CUAJ LETTERS

MRI use with artificial erection in cases of painful erections

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e read with great interest the recent case report by Barber and Domes in CUAJ describing a case of painful erections caused by epithelioid haemangioma, a rare but benign lesion.¹ They highlight the use of penile magnetic resonance imaging (MRI) with artificially induced erection in aiding diagnosis of a penile lesion that was unapparent on clinical examination.

Just prior to their article publication, we described a similar case of epithelioid hemangioma with painful erections and sleep deprivation.² Initially thought to be painful Peyronie's disease, our case also required the use of penile MRI following intracavernosal alprostadil injection for more definitive diagnosis. Barber and Domes emphasize that such a lesion may not have been seen on conventional MRI and in our report this was indeed shown to be the case. While this technique has previously been described in staging penile cancer and investigation of erectile dysfunction and Peyronie's disease,³⁻⁵ both these case reports draw attention to the use of MRI with artificial erection induction in cases of painful erections.

Evidently this raises the question of how many painful erections are misdiagnosed as Peyronie's disease on the basis of clinical history even with the use of conventional MRI. We hope both these cases illustrate that the consideration of MRI with artificial erection induction can be worthwhile.

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

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Correspondence: Mr. Luke A. McGuinness, Department of Urology, Arrowe Park Hospital, Arrowe Park Road Wirral, Merseyside, CH49 5PE United Kingdom; luke.mcguinness@doctors.org.uk CUAJ Letters is an open forum to discuss papers published in CUAJ. Letters are published at the discretion of the editors, and are subject to abridgement and editing for style and content. Letters can be sent to the Editor at journal@cua.org.

Author response: MRI use with artificial erection in cases of painful erections

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hank you for your letter¹ regarding our recent case report.² We were very interested to read your article,³ which was published following our submission. As you point out, our cases are remarkably similar in terms of patient presentation, pathology and clinical approach, including the use of penile magnetic resonance imaging (MRI) with pharmacologically induced erection. We performed penile MRI in the symptomatic erect state only, and therefore were unable to comment on whether flaccid imaging would have been sufficient for this particular lesion. In your case, MRI in the flaccid state did not show the

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.

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Microscopic hematuria and urothelial malignancy

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otb and Attia noted that "cys-toscopy 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 guestionable 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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e 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