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.