

transient prostatic urethral obstruction in the short term and may act as an intraluminal scaffold in the long term to mechanically prevent obstructive scarring at the prostatic urethra and the bladder neck. Temporary long-term prostatic stents after MIT may also help remodeling of the prostatic urethra during its healing period. The possibility of combining a stent with a MIT for prostate cancer such as HIFU may save a patient from an additional surgical intervention and may even reduce total cost.

Can this combination yield equal or higher complication-free survival rates than RP? Only comparative studies of large groups of patients can provide the answer to this question.

Conflicts of interest: The author has developed several patented and patent pending stents. Currently, he does not have any financial interest, relationship, or financial conflict with any company related to stents.

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Re: Long-term Survival Following Partial vs Radical Nephrectomy Among Older Patients with Early-stage Kidney Cancer

Tan HJ, Norton EC, Ye Z, Hafez KS, Gore JL, Miller DC

JAMA 2012;307:1629–35

Expert's summary:

The study by Tan and colleagues retrospectively evaluates the long-term survival of a large cohort of Medicare beneficiaries who underwent surgical treatment for clinical stage T1a kidney cancer. The study included 1925 patients (27.0%) treated with partial nephrectomy (PN) and 5213 patients (73.0%) treated with radical nephrectomy (RN). Over a median follow-up of 62 mo, 487 patients (25.3%) and 2164 patients (41.5%) died following PN or RN, respectively; however, kidney cancer was rarely the cause of death. Only 37 patients (1.9%) treated with PN and 222 patients (4.3%) treated with RN died of their disease. The authors controlled for confounding variables including age, Charlson Comorbidity Index score, ethnicity, and gender, and an instrumental variable analysis was used to balance measured and unmeasured variables between treatment groups. The authors found that PN improved overall survival, but there was no difference in kidney cancer-specific mortality. The survival advantage was greatest in those patients <75 yr old and those with a Charlson Comorbidity Index score ≥ 1 . Furthermore, treating seven patients with PN rather than RN would avoid one death at 8-yr follow-up. It should be noted that even in recent years (2004–2007), twice as many RN procedures ($n = 2119$) were performed compared with PN ($n = 1114$).

Expert's comments:

Both the American Urological Association and the European Association of Urology recommend that PN be performed in patients with clinical T1a renal masses, with other treatment

options such as RN, ablation, and observation as alternative options [1,2]. The greater loss of nephrons as a consequence of RN increases the risk of chronic kidney disease with resultant increase in cardiovascular disease and overall mortality [3]. The current study by Tan et al highlights what many previous studies in the urologic literature have shown: that nephron-sparing surgery is the preferred approach to small renal masses. The advantage of this study is that it is published in a high-impact journal read by a wider audience that might be able to influence patients to seek nephron-sparing surgery.

In this report by Tan et al, only one in three stage I tumors were managed by PN as recently as the years 2004–2007. Many similar studies document underutilization of PN, despite oncologic equivalence [4]. Consequently, one can ask why RN is overutilized for the management of stage I kidney cancer. Is it for lack of evidence of the superiority of PN in preventing overall mortality or lack of expertise with PN? Perhaps there is a sense that the other “normal” kidney will suffice to prevent future dialysis, despite the knowledge that even patients with chronic kidney disease who do not go on to dialysis have a decrease in survival [3]. In any case, there has been insufficient impetus up to now to encourage urologists to perform the preferred treatment most of the time. It may just require studies aimed at a broader audience of health care providers who will guide patients to the optimal treatment choice.

Conflicts of interest: The author has nothing to disclose.

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Re: Prostate Cancer Screening in the Randomized Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial: Mortality Results After 13 Years of Follow-up

Andriole GL, Crawford ED, Grubb RL III, et al

J Natl Cancer Inst 2012;104:125–32

Expert's summary:

The prostate component of the Prostate, Lung, Colorectal, and Ovarian (PLCO) cancer screening trial included 76 685 men, ages 55–74 yr, randomized to what the authors termed *systematic* versus *opportunistic* screening. At 13 yr of follow-up, there was a small increase in prostate cancer incidence in the systematic screening arm (relative risk: 1.12; 95% confidence interval [CI], 1.07–1.17) but little difference in prostate cancer mortality (relative risk: 1.09; 95% CI, 0.87–1.36). There was no evidence of a difference in effect depending on age, pretrial screening, or comorbidity.

Expert's comments:

A short note about large, well-conducted trials: It can be difficult to explain away the results. This year has seen updates of the two major randomized trials of prostate-specific antigen (PSA) screening, the European Randomized Study of Screening for Prostate Cancer and the US PLCO trial. There have been various attempts to claim that the European trial does not support PSA screening, predominately on the basis of differences in the treatment received in the screening and control arms [1]. But such arguments ignore the stage shift associated with screening: After adjusting for stage, there are few differences in treatment between groups [2].

The PLCO failed to find differences between groups, an effect most plausibly explained by the very high levels of PSA testing in the controls. But there have been attempts to reanalyze PLCO to show that it did in fact support PSA screening. Crawford et al. [3] proposed the reasonable hypothesis that the effect of PSA depends on comorbidity: Patients who are sick from other diseases, such as heart disease, are likely to die from other causes before prostate cancer might affect their survival. The authors conducted a subgroup analysis and found that, indeed, screening seemed

to work in men without comorbidity [3], but there were a number of statistical concerns with their analytic approach [4]. In this latest update of the trial, Andriole et al found no evidence to support the comorbidity hypothesis.

So, the results of the two large trials stand. Encouraging American men to use or avoid PSA testing will not have much effect on anything. Conversely, screening those who otherwise would not be screened does reduce prostate mortality but not by very much and at a high cost. We need to focus on how to make screening more effective (eg, starting early and referring screen-detected cancers for treatment at high-volume centers) and less harmful (eg, emphasizing active surveillance for low-risk disease and avoiding screening in older men).

Conflicts of interest: Andrew Vickers is named on a patent application for a statistical model to predict prostate biopsy outcome.

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