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Letter to the Editor

Reply to Franco Gaboardi, Guglielmo Mantica, and Nazareno Suardi's Letter to the Editor re: Giuseppe Simone, Umberto Anceschi, Gabriele Tuderti, et al. Robot-assisted Partial Adrenalectomy for the Treatment of Conn's Syndrome: Surgical Technique, and Perioperative and Functional Outcomes. Eur Urol 2019;75:811–6

We appreciate the Letter to the Editor from Gaboardi et al on our preliminary series of robot-assisted partial adrenalectomy (RAPA) for the treatment of unilateral aldosterone-producing adenoma (UAPA) [1]. We strongly believe that in highly selected cases this surgical approach is feasible for all urologists with advanced experience in minimally invasive nephron-sparing surgery. In our center, the rationale for an adrenal-sparing technique started from our growing experience in purely off-clamp robotic partial nephrectomy [2]. With the continuous technical refinements provided by robotic surgery, our group already supports off-clamp partial nephrectomy in the elective setting as a standard option for cT1–2 renal tumors whenever technically feasible [3]. We are pleased to note the promising results reported by the authors on their initial series of laparoscopic PA (LPA) even though we have no experience with pure LPA [4]. We agree that one of the technical challenges of PA is approximation of the adrenal margins after mass enucleation because of the friability of the remnant parenchyma. We would like to point out that this is the case for very large adenomas.

For this reason, if it is planned to attempt PA, careful preoperative selection of cases in terms of both the size and nature of lesions remains of paramount importance. Our series had a mean tumor size of 18 mm (range 16–20) [1] for well-selected UAPAs, which are usually well-defined capsulated masses isolated from the healthy adrenal parenchyma. In these cases, if the surgical cleavage plane is correctly identified, blood loss is marginal and the injury to the surrounding adrenal tissue is negligible. Approximation of the adrenal margins is undoubtedly easier via the robotic system because of its intrinsic superiority over laparoscopy in suturing techniques [5].

Similar to Gaboardi et al, we have used a vessel sealer during RAPA and in multiple other surgical procedures [6]. We strongly support the use of this device during PA since it provides excellent sealing of both veins and arteries feeding tumors and the surgical bed, while the jaw size (5–12 mm) is dictated by surgeon preference. During RAPA, a vessel sealer can easily be used by the bedside assistant via a four-port configuration, similar to the laparoscopic technique.

To date, we have performed approximately 13 RAPA procedures for UAPA. Unfortunately, we have no experience of PA for complex lesions (bilateral disease or malignant lesions) which certainly precludes any definitive conclusions, but we agree with the authors that excellent outcomes can be achieved with PA independent of the minimally invasive approach chosen.

Regardless of robotic platform costs and avoiding any speculative discussion about the feasibility of LPA, which is certainly feasible and safe in expert hands, the aim of our report was to highlight the need to consider conservative surgery for UAPA and the key role of urologists in this field thanks to their unmatchable experience gained with robotic partial nephrectomy.

Conflicts of interest: The authors have nothing to disclose

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