GLOSSARY

PEDIATRIC OBJECTIVE PAIN SCALE

A validated (0–10) scale for assessing pain, based on blood pressure, crying, movement, agitation, verbal complaint, and posture; a score of 4 indicates analgesic requirement

palmetto or placebo twice daily. In both groups, LUTS improved slightly over the year, but saw palmetto was no more effective than placebo. Notably, the confidence limits for this finding were very narrow, equivalent to a 1-point difference in AUASI score between the groups. There was no evidence of an effect of saw palmetto on any of the parameters assessed, even for subgroups of men with large and small prostates, or moderate and severe LUTS.

The authors note that saw palmetto has a strong, distinctive odor, but in this study the efficacy of blinding was confirmed by the fact that similar numbers of men in each group believed they were taking the active agent. Inadequate blinding could have biased the results of earlier studies, they suggest.

Caroline Barranco

Original article Bent S *et al.* (2006) Saw palmetto for benign prostatic hyperplasia. *N Engl J Med* 354: 557–566

Risk factors for developing contralateral vesicoureteral reflux after endoscopic therapy

Endoscopic treatment of vesicoureteral reflux (VUR) with injection of bulking agents is gaining in popularity. This technique offers minimal morbidity and few complications compared with open surgical repair, but long-term effects are not yet clear. After noting that ~13% of their patients with endoscopically treated unilateral VUR developed new, contralateral VUR within a mean of 12 weeks of treatment (the most common post-treatment complication), a US team found that girls aged <5 years might be a particularly high-risk group for development of new, contralateral VUR. Initial bilateral treatment could, therefore, be considered for such patients.

Elmore *et al.* retrospectively evaluated the medical records of 96 girls and 30 boys aged 7 months to 20 years (mean age 4.8 years) who were endoscopically treated for unilateral VUR. They found that 21% of girls aged <5 years (13 of 62 patients) developed new, contralateral VUR after treatment, compared with 6.3% (4 of 64) of the remaining patients. This association, they suggest, warrants investigation in prospective studies.

The incidence of new, contralateral VUR was similar when patients who received only

one preoperative voiding cystourethrogram were compared with those who received several, suggesting that the patients did not have unrecognized pre-existing contralateral VUR—voiding cystourethrography is known to have a high false-negative rate. The authors hypothesize that the development of new, contralateral VUR is caused by, or perhaps accelerated by, endoscopic correction of VUR.

Caroline Barranco

Original article Elmore JM *et al.* (2006) New contralateral vesicoureteral reflux following dextranomer/hyaluronic acid implantation: incidence and identification of a high-risk group. *J Urol* 175: 1097–1101

Extravesical surgery benefits patients with unilateral vesicoureteral reflux

Surgical ureteral reimplantation remains the 'gold standard' of treatment for vesicoureteral reflux (VUR), with extremely high success rates. While there is consensus that bilateral VUR is best treated by intravesical surgery, the case is less clear-cut in unilateral VUR. A European team, therefore, prospectively compared intravesical (Politano–Leadbetter) and extravesical (Lich–Gregoir) techniques for ureteral reimplantation, in children with indications for surgical repair of unilateral VUR. They found that the extravesical technique consistently outperformed the intravesical technique: it was effective and simple to perform, and was associated with less postoperative pain, less analgesic use and a shorter hospital stay.

The 44 children (29 girls, 15 boys) were randomly assigned to either intravesical or extravesical surgery. Hematuria lasted >4 days in the intravesical group, but was absent in the extravesical group. Compared with patients who underwent intravesical surgery, those who underwent extravesical surgery experienced shorter operative times (55–75 min versus 65–90 min), fewer bladder spasms (13.6% versus 45.5%), less pain (pediatric objective pain scale score 4.2 versus 5.6) and required less postoperative analgesia. Postoperative voiding dysfunction and development of contralateral VUR were comparable in the two groups.

Controversy remains over the value of direct observation of both ureteral openings during intravesical repair of unilateral VUR. New, contralateral VUR commonly resolves