Experience Key When Choosing a Robotic Surgeon

Robotic surgery was introduced to the field of Urology a little over a decade ago with the first robotic assisted prostatectomy (prostate removal) in 2001. The popularity of robotics has grown dramatically since that time. But the FDA is casting a close eye on surgeons and hospitals with robotic capabilities in the light of complications resulting from operations performed by poorly trained or inexperienced physicians. Even when competent surgeons are at the helm, the question remains: do patients truly benefit from this new technology? Recent studies indicate that robotic outcomes may not be superior to those achieved by conventional surgery, yet going the robotic route is generally more expensive. Not surprisingly, there have been calls for better training, more oversight, and increased patient awareness of benefits and risks.

Mount Sinai’s Department of Urology has three highly experienced surgeons who perform robotic surgeries on children and adults. They believe that faster recoveries and less blood loss make robotic surgery a good choice for many patients. Using the robot is based upon a patient’s medical history, the nature of his or her disease as well as personal preference. And these physicians are big advocates of training. The Department recently purchased the latest model robot, which among other innovations, features a dual console for teaching and training purposes.

Dr. David Samadi, Chief of Robotics, is considered to be one of the world’s most prominent robotic prostate surgeons. He specializes in robotic assisted laparoscopic prostatectomies (RALP) and has performed over 4500 RALPs. Using his own technique, called the Samadi Modified Advanced Robotic Technique (SMART), he is able to complete prostate removal in less than two hours with a 24-hour hospital stay and no blood transfusions. The SMART technique avoids mobilizing the nerves from the prostate, and has shown an improvement of sexual function and continence (his procedure yields continence rates of 96% and potency rates of 79% in preoperatively functional men, according to published reports). Dr. Samadi is gracious when speaking

Insights from Dr. Simon Hall, Chairman

Up to two-thirds of all kidney cancers (renal cell carcinoma) are found incidentally on imaging tests such as ultrasound or CAT scans surveying for other non-associated complaints such as pain or weight loss. These tumors tend to be significantly smaller than cancers found due to symptoms such as flank pain or hematuria (blood in the urine). This changing patient demographic parallels with the change in treatment recommendations for kidney tumors from open radical nephrectomy to minimally invasive laparoscopic partial nephrectomy, meaning removal of only the tumor and not the entire kidney. Furthermore, there is emerging evidence that many of these tumors which are smaller than 4 centimeters could be benign and thus

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about his success. “My own expertise in oncology and in open, laparoscopic and robotic surgery are key,” he says, but “my dedicated surgical team, state-of-the-art technology and support of Mount Sinai are invaluable to positive outcomes.”

Dr. Michael Palese, Director of Minimally Invasive Surgery specializes in kidney cancer and kidney disease and performs a wide range of robotic surgeries, including nephrectomy (kidney removal), partial nephrectomy (kidney sparing), pyeloplasty (surgical reconstruction of the renal pelvis to decompress the kidney), ureteral reconstruction, re-implants and adrenalectomy (removal of one or both of the adrenal glands). Dr. Palese believes being skilled in open, laparoscopic and robotic kidney procedures makes him a better surgeon and uniquely qualifies him to understand which approach is best for each patient given his or her medical history and disease state. He is enthusiastic about robotic technology. “Robotic surgery has been a game changer”, he says. “It allows for less blood loss and less pain for the patient, also a faster recovery.” He adds, “For the surgeon, there is improved visualization with 3D technology, camera control and increased dexterity. But, every circumstance is different. Robotics is not a one size fits all technique.”

Dr. Jeffrey Stock is the Director of the Division of Pediatric Urology at Mount Sinai and has performed robotic surgery on children as young as eight months. Many of his robotic procedures are pyeloplasties. Others are to correct ectopic ureters that cause children to suffer from incontinence. Although pediatric robotics can be technically challenging, Dr. Stock appreciates the detailed and precise suturing that can be achieved through “the extension of my hands.” Dr. Stock often reminds parents that the robot does not take his place (it cannot make movements on its own and freezes when the surgeon moves away from the screen), but only enhances his skills.

The future of robotics holds much promise according to these physicians. Telerobotics is the next frontier, according to Dr. Palese. He says it will allow physicians to operate at a distance, perhaps across states and countries, and in collaboration with other surgeons. More imminent is single incision robotic urologic surgery, where complex procedures can be achieved through a single opening adjacent to the belly button.
An Interview with Dr. Courtney Phillips, Assistant Professor of Urology

Dr. Courtney Phillips is one of a very few female urologic surgeons in the country (95% of the specialty are male) and the only woman treating adult patients in the Mount Sinai faculty practice. Her practice is dedicated to surgical and non-surgical management of urologic cancers (kidney, bladder, prostate, testicular, and ureteral) and kidney stones.

Dr. Phillips did her medical training at the University of Medicine and Dentistry, New Jersey Medical School. She was a urology resident at New York University and did a fellowship in minimally invasive urologic oncology at Columbia Presbyterian Medical Center.

Q: What fueled your interest in Urology?
A: About 40% of my patients are female and very few urologists are female. There is a tremendous need. From a professional perspective, we get to operate and develop long-term relationships with our patients. This is very unique in medicine.

Q: Why did you choose Mount Sinai for your professional “home?”
A: Mount Sinai’s Department of Urology is incredibly supportive. My partners here are all highly talented and have been amazing collaborators and role models. My position at Mount Sinai has allowed me to work in Queens, Harlem, Manhattan and Brooklyn. I am currently the only female faculty member treating women. People forget that women have kidneys, bladders, and kidney stones too!

Q: What are some of the most exciting developments in treatment for Urologic cancers?
A: The last 1–2 years have seen the introduction of several drugs for hormone refractory prostate cancer. More than ever in history! This is a class of patients who did not even have one decent option ten years ago, and now have several possibilities for consideration. There are also exciting advances in nephron sparing and ablative procedures for kidney cancers. Another area that is getting a lot of attention is the art of non-treatment: active surveillance for carefully selected testicular, kidney and prostate cancer patients. This is not sitting back and doing nothing. This is carefully selecting and monitoring patients. It allows us to treat patients if their disease starts to progress. We can potentially avoid overtreatment and the toxicities associated with treatment.

Q: How can patients make the most out of their visit to a urologist?
A: I think a few general recommendations hold true for visiting any doctor. The first thing to do is to tell your urologist everything you want to talk about upfront. You may not get to all of the issues in one visit but at least they are on the table. Many of the conditions in urology are embarrassing for patients to discuss and patients casually “mention” the problem on the way out the door. I want patients to understand that some of their symptoms that are difficult to talk about, like erectile dysfunction and urinary frequency can indicate other diseases and should not be ignored. And, please let me know all of your health problems and medications.

Insights from Dr. Simon Hall
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not require any treatment at all. Or, if indeed a renal cell carcinoma, would grow exceedingly slowly so that in an individual patient the tumor could be watched and intervention done only if it were to enlarge significantly and/or quickly. Mount Sinai’s Department of Urology is part of a multi-institutional program following such patients over time to help detail in depth the natural history of untreated solid kidney tumors.

An alternative approach to a laparoscopic or robotic partial nephrectomy is CT or MRI guided percutaneous ablation. This procedure is performed in partnership with an interventional radiologist with the patient (usually) under conscious sedation. A needle is placed within the tumor which is then ablated or destroyed by one of several methods, including cryotherapy (freezing) or microwave therapy. All these techniques are in their relative infancy with regard to long-term cancer control; they are desirable over minimally invasive surgery due to their decreased potential morbidity and complication rate, but as indicated previously have not yet been fully validated for the treatment of many lesions. Again, in partnership with colleagues from Interventional Radiology, the Department of Urology, part of a multi-institutional data base analysis, is tracking outcomes of these techniques and coupled with our extensive knowledge of kidney carcinoma should shed light on the likelihood of a recurrence, development of metastatic disease and the need for secondary procedures.

In many ways handling of kidney cancer parallels that of prostate cancer in that many of these cancers do not require invasive treatment and can be followed over the duration of an individual patient’s life without putting him or her at risk. The ultimate goal is to generate a long-term understanding of the outcomes of non-treatment or percutaneous treatment to better guide patients in their treatment decision-making, specifically in terms of non- or minimal treatment.
Cancer Information Online Often Inaccurate and Misleading

The Internet has opened up an entirely new way to access health information for consumers. According to the Pew Research Center, 72% of Internet users said they looked online for health information of one kind or another within the past year. More than a third of adults used the Internet to determine what medical condition they might have.

How accurate is such information? A team led by Dr. Michael Diefenbach, The Department of Urology’s Director of Behavioral Health, and Kristian Stensland, a fourth year medical student, recently undertook research to analyze and compare quality of information about prostate and breast cancers available on YouTube (over 800 million people visit the video-sharing site each month, so the potential to spread inaccurate health information is significant).

Using the search term “prostate cancer” yielded almost 45,000 results (compared to 141,000 for breast cancer). Eighty videos representing the first two search pages for prostate and breast cancers were evaluated according to type (instructional, testimonial, etc.), source, literacy level, information quality, video attributes (humor, music, and narrator) length, viewer ratings and view count. These variables were used to predict information quality as measured by the correct fact ratio (correct facts divided by the number of facts).

The results, which are being presented at the American Urological Association annual meeting in May were sobering. Videos contained an average of 10 facts, or 2.8 facts per minute (considered by the researchers as too many in that time frame for most people to process and retain) and 28% provided incorrect, misleading and/or incomplete information. In addition, 62% of the videos contained biased information (e.g., favoring a particular treatment option) and 76% were categorized as a marketing effort. Although there were no significant predictors of quality, preliminary analyses showed that biased videos and videos advertising a service or product were significantly more likely to provide inaccurate or misleading information, compared to non-biased, non-marketing videos.

Where can you go to find accurate information online?

Mount Sinai reviews all medical information posted on our site, Facebook pages and blog (mountsinai.org). Other good sites are run by the National Institutes of Health (health.nih.gov) and National Cancer Institute (cancer.gov). The American Urological Association has a website with information targeted to consumers (urologyhealth.org) and ShareCare offers opinions on medical conditions from physicians across the country (sharecare.com). Be skeptical of advice provided in chat rooms and any site promoting quick cures or products that claim to do so.

Did You Know?

How are circumcisions performed? Are there any health benefits?

Circumcision is the surgical removal of the foreskin of the penis (a small flap of skin that covers its tip), generally performed shortly after birth. Circumcision is a highly safe procedure when performed in a sterile environment by a specially trained professional or physician, such as a urologist. Bleeding is minimal and infections are rare.

The procedure can be done in two ways. At birth or within one month of birth (approximately), circumcision can be performed at bedside/in home by an obstetrician (not all obstetricians do circumcisions, so ask beforehand if you are interested) or a Mohel (professional trained for Jewish ceremonial circumcisions). When circumcisions are done in this fashion, only a local anesthetic is needed. Circumcisions performed after a child is one month old are done in an operating room using general anesthesia and performed by a pediatric urologist or other trained specialist.

Emerging evidence has demonstrated that circumcision can reduce the risk of HIV, HPV and other sexually transmitted infections as well as penile and prostate cancers and urinary tract infections (UTIs).

The American Academy of Pediatrics believes the health benefits of newborn circumcision outweigh any risks, and the decision should be left for parents to make in the context of their religious, cultural and ethical beliefs.

Dr. Grace Hyun
Associate Director, Division of Pediatric Urology
Pediatric Urology

Mount Sinai and Integrated Medical Professionals Mark One Year Anniversary

One year ago, Mount Sinai and Integrated Medical Professionals joined in a clinical affiliation in order to make it easier for patients in Long Island, New York City and the Hudson Valley to receive state-of-the-art screening, assessment, treatment and management of complex urologic conditions, as well as improved access to cutting-edge radiation oncology services for Mount Sinai-based patients in their own communities.

IMP is a group of 100+ urologists and radiation oncologists in more than 50 locations who are sending their patients who require the resources of a world-class academic center to the Department of Urology. In turn, patients seen at Mount Sinai who require radiation and community follow up can be assured of expert care by IMP board certified urologists and radiation oncologists.

Deepak A. Kapoor, MD, Chairman and CEO of IMP feels the partnership has been highly successful to date. ‘As always, our goal is to provide the best patient care we possibly can. Working seamlessly together with Mount Sinai is simply an extension of that mindset and an important bridge for patients, combining the assets of a major academic institution with those of a community practice of the highest quality.’