

# International Braz J Urol

## *EDITOR'S COMMENT*

The March - April 2006 issue of the International Braz J Urol presents interesting contributions, and as usual, the Editor's Comment highlights some important papers.

Doctors Evans and Morey, from the Brooke Army Medical Center, Fort Sam Houston, Texas, USA, well-known experts and pioneers in the field, present on page 131 a thorough review and state-of-the-art presentation on the current applications of fibrin sealant in urologic surgery. The authors verify that biosurgical preparations designed to promote surgical hemostasis and tissue adhesion are being increasingly employed in surgical specialties, and that fibrin sealant is the most widely studied and utilized biosurgical adjunct in urology. Complex reconstructive, oncologic, and laparoscopic genitourinary procedures are the most appropriate for sealant use. In this article, the authors detail the different urologic applications of fibrin sealant in the management of genitourinary injuries, surgery, and complications, and give several illustrative practical examples of its use. The authors draw attention to the fact that hemostatic agents and tissue sealants should not be viewed as a replacement for conventional sound surgical judgment or technique, but rather as complementary adjuncts to improve surgical outcome.

Doctor Romero and colleagues, from the James Buchanan Brady Urological Institute, Johns Hopkins Medical Institutions, Maryland, USA, present on page 196 a surgical technique article on the refinement of laparoscopic retroperitoneal lymph node dissection (L-RPLND) for testicular cancer. The authors have a 14-year experience on this procedure, initially for stage I nonseminomatous germ cell tumors (NSGCT) and later for post-chemotherapy patients who required resection of residual retroperitoneal masses. They have performed 92 L-RPLND for testicular cancer. Seventy-six (82.6%) patients underwent a complete template dissection, and sixteen (17.4%) patients underwent an abbreviated dissection due to positive lymph nodes found on frozen section. Median age was 30.5 years-old (range 15 to 45). Seventy-seven (83.7%) patients underwent L-RPLND for clinical stage I or II NSGCT of the testis, and 15 (16.3%) patients for residual retroperitoneal mass following chemotherapy. In this article, the authors describe the current technique employed at John Hopkins, and provide illustrations of all surgical steps, delineating the refinements of the technique over time.

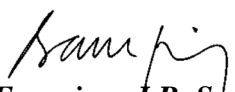
Doctor Ziaee and co-workers, from Tehran University of Medical Sciences, Tehran, Iran, assessed on page 181 the effect of allopurinol in the treatment of chronic nonbacterial prostatitis. In this randomized double blind controlled trial an "intervention group" received allopurinol (100 mg tds for 3 months) with ofloxacin (200 mg tds) for 3 weeks (n = 29) and a "control group" received

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

placebo tablets with ofloxacin (n = 27). The results show that the 2 groups were similar regarding outcome variables. In the first month of study, a significant but similar improvement in symptom scores was observed in both groups. Microscopic examination of prostate massage and post-massage samples were also similar in both groups. No side effects due to allopurinol were observed in patients. The authors did not find any advantage for allopurinol in management of chronic prostatitis versus placebo in patients receiving routine antibacterial treatment. The present study is important, because this is the only additional study on allopurinol for chronic nonbacterial prostatitis, after the paper of Persson et al. (J Urol. 1996; 155: 961-4) which had concluded that allopurinol has a significant, positive effect on nonbacterial prostatitis, and many urologists did not trust that conclusion.

Doctor Billis and colleagues, from the State University of Campinas, Sao Paulo, Brazil, compared on page 165 the clinicopathologic characteristics and the time to PSA progression following radical retropubic prostatectomy of patients with clinical stage T1c tumors to those with stage T2, T2a or T2b tumors. They analyzed 186 patients submitted to prostatectomy with clinical stage T1c (33.52%) tumors, stage T2a (45.45%) and stage (T2b 21.02%). The variables studied were age, preoperative PSA, prostate weight, Gleason score, tumor extent, positive surgical margins, extraprostatic extension (pT3a), seminal vesicle invasion (pT3b), and time to PSA progression. It was found that patients with clinical stage T1c were younger and had the lowest mean preoperative PSA. In the surgical specimen, they had higher frequency of Gleason score < 7 and more organ confined cancer. In 40.54% of the patients with clinical stage T2b tumors, there was extraprostatic extension (pT3a). During the study period, 54 patients (30.68%) developed a biochemical progression. The authors concluded that clinicopathological features are not similar considering clinical stage T1c versus clinical stages T2, T2a or T2b.

Doctor Borden and colleagues, from the Wake Forest University School of Medicine, North Carolina, USA, on an interesting article, review on page 142 five adult renal allograft recipients with ureteral obstruction managed with successful repetitive ureteral stenting. The patients underwent an average of 8.8 stent changes over a mean of 34.5-month follow up. No decline in renal function was observed. The authors demonstrate that repetitive stenting is a viable treatment option for select patients with renal allograft ureteral obstruction. Doctor Ricardo J. Duarte, from University of Sao Paulo, provided an editorial comment on this paper.

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