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Research Article

LITHIASIS IN URINARY DIVERSIONS OR POST PROSTATECTOMY

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ABSTRACT

Introduction: Radical cystectomy with the removal of bladder and adipose tissue attached to it adjacent to nearby organs such as the prostate and seminal vesicles in the man and the uterus, and the anterior part of the vagina in the woman represent the "gold standard" in the ca. Bladder with a mortality that has progressively decreased to reach levels ranging between 1.2% and 3.7% in Europe, the formation of new vascular calculus usually occurs on the points used in the creation of a new vascular system or as a result of stagnation Postnatal urine in the new vascular system, which predisposes to the onset of infections; Calculations can usually be treated endoscopically, and rarely require an open-air surgery; The purpose of the present study and that through the exposure of clinical observation data to study and evaluate the various solutions of this complication

Materials end Methods: January 2015 to December 2016 at the II Clinical Surgery and Digestive Surgery Department of General Ophthalmology and Specialized Polyclinic II University of Catania No 2 patients aged 55-79 years average age 67. Male sex Hospitalization patients had a clinical symptom characterized by; Hematuria fever uro septica piuria The ultrasound diagnostic of renal calculus based on the direct calculation of the calculus; The radiographic examination without direct contraction of the abdomen (Rx) practiced as the first CT examination is an accurate imaging technique, presenting the advantage of a high speed and a more favorable cost-effectiveness index confirmed the presence of bulky calculations that occupied 2/3 of the bladder and new vesicaal surgical treatment with an epicystolitotomy with removal of calculations of the weight of 200g and 500g. It was 5gg in the absence of complications **Results:** The pathogenesis of bladder calculus is often due to a cervicouretral obstruction, and the subsequent bladder stagnation its treatment should also result in the resolution of the latter disease. **Discussion:** Therapeutic interventions Open air surgery is 2-5.4%. The most common indications are complex calculus or calculation size, renal function exclusion, failure of other less invasive methods (SWL, PCNL), The coexistence of anatomical malformations (infundibular stenosis, particularly in the frontal calciferous calcification, concurrent urethral joint stenosis, urteteral stenosis), obesity or other co-morbidity, the need for concomitant surgery, the patient's choice. [27 The intraoperative use of ballistic lithotripsy during open-air kidney surgery can increase the effectiveness of stone free (88%), morbidity, surgical times, blood loss, hospitalization time and post-surgical renal damage. **Conclusions:** Open surgery should be reserved for the treatment of cases of very large (giant) or complicated forms of kidney stones, of other methods of failure, of coexistence of anatomy-endoscopic malformations, of severe obesity or other comorbidities, of need Concomitant open surgery or explicit patient choice

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INTRODUCTION

Radical cystectomy with the removal of bladder and adipose tissue attached to it together with nearby organs such as the prostate and seminal vesicles in the man and the uterus, and the anterior part of the vagina in the woman represents the "gold standard" in the ca. Bladder with a mortality that has progressively decreased to levels ranging between 1.2% and 3.7% in Europe. Once the bladder has been removed, it is necessary to reconstruct anatomical structures to restore

conditions to allow urine no longer collected in the bladder tank to be emitted outward. Such structures, referred to as urinary diversions, are generally made using specific portions of the gastro-intestinal tract. (1,2) Pelvic lymph nodes are also removed during surgery to verify the presence of metastatic disease outbreaks and to allow the prognosis of the patient to be defined. Current urinary tract infections are: Urethralocutaneostomy. Bricker Indicated When it is not possible or appropriate to reconstruct a continental urine collection tank the derivatives will not be continents and urine

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elimination will occur with continuous spillage (3,4,5) Urethralcutaneostomy is a urinary derivation obtained by isolating a tract Of the intestine connected to one side to the two urethral channels while on the other the outer portion is sutured to the skin of the abdomen between the navel and the iliac ridge. Out-flowing urine is collected by means of a sealed bag fitted with a special adhesive plate around the stomach. The possible complications are the onset of urinary tract infections, the fistula and the necrosis of the tract of trachea used as a conduit. Later, other complications such as renal insufficiency, stenosis (narrowing) of the skin stomach, and calculosis may appear later. This type of derivation, with respect to the simplest ureterocutaneostomy, has greater surgical accomplishment times for the benefit of having a single skin stomach without the burden of modeling catheterization (6,5,4). Radical cystectomy can go to various types of complications. These may be of an aspecific type, ie generally due to surgical intervention and anesthesiological risk, or specific for cystectomy and lymphadenectomy or specific for the type of urinary tract. Some of these complications to be resolved and require re-intervention; Overall, the frequency of reintervention after cystectomy varies between 10 and 20%. Complications, if they occur in patients already defamed or with special risk, can also cause the patient's death; Perioperative mortality is still low and is around 1%. Aspecific complications are related to the general conditions of the patient and the anesthesiological problems that may arise during the intervention. The general state of the patient and the resulting anesthesiological risk are evaluated preoperatively; This risk is not counter-indicative, but must be recognized and taken into account by both doctors and patients and their family members. The frequency of the various complications specific to the operation of radical cystectomy is about 25% of the cases; they may be more or less important or significant and affect the outcome of the intervention in a variable way. There are therefore intraoperative complications occurring during the intervention itself and postoperative complications occurring after surgery and may be premature or delayed. During the operation you may experience: bleeding, which may be important, especially if the tumor is large in size and therefore makes hemostasis difficult or involving large blood vessels; May require blood transfusions; In particular cases it may cause a shock with relative consequences; Western occult nerve lesions during lymphadenectomy, especially if localizations are present Neoplastic at lymph node level; However, this event is very rare: if recognized immediately it can be repaired during the intervention; Injury of the intestine, especially of the rectum, if there is infiltration by the neoplasm; The lesion, if limited, can be repaired immediately with the simple suture; If it is of greater magnitude, it may require the preparation of a temporary ileostomy or colostomy. (7,8,9) Early postoperative complications may be: - postoperative bleeding, which may require blood transfusion or, rarely, reintervention for control Of hemostasis; The infection of the wound, which can be superficial or deep, may require a "curettage", prolonging the time of stay; The dehiscence of the surgical wound, in turn favored by infections or collections, which may require re-intervention to effect the resurfacing of the wall; Infections, which are normally treated conservatively; In defeated individuals may also endanger the patient's life; (10) if they form saccade collections, they may require surgical

drainage; linforrea, or prolonged lymph drainage due to lymphadenectomy; Usually resolves spontaneously; In some cases it may result in the formation of lymphocytes, that is, sacculates collected from the lymph, which, especially if voluminous, may require percutaneous or surgical treatment; Intestinal obstruction or occlusion, which can be dynamic or mechanical; The dynamic occlusion, due to the delayed recovery of intestinal motility, is maintained by the maintenance of the nasogastric probe and the administration of peristalsis drugs; Mechanical occlusion, due to the formation of adherent bridges between the angles that determine the angle and prevent regular bowel movement, usually requires reintervention for the removal of the occlusion cause; The dehiscence of intestinal anastomosis, especially if the intestine is present in conditions of weakness due to previous events such as radiotherapy and chemotherapy, or due to vascular alterations due to diffuse arteriosclerosis, or excessive ischemia of the loop during l Intervention, which requires reintervention with rianastomosis and possibly the preparation of a temporary ileostomy; Intestinal lesions with the formation of stinging fistulas, especially if the intestine is injured during dressing due to adhesion from previous surgery or from previous inflammatory events; May be resolved by the use of parenteral nutrition for a few weeks, (11) or may require re-intervention with the repair of the lesion and possibly packaging of temporal stenosis; The dehiscence of anastomosis between ureter and new vascular, or between ureters and the ileus vein of a very rare oesophageal urethra, can heal spontaneously or require re-intervention; The dehiscence of a suture between the new vascular flaps, which can cause urine extravasation between the intestinal limbs; If limited, can heal spontaneously by keeping the catheter in the new vascular for a prolonged period, while, if extended or persistent, may require a reintervention to close the breach; The dehiscence of anastomosis between new vascular and urethra, which usually heals spontaneously maintaining the catheter in place for a longer period than usual; The difficulties of catheterizing a continental tank, usually solved by leaving a catheter resident for 2 or 3 weeks; Rarely requires re-intervention. Late complications are mainly related to urinary tract; You may experience: Urethral obstruction, resulting in hydroureteronephrosis; Represents the most frequent complication, mainly caused by the ischemia of the urethra end portion; It can be found in all types of derivation: at the level of anastomosis between ureter and neovesicula, between the ureter and intestinal tract in a ureteroseocutaneostomy, between the ureter and the skin in a ureterocutaneostomy; In this latter type of derivation is almost the rule, if the anchored anastomosis is not maintained. It may occur in a variable time after surgery. It may also be due to a recurrence of neoplastic anastomosis, So it has to be duly studied. If bilateral, it may cause renal failure. The treatment is often articulated and consists of a first percutaneous drainage treatment, with the placement of a nephrostomy, which allows one part to recover kidney function, and on the other the detailed study of the obstruction. Treatment of obstruction can therefore be performed by endoscopy, dilating or affecting the stenotic tract. (12) If this maneuver fails, a surgical review of anastomosis should be performed. If the cause of obstruction is a neoplastic recurrence, other types of intervention, including complex ones, may be required, depending on the extension of the affected ureter; Urethral reflux, ie the return of urine from

new vascular to the kidneys; Is an expected event if no anti-reflection technique is adopted; Usually not to be treated, may require reintervention only if it causes urethral dilation and a deterioration of renal function; Urinary incontinence, common occurrence in the first postoperative period; Can be night or night nighttime; If it manifests in mild form, ie only at night or following abrupt abdominal pain increases, it does not require causal treatment; If it manifests itself in serious form, it must first be studied to determine its mechanisms and causes and then treat it with various techniques, which may be pharmacological, rehabilitative, endoscopic or surgical; The breaking of the new bladder in areas of the little irrigated wall; It can be solved by simple percutaneous drainage or may require repair of the new bladder in open air; Hypercontinence, a possible event in the continental urinary tract in women, characterized by the inability to completely empty the bladder; It is usually treated with clean intermittent self-catheterization; the problems with the stomach, in the case of ileo cutaneous stomach, are fairly frequent, which may affect up to 25% of the patients; Are represented by the narrowing of the skin stomach, which can be treated with repeated dilations, from the hernia Near the stroma , which should be corrected surgically, especially if of large size and annoying, from the flogistic alterations of the osteoma mucosa, which should be treated with the application of Creams, from the bleeding of small peristalsis, which may require the application of hemostasis points; Systemic and metabolic disorders, such as progressive deterioration of renal function, anemia, reabsorption of substances present in the urine by the gastrointestinal tract used to build neovascular disorders, which tend to shrink over time; Hyperchloremic acidosis, which can be treated with the administration of bicarbonate; Reduced absorption of vitamins. In male patients, also a consequence of cystectomy is impotence due to the injury of the nerves responsible for erection. (13) Finally, the formation of new vascular calculations, usually on the points used in the creation of a new vascular or postnatal urine formation in the new vascular system, which predisposes to the onset of infections; Calculations can usually be treated endoscopically, and rarely require an open-air surgery; The purpose of the present study and that through the exposure of clinical observation data to study and evaluate the solutions of this complication

MATERIAL AND METHODS

January 2015 to December 2016 at the II Clinical Surgery and Digestive Surgery Department of General surgery and specialized company Polyclinic II University of Catania No 2 patients aged 55-79 years average age 67. Male sex Hospitalization patients had a clinical symptom characterized by; Hematuria fever uro septica piuria. The radiographic examination without direct contraceptive abdomen (Rx) practiced as a first-rate examination in patients with urinary calculus [1; Allowed to highlight the location, size, and nature of radiopaque calculations based on the degree of radiopacity in the observed patients. Fig. 1.2

The ultrasound diagnostic of renal calculus based on direct calculation of the calculus has a high sensitivity and low specificity for frequent false positives, due to the presence of abnormal vessels, parapelic cysts, morphological variants of excretory cavities such as pelvis Extra-renal, or joint stenosis pielooplasty [14. In the patients observed, the US examination conducted in non-specialist centers was not valid and sensitive and only showed the presence of calculations when the latter reached a considerable size. However, the method is always used in the first instance, in urgency, for ease of use and The speed of execution, and the widespread availability of equipment available for the safety of ultrasound, of particular importance in the case of pediatric patients or pregnant women [15. Urographic examination has since been the method of choice in evaluating patients with urinary calculus, providing accurate information on the identification and characterization of the calculation (size, location, radiodensity, degree, and obstruction site). Wide diffusion, the interpretation is well standardized: calculus criteria for calculus are based on the relief of a radiopaca image contained in the excretory cavities or along the urethral course, with associated opacity delay; In the case of radiolucent calculotic formation the relief is characteristic of the "filling defect" of the opaque excretory structure. Secondary diagnostic criteria include pielo-caliceal and urethral dilatation, minor renal marginalisation of peripheral lymphocyte perforation, volumetric kidney growth, and opacity delay of the excretory pathway unilaterally [16. The Urographic Survey also allows you to highlight the presence of any anomalies Or concomitant pathologies that may be associated or favoring the formation of calculations,



Fig 1 lithiasis new bladder



Fig 2 lithiasis bladder post prostatectomy radical

such as calcium diverticulates, urethral duplication, obstruction of the pielo-ureteral joint, retrograde ureter [17]. The sensitivity and specificity of urographic examination in urinary calculations is quite high (64-87% and 92-94% respectively) with an acceptable accuracy level (79.3%). Its degree of accuracy can be increased by an adequate Intestinal preparation, aimed at reducing the degree of meteorism and fecal stagnation. [18] However, in patients with a high degree of obstruction, due to an inadequate concentration of contrast media (mdc) Even at a distance of 12 to 24 hours, the level of obstruction can not be demonstrated. In the patients observed in outpatient activities given the complexity of execution of the urographic examination was replaced by the ultrasound examination. Another diagnostic examination is scintigraphy that does not play a role in lithiasis diagnostics, if not in the proper evaluation of renal function. Quantitative measurements in different segments of the kidney compared to the control kidney were apparently normal in the observed patients, but the method suggests which intervention is most appropriate for the removal of the obstruction. If the calculations are between 4-7 mm in size, the use of dynamic renal scintigraphy allows safe conservation management as it is able to monitor renal function TC is an accurate imaging technique, presenting the advantage of a high Rapidity and a more favorable cost-effectiveness index than Rx and urography, in the identification of urinary calculations; While improving the determination of the size and volume of the calculation, it can highlight extra-neurological problems and provide three-dimensional information useful in therapeutic programming [19]. Fig. 3,4,5

were surgical treatment with an epicystolitomy with removal of calculations of weight of 200g and 500g .the average stay was 5gg, without complications

RESULTS

The pathogenesis of bladder calculus is often attributable to cervicourethral obstruction, and subsequent bladder retention should also result in the resolution of the latter disease. [8 The only medical treatment of obstructive pathology leads to complications such as acute retention, 1 Renal insufficiency (4.3%) and the possibility of recurrence of bladder calculus in 17.4% of patients, and it is unwise to do so except in special circumstances (general patient conditions) 21]. The "gold standard" is represented by transurethral endoscopic treatment for both primary obstructive pathology and bladder calculus [22]. The endoscopic procedure may also use percutaneous overpopular access in particular situations (patient deformity, urethra conditions, size Of calcium) with excellent results, even more evident when it prevents urethral instrumentation, such as endemic bladder bladder calculus in developing countries [23 In the literature there is the use of ecubudged SWL. The presence of residual calculus in 53% of cases, together with the possibility of complications such as acute retardation induced by fragments, makes the procedure unacceptable.34 The option for open surgery remains applicable in calculations of large size, as in the observed cases, Which require long periods of endotoxic lithotripsy, in the face of a prolonged post-operative



Fig 1 neobladder lithiasis



Fig 2 neobladder lithiasis



Fig 3 bladder lithiasis after prostatectomy

In the two patients observed the presence of voluminous calculations that occupied 2/3 of the bladder and new bladder. The main criterion for diagnosing CT calculus was based on the calcification density relief in the context of the excretory routes TC is currently considered the most reliable imaging method for urinary calculus diagnosis with a 94-100% sensitivity, Specificity of 94-97% and accuracy of 95% [20]. Urographic Magnetic Resonance (URO-RM) allowed accurate depiction of the urinary tract, providing similar images to conventional urography, although current urography still has a better resolution. Uro-RM demonstrated the level and degree of obstruction with significant accuracy by confirming TC data, but as the method of choice for suspected and / or concurrent urinary lithiasis in the pregnant woman in case of allergy to m.d.c. Iodate and kidney failure. Obtained instrumental data

hospitalization, and if there is no experience of percutaneous access [25] patients treated with open surgery due to the large size of the calculus. In the first case, the formation of the calculus was caused by urine stagnation in the former prostate log in a patient with a previous prostatectomy for prostatic prostatectomy. In the second case the patient with previous radical cystectomy had a neoesccial calculus. In both cases the formation Of the calculation required on average 14 years after surgery to reach the observed size and produce severe clinical symptomatology. The open surgical treatment (epicystolitomy) of large volume or multiple bladder calculus was evaluated as effective and complicated without causing a relatively long period of hospitalization (> 4 days) All patients undergoing SWL or open surgery even after a First episode, have been invited to imaging diagnostics, at least for one year.

Then, undergo a simplified metabolic investigation (pH, calcium, oxalate, urinary citrate), even after a first episode. Among the examinations include those suitable to quantify some of the dietary components that contribute to the lithogenic risk (nitrogen, sodium, potassium) and to estimate the state of urine saturation. Calculation analysis is considered a useful tool in managing the patient with calculus, as the metabolic profile integrates but does not replace the resulting information. Among the analytical methods the IR spectrometry and X-diffractometry are the most reliable. The chemical exam provides useful information. Calcium supplements were also taken on meals to reduce the intestinal absorption of oxalate. Supplements of vitamin C > 1 g / day should be avoided. Dietary measures have been trimmed on metabolic-detected abnormalities. The hypoproteic and normocalcotic diet should be preferred to a hypocalcetic diet. Hyperprotective and low calorie diet diets should be prescribed with caution in patients with thrombocytic thiazide history and alkaline citrate is indicated in the prevention of calcification recurrences. Combined use should be considered as preventing diuretic hypokalaemia and has a beneficial effect on the bone. Alkaline citrate is indicated in the prevention of SWL post recurrences. Potassium citrate is used in the prevention of urinary calculus and not taken in momodose. High-grade diuresis, better associated with alkalization and thiolitics, is indicated in the prevention of cystic calcic recurrences

DISCUSION

Radical cystectomy performed before the progression of bladder cancer in muscle-invasive disease can be distinguished in two categories: - Immediate cystectomy (performed immediately after diagnosis of non-muscle-invasive disease) - Early cystectomy (performed within a short period of time after Failure of endovascular therapy with BCG). There are several reasons for indicating radical cystectomy in patients with non-muscle-invasive bladder cancer: Stable endoscopic bladder resection capacity (TURB) is low, as 27 to 51% of patients with non-muscle invasive disease (T1) undergoing Radical Cystectomy Positive Results for Invasive Muscle Disease In patients with non-muscular-invasive disease at risk of progression, who underwent early cystectomy, they have a better survival rate than those who have performed cystectomy later. (26) The potential benefit Of cystectomy should be related to the risk of morbidity and the quality of vitaphus cystectomy. It is reasonable to propose radical cystectomy to patients with non-muscle-invasive disease with high risk of progression. The conditions for identifying a high risk of progression are: - multifocal and / or bulky T1 tumor (> 3 cm) - tumor T1 with co-existence of in situ carcinoma (CIS) - recurrent T1 tumors - T1 tumors with in situ uretra carcinoma Prostate - micropapillary variants of urotelic carcinoma In the presence of T1 bladder cancer, both immediate radical cystectomy and endovascular treatment with BCG can be considered. Patients should be aware of the risks and benefits of both procedures. In patients with refractory neoformation with BCG treatment, cystectomy should be strongly recommended. Urethral oocyteanostomy or ileal duct (whose most common ureteric anastomosis technique is that according to Bricker) is a urinary derivation with longer term complications inferior to the continental pockets and orthotopic

derivatives. It is the most widespread urinary tract in the world. Retrospective and short follow-up data showed that ureterocutaneostomy (direct abdominal urethral anastomosis) is the urinary derivation with the lowest number of complications. Inflammatory historical data show for this type of urinary derivation a greater risk of stenosis at the level of the skin abdomen (due to the compressive effect on the abdominal muscle fascia) and ascending urinary infections, and it is certainly the urinary derivation weighed by a minor Invasiveness from a surgical point of view. Ureterosigmoid anastomosis is the urinary derivation in the sigma-rectal tract that involves urinary mixture with the stools. This type of urinary tract is currently not practiced due to the risk of ascending kidney infectious complications. The orthotopic New bladder Although orthotopic bladder substitution is perceived as the derivation with a higher rate of satisfaction on the part of the patient, there are no comparative quality-of-life comparable studies to support this affirmation. The presence of renal insufficiency (creatinine values 150 micromol / L or glomerular filtrate 50 ml / min) represents a contraindication to the performance of a continental urinary derivation. The ureter-intestinal anastomosis should be performed directly. This results in a very low risk of new vascular-ureteric reflux (2.7%). The use of anti-inflammatory techniques for ureter-ileal anastomosis increases the risk of anastomotic stenosis and is therefore not recommended. The presence of tumor distal urethral involvement is a contraindication to the orthotopic replacement of the bladder and should be excluded preoperatively by targeted biopsies in humans. In the woman it is recommended that a urethral margin biopsy be sent to the intraoperative examination before performing a bladder replacemen An extension of the disease to the frontal vaginal wall also represents a contraindication to the orthotopic bladder replacement in the woman. The percentage of men with orthopedic bladder with good daytime and nighttime continence is 92% and 76%, respectively. These rates do not differ significantly in women (80% and 70% respectively). Urinary retention (described in 50% of cases at 5 years) and new bladder-vaginal fistula (1-5%) represent peculiar complications of new vascular feminine. A woman to whom the orthotopic bladder is proposed should be aware of the possibility of performing intermittent catheterizations. Although there are no age limits for orthotopic bladder discharge, most patients after 70 years opt for an ileal duct since the postoperative course is less severe and the risk of significant incontinence The continental skin pocket represents surgery with high complexity , With a high rate of complications and a significant percentage of reintervention. It represents a second choice compared to the new bladder orthophotograph and finds the indication when urethra removal is necessary. Since the continental reservoir can develop high pressures, urethral anastomosis should be performed with anti-inflammatory technique. The other thing that complicates the intervention is the need to pack a continental skin stomach. There are several surgical techniques described in literature, often of high complexity and supported by inconsistent cases. While continence results are high, peculiar complications of this type of urinary tract include pocket breakdown and calculosis (up to 45%). Therapeutic interventions Open air surgery is 2-5.4%. The most common indications are complex calculus or calculation size, renal function exclusion, failure of

other less invasive methods (SWL, PCNL), The coexistence of anatomical malformations (infundibular stenosis, particularly in the frontal calciferous calcification, concurrent urethral joint stenosis, ureteral stenosis), obesity or other co-morbidity, the need for concomitant surgery, the patient's choice. [27] The intraoperative use of ballistic lithotripsy during open-air renal surgery may allow to increase the effectiveness in terms of stone free (88%), morbidity, surgical times, blood loss, hospitalization time and post-chiral kidney damage - gico. [28]. Surgical cystolithotomy usually associates with a transvesic or retropubic adenomatotomy according to Millin. The combination of minimal cystolithotomy and transurethral prostate resection (TURP) has been described as an excellent alternative to the treatment of large volume or multiple vesicular complications associated with prostatic hyperplasia, as the surgical times are only slightly longer, Morbidity has not increased and catheter and hospitalization time is similar to that of TURP alone. [Open surgery for renal calculus, guarantees a very satisfying stone-free rate (90%) [29] (LPE V). For large calculations surgery has a benefit in terms of recovery of renal function, which is instead worsened initially and unchanged at a distance after SWL. In patients with chronic renal failure, surgical treatment, especially when corrections of anatomic alterations are required, may allow for improvement in renal function. In patients with blocking calculus that are not performed in patients treated with SWL for similar clinical cadres Ureterolotomy guarantees A very high percentage of stone free (97%). Hypersensitivity (5%) has been described episodically. Post-swallowing complications require an individualized approach depending on the type of strain and the condition of the excretion route. The endoscopic treatment of urethral calcification is conditioned by the type of ureter-intestinal anastomosis: anti-reflux anastomoses require a combined anterograde-retrograde approach, whereas direct anastomosis can also be undertaken by simple retrograde access The combined approach fits well Even in the case of Urethra sigmoid anastomosis. Alche the type and shape of the tank (duct, pocket or new bladder) condition the way to access the ureter. After SWL it is advisable to evaluate the presence of residual fragments, obstruction of the excretory pathway, urinary tract infections. The evolution of CIRFs should also be monitored in the medium to long term, with approximately 18% of new cases being clinically significant. Then it is advisable to perform at least one counter (30)

CONCLUSIONS

Open surgery should be reserved for the treatment of cases of very large (giant) or complicated forms of kidney stones, of other methods of failure, of coexistence of anatomy-endoscopic malformations, of severe obesity or other comorbidities, of need Concomitant open surgery or explicit patient choice. The association of epicystolithotomy and transurethral prostate resurfacing (TURP) or surgical adenomectomy is an alternative to endoscopic lithotripsy for the treatment of large volume or multiple bladder calculus Extracorporeal lithotripsy is an effective treatment of calcification even in the presence of urinary tract infections, Although there is a risk of obstructive complication, whose Treatment requires special expertise. Orthotope bladder calculus can be treated endoscopically via transurethral or, if you want to avoid the trauma of urethro-new vascular anastomosis and the potential for worsening

continence, you can use a skin approach in different ways (cannula of Amplatz, Laparoscopic trocar, etc.). Percutaneous apnea is always preferable in the treatment of continental pockets for the delicacy of the conjunctival mechanisms of the skin stomach (nipple, valve, etc) that could be ill-tolerated by the passage of rigid large endoscopes. Flexible cystoscope is only suitable for the treatment of small dielectric calculations [. Patients with relapsing calculus are useful to undertake basal, free dietary tests, which should be carried out at least 1-2 months from an acute episode. A first check is usually set at 6 months, and subsequent yearly controls are scheduled as long as the patient takes medical therapy. Medical prevention, including regular visits, metabolic and instrumental examinations, should be recommended for patients with a recurrence rate of at least 0.72 calculation per year. The additional cost effects resulting from the loss of working capacity should be evaluated in the individual patient. In health care when defining investment priorities, in addition to the efficacy and availability of treatments, account needs to be taken of information on cost- Effectiveness of health interventions. . Economic evaluation is a relationship between the cost differences of two or more treatments and their differences of effectiveness. We will use efficient resources when we can maximize the benefits, minimizing costs

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