decision between the physician and the patient, with the physician understanding the relevant values of the patient and the patient understanding the nature of the disease and intervention, including risks and benefits. The purpose of the written consent form is to document that a process of informed consent has taken place [3].

We have a clear ethical and legal duty to fully inform our patients before any surgical procedure. The patient's right to undergo or decline a surgical procedure is protected by law, and doctors are expected to be aware of the legal principles set by relevant case law in this area [4].

Some investigators suggested that written information sheets contribute to the process of informed consent. As patients' recall of information is generally poor, the sheets might be useful medicolegally, as a permanent record of what was discussed [5]. Other studies suggested that additional written or verbal information does not improve a patient's understanding of the risks and complications of surgical procedures [6].

Studies on orthopaedic patients showed that patients feel they receive an appropriate amount of information on the nature of their injury and the actual operative procedure, but little information on possible complications and postoperative care [7]. Other studies show that visual aids to assess patients' understanding of the risks of surgery do not improve patients' understanding and recall of the risks of the surgery [8].

A significant relationship might exist between the patient's education level and age and the rate of patient recall of the potential complications of surgery [9]. It is generally recommended that information directed to the general public should have a readability index of < 40 (approximately the level of the popular press) [10]. Patients' anxiety levels are unaltered by the increase in the information they are given [6]. The information provided to patients should be simple, easy to understand and list any possible major complications to enable the patient to determine whether to undergo or decline a procedure [6].

The present study showed clearly that additional written consent does not improve patients' understanding of the nature of the surgery or the risks and complications of the procedure.

Verbal and written information supplied to a patient might be understood, but is easily and quickly forgotten. In an increasingly medicolegal environment, it is essential to gain informed consent from a patient before an intervention. The provision of an information booklet might provide nothing more than pro forma for the surgeon of information provided to the patient. Verbal and written information seems inadequate for obtaining informed consent, and the whole informed consent issue needs revisiting.

REFERENCES

1. Rogers v Whittaker 1992 175 CLR 479

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Abbreviations: TURBT, transurethral resection of bladder tumour.

YOUNG MEN WITH PROSTATE CANCER: ARE THEY DIFFERENT AND HOW SHOULD THEY BE MANAGED? Matthew R. Hotston, Helena Burden, Ramesh Thurairajat, Jonathan McFarlane* and Rajendra A. Persad – Departments of Urology, Bristol Royal Infirmary, Bristol, *Royal United Hospital, Bath and Horbay Hospital, Torquay, UK

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INTRODUCTION

Prostate cancer is currently the most common cancer in men in the UK, accounting for 20% of newly diagnosed cancers [1]. The peak incidence is in men aged 70–79 years, whilst 4% of new cases are aged <50 years, an increase from a reported 0.8% of cases in the early 1970s [1]. As PSA testing becomes more widespread, this number will continue to rise. The natural history of prostate cancer is still poorly understood. Furthermore, few studies have assessed the disease characteristics in young men. They are an important group, given the expected rise in new cases and their long life-expectancy. Does prostate cancer behave differently in young men, and if so, what are the implications for their treatment?

DIFFERENCES IN CLINICAL PRESENTATION

Many studies have investigated how men with prostate cancer present to the clinician, but few have concentrated on age-related differences. However, Ruska et al. [2] reviewed
87 men aged < 40 years who had prostate biopsies for suspected cancer. The two
commonest reasons for biopsy were an
abnormal DRE (61 men) and an elevated PSA
level (14 men); 25% of men with an abnormal
DRE and half of those with an elevated PSA
level were then diagnosed with cancer. Other
presentations included 12 with inflammatory
symptoms, seven with ejaculatory problems,
and three with a positive family history.
Overall, 23 of the 87 men were diagnosed
with prostate cancer.

IS PROSTATE CANCER MORE AGGRESSIVE
IN THE YOUNG?

One problem in ascertaining whether
younger men with prostate cancer have
more aggressive disease is that there are
few cases available, most of which are
published as case reports or retrospective
analysis, making direct comparisons difficult.
Furthermore, the endpoints used to assess
outcome are varied. With the advent of PSA
screening in some areas, there is also now a
possibility of ‘age-specific lead-time bias’,
i.e. cancers detected in older men at the
commencement of screening might be seen
as more aggressive, as they were not detected
at an earlier age.

Early clinical studies tended to report that
men aged <50 years who develop prostate
cancer had worse outcomes than older men,
suggesting that they tend to develop more
biologically aggressive tumours [3]. More
recently, Rieopel et al. [4] reviewed the data of
543 men who had a radical prostatectomy
(RP); those aged <50 years (85 men), although
having similar tumour grade, stage and
capsular penetration, had significantly more
having similar tumour grade, stage and
rate of prostate cancer. One
retrospective study found that African-
American men aged 50–59 years had
significantly higher PSA levels and Gleason
scores at diagnosis, and higher recurrence
rates after RP, than White men in the same
age group [6]. It is suggested that socio-
economic factors might influence the
medical-seeking behaviour of African-
American men and the subsequent
conservative approach from some clinicians,
leading to a delay in diagnosis and worsened
prognosis.

FAMILIAL DIFFERENCES

Men with a family history of prostate cancer
tend to develop the disease earlier in life [7,8],
but they do not carry a poorer prognosis than
men with no family history. Indeed, Bratt et al.
[7] found that men diagnosed with prostate
cancer before 51 years old had a better (but
not significantly better) prognosis if they had
a positive family history.

HOW SHOULD YOUNG MEN WITH
POtENTIALLY CURABLE DISEASE
BE TREATED?

Younger men obviously have a greater life-
expectancy. This makes watchful waiting less
attractive, but it is still an option; 10-year
survival rates of 70–90% in localized disease
have been reported [8] and there are no side-
effects apart from perhaps prolonged anxiety.
However, the recent study by Bill-Axelson
et al. [9] suggested that watchful waiting is
inferior to surgery, particularly in men aged
<65 years. After randomizing 695 men with
localized prostate cancer, 14.4% of men
managed by watchful waiting died from
prostate cancer-related causes, compared to
8.9% of the surgical group at 10 years [9].
Although most of the conservatively treated
patients were also given hormonal therapy,
their local recurrence and distant metastasis
rates were significantly worse [9]. The concept
of ‘active surveillance’, with very close PSA
level and clinical monitoring combined with
regular prostate biopsies, is more appropriate
for this age group, but is likely simply to
postpone radical treatment rather than
supplant it.

For localized disease, there are three main
curative options, i.e. RP, radical radiotherapy
and brachytherapy. According to Donovan et
al. [10], most UK urologists would advise RP
for patients aged <70 years, and radical
radiotherapy for those aged >70 years. The
reasons for this approach are unclear,
particularly as the success rates are similar
(10-year survival rate of 80–90% for RP, vs
65–90% for radical radiotherapy), and the
complications associated with radical surgery
might be more significant and prolonged [10].

Some studies showed that younger men have
better outcomes after RP. This might suggest
that the disease is less aggressive in younger
men. However, these results were not
controlled for the year of surgery, which is an
important predictor of PSA outcome.
Freedland et al. [11] took this into account
when studying the data of 1753 men who had
radical surgery; recently treated men included
a higher proportion of younger men, and men
aged <50 years had significantly lower
recurrence rates. More recently, a study of 790
men undergoing RP (by the same surgeon)
found no age-related differences in
pathological or clinical outcome [12]. Men
aged <50 years had similar preoperative and
pathological predictors of organ-confined
disease, as well as postoperative complication
rates and biochemical recurrence rates, to
those aged >50 years.

There are no studies currently available
comparing clinical or biochemical outcomes
of radiotherapy with surgery in prostate
cancer, for any age group. However, Rosser
et al. [13] retrospectively assessed the
biochemical outcomes of 964 men who all
had radical radiotherapy alone for localized or
locally advanced prostate cancer; 46% of
those aged <60 years had biochemical failure,
compared to 30% of older men.

TREATMENT-ASSOCIATED MORBIDITY IN
YOUNG MEN

In this specific cohort of men, any treatment-
induced morbidity confers increased
significance, as they tend to be more
physically active, socially aware, and
potentially burdened with side-effects for a
prolonged period. Radical surgery confers a
3% risk of total incontinence, and a varied
(20–80%) risk of erectile dysfunction,
depending on the level of expertise of the
surgeon, and the use of nerve-sparing
techniques [10]. However, potency rates
appear more favourable in younger men. In
a retrospective study of 366 men who had
uni- or bilateral nerve-sparing RP, men aged
<60 years had more reported ejections
sufficient for penetration than older men (19% vs 13% for unilateral surgery; 45% vs 38% for bilateral surgery) [14]. Unfortunately, no age-specific incontinence and potency rates after radiotherapy have been compared.

Another potential concern is that of the radiation-induced formation of a second malignancy, particularly in the context of radiation-induced formation of a second malignancy. As 3% of the men treated were aged <60 years, these ‘long-term survivors’ will therefore be burdened with a very real lifetime risk.

CONCLUSION

Clearly little is still known about the characteristics of prostate cancer in young men. However, several important conclusions can be drawn from recent studies. First, young men tend to be asymptomatic at presentation. Studies within the ‘PSA era’ found that men aged <50 years are more likely to have familial cancer, and might have a higher incidence of metastatic disease at presentation. However, this does not lead to poorer clinical outcomes than older men or men with no family history. Although radical surgery confers the risk of significant long-term side-effects, they occur less often in young men, and it remains the most effective choice of treatment for localized disease. Further studies into the characteristics of prostate cancer in this very important subgroup are warranted.

REFERENCES


2 Ruska KM, Partin AW, Epstein JI, Kahane H. Adenocarcinoma of the prostate in men younger than 40 years of age: diagnosis and treatment with emphasis on radical prostatectomy findings. Urology 1999; 53: 1179–83


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Abbreviations: RP, radical prostatectomy.

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INTRODUCTION

‘Mentors are guides. They lead us along the journey of our lives. We trust them because they have been there before. They embody our hopes, cast light on the way ahead, interpret arcane signs, warn us of lurking dangers and point out unexpected delights along the way’ [1]. Mentoring is a developmental stage in the life of all professionals. Effective mentors need to be exemplary role models, skilled in questioning, recognising their students as individuals with private lives, assuring a supportive environment for learning, comfortable with ignorance, liberal with feedback and showing patience [2].

With the increasing use of laparoscopic procedures worldwide to deal with many urological conditions and increasing numbers of patients wishing to be treated this way, the urological fraternity faced a difficult problem