

Letters to the Editor

CATHETER-ASSOCIATED HYPERTENSION

To the Editor. Stevens and Mandell described renal artery thrombosis associated with hypertension in an infant after umbilical arterial catheterization.¹ They suggested surgical intervention for uncontrollable hypertension. Our experience with more than 20 infants with catheter-associated hypertension has been reported.^{2, 3} This problem is not uncommon, especially when catheters are placed above the origin of the renal arteries and dislodged pericatheter clots move downstream to occlude vessels. Vigorous medical management normalized blood pressure in all of our infants, suggesting that an operation usually is not necessary. We support the authors' pleas for proper catheter placement, aseptic technique and careful monitoring of blood pressure during and after catheterization.

Respectfully,
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Sacramento, California 95817

1. Stevens, P. S. and Mandell, J.: Urologic complications of neonatal umbilical arterial catheterization. *J. Urol.*, 120: 605, 1978.
2. Adelman, R. D.: Neonatal hypertension. *Ped. Clin. N. Amer.*, 25: 99, 1978.
3. Adelman, R. D., Merten, D., Vogel, J., Goetzman, B. W. and Wennberg, R. P.: Nonsurgical management of renovascular hypertension in the neonate. *Pediatrics*, 62: 71, 1978.

RE: RENAL MASS IN AN INFANT

S. R. Shapiro, R. D. Adelman, D. Link, H. Tesluk and H. Phillips

J. Urol., 120: 485-489, 1978

To the Editor. In this report an ultrasonic study shows a mass at the lower pole of the kidney. In the discussion this mass is described as cystic and the differential diagnosis of a fluid-filled lesion is given. The mass does not show the features of a cyst—there is no increased "through transmission" compared to the adjacent kidney. If anything, there is slightly less transnity. The mass, therefore, is a solid mass and the differential should be that of neoplasm versus abscess. One cannot emphasize too much that an echo-free mass is not necessarily fluid. Solid homogeneous masses also are echo-free. The critical factor in deciding whether a mass is cystic or solid is the amount of "through transmission".

Respectfully,
Roger C. Sanders
Department of Radiology
The Johns Hopkins Hospital
Baltimore, Maryland 21205

Reply by Authors. We would agree with Doctor Sanders' statement that "One cannot emphasize too much that an echo-free mass is not necessarily fluid". However, it should be noted that the discussion concerned a "cystic lesion of the lower pole with some elements of debris or other echogenic material such as clotted blood". In that respect, it might have better been considered as a complex mass or relatively homogeneous solid mass. In addition, on review of the entire study, including the published photographs, the longitudinal examination is still believed to show some increased through transmission when compared to the remainder of the right kidney and to the left kidney. I would re-emphasize that Doctor Sanders' points are well taken but that the discussion concerned a mixed or a complex echographic pattern and not purely a cystic lesion.

RE: SERIAL MULTIPLE-SITE BIOPSIES IN PATIENTS WITH BLADDER CANCER

M. S. Soloway, W. Murphy, M. K. Rao and C. Cox

J. Urol., 120: 57-59, 1978

To the Editor. This report concerns the results of a prospective study conducted at the University of Tennessee Center for the Health Sciences as part of a larger collaborative effort by the National Bladder Cancer Collaborative Group A. The background and over-all plan of this group have been reported recently.¹ One of its objectives was to study the histological appearance of normal-appearing mucosa taken from preselected sites.² Thus, our data provided the results from one of the institutions in this larger cooperative study. The entire group's experience is awaited in the future.

Respectfully,
Mark S. Soloway
Department of Urology
University of Tennessee College of Medicine
Memphis, Tennessee 38163

1. National Bladder Cancer Collaborative Group A: Development of a strategy for a longitudinal study of patients with bladder cancer. *Cancer Res.*, 37: 2898, 1977.
2. National Bladder Cancer Collaborative Group A: Cytology and histopathology of bladder cancer cases in a prospective longitudinal study. *Cancer Res.*, 37: 2911, 1977.

RE: THE IMPALPABLE TESTIS: A RATIONAL APPROACH TO MANAGEMENT

S. B. Levitt, S. J. Kogan, R. M. Engel, R. M. Weiss,
D. C. Martin and R. M. Ehrlich

J. Urol., 120: 515-520, 1978

To the Editor. The authors of this excellent review article omitted an important reference on the controversial issue of testicular autotransplantation (dividing the spermatic vessels and reanastomosing them with microvascular technique to the inferior epigastric vessels).

Our paper on the subject was reported in 1976.¹ Testicle autotransplantation with microvascular reanastomosis of the spermatic vessels may or may not turn out to have merit but at least we should get credit for its initiation.

Respectfully,
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456 N. New Ballas Road, Suite 108
St. Louis, Missouri 63141

1. Silber, S. J. and Kelly, J.: Successful autotransplantation of an intra-abdominal testis to the scrotum by microvascular technique. *J. Urol.*, 115: 452, 1976.

To the Editor.* I read with interest this review article on the impalpable testis. Management as stated in the review, particularly as it relates to the preoperative evaluation from the endocrinological and radiological point of views, is entirely valid. However, I would like to call attention to what I believe is a much more efficient approach to the surgical search and management of the impalpable testis.

For 25 years I have done all orchiopexies through a midline lower abdominal incision. As the peritoneum is reflected medially it is possible to find a slight fold in the peritoneum to which the vas deferens is attached. Careful dissection and following of the vas in most cases leads to the testis, whether it is intra-canalicular, retroperitoneal or intraperitoneal. In only 2 of >100 cases did the vas fan out and not attach to the testis. Even in those cases the testes were found at the level of the renal vessels. In most cases it was then possible to provide a new opening over the pubis, ligate the

accompanying hernia sac and transplant the testis into the scrotum by a more direct route than would be available through the inguinal canal. This has been a much more effective approach to find the impalpable testes and to care for bilateral cryptorchidism and testes previously operated upon.

Respectfully,
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* *Editor's Note.* Dr. Herbert Brendler, our Associate Editor, reviewed this Letter too and indicated that the late Dr. Hugh Hampton Young described this approach in 1942, in the *Transactions of the American Association of Genito-Urinary Surgeons* and it may even have been reported before that time. Also, in 1965 Dr. Howard Goldman of Doctor Brendler's Department described this in the *Journal* and gave credit to Doctor Young.

Reply by Authors. We wish to thank Dr. Sherman Silber for bringing to our attention the fact that his original publication, describing successful autotransplantation of an intra-abdominal testes into the scrotum by microvascular surgery, was omitted from the list of references. Silber and Kelly deserve full recognition for their original and innovative approach and should be credited for their contribution, which indicated that autotransplantation of the testis could be accomplished successfully by microvascular techniques. We apologize for the omission.

We also acknowledge that the midline extraperitoneal and/or transperitoneal approach for unilateral and bilateral impalpable testes is preferred by some surgeons. Indeed, Dr. Hugh Hampton Young did describe this approach.¹ We merely wished to express our preference and appreciate another experienced surgeon's point of view. However, we wish to emphasize that the principles of exploration, including the need to demonstrate blind-ending spermatic vessels and to pursue an intraperitoneal exploration if a blind-ending vas or nothing at all is found in the retroperitoneum, should still be mandatory before diagnosis of testicular absence.

1. Young, H. H.: Intra-abdominal operation for cryptorchidism. *Trans. Amer. Ass. Genito-Urin. Surg.*, 35: 115, 1943.