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Editorial

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In the aftermath of the invasion of Iraq, with the images of the incredible destructive capacity of laser-guided technology still fresh in our minds, it is perhaps appropriate that in this issue of *PCPD* we focus on the other side of the equation, namely the ability of high technology to heal and cure. Certainly, technological advances must have contributed considerably to the improved outcomes reported by Ashlock *et al* in patients with prostatic or bladder rhabdomyosarcoma—a tumour with a fearsome reputation of old. A combination of improved imaging, and multimodality chemotherapy, radiotherapy, and surgery has recently transformed the prospects for the sufferers of this thankfully uncommon disease.

Another area where technology is increasingly impacting on the patients with prostatic disease in a positive way is benign prostatic hyperplasia (BPH). The issue of electrovaporization *vs* standard TURP is reviewed in depth by Hammadeh and Philp, while Dunsmuir *et al* provide an original report of a randomized trial with a year's follow-up. Both groups arrive at a similar conclusion, namely that electrovaporization is as effective and durable as TURP, but is associated with less blood loss. Significantly, however, the recatheterization rate was greater after electrovaporization than TURP. Although this is a short-term problem, its inconvenience should not be underestimated, because when it occurs unexpectedly it demoralizes the patient and undermines his confidence in his urologist.

For gene therapy technology to work, an effective means of gene delivery to the prostate will need to be developed. Sagi *et al* report herewith an intriguing application of the Holmium laser to achieve just this. This form of laser also seems destined to play an increasing role in the management of BPH, especially in the patient with a large vascular prostate, so urologists will undoubtedly be hearing more of it.

Arguably, prostate-specific antigen (PSA) testing is the technology within urology that has had the greatest impact on patients and physicians over the last 20 years. Little *et al* report an audit from Northern Ireland on the attitude of 400 general practitioners towards PSA. They conclude that *de facto* PSA screening is taking place in that province, in spite of recent advice from the UK national screening council to the contrary. So many factors drive the demand for PSA testing, including the ever-increasing media discussion of the subject, that it seems unlikely that Government dictates are likely to have a very great influence one way or the other in any country. Of course, this does not detract from the need for more evidence to confirm that PSA testing does indeed reduce prostate cancer mortality. The trials to determine this are currently ongoing, but results are not expected until 2005.

In a further interesting paper on the controversial PSA molecule, Martin *et al* report greater cPSA and fPSA elimination values in African-American men compared with Caucasians. They suggest that these variations in kinetics may account for some of the differences in serum PSA values between races. Clinical differences between East and West are analysed in another paper, Song *et al* describe the pathological characteristics of the prostates removed from 131 men with prostate cancer. They suggest that the tumours may differ in a number of ways from those excised in the West, however, some of this variance may reflect the relatively advanced stage and large volume of the prostate cancers operated on in Korea.

In one more paper from the East, this time Japan, Nagata *et al* report a valuable retrospective analysis of 26 patients who suffered the feared complication of metastatic spinal cord compression from prostate cancer. They conclude that aggressive management is indicated, but that for those with hormone-independent disease the prognosis is poor.

To conclude the original contributions in this issue, we look at another complication, this time iatrogenic. A case report from Petroski *et al* describes delayed life-threatening haemorrhage after transrectal ultrasound-guided biopsy of the prostate in a patient taking aspirin. With more and more men treated with antiplatelet therapies, such as aspirin and the more potent clopidogrel, caution certainly needs to be exercised when performing biopsies in men on these agents. If we follow the Hippocratic exhortation of *primum non nocere*, we would be wise to stop these medications for a fortnight before biopsy and certainly before any surgery. We physicians, like the military in Iraq, need to strive in every way to minimize 'collateral damage' incurred in our own ongoing struggle against prostate cancer and prostatic diseases.

Roger Kirby & Judd Moul