



EDITORIAL

The pursuit of excellence

Editorial comment to Godtman RA, et al. Surgeon volume and patient-reported urinary incontinence after radical prostatectomy. Population-based register study in Sweden. *Scand J Urol*. Sep 2022

It is a stark truth that urinary incontinence remains a common and devastating side-effect that affects the long-term quality of life of people undergoing radical prostatectomy. Even in the contemporary robotic era at 12 months, using a definition of no pad, urinary incontinence ranges from 4% to 31% [1]. Independently administered patient-reported outcome measures (PROMs) enable the measurement of the individual patient perceived impact of prostate cancer surgery whilst minimising the risk of selection and reporting bias. Used wisely PROMs are holistic tools which are capable of driving patient centred improvements in care.

In this issue of the *Scand J Urol*, Godtman et al. report the urinary incontinence outcomes of men undergoing Robotic-Assisted Radical Prostatectomy (RARP) in Sweden using independently administered electronic PROMS (ePROMs) from the National Prostate Cancer Register (NPCR) of Sweden [2]. Of those sent ePROMs 56% (4668/8326) undergoing RARP responded, and 14% (659/4668) responded to the question – How much leakage do you experience? – with the response ‘moderately’/‘much’/‘very much’ and were considered incontinent at 1 year after RARP. In addition, the authors demonstrated in their studied population that no surgeon volume-outcome association existed for incontinence. There were high volume surgeons with high incontinence rates and vice versa. There was variation in the incontinence rates using amongst surgeons performing the same number of operations.

Some might consider that only around one eighth of the population completed a baseline questionnaire and that the questionnaire used in the ePROM was not validated weaknesses. But acknowledging the analysis limitations of neither being able to account for the effect of surgeon learning curve nor specific relevant co-morbidity such as Body Mass Index; the present work needs to be understood in context.

This is a unique study as it describes outcomes from ePROMS administered at a national population level and this represents a major achievement for which the NPCR should be commended. The methodology of administration is briefly described and whilst not the subject of this study; the detail of this and its effects on response rates and impacts on inclusivity would be of interest to the wider readership in the future. The benefit of ePROMs as a tool for improving quality of care is obvious and ePROMs offer a potentially faster method of feedback to individual surgeons.

Godtman et al.’s findings concur with other large scale registry studies performed using validated paper-based PROMs. The National Prostate Cancer Audit (NPCA) recently

examined hospital radical prostatectomy volume outcome relationships in England. The NPCA demonstrated that when increasing hospital RARP volume was modelled as a linear function there was a non-significant increase in urinary continence and a non-clinically significant increase in sexual function for a 100-procedure increase in hospital volume [3].

All surgeons aspire to achieve excellent outcomes for their patients; including the pentefecta of: continence, potency, biochemical recurrence free survival, no post-operative complications and negative surgical margins [4] where appropriate. The NPCR has already provided a lot of data benchmarking Swedish practice (PMID: 31355454). The NPCR has previously reported that higher volume surgeons statistically more often applied a nerve sparing technique [5], interestingly in the present study multivariable analysis found no nerve sparing intent was associated with incontinence [2]. The NPCR has also shown that higher volume surgeons had a higher proportion of negative surgical margins but there was a range in outcomes within surgeons performing similar volumes [5]. No association has been identified in the NPCR between readmission rates and surgeon volume [5]. Examination of routinely collected national administrative Hospital Episode Statistics (HES) data in England similarly found that although there was evidence of a volume-outcome relationship for readmission and length of stay after RARP in England, statistically the effect size was modest [6].

So what does this information mean for us as surgeons and more importantly for our patients?

Putting patients first: whilst the present paper concentrates on the surgeon volume – incontinence outcome association it must not be forgotten that even accepting that perceptions of urinary leakage can be subjective 14% (672/4668) of patients responded that they experienced moderate to very much urinary leakage at 1 year after surgery. It essential that this information gained through the systematic collection of ePROMs is used to guide patient centred care provision nationally and ensure that patients completing the questionnaire and reporting these outcomes have been adequately supported, educated about their options and where appropriate facilitated to access specialist continence services. Furthermore it should be acknowledged that from the counselling of patients pre-operatively, to the recognition and management of complications if and when things go wrong, robotic radical prostatectomy is a team game. The impact of the multidisciplinary team who contribute to supporting patients holistically through their prostate cancer

journey may never be objectively measurable but should never be forgotten in any service provision.

For surgeons though: the overwhelming message is clear, the focus on surgical volume in radical prostatectomy surgery is a distraction and must urgently be redirected to quality. With respect to incontinence, the presented data shows that whilst there are high volume surgeons who are achieving excellent outcomes there are many that the data reflect could improve. With the present data in hand Swedish surgeons have a choice and information to inform their own pursuit of excellence.

Pat Riley former National Basketball Association player and coach aptly described 'Excellence is the gradual result of always striving to do better'. In elite sport today, performance data analysis is commonplace and provides real time evidence to feedback to athletes to help them understand exactly what they have done to be successful and where they have been unsuccessful to inform them where they can improve or make the right decision at the right time to deliver more consistent performance. Although in a few radical prostatectomy exemplar centres quality assurance of performance data analysis is performed and has been evidenced to improve practice [7] unfortunately this is not the case everywhere. The NPCR with the embedding of ePROMS is at the forefront of investigation of population-based surgery outcomes and has provided the strongest of foundations for quality improvement. If Swedish surgeons and the NPCR can now establish a process and culture to learn from surgeons evidenced to perform radical prostatectomy well that would be progress. If through doing this a national improvement in outcomes and a reduction in variation measured by the NPCR was achieved this would represent an unparalleled step change in surgical care from which the world could learn. Godtman et al. and colleagues at the NPCR have thrown down the gauntlet.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Received 12 October 2022; Accepted 13 October 2022

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