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We congratulate Kaouk et al for presenting their 2020; 144: 142-146 Prostatectomy. Urology Robotic Radical Extraperitoneal Single-Port

Letter to the Editor Re: Wilson and a quarter with positive margins on cancer and underwent concomitant nerve-sparing of patients had NCCN intermediate or high-risk prostate encouraging data on outpatient robotic radical prostatectomy may be less conducive to an extensive lymph node dissection,3 arguably even more so with the SP approach. On the basis of authors' recent adoption of the SP robot as well, and would like to seek some clarifications in an attempt to optimize our own patient outcomes.

The authors' prior publication2 seems to indicate that the patients in the current study were part of the later series of patients (ie, after the first ~40 cases with the SP robot), given the timeline of reported cases. This highlights the learning curve for these cases. It would be interesting to see what technical/surgical changes (other than from anesthesia/post-anesthesia care unit/peri-op analgesia standpoint) were incorporated to facilitate same-day discharge over this learning curve period?

What were the Indications, extent/template, and median nodal yield for patients undergoing pelvic lymphadenectomy? Extraperitoneal robotic radical prostatectomy may be less conducive to an extensive lymph node dissection,3 arguably even more so with the SP approach.

Did the authors encounter instances of the transperitoneal approach? On the basis of authors' current and prior reports, the median body mass index and prostate size were ~30 kg/m² and 55-60 gm, respectively.

Could the authors elaborate on the reasons for readmission in 7% of the cohort? It seems that the most important major complication (Clavien 3 or above) rate was lymphocele requiring percutaneous drainage (10%). Was it related to the extraperitoneal nature of the operation or the extent of lymphadenectomy (amongst other reasons)? The authors indicate that they were able to reduce their lymphocele rate in the later part of their series by using titanium clips; however, a previous randomized trial4 has shown that clips may not decrease the rate of symptomatic lymphocele compared to bipolar coagulation. Were there other specific technical modifications that decreased the rate of lymphocele, such as peritoneal interposition flaps/reconfiguration,5 fibrin glue,6 or more likely learning curve-related factors (more meticulous dissection, better patient selection)?

The authors report urinary continence (0-1 pad/day) rate of ~50% at 1 month. Do the authors feel that the extraperitoneal SP approach affects continence recovery any differently than the conventional transperitoneal or a Retzius-sparing approach, and if so, what would be the biologic rationale behind it?

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References