

Management of urolithiasis in South Asia

The article by Rizvi et al. [1] makes a great read. The authors deserve credit for their work and the data presented. A few points merit mention to summarise and put the article in perspective.

First, the authors present a mammoth database from a public sector hospital in Pakistan. In the initial era, as noted by the authors, they adopted extracorporeal shockwave lithotripsy (ESWL) as their mainstay for treating stones. ESWL as the least invasive, safe and readily available method remained the preferred option initially. However, stones seen in South Asia differ from those in the West. In this geographical area, the stone bulk is large and often not amenable to ESWL. In the subsequent period, the authors changed to percutaneous surgery. The reason for this shift, apart from large stone burden, may also have been influenced by local factors, such as long distances required to be travelled by patients to reach a healthcare facility and the lack of resources and infrastructure in remote locations. In such situations, the treatment option that offers rapid, safe, and efficacious results would be preferred. These criteria are fulfilled with the percutaneous approach to renal stones and this is what the authors did!

Second, it is worthwhile noting that the need for embolisation and/or nephrectomy is a miniscule number in this series [1]. This emphasises the importance of the basic tenet in percutaneous renal surgery that a perfect initial access is the secret to successful percutaneous removal of stones. It should be noted that in this large series the complications across all Clavien–Dindo complication grades reduced as the authors ascended the learning curve.

Third, we feel the major limitation of this study [1] was the means of assessing the stone-free rate. The authors used a combination of ultrasonography and plain abdominal radiograph of the kidneys, ureters and bladder. As acknowledged by the authors this could have possibly overestimated the stone-free rates and skewed the data and interpretation. The authors can substantiate these findings in further prospective studies.

Fourth, the paper exemplifies that stone composition, choice of approach, and patient preferences vary from region to region globally. The findings in the study [1] are similar to the results of Desai et al. [2] from India.

Last but not the least, the AUA guidelines [3] state that the optimal strategy for stone management must take into consideration patient health and economic outcomes. Stone-free requirement is global but economic implications are regional. In this context, the treatment options for similar sized stones may vary for a particular patient located in Europe or Asia. Hence, we feel this paper could be considered as a benchmark for future multicentre trials investigating treatment options and strategies for urolithiasis in South Asia.

Conflicts of Interest

None.

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