Editorial

Round up

Let's start from where we left from the editorial of the last issue – the need for an Indian guideline for common urological diseases. There are multiple guidelines on evaluation of asymptomatic microscopic hematuria. All guidelines include evaluation with cystoscopy and upper tract imaging. However, there is discordance with regard to the definition/age threshold for commencing evaluation and the type of upper tract imaging.[1] This only emphasizes the need for us to make our own guideline keeping in view the vast differences in socioeconomic standards and availability of health care in our country.

The use of cell phones during meetings to take pictures of slides/presentations is a ubiquitous practice. Often, the objective is to read the subject further or to read the references. Summary slides and take-home messages are usually of special interest. These are also shared among friends and social media. This could be against the copyright policies of the conference and a breach in data protection. It is time for the scientific community to debate and reach a consensus on this.[2]

Radical cystectomies are standard treatment of bladder cancers of urothelial origin. In an aging population, the average age at which radical cystectomy is being offered to patients is increasing. Morbidity of the procedure and its impact on hospital stay have been a concern. Multimodal enhanced recovery after surgery (ERAS) regimens have proved their value in colorectal surgery. The use of ERAS has been shown to lower blood loss and earlier discharge for patients after radial cystectomy.[3]

The United States Preventive Services Task Force (USPSTF) in its recommendation in 2011 downgraded PSA testing for screening prostate cancer to level D. This meant that there is moderate or high certainty that PSA testing has no net benefit, but harms of PSA testing are greater than the benefits. A recent article[4] looked at the change in practice of PSA screening over time. They concluded that the incidence of early prostate cancer decreased whereas that of distant disease/metastasis slightly increased following the USPSTF directives. Further studies are needed to substantiate this reverse-stage migration.

Stents are often used after endoscopic and reconstructive urological surgeries to ensure drainage of the upper tract. The use of stents often leads to adverse symptoms and the need of a second procedure to remove them. In an animal study[5] on pigs, biodegradable antireflux stents were used. These stents did not cause secondary vesicoureteral reflux and trigone irritation. There was consistent biodegradation of these stents between 3 and 6 weeks without any obstructive fragments. This innovation has a potential to reduce morbidity associated with stents.

Partial nephrectomy is the treatment of choice in incidentally detected small renal masses. It is being increasingly performed robotically or laparoscopically. Positive surgical margins have always been a concern though the incidence is low. It is associated with bilateral tumors, prior treated renal cell carcinoma at presentation, and higher nephrometry score.[6] A large series from a single institution with good follow-up showed that these patients are at a higher risk of local recurrence and distant metastasis.

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