## LDR brachytherapy: The Montreal program

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urther to our publication,<sup>1</sup> 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.<sup>2-4</sup> Their HDR program has been running for almost 2 years. We regret that we missed mentioning this large program in our manuscript.

Competing interests: Dr. Keyes declares no competing financial or personal interests.

## References

- Keyes M, Crook J, Morris WJ, et al. Canadian prostate brachytherapy in 2012. Can Urol Assoc J 2013;7:51-8. http://dx.doi.org/10.5489/cuaj.218
- Taussky D, Yeung I, Willaims T, et al. Rectal-wall dose dependence on postplan timing after permanentseed prostate brachyhterapy. Int J Radiation Oncology Biol Phys 2006;65:358-63. http://dx.doi. org/10.1016/j.ijrobp.2005.12.024
- Delouya G, Taussky D, Ji CR, et al. Relationship between prostate-specific antigen bounce body fat distribution and body mass index in permanent seed brachytherapy for prostate cancer. *Brachytherapy* 2012;11:214-8. http://dx.doi.org/10.1016/j.brachy.2011.05.009
- Zilli T, Taussky D, Donath D, et al. Urethra-sparing, intraoperative, real-time planned, permanent-seed prostate brachytherapy: Toxicity analysis. *Int J Radiat Oncol Biol Phys* 2011;81:e377-83. http://dx.doi. org/10.1016/j.ijrobp.2011.02.037

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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,<sup>1,2</sup> including one by Rompre and colleagues, found that complications decreased after about 50 to 90 cases.<sup>1</sup> 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<sup>3,4</sup> 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.<sup>4</sup>

Both Rompre and colleagues<sup>1</sup> and Horowitz and Salzhauer<sup>2</sup> 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 Koyle<sup>5</sup> 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!<sup>6</sup>