patients do the opposite of what I recommend, and I usually go along with their decision unless I am convinced that it is the wrong decision.

You don’t hear ASTRO talking about their conflict of interest in this matter. I know of a radiation oncology group in the southeastern United States which sends unsolicited letters to patients (my father received one) bragging about their success and insisting that all patients get seeds plus external radiation. Do they not have a profit motive?

Laura Thevenot, CEO of ASTRO, says we have a “perverse financial incentive.” Peter Grimm, CEO of the Prostate Cancer Treatment Center in Seattle, said, “I think it’s one of the biggest scandals in America today. Do you want your dad going to Dr. W. Jeff Terry Urology & Oncology Specialists, PC Mobile, Alabama

I read the press release from the American Society for Radiation Oncology (ASTRO) applauding the ruling of the Maryland Court of Appeals on self-referral with regard to magnetic resonance imaging, computerized tomography (CT) and radiation therapy. The more I hear about the Maryland ruling and articles like the ASTRO press release, the more my blood boils. I know there are bad doctors out there but we have to find them and do something about it. We cannot have laws tell us what machine we can and cannot own. The CT scanner in my office is the best thing that has happened to the high quality, efficient care of my patients with kidney stones in years.

My 7 physician urology practice recently merged with a 2 physician radiation oncology group. It took more than a year to do the groundwork and make sure we did everything correctly. Things are working well now. We offer robotic surgery, intensity modulated radiation therapy (IMRT) seeds and watchful waiting. Although watchful waiting is appropriate for some patients, most do not want this therapy and elect to undergo surgery or IMRT. The ASTRO press release reads as though we purposefully lead patients away from seeds and watchful waiting. I have had

Have You Read?

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Despite the tendency for premature delivery, lower birth weight and greater respiratory difficulties as a consequence, the infants required a shunt or died in the first 12 months of life at a relative risk of 0.70 compared to infants operated on postnatally (p <0.001). Prenatal repair also resulted in improved motor and mental development scores at age 30 months (p= 0.007), as well as improved secondary end points, such as fewer hindbrain herniations and improved ambulation abilities. These are pretty good results for the child despite the risk of prematurity and the 8% risk of uterine dehiscence at delivery in the prenatally operated mother. We have probably entered a new era in myelomeningocele management with this study.

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Hey Bob! ▼ Continued from page 25

somebody who has a very highly incentivized reason to give him one particular treatment that is not necessarily in his best interest!"

I think the radiation oncologists could be said to have the same conflict of interest when we send a patient to them to discuss IMRT. Are they going to tilt the discussion in favor of IMRT? Of course not. Ethical physicians will always let their patients make an educated decision. I think the radiation oncologists need to get their own house in order first.

My patients love having everything done in one place, and they make the final decision, not the physician. If the treating physicians are honest, as the majority of urologists are, ownership of the machine should not matter. What is important is the patient-physician relationship, informing the patient of all acceptable treatment options and letting the patient make the decision.

ASTRO is telling me that I have no ethics, and I have no business running my urology practice in a manner that is best for my patients and best for the financial integrity of my practice. I find the remarks from ASTRO extremely insulting. It is time to stand up for our cancer in general, and active surveillance and robot-assisted laparoscopic surgery specifically. As Associate Director for Translational Research at Roswell Park our laboratory staff focuses on the roles of the androgen receptor and androgen metabolism in racial differences in prostate cancer aggressiveness and prostate cancer recurrences during androgen deprivation therapy. We were surprised that the androgen receptor is over expressed in prostate cancer that recurs during androgen deprivation therapy, hereafter called castration recurrent prostate cancer. Our group was the first to show that the androgen receptor became hypersensitized by changing its co-activator profile and, recently, we and others have shown that phosphorylation also can hypersensitize the androgen receptor to low levels of androgens.

Although we have published on the change of specificity of the androgen receptor that derives from point mutations, we demonstrated more recently that we were wrong. In fact, adrenal androgens do not appear to transactivate the androgen receptor, but are metabolized to the preferred ligand for the androgen receptor, dihydrotestosterone (DHT). Lastly, abiraterone and other drugs that inhibit androgen metabolism have come to the fore because of our demonstration of intracrine metabolism of testicular androgens by castration recurrent prostate cancer, probably using weak adrenal androgens and even cholesterol as substrate.

I also study racial differences in the androgen axis that may contribute to racial differences in the incidence of and mortality from prostate cancer. We demonstrated that the androgen receptor is over expressed in the benign prostate and this over expression occurs to an even greater degree in the prostate cancer of African-American men. Most recently, we found a third isozyme of 5α-reduc-

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