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EC EMERGENCY MEDICINE AND CRITICAL CARE

Editorial

Conflicts of Conservative Renal Trauma Management

Murtadha Almusafer*

Professor, Urology Consultant, Basrah Medical College, University of Basrah, Basrah, Iraq

***Corresponding Author:** Murtadha Almusafer, Professor, Urology Consultant, Basrah Medical College, University of Basrah, Basrah, Iraq.

Received: August 29, 2020; **Published:** August 29, 2020

Blunt renal injury is the commonest type of urinary tract injuries. Although the conservative management of such trauma is widely recognized and practiced all over the world and established in the well known guidelines, in some countries, especially in rural and semi-urban areas, this leads sometimes to conflicts regarding the consideration of such management approach, as it is often thought that surgical treatment should be carried out in every case of trauma and this results in some sort of dis-satisfaction.

The kidney is the most commonly injured genitourinary organ, followed by the urinary bladder, in both, adults and children [1-3]. Renal injury may be encountered as an isolated injury, but in penetrating injuries, there is a high incidence of associated injuries of other organs [4-6]. As compared with penetrating injury, blunt renal trauma occurs more often but is less commonly associated with such injuries [7]. Men are affected more frequently with 72 -93% of cases [8, 9].

Computerized tomography scan of the abdomen is considered the study of choice in renal injury. It should be performed in all hemodynamically stable blunt trauma patients who present with gross or microscopic hematuria and/ or hypotension (systolic blood pressure <90 mmHg) [10].

The past concept of invasive management of renal injury has changed to conservative treatment since preservation of the kidney is more feasible [11], especially as most blunt renal injuries are of lower grade (grades I – III), and 80 to 85% of all such trauma can be managed conservatively, even so conservative treatment can be considered nowadays even in higher grades provided that the patient is hemodynamically stable [12].

Whereas this shift occurred based on evidence gathered over time, it can be sometimes difficult for patients and relatives of patients who are severely injured to understand that the best approach for the patient is to be treated conservatively and it is sometimes perceived wrongly as a disproportionate urologist action to the traumatic patient. A small group of patients and their relatives will be dis-satisfied with this approach even after extensive repeated discussions and will insist on urgent surgical intervention even being aware of the high risk of nephrectomy.

As we have been repeatedly facing such conflicts and attitudes toward conservative approach, we attempted in this short discussion to put the following recommendations:

1. Much patient education is highly recommended & extensive efforts should be attempted to explain the high risk of nephrectomy and it's bad sequelae on the patient' future life.

2. Always discuss what you are doing regarding management with the patient and his family

3. Update your knowledge with the guidelines and try to put your own guidelines according to your environment based on scientific facts and experience and use the basic guidelines as a skeleton

4. Make a full care and monitoring of the patient to avoid patient dis-satisfaction of the approach

5. The patient needs a fast and immediate solution for his problem like for example a patient with renal stone, this fact pushes toward percutaneous nephron-lithotomy and uretero-renoscopy rather than extracorporeal shock wave lithotripsy, therefore, a conservative approach for renal trauma is not often agreed by the patients and their family.

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Volume 4 Issue 9 September 2020