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Studies offer valuable advice on stone prevention

Up to 5% of Americans will be affected by stone disease over the course of their lifetime.

Despite major advances in shockwave lithotripsy and endoscopic technologies, we must not underestimate the role of medical therapy in preventing stone recur-

rence. Two studies presented at the recent AUA annual meeting and reported in this issue of *Urology Times* offer valuable lessons on this aspect of stone management.

The first study, by Manoj Monga, MD, and colleagues, suggests that the majority of patients will have progression of asymptomatic renal calculi. More than three-fourths of their patients with asymptomatic calculi developed pain, needed intervention, or experienced growth in the size of their stones.

The take-home message of this study—that most stones will eventu-

ally become problematic down the road—is in line with that of previous work suggesting that the term “clinically insignificant residual fragments” following shockwave lithotripsy or percutaneous stone removal is a misnomer, as most patients with residual fragments will ultimately become symptomatic. Eventually, residual fragments following a stone removal procedure will progress, as did the majority of asymptomatic stones in Dr. Monga’s study.

One could argue that an older patient with a single stone

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episode, no residual stones, and no family history of stones might be able to get by with observation. In most cases, however, observation of asymptomatic renal calculi is not a good option.

A second study, reported by Fredric Coe, MD and colleagues, looked at the

ability of private-practice urologists to medically manage stone disease with success rates similar to those of academic centers. In the past, it has been difficult for some urologists in private practice to obtain the sophisticated 24-hour urinalysis packages available only at major medical institutions. Now, however, patients are able to transmit samples through the mail to a commercial laboratory, allowing comprehensive analyses of 24-hour urine collections.

Dr. Coe’s group was able to achieve a nine-fold reduction in stone recurrence utilizing selective medical therapy. These results are on par with those reported from academic medical centers. This is one of only a few studies to document the benefits of a centralized laboratory for 24-hour urinalyses to make a directed diagnosis and the application of standard medical management in a “real-world,” community setting.

In summary, I will leave you with two simple but important messages: First, simple observation of existing calculi, without concomitant medical management, may not be the best option, as most stones progress over time. Second, appropriate metabolic evaluation and medical treatment of nephrolithiasis can prevent stone progression or recurrence in a private-practice office setting.

Editorial Perspective



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