androgen deprivation therapy (ADT) for at least 6 mo to achieve a prostate-specific antigen (PSA) level <1.0 ng/ml and clinical remission or stability. ADT was continued for at least 2 yr following CRP. The study group and control group (n = 38) were well balanced with respect to disease burden, primary tumor characteristics, and patient comorbidities. Open CRP was performed with acceptable perioperative complication rates and continence results (91% used no pad or one pad per day). Specimens analyzed by step sectioning revealed residual PCAs (mean: 18 ml), 83% with pT3 disease, 14% with positive margins, and 57% with lymph node involvement. Median follow-up was 35 mo and 37 mo for CRP and control groups, respectively. Median time to castrate-resistant prostate cancer (CRPC) was longer following CRP (40 vs 29 mo, \( p = 0.01 \)). Cancer-specific survival (CSS: 96% vs 84%, \( p = 0.04 \)) but not overall survival (91% vs 79%, \( p = 0.05 \)) was improved. The need for percutaneous or surgical intervention due to local progression was greater in the control group (29%).

**Conflicts of interest:** The authors have nothing to disclose.

**References**


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Ciprofloxacin Resistance in the Faecal Carriage of Patients Undergoing Transrectal Ultrasound Guided Prostate Biopsy
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Experts' summary:
The authors aimed to evaluate the prevalence of ciprofloxacin-resistant bacteria in patients undergoing transrectal ultrasound-guided prostate biopsies (TRUSBx) and the risk of developing infectious complications after prostate biopsy. Pre- and postbiopsy rectal swabs and urine cultures were taken to test antimicrobial susceptibility to antibiotics. Escherichia coli was the prevalent isolate (80.9%) and accounted for 90.6% of the ciprofloxacin resistance observed, while the prevalence of ciprofloxacin-resistant coliforms was 19%. Infectious complications were observed in 3.6% of the patient population, and ciprofloxacin-resistant organisms grew on prebiopsy rectal swabs taken from 48% of these patients \( p < 0.001 \). The increasing prevalence of infection after TRUSBx appears to be due to increasing prevalence of ciprofloxacin-resistant rectal flora.

Experts' opinion:
Infected complications after prostate biopsy often represent an important challenge for the urologist and a life-threatening event for the patient. The Global Prevalence Study of Infections in Urology study [1] demonstrated that transrectal access is the approach favoured by urologists during prostate biopsy research has been funded by Birmingham Science City, Cancer Research UK, University Hospitals Birmingham Charities, and the University of Birmingham.

References

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and CIS/invasive lesions arise from distinct urothelial subpopulations, albeit in a model system that may not fully recapitulate tumourigenesis in the human bladder. It now seems increasingly likely that the context provided by the cell of origin is key to both the oncogenic effects of the different genetic aberrations observed in LG-NMIBC and HG-NMIBC/CIS/MIBC and the very different behaviours of these two types of UBC.

Many questions still remain. How do papillary tumours progress to MBCs? Do papillary tumours always originate in the intermediate cell layer in humans? Why do patients seemingly successfully treated for organ-confined disease relapse and succumb? Where do Gr T1 tumours with mixed mutation profiles originate? It is these fundamental questions that approaches based on baseline tumour characteristics, rather than outcomes, are yet to answer. The authors do not discuss important processes such as epithelial-mesenchymal transition or the development of cancer stem cells, but their elegant utilisation of morphologic approaches is refreshing in the era of next-generation sequencing, and has contributed significantly to our understanding of this challenging disease.

Conflicts of interest: Richard T. Bryan has previously contributed to advisory boards for Olympus Medical Systems in relation to narrow-band–imaging cystoscopy.

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