

Commentary on “Successful Endoscopic Clipping in the Early Treatment of Spontaneous Esophageal Perforation”

To the Editor:

A variety of treatment options have been described for the management of Boerhaave syndrome.¹ These range from a simple total parenteral nutrition combined with broad spectrum antibiotic administration to emergent total esophageal resection with mediastinal/chest drainage and esophageal interposition grafts.² Despite the numerous described therapeutic interventions, the treatment for this condition must be individualized to the patient and clinical scenario; therefore, a claimed “gold standard” for the management of Boerhaave syndrome will be controversial and certainly elusive.

In the published case by Rokszin and colleagues, they have stated that their publication is the first reported early endoscopic clipping treatment for spontaneous esophageal perforation.³ I would not agree with this contention, as similar such reports have been published earlier within the contemporary literature. Matsuda et al⁴ published a similar case report in 2006, in which endoscopic clip application was performed within 3 hours of a spontaneous esophageal rupture after a hematemeses.

Additional further reports of nonsurgical management are welcome. These underpin the importance of the prompt diagnosis of Boerhaave syndrome and encourage the dedicated surgeon/endoscopist to apply different endoscopic treatment options in selected cases. This may avoid the escalation of management to radical surgical methods, which are often associated with high morbidity and mortality rates.

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The author declares no conflicts of interest.

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Robotic Surgery and Functional Outcomes: A Lesson From Urology

To the Editor:

I would like to congratulate Park et al¹ on their systematic work on the influence of nerve-sparing robotic surgery on functional outcomes of patients with rectal cancer. In their elegant paper, the authors emphasize the role of robotic surgery on preventing or reducing urinary and sexual problems in patients undergoing robotic transabdominal intersphincteric resection (ISR), demonstrating that this minimally invasive technology allows the identification and accurate preservation of the hypogastric plexus.

To confirm the role of robotic systems in preserving urinary and sexual function, I would like to share my urological experience of radical prostatectomy with the da Vinci system.

Robot-assisted radical prostatectomy is a valuable therapeutic option for clinically localized prostate cancer, and the most recent data have shown significant advantages in terms of blood loss and transfusion rates compared with retropubic RP and also potential advantages for postoperative urinary continence and erectile function.²

The author declares no conflicts of interest.

In terms of the preservation of sexual function, evaluating long-term outcomes in extensive worldwide series,³ it has been demonstrated that postoperative success is primarily and closely related to preoperative function (patients with erectile dysfunction before surgery cannot improve their performance after prostatectomy!). Related to this, there is also the observation that younger patients do better than older ones.

As regards surgical technique, it has been demonstrated that bilateral nerve sparing is far superior to unilateral preservation of nerves with respect to sexual outcomes. To improve erectile function after radical prostatectomy, a key point seems to be early penile rehabilitation with PDE-5 inhibitors, to prevent pathophysiological changes during the period of neural recovery.

However, another important element is time. Maximum recovery of erection occurs at 18 to 24 months, and PDE-5 inhibitors seem to be ineffectual before 6 to 9 months for on-demand use. In addition, there is poor correlation between the technical ability to have intercourse and the patient's perception of success (evaluated with the IIEF score).⁴

Nevertheless, the erectile function recovery rate after robot-assisted radical prostatectomy remains widely variable in the literature. The reasons of this discrepancy are many. Although large series of various factors influencing sexual outcomes have been analyzed, there are not enough data to explain the results on a large scale.

More extensive, prospective, controlled, and randomized studies are needed to identify clearly and understand the surgical and pathophysiological factors playing a role in the recovery of erectile function. Starting from these considerations related to the functional outcomes of urologic robotic surgery, the problem of preserving sexual function after nerve-sparing ISR seems to be more complex than the ones described above.

In my opinion, conclusions concerning the better preservation of urinary and sexual function after the robotic technique compared with open and laparoscopic surgery should be confirmed by more extensive series, with more accurate evaluations of preoperative functional parameters and standardized postoperative rehabilitation programs.

The characteristics of robotic surgery, with its magnifying view, possibility of dissection, and minimal tissue trauma, are unquestionable, but it does seem necessary to improve functional outcomes.

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ERRATUM

Evaluation of the Incidence of Complications of Lost Gallstones During Laparoscopic Cholecystectomy: Erratum

In the article that appeared in the June issue of *SLE*, Dr. Abdolreza Pazouki's affiliation appears incorrectly. The affiliations should be listed as Minimally Invasive Surgery Research Center, Iran University of Medical Sciences, Tehran, Iran.

The Publisher apologizes for this error.

REFERENCE

Pazouki A, Abdollahi A, Mehrabi Bahar M, et al. Evaluation of the incidence of complications of lost gallstones during laparoscopic cholecystectomy. *Surg Laparosc Endosc Percutan Tech*. 2014;24:213–215.