Editorial
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Robotic Radical Prostatectomy: What Do We Really Know about Its Outcomes?

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Modern medical principles must be supported by strong evidence from high quality studies. Unfortunately, however, the surgical field lacks randomized or observational trials. Thus, great debate concerning robotic-assisted laparoscopic procedures is on-going: much of the debate centers stems from a lack of evidence on the superiority or non-inferiority of robotic techniques versus traditional ones. The authors should be congratulated for their efforts to extrapolate from low-quality studies the pros and cons of robotic-assisted laparoscopic radical prostatectomy.[1] Their methodology and subsequent analysis, as well as their conclusions, were irreprehensible.

Theoretically, there are arguments in support of robotic radical prostatectomy. The paper outlines relative risks that reflect a favorable impact of robotic assistance in the procedure in terms of lower transfusion rates, fewer minor complications (Clavien-Dindo I–II), and shorter hospital stay. Moreover, functional outcomes, namely continence and potency, as well as oncological outcomes, such as surgical margins and biochemical control, seem to be improved. Nevertheless, the authors warn us in their paper of two main flaws that may affect their conclusions: one is the significant heterogeneity found in the meta-analysis for each outcome measured. While this could have originated from differences in the methods used to report data, a selection bias to allocate more favorable cases to the newest surgical technique may also be at play. The other and most important flaw in regards to the outcomes reported is that some series included in the meta analysis show an unusually high rate of incontinence in patient submitted to open radical prostactomy; consequently the comparison between the two techniques is statistically significant in favor of robotic prostatectomy, however this is not a demonstration of superiority but only of a poor surgical skill with the open technique.

The ideal study should comprise a randomized design with all procedures performed by one surgeon who has adequately mastered both techniques, although surgeon and patient preferences may make this almost impossible.

A definitive answer to our question will come probably from time, when robotic procedures will be performed with more devices and improved performance among surgeons far beyond the present standards.

REFERENCE

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