

bias. They included 15 RCTs, all with low risk of bias on almost all domains. We were more strict with grading of these studies while we only found 5 studies with a low risk of bias on all domains. The results were however similar.

In conclusion, we would like to congratulate Aboumarzouk et al and colleagues for making great efforts to show the readers of this journal what the overall evidence on this topic is. Small differences in the methodology and the execution of the review steps can be found between his review and our 2018 Cochrane paper. However, the overall conclusion stays the same: alpha-blockers have beneficial effects on stone passage, have in general only minor adverse effects, and their use is most effective in distal ureteral stones of >5mm. If this answer was already available, one could wonder the need of a tremendous effort as Aboumarzouk et al has conducted, given that new research is expected to provide some (new) form of benefit to the patient.

SUPPLEMENTARY MATERIALS

Supplementary material associated with this article can be found in the online version at <https://doi.org/10.1016/j.urology.2019.02.020>.

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Re: Comparing Off-clamp and On-clamp Robot-assisted Partial Nephrectomy: A Prospective Randomized Trial



Letter to the Editor:

We commend with Anderson and coworkers for their efforts. They performed a prospective randomized trial addressing the comparison of on-clamp vs off-clamp technique for robotic partial nephrectomy (RPN).¹ Recent systematic literature reviews already showed no impact of the technique used to manage the renal pedicle on either surgical or oncological outcomes.² This is debatable and based on pooled analyses of mostly small sample size studies, affected by several confounders, including selection bias (off-clamp approach is more likely performed in low complexity tumors) and heterogeneity in the surgical techniques used. Porpiglia et al reported on 87 patients who underwent laparoscopic partial nephrectomy by on-clamp or off-clamp approach.³ Dr. Laguna referred to the study as the one with the closest design to a quasi-randomized controlled trial comparing laparoscopic partial nephrectomy with and without arterial clamping.⁴ Notably, the strength of the study relied on the use of renal scan, assessing the operated kidney function at baseline and third month post-operatively, including both the percent reduction in split renal function and the estimated renal plasma flow (that unfortunately the authors did not include in the present study). Bertolo et al recently contributed to this field, performing a head-to-head comparison between 2 high-volume centers⁵: 400 on-clamp vs 200 off-clamp patients were analyzed after propensity-score matching for many potential confounders. They found no significant differences in key perioperative outcomes, confirming the literature trend once again. Finally, another randomized trial (the CLOCK trial, NCT02287987⁶) closed the recruitment with 301 patients who underwent RPN at 7 referral institutions. Results are awaited to be published next.

As stated by the authors themselves, the significance was not achieved in the present study due to the fact that the observed difference in the % change in estimated glomerular filtration rate (eGFR) between the treatment groups was much less than what the authors hypothesized at the time of the power analysis. Sample size was initially calculated considering the absolute change in eGFR (we would have some perplexities in basing the sample size calculation on an expected difference equal to 7 mL/min of eGFR), but surprisingly the authors used the % change (not the absolute difference) in eGFR as primary outcome. Thirty-seven vs 34 patients were actually analyzed. With a 5% alpha error and a power of 80%, the minimum effect size (Cohen's *d*) detectable by the study is 0.67, that approximately equals a 10% absolute difference between groups. Thus, the study would be unable to detect any variation below 10% as statistically significant. On the other

hand, it is questionable if a <10% difference in eGFR might be considered as clinically significant (It might for the authors who initially set 7 mL/min as a discriminatory difference).

Looking at Figure 1, it seems like there is no actual difference in the % change in eGFR between the groups. Nevertheless, off-clamp patients had larger variability that was not detected by descriptive statistics. This is not enough for drawing definitive conclusions. A larger sample size could confirm or completely change the results.

We believe the main point of the study is the “nonfinding”, namely the comparable perioperative outcomes between the techniques, that is what the “off-clamp surgeons party” would like to read. It has been hypothesized that choosing an off-clamp approach might negatively impact on the perioperative outcomes of RPN. As such, the virtually more consistent blood loss with off-clamp RPN would worsen the vision of the operative field, thus sponsoring the likelihood of surgical complications and positive surgical margins.

The nonfinding herein could be due to the single expert surgeon setting. As such, the intention-to-treat analysis almost duplicates the per-protocol one, with 1 shift only from off-clamp to on-clamp. Maybe just because of the expertise of Dr. Figenshau, none of the approaches was found as a winner. Future ongoing studies should test the eventual differences between on-clamp and off-clamp RPN in a multisurgeons setting.

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