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Editorial

Introduction

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1. Introduction

Overall, prostate cancer represents about 11% of all male cancers in Europe [1] and is responsible for 9% of all cancer deaths among men in the European Union (EU) [2].

The incidence of prostate cancer is rising rapidly in most countries (Fig. 1) [3–5] with an estimated 2.6 million new causes of cancer diagnosed in Europe [1,6]. It is suggested that in the United States and Canada the increasing incidence of prostate cancer is due to the widespread use of transurethral resection of the prostate (TURP) and prostate specific antigen (PSA) testing, whereas in the Asian countries it is possibly related to westernization [7]. PSA screening also led to an earlier diagnosis of prostate cancer, resulting in an increase of the number of patients diagnosed with localized prostate cancer.

When diagnosed with prostate cancer, the patient and his physician have to choose from a wide range of therapies. Treatment can be deferred until symptoms appear (watchful waiting) or the patient can be treated with radical prostatectomy, radiotherapy (interstitial or external), hormonal therapy, or he can undergo castration (bilateral orchiectomy). The choice of therapy may influence survival as well as the risk of therapy-induced acute or chronic side effects. To guide urologists and their patients with prostate cancer in their selection of an appropriate treatment, a 2-d symposium "New Horizons in

Urology" was held in Malta, 29–30 October, 2005. The first day of the meeting was dedicated to hormonal therapy in prostate cancer and, in particular, the optimization of testosterone control. During the second day of the meeting open and laparoscopic surgery for prostate and bladder cancer were discussed. The major topics of the symposium are reviewed in the manuscripts included in this supplement [8–11]. The final paper summarizes the main conclusions of the symposium [12].

2. Hormone therapy for prostate cancer

2.1. Guidelines versus daily clinical practice

In 2005, the European Association of Urology (EAU) published an updated version of the EAU guidelines for prostate cancer. To discuss whether these guidelines reflect the current therapy standards in daily clinical practice, an interactive voting session was held during the symposium "New Horizons in Urology," which was chaired by P. Teillac and A. Alcaraz. Four specific patient cases were introduced to the audience followed by an interactive voting session during which about 200 delegates had to select their preferred treatment option for these patients. The cases represented a patient with localized prostate cancer (T1b–T2c), a patient with advanced prostate cancer (T3–T4), a patient with

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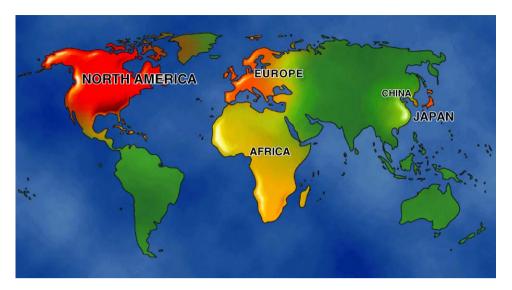


Fig. 1 - Worldwide incidence of prostate cancer [3-5]. Red and swollen areas indicate a high incidence of prostate cancer.

biochemical failure after radical therapy, and a patient with node positive disease. The outcomes of the voting session were compared with the recommendations of the EAU guidelines in a subsequent debate with the audience and 10 experts and are summarized in the manuscript entitled "Hormone therapy for prostate cancer: guidelines versus clinical practice" by A. Alcaraz and P. Teillac in this supplement [8].

2.2. Improving therapy decisions and monitoring

Due to the increased diagnosis of prostate cancer at earlier stages and the increased use of hormone therapy in earlier disease stages (i.e., in patients with a biochemical failure after radical therapy and patients with advanced prostate cancer), many patients will receive hormone therapy for a long period. As a consequence, these patients are increasingly at risk for acute and chronic side effects of hormone therapy. Therefore, the timing of initiating hormone therapy, the type of hormone therapy, and the monitoring of patients on longterm hormone therapy have become crucial in the appropriate management of patients with prostate cancer. In their talks during the symposium A. Zlotta, P.A. Abrahamsson, B. Tombal, R. Berges, and F. Debruyne discussed these items and indicated how therapy decisions and monitoring of prostate cancer patients could be improved [9]. The importance of achieving and maintaining low testosterone levels in case of luteinizing hormone releasing hormone (LHRH) agonist therapy was recognised and the efficacy of LHRH agonists, including Eligard®, a new depot formulation of leuprolide acetate, in achieving and maintaining low testosterone levels was discussed.

3. Urologic cancer surgery

3.1. Prostate cancer

In his talk "Open nerve sparing radical retropubic prostatectomy" F. Montorsi focused on new approaches in the field of open radical prostatectomy. Although radical prostatectomy is widely used as primary treatment for localized prostate cancer, it was discussed that improved knowledge of male pelvic anatomy, along with the refinement of surgical tools, led to the development of new surgical techniques aimed at the preservation of potency and continence. However, one should be aware of the fact that patient acceptance of surgical procedures increases with the development of minimally invasive surgical techniques, even in the absence of randomized clinical trials showing substantial advantages to these approaches.

G. Janetschek indicated in his talk "Laparoscopic surgery in prostate cancer" that, although open retropubic radical prostatectomy is the standard treatment for prostate cancer, laparoscopic surgery also resulted in good functional and oncologic outcomes. In this presentation, the learning curve of open surgery characterized by procedural complications and functional and oncologic outcomes was discussed and occasionally compared with the laparoscopic approach. The preliminary results of a comparative study protocol comprising a prospective study in three different centers were reported.

A summary of both presentations is reported in the manuscript entitled "Open versus laparoscopic radical prostatectomy" by G. Janetschek and F. Montorsi [10].

3.2. Bladder cancer

Bladder cancer is the second most common genitourinary malignancy, with transitional cell carcinoma (TCC) comprising nearly 90% of all primary bladder tumours. Although most patients present with superficial bladder tumours, 20–40% either present with or develop invasive disease. During the past 30 yr, radical cystoprostatectomy has emerged as one of the standard forms of therapy for patients with high-grade, invasive bladder cancer.

In his talk "Open surgery in bladder cancer", A. Heidenreich reported on the variation of radical cystectomy and especially focused on the nerve-, prostate- and seminal vesicle-sparing approaches. Special attention was paid to the lymphadenectomy associated with radical cystectomy, its lack of standard procedures, and its neglected influence on the survival and recurrence rate. Multivariate regression analysis identified risk factors for complications and provided some tools to deal with the avoidable complications after radical cystectomy. Finally, the oncologic outcomes with special focus on the recurrence-free and overall survival were reported. This presentation was concluded with a summary of outcomes that have to be met by new surgical techniques to 'replace' open surgery.

In his talk "Laparoscopic surgery in bladder cancer", R. Gaston came to the same conclusions regarding the importance of lymphadenectomy and concluded that the laparoscopic approach is best suited to perform these lymph node dissections. Functional and oncologic outcomes were reported but one has to take into account that laparoscopic radical cystectomy is a very young technique and

therefore these results should be placed in perspective when compared to open surgery.

A summary of both presentations is reported in the manuscript entitled "Open versus laparoscopic radical cystectomy" by A. Heidenreich and R. Gaston [11].

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