Prostate Cancer and Prostatic Diseases (2003) 6, 199
 1365-7852/03 $25.00
www.nature.com/pcan

Editorial

Prostate Cancer and Prostatic Diseases (2003) **6,** 199. doi:10.1038/sj.pcan.4500682

Even though we do not do 'Theme Issues' of PCPD outside the setting of a supplement, this issue has several articles related to prostate biopsy and could be loosely termed a theme issue on this hot topic. Damiano *et al* studied 165 men who underwent a 14 core systematic biopsy and concluded that eight well-placed cores were as good or better than an extended 14-core approach. The key was getting laterally directed cores and not necessarily *more* cores. There are two schools of thought in this area: one camp feels that extended cores or a saturation biopsy approach is the way to improve the accuracy of prostate biopsy; the other camp feels that it is not the number of cores that is important, but the location of the cores with emphasis on laterally directed cores where most early/small cancers hide/reside.

There are also three articles in this issue related to anesthesia for prostate biopsy and they come to divergent conclusions! Walsh and Popert report a randomized trial of local anesthetic *vs* no periprostatic injection prior to sextant biopsy finding no significant difference in pain tolerance. However, this was a small nonblinded study and it was sextant alone without extended cores. Conversely, Mclntyre *et al* reported a double-blind trial of inhalational nitrous oxide *vs* room air prior to prostate biopsy in 50 men showing the nitrous treated men to have less pain reporting. Finally, Bastide *et al* reported that pain was greatest when the biopsy was started at the apex compared to the base, and recommended that clinicians start the biopsy session with the base biopsies. They felt that this manoeuver would eliminate the need for local periprostatic block anesthesia. It has been my practice to perform periprostatic lidocaine anesthetic prior to prostate biopsy over the last 2 years. Even though I have not conducted a rigorous study as the authors report in this issue, my feeling is that it does help men tolerate the procedure better and make them more willing to undergo the procedure again should that be necessary. I do applaud these authors for studying this important issue that is one of our 'urologic bread-and-butter' issues.

Aside from prostate biopsy, there are many other hot topics covered in this issue. On the screening front, Battikhi *et al* report age-specific PSA reference ranges for Jordanian men. To my knowledge, this is the first report of this topic in Middle Eastern men. Like Caucasian and African-American men, PSA screening thresholds need to be adjusted by age of the individual men. The key message is that as we screen younger men, that is, between 40 and 60 y of age, we should strongly consider using a PSA lower than 4.0 ng/ml to prompt further evaluation. In our own practice, we use a PSA of 2.5 ng/ml or less for most men who are younger than 60 y of age.

In clinically localized prostate cancer patients subjected to radical prostatectomy, investigators from the US-based SEARCH Database confirm the value of Gleason 4, 5 and 6 to help determine prognosis. They caution against 'lumping' Gleason scores of 4–6 into one category and feel that individual scores should still be reported. This is an interesting report that must be confirmed in a larger series with longer follow-up. National database efforts in prostate cancer such as the US-based SEARCH, CaPSURE, and Department of Defense CPDR efforts are providing much needed insight into prostate cancer as we embark on the second decade of the PSA-Era.

In advanced disease, Winter and Greenberg provide an outstanding review article on transgenic models of metastatic prostate cancer. I have known Dr Norm Greenberg for many years; he is the leading expert in this area and we are honored to have him and his group contribute this wonderful review. Also, on a more clinical issue in advanced disease, Egawa and colleagues examine changes in PSA and testosterone levels after withdrawal of hormonal therapy. They show that many men who have been on prolonged androgen deprivation therapy with LH-RH agents take a very long time to recover testosterone levels out of the castrate range. This has important implications for intermittent hormonal therapy (IHT) and the continued treatment of elderly men. Dr Egawa is on our Editorial Board and we recognize the many contributions he is making in the prostate cancer field.

On the basic science front, there are interesting articles on MMP and TIMP expression (Brehmer *et al*), gene therapy and lentiviral vectors (Bastide *et al*), HK-6, 10, and 13 expression (Petraki *et al*), and myosin phosphorylation relating to the metastatic phenotype (Tohtong *et al*) to round out this issue.

On behalf of myself and my Co-Editor, Professor Roger Kirby, we thank these authors for their contributions. As we move through volume 6 of PCPD, we are grateful for attaining Medline status and will strive to continue to improve the journal and to increase our impact factor in the field. We look forward to receiving your future articles for consideration.

JW Moul & Roger Kirby