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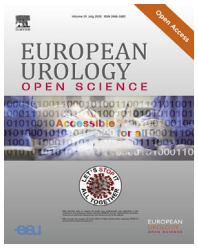


European Association of Urology

## Letter to the Editor

**Reply to Eugenio Ventimiglia, Oliver Wiseman, and Olivier Traxer's Letter to the Editor re: Andrea Bosio, Eugenio Alessandria, Simone Agosti, et al. Pigtail Suture Stents Significantly Reduce Stent-related Symptoms Compared to Conventional Double J Stents: A Prospective Randomized Trial. Eur Urol Open Sci 2021;29:1–9**

We read with great interest the letter by Dr. Ventimiglia and colleagues regarding our prospective randomized controlled trial (RCT) [1]. In their letter, they state that the final message of our article is misleading, making insightful comments and comparisons with silicone stents. We would like to reply to the authors' queries and explain why we firmly support the clarity and strength of our conclusions.

Old habits die hard: while the European Association of Urology guidelines recommend not to insert a ureteral stent after uncomplicated ureteroscopy (URS) [2], the definition of uncomplicated ureteroscopy is not standardized [3] and recent surveys have confirmed that the great majority of urologists are reluctant to perform stentless procedures, even after stone-free URS [4,5].

Dr. Ventimiglia et al highlighted the results of a RCT by Wiseman et al [6], which showed that silicone stents (Imajin, Coloplast) are better tolerated than Vortek stents after flexible URS in terms of Ureteral Stent Symptoms Questionnaire (USSQ) urinary symptoms and pain. However, the aim of our trial was to compare two differently designed devices, made of similar and commonly used material (polyurethane). The PSS conformation proved to be better tolerated than a double-J stent, while other designs, such as loop-tail stents, failed to reduce stent-related symptoms [7]. Moreover, while a robust reduction in USSQ urinary symptoms score (7 points) was immediate (2 d) for the PSS (JFil, Rocamed), the RCT by Wiseman et al showed that silicone stents provided only a 3-point advantage at day 2, reaching the best result at day 20, which exceeds the indwelling time favored by most urologists after URS. Therefore, a PSS may be more suitable than a silicone stent in cases in which the urologist decides against performing a stentless procedure and opts for a short indwelling time.

Furthermore, considering the primary endpoint of the trial by Wiseman et al (Pain Index score, measured as the sum for USSQ pain questions), the real beneficial effect on pain of silicone stents is rather difficult to interpret . Specifically, in contrast to our trial, the percentage of patients complaining of pain (>20% decrease with PSS) and Visual Analog Scale scores (2–4 point decrease with PSS) were not reported.

We do agree with the authors regarding the usefulness of a RCT comparing PSS and silicone stents and we hope to be able to conduct such a study as soon as possible.

We also agree that PSS removal represent a critical and potentially the most improvable aspect. However, in our two cases requiring rigid cystoscopy for PSS removal [1], no difficulties or consequences were noted.

Newly developed devices need time to be investigated and fully accepted. However, we believe that the results of our study are unambiguous regarding the advantages provided by PSS in terms of stent-related symptoms after uncomplicated URS. As to the inclusion criteria and the resulting applicability of the results to clinical practice, we agree with Dr. Ventimiglia and colleagues about the need to confirm the PSS security profile on a larger scale and in cases excluded from our study on a precautionary basis (distal ureteral stones and residual fragments), as discussed in our article.

However, according to the results from our study, we firmly believe that PSS could represent a significant step forward in reducing stent-related symptoms and improving patients' quality of life.

***Conflicts of interest:*** The authors have nothing to disclose.

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