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Case report / Olgu sunumu

A CASE OF RENAL TUMOR MIMICKING AN INCARCERATED ABDOMINAL HERNIA

İnkarsere abdominal herni ile karışan renal tümör olgusu

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ABSTRACT

Abdominal wall hernias constitute a group of diseases whose treatment is surgery and sometimes surprise the surgeon with unexpected contents of hernia sac. Many times, tumors become a part of this surprise by mimicking with non-incarcerated or incarcerated hernia. We have presented a case which was reported as incarcerated hernia with abdominal ultrasonography but understood that renal tumor was protruded from the anterior abdominal wall during surgery, due to it was the first case according to our research in the literature.

Key words: Renal, tumor, and incarcerated abdominal hernia.

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ÖZET

Karın duvarı fıtıkları tedavisi cerrahi olan bir hastalık grubunu oluşturmaktadır ve bazen beklenmedik fıtık kesesi içeriği ile cerrahlara sürpriz yapmaktadırlar. Birçok kez tümörler de inkarsere ya da inkarsere olmayan hernilerle karışarak bu sürprizin bir parçası olmaktadırlar. Biz de literatürde yaptığımız araştırma sonucunda bir ilk olması nedeniyle ultrasonografi ile inkarsere abdominal herni olarak rapor edilen ancak operasyon sırasında renal tümörün batın ön duvarından protrüde olduğu anlaşılan olguyu sunduk.

Anahtar kelimeler: Böbrek, tümör ve inkarsere abdominal herni.

INTRODUCTION

In the light of our current knowledge, a case of tumor mimicked with incarcerated and non-incarcerate hernias was not present so far in the literature (1). However, a case of renal tumor confusing with incarcerated abdominal hernia has not been presented before in the literature. We have presented a case which was reported as incarcerated hernia with abdominal ultrasonography but understood that renal tumor was protruded from the anterior abdominal wall during surgery, due to it was the first case according to our research in the literature (2).

Case

Fifty-four-year-old female patient had undergone right partial nephrectomy due to urolithiasis 6 years ago. Three months ago, she was diagnosed as Chronic Renal Failure (CRF) by the doctor that she applied due to the complaints of debility and fatigue. The patient was admitted to the emergency department of our hospital with the same complaints with the addition of shortness of breath. The laboratory examinations were WBC: 35 004 10*3 /mL, Htc: 15.3%, platelets: 96000 10*3 /mL, albumin: 1.9 g/dL, BUN: 183 mg/dL creatinine: 7.08 mg/dL K: 4, 6 mEq/L and the patient has been internalized to the internal medicine clinic for hemodialysis with the diagnosis of acute renal failure on chronic renal failure and with the indication of dialysis due to the infiltrates seen in posterioanterior lung radiography which were compatible with uremic lung. The patient, who has chronic renal failure and hypothyroidism in the medical history, never underwent dialisis and were using 100 mcg Levothyroxine tb. In the medical history, the patient was with a 30 pack-year

history of smoking but quitted smoking 2.5 years ago and lost 40 kg of body weigh within 6 months. The patient was evaluated due to the bowel loops herniated from the fascial defect and 120x80 mm in size were seen in the left upper midline with abdominal ultrasonography performed due to swelling and pain in the left upper quadrant of the abdomen and were interpreted in accordance with the incarcerated hernia and the consultation was requested by us. On the examination, swelling, which was about 15 cm and painful with palpation and was starting from the anterior axillary line and showing extention towars the abdominal midline in the left subcostal region at the front abdominal wall, was seen. The patient was admitted to our clinic to be operated with the diagnosis of incarcerated hernia. On the exploration performed perioperatively, it was seen that the swelling at the front abdominal wall was not hernia and was a left kidney sourced tumoral mass (Figure 1 and 2) and left nephrectomy was performed by asking perioperative consultation by the urology clinic.

Clinical follow-up;

The patient was transferred to intensive care unit on the lack of adequate postoperative oxygen saturation. The drain was removed on the 5th postoperative day and the patient was transferred to the urology clinic. During follow-up in urology clinic, the patient entered dialysis for 2 times. The patient was transferred to the nephrology clinic on the 11th postoperative day. In this process, the pathology result was interpreted as high grade invasive urothelial carcinoma and carcinoma metastases in one lymph node (Figure 3, 4 and 5). The wound infection developed on the 25th postoperative day and the patient was transfered from the nephrology unit. Enterococcus spp produced in the swab sample sent from the wound site. The antibiotherapy was organized as Piperacillin-tazobactam 4.5 gr 2x1 by the infectious diseases clinic. Regular wound debridement and wound dressing were performed and the patient was discharged on the 43th postoperative day and was referred to the oncology clinic for the oncological treatment.

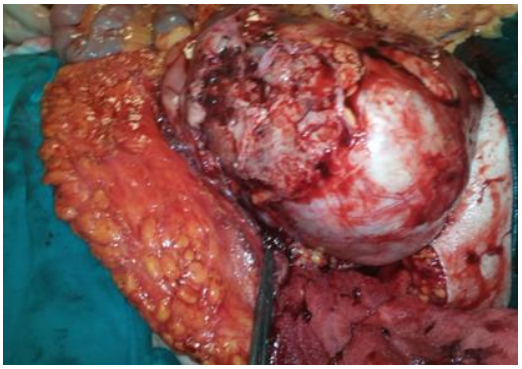

Figure 1: Renal tumor in hernia sac

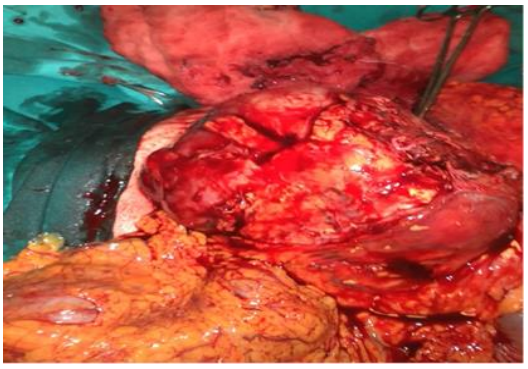

Figure 2: Renal tumor in hernia sac

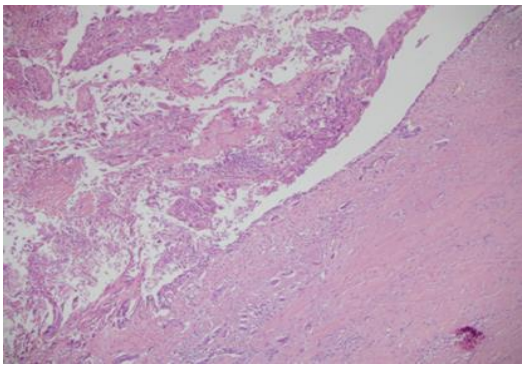

Figure 3: Transition zone of the tumor with normal mucosa of the renal pelvis

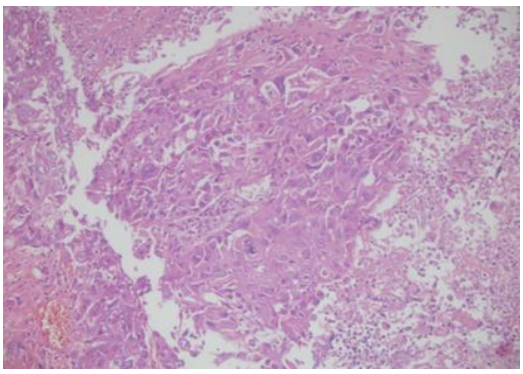

Figure 4: High Grade / Sarkomoid features close view of the tumors

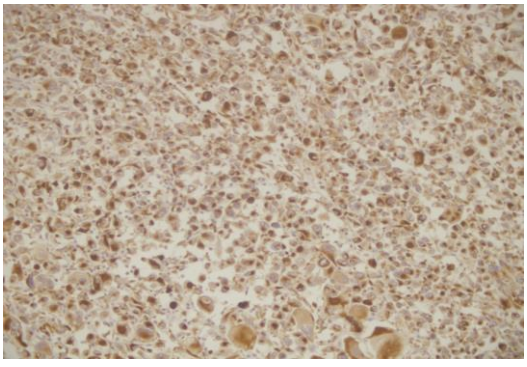

Figure 5: Immunohistochemical examination revealed diffuse strong positive staining of tumor cells with CK 7

DISCUSSION

Abdominal wall hernias constitute a group of diseases whose treatment is surgery and sometimes surprise the surgeon with unexpected contents of hernia sac. Many times, tumors become a part of this surprise by mimicking with non-incarcerated or incarcerated hernia. We did not come across a case of renal tumor mimicking with incarcerated abdominal hernia which was presented heretofore in the research we have done in the literature. This is also shows us that this case is the first case of renal tumor mimicking with abdominal hernia published in the literature. In most cases, ultrasonography is sufficient in the identification of hernias whether they are incarcerated or not. In our case, CT has not been performed due to emergency surgical intervention was made by considering incarcerated abdominal hernia according to the result of ultrasonography. However, ultrasonographic assessment has not been fully assist in the diagnosis due to some reasons such as facing with a situation which has not been seen before. This case is a condition that should be kept in mind by both the surgeons and the radiologists. At the same time, this case demonstrates to us that it is necessary that not to trust the diagnosis of incarcerated hernia only with ultrasound imaging and to make further investigations for correct diagnosis.

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