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UROLOGICAL ONCOLOGY

Delay of Radical Prostatectomy and Risk of Biochemical Progression in Men with Low Risk Prostate Cancer

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Purpose: Men newly diagnosed with prostate cancer are faced with multiple treatment options. Understanding these options and their associated side effects, and making a decision often requires time, resulting in a delay before receiving treatment. This is particularly pertinent in men with low risk disease who may be considered candidates for watchful waiting and, thus, may not experience strong pressure to undergo treatment promptly. Whether delays and especially prolonged delays, eg greater than 180 days, before RP negatively impact the disease outcome is unclear.

Materials and Methods: We examined the association between time from diagnosis to surgery, and pathological features of the RP specimen and risk of biochemical progression in 895 men with low risk prostate cancer (prostate specific antigen less than 10 ng/ml and biopsy Gleason sum 6 or less) treated with RP between 1988 and 2004 in the Shared-Equal Access Regional Cancer Hospital Database using logistic regression and Cox proportional hazards, respectively.

Results: Time from biopsy to surgery was not significantly related to high grade disease in the RP specimen, positive surgical margins or extraprostatic extension (all p-trend >0.05). After adjustment for multiple clinical covariates a longer time from biopsy to surgery was significantly associated with an increased risk of biochemical progression (p-trend = 0.002). However, this increased risk of progression was only apparent in men with delays greater than 180 days (median 263, vs 90 or fewer days RR 2.73, 95% CI 1.51 to 4.94).

Conclusions: Our data suggest that patients with low risk prostate cancer can be reassured that immediate treatment is not necessary. Whether long delays (greater than 180 days) decrease the likelihood of curability in some patients requires further study.

Editorial Comment

In contrast to the detrimental effects of delaying radical therapy in bladder cancer too long, the effect in prostate cancer treatment is different. Here, the window is open for a longer time, but still begins to close

measurably after half a year. The practical advice is to give the patient time enough to evaluate his treatment options and not proceed in a hurry. Then do your job thoroughly.

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Complications and Other Surgical Outcomes Associated with Extended Pelvic Lymphadenectomy in Men with Localized Prostate Cancer

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Objectives: More-extensive pelvic lymph node dissection (PLND) may be associated with a higher rate of complications and a longer hospital stay than more limited PLND.

Methods: Before radical retropubic prostatectomy, PLNDs were performed in 963 patients. Of these, 767 (79.6%) had ≥ 10 lymph nodes removed and examined (extended PLND [ePLND]), while 1-9 nodes (limited PLND [IPLND]) were removed in the remaining 196 (20.4%). Limits included external iliac, obturator, internal iliac, and iliac bifurcation. PLND-related complications and the length of hospital stay were recorded prospectively and analyzed according to the extent of PLND.

Results: In patients subjected to ePLND, the overall rate of complications was 19.8% versus 8.2% in those treated with IPLND ($p < 0.001$). In individual analyses of specific complications, only the lymphocele rate was significantly higher after ePLND (10.3% vs 4.6%; $p = 0.01$). Similarly, ePLND translated into a longer hospital stay (9.9 vs 8.2 d; $p < 0.001$). These differences persisted when adjustment was made for prostate-specific antigen and either clinical or pathologic tumor characteristics.

Conclusions: Our data indicate that, even in the hands of experienced urologic surgeons, ePLNDs are associated with higher complication rates and longer hospital stay. These detriments need to be taken into account when the staging benefit associated with ePLND is considered.

Editorial Comment

This is a timely article suitable into the actual discussion on the extend of lymph node dissection in radical prostatectomy (RP). The authors state clearly that extended lymph node dissection (eLND) leads to more complications and prolongs hospital stay. Therefore they caution against a too generous use of eLND before the benefits of this approach is clearly established.

Lymphoceles occurred in 10.3% vs. 4.6% of patients and blood loss was higher in eLND (median 1200 mL) vs. Limited LND (median 1000 mL). The drawbacks of this article are its obvious retrospective approach and the very few numbers of lymph nodes in both arms (median 7 in the "limited" vs. 17 in the "extended" LND).

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