Surgical Treatment of Urolithiasis in Children: Experience of a Pediatric Surgery Department in Tunisia

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Abstract

Urolithiasis is uncommon in children. This is a recurrent disease with severe evolution, which can lead to chronic renal failure. The management is multidisciplinary. Despite the innovation of new minimally invasive techniques, conventional surgery in our country remains the reference treatment. We bring our experience in the diagnostic and therapeutic management.

Keywords: Urolithiasis; Children; Endoscopy; Surgery

Introduction

The discovery of Urolithiasis in children requires a systematic and thorough etiological investigation in search of a metabolic disease, hereditary anomaly or associated Uropathy. Besides the medical care, urologic care is essential. It primarily uses extracorporeal shock wave lithotripsy (ESWL). The published data confirm that ESWL is the first-line treatment in children because of its effectiveness and safety. In case of failure or complex Urolithiasis, percutaneous nephrolithotomy (PCNL) and Ureteroscopy (URS) are indicated. The open surgery remains an effective option but it is now rarely indicated.

In our context, it retains interesting because of the non-availability of others techniques for children (suitable hardware problem, general anesthesis).

Patients and Methods

We have collected in these review 45 patients followed at the pediatric surgery department of Habib Thameur hospital for Urolithiasis over a period of 18 years from January 1996 to December 2014.

Results

The average age of our patients was six years and ten months with extreme ranging from two months to 13 years old. Our series included 29 boys and 16 girls with a sex ratio of 1.8. Different lithiasic risk factors were found: a metabolic abnormality, a malformation Uropathy, recurrent urinary tract infections, spinal trauma and neurological disease and a foreign object (Table 1). Family history of stones was found in our series in 7 cases and consanguinity in 6 cases.

The most frequent fact of discovery of Urolithiasis in our series was the urinary tract infection (20 cases). Other circumstances have been found summarized in Table 2.

Physical examination should be thorough and complete. In our study, a weight delay was noted in 11 cases, short stature in 9 cases, a lumbar contact in 8 cases, fever in 2 cases, hematuria in a case, pyuria in a case, a distended bladder in a case, hypertension in a case while the examination was normal in 33 cases (73%).

Biological examination revealed an inflammatory syndrome in 6 patients and kidney failure in 9 patients. The urine culture was positive in 8 cases (Proteus mirabilis in 5 cases and Escherichia coli in 3 cases). The metabolic evaluation, practiced for 12 patients, found hyper oxaluria in 7 cases including one case associated with hypocalciuria, cystinuria in 2 cases, hyperuricosuria with hyperphosphaturia in a case, xantinuria in a case while the checkup was normal in a case.

The crystalluria showed the presence of crystals of Whewellite in 2 cases Weddellite in 2 cases Whewellite and Weddellite and in a case, cystine in 2 cases, struvite in 2 cases, uric acid in a case, 2.8 dihydroxyadenine in a case while crystalluria was negative in a case.

In our series, we had done a Kidney-Ureter-Bladder (KUB) film in 40 patients. The stones were radio-opaque in 37 cases (Figure 1).

Ultrasound was performed in 44 children and was contributive in 95% cases. The stones were unique in 22 cases (Figure 2) and multiple in 20 cases. They were renal in 29 cases, ureteral in 12 cases and vesical in 8 cases. Lithiasis was obstructive with upstream dilatation in 32 cases and not obstructive in 10 cases. It was isolated in 39 cases and associated with Nephrocalcinosis in 3 cases. Ultrasound identified 4 Coralliform Lithiasis. It also helped to detect abnormalities of the urinary tract as unilateral pelvicalyceal obstruction in 2 cases, unilateral...
Ureteropelvic duplicity in a case and Ureteropelvic dilatation in 2 cases. The intravenous urography (IVU) was realized in 30 patients and was contributive in 97% of cases. The computed tomography (CT) was performed in our series in 4 cases. His contribution was 100% (Figure 3). A kidney rotation has been detected in a patient.

Surgical treatment was indicated for all children in our series but indications were different: 21 children had obstructive lithiasis, 9 had coralliform stones, and both had an Ureteropelvic junction obstruction associated with stones, both had escaped to medical treatment, ten had bladder stones and one child had urethral calculi (Table 3). Kidney stones (22 cases) were treated by a Posterolateral Lumbotomy which was associated with a pyelotomie (18 cases) or a nephrotomy (4 cases) (Figure 4).

The kidney stone was unique in 16 cases and multiple in 6 cases. Its size varied between a few millimeters and two centimeters. Renal Lithiasis was associated with an abnormality of the urinary tract in three cases:

* Ureteral duplicity in 1 case

* Ureteropelvic junction obstruction in 2 cases.

Pyuria was observed in 4 cases. Pyonephrosis was found in 1 case. The lithiasis was associated with a superior pole collection in 1 case.

Extraction of kidney stones was complete in 16 cases (73%) when the stone was unique and incomplete in 6 cases (27%). Nephrectomy was performed in the case of pyonephrosis because the kidney is known to be non-functional in preoperatively. For the drainage, a Redon drain was put in place in all cases. Urinary drainage was performed in 11 patients (Table 4).

Ureteral stones (6 cases) were treated by a posterolateral lumbotomy in 3 cases, a Pfannenstiel incision in one case and a horizontal iliac incision in two cases. All stones were extracted by ureterotomy (Figure 5). Stones were extracted in all cases. Ureteral wash was associated in 1 case.

Three children had drainage for their ureteral lithiasis. It was realized by bilateral nephrostomy in one case, a nephrostomy with a Foley catheter in one case and ureteral catheter with Foley catheter in one case. For bladder stones (8 cases), 4 were removed endoscopically.

**Table 3: Surgical Indications.**

<table>
<thead>
<tr>
<th>Surgical Indications</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstructive Lithiasis</td>
<td>21</td>
</tr>
<tr>
<td>Coralliform</td>
<td>9</td>
</tr>
<tr>
<td>Ureteropelvic Junction Lithiasis Associated with Stones</td>
<td>2</td>
</tr>
<tr>
<td>Failure of Medical Treatment</td>
<td>2</td>
</tr>
<tr>
<td>Bladder Stone</td>
<td>2</td>
</tr>
<tr>
<td>Urethral Stone</td>
<td>1</td>
</tr>
</tbody>
</table>

**Table 4: Drainage equipment after renal stone extraction.**

<table>
<thead>
<tr>
<th>Drainage Equipment</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Double J Stent</td>
<td>3</td>
</tr>
<tr>
<td>Foley Catheter</td>
<td>2</td>
</tr>
<tr>
<td>Nephrostomy</td>
<td>2</td>
</tr>
<tr>
<td>Nephrostomy+Foley Catheter</td>
<td>2</td>
</tr>
<tr>
<td>Pyelostomy+Foley Catheter</td>
<td>1</td>
</tr>
</tbody>
</table>

**Figure 1: KUB-renal lithiasis.**

**Figure 2: Ultrasound-bladder lithiasis.**

**Figure 3: Computed tomography showing a renal lithiasis.**

**Figure 4: Intraoperative view of renal urolithiasis.**

**Figure 5: Intraoperative view of ureteral lithiasis.**
and 4 by a Pfannenstiel incision with bladder size. For ureteral stone, it was removed by meatotomy. The lithiasic associations were found in 4 cases (renal and ureteral, urethral and bladder).

Our series include four particular observations

There were two children aged seven months and seven years, respectively, who had pre-terminal renal insufficiency and had obstructive kidney stones. The surgical procedure consisted in a nephrostomy without extraction of the stones. The evolution was marked by the improvement of the renal function. The children had subsequently a surgical extraction of the lithiasis.

The third observation is about a 9-year-old girl who was admitted for a urinary lithiasis discovered following a urinary tract infection. At the KUB film, the stone was in the bladder. We had completed with ultrasound and IVU which showed that the stone was enclosed in the right uretero-bladder junction with upstream ureteral dilation. We then carried out an endoscopy which allowed the extraction of the stone.

The fourth observation is that of a 19-month-old child attending in the Pediatric Department for adenine phosphoribosyltransferase (APRT) deficiency in pre-terminal renal failure with bilateral obstructive ureteral lithiasis. The patient had an ascent of bilateral double J catheter by endoscopy as a waiting treatment. The evolution was marked by the spontaneous expulsion of the stone after one week and the child subsequently had the ablation of the ureteral catheters.

Postoperative complications were marked by a urinary tract infection in 8 cases, kidney function distortion in 4 cases, urinoma in 2 cases and ureteral stenosis in a case. The residual stone was noted in 11 patients and recidivism in 7 children.

Discussion

The stone disease in children is less common than in adults. In Tunisia, since the late 60s and over 80s, the incidence was higher than 30 cases per year [1]. This impact has been a significant decrease and currently represents 0.4 cases/1000 pediatric admissions/year [2]. The stone disease in children affects all ages. In our series, the average age was 6.8 years and the sex ratio was 1.8. Metabolic disorders may be revealed in the interrogation. Pathologies such as primary hyperoxaluria or cystinuria are known to producing urolithiasis in children. Urinary tract infections may also constitute lithiasic risk factors.

The association of stones to a malformation uropathy in the literature varies between 9 and 34% [3]. The interrogation should also search spinal injury, foreign object in the bladder, indwelling catheter and bladder augmentation that can cause bladder stones formation. Urinary tract infection is the most frequent circumstance of discovery finding in children.

The clinical expression is still severe and it is a medical and surgical emergency. Others circumstances of discovery can be found such as hematuria, back pain, urinary disorders, kidney failure, spontaneous stone passage or accidentally.

Physical examination must be thorough and complete

The biological checkup includes the research of an inflammatory syndrome and the evaluation of renal function. The urine culture is necessary because the infection can be the cause or consequence of the stones. The study of crystalluria allows the search for metabolic abnormalities.

Radiological exploration of urolithiasis usually starts with making a Kidney-Ureter-Bladder (KUB) film. However, it has many limits. The stone cannot be seen because it is too small, radio transparent, masked by digestive gases or fecal stasis or in projection on bony prominences [4]. Ultrasound has the advantages of being easily available, non-invasive and avoiding radiation. The stone appears as a hyper echogenic image with posterior acoustic shadowing. Ultrasound can detect small stones (2-3 mm) and has significant interest in the detection of radio transparent lithiasis [4].

According to the European Association of Urology [5], ultrasound is the first radiological examination required in pediatric urolithiasis. The intravenous urogram is analyzed regarding renal function, dilatation of renal pelvi-calyceal system and ureter, location and area of the renal stone and radiological opacity. Non-opaque stones are noticed as contrast medium filling defects. Intravenous urography is contraindicated in acute ureteral stone colic, renal failure (creatinine ≥ 200 μmol/L), myeloma and similar diseases, contrast medium allergy, untreated hyperthyroidism [4].

Non-contrast enhanced computed tomography (NCCT) is regarded as the gold standard due to the high sensitivity and specificity [6]. The treatment objective is the elimination of stones. Medical treatment is also designed to prevent the formation of new stones by diluting urine and correcting metabolic disorders which cause stone formation [7]. For patients requiring surgical treatment, several techniques are available. ESWL is increasingly used and has become the therapeutic option in the treatment of the majority of pediatric urolithiasis [7]. It is a minimally invasive technique that does not require a long hospital stay and that is associated with a low complication rate [8]. The need for general anesthesia during ESWL depends on the patient’s age and the lithotripter used [9].

Some authors still have concerns about the potential biological effects of ESWL on immature kidneys and surrounding organs in children. But according to the European Association of Urology [10], no study has demonstrated irreversible functional or morphological side effects during or long-wave lithotripsy. The efficiency of ESWL in children was demonstrated by the different series published [11-13]. It can be explained by:

* The small size of the child that helps reducing energy loss of the shock wave before attaining the stone.
* The compliance of the urinary tract of the child promoting the elimination of even large fragments [14].

According to the European Association of Urology [10], the indications for ESWL in children are similar to those in adults; however, they pass fragments more easily. Children with renal stones of a diameter up to 20 mm are ideal candidates for ESWL. Otherwise, this technique has some complications such as: hematuria, skin irritation, hemoptysis, small thermal lag and lesion of the renal parenchyma [7]. Another technique can be used that is the percutaneous nephrolithotomy (PCNL). Its principle is the percutaneous insertion of an endoscope to the renal pelvis caliceal cavities to extract the stones and to fragment them if necessary [15]. It is performed under general anesthesia and under radiological control.

This technique involves five steps:

* The rise of ureteral catheter
* The puncture of cavities
* The establishment of the tunnel
lesions in the kidney, ureteral obstruction and hypertension [23]. The laparoscopic approach is not easy and requires a good expertise, particularly in laparoscopic suturing. This explains the limited number of series published in this issue [24]. The indications for this technique are those of conventional surgery.

Conclusion

Currently, the first-line treatment of Urolithiasis in children is the ESWL. The use of conventional surgery should be reserved for cases where a minimally invasive treatment would be impossible. To achieve this aim, a more enhanced multidisciplinary collaboration is needed.

References

