

Comparison of functional outcomes of off-clamp laparoscopic partial nephrectomy access techniques: A preliminary report

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The study aimed to compare outcomes between transperitoneal and retroperitoneal laparoscopic off-clamp partial nephrectomy. They included a total of 34 patients operated over a period of 7 years, 24 being trasperitoneal. There were no significant differences in complexity, size or surgical time. After 1 year, glomerular filtration rate (GFR) was similar between the 2 groups and none of the patients had a positive surgical margin. Something worth commenting on, is that the loss GFR after one year of follow up was almost double in the transperitoneal approach, although it did not reach statistical significance (5.44 ± 6.43 vs. 2.37 ± 3.75 , $p=0.141$), which may be due to lack of statistical power. The conclusion was that both techniques are similar outcomes.

One of the exclusion criteria for the study was that all patients had to have a healthy contralateral kidney and a single lesion to be resected (they excluded patients with bilateral tumors, multiple tumors in a single kidney and patients with solitary kidneys). This is something to take into consideration, especially when the primary outcome was GFR. When people have two kidneys the GFR is given by both kidneys. Furthermore, when one kidney is affected the contralateral organ tends to compensate in order to maintain GFR. This makes it hard to conclude that the similar GFR at the end of the study was a result of the surgical technique alone. The other variables to consider would be the degree of compensation from the other kidney, especially if the design of the study was not a randomized clinical trial, which could balance for such variable.

Another thing to consider is patient selection. In the study they mention that all the surgeries were done by a single surgeon (EO), but there is no mention as to how were patients selected for an off-clamp technique as opposed to a clamped technique, nor about the selection criteria for a transperitoneal vs. a

retroperitoneal approach. I would encourage the authors to specify such information in their future work in order to give the reader a more uniform idea as to who should be treated this way. It is our responsibility to give a clear representation of the population included and not only of the results, as a major aspect in surgical care is patient selection.

Finally, another thing to consider about the present work is that preoperative and postoperative GFR was estimated using creatinine values (Chronic Kidney Disease Epidemiology Collaboration equation, CKD-EPI). This is acceptable and it is widely used for clinical practice, although it may not be the ideal strategy for this kind of analysis. Perhaps the use of a renal scintigram (as mentioned by the authors) would have given more accurate information and more importantly, as previously mentioned, it would have given an idea of the contralateral kidney function as well as the operated one.

This is a very interesting analysis that shows the quality of care in your center. The clinical outcomes presented are excellent and this is a valuable experience that should be shared. I congratulate the authors for their achievement and wish that the present work serves as a hypothesis generating material for future efforts.

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