Letters to Editor

Re: Agrawal *et al*. Ultra-mini-percutaneous nephrolithotomy: A minimally-invasive option for percutaneous stone removal. Indian J Urol 2016;32:132-6

Dear Editor,

I read with great interest the article "Ultra-mini percutaneous nephrolithotomy: A minimally invasive option for percutaneous stone removal" by Agrawal et al.[1] This article presents a new method in managing renal stone with very promising result. The authors demonstrate a successful reduction in size from 30F for conventional PCNL to 11F in ultra-mini-PCNL. This reduction will reduce tissue trauma and bleeding.[1] Further, they did not routinely use a nephrostomy or stent which will possibly allow us to categorize ultra-mini-PCNL as less invasive than conventional PCNL.

However, the question which is not solved from this study was regarding the specific indication for this procedure. In this study, the authors used this procedure to treat renal stone (pelvis, upper calyx, middle calyx, and lower calyx) and upper ureteric stone size between 8 and 20 mm. The other methods of treatment were well established their specific indication. For example, in the European Association of Urology guideline, PCNL is recommended therapy to treat large renal stone (>20 mm) and smaller stones (10–20 mm) of the lower renal calyx when unfavorable factors for shockwave lithotripsy (SWL) exist.[2] Retrograde intrarenal surgery (RIRS) was recommended in treating lower pole renal stone <20 mm.[2]

Wide range of cases treated by ultra-mini-PCNL in this study included lower pole renal stone and upper ureteric stone with stone size of 8–20 mm. This broad range may include unnecessary intervention for asymptomatic cases. A previous study by Koh *et al*. found that in asymptomatic renal stone, only about 7.1% will become symptomatic and required intervention.[3] Further, they found that 20% had spontaneous stone passage with 45.9% stone size progression.[3] In another study, upper ureteric stone size 8 mm had 56% spontaneous passage rate.[4] There is thus evidence that some renal stones may not require any intervention. Therefore, selection of patients is crucial especially in establishing new gold standard treatment procedures. The authors do include in this study specific indication such as presence of narrow infundibulum with calyceal stone, diverticular renal stone, stone refractory to SWL, and failed RIRS. There was no elaboration on percentage of these types of stones and their outcomes. I do hope further studies regarding this matter will be carried out, to enable ultra-mini-PCNL as one of the recommended treatment options for specific type of renal stone.

Mohd Nazli Kamarulzaman*

Department of Surgery, Urology Unit, Kulliyyah of Medicine, International Islamic University Malaysia, 25100 Kuantan, Pahang, Malaysia

*E-mail: nazlikamarulzaman@gmail.com

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