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One of the major roles of *CUAJ* is the publication and promulgation of national and regional guidelines. The field of guideline development has evolved. The pendulum has shifted at least twice during my career. Prior to the era of evidence-based medicine (EBM), expert opinion ruled. This has been termed the “tyranny of authority.” In response to legitimate criticism of the limitations of expert opinion, EBM developed based on a hierarchy of levels of evidence. There were many benefits to this concept, and many treatment approaches did not survive as a result. However, EBM was sometimes advocated in a formulaic and dogmatic way and became the “tyranny of methodology.” This particularly disadvantaged specialties like urology, where level 1 and 2 evidence has not been available for most of what we do. Evidence-based medicine has also diminished the value of experience and clinical judgment.

There is now a widening view that clinical practice should be informed by the evidence, but not enslaved by it. Many factors, including the patient’s health, resource availability and individual patient preferences and values, may result in a clinical approach that differs from the strict evidence-based algorithm. Further, results of clinical trials may also be interpreted in more than one way. Treatment decisions must be accountable to the best evidence, but this should be leavened by clinical judgment.

The guideline by Chin and colleagues addresses a number of aspects related to assessing outcome of radical prostatectomy. Laudably, it is a collaboration between urologists, pathologists and methodologists. This combined approach supports the increasing tendency towards documenting and publicizing measurable outcomes of surgery based on pathologic reporting. We know much now about the relationship between volume, training and quality outcome for radical prostatectomy. Developing yardsticks to measure these outcomes is important.

A critique of the guideline-based approach is whether the significant time and resources required and the sophisticated and rigorous methodology used actually make a difference to the ultimate guideline and to clinical practice. Many of the recommendations in this guideline are consistent with widely accepted clinical practice. Others appear to reflect the wording of the question posed to the panelists.

However, the guideline is a very good step towards a more objective and quantifiable measure of quality outcome in radical prostatectomy. I have no doubt that it will be used by hospitals and provincial ministries of health as they move to demanding greater accountability with respect to surgical outcomes.

The paper by Touma and colleagues questions the longstanding practice of ureteral frozen sections on men undergoing cystectomy. I have long wondered about the value of this practice, given the benign natural history of coexistent carcinoma in situ in the ureter. The results offered by these authors support a more restrictive use of frozen section analysis.

The paper by Preston and colleagues addresses the ongoing problem of the acquisition of minimally invasive surgical skills by residents during a period when the consultant surgeons are transitioning to minimally invasive surgery (MIS) and also involved in skill acquisition. Compounding the problem is the longer learning curve for some MIS operations. The paper raises many questions. Should residents expect to master laparoscopic surgery during their training? Should operations be triaged, so that residents’ surgical experience is tailored to their ultimate career path? We are only beginning to ask these questions and it will take a generation to answer them. The Preston paper is a nice contribution to this discussion.

This issue also contains a summary of transobturator tape experience for stress urinary incontinence from the King Faisal Hospital in Saudi Arabia. We welcome these international contributions.