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Is the Surgeon Experience the Most Important Prognostic factor?: A Review of the Outcome of 648 Open Radical Prostatectomies by the Same Surgical Team in Private Practice

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Abstract

Introduction and Objectives: *Radical prostatectomy (RP) remains as the gold standard treatment for localized prostate cancer, whether it's open (ORP) or robotic surgery (RS). There are several studies comparing these two modalities, and most of them conclude that the surgical and oncological outcomes are equal; leading us to a debate: which surgical modality is the best for the patient? The objective of this study is to demonstrate how the surgeon's experience can become the best prognostic factor regardless of the surgical approach.*

Materials and Methods: *We analyzed 648 cases of open radical prostatectomy (ORP) with bilateral lymph node dissection done by the same surgeon and surgical team in a private practice basis, performed from 1991 to 2022. There were no limitations on age: our youngest patient was 40 years old and the oldest 87. All patients underwent a pre-operative assessment by an anesthesiologist. All surgeries were performed under spinal blockage. For the analysis of the cases, the patients were divided in four groups of 162 surgeries each one. The surgical outcome was evaluated by measuring the following factors: surgical time (ST), bleeding amount (BA), mortality (MT), use of intensive care unit (ICU), incontinence (ICT), erectile dysfunction (ED) and hospitalization time (HT).*

Results: *The overall surgical outcome results are: MT 0%, ICU 0%, BA 508 mL, HT 2.9 days, ED 18.45%, ICT 0.4%. The improvement on the surgical outcome from Group 1 to group 4 were the following: ST 36.5%, HT 21.9%, BA 21.3%, ED 10%, ICT 1.2%. ICU and MT show no improvement because they remained at 0%. The results of the análisis are shown in Table 1.*

Conclusion: *Our data show that there's an evident improvement on the surgery outcome directly related to the number of surgeries performed by the surgeon; thus confirming to us that the surgeon experience should be considered one of the most important prognostic factors in RP, regardless if it's ORP or RS.*

Keywords: Oncological Equivalence, Surgical Learning Curve, Bilateral Lymphadenectomy, Spinal Blockade Anesthesia, Private-Practice Urology

Introduction & Objectives

Radical prostatectomy (RP) remains as the gold standard treatment for localized prostate cancer (LPC) whether it is open or robotic surgery(RS). There are several studies comparing these two modalities , and most of this studies conclude that the surgical and oncological outcome are equal , and this lead us to a debate: which surgical modalitie is the best for the patient?. The objective of this study is to demonstrate how the surgeon's experience can become the best prognostic factor regardless the surgical approach.

Materials & Methods

We analyzed 648 cases of open radical prostatectomy(ORP) with bilateral lymph node dissection done by the same surgeon and surgical team in a private practice basis performed in a period of 31 years, from 1991 to 2022. There were no limitation of age: our yougest patient was 40 years old and the oldest 87. All patients underwent a pre-operative assessment by an anesthesiologist. All surgeries were performed under spinal blockage. For the analysis of the cases, the patients were divided in four groups of 162 surgeries each one. The first group was comprised of patient number 1 to patient 162, the second group of patient 163 to patient 324 , the third of group patient 325 to patient 486 , and the fourth group of patient 487 to patient 648. The surgical outcome was evaluated by measuring the following factors: surgical time(ST) , bleeding amount(BA) , mortality(MT) ,use of intensive care unit(ICU) , incontinence (ICT) , erectile dysfunction(ED) and hospitalization time (HT).

Results

The overall surgical outcome results are: Surgical time 3.04 hrs. mortality 0% , use of intensive care unit 0% , mean bleeding amount 508ml , mean hospitalization time 2.9 days , erectile dysfunction 18.45% , incontinence 0.4% . The improvement on the surgical outcome from group 1 to group 4 are the following: ST 36.5% , HT 21.9% , BA 21.3% , ED 10% , ICT 1.2%. ICU and MT show no improvement because they remained at 0%. The results of the analysis of each group is shown in the following table:

Table 1: The results of the analysis of each group

	Group 1	Group 2	Group 3	Group 4
Bleeding amount	550ml	546ml	501ml	433ml
Surgical time	4.1hrs	3.19hrs	3.15hrs	2.6hrs
Hospitalization time	3.2 days	3.07 days	3.01days	2.5 days
Erectile dysfunction	24%	21%	14.8%	14%
incontinence	1.2%	0.6%	0%	0%
Intensive care unit	0%	0%	0%	0%
mortality	0%	0%	0%	0%

Conclusion

Our data show that there is an evident improvement on the surgery outcome directly related to the number of surgeries performed by the surgeon; thus confirming to us that the surgeon experience should be considered one of the most important prognostic factors in RP , regardless if it is open or robotic surgery.

On the other hand , the overall ORP results confirms what has already been published widely: that neither ORP nor RS has shown superiority over each other. Taking this into account in our era of robotic surgery , we consider ORP must be re-evaluated and remain as a gold standard treatment for LPC; furthermore , we encourage to keep training urologists in ORP , especially in developing countries where RS is only available for a minimal percentage of the patients , mostly due to economic issues.