observation alone, it should be a wake-up call for us to stop treating non-lethal cancer with lethal and toxic treatments, including ADT.

Conflict of Interest
None declared.

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Prognostic Gleason grade grouping: data based on the modified Gleason scoring system

The ‘Gleason Grading System’ first proposed by Donald Gleason [1] in 1966 was a revolutionary system for its time. As it advocated the use of a sum score that combined the two most common patterns of prostate cancer seen in a radical prostatectomy specimen to predict the biological outcome of the tumour, rather than the worst pattern that was in common usage with other tumour types, it was truly innovative. Furthermore, although several other classification systems for prostate cancer have been proposed since then, none has stood the test of time as well as the Gleason system and certainly no other system is in widespread use internationally.

Gleason and Mellinger [2,3] went on to make adjustments and modifications to this classification system in 1974 and 1977, as the series of cases examined was expanded from the original 270 patients to >1000 patients.

Since then, there have been further changes to the Gleason Grading System with the advent of immunocytochemistry and in terms of clarification of the size and spacing of individual acini that are seen in the various patterns originally illustrated by Gleason. A tertiary pattern of prostate cancer, mentioned in passing by Gleason, has also become more clearly identified in a proportion of cases.

Possibly the most important advance regarding the Gleason Grading System was the result of an International Consensus Conference of Urological Pathologists in 2005. This meeting, comprising >80 specialist pathologists from 20 countries, published the updated or ‘Modified Gleason Grading System’ [4]. These guidelines were based on the changes in practice that had taken place in the diagnosis and treatment of prostate cancer in the previous 40 years and included evidence for the confirmation that Gleason 1 and 2 patterns should not be assigned on prostatic needle biopsy specimens and that all cribriform areas of tumour were best regarded as Gleason pattern 4 rather than Gleason pattern 3.

Although these modifications have been useful for the surgeon and pathologist, they have not clarified the Gleason
grading system for the patient. It is not easy to explain or to understand why a system that in theory could produce a range of Gleason sum scores from 2 to 10, is in practice actually limited on prostatic biopsy to Gleason sum score 6 to 10. Thus, rather confusingly, Gleason 6 is the most favourable category of prostatic carcinoma in terms of prognosis, rather than indicating a ‘middle-of-the-scale’ tumour.

The paper presented in this issue of BJUI, ‘Prognostic Gleason grade grouping: data based on the modified Gleason scoring system’ [5], attempts to compensate for this by allowing the categorisation of prostatic carcinoma not only in terms of Gleason sum score, but also into prognostic groups I to V that correlate with the sum score and may be easier for the patient to appreciate.

This is an important next step in the development of the Gleason Grading System and hopefully one that will be embraced by surgeons and pathologists and more easily accepted by patients.

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None declared.

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Robot-assisted partial nephrectomy in patients with recurrent disease: fiction or fact?

In recent decades, the detection of small renal masses (SRMs) has steadily increased with an accompanying shift of treatment towards partial nephrectomy (PN). Indications for PN have successfully expanded to more challenging cases, and robot-assisted PN (RAPN), in particular, has attracted increasing attention [1,2]; however, despite excellent cure rates for PN, parallel to the increasing number of patients with SRMs undergoing PN, cases of ipsilateral recurrence after PN are also expected to rise. In addition to the incomplete surgical removal of the primary tumour, unknown multifocality or the development of new tumours or metastasis, in a minority of cases recurrence originates at the previous surgical bed and can be considered a proper local recurrence. Retreatment in these patients represents a specific challenge with radical nephrectomy (RN), ablative treatment, repeat PN, and active surveillance in selected cases as therapeutic options. RN should be considered the least attractive option because of the further damage to renal function that it entails, yet it represents one of the most selected options worldwide. Besides ablative techniques, which should be considered under investigational circumstances only, repeat PN is one of the possible options, especially in cases of recurrences attributable to multifocality or bilateral nature.

Repeat open as well as laparoscopic PN (LPN) have been reported sparsely in the literature, but were shown to be associated with good functional and oncological outcomes.