

harms following surgery or radiation), but rather in the interest of full disclosure and true informed decision making. Finally, this study should force us to revisit new methods of anesthesia and ways of minimizing infection around prostate biopsy.

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## Re: Use of Complementary and Alternative Medicine Among Men with Prostate Cancer in a Rural Setting

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*J Community Health* 2011; **36**: 1004–1010.

The purpose of this study was to examine the prevalence and predictors of complementary and alternative medicine (CAM) use among rural patients with localized prostate cancer. The study also examined the participants' disclosure of CAM use to their physicians. Baseline and 6-month follow-up data were taken from a study examining the factors that influence treatment choice and quality of life among men diagnosed with and being treated for localized prostate cancer residing in rural southwest Georgia (N = 321). A total of 291 participants were interviewed at baseline and 6-month follow-up. Findings: At baseline, 26.4% reported ever using CAM. Among them, dietary supplements were the most commonly used (75%), and 56% of patients did not disclose their CAM use to their physicians. At 6-month follow-up, 11% of the study sample reported using CAM since starting treatment (half of these were new users). The proportions of CAM users who reported taking dietary supplements after treatment were significantly lower than the corresponding proportions before treatment. CAM use after treatment was more common among those who selected surgery and watchful waiting. While 44% of the sample disclosed using CAM to their doctors before treatment, 61% after treatment began ( $P = 0.05$ ). We found that CAM use after cancer treatment in this population was markedly less common than in nationally reported data for cancer patients. In line with national patterns, younger and more educated rural patients were significantly more likely to have ever used CAM and to use it after treatment.

**Editorial Comment:** Like many of you, my patients with prostate cancer seem to take an inordinate amount of natural remedies and dietary supplements as adjuvant therapy. Of course, my clinical practice has always been in urban settings. This study underscores that men diagnosed with prostate cancer in more rural areas react quite differently to their diagnosis. This difference appears to be related to age at diagnosis and education level as well. This finding underscores the fact that each prostate cancer survivor is an individual and that we cannot use a one-size-fits-all approach to treatment or followup in this disease.

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## Re: Trends in Radical Prostatectomy: Centralization, Robotics, and Access to Urologic Cancer Care

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*Cancer* 2012; **118**: 54–62.

Background: Robotic surgery has been widely adopted for radical prostatectomy. We hypothesized that this change is rapidly shifting procedures away from hospitals that do not offer robotics and consequently increasing patient travel. Methods: A population-based observational study of all prostatectomies for cancer in New York, New Jersey, and Pennsylvania from 2000 to 2009 was performed using hospital discharge data. Hospital procedure volume was defined as the number of prostatectomies performed for cancer in a given year. Straight-line travel distance to the treating hospital was calculated for each case. Hospitals were contacted to determine the year of acquisition

of the first robot. Results: From 2000 to 2009, the total number of prostatectomies performed annually increased substantially. The increase occurred almost entirely at the very high-volume centers ( $\geq 106$  prostatectomies/year). The number of hospitals performing prostatectomy fell 37% from 2000 to 2009. By 2009, the 9% (21/244) of hospitals that had very high volume performed 57% of all prostatectomies, and the 35% (86/244) of hospitals with a robot performed 85% of all prostatectomies. The median travel distance increased 54% from 2000 to 2009 ( $P < .001$ ). The proportion of patients traveling  $\geq 15$  miles increased from 24% to 40% ( $P < .001$ ). Conclusions: Over the past decade, the number of radical prostatectomies performed has risen substantially. These procedures have been increasingly centralized at high-volume centers, leading to longer patient travel distances. Few prostatectomies are now performed at hospitals that do not offer robotic surgery.

**Editorial Comment:** This article clearly shows that the regionalization of radical prostatectomy to high volume centers has been driven by robotic technologies, and that patients are willing to travel longer distances to have their procedures done at these hospitals. This finding does not strike me as a bad thing. Numerous studies have shown that there is a volume-outcome relationship in prostate cancer surgery. Of course, the bigger question is whether it is worth it, given the cost to hospitals to acquire the robots and the learning curve that the surgeons have to go through while they are becoming adept at robotic prostatectomy. This question remains unanswered.

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## Laparoscopy/New Technology

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### Re: Natural Orifice Transluminal Endoscopic Radical Prostatectomy: Initial Perioperative and Pathologic Results

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*Urology 2011; 78: 1211–1217.*

**Objective:** To describe the first clinical experience, pathologic, and perioperative outcomes of natural orifice transluminal endoscopic surgery (NOTES) radical prostatectomy. NOTES represents the evolution of minimally invasive surgery. The conceptual feasibility has been shown in careful laboratory and animal studies, but a scarcity of information regarding clinical applications exists. **Methods:** After institutional review board approval, 2 patients agreed to undergo NOTES radical prostatectomy for localized prostate cancer. The prostate was radically resected using a 26F resectoscope, 550- $\mu$ m laser fiber, and holmium laser. The prostate was delivered into the bladder and removed at the conclusion of the procedure through a suprapubic cystotomy for histopathologic analysis. The vesicourethral anastomosis was completed using a cannula scope, urethral-vesical suturing device, and titanium knot applier. Cystograms were taken immediately postoperatively and at catheter removal. **Results:** Both patients tolerated the procedure without operative complications. All intraoperative cystograms showed watertight anastomoses. The pathologic examination revealed Gleason score 3 + 3 and Stage pT2aNxMx for 1 patient and Gleason score 3 + 4 and Stage pT2cNxMx for 1 patient, with negative margins for both. No blood transfusions were required. Patient 2 experienced some left-sided gluteal and suprapubic pain postoperatively. **Conclusion:** NOTES radical prostatectomy appears to be a safe and feasible option for the management of carefully selected, organ-confined prostate cancer. The perioperative and pathologic outcomes show promise with this new technique; however, the high standards of oncologic and functional outcomes demand close and longer follow-up before adoption into the surgical armamentarium can be recommended.