of drug use was not significantly associated with time to testosterone recovery. However, we did not assay DHT levels.

Respectfully,
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Reply by Authors. The published series of Pickle et al regarding 267 men treated with androgen deprivation therapy and local definitive radiation therapy included 117 treated with GnRH agonists.[1] This is an important study. However, there are several key differences between that series and ours. First, as Pickles notes, DHT levels were not obtained in his study. In addition, he reports obtaining testosterone levels every 6 to 12 months (during routine followup), while we obtained testosterone levels monthly. Although general statements can be made regarding time to testosterone recovery in his study, the measurement frequency allows for some imprecision in the actual timing of testosterone normalization, and may have the effect of significantly overestimating time to testosterone recovery. Finally, as Pickles et al have reported previously, radiation to the prostate itself can decrease testosterone levels for up to 2 years following treatment, making it more difficult to interpret the kinetics of testosterone following definitive radiation therapy.[2]

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RE: PERCUTANEOUS MANAGEMENT OF CALCULI WITHIN HORSESHOE KIDNEYS

G. V. Raj, B. K. Auge, A. Z. Weizer, J. D. Denstedt, J. D. Watterson, D. T. Beiko, D. G. Assimos and G. M. Preminger

J Urol, **170:** 48–51, 2003

To the Editor. It is only recently that we came across this excellent article by Raj et al. Undoubtedly, it is the largest fully reported series on the percutaneous approach for treating patients with renal calculi in a horseshoe kidney. However, it is not clear from the article whether the authors routinely used computerized tomography (CT) in the preoperative planning of the access route. The importance of this step, if the percutaneous approach is considered on any congenitally anomalous kidney, has been emphasized previously.[1] Routine preoperative CT is needed for the precise determination of the change in the kidney position, orientation and relationships always present in these cases. Selective renal angiography to detect any vascular abnormality and pinpoint the relationship of the vessels to the proposed access route and to the stone bearing part of the collecting system has also been recommended in such patients.[1] However, recently this important information has been obtained by the less invasive CT angiography. The need to design longer dilators and rigid nephroscopes to cope with the usually deeply seated, congenitally anomalous kidney has also been emphasized.[1]

During the last decade opinions on the role of preoperative CT in the endourological treatment of lithiasis affecting horseshoe kidneys have varied between those who perform the imaging only if the retrograde puncture technique is going to be used[2] and those who consider it an essential management adjunct preoperatively (to assess renal anatomy) and postoperatively (to detect residual fragments).[3] Most recently, preoperative 16-slice CT, performed to obtain 3-dimensional volume rendered movies of the pelvicaliceal system and stone, has been used for planning percutaneous renal stone surgery within horseshoe kidneys.[4] This technique allows user-friendly, 3-dimensional, global appreciation access route planning in the operating theater.[4]

In a horseshoe kidney not all of the calices of the lower caliceal group are medially directed. It is usually possible to find a posterolateral calix suitable for accessing the renal pelvis and the rest of the kidney more directly and easily than the upper calix route that Raj et al used in the majority of cases. We have used this standard lower pole access in all of our patients with horseshoe kidney with large renal pelvic stones. With this approach, using a standard antegrade puncture, single-track, rigid nephroscopic technique under biplanar fluoroscopic guidance, we have had no difficulty in accessing or completely removing all of the stones.

Respectfully,
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RE: LYMPHATIC SPARING LAPAROSCOPIC VARICOCELECTOMY: A MICROSURGICAL REPAIR

R. Kočvara, J. Dvořáček, J. Sedláček, Z. Dítě and K. Novák

J Urol, **173:** 1751–1754, 2005

To the Editor. Laparoscopic surgery is a promising option in children and adolescents who need an operation for varicocele, and the most commonly described procedure is the transperitoneal Palomo technique. The main advantages of laparoscopic varicocelectomy are rapid convalescence and a nice cosmetic result. Nevertheless, the primary problem with the laparoscopic and open Palomo techniques is the relatively high percentage of postoperative hydrocele formation. Recently, Koyle et al reported a 6% incidence of postoperative hydrocele formation in 98 patients who underwent laparoscopic Palomo varicocelectomy.[1]

Since the etiology of hydrocele formation after varicocelectomy is thought to be interruption of the lymphatic outflow that was divided in surgery, Kocvara et al performed lymphatic sparing laparoscopic surgery. To identify and preserve the lymphatics, they placed the laparoscopic lens close to the surgical field, achieving up to 20× magnification, and, thus, decreasing the development of hydrocele to 1.9%. Although these results are promising, we think that working a short distance from the surgical field is technically difficult, and even at a close-up view the lymphatic vessels can still be difficult to identify and differentiate from venules.

We recently described a novel method of in vivo staining of the lymphatic vessels, which enables the surgeon to identify easily and spare the main lymphatic trunks.[2] Two ml methylene blue is injected into the space between the tunica vaginalis and tunica albuginea. During diagnostic laparoscopy, which follows the injection, the blue-stained lymphatic trunks can be easily identified and separated from the testicular artery and veins. This procedure had been successfully performed in several patients with no complications, and a multicenter prospective study is currently under way. We strongly believe