Selected Abstracts

Flexibe Nephroscope in Calculous Surgery. Jack W. McAninch and Raymond Fay. .J. Urol., 1982, 128: 5-7.
ThE OVER-ALL EFFECTIVENESS of the flexible nephroscope as an intrarenal tool for calculous surgical procedures is presented. The 16F tip permits localization and atraumatic removal of stone fragments. The advantages of the instrument over the rigid scope are presented, and its use is recommended before any exploration with forceps and before residual calculi are located and removed. Nine surgeons used the instrument upon 30 patients. An open surgical approach was used upon 27 and nephrostomy approach upon three. In seven patients, nephroscopy localized calculi after intraoperative radiographic studies failed to do so. No complications resulted from its use.
-David S. Cristol.

Percutaneous Renal Biopsy with Real-Time Ultrasonography.U. Backman and P.G. Lindgren. Scand. .J. Urol. Nephrot, 1982, 16: 65-67.
PERCUTANEOUS BIOPSY of the kidney, with the biopsy needle being guided by a real-time scanner, was performed successfully upon 41 patients. Using this technique, the needle as well as the kidney can be observed throughout the puncture procedure; thus, the most favourable side of the kidney can be chosen for biopsy. No complications occurred; in particular, results of ultrasonographic investigation one day after the biopsy revealed no perirenal or intrarenal hematomas. In conclusion, renal biopsy performed with a real-time scanner offers advantages over the conventional technique using fluoroscopy monitored by television and puncture guided by B-scanner and should be considered the examination method of choice for percutaneous biopsy of the kidney.
-Peter F. Winter.

Congenital Ureteric Valves-a Cause of Urinary Obstruction; a Report of S Cases. A. M. Dajani, Y.F. Dajani and S. Dahabrah. Br. .J. UroL, 1982, 54: 98-102.
FIVE PATIENTS with congenital valves of the ureter causing obstruction of the upper urinary tract were studied. Four of these patients were adults who presented with different urologic problems, including urinary calculi, pain in the flank and severe renal failure. In addition to removal of the ureteric valves, these adults also required nephrectomy or pyelolithotomy and removal of the segment bearing the constructing valve.
The fifth patient was an infant who presented with failure to thrive and, before operation, was suspected of having congenital valves. Gross hydronephrosis was present and was treated by excision of the segment containing the valve with end-to.end anastomosis of the ureter and pyeloplasty of a narrowed pelviureteric junction.
Congenital ureteric valves are rare clinical phenomena and have previously been reported in only 29 patients. These valves are developmental in origin and contain all of the structural layers of the ureter except for the adventitia. Their mode of formation remains unresolved; however, the valve seems to be a transverse fold of mucosa containing muscle fibers producing dilation of the upper collecting systems.
-Richard A. Blath.

Urinary Diversion by Heal Conduit in Gynaecologic Oncology. L. Villani, F. Sacco, P. Benedetti Panici and others. Eur. J. Gynaec. OncoL, 1981,2: 108 -112.
AN EXPERIENCE with urinary diversion by ileal conduit for 25 women with carcinoma of the

reproductive tract is described. Twenty patients had carcinoma of the uterine cervix, four had carcinoma of the endometrium, and one patient had carcinoma of the vulva.
Nineteen of the patients underwent urinary diversion immediately after radical surgical treatment, while six patients underwent the procedure later for the complications which followed primary therapy either by operation or radiotherapy. Three patients, 12 per cent, died postoperatively; eight patients, 32 per cent, had early complications, and four patients, 16 per cent, had late complications.
Based upon the results of this study, it is advocated that urinary diversion by ileal conduit, that is, Bricker's operation, may be performed only upon a selected group of patients-particularly upon those who have had irradiation to the pelvis, thus making other procedures hazardous. The operation should be avoided as a palliative procedure for patients with a poor life expectancy.
-RD. Sheth.

Polyp of the Posterior Urethra. Denis M. Murphy and Edward. J. Guiney. Eur. UroL, 1982, 8: 204-206.
A 3.5 YEAR OLD male patient with congenital polyp of the posterior urethra is reported upon, and the literature upon the lesion is reviewed. These polyps occur in the verumontanum in the posterior urethra in males, and though usually congenital, may inexplicably manifest in both children and adults the signs and symptoms of either outflow obstruction or hematuria.
Roentgenographic findings suggestive of bladder outflow obstruction are present, but on a voltage control unit, a characteristic mobile filling defect in the posterior urethra extending toward the bladder neck-descending in the urethra during voiding to return to the original position at the vesical neck upon completion-is seen. Cystoscopy may offer an additional help in diagnosis. Suprapubic transvesical excision was and is being practiced, but transurethral endo. scopic excision is the method of the choice coming in vogue, perhaps in some instances through perineal urethrotomy.
-R.D. Sheth.

Tendinitis of the Patellar Tendon. M. Martens. Acta Orthop. Beig., 1982, 48: 453-454.
IN THIS BRIEF ARTICLE, a review of 90 patients with patellar tendinitis is summarized. Four different stages of tendinitis were identified: stage 1, pain only after sports activity; stage 2, pain at the beginning and the end of sports activity which disappears after the initial warm-up phase and reappears at fatigue; stage 3, constant pain at rest and during activity, and stage 4, complete rupture of the pateilar tendon. Anatomic pathologic results revealed focal degeneration and microtearing near the insertion of the quadriceps or the patellar tendon.
Conservative treatment consisting of proper warm-up, local anti-inflammatory treatment and oral anti-inflammatory drugs was effective for patients with stage 1 and 2 disease but failed in a high proportion of those with stage 3 disease.
Operative treatment of the stage 3 lesion consisted of resection of degenerated or necrotic tissue near the insertion of the tendon. Complete ruptute, stage 4, was treated with the usual methods of repair of the tendon. It is thought that 27 of the 29 patients who underwent operation directed toward the tendon had favourable results; however, details of the evaluation are not given in this article.
-Murray .J. Goodman

The Patellofemoral Syndrome and Sports. F.A.J. Van Hussen. Acta Orthop. Beig., 1982, 48: 443452.
The classification of Ficat and Hungerford, in which four clinical types of patellofemoral syndrome are differentiated, is accepted by the author of this article. The first clinical type of patellofemoral syndrome is chondromalacia, in which the medial facet is characteristically involved in adolescents whose diagnosis is confirmed with arthroscopy. Excessive lateral pressure syndrome, the second type, involves the lateral facet of adolescents and adults; roentgenographic changes, including dysplasia of

the patellofemoral joint, subluxation and changes in the lateral facets, are described. The third type, patellofemoral arthrosis, is seen primarily in adults and usually involves the lateral facets but may involve the medial facets; its diagnosis is confirmed by the findings of joint line narrowing and osteophytes on the lateral roentgenographic view and sclerosis, osteophytes and perhaps, cysts on the axial view. The fourth type is osteochondral fracture, the diagnosis of which is suspected from he patient history and based upon routine roentgenograms and can be confirmed with arthroscopy.
Methods of treatment are discussed. These include conservative treatment using heat, rest, aspirin, bracing and splinting. Procedures of the soft tissue, patellar alignment procedures, osteotomy of the tibia, femur patella and trochlea, as well as pateilectomy and patella prosthesis and management of lesions of the cartilage by excision, shaving and spongialization, are given in a chart.
A plea is made diagnosing the underlying cause of patellofemoral syndrome, establishing the diagnosis and basing the therapy upon the proper diagnosis. The object is to restore the balance between load and compression strength of the patellofemoral joint.
-Walter W Silberman