letters

WRITE TO THE EDITOR AT BJU INTERNATIONAL, 47 ECCLES STREET, DUBLIN 7, IRELAND

SEXUAL FACTORS AND PROSTATE CANCER

Sir,
With evidence, albeit limited, that oxytocin released at the time of orgasm is associated with a reduction in the risk of breast cancer in women [1], I was disturbed by the unwarranted misinterpretation published by Fox [2], the scientific correspondent of New Scientist, of the data on the relationship between ejaculation frequency and risk of prostate cancer in the report by Giles *et al.* [3]. This led to worldwide media headlines suggesting that masturbation prevented prostate cancer. Having now had the chance to read the original data, and found no analysis between frequency of intercourse and masturbatory-related ejaculation, I am even more disturbed and wondered why Giles *et al.* did not consider oxytocin as a possible explanation of their data.

Furthermore, although the authors decided prospectively not to collect data on sexually transmitted diseases, they have concluded somewhat unscientifically that the data argued against infection having any role in the cause of prostate cancer. The data in Table 2 of their report show two divergent trends, i.e. that two to four partners reduces the risk but that any increase beyond five or more partners reduces that benefit. It would be interesting to see the risk for the proportion of partners analysed on the basis of frequency of ejaculation, i.e. are the promiscuous low-ejaculation group more likely to get prostate cancer while those not promiscuous but in the high-ejaculation group are at an even lower risk?

Possible support for this view comes from the data in Table 3 of the paper, where a high frequency of ejaculation in men in their fourth decade is associated with low ejaculation frequency of the second decade. Dividing the data on the basis of the number of partners, i.e. five or less vs more than five, and re-examining the effect of frequency of ejaculation in second and fourth decade would better assess any possible effect of an infectious element in the cause of prostate cancer.

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1 **Murrell TG.** The potential for oxytocin (OT) to prevent breast cancer: a hypothesis. *Breast Cancer Res Treat* 1995; **35**: 225–9
2 **Fox D.** Masturbating may protect against prostate cancer. *New Scientist* 2003; **16 July**
3 **Giles GG, Severi G, English DR *et al.*** Sexual factors and prostate cancer. *BJU Int* 2003; **92**: 211–6

THE FUTURE IN THE PAST, OR THE MANAGEMENT OF INVASIVE PROSTATIC CANCER IN THE THIRD WORLD

Sir,
There is a continuing perception that diethylstilbestrol (DES) therapy of invasive cancer of the prostate is unsafe [1]. This is despite overwhelming evidence to the contrary produced by the VACURG group [2]. Has the urological fraternity, especially in the Third World, not abandoned appropriate stilboestrol therapy precipitately? Patients are prescribed unaffordable options and go without treatment. We need to review the use of cheap DES; perhaps this letter will help the discussion through the pages of the *BJU International*.

The statistics for prostate cancer in the Third World are scanty but two recent studies in Jamaica (Douglas LL, personal communication) and Tobago (Patrick A, personal communication) indicate a high incidence of the disease in the Caribbean. Palliation for prostate cancer started with the Nobel Laureate Charles Huggins [3] over 50 years ago; he used cheap DES and the results were dramatic. Patients became symptom-free and had a better quality of life. In time, high-dose DES use was reviewed and thought dangerous. The main danger was thrombo-embolism, which led to death from myocardial infarction or cerebrovascular accident. Huggin's work was continued by several eminent workers who contributed to the VACURG series of 1968–75. The VACURG studies concluded that; (i) DES suppresses tumour growth; (ii) that 1 mg (low dose) daily was as effective in tumour suppression as 5 mg three times daily (high dose); (iii) that there was no increased risk of thrombo-embolism with 1 mg daily; (iv) that thrombo-embolic events occur during the first year of use of high-dose DES.

Bishop [4], in a smaller UK study, reinforced the VACURG thrombo-embolic conclusions but suggested that there may be an increased risk of deep vein thrombosis (DVT). This is rarely seen in Caribbean clinical practice (unpublished, Caribbean Association of Nephrologists and Urologists' Conference 2002). It therefore appears that a review of cheap DES therapy in prostate cancer is justified in the Caribbean, and perhaps other Third World communities.

I started a study over 2 years ago (Joint Meeting of Caribbean Urological Association and Jamaica Urological Association, Jamaica, February 2003) and enrolled 35 patients, all symptomatic. They had a full general physical examination, a DRE, estimation of serum PSA, and some had TRUS and a biopsy. The 22 men who presented with an indwelling Foley catheter had a TURP. All 35 patients were placed on 1 mg DES as a single daily dose. All became asymptomatic and were reviewed at 3 months, when the general physical examination, DRE and PSA were repeated; the PSA levels were reduced in 23 men and increased in two, but 10 patients could not afford a repeat PSA assay.

Asymptomatic patients with normal PSA levels had DES stopped and were reviewed

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after a further 3 months. Patients asymptomatic at 3 months but whose PSA levels had not returned to normal levels had the DES continued for a further 3 months and were reviewed at the end of that period. The two patients whose PSA levels were increased became clinically asymptomatic after DES, deteriorated and died during the study period.

DES very effectively and rapidly stops haematuria. I use DES 24–48 h before surgery in patients with elevated PSA levels who need TURP. A few patients preserve erections while on DES. No patient had a thrombo-embolic event during the study; all have been followed for >1 year. DES costs US $10 per year, and the therapy is palliative, but it can provide significant symptom relief and much better quality of life. Low-dose DES is safe, effective and affordable, and merits review by urologists in general and ought to be the first-line therapy in the Third World.

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2 **Byar DP.** The Veteran Administration Cooperative Urological Research Group's Studies of cancer of the prostate. *Cancer* 1973; **32**: 1126–30
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A STUDY TO DETECT *HELICOBACTER PYLORI* IN FRESH AND ARCHIVAL SPECIMENS FROM PATIENTS WITH INTERSTITIAL CYSTITIS, USING AMPLIFICATION METHODS

Sir,
We read with interest this paper [1] attempting to detect *H. pylori* DNA in fresh and paraffin-embedded bladder biopsy specimens, and thus support evidence of a possible role in interstitial cystitis (IC). Although IC has been likened to chronic peptic ulcer disease in this paper, other factors which suggest involvement of an infectious component have not been mentioned. There is a high preponderance of women with the syndrome who are known to be at greater risk of UTI because of the shorter urethra and nearness of the vaginal bacterial flora. There is often a history of previous UTIs or patients have had 'childhood bladder problems' [2]. The factors that suggest that the disease is acquired are its rapid onset, appearance in mid-life, and absence of a strong family history or association with any HLA haplotype. Several features suggest that urine and its constituents may be involved; epithelial defects are prominent, urination offers relief and urinary diversion diminishes symptoms, even though the bladder remains *in situ*. In addition, inflammatory changes on histopathological evaluation and the presence of IgA deposits in the bladder epithelium suggest that IC may be caused by an infective agent.

The authors cite only one previous study that specifically addressed the issue of *H. pylori* infection in IC [3]; there is another [4] in which a CLO test was used on bladder biopsy specimens from patients with IC and the results, as with the study by Agarwal *et al.*, did not support a role for the involvement of *H. pylori* in the pathogenesis of IC.

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1 **Agarwal M, Dixon RA.** A study to detect *Helicobacter pylori* in fresh and archival specimens from patients with interstitial cystitis, using amplification methods. *BJU Int* 2003; **91**: 814–6
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SCREENING FOR PROSTATE CANCER: HAVE YOU HAD YOUR CHOLESTEROL MEASURED?

Sir,
This comment [1] gives a comprehensive and balanced review of the available data which may plead for and against screening for prostate cancer. With these data the author also gives his personal view toward the end of the article. As the international co-ordinator of the European Randomized Study of Screening for Prostate Cancer (ERSPC) I wish to comment on the final paragraph in the section 'Randomized trials on PSA testing'. Here the problem of contamination by the use of opportunistic screening in the control arm and its influence on the power of ERSPC is addressed. While the problem is correctly indicated, the worst possible scenario, the data resulting from the Metropolitan area of Madrid (reference 40 in the paper) is chosen as an example. On behalf of the ERSPC study group my comments are as follows: (i) the group is fully aware of the problem of contamination; (ii) anticipating an increasing rate of contamination, the sample size was adapted to accommodate a 4-year contamination rate of 20% [2]; (iii) contamination is being studied in all centres, specifically by the main contributors in Finland and The Netherlands; (iv) it is not the use of the PSA test that counts, but the following of appropriate biopsy indications; (v) studying 'effective contamination', the exclusion of a biopsy indicated by an elevated PSA, Otto *et al.* [3] found a contamination rate in the Dutch contribution of 3% per year, which is well below the anticipated 20%.

The ERSPC study group has taken all the necessary measures to correct the sample size for contamination by opportunistic PSA testing. A need to prolong the 10-year planned follow-up may arise at the end, but this situation is not expected to occur. A power calculation has recently been repeated and published [2].

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1 **Boyle P.** Screening for prostate cancer: have you had your cholesterol measured? *BJU Int* 2003; **92**: 191–2
2 **Koning de HJ, Liem MK, Baan CA, Boer R, Schroder FH, Alexander FE on behalf of the ERSPC.** Prostate cancer mortality reduction by screening: power and time frame with complete enrolment in the European Randomized Study of Screening for Prostate Cancer (ERSPC) trial. *Int J Cancer* 2002; **98**: 268–73
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Rotterdam section of the European Randomized Study of Screening for Prostate Cancer. *Int J Cancer* 2003; **105**: 394–9

IDENTIFYING UNDER-PERFORMING SURGEONS

Sir,

We congratulate the authors of this important paper [1] at a time when the restructuring of cancer services is underway. It highlights issues central to change and suggests a move towards centralisation in the provision of these services. It also coincides with a recent publication in the *BMJ* examining outcomes in cardiac surgery [2]. From BAUS Section of Oncology data we know that a significant number of units lack the caseload to allow an evaluation of surgical performance. This raises the question as to whether the National Institute for Clinical Excellence guidelines are radical enough or if we should be moving towards regional 'super centres'.

A single regional 'super-centre' performing all major pelvic surgery seems a likely solution. The caseload would then be adequate to allow an assessment of performance within a short period and this might increase public confidence in specialist cancer services. However, there are some potential disadvantages with this strategy. If the emphasis is on attaining numbers then there is a real risk that inappropriate cases may be operated upon by surgeons wishing to augment their total. Second, in the event of an infective outbreak in any of these centres, all major cancer surgery in the region could potentially stop. Third, it would require a dramatic increase in capacity and funding for the specialist centres, with probably a reverse flow of the more routine cases. Conversely, there may be a reluctance to accept challenging or high-risk cases, which may lead to a loss of skills, decreased job satisfaction and provision of a poor service to the patients. Finally, there are numerous variables that could affect the final outcome of radical cystectomy, not all relating to the surgeons' performance as measured by the 30-day mortality data.

Ultimately it is the patient's choice and this aspect must not be ignored. The mortality rate is only a crude assessment of a surgeon's skill and as the paper indicates, more refined measures are needed to assess outcomes even if centralisation goes ahead.

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1 **Singh R, Smeeton N, O'Brien TS.** Identifying under-performing surgeons. *BJU Int* 2003; **91**: 780–4
2 **Bridgewater B, Grayson AD, Jackson M *et al.*** Surgeon-specific mortality in adult cardiac surgery: comparison between crude and risk stratified data. *BMJ* 2003; **327**: 13–7

BILATERAL TESTICULAR CANCER: A PREVENTABLE PROBLEM? EXPERIENCE FROM A LARGE CANCER CENTRE

Sir,

We read with interest this report by Pamenter *et al.* [1], reviewing the incidence, treatment and outcome for patients with bilateral testicular cancer. We congratulate the authors on an important study, which highlights some controversies about the management of this condition, and have one comment.

The proportion of secondary tumours presenting at an advanced stage (58%) was somewhat higher than in other studies. Notably, in 1999, Albers *et al.* [2] reported a series of 30 bilateral testicular cancers and found 83% to be stage I at diagnosis. As such, most of the patients were managed with surveillance alone and only 13% required chemotherapy for advanced disease, compared with 58% in the study by Pamenter *et al.* [1]. The survival in both series was comparable, with 100% and 95% of patients remaining disease-free at the 30- and 51-month follow-up, respectively [1,2]. However, the one death in the series by Pamenter *et al.* resulted from bleomycin toxicity, emphasising the need for early diagnosis of secondary testicular cancer and avoidance of additional chemotherapy.

In the series by Alber *et al.*, 83% of secondary tumours were detected by self-examination, but although Pamenter *et al.* mention that patients were taught self-examination, they do not indicate how many second tumours were detected in this way. It is therefore possible that differences in self-examination accounted for the discrepancies in tumour stage between the studies. Clinical features and testicular intraepithelial neoplasia have been reported to be unsatisfactory methods for predicting secondary testicular cancer [1,3]. Therefore, until an acceptable method for predicting relapse is established, perhaps an even greater emphasis on patient education and self-examination is required to ensure that second tumours are diagnosed at an early stage.

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1 **Pamenter B, De Bono JS, Brown IL *et al.*** Bilateral testicular cancer: a preventable problem? Experience from a large cancer centre. *BJU Int* 2003; **92**: 43–6
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NO-SCALPEL VASECTOMY: A CAUTIONARY TALE OF FAILURE

Sir,

Barros d'Sa and Guy's 'cautionary tale of failure' [1] unfairly links the use of the no-scalpel vasectomy technique with vasectomy failures. Their report confuses the issues: the 'no scalpel technique' refers only to the method of isolation and delivery of the vas, and does not define how the vasa should be obstructed. The optimum method of achieving vasal occlusion in vasectomy is controversial and a wide variety of techniques has been advocated, including ligatures, clips, electrosurgical diathermy, electrocautery, glue, fascial interposition or combinations of these. Whether both ends should be occluded or whether the testicular end should be left open has also been a source of debate.

Their observation that the length of vas excised inversely affects the risk of spontaneous re-canalisation has been reported elsewhere. Although excising long lengths of vas is very effective in preventing re-canalisation this should be discouraged, as this increases the chance of bleeding and

postoperative pain. Most importantly, this technique can make reversal (if required in the future) extremely difficult.

Barros d'Sa and Guy's report does not define the method of vasal occlusion that was used in their series and whether fascial interposition was used routinely. Failure rates of zero in very large personal series have been reported where a combination of segmental vasal excision, diathermy and fascial interposition has been used [2]. The evidence that fascial interposition can reduce spontaneous re-canalisation rates certainly seems clear from series where 'open-ended' vasectomy has been performed.

The 'no-scalpel' vasectomy technique has several confirmed advantages: a quicker operation, less tissue injury, less postoperative swelling and pain, and a low complication rate with a definitely lower risk of scrotal haematoma. Subsequent failures are consequent upon the method of vasal occlusion that is used and not the method of access.

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PARTNER'S INFLUENCE ON PATIENT PREFERENCE FOR TREATMENT IN EARLY PROSTATE CANCER

Sir,

We read with interest this paper [1] on the influence of partners on the patient's preference for treatment in early prostate cancer. This well performed study highlights a specific area of a much bigger problem. We recently published a systematic review article [2] covering the standard reports but also considered the mass of information available via other sources, including the media and Internet. From our study of the choices of treatment for prostate cancer, when there is poor-quality evidence or little professional consensus to support a particular treatment over another, no clinical guidelines on treatment are possible. Patients are faced with a series of options and the data reveal that the process of choosing among these options is based on input from many sources. These sources differ in the way that the benefits of treatment are emphasised over harms, and vice versa. We identified little evidence about which type of input exerts the greatest influence on patients (e.g. partners, family, friends, media, Internet, health professionals). It may be that the sources associated with the most bias have the greatest influence.

We concluded that there is a paucity of information on how patients with prostate cancer use different types of input in the process of choosing a treatment. The doctor, as principal caregiver, still appears to have the most direct influence on patient choice. Just how long this status will continue is uncertain.

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