

CA

A Cancer Journal for Clinicians

The Management of Prostatic Nodules

CA Cancer J Clin 1971;21;109-111

DOI: 10.3322/canjclin.21.2.109

This information is current as of March 18, 2010

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://caonline.amcancersoc.org>

To subscribe to the print issue of *CA: A Cancer Journal for Clinicians*, go to (US individuals only): <http://caonline.amcancersoc.org/subscriptions/>

CA: A Cancer Journal for Clinicians is published six times per year for the American Cancer Society by Wiley-Blackwell. A bimonthly publication, it has been published continuously since November 1950. *CA* is owned, published, and trademarked by the American Cancer Society, 250 Williams Street NW, Atlanta GA 30303. (©American Cancer Society, Inc.) All rights reserved. Print ISSN: 0007-9235. Online ISSN: 1542-4863.



The Management of Prostatic Nodules

*Roald N. Grant, M.D. interviews
William L. Valk, M.D., Professor of
Urology, the University of Kansas
Medical Center, Kansas City, Kansas.**



DR. GRANT: *Routine digital examination has been advocated as a worthwhile procedure for the early detection of cancer of the prostate. How important are such examinations in asymptomatic men?*

DR. VALK: We cannot overemphasize the importance of this examination in all men over forty. Carcinoma of the prostate is the third most frequent cause of cancer death in men. It is estimated that in 1971, 17,200 deaths will be caused by this disease.

DR. GRANT: *How effective is digital rectal examination in differentiating the type of prostatic nodule palpated?*

** Dr. Grant recorded this interview shortly before his death on August 24, 1970.*

- DR. VALK: The ability of the physician to determine the true nature of a prostatic nodule by rectal examination alone is much less than 100 percent accurate. Normally, the prostate is felt as a symmetrically bilobar structure with a medial sulcus between the lateral lobes. Any irregularity, nodularity or increased firmness (the normal lobes have a consistency much like the end of one's nose) should be considered cancer until proven otherwise.
- DR. GRANT: *What procedures are indicated when such an abnormality is palpated in the prostate?*
- DR. VALK: When a suspicious area in the prostate is felt, an abdominal-pelvic roentgenogram and the serum alkaline and acid phosphatase value should be obtained in addition to other routine studies.
- DR. GRANT: *Supposing these tests are positive, what then?*
- DR. VALK: The diagnosis of prostatic carcinoma must be based on a tissue analysis. We prefer the use of the Franklin modification of the Vim-Silverman biopsy needle, passing it through the perineum or rectal wall with a finger in the rectum guiding the needle to the suspicious area of the prostate to obtain tissue for microscopic examination.
- DR. GRANT: *Is this a procedure which should be done only by a urologist?*
- DR. VALK: Not necessarily, but the physician must be specially trained in the technique.
- DR. GRANT: *Does the patient have to be hospitalized?*
- DR. VALK: Although this procedure can be done under local anesthesia with a minimum of discomfort to the patient, it's not an outpatient or office procedure. It should be done either in a hospital or in a minor operating suite by one who is very well acquainted with the technique and familiar with the anatomy.
- DR. GRANT: *Where are the complications of this type of prostatic needle biopsy?*
- DR. VALK: Hematuria may occur in about seven percent of patients but the most significant complication reported in the literature is seeding of the needle tract with tumor cells. This is quite uncommon and has been reported in only five cases, an extremely low incidence considering the thousands of biopsies which have been performed.
- DR. GRANT: *How accurate is needle biopsy?*
- DR. VALK: This, of course, depends upon the surgeon's experience, the size of the lesion biopsied and the taking of multiple cores, which is desirable. The accuracy has been reported to range from 70 percent to 95 percent compared to open biopsy.
- DR. GRANT: *What about other methods of biopsy?*
- DR. VALK: There's open perineal biopsy, transrectal biopsy and transurethral biopsy with a resectoscope. Transurethral biopsy is not reliable unless the prostate is completely resected. Cytologic examination of the prostatic fluid obtained by prostatic massage is of no value as a diagnostic procedure.
- DR. GRANT: *Let's go back to needle biopsy. Supposing it is positive, how does one proceed?*

- DR. VALK: We would recommend that a radical retropubic prostatectomy or a radical perineal prostatectomy be performed within ten days.
- DR. GRANT: *Why do you prefer the retropubic operation rather than a perineal approach?*
- DR. VALK: We feel that it's a better cancer operation and that more surgeons are capable of performing radical prostatic surgery with this approach than with the perineal.
- DR. GRANT: *Speaking of radical prostatectomy for cancer, is this truly a curative procedure?*
- DR. VALK: There is some difference of opinion on this; unfortunately, we do not know the natural history or biologic potential of a carcinomatous prostatic nodule. Undoubtedly, the grade of the carcinoma is a significant factor in survival regardless of the method of treatment employed. Most of the five- and ten-year survivals reported for radical prostatectomy were in patients who had low-grade lesions. There is no question that this operation is a satisfactory treatment for low-grade carcinomas. Complete removal of the prostate with a so-called isolated prostatic nodule is necessary because almost one half of the lesions thought to be solitary preoperatively have been found to be more extensive at the time of radical surgery.
- DR. GRANT: *Thank you, Dr. Valk.*

Answers to Questionnaire on Pages 102-108

1. c	14. b	27. c	40. c	53. d	66. c
2. e	15. a	28. b	41. e	54. d	67. 1-a
3. c	16. b	29. e	42. a	55. e	3-b
4. c	17. e	30. a	43. d	56. a	2-c
5. b	18. e	31. c	44. e	57. a	7-d
6. d	19. e	32. b	45. b	58. b	8-e
7. b	20. b	33. d	46. a	59. a	9-f
8. a	21. c	34. a	47. a	60. a	5-g
9. e	22. d	35. b	48. e	61. d	6-h
10. b	23. b	36. d	49. d	62. d	4-i
11. b	24. b	37. b	50. c	63. c	10-j
12. b	25. c	38. d	51. e	64. a	
13. a	26. c	39. c	52. d	65. c	