

of cardiovascular complications, target organ damage and metabolic syndrome than essential hypertension. The laparoscopic removal of the adenoma has shown preferable and more beneficial than medical treatment or open surgery to manage functioning adrenal tumors. The authors ask an important and controversial question of organ-sparing adrenalectomy in patients with primary aldosteronism due to aldosteronoma. Moreover, they questioned the role of adrenal vein sampling as the gold standard diagnostic test to identify the side of aldosterone secretion versus high-resolution computerized axial tomography. The data revealed a total of 212 patients enrolled in this study, including 108 that underwent total adrenalectomy and 104 patients in the partial adrenalectomy group. No open conversion or blood transfusions were needed. No major intraoperative complications occurred and no tumor recurrence was noted during the mean 96-month follow-up. All patients in each group showed improvement in hypertension and in all plasma renin activity and plasma aldosterone recovered to normal after surgery. However, 32 of 108 patients (29.6%) with total adrenalectomy remained hypertensive with normal plasma aldosterone after surgery. Blood pressure was managed with 20 or 40 mg nifedipine retard daily. Patients with partial adrenalectomy no longer required antihypertensive medication after surgery and 29 patients (27.9%) were prescribed a decreased dose or fewer antihypertensive medications. The authors concluded that partial adrenalectomy for unilateral aldosterone producing adrenal adenoma is beneficial and may preserve adrenal function avoiding possible steroid replacement. Moreover, retroperitoneoscopic partial adrenalectomy is technically feasible with similar outcomes as total adrenalectomy in patients with primary aldosteronism due to aldosteronoma.

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Prostate size is not associated with recovery of sexual function after minimally invasive radical prostatectomy

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Objectives: To investigate the association of prostate weight with recovery of sexual function after minimally invasive radical prostatectomy.

Methods: Between April 2001 and September 2007, two surgeons performed 856 consecutive laparoscopic radical prostatectomies for clinically localized prostate cancer. Patients were stratified into three groups by prostate weight: < 35 g, 35-70 g, and > 70 g. Sexual and urinary outcomes were assessed prospectively using the Expanded Prostate Cancer Index Composite (EPIC) questionnaire. Patients who underwent nerve sparing (unilateral or bilateral) with complete preoperative EPIC data, a minimum preoperative Sexual Health Inventory for Men score \geq 21, and a minimum of 3 months of complete postoperative EPIC data were included in the analysis.

Results: Of the cohort of 856 men, 324 (38%) had complete, evaluable data and met the inclusion criteria for this study. Preoperatively, there were no significant differences by prostate weight in the EPIC sexual function

or bother subscale scores or the proportion of patients participating in sexual intercourse. Postoperatively, we observed statistically similar returns to baseline EPIC sexual function and bother subscale scores and participation in sexual intercourse across all gland weight groups at all time points. EPIC sexual domain scores and the proportions of patients participating in sexual intercourse continued to increase up to 24 months postoperatively, but no group returned to preoperative function at any sampling point.

Conclusions: Prostate size is not associated with postoperative recovery of sexual function in men undergoing minimally invasive radical prostatectomy.

Editorial Comment

The authors investigated the association of prostate weight with recovery of sexual function after minimally invasive radical prostatectomy. Two surgeons performed 856 consecutive laparoscopic radical prostatectomies for clinically localized prostate cancer. Patients were stratified patients according on prostate size. Sexual and urinary outcomes were assessed prospectively using the Expanded Prostate Cancer Index Composite (EPIC) questionnaire. Patients who underwent nerve sparing (unilateral or bilateral) with complete preoperative EPIC data.

Possibly, higher prostate weight may present more technical challenges and adversely affect short- or long-term validated sexual HRQoL outcomes after laparoscopic prostatectomy. However, the study demonstrated all patients had similar patterns in recovery of sexual HRQoL scores regardless of prostate size after surgery, and an immediate decrease in sexual function and an increase in sexual bother followed by gradual recovery toward individual baseline score. Although, all patients exhibited an immediate decline in participation in sexual intercourse followed by a gradual return toward baseline, there was no statistical association between gland size grouping and recovery of sexual function, bother, or intercourse. Finally, the authors emphasize the importance of more comprehensive validated questionnaires, such as the EPIC versus IIEF-5.

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IMAGING

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Is apparent diffusion coefficient associated with clinical risk scores for prostate cancers that are visible on 3-T MR images?

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