

Fistulisation of a Forgotten Non-Opaque Internal Ureteral Stent From the Lumbar Area After Replacement of Another Ureteral Stent

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Internal ureteral stents are indispensable part of the modern urology. Despite improvements in the ureteral stents some complications are still encountered and the widely usage of them increased the complications especially when selected improperly (1,2). We present a case who demonstrated how serious problems could be concerned when unsuitable internal ureteral catheter was used.

CASE REPORT

A 14 year old boy presented with the history of painful micturation and backpain to our clinic in December 1989. He had undergone left ureteroneocystostomy with the diagnosis of right renal agenesis and left hydroureteronephrosis due to vesicoureteral stricture in other hospital 3 years ago

Physical examination revealed well developed boy with an old phannenstiell incision scar and left costo vertebral tenderness. IVP showed very progressed left hydroureteronephrosis and no function on the right side. Renal scintigraphy revealed right renal agenesis and delayed left renal function. There was no reflux in voiding cystourethrogram.

We performed ureteroneocystostomy in politano-Leadbetter technique and placed double j stent to the left ureter for drainage. He was discharged on the 11th postoperative day in a well situation.

We hospitalized him again with high fever. Costo-vertebral pain and pyuria after 3 days from discharge. The double-j catheter was in its proper place on the control X-ray graphy. We began parenteral antibiotic treatment. His complaints decreased but didn't resolve completely. We discharged him 7 days later and continued peroral antibiotic treatment. He had several fever attacks during follow-up. A soft 20-25cm long catheter fistulised from his left posterior lumbar area (Figure 1,2) on the 20th postoperative day partially and the patient himself pulled it out. Then, he relieved from all

his complaints surprisingly. Unfortunately, he didn't keep the catheter. An X-ray graphy showed the proper placement of double-j stent we placed which was removed ondoscopically 2 months later postoperatively.

DISCUSSION

Double-j stents have been advocated for drainage or splintage of the ureter. The daily use of ureteral stents has increased enourmously in modern urology. This widely usage of double-j stents in the practise of modern urology has also increased the complications (3). Main complications are migration, reflux, infection, erosion and encrustation, pain and bleeding (4). In addition, we encountered a perforation of the kidney (or collecting system) by a silicone double-j stent that caused recurrent urinary infections in a 32 year old man who underwent baioon dilatation for left vesicoureteral stricture due to previous ureteroneocystostomy (Figure 3). in our report, it was very interesting that the ureteral stent moved through kidney or collecting system and left the body from lumbar area. Since no stent is ideal, it is incumbent on the surgeon to be familiar

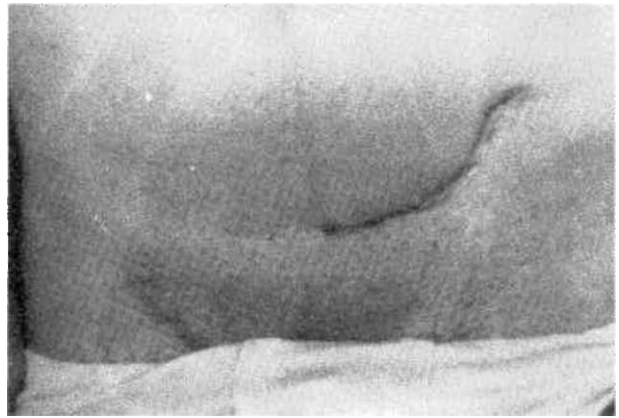


Figure 1. Gibson incision of the second operation

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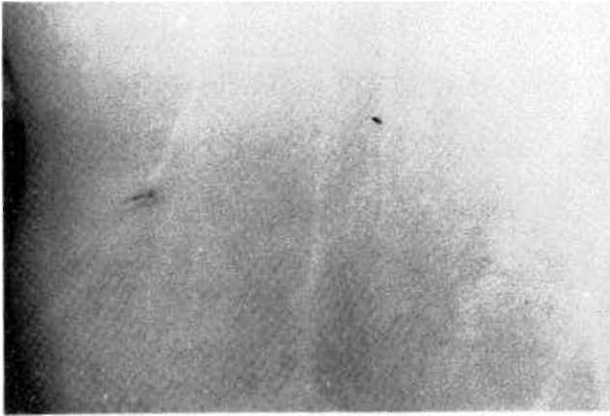


Figure 2. Fistulisation hole in the left posterior lumbar area where the first placed ureteral stent left the body

with the various indications for usage, modes of insertion and potential for complications. The surgeon has to select a stent best suited for problem presented by the patients (2.4).

The internal ureteral stent inserted during the first operation was soft, straight and nonopaque in this case. Since the stent was overlooked and not noticed, it should have been pushed upwards during the insertion of double-j in the second operation. After septic pyelonephritis attacks, previously placed stent left the body from lumbar area passing through upper urinary tract. Since the patient had a solitary kidney, it could had been life threatening for him. Furthermore, another exploration should had been necessary if the stent hadn't left the body.

Double-j ureteral stents are indispensable part of modern urology. The surgeon should be familiar with the indications, types of stents and inherent risks at



Figure 3. Silicone double-j ureteral catheter caused perforation in the kidney or upper urinary tract

ached to the use of indwelling ureteral stents and must be experienced to select a stent best suited benefits at the time placement is considered.

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