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Introduction

The goals of the urologic surgeon who treats patients with urologic cancers are varied. As scientists and academicians, we should investigate the pathophysiology of urologic cancers and design new, potentially more effective or less morbid treatment regimens. As primary physicians and surgeons, we must strive to prolong life and provide effective palliation. Our emphasis in this volume acknowledges both roles: the articles solicited from experienced investigators have been selected because of their relevance not only to treatment but also to quality of life issues in patients with urologic cancer.

Quality of life may be preserved by various methods: better treatment selection, reduction in treatment morbidity by altering or substituting techniques, and more effective palliation of the disease. As outlined in the lead article by Ms. Breslin, quality of life is not easy to quantify. Nevertheless, it must be considered when selecting treatment options or designing clinical studies.

Quality of life can be improved or preserved by modifying existing treatment techniques: e.g. radical prostatectomy with preservation of erectile function, modified retroperitoneal lymphadenectomy with preservation of antegrade ejaculation, and continent urinary diversion. Dr. Lue outlines an approach to restoration of erectile function after radical pelvic surgery; Drs. Foster, Carroll, and McAninch discuss their experience with the latter techniques. Risk assessment is one very important attempt both to improve survival and to limit morbidity. Patients with urologic malignancies identified as being at very high risk of progression can be offered more aggressive treatment, whereas those at low risk can be spared the morbidity and expense. Dr. Bjorin and associates outline their successful approach to risk assessment in patients with testis cancer. Dr. Stephenson reviews surveillance alone in one low-risk group, patients with stage A nonseminomatous testis cancers.

In their manuscript on pelvic rhabdomyosarcoma, Drs. Massad, Kogan and Ablin focus on the evolution of treatment to point out that major advances in both the prolongation of life and preservation of its quality often are the result of combining various treatment methods rather than relying on one alone. All of us, as surgeons, must realize this important point. Although morbidity and mortality as a result of surgery, irradiation or chemotherapy have steadily decreased, the impact of different treatments on the natural history of the disease process must be continually assessed and scrutinized. In the field of urologic oncology, the debate over the selection and impact of treatment for prostatic carcinoma will not be settled in the near future. However, Dr. Hinman offers some provocative thoughts regarding whether improved prostatic carcinoma detection will result in lower mortality.

Pain is common in cancer patients, and uncontrolled pain is feared second only to death. We should all be familiar with Dr. McKay's approach to pain management. Lastly, when considering various treatment options, both physician and patient must weigh the likelihood of control against the morbidity and costs of treatment. Decisions are often more difficult in patients with advanced disease where expectations are often too high and treatment may carry both a greater morbidity and a lower likelihood of cure. Drs. Wilkinson and Aronson outline the treatment of renal cell carcinoma with biological response modifiers, an exciting but still evolving treatment technique.

As the Editors of this volume, we are hopeful that the articles contained in it will provoke all of us to consider quality of life issues when designing clinical trials and selecting treatment for our patients.

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