Commentary

Lymphocele is one of the most frequent non functional complications after radical prostatectomy and pelvic lymphadenectomy, especially in cases with an indication to extend pelvic lymph node dissection.[1,2] It may be treated expectantly or actively. Active treatments are generally deserved to symptomatic/complicated lymphocele and consist of pelvic drainage with or without instillation of sclerosant agent or open/laparoscopic drainage. The paper from Raheem *et al.*,[3] is an interesting insight into the topic. Authors describe the successful outcome of the laparoscopic drainage of the lymphocele in one patient submitted to robotic radical prostatectomy and propose the procedure as a "standard" in non-infected lymphocele.[3]

However, some points should be kept in mind. As Authors stated infected collection should not be drained laparoscopically due to the high risk of dissemination through peritoneum of bacteria, at least until the infection is cured. The active treatment of a lymphocele which causes deep venous thrombosis should be delayed until the risk of consequent pulmonary embolism becomes reasonable. Last but no the least, lymphocele can relapse after percutaneous drainage which is frequently itself the cause of infection, but also after open drainage, a really difficult procedure which needs a great skill or laparoscopic drainage which is on the other hand really easier and less prone to complications. For all these reasons, I suggest to manage expectantly symptomatic lymphoceles, especially in cases with concomitant infection or deep vein thrombosis and to treat them actively when the conservative solution appears to be not suitable from the beginning or is not successful. In any case, the first active treatment option remains in my opinion the laparoscopic drainage which is an easy minimally invasive procedure with a greater chance of success respect to percutaneous drainage. The last option might be indeed the open drainage, a very difficult, invasive procedure. Some way in the middle I put the percutaneous drainage. In conclusion, beyond personal views on the topic, what we do really need now is a guideline!

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