RE: Emphysematous pyelonephritis: Is nephrectomy warranted?

Sir,
We read with great interest the article “Emphysematous pyelonephritis: Is nephrectomy warranted?” by Alsharif et al.1 This article highlights interesting updates in managing emphysematous pyelonephritis (EPN) from radical surgery to medical management. Similar finding was published earlier by Ubee et al. in their literature review.2 They noted the trend toward medical management was begun since the late 1980s. This change in management trend was associated with improve in mortality from 40% to 50% in the 1970s to 13.5% recently.2 It was similar in this paper which had the rate of 30% and 100% for overall mortality and radical nephrectomy rate, respectively. This trend of management seems to be widely accepted all over the world.

Big doubt for us regarding this paper is the selection criteria of the patient for each arm of treatment choices. These criteria were not elaborated by the authors. Furthermore, the patients were selected from three different tertiary centers, which will further increase the selection bias. The results clearly shown that both patients who undergo early nephrectomy had lower hemoglobin (Hb) level (7.1 and 7.4 g/dl), whereas others had Hb range between 9.1 and 13.1 mg/dl.1 As Hb levels usually determine the chronicity of the disease, there was a possibility that both patients had late detection. Besides that, there were three patients developed septic shock in this series. Two of these patients died; one for medical management and another one for early radical nephrectomy. Both of them had other associated medical illness. The patient who had medical management had active tuberculosis on treatment, and the other one had multiple comorbidities include diabetes mellitus, hypertension, ischemic heart disease, liver cirrhosis, and hypothyroidism.1 Whereas the patient who survived after septic shock was younger (55-year-old) and has less medical illness (only diabetes mellitus and hypertension).1 In our opinion, these showed that the mortality in this series was much related to late detection and multiple comorbidities rather than treatment option. Those patients were immune compromise at presentation. It was similar trend as in the previous paper by Ubee et al., and they suggested a management algorithm for EPN based on Huang and Tseng EPN classification.2 They proposed two groups of patients that should be suggested for nephrectomy, which were failed medical management and patients with EPN Class 3A and 3B with two or more risk factors (diabetes mellitus, thrombocytopenia, acute renal failure, altered level of consciousness, and shock).2 It was clearly showed that both papers proposed the patients who were treated with nephrectomy were in the end of sepsis spectrums. Thus, the poor outcome can already be predicted.

In our opinion, early nephrectomy had its own role in managing EPN, especially cases where the renographic clearance were <10%.3 The percentage of EPN patients undergone surgery will be markedly reduced with early detection and aggressive medical management. However, the comparison between medical management and early nephrectomy in term of mortality cannot be ascertained except similar group of EPN patient being subjected for each arm of treatment options. Patients with multiple comorbidities and in sepsis certainly had higher mortality rate regardless of whatever treatment given.

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Conflicts of interest
There are no conflicts of interest.

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