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EDITORIAL COMMENT

Partial nephrectomy (PN) has gradually become the leading surgical treatment for small renal masses over the 2 decades, especially after the dissemination of the robotic platform.[1] Mastering this challenging surgical procedure requires structured training, and a steep learning curve.[2] The authors of this intriguing study used a state-wide database (SPARCS, New York State) to evaluate the impact of a urologic fellowship on physician case-volume and immediate outcomes of robotic-assisted PN (RAPN), and to assess predictors of undergoing a RAPN by a fellowship-trained urologist. Surgical training in the era of robotic surgery remains matter of debate, as US graduates of urology residency program still perceives lack of confidence in advanced minimally invasive procedures, such as RAPN.[3] Previous literature already showed an increasing ability of those surgeons who attended a mini-fellowships and courses.[4,5] Certainly, a structured fellowship program, such as those offered by the Endourological Society or the Society of Urologic Oncology, can potentially provide exposure to larger surgical volumes and to more complex cases so that the trainees can overcome the learning curve and fill deficiencies that he/she might have experienced during residency.

Few findings of the present study are worth mentioning. Fellowship-trained urologists performed slightly higher number (56% vs 44%) of the total number of procedures done in the 5-year study period (2009-2014), which is probably less than one would expect. Not surprisingly, RAPN done at teaching hospitals was more frequently done by fellowship-trained urologists (23% vs 7%). The average surgical volume per year was also slightly higher for those fellowship trained (9.6 cases vs 7.2 .5 cases), but what strikes the most is that on average those performing RAPN in the state of New York do less than 10 cases a year. In any case, the outcomes were comparable between RAPN done by fellowship trained and those without a fellowship. And these outcomes seem to mirror those of high volume centers.[1] Last, wealthier people were more likely to be treated by fellowship trained. Previous studies demonstrated that more educated and higher wage patients have higher odds to be treated with RAPN in tertiary level hospitals, which tend to be in larger cities.[6]

The main limitation of the present study (as many other based on administrative datasets) is the lack of granular information about tumor characteristics, and surgical data within SPARCS database. One can postulate that more complex cases were done in teaching/larger volume hospitals, and by fellowship-trained urologic surgeons. Notwithstanding these limitations, we would like to congratulate the authors for the present analysis, which can contribute to the ongoing debate, raising some critical points of discussion.

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AUTHOR REPLY

We would like to thank both the editors and journal for giving us an opportunity to publish our work on the impact of fellowship training on physician case-volume and immediate perioperative outcomes in robotic-assisted partial nephrectomy (RAPN). Perhaps even more important than providing an assessment on the current landscape of urological fellowship training and its impact on both volume and outcomes, our report serves as a conversation starter to encourage urologists to think further about the utility of fellowship training as they plan out their careers. As more of our procedures move toward minimally invasive approaches, further exposure during a fellowship can be beneficial in helping a surgeon improve skills and garner confidence. However, this must be weighed against the potential financial loss by postponing training completion as well as one's personal preference on what type of practice they want to conduct.

There are 2 aspects of the study that we find noteworthy and wish to reemphasize. First, we report no observable differences in outcomes between urologists with fellowship and those without. Though encouraging, this may not tell the full story as the database lacked information on oncological outcomes and case complexity. Second, the average case-volume for fellowship-trained urologists performing RAPN is increasing over time while rates for those without fellowship are decreasing. We believe this trend is likely to continue due to factors such as patient preference and physician referral patterns to surgeons with additional training in these more complex procedures.

We encourage additional reports on the topic of subspecialization and fellowship training in the urological literature in order to help trainees make the most informed decision possible on whether or not to pursue a fellowship. It is important that, regardless of electing to pursue a fellowship or not, urology residents make a decision that fits their individual career goals.

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