

What's inside

GENITOURINARY SARCOIDOSIS

Genitourinary involvement in sarcoidosis is typically reported as single cases or small series and often escapes a consideration for most urologists. Block *et al.* and Kava^[1] review the urological manifestations of sarcoidosis and show that the disease may involve multiple organs including the adrenal, kidneys, ureter, bladder, prostate, urethra, penis, and the scrotal structures. It often mimics malignancy in the form a mass lesion. Hypercalcemia and hypercalciuria may be additional manifestations in renal sarcoidosis.

EROSION OF ARTIFICIAL URINARY SPHINCTERS

The increasing use of robotic radical prostatectomy may be accompanied by an increase in the number of incontinent patients seeking placement of an artificial urinary sphincter (AUS). Agarwal *et al.*^[2] review their large data of 1800 AUS placements with a < 6% erosion rate and conclude that the majority of erosions occur in the 1st year after implant and iatrogenic injury due to incorrect catheterization through the sphincter remains an important cause of erosions. This would be an important lesson in India where the number of such implants is low its awareness among patients and physicians is limited. The high cost of these devices often makes them once-in-a-lifetime surgery and minimizing the risk of failure may require improved counseling.

AVOIDING RADIATION IN KIDNEY DONOR WORK-UP

Minimizing harm to health, voluntary kidney donor is essential for the success of the organ donation program. Patil *et al.*^[3] evaluated 43 donors with both a computed tomography (CT) and noncontrast magnetic resonance angiogram for evaluation of the renal anatomy and showed a high degree of concordance between the two modalities such that omitting the CT would not result in adverse donor outcomes.

PELVICALYCEAL ANATOMY FROM CADAVERIC KIDNEYS

Understanding the anatomy of the pelvicalyceal system is central to all endourological upper-tract procedures.

It is uncommon to find a detailed study looking at cadaveric dissections and the report by Anjana *et al.*^[4] reconfirms the myriad variations of the pelvis and calyces. They suggest that unlike traditional expectation of independent upper, middle and lower pole calyces, the commonest anatomy consists of a bicalyceal system with the middle pole calyx draining into one of these calyces. This would be relevant while planning punctures for percutaneous access.

TRAINING FOR PERCUTANEOUS NEPHROLITHOTOMY

Even though urolithiasis is one of the most common urological problems, percutaneous nephrolithotomy (PCNL) remains a difficult surgery to learn and master. In the first of three articles in this issue related to endourology, Jaipuria *et al.*^[5] present a prospective study evaluating a step-wise training protocol using Guy's stone score to determine the surgical difficulty and suggest that using this method, they were able to reduce operative time and complications among trainees.

NEW ARMAMENTARIUM FOR PERCUTANEOUS NEPHROLITHOTOMY

The continuing quest for the ideal PCNL equipment sees a new technique and device being described by Shah *et al.*^[6] This "Super-Perc" consists of a 10/12F hollow sheath with a silicon valve mechanism for entry of the telescope to prevent air or fluid leak. Suction tubing is connected to the side port of the sheath, allowing continuous evacuation of fragments. Continuous irrigation of the collecting system is obtained through a ureteral catheter placed in the pelvis and connected to an irrigation device. The authors use a 4.5/6F ureteroscope for stone fragmentation through the sheath. They report the outcomes of this technique in 52 patients with a mean stone burden of 19 mm (ranging from 10 to 37 mm). Two patients required conversion to larger tract sizes and only three required a nephrostomy tube. The authors report a 96% clearance rate.

REDUCING PAIN DURING STENT REMOVAL

The high costs associated with flexible scopes means that most ureteral stent removals in India are performed using rigid cystoscopes under local anesthesia. This is undoubtedly an uncomfortable procedure and Karthikeyan *et al.*^[7] report a randomized trial on the use of oral diclofenac tablets to reduce the pain. Among 121 adult men, the group that received a 75 mg oral dose of diclofenac 1 h before the

procedure reported significantly lower pain measured on a visual analog scale.

DOUBLE-BREASTING THE SPONGIOSUM IN URETHROPLASTY

Urethrocuteaneous fistulae are among the most common complications following hypospadias surgery, and there are numerous techniques to reduce their incidence. Bhat *et al.*^[8] describe another technique where they “double-breast” the spongiosum over the urethral closure plate, avoiding an overlapping suture line. In a prospective study on sixty patients with a mean age of under 4 years, they report a single fistula.

INTERMEDIATE RISK PROSTATE CANCER

The D’Amico risk stratification for prostate cancer is widely followed in clinical practice. Patients are determined to have an intermediate risk if they fulfill any one of three conditions; stage T2b lesion, Gleason score of 7, prostate-specific antigen between 10 and 20 ng/ml. However, this group of patients has a heterogeneous outcome and Fuyabashi *et al.*^[9] reviewed data of 222 patients in this group who underwent radical prostatectomy. They noted a progressively worse survival with increasing number of risk factors. Further, a patient with Gleason score of 7 as a risk factor did worse than those with other factors, suggesting disease biology to be the most important determinant of outcomes.

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