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Editorial comment from Dr Lallas to robotic-assisted laparoscopic radical prostatectomy: learning curve of first 100 cases.

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This is a review of the first 100 robotic-assisted laparoscopic prostatectomy (RALP) procedures carried out by a single surgeon in Taiwan.[1] Although the majority of radical prostatectomies are carried out robotically in the USA, we are apparently witnessing the birth of this technology in Asia, as the authors have clearly stated. Predictably, they make many of the same conclusions that were made in the Western literature about a decade ago. Interestingly, and a fact that always amazes me with RALP, the reproducibility of the excellent perioperative and functional outcomes with this procedure remains stable, even across oceans. This is likely, in part, due to strong mentoring and a better ability to disseminate and teach the procedure through visual media (i.e. video).

One thing that interested me in this manuscript was the high percentage of high-risk patients represented in the surgical population (58% pT3 disease with a mean preoperative prostate-specific antigen (PSA) around 16 ng/dL). The absence of routine PSA testing no doubt had a significant influence on the authors' patient selection. These surgeons attempted more challenging cases early in their learning curve and they had the results to prove it, with a shocking pT3 positive surgical margin rate of 72.4% and a biochemical recurrence rate of 17% with very short follow up. These numbers are certainly higher than those reported in manuscripts that solely focus on the role of RALP in patients with pT3 disease, albeit with more experienced surgeons.[2] The authors make the conclusion that 100 cases are not enough to adequately manage the surgical margins in patients with locally advanced disease.

This study elucidates a continuing criticism of RALP versus open radical prostatectomy (RP), namely the efficacy of the minimally-invasive approach in patients with locally-advanced disease. At our institution, at a very early point in our learning curve, many of the high-risk patients were treated with open RP, which has proven efficacy in locally

advanced disease, and it was not until after at least 200 cases that we relaxed our risk criteria for RALP.[3] Currently, we are routinely using RALP for suspected pT3 disease. Although there is much promise for this technology, it must be implemented in a responsible manner, and patients with locally advanced disease should be treated like the morbidly obese or those who have a history of prior extensive intra-abdominal surgery; that is, high-risk cases should be undertaken by surgeons with considerable experience.

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