

Re: Guler Y, Erbin A. Comparison of extracorporeal shockwave lithotripsy and retrograde intrarenal surgery in the treatment of renal pelvic and proximal ureteral stones ≤ 2 cm in children. *Indian J Urol* 2020;36:282-7

We read the article by Guler *et al.*^[1] with interest and appreciate the authors for providing insight toward the role of extracorporeal shockwaves lithotripsy (ESWL) and retrograde intrarenal surgery (RIRS) in pediatric urolithiasis through a comparative trial. However, we have the following observations.

The authors have performed a retrospective analysis to compare success rates of both the treatment modalities. However, the original circumstances under which a particular treatment modality was used/chosen including preference of the parents must have played a role which was undermined by the retrospective design of the study. Similarly, stone numbers were statistically different between the two groups (RIRS group was having more patients with multiple stones), which could have translated into a greater number of sessions in the RIRS group.

The authors mention that the criteria for ending RIRS session were till stone was fragmented to small fragments which were deemed passable spontaneously, but all the patients underwent either three or four sessions of RIRS, the reason for which is not mentioned. In addition, the authors mention in the discussion that procedural time in the RIRS group was still shorter than that in the ESWL group even after including preoperative and postoperative DJ stent insertion and removal, respectively, the exact data of which are missing in the results. The authors mention that procedural time in the RIRS group was 43.5 ± 12 min per patient, which appears very less because all patients underwent either three or four sessions. Does it include only single-session time?

In the discussion, the author has mentioned stone size cutoff 16 mm for RIRS success and 11.5 mm cut-off

for SWL success, but they have not mentioned as to how they reached this conclusion?

The authors have quoted that anatomical factors have not been taken into consideration in the ESWL group because of nonavailability of intravenous urogram in all the patients. They have cited a study^[2] mentioning the important variables for clearance of stones from the lower calyx as infundibulum length (>3 cm), infundibular width (<5 cm), and infundibulopelvic angle ($<45^\circ$).^[2] Whereas the original study^[2] quoted mentions that infundibular width has no impact on stone clearance rate and infundibulopelvic angle cutoff was established as 40° .

The authors in the present study have rightly mentioned that stone clearance rate in impacted upper ureteric stones is lower due to lack of natural expansion space which was established in literature,^[3] but the article^[4] cited by the author concludes a view contrary to what has been quoted. This article says that ESWL is an effective and reasonable initial therapy in the management of impacted upper ureteral stones measuring <2 cm and pre-ESWL ureteral stenting provides no additional benefit over *in situ* ESWL.^[4]

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