

International Braz J Urol

EDITOR'S COMMENT

Refractory Neuropathic Mixed Incontinence

The January - February 2008 issue of the International Braz J Urol presents interesting contributions from different countries, and as usual, the editor's comment highlights some papers.

Doctor Patki and co-workers, from Royal National Orthopaedic Hospital, United Kingdom, examined on page 63 efficacy of a combination of day case intradetrusor (ID) botulinum toxin (BTX-A) bladder injections and transobturator (TOT) or tension free vaginal tape (TVT). Eleven women who are pharmacotherapy intolerant or who have drug refractory neurogenic mixed incontinence were treated. Two opted for open surgery and the remaining 9 received 1000 units of Dysport diluted in 30 mL saline cystoscopically at 30 ID sites followed by TOT in 6 or TVT in 3 as a day case combination treatment. The mean age was 56.7 years (range 41 to 78) with a mean follow-up of 19.1 months (range 7 to 33). All women were continent at 3 and 12 months. Anticholinergics were discontinued in 7 with global high satisfaction with the treatment. BTX-A injections were repeated in 4 (mean 13.5 months). The authors concluded that anticholinergic refractory women with neurogenic mixed incontinence could be effectively treated as a day case with combination of ID BTX-A injections and TVT or TOT. Dr. Kathleen C. Kobashi, from Virginia Mason Medical Center, Seattle, Washington, USA, provided editorial comment on this paper.

Doctor Constantini and colleagues, from the University of Perugia, Italy, tested on page 73 the hypothesis that preoperative Valsalva leak point pressure (VLPP) predicts long-term outcome of mid-urethra slings for female stress urinary incontinence (SUI). One hundred and forty-five patients with SUI were prospectively randomized to tension free vaginal tape (TVT) or transobturator tape (TOT). The patients were followed-up at 3, 6 and 12 months post-operatively and then annually for outcome variables. Preoperative VLPP was correlated with primary and secondary outcome variables. Mean follow-up was around 32 months for both TVT and TOT. The overall objective cure rates were 75.8% for patients with VLPP > 60 cm H₂O and 72% for those with VLPP ≤ 60 cm H₂O ($p < 0.619$). No significant differences in objective cure rates emerged when patients were stratified for pre-operative VLPP and matched for TOT or TVT procedures. The authors concluded that when patients were stratified for preoperative VLPP (≤ or > of 60 cm H₂O), preoperative VLPP was not linked to outcome after TVT or TOT procedures. Dr. M. Neuman, from Ben-Gurion University of the Negev, Jerusalem, Israel, Dr. Lior Lowenstein, from Loyola University Medical Center, Maywood, Illinois, USA and Dr. Kenneth Powers, from Albert Einstein College of Medicine, New York, well-known experts in the field, provided important editorial comments on this article.

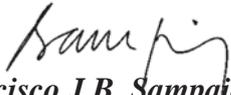
Doctor Aziz & Heyns, from the University of Stellenbosch and Tygerberg Hospital, Cape Town, South Africa. Assessed on page 15 the prevalence, onset, duration and severity of hot flashes in men after bilateral orchidectomy (BO) for prostate cancer, to evaluate body temperature changes during hot flashes

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and to determine whether an elevated temperature within a few days after BO can be caused by deprivation of androgen. A hundred and one patients (n = 101) were questioned about the characteristics of their hot flashes after BO for prostate cancer. A subgroup of these men (n = 17) were instructed to record their oral and forehead temperatures during and at fixed intervals between hot flashes daily for 4 weeks. During hot flashes, the oral temperature was 38° C to 40° C in only 3.2% of 593 readings in 17 patients. The authors concluded that the median oral and forehead temperatures are higher during hot flashes than in normal periods. Oral temperature elevation > 38° C within days after a BO is unlikely to be the result of androgen deprivation alone. Dr. Michio Naoe, from the Showa University, Tokyo, Japan, Dr. Bernardo Rocco & Dr. Marcelo Pimentel, from the European Institute of Oncology, Milan, Italy, and Dr. Eric C. Nelson & Dr. Christopher P. Evans, the University of California, Davis, School of Medicine, Sacramento, California, USA, provided important editorial comments on this somewhat controversial study.

Doctor Taylor and associates, from Carolinas Medical Center, Charlotte, North Carolina, USA, compared on page 84 the postoperative vaginal incision separation and healing in patients undergoing posterior repair with perforated porcine dermal grafts with those that received grafts without perforations. Also, the tensile properties of the perforated and non-perforated grafts were measured and compared. The study was a non-randomized retrospective cohort analysis of women with stage II or greater rectoceles who underwent posterior repair with perforated and non-perforated porcine dermal grafts. The authors found that 17% percent of patients (21/127) who received grafts without perforations developed vaginal incision dehiscence compared to 7% (5/71) of patients who received perforated grafts. Neither tensile strength or suture pull out strength were significantly different between perforated and non-perforated grafts. Also, there was no difference in the flexibility of the two grafts. The authors concluded that perforated porcine dermal grafts retain their tensile properties and are associated with fewer vaginal incision dehiscences. Dr. Martin Rudnicki, from Roskilde University Hospital, Roskilde, Denmark, provided a comprehensive editorial comment on this paper.

Doctor Zegarra Montes and colleagues, from the Peruvian University Cayetano Heredia, Lima, Peru, assessed on page 30 the diagnostic accuracy of semen and urine culture in the diagnosis of chronic bacterial prostatitis (CBP). In 70 consecutive men suspected of having chronic bacterial prostatitis along with 17 asymptomatic controls, the authors obtained urine and semen cultures followed 1 week later by the Meares and Stamey test. The authors found that while a positive semen culture in a symptomatic patient may suffice to select and start antibiotic treatment against chronic bacterial prostatitis, a negative culture does not rule out the condition. Urine cultures alone are not useful for diagnosing CBP. Dr. C. Lowell Parsons, from the University of California, San Diego, California, USA and Dr. Emrah Yatkin & Dr. Risto Santti from the University of Turku, Turku, Finland, provided editorial comments on this manuscript.


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