Editorial comment to: Sofer M, Tavdi E, Levi O, Mintz I, et al. Implementation of supine percutaneous nephrolithotomy: a novel position for an old operation. Cent European J Urol. 2017; 70: 60-65.

Supine PCNL is the way to go!

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The fact that operating a patient in the supine position is easier than in a prone position is rather intuitive: apart from PCNL and, obviously, spinal surgery, there is no surgery of retroperitoneal organs performed in the prone position.

So, why is it that nowadays PCNL is performed in the supine position only in 20% of cases worldwide? [1].

Indeed, the prone position was adopted in the pioneering era of PCNL only on an intuitive basis with the thought that in the supine position no window for puncture was present because of colon interposition. This was assumed as a postulate. As a consequence, this approach was supposed to be the only one able to prevent colonic perforation which was, and still is, considered one of the most frightening complications of PCNL. And probably at that time it really was, neither CT nor US scans were available and no chance to detect organs that lied in between the skin and kidney was possible. For decades, this concept never came into question and it was unquestionably adopted by the following generations.

But at this moment in time in which no patients undergo a PCNL without a preoperative CT scan, perseverance in this attitude is meaningless.

Also because, as already demonstrated, the incidence of a retrorenal colon is higher in the prone than in the supine position (10 *vs.* 1.9%) [2]. Moreover, we also have to consider that, as done by the majority of urologists, the fact that the preoperative CT scan is mostly carried out in the supine position, can be misleading when planning a prone PCNL [3]. As such, only in these anecdotal cases of retrorenal colon, the surgeon can decide to go back to the prone position.

On the other hand, the supine position certainly offers several advantages, as listed in detail in this interesting paper [4–7]. So then, what is still preventing the worldwide propagation of the supine position? Well, many experienced surgeons are not very eager to embrace the supine position because they are afraid that this radical change may be cumbersome and may impact surgical outcomes during the learning curve. This is something that an established surgeon does not want to experience.

This is the reason why the Authors should be congratulated; they confuted this concept demonstrating that changing position is not cumbersome and the learning curve short, yielding similar, or even better outcomes, rather quickly [7]. It is noteworthy that, paralleling what already happened when comparing open vs. robotic surgery for prostatic cancer, in this study it was not possible to continue the RCT because after less than 2 years, surgeons did not want to operate in the prone position any longer due to the clear advantages of the supine position. This is what usually happens to every surgeon after shifting to the supine position; to the best of my knowledge no surgeons wanted to go back to prone. What does this mean? I leave the answer to the readers.

In conclusion, I agree with the Authors that supine PCNL, many years after the intuition of Valdivia [8], has already passed the point of needing to prove safety and feasibility and, according to Mahatma Gandhi motto, "First they ignore you, then they laugh at you, then they fight you, then you win", only the last step is yet to be taken, but, my feeling is that it is very close to come. In the near future, it is likely that the perception toward prone PCNL will be similar to the one in athletics regarding high jump in which, after many years, the ventral technique, considered until that time the only way possible, has been abandoned in favor of Fosbury's supine technique.

Only a blind and not farseeing ostracism can prevent you to experience the clear advantages of the supine position; no more excuses, try supine PCNL and you will love it!

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