

LETTER TO THE EDITOR

Response to De Jager et al.'s "Analysis of the learning curve in robotic-assisted laparoscopic radical prostatectomy in a South African setting".

Thanks for the great start in original research which was published in the first edition of African Urology. In terms of your study objective, you structured your data and analysis to clearly determine your goals. The one aspect that I would like further clarification on, is the majority of patients (41.4%) had a preoperative ISUP score of 1. I would be interested to know what the postoperative ISUP scores were, as in research by Nunez Bragayrac, et al. Gleason 6 tumours were shown to lack metastatic potential.¹ Are patients who have medical aid funding subjected to the same standard of care in

active surveillance when remuneration is based on operations performed? I have no doubt that the future is in robotics for a radical prostatectomy, but it is important to realise that this is still an invasive procedure with risks, and as such, we should still maintain our discretion in recommending this as a treatment.

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1. Nunez Bragayrac LA, Murekeyisoni C, Vacchio MJ, et al. Blinded review of archival radical prostatectomy specimens supports that contemporary Gleason score 6 prostate cancer lacks metastatic potential. *Prostate*. 2017;77(10):1076-81. <https://doi.org/10.1002/pros.23364>.

Authors response

Dear Colleague,

Thank you kindly for your interest in our article. With regards to your question regarding the postoperative ISUP scores, I can confirm that of the 290 patients with preop ISUP scores of 1, 149 patients remained ISUP 1 on postoperative histology. In other words, 48.6% of these patients had ISUP scores ≥ 2 . One could argue that these patients would have benefited from their surgery, but your point is well taken that for 51.4% of these men, a radical prostatectomy could possibly represent overtreatment.

Other factors to consider are the following:

1. Some patients with ISUP 1 may have been intermediate risk based on PSA values clinical stage, number and percentage of cores positive etc.
2. A patient's age, comorbidities and life expectancy would factor strongly into the decision for active management. For instance, a low-risk patient that is 75yo with hypertension and diabetes would not be a good candidate for a RP, but a 63yo healthy patient would be.
3. EAU guidelines have recently evolved to recommend [STRONG]: "Offer AS to patients with life expectancy > 10 years and low-risk disease." This had previously been only very low risk, during the time the study was performed.
4. A key finding of the ProtecT study was that active monitoring (AM) was as effective as active treatment at 10 years, at a cost

of increased progression and double the metastatic risk (6% in the AM group as compared to 2.6% in the treated group). Fifty-six per cent of patients had low-risk disease, with 90% having a PSA < 10 ng/ml, 77% ISUP grade 1 (20% ISUP grade 2-3), and 76% T1c.

5. For a number of patients an mpMRI performed prior to surgery may sway the discussion towards a more active approach.
6. A patient, after informed discussion, may simply prefer to have the cancer removed despite the associated risks.

I cannot comment on the long-term metastatic outcomes of this cohort of patients as that data is unfortunately unavailable to me. The alternative to RP would either be watchful waiting, active surveillance, or radiotherapy. I can only hope that a well informed and robust conversation regarding these factors and relevant statistics form a part of all preoperative counselling. Knowing the two surgeons personally, I am almost certain this would have been the case.

For what it's worth, I agree with you that the decision to undergo a radical prostatectomy for low-risk, and even potentially low-tier intermediate risk, prostate cancer should not be taken lightly. This is supported by more recent updates to the EAU guidelines.

Regards

S de Jager