Editorial

Report from Durham

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As I write this, I want to express my sorrow for the tragic terrorist attacks that occurred in London in the last month. As soon as I heard the news, like most Americans I suspect, I was taken back to September 11th and the incredible emotions we faced. However, I also remember that Great Britain was and remains a true ally in the global fight against terrorism. To our colleagues in Professor Kirby's London office, we send our heartfelt thoughts with hopes that they remain out of harm's way and stay the course!

While you might think it strange that I started this Editorial about global terrorism, there is a connection to prostate cancer and specifically to prostate cancer research funding. The US Department of Defense (DoD) is the second leading source of funding for prostate cancer after the US National Institutes of Health (NIH). As I write this, there is grave concern that the DoD will have to decrease its funding for prostate and other medical disease research because of the war's toll on the defense budget. While we all agree that the war on global terrorism is the top priority, we in the prostate cancer field hate to see this rich source of valuable support end or drastically cut. Without injecting too much focus on religion, I would also ask that we pray for continued research funding. At this time when the NIH is also cutting their SPORE program that currently funds about a dozen center grants in prostate cancer, this prospect for decreased DoD funding is very worrying.

Now on to this issue, which contains 18 contributions in a variety of areas. To lead off, Franklin Lowe and co-workers reviewed 243 patient profiles and an International panel of experts to devise a risk of progression model for BPH. Their findings that postvoid residual urine, symptom severity, and maximum flow rate were the key determinants of progression will help us to care for BPH patients in a more standardized fashion. Also related to BPH, Gross and associates report an observational prospective study, where men were switched from phytotherapy to tamsulosin. The switch to the alpha blocker was associated with improved LUTS and sexual function and no significant increase in ejaculatory complaints. While the men on phytotherapy were not responding to that therapy, which likely biases the good response to tamsulosin, the results are very relevant to contemporary practice. In my practice, like many, it is now very common for men to try complementary and alternative medicines (CAMs) for various conditions, including BPH. My take on the study by Gross *et al* is that we can reasonably counsel men that they probably will note symptom improvement going from CAM therapy to alpha blocker therapy. Finally in the BPH arena, Ozden *et al* report a trial of 40 men scheduled for TURP, where one-half were randomized to finasteride 4 weeks before surgery and the remainder served as untreated controls. The authors report that the finasteride-treated men had a statistically lower rate of intraoperative and perioperative bleeding. While a larger trial with placebo control would have been more convincing, the results support what is now a common held belief that preoperative five-alpha reductase inhibitors reduce TURP-related bleeding.

In other clinical reports, Miano *et al* from Rome report on prostate cancer screening using a test called, 'PSA Rapid Screen'. This one-step simple test gives a 'positive' or 'negative' based on a PSA less than or greater than 4.0ng/ml. While I applaud the authors for their work on a 'point of service' simple screen, the use of a qualitative 'Yes' or 'No' will be controversial in the field. In light of the recent report of the placebo arm of the Prostate Cancer Prevention Trial (Thompson *et al*, NEJM 2005),

where no single 'cut point' for PSA was optimal, this test with a cut point of 4.0ng/ml may be good for some men but not for many others.

Jani *et al* from Chicago report on 480 men who received external beam radiation for clinically localized and locally advanced prostate cancer and investigated the impact of neoadjuvant hormonal therapy (NHT) on radiation toxicity. The bottom line was that NHT did not significantly influence the risk of radiation side effects. While this is reassuring, the overriding question is the optimal duration of HT in the neoadjuvant and adjuvant setting. There are randomized trials that support 4 months to 3 years with advocates of other durations in between. Continuing with early stage prostate cancer, Logue *et al* report a survey of UK urologists ($N=72$) and radiation oncologists ($N=58$) regarding their practice patterns for adjuvant and salvage therapy after radical prostatectomy. Not surprisingly, there was wide variation in practice and little firm consensus because we have so few randomized controlled trials (RCTs) to guide us in this area. In the area of postoperative adjuvant radiation therapy, trials from the EORTC and from SWOG were reported in abstracts at ASCO in 2004 and at AUA in 2005. Both showed a benefit of radiation in delaying clinical progression, but neither one is showing a survival benefit at follow-ups from about 5 years (EORTC) to about 10 years (SWOG). A paper on salvage cryotherapy by Weber *et al* rounds out the original clinical articles in prostate cancer.

Related to localized prostate cancer, Dennis *et al* studied the reliability of sexual histories in men above age 50y with and without prostate cancer. This topic is becoming more important as younger men are diagnosed and considering treatment. Concern for sexual dysfunction is paramount and consumes much time for counseling as do issues surrounding the cancer itself in my current practice.

In the realm of translational and basic science work, we feature six very interesting articles. While space does not permit a complete overview, the Llanes and co-workers' translational work of quantitative real-time RT-PCR for PSA expressing cell detection prior to radical prostatectomy deserves a comment. I have been involved with RT-PCR for PSA expression for over 10 years since the early 1990s when this then new technology was touted as 'molecular staging'. Like virtually all the papers in the last decade, this has not panned out! This test in its current state does not help differentiate organ-confined versus locally advanced disease.

Finally, we continue our series of clinically relevant case reports. We will continue to consider a few select case reports in each issue, although space is limited and cases must convey a clinically useful and novel concept.

On a personal but prostate-related note, I would like to welcome two new colleagues to our Duke program: Steve Freedland and Tracey Krupski. Both Steve and Tracey are 'prostate people' having completed urologic-oncology fellowships at Johns Hopkins and UCLA, respectively. They will both assist Joan McAlexander and me in the Durham Editorial Office in the months to come. Finally, Professor Kirby and I are excited that the Impact Factor for this journal rose substantially in the June 2005 rankings. Thanks to the authors, editorial board, and peer reviewers for helping make this happen!

Thanks for your support, until next time, I remain

Most respectfully,
JW Moul