

ÖZET :

30 Üreteropelvik bileşke darlığı gösteren hastada 30 endopyelotomi yaptık. 13 vakada primer Üreteropelvik darlık varken 17 vakada sekonder Üreteropelvik daralma vardı. Takip sadece 24 hastada yapılabildi.

Yeterli Sonuç : 21 vaka (%87.5)

Yetersiz Sonuç : 3 vaka (%12.5)

Septisemi iki vakada gözlemlendi. Endopyelotomi stentinden olan ciddi reflüks 2 vakada gözlemlendi. 3 vakada radyolojik düzelme saptanmadı. Endosplintin renal ucu kapalı bir sistemin devamı için kısa kalmıştır. Böyle hastalarda Nefrostomi tüpü 3-4 günde alındı. Endosplint mesanenden çekilerek 3-4.'cü hafta sonra alınabilir.

SUMMARY:

We have done 30 Endopyelotomies in 30 cases of UPJ narrowing. Primary UPJ obstruction was encountered in 13 cases and secondary UPJ narrowing was found in 17 cases. Follow-up was available for 24 cases only.

Good results: -21 cases (87.5%)

Failures: -3 cases (12.5%)

Complication of Septicemia was noted in two cases. Severe reflux through the endopyelotomy stent was noted in two cases. In the 3 cases that failed radiographic deterioration was not found. Renal end of the Endosplint can be made shorter to maintain a closed system; in such cases Nephrostomy is removed after 3-4 days. The Endosplint can be removed after 3-4 weeks by pulling it out from the bladder.

Anahtar kelimeler: Endopyelotomi. Üreteropelvik darlık.

Key words: Endopyelotomy, ureteropelvic obstruction.

MATERIAL AND METHODS:

A total of 30 percutaneous treatments for Ureteropelvic junction obstruction was performed in 30 symptomatic patients 4 to 48 years old. Primary UPJ obstruction was encountered in 13 cases and secondary UPJ narrowing was found in 17 cases.

The diagnosis of Ureteropelvic junction obstruction was made by excretory Urography (IVP) and confirmed in equivocal cases by a diuretic stimulation test. Of 30 primary and secondary UPJ obstructions 18 had concomitant rena calculi that were clearly secondary to stasis.

Post operative results were evaluated at 2 months by a careful review of symptoms and a diuretic IVP. The patients were seen at 6-months

intervals there after; 6 cases were lost to follow-up.

Operative technique:

After a ureteric catheterisation the patients is placed in a prone position. Puncture is usually done through the middle calyx and a deep postero-lateral cut at the UPJ is placed. A endosplint has a 14.0 Fr. diameter which remains at the UPJ and 7.0 Fr. double-J like extension which starts from the mid-ureter upto the bladder. A smaller size endosplint is necessary for paediatric patients.

RESULTS

Of 30 endopyelotomies 6 cases were not evaluable. Out of 24 cases (13 cases of primary UPJ narrowing and 11 cases of secondary UPJ

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narrowing) 21 cases showed radiological improvement and 3 cases did not show any improvement. However there was not deterioration of radiological features nor any deterioration in symptoms.

On evaluation 87.5% were asymptomatic with a negative diuretic IVP (rapid emptying of renal pelvis and no increase in size with diuresis). In 12.5% cases the patients did not improve symptomatically. However they have not opted for an open procedure or a repeat endopyelotomy.

Operative time averaged 110 minutes, with a range of 50 to 190 minutes. Perioperative blood transfusion was not given to any case. Mean duration of postoperative hospitalisation was 3.0 days.

Complications

Septicemia was noted in two cases; 4 and 8 days postoperatively. It was managed by blood transfusion and antibiotics in one case and only antibiotics in the other case. Severe reflux was noted in 2 case. Urine from the normal kidney was seen refluxing back from the endosplint and per urethral output remained extremely low. Perhaps this was because of the large caliber of the endosplints.

DISCUSSION

Endopyelotomy is an accepted technique now the world over. Attempts are being made to improve the results further. There are two methods to cut the UPJ; (a) Percutaneous

approach and b) Ureteroscopic approach. We find the percutaneous approach better because; (i) secondary stones can be removed (ii) better control over UPJ (iii) nephrostomy placed for 3 days so that pelvicalyceal system is thoroughly decompressed (iv) A rigid Ureteroscope may not reach the UPJ in more than fifty percent cases.

Now we cut the endosplint in such a manner that once the nephrostomy is removed the endosplint remains in the kidney and the nephrostomy site gets sealed in 2-3 days. The entire endosplint is removed from the bladder after 3-4 weeks. Special endosplints have to be prepared for such a manoeuvre (i. e, shaft of 12.0 French and tail of 6.0 french). Smaller size endosplints should be used for Paediatric cases.

KAYNAKLAR

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