Thus, additional radiation treatment should be advocated with a note of caution to patients with PSA progression, and benefits should be weighted against disadvantages.

Dr. Andreas Bohle
Professor of Urology
HELIOS Agnes Karll Hospital
Bad Schwartau, Germany

FEMALE UROLOGY

Sexual function in women with pelvic organ prolapse compared to women without pelvic organ prolapse

Novi JM, Jeronis S, Morgan MA, Arya LA
Division of Urogynecology and Reconstructive Pelvic Surgery, Temple University School of Medicine, Philadelphia, Pennsylvania, USA
J Urol. 2005; 173: 1669-72

Purpose: We compared sexual function in women with pelvic organ prolapse to that in women without prolapse.

Materials and Methods: We collected sexual function data using a standardized, validated, condition specific questionnaire. The study group consisted of 30 women with pelvic organ prolapse and it was compared with 30 unmatched controls without evidence of prolapse.

Results: The 2 groups were similar in age, race, parity and postmenopausal hormone use. Subjects in the study group were more likely to have undergone previous pelvic surgery. Mean total Pelvic Organ Prolapse/ Urinary Incontinence Sexual Function Questionnaire scores +/- SD were lower in the study group compared with controls (81.4 +/- 7.3 vs 106.4 +/- 15.5, $p < 0.001$). In the study group total questionnaire scores in women with prior pelvic surgery were similar to those in women without prior pelvic surgery (79.3 +/- 14.9 vs 82.9 +/- 10.2, $p = 0.61$).

Conclusions: Pelvic organ prolapse appears to have a significant negative impact on sexual function.

Editorial Comment

The authors report on a comparison of sexual function in women with pelvic organ prolapse and women without pelvic organ prolapse. They utilized an excellent statistical analysis involving a Likert scale as well as the PISQ (a validated, condition-specific, self-administered questionnaire that evaluates sexual function in women with pelvic organ prolapse and/or urinary incontinence). Statistical planning was utilized to identify the appropriate size study groups to detect a difference if present between the controls and the patients with prolapse.

This is a noteworthy paper that covers an issue, which is not frequently discussed in the medical office but is never far from the thoughts of a large portion of the population. The study's strength lies in the use of a validated self administered questionnaire as well as excellent statistical analysis. It did exclude women younger than 35 years perhaps to obtain a greater degree of similarity between the two groups. It addition, it only involved patients presenting for gynecological evaluation or therapy and not the general population. Several key points on which the paper may educate the reader include the findings that there was no significant difference in dyspareunia rate between women with and without previous hysterectomy as well as in women who have undergone anti-incontinence surgery those who did not. This fact will allow the urologic surgeon to clearly

respond to patients who wonder about their sexual function after their anti-incontinence operation. The publication helps characterize the sexual habits and desires of patients with prolapse compared to the general population including: observing that both groups were able to find a man when needed; both groups felt their men were sexually satisfied to the same degree; both groups wanted sex to the same degree; and both groups attempted to self pleasure at that same rate and had identical rates of anorgasmia. Differences between the two groups that were highlighted did include that women with prolapse, though masturbating at the same degree, were not able to achieve orgasm with the same degree of efficacy and that though both groups desired sexual activity to the same degree, women with prolapse were not able to participate in coitus at the same level of desired frequency.

This is an excellent paper, which should be read and appropriately digested. It would have been of extreme interest if the authors had been able to comment if there was an increased rate for women with prolapse utilizing different sexual techniques or acts of pleasure in order to allow their partner to achieve the same rate of partner satisfaction as those without prolapse in view of their altered vaginal anatomy. I recommend this article for all physicians actively involved in prolapse surgery.

Dr. Steven P. Petrou
Associate Professor of Urology
Mayo Clinic College of Medicine
Jacksonville, Florida, USA

Experience with the orthotopic ileal neobladder in women: a mid-term follow-up

Nesrallah LJ, Almeida FG, Dall'Oglio MF, Nesrallah AJ, Srougi M
Federal University of Sao Paulo (UNIFESP-EPM), Sao Paulo, Brazil
BJU Int. 2005; 95: 1045-7

Objective: To report our experience with orthotopic bladder reconstruction in women, as currently the ileal orthotopic neobladder is the diversion of choice for women requiring a bladder substitute at our institution.

Patients and Methods: From February 1995 to March 2001, 29 women with muscle-invasive bladder carcinoma underwent a nerve-sparing radical cystectomy and had an orthotopic ileal neobladder reconstructed. The outcome was evaluated at 2 and 6 months and then yearly, by a clinical history, physical examination, voiding diary, stress test and estimate of functional neobladder capacity.

Results: All patients were followed for at least 14 months (mean 27.5); there were no major complications related to the surgery. The mean (range) neobladder capacity 2 months after surgery was 250 (190-320) mL; at 6 months it increased, remaining stable for the remaining follow-up, at 450 (350-700) mL. Four patients (14%) had nocturnal incontinence and one stress urinary incontinence, associated with using three pads per day. Three patients (10%) required catheterization for a postvoid urinary residual of > 100 mL. Of the 29 patients, seven died with metastatic disease and three from causes unrelated to the reservoir or bladder cancer. Currently, 19 patients (65%) are alive and disease-free, with a mean follow-up of 35 months.

Conclusion: Orthotopic neobladder reconstruction in women, using 40 cm of ileum, is safe and gives high continence and low urinary retention rates. Therefore, it should be advised as the first option in women with good renal function and a tumour-free bladder neck.

Editorial Comment

The authors reviewed their experience with orthotopic ileal neobladder in a population of 29 women. The mean long term follow-up was 27.5 months. The authors point out their results as well as their specific technique and commentary on same. They noted that the bladder capacity stabilized at an appropriate volume at

six months with 14% of patients having nocturnal incontinence, 10% of patients requiring self intermittent catheterization to empty their reservoir and 2.5% of the study group having stress urinary incontinence.

This is an excellent review and instructional presentation by these authors. The paper is extremely strong in the area of voiding dysfunction. The use of a voiding diary and the strict criteria of urinary incontinence should be applauded. The authors' notations on their surgical technique and its positive effects should be carefully read by others performing this type of surgery and reconstruction. The very surgically precise technique including nerve sparing has done nothing but reward these physicians with excellent postoperative results. In addition, their explanation of the use of 40 cm of ileal segment for reconstruction and its positive results should be noted. A reader may question why this group required their patients with a residual > 100 cc to undergo clean intermittent catheterization. Perhaps these patients had recurring urinary tract infection or voiding dysfunction that was not clearly stated. In view of this excellent study group and their notations on the quality of life of patients after cystectomy, the authors if able should consider performing a sexual function questionnaire such as the PISQ and report their results on the sexual habits of this group that have had undergone a major yet successful urinary reconstruction. This may have a great value. The study group had a very low level of postoperative stress urinary incontinence. The authors' opinion on options for this subgroup would be of keen interest in view of other reports describing postoperative catastrophes at the time of sub urethral sling placement (1). Would they consider a trans obturator technique in view of its extra peritoneal position? The ileal conduit has been used for an extended period of time, even much to the surprise of the original describers (2). With excellent publications such as this, ileal neo-bladders will continue to increase in use when appropriate thus potentially one day surpassing ileal conduits as the most frequent urinary diversion in women. If dismissive of the orthotopic ileal neobladder, one should not discount the complications associated without diversion including stomal problems, peristomal dermatitis, stomal ischemia, peristomal hernias as well as stomal prolapse (2).

References

1. Quek ML, Ginsberg DA, Wilson S, Skinner EC, Stein JP, Skinner DG: Pubovaginal slings for stress urinary incontinence following radical cystectomy and orthotopic neobladder reconstruction in women. J Urol. 2004; 172: 219-21.
2. Hinman Jr F: Atlas of Urologic Surgery. Philadelphia, WB Saunders Co, 1989.

Dr. Steven P. Petrou
Associate Professor of Urology
Mayo Clinic College of Medicine
Jacksonville, Florida, USA

PEDIATRIC UROLOGY

Routine voiding cystourethrography is of no value in neonates with unilateral multicystic dysplastic kidney

Ismaili K, Avni FE, Alexander M, Schulman C, Collier F, Hall M
Department of Perinatal and Pediatric Nephrology, Hopital Universitaire des Enfants-Reine Fabiola and Hopital Erasme, Brussels, Belgium
J Pediatr. 2005; 146: 759-63

Objectives: To determine if two successive ultrasound examinations could rule out the presence of clinically significant contralateral anomalies in neonates with multicystic dysplastic kidney (MCDK), thereby avoiding unnecessary voiding cystourethrography (VCUG).