Renal hematoma, a case report

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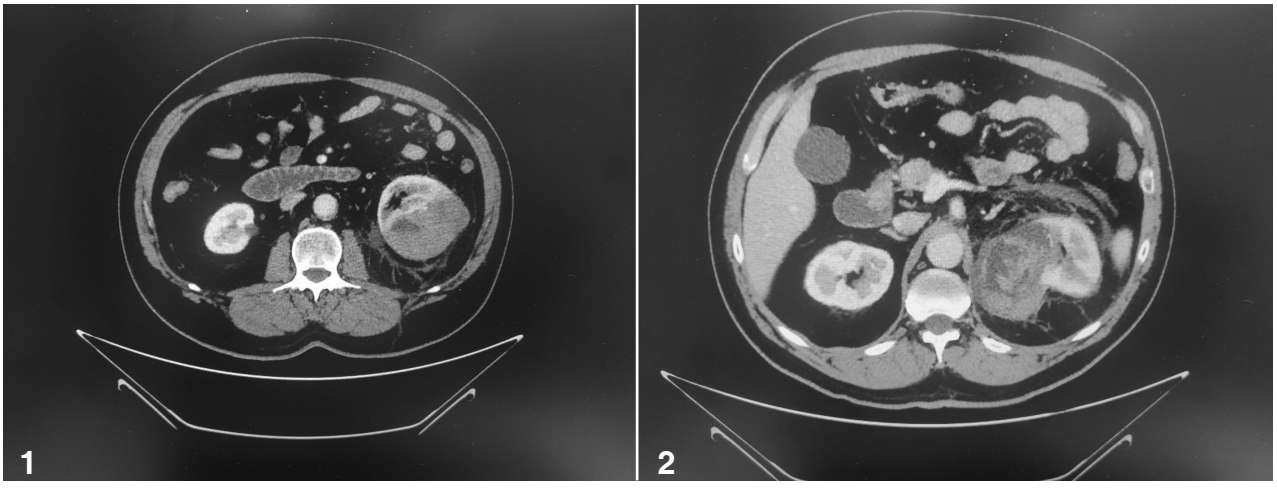
CLINICAL CASE

A 57-year-old male patient with a history of hypertension treated with ARA II, dyslipidemia treated with statins, recurrent renal colic, and aortic valvular heart disease associated with ascending thoracic aortic aneurysm, undergoing valve replacement with bioprosthesis and anticoagulant treatment with acenocoumarol. He came to the emergency room with lumbar pain radiating to the left iliac fossa after hours of evolution. She denies dysuria or other urination symptoms. She has no fever. She has taken naproxen but with no improvement.

On arrival at the Emergency Room, the patient was conscious, oriented in the three spheres, hemodynamically stable (BP: 155/100 mm Hg; HR: 62 bpm), eupneic on room air (SpO_2: 98%), and afebrile (temperature: 36.2 °C). Physical examination showed negative bilateral lumbar fist-percussion and soft abdomen, depressible, not painful on palpation, without masses or megaliths or signs of peritoneal irritation.

He was prescribed metamizole 2 g, paracetamol 1 g, pantoprazole 40 mg, and ondansetron 4 mg intravenous (IV). When the pain persisted, we prescribed morphine 3 mg/mL and tamsulosin 0.4 mg.

Blood tests showed Hb 15 g/dL, 11,400 leukocytes, INR 2.7, Cr 1.42 mg/dL, FG 54 (FG November 2021:88), CRP 0.5 mg/L, Lac 2.4 mmol/L. Venous blood gas is in acid-base balance. Urine sediment results are negative, pending urine culture. Renovesical ultrasound shows a destructured left kidney. Given the persistence of the pain and ultrasound alteration, urological computed tomography with contrast was requested, which showed a deformed left kidney with a spontaneously dense perirenal biconvex collection of approximately 10 × 7 cm; it had an eccentric focus of greater density, suspicious of vascular extravasation



Figures 1 and 2. Urological computed tomography, axial view. The image shows the left kidney deformed by a spontaneously dense perirenal collection, which presents an eccentric focus of increased density, suspicious of vascular extravasation of contrast suggestive of perirenal hematoma with suspicious signs of active hemorrhage. In the superior pole there is a 6 cm heterogeneous hypodense lesion also suggestive of hemorrhage.

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of contrast suggestive of left perirenal hematoma with suspicious signs of active hemorrhage. At the superior pole, there was a 6 cm heterogeneous hypodense lesion, also suggesting a hemorrhage.

We reversed anticoagulation with prothrombin complex (octaplex). The patient was transferred to a referral center for embolization. The procedure was performed without complications.

We define a spontaneous intra-abdominal hemorrhage as that which is not caused by trauma and which can be classified, according to the organ of origin, as hepatic, splenic, pancreatic, adrenal, renal, gynecological-obstetric, vascular, and soft tissue (peritoneal and muscular).

Renal hemorrhages are usually secondary mainly to renal tumors, such as renal cell carcinoma (RCC) and angiomyolipoma (AML). Less frequently, there are perirenal or subcapsular hematomas associated with vasculitis or, as in this case, with coagulopathies[1].

To diagnose and identify the origin of the bleeding, additional imaging tests are required. Computed tomography (CT) is the test of choice for detecting bleeding in the abdominal cavity. Ultrasound can be used as the initial study method as it detects free abdominal fluid (which may be hypoechogenic or appear as a heterogeneous collection, with hyperechogenic areas surrounding solid viscera or intestinal loops) and is minimally invasive and very accessible.

Magnetic resonance imaging (MRI) is sensitive for detecting blood in its different stages, but its use remains limited by its lower availability and higher cost[2].

What is interesting about this case is the importance of rapidly identifying, through clinical and imaging tests, a severe pathology. Given the clinical context, for this patient on anticoagulant therapy with a life-threatening hemorrhage, the immediacy of treatment prevented dire consequences for him.

The present study was undertaken under the modified Declaration of Helsinki' guidelines.

Conflict of interest: the author declares no conflict of interest.

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