Choosing the best surgical technique in prostate cancer: It depends on the surgeon

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I read the article by Gagnon and colleagues1 with great interest.

Some points of this study are controversial. Firstly, the groups are not homogenous for comparison of open and robotic assisted prostatectomy. While 43% of the patients were low risk in the robotic group, only 23% of the patients were low risk in the open group and there were significantly more patients in the high-intermediate and high-risk open group. According to the biopsy results, Gleason score 6 was significantly more and 8 was significantly lower in the robotic group.

Secondly, I understood that surgical drain was not used if the anastomosis was watertight and that the patients were discharged on postoperative day 1. Lymph node dissection rates were 82.5% and 19.5% in the open and robotic groups, respectively. How could the authors be sure that there was no drainage after watertight anastomosis and lymph node dissection?

Thirdly, what was the reason for the different catheterization time of the groups? While 63.5% of the patients had 7 days or less in the open group, only 19.5% of the patients had 7 days or less in the robotic group. In robotic group, long catheterization time (>14 days) was significantly more than in open group.

Finally, postoperative outcomes in stress urinary incontinence and erectile dysfunction are similar in groups. The tumour characteristics of the groups were not homogenous, therefore the comparison of the groups according to the postoperative outcomes will not be objective. If we evaluate the patients who underwent nerve sparing surgery, there were 87 patients in open group and 122 patients in robotic group at 12 months data.

Prostate cancer is one of the most common malignancies in developed countries. The choice of surgical techniques can make for a smooth postoperative period for patients. The best technique is one for which the surgeon has the most experience.

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Reference

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Men’s mental health

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I found the article by Matthew and colleagues1 extremely insightful.

Men’s mental health from a urology perspective represents a theme which is starting to receive greater attention. Urologists today face a potpourri of clinical problems which hold a strong psychological undercurrent of some kind. I would like to highlight this in the realm of uro-oncology.

In a 2013 study of over 900 testicular cancer survivors in Sweden, most participants reported having experienced a crisis due to their diagnosis and that their emotional needs had not been met.2 Llorente et colleagues, in their retrospective study found men with prostate cancer to have a suicide rate at least 4 times greater than average.3 Furthermore, the sexual and urinary dysfunction which can arise post prostatectomy has been linked to a higher incidence of depression. Tailored screening tools, such as the Memorial Anxiety Scale for Prostate Cancer (MAX–PC), can be employed as a means of identifying patients at risk.4

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Reference

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The clinician should therefore develop and nurture their role as advocate in men’s health, for we are in a unique position to be able to act and signpost as appropriate.

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References


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