To the Editor: The article on prostate cancer by Drs Karnath and Rodriguez [Issues in Prostate Cancer: An Update and Review of Screening and Treatment Options, vol 3 (7), p 391] is an excellent source of information for all patients and their doctors. However, I don’t believe enough emphasis was placed on the need for aggressive treatment with younger patients. Only in a couple of places was there brief mention that a younger man might benefit from more aggressive treatment. A 45-year-old man, often in denial, with a prostate-specific antigen (PSA) of 3.0 might be tempted by reading this article to follow watchful waiting as a viable option—when in fact he will mostly likely be dead of prostate cancer by age 60. I know this publication is for doctors and not for their patients; however, my doctor told me that, as long as my PSA is less than 4.0, I’ll be fine. Well, not so. Everyone, including doctors, should be educated on the necessity of aggressive treatment for any man with prostate cancer who expects to live more than 10 years.

The article also cited a Walsh study that indicated a normal sexual function rate of 86% at 18 months. Other studies typically find a normal function rate closer to 50%, as in the Prostate Cancer Outcomes Study (PCOS) trial (44% at 2 years) cited in the article. What criteria are used to determine these rates? For instance, are they measured with and without the use of Viagra or pumps, or even implants? I believe the criteria for determining function should be identified.

David Perry
Hayward, California
[The writer is a recovering prostate cancer patient.]

Reply: We read with great interest the letter by David Perry. In his letter, M. R. Perry presents a brief scenario of a 45-year-old patient who might opt for watchful waiting. In the treatment options section of our article, we state that treatment with intent to cure can be offered to patients with an absence of serious comorbid conditions and a life expectancy of more than 10 years. Watchful waiting is intended for those patients with well-differentiated and that patients must be thoroughly informed of all potential risks and benefits associated with each treatment modality.

As an urologist, Dr. Rodriguez routinely recommends to his colleagues more aggressive screening among patients at high risk for prostate cancer: those with a first-degree family member with prostate cancer, or African-American patients. In addition, we agree with the recent trend toward lowering the recommended PSA cut-off point for patients at risk for prostate cancer. We use a PSA cut-off of 2.5 ng/mL for younger men between ages 45 to 60 years, as suggested by the extensive review from Arcangeli et al. on PSA as a screening test for prostate cancer. Unfortunately, this is not yet a universal practice among all urologists or primary care physicians. We would hope that, taking into consideration a patient’s life expectancy and other medical problems, physicians intuitively recommend more aggressive diagnosis and treatment for their younger patients.

In his letter, M. R. Perry also discusses the variability in reported sexual function after prostatectomy. There are several factors that may explain this disparity. In the study by Walsh and colleagues, high rates of potency were reported when a single experienced surgeon performed a nerve-sparing prostatectomy. A validated disease-targeted quality-of-life survey was administered preoperatively and at 3, 6, 12, and 18 months. It should be noted, however, that the recovery of potency by 18 months correlated with patient age at time of diagnosis and that one third of the patients were using sildenafil, as it became available during the course of this study.

Hence, the more recent trial by Walsh and colleagues had more optimistic results in terms of sexual function, although it had a small number of subjects.

We are thankful and pleased to know that our efforts have been well received. By creating such discussions, perhaps some greater awareness of the current state of prostate cancer can be obtained by healthcare professional and patient alike.

Bernard Karnath, MD
Gabriel Rodriguez, MD

References

To the Editor: [In response to Cocaine and Myocardial Infarctions, vol 3(8), p 448], With the strong link of acute cocaine usage to prothrombotic effects, why not treat cocaine-associated chest pain with low molecular weight heparin as recommended in current guidelines for acute coronary syndromes?

Arthur J. Siegel, MD
Belmont, MA

Reply: In addition to myocardial ischemia and infarction, cocaine ingestion has been associated with other conditions that cause chest pain (ie, aortic dissection, endocarditis, pericarditis, pneumomediastinum, and pneumothorax), some of which may not respond favorably to anticoagulation. Accordingly, some physicians are reluctant to use a long-lasting anticoagulant that is not quickly reversed with protamine administration.

Richard A. Lange, MD

(continued on next page)
To the Editor: We read with interest the article by Dr Gottlieb, entitled Palliative Care in Heart Failure [vol 3(8), p 456]. We agree with the author that the natural course of heart failure is rather unpredictable, even near the end of life. This may be especially true for older adults with heart failure and preserved left ventricular systolic function. This is also in sharp contrast to the natural course of most cancers at or near the end of life.

We have empiric experience from our Geriatric Heart Failure Clinics at the University of Alabama at Birmingham and Birmingham VA Medical Center that often older adults with heart failure are referred to hospice care when they are symptomatic. Whereas these patients enjoy the benefits of intense nursing care at home, they remain symptomatic as they are often no longer evaluated by their physicians in clinics and are only seen by hospice nurses, who may not be well trained to evaluate volume status and aggressively adjust diuretics to reestablish euvolemia. Many of these symptomatic episodes are temporary and complete symptomatic relief could be achieved with aggressive diuresis.

We believe that it is appropriate to refer older adults with heart failure with New York Heart Association (NYHA) functional class IIIB to IV to hospice for palliative care. However, because relief of symptoms, such as dyspnea and fatigue, rather than control of pain is the main focus of palliative care in heart failure, these patients should be continuously and closely monitored in clinics by their primary care physicians who are comfortable in managing advanced heart failure. With hospice teams that staff nurses trained in heart failure evaluation, such clinic visits could be significantly reduced.

Ali Ahmed, M D, M PH, FACP, FACC
Phillip L. Thornton, R.Ph., Ph.D., FASCP, CGP
Birmingham, AL

Reply: I appreciate the thoughtful comments of Drs Ahmed and Thornton. Determining “euvolemia” in patients with heart failure has in the past been a matter of clinical judgment, based on clinical history and examination, and on suggestive changes in laboratory data such as a “bump” in creatinine. The widespread adoption of the Brain Natriuretic Peptide (BNP) assay may provide a measurement of volume status in patients with heart failure that can be tracked, and that will help establish treatment goals that hospice nurses may use to adjust diuretics in order to relieve symptoms. Validation of this suggestion will have to come from appropriately designed randomized clinical trials.

It is essential to make the distinction between the patient who suffers from heart failure causing functional impairment at the NYHA class IIIB-to-IV level, but who may yet respond to aggressive treatment, from the patient who has reached the intractable stage of heart failure. This is the crux of the problem in providing palliative care for patients with heart failure. Assessment and management of the heart failure patient by a multidisciplinary team seems to be the best approach to provide the level of care that these patients require, and this approach is supported by clinical trials data.

Sheldon H. Gottlieb, M D, FACC

References