

categories, which were higher in the DUT-TAM than in the placebo group (33% vs 14%). Regarding reproductive system AEs, the number of unresolved cases of erectile dysfunction (ED) after 18 mo was remarkably similar in both groups. By contrast, 6 mo after cessation of treatment, five and 23 cases of ejaculation dysfunction (EjD) remained unresolved in the placebo and DUT-TAM groups, respectively.

Experts' comments:

This article gives an interesting insight into the management of one of the most common clinical scenarios in urology. 5 α -Reductase inhibitors (5ARIs) such as finasteride and dutasteride have been consistently blamed for causing sexual dysfunction such as decreased libido, ED, and EjD in many animal and human studies [1].

This study used three MSHQ subdomains and concluded that the combination therapy lead to only EjD and not ED. The significant EjD caused by the combined therapy in this study could be due to the additive effects of both tamsulosin (α -blocker) causing retrograde ejaculation and dutasteride causing shrinkage of the prostate by at least 25–30% in size [2]. The shrinkage in prostate size could lead to a decrease in prostatic secretions, thereby reducing the ejaculate volume and causing subsequent EjD in some men. This could also explain the significant number of unresolved cases of EjD after treatment cessation.

The most interesting outcome of the study was that there was no significant difference in erectile domain between the groups. So why is it a general impression that the DUT-TAM combination causes ED? In our opinion, there are two possible answers to this question. First, most urologists do not ask about erectile function before starting LUTS treatment, although it is well known that ED is prevalent and underdiagnosed in patients consulting for LUTS [3]. Patients become aware of their sexual problems after the treatment is initiated or when the doctor questions them about details of their sexuality. Second, some “nocebo effect” may be involved. In fact, “counselling” on the possible negative impact on sexual function affects AE reporting and can cause up to three times as many men to report sexual dysfunction [4].

Libido alterations in this study were only referred to as AEs, even though there are four questions about sexual desire in the questionnaire, so it is possible that this aspect of sexual dysfunction was under-reported in the article. In fact, it seems plausible that the effect of dutasteride on testosterone and dihydrotestosterone metabolism could have led to a negative impact on sexual desire. A meta-analysis by Corona et al. [5] highlighted that 5ARIs were associated with a greater risk of hypoactive sexual desire

(odds ratio [OR] 1.54, 95% confidence interval [CI] 1.29–1.82; $p < 0.0001$) and ED (OR 1.47, 95% CI 1.29–1.68; $p < 0.0001$).

Most studies assessing sexual function have used the International Index of Erectile Function and its subdomains. Only a few have used the MSHQ total score, but we should appreciate the authors' use of the subdomains of the MSHQ.

The major limitation of the study was, of course, the exclusion of tamsulosin-only and dutasteride-only groups to better define the role of each drug in the different sexual function domains and to see if there was any additive effect of the combination.

This interesting study sheds light on this controversial topic that serves as an aid for urologists to better understand the sexual effects of common treatments for BPH/LUTS and the appropriate counselling that should be provided to this subset of patients.

Conflicts of interest: The authors have nothing to disclose.

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<https://doi.org/10.1016/j.eururo.2018.10.034>

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Re: Mechanical Failure Rates of Artificial Urinary Sphincter Components: Is the 3.5-cm Urethral Cuff at Higher Risk?

Loh-Doyle JC, Hartman N, Nazemi A, Ginsberg D, Boyd S

Neurourol Urodyn. In press. <https://doi.org/10.1002/nau.23825>

Expert's summary:

The 3.5-cm cuff was introduced in 2010 to theoretically meet the needs of surgeons who encountered smaller urethras. The authors demonstrated that a 3.5-cm cuff is more prone to mechanical failure and reoperation. Despite these higher complication rates, the authors conclude that

the 3.5-cm cuff has a role in the management of male stress incontinence, stating that it allows better urethral coaptation when compared to larger cuff sizes.

Expert's comments:

When we combine the 3.5-cm cuff data demonstrating a higher rate of mechanical failure with the findings of Simhan et al. [1], who observed an erosion rate of 21% for 3.5-cm cuffs in primary artificial urinary sphincter (AUS) patients who had received radiation therapy, I feel that routine use of 3.5-cm cuffs for primary implantation is not advisable. Routine use of 3.5-cm cuffs dooms patients to higher reoperation rates and needlessly increases the financial burden on medical establishments. As an example, in my personal experience in more than 1550 AUS procedures, I found the need to place only three (0.2%) primary 3.5-cm cuffs [2].

On the basis of the literature, surgeons should limit implantation of 3.5-cm cuffs to highly select nonprimary AUS patients who have been comprehensively counseled that a 3.5-cm cuff results in a higher complication rate, some of which are permanent and irreparable [3].

My fundamental principle guiding AUS counseling is that we need to reduce the volume of leakage rather than have perfect dryness as the specific goal. As surgeons, we feel compelled to make things as perfect as possible. The AMS 800 is far from a perfect device. The argument I hear most is that 3.5-cm cuffs reduce the volume of leakage compared to larger cuffs. This may be true in the short term, but the greater urethral compression provided by a 3.5-cm cuff comes at a cost of increased erosion and reoperation.

Therefore, given the limitations of the AMS 800, we must deal with male incontinence in the best way we can. Of course we will continually try to improve the quality of life for our patients, but we must also counsel them that many times a little bit of leakage following AUS implantation is not only acceptable, but to be expected. This is especially

true for surgeons with a low AUS volume (<10–15 implants/yr) who have not had sufficient clinical experience with the AUS to become familiar with its limits [4,5]. For these surgeons (who represent the vast majority of those carrying out implantations) very careful consideration must be given to the impulse to routinely implant small cuffs to make things “better”.

Conflicts of interest: The author has nothing to disclose.

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<https://doi.org/10.1016/j.eururo.2018.10.033>

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Re: Acute Kidney Injury After Partial Nephrectomy in Solitary Kidneys: Impact on Long-term Stability of Renal Function

Zabell J, Isharwal S, Dong W, et al

J Urol. In press. <https://doi.org/10.1016/j.juro.2018.07.042>

Experts' summary:

In a selected cohort of 90 patients who underwent partial nephrectomy (PN) for renal tumor in solitary kidney, Zabell and co-workers investigated the impact on long-term renal function of acute kidney injury (AKI) at the time of PN [1]. It is noteworthy that AKI events were adjusted for the percentage of vascularized parenchyma preserved but were not significant predictors of long-term functional outcomes. Multivariable analysis, including preoperative variables of interest such as comorbidities (hypertension and diabetes) and tumor complexity, showed that the use of warm ischemia (vs cold ischemia) and diabetes were significantly associated with a progressive decline in renal function post-PN.

Experts' comments:

We commend Zabell et al for focusing on two hot topics in PN: the assessment of long-term renal function and the solitary kidney setting. The paper adds to the body of literature demonstrating long-term recovery of renal function after AKI related to PN, even in patients with a solitary kidney. The authors found that conventional warm ischemia impeded long-term recovery of renal function, supporting the adoption of cold ischemia, in line with findings from a recent study focused on at-risk patients (including those with a solitary kidney) [2]. Unfortunately, the relentless pursuit of minimally invasive surgery has prevented the widespread diffusion of cold ischemia because of the undoubted challenges in achieving cold ischemia during minimally invasive approaches. A recent literature review identified off-clamp techniques as more feasible alternatives in patients with poor renal function [3].