TENS might be effective in children with treatment-refractory overactive bladder

Electrical neurostimulation has demonstrated good results when used as a primary therapy in studies of children with overactive bladder (OAB); however, this treatment modality has not been specifically evaluated in children with OAB who do not show symptom improvement with behavioral and pharmacological therapy. Malm-Buatsi and colleagues retrospectively reviewed the medical charts of children with pharmacotherapy-refractory OAB who were treated with transcutaneous electrical nerve stimulation (TENS).

The study included data from 18 children (mean age 9.4 years, range 5–14 years; 13 girls), of whom 15 had incontinence (mean 3.2 ± 2.1 daytime accidents) and 3 had only increased urgency or frequency. Ten patients continued to use anticholinergic drugs throughout the study. TENS was performed for 20 min twice daily for a mean of 8 ± 7 months, and children were followed up for a mean duration of 13 ± 9 months from the initiation of treatment.

Of the 15 patients with incontinence, 2 (13%) became dry (fully continent), 9 had significantly improved continence (at least 50% reduction in daytime accidents) and 4 (27%) had no improvement by the last follow-up visit. Of 12 patients with marked urinary frequency, 8 (67%) reported subjective improvement, and 1 (14%) of 7 patients with nocturnal enuresis became dry.

Despite the limitations of this study, the authors concluded that TENS was well tolerated and resulted in an improvement rate of 73% after 13 months' follow-up. Randomized, controlled trials are warranted to confirm these findings and identify factors predictive of a good response to this treatment.

Original article Malm-Buatsi E *et al.* (2007) Efficacy of transcutaneous electrical nerve stimulation in children with overactive bladder refractory to pharmacotherapy. *Urology* **70:** 980–983

Serial treatment with antiangiogenic agents for patients with metastatic RCC

Patients with metastatic renal cell carcinoma (RCC) that progresses after initial treatment with an antiangiogenic agent receive sorafenib or sunitinib as second-line antiangiogenic therapy; however, evidence for the clinical benefit of such second-line treatment is lacking. Tamaskar and colleagues, therefore, conducted a retrospective study to evaluate the efficacy and safety of sorafenib or sunitinib in 30 patients with metastatic RCC refractory to prior antiangiogenic therapy.

The patients (24 male) received sorafenib ($n = 14$) or sunitinib ($n = 16$) after therapy with at least one of thalidomide, lenalidomide, volociximab, bevacizumab, AG13736, sunitinib or sorafenib (no patient was re-treated with the same agent). Treatment efficacy was assessed by Response Evaluation Criteria for Solid Tumors (RECIST), total tumor burden change, objective response status and time to progression.

Tumor shrinkage occurred in 10 of the 14 patients who received sorafenib and 13 of the 16 patients who received sunitinib. Furthermore, a RECIST partial response was observed in one and nine patients in the sorafenib and sunitinib groups, respectively. For the entire cohort, median time to progression was 10.4 months. The toxicity profiles of the two agents were similar to those reported in other settings.

Tumor shrinkage after second-line therapy suggests that similar antiangiogenic agents have slightly different antitumor mechanisms; however, because of the small sample size and because not all first-line therapies assessed are currently in common use for RCC, the authors recommend prospective clinical trials be done to confirm their findings.

Original article Tamaskar I *et al.* (2008) Antitumor effects of sunitinib or sorafenib in patients with metastatic renal cell carcinoma who received prior antiangiogenic therapy. *J Urol* **179:** 81–86

Antiseptic lavage reduces infection of inflatable penile prostheses

Men with inflatable penile prostheses (IPPs) often require revision surgery, which is associated with an elevated risk of infection. Use of antibiotic-coated IPPs has helped to reduce the infection rate during primary surgery, but has had less effect on infection rates in subsequent procedures. To improve understanding of the sources of IPP infection, Henry *et al.*