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EDITORIAL COMMENT

Comment to: "Primary laparoscopic retroperitoneal lymph node dissection for clinical stage I nonseminomatous germ-cell testis tumor"

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In this edition of Actas Urológicas Españolas, we find the important work by Castillo et al., in which they show us the possibility of performing a laparoscopic retroperitoneal lymph node dissection as the primary treatment of clinical stage I testicular cancer.[1] The importance of this study lies in that it is the largest series published and in that the patients were operated on by a surgeon with ample oncological and laparoscopic experience. There are two aspects that we believe are worth debating in this editorial: first of all, the indication of lymph node dissection as a primary treatment and secondly, the role that laparoscopic surgery currently plays in its effort to take the place of open surgery in retroperitoneal lymph node dissections, not only in clinical stage I, but also in the salvaging of post-chemotherapy residual masses.[2]

Two trends exist in the management of clinical stage I. The retroperitoneal lymph node dissection, which is widely extended in the United States and Latin America, which requires major surgery (especially aggressive if performed in an open approach) and whose aim is to diagnose 20% of patients with a viable tumour in the retroperitoneum, thus selecting those patients that will receive adjuvant chemotherapy, as well as to prevent future growths of residual teratoma. Among its clear indications would be the impossibility or difficulty to follow up these patients with imaging and markers. The second alternative, which is widely extended in Europe, is expectant treatment in low-risk patients and treatment with two cycles of chemotherapy (BEP) in those with a high risk of retroperitoneal metastasis, who are patients with embryonal carcinoma or lymphovascular invasion in the primary tumour. With this approach, it is known that at least half of the patients are being overtreated, but we avoid a significant number of retroperitoneal lymph node dissections without repercussions in mortality.

As regards whether or not laparoscopy can replace open surgery, there is evidence that the number of recurrences is similar in both procedures when they are performed by surgeons with experience,[3] allowing to substantially reduce the morbidity of this surgical procedure and maintaining survival figures. It has helped to reduce this morbidity, especially retrograde ejaculation, the use of unilateral retroperitoneal templates, which without doubt must be used in clinical stage I. Moreover, there is evidence of its safety to be used in the salvage of residual masses.[4]

To conclude, the two trends in the treatment of clinical stage I continue to exist. Lymph node dissection will have its place especially in patients whose follow-up we cannot guarantee, and in the case it has to be performed, laparoscopy is the less morbid procedure. However, without doubt, these patients must be operated on at centres with ample experience.

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