Temsirolimus, Interferon Alfa, or Both for Advanced Renal-Cell Carcinoma


Abstract printed in J Urol 2008; 179: 497

Effects of Sorafenib on Symptoms and Quality of Life: Results From a Large Randomized Placebo-Controlled Study in Renal Cancer

R. Bukowski, D. Cella, K. Conde and B. Escudier; Sorafenib TARGETs Clinical Trial Group, CCF Taussig Cancer Center, Cleveland Clinic, Cleveland, Ohio


Abstract printed in J Urol 2008; 179: 1319

Editorial Comment: In the last 1 to 2 years there have been a number of new agents used to treat renal cell carcinoma. As knowledge is gained of the changes in the metabolism and molecular pathways of renal cell carcinoma, agents to block some of these pathways have been developed. Temsirolimus, a specific inhibitor of the mammalian target of rapamycin kinase; Sorafenib; and other compounds interfere with the hypoxia inducible factor and vascular endothelial growth factor pathways. Hudes et al demonstrated improved overall survival in patients with metastatic renal cell carcinoma treated with temsirolimus compared to those treated with interferon-α. Sorafenib and sunitinib have had favorable effects on metastatic renal cell carcinoma as well. Bukowski et al demonstrated that overall quality of life can actually be well maintained with some of these agents. Major change is occurring in our understanding and treatment of metastatic renal cell carcinoma.

Intermediate Comparison of Partial Nephrectomy and Radiofrequency Ablation for Clinical T1a Renal Tumours

J. M. Stern, R. Sventek, S. Park, M. Hermann, Y. Lotan, A. I. Sagalowsky and J. A. Cadeddu, Department of Urology, University of Texas Southwestern Medical Center, Dallas, Texas


Abstract printed in J Urol 2008; 180: 892
In Vitro Assessment of the Efficacy of Thermal Therapy in Human Renal Cell Carcinoma

L. P. Walsh, J. K. Anderson, M. R. Baker, B. Han, J. T. Hsieh, Y. Lotan and J. A. Cadeddu, Department of Urology, University of Texas Southwestern Medical Center, Dallas, Texas


Abstract printed in J Urol 2008; 180: 893

Editorial Comment: Radio frequency ablation has been reported to have less efficacy than cryotherapy or partial nephrectomy in some series. As a result it has been viewed with caution as a minimally invasive technique for destruction of small renal tumors. The Southwestern Medical Center Group at the University of Texas investigated the use of radio frequency ablation and there are some important considerations. For example when 65°C is obtained 99% or greater cell death occurs within 8 minutes. Temperatures greater than 70°C are lethal to cell lines. If only 55°C is obtained, 30 minutes are required for cell death. Greater understanding of this technology is important. The 3-year actuarial followup in 1 clinical series shows oncologic outcomes comparable to those of partial nephrectomy.

Dietary Risk Factors for Kidney Cancer in Eastern and Central Europe


Abstract printed in J Urol 2008; 180: 135

Editorial Comment: There is increasing interest in diet affecting renal tumors. This study provides evidence that diet may have a role in the development of kidney cancer. There is a protective association with a high vegetable intake. There appeared to be increased risk with consumption of preserved vegetables, as well as consumption of milk and red meat.

Fray F. Marshall, M.D.

UROLOGICAL ONCOLOGY: BLADDER, PENIS AND URETHRA CANCER, AND BASIC PRINCIPLES OF ONCOLOGY

The Association Between Extent of Lymphadenectomy and Survival Among Patients With Lymph Node Metastases Undergoing Radical Cystectomy

J. L. Wright, D. W. Lin and M. P. Porter, Department of Urology, University of Washington School of Medicine, Seattle, Washington

Cancer 2008; 112: 2401–2408.

Abstract printed in J Urol 2008; 180: 1946

Hospital Lymph Node Counts and Survival After Radical Cystectomy

B. K. Hollenbeck, Z. Ye, S. L. Wong, J. E. Montie and J. D. Birkmeyer, Michigan Surgical Collaborative for Outcomes Research and Evaluation, University of Michigan, Ann Arbor, Michigan

Cancer 2008; 112: 806–812.

Abstract printed in J Urol 2008; 180: 1946
Editorial Comment: Surgical quality is a tough nut to crack. For several cancers, the application of lymphadenectomy has been proposed as a quality indicator. There is little debate that there is an association between a more extensive pelvic lymph node dissection (PLND) and survival after cystectomy for bladder cancer. The causal role for the PLND as the reason why patients live longer has been more difficult to prove because the appropriate studies that may control for hospital and patient factors have not been conducted. Nevertheless, the observation that possibly 40% to 50% of patients undergoing cystectomy do not have a lymph node dissection that yields sufficient nodes for staging information and for a therapeutic benefit is an indictment of our limited understanding of practice patterns of surgeons.\(^1\)

If a PLND is not done, is it because the physician does not believe there is a benefit, is not comfortable with the technical aspects or recognizes patient factors that may preclude it? From a surgical quality perspective, we need to know the answer. If the urologist does not believe a PLND is worthwhile, then education on the data is the solution; if the urologist is reluctant to do the PLND because of technical skill factors, then surgical technique instruction or education on the rationale for referral of the patient is needed; if there are patient factors contributing to the difficulty of the PLND, then omission of a node dissection may in fact reflect good clinical judgment. Data to understand the reasoning behind practice patterns are not available from administrative data sets. Information on patient factors would be available from an explicit chart review for comorbidity and the operative report for intraoperative processes but such an effort is labor-intensive, expensive, potentially more subjective and unlikely applicable to the emerging pay–for-performance system.

James E. Montie, M.D.

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**UROLOGICAL ONCOLOGY: PROSTATE CANCER**

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**Five-Alpha-Reductase Inhibitors for Prostate Cancer Prevention**

T. J. Wilt, R. Macdonald, K. Hagerty, P. Schellhammer and B. S. Kramer, General Internal Medicine, Veterans Administration Medical Center, Minneapolis, Minnesota


Abstract printed in J Urol 2008; 180: 1360

Editorial Comment: This article provided a startling revelation. In the Prostate Cancer Prevention Trial (PCPT) finasteride had no significant effect on reducing the risk of cancer in men who underwent a biopsy because of an increased prostate specific antigen (PSA) or abnormal digital rectal examination, the setting in which it would be used for prevention. Its major effect was not preventing cancer, but rather preventing men from undergoing a biopsy because it lulled them into a false sense of security by lowering the PSA. However, that does not seem to matter any more according to an article published by Gina Kolata on the front page of the Sunday New York Times, June 15, 2008.\(^1\)

Kolata reports that the major effect of finasteride is to reduce “the risk of suffering from side effects of treatment for prostate cancer that most often would be better undiscovered and untreated.” At the 2008 annual meeting of the American Urological Association one of my associates heard that since urologists were not convinced to use finasteride for prostate cancer prevention, internists and general physicians were going to be pursued. However, patients and general physicians will not realize that finasteride will only lower PSA levels. Can you imagine what may happen when general physicians start prescribing finasteride thinking they are preventing the disease without understanding that these men must be monitored closely, because if the PSA begins to go up the risk of having cancer is 3-fold higher than in men without an increase in PSA and the risk of high grade disease is 6-fold higher?\(^2\) No one will know this because the warnings in the package insert are out of date.

If men do not want to know if they have prostate cancer, they should just avoid PSA testing. I have no idea why this point was not made loud and clear in the New York Times. By not undergoing PSA testing they will save $730 a year (the cost of finasteride) and will avoid side effects from the drug. If men want to prevent prostate cancer, finasteride is the last thing they
should take because all that will do is prevent them from knowing they may have lethal disease until it may be too late to cure.

Patrick C. Walsh, M.D.


UROLITHIASIS, ENDOUROLOGY AND LAPAROSCOPY

Urolithiasis: 2008

Physiology of Acid-Base Balance: Links With Kidney Stone Prevention

M. L. Halperin, S. Cheema Dhadli and K. S. Kamel, Renal Division, St. Michael's Hospital, University of Toronto, Toronto, Ontario, Canada

Semin Nephrol 2006; 26: 441–446.

Abstract printed in J Urol 2008; 179: 575

Bone Mineral Density Measurement in Patients With Recurrent Normocalciuric Calcium Stone Disease

V. Tugcu, E. Ozbek, B. Aras, B. Ozbay, F. Islam and A. I. Tasci, Urology, Bakirkoy Research and Training Hospital, Istanbul, Turkey


Abstract printed in J Urol 2008; 179: 1983

Forced Versus Minimal Intravenous Hydration in the Management of Acute Renal Colic: A Randomized Trial


Abstract printed in J Urol 2008; 179: 576

Editorial Comment: Surveying the past year, I have come away with 3 aspects of nonoperative management of urolithiasis. The first 2 points have to do with the realization that stone disease is not an isolated event, but rather a manifestation of other underlying metabolic disorders. The first aspect is the growing realization that an acid urine or hypokalemia is problematic and potassium citrate therapy should be considered. The excellent review by Halperin et al focuses on the precipitation of calcium phosphate on the basolateral membrane of the thin limb of the loop of Henle, and how administration of potassium citrate could possibly decrease this occurrence by replenishing the body’s potassium stores. The second aspect is the importance of realizing that abnormalities in calcium metabolism impact on urolithiasis and bone metabolism. Indeed, upwards of 65% of patients with normocalciuric calcium stone disease have osteopenia, and 11% have osteoporosis. Hence, a baseline bone mineral densitometry may well be an important step in the initial evaluation of the stone forming patient. The third aspect is the shibboleth shattering work from Duke University showing that the use of a “forced diuresis” in the acute stone patient is of no value and that alpha blocker is the best therapy.
Endourology: 2008

**Long-Term Success of Antegrade Endopyelotomy Compared With Pyeloplasty at a Single Institution**


Abstract printed in J Urol 2008; 179: 985

**Management of Ureteropelvic Junction Obstruction**

G. S. Gerber and S. S. Acharya, Section of Urology, University of Chicago, Chicago, Illinois


No abstract

**Progression of Disease Despite Good Endoscopic Local Control of Upper Tract Urothelial Carcinoma**

A. Z. Weizer, G. J. Faerber and J. S. Wolf, Jr., Department of Urology, University of Michigan Hospital, Ann Arbor, Michigan

Urology 2007; 70: 469–472.

Abstract printed in J Urol 2008; 180: 139

**Retrograde Ureteral Stents for Extrinsic Ureteral Obstruction: Nine Years’ Experience at University of Michigan**


Abstract printed in J Urol 2008; 180: 629

Editorial Comment: Two caveats and a helpful realization highlighted the general endourology literature this year. First and foremost in my mind was the sobering long-term study from the Mayo Clinic regarding endopyelotomy and pyeloplasty. While articles have been published stating that 5 or as short as 2-year followup is all that is needed, these authors showed that even at 10 years failures of operative therapy were occurring such that after endopyelotomy or pyeloplasty the success rates at 3 and 10 years were 64% and 41% vs 85% and 75%, respectively. Of note, these success rates are likely somewhat inflated as they were based largely on excretory urograms and anecdotal office data rather than on the more stringent criteria of a normal renal scan (ie preserved renal function and t½ 10 minutes or less) and an analog pain scale (ie 2 or less). However, this work along with other long-term studies clearly establishes the inferior results of endopyelotomy to pyeloplasty. With the advent of laparoscopic/robotic pyeloplasty, endopyelotomy appears to be on its way out.

The second warning is by Weizer et al that “even a white rose casts a dark shadow” as they reported 2 cases of low grade upper tract transitional cell cancer in which endourologically complete resection was later followed by invasive and metastatic disease. Their clarion call to use endourological resection only when there is an “imperative indication” (ie solitary kidney or renal insufficiency) is advice well given. As with therapy for ureteropelvic junction obstruction, the advent of laparoscopy/robotic surgery has decreased the morbidity of the procedure to the point where a percutaneous/ureteroscopic approach is not as strongly counterbalanced as it had been when the only alternative was an open procedure.
Lastly, there has been quite a bit of attention to the patient with cancer and ureteral obstruction. Early work with stents was not satisfactory, leading many of these patients to nephrostomy tube drainage with its attendant negative impact on body image and quality of life, just at a time when life itself is so limited. Thus, it is heartening to read of advances in stent materials and technology which can overcome malignant obstruction in upwards of 81% of patients (6Fr or 7Fr Percuflex® stents). If this fails, then either double stents (ie 2, 6Fr) can be placed in 1 ureter or the recently described metal alloy stent (ie Resonance® stent) can be inserted.

**Laparoscopy/Robotics: 2008**

**da Vinci Robot Error and Failure Rates:**
*Single Institution Experience on a Single Three-Arm Robot Unit of More Than 700 Consecutive Robot-Assisted Laparoscopic Radical Prostatectomies*

Abstract printed in J Urol 2008; 180: 173

**Incidence of Local Recurrence and Port Site Metastasis After Laparoscopic Radical Nephroureterectomy**

Abstract printed in J Urol 2008; 180: 531

**A Sealed Laparoscopic Nephroureterectomy: A New Technique**
A. Tsivian, S. Benjamin and A. A. Sidi, Department of Urologic Surgery, Wolfson Medical Center, Holon and Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel

Abstract printed in J Urol 2008; 180: 1944

**Use of Bone Wax During Laparoscopic Renal Ablative Procedures: Optimizing Port Utilization and Reducing Tract-Site Exposure**
K. C. Zorn, O. N. Gofrit and A. L. Shalhav, Section of Urology, University of Chicago Pritzker School of Medicine, Chicago, Illinois

Abstract printed in J Urol 2008; 180: 894
Lapra-Ty Holding Strength and Slippage With Various Suture Types and Sizes

K. J. Weld, J. Arzola, C. Montiglio, A. C. Bush and R. D. Cespedes, Department of Urology, Wilford Hall Medical Center, Lackland Air Force Base, Texas


Abstract printed in J Urol 2008; 180: 895

Editorial Comment: Robotic assisted laparoscopic surgery continues to grow across the United States. Recent data show that the majority of radical prostatectomies last year were performed robotically rather than by the standard open approach. A concern with the robot, especially since many of the surgeons performing robotic procedures are not skilled laparoscopic surgeons, is the reliability of the robot itself since its failure in many instances would necessitate a standard open procedure. This question has now been well answered with a failure rate of only 0.4%. Of note, if the system is checked routinely before initiating a procedure, the subsequent need for conversion can largely be avoided. In the reported series of 700 consecutive cases by Zorn et al no conversions were necessary.

One of the most challenging laparoscopic cases is nephroureterectomy for upper tract transitional cancer. The most controversial aspect of this procedure is the method of obtaining a distal ureteral cuff with suggestions ranging from standard open to transurethral resection of the ureteral tunnel. It would appear that while simple, the practice of stapling the cuff of the bladder is associated with a higher incidence of recurrence (15% vs 2%), and so while easier than an open resection, it is not as effective.

I have taken exception to this stance and have continued to use the stapler but only after extensive dissection of the bladder cuff and under transurethral endoscopic guidance. This does add to the overall operating time and is not 100% certain of taking a large cuff of bladder with the ureteral orifice. Accordingly, the recent report of using the LigaSure™ to secure the bladder cuff is of interest. This approach is quick and sure, and leaves no staples behind while presumably killing all cells within the expanse of the seal. Long-term followup of this approach is still needed to corroborate its usefulness but at first blush, it is an appealing solution.

What can make your life easier in the operating room? Two simple options come to mind, the first of which is the use of bone wax to seal leaky ports or help seal a 5 mm port around a smaller biopsy device or needle ablation probe. The second option is the use of LapraTy clips (Ethicon Inc., Cincinnati, Ohio) instead of tying knots. These absorbable clips are specifically designed to be attached to suture and hold firmly to Vicryl from 0 to 4-zero size. They are helpful in all suturing situations and have largely replaced knot tying in our operating room.

New Technology: 2008

Robotic NOTES (Natural Orifice Transluminal Endoscopic Surgery) in Reconstructive Urology: Initial Laboratory Experience

G. P. Haber, S. Crouzet, K. Kamoi, A. Berger, M. Aron, R. Goel, D. Canes, M. Desai, I. S. Gill and J. H. Kaouk, Section of Laparoscopic and Robotic Surgery, Glickman Urological and Kidney Institute, Cleveland Clinic, Cleveland, Ohio


Abstract printed in J Urol 2008; 180: 2513

Editorial Comment: NOTES (natural orifice transluminal endoscopic surgery)—what dreams may come. The appeal of completely nonincisional surgery continues to grow in the academic realm in many forms from single incision laparoscopic surgical (SILS) procedures, to NOTES assisted procedures, and on to pure NOTES via combined access through hollow visci. NOTES laboratory work and SILS clinical cases abound in the literature as various groups struggle to perfect an array of instrumentation and procedural approaches to further reduce the traditional abdominal incision to the point of extinction. Whether these efforts will lead to an entirely new form of surgery awaits practical application and in-depth clinical evaluation. In this milieu
of enthusiasm the sobering words of Gertrude Stein ring true: “A difference to be a difference must make a difference.”

Ralph V. Clayman, M.D.

RENAL TRANSPLANTATION AND RENOVASCULAR HYPERTENSION

HLA-Mismatched Renal Transplantation Without Maintenance Immunosuppression


Abstract printed in J Urol 2008; 180: 642

Editorial Comment: Immunosuppressive minimization is a major trend in transplantation. The ultimate goal is donor specific tolerance. This article describes a tolerogenic protocol using combined bone marrow and kidney transplantation in HLA mismatched donor recipient pairs with reasonable outcomes. This is quite an achievement. While this is not ready for widespread use just yet, these results were promising.

David A. Goldfarb, M.D.

MALE INFERTILITY

Mouse and Human Spermatozoa Can Be Freeze-Dried Without Damaging Their Chromosomes

H. Kusakabe, R. Yanagimachi and Y. Kamiguchi, Department of Biological Sciences, Asahikawa Medical College, Asahikawa, Japan


Abstract printed in J Urol 2008; 180: 1066

Freeze-Dried Primate Sperm Retains Early Reproductive Potential After Intracytoplasmic Sperm Injection

L. G. Sanchez-Partida, C. R. Simerly and J. Ramalho-Santos, Monash Institute of Medical Research, Monash University, Clayton, Victoria, Australia


Abstract printed in J Urol 2008; 180: 2586

Editorial Comment: Cryopreservation revolutionized fertility care, as clinicians could more carefully control the timing of reproductive treatments. Freezing sperm is substantially easier and more successful than freezing eggs, and those clinicians involved in treating infertile couples use frozen sperm in a variety of therapeutic settings. Yet cryopreservation requires deep cold, either at ~80°C or in liquid nitrogen at ~196°C. Keeping sperm so cold requires equipment, energy and space, all of which are premiums in patient care settings. Thus, a remarkable achievement would be the ability to store sperm at ambient temperature while maintaining its fertilizing capability and nucleic acid integrity.

In 2008 Kusakabe et al reported “proof of principle” results demonstrating laboratory methods that allowed mouse and human sperm to be freeze-dried while maintaining chromosomal
integrity. Sanchez-Partida et al reported outcomes of intracytoplasmic sperm injection using freeze-dried rhesus monkey sperm, observing reasonable fertilization rates (73% for freeze-dried compared to 63% fresh) and zygote cleavage. While no development was noted beyond the 8 to 16-cell stage, indicating that work still remains to be done, the day seems soon when small packages at room temperature easily transported by patients will contain freeze-dried sperm.

Sperm Aneuploidy Frequencies Analysed Before and After Chemotherapy in Testicular Cancer and Hodgkin’s Lymphoma Patients

H. G. Tempest, E. Ko, P. Chan, B. Robaire, A. Rademaker and R. H. Martin, Department of Medical Genetics, University of Calgary, Calgary, Alberta Canada


Abstract printed in J Urol 2008; 180: 1068

Editorial Comment: Urologists treat all aspects of male reproductive organs, from testis cancer to male fertility. While doctors and their male patients are naturally focused on lifesaving treatments when testis cancer strikes, men are often deeply concerned with fathering children. Sperm may be frozen before chemotherapy but this practical approach to preserving male reproductive potential is not uniformly applied. A common question posed by physicians and patients alike after chemotherapy for testis cancer is when is it safe to initiate conception with ejaculated sperm. In 2008 Tempest et al reported sperm aneuploidy before and after chemotherapy for testis cancer and Hodgkin’s lymphoma, and observed that increased aneuploidy persisted in some chromosomes for up to 2 years. While all DNA change subsequent to chemotherapy is not necessarily manifest in aneuploidy, these results describe a window in which reproduction may be risky. Thus, urologists may reasonably counsel patients that for at least 2 years after chemotherapy for testis cancer and Hodgkin’s lymphoma, genetic damage may persist in sperm that might affect offspring.

Craig Niederberger, M.D.

Erectile Dysfunction Predicts Coronary Heart Disease in Type 2 Diabetes

R. C. Ma, W. Y. So, X. Yang, L. W. Yu, A. P. Kong, G. T. Ko, C. C. Chow, C. S. Cockram, J. C. Chan and P. C. Tong, Department of Medicine and Therapeutics, Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, Hong Kong, SAR, China

J Am Coll Cardiol 2008; 51: 2045–2050.

Abstract printed in J Urol 2008; 180: 2133

Erectile Dysfunction as a Predictor of Cardiovascular Events and Death in Diabetic Patients With Angiographically Proven Asymptomatic Coronary Artery Disease: A Potential Protective Role for Statins and 5-Phosphodiesterase Inhibitors

C. Gazzaruso, S. B. Solerte, A. Pujia, A. Coppola, M. Vezzoli, F. Salvucci, C. Valenti, A. Giustina and A. Garzaniti, Cardio-Metabolic Unit and Centre for Applied Clinical Research, Clinical Institute Beato Matteo, Hospital Group San Donato, Vigevano, Italy

J Am Coll Cardiol 2008; 51: 2040–2044.

Abstract printed in J Urol 2008; 180: 2133
Editorial Comment: Erectile dysfunction (ED) is now recognized as an early sign of cardiovascular disease.\textsuperscript{1–3} This finding places great emphasis on erectile dysfunction as a disease entity beyond the sexual dysfunction realm. As a consequence, the diagnosis of ED now carries greater import.

Extending this concept to diabetic patients, Ma et al and Gazzaruso et al demonstrate that ED predicts coronary heart disease in type 2 diabetics. Gazzaruso et al suggest that ED is a powerful predictor of cardiovascular morbidity and mortality in diabetic patients with silent coronary artery disease (CAD), and that treatment with statins and type 5 phosphodiesterase inhibitors might reduce the occurrence of a major adverse cardiac event (MACE) among diabetic patients with CAD and ED. A total of 291 type 2 diabetic men with angiographically documented silent CAD were recruited for this study. Erectile dysfunction was assessed by the International Index of Erectile Function-5 questionnaire. During a followup period of 47.2 ± 21.8 months (range 4 to 82) 49 patients experienced MACE. The difference in ED prevalence between patients with and without MACE was significant (61.2% vs 36.4%, \( p = 0.001 \)). Cox regression analysis showed that ED predicted MACE (HR 2.1, 95% CI 1.6 to 2.6, \( p < 0.001 \)).

Thus, the urologist (as well as all clinicians) should ask the patient about ED. Uncovering ED in the diabetic patient seems to carry added significance with respect to cardiovascular disease morbidity.

These are extremely important data that should become incorporated into the urologists’ vernacular. The HR in survival analysis is the effect of an explanatory variable on the hazard or risk of an event. Consider the hazard ratio to be an estimate of relative risk. The HR ratio of 2.1 suggests that the finding of ED in this patient population is quite significant. Finally, the statement by Gazzaruso et al that “the treatment with statins and 5-PDE inhibitors might reduce the occurrence of MACE among CAD diabetic patients with ED” is purely speculative at this time.

Allen D. Seftel, M.D.


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**PEDIATRIC UROLOGY**

**Impact of Patient Age on Distal Hypospadias Repair: A Surgical Perspective**

A. E. Perlmutter, R. Morabito and W. F. Tary, Division of Urology, West Virginia University School of Medicine, Morgantown, West Virginia


*Abstract printed in J Urol 2008; 179: 309*

Editorial Comment: The article illustrates the evolution towards earlier and earlier surgery for hypospadias. The authors present a series of boys who underwent repair at ages 4 to 6 months. These young boys had considerably fewer complications following distal hypospadias repair than older boys. Fetal surgeons have long marveled at the minimal or absent scarring following prenatal surgery. Anesthetic risks in term infants older than 6 weeks are minimal at centers devoted to pediatric care. Most of us are now considering operating on babies at relatively young ages, even for more elective problems such as hypospadias.

**Age at Surgery for Undescended Testis and Risk of Testicular Cancer**

A. Pettersson, L. Richiardi, A. Nordenskjold, M. Kajser and O. Akre, Clinical Epidemiology Unit, Department of Medicine, Karolinska Institutet, Stockholm, Sweden


*Abstract printed in J Urol 2008; 179: 1574*
Editorial Comment: The authors examined a large cohort of Swedish men treated for cryptorchidism and followed for a mean of 12 years. The relative risk of testicular cancer among those who underwent orchiopexy before age 13 years was 2.23 compared with the Swedish general population. For those treated at age 13 years or older the relative risk was 5.40, or more than double. This convincing report shows the importance of early diagnosis and early orchiopexy in patients with cryptorchidism.

Douglas A. Canning, M.D.