral aldosterone producing adrenal adenoma is beneficial and may preserve adrenal function avoiding possible steroid replacement. Moreover, retroperitoneoscopic partial adrenalectomy is technically feasible with similar outcomes as total adrenalectomy in patients with primary aldosteronism due to aldosteronoma.

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Prostate size is not associated with recovery of sexual function after minimally invasive radical prostatectomy

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Objectives: To investigate the association of prostate weight with recovery of sexual function after minimally invasive radical prostatectomy.
Methods: Between April 2001 and September 2007, two surgeons performed 856 consecutive laparoscopic radical prostatectomies for clinically localized prostate cancer. Patients were stratified into three groups by prostate weight: < 35 g, 35-70 g, and > 70 g. Sexual and urinary outcomes were assessed prospectively using the Expanded Prostate Cancer Index Composite (EPIC) questionnaire. Patients who underwent nerve sparing (unilateral or bilateral) with complete preoperative EPIC data, a minimum preoperative Sexual Health Inventory for Men score ≥ 21, and a minimum of 3 months of complete postoperative EPIC data were included in the analysis.
Results: Of the cohort of 856 men, 324 (38%) had complete, evaluable data and met the inclusion criteria for this study. Preoperatively, there were no significant differences by prostate weight in the EPIC sexual function