Conclusions: The preservation of the one-sided vascular supply to the urethra and its entire muscular and neurogenic support should represent a slight but significant step toward perfecting the surgical technique of urethral reconstruction using a minimally invasive approach.

Editorial Comment

The authors describe modifications to the standard substitution anterior urethroplasty that help preserve the bulbospongiosum muscle and perineal nerve fibers. Previously, Yucel and Baskin showed that perineal nerves innervate the bulbospongiosus muscle and send fine branches that penetrate the corpus spongiosum, mainly in the bulbar area. Moreover, these authors demonstrated that branches of the dorsal nerve of the penis at the junction of the corpus cavernous and corpus spongiosum assemble into a network with the perineal nerves (1). Contraction of the bulbospongiosum and ischiocavernosal muscles help propel the ejaculate out of the urethra. The contraction of those is thought to help prevent urine pooling at the end of voiding. The perineal nerve endings provide sensation to the scrotum, perineum and ventral penis and frenulum. Given that the risk of weakness of ejaculation is reported to be up to 39% after substitution urethroplasty, and post void dribbling in up to 50%, the role of muscle preservation during urethroplasty has been the subject of a lot of interest.

Both series report success rates that are comparable to the published rates of about 90%. No post void dribbling or semen sequestrations were reported in up to 12 months of follow up in the first study, while the second study lacks data on erectile or ejaculatory dysfunction.

There are inherent limitations to both studies especially in the fact that they lack a control group comparison, and randomization was not performed. It would be of interest to evaluate whether the preservation of the one-sided vascular supply to the urethra and its entire muscular and nerve support or limiting the dissection to the midline would decrease morbidity from ejaculatory and erectile dysfunction in a setting of a randomized controlled trial. Still, both studies are major steps in the refinement of the technique of minimally invasive urethroplasty. It remains to be seen whether this anatomical preservation of the neurovascular supply and muscular support is going to translate into decreased morbidity.

Reference

1. Yucel S, Baskin LS: Neuroanatomy of the male urethra and perineum. BJU Int. 2003; 92: 624-30.

Dr. Sean P. Elliott
Department of Urology Surgery
University of Minnesota
Minneapolis, Minnesota, USA
E-mail: selliott@umn.edu

UROLOGICAL ONCOLOGY

European consensus conference on diagnosis and treatment of germ cell cancer: a report of the second meeting of the European Germ Cell Cancer Consensus group (EGCCCG): part I

Krege S, Beyer J, Souchon R, Albers P, Albrecht W, Algaba F, et al.
Department of Urology, Krankenhaus Maria-Hilf, Krefeld, Germany
Eur Urol. 2008; 53: 478-96

Objectives: The first consensus report presented by the European Germ Cell Cancer Consensus Group (EGCCCG) in the year 2004 has found widespread approval by many colleagues throughout the world. In November 2006,

the group met a second time under the auspices of the Department of Urology of the Amsterdam Medical Center, Amsterdam, The Netherlands.
Methods: Medical oncologists, urological surgeons, radiation oncologists as well as pathologists from several European countries reviewed and discussed the data that had emerged since the 2002 conference, and incorporated the new data into updated and revised guidelines. As for the first meeting, the methodology of evidence-based medicine (EBM) was applied. The results of the discussion were compiled by the writing committee. All participants have agreed to this final update.
Results: The first part of the consensus paper describes the clinical presentation of the primary tumor, its treatment, the importance and treatment of testicular intraepithelial neoplasia (TIN), histological classification, staging and prognostic factors, and treatment of stage I seminoma and non-seminoma.
Conclusions: Whereas the vast majority of the recommendations made in 2004 remain valid 3 yr later, refinements in the treatment of early- and advanced-stage testicular cancer have emerged from clinical trials. Despite technical improvements, expert clinical skills will continue to be one of the major determinants for the prognosis of patients with germ cell cancer. In addition, the particular needs of testicular cancer survivors have been acknowledged.

European consensus conference on diagnosis and treatment of germ cell cancer: a report of the second meeting of the European Germ Cell Cancer Consensus Group (EGCCCG): part II

Krege S, Beyer J, Souchon R, Albers P, Albrecht W, Algaba F, et al.
Department of Urology, Krankenhaus Maria-Hilf, Krefeld, Germany
Eur Urol. 2008; 53: 497-513

Objectives: The first consensus report that had been presented by the European Germ Cell Cancer Consensus Group (EGCCCG) in 2004 has found widespread approval by many colleagues throughout the world. In November 2006, the group met a second time under the auspices of the Department of Urology of the Amsterdam Medical Center, The Netherlands.
Methods: Medical oncologists, urologic surgeons, radiation oncologists as well as pathologists from several European countries reviewed and discussed the data that had emerged since the 2002 conference and incorporated the new data into updated and revised guidelines. As for the first meeting the methodology of evidence-based medicine (EBM) was applied. The results of the discussion were compiled by the writing committee. All participants have agreed to this final update.
Results: The second part of the consensus paper includes the treatment of metastasised disease, residual tumour resection, salvage therapy, follow-up, and late toxicities.
Conclusions: Whereas the vast majority of the recommendations made in 2004 remain valid 3 yr later, refinements in the treatment of early-stage as well as of advanced-stage testicular cancer have emerged from clinical trials. Despite technical improvements, expert clinical skills will continue to be one of the major determinants for the prognosis of patients with germ cell cancer. In addition, the particular needs of testicular cancer survivors have been acknowledged.

Editorial Comment

A large multidisciplinary and international team of oncological specialists from Europe involved in the treatment of testicular tumors met and brought out these two consensus papers on diagnosis, staging and treatment of seminomatous and non-seminomatous testicular cancer.

The recommendations are based on evidence and on the broad clinical experience of the group and are invaluable for every urologist dealing with testicular cancer. The recommendations are clearly outlined and give