

AUTHOR'S REPLY

Reply to: Buntrock S. Lasers and the prostate. Cent European J Urol. 2016; 69: 396.

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We thank Dr. Stefan Buntrock for his comments on our article [1]. High prevalence of benign prostate hyperplasia in the ageing population deserves our attention, especially from a surgical point of view. We all observe growing evidence regarding new operative techniques, including those involving laser technology. However, it should be emphasized that in 2016 conventional transurethral resection of the prostate (TURP) still remains the gold standard for surgical treatment of patients with benign prostate hyperplasia (BPH).

There is an on-going evolution of the use of Greenlight lasers in BPH patients. While our study was performed with the 80-W KTP laser, an expert panel of the European Association of Urology suggest to regard the 180-W XPS laser as a reference for Greenlight laser prostatectomy [2]. The up-dated results of the Goliath study demonstrated clinical safety and a durable effect of the 180-W XPS laser vaporization of the prostate. However, safety and efficacy of the treatment is comparable to TURP [3]. This conclusion remains true also for the older 80-W KTP and 120-W LBO systems, as presented within two recent meta-analyses [4, 5]. Similarly, our study did not reveal the differences regarding functional complications between the 80-W KTP laser and TURP [6].

Based on all of these considerations, one can conclude that Greenlight laser vaporization is as safe

and effective as TURP. While this statement is true, it remains incomplete. The devil is in the details. If we look into the details of the Goliath study and previously published meta-analyses on 80-W and 120-W systems, comparing Greenlight laser with TURP [3, 4, 5], there are few particular facts that need special attention. First, all of these studies present lower rate of significant bleeding requiring reoperation or transfusion in the laser arms. For this reason, laser technology seems beneficial especially in patients at the highest risk of bleeding complications, including patients on anticoagulation therapy. Secondly, all of these studies highlight a shorter catheterization time and shorter hospital stay in patients undergoing laser vaporization. The main disadvantages of Greenlight laser operations are longer surgery times and higher rates of reoperations to relieve the bladder outlet obstruction in a mid-term follow-up. Finally, functional complications, also addressed by our recent study, are similar independent of the surgical technique.

To conclude, we agree with Dr. Stefan Buntrock, that it is more or less up to the surgeon to choose his 'weapon'. However, in order to make a good, or even a better choice, you should consider not only the available technology, but also your patient's medical characteristics and your own surgical experience.

References

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