

# BJUI Letters

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## SCREENING FOR PROSTATE CANCER

Sir,  
The European and American prostate cancer screening trials have polarised professional and lay opinion on screening [1,2]. Published opinions on these trials might be formulated by academic interests and private practice. I suspect some urologists read comments by acknowledged experts reflecting on new research with careful consideration of the scientific conclusions of original papers. However, not all urologists are as vigilant. When comments on emotive scientific papers are widely published in the lay and professional press, opinion can be varied, particularly when conclusions on how research should be translated into 'real-life' practice are inconclusive.

It would be appropriate for authors commenting on published articles to declare their research interests and clinical practice. Opinion about research is often born out of professional interest, which arguably drives patient care in certain directions.

An interesting article in the aptly titled journal 'Headache' defines conflict of interest as, '... actions taken to satisfy private interests that may not serve the best interest of the wider community' [3]. Medical journals uniformly ask about conflict of interest when an article has been submitted. Currently it is the responsibility of the authors to declare such conflicts. The minority of articles submitted by authors to peer-reviewed journals have acknowledged conflicts of interest and usually conflict of interest relates to involvement with the pharmaceutical industry. In the *BJUI* over four issues (vol 104; 1–4) 12% of articles had conflicts of interests published; 90% of conflicts were related to the pharmaceutical industry. In the comment section of the *BJUI* there was no conflict of interest in the nine articles published.

In the European screening trial, 48 screen-detected prostate cancers needed to be treated in order to prevent one cancer death at nine years [1]. This does not imply that focal therapy (less morbidity) should be endorsed, although some have suggested that this might be the case. The facts are that there has never been a similar trial for focal therapy. If authors have published widely on focal therapy or they have a clinical practice that has a significant focal therapy interest, it should be declared.

Inconsistency of opinion regarding the recent prostate cancer screening trials [1,2] has led the European Association of Urology to take the surprising step of publishing a policy statement that does not endorse population-based screening [4]. Unfortunately, the popular press has not issued a similar statement.

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- 1 **Schroder FH, Hugosson J, Roobol MJ, Tammela TL, Ciatto S, Nelen V *et al.*** Screening and prostate-cancer mortality in a randomized European study. *N Engl J Med* 2009; **360**: 1320–8
- 2 **Andriole GL, Crawford ED, Grubb RL *et al.*** Mortality results from a randomized prostate-cancer screening trial. *N Engl J Med* 2009; **360**: 1310–9
- 3 **Roberts J.** An author's guide to publication ethics: a review of emerging standards in biomedical journals. *Headache* 2009; **49**: 578–9
- 4 **Abrahamsson PA, Artibani W, Chapple CR, Wirth M.** European Association of Urology position statement on screening for prostate cancer. *Eur Urol* 2009; **56**: 270–1

## FACILITATING THE MEDICAL MANAGEMENT OF BENIGN PROSTATIC HYPERPLASIA IN PRIMARY CARE

Sir,  
As a practising GP with a special interest in urology, I read with interest this article on managing BPH in primary care [1]. The authors suggest that BPH is suitable to be included in the Quality and Outcomes Framework (QOF) and clearly there are several aspects of this condition which make it highly suitable for incorporation into this system. BPH is a highly prevalent chronic condition, with well established treatment pathways that can largely be delivered in a primary-care setting. Furthermore, one of the primary aims of QOF is to try to provide some standardisation of care, and it is clear from my experience in hospital urology and in the Primary Care Diagnostic Urology service I currently work in, that there is a huge variability in the quality of primary-care management of BPH and vastly different referral thresholds between different GPs.

Whilst supporting in principle the call for inclusion of BPH in the QOF umbrella, there are features of this condition which mean that the practicalities of such a proposal need careful consideration. There are many clinical conditions now included in QOF, from those well known. e.g. diabetes, ischaemic heart disease and hypertension, through to hypothyroidism, atrial fibrillation, cancer, etc. In most of these conditions the diagnosis is clinically clear, with established diagnostic criteria. However, BPH is more troublesome; first, do we mean BPH or are we really talking about male LUTS; simply referring to BPH runs the risk of further marginalizing the diagnosis and treatment of overactive bladder in men, already often unrecognised and treated with  $\alpha$ -blockade rather than anticholinergics. The symptom pattern that is referred to as 'BPH' is also a spectrum, from mild, not bothersome symptoms through to severe, very bothersome symptoms with an

enormous impact on patient and partner quality of life. The problem is, when including a condition in QOF, how does one establish the thresholds at which a patient is diagnosed with a 'condition' or at which treatment should be initiated. The simple use of symptom questionnaires such as the IPSS ignores the multifactorial nature of the decision of when to treat patients with LUTS, not just symptoms alone, but the nature of these symptoms (acknowledging the greater impact of storage symptoms on quality of life), the associated bother and the incorporation of other factors such as sexual dysfunction, worries about cancer, partner concern, and comorbidity, including the ever increasing problem of polypharmacy (a by-product of QOF).

The issue of 'goals of therapy' is also raised, or targets, as GPs whose practice income depends on them will be more used to calling them. Again, conditions such as diabetes and hypertension lend themselves easily to target setting, with variables such as blood pressure, cholesterol and glycosylated haemoglobin control easily measured and compared to established values. However, BPH is again more difficult; the proposals in this paper are of a reduction in IPSS by 3 points and significant reductions in rates of acute urinary retention or progression to surgery. A reduction of 3 points in the IPSS is established as the minimum difference detectable clinically by a patient; therefore, in a patient with a pretreatment IPSS of 30 and highly bothersome storage symptoms, are we going to accept a decrease of 3 points in total IPSS (most likely due to an improvement in less bothersome voiding symptoms) as a marker of successful management? Surely, this would represent the worst form of 'tick-box medicine', with treatment success determined on a symptom score rather than a more overall assessment of outcome. The suggestion of reduced progression I feel is unfortunately impractical, due both to there being relatively few of these events in a given practice population over a year (standard QOF assessment period) and due to the significant delay seen between the onset of symptoms and progression to these events.

So, how could male LUTS be included in the QOF programme? I would envisage that this could be done in a way similar to depression, another highly prevalent condition, multifactorial, and in which

there is a spectrum of presentation ranging from 'normal' to severe with no definitive thresholds for diagnosis or initiation of treatment. This would mean ensuring that men presenting with LUTS are firstly offered appropriate primary-care based investigation (e.g. a DRE, frequency-volume chart, etc.), and this could be linked to forthcoming NICE guidance on the management of male LUTS. This would also include issuing information and offering PSA testing, as opposed to the current lottery whereby some patients are denied access to this test due to concerns about its reliability. It might include use of the IPSS for those commencing medical treatment, with a requirement for a repeat IPSS to be recorded at a fixed interval of, e.g. 6-12 weeks, thus using the IPSS for recording the change in symptoms rather than as a diagnostic tool. Thus, we could ensure that the process of initial management is improved, without necessarily setting unrealistic or irrelevant targets that do not reflect patient satisfaction with treatment.

The management of male LUTS in primary care is ostensibly simple for the specialist, but surprisingly complex for the generalist facing a huge array of patient- and QOF-driven demands during brief 10-min consultations. Inclusion in QOF would be an opportunity to promote better care, but the formulation of the QOF clinical indicators would take careful consideration. In the long term, a more holistic outcome measure than IPSS, incorporating domains other than simple presence of storage and voiding symptoms, would be useful for those who wish to use the QOF tool as a mechanism for promoting this change.

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- 1 Kirby R, Kirby M, Fitzpatrick J *et al.* Facilitating the medical management of benign prostatic hyperplasia in primary care. *BJU Int* 2009; **104**: 751-7

#### LINGUAL MUCOSAL GRAFTS FOR ANTERIOR URETHROPLASTY: A REVIEW

Sir,

We read with great interest the review article by Song *et al.* [1]. First, we thank the authors for having believed in and having successfully applied our pioneering

work [2]. We would like to be more specific on the topic of harvest graft site. Indeed, the authors stated that we 'reported the lateral mucosal lining of the tongue as the harvest graft site', citing our pilot study that was published in 2006 [2]. We admit that the description of the surgical technique was inaccurate in our first report. However, in a following paper [3], also cited by Song *et al.*, we better detailed our surgical technique and we made clear that the site of the harvest graft is the ventrolateral mucosal surface of the tongue, below the lining that separates the dorsum, where the papillae are situated, from the sublingual mucosa.

Finally, we would like to stimulate the debate on terminology, and it would be very interesting to have an opinion about this from Song *et al.* and other authoritative colleagues. In 2007, Markiewicz *et al.* [4], according to standard and accepted dental terminology, recommended the term 'labial mucosal graft' when referring to the alveolar mucosa of the inner lower lip and the term 'buccal mucosal graft' when referring to the alveolar mucosa of the inner cheek. Both terms should collectively be denoted as the 'oral mucosal graft'. We agree with the authors, but according to our experience and considering the embryological origin and anatomical knowledge, we think that the term 'oral mucosal graft' should include the lingual mucosal graft. Therefore, to avoid confusion between the inner lower lip and the lingual grafts we would suggest a different terminology as follows. The term 'oral mucosal graft' (OMG as a standard acronym) should include three graft donor sites, i.e. the inner lower lip (LMG as a standard acronym), the inner cheek (BMG as a standard acronym), and the tongue (TMG as a new standard acronym). The bladder mucosal graft should be referred to in a different way to avoid confusion (e.g. 'urinary bladder mucosal graft' with UBMG as a standard acronym).

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- 1 Song LJ, Xu YM, Lazzeri M *et al.* Lingual mucosal grafts for anterior urethroplasty: a review. *BJU Int* 2009; **104**: 1052-6

- 2 Simonato A, Gregori A, Lissiani A *et al.* The tongue as an alternative donor site for graft urethroplasty: a pilot study. *J Urol* 2006; **175**: 589–92
- 3 Simonato A, Gregori A, Ambruosi C *et al.* Lingual mucosal graft urethroplasty for anterior urethral reconstruction. *Eur Urol* 2008; **54**: 79–87
- 4 Markiewicz MR, Lukose MA, Margarone 3rd JE *et al.* The oral mucosa graft: a systematic review. *J Urol* 2007; **178**: 387–94