Bilateral Idiopathic Spontaneous Renal Hematoma about a New Observation and Literature Review

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Citation: Cyrille VC, Edmond GE, Pacome GGA, Félicité KN, Rommel GJJ, et al. (2021) Bilateral Idiopathic Spontaneous Renal Hematoma about a New Observation and Literature Review. J Urol Ren Dis 06: 1232. DOI: 10.29011/2575-7903.001232

Received Date: 15 August, 2021; Accepted Date: 24 August, 2021; Published Date: 27 August, 2021

Abstract

This is a 63-year-old female patient diagnosed with spontaneous bilateral idiopathic renal hematoma. She presented clinical signs of lower back pain and anemia. The diagnosis was confirmed by ultrasound, CT scan and renal CT angiography. Management consisted of transfusion and monitoring with surgical abstention.

Introduction

Spontaneous Renal Hematoma (SRH) is a renal subcapsular or peri-renal hematoma that was described in first by Wunderlich in 1856 [1]. This affection is rarely observed [2-4]. It is most often unilateral, bilaterality is even more uncommon [5-8]. SRH is a clinical entity that poses a real diagnostic and therapeutic challenge [9]. The aim of our study is to talk about the diagnostic and therapeutic aspect of SRH.

Case

It about Mrs. A.L., a 63-year-old housewife who was transferred to the urology department of Cocody University Hospital on 02/27/2017 for bilateral renal hematoma. This is a patient who presented 2 weeks before a lower back pain without notion of trauma, discomfort, and confusion. The ultrasound performed revealed a bilateral renal hematoma (Figure 1).

Figure 1: Bilateral renal hematoma on ultrasound A: left renal hematoma B: right renal hematoma.
An abdomino-pelvic scan performed confirmed the presence of bilateral renal hematoma more marked on the right kidney. No tumor lesions were found on either kidney (Figure 2).

The biological assessment found a hemoglobin (hb) level of 7.3g / dl, serum creatinine at 12mg / l, a blood urea level at 0.35g / l, blood sugar was 2.4 g/l and the blood crust was normal. We therefore concluded that there was an idiopathic bilateral spontaneous renal hematoma. The treatment was surgical abstention with monitoring, a blood transfusion of 383ml of concentrate erythrocyte, insulin therapy, and an analgesic. Considered the favourable outcome (disappearance of back pain, hb = 9.1g / dl, BP = 120/80 mm / hg), the patient was discharged on 03/13/2017 with a control scanner to be performed in 3 months. The CT scan was not performed because the patient refuses to do any further exams.

**Discussion**

The most common clinical manifestation of SRH is lower back pain [2,3,10,11]. This lower back pain was observed in our patient. It’s pain that is nonspecific and can lead to a delay in diagnosis when the pain is not severe [2]. A lumbar mass can also be observed as described by Rapp et al [12]; hypovolemic shock manifestation when the bleeding is important [2]. Para clinical diagnosis can be made with ultrasound [10,12]. It can also be done with computed tomography which also makes it possible the etiological diagnosis [10,13]. MRI can also make the etiological diagnosis [14]. Renal angiography shows the source of bleeding in case of vascular injury which will allow embolization. Embolization is performed when the patient is hemodynamically stable [4,12]. Ultrasound, computed tomography and renal CT angiography were performed on our patient without being able to find an etiology. The etiologies of SRH are dominated by malignant kidney tumors [10,14-18]. Benign tumors have also been observed such as angiomyolipoma and renal adenoma [3,15,19,20]. It can be iatrogenic, in hemodialysis patients [21,22]; patients on anticoagulants such as aspirin or low molecular weight heparin [13,23]. Other conditions such as periarteritis nodosa, amyloidosis or lupus can also lead to SRH [2,5,24]. As observed in our patient, SRH can be idiopathic [25]. Treatment consists of performing an enlarged total nephrectomy in the case of a malignant tumor [3,20]; partial nephrectomy when possible, for benign kidney tumors [3]. Embolization can also be performed [4,12] Abstention can be observed when the etiology is idiopathic and especially when the patient is hemodynamically stable [12,25,26]. That was the attitude we observed in our patient. In this case, ultrasound monitoring is necessary [7].

**Conclusion**

SRH is a rare condition that poses a diagnostic challenge due to the non-specific symptomatic and a therapeutic challenge especially when it is bilateral. Diagnosis can be made with an ultrasound or a CT scan. MRI, computed tomography and renal CT angiography allow the aetiological diagnosis to be made. Treatment consists of performing a total or partial nephrectomy,
but surgical abstention is required in cases of idiopathic SRH with hemodynamic stability or in cases of bilaterality.

References