Prostate Cancer and Prostatic Diseases (2006) 9, 199
 1365-7852/06 $30.00
www.nature.com/pcan

EDITORIAL

Report from Durham

Prostate Cancer and Prostatic Diseases (2006) **9,** 199. doi:10.1038/sj.pcan.4500908

Welcome to another issue of quality papers beginning with four timely review articles! Harkaway and Issa address one of the most challenging aspects of daily practice – helping patients make the decision between continued medical therapy for BPH versus minimally invasive surgical therapies (MIST) or more traditional surgical options. In the second review, Acher and co-workers contribute an excellent review of permanent prostate brachytherapy. This review is paired with a nice original article by Vargas *et al.* studying 1260 men with high-risk features who received combined high-dose rate brachytherapy and external beam. This article compared intermediate outcome between those receiving neoadjuvant hormones (NHT) versus none. Both the review and the original article point out the continuing controversies. In the third review, James and co-workers provide an up-to-date review of hormone-refractory prostate cancer. With the approval of docetaxel, the more effective use of bisphosphonates, and the large pipeline of agents studied, there is excitement about improving prospects. Finally, Liu provides a nice basic science review on fatty acid oxidation in the pathogenesis of prostate cancer.

In this issue, we have 13 original research contributions spanning clinical and translational work. We lead with a very clinically relevant topic – the issue of inflammation prostate and its impact on PSA and the role of antibiotics. Kaygisiz *et al.* studied 48 men with PSA between 4 and 10 ng/ml who underwent prostate massage and urinalysis assessment of inflammation followed by three weeks of antibiotics. While prostate cancer was found in 10.8% when the PSA was persistently between 4 and 10, no cancer was found in those men who dropped their PSA below four after antibiotics. While this was a small trial, it does suggest that antibiotics are reasonable to use. On the related topic of non-inflamatory 'chronic prostatitis'/chronic pelvic pain syndrome, Ku *et al.* randomized men to alpha blocker alone versus alpha blocker plus extracorporeal magnetic innervation. While this was a small pilot trial, it did suggest that the combined therapy was more beneficial. As we all know, this is a frustrating area for urologists and we applaud randomized trials in this setting.

In localized prostate cancer, Cyrille and colleagues retrospectively reviewed their experience of radical prostatectomy (RP) in men with PSA >20 ng/ml. While 61% had pT3-4 disease, the 5-year biochemical disease-free survival (bDFS) was 58% suggesting that in younger and healthier men, starting a multi-modality treatment regimen with RP is very reasonable. In a related scenario of pT3-4 disease after RP, Anscher *et al.* report on their long-term results after post-operative radiotherapy to the prostate bed. Of 159 men, 46 received post-op radiotherapy and 113 did not and the median follow-up was 20 years for surviving men. There was no statistically significant difference in overall survival between the groups, but the use of hormonal therapy was 62% in the surgery only group versus only 17% in the surgery plus radiation patients. To round out localized prostate cancer, Kastner *et al.* studied the Charlson Comorbidity Score to use in multi-disciplinary settings to help determine treatment decisions. Patriarca *et al.* performed a histological assessment of Radiofrequency Interstitial Tumor Ablation (RITA) in men who subsequently underwent RP. This may be an emerging local ablative approach and we look forward to future trials in this area.

In more advanced disease, Naoe and co-workers add to the growing literature that selective serotonin uptake inhibitors (SSRI's) are useful to treat hot flashes in men on hormonal therapy. In this case, paroxetine 10 mg/day was effective to lessen symptoms. Augustin *et al.* report a novel biomarker study of sequential prostate biopsies during the initial cycle of intermittent hormonal therapy (IHT). Of p53, bcl-2 and Ki-67 immuno-histochemical assessment, only Ki-67 expression changed significantly over time. Despite that these three biomarkers were essentially uninformative, the concept is sound and the tissue collected can be used for many other biomarker assessments including multiplex gene chip assessment.

In other molecular studies, the four final original articles study germ-line BCL-2 sequence variants; alpha-s1-Casein as a novel marker of BPH; prohibitin (PHB) gene mutations; and variations in the Y chromosome and the relation to prostate cancer and prostatic disease. Kittles *et al.* studied 860 men of either African American, Jamaican or European-American ethnicity finding that the promoter variant (938C/A) of the BCL-2 gene was associated with a 70% reduced risk of prostate cancer. Wang *et al.* report that alpha-s-1-Casein, a milk protein, may be a novel marker of BPH. Cooney *et al.* show that prohibitin mutations in men with prostate cancer are uncommon. This is an important negative finding since this gene, located near 17q21, is unlikely to be involved with the 17q susceptibility locus. Finally, Ewis *et al.* studied 92 Japanese prostate cancer patients and 109 healthy controls for Y chromosome lineages.

On a personal note, I have now been Chief of Urology at Duke University for 2 years. While we continue to grow, the DukeProstateCenter (DPC) is taking shape and our outcomes database now has over 12 000 prostate cancer patients entered-thanks to everyone for this progress!

Until next time, warmest regards and I remain

JW Moul