In similar fashion, the Rocco technique reduces tension by approximating the bladder in proximity to the urethra. Additionally, securing the bladder to the prostate bed further augments hemostasis. In our experience, postoperative visits for hematuria and clots have been virtually eliminated. Since adopting the Rocco stitch, bladder neck contractures have been further reduced to 0.4%, or 2 in 500. Regardless of early continence, the Rocco stitch applies time-proven, sound surgical technique by reducing tension and improving hemostasis. Like Menon and his colleagues, even though the RCT was negative, we continue to perform and promote the Rocco stitch: "Rocco on."

Conflicts of interest: The author has nothing to disclose.

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DOI: 10.1016/j.eururo.2011.07.031

Re: International Phase III Trial Assessing Neoadjuvant Cisplatin, Methotrexate, and Vinblastine Chemotherapy for Muscle-Invasive Bladder Cancer: Long-Term Results of the BA06 30894 Trial

International Collaboration of Trialists on behalf of the Medical Research Council Advanced Bladder Cancer Working Party (now the National Cancer Research Institute Bladder Cancer Clinical Studies Group), the European Organisation for Research and Treatment of Cancer Genito-Urinary Tract Cancer Group, the Australian Bladder Cancer Study Group, the National Cancer Institute of Canada Clinical Trials Group, Finnbladder, Norwegian Bladder Cancer Study Group, and Club Urologico Espanol de Tratamiento Oncologico Group

J Clin Oncol 2011;29:2171–7

Experts' summary:
The impact of neoadjuvant chemotherapy in patients with muscle-invasive bladder cancer is reported with the long-term results of a previously published phase 3 trial. Between 1985 and 1995, 976 patients were randomized to receive or not receive three cycles of cisplatin, methotrexate, and vinblastine (CMV) neoadjuvant chemotherapy. Definitive local treatment included cystectomy and/or radiotherapy based on patient or physician choice. Patients were stratified by this choice.

With a median follow-up of 8 yr, median overall survival was significantly increased in chemotherapy arm from 37 to 44 mo. A significant risk reduction was reported for death (16%; hazard ratio [HR]: 0.84; 95% confidence interval [CI], 0.72–0.99; $p = 0.037$), corresponding to an increase in 10-yr survival from 30% to 36%; for metastases or death (23%; HR: 0.77; 95% CI, 0.66–0.90; $p = 0.001$); and for local disease or death (13%; HR: 0.87; 95% CI, 0.75–1.01; $p = 0.067$).

Experts' comments:
Neoadjuvant or adjuvant chemotherapy can be discussed with regard to patients with localized muscle-invasive bladder carcinoma; however, the literature clearly supports the use of preoperative treatment demonstrating a survival benefit compared with surgery alone in two meta-analyses [1,2]. Despite these data, neoadjuvant chemotherapy meets resistance in the oncology community. This long-term analysis is one more brick in the edifice supporting this standard of care. Even if definitive treatment was based on local radiotherapy alone in nearly 50% of patients, stratification reduces the risk of bias induced by this nonoptimal local treatment. Moreover, risk reduction of death after chemotherapy was close in both groups: 20% with radiotherapy alone ($p = 0.07$) and 26% with surgery alone ($p = 0.022$).

Despite the proven survival benefit, we can ask about the choice of the CMV regimen. In the metastatic setting, the modified dose-dense (DD) methotrexate, vinblastine, doxorubicin, cisplatin (MVAC) regimen resulted in higher response rates and a slightly better overall survival as compared to standard MVAC [3]. The efficacy of CMV and DD MVAC regimens has not been compared directly in a randomized phase 3 trial, but DD MVAC is recognized as the most effective in 2011.

Finally, we still ask the question of the optimal number of cycles: Are three cycles or more needed for the best prevention of metastatic recurrence? Nevertheless, we may assume that a supposedly even more efficient chemotherapy regimen would lead to an even greater benefit and would reinforce the positive conclusions of this trial.

Published data and the presently actualized results support neoadjuvant cisplatin-based chemotherapy before radical cystectomy and complete pelvic lymph node dissection as a standard of care. Conversely, numerous trials tried to assess the benefit of adjuvant therapy in bladder cancer, but methodologic biases do not allow the drawing of a definitive conclusion about its efficiency. However, improvement is necessary in patient selection and chemotherapy efficacy. Accordingly, biomarkers are urgently needed to determine which patients are more likely to benefit from neoadjuvant chemotherapy.

Finally, the French Genito-Urinary Tumor Group is embarking on a randomized trial comparing DD MVAC to gemcitabine and cisplatin to determine the optimal regimen to be given in the perioperative setting.

Conflicts of interest: The authors have nothing to disclose.

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DOI: 10.1016/j.eururo.2011.07.032

Re: Abiraterone and Increased Survival in Metastatic Prostate Cancer

deBono JS, Logothetis CJ, Molina A, et al

N Engl J Med 2011;364:1995–2005

Expert's summary:

This study randomized 1195 patients with disease progression after taxotere chemotherapy for prostate cancer to receive abiraterone plus prednisone or placebo plus prednisone. In a well-balanced randomized group, with median follow-up of 13 mo, overall survival was increased significantly with abiraterone (14.8 mo vs 10.9 mo). Secondary end points such as time to prostate-specific antigen (PSA) progression, progression-free survival, and PSA response were also significantly improved with abiraterone. Side effects such as fluid retention, hypertension, and hypokalemia were more frequently seen in the abiraterone group than the placebo group.

Expert's comments:

Prostate cancer is generally considered to be a hormonally sensitive disease, but patients ultimately fail first- or second-line hormonal therapy with luteinizing hormone-releasing hormone (LHRH) agonists and antiandrogens. Some centers have utilized second-line chemotherapy with CYP-17 inhibitors such as ketoconazole or aminoglutethamide with modest responses. Patients who fail this therapy generally receive chemotherapy with docetaxel.

This important study highlights that many patients with metastatic prostate cancer are not castration resistant. These studies confirm that the androgen receptor can still respond to miniscule levels of androgen. This study with abiraterone provides evidence that despite treatment with medical castration, sufficient levels of androgen exist to continue tumor growth. Although an LHRH analog with or without antiandrogen suppresses testosterone to the range of 20–50 ng/dl, abiraterone suppresses levels to the range of 1–2 ng/dl.

The impressive response rate to abiraterone plus prednisone was noted in all subcategories, including patients with several previous chemotherapy regimens, older patients, patients with visceral disease, and patients with baseline PSA above median. Although abiraterone plus prednisone has been approved by the US Food and Drug Administration for patients who have failed taxotere chemotherapy, additional studies will be necessary to identify its proper place in the armamentarium of treatment for prostate cancer.

Conflicts of interest: The author has nothing to disclose.

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DOI: 10.1016/j.eururo.2011.07.033