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European Association of Urology

Letter to the Editor

Re: Adam C. Calaway, Lawrence H. Einhorn, Timothy A. Masterson, Richard S. Foster, Clint Cary. Adverse Surgical Outcomes Associated with Robotic Retroperitoneal Lymph Node Dissection Among Patients with Testicular Cancer. Eur Urol 2019;76:607–9

We read with great interest the report by Calaway et al [1] and their note of caution regarding the use of robotic retroperitoneal lymph node dissection (RPLND) for men with testis cancer. For their retrospective case series of five patients referred for management of recurrent intra-abdominal disease following robotic RPLND, the authors suggest that these unusual recurrence patterns were secondary to the robotic approach.

It is important that data like these are published. However, we feel it equally important that these data, while serving as a cautionary tale, should not be used as high-level evidence to warrant abandoning investigation of the role of robotic RPLND.

We agree wholeheartedly that regardless of what surgical approach is planned, cases should be discussed in a multidisciplinary setting and surgery should be carried out at a high-volume center by experienced surgeons. The ability to perform surgery robotically should not bias the clinical decision in favor of performing RPLND and should not replace the requirement for extensive RPLND experience.

We agree that in-field relapse, atypical relapse patterns, and abundant use of post-RPLND chemotherapy should be viewed as a failure. Outcomes in the setting of primary RPLND and low-volume postchemotherapy RPLND should be near-perfect; anything less is harming patients. We should all be held to this standard, regardless of surgical approach.

We further agree that, to date, there is insufficient published evidence to reach conclusions on the oncologic equivalence of robotic and open RPLND. While reports on robotic RPLND with short follow-up, routine use of adjuvant chemotherapy, and inclusion of clinical and pathological stage I disease demonstrate the feasibility of the approach, they will not contribute to a better understanding of its efficacy [2]. However, given the potential benefits of robotic RPLND, we must have quality evidence of harm before abandoning the robotic approach.

Similar relapses in odd locations have been observed after open RPLND. To cite one example, a case of relapse with a 4-cm mass in the small bowel mesentery after open RPLND was referred to us at Princess Margaret. Repeat surgery involved a bowel resection that confirmed viable germ-cell tumor invading the small bowel lumen. This case is very similar to one of the cases described by Calaway after robotic RPLND.

We retain a healthy reservation regarding adoption of robotic RPLND. Having read about recently published adverse outcomes in cervical and bladder cancer [3–5], we continue to be highly selective in choosing patients to whom we offer robotic surgery, and transparent in our approach to consent. We track our patients very closely and to date we have not seen this type of adverse outcome.

We hear the cautionary tale and so should all surgeons offering robotic RPLND. However, we feel strongly that this report should not stop efforts to reduce RPLND morbidity. There is potential for the greatest difference compared to any other application of robotic surgery.

Conflicts of interest: Gregory Nason and Michael Jewett have nothing to disclose. Robert J. Hamilton is an advisory board member for Bayer, Amgen, Janssen, and Astellas; has received research funding from Bayer (ARASENS trial) and Janssen (SPARTAN trial); has received speaker honoraria from Abbvie; and has received travel expenses from Roche.

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