COMMENTARY

# *Sexual outcomes after prostatectomy: a call for uniformity*

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This article by Cathala et al is a refreshingly complete reporting of sexual outcomes prospectively following over 500 laparoscopic prostatectomies with 24 month follow up.[1] Since here we see a series that includes all cases done by all surgeons at a high volume center over a period of time, we are presented with a cohort that represents not a highly selected subset, but rather the entire spectrum of patient presentations that one sees throughout a community or tertiary practice. The cohort contained a wide distribution of pre-op IIEF-5 scores and an average age of 60. QOD tadalafil was used with crossover to ICI for on-demand usage based on patient desire and motivation, which is I believe what most of us realistically do for our patients after prostatectomy outside of a research protocol. The results of this series therefore represent the sexual outcomes that the average patient can expect even in the best of hands.

This is a valuable report and we should take note. Nearly every reality regarding sexual outcomes after radical prostatectomy, regardless of method, found separately elsewhere in the literature are found in one report here. These findings are:

1. Maximum recovery occurs at 18-24 months.
2. IIEF-5 score, even with a penile rehabilitation regimen, will return on average to just over half of what it was before surgery at 24 months.
3. PDE-5 inhibitors are largely ineffectual before 6 to 9 months for on-demand usage.
4. Orgasm is generally preserved but can be considered less pleasurable after prostatectomy.
5. Bilateral nerve sparing is far superior to unilateral nerve sparing procedures in terms of sexual outcome.
6. There is poor correlation between the technical ability to have intercourse and the patient's perception of success (IIEF score).
7. Younger patients do better.
8. Postoperative success is strongly and primarily related to preoperative function.

I would argue that all of these findings are true for any high-volume prospective series, including mine. Figure 1 is a ubiquitous curve with minor variation based on technique and surgeon, but in general we all have the same curves in our series. I think that fact is one that needs to be more highly publicized but unfortunately is too often shrouded.

At a time when radical prostatectomy is under attack, indeed where PSA screening and prostate cancer treatment in general is under attack, I believe the best way to address what many urologists believe is an out of context, politicized presentation of the subject in the lay press is to simply be honest in presenting the facts to the patient.[2-4] Surgery is still a well applied approach to this problem, but too many years have passed without a unified presentation to patients as regards proper expectation of sexual outcomes. This report I believe can help bridge the gap between anecdote, marketing and realism.

I have found that matching patient expectations to fully achievable outcomes is the best way to provide a patient with eventual happiness.[5] This study can serve as an important educational tool towards that goal. □

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