

hybridization and DNA probes specific for chromosomes 8, 9, 13, 18, 21, X, and Y.

Significantly higher aneuploidy rates were seen in group A compared with group B, and in group B compared with group C, for each of the chromosomes tested. When analyzed on a per patient basis, results for individual chromosomes were too inconsistent to be useful in predictive testing. The authors propose, however, that the total sperm aneuploidy for at least seven chromosomes could be informative. In this study, a total aneuploidy rate of >5% seemed to predict ICSI failure; further studies will be required to determine which chromosomes should be tested and to establish an appropriate threshold value for total sperm aneuploidy.

Original article Petit FM *et al.* (2005) Could sperm aneuploidy rate determination be used as a predictive test before intracytoplasmic sperm injection? *J Androl* 26: 235–241

Combined use of PEER and Endoholder® in laparoscopic renal surgery

The use of laparoscopy in urological surgery is increasingly favored because of its association with reduced postoperative pain, shorter hospital stay and decreased recovery period compared with open surgery. The achievement of adequate exposure is particularly important during laparoscopic procedures because of factors including diminished haptic feedback, loss of three-dimensional visualization and the challenge of maintaining appropriate force and position of the retractor.

Combined use of an adjustable spring-loaded articulating instrument holder (Endoholder®, Codman, Raynham, MA) and the Padron Exposing Endoscopic Retractor (PEER) (J. Jamner Surgical Instruments Inc, Hawthorne, NY) in laparoscopic nephrectomy is described by Rehman *et al.* in a recent paper. Following intracorporeal placement through a 5 mm or 10 mm port, the retractor is secured in place with the Endoholder® and can be used to facilitate hilar, upper and lower pole dissection of the kidney. The paper reports the complication rate for the combined use of the two instruments in renal, adrenal and ureteral laparoscopy as one minor complication in over 200 cases.

The authors conclude that the technique allows safe and effective retraction of the kidney, liver and spleen during laparoscopic surgery, thereby providing reliable exposure in addition to obviating the need for a surgical assistant to perform retraction. They propose that the resultant reduction in operation time might facilitate greater uptake of laparoscopic techniques by urologists.

Original article Rehman J *et al.* (2005) Instrumentation for Laparoscopic Renal Surgery—Padron Endoscopic Exposing Retractor (PEER) and Endoholder: Point of Technique. *Surg Laparosc Endosc Percutan Tech* 15: 18–21

Nonoperative management of bladder rupture

Nonoperative treatment is considered appropriate in the management of bladder rupture following augmentation enterocystoplasty. A study by Osman *et al.* now considers this approach in children with post-traumatic intraperitoneal bladder rupture.

Eight children were treated for intraperitoneal bladder rupture following road traffic accidents or a direct blow to the full bladder. The four patients who presented early in the series (group 1) underwent classic open repair, whereas the next four children (group 2) were treated conservatively, with adequate bladder drainage using a urethral catheter or a suprapubic tube, and percutaneous intraperitoneal tube drain through the iliac fossa.

All the patients in group 2 showed significant improvements in their general condition within a few hours of treatment, none required surgical intervention, and no complications occurred. Mean indwelling catheter duration and mean hospital stay were similar in groups 1 and 2.

Rehman *et al.* conclude that the nonoperative approach described is justified in the initial treatment of children with isolated intraperitoneal bladder rupture, provided that concomitant injuries are ruled out. They advise that improper bladder drainage, prolonged urinary drainage through the peritoneal drain and/or lack of clinical improvement within the first few hours are indications for surgical intervention.

Original article Osman Y *et al.* (2005) Nonoperative treatment of isolated posttraumatic intraperitoneal bladder rupture in children—is it justified? *J Urol* 173: 955–957