

AUTHOR'S REPLY

Reply to: Antoniewicz AA. More aggressive intrarenal endoscopic maneuvers are assuring a stone free outcome and safety. Cent European J Urol. 2015; 68: 197-198.

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We would like to thank you for your considerable comments on our study and for your valuable contributions. As mentioned in the editorial comment, flexible ureteroscope with holmium laser has been more commonly used in the treatment of upper urinary system disease especially urolithiasis, small transitional cell tumors of the upper urinary tract, and ureteral strictures. Moreover, this procedure is effectively performed with a high success rate in complicated cases [1, 2]. We agree with Dr. Antoniewicz that our study had a small number of patients, which was the most important limitation of our study. Nonetheless, we accept that the combination of rigid and flexible ureteroscopies in the treatment of unilateral ureteral and renal stones is a feasible, effective, and safe alternative due to minimal complication rates and higher SFR (88.9%) [1].

SFR following RIRS (retrograde intrarenal surgery) have been described differently; SFR may be described either as residual fragments smaller than 4 mm or smaller than 2 mm in addition to no residual fragments, by different authors [3]. We consider SFR as either no fragments at all and/or presence of asymptomatic residual fragments <4 mm in the urinary system as in the majority of the studies published. As mentioned by Dr. Antoniewicz, some anatomical conditions such as hydronephrosis and unfavorable intrarenal anatomy are the most important

factors in the evaluation of stone clearance rates [4]. Unfortunately, we could not use these parameters in our study in the determination of SFR because of its retrospective nature.

UTI (urinary tract infection) is one of the most commonly encountered complications following ureteroscopy, with an incidence of <2.2%, some of which may result in urosepsis [5]. As prophylaxis, we routinely give an intravenous antibiotic (generally second generation cephalosporin) unless a urine culture suggests the use of a different antibiotic, at the outset. Compatible with the literature, UTI with fever was seen in one of our patients (1/45) [5].

There are two major advantages of a pre-stenting technique in the RIRS as referred by Dr. Antoniewicz: 1 – to prevent intraoperative ureteric injury and 2 – to prevent distal ureteral stricture [4]. We do not routinely use this technique in order to prevent second session RIRS. In case, when neither ureteral access sheath nor flexible ureteroscope can be advanced up to the kidney due to the ureteral stricture, we use a pre-stenting technique (generally 4.8F 26 cm an internal stent). These patients have been successfully treated with RIRS after at least 15 days. In the present study, we did not use a pre-stenting technique but we inserted an internal stent in 38 of 45 patients after the surgery, which was statistically significant according to the control group ($p = 0.001$) [1].

References

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