



---

## URETEROSCOPY (TELESCOPIC SURGERY) FOR STONE REMOVAL

Information about your procedure from  
The British Association of Urological Surgeons (BAUS)

---

This leaflet contains evidence-based information about your proposed urological procedure. We have consulted specialist surgeons during its preparation, so that it represents best practice in UK urology. You should use it in addition to any advice already given to you.

To view the online version of this leaflet, type the text below into your web browser:

[http://www.baus.org.uk/\\_userfiles/pages/files/Patients/Leaflets/Ureteroscopy for stone.pdf](http://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Ureteroscopy%20for%20stone.pdf)

Further general information about kidney stones can be found on the Patients' section of the BAUS website under "[I think I might have ... kidney stones](#)".

### Key Points

- The aim of this procedure is to fragment stones in the ureter (the tube that drains urine from the kidney into the bladder) using a thin telescope passed into the bladder through the urethra (waterpipe)
- We use a "semi-rigid" telescope (ureteroscope) for stones in the ureter and a flexible ureteroscope to treat stones in the kidney
- Stones are usually broken up using laser energy passed through a small laser fibre
- Ureteroscopy has largely eliminated the need for open surgery to remove stones
- Laparoscopic (keyhole), robotic-assisted or open surgery can be used if the stone is too large to be fragmented with a ureteroscope

### What does this procedure involve?

This involves using a telescope (semi-rigid or flexible) passed into your bladder through your urethra (waterpipe) to fragment and/or remove stones from your ureter or kidney. We sometimes need to leave a temporary stent in your ureter after the procedure.

## What are the alternatives?

- **Observation** – most stones smaller than 5mm in diameter pass by themselves but larger stones (greater than 7mm diameter) rarely do
- **[Extracorporeal shockwave lithotripsy \(ESWL\)](#)** – by “firing” shock waves generated under water through the skin to break the stone into fragments which you then pass yourself
- **[Antegrade ureteroscopy](#)** – stones in the upper ureter (close to the kidney) can be treated by percutaneous (keyhole) puncture of the kidney so that a ureteroscope can be passed down to the stone from above
- **[Laparoscopic \(keyhole\) or robotic stone removal](#)** – for extremely large or impacted stones in the ureter
- **[Percutaneous nephrolithotomy \(PCNL\)](#)** – for large stones in the kidney which may not be suitable for flexible ureteroscopy
- **[Open stone removal](#)** – although very unusual nowadays, if all the above techniques fail we may need to resort to open surgery, through an incision in your side, to remove your stone(s)

## What happens on the day of the procedure?

Your urologist (or a member of their team) will briefly review your history and medications, and will discuss the surgery again with you to confirm your consent.

An anaesthetist will see you to discuss the options of a general anaesthetic or spinal anaesthetic. The anaesthetist will also discuss pain relief after the procedure with you.

We may provide you with a pair of TED stockings to wear, and we may give you a heparin injection to thin your blood. These help to prevent blood clots from developing and passing into your lungs. Your medical team will decide whether you need to continue these after you go home.

If you have a stone in your ureter, we usually arrange a plain abdominal X-ray for you on the day of the operation, to be sure that the stone has not passed by itself.

## Details of the procedure

- we normally use a full general anaesthetic and you will be asleep throughout the procedure
- we usually give you an injection of antibiotics before the procedure, after you have been checked for any allergies

- we put a telescope into your bladder, through your urethra (waterpipe), and use it to put a guidewire up into your kidney, past the stone in the ureter, using X-ray control.
- we then put the ureteroscope (semi-rigid or flexible) up to the level of the stone by following the guidewire
- we fragment the stone using an energy source; this is usually a laser but, occasionally, we use a lithoclast (a tiny pneumatic drill)
- using the laser, we either “dust” the stone, leaving tiny fragments which can pass by themselves, or break it into smaller pieces (pictured) which can be removed using special grasping devices
- we usually insert a temporary drainage tube (a ureteric catheter, or a stent with a string attached) into the ureter at the end of the procedure; this is normally removed on the first post-operative morning
- occasionally, we need to perform a “second-look” ureteroscopy at a later stage to treat residual stones; if this is needed, we leave a stent in your ureter until the second procedure
- occasionally, we put in a bladder catheter which is removed the following morning
- most patients go home on the same day as their procedure or early on the first post-operative morning













If you have been admitted as an emergency (with a stone blocking your ureter), you will have had several tests and other treatment already. This means your stay in hospital will, inevitably, be longer than a single day.

Further information and a [short video of ureteroscopic stone removal](#) are available on the BAUS website.

### **Are there any after-effects?**

The possible after-effects and your risk of getting them are shown below. Some are self-limiting or reversible, but others are not. The impact of after-effects can vary a lot from patient to patient; you should ask your surgeon's advice about the risks and their impact on you as an individual:

After-effect	Risk
Mild burning or bleeding on passing urine for a short time after the procedure (especially if you have a ureteric stent)	 Almost all patients
Temporary insertion of a ureteric stent which needs to be removed later	 Almost all patients
Recurrent (new) stone formation over the next five to 10 years, requiring further surgery or other treatment	 1 in 2 patients (50%)
Residual stones requiring further surgery or other treatment (more likely for stones closer to the kidney)	 Between 1 in 7 & 1 in 20 patients (5 to 15%)
Failed to access the ureter (or reach the stone) requiring further surgery or other treatment	 1 in 20 patients (5%)
Temporary insertion of a bladder catheter	 Between 1 in 10 & 1 in 50 patients
Infection requiring antibiotic treatment	 Between 1 in 50 & 1 in 100 patients
Minor damage to the wall of the ureter (small perforation, mucosal abrasion, bleeding) requiring stenting or percutaneous nephrostomy	 1 in 100 patients (1%)
Narrowing of the ureter due to delayed scar formation (stricture) which may require further treatment	 Between 1 in 100 & 1 in 250 patients
Major damage to the wall of the ureter (large perforation, avulsion of the ureter) requiring further surgery	 Less than 1 in 1000 patients (less than 0.1%)

---

Anaesthetic or cardiovascular problems possibly requiring intensive care (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)



Between 1 in 50 & 1 in 250 patients (your anaesthetist can estimate your individual risk)

---

## What is my risk of a hospital-acquired infection?

Your risk of getting an infection in hospital is approximately 8 in 100 (8%); this includes getting *MRSA* or a *Clostridium difficile* bowel infection. This figure is higher if you are in a “high-risk” group of patients such as patients who have had:

- long-term drainage tubes (e.g. catheters);
- bladder removal;
- long hospital stays; or
- multiple hospital admissions.

## What can I expect when I get home?

- you will be given advice about your recovery at home
- you will be given a copy of your discharge summary and a copy will also be sent to your GP
- any antibiotics or other tablets you may need will be arranged & dispensed from the hospital pharmacy
- you should drink twice as much fluid as you would normally for the first 24 to 48 hours, to flush your system through and reduce the risk of infection
- recovery from ureteroscopy is usually rapid; you may return to work when you are comfortable enough and when your GP is satisfied with your progress
- if you have had a stent put in, it may cause pain in your kidney area when you pass urine, or pain in your bladder; this usually settles quickly but, if you feel unwell or feverish, you should contact your GP to check for a urine infection
- if you develop a fever, pain in the area of the affected kidney, severe pain on passing urine, inability to pass urine or worsening bleeding, you should contact your GP immediately

You can reduce your risk of further stone formation by altering your diet and fluid intake. Ask your urologist or specialist nurse for further details about this or download the BAUS leaflet [“Dietary advice for stone formers”](#).

## General information about surgical procedures

### *Before your procedure*

Please tell a member of the medical team if you have:

- an implanted foreign body (stent, joint replacement, pacemaker, heart valve, blood vessel graft);
- a regular prescription for a blood thinning agent (warfarin, aspirin, clopidogrel, rivaroxaban or dabigatran);
- a present or previous MRSA infection; or
- a high risk of variant-CJD (e.g. if you have had a corneal transplant, a neurosurgical dural transplant or human growth hormone treatment).

### *Questions you may wish to ask*

If you wish to learn more about what will happen, you can find a list of suggested questions called "[Having An Operation](#)" on the website of the Royal College of Surgeons of England. You may also wish to ask your surgeon for his/her personal results and experience with this procedure.

BAUS runs a national audit of this procedure so that surgeons can share their experience of this surgery.

Some basic patient data (e.g. name, NHS number and date of birth) are entered and securely stored. This is required so that members of the clinical team providing your care can go back to the record and add follow-up data such as length of stay or post-operative complications. This helps your surgeon to understand the various outcomes of the procedure.

The detailed surgical information is analysed to inform future development. BAUS staff **cannot** access any patient identifiable data when they download the surgical information for analysis.

### *Before you go home*

We will tell you how the procedure went and you should:

- make sure you understand what has been done;
- ask the surgeon if everything went as planned;
- let the staff know if you have any discomfort;
- ask what you can (and cannot) do at home;
- make sure you know what happens next; and
- ask when you can return to normal activities.

We will give you advice about what to look out for when you get home. Your surgeon or nurse will also give you details of who to contact, and how to contact them, in the event of problems.

### ***Smoking and surgery***

Ideally, we would prefer you to stop smoking before any procedure. Smoking can worsen some urological conditions and makes complications more likely after surgery. For advice on stopping, you can:

- contact your GP;
- access your local [NHS Smoking Help Online](#); or
- ring the free NHS Smoking Helpline on **0800 169 0 169**.

### ***Driving after surgery***

It is your responsibility to make sure you are fit to drive after any surgical procedure. You only need to [contact the DVLA](#) if your ability to drive is likely to be affected for more than three months. If it is, you should check with your insurance company before driving again.

## **What should I do with this information?**

Thank you for taking the trouble to read this information. Please let your urologist (or specialist nurse) know if you would like to have a copy for your own records. If you wish, the medical or nursing staff can also arrange to file a copy in your hospital notes.

## **What sources have we used to prepare this leaflet?**

This leaflet uses information from consensus panels and other evidence-based sources including:

- the [Department of Health \(England\)](#);
- the [Cochrane Collaboration](#); and
- the [National Institute for Health and Care Excellence \(NICE\)](#).

It also follows style guidelines from:

- the [Royal National Institute for Blind People \(RNIB\)](#);
- the [Information Standard](#);
- the [Patient Information Forum](#); and
- the [Plain English Campaign](#).

## **Disclaimer**

We have made every effort to give accurate information but there may still be errors or omissions in this leaflet. BAUS cannot accept responsibility for any loss from action taken (or not taken) as a result of this information.

### **PLEASE NOTE**

The staff at BAUS are not medically trained, and are unable to answer questions about the information provided in this leaflet. If you do have any questions, you should contact your urologist, specialist nurse or GP.