Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/annals/authorinstructions.html>. Tables and figures should only be included if absolutely essential and no more than five references should be given. The Editor reserves the right to shorten letters and subedit contributions to ensure clarity.

COMMENT ON

P Whelan. The case against radical prostatectomy. *Ann R Coll Surg Engl* 2005; **87**: 159–62

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Management of patients with prostate cancer

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It is in some ways unfortunate that the paper by Peter Whelan arguing that patients with localised prostate cancer fare just as well with watchful waiting as with surgery was published in the *Annals* the very same month that a Scandinavian group reported the results of their randomised study comparing the two treatment modalities.¹ Over a 10-year observation period, radical prostatectomy was found to reduce disease-specific mortality, overall mortality ($P = 0.04$), and the risks of metastasis and local progression ($P = 0.001$) in a surgically managed group of 347 men. The authors concluded that although the absolute reduction in the risk of death after 10 years is small, the reductions in the risk of metastasis and local tumour progression are substantial.¹

Over 30,000 men are diagnosed annually in the UK from prostate cancer and while watchful waiting is an excellent option for older individuals with low risk, well-differentiated cancers,² patients with higher Gleason scores (7 or > 7) fare much less well over time. Roehl *et al.*³ have recently reported the excellent outcome and low morbidity of several thousand patients treated by radical prostatectomy with 10-year follow-up and these results are now mirrored in the

UK. Not surprisingly, patients with poorly differentiated tumours do less well with surgery; for this small sub-group, external beam radiotherapy with preceding hormonal down-staging is still the best management option.⁴

Currently, the debate concerning the management of patients with medium-risk, localised, prostate cancer (*i.e.* Gleason score 7), who constitute the vast majority of the case load, has moved from radical prostatectomy versus watchful waiting to radical prostatectomy versus brachytherapy. Since excellent 12-year data are now being reported for brachytherapy, it is the trial of this modality versus radical prostatectomy that major interest is focused upon. With more than 10,000 deaths from prostate cancer a year in the UK, watching and waiting while men at significant risk progress and eventually die hardly seems the best way to stem the rising tide.

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AUTHOR'S RESPONSE

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My argument for the case against radical prostatectomy seems entirely to have been missed. It was not that watchful waiting is as good as surgery but that the scientific case for the treatment of localised prostate cancer by radical prostatectomy had not been made and that this operation remains technically a phase II trial procedure which is awaiting a second completed phase III study in the hope that the second one might benefit for radical prostatectomy.

Whilst I quoted the only two prospective, randomised trials concerning radical prostatectomy and watchful waiting, John Anderson, sensibly, confined himself to the Scandinavian study though both of us wrote our papers before the recent update of that study which appeared in the *New England Journal of Medicine* in 2005.

John Anderson, in order to buttress his case, used relative risk ratios which showed some difference. I had used absolute ratios which again, as I concede in my article, showed some difference although these are generally small. Whenever one sees relative risks and disease-specific mortality reductions, one has to look carefully at the overall outcome. Even the most ardent, radical prostatectomist much have a scintilla of doubt when at 10 years the progression curves for both the actively treated and the non-treated cases are still rising. One would have expected at some stage that all the patients who had been under-staged and under-graded would have been compensated for and a group identifiable as having been cured by surgery would be apparent; the graph, therefore, would go flat whilst the patients treated expectantly would continue to progress at a particular rate. At 10 years, the graphs of both groups are still going up. This re-emphasises that this study is yet to be completed in what is now the totemic trial but there remains lack of conclusive evidence to support the current practice of radical prostatectomy.

Indeed, such continuing sloppy thinking based on the tired and jaded mixture of grade 3 and 4 evidence, with the continual avoidance of treating patients with high-risk, poorly differentiated tumours is continuing. The result of this is that brachytherapy which is buttressed by equally flimsy grade 3 and grade 4 evidence is now supplanting radical prostatectomy as a procedure of choice for patients with good-risk, localised prostate cancer. Given the choice between a major operative procedure and one that can be

delivered as a day-case and, allegedly, has equal outcomes, we can perfectly understand why the patient would take such a decision.

My main and most aggressive point was that the UK had the opportunity to do a prospective trial in 1990 to answer these questions (by now, definitively, 15 years later), which was rejected although the PROTECH study in may ways resuscitated that earlier opportunity and will deliver results 10 years later than were necessary. By then, radical prostatectomy may well have fallen into obsolescence not because it has been shown to be either ineffective or effective but because people have not demonstrated a clear evidence-base by doing randomised prospective controlled trials. The latest gimmick will have overtaken it. Truly, it can be said: 'their own words will rise up to smote them'.

COMMENT ON

A Morritt. A simple method to prevent other people wearing your theatre shoes. *Ann R Coll Surg Engl* 2005; **87**: 66

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Theatre shoes – taking them one day at a time

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Another way of encouraging people not to use your theatre shoes is to write the day you use the shoes on the front as well as your name, this being particularly useful in day surgery units where sessions are relatively fixed.