
Preface

The final chapter of this book arrived the day that the US Preventive Services Task Force issued its recommendation that men should forego PSA screening for early diagnosis of prostate cancer. What a mess! Not the chapter – it was brilliant – but rather the firestorm created by this stance taken by individuals that have never had primary responsibility caring for patients with the second most common cause of cancer death in men.

This controversy may play out for a long time, but the information contained herein makes clear that we are actually preventing tens of thousands of men from dying of prostate cancer through early diagnosis and improved treatments. That fact won't go away with a dismissive remark by a group that interprets the data very differently from most experts in the field, including those who came together for this book on the topic. Despite the opinions of some critics outside the field, most urologists do prioritize avoidance of morbidity and cost of treatment for men with low-risk prostate cancer. Those men are now often managed conservatively with active surveillance – 25 % of the patients that I personally diagnose – and our treatments continue to improve for those patients who either chose or essentially have to undergo therapy. This concept of individualized care with no, appropriately delayed, or minimally invasive treatment for patients who appear to have low risk from disease morbidity or death is not new, as summarized several years ago. Nevertheless, we do acknowledge that some clinicians pursue strategies outside those described in this book, just like there is deviation in all fields of medicine and otherwise, but the fact that this behavior is outside the standards of care described by the authors in this book should not be ignored by the Task Force.

The prostate diagnostics field has witnessed a remarkable transformation in the 5 years since *Prostate Biopsy: Indications, Techniques, and Complications* was published. At that time, the standard “sextant” biopsy was still used in some quarters despite missing up to half of cancers, and the role and best technique for periprostatic local anesthesia were still occasionally debated. Now we define the biopsy standard of care as a minimum of 12 cores with at least half being from the apical and lateral aspects of the gland. Using a periprostatic anesthetic block, 20 or more core transrectal saturation biopsies can be performed routinely in an office setting, if desired, for repeat or cancer staging biopsy. Transperineal template mapping biopsy is now used in

a number of centers for both diagnostics as well as quantification and qualification of disease status for patients being considered for active surveillance or focal therapy. Prostate MRI has advanced from novelty status in a few centers to routine use in many of the world's top institutions, and a number of investigators are developing biopsy techniques that may be performed under a variety of imaging guidance modalities in the near future. Finally, we are departing an era where PSA drove most biopsy decisions to one where it becomes only one of a number of factors that determine diagnostic strategy. Hence, we have titled this edition *Prostate Cancer Diagnostics: PSA, Biopsy, and Beyond* to reflect the breadth of this growing field.

As you read the chapters that follow, it may be difficult to recall that only a few short years ago, prostate cancer diagnostics seemed relatively straightforward. All men over 50 years old were believed to need PSA screening, and if its level was over 4.0, a biopsy inevitably ensued (a change the Task Force seems to have missed completely). A negative biopsy was previously regarded as definitive and further investigation was felt unnecessary unless the PSA value rose substantially. However, we now know that there is no truly meaningful threshold PSA value. Furthermore, PSA velocity appears to be less significant from a purely diagnostic standpoint than is intuitive, and a single negative biopsy still leaves a significant chance that a small-volume cancer remains unrecognized. Pathological findings on the initial biopsy, such as high-grade prostatic intraepithelial neoplasia or atypical small acinar proliferation, carry potentially significant implications to the likelihood that the patient will be found to have cancer during further investigation. Despite all these observations, prediction of prostate cancer risk remains elusive based on variations in the target populations, especially in the repeat biopsy setting. These complexities call for further efforts to optimize cancer diagnosis.

The authors in this book represent the highest levels of expertise in this discipline. They have been key drivers that have defined the science of prostate cancer diagnostics. Their body of work continues to transform the field, improving the decision process, patient experience, accuracy, and safety. The book includes intentional overlap of several chapters to acknowledge the controversial nature and existence of differing viewpoints by authorities considered the masters of their fields. I trust you will learn as much from their contributions as I have. I am deeply indebted to them all.

Cleveland, OH, USA

J. Stephen Jones, MD, FACS, MBA



<http://www.springer.com/978-1-62703-187-5>

Prostate Cancer Diagnosis

PSA, Biopsy and Beyond

Jones, J.S. (Ed.)

2013, XIV, 386 p., Hardcover

ISBN: 978-1-62703-187-5

A product of Humana Press