Anesthesia for Prostate Biopsy

TO THE EDITOR:

Kudos to Dr. Soloway1 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


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

TO THE EDITOR:

In their article, Ellis and colleagues1 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.2 told us that the doubling time of the primary was 475 days. This figure yielded, via the formula for compound interest, an average cancer volume of 2.5 cm³ 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 sterilization.

REFERENCES


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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 Seidmon2 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 colleagues1 that the combination of ultrasound and flexible cystoscopy is the safest technique for percutaneous cystostomy.