



## Letter to the Editor

**Re: Jean-Louis Campos-Fernandes, Laurence Bastien, Nathalie Nicolaiew, et al. Prostate Cancer Detection Rate in Patients with Repeated Extended 21-Sample Needle Biopsy. Eur Urol 2009;55:600–9**

Dr. Campos-Fernandes and his cowriters must be complimented for the substantial effort which resulted in their article in the March 2009 issue of *European Urology*, not least of which include those at the Department of Pathology at which no fewer than 59 472 prostate biopsy cores were analysed [1]. They showed that 18%, 17%, and 14% of patients were diagnosed with prostate cancer (PCa) at the second, third, and fourth sets, respectively, of 21-core biopsies. Although the authors declare in the discussion that the study was biased by the participating physicians, who selected high-risk patients for biopsy at their own discretion, this important fact was perhaps not emphasized enough in the rest of the paper or in the three editorial comments that followed.

Of 2500 consecutive patients initially biopsied, 953 had no cancer. Of those 953, merely 231 were subjected to a second or more sets of biopsies. Most likely, the 722 patients having only one set of biopsies were less likely to have risk factors for PCa such as high or continuously rising prostate-specific antigen (PSA) values, high PSA density, a family history of early onset PCa, or a focus suspicious for cancer (atypical small acinar proliferation) in the first set of biopsies.

If one assumes that those 722 patients did not develop aggressive PCa during follow-up, the risk of being diagnosed with PCa was only 6% after a first set of negative biopsies. This figure is more in line with the findings by Djavan and associates, who found 10%, 5%, and 4% on the second, third, and fourth sets, respectively, of eight-core biopsies [2]. The most important difference between their study and the one by Campos-Fernandes and coworkers was that all of their patients with negative biopsies were subjected to another set of biopsies. Another difference is that all four sets of biopsies were performed during 6 mo in the former study [2], whereas the median time from the first to the fourth set of biopsies in the latter study was 3.5 yr, with substantial variation between patients [1].

Campos-Fernandes and cowriters argue that 85% of detected cancers were clinically significant [1]. No pathology-based definition of insignificant PCa, however, has been validated against the only definition that is relevant for the patient; namely, a cancer which does not cause clinical symptoms during his lifetime. Approximately half of middle-aged men do have cancer in their prostatic gland, even if it is clinically benign. We know from the Prostate Cancer Prevention Trial that, with only one set of sextant biopsies, we can diagnose PCa in eight times more men than will die from the disease [3]. That figure must necessarily be higher with repeated 21-core biopsies!

In a Swedish study of 547 men with increased PSA values (median: 7 ng/ml) and one set of negative nine-core biopsies, the standardised incidence ratio of PCa was 0.8 (ie, a 20% decreased risk) at 5 yr compared with an age-matched general male population [4]. This finding argues against the idea that there is a substantial risk of aggressive PCa for men with PSA values of 3–10 ng/ml and one set of benign prostate biopsies, at least if they do not have any of the risk factors for cancer mentioned above.

Thomas Stamey and his colleagues wrote that “any excuse to biopsy the prostate has an excellent, age-dependent chance of being positive” [5]. We urologists should remember those words and not perform repeated biopsies in men with a low risk of dying from PCa.

*Conflicts of interest:* The author has nothing to disclose.

## References

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