[18] Fluoroscopy free JJ stent placement through ureteroscope working channel after uncomplicated ureteroscopic laser lithotripsy: A novel technique

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Objective: To report a technique for ureteroscopic laser lithotripsy (URSL) and retrograde placement of a JJ stent through the ureteroscope working channel without the use of a fluoroscope compared to the conventional technique.

Methods: Between June 2015 and December 2017, 170 patients selected for URSL for the treatment of ureteric stones and JJ-stent insertions were evaluated. Patients were divided into two groups according to the use of fluoroscopy. In Group A (100 patients), a fluoroscope was used and in Group B (70) fluoroscopic guidance was not used. In Group B, URSL was performed first and followed by JJ-stent insertion via the semi-rigid ureteroscope 8.5–11 F under direct vision without fluoroscopy.

Results: The stone-free rate was 96% vs 94.3% for groups A and B, respectively. This technique was successful in all the included patients: 166 retrograde JJ stentings after URSL for ureteric calculi and four cases for anuria. Patients in Group A were exposed to radiation for a mean of 26.6 s during the URSL procedure and 4.8 s for JJ stenting. Group B was exposed to a zero dose. For Group A, the stents size was 6 F for 70% of patients, 4.7 F for 15%, and 7 F for 15%. In Group B, stents of 4.7 F and lengths of 24–26 cm were used in all patients. Failure of JJ-stent insertion was 9% (nine patients) in Group A and 18.5% (13 patients) in Group B.

Conclusion: This study shows the feasibility and effectiveness of completely fluoroscopy free URSL and JJ stenting for treating ureteric stones.

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[19] Clinical data and outcomes of unusual variants of renal cell carcinoma at a tertiary care hospital

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Objective: To present our clinical data on the incidence and clinical outcomes of unusual variants of renal cell carcinoma (RCC) at a tertiary care hospital in India. RCC accounts for 2% of total cancer burden. There are several histological subtypes of RCC due to distinct molecular alterations with varied clinical outcomes. Identification of these clinical variants by further immunohistochemistry markers is required for the correct diagnosis, as each clinical subtype carries its own prognostic implication.

Methods: A prospective observational study over 8 years, from March 2007 to May 2016, in the M.S. Ramaiah Hospital, Bangalore, India.

Results: Of 300 radical nephrectomies performed in our hospital, we found four (1.3%) cases of rhabdoid RCC, two (0.6%) of collecting duct RCC, 16 (5.3%) of chromophobe RCC, 14 (4.6%) of sarcomatoid variant of RCC (out of which eight were sarcomatoid variant of clear cell RCC, three were sarcomatoid variant of papillary RCC, and three were sarcomatoid variant of chromophobe RCC), and one (0.3%) case of medullary RCC.

Conclusion: Diagnosis of different variants of RCC is very important and a high index of suspicion is required. If there is any suspicion of an unusual variant of RCC at histopathological examination, immunohistochemistry should be done for confirmation of diagnosis. Prognosis and clinical outcome is extremely poor particularly with medullary and sarcomatoid variants of RCC. A standardised therapy regime for unusual variants of RCC is not yet available due to the rarity of these unusual variants but chemotherapy can be considered in some cases of unusual variants of RCC because of the high chance of recurrence and metastasis.

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[20] Complete tissue coverage and a tailored approach – Important factors for successful shockwave treatment of erectile dysfunction (ED)

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Objective: To provide advice on how to select and treat patients with vasculogenic erectile dysfunction (ED) using low-intensity focused extracorporeal shockwave therapy (LiESWT) with the aim of achieving the best possible results.

Methods: Based on our 5-year experience and treatment of >400 patients with different LiESWT devices, we were able to develop a new treatment technique [linear shockwave tissue coverage (LSTC-ED)] that covers the whole erectile tissue and a special algorithm for tailor-made treatment that takes into consideration various factors that could influence treatment results. We
also tested and compared two different treatment protocols.

Results: We have been able to confirm that this newly developed comprehensive approach, with an emphasis on complete tissue coverage and tailored treatment, can be very beneficial. We have also verified the success of this new approach in a single blinded placebo-controlled study.

Conclusion: We believe that complete tissue coverage and a tailored approach, together with proper patient selection are the most important factors for successful shockwave treatment of ED.

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[21] Implementation of an enhanced recovery after surgery (ERAS) protocol for radical cystectomy: a Moroccan single-centre experience

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Objective: To evaluate the impact of the implementation of an enhanced recovery after surgery (ERAS) protocol on functional results after radical cystectomy (RC) for bladder cancer, as RC is a major surgery with significant morbidity and mortality risks.

Methods: We conducted a monocentric prospective study from March 2017 to April 2018. Patients who underwent RC for bladder cancer at our institute after introduction of the ERAS protocol were compared with a control group of patients who previously underwent surgery with a standard protocol (control group). Primary endpoints evaluated were: length of hospital stay, rates of complications, gas recovery time, and first defaecation. The comparison of the means was performed using the Student’s test for quantitative variables, and the Pearson chi-square test and the Fisher’s test for the qualitative variables. The threshold for statistical significance was set at P < 0.05.

Results: We studied 45 consecutive patients, 17 operated upon with the traditional protocol and 27 according to the ERAS protocol. The mean hospital stay was 9.4 vs 11.7 days, in favour of the ERAS group (P = 0.05). The gas recovery time was longer in the control group, at 69.8 vs 36.4 h (P < 0.001). The delay of the first defaecation was less in the ERAS group, at 126.6 vs 64.6 h (P < 0.001). The general postoperative complication rate was 31% in the control group and 24.4% in the ERAS group. The rate of gastrointestinal complications was higher in the control group, at 8.8% vs 2.2%.

Conclusion: Despite the heterogeneity in ERAS protocols, which are different from one centre to another, its application significantly reduced the length of hospital stay and tended to reduce the rate of general and gastrointestinal complications, and the time to gas recovery and first defaecation.

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[22] Urinary colonisation in patients with JJ catheters

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Objective: To evaluate the prevalence of urinary colonisation in patients with JJ catheters and to define the risk factors associated with these colonisations, as urinary colonisation in patients with JJ catheters plays a key role in the physiopathology of urinary tract infections.

Methods: This was a monocentric prospective study between January 2013 and April 2017. In all, 145 JJ ureteric catheters in 120 patients, 25 of which had bilateral probes, were examined. The bacteriological profile of the urine of our patients was followed by the completion of an initial cytobacteriological examination of urine and another at the time of removal of the JJ catheter. The comparison of the means was performed using the Student’s test and the Mann–Whitney test for continuous variables and by the chi-square test and Fisher’s test for qualitative variables. The threshold for statistical significance was set at P < 0.05.

Results: The rate of colonised JJ probes was 35.8% (43/145). The urinary colonisation rate was 31.7%. The rate of urinary colonisation in patients with colonised probes was 71.1%, compared to 9.1% for non-colonised probes. Of the identified pathogens, Escherichia coli was found in 38.1% of the colonised probes; Klebsiella pneumoniae was second (19.1%), followed by Enterococcus faecalis (16.6%). The same bacteria isolated in the JJ probes were found in the urine. Diabetes mellitus (P = 0.001), emergency JJ placement (P = 0.02), and JJ implantation time (P = 0.01), were risk factors for urinary colonisation in patients with JJ probes.

Conclusion: The prevalence of urinary colonisation in patients with JJ catheters was 31.7%. Diabetes mellitus, prolonged JJ implantation, and emergency JJ placement were associated with a higher risk of urinary colonisation.

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