

groups based upon the absence or presence of post-urethrolysis bladder storage symptoms. Patients (7) in group 1 have no current bladder symptoms. Patients (8) in group 2 still require anticholinergic drug therapy for significant bladder symptoms of frequency and urgency. Data collected for the 2 groups included mean age, existence of urinary retention before urethrolysis, mean time to urethrolysis in months, urethrolysis outcome based upon subjective bladder symptoms and followup duration. For comparison of mean age between groups, the standard t test was used. Fisher's exact test was used to compare frequency of urinary retention before urethrolysis between groups. Lastly, the Mann-Whitney U test was conducted to compare time to urethrolysis between groups. All statistical analyses were conducted using the SPSS software package (SPSS, Inc., Chicago, Illinois).

Results: There was no statistically significant difference between the groups with respect to age or frequency of urinary retention before urethrolysis. Time to urethrolysis for the whole cohort ranged from 2 to 66 months. Mean followup after urethrolysis was 17.3 +/- 22.9 months. Comparison of mean time between incontinence and urethrolysis surgeries between group 1 (9.0 +/- 10.1 months) and group 2 (31.25 +/- 21.9 months) demonstrated a statistically significant difference ( $p = 0.01$ ).

Conclusions: This urethrolysis population demonstrated an unusual delay time to surgical treatment of bladder outlet obstruction. We categorized the cohort according to absence or presence of persistent bladder storage symptoms, and found a strong association between persistent bladder symptoms and greater delay to urethrolysis.

### **Editorial Comment**

The authors review their specific population of urethrolysis patients and retrospectively analyze the response to surgery and its relation to the passage of time between the original sling and the subsequent urethrolysis. The analysis revealed a strong association between persistent bladder symptoms and greater delay to urethrolysis.

This paper is very timely in view that it raises the issue of when should one intercede for relief of obstruction secondary to an outlet procedure. The paper may have had a greater degree of illumination had there been more definition of the urinary symptoms preoperatively and postoperatively. During the review of the paper, one may infer that the authors assume that all their urethrolysis patients were surgically successful and that the continuation of symptoms was basically due to anatomic/physiologic changes associated with obstruction as opposed to technique failure. Nevertheless, the take home message from this paper is that as soon as the diagnosis of infravesical outlet obstruction is diagnosed it should be definitively remedied; this may be valuable advice indeed when deciding when to intercede with this specific subset of patients.

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## **PEDIATRIC UROLOGY**

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### **The ambitions of adolescents born with exstrophy: a structured survey**

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**Objective:** To determine the factors that control quality of life as perceived by adolescent patients with bladder exstrophy, and to compare their views using standard instruments.

**Patients and Methods:** Sixteen patients (mean age 19 years, range 16-21, 11 male and five female) were recruited from the departmental database; they represented 46% of those available for the study. After giving informed consent, each had a semi-structured interview, augmented by completing a self-reported scale, with the principal investigator. They then completed the Culture-Free Self-Esteem Inventory-2 (CFSEI-2) and the Brief Symptom Inventory (BSI). The interviews were recorded on audiocassette, transcribed verbatim and evaluated using interpretative phenomenological analysis.

**Results:** In the interviews there was a remarkable consistency in the domains identified as important to the patients. There was a wish to be normal and to be treated as such. This was defined (amongst other items) as being able to void with an appropriate noise, being treated as peers at school and at home, and having an umbilicus. All patients reported some bullying (all but one in the past), but only severely in three. Concerns about self-image centred on scars and genital appearance. Very similar and effective coping strategies had been created, including practical (e.g. suitable clothes) and emotional (e.g. joking, control of revealed information) aspects. Special arrangements made to help (care by a special assistant or use of a disabled lavatory at school) served only to emphasize their abnormality and were resented. No overt psychiatric or psychological morbidity was detected. There was no difference in scores with the CFSEI-2 or BSI from established age-related norms.

**Conclusion:** This study confirms the anecdotally reported strong resilience and personality of adolescents with exstrophy. The domains that patients considered important were not those that their carers might have expected or that are used in standard quality-of-life instruments. No morbidity was identified by the two instruments used. In exstrophy, and perhaps in other uncommon conditions, the patients' views of relevant domains should be considered in assessing quality of life.

### **Editorial Comment**

There have been increasing concerns about the psychosocial health of adolescents and young adults born with severe congenital anomalies, like bladder exstrophy. There are few accurate quality of life instruments applicable to these conditions and most are not disease-specific. What data are available are via anecdote or interview and are subject to personal bias.

It is with this as a basis that this paper is of great value. Sixteen patients were evaluated (admittedly only 46% of the sample) via a number of different instruments. It is not surprising that there was an overwhelming wish to "be normal". Among the disease specific concerns was the desire to "sound" normal while emptying their bladders! Interestingly many resented support structures meant to make their lives easier, if these methods singled them out as being different. Body image was quite important as would be anticipated. This was especially so with regards to genitalia in boys and surprisingly to the umbilicus. The lack of an umbilicus drew attention to their being different and affected clothing choices! Overall, these patients appeared to be hard-working, non-complaining and very resilient. They seemed quite adept at developing coping strategies and related well to adults.

Overall the authors are to be congratulated on a very strong effort at focusing on specific quality of life issues that affect these children. This should make a large difference to clinicians caring for these patients in the future. This type of work would be of great benefit to patients with other diseases that we care for and should be encouraged.

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**The physical characteristics of young males with varicocele**

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**Objective:** To determine if there is an association with habitus in young males with varicocele, as adolescent boys with varicoceles appear to be mostly taller and leaner than age-matched controls.

**Patients and Methods:** Retrospectively reviewing our records we obtained the height and weight of 43 consecutive males (mean age 14.3 years, range 11-19) under long-term follow-up for varicocele. The body mass index (BMI), heights and weights were compared with values from the respective growth charts for boys aged 2-20 years (Center for Disease Control and Prevention), and the statistical significance of differences determined using the chi-square test.

**Results:** The height and weight distributions of patients with varicocele indicated a significant deviation from normal in the 25-95th percentiles for stature and in the 25-75th for weight ( $P < 0.05$ ). Deviations in BMI were insignificantly different from normal at each percentile.

**Conclusion:** These results indicate that patients with varicocele are significantly taller and heavier than age-matched controls. Future studies to address the key areas identified in this study will help to further assess the distribution of the incidence of varicocele in closely defined subsets of adolescent growth and development, which may provide some insight into the cause of varicoceles.

**Editorial Comment**

The relationship between body habitus and varicocele has been a matter of conjecture. Anecdotal data suggest that patients with varicoceles are tall and thin. However, this has never previously been investigated. The authors in this study compare the heights, weights and body mass index of varicocele patients to national norms. They discovered that indeed, their varicocele patients were taller than average. They also found that their patients were heavier than normal, but that their body mass index was only slightly increased.

This interesting observation leads to further conjecture about the cause of the adolescent varicocele. Why are these patients more likely to be tall? Conversely, are tall patients more likely to have varicoceles and if so, why? Does this have to do with the length of the spermatic vein? Does it have to do with posture or athleticism? Similarly, why are they heavier, but with a relatively normal body mass index? Is their weight increased due to muscle mass as opposed to adipose tissue? This nice descriptive study leaves more questions than it answers, but opens the door to future investigations. One wonders what other diseases might occur in patients with specific body habitus.

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