LDR brachytherapy: The Montreal program

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urther to our publication,¹ we wish to inform CUAJ readers that low-dose rate (LDR) brachytherapy is now fully funded in Ontario for intermediate-risk prostate cancer, demonstrating the increasing use of brachytherapy in Canada.

In addition, we would like to acknowledge CHUM-Hôpital Notre-Dame in Montreal's LDR program, established in 2005. The centre has treated over 760 patients with LDR brachytherapy.²⁻⁴ Their HDR program has been running for almost 2 years. We regret that we missed mentioning this large program in our manuscript.

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Looking over your work: TIP urethroplasty

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ven though learning hypospadias repair is a key objective of pediatric urology fellowship training, our specialty has no standards for determining whether this surgery is effectively taught or learned. Even though hypospadias repair helps define our specialty, few pediatric urologists know their own outcomes.

There are 4 reports relating to outcomes by surgeons within their initial years in practice after fellowship. Two articles,^{1,2} including one by Rompre and colleagues, found that complications decreased after about 50 to 90 cases.¹ This was attributed to a learning curve; according to the authors, there is a need for a high volume of surgeries to gain and maintain expertise. However, the other 2 reports^{3,4} found no learning curve and instead concluded that fellowship training successfully imparted the knowledge and skills needed to achieve good results from the beginning of independent practice. Ours is the only study directly comparing outcomes of former fellows to their mentors, finding no differences after distal repairs.⁴

Both Rompre and colleagues¹ and Horowitz and Salzhauer² state that the technical modifications learned in practice decreased complications. These included not incising too far distally during the tubularized incised plate (TIP) procedure and using a barrier flap over the neourethra, which most surgeon educators would likely agree should have been taught and learned during fellowship.

The conclusions reached by Rompre and colleagues and the accompanying editorial comment by Koyle⁵ might stimulate further reflection regarding quality in hypospadias surgery. Is there a minimum volume of cases needed to achieve and then maintain proficiency? If so, what are those numbers for distal and proximal repairs? The Board of Urology recently published self-reported case log volumes from pediatric urologists applying for the certificate of special qualification, finding the median number of distal repairs a year was 12, while the median of proximal repairs was only 2!⁶ Our data do not show a learning curve for distal TIP, analyzing the first 50 cases versus those subsequently.³ However, we did publish outcomes for proximal TIP showing a significant reduction in complications following technical modifications made when periodic reviews showed need to improve the operation.⁴

These observations support several conclusions. First, reconstructive surgeons need to know their own results. Resistance to change largely derives from confidence that outcomes are good, but, as Koyle points out, memory is never as reliable as data! Simply recording complications into a spreadsheet when they are diagnosed makes it easy for individual surgeons to determine when there is need for technical improvements. Second, the algorithm for hypospadias repair should emphasize few techniques so that surgeons can master their nuances. For example, we repair all cases using either TIP, inlay, or 2-stage grafts. Third, the small number of proximal cases and their high complication rates strongly argue for subspecialization – with each major centre designating a single surgeon to do these operations. Finally, surgeon educators should compare outcomes of their recent graduates to their own to be certain their teaching is effective.

It is not enough to simply do a lot of cases over time and expect results to improve. Rather, it is necessary for individual surgeons to do a quality assessment of their practice to be certain that the 10 000 hours Koyle refers to are being spent performing the task optimally!

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Robot-assisted partial nephrectomy: Excellent results even in more complex renal tumours

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obot-assisted partial nephrectomy (RAPN) has been recently developed and proposed as the natural evolution and simplification of the laparoscopic approach.¹ The advantages offered by the daVinci (Intuitive Surgical, Inc.) platform can help surgeons to perform a precise tumour excision with an adequate margin of resection, simplifying the reconstruction steps of the procedure, above all in the treatment of complex or large renal tumours.^{2,3} The most important advantage is a reduction of the hilar clamping time,^{4,5} which minimizes renal function impairment, since the warm ischemia time (WIT) is the most important parameter that affects renal function after surgery.⁶ Ploussard and colleagues recently reported an interesting single-institution Canadian experience of 65 consecutive RAPNs performed between 2011 and 2013 by 2 surgeons with prior experience in robot-assisted radical prostatectomy or pure laparoscopic partial nephrectomy.⁷ The mean tumour size was 3.9 cm and, remarkably, 47.7% of those masses were >4 cm in maximum diameter. The tumour complexity was evaluated by the R.E.N.A.L. nephrometry score.⁸ The median R.E.N.A.L. score of the cohort of patients was 8 (interguartile range: 4-11), thus reflecting an intermediate-high surgical complexity. The median WIT, operative time and blood loss were 23.4 minutes, 183 minutes and 150 mL, respectively. Postoperative complications were observed in 16 (24.6%) patients, half of which were major according to the Clavien-Dindo classification. Positive surgical margins were observed in 5 cases (7.7%), and minor impairment of the estimated glomerular filtration rate (eGFR) was observed in the postoperative period. These perioperative outcomes are remarkable, and comparable to those currently reported.^{2,9}