
**Editorial Comment:** Given the technological advances and the massive growth in online commerce during the last 20 years, it was just a matter of time until health care was formally delivered over the Internet. Currently it is clear that telemedicine is feasible and easy to deliver. The question really is whether providers and patients will accept this mode of delivery.

This small randomized clinical trial explores this question in the setting of post-prostatectomy visits. The authors randomized 55 men to either an office visit or a video visit following radical prostatectomy. No significant differences were noted in patient perception of the quality of the visit or satisfaction with the visit. Similarly there were no differences in urologist perception of satisfaction. Costs were lower with the video visits. While this must be considered a preliminary study that is limited by sample size, it still provides solid evidence that telemedicine can be applied to urological conditions.

There are many questions that remain to be answered regarding telemedicine. Can providers perform telemedicine visits with patients who live in states where the provider is not licensed? How do providers bill for these visits, and what is the appropriate reimbursement for the visit? Which types of visits are most appropriate for telemedicine? Acknowledging that telemedicine is still in its infancy, it is critical that urologists embrace telemedicine and begin to consider how they can deliver this type of care in their regular practice.

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**Imaging**

Re: Detection of Local Recurrence of Prostate Cancer after Radical Prostatectomy Using Endorectal Coil MRI at 3 T: Addition of DWI and Dynamic Contrast Enhancement to T2-Weighted MRI


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**Editorial Comment:** These authors look at the role of endorectal 3 T magnetic resonance imaging for local recurrence after radical prostatectomy. The study includes 280 patients with suspected recurrence with a history of a positive biopsy and increasing prostate specific antigen, and no history of hormonal treatment. A total of 83 patients met inclusion criteria. Patients were assessed by 1) T2-weighted imaging alone, 2) T2 plus diffusion weighted imaging, 3) T2 plus dynamic contrast enhanced (DCE) MRI or 4) T2 plus DCE MRI and diffusion imaging. The authors found the addition of diffusion weighted imaging to the T2-weighted imaging led to under detection of prostate cancer when no diffusion restriction was present in an area of abnormality on the T2-weighted imaging. They conclude that T2-weighted imaging plus DCE MRI has the highest sensitivity and specificity to detect local recurrence. Diffusion weighted imaging with apparent diffusion coefficient mapping added little value regarding lesion detection.

This is an important article for radiologists reading MRI of the prostate after prostatectomy. High resolution, detailed images with close review of the DCE MRI for focal or multifocal areas and abnormal enhancement will be valuable to identify recurrence.

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