Extracorporeal shock-wave lithotripsy (ESWL) was introduced clinically in February 1980 by Chaussy et al. [1], and it has been in clinical use for 11 years having replaced other treatment techniques for the majority of surgical calculi in the upper urinary tract. Since that time, approximately 2 million patients around the world have been successfully treated by this technique. Patient acceptance and clinical adoption of ESWL has been facilitated by the perception that ESLW does not cause severe acute or lasting side effects [2]. Most complications are related to obstruction from stone fragments lodged within the ureter with accompanying colic and/or infection and subcapsular or perirenal hematoma [3]. We report the case of a patient with a single functioning kidney who was treated with ESWL developing irreversible acute renal failure.

A 54-year-old woman was admitted to the hospital with severe renal failure (Cr = 751 µmol/l; 8.5 mg/dl). Diagnostic evaluation with ultrasound scan revealed bilateral obstructive staghorn calculi. Nephrostomy was performed in the left kidney because the right kidney showed no renal cortex. Renal function recovered to a Cr value of 132 µmol/l (1.5 mg/dl), and pyelolithotomy was performed. Two months later, ESWL was initiated to treat the remaining calculi. A total of 5,000 shock waves with the clinical power setting of 10 (on the scale of 1-10) was administered with the Wolf Piezolith 2500 lithotriptor. No ureteral stents were used. Following monitoring in the recovery room for 2 h, the patient was discharged from the hospital with the prescription of ciprofloxacin orally twice a day for 10 days. Six hours after postoperative procedure, she developed gross hematuria for 2 days. Two days later chemistry studies showed a rise in serum Cr to 398 µmol/l (4.5 mg/dl). Physical examination was normal. Blood pressure and body temperature were always in the normal range. Scan ultrasound revealed loss of corticomedullary demarcation and hypoceregenic parenchyma. Slight
ureterohydronephrosis was delimited. No intrarenal, subcapsular and perirenal hematoma was observed. A duplex Doppler scan showed permeability of the renal vasculature. Blood and urine cultures were negative. Nephrostomy catheter was placed, however, no recovery of the renal function was observed. One month later, the renal histology showed extensive fibrosis and diffuse atrophy of the tubules besides microscopic nephrocalcinosis and glomerular obsolescence. The renal function deteriorated to end-stage renal failure, and the patient was included in a hemodialysis program.

The complications of ESWL are related to the administration of shock waves and those resulting from fragmentation and the passage of particles to the ureter [4]. The former complications included acute renal damage. Recent clinical and experimental reports show that ESWL cause acute renal effects in the majority of treated kidneys [5-8]. These effects induced by ESWL appear to be dependent on a number of factors, including the type of lithotriptor used, shock wave generator power, focal size of the shock wave, total energy delivered, number of shock waves and prelithotripsy renal function [7]. Our patient was treated with piezoelectric lithotripter. This machine is associated with less tissue damage than other types of lithotriptors. The number of the shock waves and the energy delivered were the usual. ESWL-induced acute renal damage may affect the nephron, microvasculature and the surrounding interstitium (hemorrhage, edema and acute tubular necrosis). This form of renal trauma is associated with an immediate decrease in the renal function of the treated kidney, and occasionally may be permanent [9]. The decrease in renal clearance in a kidney resulting from renal trauma caused by ESWL can probably be compensated by an increased function of a healthy untreated kidney. For this reason, the measurement of total renal clearance may not detect the presence of an adverse effect of ESWL on a treated kidney unless the untreated kidney is unable to respond. The case here presented may be an example of this. The patient developed acute renal failure in the absence of sepsis, vascular damage, obstruction and nephrotoxic drugs. The pathogenic factor of acute illness would be intraparenchymal edema and/or hemorrhage and subsequent fibrosis. Sonographic changes and renal histology are compatible with this hypothesis.

Although ESWL is a safe mode of stone treatment when used judiciously in the vast majority of cases, acute renal failure can occur in a patients with only 1 functioning kidney and/or previous chronic renal failure in spite of using the less traumatic lithotriptor and normal number of shock waves. In these patients, the renal function should be monitored closely postoperatively.

References


Editor's Note
We are saddened to hear of the recent death of Professor J. F. Maher, Bethesda, Md. His work on the editorial board was much appreciated. He will be sorely missed by the nephrological community throughout the world.

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