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Trends Toward Laparoscopy for Prostate Cancer

TRENDS TOWARDS LAPAROSCOPY FOR PROSTATE CANCER

We are still working to minimize the major risks of complications involved in minimally invasive prostatectomy. This becomes even more important as more patients undergo these procedures. How has the training and certification process impacted our success and what improvements can we expect in this minimally invasive technique for prostate cancer in the years to come. Welcome to the Clinician's Roundtable.

I am your host, Dr. Mark Nolan Hill, Professor of Surgery and Practicing General Surgeon, and our guest is Dr. Jim Hu, Assistant Professor of Surgery at Harvard Medical School and Director of Minimally Invasive Urologic Oncology at the Brigham and Women's Hospital and the Dana Farber Cancer Institute in Boston.

DR. MARK NOLAN HILL:

Welcome Dr. Hu.

DR. JIM HU:

Hi Mark, thanks for having me on ReachMD.

DR. MARK NOLAN HILL:

We are discussing trends towards laparoscopy for prostate cancer. Dr. Hu tell us a little bit about your background. I believe you are one of the few surgeons in the United States, who had a fellowship exclusively in robotic surgery.

DR. JIM HU:

That’s right, although I think its becoming more and more commonplace. I completed a 6-year urology residence training program at UCLA and then did a 1-year fellowship in robotic urologic oncology at City of Hope in Los Angeles area.

DR. MARK NOLAN HILL:

And your research that you are involved with. What specifically are you studying?

DR. JIM HU:

I am studying outcomes for minimally invasive radical prostatectomy, as they compare to open radical prostatectomy and when I use the term minimally invasive, I mean both laparoscopic as well as robotic-assisted laparoscopic radical prostatectomies. We also looked at the trend and diffusion of the minimally-invasive approaches from a period of time from 2003 to 2005.

DR. MARK NOLAN HILL:

What happens when you are teaching your residents about robotic surgery and they have the instance where they have to open up the patient. Can they handle an open radical prostatectomy as well as someone who has been doing it for 30 years?

DR. JIM HU:

I think that's certainly a very valid concern and one that a lot of training centers around the country, residency training programs are facing as more and more radical prostatectomies are done via the robotic approach. I certainly think that naturally as less and less people do the open, it will be a more and more rare event to need to covert to open surgery; however, certainly it may be the case where one needs to consult with a more experienced surgeon if there is a conversion in the future or in the present day I should say going from robotics to open surgery. I don't think that there is a panacea, but if the trend continues, I think open surgery will be the exception rather than the rule.

DR. MARK NOLAN HILL:

These patients who undergo the robotic surgery, how long are they in the hospital?

DR. JIM HU:

Typically 24 hours, however, I have to be fair and say that there are centers that perform open radical prostatectomy that will discharge their patients in a 24-hour timeframe as well. So a lot of physician practice patterns, individual practice styles may dictate length of stay and its difficult to just make the generalization that minimally invasive radical prostatectomies will go home sooner than open radical prostatectomies.

DR. MARK NOLAN HILL:

And generally how do these patients with robotic surgery do?

DR. JIM HU:

Generally they do very well. I am speaking from personal experience. However, when we also look at what our data showed, however, I think when you look at the experience of all surgeons that are doing minimally-invasive radical prostatectomy across the country, our study showed that there is an increased risk for needing other procedures to control the cancer, short period after surgery. So I think that, and furthermore what our study showed was that increasing surgeon experience led to a lower need for such salvage therapies such as radiation or hormonal therapy after surgery for minimally-invasive surgeons.

DR. MARK NOLAN HILL:

If a patient presented to you and needed a prostatic operation for cancer and they said well tell me really that the main reasons I should do a minimally-invasive approach or robotic approach, what would you say?

DR. JIM HU:

Well I tell them to try to separate the technique or the sexiness of the approach. In other words, this is a new technology, but try to separate yourself from being <_____> to new technologies. In other words the analogies that I always use for them which maybe applicable to a lot of medical professionals, who like to play golf is that if you look at Tiger Woods playing with a golf club from 20 or 30 years ago would still do much better than me playing with a newest golf club today. I try to make the point that technology is not a substitute for surgical experience. However, I do try to convey to them that the advances in technologies such as laparoscopy or the robotic approach do lead to potential advantages should the surgeon be able to take advantage of them.

DR. MARK NOLAN HILL:

And is this general philosophy and understanding felt by all urologists in the United States?

DR. JIM HU:

I don't think so. I think certainly everyone is somewhat biased towards what they do or what they have to offer and there certainly are stake holders and their positions depend on what they do in terms of how many radical prostatectomies they perform open versus via robotic or laparoscopic approach. I think that if you spoke to most people in leadership positions around the country, who are chairman of respective departments, those individuals tend to be the open radical prostatectomy surgeons and hence may not have been an early adoptor to laparoscopic or robotic radical prostatectomy.

DR. MARK NOLAN HILL:

If you have just joined us, you are listening to the Clinician's Roundtable on ReachMD. I am your host, Dr. Mark Nolan Hill and our guest is Dr. Jim Hu, Assistant Professor of Surgery at Harvard Medical School and Director of Minimally-Invasive Urologic Oncology at the Brigham and Women's Hospital and the Dana Farber Cancer Institute in Boston. We are discussing trends towards laparoscopy for prostate cancer.

Dr. Hu you have a fellowship specifically in robotic surgery, what does the practicing urologist do if they want to learn the robotic approach?

DR. JIM HU:

Currently the food and drug administration requires a surgeon or urologist, who is interested in offering robotic radical prostatectomies to take a 2-day course and that's the mandate. Now after the 2-day course, often times a surgeon will have proctoring from other surgeons, who have done robotics, a robotic prostatectomy and so they will book a case and have a proctor that may just direct them through the case, giving them feedback or else at times should they require or called upon to intervene, they can jump on the surgeon console and get them out of trouble. So realistically that's the current state of affairs for the training of practicing surgeons in terms of adoption of robotic radical prostatectomy.

DR. MARK NOLAN HILL:

Well what if you are in an area of the country in a rural area where there are no proficient robotic operators.

DR. JIM HU:

I think certainly as a patient and I see this all the time to patients if you are in an area where there is not an experienced robotic surgeon, you have to look at what your long-term goals of therapy are and that is again to cure the cancer, to remain continent, and to remain potent, and if those are your primary goals rather than to have surgery done with latest and the greatest technology or getting out of the hospital a day sooner then you have to go someone, who has a lot of experience doing open surgery in that rural area.

DR. MARK NOLAN HILL:

Are the hospitals having standardized credentialing parameters or is this based really individually on each hospital?

DR. JIM HU:

I think each hospital certainly looks at whether or not the surgeon has done the 2-day course, but I think that there is a great deal of variability in what the surgeon experience should be before they go out and put cases on their own or do things without a proctor. I think again the autonomy that surgeons enjoy in this country probably have a great deal to do with that as well as the fact that a lot of hospitals are eager to recoup their fixed costs on a rather very expensive piece of capital equipment. So I think that there is certainly enthusiasm from a hospital administrator, who has recently plopped down $1.7 million to get some return on their investment.

DR. MARK NOLAN HILL:

Are these procedures being done in other countries?

DR. JIM HU:

Yes they are. I think that initially great deal of the volume came from the United States, but when you look at the installation of robotic systems across the globe. In Europe, there is certainly been a lot of da Vinci robots that have been installed as well as in Asian countries as well, but I think that because of the more free market economy of the United States, we have been the most rapid adoptor

of robotics, we have been the most free spending certainly in that instance and I think in other healthcare systems where cost carries a bit more ration than here and things are a bit more planned, there has been slower adoption of robotic surgery.

DR. MARK NOLAN HILL:

I hate to bring up remuneration, but do all insurance companies cover robotic surgery for prostatic cancer?

DR. JIM HU:

I don't that really the payers reimbursed a greater extent, robotic surgery versus an open surgery in general; however, I think that the reimbursement for just on the surgeon side for a laparoscopic robotic surgery based on what Medicare will reimburse is roughly about $150 more than for a open radical prostatectomy. So at least at the surgeon fee level you are not seeing a significant difference in reimbursement and on the hospital level again I don't think that there is a significant difference either. I think that a lot of hospitals are trying to charge a facility fee as well in terms of the robotics, but its variable in terms of how successful they are in getting the payer remunerate based on that facility fee.

DR. MARK NOLAN HILL:

So if I am a urologist, who has been taking out prostates for a million years and good at it and I am in a small hospital in the country and I call you up and I say, Dr. Hu I really would like to start doing the robotic surgery and our hospital is thinking of getting one, but there is no one for 200 miles around who has done robotic surgery. What would you say to this urologic surgeon?

DR. JIM HU:

I'd say that as with adoption of any approach or achieving excellence in anything you do is a matter of commitment and in this case without any supporting surgeons close by or anyone that one could easily go watch, certainly there exists a lot of DVDs or videos now of robotic surgeries and have high volume robotic surgeons that the device manufacturer actually makes readily available, so I think studying those videos will help a great deal. There is also the option of doing a mini fellowship in minimally-invasive surgery or robotics that some centers offer around the country, which is about 1 week of dedicated exposure to the robot and robotic-assisted surgery. So I think those would be the main options in terms of someone who is looking to have greater exposure to robotics.

DR. MARK NOLAN HILL:

And what about in the future, perhaps I am doing a robotic surgery in a small town and I video conference you in Boston and have you look in through the electronic marvels and actually see what I am doing and advise me, is that feasible?

DR. JIM HU:

That's a very interesting point, Mark. The original intent of the da Vinci robot and it was actually developed with a lot of money from the Department of Defense, but the original intent was for the surgeon to be faraway from the battlefield and then using a high-speed internet connection to have the slave device robot to operate on a wounded soldier there closer to the battlefront and so as our technology continues to improve, I think that there is opportunities for an experienced robotic surgeon not only to teleconference in, but

also to have a form of proctoring whereby he may be able to take over controls over high speed internet connections from far distances.

DR. MARK NOLAN HILL:

And finally 10 years from now, looking in your crystal ball, how many prostate surgeries are going to be done robotically?

DR. JIM HU:

Well I think that there are several issues, #1, I think honestly we probably over-operate on men with prostate cancer, so hopefully we will have a better marker that will allow us to have better predictive ability in terms of who really needs the surgery, but as far as people getting the surgery go, I think that it will be close to 95 or 100% of men having robotic-assisted laparoscopic surgeries compared to an open radical prostatectomy.

DR. MARK NOLAN HILL:

I want to thank our guest, Dr. Jim Hu. We have been discussing trends towards laparoscopy for prostate cancer.

I am Dr. Mark Nolan Hill. Be sure to visit our web site at reachmd.com featuring on-demand podcasts of our entire library, and thank you for listening.