

Prostate Cancer?
Why Radical Surgery/Robotic Prostatectomy
Is NOT For You.

Bert Vorstman MD, MS, FAAP, FRACS, FACS

Urological surgeons are well aware that most men die with their prostate cancer without impact and not from it, and that generally prostate cancer is overdiagnosed and overtreated.

The dilemma for physicians and also for afflicted men is to determine which prostate cancers are significant enough to warrant treatment, and by which method.

Despite this background, many uninformed, vulnerable men with a diagnosis of prostate cancer are attacked with a traditional misguided surgical assault as if attempting to extinguish a firestorm. Unfortunately, whether by conventional surgery or through the assistance of a robotic device, the fundamental process utilized in both of these approaches for treating localized prostate cancer is that of surgical excision. This excision method has not resulted in any significant long term curative benefits, and remains all risk and with very significant negative quality of life (QoL) issues.

The following long list of issues simply underscores the many concerns regarding radical surgical robotic prostatectomy and the need for men and their wives/partners to take all the time necessary to empower themselves before considering this invasive, irreversible and high risk treatment journey.

Why Radical Surgery/Robotic Prostatectomy is NOT for your Prostate Cancer.

1. absolute absence of rigorous, long-term, scientific studies for curative life extension, i.e. no scientific evidence for cure and no additional years of life
2. significant overtreatment of low volume, low risk prostate cancer, many of which can be simply followed through active surveillance
3. very high rate of significant complications such as:
 - a) positive margins or untreated cancer left behind in 20-40% of all operative cases (often misconstrued as iatrogenic or the way the prostate was cut out) subsequently requiring radiation
 - b) shortened penis
 - c) total impotence or erectile dysfunction of varying degrees and who now usually require medicines and/or devices for any sexual activity
 - d) ejaculation of urine in some men where a partial erection has been maintained or recovered
 - e) urinary incontinence commonly necessitating wearing of pads or diapers for varying time frames
 - f) bladder neck scarring or contracture often requiring incision
 - g) and potentially, a long list of other significant immediate (such as recto-urethral fistula or death) and delayed complications, medical and

psychological

4. highest rate of secondary surgeries to correct complications of incontinence, bladder neck contracture and impotence compared to other treatment options for prostate cancer

5. significant negative quality of life (QoL) issues not only with patient but also with spouse/partner

6. total absence of any significant long-term scientific randomized clinical trial (RCT) data and evidence-based medicine (EBM) support

7. deceitful practice of claiming Food and Drug Administration (FDA) approval, when in reality, the approval for radical surgery/robotics was simply rubber-stamped by FDA with a "pass" and never scientifically evaluated for long term risk or reward

8. pervasive but misleading use of self-serving "clinical study" information intentionally misconstrued as Scientific Data

9. intentionally misleading talk of zero PSA progression and survivorship at 5-10 years, whereas it is well known that generally the prostate cancer cell grows slowly with a doubling time of 1-2 years; consequently, zero PSA progression rates and survivorship talk are meaningless for 5-10 year time frames and meaningful only when men are followed 20-30 years after treatment

10. liberal use of the intentionally misleading self anointed but meritless "gold standard" as well as "standard practice" labels

11. pervasive use of pathological and imaging studies severely tainted by subjectivity issues which therefore impact accuracy of prostate cancer diagnosis and evaluation

12. misleading marketing of "nerve sparing" or "potency sparing" surgery by implying that these important nerves can be identified and spared routinely to preserve the neurovascular bundle and therefore sexual function. In reality, at best, the important nerves for sexual function may only follow the course of the blood vessels in about 50% of cases, making the term "neurovascular bundle" misleading and the term "nerve sparing" or "potency sparing" equally misleading. Similarly, the erudite anatomical descriptions regarding the fascial layers involving the prostate for these "nerve sparing" approaches by these self absorbed surgeons may be more fanciful than real as the anatomy of these fascial layers is highly controversial

13. pervasive use of misleading, non-standard, self-serving definitions in clinical reports of what constitutes treatment success or a surgical treatment complication

14. rampant conflicts of interest in the evaluation of surgical/robotic treatment results in these clinical reports

15. perpetuating the myths regarding alleged value of surgical/robotic treatment for prostate cancer in men who are relatively young or in those

where the tumor is aggressive or high risk

16. perpetuating the myths regarding alleged benefits of surgical local cancer control and debulking of prostate cancer
17. intentionally advancing the misleading impression that “one size fits all” and that the surgery/robotic approach is suitable for most prostate cancers
18. misleading talk of importance of surgical staging for patients’ welfare
19. deceitful practice of using hopeful sounding but scientifically unproven “high-tech” and “robotics” talk as a potentially curative treatment for prostate cancer when this robotic surgery simply engenders false hope
20. false characterization of “superior outcomes”

Discussion

Currently, men concerned about possible prostate cancer will enter the unbelievable circus of prostate cancer evaluation and treatment where inaccuracies, subjectivity issues, misuse of investigational aids, shameful use of non-standard and self-serving definitions of success and complications in self-serving clinical studies as well as blatant conflicts of interest and financial incentives are pervasive. In addition, there is a common ploy by physicians for intentionally implying a sense of urgency and coercing an impulsive, uninformed, gullible and unsuspecting patient’s decision for robotic surgery. This despicable process is coupled commonly with the practice of fear mongering and providing misleading information intentionally in order to manipulate a patient psychologically with the word “cancer” towards a high-risk, invasive and irreversible surgical treatment. In most educated circles, this would be called abuse.

Not generally appreciated by patients, let alone the primary care doctors referring patients for evaluation of possible prostate cancer, are the very considerable issues of subjectivity/reliability severely tainting and impacting the accuracy of prostate cancer evaluation and treatment. These issues include:

- * what endpoint to use for the unreliable PSA in prostate cancer screening before considering a prostate biopsy
- * subjectivity issues regarding actual location within the prostate from where these biopsies really came during transrectal sonography
- * the reliability of determining the amount of cancer (the standard office 12 core biopsy has about a 70% reliability, i.e. 30% unreliable)
- * many questions regarding the subjectivity and reliability of the prostate biopsy interpretation by the pathologist
- * many questions regarding subjectivity and reliability issues of the imaging interpretation by the radiologist

Despite years of clinical study, urologists still have no reasoned scientific consensus on when to treat a prostate cancer, how much and what level of cancer is worthy of treatment, what treatment option we should employ or even whether there are locality of disease issues within the prostate that make one type of treatment preferred over another. Are there special criteria for focal rather than whole prostate gland treatment and are there special situations when to use one minimally invasive modality over another? Over the last few years, sophisticated advancements in several

minimally invasive technologies such as cryoablation, radiation/proton, hifu and others have seriously questioned once more the very unfounded and controversial place of the heavy-handed, high-risk traditional surgical and robotic excision of prostate cancer. Time has made it quite clear that no amount of technology can circumvent the problems that necessarily result from the cutting out of your prostate.

Prostate cancer information remains very murky and the fact that radical surgery/robotic prostatectomy for the treatment of prostate cancer lacks legitimacy is self evident.

Surgical treatment for prostate cancer is no panacea and the shameless marketing of this surgery by those with unchecked, super-inflated but meritless egos should have embarrassed the medical community and brought about corrective action long ago. In fact, the broadcasting of the thousands of cases operated on by some of these physicians not only questions the very important concern of appropriateness of treatment but should have invited a surgical audit. Physician intellectual dishonesty when fortified with financial rewards in an endless consumption driven healthcare business have patients at their mercy for all the wrong reasons.

Instead of the ignorant and arrogant academic bullying for deliberate and continued promotion of radical prostate surgery/robotics as the “preferred” treatment, as well as the accepted use of inadequate and incomplete clinical information used to counsel and treat a patient with prostate cancer today, there is an urgent need to approach this disease with a fresh, unprejudiced and scientific mind. We can rectify this long list of inaccuracies and subjectivity issues found to be quite acceptable in the prostate cancer arena because of current “treatment philosophies” and generate the appropriate, long-term, randomized clinical trials (RCT)/evidence based medicine (EBM) studies to determine scientifically, objectively and reliably the critical information needed. With real scientific data we can truly inform men on when and how to treat localized prostate cancer and with the appropriate technique. All the lame excuses about how the RCT/EBM studies are difficult to undertake and time consuming are spurious and irrelevant compared to the current urological culture of accepting bogus study information and surgical treatment complications. The current so-called “gold” standard approach for radical prostate surgery/robotic treatment in men who present without symptoms and who then become lifelong prostate cancer sufferers as a result of their misguided surgery with after effects and symptoms now worse than the prostate cancer disease they started off with represents simply, callous indifference and not patient advocacy. This refusal of surgeons to acknowledge the need to examine critically a traditional operative procedure where the fundamental goal of cure may never have been realized and where significant lifelong complications are indisputable questions character and requires very urgent redress. Only after these long-term scientific RCT/EBM studies have been undertaken and completed will physicians have the pivotal information to make men truly informed and stop this ongoing human experimentation with robotic prostate cancer treatment.

Finally, urologists can be held hostage no longer to the culture of consensus medicine where collegiate cronyism, intimidation and allergy to challenge has clouded common sense and the ability to discern what is

right. The continued pretense for caring as well as the financial and industry-driven promotion of the radical surgical/robotic approach for prostate cancer treatment worldwide has been an incredible disservice to man and this procedure belongs in the same Hall of Shame to where the terribly misguided radical mastectomy was eventually relegated. History has not been a good teacher even in medicine and we forfeit our values as physicians when necessary introspection is jaundiced by conceit and fails to be undertaken. As a consequence, urological surgeons make a mockery of “conventional wisdom”, “patient informed consent” and “best practice guidelines” as well as bring into serious question their sincerity behind the term “standard of care” when applied to prostate cancer surgery/robotics.

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About Bert Vorstman MD, MS, FAAP, FRACS, FACS

Dr. Vorstman is a Board Certified Urological Surgeon with some 30 years of experience. He is Fellowship trained in Pediatric and Adult Reconstructive Urology at the Eastern Virginia Medical School in Norfolk, Virginia, a former NIH surgeon researcher and a former Urology Faculty member at the University of Miami, Florida. He also earned the honor of a Masters of Surgery Diploma through the Otago University, Dunedin, New Zealand for pioneering research on Urinary Bladder Reinnervation using nerve crossover techniques with the aid of nerve grafts. This technique could have possible application in patients with neurogenic bladders.

Dr. Vorstman is well published and has lectured nationally and internationally. He belongs to a number of organizations including the prestigious Societe Internationale d'Urologie.

Dr. Vorstman's passion and dedication is to help men and their spouses/partners fully understand their particular prostate cancer as well as the minimally invasive treatment options available and the possible complications from treatment. He works to promote the acceptance of

minimally invasive treatment options such as hifu, and cryoablation for very selected patients with localized prostate cancer as well as radiation/proton for others. In that regard he has developed a Center for Minimally Invasive Treatment Options for localized prostate cancer.

Dr. Vorstman has also developed a leading urology practice, Florida Urological Associates, pa, was instrumental in developing the Coral Springs Surgical Center and developed websites highlighting prostate cancer issues, including www.urologyweb.com