Correspondence

Antenatally detected pelvi-ureteric junction obstruction: concerns about conservative management

Sir,

The authors [1] describe the treatment outcome in patients with unilateral hydronephrosis consistent with PUJ obstruction (18 patients underwent unilateral nephrectomy). Thirty-three required an early pyeloplasty because of a differential function (DF) of 40–20%. Forty-nine patients with a DF of >40% were allocated to conservative follow-up (39 successfully) but 10 had a delayed pyeloplasty because of decreasing DF (eight patients) or symptoms (two patients).

The authors give great prominence to the observation that DF improved less after delayed than after early pyeloplasty. It is not clearly stated if they mean that early would be a better treatment than delayed pyeloplasty but it may be strongly surmised. The important point is not the degree of increase in DF but whether function is restored or not. In this study, the final DF with early pyeloplasty was 42.3% (range 37–47) and with delayed 42.0% (range 38–46), i.e. identical. Thus it cannot be construed that one treatment is the better than the other.

The mean (range) difference in improvement of 13.9% (9–17) vs 9.1% (4–13) may be caused by different ages at pyeloplasty (as Mr Malone indicates in the accompanying Editorial comment and if the ages differed; it is unclear if the values in Table 1 are for age at follow-up or at surgery). Another explanation could be that the lower the preoperative DF the higher the postoperative DF; this may be corroborated by the respective values stated (28.3% with early pyeloplasty and 32.9% with delayed, the final values nevertheless becoming identical).

The statement that an anteroposterior diameter (APD) of >2 cm is ominous seems to be without support. Again, in Table 1 it is unclear whether the APDs are the initial or final values; the same is true in Figure l and APD is referred to twice in the results with similar uncertainty.

The papers referred to in the discussion are a poor choice; Chevalier's method (reference 7) to create an obstruction is unphysiological, as indicated by the intra-ureteric pressure. References 8–14 are badly written, often sloppy, misleading and too old; King *et al.* compared newborn with 5–21-year-old patients and furthermore they changed their views on conservative treatment some years ago. Mayor *et al.* include nine patients with VUR among their 24 patients and furthermore included only four with PUJ obstruction. Taki *et al.* also created too severe an obstruction (as shown by their intrapelvic pressure measurements). Such sources should be evaluated more critically. The frequency of complications (10 of 49, 20%) was interesting, corroborating the estimates of Ransley *et al.* (reference 1) and Koff *et al.*, but otherwise the paper contained few convincing messages.

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1 Subramaniam R, Kouriefs C, Dickson AP. Antenatally detected pelvi-ureteric junction obstruction: concerns about conservative management. *BJU Int* 1999; **84**: 335–8

Reply

We thank Dr Josephson for his correspondence; the paper was an observation on our clinical practice. Although the end-point of renal function of the kidneys was the same in the early and late pyeloplasty groups, there was a significant difference in the mean function of the two groups at the original presentation. In the early pyeloplasty group before surgery the kidneys were contributing 28% of the child's total renal function, but in the delayed pyeloplasty group the kidneys were contributing a mean of 45% of total renal function. It seems disappointing to us that both groups should have the same end-point but abnormally reduced function.

We have observed that if pyeloplasty is delayed in severely dilated but well functioning kidneys the end-point is no better than in those with significantly reduced function at first presentation. We are now assessing in current clinical practice whether operating early on the severely dilated antenatally diagnosed PUJ obstruction preserves renal function.

The ages in Table 1 are those at the latest follow-up in the conservative group and the age at operation in the operated groups. The APDs in Table 1 refer to their first measurement; this is made clear in the results section of the abstract of the paper.

We would not be as critical as Dr Josephson of the reports referenced in our paper. We also find it interesting that conclusions based on our clinical observations match the estimates of Ransley *et al.* and Koff *et al.* From our review, we have found that most problems can be predicted on the basis of the original APD of the renal pelvis and we have changed our practice accordingly.

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Penile refracture

Sir,

We read with interest the paper describing the management of a patient with penile refracture [1]. The authors note the possible

advantage of using nonabsorbable sutures in such cases. We have managed and reported on our patients with penile fractures, where we advocate the use of the 'roll' sign to accurately identify the tear, and with an incision directly over the haematoma, to gain access to the defect. It is then repaired with an absorbable suture [2,3]. This operation allows the rupture to be sutured under local anaesthesia, as a same-day procedure, and most importantly, circumvents the need for more extensive dissection such as degloving and circumferential incisions. In our series, we have yet to encounter a recurrence, with patients being followed for >15 years to date [4]. We believe that a conservative approach (rather than suture material) in this condition may allow faster healing, an important factor in tissue strength.

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1 Punekar SV, Kinne JS. Penile refracture. *BJU Int* 1999; **84**: 183–4
2 Kuruvilla T, Rampaul RS, Maharaj D *et al.* Same day surgery for fractured penis – use of the 'roll' sign. *West Indian Med J* 1999; **48**: 27
3 Naraynsingh V, Maharaj D, Kuruvilla T, Ramsewak R. Simple repair of fractured penis. *J Royal Coll Surg Edin* 1998; **29**: 483
4 Naraynsingh V, Raju C. Fracture of the penis. *Br J Surg* 1985; **72**: 305–6

Sir,

We read this case report with interest [1]; we had a similar case of a 40-year-old man who sustained a fractured penis during sexual intercourse. At exploration he had a long transverse tear in the tunica albuginea of the right corpus cavernosum that extended across most of the urethra. The urethra was repaired with interrupted absorbable sutures (poliglecaprone) whilst the tunica was repaired with nonabsorbable inverting sutures (polypropylene). The patient made an uneventful recovery, reporting normal erections, had a normal urethrogram and after 6 weeks recommenced normal sexual life. Eight weeks after the original injury the patient re-presented with the same complaint and again at exploration there was a long tear in the tunica at the same site, extending into the urethra. A similar repair was undertaken. The patient failed to attend for follow-up, so the state of his current erectile function is unknown. This brings the number of reported cases of recurrent ipsilateral penile refracture to three [1,2]. It shows that the use of nonabsorbable sutures to repair the tunica, although sensible, is not entirely protective against refracture. Furthermore, it would seem prudent to advise those with long lacerations of the tunica extending into the urethra to refrain from sexual intercourse for longer.

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1 Punekar SV, Kinne JS. Penile refracture. *BJU Int* 1999; **84**:183–4
2 Kattan S, Yaussef A, Onuora V, Patil M. Recurrent ipsilateral fracture of the penis. *Injury* 1983; **24**: 685–6

The urology of Pharaonic Egypt

Sir,

I thank the editors of BJU Int and commend the authors on the excellent review of this subject [1]. I wish to make three comments:

(i) The reported syllable (å-a-å) is a typical squeal which accompanies the body movements associated with painful hesitancy. It is 'the agony song and dance' of a bladder acutely infested with bilharzial ova. It was commonly observed in young rural patients during the expulsion of terminal drops of haematuria, while spiked ova are squeezed through the bladder mucosa.

(ii) The use of anaesthetics for major surgery, although not mentioned in the famous papyrus papers in connection with urological procedures, is documented in connection with craniotomy for subdural haematoma or the removal of brain tumours. A man (the 'squelcher') accompanied the surgeon and specialized in safely 'knocking out' the patient and maintaining haemostasis by using hot rods during the procedure.

(iii) Circumcision, after becoming popular and common for babies and young children was, and still is, undertaken in most parts of the country, with no anaesthetic. Traditional circumcisers inherited a technique in which an assistant holds the patient firmly in his lap while the patient's elbows encircle the assistant's knees in a squatting position. As a medical student I questioned the man who had been a circumciser (and an injection therapist responsible for the primary healthcare of some 5000 country people for >50 years), about the pain such procedure may cause. He affirmed: 'Not painful if you learn two things — to do it in five seconds flat and to keep your fingers out of the way.' He added: 'I did it for you when you were 3 years old, what do remember about it?' He taught me the 'bone forceps' technique. I dare not tell him that I have painful memories about some of his intramuscular injections, but only remember the joyful celebration after circumcision.

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1 Shokeir AA, Hussein MI. The urology of Pharaonic Egypt. *BJU Int* 1999; **84**: 755–61