T1c, prostate-specific antigen density < 0.15 ng/mL, Gleason score ≤ 6, two or fewer cores with cancer, and ≤ 50% cancer involvement of any core.

During the follow-up period the proportions of men who underwent curative intervention (p = 0.026) or had biopsy reclassification (more than 2 cores, Gleason score > 6, or > 50% cancer involvement of any core) (p < 0.001) were significantly lower in men who met very-low-risk criteria. There were also no prostate cancer deaths in this cohort of patients.

The authors conclude that for carefully selected men, active surveillance limited to patients with very-low-risk cancers according to Epstein's criteria for insignificant cancer may significantly reduce the frequency of adverse outcomes.

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Testicular Vasculitis: A Series of 19 Cases

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Objectives: Because of limited reported cases, it is unknown how often testicular vasculitis represents isolated or systemic disease.
Methods: We report 19 cases (15 consultation; 4 in-house cases) of localized testicular infarction with associated vasculitis spanning 24 years.
Results: All were orchiectomy specimens; detailed clinical information was available in 16 cases. Mean age was 38 years. Clinical presentation was testicular pain in 13 and mass in 3 patients. Preoperative impression was testicular cancer in 13 cases. In all cases, localized testicular infarction associated with vasculitis was present and in none was tumor identified. Most cases (n = 14) showed polyarteritis nodosa (PAN)-like features with transmural necrotizing inflammation of small-medium arteries. In 4 cases, vasculitis was granulomatous (2 necrotizing; 2 non-necrotizing) and in 1 case was lymphocytic. An infectious etiology was excluded clinically and by special stains. Four patients were subsequently confirmed with systemic vaculitis: one with PAN, one with Wegener vasculitis, one with vasculitis not otherwise specified and one with subclinical systemic vasculitis. Two of those 4 patients had testicular PAN-like vasculitis and 2 had granulomatous vasculitis.
Conclusions: Testicular vasculitis can cause localized infarction that clinically mimics cancer. Although testicular vasculitis is an isolated finding in most patients an associated systemic vasculitis is not a rare event (4/16, or 25%), especially if the vasculitis is granulomatous (50% in this series). All patients should be clinically investigated for systemic disease.

Editorial Comment

This is a large series of a rare condition in the testis. Testicular vasculitis can cause localized infarction that clinically may mimic cancer (1). Testicular vasculitis may be an isolated finding, however, in most patients is associated with systemic vasculitis. All patients should be clinically investigated for systemic disease. In this series of 19 cases the mean age was 38 years and most cases (n = 14) showed polyarteritis nodosa-like features with transmural necrotizing inflammation of small-medium arteries (2). The pathologist must be aware of this condition and look for vasculitis whenever a patient with an infarcted testis has no history of torsion or trauma.

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Lymph node dissection at the time of radical nephrectomy for high-risk clear cell renal cell carcinoma: indications and recommendations for surgical templates

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Background: Observational studies suggest a proportion of patients with lymph node metastases will benefit from lymph node dissection (LND) at the time of nephrectomy for clear cell renal cell carcinoma (RCC).
Objective: Our aim was to report the performance of five previously identified high-risk pathologic features assessed by intraoperative examination on prediction of lymph node metastases and propose a template for LND based on locations of lymph node involvement.
Design, Setting, and Participants: The study included a historical cohort of consecutive patients from a single institution who received LND in conjunction with nephrectomy for high-risk clear cell RCC between 2002 and 2006.
Interventions: All patients underwent nephrectomy and LND.
Measurements: Patients were considered high risk for nodal metastasis if two or more of the following features were identified during intraoperative pathologic assessment of the primary tumor: nuclear grade 3 or 4, sarcomatoid component, tumor size ≥10cm, tumor stage pT3 or pT4, or coagulative tumor necrosis. Based on these