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European Association of Urology

## Letter to the Editor

### Reply to Francesco Montorsi and Giorgio Gandaglia's Letter to the Editor re: Georg Jancke, Firas Aljabery, Sigurdur Gudjonsson, et al. Port-site Metastases After Robot-assisted Radical Cystectomy: Is There a Publication Bias? *Eur Urol* 2018;73:641–2

We thank Professor Montorsi and Doctor Gandaglia for their comments based on their vast experience with robot-assisted radical cystectomy (RARC). We agree that the adoption of minimally invasive surgery in patients with muscle-invasive bladder cancer should not be discouraged. However, to further extend the debate, we would like to explain the setting in which our case series data were collected [1] and add a few thought-provoking facts.

The 0.3% incidence of port-site metastases observed at nine centres of excellence [2] might not be at the same low level in a population-based setting. Five of the eight cases with port-site metastases after RARC occurred during the first 100 procedures, and the other three during the first 200 cystectomies performed with robot assistance in the respective institutions. This suggests an incidence that is at least twice as high (0.7%) during the learning curve, not taking into account clinical underreporting.

Regarding oncological outcomes after RARC, positive bladder margins in 4–15% of cases in randomised studies have been reported [3–5]. Thus, it seems that this endpoint must also be carefully monitored when adopting RARC. This is further supported by the recent update with long-term oncological follow-up from another randomised investigation [6], which revealed a higher risk of abdominopelvic recurrences after RARC.

In the current series, 50% of the patients received neoadjuvant chemotherapy, and four patients (aged 70, 71, 75, and 79 yr) underwent surgery without such pretreatment. We agree with Montorsi and Gandaglia that one or two of these elderly patients might have been treatable with cisplatin-based combination chemotherapy before cystectomy, which as of 2016 was administered to 59% of all patients with muscle-invasive disease aged  $\leq 75$  yr undergoing surgery in Sweden [7]. Although neoadjuvant

chemotherapy can never salvage suboptimal surgery, we cannot rule out that such treatment would have influenced the outcome for these patients.

In summary, we do not discourage the use of RARC, nor do we want to “throw the baby out with the bathwater”. Indeed, the fact that 7/8 patients with port site metastases in our series had lymphovascular invasion might instead represent an opportunity to maintain the bathwater at an optimal temperature by preoperatively identifying patients at risk of metastases. However, more randomised studies are needed to determine if and how some patients should be selected for open cystectomy instead of RARC and to compare other endpoints such as functional outcomes.

**Conflicts of interest:** The authors have nothing to disclose.

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