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Invited Commentary to: The diagnostic value of prostate cancer between holmium laser enucleation of the prostate and transurethral resection of the prostate for benign prostatic hyperplasia, Comparative Study - Retrospective Cohort. IJS-D-19-01006R1

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Invited Commentary on “The diagnostic value of prostate cancer between holmium laser enucleation of the prostate and transurethral resection of the prostate for benign prostatic hyperplasia, Comparative Study - Retrospective Cohort”

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1 **Invited Commentary to: The diagnostic value of prostate cancer between holmium laser**
2 **enucleation of the prostate and transurethral resection of the prostate for benign prostatic**
3 **hyperplasia, Comparative Study - Retrospective Cohort. IJS-D-19-01006R1.**

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5 We read with interest the article written by He *et al.* on the diagnostic value of Holmium laser
6 enucleation of prostate (HoLEP) and transurethral resection of the prostate (TURP)¹. The authors
7 highlight that HoLEP can provide a higher detection rate of Prostate cancer (PCa) when compared
8 with TURP, especially in patients with PSA less than 10 ng/ml. HoLEP removes more tissue when
9 compared with TURP, especially the tissue close to the peripheral zone, which presents a relatively
10 higher risk of PCa. They honestly report the results of ten years' data (2008 to 2018) of 2909
11 patients (1362 HoLEP and 1547 TURP). The total detection rate of PCa was 6.24% vs 3.94% in the
12 HoLEP and TURP groups, respectively. Interestingly, when the PSA was in the grey zone (PSA 4-10
13 ng/ml), PCa was found in 13.9% of patients after HoLEP

14 HoLEP is feasible in prostates of all sizes² and provides better haemostasis and intra-
15 operative safety than TURP and Open prostatectomy (OP). Peri-operative parameters like
16 catheterization time and hospital stay are in favour of HoLEP, and long-term functional results of
17 HoLEP are comparable to OP, better than TURP (LE 1a). Even though HoLEP achieves better results
18 than TURP, many still consider TURP the "current standard" for men with prostate sizes of 30-80
19 mL and moderate-to-severe LUTS secondary of BPO, as it is still the most frequently used
20 technique worldwide.

21 Both techniques (TURP and HoLEP) allow collecting all the resected tissue for anatomical
22 analysis, unlike other procedures such as laser vaporization or water vapour energy ablation. The
23 incidence of PCa on published TURP series varies from 5.5% to 21%, in line with the present study.
24 We fully agree with the authors that HoLEP can remove more tissue than TURP and that this
25 probably translates into a better diagnostic yield for PCa. Although most often PCa arises in the
26 peripheral zone, 5-20% of cancers grow into the transitional zone or close to the peripheral zone
27 and thus can be removed and detected by HoLEP. Furthermore, after HoLEP, PSA levels usually
28 drop and remain lower than 1 ng/mL³.

29 The authors note that there was no difference between the two groups when the PSA was
30 over 10 ng/ml. However, it is noteworthy that PCa rates were high in this subgroup, 25.9% and
31 22.8% for the HoLEP and TURP groups, respectively. The use of tools such as mpMRI is only briefly
32 mentioned. We want to emphasize that it is crucial to rule out PCa before offering surgical
33 treatment of BPE. In this sense, we think that it is no longer best practice to rule out PCa with DRE,
34 PSA and conventional TR biopsy; if possible, tools such as mpMRI, Micro-ultrasound and
35 biomarkers should be used⁴.

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42 **Conflict of interest:**

43 None declared.

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45 Provenance and peer review

46 Invited Commentary, internally reviewed

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