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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Extracorporeal shock wave lithotripsy: the first 50 patients treated in Britain

SIR,—Surely you might have asked Mr J E A Wickham and his colleagues to state how many of their 50 patients passed their lithotripsied renal stones in the fullness of time? When discharged only seven patients were stone free, 34 stones had "progressed" and, presumably, the remaining nine were as yet unmoved. Eight kidneys showed ultrasound evidence of obstruction, though we are not told the incidence of obstruction before treatment. These data hardly support the conclusion that this method is superior to all other forms of removing renal stones. It is a great pity that the final results of treatment were not included.

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SIR,—Mr J E A Wickham and his colleagues (20 April, p 1185) are to be congratulated on their interesting description of the first 50 patients treated by lithotripsy in the United Kingdom. However, their claim in the abstract that this new procedure is "safe, cost effective, extremely well received by patients, and superior to all other methods of removing renal stones" is not justified by what follows in the rest of the paper.

The authors describe a complication rate of almost 10%, including a case of acute renal failure, and this is surely not inconsiderable. No comparable information is given for complication rates after conventional and percutaneous renal surgery for removal of stones. There is no knowledge about the long term sequelae of treatment on the lithotripter, and perhaps it is a little premature to assume that it is safe.

It has yet to be established that this new device is cost effective. To do so there has to be a comparison with the alternative modes of therapy. This has yet to be provided. Mr Wickham and his colleagues do not tell us how patient reception was measured. We would be interested to know on what basis he concluded that the lithotripter has been very well received.

I am sure that the authors do not intend that this should become the final word on lithotripsy, as a great deal of further information must be obtained before it can be estimated as "superior to all other methods of removing renal stones."

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** The authors reply below.—ED, *BMJ*.

SIR,—In response to Mr Jamieson and Dr Challah and others we would make the following observations.

Firstly, our article reports the initial response of our patients to extracorporeal shock wave lithotripsy (ESWL) and we shall obviously communicate our later follow up results in due course. Our results at the time of our article were entirely in accord with the experiences of our German colleagues, which we clearly referenced. For example, in 1200 patients from Stuttgart 85% were stone free at three months and of the remainder 11 passed their fragments spontaneously and only four required a second ESWL procedure, percutaneous nephrolithotomy, or ureterorenoscopy for removal.[1,2]

Secondly, all our complications were minor apart from the one patient with obstructive anuria in a solitary kidney who was not managed at our centre but subsequently made a full recovery. This case well demonstrates the need for management of such patients in a stone centre with percutaneous skill.

Thirdly, obviously in a short article it is not possible to give a comprehensive review of the whole subject and results of open stone surgery versus percutaneous nephrolithotomy, but cost effectiveness has been shown in practice in West Germany and the USA and by epidemiological survey and statistical forecast in Australia and the UK.[3,4] (Fair W, paper at Urological Society of Australasia 38th annual scientific meeting, 1985, and Professor N Blacklock, personal communication.)

When percutaneous nephrolithotomy and open surgery were compared complications were found to be about equal with each type of treatment but with percutaneous nephrolithotomy resulting in a much more rapid convalescence, diminished pain, and increased cost effectiveness.[5,6] ESWL in clinical practice has existed for nearly five years and follow up to three years is well documented. In fact, percutaneous nephrolithotomy, which Dr Challah and colleagues acknowledge as a safe