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The concept of aspiration biopsy of organs for purpose of diagnosis of cancer was first developed at Memorial Hospital For Cancer in New York city by MARTIN and Ellis, as a compromise between a formal tissue biopsy and purely clinical assessment of spread of cancer prior to radiotherapy.

The term "Aspiration Biopsy" is partly a misnomer : Fine-needle aspiration biopsy is more correctly referred to as "ATAUMATIC THIN CUTTING NEEDLE BIOPSY WITH ASPIRATION."

RUSSELL FERGUSON, a urologist at Memorial Hospital, performed amongst the first aspiration biopsies of the prostate gland and described a transperineal aspiration technique using an 18 - gauge needle. However, it was not until the 1960s that aspiration biopsy of the prostate was popularized by SIXTEN FRANZEN and his associates at Sweden's Karolinska Institute.

Prostatic disease is one of the common problem of old age group and though nominally the province of urological specialist will often present to general surgeon. In the course of routine rectal examination, palpable abnormalities in the gland are commonplace
and require full investigation, as proper diagnosis before the initiation of treatment is mandatory.

Early diagnosis of prostatic disease, specially of cancer cannot be clinched by currently available biochemical and radiological investigations. Prostatic aspiration being a relatively non-invasive procedure can be usefully employed to confirm the clinical suspicion.

It can be performed transperineally or transrectally with less risk of bacterial contamination with the former and more precise sampling with the later. Open perineal biopsy is performed infrequently because it consists risk of at least temporary impotence and is a more extensive surgical procedure. Transurethral biopsy is also used infrequently because most early lesions are situated in the peripheral regions of the gland.

With skilled operator, the rate of successful atraumatic collection of highly diagnostic specimens from the prostate gland realistically approaches ninety nine percent, and the sensitivity of the procedure in diagnosing carcinoma is equal to or greater than eighty five percent (KLINE T. S. 1984).

Grading of prostatic cancer may have significant therapeutic

FNAC is easy to perform and to comment upon requires no extraordinary appliances, is less painful, easily repeatable, can be performed as an out patient department procedure or even bedside, without any anaesthesia and is well tolerated by patients.

Complication rate is generally less than 2% and problems are most often infectious in nature and can easily be dealt with.

FNAC and core Biopsy, both carry a slight, but well documented risk of implantation of tumour down the track taken by the needle (Blackard et al 1971). Such a risk is small when compared with the large numbers in whom this method is used, and is negligible when compared to the risk of condemning a patient who does not have a cancer to the risks and unpleasantness of unnecessary treatment. All of us have seen quite young patients castrated unnecessarily or rendered emasculate by hormones for what in the event turned out to be only chronic prostatitis. This is indefensible (JOHN BLANDY, in his
text book of Urology).

In fact, there has been a suggestion that transrectal fine needle aspiration biopsy serves as a good alternative to transperineal core biopsy in the prevention of tumor seeding (HADDAD F.S., SMOSIN A.A. 1987).