New procedure for endoscopic decompression of ectopic ureterocele shows promise

Endoscopic decompression is preferred to open surgery as first-line therapy for children with ectopic ureterocele in some centers because the endoscopic procedure is easier to perform and is associated with minimal morbidity. Reliable data that compare the success of different endoscopic treatments for ectopic ureterocele are, however, lacking. Kajbafzadeh and colleagues have reviewed data from 46 children treated at their center; during a 10 year period (1995–2005) their standard endoscopic treatment evolved from ureterocele incision (unroofing) to double puncture, followed by insertion of a Double-J® (Cabot Technology Corporation, Santa Barbara, CA) stent and intraureterocele fulguration. Their current procedure also includes endoscopic subureteral injection of tricalcium phosphate ceramic to mimimize postoperative vesicoureteral reflux (VUR).

All 46 children (mean age 2.3 years, 17 male) had duplex collecting systems and ectopic ureteroceles. Follow-up ranged from 1 to 9 years. Treatment was completely successful in 0%, 25% and 33% of the patients treated with ureterocele incision ($n = 4$), single ureterocele puncture ($n = 4$), or single puncture with insertion of Double-J® stent ($n = 9$), respectively. Ureterocele double-puncture and intraureterocele fulguration ($n = 29$) was completely successful in 90% of patients. Of the 17 who underwent common endoscopic treatments, 6 patients developed new-onset VUR in the ureterocele moiety; in the double puncture group ($n = 29$) no patient developed VUR in the ureterocele moiety.

The authors suggest that the intraureterocele fulguration used in their double-puncture procedure encourages layer adhesion and creates muscular support that prevents postoperative VUR.

Original article Kajbafzadeh A *et al.* (2007) Evolution of endoscopic management of ectopic ureterocele: a new approach. *J Urol* **177:** 1118–1123

Adjuvant, intravesical BCG therapy is cost-effective

Adjuvant, intravesical bacillus Calmette–Guérin (BCG) therapy reduces the risk of recurrence and progression of superficial bladder cancer, but confers a considerable risk of local and systemic complications. BCG therapy is, therefore, usually offered only to patients with high-risk bladder cancers. Uchida and colleagues suggest that the decision to use BCG therapy rests on this balance between efficacy and benefit; they therefore compared the outcomes of various intravesical bladder-cancer therapies.

The authors evaluated 138 patients with superficial bladder tumors initially treated by transurethral resection at a single Japanese center (mean follow-up 86 months). Overall 5-year and 10-year survival was 38% and 29%, respectively. Patients who received intravesical chemotherapy (mitomycin C, doxorubicin or pirarubicin), whether immediately after surgery or after 2 weeks' delay, had similar outcomes to those who did not. By contrast, the 35 patients who received intravesical BCG therapy (mean 8 instillations, range 1–20) had markedly improved recurrence-free survival at 5 years—despite their initially higher-grade tumors—compared with those who did not (78% versus 28%). Local adverse effects of BCG therapy (pain and cystitis) were controlled within 3 days by NSAIDs, antibiotics, or anticholinergic medication. The mean cost of BCG therapy was US$1,936 per patient, and its cost-effectiveness ratio was US$525 per recurrence-free year.

The authors conclude that intravesical BCG can be recommended for most patients with bladder cancer, except those with a history of complications after BCG therapy, an uncontrolled urinary tract infection, or immunodeficiency.

Original article Uchida A *et al.* (2007) Intravesical instillation of bacille Calmette–Guérin for superficial bladder cancer: cost-effectiveness analysis. *Urology* **69:** 275–279

The goal of therapy for ED should be maximal erection hardness

Although phosphodiesterase 5 (PDE5) inhibitors are a highly effective and easy-to-use treatment for erectile dysfunction (ED), many men discontinue therapy. Inadequate education and follow-up of patients contribute to high discontinuation rates, so clinical practice guidelines emphasize that men with ED who receive PDE5 inhibitors should be monitored to assess their response to treatment. Current guidelines do not define this response; consequently, many men with ED are managed without clear treatment goals.