Reply by Authors. We appreciate the interest of Delgrange in our study. MacRoprolactinemia is a clinically and biologically heterogeneous condition. Leslie et al studied 55 women with typical hyperprolactinemia and reported that symptoms of typical hyperprolactinemia were uncommon.[4] Vallette-Kasic et al examined 106 patients with macroprolactinemia and found that 61% had normal menstruation and 54% did not have galactorrhea.[5] On the other hand, Gibney et al examined 453 patients with macroprolactinemia and found that oligomenorrhea/amenorrhea and galactorrhea were more common in patients with true hyperprolactinemia, although they were also frequently present in patients with macroprolactinemia.[2] They also reported that cases of macroprolactinemia could not be differentiated from true hyperprolactinemia on the basis of clinical features alone. Although plasma levels of estradiol and luteinizing hormone, and luteinizing hormone-to-follicle-stimulating hormone ratio were significantly greater in macroprolactinemic compared to true hyperprolactinemic cases, normal estradiol levels also occurred in the setting of true hyperprolactinemia, while, conversely, estradiol levels were sometimes suppressed in macroprolactinemic cases.

The bioactivity of macroprolactin is also unclear. De Schepper et al studied clinical and biological characterization of macroprolactinemia and found that PRL-IgG complexes possess a PRL-like biological activity in the Nb2 assay.[6]

Finally, macroprolactinemia can be classified as "idiopathic hyperprolactinemia" in the differential diagnosis of hyperprolactinemia. The screening for macroprolactin in patients with hyperprolactinemia is important with regard to cost-effectiveness, and can alter treatment in up to 20% of patients with hyperprolactinemia. Our study focused on the frequency of female sexual dysfunction in patients with hyperprolactinemia. We think that examination of the difference in female sexual dysfunction between true hyperprolactinemic and macroprolactinemic cases could also be important. However, this comparison was outside the scope of our study and needs to be examined in further studies.

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Re: No-Needle Jet Anesthetic Technique for No-Scalpel Vasectomy

R. S. Weiss and P. S. Li

J Urol, **173:** 1677–1680, 2005

To the Editor. No-needle jet injection promises to address patient fears regarding the needle traditionally used for anesthesia in vasectomy. The hope is that one more obstacle to men seeking vasectomy as a viable method of permanent contraception will be eliminated. Jet injection achieves an immediate and profound local anesthesia of the vas deferens. It achieves this anesthesia with a fraction, one tenth the volume, of the plain lidocaine normally used in conventional vasal block anesthesia. However, while the onset of anesthesia is rapid and profound, the duration may be compromised as a result of the lower volume of a short acting agent such as lidocaine.

I routinely record my observations during each procedure and have noted that when there is some discomfort it more often is on the second of the 2 vasa being operated on. In a series of 1,095 cases performed between April and October 2005 there were 59 observations of mild discomfort overall, 14 on the first vas alone, 34 on the second vas alone and 11 on both sides. In no case was supplemental anesthesia necessary. Patients reported overall pain by use of a visual analogue scale (VAS) identical to that used in the present study, which revealed scores of 1.46 (out of a possible 10, median 1.2) for pain experienced with administration of anesthesia by jet injection and 0.59 (median 0.2) for pain experienced during the vasectomy itself following anesthesia.

I compared this series of no-needle no-scalpel vasectomies using lidocaine 2% with a series using a 50:50 mixture of lidocaine 2% and bupivacaine 0.5%, a longer acting agent. In a series of 843 cases performed between October 2005 and February 2006 there were 4 observations of discomfort on the first vas alone, 18 on the second vas alone and 9 on both sides. In no case was supplemental anesthesia necessary. Patients reported overall pain by use of a VAS, again identical to that used in the present study, which revealed scores of 1.68 (out of a possible 10, median 1.4) for pain experienced with administration of anesthesia by jet injection and 0.57 (median 0.2) for pain experienced during the vasectomy itself following anesthesia.

While these findings are limited, the small VAS score differences support subjective impressions that patients experience less discomfort during vasectomy with the addition of bupivacaine, at the cost of slightly more discomfort on application of the anesthetic. This difference has resulted in a change in my practice to the use of the bupivacaine-lidocaine mixture.

An interesting side note to these findings is that I found the injectors used during this period required less frequent servicing. With time jet injectors lose efficacy and require factory servicing. It is possible that a more "forgiving" mixture of anesthetic solutions makes up for a potential reduction in efficacy, up to a point, during the ongoing use of these injectors. Given the inconvenience and expense of injector

servicing, this finding may represent a significant benefit to the practitioner with time.

Respectfully,
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Re: Testicular Fixation Following Torsion of the Spermatic Cord—Does it Guarantee Prevention of Recurrent Torsion Events?

Y. Mor, J. H. Pinthus, A. Nadu, G. Raviv, J. Golomb, H. Winkler and J. Ramon

J Urol, **175:** 171–174, 2006

To the Editor. I read with great interest the report on testicular fixation following torsion of the spermatic cord. Of particular interest were the statements regarding subdartos orchiopexy as a recommended method of management to prevent recurrent torsion of the testis. I have now had a more than 10-year favorable experience using the subdartos scrotal pouch orchiopexy as an exclusive method of fixation of the testis in cases of testicular torsion. The technique used is unchanged from the way it was first reported and illustrated in 1995.[1] Many urologists would agree that this method is laudable because it uses a proved technique, which has been used extensively for the management of undescended testes, and also because it avoids damage to the vasculature of the testes that is associated with intratesticular sutures used in the standard fixation techniques.[2] Even so, it is probably true that few urologists are using the highly recommended technique of subdartos orchiopexy in the management of testicular torsion.[2] The reason may be that it is technically more difficult and time consuming than the simple placement of sutures through the testes and scrotal wall, or the suturing of the incised parietal tunica vaginalis to the edges of the longitudinally incised tunica albuginea of the testis.[3]

In concept the subdartos pocket technique is simple. However, it differs somewhat from the standard subdartos orchiopexy used in boys with cryptorchidism. In boys with torsion of the testis the scrotum is incised through its tunics entering the parietal tunica vaginalis. As the testis is extracted from the scrotum, the parietal tunica vaginalis thus becomes visceral as it now invests the spermatic cord. The appearance is similar to an undescended testis that has been prepared for orchiopexy. However, the "scrotal cavity" has been obliterated and now a new pocket for the testis must be made.

Herein lies an important point of the technique. Patients with testicular torsion are usually postpubertal, and consequently the testis is, or approaches, adult size. The pocket cannot be made adequate simply with the spreading of a hemostatic clamp beneath the dartos tunic. The pocket must be developed and sufficiently enlarged with the use of retractors, such as Senn or Army-Navy retractors, with careful attention to the fulguration of vessels, which will tear if stretched. This portion of the procedure is relatively simple but requires a deliberate dissection. The closure is completed by simultaneously suturing the dartos tunic, while incorporating the now visceral tunica vaginalis covering the spermatic cord. It is strongly recommended that all urologists who manage testicular torsion will take the time to learn the technique of subdartos orchiopexy.

Respectfully,
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Re: Multi-Institutional Validation Study of Neural Networks to Predict Duration of Stay After Laparoscopic Radical/Simple or Partial Nephrectomy

S. J. Parekattil, I. S. Gill, E. P. Castle, S. V. Burgess, M. M. Walls, R. Thomas, U. Kumar, J. A. Purifoy, C. S. Ng, Y. Kang, G. J. Fuchs, E. S. Weise, H. N. Winfield, C. Lallas and P. E. Andrews

J Urol, **174:** 1380–1384, 2005

To the Editor. This article describing the use of neural network to predict duration of stay (DOS) after laparoscopic nephrectomy is interesting. It is expected to be one form of outcome analysis that could help resource allocation. Currently, there are many medical applications described. However, as the results suggest, this particular model showed 72% accuracy for laparoscopic nephrectomy and it did not work uniformly, especially for the laparoscopic partial nephrectomy. The authors have suggested continued testing and refinement.

Predicting postoperative DOS is affected by many confounding variables, as stated by the authors, which could have influenced its accuracy. There are various issues that could help its refinement that were not addressed in the article. There were no details regarding the patients receiving validated and uniform information about the intervention that was shown to influence outcomes, including DOS, significantly.[1] Development and dissemination of such information would be helpful.

The current model is primarily applicable to the practice patterns of the authors. However, considering various other practice patterns across different countries, it might have limited application as additional confounding factors that influence DOS would be involved.

In this regard, fundamentally it may be more relevant to measure or predict a postoperative state of independent