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Letter to the Editor Re: Wilson et al. Outpatient Extraperitoneal Single-Port Robotic Radical Prostatectomy. Urology. 2020; 144: 142-146

We congratulate Kaouk et al¹ for presenting their encouraging data on outpatient robotic radical prostatectomy using the single port (SP) robot. Majority (~90%) of patients had NCCN intermediate or high-risk prostate cancer and underwent concomitant nerve-sparing (90%), with about half harboring extraprostatic disease and a quarter with positive margins on final pathology. About 90% of patients were able to be discharged the same day, and opiates were increasingly less likely prescribed. These achievements reflect a truly commendable work by the authors, especially in light of twin CoViD-19 and opioid pandemics in the country. We have recently adopted 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 breach? If so, how were they handled and more importantly, how did that affect the intraoperative and perioperative pathway?
- Did the authors feel that factors such as obesity, prostate size/anatomy, or prior prostate surgeries were important determinants in assessing the feasibility of SP 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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