

Editorial referring to the paper: Gómez Rivas J, Alonso y Gregorio S, Tabernero Gómez Á, et al. Laparoscopic radical cystectomy with prostate capsule sparing. Initial experience. Cent European J Urol. 2016; 69: 25-31.

Prostate capsule sparing radical cystectomy – a safe procedure for few

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The authors present a four-year experience with prostate capsule sparing (PCS) laparoscopic radical cystectomy (RC) [1]. First, these authors should be commended for their execution of a technically challenging procedure. Although this is a small series, the perioperative outcomes (operative time, blood loss, length of stay (LOS)) are similar to published data for the robotic-assisted procedure [2]. Of note, this paper once again shows that hospital LOS is not shortened with a minimally invasive approach, questioning the benefit to patients (the addition of PCS does not contribute to the perioperative convalescence). The authors present impressive potency (90%) and continence (90% day, 85% night) results, showcasing the quality of life (QOL) benefits of PCS. These numbers are consistent with other centers of excellence [3].

This leaves the oncologic outcomes as the controversial aspect of this procedure. There are two cancers to be considered: urothelial carcinoma of the prostate (UCP) and prostate adenocarcinoma (PC). As the authors point out, local recurrence rates of UCP are low with this technique (none in the present report). Similarly, Mertens et al. found UCP recurrence of <1% in 120 patients undergoing PCS RC [3]. In our opinion, this is the most important aspect of avoiding a total prostate resection. Lest we forget that the basis for en bloc prostate removal is to reduce the amount of urothelium left behind. With strict selection criteria such as that

in this study, missed ductal or stromal invasion is unlikely. Tumor at or distal to the trigone and the presence of carcinoma in-situ are known risk factors for UCP at time of RC [4, 5], providing guidance for patient selection.

Regarding the missed diagnosis of PC, we would contend that this is a substantially over-argued point. If the argument is related to the difficulty treating PC after one has undergone orthotopic neobladder creation, then consider the extremely low likelihood of requiring PC treatment after PCS RC in the literature (<1%). RC can be performed on patients who have previously undergone prostatectomy without added morbidity, so in the rare event of an occurrence of clinically significant PC, subsequent prostatectomy would likely be feasible. Given the significant QOL improvement associated with PCS, the criteria for prostate removal during RC should be based on preoperative clinical concern for PC, including biopsies as indicated.

The continence and potency benefits of a PCS RC may both be realized with an orthotopic neobladder, a minority of urinary diversions (30–50% at high volume centers) [6]. However, the more commonly performed cutaneous diversion would see less benefit. Combine this fact with the average age of patients with bladder cancer requiring a RC (over 65, most with poor baseline potency) as well as the pathologic selection criteria, and you realize that PCS RC may be a great procedure, but only for a select few.

References

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