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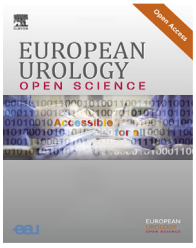

European Association of Urology

Letter to the Editor

Reply to Pankaj N. Maheshwari, Aditya Goal, and Pushkar Srivastava's Letter to the Editor re: Manuel Armas-Phan, Benjamin N. Schmeusser, Nicholas W. Eyrich, and Kenneth Ogan. Double-J Stent Misplacement in the Inferior Vena Cava and Right Atrium: A Urovascular Nightmare. Eur Urol Open Sci 2022;46:128–34

We appreciate the interest expressed by Dr. Maheshwari and colleagues regarding our manuscript detailing ureteral stent misplacement during gonadal vein to bladder anastomosis [1]. Their comments on our article are well received and we are happy to answer their questions, particularly surrounding the issue of gonadal vein thrombosis and the decision to embolize the gonadal vein.

We enjoyed learning from Maheshwari et al about the high rate of gonadal vein thrombosis following hysterectomy. In our case, preoperative computed tomography revealed no evidence of gonadal vein thrombosis. In addition, intraoperative angiographic evaluation of the gonadal vein and inferior vena cava revealed a patent gonadal vessel with no evidence of thrombosis. In light of these findings, the urology and vascular surgery services made the joint decision to proceed conservatively given the rarity of this clinical situation. We established through-and-through access before stent removal in order to maintain access for further vascular interventions. We visualized the iatrogenic fistula with a cystoscope to assess the presence bleeding. While there was no active bleeding at that time, it was not immediately clear whether or not bleeding would ensue once the wire was removed from the gonadal vein. Therefore, a joint decision to coil embolize the gonadal vein was made while the two services were simultaneously available.

We agree with Maheshwari et al that cystoscopic stent removal alone represents a safe alternative management option, as demonstrated by other authors and included in our discussion [2,3]. Alternatively, several other reports included vascular approaches for stent removal [4–7], highlighting once again the case-dependent management of these complex scenarios. We feel that much of the decision-making process depends on the individual case and resources available at the time.

It should also be noted that the patient in this specific case had been through multiple surgical complications and mishaps over the previous several months. Therefore, our aim was to take all precautions necessary for a swift, complication-free path to recovery while all resources were available. Our patient has since undergone a successful ureteroneocystostomy and has not experienced any complications following this procedure.

Finally, we have reviewed with great interest the manuscript by Maheshwari et al [3] describing anastomosis of the gonadal vein to a Boari flap with subsequent ureteral stent-inferior vena cava involvement. We commend their group on the safe management of their patient, and are impressed with their knowledge regarding this complex and rare scenario.

Again, we thank Dr. Maheshwari and colleagues for their thoughts and considerations regarding our manuscript.

Conflicts of interest: The authors have nothing to disclose.

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