preoperative computed tomography scan prior to surgery. Functional studies were not obtained as part of the preoperative evaluation for stone management, but two patients with suspected ureteropelvic junction obstruction did undergo MAG3 renal scans. Stone burden and surgeon preference were the two main determinants in deciding among percutaneous nephrolithotomy (PCNL), ureteroscopy (URS), or shock-wave lithotripsy. There were four patients in the PCNL cohort with staghorn stones. Of the patients with staghorn calculi, three (75%) required additional procedures, including one who required sandwich therapy with shock-wave lithotripsy and repeat PCNL. Only one (25%) patient was rendered entirely stone-free in this group and three (75%) had residual asymptomatic stones less than 4 mm. In our PCNL group, we did have a 27% rate of secondary procedure; however, this is consistent with other recent series.[1,2] There was not a statistically significant difference between secondary procedure rate in our group in the era prior to and the era after routine use of flexible nephroscopy, but we believe that as scope technology and maneuverability improve these rates will likely decline. There were two patients with ureteropelvic junction obstruction and both underwent pyeloplasty after PCNL but no concomitant endopyelotomies were performed. None of our patients underwent tubeless PCNL, but we do believe it would be reasonable to do so in the horseshoe kidney population and this has been described in the literature.[3] The average operating time was 80.1 minutes in the PCNL group and 67.7 minutes in the URS group. The fluoroscopy time and volume of irrigation were not regularly reported within the surgical record. Due to the referral basis of our practice, we were not able to reliably determine the number of patients on medical therapy in our cohort and the impact that medical therapy had on stone recurrence in this group. Patients who presented with infected stones routinely had either double J ureteral stents or nephrostomy tubes placed prior to any intervention. In our PCNL cohort, there was one patient with a preoperative nephrostomy tube and two patients with preoperative double J ureteral stents. In the URS group, there were two patients with preoperative double J ureteral stents. Although preoperative ureteral stenting anecdotally seems to make URS easier, we did not see any difference in success rate.

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Re: Fascelli et al: Combined Biparametric Prostate Magnetic Resonance Imaging and Prostate-specific Antigen in the Detection of Prostate Cancer: A Validation Study in a Biopsy-naive Patient Population (Urology 2016;88:125-134)

TO THE EDITOR:

I read with interest the article by Fascelli et al[1] The authors aimed to validate the use of biparametric (T2- and diffusion-weighted) magnetic resonance imaging and prostate-specific antigen (PSA) or PSA density in a biopsy-naive cohort at risk for prostate cancer (PCa) and they used formulas for validation.

The authors defined the positive threshold for PSA level as >4 ng/mL. Besides, according to this threshold, sensitivity, specificity, positive predictive value, negative predictive value, and overall accuracy of cancer detection were assessed (table 2A). The cut point of 4 ng/mL for PSA has been historic threshold.[2] The European Randomised Study of Screening for Prostate Cancer uses a cut point of 3 ng/mL, and suggests that PSA screening will correctly predict the presence of PCa (approximately 25%).[3,4] If the authors use the cut point of PSA as 3 ng/mL, they will find the sensitivity of PSA and composite 1 (PSA + 6 × the number of screen positive lesions) for detecting PCa higher.

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