is fast becoming a new destination for conducting the multi-centric trials. I would like to put a word of caution here that we should not consider this as another avenue for revenue, but should be treated as an opportunity to participate in research[7,8], while signing the clinical research agreement (CRA).

Well formulated programs by dedicated teams appear like silver lining. Here I would like to make a mention of the regular programes conducted by Indian Journal of Ophthalmology in association with P.D.Hinduja National Hospital and Medical Research Centre on Research Methodology and Scientific Writing. We have noticed a steady increase in the demand and popularity of this course and the feedback from the attendees has been very encouraging and we keep receiving plenty of appreciation letters. Developing interest in research is also evident by the popularity of the short term studentship (STS) programme of ICMR[9]. It is only natural to acknowledge that some ophthalmic institutions in India have set up good research facilities. It would be inappropriate not to make a mention of five institutions in this regard : Dr. Rajendra Prasad Centre for Ophthalmic Sciences, New Delhi; L.V. Prasad Eye Institute, Hyderabad; Post Graduate Institute, Chandigarh; Sankara Nethralaya, Chennai and Aravind Eye Hospital, Madurai.

To conclude, the research scenario in India was not very good some time back, but things are changing, opportunities are being created and support system, as well as, infrastructure is improving. Above all, the mind set is changing and approach towards research is becoming positive. I am quite optimistic and can say it with confidence that we are on the right path.

## REFERENCES

1. **Wong TY, Tan DT.** *The SERI-ARVO Meeting and future challenges of ophthalmic research in Asia. Br J Ophthalmol. 2003 Apr;87(4):379-80.*
2. **Thatte UM, Bavdekar SB.** *Clinical research in India: Great expectations? J Postgrad Med 2008;54:318-23.*
3. **Thomas R, Dogra M.** *An evaluation of medical college departments of ophthalmology in India and change following provision of modern instrumentation and training. Indian J Ophthalmol 2008;56:9-16.*
4. **Murthy G, Gupta SK, John N, Vashist P.** *Current status of cataract blindness and Vision 2020: The right to sight initiative in India. Indian J Ophthalmol 2008;56:489-94.*
5. **Gogate P, Deshpande M, Dharmadhikari S.** *Which is the best method to learn ophthalmology? Resident doctors' perspective of ophthalmology training. Indian J Ophthalmol 2008;56:409-12.*
6. **Grover AK.** *Postgraduate ophthalmic education in India: Are we on the right track?. Indian J Ophthalmol 2008;56:3-4.*
7. **Barun Kumar Nayak,** *Finer nuances of clinical study agreements for research trials Indian J Ophthalmol. 2008 Jul–Aug; 56(4): 267–268.*
8. **Nayak BK.** *Conflict of interest in biomedical publications. Indian J Ophthalmol 2007;55:409-10.*
9. **Deo MG.** *Undergraduate medical students' research in India. J Postgrad Med. 2008 Jul-Sep;54(3):176-9.*

## LITERATURE REVIEW

***Clinical Features of confirmed versus suspected Urogenital Tuberculosis.*** *Zarrabi AD, Heyns CF, Urology. 2009 May 8.*

This study compared the characteristics of confirmed vs suspected cases of urogenital tuberculosis (UGTB) in a geographic region with an extremely high prevalence of pulmonary tuberculosis. UGTB is notoriously difficult to diagnose. A retrospective clinical record review was performed of 68 patients treated from March 1989 to July 2007. Group 1 has UGTB confirmed by microbiologic or histologic examination. Group 2 had a high suspicion of UGTB because of the clinical features, but no microbiologic or histologic confirmation. This data were collected and statistically analyzed using Students t-test for parametric data and parametric data and Fisher's exact test for contingency tables (P<0.05 was accepted as statistically significant, except for flank pain (14%vs43%), renal cavitation (14%vs44%), urolithiasis (0%vs25%), and uretteral stricture formation (7%vs39%) in groups 1 and 2, respectively. Anti TB medication was given to patients (30%) in group 2 dispite the lack of a confirmed diagnosis. The out come in terms of complications and renal function loss was not significantly different between the 2 groups. Flank pain, renal cavitation, urolithiasis, and ureteral stricture formation were signficatlly more common in the group with suspected UGTB than in those with confirmed UGTB. However, other clinical characteristics did not differ significantly between the 2 groups. In patients with clinical features highly suspicious of UGTB, it appear reasonable to institute anti-TB treatment, despite the lack of a confirmed diagnosis.

***Erectile dysfunction after prostatectomy: An evaluation of the risk factors.*** *Soleimani M, Hosseini SY, Aliasgari M, Dadkhah F, Lashay A, Amini E. Scand J Urol Nephrol 2009 April 29:1-5 `*

The occurrence of erectile dysfunction (ED) in patients who have undergone prostatectomy has been assessed in the previous studies; however, its rate and risk factors vary in different studies. This study was conducted to assess the possible risk factors for ED after prostatectomy. *MATERIAL AND METHODS:* In total, 246 men with benign prostatic hyperplasia (BPH) who were candidates for either open prostatectomy or transurethral resection of the prostate (TURP) were admitted in this study during a period of 3 years between December 2000 and December 2003. Cardiac risk index was assessed before the operation using American Heart Association guidelines and erectile function was assessed both preoperatively and 6 months after surgery. Patients with moderate to severe ED according to the five-item version of the International Index of Erectile Function were considered as ED afflicted. In this study, the prevalence of preoperative ED, the incidence of postoperative ED, and those conditions that could lead to an increase in the incidence of postoperative ED in either procedure were determined. *RESULTS:* The mean age of the patients was 63.7+/-9.7 years. The prevalence rates of preoperative ED were 24.6% and 25.9% in TURP and open prostatectomy groups, respectively. Among patients with no or mild ED preoperatively, 12.5% showed moderate to severe ED postoperatively (13.4% in TURP group vs 11.25% in open prostatectomy group). *CONCLUSIONS:* The incidence rate of postoperative ED after prostatectomy was 12.5%. Risk factors for its appearance included hypertension, diabetes mellitus, higher transfusion rates, higher cardiac risk index and an older age.