**Editorial Comment**

This report by Dalpiaz and cols. is strikingly important. They present a 35 month follow-up of male patients with SUI who underwent Argus sling placement. Their data point out an unacceptably high rate of complications (83%) of which more than half (58%) were grade 3 according to the Clavien system. Seventy-two percent of patients referred dissatisfaction with treatment. Only 17% remained dry, although 79% of subjects were dry when discharged home after the procedure, which shows the non sustainable efficacy of the device.

Ninety three percent of the studied population was classified as having a moderate / severe incontinence according to the number of pads used which may have influenced the low success rate. But the high complication rate obviates a need to review not only the device but the surgical technique for implantation itself.

Other reports on the Argus system are encouraged in order to corroborate these findings, but a red flag must be raised.

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**GERIATRIC UROLOGY**_____

**Age-adjusted validation of the most stringent criteria for active surveillance in low-risk prostate cancer patients**
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Background: The authors tested the performance of the currently used clinical criteria reported in populations studied by van den Bergh et al. and Carter et al. for the selection of patients with prostate cancer (PCa) for active surveillance (AS) according to age.
Methods: Data were analyzed from 893 patients who underwent with radical prostatectomy (RP). The authors investigated the rates of unfavorable PCa at RP (extracapsular extension, seminal vesicle or lymph node invasion, or Gleason score 7-10) in patients who fulfilled AS criteria according to age tertiles (ages ≤ 63 years, 63.1 to 69 years, and > 69 years). Area under the plasma concentration time curve (AUC) analyses tested the criteria for predicting unfavorable PCa. Then, the patients were stratified according to the cutoff age of 70 years. Multivariate analyses were used to test the role of age in predicting unfavorable PCa.
Results: The rate of unfavorable PCa characteristics was between 24% and 27.8%. In the van den Bergh et al. population, after age 70 years, the rate of unfavorable PCa characteristics was 41% compared with 23.2% and 24.1% in patients in the previous age tertiles (ages ≤ 63 years and 63.1 to 69 years, respectively). In the Carter et al. population, the rate of unfavorable PCa was 41.2% compared with 17.3% and 18.6% in the previous age tertiles (ages ≤ 63 years and 63.1 to 69 years, respectively). When the 70-year age cutoff was used, unfavorable PCa was identified in 17.9% to 23.6% of patients aged < 70 years versus 4% to 41.2% of patients aged > 70 years (all $P < .001$). AUC analyses revealed significantly lower performance in older patients. In multivariate analyses, after adjustment for prostate-specific antigen, prostate volume, and the number of cores, age represented an independent predictor of unfavorable PCa.

Conclusions: The currently used AS criteria performed significantly better for patients aged < 70 years. The authors concluded that the current results should be taken into account when deciding whether to offer active surveillance to patients with low-risk PCa.

**Editorial Comment**

The major issue related to an initial surveillance policy is the possibility of losing the window of curability of the disease, and this is directly related to patients' life expectancy according to their comorbidity profile and disease natural history that are very heterogeneous and unpredictable, in part due to the misclassification of patients regarding these variables.

Previous studies suggest an association between age and prostate cancer aggressiveness, this study though retrospective and not including patients under active surveillance, highlights that older patients are affected more frequently by more aggressive disease at final pathology compared with their younger counterparts, even when they are affected by very-low-risk disease according to the criteria proposed by van den Bergh et al. and Carter et al..

In this context, mortality should be considered as the main outcome in future confirmatory studies and while older patients are typically encouraged to undergo active surveillance due to virtually shorter life expectancy, better tools predicting life expectancy and disease natural history are warranted.

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**Association of Clinical Benign Prostate Hyperplasia with Prostate Cancer Incidence and Mortality Revisited: A Nationwide Cohort Study of 3 009 258 Men**
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Background: Although benign prostate hyperplasia (BPH) and prostate cancer (PCa) share features such as hormone-dependent growth and response to treatment with antiandrogen therapy, BPH is generally not considered a premalignant lesion.

Objective: To determine whether clinical BPH is associated with an increased risk of PCa incidence and mortality.

Design, Setting, and Participants: Using designs with individual participant data from five national registries, we studied the entire Danish male population from 1980 through 2006, a total of 3 009 258 Danish men. We collected PCa diagnoses (n = 53 315), information on PCa mortality (n = 25 459), and ascertained clinical BPH (not histologically proven BPH) through hospitalization (n = 187 591) and/or surgery (n = 77 698) from 1980 to 2006 and the use of α-adrenergic receptor antagonists (n = 143 365) and/or the use of 5α-reductase inhibitors (5-ARIs) (n = 47 465) from 1995 to 2006.