

Practice variation in Urology

The article by Choo et al is an interesting analysis of variations in clinical practice in the management of seminoma. Seminoma is a relatively common disease, with an extremely predictable natural history, an effective, relatively non-morbid treatment (abdominal radiation) and an excellent outcome for most patients. One would think that the treatment would be relatively standardized. In fact, Choo and colleagues found quite substantial differences in practice patterns. This emphasizes that, even for diseases that are straight forward, consensus is often lacking.

Small area variations in practice patterns have been a powerful tool for epidemiologists and health policy analysts to identify 'problem areas' in medicine. It is noteworthy that the first procedures for which large variations in practice patterns between regions were identified, (by John Wennberg at Dartmouth), were TURP and tonsillectomy rates. These variations typically occur where existing treatment algorithms are not supported by high quality evidence. As such, they provide a road map to opportunities for clinical trials. The history of the management of BPH is a case in point. Wennberg's seminal observation (published in the 1975 Journal of the Maine Medical Association) was followed by a large series of randomized clinical trials carried out in the 1980's. These fundamentally altered the treatment of this condition by clarifying the natural history of BPH/LUTS and the limitations of TURP. (The advent of long acting selective alpha blockers also played a role).

Beyond small area variations, the national variations in practice patterns between the United States and Canada fuel debate and speculation. These are the consequence of difference incentives in our respective health care systems. According to Choo's study, for patients with stage 1 seminoma wishing fertility preservation, 56% of Canadian practitioners offer patients surveillance, compared to 8% of Americans. This reflects the fact that practice patterns follow reimbursement incentives. For overworked, modestly reimbursed Canadian radiation oncologists, surveillance is appealing; for American practitioners, competing for patients and considerably higher paid for delivering treatment, the tendency is to prescribe adjuvant radiation. Both groups will argue that the decision involves trade offs, that patients are given the choice, and that their approach is rationale and evidence based. And yet: 7 times more physicians in Canada choose surveillance. The same issue arises with respect to surveillance versus RPL for non-seminoma, and conservative management of favourable clinically localized prostate cancer.

The article by Speiss and colleagues is an honest appraisal of the limitations of the long term use of artificial sphincters in the pediatric spina bifida population. This type of critical appraisal of devices and technologies used in Urology is all too rare. This important study should result in serious rethinking of the role of artificial sphincters in this population.

This issue contains the CJU's policy on scientific misconduct. It is the Editor's view that this policy will, in all probability, never require implementation. However, we hope that clearly defining our approach to this serious problem will, in a small way, encourage investigators to stay on the straight and narrow.

Laurence H. Klotz
Editor-in-Chief
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