



**Arab Journal of Urology**  
(Official Journal of the Arab Association of Urology)

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**ONCOLOGY/RECONSTRUCTION**

**EDITORIAL**

**Prostate sparing cystectomy: A procedure with limited indications**

Invasive bladder cancer (BC) is a lethal disease and a significant number of patients present with advanced disease at time of definitive treatment. Radical cystectomy (RC) and pelvic lymphadenectomy remains the gold standard treatment for invasive BC [1–5]. However, the morbidity and the long term consequences associated with RC on the quality of life cannot be denied. Erectile dysfunction and Incontinence mainly at night remains troublesome for many RC patients. Prostate sparing cystectomy (PCS) can decrease the morbidity and improve these functional outcomes with preservation of potency and continence. However, the cost of improving these functional outcomes might be the patient's life.

The oncological concerns preclude the general applicability of PCS. It seems very risky to perform a more conservative or limited procedure to treat invasive BC while the 5 year survival rates after RC is only 50–70% [1]. The incidence of prostate cancer (PCA) and prostatic involvement with urothelial cancer (UC), which is definitely a more dangerous oncological risk, in RC series, is 27–46% and 12–48%, respectively [4,5]. The observed distant failures after PCS are twice as high as RC, and they generally end with death due to cancer [2,4]. It is not clear, whether this is due to tumour spill during prostatectomy or haematogenous spread at time of surgical manipulation of the prostate.

Evaluation of PCS series is very difficult because of the selection bias and lack of standardization. Younger age in PCS series can be one of the factors correlated to better functional outcomes. Inadequate time or regimens of follow up can give a false impression about a comparable oncological outcome to RC. Moreover, there are no standard indications or technique for PCS. The only way to know the final answer about the oncological safety of PCS is to perform a prospective randomized study comparing RC and PCS with long term

oncological outcomes, a study that does not exist, and might not exist later on.

In absence of randomized studies, Abdelrazak et al. tried to explore the outcomes of PCS with the concerns about the oncological safety by studying patients operated upon in two centres at two different countries. They supported their data and findings by data from reviewing the currently available literature. They identified the good functional outcomes associated with PCS but more importantly, confirmed the oncological risk in performing such procedure. Their study convinces us more why we should remove the prostate in RC.

Focusing only on functional outcomes, you can agree that PCS provides better potency and continence (especially nighttime continence) outcomes compared to RC [6–8]. However, urinary retention might develop in PCS patients and they may need intermittent catheterisation [4]. The technique of nerve sparing RC, the availability of oral and injectable therapies, and the recent developments of penile prosthetic devices has decreased the apprehension about impotence following RC. Currently, many patients can be satisfied by their sexual life after RC.

PSC might be offered only in selected patients with strict criteria including a well informed younger patient who cares about functional outcomes including potency and continence more than the risk of dying from cancer. Also the tumour should be organ confined away from bladder neck, not associated with CIS or multifocality and there should be clinical criteria excluding higher risk of harbouring prostate cancer like normal DRE, PSA < 4 ng/ml and/or negative prostatic biopsies [2–4]. Another aspect to be considered is preoperative potency and continence status, especially knowing that many of bladder cancer patients are old age, smokers who might have associated co-morbidities. It would not be appropriate to think in preserving the prostate in patients who already suffer impairment of potency and/or continence.



Patients and physicians will continue to care more about the oncological outcomes than functional outcomes. In 2011, RC remains the gold standard treatment for invasive BC and PCS should be only carefully applied to selected individuals, after careful counseling.

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Available online 9 September 2011