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TRAUMA AND RECONSTRUCTIVE UROLOGY

Sometimes the communications are of special value

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In everyday practice, emphasis should be put on a well-evidenced series of procedures over individual cases, even when these are accomplished successfully and spectacularly. Nevertheless, sometimes communication regarding “rare birds” is of special value, particularly in surgery, because with time they may become the swallow which makes the summer.

In this issue of CEJU [1], authors from a highly laparoscopically-experienced center report a case of reimplantation of a strictured ureter in a transplanted kidney. It is a pity that data regarding only one case, followed-up for 3 years, is presented; however, the authors do acknowledge that up to now they have performed five procedures of this kind.

Although complications after kidney transplantation associated with the anastomosis of the donor ureter to the recipient bladder rarely cause graft loss, they are usually complicated and difficult to treat. Depending on the definition used, the incidence of ureteral complications may vary from 2.4 up to 12.5% [2, 3]. The incidence depends on several conditions, including the quality of the organ retrieved for transplantation, the length and vascularity of the ureter, personal surgical technique (extravesical or intravesical anastomosis), the center's volume, and the option of ureteric stents to provide better outflow from the transplanted kidney to the bladder. The differential diagnosis between an early ureterocystoneostomy leak or distal ureteral necrosis and acute renal insufficiency may be difficult sometimes, and even life-threatening [4].

In most cases, open reimplantation is considered a second-line treatment after failed endoscop-

ic attempts. It usually consists of antegrade double J stent placement and balloon dilatation, with a success rate of 44–62% [5]. Other endourologic methods of treatment, including antegrade or retrograde endoureterotomy using electrocautery, laser or cold knife, offer greater success rates [6, 7]. As laparoscopy, with all its well-known benefits, successfully replaces the classical open approach, it was only a matter of time before being implemented in the treatment of ureteral strictures [7]. Based on personal experience, I fully agree with the authors that the most difficult step of the aforementioned procedure is to identify the ureter without compromising its vascularity. They used an intraoperative pyelography for the identification of the ureter. It is both a clever and elegant trick. However, one must remember that in cases of long ureteral strictures (>5–6 cm), a Boari flap or psoas hitch procedure may be necessary, possibly requiring more laparoscopic experience. It would be interesting to know what the authors usually consider a first-line treatment. My experience with an endoscopic approach is limited. All transurethral devices are designed for straight-forward working direction and do not allow for an attempt at ureterocystoneostomy located on the anterior wall. At times, this makes the localization or insertion of any guide-wire difficult or even impossible. The authors of this paper raised an interesting question regarding the best method of treatment of ureteral strictures following kidney transplantation and, with the presented case, they demonstrate a possible solution and approach for the future.

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