

PENINSULA UROLOGY CENTER, INC NEWSLETTER

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A NOTE FROM DRs. THREATT AND BRUNO

Welcome back to our monthly newsletter. This issue will address recent advances in the surgical treatment of prostate cancer with respect to the daVinci laparoscopic assisted robotic prostatectomy, with next month's issue focusing on recent advances in diagnostic modalities for prostate cancer—Namely the "buzz" regarding EPCA-2 (prostate cancer antigen-2). Preliminary data from Johns Hopkins researchers has suggested that EPCA-2 may supplant PSA in routine prostate cancer diagnosis if further studies prove to be consistent with seminal research. We are gladly available for routine questions regarding urologic issues as well as more in depth queries regarding interesting cases or diagnostic dilemmas.

EDUCATION CORNER

Historically prostate cancer has been the most common male solid organ malignancy and the second most common cause of cancer related death in men. With a 1 in 6 lifetime risk of developing prostate cancer, this malignancy continues to be a significant health issue for American men. Although we have been unable to eradicate prostate cancer, there have been a number of recent advances in the treatment of this disorder. One of the most promising recent surgical advances in the treatment of organ confined prostate cancer has been the daVinci robotic assisted laparoscopic prostatectomy (dVp).

For decades, the open radical prostatectomy has been the mainstay of curative intent therapy for organ confined prostate cancer. Unfortunately a number of theoretical risks/side effects such as impotence, incontinence and post operative pain have been a significant concern for patients undergoing this procedure. The dVp was popularized in 2000 as an attempt to improve upon the benefits of open radical prostatectomy such as favorable cancer control, as well as attempting to mitigate some of the side effects of the open prostatectomy such as blood loss, hospitalization time, post operative narcotic

usage, incontinence and impotence. Although initial enthusiasm for the dVp was lacking, a number of recent peer review articles as well as patient testimonials have suggested that the dVp offers equivalent to superior cancer control compared to the traditional open radical prostatectomy, while lessening blood loss, narcotic usage, hospitalization time, incontinence and impotence rates. Currently the dVp accounts for 50+% of radical prostatectomies performed annually. Unfortunately there is a significant learning curve associated with mastering the dVp, with these procedures almost uniformly being offered at large medical centers primarily related to the cost associated with purchasing the daVinci robot (1.5M USD) as well as the need for a dedicated robotic team in order to offer consistent and competitive results.

Technically, the daVinci robot offers a number of inherent advantages over traditional laparoscopy including a marked improvement upon mechanical advantage and maneuverability, elimination of any tremor, increased visualization secondary to image magnification, three dimensional visualization (traditional laparoscopy is two dimensional), decreased operating room time usage (depending on the procedure being performed), and a significantly shorter learning curve.

Appropriate patients for dVp are those whom are candidates for the open prostatectomy and primarily centers around patients with organ confined disease. Occasionally patients with extra-capsular extension yet clinically localized disease are candidates for radical prostatectomy. Whereas operating on the obese patient can often times be a technically challenging case when performed in an open fashion, in many instances these cases can be technically easier in the obese patient if the robot is used. Patients that have had a number of prior abdominal surgeries or those patients whom are not good candidates for laparoscopy are generally not ideal candidates for the dVp. The dVp team typically

includes a surgeon that operates the robot using a virtual screen and instruments (called the console), as well as a patient side surgical assistant, a surgical technician, a circulating nurse, and an anesthesiologist.

The procedure typically takes 2-3 hours (depending on the complexity) with a well-seasoned team. Typical hospitalization times are 1-2 days with patients routinely being admitted on the day of surgery. Upon discharge, the patient typically will wear a foley catheter that is routinely removed one week after surgery. The procedure is usually performed through 5-6 laparoscopic ports.

Figure 1. Typical dVp laparoscopic port placement sites.

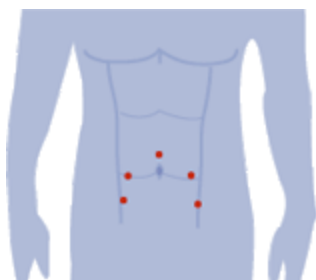


Figure 2. dVp console (background) with the patient side assistant (foreground).



As with any relatively new surgical procedure, the obvious question is quality control and outcomes analysis of the various prostatectomy series. Most experts agree that it takes a significant number of procedures completed to become proficient, but there is no consensus on the exact number needed. Furthermore there are many different levels of proficiency to be attained, and the best results are seen only after hundreds of cases performed. Normalizing for variations in regional trends, patient costs are similar to those of traditional open surgery and patient risks are consistent with those of generalized laparoscopy.

With the addition of Dr. Dieter Bruno to the Peninsula Urology staff comes expertise in dVp as well as other urologic robotic applications. Dr. Bruno was credited with performing the first robotic nephrectomy and second robotic prostatectomy in the state of North Carolina. He has over five years of experience in robotic surgery and is currently a national proctor for Intuitive Surgical. Dr. Bruno in conjunction with Intuitive Surgical Corporation is proud to offer referring physician and patient education seminars regarding the urologic application of robotic techniques in hopes of furthering patient education and expanding patient choices with respect to prostate cancer management options.

CENTER FOR CONTINENCE

Our Center for Continence in conjunction with Dr. Bruno will be offering Interstim treatment for overactive bladder not responding to treatment and for non-obstructive urinary retention.

EMERGING TREATMENTS

Our office is currently enrolling patients in several clinical trials. One trial involves a one-time injection of medicine directly into the transitional zone of the prostate for BPH. We also are enrolling patients in an OAB study as well as an OAB study with LUTS associated with BOO. If you have any patients you think would be good candidates have them call Linda at 650-306-0750.

UPCOMING TOPICS

1. Advances in prostate cancer diagnosis -EPCA-2
2. Advances in female urologic surgical techniques
3. Erectile Dysfunction
4. Kidney Stones
5. Incontinence
6. Hematuria
7. Renal, Bladder, Prostate, Testicular Cancer
8. Male Menopause
9. Interstitial Cystitis
10. Treatment Advances for UPJ Obstruction
11. Recurrent UTI's
12. Infertility