

EDITORIAL COMMENT

The authors of this report focus on timely issues in the management of prostate cancer.¹ First, there is an increasingly recognized importance of pelvic lymphadenectomy (PLND), either as a diagnostic or a therapeutic procedure at the time of prostatectomy. At the same time there is a widespread and dramatic increase in the adoption of robotic technology for prostatectomy.^{2,3} The question is how are surgeons approaching extended PLND during the early experience with a new robotic technique.

Evidence has been mounting which suggests that if a PLND is planned at the time of radical prostatectomy, it should be extended as limited PLND is associated with a high rate of false-negative findings and a greater nodal yield may have therapeutic benefits.^{2,4} Nevertheless, only two other recent reports have compared the adequacy of PLND in open versus robot-assisted radical prostatectomy with differing results.^{5,6}

Findings from the current study likely echo the experience of most early robotic series and the candor with which these are reported is laudable. Without question, the vantage point and approach for robotic PLND differs from the open technique. A familiarity with the anatomy and coordination of the assistant's maneuvers with the robotic movements must be developed. Unfortunately, it is likely that robotic surgeons with less experience are more willing to dedicate extra time during the operation to ensuring adequate prostate dissection rather than appropriate PLND.

In short, recognizing the inherent learning curve of a new technique we strongly urge not to misunderstand the take-home message from this report. High-risk patients should not necessarily be managed with open PLND, but during one's early learning curve a surgeon should maximize attention to proper surgical technique and the proper anatomical boundaries of PLND.

References

1. Yates J, Haleblan G, Iannotti H, Stein B, Miller EB, Renzulli J, Pareek G. The impact of robotic surgery on pelvic lymph node dissection during radical prostatectomy for localized prostate cancer: the Brown University early robotic experience. *Can J Urol* 2009;16(5):4842-4846.
2. Briganti A, Blute ML, Eastham JH, Graefen M, Heidenreich A, Karnes JR, Montorsi F, Studer UE. Pelvic lymph node dissection in prostate cancer. *Eur Urol* 2009;55(6):1251-1265.
3. Guru KA, Hussain A, Chandrasekhar R, Piacente P, Bienko M, Glasgow M, Underwood W, Wilding G, Mohler JL, Menon M,

Peabody JO. Current status of robot-assisted surgery in urology: a multi-national survey of 297 urologic surgeons. *Can J Urol* 2009; 16(4):4736-4741.

4. Joslyn SA, Konety BR. The impact of extent of lymphadenectomy on survival after radical prostatectomy for prostate cancer. *Urology* 2006;68(1):121-125.
5. Polcari AJ, Huguenin CM, Sivarajan G, Woods ME, Paner GP, Flanigan RC, Quek ML. Comparison of open and robot-assisted pelvic lymphadenectomy for prostate cancer. *J Endourol* 2009; 23(8):1313-1317.
6. Cooperberg MR, Kane CJ, Cowan JE, Carroll PR. Adequacy of lymphadenectomy among men undergoing robot-assisted laparoscopic radical prostatectomy. *BJU Int* 2009 Jun 22. (Epub ahead of print).

Riccardo Autorino, MD and Robert J. Stein, MD
Center for Laparoscopic and Robotic Surgery,
Glickman Urological and Kidney Institute
Cleveland Clinic, Cleveland, OH, USA