

Video can be found at <http://ceju.online/journal/2022/endoscopic-ureteral-stricture-ureteroenteric-stricture-cystectomy-2249.php>

Endourological treatment of uretero-enteric benign stricture after radical cystectomy and kidney transplant

Angelo Territo¹, Paolo Verri¹, Alessandro Uleri¹, Pietro Diana¹, Andrea Gallioli¹, Michael Baboudjian¹⁻⁴, Josep Maria Gaya¹, Francesco Sanguedolce¹, Julia Aumatell¹, Giuseppe Basile¹, Alejandra Bravo¹, Joan Palou¹, Alberto Breda¹

¹Department of Urology, Fundació Puigvert, Autònoma University of Barcelona, Barcelona, Spain

²Department of Urology, APHM, North Academic Hospital, Marseille, France

³Department of Urology, APHM, La Conception Hospital, Marseille, France

⁴Department of Urology, La Croix du Sud Hôpital, Quint Fonsegrives, France

Article history

Submitted: Nov. 22, 2022

Accepted: Nov. 27, 2022

Published online: Dec. 9, 2022

Citation: Territo A, Verri P, Uleri A, et al. Endourological treatment of uretero-enteric benign stricture after radical cystectomy and kidney transplant. Cent European J Urol. 2023; 76: 70.

Key Words: endoscopic ◊ ureteral stricture ◊ uretero-enteric stricture ◊ cystectomy ◊ kidney transplant

Benign ureteral stricture after radical cystectomy is a common post-operative complication. In case this scenario occurs in kidney-transplanted patients, the surgeon needs to face a challenging anatomy and the obligation of nephron preservation. We present a 76-year-old male that underwent open renal transplantation in 2019 and open radical cystectomy with ileal conduit in 2021 for a high-grade pT3N0M0 urothelial tumor. After four months, the patient presented with worsening renal function (glomerular filtration rate 21 mL/min/1.73 m²) and grade III–IV graft hydronephrosis at computed tomography scan. A nephrostomy tube was placed, and anterograde pyelography showed a <1 cm stricture of the distal ureter.

The surgical steps were the following. The patient was placed in supine position. Two Amplatz guide-wires were placed through a dual lumen ureteral access catheter (5–10 Fr and a length of 24 cm) after nephrostomy tube removal. After positioning of a ureteral access sheath (10–12 Fr) an antegrade flexible-ureterorenoscopy was performed to reach

and identify the stricture. Endoscopic balloon dilation was performed reaching a pressure of 30 atmospheres. After inspection, the stricture was incised with thulium laser (15–20 W) until exposure of peri-ureteral fat. A second dilation was performed to ensure successful treatment. A uni-J ureteral catheter (8 Fr) was left for 1 week. After 30 days, anterograde pyelography (via nephrostomy tube) was carried out demonstrating the stenosis resolution.

In conclusion, the endoscopic treatment of uretero-enteric benign strictures in renal transplant patients after radical cystectomy is feasible and safe with optimal outcomes. Renal function preservation is the ultimate goal in these patients and the endourological approach represents an alternative effective technique.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

Corresponding author

Alessandro Uleri
alessandrouleri@outlook.it