The impact of nerve-sparing robotic-assisted radical prostatectomy on positive surgical margins: Uncertainty

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Dear Editor,

We read with great interest the recent publication in the *Journal of the Chinese Medical Association* entitled "Effects of nerve-sparing procedures on surgical margins after robot-assisted radical prostatectomy."[1] The authors attempted to evaluate the feasibility and oncological safety of using nerve-sparing (NS) robot-assisted radical prostatectomy (RARP) in the management of prostate cancer (PC) patients.[1] They used the "presence of positive surgical margins (PSM)" as a marker to test their hypothesis.[1] The authors found the unilateral NS RARP had an increased PSM rate compared to those in either complete NS RARP (odd ratio [OR] 2.187) or non-NS RARP (OR 2.237) with a statistically significant difference, contributing to their conclusion of concern about the oncological safety (a higher risk of the presence of PSM) of using unilateral NS RARP in the management of PC patients.[1] We applauded their success, although they did not provide additional information addressing the preoperative or postoperative risk stratification to improve personalized risk assessment in PC patients and subsequently guided further therapeutic choice (NS RARP) to minimize the adverse events without compromising the therapeutic effects compared to the standard RAPR surgery. In fact, this concept of using the strict criteria to select a certain population of any cancer patients for minimally invasive surgery and/or less radical surgery to minimize the risk of therapy-related toxicity is of paramount importance.[2–4] However, we are confused about some of their descriptions, and we hope to see their response.

The authors enrolled 419 PC patients undergoing RARP, but 417 patients had a pathological T stage compared to 419 patients with a clinical T stage.[1] Could the authors explain the discrepancy between both?

Additionally, the audience may be confused about how many patients were treated with unilateral, bilateral, and non-NS RARP (traditional RARP). Furthermore, the PSM rates of PC patients treated by unilateral, bilateral NS RARP, and traditional RARP were 30.3%, 28.8%, and 50%, respectively, as described by the authors. Could the authors clearly demonstrate how to calculate the aforementioned percentage? Please provide the accurate number of patients in each group. Based on their data, RARP seemed to have a 50% probability of the presence of PSM (50compared to either 30.3% in a unilateral NS RARP group or 28.8% in a bilateral NS RARP group, respectively). However, it is confusing to us since the authors said that after application of "artificial or manual models" to analyze their data, they found the risk of PSM was statistically significantly increased in the unilateral NS RARP group, although they claimed this finding was obtained from "statistical analysis."

If possible, could the authors investigate the difference in PSM between NS RARP (a combination of unilateral NS RARP and bilateral NS RARP) and RARP?

Finally, we should emphasize the importance of meaningful and useful information between clinical significance and statistical significance. Without a clinically meaningful recommendation, it should be interpreted very carefully.[5,6]

REFERENCES

1. Yang CW, Wang HH, Hassouna MF, Chand M, Huang WJ, Chung HJ. Effects of nerve-sparing procedures on surgical margins after robot-assisted radical prostatectomy. *J Chin Med Assoc* 2022;**85**:1131–5.
2. Wang PH, Yang ST, Liu CH, Chang WH, Lee FK, Lee WL. Endometrial cancer: Part I. Basic concept. *Taiwan J Obstet Gynecol* 2022;**61**:951–9.
3. Liu CH, Yang ST, Wang PH. DNA mismatch repair deficient (dMMR) endometrial cancer. *Taiwan J Obstet Gynecol* 2022;**61**:741–3.
4. Liu CH, Yang ST, Wang PH. Organ- or function-preservation surgery is recommended, but who is a candidate? *J Chin Med Assoc* 2023;**86**:3–4.
5. Li YT, Yang ST, Wang PH. Is it real of lower incidence of vitamin D deficiency in T2DM patients? *J Chin Med Assoc* 2022;**85**:958.
6. Chang WH, Yang ST. Antibiotics use and worse outcome: a possibility of mis-interpretation. *J Chin Med Assoc* 2022;**85**:1163.

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