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Editorial

Report from London

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It hardly seems possible, but it is now almost a decade since we first conceived the idea of *Prostate Cancer and Prostatic Diseases*. Now into our eighth volume, we have established electronic publishing, with early online release of key papers (Advance Online Publication). Our original scientific papers and reviews are now included in Medline and Current Contents. We are privileged to attract a good flow of excellent papers and our special thanks go to our ever-extending panel of expert reviewers for their efficient work and dedication in appraising and selecting quality submissions for timely publication.

I am delighted to announce the winner of the AstraZeneca Prize for the best paper in the journal over the four issues published in 2004. The prize of a $2000 educational grant goes to Dr Shin Egawa for his exceptional paper 'Impact of biochemical failure on long term clinical outcome after radical prostatectomy'. We are also extremely pleased to announce AstraZeneca's continuing sponsorship of this prize for this year and we therefore encourage authors to continue to submit high-quality papers with this valuable prize in mind.

In this issue, we have several excellent reviews that you are certain to find stimulating. The key to the development and progression of prostate cancer is the genetic perturbations and dysregulation of the molecular signalling pathways that initiate and perpetuate the malignant process. A number of studies now indicate that disease progression is linked to apoptosis resistance, which Li *et al* convincingly argue may be linked to the phosphatidylinositol 3-kinase (PI3-K)-Akt pathway. They also point to the potential for the development of valuable biomarkers as well as therapeutic strategies for prostate cancer based on targeting the PI3-K-Akt pathway.

Another fascinating molecular signalling pathway is reviewed by Yardy and Brewster who examine the Wnt pathway which directs embryonic growth and is important in maintaining stem cell populations. Again, the potential for chemoprevention, early identification and treatment of prostate cancer based on a clearer understanding of the molecular mechanisms involved in tumorigenesis will not escape our readership.

Angiogenesis provides another molecular target of obvious potential in men with prostate cancer. Woodward *et al* survey the effects of androgen suppression and radiation and suggest a potential role for angiogenesis blockade. In patients with previously untreated metastatic colon cancer, the new angiogenesis inhibitor bevacizumab has recently been given with chemotherapy (irinotecan/5-fluorouracil/leucovorin) and demonstrated to improve survival by an average of five months. It also increased survival when added to oxaliplatin/5-fluorouracil/leucovorin. Since docetaxel has recently been demonstrated to prolong survival in men with hormone-relapsed prostate cancer (HRPC),[1] it would seem logical to test taxane-based chemotherapy plus an angiogenesis inhibitor in combination in this clinical setting, or even before hormone relapse has occurred.

But the question that worries clinicians and their patients most of all today is which treatment should be selected for men presenting with clinically localised prostate cancer. Radical retropubic prostatectomy (RRP) is still the therapy that most urologists and many patients favour. Gontero *et al* review the precise operative technique with special reference to nerve-sparing, which has significantly reduced the morbidity of the procedure in terms of sexual dysfunction. Khan *et al*, however, provide a slightly sobering assessment of the outcome of the operation in terms of freedom from PSA recurrence over 5 y of follow-up. They conclude that relapse is not uncommon and that it is not dependent on the age of the patient at the time of the surgery. This of course begs the question as to which adjunctive therapies are in order and when they should be administered. Interestingly, Ahlering and Skarecky point to the fact that not every patient with a detectable PSA after RRP requires treatment. In their series, 40% of cases were managed by watchful waiting without intervention. Higher risk patients, with T3b disease, on pathologic evaluation, are however, likely to require further therapy. In the study of Kasibhatla *et al*, men with seminal-vesicle invasion treated with external beam radiotherapy and androgen ablation in combination fared significantly better than those treated by radiotherapy alone. The value of androgen ablation in delaying PSA progression after RRP, radiotherapy or watchful waiting is also apparent in the paper from Wirth *et al* who conclude that the addition of bicalutamide significantly improves objective progression-free survival, but not overall survival. Significantly, they conclude that long-term bicalutamide is useful in patients with locally advanced disease, but not appropriate for the management of men with localised disease. Kaisary's review evaluating early hormonal therapy in patients with localised or locally advanced prostate cancer emphasises the importance of both patient choice and quality of life considerations when deciding the appropriate timing and agent for hormonal therapy.

On a final note, I suspect that many of our readers will find e-mail a double-edged sword. While it undoubtedly is a powerful and efficient communication tool, it can also be something of a bugbear to an already overburdened clinician or researcher. The message from Katzen *et al* in this issue is clear: e-mail is favoured by patients for increased convenience, efficiency and timeliness. Since they are the clients and we are the providers, we seem to have little option but to comply — all we need is a few more hours in the day!

RS Kirby

Reference

1 Petrylak DP, Tangen CM, Hussain MHA. Docetaxel and estramustine compared with mitoxantrone and prednisone for advanced refractory prostate cancer. *N Eng J Med*. 2004; **351**: 1513–1520.