Introduction

Semi-Rigid Ureteroscopy (URS) is well acknowledged for the management of urolithiasis in the mid and lower ureter. With the recent development of Flexible Ureteroscopy (fURS) and laser technology, more intra-renal and proximal ureteral stones are successfully treated through natural lumen [1,2]. Bilateral Same-Session Ureteroscopy (BSU) possesses advantageous potentials, such as decreased procedure number and anesthesia, shorter hospital stay and lower cost. However, it was not widely practiced in older times, or even regarded as risky with higher chance of bilateral ureteral injury and other complications [3]. In the background of contemporary endourology, we sought to investigate the effectiveness and safety of BSU and designed this prospective study.

Material and Methods

Inclusions, grouping and exclusions

Patients with bilateral urolithiasis in the upper urinary tract were included by following criteria: age over 18 yrs old; overall stone burden (accumulated diameter) ≤40mm; size of single stone ≤20mm in the major burden side and ≤15mm in the minor; preoperative Serum Creatinine (sCr) normal. Patients were grouped into low burden (<20mm) and high burden (≥20mm) by overall stone burden. Parameters of operation and follow up were evaluated and compared.

Results: 32 cases (male19, female13; age 53.2±14.2yrs) were included from Jan 2013 to Dec 2014. Overall stone burden was 23.7±7.6 (14-40) mm, total stone number 109 (renal 78, ureteral 31). Operative time was 99.2±32.5 (50-175) mins, postoperative hospitalization 2.4±1.4 (1-6) days. Staged procedure took place in two cases. The immediate SFRs after first procedure and overall were 72.0% and 91.0%. However, the immediate SFRs in low burden and high burden were 100% and 50.0% (P=0.002) respectively. No significant sCr change was detected (p=0.711) and no major complications occurred.

Conclusions: BSU for selective cases with bilateral urolithiasis in the upper urinary could be redefined at contemporary endourology. From our study, it is effective and safe with high SFRs, no renal damage and minimal complications. Patients with low bilateral burden (<20mm) may benefit from the immediate stone clearance.
Semi-rigid URS (8/9.6F, Olympus), fURS(URF-P5, Olympus) and digital fURS (URF-V, Olympus) were used. Holmium laser system (Power Suite 100W, Lumenis) was for lithotripsy with 200µm or 365µm fibers. C arm (Siremobil Compact L, Siemens) was utilized in every procedure. 1000ml-bagged normal saline in pressurized cuff was for irrigation. 0.035" hydrophilic guidewire (nitiol, Bard), ureteral catheter (F5, Bard), ureteral access sheaths (AUS, F12/14 35cm COOK or F11/13 36cm Boston Scientific) and baskets (F1.7 Ngage, COOK or F1.9 ZeroTip, Boston Scientific) were prepared.

Procedure

All procedures were performed by the same surgical team. Stone free status was defined as fragments <2mm. When the stone was in the distal ureter, semi-rigid URS was performed. For stones in the proximal ureter, semi-rigid URS was used first to break and then push back to the kidney. When stones were located inside the kidney or pushed back, fURS was performed under standardized manipulations as described elsewhere [4].

Setting of the holmium laser usually started at 3.6W(0.6)x6Hz), and ramped up as needed. After dusting and fragmentation, a basket was used to remove fragments bigger than 2mm. Staged procedure was considered by operation length, stone load, and intraoperative complications. Ureteral catheters or stents were placed bilaterally and removed in 24-72 hours or 2-4 weeks. sCr level was checked immediately after the procedure, and monitored continuously if elevated. KUB (radio-opaque) or NCCT (radiolucent) was taken in the first operative day and one month after stent or catheter removal. If patients did not come back timely, further evaluation was to be completed at later time. Patients with seeming intraoperative injuries should be followed up to 12m for late complications. Parameters, such as preinsertion, operation time, procedure number, postoperative hospitalization, immediate and overall SFR, and early and late complications were recorded and compared.

Table 1: Patient’s data and operative parameters.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall stone burden (mm)</td>
<td>23.7±7.6 (14~40)</td>
</tr>
<tr>
<td>Renal burden</td>
<td>15.4±9.7 (0~37)</td>
</tr>
<tr>
<td>Ureteral burden</td>
<td>8.2±7.2 (0~34)</td>
</tr>
<tr>
<td>Stone#</td>
<td>3.4±1.6 (2~10)</td>
</tr>
<tr>
<td>Renal stone#</td>
<td>2.4±1.7 (0~8)</td>
</tr>
<tr>
<td>Ureteral stone#</td>
<td>1.0±0.7 (0~3)</td>
</tr>
<tr>
<td>Prestenting</td>
<td>23/32 (71.9%)</td>
</tr>
<tr>
<td>Procedure</td>
<td>1.1±0.2 (1~2)</td>
</tr>
<tr>
<td>Operation time (min)</td>
<td>97.7±32.0 (50~175)</td>
</tr>
<tr>
<td>Postoperative stay (day)</td>
<td>2.4±1.4 (1~6)</td>
</tr>
<tr>
<td>sCr preoperative (µmol/L)</td>
<td>78.3±15.0 (47.5~97.0)</td>
</tr>
<tr>
<td>sCr postoperative (µmol/L)</td>
<td>77.9±15.3 (35.4~111.0)</td>
</tr>
<tr>
<td>Immediate SFR after 1st procedure</td>
<td>23/32 (72.0%)</td>
</tr>
<tr>
<td>Overall SFR</td>
<td>29/32 (91.0%)</td>
</tr>
<tr>
<td>Complications</td>
<td>Hemorrhage 1, Fever 4</td>
</tr>
</tbody>
</table>

### Results

At the approval from the Institutional Ethical Committee, 32 cases (male 19, female 14) were included from Jan 2013 to Dec 2014. Age 53.2±14.2 (19~79); BMI 25.6±3.1 (19.9~35.3)kg/m²; overall stone burden 23.7±7.6 (14~40)mm; renal stones 15.4±9.7 (0~37)mm with 47.4% in the lower pole; ureteral stones 8.2±7.2 (0~34)mm with 51.5% in the proximal 48.5% in the distal. Total stone number 109, renal 78 (37 in the lower pole) and ureteral 31 (15 proximal and 16 distal). A concurrent strictured infundibulum in the lower pole was found in 1 case and an upper pole diverticulum with stones in another case. 2 cases had elevated sCr due to obstruction, which was relieved by stenting. 71.9% (23/32) cases received preplaced stents.

Totally, 34 procedures of URS with/or fURS were performed with 2 cases having a second staged procedure. Average operation time was 99.2±32.5 (50~175)mins, postoperative hospitalization 2.4±1.4 (1~6)days. No significant sCr changes was detected (P=0.711), preoperative 78.3±15.0 (47.5~97.0)µmol/L vs. postoperative 77.9±15.3 (35.4~111.0)µmol/L. Elevated sCr was found in 1 case and returned to normal in 2 weeks. Immediate SFR after the first procedure was obtained in 72.0% (23/32) and the overall SFR 91.0% (29/32). We had 3 cases with residual stones. In the first one, an asymptomatic upper pole diverticulum with stones was not found during the procedure. In the second case, a radiolucent stone in the lower pole was missed. The third case had discontinued procedure due to hemorrhage for incision of infundibulum to reveal a calyceal stone. Complications were observed in 5 cases, degree as Clavien II in 4 (hemorrhage 1, and fever 3) and Clavien I in 1 (fever 1). In one case of fever, blood culture turned positive of E coli., but no signs of septic shock. The case of hemorrhage was the one of infundibulum incision. They were statistically significant.

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all managed conservatively. During the median follow up of 20(7-30) months, no ureteral stricture was observed (Table-1).

14 and 18 cases were grouped into low and high burden respectively. In the high burden group, more preplaced stenting (88.9% vs 50.0%, P = 0.015) and longer operation time (116.1±29.8 vs 73.9±14.3min, P<0.001) were observed, but much lower immediate SFRs after the first procedure than in the low burden group (50% vs 100%, P=0.0002). Other parameters, such as age, sex, BMI, stone number, procedure number, postoperative hospitalization, overall SFR, and complications, were not significantly different in the two groups (Table-2).

Discussion

Effectiveness and safety of BSU has been in the argument for some time [3,5-9]. When compared with separate staged procedures, potential to reduce procedure number, operation time, anesthesia, hospitalization and cost is straightforward [3,5]. But in the previous publications, BSU was subject to bilateral ureteral surgical injuries [6,8]. 22% ureteral perforation rate was reported by Deliveliotis et al [5] using a F10.5-11 semi-rigid URS. And it was claimed BSU was only indicated bilateral distal ureteral stones [5,10]. However, due to the growth of industry and endourology, URS practice has very much improved. With the miniaturized endoscopy and experience accumulation, overall URS complication rate dropped to 5-9% and perforation less 2% [11]. Although good results were published for BSU by semi-rigid URS [12] or combined with iURS [13,15], those studies were retrospective, long in time gaps (5-15yrs) and of mixed lithotripsy, thus less coherent and promising, and we did not find any study about BSU last 3 years. In the current study, a prospective design was made up with careful inclusions and exclusions. Excellent URS and/or iURS together with holmium laser and modern consumables were used in all procedures, as the standard setup for contemporary endourology.

Factors, such as stone burden, composition, location and anatomy, may have impact on effectiveness [12,16]. For simplification, stone burden of accumulated diameters was taken as inclusion in the study. Single stone size was defined further based on our previous experience. Renal function is crucial as well. Although relief of bilateral obstruction was intriguing, acute renal insufficiency and anuria following BSU had been reported in those of preoperative bilateral obstruction was noted. In our study, immediate SFR (72.0%) after first procedure and overall SFR (91.0%) was comparable to those in other reports. Fragment retrieval was performed with a basket as much as possible to ensure a good stone clearance [19]. This may explain that our operation time was relatively longer. However, when patients were grouped by stone burden, 100% immediate stone clearance was seen in low burden (<20mm). It is understandable that high burden is related with more operation time and a lower immediate SFR even though fragmentation was done as completely as possible. During immediate postoperative imaging, more fragments were left in high burden group and some might stay too close to be distinguished. For every patient, however, a good immediate SFR may relieve the patient’s worry and suffers from fragment expulsion.

No significant renal function damage was detected in our study, which was comparable to that by Huang et al [18]. Only 1 case experienced postoperative elevated sCr(111.0) and resumed to normal(81.0) in 2 weeks. In this case, operation time over 1 hour on each side was performed in order to reach an immediate stone free status. Thus, prolonged operation time should be avoided. Though complications took place in 17.8% (5/32), no severe life or organ threatening event happened and all managed conservatively. With the care to the ureter, no stricture was found postoperatively.

Our study is not without limitations. Due to the relatively small volume, a multivariant analysis to find out independent influencing factors on SFRs and complications could not be made. Renal scan to clarify detailed split renal function and a reliable intra-renal pressure sensing may help monitor and control the process of the procedure. Further studies may focus on these issues or randomized trials with a larger volume would be better to establish the fundamentals of BSU.

Conclusions

BSU for selective cases with bilateral ureolithiasis in the upper urinary could be redefined at present endourology. From our study, it is an effective and safe treatment with excellent stone clearance, no adverse impact on renal function and minor complications. Apart from overall cost-effective potentials, patients of low bilateral stone burden(<20mm) may benefit from immediate stone clearance, minimizing the expulsion related sufferings and worries.

Acknowledgments

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References


