

CT Urography and MR Urography have increased the sensitivity and specificity of diagnostic work up.

Kalra OP et al highlighted the importance of medical management in treatment of urolithiasis. Variety of medical treatments can prevent recurrence of stones⁵ About 90% of stones 4 mm or less in size usually will pass spontaneously, however 99% of stones larger than 6 mm will require some form of intervention. There are various measures that can be used to encourage the passage of a stone. These can include increased hydration, medication for treating infection and reducing pain, and diuretics to encourage urine flow and prevent further stone formation. A detailed diagnostic work up is essential and prerequisite for medical management Dietary modifications like high fluid intake and Animal protein restriction are essential for any type of stone disease. Specific modalities like Potassium citrate, thiazide diuretics, allopurinol and treatment of infections might help in preventing recurrent stone disease in specific situations.

Surgery is necessary when the pain is persistent and severe, in renal failure and when there is a kidney infection. It may also be advisable if the stone fails to pass or move after 30 days. In most of these cases, non-invasive extracorporeal shock wave lithotripsy (ESWL) will be used. Otherwise some form of invasive procedure is required; with approaches including ureteroscopic fragmentation (or simple basket extraction if feasible) using laser, ultrasonic or mechanical (pneumatic, shock-wave) forms of energy to fragment the larger stones. In recent years, as clinical experience with ESWL revealed its limitations, the role of PCNL for treating urolithiasis was redefined. According to the literature reviewed by. Anil varshney and associates PCNL should be the first line treatment of large or multiple kidney stones, and stones in the inferior calyx.⁶ Furthermore, improvements in instruments (i.e. ureteroscopes) as well as lithotripsy technology (i.e. ultrasound / pneumatic devices, Holmium-YAG-Laser) increased the efficacy of percutaneous stone disintegration yielding stone free rates of >90%. Pediatric urolithiasis is endemic in developing countries including India. An underlying metabolic disorder is the cause in about half of children, infection being the cause in the other half. In Uttar Pradesh, parts of Gujrat and Maharashtra, vesical calculi are very frequent. The mean age of presentation is 6.9 years for girls and 5.2 years for boys. Infected stones generally present early before 4 years of age. Recurrence rates range from 3.6% to 68% and is the highest for children with metabolic risk factors.^{7,8} . Aggarwal et al have laid out more focussed approach for treatment of urolithiasis in paediatric age group.

Although Medical and surgical management constitutes the cornerstone of treatment of nephrolithiasis, in India, alternative and complimentary systems provide many opportunities and claims for cure for this recurring disease. Review of literature by Saxena et al highlights some of the important remedies in alternative system which many patients resort to escape surgery.

I would like to complement JIMSA for bringing out a dedicated issue on nephrolithiasis.

REFERENCES

1. *Curhan GC: Epidemiology of stone disease. Urol Clin North Am 2007, 34:287-293.*
2. *Hughes P: The CARI guidelines. Kidney stones epidemiology. Nephrology (Carlton) 2007, 12 Suppl 1:S26-30.*
3. *Agarwal SK, Dash SC. Spectrum of renal diseases in India in adults. J Assoc Phy India 2000; 48:594-600.*
4. *Menon M, Resnick MI. Urinary lithiasis: etiology, diagnosis, and medical management. In: Walsh PC, Retik AB, Vaughan ED Jr, Wein AJ. Campbell's Urology. 9th ed. Philadelphia, Pa: WB Saunders Co; 2002:3229-305.*
5. *Pak CY, Resnick MI. Medical therapy and new approaches to management of urolithiasis. Urol Clin North Am 2000; 27: 243-253.*
6. *Albala DM, Assimos DG, Clayman RV, Densted JD, Grasso M, Gutierrez-Aceves J et al. Lower pole I: a prospective randomized trial of extracorporeal shock wave lithotripsy and percutaneous nephrolithotomy for lower pole nephrolithiasis – initial results. J Urol 2001; 166: 2072-2080.*
7. *Kroovand RL. Pediatric Urolithiasis. Urol Clin North Am 1997; 24: 173-84.*
8. *Sinno K, Boyce WH, Resnick MI. Childhood Urolithiasis. J Urol 1979;121: 662- 664.*

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