Ureter Retro Cave about A Case to the Hospital Military Training Rabat Mohamed V

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Abstract

We report one case of right ureter Retro cave in a 16 year old patient. The symptomatology was marked by straight back pain and paroxysmal fever. The diagnosis of ureter Retro cave was confirmed by CT urography. Surgical treatment consisted of resection of the ureter Retro cave portion followed by an anastomosis ureteral oblique end to end by way open. The postoperative course was simple. The clinic also well controls radiological exams at 4 months were satisfactory showing a reduction of hydrenephrosis. The current trend is to laparoscopy should replace the door open.

Key Words: Ureter Retrocave Pain; CT Urography Resection; Anastomosis; Hydrenephrosis; Laparoscopy

Introduction

Ureter retro cave is an embryological disorder characterized by encircling the inferior vena cava by the ureter passes behind her, then along its inner edge, clean its front face and is found in a normal situation on its outer sidewall. This is a fairly rare condition, often asymptomatic [1]. The diagnosis is made several years after birth due to the latent nature of the symptoms. The obstructive upper urinary tract is the essence of this pathology. The indication of surgical treatment arose when renal function is impaired or threatened. The aim of our study was to report the case to the literature observed rare occurrence in our training.

Observation

Mr. M. A. aged 16, an economics student, living in Fes, in no particular history, consulted for straight back pain paroxysms lasting for a month with fever without other associated signs. On admission, the patient had a good condition, but a clear conscience renal balance was slightly altered with a glomerular filtration rate 60 ml / min (creatinine 18 mg / l). Throughout hospitalization, blood pressure was regularly encrypted 130/80 mm Hg, pulse 78 beats / minute, respiratory rate of 27 cycles / minute and the temperature at 37.5 ° C.

Palpation of the right lumbar pit woke without a touch lumbar pain. The abdomen was soft, no palpable mass. Examination of the external genitalia was an unremarkable and pelvic examination were normal. Renal ultrasound showed right hydrenephrosis. Abdominal pelvic CT with contrast medium injection concluded a ureter Retro cave with moderate dilatation of upstream (Figures 1 and 2).

The patient underwent emergency anti-inflammatory symptomatic treatment by direct intravenous based ketoprofen 100 mg twice daily for three days, associated with an antispasmodic, the phloro-glucinol80 mg intravenous basis of one employee three times a day, and an antibiotic therapy involving Ceftriaxone 1 g intravenous in five days with a single injection of 160 mg Gentamycin intramuscular. After isolation the bacteriological examination of Escherichia coli sensitive to ceftriaxone therapy alone Ceftriaxone was continued for 10 days.

For a restorative intervention ureter retro cave, the patient is reviewed one month after the anesthesiology department and then by us with the above mentioned radiological examinations, a sterile urine culture and renal always steady balance.

Under general anesthesia and in lithotomy position, we realized, in a first time, an endoscopic probe mounted double j on the right. In a 2nd time after change of position, a straight lobotomy carried out between the 11th and 12th rib followed by the opening of the renal space and the pelvis exposure. We proceeded as follows: dissection of the anterior surface of the inferior vena cave left edge, releasing the posterior surface of the urethra and pelvic ureter under which hung on a lake (dilation clearly visible right pelvis upstream retrocaval the passage of the ureter in height of the right transverse process of L3). Then we cut obliquely ureter the distal end of its journey in the inferior vena cava, then we externalized its Retrocaval portion which subsequently excised. Finally, ureterovenous vesical ureteral anastomosis was made by separate points over Vicryl R 5/0 about the double J stent first at the posterior end up plan before the previous plan.

The parietal closure was performed in three planes above with a drain placed in the right renal space and exteriorized by a cons incision. The removal of the drain renal lodge was performed on the second postoperative day and that of the probe did the 30th postoperative day.

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Discussion

Generally, the literature is marked by small series that include Chen Z. et al. [2] (12 patients), of Gaudiano et al. [3] in Italy in 2012 (only 1 patient), HZ Li et al. [4] in 2010 in China (10 patients), Dogan HS [5] Turkey (4 cases).

In current practice, the man reached in almost identical proportions with respect to women. By cons, in most autopsy series, this malformation is more common in men in the order of 3 to 4 times. [6] In children, specifically the age of 15, a study from almost 40 years (Viville 1977) identified 22 cases [7]. In the recent literature in 2010, P Ravi K et al. represented only 9 children. [8] This condition would manifest so rarely in children although congenital.

The clinical manifestations are related to obstruction of the upper urinary tract and its complications. The appearance of symptoms depends on the degree of obstruction. This symptomatology was dominated by pain from the right flank could even achieve chart renal colic [9]. Lithiasic of complications as a result of the obstruction can be reported as the study Ravi P. K. [8] with a case of stones enclosed in retrocaval part of the ureter.

Infection of the upper urinary tract has been often the mode of revelation, especially in children as in adults is renal colic right which serves the telltale sign [7]. The hematuria may exist outside of obstruction and be accompanied by low back pain and urinary tract infection as reported by Cao Avellaneda E et al. [10]. Voiding disorders are often present but with less frequency.

Renal ultrasonography is the first supplementary examination before the pain from the right flank. It is more a matter of urétérohydronephrose, as in our study, and often associated with a reduction in renal cortex to 1 in 16 in the Serbian study by J.
Hadzi-Djokic et al. in 2008 [11]. In the same study, a computed tomography (CT 3-D) Abdominal was performed in three patients for diagnostic confirmation, as in our study.

The intravenous urography excretory has evocative sign, a middle deflection of the lumbar ureter, which requires a diagnostic confirmation by retrograde urétéropéylographie according Chevassu and cavography of the inferior vena cava as performed by the team of J. Serb Hadzi-Djokic [12, 13]. Moreover, urography also shows the level of obstruction and the type of ureter Retro cave. This may be the type as in our case, or the ureter crosses retro original
IVC gives an inverted J in appearance.

This image is typical, but would meet only 60% of cases [14]. Sometimes the expansion is such that the renal cavities and the initial ureter are blown giving a junction syndrome aspect with a ureter underlying not previewed. The ureter retro cave is usually treated surgically, depending on complications and their progress. Treatment depends on the degree of obstruction.

Several surgical techniques have been described. Include resection of the ureter with antérisation and reanastomosis, resection and reanastomosis of the inferior vena cava, v. cava supporter, nephrectomy, and laparoscopic surgery. Many authors believe that laparoscopy surgery should be preferred in the surgical treatment of Retrocaval ureter due to its minimally invasive nature and shorter recovery time compared to open surgery.

Regarding our case, the establishment of a double j in a first time served as a landmark for open surgery. The patient underwent an unwinding of the ureter with a resection Retrocaval portion of the ureter followed by anastomosis. We have obtained satisfactory functional results and the disappearance of hydrenephrosis in patients with ultrasound guidance to 3 months. We expect to see him for a scanning appliance control at 6 months.

Many books have dealt with the issue of the ureter Retro cave usually as case reports [15, 16]. Some abnormalities such as hyperplasia, rotate evil or renal agenesis, kidney Horseshoe is often associated with the ureter retro cave [17, 18]. No abnormalities associated about our cases were detected.

Conclusion

The ureter retro cave is a rare congenital anomaly, especially in the Moroccan context. Abdominal ultrasound and scanner is sufficient for a positive diagnosis. The evolution after open surgery is favorable. Although this conventional treatment has satisfactory results, laparoscopic surgery is a step forward for treatment.

Author Contributions

All authors contributed to the conduct of this work. All authors also claim to have read and approved the final manuscript.

References


