Commentary

Prostate Cancer Claims for a Personalized Medicine

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Hippocrates (Kos, Greece c. 460-c. 370 BC), generally referred to as the "Father of Western Medicine" remembers us "It is more important to know what sort of person has a disease than to know what sort of disease a person has." Understanding the personal qualities of the patient, his lifestyle, and his previous medical history is a necessary base to approach prostate cancer (PCa). In times of worldwide changes, globalization, and migration, there is one value that needs maximum protection, since it represents a steady value and it is capable of representing a safe path through the difficulties of the present medicine toward the light of the future. That value is, undeniably, the human being. We have to pursue such commitment by our humanism and our medical culture. They are not a sheer amount of mere human attitude, or technical knowledge, or the tradition of a particular social group but they represent a theoretical and practical attitude consisting of multiple skills concerning the understanding of a disease in its personal and social implications and the ability to develop a balanced and sensible treatment.

The ideal PCa decision-making process is a wise balance between idealism and realism. PCa screening and diagnosis should lead not only to discriminate men with or without cancer, but also should emerge and discriminate indolent from clinically significant tumors. It is just a single step in the long journey of our PCa patients. Our medical skill has to dictate the treatment, counseling patients about prognosis, and take the responsibility of a life-long follow-up.

PCa is to be put into the contest of many variables: Race, family history, age, obesity, previous negative biopsies, local inflammation (prostatitis), and new minimally-invasive therapies. In 2012, the most recent year for which numbers have been adequately reported, black men had the highest rate of getting PCa, followed by American and European white, Hispanic, American Indian/Alaska Native men, and Asian/Pacific Islander.[1] However, in the next years, those population are expected to mix each other, and PCa incidence and prevalence might significantly change.

PCa incidence increases with age and because of the aging of the population and longevity of older persons, clinicians will increasingly be faced with balancing risks and benefits of PCa treatment. Given that older patients with PCa often have other significant medical problems, it is crucial to stage the aging to assess the patient's physiologic age as opposed to chronologic age when making the treatment decisions.[2]

PCa is dogmatically regarded as a genetically heterogeneous and pathologically multifocal disease, and is, therefore, usually treated with a radical whole-gland approach. Radical prostatectomy and radiotherapy are effective therapies for patients with clinically localized PCa. Despite improvements in surgical techniques, such as the introduction of robotic-assisted laparoscopic

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prostatectomy, or new machine for delivery target energy, urinary incontinence, erectile dysfunction, and bowel dysfunction are not uncommon. Physicians and the public have started to be interested in the notion of prostate-sparing focal therapy.[3]

Finally, our understanding of PCa biology is rapidly increasing, as is the availability and affordability of high throughput technologies for comprehensive molecular characterization of PCa and the individual's own genetic makeup.[4]

We are entering an exciting era in which it is possible to provide rational therapy to patients on the basis of their omni-comprehensive drivers. This may provide the greatest opportunity in history to take giant steps forward a PCa personalized medicine.

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