

Duplicating research and befriending technology

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At the recently concluded national conference of the Urological Society of India in New Delhi, one of the speakers suggested that urologists working in India need to contribute more original research in the field. What he probably meant was that the majority of the publications coming from India are based on research that duplicates existing research. His candid and straightforward comments did not elicit a rejoinder probably because it is accepted that our contributions in the area of basic research are limited, despite the vast clinical experience of urologists practicing in the country. This is true in most field of medicine and India's publication output was 1.59% of the total world publications from 1999 to 2008 with a lack of high quality research.^[1] Similar sentiments were echoed in the 2nd National Assembly of Medical Editors organized by the Journal of Indian Medical Association in 2009.^[2]

However, is duplicating research really inappropriate? In a number of areas such as the use of high end technology in clinical practice and the use of new anticancer drugs which provide a glimmer of hope for increasing survival, practicing clinicians in the country have opinions that are at variance with the published literature. This is based on differences in cost-effectiveness, availability and efficacy of drugs in the "intent-to-treat" scenario where the outcomes are not as good as shown in the literature.

One possible reason is the difference in class of subjects recruited. An important example is metastatic renal cell carcinoma (RCC) where outcome analysis depends on risk criteria. Hemoglobin <12 gm% and serum calcium <10

mg% are two risk factors whose presence would change the outcome drastically. Indian patients frequently have these risk factors, while the majority of patients studied in trials for newer drugs for RCC do not have such risk factors. This is where the role of duplicating research by collecting regional data becomes important. Modifying protocols based on these studies would make a real difference in the life not only of the cancer patient but the entire family, which already is financially challenged.

Similarly technology is a big boon, enabling us to scale up our practice to a new level. However, at the same time, we need to harness this technology to improve outcomes cost-effectively where we still have not achieved potential goals of giving life years to cancer patients, best functional outcomes to a man with prostate cancer, problem free neo-bladder with no night time incontinence, contracture and stricture free surgery for benign prostatic hyperplasia (BPH) etc.

In this issue, Altaf Mangera and Christopher Chapple from Sheffield Teaching Hospital, UK guest edit a symposium on current management of BPH, which will provide our readers a lucid and comprehensive review on managing one of the most common clinical conditions in urology. Apart from effective medical treatment, surgical treatment of BPH is an area that has witnessed technology growth in leaps and bounds. Interestingly, in one of the articles, Nimesh Thiruchelvam describes more than 25 ways to treat this clinical condition surgically. This large number of procedures to treat one clinical problem suggests that we have still not reached the goal of achieving problem free voiding and merely incorporating new technology may not give us the best outcome.

Ureteric stents are among the most common devices used by urologists. A "forgotten stent" is commonly seen in our practice and at times, leads to major morbidity. Sabharwal et al. described a computer-based registry for double J stents that uses mobile phones and short-message-services for improving stent removal rates.^[3] The wide availability of mobile phones in the country may help minimize these avoidable complications and would be a welcome step to incorporate in our practice. Nerli et al. use the unfortunate occurrence of treatment delays to their advantage in calculating tumor doubling times in RCC and Prasad et

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al. review their large series of blunt renal trauma cases to identify predictors of nephrectomy.^[4,5]

These manuscripts highlight some of the inherent problems faced by urologists in the country where robotic surgery, forgotten stents, and delayed surgery for cancer coexist. It is thus important that we befriend technology thoughtfully, aiming at the best possible outcome.

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