Author's response to reviews

Title: Laparoscopic nephrectomy for Giant staghorn calculus with non-functioning kidneys. Is associated unsuspected urothelial carcinoma responsible for conversion?

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Author’s response to reviews:

Date 6/10/2005

To,
Editor,

BMC Urology

Subject- Submission of article "Laparoscopic nephrectomy for Giant staghorn calculus with non-functioning kidneys. Is associated unsuspected urothelial carcinoma responsible for conversion?"

Respected Sir,

We are sending herewith revised article "Laparoscopic nephrectomy for Giant staghorn calculus with non-functioning kidneys. Is associated unsuspected urothelial carcinoma responsible for conversion?"

Kindly evaluate the same for publication in BMC Urology.

The comments by both the reviewers are addressed to herewith and the manuscript is revised accordingly.

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Thanking you,

Sincerely yours,

Dr. Hemendra N. Shah

Reply to reviewer Serdar Deger report:

Comment 1: The authors mentioning that surgeons should keep in mind that some non-functioning kidneys can hide malignant disease and recommending a operative strategy to perform a dissection outside of the gerota fascia. It should also be addressed that this kidneys should be removed via laparoscopic bag when the procedure is completed laparoscopically.

Reply: The statement that "kidneys should be removed via laparoscopic bag when the procedure is completed laparoscopically" is added in conclusion section of revised manuscript.

Comment 2: These two cases are not selectively converted because of known malignancies. In the first case there was an incidently injury of renal pelvis and tumour material came out and the second case was converted due problems of laparoscopic dissection. So in specially second case the surgeon did not know...
exactly that he is dealing with malignant disease when he converted. The question in the title is places well and is not discussed in conclusions. It is recommendable to change the title.

Reply: In both the described cases, we had not suspected malignancy during conversion. It was diagnosed only postoperatively after we got report of histopathological examination of nephrectomy specimen. In first case, patient had history of pulmonary kochs in childhood. In view of it, we thought that patient had renal kochs with caseous putty material coming out from renal pelvis. These details are added in revised manuscript. In title, we had mentioned word "unsuspected", since the malignancy was not suspected in these patients during elective conversion. The necessary changes are made in conclusion section of the revised manuscript.

Reply to reviewer Maxwell v Meng report

Comment 1: Additional details would be helpful. These include operative time, associated morbidity, blood loss. Also, discussion about the subsequent open procedure would be educational -- type of incision, etc.

Reply: The detail information about operative time, associated morbidity, blood loss and incision added in revised manuscript.

Comment 2: The authors approached each case differently (i.e. transperitoneal vs. retroperitoneal). Why was this the case? A discussion of the rationale would be desirable.

Reply: We started laparoscopic nephrectomy in our department from January 2000. Initially we employed transperitoneal approach and later on with increasing experience we progressed towards retroperitoneoscopy. Hence first case in our report was approached transperitoneally and the second case retroperitoneoscopically. This explanation is added in revised manuscript.

Comment 3: In the second patient, why was nephrectomy undertaken despite a differential renal function of 12%? What was this patient’s creatinine? Potentially, multiple percutaneous procedures or anatrophic nephrolithitomy could have been successful.

Reply: We agree with reviewer that patents could also have been managed by PCNL employing multiple tracts. In view of patient’s age, normal serum creatinine & normally functioning opposite kidney, option of renal conservation versus nephrectomy were discussed with patient. She opted for retroperitoneoscopic nephrectomy. The necessary comment added in revised manuscript.

Comment 4: The Discussion section should emphasize the key points. I believe these include (1) the difficulty in surgery (of any type) for inflammatory renal conditions, (2) intra-operative decision to convert to open surgery, and (3) suspicion for underlying malignancy in non-functional, XGP-type kidneys.

Reply: All the above 3 points are discussed in detail in revised manuscript. Similarly relevant references (number 14 and 15) are added in the revised manuscript.

Comment 5: Another important point would be the role of cross-sectional imaging. In 2005, I would think that computed tomography is readily available, depending on location; however, it is conceivable that CT in these 2 patients could have suggested underlying tumors or lesions, and this may have influenced the surgical approach and/or decision to attempt laparoscopy.

Reply: The role of CT scan is added in revised manuscript. "We had not done computerized tomography in our patients, and retrospectively feel that in first patient we could have identified lymphadenopathy on the computerized tomography. Although the exact role of a computerized tomography and cytology in preoperative workup for detection of possible associated malignancy in such condition is yet to be defined, computerized tomography may help in identifying xanthogranulomatous pyelonephritis or renal mass with or without associated lymphadenopathy in such scenario."

Comment 6: The author name in reference 3 is spelled different in the Reference list and discussion (page 5)

Reply: Necessary spelling correction made in revised manuscript.