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## Adenocarcinoma of the prostate: an overview

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### Adenocarcinoma of the Prostate: An Overview

This issue of the Journal focuses on a major national health concern for men, carcinoma of the prostate. Papers presented at the Prostate Cancer Symposium in the summer of 1988 are the basis of this feature section.

Adenocarcinoma of the prostate is the second leading cause of cancer in American men and the third leading cause of death from cancer. American black males have an age-corrected incidence and mortality 50% higher than white males and, in fact, have the highest incidence and death rate from carcinoma of the prostate in the world. Despite these significant racial differences in clinical incidences, autopsy studies have shown no racial differences in the incidental finding of prostate carcinoma. Epidemiologic studies have found no factors that could be considered causative. No significant correlation has been demonstrated between prostate cancer and genetic, environmental, socioeconomic, or infectious factors. Most studies also show that hormonal factors play a permissive but not causative role.

Approximately 60% of patients with clinical prostate cancer will present with locally advanced or metastatic disease. This unfortunate statistic helps explain the relatively high (and increasing) death rate from this disease. As discussed in the article "Screening for Adenocarcinoma of the Prostate," routine physical examination with a well-performed rectal examination *can* improve cure and survival in this disease. Ultrasound of the prostate is an exciting new addition to our diagnostic armamentarium, although the limits of its usefulness have yet to be defined. Studies are being carried out nationwide to ascertain the usefulness and feasibility (economic and otherwise) of ultrasound alone and in combination with prostate specific antigen as screening tools.

Having made a diagnosis of localized and potentially curable disease, physicians are nonetheless hampered by the lack of pathologic prognostic indications as described in the excellent review by Peters and Crissman. We hope that cytophotometric analysis and molecular genetic studies will bear fruit in this important arena. Because of this lack of prognostic indicators,

accurate staging of the neoplasm is crucial in choosing the appropriate therapy, as Cerny reviews in his paper.

Treatment of prostate carcinoma has remained unchanged for three decades except for minor variations. Although <sup>125</sup>I radioactive implants and the nerve-sparing radical prostatectomy procedure have lowered the complications of curative therapy, surgical or radiation extirpation remain the only treatment choices for localized disease. As Miles discusses in his second paper, the mainstay of treatment for advanced disease is hormonal management. Despite numerous trials by national cooperative oncology groups, none of the various chemotherapeutic agents have been found to have any significant value in metastatic disease.

Hope for improvement in the management of prostate carcinoma remains high. Interest in this disease has increased dramatically, and educational efforts to dispel the notion of prostate malignancy being a benign cancer are rising. These efforts should encourage men to understand the role of the prostate and seek medical attention for a yearly rectal examination. A *rectal examination* should be considered the male "Pap" test until prostatic ultrasound is improved as a screening tool. Only early detection can improve survival statistics, and only education of the patient and primary physician can improve early detection capabilities. This edition of the Journal is another step in the right direction. In future issues we will address advances in interstitial radiation therapy, nerve-sparing radical prostatectomy, and their associated complications and management.

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