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Dear Editor,

We read with interest the study by Magistro et al. which compares the occurrence of asymptomatic and symptomatic lymphoceles after radical prostatectomy at a high surgical volume European center [1]. The crude prevalence of lymphocele was higher in the group of robot-assisted radical prostatectomy (RARP), accounting for 16.7%, while in the retro-pubic radical prostatectomy (RRP) group, it was 8.2% ($p = 0.049$). Also, symptomatic lymphoceles were most frequent in the RARP group, but the difference between the two groups did not reach statistical significance (11.7% vs 7.4 %). Both groups were homogeneous regarding clinico-pathological parameters, and sealing techniques were also similar, including clipping and electrical coagulation. Taking into account the limits of this study (retrospective and not randomized), we emphasize that the positive result in favour of RRP could be strengthened by the introduction of the advanced bipolar technology applied to new surgical devices available in open surgery. The sealing produced by advanced bipolar ultrasound energy or advanced bipolar radiofrequency, which were developed to allow the optimal closure of blood vessels, confers an effective sealing technique for lymphatic vessels too. These methods act by coagulation until the vessel is completely obliterated, avoiding the carbonization of the stumps, which could worsen the lymph loss. This control is due to an offset electrode design which

interrupts the energy flow once a critically warm level is reached within the jaws [2]. While clipping and cauterization are carried out as interrupting actions, the handling with the new surgical devices makes the sealing effect continuous for the entire lymphadenectomy, thus producing optimal closure of lymphatic tissues. On the contrary, the tips of the robotic arms, including forceps and dissector, which are based on a traditional mono-bipolar energy, might not give a proper sealing effect on lymphatic vessels, even if done with a soft touch on a thin surface. We support this consideration based on our experience from a retrospective series of 181 RRP performed in four years. We recorded 15 asymptomatic lymphoceles (5%), of which three patients (1.6%) required intervention for drainage. All patients with lymphocele were node positive at histopathologic examination (unpublished data). Other authors reported positive nodes as an independent risk factor of lymphocele as well as a high number of retrieved nodes [3]. We congratulate the authors for throwing light on one of the main complications after radical prostatectomy. Our opinion is that RRP, improved by surgical magnification loupes and the use of new generation sealing devices, is still competing against robotic surgery, just 21 years after the introduction of the first RARP [4].

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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