

available at [www.sciencedirect.com](http://www.sciencedirect.com)  
journal homepage: [www.europeanurology.com](http://www.europeanurology.com)



Platinum Priority – Editorial and Reply from Authors  
Referring to the article published on pp. 1188–1193 of this issue

## The Time Is Now—the Ability Is Yours

Jean de la Rosette\*

Department of Urology, AMC University Hospital, Meibergdreef 9, 1105 AZ Amsterdam Z-O, The Netherlands

Urologists today should be prepared to be asked about their knowledge, activities, achievements, and outcomes in their daily clinical practice. Third parties are already using administrative databases to assess our clinical performance. In the near future, they will likely determine the professionals and hospitals that provide the best practice and, consequently, the highest quality of care. Patients are also increasingly concerned about the provision of optimal and safe treatment, are becoming involved in the clinical decision-making process, and are demanding objective data on outcomes. There is a strong tendency to ask for (in the case of patients) or to offer (in the case of physicians) a second opinion, either before or after treatment. As a consequence of this process, the number of legal claims provoked by treatment complications is increasing. Moreover, in urology “over the last two decades, interest in developing clinical practice guidelines has surged, fueled by the discovery of large, unexplained variation in clinical care and the documentation of inappropriate care as well as an interest in managing ever-rising health care costs” [1].

Over the past 30 yr, an increasing number of innovative surgical techniques and devices have been introduced, leading to the evolution of endourology and its related fields in the main body of urologic surgery. Parallel to these developments has been a flow of urologic research. Randomized controlled trials (RCTs) have been considered the reference standard for the evaluation and establishment of diagnostic procedures and therapeutics. However, the rate of accrual of RCTs often remains low, and because of their strict inclusion criteria driven by the need to answer to a very precise research question, RCTs frequently do not reflect real-life practice. High-quality clinical databases offer an alternative approach. Because of their wide ownership, clinical databases have the potential to respond to daily practice questions. A further advantage is that the participation of

various clinicians of distinct hospital types fills the gap between the centers of excellence and hospitals with low caseloads, allowing for a generalization of outcomes.

The British Association of Urological Surgeons (BAUS) national data registry for percutaneous nephrolithotomy (PCNL) fulfills the requirements just mentioned. The initiative of the BAUS section of endourology in undertaking a national data registry for PCNL deserves to be applauded [2]. The objectives of this work are to assess the current practice and outcomes of PCNL in the United Kingdom in a prospective manner. The figures presented mimic the results of a previous wider international clinical database: the percutaneous nephrolitholapaxy study of the Clinical Research Office of the Endourological Society (CROES) conducted between November 2007 and December 2009 [3]. Approximately 100 sites from Asia, Europe, and the Americas participated in the CROES PCNL Global Study, and in the course of 1 yr (per institute), almost 6000 patients were included. Data from this study are currently analyzed to answer multiple questions related to PCNL. Both registries cover the entire spectrum of clinical research, from learning curves to efficacy of different treatment modalities. Further advantages of prospective clinical national and international databases or registries include relatively low costs per study; the ability to generate large samples rapidly; the opportunity to collect a significant sample of a rare condition or nonstandard intervention; and the provision of accurate information for clinical practice, audit, and administration. It is reassuring that the findings from the BAUS endourology section registry on PCNL are foremost in line with outcomes coming from the CROES PCNL database.

Beyond the numerical figures, a clear and straightforward conclusion can be inferred: Such registries are unique resources providing vital information on current practice and critical outcome data, and they should be used to set

DOI of original article: 10.1016/j.eururo.2012.01.003

\* Tel. +31 20 5666030; Fax: +31 20 5669585.

E-mail address: [JJ.delarosette@amc.uva.nl](mailto:JJ.delarosette@amc.uva.nl).

0302-2838/\$ – see back matter © 2012 European Association of Urology. Published by Elsevier B.V. All rights reserved.

national and international standards. Besides, these registries offer the participants the possibility to compare their practice with national outcomes and provide an excellent basis to fulfill the clinical governance purposes. Finally, these resources will help the individual surgeon to counsel patients during the informed discussion on possible outcomes in cases of complex endourologic procedures.

Those of us who firmly believe that it is no longer acceptable to perform procedures without feedback on indications and outcomes should consider multicenter, clinically based, prospective registries as the way to go. In the form of either national or supranational initiatives, these registries represent the first step in strengthening our position in front of third parties, striving to offer the best clinical care, or setting up comprehensive, clinically based quality indicators.

However, there are two “musts” to ensure the reliability of a clinical registry. First, it must feature an easy data flow between the clinicians and the data managers. The latter communicate with the researchers in case of questions, inconsistencies, or missing data, providing regular feedback to ensure the completeness of the data. Second, high-quality, trustable data can only be guaranteed when audits take place. The example of CROES’s making public the creation of an audit committee to assess quality and regulate the participation of the centers closes the safety circuit [4]. Results of the clinical registries will become

fortified when supported by a clear scrutiny of the data from which they were inferred.

We must ensure the ethical and scientific integrity of clinical research globally, promote harmonization of international research, and reach the ultimate goal of our professional career: to provide the absolute best, least invasive quality of care for all patients. The time is now—the ability is yours.

**Conflicts of interest:** The author has nothing to disclose.

## References

- [1] Dahm P, Chapple CR, Konety BR, et al. The future of clinical practice guidelines in urology. *Eur Urol* 2011;60:72–4.
- [2] Armitage JN, Irving SO, Burgess NA, for the British Association of Urological Surgeons Section of Endourology. Percutaneous nephrolithotomy in the United Kingdom: results of a prospective data registry. *Eur Urol* 2012;61:1188–93.
- [3] De la Rosette J, Assimos D, Desai M, et al. The Clinical Research Office of the Endourological Society (CROES) percutaneous nephrolithotomy (PCNL) global study: indications, complications and outcomes in 5803 patients. *J Endourol* 2011;25:11–7.
- [4] Preminger GM, Alken P, Habuchi T, Wijkstra H. The Clinical Research Office of the Endourological Society Audit Committee. *J Endourol* 2011;25:1811–3.

doi:10.1016/j.eururo.2012.01.057

## Platinum Priority

**Reply from Authors re: Jean de la Rosette. The Time Is Now—the Ability Is Yours. *Eur Urol* 2012;61:1194–5**

### ***Prospective Data Registries: Opportunities for International Collaboration in Endourology***

**James N. Armitage\*, Stuart O. Irving, Neil A. Burgess for the BAUS Section of Endourology**

Norfolk and Norwich University Hospital NHS Foundation Trust, Norwich, United Kingdom

We would like to thank de la Rosette for his kind and constructive editorial comments [1] on our paper, “Percutaneous nephrolithotomy in the United Kingdom: results of a prospective data registry” [2].

The attributes of such high-quality prospective registries are many. For example, the rapid accrual of data on large numbers of patients might allow the identification of rare but serious complications. Furthermore, compared to

randomised controlled trials, data registries are relatively inexpensive to maintain over many years, giving information on late complications and the durability of treatments. In addition, they permit national or international reference standards to be derived. These will facilitate audit, which is likely to form an important part of the revalidation process of surgeons in the United Kingdom to ensure that they are fit to practice [3]. Demonstrating involvement in national audit by contributing to prospective data registries would help to satisfy this requirement and may soon become mandatory within the United Kingdom, as it is for cardiothoracic surgeons [4].

We believe that the value of national data registries is further enhanced by the participation of all centres, not only those units considered to be centres of excellence, as this will give an indication of real-life practice and reflect true national outcomes. The British Association of Urological Surgeons (BAUS) Section of Endourology has sought to encourage all surgeons undertaking percutaneous nephrolithotomy (PCNL) in the United Kingdom to contribute to the registry.

However, for national outcome data derived from prospective data registries to be useful, the data must not only be complete but also accurate, and where comparisons are made between centres or individual surgeons, the data

DOIs of original articles: 10.1016/j.eururo.2012.01.003, 10.1016/j.eururo.2012.01.057

\* Corresponding author. Norfolk and Norwich University Hospital NHS Foundation Trust, Colney Lane, Norwich, NR4 7UY, United Kingdom. Tel. +44 1603 286286 (w) +44 7980 004883 (m); Fax: +44 1603 287211. E-mail address: jim\_armitage@hotmail.com (J.N. Armitage).