AUTHOR'S REPLY

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From our point of view, ureteral reimplantation is the definitive treatment of ureteral stricture in renal transplants. Endourological maneuvers are alternative with 75% success rates in more optimistic series [1]. In many cases patients are forced to carry ureteral pigtail stent chronically with periodical removal/changes and with problems typical for immunocompromised patients. With results obtained by our technique of laparoscopic ureteral reimplantation we try whenever possible a definitive surgical treatment [2].

Indeed, the most common cause of ureteral stenosis is distal ischemia, which is a fact that in the past was resolved considerably by employing a graft ureter as short as possible. Unfortunately, the problem has not disappeared altogether and is estimated at a rate of 5–8% [3]. In any case, the most common circumstance is distal juxtavesical stricture of greater or lesser length, and in these cases ureteral reimplantation is the most effective treatment. However, in some cases we can find strictures so long that ureteral reimplantation is not feasible. In these cases the most efficient alternative is the pyelo–pyelic anastomosis with the native ureter [4]. The experience of our group in laparoscopic ureteral reimplantation of the native ureter (iatrogenic strictures) is more than 40 cases currently [2] and only in one case we needed to perform a Boari flap. In most of cases we made a vesico–psoas hitch. In the group of transplanted patients these resources are unusual because as mentioned, if the stricture is very long the best to perform is a pyelo–pyelic anastomosis.

References

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