



Opinion: Open Science

Prehabilitation Programs Before Radical Prostatectomy: An Interesting Approach that Merits Further Evaluation

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In addition to sound surgery, detailed patient counseling before radical prostatectomy (RP) is crucial for postoperative patient satisfaction. From my own personal experience and from that of my close colleagues, I often note that many patients have great difficulties in fully processing the implications of prostate cancer diagnosis and treatment. Even after detailed counseling about the course of action for RP, questions commonly arise after surgery that show that the patient did not understand the procedure and its possible implications to the extent I expected. Did you have to remove the entire prostate? Will I be incontinent because both neurovascular bundles could not be preserved? Did you bridge the gap between the bladder and urinary sphincter with a stent? These are just some of the questions that patients have asked me after surgery, which often take me by surprise since we spoke at length about these issues before RP. Does this mean that I need to work on my preoperative counseling skills? Maybe. However, I strongly believe that most urologists are familiar with this phenomenon, indicating that we could often do a better job in preoperative patient counseling.

In this spirit, the report by Ploussard et al [1] in this issue of *European Urology Open Science* is of particular interest. Using data for 194 patients, the authors evaluated whether a 1-d perioperative multidisciplinary workshop scheduled 2–3 wk before robot-assisted RP (RARP) could optimize perioperative outcomes. The authors found that perioperative outcomes such as the perioperative surgical time, length of hospital stay, and same-day discharge rates did indeed significantly improve for those who participated in the 1-d prehabilitation program. Some of these results might first perplex some readers. Why would this program, for example, lead to shorter surgical time or less (although

not statistically significant in this study) intraoperative blood loss? A possible explanation for these observations might be that the 1-d prehabilitation program includes dietary and physical activity sessions with behavioral suggestions for the time up to RARP. As a consequence, patients might be in (slightly) better shape and are thus easier to operate on. However, it is likewise possible that between-group differences existed that were not accounted for (eg, body mass index, previous abdominal or prostatic surgery) and might have influenced the results observed. Another interesting and maybe more important finding (at least from an economic perspective) is the remarkably higher same-day discharge rate of almost 20% versus approximately 3%. Presumably, this difference is at least partly caused by better patient counseling. In particular, being discharged with a catheter can be a severe burden for some patients, as most have absolutely no experience with a catheter and might thus feel helpless and overstrained. Again, better patient counseling before surgery might help to overcome those fears and insecurities.

Despite these interesting and encouraging findings, it is questionable whether a program as introduced in this report can be offered to all patients scheduled for (RA)RP. In particular, centers with a very high case load (eg, >10 RPs per week) might have difficulty in providing the manpower to constantly offer this program. Moreover, the differences observed for some of the endpoints evaluated, such as blood loss and intraoperative time, are rather small and not very meaningful from a clinical perspective. Nevertheless, I strongly welcome the authors' idea of a multicenter trial evaluating the effect of a prehabilitation program before (RA)RP on different endpoints, such as functional outcomes (eg, urinary continence and erectile dysfunction rates),

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socioeconomic outcomes (length of hospital stay, operative time, time to resumption of work), and overall patient satisfaction. Such a trial has lots of potential to answer some controversial issues, such as the effect of preoperative pelvic floor muscle training. If such a trial were to show improved outcomes, prehabilitation programs should be routinely implemented in clinical practice as both patients and surgeons would benefit from them.

Conflicts of interest: The author has nothing to disclose.

Reference

- [1] [Ploussard G, Loison G, Almeras C, et al. One-day prehabilitation program before robotic radical prostatectomy in daily practice: routine feasibility and benefits for patients and hospitals. Eur Urol Open Sci 2020;21:14–6.](#)