Conflicts of interest

We declare that there are no conflicts of interest.

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To the Editors:

Re: Outcome of retrograde ureteric stenting as a urinary drainage procedure in ureteric obstruction related to malignant lesions

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We read with interest the article by *Wijayarathna et al*. offering retrograde ureteric stenting (RUS) as the urinary drainage of first choice to all patients with recurrent malignancies in the pelvic cavity causing malignant ureteric obstruction (MUO) [1]. The authors knew that most of these patients had exhausted the primary modalities of treatment of their respective malignancies and regrettably, they still performed 'palliative' urinary diversion routinely. This paper fails to state the number of patients with bilateral ureteric obstruction, percentage of them with uraemia, and ureteric units successfully stented. In MUO, 'palliative' urinary diversion, percutaneous nephrostomy (PCN) or RUS, should be performed only if there is a definitive treatment plan available for the patient as the quality of life can be suboptimal and the patient's ability to return home for at least 2 months prior to death is often compromised by such unnecessary intervention.

Fifty three patients (64.6%) had demonstrable pelvic tumour recurrence but RUS was successful only in 15 patients (28.3% of this group). The authors fail to state what they offered to the majority (38 patients) that failed RUS. Were they considered for immediate PCN? The finding that in spite of successful RUS 13 of 15 patients (87%) were dead within 3 months of stenting corroborates my notion that routine RUS /PCN is not in the best interest of the patient. What was the plight of those patients with pelvic tumour recurrence that failed RUS? Early deaths, in 87% of patients with successful stent placement, should be construed as non-palliated, although RUS is offered as a palliative procedure. The question that begs an answer is what symptom palliation have you achieved using RUS? This paper fails to portray the cardinal symptoms affecting the patients with MUO that the authors set out to palliate, the severity of such symptoms and the onset, duration and the degree of symptom improvement after RUS. Palliation should be viewed as a three-dimensional concept, namely onset, duration and degree of symptom relief [2]. Prophylaxis before surgery (9 cases), certainly not ureteric obstruction, should be excluded. The authors do not define high/low serum creatinine.

Izumi et al. reported a series of gynaecological and gastrointestinal MUO patients [3]. Four prognostic factors: pre-diversion serum creatinine (over 1.2 mg/dl), availability of cancer therapy, location of primary malignancy and presence of bilateral ureteric obstruction

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allowed ranking into prognostic groups of good, intermediate and poor outcomes with median survival of 403, 252 and 51 days respectively. In the future urologists should more accurately predict overall survival and guide decision making based on contemporary modern studies that propose prognostic groups [3].

The authors lamented on the lack of data on carcinoma of the cervix patients in the world literature having quoted *Izumi et al*., failing to realize that the most common cancer in that Japanese study was carcinoma of the cervix (21%). Another recent study from the Brazilian National Cancer Institute demonstrated that in a consecutive series of fifty recurrent cervical cancer patients (mean age 44 years) the median overall survival after PCN was a dismal 8.9 weeks, once again proof of the futility of palliative urinary diversion [4].

Our policy is to perform urinary diversion, either PCN or RUS, only on uraemic patients who would benefit from such intervention where the gynaecologist gives a guarantee to carry out definitive therapy eg. pelvic exenteration, once the SCr has been lowered to normal/near normal levels, with consequent substantial prologation of life. Very infrequently, if the decision is made by the patient and her/his family to have palliative urinary diversion done so that the couple of months of extended life permits the patient to attend to family/social function we bow down to such requests. However, we recommend contraindication to palliative urinary diversion if there is unavailability of efficacious therapy, the premise being that RUS/PCN should not substitute a peaceful uraemic death for a painful poor quality life with negligible improved survival.

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Authors reply

We appreciate the constructive comments made by *Goonewardena and Vickneswaran* from the premier urological centre in Sri Lanka regarding our publication [1]. They have agreed fully with the conclusions of our study though they have made few suggestions which would have improved the methodology of the study. Their approach to the management of lower ureteric obstruction related to extrinsic malignancies based on long years of personal experience which has not been evaluated in a formal research study and documented has been substantiated by our study which will be available in the scientific domain hereafter for the clinicians to follow as robust scientific evidence.

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