

is outlined in the accompanying Table 2.

Table 2: Apollo experience with neonatal obstructive uropathy 2004 – 2007 (n = 49)

Diagnosis		
<i>Bladder outlet obstruction</i>		
Posterior urethral valve	17	
Ureterocele		07
Anterior urethral valve	01	
Congenital urethral stenosis		01
Dysfunctional voiding	03	
<i>Vesicoureteric junction obstruction</i>		
<i>Pelviureteric junction obstruction</i>	15	
Follow up results 15 PUJ		01-36 months
		Mean = 12
Death due to renal failure		
Living with renal failure	01	
Fall in differential renal function	03	
Improvement in Diff renal function	05	
No significant change	05	
Improvement in drainage		10
Growth of cortical matter		10
Success defined as stable differential renal function or improvement, reduction in pelvic dilatation, improvement in drainage and increase in cortical thickness 10/15.		

Pelviureteric junction obstruction can be severe enough in a small proportion of babies to require intervention early. The outcome of surgery in newborn is dependant on the quality of renal parenchyma, length of the obstructing segment, quality of surgery and feasibility of DJ stenting.

CONCLUSION

Neonatal obstructive uropathy is one of the commonest cause of reversible urosepsis and renal failure in newborns. The symptoms are more

pronounced if there is infravesical obstruction or obstruction in a single functioning system. The corner stone of diagnosis of infravesical obstruction is a micturating cystourethrogram.

The vast majority with obstructive pathology below the bladder can be managed by a neonatal resectoscope (9 F) or a cystoscope and cold knife (7.5 F). The babies who undergo such treatment must have a check at 3 months for improvement in clinical symptoms and radiological sign with reversal of biochemical parameters. A small proportion will need temporary urinary diversion.

Vesicoureteric junction is not common. However, in case it warrants intervention, it is usually temporary and definitive repair is done at one year.

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