

Editorial Commentary

This paper describes the outcome of photoselective vaporization of the prostate (PVP) in 18 men while on a potent specific anti-platelets medication Clopidogrel. This is a difficult surgical situation, since surgeons and anesthesiologists would usually refrain from performing surgery that involves tissue resection while patients are on drugs that seriously affect their homeostasis. The choice was always towards stopping the medication before embarking on surgery, and this might aggravate the risk of further unwanted vascular thrombotic events such as coronary artery clotting whether stented or not. Prostatectomy, whether transurethral or open is one such operation that is well known to be associated with moderate to severe bleeding especially when the adenoma is congested or large in size. If it is possible to operate on patients while they are on active antiplatelet therapy, then this would be a great advantage, that might be accomplished by using the greenlight laser in performing photoselective prostatectomy, since it posses the ability to vaporize the prostatic obstructive adenoma without the fear of excessive intraoperative bleeding or the risk of post-operative clot retention.

Studying and reporting a series of patients undergoing PVP while on active Clopidogrel treatment require courage and confidence in the technique and in the supportive medical facilities that are available to the surgical team. An early report entitled "Photoselective laser vaporization prostatectomy in men receiving anticoagulants"^[1] reported 24 patients on different anti-coagulants, only two of them were on Clopidogrel. A later more comprehensive multicenter report included 70 anticoagulated patients undergoing greenlight laser PVP, some of them with glands larger than 80 grams thus at a major risk of intraoperative excessive bleeding and postoperative clot retention^[2]. 13 patients only out of those 70 were on Clopidogrel. The rest were either on Acetyl Salicylic Acid (ASA) or Warfarin. ASA is usually used for prophylaxis and is known to be of lesser potency than Clopidogrel. As mentioned in the article, some minimally invasive surgeries other than laser are reported to be performed safely while patients are on ASA. Warfarin can be switched to the better controlled short acting parentally administered Heparin, since a potent antidote is available for immediate administration when required.

Although on a relatively small number of patients on Clopidogrel, yet, this current study adds to the accumulating body of evidence that performing PVP using greenlight laser for those men is safe and effective even for somewhat larger obstructive prostatic adenomas. Another technical point to be mentioned here is to reassure the greenlight laser users that if the transurethral maneuvers were meticulously observed then the operative field will stay bloodless and clear therefore the procedure should continue smoothly and end in a successful result.

I agree with the authors that the ability to continue therapeutic anticoagulation in particular antiplatelets agents is a significant advantage for greenlight laser with its high affinity to hemoglobin over other lasers and certainly over conventional TURP. This is clearly supported by the literature^[3].

In patients who suffer retention of urine secondary to BPH and on Clopidogrel therapy (in this series $n=5$ or 36% of patients), if the hematologist insists on continuing this therapy- say to prevent a coronary artery stent clotting- and neither the surgeon nor the anesthetist agrees to perform a risky surgery, then those patients will likely spent the rest of their lives with an indwelling urinary catheter, a situation that could severely jeopardize the quality of life. Greenlight laser PVP offers a unique solution for this problem. Currently, we receive the majority of those patients as they are referred from other centers who decline to provide surgical management for such patients because they do not have this particular laser facility. In our opinion, greenlight laser PVP may well soon be the only safe surgical choice considered in such situation, therefore the golden standard for high risk patients with bladder outlet obstruction.

Hisham A. Mosli

Department of Urology, King Abdulaziz
University Hospital, Jeddah, Saudi Arabia
E-mail: hmosli@hotmail.com

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