LETTERS TO THE EDITOR

How can we recognize low risk prostate cancer?

¿Qué podemos hacer para reconocer el cáncer de próstata de bajo riesgo?

At the request of the Editor of Actas, I am prepared in this Letter to the Editor to complement that of Dr. Vera, and first I must admit that I adhere to his wise comments before what I consider the most important urological care problem in our specialty, overtreatment of low-risk prostate cancer (LR PCa).

The aforementioned PIVOT study has confirmed what many urologists, I do not know if so many radiotherapists in own response to the letter from Dr. Vera, thought about LR PCa. However, I bear in mind that the slide that I have seen so many times in different conferences on the cat and tiger is not yet resolved. In the same U.S. Congress data that could be considered the same depth as the PIVOT have been presented; the ERSPC offers a reduction in the relative risk of metastatic progression of 31% at 12 years of follow-up, and with two more years of follow-up, decreased relative risk of death from PCa is observed in the screening group versus the control group of 0.40% (CI 95%: 0.17–0.64), requiring to treat only 12 men of those diagnosed to save one from dying from PCa, data quite comparable to those from screening programs in breast cancer, currently covered by our health institutions. All this suggests to me that in the future the problem will be not in stopping diagnosing PCa, but in differentially managing the PCa detected in a screening that, covered or paid by the public health, will be performed in a more established way than at present. And within that differential management, I believe that active surveillance (AS) should play an important role.

We cannot discredit before society the treatment of a tumor that, we must not forget, causes countless deaths a year in our country. Patients who had wanted an early diagnosis of their illness, and those for whom it would be a mistake to go against the evidence we have with screening. In my opinion, we must first imperiously look for molecular markers that allow us to recognize the tiger (as it is difficult for clinicopathologic markers to give more of themselves).

We must test the new markers, which the same as PCA3 will complement, not replace, palpation and PSA, not only to save up to 49% of unnecessary biopsies, but as prognostic factors that in isolation or combined with other molecular markers help us recognize which ‘low risk’ PCa we must actively treat and which can be included in active surveillance (AS). However, we have to keep in mind the hypothesis of late mutation of PCa, not early, to a more aggressive phenotype.

Once the LR PCa is diagnosed, with a standardized biopsy of at least 10–12 cylinders, we must implement rigid criteria for inclusion in AS protocols, as also in the congress of the AUA an early repeat biopsy of 16 cylinders was shown, and the central review of these rejects at three months up to 41% of the patients initially candidates for AS with a 12-cylinder biopsy (A1095). The patient must understand a strategy in which they can progress in 14% of the cases at 4 years and in 25% of the cases at 6.8 years of follow-up, and nevertheless be cured; they must also engage and be able to perform a close follow-up/compliance with evolutionary biopsies and must ultimately learn to live with the anxiety of not being treated. Reporting well should not be compared with convincing anyone.

In this dilemma, I believe age is a decisive factor both to restrict biopsies and to implement AS. We know that PCa has a slow timeline, that observation of a cT1-2 PCa for over 15 years has a relative risk of 6.4 (2.3–17.8) of increase of that PCa mortality, time probably higher in the PSA era due to the advancement that the use of this in the diagnosis of PCa (lead time bias) involves. On the other hand, our population ages with better and better quality of life indexes. Both realities must be seen when we inform a patient that he is a candidate for an AS protocol.

Until we have better prognostic molecular panels, another reality to consider, and that in itself justifies our recommendation of a military protocol compliance of AS, is the 30% of the tumors that we have operated with LR PCa criteria and that the pathological anatomy shows that had been understaged and/or undergraded. The heterogeneity of PCa is treacherous. Currently, we include some patients in AS protocols and we are wrong; although most are redeemable with active treatment, in the event of progression, it is humane for the patient to think that they should not have performed AS and we have no arguments to say otherwise.

Our goal as urologists is to continue increasing the decline in PCa mortality observed in European countries (from 15 to 12.5/100,000 men between 1995 and 2006, respectively). To do this we will have to optimize the rational use of the

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weapons we have, such as the ERSPC risk calculator, and validate the new ones as they appear, delimiting all to their differential use according to age and prognostic panels. We will also have to validate new prognostic molecular markers for the patients already diagnosed. Finally, we will have to process all that information to patients with LR PCa for them to be the ones that choose the strategy to follow among the different alternatives, which hopefully in the future will be extended to focal therapy. And if they choose A5, we will have to agree when we have to actively treat without compromising the prognosis of our patient.

References


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Comments to the article ‘Robotic surgery: History and impact on teaching’

Comentarios al artículo «Cirugía robótica: Historia e impacto en la enseñanza»

Dear Editor:

Regarding the interesting article ‘Robotic Surgery: History and impact on Education’ published by R. Valero et al., in the issue of Actas Urológicas Españolas of October 2011, we would like to make some brief clarifications that perhaps could enrich some of the historical issues that the authors refer to.1

The dating of the term ‘robot’ in 1921, as noted in the article, is not entirely accurate. The play Rossum’s Universal Robots, in which the word robot (robota in Czech) was first coined, was written by Karel Čapek in the early 1920s, as stated by his biographers Ivan Klima2 and Bohuslava Bradbrook,3 his translator into English, Norma Comrada,4 and several authors in the field of robotics.5-7 The fact that the play was premiered in Prague in 1921 and in London in 1923 contributes to the misunderstanding.

On the other hand, if we state that the Slavic voice robota means ‘work’, we think there is a risk of simplifying the effort of Čapek when expressing the then novel concept of android designed to work. In the etymology of robota, two concepts are gathered: ‘work’ and ‘slavery’ (as work of the glebe or exploitation).8-10 which we should record to fully understand the meaning of the word robot,6 especially when in robotics own nomenclature master-slave is used,11,12 for example, the da Vinci Surgical System8,13

Regarding the statement ‘autonomous machines date from year 400 BC’, by Archytas of Tarentum, we would like to express that if it is true that this engineer of antiquity is acknowledged as the father of Western robotics, the origins of automatic machines are much older and date back to ancient Egypt (1500 BC) when devices such as the water clock, essential for understanding the evolution of robotics, were developed. On the other hand, when the authors argue that Leonardo da Vinci was the first to build a robot imitating human movements, they omit other builders who had already presented their humanoids centuries before, most notably Albertus Magnus, Roger Bacon, and Villard d’Honnecourt.

We are also surprised that the historical review goes unnoticed in the 18th century, forgetting none other than Von Kemptelen (builder of the legendary chess player) or Jacquard (programming of textile mill), and it makes the news rightly citing Asimov, but omitting the main precursors of robotics of the 19th and 20th centuries such as the Maillardet brothers (writer robot), Robert-Houdin (circus robots), Roselund and Pollard (first articulated arm), Hadler (industrial automation), Touring (machinery test), or Devol (first industrial patent), among others. For our part, we had put on record the importance of those figures in two articles on the history of robotics, published in this journal in 200714,15 to which, unfortunately, the authors do not refer.

Other than that, we believe that the authors offer an interesting and complete review of simulators for teaching in robotic surgery, providing relevant data that track the evolution of this branch of knowledge in urology.

References