

lesions well, and subsequent MRI with pharmacologically induced erection more clearly delineated the lesions and their origin. This demonstrates that even for gross soft tissue lesions of the penis, there can be value added when this technique is employed. We agree with the conclusion of your letter, that MRI with pharmacologically induced erection should be considered in the setting of painful erections.

Competing interests: Authors declare no competing financial or personal interests.

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Microscopic hematuria and urothelial malignancy

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Kotb and Attia noted that “cystoscopy is highly recommended for young adult men, with significant levels of microscopic hematuria, due to the 20% incidence rate of associated urological malignancy.”¹ In fact, there are several etiologies of microscopic hematuria.² Using cystoscopy might be useful, however, it is questionable due to its invasiveness. There may be some useful additional tests for the differential diagnosis of other causes of hematuria, such as urine biochemistry and urine red cell morphology study. As noted by McDonald and colleagues, the use of urine cytology should be considered before deciding to use cystoscopy to investigate a patient with hematuria.³ A recent medical economics study concluded that “for low-risk patients the use of immediate cystoscopy could be avoided if cystoscopy were used for follow-up patients with a negative initial test using tumour markers and/or cytology.”⁴

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Author response: Microscopic hematuria and urothelial malignancy

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We would like to thank Tin and colleagues¹ for their interest in our publication.² There are many etiologies of microscopic hematuria (MH), other than urinary tract malignancy; however, the presence of dysmorphic red blood cells, proteinuria, casts and/or renal insufficiency or any other clinical indicator suspicious for renal parenchymal disease warrants concurrent nephrologic and urological workup.³