trial of labor, was found to be associated with a significantly lower prevalence of postpartum SUI. Whether the prevention of pelvic floor injury should be an indication for elective cesarean section is yet to be established.

Editorial Comment

The authors attempt to illuminate the timing and role of cesarean section with regard to postpartum stress urinary incontinence by examining a study population divided into three subgroups. The first group being 145 primiparae women who underwent spontaneous vaginal delivery, the second group being 118 primiparae women who underwent selective cesarean section and a the third group of 100 primiparae women who underwent cesarean section for obstructed labor. The authors, in their paper, come to a clearly defined conclusion that childbirth induced stress urinary incontinence is best prevented through elective cesarean section prior to the onset of labor. In addition, it is noted in the report that cesarean section performed for obstructed labor was not associated with a diminished incidence of postoperative stress urinary incontinence. They also found that patients who have new onset stress urinary incontinence during pregnancy will have an increased risk of stress urinary incontinence at one year postpartum measurements.

The authors should be commended for this excellent paper for it is noteworthy in that it compares cesarean section performed before and after obstructed labor and contrasts the results of same. Urologists are often asked by female patients whether having a cesarean section may help them avoid incontinence later in life; this paper answers that question.

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PEDIATRIC UROLOGY

Long-term outcome of Fowler-Stephens orchiopexy in boys with prune-belly syndrome

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Purpose: Intra-abdominal testes in boys with prune-belly syndrome have been conventionally managed by 1 or 2-stage orchiopexy with division of the gonadal vessels. We reviewed a series of adults with prune-belly syndrome to assess the morphological and functional outcome of orchiopexy in childhood with specific reference to the spontaneous onset of puberty, hormonal profiles and sexual function.

Materials and Methods: A total of 41 boys were divided into 3 groups depending on the type of orchiopexy performed, namely group 1 - 20 with bilateral 1-stage orchiopexy, group 2 - 10 with unilateral 1-stage and contralateral 2-stage orchiopexy, and group 3 - 11 with bilateral 2-stage orchiopexy.

Results: In group 1, 9 of 20 patients had good scrotal testes bilaterally, 6 had a good scrotal testis on 1 side and 3 had small testes on each side. Two boys required testosterone supplementation but 18 had normal hormonal and sexual function. In group 2 6 of 10 patients had good scrotal testes bilaterally and 4 had a good scrotal testis on 1 side. All patients underwent spontaneous puberty with good sexual function. In group 3, 7 of 11 boys had good scrotal testes bilaterally and 3 had 1 good testis with normal puberty and sexual function. These 10 patients underwent spontaneous puberty with good sexual function.

Conclusions: The majority of boys with prune-belly syndrome had a satisfactory outcome after orchiopexy with division of the gonadal vessels with testicular function sufficient to induce puberty and maintain satisfactory sexual function in adult life.

Editorial Comment

In pediatric urology, many papers on long-term follow-up are based on observations made over several years. This paper is highly significant in that it assesses outcome on average 17 years after surgery. Early outcomes orchiopexy in the prune belly syndrome have been thought to be good, particularly when the operation has been done at an early age. However, this series provides another, more important view. Over time, particularly past the age of puberty, accurate assessment of testicular growth and function is more possible. In this series, of patients undergoing Fowler-Stephens orchiopexy in expert hands, only 22 of 41 patients had morphologically normal testes bilaterally. There was a slightly higher rate of success in those who underwent a bilateral two-stage Fowler-Stephens orchiopexy (7/11), but even this is not as positive as most surgeons would like. Fortunately, only 2 patients in the series require testosterone replacement and the rest underwent spontaneous puberty and reported good sexual function. The authors are to be congratulated on an important "long-term" follow-up.

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The urological care and outcome of pregnancy after urinary tract reconstruction

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Objective: To assess the obstetric and urological outcomes during and after pregnancy following urinary tract reconstruction, as pregnancies after such surgery can have a significant effect on the function of the reconstructed urinary tract, and the reconstruction can significantly affect the delivery of the fetus.

Patients and Methods: We retrospectively reviewed the obstetric and urological history of 11 patients (12 pregnancies; 10 singletons and one twin) with previous urinary reconstruction, delivered between 1989 and 2003. Antepartum and postpartum urological function and obstetric outcomes were investigated.

Results: All the patients had some difficulty with clean intermittent catheterization (CIC) during pregnancy, and four needed continuous indwelling catheters. During pregnancy 10 women had several bladder infections and all received antibiotic suppression. There were eight Caesarean sections, two vaginal deliveries and one combined delivery. Six Caesareans were elective and three were emergent. The use of CIC returned to normal in all patients after delivery.

Conclusions: Women with a urinary reconstruction can have successful pregnancies. The complexity of the surgery and the concern for possible emergency Caesarean section resulted in most patients having an elective Caesarean delivery before term. Antibiotic prophylaxis is recommended and patients may require indwelling dwelling catheters while pregnant but normal CIC can be resumed after delivery.

Editorial Comment

Nearly all parents of girls with major urological anomalies are interested in the reproductive possibilities for their children and whether the reconstructive procedures used to correct them will interfere with sexual function, fertility and pregnancy. The authors report a fascinating series of patients who became pregnant after extensive urinary tract reconstruction, including continent urinary diversion in most and augmentation cystoplasty in others. Many had continent urinary stomas and all were on intermittent catheterization. Surprisingly, problems were encountered with intermittent catheterization in all patients during the pregnancy. In four cases this resulted in chronic indwelling catheter drainage during the pregnancy. Most all the patients had significant urinary tract infections during the pregnancy and most required a Caesarean section. Indeed, a number of the patients underwent an elective Caesarean section prior to term due to the complexity of the procedure in the face of the complex reconstruction with atypical blood supply to the urinary reservoir and stoma. All patients returned to baseline post-delivery including being able to resume normal intermittent catheterization. This report will be very useful in counseling parents and patients prior to major urological reconstructive surgery.

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