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AUTHOR REPLY

Prostate cancer (CaP) patients treated with radical prostatectomy (RP) may have a longer life expectancy than the age-matched general population.¹ At first glance, this might be a counter-intuitive observation. However, it is based on a heavy selection bias in the diagnostic and treatment decision-making process prior to RP. This might be 1 explanation why obesity is under-represented in a surgically treated cohort compared to the general population as correctly pointed out in this editorial.

Beyond the differences in surgical complication rates between open and robotic-assisted RP (ORP and RARP) in obese men, the accompanying commentary complements our findings and emphasizes important racial and socioeconomic disparities in treatment outcomes of CaP patients. Accordingly, it was shown that wealthier patients are more likely to receive RARP than ORP.² The commentator states that “The obese patient is more likely to be black, poor, and treated at a low or medium volume hospital” and calls for a renewal in addressing health care disparities in CaP treatment. We completely agree with this claim and endorse that outcome differences based on the surgical approach for RP probably have a lower impact compared to outcome differences that are based on social, racial, and even geographical disparities.^{3,4} Nevertheless, in centers or regions in which both surgical approaches are available, our study supports the current evidence that obese patients can expect fewer complications if treated robotically-assisted.

Last but not least, another patient group should not be forgotten in the debate addressing outcome inequalities in CaP treatment: the old patient. Several recent studies demonstrated the underutilization of local treatment options in chronologically older men with a long life expectancy.⁵ Besides the above-mentioned sources for disparities, this growing group of patients deserves careful attention since recent data argue against a strong inherent effect of age on risk of CaP death and indicate that in current clinical practice, old men with CaP receive insufficient diagnostic workup and subsequent curative treatment.⁶

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EDITORIAL COMMENT



This study focuses on the impact of obesity on perioperative outcomes at robotic-assisted and open radical prostatectomy.¹ Putting aside the fact that a much lower percentage of this population was obese when compared to the general population, obesity clearly increased both the risks and the costs of surgery.

The comparison of robotic assisted vs open radical prostatectomy is less relevant in countries who have already adopted robotic surgery, as the vast majority of cases are done robotic assisted, despite prior studies showing no significant difference in functional outcomes between the 2 approaches.^{2,3} As others have observed, it is almost certainly the case that the individual skill of the surgeon is a more important factor than the surgical approach employed.³

Obesity increases the risks regardless of the method of surgery, and as the authors suggest, it is clearly a growing public health issue. The obese patient is more likely to be black, poor, and treated at a low or medium volume hospital.¹

The gold standard for prostate cancer remains a radical prostatectomy. African Americans are at higher risk of prostate cancer, and yet there is compelling evidence that they are less likely to receive definitive treatment and experience a significantly poorer quality of care overall.^{4,5} A renewed emphasis should be placed on addressing health care disparities in prostate cancer care.

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