

Surgeon gestalt and continence recovery after RARP: Interpreting intraoperative difficulty

Re: Does intraoperative difficulty at time of robotic-assisted radical prostatectomy predict urinary continence recovery?

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Rajih et al recently investigated whether surgeon-perceived intraoperative difficulty predicts urinary continence recovery after robot-assisted radical prostatectomy (RARP).¹ The authors found that intermediate- and high-difficulty cases were associated with delayed continence recovery, suggesting that the surgeon's intraoperative impression may carry prognostic value. The authors address a clinically relevant question: while oncologic control remains the primary objective of radical prostatectomy, urinary continence, alongside sexual function, is a key functional endpoint with major implications for quality of life, counseling, and patient satisfaction. Identifying an intraoperative signal that may anticipate continence recovery is, therefore, meaningful.

The central question is not whether surgeon-perceived difficulty is associated with continence recovery, but what this variable truly represents. A global difficulty score is unlikely to reflect a single operative feature. More plausibly, it captures the surgeon's integrated assessment of operative conditions relevant to continence recovery, including pelvic depth and exposure, tissue quality, apical dissection, bleeding that may obscure surgical planes, preservation of urethral length, and vesicourethral anastomotic quality. In this sense, surgeon-perceived difficulty may represent a clinically meaningful, but non-standardized, summary of intraoperative conditions that influence functional recovery. This interpretation is consistent with recent evidence that surgeon gestalt can predict adverse postoperative outcomes, particularly when combined with structured risk assessment.²

If perceived difficulty partly reflects the quality of apical exposure, preservation of urethral length, and dissection around the membranous urethra, then its relationship with continence recovery is biologically plausible; however, several elements within this construct overlap with established measurable predictors. Membranous urethral length, for example, is strongly associated with continence recovery after RARP.³ Thus, perceived difficulty should probably be viewed not as a replacement for objective anatomical predictors, but as a complementary intraoperative signal that may summarize unmeasured technical complexity.

The practical challenge, therefore, is how to move from impression to measurement. Experience from other surgical fields is informative. In robotic hepatectomy, operative difficulty has recently been formalized through the Tampa Difficulty Score, which uses predefined variables to estimate procedural complexity.⁴ Although not directly transferable to RARP, this example shows how surgical difficulty can be formalized. A similar framework could clarify whether perceived difficulty adds prognostic value beyond established clinical, anatomical, and operative variables.

Overall, Rajih et al highlight an important and underexplored concept: intraoperative surgical judgment may contain prognostic information. Yet, the broader implication of these findings may be that surgeon-perceived difficulty functions primarily as a surrogate for multiple measurable anatomical and technical variables that have not been fully captured. While subjective assessment may demonstrate predictive value, reliance on a global impression risks transforming complex operative determinants into a "black box" variable that is difficult to standardize, interpret, or act upon clinically.

The more consequential next step is not simply validating surgeon gestalt as a predictor, but systematically dissecting the specific operative components underlying this perception. Such an approach may yield more reproducible and clinically actionable insights into continence recovery after RARP, while

also identifying technical factors that could potentially be modified in real time to improve functional outcomes.

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