of the phallus. If the same hospitalized patient would rather die or lose the penis than to reveal his homosexuality, it is ludicrous to suggest that this information could have been obtained before an elective circumcision in the office. How was an HIV test obtained when law requires written and informed consent from this patient who denied high risk behavior?

Respectfully,
John T. Hotter
1085 Fairhaven Boulevard
Eln Grove, Wisconsin 53122

RE: HISTOPATHOLOGICAL AND CYTOTOLOGICAL
CORRELATIONS OF PERCUTANEOUS TESTIS BIOPSY AND
OPEN TESTIS BIOPSY IN INFERTILE MEN

D. N. Kessaris, P. Wasserman and B. C. Mellinger

To the Editor: While there is no question that testicular biopsy can be reduced to a percutaneous method that will provide excellent histopathological and cytopathological information, it is also true that by obtaining the biopsy percutaneously the opportunity to examine the epididymis with magnification (loupes) is lost. Performance of a testicular biopsy with a spermatic cord block using intravenous sedation with diazepam through a small transverse scrotal incision in the office affords the opportunity to evaluate the epididymis visually in addition to obtaining biopsy material. The appearance of the epididymis provides extremely valuable information to exclude obstruction as the etiology of infertility and it also can help define obstruction involving the vasa efferentia. This is an instance when I argue against oversimplifying a technique.

Respectfully,
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Reply by Authors. The visual appearance of the epididymis may often suggest obstruction. However, visual inspection is certainly not conclusive. An obstruction can only be demonstrated adequately at surgical exploration. An obstruction is present when the testis has been determined to produce mature sperm and when no sperm can be identified in the vasal fluid distal to the site of obstruction. A small incision into the hemiscrotum, which would permit adequate visual inspection, may also subsequently lead to significant adhesions that may make reconstructive microsurgery somewhat more difficult. Most infertility specialists also advocate using the “window” technique when performing open testicular biopsy, since this may lessen the incidence of postoperative adhesions. The purpose of testicular biopsy is only to determine whether there is relatively normal spermatogenesis. Ductal obstruction is conclusively demonstrated at subsequent surgical exploration.

Reply by Authors. Bangma and Schröder are concerned about the reproducibility of various volumetric methods in sets of images of identical prostate, especially the reproducibility of the methods used for planimetric volumetry, since step-section volumetry appears to be the most reproducible method. The differences described in our article occur because different methods were used to obtain the volumes. The clinical and transverse volumes were obtained at the clinic using the built-in volumetry method of the Kretz Combon ultrasound scanner. The differences reported between the longitudinal and transverse volumes indicate the limitations of this method. The area for capturing ultrasound is limited to 150 cc. Contour following with the track ball can easily lead to displaced contours. At our clinic routine outlining has been performed in the longitudinal plane to overcome the “salami” effect that may occur in the transverse plane (reference 3 in Letter). Interpretation differences may be introduced using different planes. The clinical intersection distance (or step size) was not fixed but selected manually and errors may occur in clinical outlining due to time pressure. These reasons will lead to a large variability for the built-in volumetry of the echo scanner. The results were compared to the off-line outlining.
Another point of discussion is the reproducibility of the automated method when an identical prostate is measured using another set of images. The quality of planimetric volumetry can be expressed by the accuracy and reproducibility. We are aware of the limitations of numerical integration influencing the accuracy and reproducibility. Possible influences are first step effect, step size and "salami" effect. Testing the reproducibility of the automated method is also a test for the reproducibility of prostatic ultrasound. From a computer analysis, we concluded that in theory the accuracy error for 4 mm. step size is 2.3 to 1.8%, depending on the selection of the first section and the length of the prostate. Also, rotational movements leading to a tilted prostate axis compared to the probe axis can be an influence. From this analysis, we can conclude that several sets of images from 1 patient will have a theoretical accuracy of more than 97%. The objective of our study, however, was to compare the computer outlining in prostatic images to the manual outlining by an experienced ultrasonographer in images stored in the computer. The reproducibility of this off-line outlining will be equal to or better than the reproducibility found by Stone et al in a clinical application of step-section volumetry.
