detailed help in almost every case, from low-risk tumor with virtually 100% survival to high-risk cancer to almost 50% cure rate if treated appropriately. Again, these consensus papers are highly recommended reading.

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Local progression among men with conservatively treated localized prostate cancer: results from the Transatlantic Prostate Group

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Objectives: Men with clinically detected localized prostate cancer treated without curative intent are at risk of complications from local tumor growth. We investigated rates of local progression and need for local therapy among such men.
Methods: Men diagnosed with prostate cancer during 1990-1996 were identified from cancer registries throughout the United Kingdom. Inclusion criteria were age < or =76 yr at diagnosis, PSA level < or =100 ng/ml, and, within 6 mo after diagnosis, no radiation therapy, radical prostatectomy, evidence of metastatic disease, or death. Local progression was defined as increase in clinical stage from T1/2 to T3/T4 disease, T3 to T4 disease, and/or need for transurethral resection of the prostate (TURP) to relieve symptoms >6 mo after cancer diagnosis.
Results: The study included 2333 men with median follow-up of 85 mo (range: 6-174). Diagnosis was by TURP in 1255 men (54%), needle biopsy in 1039 (45%), and unspecified in 39 (2%). Only 29% were treated with hormonal therapy within 6 mo of diagnosis. Local progression occurred in 335 men, including 212 undergoing TURP. Factors most predictive of local progression on multivariable analysis were PSA at diagnosis and Gleason score of the diagnostic tissue (detrimental), and early hormonal therapy (protective). We present a nomogram that predicts the likelihood of local progression within 120 mo after diagnosis.
Conclusions: Men with clinically detected localized prostate cancer managed without curative intent have an approximately 15% risk for local progression within 10 yr of diagnosis. Among those with progression, the need for treatment is common, even among men diagnosed by TURP. When counseling men who are candidates for management without curative intent, the likelihood of symptoms from local progression must be considered.

Editorial Comment

The course of conservatively treated patients with prostate cancer is largely unknown. These patients are rarely found in clinical trials and therefore, knowledge is sparse. This multi-institutional group of authors followed a large cohort of 2333 patients for a median of 85 months and determined the rate of progression. The results are hampered by the fact that 54% of cases were detected by initial transurethral resection of the prostate, that is, by symptoms of prostate cancer. Still, the 10-year disease-specific mortality rate was 24%. Roughly, 15% of patients had progression, most within 5 years after diagnosis. Most important risk factors were high initial PSA, T3 disease and Gleason grade 4. Interestingly, early hormonal treatment was associated with significantly less progression. As the authors state correctly, these findings suggest that there is a subgroup of

men with prostate cancer in whom conservative management might be the preferred option. Men with worrisome clinical features in contrast might benefit from treatment that is more active.

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NEUROLOGY & FEMALE UROLOGY

Identification of risk factors for genital prolapse recurrence

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Aims: To assess the relationship between prolapse recurrence and some risk factors in a group of women submitted to reconstructive pelvic surgery.
Methods: Women referred to our Urogynaecological Units complaining of prolapse symptoms were prospectively included. We excluded women who were affected by apical vaginal prolapse > stage I after a previous hysterectomy. All women had pelvic surgery with traditional techniques without using grafts. Each woman was reassessed at 1, 6, and 12 months and then yearly postoperatively. We defined as prolapse recurrence a vaginal descent > or = II stage involving the operated compartments.
Results: A total of 360 consecutive women were recruited and submitted to vaginal reconstructive pelvic surgery. At a mean follow-up of 26 months, 36 women (10%) had a recurrent prolapse. A preoperative vaginal descent > or = III stage was the only significant risk factor for recurrence (P = 0.02, OR 2.4, 1.1-5.1 95% CI).
Conclusions: Women with prolapse > or = III stage had a significant higher risk of developing prolapse recurrence after surgical repair without grafts.

Editorial Comment

The authors review their population of females who underwent reconstructive vaginal surgery for pelvic prolapse. They excluded patients who had already had prolapse surgery or who had > stage II vaginal prolapse after previous hysterectomy. None of their patients had graft utilized in the reconstructive repair or had a synchronous concomitant anti-incontinence operation. The authors found that the only truly significant risk factor for recurrence of pelvic prolapse in their study was preoperative vaginal prolapse ≥ stage III.

An interesting study in that it treats a relatively pure population of patients who were treated for prolapse that had no previous anti-prolapse procedure performed, did not utilize any graft as part of the repair and did not have a synchronous anti-incontinence operation performed at the time of the surgery. The authors do self identify one of the weaknesses of this study in that they define recurrent prolapse as > stage II in the same operating vaginal compartment thus ignoring any potential vaginal vector shifts causing a production of prolapse in a separate compartment. That being said, I found it to be an excellent article of reference, which reviews classic pelvic floor reconstructions without potential complicating factors of graft material or concomitant anti-incontinence operations. Though current reports are highlighting the downside of graft materials, the