

approach. An experienced surgeon should likewise practice surgical humility. Perhaps these intangibles may best serve the surgeon in their learning curve. Novice or expert, the ease of port configuration, and the flexibility of port exchange with the newest Xi platform should lower our threshold for adding a fourth arm and leaving our pride at the scrub sink.

Ultimately, the current study has significant limitations and cannot be used to judge the superiority of a 3-arm vs a 4-arm approach. The question the authors ask is nevertheless completely relevant. As surgeons, we must be mindful to practice cost effectiveness and to seek opportunities to improve quality and efficiency through elimination of waste. We must likewise avoid becoming so inflexible with our approach that pragmatism is disregarded. We challenge the authors, and all of us who perform robotic partial nephrectomy with regularity, to consider a prospective, randomized trial that helps to better answer the debate. Until that time, the bar argument will continue.

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<https://doi.org/10.1016/j.urology.2018.06.069>
UROLOGY 123: 144–145, 2019. © 2018 Elsevier Inc.

AUTHOR REPLY



We whole-heartedly agree that the statistically different outcomes in warm ischemia time and margin positivity noted in this study are more likely an anomaly rather than statistical fact. We appreciate and acknowledge the “intangibles” of surgical technique, but to claim them as an advantage requires scientific

proof. The commenters offer no evidence of this aside from anecdote. We have never encountered an issue retracting the liver with a 3 mm subxiphoid port which is decidedly less morbid than 8 mm robotic arm port. We likewise have no trouble manipulating the kidney with 1 arm once appropriately dissected. While it is rare for a patient to complain of the cosmesis of a single port over other ports, port-site hernias are a real and significant complication, even for 8 mm ports. Any port reduction offers a benefit, and the commenters cannot claim noninferiority without data to substantiate it.

We are unaware how a static and uncontrolled fourth arm acts as a “kidney saver,” but if an acute renal hilar injury occurs, we feel the fourth arm is unlikely to salvage an otherwise lost renal unit. The hilum should be dissected with grace and care regardless of the number of arms. We likewise have found no advantage of the Xi platform in our surgical technique or port placement.

Safely and effectively performing a surgical procedure with reduced cost and less morbidity is to the benefit of the patient and the health care system. The commenters evocation of it being a matter of “pride” and “humility” is nonsensical. Perhaps the commenters ought to leave their credit cards at the scrub sink when justifying the use of the fourth arm without evidence of improving outcomes?

We acknowledged that the retrospective nature of this study is a limitation, however, what other “significant limitations” do the commenters feel nullify our findings? They stress avoidance of inflexibility and a disregard of pragmatism, however, that is precisely the theme of our findings. We ask surgeons to not be “inflexible” and not to “disregard pragmatism” in their consideration that the 3-arm technique is safe, effective, cost conscious, and perfectly feasible.

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<https://doi.org/10.1016/j.urology.2018.06.070>
UROLOGY 123: 145, 2019. © 2018 Elsevier Inc.