

Comment on “does aquablation wash away holmium laser enucleation of the prostate (HoLEP)?: a comparison of the techniques and outcomes”

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The review by Helfand et al. addresses an important and timely topic in the surgical management of benign prostatic hyperplasia (BPH).¹ As interest in Aquablation expands following publication of the WATER trials, comparisons with holmium laser enucleation of the prostate (HoLEP) have become increasingly important.^{2,3}

The authors should be commended for providing a balanced overview of the available evidence regarding Aquablation and AEEP/HoLEP. The manuscript highlights clinically important issues, including the learning curve, functional outcomes, sexual function preservation, and perioperative morbidity. It also appropriately emphasizes patient-centered decision making when selecting surgical therapy for BPH.

At the same time, careful interpretation of the evidence remains essential. Although the WATER and WATER III studies provide important prospective comparative data supporting Aquablation as an effective treatment, the currently available evidence may not yet justify the conclusion that Aquablation has superseded HoLEP/AEEP as the reference surgical therapy for BPH.

HoLEP is supported by decades of accumulated evidence, including extensive real-world experience, low retreatment rates, and durability exceeding 10 years. In contrast, Aquablation still has relatively limited long-term follow-up and less mature real-world evidence. Moreover, the WATER studies primarily

demonstrate non-inferiority and selective functional advantages rather than superiority across all clinically meaningful outcomes.

Importantly, the economic implications of widespread Aquablation adoption also remain insufficiently addressed. The manuscript itself acknowledges that there is currently no comprehensive published cost analysis directly comparing AEEP/HoLEP with Aquablation. Nevertheless, available evidence suggests that Aquablation is associated with substantial disposable and platform-related costs. Müllhaupt et al. demonstrated significantly higher in-hospital costs for Aquablation compared with TURP, largely driven by consumable and device-related expenses.⁴ Similarly, the NICE technology briefing highlighted the substantial per-case costs associated with its single-use handpiece and dedicated robotic platform.⁵ In contrast, HoLEP laser systems are multifunctional and may be shared across other endourological procedures, potentially reducing the effective per-case cost in high-volume centers.

Therefore, although Aquablation has clearly emerged as an important addition to the surgical armamentarium for BPH, it may be premature to conclude that it has “washed away” HoLEP. Rather, current evidence suggests that Aquablation has earned a place alongside HoLEP among contemporary surgical options for BPH, while the question of long-term superiority remains open and requires continued investigation.

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Ethics Approval

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Conflicts of Interest

The author declares no conflicts of interest.

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