Survivor Study were surveyed to identify factors that increase the need for additional prostate cancer survivorship information. Previous studies have shown discrepancies between subsets of prostate cancer survivors, based upon social, pathological, and treatment-based factors [2–5]. Indeed, the need for improved patient-centric information for all cancer survivors has resulted in the American Cancer Society publishing guidelines on how to best manage prostate cancer survivors, which account for four of every 10 male cancer survivors [6].

The authors [1] identify several critical aspects of post-treatment prostate cancer survivors. First, more than half of patients needed more information about their symptoms. This may be a departure from the views of many urological surgeons, who believe their patients are symptom-free after treatment. Second, the information needs of respondents were intuitively tied to their specific symptoms. For example, men who received combined therapy – thus, suggesting concern for incomplete control with primary treatment – were more concerned about recurrence; married men were more concerned about the effects of prostate cancer on their significant other; and men with more profound bowel or sexual symptom burdens were more concerned about the long-term effects and recovery period. Third, prostate cancer survivors remain concerned about diagnosis and treatment of their disease, even after they have received curative treatment. Topics such as early detection, diagnosis, and prevention of cancer were identified in double-digit percentages of respondents. Finally, there exists a correlation between the severity of symptom burden and associated information needs. A subset of symptoms (urinary, sexual, and bowel) may be directly related to treatment techniques and technologies. Thus, improvements in these fields may have long-term survivorship benefits.

While enlightening, these results are nevertheless susceptible to the inherent limitations of a survey-based study. Selection bias suggests that the true range of information needs and associated symptom burdens are not completely captured in these results. Additionally, these findings are not subdivided based on pathological stage or treatment method, which probably play important roles in cancer treatment, post-treatment symptoms, and patient concerns.

What are we to do with the results presented in this report? Clearly, easy access to informational resources about cancer survivorship needs to be offered as a standard of care for men with prostate cancer, which should be initiated before starting treatment. Additionally, men who are at-risk for requiring additional information on cancer survivorship (non-White race, received multimodality treatment, recurrent cancer, or high symptom burden) should receive additional counselling to ensure their informational needs are met. Finally, studies validating the effectiveness of these resources should be studied prospectively. Just as no two prostates are the same, so too should the paradigm be for prostate cancer treatment and survivorship.

Conflicts of Interest
None disclosed.

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References

Robotic simulation: are we ready to go?

In a study in this issue of BJUI, Aghazadeh et al. [1] were able to show that there was a significant relationship between simulated robotic performance and robotic clinical performance. The authors conclude that this supports the implementation of such robotic training tools in a standardized robotic training curriculum. Evidently, particularly in minimally invasive surgery, we must assess and learn from our surgical errors in order to prevent them in
 Nevertheless, there is still a long way to go! The authors have already conceded that there are some limitations to their study. It involved a small cohort of urological surgeons of different levels of expertise. It was not a randomized study comparing the impact of virtual simulator training on the surgical outcome, therefore, the authors could only show that they might be able to predict a surgeon’s performance during a real case based on his/her performance at the simulator. Based on this, the simulator training could theoretically pre-assess surgeon’s quality in robot-assisted surgery.

The authors probably chose endopelvic dissection because it represents a relatively easy part of robot-assisted radical prostatectomy. Accordingly, it remains unclear whether such basic tasks are really the best models to prepare a surgeon for this operation. Using low-fidelity training models, including vesico-urethral anastomosis, we were able to demonstrate the transfer validity of a six-step training programme [4]. It would be interesting to see the impact of the simulator training on clinical performance of robot-assisted vesico-urethral anastomosis because a valuable exercise for this already exists on the da Vinci Skills Simulator.

Despite this progress, we must recognize that we are far away from equalling the simulator training of pilots [3]. It is much easier to simulate turbulence during a flight than significant bleeding during robot-assisted surgery. Trials in simulating a complete laparoscopic procedure are still in their infancy [5]. This may differ with regard to other minimally invasive procedures such as ureteroscopy, where sophisticated trainer exercises exist; however, even in this field there is actually no proven evidence of the significant impact of simulators on shortening the learning curve. For all ‘hands-on’ simulation there will be always the problem of soft-tissue engineering and navigation [6]. Robotic simulators have the advantage compared with laparoscopy of three-dimensional video technology and the fact that there is no tactile feedback for the surgeon.

Evidently, information technology is continuously advancing and we may one day have a robotic simulator that can compare with the flight simulators used in aviation; however, to date, only training on basic skills can be provided and evaluated using the existing simulation systems in urology.

**Conflict of Interest**

None declared.

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