

Effect and Results of Retrograde Intrarenal Surgery in Pediatric Patients According to Stone Size and Location

Çocuk Hastalarda Böbrek Taşı Boyutu ve Yerleşimine Göre Retrograd Intrarenal Cerrahinin Etkisi ve Sonuçları

Mehmet Özay Özgür¹ , İbrahim Halil Baloğlu² , Gökçe Karlı² , Kaya Horasanlı² 

¹ Division of Pediatric Urology, Mersin City Hospital, Mersin, Türkiye

² Division of Pediatric Urology, University of Health Sciences, Şişli Hamidiye Etfal Training and Research Hospital, İstanbul, Türkiye

Cite as: Özgür MÖ, Baloğlu İH, Karlı G, Horasanlı K. Effect and results of retrograde intrarenal surgery in pediatric patients according to stone size and location. Grand J Urol 2026;6(1):7-12

Submission date: 18 October 2025 **Acceptance date:** 11 December 2025 **Online first:** 18 December 2025 **Publication date:** 20 January 2026

Corresponding Author: İbrahim Halil Baloğlu / University of Health Sciences, Şişli Hamidiye Etfal Training and Research Hospital, Division of Pediatric Urology, İstanbul, Türkiye / ibrahimhalilbaloglu@gmail.com / ORCID ID: 0000-0001-6370-4345

Abstract

Objective: We aimed to evaluate the outcomes of RIRS according to kidney stone location and size of kidney stones in the pediatric population.

Materials and Methods: A total of 32 pediatric patients with upper urinary tract stones with 40 renal units were investigated in terms of stone size and location. Stone location, gender, stone size, stone Hounsfield unit, preoperative stenting, access sheath size, complication, length of hospital stay, and stone-free rates were retrospectively analyzed. Patients were divided into two groups. The first group patients of had stones smaller than 2cm, and the second group who had stones larger than 2 cm.

Results: The mean age of the patients in Group 1 was determined as 10,8 (4-17) years, and the mean age of Group 2 was determined as 15,1 (10-17) years. The age difference was statistically significant ($p=0.003$). There was no statistically significant difference in gender distribution ($p=0.289$). The average stone size of Group 1 was measured as 12,6 mm (11-17), and the Group 2 stone size was measured as 25,2 mm (20-43) on average. In terms of operation times, the average operation time in Group 1 was 48 (30-70) minutes, and the average operation time in Group 2 was 65 (40-95) minutes, and a statistically significant difference was observed ($p=0.015$). In the first group, the stone-free rate in a single session was 76.3%, and in the second group, the stone-free rate in a single session was 62%. There was no statistically significant difference between the groups in terms of stone-free rates ($p=0.295$).

Conclusion: RIRS is a method that can be used safely and effectively in pediatric patients with kidney stones smaller than 2 cm, with high stone-free rates. Although; the stone-free rate was lower in stones larger than 2 cm compared to those smaller than 2 cm, this difference was not statistically significant.

Keywords: upper urinary system stones, pediatric urolithiasis, retrograde intrarenal surgery, stone-free rate

Özet

Amaç: Bu çalışmada, pediatrik popülasyonda böbrek taşı lokalizasyonu ve boyutuna göre RIRC etkilerini ve sonuçlarını değerlendirmeyi amaçladık.

Gereçler ve Yöntemler: Üst üriner sistem taşına sahip toplam 32 pediatrik hasta ve 40 renal ünite, taş boyutu ve lokalizasyonu açısından incelendi. Taş lokalizasyonu, cinsiyet, taş boyutu, taşın Hounsfield ünitesi, preoperatif stentleme, erişim kılıfı boyutu, komplikasyonlar, hastanede kalış süresi ve taştan tamamen kurtulma oranları retrospektif olarak analiz edildi. Hastalar taş boyutuna göre iki gruba ayrıldı. Birinci grup, 2 cm'den küçük taşlara sahip hastaları; ikinci grup ise 2 cm'den büyük taşlara sahip hastaları içermektedir.

Bulgular: Renal ünite bazında değerlendirildiğinde, Grup 1 hastalarının ortalama yaşı 10,8 (4-17) yıl, Grup 2 hastalarının ortalama yaşı ise 15,1 (10-17) yıl olarak belirlendi. Yaş farkı istatistiksel olarak anlamlıydı ($p=0,003$). Cinsiyet dağılımında istatistiksel olarak anlamlı bir fark saptanmadı ($p=0.289$). Grup 1'in ortalama taş boyutu 12,6 mm (11-17), Grup 2'nin taş boyutu ise ortalama 25,2 mm (20-43) olarak ölçüldü. Operasyon süresi açısından, Grup 1'in ortalama ameliyat süresi 48 (30-70) dakika, Grup 2'nin ise 65 (40-95) dakika olup, istatistiksel olarak anlamlı bir fark bulundu ($p=0.015$). İlk grupta tek seansta taşsızlık oranı %76,3, ikinci grupta ise %62 olarak belirlendi. Taşsızlık oranları açısından gruplar arasında istatistiksel olarak anlamlı bir fark yoktu ($p=0.295$).

Sonuç: RIRS, 2 cm'den küçük böbrek taşlarına sahip pediatrik hastalarda yüksek taşsızlık oranları ile güvenli ve etkili bir yöntem olarak kullanılabilir. 2 cm den büyük taşlardan taşsızlık oranları 2 cm den küçük taşlara kıyasla düşük olsa da verilerimizde istatistiksel anlamlı olarak saptanmamıştır.

Anahtar kelimeler: üst üriner sistem taşları, pediatrik ürolitiazis, retrograd intrarenal cerrahi, taşsızlık oranı

ORCID ID: M.Ö. Özgür 0000-0002-5767-4802

G. Karlı 0000-0003-2470-8858

K. Horasanlı 0000-0001-5263-5727

Introduction

Childhood (<18 years) urinary system stones are seen with a frequency of 1-2% in society. In recent years, the incidence of pediatric stones has increased especially in adolescence due to carbohydrate-rich diet, high salt consumption and sedentary lifestyle. In younger children, kidney stones are less common and are more likely to occur for metabolic or anatomical reasons, and can recur more frequently and earlier [1]. Today, with technological advances, the miniaturization of endoscopic instruments and the development of non-invasive methods, high success can be achieved in pediatric stone surgery, especially in difficult cases [2]. Pediatric patients with stones larger than 5 mm have a lower probability of spontaneous passage and need treatment [3]. Among these treatments, extracorporeal shock wave lithotripsy (ESWL) is a non-invasive treatment that has been used safely and successfully in adults for a long time and it is known that children respond better to ESWL than adults [4,5]. In addition, with the development of technology and the increased access to miniature instruments, methods such as retrograde intrarenal surgery (RIRS), ureterorenoscopy (URS), and percutaneous nephrolithotomy (PNL) can be applied successfully in pediatric patients. In these operations, in addition to surgical instruments, factors such as the location of the stone, its size and the Hounsfield unit (HU) may also affect stone-free rates. Although ESWL is considered the first choice for treatment of stones up to 20 mm, the fact that the procedure is performed under general anesthesia and requires multiple sessions may limit the use of ESWL in children due to low success in metabolic stones (cystine) [6,7]. On the other hand, studies have shown the safe use of RIRS even in infants <1 year old [7].

Although mini PNL seems to be more successful than retrograde intrarenal surgery in terms of stone-free rates in stones between 10 mm and 20 mm and larger than 20 mm, RIRS can be recommended as an alternative for stones larger than 20 mm [8]. With technological advances, thin instruments, image quality and the development of instruments with increased deflection ability, the preference for retrograde intrarenal surgery for most stones in all localization of the kidneys is increasing. In this study we aimed to examine the effects and results of retrograde intrarenal surgery according to the location and size of kidney stones in pediatric population.

Material and Methods

After obtaining ethical approval from the Clinical Research Ethics Committee (Date: 09.04.2025 No: 2025/380), between 2018 and 2024 a total of 32 patients under the age of 18 years and 40 renal units who underwent retrograde intrarenal surgery were included in the study. Patients were divided into 2 groups according to stone size. There were 25 renal units with a size of less than 20 mm in the first group and there were 15 renal units with a size of more than 20 mm in the second group.

In addition, patient demographics, stone localization, age, gender characteristics, HU of the stones, preoperative ureteric double J (JJ) stenting, use of access sheath, and stone-free rates were retrospectively analyzed.

Before the operation, computed tomography and ultrasonographic images of the patients were examined. The patients' operative information was obtained from the hospital database and their records were obtained. After the operation, the patients' follow-up ultrasonography and direct urinary system radiographs were investigated.

Operations were performed using a 4.5/6.5 Fr ultrathin semi-rigid ureterorenoscope (Richard Wolf, Germany) and a fiberoptic reusable flexible ureteroscope (Karl Storz Flex-X2, Germany). Stones were broken with a 30W holmium- YAG laser (Litho, Quanta, Milano, Italy), 9.5/11.5 Fr access sheath (Plastimed, Istanbul, Turkey) was used. JJ stents (Plastimed, Istanbul, Turkey) appropriate to the age and height of the patients were used.

All data were calculated using IBM SPSS Version 23.0 statistical package program (IBM SPSS Statistics for Windows, Version 23.0. Armonk, NY: IBM Corp). Continuous variables were found as mean \pm standard deviation (median, minimum, maximum) values and categorical variables were found as numbers and percentages. The Mann-Whitney U test was used to compare continuous variables between two groups, and the Chi-square test and Fisher's exact chi-square test were used to compare categorical variables. Statistical significance level was accepted as " $p < 0.05$ ".

Results

According to the stone size, the patients were divided into 2 groups; the mean age of the first group was 10.8 (4-17) years, and the second group was 15.1 (10-17) years, and the age difference was statistically significant ($p = 0.003$). No statistically significant difference was found in terms of gender distribution of the patients $p = 0.289$. According to the renal unit, 25 patients had stones smaller than 20 mm, and 15 had stones larger than 20 mm. [Table 1]

While lower calyceal stones were most frequently seen in group 1 (40%), renal pelvis stones were most frequently seen in group 2 (40%). There was no statistically significant difference in stone location between the groups ($p = 0.294$). [Table 2]

Preoperative JJ stents were placed for passive dilatation in 17 renal units (68%) in the first group and in 8 renal units (53.3%) in the second group. RIRS procedures of these patients were planned for later sessions. No statistically significant difference was observed between the two groups in terms of stent placement (pre-stenting) for passive dilatation of the ureter before the procedure ($p = 0.315$). During RIRS, access sheaths were used during surgery in 18 renal units (72%) in the first group and in 13 renal units (86.6%) in the second group. No statistically significant difference was observed between the groups in access sheath use ($p = 0.122$). According to stone size, the stone-free rate in a single session was 76.3% in the first group and 62% in the second group, and no statistically significant difference was observed ($p = 0.295$). The average HU of the stones was measured as 844.9 (min: 233-max: 2100) in the first group; and the average HU was 795 (min: 210-max: 2015) in the second group, and no statistically significant difference was observed between the stone-free rates in terms of HU between the two groups. ($p = 0.340$) [Table 3]

Table 1. Distribution of patients according to age, gender and stone size

Stone size	Group 1 (n: 25) <20 mm	Group 2 (n:15) >20 mm	P value
Girl	12 (%48)	10 (%66,7)	
Boy	13 (%52)	5 (%33,3)	
Age	10,8 (4-17) year	15,1 (10-17) year	0,003
Stone size mm	12,6 (11-17)	25,2 (20-43)	0,012
Operation time	48 (30-70) min	65 (40-95) min.	0,015
Stone free rate	76,3%	62%	0,295

Table 2. Distribution of stones according to localization

Renal unit	Group 1 (n:25)	Group 2 (n:15)
Renal pelvis	6 (24%)	6 (40%)
Upper calyx	3 (12%)	-
Middle calyx	2 (8%)	1 (6,7%)
Lower calyx	10 (40%)	4 (26,7%)
Proximal ureter	3 (12%)	-
Multiple	1 (4%)	4 (26,6%)

Table 3. Number of renal units of stones, Hounsfield units and stone-free rate, use of prestanting and acces sheaths

Renal units	Group 1 (n=25)	Group 2 (n=15)	P value
Operation time	48,88±8,75	65,66±17,58	0,015
Acces sheat	18 (72%)	13 (86,6%)	0,122
Prestenting JJ	17 (68%)	8 (53,3%)	0,315
HU (Hounsfield unit)	844,9 (min:233-max: 2100)	795 (min:210-max:2015)	0,340
Stone free rates	76,3%	62%	0,295

Discussion

Over the years, the development of flexible ureteroscopes (f-URS) and fiberoptic systems, and the simultaneous use of laser technologies, have enabled the successful retrograde fragmentation of kidney stones. It was first described by Huffman et al. in 1983 with the fragmentation of kidney stones using a rigid rod-lens structured ureteroscope and an ultrasonic lithotripter, and in 1990, Fuchs et al. published the first series of RIRS using f-URS [9,10]. ESWL, RIRS and PNL are recommended in the treatment of urinary system stone diseases in children

As a minimally invasive technique, ESWL was initially used in adults, but it was not initially applied to pediatric patients because it was thought to have a negative effect on child development. ESWL can achieve high stone-free success rates, especially for stones smaller than 10 mm, depending on the stone type, size, location, and urinary tract anatomy [11]. ESWL is recommended as the primary treatment for lower-pole stones smaller than 10 mm and other upper-system stones smaller than 2 cm in children [12]. However, although ESWL achieves success rates of 75-92% in pediatric patients, studies have shown that stone-free rates after ESWL for stones <10 mm are 100%, whereas this rate decreases to 66.6% for stones >20 mm [13]. There are also studies suggesting negative effects on kidney development after ESWL in pediatric patients [14].

Although the length of hospital stay and complication rates are lower after ESWL, the possibility of additional interventions is higher after ESWL. In a recent prospective study by Mokhles

et al., the results of ESWL and RIRS for 10-20 mm stones in preschool children were compared, and the overall stone-free rates were found to be 93% and 96% respectively [6]. According to this result, ESWL is recommended for stones up to 20 mm. The fact that the procedure requires general anesthesia in repeated sessions in children, is associated with renal scarring, hypercalciuria, hypertension and chronic renal failure in the long term, and stones such as cystine stones do not respond adequately to treatment limits the use of this technique in children [6,15]. In addition, while patients who underwent ESWL required multiple sessions, very few patients who underwent RIRS required additional interventions later on [16]. In this study, it was reported that medium-sized stones in children under 6 years of age could be broken safely with RIRS. Another method for the treatment of kidney stones in children is percutaneous nephrolithotomy. With technological developments, Mini-PNL using small instruments between 11Fr and 21 Fr and recently Micro-PNL using a 4.8Fr nephroscope can be successfully performed. In a meta-analysis of 7 studies, 280 micro-PNL and 259 RIRS patients were compared and although stone-free rates were found to be higher in patients who underwent PNL, overall complication rates were found to be higher. Desai et al. reported that intraoperative bleeding during PNL is related to the diameter of the tract and should not exceed 22Fr in children [17]. Mini, ultramini, and micro modifications are used to reduce the risk of complications, and despite all modifications and high success, major risks, organ injuries, urosepsis, and severe bleeding are seen up to 10% [18].

Today, with advances in endoscopy, the RIRS technique is widely used in many centers. Many studies have shown that

ureterorenoscopy in children does not carry significant risks such as ureteral stricture and reflux. RIRS is applied in children, with stone-free rates ranging from 60% to 100% depending on the stone's location and burden. In a large series of publications, it has been reported that lower-pole calyx stones up to 20 mm in size can be broken with a 94% stone-free rate with multiple additional attempts without the use of an access sheath [19]. In our study, lower calyceal stones were detected in 14 patients with a stone-free rate of 61.2% after a single intervention.

In a study conducted by Smaldone et al. Examining 100 patients, the average age was 13.2 years, the average stone size was 8.2 mm, and stones located in the upper pole, pelvis and lower pole were broken with a 92% stone-free rate [20]. In our study, stone-free rates were found to be 76.3% in the first group and 62% in the second group according to stone size, and no statistically significant difference was found ($p=0.295$). In the literature, it has been reported that stone-free rates depend on the size of the stone, regardless of its localization, and that additional intervention may be required, especially for stones larger than 6 mm [21]. Complication rates are low in retrograde intrarenal surgery and perforation has been reported between 0-4% in many studies [22]. In our study, no perforation developed in the patients. Although there is insufficient data on the routine use of preoperative JJ stents, no significant difference in stone-free rates or complications was observed in retrospective studies [23]. Hubert and Palmer have shown that previously inaccessible ureters in pediatric patients can be accessed by passive dilation with a JJ stent [24]. In our study, preoperative JJ stent placement (prestenting) was applied to 25 renal units for passive dilatation of the ureter before the procedure. When the patients who underwent passive dilatation and those who did not undergo it were examined in terms of stone-free status and complications, no statistically significant difference was observed between the two groups of patients. Another controversial issue is the use of access sheath. There are discussions about the possibility that the use of thick access sheaths may impair ureteral blood circulation. Studies show that a safer wide-lumen access sheath can be used by performing passive dilatation before insertion, thus providing a wider view [25]. In the study by Smaldone et al., 54% of patients underwent preoperative passive dilatation, and 24% used an access sheath. As a result of the study, no correlation was found between passive dilatation or access sheath use and complications [20]. In our study, an access sheath was used in 31 patients. No statistically significant difference was found in terms of stone free rate and complications.

The HU, which reflects stone density, is another modality that indicates the success of the treatment as well as the stone's size and intrarenal localization. In the study conducted by Quizad et al., the HU of 50 patients was measured and the threshold value was determined as 970, and the success rate after ESWL treatment for stones with HU <970 was 96%, and for stones with HU >970, the success rate was 36% [26]. The HU value of the stones can also affect the PNL results. Gücük et al. found that HU values of stones in 179 patients who underwent PNL were an independent factor affecting PNL success [27].

In a multicenter study, it was determined that stone size and localization were predictive factors for residual fragments in retrograde intrarenal surgery, independent of stone density [28]. In our study, the effect of stone density on stone-free rates was not

found to be statistically significant. Similarly, stone size was also not found to have a significant impact on stone-free outcomes in the pediatric population.

In a study by Türedi and colleagues comparing conventional access sheaths with suction-assisted access sheaths, higher stone-free rates were reported with the use of suction-assisted access sheaths. However, this study did not evaluate stone-free rates specifically in patients with stones larger than 2 cm. Investigating stone-free rates in this patient group would provide clearer insight into the benefits of suction-assisted access sheaths for stones over 2 cm [29]. In our study, data from 15 renal units with stones larger than 2 cm treated using conventional access sheaths may serve as a reference for future evaluations of patients treated with suction-assisted access sheaths.

In the current studies in the literature, we see that especially medium-sized stones can be successfully broken with retrograde intrarenal surgery in preschool children. Although our study was conducted with a small number of patients, it supports the fact that retrograde intrarenal surgery can be used safely and effectively with low complication rates in the pediatric population. Future studies could be designed to compare outcomes in pediatric patients with stones larger than 2 cm with those in whom suction-assisted access sheaths were utilized, to better evaluate the effectiveness and safety of this approach in managing larger stone burdens.

Conclusion

According to the results of our study, RIRS can be safely performed in children with low complication rates. However, in cases of lower pole and large-sized stones, surgical success rates tend to decrease and may require additional interventions. Stone-free rates were found to be high in stones smaller than 20 mm, and due to its low complication rates, RIRS can be safely used in the pediatric population. With the advancement of technology, the miniaturization of instruments, improved maneuverability, the use of suction-assisted access sheaths, and enhanced image quality, we believe that RIRS may also become a first-line treatment option for stones larger than 2 cm.

Ethics Committee Approval: Ethical approval for this study was obtained from Mersin University Clinical Research Ethics Committee (Date: 09.04.2025 No: 2025/380).

Informed Consent: An informed consent was obtained from all the patients.

Publication: The results of the study were not published in full or in part in form of abstracts.

Peer-review: Externally peer-reviewed.

Authorship Contributions: Any contribution was not made by any individual not listed as an author. Concept – Ö.M.Ö., B.İ.H.; Design – Ö.M.Ö., B.İ.H.; Supervision – Ö.M.Ö., H.K.; Resources – B.İ.H., K.G.; Materials – B.İ.H., K.G.; Data Collection and/or Processing – B.İ.H., K.G.; Analysis and/or Interpretation – K.G., H.K.; Literature Search – B.İ.H., K.G.; Writing Manuscript – Ö.M.Ö., B.İ.H.; Critical Review – Ö.M.Ö., H.K.

Conflict of Interest: The authors declare that they have no conflicts of interest.

Financial Disclosure: The authors declare that this study received no financial support.

References

- [1] Resorlu B, Sancak EB, Resorlu M, Gulpinar MT, Adam G, Akbas A, et al. Retrograde intrarenal surgery in pediatric patients. *World J Nephrol* 2014;3:193–7. <https://doi.org/10.5527/wjn.v3.i4.193>
- [2] Resorlu B, Unsal A. Retrograde Intrarenal Surgery (RIRS) for Renal Stones. *Türk Üroloji Seminerleri/Turkish Urology Seminars* 2011;2:64–7. <https://doi.org/10.5152/tus.2011.13>
- [3] Pietrow PK, Pope JC, Adams MC, Shyr Y, Brock JW. Clinical outcome of pediatric stone disease. *J Urol* 2002;167:670–3. [https://doi.org/10.1016/S0022-5347\(01\)69121-3](https://doi.org/10.1016/S0022-5347(01)69121-3)
- [4] Mandeville JA, Nelson CP. Pediatric urolithiasis. *Curr Opin Urol* 2009;19:419–23. <https://doi.org/10.1097/MOU.0b013e32832c9096>
- [5] Schmiedt E, Chaussy C. Extracorporeal shock-wave lithotripsy (ESWL) of kidney and ureteric stones. *Int Urol Nephrol* 1984;16:273–83. <https://doi.org/10.1007/BF02081861>
- [6] Mokhless IA, Abdeldaeim HM, Saad A, Zahran AR. Retrograde intrarenal surgery monotherapy versus shock wave lithotripsy for stones 10 to 20 mm in preschool children: a prospective, randomized study. *J Urol* 2014;191:1496–9. <https://doi.org/10.1016/j.juro.2013.08.079>
- [7] Unsal A, Resorlu B, Kara C, Bozkurt OF, Ozyuvali E. Safety and efficacy of percutaneous nephrolithotomy in infants, preschool age, and older children with different sizes of instruments. *Urology* 2010;76:247–52. <https://doi.org/10.1016/j.urology.2009.08.087>
- [8] Resorlu B, Unsal A, Tepeler A, Atis G, Tokatli Z, Oztuna D, et al. Comparison of retrograde intrarenal surgery and mini-percutaneous nephrolithotomy in children with moderate-size kidney stones: results of multi-institutional analysis. *Urology* 2012;80:519–23. <https://doi.org/10.1016/j.urology.2012.04.018>
- [9] Huffman JL, Bagley DH, Lyon ES. Extending cystoscopic techniques into the ureter and renal pelvis. Experience with ureteroscopy and pyeloscopy. *JAMA* 1983;250:2002–5. <https://pubmed.ncbi.nlm.nih.gov/6620500>
- [10] Fuchs GJ, Fuchs AM. [Flexible endoscopy of the upper urinary tract. A new minimally invasive method for diagnosis and treatment]. *Urologe A* 1990;29:313–20. <https://pubmed.ncbi.nlm.nih.gov/2291255/>
- [11] Bujons A, Burgu B, Castagnetti M, Pakkasjärvi N, Quaedackers J, Rawashdeh Y, et al. Paediatric Urology EAU Guidelines on. 2025. <https://uroweb.org/guidelines/paediatric-urology>
- [12] Durkee CT, Balcom A. Surgical management of urolithiasis. *Pediatr Clin North Am* 2006;53:465–77, vii. <https://doi.org/10.1016/j.pcl.2006.02.009>
- [13] Aksoy Y, Ozbey I, Atmaca AF, Polat O. Extracorporeal shock wave lithotripsy in children: experience using a mpl-9000 lithotripter. *World J Urol* 2004;22:115–9. <https://doi.org/10.1007/s00345-003-0385-5>
- [14] Thomas R, Frentz JM, Harmon E, Frentz GD. Effect of extracorporeal shock wave lithotripsy on renal function and body height in pediatric patients. *J Urol* 1992;148:1064–6. [https://doi.org/10.1016/s0022-5347\(17\)36818-0](https://doi.org/10.1016/s0022-5347(17)36818-0)
- [15] Desai M. Endoscopic management of stones in children. *Curr Opin Urol* 2005;15:107–12. <https://doi.org/10.1097/01.mou.0000160625.59107.fd>
- [16] Ferroud V, Lapouge O, Dousseau A, Rakototiana A, Robert G, Ballanger P. [Flexible ureteroscopy and mini percutaneous nephrolithotomy in the treatment of renal lithiasis less or equal to 2 cm]. *Prog Urol* 2011;21:79–84. <https://doi.org/10.1016/j.purol.2010.08.013>
- [17] Desai MR, Kukreja RA, Patel SH, Bapat SD. Percutaneous nephrolithotomy for complex pediatric renal calculus disease. *J Endourol* 2004;18:23–7. <https://doi.org/10.1089/089277904322836613>
- [18] Michel MS, Trojan L, Rassweiler JJ. Complications in percutaneous nephrolithotomy. *Eur Urol* 2007;51:899–906; discussion 906. <https://doi.org/10.1016/j.eururo.2006.10.020>
- [19] Johnson GB, Portela D, Grasso M. Advanced ureteroscopy: wireless and sheathless. *J Endourol* 2006;20:552–5. <https://doi.org/10.1089/end.2006.20.552>
- [20] Smaldone MC, Cannon GM, Wu H-Y, Bassett J, Polsky EG, Bellinger MF, et al. Is ureteroscopy first line treatment for pediatric stone disease? *J Urol* 2007;178:2128–31; discussion 2131. <https://doi.org/10.1016/j.juro.2007.07.050>
- [21] Tanaka ST, Makari JH, Pope JC, Adams MC, Brock JW, Thomas JC. Pediatric ureteroscopic management of intrarenal calculi. *J Urol* 2008;180:2150–3; discussion 2153–4. <https://doi.org/10.1016/j.juro.2008.07.079>
- [22] Portis AJ, Rygwall R, Holtz C, Pshon N, Laliberte M. Ureteroscopic laser lithotripsy for upper urinary tract calculi with active fragment extraction and computerized tomography followup. *J Urol* 2006;175:2129–33; discussion 2133–4. [https://doi.org/10.1016/S0022-5347\(06\)00311-9](https://doi.org/10.1016/S0022-5347(06)00311-9)
- [23] Shields JM, Bird VG, Graves R, Gómez-Marín O. Impact of preoperative ureteral stenting on outcome of ureteroscopic treatment for urinary lithiasis. *J Urol* 2009;182:2768–74. <https://doi.org/10.1016/j.juro.2009.08.043>

- [24] Hubert KC, Palmer JS. Passive dilation by ureteral stenting before ureteroscopy: eliminating the need for active dilation. *J Urol* 2005;174:1079–80; discussion 1080. <https://doi.org/10.1097/01.ju.0000169130.80049.9c>
- [25] Schoenthaler M, Wilhelm K, Katzenwadel A, Ardelt P, Wetterauer U, Traxer O, et al. Retrograde intrarenal surgery in treatment of nephrolithiasis: is a 100% stone-free rate achievable? *J Endourol* 2012;26:489–93. <https://doi.org/10.1089/end.2011.0405>
- [26] Ouzaid I, Al-qahtani S, Dominique S, Hupertan V, Fernandez P, Hermieu J-F, et al. A 970 Hounsfield units (HU) threshold of kidney stone density on non-contrast computed tomography (NCCT) improves patients' selection for extracorporeal shockwave lithotripsy (ESWL): evidence from a prospective study. *BJU Int* 2012;110:E438-42. <https://doi.org/10.1111/j.1464-410X.2012.10964.x>
- [27] Gücük A, Uyetürk U, Öztürk U, Kemahli E, Yıldız M, Metin A. Does the Hounsfield unit value determined by computed tomography predict the outcome of percutaneous nephrolithotomy? *J Endourol* 2012;26:792–6. <https://doi.org/10.1089/end.2011.0518>
- [28] Keat WOL, Somani BK, Pietropaolo A, Chew BH, Chai CA, Inoue T, et al. Do Hounsfield Units have any significance in predicting intra- and postoperative outcomes in retrograde intrarenal surgery using Holmium and Thulium fiber laser? Results from the FLEXible ureteroscopy Outcomes Registry (FLEXOR). *World J Urol* 2023;41:2881–8. <https://doi.org/10.1007/s00345-023-04362-7>
- [29] Turedi B, Sezer A. Comparison of flexible and navigable suction ureteral access sheath with conventional ureteral access sheath for pediatric retrograde intrarenal surgery: a single-center propensity-matched analysis. *Urolithiasis* 2024;53:17. <https://doi.org/10.1007/s00240-024-01686-w>