
References

- [1] Finn OJ. Immune Response as a Biomarker for Cancer Detection and a Lot More. *N Engl J Med* 2005;353(12):1224–35.
- [2] Diamandis EP, van der Merwe D-E. Plasma protein profiling by mass spectrometry for cancer diagnosis: opportunities and limitations. *Clin Cancer Res* 2005;11(3):963–5.

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Incidence and Follow-Up of Patients with Focal Prostate Carcinoma in 2 Screening Rounds After an Interval of 4 Years

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Expert's summary:

This study evaluated the clinicopathologic features of patients with focal carcinoma (≤ 3.0 mm in only one core of sextant biopsies, lacking Gleason patterns 4 and 5). The patients underwent radical prostatectomy (RP, $n = 103$) or were monitored regularly (the “wait and watch” method [WW], $n = 108$). RP specimens were categorized into minimal tumours (volume < 0.5 ml, no Gleason patterns 4 and 5, organ confined, and negative surgical margins) or moderate-to-advanced tumours (volume ≥ 0.5 ml, Gleason pattern 4 or 5 detectable, extracapsular extension, or positive surgical margins). The median tumour volume in RP specimens was 0.13 ml, and in 78.6% of the cases it was < 0.5 ml. In 3 specimens, no tumour was found. A prostate-specific antigen (PSA) density cutoff level of ≤ 0.1 ng/ml/cm³ predicted a tumour volume of < 0.5 ml in 94% of cases. Because it was part of the European Randomized Screening Study for Prostate Cancer, the study also showed that the proportion of patients with focal prostate carcinoma increased significantly, from 16% during the first screening round to 29% during the second round, 4 years later. The median tumour volume in the first round (PSA ≥ 4) was 0.16 ml, and that in the second round (PSA ≥ 3) was 0.07 ml, but this difference did not reach statistical significance.

Expert's opinion:

The authors concluded that the WW policy with delayed curative intent may be recommended in patients 55–75 yr old who have focal carcinoma and a PSA density < 0.1 ng/ml/cm³. Natural-history

data from other cohorts have shown the indolent character of low-grade prostate cancer, with 15-year disease-specific survival rates of approximately 80% [1,2]. The follow-up time of the present study is still short, and the mortality in the RP and WW groups cannot be analyzed yet. A Scandinavian randomized study [3] showed better results for patients with RP, but most cancers were clinically detectable. Even then, because of a small absolute reduction in prostate cancer mortality, 19 patients needed to be treated to prevent one death at 10 years. Respective speculations for today's low-risk small tumours increase this number to 100 patients [4]. This is ethically unacceptable. It is impossible to stop prostate cancer screening, but if the PSA threshold is lowered from 4 to 3 or even lower, and 12 biopsies are routinely done, we are going to find a large number of insignificant cancers. Surgeons like to operate, but it is not meaningful to shoot mosquitoes with a cannon. Proper guidelines for screening and the WW policy are urgently needed.

References

- [1] Albertsen PC, et al. 20 year outcomes following conservative management of clinically localized prostate cancer. *JAMA* 2005;293:2095–101.
- [2] Johansson JE, et al. Natural history of early, localized prostate cancer. *JAMA* 2004;291:2713–9.
- [3] Bill-Axelsson A, et al. Radical prostatectomy versus watchful waiting in early prostate cancer. *N Engl J Med* 2005;352:1977–84.
- [4] Klotz L. Active surveillance for prostate cancer: for whom? *J Clin Oncol* 2005;23:8165–9.

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