radiotherapy. Racial disparities in adjuvant treatment options could have influenced our results in regard of CSM. Therefore, future studies are required to observe racial disparities in adjuvant treatment modalities.

In conclusion, contemporary North American AA patients treated with RP have equal access to LND, same LNI rates and CSM rates as NHWs. However, the extent of LND is lower in AAs than NHWs. The results regarding LND rates are encouraging. However, improvements are required regarding LND extent in AAs.

Acknowledgment
The protocol for the research project was approved by the institutional review board and it conforms to the provisions of the Declaration of Helsinki (as revised in Fortaleza, Brazil, October 2013).

Conflict of interest
None declared.

References

Supporting information
Additional Supporting Information may be found in the online version of this article at the publisher’s web-site:
Table S1. Univariable and multivariable Cox regression models predicting CSM in PCA patients treated with RP and LND adjusted for clinical or pathological tumor characteristics.

Editorial Comment
Editorial Comment to Racial disparities in lymph node dissection at radical prostatectomy: A Surveillance, Epidemiology and End Results database analysis

In this issue of International Journal of Urology, Preisser et al. address one of the most important clinical (and equally political) questions in prostate cancer treatment in the USA, which is why African American men have significantly worse disease outcomes compared with white American men.1

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Previously reported methodology comparing quality of care between African American men and white American men suggested many complex quality of care indicators for radical prostatectomy including lymph node dissection (LND). Whereas previous reports still identified less frequent rates of LND in black men, Preisser et al. found that contemporary North American African American patients (Surveillance Epidemiology and End Results [SEER]-data cohort including the years from 2010 to 2014) treated with radical prostatectomy had equal access to LND, the same lymph node invasion rates and the same cancer-specific mortality rates compared with their white counterparts. Although our investigation of a SEER-Medicare cohort from 1991 to 2009 still showed disparities in LND, the current data are encouraging evidence for a mitigating disparity.

It remains worrisome, however, that the number of removed lymph nodes is fewer and the extent of LND is still less in African American men than in white American men. Although the actual extent of LND is still under debate, and despite the yet unproven benefit in terms of biochemical recurrence, metastasis-free survival or cancer-specific survival, LND facilitates unsurpassed accuracy with regard to staging for our patients.

Despite important constellations of poorer quality of care for African American men undergoing radical prostatectomy, such as limited access to care, treatment delay, higher rates of re-operations and readmissions, and associated higher costs, we previously did not detect significant differences in overall and cancer-specific survival, which is also corroborated by the current study. In summary, these observations show a shift from the generally accepted paradigm of worse prostate cancer survival in African American men. However, certain geographic variations in quality of care linked to racial disparities are still undeniable. In addition, Kaur et al. most recently warned that improvements in survival disparities in the prostate-specific antigen era might be smaller than observed as they affect both African American and white American men equally. Such “artifacts of screening” need to be taken into account when interpreting current prostate cancer survival data. Although the current study gives hope to those affected, true convergence to equal care seems to be far from over.

Marianne Schmid M.D.1 and Christian P Meyer M.D.2
1Department of Urology, University Medical Center Göttingen, Göttingen, and 2Department of Urology, University Medical Center Hamburg-Eppendorf, Hamburg, Germany
dr.marianne.schmid@gmail.com
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