

Editorial Comment

Why has the flexible cystoscope not yet been widely used?

As Yoshimura *et al.* have pointed out, flexible cystoscopy has not been widely used by most urologists.¹ They investigated the reasons for the low acceptance of the flexible cystoscope by sending a questionnaire to urologists. The authors stated that doctors who examined many patients using the flexible cystoscope thought it was advantageous in decreasing the patients' pain and it was clinically efficacious.

I agree with this result. The fact that the flexible cystoscope has a lower quality image and perfusion is one thing and the clinical usefulness which the flexible cystoscope provides in terms of less pain to the patients is another. In my opinion, the reasons for the limited use of the flexible cystoscopy are as follows.

1. As the tip of the endoscope bends, operators who are familiar with rigid endoscopes are liable to lose their orientation in the urinary bladder.
2. By using a rigid cystoscope with a 90° or 70° optical lens, it is relatively easy to find the ureteral orifices, but it is not easy for beginners to find them quickly with a flexible cystoscope. From my own data² one side of the ureteral orifice cannot be found in 10% of patients by using a flexible cystoscope without the so-called 'antegrade view'.
3. Urological doctors and co-medical staff are not familiar with handling and disinfecting flexible endoscopes.

In order not to lose orientation in the bladder, I always suggest to young doctors who are beginning to learn how to use a flexible cystoscope that the three motions (rotation, flexion and insertion) of the cystoscope should be separated. If the flexion is fixed at a certain degree, a flexible endoscope can be handled like a rigid one for rotation, insertion and drawing. Without rotating the tip of a flexible cystoscope, it is easy to find the site which operators are trying to observe by flexing, inserting and drawing. The second suggestion for novices is that the ureteral orifices

should not become the main landmarks. As air bubbles at the dome can be found easily, novices can find their orientation by coming back to the air bubbles. Even if the ureteral orifices are not found directly, they can be observed from inside the bladder with an 'antegrade view' very easily.

In my outpatient clinic we examine the lower urinary tract with a flexible cystoscope in almost all patients who are indicated to have the cystourethroscopy. As in some other clinics,³ we also perform ureteral catheterization, the removal of ureteral stents, fulguration of small recurrent tumors of the bladder, laser irradiation of the bladder or urethral stones and the insertion of ureteral stents (except in patients with a severe ureteral stricture), with topical anesthesia on an outpatient basis. It has been reported by Clayman *et al.*⁴ and other authors that there is no difference in terms of diagnostic accuracy between the flexible cystoscope and the rigid cystoscope. It is my impression that, except in patients with severe hematuria, the whole bladder is more easily observed using a flexible cystoscope because the tip of the endoscope can move freely and the bladder neck can be observed from inside the bladder. I do believe that the use of a flexible cystoscope provides less patient discomfort and savings in the health budget in that it avoids patients being admitted to hospital for transurethral procedures. As far as looking at the video monitor, there is little difference in image quality between the new videoscope and rigid endoscope equipped with a CCD camera. As the authors stressed in their article, urologists should use the flexible cystoscope as often as possible out of consideration for their patients' comfort.

References

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