

## MEditorial May 2012

### “Timing is Everything”

“You may delay, but time will not”. *Benjamin Franklin*.

“Take time to deliberate, but when the time for action arrives, stop thinking and go in”. *Napoleon Bonaparte*.

The timing of a medical intervention is sometimes as important as the treatment itself. In my surgical specialty, urology, deciding not only IF but WHEN to operate has ramifications for patient outcomes and their safety. It also affects the patient’s psyche, as well as cost of medical care. Distinguishing a true emergency from something less urgent is a part of this decision process.

Truth be told, there is less economic incentive than ever before for surgeons like myself to perform surgery, but there are still those among us who will try to convince a patient that his or her condition, not emergent or life-threatening, needs surgery that day or in the near future. In extreme cases, this plays to the medical naivety of patients; turning a semi-elective surgery into an emergency will not allow time for the patient to deliberate or perhaps obtain a 2<sup>nd</sup> opinion. Unequivocally, the cost of medical care is considerably higher when delivered on an emergency basis.

In urology, surgical emergencies do occur. Emergencies imply a threat to life or loss of body function [which could be permanent] or significant correctable pain not amenable to optimal pain management. These situations include urinary bleeding to the point the patient needs transfusions, is rapidly becoming anemic, has unstable vital signs from hemorrhage and/or has a bladder full of blood clots which cannot be managed by irrigating through a urinary catheter. Certain types of infections need urgent intervention, sometimes in hours, other times within a day or two. Any “closed space” infection can lead to dissemination of bacteria throughout the body, cardiovascular instability and shock with dysfunction or failure of multiple organ systems. Examples would be spontaneous or postoperative abscesses; or blocked kidneys (often by stones)

with chills and fevers. Vascular problems as seen in spermatic cord torsion, usually in children and adolescents (twisting of cord leads to shut-off of arterial flow to testicle) need urgent intervention, since there is a limited time (perhaps 4-6 hours) before which interruption of blood flow will lead to permanent non-function of the organ.

I will give a few examples where the urgency of intervention is less clear. Kidney stones passing into the ureter (tube between each kidney and bladder) can be quite painful and may need surgical intervention even if not causing a serious infection. Although pain can be unbearable, it is often controllable with appropriate narcotic analgesics. Oftentimes (unlike in the past), the patient can go home and try to pass the stone spontaneously, perhaps helped by so-called alpha-blockers (e.g., tamsulosin/Flomax) which can relax the muscular tissue in the ureter allowing it to relax its “grip” on the stone. The 1<sup>st</sup> attack of pain from a stone is often the worst. Therefore if the stone is not too large, especially under 6 mm. (1/4 inch), it is reasonable to follow the patient with exams and x-rays and allow several weeks, or longer (barring ongoing severe symptoms) for the stone to progress downward and hopefully be eliminated. About 90% of stones under 4 mm. and over 70% of stones between 4 and 6 mm. will pass spontaneously. A urologist could argue that even for the stone likely to pass, pain and loss of work are not worth any delay, and interventions such as ureteroscopic stone removal and shockwave lithotripsy have a high success rate and low chance of causing problems—however, counterarguments include surgical risks, failure of the procedure to eradicate the stone and, of course, the cost issue.

Another contentious example is with urinary retention in men, not infrequently related to chronic prostate enlargement. If the man ends up needing a urinary catheter when he cannot void at all, does this mean it is time for more urgent surgery? Perhaps. However, this is somewhat dependent on how often this event has happened, the severity of antecedent urinary symptoms, whether the man has been tried on drugs to help the bladder compensate for the obstructing prostate, and whether one or more “trials of voiding” are to be offered. The latter simply means removing the catheter and seeing if the urinary retention

has resolved spontaneously. In my practice, well over 50% of men needing a catheter for retention will overcome the problem and not require “urgent” surgery—some may need an operation, e.g., transurethral resection of prostate (TURP), @ a later date, when they are more (physically and psychologically) ready and accepting of the surgery--and its potential adverse effects. If a man with retention were to say “I do not want this to happen again” and he has a known prostate obstruction and especially pre-existing bothersome urination symptoms, I will probably omit the “trials of voiding” and proceed to scheduling a surgery.

Cancer surgery is another interesting example. As expressed in the wonderful Pulitzer-Prize winning book by Siddhartha Mukharhjee “The Emperor of All Maladies: A Biography of Cancer”, the fear factor from the diagnosis of cancer is unrivaled among diseases. Most patients facing this condition want it eradicated right away, hopefully never to resurface. However, in Urology, several cancers we deal with do not necessarily require immediate surgery; and deliberation without undue delay is preferable. Examples of these would include (1) most garden-variety prostate cancers (grow slowly, present low risk of reducing longevity, especially to those diagnosed over 70); (2) small solid kidney masses, usually under 3 cm., which--although they could be cancerous--would be slow to disseminate to other parts of the body—and the myriad of newer minimally invasive treatment options dictate thoughtfulness, not haste in decisions; (3) most superficial bladder cancers, which do not even necessarily need urgent transurethral resection if they appear [to the experienced urologist] low-grade and are not causing significant bleeding.

On the other end of the spectrum are more aggressive urological tumors which, if still felt to be curable or at least more controllable with surgery, should be dealt with more urgent timing. These include but are not limited to all testicular cancers, large solid renal masses (likely kidney cancer) and high grade/invasive (often into muscle) bladder cancers.

Timing of surgery also relates to the age and condition of the patient. In a non-emergent situation, the urologist should consult with the patient’s other

**doctor(s) to understand how the surgery (more so should complications ensue) may affect the patient's other medical conditions; and whether so-called "comorbidities" will potentially adversely affect the outcome of surgery. Blood thinners such as aspirin, Plavix, Coumadin, and Pradaxa should, if at all possible, be held for the appropriate number of days before any surgery. In the frail or older patient unsuitable for surgery (or if such surgery were deemed too complicated and/or not likely to work), alternatives should be offered, e.g., a chronic bladder tube to be changed on a regular schedule in a man with prostate enlargement who can no longer void spontaneously.**

**A urologist with a good sense of surgical timing and perspective will do the right thing when the patient is ready; avoid unnecessary delays in treatment; limit pain and suffering; and contribute his or her share to lowering the cost of medical care.**

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