



# EMJ Interview



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### Q1 Was there a defining moment or set of moments that led you to choose a career in urology and specifically prostate cancer (PCa) surgery?

When I was a House Officer after finishing medical school, the first job I did was in urology. I had never considered urology beforehand and had not been exposed to it much through medical school. When I did that urology job, I remember meeting the consultants and thinking that this was actually very nice. I remember going to some of their houses and they all had nice sports cars and houses, and I thought this is a job with a good lifestyle.

Following this, I went to London and worked for Lord Bernard Ribeiro, who became the first Black President of the Royal College of Surgeons (RCS). I worked for him, and he was a true General Surgeon. He worked in general surgery, and also did thyroids and urology. When I worked for him, I really enjoyed the urology aspect of the role, so that pushed me into urology.

In terms of PCa, when I was a Junior Trainee, one of my programme directors took a liking to me and sorted me out with a fellowship in New York, USA, for a few years with a very famous PCa

surgeon to learn robotic PCa surgery from him.

### Q2 Your personal education and professional experience have involved you travelling to numerous destinations such as the USA and Germany. Where do you believe you gained the most experience, and do you believe travelling was integral for you to make it to where you are today?

Yes, it was certainly the case. I believe you always learn more when you learn from different people and different systems. So, even if you work with great people here, there is more to learn elsewhere as well. There's more than one way of skinning a cat and there's more than one way of doing something, and there's more than one good way of doing something.

It's very useful, no matter how good your training is locally, to expand your horizons, see different perspectives, and actually going and working with the best in the world. New York, Sweden, Oxford, and London, etc., it all adds to that mix of who you are as a doctor, as a urology surgeon, as a PCa surgeon. Therefore, it was a really helpful experience because it gave me different perspectives and different ways of doing things. I always learn something from different people

who are all experts in their field. It's not like it's a competitive thing; it is in fact a collegial thing.

In terms of bang for my buck, I believe the place where I gained the best experience was in New York, USA, because I went on fellowship there for 18 months. On most days, I pretty much worked from 6 a.m.–8 p.m. While there, I published 36 papers in 18 months, presented over 50 times at international meetings in 18 months, and had 11 months in surgery. I did what would have been quite a few years' worth of training condensed into a very short period of time because of the level of intensity. It was where I trained with one of the world leaders in my field of PCa, and is probably where I learnt the most in the shortest period of time.

**Q3** You currently have two published books, over 20 book chapters, and 10 newspaper articles to your name for your research in PCa and robotic surgery. What do you believe to be the current gaps in literature and what topics merit greater attention?

One of the things that I'm very much interested in is the value of surgery and robotic surgery, in particular in males who are suffering from more advanced disease. We have demonstrated, through a lot of the work that I and others across the world have done, the value of robotic surgery for localised PCa, curing cancer, or the long-term control of cancer, and also in reducing side effects. We have optimised surgery for localised PCa; however, what we haven't been able to do yet is to identify males who have life-threatening disease, beyond localised disease, and who may benefit from a cure and actually increase their life expectancy for a disease that would otherwise be considered incurable. We now need to move from just optimising outcomes in the population with localised PCa, and move on to these advanced cases. Currently, we are looking to see how

we can actually improve cure rates and long-term cancer control rates in males who are diagnosed with advanced disease, and trying to stop it from then progressing onto very advanced, life-threatening disease. We need to get to that bridge of actually expanding our surgical indication or treatment indications to capture males who need it more because they are more likely succumb to their disease.

**Q4** You have contributed greatly to the field of urology. Could you share any exciting findings or current research going on in your department?

I have two or three different affiliations, but my main NHS clinical affiliation is at University College London Hospitals (UCLH), UK. We've just received a grant for our hospital through The Urology Foundation (TUF) Innovation and Research Fund to run a study looking at males who are highly likely to be incontinent after robotic prostatectomy. We are running a study where we compare conventional robotic surgery with a new type of robotic surgery called Retzius-sparing robotic-assisted surgery, which is only performed by a few expert surgeons across the entire country. I'm one of those surgeons and, therefore, in a good position to run such a study. We're looking to see if males who are likely to be incontinent after standard robotic surgery can do better with this newer form of robotic surgery. This is an innovative study, and we're hopefully going to start this study soon at UCLH.

I also work privately at Cleveland Clinic London, UK, where I'm the Lead for urology. There, we are hopefully going to set up other studies that are mostly going to look at patient-reported outcome measures, so that we are able to assess how males recover after surgery from our perspective as doctors, and also ask patients directly. What you find actually is, when you look at patient reported outcomes, they often vary considerably compared to what doctors



think. For example, if a doctor asks if you are incontinent, you're far less likely to say "Yes" than when filling out an evaluation, because of an underlying desire to please the doctor, an attitude that many patients have. In order to truly see how patients are reacting and responding to the interventions given to them, it's important to carry out patient reported outcomes. We're investing a lot of time and effort in trying to get those embedded within all patients who present with PCa and other urological diseases that have outcomes that require management.

**Q5** Advanced PCa is one of the most common urological diseases. Have you seen much improvement in its treatment over the last few years?

Advanced PCa, which is not contained and has already spread outside the prostate, beyond the lymph nodes, and perhaps into the bones or other places, is typically considered incurable; however, now we have newer systemic drugs beyond hormone treatment or standard hormone treatment, such as abiraterone, and chemotherapeutic agents that have already been shown to improve survival from this population. At present, a male who is diagnosed with metastatic or advanced PCa is likely to do a lot better than they would have done a few years ago.

On top of that, my interest is looking to see whether curative modalities such as surgery can also further improve survival rates in these patients. That is where I think there's still some work to be done. That is where we are focusing our efforts: to try and improve survival rates of these affected males.

**Q6** Are there any innovations on the horizon in the field of urological surgery that you think are particularly noteworthy?

One of the great things about urology surgery is that there are always lots

of innovations, because it's a very technical specialty with a lot of gadgets. Although it's a surgical specialty, there's not a huge amount of open surgery anymore; however, there are a lot of robotics, and endoscopic surgery with telescopes. It's endoluminal, endoscopic surgery, or robotic surgery, and there are new robots and tools. These are bigger and better tools with smaller footprints, more versatility, and better vision. Additionally, better dexterity platforms are emerging that will help to improve the outcomes for patients, which, at the end of the day, is what it's all about. It's a bit like a PlayStation 1. We thought it was great but now we have the PlayStation 5, and PlayStation 1 seems outdated. It's the same way with urological surgery. It is much more advanced now, with instrumentation and robotic devices that we can use which, of course, have improved outcomes for our patients.

**Q7** You currently are in the research panel of TUF. Can you talk about the ways in which TUF aims to empower patients and create a dialogue aimed at optimal healthcare benefits?

TUF is a very nice charity. I've been involved with this organisation for many years, even before I was appointed to the research panel; now, I'm involved in the assessment of research proposals from different colleagues to see which ones are worth funding. Back in the day, even before I became a PCa surgeon, they helped fund me to go on some visits to the USA, from Florida to New York, to see what PCa surgery and robotic surgery was all about. They inspired me to go off and learn that technique, so they've been very instrumental in supporting urologists like me. They funded my research and a trial that I've just finished, which has been recently been published.

Additionally, they have funded a study of the new surgical technique that I mentioned earlier: Retzius-sparing

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robotic-assisted surgery. The way in which they support urology patients is by supporting urology doctors and by funding these doctors to do patient-related research. If you look at all of my research, it's all patient-focused research. It's not about sitting in a lab with test tubes of DNA. Instead, it's been patient-focused, looking into patient outcomes and at various techniques and surgical modalities, and then comparing them to see what's best for the patient. TUF is very good at that kind of research and getting great buy-in from patients to participate, and also to propagate the findings of that research to patients.

**Q8** As a committee member of the UK National Cancer Research Institute (NCRI) Advanced Prostate Clinical Studies Group, could you please explain what this position entails, and how it contributes to the success of the association and patients' healthcare?

The NCRI has various groups; PCa is one, and there is an advanced PCa subgroup. It is a government research structure. So, for example, if you decide you want to do research in PCa, you need to have approval after peer review process from some form of governance such as the NCRI in order for you to get funding from a large funding body.

People who want to do research in advanced PCa present their idea to the NCRI advanced PCa subgroup. We will look at all those proposals, critique them, and provide feedback, so that

when they then apply for funding, they have the best proposal to try with. Additionally, the funders know that it's been through us, a peer review group of experts who have looked at this proposal and approved it. It's a way of being engaged with the PCa community, to see what researchers and other experts in the UK are doing, being able to provide input into that and, therefore, being able to create a high-quality research agenda for the country.

We are also interested in understanding what patients want, as there's no point in patients joining research studies that are not likely to succeed, or are of no use. If we're going to ask patients to go the extra mile and take part in a study, which may not necessarily affect them directly but will help others like them, then we need to make sure it's the best quality research. Being able to participate in that governance structure to ensure that we have high-quality research coming through is very rewarding for me.

### **Q9** Are there any innovations on the horizon in the field of urological surgery that you think are particularly noteworthy?

There are new robotic manufacturers out there. Intuitive (Sunnyvale, California, USA) dominated the market for 20 or more years. It was the same way when I was growing up, when BT (London, UK) was the only telephone provider. Now, of course, we can get phones from hundreds of different providers. In the same way, there are lots and lots of different robotic manufacturers coming into the market, and that raises the bar for everybody. When you have a monopoly in any field there's no reason for innovation and progress, but as soon as that monopoly is broken and new people come in, the quality goes up and cost goes down. That benefits patients in the long run. I think that having more competition in the market is creating greater versatility of robotic procedures and at a lower

cost, which also benefits patients.

### **Q10** Finally, what advice would you give to young healthcare professionals pursuing a career in this discipline? Where do you hope they will take the field of urology and, specifically, robotic surgery and PCa research and developments over the coming decades?

The future is bright for urology because we have so much innovation, with new robots and technologies coming into the market. I would tell them to stick with urology and pursue it, as it provides you a great mixture of medicine, minimally invasive surgery, and robotic and endoscopic surgery, and it has a huge variety for them.

In terms of research, a lot of it is urology surgery but also diagnostic urology, which has a lot to do with cancer work. A quarter of all cancers across the board are urological cancers, with PCa being the most common cancer for males in the Western world. There's a huge potential to improve the field of cancer and do cancer research, while still working as a practising urologist. One could do basic science, cancer research, clinical cancer research, and clinical operating work as well, so there's so much variety in the field.

I believe the field of robotics will continue to get better, just as it has in robotics outside of urology. The same way we can put the Mars Rover on the moon, we'll be able to have better surgical robots for enhanced surgical procedures, and even more precise procedures. That's a huge benefit for urologists but also the research side in terms of cancer biology, and trying to find better treatments and better cures for cancer which, again, is hugely exciting. Hopefully I will see that in my career over the next 10–20 years. ●