Editorial

What's inside

THE IMPACT OF SESTAMIBI SCAN ON CLINICAL DECISION-MAKING FOR RENAL MASSES: AN OBSERVATIONAL SINGLE-CENTER STUDY

It is of utmost importance to know the nature of small renal masses (SRM) for a urologist. Operating on a benign SRM poses an avoidable risk to the patient. Yong *et al*. have studied the role of sestamibi in decision-making for SRM.[1] Forty-three patients with SRM who had a sestamibi scan done were analyzed. 99m-Tc sestamibi has a high affinity for cells rich in mitochondria, such as cells of oncocytomas. Sestamibi may be better at predicting an oncocytoma than features such as enhancement and scarring on cross-section imaging. In this series of patients, 10 SRMs were sestamibi positive, of which 7 lesions were biopsy-proven oncocytomas; the other three were kept on surveillance based on the scan and showed no increase in the growth kinetics. The authors conclude that sestamibi scan can help in the decision-making for SRMs, although it needs to be answered that should all the SRMs diagnosed on cross-sectional imaging should be subjected to a sestamibi scan.

GLANS-CAP-PRESERVING DORSAL-INLAY FREE-GRAFT AUGMENTATION TECHNIQUE FOR RECONSTRUCTION OF MEATAL STENOSIS AND FOSSA NAVICULARIS STRICTURES: ANALYSIS OF SHORT-TERM FUNCTIONAL OUTCOMES

The Glans-cap-preserving dorsal-inlay free-graft augmentation technique, was used for the management of meatal stenosis and fossa navicularis stricture (FNS). This technique prevents splitting of the glans and helps maintaining the cosmetic contour of the glans. The authors report a retrospective case series of 26 men in which 15 men had lichen sclerosis, 7 were iatrogenic, and 4 were post hypospadias repair.[2] The surgery was done using a subcoronal incision. Without splitting the glans, a ventral urethrotomy was given, followed by a dorsal incision on the urethral plate. An inlay graft (buccal mucosa/Inner preputial skin) was placed. The mean length of urethral stricture was 3.8 cm and the mean duration of surgery was 67 min. Postoperatively, the catheter was placed for 14 ± 2 days. Two men in the series developed complications of bleeding and stitch granuloma, requiring intervention. At the end of 40 months, four men who had lichen sclerosis (out of 26) developed a stricture again. The authors concluded that this procedure is safe and feasible with acceptable short-term outcomes.

INTRAVESICAL BUPIVACAINE IN REDUCING CATHETER-RELATED BLADDER DISCOMFORT AND LOWER URINARY TRACT SYMPTOMS AFTER TRANSURETHRAL SURGERY: A RANDOMIZED CONTROLLED TRIAL

Catheter-related bladder discomfort (CRBD) has been a difficult symptom complex to manage for a urologist. Various locally acting agents and systemic medication have been used for its management. Purushothaman *et al*. studied the role of intravesical bupivacaine in the management of CRBD that was instilled 6-h after the procedure.[3] It is a randomized-control trial comparing single instillation of saline or bupivacaine and its effectiveness over 24 h. The authors conclude that a single dose of intravesical bupivacaine reduces CRBD. The pain frequency and dysuria experienced by the patient on catheter removal also decrease in these patients. It remains to be studied whether an additional dose of bupivacaine further reduces patient discomfort.

DESCRIPTIVE EPIDEMIOLOGY OF PROSTATE CANCER IN INDIA, 2012-2019: INSIGHTS FROM THE NATIONAL CANCER REGISTRY PROGRAM

In this article, the authors present an analysis of epidemiological data on carcinoma prostate using the National Cancer Registry Program of India. The data from the years 2012 to 2016, from a population-based cancer registry were used for estimating various epidemiological parameters. In this study, the incidence of prostate cancer was higher in urban registries as compared to rural registries. The cumulative risk of prostate cancer was 1 in 42 to 1 in 47 in urban India and as low as 1 in 462 persons in rural India.[4] There was a rise of the incidence of cancer after the age of 50 years and a steep rise after the age of 64 years. Majority of cases, i.e., 42.9% were found to be metastatic at presentation, whereas 27% were locoregional, and only 29.9% of patients presented with localized disease. Surgery and radiotherapy were used as the mainstay of treatment in localized and locoregional disease. The authors concluded that the incidence of prostate cancer is increasing, which may be a consequence of increasing life span and urbanization.

DO INDIAN MEN HAVE SIMILAR ONCOLOGICAL OUTCOMES WITH ABIRATERONE PLUS ANDROGEN DEPRIVATION THERAPY IN THE SETTINGS OF METASTATIC HORMONE-SENSITIVE PROSTATE CANCER AS REPORTED IN THE WEST? A PROSPECTIVE OBSERVATIONAL STUDY

This edition also showcases a prospective observational Indian study comparing androgen deprivation (ADT) alone versus ADT + abiraterone acetate (AA) for metastatic hormone-sensitive prostate cancer. A total of 115 patients were analyzed, 40 in the ADT arm and 75 in the ADT + Abiraterone arm. The authors used overall survival, radiographic progression-free survival, and PSA progression-free survival as outcome measures. At the median follow-up of 20.3 months, 27.5% of patients died in the ADT group versus 20% in the ADT + AA group. The overall survival was 70% in the ADT group and 85% in the ADT + AA group. The ADT + AA had a 60% lower risk of radiographic progression-free survival and a 75% lower risk of PSA progression. The risk of death was reduced by 28% using ADT + AA, which is lesser as compared to the Stampede and Latitude trials.[5] The real-world scenario suggests significant treatment discontinuation due to cost constraints. The overall survival data of the study is also yet to mature.

THE COST-EFFECTIVENESS OF REUSABLE FLEXIBLE URETEROSCOPES: AN INSTITUTIONAL AUDIT

This study describes the durability and per-case cost of a FU in an institutional practice. An institutional registry of damaged FUs was reviewed retrospectively, and it was found that 17 FUs were used, of which the authors studied 11 fiberoptic (Karl Storz) and 2 digital scopes (Seesheen). All the scopes were re-sterilized using the plasma sterilization method. On an average, Khedekar *et al.* used a single fiberoptic scope for 159 procedures (range 25–334). The cost of each fibreoptic scope was rupee (INR) 338,951 and the reprocessing cost was INR 557 that brings the cost of each procedure to be INR 2658.76.[6] Only two digital scopes were used and a similar cost calculation for limited-use disposable scope was INR 7089.50 per case, assuming the estimated cost of disposable digital scope to be between INR 60,000 to 107,427. The maximum and minimum duration for which the scope lasted was 31 and 4 months, respectively. Although the quality of vision between the two groups was not objectively evaluated, the fiberoptic scopes were more cost-effective.

PRIMARY EWING SARCOMA/PRIMITIVE NEUROECTODERMAL TUMORS OF THE KIDNEY: CASE SERIES OF EIGHT CASES FROM A SINGLE CENTER WITH FOLLOW-UP DETAILS

Primitive neuroectodermal tumor (PNET) is a rare malignancy involving the kidney. Pathak *et al.* have presented their experience of managing eight such cases. Immunohistochemistry showed CD 99 positivity in all the patients and was the hallmark of diagnosis. All the described cases were locally advanced and required surgery plus adjuvant therapy. The adjuvant therapy can be a combination of chemotherapy and radiotherapy, as per the authors experience. Although the malignancy was found to be aggressive and affecting the young population, 5-year cancer-specific survival was 75%.[7] Preoperative diagnosis of these patients, based on radiology, is difficult, though a relatively endophytic, infiltrative mass, enhancing less than the renal cortex, may point towards a PNET. This retrospective case series concludes that preoperative diagnosis of this condition is difficult and it requires multimodal management.

THE PROGNOSTIC ROLE OF PREOPERATIVE NEUTROPHIL-TO-LYMPHOCYTE RATIO IN UPPER TRACT UROTHELIAL CARCINOMA

Ghorai *et al.* have studied the role of neutrophil-to-lymphocyte ratio (NLR) in prognosticating upper tract urothelial cancers (UTUC).[8] The authors retrospectively analyzed 91 patients with upper tract urothelial carcinomas who had a mean follow-up of 49 months. The authors found that using an NLR cutoff value of 2.5, they could prognosticate these patients. The patients with NLR >2.5 had higher stage, greater amount of necrosis in the final specimen, higher lympho-vascular invasion, more chances of lymph node involvement, and need for adjuvant chemotherapy. Higher NLR predicted a worser overall survival with a hazard ratio of 9.87, but a ratio of <2.5 does not predict a higher recurrence-free survival. The authors concluded that NLR is an inexpensive and widely available tool for prognosticating UTUC and may have a role in risk stratifying these diseases.

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Financial support and sponsorship: Nil.

Conflicts of interest: There are no conflicts of interest.

Access this article online	
Quick Response Code:	Website: www.indianjurol.com
	DOI: 10.4103/iju.iju_246_24

How to cite this article: Singh AG. What's inside. Indian J Urol 2024;40:148-50.