letters

WRITE TO THE EDITOR AT BJU INTERNATIONAL, 47 ECCLES STREET, DUBLIN 7, IRELAND

NOCTURIA IN RELATION TO SLEEP, SOMATIC DISEASES AND MEDICAL TREATMENT IN THE ELDERLY

Sir,

In a well-described study, Asplund [1] reported the influence of several somatic diseases, symptoms and medication on nocturnal micturition in an elderly population. However, we have some concerns about this study. First, the data were derived from self-administered questionnaires; we have previously shown that such data are inadequate to rate (nocturnal) voiding frequency [2]. Questionnaire data (and interview data) are especially subject to recall bias, which may be greater in elderly people, those with sleep disorders or other somatic disorders, and people with poorer health status. Frequency-volume charts are not subject to such recall bias and therefore provide more valid data [3]. The use of frequency-volume charts could have resulted in different conclusions.

Second, other important determinants of increased nocturnal voiding frequency, e.g. (other) LUTS and nocturnal polyuria, were not considered. These conditions may 'overrule' the almost insignificant effect of somatic disorders presented by the author, as was shown in our population-based study on nocturia [2].

Third, the author concluded that poor sleep is an independent correlate for nocturia. Previously the author concluded that nocturnal voids have an important relation to sleep disorders [4]. No answer is given to the question 'what comes first?' Given that men with nocturia have to get up to void during the night, the odds ratio for poor sleep of 2.6 is not very high. As to possible reasons for nocturnal awakening, more data were collected than reported in this article [5]. Could the author provide some insight into the relationship between nocturia and poor sleep, when adjusting for nightly symptoms such as 'troubled by nightmares', 'troubled by thirst', and 'getting up to drink'?

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LEUPRORELIN ACETATE GRANULOMAS: RECURRENT SUBCUTANEOUS NODULES MIMICKING METASTATIC DEPOSITS AT INJECTIONS SITES

Sir,

I read this case report [1] with interest; our hospital changed its contract to leuprorelin acetate less than 2 years ago. In that period I have seen subcutaneous nodules in two patients that appeared to be caused by leuprorelin acetate. In one patient the nodule developed after the first injection and was >5 cm in diameter when the GP decided to refer him to a general surgeon. The general surgeon excised this nodule, which had a similar histology to that reported by Whitaker *et al.* [1]. The patient's treatment was then changed to goserelin for his subsequent injections, with no problems. The second case also developed a nodule after the first injection but this resolved before his next injection was due in 3 months. He has also had the drug changed to goserelin for subsequent injections as a result. I reported both these cases to the Committee on the Safety of Medicines in the UK. The report back from them in July 2002 suggested that seven to nine cases have now been reported of this reaction. It is known that many adverse reactions are not reported to the Committee and so this problem may be more common than it appears. Urologists need to be made aware that this reaction can occur when using leuprorelin acetate.

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1 Whitaker IS, Fazel MZ, Joshi HB *et al.* Leuprorelin acetate granulomas: recurrent subcutaneous nodules mimicking metastatic deposits at injections sites. *BJU Int* 2002; **90**: 350

HAND-ASSISTED LAPAROSCOPIC NEPHRECTOMY: COMPLICATIONS RELATED TO THE HAND-PORT SITE

Sir,

This article [1] was interesting in that it highlighted the limitations of 'first generation' hand-assistance devices (HADs). It would have been interesting to record which of the described devices were involved in the three reported cases of severe infections and

incisional hernia. It is possible to extrapolate that the case requiring conversion because of gas leakage must have been associated with either the Intromit™ or Pneumosleeve™. The Intromit (which has now been phased out) had a rigid inner flange, which could have contributed to the hand-port site related morbidity.

The siting of the port site for the hand-assistance device is paramount; it has to be ergonomic and effective. Neither of these seem to be the case with the ports sited as shown in the illustrations accompanying the article. Dealing with a left kidney with the port in the left iliac fossa will surely cause hyperflexion of the hand when the surgeon attempts to deal with the lateral aspect of the kidney; this contributes to hand fatigue and stress with the device. The HandPort™ is an effective device, but its major problem is one of 'pop-outs', when the entire device comes out of the wound with sudden 'in and out' movements. The device then has to be deflated, reinserted, re-inflated and pneumoperitoneum re-established to enable the surgery to continue. This may further contribute to hand port-site related morbidity.

The GelPort™ (Applied Medical, Rancho Santa Margarita, CA, USA) is a second-generation HAD, which combines ease of use with robust construction and appears to result in minimal hand fatigue for the surgeon [2]. To date, we have performed 53 hand-assisted laparoscopic nephrectomies, 35 of which were for malignant disease; of these, 13 were single-incision radical nephroureterectomies. We have used the GelPort for 41 of the procedures. We prefer to place the device in the midline; for left-sided procedures the device is placed supra-umbilically, and for right-sided procedures it is usually sited infra-umbilically or straddles the umbilicus. Interestingly, we have had only one minor wound infection.

I agree that hand-assisted laparoscopy is unnecessary for extirpative procedures for benign disease, and likewise it seems to have no role in reconstructive surgical procedures such as pyeloplasty. However, it seems to have a definite niche as a training tool to aid the dissemination of surgical skill by affording a greater level of confidence to the novice [3,4]. It also seems to have a place in circumstances wherein intact specimen removal is considered mandatory, there is a need to keep operative duration to a minimum, in very large tumours and in some obese patients. Appropriately executed, HAD surgery seems to work well [5–7]; newer devices have helped.

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PREVENTING CLOT RETENTION AFTER UROLOGICAL SURGERY

Sir,
It is 35 years since I regularly nursed patients after prostatectomy but I well remember being blamed at that time if a catheter was blocked with clots. Even so I was at a loss to see how I could have done anything more than I did to prevent it happening. I had certainly kept fluids going into the patient and had persistently 'milked' his drainage tube. What about the current practice? Is there anything more that nurses can do to prevent the blockage of catheters with clots? I am not sure, but recently I read that a large-capacity two-bag system of irrigation is used (continuous irrigation) to prevent clot retention [1]. This might be an improvement on the one-bottle system used in the past (because the irrigation is not so likely to be interrupted). However, it seems that 'milking' and bladder washouts are still sometimes needed when clots manage to form and block the catheter [1].

In the early 1990s I realised that 'milking' the tubing of these drainage systems is dangerous, as is the use of bladder washouts [2,3]. I find it disturbing that such measures are still being advocated. Is this because no surgeon has devised a better way of dealing with this demanding circumstance? For instance, would it not be possible for a nurse to swiftly change the blocked catheter, with the new one being inserted using the special technique of Harkin *et al.* [4], but with a lubricated (gelled) form of saline in the syringe attached to the catheter?

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