Conflicts of interest: The authors have nothing to disclose.

References


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Re: Outcome of Dorsal Buccal Graft Urethroplasty for Recurrent Urethral Strictures
O’Riordan A, Narahari R, Kumar V, Pickard R

BJU Intl 2008;102:1148–51

Expert’s summary:
Rob Pickard’s group in Newcastle, UK, audited their results of dorsal buccal mucosal graft urethroplasty for recurrent bulbar urethral strictures to compare them with those from specialist centres. Their overall success rate was 86%, and they concluded that their outcomes were as good as those of experts working in specialised centres. The implication is that anybody with an interest in urethroplasty and a sufficient throughput of patients could treat bulbar strictures by dorsal buccal graft urethroplasty in less specialised centres. This is an interesting and important conclusion from a reliable surgeon working in a reputable department.

Expert’s comments:
In England, with a population of about 50 million, there are about 700 urethroplasties performed a year, and about 40% of these are performed for bulbar urethral strictures. Some of these strictures may be amenable to excision and end-to-end anastomosis, but the majority of them are too long and require a patch urethroplasty. In addition, about 16,000 patients undergo urethrotomy or dilatation. Although the data are unclear, many of these patients will have bulbar urethral strictures, so many will be undergoing repeat dilatation, in most instances without any hope of a cure. Palliation is a perfectly reasonable form of treatment, but many of these patients will be suitable for bulbar urethroplasty, which would be not only curative but a much more cost-effective approach to their treatment. The numbers of patients coming for bulbar urethroplasty should, therefore, increase and, indeed, are increasing. There will be a greater demand for bulbar urethroplasty, and if this can be performed outside of a specialist centre, then that would be better for the patients. It would maintain an interest for those urologists who are keen to do this sort of work but who do not work in a specialist centre, and it would mean that those working in highly specialised centres could concentrate on more difficult problems. The technique is well established, and there is no particular requirement for highly specialised support. In short, there is no reason that patients should not transfer from a specialist to a generalist setting.

It does, however, raise two further questions. First, what is the caseload required to maintain expertise? Second, what are the implications for training? Pickard’s group reported 52 patients over a 5.5-yr period, which is about 10 patients per year. It is reasonable to assume that they had at least another five patients per year with shorter bulbar strictures who underwent primary excision and end-to-end anastomotic repair. Fifteen cases a year is regarded in some circumstances (principally in cancer surgery and vascular surgery, for which these issues have been most carefully studied) as the minimum caseload to maintain expertise. There is little doubt that the higher the volume, the greater the expertise and the better the results. In short, if a unit is putting through ≥15 cases of bulbar urethroplasty per year, there is no reason that unit should not continue to do that work and to train others to do that work, as long as caseload and expertise are maintained and as long as the unit is subject to periodic peer review, as we all should be.

Other types of urethral strictures are much less common but the same considerations should probably apply. Thus, as a corollary, surgeons who are not performing 15 penile urethral reconstructions or 15 posterior urethroplasties a year should be referring patients to specialised centres where the caseload is sufficient to maintain...
expertise. The data to support this assumption do not exist at the moment, but it is probably true, nonetheless.

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

Re: Multicenter Phase II Study of Combined Neoadjuvant Docetaxel and Hormone Therapy before Radical Prostatectomy for Patients with High Risk Localized Prostate Cancer

Chi KN, Chin JL, Winquist E, Klotz L, Saad F

J Urol 2008;180:565–70

**Expert’s summary:**
Chi et al have evaluated the feasibility, the tolerability, and the efficacy of a neoadjuvant therapy combining docetaxel and androgen deprivation prior to radical prostatectomy (RP) in high-risk localized prostate cancer patients. The study did not meet the primary end point predefined criterion for success, which was a 20% pathologic complete response. Of the 64 patients completing protocol therapy, only 2 patients had a pathologic complete response, and 16 additional patients had <5% remaining tumor in prostatectomy specimens.

**Expert’s comments:**
Given the modest but clinically relevant activity of docetaxel-based therapy in advanced disease, exploration of early administration of systemic treatment is of clinical interest in patients with high risk of treatment failure. The weekly scheme of docetaxel used in this trial may be less efficient than the 3-wk schedule. Until today, only small clinical trials have tested neoadjuvant chemotherapy before RP. Magi-Galluzzi et al [1], similarly to the study by Febbo et al [2], detected no complete pathologic response in patients who received single-agent docetaxel before undergoing RP. Androgen deprivation prior to RP has not been retained in guidelines [3]. Combined chemohormonal therapy has equally never been shown to improve outcomes for patients with hormone-sensitive localized or advanced prostate cancer. Nevertheless, there is preclinical evidence in the androgen-dependent Shionogi and LNCaP tumor models demonstrating a superior efficacy of chemother-

apy plus castration compared to the same sequential therapies [4].

Despite the disappointing results of the present phase 2 trial, the potential benefit of neoadjuvant chemohormonal therapy still needs to be further evaluated in large randomized studies using progression-free survival (PFS) or overall survival as primary end points. Several phase 3 trials are ongoing to evaluate this approach before RP (Cancer and Leukemia Group B [CALGB] 90203 trial) or radiotherapy (led by D’Amico). Presently, only the Groupe d’Etudes des Tumeurs Uro-Génitales (GETUG) 12 trial, in France, has completed its accrual, and 413 patients have been randomized following lymphadenectomy to be treated by either neoadjuvant androgen deprivation alone for 3 mo or androgen deprivation plus four courses of a combination of docetaxel (75 mg/m² every 3 wk) and estramustine, followed by local treatment. Androgen deprivation was subsequently prolonged for a total of 3 yr. The goal was to obtain a 12% difference in PFS in favor of the combination arm. Primary results will be available in 2–3 yr. Until then, neoadjuvant chemohormonal therapy has no indication outside of clinical trials.

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

**References**


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