Anesthesia for Prostate Biopsy

TO THE EDITOR:

Kudos to Dr. Soloway[1] for clearly expressing the concept of maximal patient comfort during a procedure that has several givens—the rectal penetration is uncomfortable, the biopsies are painful, and the overall experience and potential outcome is frightening. I have found that in addition to the prostate nerve block, the use of oral diazepam (10 mg) 1 hour before the procedure is useful in terms of easing anxiety and facilitating sphincteric relaxation and thus placement of the probe. What has also proven extremely helpful is that on the day that the decision is made to pursue the prostate ultrasound and biopsy, the patient is walked down the hallway and introduced to the ultrasound technologist who will be assisting me who, in turn, shows the patient the ultrasound machine and biopsy room and reviews the entire process, in order to familiarize the patient with the procedure and help assuage fears.

It behooves us to treat all of our patients the way we would want our parents, siblings, children, spouses, and ourselves treated.

REFERENCE

1. Soloway MS: Do unto others—why I would want anesthesia for my prostate biopsy. Urology **62:** 973–975, 2003.

Andrew Siegel, M.D.
Hackensack, New Jersey

doi:10.1016/j.urology.2004.01.031

Prostate Cancer Cells: Detection and Isolation from Peripheral Blood and Bone Marrow

TO THE EDITOR:

In their article, Ellis and colleagues[1] speak vaguely of time spans in prostate cancer, as though the cell kinetics were not known. They refer to "late," "more than 5 years after surgery," and "long-term dormancy." In fact, the kinetics of prostate cancer is known with precision. Berges *et al.* told us that the doubling time of the primary was 475 days. This figure yielded, via the formula for compound interest, a 52-year history from the fatal chromosomal error to death at 1000 cm^3 of total cancer.[2] We know also from the formula that at the time of radical prostatectomy, assuming an average cancer volume of 2.5 cm^3 and that metastases start at a diameter of 2 mm,[3] metastases have been occurring for 12 years. The mean time to death for T1c prostate cancer has been determined to be 17.5 years.[4] Excess mortality due to prostate cancer in men who have survived 10 years ceases at 20 to 23 years.[5]

It is probably true that most of these cytokeratin-positive cells die in the marrow without establishing a "foothold." The high apoptotic rate of some cancers has been known since the early 1970s.[6] However, it is surely equally true that not all die. Everybody has a story of how indolent the disease can be.[7] Surely these bone marrow results cry for acknowledgment that total prostatectomy, however practiced, is a cytoreductive procedure, not cancer sterilizing.

REFERENCES

1. Ellis WJ, Pfitzenmaier J, Colli J, *et al:* Detection and isolation of prostate cancer cells from peripheral blood and bone marrow. Urology **61:** 277–281, 2003.

2. Berges RR, Vukanovic J, Epstein JI, *et al*: Implications of cell kinetic changes during the progression of human prostatic cancer. Clin Cancer Res **1**:473–480, 1995.

3. Li CY, Shan S, Cao Y, *et al:* Role of incipient angiogenesis in cancer metastasis. Cancer and Metastasis Rev **19:** 7–11, 2000.

4. Horan AH, and McGehee M: Mean time to death of apparently clinically localized prostate cancer: implications for cut-off ages for PSA screening and ablative therapy. Br J Urol **39:** 1063–1066, 2000.

5. Adolfsson J, Rutquist LE, and Steinbeck G: Prostate carcinoma and long term survival. Cancer **80:** 748–752, 1997.

6. Charbit A, Malaies EP, and Tubiana M: Relation between the pathological nature and growth rate of human tumors. Eur J Cancer **7:** 307–315, 1971.

7. Grabstaid H, Chabon A, and McSherry C: Prostate cancer: unusual metastases 20 years after 125 brachytherapy. J Urol **154:** 203–204, 1995.

Anthony H. Horan, M.D.
Evanston, Wyoming

doi:10.1016/j.urology.2003.03.001

Suprapubic Stab Cystostomy

TO THE EDITOR:

We read with great interest the article by Lawrentschuk *et al.*[1] They propose a safe combination of ultrasonography and flexible cystoscopy for suprapubic catheter insertion. In the article they state that the use of flexible cystoscopy for suprapubic catheter insertion has not been previously discussed.

Alagiri and Seidmon[2] described in 1998 a simple technique based on the principle of the percutaneous endoscopic gastrostomy procedure. They called the method percutaneous endoscopic cystostomy: the bladder dome and its relative position on the lower abdomen are localized using a flexible cystoscope, light source, and abdominal palpation. This reference was not credited in the article by Lawrentschuk *et al.*

We routinely use ultrasonography with or without flexible cystoscopy in difficult cases of suprapubic tube insertion and we agree with Lawrentschuk and colleagues[1] that the combination of ultrasound and flexible cystoscopy is the safest technique for percutaneous cystostomy.