

Materials and Methods: During the 10-year study period 51 patients fulfilled the entry criteria of past simultaneous TURBT and TURP, histologically confirmed transitional cell carcinoma of the bladder and benign prostatic hyperplasia, a preserved bladder and a minimal followup of 12 months. Their records were analyzed retrospectively. Patients were divided into 28 with single (group 1) and 23 with multiple (group 2) bladder tumors.

Results: During the 12 to 120 months of followup (mean 37.3) the average tumor recurrence rate was 68.6%, that is 53.6% in group 1 and 86.9% in group 2. Recurrences appeared within an average of 14.9 months, that is within 18 (range 4 to 36) in group 1 and 13.5 (range 3 to 36) in group 2. Tumor recurrence was at the bladder neck and/or prostatic urethra in 11 of the 51 cases (21.5%). Average time to recurrence at the prostatic fossa was 23.8 months, that is 27 (range 13 to 46) in group 1 and 21.6 (range 4 to 60) in group 2. Only 1 patient had a single recurrence in the prostatic fossa, while the others also had synchronous and metachronous recurrences at other bladder sites. Tumor progression to invasiveness was diagnosed in 3 of the 51 patients (5.9%).

Conclusions: Our data indicate that simultaneous TURBT and TURP do not negatively affect tumor recurrence at the bladder neck and prostatic urethra.

Editorial Comment

Implantation of bladder tumor cells is an interesting topic and base of renewed interest of the scientific community. Here, the authors tried to answer clinically if implantation occurs predominant at resection sites, such as the prostatic urethra after TUR of the prostate. Their data do not support the hypothesis of predominant implantation in the previously resected area. On the other hands, the biological facts of implantation are by far more complex than the clinical situation analyzed. Implantation occurs on areas coated e.g. with fibronectin, an intermediate matrix protein. Simplified, this protein is shed by bleeding and attaches on the bladder surface, not only on traumatized surfaces. Therefore, during and after resection of the prostate, large areas of the bladder are covered with this protein, representing an ideal surface for bladder tumor implantation. The recurrence rate in their analysis is very high. Given the fact that intermediate risk tumors are resected, the authors have an average recurrence rate of around 70% within a follow up of slightly more than 3 years, and even 87% in group 2. This recurrence rate seems very impressive and rather supports the notion that simultaneous transurethral resection of the prostate should not be performed because of the higher probability of an overall tumor cell implantation. This statement, however, needs to be scientifically proven.

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FEMALE UROLOGY

Stress incontinence surgery for patients presenting with mixed incontinence and a normal cystometrogram

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Objective: To evaluate the outcome of surgery for stress urinary incontinence (SUI) in patients presenting with a combination of stress and sensory urge UI.

Patients and Methods: The study comprised 75 women presenting with mixed incontinence; the most important inclusion criterion was a negative cystometrogram for detrusor overactivity. Based on random selection, a third of the patients received a 6-month course of anticholinergic treatment (group 1) and 50 (group 2) had surgery for SUI. The surgical procedure depended on the Valsalva leak point pressure (VLPP); those with a VLPP of ≥ 90 cm H₂O underwent Burch retropubic bladder neck suspension (group 2a, 24 patients) while 26 (group 2b) with a VLPP of < 90 cm H₂O had pubovaginal sling (PVS) surgery. A further group of 20 patients with pure SUI (no urge UI) underwent surgery (PVS in 12 and Burch in eight) as a control group (group 3). After at least 6 months of follow-up (mean 9.3, SD 1.7), 68 patients were evaluable; they were assessed subjectively and objectively for dryness, and by a urodynamic evaluation and quantitative assessment using the SEAPI scoring system.

Results: In group 1 none of the patients became completely dry; there was persistent stress with and without urge UI in nine (43%) and 12 (57%) of the available 21 patients, respectively. Only three of those who had persistent SUI with no urge in the whole study group were satisfied and chose to continue anticholinergic therapy despite SUI. In this group the mean (SD) improvement in the subjective and objective SEAPI score was 3.4 (1.0) and 2.3 (3.8), respectively. In group 2a, 20 of the available 23 patients (87%) became completely dry (both stress and urge continent). The mean improvement in the SEAPI scores was 7.8 (0.9) and 7.8 (1.3), respectively. In group 2b, 20 of the 24 (83%) became completely dry, with mean improvements in SEAPI scores of 8.2 (0.4) and 7.9 (0.3), respectively. The improvement was statistically significant after surgery, vs. anticholinergic therapy, for all variables ($P < 0.05$). The incidence of persistence urge UI was highest in group 1 (43%), being 13% in group 2 (13% and 12% in 2a and b, respectively). In group 3 there was de novo urge UI in four of the 20 patients, and not significantly different from that in group 2.

Conclusion: Most patients with mixed stress and urge UI and a normal cystometrogram were cured of both symptoms by surgery. The incidence of residual urge in such patients was no higher than that of de novo urge after surgery in patients with genuine SUI.

Editorial Comment

This is a randomized study to evaluate the outcome of surgery for stress urinary incontinence (SUI) in a population of women who had a combination of SUI and symptoms of urinary urge incontinence combined with a preoperative cystometrogram that had no evidence of uninhibited detrusor contractions. The study involved 3 basic groups: the first group of 25 patients had their therapy limited to anticholinergic medication for over 6 months; the second was a surgical group of 50 patients which was divided into 3 subgroups of which one group had a Burch retropubic suspension on the basis of a urodynamically proven Valsalva leak point pressure of > 90 cm H₂O and a second subgroup of patients who underwent a pubovaginal sling with a criteria of a Valsalva leak point pressure of < 90 cm H₂O; lastly, the third group was a control group of patients who had stress urinary incontinence but no complaints of urinary urge incontinence who also underwent a pubovaginal sling or a Burch depending on their preoperative VLPP determination. After at least 6 months of follow-up, the patients were assessed subjectively and objectively on the basis of a SEAPI score. Conclusions of the authors based on their findings included the observation that anti-incontinence surgery has an excellent cure rate for both symptoms in those patients with both stress and symptoms of urinary urge incontinence and that clinical efficacy and patient satisfaction of medical therapy was sub-optimal. In addition, the authors noted that the rate of postoperative urinary urge incontinence was similar between the group of patients who had preoperative symptoms of urinary urge incontinence combined with their stress urinary incontinence and the control group who had only stress urinary incontinence and no complaints of urinary urge incontinence.

This is a valuable paper for the interested in female urology. It is notable that the incidence of post operative urinary urge incontinence was similar in both the surgical group of patients who had preoperative urinary urge incontinence and the control group who had no preoperative urinary urge incontinence. Also of specific interest is that though the patients who preoperatively complained of urinary urge incontinence had negative cystometrograms, 9 of 10 patients had cystometric evidence of detrusor overactivity when plagued with postoperative urinary urge incontinence. In addition, other noteworthy urodynamic changes noted in the study group was a diminution in the maximum flow rate in the patients who had persistent urinary urge incontinence. The authors through their documentation of these urodynamic parameters and their noted difference in the pre- and post-operative patients raised a valuable point: is the etiology of preoperative urinary urge incontinence different from the etiology of postoperative urinary urge incontinence? The authors lead us to believe that this is definitely possible with postoperative urinary urge incontinence potentially being related to an infravesical outlet obstruction as opposed to a preoperative idiopathic condition.

The discussion section by Dr. Osman is of great value and warrants careful reading both for the facts, which it presents as well as the questions that it raises with regard to the etiology of this most troublesome malady. It would be of genuine interest if the author could expand on the urodynamic differences pre and postoperatively between the group that underwent a Burch urothorpey vs. those who underwent a suburethral pubovaginal sling secondary to the historical claim of the potentially obstructive nature of a suburethral sling.

In conclusion, the paper's findings are along the same line as those voiced by Dr. McGuire in the past in that the finding of detrusor instability on a preoperative cystometrogram does not preclude a good result (1). Interested readers should consider other landmark papers of great value on this topic (1,2).

References

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PEDIATRIC UROLOGY

Vesicoureteral reflux in the Hispanic child with urinary tract infection

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Purpose: Hispanic individuals have become the largest minority in the United States. Prior studies of minorities revealed real differences in vesicoureteral reflux rates between white and black Americans. We studied the incidence of reflux in the Hispanic population to see if the reflux rate was different from that of the white population.

Materials and Methods: We reviewed the results of voiding cystourethrograms performed in Hispanic children as our normal screening for reflux and compared them to voiding cystourethrograms results in a group