Editorial

Radical Prostatectomy: Open? Laparoscopic? Robotic?

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This issue of European Urology offers two extensive reviews of laparoscopic radical prostatectomy (LRP) written by two famous urologists who have pioneered the technique, explored its different modalities, and become worldwide recognized experts in the field.

J. Rassweiler [1], through a methodic literature search, has put together one of the best reference lists regarding laparoscopic and robotic prostatectomy and their comparisons to open surgery. Based on his analysis, the “fast” reader will easily conclude that the case is closed and that laparoscopic urologists have indeed sent open radical prostatectomy to the museum of dead surgical techniques. His main argument is that LRP is equivalent from a functional and oncologic standpoint to open surgery and superior as far as pain, complications, blood loss, and cosmesis are concerned. However, if one looks carefully at the numerous tables accompanying the article and more specifically at Table 6, it is surprising to note that of the seven series comparing open and laparoscopic prostatectomy, four contain no information regarding sexual potency, two no evaluation of continence, and four no data on prostate-specific antigen (PSA) relapse. Furthermore, the authors fail to discuss the results of radical perineal prostatectomy and particularly those of Keller (references 69 and 70 in the article), who in a prospective study comparing LRP, retropubic prostatectomy, and perineal prostatectomy done by experts of each technique, showed that perineal prostatectomy was superior to LRP and retropubic prostatectomy far as continence and positive margins were concerned—results that definitely tend to support the 10th commandment of the “Society for the Protection of the Prostate” founded a few years ago at a meeting of the American Association of Genito Urinary surgeons who prescribed: “I will not learn to do a laparoscopic radical prostatectomy before I have mastered the technique of open perineal prostatectomy.” There is no doubt that as far as pain, complications, transfusion rate, continence, positive margins, and cosmesis, radical perineal prostatectomy meets every goal of minimally invasive surgery.

Furthermore, urologists should keep in mind that laparoscopy is no more and no less than a technique; therefore the concept of “laparoscopic urology / urologists” is a dangerous one, exposing urologists to become mere “proceduralists” exactly like cardiac surgeons and to lose the exceptional role gained in the comprehension of disease mechanisms, biology, and treatment.

B. Guillonneau [2] is to be commended for having provided such an honest and unbiased review of the achievements of LRP, a technique he has been among the first to pioneer and for which he has an extensive experience.


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One can only subscribe to these conclusions:

- If LRP offers over open radical retropubic prostatectomy (RRP) the major advantage of a reduced blood loss, LRP is identical to open RP in hospitalization time, driven by cultural habits and variations in health care systems.
- LRP has yet to prove that it is superior or at least as good as open RP in:
  1. Achieving, when necessary, an extended pelvic lymph node dissection (PLND). The fact that the procedure is done through the laparoscope should not be an excuse to do a suboptimal node dissection in patients requiring an extended one. Until new imaging modalities (sophisticated magnetic resonance imaging, isotope-guided sentinel node dissection) are validated, it is the responsibility of the expert laparoscopic prostatectomists to show that their node dissections are at least as good as those achieved by open surgery and that their technique teachable and transmissible.
  2. Reaching the same oncologic results assessed by the positive margin rates and PSA relapse-free survival in organ confined (Pt2) disease. The incidence of positive margins in organ-confined prostate cancer is directly related to the quality of the surgery, as well as capsular incisions [3] provided the pathologic examination of the specimen is standardized. The PSA relapse-free survival in Pt2 disease provides a fair assessment of the quality of the lymph node evaluation. These data should be available and extracted from large series using clear definitions of biochemical relapse and pathologic evaluation.
  3. Providing the same functional results regarding continence and erectile function using clear definition of both functions evaluated by validated questionnaires.

More importantly, this paper sends a long-awaited and well-deserved wake up call to the urologic community. Despite having performed thousands of laparoscopic prostatectomies worldwide, and having at our disposal evaluation tools in the form of simple, patient-friendly, validated questionnaires, our achievements in the area of quality control, that is, the evaluation of the quality of the service (oncologic as well as functional) that our patients are entitled to expect from us is at best suboptimal.

It is high time that urologists, justifiably overwhelmed by the technical achievements made possible by laparoscopic surgery, accept to go beyond purely technical considerations and start to evaluate objectively their results, along the lines proposed by Salomon et al. [4]. If they fail to do so, they should ready themselves for difficult times ahead in the field of prostate cancer if to the risk of overtreatment, induced by screening, is added the use of a poorly evaluated surgical procedure.

References