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**The Wallstent®: 23 years of experience in the treatment of benign ureteroenteric anastomotic strictures after Bricker deviation**

T. Campschoer, T.M.T.W. Lock

*University Medical Centre Utrecht, Utrecht, The Netherlands*

**Introduction:** Stenosis of the uretero-ileal (UI) anastomosis following Bricker deviation is seen in 4-10% of all cases. Many minimal invasive techniques (balloon dilatation, double-J-stenting or laser endoureterotomy, cold and hot knife incision) have been described, but long-term results are disappointing with failure rates up to 30 to 80%. Especially in unfit patients (ASA  $\geq$  2) positioning of a Wallstent® under local anaesthesia is an attractive alternative. We describe our experience with the Wallstent® in benign obstruction and compare results with data available from a literature search.

**Methods:** From 1989, of all patients with benign UI-strictures and end-to-side anastomosis, we retrospectively collected data on clinical history, complications, auxiliary measures and patency rates and compared these with available data from literature.

**Results:** A total of 46 patients underwent 51 Wallstent® procedures (mean age: 63 yrs). Placement of the Wallstent was possible in 100% of the patients and without auxiliary treatment the patency remained well in 14 patients (mean follow-up time 46 months). In 16 patients due to stent obstruction (hyperplastic reaction or encrustation) or migration a second treatment (laser vaporization and/or balloon dilatation) was performed with success. Combined primary and secondary patency rates were therefore 58.8% (30/51 Wallstents®, mean follow-up time 55.4 months), comparable with patency rates between 36 and 100% described in literature with a wide variety in number of cases and much shorter follow-up period.

**Conclusion:** To our knowledge this is the longest follow-up and largest series of Wallstent® stenting in benign UI obstructions. We proved that in selected cases, in experienced hands, to preserve quality of life, placement of a Wallstent can lead to a permanent desobstruction in approximately 6 out of 10 patients with UI anastomotic stricture.

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