National Institute for Health and Clinical Excellence

39a – Laparoscopic radical prostatectomy (review)

Comments table

IPAC date: 15 September 2006

Consultee name and organisation	Section no.	Comment no.	Comments	Response Please respond to all comments
Individual respondent - clinician	1 – Provisional Recommendations	1	I am a member of the BAUS Section of Oncology and the Section of Endourology and am not aware that BAUS has produced training standards yet.	BAUS have informed the IP Programme that training standards will be considered at the BAUS Council in October 2006
Prostate Cancer Network	1 – Provisional Recommendations	2	The text in the opening box above is confusing. Standard LRP is performed ""manually"" by a single surgeon. Robotic RP is newer, performed, I understand, by a surgeon from a remote console (Da Vinci robot), giving instructions to a full operating team. Although the techniques are similar, the basic difference should be explained.	The “lay box” does not form part of the guidance
Continence foundation	1 – Provisional Recommendations	3	We agree with the recommendations but would suggest adding a requirement for audit of results e.g. via a database held by BAUS	Guidance requiring “normal arrangements” for audit do not stipulate audit requirements

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BUPA	1 – Provisional Recommendations	4	BUPA agrees - might 1.3 be picked apart to emphasise that training is different for laparoscopic and robotically assisted laparoscopic radical prostatectomy?	BAUS training standards do not include training for robotic application
Individual respondent - clinician	2.1 – Indications	5	High-intensity focused ultrasound therapy.	Section 2.1.2 amended to read: “high-intensity focused…”
Prostate Cancer Network	2.1 – Indications	6	2.1.2 PCaSO differentiates between ""watchful waiting"" (i.e. not curative, but palliative) and ""active surveillance"" (i.e. regular pro-active monitoring leading to radical curative treatment where indicated), as undertaken at Royal Marsden Hospital. HIFU stands for ""High-Intensity Focused Ultrasound"", not ""high impact frequency ultrasound"", a treatment we have not come across. This may be a misprint.	Section 2.1.2 amended to read: “high-intensity focused…”

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Individual respondent - clinician	2.2 – Outline of the Procedure	7	There is no evidence that "Robotically assisted laparoscopic prostatectomy....may allow greater precision in the manipulation of instruments used for the resection". This statement should be omitted and be replaced with "Robotically assisted laparoscopic prostatectomy is a development of this procedure but it is not yet clear what advantage the addition of the robotic assistance has over conventional laparoscopy."	Section 2.2 amended to read: "Robotically assisted laparoscopic prostatectomy is a development of this procedure but it is not yet possible to ascertain whether there is any advantage to robotic assistance over conventional laparoscopy."
Prostate Cancer Network	2.2 – Outline of the Procedure	8	Lymph nodes need not necessarily be removed, as far as I understand, though this is common. There is no mention of low blood loss (mine was just 100ml, though 200ml is more normal - considerably less that for open prostatectomy; nor mention of quick recovery time (3 weeks) and relatively pain-free post operation.	Outcomes presented are those that are reported in the published studies
Individual respondent - clinician	2.2 – Outline of the Procedure	9	The sentence regarding ""may allow greater precision"" is based on conjecture and if guidance is based on facts should be excluded	Noted, thank you.
Individual respondent - clinician	2.3 – Efficacy	10	In 2.3.3 I feel that in the light of the evidence the word ""may"" has no place in this recommendation	Noted, thank you.

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BUPA	2.3 - Efficacy	11	The clear statement in 2.3.1 that (given the quality of the evidence available) the outcomes of all the forms of radical prostatectomy are the same is a useful summary of the situation.	Consultee agrees with guidance – thank you.
Individual respondent - clinician	2.4 – Safety	12	The potency figures in the robotic literature are widely disbelieved and should not be quoted. For instance, the Detroit group have recently updated their potency rates from 97% to 100%, which is as comical to urologists as it is misleading to members of the public. You should comment on the economics of robotic radical prostatectomy.	Outcomes presented are those that are reported in the published studies. Economic assessment is not within the remit of the IP programme.
Prostate Cancer Network	2.4 – Safety	13	Results from surgeons who perform a high number of LRPs annually appear to have been good, and those of our members who have recently had standard LRPs at Basingstoke appear to have been well satisfied with the outcome. Few have had any significant continence problems. (I personally was totally continent immediately post-op.)	Consultee agrees with guidance – thank you.

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Individual respondent - clinician	2.4 – Safety	14	1.There is universally reported in every paper on laparoscopic radical prostatectomies a lower blood loss and transfusion rate than contemporary series of open radicals. To state that there is an additional risk of haemorrhage is not only untrue but in fact the opposite applies. 2.Bowel damage is a theoretical problem with transperitoneal not extraperitoneal.	Section 2.4.3. is a summary of specialist advisors opinion which includes theoretical risks. New section 2.4.1 added: “The procedure was considered as a generic procedure, and no distinction is made between different approaches.”