factors that predict recurrence rates and disease behavior is, therefore, important. Dall'Oglio and colleagues have evaluated clinical and pathologic factors that might predict disease-free and cancer-specific survival in patients with RCC who undergo surgical treatment.

The records of 230 consecutive patients (mean age 58.7 years, 73% men) who had undergone radical or partial nephrectomy at a single institution between 1988 and 2003 were retrospectively reviewed. The clinical parameter assessed was the presence or absence of symptoms at diagnosis; postoperative pathologic parameters were tumor size, tumor cell type, Fuhrman nuclear grade, microvascular invasion and lymph node involvement.

Median follow-up was 36 months and median time to disease recurrence was 22 months. Mean overall survival was 130 months. On univariate analysis, tumor size ≥7.1 cm, high Fuhrman tumor grade, microvascular invasion, lymph node involvement, presence of symptoms at diagnosis and sarcomatoid tumor differentiation were significant predictors of disease recurrence and death ($P<0.05$). On multivariate analysis, however, only microvascular invasion was an independent predictor of survival (hazard ratio 3.033, 95% CI 1.048–8.777, $P=0.041$).

The authors conclude that, while all pathologic factors are individually important when predicting the survival of patients with RCC, the presence of microvascular invasion is an independent prognostic parameter and should be included in all pathological reports.

Original article Dall'Oglio MF *et al.* (2007) Impact of clinicopathological parameters in patients treated for renal cell carcinoma. *J Urol* **177:** 1687–1691

Survival is not affected by timing of recurrence in high-risk bladder cancer

Radical cystectomy is the standard treatment for persistent or recurrent high-risk bladder cancer after Bacillus Calmette–Guerin (BCG) induction therapy. Delaying cystectomy in favor of alternative drug therapies or maintenance BCG could result in a raised risk of invasive disease. Lerner *et al*., therefore, analyzed the Southwest Oncology Group 8507 trial data for maintenance BCG therapy to investigate whether the timing of disease recurrence affected patient survival. They found that long-term survival was not affected by the timing of recurrence.

Of 550 patients with resected Ta or T1 tumors who were randomly assigned to BCG maintenance or observation, 501 were available for follow-up. Disease recurred in 251 patients, of whom 117 had early recurrence (<12 months after randomization) and 134 had late recurrence. In all, 59% of patients who had recurrence died. Recurrence more than doubled the risk of death compared with no recurrence, but the risks were similar for early and late recurrence. Cystectomy was performed in 56 of the 251 patients with recurrence; the median time to cystectomy was 11 months for patients on BCG therapy, compared with 24 months for those not receiving BCG. The risk of death among patients who underwent cystectomy was raised significantly compared with that among those who did not (hazard ratio 2.58, 95% CI 1.62–4.11), but maintenance BCG therapy plus cystectomy significantly reduced the risk of death (hazard ratio 0.37). These secondary findings should be considered hypothesis generating.

Original article Lerner SP *et al.* (2007) Patterns of recurrence and outcomes following induction Bacillus Calmette–Guerin for high risk Ta, T1 bladder cancer. *J Urol* **177:** 1727–1731

A significant correlation between PSA and PSA velocity in men with prostate cancer

Measurement of PSA velocity (PSAV) is often used in preference to PSA for the early detection of prostate cancer, but how much additional predictive information PSAV provides is unclear. Yu *et al.* examined the interaction between the two biomarkers by studying the correlation between PSA and PSAV in 13,726 men enrolled in a 10-year, community-based prostate cancer screening study.

The analysis showed that mean and median PSAV increased significantly as the total PSA increased ($P<0.0001$). The overall Pearson correlation coefficient between PSA and PSAV was 0.68, and was 0.66 in men with a PSA >4 ng/ml. The correlation between PSA and PSAV increased slightly with age and remained highly significant in men of all ages ($P<0.0001$).