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INVITED COMMENTARY

Prostate Cancer

Extended lymph node dissection for intermediate and high-risk prostate cancer: do we have all the evidence?

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In the article “extended lymph node dissection in robot-assisted radical prostatectomy: lymph node yield and distribution of metastases” published on *Asian Journal of Andrology*, Kim *et al.*¹ present their robot-assisted experience for an extended pelvic lymph node dissection (E-PLND) in the management of intermediate and high-risk prostate cancer patients. The reported lymph node yield and positivity is comparable to literature published in robot-assisted and open approaches for radical prostatectomy.² Increasing reports of a decline in the incidence of lymph node dissection,³ have questioned the adequacy of an E-PLND performed through the robot-assisted approach. Furthermore claims that surgical modality may be a factor in determining the adequacy of a lymph node dissection during prostate cancer surgery have emerged. This manuscript presents a legitimate argument against both claim. In addition, the authors also highlight a high incidence of positive lymph nodes at the internal iliac and common iliac areas highlights that the extent of lymph node dissection is more important than the absolute number of lymph nodes removed during E-PLND. Variations in the extents of an E-PLND template and differences in guidelines for the indications of such dissections may have also been the contributing to the discrepancy in the utilization of an E-PLND. E-PLND offers increased accuracy in detecting occult lymph node metastases when compared to standard lymph node dissections.^{2,4} This is emphasized by the finding of single positive

nodes at the internal iliac area in 20% of the patients studied. Several studies have also reported improved survival following an extended template dissection.^{5,6} Nevertheless applying an extended template of lymphadenectomy is associated with an increased risk of morbidity, namely lymphocele, nerve and vessel injury. However, several reports associate worse potency outcomes following an E-PLND,⁷ these potency outcomes remain underreported.

The manuscript has established that the robotic technique is not a prohibitive factor in performing E-PLND. It is essential to reach a consensus on the extent of a lymphadenectomy covering all primary-landing sites of prostate cancer. Furthermore, there is a need for randomized trials determining which patients would most benefit from an extended lymphadenectomy in high-risk prostate cancer.

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