

## *EDITOR'S COMMENT*

The September - October 2005 issue of the International Braz J Urol presents interesting contributions, and the Editor's Comment highlights some important papers.

Doctor Al-Qudah and colleagues, from Wayne State University School of Medicine, Detroit, Michigan, USA, performed voiding cystourethrogram (VCUG) on their anterior urethroplasty patients on days 3 (anastomotic) and 7 (buccal) in an effort to determine the earliest day for removal of the urethral catheter (page 459). Seventeen patients had early catheter removal (12 anastomotic and 5 ventral buccal onlay urethroplasty) and were compared to 12 who had late removal (7 anastomotic and 5 buccal). The authors concluded that catheter removal after anastomotic and buccal mucosal urethroplasty could be safely attempted on the 3rd and 7th postoperative days respectively, with a low rate of extravasation on VCUG. It was pointed out that eliminating the catheter as soon as possible should improve patient comfort without harming results and decrease the overall negative impact of surgery on the patient. Doctor Mostafa A. Al-Rifaei, from University of Alexandria, Egypt, and Doctor Sava V. Perovic, from University of Belgrade, Belgrade, Serbia and Montenegro, provided editorial comments on this paper.

Doctor Nicanor and co-workers, from Hospital for Sick Children, University of Toronto, Ontario, Canada, presented on page 477 their experience with the urofacial or Ochoa syndrome, which is a rare disease characterized by the presence of functional obstructive uropathy associated with peculiar facial features when patients attempt to smile or laugh. Because of lack of recognition of the disease, many patients remain without proper diagnosis or adequate treatment, which can ultimately result in upper tract deterioration and eventual renal failure. The authors identified 3 patients who presented initially with acute renal failure, urinary tract infection and severe dysfunctional elimination. Two patients (aged 4 and 9 years) presented with the typical facial features when attempting to smile or laugh. One newborn presented with urinary and fecal retention and septicemia. The authors pointed out that their series demonstrates that early recognition of this rare syndrome is necessary to adequately treat and prevent upper tract deterioration in these unique individuals.

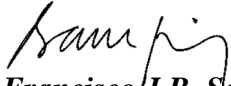
Doctor Dall'Oglio and co-workers, from Federal University of Sao Paulo, Brazil, studied on page 437 the relationship between preoperative PSA levels and clinical outcome following radical prostatectomy in men with clinical stage T1c. Their authors found no biochemical recurrence of disease when the PSA was lower than 4 ng/mL, regardless of Gleason score. Biochemical recurrence-free survival according to PSA between 0-4; 4.1-10; 10.1-20 and > 20 ng/mL was 100%, 87.6%, 79% and 68.8% for Gleason scores 2-6, and 100%; 79.4%; 40% and 100% for Gleason

## **EDITOR'S COMMENT** - *continued*

scores 7-8 respectively. When all individuals were grouped, regardless of their Gleason scores, the probability of biochemical recurrence-free survival was 100%, 65.1%, 53.4% and 72.2% according to PSA between 0-4; 4.1-10; 10.1-20 and > 20 ng/mL respectively. Based on these results, the conclusion is that the non-palpable prostate cancer presents higher chances of cure only when the PSA is inferior to 4 ng/mL.

Doctor Danilovic and colleagues, from University of Sao Paulo Medical School, Brazil, evaluated on page 431 the likelihood of retrograde double-J stenting in urgent ureteral drainage according to obstructing pathology. Forty-three consecutive patients (47 procedures) with ureteral obstruction who needed urgent decompression were studied. Failure in retrograde ureteral stenting occurred in 9% (2/22) and 52% (13/25) of the attempts in patients with intrinsic and extrinsic obstruction respectively ( $p < 0.001$ ). All attempts of retrograde catheter insertion failed in obstructions caused by prostate or bladder pathologies (6/6). The authors concluded that retrograde double-J stenting has a low probability of success in extrinsic ureteral obstruction caused by prostate or bladder disease. They proposed that such cases might be best managed with percutaneous nephrostomy. Dr. Mahesh R. Desai, from Muljibhai Patel Urological Hospital, Gujarat, India, provided an interesting editorial comment on this paper.

Doctor Branco and colleagues from Red Cross Hospital, Parana, Brazil, reported on page 421 their experience with right laparoscopic live donor nephrectomies. Operative data and postoperative outcomes were collected, including surgical time, estimated blood loss, warm ischemia time, length of hospital stay, conversion to laparotomy and complications after operating on 28 patients. The data obtained confirm the safety and feasibility of right laparoscopic donor nephrectomy. The authors suggest that the right kidney should not be avoided for laparoscopic donor nephrectomy when indicated. Doctor Cassio Andreoni, from Federal University of Sao Paulo, Brazil, provided an editorial comment on this paper.

  
**Dr. Francisco J.B. Sampaio**  
Editor-in-Chief