Professor Jay Simhan: surgery improves the quality of life for patients

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Professor Jay Simhan (*Figure 1*) is Director of Urologic Trauma, Reconstruction and Prosthetics for the Fox Chase/Einstein Urologic Institute and an Assistant Professor of Urology at the Fox Chase Cancer Center. He is a member of the American Urologic Association, the Mid-Atlantic section of the AUA, the Philadelphia Urologic Society, the Sexual Medicine Society of North America, and the Society of Genitourinary Reconstructive Surgeons.

Dr. Simhan's clinical interests include urethral stricture disease, open and robotic urinary tract reconstruction, penile implant surgery, male anti-incontinence surgery, revision male prosthetic surgery, Peyronie's disease, and complications from prostate cancer treatment. Dr. Simhan has published on a variety of topics in urology including numerous contributions to the field of urologic reconstruction, trauma, and prosthetics. Having authored or co-authored over 100 peer-reviewed publications, abstracts, and book chapters, Dr. Simhan has been published in many leading peer-reviewed journals including the *Journal of Urology*, *European Urology*, *Urology*, and *the British Journal of Urology International*. I met Dr. Simhan during the American College of Surgeons (ACS) Clinical Congress 2015 in Chicago and was honored to do the interview with him.

TAU: What brought you into the field of urologic trauma?

Prof. Simhan: Urological trauma is composed of genitourinary injury and genitourinary reconstruction. For me, I was really interested in pursuing a field where a lot of surgeons were tackling these acute surgical problems in many patients. Currently, many patients are treated with conservative methods instead of surgical treatment, because surgical treatments have not been well described, educated, or learned. I felt if I were well educated in such techniques, I can help benefit many patients.

Figure 1 Professor Jay Simhan.

TAU: You've participated in a discussion with the topic "Morbid obesity is not associated with the worse outcomes following surgery for renal cell cancer". How did this conclusion come?

Prof. Simhan: This conclusion is related to interesting research done in the University of Wisconsin. Some experts there looked at a large series of obese patients with renal cell carcinoma and compared the outcomes over a 13- or 14-year period. What they demonstrated was that the obese patients did not seem to have poorer outcomes following renal cell carcinoma treatment. This finding was in contrast to the prior studies done in kidney cancer which have showed that obese patients were at a higher risk of developing cancer. What the Wisconsin group has shown is that even though obese patients have a higher risk

of developing cancer, their cancer specific outcomes are equivalent to that of non-obese patients.

TAU: Is further study needed to demonstrate the conclusion?

Prof. Simhan: The best way to answer this question is prospective study with patients followed over a longer term. A primary limitation of the Wisconsin's study was that it was a retrospective study. But I imagine that they are continuing doing this work in a prospective fashion now. I am sure there will be an answer shortly.

TAU: Currently, do you and your team have any new and exciting investigations in plan or underway?

Prof. Simhan: My practice primarily focuses on genitourinary trauma, reconstruction, and prosthetics. Several things I have been doing related to reconstruction include minimally invasive surgery for repairing ureteral trauma and ureteral stricture. Another area relates to prosthetics in particular. I have a very busy practice with penile implantation and artificial urinary sphincter surgery. What we are starting to do and what we've done the most of within our regions include alternative reservoir and balloon placement in the high submuscular space. This technique most likely best avoids abdominal complications from urologic prosthetic surgery. Due to our cutting edge technique, we have even extended this application to prostate cancer patients with pre-existing refractory erectile dysfunction that undergo prostatectomy to have concomitant penile implantation done with alternative reservoir placement. After all, patients can have one recovery from two surgeries with full potency within 4 weeks following surgery. We have recently developed a video demonstrating such important techniques for surgeons to consider when attempting concomitant prostatectomy with penile implantation.

TAU: What do you love about surgery?

Prof. Simhan: Almost every patient that I am operating on has a quality of life problem. Many patients with cancer and many patients even without cancer have real quality of life problems that I see in my clinics every day. Many times, such quality of life problems that I see with great frequency, including urethral stricture, ureteral stricture, curvature of the penis, refractory erectile dysfunction or male stress incontinence, are problems that can only be cured with surgery.

TAU: Thank you and Dr. Allen Morey for organizing a focused issue "Contemporary Management of Urethral Stricture" (V4N1) for our journal TAU. Do you have any recommendation for this issue?

Prof. Simhan: Dr. Morey and I co-guest edited the focused issue "Contemporary Management of Urethral Stricture." This focused edition does a good job of synthesizing and delineating various contemporary management options. Gone are the days when dilation is a "good enough" surgery to treat strictures. Nowadays, urethral reconstruction is really an excellent treatment for strictures. What we present in this edition is cutting-edge because we look at key treatments or key anatomical areas that urologists often struggle with. We have gone through a very systematic approach of how to treat these patients. For example, we look at how patients can be managed differently with pelvic fracture urethral injury, the refractory situation confronted with radiation-induced stricture and how patients can be managed successfully with surgical intervention. We also look at penile strictures and different types of buccal grafting utilized in repair. Although buccal grafting itself was reported centuries ago, its use has only gained traction in the last couple of decades. In summary, we attempt to look at all management options for urethral stricture in a contemporary way in order to demonstrate urethroplasty (and all of its various forms) as excellent treatments for patients who suffer from these serious problems.

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Footnote

Conflicts of Interest: The author has no conflicts of interest to declare.

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