AUTHOR'S RESPONSE

JAMES SKIPWORTH
UCL Department of Surgery, London, UK
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CORRESPONDENCE TO

James Skipworth, UCL Department of Surgery, 4th Floor, Medical School Building, 74 Huntley Street, London WC1E 6AU, UK
E: j.skipworth@ucl.ac.uk

Following discussion amongst the authors, we have two main comments:

1. Mr Shah states: 'In this particular case, re-anticoagulation with warfarin seems to be one of the predisposing factors causing secondary bleed'. In this case, the patient complained of feeling unwell and lethargic, looking pale, and having abdominal and shoulder-tip pain on the first day following colonoscopy, leading her GP to prescribe antibiotics for a presumed respiratory tract infection. Therefore, we feel that re-anticoagulation with warfarin, when it was only re-instituted 4 days following commencement of symptoms (particularly after only 2 doses and when warfarin had been ceased for the nine previous days) cannot be said to be anything more than a potential exacerbating factor in this patient, in whom there is no conclusive evidence of a significant secondary bleed.
2. Mr Shah also states: 'The spleen was found to be shattered with very little enhancing tissue on the computed tomography scan highlighting that injury was due to traction injury to the atheromatous splenic vessels rather than the capsular tear as seen in our case report'. We feel that the extent of injury seen in this case is unlikely to be sustained following traction injury to the splenic vessels alone, and that, therefore, there must have been at least some concurrent damage to the splenic capsule.

Truly tubeless percutaneous nephrolithotomy

RJ CETTI, SR KEOGHANE, BH WALMSLEY
Queen Alexandra Hospital, Portsmouth, UK
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CORRESPONDENCE TO

RJ Cetti, Southampton General Hospital, Tremona Road, Southampton SO16, UK. E: richcetti@hotmail.com

COMMENT ON

Yates DR, Safdar RK, Spencer PA, Parys BT. 'Nephrosotomy-free' percutaneous nephrolithotomy: experience in a UK district general hospital. *Ann R Coll Surg Engl* 2009; **91**: 570–7.

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The technique of percutaneous nephrolithotomy (PCNL)

has been steadily refined since its development in the 1970s. As the procedure has evolved, avoiding the potential morbidity of a large bore nephrostomy tube has led to the search for alternatives to drain the kidney. These have included a smaller bore nephrostomy, externalised ureteric catheter, or internal ureteric stent. Desai and colleagues¹ compared uncomplicated PCNLs randomised to have a small 9-Fr nephrostomy versus a conventional 20-Fr tube versus a JJ stent. The group with a smaller tube had reduced analgesic requirements and hospital stay, without additional complications, and the stented group had the lowest analgesic requirement and shortest hospital stay. However, this approach does induce stent-related morbidity which is variable in nature but sometimes significantly affects the patient's quality of life and requires a separate procedure for removal.¹ In a recent series of 170 patients in whom a stent was placed post PCNL, five required a postoperative emergency nephrostomy insertion for obstruction.² In the series of Yates *et al.*,³ immediate and early complication rates were higher in the stented group including haematuria requiring re-admission, clot colic, stent pain and stent migration. They also described a delayed presentation of perinephric haematoma and abscess formation.³

True tubeless PCNL has been evaluated by Crook and colleagues^{4,5} and found to be safe and well-tolerated. No differences were seen in stone free rates, transfusion, and complication or re-admission rates. Mean length of stay was shorter in the tubeless group (2.3 days vs 3.4 days).^{4,5}

Yates and colleagues advocate that a nephrostomy-free PCNL should be adopted as the standard for patients requiring PCNL in the UK. We would argue that this exposes patients to an increased risk of complication, as demonstrated by their study. Instead, patients should be treated as individuals. If postoperative bleeding or retained calculi are a possibility requiring a 'second-look', then a nephrostomy should be sited to provide access or a tamponade effect. The use of a ureteric stent or catheter provides neither of these. They should otherwise be left truly tubeless. By stenting every patient, are the authors' treating the patient or themselves?

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