Letters and comments

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COMMENT ON

JR Wilson, GH Urwin, MJ Stower. The role of percutaneous nephrostomy in malignant ureteric obstruction. *Ann R Coll Surg Engl* 2005; **87**: 21–4

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Intervention to decompress the upper tracts in patients with established pelvic malignancies

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Intervention to decompress the upper tracts in patients with established pelvic malignancies is fraught with both technical and ethical difficulties. Two issues have become increasingly clear in the management of such cases – neither of which is particularly clear from the article. First, for decompression, percutaneous procedures are preferable to attempts at retrograde stenting. Chitale and co-workers,¹ for example, compared the relative success rates and reported a 21% success rate with retrograde stenting and a 100% success rate with nephrostomies. Additionally, it would appear that even if retrograde stenting is successful, there is considerable doubt over the efficacy of the ureteral stents given that intra-uretral stent placement alone has only a marginal effect on improving renal function. It would seem that there is a complex interplay between ureteral peristalsis, venting stent side-holes and flow rate. At the most basic level, failure of ureteral co-aptation prevents extraluminal urine flow so

that intraluminal stent flow becomes increasingly important – a factor often compromised in extrinsic compression.² Second, the selection of patients who might benefit from intervention is less disease specific (as the authors intimate) and instead better related to available treatment options.³ In the study by Watkinson *et al.*,³ the authors reviewed 50 patients with advanced abdomino-pelvic malignancies who underwent percutaneous nephrostomy. Four groups were sub-classified by median survival times. In that group with relapsed disease for which there was no conventional treatment option, the median survival time was extremely poor (median, 38 days) with no long-term survivors – poorer outcomes than any described by Wilson *et al.* Intervention in this group of patients necessarily needs to be individualised and considered on a case-by-case basis by a multidisciplinary team. Only then can patients make an informed judgement about the merits of intervention.

References

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3. Watkinson AF, A'Hern RP, Jones A, King DM, Moskovic EC. The role of percutaneous nephrostomy in malignant urinary obstruction. *Clin Radiol* 1993; **47**: 32–5.

AUTHORS' RESPONSE

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In our article, there was a 100% success rate in the primary placement of percutaneous nephrostomies in patients presenting with malignant ureteric obstruction. Subsequently, only 19 of the 52 patients (59.4%) underwent a successful staged antegrade ureteric stent placement. This figure is lower than the 98% quoted by Chitale *et al.*¹ However, the number of patients in our study was rather small. Primary cystoscopic retrograde ureteric stent placement was not attempted in the management of any of the patient cohort in our study.