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بسم الله الرحمن الرحيم

شبكة المعلومات الجامعية

التوثيق الالكتروني والميكروفيلم

شبكة المعلومات الجامعية

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التوثيق الالكتروني والميكروفيلم

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MANAGMENT OF URETERAL STRICTURE

Surgical And Endoscopic

Thesis

SUBMITTED FOR PARTIAL FULFILLMENT OF M.SC. DEGREE IN UROLOGY

By

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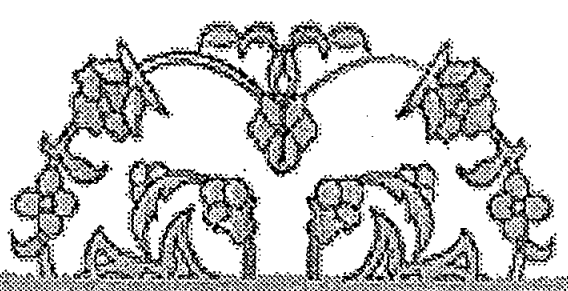
Minia Univercity

1998

﴿وعلمك ما لم تكن تعلم

وكان فضل الله عليك عظيماً﴾

صدق الله العظيم



TO MY WIFE
AND
TO SPIRIT OF MY PARENTS

ACKNOWLEDGMENTS

All thanks are due to God.

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INTRODUCTION AND AIM OF THE WORK

The Ureter function as a fibromuscular conduit carrying urine from the kidney to the bladder. Any pathological process that interferes with this activity can cause renal abnormalities. Ureteral stricture is the most common and critical pathologic process affecting the ureter. (*Netlo et al., 1990*)

The treatment of ureteral stricture has changed dramatically with the development of less invasive surgical techniques. However, improved instrumentation and advances in endourological technique have provided less invasive means of treating ureteral stricture disease that are likly to lead to decrease in morbidity and cost. (*M. Y. El-Gammal 1989*).

Urinary Bilharziasis being a national problem and a cause of ureteral strictures takes a great toll on our patients and exhausted economy due to associated morbidity and its delitricious effects on renal function, so endoscopic techniques provided the hope of being a simple economical method of correcting strictures without the need for open surgery except in resistant fibrous cases. (*Wishahi 1987*).

The aim of this study is to diagnose the degree of ureteral stricture in order to compare the results of surgical versus endoscopic treatment of ureteral stricture.

ANATOMY OF THE URETER

ANATOMY OF THE URETER

Gross Anatomy:

The ureters are pair of distensible tubes whose peristaltic contraction convey urine from the kidneys to the urinary bladder.

They are approximately 25-30 Cm long and their course follows a smoothly shaped "S". They are thick walled, narrow and continuous superiorly with the funnel shaped renal pelvis with slight constriction may mark this junction. Each ureter descends slightly medially anterior to the Psoas major muscle entering the pelvic cavity to open into the base of the urinary bladder. (*Gosling 1983*).

The ureter may be divided by the iliac artery into approximately two equal portions: Abdominal and pelvic. The ureters lie in a bed of loose areolar connective tissue in the retro-peritoneal space, but when the peritoneum is reflected the ureters remain attached to the under surface of the peritoneum. Because they are not fixed to the surrounding structures, wormlike movements can be seen under normal circumstances and the ureters can be displaced or obstructed by retroperitoneal masses such as aortic aneurysms and tumurs. [*G. A. G. Decker86*]

The narrow lumen is not of uniform caliber. In general its diameter is about 3mm, but it is slightly constricted at different levels.

1. At the pelviureteric junction.

2. As the ureter crosses the pelvic brim.

3. As the ureter enters the bladder wall.

(Olsson, 86)