was reduced to 42% at 2 wk, 49% at 6 mo, and 42% at 2 yr. The peak flow rate was improved by 30% at all intervals. No compromise in erectile or ejaculatory function was observed.

**Experts’ comments:**
The procedure tested in this study is new, is minimally invasive, and is based solely on a mechanical compression of prostate lobes, relieving urethral obstruction without any tissue ablation. It seems to be well tolerated, is effective on LUTS, and is even feasible in the office for selected patients. Would it be too good to be true? None of the previous and so-called mini-invasive procedures proposed as alternatives to medical therapy have achieved such results in terms of feasibility and tolerance. Ablative procedures such as transurethral microwave thermotherapy or transurethral needle ablation are no longer considered, as such, and urethral stents have been all but abandoned because of their reported morbidity. This first study on midterm results, together with a recent report focusing on sexual outcomes [1], is encouraging and anticipates nice perspectives. The single-blinded comparative LIFT study, aiming to determine the safety and effectiveness of the procedure versus placebo, has completed its enrolment and is now in the follow-up phase [2]. Further studies will be needed to compare UroLift with medical therapy, to identify predictive factors of effectiveness, and to better select potential candidates.

**Conflicts of interest:** The authors have nothing to disclose.

**References**


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The long-term survival of a large cohort of Medicare beneficiaries who underwent surgical treatment for clinical stage T1a kidney cancer. The study included 1925 patients (27.0%) treated with partial nephrectomy (PN) and 5213 patients (73.0%) treated with radical nephrectomy (RN). Over a median follow-up of 62 mo, 487 patients (25.3%) and 222 patients (4.3%) treated with PN and RN died of their disease. The authors controlled for confounding variables including age, Charlson Comorbidity Index score, ethnicity, and gender, and an instrumental variable analysis was used to balance measured and unmeasured variables between treatment groups. The authors found that PN improved overall survival, but there was no difference in kidney cancer–specific mortality. The survival advantage was greatest in those patients <75 yr old and those with a Charlson Comorbidity Index score ≥1. Furthermore, treating seven patients with PN rather than RN would avoid one death at 8-yr follow-up. It should be noted that even in recent years, twice as many RN procedures (n = 2119) were performed compared with PN (n = 1114).

Expert’s comments:
Both the American Urological Association and the European Association of Urology recommend that PN be performed in patients with clinical T1a renal masses, with other treatment options such as RN, ablation, and observation as alternative options [1,2]. The greater loss of nephrons as a consequence of RN increases the risk of chronic kidney disease with resultant increase in cardiovascular disease and overall mortality [3]. The current study by Tan et al highlights what many previous studies in the urologic literature have shown: that nephron-sparing surgery is the preferred approach to small renal masses. The advantage of this study is that it is published in a high-impact journal read by a wider audience that might be able to influence patients to seek nephron-sparing surgery.

In this report by Tan et al, only one in three stage I tumors were managed by PN as recently as the years 2004–2007. Many similar studies document underutilization of PN, despite oncologic equivalence [4]. Consequently, one can ask why RN is overutilized for the management of stage I kidney cancer. Is it for lack of evidence of the superiority of PN in preventing overall mortality or lack of expertise with PN? Perhaps there is a sense that the other “normal” kidney will suffice to prevent future dialysis, despite the knowledge that even patients with chronic kidney disease who do not go on to dialysis have a decrease in survival [3]. In any case, there has been insufficient impetus up to now to encourage urologists to perform the preferred treatment most of the time. It may just require studies aimed at a broader audience of health care providers who will guide patients to the optimal treatment choice.

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References


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