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Platinum Priority


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We applaud Karnes et al. [1] for their critique of our study that demonstrates fewer positive surgical margins and less additional cancer therapy within 2 yr for robot-assisted versus open radical prostatectomy [2]. They raise concerns about the validity of our study findings.

The Surveillance, Epidemiology, and End Results (SEER) program is an epidemiologic surveillance system funded by the US National Cancer Institute and consisting of population-based tumor registries that routinely collect information on all newly diagnosed cancer (incident) cases that occur in persons residing within the confines of SEER areas. The information collected about each incident cancer diagnosis includes the patient’s sociodemographic characteristics, date of diagnosis, and cancer histology, stage, and grade [3]. As mentioned in our limitations section and by Karnes et al. [1], surgical margin status for pathologic pT3b disease is not recorded by SEER, leading to these exclusions. However, men with pT3b accounted for only 6.7% of all radical prostatectomies during our study period, and 53.2% required additional cancer therapy within 24 mo of radical prostatectomy.

Additionally, 59.6% versus 37.5% of pT3b subjects were classified as having high-risk versus intermediate-risk disease, and the exclusion of this significant difference contributes to the similar utilization rates of postprostatectomy cancer therapy for intermediate- and high-risk disease, questioned by Karnes et al.

Finally, Shah et al. [4] found that 75% of pT3b had positive surgical margins, and the presence of this aggressive feature overwhelmingly prognosticates biochemical recurrence–free survival and prostate cancer–specific mortality. Thus differences in surgical margin status in the setting of seminal vesicle invasion contribute little to differences in our robot-assisted versus open radical prostatectomy cancer-control outcomes.

Another Hu et al. SEER-Medicare comparative effectiveness study of utilization and complications used propensity matching and found a lower likelihood of robot-assisted radical prostatectomy (RARP) transfusions, anastomotic strictures, and shorter lengths of stay, albeit with more frequently diagnosed RARP incontinence and erectile dysfunction compared with open radical prostatectomy during early adoption of RARP [5]. This finding is reinforced by worse urinary function for initial RARP versus open radical prostatectomy in a multisurgeon single-institution study that also demonstrated a shorter learning curve for continence preservation compared with open surgery that ultimately resulted in equal or better continence for RARP [6]. The Hu et al. study [5] also epitomizes caveat emptor for men considering robot-assisted surgery, and led to a defensive by surgeons performing robot-assisted procedures and the device manufacturer alike against the potential sales pitches made by open surgeons.

Although SEER-Medicare data have limitations, such as the absence of postprostatectomy urinary and sexual function outcomes, the Institute of Medicine cited it as one of the few population-based data resources available for analyses of the quality of cancer care [7]. Failure of surgeons who perform robot-assisted procedures to accept increased urinary incontinence and erectile dysfunction during the learning curve or failure of an average open-procedure surgeon to acknowledge higher positive margins and adjuvant/salvage treatment rates brings to mind the timeless words of Pulitzer Prize winner Upton Sinclair, the muckraking American author: “It is difficult to get a man to understand something, when his salary depends on his not understanding it” [8].

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References


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