

“advancement,” in other words, all comments that imply comparisons, are meaningless. Meanwhile, individual urologists may make clinical judgements (e.g., “I am sure that this surgical technique will benefit this group of patients”), but certainly this is not adequate for the whole urological community, which cannot yet use these data to improve patient care. Then, too, the experience and expertise accumulated over the years by surgeons, involving thousands of patients and requiring significant personal involvement and significant financial resources, becomes ultimately non-transmissible, and therefore unfortunately wasted.

It is probably the right time for urologists to raise the essential questions prospectively and to use the means needed to provide answers. Many prospective randomised trials have been conducted in medical and radiation oncology, and even the field of surgical oncology has successfully recruited patients for prospective randomised trials [5]. It is really questionable why urologists have been unable to conduct such trials. Conducting such trials is one of the main roles of academic medicine.

Laparoscopic surgery will find its definitive place within the surgical armamentarium only when the urologists involved in its evaluation provide the data that answer two basic questions: What are the benefits? Which patients will benefit? Meanwhile, we are all condemned to reading about phase 1 and 2 surgery studies that do not provide enough evidence to generate any changes in daily surgical practice. Or even worse: if we accept as evidence what are only hypotheses, the drift to the world of the nonacademic medicine will open Pandora’s box, and one can bet that soon, we would accept our medical practice

being driven by advertising arguments, commercial objectives, and soon by business plans of companies, the NASDAQ or CAC 40 indexes. Personally, I am not convinced that the economic market is the best regulator of medical quality.

Now that laparoscopic radical prostatectomy has proven to be a feasible and mature technique, now that the experience reported in this article brings additional factors to our thoughts in terms of possible benefits and possible disadvantages, it is time for all of us to become committed to answering these medical questions.

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Rebuttal from Authors re: Bertrand Guillonnet. To Demonstrate the Benefits of Laparoscopic Radical Prostatectomy? *Eur Urol* 2006;50:1160–1

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We would like to express our thanks for the helpful comments by Dr. Bertrand Guillonnet and agree with the general suggestions. However, some further detailed considerations need to be made.

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The stated requirements with respect to the quality of studies have only been met in a few studies until now. This applies to open, laparoscopic, and robot-assisted laparoscopic radical prostatectomy. The current systematic literature survey on robot-assisted laparoscopic radical prostatectomy also once again highlights this [1]. The main problem is that the urologic community has so far not succeeded in formulating standard guidelines for judging surgical margins, defining incontinence, and evaluating prostate-specific antigen (PSA) failure and erection rates. Therapeutic procedures are assessed and recommendations are expressed on the basis of these parameters. Because clear definitions of criteria are lacking, clear-cut therapeutic recommendations cannot be made. Therefore, the demands of Dr. Guillonnet to

analyse the results of clinical studies only with validated methods and questionnaires must be fully supported. They would form the basis for truly reliable data.

In this context I would like to point to the problem of reports on positive surgical margins. In many publications a detailed description of the handling of the specimens by the pathologists is lacking. If, for example, the dissection width (sectioned transversely) is increased, the operating surgeon obtains more "favourable" histopathologic results. Frequently, the assignment to the tumour stage (pT2 or pT3) is also lacking. This is unacceptable for a comparative assessment. The literature reports of positive margins rate by well-established centres for pT2 range between 5% and 25% and for pT3 between 35% and 75%. Not only is this variation found among different institutions but reviews from one institution may show surprising differences as well. At the end of the day, the question still remains as to why we use the "additional parameter" of positive surgical margins if we have short-term and medium-term data on PSA-free survival at our disposal. What is the intention here?

Through robot-assisted laparoscopic radical prostatectomies these aspects are still gaining importance at present. Robotic radical prostatectomies are available at our centre and at many other European centres, but above all are being extensively marketed in the United States. It is now being postulated that robotic laparoscopic radical prostatectomies are superior. In the work of Joseph et al, an overall positive surgical margin rate of 13% (pT2: 5-11%; pT3: 27-37%) and a 93% continence rate at 3 mo is reported [2]. These are outstanding results and a comparative assessment under the demanded conditions is necessary.

However, our opinion is that the main advantage of laparoscopic radical prostatectomy is 2-fold at present, namely, excellent visibility of the operative field and benefits for patients as a result of shorter convalescence due to a less traumatic procedure. How can we prove this under the aforesaid conditions?

Identical conditions must exist for prospective randomised studies. This is often difficult to achieve. In the large centres where laparoscopy is a routine procedure for major urologic interventions, open radical prostatectomies are often no longer performed on a frequent enough basis. Despite undoubtedly encountering similar difficult logistical and organisation problems, the surgical colleagues nevertheless succeeded in carrying out a randomised prospective study, as stated by the reviewer [3]. After all, 29 participating hospitals were involved. Why should we urologists not be able to start a similar project, so that short-term and long-term outcome data for different forms of radical prostatectomy could finally be conclusively proven, even allowing for cost considerations? The European PSA Study, for example, should be a model for us. Only by doing so will we be able in the future to force through innovative therapeutic procedures, although they may be more cost intensive, in the interest of our patients. I would be very pleased if the problem raised by Dr. Guillonneau and also voiced by others based on our report about the 1000 laparoscopic radical prostatectomies could be solved beyond national boundaries, for example, within the framework of the European Association of Urology. Let's tackle it together!

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