URO

Observation time: 10/27/2010 09:07

Operative Summary

Lenskyj, Adam Adolf Mr
MRN: 203-1473
D.O.B. -----

CLINICAL NOTE:
Mr. Lenskyj is a 69-year-old gentleman with a history of a distal UVJ stone which led to pyelonephritis and sepsis approximately one year ago. Since that time, he has passed the stone but he refused any further interventions, and as such, has had the stent in situ for the past year. He has had a CT scan which showed no evidence of ureteric stone; however, he does have 2 lower pole stones en the right side. We brought Mr. Lenskyj here today to remove his stent as it has been long overdue.

PROCEDURE IN DETAIL:
Mr. Lenskyj was brought to the lithotripsy suite and placed on the table in lithotomy position. He was prepped and draped in the usual sterile fashion. A KUB was first performed and everything looked clear in terms of the ureter. The stones in the lower pole calyx were not visible on the KUB.

We began by inserting a flexible cystoscope into the penis. The anterior urethra appeared normal. Posterior urethra showed evidence of moderate hypertrophy. The scope entered the bladder easily. Once inside, we saw the stent with a tether. This was grasped and pulled out the meatus. This was done under fluoroscopic guidance. The stent came out easily with no complications. It was intact. The patient tolerated the procedure well.

We will send Mr. Lenskyj home today with a prescription for Macrobid for which his infection was sensitive to up a year ago. Given his urinalysis demonstrating a pH of 5.5 and his radiolucent stones, we will assume that these are uric acid in nature and we will treat him with Sodium Bicarb. We will see him back in 3 months time with an ultrasound and hopefully, the medical dissolution therapy will have worked and no further intervention was required for his stones and report me if there are any complications such as fever or pain, he should return at the Emergency Department or contact our office.

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Dictated by Benjamin Johnson, MD

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