HFM - 003528

ropubic prostatic removal combined with lymph node intervention. Recent reviews and summaries[7] of the results of this approach appear to justify its use. However, longer follow-up is needed.

Interstitial therapy for localized prostate cancer has been introduced using I^{125}. Extensive results have been described by Whitmore and associates and are being followed closely.[12] Thus, one has a variety of surgical approaches to early or localized stages of disease combined with variations in lymph node dissection, with or

"...There are some patients who are now benefiting from retropubic prostatic removal combined with lymph node intervention."

without the addition of interstitial operative applications.[6] The techniques, the numbers and the degrees of lymph nodes are currently subjects of dispute and debate. There are at present no randomized studies, nor should there necessarily be any. However, it is important to note that these results are promising,[6] and, in and of themselves, they afford a therapeutic option.

Bagshaw's observations with external radiation for localized disease indicate that short-term, disease-free survival is possible in over 87 percent of patients with negative lymph node biopsies. Patients in an intermediate phase, with positive lymph node biopsies only in the pelvic region following extended field radiation therapy also have an improved survival rate, nearly 72 percent. Patients with positive periaortic node and pelvic node biopsies have a diminished survival. The randomized trial conducted by Bagshaw and associates has been recently reported and continued promising results are seen.[15] There are other features of radiation therapy reported and described that cannot be ignored. The question of the use of exogenous estrogens as a form of endocrine therapy, has been most recently reported; those interested in reviewing the divergent opinions may wish to consult a recent review.[6] Hormones should be considered essentially palliative and should not be confused with primary treatment.

Surgery and radiation therapy as primary treatment afford a reasonable opportunity for disease-free interval and possible cure. The author does not prefer surgery, interstitial therapy or external radiation therapy on the basis of any results currently available. In the author's present viewpoint, no one mode is definitely proven to be superior to any other. Urologic surgeons and others should afford patients the opportunity for the selection of treatment best suited to their particular needs, depending upon a variety of interpersonal factors and possible medical conditions. In terms of primary therapy, it must be remembered that lymph node dissection is not without its possible complications. Moreover, lymphangiograms may or may not be desirable. Radiation therapy has an important role to play as does primary surgery. An attempted resume of the current status of the therapy as employed today by radiotherapists and urologists is reflected in Table 3. The biggest problem with the interpretation of Table 3 is that many of the stages depend upon precise surgical staging. They are not clinical stages. Whether or not node dissection or node sampling is done remains an important and irresolvable distinction.

Palliation Therapy

Palliation, or hormonal, therapy is neither intended nor claimed to be curative. Whether one uses a different dose of estrogen combined with the presence or absence of orchiectomy, remains a source of occasional concern. It is appropriate to restate results from our own institution as an example of full term follow-up and high percentage autopsy examination of patients with widespread or metastatic prostatic cancer who are treated with either orchiectomy or combination treatment (Table 3). Without question, prostate carcinoma remains the all-time and major cause of death in all such patients. There

TABLE 3
CURRENT STATUS OF
MOST COMMONLY EMPLOYED METHODS OF PRIMARY THERAPY

Stage	Examples of Therapeutic Choices Currently Being Employed
A_1 A_2	Some prefer surgery, others observation.
B_1	1) Radical prostatovesiculectomy (either retropubic or perineal approach*) ± lymph node dissection 2) Radiation therapy
B_2	1) Radical retropubic prostatovesiculectomy with pelvic lymphadenectomy 2) Radiation therapy ± node sampling
C	1) Radical retropubic prostatovesiculectomy with pelvic lymphadenectomy 2) Interstitial radiation with pelvic lymphadenectomy 3) Radiation therapy ± lymph node sampling 4) Some prefer observation ± endocrine treatment
D_1	See text

*A few centers employ cryosurgical destruction ± lymph node dissection in all the stages depicted in this table.

are no significant statistical differences in this particular hormonal program. We are aware of the ability to measure dihydrotestosterone (DHT) and other substances in the serum, but these should not be used as a guide to the adequacy of palliation therapy. The patient himself will inform the clinician regarding pain relief, sense of well being, weight, appetite, etc. A variety of doses are useful and have been found adequate. Levels of hormones in one partition of the total body compartment cannot possibly be of predictive value, although some may feel that is the case. Only extended metabolic studies over 24 hours including all possible components