AUTHOR'S REPLY

UROLOGICAL ONCOLOGY

Costs in medicine – the lesser of two evils

Michał Andrzej Skrzypczyk, Jakub Dobruch

Centre of Postgraduate Medical Education in Warsaw, Poland

Many aspire to drive a modern car with high engine power and modern equipment with all the new fancy tools rather than the average, small and poorly outfitted one. However, can we all afford it? The answer seems obvious, doesn't it?!

We deeply acknowledge the thoughtful editorial by Prof. Mark Soloway [1] written in response to the article published in a recent edition of CEJU [2] and agree with the statement that it is better to have a pathological report instead of having only preoperative diagnostics. The purpose of the study was to establish the subgroup of surgically managed patients due to BPH who might be spared the histologic evaluation of the specimen, yet have no compromise in the diagnosis of contingent cancer (PCa – prostate cancer). Although we feel such a group exists, we were unable to discover clinical features to support the hypothesis. It is reasonable to consider that the better the diagnostic modalities implemented in prostate cancer explorations, the lower the need for pathological evaluation of the specimens received after BPH surgery. After all, ablative techniques are becoming more widely applied year by year.

According to our data, it is easier to select patients in whom pathological examination of the specimen taken during BPH surgery is mandatory than those in whom it would bring only benign histology. These are mainly young adults in whom omitting potentially curable cancer may be harmful, including those who underwent negative biopsy before prostate surgery but are still suspected to have cancer. Our data suggests that the risk of incidental cancer diagnosis is greater in those patients. A few years ago van Renterghem et al. showed that TURP performed in patients previously subjected to multiple prostate biopsies improves prostate cancer diagnosis [3]. Even extended biopsy protocols are not fully accurate in regard to the oncological characteristics of cancer.

To elaborate active surveillance (AS) mentioned in the editorial, we may speculate upon those who undergo management yet still experience deterioration of their lower urinary tract symptoms and deny radical surgery. In the absence of data suggesting otherwise, we think pathological examination of specimen taken after BPH surgery should not be omitted in patients submitted to AS. If cancer progression is observed, radiation may be introduced.

Nowadays, with the availability of sophisticated diagnostic tools, the need for searching for cancer in surgical specimens extracted from elderly males with no suggestive clinical symptoms needs at least some attention. The risk of diagnosis and death due to PCa in this cohort is extremely low. If it is too risky to abandon histological examination of tissue removed during benign prostate hyperplasia surgery should we eliminate minimally invasive or vaporization techniques from our practice altogether?

References

1. Soloway MS. Pathology examination cannot be done without a urologist's help. Cent European J Urol. 2014; 67: 233.
2. Skrzypczyk MA, Dobruch J, Szostek P, Nyk Ł, Szempliński S, Borówka A.Should all specimens taken during surgical treatment of patients with benign prostatic hyperplasia. Cent European J Urol 2014; 67: 227–232.
3. Van Renterghem K, van Koeveringe G, Achten R, van Kerrebroeck P. Prospective study of the role of transurethral resection of the prostate in patients with an elevated prostate–specific antigen level, minor lower urinary tract symptoms, and proven bladder outlet obstruction. Eur Urol. 2008; 54: 1385. ■

10.5173/ceju.2014.03.art4