Letters to the Editor

Comment on: Laparoscopic transperitoneal ureterolithotomy for large ureteric stone

Sir,

I read with great interest the article titled “Laparoscopy transperitoneal ureterolithotomy for large ureteric stone” by Al-Sayyad.\textsuperscript{[1]} The report is very informative, with some insight into the current trend of large proximal ureteric stone management. I have some comments on this work. Due to the nature of retrospective study, the value of this report is limited. The author did not define the meaning of large proximal ureteric stone clearly. In most of previous studies this classification was precise in term of size and site of ureteric stone. As an example, Goel et al.\textsuperscript{[2]} classify it as stone located between the ureteropelvic junction and the lower border of the 4\textsuperscript{th} lumbar vertebra, whereas Cengiz et al.\textsuperscript{[3]} use 5 cm distal to the ureteropelvic junction. Goel et al.\textsuperscript{[2]} found that the best option for those types of stone is percutaneous nephrolithotomy (PCNL) which give stone free rate of 98.5%. This success rates were almost similar to laparoscopic ureterolithotomy done by the author.\textsuperscript{[1]} In contrast the laparoscopic ureterolithotomy in this study showed higher morbidity in comparison to the PCNL in Goel et al.\textsuperscript{[2]} These shown by longer operative time (mean of 90 vs. 47 minutes) and longer hospital stay (mean of 62.4 vs. 46 hours).\textsuperscript{[1,2]} If we treat the patient individually with precise diagnosis of site and size of stone, the choice of treatment mode will be more accurate. Endourology procedures are documented as minimal invasive procedure with very low morbidity, but highly operator dependent. I would say that the best option for stone located close to ureteropelvic junction (5 cm) is PCNL. This endourology procedure will give high success rate with reasonable morbidity in an expert hand. Laparoscopic ureterolithotomy only reserve for those cases which was contraindicated for PCNL.

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Inflammatory myofibroblastic tumors of the bladder

Sir,
I read with great interest the article by Yagnik et al. [1] regarding inflammatory myofibroblastic tumor (IMT) of the bladder. The authors have succinctly described the pathology with relevant pictures. I congratulate the authors for the write up. The article however fails to provide details pertinent to this entity in general and the case in specific. After review of current literature, [2,3] I would like to raise a few questions and make a few points.

First, the authors in the article describe an “irregular heterogeneously enhancing polypoidal bladder base lesion infiltrating bilateral seminal vesicle” on CT imaging; however, no pictures are provided. A contrast-enhanced CT scan picture would have given a wealth of information to the readers. The readers would have become wise if further information was provided on lymph nodes, given the fact that the mass had suspicion of involvement of the seminal vesicles and the prostate.

Second, the authors describe having taken “multiple biopsies” from the tumor. They do not mention if the biopsy included the muscle. Did the authors completely resect the tumor? The article does not throw any light on this fact.

Third, as it is famously said “the proof of the pudding is in eating it”. The authors state in the article that these tumors tend to recur. I would be more worried, if the tumor recurred, particularly so if the tumor was not completely resected at the first instance. A postoperative imaging study of the patient in the form of either an ultrasound or CT imaging would have educated the readers.

Last but not the least, the authors describe a well-described rare entity, [2,3] but it would have gone a long way for the readers, if the authors had addressed the dilemmas with imaging, core issue of recurrence and the importance of follow-up in IMTs.

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