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The CUA guidelines committee has made a nice contribution to clinical practice with the publication of the prostate biopsy guideline in this issue.¹ The guideline is practical and concise, and addresses a number of relevant issues in clinical practice. Prostate biopsy is a procedure associated with important potential risks, and is operator dependent. These guidelines should result in greater consistency of practice, including management of platelet inhibitors, role of antibiotic prophylaxis, technique of local anesthesia, biopsy strategy, and management of prostatic intraepithelial neoplasia and atypical small acinar proliferation. This should be required reading for all those who do prostate biopsies.

Practicing evidence-based medicine (EBM), like leading a virtuous life, is a goal that many give lip service to, but is challenging to achieve in practice. Many physicians find it difficult to use new evidence in their daily practice. The most common reason reported is insufficient time. Others cite lack of familiarity with EBM techniques, including the recognition and formulation of questions, and the formulation of answers to questions from the available literature. Translation of those answers to the individual patient can be difficult.

Physicians can be resistant to change in practice. Residents have different barriers to practicing EBM than established physicians. Changing their own practice might be easier because their habits are not as entrenched.

The report by Roth and Siemens on resident experience with EBM found that the understanding of important EBM terminology and resources was limited.² This limitation was due primarily to time constraints and a lack of expert educators.

Solutions can be simple and inexpensive. A study by Sackett in the late 90s reported that an EBM cart on the ward, consisting of secondary sources textbooks, and computerized (summary) sources such the Cochrane Library and MEDLINE, dramatically increased the number of searches for evidence. Ninety percent of the searches were completed 90 seconds.³ A commitment to the principles of EBM in residency training would require little more than a shift in emphasis by urology educators, and ready access to these kind of resources. We need to do this. The vision of CUAJ is that Canadian urologists be recognized worldwide for their commitment to EBM.

We also include an article from Tunisia on the advantages of a 20-core biopsy scheme.⁴ There is increasing support for a more aggressive biopsy strategy in many centres. More cores means more prostate cancer identified. The downside is the risk of increasing numbers of clinically insignificant disease, and perhaps an increase in sepsis rates. My own strategy is to stick with the "Vienna nomogram" for core number (usually 10 to 12 cores, depending on age and prostate volume), and target the anterior and antero-lateral horns on re-biopsy. This remains a controversy.

Another interesting topic raised in this issue is the need for more urologists in Canada. Rawson and Saad predict the number of Canadian urologists needed to meet the projected numbers of BPH and LUTS patients amongst the aging population over the next decade.⁵ The number of urologists is expected to fall short, with up to a 133% increase required in some provinces. The number of urology residents training in Canada has increased substantially over the last 5 to 10 years, and this analysis suggests that this is appropriate. An overall manpower assessment of expected needs relative to the current and projected numbers in Canada is long overdue.

References

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