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Letter to the Editor

Reply to Siebren Dijkstra and Carl J. Wijburg's Letter to the Editor re: Bernard H. Bochner, Guido Dalbagni, Karim H. Marzouk, et al. Randomized Trial Comparing Open Radical Cystectomy and Robot-assisted Laparoscopic Radical Cystectomy: Oncologic Outcomes. Eur Urol 2018;74:465–71. Can the Pattern of Cancer Recurrence Truly be Assigned to the Surgical Modality?

We appreciate the opportunity to respond to the letter by Dijkstra and Wijburg in regard to our cancer-specific outcomes from our randomized open versus robotic radical cystectomy trial [1]. Their letter details their institutional recurrence outcomes following robot-assisted radical cystectomy (RARC) and intracorporeal diversion. Their series is retrospective, without a randomized or nonrandomized contemporary open surgery comparison group, consists of a cohort in which approximately half of their patients had extravesical disease, and has reported follow-up of only 1.6 yr. On the basis of their recurrence information, the authors state that their outcomes are in "conflict" with our findings and suggest that there is no reason to think that patients treated with RARC have a greater risk of local-regional recurrences.

As clearly stated in our manuscript, our randomized study was not powered to definitively evaluate cancer-specific outcomes. Cancer outcomes were predefined secondary endpoints of our trial. However, the patterns of first recurrence we observed are of sufficient interest to warrant further study and discussion. Comparing randomized trial data with median follow-up of 4.9 yr to a retrospective, nonrandomized group of patients with 1.6-yr follow-up does not provide a robust assessment that can lead to any definitive conclusions about cancer outcomes. The 26% recurrence rate in their cohort (despite nearly half with extravesical disease) highlights the immature nature of the follow-up. Multiple previous radical cystectomy series would suggest that a group of patients in which half of whom have $\geq$pT3 disease would have a significantly greater risk of recurrence [2,3]. Cancer outcome data from our randomized trial and from other nonrandomized institutional studies have suggested that the frequencies of local and abdominal recurrences following RARC need to be scrutinized [4]. The fact that some studies have noted a higher rate of pelvic and abdominal recurrences while others have not reported similar findings [5] suggests that differences in technique may play a critical role. It is possible that breaks in technique have different consequences depending on the technology/technique used. This we feel is the important question that requires ongoing scrutiny. As a surgical community we must open the discussions necessary to better understand what the optimal steps and approaches are to minimize or eliminate unanticipated pelvic or abdominal relapses. We strongly agree with Dijkstra and Wijburg that well-designed future randomized studies that include sufficient patients with higher-stage tumors be completed to more clearly assess the patterns of recurrence after RARC. Until then, surgeons should remain aware that such data exist while we await the data required to clarify long-term cancer outcomes following RARC.

Conflicts of interest: The authors have nothing to disclose.

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DOIs of original articles: https://doi.org/10.1016/j.eururo.2018.04.030, https://doi.org/10.1016/j.eururo.2019.01.036.
https://doi.org/10.1016/j.eururo.2019.01.037

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January 22, 2019