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staging of prostate cancer is a key clinical metric for estimating treatment efficacy and for predicting patient outcomes. conventional approaches for clinical staging have limitations, particularly in cases of low-risk prostate cancer. a detailed analysis of the literature identified 10 validation studies on the prognostic value of staging (clinical and bone scintigraphy) of patients with prostate cancer treated with external beam radiotherapy and radical prostatectomy and investigated the presence of differences in treatment efficacy between patients with bone metastases and patients without bone metastases (table 6). however, the results of the 10 studies were different and none of these studies demonstrated a significant difference in outcomes. therefore, it was impossible to classify patients with bone metastases as high-risk or low-risk and discriminate between patients with metastases and those with metastases that did not exhibit a propensity for bone metastasis. this information is useful for future patient counselling and for evaluating treatment selection and is summarised in table b in s1 file . focal prostate cancer is defined as disease confined to one site and it is the most common form of prostate cancer. in focal prostate cancer, the tumor exhibits a low gleason score and is composed of small, low-grade carcinomas. local extension to adjacent organs is uncommon. recently, several series have reported on the association between focal prostate cancer and outcomes after prostatectomy. data on local control and survival are conflicting. for a more detailed analysis, a recent meta-analysis of six series, with a total of 18,656 patients included, found a positive correlation between bcr and negative surgical margins in focal prostate cancer; in fact, this association was strong and significant when gleason score was below 7 and less than 2 foci were observed (table 6).

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the patients in this cohort had significantly higher rates of multivessel coronary artery disease and previous myocardial infarction. this may have contributed to their greater vascular complications, mortality and non-fatal myocardial infarction during the follow-up period. the higher rates of previous myocardial infarction and stable angina pectoris in the first group are consistent with the findings of the authors of the prima trial. the results highlight the concern that high-risk patients may receive sub-optimal bmt. patients who form high-risk clots early can be identified before they present with a clinical event. the use of acetylsalicylic acid is not supported by the prima trial because of the lack of efficacy and increased bleeding risk. it is not clear whether percutaneous coronary interventions are useful in patients with a high risk of thrombosis; the use of potent antiplatelets might reduce the overall risks in this group but more data are needed.101 the authors stress that the finding of a higher rate of symptomatic in-stent restenosis (sis) in patients with poor pre-procedural neurological status may indicate that restenosis rates are influenced by the extent of the underlying pre-procedural neurological damage. furthermore, favourable neurological outcomes did not exclude the presence of in-stent restenosis the meta-analysis showed that patients with the majority of their pvt risk factors were more likely to have portal vein thrombosis, and that these risk factors were more prevalent in patients with pht. in contrast, patients without these risk factors were more likely to have non-portal vein thrombosis. the authors suggest that aggressive management of risk factors, such as the use of warfarin in early pht, may contribute to a reduction in pvt, which, in turn, may also reduce pht. meticulous attention to risk factors in patients with pvt increases the likelihood that clinicians can make correct diagnoses and prescribe appropriate treatment. 5ec8ef588b

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