AUTHOR'S REPLY

Reply to: Giusti G, Proietti S. Supine PCNL is the way to go! Cent European J Urol. 2017; 70: 66-67.

PCNL: understanding the beauty of the supine position

Mario Sofer

Director of Endourology Tel-Aviv Sourasky Medical Center, affiliated to the Sackler School of Medicine, Tel-Aviv University, Tel-Aviv, Israel

Having received the opportunity to add my comments to this outstanding editorial represents for me a great honour and pleasure for two reasons. First, Dr. Giusti is a prominent figure in endourology and an enthusiastic teacher of supine PCNL, therefore forming an ideal academic partnership with Dr. Proietti in propagating this procedure around the world has been a truly outstanding experience. Secondly, Dr. Giusti served as my mentor in implementing supine PCNL. I could even say that I fell in love with this procedure at first sight. It has not only been the curiosity, but has been the challenge of implementing a new approach. I have performed almost one thousand prone PCNLs and have had to combat with several issues such as: long hours of bending over while in a standing position over the patient, while bearing the weight of a lead apron on my shoulders, changing the patient's position during the operation, arguing with the anaesthesiologist about access to the patient's airway and monitoring devices, performing additional percutaneous accesses in certain cases and puncturing supracostally with the subsequent inevitable pleural complications in order to treat staghorn stones. I have understood that it can be done differently, and that Valdivia et al. [1]. solved those problems in an ingenious way. Once I had performed my first supine approach, in a seated position, with the anaesthesiologist relaxed and uncomplaining, puncturing the lower calyx for an effective access to the entire collecting system, and, if necessary, achieving an easy combined endoscopic approach, I could not return to the prone position anymore. The editorial of Giusti and Proietti summarizes the evolution and advantages of supine PCNL, supporting the rationale of operating with the patient in this position. Our recently published article shows how easy it is for an experienced endourologist to switch to the supine approach. This paper has been preceded by two other studies in our group. The first one, based on cross-sectional imaging and intraoperative findings, showed that a lower calyx access with the patient in a supine position, provides excellent accessibility to the collecting system while challenging the paradigm that staghorn and complex stones should be always approached through an upper calyx with the patient in prone position [2]. The second one further supported the suitability of the supine approach for patients with any morphometric condition [3]. We hope, that our experience published here, will make a significant contribution in popularizing supine PCNL, which we believe should be the first-line approach for large and complex renal stones.

References

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