

DISCUSSION

Spontaneous subcapsular of perinephric hemaotma in the absence of anticoagulation, arteritis or trauma is most likely to be due to an underlying tumour¹. Adenocarcinoma can present as acute abdomen due to subcapsular renal hematoma². Regarding etiology Brkovic etal studied 18 patients and found that SPH was secondary to angimyolipoma (n-4), poly arteritis nodosa (n-3) Polycystic kidneys (n-4) renal cell carcinoma (n-2) glomerulo nephritis, pyelonephritis and cortical adenoma (N-1 each). Hemorrhage was identified by Ultrasound in 56% and CT in all cases. The most common etiology of SPH was benign or malignant neoplasms, 61% being angiomylipoma predominantly, followed closely by renal cell carcinoma. Vascular disease was the next most common cause and poly arteritis nodosa was found to be the other less common cause⁴. CT is the most valuable investigation to detect SPH⁵. Morgentaler A etal suggested that patients with clinical evidence of SPH should be evaluated by CT with arteriography added whenever the underlying cause remains uncertain⁶.

Kendall etal proposed Radical Nephrectomy as treatment of such conditions where there is no apparent etiology and the contra lateral kidney is normal followed by careful pathological examination because of the high incidence of small renal tumors (1) Morgentaler etal. Proposed nephrectomy only in patients with non fatty lesions with hematoma. All other patients were followed by serial CT scan Bosniak etal claimed that operative exploration is not necessary in most cases with unexplained etiology because of the diagnostic

accuracy of CT scan. If the etiology cannot be determined at the primary examination follow up CT should be performed at 3 months intervals until the hematoma resolves and a definite diagnosis is possible.

In our patient hypertension was the only causative factor as malignancy, infection and vasculopathy were ruled out.

CONCLUSION

Spontaneous sub capsular hematoma can be caused by many causes. The cause may not be evident in many cases. In our case hypertension might have been the cause.

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Idopathic Renal Vein Thrombosis – A Case Report.

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Abstract : We report a case of 45 year old lady presenting with left loin pain . She was on oral contraceptives. On evaluation she was found to have left renal vein thrombosis on Colour Doppler Ultra sonography confirmed with contrast CT scan . She was on initial heparin followed with oral anticoagulant. Left renal vein flow reestablished on 3 months follow up.

INTRODUCTION

Renal vein thrombosis is a rare pathology, difficult to diagnose. It has varied clinical manifestations. The diagnosis is based upon radiologic investigations. Detection of this condition may lead to restoration of renal function compromised by renal vein thrombosis. The treatment of renal vein thrombosis is mainly medical and based on anticoagulants. Surgery is exceptional. We report one case of idiopathic thrombosis of the renal vein in an adult patient.

CASE REPORT

A 45 year old lady presented with history of left sided abdominal pain of 1 week duration . She was on oral contraceptives . There was no history of trauma , severe dehydration. Physical examination was unremarkable . Laboratory examination showed normal values for blood count , renal function and coagulation profile . Urine microscopy revealed numerous RBC's , Colour Doppler Ultrasonography showed left renal thrombosis . Right renal vein and both side renal arteries were normal . Both kidneys were normal in size , shape and position. Contrast CT scan confirmed above findings (Fig). No other pathology was detected in the abdomen . Chest Xray was normal . She was treated initially with heparin followed with oral anti coagulant warfarin . On follow up doppler ultraconography at 3 months left renal vein flow was reestablished .

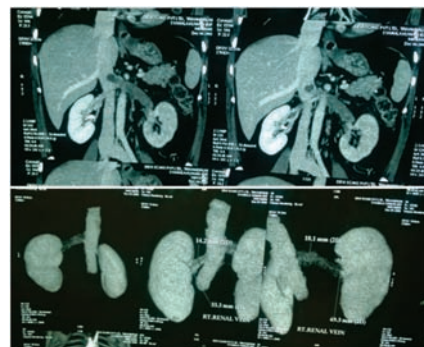


Figure: Contrast CT scan confirmed kidneys were normal in size, shape and position.

DISCUSSION

Thrombosis of the renal vein in adult patients is a rare entity, commonly associated to tumoural masses or hyper coagulability states. Renal veins rarely thrombose. Acute RVT is usually due to trauma, severe dehydration (or) generalized hypercoagulable state, multiple myeloma, kidneys cancer. Typically presents with symptoms of renal infarction including flank pain, microscopic (or) gross hematuria, a marked elevation in serum LDH and on increase in renal size on radio graphic study . Bilateral RVT may present with acute renal failure. Factors reported to be associated with RVT in

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