After reading the outstanding review by Briganti et al [1], I cannot help but think of how our care of men with prostate cancer might change if the global economic downturn continues and worsens. As an American urologist I have the added stress of change that a new presidential administration brings and the prospects of a revised American health care system [2,3]. This global economic slowdown is also playing out in the context of an aging population, an obesity epidemic, and a shortage of physicians and urologists (in the United States). These negatives, however, are balanced by a plethora of molecular discoveries, novel pathways and agents in the global pipeline, and potential government stimulus packages that could pump funding to move more treatments from bench to bedside. One might think it a stretch to discuss these issues related to pelvic lymph node dissection (PLND), but this example is as good as any.

Despite the compelling arguments made by these highly regarded authors for extended pelvic lymphadenectomy (EPLND) [1], the procedure is not commonly performed in the United States (and, I suspect, in many other countries). The reasons for this include economics, expertise, and evolving stage migration. Although it may not by politically correct to discuss, I believe the main reason that EPLND is not done more often is the concept of “time is money.” In other words, the insurance reimbursement for EPLND is not generally greater than for standard PLND. In the U.S., PLND is “bundled” for payment with open RRP and no additional reimbursement is derived from EPLND. For RALP, a PLND can be billed separately but there is no additional payment for EPLND. This factor, combined with the added time needed to perform the extended dissection, limits its popularity among busy US urologic surgeons. Additionally, the expertise needed to perform EPLND, especially with robotic-assisted laparoscopic prostatectomy (RALP), probably does not exist at most US centers or it is not felt to be worth the effort to learn. While I am, admittedly, not a big fan of RALP and feel it has not been proven to be equivalent to the gold standard of open radical retropubic prostatectomy (RRP) [4], it has become very popular in the United States, with >50% of radical prostatectomies (RPs) performed by this method [5]. Moreover, the massive stage migration seen in the United States over the last decade has been profound, with more and more men having low-risk disease. In our Duke Prostate Cancer Outcomes Research Database [6,7], 51.6% of men undergoing RP in the last year (2008) had low-risk disease. For the 36.2% who had intermediate risk and the 11.2% who had high risk, 37% underwent an RALP, leaving only 30% who could or should have undergone an EPLND.

Various global economic scenarios may alter this landscape even more profoundly. What if prostate-specific antigen (PSA) screening for prostate cancer...
is decreased as the result of a global depression or of government-mandated changes? We might see a reverse of stage migration. Shall we call this stage degradation? We could go back to the pre-PSA era, when 20–25% of men presented with metastatic disease and the incidence of T3/4 and N+ disease was much greater. On the one hand, there may be more high-risk men who would be candidates for EPLND; on the other hand, the greater tumor burden might obviate the need for extended dissection. What if a nationalized health care system mandates more cost-effective care? We certainly know that RALP costs any health care system more in time and equipment. Under this scenario, robotic surgeons would have even less incentive to take the time to perform a robotic EPLND. Alternatively, hospitals might be forced to abandon their expensive robots and revert to the more efficient open RP. While this would potentiate more opportunity for EPLND, it still might not be used. The government single-payer system, which is in place in many countries, has a huge impact on availability of health care services and might affect future EPLND availability. With the aging population, health care rationing may ensue and further limit not only EPLND but many other aspects of prostate cancer care, especially if governments start to consider prostate cancer a less important health condition.

The global obesity epidemic may also have a growing (no pun intended) impact [8]. At least from my perspective in the southeastern United States, where upward of one-third of the population is obese, we are seeing more and more men for whom we are altering our optimal management of prostate cancer. In a young man (age <50 or <55), for example, who is morbidly obese (body mass index >40–45) with high-risk disease, RALP or open RRP is desirable but is not always feasible. In this case, we may be reluctant to embark on RP with even a standard PLND, much less an EPLND! Even if we agree that EPLND is the way to go, we may not want to risk the potential for increased morbidity in these obese men who are already at greater risk for complications. And with the push for deep venous thrombosis prophylaxis using perioperative heparin or low-molecular-weight heparin, some surgeons may not want to risk lymphocele and/or heparin or low-molecular-weight heparin, some venous thrombosis prophylaxis using perioperative risk for complications. And with the push for deep vein extension, we are seeing more and more men for whom this benefit will be very difficult to prove, given the contamination of the effect of early hormonal therapy [9], whole-pelvis radiotherapy, and competing mortality in older men. Specifically, an example is the man who undergoes RP with no PLND or standard PLND and has missed occult positive nodes in the pelvis or retroperitoneum. The occult disease will soon become manifest by a rising PSA, and the current concepts of PSA doubling time or PSA velocity should allow salvage treatment that might provide the same chance for cure or disease control as the EPLND [10]. And if EPLND is so valuable, why aren’t the authors also advocating it in men who elect primary radiotherapy? The debate among urologic surgeons about standard PLND versus EPLND seems, to me, similar to the debate that radiation oncologists have about prostate-only/small-field and whole-pelvis radiotherapy. A procedure might be beneficial, but the potential for increased morbidity and time has, to date, generally outweighed the potential for improved outcomes.

Again, I want to congratulate the authors for a very well-written and well-referenced summary of the current state of the art of pelvic lymphadenectomy. While I am not personally convinced of the efficacy of EPLND, I do think it is reasonable for the well-counseled man with high-risk localized disease and for selected intermediate-risk patients.

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**References**


