



## NEWS AND VIEWS

# Is Scandinavia ready for Aquablation? Reflections on the WATER III Trial

Patrick Juliebø-Jones, Jill-Randi Harneshaug and Stephen Baug

Department of Urology, Haralds plass Deaconess Hospital, Bergen, Norway

## Manuscript

Ten years after the first-in-human study, Aquablation has reached another stage in its development. Previous randomised trials established its role against Transurethral resection of prostate (TURP). WATER III asks a different question: how does Aquablation compare with enucleation, the guideline-recommended endoscopic approach for large prostates? [1].

This is an important question in Scandinavia, where treatment options for very large prostates are largely limited to endoscopic enucleation, robot-assisted simple prostatectomy, and, in selected patients, prostatic artery embolisation [2, 3]. WATER III therefore addresses a genuine evidence gap.

Aquablation combines real-time ultrasound imaging with robotically controlled waterjet resection. Unlike laser enucleation, tissue resection is automated once the surgeon has mapped the treatment plan. Yet uptake in Scandinavia has been relatively slow compared with North America. Is this simply because evidence in large prostates has been limited or are implementation and health-system factors equally important?

WATER III included 202 men with prostates between 80 and 180 mL. Symptom improvement was similar after Aquablation and laser enucleation, with no difference in major complications. Aquablation preserved ejaculation more often, and no patient had stress urinary incontinence at 3 months. Laser enucleation produced greater improvement in urinary flow and removed substantially more tissue.

Does this change practice? Probably not yet. Laser enucleation is supported by mature long-term evidence, with established durability and low retreatment rates. Comparable evidence for Aquablation in very large prostates is not yet available. The planned 5-year follow-up of WATER III will therefore be important in determining whether these encouraging early functional outcomes are accompanied by durable symptom relief and low retreatment rates.

The 3-month comparison also requires caution. Continence after enucleation may continue to improve beyond this period. In our practice, continence is routinely assessed at 6 months for this same reason. Moreover, recruitment during the COVID-19 pandemic meant that not all patients underwent randomisation, resulting in a hybrid randomised and non-randomised design, with both cohorts incorporated into the Bayesian analysis.

## ARTICLE HISTORY

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The trial was powered to demonstrate non-inferiority for International Prostate Symptom Score (IPSS) rather than for continence or sexual function. These limitations do not invalidate the findings, but they constrain how confidently the functional differences should influence current practice.

One finding is particularly interesting. Laser enucleation removed substantially more tissue, yet symptom improvement was similar. For decades, Benign prostate hyperplasia (BPH) surgery has been judged by technical metrics [4]. How much tissue was removed? How much did urinary flow improve? What was the retreatment rate? Those measures remain important.

But are they enough? Patients rarely ask how many grams were removed. Instead, they are focused on what they will *keep*: continence and ejaculation. Perhaps the next step is not to stop measuring what surgery removes, but to place equal emphasis on what patients keep.

Randomised trials, however, tell us whether treatments work under study conditions; they do not necessarily tell us whether healthcare systems can deliver them. Aquablation requires investment. There is the capital cost of the platform, ongoing disposable costs and, in many publicly funded healthcare systems, no established reimbursement tariff for a new procedure. Cautery may also be required at the end of the procedure, meaning that TURP equipment may need to be available on standby. Hospitals introducing Aquablation may therefore need to absorb those additional costs within existing budgets. These behind-the-scenes health-economic implications should not be overlooked [5].

Laser enucleation also requires investment, although of a slightly different kind. The investment is in training. The learning curve is well recognised, and maintaining expertise requires sufficient case volume. Despite the merits of enucleation being clearly outlined in guidelines, uptake in countries such as Norway is low.

If Aquablation can deliver reproducible outcomes with a shorter learning curve, the conversation changes. The relevant

question becomes whether it could allow more patients with large prostates to receive effective surgical treatment closer to home. Such system-level benefits are difficult to capture in efficacy trials but are highly relevant in geographically dispersed healthcare systems [5].

Only time will tell whether this potential is realised. However, one important lesson from WATER III is that, while we have traditionally measured surgical success by what is removed, the future may instead be defined by what our patients are able to preserve.

### Conflicts of interest

Nil

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Nil

### Disclosure statement

Nil

### Ethical approval

Not applicable

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