whose symptoms recurred typically underwent TURP or other invasive procedures (48.5%), but some (20%) responded to reintroduction of α-antagonist therapy. Initial use of TUNA followed by TURP when required was not cost-effective; this strategy increased costs by $1,377 per patient over TURP alone.

The authors suggest that TUNA might benefit patients at high surgical risk or with limited life expectancy.

**Original article** Rosario DJ *et al.* (2007) Durability and cost-effectiveness of transurethral needle ablation of the prostate as an alternative to transurethral resection of the prostate when α-adrenergic antagonist therapy fails. *J Urol* **177:** 1047–1051

## Risk of renal failure after bariatric surgery in patients with kidney stones

Jejunoileal bypass was the first widely applied form of surgical treatment for obesity. Hepatic and renal complications—including nephrolithiasis secondary to hyperoxaluria—led to this procedure being banned in the US in 1980. Asplin and Coe have evaluated the prevalence of hyperoxaluria in a group of obese kidney stone formers who had undergone currently used bariatric procedures such as gastric banding and resection.

The authors analyzed urine chemistry data of 132 patients with nephrolithiasis who had undergone bariatric procedures and compared them with data from 27 patients who had undergone jejunoileal bypass, 2,048 non-surgical patients with kidney stones, and 168 healthy individuals.

Rates of urinary oxalate excretion in patients who had undergone bariatric surgery were higher than those in untreated kidney stone formers or healthy individuals (mean values of 83 mg per day vs 39 mg per day and 34 mg per day, respectively; $P<0.001$ for both comparisons), but less than those of patients treated with jejunoileal bypass (102 mg per day; $P<0.001$). Supersaturation of urine with calcium oxalate—the cause of calcium oxalate stone formation—was highest in patients who had undergone bariatric surgery ($12.1 \pm 0.5$ in bariatric surgery group vs $9.0 \pm 0.1$ in untreated stone formers, $7.4 \pm 0.3$ in healthy individuals, and $8.9 \pm 1.1$ in those who had undergone jejunoileal surgery).

Clinicians should be aware of the possibility of patients developing stone disease and renal damage after bariatric surgery.

**Original article** Asplin JR and Coe FL (2007) Hyperoxaluria in kidney stone formers treated with modern bariatric surgery. *J Urol* **177:** 565–569

## High cisplatin dose increases risk of metabolic syndrome in survivors of testicular cancer

Although advances in the treatment of testicular cancer have markedly increased life expectancy, a number of reports have indicated an increased risk of cardiovascular disease in survivors, possibly mediated through the metabolic syndrome. Haugnes *et al.* examined the prevalence of metabolic syndrome in a national follow-up study involving 1,135 survivors of testicular cancer. Median follow-up was 11.1 years.

Participants were classified into the following groups on the basis of treatment regimen: surgery ($n=225$); radiotherapy ($n=446$); chemotherapy with a cumulative cisplatin dose of ≤850 mg ($n=376$); and chemotherapy with a cumulative cisplatin dose of >850 mg ($n=88$). A control cohort of 1,150 men was recruited from the Norwegian population-based Tromsø Study. Metabolic syndrome was defined, in accordance with a modified US National Cholesterol Education Program definition, as the presence of two or more of the following components: obesity; hypertension; hypercholesterolemia; or diabetes.

Metabolic syndrome was documented in 40% of the patient population. The age-adjusted prevalence of metabolic syndrome was markedly higher in the two chemotherapy groups than in the surgery group (odds ratios: 1.48 for cisplatin ≤850 mg and 2.76 for cisplatin >850 mg). Compared with the control cohort, the age-adjusted prevalence of metabolic syndrome was not increased in the total patient population. By contrast, subgroup analysis revealed an odds ratio of 2.1 for metabolic syndrome in the cisplatin >850 mg group compared with the control cohort. On the basis of these results, the authors suggest that clinicians should consider screening cisplatin-treated survivors of testicular cancer for metabolic syndrome.

**Original article** Haugnes HS *et al.* (2007) Components of the metabolic syndrome in long-term survivors of testicular cancer. *Ann Oncol* **18:** 241–248