AUTHOR'S REPLY

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It is a great honour and privilege to have our article commented by Professor Mark Soloway, and on behalf of other authors I would like to thank him for his time spent on this comment.

Hereby, I would like to answer some questions raised in his editorial.

In many publications fluorochinolone–resistant E. coli strains derived from the rectum are recognized as the major cause of mild to severe post–biopsy infections. This pathogen is reported in 20–25% of rectal swab cultures taken from patients who undergo biopsy [1]. Our department takes part in Global Prevalence Study on Infections in Urology (GPIU) by EAU Section of Infections in Urology (ESIU) [2]. In this study it was demonstrated that high prevalence (about 60%) of fluoroquinolone resistance amongst E. coli isolates from men with symptomatic UTI after prostate biopsy. The rate was higher than expected comparing with other hospital settings, that ranged from 22.7% to 30.8% [3]. Unfortunately data about fluoroquinolone resistance from our department are missing, but the study is ongoing, and its results can change our biopsy procedure. Therefore we think about switch from ciprofloxacin to other prophylaxis, pressumably cephazolin or caphalexin. Regimen proposed by Prof. Soloway (ciprofloxacin 3 hours before biopsy and 3 days after, in addition, one gram of cephalexin intramuscularly) is interesting, and we may think about accepting it in our institution.

MRI, especially with rectal coil, seems to be an interesting option in prostate cancer diagnosis. As for now it is not a standard diagnostic method based on the EAU guidelines, but biopsy is not always necessary to perform an ablative procedure as in case of kidney tumours. Hopefully one day prostate imagining will be so accurate that prostate surgery will also be possible without sample taking. We still need to keep in mind that diagnostic procedure with only 30% positive detection rate should be as safe as possible.

In Poland 4 ng/ml is a cut–off level of PSA for referring men to a urologist. On the other hand there is still a lot of patients referred with PSA much greater than that. In our study median of PSA was 9.16 ng/ml with mean value of 19,16 ng/ml and maximal value of 660 ng/ml. Gleason score was not much different from the cited in patients with presumably low risk disease, with highest number of patients with Gleason 6 (49.40%). Number of patients with high risk disease (patients with Gleason 8–10) was higher and accounted for 17% (Table 1) [4].

Reporting tumour stage was not the aim of this study and was not taken under consideration. To those eligible patients active treatment was offered which raises the question of possible overtreatment. Instead of this different approach, for example active surveillance as Prof. Soloway proposes can be proposed [5].

References

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