

Letters

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

ORAL COMPLICATIONS AFTER BUCCAL MUCOSAL GRAFT HARVEST FOR URETHROPLASTY

Sir,

We read with great interest this article [1] reporting the oral complications after buccal mucosal grafting for urethroplasty. They rightly highlighted and emphasised that it is necessary to mention the oral complications at the time of obtaining consent from the patient for buccal mucosal urethroplasty. Interestingly, there were two abstracts presented at the Annual meeting of AJA in 2004 that assessed the morbidity of harvesting the buccal mucosal graft. In the report by Greenwell *et al.* [2], a retrospective study of 110 men of whom 48 responded, 82% had associated immediate postoperative pain, but 89% resumed a normal diet within a week. Difficulty in opening their mouth initially was noted in 66% of the patients, but persisted in only 7% after 6 months. These results prompted the authors to conduct a prospective study of 20 patients each, where they compared closing or not closing the donor site on postoperative pain. The mean pain score for closing and not closing was 3.42 and 2.61 respectively ($P < 0.01$, unpaired *t*-test), i.e. statistically significant. They concluded that the donor site can be left unsutured to lessen pain. Another study by Jang *et al.* [3] compared the morbidity of harvesting of mucosa from the lower lip (group 1) and the cheek (group 2); they reported 12% with pain in group 1, whereas there was no pain in group 2 after 3 months. At 6 months there were minimal neurosensory deficits in 65% of patients in group 1 and none in group 2. There were no neuromotor or major neurosensory deficits in either group. These results are in contrast with those from the study by Dublin and Stewart [1], who reported persisting neurosensory and neuromotor deficits in many patients (16% with numbness, 32% with tightness).

It could be concluded that not closing the harvest site is a promising modification to reduce morbidity at the donor site. However, the effect on delayed symptoms such as numbness, tightness of opening the mouth and other motor deficits needs to be assessed.

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- 1 Dublin N, Stewart LH. Oral complications after buccal mucosal graft harvest for urethroplasty. *BJU Int* 2004; **94**: 867–9
- 2 Greenwell TJ, Andrich DE, Mundy AR. The morbidity of mucosal graft harvest for urethroplasty and the effect of non-suture of the graft site on post-operative pain. *J Urol* 2004; **171**: A240, 63
- 3 Jang TL, Medendorp A, Gonzalez CM. Comparison of donor site intra-oral morbidity following buccal mucosal graft harvesting for urethral reconstruction. *J Urol* 2004; **171**: A241, 63

DOES BODY-COIL MAGNETIC-RESONANCE IMAGING HAVE A ROLE IN THE PREOPERATIVE STAGING OF PATIENTS WITH CLINICALLY LOCALIZED PROSTATE CANCER?

Sir,

We read this paper [1] with interest. It is clear that patients with extracapsular disease need to be identified before radical surgery, but it is also prudent to avoid unnecessary delay with unhelpful investigations between diagnosis and curative treatment. The NICE guidelines [2] suggested that MRI may have a role in the preoperative evaluation of patients who are considered to be at intermediate or high risk, and specifically highlighted those with a PSA level of >10 ng/mL. Most units would accept

that for those at high risk (PSA >10 ng/mL, Gleason score >7), MRI is warranted. However, for those at intermediate risk, the value of staging MRI is unclear. Hence we welcomed this study, which analysed a series of radical prostatectomies; however, it is difficult to draw firm conclusions from these data and we feel that the conclusions drawn by the authors may mislead. First, in the intermediate-risk group, which is the most interesting, there were only eight patients; this is far too few from which to quote sensitivities and specificities, and to recommend its use in this group. We recently audited 78 patients with a PSA level of <10 ng/mL and a Gleason score of 7, 22 of whom were treated by radical retropubic prostatectomy in our cancer centre. In contrast to the findings of Allen *et al.*, we showed that even with specialist urological radiologists reporting on the films, for this group MRI had a sensitivity of 33%, a specificity of 60%, positive predictive value of 25% and negative predictive value of 69%. Using the same approach as Allen *et al.*, this gives a likelihood ratio close to 1, suggesting little value for MRI staging of intermediate-risk patients.

Second, the tables of data in this paper are misleading; the raw data presented in Table 1 suggests a sensitivity of 50% overall, where the ratio of true positive to true positives and false negatives is actually 22%. A similar pattern of inaccuracy is found throughout the table, and as such, doubt is cast over all the conclusions drawn. Specifically, in the intermediate-risk group, we calculate that both the specificity and sensitivity are 50%, giving a likelihood ratio of 1, regardless of whether the radiologist had a specialist interest in prostate MRI. Finally, it is confusing that Table 2, detailing the reports of false-negative and false-positive cases, outlines 10 false-negatives and seven false-positives, values which do not tally with Table 1.

Taken together, these inconsistencies are worrying in a peer-reviewed journal,