Editorial

Report from Durham

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As we finalize the first issue of Volume 8, this Editorial is originating from Duke University in North Carolina. Since the last Editorial, I retired from the US Army Medical Corps, Walter Reed Army Medical Center and the Uniformed Services University on July 1 2004 and moved to Duke University Medical Center in Durham, North Carolina as the Professor and Chief of the Division of Urologic Surgery. I had a full 26-year career in the Army and am very grateful to have been given the opportunity to serve as Director of the Department of Defense Center for Prostate Disease Research (CPDR) for the last 12 years. At that office, Ms Justine Cowan was my trusted Managing Editorial Assistant and did a spectacular job. Justine recently assumed a key position at the National Cancer Institute – I want to thank her for her service to *Prostate Cancer and Prostatic Disease* and wish her the very best in her new position.

Now at Duke for the past six months, I am fortunate to be at such a dynamic university and associated with one of the top urology programs. In the prostate domain, Duke Urology was the site of the only randomized trial of radical prostatectomy *vs* external beam radiation therapy (Paulson *et al*, *Journal of Urology* 1981) and the birthplace of DU-145, one of the key cell lines used in prostate cancer research. Furthermore, the radical perineal prostatectomy database of cases performed at Duke since 1930 is the largest of its kind in the world. I was excited to bring the US editorial office to this place with such rich prostate heritage! In this light, I would like to introduce Ms Joan McAlexander, as my new Managing Editorial Assistant. Already, Joan has distinguished herself as a tireless advocate for PCAN and key team member.

In this issue, we have a venerable smorgasbord of contributions to the prostate literature. To start off, we have four reviews on very timely 'hot' topics. Drs Zeng and Kyprianou give us a nice overview of PIN and the role of the biomarkers TGF- β , p27, and smad-1 in the 'faithful' characterization of this histologic probable precursor of prostate cancer. Dr Kuruma and colleagues discuss the 'prostate proteome' in a nice overview. This is a very hot topic with the issue of serum proteomics as a new way to diagnose prostate cancer as but one example of how this area is emerging. Dr Hall and colleagues have a nice review of the impact of age as a risk-stratification factor that they contend is just as important as stage, grade, and PSA level. This is timely since the 'Baby Boom Generation' is now aging and the oldest of this huge generation are now coming into the peak age of prostate cancer diagnosis while the youngsters are now contemplating 'to-screen-or-not-to-screen'. Finally, Dr Ahmed and colleagues give us a nice overview of salvage cryosurgery for recurrence after radiotherapy. I was involved with this technology in the 2nd generation

with five large cryoprobe and using liquid nitrogen. Like most of my colleagues, I abandoned that technique due to morbidity such as severe incontinence. However, now that we have 4th-generation equipment using very small cryoprobes, brachytherapy perineal templates, better computer control of the iceball, and better transrectal ultrasound imaging, I am a new believer. My colleague, Dr Tom Polascik, has convinced me that this deserves consideration in the salvage setting.

In the original article section, we have an equally impressive array of contributions. While I do not have the space here to mention all 12 papers, I do want to make a few selected comments. Lorenzo and colleagues examine COX-2, bcl-2, and microvessel density (MVD) as prognostic markers in localized and advanced disease. My former group at CPDR did quite a bit of work on bcl-2 and MVD in radical prostatectomy patient specimens as prognostic markers of progression after surgery (reviewed in Moul JW, *European Urology* 1999; 35: 399–407). Like many other groups, we found that molecular biomarkers were useful if the radical specimen was used and care was taken to do sufficient sampling. However, in the 'real world' these and other markers have not come into widespread clinical use due to the multifocality and heterogeneity of prostate cancer.

Bai and colleagues from China and the National Cancer Institute in the US examined a large cohort of Chinese men examining family history of prostate and other cancers. Remarkably, none of the 238 cases or 471 controls reports any family history of prostate cancer showing the remarkable difference in this disease in different parts of the world.

Montgomery and associates report a study of 50 men receiving two different LHRH agonist injections comparing pain with two different needle sizes (16 *vs* 23 gauge). Interestingly, no significant differences were reported. At least in the US, this is a hot topic with government reimbursement for these injections shrinking. Cost considerations will be driving treatment decisions to a great extent in 2005 and beyond and having data such as these are clinically useful. Finally, in a related hormonal therapy paper, Saltzstein *et al* examine both tamoxifen and anastrozole to prevent bicalutamide monotherapy induced gynecomastia. Tamoxifen 20 mg/day, but not anastrozole, reduced breast pain and gynecomastia in this setting and should be studied further. Since the use of bicalutamide alone in doses of 50–150 mg/day is quite commonly used in the setting of treatment of biochemical recurrence in men who remain potent after local therapies, this is an important preliminary report.

With best wishes until next time, I remain

J Moul