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 N0 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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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

work under way will also help in a better understanding of the advantages of intracorporeal urinary diversion [2]. Issues of concern such as peritoneal spread have been studied to ensure that there is no negative impact for patients [3].

Every surgeon desires excellent visualization. The current technology for RARC provides surgeons with an unparalleled view of the pelvis, allowing the ability to maneuver around the complex anatomy packed within the pelvis. The issue of training surgeons in ORC will evolve and repeat surgery is already being performed and will become part of the training process [4]. By analogy to the change from the horse and buggy to automobiles, urologists have stopped open surgery for stones and have switched to endoscopic surgery despite opportunities to train in open nephrolithotomy. Instead of denial, we should cautiously incorporate advances (eg, indocyanine green fluorescence imaging). Just as automation revolutionized aviation, artificial intelligence–based intraoperative navigation and data-driven decision-making (node dissection or not) are likely to be incorporated sooner than we can imagine [5].

Conflicts of interest: The authors have nothing to disclose.

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