Letters to Editor

Re: Bansal D, Nayak B, Singh P, Nayyar R, Ramachandran R, Kumar R, *et al*. Randomized controlled trial to compare outcomes with and without the enhanced recovery after surgery protocol in patients undergoing radical cystectomy. Indian J Urol 2020;36:95-100

We read with interest this article[1] and applaud the authors for their efforts on performing the first randomized controlled trial (RCT) in an Indian setting, comparing enhanced recovery after surgery (ERAS) and conventional care in patients undergoing radical cystectomy and urinary diversion. The dietary pattern, sociocultural factors, and health facilities provided to Indian population differs from the western population, hence prospective studies in Indian scenario is the need of the hour.

The concept of ERAS has been around for over two decades, being extrapolated into urology from studies in colorectal cancer patients. Most of the studies regarding its use in urological settings are retrospective. These studies indicate that ERAS is associated with a faster return of bowel function and may significantly reduce the length of hospital stay.[2] Few RCTs have demonstrated reduced hospital stay, decreased time to first flatus passage and decreased time to first bowel movement with similar complication rates compared to conventional care.[3]

The current study also demonstrates faster bowel recovery in the ERAS subgroup but fails to demonstrate a decrease in length of stay and complication rate. Three patients (1 in ERAS and 2 in conventional protocol underwent neobladder formation in the study and the rest ileal conduit. It would be interesting to have a subset analysis to know whether the creation of neobladder has any different effect on the outcome as compared to the ileal conduit concerning ERAS because neobladder creation takes longer time and more bowel handling as compared to ileal conduit. One patient with cT4b disease underwent bilateral ureterostomy. Why bilateral and not unilateral? Was is not a more morbid procedure than neoadjuvant chemotherapy followed by cystectomy, if feasible.

Laparoscopic radical cystectomy and intracorporeal conduit/neobladder have further hastened bowel recovery and whether it translates to decreased complications and lesser hospital stay, has to be evaluated in future studies. The introduction of intracorporeal urinary diversion with proposed advantages of faster bowel recovery, less bowel handling, reduced fluid loss by evaporation, less extensive mobilization of ureters, and lesser postoperative pain is another new development. Prospective randomized studies incorporating robot/laparoscopic radical cystectomy, intracorporeal diversion, and ERAS may be the most promising approach. We agree with the authors that future directions may include the impact on patient's quality of life and immunonutrition/TAP catheter use may have a promising role in improving the current ERAS protocols and patient outcomes.

Ankit Misra, Swarnendu Mandal*, Manoj K Das, Prasant Nayak

Department of Urology, AIIMS, Bhubaneshwar, Odisha, India

*E-mail: dr.swarnendu@gmail.com

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Received: 14.04.2020, **Accepted:** 20.04.2020, **Published:** 01.07.2020

Financial support and sponsorship: Nil.

Conflicts of interest: There are no conflicts of interest.

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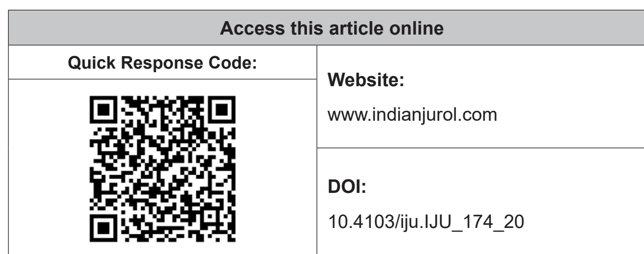

Website: www.indianjurol.com

DOI: 10.4103/iju.IJU_174_20

How to cite this article: Misra A, Mandal S, Das MK, Nayak P. Re: Bansal D, Nayak B, Singh P, Nayyar R, Ramachandran R, Kumar R, et al. Randomized controlled trial to compare outcomes with and without the enhanced recovery after surgery protocol in patients undergoing radical cystectomy. Indian J Urol 2020;36:95-100. Indian J Urol 2020;36:239-40.

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