

Re: Urogenital Involvement in the Klippel-Trenaunay-Weber Syndrome. Treatment Options and Results

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Int Braz J Urol, 32: 697-704, 2006

To the Editor:

With the intention to provide more information about this rare and difficult disease, we communicate that the boy from the Case 3 underwent a right transfemoral amputation due to massive enlargement and walking inability in November 2006. In January 2007, he had a massive enterorrhagia probably related to the growth of the vascular tumor and involvement of the colon. Despite multiple transfusions and medical measures, stabilization was not achieved and he died before surgical procedure could be attempted. The patient of the Case 1 is a mulatto man, and not a black man as described.

We wish to thank Dr. José Luis Borges de Mesquita who participated in the treatment of Case 5 and Dr. Antonio Marmo Lucon, who provided the data of the patient of the Case 1.

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Re: Pudendal Nerve Latency Time in Normal Women via Intravaginal Stimulation

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Int Braz J Urol, 32: 705-712, 2006

To the Editor:

We have to congratulate Cavalcanti et al. for their very nice study adding information on pudendal

pathologies. They concluded that the vaginal approach represents an alternative for pudendal nerve distal

motor latency time, with similar results to those achieved through the transrectal approach. Normative values obtained might serve as a comparative basis for subsequent physiopathological studies.

We have for long time used the 2 approaches (vaginal and rectal) and find sometimes bizarre results. We recall that for measuring pudendal nerve motor time conduction a special device was developed at the St Mark's London Hospital. It consists of a bipolar stimulating electrode fixed on a gloved index finger. A pair of surface recording electrodes is placed 3 cm proximally on the base of the finger. Using a rectal pathway the stimulating electrode is placed near the ischial spine. The recording electrode is at the level of the anal sphincter. Geraldo and al. describe a transvaginal stimulation. Pudendal nerve motor latency time obtained by transrectal or transvaginal stimulation has to be viewed with some uncertainty and doubts because we must have in mind the imprecision of the stimulation point, which is at the level of the ischial spine.

An entrapment at this site cannot be detected and distortion of the stimulating potential by the different layers of tissues to go through can explain normal results even in presence of a neuropathy (Cavalcanti et al.). For the last 6 months, we have been use an insulated regional analgesia needle with

electro-neuro-stimulation port (100 or 120 mm) placed above the ischial spine (by a transmuscular perineal route parallel to the ischiorectal fossa) to stimulate the pudendal nerve. The recording is made with a circular bipolar electrode placed in the anal sphincter with some advantages: the stimulations are made above the ischial spine permitting a detection of an entrapment even at this site, it localize with accuracy the site of entrapment (sacrospinous ligament, falciformis process, pudendal tunnel), there is less or no distortion of the potential, it can be used in women and men, it can be used as an intraoperative monitoring, it inform the surgeon at the time of the decompression on the ongoing of the procedure or the necessity of completing it, therefore, improving the surgical procedures.

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REPLY BY THE AUTHORS

We are grateful for the interest shown in our study and especially thank you for information on potentials improvements in the technique used by Dr. Eric de Bisschop and Dr. Jean Pierre Spinosa.

They shared their experience in obtaining the pudendal nerve terminal motor latency (PNTML) for both approaches (vaginal and rectal). We agree that imprecision of the stimulation point and the interposition of different layers of tissues between the pudendal nerve and the stimulus electrodes represent technical and biological factors that may interfere in the M-wave recordings, even reaching the

supramaximum stimulus. However, the latency value must not be altered by these factors.

They also described an interesting and novel technique to obtain the PNTML by utilization of needle electrode for pudendal nerve stimulation instead of St. Mark's electrode. Other authors also designed an intra-rectal incurvated metallic rod stimulator with similar arguments, as an alternative method to assess the PNTML (1). A needle stimulator could obtain more quality recordings because the direct stimuli of the nerve can be reached and specific stimulation areas can be localized with accuracy. But the

St. Mark's electrode used in the study has the distance between the stimuli and recording sites known in a region of difficult access for measuring. This would become the method more standardized and appropriate for pelvic floor, besides probably causing less discomfort than the transmuscular perineal route. These alternative methods for PNTML assessment might be useful in routine practice, mainly for

intraoperative monitoring. Nevertheless it should be tested in further studies.

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Re: Percutaneous Nephrolithotomy with and without Retrograde Pyelography: A Randomized Clinical Trial

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Int Braz J Urol, 33: 19-24, 2007

To the Editor:

This article by Tabibi et al. evaluates whether there is a benefit to performing cystoscopic ureteral catheter placement, for retrograde opacification of the renal pelvis and calyces, in order to obtain access prior to percutaneous nephrolithotomy (PCNL). The study was randomized to either no catheter placement (intervention group) or catheter placement (control group). No statistical differences were found when comparing demographic or intraoperative parameters (surgical duration, radiation exposure, hospital stay, postoperative fever) between the 2 groups. Interestingly, postoperative hemoglobin decrease was found to be significantly higher in the catheterized group ($p < 0.001$). While no statistical difference was identified for outcome ($p = 0.136$), a greater percentage of patients were found to be "stone free" on KUB in

the catheterized group than the noncatheterized group, 93% vs. 79%, respectively. Based on these results, it would appear that while retrograde placement of a ureteral catheter does not influence the safety or duration of the procedure, it may facilitate the efficacy of PCNL in terms of achieving stone free status.

The decision for selecting a noncatheterized versus a catheterized approach should take into account the experience of the individual obtaining access as well as the clinical scenario in terms of stone location and burden. In many institutions, initial access is obtained by an experienced interventional radiologist followed by PCNL that is performed by the urologist. Even in this circumstance, it is not uncommon for the interventionalist to request a ureteral catheter for retrograde opacification of the

collecting system. Early in one's experience, a catheterized approach may be beneficial for maximizing successful access with minimal complications. Once a level of comfort with percutaneous anatomy is achieved, a noncatheterized approach may be a natural evolution to performing percutaneous nephrolithotomy.

A larger randomized study would assist in determining the value of pre-procedure catheter placement for obtaining optimal access to the

collecting system. As there are a limited number of published randomized studies on access relating to percutaneous nephrolithotomy, the authors should be congratulated on their contribution."

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Re: Antibiotic Resistance and Trend of Urinary Pathogens in General Outpatients from a Major Urban City

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Int Braz J Urol, 33: 42-49, 2007

To the Editor:

Investigations of antibiotics susceptibility profiles on urinary tract infections in outpatients in São Paulo, Brazil, were aimed to recommend the ideal empirical therapeutic recipe in suspected cases of urinary tract infections (1). That had been a commendable exercise through for the maximal utility of any retrospective data in clinical practice, it would have been better to evaluate identical profiles in hospitalized patients as well. Clinicians would be treating patients during and after hospitalization. A watch is being continued on combined susceptibility pattern in a private, tertiary care hospital in the Indian capital metropolis.

Effective October 2004, susceptibility data was compiled at Sant Parmanand Hospital, a 140-

bedded tertiary care hospital catering to population in the capital and adjoining townships. The antimicrobial susceptibility on urinary isolates would be determined using disk diffusion method for amoxicillin-clavulanic acid, ampicillin-sulbactam, cefaclor, cefuroxime, ceftriaxone, ceftazidime, cefotaxime, ceftizoxime, amikacin, gentamicin, netilmicin, ciprofloxacin, ofloxacin, pefloxacin, norfloxacin, nalidixic acid, chloramphenicol and nitrofurantoin. The outstanding antimicrobials were selected based on the previous quarterly susceptibility pattern, from October to December 2004. Based on the picture in 130 isolates namely, *E. coli*, 103, *Klebsiella* species, 20, *Proteus* species, 13 and *Pseudomonas* species 11, data was computed to

determine a cut-off value of 75% or more in-vitro susceptible. Antimicrobials selected were categorized into oral or parenteral antimicrobials (2). The oral recipe identified was of amoxicillin-clavulanic acid,

chloramphenicol and nitrofurantoin, the parenteral recipe of amikacin, netilmicin and ceftazidime. Subsequently, similar data from inpatients and outpatients for the every quarter was assessed in

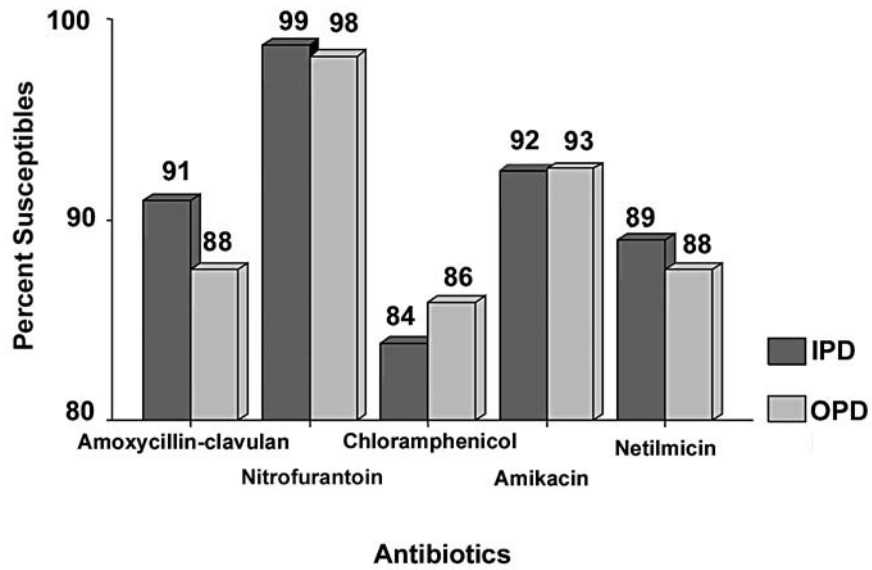


Figure 1 – Outpatients (OPD) and inpatients (IPD) susceptibility profile.

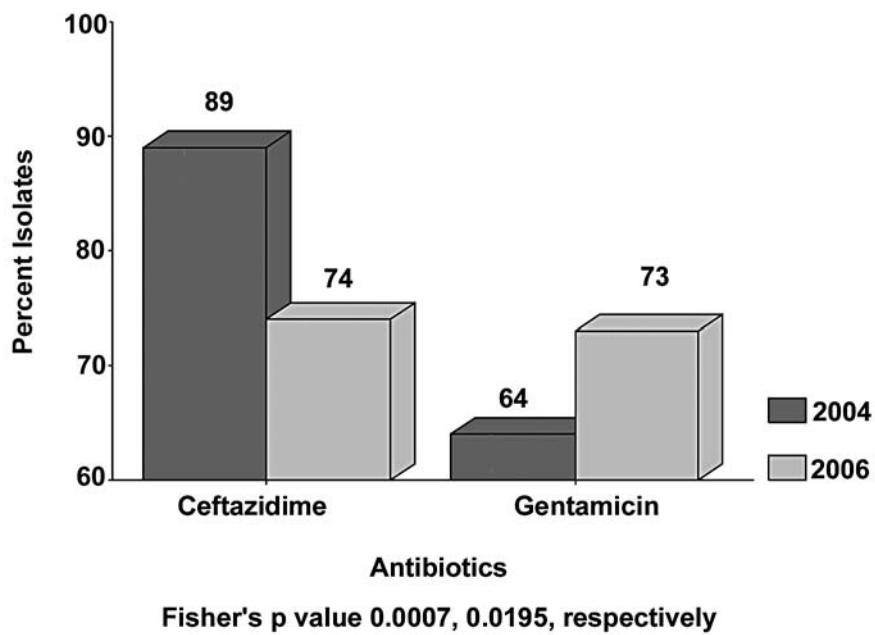


Figure 2 – Altered susceptibility profile.

relation to the retrospective data. There was no significant change during 2005.

The susceptibility pattern during the 12-month duration from December 2005 to 2006 from outpatients and inpatients was not all diverse. Isolates had included *E. coli*, 1209 strains, *Klebsiella*, 650, *Proteus*, 379, *Pseudomonas*, 32 and *Enterococcus faecalis*, 6 strains. The contribution of inpatients was of *E. coli*, 269 strains, *Klebsiella*, 147, *Proteus*, 44, *Pseudomonas*, 12 and *Enterococcus faecalis*, 2 only. There was no significant difference for amoxicillin-clavulanic acid, chloramphenicol, nitrofurantoin, amikacin and netilmicin susceptibility among inpatient and outpatient isolates (Figure-1). There was a significant reduction in the prevalence of isolates susceptible to ceftazidime, accompanied by an increase in isolates susceptible to gentamicin (Figure-2).

The clinical course in neonates with urinary tract infections treated with short-term intravenous antibiotic followed by oral treatment is highly favorable, both in short and long terms (3). Selection of appropriate intravenous and oral antibiotics against isolates in local circulation should be a reality through updates to the susceptibility profile of urinary isolates (1) encountered among patients seeking treatment in

the hospital premises (2). That would also encourage frequent dialogues amongst clinical microbiology personnel and those responsible for patient care and guarantee better empirical recipe in urinary tract infections.

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Re: Wet Heat Exposure: A Potentially Reversible Cause of Low Semen Quality in Infertile Men

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Int Braz J Urol, 33: 50-57, 2007

To the Editor:

Dry and wet heat differ mainly in the speed of energy transfer, as heat transfer by convection and

contact in water is increased than in air, and because heat dissipation by sweat evaporation is blocked into

the water (1), thus this study express the concern of recreational immersion in hot water over male reproductive health.

The current article by Shefi and colleagues proves the reversible effect of this spermatogenic harm through the comparison of total motile count during wet heat exposure and after cessation. Heat effects over sperm quality are like to happen within 3 days of exposure (2) and it seems to be reversible as in heat injury from other sources (3).

In spite of the important results demonstrated, this study does not privileges some issues as sperm DNA fragmentation, and other molecular pathways, like heat shock proteins (Hsp) expression. Heat stress produced by cryptorchidism and varicocele is well characterized as a DNA fragmentation inducer (4,5) even when normal morphology is observed (5), and may affect ART outcomes (4). Also, Hsp_s reestablish a homeostatic mechanism and equilibrium between protein synthesis and degradation in the cells (6) and differential expression of HSP70 and HSP90 was shown in the heat-induced stress (7).

Investigation of these underlying factors process should be considered in further studies intending to elucidate the mechanisms and differences of wet heat gonadotoxicity and induced infertility.

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REPLY BY THE AUTHORS

We agree that the functional capacity of sperm should be evaluated after wet heat exposure to un-

derstand if the mechanisms of impairment are similar to that described for other forms of heat stress.

Re: Laparoscopic Upper-Pole Nephroureterectomy in Infants

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Int Braz J Urol, 33: 87-93, 2007

To the Editor:

The authors reported the results of laparoscopic upper-pole nephroureterectomy, and demonstrated that this procedure is safe and feasible in the infant population without compromise of results. Seven procedures were performed in the transperitoneal fashion, with reasonable operative times, short convalescence and overall improvement in tubular function.

Acceptance of pediatric urologic laparoscopy, particularly in the infant population has lagged behind its adult counterpart, in large part due to the nature of

the practice of pediatric urology. However, compared to the adult population, the laparoscopic approach to partial nephrectomy in children is more straightforward due to clear anatomic and vascular planes between the upper and lower duplex systems, decreasing the risk for damage to the vascular supply to the remnant pole.

Based on their findings, transperitoneal laparoscopic upper-pole nephroureterectomy should be considered a viable treatment modality in an infant with a nonfunctioning upper or lower renal moiety.

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