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The comments made by Campodonico and Introini bring a new aspect into the equation. According to the authors' experience the use of surgical instruments based on bipolar energy sources provide a safer pelvic lymph node dissection (PLND). In their own small series of patients with N+ metastasized prostate cancer (n = 181 in 4 years) only 1.6% developed symptomatic lymphovascular complications after open retropubic radical prostatectomy (RRP), which is below the reported incidences in the literature (2–9.1%) [1–4]. We congratulate the authors on their excellent surgical performance. Their point is well taken, however, the assumption that robotic-assisted surgery relies exclusively on monopolar energy is incorrect. Forceps based on bipolar energy, as used in the current study, are available for robotic systems and therefore, we may exclude this concern. Although we observed a tendency towards more symptomatic events after robot-assisted radical prostatectomy (RARP), this was not statistically significant in our series.

PLND is an integral part of the surgical management of localized intermediate – and high-risk prostate cancer providing important information for staging, risk assessment and prognosis. Despite the mounting clinical evidence, the oncological value and technical considerations of PLND are still an open area for discussion. Indeed, a recent systematic review including 66 studies with a to-

tal of 275,269 patients questioned the overall oncological benefit [5]. Among others, a serious impact on postoperative complications including lymphovascular complications was revealed. The occurrence of symptomatic lymphoceles is one of the most frequently reported complications after both RRP and RARP. Numerous studies attempted to identify risk factors for this particular complication. Overall, there are patient-related factors and surgical aspects that need to be acknowledged. On the patient's side parameters such as age, body mass index and medication (low molecular weight heparin) were discussed for potential roles. Additionally, in the current study we were able to add a novel aspect to the board. We clearly determined a significant impact of the primary tumor grading. The presence of high-grade disease was associated with an almost 5 times higher risk for symptomatic lymphoceles compared to Gleason scores <8. The surgical factors affecting the risk for symptomatic lymphoceles comprise the choice of technical procedure (RRP vs RARP), the surgical approach, the extent of the PLND and various sealing approaches including reconstructive techniques. In this regard, our data in concert with published studies confirmed that a higher lymph node yield is associated with a higher risk for lymphovascular complications. This observation was not dependent on the technical procedures RRP or RARP. Finally, we should not forget,

that the surgeon's proficiency must always be considered as the mainstay of a safely and accurately executed PLND. Altogether, as discussed in the current study, published data on risk factors and the impact of technical approaches are quite heterogeneous and conflicting. This topic goes beyond just

technical differences between RRP and RARP, and our results in accordance with published data suggest applying a wider perspective.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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