As the editorial stated, several randomized controlled studies have demonstrated an impressive decrease in positive surgical margins or an improved rate of organ-confined disease (OCD). However, recent reports demonstrated that there was no statistical difference between the control group and the neoadjuvant therapy group with respect to PSA failure. These results alerted urologists to the pessimistic outcome of the conventional 3 months of neoadjuvant therapy. The editorial also stated the importance of justifying the use of neoadjuvant therapy although it failed to comment on the design of neoadjuvant therapy. It was also mentioned that we should present PSA failure rate according to PSA nadir levels.

The present study is a single institutional retrospective pilot study on PSA nadir and additional PSA failure without randomized control. Thus, it is not adequate to draw any conclusions on the benefit or ill effects of neoadjuvant therapy. Although there was no statistical difference and we chose not to present this data in the text, here it is as requested. In terms of PSA failure according to stratified PSA nadir levels in the 31 patients who had never received any form of adjuvant therapy, the probability of a PSA failure-free rate at 2 years was 76% in patients with a PSA nadir \(\leq 0.1\) ng/mL whereas the probability of a PSA failure-free rate at 2 years was 63% in patients with a PSA nadir \(\geq 0.2\) ng/mL. On the probability of a PSA failure-free rate at 2 years, the patients with a PSA nadir \(\leq 0.1\) ng/mL showed more favorable results than the patients with a PSA nadir \(\geq 0.2\) ng/mL.

Although PSA failure is a surrogate end point, we are aware that many studies on PSA failure have been carried out but have failed to prove or disprove any survival benefit of neoadjuvant therapy. We agree that it is important to know whether or not neoadjuvant therapy can be justified. We also believe it is equally important to know why the conventional 3 months of neoadjuvant therapy failed to prove its potential. As many studies were carried out, it is important to follow the patients who have already received neoadjuvant therapy prior to radical prostatectomy. It seems prudent to wait until long-term survival data becomes available since the jury is still out. Therefore it may also be reasonable to restrict the treatment to a clinical study setting until any survival benefit is proven or disproven.

On the other hand, although many papers commented that there is no proof of any survival benefit for neoadjuvant therapy, there is a surprising phenomenon. First, although trials of neoadjuvant therapy were carried out as an experimental measure, approximately 45% of patients in Japan underwent neoadjuvant therapy.\(^1\) Second, many patients in Japan, even with localized prostate cancer, receive androgen deprivation as a provisional therapy before the final decision to proceed to definitive treatment. This is probably because it had been emphasized that the possibility of adverse effects and/or morbidity from androgen deprivation has been low in Japanese men. Thus androgen deprivation continues to be a basic treatment for prostate cancer in Japan even after the classic Veterans Administration Co-operative Urological Research Group reports. Our concern was whether doing provisional androgen deprivation or neoadjuvant therapy followed by surgery without prediction of the final pathologic stage was likely to lead to achievement of either a higher pathologic cure rate or a higher biochemical cure rate. As long as there is the reality that many patients in Japan receive hormonal therapy before definitive treatment, we should be careful in changing the treatment and proceeding to surgery since patients with NOCD after neoadjuvant therapy showed an earlier PSA failure. Of course, should the policy of provisional androgen deprivation in Japan change, this will no longer be the case.

We thank the editor for his comments.

Reference

1 Arai Y, Egawa S, Tobisu K et al. Radical retropubic prostatectomy: time trends morbidity and mortality in Japan. Br. J. Urol. 2000; 85: 287–94.