Editorial

Roundup

The last 3 months in urology have been dominated by news and views on prostate cancer yet again. Ranging from demonstration of da Vinci robot in one of the malls in Germany to sensitize people to robotic surgery to randomized trials on the treatment choices for localized prostate cancer to look for the elusive answer to the moot question, i.e. to burn, to watch, or to take it out!

Results of ProtecT trial on men with screen-detected localized prostate cancer, randomized to receive either active monitoring (545), radical prostatectomy (553), or external-beam radiotherapy (545) were published this month.[1] The primary outcome was prostate cancer mortality at a median of 10 years, and metastasis was a secondary outcome. There were eight, five, and four deaths in active monitoring, surgery, and radiation group, respectively, at 10 years, which was not significant, but metastasis developed more likely in men on active monitoring, i.e., 33 patients versus 13 and 16 with surgery and radiation, respectively, which was statistically significant. The inference drawn from this intention to treat analysis was that active surveillance is not a good choice to treat localized prostate cancer in men with expected survival of more than 10 years. This was when about 50% of men initially assigned to active surveillance actually received radical treatment by 10 years. This trial could indirectly support the approach of not offering an active monitoring to our patients in India, where detection of a localized disease is not based on prostate-specific antigen (PSA) screening.

There is some respite for surgeons who do not have access to a robot to perform radical prostatectomy. A randomized controlled trial between robot-assisted radical prostatectomy and open retropubic radical prostatectomy has shown an equal functional outcome at 12 weeks in terms of margin rates and complications and recommends that it is still the expertise of a surgeon and not the machine, which provides the outcome of surgery.[2] In my opinion, the ease and comfort of a surgeon due to vision and access to deep-seated organs in the pelvis would never be the same as in open surgery. Even an expert surgeon may come across difficulties imposed by the body mass index and android shape of the pelvis, particularly during the vesicourethral anastomosis. These could be important confounding factors accounting for the outcome, which should not be ignored.

Another interesting thought doing the rounds is whether we should stop doing digital rectal examination (DRE) when we are doing PSA screening to detect early prostate cancer.[3] This was based on the dataset on screening done in PLCO trial where authors found that DRE had poor sensitivity and positive predictive value and acted as a barrier for normal healthy men to come forward for screening. By not doing DRE, we could only miss 2% of clinically significant prostate cancer.

When screening itself is mired in controversy, we should not base our opinion on these data, particularly when we are screening men presenting to us with LUTS. Rectal examination (RE) is a useful adjunct to clinical examination in symptomatic men with no PSA available during the first examination. Despite advancements in imaging, DRE has some value to get a mental picture of the disease in terms of its location and also haptic feel of fixation to the rectal mucosa. Therefore, instead of shunning DRE, we should shun D out of DRE and call it RE!

Another interesting clinical trial, i.e. Refractory Overactive bladder: Sacral neuromodulation versus Botulin Toxin (BT) Assessment (ROSETTA) trial, has been published.[4] The trial was designed to assess the superiority of BT over InterStim (Medtronic) in controlling urge incontinence (UI) in women with refractory UI. Refractory UI was defined as 6 episodes of UI in 3 days bladder diary in women who have tried at least one supervised behavioral or physical therapy and minimum of two anticholinergics.

Apart from various quality of life outcomes assessed, the significant clinical endpoint analyzed was 50% reduction in the episodes of UI recorded in 3 days bladder diary at regular interval and at 6 months. The dose of BT used was 200U (Botox A, Allergan) and injected intra-detrusor. Clean intermittent catheterization (CIC) was done when residue was 300 cc or, more than 200 cc with a symptom of incomplete voiding. BT marginally scored over the InterStim, i.e., at 6 months; more than 50% reduction in UI was seen in 67% patients with BT and 52% with InterStim (p0.05). However, with BT, CIC at any visit was required in 20% of women through the 6 months and they had a higher risk of urinary tract infection (UTI) by 34% compared to no need for CIC and 11% risk of UTI with InterStim. The absolute difference found in this trial in improving episodes of UI was 0.64, which was originally powered to detect the difference of at least 2 episodes. Looking at the moderate benefit with these two modalities in women with refractory UI, this field in urogynecology has tremendous scope of research to have a less invasive option.

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Anil Mandhani*

Director, Uro-oncology and Minimally Invasive Surgery, Fortis Escorts Kidney and Urology Institute, New Delhi, India

*E-mail: anilpall@yahoo.com

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