

ised renal masses for whom PN is not oncologically unsafe and appears to be technically feasible in experienced hands.

More research is needed to improve the prediction of cancer-specific mortality and define the true oncological limits of PN, as well as of patients' life expectancy and NCRM, to evaluate whether they might benefit from PN. In the meantime, under elective conditions, we should pursue the concept of precision surgery and never limit PN for technical reasons unless it would be oncologically unsafe.

Conflicts of interest: The authors have nothing to disclose.

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<https://doi.org/10.1016/j.eururo.2016.11.038>

<https://doi.org/10.1016/j.eururo.2019.05.021>

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Re: Extended Versus Limited Lymph Node Dissection in Bladder Cancer Patients Undergoing Radical Cystectomy: Survival Results from a Prospective, Randomized Trial

Gschwend JE, Heck MM, Lehmann J, et al

Eur Urol 2019;75:604–11

Experts' summary:

This prospective, randomized, multicenter phase 3 trial investigated the oncological impact of the extent of lymph node dissection (LND) in patients undergoing radical cystectomy (RC) for bladder cancer (BC) [1]. A total of 401 patients were randomized to receive either limited LND (bilateral obturator and internal and external iliac nodes) or extended LND (also including deep obturator fossa, common iliac, presacral, paracaval, interaortocaval, and para-aortal nodes up to the inferior mesenteric artery). Limited LND was performed in 203 patients (group A) and extended LND in 198 patients (group B). The 5-yr recurrence-free (RFS), cancer-specific (CSS), and overall survival (OS) rates were 59.2%, 64.5%, and 49.7% in group A, and 64.6%, 75.9%, and 58.9% in group B. However, these differences did not reach statistical significance (all $p > 0.05$). Overall, 30-d and 90-d complications did not

differ between the groups. In summary, extended LND did not convey a clinical benefit over limited dissection.

Experts' comments:

RC with bilateral pelvic LND, eventually accompanied by perioperative platinum-based systemic chemotherapy, is the standard of care for the treatment of muscle-invasive and very high-risk non-muscle-invasive BC. LND in BC is generally performed with two aims: diagnostic and therapeutic. The ability of nodal status to predict oncological outcomes is well established, with CSS rates varying from 44% in N1 patients to 27% and 0% in N2 and N3 patients, respectively [2]. Likewise, it has been shown that lymph node density can predict CSS among patients with node-positive disease after surgery and, in some trials, has superior accuracy to TNM classification [3]. Moreover, understanding the pathological nodal status of patients undergoing RC plays a fundamental role in decision-making regarding the indication for adjuvant systemic therapy and follow-up intensity. Finally, retrospective evidence suggests that LND may improve oncological outcomes in selected patients, such as those with metastases or micrometastases to a few nodes. On the basis of this evidence, LND is mandatory in all patients undergoing RC for BC.

The extent of LND remains debatable. While the majority of the literature agrees on the benefit of extended LND (up to the common iliac nodes) over a limited template (external iliac + obturator nodes only), the advantage of dissecting nodes up to the inferior mesenteric artery is still controversial. Some retrospective series reported a survival benefit for patients undergoing LND up to the aortic bifurcation (including the presacral nodes), irrespective of T stage and nodal status [4]. However, these findings are not consistent across the literature [5]. Besides, the fact that removal of more nodes conveys a survival advantage for both NO and N+ patients suggests that better outcomes reflect a selection bias rather than a true curative effect.

The authors should be complimented for their effort in conducting a prospective study, overcoming the well-known difficulties related to accrual of patients in randomized surgical trials. This paper, until the results of the SWOG S1011 trial become available, represents the highest level of evidence to date on the topic and could serve as guidance in clinical practice. However, it should be acknowledged that several factors may have contributed to these results and could have acted as confounders. First, it should be highlighted that the LND templates represent extended versus super-extended rather than limited versus extended. Second, as declared by the authors, the high rate of patients with high-grade pT1 non-muscle-invasive BC (14%) may have limited the strength of the results. Finally, a cutoff of 15% for the difference in expected 5-yr RFS could be considered ambitious if we think that neoadjuvant chemotherapy (conveying a survival advantage 6–8%) is standard of care. Notably, extended LND was superior in terms of 5-yr RFS (65% vs 59%), CSS (76% vs 65%), and OS (59% vs 50%), albeit not statistically significant.

These differences, despite the lack of statistical significance, provide a basis for further larger prospective trials to test the reproducibility of the findings and to identify patients who might benefit from super-extended

LND, moving another step towards the era of precision medicine.

Conflicts of interest: The authors have nothing to disclose.

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<https://doi.org/10.1016/j.eururo.2019.03.042>

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Re: Rates and Predictors of Conversion to Open Surgery During Minimally Invasive Radical Cystectomy

Ko OS, Weiner AB, Smith ND, Meeks JJ

J Endourol 2018;32:488–94

Experts' summary:

Will open radical cystectomy (ORC) always remain the gold standard for bladder cancer? Robot-assisted radical cystectomy (RARC) is one of the few minimally invasive surgical techniques for which randomized controlled trials have shown equivalence to ORC. The study by Ko and colleagues using data from the National Cancer Data Base demonstrates that RARC has slowly been adopted, with a 10% increase over a decade and a corresponding decline in ORC [1]. When does noninferiority become superiority? The most interesting observation was a low open conversion rate (4.3%) and its continued downward trend. Conversions were independent of or were not impacted by clinical tumor stage or annual RC volumes. Only the year of RARC impacted

the conversion rate. This captures the maturation of the modern surgeon's skill (visual cues take over from tactile feedback). The RARC procedures converted to ORC were associated with poorer surgical margins (lack of tactile feedback), lower lymph node yield (despite no difference in node dissections), longer hospital stay, and a higher rate of 30-d readmission, but they were not different from ORCs that were planned a priori. Notably, multivariate analysis revealed that ORC was associated with a greater incidence of positive surgical margins. The increasing rates of RARC and decreasing rates of conversion indicate overall adoption of RARC.

Experts' comments:

Despite the costs and adaptations required, advances are never subject to U-turns; instead, improvisation is applied. The key lies in “do no harm”. Urological surgeons, who have helped in the adoption of RARC, have shown caution with thorough scientific vigor and dedication to quality. Current