



## Editorial

# The Future of Oncological Urology in Europe: Are we Prepared?

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Oncological urology constitutes a major part of the general urologist's daily practice. Urological tumors are quite common solid tumors among all human malignancies. Prostate cancer is the most common cancer in the male population and is the second most common cause of cancer deaths in the male [1,2]. Better using of PSA will cause more cancers detected at an early stage and thus amenable to cure by surgery. However, still 30% of patients with clinically localized prostate cancer will require some further treatment. Bladder cancer is also common, ranking as the fifth most common cancer in the males and constitutes 5% of all diagnosed tumors [3]. Superficial tumors can be treated endoscopically by the urologist. On the other hand patients with advanced disease may need additional treatment before or after surgery. There is an increased incidence of kidney cancer all around the world. The incidence has increased 2 to 4% per year since 1970 [4]. Thanks to widespread use of imaging modalities many incidental tumors are diagnosed at an earlier stage and can be cured by surgery. However, 25% still may recur during follow-up. Renal cell carcinoma is the most lethal of the common urological malignancies with 40% eventually dying of cancer progression. Unfortunately the chance of cure in advanced and metastatic cancer is rather slim. Testicular tumors have an important place in oncological urology. First, they are seen in young men, and cure can be accomplished even in advanced stages. Multimodal treat-

ment of testicular tumors has made this disease one of the fields where we have won the fight against cancer.

As in other ways of life, medicine, urology and in particular oncological urology is changing very rapidly. The last couple of years made us witness the tremendous change in this subspecialty. This change is more prominent in the treatment of advanced and metastatic cancer. While in the past *one suit for all* approach, i.e. chemotherapy was the standard of care for all advanced urological malignancies; today individualized therapies are dominating the field. Better understanding of the molecular pathways of carcinogenesis made us aware that this new way of approach is more logical. Henceforth, targeted therapies and biological treatments are overtaking from chemotherapy.

Chemotherapy in most parts of Europe is administered by the medical oncologists and clinical oncologists. Most urologists who are subspecialised in oncological urology were not trained; and understandably are afraid to administer such therapies. Today, the new therapeutic approaches are far less toxic than chemotherapy, even sometimes administered orally and can be handled by the urologists well trained in this discipline. Biological agents, antiangiogenic treatments and other targeted therapies can be easily used by the oncological urologists if they are trained and educated.

Our medical oncologist colleagues have prepared themselves in advance for the future and trained

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their young doctors in basic research, translational research and finally clinical research. This mentality has rendered them capable of handling new treatment modalities with ease and taking the lead of cancer treatment. It is hard to say the same for the oncological urologists. The reason for this is that we, the oncological urologists can treat our patients by surgery most of the time. When they have progressed or recurred, then we consult with our colleagues in different disciplines. In other system cancers neoadjuvant treatments and upfront multimodal treatments are very common. Cancer is a disease that requires multidisciplinary approach. On the other hand, each discipline should know about the other treatment modalities. Unless we train ourselves and get acquainted with the new developments, cancer, being one of the most common urological disease that we, urologists treat in our daily practice will be moving away from the hands of the average practicing urologist.

It has been shown in a number of studies that case load and treatment at specialized centers give better results in cancer treatment [5]. Thus, in the future, more and more patients will be treated in these centers either by the referral from the urologists or driven by the healthcare system. The health awareness of the general population is also likely to cause such trend. The major paradigm change in the understanding of urological cancer, the use of non-surgical treatments at an earlier phase of cancer and multimodality management of the urological cancer patient are causing our medical oncologist colleagues to be involved in the care of these patients at a much earlier stage. It seems inevitable that the oncological urologists should be involved in the non-surgical treatments. We have been treating advanced prostate cancer with hormonal therapy in the last 50 years. Why should not we be able to use other treatment modalities that are on the rise? In fact, we, the urologists are the ones who see these patients initially, make the diagnosis and gain the confidence of the patient. We provide the best medical care to our knowledge thanks to the European Association of Urology (EAU) who has set the guidelines and have been very active in the last decade. We must certainly improve our knowledge of the new developments.

It is time for the EAU to be more proactive, show leadership and train its members to be involved

more in the management of urological cancer patients. The urologists must be up to date with the latest developments in the field. We should spend more time, energy and money to support basic and translational research in oncological urology. We have to endorse the idea of getting involved more in the changes in the field of oncological urology. We must educate our members more in the new paradigms of cancer management. We can start a Task Force to deal with these issues and seek advice and collaboration from our medical and clinical oncologist colleagues.

The above mentioned concerns on the role of the urologists in the overall management of the urological cancer patient are not restricted to Europe. Similar issues are also on the agenda of other national and international societies. International collaboration can be sought to encourage basic and translational research and lobbying on this issue. I believe that we in Europe are stronger to make things happen due to our multicultural and *lateral thinking* mentality.

Things do not change in a short period of time. Let us give these ideas a thought. It is after all our duty to plan and get prepared for the future. These issues are important for the future of our profession. Members of our profession deserve the chance to be furnished with the new developments and we should seek the ways and methods to achieve that.

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