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The European Association of Urology Guidelines on Urolithiasis: The Role of the Nephrologist

By María Ramos Cebrián

The prevalence of urolithiasis has increased worldwide over the past decades. Urolithiasis represents a longitudinal health problem requiring continuity of care that may extend beyond the treatment of stone episodes. It may seriously impair quality of life (1–3). Urolithiasis is additionally associated with increased morbidity and mortality, including an increased risk of chronic kidney disease and end stage kidney disease, mineral and bone disorders, bone fractures, and cardiovascular diseases (4–6).

The recently updated guidelines on urolithiasis from the European Association of Urology (EAU) (7) represent an advancement in the treatment of stone disease because they consider the associated risk of urolithiasis and the need for follow-up (Figure 1). There is a lack of clinical collaboration between the nephrologist and the urologist in the treatment of complex metabolic abnormalities in patients with urinary stones (7). The identification of patients with high clinical risk of recurrence is necessary and mandatory for improving the quality of life of patients and for collaborating for the sustainability of the health system. The factors that define a patient at high risk for stone recurrence are the presence of monogenic genetic diseases, anatomic and metabolic disorders, and diseases associated with stone formation.

Urologists have a chance to identify patients with conditions that need a multidisciplinary approach. Although the suspicion of secondary causes of urolithiasis and the metabolic alterations associated with stone disease were the main reasons for referral to nephrologists, unfortunately, the medical management of urolithiasis does not constitute a professional priority for nephrologists and is thus not emphasized during their training. On the other hand, lack of referral to nephrology by urology could be because many urologists are comfortable giving initial recommendations and only refer when impaired kidney function is identified. However, a close collaboration with the nephrologist is needed, not only during the acute phase of stone-related kidney injury but also during the clinically stable phase of the disease.

The new EAU guidelines emphasize patient follow-up after stone identification. Patients with low risk of recurrence should be monitored with an imaging test at 6 months, 12 months, and thereafter annually. Patients with a high risk should be followed up with an imaging test, a metabolic evaluation, and treatment monitoring at 8–12 weeks after starting pharmacological prevention of stone recurrence. This enables the drug dosage to be adjusted if urinary risk factors have not normalized, with further 24-hour urine measurements if necessary. Once urinary parameters have been normalized, it is sufficient to perform a 24-hour urine evaluation every 12 months.

The main limitations of the EAU guidelines are the lack of consideration of quality of life, patient preferences, and shared decision-making. Therefore, some concepts might

be more appropriate in future releases to substitute the term “fluid” with “water” when referencing intake. It seems that a new time for collaboration has come between nephrologists and urologists. ■

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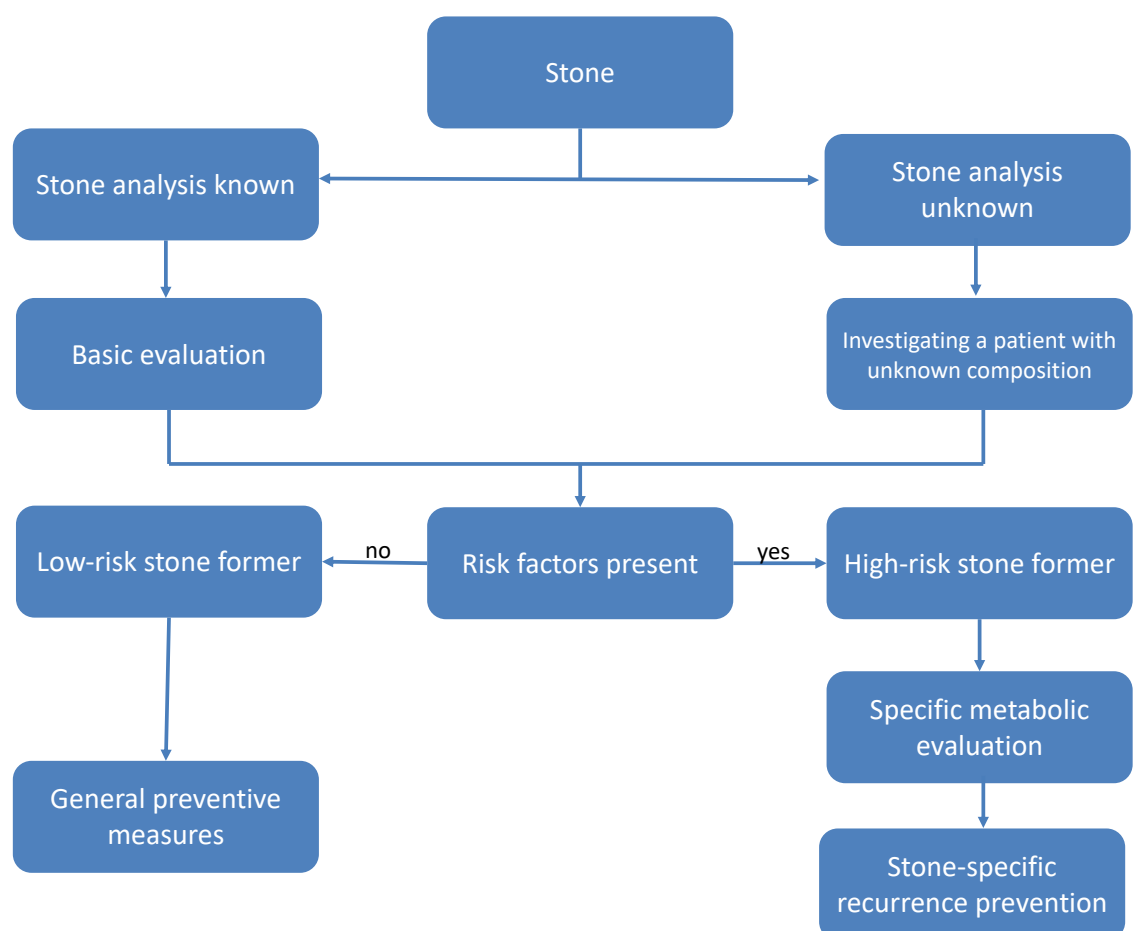
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Figure 1. Assignment of patients to low- or high-risk groups for stone formation



Reprinted from the European Association of Urology (7).